PREVENTION OF MOTHER-TO-CHILD TRANSMISSION AND IMPROVING NEONATAL OUTCOMES AMONG DRUG-DEPENDENT PREGNANT WOMEN AND CHILDREN BORN TO THEM IN UKRAINE

FINAL EVALUATION REPORT

Prepared by
TAMAR GOTSADZE, MD., PHD

OCTOBER 2014
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# ABBRIVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>ART</td>
<td>Antiretroviral treatment</td>
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<td>CICP</td>
<td>Centres for the Integrated Care of Pregnant</td>
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<td>CIS</td>
<td>Commonwealth of Independent States</td>
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<td>CO</td>
<td>Country Office</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<td>DR</td>
<td>Desk Review</td>
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<td>EF</td>
<td>Evaluation Framework</td>
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<td>eMTCT</td>
<td>Elimination of mother to child transmission</td>
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<td>FGD</td>
<td>Focused Group Discussion</td>
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<td>FSW</td>
<td>Female Sex Workers</td>
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<td>HIV</td>
<td>Human immunodeficiency virus infection</td>
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<td>ICM</td>
<td>Integrated Care Model</td>
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<td>IDI</td>
<td>In-depth Interview</td>
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<td>IDU</td>
<td>Injecting Drug User</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MTCT</td>
<td>Mother-to-child transmission</td>
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<td>NAS</td>
<td>Neonatal Abstinence Syndrome</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<td>OST</td>
<td>Opioid substitution therapy</td>
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<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<td>RF</td>
<td>Results Framework</td>
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<td>SV</td>
<td>Site Visit</td>
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<td>TOR</td>
<td>Terms of Reference</td>
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<td>UCDC</td>
<td>Ukrainian Centre for Diseases Control</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNICEF</td>
<td>The United Nations Children's Fund</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<td>WHO</td>
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EXECUTIVE SUMMARY

CHALLENGES OF INJECTING DRUG USING WOMEN IN UKRAINE

Ukraine has the highest adult HIV prevalence in all of Europe and Central Asia. Annual HIV diagnosis in Ukraine has more than doubled since 2001 (UNAIDS, 2010). The HIV epidemic is still concentrated among most-at-risk populations. If until 2008 the main mode of HIV transmission was parenteral through injecting drug use, the sexual mode of transmission is prevailing at present. However the injecting drug use remains a driven force of epidemic2. The risk of a generalized epidemic continues to grow. Due to their biological and social vulnerability, women are more prone to infection. Currently, they represent 45 per cent of all adults living with HIV in Ukraine. Most of them are in childbearing age.

A state programme to prevent mother-to-child transmission of HIV (PMTCT) was established in Ukraine in 2001, and the Government currently guarantees free HIV testing and ART to all HIV-infected pregnant women. A national level of HIV transmission from mother-to-child (MTCT rate) reduced in 2012 to 4.3 % comparing to 27.8% in 20013. Despite progress, in order to achieve further advances towards the elimination of MTCT it will be essential for Ukraine to reduce the number of new infections among women of child-bearing age, sustain and improve quality of PMTCT services provided as well as focus on increasing access and uptake of services by those segments of the population that are currently not accessing PMTCT services or accessing them too late. In 2011, more than 5,000 pregnancies were registered among HIV-positive women in Ukraine. The absolute cumulative number of children infected with HIV through mother-to-child transmission (MTCT) continues to increase, as there is on average 130 -140 cases of newly diagnosed HIV-infection in children registered annually.

Injecting Drug Use (IDU) became increasingly common in Ukraine from early 1990s, and is thought to reflect a range of factors including the socio-economic changes accompanying the break-up of the USSR, increased trafficking of drugs through Ukraine and a rising domestic opiate and amphetamine production4,5. Around 28% of IDUs in Ukraine are female6. Female IDUs often experience numerous medical and social problems, including psychiatric co-morbidity; gender based violence, intimate partner violence (IPV), parentally and sexually transmitted infections and economic hardship, as well as the direct physical effects of drug abuse7. They are more likely to acquire HIV than male IDUs, reflecting more risky injection practices, including being injected by others (“second on the needle”) and sexual risks (having IDU sex partners, transactional sex, low use of condoms, co-infection with STIs)8. In Ukraine, number of officially registered HIV infected pregnant women with newly diagnosed HIV infection shows decreasing trend since 2008. Out of officially registered HIV infected pregnant women, those infected through injecting drug use decreased from 15.2% in 2005 to about 6.1% in 20139. According to UNODC decreasing

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2 ‘HIV-infection in Ukraine’. Information bulletin #41, Ministry of Health of Ukraine, Kyiv, 2014
3 Ukrainian Center for Diseases Control data
7 S. Pinkham and A. Shapoval, Making Harm Reduction to Work for Women: The Ukrainian experience, Open Society, New York
9 UCDC official data, 2014
trend can be explained by weaknesses in identification of drug users in general and pregnant IDU women in particular and shifting of drug scene from injection to other psychoactive substance use.\textsuperscript{10}

Barriers to accessing services are greater among female IDUs, and particularly mothers or pregnant women than among man. These may include avoidance of contact with services because of fears regarding child custody, an absence of gender specific services, family and childcare responsibilities and additional stigmatization / discrimination due to pregnancy. Many drug-using women in Ukraine do not have residency registration, preventing access to free medical and social services.\textsuperscript{11,12} Insufficient knowledge about HIV/AIDS among the general population and care providers produces fear and stigmatization of HIV-infected people, and leads to infringement of the rights of women and children.

Among HIV-positive pregnant women in Ukraine, there has been an encouraging increase in the proportion of those who are aware of their infection status before pregnancy. However 6\%-7\% of HIV positive IDU women remain undiagnosed until testing in labor, reflecting very late or lack of access to antenatal care whereas share of non-IDU women being diagnosed during the labor has been below 2\% since 2009. IDU women diagnosed with HIV for the first time in pregnancy are significantly more likely to be diagnosed later during pregnancy than non-IDU women.\textsuperscript{13} The proportion of IDUs not receiving ART is significantly higher than non-IDU pregnant women in Ukraine, although over the period of 2007-2012 declining trend is observed. There is an evidence of substantial disengagement from HIV care among IDU women and or lack of access to HIV care after the initial positive HIV test. Half of the surveyed IDU women who received no antenatal ART had been diagnosed as HIV positive before the pregnancy, with 16\% diagnosed intrapartum through rapid testing and the remainder identified in antenatal period.

In the Ukraine system, pregnant women are managed by different doctors and in different setting for different infections. Many IDUs have several co-infections and therefore face challenges in accessing appropriate care, due to management by different physicians and in a variety of places where HIV positive drug using women are receiving substitution therapy, HIV and MCH services in different places reduce their access to services. Cost of treatment is another barrier that impedes pregnant IDU women and their partners to medical services (consultations, examinations and treatment).\textsuperscript{14} The situation is further complicated by lack of knowledge, skills and attitudes of health professionals and social service staff. Drug-dependent women not seek services due to a fear of hostility from medical practitioners or of having their children taken away from them after delivery.

The biggest problems faced by women and families affected by HIV are partially attributed to a lack of a coordinated system of social services. Services do not exist to address or even effectively identify vulnerabilities at early stages. Social services are not sufficiently inclusive or sufficiently flexible to be able to adapt to the various profiles of children or their families within their communities, and thus avoid unnecessary separation. Among HIV-infected women who were currently using injecting drugs at the time of enrollment in the Women’s

\textsuperscript{10} Drug scene in Ukraine, 2013, UNODC (presentation) available http://www.slideshare.net/jalyna/2013-2-29501516
\textsuperscript{11} “Violation of the right of female drug users (FDUs) to access to medical and social services in the field of sexual and reproductive health: pregnancy planning period, as well as antenatal, natal and postnatal periods”. All-Ukrainian CF “Coalition of HIV service organizations”, 2012
\textsuperscript{12} Ibid 10
\textsuperscript{13} Ibid 27
\textsuperscript{14} Assessment of existing chains of RH/FP service delivery to injecting drug users and their partners in Kyiv city, Kyiv, Mykolayiv and Kirovograd oblasts, 2013, Health Department of the Kyiv City State Administration, Kyiv City Clinical Narcological Hospital “Sociotherapy”
Study, 18% were not living with their youngest child at enrolment, although some of these women were living with at least one of their older children. A small number of HIV-positive women in the study were not living with their baby because of imprisonment.\textsuperscript{15}

**PROJECT DESCRIPTION**

To remove inequity in care, treatment and support for drug-addicted pregnant women, overcoming barriers to the provision and utilization of services by them, UNICEF initiated a pilot project ‘Prevention of Mother-to-Child Transmission and Improving Neonatal Outcomes among Drug-Dependent Pregnant Women and Children Born to Them in Three Cities in Ukraine’. The pilot project was developed as a model of PMTCT service provision for drug dependent pregnant women expected to result in better coverage, quality and uptake of services for pregnant drug-dependent women. This would, in turn, lead to improved health outcomes for their own health and for the health of their babies.

The main objective of the project is: to establish, maintain, and improve gender responsive, comprehensive, and integrated services that address the needs of drug-dependent pregnant women and children born to them. Expected impact of the project is the reduction of mother-to-child transmission of HIV among vulnerable pregnant drug addicted women in selected pilot cities through provision of support to the government and civil society organizations to develop and implement effective HIV prevention, treatment and care services for drug addicted pregnant women and their children.

The project focuses on introducing integrated services for drug addicted pregnant women by establishing Centres for Integrated HIV Prevention, Care and Support Services. Centres provide a range of medical and psychosocial services to drug addicted women and their children: offering antenatal care, HIV testing and counseling, ARV treatment to prevent HIV transmission from mother-to-child, assisting in delivery, postnatal care, and treatment of neonatal withdrawal syndrome, drug dependency treatment, psychosocial counseling and social support to families.

Over the life span of the project (2011-2014), the pilot was implemented in three phases. The initial phase (June - December 2011) aimed at assessment of situation and design of the most appropriate and feasible service delivery model. As a result, the needs in establishment of two types of model of services for drug-dependent pregnant women and their children in pilot districts have been identified. In the 1\textsuperscript{st} phase – pilot phase of the project (2012 – 2013) the pilot was launched in three cities of Ukraine – Kiev City, Dnipropetrovsk and Poltava and ensured provision essential equipment, drugs and medical supplies to new sites as well as building capacity of service providers. The 2\textsuperscript{nd} phase of the project (mid 2013 – 2014), the project has been expanded to Kryvyi Righ, the city most affected by HIV and drug abuse and with high needs in gender sensitive services provision.

Addressing the health and social needs of drug-using women and their infants is a challenge, as it requires strong coordination and functioning referrals between various stakeholders and service providers. The project was built on established close partnership between public and civil society organizations. Different organizations and non-state actors were involved into project design and implementation: UNICEF; UN Joint Team on HIV and UN Team Group on HIV, including WHO, UNODC and UNAIDS within the UN Joint Programme of Support on HIV/AIDS to the Government of Ukraine for 2012-2016); Charitable Fund/ William J. Clinton Foundation in Ukraine (WJC Foundation); Open Society Institute (OSI); Eurasian Harm Reduction Network; Coalition of HIV-services organizations; Ministry of Health of Ukraine;

\textsuperscript{15} C. Thorne, Reduction of MTCT risks among pregnant IDU women, 2013
Oblast State Social Services for Family, Children and Youth; All-Ukrainian Network of People Living with HIV/AIDS; HIV-services organizations and Steering Committee established within the pilot as oversight body.

The main donor supporting the project is the Austrian government. The project has also being supported by HIV/AIDS Thematic Fund, Norwegian and German Governments and the project implementing partner WJ Clinton Foundation (WJCF).

PURPOSE, OBJECTIVES, METHOD AND SCOPE OF EVALUATION

EVALUATION PURPOSE - The purpose of evaluation is to produce relevant information on the design and effectiveness of the pilot project and identify lessons learned and provide strategic policy and implementation recommendations. These recommendations provide guidance on how to strengthen the on-going pilot, how to ensure that expected outcomes are achieved and how to ensure that relevant policies and support is provided to ensure that adequate models of service provision for drug-dependent women are adopted and sustained in the future.

OBJECTIVES - Present formative evaluation analyses of whether outputs and activities within the project are lead to expected outcomes and goal of the project; analyses of the bottlenecks and barriers, including policies, practices and other structural barriers in medical and social areas; document lessons learned and good practices of the pilot project activities, along with evidence of outcomes; based on evidence to demonstrate whether or not a nation-wide scale up of the pilot approach and practice is possible and whether a scale up will effectively lead to closing of equity gaps in the area of work; and provide recommendations of how the on-going pilot can be effective and sustained in future, thus informing policy development and framework of the national scale-up of the pilot.

SCOPE OF EVALUATION - The evaluation covers all period of the pilot project implementation from June 2011 when the project was launched in three cities of Ukraine – Kiev City, Dnipropetrovsk and Poltava until 2014 when the project was expanded to one more city of Krivui Rig, Dnipropetrovsk oblast.

EVALUATION METHODOLOGY - The evaluation examines relevance, effectiveness, efficiency, impact and sustainability of the project and utilizes OECD DAC evaluation criteria as defined in the UNICEF guidance on equity-focused evaluations, 2011. For achieving evaluation objectives, the evaluation framework (EF) has been developed. The evaluation focus areas were assessed against OECD evaluation criteria and the report answers questions stipulated in the TOR. Furthermore, the evaluation also integrated Human Rights (HRB) and equity (EQ) based dimensions. The evaluation questions were informed by i) the UNEG guidance on how to integrate Human Rights HRB & EQ considerations in evaluations and ii) UNICEF’s equity based evaluation. It examines to what extent the PMTCT project benefited right-holders, including a wide range of program beneficiaries and strengthened the capacities of duty bearers and other key players to fulfill their obligations and responsibilities. In order to assess attainment of stated targets for programs outcomes and outputs, the RF was reconstructed as the current one lacked measurable outcome and output indicators. Where possible, these data has been used to establish causal relationship

between results and interventions. Present report documents lessons learned, draw conclusions and formulate recommendations.

**EVALUATION METHODS:** The methodology comprised a mix of site visits and observations, face-to-face in-depth interviews, focus group discussions, desk-based research and review of existing reports, documents and available secondary data.

**DESK REVIEW** - Review of documents was a major part of the assignment and studied all program related documentation, legislative and normative documents, monitoring and evaluation reports, studies and researches performed as well as the qualitative and quantitative secondary data available around the themes of the evaluation.

**FIELD VISITS** were organized to all four pilot project sites were in-depth interviews were carried out with local key stakeholders as well as visits to service provider facilities were performed.

**FOCUS GROUP DISCUSSIONS (FGDS)** - FGDS were conducted as complements to the in-depth interviews, in order to elicit the range of opinions and perspectives on project elements. In the context of this evaluation, the FGDS served to capture the perspectives of service providers, as well as of beneficiaries. FGDS were organized in pilot project sites for three groups of stakeholders and beneficiaries: i) service providers; ii) Women and their partners who used project services and iii) Women and their partners who did not use project services. FGDS with service providers included staff of medical and social service institutions. FGDS were conducted in each visited project site with service providers. FGDS with beneficiaries brought together a mix of pregnant drug dependent women and their partners who i) received services under the project and ii) those who never utilized services at project sites. Service user injecting drug dependent women were recruited with the help of social and outreach workers, whereas women who never used integrated services were recruited at OST sites. The purpose of FGDS with beneficiaries was to gauge the extent to which project support might have contributed to utilization of services, measure satisfaction as well as identify key bottlenecks/challenges and remaining unmet needs of the target population. FGDS were organized in all four sites visited and recruited about 32 target population in total and about 10 partners/family members. The FGDS were conducted as informally as possible at the clinic or service they were attending and verbal consent obtained from FGD participants.

**DATA ANALYSIS AND QUALITY ASSURANCE** - Both quantitative and qualitative data was analyzed to assess evaluation domains and criteria. Findings based on qualitative data were triangulated across key informants, compared with available documentary evidence and validated before drawing conclusions and formulating recommendations. Qualitative data analysis entailed documentation, conceptualization, coding, and categorizing, as well as examining relationships. More specifically, the qualitative data allowed obtaining in depth perspective on context, actors and processes related to the project design and implementation and testing/identification of the factors shaping the pattern of project contribution. Information derived from each of the sources of qualitative and quantitative data used at every stage of the study was triangulated within and between data sets with the aim of identifying common understandings of the experiences of issues at focus, as well as differences of opinion between various stakeholders. Following triangulation, the data sets were used to develop specific analyses, such as timelines summarizing the chronology of program implementation, descriptions of particular processes used in the design or
implementation of the programs and stakeholder analyses of actor positions on specific features of the design and implementation at specific time.

To account for the data quality and assess the strength of conclusions the “robustness scoring” approach was used for each finding. Consequently, four score (A to D) robustness matrix was developed and used in this process.

EVALUATION LIMITATIONS- The evaluation experienced number of limitations: i) Recent political events in Ukraine followed by structuring of the government, limited participation of some key policy makers and most knowledgeable key informants at the Ministry of Health, Ministry of Social protection and other government institutions in the evaluation process; ii) The timing of field visit coincided with the annual leave season therefore some of the key informants being directly involved in the project were not available for semi-structured interviews; iii) Due to time and budget constraints, the proposed evaluation method did not include an extensive population-based survey, but largely relied on national and service statistics, qualitative data collected through interviews and focus group discussions as well as secondary quantitative data available. This limits the evaluation’s ability to measure the programme outcomes in strict quantitative terms; iv) Limited number of social (one per facility) and outreach workers (1-2 per site) restricted the evaluation to form a separate group for focus group discussions rather they have been interviewed separately; v) In addition, “Ethical Committee” approval was not possible to obtain due to ongoing reform of the executive branch of the government and identification of responsible institution for granting approval. However, UNICEF discussed the data collection methodology, particularly FGD, with the State Service on HIV/AIDS and Other Socially Dangerous Diseases and obtained verbal consent for qualitative data collection from direct beneficiaries.

STAKEHOLDER PARTICIPATION AND ETICAL ISSUES - The evaluation ensured active participation of key stakeholders in all phases of the evaluation process. The preliminary evaluation findings and recommendations were presented and verified at the meeting with State Service on HIV/AIDS and Other Socially Dangerous Diseases before final version of the report was produced. Relevant stakeholders were given the opportunity to comment on the draft evaluation report and the final evaluation report reflects these comments and suggestions. The evaluation ensured impartiality and independence at all stages of the evaluation process, which contributes to the credibility of evaluation and the avoidance of bias in findings, analyses and conclusions. Furthermore, it guaranteed a maximum level of objectivity. Statement of facts is methodically clearly distinguished from opinions; the different perspectives were taken into account, as well as strengths and weaknesses; results, conclusions and recommendations are supported by evidence and are comprehensible. And finally, to account for the data quality and assess the strength of conclusions the ET used the “robustness scoring” approach for each finding.

EVALUATION FINDINGS

Project demonstrates high relevance - the evaluation discloses project’s high relevance. It is fully aligned with national context, national HIV policies and strategies as well as with the country cooperation programme of UNICEF and its mandate. Project remains to be relevant for coming years.

Relative effectiveness of project implementation – The project has identified key strategic measures related to improved access to services of HIV positive drug users, including pregnant women. Project design, interventions as well as choice of models in particular
settings, were customized to local needs of IDU pregnant women and were appropriate to achieve project’s defined objectives. Introduction of integrated approach to medical and social care delivery to target population group confirms project’s strong focus on PMTCT. ICM model presents improved access to care and treatment and increasing cooperation across medical disciplines. Various methods used to reach out clients failed to ensure higher utilization of services by target beneficiaries. The main project limitation was weak client identification system by outreach workers as well as health and social services.

Those who used services at integrated care facilities had high uptake of core medical and social services. The capacity building activities implemented within the project together with international knowledge sharing resulted in improved staff attitudes towards IDU pregnant women as well as improvement of quality of services. Project clients express satisfaction with the quality of services received and staff attitudes at Centers of Integrated Care (CIC) compared to non-project clients.

Wide range of partners involved in project implementation leveraged financial and expert resources together with sound coordination contributed to the effectiveness of the project. The project could have benefited more from results based management and more strait forward and operational monitoring and evaluation framework and practices.

Nevertheless, the project was moderately effective in its contribution towards removing key bottlenecks in project areas. So far, none of the pilots have yet been able to completely fulfill the goal of truly bridging different parts of the health care and social systems, particularly public social services, in order to improve the continuity of care and outcomes for drug dependent women and children born to them. At present the project demonstrates integration of both services, though the role of social services and support is mainly played by NGOs, whereas the role of state social services is less evident. Legal, organizational and regulatory structure of Ukraine’s medical and social systems and uncertainty with ongoing reforms in both sectors on the one hand, and, on the other hand, inadequate funding issues, staffing shortages et alia negatively affect true integration. It is however clear that the Integrated Care Model has huge potential to reshape Ukrainian health and social sectors for the better, and not only for people dealing with drug dependency.

More operational project performance monitoring could have resulted in enhanced effectiveness of the project. Failure to define size of drug dependent women population in pilot sites at the beginning of the pilot, limited project to examine coverage rates, effectiveness of different outreach methods used and elaboration of most effective measures to increase client recruitment. Targeting of IDU pregnant women partners was less emphasized by the project.

Project demonstrates relative efficiency in utilization of available resources. Project demonstrates relative efficiency of resources used for technical assistance, human resource capacity building and evidence generation that contributed to the attainment of project objectives, however a high share of management cost compared with international practice raises concerns about financial efficiency as well as sustainability of this intervention. The project like other NGO run projects directed towards IDU populations are characterized by high costs relative to the number of targeted population. The evaluation failed to assess whether project resources particularly prioritized the most marginalized and vulnerable drug dependent pregnant women as socio-demographic characteristics of project clients are not tracked by the project monitoring system.
Impact of the project – Project demonstrated decreasing trend of MTCT rates among pregnant drug addicted mothers in pilot sites. In Kyiv and Poltava regions no single case of mother to child transmission has been observed and MTCT rates are 0%, whereas in Dnipropetrovsk it decreased from 35.7% in 2010 to 7.7% in 2012. Impact can be maximized with expansion of target group coverage, which is only 3% at project pilot sites.

The project was largely instrumental in elimination of service access barriers experienced by drug dependent pregnant women in pilot sites, though some unmet needs remain.

Prospects for sustainability - The national health and social sector policies and legislation along with health human resource capacity established by the government, serves as prerequisite for addressing the needs of drug dependent women in a sustained manner. However both, health and social systems still remain as vertically operated systems and lack clarity on integrated health and social service delivery. The government may embark on national scale of ICM, however it will not resolve the problem of integration weaknesses currently observed in the pilot sites if comprehensive health and social service strategy that meets drug dependent women’ needs and assures equal access is not elaborated. Tense political environment in the country, refocusing of public funding to other priority spending categories alongside with sharp decline in external funding further accelerates current system wide challenges in both sectors and presumably will undermine sustainability of ICM model and its scale up.

Remaining barriers - Nonetheless of positive results attained so far, number of barriers remain, restricting access to integrated care services as well as sustainment of achievements. The evaluation reveals that people who have drug dependency problems in many cases face a range of other difficulties in their lives. Drug dependant individuals, especially pregnant women still feel being marginalized and experience fear to contact public institutions other then ICM. Their friends and former community members are still hesitant to use services due to the stigma and public attitude. Furthermore, they lack information about available services.

Notably, geographical access barriers to integrated services and transportation costs remain as access barrier due to small number of CICs in project target locations. Women on average spend two to four hours for round trip daily to get their OST, if it is prescribed and find difficult to afford even transportation costs. These women often lack parental and/or family support to continue treatment and bring up a child, which in its term appears as a barrier to pay everyday visit to OST clinic and pushes them to return back to their society. In such cases they are at risk of loosening parental right. Those, who managed to enroll on OST, face psychological pressure from their drug dependent partners that push them to return to their old life style.

Current design of the ICM puts less emphasis on ensuring postnatal care and care of children at pediatric hospitals frequently sites by drug dependent women during FGDs. Medical staff at Pediatric hospitals often demonstrate unfavorable attitude towards drug dependent women and their children and often request payment for services.

Lack of OST prescription, take-home allowances or pharmacy dispensing has been named as another barrier. The national legislation restricts OST without direct observation of medical personnel at the dispensing clinic. This practice is not typical of better-established OST
programmes in other countries, and creates major, clinically pointless hurdles to patients’ efforts to achieve a normal life free of illegal drugs.

Being unemployed is another strong barrier for bringing up a child and their social integration into the society. Non-responsiveness and discriminatory attitudes of public employment agencies were named as important challenge faced by drug dependent pregnant women. Willingness to receive vocational education that would help them find jobs was highlighted during interviews with them.

LESSONS LEARNED

Lesson 1: Bridging health and social systems has potential to close equity gap
The pilot project helped to bridge the health care and social systems in order to improve the continuity of care and outcomes for vulnerable to HIV pregnant women and children born to them. Albeit none of the pilots have yet been able to completely fulfil the goal of truly bridging different parts of the health care and social systems in order to improve the continuity of care and outcomes for patients. Much of the reason for this has to do with the legal, institutional and regulatory structure of Ukraine’s medical and social systems, uncertainty with on-going reforms in both sectors, funding issues, staffing shortages and other problems. But it is equally clear that ICM has huge potential to reshape Ukrainian health and social sectors for the better, close equity gaps not only for people dealing with drug dependency.

Lesson 2: Shaping staff attitudes and tackling stigma among service providers
The pilot project exhibited other positive, but less tangible, results as well. The project had clear impact on shaping staff attitudes and tackling stigma among service providers, and confirms recognition by medical personnel that the ICM helps better to serve their clients. Many staff cited feelings that they are now better able to serve their clients, and consequently more fulfilled in their work, under the IC model. “We got used to our patients, learned to trust each other under this system, and now we see them, I’d say, almost like relatives,” said the head of maternity department at Dnepropetrovsk. Patients’ experiences have mirrored this, as in the words of Natalia, a participant in the Dnipropetrovsk ICM programme: “I like the attitude of the medical staff very much. They are kind and supportive, and they treat us as equals. It’s the furthest thing from many other clinics.” While this is true for the health providers the state social sector still remains largely unchanged.

Lesson 3: Recognition as a global model for IDU care
Experience with innovative ICM model piloted in Ukraine has been shared within the CEECIS region. The project’s experience was presented at the International Harm Reduction Conference in Vilnius on 11th of June 2013 in Lithuania. The Ukrainian approach to the issue was recognized as the best practice in the CEECIS region that should be replicated to other countries.

Lesson 3: Setting a scene … before national scale up
Considering highly vertical public health and social systems design, establishing an integrated treatment model for IDUs in Ukraine that has gained recognition as a global model for IDU care faces many challenges along the road. Uncertainty with on-going political and economic crisis and reforms in health and social sectors, funding issues and staffing shortages, lack of correspondence between the legal and regulatory structure of
RECOMMENDATIONS FOR EFFECTIVE PROJECT IMPLEMENTATION

Recommendation #1: Elaborate most effective outreach interventions for increased targeting of drug dependent pregnant women - The evaluation revealed low coverage of target population by the project. If the government is committed to attainment of stated objective, effective outreach approaches have to be elaborated to ensure that those on the margins of society are aware and able to demand services. For this purpose it is highly recommended to develop the most effective outreach interventions.

Recommendation #2: Ensure continuity of care and strengthen family and government support, particularly for most disadvantaged - A certain degree of continuity in service provision to drug dependent pregnant women and children born to them are confirmed by evaluation, though some needs of target population remain either partially met or unmet. The ICM takes relatively good care of women during pregnancy and delivery by provision of antenatal care, access to VCT, ART and OST, but less focuses on the provision of postnatal care. Evaluation findings show a great need in strengthening postnatal care for women and children with particular emphasis on early childhood development. The Government of Ukraine as well as all partners involved is strongly advised to expand the basic package of health services for drug dependent women and children born to them by inclusion of postnatal care and early childhood development for target beneficiaries.

The project demonstrated good practices in provision of access to social services and other services to women after delivery and their children. The evaluation also disclosed cases of partner and/or family member involvement in care and support activities, though not in a systematic manner. Many women interviewed voiced lack of partner and family support as important barrier to stay “free of drugs” and bring up a child in a healthy environment. It is advised to design family support mechanism(s) promoting early recruitment of partners and/or family members in the project.

Recommendation #3: Explore other opportunities for social service provision to most disadvantaged - Furthermore it is recommended to explore other opportunities for effective integration of health and social sectors, particularly by using existing social service institutions (day care centers, child homes, shelters, etc.) for the benefit of most disadvantaged and marginalized drug dependent women and their children.

Recommendation #4: Enhance regular data collection and analysis for monitoring project impact and outcomes - The project lacked well-formulated results framework allowing measuring impact, outcomes of the project and implementation progress. Therefore it is recommended that Project Results Framework is streamlined by adding quantitative and qualitative indicators, regular analyzes of collected data practiced, problems identified and corrective measures implemented. Moreover, in order to measure project impact a qualitative Knowledge, Attitude, Practice survey has to be implemented in the pilot districts and compared with non-pilot data. Introduction of post-pilot anonymous patient satisfaction
surveys that measure attitudes, quality of service provision and level of social support will also inform project effectiveness.

RECOMMENDATIONS FOR SUSTAINABILITY AND SCALING UP

Recommendation #5: Develop integrated strategy for care and support of drug dependent pregnant women and children born to them

There has been an increased focus of the Government of Ukraine on the benefits of providing service within an integrated service delivery framework that crosses traditional organizational boundaries and brings together a range of professionals to provide health, social and other services for key groups of population, particularly for drug dependent women as stipulated in various health and social policy documents. The integrated service model, piloted by this project, is currently seen as one of the most effective ways of promoting optimal care and support for drug using women and their children. To make this model (ICM) sustain before scale-up, the government is advised to develop an integrated national strategy for care and support of drug dependent pregnant women and children born to them. The strategy should be explicit on the integrated service provision model design, service packages, roles and responsibilities of multiple government actors in health and social sectors as well as front line service providers, integrated standard operation procedures, service provider reimbursement mechanisms and accountability standards.

Recommendation #6: Develop national legislation framework regulating ICM - In order to ensure sustainability, the government is advised to develop and endorse national legislation, which regulated governance of ICM, integrated service packages, structure, staffing norms, functions, standard operation procedures, referral algorithms, accountability forms and procedures as well as performance monitoring requirements. Furthermore timely adoption of and full compliance with integrated service delivery guidelines and protocols, including new PMTCT and NAS has to be regulated by respective legislation. More importantly, the importance of social contracting should be emphasized and required legislation enabling contracting out of selected social services to NGOs and private sector should be made available.

Recommendation #7: Explore options for ICM scale-up - The project is a good demonstration of government’s dedication and attempt to meet MDG 6 targets, particularly by targeting drug dependent pregnant women and children born to them. However limited number of integrated care centres can undermine targeting a critical mass of target population. Thus further expansion of ICM is highly recommended which will ensure improved coverage and provision of better access to integrated services for target beneficiaries. Acknowledging the difficult financial situation the country faces at present and ability to scale up the model nationally, the phased approach to national scale up is recommended. In the first instance the focus should be made to the regions, which demonstrate high HIV prevalence, high concentration of drug using population, availability of newly established perinatal centers and ideological as well as financial readiness of the local governments to support the ICM introduction. Presence of newly established perinatal centers would limit investment costs required for ICM introduction. Further expansion of the model can be guided by the country’s ability to provide political and financial support.

Recommendation #8: Ensure adequate funding of Integrated Service Centers - Inadequate funding of health services in general and medicines and medical supplies for CICPs in particular challenges the Government’s commitment for free service delivery to drug
dependent pregnant women. The situation may further deteriorate with already introduced budget cuts for health and social services and the declining external support. Therefore, the government is advised to fully utilize the ICM costing methodology tool developed by UNAIDS in forecasting adequate funding for CICPs and safeguard adequate budget execution.

**Recommendation #9: Build health workforce capacity** - The ability of the country to meet its PMTCT goal depends largely on the knowledge, attitudes, skills, motivation and deployment of the people responsible for organization and delivery of integrated services. The Government of Ukraine acknowledged the lack/shortage of human resources needed to deliver essential quality integrated services. Therefore the government is advised to streamline the education of integrated service provider professionals.
1. INTRODUCTION

1.1 STRUCTURE OF THE REPORT

This report provides findings of formative evaluation of UNICEF pilot project ‘Prevention of Mother-to-Child Transmission and Improving Neonatal Outcomes among Drug-Dependent Pregnant Women and Children Born to Them in Three Cities in Ukraine’.

The report is structured as follows:

**Chapter 1.** Provides an introduction to the evaluation, brief description of HIV epidemics in Ukraine, the role of intravenous drug use in HIV epidemics and MCTC rates, challenges faced by drug dependent women and describes the project subject to evaluation.

**Chapter 2.** Presents description of the approach and methodology used to carry out the evaluation.

**Chapter 3.** Details the findings of the review in relation to five OECD evaluation criteria. Each section (one for each of the five criteria) begins with a brief introduction of key evaluation questions answered in the section to ensure that the reader understands the context for the findings followed by a detailed discussion of the results found in the evaluations. At the end of the chapter a separate section summarizes findings and provides the conclusions of the evaluation.

**Chapter 4.** Specifies Lessons Learned based on the findings of evaluation

**Chapter 5.** Stipulates strategic policy and implementation recommendations. These recommendations provide guidance on how to strengthen the on-going pilot, how to ensure that expected outcomes are achieved and how to ensure that relevant policies and support is provided to ensure that adequate models of service provision for drug-dependent women are adopted and sustained in the future.

1.2 EVALUATION RATIONALE, OBJECTIVES AND SCOPE

Evaluation is undertaken when the pilot model is expanded in 2014 to four project sites and already demonstrates results that should be documented. It is especially important at the time when the government is increasingly interested in ensuring the provision of services to marginalized pregnant women and reaching the goals of EMTCT. There is a need to document and assess the results of the piloted model along with evidence of the project outcomes. Lack of information affects the government’s ability to design appropriate preventive and protective measures for vulnerable drug-addicted pregnant women both on a normative level (including standards, guidelines, and protocols) and on a service delivery level (including preventive programmes, reintegration programmes).

**Objectives:** The evaluation results provide answers to the questions what could be done to reduce inequity in access to the PMTCT and of how to strengthen social services to identify women’s vulnerabilities at an early stage as an entry point to the system of integrated treatment and care for them and their children.
The objectives of the formative evaluation are:

1. To analyze whether outputs and activities within the project are leading to expected outcomes and goal of the project;
2. To assess and analyze the bottlenecks and barriers, including policies, practices and other structural barriers in medical and social areas for the Project pilot implementation;
3. To document lessons learned and good practices of the pilot project activities, along with evidence of outcomes;
4. To demonstrate, based on evidence, whether or not a nation-wide scale up of the pilot approach and practice is possible and whether a scale up will effectively lead to closing of equity gaps in the area of work; and
5. To develop strategic, policy and implementation recommendations of how the on-going pilot, if achieved its key outcomes, will be efficient and sustainable in future, thus informing policy development and framework of the national scale-up of the pilot.

The purpose of evaluation is to produce relevant information on the design and effectiveness of the pilot project and identify lessons learned and provide strategic policy and implementation recommendations. These recommendations provide guidance on how to strengthen the on-going pilot, how to ensure that expected outcomes are achieved and how to ensure that relevant policies and support is provided to ensure that adequate models of service provision for drug-dependent women are adopted and sustained in the future.

Scope: The evaluation covers all period of the pilot project implementation from June 2011 when the project was launched in three cities of Ukraine – Kiev City, Dnipropetrovsk and Poltava until 2014 when the project was expanded to one more city of Krivui Rig, Dnipropetrovsk oblast. The scope of evaluation focuses on the progress in achieving expected results based on project outputs and outcomes.

State and regional health authorities – duty barriers: The findings of the evaluation will contribute to the design and development of PMTCT interventions that would ensure access to quality medical services and social support for women who are most vulnerable to HIV infection, including drug-dependent pregnant women. It is expected that the evaluation results will help the results primary users, such as national and regional health and social state authorities, as duty bearers, to inform the way forward in the national scale up of the pilot of integrated medical and social services for drug addicted pregnant. It will help to identify how this can be done and what type of actions is needed to achieve the goal of the pilot and how the model can be replicated on a national scale. It is also expected to inform national PMTCT policy development and adjustment.

HIV-service NGOs: HIV-service NGOs as representatives of vulnerable groups of pregnant IDUs, will use the results of evaluation as advocacy instrument for inclusion of integrated service model in national policy, while participating in its development.20

UNICEF: Findings will be used by UNICEF to advocate for the enhancement of the integrated services approach in view of national scale up and implementation through 2018. All stakeholders are expected to use the findings, conclusions and recommendations to further

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20 Development of national regulation is a participatory process in Ukraine. The National Coordination Council on HIV, which coordinates all HIV/AIDS Programme and Working Groups on development of regulations, has representations of the beneficiaries.
develop policy and framework to achieve positive impact for children and women, in particular those most vulnerable to HIV.

1.2 CHALLENGES OF INJECTING DRUG USING WOMEN IN UKRAINE

Ukraine has the highest adult HIV prevalence in all of Europe and Central Asia. Annual HIV diagnosis in Ukraine has more than doubled since 2001 (UNAIDS, 2010). The HIV epidemic is still concentrated among most-at-risk populations. If until 2008 the main mode of HIV transmission was parenteral through injecting drug use, the sexual mode of transmission is prevailing at present. However the injecting drug use remains a driven force of epidemic. The risk of a generalized epidemic continues to grow. Due to their biological and social vulnerability, women are more prone to infection. Currently, they represent 45 per cent of all adults living with HIV in Ukraine. Most of them are in childbearing age.

INJECTING DRUG USE IN UKRAINE

Injecting Drug Use (IDU) became increasingly common in Ukraine from early 1990s, and is thought to reflect a range of factors including the socio-economic changes accompanying the break-up of the USSR, increased trafficking of drugs through Ukraine and a rising domestic opiate and amphetamine production. Today there is an extraordinary amount of IDUs in Ukraine, with one in 50 to 100 adults believed to inject drugs. It is difficult to obtain accurate estimates, as IDUs are a hard to reach population for surveillance and research. Published reports suggest that there are 11.6 IDUs per 1000 population, with estimates of between 278,000 and 560,000 IDUs in Ukraine. Most IDUs start injecting in adolescence and up to half of Ukraine’s IDU population is believed to be aged less than 25 years.

Injection of homemade opiates (“hanka” “hemia”) and heroin has predominated in Ukraine historically, but there is increasing use of injected stimulants (“vint” “Shirka”) and home made desomorphine (“krokodil”), particularly among young drug users. Misinformation about injection risks and abusive law enforcement with respect to drug use has also been identified as contributors to HIV transmission. In 2013 out of 139, 573 newly registered cases of HIV-infection, 56, 949 (40.8 %) were among injecting drug-users.

FEMALE DRUG USERS AND SPECIFIC ISSUES RELATED TO SUBSTANCE USE IN PREGNANCY

Around 28% of IDUs in Ukraine are female. Female IDUs often experience numerous medical and social problems, including psychiatric co-morbidity; gender based violence, intimate partner violence (IPV), parentally and sexually transmitted infections and economic

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21 ‘HIV-infection in Ukraine’. Information bulletin #41, Ministry of Health of Ukraine, Kyiv, 2014
24 International Harm Reduction 2010
26 Eurasian Harm Reduction Network and International Harm Reduction Association, 2010
hardship, as well as the direct physical effects of drug abuse. They are more likely to acquire HIV than male IDUs, reflecting more risky injection practices, including being injected by others (“second on the needle”) and sexual risks (having IDU sex partners, transactional sex, low use of condoms, co-infection with STIs).

In Ukraine, number of officially registered HIV infected pregnant women with newly diagnosed HIV infection shows decreasing trend since 2008. Out of officially registered HIV infected pregnant women, those infected through intravenous drug use decreased from 15.2% in 2005 to about 6% in 2012 (Figure 1). However, factors such as psychiatric morbidity may contribute to increased substance use and greater vulnerability to HIV infection.

Figure 1: Number of HIV infected pregnant women through Intravenous drug use 2005-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Officially registered HIV-infected pregnant women with newly diagnosed HIV infection, persons</th>
<th>Of those infected through IDU</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>5.96%</td>
<td>5.6%</td>
</tr>
<tr>
<td>2011</td>
<td>6.97%</td>
<td>8.33%</td>
</tr>
<tr>
<td>2010</td>
<td>8.43%</td>
<td>6.97%</td>
</tr>
<tr>
<td>2009</td>
<td>10.9%</td>
<td>8.33%</td>
</tr>
<tr>
<td>2008</td>
<td>11.4%</td>
<td>9.8%</td>
</tr>
<tr>
<td>2007</td>
<td>14.4%</td>
<td>10.9%</td>
</tr>
<tr>
<td>2006</td>
<td>15.2%</td>
<td>11.4%</td>
</tr>
<tr>
<td>2005</td>
<td>15.2%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

Opioid dependence among pregnant women is a specific public health challenge as there are repercussions for the baby as well as the mother. For example, exposure to cycles of intoxication and withdrawal increase likelihood of adverse pregnancy outcomes, including fetal demise and preterm labour. Other factors associated with poor obstetric and neonatal outcomes among opiate addicted pregnant women include late or lack of presentation to antenatal care (ANC), high rates of smoking, poor nutrition and high rates of infections. Offering pregnant drug using women OST is the international standard of care, supports good maternal and neonatal outcomes and is a critical component of a comprehensive approach to preventing HIV infection among infants. For example, benefits of OST include stability of the intrauterine environment and prevention of fluctuations in drug levels that could adversely affect the fetus and the potential to engage women in regular antenatal care.

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30 S. Pinkham and A. Shapoval, Making Harm Reduction to Work for Women: The Ukrainian experience, Open Society, New York
32 Ibid 10
33 “Violation of the right of female drug users (FDUs) to access to medical and social services in the field of sexual and reproductive health: pregnancy planning period, as well as antenatal, natal and postnatal periods”. All-Ukrainian CF “Coalition of HIV service organizations”, 2012
34 Ibid 10
35 L. Finnegan, Treatment Issues for opioid dependent women during the prenatal period, 1991, Psychoact drugs: 23-191-201
36 WHO Europe, Risk factors impacting on the spread of HIV among pregnant women in Russian Federation, 2007, Copenhagen
For drug-using women accessing ANC can provide the opportunity to deliver a broad range of services with respect to maternal and child health, including family planning, PMTCT, HIV treatment and care and general health services. Although a pregnancy and forthcoming motherhood can improve health-seeking behaviour of IDUs, it is important that pregnant drug using women are a vulnerable group. For example, some studies have shown that up to 60-70% of drug dependent women have symptoms of anxiety and depression, with these mental health problems associated with discontinuation of OST and disengagement from care. An additional constraint with respect to management of pregnant drug using women is that pregnancy is a time-limited condition and there is a need to engage pregnant drug using women into care as quickly as possible for them and their infants to benefit from ANC, OST and PMTCT.

PMTCT

HIV can be transmitted from a HIV-infected mother to her baby during pregnancy, delivery and breastfeeding. HIV-positive pregnant women need to receive a preventive course of antiretroviral medicines (ART) to prevent HIV transmission to their newborns. A state programme to prevent mother-to-child transmission of HIV (PMTCT) was established in Ukraine in 2001, and the Government currently guarantees free HIV testing and ART to all HIV-infected pregnant women in Ukraine.

The elimination of mother to child transmission (eMTCT) of HIV is a global goal that has been endorsed by national governments in partnership with UNAIDS, WHO and UNICEF and a number of other national and international stakeholders. In Eastern Europe and Central Asia the strategy of elimination builds on on-going efforts to reduce the vertical transmission of HIV through the building of systems that are able to strengthen functional linkages and integration between existing maternal and child health systems and the HIV treatment, care and support systems in the region. Ukraine recently confirmed its commitments to scale up Prevention of Mother-to-Child Transmission of HIV programme (PMTCT) towards elimination of mother-to-child transmission by 2015, approving a new National AIDS Programme for 2014 -2018.

A national level of HIV transmission from mother-to-child (MTCT rate) reduced in 2011 to 3.7 % compared to 27.8% in 2001. Despite progress, in order to achieve further advances towards the elimination of MTCT (defined as less than 2% at 6 weeks of age among children born to HIV-positive mothers by 2015), it will be essential for Ukraine to reduce the number of new infections among women of child-bearing age, sustain and improve quality of PMTCT services provided as well as focus on increasing access and uptake of services by those segments of the population that are currently not accessing PMTCT services or accessing them too late. In 2011, more than 5,000 pregnancies were registered among HIV-positive women in Ukraine. The absolute number of children infected with HIV through mother-to-child transmission (MTCT) continues to increase, as there is an average 130 - 140 cases of newly diagnosed HIV-infection in children registered annually.

The country has the highest coverage of PMTCT services in the CIS region, including a very high proportion of HIV-positive pregnant women receiving ARV prophylaxis (96. 2 % in 2013). However, coverage of those segments of the population who are most vulnerable to HIV-

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39 Ukrainian Center for Diseases Control data
infection (including IDUs, FSWs) with PMTCT services is still low. Official epidemiological data for 2014 indicate that MTCT rate in vulnerable pregnant women who inject drugs (IDUs) is 13.7%\(^40\), and this leads to the “elevation” of the national MTCT rate. Drug-dependent women remain most at risk to transmit HIV to their newborns. Drug-using pregnant women often receive prenatal care only towards the end of their pregnancy or attend a clinic for the first time for the delivery, missing out on the possibility of taking the preventative course of ART. Official data of MTCT rate in vulnerable pregnant women who inject drugs (IDUs) is 13.7%.\(^41\) However, the estimates suggest the real rate of MTCT among IDU women is closer to 23%.\(^42\)

In 2011, injecting drug use was identified as the risk factor of mother-to-child transmission of HIV in 19.1% of HIV-positive reproductive-aged women, and 3.5% of pregnant HIV+ women reported active drug use during latest pregnancy (probably an underestimate due to the stigma of admitting drug use, especially in pregnancy)\(^43\). Only 29 of 395 (7.3%) of pregnant HIV+ pregnant women who used drugs got substitution maintenance therapy and most opioid dependent pregnant women continued using drugs during pregnancy. Pregnant women who inject drugs have worse outcomes than other women: more advanced disease (14% vs. 6%), less access, more adverse outcomes (preterm delivery 16% vs. 7%), and a higher mother-to-child transmission rate\(^44\). They are also 3.5 times more likely to be diagnosed with HIV in labour than other women. Relatively few HIV+ pregnant women who injected drugs received ARV prophylaxis, which can prevent HIV transmission to newborn (65% compared with 94.5% overall)\(^45\).

**SOCIO-DEMOGRAPHIC CHARACTERISTICS OF DRUG USING MOTHERS**

The series of researches, initiated by UNICEF in 2012 – 2013, identified social and medical determinants of HIV transmission to children and the areas of concern.

**Age of drug using women:** Consistent with general population norms in Ukraine, most IDU are relatively young. Among HIV positive women, there has been a gradual increase in age at delivery since 2007 and significant decline in the proportion of pregnant IDUs aged less than 25 years at delivery, from around quarter in 2007-2008 or less than one in six by 2011-2012\(^46\).

**Marital Status:** The majority of pregnant drug users are married or in relationship where they live with their partners (Table 1). Their partners are usually also drug users-but there is some variability with respect to the current drug use status within these partnerships. In some cases, both husband and wife are OST clients, but in other the husband/partner has not accessed drug treatment services and is either trying to abstain from street drugs without medical assistance, or continues using drugs\(^47\). According to medical staff

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\(^{42}\) Dr Claire Thorne, UCL Institute of Child Health, University College London. Report on injecting drug use in pregnant HIV-positive women in Ukraine: data from the Ukraine European Collaborative Study and the Cohort Study of HIV-infected childbearing women. September, 2012.

\(^{43}\) Martynovskaya V., Ukrainian Center for Diseases Control data, 2012.

\(^{44}\) Dr Claire Thorne, UCL Institute of Child Health, University College London. Report on injecting drug use in pregnant HIV-positive women in Ukraine: data from the Ukraine European Collaborative Study and the Cohort Study of HIV-infected childbearing women. September, 2012.


\(^{46}\) Claire Thorn, Reduction of MTCT risks among pregnant IDU women in Ukraine, 2013

\(^{47}\) Socio-demographic and medical determinants of the risk of mother-to-child transmission of HIV in Ukraine, 2013, UNICEF
interviewed if both partners are committed to stopping use of street drugs, then there is no problem with adherence to OST by the women, and that the situation of couples incentivizing each other to stop drug use is quite common.

**Housing:** Majority of drug using women report having own apartment or house (Table 1) and or renting. Very few IDU women surveyed are homeless, although this observation is difficult to interpret as it could mean that most pregnant drug addicts are not homeless, or alternatively, that homeless pregnant drug addicts are not accessing services. Insecure housing is another problem named by IDU pregnant women particularly where they are dependent on goodwill of parents, parent’s in-law or other family members for accommodation.

**Education:** Findings of multiple studies confirm that low educational level is one of key social factors of risky behaviour. According to the Socio-demographic and medical determinants of the risk of mother-to-child transmission of HIV in Ukraine study conducted by Kyiv International Institute of Sociology in 2011, in Ukraine 25.1% of women (and 22.6% of men) have complete higher education; 27.8% of women (and 26.9% of men) studied in technical schools; 24.0% of women (and 15.6% of men) have secondary school education, while 3.6% of women (and 1.1% of men) have primary education only. By educational level, 44.8% of respondents had complete general secondary education; 20.4% graduated from vocational and technical schools. Only 13.8% of respondents received higher education.

**Income and employment:** The information about employment and income of drug using women is largely absent, however the study of socio-demographic and medical determinants reports that the level of monthly incomes of families with HIV positive children is significantly lower than country average. The majority of women report that both during pregnancy and at the date of interview their monthly family budgets varied from UAH 1,000 to 2,000 per month. During pregnancy the main sources of income for mothers of HIV positive children are salaries of their husbands or partners (42.4%), their own salaries (38.4%), and paid maternity leave (35.7%), and after the birth – paid maternity leave (45.4%) and salaries of a husband/partner (40.0%). Significance of social benefits and their contribution in the budget of families with HIV positive children increases considerably after the birth of a child and confirmation of his/her HIV positive status – from 5.0% to 65.0%. The main family income for 3.0% of mothers of HIV positive children women was their participation in commercial sex.

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48 Socio-demographic and medical determinants of the risk of mother-to-child transmission of HIV in Ukraine, 2013, UNICEF
49 Socio-demographic and medical determinants of the risk of mother-to-child transmission of HIV in Ukraine, 2013, UNICEF
50 According to the State Statistics Service of Ukraine’s “Household Expenditures and Resources” for 2011, average monthly total resources per one household were UAH 3,841.70.
51 Socio-demographic and medical determinants of the risk of mother-to-child transmission of HIV in Ukraine, 2013, UNICEF
Behavioral risks - About 80% of pregnant drug users smoke, although many try to cut down in pregnancy. Heavy alcohol use is rare among drug using women, but these are cases of alcohol abusers in this patient group. Only 41% of HIV-positive women currently using injecting drugs reported drinking alcohol with low drinking levels reported by the IDU women’s study\textsuperscript{52}.

Among HIV positive women who had sexual contacts during pregnancy, 91.8% had one sexual partner, 6.5% – two partners, and 1.7% – three partners. The majority (70.0%) of known sexual partners of surveyed women had one or several factors of risky behaviour (Table 2). During pregnancy 70.0% of male partners of HIV positive pregnant women practice one or several risky behaviours, predominantly alcohol abuse (28.6%) and injecting drug use (28.0%). 2.7% of mothers of children under study provided sex services for reward (money, drugs, goods and products) during pregnancy.

Violence - The first aspect of violence against HIV-positive women is HIV infection as a result of violence. According to the study "Gender aspects of the provision of services for people living with HIV\textsuperscript{53},” 8% of women and 4% of men claim to have received HIV status is a result of the violence, 12 more % of women and 9% of men admit such a possibility, that is, were the victims of violence. According to the same research workers of HIV service organizations were significantly more likely to observe cases of violence on women than on men, with situations of psychological violence (70% mentioned the case of women, 46% - with men), physical abuse (57% and 25%, respectively), economic dependence (49% and 23%), birth control sabotage (54% and 15%), forced abortion (46%), forced to bear a child (31%) and less often remembered pressure to use drugs (15% and 13%).

Stigma and discrimination – It is sound evidence that people living with HIV routinely encounter discrimination and violence, which prevents them from receiving necessary information and services. Stigma limits access of HIV positive individuals to prevention and treatment programmes, as well as to care and support for PLWH in need of such services. In Ukraine women find it difficult to access appropriate psychosocial, social and medical supports when identified as “HIV positive” and as “drug users” because of stigma and discrimination. Stigma and discrimination in connection with HIV positive status is common for 16.0% of respondents who typically experience moral and ethical humiliation and verbal abuse in this regard. Health workers (76.0%), relatives (52.0%) and friends (28.0%) are persons who typically reveal stigmatizing and discriminating attitudes towards HIV positive individuals. IDU women usually try to conceal their drug use from their family, particularly parents.

In Ukraine non-medical use of drugs is considered as crime. Drug users, who need health services, are often chased by law –enforcement agencies in their fight against illicit drug use.

\textsuperscript{52} Socio-demographic and medical determinants of the risk of mother-to-child transmission of HIV in Ukraine, 2013, UNICEF
\textsuperscript{53} Gender aspects of the provision of services for people living with HIV, All-Ukrainian Network of PLWH, 2012
Female drugs users are particularly vulnerable in this situation. Current legislation in the area of illicit use of drugs is based on restrictions, prohibitions and criminalization of actions related to illicit use of drugs, while actions of an individual who stores drugs for his/her personal use, like a daily drug dose, are called a criminals. The legislationpunishes drug users rather than focuses on health services, including socio-medical services for those who need them⁵⁴.

**The social factors**, such as household responsibilities, lack of family support, lack of social networks, lack of financial resources, lack of privacy and confidentiality, and fear of being stigmatized create the barriers to accessing services. Behavioral patterns, particularly low level of adherence to the healthy life style in the target group also lead to avoidance of contacts with the state services.

**More children are born with HIV and unnecessarily abandoned due to the lack of social service safety nets.** While critical steps have been taken to improve children’s wellbeing, their vulnerability remains high. Families with children are twice as likely to live in poverty as families without children (31.3% versus 15.7%). Most HIV-positive children are born into socially disadvantaged, younger families, with 85% of the parents under the age of 30.

Vulnerable families and women HIV-affected and/or substance dependent, don’t have access to necessary social protection that would enable them to properly care for their children. Social interventions fail to be initiated at early stages to address root causes of the HIV or substance use. Often services are not even responsive to these families’ existing needs, due to lack of understanding and stigma.

Too often social service responses to vulnerabilities of families such as HIV-affected women are to remove the children and place them in residential care. In 2010, 1.2% of the child population was orphans or children without parental care; every year approximately 8,000 children ‘lose’ their parents through termination of parental rights⁵⁵. When children are removed from their families, little is done to work with the families to address root causes for separation that could enable safe reintegration of the children into their families. In 2010, 1.2% of the child population was orphan or children without parental care; every year approximately 8,000 children ‘lose’ their parents through termination of parental rights. Only small share of children and families affected by HIV receive care and social support services, whereas 10 % of HIV-positive mothers abandon their children to state-run orphanages⁵⁶.

In terms of **gender equality**, women are excluded from decision making at the highest political level. While 76% of civil servants and 51% of village council members are women, only 11.1% of national parliamentarians and 13% of cabinet members are women. In terms of economic participation, although education levels of both genders in Ukraine are equivalent, women on average make only 75% of men’s earnings. Violence against women is widespread in the Ukraine with nearly 45 per cent of women experiencing violence at least once in their lifetime and only 1 of 4 women who experienced domestic violence in Ukraine seek support from law enforcement and legislative system. A positive development of the past year was the adoption of the State Programme “On Ensuring Equal Rights and Opportunities for Women and Men for 2013 - 2016”.

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⁵⁴ Access to services for female drug users, All Ukrainian Charitable Foundation “Coalition of HIV service organizations”, 2012
⁵⁵ UNICEF Briefing Note, 2013
⁵⁶ UNICEF Briefing Note, 2013
ACCES BAARIERS TO SERVICES

Insufficient knowledge about HIV/AIDS among the general population and care providers produces fear and stigmatization of HIV-infected people, and leads to infringement of the rights of women and children. Furthermore lack of knowledge about HIV transmission.

Family planning - Many pregnant IDUs did not plan their pregnancy, although this does not necessarily mean that the pregnancy is unwanted. Among recently delivered HIV-positive IDUs, 41% reported that most recent pregnancy was unplanned, a substantially greater proportion that seen among HIV-positive non-IDUs (26%). It is a common practice in Ukraine that family planning counseling and services are provided in the postnatal period, to avoid future unplanned pregnancies. The intrauterine device is the most common planning method used, involving a follow-up visit one month postpartum

Timing of HIV diagnosis among pregnant IDUs - Timely diagnosis of HIV infection in pregnant women is critical for the optimum application of PMTCT interventions. Among HIV-positive pregnant women in Ukraine, there has been an encouraging increase in the proportion of those who are aware of their infection status before pregnancy (Figure 2). This is likely to reflect improvements in access to HIV testing outside of the context of pregnancy and due to repeated pregnancies among diagnosed women. However 6%-7% of HIV positive IDU women remain undiagnosed until testing in labor, reflecting very late or lack of access to antenatal care whereas share of non-IDU women being diagnosed during the labor has been below 2% since 2009. IDU women diagnosed with HIV for the first time in pregnancy are significantly more likely to be diagnosed later during pregnancy than non-IDU women

Receipt of PMTCT services - With respect to timing of ART during pregnancy, the proportion of IDUs not receiving ART is significantly higher than non-IDU pregnant women in Ukraine, although over the period of 2007-2012 declining trend is observed. There is an evidence of substantial disengagement from HIV care among IDU women and or lack of access to HIV care after the initial positive HIV test. Half of the surveyed IDU women who received no antenatal ART had been diagnosed as HIV positive before the pregnancy, with 16% diagnosed intrapartum through rapid testing and the remainder identified in antenatal period. Thus the vast majority (over 80%) had identified HIV infection and should have received antenatal prophylaxis and/or treatment

Fragmented design of healthcare system – In the Ukraine system, pregnant women are managed by different doctors and in different setting for different infections: for example, a women with chlamydia would be treated by antenatal clinic doctor, but syphilis is treated by an infectious disease doctor and HIV is managed by specialists at the AIDS Center.

57 Ibid 27
58 Ibid 27
59 Ibid 27
IDUs have several co-infections and therefore face challenges in accessing appropriate care, due to management by different physicians and in a variety of places where HIV positive drug using women are receiving substitution therapy, HIV and MCH services in different places reduce their access to services.

Cost of treatment - The vast majority of state medical institutions, in accordance with the order of the Cabinet of Ministers, have a system of so-called “charitable contributions” that makes it almost impossible for IDUs to get treatment/medical help for free (as in most of the cases a patient has to make “charitable contribution” to the institution before he will be treated. Thus, referral to STI clinics for screening of women is not effective, since the main obstacle is the price - 1,500 UAH for a full check-up. In general, cost of consultation of gynecologist and dermatologist ranges from 50 to 200 UAH or higher, depending on the region. Other consultations start from 100 UAH, RW - 40 to 65 UAH, markers for viral hepatitis - from 140 to 270 UAH. All this makes it extremely difficult for IDUs and their partners to access medical services (consultations, examinations and treatment)60.

Knowledge, skills and attitudes of health professionals - Healthcare workers at MCH services are lacking knowledge and skills to provide care for pregnant women using substances and rely on referral expertise of addiction and HIV specialists. Addiction specialists have very limited knowledge about pregnancy, reproductive health and family planning and rely on MCH specialists61. Drug-dependent women not seek services due to a fear of hostility from medical practitioners or of having their children taken away from them after delivery.

Lack of coordinated social services - The biggest problems faced by women and families affected by HIV are partially attributed to a lack of a coordinated system of social services. Services do not exist to address or even effectively identify vulnerabilities at early stages. Social services are not sufficiently inclusive or sufficiently flexible to be able to adapt to the various profiles of children or their families within their communities, and thus avoid unnecessary separation. Service provision has largely been put in place without coordinating with other social support such as social benefits, and thus opportunities for synergy are limited. Local government does not have sufficient autonomy to manage the development of services and lacks financial resources.

Child custody issues are an important issue for drug using mothers who are not enrolled in OST program. Among HIV-infected women who were currently using injecting drugs at the time of enrollment in the Women’s Study, 18% were not living with their youngest child at enrolment, although some of these women was living with at least one of their older children. A small number of HIV-positive women in the study were not living with their baby because of imprisonment.

Harm reduction NGOs are not institutionally involved in service provision for pregnant women using drugs, being mostly donors’ funded organizations; they have limited knowledge about specific needs of women using drugs, including prevention of unintended pregnancies, provision of basic services to pregnant women and their referral to ANC62.

60 Assessment of existing chains of RH/FP service delivery to injecting drug users and their partners in Kyiv city, Kyiv, Mykolayiv and Kirovograd oblasts, 2013, Health Department of the Kyiv City State Administration, Kyiv City Clinical Nargological Hospital “Sociotherapy”
1.3 PROJECT DESCRIPTION

To remove inequity in care, treatment and support for drug-addicted pregnant women, overcoming barriers to the provision and utilization of services by them, UNICEF initiated a pilot project ‘Prevention of Mother-to-Child Transmission and Improving Neonatal Outcomes among Drug-Dependent Pregnant Women and Children Born to Them in Three Cities in Ukraine’.

The pilot project was developed as a model of PMTCT service provision for drug dependent pregnant women expected to result in better coverage, quality and uptake of services for pregnant drug-dependent women. This would, in turn, lead to improved health outcomes for their own health and for the health of their babies.

The main **objective** of the project is: to establish, maintain, and improve gender responsive, comprehensive, and integrated services that address the needs of drug-dependent pregnant women and children born to them.

The **expected impact** of the project is the reduction of mother-to-child transmission of HIV among vulnerable pregnant drug addicted women in selected pilot cities through provision of support to the government and civil society organizations to develop and implement effective HIV prevention, treatment and care services for drug addicted pregnant women and their children.

The lessons learned from the model are expected to inform the system changes required and the process of scale-up of such services to other geographical areas of Ukraine. When expanded to the national level, improved access to better quality services will result in more women benefiting from services adapted to their needs, leading to improved neo-natal outcomes for their children, including the realization of their right to be born free of HIV.

**Strategies**

To achieve the expected results, the following strategies have been used:

- **Targeted advocacy and communication** aimed at promotion of gender sensitive and human rights-based approaches towards female IDUs.
- **Partnership with:**
  - **National and local health authorities** (Ministry of Health, State AIDS Service, Ukrainian Centre for Disease Control, Ministry of Social Policy) to enable the positive policy environment for pilot projects’ implementation. Continuing partnership allowed to improve and updated the regulatory framework (national and local health policies, information letters approving a referral system in the expanded pilot site - Kriviy Rig etc.);
  - **Non-state actors**, such as implementing partner the International Charitable Fund/ William J. Clinton Foundation in Ukraine (WJC Foundation), national and international research institutions; national NGOs (All Ukrainian Network of PLWH, International AIDS Alliance in Ukraine and other HIV-services NGOs) and Eurasian Harm Reduction Network and Coalition of HIV-services organizations, joining the partners’ efforts and leveraging of complementary technical resources;
  - **UN agencies**, as a member of the UN JT and UNTG on HIV/AIDS, supporting implementation of the pilot project within the UN Joint Programme of Support on HIV/AIDS to the Government of Ukraine for 2012-2016.
• **Establishment of gender-responsive integrated services** addressing needs of female IDUs, establishing the Centre of the Integrated Care for Pregnant Women in one more city (Krivy Rig);

• **Capacity building of service providers** filling the gaps in knowledge and skills to manage pregnant drug addicted women and children born to them through the training;

• **Monitoring and evaluation**, documentation of lessons learned at the pilot sites for further scaling up at national level.

The logic model, as a part of Theory of Change\(^6\) (Figure 3) is:

Figure 3: Theory of Change: Building services for pregnant women using drugs

- Transforming the services for pregnant women using drugs from vertical and fragmented system to horizontal and integrated will create an enabling environment in which gender sensitive HIV prevention, treatment, care and support services are available for pregnant women using drugs and their children. Setting up such functional linkages between MCH, HIV services, addiction services and integration with social services will prevent MTCT among pregnant drug using women and will contribute towards elimination of MTCT in the country.

- This should increase number of drug-addicted HIV-positive mothers and their newborns that received timely social support, diagnosis of HIV, treatment and care to prevent mother-to-child transmission and, in turn, reduce number of children born with HIV.

- Provision of, access to and uptake of gender responsive, non-discriminatory and integrated medical and social services targeting HIV vulnerable groups, including drug using pregnant women, is the precondition for further reduction of HIV transmission to newborns and elimination of MTCT in country.

\(^6\) Provided by UNICEF CO
- By decreasing the risk of HIV MTCT rate among drug using pregnant women, the project will decrease the MTCT rate at national level, thus contributing towards elimination of MTCT in the country.

The project focuses on introducing integrated services for drug addicted pregnant women by establishing Centres for Integrated HIV Prevention, Care and Support Services. Centres provide a range of medical and psychosocial services to drug addicted women and their children: offering antenatal care, HIV testing and counseling, ARV treatment to prevent HIV transmission from mother-to-child, assisting in delivery, postnatal care, and treatment of neonatal withdrawal syndrome, drug dependency treatment, psychosocial counseling and social support to families.

GEOGRAPHICAL COVERAGE AND IMPLEMENTATION PHASES

Over the life span of the project (2011-2014), the pilot was implemented in three phases. The initial phase (June - December 2011) aimed at assessment of situation and design of the most appropriate and feasible service delivery model. As a result, the needs in establishment of two types of model of services for drug-dependent pregnant women and their children in pilot districts have been identified. In the 1st phase – pilot phase of the project (2012 – 2013) the pilot was launched in three cities of Ukraine – Kiev City, Dnipropetrovsk and Poltava and ensured provision essential equipment, drugs and medical supplies to new sites as well as building capacity of service providers. The 2nd phase of the project, which started from mid 2013 – 2014, the project has been expanded to Kryvyi Righ, the city most affected by HIV and drug abuse and with high needs in gender sensitive services provision.

PROJECT KEY STAKEHOLDERS

Addressing the health and social needs of drug-using women and their infants is a challenge, as it requires strong coordination and functioning referrals between various stakeholders and service providers. The project was built on established close partnership between public and civil society organizations. Different organizations and non-state actors were involved into project design and implementation: UNICEF; UN Joint Team on HIV and UN Team Group on HIV, including WHO, UNODC and UNAIDS within the UN Joint Programme of Support on HIV/AIDS to the Government of Ukraine for 2012-2016); Charitable Fund/ William J. Clinton Foundation in Ukraine (WJC Foundation); Open Society Institute (OSI); Eurasian Harm Reduction Network; Coalition of HIV-services organizations; Ministry of Health of Ukraine; Oblast State Social Services for Family, Children and Youth; All-Ukrainian Network of People Living with HIV/AIDS; HIV-services organizations and Steering Committee.

Duty bearers: Ministry of Health, State Department on HIV/AIDS and other socially dangerous diseases, Oblast State Social Services for Family, Children and Youth, Kyiv city, Dnipropetrovsk and Poltava oblast and city health administrations, All-Ukrainian Network of PLWHA, HIV-services organizations in the pilot cities that represent the interests of the drug-addicted women and provided outreach within the project.

Rights holders: Women, Adolescents, Youth, Babies.
Project duration: The project implementation commenced in 2011 and will end in January 2015.

PROJECT FUNDING
The main donor supporting the project is the Austrian government, which allocated around 277,000 US$ for the entire project period. The project has also being supported by HIV/AIDS Thematic Fund, Norwegian and German Governments and the project implementing partner WJ Clinton Foundation (WJCF) (Figure 4). The WJCF has contributed a total USD US$ 52,800 from their resources within the project cooperation agreements.
2. EVALUATION METHODOLOGY

2.1 EVALUATION FRAMEWORK

As describer earlier, the evaluation is formative in nature and as stated in the Terms of Reference (TOR) (ANNEX 8: TERMS OF REFERENCE), the evaluation examines the relevance, effectiveness, efficiency, impact and sustainability of the project and utilizes OECD DAC evaluation criteria as defined in the UNICEF guidance on equity-focused evaluations, 2011.

For achieving evaluation objectives, the evaluation framework (EF) (ANNEX 3: EVALUATION FRAMEWORK) has been developed. The EF structures questions stipulated in the TOR (see Table 2 below) as indicators that are measured or assessed during the evaluation. It also identifies the sources of information, methods the evaluation applied, the range of documents reviewed and key informants being interviewed.

The evaluation questions are informed by i) the UNEG guidance on how to integrate Human Rights HR & EQ considerations in evaluations and ii) UNICEF’s equity based evaluation. It examines to what extent the project benefited right-holders and strengthened the capacities of duty bearers and other key players to fulfill their obligations and responsibilities. The EF includes additional questions provided in bold and italic in Table 3 below.

Table 3: Evaluation Criteria

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<tr>
<th>Criterion</th>
<th>Questions/Sub-questions</th>
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| **Relevance** | - Was the project design relevant within the Ukrainian context: was this intervention in line with national AIDS priorities, strategies and goals?  
- To what degree has the project objectives been relevant to the priorities and needs of women and children, particularly the most vulnerable groups of children in Ukraine?  
- *The extent to which project is designed and implemented to align and contribute to the needs of duty bearers*  
- *The extent to which the project was relevant to the UNICEF mandate and its programming principles/strategy* |
| **Effectiveness** | - To what extent has the underlying theory of change been valid at this point? To what extent is the expected results chain occurring as planned?  
- To what extent has the design of the pilot model and its evolution, including type of intervention, the choice of beneficiaries, funding, and stakeholder/beneficiary involvement enabled to achieve the project’s defined objectives?  
- To what degree has the project contributed to removing bottlenecks hampering the improvement of MTCT rate in Ukraine?  
- Did the project result in better coverage, quality and uptake of services for pregnant drug dependent women in selected sites?  
- To what extent has medical and social services been integrated within the project and how has it made an effect on the project results?  
- To what extent have capacity-building activities for service providers resulted in service quality improvement and increase of PMTCT coverage?  
- *Were UNICEF inputs to the programme provided in a timely way?*  
- *How and to what extent has the programme management, coordination, partnership, and monitoring and evaluation contributed to the effectiveness of the project?* |
| **Efficiency** | - How cost effective are the project activities compared to similar activities in Ukraine?  
- Has the initiative used resources (funds, expertise, time) in the most economical manner to achieve the results?  
- *The extent to which the allocation of resources to target group takes into account the* |

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64 Evaluation Criteria  
65 The DAC Principles for the Evaluation of Development Assistance, OECD  
67 How to design and manage Equity–focused evaluations, UNICEF, 2011  
68 Questions in bold are additions to the questions stipulated in the Evaluation TOR
Apart from the EF the Program Results Framework (RF) has been used to demonstrate how project activities eventually resulted in achieving its objectives. During the inception phase the original Project’s Results Framework has been considered non-effective to measure project impact, outcomes and outputs, therefore the project’s Results Framework was revised (ANNEX 4 A: ORIGINAL RESULTS FRAMEWORK; ANNEX 4 B: REVISED RESULTS FRAMEWORK) filled in with available data obtained from original RF, project progress reports, national statistics as well as from available secondary data.

Formative evaluation of the project, which continues within the government framework, assessed what is the progress in delivering integrated services to date and how best it can be modified for further improvement and expansion of the programme through optimal use of limited resources. For this purpose, the evaluation used WHO Health System Framework70 (Figure 5). Through a holistic understanding of a health system’s building blocks, systems thinking helped to identify where the system succeeds, where it breaks down, and what kinds of integrated approaches will strengthen the overall system. By coordinating actions

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<th>Primary beneficiaries:</th>
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<td>- To what extent have the primary beneficiaries experienced increased access to various integrated services, or increased ability to demand/seek support?</td>
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<td>- To what extent have the primary beneficiaries satisfied with the quality of services available for them up until now?</td>
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<td>- To what extent have the primary beneficiaries perceived that their unique needs and sensitivities are reflected in the established services?</td>
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<td></td>
<td>- To what extent have the primary beneficiaries been able to take up (use) on the available services?</td>
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<td></td>
<td>- To what extent has the equity gap closed (or likely to close) in the access to services of vulnerable groups of drug using pregnant women?</td>
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<td></td>
<td>- To what extent has the gender, human and child rights and capacity-building issues, including cross sectoral cooperation between medical and social sectors, taken into account in the pilot model and to what extent have they have contributed to achieving of the results?</td>
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| Sustainability | - To what extent have partnership and stakeholders’ involvement at different stages of the project been decisive for the project in attaining its expected results up until now? |
|                | - To what extent has the project contributed to the advancement and the progress of fostering national ownership, engagement and capacity? |
|                | - Will the system change for improved access of pregnant IDUs and their infants be sustained in the country without support from UNICEF and other development partners? If not, what are the key factors and bottlenecks that may affect the sustainability of the results? |
|                | - Have national and/or local institutions shown technical capacity and leadership commitment to keep working with the project or to scale it up? |

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across different blocks of the health system, ICM can increase coverage and reduce barriers to the use of various services.

Effective scale up of the project to the national program should assemble packages of appropriate reforms in each of the six main building blocks of the health system (Figure 5):

- **Governance** of the health sector - to provide sectoral policy and regulatory mechanisms, and partnerships with the private sector;
- **Infrastructure and technologies** - required for quality service provision;
- **Human resources** - to scale up the availability of skilled personnel;
- **Financing** - to reduce financial barriers for patients and incentivize providers; and
- **Services** - to ensure quality and an appropriate configuration of maternal and child health services.

Utilization of the given framework permitted evaluation to formulate right mix of interventions for the health system that would ensure further improvement and expansion of the project through optimal use of limited resources.

To document lessons learned and good practices of the pilot project activities, along with evidence of outcomes, the evaluation draws conclusions, provides recommendations, and address broader questions on lessons learned, as shown in Box 1.

### 2.2 EVALUATION PROCESS

The evaluation was implemented in three phases. In the **Phase 1: Preparation Phase** the desk review was carried out and detailed evaluation design was completed including stakeholder mapping (key informants), evaluation and results frameworks, interview and focused group discussion guides, as well as a detailed plan for data collection, including selection of project sites and beneficiaries. The methodology and instruments were shared for validation to UNICEF CO, partners and other stakeholders.

**Phase 2: data collection/field phase** - A mission of around two weeks to the country was undertaken and all data collection exercises (qualitative as well as quantitative) were completed. At the end of the evaluation mission, the preliminary evaluation findings and recommendations were presented to the key stakeholders for validation.
Phase 3: reporting phase - based on the analysis of data collected from all sources the final draft evaluation report. The draft report was subject to a formal review process by stakeholders and UNICEF and incorporates recommendations and comments by the reviewers.

2.3 EVALUATION METHODS

The methodology comprised a mix of site visits and observations, face-to-face in-depth interviews, focus group discussions, desk-based research and review of existing reports, documents and available secondary data.

Desk review: Review of documents was a major part of the assignment. The desk review studied all program related documentation, legislative and normative documents, monitoring and evaluation reports, studies and researches performed as well as the qualitative and quantitative secondary data available around the themes of the evaluation. The list of documents reviewed is provided (ANNEX 1: PRELIMINARY LIST OF DOCUMENTS FOR DESK REVIEW).

Site visits: Field visits were organized to all four pilot project sites were in-depth interviews were carried out with local key stakeholders as well as visits to service provider facilities were performed.

In-depth Interviews (IDI): Prior to visiting key informants, IDI topic guides were developed based on the Evaluation Framework to help ensure systematic coverage of questions and issues. The interview topics were selected around the evaluation questions, but grouped and targeted according to the organization and/or individual to be interviewed. The objectives of IDI’s were twofold: i) Solicit stakeholders views on the key evaluation questions and ii) Gather data and other evidence that supports analysis. In total 61 key informants have been interviewed during the evaluation (ANNEX 2: LIST OF PEOPLE MET).

Focus group discussions (FGDs) were conducted as complements to the in-depth interviews, in order to elicit the range of opinions and perspectives on project elements. In the context of this evaluation, the FGDs served to capture the perspectives of service providers, as well as of beneficiaries. FGDs with service providers included staff of medical and social service institutions and outreach personnel and were conducted in each visited project site with service providers.

FGDs with beneficiaries brought together a mix of pregnant drug dependent women and their partners who i) received services under the project and ii) those who never utilized services at project sites. Service user intravenous drug dependent women where recruited with the help of social and outreach workers, whereas women who never used integrated services were recruited at OST sites. The purpose of FGDs with beneficiaries was to gauge the extent to which project support might have contributed to utilization of services, measure satisfaction as well as identify key bottlenecks/challenges and remaining unmet needs of the target population. Each FGD targeted eight to ten participants and lasted about 60 minutes. For each FDG the FGD guides were designed (ANNEX 6: FGD GUIDES) that directed discussions. FGDs were organized in all four sites visited and recruited about 32 target population in total and about 10 partners/family members, however upon drug dependent women’s request both, project clients and non-clients were put together for FGDs. Verbal consent was obtained form each FGD participants using the standard consent text (ANNEX 6.6 FGD PARTICIPANT’S CONSENT).
The FGDs were conducted as informally as possible at the clinic or service they were attending. Although it was originally planned FGDs to be tape-recorded and afterwards transcribed in verbatim, participants did not provide consent for tape-recording therefore field notes were taken directly after each FGD. Key points in the transcripts were categorized using content analysis\textsuperscript{71,72}. Care was taken to ensure that all selected quotations, following a particular statement of text, are from different individuals. The evaluation adopted a policy of not noting the origin of each quotation to ensure confidentiality of respondents.

**Quality Assurance and Triangulation of findings** - Both quantitative and qualitative data was analyzed to assess evaluation domains and criteria. Findings based on qualitative data were triangulated across key informants, compared with available documentary evidence and validated in the focus groups before drawing conclusions and formulating recommendations.

Qualitative data analysis entailed documentation, conceptualization, coding, and categorizing, as well as examining relationships. More specifically, the qualitative data allowed obtaining in depth perspective on context, actors and processes related to the project design and implementation and testing/identification of the factors shaping the pattern of project contribution. Information derived from each of the sources of qualitative and quantitative data used at every stage of the study was triangulated within and between data sets with the aim of identifying common understandings of the experiences of issues at focus, as well as differences of opinion between various stakeholders. Following triangulation, the data sets were used to develop specific analyses, such as timelines summarizing the chronology of program implementation, descriptions of particular processes used in the design or implementation of the programs and stakeholder analyses of actor positions on specific features of the design and implementation at specific time.

For the analysis of project impact, outcomes and outputs, the data collected from project M&E database and government was used. The data from various sources has been examined and analyzed to answer main questions of the evaluation. Responses from each data source were compared in order to identify discrepancies. To account for the data quality and assess the strength of conclusions the “robustness scoring” approach was used for each finding. Consequently, four score (A to D) robustness matrix was developed and used in this process (Table 4).

**Table 4: Robustness Ranking for Evaluation Findings**

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<th>DESCRIPTION</th>
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<tr>
<td>A</td>
<td>The finding is consistently supported by the full range of evidence sources, including quantitative analysis and qualitative evidence (i.e., there is very good triangulation); and/or the evidence source(s) is/are of relatively high quality and reliable to draw a conclusion (e.g., there are no major data quality or reliability issues).</td>
</tr>
<tr>
<td>B</td>
<td>There is a good degree of triangulation across evidence, but there is less or ‘less good’ quality evidence available. Alternatively, there is limited triangulation and not very good quality evidence, but at least two different sources of evidence are present.</td>
</tr>
<tr>
<td>C</td>
<td>Limited triangulation; and/or only one evidence source that is not regarded as being of a good quality.</td>
</tr>
<tr>
<td>D</td>
<td>There is no triangulation and/or evidence is limited to a single source and is relatively weak; or the quality of supporting data/information for that evidence source is incomplete or unreliable.</td>
</tr>
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\textsuperscript{71} Gilham B, The Research Interview. London Continuum, 2000
source of evidence (e.g., as determined by sample size, reliability/completeness of data, etc.). Table 4 shows detailed description for “robustness score” assignment.

**Data sources** - The four major sources of data were used during the Evaluation.

- **People** Individuals were consulted through individual (in-depth) interviews and focus groups;
- **Site visits** - Data collected during the visits to sampled project supported sites.
- **Documents** - All project and thematic area related documents (primary and secondary data sources) had been reviewed.

### 2.4 EVALUATION LIMITATIONS

The evaluation experienced number of limitations:

- Recent political events in Ukraine followed by restructuring of the government, limited participation of some key policy makers and most knowledgeable key informants at the Ministry of Health, Ministry of Social Policy and other government institutions in the evaluation process. The evaluation tried to reach all, former staff members as well as those that still remained in these structures.
- Due to the annual leave season some of the key informants being directly involved in the project were not available for semi-structured interviews. Some of these stakeholders have been reached after their return and interviewed through Skype.
- Due to time and budget constraints, the proposed evaluation method did not include an extensive population-based survey, but largely relied on service statistics, qualitative data collected through interviews and focus group discussions as well as secondary quantitative data available. This limits the evaluation’s ability to measure the programme outcomes in strict quantitative terms.
- Limited number of social (one per facility) and outreach workers (1-2 per site) restricted the evaluation to form a group for focus group discussions rather they have been interviewed individually.
- In addition, “Ethical Committee” approval was not possible to obtain due to ongoing reform of the executive branch of the government and identification of responsible institution for granting approval. However, UNICEF discussed the data collection methodology, particularly FGD, with the State Agency for HIV/AIDS and other socially dangerous diseases and obtained verbal consent for qualitative data collection from direct beneficiaries (ANNEX 6.6 FGD PARTICIPANT’S CONSENT).
- In order to assess cost effectiveness of the project interventions, attempt was made to assess project inputs (financial) relative to spending of different projects implemented by partners. To make this comparison more meaningful, evaluation tried to obtain disaggregated expenditure for similar activities and compare project’s investments into training and technical assistance & monitoring with the comparable spending. Extensive efforts to obtain disaggregated comparable data from partners proved impossible. Therefore in this section evaluation only focuses on project-specific financial data to determine their relative financial efficiency.

### 2.5 STAKEHOLDER PARTICIPATION AND ETHICAL ISSUES

In order to develop ownership and ensure the involvement and interest of the stakeholders for sustainable changes and future developments, the evaluation was conducted in a
participatory way, involving policy makers, program staff, service providers and partners’ staff, beneficiaries and their partners and other people directly or indirectly involved in the project.

The evaluation ensured active participation of key stakeholders in all phases of the evaluation process. The preliminary evaluation findings and recommendations were presented and verified at the meeting with State Agency on HIV/AIDS and Other Socially Dangerous Diseases before final version of the report was produced. In close consultation with UNICEF the evaluation comments, suggestions and clarifications provided by the stakeholders have been adequately addressed in the evaluation report. Moreover, initial draft of the final evaluation report has been shared for comments and feedback received were reflected in the final report.

During the evaluation process impartiality and independence was ensured at all stages of the evaluation process, which contribute to the credibility of evaluation and the avoidance of bias in findings, analyses and conclusions. Furthermore, a maximum level of objectivity was ensured. Statement of facts is methodically clearly distinguished from assessments, the different perspectives taken into account, as well as strengths and weaknesses, results, conclusions and recommendations are supported by evidence. To guarantee reliability of the evaluation findings, the evaluation utilizes all available data in order to prove the assessment and the conclusions in a credible fashion.

The evaluation methodology was based on the UNEG ethical guidelines for evaluation73 and the following approaches were utilized:
- The FGD and in-depth interviews were kept as brief and convenient as possible to minimize disruptions in respondents work process.
- Key informants were interviewed face to face without presence of other individuals and their identities are not revealed and or statements attributed to a source.
- Participants were informed and allowed to make informed decision on participation in the evaluation. Key informants and FGD participants, particularly IDU women and their partners were informed about the purpose of evaluation and final outcome as well as the process and duration of interview and/or FGD.
- The respondents and FGD participants were informed about the confidentiality of the source for obtained information and allowed them to retain from answering the questions posed in case they felt uncomfortable to respond; The FGDs were conducted as informally as possible at the clinic or service they were attending.
- As for the FGD, to encourage open discussion around the evaluation questions the grouping was applied by avoiding presence of their superiors. Participants recruited for FGDs were mostly between 18-35 years old not requiring parents’ consent.
- Information was analyzed and findings reported accurately and impartially.
- As “Ethical Committee” approval was not possible to obtain due to ongoing reform of the executive branch of the government and identification of responsible institution for granting approval, the verbal clearance for qualitative data collection from direct beneficiaries was obtained from the State Agency for HIV/AIDS and other socially dangerous diseases as well as verbal consent was obtained from participants of FGDs.

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73 UN Evaluation Group Ethical Guidelines for evaluation, March 2008 http://www.unevaluation.org/ethicalguidelines
3. EVALUATION FINDINGS

3.1 RELEVANCE

This section examines the relevance of the project against: i) relevance to country’s HIV epidemic situation and priorities as outlined in national strategies and policies; ii) relevance of program specific objectives to the priority needs of women and children in general and particularly of vulnerable and most at risk groups as evidenced by the available data; and iii) relevance to the UNICEF mandate and its programming priorities and summarizes the information derived from the desk review and key informants interviews. Evaluation findings presented below are structured in a way to provide answers to the questions outlined for the given criterion in the Box 2 and Evaluation Framework.

Box 2: Relevance Evaluation Questions

- Was the project design relevant within the Ukrainian context: was this intervention in line with national AIDS priorities, strategies and goals?
- To what degree has the project objectives been relevant to the priorities and needs of women and children, particularly the most vulnerable groups of children in Ukraine?
- The extent to which project is designed and implemented to align and contribute to the needs of duty bearers
- The extent to which the project was relevant to the UNICEF mandate and its programming principles/strategy

RELEVANCE TO UKRAINIAN CONTEXT

Since 2001 Ukraine has achieved a significant progress in prevention of mother-to-child transmission of HIV (PMTCT). Implementation of the national strategy of PMTCT programme is the only prevention intervention in Ukraine that covered the major proportion of its target group with high quality interventions and led to the reduction of frequency of mother-to-child transmission of HIV (MTCT) rate. Since 2001, during the period of PMTCT programme implementation in Ukraine, the frequency of mother-to-child transmission of HIV has been reduced 6-fold, from 27.8% in 2001 to 4.3% in 2011.74 Of 4,003 children born to HIV infected mothers in 2011, HIV diagnosis was established for 136 children; 3,537 children were removed from medical check-up lists due to the absence of HIV-infection; 330 children remained with HIV diagnosis to be confirmed because their parents refused from examination, or because the place of residence of children was unknown and there was a need to perform a further follow up for the child to confirm his or her HIV status.

In spite of a certain progress of the PMTCT programme, Ukraine still has serious challenges that need to be addressed. The largest number of HIV infected children live in the regions with high HIV prevalence where epidemic process is fuelled by the transmission of the virus in most-at-risk populations, first of all, among injecting drug users (IDUs).

Current trends of HIV epidemic development suggest that on the background of ‘feminization’ of the epidemic one can expect a further growth of the numbers of children born to HIV infected women, and it requires to ensure a permanent monitoring and to timely implement PMTCT interventions.

74 Ibid 39. The latest data available is for year 2012 as MTCT rates are calculated when a child reaches 18 months.
Within the global strategy of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) on elimination of mother-to-child transmission of HIV, Ukraine as one of the UN member states committed to strengthen and scale up the PMTCT programmes by 2015.

In 2012 the Government of Ukraine conducted an evaluation of the National Programme on Prevention of HIV Infection, Treatment, Care and Support to HIV Infected and AIDS Patients for 2009-2013, approved by the Law of Ukraine #1026-VI as of 19.02.2009 (NPHA), which helped to identify obstacles to key intervention of epidemic response, including the sphere of prevention of mother-to-child transmission of HIV in Ukraine. The given assessment was followed by the initiated and supported by UNICEF study of socio-demographic factors that contribute to the transmission of virus to the newborns, as well as medical aspects of vertical transmission. The results of this study demonstrated that the sub-group of drug using women was the most vulnerable to mother-to-child transmission of HIV during pregnancy and/or labour. They experience limited or no access to health and social services, demonstrate low coverage and adherence rates to ART and OST, and are learn about their HIV-positive status right before delivery or during the second test for HIV. These findings confirm relevance of the subject project to the national context, its importance in targeting drug addicted pregnant women and the meeting their needs through introduction of integrated services.

Relevance to priorities and needs of right holders - The project is consistent with the needs, interests and circumstances of the vulnerable and most at risk groups of women, particularly of drug dependent pregnant women. As described in introduction section of the report drug dependent pregnant women face access barriers to required health and social services due to the stigma and discrimination from society, family members and particularly of health professionals, fragmented provision of different health and social services, fees required for services such as laboratory tests, consultation, diagnostics, medical consumable and medicines for treatment, etc. The ICM design addresses majority of barriers experienced by the target group.

Relevance to needs of duty bearers - The design of the ICM allows duty bearers for provision of comprehensive quality health and social services to the drug dependent pregnant women. The project entails setting of enabling environment for the provision of quality services, development of service standard guidelines and protocols for effective management of pregnant drug dependent women and capacity building of the health and social service providers as well as NGOs working with drug dependent individuals, leading to elimination of discrimination and stigma associated to HIV and drug use in Ukraine so that right holders fully benefit from health and social services provided to them and their children.

Relevance to National AIDS Program – The State Program to ensure HIV prevention treatment, care, and support to HIV-positive people and patients with AIDS for years 2009-2013 (National AIDS Programme) is the key national strategic framework that guided the national response to the HIV epidemic in Ukraine. The National AIDS Programme (NAP) was adopted as a law by Verkhovna Rada (the Parliament of Ukraine) and ratified by the President of Ukraine on 19 February 2009. It sets forth Ukraine’s national response to the HIV epidemic by defining clear objectives and expected results to be achieved within an

agreed timeframe to reduce the level of HIV prevalence and the number of AIDS related deaths in the country. Moreover, it introduces the detailed plan of activities to be implemented within this timeframe for scaling-up towards universal access to HIV prevention, treatment, care and support to all people living with and affected by HIV. The priorities set out by NAP cover four key programme areas: prevention; treatment; care and support; and organizational support and development.

Figure 6: Project relevance to national priorities

More specifically, NAP aims at (Figure 6):

- Enhancing the mechanism for preventing mother-to-child transmission (MTCT) of HIV
- Scaling up access of people who inject drugs to substitution maintenance treatment (SMT) and rehabilitation programmes
- Providing people living with HIV with antiretroviral treatment (ART) in accordance with relevant standards and clinical protocols
- Providing social services, ensuring social and psychological support to and non-medical care for people living with HIV and patients with HIV-related illness.

Furthermore the project continues to be relevant to the most recent NAP “National Target Social Program in Response to HIV/AIDS for 2014-2018” adopted by Verkhovna Rada and ratified by the President on 20th of October 2014.\(^7\)

Relevance to UNICEF mandate - The Program exhibits its relevance to UNICEF mandate, program principles and strategies. The programme is in accordance with the UNICEF global programme on HIV/AIDS, which aims to increase access to and use of proven HIV prevention

\(^7\) Law No 1708-VII
and treatment interventions by all children, pregnant women and adolescents. It is further framed by the UNICEF Country Programme Document 2012-2016 for Ukraine, in particular under the ‘Protective and Inclusive Services’ component which seeks to ensure that excluded children, adolescents and women benefit from quality health and social services by the end of 2016. This program area was expected to contribute to the National AIDS Program (2009-2013) objective of enhancing the mechanism for preventing mother-to-child transmission (MTCT) of HIV.

The model of integrated care proposed by the pilot project under evaluation directly responds to four relevant objectives of the National AIDS Program (2009-2010) of Ukraine as schematically presented on the Figure 6 above.

The project is delivered through advocacy and partnership, policy work, strengthened monitoring and evaluation systems, through changing societal norms and values and through advocating for child rights demonstrated by mapping the inputs necessary for the delivery of YFHSP intervention package onto UNICEF’s Core Roles (Table 5 below).

**Table 5: Project contribution to UNICEF Core Roles**

<table>
<thead>
<tr>
<th>UNICEF CORE ROLES</th>
<th>YFHSP PROGRAM INTERVENTIONS</th>
<th>SIGNIFICANCE</th>
</tr>
</thead>
</table>
| 1 | The ‘Voice’ for children and adolescents – Advocating and communicating around key national policies, social issues, mindsets and attitudes | Advocacy to:  
- In pre-pilot phase UNICEF advocated the policy makers on importance of integrated approach as key instrument for elimination of the MTCT  
- Presentation of the project concept to the policy makers (State Service on HIV, MoH, UCDC and local health authorities)  
- Discussion of the integrated approach as key instrument for elimination of the MTCT Technical working group on PMTCT  
- Presentation of the concept and model to the Local Governments and Health Authorities | HIGH |
| 2 | Monitoring and evaluation – Assisting independent assessments of the functioning of the Child Rights guarantee systems, the progressive realization of child rights and the reduction in equity gaps in child well-being; | - Pilot Program Mid Term evaluation (2012)  
- Selected indicators of the ICM were developed and integrated in the state medical statistical reporting system  
- Quarterly Programmatic reporting was closely monitored  
- A special studies and researches including Socio-demographic determinants, population size estimates etc., were carried out throughout the project | MODERATE |
| 3 | Policy advice and technical assistance – through well-designed UNICEF positions (based on local, regional, international best practices) on key issues, supporting the development of the normative frameworks related to specific national legislation, policy or programme as well as private sector standards that can improve equity | - Initiation of existing PMTCT policy framework revision  
- Participated and provided technical assistance in the development of the PMTCT guidelines and protocols with the new focus on the target group  
- The cost estimation of ICM services for drug addicted pregnant women was developed and is planned by the authorities to use for budgeting purposes  
- Initiated piloting of WHO standard screening tool for timely identification of addiction in pregnant women  
- ICM model integrated in the National HIV Program 2014-2018 | MODERATE |
<table>
<thead>
<tr>
<th>EVALUATION QUESTION</th>
<th>FINDINGS</th>
<th>ROBUSTNESS RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the project design relevant within the Ukrainian context: was this intervention in line with national AIDS priorities, strategies and</td>
<td>The project design is relevant to Ukrainian context, is in line with National AIDS program, its objectives and priorities</td>
<td>A</td>
</tr>
</tbody>
</table>

**SUMMARY OF FINDINGS ON RELEVANCE**

| MODERATE |

- **Leveraging resources from the public and private sectors**
  - Accompanying and redirecting reforms, including those supported by the EU, IFIs, bilateral and national/multi-national corporations;
  - UNICEF obtained funding from Austrian government and other donors
  - Leveraged resources from partners such as W. Clinton Foundation in support of the pilot project
  - PMTCT policy revision and ICM costing was carried out with financial support from UNAIDS
  - Safeguarded public funding for ICM in pilot cites from local governments
  - The ICM model has supported by other CSOs and international implementing agencies financed through the Global Fund, Soros Foundation and other donors.

- **Facilitating national dialogue towards child friendly social norms**
  - Bringing together government, private sector and civil society, as well as convening divergent forces to enhance public debate, participation and action around equity and child rights
  - Facilitated partnership between the state and civil society organization

- **Enabling knowledge exchange**
  - Fostering horizontal cooperation and exchange of experience among countries and regions on ‘what works’ for enhancing child wellbeing and equity.
  - The pilot project was presented at International Harm Reduction Conference in 2013, Vilnius, Lithuania
  - Project ensured knowledge exchange horizontally at annual National HIV Conferences since 2010.
  - Study tour to Scotland in 2011 to learn the best model of ICM for drug user pregnant women
  - One week training course on Management of drug addicted pregnant women in Salzburg, Austria was organized for health providers, NGOs social worker and local health authorities twice during the project implementation (2012 and 2013)
  - The case study on the results of the pilot was selected by UNICEF HQ “as a best practice case in child protection” and will be published shortly

- **Modeling/piloting**
  - Demonstrating how system could meaningfully evolve to reduce equity gaps and children’s rights violations
  - Project ensured vertical (policy, political, institutional) and horizontal (replication and geographical expansion) expansion of ICM pilots

- **SUMMARY OF FINDINGS**

  - Findings are substantiated through document review (National AIDS Program, CPAP, Progress Reports, etc.) and supported by
<table>
<thead>
<tr>
<th>Questions</th>
<th>Findings</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what degree has the project objectives been relevant to the priorities and needs of women and children, particularly the most vulnerable groups of children in Ukraine?</td>
<td>The project objectives are relevant to priority needs of drug dependent women in general and drug dependent pregnant women and children born to them in particular.</td>
<td>Findings are substantiated through documentary review and supported by qualitative data from FGDs and Key stakeholders.</td>
</tr>
<tr>
<td>The extent to which project is designed and implemented to align and contribute to the needs of duty bearers</td>
<td>The project design also addresses and contributes to the needs of duty bearers</td>
<td>Findings are substantiated through documentary review and supported by qualitative data from FGDs and Key stakeholders.</td>
</tr>
<tr>
<td>The extent to which the project was relevant to the UNICEF mandate and its programming principles/strategy</td>
<td>The Project exhibits its relevance to UNICEF mandate, program principles and strategies</td>
<td>Findings are substantiated through review of UNICEF programmatic/strategy documents and supported by qualitative data obtained from (CPAP, AWP, M&amp;E Reports, etc.).</td>
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</tbody>
</table>
3.2 EFFECTIVENESS

This section of the report focuses on the evaluation of the project effectiveness by examining effectiveness of program design, implementation and management structures; effectiveness in removal of bottlenecks and creating the program ownership of right holders and right bearers. Findings are presented to provide answers to the questions outlined for the given criterion in the Box 3 below and Evaluation Framework.

Box 3: EFFECTIVENESS EVALUATION QUESTIONS

- To what extent has the underlying theory of change been valid at this point? To what extent is the expected results chain occurring as planned?
- To what extent has the design of the pilot model and its evolution, including type of intervention, the choice of beneficiaries, funding, and stakeholder/beneficiary involvement enabled to achieve the project’s defined objectives?
- To what degree has the project contributed to removing bottlenecks hampering the improvement of MTCT rate in Ukraine?
- Did the project result in better coverage, quality and uptake of services for pregnant drug dependent women in selected sites?
- To what extent has medical and social services been integrated within the project and how has it made an effect on the project results?
- To what extent have capacity-building activities for service providers resulted in service quality improvement and increase of PMTCT coverage?
- Were UNICEF inputs to the programme provided in a timely way?
- How and to what extent has the programme management, coordination, partnership, and monitoring and evaluation contributed to the effectiveness of the project?

VALIDITY OF UNDERLYING THEORY OF CHANGE

The validity of theory of change (TOC) has been assessed to identify whether project’s underlying theory of change or assumptions were correct by analyzing the causal chain. Results of TOC validity analysis inform the evaluation findings on whether the success, failure or mixed results of the intervention was due to project theory and assumptions, or implementation.

As formulated in the original project TOC (Figure 3), the pilot project aims at keeping drug using woman alive with her HIV negative child and is supported by community and government through ensuring achievement of following three objectives (labeled as results in original TOC): i) pregnant drug using women and her children receive support from community and family, ii) the harm of street drugs to pregnant women, fetus and infants are reduced, and iii) discrimination of pregnant women using drugs in health care settings are eliminated and they fully benefit from health and social services provided to them and their children in integrated manner.

Based on identified challenges and bottlenecks faced by target population in accessing health and social services described in the introductory chapter of the report, introduction of the model of integrated health and social service provision which ensures non-discriminatory attitudes of health and social service staff, provision of comprehensive quality health and social services to the target beneficiaries is considered to be an appropriate intervention. Integrated care model is assumed to increase an uptake and utilization of services by the one of the most marginalized and stigmatized group of population such as
drug using women. Expected improved access to and utilization of integrated health services will eventually result in decrease of MTCT rates among target population thus keeping women alive with her HIV negative child.

The TOC considers that design, introduction and institutionalization of ICM can be achieved through production of the following outcomes: i) Design of ICM that meets target beneficiary needs and is informed by the best international practices; ii) Availability of enabling legal and policy framework alongside with protocols for drug using pregnant women management by health and social services; iii) capacity building of qualified health and social workers for provision of quality services to pregnant IDU women; iv) Ob/ Gyn, neonatologists, HIV specialists and social workers from harm reduction NGOs working as multidisciplinary team guided by Case Managers; iv) IDU pregnant women report change of healthcare worker attitudes at ANC and maternities; v) Uptake and adherence to PMTCT services by drug using pregnant women improved; and vi) Pregnant women and young mothers using drugs receive social support and keep custody for their children.

The TOC also assumes that production of following outputs will ensure achievement of stated outcomes: i) IDU population size assessment conducted and national estimates established; ii) Inception workshop among policy makers conducted and strategic partnership between government and civil society organizations established; iii) Pilot project to build integrated services for pregnant IDU women approved by MoH Decree and sites identified; iv) Learning visit to Scotland to learn from 30 years’ experience to work with IDU women and series of capacity building workshops at pilot sites carried out; v) Changes in infrastructure for OST service delivery became available at ANC clinics and maternities. NGOs start to refer pregnant IDU women to project sites.

**SELECTION OF PILOT PROJECT SITES**

The selection of pilot sites was guided by two main criteria such as HIV prevalence in pregnant women and commitment of local governments to introduce ICM. Based on epidemiological data three pilot sites – Kyiv, Dnipropetrovsk and Donetsk were selected for the initial phase of the pilot project implementation. However Government of Donetsk did not express any interest and commitment to the implementation of the pilot project, whereas Poltava government showed determination and ensured full commitment to the introduction of the new service model (Figure 7). Therefore the MoH and UNICEF made decision to change Donetsk to Poltava, though the latter was characterized with medium prevalence rate of HIV in pregnant women. Starting from 2013, the ICM was replicated in Kryvyi Righ on the initiative of Dnipropetrovsk government.

**Figure 7: Project sites**

PREVALENCE OF HIV IN PREGNANT WOMEN

Source: MoH, UCDC
PILOT PROJECT IMPLEMENTATION

The project implementation commenced in June 2011. Over the life span of the project (2011-2014), the pilot was implemented in three phases (Figure 8). The initial phase (June - December 2011) aimed at assessment of situation and design of the most appropriate and feasible service delivery model.

Figure 8: Road map of pilot ICM model implementation

UNICEF carried out number of advocacy activities along with roundtable discussions and workshops with wide participation of stakeholders. As a result, a need for establishment of two types of service model for drug-dependent pregnant women and their children in pilot districts have been identified.

- **Model 1: ‘Under one roof’** type of model was recommended for small cities. According to the model, integrated services, antenatal care, including HIV testing and counseling on PMTCT, management of pregnancy, labour and postpartum period, management of withdrawal syndrome in newborns, and psychosocial counseling were provided at one facility.
- **Model 2: ‘Two sites’** type of model. This type of model was recommended for big cities to ensure geographical access to target groups.

The Orders issued by the national and local health administrations related to the introduction and piloting of integrated medical services for the drug addicted women, established basic enabling legal environment (including the MOH order # 623 dated 27.09.2011) (Figure 9).
In the 1st phase – pilot phase of the project (2012 – 2013) the pilot was launched in three cities of Ukraine – Kiev City, Dnipropetrovsk and Poltava and ensured provision of essential equipment, drugs and medical supplies to new sites as well as building capacity of service providers. Cities varied in size, therefore both proposed models were applied. In Poltava Model 1 “under one roof” has been introduced, while the Model 2 “two sites” was more considered more relevant to Dnipropetrovsk and Kiev cities.

Two sites established in Dnipropetrovsk were: Dnipropetrovsk Clinical Hospital # 9, offering antenatal care and Medication Assisted Treatment (OST); and Dnipropetrovsk City Maternity Hospital #1, providing antenatal care, hospital treatment, and delivery, postpartum and postnatal care for mothers and infants for all projects’ clients, including those who referred from Dnipropetrovsk’s Clinical Hospital # 9. It makes services more accessible and convenient for clients.

A ‘two sites type of model’ was also established in Kiev. The Kiev City Centre of Perinatology and Reproductive Health (KCCPRH) provide all types of antenatal and perinatal services. The additional site in Kyiv became operational at the Consultative Diagnostic Centre #1 of Darnytsky district.

During the pilot phase the project mainly focused on introduction of integrated medical services through 1) Capacity building of health services providers, i.e. building knowledge about and development the skills in needs identification of drug-dependent women and their infants; 2) Strengthening of linkages and partnership between the state and civil society organizations, the precondition for effective identification of the clients and improvement of referral system, which includes: client’s referrals to Centers of Integrated Care (CIC) from NGOs and State Social Services for Family, Children and Youth and social support for drug-dependent women and children born to them by the NGOs and State Social Services for Family, Children and Youth; 3) Support of technical capacity of the established CIC; 4) Gathering the data and analyzing of the experience and lessons learned within the project for its further implementation. Monitoring of the project allowed observing the
dynamics of the coverage of pregnant drug dependent women and children born to them with services and care provided; v) Strengthening technical capacity of the project sites through provision of essential medical equipment, medicines and supplies, enabled to provide services for drug-addicted pregnant women. Three counseling rooms in Dnipropetrovsk, Poltava and Kiev sites were renovated to ensure appropriate conditions required for provision of MAT for drug dependency treatment.

The 2nd phase of the project, which started from mid 2013 – 2014, was largely informed by the assessment of the pilot phase. Taking into account the recommendations of the assessment, the second phase of the project planned mainly to focus on:

- **Expansion of target group and outreach activities as well as geographical location of project.** The project has been expanded to Kryvyi Rih on request and initiative of the Dnipropetrovsk local government, the city being most affected by HIV and drug abuse and with high needs in gender sensitive services provision.

- **Enhancement of service integration:** maintaining and strengthening linkages between PMTCT and harm reduction services, including Medication Assisted Treatment (OST), family planning and STI prevention services for pregnant drug addicted women and social services for children born to them. This was planned to be achieved through development and introduction into a practice the model of case management, including clients, medical and social workers and the community organizations that was introduced in four cities.

- **Improvement of a service quality provided by CICs** through training for medical and social workers in management of pregnancy and provision of integrated services to drug-dependent pregnant women and children born to them.

- **Continuation of massive informational campaign,** to enroll more clients to the project and promote the rights of service users for appropriate nonjudgmental services, thus enabling easy access to treatment and continuity of care through development and distribution information brochures on service availability, location and procedures for utilization of integrated services. NGOs, peers, Family Physicians, Diagnostic and consultancy centers, Reproductive Health/Family Planning centers, AIDS centers, TB centers, Youth Friendly Clinics, and narcology centers were proposed to be used as distribution sites;

- **Intensification of advocacy efforts to ensure sustainability of integrated care model and promoting the “top down” integration,** which is mandated to include integrated care model by the national level, defining the integration policies and funding models, thus ensuring model sustainability through round-table discussions, stakeholders meetings and participation in development of the national and local regulations.

- **The development and enactment of the project’s M&E framework** that measures quantitative and qualitative indicators. The data obtained within the project was planned to be used for the national system of indicators detailing the target population, treatments, care provided and outcomes. The anonymous patient surveys that measure knowledge, attitudes and practice as well as satisfaction with quality of service provision and level of social assistance and support was planned and conducted.

**PROJECT DESIGN AND BOTTLENECKS ADDRESSED**

The design of Integrated Care Model attempted to address all system barriers identified during the situation analysis described below.

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28 T. Gotsadze, Assessment of the pilot “PMCTC and improvement of neonatal outcomes among drug dependent pregnant women and children born to them in three cities of Ukraine”, 2012
Fragmentation and lack of coordination between health and social services - The project focused on introducing integrated services for drug addicted pregnant women by establishing Centres for Integrated HIV Prevention, Care and Support Services.

Figure 10: Integrated Service Provision Model

CICs provide a range of medical and psychosocial services to drug addicted women and their children: offering antenatal care, HIV testing and counseling, ARV treatment to prevent HIV transmission from mother-to-child, assisting in delivery, postnatal care, and treatment of neonatal withdrawal syndrome, drug dependency treatment, psychosocial and legal counseling as well as social support to families (Figure 10).

Access to and timeliness of health services was identified as one of the major reason for increasing MTCT rate in Ukraine. To minimize this bottleneck, the ICM model considered proactively identifying drug dependent pregnant women at early phase of pregnancy and encouraging recruitment into the project through using NGO outreach workers and peer support groups along with adverts on availability of such services. Since the pilot project commencement in 2011, 231 women had been enrolled in the project by time of evaluation (Figure 11). The project used a variety of methods to reach new clients for the service, including through NGO outreach and social workers, outreach van, needle/syringe exchange points, peer support groups, medical professionals (particularly antenatal care doctors), social workers and advertising.
Among participants of FGDs, some have seen adverts about services, friends who had heard of it or were using services had referred other, and some were referred from antenatal care clinics and other by social workers. Use of peer social workers is particularly effective, given personal experience of the issues faced by pregnant drug using women as women stated, “Some people need to be taken to OST clinic by the hand”. However, as the assessment of the pilot project\textsuperscript{79} and interviews with stakeholders showed, recruitment has been slower than expected. In response, the project intensified its communications. Namely, continued an information campaign in the project cities approaching health care institutions, NGOs, rehabilitation programs and commercial drug treatment centers and established partnership relationships.

An important element of the campaign was project presentations, sharing the key objectives and outcomes of the program. These presentations were conducted at: thematic professional trainings organized by municipal health departments in Kyiv, Dnipropetrovsk, Poltava and Kryvyi Rih cities; informational sessions for pregnant women organized by Pechersk outpatient district clinic (Kyiv); thematic meetings in Kyiv City Social Services for Family, Children and Youth Center; thematic meetings at NGOs Convictus, Krok za Krokom, Kyiv PLHA Network branch, Health right, Drop in Center, Club NA (Eney); drug dependent women self-support groups meetings; and at Poltava NGO Svitlo Nadii, at Kryvyi Rih NGO Public Health. In addition printed project booklets and “Mommy, Baby, Methadone” brochures and wall posters containing essential information about the project. The informational materials were distributed in the city of Kyiv according to the distribution plan provided by Kyiv City Health Department. The plan included Youth Friendly clinics, Kyiv City Maternity Hospital # 3, Kyiv City Reproductive and Perinatal Medicine Center, Kyiv City Maternity Hospital # 5, District Health Departments in Holosiivskyi, Darnytskyi, Desianskyi, Dniprovskyi, Obolonskyi, Pecherskyi, Podilskyi, Sviatoshynskyi, Solomianskyi and Shevchenkivskyi districts for further distribution in outpatient and inpatient clinics and maternity hospitals located in each territory. In DP the materials were distributed among 12 primer medical care centers and also via Dnipropetrovsk region Health Department and NGOs Nadiya Plus, Doroga Zhyttia, PLHA; in Poltava – among 10 primer medical care centers, an NGOs Svitlo Nadii; in Kryvyi Rih – among primer medical care centers, Social Services and an NGO Gromadske Zdoroviya.

\textsuperscript{79} T. Gotsadze, Assessment of the pilot project “PMTCT and improving neonatal outcomes among drug dependent pregnant women and children born to them in three cities of Ukraine”, 2012, UNICEF
The analysis of the project data displays 62% of project clients out of total 231 in all project sites, being enrolled through NGO outreach workers, 17% referred by the health facilities, particularly antenatal clinics, 13% were self-referrals whereas 8% of project client were recruited through maternities when their HIV and drug status was diagnosed during deliveries (Figure 12). These data shows importance of strong NGO presence to be a prerequisite for client recruitment into the project. Nevertheless, of all efforts put in place to increase coverage, the effectiveness of each method used has not be assessed by the project.

The project was not successful in early recruitment of clients, as only 9% of pregnant drug dependent women have enrolled in the project during the first trimester of pregnancy and 9% during the labor as shown on the Figure 13. Although the total number of pregnant women that enrolled in the first trimester of gestation is low, the project managed to gradually improve early identification and enrollment of pregnant drug using women them into the project as demonstrated by annual increase of number of such clients (Figure 14).

If in the first year of the project only 4 women were enrolled in the first trimester, the number quadrupled in 2012. During the first six-month in 2014, 12 (63%) women were recruited in the first trimester compared to 19 cases during the entire year in 2013.

The pregnant women without known HIV status were provided pre-test counseling, testing and post-test counseling. The number of women without HIV status accounted a total of 22 women (10% of total project clients). Every second women (52%) enrolled in the project were HIV positive and the project assisted women to start antiretroviral therapy (ART) and provided regular monitoring and counseling on the importance of adherence to ART. Participants of FGDs confirmed that physicians at ANC clinics regularly provided counseling on importance of adherence to ART.

*Every time I visited clinic doctor asked whether I regularly take my pills and explained that if I take them regularly I have a chance that my child will not be infected....*.”

*Quote from FGDs with project client*
In initial phase of the project, drug using pregnant women enrolled in the project experienced difficulties accessing state provided OST services on time due to non-eligibility (eligibility criteria were two prior inpatient detox attempts, age >18 years and long term (> 5years) use of drugs), or because they were put on a waiting list requiring almost 3 years to get on the program.

These issues were brought up to the attention of the policy makers and discussed by the project-implementing partner, NGOs, other partners active in OST and UNICEF, which resulted in revision of respective regulation granting free access to OST services to pregnant women.

The project demonstrates high enrolment of project clients into OST. Based on project data analysis for the period of 2011 and first six month of 2014, out of total number of clients on OST 85% started OST after being recruited in the project (Figure 15). The highest number of clients (27 women) enrolled in OST has been registered in Kiev along with 32 women recruited by the project who already were on OST.

Remaining project sites show almost 100% enrollment of clients in OST by the project, though numbers are rather low.

**Cost of health services** has been acknowledged as one of the barriers hampering women’s access to health services. The integrated health service provision models being established in public institutions and being financed from the local government in theory should be free of charge. However, health sector in general being severely underfinanced in Ukraine alongside with deep routed informal payments practice raised potential risks of maintaining financial access barrier. In order to mitigate this risk the project has invested in provision of medicines and medical supplies besides development of facility basic infrastructure and provision of basic equipment for service provision. More specifically, to ensure that all necessary consultations and diagnostic tests, not covered by the public funding were available for drug dependent pregnant women and children born to them were provided by the project. In addition the implementing partner mobilized additional financial resources to cover the costs of medicines and medical consumables for drug dependent pregnant women and children born to them. Albeit the project addressed financial access barrier, the evaluation during the site visits revealed few cases in Kiev center where pregnant drug dependent women had to purchase medicines, bring medical supplies and pay for diagnostic services whereas in remaining three project sites direct beneficiaries anonymously reported their satisfaction.

"I was told by the clinic doctor that had to qualify for inclusion criteria before starting ...”.

*Quote from FGDs with non-project client*

" although the OST clinic staff were informed by my social worker, I was put on a waiting list. When asked for how long received indefinite answer and the doctor referred to the Ministry... But my friend recently has been immediately admitted to the ... clinic without requesting to have two attempts of detox”

*Quote from FGDs with project client*

**Figure 15: Total number of clients starting OST after enrollment into the project by sites**

<table>
<thead>
<tr>
<th>Site</th>
<th>Total Number of Clients starting OST in the project</th>
<th>Total Number of Clients on OST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>38</td>
<td>44</td>
</tr>
<tr>
<td>Kr.Rih</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Poltava</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>DP</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Kiev</td>
<td>27</td>
<td>32</td>
</tr>
</tbody>
</table>

“We used our own resources to provide additional consultation, medicines and medical supplies to the centers....”.

*Quote from Key Informant*
with free services at project sites. In summary, the project failed to fully address subject bottleneck.

**Poor knowledge, skills and attitudes of health professionals** - To address given bottleneck, the project heavily invested in building health workforce capacity through training and capacitated 56 medical workers jointly with UNFPA with necessary knowledge and basic skills for provision of quality medical services as well as stimulated change of their behavior, attitude, and practice towards drug-dependent women in the pilot sites.

Capacity building activities also included the seminar in Saltsburg in 2012 devoted to the management of pregnancy among drug-addicted women. The effectiveness of project contribution in elimination of this bottleneck can be demonstrated by satisfaction of drug dependent pregnant women with the services received. The research on pregnant drug dependent women revealed positive staff attitudes towards drug dependent women as demonstrated on the Figure 16 below.

More specifically, 82% of women acknowledge positive attitude and 11% indifferent attitude from the OST clinic staff, whereas 32% of ANC clinic staff demonstrated support and readiness to assist and 48% same attitudes as other pregnant women. Notwithstanding discriminatory attitudes towards drug dependent women improved in ICM sites, the room for further improvement still remains. About 20% and 7% of research respondents reported negative judgmental attitudes at antenatal care clinics and OST clinics respectively and 4% were refused to receive required antenatal services.

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While staff knowledge improved in management of drug dependent pregnant women in antenatal, intrapartum and postnatal period, the management of newborn withdrawal syndrome (NAS) remains to be a challenge. There are no national adopted guidelines at present on managing NAS in Ukraine and this has proved to be very challenging to those involved in the care of neonates of drug using women and of those receiving OST. According to project monitoring data NAS syndrome has been diagnosed in 37% of newborns (Figure 17) that received symptomatic treatment at maternities.

It was clear from interviews that from a neonatal perspective, there is more experience and confidence with respect to managing buprenorphine exposed infants than those exposed to methadone. This is partly explained by the longer time that buprenorphine has been used in OST nationally, the availability of phenobarbital for management of NAS, the lack of morphine drops for managing neonates with methadone-associated NAS and the greater severity of NAS seen with methadone versus buprenorphine. A national guideline on substance use in pregnancy, including use of OST and illicit drugs, but also tobacco and alcohol, is currently being developed alongside with NAS guidelines and will be very much welcomed by health professionals. Furthermore health professional at visited centers, particularly pediatricians noted that the child dose of morphine is not registered in the country and they use an adult dose (vial) to extract required dose for the newborn. The remaining portion is wasted according to the regulations of the MoH. In certain cases other medicines are used instead of morphine. It is believed that, adoption of NAS guideline and protocol will eventually result in inclusion of morphine (child dose) into the essential list of medicines and available at the maternities.

**Lack of coordinated social services and child custody issues** - The biggest problems faced by women and families affected by HIV are partially attributed to a lack of a coordinated system of social services. To fill in existing deficiencies in the social services, the project design considered establishment of case management function currently operated by the NGOs involved in the project (Figure 11). Right after identification and recruitment of drug dependent pregnant women by outreach worker, the social worker of the NGO initiates case management through development of individual plan jointly with the client. Notably, the evaluation was not able to find hard evidence on using standardized assessment methodology and/or check list (to identify vulnerabilities) utilized by all project sites, rather more individual approach has been practiced by local NGOs in each project targeted area as informed by key informants.

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Gaalema et al, 2012
According to the identified needs of the client the social worker/case manager initiates organization of all required services by giving priority first to health services followed by others such as social, legal, peer support, educational, psychological and other services.

During site visits the evaluation observed peer support group’s and education sessions, mothers with their child and/or children and sometimes with partners spending time at the NGO organized day center, washing clothes, attending vocational training courses, receiving food and hygiene packages, homeless mother’s with their newborns in shelters.

The evaluation also revealed a good evidence and progress of integration different services – both medical and social in Poltava and Dnipropetrovsk. In Dnipropetrovsk model of integrated care for drug using women and children born to them a day care center for mothers and children was officially opened 24 September 2013 operated by the NGO “Hope Plus” with the funding support from USAID, project “Response”. The funds from USAID aimed on expansion of the integrated care and treatment model for drug addicted women and their children, initiated by UNICEF.

TIMELINESS OF UNICEF INPUTS

The project implementation was hampered by number challenges at different stages of implementation, resulting in delays of UNICEF inputs.

- Though donor funding was made available at the beginning of 2011 (Figure 18), the project commenced with 6 month delay due to the lengthy tendering procedures and inflexible national regulations that slowed down the process of signing contract with the implementing partner.
- The project commencement coincided with administrative reforms in the country. The change of management and overall reorganization within the Ministry of Health, other Ministries and local governments, which were strategic counterparts within the project, had a negative impact on inter-ministerial cooperation and government’s commitment for initiation of the project.
- Another challenge was the pressure from law enforcement agencies in 2011 – 2012 on integration of OST programme, an important part of the package of integrated services, within the project sites. This resulted delays in establishment of Centers for integrated services as well as in obtaining required licenses for those sites where ICM model 2 “under one roof” was introduced.
- At the end of the first quarter of 2012, the Government approved UNICEF’s new Country program (2012-2016) that resulted in temporary postponement of project funding at the beginning of 2012, however this gap has been bridged by the
implementing partner using their own resources as well as by contributions from other donors that ensured continuity in provision of services to project clients.

Figure 18: Implementation timeliness and challenges faced during project implementation

- Due to above mention challenges UNICEF was not able to fully utilize project funds within agreed time frame with the donor. Therefore UNICEF requested no costs extension that was submitted to donor three months prior to expiry date. The Austrian Government granted extension.
- By the end of 2012, UNICEF jointly with the government prepared a new proposal for Austrian government funding for the period 2013-2014. Within the frames of the newly funded project UNICEF went through new tendering procedure for contracting the implementing partner. This process was much faster at present compared to the initial phase of the project.

In summary with all challenges faced during the pilot project implementation the overall duration of the project from funding perspective was 36 months instead of 47 months. Nonetheless, the bridging strategy used by the implementing partner has smoothen the implementation process and allowed provision of uninterrupted services to the drug dependent pregnant women and children born to them.

PROJECT MANAGEMENT, COORDINATION AND PARTNERSHIP

Key partners of this project include the Ministry of Health of Ukraine (MOH); Ministry of Social Policy; State Services on HIV/AIDS and Other Socially Dangerous Diseases; Ukrainian Centre for Socially Dangerous Disease Control of the Ministry of Health of Ukraine; National Centre for Alcohol and Drugs Monitoring; Regional and Municipal State Health Administrations in Kyiv City, Dnipropetrovs’k, Poltava and Krivui Rih; Regional and Municipal HIV Coordination Councils; Municipal Social Services for Family, Children and Youth in Kyiv.
City, Dnipropetrovs’k, Poltava and Krivui Rih; UN Agencies (WHO, UNAIDS, UNFPA, UNODC) in Ukraine; Open Society Institute; International HIV/AIDS Alliance in Ukraine; All Ukrainian Network of PLWHA; Coalition of HIV Service Organizations; Ukrainian Foundation for Public Health and HIV-services organizations in the pilot cities.

At the onset of the epidemic, a highly developed organizational framework for the coordination of the national response to HIV was established in Ukraine. The framework includes the National HIV Council and its Regional and Program Sub-Committees, governmental and non-governmental partners, MOH technical working groups, UN Country Team, and Regional and Municipal HIV Coordination Councils. Collaboration with these partners to utilize existing resources, expertise and structures, as well as the lessons learned has been promoted during the project implementation. Regional and Municipal HIV Coordination Councils ensured a supportive project implementation environment and a multi-sectoral approach.

Achieving project’s challenging goal required strong governmental commitment and the joint efforts of a broad range of state, non-governmental and civil society partners at national and local levels. Hence project involved implementing partners such as health and social service providers in selected cities, local antenatal clinics, perinatal centres, narcological dispensaries, and AIDS centres.

The project was effective in leveraging resources of the main stakeholders working in the HIV/AIDS area in Ukraine, including Olena Pinchuk- ANTIAIDS Foundation, OSI, Eurasian Harm Reduction Network, Ukrainian Foundation for Public Health, HIV Alliance Ukraine, All-Ukrainian Network of PLHA, and the Coalition of HIV- Services Organizations to enrich the project with expertise and complimentary resources where applicable.

The multidisciplinary teams established within the project at local levels, helped to bridge health care and social services, allowed maintaining effective and timely exchange of information about the project clients and ensuring continuity of care, treatment and support services for drug using women and their children. Multidisciplinary Teams include medical professionals and social workers mainly from HIV-services organization. There is a strong referral system between health specialists established and functioning. Now narcologists, obstetrician-gynecologist and other necessary specialists, including social workers, jointly observe pregnant women having a joint plan of management for each pregnant woman. Cases that require referral to social services are discussed at multidisciplinary team meetings and local governments officially request state social services to support referred individuals.

The Figure 19 below describes project management structure. The project is implemented by WJC Foundation and supervised by UNICEF. UNICEF team is presented by the HIV/AIDS Officer, which among other programmatic tasks carries out advocacy, policy dialogue, multi-

“Advocacy of local municipal leadership defined implementation effectiveness. The decree was developed for pilot site and multi-disciplinary team established by local government leadership including all specialists - OST, Ob/Gyn, pediatricians, neonatologists, NGOs, epidemiologists, social workers ensured effective implementation of the model. Also journalists were invited and involved for information dissemination...”

“ We had regular meetings. All problems related to legal documents and coordination of service provision were discussed and ways for resolving them planned...”

“Municipal social services were also involved. The latter sent letters to local district social centers to support referred individuals ...”

Quotes from Key Informants
sectoral cooperation, coordination and monitoring of project implementation. The Project Assistant supports the Project Officer.

A standard project cooperation agreement between the WJC Foundation and UNICEF provides the legal basis for the project implementation. In collaboration with UNICEF, the WJC Foundation is responsible for the overall project management and coordination including project staff selection and orientation, project implementation, daily management, plans and reports preparation, funds disbursement, routine programmatic and project implementation monitoring, project results documentation. The WJC Foundation ensures close cooperation and coordination with the State Services on HIV and other Socially Dangerous Diseases, municipal Social Services for Youth, and other relevant partners.

**Figure 19: Project Management Structure**

In terms of team composition, the following professional team serves as project managers:

- **Project Medical Coordinator** - responsible for supervision and analysis of medical data, process of diagnostic and treatment, eligibility of supplies to be provided within the project and expenditures.
- **Project Manager** - responsible for overall project coordination, activities planning, analysis of timelines and performance, communication with project consultants and partners, drafting of the narrative reports, and preparation and submission of financial reports, preparation of the documents needed for contracting personnel for project implementation.
- **Local Project Coordinators** - Their scope of responsibilities are: coordination of multidisciplinary teams’ work and regular meetings; sharing of project information during relevant meetings and working groups; information sharing through the partners’ network; on-going consultations and participation in the relevant working groups,
collection information about project’s implementation, clients, used medicines and medical supplies, and drafting monthly reports.

In addition, the WJC Foundation staff members provide technical and managerial support to the project, and supervise project implementation.

Strong field based management contributed to effectiveness of project implementation. It allowed to immediate resolution of challenges and problems as they arise in coordinated manner by multidisciplinary teams, whereas more system related challenges were communicated to WJC Foundation and reported to UNICEF for further action.

PROJECT MONITORING AND EVALUATION

Improved national statistical reporting - Until 2011 the PMTCT related statistical reporting in Ukraine did not monitor and collect data for IDU pregnant women rather only included the data about the number of pregnant women with parenteral (related to injecting drug use) HIV-infection. Since 2012 the data needed for this indicator were received within the process of improvement of PMTCT-related reporting and recording system largely supported by UNICEF.

According to the Order № 612 of the Ministry of Health of Ukraine “On approval of the forms of primary registration documents and reporting on the monitoring of PMTCT activities and instructions on filling them out”, statistical data about the number of HIV-infected pregnant women, including specification of their injecting drug use, are being collected since 2012. The Ukraine Harmonized AIDS Response Progress Report82 prepared in 2012 contains an indicator “percentage of HIV-infected pregnant women, who inject drugs”, which measures the share of HIV-infected women actively injecting drugs during pregnancy. The indicator was calculated on the basis of Joint Reporting Tool on Health Sector Response to HIV/AIDS developed by WHO, UNAIDS and UNICEF. However, it is acknowledged and national statistics may not accurately reflect the real situation in the country, as HIV-infected pregnant women, who inject drugs, remain a hard-to-reach population to implement interventions aimed at prevention of vertical transmission of HIV.

Internal and external monitoring and evaluation of the project: The Program lacked well-designed Results Framework (RF) allowing measuring impact and outcomes at the onset of the program. In response, the new RF has been developed for the third phase of project implementation (2012-2014). The quality of indicators were examined by the evaluation and weaknesses identified such as: absence of logical structure of the RF, weaknesses in formulation of relevant, specific and measurable and operational impact, outcome and output.

indicators. The project-implementing partner, WJC Foundation, collects and reports a small set of quantitative indicators on a quarterly basis, but most of these indicators are not included in RF and are only health service related. Furthermore, there is major disconnect between original project TOC and the project’s RF.

UNICEF regularly monitors the project jointly with local Implementing partners and WJC Foundation. The appraisal of the monitoring reports revealed weaknesses in recording outcome indicator progress. In some reports challenges were identified, discussed with multidisciplinary team in each project location and corrective measures agreed on.

An external international consultant assessed the project implementation at the end of the first phase in 2012. It has to be acknowledged that majority of recommendations provided were addressed by the project design for the second phase.

WJC Foundation closely monitors visits data, problems and challenges during implementation, documenting the results and databases of clients and services, including detailed budget and records of expenditure of the project and reports regularly to UNICEF.

The performance of the ICM model was also monitored and reported by centres of integrated services. During the site visit an annual monitoring chart of performance indicators, displaced on the wall of the administrative department at Dnipropetrovsk maternity was observed. Though evaluation was not able to receive information from respondents how the monitoring results inform measures for improvement of services at these centers. It has been acknowledged that management of integrated service providers require to deepen their knowledge in data analysis and evidence based planning.

For the evaluation purpose the project’s Results Framework was revised (ANNEX 4: REVISED RESULTS FRAMEWORK) filled in with available data obtained from original RF, project progress reports, national statistics as well as from available secondary data. Results of this exercise are provided in the Table 6 below.

Table 6: Project Performance indicators

<table>
<thead>
<tr>
<th>Outcome/Output</th>
<th>No. Indicators</th>
<th>Met</th>
<th>Partially Met</th>
<th>Not Met</th>
<th>Not Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Drug using woman is alive with her HIV negative child and is supported by community and government</td>
<td>4</td>
<td>3</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Outcome 1</td>
<td>Uptake and adherence to quality PMTCT services by drug using pregnant women improved</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Outcome 2</td>
<td>The harm of street drugs to pregnant women, fetus and infants are reduced</td>
<td>4</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Outcome 3</td>
<td>Pregnant women and young mothers using drugs receive family, community and social support and keep custody for their children</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
</tbody>
</table>
CM that meets target beneficiary needs and is informed by the best international practices is designed, owned by all parties provides quality health and social services to pregnant drug using mothers

Enabling legal, financial and policy framework fully implemented

The governance structure of the ICM demonstrates effective operations

Family and community support mechanisms defined and implemented

<table>
<thead>
<tr>
<th>Output</th>
<th>Description</th>
<th>Shade</th>
<th>Value 1</th>
<th>Value 2</th>
<th>Value 3</th>
<th>Value 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output 1</td>
<td>CM that meets target beneficiary needs and is informed by the best international practices is designed, owned by all parties provides quality health and social services to pregnant drug using mothers</td>
<td>Green</td>
<td>9</td>
<td>2</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Output 2</td>
<td>Enabling legal, financial and policy framework fully implemented</td>
<td>Yellow</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Output 3</td>
<td>The governance structure of the ICM demonstrates effective operations</td>
<td>Green</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Output 4</td>
<td>Family and community support mechanisms defined and implemented</td>
<td>Green</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

The reconstructed RF evidently exhibits weaknesses in project indicator measurement (45% of indicators not measured), thus limiting evaluation to objectively assess project effectiveness.

Research and Studies

Number of studies and researches were conducted during the project life span. They focused on drug-addicted women and provided situation analysis regarding their access to services, social and demographic characteristics and determinants of mother-to-child transmission, the level of coverage by medical and social interventions, identified the estimated number of drug-addicted women of reproductive age and pregnant HIV-positive women *inter alia*. All obtained data formed a baseline and used for setting up the targets within the pilot project.

- **Reduction of HIV MTCT risks among pregnant IDU women in Ukraine (2013)** – The study aimed at increasing understanding of HIV infection and substance use in pregnancy and their management in order to build a regional advocacy plan to improve services for pregnant women using drugs and to develop new strategies for PMTCT among IDU women. It provides characteristics of IDU pregnant women with respect to socio-demographics, HIV transmission risk behaviour, HIV status and patterns of substance use, type and severity. The study also explores complex biomedical, neuropsychiatric, psycho-social, socio-cultural challenges associated with drug addiction during pregnancy. It compares access and utilization of services by the IDU pregnant women at CICs with those IDU pregnant women accessing standard care, explores whether receipt of behavioural interventions result in behavioural change among IDU women that could impact vertical or horizontal transmission of HIV including adherence to ART and OST. For this purpose a survey of drug using women – those pregnant and those who had delivery in past few years (some before and some after the introduction of ICM) – was carried out in OST clinics and maternity hospitals in Kiev, Poltava and Dnepropetrovsk and Krivui Rih.

- **Socio-demographic and medical determinants of the risk of mother-to-child transmission of HIV in Ukraine (2013)**3 - research aimed at studying of social and demographic determinants of the risk of mother-to-child transmission of HIV and preconditions for understanding the epidemiological and social factors contributing to the success of the program for prevention of mother-to-child transmission of HIV (PMTCT) and, correspondingly, to develop recommendations for elimination of HIV infection cases among children born to HIV infected mothers in Ukraine.

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3 Socio-demographic and medical determinants of the risk of mother-to-child transmission of HIV in Ukraine
- **Population size estimate of drug addicted women of reproductive age and of drug addicted pregnant women in Ukraine (2014)** - It is well known that injecting drug use, as well as use of other substances is always accompanied with stigma and discrimination, which makes the patients hide this fact. In view of this, the real number of injecting drug users among HIV-infected pregnant women can be significantly higher. This situation is hampering the opportunities to provide timely PMTCT services, substitution maintenance therapy, other health, social and prevention services to HIV-infected pregnant women, who are actively injecting drugs. Therefore a demand to conduct a more realistic assessment of the population size of drug addicted women of reproductive age, pregnant women who use drugs and HIV-positive pregnant women, who were infected due to drug use have been widely acknowledged by the government. In response, the Social Monitoring Centre with the technical support from the United Nations Children’s Fund (UNICEF) Country Office in Ukraine conducted an institutional research on “Assessment of the Population Size of Drug Addicted Women of reproductive Age in Ukraine” was conducted in 2012–2013 in the four administrative units of Ukraine: in the cities of Dnipropetrovsk, Kyiv, Poltava and Volyn oblast. The national population size estimates were made on the basis of extrapolation of the available estimates to the national level. The estimates of the target population size that were received and agreed with the experts were then extrapolated to the national level on the basis of the evaluation of the IDU population size conducted in 2012. The data about the population size of drug addicted women can be used for the effective planning, implementation and evaluation of projects aimed at scaling-up of integrated services for drug addicted women vulnerable to HIV and already HIV-infected, in order to reduce the rate of mother-to-child transmission of HIV, as well as to monitor the country achievements towards elimination of transmission of HIV from mother to child.

- **Cost of Integrated service model for drug using pregnant women in Ukraine** – The subject study was initiated by UNICEF for which the funding was leveraged from UNAIDS. The purpose of the given costing study was to estimate a cost of a model of integrated care and treatment for drug using pregnant women. The cost estimate was thought for inclusion into the budget of a new National AIDS programme for 2014 – 2018 for its further funding and replication at national scale.

### SUMMARY OF FINDINGS ON EFFECTIVENESS

<table>
<thead>
<tr>
<th>EVALUATION QUESTION</th>
<th>FINDINGS</th>
<th>ROBUSTNESS RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent has the underlying theory of change been valid at this point? To what extent is the expected results chain occurring as planned?</td>
<td>The underlying theory of change remained valid.</td>
<td>B</td>
</tr>
<tr>
<td>To what extent has the design of the pilot model and its evolution, as choice of models in particular settings, were customized to local needs of IDU</td>
<td>The project design, interventions as well as choice of models in particular settings, were customized to local needs of IDU</td>
<td>A</td>
</tr>
</tbody>
</table>

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85 T. Gotsadze, Cost of Integrated service model for drug using pregnant women in Ukraine, 2013, UNAIDS
<table>
<thead>
<tr>
<th>Question</th>
<th>Findings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>including type of intervention, the choice of beneficiaries, funding, and stakeholder/beneficiary involvement enabled to achieve the project’s defined objectives?</td>
<td>pregnant women and were appropriate to achieve project’s defined objectives</td>
<td>widely corroborated by project quantitative and qualitative data collected through IDIs and FGDs</td>
</tr>
<tr>
<td>To what degree has the project contributed to removing bottlenecks hampering improvement of MTCT rate in Ukraine?</td>
<td>The project was moderately effective in its contribution towards removing key bottlenecks hampering improvement of MTCT in project areas.</td>
<td>Findings are substantiated through documentary review and widely corroborated by project quantitative and qualitative data collected through IDIs and FGDs</td>
</tr>
<tr>
<td>Did the project result in better coverage, quality and uptake of services for pregnant drug dependent women in selected sites?</td>
<td>The project provided better access and quality of services to IDU pregnant. It demonstrates high uptake rates by beneficiaries of ART and OST services.</td>
<td>Findings are substantiated through documentary review and widely corroborated by project quantitative and qualitative data collected through IDIs and FGDs</td>
</tr>
<tr>
<td>To what extent has medical and social services been integrated within the project and how has it made an effect on the project results?</td>
<td>The integration of medical and social services was the main purpose of the ICM. At present the project demonstrates integration of both services, though the role of social services and support is mainly played by NGOs, whereas the role of state social services is less evident.</td>
<td>Findings are substantiated through documentary review and information collected from key informants and direct beneficiaries IDU women</td>
</tr>
<tr>
<td>To what extent have capacity-building activities for service providers resulted in service quality improvement and increase of PMTCT coverage?</td>
<td>The capacity building activities implemented within the project together with international knowledge sharing resulted in improved staff attitudes towards IDU pregnant women as well as improvement of quality of services.</td>
<td>Findings are substantiated through documentary review and widely corroborated by quantitative and qualitative data collected through IDIs</td>
</tr>
<tr>
<td>Were UNICEF inputs to the programme provided in a timely way?</td>
<td>The project implementation faced challenges in timeliness of UNICEF’s inputs, albeit these challenges did not influence effectiveness of project implementation as it was bridged by the WCF from their own resources.</td>
<td>Findings are substantiated through documentary review and widely corroborated by project quantitative and qualitative data collected through IDIs</td>
</tr>
<tr>
<td>How and to what extent has the programme management, coordination, partnership, and monitoring and evaluation contributed to the effectiveness of the project?</td>
<td>Wide range of partners involved in project implementation leveraged financial and expert resources together with sound coordination contributed to the effectiveness of the project. The project could have benefited more from results based management and more strait forward and operational monitoring and evaluation framework and practices.</td>
<td>Findings are substantiated through documentary review and widely corroborated by qualitative data collected through IDIs</td>
</tr>
</tbody>
</table>
3.3 EFFICIENCY

This section of the evaluation report examines whether the project resources have been used efficiently in order to achieve the stated results.

**Box 4: EFFICIENCY EVALUATION QUESTIONS**

- How cost effective is the project activities compared to similar activities in Ukraine?
- Has the initiative used resources (funds, expertise, time) in the most economical manner to achieve the results?
- The extent to which the allocation of resources to target group takes into account the need to prioritize those most marginalized?

In order to assess cost effectiveness of the project interventions, attempt was made to assess project inputs (financial) relative to spending of different projects targeted at IDUs and implemented by partners within the frame of GFATM and other donor financed AIDS program. To make this comparison more meaningful, evaluation tried to obtain disaggregated expenditure for similar activities and compare project’s investments into training and technical assistance & monitoring with the comparable spending. Extensive efforts to obtain disaggregated comparable data from above mentioned partners proved impossible. Therefore in this section evaluation only focuses on project-specific financial data to determine their relative financial efficiency.

UNICEF and WJC Foundation provided financial data was categorized in three broad categories: a) management costs (UNICEF and WJC staff salaries and project national/local consultants/specialists); b) investment costs which included all minor infrastructure renovation, equipment purchased and medicines and supplies delivered to CICs and cost of publications/information materials and c) training, consultancy and monitoring costs – all lumped together. No adjustments were made to the supplied information.

According to the project expenditure analysis (Figure 20) 62% of total project resources was used for paying project staff at central and pilot project locations and specialist’s services ensuring service provision to target IDU pregnant women. 8% of available resources were utilized for investment purposes (site renovation, provision of equipment and medicines) and 30% of resources were spent for staff training, technical assistance and M&E related activities.

Such a high share of management cost compared with international practice of 20% raises concerns about financial efficiency as well as sustainability of this intervention.

In the initial phase (2011-2013) of the pilot project about 9% of total available resources were invested in infrastructure renovation at CICPs (Figure 21), purchase of equipment and provision of medicines and medical supplies
that contributed to the operation of health centers where ICM model has been introduced, thus it is presumed that investment spending was relatively efficient.

Project expenditure on training, technical expertise and monitoring and evaluation gradually increases over the years from 23% in 2011 to 55% in 2013 (expenditures for 2014 being not a full year is not taken into account) and is considered to be relatively cost efficient compared to the results achieved such as:

- Improved knowledge, skills and attitudes of health professionals as demonstrated in previous sections;
- Extensive knowledge base generated through various studies on preferences, needs and satisfaction of IDU pregnant women, socio-demographic characteristics of target population, bottlenecks for achieving EMTCT goals as well as population size estimate which will guide evidence based advocacy, evidence based policy and establishment of enabling environment for the national scale-up of ICM model.
- Majority of recommendations provided by the assessment of the first phase of the pilot informed the design of the following phase.

The evaluation also examined an average cost per IDU pregnant women enrolled in the project, which accounts to almost USD 4,622 per project client and a child born to them. Albeit the efficiency can be questioned, in the absence of comparable data from partners the document review finding shows that almost all NGO run projects directed towards IDU populations are characterized by high costs relative to the number of targeted population. Taking this finding into consideration it can be assumed that resources utilized by the project per client served are relatively efficient compared to other similar interventions implemented in the country.

Drug dependent pregnant women, the key target group of the project, are considered to be the most marginalized population. However socio-demographic characteristics of women in the given group varies. Based on various study findings most vulnerable and marginalized are those lacking family support, with low education level, homeless, residing in rural areas etc. The evaluation was limited to obtain any hard evidence whether project implementation and/or resources particularly prioritized the most marginalized and vulnerable drug dependent pregnant women among the target group. The socio-demographic characteristics of project clients are not tracked by the project, nevertheless the key informants reported that drug dependent population in general and women in particular from rural areas migrate to regional centers where they have better access to illicit drugs as well as are less stigmatized by immediate family members and marginalized by the community. Participants of the FGDs concurred with this finding and openly disclosed that majority of them are from rural areas and migrated to the center due

86 Assessment of existing chains of RH/FP service delivery to injecting drug users and their partners in Kyiv city, Kyiv, Mykolaiv and Kirovograd oblasts, 2013, Health Department of the Kyiv City State Administration, Kyiv City Clinical Nargological Hospital “Sociotherapy”
to the reasons mentioned above. Furthermore, managers of two CICs confirmed admitting and providing services to drug dependent pregnant women from other districts and regions. In summary, although the project resources were not prioritized for targeting the most vulnerable and marginalized drug dependent pregnant women, it eventually captured them.

**SUMMARY OF FINDINGS ON EFFICIENCY**

<table>
<thead>
<tr>
<th>EVALUATION QUESTION</th>
<th>FINDINGS</th>
<th>ROBUSTNESS RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>How cost effective are the project activities compared to similar activities in Ukraine?</td>
<td>Extensive efforts to obtain disaggregated comparable data from partners proved impossible. Therefore evaluation only focuses on project-specific financial data to determine their relative financial efficiency. The project expenditure analysis shows relative efficiency in spending on training, technical assistance and M&amp;E, whereas spending on management has been considered high compared to international evidence.</td>
<td>B  Findings are substantiated through quantitative analysis of the project expenditure and supported by qualitative data from desk review</td>
</tr>
<tr>
<td>Has the initiative used resources (funds, expertise, time) in the most economical manner to achieve the results?</td>
<td>In the absence of comparable data from partners the document review finding shows that almost all NGO run projects directed towards IDU populations are characterized by high costs relative to the number of targeted population, therefore it is assumed that project resource spending is relatively cost efficient.</td>
<td>B  Findings are substantiated through quantitative analysis of the project expenditure and supported by qualitative data from desk review</td>
</tr>
<tr>
<td>The extent to which the allocation of resources to target group takes into account the need to prioritize those most marginalized?</td>
<td>The project resources were not prioritized for targeted the most vulnerable and marginalized drug dependent pregnant women, though eventually captured them.</td>
<td>B  Findings are substantiated through qualitative data from desk review, key informants and FGDs</td>
</tr>
</tbody>
</table>
3.4 IMPACT

This section of the report attempts to measure project’s potential contribution to the MTCT prevalence in project targeted areas and further assesses the impact of the pilot project on the primary beneficiaries as well as local and national health authorities and medical professionals. More specifically it looks at whether primary beneficiaries experienced increased or decrease of access to various integrated services, their satisfaction with the quality of services received; whether their unique needs and sensitivities are reflected in the established services and how the equity gap was closed or is likely to be closed.

Box 5: IMPACT EVALUATION QUESTIONS

Primary beneficiaries:
- To what extent have the primary beneficiaries experienced increased access to various integrated services, or increased ability to demand/seek support?
- To what extent have the primary beneficiaries satisfied with the quality of services available for them up until now?
- To what extent have the primary beneficiaries perceived that their unique needs and sensitivities are reflected in the established services?
- To what extent have the primary beneficiaries been able to take up (use) on the available services?
- To what extent has the equity gap closed (or likely to close) in the access to services of vulnerable groups of drug using pregnant women?
- To what extent has the gender, human and child rights and capacity-building issues, including cross sectoral cooperation between medical and social sectors, taken into account in the pilot model and to what extent have they have contributed to achieving of the results?

Local and national authorities:
- How has the project influenced or affected local and national authorities and the wider community to provide integrated health/social services targeting vulnerable groups of women?
- To what extent has the project changed behaviors and attitudes of local and national authorities towards the rights of vulnerable groups of women including drug using pregnant women (or likely to change)?
- To what extent the project has changed (or likely to change) behaviors and attitudes of healthcare and social service workers towards drug using pregnant women?

The section further elaborates on how the project influenced or affected local and national authorities and the wider community to provide integrated services to the target beneficiaries. How the project changed behaviors and attitudes of local and national authorities towards the rights of vulnerable groups of women including drug using pregnant women and what was the project impact on changing the attitudes and behaviors of healthcare and social workers towards drug using women.

**IMPACT ON MOTHER TO CHILD TRANSMISSION OF HIV**

Impact of the project was evaluated using various quantitative and qualitative data from the reports supplied by the country office and obtained by evaluators, key informant interviews and focused group discussions.

Since 2001 Ukraine demonstrates steady decrease of HIV transmission from mother to child from 27.8 in 2001 to 4.28
in 2012\textsuperscript{87}. MTCT rates among IDUs in project pilot sites exhibit substantial decrease (Figure 22). Although presented data is for the year 2012, only one case of mother to child transmission was observed among project IDU clients in Dnipropetrovsk. 81 children born to HIV positive drug using women received EID with DNA PCR in the first month of life and all women chose to formula feed their children. These indicators can be considered as proxy measures for assessing potential contribution of the project towards improvement of MTCT rates.

Notably, the project failed to collect the coverage data due to the absence of population size estimation, which was only produced late 2013. To address this gap, the evaluation using the IDU women population size estimates calculated estimated coverage of target beneficiaries per each project site using: Population size estimate of reproductive age IDU women; Estimation of the IDU pregnant women who actually delivered in 2012 in each site\textsuperscript{88}; Data from 2012 on number of new IDU mothers, the assumption was made that same number of IDU women deliver every year and calculated estimated number of all IDU women who could have given a birth to a child during the period of July 2011 - July 2014 in all three administrative units where the pilot ICM model was operational (Table 7).

Table 7: Coverage of IDU pregnant women by the project

<table>
<thead>
<tr>
<th>Regions</th>
<th>Estimated population size of female IDUs of reproductive age ( \textsuperscript{89} )</th>
<th>Number of IDU women who delivered in 2012</th>
<th>Estimated total number of IDU pregnant women (July 2011-June 2014)</th>
<th>Number of pregnant IDUs covered by the project (July 2011-June 2014)</th>
<th>Share of pregnant IDU women covered under the project (July 2011-June 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dnipropetrovsk</td>
<td>2,532</td>
<td>57</td>
<td>171</td>
<td>29</td>
<td>17%</td>
</tr>
<tr>
<td>Kyiv</td>
<td>9,327</td>
<td>89</td>
<td>267</td>
<td>134</td>
<td>50%</td>
</tr>
<tr>
<td>Poltava</td>
<td>1,044</td>
<td>12</td>
<td>36</td>
<td>25</td>
<td>69%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12,903</td>
<td>158</td>
<td>474</td>
<td>188</td>
<td>40%</td>
</tr>
</tbody>
</table>

As a result, the project was able to reach 40% of IDU pregnant women in all four-project sites. Higher coverage of drug dependent pregnant women in pilot sites could have maximized project’s contribution to the declining trend of MTCT rates.

**IMPACT ON PRIMARY BENEFICIARIES**

Addressing the health and social needs of drug using women and their infants is a challenge as it requires strong coordination and functioning referrals between various service providers, including maternal & child health services, addiction services and HIV services as well as referrals to state social services and outreach provided through civil society organizations.

The evaluation examined whether health and social needs were met by the pilot project and barriers to service utilization were eliminated. For this purpose the evaluation analyzed and triangulated data collected through FGDs, studies and researches, as well as quantitative

\textsuperscript{87} UCDC data, Martsinovskaya, 2014
\textsuperscript{88} Prevention of mother-to-child transmission of human immunodeficiency virus among pregnant women using injecting drugs in Ukraine, 2000-2010. \texttt{http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3272221/}
data from project monitoring database and secondary sources. However absence of baseline data limited tracking the progress of indicators.

To feel the gap, the given section provides comparison of qualitative data between non-project and project clients as well as at some instances presents quantitative data where available.

ACCESS TO HEALTH SERVICES

Intravenous drug using women not targeted by the project - The “Assessment of existing chains of RH/FP service delivery to injecting drug users and their partners in Kyiv city, Kyiv, Mykolayiv and Kirovograd oblasts” study 90 revealed that in many narcological clinics and hospitals pregnant women are not offered substitution therapy nor admitted to hospital to undergo detoxification, referring to the fact that there may be complications. In most cases the FGD participants referred to the problems they faced in getting their OST daily dose at maternities. They had to escape from maternity, travel to OST site in order to get their daily dose of medicine.

Another survey which examined access to reproductive ealth services of female drug users91 revealed that many female drug users usually prefer use of condoms over any other contraception. Some give a preference to this method of family planning because of their HIV status or presence of other infections. Women receive condoms mainly within the framework of implemented projects, particularly from NGOs and/or outreach workers. Absence of family planning counseling at the health facilities other than those dealing with pregnant women (antenatal clinics and maternities) appears to be a common practice in Ukraine.

90 Ibid 50
91 Access to services for female drug users, All Ukrainian Charitable Foundation “Coalition of HIV service organizations”, 2010
According to MoH decree on “organization of family planning/reproductive health service in Ukraine” female drug users are given an opportunity to receive sexual and reproductive health services through drug rehabilitation facilities. In real life, as informed by key informants, such collaboration is relatively established only by AIDS centers due to implemented social projects with support and supervision of HIV service NGOs and financial support of international donor financed projects.

Intravenous drug using women targeted by the project – The integrated service model provides increased access to needed service to IDU pregnant women demonstrated by project quantitative data (See section 3.2 Effectiveness). Participants of FGD also appreciated increase access to services. Women often sited being able to receive required services at CICPs. Examples such as receiving regular check-ups instrumental and laboratory testing (either at the same site or referred to other clinic) during pregnancy, receiving counselling and testing on HIV, OST at antenatal clinic and right after delivery in maternity.

Increased access has also been confirmed by a study on reduction of HIV MTCT risks among pregnant IDU women in Ukraine\textsuperscript{92}, clients of OST program believed that the possibility to enrol in the service without registration was a major benefit. This finding is further validated by the project data on utilization of OST services by the project clients (Figure 23). 86% of IDU pregnant women recruited in the project started OST.

**Figure 23: Improved uptake of OST by pregnant drug using women (in %)**

<table>
<thead>
<tr>
<th>Total Number of Clients starting OST in the project</th>
<th>Total Number of Clients on OST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
</tr>
<tr>
<td><strong>Kr.Rih</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td><strong>Poltava</strong></td>
<td><strong>6</strong></td>
</tr>
<tr>
<td><strong>DP</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td><strong>Kiev</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

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38\% of IDU pregnant women recruited in the project started OST.
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\textsuperscript{92} C. Thorne, Reduction of HIV MTCT risks among pregnant IDU women in Ukraine, 2013, UNICEF
They were generally very happy with the opportunity to receive OST, particularly those who had previously had to pay for this services at the private clinics and those who had gone through a pregnancy prior to the availability of OST program. Women also describe how their lives had improved with the enrolment of their partners and husbands in the program.

**REFERRALS FOR MEDICAL SERVICES**

Intravenous drug using women not targeted by the project - Almost half of all visits of IDUs to medical institutions are performed without official referral, rather IDUs use personal relations and connections of patients themselves, their relatives and friends. In the other half cases, referral of IDUs is done using long-term good personal relations of NGOs with particular medical institutions. Usually the referral is done over the phone (phone call from NGO to medical institution) and takes from 2 to 5 days. Although NGOs usually have official memorandums or collaboration agreements with medical institutions, in reality, they are little of use and most of referrals are based on personal connections. The study finding has been also confirmed by non-project clients during the FGDs.

Intravenous drug using women targeted by the project - All project clients recruited in FGDs acknowledged their satisfaction with the health services they receive (Details on client satisfaction are more elaborated in following section below). They were pleased to receive all required services at the same place and/or being referred to the clinics and being accompanied by the project social worker. Companionship of social worker ensured adequate attitude of health professionals towards drug dependent pregnant women. The project quantitative data confirms that more than half of project enrolled pregnant IDU women received needle exchange, family planning, HIV testing services and almost every third women was referred to ANC, OST, HIV care (Figure 24).

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93 Assessment of existing chains of RH/FP service delivery to injecting drug users and their partners in Kyiv city, Kyiv, Mykolayiv and Kirovograd oblasts, 2013, Health Department of the Kyiv City State Administration, Kyiv City Clinical Nargological Hospital

“Sociotherapy”
COST OF HEALTH SERVICES

Intravenous drug using women not targeted by the project - The vast majority of state medical institutions, in accordance with the order of the Cabinet of Ministers, have a system of so-called “charitable contributions” that makes it almost impossible for IDUs to get treatment/medical help for free (as in most of the cases a patient has to make “charitable contribution” to the institution before she will be treated.

This is confirmed by the “Assessment of existing chains of RH/FP service delivery to injecting drug users and their partners in Kyiv city, Kyiv, Mykolayiv and Kirovograd oblasts” study reporting that referral to STI clinics for screening of women is not effective, since the main obstacle is the price - 1,500 UAH for a full check-up. Obstacle is the price - 1,500 UAH for a full check-up. In general, cost of consultation of gynecologist and dermatologist ranges from 50 to 200 UAH or higher, depending on the region. Other consultations start from 100 UAH, RW - 40 to 65 UAH, markers for viral hepatitis - from 140 to 270 UAH. All this makes it extremely difficult for IDUs and their partners to access medical services (consultations, examinations and treatment).

Intravenous drug using women targeted by the project – Almost all project clients who participated in FGDs acknowledged that services at project sites are absolutely free of charge and they are not requested even to pay the “charitable payment”. The only exclusion was observed during the project site visit at CICP in Kiev when the pregnant IDU client brought gloves and sanitary pad to the antenatal clinic and “It is very dangerous to stay in-patient in maternity if you are pregnant – you have to pay for all pills and tip medical personnel to get adequate attention and treatment”.

“It is common to bring gloves, gel for ultrasound, pay for all tests, instrumental diagnosis and buy drugs for treatment which many of my peers can not afford and therefore wait until last minute to see a doctor”.

“there is other payment so called “charitable payment” asked by the health worker to be paid before you receive any service”.

Quotes from FGDs with non-project clients

“I was surprised that nobody asked to pay for any service”.

Quotes from FGDs with project clients

94 Ibid 50
95 Ibid 50
was requested to pay for ultrasound examination.

**ATTITUDES OF HEALTH PROFESSIONALS**

**Intravenous drug using women not targeted by the project** - During FGD with non-project services users, IDU women expressed a lot of concerns with regard to discriminatory attitude of health professionals. These circumstances discourage them to timely seek health services.

The challenge with stigmatization of women IDUs by health professionals is also confirmed by the research on “Assessment of existing chains of RH/FP service delivery to injecting drug users and their partners in Kyiv city, Kyiv, Mykolayiv and Kirovograd oblasts” study.

**Intravenous drug using women targeted by the project** – Recent research conducted in 2013 on drug using women reports that women are particularly satisfied with adequate staff attitudes at ANC clinics (Figure 25). 52% of women being either pregnant at a time of survey or being pregnant within previous 2 years in the project sites, rated staff attitude as very good and 37% considered that there is a room for improvement. Apparently staff attitudes are less adequate at OST and HIV/AIDS centers. Only one fourth of surveyed women receiving OST and one in every ten IDU women ranked services as good and very good. As the research does not provide breakdown of data for project client and non-client population, findings have been varified with project clients during the FGDs.

Participants noted exemplary attitude of health workers in the CICs compared to other health clinics where they received services in past. Many of them appreciated friendly relationship they established with antenatal care workers; special support received from the health staff of CICs in obtaining other health services.

“In this clinic I like very much an attitude of the medical staff. They are kind and supportive, and they treat us as equals. That makes it special compare to many other clinics”. “Me and my doctor have such relationship that I can call him up any time I need to consultant, ask questions…” “My doctor at the clinic was so helpful ... He called his colleague, explained my situation and asked to find ways to provide free services (day surgery)...” “I couldn’t see myself stopping without the support, it would have been a disaster”

Quotes from FGDs with project clients

“In this clinic I was operated... I hided being drug user... During the operation doctors realized that I was drug dependent... It was awful! ... I had terrible pain and was too weak... Asked medical personnel to give painkillers but nobody paid attention... nobody gave me any pill.... Nobody treats animal like they treated me....”

Quote from FGD with non-project clients
services not provided by the centers. The evaluation learned about couple of cases when physicians at CIC used their personal connections to ensure required service provision to pregnant IDU women. Nevertheless, the room for further improvement is substantial, especially at OST and HIV/AIDS centers.

**ACCESS TO SOCIAL SERVICES**

In the absence of the quantitative data to examine satisfaction with social services received by the project beneficiaries, the evaluation is limited to the analysis of qualitative data collected from non-project and project beneficiaries during the FGDs.

**Intravenous drug using women not targeted by the project** – Absence of access to social and psychological services were highlighted by non-project drug using women. Many of them recalled unpleasant experiences dealing with state social service workers. They avoid contacts with the public institutions as fear to be stigmatized.

Some had tried self-detoxification, not realizing the dangers to the baby. However, by contrast, many had tried to block out the pregnancy initially. Their drug use continued and even increased to help to forget everything. Nearly all thought the pregnancy was a tremendous impetus to change their lives in light of unemployment and economic hardship, absence of family and partner support.

**Intravenous drug using women targeted by the project** – Like non-project clients, participants of this group (pregnant women and young mothers) also fear having any contact with SWs from state social services, but there were many examples of valued long-standing relationships with project’s NGO staff, professionals and social workers. In some cases there was a heavy reliance on the NGO social worker. Some of participants referred to the

“There can be a stigma with them, you know what I mean... I didn’t trust them as a result of that previous incident... They said it was confidential and turned out it wasn’t at all, just made things worse for me”

“When I got pregnant decided to get off needle... It was very difficult... often had nervous breakdown and needed support, but had no idea where to go…”

“When pregnant, I was afraid how to survive and bring up my child... I hardly get money for drugs and how to feed a child... Nobody supported... and made an abortion”

“The social workers took over my child... I miss him a lot, but do not know how to return back... does not have work... often can not pay for electricity...

Quotes from FGDs with non-project clients

“I was angry for a while (referring to pre-project experience), they (SW) sneaked into my life... but I didn’t realize how supportive she would be... I think, now, looking back, I think it was probably the best thing that could have happened because it made me waken up, opened my eyes. I thought this is serious...”

“Excellent help getting a house, she’s (refers to NGO social worker) been excellent really...”

“Me and my baby survived only due to the formula and food packages as well as cloths given to us by the NGO ...”

“Without her (refers to NGO social worker) I could have lost parenting right... She helped me to organize myself, do all documents... She even called a lawyer to help me out...”

“I wanted to find a job but had nobody to leave a child... This is great that here (refers to NGO) is a possibility to leave my child when I look for a job... people here are so attentive and friendly I can trust to leave my child with them.”

“I was asked by land lord to leave a room I was renting... I did not know where to go... SW calmed me down and arranged a shelter in children’s home where I was allowed to leave with my baby... I was allowed to leave the child at the Child home during a day until I found a job... Now we have income and I rent apartment ... Thanks to them I can get around myself ...”

Quotes from FGDs with project clients
possibility of using day care center to leave babies when they either look for a job, or go to OST clinic, or run around to get required documentation from public services. Women also were happy to receive baby formula, hygiene and food packages on a regular basis. Notably those women who were better off decided not to get packages, rather leave for the most needed.

There was strong appreciation for receiving the physiological support at NGOs, particularly the peer group support sessions; educational classes/lectures on different topics along with vocational trainings were named to as most helpful.

Albeit vast majority of FGD participants (project clients) report satisfaction with the social, psychological and legal services being provided by the NGO partners in the project, the few number of respondents restricts generalization of findings.

OVERALL SATISFACTION WITH THE QUALITY OF RECEIVED SERVICES AND REMAINING CHALLENGES

The data from recent research conducted in 2013 on drug using women informed the evaluation on the satisfaction related quantitative data. Findings presented in Figure 26 below can not be specifically attributed to the satisfaction of project clients with the services received as the study interviewed drug using women who utilized CIC services as well as those who were not enrolled in the project. However the evaluation validated the findings with the qualitative information collected through FGDs, which confirms that there is a general satisfaction with services received.

There was strong appreciation when confidentiality was kept and this facilitated the
development of trusting relationships between the professionals and clients. Satisfaction with confidentiality varies between services ranging from 49% at ANC clinics to 88% at AIDS centers. 66% of women were satisfied with AIDS center staff friendliness towards pregnant women and 89% with child friendliness, though satisfaction for these indicators are much lower at OST centers. The staff skills and knowledge desires improvement especially at ANC and OST clinics as reported by the study. 33% of ANC service consumers and 24% of OST clients were content with staff professionalism.

Majority of respondents find location of AIDS and OST services inconvenient, creating a geographical access barrier to services, whilst 50% of women are pleased with ANC clinic location. About 2/3 of interviewed women complained about working hours of OST clinic as well as waiting times required to get services in all types of service providers. Notwithstanding, FGD participants also noted challenges and desires for further improvement of services. In those locations where “two site” ICM model is operational, most of the FGD participants reported requiring 2-3 hour round trip to the clinic to obtain their dose and described the challenge of this in various situations – whilst heavily pregnant, with a baby, in severe weather conditions and when there are public transportation problems. Visiting clinic on a daily basis are particularly challenges for those with no parents or partner help and those living in rural areas. The long queues at the clinic to get their methadone or buprenorphine dose are another key issues, particularly for women who have to take their baby with them. Participants desire to have OST drugs distributed through pharmacies.

Challenges of access to OST faced by target population such as proximity and waiting time has been discussed with respective stakeholders at policy and service provision levels. All respondents acknowledged OST related issues to have a general character and being widely discussed, though with recent political turmoil in the country followed by on-going reforms of the government this issue has been temporarily placed in a parking lot of issues requiring resolution.

NATIONAL AND LOCAL AUTHORITIES

The project positively influenced the national and local governments and wider community to provide integrated services to targeted vulnerable women. At national and local levels the model generated interest and enabled piloting. In particular positive outcomes were related to leaders having a clear understanding of the features of integrated service provision and how it would operate in the their context. There is couple of good examples demonstrating interest and commitment of the local governments towards further extending the model.

One of them is an establishment of a Crises Center, jointly with the NGO ‘Svitlo Nadii’ for women in difficult live circumstances in Poltava. The oblast government leased 700 sq.m. building space for the center at symbolic price, co-financed facility renovation and covers communal costs. Furthermore, the special Department of Social Development, established as a structure of the city state administration, provides employment assistance to individuals in crises and with NGO ‘Svitlo Nadii’ co-funds (50 x 50) the salary of the persons when they

“Even with the small baby you can not jump the queue… We dream to get our drugs at pharmacy”

“ Even though I can get OST at the center (refers to CIC), I need to change 2 public transports to get here every day…”

Quote from FGD participants
start their job. This is very important for the pilot project clients, who are unemployed and helpful for they’re re socialization and integration into the community.

Under the leadership of Poltava local government and health authorities access to CIC has been extended by involvement of rayon centers’ health facilities and specialists who collaborate with Poltava city maternity (CIC) and refer pregnant women with the problem of drug dependency and HIV.

Another good example is replication of ICM model to Kr. Rig on request of Dnepropetrovsk local government.

Necessity of improved coverage of drug dependent pregnant women is widely acknowledged by local governments. When explained by UNICEF, they expressed full readiness to pilot “ASSIST" tool at the level of PHC, which will enable early identification substance use during pregnancy, and timely referral to the required health services.

The project also fueled better cooperation and coordination of local NGOs active in the field of HIV and IDU population demonstrated by NGO operated day care and child centers in Poltava and Krivy Rih.

The CICs involved the whole senior management team in the initial decision making about whether or not to become a center for integrated services. In addition, they guided a gradual shaping of services provision to reflect needs of the target beneficiaries. So to a considerable degree these integrated models involve both top-down and bottom-up approach and local involvement and commitment to work together may have contributed to more successful outcomes.

### SUMMARY OF FINDINGS ON EFFICIENCY

<table>
<thead>
<tr>
<th>EVALUATION QUESTIONS</th>
<th>FINDINGS</th>
<th>ROBUSNESS RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent have the primary beneficiaries experienced increased access to various integrated services, or increased ability to demand/seek support?</td>
<td>The primary beneficiaries experienced increased access to various integrated services. Quantitative data on service utilization clearly demonstrates results.</td>
<td>A Findings are substantiated through quantitative analysis and supported by qualitative data from FGDs and researches</td>
</tr>
<tr>
<td>To what extent have the primary beneficiaries satisfied with the quality of services available for them up until now?</td>
<td>In general they are satisfied with the quality of health services received, although also identified some weaknesses and shortcomings.</td>
<td>A Findings are substantiated through quantitative analysis and supported by qualitative data from FGDs and researches</td>
</tr>
<tr>
<td>To what extent have the primary beneficiaries perceived that their unique needs and sensitivities are</td>
<td>The FGD participant acknowledged that the integrated care model satisfies most of their needs, though also pointed out shortcomings.</td>
<td>B Findings are substantiated through quantitative analysis and supported by qualitative data from FGDs</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td>Methodology</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>To what extent have the primary beneficiaries been able to take up (use) on the available services?</td>
<td>Those reached out by the ICM, were able to utilize available services</td>
<td>A Findings are substantiated through quantitative analysis and supported by qualitative data from FGDs and researches</td>
</tr>
<tr>
<td>To what extent has the equity gap closed (or likely to close) in the access to services of vulnerable groups of drug using pregnant women?</td>
<td>The project mainly covered drug using pregnant women. Although the project has not prioritized targeting the most vulnerable and marginalized IDU pregnant women among drug dependent pregnant women, it eventually captured them.</td>
<td>B Findings are substantiated mainly by qualitative data from key informants and FGDs</td>
</tr>
<tr>
<td>How has the project influenced or affected local and national authorities and the wider community to provide integrated health/social services targeting vulnerable groups of women?</td>
<td>The project positively influenced the national and local governments and wider community to provide integrated services to targeted vulnerable women.</td>
<td>A Findings are substantiated mainly by qualitative data from key informants and project progress and M&amp;E reports as well as site visits.</td>
</tr>
<tr>
<td>To what extent has the project changed behaviors and attitudes of local and national authorities towards the rights of vulnerable groups of women including drug using pregnant women (or likely to change)?</td>
<td>There is couple of good examples demonstrating interest and commitment of the local governments towards further extending the model and improving access of drug dependent pregnant women to integrated services.</td>
<td>B Findings are substantiated mainly by qualitative data from key informants, project progress and M&amp;E reports</td>
</tr>
<tr>
<td>To what extent the project has changed (or likely to change) behaviors and attitudes of healthcare and social service workers towards drug using pregnant women?</td>
<td>Project demonstrates improved behaviour and attitudes of healthcare workers towards drug using pregnant women, though no less change is observed with state social service workers.</td>
<td>A Findings are substantiated through quantitative analysis and supported by qualitative data from FGDs and researches</td>
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3.5 SUSTAINABILITY

This section of the report attempts to assess prospects for national scale up of integrated service model by examining national and local ownership, capacity, ability to sustain integrated service model when external funding, particularly from UNICEF, ends.

Box. 5 SUSTAINABILITY EVALUATION QUESTIONS

- To what extent have partnership and stakeholders’ involvement at different stages of the project been decisive for the project in attaining its expected results up until now?
- To what extent has the project contributed to the advancement and the progress of fostering national ownership, engagement and capacity?
- Will the system change for improved access of pregnant IDUs and their infants be sustained in the country without support from UNICEF and other development partners? If not, what are the key factors and bottlenecks that may affect the sustainability of the results?
- Have national and/or local institutions shown technical capacity and leadership commitment to keep working with the project or to scale it up?

Strong UNICEF advocacy, evidence generated through assessment of pilot project and effective partnerships built with stakeholders resulted in Government’s recognition of the pilot model. UNICEF was the principle actor who initiated the early dialogue with the government and with the leading national experts on necessity to address needs and challenges of IDU pregnant women. Initial sensitization of opinion leaders, followed by extensive technical assistance and implementation support, largely offered by UNICEF was critical for introduction of ICM model as a pilot in three project districts.

Strong partnerships established with National and local health authorities (Ministry of Health, State AIDS Service, Ukrainian Centre for Disease Control, Ministry of Social Policy) generated positive policy environment for pilot projects’ implementation. Continuing partnership allowed development of enabling regulatory framework, national and local health policies, and information letters approving referral system in all pilot sites and expanding it to one more city in Krivuy Rig originated by the Dnipropetrovsk local government.

The Government of Ukraine demonstrates ownership though lacks capacity to change the system that guarantees improved access of pregnant IDUs and their infants to quality health and social services.

- **Being active player throughout the process and major contributor of necessary assistance led to government’s readiness to expand the model of integrated services to national level.** UNICEF’s support such as: initial sensitization of opinion leaders, adaptation of international PMTCT guidelines to the local context, empowerment of national champions and creation of critical mass of individuals (both on a national and local level) that became agents of change, continuous sourcing and deployment of the leading regional or global experts for the provision of the needed technical assistance, elaboration of the national policy as well as regulatory documents, such as ministerial...
decrees and local government resolutions (whichever applicable), provision of necessary inputs to deliver the intervention, effective, continuous and sustained coordination with the government and partners led to government’s readiness to expand the model of integrated services to national level. This is confirmed by inclusion of the services to the vulnerable HIV drug using women of reproductive age to the National HIV/AIDS Programme (NAP) for 2014 - 2018, approved by the President of Ukraine in October 2014. National scale up of ICM, as an important step towards eMTCT, is addressed in NAP. Specifically, the NAP safeguards: All vulnerable to HIV pregnant women in Ukraine will receive proper health and social services; All HIV-positive pregnant women, including drug using, will receive access to OST and ART to prevent transmission of HIV to babies; No child born with HIV; No baby will be left by mother; All mothers and families have access to social support.

Finalization and approval of new PMTCT guidelines along with regular compliance monitoring and health workforce capacity building will ensure provision of quality services to IDU pregnant women. National PMTCT protocols, regulating measures to prevent mother-to-child transmission of HIV, are consistent with WHO/EURO recommendations. However, they were adopted in 2007 without focus on the subgroup of female injecting drug users. To support the planning and implementation of Option B/B+, and to help Ukraine in scaling up more effective PMTCT interventions and programmes to achieve the goal of the Elimination of New HIV Infections among children by 2015, the government initiated revision of the outdated existing guidelines and development of a new clinical protocol on PMTCT in 2013. New guideline and protocol on PMTCT has to correspond to the modern policies and outline a new approaches introducing integration of HIV testing, treatment, and care services for drug using pregnant women, including the postnatal continuation of ART and opioid substitution treatment for drug-addicted women. The essential part of a new guideline is a substance use-screening tool (ASSIST) for pregnant women. UNICEF provides technical assistance to the government in revision and development of the guidelines.

The introduction of this tool into routine family planning and antenatal and pregnancy management services would allow to address timely identification of those women who have a special needs and referral them to the appropriate social and medical services. This is crucial for preventing maternal and pediatric morbidity and mortality, MTCT and poor outcomes in HIV-exposed infants, including those associated with maternal drug addiction, illness and orphan hood. Poltava and Dnipropetrovsk health authorities expressed commitment for piloting ASSIST tool in coming year before its national scale up.

99 Presidential Decree № 1708-VII, 20 October, 2014 on approval of the National Targeted Social AIDS Programme 2014-2018
- **Neonatal Abstinence Syndrome (NAS) management protocol is under preparation.**

  With UNICEF’s technical assistance the government initiated development of the newborn withdrawal syndrome management guidelines by extensive involvement of international and national experts as well as neonatologists from project sites and is expected to be finalized and approved by end of 2014. Introduction of this treatment protocol will consequently require inclusion of liquid methadone for the NAS treatment in the national list of essential medicines.

- **Certain progress has been achieved in the area of social services provision, such as forming the new legislative base**

  In addition, the new Law of Ukraine No. 4523-VI of March 15, 2012 “On Introducing Changes to some Legislative Acts of Ukraine on the Provision of Social Services” implied amendments in the Laws of Ukraine “On Public Associations”, “On the State Social Standards and the State Social Guarantees” and “On Social Services” in the context of defining local communities’ needs in social services, their types and amounts; planning and delivery of services in line with identified needs; introducing social service standardization; involving non-governmental and private sectors in service provision through mechanisms of social service commissioning; granting the right to public associations to directly conduct non-for-profit economic activities; and introducing differentiated approach in the payment for social services depending on the recipients’ incomes.

  The Concept of Reforming the System of Social Services, approved by the Cabinet of Ministers of Ukraine Directive No. 178 of April 13, 2007 (Official Herald of Ukraine, 2007, No. 28, p. 1122), was not implemented in full measure due to the absence of legislative regulations of the number of issues, including commissioning of social services; assessment of needs of an administrative-territorial unit in social services, their types and amounts; planning and delivery of social services in line with identified needs; and introduction of service standardization.

  The goal of the strategy for reforming the system of social service provision is to ensure accessibility of social services for vulnerable individuals, to enhance quality and effectiveness of services provision. In order to attain this goal, the following strategies are formulated: Introduce mechanisms for preventing difficult life circumstances, and enhance the system of management, coordination and collaboration of social service providers; Upgrade the existing infrastructure of social services, and set up a competitive service market by means of introducing incentive mechanism for service providers to ensure on-going enhancement of service quality; Expand the range of community-based social services available to recipients; Approve the list of social services, and introduce service standardization in order to ensure their delivery in the

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amount, guaranteed by the state; Identify criteria of activities of social service providers; and Develop and introduce methodology of needs assessment of a child and his/her family as a mandatory condition for planning and delivery of social services.

Implementation of the Strategy will contribute to realization of a single government policy in the area of reformation of the system of social service provision, thus enabling: Development of effective system of social services, improvement of service quality, and better satisfaction of needs of service recipients; Optimization of the existing network of communal institutions and facilities offering social services; Introduction of innovative social services that would contribute to improved accessibility and satisfaction of all needs of vulnerable individuals in social services; Greater effectiveness of the use of budget funds. Implementation of the Strategy will also contribute to the establishment of appropriate conditions for legal, economic and organizational support to the reformation of the system of social services provision, thus making it possible to ensure broad access of vulnerable individuals to high-quality and effective social services.

In summary, the national health and social sector policies and legislation developed by the government serves as prerequisite for addressing the needs of drug dependent women, however they still remain as vertically operated systems and lack clarity on integrated health and social service delivery. The government may embark on national scale of ICM, however it will not resolve the problem of integration weaknesses currently observed in the pilot sites in the absence of comprehensive health and social service strategy that meets drug dependent women’s needs.

The government attempted to link health and social services by issuing legislation that allows health facilities to deploy social workers. The MoH Decree # 30 gives space for deployment of social workers in health care facilities and this initiative is welcomed by maternities, OST clinics and AIDS centers, however qualification requirement set by the legislation, such as higher education in social science, limits health facilities to deploy former members of key populations as social workers, which proved to operate more effectively compared to public social worker.

Health human resources involved in the project are incapacitated, national training capacity created, though health workforce beyond pilot sites lack knowledge and require change in attitudes. With UNICEF’s support the government was successful to create national training capacity by creating a pool of master trainers, development and approval of training curricula and modules, establishment of training centre at Kiev Reproductive Health and Perinatal Center being a pioneer in teaching health specialists how to manage and communicate with IDU women. The centre is a teaching and practical base for the post diploma and continuous medical education. The PMTCT training module is included in undergraduate and postgraduate education programs. Whereas existing human resource development capacity is in place, knowledge, skills of health workers at CICPs built and attitudes changed, much remains to be done. As reported by respondents and target beneficiaries, knowledge, skills and attitudes of health professionals in other health facilities not targeted by the project yet have to be developed.

Reform of the HIV governance structure may negatively affect integration of health and social services. The State Service for AIDS and Other Socially Dangerous Diseases under the cabinet of ministers of Ukraine, was the key entity governing design, implementation and monitoring of national multi-sectoral response to HIV epidemics in the country during 2011-2014. UNICEF’s long-term engagement with the state service agency and advocacy efforts,
alongside with demonstration of integrated service model results, built a strong ownership and initiated planning for ICM replication in all major oblasts of the country. Though, recent political events in the country followed by reorganization of government structures resulted in abolition of the entity and shifting State Agency’s functions to the Ministry of Health. The State Service for AIDS and Other Socially Dangerous Diseases was liquidated on September 10, 2014 based on the resolution of the Cabinet of Ministers № 442 "On the optimization of central bodies of executive power." With this change, it is less likely that MoH will have the same leverage to ensure multi-sectoral response required for further enhancement of ICM and scale up on a national level.

**Insufficient health financing and widely levied user charges puts sustainability of integrated service provision is at risk.** Inadequate financing of health system persists in Ukraine for more than a decade. Officially, Ukraine has a comprehensive guaranteed package of health care services provided free of charge at the point of use as a constitutional right, nevertheless user charges are widely levied in the Ukrainian health system. Government attempts to define a more limited benefits package have left it to the individual facilities to determine which services are covered by the budget and which are subject to user charges. This has led to a lack of transparency in the system, which has contributed to an increase in informal payments.

Furthermore inadequate financing along with weak financial management practices results in debt accumulation by the health facilities. The formal procedure applied by the government across all health facilities in the country, immediately transfers facility revenues towards accumulated debt for communal services, thus leaving facilities without working capital. Majority of key informants interviewed at visited pilot sites, complained about insufficient funding, especially for maintenance of continuous stock of medicines and supplies. Albeit required medicines and supplies for IDU pregnant women is made available by the project, given funding modality does not provide assurances of stock availability after the project ends.

**Local budgets for HIV prevention and treatment lack focus on key populations.** Over 50% of annual expenditures on the HIV response are from external sources, with annual increases in financial needs and gaps. The central state budget funds ART

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101 Health system in transition, WHO, 2010
procurement and PMTCT, while local budgets support labour, facilities maintenance and PMTCT, ART and other treatment services. However, local budgets have almost no funding for focused prevention among key populations, including drug dependant women. In support of adequate financial allocations by national and local governments, the ICM model costing methodology were developed by UNAIDS in close collaboration with UNICEF. National leaders as well as local authorities believe ICM costing methodology to be a useful tool for forecasting the budget, which sufficiently finances prevention, treatment, and care services for drug dependent pregnant women. The UCDC representative considers necessity to build local government’s capacity in using the costing methodology for their planning purposes.

Decreasing trend of external financing may hamper access to services by HIV affected key populations including drug dependant women.

- Sustainability of services, particularly in the ART programme, is a major concern. The Global Fund grant is coming to an end, and 10,020 PLHIV receiving ART financed by GFATM will have to be taken on by the state for continued treatment and care. With the current lack of financial resources and low coverage of ART, the capacity of the state to significantly scale up ART is questionable, if resources are not raised. Sustainability of other important projects funded through GFATM is also uncertain. Sustained HIV rapid testing among key populations, as well as scale up and integration of OST, are evidence-based initiatives that are under threat of discontinuation.

- The government fully acknowledges the complementary role that civil society organizations play in reaching key populations with HIV prevention and care. In recent years there has been an increase in the number of NGOs working in HIV prevention among key populations, but legislation that clearly outlines guidance and parameters for NGO service provision yet has to be developed. There are few good examples of social contracting practiced in Kiev and Poltava, though as informed by the state social service representatives, they lack clarity and standard approach for selection, contracting and monitoring of NGO work. Until these standards are not developed feasibility of utilizing social contracting mechanism on a wider scale is unrealistic.

Thus Inadequate public funding, absence of enabling legislation for social contracting together with shrinking external funding places the scope and scale of NGO led outreach activity funding under risk.

Insufficient funding, scarcity of qualified and motivated workforce and practical experience to work with IDUs as well as inefficient operation of social service institutions is added impediment for provision of integrated health and social services to target population and its sustainment.

Insufficient funding of the social services is widely acknowledged by the Ministry of Social Policy and international partners. Attempts were made to increase funding and expand

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102 HIV treatment and care in Ukraine, Evaluation Report, 2013, WHO
targeting of socially vulnerable layers of population back in 2012. As a result of financial allocations from President’s fund, 12,000 social workers were deployed countrywide with the objective to perform home visiting, identify most in need and provide customized social services. With UNDP technical assistance the government succeeded in revision of legislation, development of service standards, provision of training to newly recruited social workers and managers of social services.

Although capacity of social services was extended, they did not focus on IDUs and HIV infected individuals, as these categories are not explicitly included in the listing of the social vulnerable category by the legislation.

As originally planned, starting from 2014 funding of extended social services were handed over to local governments, as main providers of social services. To empower local governments UNDP assists the Ministry of Social Policy in the development of Methodological guidelines (UNDP) for community level social service planning and budgeting.

It is unfortunate that due to the funding deficit in 2014 about more than 4,000 trained social workers lost their jobs and social services are no longer in a position to provide services to target beneficiaries. Key respondents interviewed in pilot sites confirmed limited funding of social services, except Krivy Rogh, which managed to maintain the army of social workers.

At the same time, current system of social service provision lacks effectiveness. Efficient mechanisms of early identification of vulnerable individuals, particularly of drug using population, as well as effective planning and provision of social services on the basis of identified needs are yet to be introduced at the level of administrative-territorial units. Delivery of social services heavily relies on the capacity of the existing network of communal institutions and establishments, which makes it virtually impossible to fully meet the needs of vulnerable individuals.

Furthermore, legislation regulating social services does not differentiate between social workers working at social service offices as clerks and those working with vulnerable population. The qualification requirements, special higher education, set for social workers discourage educated workforce to seek deployment at social services.

At present social services are also provided by non-governmental, charitable and faith-based organizations. NGOs being largely financed by donors, implement innovative projects, including initiatives aimed at providing social services to prevent difficult life circumstances, and at enhancing professional competence of social workers and other service providers. Local executive bodies and self-governments in some regions offer financial support to such

“people with high education are not motivated to work...”

Quote from Key Informant

“The budget of Kyiv municipal social services decrease every year. This year our budget is only US$ 300,000... It is absolutely not sufficient to cover the needs...”

“This year the budget cut was introduced and staff reduced...”

Quotes from Key Informant

“Simple transfer of social services from NGOs to state social services will not be effective as the bureaucracy bottlenecks limit social services to continue the same model of services as NGO provide...”

Quote from Key Informant
organizations, thus ensuring further development of the system of social services, particularly those delivered by the non-governmental sector. Albeit, no systemic work is carried out to involve non-governmental, charitable and faith-based organizations in the provision of social services, and to ensure their support, including financial.

With decreasing public and external funding respondents are extremely concerned of bureaucracy bottlenecks, which will limit social services to continue provision of services the way NGOs provide.

**SUMMARY OF FINDINGS ON SUSTAINABILITY**

<table>
<thead>
<tr>
<th>EVALUATION QUESTION</th>
<th>FINDINGS</th>
<th>ROBUSTNESS RANKING</th>
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<tbody>
<tr>
<td>To what extent have partnership and stakeholders’ involvement at different stages of the project been decisive for the project in attaining its expected results up until now?</td>
<td>The partnerships and stakeholders’ involvement at different stages of project contributed to attainment of project outcomes and outputs. However room for improvement remains</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Findings are substantiated through documentary review, quantitative analysis and supported by qualitative data from Key stakeholders</td>
<td></td>
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<tr>
<td>To what extent has the project contributed to the advancement and the progress of fostering national ownership, engagement and capacity?</td>
<td>The project generated national and local governments’ buy in into the ICM. It created ownership and built government’s critical capacities, mostly in the health sector whereas engagement of the public social services in ICM remains detrimental.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Findings are substantiated through documentary review and supported by qualitative data from Key stakeholders</td>
<td></td>
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<tr>
<td>Will the system change for improved access of pregnant IDUs and their infants be sustained in the country without support from UNICEF and other development partners? If not, what are the key factors and bottlenecks that may affect the sustainability of the results?</td>
<td>Tense political environment in the country, refocusing of public funding to other priority spending categories alongside with sharp decline in external funding further accelerates current system wide challenges in both sectors and presumably will undermine sustainability of ICM model and its scale up.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Findings are substantiated through documentary review and supported by qualitative data from Key stakeholders</td>
<td></td>
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<tr>
<td>Have national and/or local institutions shown technical capacity and leadership commitment to keep working with the project or to scale it up?</td>
<td>There is a demonstrated willingness of the government to keep working with the project and considers opportunities for further scale up of the model, though comprehensive scale up strategy is not yet developed.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Findings are substantiated through documentary review and supported by qualitative data from Key stakeholders</td>
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3.6 SUMMARY OF EVALUATION FINDINGS

This section of the report summarizes key findings and conclusions of the project evaluation.

**Project demonstrates high relevance** - The evaluation discloses project’s high relevance. It is fully aligned with national context, national HIV policies and strategies as well as with the country cooperation programme of UNICEF and its mandate. Project remains to be relevant for coming years.

**Relative effectiveness of project implementation** – The project has identified key strategic measures related to improved access to services of HIV positive drug users, including pregnant women. Project design, interventions as well as choice of models in particular settings, were customized to local needs of IDU pregnant women and were appropriate to achieve project’s defined objectives. Introduction of integrated approach to medical and social care delivery to target population group confirms project’s strong focus on PMTCT. ICM intervention presents improved access to care and treatment and increasing cooperation across medical disciplines. Various methods used to reach out client failed to ensure higher utilization of services by target beneficiaries. The main project limitation was weak client identification system by outreach workers as well as health and social services.

Those who used services at integrated care facilities had high uptake of core medical and social services. The capacity building activities implemented within the project together with international knowledge sharing resulted in improved staff attitudes towards IDU pregnant women as well as improvement of quality of services. Project clients express satisfaction with the quality of services received and staff attitudes at CICPs compared to non-project clients.

Wide range of partners involved in project implementation leveraged financial and expert resources together with sound coordination contributed to the effectiveness of the project. The project could have benefited more from results based management and more strait forward and operational monitoring and evaluation framework and practices.

Nevertheless, the project was moderately effective in its contribution towards removing key bottlenecks hampering improvement of MTCT in project areas. So far, none of the pilots have yet been able to completely fulfill the goal of truly bridging different parts of the health care and social systems, particularly public social services, in order to improve the continuity of care and outcomes for drug dependent women and children born to them. At present the project demonstrates integration of both services, though the role of social services and support is mainly played by NGOs, whereas the role of state social services is less evident. Legal, organizational and regulatory structure of Ukraine’s medical and social systems and uncertainty with ongoing reforms in both sectors on the one hand, and, on the other hand, inadequate funding issues, staffing shortages inter alia negatively affect true integration. It is however clear that the Integrated Care Model has huge potential to reshape Ukrainian health and social sectors for the better, and not only for people dealing with drug dependency.

More operational project performance monitoring could have resulted in enhanced effectiveness of the project. Failure to define size of drug dependent women population in pilot sites at the beginning of the pilot, limited project to timely examine coverage rates, effectiveness of different outreach methods used and elaboration of most effective
measures to increase client recruitment. Targeting of IDU pregnant women partners was less emphasized by the project.

**Project demonstrates relative efficiency in utilization of available resources.** Project demonstrates relative efficiency of resources used for technical assistance, human resource capacity building and evidence generation that contributed to the attainment of project objectives, however a high share of management cost compared with international practice raises concerns about financial efficiency as well as sustainability of this intervention. The project like other NGO run projects directed towards IDU populations are characterized by high costs relative to the number of targeted population. The evaluation failed to assess whether project resources particularly prioritized the most marginalized and vulnerable drug dependent pregnant women as socio-demographic characteristics of project clients are not tracked by the project.

**Impact of the project** – Project demonstrated decreasing trend of MTCT rates in pilot projects. In Kiyv and Poltava regions no single case of mother to child transmission has been observed and MTCT rates are 0%, whereas in Dnipropetrovsk it decreased from 35.7% in 2010 to 7.7% in 2012. Impact can be maximized with expansion of target group coverage, which is only 40 % at project pilot sites. The project was largely instrumental in elimination of service access barriers experienced by drug dependent pregnant women in pilot sites, though some unmet needs remain.

**Prospects for sustainability** - The national health and social sector policies and legislation along with health human resource development capacity established by the government, serves as prerequisite for addressing the needs of drug dependent women in a sustained manner. However both, health and social systems still remain as vertically operated systems and lack clarity on integrated health and social service delivery. The government may embark on national scale of ICM, however it will not resolve the problem of integration weaknesses currently observed in the pilot sites if comprehensive health and social service strategy that meets drug dependent women’ needs and assures equal access is not elaborated. Tense political environment in the country, refocusing of public funding to other priority spending categories alongside with sharp decline in external funding further accelerates current system wide challenges in both sectors and presumably will undermine sustainability of ICM model and its scale up.

**Remaining barriers** - Nonetheless of positive results attained so far, number of barriers remain, restricting access to integrated care services as well as sustainment of achievements. The evaluation reveals that people who have drug dependency problems in many cases face a range of other difficulties in their lives. Drug dependant individuals, especially pregnant women still feel being marginalized and experience fear to contact public institutions other then ICM. Their friends and former community members are still hesitant to use services due to the stigma and public attitude. Furthermore, they lack information about available services. Notably, geographical access barriers to integrated services and transportation costs remain as access barrier due to small number of CICPs in project target locations. Women on average spend two to four hours for round trip daily to get their OST and find difficult to afford even transportation costs. These women often lack parental and/or family support to continue treatment and bring up a child, which in its term appears as a barrier to pay everyday visit to OST clinic and pushes them to return back to their society. In such cases they are at risk of loosing parental right. Those, who managed to enroll on OST, face
psychological pressure from their drug dependent partners that push them to return to their old life style.

Current design of the ICM puts less emphasis on ensuring postnatal care and care of children at pediatric hospitals frequently sites by drug dependent women during FGDs. Medical staff at Pediatric hospitals often demonstrate unfavorable attitude towards drug dependent women and their children and often request payment for services.

Lack of OST prescription, take-home allowances or pharmacy dispensing has been named as another barrier. The national legislation restricts OST without direct observation of medical personnel at the dispensing clinic. This practice is not typical of better-established OST programmes in other countries, and creates major, clinically pointless hurdles to patients’ efforts to achieve a normal life free of illegal drugs.

Being unemployed is another strong barrier for bringing up a child and their social integration into the society. Non-responsiveness and discriminatory attitudes of public employment agencies were named as important challenge faced by drug dependent pregnant women. Willingness to receive vocational education that would help them find jobs was highlighted during interviews with them.

3.7 HUMAN RIGHTS BASED APPROACH AND GENDER EQUALITY

The evaluation examined whether the Human Rights Based Approach (HRBA) to programming and Gender Equality (GE) aspects were incorporated into the project planning, implementation and evaluation.

The HRBA was mainly acknowledged as a right to health of drug dependent pregnant women and children born to them in the project design. The design of ICM model introduced was largely informed by the needs and challenges faced by drug dependent women. The project implementation addressed key access bottlenecks and ensured provision of high utilization to health and social services for drug dependent pregnant women and their children. The project was instrumental in reduction of discriminatory practices widely practiced in health and social systems, by training of integrated service providers at CICs and resulting in high satisfaction of services users. The project also demonstrates differentiated support provided to most in need clients.

Whereas the project shows good examples of addressing drug dependent women’s rights to health it was less successful to demonstrate equity in integrated service utilization by residence, age and ethnicity of drug dependent women as given criteria were not considered in the project monitoring framework.

The project also failed to ensure gender equality. Inclusion of partners of project clients for targeting under the project was recommended by the assessment of the pilot phase carried out in 2012. Although during the site visits and FGDs few cases of partner involvement in the project were detected, a systematic approach was largely lacking.
4. LESSONS LEARNED

Lesson 1: Bridging health and social systems has potential to close equity gap

The pilot project helped bridge the health care and social systems in order to improve the continuity of care and outcomes for vulnerable to HIV pregnant women and children born to them. Albeit none of the pilot sites in Ukraine have yet been able to completely fulfil the goal of truly bridging different parts of the health care and social systems in order to improve the continuity of care and outcomes for patients. Much of the reason for this has to do with the legal and regulatory structure of Ukraine’s medical and social systems, uncertainty with on-going reforms in both sectors, funding issues, staffing shortages and other problems. But it is equally clear that ICM has huge potential to reshape Ukrainian health and social sectors for the better, close equity gaps not only for people dealing with drug dependency.

Lesson 2: Shaping staff attitudes and tackling stigma and discrimination among service providers

The pilot project demonstrated other positive, but less tangible, results as well. The project had clear impact on shaping staff attitudes and tackling stigma among service providers, and confirms recognition by medical personnel that the ICM helps better to serve their clients. Many staff cited feelings that they are now better able to serve their clients, and consequently more fulfilled in their work, under the IC model. “We got used to our patients, learned to trust each other under this system, and now we see them, I’d say, almost like relatives,” said the head of maternity department at Dnepropetrovsk. Patients’ experiences have mirrored this, as in the words of Natalia, a participant in the Dnipropetrovsk ICM programme: “I like the attitude of the medical staff very much. They are kind and supportive, and they treat us as equals. It’s the furthest thing from many other clinics.” While this is true for the health providers social sector still remains largely unchanged.

Lesson 3: Recognition as a global model for IDU care

Experience with innovative ICM model piloted in Ukraine has been shared within the CEECIS region. The project’s experience was presented at the International Harm Reduction Conference in Vilnius on 11th of June 2013 in Lithuania. The Ukrainian approach to the issue was recognized as the best practice in the CEECIS region that should be replicated to other countries.

Lesson 4: Setting a scene … before national scale up

Considering highly vertical public health and social systems design, establishing an integrated treatment model for IDUs in Ukraine that has gained recognition as a global model for IDU care faces many challenges along the road. Uncertainty with on-going political crisis and reforms in health and social sectors, funding issues and staffing shortages, lack of correspondence between the legal and regulatory structure of Ukraine’s medical and social systems creates obstacles for national scale up. Presence of legal, financial and policy framework that provides holistic approach to comprehensive integrated health and social
service provision to most vulnerable layers of population with particular attention to drug using women is prerequisite for national scale up of ICM model.

5. RECOMMENDATIONS

This Section provides two sets of key recommendations based on the findings of the evaluation. The first set of recommendations address key issues impeding effectiveness of current integrated service delivery to drug dependent pregnant women and children born to them, whereas the second set of recommendations provides advice on sustainability of ICM and national scale-up.

5.1 RECOMMENDATIONS FOR EFFECTIVE PROJECT IMPLEMENTATION

**Recommendation #1: Elaborate most effective outreach interventions for increased targeting of drug dependent pregnant women**

The evaluation revealed rather low coverage of target population by the project. If the government is committed to attainment of stated objective, effective outreach approaches have to be elaborated to ensure that those on the margins of society are aware and able to demand services. For this purpose it is highly recommended to develop the most effective outreach interventions by using the following approaches:

- Collect detailed data on sources of project client recruitment (outreach worker, outreach van, peer to peer, advertisement etc.). Quantitative analysis of this data will inform the design of a set of interventions for effective recruitment of project clients and increase coverage;
- Conduct qualitative research “client opinion research” led by project clients and outreach workers and identify key sources of information utilized by drug dependent women in general and pregnant women in particular;
- Consult other partners working with PWID population on recruitment strategies they use and learn about best practices;
- Promote piloting and institutionalization of ASSIST tool at PHC level followed by capacity building of PHC providers. The latter will facilitate early identification of substance use in target group and timely referral to CICPs;
- Consider introduction of financial and/or non-financial incentives for referring source (outreach workers, peers, health, education, social service providers, NGOs etc.) acknowledging their contribution for recruitment of clients.

**Recommendation #2: Ensure continuity of care and strengthen family and government support, particularly for most disadvantaged**

A certain degree of continuity in service provision to drug dependent pregnant women and children born to them are confirmed by evaluation, though some needs of target population remain either partially met or unmet. The ICM takes relatively good care of women during pregnancy and delivery by provision of antenatal care, access to VCT, ART and OST, but less focuses on the provision of postnatal care. Evaluation findings show a great need in strengthening postnatal care for women and children with particular emphasis on early childhood development. The Government of Ukraine as well as all partners involved are strongly advised to expand the basic package of health services for drug dependent women and children born to them by inclusion of postnatal care and early childhood development for target beneficiaries.
The project demonstrated good practices in provision of access to social services and other services to women after delivery and their children. The evaluation also disclosed cases of partner and/or family member involvement in care and support activities, though not in a systematic manner. Many women interviewed voiced lack of partner and family support as important barrier to stay “free of drugs” and bring up a child in a healthy environment. Partners are advised to design family support mechanism(s) promoting early recruitment of partners and/or family members in the project.

**Recommendation #3: Explore other opportunities for social service provision to most disadvantaged**

Furthermore it is recommended to explore other opportunities for effective integration of health and social sectors, particularly by using existing social service institutions (day care centers, child homes, shelters, etc.) for the benefit of most disadvantaged and marginalized drug dependent women and their children.

**Recommendation #4: Enhance regular data collection and analysis for monitoring project impact and outcomes**

As described earlier in the report the project lacked well-formulated results framework allowing measuring impact, outcomes of the project and implementation progress. Therefore it is recommended that Project Results Framework is streamlined by adding quantitative and qualitative indicators, regular analyzes of collected data practiced, problems identified and corrective measures implemented. Moreover, in order to measure project impact a qualitative Knowledge, Attitude, Practice survey has to be implemented in the pilot districts and compared with non-pilot data. Introduction of anonymous patient satisfaction surveys that measure attitudes, quality of service provision and level of social support will also inform project effectiveness.

### 5.2 RECOMMENDATIONS FOR SUSTAINABILITY AND SCALING UP

**Recommendation #5: Develop integrated strategy for care and support of drug dependent pregnant women and children born to them**

There has been an increased focus of the Government of Ukraine on the benefits of providing service within an integrated service delivery framework that crosses traditional organizational boundaries and brings together a range of professionals to provide health, social and other services for key groups of population, particularly for drug dependent women as stipulated in various health and social policy documents. The integrated service model, piloted by this project, is currently seen as one of the most effective ways of promoting optimal care and support for drug using women and their children. Assumptions underlying the success of an integrated model include benefits resulting from reduced complexity navigating the system (e.g. a single point of entry which reduced the need for multiple assessments), more timely service delivery and decreased likelihood of target groups “falling through the cracks”. In addition, from a preventative science viewpoint, the capacity for an integrated model to provide universal, targeted services that address multiple risk and protective factors and operate across multiple environment such as health
facility, social service, home and community, increases likelihood that the holistic needs of drug dependent pregnant women and children born to them will be met.

To make this model (ICM) sustain before further scale-up, the government is advised to develop an integrated national strategy for care and support of drug dependent pregnant women and children born to them. The strategy should be explicit on the integrated service provision model design, service packages, roles and responsibilities of multiple government actors in health and social sectors as well as front line service providers, integrated standard operation procedures, service provider reimbursement mechanisms and accountability standards.

Schematically elements of integrated strategy implementation are provided in Box 6.

UNICEF together with other development partners, such as WHO, UNAIDS, UNDP, WB and others can be instrumental in provision of financial and technical expertise to the government for the development of integrated service strategy document in participatory manner.

**Recommendation #6: develop national legislation framework regulating ICM**

In order to ensure sustainability, the government is advised to develop and endorse national legislation, which regulated governance of ICM, integrated service packages, structure, staffing norms, functions, standard operation procedures, referral algorithms, accountability forms and procedures as well as performance monitoring requirements. Furthermore timely adoption of and full compliance with integrated service delivery guidelines and protocols, including new PMTCT and NAS has to be regulated by respective legislation. More importantly, the importance of social contracting should be emphasized and required legislation enabling contracting out of selected social services to NGOs and private sector should be made available.

**Recommendation #7: Explore options for ICM scale-up**

The project is a good demonstration of government’s dedication and attempt to meet MDG 6 targets, particularly by targeting drug dependent pregnant women and children born to them. However limited number of integrated care centres can undermine targeting a critical mass of target population. Thus further expansion of ICM is highly recommended which will ensure improved coverage and provision of better access to integrated services for target beneficiaries. Acknowledging the difficult financial situation the country faces at present and ability to scale up the model nationally, the phased approach to national scale up is recommended. In the first instance the focus should be made to the regions, which demonstrate high HIV prevalence, high concentration of drug using population, availability of newly established perinatal center and ideological as well as financial readiness of the local governments to support the ICM introduction. Presence of newly established perinatal
centers would limit investment costs required for ICM introduction. Further expansion of the model can be guided by the country’s ability to provide political and financial support.

**Recommendation #8: Ensure adequate funding of Integrated Service Centers**

Inadequate funding of health services in general and medicines and medical supplies for CICPs in particular challenges the Government’s commitment for free service delivery to drug dependent pregnant women. The situation may further deteriorate with already introduced budget cuts for health and social services and the declining external support. Therefore, the government is advised to fully utilize the ICM costing methodology tool developed by UNAIDS in forecasting adequate funding for CICPs and safeguard adequate budget execution.

**Recommendation #9: Build health workforce capacity**

The ability of the country to meet its PMTCT goal depends largely on the knowledge, attitudes, skills, motivation and deployment of the people responsible for organization and delivery of integrated services. The Government of Ukraine acknowledged the lack/shortage of human resources needed to deliver essential quality integrated services. Therefore the government is advised to streamline the education of integrated service provider professionals.
ANNEXES

ANNEX 1: LIST OF DOCUMENTS REVIEWED

1. The State Program to ensure HIV prevention, treatment, care, and support to HIV-positive people and patients with AIDS for years 2009-2013
2. Progress in prevention of mother-to-child transmission of HIV infection in Ukraine: Results from a birth cohort study
3. Ukraine Health System Assessment, 2011
5. The assessment of the preconditions for introduction of the innovative model, Mary Hepburn, 2010
7. Reduction of HIV MTCT risks among pregnant IDU women in Ukraine, 2013
11. Impact of expanded access to combination antiretroviral therapy in pregnancy: results from a cohort study in Ukraine’, Heather Bailey, a Claire L Townsend, b Igor Semenenko, b Ruslan Mal yuta, b Mario Cortina-Borja, a Claire Thorne a for the Ukraine European Collaborative Study Group in EuroCoord, 2013.
17. “Violation of the right of female drug users (FDUs) to access to medical and social services in the field of sexual and reproductive health: pregnancy planning period, as well as antenatal, natal and postnatal periods’. All Ukrainian CF ‘Coalition of HIV-services organizations, Eurasian Harm Reduction Network, 2010.
20. Evaluation report on training in providing care for pregnant women using drugs and alcohol
21. MOH Decree #417, 15/07/2011
23. Draft Law of Ukraine On Approval of the National Target Social Program in Response to HIV/AIDS for 2014-2018
24. ‘HIV-infection in Ukraine’. Information bulletin #41, Ministry of Health of Ukraine, Kyiv, 2014
29. R.Booth at al, Predictors of HIV status among drug injectors at three Ukraine sites, 2006, AIDS, 20(17) -2217-23
31. S. Pinkham and A. Shapoval, Making Harm Reduction to Work for Women: The Ukrainian experience, Open Society, New York
33. Violation of the right of female drug users (FDUs) to access to medical and social services in the field of sexual and reproductive health: pregnancy planning period, as well as antenatal, natal and postnatal periods. All-Ukrainian Coalition of HIV service organizations”, 2012
34. L. Finnegan, Treatment Issues for opioid dependent women during the prenatal period, 1991, Psychoact drugs: 23-191-201
35. WHO Europe, Risk factors impacting on the spread of HIV among pregnant women in Russian Federation, 2007, Copenhagen
40. Martsynovskaya V., Ukrainian Center for Diseases Control data, 2012.
42. Assessment of existing chain of RH/FP service delivery to Injecting Drug Users and their partners in Kyiv City, Mykolayiv and Kirovograd oblast’. Yarui V., Kyiv, 2013.
43. The assessment of the preconditions for introduction of the innovative PMTCT model in Ukraine’. Dr Mary Hepburn, 2010.
44. T. Gotsadze, Assessment of the pilot “PMCTC and improvement of neonatal outcomes among drug dependent pregnant women and children born to them in three cities of Ukraine”, 2012
45. UN Evaluation Group Ethical Guidelines for evaluation, March 2008
   http://www.unevaluation.org/ethicalguidelines
47. Women, harm reduction and HIV – Key findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine, Open Society Institute, 2009
49. Women’ access to Harm Reduction and Reproductive health services in Ukraine, CIDA, OSI, 2008
ANNEX 2: LIST OF PEOPLE MET

1. Giovanna Barberis, Resident Representative, UNICEF
2. Tetyana Tarasova, HIV/AIDS Officer, UNICEF
3. Gabbi Akimova, Child Protection Specialist, UNICEF
4. Vlad Lashko, Social Services Officer, UNICEF
5. Iryna Grishaeva, Director, International Charitable Fund/William J. Clinton Foundation in Ukraine
6. Alvina Ilchenko, Consultant on work with clients, International Charitable Fund/William J. Clinton Foundation in Ukraine
7. Lyudmila Storozhuk, Chief of Medical & Social Assistance Section, Department of Counteraction to HIV/AIDS
8. Vladimir Kurpita, Head, State Service on HIV and Other Socially Dangerous Diseases
9. Maryna Zelenskaya, Head of the Department of Counteraction to HIV/AIDS
10. Vyacheslav Vladimirovych Kaminskiy, Professor, Director, Kiev City Reproductive & Perinatal Health Centre, CCIP
11. Vorobei Lyudmila, ob-gyn, Deputy Director, Kiev City Reproductive & Perinatal Health Centre
12. Dubik Galina, obstetrician-gynecologist in ANC, Kiev City Reproductive & Perinatal Health Centre
13. Golikova Oksana, Deputy Director on outpatient clinic issues, Kiev City Reproductive & Perinatal Health Centre
14. Filenko Larisa, Head of intensive care for newborns ward, Kiev City Reproductive & Perinatal Health Centre
15. Cherkashyna Lyudmila, Deputy Director, Kiev City Centre for Social Services for Family, Children and Youth
16. Yaroslava Kolobova, Deputy Director, Kiev City Centre for Social Services for Family, Children and Youth
17. Lyubov Loriashvili, Senior Specialist, Kiev City Centre for Social Services for Family, Children and Youth
18. Galina Skipalska, Director NGO 'Ukrainian Foundation of Public Health
19. Alla Gagarina, Psychologist, NGO ‘Ukrainian Foundation of Public Health
20. Valentyna Zalesskaya, Head of the children hospital № 4, Central Antenatal Clinic, Darnitsa district, Kyiv
21. Udod Natalia Vasylieva, Head of the ANC, Central Antenatal Clinic, Darnitsa district, Kyiv
22. Vladimir Rostunov, Director of the Clinical-Diagnostics Centre, Darnitsa district, Kyiv
23. Eleonora Gvozdeva, UNAIDS Strategic Information Adviser in Ukraine
24. Yuriy Kurilko, Deputy Director of Poltava Department of Health, Poltava oblast state administration
25. Igor Alexandrovych Perogov, Deputy Head of Oblast Health administration, Poltava
26. Lyudmila Ivanova, Chief oblast Ob-Gyn, Poltava
27. Stella Galinovska, Acting Senior Narcologist, Poltava
28. Nataliya Olegovna Udovitska, Head, City Maternity, ICDC, Poltava
29. Korotych O, Deputy Chief, City maternity hospital, ICDC, Poltava
30. Fedorova Olga, Ob/Gyn, Head of out-patient (antenatal) clinic, City maternity hospital, ICDC, Poltava
31. Lyudmila Lapshyna, Neonatologist, City maternity hospital, ICDC, Poltava
32. Nadezhda Tymoshenko, Deputy Director, NGO ‘Light of Hope’, Poltava
33. Sergiy Zhuk, Deputy Director, NGO ‘Light Hope’, Poltava
34. Maryna Gorulko, Psychologist, City Centre of Social Services for Families, Children and Youth Oblast entre of Social Services for Families, Children and Youth
35. Makedonskiy Igor Alexandrovych, Head of oblast health administration, Dnipropetrovsk
36. Mikhailova Victoria Victorovna, Deputy Head of oblast health administration, Dnipropetrovsk
37. Kaira Ekateryna Vladimirovna, Deputy Head of oblast health administration, Dnipropetrovsk
Dr. Leonid Vlasenko, Medical Coordinator in the pilot project, International Charitable Fund/ William J. Clinton Foundation in Ukraine (WJC Foundation),

Sofia Koba, Project Manager, International Charitable Fund/ William J. Clinton Foundation in Ukraine (WJC Foundation)

Olena Shcherbakova, Chief of the maternity hospital, ICDC, Dnipropetrovsk

Valentyn Kornienko, Chief of the Antenatal Clinic, ICDC, Dnipropetrovsk

Lyudmila Kashcheeva, Narcologist of the ICDC, Dnipropetrovsk

Alexander Kolesnik, Director DP branch of the All Ukrainian Network PLWHA,

Lyudmila Kolomoets, Social Worker, Day care Centre for IDUs mothers & children 'I am a Mother', Dnipropetrovsk

Ekateryna Lusenko, Social worker/midwife, Dnipropetrovsk branch of AUNPLWHA

Elena Loginova, Senior Social Worker, Day care Centre for IDUs mothers & children 'I am a Mother', Dnipropetrovsk

Olena Ivanova, psychologist, Day Care Centre for IDUs mothers & children 'I am a Mother'

Mikhailo Yaroshevs'ky, International HIV/AIDS Alliance in Ukraine, Regional coordinator, Dnipropetrovsk

Elena Arestovna Lesnichaya, Director, City AIDS Centre (based on the oblast hospital #21) and OST site, Dnipropetrovsk

Fatneva Inna Aleksandrovna, Director City Social services for Family, Children and Youth, Dnipropetrovsk

Dorokhina Larisa Vasilievna, Chief Oblast Narcologist, Oblast Narcologic al Dispensary, Dnipropetrovsk

Konstantin Viatlievych Murashko, Head, City Health administration, Krivui Rig

Osipova Svetlana Arkadievna, Head, NGO 'Public Health, Krivui Rig

Inna Tyurkova, Head of NGO 'Our Future', Krivui Rig

Ella Sokolyuk, Head of the Krivui Rig city branch of the All Ukrainian Network People Living with HIV/AIDS, Krivui Rig

Dabizha Pavel Mykolayuvych, Director city CSSFCY, Krivui Rig

Natalia Anatolievna Saprukina, Deputy Head, City Perinatology Centre (ICDC site), Krivui Rig

Cheply Tetyana, ob-gyn., Chief of clinical - diagnostics department, City Perinatology Centre (ICDC site), Krivui Rig

Galina Volodymurivna Zheleznyak, Narcologist of the project, Krivui Rig

Natalya Chupira, Social Worker, NGO 'Public Health', Krivui Rig

Samsonenko Natalya, Deputy Head, Shelter for clients on the basis of the Specialized Children's Home, Krivui Rig

Lyudmila Tymofeeva, Head of the Dnipropetrovsk City Hospital #21 (where City AIDS Centre is located.)
**ANNEX 3: EVALUATION FRAMEWORK**

*Lines in Italic are questions added by the Evaluation Team to the list of questions outlined in the TOR*

<table>
<thead>
<tr>
<th>ID</th>
<th>CRITERION/QUESTIONS</th>
<th>SPECIFIC QUESTIONS/INSTRUCTIONS</th>
<th>PERFORMANCE</th>
<th>METHODS OF DATA COLLECTION</th>
<th>METHODS OF DATA ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DR</td>
<td>IDI</td>
</tr>
<tr>
<td>R1</td>
<td>Was the project design relevant within the Ukrainian context: was this intervention in line with national AIDS priorities, strategies and goals?</td>
<td>Conduct situation analysis, Project design, objectives, interventions and target groups are relevant to country context</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R2</td>
<td>To what degree has the project objectives been relevant to the priorities and needs of women and children, particularly the most vulnerable groups of children in Ukraine?</td>
<td>Conduct situation analysis Identify needs, interests and circumstances of vulnerable and risk groups Project is consistent with the needs, interest and circumstances of the of women and children, particularly the most vulnerable groups of children in Ukraine</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R3</td>
<td>The extent to which project is designed and implemented to align and contribute to the needs of duty bearers</td>
<td>Assess whether project design and interventions are in line with the needs of duty bearers Project is designed and implemented to align and contribute to the needs of duty bearers</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**EFFECTIVENESS**

| EF1 | To what extent has the underlying theory of change been valid at this point? To what extent are the expected results chain occurring as planned? | Assess the underlying theory of change and identify whether results chain addresses current situation of the target groups. Examine results attained and compare with the planned result chain The Project’s underlying theory of change is valid at this point and expected results chain occur as planned | ✓  | ✓  | ✓  | ✓  | ✓  | ✓  |
| EF2 | To what extent has the design of the pilot model and its evolution, | Assess model design, monitoring reports, identify The design of the pilot model and its evolution, including | | | | | | |
| EF3 | To what degree has the project contributed to removing bottlenecks hampering the improvement of MTCT rate in Ukraine? | Assess MTCT bottlenecks and examine project's contribution/response in removing these bottlenecks | The project contributed to removing bottlenecks hampering the improvement of MTCT rate in Ukraine | ✓ | ✓ | ✓ | ✓ |
| EF4 | To what extent has the resources, including human resources and funding been used effectively and contributed to or hindered the achievement of results? | Assess adequacy and use of available human and financial resources | The resources, including human resources and funding been used effectively and contributed to or hindered the achievement of results | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| EF5 | Did the project result in better coverage, quality and uptake of services for pregnant drug dependent women in selected sites? | Examine baseline and end line data on coverage, quality and uptake of services for pregnant drug dependent women in selected sites | The project result in better coverage, quality and uptake of services for pregnant drug dependent women in selected sites | ✓ | ✓ | ✓ | ✓ |
| EF6 | To what extent have medical and social services been integrated within the project and how has it made an effect on the project results? | Assess degree of integration, referral guidelines and practices | The medical and social services have been integrated within the project and positively affected project results | ✓ | ✓ | ✓ | ✓ | ✓ |
| EF7 | To what extent have capacity-building activities for service providers resulted in service quality improvement and increase of PMTCT coverage? | Examine capacity-building activities carried out by the project on its relevance and effectiveness. Assess use of acquired knowledge and skills in the daily work of service providers | The capacity-building activities for service providers resulted in service quality improvement and increase of PMTCT coverage | ✓ | ✓ | ✓ | ✓ | ✓ |
| EF8 | Were UNICEF inputs to the programme provided in a timely way? | Examine AWPs and progress reports | Robust evidence exists demonstrating timely provision of inputs | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| EF9 | To what extent and in what ways has ownership, or the lack of it, impacted on the effectiveness of the project? | Examine positive and or negative effects of ownership on the effectiveness of the project | Robust evidence exists demonstrating ownership effects (+/-) on the effectiveness of the project | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| EF10 | How and to what extent has the project management, coordination, partnership, and monitoring and evaluation contributed to the effectiveness of the programme? | Assess: | | | | | | | | |
| | **Project management** by structure, staffing, technical skills, and budget. Review M&E reports on the challenges identified and corrective measures of the program management | Project management demonstrates: adequate staffing, availability of technical knowledge of staff, and sufficient funding. Risk and challenges are identified in a timely manner and reaction generated | ✓ | ✓ | ✓ | ✓ | ✓ | |
| | **Coordination** by assessing coordination mechanism set, its operation and effectiveness. Identify strength and weakness of coordination and examine its implications on the program implementation effectiveness | Coordination mechanism in place, demonstrates regularity and effectiveness (measured by avoidance of duplications) of coordination efforts | ✓ | ✓ | ✓ | |
| | **Partnership** – examine partnership arrangements, type of support provided, assess attribution/contribution to the program performance | NA | ✓ | ✓ | ✓ | ✓ | ✓ | |
| | **M&E** – assess M&E system set, reporting procedures and guidelines, degree of knowledge of users, M&E budgets and expenditure. Examine frequency, regularity and quality (key challenges and | Robust evidence exists on effectiveness of M&E system. | ✓ | ✓ | ✓ | ✓ | ✓ |
weakness identified, reported and corrective measures planned and implemented of monitoring visits by reviewing M&E reports and quality data obtained from users. Identify whether data analysis guides further actions.

### EFFICIENCY

| EFF 1 | How cost effective are the project activities compared to similar activities in Ukraine? | Observe expenditure data for similar activities and compare costs against results achieved | Project activities compared to similar activities in Ukraine are cost effective | ✓ | ✓ | ✓ |
|------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------------------------------------| ✓ | ✓ | ✓ |
| EFF2 | Has the initiative used resources (funds, expertise, time) in the most economical manner to achieve the results? | Examine resource utilization modalities and patterns | The initiative used resources (funds, expertise, time) in the most economical manner to achieve the results | ✓ | ✓ | ✓ |
| EFF3 | The extent to which the allocation of resources to target group takes into account the need to prioritize those most marginalized? | Perform project financial data analysis | The allocation of project resources to target group takes into account the need to prioritize those most marginalized | ✓ | ✓ | ✓ |

### IMPACT

<p>| IM1  | To what extent have the primary beneficiaries experienced increased access to various integrated services, or increased ability to demand/seek support? | Using project results framework assesses data on outcome output indicators and compare with baselines and targets. Evaluate whether targets were met or not. Use categorization of results – fully met, partially met, not met. Assess attribution/contribution of UNICEF’s support against results attained | The primary beneficiaries experienced increased access to various integrated services, or increased ability to demand/seek support | ✓ | ✓ | ✓ |
| IM2  | To what extent have the primary beneficiaries satisfied with the | Examine available quantitative and qualitative data on client | The primary beneficiaries are satisfied with the quality of | ✓ | ✓ | ✓ |</p>
<table>
<thead>
<tr>
<th></th>
<th>quality of services available for them up until now?</th>
<th>satisfaction</th>
<th>services available for them up until now</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>IM3</td>
<td>To what extent have the primary beneficiaries perceived that their unique needs and sensitivities are reflected in the established services?</td>
<td>Obtain qualitative data</td>
<td>The primary beneficiaries perceive that their unique needs and sensitivities are reflected in the established services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IM4</td>
<td>To what extent have the primary beneficiaries been able to take up (use) on the available services</td>
<td>Obtain qualitative data</td>
<td>The primary beneficiaries were able to use available resources</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>IM5</td>
<td>To what extent has the equity gap closed (or likely to close) in the access to services of vulnerable groups of drug using pregnant women?</td>
<td>Obtain qualitative data from women who have not used the services</td>
<td>The equity gap was closed (or likely to close) in the access to services of vulnerable groups of drug using pregnant women</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>IM6</td>
<td>To what extent has the gender, human and child rights and capacity-building issues, including cross sectoral cooperation between medical and social sectors, taken into account in the pilot model and to what extent have they have contributed to achieving of the results?</td>
<td>The gender, human and child rights and capacity-building issues, including cross sectoral cooperation between medical and social sectors, were taken into account in the pilot model and have contributed to achieving of the results</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IM7</td>
<td>How has the project influenced or affected local and national authorities and the wider community to provide integrated health/social services targeting</td>
<td>Use data obtained from previous sections to arrive to conclusion</td>
<td>The project influenced or affected local and national authorities and the wider community to provide integrated health/social</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

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103 Integrating Human Rights and Gender Equality in Evaluation – Towards UNEG Guidance
http://www.uneval.org/papersandpubs/documentall.jsp?showAll=1&doc_source_id=0&doc_cat_source_id=4&doc_source_extra_id=0&doc_cat_id=74
<p>| | |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td><strong>vulnerable groups of women?</strong></td>
<td><strong>services targeting vulnerable groups of women</strong></td>
</tr>
<tr>
<td><strong>IM8</strong></td>
<td></td>
</tr>
</tbody>
</table>
To what extent has the project changed behaviors and attitudes of local and national authorities towards the rights of vulnerable groups of women including drug using pregnant women (or likely to change)?  
Use data obtained from previous sections to arrive to conclusion  
The project changed behaviors and attitudes of local and national authorities towards the rights of vulnerable groups of women including drug using pregnant women |

|   | ✓ | ✓ | ✓ | ✓ |
| **IM9** |  
To what extent the project has changed (or likely to change) behaviors and attitudes of healthcare and social service workers towards drug using pregnant women?  
Collect qualitative and quantitative data if available on the attitudes of healthcare and social service workers and compare with the baseline  
The project has changed behaviors and attitudes of healthcare and social service workers towards drug using pregnant women |

|   | ✓ | ✓ | ✓ | ✓ |

**SUSTAINABILITY**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ST1</strong></td>
<td></td>
</tr>
</tbody>
</table>
To what extent have partnership and stakeholders’ involvement at different stages of the project been decisive for the project in attaining its expected results up until now?  
Assess partner’s and stakeholders’ involvement at different stages of the project and identify size/volume of their contribution as well as degree ownership  
Partnership and stakeholders’ involvement at different stages of the project been decisive for the project in attaining its expected results up until now |

|   | ✓ | ✓ | ✓ | ✓ |
| **ST2** |  
To what extent has the project contributed to the advancement and the progress of fostering national ownership, engagement and capacity?  
Analyze project contribution towards national/local ownership development and capacity creation  
The project contributed to the advancement and the progress of fostering national ownership, engagement and capacity |

|   | ✓ | ✓ |
| **ST3** |  
Will the system change for improved access of vulnerable target groups be sustained in the country without support from UNICEF and other development partners? If not, what are the key factors and bottlenecks that may affect the sustainability of the results?  
Identify key strength and weaknesses  
NA  
Identify key strength and weaknesses |

|   | ✓ | ✓ | ✓ | ✓ |
| ST4 | Have national and/or local institutions shown technical capacity and leadership commitment to keep working with the project or to scale it up? | The national and/or local institutions **leadership** and **technical capacity** to be measured by clear assignment of roles and responsibilities to particular structure, adequacy of staffing, financial and material resources, ability to plan, monitor/supervise service delivery, analyze results, identify problems/risks and plan for corrective measures. | The national and/or local institutions demonstrate sound technical capacity and leadership commitment. | ✓ | ✓ |  | ✓ |
## ANNEX 4 A: ORIGINAL RESULTS FRAMEWORK

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Verifiable Indicator</th>
<th>Baseline*</th>
<th>Target**</th>
<th>Underlying Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence base for recognition of HIV pregnant IDUs and children born to them as a target group for HIV response and provision of integrated services created</td>
<td>Availability of evidences of the role of target group (pregnant IDUs) as a contributor to national MTCT rate elevation</td>
<td>0</td>
<td>Knowledge generated by research and studies about the MTCT determinants are available</td>
<td>Series of researches and studies identified social and demographic characteristics of HIV-positive women transmitted HIV to their babies and interrelation between drug use in pregnant and MTCT of HIV (list of studies see pp. 8-10)</td>
</tr>
<tr>
<td>The policy barriers to services for pregnant IDUs removed.</td>
<td>PMTCT Policy</td>
<td>0</td>
<td>The policy barriers to services for pregnant IDUs removed. Guidelines and Protocol on PMTCT with focus on pregnant IDUs updated and approved.</td>
<td>In progress</td>
</tr>
<tr>
<td>Vulnerable groups of pregnant women are accessing and using the HIV integrated services in selected pilot cities</td>
<td>No of Centres of Integrated Services (CIS) established</td>
<td>0</td>
<td>4</td>
<td>The local capacity of state supported institutions and service providers in cooperation with local NGOs in four selected pilot cities enhanced in managing and providing essential HIV services to pregnant IDUs. Model is evaluated and documented.</td>
</tr>
<tr>
<td>Number of pregnant IDUs</td>
<td>Estimated No. of pregnant IDUs - 1,300</td>
<td>No increase by 2016</td>
<td>Repeated PSE study will be conducted in 2015</td>
<td></td>
</tr>
<tr>
<td>Percentage of vulnerable to HIV and already HIV-infected pregnant IDUs accessing and utilizing integrated package of services, including OST</td>
<td>0</td>
<td>90% in pilot sites</td>
<td>168 women covered by the integrated services in four pilot cities (66, 9% in four pilots and 12.9% related to national estimates) in 2013. In progress</td>
<td></td>
</tr>
<tr>
<td>Health care providers and social workers have appropriate knowledge and skills to provide quality services for pregnant IDUs and children born to them. The attitude and practices towards vulnerable to HIV pregnant IDUs changed to positive</td>
<td>Number of service providers trained</td>
<td>0</td>
<td>400 (pilot project target)</td>
<td>250 health care providers and social workers have appropriate knowledge and skills to provide quality services for drug using pregnant women and children born to them (confirmed by evaluation and researches data) In progress</td>
</tr>
<tr>
<td>Proportion of clients satisfied by services</td>
<td>N/A</td>
<td>90%</td>
<td>Research data 82%. Quality of services increase clients’ satisfaction</td>
<td></td>
</tr>
<tr>
<td>Risk of mother-to-child transmission of HIV in IDUs reduced</td>
<td>MTCT rate HIV for IDUs and for all women</td>
<td>16.4% for IDUs(^{104}) (ECS, 2008); 6.2% for all women(^{105}) (2007);</td>
<td>Less than 2% among all women (national target)</td>
<td>Research for MTCT rate among IDUs to be conducted in 2015</td>
</tr>
<tr>
<td>To increase access of pregnant IDUs to integrated medical and social services</td>
<td>Pregnant drug using women as a target group included into the National AIDS Plan</td>
<td>No</td>
<td>Yes</td>
<td>Implemented</td>
</tr>
</tbody>
</table>

\(^{104}\) Dr Claire Thorne, UCL Institute of Child Health, University College London. Report on injecting drug use in pregnant HIV-positive women in Ukraine: data from the Ukraine European Collaborative Study and the Cohort Study of HIV-infected childbearing women. September, 2012.

\(^{105}\) The MoH, Information Bulletin # 38, 2009
<table>
<thead>
<tr>
<th>2014-2018</th>
<th>Proportion of IDUs pregnant women covered by ART</th>
<th>48% in 2013\textsuperscript{106}</th>
<th>98% by 2016</th>
<th>Research to be conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of the IDUs -clients' satisfaction with the quality of services (projects' data)</td>
<td>100% by 2016</td>
<td>To be assessed in 2015</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ANNEX 4 B: REVISED RESULTS FRAMEWORK

<table>
<thead>
<tr>
<th>MOBES</th>
<th>IMPACT</th>
<th>INDICATOR</th>
<th>MEANS OF VERIFICATION</th>
<th>BASELINE 2010</th>
<th>TARGET by end of 2014</th>
<th>FREQUENCY</th>
<th>ACTUAL as of June 30, 2014</th>
<th>STATUS &amp; COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>IMPACT</td>
<td>Drug using woman is alive with her HIV negative child and is supported by community and government</td>
<td>I.1 National MTCT rate</td>
<td>National Statistics (UCDC)</td>
<td>4.9%</td>
<td>Biannual</td>
<td>4.28% (2012)</td>
<td>DECREASING TEND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.2 MTCT rate in pilot project administration units among HIV+ IDU women</td>
<td>I.2.1 Dnipropetrovsk</td>
<td>National Statistics (UCDC)</td>
<td>35.7%</td>
<td>NA</td>
<td>Biannual</td>
<td>7.7% (2012)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.2.2 Kyiv</td>
<td>National Statistics (UCDC)</td>
<td>5.3%</td>
<td>NA</td>
<td>Biannual</td>
<td>0% (2012)</td>
<td>DECREASING TEND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.2.3 Poltava</td>
<td>National Statistics (UCDC)</td>
<td>4.9%</td>
<td>NA</td>
<td>Biannual</td>
<td>0% (2012)</td>
<td>DECREASING TEND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.3 AIDS related mortality in drug using pregnant women</td>
<td>National Statistics (UCDC)</td>
<td>NA</td>
<td>NA</td>
<td>Annual</td>
<td>Not Available</td>
<td>NOT MEASURED</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.4 New pediatric HIV infection among children born to drug using pregnant women in pilot regions:</td>
<td>I.4.1 Dnipropetrovsk</td>
<td>National Statistics (UCDC)</td>
<td>35</td>
<td>NA</td>
<td>Annual</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.4.2 Kyiv</td>
<td>National Statistics (UCDC)</td>
<td>10</td>
<td>NA</td>
<td>Annual</td>
<td>0</td>
<td>DECREASING TEND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I.4.3 Poltava</td>
<td>National Statistics (UCDC)</td>
<td>3</td>
<td>NA</td>
<td>Annual</td>
<td>0</td>
<td>DECREASING TEND</td>
</tr>
<tr>
<td>Outcome</td>
<td>Indicator</td>
<td>Description</td>
<td>Source</td>
<td>Project</td>
<td>Targets</td>
<td>Reporting Frequency</td>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>-------------</td>
<td>--------</td>
<td>---------</td>
<td>---------</td>
<td>---------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td><strong>3</strong></td>
<td><strong>Outcome 1</strong></td>
<td>Uptake and adherence to quality PMTCT services by drug using pregnant women improved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O.1.1</td>
<td>Percentage of IDU pregnant women enrolled in pilot project</td>
<td>Project Reports</td>
<td>0</td>
<td>90%</td>
<td>Annual</td>
<td>40%</td>
<td><strong>PARTIALLY MET</strong> (in the absence of the target, considered to be partially met)</td>
<td></td>
</tr>
<tr>
<td>O.1.2</td>
<td>Cumulative number of IDU pregnant women enrolled in the project</td>
<td>Project Reports</td>
<td>0</td>
<td>250</td>
<td>Annual</td>
<td>231</td>
<td><strong>PARTIALLY MET</strong></td>
<td></td>
</tr>
<tr>
<td>O.1.3</td>
<td>Percentage of IDU pregnant women enrolled in the project in the first trimester</td>
<td>Project Reports</td>
<td>0</td>
<td>NA</td>
<td>Annual</td>
<td>9%</td>
<td><strong>PARTIALLY MET</strong> (Annual increase reported)</td>
<td></td>
</tr>
<tr>
<td>O.1.4</td>
<td>Percentage of new clients with unknown HIV status at the project entry tested on HIV</td>
<td>Project Reports</td>
<td>0%</td>
<td>NA</td>
<td>Annual</td>
<td>100%</td>
<td><strong>MET</strong></td>
<td></td>
</tr>
<tr>
<td>O.1.5</td>
<td>Percentage of IDU women enrolled in the project receiving ART</td>
<td>Project Reports</td>
<td>0</td>
<td>NA</td>
<td>Annual</td>
<td>Not Available</td>
<td><strong>NOT MEASURED</strong></td>
<td></td>
</tr>
<tr>
<td>O.1.6</td>
<td>Knowledge (%) of IDU women on HIV transmission</td>
<td>BSS, Knowledge Attitude and Practice survey</td>
<td>NA</td>
<td>NA</td>
<td>By-annual</td>
<td>Not Available</td>
<td><strong>NOT MEASURED</strong></td>
<td></td>
</tr>
<tr>
<td>O.1.7</td>
<td>Increased compliance with PMTCT guidelines in management of IDU pregnant women and child born to them</td>
<td>Quality audit (Direct observation and Criterion Based audits)</td>
<td>NA</td>
<td>NA</td>
<td>Annual</td>
<td>Not Available</td>
<td><strong>NOT MEASURED</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome 2</strong></td>
<td>The harm of street drugs to pregnant women, fetus and infants are reduced</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O.2.1</td>
<td>Percentage of IDU pregnant women starting OST after enrollment in the project</td>
<td>Project Reports</td>
<td>0</td>
<td>NA</td>
<td>Annual</td>
<td>85%</td>
<td><strong>PARTIALLY MET</strong> (Annual increase reported)</td>
<td></td>
</tr>
<tr>
<td>O.2.2</td>
<td>Percentage of IDU pregnant women continuing OST after delivery in the project</td>
<td>Project Reports, Survey</td>
<td>0</td>
<td>NA</td>
<td>By-annual</td>
<td>Not Available</td>
<td><strong>NOT MEASURED</strong></td>
<td></td>
</tr>
<tr>
<td>O.2.3</td>
<td>Percentage of newborns born to drug dependent women with neonatal withdrawal syndrome managed according guidelines</td>
<td>Project Reports</td>
<td>NA</td>
<td>NA</td>
<td>Annual</td>
<td>Not Available</td>
<td><strong>NOT MEASURED</strong></td>
<td></td>
</tr>
<tr>
<td>O.2.4</td>
<td>Knowledge (%) of IDU women on the harm of drug use on</td>
<td>BSS, Knowledge Attitude and</td>
<td>0</td>
<td>NA</td>
<td>By-annual</td>
<td>Not Available</td>
<td><strong>NOT MEASURED</strong></td>
<td></td>
</tr>
<tr>
<td>OUTCOME 3</td>
<td>Practice survey</td>
<td>Project Reports</td>
<td>NA</td>
<td>NA</td>
<td>Annual</td>
<td>NOT AVAILABLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>----</td>
<td>-----</td>
<td>---------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant women and young mothers using drugs receive family, community and social support and keep custody for their children</td>
<td>Percentage of IDU pregnant women and young mothers receiving basic package of social services</td>
<td>Project Reports</td>
<td>NA</td>
<td>NA</td>
<td>Annual</td>
<td>NOT MEASURED</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of IDU mothers who lost parental rights after enrollment in the project</td>
<td>Project Reports</td>
<td>NA</td>
<td>0</td>
<td>Annual</td>
<td>2 cases</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPUT 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CM that meets target beneficiary needs and is informed by the best international practices is designed, owned by all parties provides quality health and social services to pregnant drug using mothers</td>
<td>Evidence on the IDU pregnant women and young mothers needs, health and social service access barriers available</td>
<td>Research/Study</td>
<td>NA</td>
<td>NA</td>
<td>Knowledge generated by research and studies about the MTCT determinants are available</td>
<td>4</td>
</tr>
</tbody>
</table>

| OP.1.1                                                                      |                                                                                       |               |    |     |         |                |
|                                                                            | Number of ICDC established                                                              | Project Reports | 0  | 4  | Annual | MET            |
|                                                                            | Share of relevant stakeholders who participated in project design, implementation and M&E | Project Reports | NA | NA | Annual | NOT AVAILABLE  |
|                                                                            | Referral algorithms developed, approved and fully complied                              | Project Reports, Quality Audit reports | NA | Referral algorithms developed, approved and fully complied | Referral algorithms developed and utilized in Kyiv |
|                                                                            | Number of service providers trained                                                     | Project Reports | NA | 400 (pilot project target) | Annual | 250 health care providers and social workers have | PARTIALLY MET |

<p>| OP.1.2                                                                      |                                                                                       |               |    |     |         |                |
|                                                                            |                                                                                       |               |    |     |         |                |
|                                                                            |                                                                                       |               |    |     |         |                |
|                                                                            |                                                                                       |               |    |     |         |                |
|                                                                            |                                                                                       |               |    |     |         |                |
| OP.1.6 | Percentage of IDU pregnant women and young mothers satisfied with the health staff attitudes | Survey | NA | NA | By-annual | appropriate knowledge and skills | PARTIALLY MET (Low level of satisfaction at OST and AIDS centers) |
| OP.1.7 | IDU pregnant women and young mother satisfaction with the quality of health services | Survey | NA | 100% by 2016 | By-annual | Overall satisfaction not available though satisfaction according number of indicators collected | NOT MEASURED |
| OP.1.8 | IDU pregnant women and young mother satisfaction with the quality of social services | Survey | NA | NA | By-annual | Not Available | NOT MEASURED |
| OP.1.9 | Number of international knowledge sharing activities | Project Reports | NA | 3 | By-annual | 3 | MET |
| OP.2.1 | PMTCT Policy developed | Project Report | NA | | | Guidelines and Protocol on PMTCT with focus on pregnant IDUs under development | PARTIALLY MET |</p>
<table>
<thead>
<tr>
<th>OUTPUT</th>
<th>Description</th>
<th>Key Elements</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>The governance structure of the ICM demonstrates effective operations</td>
<td>Plan for national scale up of ICM developed and approved</td>
<td>Project Report, Plan</td>
<td>Not Available</td>
</tr>
<tr>
<td>4</td>
<td>Funding for the scale-up of integrated service delivery model ensured from public and/or external resources</td>
<td>Funding for the scale-up of integrated service delivery model ensured from public and/or external resources</td>
<td>Project Report, National/local funding data</td>
<td>Not Available</td>
</tr>
<tr>
<td>3</td>
<td>ICM model, governance structure, staffing, job descriptions, basic packages of health and social services approved</td>
<td>ICM model, governance structure, staffing, job descriptions, basic packages of health and social services approved</td>
<td>Project Report, MoH Decree(s)</td>
<td>Legal framework endorsed and fully implemented</td>
</tr>
<tr>
<td>3</td>
<td>Number of most vulnerable IDU pregnant mother and young mothers receiving social protection</td>
<td>Number of most vulnerable IDU pregnant mother and young mothers receiving social protection</td>
<td>Project Report</td>
<td>Annual</td>
</tr>
<tr>
<td>4</td>
<td>Models of family and community support developed</td>
<td>Models of family and community support developed</td>
<td>Project Report</td>
<td>Not Available</td>
</tr>
</tbody>
</table>
ANNEX 5: IN DEPTH INTERVIEW GUIDE

Even though IDI are flexible, they require rigorous preparation. Based on the Evaluation criteria, the Evaluation Team will decide which questions (provided in the Evaluation Framework) are most appropriate for the subject respondent and list them as a checklist. The given checklist/guide will be used during the interview.

Illustrative example of IDI guides include the questions (EF questions codes are used for easy representation) as given in Table below:

<table>
<thead>
<tr>
<th>Instructions for interviewer:</th>
<th>UNICEF</th>
<th>Implementing Partners</th>
<th>National and Local Agencies</th>
<th>Development Partners</th>
<th>Service Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Draw up a consent form specifying the rules of the interview and the confidentiality commitment;</td>
<td>R1, R2, R3 EF1, EF2, EF3, EF4, EF6, EF7, EF8, EF9, EF 10 EFF1, EFF2 IM1, IM 2, IM7, IM8, IM9 ST1, ST 2, ST 3, ST4</td>
<td>R1, R2, R3 EF1, EF2, EF3, EF4, EF6, EF7, EF8, EF9, EF 10 EFF2 IM1, IM 2, IM7, IM8, IM9 ST1, ST 2, ST 3, ST4</td>
<td>R1, R2, R3 EF1, EF2, EF3, EF4, EF6, EF7, EF8, EF9, EF 10 EFF2 IM1, IM 2, IM7, IM8, IM9 ST1, ST 2, ST 3, ST4</td>
<td>R1, R2, R3 EF1, EF2, EF3, EF4, EF6, EF7, EF8, EFF1, EFF2 IM1, IM 2, IM7, IM8, IM9 ST1, ST 2, ST 3, ST4</td>
<td>R2, R3 EF1, EF2, EF3, EF4, EF6, EF7, EF8, EF9, EF 10 EFF2 IM1, IM 2, IM7, IM8, IM9 ST1, ST 2, ST 3, ST4</td>
</tr>
</tbody>
</table>
ANNEX 6: FGD GUIDES

ANNEX 6.1 GUIDE FOR HEALTHCARE SERVICE PROVIDERS

- Introduction to the objectives of the research
- A brief introduction to the rules of focus groups
  o Everything said and done is confidential and will not be used outside the room except for the purposes of this research;
  o Every statement is right;
  o Please do not hesitate to disagree with someone else;
  o But do not all talk at once
- Ask people to describe who they are and say few words about themselves
- Introduce the topic under review
- Ask questions

1. Which guidelines and or service protocols you usually use in a daily work?
2. Please name type of trainings you received
3. Please explain relevance of knowledge and skills acquired to your daily work
4. Please explain how you use the knowledge and skills acquired in daily practice. Are there additional needs for training? If yes, please give examples
5. Which resources (financial, material, human) do you have and what are missing/needed ones? How often you receive replenishment of supplies and medicines?
6. What are the most demanded services from IDU pregnant women?
7. What are the service(s) that are demanded by IDU pregnant women but not provided at present?
8. Where and how you spread information about CIPC services your center provides?
9. What are main challenges in provision of services to IDU pregnant women if any? Please give examples
10. What type of support you receive from management (facility and district health authorities)?
11. How would you rate on the scale from one (no ownership) to five (strong ownership) the ownership of the management of the facility and local health authorities? Please give examples regardless the degree of ownership.
12. Please explain whether and how “companionship of outreach worker” motivates IDU pregnant women to seek services they need at ICPC centers?
13. How would you rate coordination between social workers and health service providers? How would you rate the referral system in place on the scale from 1 to 3, where 1 is excellent and 3 is bad?
14. What are key benefits of program to you personally; to your center and IDU pregnant women you serve?
15. Do you think when donor funding ends you can still continue provision of services to IDU pregnant women in the same way you do now? If not, please explain why
16. Please explain your willingness to continue provision of same services after external funding ends.

- Ask if they would like to add further comments.
- Bring the meeting to a close by summarizing the main points.
- Thank you
ANNEX 6.2 FGD GUIDE FOR DRUG-DEPENDENT WOMEN WHO RECEIVED SERVICES

- Introduction to the objectives of the research
- A brief introduction to the rules of focus groups
  - Everything said and done is confidential and will not be used outside the room except for the purposes of this research;
  - Every statement is right;
  - Please do not hesitate to disagree with someone else;
  - But do not all talk at once
- Ask people to describe who they are and say few words about themselves
- Introduce the topic under review
- Ask questions

1. How often do you use CIPC Services and what are these services?
2. Where and how do you get information about the CIPC services?
3. How would you characterize availability of and access to information about CIPC services for urban and rural women, women of different ethnicities, age groups?
4. What are the things that you like about CIPC centre?
5. What are the things that you do not like about CIPC centre?
6. How would you characterize availability of all those services you need at CIPC centers? If not all services are provided that you need where do you go to get these services?
7. What are the services that you need, but not provided by CIPC centers at present?
8. Based on you experience how would you characterize attitude of medical personnel to you personally as well as to your peers?
9. Based on you experience how would you characterize availability of all medical supplies needed at the time of the visit?
10. How often you are referred to other service providers for required services (testing, specialist consultation, social services etc.)?
11. How often if at all you share information about your experience of CIPC services with your peers and how do you do this?
12. Do you prefer to use CIPC services in close proximity or far from where you live and or study and provide your explanation (why).
13. Please explain what are main barriers you have to freely access CIPC services (proximity, availability of CIPC, attitude of medical personnel, religion, payment, peer pressure etc.)
14. How would you assess the visit and services you received at CIPIC, duration and process of the visit and topics of counseling if you received it?
15. Do you think that social workers helped you to access the services?
16. Did you face any ethical or other types of barriers to access services?
17. Where you involved in the design of CIPIC model?
18. If you were to decide the design of integrated service provision, what will you propose?
19. How outreach services work and how it can be improved?
20. Do you think the way it is organized now outreach services can reach more young people? Please explain
21. What can be done to bring more drug dependent women to use the services at CIPC centre?
22. Can you please explain what potential role case manager plays or can play to inform and encourage drug using women to use CIPC services?
23. What role you can play to reach out others and what would you need to do so?
24. Please explain how “social benefits, food and hygiene packages” motivates you and your peers to seek services and provide examples/explanation
25. Have you noticed any changes recently since 2013? If so, what were these changes? Please give examples and/or explain.
26. Will you recommend/advocate your friends and community members to use CIPC services? If not please explain the reason.

- Ask if they would like to add further comments.
- Bring the meeting to a close by summarizing the main points.
- Thank you
ANNEX 6.3  FGD GUIDE FOR DRUG-DEPENDENT WOMEN WHO HAVE NOT RECEIVED SERVICES

- Introduction to the objectives of the research
- A brief introduction to the rules of focus groups
  - Everything said and done is confidential and will not be used outside the room except for the purposes of this research;
  - Every statement is right;
  - Please do not hesitate to disagree with someone else;
  - But do not all talk at once
- Ask people to describe who they are and say few words about themselves
- Introduce the topic under review
- Ask questions

1. Please explain what are your major concerns?
2. What are the information and services you need most in this context?
3. Where do you get required services? Please list and give examples
4. Can you estimate number of your peers who have no access to health services by using the following estimates:
   a. Very few
   b. Few
   c. Some
   d. Most of them
   e. DKN
5. With whom you usually share information about your health status?
   a. Peers?
   b. Parents?
   c. Partner?
   d. Relatives?
   e. Medical personnel?
   f. Teachers?
   g. Other?
6. Have you ever heard about CIPC services from any source (peers, friends, relatives, TV, radio press) and do you know type of services they provide? If not FGD facilitator should explain
7. What are the conditions that CIPC has to meet for you to use them?
8. Please explain why you did not seek services at CIPC clinic?
   a. No need?
   b. No result?
   c. Lack information?
   d. Geographic location of CIPC center?
   e. Service costs?
   f. Attitude of medical personnel?
   g. Confidentially related issues?
   h. Cultural/societal issues?
   i. Parent consent?
   j. Peer pressure?
   k. Other?
9. Do you think outreach service (explain purpose and how it functions) is an effective way to reach out drug user women? If not, explain why and suggest
a. How it can be improved?
b. What can work better?

10. What are the sources and types of information you will be interested to receive that can encourage you to seek care?

11. If you were to decide the design of integrated service provision, what will you propose?

12. Will you listen to your friend’s and community member’s recommendation to use CIPC services? If not please explain.

13. Will you be willing and interested to reach out others and what would you need to do so?

- Ask if they would like to add further comments.
- Bring the meeting to a close by summarizing the main points.
- Thank you
ANNEX 6.4  FGD GUIDE FOR SOCIAL WORKERS

- Introduction to the objectives of the research
- A brief introduction to the rules of focus groups
  - Everything said and done is confidential and will not be used outside the room except for the purposes of this research;
  - Every statement is right;
  - Please do not hesitate to disagree with someone else;
  - But do not all talk at once
- Ask people to describe who they are and say few words about themselves
- Introduce the topic under review
- Ask questions

1. Please name type of trainings you received
2. Please explain relevance of knowledge and skills acquired to your daily work
3. Please explain how you use the knowledge and skills acquired in daily practice. Are there additional needs for training? If yes, please give examples
4. Which resources (financial, material, human) do you have and what are missing/needed ones? How often you receive replenishment of supplies and medicines?
5. What are the most demanded services from IDU pregnant women?
6. What are the service(s) that are demanded by IDU pregnant women but not provided at present?
7. What are main challenges in provision of services to IDU pregnant women if any? Please give examples
8. What type of support you receive from management and district authorities?
9. How would you rate on the scale from one (no ownership) to five (strong ownership) the ownership of the management and local authorities? Please give examples regardless the degree of ownership.
10. Please explain whether and how “companionship of outreach worker” motivates IDU pregnant women to seek services they need?
11. How would you rate coordination between social workers and health service providers? How would you rate the referral system in place on the scale from 1 to 3, where 1 is excellent and 3 is bad?
12. What are key benefits of program to you personally; to your center and IDU pregnant women you serve?
13. If you were to decide the design of integrated service provision, what will you propose for the social package? What will be the role of social workers?
14. 
15. Do you think when donor funding ends you can still continue provision of services to IDU pregnant women in the same way you do now? If not, please explain why
16. Please explain your willingness to continue provision of same services after external funding ends.

- Ask if they would like to add further comments.
- Bring the meeting to a close by summarizing the main points.
- Thank you
ANNEX 6.5  FGD GUIDE FOR OUTREACH WORKERS

- Introduction to the objectives of the research
- A brief introduction to the rules of focus groups
  o Everything said and done is confidential and will not be used outside the room except for the purposes of this research;
  o Every statement is right;
  o Please do not hesitate to disagree with someone else;
  o But do not all talk at once
- Ask people to describe who they are and say few words about themselves
- Introduce the topic under review
- Ask questions

1. Please name type of trainings you received
2. Please explain relevance of knowledge and skills acquired to your daily work
3. Please explain how you use the knowledge and skills acquired in daily practice. Are there additional needs for training? If yes, please give examples
4. Which procedures, guide do you use in your outreach work?
5. Which resources (financial, material, human) do you have and what are missing/needed ones? How often you receive replenishment of supplies and medicines?
6. What are the most demanded services from IDU pregnant women?
7. What are the service(s) that are demanded by IDU pregnant women but not provided at present?
8. What are main challenges in provision of services to IDU pregnant women if any? Please give examples
9. What type of support you receive from management and district authorities?
10. How would you rate on the scale from one (no ownership) to five (strong ownership) the ownership of the management and local authorities? Please give examples regardless the degree of ownership.
11. Please explain whether and how “companionship of outreach worker” motivates IDU pregnant women to seek services they need?
12. How would you rate coordination between social workers and health service providers? How would you rate the referral system in place on the scale from 1 to 3, where 1 is excellent and 3 is bad?
13. What are key benefits of program to you personally; to your center and IDU pregnant women you serve?
14. If you were to decide the design of integrated service provision, what will you propose for the social package? What will be the role of outreach workers?
15. Do you think when donor funding ends you can still continue provision of services to IDU pregnant women in the same way you do now? If not, please explain why
16. Please explain your willingness to continue provision of same services after external funding ends.

- Ask if they would like to add further comments.
- Bring the meeting to a close by summarizing the main points.
- Thank you
ANNEX 6.6  FGD PARTICIPANT’S CONSENT

PURPOSE: You are asked to participate in a research study. UNICEF conducts the study in cooperation with the Government of UKRAINE. Independent consultant Dr. Tamar Gotsadze leads the study. The purpose of the study is to better understand the conditions within your community in order to improve available health and social services. You are being asked to participate in this study because you live in one of the communities selected for the present study.

PROCEDURES
You are invited to participate in the focus group discussions together with other women. The independent consultant will talk to you, ask questions and seek for your responses.

RISKS
You may feel uncomfortable answering some of the questions, which may gather information that is private.

BENEFITS
We hope to have a better understanding about current government services designed to improve community and household wellbeing through your participation in the study. However, there may be no other direct personal benefits for you from this research.

PAYMENT FOR PARTICIPATION
You will not be paid for being in this study.

ALTERNATIVES
Your alternative is to not participate in this study.

CONFIDENTIALITY
Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. The study will focus on the average answer within your community and not on individual answers. The honesty of your answers is very important.

SOURCE OF FUNDING
Funding for this research study is provided by the World Bank.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
Your participation in this study is voluntary. You may decide not to participate or you may leave the study at any time. Your decision will not result in any penalty or loss of benefits to which you are entitled.

Your participation in this study may be stopped at any time by the study staff or the sponsor without your consent for any of the following reasons:

- if it is in your best interest;
- or for any other reason.

QUESTIONS
If you have any questions, please feel free to ask the interviewer at any time during the interview.
Contact ____________ at __________ if you have any questions about your participation in this study.

Do not agree to be in this research unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

**CONSENT**
I willingly agree to participate. I may withdraw my consent at any time and stop participation without penalty. All my questions about the study and my participation in it have been answered.

By agreeing to be in this research, I have not given up any of my legal rights.

Participant gave consent

☐ YES

☐ NO
1. Context

Ukraine has the highest adult HIV prevalence in all of Europe and Central Asia. Annual HIV diagnosis in Ukraine has more than doubled since 2001 (UNAIDS, 2010). The HIV epidemic is still concentrated among most-at-risk populations, and HIV is still mostly transmitted through injecting drug use, but the risk of a generalised epidemic continues to grow. Due to their biological and social vulnerability, women are more prone to infection. Currently, they represent 45 per cent of all adults living with HIV in Ukraine. Most of them are in childbearing age.

HIV can be transmitted from a HIV-infected mother to her baby during pregnancy, delivery and breastfeeding. HIV-positive pregnant women need to receive a preventive course of antiretroviral medicines (ART) to prevent HIV transmission to their newborns. A state programme to prevent mother-to-child transmission of HIV (PMTCT) was established in Ukraine in 2001, and the Government currently guarantees free HIV testing and ART to all HIV-infected pregnant women in Ukraine.

The elimination of mother to child transmission (EMTCT) of HIV is a global goal that has been endorsed by national governments in partnership with UNAIDS, WHO and UNICEF and a number of other national and international stakeholders. In Eastern Europe and Central Asia the strategy of elimination builds on on-going efforts to reduce the vertical transmission of HIV through the building of systems that are able to strengthen functional linkages and integration between existing maternal and child health systems and the HIV treatment, care and support systems in the region. Ukraine recently confirmed its commitments to scale up Prevention of Mother-to-Child Transmission of HIV programme (PMTCT) towards elimination of mother-to-child transmission by 2015, approving a new National AIDS Programme for 2014-2018.

A national level of HIV transmission from mother-to-child (MTCT rate) reduced in 2011 to 4, 5% comparing to 27, 8% in 2001107. Despite progress, in order to achieve further advances towards the elimination of MTCT (defined as less than 2% at 6 weeks of age among children born to HIV-positive mothers by 2015), it will be essential for Ukraine to reduce the number of new infections among women of child-bearing age, sustain and improve quality of PMTCT services provided as well as focus on increasing access and uptake of services by those segments of the population that are currently not accessing PMTCT services or accessing them too late. In 2011, more than 5,000 pregnancies were registered among HIV-positive women in Ukraine. The absolute number of children infected with HIV through mother-to-child transmission (MTCT) continues to increase as there is a 20-30 per cent yearly increase in HIV-infected pregnant women.

The country has the highest coverage of PMTCT services in the CIS region, including a very high proportion of HIV-positive pregnant women receiving ARV prophylaxis (95, 5 % in 2011). However, coverage of those segments of the population who are most vulnerable to HIV-infection (including IDUs, FSWs) with PMTCT services is still low. Official epidemiological data indicate that MTCT rate in vulnerable pregnant women who inject drugs (IDUs) is 13,1%108, and this leads to the “elevation” of the national MTCT rate. Drug-dependent women remain most at risk to transmit HIV to their newborns. Drug-using pregnant women often receive prenatal care only towards the end of their pregnancy or attend a clinic for the first time for the delivery, missing out on the possibility of taking the preventative course of ART. Official data of MTCT rate in vulnerable pregnant women who inject

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107 Ukrainian Center for Diseases Control data. In 2001 MTCT rate was 27, 8%.
drugs (IDUs) is 13.1%. However, the estimates suggest the real rate of MTCT among IDU women is closer to 23%. In 2011, injecting drug use was identified as the risk factor of mother-to-child transmission of HIV in 19.1% of HIV-positive reproductive-aged women, and 3.5% of pregnant HIV+ women reported active drug use during latest pregnancy (probably an underestimation due to the stigma of admitting drug use, especially in pregnancy). Only 29 of 395 (7.3%) of pregnant HIV+ pregnant women who used drugs got substitution maintenance therapy and most opioid-dependent pregnant women continued using drugs during pregnancy. Pregnant women who inject drugs have worse outcomes than other women: more advanced disease (14% vs. 6%), less access, more adverse outcomes (preterm delivery 16% vs. 7%), and a higher mother-to-child transmission rate. They are also 3.5 times more likely to be diagnosed with HIV in labour than other women. Relatively few HIV+ pregnant women who injected drugs received ART prophylaxis, which can prevent HIV transmission to newborn (65% compared with 94.5% overall).

Pregnant women injecting drugs (IDU), who could be also infected with HIV, form a subgroup of female injecting drug users with specific needs. However, women find it difficult to access appropriate psychosocial, social and medical support when identified as "HIV positive" and as "drug users" because of stigma and discrimination.

Fragmented design of healthcare system where HIV positive drug using women are receiving addiction, HIV and MCH services in different places reduce their access to services. Healthcare workers at MCH services are lacking knowledge and skills to provide care for pregnant women using substances and rely on referral expertise of addiction and HIV specialists. Addiction specialists have very limited knowledge about pregnancy, reproductive health and family planning and rely on MCH specialists.

Drug-dependent women not seek services due to a fear of hostility from practitioners or of having their children taken away from them after delivery. The social factors, such as household responsibilities, lack of family support, lack of social networks, lack of financial resources, lack of privacy and confidentiality, and fear of being stigmatized create the barriers to accessing services. Behavioral patterns, particularly low level of adherence to the healthy lifestyle in the target group also lead to avoidance of contacts with the state services.

The biggest problems faced by women and families affected by HIV are partially attributed to a lack of a coordinated system of social services. Services do not exist to address or even effectively identify vulnerabilities at early stages. Social services are not sufficiently inclusive or sufficiently flexible to be able to adapt to the various profiles of children or their families within their communities, and thus avoid unnecessary separation. Service provision has largely been put in place without coordinating with other social support such as social benefits, and thus opportunities for synergy are limited. Local government does not have sufficient autonomy to manage the development of services and lacks financial resources.

Harm reduction NGOs are not institutionally involved in service provision for pregnant women using drugs, being mostly donors’ funded organizations; they have limited knowledge about specific needs.

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109 Ibid
111 Martsynovskaya V., Ukrainian Center for Diseases Control data, 2012.
of women using drugs, including prevention of unintended pregnancies, provision of basic services to pregnant women and their referral to ANC.  

2. The Project to be evaluated

To remove inequity in care, treatment and support for drug-addicted pregnant women, overcoming barriers to the provision and utilization of services by them, UNICEF initiated a pilot project ‘Prevention of Mother-to-Child Transmission and Improving Neonatal Outcomes among Drug-Dependent Pregnant Women and Children Born to Them in Three Cities in Ukraine’. The pilot project was developed as a model of PMTCT service provision for drug dependent pregnant women expected to result in better coverage, quality and uptake of services for pregnant drug-dependent women. This would, in turn, lead to improved health outcomes for their own health and for the health of their babies. The main objective of the project is:

- To establish, maintain, and improve gender responsive, comprehensive, and integrated services that address the needs of drug-dependent pregnant women and children born to them.

The lessons learned from the model are expected to inform the system changes required and the process of scale-up of such services to other areas of Ukraine. When expanded to the national level, improved access to better quality services will result in more women benefiting from services adapted to their needs, leading to improved neo-natal outcomes for their children, including the realization of their right to be born free of HIV. The logic model, as a part of Theory of Change is:

- Transforming the services for pregnant women using drugs from vertical and fragmented system to horizontal and integrated will create an enabling environment in which gender sensitive HIV prevention, treatment, care and support services are available for pregnant women using drugs and their children. Setting up such functional linkages between MCH, HIV services, addiction services and integration with social services will prevent MTCT among pregnant drug using women and will contribute towards elimination of MTCT in the country.
- This should increase number of drug-addicted HIV-positive mothers and their newborns that received timely social support, diagnosis of HIV, treatment and care to prevent mother-to-child transmission and, in turn, reduce number of children born with HIV.
- Provision of, access to and uptake of gender responsive, non-discriminative and integrated medical and social services targeting HIV vulnerable groups, including drug using pregnant women, is the precondition for further reduction of HIV transmission to newborns and elimination of MTCT in country.
- By decreasing the risk of HIV MTCT rate among drug using pregnant women, we decrease the MTCT rate at national level, thus contributing towards elimination of MTCT in the country.

The chart form of the logic model (Theory of Change) is presented in Annex1 ‘Theory of Change Chart’.  

The Risks and assumptions (events and conditions) likely to affect implementation and outcomes:

- Allocation of proper funds for integrated services for pregnant IDUs within new the NAP for 2014 – 2018, if not sufficient, may hamper scale up of the model at national level.
- Social perception of illegality of drug use, criminalization, stigma and marginalization and lack of recognition of medical and social support to IDUs as a legal and inalienable component of support are likely to lead to stigma and affect access and utilization of services.

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115 'The assessment of the preconditions for introduction of the innovative PMTCT model in Ukraine’. Dr Mary Hepburn, 2010.
• Low level of adherence to the healthy lifestyle in the target group may lead to avoidance of contacts with the state services.
• The system of social protection of families and vulnerable to HIV group, if not effective, may compromise the model of integrated services and decrease a trust of the target group to the state institutions. Strong governmental commitment to eliminate MTCT should be maintained and strengthened to ensure coordination between medical and social sectors.
• Insufficient joint efforts of a broad range of state, non-governmental and civil society partners reduce access of the target group to outreach services.
• Lack of partnership between the state institutions and nongovernmental organizations, in which individual case management of vulnerable to HIV drug using pregnant women and children born to them is seen as the operating principle of integrated services provision.
• Enhanced policy environment with provision of new regulatory (operational guidelines, protocols) and budgetary provisions would provide better support to vulnerable groups of pregnant women and their children.
• Professional trainings, experience exchanges and involvement of social services and civil society will change the attitude of health and social care workers towards pregnant drug using women, and will facilitate their early access to ANC and will improve maternal and child health outcomes, including prevention of HIV mother-to-child transmission.
• Pilot projects in selected cities, if proven successful through the evaluation and with evidence, will contribute towards the national scale up to ensure access of the most vulnerable pregnant women to PMTCT and elimination of MTCT in the country.

Pilot Project Interventions:
The project focuses on introducing integrated services for drug addicted pregnant women by establishing Centres for Integrated HIV Prevention, Care and Support Services. Centres provide a range of medical and psychosocial services to drug addicted women and their children: offering antenatal care, HIV testing and counselling, ARV treatment to prevent HIV transmission from mother-to-child, assisting in delivery, postnatal care, and treatment of neonatal withdrawal syndrome, drug dependency treatment, psychosocial counselling and social support to families.

Key Stakeholders:
Addressing the health and social needs of drug-using women and their infants is a challenge, as it requires strong coordination and functioning referrals between various stakeholders and service providers. The project was built on established close partnership between public and civil society organizations. Different organizations and non-state actors were involved into project design and implementation:
• UNICEF
• UN Joint Team on HIV and UN Team Group on HIV, including WHO, UNODC and UNAIDS within the UN Joint Programme of Support on HIV/AIDS to the Government of Ukraine for 2012-2016
• Charitable Fund/ William J. Clinton Foundation in Ukraine (WJC Foundation)
• Open Society Institute (OSI)
• Eurasian Harm Reduction Network
• Coalition of HIV-services organizations
• Ministry of Health of Ukraine
• Oblast State Social Services for Family, Children and Youth
• All-Ukrainian Network of People Living with HIV/AIDS
• HIV-services organisations
• Steering Committee

Duty bearers:
Ministry of Health, State Department on HIV/AIDS and other socially dangerous diseases, Oblast State Social Services for Family, Children and Youth, Kyiv city, Dnipropetrovsk and Poltava oblast and city health administrations, All-Ukrainian Network of PLWHA, HIV-services organisations in the pilot cities that represent the interests of the drug-addicted women and provided outreach within the project.

Rights holders:
- Women, adolescents, youth, babies.

Time period and geographical scope:
Started in June 2011 the pilot was launched in three cities of Ukraine – Kiev City, Dnipropetrovsk and Poltava. In 2014 the project was expanded to one more city Krivui Rig, Dnipropetrovsk oblast.

Budget:
USD 433,181.05 (UAH 3,669,909.85) have been transferred to implementing partner - WJ Clinton Foundation within Project Cooperation Agreement with UNICEF. Annual breakdown is as follows:

2011 - UAH 1,112,299.53
2012 - UAH 1,342,126.91
2013 - UAH 1,215,483.41

In 2014 there will be three more cash transfers:
March-May 2014 - UAH 280,066.87
June-August 2014 - UAH 279,614.56
September-November 2014 - UAH 288,301.49

The phases of the project:
- The initial phase June - December 2011 aimed at assessment of situation and design of the project followed by establishment of partnership with stakeholders.
- The 1st phase of the project 2012 – 2013 service provision and building capacity of service providers.
- The 2nd phase of the project mid 2013 – 2014 continuation of the project and advocacy for inclusion of the model in the new five year National AIDS strategy for 2014 – 2018;

3. Rationale

Evaluation is undertaken when the pilot model is expanded in 2014 to four project sites and already demonstrates results that should be documented. It is especially important at the time when the government is increasingly interested in ensuring the provision of services to marginalized pregnant women and reaching the goals of EMTCT. There is a need to document and assess the results of the piloted model along with evidence of the project outcomes. Lack of information affects the government’s ability to design appropriate preventive and protective measures for vulnerable drug-addicted pregnant women both on a normative level (including standards, guidelines, and protocols) and on a service delivery level (including preventive programmes, reintegration programmes).

It is expected that the evaluation results will give an answers to the questions what could be done to reduce inequity in access to the PMTCT and of how to strengthen social services to identify women’s vulnerabilities at an early stage as an entry point to the system of integrated treatment and care for them and their children.

The findings of the evaluation should contribute to the design and development of PMTCT interventions that would ensure access to quality medical services and social support for women who
are most vulnerable to HIV infection, including drug-dependent pregnant women. It is expected that the evaluation results will help the results primary users, such as national and regional health and social state authorities, as duty bearers, to inform the way forward in the national scale up of the pilot of integrated medical and social services for drug addicted pregnant. It will help to identify how this can be done and what type of actions is needed to achieve the goal of the pilot and how the model can be replicated on a national scale. It is also expected to be used for further national PMTCT policy development and adjustment.

HIV-services NGOs, as representatives of vulnerable groups of pregnant IDUs, will use the results of evaluation as advocacy instrument for inclusion of integrated service model in national policy, while participating in its development.  

Findings will be used by UNICEF to advocate for the enhancement of the integrated services approach in view of national scale up and implementation through 2018. All stakeholders are expected to use the findings, conclusions and recommendations to further develop policy and framework to achieve positive impact for children and women, in particular those most vulnerable to HIV.

4. Objective

The objectives of the formative evaluation are as follows:

6. To analyze whether outputs and activities within the project are leading to expected outcomes and goal of the project;
7. To assess and analyze the bottlenecks and barriers, including policies, practices and other structural barriers in medical and social areas for the Project pilot implementation;
8. To document lessons learned and good practices of the pilot project activities, along with evidence of outcomes;
9. To demonstrate, based on evidence, whether or not a nation-wide scale up of the pilot approach and practice is possible and whether a scale up will effectively lead to closing of equity gaps in the area of work; and
10. To develop strategic, policy and implementation recommendations of how the on-going pilot, if achieved its key outcomes, will be efficient and sustainable in future, thus informing policy development and framework of the national scale-up of the pilot.

The purpose of evaluation is to produce relevant information on the design and effectiveness of the pilot project and identify lessons learned and provide strategic policy and implementation recommendations. These recommendations would provide guidance on how to strengthen the on-going pilot, how to ensure that expected outcomes are achieved and how to ensure that relevant policies and support is provided to ensure that adequate models of service provision for drug-dependent women are adopted and sustained in the future.

5. Scope and Questions:

The evaluation will cover all period of the pilot project implementation from June 2011 when the project was launched in three cities of Ukraine – Kiev City, Dnipropetrovsk and Poltava until 2014 when the project was expanded to one more city of Krivui Rig, Dnipropetrovsk oblast. The scope of evaluation will focus on the progress in achieving expected results based on project outputs and outcomes. The evaluation questions (not exclusive to the list below) are grouped according to the Development Assistance Committee (DAC) evaluation criteria as defined in the UNICEF guidance on equity-focused evaluations, 2011:

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116 Development of national regulation is a participatory process in Ukraine. The National Coordination Council on HIV, which coordinates all HIV/AIDS Programme and Working Groups on development of regulations, has representations of the beneficiaries.
A. Relevance:
  ✓ Was the project design relevant within the Ukrainian context: was this intervention in line with national AIDS priorities, strategies and goals?
  ✓ To what degree has the project objectives been relevant to the priorities and needs of women and children, particularly the most vulnerable groups of children in Ukraine?

B. Effectiveness:
  ✓ To what extent has the underlying theory of change been valid at this point? To what extent are the expected results chain occurring as planned?
  
  To what extent has the design of the pilot model and its evolution, including type of intervention, the choice of beneficiaries, funding, and stakeholder/beneficiary involvement enabled to achieve the project’s defined objectives?
  To what degree has the project contributed to removing bottlenecks hampering the improvement of MTCT rate in Ukraine?
  To what extent has the resources, including human resources and funding been used effectively and contributed to or hindered the achievement of results?
  Did the project result in better coverage, quality and uptake of services for pregnant drug dependent women in selected sites?
  To what extent has medical and social services been integrated within the project and how has it made an effect on the project results?
  To what extent has capacity building activities for service providers resulted in service quality improvement and increase of PMTCT coverage?

C. Efficiency:
  How cost effective are the project activities compared to similar activities in Ukraine?
  Has the initiative used resources (funds, expertise, time) in the most economical manner to achieve the results?

D. Impact:

  Primary beneficiaries:
  ✓ To what extent have the primary beneficiaries experienced increased access to various integrated services, or increased ability to demand/seek support?
  ✓ To what extent have the primary beneficiaries satisfied with the quality of services available for them up until now?
  ✓ To what extent have the primary beneficiaries perceive that their unique needs and sensitivities are reflected in the established services?
  ✓ To what extent have the primary beneficiaries been able to take up (use) on the available services?
  ✓ To what extent has the equity gap closed (or likely to close) in the access to services of vulnerable groups of drug using pregnant women?
  ✓ To what extent has the gender, human and child rights and capacity-building issues, including cross sectoral cooperation between medical and social sectors, taken into account in the pilot model and to what extent have they have contributed to achieving of the results?

  Local and national authorities:
  ✓ How has the project influenced or affected local and national authorities and the wider community to provide integrated health/social services targeting vulnerable groups of women?

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117 Integrating Human Rights and Gender Equality in Evaluation – Towards UNEG Guidance
http://www.uneval.org/papersandpubs/documentall.jsp?showAll=1&doc_source_id=0&doc_cat_source_id=4&doc_source_extra_id=0&doc_cat_id=74
To what extent has the project changed behaviours and attitudes of local and national authorities towards the rights of vulnerable groups of women including drug using pregnant women (or likely to change)?

E. Sustainability:

To what extent have partnership and stakeholders’ involvement at different stages of the project been decisive for the project in attaining its expected results up until now?

These questions are intended to give a more specific and accessible form to the evaluation criteria and articulate the key issues of concern to stakeholders, thus optimising the focus and utility of the evaluation.

Limitations to the evaluation – Evaluator will have access to all sources of information, available at the time of evaluation, including state statistics, research and study data and data related to the project budget and implementation. The project clients in all sites, as representatives of vulnerable groups, will be involved during the in-country phase of the evaluation to the possible extent for interview and meetings as well as national and local stakeholders. The availability of key informants (i.e. those directly involved in the project) for interview and clients for focus group discussions during the in-country phase of the evaluation could be limited due to the summer holidays season.

Other limitations for evaluation related to the methodology, source of information and baseline will be identified and documented by the evaluator during the preparation phase of the evaluation while developing desk review and methodology.

Data quality, reliability, and validity – All data provided for evaluator for desk – review and further analysis, are from the official sources and validated by the authorities, thus reliable. This includes state statistics and the Ministry of Health Information bulletins. Ukraine’s state authorities, including Ministry of Health, State Statistics Service of Ukraine, and Ministry of Social Policy all have a wealth of statistics and data relating to the project both within the pilot sites as well as nation-wide, which would be useful for the evaluator.

Approach

While designing the evaluation methodology, and implementing the evaluation, the following approaches should be applied: i) Keep evaluation procedures (e.g. interviews) brief and convenient to minimize disruptions in respondents work process; ii) Ensure that potential participants can make an informed decision about the process and duration of face to face interview; iii) Follow the principle of confidentiality; iv) Accurately and impartiality in data collection and analysis of information and reported findings.

Elements of a successful modelling

The pilot model should be assessed and analysed according to the 6 elements of modelling118, specified as following:

1. An equity-based hypothesis (H) to describe the pathways from model to the national system of care and treatment for vulnerable to HIV groups of pregnant women, in particular drug-addicted;
2. Expected equity-based Overall Results formulated as Child Rights Realisation and which meet international HR standards, technical protocols and guidance;
3. Baseline as a basis for (H) above, including equity-increasing impact indicators;
4. Set Sustainability/Exit Strategy and Termination date agreed with partners;
5. Monitoring mechanisms, including for process indicators; and
6. Strategies and budget to disseminate results of evaluation (communication, advocacy).

The evaluation should follow the UNEG Norms and standards (see Hyperlink available in English and Russian). http://www.uneval.org/normsandstandards/index.jsp?doc_cat_source_id=4

118 Fulfilling these elements would be a prerequisite to a national scale up of the ‘model’.
6. Methodology

The evaluation methodology should be comprised of a mixed-method evaluation design, which includes site visits and observations, face-to-face interviews of key informants, including drug-dependent women, service providers and stakeholders. Qualitative and quantitative components are conducted in parallel.

The evaluation combines collection and analysis of quantitative data, from both surveys and secondary data, with more in depth qualitative methods. The principal data collection methods are a sample of focus groups selected in the pilot sites, combined with structured interviews and direct observation of services provided at health/community facilities. The primary data will be complemented by an analysis of the extensive secondary data available from national record and other sources. Secondary data will be used as an independent source to triangulate with primary survey data in order to test for consistency.

Data collected during the on-site stage of the evaluation (interviews, meetings etc.) will be complemented by a desk-based research and review of existing reports, documents and secondary data that has been collected during the planning and implementation of the project:

- **A number of studies and researches** conducted in 2010-2011. They focused on drug-addicted women and provided situation analysis regarding their access to services, social and demographic characteristics and determinants of mother-to-child transmission, the level of coverage by medical and social interventions, identified the estimated number of drug-addicted women of reproductive age and pregnant HIV-positive women *inter alia*. All obtained data formed a baseline and used for setting up the targets within the pilot project.

- **Internal and external monitoring and evaluation data of the project:**
  - Report of external mid-term evaluation of the pilot project conducted by international expert in 2012;
  - Monitoring visits data, project observation, documenting the results and databases of clients and services, including detailed budget and records of expenditure of the project.

- **State statistics** (Ministry of Health Informational Bulletins, state PMTCT M&E forms).

(see Annex 2 'Key documentation for the evaluation').

Evaluation approach and data collection to be human /child rights based and gender sensitive. Evaluation methods should include analysis of both qualitative and quantitative data, including baseline indicators and established targets (Annex 3 ‘Indicators’).

7. Work Plan

Evaluation phases include key stages with the following timeline:

1. **Preparation phase**
   - Initial desk review, development of methodology and Instrument/tools for the pilot evaluation – (4 days)
   - The validation of methodology and instruments to be done by UNICEF CO and the Steering Group established within evaluation (representing UNICEF CO, partners and other stakeholders) - (3 days)
   - Desk review of research, studies available and documentation from other sources which evaluator finds relevant and useful - (3 days) inception report

2. **Field phase**
   - In country data collection, including visits to four project sites – (10 days)
   - Preliminary analysis - (1 days)
• Presentation of preliminary finding and analysis to Steering Group meeting in the country – (1 day)

3. Synthesis phase
• Final analysis of finding - (4 days)
• Draft of the pilot evaluation report for review and comments by the stakeholders and UNICEF – (4 days)
• Revision of the draft of evaluation by stakeholders and UNICEF – (3 days)

4. Feedback and Dissemination
• Finalization of evaluation report – 3 days;
• Presentation of report to Steering Group and dissemination of report among stakeholders – (to be done by UNICEF CO as part of communication and advocacy strategy) by 20 July 2014

All deliverables to be submitted to UNICEF in electronic form for feedback and evaluation. The evaluator should be available for follow-up clarification and revisions of the report until its finalization.

Estimated cost of the contract and funding source by Grant:
Estimated cost of the research is 22,200 USD. 16,200 USD (540 USD per day, 30 days) for international consultant and 6,000 USD for in-country phase (fields’ visit to three pilot sites).
Funding source: Grant SC130023, Exp. 11.01. 2015.

8. Structure of Evaluation report

The evaluation report to be produced must be compliant with the UNICEF Evaluation report standards:

The final pilot report produced and presented to UNICEF should be presented in the following format:
Executive Summary

Detail information on the purpose of the evaluation, approaches and the process of evaluation.
• Evaluation methodology and limitations;
• Overall overview of state policies and issues in PMTC, social protection and child care sphere.
An overview of the government’s current policy and priorities in the sphere of PMTCT, social protection and child care, including a review of key strategic documents. An overview of the key problems identified at national and local levels and the link with local practices.
• Key findings
• Conclusions and Recommendations (plan of follow up actions)

Conclusions: based on evidence, whether or not a nation-wide scale up of the pilot approach and practice is possible and whether a scale up will effectively lead to closing of equity gaps in the area of work. Recommendations for increasing the effectiveness of integrated medical and social services for drug addicted pregnant women vulnerable to HIV and their children within the country. Develop strategic, policy and implementation recommendations of how to ensure the model’s efficiency and sustainability in future and inform policy development and framework of the national scale-up of the pilot.

9. Qualifications/specialized knowledge/experience required to complete the task
5. Solid and demonstrated knowledge and understanding of PMTCT and social protection thematic area;
6. Clear understanding of child/human rights and gender equality issues and how they should be applied in the respective area of evaluation;
7. Proven experience and skills in conducting qualitative and quantitative data collection and analysis;
8. At least a university degree in a relevant discipline;
9. Minimum 8 years’ experience of consulting at National level with government
departments, development partners etc;
10. Ability to manage multiple, complex tasks being undertaken concurrently;
11. Ability to conduct key informant interviews and focus group discussions;
12. Ability to analyze, interpret and synthesize information from a number of sources;
13. Ability to work in a team;
14. Strong communication skills;
15. Experience with the execution of assessments, reviews or evaluations;
16. Experience in writing analytical reports;

10. Ethical Issues
All interviewees, including children, should be provided the “UNICEF Principle Guidelines for the
Ethical Reporting on Children and Young People under 18 years old” and should be informed about
the objectives of the analysis and how findings will be used; they also should be informed that
collected data and any statement about the programme will be kept confidential and respondents will
not be named or identified in the reports with regard to their statements.

All interviewees should agree without coercion to take part in the analysis and be given the option to
withdraw or not to participate at any time during the process. All gathered data should be
confidential and names of individuals deleted from the data and replaced by codes in the analysis
notes.

Ownership of all data/information/findings gathered, databases and analysis prepared for the
analysis lies with UNICEF. The use of the data/information/findings for publication or any other
presentation or sharing can only be made after agreement with UNICEF.

11. Definition of supervision arrangements
The HIV/AIDS Officer, UNICEF Ukraine in close coordination with the UNICEF Ukraine Monitoring and
Evaluations Specialist will supervise consultant.

12. Description of official travel involved
Travels are envisaged to the sites within the in-country pilot evaluation mission. The local travel will
be paid separately. No travel shall be undertaken prior to completing the UN Basic and Advanced
Security in the Field Courses.

13. UNICEF recourse in the case of unsatisfactory performance
In the event of unsatisfactory performance, UNICEF reserves the right to terminate the Agreement. In
case of partially satisfactory performance, such as serious delays causing the negative impact in
meeting the programme objectives, low quality or insufficient depth and/or scope of the assessment
completion, UNICEF will decrease the payment by the range from 30 to 50%.

14. Support provided by UNICEF
Day-to-day support for the assignment will be provided by the HIV/AIDS Officer and will include
relevant information sharing via e-mail, briefing and de-briefing sessions, and facilitation of the
researcher’s meetings with UNICEF counterparts when necessary.