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UKRAINE
GENDER ASSESSMENT

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ACRONYMS

ART	antiretroviral treatment
ARV	antiretroviral
CITI	Community Initiated Treatment Interventions
DoD	Department of Defense
GBV	gender-based violence
GoU	Government of Ukraine
HTC	HIV testing and counseling
IBBS	integrated bio-behavioral surveillance
INGO	international NGO
IP	Implementing Partner
LGBT	lesbian-gay-bisexual-transgender
LTFU	loss to follow-up
MAT	Medication-Assisted Treatment
MER	Monitoring, Evaluation, and Reporting
MIS	Medical Information System
MSM	men who have sex with men
MTCT	mother-to-child transmission
NAMS	National Academy of Medical Sciences
NGO	non-governmental organization
OST	opioid substitution therapy
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
PWID	people who inject drugs
TB	tuberculosis
UCDC	Ukrainian Center for Disease Control
UIC	unique identified code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
US CDC	US Centers for Disease Control
USAID	United States Agency for International Development
USG	United State Government
VL	viral load
WSW	Women who have Sex with Women

EXECUTIVE SUMMARY

This Gender Analysis was specifically geared to inform the primary goal of the PEPFAR Ukraine program: An aggressive scale-up of antiretroviral treatment (ART) among HIV-positive people who inject drugs (PWID) and their sexual partners.

SUMMARY OF KEY FINDINGS

PWID are estimated to most significantly contribute to the continuing HIV/AIDS epidemic escalation in Ukraine. In response, PEPFAR Ukraine pivoted its program to reach approximately 72% ART coverage among HIV-positive PWID and their sexual partners by mid-2017. The program is geographically concentrated in the five highest burden regions of Ukraine. PEPFAR Ukraine focuses on reducing "leakage" of PWID across the HIV service cascade by increasing access to HIV testing for PWID, improving linkages between testing and enrollment in care (registration at AIDS Centers) for PWID, and reducing loss to follow-up (LTFU) post-registration among PWID. PEPFAR Ukraine's work includes an additional focus on scaling up access to HIV testing and counseling (HTC) and ART among the sexual partners of PWID and among men who have sex with men (MSM). The goal of the assessment was therefore to identify gender-specific vulnerabilities, needs, barriers, and gaps to accessing and adhering to the HIV service cascade – from testing to viral load suppression – for women and men who inject drugs, their sexual partners, and men who have sex with men.

The assessment found that while some data on PWID across the HIV service cascade is available in Ukraine, sex-disaggregated data on PWID is limited. Women are estimated to comprise 23.6% of PWID in Ukraine, or an estimated 73,160 women who inject drugs nationally. Parenteral transmission via injecting drug use accounts for 32.7% of people living with HIV (PLHIV), but only 10.9% of people on ART are PWID. Women who inject drugs have disproportionately high rates of HIV infection compared to men: 22.4%, compared to 18.8% in men who inject drugs. Loss to follow up between diagnosis and engagement in active medical care is higher for HIV-positive PWID than for PLHIV who do not inject drugs, but sex-disaggregated data is not available. Gender-specific data on PWID is not collected or reported, such as data on mother-to-child transmission (MTCT); however, a cohort study in Ukraine found that injecting drugs was associated with a two-fold increased risk of MTCT. Coverage of services critical to supporting access and adherence to ART for PWID – notably Medication-Assisted Treatment (MAT) – is extremely low in Ukraine, with only 3.1% of opioid-using PWID accessing public MAT services, and women have disproportionately low access to MAT. There are high rates of HIV in the prison system, largely associated with injection drug use, and HIV prevalence among women prisoners is over three times that of their male counterparts. HIV prevalence among the sexual partners of PWID is estimated at between 7% and 30%. Data on MSM shows a 5.9% infection rate in 2013, and a more than 10-fold increase in the number of officially registered cases of HIV in this group between 2005 and 2013.

Gender norms adversely impact access to HIV services for women who use drugs. Childcare responsibilities in particular are often cited as a reason why women do not attend harm reduction, drug treatment, or HIV services. In addition, women may be fearful of attending health services because they fear loss of child custody if they are identified as a drug user. Fear of violence or abandonment by their male partner made some HIV-positive women who inject drugs unwilling to start or continue ART after giving birth, out of concern they might have to disclose their HIV status. Gender-based violence (GBV) was also a barrier for MSM to access HIV services. MSM service providers and beneficiaries in Kyiv and Odesa reported attacks on their community centers and on their volunteer outreach workers, and some beneficiaries reported having to pay off police officers to avoid being "outed" as gay. Misperceptions about ART, prevention of mother to child transmission (PMTCT), and MAT impacted access to the HIV service cascade for women who inject drugs: women reported that they believed ART would hurt their baby and refused PMTCT, believed they should discontinue ART in order to breastfeed safely, or believed that MAT would harm their fetus or make it dangerous for them to breastfeed.

Stigma and discrimination impact access to health services for key populations, including the key populations on which this assessment focuses – PWID and MSM, particularly in the case of doctors working outside AIDS Centers. Access to appropriate sexual health services is particularly challenging for MSM because doctors at reproductive health clinics are not qualified, or comfortable, addressing MSM sexual health concerns. Stigma about HIV within the MSM community itself also poses a barrier to HIV testing: NGO service providers report that MSM may be unwilling to undergo testing in a clinic where there are other MSM, because, should there be any suspicion that they are HIV-positive, they would be unable to find a sexual partner. MSM reported that family members sought to "cure" their homosexuality, taking them to doctors who could "cure them" and pressuring them to undergo hormone therapy to make them "more male."

Patterns of power and decision-making impact vulnerability to HIV infection among women who inject drugs. Women beneficiaries interviewed for the gender assessment reported that access to drugs was primarily controlled by their male partner – who procured the drugs – and that women's initiation into drug use was often in the context of an intimate relationship with a man who injects drugs. Women who inject drugs are often "second on the needle": The man procures and prepares the drugs, injects himself first, and then injects his partner. Sharing needles in this manner forms an integral part of intimate relationships. Access to harm reduction services is also largely controlled by men, who may be reluctant to allow their female partner to seek out medical services. Drug-related barriers to accessing reproductive health were evident among women beneficiaries, some of whom reported pressure from medical professionals to get an abortion on the basis of their drug use.

A number of structural systemic barriers impact access to the HIV service cascade for PWID and MSM, and can prove particularly potent barriers for women who inject drugs. In the area of HIV testing, only medical personnel are allowed to perform an HIV test and disclose the result to a client. However, community-based HIV testing has been widely implemented in Ukraine by the Alliance in Ukraine with support from the Global Fund. Initially, NGOs worked with AIDS Center doctors, providing incentives for doctors to provide HIV testing in community settings. Following a draw down of Global Fund support, these programs were eliminated. Self-testing is allowed in Ukraine, and the Alliance supports non-governmental organization (NGOs) to provide self-test kits, and social workers offer supervised self-testing for clients. In order to be officially diagnosed, patients must register at a government AIDS Center. Beneficiaries reported long lists of required tests, some with little obvious relevance to HIV, testing fees that are difficult for PWID to pay, and long waiting periods for test results, that adversely impact attendance and adherence. Although no comprehensive study of the gender-differentiated impact of these requirements for registration at AIDS Centers has been conducted, the time and expense required in order to meet registration requirements is likely to particularly impact women with small children, who must either bring their children with them or seek out childcare – an obstacle to attending services for many women who inject drugs. The burden of registration requirements is particularly challenging for those who live in rural areas, and must travel long distances at considerable expense to undergo the tests required for registration.

There is little consensus on which organizations – governmental or non-governmental – are responsible for ensuring that clients who have registered at AIDS Centers remain actively engaged in care, particularly for those clients who do not qualify for ART at the time of registration. No work has yet explored the gender-differentiated impact of this gap. NGOs undertaking case management argue that follow-up with clients who are registered in care is primarily the responsibility of the AIDS Center, and case management projects often close client cases once registration at an AIDS Center has been successfully completed. Doctors at AIDS Centers, and government officials, argue that NGOs receive donor funding to support adherence to treatment, that NGO workers are generously remunerated, and that NGOs make additional payments to friendly doctors, and that, for these reasons, NGOs should take responsibility for supporting adherence, following registration at the AIDS Center.

There is a dearth of services to support women who have undergone gender-based violence, and no services for MSM or transgender people who have experienced gender-based violence, making it challenging to effectively address this critical barrier to service access. Shelters for women who have undergone gender-based violence do not offer HTC, and some will not accept women who have infectious diseases. Knowledge of, and availability of post-exposure prophylaxis (PEP) – a critical intervention for people who have experienced sexual assault, is extremely limited.

MAT is a critical intervention that supports access and adherence to the HIV service cascade, yet the proportion of women attending MAT is not commensurate with their numbers in the drug-using population. MAT services in Ukraine are weakly integrated into AIDS Centers – less than 8% of MAT clients access this service at an AIDS Center, and MAT clinics located at AIDS Centers are undersubscribed. MAT services at other locations do not provide on-site HIV testing – tuberculosis (TB) doctors, for instance, are not allowed to provide HIV testing services and they are not provided with test kits to offer supervised self-testing for clients. Other barriers to MAT, noted by beneficiaries and service providers, include a requirement to demonstrate multiple unsuccessful attempts to quit drugs, documents to prove place of residence – the *propiska* – and a requirement to register with narcological services, which, in Odesa, requires a 10-day to two-week fee-based in-patient detoxification – a prohibitive barrier for women with small children. Access to MAT during pregnancy is very limited; in Dnipropetrovsk, for example, one maternity hospital provides referral to MAT, but there are no protocols on appropriate dosing for pregnant women, reported dosing is very inadequate, and there are no provisions for MAT during labor – which would support new mothers to care for their newborns and facilitate HIV treatment, follow-up and adherence – or evidence-based treatment for neonatal abstinence syndrome.

Research on gender and drug use, and gender-sensitive interventions for people who inject drugs and their partners – including support for access to ART, have a rich history in Ukraine, dating as far back as 2007. Current PEPFAR implementing partners have extensive experience offering gender-sensitive services to PWID: The Alliance for Public Health has developed projects that increase access to women who inject drugs and reach out to the female sexual partners of men who inject drugs, train social workers on the sexual and reproductive health of PWID, and offer couples counseling. The PEPFAR-supported RESPOND project, implemented by Pact, developed a Gender Roadmap in 2014, conducted orientations on gender for its own and partners' staff, integrated gender considerations into its strategic information activities, supported NGOs to provide gender-sensitive services for female prisoners and women who inject drugs and their partners, and incorporated a gender focus into its Seven Steps intervention, which addresses HIV prevention, testing, and linkage to care for PWID and their sexual partners. With support from AIDS Life Verein (Austria), the United Nations Office on Drugs and Crime (UNODC) implemented a project on gender-sensitive services for PWID and prisoners, including providing grants to six implementing NGOs. The PEPFAR-supported HIV Reform in Action project, implemented by Deloitte, addresses gender issues by providing trainings for primary health care workers on gender and stigma and integrating gender and stigma into its Investment Case. PEPFAR-supported projects have also made progress in supporting access to critical HIV services for MSM. Innovative MSM-support organizations, such as NGO Fulcrum, have set up MSM-friendly clinics and offer legal support, a convenient and confidential on-line system for setting appointments, a friendly doctor – employed by an AIDS Center and also offering testing and consultations at a dedicated MSM clinic, and easy referral linkage to the city AIDS Center where clients meet with the friendly doctor from the MSM clinic. The program found that 85% of the clients who saw the friendly doctor and tested positive, went to the AIDS Center for a confirmatory test.

SUMMARY OF GAPS

The gender analysis identified a number of gaps:

- On data, the assessment noted that national data systems to track LTFU for key populations, including PWID and MSM, across the HIV service cascade are not in place, and national data on LTFU is not disaggregated by sex.
- In the area of laws and policies, legislation to protect the lesbian-gay-bisexual-transgender (LGBT) community from stigma, discrimination, and violence, is not in place in Ukraine, and there is no legislation in place to protect transgender populations.
- Training programs are a critical component of PEPFAR-supported programs and, while a number of gender-focused trainings have been developed and delivered, there appears to be little collaboration or learning across implementing partners (IPs), leading to possible duplication of efforts and lost opportunities for cross-learning.
- Interventions for the sexual partners of PWID are under-developed, do not always draw on international best practices, and do not always build on lessons learned over the past eight years of similar project implementation in Ukraine.
- Little effort has focused on scaling up MAT or on making MAT services friendly and responsive to the needs of women who inject drugs. MAT is offered at more TB dispensaries in Ukraine than it is at AIDS Centers, yet no progress has been made on integrating on-site HIV testing or treatment at TB facilities, and no efforts have been made to make TB services gender-responsive.
- While it is well recognized that providing services to PWID and MSM who live in rural areas is particularly challenging, a geographically appropriate and gender-sensitive strategy to address key populations in rural areas has yet to be developed.
- With the draw down of Global Fund support, sustainability of interventions is critical, and efforts need to be made to ensure that labor and capital intensive interventions, such as case management, have a sustainability plan, including gender budgeting.
- New mechanisms to finance critical interventions for PWID and MSM, including linkage to HIV care and treatment – such as social contracting – are in their infancy, and require further development and support to ensure that they can meet the needs of men and women who inject drugs, their sexual partners, and MSM.

SUMMARY OF RECOMMENDATIONS

- Institutionalize gender expertise across projects, by establishing gender focal points
- Institutionalize gender-sensitive ART expertise across IP grantees
- Support collection of gender-specific data, especially data on gender-based violence
- Support collection and reporting of sex-disaggregated data for key prevention services for PWID, notably MAT
- Consider developing gender-specific indicators for PWID, and systems to collect data on those indicators
- Support the development of data systems that can track PWID and produce sex-disaggregated data across the HIV service cascade
- Support advocacy for laws and policies that protect the rights of the LGBT community

- Support strengthening of laws and policies on gender-based violence, and legal support to beneficiaries
- Support assessment of transgender vulnerabilities and needs in Ukraine and interventions that can address those needs
- Support gender-sensitive case management from testing through viral load (VL) suppression
- Support simplification and standardization of HIV testing procedures and requirements for registration in care and treatment and remove gender-specific barriers
- Develop standard PEPFAR training materials and guidelines on gender and PWID for IP and grantee use
- Expand training for government medical professionals, including in female-specific services
- Coordinate with ongoing projects in Ukraine that address critical aspects of access to HIV services for PWID, including gender-specific barriers
- Develop evidence-based approaches based on international best practices for reaching the sexual partners of PWID, and MSM
- Support quality improvement and scale-up of gender-sensitive MAT services
- Support integration of Government and NGO services for testing and treatment
- Support integration of HIV testing and referral to care via TB services and introduce gender-sensitive approaches to working with female PWID who are coinfected with TB and HIV
- Develop geographically appropriate strategies to reach men and women who inject drugs, and MSM, in rural areas
- Focus interventions for men who inject drugs in key locations such as in police custody, pre-trial detention centers and prisons
- Document and disseminate good practices for MSM and PWID to support learning and avoid duplication
- Ensure that gender-responsive interventions are appropriately budgeted
- Support sustainable gender-sensitive strategies
- Going Forward: Integrate gender considerations into test and treat

I. INTRODUCTION

There are an estimated 210,000 people living with HIV (PLHIV) in Ukraine, the majority of whom are men. The epidemic is concentrated in key populations: HIV prevalence among people who inject drugs (PWID) stands at 19.7% and is estimated at between 7% and 30% among the sexual partners of PWID; among female sex workers at 7.3%; and among men who have sex with men (MSM) at 5.9%. Despite declines in transmission among people who inject drugs, injection drug use still accounts for 20-40% of new infections. The majority of infections among PWID occur among men, who account for an estimated 76% of PWID, but women who inject drugs have higher rates of HIV infection than men. The majority of antiretroviral (ARV) drugs in Ukraine are procured by the national budget, with approximately 20% of ARV supplied with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Under the New Funding Model, the Global Fund decreased its support to Ukraine by more than $80 million, and the current Global Fund grant will conclude in 2017. Economic contraction in 2014, and the devaluation of Ukrainian currency, which lost nearly 75% of its purchasing power in one year, has adversely impacted the government's ability to procure test kits and ARV drugs in 2014 and 2015, and stock-outs of ARV drugs have been averted to-date through reprogramming of the current Global Fund grant. The Global Fund grant will conclude in 2017, and Ukraine will no longer be eligible for Global Fund support after that date. The ongoing conflict in the east of the country has led to an influx of over 1 million internally displaced people, primarily from Donetsk.

II. GOAL AND FOCUS OF THE GENDER ASSESSMENT

A gender assessment of HIV/AIDS policies and programming in Ukraine was undertaken in December 2015. The gender assessment was specifically geared to inform the primary goal of the PEPFAR Ukraine program: An aggressive scale-up of ART among people who inject drugs. PEPFAR Ukraine plans to support scale-up antiretroviral treatment (ART) coverage to approximately 72% of PWID (at CD_4 <500) by mid-2017 in the five highest burden regions of Ukraine – Dnipropetrovsk, Mykolayiv, Odesa, Kherson, and Kyiv City. To achieve this ambitious goal, PEPFAR Ukraine focuses on reducing "leakage" of PWID across the HIV service cascade by increasing access to HIV testing for PWID, improving linkages between testing and enrollment in care for PWID, and reducing loss to follow-up (LTFU) post-registration among PWID. PEPFAR Ukraine's work includes an additional focus on scaling up access to ART among the sexual partners of PWID and among men who have sex with men. The goal of the gender assessment was therefore to identify gender-specific vulnerabilities, needs, barriers, and gaps to accessing and adhering to the HIV service cascade – from testing to viral load (VL) suppression – for women and men who inject drugs, their sexual partners, and MSM. In light of the completion of the current Global Fund grant in Ukraine after 2017, and uncertainty about future Global Fund support, PEPFAR works with key partners, such as the Global Fund and the Government of Ukraine (GoU), to develop strategies and set up systems that can preserve the gains of the HIV response in Ukraine and ensure sustainability. The gender assessment supports this process by providing a gender perspective on sustainable access to ART, with a focus on the key populations prioritized by PEPFAR.

III. METHODOLOGY

A team of two consultants conducted a desk review of PEPFAR gender guidance, PEPFAR Ukraine documents, PEPFAR Ukraine Implementing Partner (IP) work plans and other documentation, Global Fund reports, GoU data and reports, non-governmental organization (NGO) reports, and other research on gender and HIV globally and in Ukraine (see Annex II for list of resources consulted). The team conducted key informant interviews in Ukraine between December 4th and 21st, 2015. The geographic focus of the interviews was determined by the United States Government (USG) Mission in Ukraine and focused on three high-impact regions of Ukraine – Dnipropetrovsk, Odesa, and Kyiv City. Supported by a logistics coordinator, the consultants conducted a total of 40 separate meetings with 81 key informants, and three focus group discussions with a total of 27 beneficiaries. Two additional interviews were conducted by telephone after the interviews in Ukraine were completed. (See Annex I for list of people contacted). The assessment focused on policies and programs supported by the Government of Ukraine, programs supported by PEPFAR, and also included programs supported by the Global Fund and bilateral donors. Interviews spanned the range of stakeholders and included four of the five USG agencies in Kyiv – the United States Agency for International Development (USAID), the US Centers for Disease Control (US CDC), Peace Corps, and the Department of Defense (DoD) – PEPFAR Implementing Partners, NGO service providers supported by IPs and by other development partners, technical partners, and beneficiaries. IPs and NGO service providers whose projects focus on activities that support PEPFAR's priority key populations – PWID, their sexual partners, and MSM – were prioritized for interviews.

LIMITATIONS

The selection of geographic focus and key populations was made by GH Pro and the PEPFAR Ukraine program, taking into consideration the limited time for the consultants to undertake in-country interviews, and in line with the global PEPFAR pivot to focus on regions and key populations with the highest prevalence, and therefore where interventions have the greatest potential for impact. Regions outside the geographic focus area, and issues impacting other key populations, such as sex workers who do not inject drugs, were therefore not explored. Interviews were conducted exclusively in regional capital cities and in Kyiv. Due to time constraints, it was not possible to visit other cities or rural areas at the regional (oblast) level. Some of the interventions undertaken by NGOs supported by PEPFAR implementing partners to improve access to HIV testing and linkage to care, were not being implemented in the cities visited for the gender assessment. The team was therefore not able to assess their success or the extent to which they incorporated gender considerations.

ORGANIZATION OF THE REPORT

The report is organized according to the areas of investigation laid out in PEPFAR guidance document, *Gender Analysis: Key Principles and Minimum Standards 2015,* and the questions set out in the Scope of Work. The first section focuses on socio-cultural gender norms, inequities, and inequalities that impact access to the HIV service cascade, and includes the sub-sections delineated in PEPFAR's gender guidance: data, laws and policies, gender norms, engagement in community and family life, access to and control of resources, and power and decision making. The second section examines key structural barriers to accessing the HIV service cascade in Ukraine that directly impact PWID, as well as their sexual partners and MSM. The third section outlines the current approaches in Ukraine to improving access to the HIV service cascade for men and women who inject drugs, their sexual partners, and MSM, including programs supported by PEPFAR, other bilateral donors, and the Global Fund. The fourth section identifies gaps and opportunities. The fifth and final section provides recommendations on strategies and approaches to improve PEPFAR Ukraine's support for gender-sensitive programing to link PWID, their sexual partners, and MSM to the HIV service cascade. In line with the priorities of the PEPFAR Ukraine program, the primary focus of each section is on PWID, with a secondary focus on the sexual partners of PWID and on MSM.

IV. SOCIO-CULTURAL GENDER NORMS, INEQUITIES, AND INEQUALITIES

DATA

Sex-disaggregated data on PWID in Ukraine is limited. According to the Ukrainian Center for Disease Control (UCDC) there are an estimated 310,000 PWID in Ukraine, the majority of whom are men. Sex-disaggregated data on PWID are not reported nationally; however, integrated bio-behavioral surveillance (IBBS) conducted in 2013 by the Alliance for Public Health in Ukraine (the Alliance), found that women comprise 23.6% of PWID, or an estimated 73,160 women who inject drugs nationally.

HIV-positive PWID are less likely to access ART than PLHIV who do not have a history of drug use. Nationally, as of January 1, 2015, there were 64,409 people on ART, 7,025 of whom were PWID. Parenteral transmission via injecting drug use accounts for 32.7% of PLHIV,[1] but only 10.9% of people on ART are PWID.[2] National data on access to ART is not disaggregated by sex.

Overview of ART (January 1, 2015)				
Data	National	Dnipropetrovsk	Odesa	Kyiv
# of sites	216	32	23	6
# of people on ART	64,409	8,745	6,745	1,798
# PWID registered and under medical supervision at AIDS Centers	53,920	not available	not available	not available
# MSM registered and under medical supervision at AIDS Centers	1,221	not available	not available	not available

Source: UCDC, *HIV-infection in Ukraine Bulletin No. 43*, Kyiv 2015.

Data on the types of drugs used is important when devising programs to effectively support PWID to access the HIV service cascade, but this data is not disaggregated by sex in Ukraine. The Alliance reports that 87% of PWID in Ukraine use opioids, but the male-female breakdown is not available, and little is known about gender differences in male and female drug use preferences and patterns – an important consideration when assessing gender-differentiated needs for evidence-based drug treatment approaches that effectively support access and adherence to ART for PWID. One service provider interviewed for the gender assessment reported that stimulants were more popular among men because "Men use stimulants to improve their sexual performance," but there is no data to determine whether this is indeed a gender-specific trend in drug use preferences.

Women who inject drugs account for a minority of PWID, but have disproportionately high rates of HIV infection. 2013 IBBS data shows that women who inject drugs account for 27% of HIV-positive PWID.

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[1] *Ukraine Harmonized AIDS Response Progress Report*, January 2012 – December, 2013.

[2] Calculated on the basis of the number of PWID receiving ART in health care facilities of the Ministry of Health and National Academy of Medical Sciences (NAMS) of Ukraine, and does not include people on ART in the penitentiary system, as reported in UCDC, *HIV-infection in Ukraine Bulletin No. 43*, Kyiv 2015.

HIV prevalence in all PWID was 19.7%, and women who inject drugs had an infection rate of 22.4 %, compared to 18.8 % in men who inject drugs.

HIV-positive women who inject drugs are more likely to enroll in care than their male counterparts, but it is not clear whether they remain in care, or simply access ART during pregnancy and then fail to continue treatment post-partum. IBBS found that HIV-positive women who inject drugs are more likely to enroll in care (68.3 %) than their male counterparts (57.5 %), and more likely to initiate ART (40.4 % of women compared to 37.6 % of men). The reasons for these gender differences in access to care and treatment have not been analyzed, but key informants interviewed for the gender assessment hypothesized that women's comparatively higher access to treatment was associated with attendance at antenatal care and access to ART for prevention of mother to child transmission (PMTCT). Ukraine does not use Option B+ for pregnant women, and data on the numbers and percentage of women PWID who received PMTCT but did not continue on ART post-partum, are not reported. For this reason, it is not clear whether or not reported higher rates of access to treatment among women PWID reflect women's short-term access to ART during pregnancy, although these women do not continue on ART post-partum.

IBBS 2013 data shows that LTFU between diagnosis and engagement in active medical care is higher for HIV-positive PWID than for PLHIV who do not inject drugs, but IBBS data is not disaggregated by sex. IBBS 2013 found that 48% of non-PWID PLHIV were enrolled in active medical care, compared to only 33% of PWID PLHIV. A national system for tracking LTFU for key populations is not in place, and Ukraine does not have a national unique identifier code (UIC) system. Key PEPFAR IPs have established different UICs and separate data collection systems. One IP, the All-Ukrainian Network of People Living with HIV, is working to introduce UICs in the framework of the HIV medical information system (MIS) to trace patients and avoid duplication at the facility level, but this does not extend to the national data collection forms. Regional AIDS Centers report data on the number of patients who had a viral load test and those who have undetectable viral load, and that data is disaggregated by key population, but not by sex.

Gender-specific data on PWID is not collected or reported in national data systems, such as data on mother-to-child transmission (MTCT) and access to PMTCT among pregnant women who inject drugs. However, a cohort study in Ukraine found that injecting drugs was associated with a two-fold increased risk of MTCT,[3] and identified injecting drug use as the single most important risk factor for child abandonment by HIV-positive women in Ukraine.[4]

Coverage of services critical to support access and adherence to ART for PWID – notably Medication-Assisted Treatment (MAT) – is extremely low in Ukraine, with only 3.1% of opioid-using PWID accessing public MAT services,[5] and available data shows that women have disproportionately low access to MAT: the UCDC reports that 8,398 PWID were accessing MAT in the public sector as of November 2015, 19% of whom were women, although nationally, women comprise 23.6% of PWID. The Association of Substitution Treatment Advocates has argued that women are chronically under-

[3] Claire Thorne, Igor Semenenko and Ruslan Malyuta for the Ukraine European Collaborative Study Group in EuroCoord, "Prevention of mother-to-child transmission of human immunodeficiency virus among pregnant women using injecting drugs in Ukraine, 2000–10," *Addiction*, 107, 118–128, 2011.

[4] H. Bailey, I. Semenenko, T. Pilipenko, R. Malyuta, and C. Thorne, "Factors associated with abandonment of infants born to HIV-positive women: results from a Ukrainian birth cohort," *AIDS Care*, vol. 22, no. 12, pp. 1439–1448, 2010.

[5] The denominator is the estimated number of opioid using PWID. In national reporting, the denominator is the number of opioid PWIDs who are registered with narcological dispensaries.

represented at MAT services, with percentages as low as 8% of clients at some MAT sites.[6] At the MAT site in Odesa visited for the gender assessment, only 14% of clients were women. No gender analysis of MAT services has been conducted in Ukraine. MAT, using methadone and buprenorphine, is available in the private sector, but there is no system in place to track or collect data on private sector MAT services, and this data is not reported, either in aggregate, or sex-disaggregated form.

Injecting drug use is also an important risk factor in the penitentiary system in Ukraine, and women prisoners have significantly higher HIV infection rates than male prisoners. Research conducted by United Nations Office on Drugs and Crime (UNODC) found that 48.7% of prisoners in Ukraine have a history of drug use. Only 5.7% of prisoners in Ukraine are women, but HIV prevalence among women is over three times that of their male counterparts – 33% among women and 10.1% among men. [7]

HIV prevalence among the sexual partners of PWID is estimated at between 7% and 30%,[8] and data on sexual behavior among PWID is not disaggregated by sex. Aggregated data suggests high levels of sexual risk behavior among PWID: only 54.1% of PWID report condom use during last sexual intercourse – compared with 65.6% of all adults aged 15-49.[9] Among the regions investigated for the gender assessment, higher rates of condom use were reported among PWID in Kyiv (61.8%) and Odesa (60.7%), while in Dnipropetrovsk, only 39.1% of PWID reported using a condom at last sex[10] – suggesting there may be particularly high HIV infection rates among the sexual partners of PWID in Dnipropetrovsk.

People who inject drugs and also sell sex are thought to have exceptionally high HIV infection rates, but data on the overlap between female drug use and sex work is varied: One NGO in Odesa interviewed for the gender assessment reported that 71% of women PWID attending their services also sold sex. A study conducted by the All-Ukrainian Network of People Living with HIV in 2011 found that 25% of female PWID receive money for sex and 36% of female sex workers inject drugs.[11] A study conducted in 2004 reported that 40% of women who inject drugs also sold sex, and 18-70% of female sex workers injected drugs.[12] There is no data on HIV infection rates among male sex workers, or on any overlap between drug use and male sex work.

Data on MSM suggests an escalating epidemic in this population. Data shows a 5.9% infection rate in 2013,[13] and a more than 10-fold increase in the number of officially registered cases of HIV in this group between 2005 and 2013.[14] There are an estimated 10,369 HIV-positive MSM in Ukraine,[15] but only 1,221

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[6] Lintsova Viktoria, UPO "The Association of Substitution Treatment Advocates of Ukraine," regional representative of "The Association of Substitution Treatment Advocates of Ukraine" in Kirovograd region. http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/gensens/r2.htm

[7] UNODC, Analysis of the HIV/AIDS Response in the Penitentiary System of Ukraine, 2012. http://unaids.org.ua/files/Analysis_of_HIVAIDS_response_in_penitentiary_system_of_Ukraine.pdf

[8] Ukraine COP 15, p. 7

[9] *Ukraine Harmonized AIDS Response Progress Report*, January 2012 – December, 2013, p. 42 and p. 30.

[10] Ukraine Harmonized AIDS Response Progress Report, January 2012 – December, 2013, p. 42.

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

[12] P. Kyrychenko and V. Polonets, "High HIV risk profile among female commercial sex workers in Vinnitsa, Ukraine," *Sexually Transmitted Infections*, vol. 81, no. 2, pp. 187–188, 2005

[13] Alliance IBBS 2013.

[14] *Ukraine Harmonized AIDS Response Progress Report*, January 2012 – December, 2013, p. 20 and p. 7.

[15] PEPFAR Ukraine COP 15.

cases of HIV officially registered at AIDS Centers as MSM at the end of 2014.[16] According to the Alliance, the HIV incidence rate among MSM exceeded that of PWID in 2015.[17]

LAWS AND POLICIES

Ukraine's National AIDS Program for 2014-2018, approved by the Verkhovna Rada on October 20, 2014, supports a gender-based approach and makes (one) mention of violence in the context of gender issues, and also includes provisions to reduce stigma towards PLHIV, improve access to prevention services for key populations including for PWID and MSM, and scale up coverage of MAT to 20,892 PWID by 2018. Ukraine's *Procedure of providing substitution maintenance therapy for patients with opioid dependence* specifies preferred access to MAT for pregnant women, although in 2014, only 51 MAT clients gave birth.[18]

Legislation protecting the rights of the lesbian-gay-bisexual-transgender (LGBT) community is virtually non-existent. Existing legislation does not contain direct references to sexual orientation, making it very difficult to protect the rights of LGBT people in court and anti-homosexual legislation has been considered in Ukraine. For example, in October 2012, the Parliament considered a bill that would outlaw "pro-homosexual propaganda" that gives a "positive depiction" of gay people.[19] Gender equality took an important step forward in November 2015, when the Ukrainian Parliament passed an anti-discrimination amendment to the Labor Code, prohibiting discrimination at the work place on the basis of sex, gender identity, sexual orientation, or suspected presence of HIV/AIDS, among others.

Ukraine is signatory to key international conventions that support women's rights, and has also developed a range of national legislation and regulatory frameworks addressing gender equality. (See Annex III). Data suggests, however, that gender equality remains elusive in Ukraine. Rates of gender-based violence, for example, remain high and are growing. A study conducted in 2014 found that one in five women aged 15-49 years experienced physical violence since she turned 15 years old, representing an increase from 2007 levels when 17% had experienced violence.[20] Intimate partner violence increases the risk of HIV infection by around 50%, and violence – and the fear of violence – deters women and girls from seeking HIV services.[21] Yet HIV prevention, care, and treatment programming in Ukraine is not geared to addressing gender-based violence, and, under the indicator "Proportion of ever-married or partnered women aged 15-49 years who have experienced physical or sexual violence from a male intimate partner in the last 12 months" the *Ukraine Harmonized AIDS Response Progress Report*, January 2012 – December, 2013, states: "The indicator is not relevant to our country."[22]

Data on gender-based violence against MSM is not collected or reported in Ukraine. MSM organizations interviewed in the course of the gender assessment reported that physical violence against MSM due to their sexual orientation was commonplace, and is not recognized as a hate crime under current Ukrainian legislation.

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[16] *Ukraine Harmonized AIDS Response Progress Report*, January 2012 – December, 2013, p. 7.

[17] Data not available at the time of the gender assessment.

[18] UCDC, *HIV-infection in Ukraine Bulletin No. 43*, Kyiv 2015.

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

[20] UNFPA, *The Prevalence of Violence against Women and Girls*, Kyiv 2014.

[21] *Women living with HIV speak out against violence 2014.* http://www.unaids.org/en/resources/documents/2014/womenlivingwithhivspeakout

[22] *Ukraine Harmonized AIDS Response Progress Report*, January 2012 – December, 2013, p. 17.

GENDER NORMS

Gender norms and gendered expectations of female and male behavior impact access to HIV prevention, care, and treatment services for PWID in Ukraine. Service providers and beneficiaries reported that risky behaviors, including injection drug use, were more socially acceptable for men than for women, and that men who inject drugs tend to have wider social and injecting circles than women. NGO service providers working with PWID reported that male clients were more willing to attend prevention services, such a needle and syringe exchange points, but may be less willing to attend HIV services, unless they are experiencing symptoms.

Gender norms that assign primary responsibility for childcare and other caregiving responsibilities to women, adversely impacted access to HIV services for women who use drugs. Research on women who use drugs in Ukraine has found that childcare responsibilities are often cited as a reason why women do not attend harm reduction services.[23] Women PWID interviewed for the gender assessment reported that they were unable to attend services such as MAT, or undertake the long list of medical tests required in order to enroll at AIDS Centers, due to lack of childcare options. Women who use drugs are also fearful of attending health services, including HIV and drug treatment services, because they fear loss of child custody if they are identified as a drug user.[24]

Gender-based violence can also impact access to medical services, including HIV services, for women who inject drugs. Although there is no data from Ukraine on gender-based violence and women PWID, research in Eastern Europe and Central Asia has found that women who use drugs experience high levels of domestic violence and are unlikely to report incidents to the police or to access medical or legal services after they have been beaten or raped. Women who inject drugs and sell sex report high levels of violence from their clients,[25] but are often unwilling to seek medical care. The practice by which medical staff inform police in cases where they suspect a woman has experienced domestic violence also deters women who fear being identified as a drug user, or a sex worker, from accessing medical care after a violent attack.[26] Women interviewed for the gender assessment reported a normalization of gender-based violence, including a widespread perception that: "If he beats you, it means he loves you." Social workers reported that fear of violence or abandonment by their male partner made some HIV-positive women who inject drugs unwilling to start or continue ART after giving birth, out of concern of having to disclose their status, or explain why they are going to the hospital or what medications they are taking. Similarly, a study carried out in 2011 by the All-Ukrainian Network of People Living with HIV found that: "Many women do not disclose their HIV-positive status to the partner, being afraid of losing him or being fearful of violence."[27] Gender norms including fear of

> "Our clients do not understand that this [violence] is a problem. They deny it. Even when the husband also beats their baby."
>
> – NGO worker, Dnipropetrovsk

[23] Katya Burns, *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*, International Harm Reduction Development Program, Open Society Institute, 2009.

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

[25] The Alliance for Public Health in Ukraine, *Analytical report of results of formative study of gender-oriented programs, projects, interventions and services in harm reduction*, 2015. http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/gensens/index.htm

[26] Katya Burns, *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*, International Harm Reduction Development Program, Open Society Institute, 2009.

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

violence can also impact women's ability to access MAT services, and women who do attend MAT may attempt to conceal this from their partner.[28]

Gender-based violence was also a barrier for MSM to access HIV services. MSM service providers and beneficiaries in Kyiv and Odesa reported attacks on their community centers and on their volunteer outreach workers. One service provider reported that a coordinator of an MSM community center was brutally beaten and hospitalized for two weeks, and his attackers used homophobic language during the attack. MSM report fear of approaching the police in these instances, and police refusal to register attacks as hate crimes or to document homophobic abuse. Some beneficiaries reported having to pay off police officers to avoid being "outed" as gay.

Among women who inject drugs, misperceptions about ART also impacted access to the HIV service cascade. Medical professionals in Kyiv, Odesa, and Dnipropetrovsk, and harm reduction beneficiaries in Kyiv, reported that pregnant women living with HIV believed that ART would hurt their baby and refused PMTCT or believed they should discontinue ART in order to breastfeed safely. Women who inject drugs reported a belief that MAT would harm their fetus or make it dangerous for them to breastfeed. Some women beneficiaries reported that they avoided pregnancy due to their HIV status, or their drug use, or both, and believed that they could not have a healthy baby or be a good mother. Women who use drugs often experience amenorrhea (no menses), and may therefore believe that they cannot get pregnant or else not realize they are pregnant until the pregnancy is far advanced. For this reason, women who use drugs are particularly prone to unplanned pregnancies, and tend to attend antenatal care at later stages in their pregnancy, when it is too late to benefit from the full course of PMTCT. Some women interviewed for the gender assessment reported that when they became pregnant, they attempted to get an abortion, believing their child would necessarily be HIV positive. Others reported that service providers encouraged them to continue their pregnancy, but then failed to provide proper care, including adequate PMTCT or early infant diagnosis.

> "When I became pregnant, I tried to get an abortion, but the doctors talked me out of it. They said my baby would be fine. They gave me some [pediatric ART] syrup to give him for a week. But he is sick, nothing is fine…"
> – Woman beneficiary, Kyiv

Gender norms also impacted the way in which service providers interact with women and men who inject drugs. A study conducted by the Alliance found that social and outreach workers at NGOs considered women who inject drugs to be "vulnerable, lacking self-assurance, sometimes are treated like children, while men are considered to be strong, assertive, able to take up responsibility not only for themselves, but for their relatives too. Based on this, in counseling males, more attention is paid to safe behavior, and in working with women, the image of a beautiful woman and a good mother is cultivated. Women are weak and vulnerable, men are strong and independent. Based on this, it is considered that for women it is more difficult to handle problems in their life, including their problems related to drug use." [29] The study also found that NGO service providers were more likely to discuss condom use and negotiation with a male client than with a female client. Similarly, advocates for access to MAT argue that gender

> "Women do not want to go on opioid substitution therapy (OST) when they are pregnant, and doctors do not want to give it to them either."
> –NGO worker, Kyiv
>
> "I tried to refer her [pregnant woman who injects drugs] to OST, but she did not agree. So I gave her some clean needles."
> –NGO worker, Odesa

[28] One activist cited the problem of being an opioid substitution therapy (OST) patient and wife (when husband is not aware of the problem). http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/gensens/r2.htm

[29] The Alliance for Public Health in Ukraine, *Analytical report of results of formative study of gender-oriented programs, projects, interventions and services in harm reduction*, 2015. http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/gensens/index.htm

stereotypes of "strong" men lead men who inject drugs to believe that seeking psychological help is shameful and to avoid participation in critical counseling services that can support adherence to ART, while stereotypes of "weak" women lead social workers to avoid important conversations, such as condom negotiation, with women.[30] Some medical professionals in Dnipropetrovsk interviewed in the course of the gender assessment argued that a mother who uses drugs is, by definition, a bad mother, and described women who use drugs as "very difficult to work with," "irresponsible," and "not good mothers."

ENGAGEMENT IN COMMUNITY AND FAMILY LIFE

Women who inject drugs and men who have sex with men reported that gender-specific stigma impacted family life and their ability to access HIV services. Beneficiaries from both these groups reported that some health care workers in services that are not directly focused on HIV, such as at primary health care facilities, are not comfortable working with PLHIV, MSM or PWID. NGO service providers in Odesa, for example, reported that some hospitals refused to accept PWID and that: "There are a lot of problems with stigma and discrimination from doctors in rural areas, especially infectious disease doctors." Both men and women who inject drugs in Kyiv and Odesa reported that doctors at city AIDS Centers were sensitive to the needs of PWID, and were supportive and helpful.

MSM service providers, on the other hand, reported instances of discrimination at AIDS Centers and indicated that their beneficiaries often did not disclose their sexual orientation when they attended HIV services. Stigma about HIV within the MSM community itself also poses a barrier to HIV testing: NGO service providers report that many MSM are unwilling to undergo testing in a clinic where there are other MSM, because, should there be any suspicion that they are HIV-positive, they would be unable to find a sexual partner. Access to appropriate sexual health services is particularly challenging for MSM because doctors at reproductive health clinics are not qualified – or comfortable – addressing MSM sexual health concerns. Stigma also severely impacted the family lives of both MSM and women who have sex with women (WSW). Service providers reported that some WSW got married to men and had children in order to fulfill familial and societal expectations, then divorced and lived with their female partner. MSM reported that family members sought to "cure" them, taking them to doctors who could "cure homosexuality" and pressuring them to undergo hormone therapy. Service providers reported that these kinds of pressures, together with high levels of violence against MSM, have led to high levels of suicide in the MSM community. Intolerance of MSM is particularly problematic in rural areas and MSM service providers in Kyiv reported significant migration of MSM from rural areas to urban centers, in search of a more tolerant environment and a supportive community.

> "When I went to get an HIV test at the AIDS Center, the doctor asked me: "Are you one of *those*?"
> –MSM beneficiary, Kyiv
>
> "At the AIDS Center they asked me: "What is code 103? We don't have such a thing here."
> –MSM beneficiary, Kyiv

ACCESS TO AND CONTROL OVER RESOURCES

Both men and women who use drugs reported that fees for the tests required to register at AIDS Centers were high, and sometimes prohibitive. A study conducted by the Alliance found that men who inject drugs were more likely to have full-time regular employment than women, and that difficulties in finding childcare were cited as a primary reason why women could not take on full-time regular

[30] Lintsova Viktoria, UPO "The Association of Substitution Treatment Advocates of Ukraine," regional representative of "The Association of Substitution Treatment Advocates of Ukraine" in Kirovograd region. http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/gensens/r2.htm

employment.[31] Women were more likely to have temporary employment, or to sell sex. The gender assessment found no gender-specific variation in access to financial resources that impacted men and women drug users' ability to attend HIV services.

No MSM NGO service providers or beneficiaries reported financial resources as a barrier to accessing HIV services.

PATTERNS OF POWER AND DECISION MAKING

> "Most clients are men. They won't bring their partner right away. Maybe on the third or fourth visit."
>
> –NGO Odesa

Patterns of power and decision-making impact vulnerability to HIV infection among women who inject drugs. Women beneficiaries interviewed for the gender assessment reported that access to drugs was primarily controlled by their male partner – who procured the drugs – and that women's initiation into drug use was often in the context of an intimate relationship with a man who injects drugs. According to research conducted by the Alliance, 92% of women who inject drugs are married to or partnered with a man who also injects drugs.[32] Research on women who inject drugs has found that women are often "second on the needle": The man procures and prepares the drugs, injects himself first, and then injects his partner. Sharing needles in this manner forms an integral part of intimate relationships. Access to harm reduction services is also largely controlled by men, who may be reluctant to allow their female partner to seek out medical services.[33] Service providers interviewed for the gender assessment also reported that men may refuse to bring their partner, or delay bringing her to services.

Power differentials in drug-injecting couples have also been found to put women at risk of sexual transmission of HIV: Studies have found that some men who inject drugs coerce their female partners into sex work in order to get money to buy drugs. Women who inject drugs and sell sex tend to be marginalized within the sex worker community, considered "low level," and may be more likely to agree to unprotected sex and be vulnerable to violence, than sex workers who do not inject drugs.

Testing Requirements to Register at AIDS Center		
Republican AIDS Center	**City AIDS Center Dnipropetrovsk**	**City AIDS Center Odesa**
Confirmatory test Chest X-Ray	Confirmatory test Biochemistry blood test Chest X-Ray	First confirmatory HIV test. It takes 5 days to get the results from the first test. Second confirmatory HIV test. It takes 5 days to get the results from the second test. Dental exam Ophthalmological exam Electro-Cardiogram Chest X-Ray Ultrasound Gynecologist

[31] The Alliance for Public Health in Ukraine, *Analytical report of results of formative study of gender-oriented programs, projects, interventions and services in harm reduction*, 2015. http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/gensens/index.htm

[32] Ibid.

[33] Katya Burns, *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*, International Harm Reduction Development Program, Open Society Institute, 2009; Sophie Pinkham and Anna Shapoval, *Making Harm Reduction Work for Women: The Ukrainian Experience*, International Harm Reduction Development Program, Open Society Institute, 2010.

In terms of access to reproductive health services, the Alliance study cited above found decisions about whether to preserve a pregnancy and how to bring a child up were made equitably by couples who inject drugs, although women were primarily responsible for caring for children. Interviews with beneficiaries in the course of the gender assessment similarly found no evidence that power differentials within couples posed a barrier to women accessing reproductive health or HIV services, and beneficiaries with children reported that they attended antenatal care during their pregnancies. Drug-related barriers to accessing reproductive health, however, were evident among women beneficiaries, some of whom reported pressure from medical professionals to get an abortion on the basis of drug use. NGO service providers did note that lack of support for safe disclosure of HIV status was a challenge for both men and women who inject drugs and constitutes a barrier to accessing the sexual partners of PWID.

STRUCTURAL ISSUES

HIV Testing

In Ukraine, only medical personnel are allowed to perform an HIV test and disclose the results of the test to a client. However, community-based HIV testing has been widely implemented in Ukraine by the Alliance, with support from the Global Fund. At first, NGOs worked with AIDS Center doctors, providing incentives for doctors to provide HIV testing in community settings such as NGO offices, needle and syringe exchange sites, and mobile clinics. However, following a draw down of Global Fund support, these programs were eliminated. Self-testing is allowed in Ukraine, and the Alliance supports NGOs to provide self-test kits, and social workers offer supervised self-testing for clients.[34] No study of the gender-differentiated impact of this approach has been conducted.

Registration at the AIDS Center

The registration requirements at AIDS Centers are burdensome and vary widely by region. Both men and women who inject drugs report long lists of required tests, some with little obvious relevance to HIV (a dentist's examination was required in Odesa), testing fees that are difficult for PWID to pay, and long waiting periods for test results, that adversely impact attendance and adherence. The time to register at AIDS Center ranges from approximately a month in Kyiv, to two months in Odesa. Although no comprehensive study of the gender-differentiated impact of these requirements on registration at AIDS Centers has been conducted, the time and expense required in order to meet registration requirements is likely to particularly impact women with small children, who must either bring their children with them or seek out childcare – an obstacle to attending services for many women who inject drugs.

The burden of registration requirements is particularly challenging for those who live in rural areas. NGO service providers in Odesa and Dnipropetrovsk reported challenges providing linkage to care in rural areas, including lack of appropriate infrastructure to transport blood samples to AIDS Centers for confirmatory tests, and harm reduction and drug treatment options in rural areas for both men and women who inject are very limited. PEPFAR IPs in Kyiv report that in order to register at an AIDS Center, people living in rural areas must travel long distances to reach the AIDS Center and undergo

[34] East Europe and Central Asia Union of PLWH, *Analysis of legislative and policy barriers for introduction and effective operation of community-based HIV testing and counseling in 7 countries of Eastern Europe and Central Asia*, 2015

the various tests required for registration. Often, this is not feasible due to time and financial constraints. For women with small children and other caregiving responsibilities, this may be impossible.

Knowledge of, and availability of post-exposure prophylaxis (PEP) – a critical intervention for women who have experienced sexual assault, is extremely limited. In Dnipropetrovsk, for example, the gender assessment found that PEP is only available at one location, the city AIDS Center, which is closed on the weekend.

Linkage to Care Following Registration

There is little consensus on which organizations – governmental or non-governmental – are responsible for ensuring that clients who have registered at AIDS Centers remain actively engaged in care, particularly for those clients who do not qualify for ART at the time of registration. No work has yet explored the gender-differentiated impact of this gap, but lack of clarity about the responsibility for follow-up post-registration impacts both men and women who use drugs.

NGOs undertaking case management argue that follow-up with clients who are registered in care is primarily the responsibility of the AIDS Center. Indeed, under the Community Initiated Treatment Interventions Project (CITI) supported by the Global Fund and PEPFAR, case management cases are closed when a client starts ART or when a client registers at the AIDS Center but does not yet qualify for ART. AIDS Centers argue that follow-up with clients, particularly those who are registered but do not qualify for ART, should rightly be the responsibility of NGOs. Doctors at AIDS Centers, and government officials, argue that NGOs receive donor funding to support adherence to treatment, that NGO workers are generously remunerated, and that NGOs make additional payments to friendly doctors. For these reasons, professionals in the public sector argue that NGOs should take responsibility for supporting adherence, following registration at the AIDS Center. Some government medical professionals argue that NGOs case management work improperly assigns medical responsibilities to under-qualified NGOs, and that donor support should focus instead on government institutions, which can assure high coverage and proper follow-up, if funding were available.

> "AIDS Centers do not follow up with our clients after we get them registered. They just register them. Then, after one year, if the client has not come to the AIDS Center, they remove clients from the registry."
> –NGO worker Kyiv

> "The problem is that NGOs only have targets for the number of people they register at AIDS Centers. They don't have to report on the number of cases that continue to come to the AIDS Center. So they don't bother to do this. With all the money they get from donors, they should do this work. We don't have the staff or funding to do it."
> –GoU representative

Gender-Based Violence Services

There is a dearth of services to support women who have experienced gender-based violence, and no services for MSM or transgender people who have experienced gender-based violence. There are few shelters in Ukraine, and the barriers to entry vary from shelter to shelter and can be prohibitive for women who inject drugs. Government supported shelters require proof of residency (*propiska*), a passport, and a document from a district police officer that confirms that domestic violence took place; in some instances children over the age of 12 are not admitted, and drug users may be turned away. Women with mental disorders, infectious diseases, or wounds are not admitted.[35]

MAT

[35] http://fam-center.at.ua/index/pritulok/0-5

MAT plays an important role in improving access and adherence to ART, and significantly improves pregnancy outcomes for women who inject drugs. A recent overview of the impact of MAT on ART outcomes, conducted by the Alliance, Bristol University, and the London School of Hygiene and Tropical Medicine, found that concurrent MAT and ART increased the coverage of ART by 54% and uptake by 69%, increased adherence two-fold and viral suppression by 45%, and reduced attrition by 23%.[36] Yet MAT coverage in Ukraine is low, and nationally, women have disproportionately poor access to this service. From the outset, when MAT was introduced in Ukraine in 2004, (buprenorphine was introduced in 2004, methadone in 2008), researchers noted that women, particularly pregnant women and women with young children, were not accessing MAT in numbers proportionate to their presence in the drug-using population.[37] Today, the proportion of women attending MAT varies widely by region: The MAT site at Odesa City AIDS Center, visited in the course of the gender assessment, had 112 clients, of whom just 14.2% (16 women) were female. In Dnipropetrovsk, however, women comprised 30% of clients attending MAT services at the City AIDS Center. Although MAT directly supports adherence to ART, MAT services in Ukraine are weakly integrated into AIDS Centers – less than 8% of MAT clients access this service at an AIDS Center, and MAT clinics located at AIDS Centers are undersubscribed. The MAT service at the Dnipropetrovsk City AIDS Center has slots for 70 clients but had only 55 clients at the time of the gender assessment, while the MAT service at the Odesa City AIDS Center had slots for 127 clients, but only 112 filled. MAT services at other locations do not provide on-site HIV testing – and TB doctors, for instance, are not allowed to provide HIV testing services or provided with test kits to offer supervised self-testing for clients.

> "The hours for the OST clinic are not convenient. It is very strict. Only open from 9 in the morning until noon. If you come late, they won't give it to you."
>
> —NGO Odesa

Location of MAT Service as of 01.01.2015

Location	Number of MAT sites	Percentage of MAT clients covered
Drug treatment clinic	35	50%
TB Dispensaries	22	3.7%
AIDS Centers	**9**	**7.7%**
Neuropsychiatric/ psychiatric hospitals	8	7.4%
Female-specific health services	**0**	**0%**
Other health facilities	95	30.8%
Total	170	100%

Source: UCDC, *HIV-infection in Ukraine Bulletin No. 43*, Kyiv 2015

Paradoxically, both women and men who inject drugs interviewed in the course of the gender assessment reported that they had experienced challenges registering for MAT due to a lack of available slots at MAT services, and long waitlists. Other barriers to MAT, noted by beneficiaries and service providers, include a requirement to demonstrate multiple unsuccessful attempts to quit drugs, documents to prove place of residence – the *propiska* – and

[36] Andrea Low, Gitau Mburu, Nicky Welton, Margaret May, Charlotte Davies, Clare French, Katy Turner, Katherine Looker, Hannah Christensen, Susie McLean, Tim Rhodes, Lucy Platt, Andy Guise, Peter Vickerman, *Impact of Opioid Substitution Therapy on Antiretroviral therapy: a systematic review and meta-analysis*, Poster Session at IAS 2015. http://pag.ias2015.org/PAGMaterial/eposters/2942.pdf; and The Alliance for Public Health, *How methadone is promoting ART adherence for drug users in Ukraine,* 2015. http://www.aidsalliance.org/our-impact/making-it-happen/609-how-methadone-is-promoting-art-adherence-for-drug-users-in-ukraine

[37] Roman Yorick, Halyna Skipalska, Svetlana Suvorova, Olga Sukovatova, Konstantin Zakharov, and Sara Hodgdon, "HIV Prevention and Rehabilitation Models for Women Who Inject Drugs in Russia and Ukraine," *Advances in Preventive Medicine*, Volume 2012, Article ID 316871, 24 October 2012; and S. Dvoriak, "Overview of opioid substitution treatment in Ukraine," in *National Conference on Harm Reduction*, Kyiv, Ukraine, February 2006.

a requirement to register with narcological services, which, in Odesa, requires a 10-day to two-week in-patient detoxification. In Dnipropetrovsk, registration at narcological services is also required in order to access MAT, although the in-patient period is 72 hours. Most MAT clients are in their mid-30s with an average of 15 years of experience of injecting drugs and numerous documented unsuccessful attempts to quit.[38] This effectively excludes young women in their childbearing years. Beneficiaries noted that fees for the tests required for registration with narcological services were prohibitive, and, for women with children or other caregiving responsibilities, undertaking a lengthy in-patient detoxification, was not feasible. MAT services in Odesa reported that prior to 2007, in-patient treatment at narcology services was not required, and that following introduction of this requirement, the number of MAT clients dropped by half. Employers can access narcology records, and registration can adversely impact employment opportunities, posing another concern for people who inject drugs. MAT services are only open a few hours a day in the morning, making it difficult for both men and women to attend. Take-home doses are not provided in Ukraine, and clients can be removed from the MAT program if they fail to attend for three days in a row. Access to MAT during pregnancy is very limited and in Dnipropetrovsk, one maternity hospital provides referral to MAT, but there are no protocols on appropriate dosing for pregnant women, reported dosing is very inadequate, and there are no provisions for MAT during labor – which would support new mothers to care for their newborns, or evidence-based treatment for neonatal abstinence syndrome. Instead, babies born to women who use drugs are routinely separated from their mothers and placed in special wards for periods of up to five days – a non-evidence based practice that severely undermines mother-child bonding, aggravates neonatal abstinence syndrome, and causes intense distress to both mother and baby. Failure to provide MAT in maternity wards forces women out of the hospital immediately after giving birth in search of drugs to relieve withdrawal. These women tend to be lost to follow up for HIV-related care.

[38] UCDC, *HIV-infection in Ukraine Bulletin No. 43*, Kyiv 2015.

V. IMPROVING GENDER-SENSITIVE ACCESS TO THE HIV SERVICE CASCADE FOR PWID IN UKRAINE: UKRAINE'S APPROACHES UNDER PEPFAR, THE GLOBAL FUND, AND OTHER DONORS

Research on gender and drug use, and gender-sensitive interventions for PWID and their partners – including support for access to ART, have a rich history in Ukraine. As far back as 2007, the Open Society Foundations, with support from the Canadian International Development Agency, commissioned research on women and harm reduction in Ukraine,[39] and subsequently funded gender-sensitive interventions at six NGOs offering harm reduction services across Ukraine. These early programs developed innovative methodologies to identify gender-specific vulnerabilities and address the needs of women who inject drugs, and built the capacity of NGOs to provide gender-responsive services: In Poltava, NGO Light of Hope advocated for uninterrupted access to MAT for pregnant women who use drugs in maternity hospitals. In Kyiv, NGO Krok za Krokom reached into local women's health clinics to identify women who use drugs, provide them with low threshold harm reduction services, and link them to HIV testing and treatment. The Ukrainian Foundation for Public Health MAMA+ Project worked with pregnant HIV-positive women who use drugs and their families to support mothers to keep their babies at home, and also ran a campaign to promote access to MAT for women. In Dnipropetrovsk, NGO Virtus supported young mothers who use drugs to access MAT, sexual and reproductive health care, and psychological, legal, and social aid.

Subsequent work in Ukraine built on the experience of these early projects. With support from PEPFAR's SUNRISE Project and the Global Fund, the Alliance supported gender-sensitive harm reduction projects in Donetsk, Cherkasy, Odesa, and Mykolayiv oblasts.[40] Geared to increasing access to women who inject drugs and reaching out to the female sexual partners of men who inject drugs, the projects introduced harm reduction services specifically targeted to women who use drugs, trained social workers on the sexual and reproductive health of PWID, and offered couples counseling.[41] In 2016, with support from the Expertise France 5% Initiative, the Alliance will implement a new project entitled Capacity Development for Quality Assured Gender Sensitive Harm Reduction Interventions in Ukraine. The goal of the project is to ensure that women and men who inject drugs and their sexual partners have equal access to gender sensitive and quality assured HIV prevention and care in Ukraine. The project will design and test interventions on essential community-based harm reduction services and MAT, including quality assurance and mechanisms for the enrolment and retention of clients in projects; develop and implement a staff development program for HIV-service NGOs and governmental authorities to introduce a gender-sensitive approach in harm reduction programs, and deliver social and medical services to PWID and their sexual partners; and establish a mentorship program including for sexual and reproductive health services. [42]

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[39] Katya Burns, *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*, International Harm Reduction Development Program, Open Society Institute, 2009.

[40] The Alliance, *Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users*, 2011.

[41] The Alliance, *Keeping Women who Use Drugs Health: Alliance Ukraine's experience integrating HIV, harm reduction, and sexually and reproductive health programming*. 2013.

[42] http://www.aidsalliance.org.ua/ru/gensens/pdf/Project%20announcement_en.pdf

The PEPFAR-supported RESPOND project, implemented by Pact, has also integrated gender into its work. RESPOND developed a Gender Roadmap in 2014; conducted orientations on gender for its own and partners' staff; integrated gender considerations into its strategic information activities; supported NGOs to provide gender-sensitive services for female prisoners and women who inject drugs and their partners; and incorporated a gender focus into its Seven Steps intervention, which addresses HIV prevention, testing, and linkage to care for PWID and their sexual partners. In the context of the Seven Steps, RESPOND provided trainings for partner NGOs, including supporting gender-specific referrals for gender-based violence, legal support, livelihoods, parenting classes, social support, and antenatal care and PMTCT for pregnant women. RESPOND's Quality Improvement project focused on increasing HIV testing uptake, timely enrollment of HIV-positive clients into care and early initiation of ART among key populations, including PWID. RESPOND's Marketplace supports partners to address violence and coercion, and grantees undertook activities such as conducting seminars on violence in which participants discuss fear of violence and how to negotiate with partners, using role-plays related to violence and fear of communicating with a partner. Social workers were trained in violence-related issues and on how to use this knowledge when working with clients. One grantee included fear of violence and negotiating with partners in its counseling standards. Grantees also worked with those who carry out violence.[43] RESPOND also designed an intervention to reach the sexual partners of PWID which aims to facilitate access to HIV testing. The intervention is integrated into the Seven Steps project and involves two counseling sessions – one for clients, and another one for their sexual partners.

The PEPFAR-supported PLEDGE project, implemented by UNODC, and focusing specifically on PWID and on prisoners, also incorporates gender into its work by providing training workshops for law enforcement, prison staff, health services, and NGOs that include materials on the needs and rights of women who inject drugs and female prisoners, stigma reduction and appropriate referrals to comprehensive HIV prevention, treatment and care services, and strategies to address violence and abuse, including sexual violence. PLEDGE also provides support in the development of the national clinical protocol on MAT to insure that the specific needs of women who inject drugs are addressed and that gender-sensitive treatment strategies are incorporated. With support from AIDS Life Verein (Austria), UNODC also implemented a project on gender-sensitive services, including providing grants to six NGOs.

The PEPFAR-supported HIV Reform in Action project, implemented by Deloitte, also addresses gender issues by providing trainings for primary health care workers on gender and stigma and integrating gender and stigma into its Investment Case. Deloitte invited a gender expert from its home office to provide training for its own staff on gender, and has made gender a cross-cutting issue across all its projects.

PEPFAR-supported projects have also made progress in supporting access to critical HIV services for MSM. To address barriers to accessing sexual health and HIV services, innovative MSM-support organizations, such NGO Fulcrum, have set up MSM-friendly clinics in Kyiv, Dnipropetrovsk, and Odesa, as well as Lviv, Poltava, Uzhhorod, Kharkiv, Kherson, and Chernihiv. In Kyiv, NGO Fulcrum offers legal support, a convenient and confidential on-line system for setting appointments, a friendly doctor – employed by an AIDS Center and also offers testing and consultations at a dedicated MSM clinic as well as easy referral linkage to the city AIDS Center, where clients meet with the friendly doctor from the MSM clinic. The program found that 85% of the clients who saw the friendly doctor and tested positive, went to the AIDS Center for a confirmatory test.

[43] *Integrating Gender into RESPOND: A Roadmap*. 6/5/2014.

VI. GAPS AND OPPORTUNITIES

DATA

Gap: National data systems to track LTFU for key populations, including PWID and MSM, across the HIV service cascade are not in place, and national data on LTFU is not disaggregated by sex. PEPFAR implementing partners do track LTFU for key populations at some points along the cascade, but unique identified codes are not compatible across implementing partners, posing a barrier to aggregating data. There is currently no plan in place to address disparate UICs across implementing partners.

Opportunity: The electronic MIS system currently under development by the Network, with PEPFAR support, will be compatible with the GoU (Ukrainian Center for Disease Control or UCDC) system and will be able to track LTFU among PWID nationally. This provides an opportunity to generate sex-disaggregated data on LTFU among PWID.

LAWS AND POLICIES

MSM

Gap: Apart from the recent modification of the Labor Code, legislation to protect the LGBT community from stigma, discrimination, and violence is not in place in Ukraine.

Opportunity: MSM organizations and service providers supported by PEPFAR are advocating for policy change and incorporate legal aid into their projects. This provides an opportunity to build on ongoing efforts for legal change.

Transgender Populations

Gap: Globally, transgender populations have greater vulnerability and higher HIV infection rates than MSM. Yet, there is virtually no research or data on the transgender community in Ukraine, and no funding directed to addressing the vulnerabilities and needs of this distinct population, including assessing and improving access to ART. As a result, little is known about HIV infection rates among transgenders in Ukraine, the barriers they experience to accessing HIV testing, registering in care, accessing ART, and adhering to treatment.

Opportunity: Current MSM interventions supported by PEPFAR are acutely aware of the specific issues facing transgender population access to the HIV care cascade and can therefore provide a strong platform to move forward with addressing transgender-specific barriers to accessing services.

CASE MANAGEMENT

Gap: PEPFAR IPs are implementing a number of innovative case management approaches that dramatically increase access to HIV testing for PWID and improve PWID registration rates at AIDS Centers. The Alliance CITI project, for example, currently supported by the Global Fund, employs caseworkers to work with each client for six months from the time they test positive for HIV. Caseworkers provide counseling, assist with registration at the AIDS Center, and accompany clients on each visit. The caseworkers also work with doctors to ensure that PWID receive the services to which they are entitled. PWID who have previously registered at an AIDS Center but have not gone on to receive ART are also supported. Additional funding from the Alliance's Innovation Fund has allowed the Alliance to develop CITI+ which extends the period individuals are supported to 18 months, and provides peer-led group sessions, individual counseling sessions, the introduction of family supporters, and the use of SMS treatment reminders, in order to assess whether caseworkers are able to improve adherence to ART as well as enrolment. Clients of CITI are able to access ART within an average of 22 days from initial testing, compared with two years under the referral-only system.

At the moment, a number of key aspects of this case management approach are unclear: (1) It is not clear how projects like CITI are following up with clients' post-registration at AIDS Centers. Key informants interviewed during the gender assessment reported that cases are closed under the following circumstances: when the client registers at the AIDS Center, when the client start ART, when a client transfers to a care and support project, when a client transfers to MAT, when a client moves, is put in prison, becomes an in-patient at a TB dispensary, refuses services, or dies. (2) Case management approaches to integrating gender are not clearly articulated. (3) Given caseworker high client loads – under CITI each caseworker supports 30 to 40 people – programs to prevent caseworker burnout are critical, especially for female caseworkers and caseworkers working with female PWID, as these caseworkers tend to burnout more quickly than caseworkers who work with male clients – but it is not clear whether or not burnout programs are in place, and if so, whether they are gender-responsive.

Opportunity: Current case management programs are already in close touch with target populations and provide an excellent opportunity to (1) extend case management to support adherence following registration in care, (2) build gender-sensitive approaches to working with women who inject drugs, and (3) develop gender-sensitive burnout prevention programs for caseworkers.

Testing algorithm

Gap: The current testing algorithm is burdensome, especially to key populations such as PWID and to women PWID in particular, and frustrates doctors at AIDS Centers as well. As one AIDS Center doctor reported during the gender assessment: "I wish we could get express tests at the AIDS Center, but it requires a lot of paperwork and anyway they are too expensive."

Opportunity: The PEPFAR Ukraine program is already working to simplify the testing algorithm. This provides an opportunity to build in gender-sensitive approaches to supporting women who inject drugs to access HIV testing and adhere to the HIV service cascade.

Registration at AIDS Centers

Gap: Registration requirements vary widely across regions and AIDS Centers, but the range of approaches to registration across the country has not been documented and plans to standardize and simplify registration procedures nationally are not in place. Although women interviewed for the gender assessment reported that childcare responsibilities and fears of losing child custody made it difficult for them to complete registration requirements, no systematic research has documented the gender-differentiated impact of registration requirements on men, women, and LGBT populations.

Opportunity: The challenges posed by the registration requirements at AIDS Centers are well known to the PEPFAR Ukraine program, and efforts are underway to simplify the registration process. This provides an opportunity to integrate gender considerations into these efforts, such as working to remove women-specific requirements (for example, the gynecological examination), or working to ensure that registration at AIDS centers does not jeopardize child custody for women who inject drugs.

Training

Gap: Training is a central component of PEPFAR-supported programs, including training on gender issues. PEPFAR IPs have developed gender strategies, gender mainstreaming policies, and gender training materials. Some IPs, with support from other donors, have developed additional training materials and conducted research on gender-related issues in Ukraine. While these efforts are important, there appears to be limited coordination among the various training programs, although the focus of their work is broadly similar. In addition, the bulk of IP work on gender training focuses on training for NGO grantees, with comparatively less focus on the government programs that beneficiaries must attend for critical HIV-related services.

Opportunity: PEPFAR IPs have already developed a range of gender-focused training materials. This provides an opportunity to streamline and standardize these materials across IPs, and also to share these materials with relevant government programs.

Coordination with technical partners

Opportunity: A number of technical partners are working on projects that directly complement PEPFAR Ukraine's focus on ART scale up for PWID. These include the current Global Fund-supported project of the Eastern Europe and Central Asia Network of PLHIV – which focuses on barriers to ART access for PWID, and UNAIDS planned projects in 2016 to conduct a gender assessment of regional AIDS programs and provide training on gender budgeting. This provides an excellent opportunity to coordination with PEPFAR's work to strengthen gender programming.

Interventions for the sexual partners of PWID

Gap: Although interventions to reach the sexual partners of PWID are key to PEPFAR Ukraine's strategy, to date, these strategies are not fully articulated in IP work plans, and do not clearly draw on good practice examples of programs for the sexual partners of PWID implemented globally – such as ongoing projects supported by UNODC and international NGOs (INGOs) in South and Southeast Asia.[44] These programs reach out to partners of PWID and provide sustained family support for long-term adherence to the HIV service cascade. Effectively reaching partners of PWID in Ukraine will require a recognition and understanding of the barriers that partners face to accessing services, and a clear strategy to address those barriers and support adherence to the HIV service cascade.

Opportunity: PEPFAR programs have already initiated work with the partners of PWID and initial results are promising. This provides an opportunity to expand existing programs to support adherence long-term, by building in lessons learned under current programs and building on international good practices.

MAT

Gap: Coverage of MAT in Ukraine remains too low to impact the epidemic or adequately support access and adherence to ART for PWID. MAT services are not gender-sensitive, and linkages between female-specific medical services and MAT have not been established. Knowledge and understanding of MAT and its benefits remains very inadequate among beneficiaries and many NGO service providers.

Opportunity: PEPFAR IPs have already provided training and technical support for MAT. This provides an opportunity to build a gender component into current technical support initiatives.

Integration of Government and NGO services for testing and treatment

Gap: Effective linkage of PWID clients to confirmatory HIV testing and ART depends on good coordination between the NGOs that reach clients, and the government services that provide medical care and treatment. While much has been done to ensure smooth coordination, mutual understanding of the responsibilities for retaining clients in care after registration remain elusive – especially in the case of clients who do not qualify for ART at the time that they register at the AIDS Center. No assessment of the gender-differentiated impact of this gap has been conducted.

Opportunity: Both NGOs and government facilities are already working with PWID – men and women – and many have either directly received training in case management, or else are aware of the

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[44] See, for example, UNODC Pakistan, *Prevention Treatment and Care for Female Drug Users / Injecting Drug Users and Female Prisoners in Pakistan*, and *Success Stories*, available at https://www.unodc.org/pakistan/en/publications.html; Youth Vision, *The Hidden Truth – Nepal*, 2011, available at http://media.wix.com/ugd/c0eb6b_ef96d158cc86bf494b62a713f30669cb.pdf; and Nai Zindagi, The Hidden Truth – Pakistan, 2008, available at http://media.wix.com/ugd/c0eb6b_20987f8f1b8e8ba43a1c6b0eee3a7a09.pdf.

case management approach. This provides an opportunity to (1) build mutual understanding of the responsibilities and best approaches to supporting men and women who inject drugs to adhere to the HIV service cascade after registration at AIDS Centers, (2) work together to understand the gender-specific issues that impact adherence, and (3) develop gender-sensitive approaches to supporting adherence after registration.

TB

Gap: PEPFAR-supported TB projects are not focused on improving access to HIV testing and treatment for PWID; however, the Chemonics/StbCU project includes training components for medical professionals.

Opportunity: Ongoing training activities provide an opportunity for improving TB doctors' capacity to support access to HIV services for PWID, particularly in light of the co-location of TB and MAT services at 22 sites across Ukraine.

Rural Areas

Gap: PWID and MSM in rural areas face additional barriers to registering in care, including poor access to medical professionals who have training or expertise in HIV, weak infrastructure for key services such as transporting blood samples, and stigma and discrimination.

Opportunity: PEPFAR IPs and NGO grantees are already working in rural areas of high prevalence regions. This provides an opportunity to (1) compile the learnings from current work in rural areas, (2) share experiences on gender-specific vulnerabilities and needs among PWID and MSM in rural areas, and (3) develop gender-sensitive approaches to improving access to the HIV service cascade for men and women who inject drugs and MSM living in rural areas.

Prisoners

Gap: More men who inject drugs are arrested by police and imprisoned than women, and HIV infection rates among female prisoners are approximately three times higher than among male prisoners. Yet MAT is not available in the penitentiary system and approximately half of the prisoners in need of ART in Ukraine do not receive it.

Opportunity: PEPFAR-supported IPs are already working to support access to the HIV service cascade among prisoners and to conduct police trainings. This provides an opportunity to expand ongoing programs and to introduce gender-sensitive training for police and for prison staff.

GOOD PRACTICES

The gender assessment noted a number of good practices, including the MSM projects of NGO Fulcrum, discussed above, as well as the projects the MSM Liga in Odesa, which has recruited friendly doctors at the AIDS Center, employs a psychologist and a lawyer, and works with families of LGBT youth and discordant couples.

In another good practice observed during the gender assessment, a harm reduction NGO in Odesa invited a doctor from the AIDS Center to provide a lecture on ART and adherence. Although funding for this activity was virtually non-existent (funding was cut with the drawdown of Global Fund support), the activity continued with only nominal compensation for the doctor who provided the lecture on her day off.

SUSTAINABILITY

Innovative gender-sensitive programs to reach women who inject drugs began operating in Ukraine as early as 2007, yet, while some strategies developed at that time are still in operation, many of those original projects are no longer functioning and some critical strategies have been lost – such as "in-

reach" to women's health clinics to identify and support women who inject drugs, and projects to improve access to MAT for pregnant women who inject drugs. Learnings from previous projects are not systematically documented and captured, and as a result, multiple studies and assessments have been undertaken that largely duplicate earlier work and repeat its findings. The work that has continued has exclusively been undertaken by NGOs, supported by donors, and has not been integrated into government services. This poses challenges for sustainability going forward.

Case management approaches, including gender-sensitive case management, is labor and capital intensive, and to date, has not been supported by government budgets. Similarly, key services for PWID, such as MAT, is almost entirely supported by the Global Fund, and gender-sensitive approaches to MAT, including MAT for pregnant and nursing women, are poorly developed. Apart from the Global Fund support, donor support has not focused on improving the quality of MAT services, integrating them into HIV services, or making them equally accessible to women and men.

Social contracting systems have the potential to address the government funding gap, but remain largely under-developed and challenging for HIV-service providing NGOs. Social contracting is governed by the Ministry and Departments of Social Policy – which is not focused on key populations, not by the Ministry or Departments of Health, and social contracting arrangements vary widely by region. The maximum annual award is USD 20,000, and in some regions, such as Odesa, social contracts only provide funds after the project is complete, making it impossible for many NGOs to compete. As one NGO in Odesa explained to the gender assessment team: "We wanted to compete for a social contract from the city administration. But the terms are too difficult. They only pay after the work is done. What NGO can do that?" On a hopeful note, on October 2, 2015, the Poltava Regional Council adopted a Regional AIDS Program for 2015-2018, which includes allocations from the regional budget for procurement of MAT drugs (999,000 UAH) and for harm reduction programs (706,000 UAH), and requires financing of social services provided by HIV service NGOs.[45]

[45] Newsletter HIV Reform in Action USAID Project, No. 3 2015, p. 18.

VII. RECOMMENDATIONS

Institutionalize gender expertise across projects

To support institutional strengthening in gender, ensure that all PEPFAR IPs have a designated Gender Focal Point who can oversee gender mainstreaming, support gender-responsiveness across projects and interventions, and lead capacity building activities for IP staff and NGO grantees.

Institutionalize gender-sensitive ART expertise across IP grantees

IP grantees who work with PWID may have been focusing on the range of prevention interventions (harm reduction) and may lack sufficient in-house expertise on treatment. To ensure that grantees can provide accurate information on ART, require each grantee to have at least one staff member with the requisite knowledge to serve as ART focal point.

Support collection of gender-specific data, especially data on gender-based violence

Ukraine does not collect or report data on gender-based violence. This data is critical to understanding the impact of GBV on women, including on women PWID, and the barriers that GBV poses to women's access and adherence to the HIV service cascade. Ukraine should collect and report on monitoring, evaluation, and reporting (MER) indicator GEND_GBV: Number of people receiving post-gender based violence clinical services minimum package, including disaggregated by key population to track GBV among PWID.

Support collection and reporting of sex-disaggregated data for key prevention services for PWID, notably MAT

Available data indicates that women who inject drugs have weaker access than their male counterparts to critical services that support prevention as well as access and adherence to ART across the HIV service cascade. Although this data is collected in Ukraine, it is not routinely reported and has not been used in program development to ensure that these services are gender-sensitive.

Consider developing gender-specific indicators for PWID, and systems to collect data on those indicators

Particularly useful data would include: (1) percentage of ever pregnant HIV+ women who inject drugs, who received the full course of ART for PMTCT during their pregnancy; (2) percentage of ever pregnant HIV+ women who inject drugs who received ART for PMTCT and were eligible for ART under Ukraine's current guidelines, who continued on ART for 12 months after giving birth; (3) percentage of women who inject drugs and sell/transact sex, who experienced GBV from a client in the past 12 months; and (4) percentage of women who inject drugs who report that their intimate partner ever prevented them from accessing HIV prevention or treatment services.

Support the development of data systems that can track PWID and produce sex-disaggregated data across the HIV service cascade

PEPFAR has already been supporting the development of these important data systems. To ensure generation of useful data for program planning, systems are needed that can track LTFU for key populations, including sex-disaggregated data, and can identify the points of drop out as well as the reasons for drop out.

Support advocacy for laws and policies that support the rights of the LGBT community

PEPFAR IP grantees are already advocating for laws and policies that protect the rights and health of the LGBT community. Supporting and expanding these efforts will improve LGBT access to critical HIV testing and treatment services.

Support strengthening of laws and policies on gender-based violence, and legal support to beneficiaries

Support integration of GBV services across all PEPFAR-supported NGO grantees, including legal literacy for beneficiaries, access to legal services (such as street lawyers), and access to safe houses or shelters. Support removal of barriers specific to HIV-positive women who inject drugs, such as regulations by which shelters will not accept women who have an infectious disease or who use drugs. Support programs to provide HTC at shelters and safe houses for women who have experienced GBV.

Support assessment of transgender vulnerabilities and needs in Ukraine and interventions that can address those needs

The transgender population in Ukraine has received very inadequate attention to date. Working with ongoing MSM interventions, an assessment of transgender vulnerabilities and needs should be carried out, and appropriate interventions development and implemented to improve access to HIV services for this key population.

Support gender-sensitive case management from testing through VL suppression

Case management approaches in Ukraine to date have focused primarily on ensuring that clients register with AIDS Centers. Ensuring adherence post-registration will require additional support and training for case managers on ART, including gender-sensitive approaches to supporting women who inject drugs and the female sexual partners of men who inject drugs. To support case managers in this process, burnout prevention strategies should be developed and implemented, particularly for female case managers working with women who inject drugs.

Support simplification and standardization of HIV testing procedures and requirements for registration in care and treatment and remove gender-specific barriers

Simplifying the HIV testing algorithm, including removing the requirement that only a medical doctor can administer an HIV test, and accepting rapid tests as confirmatory, will facilitate community-based testing for PWID, and support testing scale up. Developing standard national guidelines on registration in care – and eliminating non-relevant testing requirements, will improve PWID access to care and treatment. Guidelines should be gender-sensitive and incorporate measures to improve access for women who inject drugs – such as removing requirements for a gynecological examination in order to enroll in care. Providing test and treat for key populations, especially for PWID, and for discordant MSM couples, will improve ART outcomes.

Develop standard PEPFAR training materials and guidelines on gender and PWID for IP and grantee use

To eliminate duplication of efforts across IPs, a standard package of training materials on gender and injection drug use should be developed and used to build capacity of IPs and to ensure that grantee projects offer state-of-the-art gender-responsive services. Gender-based violence was a training gap noted during the gender assessment, and should be incorporated into the standard training package. The package should also include a module on safe disclosure of HIV status in the context of injection drug use, to support expanded access to the sexual partners of PWID.

Expand training for government medical professionals, including in female-specific services

As more PWID and MSM enter the government system for treatment, the need for doctors to be aware and sensitive to the needs of PWID, including of female PWID, and MSM, will expand. Providing additional training for AIDS Center doctors will support these services to better meet the needs of PWID and MSM patients. There is also an urgent need for training on injection drug use among doctors at women's health clinics and maternity hospitals to enable them to identify the needs of these patients and effectively address them. Programs already in place to train primary health care providers in HIV testing, linkage to care, and treatment, should be expanded, and include training on gender-specific

vulnerabilities and needs. Training of drug treatment service providers offering MAT, particularly on working with pregnant women who inject drugs and on treating neonatal abstinence syndrome, is also needed.

Coordinate with ongoing projects in Ukraine that address critical aspects of access to HIV services for PWID, including gender-specific barriers

Conducting a stocktaking of on-going projects in Ukraine that work to improve PWID access to ART will support PEPFAR-supported projects to move forward without duplicating the efforts of others.

Develop evidence-based approaches based on international best practices for reaching the sexual partners of PWID, and MSM

Globally, a number of programs have successfully reached out to the sexual partners of PWID to offer HIV testing, counseling, and enrolment in care for those who test positive. Global programs have also worked to support access to the sexual partners of MSM. Conducting an overview of these approaches, and developing a standard set of PEPFAR guidelines for accessing the sexual partners of PWID and MSM, will help IPs and NGO grantees to maximize the impact of this important intervention. Ensure that safe-disclosure is addressed in the guidelines.

Support quality improvement and scale up of gender-sensitive MAT services

Provide training and awareness-raising on MAT to NGO service providers and beneficiaries, including on MAT during pregnancy and breastfeeding.

Support simplification and standardization of MAT registration requirements and ensure that they are female-friendly. Coordinate with other donors who are working on this issue. The Global Fund is currently working to pilot a program in Odesa that eliminates the requirement to register with narcological services in order to access MAT.

Build the capacity of MAT service providers on providing MAT to pregnant and breastfeeding women and support expanded co-location of MAT and HIV government services. Beneficiary and NGO service provider knowledge of MAT remain under-developed, and misperceptions about MAT are widespread. Both NGO service providers and beneficiaries require training on MAT to dispel myths and build demand. Ensure that all NGO service providers have a MAT focal point who is well-versed in MAT benefits and can provide ongoing training, support, and mentorship for staff and beneficiaries.

Support the development of national guidelines that simplify access to MAT by eliminating the requirement of registration with narcological services, allowing take-home doses, and expanding the hours of operation of MAT clinics. Ensure that these guidelines include gender-specific issues, such as proper dosing for pregnant women and treatment of neonatal abstinence syndrome.

Support the introduction of on-site MAT services at maternity hospitals and women's health clinics.

Build the capacity of MAT services to work with pregnant women, including instruction on proper dosing and evidence-based treatment of neonatal abstinence syndrome.

To make MAT services women-friendly, support the development of gender-sensitive guidelines for MAT, including providing childcare at MAT facilities and offering referral to reproductive health services and antenatal clinics, and build the capacity of MAT service providers to provide MAT to pregnant women by including medical professionals from women's health clinics and maternity hospitals in MAT trainings, and offering a training module on MAT during pregnancy and treating neonatal abstinence syndrome.

Support efforts to advocate for community-based MAT.

Support integration of Government and NGO services for testing and treatment

To ensure retention in care and treatment, support the development of clear gender-sensitive protocols that delineate the role and responsibilities of government organizations and NGOs in supporting PWID and MSM to adhere to care and treatment, post-registration.

Support integration of HIV testing and referral to care via TB services and introduce gender-sensitive approaches to working with female PWID who are coinfected with TB and HIV

Support interventions that facilitate on-site HIV testing at TB dispensaries, particularly those that offer MAT. Introduce gender-sensitive approaches into TB services using the new gender-sensitive guidelines and materials developed by Stop TB.

Develop geographically appropriate strategies to reach men and women who inject drugs and MSM in rural areas

PWID, their sexual partners, and MSM face intensified stigma and discrimination in rural areas where they may be isolated and cut off from services. Conduct a quick assessment of vulnerabilities and needs of PWID and MSM in rural areas and develop a strategy to address their specific needs, including gender-specific needs, through appropriate outreach, case management, and linkage to services.

Focus interventions for men who inject drugs in key locations, such as in police custody, pre-trial detention centers, and prisons

Continue to support implementing partners to provide police sensitization and training, and to advocate for harm reduction and MAT in the penitentiary system to increase access to vulnerable men and improve uptake of HIV testing and treatment. Support the introduction of gender-sensitive programs for women in the penitentiary system.

Document and disseminate good practices for MSM and PWID to support learning and avoid duplication

The gender assessment noted a number of good practice interventions, including interventions for MSM in Kyiv and Odesa; coordination between AIDS Center doctors and harm reduction NGOs, "in-reach" into women's health clinics, and multi-disciplinary case management at the City AIDS Center in Dnipropetrovsk. Documenting, compiling, and disseminating these good practices will support learning across projects and avoid duplication of efforts.

Ensure that gender-responsive interventions are appropriately budgeted

Lack of adequate budget is a driver of weak interventions. To ensure that PEPFAR-supported interventions are appropriately budgeted, conduct a gender review of budgets and undertake gender budgeting.

Support sustainable gender-sensitive strategies

Case management approaches are labor and capital intensive. To ensure that they will be both effective and sustainable, develop a sustainability plan for case management, including strategies for ensuring future finance from government sources. Ensure that gender considerations, including gender budgets, are built into sustainability plans.

Going Forward: Integrate gender considerations into test and treat

Ukraine is currently in the process of moving to the new WHO test and treat guidelines. To support gender sensitivity in this process, in the context of PWID and MSM: (1) support test and treat for the sexual partners of PWID and MSM; (2) support Option B+, especially for women who inject drugs and for the sexual partners of men who inject drugs; (2) consider supporting PrEP for the sexual partners of PWID and MSM.

ANNEXES

ANNEX I: PERSONS CONTACTED

Kyiv

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Iryna Borushek, Head of Board

Deloitte Consulting Overseas Projects LLC
Nata Avaliani, Chief of Party, HIV Reform In Action (USAID Project)
Maria Makovetska, Deputy Chief of Party, HIV Reform In Action (USAID Project)

All-Ukrainian Public Organization "Gay Alliance Ukraine"
Volodymyr Naumenko, Executive Director, Regional Development Manager

Maria Makarova, Commercial Director

All-Ukrainian Charitable Organization "Fulcrum"
Bogdan Globa, Executive Director
Yuriy Bilokur, Development Manager

State Enterprise "Ukrainian Center for Disease Control," under the Ministry of Health Care of Ukraine
Natalia Nizova, Doctor of Medical Science, Director
Yaroslava Soboleva, Department of Treatment of HIV Patients

NGO "Klub Kyanka", (RESPECT)
Vira Varyga, Support Group Manager

NGO "Convictus Ukraina"
Two Focus Groups with PWID: (1) 12 participants, 5 women, 7 men; (2) 8 participants, all women.

Chemonics, Inc.
Kartlos Kankadze, Chief of Party, USAID "Strengthening TB control in Ukraine"

U.S. Peace Corps
Vika Zhuvokva, PEPFAR Program Manager

Odesa

NGO "Zdorovia. Zhinka. Dovholittia"
Yulia Stadnik, Head of Board, Psychologist
Volodymyr Odynets, Member of Board, Ob/gyn

Odesa City AIDS Center
Vitaly Novosvitniy, Chief Physician

Foundation "Razom za zhyttia"
Oleg Zinchenko, Head of Section, HIV/AIDS Care & Services in Odesa
Hanna Suvorova, Head of Section, HIV/AIDS Care & Services in Odeska Oblast
Maria Sokolova, Specialist, Head of Section, TB Care & Services (under RESPOND)
Focus group with 7 participants: three single men, one male-female couple, and two single women.

Public movement 'Vera. Nadezhda. Liubov'
Oksana Pchelnikova, Project Coordinator, 'HIV Prevention among FSW in Odesa'
Tatyana Semikop, Chairperson

Odesa City AIDS Center's branch
Liubov Myroshnychenko, Psychiatrist-Narcologist, Integrated ARV and OST site
Yulya Stadnik, social worker

Odesa Oblast AIDS Center
Valentina Lukyanikova, doctor

NGO 'Zhyttia+'
Iryna Grygoryeva, Head of Board, Psychologist

Andriy Grygoryev, Vice-Head of Board, Project Manager

NGO 'Soniachne Kolo'

Albina Kotovych, Specialist, Daycare center for HIV-positive children
Olga, social worker
Sasha, social worker
Lawyer
Four peer counsellors

Odeska Oblast State Administration

Tetiana Lyapchuk, Head of Department of Health Care and Social Protection
Maria Gaidar, Deputy Governor, Issues of Health Care and Social Protection
Levan Iosava, Specialist, Issues of Health Care and Social Protection

NGO 'LGBT Association "Liga"

Marian Kavetsky, Branch Leader, Odesa Branch

Foundation "Razom za zhyttia" / Youth Development Center

Konstantyn Talalayev, Associate Professor, Odessa National Medical University,

Odesa charitable foundation "Doroga k domu"

Natalia Kytsenko, Head, Harm Reduction and HIV/AIDS Prophylaxis Department
Yulya Podola, doctor
Elena Podseedko, press secretary
Dima Seioyavest, case manager

Stop AIDS Odesa

Anna Artywenko
Tenrikh Repp

Odesa Regional Organization "Colleagues of Doctors"

Vyacheslav Polyasnyi, Head
Elena Teryaeva, Deputy Head

Dnipropetrovsk

NGO "Doroha Zhyttia Dnipro"

Svitlana Kalinichenko, Head of Board
Olga Piven, Coordinator

Network of PLHIV, Dnipropetrovsk branch

Larisa Sokirka, Chief Financial Officer
Marina Rodzinkevich, Project Facilitator
Lyumila Kolomoecz, Project Coordinator
Elena Ivanova, Case Manager
Elena Loginova, Project Coordinator

Dnipropetrovsk City AIDS Center, City Infectious Diseases Hospital

Olena Chorna, Dermatologist / Acting Head of the City AIDS Center
Iryna Davydenko, Ob/Gyn
Lyudmila Kibovckaya, social worker at MAT site
Tatyana Sadyrima, nurse at MAT site

"Chistyi Sertsa"
Andrei Shukov, Head

Dnipropetrovsk narcological institution
Natalia Bila, Chief Physician, Chief Oblast Narcologist
Larysa Dorokhina, Deputy Chief Narcologist /doctor
Tatyana Tavrishenko, Narcologist

Dnipropetrovsk Oblast State Administration, Health Department
Yulia Chernyak, Representative
Irina Petrova, Specialist
Olena Luhova

Dnipropetrovsk Maternity Hospital No.1
Elena Sherbanova**,** Chief Physician
V. A. Dornisenko, Chief Obstetrician

Remote Interviews

U.S. Department of Defense
Dmytro Moskalenko, Program Management Assistant ODC/Bilateral Affairs Office

Global Fund to Fight AIDS, Tuberculosis and Malaria
George Sakvarelidze, Senior Fund Portfolio Manager Eastern Europe and Central Asia Team

ANNEX II: REFERENCES

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Order as of 08.02.2013 No. 104

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Order as of 05.11.2013 No.955

"*On procedure of Post Exposure Prophylaxis of HIV infection in health care specialists at performance of professional duties*."

Order as of 22.12.2015, No.887

"*On approval of amendments to the clinical protocol of antiretroviral therapy of HIV in adults and adolescents*".

ANNEX III: LAWS AND POLICIES OF UKRAINE

In regard to gender equality, Ukraine has a developed regulatory framework that consists of the international conventions and treaties and of the national legislation.

The international conventions include (the list is not exhaustive):

- UN Charter (1945);

- Universal Declaration of Human Rights (1948);

- Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others (1949);

- Convention for the Protection of Human Rights and Fundamental Freedoms (1950);

- Declaration on the Elimination of Discrimination against Women (1967);

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (ratified in 1981), and the Optional Protocol on Violence Against Women (in 2003);

- Beijing Declaration and Platform for Action (1995);

- Millennium Development Goals (2000);

- Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) (signed in 2011; the ratification process is under way).

The Ukrainian national legislation and regulatory framework on gender equality include (the list is not exhaustive):

- Constitution of Ukraine (1996);

- Family Code of Ukraine (2002);

- Law of Ukraine on Prevention of Violence in Family (2002) (to be replaced with a new Law – on prevention and combating domestic violence, which aligns with the Istanbul convention);

- Law of Ukraine on Ensuring Equal Rights and Opportunities of Women and Men (2005);

- Law of Ukraine on Combating Trafficking in Human Beings (2012);

- Resolution of the Cabinet of Ministers of Ukraine "On approval of the State Program of Ensuring Equal Rights and Opportunities of Women and Men for the Period until 2016" (2013);

- Law of Ukraine on Principles of Prevention and Combating Discrimination in Ukraine (2013) ;

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- Labor Code (2015)