Alliance for Public Health

REACT

ANALYTICAL REPORT

IMPLEMENTING THE REACT PROJECT IN UKRAINE:

KEY POPULATIONS' RIGHTS VIOLATIONS IDENTIFIED IN THE CONTEXT OF HIV/TB AND RESPONSE TO THEM

NOVEMBER 2019 – OCTOBER 2020

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Further information about the REAct project is available at:
www.react-aph.org

https://www.facebook.com/REAct.Ukraine

Join the REAct system: **https://react-aph.org/join-react/**

REPORT A RIGHTS VIOLATION INCIDENT INVOLVING VULNERABLE POPULATIONS:

REACT

SCAN QR CODE

CONTENTS

GLOSSARY

AIDS	Acquired Human Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CCU	Criminal Code of Ukraine
CO	Charitable Organization
COVID-19	Coronavirus Infection COVID-19
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CUAO	Code of Ukraine on Administrative Offenses
EECA	Eastern Europe and Central Asia
HCF	Health Care Facility
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
ICF	International Charitable Foundation
KP	Key Populations
LGBT	Lesbian, Gay, Bisexual, and Transgender People
MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organization (Community-Based Organization)
NPM	National Preventive Mechanism
PLHIV	People Living With HIV
PTDC	Pre-Trial Detention Center
PWID	People Who Inject Drugs
REAct	Rights – Evidence – Action
SMT (OST)	Substitution Maintenance Therapy
SOGI	Sexual Orientation and Gender Identity
SW	Sex Workers
TB	Tuberculosis
UCF	All-Ukrainian Charitable Foundation

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EXECUTIVE SUMMARY

The international community has recognized that the HIV/AIDS epidemic can be effectively addressed only through the wide adoption and integration of human rights-based approaches into HIV programs. Violations of the rights of key populations hinder the effectiveness of national HIV and TB prevention and treatment responses.

With a view to identifying the existing human rights-related barriers to accessing HIV and TB services for key populations, the REAct project was launched in Ukraine. The REAct system allows community-based organizations not only to document rights violations but also to respond to barriers identified.

The REAct system is being implemented by ICF "Alliance for Public Health" through the funding from the Global Fund and technical support from Frontline AIDS. Twenty-eight non-governmental organizations across four regions are involved in documenting incidents where the rights of key populations vulnerable to HIV/TB have been violated.

During the first year of the project, i.e., from November 2019 through October 2020, the REAct implementation efforts resulted in documenting 775 cases of rights violations against members of key populations vulnerable to HIV and TB. These cases were reported by 760 people, i.e., some clients sought help more than once. Kyiv, Odesa, Dnipro and Kryvyi Rih were the first cities to deploy the system. It is worth pointing out 21% of the incidents were reported via the National OST Hotline that covers all regions of the country.

Most rights violation incidents within the REAct framework were reported by people who inject drugs (PWID) – 476, people living with HIV (PLHIV) – 290, OST patients – 200, men who have sex with men (MSM) – 108. The number of rights violation incidents reported by prisoners/ex-convicts totaled 69, whereas this figure for people living with TB was 40 and that for sex workers (SW) – 37.

THE PERPETRATORS OF RIGHTS VIOLATIONS against key populations were most commonly **government agencies' staff** – 72%, those predominantly being health workers (44%). The most frequent rights violations across all violations reported included **denial of access to services** – 36% (primarily public health services), **discrimination/stigma due to belonging to a most-at-risk group** – 27%, **physical violence** – 15% and **emotional abuse** – 11%. 62 incidents reported by clients were documented in the REAct system and involved **rights violations associated with COVID-19-related quarantine policies**.

PEOPLE WHO INJECT DRUGS, were the most likely to have their rights violated by health workers and police personnel.

Health care workers were routinely found to deny PWID access to outpatient care and inpatient treatment, emergency and hospitalization care in all settings. Often, PWID were denied access to OST regardless of clients' comorbidities. Discriminatory and stigmatizing attitudes on the part of health care workers were also evident in their rude, disrespectful, and indifferent behaviors, disclosure of clients' drug use status, incomplete or poor-quality health care, as well as the demands of payment for free-of-charge public health services.

Police officers were often reported to exhibit rude and disrespectful behavior as well as biased attitudes. PWID were often arbitrarily detained and stopped on the street for identity checks and body searches, with acts of police violence being not uncommon. Denial of protection or investigation were also reported by clients as fitting into a consistent pattern of police behavior.

PWID faced the risks of being forcibly placed in illegal "rehabilitation centers." Women who used drugs reported being denied access to assistance against domestic violence in state social welfare institutions (due to their drug users' status). Manifestations of stigma and discrimination also occurred in relation to children whose parents were PWID, particularly in preschools and secondary schools.

OST PROGRAM PATIENTS, just as PWID, were also the most likely to report experiencing rights violations by health workers and law enforcement personnel. There were documented cases where health workers refused to transfer patients to take-home OST regimens, even if such a request was reasonable and justified. Stigmatizing attitudes were reported not only on the part of doctors, but also on the part of pharmacists in pharmacies, who refused to sell OST drugs, behaved rudely and insulted clients. A number of rights violation incidents were linked to COVID-19-related public transportation restrictions preventing visits to OST sites across the city.

OST patients, even more often than PWID, encountered illegal body searches by police. Common rights violations included cases where OST medications were seized by police officers intentionally, even when OST patients presented appropriate authorizations.

In the majority of documented cases, **PEOPLE LIVING WITH HIV** experienced rights violations by health workers. Such violations included denial of access to ART (for lack of identity documents or residential registration in the area of service-providing health care facilities), denial of access to outpatient and inpatient care, or hospitalization (after disclosure of clients' HIV status). COVID-19-related restrictions in public transportation have created barriers preventing visits to health care facilities for access to ART. In addition to refusals to provide medical care by public-sector doctors, PLHIV also reported encountering similar refusals in private clinics, for example, when seeking dental services.

There have also been documented cases of stigma and discrimination by employers when PLHIV were forced to undergo mandatory HIV testing or disclose their HIV status by providing a test certificate. Stigma was also shown by staff of educational institutions, in particular, pre-schools, when educators openly showed negative attitudes towards children, whose parents' HIV status was known to be positive. Recorded PLHIV rights violations were concerned with breach of confidentiality, mostly regarding disclosure of HIV status.

SEX WORKERS were the most likely to have their rights violated by the police. SWs are vulnerable in their interactions with the police as providing sex services is formally illegal in the country, which opens wide opportunities for abuse by unscrupulous police personnel. Threats, blackmail, extortion of money and free sexual services, physical violence, and refusal of protection by the police with respect to sex workers were reported as common and widespread.

Sex workers reported being denied access to care by health care providers, specifically by gynecologists – as part of outpatient care, as well as prenatal care and skilled birth attendance. In cases of physical violence committed by their partners or clients, SWs were unable to get protection from the police due to the fear of stigma and disclosure of being an SW.

Perpetrators of rights violations against **MEN WHO HAVE SEX WITH MEN** were mostly people in their close environment (family members, partners), as well as unknown individuals (including members of radical groups). Domestic violence was committed against MSM by family members who refused to accept their sexual orientation. Acquaintances, friends, as well as police officers, being aware of their sexual orientation, committed acts of extortion and blackmail in exchange for not-disclosure of this information to others. In some cases, police officers cover up rights violations against MSM and help the perpetrators evade punishment by failing to act on the incident reports. There have been cases of physical violence against MSM by unknown individuals or radical groups driven by hatred based on sexual orientation. Furthermore, MSM have faced widespread stigmatization and discrimination by employers on the basis of their sexual orientation: being refused employment or forced to quit.

PEOPLE LIVING WITH TB, reported rights violations by health care workers, such as denial of access to health care and treatment or hospitalization. A number of cases of rights violations were concerned with COVID-19-related restrictions, specifically: the requirements that people living with TB be treated in the area of their residence or that patients with communicable TB be hospitalized only for up to two weeks. The ongoing reform of TB facilities in Ukraine has further increased the risks of inadequate medical care and treatment for people with TB.

The perpetrators of rights violations against prisoners were most commonly healthcare workers and employees of other government agencies, specifically staff of penal and correctional institutions (administrative personnel in prisons and other places of deprivation of liberty). Prisoners were most likely to report being denied access to health care, such as denial of access to continuous OST for OST patients and substance abuse treatment; inadequate provision of ARV treatment; denial of access to medical advice and treatment for existing medical conditions; denial of access to medical care for TB.

The REAct system has demonstrated NGOs' robust potential and broad application prospects in providing assistance and responding to rights violation incidents. **84% of the services provided were delivered directly in an NGO setting at the location of the REActors.** As part of the response to rights violations committed against clients, several types of assistance were provided by REActors – **primary legal assistance** (68%), **psychosocial support** (26%) and **secondary legal assistance** (6%). Client referrals mostly occurred as part of psychosocial support and secondary legal assistance.

1 INTRODUCTION

Ukraine is among the countries with the double burden of HIV and tuberculosis (TB).[1] The HIV epidemic in Ukraine is concentrated among the key populations: people who inject drugs (PWID), sex workers (SW), men who have sex with men (MSM), trans*people, and prisoners *(Table . 1)*.

TABLE 1. HIV PREVALENCE RATES AND ESTIMATED NUMBERS AMONG KEY POPULATIONS IN UKRAINE

KEY POPULATION	HIV PREVALENCE	ESTIMATED POPULATION
PWID	20,3%[2]	350 300[3]
SW	5,2%	86 600
MSM	7,5%	179 400
Trans*People	2%[4]	9 963[5]
Prisoners	8,9%[6]	50 813[7]

As part of the national response to the HIV and TB epidemics, Ukraine has achieved good coverage of HIV and TB prevention and treatment services for vulnerable populations. However, increased service coverage is a necessary but not sufficient condition for halting the spread of HIV and TB by 2030[8]. The scale, quality and comprehensiveness of services offered are essential, but not the only sufficient indicators to

1 *Tuberculosis in Ukraine: Analytical and Statistical Reference Book 2019. – K.: Public Health Center of the Ministry of Health of Ukraine, 2020. – 197 p. Available at this link: https://www.phc.org.ua/sites/default/files/users/user90/TB_surveillance_statistical-information_2019_dovidnyk.pdf*

2 *HIV Infection in Ukraine: Information Bulletin No. 51. – K.: Public Health Center of the Ministry of Health of Ukraine, 2020. – 109 p. Available at this link: https://www.phc.org.ua/sites/default/files/users/user90/HIV_in_UA_51_2020.pdf*

3 *Estimation of Key Population Sizes. Ya. Sazonova, G. Duchenko, O. Kovtun, I. Kuzin. ICF "Alliance for Public Health," 2019 – 84 p.*

4 *Analytical Report Based on Integrated Bio-Behavioral Survey Among Prisoners. – / Balakireva O., Bondar T., Vasiliev S., Ganiukov O., Titar I. – K., 2019..*

5 *Size Estimations of Key Groups, Bridging Groups and Other Populations in Ukraine, 2020: The Network Scale-Up Method. – Kovtun O., Saliuk T., Sakhno Y., Paniotto V., Kharchenko N., Lishtva O. – K.: ICF "Alliance for Public Health," 2021. – 82 p.*

6 *Analytical Report Based on Integrated Bio-Behavioral Survey Among Prisoners. – / Balakireva O., Bondar T., Vasiliev S., Ganiukov O., Titar I. – K., 2019.*

7 *Council of Europe Office in Ukraine: Impact of Covid-19 on European Prison Populations: New Study and Situation in Ukraine. Available at this link: https://www.coe.int/uk/web/kyiv/-/impact-of-covid-19-on-european-prison-populations-new-study-and-situation-in-ukraine?fbclid=IwAR3Pk13CvtN18rJt0qWMmzF0BnUa624SFB_ZnxpyLJa0s0aHWnJuggoSLYY*

8 *Stangl, A.L., Singh, D., Windle, M. et al. A systematic review of selected human rights programs to improve HIV-related outcomes from 2003 to 2015: what do we know?. BMC Infect Dis 19, 209 (2019). https://doi.org/10.1186/s12879-019-3692-1*

address the epidemics: the key issue has been and remains access to services[9].

The international community has long recognized that overcoming the HIV/AIDS epidemic requires a broad adoption of human rights-based approaches[10, 11]. There is a direct correlation between progress in the fight against HIV/AIDS and progress toward universal health coverage and the right to health care[12].

Key populations often experience stigma and discrimination and violations of their basic human rights. In turn, this leads to widespread distrust in public authorities and their representatives, which significantly reduces the capacity for effective HIV and TB prevention and treatment among these key communities.

Human rights violations, including stigma and discrimination, inequality, lack of human rights mechanisms and legal barriers, in addition to health damage for key populations, hinder the effectiveness of national HIV prevention and treatment measures, country progress toward the implementation of commitments under the Political Declaration on HIV/AIDS (2016), as well as the global targets geared towards ending AIDS as a public health threat by 2030 and the UN Sustainable Development Goals[13].

In this regard, it is essential to **understand the existing human rights-related barriers to accessing HIV and TB services**, as well as other health services for key populations. To identify such barriers, the REAct project was launched in Ukraine with a view to documenting evidence for the subsequent planning, implementation and scale-up of effective programs aimed at removing human rights-related barriers to accessing HIV and TB services.

This report presents the results of ***REAct*** implementation in Ukraine, specifically in the regions where the system was piloted – **Kyiv, Odesa, Dnipro and Krivyi Rih** during the period from **November 2019 to October 2020**.

9 *Technical Brief on HIV and Key Populations: Programming at Scale with Sex Workers, Men Who Have Sex with Men, Transgender People, People Who Inject Drugs, and People in Prison and Other Closed Settings. – Geneva: The Global Fund, 2019. – 46 p. Available at this link: https://www.theglobalfund.org/media/9991/core_keypopulations_technicalbrief_ru.pdf*

10 *UNAIDS (2019) Guidance: Rights-Based Monitoring and Evaluation of National HIV Responses. Available at this link: https://www.unaids.org/sites/default/files/media_asset/JC2968_rights-based-monitoring-evaluation-national-HIV-responses_en.pdf*

11 *OHCHR and UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights. Available at this link: https://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesru.pdf*

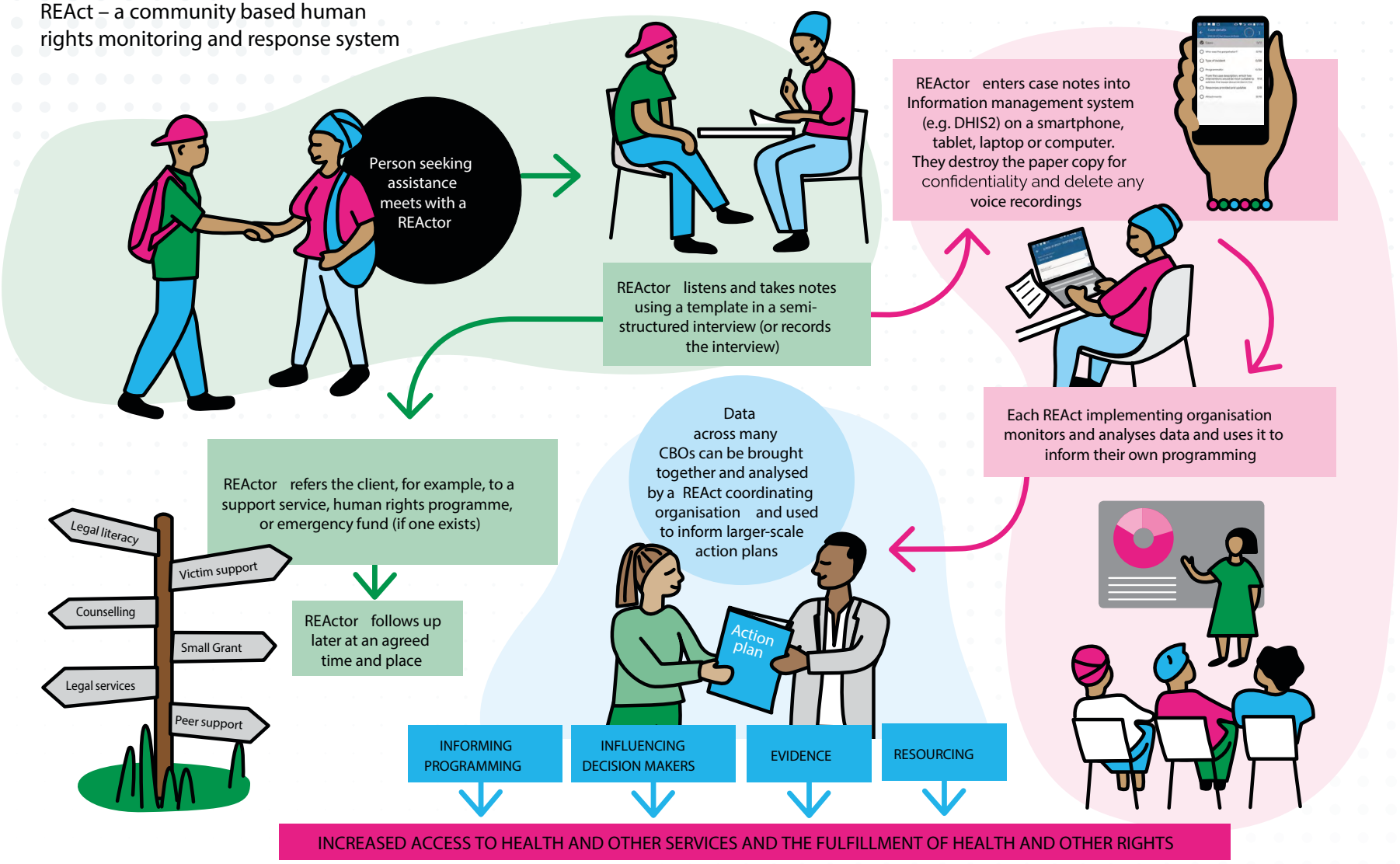
12 *UNAIDS (2017) Right to health. Available at this link: https://www.unaids.org/sites/default/files/media_asset/RighttoHealthReport_Full_web%2020%20Nov.pdf*

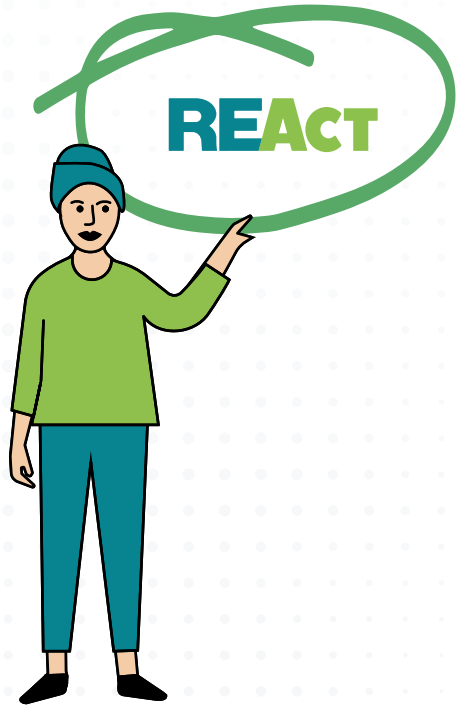
13 *Frontline AIDS (2020): A practical guide implementing and scaling up programmes to remove human rights-related barriers to HIV services. Available at this link: https://frontlineaids.org/wp-content/uploads/2020/04/Implementers-Guide_Eng_220420.pdf*

2 ABOUT THE REACT PROJECT

FIGURE 1 HOW REACT WORKS

REAct – a community based human rights monitoring and response system





REAct[14] (*Rights – Evidence – Action)* – is a tool developed by ***Frontline AIDS***[15] to monitor and respond to human rights violations at the community level. **REAct allows community-based organizations to document cases** of rights violations in key populations and **respond to human rights-related barriers** to accessing HIV and TB prevention, treatment, and health care services.

As part of the REAct framework, organizations can record relevant data on human rights violations as well as assistance provided (either directly by the organization or through client referrals to other organizations) in accessing health, legal, and other services. This data can also be used for programs, policies, and advocacy on HIV and TB at the national, regional, and global levels *(Figure 1)*.

The REAct system allows specially trained NGO-based personnel (REActors) to record barriers related to human rights violations against clients seeking to access HIV and HIV services *(Figure 2)*. **The system makes it possible to record individual cases in order to**:

- Respond to individual incidents involving clients' rights violations;
- Provide services or refer clients to another organization where they can access them;
- Create an evidence base for advocacy;
- Gather evidence that can be used to recommend legal programs and interventions against human rights violations;
- Use the data for analysis and research.

14 *https://frontlineaids.org/our-work-includes/react/*

15 *https://frontlineaids.org/*

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FIGURE 2. COMPONENTS OF THE REACT SYSTEM

REGISTRATION AND RESPONSE

- REGISTRATION OF HUMAN RIGHTS VIOLATIONS CASES
- RESPONSE AND SUPPORT

PROGRAMMES AND INTERVENTIONS

- PREVENTION OF FUTURE CASES
- HUMAN RIGHTS INTERVENTIONS

REACT

ANALYSIS

- TYPE OF VIOLATIONS/ REGION/KP/SEX, AGE
- LINKING HUMAN RIGHTS VIOLATIONS CASES WITH ACCESS TO HIV/TB AND OTHER HEALTH SERVICES

ADVOCACY

- PROTECTION OF RIGHTS
- INFORMING PROGRAMS
- CHANGING POLICIES

FEATURES OF THE REACT SYSTEM:

- **Client-oriented** – The basic unit of information used is a person, rather than an individual incident, ensures the ability to collect a history of cases.
- **Access online / offline / via mobile app** – You can record cases "in the field" even without access to the Internet, and then upload the information to the database in the office.
- **Information is stored in the cloud** – This eliminates data loss/theft or hacking, as all data is stored on secure Amazon servers.
- **Simple and adaptive** – Simple and clear interface, the possibility of multiple language versions and adaptation of the data collection tool to match the needs and particularities of each country.
- **Immediate response and collaboration** – Cases appear in the database instantly and can be immediately processed by legal experts or other employees in the organization who have access to the cases.
- **Fast monitoring and charting** – Multiple functions and features for analysis and visualization of the information collected.

The REAct system is being implemented by ICF "Alliance for Public Health" through the financial support from the ***Global Fund***[16] and with technical assistance from ***Frontline AIDS***[17]. Ukraine became the first country in Eastern Europe and Central Asia (EECA) where the REAct system was deployed. Besides Ukraine, REAct is also operating in four countries: Georgia, Kyrgyzstan, Moldova, and Tajikistan.

Detailed and updated information on REAct implementation in Ukraine and other EECA countries can be found on the REAct project's website at – ***https://react-aph.org/***

16 *https://www.theglobalfund.org/en/*

17 *https://frontlineaids.org/*

3 KEY INTERNATIONAL RECOMMENDATIONS FOR ENSURING THE RIGHTS OF VULNERABLE POPULATIONS IN THE CONTEXT OF HIV AND TB EPIDEMICS

The human right to health is recognized in numerous international documents. The most comprehensive article on the right to health is contained in the **International Covenant on Economic, Social and Cultural Rights,**[18] which enshrines the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The right to health is one of the internationally agreed-upon human rights standards and is inseparable from other rights. This means that the right to health is crucial to the realization of other human rights (to food, housing, work, education, information, and participation), and also depends on the realization of these rights.

The right to health imposes a clear set of legal obligations on states to ensure adequate conditions for promoting the health of all persons without discrimination[19].

THE STATE'S OBLIGATIONS IN RELATION TO HUMAN RIGHTS FALL INTO THREE CATEGORIES, NAMELY TO RESPECT, PROTECT AND FULFILL[20].

OBLIGATION TO RESPECT

REQUIRES THE STATE TO REFRAIN FROM INTERFERING DIRECTLY OR INDIRECTLY WITH HUMAN RIGHTS

OBLIGATION TO PROTECT

REQUIRES THE STATE TO PREVENT THIRD PARTIES FROM INTERFERING WITH THE EXERCISE OF HUMAN RIGHTS

OBLIGATION TO FULFILL

REQUIRES THE STATE TO TAKE APPROPRIATE LEGAL, ADMINISTRATIVE, BUDGETARY, PROMOTIONAL, AND OTHER MEASURES FOR THE FULL REALIZATION OF HUMAN RIGHTS

18 *OHCHR (1966) International Covenant on Economic, Social and Cultural Rights. Available at this link: https://www.ohchr.org/ru/professionalinterest/pages/cescr.aspx*

19 *WHO: Human Rights and Health. Available at this link: https://www.who.int/ru/news-room/fact-sheets/detail/human-rights-and-health*

20 *WHO: The Right to Health, Fact Sheet. Available at this link: https://www.ohchr.org/Documents/Publications/Factsheet31ru.pdf*

THE STATE'S OBLIGATIONS REGARDING THE REALIZATION OF HUMAN RIGHTS

- **The obligation to respect** the right to health requires States, among other things, to refrain from prohibiting or restricting equal access to health services for all; from establishing discriminatory practices as State practice.
- **The obligation to protect** implies, among other things, the obligation of states to enact legislation or take other steps to ensure equal access to health care and health services provided by third parties. States must also ensure that third parties do not limit public access to health information and services
- **The obligation to fulfill** requires States, among other things, to give due place to the right to health in national political and legal systems, preferably by enshrining it in law, and to adopt a national health policy with a detailed plan for realizing the right to health.

The international community has reached consensus on the importance of respecting, protecting and promoting human rights and integrating a human rights-based approach into HIV programs. A human rights-based approach seeks to keep communities that suffer from marginalization and discrimination at the center of program and policy development[21]. Programs and policies with this approach at their core encourage rights holders (such as individual members of communities) to assert their rights while building up the capacity of duty-bearers (such as health care providers) to fulfill their obligations.

The need for human rights-based approaches in implementing programs to prevent and treat HIV and TB is evident in the guidelines of the leading organizations and institutions governing this area, i.e., the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), the United Nations Development Program (UNDP), the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GF). Human rights are one of the core activities of these organizations, and the elimination of barriers to accessing HIV and TB services related to human rights is recognized as one of the strategic objectives[22].

UNAIDS AND GLOBAL PARTNERS RECOMMEND SEVEN KEY PROGRAM AREAS THAT CAN HELP ADDRESS HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES

21 *Stangl, A.L., Singh, D., Windle, M. et al. A systematic review of selected human rights programs to improve HIV-related outcomes from 2003 to 2015: what do we know?. BMC Infect Dis 19, 209 (2019).* ***https://doi.org/10.1186/s12879-019-3692-1***

22 *The Global Fund (2019) Removing human rights-related barriers: Operationalizing the human rights aspects of Global Fund Strategic Objective 3. Available at this link:* ***https://www.theglobalfund.org/media/9020/oig_gf-oig-19-023_report_en.pdf***

These programs[23] are aligned with the global goals of zero new infections, zero AIDS-related deaths, and zero stigma and discrimination[24]. These following program areas are key in the fight against the epidemics:

IN THE CONTEXT OF HIV:

1. HIV-related stigma and discrimination reduction.
2. Training for health care providers on human rights and medical ethics.
3. Sensitization of lawmakers and law enforcement agents.
4. Reducing discrimination against women and girls in the context of HIV.
5. Legal literacy (Know Your Rights).
6. HIV-related legal services.
7. Monitoring and reforming relevant HIV-related laws, regulations and policies.

IN THE CONTEXT OF THE FIGHT AGAINST TB:

1. Ensuring TB-status confidentiality and privacy.
2. Mobilizing and empowering communities (participation in decision-making about health care policies and programs.)
3. Implementing programs to ensure access to TB services in prisons and other closed settings.

THE PROGRAMS OUTLINED ABOVE ENSURE THE FOLLOWING:

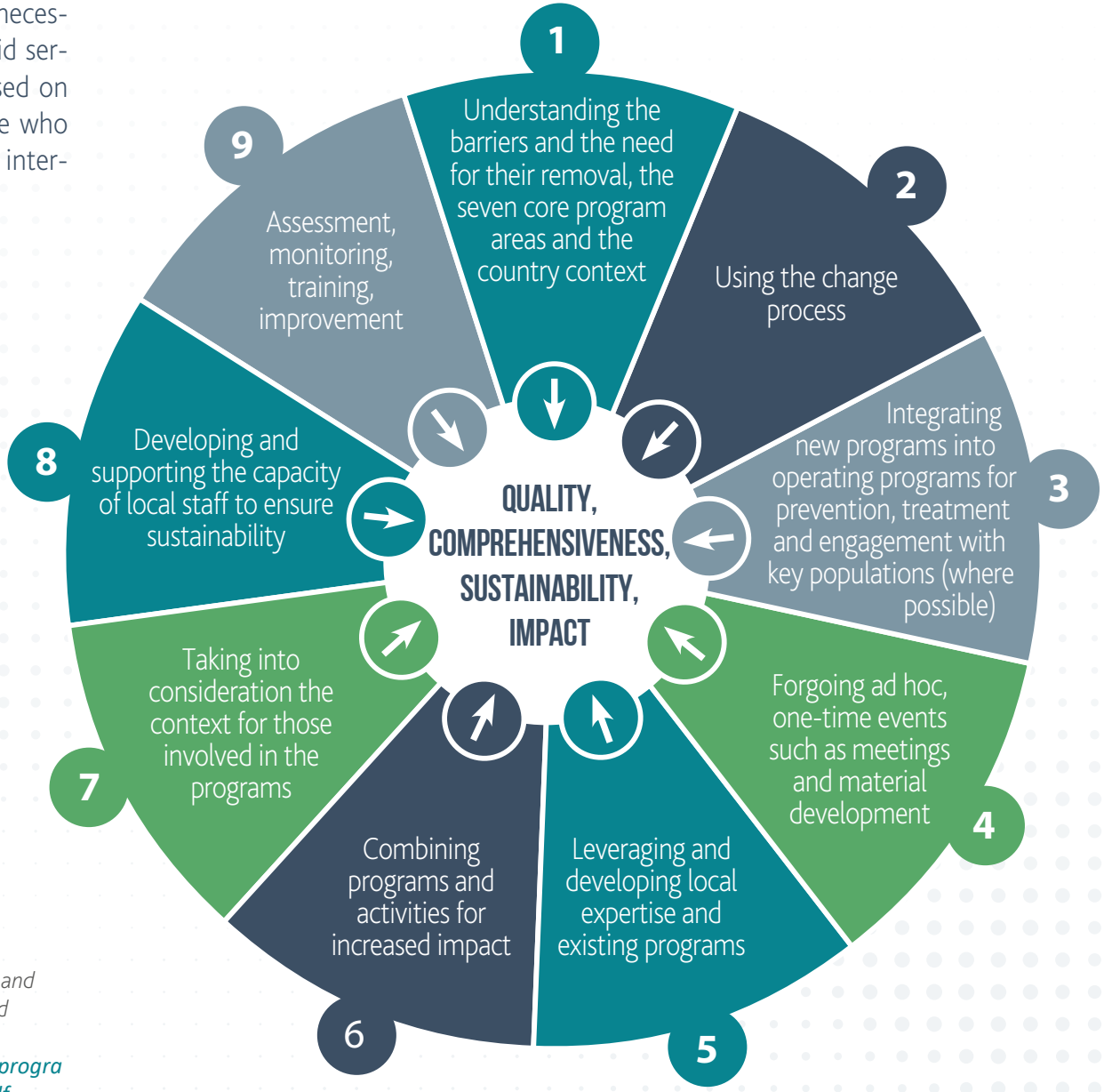
- Reaching the most affected populations with health care and other related services;
- Protection of human rights;
- Empowering key communities to overcome complex social and legal barriers that limit their access to HIV and TB services;
- Supporting the use of programs and retention of key communities in them;
- Strengthening community systems and health systems.

23 *Frontline AIDS (2020): A practical guide implementing and scaling up programmes to remove human rights-related barriers to HIV services. Available at this link:* ***https://www.theglobalfund.org/media/9975/crg_programmeshumanrightsbarriershivservices_guide_ru.pdf***

24 *UNAIDS (2019) Guidance Rights-Based Monitoring and Evaluation of National HIV Responses. Available at this link:* ***https://www.unaids.org/sites/default/files/media_asset/JC2968_rights-based-monitoring-evaluation-national-HIV-responses_en.pdf***

Programs that address barriers to accessing HIV and TB prevention and treatment services should seek to ensure the **quality, comprehensiveness, sustainability and impact of such programs**. This necessitates programs that support and integrate said services. Such programs should be developed based on the available information on barriers and those who experience them and provide for implementing interventions to address these barriers *(Figure 3)*[25].

FIGURE 3. KEY COMPONENTS OF QUALITY, COMPREHENSIVE AND SUSTAINABLE PROGRAMS FOR ENSURING THE REQUIRED IMPACT



25 *Frontline AIDS (2020): A practical guide implementing and scaling up programmes to remove human rights-related barriers to HIV services. Available at this link: https://www.theglobalfund.org/media/9975/crg_programmeshumanrightsbarriershivservices_guide_ru.pdf*

4 OVERVIEW OF THE NATIONAL REGULATORY FRAMEWORK IN THE CONTEXT OF HIV/TB AND THE RIGHTS OF KEY POPULATIONS

Below are the key international human rights treaties ratified by Ukraine:

- The Universal Declaration of Human Rights.
- The International Covenant on Civil and Political Rights.
- The International Covenant on Economic, Social and Cultural Rights.
- The International Convention on the Elimination of All Forms of Racial Discrimination.
- The European Convention for the Protection of Human Rights and Fundamental Freedoms.
- The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

As the fundamental provision, the above-mentioned instruments prohibit any kind of discrimination or the unlawful restriction of human rights. These international instruments form an integral part of Ukraine's national legislation and must be adhered to at all times.

The same prohibitory requirements are contained in applicable national statutes and regulations. For example, in accordance with Article 3 of ***the Constitution of Ukraine***[26], an individual, his or her life and health, honor and dignity, inviolability and security shall be recognized in Ukraine as the highest social value. Human rights and freedoms and guarantees thereof shall determine the essence and course of activities of the State. The State shall be responsible to the individual for its activities. **Affirming and ensuring human rights and freedoms shall be the main duty of the State.** Article 24 of the Constitution of Ukraine provides that all citizens shall have equal constitutional rights and freedoms and be equal before the law. The same article requires that there should be no privileges or restrictions on the grounds of race, skin color, political, religious or other beliefs, sex, ethnic and social origin or property status, place of residence, language or other characteristics. **Under Article 49 of the Constitution of Ukraine, everyone shall have the right to health protection and medical care.**

26 *The Constitution of Ukraine of June 28, 1996 (No. 254k/96-VR). Available at this link: https://zakon.rada.gov.ua/laws/show/254к/96-вр#top*

4.1. REGULATORY FRAMEWORK ON HIV AND AIDS

Ukraine has adopted and is implementing **the National HIV/AIDS Strategy until 2030**[27]. The goals and implementation instruments for this Strategy are based on the key principles such as:

- **Respect for human rights** and non-discrimination on the basis of health, age, social status, sexual orientation, gender identity, occupation or any other characteristics;
- **The priority of the right to health**, which shall not only ensure full and equitable access to health services, but also create an enabling environment for people to exercise their rights and take proactive care of their own health and the health of their families.

! **THE CRIMINAL CODE OF UKRAINE** COVERS SEVERAL PUNISHABLE CRIMINAL OFFENSES RELATING TO KNOWINGLY PLACING ANOTHER PERSON AT RISK OF BECOMING INFECTED WITH HIV AND KNOWINGLY TRANSMITTING HIV TO OTHERS. THESE OFFENSES ARE PUNISHABLE BY RESTRICTION OF LIBERTY (PROBATION) OR IMPRISONMENT.

The Law of Ukraine on Combating the Spread of Diseases Caused by the Human Immunodeficiency Virus (HIV) and the Legal and Social Protection for People Living with HIV[28] defines the principles of state policy in the fight against HIV.

THE LAW ESTABLISHES A NUMBER OF STATE GUARANTEES IN THE AREA OF HIV, INCLUDING THOSE SET OUT BELOW:

- Ensuring accessibility and quality of HIV testing, including that provided in anonymous settings, together with pre- and post-test counseling;
- Free access to post-exposure prophylaxis services and counseling;
- Free access to services for preventing HIV transmission from HIV-positive pregnant women to their newborn babies;
- Implementing consistent policies aimed at promoting tolerant attitudes towards people at high risk of HIV infection and people living with HIV;
- Conducting awareness-raising activities aimed at developing more tolerant public attitudes and preventing discrimination against people at high risk of HIV infection and people living with HIV;
- Ensuring social protection and access to medical care and social services for people living with HIV;
- Preventing the spread of HIV infection among people who inject drugs and psychotropic substances through rehabilitation and harm reduction programs, including but not limited to substitution therapy, and creating opportunities for exchanging used needles and syringes with sterile ones and further disposal arrangements.

27 *Ordinance No. 1415-r of the Cabinet of Ministers of Ukraine of November 27, 2019, On Approval of the State Strategy on HIV/AIDS, TB and Viral Hepatitis for the Period up to 2030. Available at this link: https://zakon.rada.gov.ua/laws/show/1415-2019-p#Text*

28 *Law of Ukraine No. 1972-XII of December 12, 1991 On Counteracting the Spread of Diseases Caused by the Human Immunodeficiency Virus (HIV) and the Legal and Social Protection of People Living with HIV. Available at this link: https://zakon.rada.gov.ua/laws/show/1972-12#Text*

29 *Criminal Code of Ukraine of April 5, 2001, No. 2341-III. Available at this link: https://zakon.rada.gov.ua/laws/show/2341-14#top*

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4.2. REGULATORY FRAMEWORK ON TB

Ukraine has adopted and is implementing the **Concept of the National Targeted Social Program for TB Control for 2018-2021**[30]**.** The Concept recognizes TB as a national public health problem as well as the need for adopting an integrated approach to articulating and implementing state policy on TB.

The Concept delineates the following tasks and objectives as part of the strategy for **countering the spread of TB**:

- Implementing systematic screening, specifically active TB case-finding, identifying multidrug-resistant TB and related contacts, including those among populations at high risk of TB disease;
- Ensuring early detection of all forms of TB and comprehensive access to drug-susceptibility testing, in particular through the use of rapid tests;
- Adopting a patient-centered approach and focusing on socially disadvantaged patients, introducing short-course treatment regimens and new drugs in line with WHO recommendations;
- Reforming the health care system for people with TB by introducing treatment models with a focus on outpatient care;
- Ensuring patient- and family-centered social support for people with TB to facilitate adherence to treatment throughout the entire course;
- Implementing collaborative TB/HIV/AIDS co-infection activities and tracking co-morbidities;
- Ensuring appropriate access for people with HIV/AIDS and TB to early and controlled antiretroviral treatment and providing cotrimoxazole preventive therapy;
- Ensuring access to preventive TB treatment for people with psychotropic substance abuse issues receiving harm reduction services.

30 *Ordinance No. 1011-r of the Cabinet of Ministers of Ukraine of December 27, 2017 On Approval of the Concept of the National Targeted Social Program for Tuberculosis Control for 2018-2021. Available at this link: https://zakon.rada.gov.ua/laws/show/1011-2017-p#Text*

The Law of Ukraine On Counteracting Tuberculosis[31] establishes the rights, obligations and responsibilities with regard to TB control. The law provides for the following **state guarantees in the area of TB control**:

1. TB-related medical care, diagnosis, chemoprophylaxis, and health resort treatment for people with TB in public and communal health facilities shall be provided free of charge.

2. During the treatment period, people with TB should be continuously provided with free anti-tuberculosis drugs according to the list and within the scope approved by the Ministry of Health.

3. People with TB as well as minors and young people infected with Mycobacterium tuberculosis shall be provided with free meals during their inpatient or health resort treatment in TB facilities.

The organization of health care for people with TB and the implementation of TB infection control measures, in turn, imply the following:

- Medical care for people with TB is provided at a TB facility on an outpatient or inpatient basis;

- The written informed consent of the patient or his/her legal representative or guardian and a written warning of the need for adherence to anti-epidemic measures are mandatory conditions for anti-TB treatment;

- Patients with infectious forms of TB disease will be admitted to a TB facility;

- If a person with infectious TB refuses to be hospitalized, he or she can be treated on an outpatient basis if their home isolation can be ensured.

31 *Law of Ukraine No. 2586-III of July 5, 2001 On Counteracting Tuberculosis. Available at this link. Available at this link: https://zakon.rada.gov.ua/laws/show/2586-14#Text*

4.3. REGULATORY FRAMEWORK ON DRUG CONTROL

In 2015, the Cabinet of Ministers of Ukraine decreed that the **Ministry of Health of Ukraine would be the main body responsible for the development and implementation of state policies regarding the control and regulation of narcotic drugs, psychotropic substances, their analogues and precursors, as well as measures for combating their illicit trafficking**[32]. Previously, relevant approaches to drug policy were developed in coordination with the Ministry of Internal Affairs of Ukraine. Changes within the hierarchy of the responsible authorities made it possible to increase opportunities for implementing therapeutic and humanitarian approaches in Ukraine's drug control framework, as opposed to those that were purely repressive.

Ukrainian policies and regulations on drug control and combating illicit drug trafficking are generally based on the laws and statutory instruments below:

- **The Law of Ukraine On Narcotic Drugs, Psychotropic Substances and Precursors**[33], which establishes the regulatory and organizational framework of Ukraine's state policy with respect to narcotic drugs, psychotropic substances and precursors inside the country, defines state control procedures, the powers of executive authorities, as well as the rights and responsibilities of individuals and legal entities regarding narcotic drugs, psychotropic substances and precursors.

- **The Law of Ukraine On Measures Against Illicit Traffic in Narcotic Drugs, Psychotropic Substances and Precursors and Their Abuse**[34], which establishes a system of measures against illicit trafficking in and abuse of narcotic drugs, psychotropic substances and precursors in Ukraine and defines the rights and responsibilities of legal entities and individuals associated with the implementation of this law.

- **The Law of Ukraine on the National Police**[35], which defines the regulatory basis for the organization and activities of the National Police of Ukraine.

- **The Criminal Code of Ukraine**[36] i.e., Articles 305-321, as well as the **Code of Ukraine on Administrative Offenses**[37] i.e., Articles 44, 44/1, 106/1, 106/2, 130, which form an integral part of Ukraine's "anti-drug" legislation.

! **LOW LEGISLATIVE THRESHOLDS FOR DRUG POSSESSION AND TRAFFICKING** IN UKRAINE ARE CURRENTLY AN ISSUE THAT NEEDS ADDRESSING

32 *Decree No. 267 of March 25, 2015 by the Cabinet of Ministers of Ukraine. Available at this link: https://zakon.rada.gov.ua/laws/show/267-2015-n#Text*

33 *Law of Ukraine No. 60-95-VR On Narcotic Drugs, Psychotropic Substances and Precursors (Revised as of July 5, 2020). Available at this link: https://zakon.rada.gov.ua/laws/show/60/95-%D0%B2%D1%80#Text*

34 *Law of Ukraine No. 62/95-VR On Measures Against Illicit Traffic in Narcotic Drugs, Psychotropic Substances and Precursors and Their Abuse (Revised as of July 3, 2020: https://zakon.rada.gov.ua/laws/show/62/95-%D0%B2%D1%80#Text*

35 *Law of Ukraine No. 580-VIII of July 2, 2015 on the National Police. Available at this link: https://zakon.rada.gov.ua/laws/show/580-19#Text*

36 *Criminal Code of Ukraine No. 2341-III of April 5, 2001. Available at this link: https://zakon.rada.gov.ua/laws/show/2341-14#top*

37 *Code of Ukraine on Administrative Offenses No. 8073[1]-X (Revised as of April 17, 2021): https://zakon.rada.gov.ua/laws/show/80731-10#Text*

The law defines the quantities of drugs that are considered small, illegal operations with them, such as manufacturing, purchasing, possession, etc., which entail *administrative liability*. Similar illegal operations involving drugs in larger quantities will incur *criminal liability*[38] *(Table 2)*.

TABLE 2 SELECTED EXAMPLES OF THE THRESHOLD QUANTITIES OF CERTAIN NARCOTIC DRUGS INVOLVED IN ILLICIT TRAFFICKING

NAME OF NARCOTIC DRUG	LEGISLATIVE THRESHOLDS (SMALL QUANTITIES) ADMINISTRATIVE LIABILITY	LEGISLATIVE THRESHOLDS (QUANTITIES LARGER THAN SMALL BUT NOT LARGE) CRIMINAL LIABILITY	LEGISLATIVE THRESHOLDS (LARGE QUANTITIES) CRIMINAL LIABILITY
Cannabis (marijuana)	Up to 5.0 g	5.0 g – 500 g	500 g and above
Poppy straw concentrate (extractable opium)	Up to 0.5 g	0.5 g – 50.0 g	50.0 g and above
Methadone (Phenadon)	Up to 0.02 g	0.02 g – 1.6 g	1.6 g and above
Opium acetylated	Up to 0.005 g	0.005 g – 1.0 g	1.0 g and above
Heroin	Up to 0.005 g	0.005 g – 1.0 g	1.0 g and above

The Criminal Code of Ukraine (CCU) and the Code of of Ukraine on Administrative Offenses (CUAO) establish measures **to prevent illicit drug trafficking and defines liability for related offenses**.

38 *Order No. 188 of August 1, 2000 by the Ministry of Health of Ukraine on Approval of the Tables of Small, Large and Especially Large Quantities of Narcotic Drugs, Psychotropic Substances and Precursors Involved in Illicit Trafficking. Available at this link:* *https://zakon.rada.gov.ua/laws/show/z0512-00#Text*

ADMINISTRATIVE LIABILITY

➡ Article 44 of the CUAO provides that, **the illegal manufacturing, acquisition, storage, transportation, shipment of narcotic drugs or psychotropic substances in small quantities without intent to sell** incur administrative liability and are punishable by:

- A fine of 25 to 50 non-taxable minimum incomes (UAH 425 – UAH 850 (~$15 – $30)) or
- Community service work for a period of 20 to 60 hours or
- Administrative arrest for up to 15 days

In actual practice, courts normally tend to impose fines for such offenses.

➡ According to the same Article 44 of the CUAO, **a person who voluntarily surrenders narcotic drugs** or psychotropic substances that were in his or her possession (in small quantities) without intent to sell shall be exempt from administrative liability for the actions provided for in the said article.

CRIMINAL LIABILITY

- According to Article 309 (Part 1) of the Criminal Code of Ukraine, **the same activities with drugs** as those set forth under Article 44 of the CUAO, **but involving larger than small quantities**, entail **criminal liability**.

- Article 309 (Part 1) of the Criminal Code of Ukraine, following a significant increase in the amount of the fine in July of 2020, provides that the same activities shall be punishable by:

  - A fine of 1,000 to 3,000 non-taxable minimum individual incomes (UAH 17,000 – UAH 51,000 (~$607 – $1,821)) or
  - Correctional labor for up to 2 years or
  - Detention under arrest for up to 6 months or
  - Restriction of freedom for up to 5 years.

In actual practice, previously, the courts of law tended to impose fines for such offenses, or less frequently passed a sentence of imprisonment (with or without probation). However, as of today's date, after a significant increase in fine amounts in July of 2020, the courts of law are more likely to sentence offenders in such cases to probation (restriction of freedom) or a term of imprisonment, respectively. People with drug addiction issues which commonly have no regular and legal source of income often find it impossible to pay these increased fines and the courts of law recognize this de facto situation in their sentencing options.

- Article 309 (Part 2) of the Criminal Code of Ukraine provides that **the same activities, but involving large quantities of narcotic drugs, or committed by a group of individuals or within a year after conviction under this Article**, are punishable by:

  - A fine of 2,000 to 5,000 non-taxable minimum individual incomes (UAH 34,000 – UAH 85,000 (~$1,214 – $3,035)) or
  - Imprisonment for up to 3 years.

- According to Article 309 (Part 3) of the Criminal Code of Ukraine, **the acts outlined above but committed with the involvement of a minor**, and those involving drugs in especially large quantities, are punishable by imprisonment for a term of 5 to 8 years.

- According to Article 309 (Part 4) of the Criminal Code of Ukraine, **a person who voluntarily seeks drug addiction treatment and admitted to a healthcare facility for its initiation** shall be exempt from criminal liability for the acts specified in Article 309 (Part 1) of the Criminal Code of Ukraine.

- Article 316 of the Criminal Code of Ukraine provides that **the illegal use of narcotic drugs in public areas or by a group of individuals** in places intended for *educational, sports or cultural activities*, and in other public areas is punishable under criminal law by:

  - Restriction of freedom for up to 4 years or
  - Imprisonment for up to 3 years, or, if aggravating factors are present, for a term of 3 to 5 years*.

** However, in actual practice, Article 316 of the Criminal Code of Ukraine is not applied by the courts of law very often.*

It should be pointed out that **Article 309 *(Part 1)* of the Criminal Code of Ukraine** is the most relevant and applicable one to drug-addicted people who are clients of the REAct project and who are driven by their addiction into manufacturing, storing or carrying drugs for personal use.

Article 309 of the Criminal Code of Ukraine does not provide for any liability for the use of narcotic drugs, psychotropic substances or their analogues. However, the process of drug use, in and of itself, is associated with the prior production, acquisition, storage or transportation of such drugs. It may therefore be noted that drug users are being held liable and accountable, if not technically for drug use itself, then for the activities involved with it.

4.4. REGULATORY FRAMEWORK ON OST PROGRAM IMPLEMENTATION

The substitution maintenance therapy (OST) program was introduced in Ukraine in 2004 through pilot projects and is currently being implemented in all regions of Ukraine.* The number of patients accessing methadone and buprenorphine in healthcare facilities totals 13,786, of whom 12,012 patients receive methadone hydrochloride (sublingual tablets), 184 patients receive methadone hydrochloride (liquid) and 1,590 patients receive buprenorphine hydrochloride.[39]

The use of OST by people addicted on opioid drugs as well as needle/syringe exchange programs are guaranteed and regulated by the applicable legislation of Ukraine listed below:

- *The Law of Ukraine On Counteracting the Spread of Diseases Caused by the Human Immunodeficiency Virus (HIV) and the Legal and Social Protection of People Living with HIV*[40] **lays down guarantees for the implementation of OST and syringe exchange programs;**

- *Order of the Ministry of Health of Ukraine On Approval of the Procedure for Substitution Maintenance Therapy for Patients with Opioid Dependence*[41] **establishes the organizational framework for the provision of OST;**

* *Excluding territories outside the control of Ukraine*

39 *Public Health Center of the Ministry of Health of Ukraine: OST Statistics. Available at this link: https://phc.org.ua/kontrol-zakhvoryuvan/zalezhnist-vid-psikhoaktivnikh-rechovin/zamisna-pidtrimuvalna-terapiya-zpt/statistika-zpt*

40 *Article 4 of Law of Ukraine No. 1972-XII of December 12, 1991 On Counteracting the Spread of Diseases Caused by the Human Immunodeficiency Virus (HIV) and the Legal and Social Protection of People Living with HIV https://zakon.rada.gov.ua/laws/show/1972-12#Text*

41 *Order No. 200 of March 27, 2012 by the Ministry of Health of Ukraine On Approval of the Procedure for Substitution Maintenance Therapy for Patients with Opioid Dependence. Available at this link: https://zakon.rada.gov.ua/laws/show/z0889-12#Text*

- *Resolution of the Cabinet of Ministers On Approval of the Procedure for the Acquisition, Transportation, Storage, Dispensing, Use and Destruction of Drugs, Psychotropic Substances and Precursors in Health Care Facilities*[42] **establishes a mechanism for controlling the circulation of narcotic drugs, psychotropic substances and precursors in health care facility settings.**

In January of 2021, a number of significant changes were made to *the Order of the Ministry of Health On Approval of the Procedure for Substitution Maintenance Therapy for Patients with Opioid Dependence*[43] **THUS CREATING OPPORTUNITIES FOR THE FOLLOWING**:

- **DISPENSING OST IN HEALTHCARE FACILITIES OF THE STATE PENITENTIARY (PENAL) SERVICE**, i.e., in prison hospitals, medical units that serve pre-trial detention centers;
- **DISPENSING OST** in health care facilities **REGARDLESS OF THEIR FORM OF OWNERSHIP OR FORM OF ORGANIZATION** (i.e., including private medical institutions) that are duly licensed to practice medicine and engage in operations involving narcotic drugs, psychotropic substances and precursors.

Until that point in time, it was only formally possible to implement OST programs in incarcerated settings. [44] In practice, though, this often implied the need for detainees be taken out of pre-trial detention facilities on a daily basis for access to OST in appropriate treatment centers, thus frequently creating conflicts due to the additional workload for escort duty personnel and resulting in the pre-trial detention center administration having to forgo further participation in OST programs.

Currently, based on the adopted amendments, **Head of the Health Care Center of the State Penal Service of Ukraine is endowed with the authority to**:

- Determine the healthcare institutions of the State Penal Service of Ukraine within the administrative jurisdiction of the Ministry of Justice of Ukraine where the OST drugs will be dispensed; the number of patients in need of treatment;
- Ensure control over the intended use of OST medications, approve their distribution and, if so required, redistribute them among subordinate health care facilities;
- If necessary, refer patients needing OST to social and psychological services in penal and correctional settings.

42 *Resolution of the Cabinet of Ministers No. 333 of May 13, 2013 On Approval of the Procedure for the Acquisition, Transportation, Storage, Dispensing, Use and Destruction of Drugs, Psychotropic Substances and Precursors in Health Care Facilities. Available at this link:* *https://zakon.rada.gov.ua/laws/show/333-2013-n#Text*

43 *Order No. 2630 of November 16, 2020 by the Ministry of Health of Ukraine*

44 *Order No. 821/937/1549/5/156 of October 22, 2012 by the Ministry of Health of Ukraine, the Ministry of Internal Affairs of Ukraine, the Ministry of Justice of Ukraine, the State Service of Ukraine for Drug Control On Approval of the Procedure for Interaction Between Healthcare Institutions, Internal Affairs Bodies, Pre-Trial Detention and Correctional Facilities for Ensuring Continuous and Uninterrupted Substitution Therapy:* *https://zakon.rada.gov.ua/laws/show/z1868-12#Text*

The Resolution of the Cabinet of Ministers On Approval of the Procedure for the Acquisition, Transportation, Storage, Dispensing, Use and Destruction of Drugs, Psychotropic Substances and Precursors in Health Care Facilities establishes control mechanisms for narcotic drugs, psychotropic substances and precursors used in healthcare facilities (HCF). According to this mechanism, patients receiving treatment for drug addiction (including patients of OST programs) in outpatient settings (and those who receive inpatient care in home-based settings) can be provided with OST drugs in health care facilities or pharmacies upon prescription within levels not exceeding 10 days' supply, and during palliative and hospice care – within levels not exceeding 15 days' supply.[45]

This arrangement allowed patients enrolled in OST programs to receive medication not only in the OST room on pre-scheduled days, but also **have the option to access take-home medication** if there are individual indications for outpatient or hospice care.

45 *Resolution of the Cabinet of Ministers No. 333 of May 13, 2013 On Approval of the Procedure for the Acquisition, Transportation, Storage, Dispensing, Use and Destruction of Drugs, Psychotropic Substances and Precursors in Health Care Facilities. Available at this link* ***https://zakon.rada.gov.ua/laws/show/333-2013-n#Text***

46 *The Committee on Economic, Social and Cultural Rights. Concluding Observations on the 7th Periodic Report of Ukraine (E/C.12/UKR/CO/7), April 2020. Paragraphs 42, 43.. Available at this link: http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuWxT7OYZyYjJGL8qwRLmzDL%2fvGZyEn3i0uiQ8QMBJeVxr4Jaon5%2fgI7IPnOTr2gopfheMGlLfM4YRKoIKk5Y%2btYbh7SNaX4onpDfOPO0K7nMi*

However, **in Ukraine emphasis on punitive measures to control drug trafficking remains in place**, which has a negative impact on the rights of people who use drugs.

In 2020, **the Committee on Economic, Social and Cultural Rights** expressed concern about the low threshold quantities of trafficable drugs that incur criminal prosecution. The Committee noted that this prevents drug users who fear prosecution from accessing necessary treatment or harm reduction programs. The Committee also deplored the limited access of prisoners to opioid substitution therapy and harm reduction programs, as well as the continuing social stigmatization of drug users.

THE COMMITTEE RECOMMENDED THAT UKRAINE:

- **Adopt a consistent human rights-based approach towards drug users** and consider decriminalizing the possession of narcotic drugs for personal consumption;
- Continue its efforts to **scale up harm reduction programs**, especially in prison settings, and ensure that privatized opioid substitution therapy programs are of adequate quality;
- Take the necessary measures to **combat the social stigmatization of drug users** through the training of police personnel, social workers, child protection workers and health-care professionals and by raising public awareness, especially regarding the right to health of drug users[46].

4.5. SEX WORK AND REGULATORY RESTRICTIONS

In 2006, Ukraine officially decriminalized prostitution but **administrative and legal liability** for engaging in sex work is still imposed,[47] **as well as criminal liability** for activities related to organizing sex work ("pimping").[48].

ADMINISTRATIVE LIABILITY

- Article 181/1 of the Code of Ukraine on Administrative Offenses provides that engagement in prostitution incurs a warning or a fine of 5 to 10 non-taxable minimum individual incomes (up to UAH 170 ~ $6);
- The same acts if committed again within one year after the imposition of an administrative penalty shall be punishable with a fine ranging from 8 to 15 non-taxable minimum individual incomes (up to 255 hryvnias ~ $9).

CRIMINAL LIABILITY

- According to Article 303 of the Criminal Code, pimping is defined as any actions of a person that ensure the prostitution of another person, such as misleading or coercing anyone into engaging in prostitution through the use of deception, blackmail or the vulnerability of that person, or by using or threatening to use violence;
- Such offenses carry a penalty of imprisonment for 3 to 5 years, or more, depending on the severity of the offense (up to 15 years).

In practice, this article is applied only infrequently, but police officers may threaten to use it against sex workers by way of blackmail or extortion for obtaining services or money.

It should be noted that international bodies and human rights organizations recommend that all punitive measures, even administrative ones, against sex work be abolished[49].

47 *Code of Ukraine on Administrative Offenses No. 8073-X of December 7, 1984. Available at this link. Available at this link: https://zakon.rada.gov.ua/laws/show/80731-10#Text*

48 *Criminal Code of Ukraine No. 2341-III of April 5, 2001. Available at this link: https://zakon.rada.gov.ua/laws/show/2341-14#top*

49 *Cf., e.g., U.N. Doc.CEDAW/C/RUS/CO/8, 2015, Paras. 25-26. Available at this link: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fRUS%2fCO%2f8&Lang=en*

4.6. REGULATORY FRAMEWORK WITH REGARD TO MEN WHO HAVE SEX WITH MEN AND TRANS*PEOPLE

Sexual intercourse between consenting adults of the same sex is not prohibited by Ukrainian law. **Homosexual relationships have been decriminalized** in Ukraine since 1991, yet **MSM often face stigma and discrimination** as well as experience intolerance-induced violence due to their sexual orientation.

Article 51 of the Ukrainian Constitution provides that marriage is a voluntary union between a man and a woman. This brings forth the other provisions premised on the implementation of the said constitutional provision. In practice, this implies that the conjugal union of a man and a woman as a married couple is regulated by law in various contexts and relationship areas, thus making it much more difficult for homosexual couples to gain recognition, e.g., with regard to their property rights, inheritance of marital property by a partner, joint child adoption, etc.

Prior to 2016 there was a **legal gender recognition procedure** for trans*people in Ukraine, which provided for a number of restrictions as well as discriminatory contraindications and requirements. Thus, according to the pre-existing procedure, the Commission on Gender Identity Change (Correction) was the only state institution empowered to authorize the replacement of documents, including changing the gender marker in documents (the mandatory field "sex," i.e., female or male).

The Commission met only twice a year in Kyiv, thus annually assessing up to 20 trans*people. Additionally, the previous procedure required the diagnosis of transsexualism. Trans*people reported that the actual procedure for legal recognition of gender identity in Ukraine took between 1 and 4 years[50].

In 2016, Ukraine approved a Protocol that regulates **procedures for legal recognition of gender identity**, *i.e., the Unified Clinical Protocol for Primary, Secondary (Specialized) and Tertiary (Highly Specialized) Medical Care [Gender Dysphoria]*[51]. Based upon this protocol, the diagnosis of gender dysphoria (F64) (according to the International Classification of Diseases, Tenth Revision) requires two years of outpatient observation or two weeks of inpatient evaluation[52].

50 *Insight, Text Analysis of the Unified Clinical Protocol for Primary, Secondary (Specialized) and Tertiary (Highly Specialized) Medical Care [Gender Dysphoria].* ***http://insight-ukraine.org/analiz-tekstu-unifikovanogo-klinichnogo-protokolu-pervinno%D1%97-vtorinno%D1%97-specializovano%D1%97-ta-tretinno%D1%97-visokospecializovano%D1%97-medichno%D1%97-dopomogi-ukpmd-genderna-disforiy/***

51 *Order of the Ministry of Health of Ukraine No. 972 of September 15, 2016. The Unified Clinical Protocol for Primary, Secondary (Specialized) and Tertiary (Highly Specialized) Medical Care [Gender Dysphoria]. Available at this link:* ***https://www.dec.gov.ua/wp-content/uploads/2019/11/2016_972_ykpmd_gendysfor.pdf***

52 *Report Based on Operations Research Findings: Assessment of Preventive Interventions for Trans*People in Ukraine and Identification of Ways for Their Improvement / Neduzhko O., Kovtun O., Semchuk N., Saliuk T. – K.: ICF "Alliance for Public Health," 2021. – 54 p. Available at this link:* ***https://hivdata.org.ua/wp-content/uploads/2021/02/Report-Transgender-people_web_ukr.pdf***

In general, the procedure is still rather non-transparent, which considerably complicates the document replacement process and creates conducive conditions for abusive and corrupt practices by healthcare experts and governmental bodies[53]. Undergoing evaluation to obtain a certificate for diagnosis associated with gender dysphoria (F64) is the only option for proceeding with further documentation changes. The legal gender recognition procedure, in and of itself, is inaccessible for many trans*people, who are left with official documents containing the gender marker that does not match their appearance[54].

Trans*people's rights in Ukraine are often violated, while they are the target of persistent stigma and discrimination. Trans*people often experience violence from their Inner circle and society at large, which act as significant barriers to seeking services.

53 *Insight, Text Analysis of the Unified Clinical Protocol for Primary, Secondary (Specialized) and Tertiary (Highly Specialized) Medical Care [Gender Dysphoria]. Available at this link* ***http://insight-ukraine.org/analiz-tekstu-unifikovanogo-klinichnogo-protokolu-pervinno%D1%97-vtorinno%D1%97-specializovano%D1%97-ta-tretinno%D1%97-visokospecializovano%D1%97-medichno%D1%97-dopomogi-ukpmd-genderna-disforiy/***

54 *Insight, Transgender People in Ukraine: Social Barriers and Discrimination, Kyiv, 2016. Available at this link:* ***http://insight-ukraine.org/wp-content/uploads/2016/03/broshura_transgender_ukr_OK_FULL.pdf.***

Ukraine has adopted and is implementing *the Law on the Principles of Preventing and Combating Discrimination in Ukraine*[55], which establishes the regulatory **framework for counteracting discrimination** with a view to ensuring equal opportunities for the realization of human and civil rights and freedoms. This law defines discrimination as a situation where a person and/or a group of persons are subject to any restrictions in respect of the recognition, exercise or enjoyment of their rights and freedoms in any form by reason of certain characteristics. However, **sexual orientation and gender identity are not explicitly mentioned in the list of such characteristics, although they fall within the definition**.

Article 161 of the Criminal Code of Ukraine **establishes criminal liability** for any deliberate acts aimed at:

- Inciting national, racial or religious enmity and hatred;
- Degrading the honor and dignity or insulting the feelings of people because of their religious beliefs;
- The direct or indirect restriction of rights or the establishment of direct or indirect privileges for any individuals on the grounds of their race, skin color, political, religious or other beliefs, sex, disability, ethnic and social origin or property status, place of residence, language or other characteristics.

55 *Law of Ukraine No. 5207-VI On the Principles of Preventing and Combating Discrimination in Ukraine (Revised as of May 30, 2014), № 5207-VI. Available at this link:* ***https://zakon.rada.gov.ua/laws/show/5207-17#Text***

The "other characteristics" referred to in the disposition of the article can also be understood to include sexual orientation and gender identity, however, such an interpretation is left to the discretion of the court, as it is not explicitly stipulated. In addition, the wording of the part of the article regarding inciting hatred and enmity is defined for a closed list of protected characteristics and does not allow for the possibility of any such interpretation. In theory, it might be applicable only to limiting rights or establishing privileges, i.e., manifestations of discrimination.

Violations of the **right to freedom from discrimination against LGBT persons** in Ukraine were highlighted by the *United Nations Committee on Economic, Social and Cultural Rights in 2020*. In particular, the Committee noted that despite the express prohibition of discrimination in the workplace on the grounds of gender identity and sexual orientation, the Labor Law and the Law on the Principles of Preventing and Combating Discrimination in Ukraine do not explicitly refer to gender identity and sexual orientation in their provisions.

The Committee pointed out that the law enforcement authorities rarely apply Article 161 of the Criminal Code in cases of discrimination on the grounds of sexual orientation and gender identity. In general, the legislative framework for protection against discrimination is fragmented and does not incorporate the concept of multiple discrimination or **provide effective legal remedies against various forms of discrimination**.

IN THIS REGARD, THE COMMITTEE RECOMMENDED THAT THE GOVERNMENT OF UKRAINE:

- Provide for the explicit prohibition of discrimination on the basis of sexual orientation or gender identity in the Law on the Principles of Preventing and Combating Discrimination in Ukraine;
- Provide the necessary training to law enforcement personnel, judiciary staff and other legal professionals to deal with cases of discrimination on the grounds of sexual orientation and gender identity, including those covered by Article 161 of the Criminal Code of Ukraine;
- Increase efforts to eradicate negative stereotypes and stigmatization of LGBT persons, including through awareness-raising campaigns for the public, medical personnel, social workers, law enforcement officials and other public officials;
- Adopt a comprehensive and coherent anti-discriminatory regulatory framework by accelerating pending legislative reforms to unify anti-discriminatory legislation and strengthen legal protections against discrimination, taking into account the Committee's General Comment No. 20 (2009) on non-discrimination in economic, social and cultural rights[56].

56 *The Committee on Economic, Social and Cultural Rights. Concluding Observations on the 7th Periodic Report of Ukraine (E/C.12/UKR/CO/7), April 2020. Paragraphs 10,11. Available at this link: http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuWxT7OYZyYjJGL8qwRLmzDL%2fvGZyEn3i0uiQ8QMBJeVxr4Jaon5%2fgI7IPnOTr2gopfheMGlLfM4YRKoIKk5Y%2btYbh7SNaX4onpDfOPO0K7nMi*

4.7. HEALTHCARE REGULATORY FRAMEWORK FOR PLACES OF INCARCERATION

The United Nations Standard Minimum Rules for the Treatment of Prisoners provide that *"sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers. The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures"*[57].

The basic legislative act that governs the procedure and conditions for the service of criminal sentences in prisons, legal status, medical care delivery, including treatment of HIV/AIDS, drug addiction and TB, as well as prevention of torture and inhuman or degrading treatment of convicts, is ***the Penal Enforcement Code***.[58] Thus, Article 8 of the Code **establishes the right of inmates to health care** to be ensured by a system of medical, sanitary, rehabilitation and preventive health care measures and a combination of free and fee-based healthcare services. Inmates **are guaranteed the right to freely choose and access a doctor for medical care**, including that available at their own expense. Inmates with mental and behavioral disorders associated with the use of alcohol, narcotic drugs, psychotropic substances or their analogues or any other intoxicating substances may undergo treatment for such disorders subject to their written consent.

However, the reports of Ukrainian human rights organizations on the results of their monitoring visits to correctional facilities within the framework of the National Preventive Mechanism (NPM) indicate that **prisons and detention facilities are understaffed with doctors** and that the standards of health care provision at said penitentiary institutions are at a critically low level. For example, the monitoring visits[59] reveal the following **problems with regard to the right of prisoners to treatment and medical care while in detention**.

- Insufficient supply or unavailability of medicines. Often inmates have to buy them at their own expense (or that of their relatives);
- Doctors do not monitor the state of health of their patients, nor do they make daily rounds or even pay a visit upon inmates' request;

57 *The United Nations Standard Minimum Rules for the Treatment of Prisoners adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders held at Geneva in 1955 and approved by the Economic and Social Council in its Resolutions 663 C (XXIV) of July 31, 1957 and 2076 (XII) of May 13, 1977. Available at this link:* http://www.memo.ru/prawo/pen/550830.htm

In addition, health standards to be observed in prisons and other places of detention. are established by Part III of the European Prison Rules (Recommendation No. R (2006)2 of the Committee of Ministers of the Member States of the Council of https://docs.cntd.ru/document/420361984

58 *The Penal Enforcement Code of Ukraine of July 11, 2003 (No. 1129-IV). Available at this link:* https://zakon.rada.gov.ua/laws/show/1129-15#Text

59 *Review of publications on NPM visits regarding violations of prisoners' rights. Available at this link:* http://pk.khpg.org/index.php?r=2.6

- If an inmate needs further examinations or treatments that cannot be arranged in a prison setting, they are either not conducted at all or are carried out after lengthy delays (3-4 months);
- HIV/AIDS treatment involving ART, as well as (and especially) TB treatment, are not adequately provided for;
- OST is essentially unavailable.

Although the provision of OST in pre-trial detention centers and penal colonies within the Ukrainian penitentiary system was formally regulated back in 2012,[60] this issue has not been adequately addressed. The established responsibilities of law enforcement authorities and penitentiary institutions with regard to ensuring access to OST by patients in detention and correctional facilities, including on-site medication delivery, are rarely met in real-life situations.

There are a number of reasons that prevent the introduction of OST in penitentiary institutions: legislative obstacles, organizational difficulties (licensing, drug storage, ensuring care continuity during prisoner transfers), lack of political will[61].

60 *Order No. 821/937/1549/5/156 of October 22, 2012 by the Ministry of Justice, the Ministry of Internal Affairs, the Ministry of Health, the State Service of Ukraine for Drug Control On Approval of the Procedure for Interaction Between Healthcare Institutions, Internal Affairs Bodies, Pre-Trial Detention and Correctional Facilities for Ensuring Continuous and Uninterrupted Substitution Therapy. Available at this link:* *https://zakon.rada.gov.ua/laws/show/z1868-12#Text*

61 *Human Rights Behind Bars: A Practical Guide / Fedoruk A.A., Yakovets I.S. – K.: The Association of Ukrainian Human Rights Monitors on Law Enforcement (Association UMDPL), 2018 – 256 p. – p. 89*

As mentioned above, in January of 2021, the Ministry of Health of Ukraine adopted amendments to its Order No. 200 of March 27, 2012 to enable the direct implementation of substitution therapy in the healthcare facilities of the State Penal Service, i.e., prison hospitals, medical units that serve pre-trial detention centers.

Following its visits to places of detention in Ukraine, *the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)*[62] offered a number of recommendations regarding the delivery of OST. In doing so, the CPT stressed that:

- ➡ Treatment for drug-dependent prisoners should be diversified, combining detoxification, psychological support, social and educational programs, as well as rehabilitation and OST programs.
- ➡ Prisoners should have access to OST to the same extent as those who are outside prison settings. This is in line with the general principle of equivalence of health care in prisons with that in the outside community.

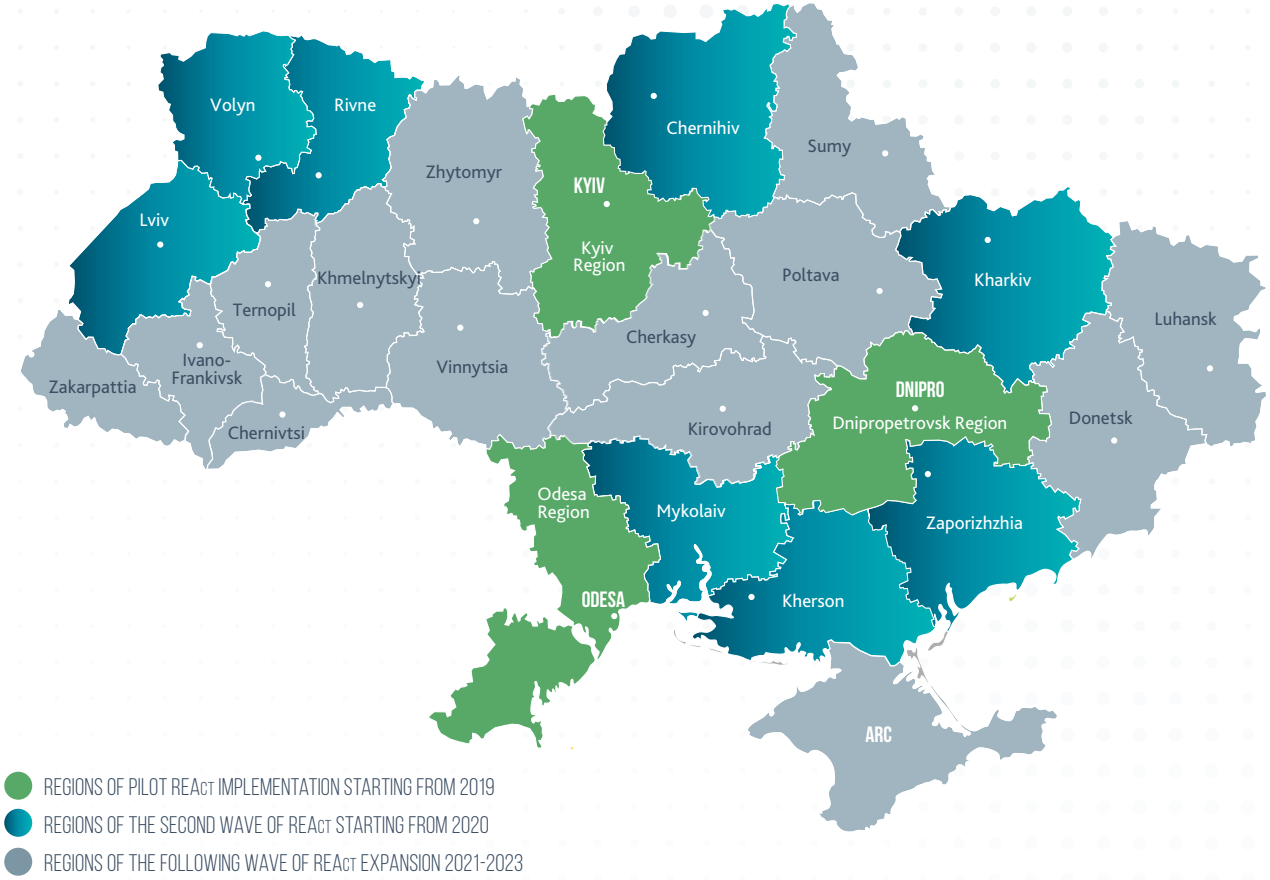
62 *https://www.coe.int/en/web/cpt/about-the-cpt?p_p_id=56_INSTANCE_2sd8GRtnPW2B&p_p_lifecycle=0&p_p_state=normal&p_p_mode=view&p_p_col_id=column-4&p_p_col_count=1&_56_INSTANCE_2sd8GRtnPW2B_languageId=ru_RU*

5 OVERVIEW OF REACT PROJECT IMPLEMENTATION IN UKRAINE

In order to identify violations of the rights of key populations in the context of access to HIV/AIDS and TB treatment, the REAct project was launched in Ukraine in the fall of 2019 with the financial support of the Global Fund.[63]

The regions where the system was piloted were Kyiv, Odesa, Dnipro and Kryvyi Rih. In the fall of 2020, the system was also introduced in eight more regions, i.e., Lviv, Rivne, Lutsk, Chernihiv, Zaporizhzhia, Kharkiv, Kherson and Mykolaiv. As of **October 2020, REAct was in place across twelve regions of Ukraine**. In addition, phone calls to the National Drug Addiction and OST Hotline were also recorded across all regions of Ukraine.

The target key populations are those vulnerable to HIV/TB and supported by the project, i.e., people who inject drugs (PWID), OST clients, people living with HIV (PLHIV), men who have sex with men (MSM), trans*people, sex workers (SW), people living with TB, prisoners (and ex-prisoners), homeless people, adolescents most at risk for HIV/TB, and Roma.



63 *Up-to-date information regarding the implementation of the REAct project in Ukraine is available on the REAct project's website at https://react-aph.org/en/home/*

5.1. ORGANIZATIONS THAT ARE PART OF THE REAct SYSTEM IN UKRAINE*:

DNIPROPETROVSK REGION

NGO ALLIANCE.GLOBAL, Dnipro

NGO Synergiia Dush (Synergy of Souls)

CO CF VOLNA

Novomoskovsk District NGO Family Support Center

CO 100%Life Dnipro

CO Positive Women

CF Impuls Kamyanske

NGO Road of Life Dnipro

Zhovti Vody City Charitable Fund Promin

NGO Protego

NGO Gay Alliance Ukraine

CO CF Public Health, Kryvyi Rih

NGO ALLIANCE.GLOBAL, Kryvyi Rih

CO 100% Life Kryvyi Rih

CO Legalife-Ukraine

ZAPORIZHZHIA REGION

CO CF Spodivannia

CO CF Vse Mozhlyvo

Comprehensive Crisis Services Center for Gender-Based Violence Victims Fialka

CO 100% Life Zaporizhzhia

KYIV REGION

NGO ALLIANCE.GLOBAL

ICF Roma Women Fund Chiricli

CF Hope and Trust

All-Ukrainian Association of Drug-Dependent Women VONA

NGO Club Eney

AUCF Drop-In Center

NGO TRANS GENERATION

ALCO CONVICTUS Ukraine

NGO VILNA

CO CF VOLNA

NGO INSIGHT

VOLYN REGION

Rivne Regional Charitable Fund Our Future

CF Chance

All-Ukrainian Association of Drug-Dependent Women VONA

LVIV REGION

CO 100% Life Lviv

CO Free Zone in the Lviv oblast

NGO Center Doroga

CO CF VOLNA

CF SALUS

MYKOLAIV REGION

CF Vykhid

MCF Unitus

NGO Chas Zhyttia

NGO Penitentiary Initiative

NGO The Chysti Sertsya Movement

Ombudsman's Office in Mykolaiv

ODESA REGION

CO 100%Life Odesa

NGO Together for Life

CO CF VOLNA

NGO Sunny Circle

NGO Youth Development Center

NGO The Public Movement Faith, Hope, Love

NGO LGBT Association LIGA in Odesa

NGO Youth Public Movement Partner

CF Way Home

RIVNE REGION

Rivne Regional Charitable Fund Our Future

NGO Social Support Center Prometheus

KHARKIV REGION

NGO Spectrum Kharkiv

NGO ALLIANCE.GLOBAL

All-Ukrainian Association of Drug-Dependent Women VONA

CO Positive Women

CO Parus

Kharkiv City CF BLAGO

KHERSON REGION

CO 100% Life Kherson

NGO Ukraine Without Tortures

Kherson Regional Charitable Fund Mangust

Information and Help Center for Homeless Persons (based at KhRCF Mangust)

CHERNIHIV REGION

NGO MART

CO 100% Life Chernihiv

NGO Resocialization Center for Chemically Dependent People VEDIS

NGO Chernihiv Center for Social Adaptation of Homeless and Street people

** List of organizations in 12 regions of Ukraine. This report covers the results of the REAct project implementation in 4 pilot regions.*

5.2. REActor's PROFILE

Violations of the rights of key communities vulnerable to HIV/TB in the four regions are being documented by **twenty-eight community-based organizations (NGOs)**. The project documentation clerks (REActors) are NGO staff who have direct contact with vulnerable communities, i.e., social workers, project coordinators and specialists, prevention project documentation clerks, legal experts and others *(Figure 4)*.

Each REActor is responsible for a different focus area and engages with specific risk groups. Some risk groups are therefore less representative of appropriate REAct project data. REActors primarily interact with PLHIV, PWID and OST program clients *(Figure 5)*.

FIGURE 4 PROFILE OF THE REActor

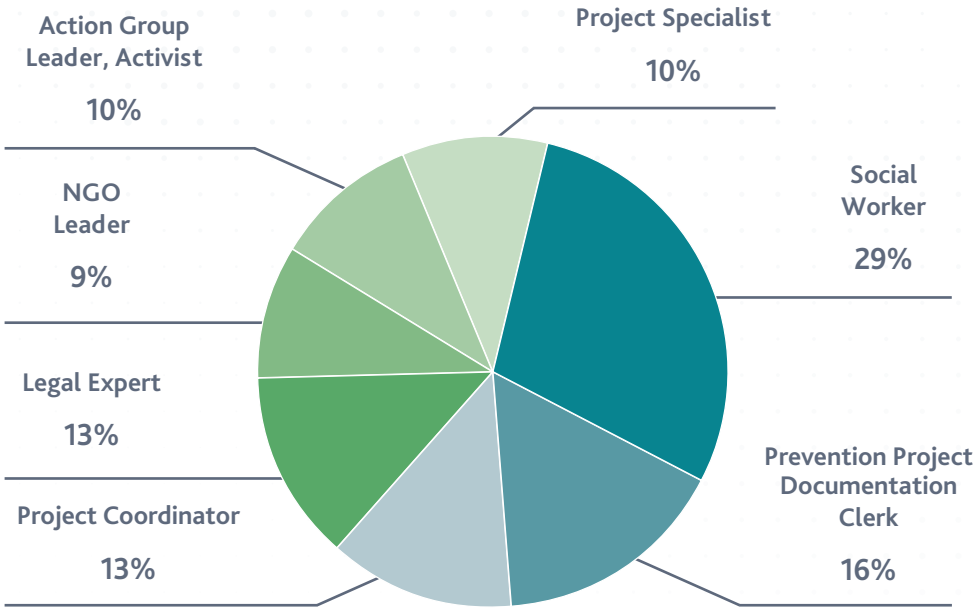
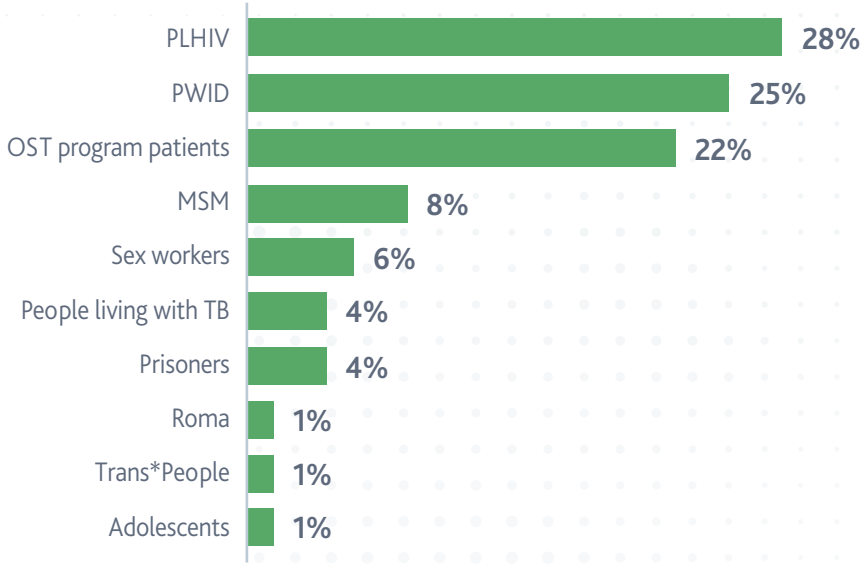
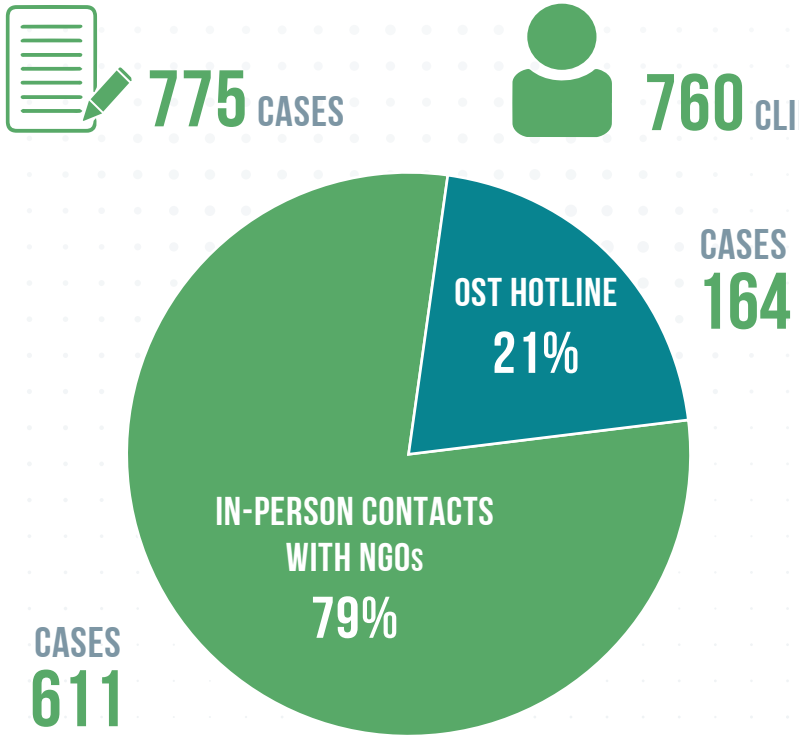


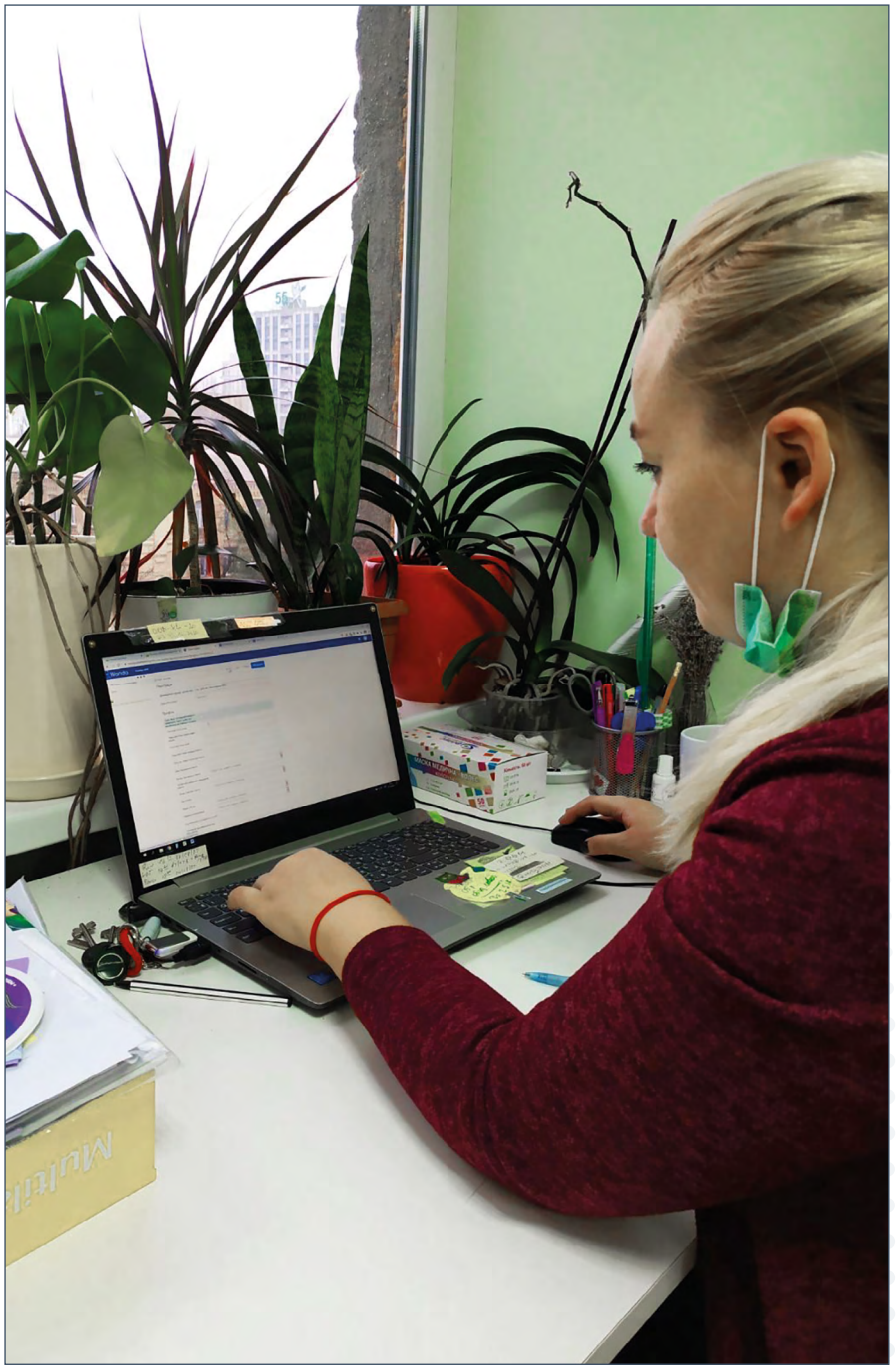
FIGURE 5 FOCUS WORK AREAS FOR REActors BY RISK GROUP



During the implementation period of the REAct project in Ukraine from November 2019 to October 2020, **there were 775 recorded incidents of rights violations against key populations vulnerable to HIV/TB**. These **incidents were reported by 760 people**, hence, some of the clients had sought help more than once. It is noteworthy that 21% of the recorded cases came in through phone calls to the National OST Hotline *(Figure 6)*. In a vast majority of these cases, representatives of state bodies failed to meet their responsibilities associated with ensuring the right to health and other human rights to this or that extent. As part of each individual case, the project documentation clerks responded with the client's interests in mind, seeking to protect and restore their rights.

FIGURE 6 CHANNELS OF CASE REPORTING TO REACT





5.3. IMPACT OF COVID-19 ON THE IMPLEMENTATION OF THE REACT PROJECT

The implementation of REAct in Ukraine in 2020 brought forth the need for adapting to certain restrictions related to the COVID-19 pandemic. During Ukraine's March-April 2020 nation-wide lockdown period, quarantine policies were particularly stringent throughout the country. During this time frame, public transportation was suspended, the opening hours of public and governmental agencies changed, and the actual availability of some client services reduced.

Specifically, these restrictions had an impact on the way REActors interacted with clients. Thus, when collecting information about cases or responding to the client's situation they often switched to remote work format via various forms of communication (phone, social messaging, e-applications to organizations).

These constraints had an impact on the format and speed of assistance to clients. Issues that required government agencies' involvement (e.g., preparing the paperwork, dealing with social welfare services) could take longer to resolve than before, as these agencies operated only at a limited capacity. Referring clients to other NGOs was also complicated by scheduling issues and specialists' limited availability.

It is worth noting, however, that all these limitations notwithstanding, REAct continued to operate successfully. Due to the new realities, some positive lessons have been learned:

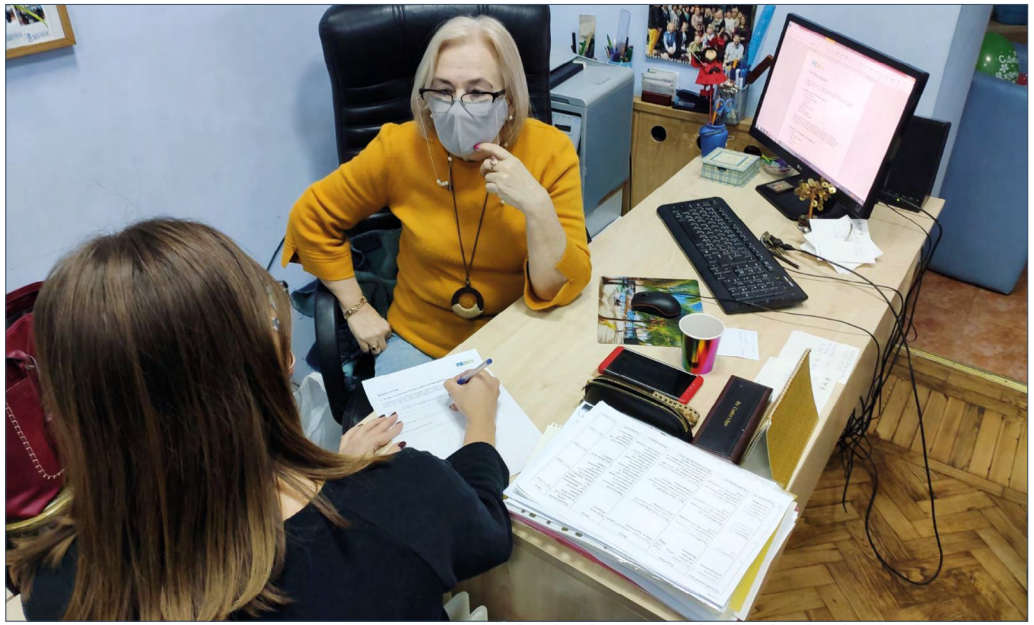
- The availability of services to clients depends on the extent to which community-based organizations are able to pool their efforts and resources;
- The effective response and assistance can be provided to clients remotely;
- Effective mechanisms for communication were identified between REActors and regional coordinators, while their interaction was only strengthened.

"Remote working under epidemic and quarantine restrictions has demonstrated that client support services can be provided online and over the phone."

L. Vlasenko,
REAct Regional Project Coordinator in Dnipro

"It was a lesson in managing project activities when the parties can interact only in a limited way and maintaining effective communication."

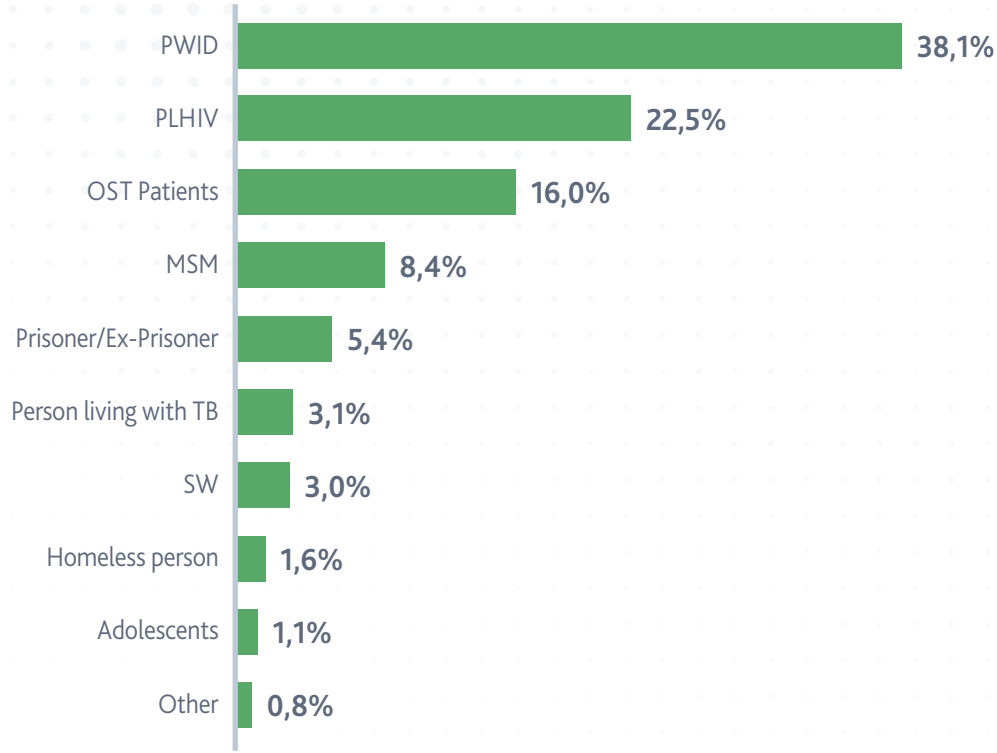
A. Tolopilo,
REAct Regional Project Coordinator in Odesa



5.4. OVERALL PROFILE OF CLIENTS SEEKING HELP VIA REACT

The majority of REAct clients were PWID, PLHIV, OST program clients, and men who have sex with men. The distribution of clients by risk group is presented in *Figure 7*.[64]

FIGURE 7 DISTRIBUTION OF REACT CLIENTS BY RISK GROUP



64 *One client may belong to multiple risk groups.*

It is worth noting that the lower representation of some risk groups in the overall structure of client case processing is no indication that these groups are less exposed to violations of their rights. The distribution of clients according to risk groups is primarily determined by the communities with which NGOs and REActors involved in the REAct system are interacting, as well as the number of such NGOs and REActors, respectively.

There is strong and ample evidence that some at-risk groups, e.g., sex workers (SWs), are also exposed to rights violations to a large extent, but the ability to capture such cases remains limited. Reasons for this include the difficulty of reaching out to this group and earning their trust, the frequent lack of willingness of sex workers' clients to report their situation, and the lack of belief in the possibility of making any difference by sharing their experiences of rights violations.

In terms of gender, the majority of clients are male, i.e., 57.9%; while in terms of age category, the majority of clients belong to the 35-44 age group *(Figure 8)*.

FIGURE 8 DISTRIBUTION OF REACT CLIENTS BY GENDER AND AGE

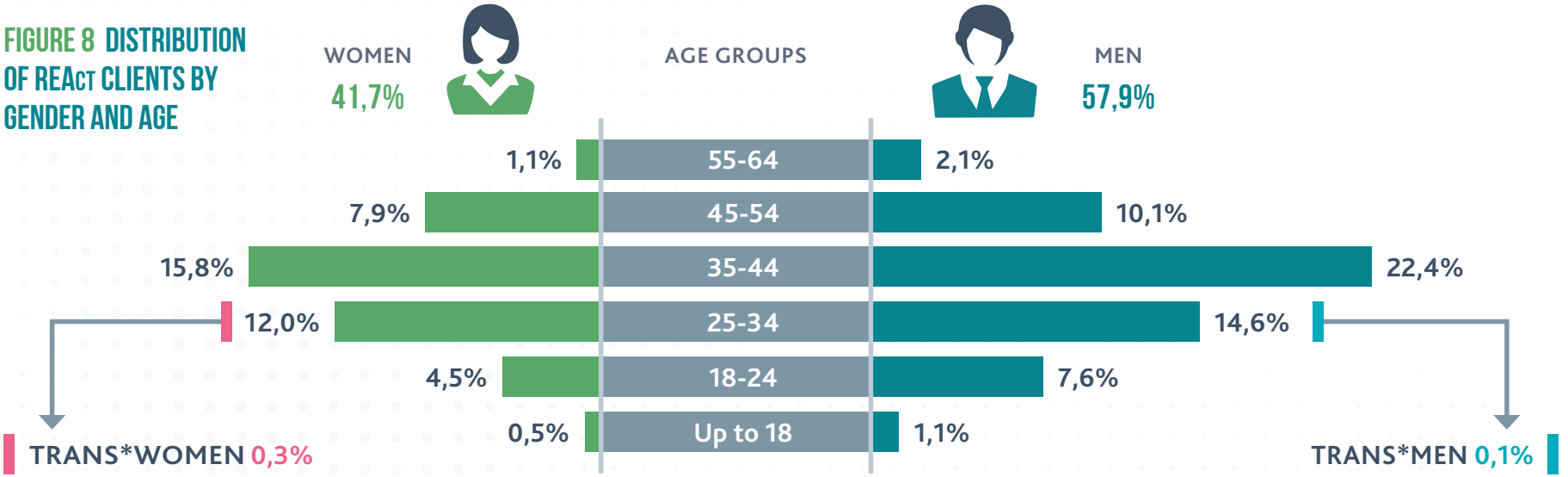
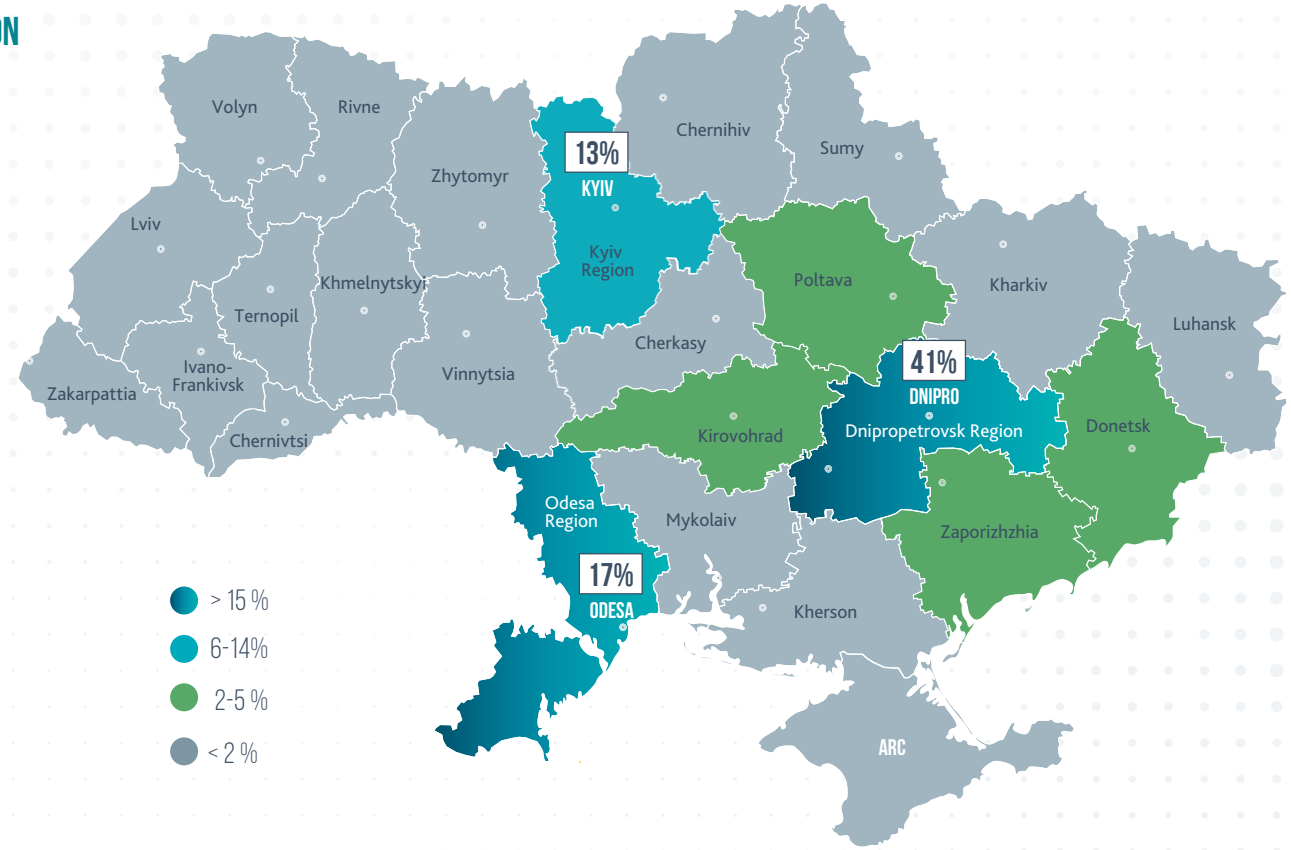


FIGURE 9 DISTRIBUTION OF REACT CLIENTS BY REGIONS



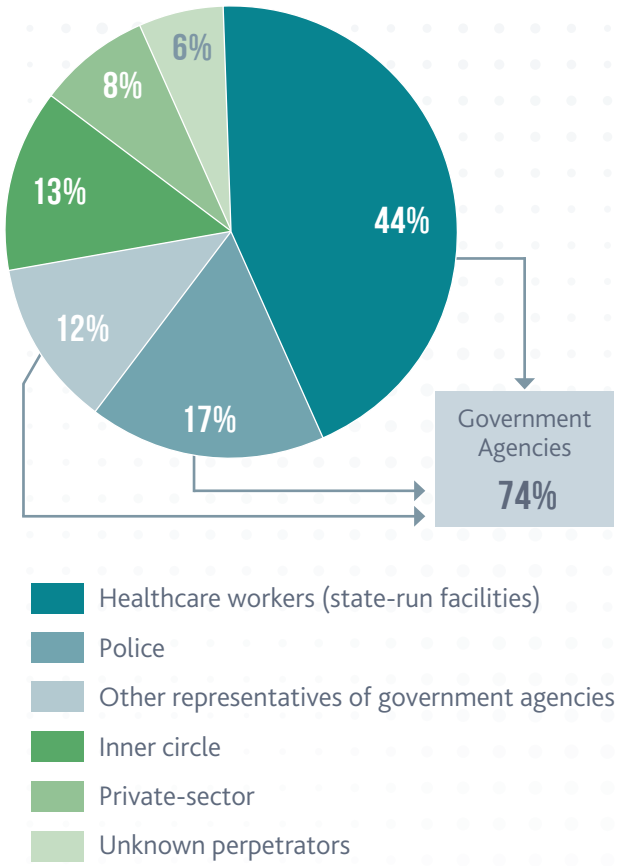
6 THE MAIN TYPES OF VIOLATIONS AND PERPETRATORS INFRINGING THE RIGHTS OF KEY POPULATIONS

6.1. KEY TYPES OF PERPETRAITORS AND VIOLATIONS

The most frequent perpetrators of rights violations against key populations (i.e., those responsible for causing the situation leading to rights violation incidents) were representatives of government agencies – 74%, the majority among them being healthcare workers (44%), as well as, to a large extent, police officers (17%). Other representatives of government agencies, e.g., staff of correctional and custodial facilities, human services and social service providers, and educators accounted for twelve percent (12%).

Clients' close contacts (family members, partners, neighbors, work colleagues, etc.) acted as perpetrators of rights violations in 13% of the recorded cases. Private-sector representatives (employers, private doctors and educators) were reported as rights violators in 8 percent of the cases. It is also worth pointing out that in a number of cases, unknown perpetrators were also reported, i.e., 6% (radical groups, passers-by, others)[65] *(Figure 10)*.

FIGURE 10 TYPES OF PERPETRATORS TOWARDS KEY RISK GROUP

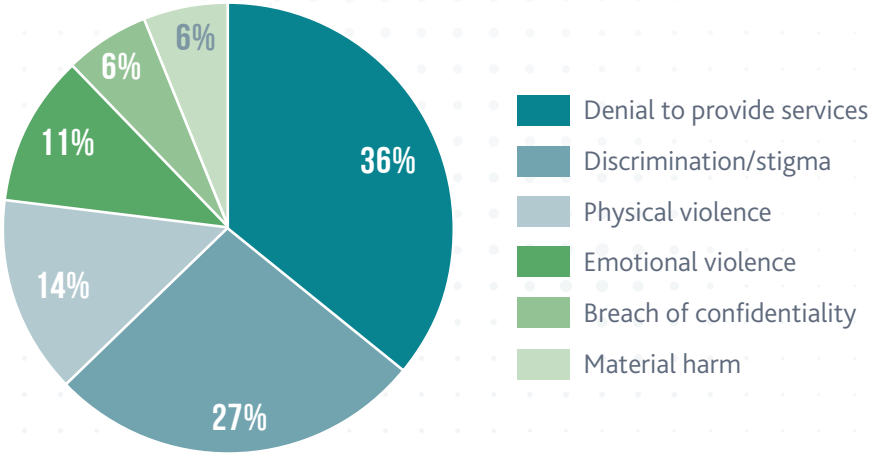


65 *Multiple types of perpetrators are possible within a single case.*

FOR PWID, OST PATIENTS AND SW, THE MOST FREQUENT PERPETRATORS WERE HEALTHCARE WORKERS AND POLICE, FOR PLHIV – HEALTHCARE WORKERS, WHILE AMONG MSM INNER CIRCLE OR UNKNOWN PEOPLE.

Key types of rights violations include denial of access to services – 36% (more commonly public health services), discrimination/stigma due to a person's most-at-risk / KP status – 27%, physical violence – 15% and emotional abuse – 11%[66] *(Figure 11)*.

FIGURE 11 TYPES OF RIGHTS VIOLATIONS TOWARDS KEY RISK GROUP



66 *Multiple types of rights violation incidents are possible within a single client-reported case.*

NOTABLY, PWID, OST PATIENTS AND PLHIV WERE MORE LIKELY TO EXPERIENCE DENIAL OF ACCESS TO SERVICES/ASSISTANCE AND DISCRIMINATION, DISCRIMINATION/STIGMA PREVAILED AMONG SW, WHEREAS DENIAL OF ACCESS TO SERVICES/ASSISTANCE AND PHYSICAL VIOLENCE OCCURRED WITH EQUAL FREQUENCY. AMONG MSM, DISCRIMINATION/ STIGMATIZATION AND EMOTIONAL ABUSE WERE LIKELY TO BE REPORTED AS MORE FREQUENT OCCURRENCES.

6.2. THE ROLE OF THE STATE IN RIGHTS VIOLATIONS IDENTIFIED

The human right to health is recognized in a number of international instruments, as partially highlighted in the previous sections. Everyone has the right to access HIV and TB prevention and treatment services, as well as treatment for concurrent conditions. It is the responsibility of the state to create an enabling environment in which human rights are respected. Furthermore, if the state fails to properly fulfill its responsibilities, **the role of the state, in cases of violations of the rights of key communities, may be as follows**:

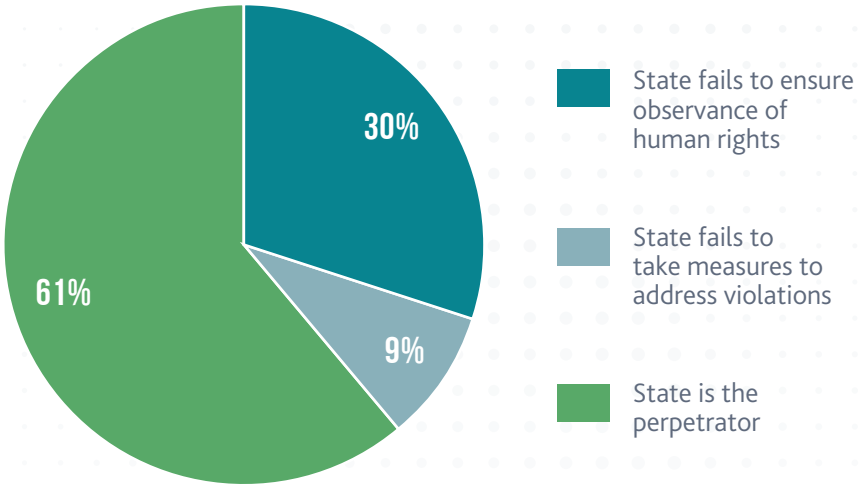
1. ***The state is the perpetrator*** *(disregard for human rights)*. The state representative initiated the situation that led to the violation of human rights.

2. ***The state has failed to act on the case*** *(failure to provide protection)*. The state or local authorities failed to take the necessary measures to protect human rights or prevent human rights violations.

3. ***The state has failed to enforce human rights standards*** *(obstruction/non-compliance)*. State policies and/or national legislation do not protect people who find themselves in situations of human rights violations[67].

As part of the REAct project, **the state violated the rights of most-at-risk groups** in a majority of the recorded cases (61%) and **failed to respect human rights standards** (30%) (the state may have failed to respect several fundamental principles within a single client case) *(Figure 12)*.

FIGURE 12 THE ROLE OF THE STATE IN HUMAN RIGHTS VIOLATIONS AGAINST MOST-AT-RISK GROUPS



67 *Frontline AIDS: REAct User Guide. Available at this link: https://frontlineaids.org/wp-content/uploads/2019/11/REAct-Guide_FINAL.pdf*

7 THE RIGHTS VIOLATIONS MOST COMMONLY COMMITTED AGAINST KEY POPULATIONS

7.1. PEOPLE LIVING WITH HIV

Among PLHIV there were 290 reported cases of rights violations. The most frequent violations included denial of access to services/assistance – 41%, as well as discrimination/stigmatization because of HIV status – 28%. The perpetrators were most likely to be healthcare workers from public-sector medical institutions – 53% *(Figures 13, 14)*.

FIGURE 13 TYPES OF RIGHTS VIOLATIONS AGAINST PLHIV

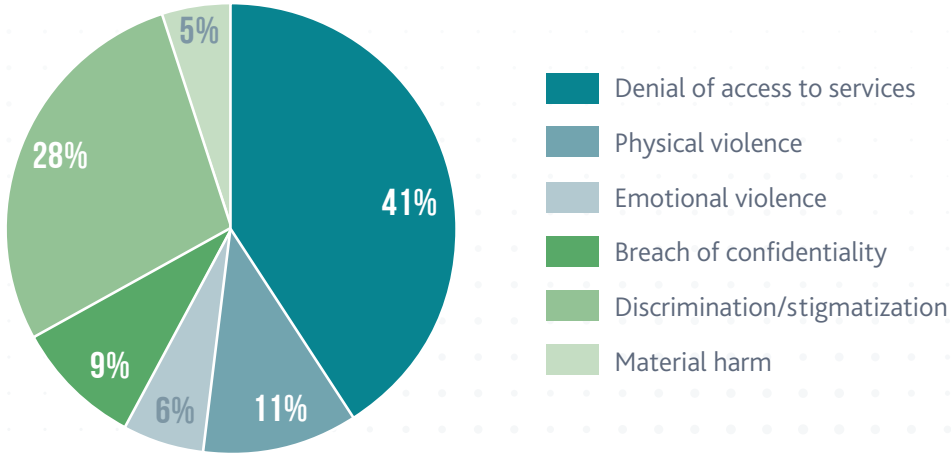
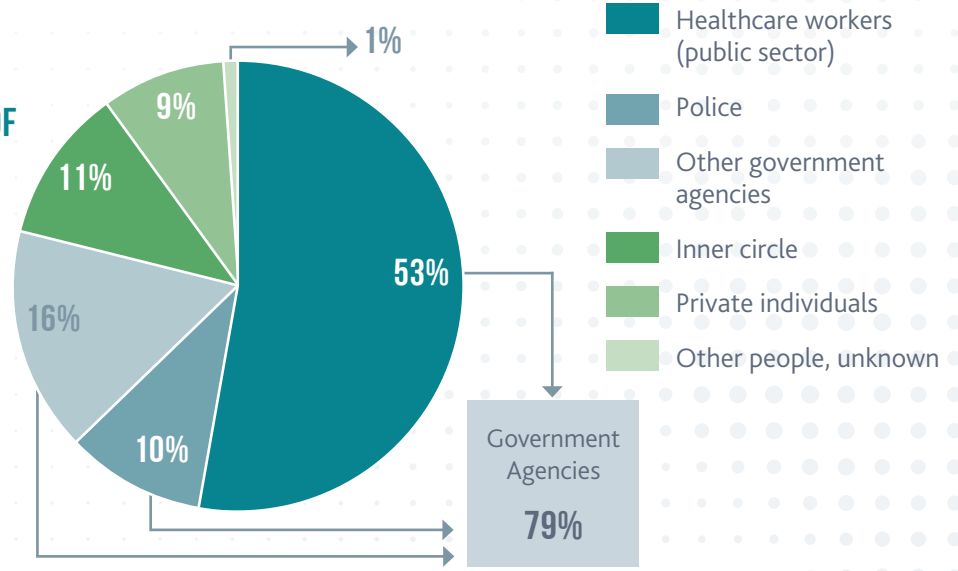
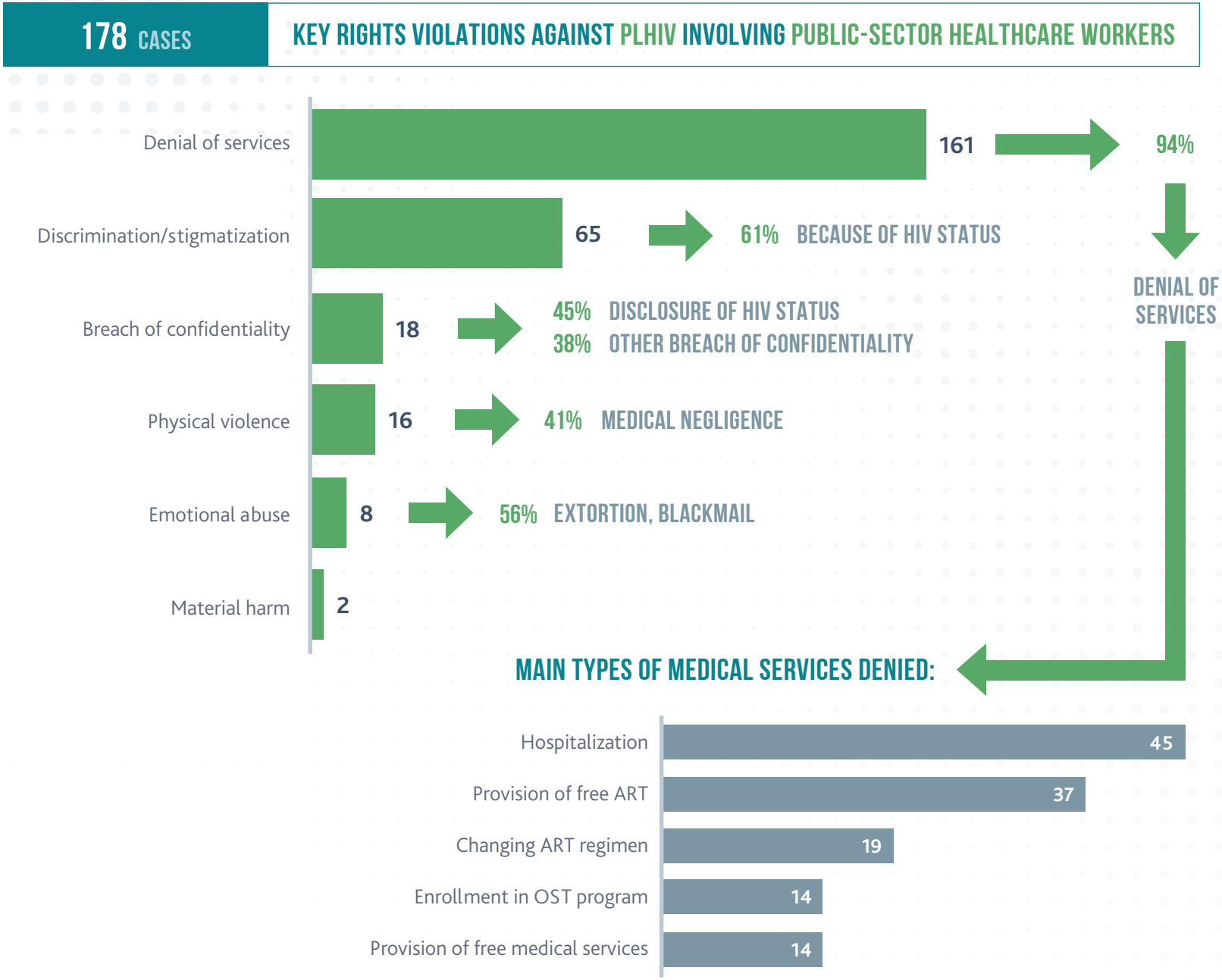


FIGURE 14 TYPES OF PERPETRATORS OF RIGHTS VIOLATIONS AGAINST PLHIV



1 2 3 4 5 6 7 8 9 10 11

FIGURE 15 KEY RIGHTS VIOLATIONS AGAINST PLHIV INVOLVING PUBLIC-SECTOR HEALTHCARE WORKER



DENIAL OF SERVICES

The most common type of rights violations against PLHIV was **denial of access to services/assistance**, i.e., 225 recorded cases. Here, 178 rights violations were concerned with **denial of access to healthcare services/care** *(Table 3)*.

TABLE 3 TYPES OF RIGHTS VIOLATIONS AGAINST PLHIV: DENIAL OF ACCESS TO SERVICES

TYPE OF RIGHTS VIOLATIONS AGAINST PLHIV: DENIAL OF ACCESS TO SERVICES	TOTAL REPORTED CASES[68]
Denial of access to healthcare services/care	178
Denial of protection / investigation by the police	21
Denial of shelter	8
Employment termination	8
Refusal to issue identity documents	7
Denial of employment	5
Denial of access to personal services (beauty care, hair and massage salons, swimming pools)	5
Denial of access to educational services	5
Denial of parental rights	5
Denial of legal services (public legal counsel)	4
Delays with court proceedings	2
Denial of social services	2

68 *Multiple types of rights violations (incidents) are possible within a single client-reported case..*

Access to Emergency and Inpatient Care as Well as Hospitalization

In 45 reported cases, **PLHIV were denied access to inpatient treatment, emergency medical care, or hospitalization care**. The refusals were based on clients' disclosure of their HIV status, which is also indicative of explicit discrimination and stigma on the part of health care workers:

- *The client came to see the surgeon located in his area of residence and informed him of his HIV status during a medical consultation. The surgeon immediately refused to perform the surgical procedure or refer the patient to the regional hospital.*

- *The patient contacted the Emergency Medical Assistance Service complaining about pain in the lower abdomen and groin area. The ambulance doctor diagnosed a case of acute appendicitis and had the patient transported to the hospital. The admitting surgeon confirmed the diagnosis upon examination, but refused to hospitalize the patient because of his HIV-positive status.*

Cases were reported where a client had died due to the refusal of hospitalization and failure to provide emergency medical services, even after the intervention of a REActor or other community-based organizations:

- *An HIV-positive woman, who worked as a social worker for a community-based organization serving key communities, noticed a sharp deterioration in her condition and reported complaints such as feeling unwell, abdominal pain, leg swelling and dizziness. That evening, she was brought to the hospital after a prior arrangement with the chief physician of the city hospital. Despite the arrangements made earlier, the medical staff on duty, after finding out that the woman was*

HIV-positive, refused to admit her to the hospital, even though her condition was getting worse. It took three hours for her to be admitted to the hospital. She was offered no painkillers in the meantime. Instead of the gastroenterology department, she was temporarily admitted to the internal medicine unit. In the morning, the head of the department made a loud scene screaming that this case was outside the scope of her unit and discharged this woman. It took almost half a day until her transfer to the gastroenterology department was arranged, and this whole time the woman was waiting in the hospital corridor while in critical condition and without getting any treatment. A few days later, following a visit to the hospital by the head of the community-based organization and a case conference with the physicians, she was transferred to a separate room on the gastroenterology ward, with the organization's staff around her. The same evening, due to her critical condition, she was moved to the intensive care unit but unfortunately, she died that night.

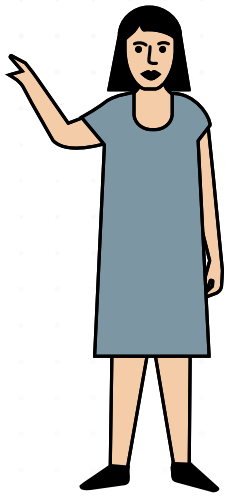
- *A man who was HIV-positive also had TB. He was registered with the TB center and receiving treatment. The man was living alone in his apartment. But his condition became much worse and he no longer was able to remember when and how often he was supposed to take his ART and TB drugs. He sought help from his sister and, through his friends, from a social worker (REActor). Together with the man and his sister, the social worker tried to call an ambulance for him, but they refused to respond to a call at his address after hearing that the patient had HIV and TB. The documentation clerk asked for help from the working group of the city's HIV Coordination Council. They were advised to call for an ambulance reporting him as a stroke patient. But upon arrival, the ambulance crew refused to take the man to the hospital. They also refused to provide any identifying information, such as their ambulance crew number. The client was offered no treatment and he ended up dying two days later at home.*

In addition to being denied medical care by public-sector doctors, PLHIV also experienced similar refusals in private clinics:

- *A client is HIV-positive and receiving OST. He contacted a private clinic to have surgery on his eye, as the condition required urgent surgical intervention. The staff, when informed of the client's HIV status, refused to provide medical care giving a number of reasons (one of them, according to the client, being that this surgery for an HIV-positive person would necessitate high-cost procedures and materials). The client was in a depressed state of mind after this kind of treatment from the private clinic..*

Access to Antiretroviral Therapy (ART)

In 37 reported cases, PLHIV were **denied access to ART** and in the majority of cases the refusal was based on the client's lack of the necessary documents for medical registration.There were documented cases where access to ART was not provided in due course, e.g., a client was dispensed medicines past their expiration date:



- *After undergoing the necessary examinations and tests, a patient with HIV came to see the infectious disease physician to pick up his next dose of antiretroviral therapy. However, the healthcare provider gave him medication with an expired shelf life, explaining that it is still useable for another year as the supply chain has been broken and the available supply of drugs for next year would not be enough to go around for everyone.*

There have also been cases where doctors additionally and inappropriately demanded that clients should meet their **illegitimate demands as a condition for further access to ART**:

- *The patient is registered with the Center for Prevention and Control of AIDS. When he came back a month later to see the doctor, the infectious disease specialist reminded him that he had not brought around any of his partners for an HIV test during the previous month and provided none of their contact information, although, according to this infectious disease specialist, the client promised he would do so. The doctor gave him a week to resolve this situation and warned that he would have difficulty accessing ART if he does not bring to the center at least one of his partners.*

- *The infectious disease physician working at the AIDS Center forces a woman client into seeing her family pediatric physician and disclosing her HIV status. The doctor says she will not be prescribing ART drugs for this woman without a note from her family pediatric physician.*

In 19 reported cases, clients' **request for making changes to their ART regimens** (due to feeling poorly) **was declined**, or the treatment regimen was forcibly changed by the doctor without having the client undergo the necessary evaluation and tests. This change in treatment regimens was most commonly explained by the doctors by a lack of drug supplies in the healthcare facility. However, clients' concerns about the possibility or actual occurrence of side effects due to the change in treatment were ignored by health care workers:

- *The client's ART regimen is being modified on an ongoing basis while this has a negative impact on how he is feeling and his overall health, but the doctor will not explain the reasons for these ongoing adjustments to the treatment regimen and ignores the client's complaints about the negative effects this has on the way he feels.*

- *One client visited the AIDS center to receive ART, but noticed that the drugs were different from the ones he had received before. During the appointment, the doctor said, "Don't worry! You will get your new tablets today. They have the same effect and are just combined into one tablet." The doctor went on to tell him that the electronic prescription form can be filled out only once a day and assured him that this regimen was good and there should be no problems. The doctor also pointed out that he was unable to dispense the previous regimen as the drug was no longer available due to supply issues. The client refuses to take the new medication to avoid any possible adverse events.*

In addition to medical staff, in some cases, access to ART was limited due to people in clients' immediate environment who showed stigmatizing attitudes, thus hindering access to treatment. This situation was typically reported when clients were living together with their families and those were aware of their HIV-status:

- *Recently, this client tested positive for HIV, got registered with appropriate services and accessed a month-long course of medication. He had been taking them for a week when his mother, while checking through his things, found the jars with the pills. She asked him what they were, and the boy had to tell her about his HIV status. His mother turned on him, took away the pills, and started insulting her son about his HIV-positive status. She said, "You've brought this disease into our home, now you're grounded and don't you dare step out of my sight! You go directly to your technical school and right back home afterward, I'll be dropping you off and picking you up. You'll be supervised even when you go out to the stores! I'm taking away your tablets as they do nothing but harm anyway, turning you into a vegetable." From that point on, the mother was constantly emotionally abusing the boy and gave him a separate set of kitchen utensils (a plate, a mug, and cutlery). The boy says she is even afraid to touch him. He tried to explain that it was safe to be around him as you can't catch the disease from him, and that without regular access to medication his health was bound to deteriorate, but his mother wouldn't even listen.*

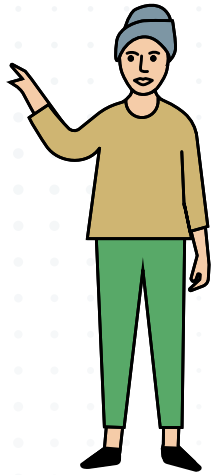
Denial of Access to Free Medical Services

In 14 reported cases, PLHIV were denied access to **free medical services/assistance** by health care workers. The services for which a fee was charged included ART, viral load and CD4 testing:

- *An HIV-positive woman contacted the AIDS Center with a full set of documents to be linked to free treatment. The AIDS Center informed her that there were currently no free courses available, but she could be treated for a fee.*
- *A nurse asked a PLHIV client to donate a contribution of 30 hryvnias towards the renovation of the office. The tests for HIV, viral load and CD4 cell counts are also charged on a fee basis.*

In a number of cases, PLHIV women who came to see the gynecologist or sought maternity clinic services were also asked to make charitable donations, or to buy medicines and other consumables specified in a certain list:

- *A woman client showed up with a problem complaining that the women's health center where she is a registered client for her pregnancy gave her a list of medical drugs and supplies she needs to purchase as a condition for checking into their birthing center for delivery. They explained that buying the items on the list at the client's expense was a mandatory requirement.*



- *The PLHIV woman patient presented to the hospital admissions department with high fever where she was given a list of medications to purchase, a referral to the gynecologist, and the notice informing her that she had to make a charitable contribution to the hospital. For the first two days, no diagnostic or treatment services were provided (until the contribution was made and the medications paid for).*

Stigma and Discrimination

There were 115 documented cases where PLHIV experienced discrimination and stigmatizing attitudes due to their HIV status. The manifestations of stigma and discrimination **by health care providers** against PLHIV were observed while the clients were seeking medical services, in that doctors made stigmatizing comments about the client, provided poor-quality care, or artificially inflated the cost of medical services:

- *The client is an injecting drug user, a person living with HIV. He used to take ARV therapy, but then stopped taking the medication because he was feeling well and had no health complaints. However, his health condition has recently deteriorated. During an appointment with the infectious disease physician, he shared his complaints, to which the doctor responded by starting to insult the client, ending up saying that people like him should die, rather than waste time and public funds.*

- *The client wanted to call an ambulance, but when they heard he had HIV, they told him to seek help from "his" hospital where HIV patients are treated.*

- *The man underwent surgery. Once his course of treatment was completed, he was given a discharge summary stating that he had tested positive for HIV based on rapid test results. The man revealed that he had long been under medical supervision at the AIDS Center, was taking ART and had an undetectable viral load. His request to have the diagnosis of HIV infection removed from his discharge summary was declined. Additionally, when they found out that the man had HIV, the fee for his surgical procedure was increased without giving any reasons from UAH 16,000 to UAH 19,000.*

Discrimination by **private health care providers** was also recorded in situations where PLHIV were seeking dental services or were denied access to personal services (beauty care salons, swimming pools, etc.):

- *The woman client who was trying to book an appointment with a dental clinic decided to check with the receptionist whether her HIV-positive status would be a barrier to getting dental care, and was immediately turned away. When the client asked what the reason for the refusal of service was, she was told, "Let's not discuss this, we reserve the right to refuse service.*

There is widespread stigma and discrimination against PLHIV **by employers** (both in public and private sector settings) when they are pressured or forced into testing for HIV or disclosing their HIV status and providing an appropriate form of certificate. Whenever a PLHIV person is found to be HIV-positive, this circumstance is considered sufficient cause for dismissal or refusal of employment:

- *A woman client was denied employment at a confectionery factory because she was unable to provide a clean bill of health as proof of her negative HIV status.*

- *When applying for a job, the client was required to provide a certificate of HIV status. He wouldn't comply because he was aware of his right to not disclose it. The head of the appropriate department refused to hire him because of it.*

- *The woman client is HIV-positive. She was working at a company outside the metropolitan area. After the COVID-19-related quarantine policies becoming effective, her employer demanded she undertake a comprehensive health check-up, including testing for HIV markers. The client agreed to take the tests without worrying about losing her job, but when the test results came back, the employer announced that her contract would be terminated.*

Stigma and discrimination **by employees of educational institutions**, specifically pre-schools, were also reported. Educators showed openly negative attitudes towards children whose parents' HIV status was known to be positive:

- *A PLHIV woman was enrolled in the OST program. She took her child to daycare and during the quarantine period the child said that she was not going there again because the teacher started treating her badly – insulting the girl in front of the other kids, giving her unsweetened tea and so on. It turned out that the daycare teacher had found out about her mother's HIV status.*

People from the inner circle of PLHIV, i.e., family members, sexual partners, and neighbors are also reported to show stigmatizing and discriminatory attitudes towards PLHIV, threatening to disclose their HIV status to others, deprive them of their parental rights, or have them evicted from their homes:

- *The client is an PWID. Her relationship with her mother deteriorated once her HIV-positive status was disclosed. The mother has made repeated attempts to throw her daughter out onto the street. On several occasions, she had spent the night with friends or out on the street. The apartment from which her mother is trying to evict her is listed as the daughter's official place of residence. The mother also threatens to take her to court and deprive her of child custody (her parental rights).*

- *A drug-using woman from among PLHIV is seeking help about her sister's disclosure of her HIV-positive status and drug use, as well as recurring physical violence by her sister, discrimination by neighbors due to her known status as a drug addict and HIV-infected.*

This kind of stigma against PLHIV has a negative impact on their health status and also affects their adherence to antiretroviral therapy and access to and use of health and social services[69].

Breach of Confidentiality

There were 50 reported cases of breach of confidentiality involving PLHIV, most of which were concerned with **HIV status disclosure** (36 cases). HIV status disclosures were linked to public health care workers (13 cases), close associates of PLHIV (12 cases), police officers (6 cases), and public-sector social service providers (5 cases).

Most commonly, HIV status disclosures by health care workers occurred when clients' HIV status was recorded in their medical case history when the hospital discharge summary with their HIV status details was released. This, in turn, allowed clients' relatives, as well as other doctors or patients at the healthcare facility to gain access to this sensitive information:

69 *Rueda S, Mitra S, Chen S, et al. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. BMJ Open. 2016;6(7):e011453. Published 2016 Jul 13. doi:10.1136/bmjopen-2016-011453* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4947735/

- *The man was admitted to the City Hospital's Department of Internal Medicine. He was later discharged and obtained his Return-to-Work Release Form. His medical case history was not released to him as the doctor was still working to complete it. On the same day in the afternoon, his father came to the hospital to pick up the client's personal belongings as he reported to the hospital staff. The doctor on duty gave the man, along with his other things, his son's discharge summary, which was ready by now. Thus, the father and other relatives came to know about the client's HIV-positive status and other medical details that he was hiding (past illnesses, drug use experience, etc.)*

- *The client was hospitalized with a suspected case of pneumonia. He refused to get tested for HIV and gave written consent to the release of his HIV-status information from the AIDS center where he was being observed to the hospital where he was currently being treated. The response to the request was received. After some time, he found out that information about his HIV-positive status became known not only to medical staff, but to other patients as well. When he was escorted to the X-ray room he noticed "HIV +, HCV +" marked in large red letters in the upper right corner of the title page of his medical case history. The next day, he saw his medical record on the nurses' station desk, so his confidential medical information was open for anyone to see.*

- *The woman was being treated for COVID-19 in the hospital. At the end of the course of treatment, she was given a discharge summary with the positive HIV test results and the diagnosis of Stage 3 HIV infection. Her request for having the HIV diagnosis removed from her discharge summary was denied.*

HIV status disclosures also occurred through rapid HIV testing when third parties were present during the test:

- *The client came in complaining about the disclosure of his HIV status in the TB center through third parties being present in the doctor's office at the time of the rapid test.*

Disclosure of clients' HIV status **by people in their inner circle** was most commonly accompanied by psychological and physical violence resulting from the conflicts that arose:

- *The woman living with HIV, an OST program patient, is subjected to violence by her brother, who lives together with her in the same building. Following fights and arguments, he throws her out onto the street, destroys her clothes and food products. The woman repeatedly called the police, but her requests for help were declined every time as she is a drug user. The client's brother starts another fight, causes bodily injuries to the woman, destroys her clothes, and discloses her HIV status.*

7.2. PEOPLE WHO INJECT DRUGS

476 reported rights violation incidents involving people who inject drugs (PWID) have been documented. The majority of cases were related to denial of access to services and assistance, i.e., 43%. The perpetrators of rights violations most commonly were public-sector healthcare workers – 51%, as well as police officers – 20% *(Figures 16, 17)*.

FIGURE 16 TYPES OF PERPETRATORS OF RIGHTS VIOLATIONS AGAINST PWID

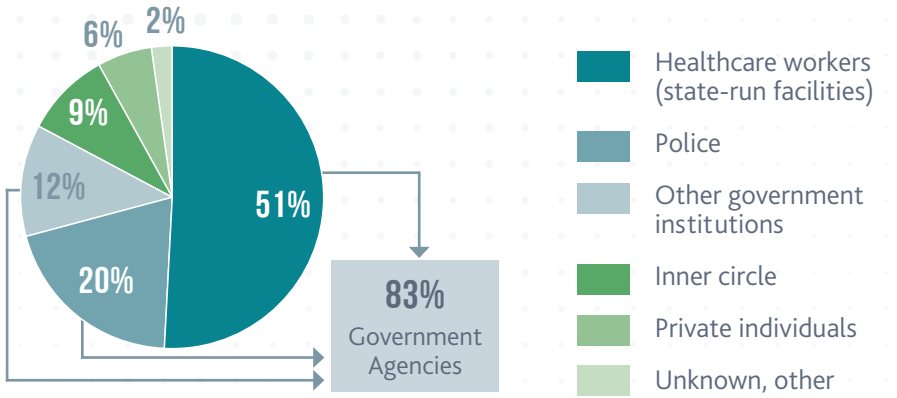


FIGURE 17 TYPES OF RIGHTS VIOLATIONS AGAINST PWID

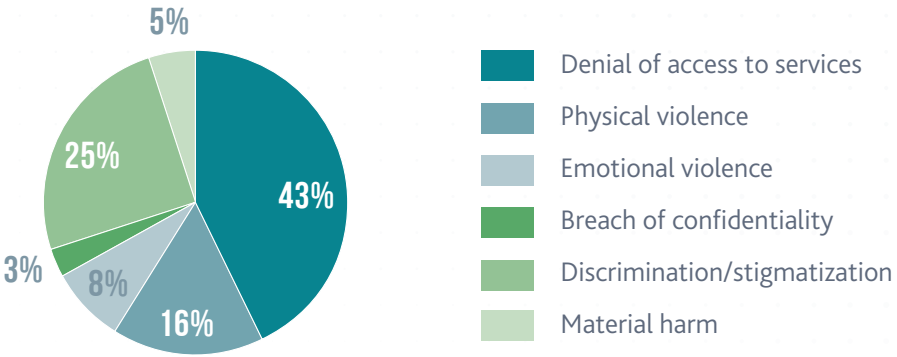


FIGURE 18 KEY RIGHTS VIOLATIONS COMMITTED AGAINST PWID INVOLVING PUBLIC-SECTOR HEALTHCARE WORKERS

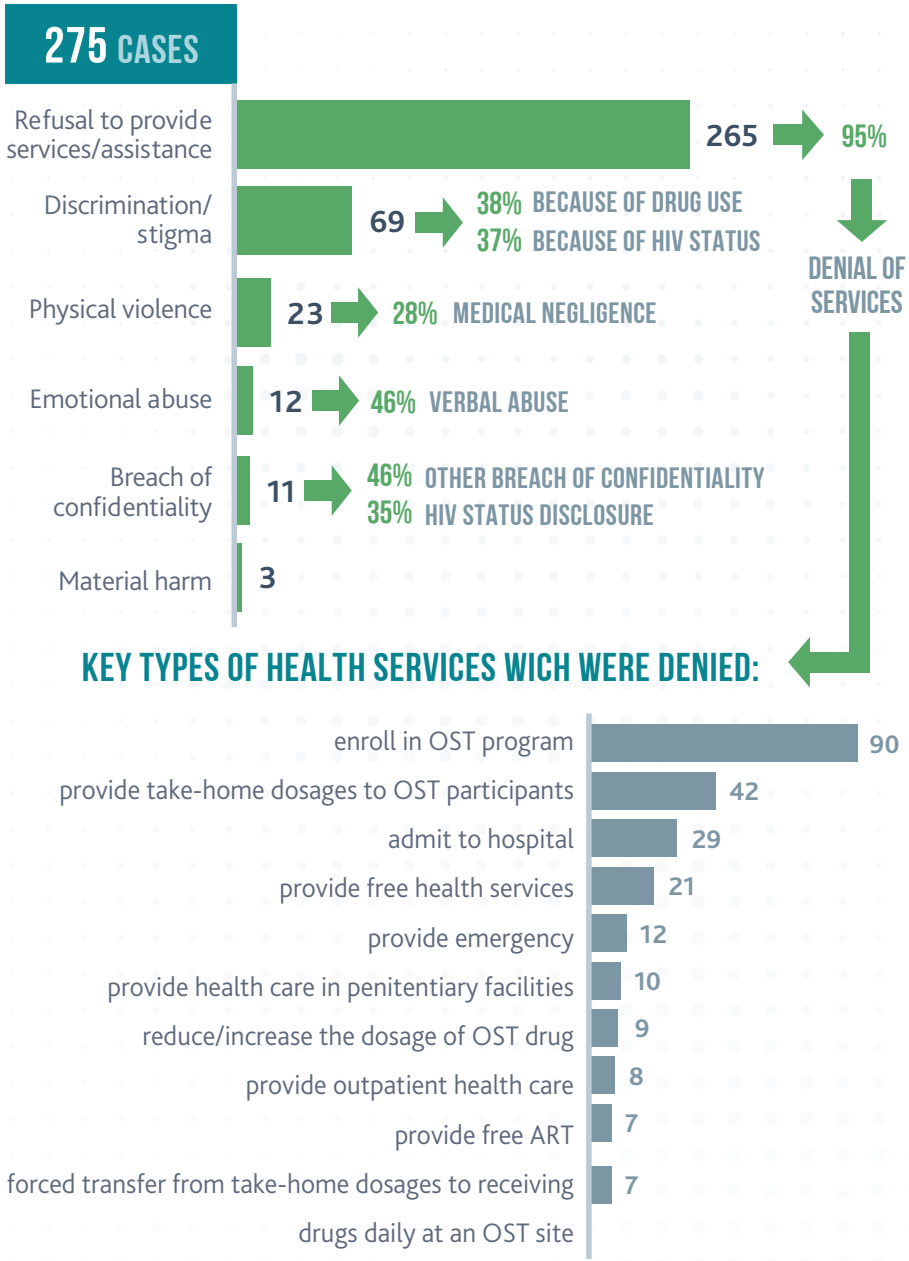
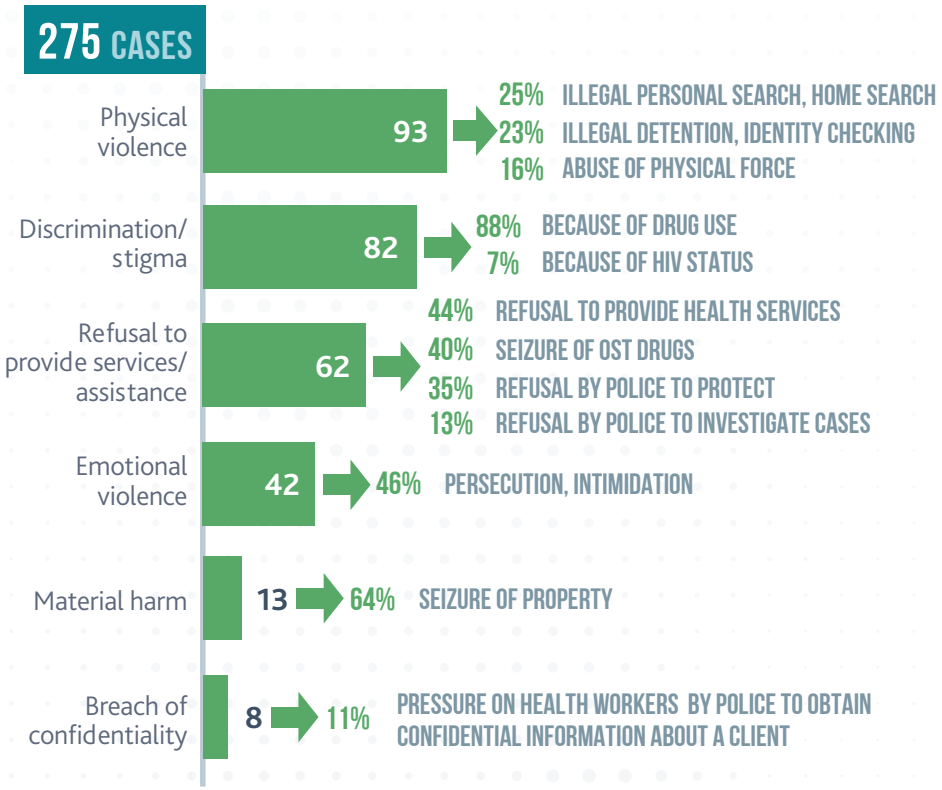


FIGURE 19 KEY RIGHTS VIOLATIONS COMMITTED AGAINST PWID INVOLVING POLICE



Denial of Services

From among 476 rights violations reported by PWID, 379 incidents were recorded because of denial of access to services / assistance *(Table 4)*, of which 83% (316 cases) were concerned with **denial of access to medical services or care**.

TABLE 4 TYPES OF RIGHTS VIOLATIONS AGAINST PWID: DENIAL OF ACCESS TO SERVICES

TYPE OF RIGHTS VIOLATIONS AGAINST PWID: DENIAL OF ACCESS TO SERVICES	TOTAL REPORTED CASES[70]
Denial of access to healthcare services	316
Denial of protection / investigation by the police	37
Denial of parental rights	10
Refusal to issue / re-issue (identity) documents	9
Denial of employment	6
Denial of shelter	6
Denial of legal services	5
Denial of educational services	5
Denial of social services	4

Access to OST

Taking into account the fact that a significant proportion of PWID are OST patients, denial of medical services was most commonly concerned with clients' access to OST, i.e., OST drugs (94 cases), refusal to transfer patients to take-home OST (43 cases), seizure of OST drugs by the police (30 cases). 14 cases were related to denial of access to OST in places of detention.

70 *Multiple types of rights violation incidents (cases) are possible within a single client-reported case.*

In a number of cases, clients repeatedly sought help from healthcare facilities for a long time to be included in the OST program but were denied access to therapy. Some clients were **on the waiting list for inclusion in OST for more than a yea**r. Many clients who were denied access to OST also had comorbidities, such as HIV and HCV, which doubly aggravated their health condition:

- *A client with drug addiction issues has sought help on multiple occasions complaining that he has been trying to get enrolled in the OST program for more than a year, repeatedly reaching out for assistance to the relevant healthcare center, but with no result, although he has severe comorbidities such as HIV and HCV.*

Access to OST is globally recognized as an effective tool in preventing HIV and HCV among PWID. Additionally, it also has an important impact on social behavior of PWID by reducing their potential criminal involvement. PWID who have been denied access to OST are more likely to return to street drug use, thus remaining at risk for HIV and HCV[71, 72].

71 *MacArthur G J, Minozzi S, Martin N, Vickerman P, Deren S, Bruneau J et al. Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis BMJ 2012; 345 :e5945 doi:10.1136/bmj.e5945* https://www.bmj.com/content/345/bmj.e5945

72 *Day E, Hellard M, Treloar C, et al. Hepatitis C elimination among people who inject drugs: Challenges and recommendations for action within a health systems framework. Liver Int. 2019;39(1):20-30. doi:10.1111/liv.13949* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6868526/

Access to Outpatient, Inpatient and Emergency Health Services

49 reported cases[73] were concerned with healthcare workers refusing to provide outpatient, inpatient and emergency health services, have the client hospitalized or deliver care in an inpatient setting. Most often, the reasons for refusal of service included clients' PWID status, as well as self-reported disclosure of HIV status by clients (when they were both PWID and PLHIV), or doctors' suspicions regarding their HIV status due to drug use. Thus, explicit discrimination and stigmatization on the part of doctors was in ample evidence:

- *A woman has been a longtime drug user who recently became homeless. In February of 2020, she developed a severe pelvic infection caused by exposure to low temperatures and sought help from a social worker (REActor), who advised her to see the gynecologist at the nearest outpatient clinic. But the client never got to see the doctor as she was met at the reception desk with negative and judgmental attitudes toward herself. She was insulted and called a panhandling beggar and a "no-good junkie." This outburst was provoked by the fact that she had no money to pay for a medical card, as required under the procedure in place.*

- *The client reported having a festering wound in the groin area and body temperatures rising up to 39°C. He went to see the surgeon, who recommended urgent hospitalization and referred him to the Hospital's Septic Surgery Unit. The client was not admitted to the hospital upon arrival, as he was told that he should cut back on shooting up drugs and get his AIDS treated.*

73 *Multiple types of rights violation incidents (cases) are possible within a single case.*

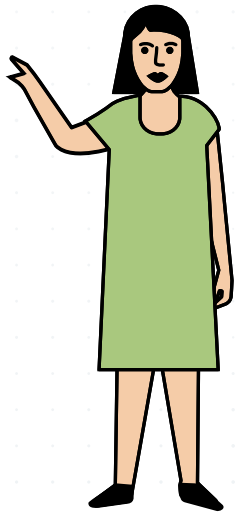
- *A drug-addicted woman living with HIV contacted a medical center regarding osteoarthritis-related surgery on her knee she had been seeking for a long time. As soon as the woman admitted she had drug dependence issues, staff attitudes towards her radically changed, and when they found out she was HIV-positive, she was denied further treatment and told that the doctor would not operate on her, and that she had to go to another hospital.*

The **denial of access to emergency medical care** occurred in several forms: when clients were seeking help over the telephone, if a link was established between clients' request for care and drug use, or right on the spot, when the ambulance crew found evidence of risky injecting behavior:

- *The client called for an ambulance with high fever and body temperatures rising up to 39.5°C, muscle pain and inflammation. Upon arrival, the ambulance team refused to provide services, seeing an abscess and inflammation in the client's leg at the drug injection site. The medics refused to provide both emergency care and medical drugs, referring him to a hospital to which the client could not get on his own.*

The denial of access to emergency health services could also be accompanied by the refusal of hospitalization due to **the doctors' lack of necessary medical qualifications**, or unwillingness to address the client's case:

- *An HIV-positive OST patient reached out for help. She had difficulty moving her legs reporting an inflamed vein in the groin area, a badly swollen leg, and high fever. She called for an ambulance, but they wouldn't help the woman saying that they did not know where to send her, refusing to hospitalize her.*



There have been documented cases in which the lack of necessary qualifications of doctors coupled with **discriminatory and negligent attitudes** to PWID resulted in fatal outcomes:

- *This woman client sought medical help for her swollen leg and high fever, but she was denied care without giving any explanation. All the specialists who examined the client saw a serious problem, some said that the leg had to be amputated to save her life, but the woman was not even hospitalized. Her leg was getting increasingly swollen, the pain and fever reaching an unbearable point, the client called for an ambulance sometimes three times a day, but she was left at home without any help. One of the ambulances took her to the Vein Institute, where she was told that an amputation was needed, but they did not have a specialist who could perform it, and the client was sent back home without getting the emergency care. The client was finally hospitalized and she agreed to undergo the surgery, but she was not operated on. Late at night, the woman was taken to the intensive care unit, where she died the following night without getting any care or assistance.*

Denial of Access to Free Medical Services

In 21 reported cases, PWID were denied access to free health-care services. The doctors' demands regarding payments for state-guaranteed free services were related to **clients' enrollment in OST programs, medical examinations and interventions, as well as purchase of consumables**:

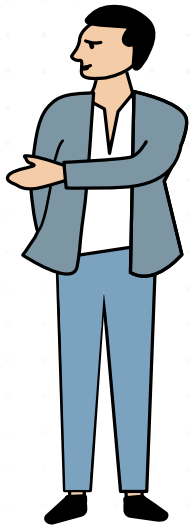
However, the refusal to provide free medical care was coupled with discriminatory and stigmatizing attitudes by

medical staff, whereas demands for payment for services were linked to clients' PWID and, in some cases, PLHIV status:

- *The woman went to the hospital for the surgery needed. At the hospital, after learning that she was HIV-positive and linked to OST, the woman was told she had to pay for the medication and equipment needed for the surgery. When she answered that she was not able to pay this much, they told her, "You find money for your drugs so you will find money for your medicines."*
- *The drug-injecting woman contacted the trauma unit over a suspected brain concussion. Medical staff showed stigmatizing and discriminatory attitudes and unduly demanded a bribe for medical services.*

Denial of Protection or Investigation by the Police

In 37 reported cases, PWID were denied protection or investigation by the police. Police officers would not enforce appropriate steps to take clients' statement on the rights violation or draw up an incident report regarding the subject matter of the complaint. **Police officers' refusal was coupled with stigmatizing attitudes.** In some situations, police protection was refused in cases of domestic violence, attempted deprivation of parental rights, interpersonal conflicts involving bodily injuries and unlawful eviction:



- *The neighbor constantly threatens to have the client deprived of her parental rights for using drugs and being a bad mother. Although the woman takes good care of her child and is working to get rid of her addiction. She asked the district police officer to talk to her neighbor and wanted to file charges against the neighbor, but he turned away her petition saying there was no rights violation involved or grounds for filing charges, as she's only got herself and her drug use to blame here.*
- *As the client is a drug user, his own sister kicked him out of his home, changed the locks on the front door and does not let him into the apartment, although the apartment is registered as the man's official place of residence and part of the living space belongs to him. The client turned to the district police officer for help but his request for getting the case officially recorded and acted on was declined.*
- *The drug-addicted woman living with HIV shares the living space with a cohabiting partner and two young kids. The cohabitant abuses the woman when he's drunk. After another fight, the woman called the police, but they did not respond explaining that the woman had repeatedly contacted them and was a drug addict.*

Stigma and Discrimination

In 216 reported cases, PWID experienced discrimination and stigmatizing attitudes due to their drug use. Such attitudes towards PWID **most commonly manifested themselves when it came to contacting the police or accessing medical and social services**.

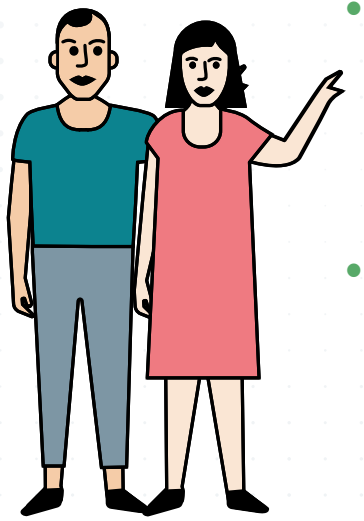
Police officers arbitrarily detained and harassed PWID, conducted unlawful searches, as well as physically and emotionally abused them:

- *The client is an injecting drug user, and police officers arbitrarily tried to stop her, subjected her to a pat-down search in an inappropriate place, insulted, verbally abused and pushed her. The body search was conducted not by a woman, but by a patrol officer, who used force and behaved aggressively, trying to find money.*

- *The PWID client showed up on the outreach route to get tested and pick up clean syringes. After accessing the project services, the client went away. On the way home, he was then intercepted and "pressured" by police, who accused him of drug use and tried to detain him allegedly on the grounds of resembling a person suspected of a recently committed crime. They talked rudely, tried to provoke him claiming they had witnesses to support their accusations. They demanded that the client should inform on his fellow drug addicts, his friends who allegedly were his partners in crime.*

- *A drug-injecting client was detained by police without any legitimate grounds. The law enforcement officers proceeded to body-search him without any witnesses present and without giving any valid reasons. After that, the police officers used brutal physical force against the client.*

Stigma was also evident in reactions from the police when they refused to provide protection to members of the PWID community in connection with their rights violations committed by other people. On a number of occasions, the police officers' conduct was humiliating to the person seeking their help:



- *A man who had been using drugs for some time was beaten up by his neighbor and passers-by called the police. When they arrived and saw the drug-dependent person they knew, rather than offer help they went on to inflict bodily injuries on the man and shook hands with the neighbor. The victim was escorted to a lawyer and offered some useful advice, but he refused to file charges with the police and act on this situation for a lack of belief in the positive outcome.*

Discriminatory and stigmatizing attitudes **on the part of health care workers** were manifested in rude, disrespectful, and indifferent behaviors, disclosure of drug use, refusal to provide medical services, provision of incomplete or poor-quality care, refusal to sign a Patient Declaration Form with the family doctor due to clients' drug injecting practices:

- *The woman was referred by a doctor to the designated agency to apply for disability benefits (she had trophic ulcers) but she was turned away on the grounds that these ulcers were linked to her drug addiction and the doctor would not have her examined by the physical evaluation board trying to avoid wasting public funds.*

- *The woman who injects drugs was referred for a chest fluoroscopy by the doctor. In the X-ray room, with other patients around waiting their turn in the hall, her drug user's status was publicly disclosed in harsh language with the nurse commenting out loud that the entire area along with the corridor must be cleaned and disinfected after patients like her.*

- *When contacting the addiction treatment department for a certificate, a client turned to the reception desk clerk and experienced rude and disrespectful treatment, was insulted and discriminated against because of the visual evidence of her drug use. When asked to identify herself, the reception clerk refused to reveal her name and continued with the argument.*

- *The client came to see the primary care physician about some health complaints at the outpatient health center. After the doctor found out that the client was a drug user, he went on to use degrading, humiliating and disrespectful language. The client never got the medical advice needed.*

Not only doctors, but also **pharmacists in pharmacies** were reported to display stigmatizing attitudes and refuse to sell syringes, as well as behave rudely and insult clients:

- *This client came to the pharmacy to buy one syringe. The pharmacist refused service to him saying that the syringes were only sold in batches of ten pieces. The client expressed his dissatisfaction because of this and pointed out that they followed a different policy for other buying customers. To which the pharmacist replied, "If you want to shoot up, buy them in a batch of ten."*

Women who use drugs reported encountering the **lack of access to assistance** and protection against domestic violence in **state-funded social protection agencies** due to their status:

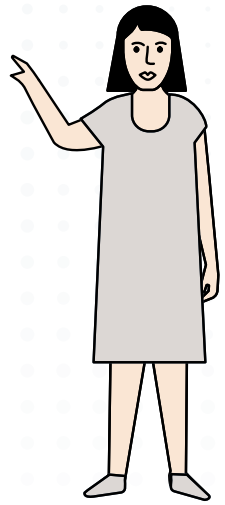
- *The woman client is drug dependent, has two minor children and suffers from domestic violence at the hands of her partner. Her application to the Center for Social Services for Family, Children and Youth for help with finding a place for her at an emergency shelter for domestic violence victims was rejected as the crisis center was not authorized to provide services to drug-dependent women. The request for having her two children placed in a crisis center was not even considered.*

PWID also reported facing the risk of **being forcibly placed in illegal 'rehabilitation centers,'** which is sometimes requested by drug-dependent clients' family members for holding them in isolation against their will. This practice is accompanied by unlawful confinement, violence and cruel and degrading treatment, as well as illegal worker exploitation:

- *A paralegal REActor was approached by a drug-injecting woman who reported having been held against her will in a so-called "rehabilitation center" for drug addicts where she had been sexually abused. The woman received legal advice from the REActor. She was referred to see the psychologist, but refused to report the sexual abuse to the police.*

Stigma and discrimination were displayed toward the children of drug-injecting parents **in preschool and secondary school settings**. Thus, children whose parents were PWID were subjected to discrimination and bullying by both students and teachers:

- *The organization was approached by a client (PWID) who had previously applied to a preschool educational institution (daycare center) in the area of his residence to have his child placed in a nursery group. However, his application was rejected due to the daycare center staff's biased attitudes toward the client's status ("because he's a drug addict," "we have enough of that kind around as it is"). The formal reason for the refusal, however, was the lack of places available (which was not true).*



- *The drug-addicted woman approached a paralegal REActor for help about her child being regularly bullied at school. Staff at the school found out the woman was a drug user, and the bullying was carried out by both the students and the teacher.*

7.3. PATIENTS OF OST PROGRAMS

There were 200 rights violation incidents reported by patients in OST programs. Half of all the cases of rights violations against this group were concerned with denial of access to services/assistance. The most frequent perpetrators of rights violations here were public-sector health care workers – 52% *(Figures 20, 21)*.

FIGURE 20 TYPES OF RIGHTS VIOLATIONS AGAINST OST PATIENTS

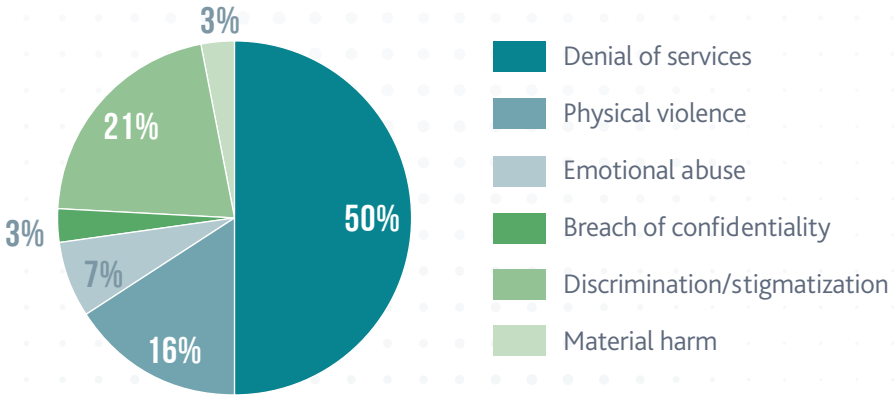


FIGURE 21 TYPES OF PERPETRATORS OF RIGHTS VIOLATIONS AGAINST OST PATIENTS

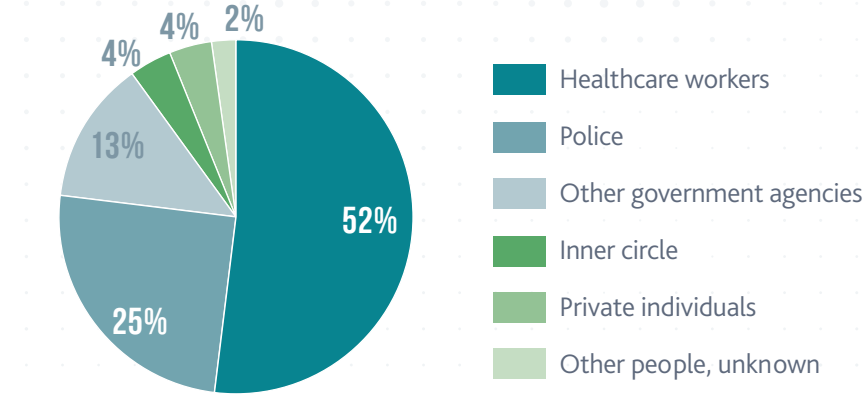


FIGURE 22 KEY RIGHTS VIOLATIONS COMMITTED AGAINST OST PATIENTS INVOLVING PUBLIC-SECTOR HEALTHCARE WORKERS

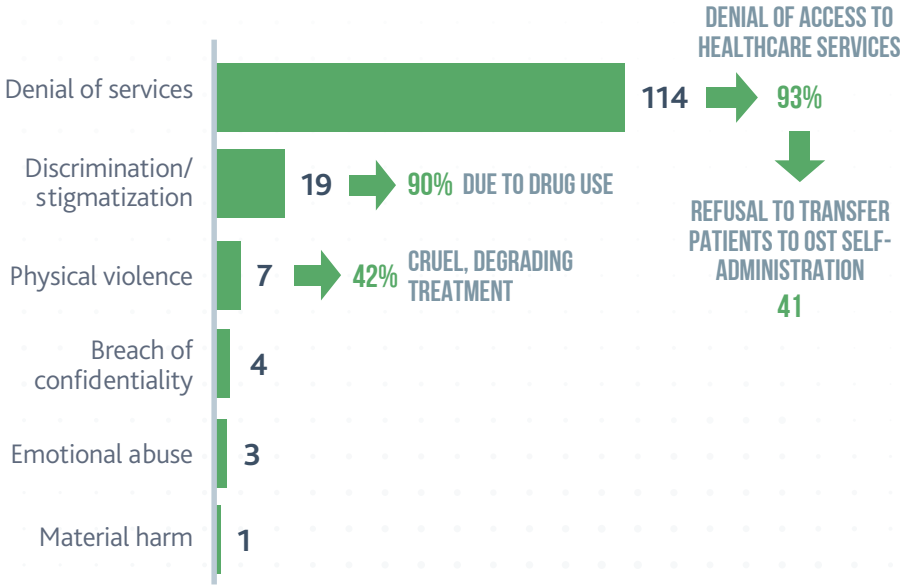
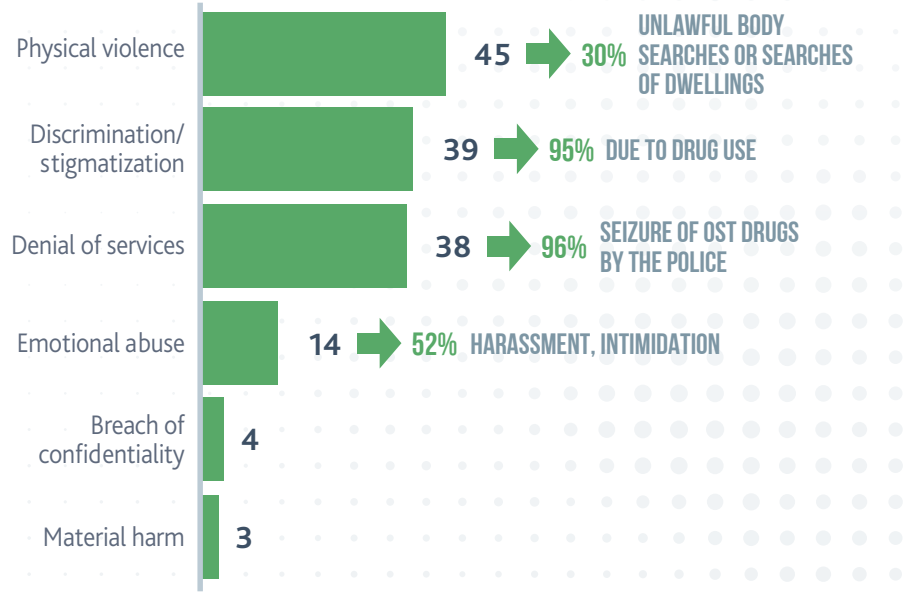


FIGURE 23 KEY RIGHTS VIOLATIONS COMMITTED AGAINST OST PATIENTS INVOLVING POLICE



Denial of Services

171 documented cases of rights violations were concerned with denial of access to services/assistance. 156 cases of rights violations were related **to denial of access to health services or care** *(Table 5)*.

TABLE 5 TYPES OF RIGHTS VIOLATIONS AGAINST OST PATIENTS: DENIAL OF SERVICES

TYPE OF RIGHTS VIOLATIONS AGAINST OST PATIENTS: DENIAL OF ACCESS TO SERVICES	TOTAL RECORDED CASES[74]
Refusal to provide a take-home OST	42
Seizure of OST drugs by the police	30
Denial of access to healthcare services free of charge / without extra payment	10
Refusal to hospitalize, provide inpatient medical care	8
Forcible (non-consensual) change in OST dosage	9
Forcible (non-consensual) transfer from self-administered to site-controlled OST regimens	7
Denial of access to emergency healthcare services	3

74 *Multiple types of rights violation incidents (cases) are possible within a single client-reported case.*

Access to OST

The denial of access to healthcare services most commonly involved **refusal to transfer a patient on OST to a self-administered regimen** (take-home OST):

- *The patient reported a complaint saying that he had been on the OST program for nine years with all his tests coming back clean, and he faithfully adhered to all policy guidelines the whole time, but they still refused to switch him to a self-administered regimen.*

Not only doctors, but also pharmacists in pharmacies were reported to display stigmatizing attitudes and refuse to sell OST drugs, as well as behave rudely and insult clients:

- *The client walked into the pharmacy with a prescription from an addiction treatment practitioner to buy his SMT drugs, but the pharmacist rudely refused to supply his request, insulted him calling him a "junkie," tore up his prescription, and went on to hustle him out of the pharmacy, threatening to call security.*

Furthermore, **police officers were reported to prevent access to care**, e.g., by seizing OST drugs. The medication was confiscated even if the client showed the authorization to carry it:

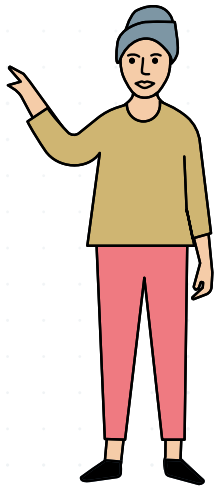
- *A client walks out of the OST-dispensing site where he has been in the program for about two years. A police officer approached him and demanded he should step out of the health care facility to give a verbal statement. That day, the client had received Methadone for self-administration. Outside the grounds of the healthcare facility, the client was stopped and detained by law enforcement officers. They had him empty his pockets for inspection, patted him down and searched him. During the search they found and seized Methadone. The client produced documentary proof showing that he had obtained the drug legally. The police officers threatened to hurt the client if he complained about or questioned their illegal activities.*

- *The local patrol police are aware that the client is receiving the medication for self-administration but they constantly stop and search him. They treat him rudely and behave in an arrogant manner. They often search him with no witnesses around. The client is worried about his safety. He's concerned that at some point the police might plant illegal drugs on him or seize the Methadone dispensed to him in the treatment program.*

In addition to the seizure of OST drugs, the police were also reported to act arbitrarily and rudely to clients when conducting, **without any legitimate cause, pat-downs and body searches or searches of their homes resorting** to physical violence and extortion:

- *The patrol police stopped the client without giving a reason. At first, they made him turn out his pockets, then body-searched him out on the street without taking him to the district precinct or local police station. The patrol officers said they suspected him of being involved in a recently committed crime and inquired where his money came from. The client reported that he had a job and they could contact his employer to verify that but they would not listen to his explanations. The patrol officers confiscated all the money and the prescription methadone tablets they could find, thus leaving the client with no money to make it back home.*

Police awareness of the possible presence of OST drugs on specific individuals may have been based on using their personal sources and contacts. E.g., in a small town, police officers knew who the OST patients were. They could also be informed, in violation of the law, by health care workers who might **supply confidential information about OST patients** on request by the police:



- *A client of the OST program learned from the program's physician that some police officers demanded some confidential information about him from medical staff at the OST-dispensing site, i.e., his home address and contacts, HIV status, psychoactive substances used, what kind of drugs were dispensed to him for self-administration or taken on a daily basis. The police argued that they were looking for the client. The health care worker provided this information, thus violating the client's privacy and confidentiality. In addition, the health care worker had not received a formal request for data disclosure and had not previously notified the client of this disclosure. The client maintains that he is not a suspect or wanted for any crime and he does not understand the reason behind this request for his personal data.*

In a number of cases, following seizures of OST drugs by the police, **health care providers refused to re-dispense the medication**, thus interrupting the continuum of care for a period of time:

- *The home of an OST client who has Category 2 disability and is bedridden due to concomitant conditions was searched by the police based on a court order. As a result, his legally obtained ten-day supply of Methadone (OST drugs being dispensed to him in ten-day supplies), duly supported by appropriate authorization and intended for self-administration, was seized. Additionally, no search record was given to the client, which would serve as the basis for accessing further medication. Following relevant policy guidelines, the physician refused to dispense the supply of medication to the client's representative for the next ten days without seeing the confiscation record for the previously dispensed drugs. The investigator who had conducted the search delayed issuing the confiscation record, although under the applicable guidelines the record of investigative actions must be drawn up on site in two counterparts, one of which is to be immediately handed to the suspect.*

7.4. SEX WORKERS

There were 37 reports of rights violations against sex workers. The most frequent perpetrators were police officers – 42% and healthcare workers – 28%. SWs were the most likely to experience discrimination/stigma – 35%, physical violence – 20%, denial of access to services/assistance – 21% *(Figures 24, 25)*.

FIGURE 24 TYPES OF PERPETRATORS OF RIGHTS VIOLATIONS AGAINST SW

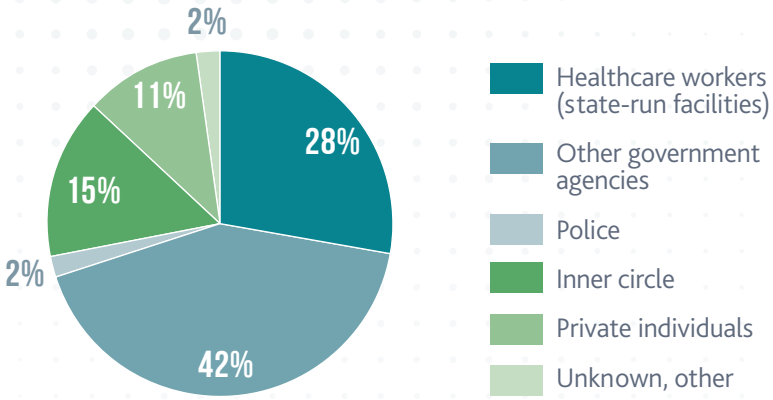


FIGURE 25 TYPES OF RIGHTS VIOLATIONS AGAINST SW

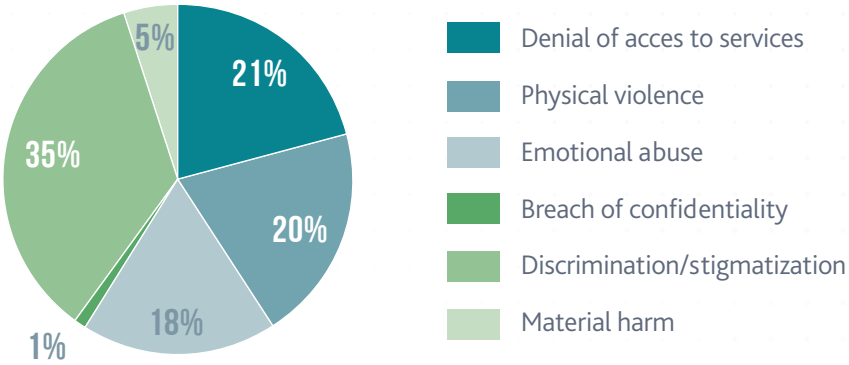
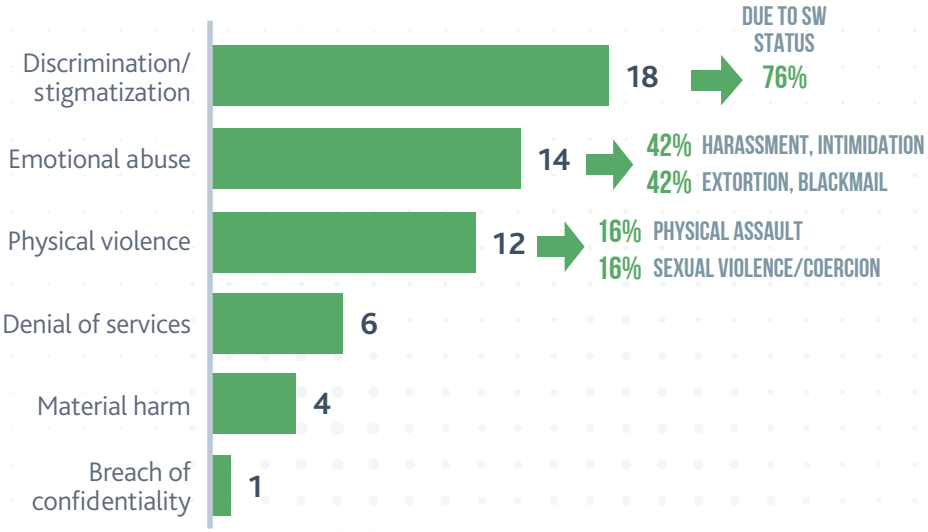


FIGURE 26 KEY RIGHTS VIOLATIONS COMMITTED AGAINST SW INVOLVING POLICE



From among 37 incidents reported by SW, 19 documented cases[75] of rights violations were concerned with denial of access to services/assistance, of which 68% were related to **denial of access to healthcare services/care** and 31% – to **denial of police protection**:

Denial of Access to Healthcare Services

In 13 recorded cases, SWs reported being denied access to healthcare services. Most commonly, assistance was required from **a gynecologist – as part of outpatient care**. When the SW came to see the gynecologist and disclosed her most-at-risk status, she was turned away and no medical care was provided.

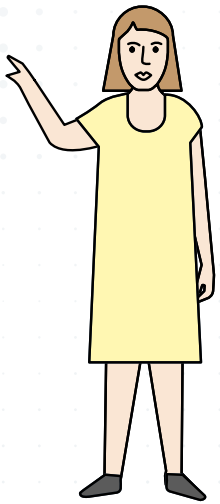
75 *Multiple rights violation incidents (cases) are possible within one client report.*

- *The gynecologist refused to see the client when she explained she was a sex worker.*

- *The girl, a sex worker, was seeking medical help from the gynecologist at the city clinical hospital, but was turned away without being given any reason. The doctor chased her out of her office.*

SWs also reported being **denied access to prenatal care and skilled birth attendance**. The intensity of sex work stigma far outweighed the healthcare worker's professional duty to provide medical care to a pregnant SW. In some cases, such negligence created a serious threat to the life of both mother and baby:

- *Along the route of the mobile outpatient clinic, social workers once found an SW standing with an infant and begging for help. A conversation with the client revealed that during her pregnancy she had approached a healthcare facility to get registered, but was turned away as she had no identity documents or money. The client also described how she pleaded with the doctor to get her registered, being stuck in a difficult life situation as she had no place to live and was engaged in providing sex services, but due to her pregnancy she was not able keep on making a living from that. The doctor refused to provide any services for her, and when she turned to other medical institutions, she got similar treatment. As a result of this indifference, she had to give birth to her child in a field, not far from the highway.*



Denial of Protection by the Police

It is worth noting that in a number of cases involving physical violence committed by their partners or clients, SWs were not able to get protection from the police for **fear of stigma** and disclosure of sex work:

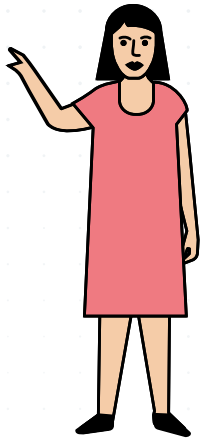
- *A woman was beaten by her cohabiting partner when he found out she was a sex worker. He inflicted bodily harm on her and threatened public exposure. The client did not report this incident to the police for fear of stigma.*

Only some sex workers report rights violations to and seek protection from the police. In 6 recorded cases, SWs sought protection from the police when their partners committed acts of domestic violence or their commercial sex partners physically assaulted them, but received no help as **police officers refused to draw up an incident report**:

- *The client contacted the organization asking to help her. During the conversation it was established that the woman and her child almost daily suffered from domestic violence by her husband. Seeking help from the police on numerous occasions yielded no results as the man told the police she was a sex worker and she was afraid to return home and worried about her life and safety.*

- *The man refused to pay the agreed-upon fee for the services rendered, took away the client's cell phone and beat her up. At that point, a patrol police vehicle was passing by near the site of the fight. The man accused the woman saying to the police that he was giving her a lift in his car and that she stole money from him. There were allegedly signs of beating on her body at the time she was getting into his car. The woman turned to the police for help and asked them to protect her, confirming she was prepared to testify, but the patrol officers said that was all her fault and drove off.*

- *This woman, a sex worker, suffered acts of violence at the hands of her client who physically assaulted her when she refused to service him. The woman called the police but they refused to refer her for a forensic medical examination and file charges against the man who abused her and threatened to hurt her knowing where she lived.*



Emotional Abuse and Physical Violence

In 34 recorded cases, SWs reported experiencing emotional and physical violence from the police, their intimate or commercial sex partners. It is noteworthy that **acts of emotional and physical violence were more likely to be committed by police officers**.

Police officers were reported to intimidate and blackmail SWs, extort money, coerce them into "cooperating" as witnesses on cases involving other SWs, force them into engaging in unprotected sexual acts without payment, or threaten them with arrest. Police officers were often reported to initiate engagement with SWs posing as clients

- *A SW has to pay 5,000 hryvnias every month at the demand of a police officer to avoid disclosure and being arrested for prostitution.*
- *Another SW client reported that police officers, passing themselves off as clients, had entered her dwelling, demanded money and tried turning her into a cooperating witness informing on other girls who were individually offering sex services in an apartment setting. The goal is to file charges and obtain a conviction against them for keeping a brothel. The police officers demand regular payments and harass those who refuse to pay. The client keeps changing her work address and her phone numbers, but they still track her down and continue to intimidate her.*
- *A sex worker working on the bypass highway was forced into providing free services involving unprotected sex with a police officer to avoid being booked and arrested. During a police raid, the client was detained on the bypass highway by two police officers. Without even bothering to read her "Miranda rights," they started insinuating that she should offer to provide them with sexual favors. She was roughly hustled into the police patrol vehicle, locked up and pressured into providing sexual services by use of force. The client shared that, unfortunately, incidents like these are not uncommon.*
- *Posing as clients, three so-called "vice police" officers came to the SWs' apartment, threatening to take them to the police station and throwing them in jail for three days. They demanded that the girls should pay off 5000 hryvnias for the two of them to be left alone. The girls paid the money and the police left.*

Stigma and Discrimination

There were 31 recorded cases of stigma and discrimination against SWs, which, if committed **by the police**, were most commonly **associated with their sex work.** This manifested itself in harassment, threats and extortion of money or free sexual services, as well as refusal to provide protection by the police:

- *The client shared with the social worker that she had been abused by her client. She was planning to file charges with the police but was told that it was all her own fault and her statement was not accepted.*

Stigmatizing attitudes on the part of **health care workers** might be a barrier to accessing essential treatment for SWs living with HIV:

- *When accessing assisted testing and counseling, the client's test came back positive. She reported she had been aware of her status since 2018 but she never followed through with treatment as she was unable to access medical care due to health workers' attitudes and practices on the grounds of her involvement in sex work, as well as the lack of necessary documents.*

7.5. MEN WHO HAVE SEX WITH MEN

There were 108 reported rights violation incidents involving MSM. Most commonly, these were concerned with discrimination/stigmatization due to clients' sexual orientation – 32% and emotional abuse – 24%. The perpetrators were primarily people from their inner circle (family members, sexual partners, neighbors) – 31% and unknown (including radical groups) – 27% *(Figures 27, 28)*.

FIGURE 27
TYPES OF RIGHTS VIOLATIONS AGAINST MSM

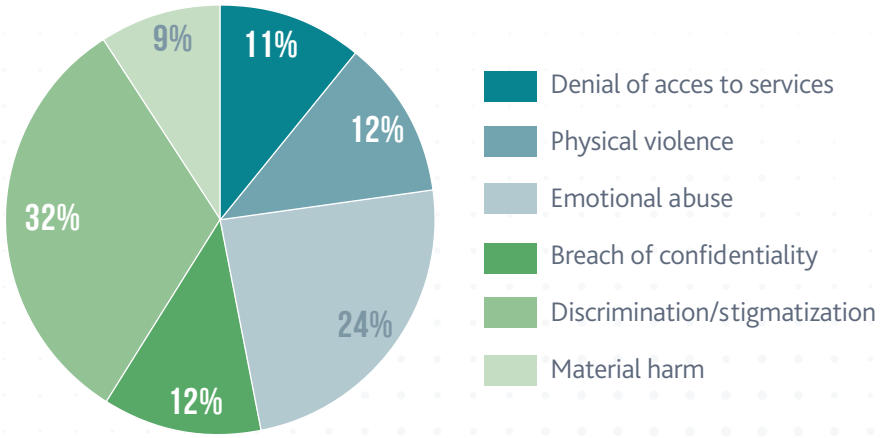


FIGURE 28
TYPES OF PERPETRATORS OF RIGHTS VIOLATIONS AGAINST MSM

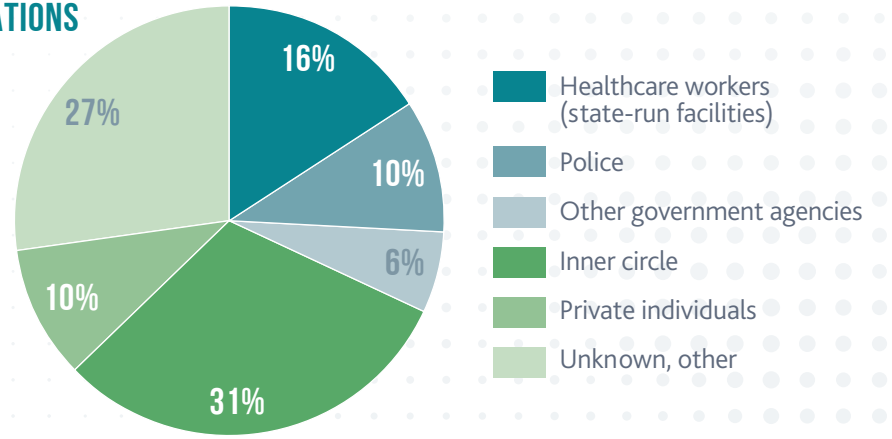
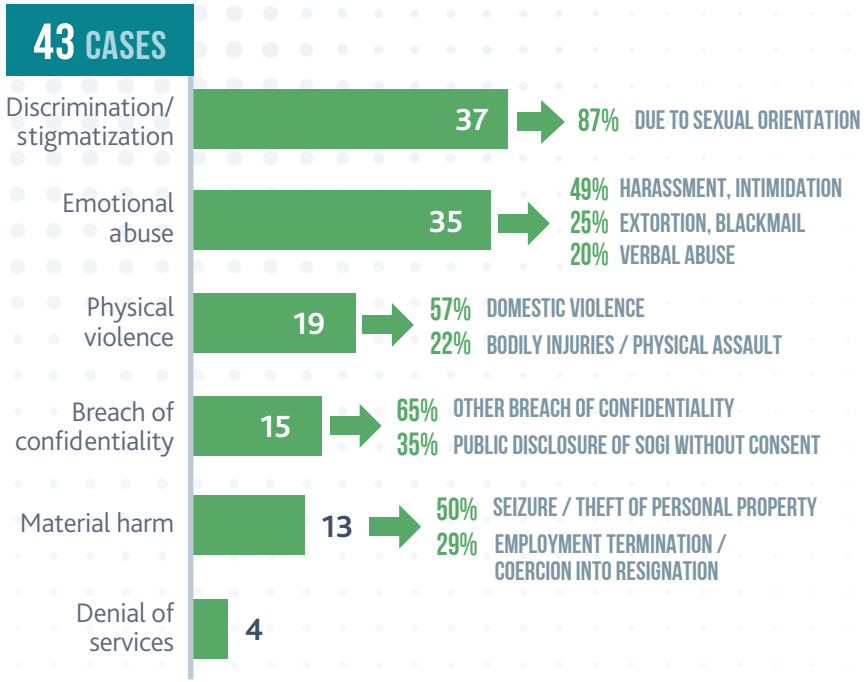
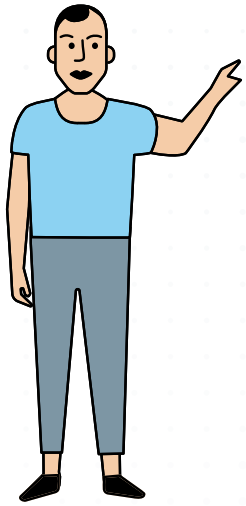


FIGURE 29 KEY RIGHTS VIOLATIONS AGAINST MSM INVOLVING INNER CIRCLE



Emotional Abuse and Physical Violence

In 65 cases, MSM experienced emotional abuse and in 34 cases they experienced physical violence. In half of the cases, emotional abuse came from **people in their close environment, i.e., family members, acquaintances, neighbors**, which took the form of insults as well as harassment and intimidation. Rights violations committed by family members most commonly took place if clients were living with their parents. **Family members** would not accept clients' (MSM) sexual orientation, showing an absolute disrespect and intolerance, sometimes even restricting clients' freedom, access to familiar things or trying to control their behavior. Acts of domestic violence against MSM might be committed as well:



- *The client confessed to being gay to his family. Since then he has been forbidden to go out, his messages on apps are being thoroughly inspected. His older brother is constantly bullying, insulting, mocking and humiliating him. The client cannot freely use his cell phone and talk with his friends because he is not permitted to do so. Nor may he access his computer, which he needs for his studying. The client's mother asks the neighbors to keep an eye on the front door to make sure the boy does not sneak out when they are not around, explaining that they are trying to cure him of his "faggot ways." The client is having suicidal thoughts. Only his aunt supports him, but she lives in another city.*

- *The client decides to come out to his family about his sexuality. His father is furious and devastated over the news launching into insults and threatening physical violence. The mother is trying to smooth out the conflict. A few days later, the client gets back home from work to find his belongings packed into bags at the front door. For more than three weeks, the father is barely able to put up with sharing his living space with his son and insists that he move out. On multiple occasions, the father has tried to lock him out of the apartment so he spends the night at friends'. His father believes he is sick and needs to be treated for his homosexuality.*

- *After finding out about his sexual orientation and gender identity, the parents took away the client's cell phone so he can't use the social networks and messengers. The client bought this cell phone with the money he had earned during the summer working odd jobs. The client is upset and they give him some old cell phone instead. They delete his accounts on Telegram and other messengers after reading his information stored here.*

An MSM client's **neighbors** also displayed intolerant attitudes toward him because of his sexual orientation, insulting him and threatening to use force and deface his property:

- *This client's neighbor threatens to physically hurt him and damage his property on the grounds of his sexual orientation and gender identity. Earlier, this neighbor posted a note saying, "You f*cking faggot, if I catch you bringing home men, you'll end up with a broken nose. I'll burn your place down, too." The note was unsigned, but the client guessed it was the neighbor who had previously made threats to the same effect.*

MSM's acquaintances, friends, as well as police officers, being aware of their sexual orientation, committed acts of extortion and blackmail in exchange for non-disclosure of sexuality-related information to others:

- *While visiting with his friend, this client logged on to his social media account via the host's computer. Later on, the client's friend called to inform him that he had forgotten to log out of his accounts and that the friend had read through his correspondence and made screenshots of the bookmarks tab (showing groups with homoerotic content). In exchange for keeping the secret, this friend demanded that a part of the client's student allowance money be handed over to him every month. The passwords were changed, but this "friend" still keeps the screenshots of the sensitive correspondence and the bookmarks.*

- *This client (MSM), cross-dressed as a woman, was heading home. Not far from his destination, he was stopped by a police patrol vehicle, asked for his ID and told to wait in the vehicle. Inside the vehicle, the police officers surreptitiously took some pictures of the boy on their cell phone cameras and let him go after asking a few questions establishing his full name, date of birth, home address, phone number, place of work, and job title. On the evening of the following day, the client received a call on his cell phone from an unidentified number, demanding that 3,500 hryvnias be transferred to a PrivatBank card, and threatening, unless their demand was complied with, to inform his family and fellow workers about the double life the client was leading.*

In 20 recorded cases, MSM reported experiencing harassment and intimidation due to their sexual orientation by **unknown individuals**. Harassment was accompanied by blackmail, threatening to reveal the client's sexual orientation, and extortion of money. Such cases are common and widespread among **MSM seeking dates on the Internet**:

- *This client was looking for a partner via the Internet. After responding to one of the ads, the would-be victim and his new potential partner struck up a correspondence. As they kept exchanging messages, the stranger asked the client to send him a photo just taken with the OK sign allegedly to make sure the person on the other end was the one shown in the main profile picture. The client complied with the stranger's request, following which that person moved on to using threats and blackmail saying, "I have taken a screenshot of our exchange, made a copy of the list of your friends and will send these to all your friends and acquaintances, unless you immediately transfer 2,000 hryvnias to my e-wallet account. The abuser gave the client two days to carry out his demand. Every day he sent personal messages, reminding the client of his "debt" and threatening him.*

- *A client met a stranger via the Hornet App. After a short exchange, the client went out to meet the stranger in an apartment rented beforehand for the purpose of having sex. After the event, when the client got back home, he received a message from the man, whose name he does not know, just as he does not know any other details about him, including his cell phone number, saying that he was caught on camera having sex and the client was expected to pay 3,000 hryvnias to keep the video off the Internet. The client paid the amount but the blackmail has been going on to this day: the abuser is asking for another UAH 3,000. He cannot provide evidence of blackmail and money transfers, nor are there any witnesses.*

The use of physical violence against MSM was **motivated by intolerant attitudes and hatred based on their sexual orientation**. Most commonly, the perpetrators were unknown individuals or radical groups. In some cases, the situations were life-threatening for MSM:

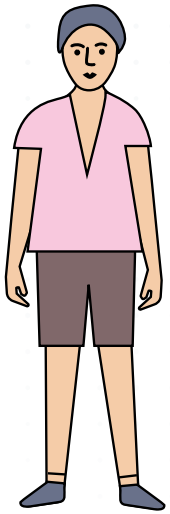
- *One evening, when an MSM client stepped out of his home to go to a nearby store, he was attacked by a dozen people with their faces covered. The assailants beat the man up out of hatred for him being gay. They took away his cell phone and domestic passport. After a while, the neighbors found the victim and called an ambulance, which took him to the city hospital. The police were also called there and a police report was taken to document the incident.*

Stigma and Discrimination

In 88 reported cases, stigma and discrimination was most commonly experienced by MSM **because of their sexual orientation**.

Cases were documented when private-sector individuals, specifically employers, **refused to hire** or **fired clients** after learning about their sexual orientation:

- *A client tried to get a job at a cafe. After working two weeks as a trainee on minimum wage (100 hryvnias per day during the on-the-job training period), the client thought he would get hired as he was doing a good job with his duties and made friends with the team. The day when his training period ended, the lead manager informed him that they were not hiring him because, "You're a hard worker, but you look gay and you act gay, and people don't like that. You lose your "gay ways" and come back again."*
- *This client is officially employed as a waiter in a pizzeria chain. During the quarantine period, the pizzeria operates only as a take-out place so management suggested he should take a leave of absence without pay. The client found out that no other waiter on staff had been told to do that. When he went to see the manager to find out what the matter was, he was told, "Well, you're one of that kind of guys, you'll find another way to earn some money."*



MSM reported being **denied access to rental housing** when the landlord became aware of their sexual orientation:

- *A same-sex couple living as a family was evicted from a rented apartment without reimbursement of the security deposit or rent paid for the following month after the owners found out about their sexual orientation. According to them, they followed the tenants around for about a week after their suspicions were aroused. And they would not like any "AIDS-infected" guys living in their apartment as they would "get everything infected here" and that's not the "Christian thing" to do. The victims called the police, but no one responded to their calls. Fearing violence from the landlords, these people just packed up and left.*

Manifestations of stigma and discrimination were recorded in **educational institutions**, when MSM clients experienced pressure, humiliation, and bullying by their classmates, as well as lack of protection from teachers because of their sexual orientation:

- *A mother of a teenager came forward with this problem: her son has been discriminated against and stigmatized by his fellow students for more than half a year because of his sexual orientation and gender identity. When they were finishing grade nine, the boy's classmates got a hold of his cell phone and found erotic content indicating his homosexuality. Since that time the boy has been constantly harassed and bullied. For the last few months, neither the class teacher, nor the school psychologist or the school administration, have done a thing to steer the classroom relationships between the students back to normal. The boy complains that his things (various minor items) such as office supplies and notebooks have begun to disappear recently. His fellow students write nasty things in his books and report card threatening and advising him to switch schools. The boy's mother has formally approached the school administration and the Office of Juvenile Justice and Delinquency Prevention for help, but the situation remains unchanged.*

Such rights violations, i.e., stigmatization and discrimination against MSM tend to have a significant impact on MSM clients' mental health as well as increase the level of anxiety and depressive symptoms. This also increases the chances of risky behavior and decreases participation in HIV prevention and testing programs[76].

76 *Rueda S, Mitra S, Chen S, et al. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. BMJ Open. 2016;6(7):e011453. Published 2016 Jul 13. doi:10.1136/bmjopen-2016-011453* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4947735/

7.6. PEOPLE LIVING WITH TB

There were 40 rights violation incidents reported by people living with TB. In 44% of the cases, clients' rights were violated through denial of access to services/assistance. In 62%, the perpetrators were healthcare workers *(Figures 30, 31)*.

FIGURE 30 TYPES OF RIGHTS VIOLATIONS AGAINST PEOPLE LIVING WITH TB

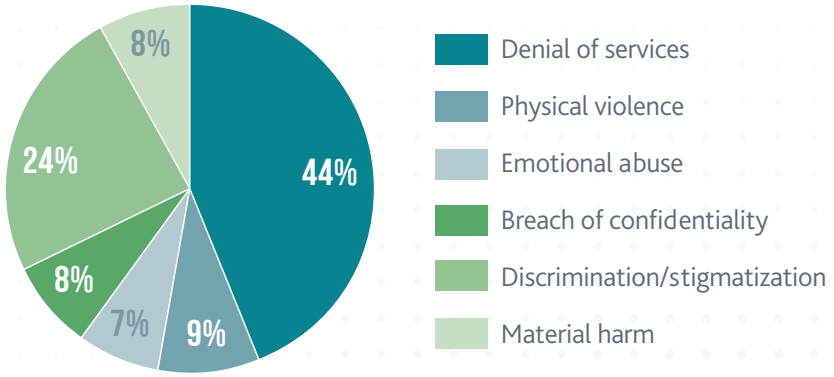
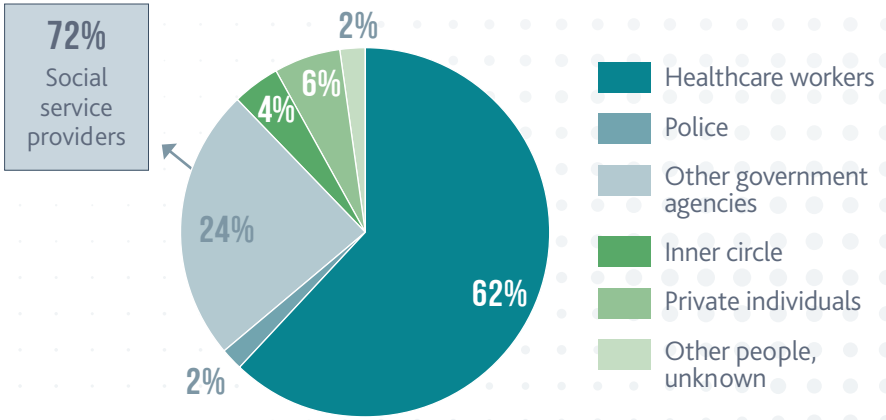


FIGURE 31 TYPES OF PERPETRATORS OF RIGHTS VIOLATIONS AGAINST PEOPLE LIVING WITH TB



Denial of Services

There were 31 documented cases involving denial of access to services/assistance to people living with TB. Most of them were concerned with **refusal to provide medical care** and **social services**. The reform of the TB control and treatment system, reorganization of the healthcare facility, lack of necessary medications, and other formal excuses were given by health care workers as reasons for refusal to provide medical care. The **reform of the TB control and treatment system**, reorganization of the healthcare facility, lack of necessary medications, and other formal excuses were given by health care workers as reasons for refusal to provide medical care.

The reform of the TB control and treatment system is understood to be the reorganization associated with the consolidation of several TB treatment centers and facilities into one specialized medical institution and the closure of "redundant" ones (according to the reformers). Such innovations, although having an economic basis, have not been properly understood by people living with TB or those wishing to access relevant services, who are being forced to experience additional difficulties because of the reform-related complications. The very process of this reorganization is proceeding in a manner that often leads to violations of the rights of people living with TB

- *After being examined and diagnosed with pulmonary tuberculosis, the client went to the city TB center for treatment. The consulting doctor suggested the client go to the regional hospital where she is registered, although she was living and working in the city. The reason given was the lack of medicines at the moment due to the reorganization of the medical institution. No referral to another specialized care provider in the city was offered, either. The situation looked like being denied access to medical care.*

In a number of cases, clients were unable to get the treatment needed because they **had no identity documents**:

- *A REActor has been contacted by a client with TB who is confined to the home. The client needs care but receives no benefit payments, has no social worker support and no access to treatment due to the lack of necessary documents (domestic passport, tax identity number).*

There were documented cases recording stigmatizing attitudes on the part of healthcare staff, refusal to provide treatment advice and guidance, **TB treatment combined with ART or evaluate clients' health status**:

- *An HIV-positive client who is being treated at the TB center is seeking help over the violation of her right to access care. The woman feels bad after taking the medication prescribed at the TB center. She asked the doctors to provide further information about the drugs prescribed to find out whether they were compatible with ART she is also taking, as well as point out the reason why she feels sick. The doctor rudely declined to answer her questions saying, "If you don't like it, don't bother taking it. There's no way I'm gonna let you call the shots and act like a big boss here!" That said, the doctor canceled her treatment and dispensed no drugs.*

Denial of access to social services included refusal to provide social protection and social care:

- *The woman client with TB has applied to the Social Services Office for welfare (pension) benefits in connection with her illness and social support for her two minor children. But no help was provided. Thus, through the negligence of social service workers, the client's right to access social assistance provided for under the law of Ukraine was violated.*

7.7. PRISONERS / EX-PRISONERS

69 rights violation incidents documented in the REAct system were concerned with prisoners who were incarcerated at the time of their complaint, or ex-prisoners. In 46% of the cases, the rights of the vulnerable group were violated in the form of **denial of access to services/assistance**. The perpetrators were mostly healthcare workers, as well as employees of other public-sector bodies, specifically those working in the penitentiary system *(Figures 32, 33)*.

FIGURE 32 TYPES OF RIGHTS VIOLATIONS AGAINST PRISONERS

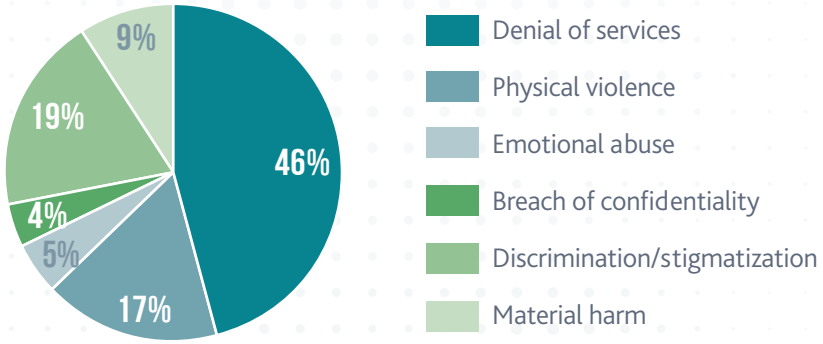


FIGURE 33 TYPES OF PERPETRATORS OF RIGHTS VIOLATIONS AGAINST PRISONERS

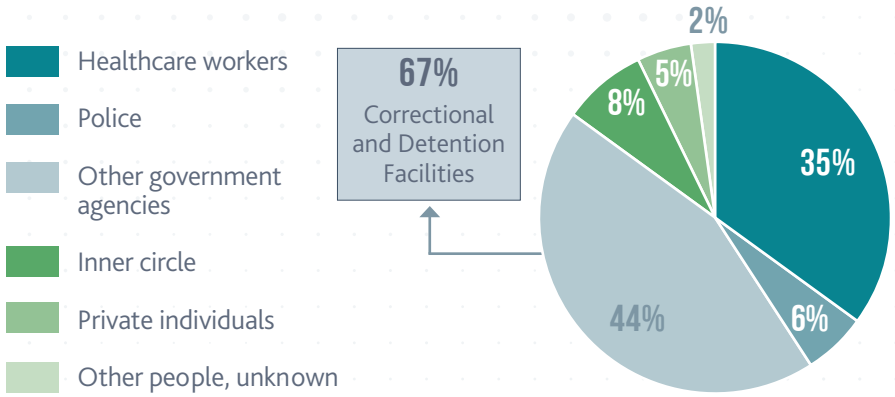


FIGURE 34 KEY RIGHTS VIOLATIONS COMMITTED AGAINST PRISONERS / EX-PRISONERS INVOLVING PUBLIC-SECTOR HEALTHCARE WORKERS

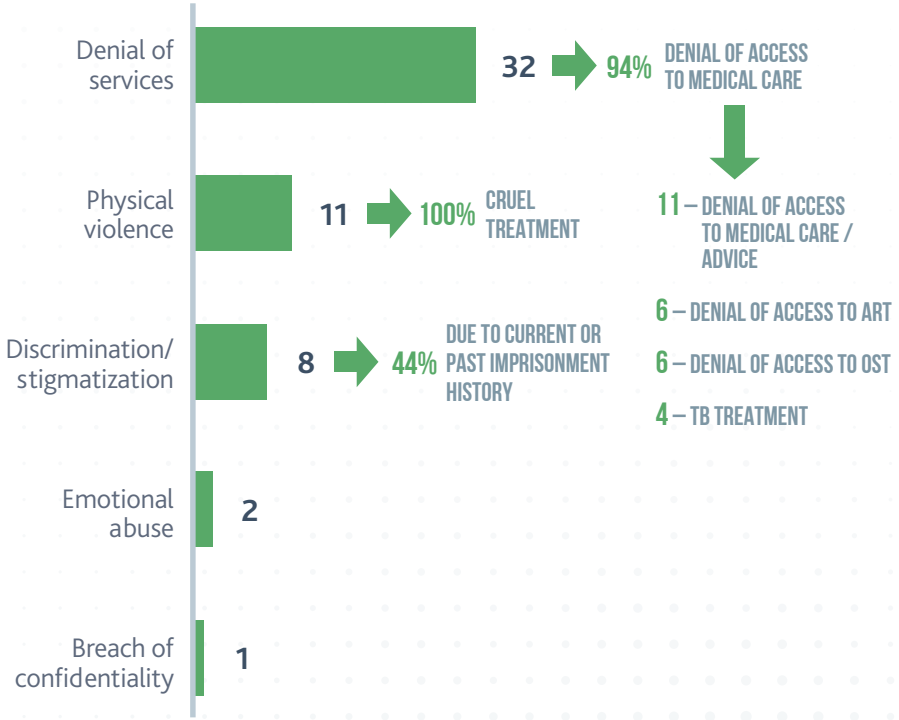
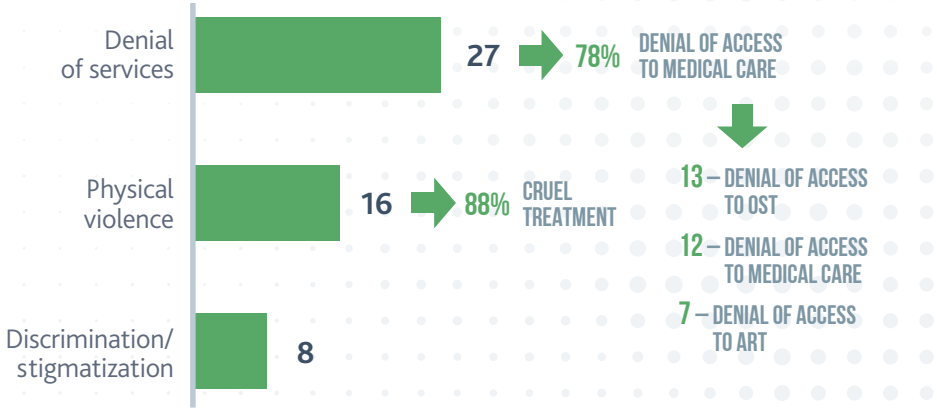


FIGURE 35 KEY RIGHTS VIOLATIONS COMMITTED AGAINST PRISONERS / EX-PRISONERS INVOLVING EMPLOYEES OF THE PENITENTIARY SYSTEM



Denial of Access to Medical Care

In 43 recorded cases, prisoners reported experiencing rights violations **by administrative personnel and healthcare workers at the places of detention** such as:

- Denial of access to continuous OST for OST patients and substance abuse care;
- Inadequate provision of ARV treatment;
- Denial of access to medical advice and treatment for existing medical conditions;
- Denial of access to medical care for TB.

  - *The client was arrested. When at large, he was receiving OST medications at the OST-dispensing site. At the time of the detention, he said he was suffering from severe withdrawal and needed help from a drug addiction specialist, but all his requests were ignored both at the district police department and by the doctor in the detention center's medical unit. The client commonly experiences severe Methadone withdrawal symptoms, and as soon as he was in the detention center he contacted the REActor for help.*

  - *The client was arrested. Previously the organization's social workers escorted him to see the immunologist and helped him in getting ARV therapy. But when arrested, he was taken to the pre-trial detention facility and all his pleas for access to ARV therapy were ignored.*

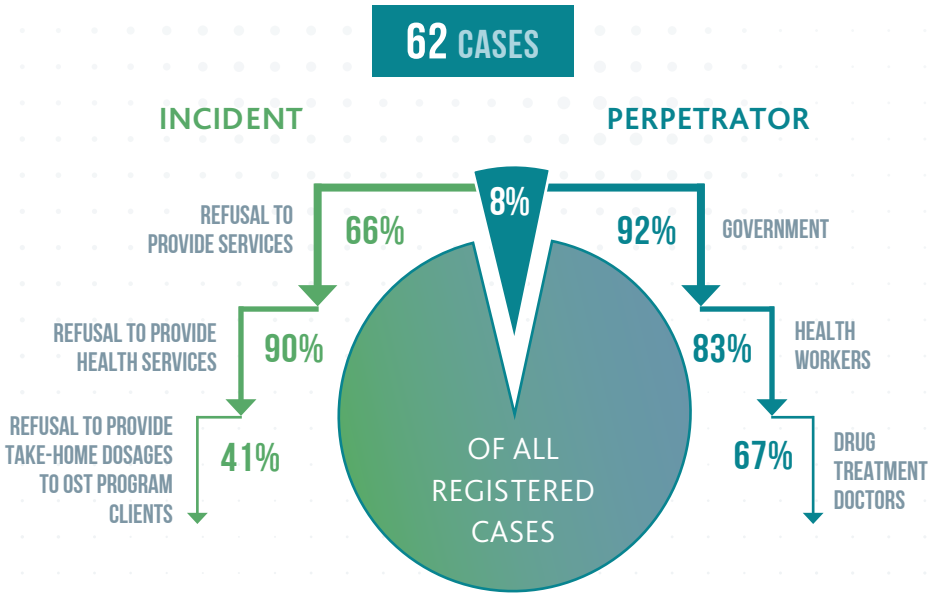
  - *The REActor received a phone call from a female inmate who was serving a sentence of imprisonment complaining about being deprived of access to ART and medical care (the woman had repeatedly approached the administration, presenting her requests in writing as well, but she was not taken out for an examination, nor any doctors were allowed to evaluate her, the administration neglecting to make sure the prisoner had proper access to ART).*

  - *The client has been arrested and is being held at the pre-trial detention center. He is also most at risk for TB as he has had TB before. When the client felt the familiar symptoms he asked the doctors for help in getting medication, but his request was rejected.*

8 COVID-19 AND RIGHTS VIOLATIONS AGAINST KEY POPULATIONS

Representatives of vulnerable communities often experienced barriers to exercising their rights in terms of effective access to treatment and medical care because of the situation with COVID-19. There were **62 documented incidents concerned with clients' violations of rights due to COVID-19-related quarantine restrictions** *(Figure 36)*.

FIGURE 36 COVID-19 RIGHTS VIOLATIONS



Such violations of rights include the following

1. **Repurposing of infectious diseases hospitals for the treatment of patients with COVID-19**, which necessitates referrals of PLHIV to other, non-specialized medical institutions. As a consequence of the repurposing of healthcare facilities, in a number of cases it has become impossible for some patients to receive inpatient treatment or be hospitalized. A case was reported where a client had died due to the constraints described.

   - *The client is a person with Category 3 disability. Every few years, he has to undergo a mandatory medical evaluation involving a hospitalization to have his condition re-evaluated by the medical assessment board and get his disability status re-approved and extended. In order to obtain a referral to the designated medical institution, the client came to see the infectious disease doctor at the AIDS Center. He reported to the doctor that he had recently noticed a significant deterioration in his health, as evidenced by his examination and test results. Seeing that, since March 2020, the infectious diseases hospital was re-purposed to treat patients with COVID-19, PLHIV have been re-directed to the municipal hospital. But they turn him away and refuse to have him hospitalized because, in the opinion of the doctors, his condition "is not critical and*

the hospital is unable to accommodate patients with this kind of situation," thus violating his right to treatment. It was impossible to complain to the health department in person due to the city's quarantine policies and limited ability to process personal matters.

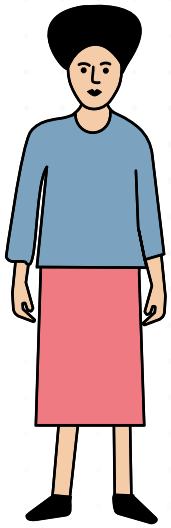
- *An OST patient contacted the REActor for a consultation. Her husband, who is also a drug-dependent person, has TB / HIV and is feeling poorly. When they had called for an ambulance, on two previous occasions, the medics provided medical care at home, but refused to take the patient to the hospital saying that only a TB specialist may refer him to the TB treatment facility and only an infectious disease doctor may refer him to the regional AIDS center, and that both clinics would not hospitalize patients brought in by an ambulance.*

- *A paralegal assistant got in touch with the NGO's senior social worker and was told that since this patient had only been discharged from the AIDS Center's inpatient unit on March 25, 2020 he could be re-hospitalized into the AIDS Center or hospice only after March 30, at the earliest. The paralegal gave the client contact information for the TB treatment center's social worker, the senior social worker at the AIDS Center, and the hotline numbers. After inquiries it was established that, first, because of the COVID-19 pandemic, the ambulance was not transporting patients to any specialized healthcare facilities, such as the TB treatment center or the Regional AIDS Center's inpatient unit, and second, that the Regional AIDS Center's inpatient clinic was converted into a reserve hospital to deal with COVID-19 patients in case the capacity of the city's hospitals would be not enough to accommodate the surge in patients. This patient died early Monday morning, on March 30, 2020.*

2. **Payment required for getting tested for COVID-19 when seeking care at a healthcare facility amid financial hardship due to lack of work provoked by COVID-19-related quarantine policies:**

   - *The client approached the REActor complaining about the doctor refusing to refer him to the designated physicians to have his condition re-evaluated by the medical assessment board and get his disability status re-approved and extended. The doctor is using blackmail by saying that he will be hospitalized only if he pays for two COVID-19 tests. Hospitalization is a mandatory condition for the medical assessment board to re-examine his health status.*

3. **Limited access to healthcare services and social assistance amid high unemployment:**



   - *Due to COVID-19-related quarantine restrictions, a woman client with HIV is unable to work and receive pay, which makes it impossible for her to support her two minor children. Her application to social services for assistance has been declined (as she does not meet the criteria to be eligible for additional social protection covered by the city's budget).*

   - *The client has been denied access to ARV drugs because she has not presented a test certificate required by the doctor. The doctor did not take into account the fact that the client would not be able to take these tests for free as she has no money to pay for the tests having been out of work for more than a month and staying at home in compliance with the COVID-19 quarantine policies.*

4. **Requirement that people living with TB be treated in the area of their residence, whereas the issue of their access to anti-TB drugs needed for treatment remains unresolved:**

   - *A client was being treated as an inpatient at the TB center. Due to the fact that starting from April 1, 2020 TB patients have to be treated in the area of their residence (due to COVID-19-related quarantine restrictions), he was transferred to the designated healthcare provider for treatment, but supplied with no medication needed.*

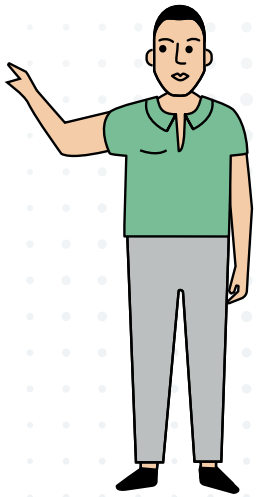
5. **The requirement that patients with communicable TB may be hospitalized only for up to two weeks, followed by subsequent transfer to a local outpatient setting:**

   - *The woman client went to see a TB specialist for assistance in accessing medical care and hospitalization services, but the doctor refused to help her because, starting from April 1, 2020, due to restrictions related to the COVID-19 pandemic, anyone with communicable TB may be hospitalized only for two weeks and then transferred to an outpatient treatment setting in the area of their residence. Also, she was refused medications and told to buy them at her own expense, as the TB center does not have the drugs needed.*

6. **Restrictions in public transportation have created travel problems and obstacles to visiting treatment facilities for ART and OST-dispensing sites:**

   - *The REActor was approached for help by an OST patient. During the telephone conversation, he shared details about the high-risk situation and non-adherence to the recommendations issued of the Ministry of Health regarding COVID-19-related quarantine policies. That day, a crowd of patients had gathered around in front of the OPT-dispensing site as the medication was to be dispensed both to those scheduled for Thursday and to those whose appointments were moved from Friday, May 1, the official day-off. Public transportation services during the quarantine period are only limited. City transportation runs with long delays. Patients who go out to work experience much difficulty getting to the OST site at 8 a.m. and then making it across the city to show up at work by 9 a.m. Due to a large crowd gathering outside, the anti-pandemic policies were not strictly adhered to, and many people were not wearing a face covering. The line was moving very slowly. Many patients were running late for work and this triggered loud arguments and shoving around.*

   - *The client lives in a remote area of the city and has to change buses when traveling to the AIDS Center. Due to the COVID-19 quarantine policies and the fact that you are allowed to travel on the fixed-route shuttle buses only if you produce a pass from work (the client has none as he is unemployed), he was not able to pick up his next batch of ARV medication. The client cannot afford to call a cab as it is too expensive for him.*



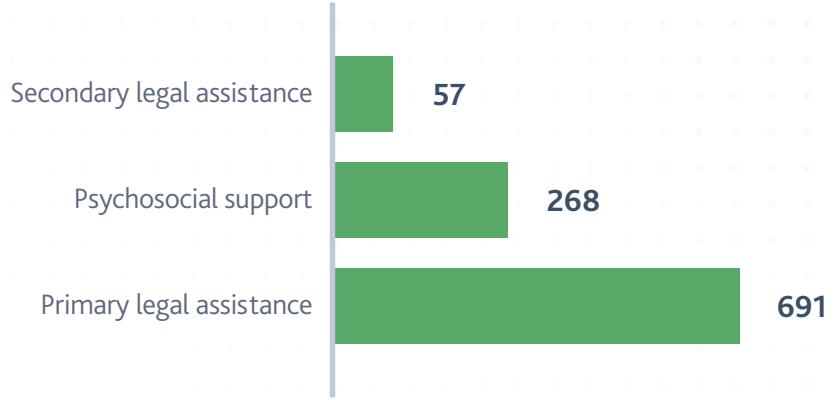
9 RESPONSE TO RIGHTS VIOLATIONS

The REAct system has demonstrated NGOs' robust potential and broad application prospects in providing assistance and responding to rights violation incidents.

> ! 84 % OF THE SERVICES PROVIDED WERE DELIVERED DIRECTLY IN AN NGO SETTING AT THE LOCATION OF THE REACTORS.

As part of the response to rights violations committed against clients, several types of assistance were provided by project REActors – **primary legal assistance** (68%), **psychosocial support** (26%) and **secondary legal assistance** (6%).

FIGURE 37 SERVICES PROVIDED AS PART OF THE REACT SYSTEM (TOTAL SERVICES)



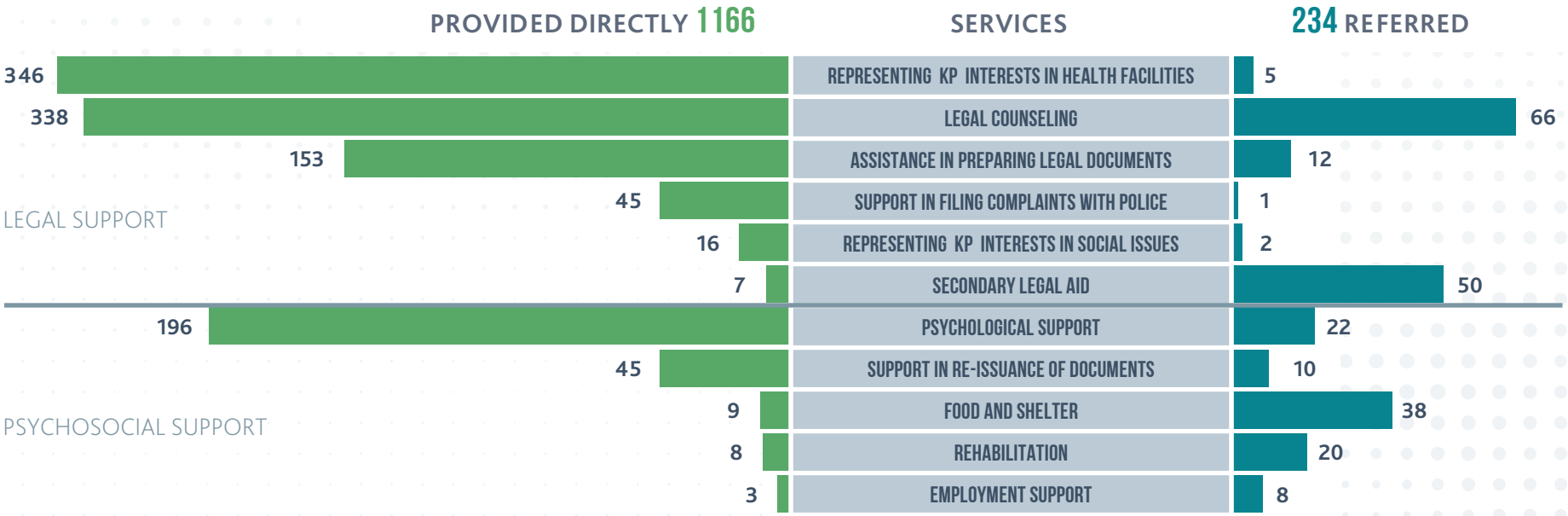
Primary legal assistance was most often provided to clients directly by the organization contacted. Primary legal assistance included:

1. Representation of clients' interests in addressing social support issues;
2. Providing client support for initial police interactions;
3. Assistance with drafting simple legal documents;
4. Legal consultation;
5. Representation of client interests in health care facilities.

In cases where a client's case required **secondary legal assistance,** clients were more likely to be referred to other organizations.

Psycho-social support services, such as psychological counseling and assistance with documents, were also, in most cases, provided directly to clients by the organization contacted. However, services such as assistance in getting access to food and shelter, rehabilitation services and employment were more commonly provided through referrals to other organizations.

FIGURE 38 RESPONSE TO VIOLATIONS OF THE KEY POPULATIONS' RIGHTS



10 CONCLUSIONS

- The right to health and the ability to exercise it are critical to both reducing vulnerability to HIV and TB and ensuring universal access to HIV and TB prevention, treatment, care and support[77]. Violations of the right to health are a significant barrier that limits efforts to engage with key populations at risk of HIV and TB in HIV and TB prevention, care and treatment activities and ensure client retention on a regular and sustainable basis. Manifestations of stigma and discrimination on the part of police, health care workers and other perpetrators reduce the willingness of key populations to stand up for their rights, contribute to and reinforce the feelings of legal insecurity and distrust towards state-funded institutions.
- The lack of government focus on human rights has a negative impact on the long-term outcomes of HIV and TB programs. Policies ensuring that human rights are duly respected, protected and fulfilled can lead to improved public health[78]. At the same time, laws designed to protect key populations, if incomplete or poorly enforced, can be harmful or ineffective.
- State guarantees in the context of HIV and TB, which are enshrined in a number of Ukrainian regulations, are declarative in nature. The implementation of these provisions is fragmented and inconsistent. Criminalization of the behavior of some most-at-risk communities, specifically PWID and SW, makes it possible to discriminate against them and legitimize their discrimination by other actors, as well as undermines their access to justice, serves as a cover-up and license for the police and non-state actors to violate their rights[79].
- The use of the REAct system in Ukraine has made it possible to document a number of rights violations against key communities in the context of HIV/TB. Due to the particularities of the system design, each case of rights violations was documented and cross-referenced to specific individuals, thus making it possible to track repeated applications and assistance provided in each particular case. The implementation of the REAct system has demonstrated a strong presence and capacity of civil society organizations across the project-sponsored regions in providing assistance and responding to cases of rights violations. The REAct system is working to strengthen interaction and collaboration between HIV-service and human rights organizations at the local level in that REAct enables service organizations to find resources for linking their clients to legal assistance.
- The recorded data provide an evidence base for implementing and expanding effective programs to address human rights-related barriers to accessing HIV and TB services, developing programs to protect the rights of key populations and improve legal literacy, as well as taking advocacy actions at both the regional and national levels.

77 *Meier BM, Gelpi A, Kavanagh MM, Forman L, Amon JJ. Employing human rights frameworks to realize access to an HIV cure. J Int AIDS Soc. 2015 Nov 13;18(1):20305. doi: 10.7448/IAS.18.1.20305. PMID: 26568056; PMCID: PMC4644771. https://pubmed.ncbi.nlm.nih.gov/26568056/*

78 *Enoch J, Piot P. Human Rights in the Fourth Decade of the HIV/AIDS Response: An Inspiring Legacy and Urgent Imperative. Health Hum Rights. 2017 Dec;19(2):117-122. PMID: 29302169; PMCID: PMC5739363. https://pubmed.ncbi.nlm.nih.gov/29302169/*

79 *Decker MR, Crago AL, Chu SK, et al. Human rights violations against sex workers: burden and effect on HIV. Lancet. 2015;385(9963):186-199. doi:10.1016/S0140-6736(14)60800-X https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4454473/*

11 RECOMMENDATIONS

Recommendations for civil society organizations, including those involved in documenting human rights violations:

1. Initiate regular training in an accessible form for police personnel on HIV/AIDS prevention, harm reduction and OST programs, as well as their impact on reducing criminal activity by communities such as PWID, guarantees of their rights, including the right to access OST and continuous treatment. Such training should be conducted with the involvement of successfully socialized representatives of key populations, whose personal example can help demonstrate the importance of such programs for communities.

2. Initiate trainings for health care workers to eliminate stigma and discrimination against key populations, raise awareness regarding the legislative guarantees of treatment and access to health care services, especially in the context of HIV/TB prevention, as well as the negative consequences of rights violations and liability for non-compliance. Such trainings should be conducted with the involvement of representatives of key communities, as well as legal experts from NGOs or cause-friendly lawyers.

3. Initiate trainings for representatives of key populations to improve their legal literacy, with a focus on typical cases concerned with violations of their rights. Preferably, such trainings should be conducted for each key group separately to duly address the specifics involved.

4. Prepare and distribute ***"Know Your Rights"*** compact-sized printed products (booklets, brochures) among key communities and present relevant information in an accessible form about the rights of key communities to access services and treatment, other rights, as well as ways to protect them.

5. Using various platforms for dialogue with government agencies, prepare a well-reasoned statement to call on the competent bodies to address the inefficacy of state policies in the area of combating HIV/AIDS and TB among the key groups in Ukraine, based on the evidence collected by the REAct system.

Recommendations for government agencies:

1. Consider adopting a consistent human rights approach to drug users and decriminalizing possession of drugs for personal use.

2. Facilitate the expansion of harm reduction programs, especially in prisons and detention facilities, as well as ensure the quality and adequacy of privatized OST programs.

3. Take necessary measures to combat the social stigmatization of drug users by training police, social workers, child protection workers and medical professionals and raising public awareness, especially regarding the right to health of drug users.

4. Pass legislation to ensure the explicit prohibition of discrimination on the basis of sexual orientation or gender identity. Train law enforcement, the judiciary, and other legal professionals to work on cases of discrimination on the basis of sexual orientation and gender identity.

5. Promote the elimination of negative stereotypes and stigmatization of most-at-risk populations, including through public awareness campaigns for the public, medical personnel, social workers, law enforcement, and other government officials.

6. Consider abolishing all forms of punishment for sex work, including administrative liability for engaging in prostitution. Develop and implement departmental guidelines for law enforcement officials on the limited use of criminal prohibitions against any actions associated with organizing prostitution where there are no indications of human trafficking or exploitation of prostitution.

7. The Ukrainian Parliament's Commissioner for Human Rights should expand opportunities for the use of information regarding human rights violations documented by human rights and other public organizations supporting victims of human rights violations. Provide for the possibility of discussing legislative initiatives to prevent massive and systematic human rights violations. Develop a National Preventive Mechanism (NPM) as a system for monitoring places of detention of various institutional subordination with NGOs participation; increase number of NPM monitors and monitoring visits; strengthen the public participation in the "Ombudsman +" model; improve informing the public on the monitoring visits findings, gained information, taken measures and effectiveness of the visits.

8. Bring the conditions of detention and the system of medical care at all places of deprivation of liberty in line with existing national legislation, recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the UN Standard Minimum Rules for the Treatment of Prisoners and the European Prison Rules. Ensure conditions for more effective independent monitoring of conditions of detention, including (but not limited to) the National Preventive Mechanism (NPM).

9. The bodies of the State Bureau of Investigation and the Prosecutor's Office should develop departmental instructions and procedures to ensure a prompt response to reports from public (community-based) organizations on cases of extortion by police officers. Take into account the need to ensure the safety of NGO representatives who report such cases, including through non-disclosure of information about the complainants, while respecting the requirements of a fair trial.

FOR NOTES

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ANALYTICAL REPORT

IMPLEMENTING THE REACT PROJECT IN UKRAINE: KEY POPULATIONS' RIGHTS VIOLATIONS IDENTIFIED IN THE CONTEXT OF HIV/TB AND RESPONSE TO THEM

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