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TRACKING GLOBAL HIV/AIDS INITIATIVES AND THEIR IMPACT ON HEALTH SYSTEMS IN UKRAINE: CONTEXT REPORT

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January 2007
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Kyiv, January 2007
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFEW</td>
<td>AIDS Foundation East West</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organisation</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordination Mechanism</td>
</tr>
<tr>
<td>CGS</td>
<td>Coordinating Groups of Sites</td>
</tr>
<tr>
<td>FSWs</td>
<td>Female Sex Workers</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GHI</td>
<td>Global HIV/AIDS Initiatives</td>
</tr>
<tr>
<td>GHIN</td>
<td>Global HIV/AIDS Initiatives Network</td>
</tr>
<tr>
<td>GoU</td>
<td>Government of Ukraine</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund</td>
</tr>
<tr>
<td>GFATM</td>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HR</td>
<td>Harm Reduction</td>
</tr>
<tr>
<td>IDUs</td>
<td>Injection drug users</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MAP</td>
<td>Most at-risk population</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education and Science of Ukraine</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NASA</td>
<td>National AIDS Spending Assessment</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Accounts</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic infections</td>
</tr>
<tr>
<td>OSI</td>
<td>Open Society Institute</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>Presidents Emergency Plan for AIDS Relief (U.S.)</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
</tr>
<tr>
<td>ST</td>
<td>Substitution Therapy</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TPAA</td>
<td>Transatlantic Partners Against AIDS</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing on HIV</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint UN Programme of Fighting HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>The United States Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Executive Summary

- Ukraine lacks complete and reliable information on the HIV/AIDS epidemic. Official statistical data are complimented by research data and experts’ estimations, sometimes contradicting each other on trends of HIV/AIDS spread in the country. Hence it is difficult to evaluate the effects of the GFATM on patterns of HIV/AIDS.

- Nevertheless there is consensus that there has been a rapid increase in HIV prevalence nationally, on average rising 16% annually (since 1995). The prevalence of HIV has consistently exceeded 5% among various subpopulations: intravenous drug users, female sex workers and men who have sex with men. The most HIV-affected age groups in Ukraine are people aged 20-24 years (15.6% of all new cases in 2005), 25-29 years (21.8% of cases) and 30-39 years (28.8% of cases). Prisoners are also considered to be vulnerable to HIV/AIDS infection.

- Data suggest that there have been changes in patterns of HIV/AIDS transmission: between 1987 and 1994 heterosexual transmission was most prevalent; between 1995 and 1998 the dominant mode of transmission was through intravenous drug users sharing needles/syringes; between 1999 and 2005 the number of cases of heterosexual transmission increased, as well as the number of HIV-infected pregnant women and children born HIV+.

- In the early years of epidemic, the majority of HIV+ cases were found in the regions of Odesa and Mykolayiv. Currently the most affected areas are in the south and east of Ukraine: Mykolayiv, Donetsk, Odesa, Dnipropetrovsk oblasts and Crimea. Over two-thirds of all HIV cases have been reported to date in ten regions in southern and eastern Ukraine, although recent evidence points to rapid increases in other regions. Sharp increases in reported infections are now also occurring primarily among at risk populations of intravenous drug users, female sex workers and people with STIs in central and northern regions of Ukraine – regions previously thought to be significantly less affected by the epidemic.

- Ukraine has a comprehensive and in principle, progressive legislative base for tackling HIV/AIDS, compatible with international norms. Moreover, through the GFATM grant considerable financial resources are now available to tackle the disease.

- Community-based organisations of PLWHA supported by international donors and national epidemiologists and AIDS medical doctors are a key force in driving HIV/AIDS policy. However there is strong opposition to programmes supporting vulnerable groups due to widespread stigmatisation of these groups from many members of the general population.

- The national response to HIV/AIDS is, in practice, uncoordinated at both national and regional levels. Political factors inhibiting the development of more effective HIV/AIDS policy include lack of political leadership, limited financial resources, lack of coordination, the absence of a coherent HIV/AIDS strategy with identified priorities and clear targets, as well as inertia within a non-transparent bureaucratic state apparatus.

- The existence of numerous coordination bodies and structures lacking delineated lines of responsibility and accountability, overlapping mandates and poor governance has undermined efficient coordination of the respond to the HIV/AIDS epidemic. The creation of the National Coordinating Council (NCC) for the Prevention of HIV/AIDS Spread in 2005 tends to be seen as a positive development in improving levels of coordination.

- The NHA HIV/AIDS Sub-Account Analysis (2003-04) reveals that a small portion (13.5%) of HIV/AIDS expenditures are provided by state and local budgets. External donors including the GFATM provided 23.1% of resources; private/out-of-pocket household expenses accounted for the majority of expenditures (63.4%). In 2005 the bulk of funding was used for treatment and care (46%) and prevention programmes (45%). Current resources are inadequate: only around 33% of those in need of ART receive it. Coverage rates for prevention, care and support services are estimated to be between 10 and 15%.
There are two global HIV/AIDS initiatives currently implemented in Ukraine: the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) Round One grant managed by the International HIV/AIDS Alliance in Ukraine. The Round Six grant approved in November 2007 will be jointly managed by the International HIV/AIDS Alliance and the All-Ukrainian Network of PLWHA. A World Bank Loan to fight TB and HIV/AIDS managed by the Ministry of Health is currently suspended.

The GFATM Round One grant has supported a range of activities including: diagnostics and counselling, treatment and medical care, substitution therapy, social support, terminal care and prevention work among vulnerable groups. The bulk of the funding has been disbursed to six regions of Ukraine reflecting high levels of HIV/AIDS prevalence: Kyiv city and oblast, Odesa, Mykolayiv, Donetsk, Dnipropetrovsk and Crimea. However, all regions receive some GFATM funding. A significant share of the grant was spent on ARV treatment, testing systems and non-medical care for PLWHA. The preventive work with most at-risk groups is relatively modest in comparison. Some stakeholders are critical of this approach since they see prevention programmes among these groups as a key priority. Substitution therapy and palliative care are in the early stages of development.

Despite significant new interventions supported by the GFATM grant the number of newly registered HIV cases increases, as does AIDS mortality. The numbers infected through intravenous drug use decreased from 83.6% out of all cases in 1997 to 45.5% in 2005. However this form of transmission is still regarded as most prevalent.

The GFATM in Ukraine has made a dramatic impact on scaling-up services for different target groups, especially HIV testing, ART treatment and as well as improvement of access to these services. These initial research findings also suggest that the quality of services have been improved; important progress has been made in terms of the development of system capacity and sustainability of Ukrainian HIV-services.

Problems with the implementation of global health initiatives in Ukraine demonstrate the inability of the state system, in particular the Ministry of Health, to absorb funding and disburse it in effective and transparent way. The national health system is ill-equipped to address the growing needs for prevention, care and support services, including palliative care.
Introduction

In July 2006, the implementation of an international research project ‘Tracking Global HIV/AIDS Initiatives and their Impact on Health Systems: Ukraine’ started. The School of Public Health of the National University of “Kyiv-Mohyla Academy” in cooperation with School of Social Work launched the research project in partnership with the London School of Hygiene and Tropical Medicine and the Royal College of Surgeons in Ireland. The Open Society Institute (OSI) financed the study in Ukraine, together with comparable studies in Kyrgyzstan and Zambia. A summary of the Ukrainian study stages and key research questions is included in Attachment 1 of this report.

Similar research is being conducted in other countries financed by a number of international donor organisations. In total researchers from 21 countries form a research Network – the Global HIV/AIDS Initiatives Network (GHIN: http://www.ghin.lshtm.ac.uk). The aims of GHIN include coordinating technical support among the country studies and facilitating the dissemination of research outputs to global policymakers about the effects of global HIV/AIDS initiatives.

Between July and October 2006 the first stage of this research was carried out in Ukraine. The aim of this stage was to conduct a situational analysis and prepare a context report describing the current situation in Ukraine related to HIV/AIDS policy and the activities of the global HIV/AIDS initiatives.

During the preparatory stage, activities included research team building and establishing effective dialogue with national stakeholders. This involved briefing key stakeholders about the research and its objectives including: ministries and government departments, state structures, the mass media and HIV-service organisations including the Ukrainian HIV/AIDS Centre, the All-Ukrainian Network of PLWHA, the World Bank in Ukraine, Belarus and Moldova, the WHO, the Coalition of HIV-Service NGOs in Ukraine, the State Social Service for Youth, UNAIDS Ukraine, and the Principal Recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) the ‘International HIV/AIDS Alliance in Ukraine’. During the course of the study these organisations will be approached regularly to gather research data. It is also anticipated they will have a strong interest in research outputs. A number of agencies have also been approached to form a study Advisory Group.

A semi-structured interview guide (Attachment 2) was developed to elicit national stakeholders’ views. The guide was aimed to a number of key issues: the influence of international aid on the HIV/AIDS epidemic in Ukraine; the consequences of international aid for state for marginalized groups, their access to medical and social services, and role of these groups in political processes; priorities of international aid in accordance with Ukrainian needs; the role of governmental and non-governmental organisations in the implementation of HIV/AIDS programmes; the role of state bodies on the coordination of international help; the integration of global initiatives in the national system of medical and social services. Direct quotes from interviews are included in this report to illustrate their perspectives on key issues.

Secondary data and document analyses were also conducted. This involved analysing official state documents, statistical information, research outputs, documents on the Ukrainian application for a GFATM grant, together with relevant documents prepared by different governmental and non-governmental organisations. The preparation of this context report is intended to inform further development of the research methodology, the selection of regions for detailed sub-national study and for the formulation of detailed research questions to be addressed as part of the study.

The first stage of the research revealed a number of challenges particularly relating to the analysis or documents and secondary data sets. For example, whilst data regarding health care system functioning are available at the national level, detailed information on the situation in different regions is not publicly accessible through national level data sources, as well as full, coherent and consolidated information of HIV/AIDS epidemic in Ukraine. Moreover from the beginning it was planned to organise field research at rayon/district level. During the first stage of the study it was apparent that GFATM-supported projects operate mostly at the oblast/region (not rayon) level, as do many NGOs and advocacy groups. The task to provide
detailed rayon-level information regarding marginalized groups was also challenging and in many cases data
generally in the form of expert estimations) are available only at national or oblast levels.

The research team express acknowledgement to representatives of Ukrainian and international organisations
who agreed to share data used in this study, and for their participation in Advisory Group meetings, and
providing feedback and recommendations during the early stages of the project, in particular to: the All-
Ukrainian Charitable Fund ‘Coalition of HIV-service organisations’, the UK Department for International
Development (DFID), the International Alliance of HIV/AIDS in Ukraine, the Ukrainian Centre for AIDS-
prevention and AIDS-fighting, the charitable fund the ‘All-Ukrainian Network of PLWH’, UNAIDS in Ukraine,
Substance Abuse and AIDS Prevention Foundation, TPAA (Transatlantic Partners Against AIDS), the State
Social Service for family, children and youth and the ‘All-Ukrainian Harm Reduction Association’.

Kyiv, January 2007
Section 1
The HIV/AIDS Epidemic in Ukraine: Status and Trends

1.1. Data on HIV/AIDS spread in Ukraine

1.1.1. HIV/AIDS data gathering and interpretation in Ukraine

The current system of epidemiological surveillance of HIV/AIDS in Ukraine consists of two components: routine epidemiological surveillance and sentinel surveillance surveys. There are also results of different behavioural studies and expert estimations of HIV/AIDS prevalence.

Routine epidemiological surveillance is institutionalised within the Ministry of Health, and is strictly regulated. Surveillance is implemented by the network of regional AIDS centres and regional sanitary surveillance departments, as well as by authorized departments in specific sectors, such as the Penitentiary Department. Most surveillance is does little to encourage those most at-risk to come forward to be tested for HIV.

Thus, in spite of the scale of epidemiological surveillance for HIV/AIDS in Ukraine, it is widely accepted that official statistical data underestimate the scale of the HIV/AIDS epidemic. According to the most recent National Consensus Estimates on HIV/AIDS [1]:

‘the official data only provides information about persons who have been tested, diagnosed with HIV and included into the official national registry of HIV cases’

The report suggests that much testing at AIDS centres is anonymous, and that registration is voluntary even for HIV+ cases. Indeed, since 2001, according to current legislation, testing for HIV/AIDS is voluntary and anonymous for all groups of population, as well as registration of the HIV+ cases. However, not all positive cases know their status, or would necessarily be included in official figures.

Sentinel surveillance is used to assess the extent to which different at-risk populations are infected. Started in Ukraine in 1999, sentinel surveillance is now conducted in 13 cities to determine HIV prevalence among different groups of injecting drug users (IDUs), female sex workers (FSWs) and STI patients. This research is coordinated by the Ukrainian AIDS Centre in collaboration with regional AIDS centres and is funded by the GFATM. However, the results are rarely used to inform programmatic planning despite the fact that sentinel surveillance reports show that prevalence levels among IDUs and FSWs in certain cities of Ukraine have reached unprecedented levels. Few, if any changes have been made to prevention programmes to reflect these findings.

A number of recent behavioural studies on the Ukrainian HIV/AIDS epidemic have been conducted. These were supported mostly by the International HIV/AIDS Alliance in Ukraine as part of the GFATM programme. Study results provide valuable additional information on most-at-risk population and changes in their behaviour although are not always consistent with other studies/surveillance data*. It is therefore important to stress that accurate, complete data on HIV in Ukraine are unavailable: there is a wide discrepancy between registered official numbers of HIV cases and estimated figures, with no consensus on the ‘actual’ total.

* Reports are accessible on the website of the International HIV/AIDS Alliance in Ukraine – http://www.aidsalliance.org.ua
1.1.2. HIV surveillance data

From early 1991 when the HIV/AIDS epidemic was officially recognized in Ukraine, there has been a rapid increase in HIV prevalence nationally, on average rising 16% annually (since 1995). 8,761 new incidents of HIV infection were officially registered in 2002. Annually new incidents have increased since then (see Table 1.1).

Table 1.1. Reported HIV/AIDS Cases in Ukraine from 1987 to end-June 2006 *

<table>
<thead>
<tr>
<th>Year Reported</th>
<th>Annually reported N of new cases of HIV</th>
<th>Cumulative N of reported cases of HIV</th>
<th>Including N of HIV cases related to injecting drug use</th>
<th>Including N of HIV cases related to heterosexual transmission</th>
<th>Cumulative N of reported AIDS cases</th>
<th>Cumulative N of reported AIDS deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987-1994</td>
<td>398</td>
<td>398</td>
<td>3</td>
<td>121</td>
<td>37</td>
<td>18</td>
</tr>
<tr>
<td>1995</td>
<td>1,499</td>
<td>1,897</td>
<td>1,021</td>
<td>312</td>
<td>82</td>
<td>20</td>
</tr>
<tr>
<td>1996</td>
<td>5,422</td>
<td>7,319</td>
<td>4,360</td>
<td>709</td>
<td>228</td>
<td>70</td>
</tr>
<tr>
<td>1997</td>
<td>8,934</td>
<td>16,253</td>
<td>7,448</td>
<td>1,007</td>
<td>421</td>
<td>85</td>
</tr>
<tr>
<td>1998</td>
<td>8,590</td>
<td>24,843</td>
<td>6,516</td>
<td>1,385</td>
<td>820</td>
<td>150</td>
</tr>
<tr>
<td>1999</td>
<td>5,830</td>
<td>30,673</td>
<td>3,771</td>
<td>1,323</td>
<td>1,406</td>
<td>253</td>
</tr>
<tr>
<td>2000</td>
<td>6,216</td>
<td>36,889</td>
<td>3,881</td>
<td>1,427</td>
<td>2,054</td>
<td>415</td>
</tr>
<tr>
<td>2001</td>
<td>7,009</td>
<td>43,898</td>
<td>3,964</td>
<td>1,885</td>
<td>2,922</td>
<td>474</td>
</tr>
<tr>
<td>2002</td>
<td>8,761</td>
<td>52,659</td>
<td>45,487</td>
<td>2,499</td>
<td>4,278</td>
<td>837</td>
</tr>
<tr>
<td>2003</td>
<td>10,013</td>
<td>62,672</td>
<td>4,815</td>
<td>3,043</td>
<td>6,194</td>
<td>1,285</td>
</tr>
<tr>
<td>2004</td>
<td>12,494</td>
<td>75,166</td>
<td>5,778</td>
<td>4,041</td>
<td>8,939</td>
<td>1,775</td>
</tr>
<tr>
<td>2005</td>
<td>13,786</td>
<td>88,952</td>
<td>6,282</td>
<td>4,586</td>
<td>13,159</td>
<td>2,188</td>
</tr>
<tr>
<td>1st half of 2006</td>
<td>8,058</td>
<td>97,010</td>
<td>3,649</td>
<td>2,840</td>
<td>15,552</td>
<td>2,236</td>
</tr>
</tbody>
</table>

* These data include all reported cases of HIV/AIDS in Ukraine up to mid-2006, including persons who have died or been lost to follow-up. Source: Ministry of Health of Ukraine, 2006.

Although prevention programmes have been greatly enhanced by the current GFATM Round 1 Grant to Ukraine, a record 8,058 new cases of HIV were reported in the first six months of 2006. This represents an increase of 21% from the same period in the previous year, and is almost 2.5 times higher than the number of cases identified during the same period in 2000. Even these figures understate the actual size of the epidemic significantly, as they include only infections diagnosed among citizens of Ukraine who have been in direct contact with official testing facilities and people who were confirmed as HIV+.

As of the end of June 2006, 67,974 people were diagnosed as living with HIV and were under clinical observation in the network of regional AIDS centres throughout the country. However, only a small portion of PLWHA in Ukraine know their HIV status. Based on the current estimates of the number of infections, fewer than one in six people in Ukraine living with HIV have been tested and are aware that they are infected (2).

These figures are estimates based on research data, routine surveillance data and expert estimations on the HIV/AIDS epidemic. The expert estimations are detailed in Attachment 3. Based on this study it is believed that there may be 377,600 people living with HIV as of the end of 2005. These estimates include 344,000 people living with HIV aged 15-49, or an estimated adult prevalence of 1.46%. Despite the high prevalence, the epidemic in Ukraine is still classified as concentrated. The prevalence of HIV has consistently exceeded 5% among various subpopulations: IDUs, FSWs, and MSM. Less than 1% of pregnant women living in urban
areas are infected although by mid-2006, HIV prevalence among pregnant women in five of the most affected regions of Ukraine had exceeded 0.81% (3), indicating that Ukraine is rapidly approaching a generalized epidemic.

1.1.3. Patterns of HIV/AIDS transmission

Data generated by the Ukrainian AIDS Centre demonstrate changes in patterns of HIV/AIDS transmission:

- 1987–1994: heterosexual transmission was most prevalent;
- 1995–1998: the dominant mode of transmission was through opiate IDUs sharing needles/syringes;
- 1999–2005: the number of cases of heterosexual transmission increased, as well as number of HIV-infected pregnant women and children born with HIV (4).

Among the former Soviet Union countries Ukraine most vividly illustrates the speed with which the epidemic is moving beyond populations most at-risk into the general population. Among newly reported cases in 2006, those infected through injecting drug use remained the largest group, accounting for 45.3% of the total number of cases. Heterosexual transmission accounted for 35.4%, and children born with HIV accounted for 16.4%. The mode of transmission was undetermined among 228 newly reported cases (2.8% of all reported cases). The proportion of those infected through sexual transmission (typically heterosexual transmission) has increased from 14% of new cases (1999-2003) to over 35% (January-June 2006). Such patterns are most evident in Donetsk, Dnipropetrovsk and Odesa oblasts and Crimea.

Research (5-11) highlights that against a high rate of other sexually-transmitted infections, e.g. syphilis and genital herpes, the HIV/AIDS epidemic is expanding rapidly in Ukraine, with injecting drug use the driving force. This conclusion demonstrated in earlier (12-13) and more recent local research (14-16), despite growing rates of heterosexual and mother-to-child transmission (17), which at first sight could be interpreted as indicative of an epidemic becoming generalized. Through more detailed epidemiological data analysis, research (18) shows that it may be caused by the changes in testing practices, e.g. testing fewer IDUs and more pregnant women, in addition to the observation that the majority of those cases were female sexual partners of current or ex-IDUs, or with a history of injecting drugs themselves.

There is considerable disagreement among commentators about the state of the epidemic. For example, Grund, Botschikova et al. (2003) (19), research done for an UNGASS Report on Ukraine (20), and official HIV/AIDS statistical data point to a sharp increase in the number of PLWHAs in the country. Conversely Mavrov and Bondarenko (2002) (21) argue that the HIV/AIDS epidemic is becoming stable after a sharp increase in 1997.

1.1.4. Gender and age dispersion

By the end of 2005, the male to female ratio of new cases of HIV was 1.3:1. 79% of IDUs with HIV were male, whereas the majority of reported cases of HIV through heterosexual transmission were females (66%). Among males reporting HIV through heterosexual transmission, the highest proportion is in the age group 30-39 years (35.5%). Among females with the same risk factor, the most were in the age range 20-29 (58.2%).

Among the 8,058 newly reported cases in 2006 nationally, 3,344 cases (41.5%) were women, most of them in their peak reproductive years. As a result, the number of children born to HIV+ mothers continues to rise, reaching a record of 1,320 in the first half of 2006.

The most HIV-affected age groups in Ukraine are 20-24 years (15.6% of all new cases in 2005), 25-29 years (21.8%) and 30-39 years (28.8%). Among IDUs, the largest proportion of reported HIV cases is among men and women in the age group 30-39 (41.5% and 39.2% respectively) (22).

1.1.5. Geographical dispersion

In the early years of epidemic, the majority of HIV cases were found in the regions of Odesa and Mykolayiv. Currently the most affected areas are: Mykolayiv, Donetsk, Odesa and Dnipropetrovsk oblasts and Crimea.
Over two-thirds of all HIV cases have been reported to date in ten regions in southern and eastern Ukraine (Mykolayiv, Donetsk, Odesa, Dnipropetrovsk, Kirovograd, Zaporizhza, Kharkiv and Kherson oblasts and Crimea), although recent evidence points to rapid increases in other regions. Indeed, cases have been reported within all 27 regions of the country (23).

Sharp increases in reported infections are now also occurring primarily among at risk populations of IDUs, FSWs and patients with STIs in central and northern regions of Ukraine – regions previously thought to be significantly less affected by the epidemic. There is a growing risk that the epidemic will take hold in these and other regions unless more comprehensive prevention efforts are introduced.

1.1.6. TB/HIV co-infection

Ukraine also faces a tuberculosis epidemic: annually around 27,000 cases are registered (24). The disease is therefore becoming a major problem in Ukraine, and multi-drug resistant strains, particularly among prison populations, have started to emerge.

In many cases PLWHA are active IDUs and co-infected with TB. In 2005, 3 028 cases of HIV-associated TB were reported among officially registered HIV+ people in Ukraine. The regions most affected by HIV-associated TB are: Donetsk (877 registered cases), Odesa (487 cases), Dnipropetrovsk (481 cases), Crimea (258 cases), Mykolayiv (180 cases), Kyiv city (147 cases) and Kyiv oblast (93 cases) (25).

1.1.7. AIDS data

As of mid-2006, a total of 15,552 individuals have been diagnosed with AIDS in Ukraine, including 6,345 patients currently living with AIDS under clinical observation, and 8,703 people are recorded to have died of AIDS (26). During 2006, the number of AIDS patients in Ukraine increased by more than 4 times, and mortality increased 3.8 times. In Ukraine the average life span of people living with HIV is 5-8 years, and with AIDS it is 1-2 years (27).

The introduction of ARV treatment has modest impact to date. Mortality still increases, although the rate of growth has decreased and the index of mortality (the proportion of infected people who die) dropped from 0.67 in 2003 to 0.49 in September 2006 (28).

1.1.8. Socioeconomic and demographic impacts of the HIV/AIDS epidemic in Ukraine

It tends to be accepted that HIV/AIDS is not solely a medical problem: it has serious social and economic dimensions. According to a new World Bank (WB) report “Socioeconomic Impact of HIV/AIDS in Ukraine,” under a pessimistic scenario, HIV/AIDS in Ukraine could reduce GDP by up to 6% between 2004-2014, reduce investment by 9% and leave up to 169,000 children orphaned. The report finds that HIV/AIDS is a major obstacle to economic growth, affecting households, businesses, and the government. Since relatively young people are hit hardest by the epidemic, Ukraine’s already declining population is likely to shrink even faster than in a generalised epidemic. A worsening epidemic could lead to reduced labour supply and worker productivity, spiralling healthcare costs, and decreased public and private savings and investments.

Based on the findings of a study, the epidemic poses a significant long-term threat to Ukraine’s socioeconomic development. By 2014, it is projected that Ukraine may reach 820,000 cases of HIV, or 3.5% of the adult population – almost 3 times current estimates. The number of cumulative AIDS deaths is projected to reach 300,000 by 2014. Ukraine is already facing a demographic crisis, with the annual number of deaths exceeding births by a factor of two. Excluding the impact of AIDS, Ukraine’s population is already projected to shrink from 48 million in 2006 to 44.2 million by 2014. Factoring in the potential impact of AIDS, the population could shrink further to 43.7 million. By 2014, it is projected that AIDS will reduce male life expectancy by an average of 2-4 years and female life expectancy by 3-5 years. By 2014, AIDS is expected to account for over 35% of all male deaths and over 65% of all female deaths in the age group 15-49 (29).
1.2. Most-at-risk populations

1.2.1. Groups vulnerable to HIV infection

In Ukraine, IDUs and FSWs are considered the groups most vulnerable to HIV/AIDS infection. The GFATM and other HIV/AIDS programmes in Ukraine consistently target these groups. A number of programmes now also target prisoners and ex-prisoners. In the last two years increasing attention is paid to MSM.

These groups often have most difficulties accessing services for two reasons. Firstly, due to social stigmatisation of these groups, who are seen as ‘social outcasts’. The same is true of public perceptions of PLWHA: according to the data of the Ministry for Youth and Family Affairs of Ukraine, surveys demonstrated 0% of tolerance among youngsters of 15-24 years toward PLWHA and 2% of tolerance among adults 25-49 years toward (30). Secondly, IDUs, FSWs and MSM are often afraid of the repressive practices of police. Consequently data regarding number of these groups, spread of HIV/AIDS among them and service coverage are rather tentative.

1.2.2. Intravenous drug users

IDUs are the single most heavily affected group: over 45% of new HIV cases reported in the first half of 2006 were from this group, although this a reduction from an average of 59.5% of cases in the same six-month period in 2001, when Ukraine submitted its Round 1 proposal to the GFATM. While this suggests a reduced proportion of IDUs among all new cases of HIV, the epidemic among IDUs is not slowing down: in the first half of 2006, the number of IDUs registered with HIV increased by 34% since 2003, bringing the total number of IDUs diagnosed with HIV to over 56,000.

Recent sentinel surveillance studies in the eight most affected regions of Ukraine indicate that an alarming percentage of IDUs are already infected with HIV, ranging from 9.6% to 66.4% (31). A significant proportion (33.4%) of newly diagnosed HIV-infected IDUs are under 30 years of age, and a large proportion (31.6 %) is female.

1.2.3. Sex workers

A key factor contributing to the rapid increase in sexual transmission of HIV is an overlap between injecting drug use and commercial sex work among women. Sentinel surveillance data indicate that HIV prevalence among FSWs who reported injecting drug use was between 8.3% and 100% depending upon the study site, whereas among FSWs who did not report injecting drug use, prevalence ranged between 0% and 21.1%. Prevalence data among FSWs indicates a consistent and rapid increase of HIV since 2000 when sentinel surveillance among this population began (32). The latest data indicates that the coverage and intensity of prevention programmes among FSWs need to be urgently increased to both protect these women from HIV infection.

1.2.4. Men who have sex with men

Another particularly vulnerable group is MSM. According to sentinel surveillance data the spread of HIV-infection among MSM is high in those regions where data were gathered. In the city of Odesa, for example, of the 25 MSM who were tested 7 were HIV+, in Sebastopol – 3 out of 22 cases (33).

Experts from the Ukrainian AIDS Centre suggest that an increasing number of men who reported to be infected through heterosexual transmission had had sex with men. This is because they experience additional social stigmatisation and may not be willing to disclose how they believe they were infected. In practice preventative services tend to find it difficult to reach this group (34).
1.2.5. Prisoners

People who were placed to prisons and correctional institutions are also vulnerable to HIV/AIDS infection. As for April 2006, there were 4,397 people reported with HIV-infection in the Ukrainian prison system, including 132 persons with AIDS. In a population of over 160,000 prisoners, this indicates HIV prevalence in the prison population is 2.7%, which is considerably higher than in the general population.

1.2.6. Pregnant women

It is important to emphasize that in order to avoid vertical transmission special attention in Ukraine is paid to pregnant women who are strongly encouraged by doctors to undertake HIV tests. Those who are registered as HIV+ receive ARV treatment. In 2005, a high level of HIV spread among pregnant women was disclosed in several regions of Ukraine – Mykolayiv (0,7%), Dnipropetrovsk (0,65%), Odesa (0,62%), Donetsk (0,6%), Chernihiv (0,5%). The average level for Ukraine was 0,3%.

1.2.7. Interviewees’ views on the targeting of groups vulnerable to HIV

Interviewees were asked whether HIV/AIDS programmes funded by the GFATM and World Bank should target vulnerable groups or the more generalised population.

The analysis of responses to this question show that most interviewees doubt the appropriateness of primarily targeting vulnerable groups. The majority suggested that it necessary to pay attention to the whole population because the epidemic appears to be spreading beyond key high-risk groups. For example an interviewee said:

‘...All help from the GF is aimed at the vulnerable groups such as drug addicts, MSM, women in the sex industry, and there are no initiatives at all from the GF towards prevention. Then there rises a problem: if the GF keeps on sticking to such a strategy, then it just falls behind all the time. HIV is spreading, that is we don’t prevent the cases but we use the GI for the existing cases and for the prophylaxis procedures, care and support among this small group of population. I think it’s not right’ (Governmental organisation).

This same interviewee also noted that not enough work was being carried out among the general public leading to new cases of HIV:

‘...Funds need to be directed to prevention... that is not only to the at-risk groups but to the general public because if we don't work with the general public or work insufficiently or ineffectively, then it happens that these at-risk groups are constantly being added to here.’ (Governmental organisation).

Other interviewees spoke in favour of prevention programmes and expansion of priorities of the target audience of the GF projects. One noted much higher level of knowledge about HIV/AIDS among at-risk groups that the general population:

‘Even now the at-risk groups demonstrate more knowledge than the youth. Nevertheless, we have 40% of injection transmission and also 40% of sexual transmission. That's why it's necessary to start paying attention to the general public, to the public that risk without risking.’ (Governmental organisation).

In addition, some interviewees insisted that other groups were also vulnerable and therefore required consideration:

‘I’d say the list of vulnerable groups is very imperfect. Separate groups are included – injection drug users or sex industry workers, and MSM. The rest of the groups vulnerable at their work places – doctors, nurses, and transportation workers, taxi drivers, truck drivers,.. train conductors, or service

* Here and below in italic text is a direct quote for stakeholder interview. The representation of stakeholder (governmental, national non-governmental or international organisation) is named in brackets.
personnel such as merchants at the markets or hotel workers, tourism – very vulnerable groups, but they are not considered as such, they are not included into the national programme as vulnerable groups. And there is no work being carried out among them. I think the group of military personnel is quite vulnerable among whom there is no work either.’ (National NGO)

Other interviewees mentioned women, children and families who were insufficiently considered, putting them at risk. An interviewee said:

‘…Women. Simply women, even if they are not IDUs, even if they are not FSWs. … Women are under tremendous threat. Number one or two – it’s very hard to choose. They need to be kept safe and guarded, protected.’ (International NGO)

Another interviewees suggested:

‘Children and everything that has to do with them are not the subject of GI at all here. Vulnerable children, children from the streets and children infected with HIV have been excluded altogether, but in my opinion, there can be a discussion who should and who should not be considered a vulnerable group.’ (Governmental organisation).

‘The GF programme provided insufficient coverage of orphans, children who live in orphanages. Also, the big problem is that parents abandon children infected with HIV. It provokes social orphanhood. And little work is being carried out with.’ (National NGO)

Two perspectives are therefore apparent in interviewees’ accounts of the groups targeted by HIV/AIDS programmes. Firstly, some experts think that it is more expedient to develop preventative services aimed at the whole population, not to concentrate on certain groups exclusively. Secondly, they pointed out the importance of expanding the list of the groups at risk, and thereby drawing attention to the groups vulnerable to HIV at their work places, as well as women and children.
Section 2
Ukraine’s National Response to the HIV/AIDS Epidemic

2.1. Legislative and regulatory grounds for public policy in the area of HIV/AIDS

2.1.1. Ukrainian legislation on HIV/AIDS

Overall management of the HIV/AIDS response is grounded in a number of legislative and strategic frameworks, most significantly the National HIV/AIDS Strategy and the National AIDS Programme 2004-2008.

The cornerstone of the Ukraine’s national HIV/AIDS legislation continues to be the ‘Law on the prevention of the spread of AIDS and social protection of population’ adopted by the Verkhovna Rada/Parliament of Ukraine in December 1991, which, according to the views of a number of authors (36-38) is progressive by international standards that define how the rights of HIV+ people to health care, social welfare, and against discrimination can be protected. For example, it sets out that testing for HIV is free, voluntary and anonymous, indeed, disclosing the HIV-status of a patient is a prosecutable criminal offence. The law articulates the rights and obligations of the Government to ensure that the national response is ‘one of the priority tasks for the state in the field of health protection of the population’. Other commentators argue that Ukraine does not have a very strong human rights record for PLWHA and at-risk groups – in practice at least (39-40).

Beginning in 1992, a series of five National AIDS Programmes were developed and implemented by the Government of Ukraine. The current National AIDS Programme (2004-2008) provides the basis for intersectoral cooperation between governmental agencies, and between government, non-governmental and international organisations (41). However, not all commentators agree the Programme is a strong basis for national policy, arguing that the document lacks budget mechanisms for its implementation, visible sharing of responsibilities between different governmental bodies and sound monitoring system (42). The programme prioritises prevention interventions among vulnerable populations and treatment and care for PLWHA. It also emphasises the importance of including representatives of target populations, particularly PLWHA, in the design, implementation, monitoring and evaluation of the national AIDS programme. Previous state programmes tended not to incorporate evaluation of performance; neither did they apply lessons learnt from preceding strategies or programme. Other aspects of the overall strategy, its priorities, content and structure of the current Programme remain similar to the four previous national state programmes.

An important development that strengthened HIV/AIDS legislation in Ukraine by introducing a human rights-based approach within the national response to the epidemic, was signing the UNGASS Declaration of Commitment to combat HIV/AIDS by the Ukrainian Government in June 2001, which has the status of Law in Ukraine.

In 2004, the Cabinet of Ministers of Ukraine also endorsed the “Strategic Concept of Government Actions Aimed at Preventing Spread of HIV-infection and AIDS for the Period until 2011”. This document provides an overall strategic action framework to address HIV/AIDS with both national and international partners up to 2011.

2.1.2. Related Ukrainian HIV/AIDS policy initiatives

In addition to HIV-specific global initiatives described later, the Government of Ukraine has adopted a series of programmes within the national development framework that are directly relevant to HIV/AIDS. These include:
- Intersectoral Integrated Programme “Health of the Nation” for 2002-2011;
- Concept of Reproductive Health of the National Governmental programme (2006-2015);
- Ukraine-EU Action Plan;
- Strategy of Enlisting International Technical Assistance (2005-2007);
- State Programme for Social Adaptation of the Persons Discharged from Penitentiary Institutions for (2004-2006);
- National Programme on Youth Support (2004-2008);
- Main Directions for Strengthening Social Protection of Military Servicemen and Family Members (until 2010);
- Programme for Development of Donation of Blood and Blood Components (2002-2007);

However, the majority of these programmes contain only limited resources for achieving the overall goals outlined, with explicit provisions to encourage external and other non-governmental partners to contribute.

The President of Ukraine’s signing of the UNGASS Declaration in 2001 instigated a number of key initiatives, which cascaded into corresponding decisions of the Cabinet of Ministers and Ministry of Health. Of importance among those initiatives were the following:

1. Consider Ukraine’s participation in the GFATM to tackle HIV/AIDS;
2. Explore the possibility to create, jointly with UN Office in Ukraine, the Eastern European International Knowledge Hub on the prevention of HIV/AIDS;
3. Explore setting up a scientific research institute for HIV/AIDS problems within the Ukrainian AIDS Centre;
4. Set up a charitable fund to fight HIV/AIDS and arrange a charitable lottery in 2002;
5. By the start of 2002, to finish setting up regional AIDS centres, where they are absent, as well as in cities where number of HIV-infected exceeds 500 people;
6. Explore the possibility of setting up a scientific - practical centre to develop and produce drugs for treatment and prevention of HIV/AIDS.

Some of those decisions were implemented (apart from cases of #3 & #6, and in case of #5, implemented only partially) between 2002 and 2004.

The national initiative ‘Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine’ by 2010 was based on the input from more than 300 national and local participants. As was the national “Road Map on Scaling-up Towards Universal Access” prepared in February 2006. The Road Map, which was officially developed by the Ministry of Health and endorsed by the National Coordination Council (NCC), outlines the priority gaps and needs for achieving universal access in Ukraine by 2010, with a focus on the most vulnerable populations.

Thus, since the early 1990s Ukraine had developed the legislative and regulatory grounds in the area of HIV/AIDS compatible with international best practice and commitments. These were strengthened over 2000-2004 with the UNGASS Declaration and Presidential orders.

2.1.3. Key aspects of legislation undermining effective HIV/AIDS policy

A recent Human Rights Watch report (43) vividly demonstrates that although overall HIV/AIDS national legislation is supportive and complies with the international best practice and declarations, there are a number of obstacles that and seriously undermine the ‘letter and spirit’ as well as implementation of the HIV/AIDS national strategy and programmes.

First of all, there is a punitive drug policy which adopts a exclusively abstinence–focused approach to illegal drug-use reflected in respective norms in the Criminal and Civil Codes, and in their local interpretation by law enforcement bodies, that over-criminalise and penalize drug possession. A person might be arrested for possession of small quantities of prohibited drugs, sometimes less than one dose, potentially leading to imprisonment. For example, according to article 309 of the Criminal Code of Ukraine individuals possessing
any amount of heroin up to 1 gram; 0.15-1.5 grams of amphetamine or MDMA; or 0.1-10 grams of acetylated opium are subject to three years in prison. Moreover, according to drug users and service providers’ accounts police planted drugs in their homes or on their person, and used this as evidence to arrest or abuse them.

The police sometimes detain peer outreach workers despite the fact that Ukraine government policy recognises that the most effective and in some cases the only possible AIDS educators of members of marginalised groups, such as injecting drug users, are their peers. But peer educators and others who reach out to marginalized groups are often held in the same contempt as the individuals with whom they work, and subjected to discrimination and violence at the hands of the government. Several NGOs that work with drug users said that police abuse of outreach workers had abated in recent months as a result of concerted efforts on their part to educate police about their work.

Other factors inhibit access to drug treatment. These include official registration requirements that expose drug users to police and undermine employment prospects; ineffectiveness of treatment that is provided; and poor attitudes of medical professionals toward drug users. Drug users and service providers interviewed for this report told Human Rights Watch that drug users avoided seeking drug treatment out of concern about registration with narcologists and by police. They also said that drug users avoided seeking healthcare for the effects of drug use such as abscesses out of fear that health care workers would report their drug use to the police, or that their employers would fire them if they discovered that these effects were related to drug use.

One more serious factor is the legal prohibition of the methadone despite Ukraine’s national HIV/AIDS program which identifies the implementation of a substitution therapy program linked with HIV prevention, care, and treatment programs as one of its main goals. The Ukrainian parliament has also recommended implementing substitution therapy to prevent HIV infection among drug users. But because of significant opposition in some parts of government—most notably, the Committee on Narcotic Drugs Control, Ministry of Interior, and the Security Services of Ukraine—substitution therapy is largely unavailable in Ukraine.

In mid-2005, the Cabinet of Ministers proposed to ban methadone altogether. In November 2005, following significant protest by domestic and international human rights, HIV/AIDS, and harm reduction advocates, Ukraine agreed to partner with the Clinton Foundation HIV/AIDS Initiative to “pilot and then scale up methadone-based drug substitution therapy.” At this writing, methadone remains unavailable, and the government has not announced plans for its use in substitution therapy programs. Only injectable buprenorphine (that is more expensive than methadone) has been used to treat opiate addiction in Ukraine for some years, both in drug detoxification, and on a more limited basis, for short-term substitution therapy.

The law on commercial sex work is officially less strict now than in the past. Individual prostitution with adults was criminalized in September 2001 and then decriminalized in January 2006. Prior to 2001, individual prostitution with adults was covered only under the Administrative Code, violation of which incurred a small fine. The 2001 amendments increased the penalties for prostitution, including by increasing fines, subjecting those convicted of individual prostitution to correctional labour, and subjecting those convicted of certain prostitution-related offences to prison sentences. The 2001 amendments increased sex workers' fear of contact with police as well as service providers, and made it more difficult to conduct outreach work with sex workers. Despite the decriminalisation of commercial sex work, CSWs are often subjects of police abuse. Many sex workers migrate to Ukraine’s cities from villages in Ukraine or other countries in the region; their lack of official registration and identity documents required for legal residence and access to city services makes these sex workers more vulnerable to police abuse than their counterparts with registered residency. Ill-treatment by police, sometimes reaching the level of torture, has been acknowledged as a widespread problem in Ukraine by domestic and international human rights bodies.

One more inhibiting factor is the lack of a system for protecting human rights more broadly, so police face little risk of censure for their abusive activities. The Human Rights Watch report notes that police actions frequently violate fundamental human rights protections against torture and other forms of ill-treatment, and due process. Numerous drug users, sex workers, and service providers reported that police had extorted money and information from drug users by applying physical and psychological pressure, including severe beatings, electroshock, partial suffocation with gas masks, and threats of rape, both at the time of arrest and during detention, and had directly interfered with the provision of HIV prevention information and services for drug users and sex workers.
The overall conclusion of the Human Right Watch is that the Ukrainian police have a legitimate interest in controlling illicit drug possession and commercial sex work, to the extent that both are proscribed by Ukrainian law. But Ukraine’s law enforcement practices are undermining government efforts to provide HIV information and services to drug users and sex workers, the very people whom the government has identified as at highest risk of HIV/AIDS. Indeed, police practices drive people at risk away from services that prevent HIV/AIDS.

2.2. Stakeholders and institutional structures

2.2.1. Institutional coordination

Ukraine has a complicated and fragmented system of administrative bodies implementing and monitoring HIV/AIDS policy. In Attachment 4 the coordination and monitoring mechanisms in Ukraine are detailed. Moreover, the connections between different national and international stakeholders are complicated. Coordination is considered a serious problem for HIV/AIDS policy: many coordination bodies have been established (and then abolished).

UNAIDS in Ukraine and DFID have recently conducted a study of stakeholders in the HIV/AIDS sphere in Ukraine within the Support to Three-Ones Implementation project framework. It concludes that against a background of the growing number of stakeholders engaged in HIV/AIDS programmes, an interagency, intersectoral coordinating mechanism has yet to be created (44).

2.2.2. National Stakeholders

The following is a list of key stakeholders relating to HIV/AIDS policy in Ukraine.

National government. This consists of the President, Parliament, and Cabinet of Ministers. Their responsibilities include developing the legislative grounds for HIV/AIDS policy.

Ministry of Health (MoH). The MoH has considerable interest in combating HIV/AIDS. However, its capacities to deal effectively with the issues of HIV/AIDS are undermined by other challenges. Key issues include: systemic crisis across the healthcare system, scarce funds, poorly trained staff with low motivation, the parallel tuberculosis epidemic, the hidden epidemic of cardio-vascular disease and cancers, strong professional medical networks (e.g. a narco-logical lobby opposed to new approaches to drug addiction treatment for HIV prevention). There may be specific vested interests in taking up separate aspects of response to HIV/AIDS, like mass testing or lab equipment or expensive ART and opportunistic infections treatment by running tenders and lobbying certain business interests of the local producers of testing kits or foreign drugs and equipment suppliers (as there were no locally produced ART drugs).

Local government. This level of government is interested in effective control and prevention of HIV/AIDS, as they were the closest to frontline healthcare provision, mostly paid from local budgets. Capacities to deal with the issues are limited by scarce local budgets and lack of trained staff.

Civil society. Most civil society organisations involved in HIV/AIDS are NGOs, which have a positive interest in effective responding to HIV/AIDS. Many provide services with GFATM grant money. However, some NGOs have extremist views and outward discriminatory attitudes to IDUs and CSWs and hence strongly advocate against implementation of substitution programs, methadone therapy and other interventions.

The All-Ukrainian Network of People Living with HIV/AIDS (PLWHA). This is a civil society organisation that is a key sub-recipient of the GFATM grant described in more detail later in this report.

National epidemiology and AIDS medical specialists. These specialists have strong professional development and business interests as well as moral incentives to be active players in the area of HIV/AIDS.
Jointly with their international colleagues and local HIV-service NGOs they constituted the core policy community driving and advocating for effective HIV/AIDS policy in Ukraine.

**Healthcare providers.** In practice many healthcare staff are understood to be poorly motivated due to perceptions of the hazards of working with PLWHA without adequate pay from the state. Strong stigma towards HIV positive people was reported to be among healthcare staff.

**Medical goods supply and the private pharmaceutical sector.** These stakeholders have a strong economic interest in particular aspects of the HIV/AIDS policy - testing and treatment and care - through large volumes of guaranteed state procurement of testing kits, expensive laboratory equipment and harm reduction commodities (for example syringes and needles) and ART drugs. The testing market was predominantly controlled by a small number of local producers, while pharmaceutical sector with regard to HIV/AIDS was exclusively represented by foreign large producing and distributing corporations, mostly from India (e.g. Cipla Pharmaceuticals), although transnational companies, like GlaxoSmithKline or Boehringer Ingelheim also have considerable business interests in Ukraine.

**Illegal drugs trafficking and trade business.** These stakeholders control opiate supply and have a strong negative interest in effective, evidence-based HIV/AIDS policy in Ukraine in particular supplying IDUs with substitution therapies (STs) as this could significantly reduce demand for illicit drugs. The scope and structural opportunities for corrupting the government, including police, security, health officials and practitioners at all levels to lobby aggressive anti-ST policies were significant (45).

In general stakeholders with positive or at least neutral interests in effective HIV/AIDS policy prevail in Ukraine, with civil society organisations including PLWHA organisations supported by international donors, together with considerable support from national epidemiologists and AIDS medical doctors being the key positive driving force of HIV/AIDS policy. However their positions are opposed by groups with negative interests such as illegal drug traffickers, deep-rooted structural and petty corruption in the health care sector, deep-seated stigma towards vulnerable to HIV-risk groups (especially IDUs, FSWs and MSM), and some NGOs with radical discriminatory views towards HIV+ people.

### 2.2.3. International stakeholders

International organisations also have significant influence on public policy formulation and implementation.

**International multilateral organisations.** These include the UN agencies - WHO, UNICEF, UNFPA, UNDP, UN Fund for Drug Abuse Control and the Joint UN Programme on HIV/AIDS (UNAIDS), and providers of international public goods (e.g. evidence-based preventive strategies and methods, treatment and care protocols, new drugs, microbicides) have a strong positive interest in combating HIV/AIDS in Ukraine.

**World Bank.** The World Bank has an additional interest in scaling up the HIV/AIDS response through disbursing loans. World Bank activities in Ukraine are discussed later in this report.

**Bilateral donors.** A number of key donors provide significant financial resources to respond to HIV/AIDS in Ukraine, mainly through NGOs but also UN multilateral channels. These include USAID (a key donor for HIV/AIDS programmes although PEPFAR programmes do no operate in Ukraine) and the European Union.

The USAID-funded SUNRISE project (2004-2009) supports the following activities in 8 most affected regions, as well as providing information and additional services to IDUs and CSW: increasing the accessibility of high-quality care and support for PLWH, introduction of prevention techniques for HIV+ people; strengthening the prevention-care continuum, with a particular focus on improving the quality and accessibility of VCT services by strengthening the role of NGOs in VCT provision; strengthening the ability of local organisations and communities to collaboratively analyze, plan, deliver, monitor and evaluate new information and services. Within the USAID-funded Health Policy Initiative (HPI) Project support is provided for regional HIV and AIDS coordination councils, including: development of the regional system for M&E; development and implementation of policies for VCT, PMTCT, paediatric HIV, capacity building for AIDS service organisations and PLWH.
The European Union’s support for HIV/AIDS control in Ukraine was based on a human rights/ethical position and more pragmatic interests of having Ukraine as a healthy neighbour and trading partner at their borders with a healthy workforce. For example, the EU-Tacis project supports prevention activities among MSM. The UK Department for International Development (DFID). A DFID-funded project supporting HIV+ people currently runs in two cities. A further project supporting HIV and STI prevention among MSM is currently running in two cities in eastern Ukraine. It is hoped that the projects will be sustained through a Round 6 grant of GFATM when DFID funds are withdrawn in 2007.

The Clinton Foundation HIV/AIDS Initiative (CHAI). The initiative began working with Ukraine in late 2004, and subsequently enhanced their collaboration in 2005 by establishing a country team/presence. CHAI is assisting with procurement of high-quality, low-cost drugs and diagnostics, provision of technical assistance, a possible drug donation for paediatric care, a pilot programme for integrated care of HIV patients in Dnipropetrovsk Oblast, substitution therapy (including registration of methadone) and other activities.

The Elton John AIDS Foundation. The foundation funds projects providing preventative interventions and care for HIV+ MSM. The projects are currently implemented by the All-Ukrainian Network of PLWHA covering ten major cities over three years.

The International Harm Reduction Development Programme (IHRD) funded by the Open Society Institute (Soros Foundation). This was a key donor for harm reduction in Ukraine until 2003, focusing mainly on advocacy for drug policy reforms and developing an enabling environment for effective scale-up of harm reduction. IHRD activities include (i) technical assistance to all harm reduction programmes and substitution treatment projects funded by the GFATM Round 1 grant, and (ii) ensuring equal access for IDUs to ARV treatment.

It is planned that the Ukrainian Red Cross, with support from French and Italian Red Cross Societies, will provide training on ST for health care practitioners in Zaporizhzhya and will provide ST for ten clients on buprenorphine and twenty clients on methadone at Zaporizhzhya AIDS Centre. These activities will be performed in the framework of the project: AIDS and Drug Dependence in Ukraine to reduced HIV transmission in Kyiv and in Zaporizhzhya 2006-2007 (46).

Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM). A global health initiative financing HIV/AIDS programmes. Its work is described in detail later in this report.

2.2.4. Coordination of HIV/AIDS policy

The important aspect of the national response to HIV/AIDS epidemic is the establishment of an overarching coordination mechanism for the various interventions in the area of HIV/AIDS. Since the beginning of 2001, there has been a succession of Cabinet Ministers and a number of resolutions establishing different coordination structures (see the chronology of the establishment of governmental bodies on HIV/AIDS coordination in Attachment 5).

All these bodies shared not only the purpose of fighting HIV/AIDS in Ukraine, but also certain common features: their membership were almost identical; they were all chaired by one person - the Vice Prime Minister of Ukraine responsible for humanitarian issues; none of them coordinated with other coordination structures working in HIV/AIDS area; the state HIV/AIDS Programme, joint GoU/WB HIV-TB Control Loan Project, and GFATM HIV/AIDS Grant Project were all treated separately; objectives, functions and responsibilities of these bodies were quite broadly defined, not well delineated and often overlapped; all the structures were perceived as public sector bodies; their work was neither transparent, nor accountable, with no information about the meetings and decisions taken there made public in press or on the official governmental websites.

In addition to the context outlined above, in early 2003 the Agreement between GFATM and MoH, stipulated the creation of a Country Co-ordination Mechanism (CCM) as a separate body to coordinate proposals from the country and to control implementation of measures approved within the grant project, at the same time, serving as a forum of all stakeholders dealing with the issues of HIV/AIDS in Ukraine, promoting partnership of all sectors, including the government, donors, NGOs, religious organisations and private business.

Kyiv, January 2007
In 2005, the Cabinet of Ministers of Ukraine issued Regulation #352 for the establishment of the National Coordinating Council (NCC) for the Prevention of HIV/AIDS Spread. This demonstrated that the issue of HIV/AIDS had become one of the priorities for Ukrainian national social policy. The main objective of NCC activities is the coordination of the activities of relevant ministries, central and local governmental bodies, international organisations and NGOs, including organisations of PLWHA in order to implement effectively coherent policy, to consolidate expenditure and to improve the monitoring system for HIV/AIDS control and prevention.

The NCC membership is composed of representatives according to quotas of major stakeholders in the field of HIV/AIDS. To define the representation quotas, a criterion recommended by the GFATM for the public-private sector ratio was used: no less than 40% representatives of the private sector in the total number of the coordinating authority members (47). Quota distribution between stakeholder groups (48) is presented in Table 2.1.

**Table 2.1. Distribution quotas for representation of stakeholder groups in the National Coordinating Council**

<table>
<thead>
<tr>
<th>CONSTITUENCY</th>
<th>QUOTA</th>
<th>CONSTITUENCY</th>
<th>QUOTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vice Prime Minister of Ukraine</td>
<td>1</td>
<td>AIDS centres</td>
<td>1</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>1</td>
<td>Nongovernmental organisations</td>
<td>1</td>
</tr>
<tr>
<td>Ministry of Education and Science</td>
<td>1</td>
<td>Network of people living with HIV/AIDS</td>
<td>2</td>
</tr>
<tr>
<td>Ministry for Family, Youth and Sports</td>
<td>1</td>
<td>UN agencies</td>
<td>1</td>
</tr>
<tr>
<td>Affairs</td>
<td></td>
<td>Multilateral intergovernmental agencies</td>
<td>1</td>
</tr>
<tr>
<td>Ministry of Labour and Social Policy</td>
<td>1</td>
<td>Bilateral intergovernmental agencies</td>
<td>1</td>
</tr>
<tr>
<td>State Department for Execution of</td>
<td></td>
<td>International nongovernmental</td>
<td></td>
</tr>
<tr>
<td>Punishments</td>
<td></td>
<td>organisations</td>
<td></td>
</tr>
<tr>
<td>Local executive authorities</td>
<td>1</td>
<td>Private organisations</td>
<td>1</td>
</tr>
<tr>
<td>Members of Ukrainian Parliament</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The NCC designated six major areas of its activity and, pursuant to the NCC regulation, established for each of them permanent committees composed of representatives of executive power institutions, international and civil society organisations:

1. Committee on strategic planning, budgeting, M&E – 18 members;
2. Committee on regional policy – 11 members;
3. Committee on healthy lifestyle promotion – 18 members;
4. Committee on vulnerable groups – 15 members;
5. Committee on protection of rights of PLHA and vulnerable groups – 14 members;
6. Committee on treatment, care and support – 12 members.

Committee members are not only elected NCC members but also other stakeholder representatives. This secures broad participation of partners from public and private sectors in decision making on agenda items. Overall, 65 representatives of stakeholders take part in the work of the NCC and its committees.

At the first meeting of the NCC a number of regulations were adopted relating to the creation of several auxiliary institutions that would help implement the strategy of the Council. Specifically, a regulation was adopted on the creation of committees that would recruit experts, doctors and public activists to work in the NCC. A further regulation was adopted relating to the Secretariat of the NCC, and a regulation drafted on the creation of regional and municipal coordination councils to support the work of the National Committee. These committees oversee the implementation of policy and developing systems of monitoring and evaluation relating to HIV/AIDS programmes.

Whilst the majority of experts who were interviewed welcomed the creation of the NCC, not all evaluated its work positively. One interviewee suggested:
‘as a whole this system is still bureaucratic, vertical [structures] are created… those coordination councils are created down to the bottom, but everything is like it’s used to be. Meetings, conferences, happy reports, everything is done, but the epidemic is spreading’. (NGO).

The NCC stopped functioning actively in early 2006: this caused major indignation from some stakeholders. For example, the All-Ukrainian Network of PLWHA addressed the President of Ukraine with an open letter demanding the body reformed. The NCC resumed its activities during the preparation of the GFATM sixth round proposal, albeit not at full capacity.

It is also important to note that besides NCC and the regional coordination councils there exist parallel coordination mechanisms that are not implemented through the state organisations. In particular, in Ukraine there is a position of regional coordinator, and these coordinators work in majority of regions, where GFATM projects are implemented (Sevastopol, Odesa, Cherkasy, Mykolayiv, Kyiv, Kherson, Dnipropetrovsk, Donetsk). Major responsibilities of the regional coordinator are the following: preparing and conducting working meetings with the representatives of HIV-service NGO Alliance granters of projects of the Kyiv region (with participation of the interested persons/organisations), participation in meetings of oblast and city coordination councils on HIV/AIDS prevention, informing HIV-service organisations about the main epidemic trends, existing initiatives and measures, adjusting of contacts and cooperation with regional mass-media, collection and analysis of information necessary for development of strategy and priorities of Alliance Ukraine work in the region; participation in determination of possibilities and needs of regional partner organisations; participation in the working meetings, round tables, seminars and conferences.

Furthermore, in 2006 in order to coordinate the efforts in HIV prevention in the regions of Ukraine, the creation of the Coordinating Groups of Sites (CGS) was initiated. These groups include and are supported by major existing and potential interested parties, and also representative groups. The CGS are created in all regions, where HIV-service organisations the projects of which are financed by the GFATM grant. Responsibilities of the CGS are the following: coordination of comprehensive measures in response to HIV epidemics, determination of principles of work within site, determination of organisations to realize projects within site, development and approval of project suggestions, controlling the implementation of projects within site, giving suggestions for the improvement of activity in the field of project realization within site.

To summarize, the simultaneous existence of the numerous coordination bodies and structures without clearly delineated lines of responsibility and accountability, overlapping mandates and overall poor governance appears to have undermined efficient coordination of the respond to the HIV/AIDS epidemic. However, a number of experts interviewed saw the creation of the NCC as a positive development in improving levels of coordination.

2.3. Financing HIV/AIDS initiatives in Ukraine.

2.3.1. Resource tracking systems

Information on financing for HIV/AIDS is required to ensure the optimal allocation of resources. Financial information on expenditures can be used to illustrate the total scope of expenditures from both governmental and non-governmental sources, and what services and other costs are covered by these expenditures.

National Health Accounts (NHA)\(^1\) with sub-account analysis for HIV/AIDS, and National AIDS Spending Assessments (NASA)\(^2\) are internationally recognized as effective methods of calculating national expenditures on HIV/AIDS.

\(^1\) The National Health Accounts (NHA) is a method to calculate, describe and analyse the amount and structure of funding of the national public health care systems. The NHA includes only issues related to the medical aspects of health care. The assessment boundaries have been methodologically determined within the disease prevention activities contributing to health, treatment, rehabilitation and long-term care.
In Ukraine NHA analysis is funded by USAID funds and implemented by Abt Associates, covering the period 2003-2004. The NHA report was completed in 2006 (49). Further analysis is currently being carried out using the NASA methodology in order to generate more detailed data on HIV/AIDS expenditures for the period 2004-2005. This NASA Project is being implemented by the International HIV/AIDS Alliance in Ukraine financed by UNAIDS. The information provided below is mostly based on the results of these studies.

2.3.2. Sources for HIV/AIDS related expenditures

NHA data for 2004 suggest that health service delivery was financed from the state and local budgets (58% of the total), private/out-of-pocket sources (41.3%) and donor support (0.7%). Other research data show that out-of-pocket payments constitute up to 70-90% of all payments for medical care in Ukraine (diagnostic, treatment, hospitalisation for all kind of diseases) (50).

According to the NHA HIV/AIDS Sub-Account Analysis for 2003-04, only a small portion (13.5%) of expenditures for HIV/AIDS in this period were covered by the state and local budgets. In contrast, external development partners, particularly the GFATM, covered significantly more than government funding (23.1%), whilst private and out-of-pocket household contributions accounted for the majority of expenditures (63.4%). Current resources remain inadequate, covering treatment for only around 33% of those estimated to be in need of ART, and coverage rates for prevention, care and support services are between 10 and 15% (51).

Unlike the results for 2003 and 2004, where the primary data collection and recording used NHA methods, the 2005 results are based on the NASA approach. Whilst they reveal a slightly different picture (see Figure 2.1) the dominance of private household expenditures continues to be apparent (52).

![Figure 2.1. HIV/AIDS-related expenditures in Ukraine in 2005](image)

National AIDS Spending Assessment (NASA) is a method aimed to provide data about the gaps between needed and available resources by the recommendation of the UNAIDS Global Consortium to monitor resources in order to develop the national capacity at both central and regional levels to track the cash flows and expenses on HIV/AIDS response. The NASA approach takes into account activities related to education, social development, social security, as well as a number of other functions beyond the boundaries of health care system in the country.
It should be noted that in the period 2003 – 2005 the overall amount of government funds to finance HIV/AIDS programmes has risen. However in 2006 state expenditure significantly dropped at the same time as funding for HIV/AIDS from external sources increased (see Table 2.2).

**Table 2.2. Financing of the HIV/AIDS-related activities (in USD)**

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006 (plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Programme to Fight HIV/AIDS</td>
<td>4 599 881</td>
<td>11 379 505</td>
<td>9 536 574*</td>
</tr>
<tr>
<td>World Bank Loan</td>
<td>356 976</td>
<td>146 277</td>
<td>9 065 581*</td>
</tr>
<tr>
<td>Internal resources in total</td>
<td>4 956 857</td>
<td>11 525 782</td>
<td>18 602 155*</td>
</tr>
<tr>
<td>GFATM</td>
<td>12 402 687</td>
<td>15 212 100</td>
<td>21 168 495</td>
</tr>
<tr>
<td>USAID</td>
<td>6 887 900</td>
<td>6 823 906</td>
<td>4 101 164</td>
</tr>
<tr>
<td>UN agencies</td>
<td>2 328 925</td>
<td>3 065 623</td>
<td>2 881 736</td>
</tr>
<tr>
<td>Other donors</td>
<td>1 000 000</td>
<td>1 500 000</td>
<td>1 700 000</td>
</tr>
<tr>
<td>External resources in total</td>
<td>22 619 512</td>
<td>26 601 629</td>
<td>29 851 395</td>
</tr>
<tr>
<td>All available resources</td>
<td>27 576 369</td>
<td>38 127 411</td>
<td>48 453 550*</td>
</tr>
<tr>
<td>Financial gap – estimate</td>
<td>37 423 631</td>
<td>31 872 589</td>
<td>36 546 450</td>
</tr>
</tbody>
</table>

Source: GFATM Sixth Call for Proposals – Ukraine (2006).

* At the moment of the report writing the loan was still suspended, so actual funding is significantly low.

**2.3.3. HIV/AIDS-related expenditures**

A detailed structure of HIV/AIDS expenses in 2005 by functions is presented in Figure 2.2.
Figure 2.2. HIV/AIDS-related activities in 2005

Distribution of expenses into functions demonstrates that the treatment and care component (46%) and prevention component (45%) receive more funds than other functions. It is highly revealing to disaggregate care/treatment and prevention activities by funding source (Fig. 2.3).

Prevention programmes are funded primarily through private household expenses (76%) and through international donor funding. Private household expenses are mostly spent on syringes and condoms in the retail network. Moreover, expenses of private households comprise the major share of private expenses on treatment and care (55).

Most government funding for prevention programmes is used to supply HIV/AIDS test kits, for the organisation of blood safety procedures and to the maintenance of the network of narcological clinics and dispensaries. In the NHA sub-analysis all these listed activities are considered as treatment.

Figure 2.3. Financing sources of the HIV/AIDS-related activities in Ukraine in 2005

Preliminary NHA and NASA results indicate that there is a significantly larger pool of resources for HIV/AIDS in Ukraine than was earlier believed. The areas in which these resources are being disbursed, and the low programmatic coverage being achieved by these programmes also suggest that the currently available resources may not being used in an efficient manner (56).

Government funds (as opposed to the declared budget statements in the national and international strategic documents) are primarily allocated to finance treatment (but not prevention), and they form only a minor share of funding of activities to respond to the spread of HIV/AIDS. The main share of expenses is carried by households both for prevention and treatment. The increase of funding occurs primarily at the expense of the finances from international donors, in particular, of the GFATM.

2.4. Policy on monitoring and evaluation systems

UNAIDS recommends that monitoring and evaluation activities occur under the umbrella of a unified national strategic plan that should include a single set of standardized indicators endorsed by all stakeholders in the country. In Ukraine, a national monitoring and evaluation plan was drafted in 2003. A national reference
group has informally existed since 2003 as part of a technical working group on Strategic Planning/ UNGASS under the UN Theme Group on HIV/AIDS in Ukraine. As one of the many outcomes of this collaboration, Ukraine has developed a standardized list of 24 (19 basic plus 5 additional) national monitoring and evaluation indicators for HIV/AIDS, with timelines for data collection and reporting agreed among seven national ministries and government agencies. Data for these indicators have been collected and used to complete three comprehensive UNGASS reports for 2003, 2005 and 2006, with extensive support from the GFATM grant and the involvement of a wide array of national researchers, epidemiologists and technical experts (57). Data were collected by key national ministries and other government agencies, with additional special studies being conducted on the basis of an open and transparent tender process.

Whilst Ukraine has achieved measurable progress in the development of national system for monitoring and evaluation, it still lacks a single, fully functional system. An interviewee suggested:

‘The indicators of monitoring and evaluation have to improve every year, or reach some objective set at the beginning of the project. In principle, it is happening. There is no other way to determine the influence of certain actions on the epidemic, very difficult. It is possible only at the national level. What's going on locally is actually unknown. Moreover, it's unknown if these indexes would have changed, had there been no intervention. That is there's nothing to compare to. For example, covering of vulnerable group with preventative programmes. This indicator was obtained only once – nothing to compare to. But it exists. In general, we can say that there are positive influences, some changes in the direction that was set.’ (Governmental organisation).

At the same time, it should be noted that not all stakeholders are familiar with the system of national monitoring and evaluation:

‘There is no national system of monitoring and evaluation. There are no national indicators. Every body acts based on the needs and norms of its own. That’s why it’s difficult even to evaluate all of Ukraine, how many infected with HIV we have. Who receives services and who provides what services, it's impossible to generalize – we don’t have it. Regions don’t have it, and it's clear that nationally either.’ (Governmental organisation).

Respondents’ views and findings from other studies (58) highlight that Ukraine continues to lack a clearly recognized authority for overall coordination of the national monitoring and evaluation system for HIV/AIDS programmes and the government continues to lack a plan to address this issue.

2.5. Factors influencing the Ukrainian national response to HIV/AIDS

In summary the following key factors influence HIV/AIDS policy in Ukraine:

- Despite the high rate of other STIs, the growing but still concentrated HIV/AIDS epidemic in Ukraine is mainly driven by injecting drug use;
- While the core HIV/AIDS national legislation is progressive and complies with the international commitments, punitive drug and prostitution policies are considered to be key stumbling blocks to effective HIV/AIDS prevention policy;
- Lack of state funding to respond to HIV/AIDS as well as lack of trust and cooperation between the state and civil society are highlighted as major obstacles to effective HIV policy;
- The role of NGOs and CBOs providing a growing volume of services to HIV+ people and vulnerable groups is considered a significant enabling factor;
- The role of local politicians and state bureaucracy is more inhibiting than enabling. A medical approach to HIV/AIDS dominates together with limited personal motivation to combat the epidemic among staff and limited reference to basic evidence in developing effective HIV/AIDS strategies;
- The potential role of the media could have in changing public understanding of and attitudes to HIV/AIDS has been under-utilised by policymakers in Ukraine.

There are two broad groups of factors influencing the policy process: endogenous, determined mainly by the internal content of a policy, and exogenous or external existing independently from a policy and serving as its
context. Among exogenous factors, four are most important: structural (political, institutional, demographic, health system), cultural, environmental or international and situational (relating to specific events).

Exogenous structural and sociocultural factors were identified as particularly significant influences on the formulation and implementation of HIV/AIDS policy in Ukraine in 2000-2004. Political factors were considered the most influential: some factors enabled the effective implementation of HIV/AIDS policy (mostly associated with the raised profile of HIV/AIDS and increased international donor funding); some political factors inhibited HIV/AIDS policy including a lack of political leadership, the absence of a clear strategy and lack of coordination among key stakeholders.

International donor assistance, primarily through the GFATM grant and the World Bank HIV-TB Control Loan, is considered a key enabling factor in the development of the Ukrainian HIV/AIDS policy. Indeed, internal sources amounted to less than a fifth of the country's aggregate expenses for combating HIV/AIDS in 2004. This raises a serious question about national policy being over-dependent on external funding, and hence a threat to the nationally determined policy beyond 2007.

Weaknesses in the healthcare system inhibit the development of HIV/AIDS programmes. The absence of a coherent health policy, and a lack of trained staff, appear to be critical obstacles to developing HIV/AIDS policy. Corruption remains a significant crosscutting issue influencing HIV/AIDS policy (59).

There is need for better integration of HIV/AIDS programme into the primary health care system especially in the area of STI treatment, reproductive health services and infectious diseases management (particularly Hepatitis B, C, and TB). Thus poor linkages and interaction with other communicative disease prevention and control systems are considered important factors influencing effectiveness of the HIV/AIDS policy.

Moreover, the implementation of commitments made and the resulting impact on the HIV/AIDS epidemic in Ukraine in 2000-2006 were limited. Epidemiological and behavioural evidence on the HIV/AIDS epidemic was not drawn on in policy planning and implementation against the background of the concurrent epidemic of drug abuse and TB.

There is also conflict between the public health need to prioritize prevention among most at risk groups and widespread (in particular among the health care staff) and deep-seated stigma and social exclusion of these same groups in the society, with little recognition among policymakers of the drivers of the epidemic in Ukraine: poverty and low levels of social capital.
Section 3
Overview of Global HIV/AIDS Initiatives in Ukraine

3.1. The Global Fund to Fight HIV/AIDS, TB and Malaria Grant

3.1.1. Objectives and terms of the GFATM Programme in Ukraine

The successful application for a Round 1 GFATM grant was submitted in June 2002. In January 2003, the agreement on the programmatic grant between the GFATM and Ministry of Health of Ukraine and UNDP/Ukraine was signed. The programme “Overcoming HIV/AIDS epidemics in Ukraine” is aimed at substantial reinforcement of the national response to the epidemic. The main programme objective is to reduce HIV incidence and morbidity rates, and also the AIDS mortality rate in Ukraine. The programme’s strategy has focused on supporting and expanding community-based prevention and care interventions for vulnerable and hard to reach communities, and providing up-to-date and tailored information and resources. Integral to this approach are linkages between prevention and care and support services.

The Ukrainian Ministry of Health was appointed to manage this grant in 2003; however, at the beginning of 2004 the grant was suspended as a result of concerns about the slow pace of the programme’s implementation, as well as problems in project management on the Ukrainian side. An expert who participated in the stakeholder interviews commented on the situation with the suspension of the grant in the following way:

“[The Ministry of Health] cannot be blamed because at that moment it was an absolutely new system of accounting for them, there were no personnel, no people at the Ministry who could have done it all” (International NGO)

In March 2004, the International HIV/AIDS Alliance was selected as Interim Steward of the GFATM HIV grant by a special Stewardship Agreement (60). The National Coordination Committee (NCC) described in chapter 2.2.4 now plays a role of the GFATM country coordination mechanism (CCM).

The first phase of the grant expired on September 30, 2005; the budget for the period was 23,379,000 USD. At this time the GFATM invited Ukraine to apply for the continuation of financing (the second phase) according to the grant agreement. The second phase is still in effect having started on October 1, 2005, and it will expire on September 30, 2008. The total budget for this period is 67,182,532 USD (61). Thus, financing for the two periods came to 92,162,320 USD. GFATM funds are provided to Ukraine as a grant without need for repayment to the donor.

3.1.2. GFATM target groups

In accordance with an agreement between GFATM and International HIV/AIDS Alliance in Ukraine the following groups were defined as the main beneficiaries of the programme:

1. People most vulnerable to HIV/AIDS including IDU, FSW, MSM and prisoners;
2. People living with HIV/AIDS;
3. Children affected by the HIV/AIDS epidemic;
4. Children and youth in the state educational system;
5. Homeless and unsupervised (“street”) children;
6. People in uniform (military personnel, law enforcement personnel);
7. Organisations that deal with prevention of HIV/AIDS and provide services to the PLWHA and vulnerable groups;
8. Bodies responsible for the national response to the HIV/AIDS epidemic;
9. General public.

However, experts interviewed stated that the true priorities of the GFATM grant are the four groups defined as the most vulnerable to HIV:

‘Separate groups are included – injecting drug users or sex industry workers, and MSM…also prisoners are considered vulnerable…’ (National NGO)

### 3.1.3. The geographical distribution of GFATM funding

Agreement between the GFATM and the International HIV/AIDS Alliance in Ukraine also provided for the implementation of the full range of HIV services, in particular ARV therapy, to be carried out in eight regions of the country (in Dnipropetrovsk, Donetsk, Mykolayiv, Odesa oblasts, Crimea, Kyiv and Kyiv oblast immediately, and more gradually in Kherson and Cherkasy). Subsequently GFATM funds are used to support programmes in all regions of Ukraine, albeit unevenly distributed.

According to data provided by the International HIV/AIDS Alliance in Ukraine (62) on the geographical distribution of the grant’s funding in 2005 (Attachment 6) most funding was disbursed in the six major regions: Kyiv and Kyiv oblast, Odesa, Mykolayiv, Donetsk, Dnipropetrovsk oblasts and Crimea. Importantly, an interviewee explained:

“First of all, it [the Global Fund] allows the country to find its way. It doesn’t push or influence. It sets them apart completely from the USAID. USAID defines both the priority regions and the at-risk groups. They are dictators.” (International NGO)

However, all respondents noted that in practice GFATM programmes tended to be established in similar areas to USAID programmes. An interviewee said:

‘Global Initiatives work in the places where USAID’s help strategy is present’ (National NGO)

Interviewees felt that most GFATM funding was directed into these regions in order to increase level of service coverage, and because the presence of USAID programmes in these areas meant that infrastructure was relatively well developed. According to the views of one interviewee this allowed the use of GFATM funds more effectively. Other experts who were interviewed expressed an opinion that the ‘priority’ regions had been selected based on two major criteria: levels of HIV/AIDS prevalence and levels of regions’ abilities to receive funding. In particular, the following opinion was voiced:

‘The priority regions were selected not because of the horrible consequences of the epidemic or something, but because work had already been started earlier there. The epidemic started there earlier. In general the NGOs turned out to be ready to receive funds and took the responsibility… As to the governmental structures, for example, Donetsk region has always had a very strong AIDS centre. This is the role of “a personality in history” because their chief doctor in charge understood it was important. The centre is cooperating very closely with the NGO, supporting different initiatives. But Chernihiv region, for example, they still don’t have an AIDS centre as it should be. It’s just a department at the infection clinic there. It depends quite a bit on the personality. (Governmental organisation)

A similar perception of the ‘human factor’ was expressed by other experts in their accounts of the HIV/AIDS epidemic:

‘…The human factor plays a large part, that is the people who have authority and form policies based on their own opinions as a rule. (National NGO)

The epidemiological situation is recognized as changing; in particular it is spreading onto the general population, as well as the worsening in central, western and northern regions of Ukraine. In response the decision was made to increase financing in these regions. Thus, all regions of Ukraine have started receiving funding from the GFATM now, initially for treatment and HIV testing.
3.1.4. The breakdown of GFATM funding by activities

The structure of the programme “Overcoming HIV/AIDS epidemics in Ukraine” which was supported during GFATM Round One Grant and is being carried out at present by the International HIV/AIDS Alliance in Ukraine has four inter-related components:

- improving quality and availability of treatment, care and support for HIV+ people ($52,749,426);
- development and scaling-up of prevention services for vulnerable communities, including IDUs, sex workers, MSM and prison populations ($13,549,455);
- supporting an enabling environment through information, education and advocacy ($10,217,756);
- improving the national system of monitoring and evaluation ($3,087,590) (63).

Figure 3.1 shows the distribution of GFATM grant money by these categories. More details on distribution of GFATM money according to activities for the 5 year GFATM Programme is included in Attachment 7.

![GFATM Round One Grant: Money flows](image)

3.1.5. Sub-recipients of the International HIV/AIDS Alliance in Ukraine

Three main groups of organisations act as GFATM sub-recipients (see also Figure 3.2):

1. Financing of treatment is distributed through the Ministry of Health (national AIDS centre);
2. Care and support are provided by the All Ukrainian network of PLWHA;
3. About 150 different Ukrainian NGOs implement preventative programmes.
The National AIDS Centre purchases ARV-treatment and the drugs to treat OIs and distributes them among regional and municipal AIDS centres.

The Network of PLWHA also receives funds to deliver care and support services in different regions of Ukraine. Since 2003, the Network has managed the project ‘Providing care and support for people living with HIV/AIDS’. The total project budget to date has been $6,115,600. Its main achievements include:

- Providing grants to 47 partner organisations;
- Providing care and support services to PLWHA, among them children;
- Providing a wide range of care and support services to PLWHA in through community centres;
- Providing care and support to HIV+ children through children centres;
- Establishing care and support programmes for PLWHA in prisons;
- Conducting annual events, including the Day of Solidarity with HIV+ people and World AIDS Memorial Day;
- Gathering and analysing information concerning protecting the rights of PLWHA;
- Establishing a company for conducting activity in the sphere of social enterprise (57).

The 150 sub-recipient NGOs take part in open or closed bids advertised according to the stipulations of the agreement signed with the GFATM. They are mainly involved in educational, prevention and advocacy programs.

3.1.6. GFATM Round Six: Ukrainian participation

Ukraine applied for a GFATM Round Six grant. The decision about Ukrainian participation was made by the National Coordination Council on prevention of HIV/AIDS spread on May 10, 2006. Ukraine has made a request for 151,077,432 USD in its application to the GFATM for further financing of the programme “Overcoming HIV/AIDS Epidemic in Ukraine” in 2007-2011 (64).

Both representatives of governmental structures and international and Ukrainian NGOs, donor agencies, professional unions, businesspeople, PLWHA and representatives of HIV vulnerable groups were brought in to develop the application. The working group consisting of about 30 members gathered 55 applications from more than 40 organisations from all over Ukraine.
The Round Six programme’s objective corresponded with the Round One grant, although the new objective states more clearly that the programme will concentrate on the groups most vulnerable to HIV infection. The new application sets quite ambitious goals that some stakeholders believe may be difficult to achieve in practice. Two Principal Recipients were chosen during the application development process: the International HIV/AIDS Alliance in Ukraine and the All Ukrainian Network of PLWHA. Activities of these two organisations will be divided into two key areas within the project: the All-Ukrainian Network PLWHA will deal with treatment, care and support of people living with HIV, and the International HIV/AIDS Alliance in Ukraine will be responsible for prevention, education and advocacy.

On the 3rd of November 2006 the Board of the GFATM approved the application from Ukraine. In accordance with the existing procedures, the Fund signs an agreement for the first two years of programme implementation, this means that Ukraine may soon receive the first transfer ($29,649,187) for the period of 2007-2008. To sign the final agreement, Ukraine must fulfil a number of requirements. These include increased budget allocations for HIV/AIDS work, constructive negotiations to re-launch the suspended World Bank AIDS Loan and ensure the government’s support to substitution treatment for injecting drug use, which remains the driving force behind the HIV epidemic in Ukraine. After presenting an account of these and other issues, the negotiation process will take up to four to five months, and in the best case scenario the GFATM financed programme will be launched in March-April 2007 (65).

3.2. The World Bank Loan

3.2.1. Objectives and terms of the World Bank Loan

The history of the World Bank Loan to fight TB and HIV/AIDS is characterized by long-standing negotiations and misunderstandings. The design/preparation stage of the WB Loan in Ukraine began in 2000. In July 2002, the Loan design reached its final stage: setting up of the Project Supervisory Board by the GoU. This process was accompanied by massive public discussions on the necessity to take a loan for HIV/AIDS programmes. The public opinion and positions of many political leaders were rather negative. Nevertheless in October 2002, negotiations between the official Delegation from Ukraine and International Bank of Reconstruction and Development (IBRD) on Loan took place in Washington D.C. In December 2002 the Loan, totalling $60M was approved by the IBRD/World Bank Board of Directors. In April 2003, an agreement was signed between the Government of Ukraine and the IBRD and was ratified by the Ukrainian Parliament (Verkhovna Rada) in November 2003.

The Loan project is being implemented by the MoH and State Department of Corrections and became operational in March 2004. The objective is to reduce TB and HIV/AIDS morbidity and mortality through an effective National Strategy for TB control adapted to international standards and an HIV/AIDS programme focused on prevention of transmission among high-risk groups. The GoU also agreed to provide $21.9M from the state budget for financing the programmes. It was agreed that half of the Loan would be allocated to HIV/AIDS programmes.

The commodities, training and information campaign supported by the Loan project were intended to supplement the proposed GFATM prevention activities for IDUs, FSWs, prisoners and MSM. Provision of drugs for treatment of OIs in AIDS centres and improved laboratory capacity in TB clinics are intended to benefit those patients who will be referred to the AIDS and TB centre.

In the penitentiary system, funding from the Loan had been secured to scale up prevention services, with special emphasis on training 2,000 peer-to-peer counsellors, VCT training for healthcare practitioners in the penitentiary system, provision of informational materials, condoms and disinfectants. This component was designed separately because of the institutional nature of the prison system, a self-contained and centrally managed system.
3.2.2. The disbursement of the World Bank Loan

It is not possible to track the geographical distribution of the World Bank Loan money since the funds are managed by the MoH as part of overall healthcare funding.

Initially it was planned to disburse money as follows:

- procurement and distribution through harm reduction programmes of disposable syringes and needles, disinfectant solutions, and alcohol wipes among IDUs for HIV/AIDS prevention ($6.65M/4 years);
- procurement and distribution of condoms through harm reduction and other prevention programmes for most at risk populations ($2.16 million);
- a public information and education campaign to increase awareness of the general population and vulnerable groups on HIV/AIDS and TB prevention and changes to a more tolerant attitude to people living with HIV and tuberculosis ($6.26 million);
- provision of condoms to prison inmates ($1.7 million);
- development of treatment protocols and provision of drugs and supplies for the treatment of opportunistic infections ($2.06 million);
- strengthen capacity of TB care providers in providing TB care through training ($2 million);
- improvement of a laboratory capacity within government TB clinics for TB diagnosis ($8.77 million) (66).

Whilst GFATM and the WB programmes differ, they are intended to compliment each other and are coordinated at the executive level of both institutions. The WB’s priorities were prevention and programmes created to lessen the damage as opposed to the GFATM where the main priority is financing of treatment care and support. A representative of the WB is a member of the National Coordination Council of Ukraine on prevention of HIV/AIDS spread – the main coordinating mechanism in the country.

3.2.3. Suspension of the World Bank Loan

In April 2006, the World Bank announced the suspension of its loan because of lack of progress in implementing the programme. After three years only 2% of the $60 million available had been disbursed by the Ukrainian government (67). Around 90% of the money used was paid by Ukraine to the WB as the commission for the loan. The problems disbursing the Loan are attributed to low capacity of the Ukrainian health system to absorb external money for public health programmes. Research data suggest that the absence of a coherent health policy and lack of trained staff were the most significant factors inhibiting its implementation (68).

In October 2006 World Bank representatives discussed with the government of Ukraine precise proposals to restructure the suspended Loan. However political problems, including the fact that the Minister of Health resigned, may undermine progress.
Section 4
HIV/AIDS-related interventions and services in Ukraine

4.1. Problems mapping HIV-services in Ukraine

Decentralization. All regions of Ukraine have similar government departments (healthcare, education, family, youth and sport affairs, labour and social welfare and others) and the same institutions (hospitals, clinics, state social services for children, families and youth). However, the services that they provide can differ depending on the region; not all regions have the same number of institutions and personnel. That means that HIV-services depend considerably on local bodies with the executive power and local government agencies that finance and control these institutions. Study respondents note that some local policy-makers do not prioritize the problems of HIV/AIDS.

Fragmentation. Ukraine is known for its long-standing tradition of overlapping functions, for example four Ministries are responsible for support of disabled children. In a single city a number of medical facilities may be run by different government departments including the Ministry of Health, Ministry of Transport, Ministry of Internal Affairs and the State Department of Corrections. Whilst the distribution of functions for HIV/AIDS control among different ministries and other governmental bodies is relatively well defined, some functions are duplicated and it is unclear who is responsible for some areas of performance.

Limited accountability. Although all medical institutions must have a medical license it is difficult to get information on their activities. In particular some services for PLWHA and most at risk groups lack transparency, especially relating to the treatment of STIs and drug addiction. Social institutions are not licensed and social workers are not registered. The system of governmental bodies, namely institutions that provide medical and social services is non-transparent when it comes to providing information about their activities. This makes it difficult for citizens to understand what services are available and their entitlement to those services. NGOs are registered at different levels and no registration lists are available. Considerable dependence of NGOs on the donor money causes instability in the functioning of some organisations which work only for a few years while the grant funds they received are available.

Discrepancies between declared and actual services. The constitution of Ukraine entitles people to medical care free at the point of delivery. In practice it is often not available for clients. All state social services for children, family and youth are supposed to provide support for PLWHA and groups vulnerable to HIV, although in reality regional services have limited the number of staff and have limited capacity to deliver programmes they are responsible for. NGOs declare they provide HIV services and other social services. Survey results show that in practice these services do not always perform according to their intended functions (69).

4.2. Different types of intervention and services

4.2.1. Typical providers of services in regions

In Ukraine there is large network of state institutions providing HIV/AIDS-related services throughout the country.

The Ministries that deal with HIV/AIDS services are:
- Ministry of Health;
- Ministry of Family, Youth and Sports Affairs
- Ministry of Education and Research;
- Ministry of Labour and Social Policy;
These ministries perform their duties through a number of local institutions (see Table 4.1.) which are also subordinate to the local authorities. Hence, in terms of executive power, the system of HIV-services is managed by the corresponding Ministry at the national level and by local administrations at the level of the 27 regions (oblasts) and 490 districts (rayons).

**Table 4.1. State HIV-services**

<table>
<thead>
<tr>
<th>Ministries</th>
<th>Institutions on regional level</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>- AIDS centres&lt;br&gt;- communicable diseases hospitals&lt;br&gt;- drug clinics, tuberculosis clinics&lt;br&gt;- skin disease and STD clinics&lt;br&gt;- hospitals and polyclinics for children and adults at the places of their residence&lt;br&gt;- obstetrics hospitals&lt;br&gt;- obstetrics and gynaecological consultations&lt;br&gt;- sanitary and epidemiological services</td>
<td>- Diagnostic,&lt;br&gt;- Treatment (including ARV, substitution therapy),&lt;br&gt;- Medical care&lt;br&gt;- Surveillance</td>
</tr>
<tr>
<td>Ministry of Family, Youths and Sports Affairs</td>
<td>- State social services for children, families and youth</td>
<td>- Primary prevention (behavioural change communication)&lt;br&gt;- Work with most at risk populations&lt;br&gt;- Special services for families affected by HIV/AIDS</td>
</tr>
<tr>
<td>Ministry of Education and Research</td>
<td>- Secondary schools, &lt;br&gt;- Universities &lt;br&gt;- Other educational establishments</td>
<td>- Prevention</td>
</tr>
<tr>
<td>Ministry of Labour and Social Policy</td>
<td>- Regional departments of social protection</td>
<td>- Cash benefits to those entitled for benefits to disable people</td>
</tr>
<tr>
<td>State Department of Corrections</td>
<td>- Prisons &lt;br&gt;- Other correctional institutions &lt;br&gt;- Hospitals for prisoners</td>
<td>- Prevention programme&lt;br&gt;- Medical care</td>
</tr>
</tbody>
</table>

The state specialized treatment and prevention institutions of the MoH that carry out the state policy in the field of HIV/AIDS control are centres for the prevention and fight with AIDS (AIDS centres). The main tasks of these centres are:

- Developing interventions aimed at prevention of HIV/AIDS.
- Epidemiological monitoring and epidemiological surveillance of HIV/AIDS.
- Providing of organisational and methodological management of healthcare institutions on the issues of HIV counselling services, diagnostics, treatment and preventative services to the public.
- Arranging and providing necessary medical, psychological and social help to people with HIV/AIDS.
- Diagnosing HIV and opportunistic infections.
- Arranging and providing support to people with HIV/AIDS outside medical institutions.
- Surveillance of people with HIV/AIDS in clinics.
- Registration, preventative treatment and hospitalization of medical personnel at risk of being infected while performing their professional duties.
- Arranging voluntary testing along with pre-test and post-test counselling.
- Educating medical personnel of healthcare institutions about prophylaxis of HIV.
- Providing development and fulfilment of the national, regional and municipal programmes for HIV/AIDS prevention, monitoring and evaluation of success in their implementation.
− Arranging educational and informational events to reduce the risk of HIV infection among different population strata concentrating on the vulnerable groups.
− Cooperating with mass media on publicising issues related to HIV/AIDS problems; arranging informational and educational events to overcome discrimination of people with HIV.
− Cooperation with other governmental, public and international organisations on HIV/AIDS issues; inviting members of NGOs that provide HIV services, the Red Cross, the All-Ukrainian Network of PLWHA, social services and groups providing mutual psychological, social and juridical help to those with HIV/AIDS and to their families.
− Keeping a database of existing services for people with HIV/AIDS including services provided by NGOs and providing patients with information about relevant services (70).

The network of AIDS centres consists of 35 centres in all regions of Ukraine:
− Ukrainian National Centre;
− Crimean Republican Centre;
− Kyiv and Sevastopol Municipal Centres;
− 26 regional AIDS Centres;
− Mariupol, Makiyivka, Gotlivka, Slavic municipal (Donetsk oblast), as well as Kryviy Rig municipal centre (Dnipropetrovsk oblast).

AIDS centres exist in all 27 regions of Ukraine, however, there are several municipal AIDS centres in some places besides the regional ones. The number of services and their quality, coverage of clients with HIV-services differ. Some centres do testing only, others also provide treatment. Interviewees suggested that that infrastructure was developed in regions in which HIV/AIDS was more prevalent or were local managers were more active and influential.

Social services are included in regional AIDS centres remits although limited human resources undermine their ability to providing them. In practice NGOs provide social services, in some cases delivered through AIDS centres. For example, a NGO supported by the GFATM provides care and support for people who are getting ready to receive or are receiving ARV-therapy in the Kyiv municipal AIDS centre. The organisation runs adherence to treatment programmes and arranges transportation for those people who are physically unable to get to the AIDS centre, as well as supporting a self-help group of HIV+ people and referring clients to other services. Another NGO established a syringe exchange service financed by the GFATM delivered through the AIDS centre.

The leading provider of state social services, mostly of preventative nature, is the network of state social services for family, children and youth subordinate to the Ministry of Family, Youth and Sports Affairs. This network consists of:
− The State social service for family, children and youth;
− Republican (the Crimean Republic) centre of social services for family, children and youth;
− 27 regional centres;
− 168 municipal centres;
− 40 centres in municipal districts;
− 479 in districts;
− 43 in villages;
− 490 village centres of social services for family, children and youth.

These services can be a base for the specialized services that include, for example, the services working with IDUs, numbering 2,020 of them functioning in all of Ukraine at the moment.

There tend to be the following types of NGO HIV/AIDS services in the regions:
− branches of the Network of PLWHA (on the basis of these branches, community centres, day centres for children living with HIV/AIDS and other centres are founded);
− self-help groups;
− faith-based organisations (including rehabilitation services for IDUs);
− NGOs and voluntary organisations;
- private institutions.

In summary, HIV/AIDS diagnostics and treatment, PMTCT and blood safety are the responsibility of government health systems, while care and support, harm reduction, other work with vulnerable groups and advocacy are carried out primarily by NGOs/CBOs. Some services are, however, provided jointly by state services and NGOs.

The geographical distribution of services (governmental and non-governmental) supported by GFATM is presented in Attachment 8.

4.2.2. Diagnostics and counselling

As a general rule, HIV testing is voluntary in Ukraine. However, as interviewees suggest, there are exceptions:

*Only pregnant women and blood donors must go through obligatory testing at this point. All others, it seems like, are to be HIV tested voluntarily. However, every region has its own testing policy. For example, in Sevastopol according to the commander’s orders all sailors are HIV tested if they go out for a term of about a year. There were incidents when sailors would die at the sea and then they had to pay considerable insurance money to their relatives. That is why they do it to protect themselves.*

(Governmental organisation)

It is most often that HIV+ people find out about their status at:

- AIDS centres;
- drug rehabilitation clinics (hospitals);
- tuberculosis clinics;
- STD clinics;
- hospitals and polyclinics (out patient care) at their places of residence when treating other diseases, as well as when testing pregnant women and blood donors;
- communicable diseases hospitals or at the communicable diseases departments at the hospitals of the place of residence;
- anonymous HIV-testing services at the hospital of the place of residence;
- prisons.

With the participation of the International HIV/AIDS Alliance a national protocol on HIV voluntary testing and counselling was developed that was approved by the MoH in late 2005. It stipulates that all people receiving testing should be entitled to pre-test and post-test counselling. Case study research suggests that doctors and those who are involved in the process of testing are not always familiar with the requirements of this protocol (71).

4.2.3. Treatment and medical care

According to Ukrainian legislation all medical institutions must provide medical help to PLWHA without any obstacles including treatment of OIs. As of the end of 2003 primary medical and sanitary care was provided to urban citizens by 2,750 independent polyclinics and 668 polyclinics situated within hospitals, and to rural groups by 734 ambulatory departments of district hospitals, 2,892 medical ambulatory offices in villages, 1,451 ambulatory general practitioner’s offices, and 15,655 midwife and delivery stations. Also, there are 592 municipal hospitals, 104 municipal children’s hospitals, 486 district hospitals, 125 specialized hospitals, 734 catchment hospitals and 25 regional hospitals nationally. In total there are 458,351 hospital beds nationally (72).

Exact numbers of private providers are not available. Discrepancy in data provided by various subdivisions of the Ministry of Health is large, ranging from 1,000 to 3,500 self-sustained private medical institutions. Additionally, there are about 30,000 private practices run by individual doctors/specialists. The majority of private medical care providers are small in capacity, and their overall impact on the volume of medical
services rendered to population is minor (73). The majority of pharmacies were privatised in the 1990s. The lack of proper government regulations resulted in uncontrolled market development with fast growing prices of drugs and medical items/products. The pharmaceutical industry was seen as having a significant influence on drugs supply through influencing the prescription practices of physicians (74).

Most often HIV+ people approach local polyclinics where they get a referral to a specialised clinic, usually an AIDS centre. If there is no AIDS centre locally HIV+ people might be sent to a communicable diseases clinic or to a tuberculosis clinic where they should receive free medical care. IDUs also receive services at drug rehabilitation hospitals.

A lot of HIV+ people avoid approaching polyclinics where they receive treatment locally because of negative and prejudiced attitude of personnel that is caused in most cases by insufficient information. Instead patients often approach a municipal or regional AIDS centre directly, a communicable diseases clinic, or a drug rehabilitation clinic where, as a rule, there are special areas for HIV+ individuals (beds or separate wards). According to the Ukrainian Centre of HIV/AIDS Prevention data (2005), the number of specialized beds for PLWHA in different types of public healthcare institutions is 1,239 (75) (Table 4.2).

Table 4.2. Distribution of beds for HIV-infected and people with AIDS in Ukraine, 2005

<table>
<thead>
<tr>
<th>Institutions</th>
<th>N of AIDS-beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS Centres</td>
<td>310</td>
</tr>
<tr>
<td>TB dispensaries</td>
<td>235</td>
</tr>
<tr>
<td>Narcological clinics</td>
<td>124</td>
</tr>
<tr>
<td>Healthcare institutions of the general medical network</td>
<td>570</td>
</tr>
<tr>
<td>Total number of beds for HIV-infected people</td>
<td>1239</td>
</tr>
</tbody>
</table>

There is a specialized maternity centre in Kyiv which HIV+ women are directed to for medical help during delivery and childbirth.

It should be noted that as a general rule, after a child is born to an HIV+ mother, the child’s health is monitored by AIDS centre staff until the child reaches 18 months, and also by a local paediatrician. Also, the child is administered treatment at the AIDS centre, and then when they reach 18 months they get tested and can be taken off the registration list of the AIDS centre depending on the result. HIV+ children tend to receive ARV-therapy directly at AIDS centres.

4.2.4. Access to ARV treatment

Implementation of the GFATM programme has significantly scaled-up the provision of ART in Ukraine. At the start of the GFATM Programme, there were only 65 people receiving ART. During the summer of 2004 the first batch of ARV drugs was delivered to Ukraine to be used to provide large-scale treatment within the GFATM programme for 2,100 HIV+ people, out of whom 100 were children. Drugs were directed to six priority regions (Crimea, Odesa, Mykolaiv, Dnipropetrovsk and Donetsk oblasts and Kyiv city).

Later in 2004 the International HIV/AIDS Alliance received a second batch of ARV drugs, and supported by its partners, arranged delivery and distribution of those drugs necessary for the treatment of opportunistic diseases, prophylaxis of infection from mother to child and post-contact prophylaxis drugs in the priority regions.

Since a limited number of people were willing to receive ARV-therapy at this point a series of press club meetings started on the issues of expansion of ARV-therapy in the priority regions of Ukraine. As a result of these meetings new possibilities in treatment and attraction of more people to treatment among participants were a highlight of mass media reports (76).

The number of Ukrainians receiving ARV treatment increased from 1,743 people in May 2005 to 3,186 as of April 2006. Of those, 2,766 people received ARVs with funds provided by the GFATM; 420 persons received ARV treatment provided by budgetary funding or other sources. At present ARV-therapy is available in 21 out of 27 regions in Ukraine.
Hence, since August 2004, with support from the GFATM, access to ARV drugs for children has expanded. Children are now guaranteed first-priority access to ARV-treatment. Prior to 2004, only 56 children had received ARV-treatment. By October 2005, that number had increased to 369 children (only 31 of these treatments were paid for from public funds).

According to Ukrainian MoH data 86% of HIV+ pregnant women received a full course of ARV treatment in order to decrease the risk of HIV vertical transmission in 2005. The prevention of vertical transmission in Ukraine, among other factors, appears to have reduced the percentage of children who receive HIV from their mothers from 27.6% in 2001 to 7.7% in 2005.

In light of the rapid spread of HIV/AIDS in Ukraine this level of ARV treatment is generally regarded as insufficient. According to the Ukrainian MoH during the first three months of 2006, 5,651 people developed AIDS and, therefore require ARV treatment. WHO/UNAIDS estimated that by the end of 2005, there were as many as 17,300 people without access to needed ARV treatment (77).

The issue of the introduction of ARV-therapy in prisons remains unsolved, notwithstanding the fact that the Cabinet of Ministers of Ukraine adopted a document stating that prisoners in detention and penitentiary facilities should receive treatment. In 2005, the International HIV/AIDS Alliance in Ukraine started introducing the first ARV programme for 30 patients in the penitentiary system (Daryivska penitentiary institution № 10 in Kherson oblast).

The GFATM Programme in Ukraine, as it was originally written, would have provided treatment for only 340 people. It became clear that the programme was exceeding all expectations, and hence the grant was re-engineered so that eventually up to 6,000 people will be able to receive treatment (78). The GFATM Six Round application states that the Ukrainian government will deliver ARV-treatment programmes from the state budget. This intention raises questions about the sustainability of ARV-treatment in Ukraine, since some stakeholders question the commitment, capacities and resources of the Ukrainian government in the longer term.

4.2.5. Substitution therapy

The introduction of substitution therapy (ST) in Ukraine became one of the most important tasks of the GFATM programme in 2004 since many HIV+ people remain active IDUs. Indeed, they are not entitled to receive ART unless they receive ST. Despite the fact that methadone treatment is recognised internationally as the most effective ST, no programmes supply methadone to date in Ukraine.

On October 15, 2004, as a result of advocacy activities, the International HIV/AIDS Alliance signed an addendum to a Memorandum of mutual understanding with the MoH that approved a scheme for the delivery of ST drugs (buprenorphin) (79). Initially this ST was introduced in Crimea, Dnipropetrovsk, Mykolayiv and Odesa regions and in Kyiv city as an experimental programme through drug rehabilitation hospitals. Only 214 people received substitution therapy in 2006, out of whom 163 were HIV+ and 54 are receiving HAART. In March 2006, the MoH approved the expansion of this programme to two more oblasts – Vinnitsa and Poltava (80). In September 2006, it was expected to have 600 IDUs on ARV therapy receiving ST. However, the GFATM Programme did not achieve this target having slightly over 200 patients receiving treatment (81).

The International HIV/AIDS Alliance in Ukraine lobbies for the legalization of methadone in Ukraine. Using this drug is seen as greatly decreases the cost of ST. However, the introduction of ST in Ukraine continues to be inhibited by legislative and organisational problems, as well as negative professional and public views.

4.2.6. Care and social support

The Ukrainian GFATM Sixth Round proposal states that in the area of non-medical care and support there are currently fewer than 15,000 PLWHA who receive care and support services in 2006 (82). The International HIV/AIDS Alliance’s data show an even more modest number of care and support services: in
2005 care and support services covered 4,000 HIV+ people in 15 regions of Ukraine (83). In any case, the number of those who receive these services is low in comparison to number of officially registered PLWHA.

These care and social support services include adherence counselling, self-help groups at community drop-in centres, childcare and home care. The main provider of these services is the All-Ukrainian Network of PLWHA. Care and support activities are carried out in close cooperation with regional AIDS centres, and other government agencies and NGOs with financial support from GFATM and other donors.

The main forms of care and support provided by the All-Ukrainian Network of PLWHA are:

- Medical, social and psychological support for adults and children on ART (improving their knowledge, skills and motivation with regard to adhering to ARV therapy in accordance with the doctor’s recommendations; counselling and emotional support; creating conditions for psychological comfort by means of counselling, informational and educational work and case management);
- Non-medical and nursing care (including social support at home; psychological support; assistance in getting medical help; restoration of documents; nursing care; injections);
- Community centres for PLWHA and their immediate families (psychological and social support; educational activities; positive prevention; teaching life skills, particularly with the purpose of further job placement; legal and social services; hobby classes; recreational activities and dating services);
- Medical and social support of HIV+ pregnant women, new mothers and babies aged under 18 months born to HIV+ women (post-test counselling; groups of self-help; supporting the adherence of HIV+ pregnant women to ARV therapy; accompanying HIV+ pregnant women and/or referrals to other institutions; education of new mothers and their family members about newborn care);
- Reproductive healthcare and family planning; work with discordant couples (family counselling; psychological and social support of family members; assistance in diagnostics and sperm cleaning with further impregnation; referrals to other HIV-service organisations);
- Care and support for HIV+ children and their immediate families (socialization of children with HIV/AIDS; psychological and social support; social support; legal services; counselling using peer methods; mutual support groups for their immediate families);
- Care and support of HIV+ prisoners (counselling; informational, legal and counselling services; assistance in receiving medical help by HIV+ prisoners; arranging self-help groups);
- Development of self-help movements for PLWHA (mobilization of the PLWHA community; support for initiatives of self-help groups in the field of care and support);
- Therapeutic summer camps for PLWHA, IDUs and other vulnerable groups (psychological, therapeutic, educational, health and recreational support of the members of the PLWHA community and personnel of preventative, care and support projects).

The All-Ukrainian Network of PLWHA has established 7 comprehensive (complex) centres in Kyiv, Odesa, Donetsk, Kriviy Rig (Dnipropetrovsk oblast), Simferopol (Crimea), Kherson, Chernihiv. These centres provide slightly different services. For example, the centre in Simferopol opened in August 2003 before receiving GFATM support, although subsequently received GFATM and other funds. The centre provides a number of services including a day care centre for children, support for pregnant women and women who recently gave birth and support for HIV+ prisoners.

The All-Ukrainian Network of PLWHA promotes the idea of community centres for adults. Such centres currently exist in 9 regions (sometimes under the umbrella of complex centres, sometimes situated elsewhere). In these centres PLWHA receive peer counselling, information and psychological support, find friends, adapt to living with HIV, as well as home-based care and support for people at the terminal stage of AIDS (nursing and non-medical services).

In 2004 and 2005, as part of the project ‘Providing care and support for people living with HIV/AIDS’, implemented by the All-Ukrainian Network of PLWHA with the support of the GFATM Programme, the following interventions were established:

- New medical, social and psychological care services in 19 regions aimed at promoting adherence to ART (Donetsk, Kyiv, Odesa, Dnipropetrovsk, Mykolayiv, Kherson, Cherkasy, Zaporizhzhya, Poltava,
- Lugansk, Kharkiv, Ivano-Frankivsk, Vinnitsya, Khmelnytskyi, Lutsk, Sumy regions, Kyiv and Sevastopol,
- Medical, social and psychological support for pregnant women recently confirmed as HIV+ and their children (up to 18 months), in 6 regions (Donetsk, Kyiv, Odesa, Dnipropetrovsk, Mykolayiv region and Crimea).
- The ‘Summer school for children and parents, living with HIV’;
- A new model of children’s support with rehabilitation elements. Relaxation for 100 HIV+ children older than 18 months were organised in 11 regions (Kyiv, Kherson, Cherkasy, Odesa, Simferopol, Mykolayiv, Chernihiv, Kharkiv, Poltava, Kryvyj Rig).
- Additional support through two already established centres in Cherkasy and Donetsk. New interventions included social and psychological support, cultural and entertainment activities, supporting families’ socialization and food for HIV+ children.

Currently, 12 Day Care Centres for families with children affected with HIV/AIDS are established in Ukraine. Some of these centres are part of the complex centres for PLWHA.

In 2004 the Right-Bank Day Care Centre was established in Kyiv with cooperation of Kyiv Social Service for youth by means of UNICEF and Elton John AIDS Foundation.

In 2005 five new Day Care Centres were established in Chernihiv, Poltava, Simferopol, Kryvyj Rig and Mykolayiv. They are supported by different donors, including the GFATM.

In Day Care Centres there are rooms for individual and group work with children and consultation rooms for parents and close relatives. Social workers, legal advisors, psychologists, paediatricians and educators work with children and their parents. Specialists help children to study and develop their skills. Close relatives can visit self-help groups and also receive medical support. The target group of these programmes is HIV+ children of all ages.

Eleven self-help groups of PLWHA operate in Ukraine based on GFATM funding.

A national telephone hotline on HIV/AIDS problems was launched in July 2003 with GFATM funding. Between October 2005 and September 2006, the total number of calls to this free, 24-hour service exceeded 38,000. The project has also developed off-line internet counselling sessions and maintains a website that provides information (84).

Other NGOs support PLWHA including the Red Cross of Ukraine, and faith-based organisations that provide home-based care and non-medical services supported by different donors.

It is also expected that state-run social services for children, young people and families provide care and support for HIV+ children and adults. In reality, in some regions these state services may cooperate with the All-Ukrainian Network of PLWHA and organise joint services/centres, and organise services for families in crisis (families with a HIV+ child are regarded as in crisis).

4.2.7. Terminal care

The first application by Ukraine for a GFATM grant proposed the establishment of 6 hospices for people with AIDS. This target was not reached; moreover the task was eventually excluded as a programme target (85). This is because the health system lacks the infrastructure necessary for the establishment of these institutions. This is true both for people with AIDS and other groups of patients. In general, the availability of terminal (palliative) care services is extremely limited in Ukraine, with only one hospice for terminally ill cancer patients (86).

Currently there are different organisations working in Ukraine (non-profit and commercial, faith-based and secular, non-governmental and governmental) that provide help to terminally ill patients. Most non-medical services/care is provided by NGOs and mutual support activities of PLWHA themselves and their families.
Elements of palliative care for PLWHA are implemented by the All-Ukrainian Network of PLWHA (in comprehensive centres), the Red Cross and through some AIDS centres.

In light of the growing epidemic it is expected that the need for palliative care will rapidly increase. Recognizing this need the Ukrainian application for a sixth round GFATM grant contains proposed palliative care activities. It is expected:

- to develop standards and train service providers to provide palliative care;
- to provide palliative care for 100 terminally-ill clients in Year 1 to a total of 3,500 PLWHA in Year 5 who require chronic home care or end-of-life care.
- to provide intensified support for 1,500 people co-infected with HIV/AIDS and TB,
- to establish the first HIV/AIDS hospice in Ukraine in Year 3 (87).

4.2.8. Prevention and work with most at risk populations

Success in countering HIV/AIDS, given the concentrated nature of the epidemic, is dependent on effective large-scale coverage of vulnerable groups with prevention services and primary prevention activities (educational and other activities among all population).

In Ukraine primary preventative measures target young people and people in uniform, as well as IDUs, FSW, MSM and so-called bridge groups (people that have sexual contacts with most at risk populations). There are also preventative interventions at work places. HIV/AIDS prevention activities are carried out by:

- NGO projects supported by different donors;
- State-run centres of social services for family, children and youth;
- AIDS centres;
- Educational institutions.

By November 2006 projects supported by the International HIV/AIDS Alliance Ukraine had provided prevention services to more than 100,000 IDUs, over 14,000 FSWs, 5,500 MSM, and nearly 26,000 prisoners. Prevention services cover 29 correctional institutions (88).

Over the course of the GFATM Programme 5,353,072 syringes were exchanged (at 450 active exchange points), 1,763,938 condoms were distributed, and 3,154,580 copies of information materials were disseminated (as of December 31, 2005).

In 2005, the International HIV/AIDS Alliance launched coordinated measures to provide services to vulnerable communities. The activities aimed to link clients to respective services, and to meet their specific needs. Apart from access to sterile injection equipment and condoms, project clients receive counselling and support from psychologists, social workers, infectious disease doctors, drug experts, surgeons and lawyers (89).

Harm Reduction Programmes are also supported by the International Renaissance Foundation (the Soros Foundation in Ukraine) that spent nearly $1M on different activities. There were also inputs from UNICEF (mainly to state services for children, families and youth) for provision of harm reduction services to IDUs.

One aspect of prevention work among children and young people within the system of education involves the active participation of educators – teachers of secondary schools, colleges and higher educational institutions and with cooperation with the Ministry of Education and Science of Ukraine (the MoES). The International HIV/AIDS Alliance signed a memorandum of mutual understanding and cooperation with the MoES. Eight projects were implemented in 2004 promoting safe behaviour among children and young people.

The implementation of primary prevention programmes based on life skills within the Ukrainian education system as part of the GFATM programme consists of the following:

- Basic training – 1,500 directors and teachers of educational institutions; 28,000 parents;
Training based on life skills – almost 5,000 teachers, over 51,000 students and 55,000 parents;
Education based on life skills – 210,000 students of the 5th and 6th grades (90).

The Ukrainian sixth round GFATM proposal incorporates no primary prevention activities for schoolchildren. Instead it is expected that schoolteachers will provide this, and hence paid for through the MoES.

Currently young people’s preventative activities are also carried out by many NGOs funded by international and local sponsors.

It should be noted that state organisations and NGOs have different tactics for preventative work. An interviewee indicated:

‘There is no coordination in the informational work now in Ukraine. There is no unified informational and educational policy; the MoH hangs some posters in medical offices. The MoES publishes textbooks. Maybe this work is coordinated somewhere, but the Safe service for children, families and youth can order commercials that can cross out two years of informational work of other organisations’. (State organisation)

Thus, there is considerable work being carried out in Ukraine to prevent HIV risk behaviour mostly by NGOs. The few preventative services provided by government agencies are supported by NGOs.

### 4.3. Access to services

The majority of interviewed experts agreed that the number of services received by HIV+ people had increased and that access to these services is becoming better. Nevertheless some suggested that the provision of universal access to services - declared as a strategic direction of Ukrainian policy - will require considerably more resources to deliver that are currently available. Despite the scale-up of care and support programmes, current coverage represents only 18.5% of the total number of people diagnosed with HIV, and only 3.3% of the total number of people estimated to be living with HIV. For example an interviewee said:

“Those representatives of vulnerable groups who had an opportunity to receive help and received it are already covered with services. For example, ST will scale-up in Simferopol and Sevastopol. The format of these services is that those who live in Yalta will not be able to receive a service. There is no AIDS centre there, nobody licensed to obtain necessary drugs. It requires attraction of very large resources. At the moment there is no way to cover all 100% of those who would want to and would be able to be covered.” (State organisation)

A public opinion survey of PLWHA in 16 Ukrainian cities reveals the following experiences of service access:

- the most accessible services are diagnostics and treatment of tuberculosis: diagnosis of this disease, according to the majority of respondents, is free in their city; treatment is also widely understood to be accessible and free by (46.4% of respondents);
- awareness of PLWHA concerning their need for treatment of OIs and hepatitis is rather low. The reason for this may be both the inaccessibility of diagnostics for such diseases in their locations and a low general culture of health among respondents;
- there appears to be a gradual increase in numbers of those who accessed HIV testing voluntarily. The majority of respondents who were tested for HIV over six years ago were tested without their consent, while among those who were tested for HIV within the last 12 months, over half were tested voluntarily.
- pre- and post-test counselling is provided with procedural violations, and is sometimes not provided at all; half of respondents noted that this counselling did not achieve its main goals;
- social and psychological assistance (according to the survey results) is not universally accessible. Membership of PLWHA organisations or involvement in HIV-services allows HIV+ people greater access to services and to information about them;
- the most accessible services for HIV+ people are information services, self-help groups, peer education and psychological counselling; comparatively less accessible are the telephone hotlines, home-based care, legal counselling and acquaintance clubs (91).
Poor accessibility is explained also by the geographical location of health facilities, economic constraints and poor quality of services for all groups of patients:

- There is a relatively large number of medical staff in Ukraine (about 4.5 doctors per 1,000 persons) compared to western countries (e.g., in Germany there are 2.9 doctors per 1,000 persons). However, the number of doctors per 1,000 inhabitants varies considerably from one region to another. There is a strong imbalance between the availability of healthcare services in cities and in rural areas;
- Only 20% of healthcare financing goes to outpatient care;
- 80% of equipment is outdated;
- Low salaries do not motivate medical staff to provide good services;
- Overspecialization of hospitals;
- Limited availability of free medical care;
- 90% of respondents evaluated the quality of services in medical care settings as “relatively low” and “extremely low”; nearly 80% of respondents feel that they would be financially vulnerable in the event of them requiring medical care (92).

Research data also highlight the issue of violation of rights of PLWHA that may also affect their use of health and other services. Human rights and HIV support organisations note the low level of awareness of PLWHA about their rights despite guarantees of social protection provided by Ukrainian legislation that prohibits discrimination against a person on the grounds of being HIV+. However, research (for example, a study ‘Access to services and the rights of people living with HIV in Ukraine’ by the All-Ukrainian Network of PLWHA) suggests that in reality the overwhelming majority of PLWHA feel stigmatised and discriminated against (93).

The usual types of violations include:

- The absence of pre- and post-testing counselling and support;
- Compulsory HIV-testing and the system of the concealed testing;
- Disclosure of the diagnosis (in some cities an HIV diagnosis is recorded on a person’s medical card);
- Refusal to provide medical assistance because of the positive HIV status (usually in case of surgical operations).

Other problems with access to services include:

- Social support services are developed unequally in different regions of Ukraine, mostly in big cities;
- In the absence of easy access to VCT, harm reduction and ST, active IDUs with HIV remain the most marginalized population, with little or no access to ART;
- Access to HIV treatment, care and support services for inmates in the penitentiary system is also severely limited, though the need is large and growing;
- There is also a serious deficit of facilities caring for orphans with suspected and confirmed HIV-infection; access to education and other social benefits for HIV+ children is also urgently needed (94).

4.4. The Integration of the GFATM into national systems

The programme supported by the GFATM contributes considerably to the fulfilment of most aspects of the national Ukrainian programme for prevention of HIV, support and treatment of people with HIV/AIDS. Activities within this programme resulted in expanding treatment programmes for HIV+ people. The International HIV/AIDS Alliance’s 2004 Annual Report indicates that in August 2004 the government provided ARV-treatment to 137 patients nationally. By the end of that year more than a thousand people were receiving treatment through GFATM funding.

The International HIV/AIDS Alliance in Ukraine aims to contribute to existing national systems rather than create parallel systems and services. Hence, it works closely with National and regional AIDS centres and
aims to coordinate its work with the state social services for children, young people and families. However, no one national public service is accountable for overall support of PLWHA, and as described earlier in this report, the Ukrainian health system lacks strategic coordination. This limits the extent to which GFATM activities can be integrated within national systems.

The Ukrainian programme is among 10% of the most successful projects supported by the GFATM. This conclusion has been made based on the results of the analysis of all grant recipients’ activities that were conducted by the GFATM all over the world (95).
Section 5
Stakeholders views on effects of GHI in Ukraine

5.1. The GFATM and its impact on epidemic in Ukraine

The HIV/AIDS epidemic is spreading at a different pace and in different ways across different regions of Ukraine. This exacerbates some of the problems of monitoring the spread of the epidemic described earlier in this report. In understanding the epidemic it is important to review the various statistical datasets and documents produced by agencies developing HIV/AIDS policies and programmes. The perceptions of stakeholders interviewed as part of this research also provide a valuable insight into the epidemic and the impacts the GFATM is having. Nevertheless stakeholders’ views differ considerably, although all interviewees noted that the spread of HIV/AIDS epidemic cannot yet be stopped in any region of Ukraine:

‘Of course to boast that we slowed down the epidemic, I wouldn’t take a risk to say that.’ (International NGO)

Interviewees expressed different opinions as to the effects of the various programmes on the spread of epidemics:

‘… if there are regions where there is a lot of officially registered people with HIV, and there are regions with less infections, then it turns out that where the international organisations and donors work, they don’t effect the epidemic all the same. If we take Odesa, Dnipropetrovsk, South, Donetsk, how much money was dumped in there but the epidemic hasn’t been stopped even in separate districts, and it’s spreading.’ (State organisation)

However, it should be taken into account that when expressing such opinions some interviewees referred only to statistical data (for example the number of new cases, death rates and accumulated number of officially registered cases) and did not always take the context into consideration:

‘in our opinion the situation hasn’t changed because the epidemic hasn’t been stopped… and the number of cases of HIV-infecting is not decreasing. If we talk about some positive changes, it’s clear that they are happening, but in general we can speak about the change in the situation when we are able to state that the infection rates are going down, but there is no such tendency yet’. (State organisation)

‘It affects the quality of their lives, comfort altogether, some habits, behavioural principles but not the epidemic as a whole’ (State organisation)

When evaluating the effects of the GFATM on the development of the epidemic it is important to consider how epidemiological data are generated and changes in how services are delivered. For example, the process and the procedures of registration of new cases of infection are important, access to testing for the public in general and for vulnerable groups in particular, and many other factors that can influence statistical data. Such information can explain the reasons behind the increase or decrease in the number of new cases:

‘In some regions, for example, in Vinnitsa region, we can say that the epidemic has slowed down among clients, but in real life they just stopped HIV testing them, and it’s not just that someone came up with this policy and stopped testing them, no, there just was no money and they didn’t test anybody except donors, that’s why there is an imaginary decrease of the epidemic.’ (International NGO)

Nevertheless interviewees' accounts emphasise the significance of the work of the GFATM in Ukraine with the absence of any other major programme of HIV/AIDS control:

‘In principle, if the Global Fund stops financing today, all preventative measures will cease, there will be nothing left, just nothing.’ (International NGO)
5.2. Attribution of changes in HIV-services to the GFATM

When evaluating the effects of global health initiatives it was the GFATM that all respondents spoke of rather than the World Bank loan:

As to the WB, this loan (…) it is not used and it’s impossible to evaluate its influence on what’s going on in the country. Well, it doesn’t evoke any feelings besides disappointment.’ (National NGO)

There has been a definite expansion of the range of services and access to them for different target groups. Indeed, GFATM activities in Ukraine are diverse:

‘Many things have changed since the Global Fund came. Of course, besides that very large resources became available for work, HIV/AIDS, the attitude in general, more extensive implementation of preventative programmes, as well as treatment, there are care services and support of people living with infection and everyone around them so to speak’. (International NGO)

‘Of course the GF contributed tremendously to the preventative programmes, to planning of these programmes. Programmes aimed to decrease the harm have expanded, it’s for sure, that’s what we see, and the indexes that have been set are of great importance too.’ (International NGO)

Thus, the majority of interviewees stressed the evident effect of the GFATM on the development and implementation of services accessible to PLWHA and other vulnerable groups in Ukraine:

‘… the help of the Global Fund, it covers probably up to 70% of all HIV/AIDS services that are provided in our country nowadays. I can’t imagine what it would have been like, had we not had the Global Fund project. Everything that is being done with the vulnerable groups, treatments, secondary prophylaxis – everything, well almost everything is financed by the Global Fund.’ (National NGO)

According to the accounts of most interviewees, the main priority of the GFATM was to improve accessibility to treatment. This is seen as having been successfully implemented in Ukraine:

‘Major changes. First of all, access to treatment became easier considerably. It was an incredible leap, I mean how many people started receiving free ARV-therapy with the Global Fund.’ (International NGO)

‘If not for the global money, I doubt we could say proudly today that we are treating 3,781 people [in Ukraine].’ (International NGO)

‘I would even call this approach to treatment, providing treatment revolutionary, it is at such a considerable pace that the number of people who received treatment increased within basically a couple of years.’ (International NGO)

Some interviewees felt that full ART coverage is now available for those who need it:

‘As of today 100% of patients who need ARV-therapy receive it. The situation has improved over the last two years – only 3% of patients used to receive ARV-therapy they needed.’ (State organisation)

Not all the interviewees viewed the influence of the GFATM on the development of HIV/AIDS services so positively. Some described the GFATM as having limited impact on the development of services and facilitating of access to them:

“It just let some NGOs exist and function during some period of time, because a large portion goes to management expenses in these projects and not the work itself. That is the ratio is shifted towards management here and not the services.” (State organisation)

Despite the positive comments of most interviewees on the improved accessibility of treatment in Ukraine, they also referred to problems, in particular, problematic access to substitution therapy programmes which effects adherence to treatment and thus its effectiveness:
‘... how many people got to receive let’s say not the substitution therapy because this issue is still complicated, problematic, but the therapy, that is IDUs who receive ARV therapy, programmes have been created for them, monitoring, registration of IDUs, treatment of them, accompanying social services. Everything has started improving and the number of people started increasing considerably, dramatically.’ (International NGO)

Thus, not all IDUs who are HIV+ and receive treatment have access to substitution therapy programmes. Even in regions where substitution therapy has recently started being implemented, some interviewees referred to problems relating to these programmes' implementation, their social component in particular:

‘There is a programme of adherent therapy at our facility on account of which we are trying to achieve adherence of the IDUs to adherent therapy. And I'd like to warn right away that adherence can't be achieved on account of the substitution therapy solely. The substitution therapy as it is worthless, if it is not backed up by quite potent social rehabilitation programmes. To my regret, Ukraine can't boast of it today and Kyiv neither.’ (State organisation)

A part of GFATM financing is also directed to the development of standards and protocols on counselling, testing and treatment. Thus the GFATM’s work in Ukraine is not only about “humanitarian help” in the form of direct service delivery, but also an attempt to elaborate and implement the service quality standards, and thus an influence on the system of service provision existing in Ukraine:

‘And of course along with it the attitude has changed towards, well, not standards, I'd just put it in quotation marks, I mean towards standards of dealing with the cases, I mean implementation of international standards of treatment, utilization of protocols, necessity… the effective approach to educating specialists, consistency and even complexity, because as you know there is a very positive tendency within the GF, with additional resources of course, to educate the teams on multiple subjects.’ (International NGO)

The problem of Ukraine’s dependence on the GFATM financing remains. Interviewees raised this sustainability problem:

There are only 500 patients in Ukraine who receive ARV-therapy out of the state budget. Thus, the problem exists today. Treatments are being provided while the Global Fund is here, but what decision will be made then? (State organisation)

It is widely acknowledged that GFATM support will end sooner or later. Acknowledging this reality interviewees noted the importance of attracting a large number of interested parties to the implementation of measures aimed at countering the HIV/AIDS epidemic:

‘...The Global Fund project has united many partners. It is also important. And this forum that created partners had been put together, I wouldn’t say thanks to, but in order to make decisions together on how to implement this project, it helped a lot arrange such partnership mechanisms of work and of the forum.’ (International NGO)

In summary the GFATM in Ukraine has made a dramatic impact on scaling-up services for different target groups, as well as improvement of access to these services. These initial research findings also suggest that the quality of services have been improved; important progress has been made in terms of the development of system capacity and sustainability of Ukrainian HIV-services.

5.3. Impact of the GFATM on HIV/AIDS policy

Most interviewees agreed that the GFATM had had a definite influence on the state policies and strategies:

‘I think international assistance is something significant and large, and then it pushes our state to make decisions because it is very difficult to get any kind of support in your own country, and when you have some ideas, some kind of a project, some conclusions, and something else, etc., then you can turn to somewhere, that’s why I think it is significant. And when you talk about the Global Fund, in principle, it works out in this case too.’ (International NGO)
On the other hand, interviewees from some state institutions were critical of the fact that an international organisation was the GFATM Principal Recipient, and hence had considerable influence on Ukrainian HIV/AIDS policy:

‘Help to the government and the state from the Global Fund should be provided as the help to the government, but what we have is to the government through the international organisation. It’s nonsense, I think. The international organisation can’t shape the policy. The policy should be formed by the state bodies. And it turns out to be the other way.’ (State organisation)

Another respondents stated during the interview:

He who pays the bill orders the meal. There is always reaction to money. And most importantly – political reaction. Political will. (International NGO)

The government of Ukraine originally managed the GFATM grant. In practice this became highly problematic. Interviewees representing NGOs are more positive towards current grant management:

‘Basically, the support of the Global Fund was effective because it was clear with whom to work, whom to educate, for whom to make arrangements. The story of purchases is well known, let’s not come back to it, AIDS centres couldn’t influence it in any way. The situation depended solely on the Ministry of Health. And when it has been overcome altogether, the programme of ARV-therapy, it is working now.’ (International NGO)

In addition, the argument of the non-governmental sector in favour of the grant management by an international organisation reflects a degree of distrust of state institutions and a belief in their corruption and financial interests, as well as limited motivation and complex legal processes:

‘And again, political will. Because some are interested in these contributions, other are not. Roughly speaking, when they don’t see any gain in it, nobody is interested. Some can get something, let’s omit the subject of corruption, directly, what they can get – it is their personal promotion.’ (International NGO)

‘On one hand, probably, it’s the procedural imperfection of Ukrainian I don’t mean the legislation, no, more like numerous by-law acts that stay in the way. On the other hand, weak loyalty of officials.’ (State organisation)

The GFATM Round Six grant led renewed commitment to the National Coordination Council:

‘The most vivid example is the creation of NCC. As soon as it was said that Ukraine would be most likely to win the bid process, project proposal, NCC was created right away, everything was recreated in no time. The Ministry of Health worked very well, excellent, till 4 a.m. every day. A huge pile of papers was submitted, everything was reviewed, signed, created. It was a high quality job. And such leaps are possible only with considerable investments into the country.’ (International NGO)

Interviewees saw this as positive reflecting a more professional approach, but also expressed some doubt about the motives of the state officials in combating HIV/AIDS. Nevertheless, an outcome of such a coordination mechanism is greater unity among all interested parties:

‘It was the Global Fund that let both public and state organisations look at each other.’ (International NGO)

‘Besides the fact that coordination has become our concrete task, the partners who implement these projects, they started communicating so to speak, became equal partners. And the attitude of the state to the non-governmental sector has also changed. And I think that this is a big plus too… that they [non-governmental sector] are performers, alternative performers of those tasks that the state should actually do. (International NGO)

An important achievement of the NCC as a coordinating mechanism was that PLWHA were represented within the structure:

Kyiv, January 2007
Well, first of all, as I mentioned, when the NCC was created, the NCC’s mandatory condition was to have a representative of PLWHA as a co-director of NCC, Vladimir Zhovtyak, as an example we all love. Has anyone at all heard of letting PLWHA voice their opinion before the GF grant to Ukraine? They were left alone, allowed to live, and here let them speak in addition. It became possible only under the mandatory condition of creating the NCC where the co-director would be a representative of PLWHA. The GF has to do with this directly. (International NGO)

5.4. Influence of the GFATM on the situation of marginalised groups

Interviewees described a number of positive impacts of the GFATM on the situation of marginalised groups:

‘Of course the Global Fund is a very big contribution to work with the vulnerable groups. It is because the Global Fund started working of course that these three main at-risk groups [IDUs, FSW, MSM] receive services.’ (International NGO)

‘The Global Fund facilitated access to medical and social services for the vulnerable groups.’ (National NGO)

‘The Global Fund created a sort of a bridge between the mainstream and the vulnerable groups, and they also have some opportunities to receive the same help as you and I, or maybe even better.’ (National NGO)

Prejudice towards these groups continues to be widespread. Interviewees highlighted considerable problems of stigmatisation and discrimination among many members of the general population:

‘If you take me for example, I can’t imagine how the life of IDUs improved. I know that they have always been after, and still are. Nothing has changed.’ (International NGO)

‘It seems like there is the most urgent necessity, de-stigmatisation of PLWHA, and it is probably an issue that is… how to say it in Ukrainian… intrinsic, that is it is inseparable from the global initiatives themselves aimed at HIV/AIDS. So, it’s obvious that if something is directed somewhere, then it creates basis for stigmatisation. I mean why does international help support people with HIV/AIDS?’ (National NGO)

However, interviewees described positive changes in public attitudes to PLWHA since information levels on HIV/AIDS are increasingly made available:

‘They are being accepted, listened to, they are now being taken into account.’ (International NGO)

‘… it opened more possibilities. At least the fact that PLWHA could establish their own organisation. It created new jobs. At these jobs… with certain agreements… they got access to medical services: they can have dental care, they can be operated on, they can live, they can have social services. Maybe even more than HIV/negative people have because now they have direct ways, direct connections, jobs. Turning to such organisations they can have more quality to their lives.’ (International NGO)

‘They have felt their strength because they were educated, treated, given an opportunity to develop different communities. So in this case it is clear that the impact has been made. Network of PLWHA has increased considerably.’ (State organisation)

Participation of PLWHA in the development of HIV-services also positively affects work with vulnerable groups. When planning programmes and services, problems and needs of clients are taken into consideration to a large degree:

‘it seems to me that in fact a lot of things have changed, a lot, and vulnerable groups started feeling I would say more comfortably about HIV/AIDS, they have services now and probably don’t feel so abandoned.’ (State organisation)
Despite the recognition of these changes in connection with improvement of access to a range of services for vulnerable groups, some interviewees noted that these changes are not able yet to influence the epidemic as a whole.
Conclusions

Ukraine has a comprehensive and in principle, progressive legislative base for tackling HIV/AIDS, compatible with international norms, and through the GFATM grant considerable financial resources have been mobilised to tackle the disease. The GFATM Round One grant supports a range of activities including diagnostics, counselling, treatment, substitution therapy, social support, terminal care and prevention work among vulnerable groups. Programmes supported by the GFATM target vulnerable groups including injecting drug users, female sex workers and men having sex with men. All regions of Ukraine receive GFATM funding although the bulk has been disbursed to six regions reflecting high levels of HIV/AIDS prevalence: Kyiv city and oblast, Odesa, Mykolayiv, Donetsk, Dnipropetrovsk and Crimea. A significant share of the grant was spent on ARV treatment, testing systems and non-medical care for PLWHA.

Based on interviews with stakeholders it appears that the GFATM in Ukraine is having a dramatic impact on scale-up and accessibility of services, especially HIV testing, ART treatment, as well as on improved quality of services. Important progress appears also to have been made in terms of the development of system capacity and the sustainability of Ukrainian HIV-services. Interviewees taking part in this research emphasise the significance of the work of the GFATM in Ukraine. Indeed, whilst other HIV/AIDS control programmes exist in Ukraine they are comparatively limited in scale.

Some interviewees were critical of the fact that an international organisation, the International HIV/AIDS Alliance, became the GFATM First Round Principal Recipient, and hence has considerable influence on Ukrainian HIV/AIDS policy. Others recognise that the grant is more appropriately managed by an international organisation since government departments have to date lacked transparency and the impetus to scale-up HIV/AIDS programmes. Management of the Sixth Round GFATM grant will be shared between two organisations: the International HIV/AIDS Alliance and the All-Ukrainian Network of PLWHA.

Stakeholders felt that the spread of HIV/AIDS epidemic has not yet been halted in any region of Ukraine, despite the fact that the GFATM grant represents significant new funding to tackle HIV/AIDS. A number of political and institutional factors inhibit the development of more effective HIV/AIDS policies and programmes. The national response to HIV/AIDS is, in practice, uncoordinated at national and regional levels. Political leadership is seen as lacking, a coherent HIV/AIDS strategy is absent and there remains considerable inertia among non-transparent bureaucratic state agencies that are unable to absorb funding and disburse it in an effective way. There is also strong opposition to programmes supporting groups vulnerable to HIV infection and PLWHA due to widespread discrimination among many members of the general population, including health and social care service providers. However, interviewees described some positive changes in public attitudes to PLWHA since information levels on HIV/AIDS are increasingly made available.
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## GHI Study in Ukraine (July 2006-December 2008)

### Stage 1 (Jul - Oct '06)
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<td>- What are the main obstacles and inhibiting factors to HIV/AIDS policy in Ukraine?</td>
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<td>- Are the right groups being targeted?</td>
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- **Regional-1**

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<tr>
<td>- What is the reason for not using the services?</td>
<td>- Semi-str. service user interviews,</td>
</tr>
<tr>
<td>- How can access be improved for MAP groups?</td>
<td>- Semi-str. CBO interviews</td>
</tr>
</tbody>
</table>

### Stage 3 (Nov '07 – Jan '08)
- **National-2**

<table>
<thead>
<tr>
<th>Key RQ:</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What changes had happened over a year?</td>
<td>- Document review</td>
</tr>
<tr>
<td>- What is the relative power of different groups within the policy development and process, especially civil society groups and representatives of the marginalized populations?</td>
<td>- Secondary analysis</td>
</tr>
<tr>
<td>- How is government coordinating with and managing the increasing numbers of civil society actors?</td>
<td>- Interviews w/national stakeholders</td>
</tr>
<tr>
<td>- What changes in legal regulation and public policy practice may be attributed to GHI effects?</td>
<td></td>
</tr>
<tr>
<td>- What can be done to address issues and challenges raised during the previous research stages?</td>
<td></td>
</tr>
</tbody>
</table>

### Stage 4 (Feb –Aug '08)
- **Regional -2**

<table>
<thead>
<tr>
<th>Key RQ:</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What changes had happened over a year?</td>
<td>- Resource tracking,</td>
</tr>
<tr>
<td>- How has the implementation of the initiatives taken place in practice?</td>
<td>- Facility survey,</td>
</tr>
<tr>
<td>- What are the strengths and weaknesses of the HIV/AIDS interventions implemented by governmental and non-governmental organisations at the local level?</td>
<td>- Semi-str. sub-national stakeholder interviews,</td>
</tr>
<tr>
<td>- What are the service utilization patterns?</td>
<td>- Str. service provider/service manager interviews,</td>
</tr>
<tr>
<td>- How do service patterns differ between different areas according to socioeconomic profile of the users?</td>
<td>- Str. service user interviews,</td>
</tr>
<tr>
<td>- What is the level coordination of HIV/AIDS GHI and non-GHI services provided by public sector agencies and NGOs?</td>
<td>- Str. CBO interviews</td>
</tr>
</tbody>
</table>

### Outputs:
- Context report
- Criteria for selection regions
- Detailed RQ for 2nd stage
- Interim report
- Interim event (workshop)
- Briefing sheet
- Journal article
- Detailed RQ for 3rd stage
- Journal article
- Detailed RQ for 4th stage
- Final report,
- Final event (conference, press-conference)
- Briefing sheet
- Journal article
Guide for semi-structured interview with stakeholders

1. In your opinion, how does international support, in particular the support of Global Fund, influence the HIV/AIDS epidemic in Ukraine? Did the situation become better? How much?
   - How widely are the global initiatives involved in Ukraine (population, territory)?
   - To what extent do you think are global initiatives resources enough for providing necessary services in Ukraine?
   - What challenges stand on a way of global initiatives activities in Ukraine?
   - Which target groups, in your opinion, should be helped?

2. What consequences does international funding in particular, the Global Fund, have for vulnerable groups’ status?
   - How did the work of the global initiatives extend access of vulnerable groups to medical and social services? How equal is that access?
   - How does the work of the global initiatives assist vulnerable groups to participate in policy forming in HIV/AIDS field, i.e. in decision-making process?
   - How does introduction of global initiative-supported activities correspond to the needs of vulnerable groups?
   - How are the interests of vulnerable groups represented at planning and distribution of global initiatives costs?
   - How are priorities which determine the distribution of global initiatives costs defined?

3. To what extent do international funds, in particular, the Global Fund programmes, correspond to the needs of Ukraine? Why do you think so?

4. What is the role of governmental and non-governmental organisations in implementing global initiative-supported projects and programmes in Ukraine?
   - What impact do governmental institutions have on coordination of the global initiatives?
   - How effective is the collaboration of governmental institutions and nongovernmental HIV-service organisations?

5. How integrated do you consider international initiatives to be in the national system of medical and social services?

6. What is the role of International HIV/AIDS Alliance Ukraine as the Principal Recipient of Global Fund finances?

7. How can you evaluate activity of HIV-service organisations which are not supported by global initiatives? What part do they take in providing HIV-services? In what regions are they concentrated? What sources of financing do these organisations have?

8. What governmental structures directly provide HIV-related services? How would you assess their work?
Attachment 3

Summary of estimations of the size of at risk population groups (end of 2005)

<table>
<thead>
<tr>
<th>Population group</th>
<th>Evaluated size of population groups</th>
<th>Evaluated HIV prevalence (%)</th>
<th>Average number of adult PLWHA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>1. Groups of most-at-risk population (adults 15-49)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injecting drug users (IDUs)</td>
<td>325 000</td>
<td>425 000</td>
<td>11,0%</td>
</tr>
<tr>
<td>Men who have sex with men (MSM)</td>
<td>177 000</td>
<td>430 000</td>
<td>3,0%</td>
</tr>
<tr>
<td>Female sex workers (FSWs)</td>
<td>110 000</td>
<td>250 000</td>
<td>8,0%</td>
</tr>
<tr>
<td>Men who are clients of SW</td>
<td>330 000</td>
<td>750 000</td>
<td>2,0%</td>
</tr>
<tr>
<td>Total</td>
<td>942 000</td>
<td>1 855 000</td>
<td></td>
</tr>
</tbody>
</table>

2. Partners of most-at-risk groups representatives (Adults 15-49)

<table>
<thead>
<tr>
<th></th>
<th>Evaluated size of population groups</th>
<th>Evaluated HIV prevalence (%)</th>
<th>Average number of adult PLWHA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>IDU partners</td>
<td>422 500</td>
<td>552 500</td>
<td>8,0%</td>
</tr>
<tr>
<td>Women who are partners of MSM</td>
<td>177 000</td>
<td>430 000</td>
<td>1,0%</td>
</tr>
<tr>
<td>Partners of SW clients</td>
<td>825 000</td>
<td>1 875 000</td>
<td>0,6%</td>
</tr>
<tr>
<td>Total</td>
<td>1 424 500</td>
<td>2 857 500</td>
<td></td>
</tr>
</tbody>
</table>

Summary of estimations of HIV/AIDS in Ukraine (end of 2005)

3. Estimated number of people living with HIV (adults aged 15-49)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Men who live with HIV</td>
<td>178 262</td>
</tr>
<tr>
<td>Women who live with HIV</td>
<td>166 111</td>
</tr>
<tr>
<td>Total number of adults in Ukraine (aged 15-49), who are evaluated living with HIV, by the end of 2005</td>
<td>344 373</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-infection prevalence</td>
<td>1,46%</td>
</tr>
<tr>
<td>Percentage of IDU among people living with HIV</td>
<td>41,9%</td>
</tr>
<tr>
<td>Percentage of women among people living with HIV</td>
<td>48,2%</td>
</tr>
</tbody>
</table>

4. Estimated number of people living with HIV (all ages)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Men who live with HIV</td>
<td>205 660</td>
</tr>
<tr>
<td>Women who live with HIV</td>
<td>171 940</td>
</tr>
<tr>
<td>&gt; including children who live with HIV (0-14)</td>
<td>2 850</td>
</tr>
<tr>
<td>Total estimated number of people living with HIV by the end of 2005</td>
<td>377 600</td>
</tr>
</tbody>
</table>

Coordination and Monitoring mechanisms in Ukraine

The Cabinet of Ministry of Ukraine

Government commission on issues to fight HIV/AIDS

National Coordination Council on issues of the prevention of HIV–infection/AIDS spreading

Central Bodies of Executive Power

The Ministry of Labour and Social Policy
The State Department of Corrections
The Ministry of Family, Youth and Sports Issues
The State Committee for Television and Broadcasting
The Ministry of Finance
The Ministry of Defence
The Ministry of Education and Science
The Ministry of Health of Ukraine

Ukrainian HIV/AIDS Centre
Coordinating Centre on Monitoring and Evaluation

Regional Coordination Councils

State Oblast Administrations

Oblast intersectoral working groups

Regional AIDS Centres

Donor Organisations

NGOs (national)

NGOs (regional)

## Chronology of establishment of governmental bodies on HIV/AIDS coordination

<table>
<thead>
<tr>
<th>Year</th>
<th>Name of the body</th>
<th>Reporting to</th>
<th>Legal background</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>Governmental Commission on managing development and implementation of AIDS related countermeasures in Ukrainian SSR</td>
<td>Cabinet of Ministers of the Ukrainian SSR</td>
<td>Regulation #68 of the Cabinet of Ministers of the Ukrainian SSR “On establishment of the Governmental Commission to Manage Organisation and Implementation of Anti-AIDS Activities in the Ukrainian SSR”</td>
</tr>
<tr>
<td>1992</td>
<td>National Committee on AIDS Control</td>
<td>President of Ukraine</td>
<td>Decree # 313 of the President of Ukraine “On the National Committee for Struggle against AIDS”</td>
</tr>
<tr>
<td>1996</td>
<td>National Committee on Prevention of AIDS and Drug Addiction</td>
<td>President of Ukraine</td>
<td>Decree of the President of Ukraine “On the National Committee on Prevention of AIDS and Drug Addiction”</td>
</tr>
<tr>
<td>1997</td>
<td>Committee on Prevention of AIDS and Drug Addiction (was abolished in 1998 by decree of the President of Ukraine)</td>
<td>Ministry of Health of Ukraine</td>
<td>Decree # 1275 of the President of Ukraine “On the Committee on Prevention of AIDS and Drug Addiction”</td>
</tr>
<tr>
<td>1999</td>
<td>National Coordinating Council on AIDS Prevention</td>
<td>Cabinet of Ministers of Ukraine</td>
<td>Regulation #1492 of the Cabinet of Ministers of Ukraine “On establishment of the National Coordinating Council for AIDS Prevention under the Cabinet of Ministers of Ukraine”</td>
</tr>
<tr>
<td>2006</td>
<td>Committee on Combating HIV/AIDS and Other Socially Dangerous Diseases</td>
<td>Ministry of Health of Ukraine</td>
<td>Regulation #759 of the Cabinet of Ministers of Ukraine “On establishment of the Committee on Combating HIV/AIDS and Other Socially Dangerous Diseases”</td>
</tr>
</tbody>
</table>
Attachment 6

Breakdown of GFATM funding by regions of Ukraine in 2005 (USD)

### GFATM Round One grant: Ukrainian budget

<table>
<thead>
<tr>
<th>Phase</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total</th>
<th>All together within the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programme administration and application</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 681 000</td>
<td>2 350 505</td>
<td>2 645 804</td>
<td>2 630 784</td>
<td>7 627 093</td>
</tr>
<tr>
<td></td>
<td>11,47%</td>
<td>11,04%</td>
<td>11,60%</td>
<td>11,40%</td>
<td>11,35%</td>
</tr>
<tr>
<td><strong>Treatment, care and support</strong></td>
<td>1 062 531</td>
<td>13 282 000</td>
<td>11 978 191</td>
<td>13 397 221</td>
<td>38 404 895</td>
</tr>
<tr>
<td></td>
<td>56,81%</td>
<td>56,24%</td>
<td>57,13%</td>
<td>58,03%</td>
<td>57,16%</td>
</tr>
<tr>
<td><strong>Prevention among vulnerable groups</strong></td>
<td>132 051</td>
<td>2 319 000</td>
<td>3 665 404</td>
<td>3 712 280</td>
<td>11 098 404</td>
</tr>
<tr>
<td></td>
<td>9,92%</td>
<td>17,21%</td>
<td>16,28%</td>
<td>16,12%</td>
<td>16,52%</td>
</tr>
<tr>
<td><strong>Information, education and advocacy</strong></td>
<td>345 515</td>
<td>3 326 000</td>
<td>2 172 585</td>
<td>2 191 882</td>
<td>6 546 241</td>
</tr>
<tr>
<td></td>
<td>14,23%</td>
<td>10,20%</td>
<td>9,57%</td>
<td>9,49%</td>
<td>9,74%</td>
</tr>
<tr>
<td><strong>Monitoring and estimation</strong></td>
<td>51 114</td>
<td>1 021 000</td>
<td>632 274</td>
<td>737 130</td>
<td>646 072</td>
</tr>
<tr>
<td></td>
<td>4,37%</td>
<td>2,97%</td>
<td>3,23%</td>
<td>2,80%</td>
<td>3,00%</td>
</tr>
<tr>
<td><strong>Grant administration costs</strong></td>
<td>750 000</td>
<td>500 000</td>
<td>500 000</td>
<td>500 000</td>
<td>1 500 000</td>
</tr>
<tr>
<td></td>
<td>3,21%</td>
<td>2,35%</td>
<td>2,19%</td>
<td>2,17%</td>
<td>2,23%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1 591 211</td>
<td>23 379 000</td>
<td>21 298 959</td>
<td>471</td>
<td>23 086 679</td>
</tr>
</tbody>
</table>

Geographical distribution of services supported by the GFATM (2005)