Comprehensive External Evaluation of the National AIDS Response in Ukraine

Consolidated Report

January 2009

Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report (English original, January 2009)

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Preface

In twenty years since the epidemic was first recognized, Ukraine has mobilized unprecedented domestic and international support in response to AIDS, and has implemented an extensive range of HIV programmes and services. Yet, Ukraine continues to have the highest HIV prevalence in Europe and the Commonwealth of Independent States. With little indication that the alarming growth of the epidemic has peaked or slowed, AIDS now represents a threat to Ukraine's national socio-economic development and demographic stability.

The National Council requested UNAIDS to facilitate an external evaluation of the national AIDS response. The purpose of the evaluation was to identify why the epidemic has been unresponsive to efforts to control it, and to generate recommendations to strengthen Ukraine's response to AIDS. The new National AIDS Programme currently under development represents an opportunity to reflect on the results of the evaluation, and to redouble efforts to ensure that Ukraine reaches Millennium Development Goal 6 – to halt and begin to reverse the spread of HIV and AIDS by 2015.

The Evaluation Team, comprised of 32 independent international experts, conducted a comprehensive evaluation to assess the achievements, strengths, shortcomings and challenges to the national AIDS response. The results of the evaluation feature an extensive set of findings and time-bound recommendations on to how to improve key outcomes and impacts. The Evaluation Team encourages national partners to consider their timely implementation.

The key finding of the evaluation is that, in spite of important achievements made on specific issues, the national AIDS response must be significantly strengthened in order to have an impact on the epidemic. Renewed leadership of the Government of Ukraine is needed to implement widespread changes in national systems for planning, financing, management and coordination in order to ensure sustained progress and performance of the national AIDS response. Most urgently, the format and content of the new National AIDS Programme must be significantly enhanced if it is to serve as the overall framework for reversing the epidemic.

On behalf of the Evaluation Team, I would like to express our appreciation to the Government of Ukraine, non-governmental and international organizations, and many other key informants who contributed their precious time, views and provided access to invaluable information. It was a great pleasure to work with you.

I would also like to express our appreciation to all those in the UNAIDS Secretariat and Cosponsor agencies, and national experts who made extensive preparations for the evaluation, provided invaluable support to the Evaluation Team, and assisted in reviewing the results and finalizing the evaluation report.

The Evaluation Team assumes full responsibility for the content of this report. The long and complex task of the evaluation has now been completed, but the urgent task of considering and implementing the recommendations rests ahead. The ultimate impact of this evaluation will be determined by national partners in Ukraine.

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January 2009

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[1] The list reflects the organizational affiliations of individual members of the Evaluation Team at the time of the completion of the in-country phase of the Evaluation.

[2] This Evaluation reflects the collective views of the Comprehensive External Evaluation Team. The organizations that provided financial and in-kind contributions to the Evaluation are not responsible for the findings of the Evaluation, and their support should not be interpreted as their endorsement of its findings or conclusions.

Peace Corps
United Nations Children's Fund (UNICEF)
United Nations Development Programme (UNDP)
United Nations Fund for Population Activities (UNFPA)
United Nations Office on Drugs and Crime (UNODC)
United States Agency for International Development (USAID)
UN-AMICAALL Partnership Programme / United Nations Office of Project Services (UNOPS)
U.S. Centers for Disease Control and Prevention (CDC)
World Bank
World Health Organization Regional Office for Europe (WHO/EURO)

List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
Alliance	International HIV/AIDS Alliance in Ukraine
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioural Change Communication
CCM	Country Coordination Mechanism
CHAI	Clinton Foundation HIV/AIDS Initiative
CIDA	Canadian International Development Agency
CIS	Commonwealth of Independent States
Committee	Committee on HIV/AIDS and Socially Dangerous Diseases within the Ministry of Health
CSSFCY	Centre of Social Services for Families, Children and Youth
DPKO	UN Department of Peacekeeping Operations
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EIA	Enzyme Immunoassay
EU	European Union
FSW	Female Sex Worker
FBO	Faith-based Organization
GCP	Good Clinical Practice
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMP	Good Manufacturing Practices
GoU	Government of Ukraine
GTT	Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HLM	United Nations General Assembly High-Level Meeting on HIV/AIDS
HPI	Health Policy Initiative
HR	Human Resources
IBBS	Integrated Biological and Behavioural Survey
IDA	International Dispensary Association
IDU	Injecting Drug Users
ICF	International Charitable Foundation
IEC	Information, Education and Communication
ILO	International Labour Organization
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IT	Information Technology
JPS	Joint UN Programme of Support
KR	Key Recommendations
LFA	Local Fund Agent
LSBE	Life-skills based Education
MARA	Most at-risk Adolescents
MARP	Most at-risk Population
MARY	Most at-risk Youth
MDG	Millennium Development Goals
MEWG	Monitoring and Evaluation Working Group
MIS	Management Information System
MOEC	Medical Occupational Expert Commission
MoES	Ministry of Education and Sciences
MoFYS	Ministry of Family, Youth and Sport
MoH	Ministry of Health
MR	Main Recommandations
MSF	Médecins Sans Frontières
MSM	Men Who Have Sex with Men
M&E	Monitoring and Evaluation

NASA	National AIDS Spending Assessment
Network	All-Ukrainian Network of People Living with HIV
NC	National Council for the Prevention of Tuberculosis and HIV/AIDS
NGO	Non-governmental Organization
OCC	Oblast Coordinating Council
OHMADYDT	Hospital for the Care and Mothers and Children (Kyiv)
OI	Opportunistic Infection
OST	Opiate Substitution Treatment
PATH	Program for Appropriate Technology in Health
PDI	Peer Driven Interventions
PEP	Post Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PIU	Project Implementation Unit (for the World Bank-supported TB/HIV Loan Project)
PLWH	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient
Programme	National Programme for the Prevention of HIV-infection, Treatment, Care and Support for People Living with HIV and AIDS Patients
PSM	Procurement and Supply Management
Road Map	Road Map for Universal Access
RCF	Request for Continued Funding
SAT	Strategic Self-Assessment Tool
SDES	State Department for the Enforcement of Sentences
SGS	Second Generation Surveillance
SHR	Sexual and Reproductive Health
SSSFCY	State Social Services for Families, Children and Youth
SIDA	Swedish International Development Cooperation Agency
STARHS	Serologic Testing Algorithm for Recent HIV Seroconversion
STI	Sexually Transmitted Infections
SW	Sex Worker
SYREX	Syringe Exchange Database for Client Monitoring
TB	Tuberculosis
ToR	Terms of Reference
TRIPS	WTO Agreement on Trade Related Aspects of Intellectual Property Rights
UA	Universal Access
UIC	Unique Identifier Code
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
VL	Viral Load
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

Part 1: Executive Summary and Key Recommendations

1.1 Status of the AIDS Epidemic in Ukraine

Ukraine has the most severe HIV epidemic in Europe and the Commonwealth of Independent States. As of the end of 2007, Ukraine had registered 122,674 persons with HIV-infection. 25,318 deaths were officially reported among persons living with HIV, including 12,490 AIDS-related deaths, and 12,828 deaths among persons with HIV related to other causes.

The size of the HIV epidemic is steadily increasing, with a growing number of newly reported HIV infections every year since 1999. In 2007, 17,687 persons with HIV-infection were officially reported in Ukraine, the largest number ever reported since the beginning of HIV surveillance in 1987. This represented an annual increase of 10% in comparison to the number of new infections reported in 2006 (16,094).

All 27 regions of Ukraine have registered people living with HIV, but there is significant diversity in the epidemic between and within different regions. The highest levels of HIV-prevalence have been registered in South-Eastern Ukraine. In recent years, newly reported HIV infections have rapidly increased in central, northern, and western regions of Ukraine. Within regions, the epidemic is concentrated in large cities, with 78% of newly reported HIV infections in 2007 registered among urban residents. The number of officially registered HIV infections may also correlate with the number of tests performed and the structure of HIV surveillance within regions. In a majority of regions where the availability of testing remains limited, particularly among most at-risk populations (MARPs), HIV infections may be significantly underreported.

The HIV epidemic in Ukraine remains concentrated among MARPs, including injecting drug users (IDUs), women and men who sell sex (often called sex workers, SWs), men who have sex with men (MSM), and sexual partners of these populations. In 2007, officially reported modes of transmission indicate that 40% of newly diagnosed HIV infections were related to injecting drug use, 38.4% related to sexual transmission, and 19.4% related to mother-to-child transmission.[3] Among pregnant women, HIV prevalence has steadily increased in recent years. At the end of 2007, HIV prevalence among pregnant women in Ukraine was 0.52% – the highest of any country in Europe.

The number of officially reported HIV infections understates the magnitude of the epidemic. Based on the most recent estimates of the Ministry of Health, approximately 440,000 people [range 255,000–640,000] were living with HIV in Ukraine at the end of 2007. This is equal to an estimated HIV prevalence of 1.63% among the adult population of Ukraine (age 15-49). This prevalence is significantly higher than in any other country in Europe or in the Commonwealth of Independent States (CIS).

At the end of 2007, 7,657 people living with HIV were receiving antiretroviral treatment, including 908 children. The introduction of antiretroviral therapy (ART) has not produced a concomitant decrease in AIDS mortality. The continued increase of AIDS mortality indicates that the scale-up of ART is currently insufficient to reduce the rate of clinical progression of HIV-infection to AIDS and death.

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[3] Consistent with Ukrainian law, official figures on mother to child transmission include all children born to women with HIV, based on a positive antibody test. While newborns may initially test HIV-antibody positive, follow-up testing confirms that the majority are HIV-negative, leading to inflated figures in the cumulative number of persons diagnosed with HIV, and the proportion of persons infected via mother to child transmission. The accurate proportion of cases related to mother to child transmission is considered to be significantly smaller.

1.2 Status of the National AIDS Response

Since 2004, the national response to AIDS in Ukraine has significantly expanded and improved. A large and growing number of governmental, non-governmental and international partners at the national and sub-national levels have become actively involved in planning, implementation, advocacy and monitoring and evaluation (M&E) of HIV programmes and activities. Unprecedented national and external donor resources have been mobilized to support the implementation of programmes with a national scope.

Despite these achievements, the national response to AIDS in Ukraine remains inadequate to have a significant impact on the epidemic. With the exception of the national programme to prevent mother to child transmission, prevention programmes continue to lack the quality, coverage, intensity and scope to have a significant impact on halting the spread of HIV. The availability of ART has been expanded to all regions of Ukraine, but the scale-up of treatment does not cover the majority of those in need and remains inadequate to reduce AIDS-related mortality. The health sector lacks the capacity to diagnose, monitor and treat hundreds of thousands of Ukrainians that are estimated to be living with HIV – the majority of whom remain unaware of their status. As the epidemic continues to mature, there is extensive evidence to suggest that the current national response will not be effective in halting the spread of HIV or reducing AIDS morbidity and mortality.

The response of the Government of Ukraine remains inadequate to meet the current and future needs of such a serious and complex epidemic. While Ukraine is distinguished by exceptional leadership on AIDS at the highest level, demonstrated by President Yushchenko’s bold and consistent attention to the epidemic, leadership by the Head of State cannot compensate for a lack of commitment and management capacity in the Government of Ukraine. The national response to AIDS is being undermined by weak systems, out of date approaches and suboptimal programmes, particularly in the governmental sphere. Despite the significant and consistent increases in funding provided through the state budget, these resources have achieved few measurable results in the absence of adequate and consistent attention and support for the national AIDS response from senior levels of Government.

The Ukrainian National Law on AIDS and the National AIDS Programme provide the Ministry of Health with a leading role to coordinate the national response to AIDS. The Ministry of Health has not successfully fulfilled this role within the health sector. The Ministry of Health has also been unsuccessful in coordinating other governmental sectors that are directly responsible for HIV prevention, non-medical care and support, and has performed a limited role in supporting the contributions of non-governmental organizations (NGO), international organizations and development agencies. As a result, the National AIDS Programme (2004-2008) has consistently failed to meet its key goals of reducing AIDS morbidity and AIDS-related mortality, and has made little or no progress towards its other objectives.

With the adoption of the new Concept of the National AIDS Programme, and the development of the new National Programme for the Prevention of HIV-infection, Treatment, Care and Support for People Living with HIV and AIDS Patients - 2009-2013 (Programme), Ukraine will establish a new strategic framework for the national response to AIDS. While the new National AIDS Programme is the most comprehensive and well resourced programme ever developed in Ukraine, it has serious shortcomings, and still does not address many of the critical challenges that must be overcome if Ukraine is to reverse the epidemic in coming years. Early indications suggest that this new Programme, if adopted in its current form, will not be adequate to meet the most imminent challenges posed by the epidemic. This evaluation has outlined a series of recommendations that merit serious consideration and prompt action to further strengthen Ukraine’s national response to AIDS.

1.3 Key determinants of the continued growth of the epidemic

The HIV epidemic in Ukraine remains concentrated among MARPs, including, most significantly, IDUs. There is an exceptionally large population of IDUs in Ukraine, the majority of which remains beyond the reach of current prevention programmes. HIV prevalence among IDUs is significantly higher than in any other population, ranging from 18.0% to 62.8%. Emerging risk factors, such as injecting with preloaded syringes are not adequately addressed by current programmes. The same holds true for overlapping risk behaviours such as unsafe injecting coupled with unsafe sex and/or selling sex. Data indicates that the new wave of sexual transmission is closely related to unsafe sexual behaviour between IDUs and their sexual partners.

Female sex workers (FSW) and MSM are populations that report widespread risky behaviours and are also experiencing large and growing HIV epidemics. Surveillance among FSWs indicates HIV prevalence from 4% to 31%, with prevalence significantly higher among sex workers who also inject drugs and IDUs who sell sex for drugs. HIV prevalence among MSM ranges from 4.4% to 23.2%, indicating that male to male sexual transmission of HIV is significant. However, these groups are largely overlooked in the Ukraine's official system for epidemiological surveillance, which does not specify what proportion of sexual transmission is related to sex work or sex among men.

The coverage and quality of prevention programmes among these populations and sub-groups of most at-risk youth (MARY) and adolescents remain inadequate. Particular attention must be paid to prevention programmes targeting most at-risk adolescents (MARA). Evidence indicates that in addition less frequent coverage than their older counterparts, risk behaviour among MARA is more frequent and their vulnerability to HIV higher due to much lower levels of HIV-related knowledge, skills and perception of risk. Currently, no prevention programmes specifically target sexual partners of these MARPs or other bridge populations.

The rapid increase of HIV prevalence among pregnant women suggests that the epidemic is also growing among the general population. However, it is believed that the majority of new cases of sexual transmission are closely related to risk behaviours of MARPs. Data do not indicate any significant proportion of new HIV infections among the general population that is independent of sexual transmission originating from MARPs. Despite the growing number of children born to women with HIV, mother to child transmission accounts for a small and decreasing proportion of all reported HIV infections.

1.4 Summary of Current Scope of Programmes and Activities[5]

Section A: Programmes and Services

1.4.1 Prevention among Most At-Risk Populations

Importance: High
Progress: Moderate

Prevention programmes among most at-risk-populations and their sexual partners have a decisive role in determining the course of the HIV epidemic in Ukraine. At the end of 2007, over 300 governmental and NGOs were providing prevention services for these populations. Despite progress in the implementation of some programmes and services, prevention programmes among MARPs remain inadequate to keep pace with the scale and the intensity of the epidemic. The geographic scope of programmes has been uneven and the coverage of specific MARPs remains imbalanced. The scope, scale, quality and intensity of these prevention programmes remain inadequate to halt the spread of HIV among these groups and to limit the potential spread of HIV to the general population.

Among all MARPs, the most significant progress has been made in the scale-up of prevention services for IDUs in all regions of Ukraine. At the end of 2007, prevention services were provided for over 140,000 IDUs – 43% of the low estimated number of IDUs in Ukraine, but still inadequate to have a significant impact on the epidemic among IDUs.

Limited progress has been made in scaling-up prevention programmes among other MARPs. As of the end of 2007, only 21,000 FSWs, or 19% of the low estimated number of 110,000 sex workers had ever been reached with some form of HIV prevention services. Progress among MSM is even more inadequate – less than 10,000 MSM, or 5% of the low estimated number have ever been reached with prevention services The coverage, scope and quality of prevention interventions for the MARA also remains extremely low. Current programmes have not implemented early interventions among MARA and especially vulnerable adolescents who are on the verge of engaging in risk behaviours.

Prisoners are the only MARP that could be easily reached with comprehensive prevention programmes. Yet, only 45,000 of 130,000 prisoners, or 35% have ever been covered with any prevention services. Prison authorities remain opposed to the implementation of harm reduction and substitution therapy programmes, even though such programmes are advocated by government policy, and widely available outside of detention settings.

Serious gaps remain in the quality and coverage of priority interventions essential to the prevention of HIV among the MARPs. The most significant shortcomings include the insignificant coverage of opiate substitution therapy (OST) among IDUs, and the lack of prevention programmes among people living with HIV and their sexual partners. Targeted prevention programmes do not exist for many sub-populations at high risk, including for sexual partners of MARPs (i.e. sexual partners of IDUs, clients of sex workers, female partners of MSM), non-IDUs who are at increased risk of initiation of injecting drug use, and MARPs who remain beyond the scope of current prevention services. Few prevention programmes are designed to adequately address overlapping risk behaviours. There are extensive gaps in the evidence base related to sex work. Most prevention programmes are not gender-sensitive, and do not provide services for minors.

The quality and coverage of these prevention programmes need to be rapidly increased to optimal levels. However, coverage data suggests that the uptake of prevention programmes among MARPs is slowing down. The mechanisms for the delivery of these programmes

[5] The Executive Summary contains only a brief overview of the key findings of the evaluation. More detailed information on each of these areas is described in Part 4 of the Consolidated Report (National Response to AIDS - Main Findings), and the relevant technical reports.

need to be replanned and expanded to include more governmental services and services in smaller cities and towns. The quality of these programmes needs to be enhanced to rapidly increase coverage, ensure long-term sustainability, and demonstrate their impact on the epidemic among these populations.

Ukraine is one of the first countries of the Commonwealth of Independent States that has taken commendable measures to change and repeal all laws or policies that explicitly discriminate against MARPs, and removed explicit legal restrictions to the implementation of HIV prevention programmes and services. Yet, the Government of Ukraine is providing very limited financial support for prevention activities among IDUs, prisoners and some MARA, with no support provided for or involvement in prevention programmes among sex workers and MSM. The majority of prevention programmes among MARPs are supported by contributions from external donors – most significantly the Global Fund to Fight AIDS, TB and Malaria (Global Fund), and implemented by non-governmental and some faith-based organizations (FBOs), with little Government support or oversight.

The delivery of prevention services between governmental and non-governmental service providers remains poorly coordinated and presents a serious risk to the sustainability of prevention programmes currently supported by the Global Fund grants and the viability of overall national prevention efforts. If these obstacles are not urgently and seriously addressed, the HIV epidemic in these populations, already unresponsive to current prevention programmes, will continue to deteriorate.

1.4.2 Prevention among the General Population
Importance: Medium
Progress: Inadequate

HIV awareness and HIV prevention activities among the general population have improved in recent years, but the majority of key groups in the population remains beyond the reach of current programmes. Despite some notable exceptions among specific target populations, progress has been inadequate, with few measurable results.

Despite significant progress in promoting HIV awareness through life-skills-based education in the Ukrainian school system, in 2007 only 40% of young people knew how to protect themselves against HIV infection. A scarcity of trained teachers and resource materials has limited the consistent and comprehensive implementation of HIV awareness programmes in Ukrainian schools. University and college students, the most sexually-active age-group in Ukraine, are currently not covered by any consistent national HIV prevention activities.

Some positive HIV education and prevention programmes are being implemented for specific population groups, including prevention programmes among the military and some sub-populations of children, such as street children in shelters. Most key groups in the general population, however, remain beyond the reach of current programmes. Almost half of Ukraine’s workforce is employed in the private sector, and workers in the tourism sector and some industrial sector workers are at heightened risk, as many industries are located in regions with high levels of HIV prevalence. Yet, HIV education and prevention programmes in the workplace have been limited to pilot projects, covering some trade unions and a small number of private and public sector employers. Despite the rapid growth of sex tourism, current prevention programmes do not target clients of sex workers or sex tourists. Condoms are not regularly available in public toilets or hotel rooms throughout Ukraine.

Many existing public awareness programmes have limited coverage, suffer from poor design, implementation, M&E, and require extensive revisions and improvement. A successful national hotline and website are supported with funding from the Global Fund grant, but they receive little guidance and no support from the Government of Ukraine. Ukraine has yet to pursue innovative means to promote public HIV awareness among the general population, such as HIV education via the national mobile telephone network, consistent public service announcements on radio and television and public advertising, or

the integration of HIV awareness campaigns into larger public events such as high-profile sporting or cultural events.

In the absence of a national strategy for HIV prevention and national standards for the provision of prevention services, the quality and coverage of HIV prevention activities among general population groups, including public information and education programmes, remain low, with great variation in the quality of services provided.Primary HIV prevention and public awareness have an essential role in the comprehensive response to the AIDS epidemic in Ukraine. With limited resources, prevention programmes among the general population are not the most urgent priorities for the national AIDS response when the epidemic remains concentrated among MARPs. In the next few years, prevention programmes among the general population are not expected to have a decisive impact at reducing the number of new cases of HIV. Nevertheless, activities aimed at prevention and awareness among the general population, including stigma reduction, are an essential component in mitigating the impact of AIDS, and also play a pivotal role in creating a more supportive environment.

1.4.3 Voluntary Counselling & Testing and Rapid Testing

Importance: High
Progress: Moderate

The national system of voluntary counselling and testing (VCT) is one of the most developed components of the national response to AIDS. The coverage of VCT for many groups in the general population is increasing, with government facilities for VCT now available in all districts of Ukraine. Yet, the latest estimates indicate that as many as 350,000 people estimated to be living with HIV in Ukraine may not even know that they are infected. The majority of HIV testing is conducted among pregnant women and blood donors (37% and 31% of all tests, respectively), who are at relatively low-risk for HIV. The coverage of HIV testing and counselling among MARPs who are in urgent need of VCT, particularly IDUs, as well STI and TB patients, and prisoners, is low and inconsistent.

Large disparities exist between regions in the coverage of HIV testing and counselling and in the number of newly reported HIV infections. These disparities may be hiding the true extent of the epidemic in many regions that have allocated inadequate resources for the procurement of HIV test kits from local budgets, or who do not ensure that VCT is accessible for MARPs.

The National Law on AIDS specifies that all HIV testing is to be done on a voluntary basis, except for mandatory testing of donor's blood and organ samples, and must be accompanied by pre- and post-test counselling. In practice, however, several groups regularly undergo mandatory HIV testing, i.e. refugees do not receive pre or post-test counselling as part of the mandatory procedures for refugee status determination.[6] Children in temporary state shelters for minors are also regularly tested for HIV on a mandatory basis.

Voluntary HIV testing and counselling, consistent with the national VCT protocol, is most consistently provided by AIDS centres. Otherwise, the coverage and quality of informed consent and counselling remain poor and inconsistent. By law, only government clinics may provide VCT, but condoms or other prevention commodities are not regularly available in government facilities. Although testing is supposed to be free, an official certificate indicating a person's HIV status is usually provided in exchange for payment.

Rapid HIV testing has been recently introduced in Ukraine, with a focus on the use of rapid tests in maternity hospitals and on a pilot basis among MARPs. The experience with rapid testing among pregnant women is generally good, with rapid tests universally available at all maternity hospitals in Ukraine.

Based on the initial experience with rapid testing among MARPs, however, the quality of such testing is poor and the coverage remains extremely limited. Less than 50% of MARP

[6] Participants at training on HIV for leaders of refugee communities (UNDP, 2007)

clients with positive rapid test results have reported to AIDS Centres for confirmatory testing, indicating poor quality of VCT and ineffective referral systems by NGOs that are providing these services. Yet, the use of rapid tests among MARPs represents a unique opportunity to reach persons with high risk behaviours who may be already infected with HIV. Urgent revisions are required in the legal and regulatory framework to support the large scale-up of quality rapid testing by NGOs, in close collaboration with medical institutions. Additional changes are needed in regulation for the provision of follow-up services, particularly for MARA and homeless MARPs.

1.4.4 Laboratory Diagnostics and Patient Monitoring

Importance: High
Progress: Inadequate

The quality of laboratory diagnostic services is essential to ensure the accuracy of epidemiological data, and guide the decisions about treatment for patients with HIV. Yet, Ukrainian laboratories that specialize in HIV consistently lack adequate resources and conditions to provide quality assured results. Laboratory staff does not receive adequate training and support to perform their role, and the current infrastructure of most laboratories is not capable of handling the existing requirements. To meet future needs for diagnosis and clinical management, a massive expansion in HIV testing and a ten-fold increase will be required in the laboratory testing for clinical staging and monitoring of treatment outcomes. Slow progress is being made with the establishment of the national reference laboratory. However, in the absence of a national laboratory strategic plan and resources to improve the national laboratory system, the establishment of the national reference laboratory will still not resolve most of the serious shortcomings facing the laboratory system.

The national laboratory services need to be expanded and their capacity strengthened to meet the ambitious national targets set for HIV counselling and testing and to scale up the provision of antiretroviral treatment. This requires the immediate implementation of a rigorous laboratory system for accreditation, quality assurance, including external quality control and a procurement and supply management (PSM) system to ensure the regular and timely supply of laboratory supplies and equipment.

Serious shortcomings exist also in the area of registration, procurement and supply of HIV test kits. The majority of HIV tests in Ukraine are performed using test kits from one Ukrainian manufacturer. While it is assumed that these test kits are dependable, the accuracy and reliability of these test kits have never been independently assessed or validated, as required by international standards. The process for registration of test kits in Ukraine does not ensure that registered products have adequate sensitivity and specificity for use in the Ukrainian setting. The continued lack of any system for external quality control and quality assurance is a critical shortcoming that raises questions about the validity of all laboratory data for HIV surveillance and patient monitoring. Tendering procedures for laboratory equipment and supplies are also seriously flawed. The tender decisions are based exclusively on price, and do not adequately reflect the quality of the products and their appropriateness to the specific tasks, which often results in shortages and gaps in the supply of HIV tests and reagents.

1.4.5 Blood and Injection Safety, and Post-Exposure Prophylaxis

Importance: High
Progress: Inadequate

Systems for blood safety in Ukraine are well developed, and continue to receive priority Government attention and resources. The blood transfusion system, which tests all donated blood for HIV, is considered to be safe, and relatively well–protected from the risk of HIV transmission. The current surveillance system seems to be quite effective in detecting cases of HIV among blood donors, but it is not possible to exclude the risk of a small number of individual cases of HIV transmission through the blood transfusion system. Although HIV

prevalence among blood donors in Ukraine is the highest in Europe,[7] the number of HIV infections through contaminated blood or blood products remains very small. These risks do not represent a significant threat to public health, and are minor in comparison to other sources of HIV transmission, including mother to child transmission.

It is not possible to significantly reduce risks without shifting from the current practice of paid donorship to the establishment of a regular pool of voluntary blood donors with low risk behaviour. However, there are an insufficient number of voluntary blood donors with low-risk behaviour to provide a safe and adequate blood supply. Medical personnel regularly recommend blood transfusions for patients in exchange for financial gain, even if such transfusions are not medically justified, which further increases the risk of HIV transmission.

The safety of the blood supply is also severely hampered by the lack of any system for external quality assurance and quality control for laboratory test kits that are used in Ukraine. Plans to increase blood safety through the use of expensive testing laboratory equipment should not be implemented without first addressing the other basic problems identified above.

In the area of injection safety, there are adequate policies and procedures in the health system regarding use of disposable needles and syringes in hospitals, clinics and pediatric immunization centres. In practice, medical personnel regularly forgo the standard use of protective barriers. Some disposable commodities, such as disposable needles, syringes, latex gloves, and boxes for the disposal of syringes are in limited supply, particularly in resource poor regions. Patients are frequently expected to pay for such supplies out of pocket, or bring their own disposable supplies with them, which represents a risk for the safety and universal coverage of medical procedures. The lack of free and adequate supplies for safe injections also perpetuates fears among health workers of iatrogenic transmission of HIV. These fears may also enhance the discrimination of patients perceived to be infected with HIV.

HIV post-exposure prophylaxis (PEP) is available in all regions of Ukraine. However, PEP is stored and administered only at the regional AIDS Centres. Medical personnel outside of AIDS Centres have little training or knowledge about PEP for occupational exposure, and there is inconsistent use of PEP following non-occupational exposure to HIV in different regions of Ukraine.

1.4.6 Medical Care and Treatment

Importance: High
Progress: Moderate

The coverage and quality of ART programmes have a decisive influence on AIDS mortality and survival, and can also have a direct impact on reducing the transmission of HIV. Since 2004, rapid progress has been made in the provision of medical care and treatment for people living with HIV and AIDS in Ukraine. ART is now available in all 27 regions of Ukraine. Yet, the coverage of ART is not sufficient to meet the growing number of new patients in need of treatment. AIDS mortality remains high and continues to increase. 2,507 AIDS-related deaths were reported in 2007 – the highest number of AIDS related deaths since the beginning of the epidemic, indicating that the scale-up of treatment remains inadequate to have an impact on mortality.

Current plans in the new National AIDS Programme aim to provide over 40,000 patients with access to ART by 2013. Based on conservative estimates, this may be sufficient to meet the needs of only half of all patients with advanced HIV by 2013, leaving a large and growing gap in the coverage of treatment.

Opiate substitution therapy (OST) among opiate IDUs on ART can also have a significant impact on adherence and survival. However, the coverage of the current programme for OST remains insignificant, with no access permitted for IDUs under the age of 18. Serious

[7] To date, there have been reported a total of 21 cases of HIV infection related to contamination of blood and/or blood products, including 2 cases in 2006 and 1 case in 2007.

shortcomings also exist in the management of opportunistic infections, most significantly in the quality of diagnosis and treatment of tuberculosis (TB), which is the leading cause of death among AIDS patients.

The design and implementation of programmes for medical care and treatment partially meet current needs. In order to meet future needs, extensive revisions and improvements are needed in the strategy for the provision of treatment services and for the availability of adequate infrastructure and other resources. The most urgent issues that require attention are the decentralization of the provision of ART, the rapid scale-up of methadone-based OST, and the effective prevention, diagnosis and treatment of TB among people living with HIV.

The large projected increase in the number of people living with HIV in need of treatment and support represents a serious challenge for the Ukrainian medical system, which remains ill-equipped to manage a task of such scope and complexity. Urgent measures need to be taken to plan and implement the decentralized and integrated provision of medical care and treatment for people living with HIV, based on the successful experience in Donetsk oblast.

Systemic shortcomings also need to be addressed in this area, requiring extensive time and effort. These include the excessively high prices for some ART medications procured through the Ministry of Health, widespread illegal out of pocket payments by patients for diagnostic and some medical services, widespread stigma and discrimination faced by people living with HIV and members of vulnerable groups, and the lack of integrated, patient-oriented services. Effective treatment is hampered by the highly vertical nature of the medical system in Ukraine which is not focused on the needs of patients. Patients with multiple conditions (HIV, TB, opiate drug dependence) must visit different specialized health services almost daily, and often receive uncoordinated or inappropriate treatment and care. Approaches to provide integrated treatment and care services have been successfully piloted in select clinics, such as the Kyiv City AIDS Centre, and should be rapidly scaled up to other cities and regions.

The overall number of personnel working in the treatment and care of HIV is inadequate to meet future needs, underscored by the absence of a national plan for human resource development for AIDS.

1.4.7 Non-Medical Care and Support

Importance: Medium
Progress: Inadequate

A range of important non-medical care and support services now exists for people living with HIV in Ukraine. The majority of these services are being implemented by over 50 NGOs, mainly in large Ukrainian cities, and supported primarily by the Global Fund grants. Some of these services have produced notable outcomes in improving the quality of life for clients, particularly in the areas of adherence counselling, care for orphans and vulnerable children affected by HIV, and peer support for people living with HIV. However, the coverage of care and support services remains extremely low and inadequate to meet the scope and complexity of existing and future needs. As of the end of 2007, care and support services provided through the All-Ukrainian Network of People Living with HIV (Network) reached a cumulative number of 27,500 adults and children. This represents only 33% of all persons reported with HIV-infection, and only 6% of all persons estimated to be living with HIV in Ukraine.

The integrated care and support services that are currently available are provided at high cost for a small number of clients, without adequate focus on providing essential services for the most vulnerable clients. A large and growing number of people living with HIV do not have access to these services. This makes it increasingly difficult for organizations providing these services to focus on reaching persons living with HIV who need essential care and support services, instead of sustaining support for clients that access other, non-essential services that may be less viable to sustain. Care and support services should be replanned to ensure equitable coverage and sustainability for the most essential services. Variations in

the coverage and quality of care and support services are compounded by the consistent lack of government standards and funding. Extensive changes are also needed in the government system for provision of medical disability benefits for patients with HIV. The Medical Occupational Expert Commission (MOEC) is inefficient, providing people with HIV with limited assistance for short periods of time and is excessively complex to navigate.

1.4.8 Prevention of Mother to Child Transmission & Pediatric Care
Importance: Medium
Progress: High

Since 2004, excellent progress has been made in the prevention of mother to child transmission of HIV (PMTCT) and the treatment and care of children living with HIV. While the number of pregnant women with HIV continues to increase, the coverage of medical prophylaxis for PMTCT has increased to over 92%. The significant reduction in the rate of mother to child transmission is the only target achieved in Ukraine from the targets agreed to at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Despite this progress, a number of obstacles and shortcomings remain, including urgent needs to improve early diagnosis of newborns, and ensure overall coordination and monitoring of the national system for the PMTCT. If rapid and consistent action is taken, Ukraine is well positioned to further reduce mother to child transmission of HIV to meet international targets within the next few years.

In the area of treatment and care, children with HIV are regularly provided with preferential access to ART. In May 2008, the long-awaited National AIDS Pediatric Centre was opened at the OHMADYDT Hospital for the Care and Mothers and Children in Kyiv, providing pediatricians and their patients with an important source of clinical support and mentoring. However, serious obstacles remain in the coverage and quality of diagnosis and treatment of opportunistic infections among pediatric patients in many Ukrainian regions. Other barriers also exist in the areas of laboratory monitoring, the quality and supply of pediatric antiretroviral formulations. A limited number of medical specialists have experience in the timely diagnosis and treatment of children with HIV and AIDS.

Section B: Leadership, Coordination, and Institutional Capacity

1.4.9 Leadership
Importance: High
Progress: Moderate

The President of Ukraine has demonstrated exceptional leadership in the response to AIDS. However, the development of state policies and the implementation of programmes for the response to AIDS are the primary responsibility of the Parliament and the Cabinet of Ministers. In recent years, the Parliament has demonstrated limited interest or involvement in AIDS. Senior levels of the Government of Ukraine, from the Cabinet of Ministers to key governmental Ministries and agencies, have not exercised their potential role in leading or coordinating an effective national AIDS response. This situation is complicated by frequent turmoil in Ukrainian politics and frequent changes in government, which are undermining an effective national response to AIDS. If the national response to AIDS is a priority for the Government of Ukraine, the Cabinet of Ministers needs to rise above current political obstacles, demonstrate leadership and adopt consistent measures to refocus its commitment to AIDS.

1.4.10 Coordination
Importance: High
Progress: Inadequate

Ukraine has the architecture for coordination in AIDS that provides for representation and coordination among governmental and non-governmental partners at the national and subnational levels. In practice, however, this system is not functioning. Undermined by frequent political changes and inconsistent leadership by the Government, Ukraine continues to lack an effective system to ensure coordination of the national response to AIDS. In order to make much needed progress, extensive revisions are required to improve the performance of coordination systems at the national and subnational levels.

The National Council for the Prevention of TB and HIV/AIDS (National Council) has not performed its central role as the overall national authority to coordinate the national AIDS response. Since mid-2007 a number of urgent issues have not been seriously considered by the Council or any other governmental body.[8] The Committee on HIV/AIDS and Socially Dangerous Diseases within the Ministry of Health has been assigned the function of the Secretariat to the Council, but continues to lack sufficient capacity and has limited interaction with the Council's constituencies to perform this function effectively.

The recent establishment of the Coordinating Council on HIV/AIDS, TB and Drug Addiction under the President of Ukraine, provides much needed attention and high-level national leadership on AIDS. However, in order to minimize the risks of duplication, Ukraine must clarify the roles and responsibilities of the various policy development and coordination mechanisms, as well as ensure sufficient capacity for secretariat management to facilitate effective national coordination. In the absence of a functioning system for coordination, the contributions of various partners, particularly within the Government, will remain highly fragmented and ineffective.

1.4.11 National AIDS Programme
Importance: High
Progress: Inadequate

The National AIDS Programme is the key national framework that guides the national response to AIDS in Ukraine. The National AIDS Programme (2004-2008) has consistently

[8] Some of the urgent issues that have received little or no attention by the National Council include planning and guidance related to the development of the new National AIDS Programme, overall national coordination, the national system for PSM, human rights violations, slow implementation of substitution therapy, systematic problems with the World Bank loan supported project, guidance to the regional and local coordination councils, and effective oversight and support of the Global Fund grants.

failed to achieve its key objectives, making progress only in its objective to reduce the level of mother to child transmission of HIV. The Programme has been hindered by a series of shortcomings, from the lack of clearly defined responsibilities for management and implementation to the absence of dedicated funding for HIV programmes outside of the health sector. The Programme has been focused almost exclusively on government contributions, and has provided little guidance and support to non-governmental and external partners as to how to make coordinated contributions to the overall national response. The Programme has not specified measurable targets or indicators, and has lacked a M&E framework. Despite these obstacles, the Programme has witnessed a significant increase in annual funding from the state budget far beyond what was originally planned. These increases have enabled the scale-up of the coverage of some government services, particularly for voluntary testing and counselling, and ART for people with advanced HIV.

Some of these shortcomings have been addressed in the development of the new National AIDS Programme (2009-2013). The new National AIDS Programme represents the most comprehensive and well-funded programme ever developed by the Government of Ukraine. The elevation of the new Programme to the legal status of an 'All-National Programme' will ensure it is eligible for priority budget contributions from all levels of government (state, oblast, district). The new National AIDS Programme also includes a substantial increase of funding for key commodities, including, most significantly antiretroviral drugs, and unprecedented resources for other Ministries outside of the health sector.

However, questions persist as to whether the new National AIDS Programme includes the technical rigour and adequate resources to confront the serious challenges posed by the epidemic in the next five years. In December 2007, the President of Ukraine declared that the new National AIDS Programme must include adequate state resources to respond to the epidemic. In June 2008, the Cabinet of Ministers submitted the new National AIDS Programme to Parliament with a state budget contribution of 2,905M UAH (USD575M) for five years. While this represents a significant increase in state resources for AIDS, it will not be adequate to close the growing gaps for essential prevention and treatment services for all those in need.

The format and content of the new National AIDS Programme also repeats many of the structural shortcomings of the current Programme. The new Programme continues to assign responsibility for the majority of activities to multiple parties, so it remains unclear who is accountable for implementation of specific activities, and what is the role of other partners. While the contributions of the Global Fund grants are clearly specified in the new Programme for the first time, the specific contributions of other external donors and non-governmental partners are not indicated. The new National AIDS Programme does not specify clear priorities to guide prevention activities that are consistent with the pattern of the concentrated epidemic in Ukraine. These structural impediments will make it virtually impossible to monitor the extent to which the Programme is proceeding as planned, and whether specific activities are contributing to the specified outcomes and impacts.

The new National AIDS Programme also contains widespread gaps in the coverage of essential programmes, and does not specify how the Government will ensure that programmes for prevention, care and support will be sustained and enhanced upon the completion of external donor funding. It also remains unclear whether the new Programme can be effectively used for planning and budgeting of AIDS-related activities at the sub-national level. While regional governments had only limited input into the process of development of the Programme, they will be primarily responsible to deliver the enhanced services envisioned under the new Programme. The new Programme also does not specify what level of services is to be delivered in different regions, and how adequate resources will be mobilized. The new Programme also lacks a clear indication of the total volume of resources required, to what extent needs are covered, what gaps remain in meeting the resources needed and how these gaps may be filled. This will make it difficult to use the Programme to mobilize additional funding from various levels of the Government of Ukraine, and to use the Programme as the basis to apply to the Global Fund or other external donors for additional resources.

1.4.12 Planning, Budgeting and Financing
Importance: High
Progress: Inadequate

The Government of Ukraine has significantly increased state expenditures on activities for AIDS from 13.6M UAH (USD2.7M) in 2003 to over 108M UAH in 2008 (USD21M). Even larger state resources are planned under the new National AIDS Programme. However, if Ukraine aims to meet its international commitments to reach Universal Access to prevention, treatment, care and support, it is essential for the Government of Ukraine to significantly enhance the amount of resources it has committed to date. The budget limitations already facing the Government of Ukraine may undermine Ukraine's future capacity to mobilize the resources envisaged in the new National AIDS Programme, which are already inadequate. In the absence of a substantial increase in additional funding from the state budget, national and local governments will face increasing difficulty to deliver the services that are planned under the new National AIDS Programme, and may even risk a reversal of the hard-won progress achieved in recent years.

The potentially devastating impact of AIDS on Ukraine's medium-term socio-economic development has been well documented by the World Bank.[9] However, these projections have not been reflected by the Ministry of Economy in its development or revision of Ukraine's medium-term forecast of socio-economic development, and are not addressed in the new National AIDS Programme.

The process of government planning, budgeting and financing for AIDS is highly complex, and does not reflect fully the contributions of all partners. The process of planning and implementation of the National AIDS Programme does little to set clear programmatic and financial priorities. The National AIDS Programme lacks a comprehensive work plan with measurable targets, indicators, and clear delineation of responsibilities. The process of budgeting and disbursement of resources remains ad hoc and non-transparent, and is not well suited to the exceptional needs of the AIDS epidemic in Ukraine. Even once budget levels have been set, the expenditure of state funds by the Ministry of Health is extremely slow and unpredictable.

While the Ministry of Health has overall responsibility for the development of the National AIDS Programme and its related budget, the Ministry of Finance exercises a *de facto* "veto" over activities and costs that it deems inappropriate for the Government to cover. The Ministry of Finance lacks the technical expertise to appreciate the potentially devastating consequences of such decisions on the development of the epidemic. The current practice of limiting state budget allocations for AIDS is in conflict with other laws of Ukraine that guarantee free access to prevention, VCT, treatment, care and support services.

Estimates of expenditures for AIDS indicate that over half of all expenditures in Ukraine are out of pocket expenditures of private citizens, or contributions from external donor sources. Although free healthcare for all citizens of Ukraine is a constitutional right, the fact that external donors and individuals living with HIV are paying for a significant portion of their care suggests that the Government of Ukraine is not providing adequate financial resources for covering these services.

Expenditure tracking is also essential in the planning, costing, budgeting, financing and reporting on HIV-specific activities. Yet, the state budget classification does not include a separate budget line specific to AIDS, making it impossible to monitor the amount, rate and adequacy of government expenditures on AIDS at the national and subnational levels.

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[9] The Socioeconomic Impact of HIV/AIDS in Ukraine (see: http://siteresources.worldbank.org/INTUKRAINE/Resources/328335-1147812406770/ukr_aids_eng.pdf)

1.4.13 Government Sector Management and Stewardship
Importance: High
Progress: Inadequate

The top-down approach to central planning in most Government institutions has resulted in extensive bureaucracy with high costs and slow management processes, which are especially detrimental to the Government's response to AIDS. The vertically structured systems for planning and implementation of state programmes within Ministries and between government sectors create serious barriers to multi-sectoral collaboration and flexibility that is essential to an effective national response to AIDS.

The management of the National AIDS Programme continues to be dominated by medical specialists who have limited experience in planning and management. Within the Ministry of Health, the Committee on HIV/AIDS and Socially Dangerous Diseases continues to lack adequate staff, resources and office space to perform its role as body of the Government of Ukraine responsible for the implementation of the National AIDS Programme. Staff within the Committee are responsible for coordination and implementation of complex, technical issues for which they lack adequate experience and training. A series of revised Government policies now require the implementation of approaches to planning and management of state programmes that encourage performance and generate results.[10] Yet, these approaches are being implemented slowly in the health sector, and there is limited evidence of their influence in improving the Government's management of the national response to AIDS.

The Government needs to radically reform its approach to management of the national response to AIDS, beginning with the stewardship and coordination functions of Ministry of Health. The response needs to be refocused to enable senior levels of management to lead, support and empower those who are implementing AIDS programmes and activities, and provide incentives, instead of sanctions, for better performance.

1.4.14 Procurement and Supply Management
Importance: High
Progress: Unacceptable

The challenges identified in the area of PSM represent a systematic weakness in Ukraine's national response to AIDS. Although much focus has been on the high cost of antiretroviral medications procured by the Ministry of Health, Ukraine continues to lack a clear national policy and system for PSM of commodities, equipment and service for AIDS, resulting in poor coordination among key national partners.

The Government Procurement Law and tender regulations allow undue influence of a limited number of suppliers and the ability of suppliers to appeal at will. Bidding processes are out of date and overly restrictive, focusing excessively on the price of tender submissions, and not on the quality or suitability.

The ongoing political instability in Ukraine's government has led to frequent changes of Ministers of Health and other senior officials, perpetuating neglect of the shortcomings in the area of PSM. In 2008, the Ministry of Health has demonstrated significant progress in purchasing antiretroviral drugs at considerably lower prices than in the past, indicating that progress is finally being made. However, the prices paid by the Ministry of Health for some items remain significantly higher than prices paid for the same commodities by procurement mechanisms managed by the International HIV/AIDS Alliance in Ukraine (Alliance), with support from the Global Fund grants.

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[10] These policies and regulations include revisions to the Budget Code of Ukraine, the Law of Ukraine on State Targeted Programmes, the Law of Ukraine "On State Forcasting and Development of Programmes on Social and Economic Development of Ukraine," and the Resolution of the Cabinet of Ministers of Ukraine "On endorsement of the concept of applying the targeted programme approach to the budgetary process".

In order to sustain and expand access to essential equipment and commodities for prevention, diagnosis and treatment on a timely and cost effective basis, the Government of Ukraine needs to adopt a strategic approach to PSM that addresses the urgent needs of the National AIDS Programme. The extent and speed with which the Ministry of Health is able to implement significant changes in the area of PSM for AIDS can result in the savings of tens of millions of hryvnia, which could be better used to expand the coverage and quality of programmes and services.

1.4.15 Human Resource Development

Importance: High
Progress: Moderate

Ukraine has an adequate supply of highly educated and well trained human resources in the health sector to address the future needs of the AIDS epidemic. The majority of personnel that are currently providing services specifically focused on HIV have received basic training and many medical personnel at the regional AIDS Centres have received advanced training and some mentoring. However, there is a systematic lack of reliable information on the number and skills of human resources that are currently involved in HIV/AIDS activities in Ukraine. The current status of human resources is not centrally monitored, as no system exists to collect and use information on human resources to address current and future needs.

While adequate human resources exist in Ukraine, they have yet to be effectively mobilized for the national response to AIDS. Many of the personnel who are engaged in the delivery of health or social services are severely underpaid and frequently overworked, which represents a significant barrier to the mobilization of additional human resources. Widespread shortages of human and institutional capacity exist in the delivery of programmes and activities for AIDS. Particularly in the health sector, thousands of personnel that should be providing HIV services have never received any training or support. The NGO sector is also facing limitations, unable to hire and train adequate personnel to meet ambitious targets for prevention, care and support services. HIV prevention has yet to be mainstreamed into the social, education and legal sector at large, as well as into training programmes for non-HIV specific health services, which would increase coverage and entry points for HIV prevention.

The unequal salary scale in governmental and NGOs providing HIV services has led to increased tension between the two sectors, and in brain drain from governmental institutions to NGOs.

If strategic measures are taken to better coordinate, recruit, develop and maintain human resources, Ukraine is well positioned to mobilize existing human resources to ensure the provision of an adequate workforce for the national response to AIDS.

1.4.16 Epidemiology & Surveillance

Importance: High
Progress: Substantial

The Ukrainian AIDS Centre has done a commendable job with limited staff and available resources to manage an accurate and up to date national system of case reporting for HIV and AIDS, sentinel surveillance and the compilation of national HIV testing data. These efforts have yielded a reasonable epidemiologic portrait of the large Ukrainian epidemic. These data have also enabled the development of prevention, care and treatment efforts and for national and local partners to address some of the most pressing aspects of the epidemic. Ukraine has also developed a series of up to date national estimates of the HIV epidemic, based on the best available data and internationally recommended tools and methods. However, there is inadequate staff at the Ukrainian AIDS Centre and at regional AIDS centres to manage a national case reporting system of this scale and complexity.

Significant progress has been made in improving the quality and coverage of behavioural and sentinel surveillance among MARPs. However, the Government provides little or no financial support for these priority areas of epidemiological research. Linked behavioural and sentinel surveillance among MARPs, which is essential to monitor trends in the epidemic, is supported almost exclusively by contributions from external donors. Valuable epidemiological data on outbreaks, trends, and emerging risk factors are still not adequately analyzed or used to design and implement more effective prevention programmes.

1.4.17 Monitoring and Evaluation

Importance: High
Progress: Substantial

M&E has been an area of important achievements in Ukraine, including the recognition at national and regional levels of the importance of M&E for evidence-informed policies and programmes. The formulation and endorsement of a set of national M&E indicators has also been a significant development. These indicators were used to prepare a series of Ukraine's UNGASS reports, including the recent 2008 UNGASS report, which is a strong summary of the status of Ukraine's national response to AIDS. Led by the Alliance, progress has also been made in the development of a robust national system for progamme monitoring. At the subnational level, regional M&E indicators have been successfully piloted, and provide a strong basis for the regular collection of M&E data that can be compared between regions.

Despite these achievements, one integrated national M&E system still does not exist. The main obstacle is the continued lack of a national M&E centre with a mandate to provide overall guidance and coordination to the national M&E system. The lack of harmonised programmatic M&E systems and tools is also a barrier to more efficient monitoring of programmes and services. Most M&E data-collection of programmes and activities is still driven by external reporting requirements from donors and for UNGASS reporting, rather than by the national and local information needs of service providers, programme managers and policy-makers. The new National AIDS Programme was not developed using evidence from the national M&E system, and critically lacks an M&E framework. The capacity and ability of national experts to collect, analyze and use M&E data to plan and improve programmes still remains limited.

Section C: Cross-Cutting Issues

1.4.18 Human Rights
Importance: High
Progress: Inadequate

The Ukrainian National Law on AIDS is recognized as an example of national legislation that contains extensive and commendable provisions for the protection of human rights of people living with HIV, and some other groups affected by the epidemic. There are also no explicit legal restrictions or barriers in Ukrainian law to the implementation of HIV/AIDS progammes and services.

Despite the extensive provisions for the protection of human rights in Ukrainian legislation, these laws and regulations are not being enforced. People living with and affected by HIV/AIDS face pervasive stigma and discrimination, which is a serious impediment to the accessibility and effectiveness of services. Poor prison conditions and abusive police practices increase vulnerability to infection, hamper prevention and treatment efforts, and perpetuate stigma and discrimination against MARPs and people living with HIV. The legal rights of refugees to access HIV treatment, care and support services need to be clarified, and stronger mechanisms are needed to prevent, monitor, and address human rights violations against IDUs and sex workers. There are also serious shortcomings in the regulations and enforcement mechanisms for child protection, which fail to protect children who are especially vulnerable or most at-risk for HIV infection from violations of their rights. Many of these shortcomings could be addressed through the rapid development and implementation of a national policy to protect MARPs and people living with HIV from stigma and discrimination in all governmental and non-governmental services. However, changes or revisions to laws and regulations will not lead to improvements in human rights if mechanisms are not strengthened to ensure their enforcement.

1.4.19 Contribution of the Global Fund Grants to the National AIDS Response
Importance: High
Progress: High

As of December 2007, the Global Fund Board had approved total funding of US$130M for Rounds 1 & 6 grants for HIV prevention, treatment and care in Ukraine. The programmes supported by these grants have made substantial contributions towards the national AIDS response in Ukraine, catalyzing the process of scaling-up essential national programmes and services. These contributions are most significant in the areas of access to harm reduction among IDUs, ART, non-medical care and support, VCT, PMTCT, school-based HIV education and building local capacity. Impressive progress in the implementation of the Global Fund supported programme was achieved by the Alliance, which has served as the sole Principal Recipient (PR) for the Round 1 grant since early 2004. Despite this progress, it is too early to conclude that the Global Fund grants have had a singular or decisive impact on reduction of HIV morbidity or AIDS-related mortality.

In the area of prevention among IDUs, the Global Fund Round 1 grant has played a unique role in the significant scaling-up of prevention programmes among IDUs in almost all regions of Ukraine. As a direct result of the support from the Global Fund, Ukraine now has one of the largest national prevention programmes among IDUs in Eastern Europe. Insofar as IDUs remain the population most heavily affected by HIV in Ukraine, this is one of the most substantial achievements in the national response to HIV. Even in this area, however, evidence is insufficient to indicate that the Global Fund programmes have resulted in a change in the course of the epidemic among IDUs.

Progress has been limited under the Global Fund Round 1 grant in scaling-up prevention programmes among other populations engaging in HIV risk behaviours, including sex workers, MSM, vulnerable groups such as prisoners, and the sexual partners of these

MARPs. Very limited attention has been paid to minors and young people who engage in HIV risk behaviours and other groups of MARA. If the current Global Fund Round 6 grant is to have an impact on the epidemic among key MARPs, then the quality of services delivered will need to be improved and their coverage rapidly expanded.

The Global Fund's principle of performance-based funding, with a strong focus on accountability, encouraged the Alliance to ensure the timely implementation of activities, systematic monitoring of service delivery and use of this monitoring data for evidence-informed decision making. The implementation of the Global Fund grants has effectively mobilized civil society and has contributed to community systems strengthening for the national response to AIDS. Support from the Alliance as PR was instrumental in the development of the organizational capacity of NGO partners and community based organizations. More than 150 national, regional and local NGOs have served as sub-recipients of the Round 1 Global Fund grant and continue to provide essential prevention, care and support services. The impressive performance of the Alliance as a PR demonstrates that direct financing of Global Fund grants to civil society recipients can improve the speed of grant implementation and help to mobilize additional implementation capacity.

Despite these achievements, the implementation of the Global Fund grant supported programmes continue to face a series of serious challenges and shortcomings:

I. The lack of Government ownership of the Global Fund grants leaves responsibility for their implementation largely in the hands of civil society. The Government needs to fulfill its role to work in partnership with the different sectors and stakeholders in order to ensure that the Global Fund grants are being aligned and harmonized to meet national goals and objectives.

II. The National Council is not fulfilling its oversight responsibility for grant implementation. The Global Fund requirements specify that a country coordination mechanism (CCM) should ensure that the Global Fund grants are being implemented according to the agreed work plan and harmonized and aligned with the overall national response.

III. The Government of Ukraine has not developed plans to ensure the long-term sustainability of the programme activities supported by the current Global Fund grants. Unless there is a significant change in Government policy to strengthen government support and increase funding for services provided by NGOs that are currently funded by the Global Fund grants, the majority of ongoing services cannot be sustained when the current Global Fund grants come to an end.

IV. Internal mechanisms of each of the PRs remain inadequate to manage risks and provide effective governance and technical oversight of grants of this size and complexity, and need to be rapidly enhanced for compliance with international standards for governance.

V. Initial experience with implementation of the Round 6 grant has highlighted a number of serious challenges, some of which are a function of poor planning, inadequate coordination, and the sub-optimal division of responsibilities between the PRs.

VI. The recent problems encountered by the Government's refusal to grant duty-free status to medicines procured under the Global Fund grant supported programmes is a serious obstacle to the implementation of these programmes, and undermine Ukraine's credibility as a supportive recipient of Global Fund grants. This issue can only be resolved through engagement by the Government of Ukraine and should be done on a priority basis.

These and other shortcomings facing the Global Fund grants must be addressed prior to commencement of Round 6, Phase 2 grant, and before Ukraine applies for any new grants from the Global Fund.

Section D: Conclusions and Key Recommendations

1.5 Overall Assessment of the National AIDS Response in Ukraine

The national AIDS response in Ukraine needs to be significantly and rapidly enhanced in order to have a positive impact on the epidemic. Despite important achievements on specific issues, overall progress remains inadequate in key programmatic areas of prevention, treatment, care and support. There is little, if any evidence to indicate the epidemic is stabilizing, or that the the most extensive activities and interventions are having a decisive or even significant impact on overall trends.

Significant progress has been made towards some national targets, particularly in the area of improving knowledge and awareness of HIV and enhancing safer behaviours among some MARPs. Otherwise, progress and performance in almost all other areas has been consistently moderate or inadequate, and falls far short of the objectives of the National AIDS Programme and Ukraine's international commitments in response to AIDS. Current trends suggest that Ukraine will not reach national targets specified by its international commitments under the UNGASS Declaration of Committment or the Political Declaration on HIV/AIDS adopted at the 2006 UN High Level Meeting on AIDS, such as the achievement of Universal Access to prevention, treatment, care and support by 2010. There is still adequate time and potential to reach the Millennium Development Goal 6 – to halt and begin to reverse the spread of HIV and AIDS by 2015. However, achieving this goal will require a significant redoubling of efforts by the Government of Ukraine, national partners, and external donors.

Serious shortcomings exist in the design and implementation of the National Programme and activities – foremost is the coverage and quality of priority interventions essential to the prevention of HIV among MARPs. Excessive focus has been on the rapid scale-up of coverage of programmes, without adequate attention to ensure the quality and intensity of interventions that will result in consistent changes towards safer behaviours.

Among IDUs, these gaps are being addressed too slowly and superficially to have an impact on the spread of HIV that is already far advanced in this population. OST is one such essential intervention already facing serious barriers to implementation. The current coverage and future plans for scale-up of OST are inadequate to halt the spread of HIV among IDUs.

Except for limited funding provided by the Government for prevention among IDUs and prisoners, the Government provides no financial or programmatic support for prevention programmes in sex work settings and for MSM, and other high priority bridge populations, where coverage remains suboptimal or insignificant.

Other national initiatives which have limited support from the Government, such as public HIV awareness campaigns or public events, should be essential components of a comprehensive response. But the implementation of these initiatives has been ad hoc and poorly coordinated, with little impact on preventing new cases of HIV.

The PMTCT is the only area where progress has been high, and results have consistently met or exceeded targets. The coverage of the national programme for the PMTCT can be cited as model to other countries as a successful national intervention. Significant obstacles remain in this area, but with prompt attention and limited resources, they can be quickly overcome with relative ease.

Ukraine has a highly developed health infrastructure and resources, but these resources have been poorly mobilized to support the integrated diagnosis and treatment of people living with HIV and AIDS who are also facing other life-threatening health conditions. In key areas, such as the prevention, diagnosis and treatment of TB in people living with HIV, existing vertical health systems are not integrated, which contributes to excessive morbidity and mortality among patients with advanced HIV.

The majority of HIV testing is done without informed consent and pre- and post-test counselling, as required by law. Most people tested for HIV are low risk blood donors and pregnant women, with low and inconsistent coverage of other populations. NGOs lack a legal basis to provide rapid testing for HIV, but continue to implement VCT among MARPs without adequate training and quality procedures. AIDS Centres remain vehemently opposed to the rapid testing offered by NGOs, but are not able to provide other mechanisms to reach these populations. As long as the majority of people engaging in HIV high risk behaviour have never been tested and remain unaware of their HIV status, the epidemic will remain unresponsive to prevention and treatment efforts. HIV testing among MARPs and MARA, especially for those living on the streets, also requires better regulation and provision of adequate follow-up support and care services, which are not yet in place.

The capacity of the network of AIDS Centres is severely limited, and in many regions is already overburdened. No system for laboratory accreditation and external quality control of laboratory testing exists – critical shortcomings which raises questions about the accuracy and validity of all HIV test results. Despite progress in the area of treatment, Ukraine is not able to provide free and sustainable treatment for a majority of patients living with advanced HIV access, as required by Ukrainian law. Tens of thousands of new patients with advanced HIV will require treatment in coming years, yet the health sector is unprepared to provide effective diagnosis, laboratory monitoring and treatment. There is no national plan for development of human resources in the health sector, and the majority of health personnel have never received any training on HIV prevention, counselling, or treatment. The same lack of preparedness exists in non-medical sectors (i.e. social services), which play a critical role in HIV prevention, harm reduction and the provision of care and support services.

Despite exceptional leadership by the President of Ukraine, the Cabinet of Ministers has not exercised its potential role in leading or coordinating an effective national response to AIDS. Frequent turmoil in Ukrainian politics and frequent changes in government continue to undermine the central role of the Government in the national response. The Ministry of Health and its Committee on HIV/AIDS and Socially Dangerous Diseases continues to lack the capacity to manage the implementation of the National AIDS Programme at the national and subnational levels, especially in the area of HIV prevention. If the Government of Ukraine does not enhance its commitment to AIDS to ensure the implementation of an effective national response, the AIDS epidemic will continue to deteriorate, and threaten Ukraine’s socio-economic development and demographic stability.

The National Council has not performed its central role as the overall national authority for the coordination of the national response to AIDS in Ukraine. The recent establishment of the Coordinating Council on HIV/AIDS, TB and Drug Addiction under the President of Ukraine enhances the political visibility of AIDS, but enhances the risks of duplication and confusion as to which body has ultimate responsibility for AIDS. Ukraine must clarify one body with overall national authority for the coordination of the national AIDS response, and ensure that this body is functional. In the absence of a functioning system for coordination, the contributions of various partners, particularly within the Government, remain highly fragmented and ineffective.

The new National AIDS Programme (2009-2013) represents the most comprehensive and well-funded programme ever developed by the Government of Ukraine, and includes unprecedented state resources for AIDS. However, this new programme still lacks the technical rigour and adequate resources to confront the serious challenges posed by the epidemic in the next five years. If the content and mechanism for implementation of the new programme is not significantly improved, it will not be possible to use the Programme as the basis to close the growing gap for essential services for prevention, treatment, care and support for all those in need.

A range of shortcomings in government systems continue to undermine the effectiveness of current activities. Government systems for PSM, ad hoc approaches to human resource

development and systematic stigma and discrimination towards people living with HIV and vulnerable groups in government services represent critical shortcomings in the national response to AIDS. These shortcomings are compounded by widespread examples of weak or inconsistent Government leadership, oversight, funding and support for externally-supported programmes, including most significantly, the Global Fund grants. Despite large and growing contributions from non-governmental and international partners, including civil society, the United Nations, and key bilateral partners, the focus and impact of these contributions are limited by the overall lack of Government commitment to support these programmes.

Ukraine's response to AIDS is distinguished by the leading role of NGOs, and in particular of people living with HIV, as key partners at all levels of the response. NGOs have been effective advocates for strengthening the national response to AIDS, and leading the movement towards Universal Access. Led by the Alliance and the Network, a large and growing network of Ukrainian NGOs have demonstrated their capacity to develop, implement and monitor successful programmes and activities that consistently meet or exceed targets.

With support from the Global Fund grants, many of these programmes have provided catalytic support for government programmes in VCT, PMCT, and ART, effectively compensating for the lack of adequate Government resources and support. As organizations such as the Network focus on implementation of large programmes and services as the PR for Global Fund grants, they risk undermining their role as effective and independent advocates on behalf of civil society. The systematic lack of Government involvement and support for programmes and activities implemented by NGOs also represents a serious risk to their short-term results and long-term sustainability.

1.6 Main Strengths and Achievements of the National AIDS Response

The main strengths and achievements of the national AIDS response include:

- laws and legislation that provide a strong legal foundation for an effective national response to AIDS
- exceptional leadership by the President of Ukraine in drawing much-needed attention to AIDS and encouraging the Government to increase resources and improve performance
- significant increase in resources for the national response to AIDS, particularly from the state budget
- architecture for a coordinated response to AIDS exists at the national and sub-national levels
- large and growing national programme for harm reduction and HIV prevention among IDUs, implemented by governmental and non-governmental organizations
- effective national programme for the PMTCT
- leading role of NGOs, including a high profile role for people living with HIV
- networks for coordination and collaboration within sectors and among some partners
- international interest and donor commitment in support of the national AIDS response
- highly developed system for routine epidemiological surveillance that provides timely data for monitoring of trends
- key elements of a national system for M&E exist, including a system for programmatic monitoring and regular linked epidemiological and behavioural surveillance studies
- successful implementation of the Global Fund Round 1 grant supported programme that has made effective contributions to the national response
- some prevention and care activities that have been initiated in almost all areas of the national response which provide a basis for future scale-up of programmes

1.7 Main Shortcomings and Weaknesses of the National AIDS Response

The main shortcomings and weaknesses of the national AIDS response include:

- systematic lack of implementation of national laws and legislation
- weak and inconsistent leadership, management and coordination of the national response to AIDS by the Government of Ukraine and the Ministry of Health
- poor and uneven performance of the National Council as the one national authority responsible for coordination of the overall national response to AIDS
- lack of an overall national body with authority and expertise to plan and coordinate prevention activities
- majority of prevention programmes do not meet quality standards and are limited in coverage and scope
- inadequate progress with the implementation of substitution therapy, which is essential for progress in the prevention of HIV among IDUs and to have an impact on the overall course of the epidemic
- critical lack of Government support and involvement in prevention programmes among sex workers, MSM, especially for younger age groups, and other vulnerable populations
- lack of attention to urgent needs of MARA, despite high levels of vulnerabilities and risks, and an opportunity to intervene given the young nature of the epidemic
- lack of interventions to reduce violence, vulnerability and protect the rights of women who sell sex
- lack of effective, comprehensive prevention programmes in the prison system, including most importantly, harm reduction and substitution therapy
- insufficient efforts made to mainstream HIV prevention into non-HIV specific health, social and other services, and to utilize alternative HIV prevention entry points, such as pharmacies
- lack of Government funding for NGOs to provide and sustain prevention, care and support services, particularly for vulnerable populations
- lack of Government oversight, funding and support to sustain and enhance externally-supported programmes and activities, including most significantly, the Global Fund grants
- inadequate management capacity and resources within the Ministry of Health as the lead agency of the Government of Ukraine responsible for coordination of the national response and implementation of the National AIDS Programme
- limited capacity of NGOs to continue to scale up services for prevention among MARPs, and for non-medical care and support
- inadequate and inefficient use of human resources
- absence of a national centre for M&E, essential to future progress in the development of one national system for M&E
- poor or non-exist M&E of specific programmes and projects to demonstrate their outcomes and impacts
- inadequate use of data as the basis for development of policies and programmes and to guide the improvement of services and activities

1.8 Critical Barriers

The Evaluation identified the following critical barriers which are external to the national AIDS response, but need to be addressed to enable strategic modifications and strengthen performance:

- Government of Ukraine has limited experience and underdeveloped mechanisms to provide funding to NGOs to support and sustain provision of essential services for prevention, treatment, care and support
- outdated processes and systems for Government planning and management do not encourage results-based performance
- excessive bureaucratic regulation of Government decisions and processes undermine flexibility and inhibit responsiveness to changes in the epidemic

- systematic shortcomings in Government systems for PSM risk the ability of the Ministry of Health to manage an effective national system for PSM for essential HIV commodities (primarily HIV test kits, laboratory equipment and medications)
- poor mechanisms for planning, coordination and implementation of programmes and activities between the national and subnational levels
- limited capacity of NGOs to further scale up services to meet ambitious targets for coverage, especially among population groups and in cities and towns with limited or no coverage
- political instability and the frequent turnover of key decision makers has undermined continuity and leadership on AIDS at the national and subnational levels

1.9 Are the targets endorsed for Universal Access to prevention, treatment, care and support ambitious and achievable by 2010?

In June 2006, Ukraine joined other member states at the United Nations General Assembly to adopt the Political Declaration of the 2006 High Level Meeting on AIDS. This Declaration included the commitment to scale up towards Universal Access to prevention, treatment, care and support by 2010. In order to fulfill this commitment, national partners undertook an extensive process of planning to scale up towards Universal Access. Based on extensive consultation with partners at the national and subnational levels, ambitious national targets for Universal Access to prevention, treatment, care and support by 2010 were agreed in Ukraine. The Road Map for Universal Access (Road Map) sets clear objectives to reach Universal Access in Ukraine, as well as some operational targets to facilitate the implementation of the strategy.

Although the Road Map was officially endorsed by the National Council, the targets specified in the Road Map were never formally integrated into the National AIDS Programme or translated into an implementation plan. The new National AIDS Programme does not specifically include Universal Access as one of its aims, and does not reflect any of the targets that were developed in the Road Map. In the absence of a formal strategy or operational plan on how to reach Universal Access to prevention, treatment, care and support, it is not expected that any of the targets for Universal Access will be achieved by 2010.

1.10 Key Recommendations

The results of the evaluation are designed to enable national partners in Ukraine to consider and implement practical and time-bound recommendations to improve the overall national AIDS response. The Executive Summary features a short list of “key recommendations” (KR) that are systematic in nature, and merit serious consideration by all national partners. The consolidated report also contains several hundred “main recommendations” (MR) on how to improve the performance in specific technical areas of the national response. All recommendations in the consolidated report will require special efforts to ensure their timely implementation and monitoring to guide their performance.

It will take a concerted effort by the Government of Ukraine and other national partners to consider the following key recommendations, and translate them into action:

KR.I The Government of Ukraine should reassess the impact and potential importance of AIDS in all national plans and programmes, and reinforce its leadership in and contribution to the National AIDS Response

This will require extensive revisions to a myriad of existing programmes and practices, beginning with extensive revisions and ongoing improvements to the new National AIDS

Programme (2009-2013). Benefits from a stronger and more coordinated Governmental response to AIDS will have significant spill-over effects for larger Government priorities in health, socio-economic development, and lead the way for Ukraine's commitments to the Paris Declaration on Aid Effectiveness, achievement of the Millennium Development Goals, and gradual integration into the European Union.

Specific Recommendations:

KR.I.i	Declare AIDS as a leading national health and social priority for the State of Ukraine, and adopt measures to insulate the implementation of Government's commitments on AIDS from future political changes
KR.I.ii	Clarify the roles and responsibilities for leadership, policy development, coordination and management of the Presidential and National Councils, the Ministry of Health and its Committee on AIDS, and sectoral Ministries
KR.I.iii	Assign primary responsibility for the national response to AIDS to the Vice Prime Minister for Humanitarian Affairs, and reinvigorate the National Council under his leadership
KR.I.iv	Increase the amount and proportion of government funding for AIDS to ensure the rapid scale-up and long-term sustainability of all AIDS programmes and activities, including the provision of funding to NGOs for HIV-specific services
KR.I.v	Provide urgent guidance and support to oblast governments in the development, implementation, M&E of new regional AIDS programmes (2009-2013)
KR.I.vi	Ensure all government sectors and levels develop detailed annual workplans and budgets on AIDS as a complement to the new National AIDS Programme
KR.I.vii	Revise the new National AIDS Programme to address systematic shortcomings and specify how Ukraine will scale up towards Universal Access
KR.I.viii	Revise other related national programmes and projections on socio-economic development to reflect the impact of the AIDS epidemic
KR.I.ix	Create a separate budget code to monitor all government allocations and expenditures on AIDS at the national, oblast and district levels

KR.II Intensify HIV prevention programmes and policies to have an impact on the epidemic

This will involve the development of detailed policies and annual workplans that specify the full cost of prevention programmes and services, and clearly indicate the proportion of resources to be covered by different sources, and any gaps. This is essential to guide and support priorities for HIV prevention programmes at the national and regional levels, and support the rapid scale-up of coverage and quality of prevention programmes to levels that can have an impact on the epidemic. The focus on behaviour change among MARPs and their sexual partners should be reinforced, with prevention programmes among groups in the general population redirected at raising awareness, and combating stigma and discrimination.

Specific Recommendations:

KR.II.i	Develop and implement a detailed comprehensive national strategy of HIV prevention and behaviour change communication (BCC) as a subcomponent to the new National AIDS Programme; such a strategy should be multi-sectoral and include vulnerability reduction strategies to address the drivers of the epidemic, reflect gender- and age-specific needs, as well as the needs of different sub-groups
KR.II.ii	Increase the amount and proportion of government funding and support for prevention programmes for adult and adolescent IDUs, sex workers, MSM, prisoners and the sexual partners of these populations implemented by governmental and NGOs to scale up coverage and quality and ensure long-term sustainability
KR.II.iii	Rapidly increase the coverage of harm reduction and substitution therapy, including in the prison system and for adolescents

KR.II.iv Promote the diagnosis and treatment of STIs, including through the use of syndromic management of STIs; explore the potential integration of the government network for treatment of STIs into the network for HIV prevention, diagnosis and treatment

KR.II.v Ensure the distribution of free condoms at all government clinics and programmes that provide services for most at-risk and vulnerable populations and their sexual partners

KR.II.vi Increase entry points to HIV prevention by mainstreaming HIV prevention programmes into non-HIV specific health, social, legal, vocational and other relevant services

KR.II.vii Reduce access barriers to HIV prevention services and to sustaining safer behaviours, such as oppressive street raids by the police aimed at MARPs and MARA

KR.II.viii Develop prevention interventions to reduce the initiation of most at-risk behaviours

KR.III Expand the coverage and quality of Voluntary Counselling and Testing

This is urgently needed to ensure the majority of people in Ukraine who are estimated to be infected with HIV may learn their HIV status, and access prevention, treatment, care and support services.

Specific Recommendations:

KR.III.i Ensure provision of quality VCT, including pre- and post-test counselling, risk reduction and condom provision at all sites providing VCT

KR.III.ii Expand access to rapid HIV testing for MARPs, based on revised regulations, quality control and follow-up procedures, and close collaboration between NGOs and medical institutions

KR.III.iii Abolish contradictions between the National Law on AIDS and the Civil Code with regard to enabling access to VCT for children above the age of 14 years without the consent of a legal representative

KR.III.iv Ensure the timely provision of HIV test kits on a centralized basis to meet the needs for VCT among all other population groups (pregnant women and donors are already adequately covered)

KR.IV Improve the quality and accessibility of all HIV-related laboratory diagnostics

This will involve the wholesale revision of policies and regulations related to the registration and quality control for laboratory test kits, equipment and supplies and enhanced Government support for laboratory infrastructure and resources, including personnel. This is also urgently needed to address the poor capacity to diagnose many opportunistic infections on a free and timely basis, particularly for TB.

Specific Recommendations:

KR.IV.i Implement a comprehensive quality assurance programme for all aspects of HIV related diagnostics to assure the validity and accuracy of all laboratory data for HIV surveillance and patient monitoring

KR.IV.ii Improve the quality and free access to diagnosis for opportunistic infections, with a priority focus on quality-assured TB diagnosis, including drug sensitivity testing to detect drug resistant TB

KR.V Develop strategies and policies to guide the massive scale-up of treatment and care for patients with advanced HIV and related conditions

A series of detailed strategies and policies need to be rapidly developed and implemented to guide how the system for medical treatment and care for people living with HIV will be

reorganized to meet current and future needs for at least 80,000 patients with advanced HIV and related conditions.

Specific Recommendations:

KR.V.i Ensure the integrated provision of treatment and care for patients with multiple conditions (i.e. ART, substitution therapy and DOTS for patient with TB/HIV co-infection)

KR.V.ii Decentralize the provision of routine medical care for patients with HIV beyond regional AIDS Centres to the district level

KR.V.iii Rapidly promote Universal Access to ART and eliminate user fees (official and unofficial) for provision of medical services, as required by Ukrainian law

KR.VI Implement a national system for procurement and supply management for HIV/AIDS commodities and services

This will require a strong political commitment by the Government of Ukraine to implement rapid and significant actions that will provide much needed reliability and transparency in the PSM for HIV commodities and services. The extent and speed with which the Ministry of Health is able to implement significant changes in this area can result in the savings of tens of millions of hryvnia, which could be better used to expand the coverage and quality of programmes and services.

Specific Recommendations:

KR.VI.i Develop a national plan to establish a functioning national system for PSM for HIV

KR.VI.ii Revise the government procurement law for consistency with international best practice principles and WTO requirements, with a focused section on public procurement in the health sector

KR.VI.iii Pursue the procurement for ART and select laboratory tests through IDA, CHAI and other international sources of preferential pricing for HIV-specific commodities

KR.VII Develop national plan for human resource development for HIV

This is needed to mobilize and train tends of thousands of new and existing personnel to meet the current and future needs for the provision of HIV-specific and related services.

Specific Recommendations:

KR.VII.i Ensure relevant medical personnel receive advanced training on HIV (TB, obstetrics and gynecology, narcology, STI, and pediatric personnel)

KR.VII.ii Require that all medical personnel receive basic training on universal precautions, HIV-related counselling, confidentiality, stigma and discrimination

KR.VII.iii Require that all non-medical personnel that provide services for most at-risk and vulnerable populations (police, procurator and courts, prison staff, social workers, teachers) receive basic training on HIV transmission, and stigma and discrimination

KR.VIII Strengthen the national system for epidemiology and surveillance

The national system for epidemiology and surveillance requires additional resources and personnel to continue to monitor the epidemic and generate strategic information on developments and trends.

Specific Recommendations:

KR.VIII.i Allocate adequate Government resources to support dedicated personnel, epidemiological surveillance and research, and robust information systems at the national and subnational level

KR.VIII.ii Expand the coverage of linked epidemiological and behavioral surveillance studies to cover all regions of Ukraine on a periodical basis

KR.VIII.iii Revise job descriptions of epidemiogists at AIDS Centres to serve as lead focal points for implementation, interpretation and use of data from epidemiological and behavioral surveillance studies

KR.VIII.iv Systematize and unify the disaggregation of all epidemiological data by sex, age (standardized age breakdown), social status, risk behaviour and population group, and ensure data is publicly accessible

KR.IX Establish one national system for monitoring and evaluation

This will require that developments in M&E are consolidated in one national plan, which will be implemented under the guidance of a new national centre for M&E of AIDS.

Specific Recommendations:

KR.IX.i Develop and implement a national plan for M&E as a subcomponent of the new National AIDS Programme

KR.IX.ii Establish the national centre for M&E, with guidance and support for the establishment of regional centres for M&E

KR.IX.iii Conduct detailed monitoring of budget allocations and expenditures to inform the reallocation of resource needs and budgets on an annual basis

KR.IX.iv Guide future research efforts through a national research agenda specific to HIV

KR.IX.v Prioritize operations research to ensure the most (cost) effective programmes and services are identified, scaled up and duplicated

KR.IX.vi Conduct regular monitoring of the National AIDS Programme and periodic evaluations of the national response to AIDS, with the active role and participation of Ukrainian partners

KR.X Enforce the laws of Ukraine that protect the human rights of vulnerable populations and people living with HIV

This is needed to protect human rights, reduce stigma and discrimination, and also to ensure that services are accessible, user-friendly and have the trust of their clients. Delays in implementing such a policy will perpetuate barriers to scaling-up the coverage of services, undermine their effectiveness, and result in the continued drop-out of clients in need of services.

Specific Recommendations:

KR.IX.i Implement a national policy of zero tolerance for discrimination and breeches of confidentiality among all service providers (governmental and non-governmental) towards vulnerable populations (including refugees) and people living with HIV

KR.IX.ii Revise national laws and regulations to provide clearer protection of human rights for people living with HIV and others affected by HIV

KR.IX.iii Strengthen mechanisms for the enforcement of laws and regulations to protect human rights

KR.XI Integrate the Global Fund grants and other external donor contributions into the National AIDS Programme with active engagement by the Government of Ukraine and effective oversight by the National Council

Urgent measures are required to strengthen Ukraine's reputation as a reliable recipient of external donor funds – most significantly from the Global Fund. The pace and extent to which this is achieved may significantly influence donors to continue to support or increase their commitments to support AIDS programmes and activities in Ukraine.
Specific Recommendations:

KR.IX.i The Government of Ukraine should take immediate measures to resolve the issue of duty-free import of medicines as humanitarian aid and ensure that any related problems are addressed on a priority basis in the future

KR.IX.ii Strengthen national ownership of the Global Fund grant supported programme and ensure that the National Council fulfills its role and responsibility as a CCM in overseeing their implementation throughout the life cycle of the grants

KR.IX.iii Prioritize cooperation and support for AIDS in negotiations with external donors, with a focus on AIDS in the new enhanced cooperation agreement currently under negotiation between the European Union and Ukraine, and additional support from the US Government through the President's Emergency Plan for AIDS Relief (PEPFAR)

KR.IX.iv Develop a time-specific workplan to implement the recommendations in this evaluation specific to the Global Fund programmes by the PRs and other relevant partners, with any significant revisions to be reflected in the Round 6, Phase 2 Request for Continued Funding

KR.IX.v Enure that all national stakeholders (sectors, NGOs, INGOs, FBOs, international agencies, donors) align their contributions to support the National AIDS Programme

Part 2: Evaluation Objectives, Focus and Methodology

2.1 Evaluation objectives

This evaluation, which was requested by the National Council,[11] was conducted by an independent team of external experts (Evaluation Team). The in-country phase of the evaluation took place from October to December 2007, with additional meetings, data collection and compilation of evaluation outputs from January to December 2008.

The three objectives of the evaluation were to:

- assess the achievements, strengths, shortcomings and weaknesses of the national AIDS response in Ukraine;
- generate strategic recommendations as to how to improve key outcomes and impacts in a new All-National AIDS Programme in Ukraine;
- assess the specific value of the contributions of the programme supported by the current Global Fund grant, and to generate recommendations on how to strengthen the contributions of current and future Global Fund grants.

Focus of the evaluation
The evaluation focused on the following five areas:

1. Status of Epidemic and Scope of Response
   - What is the current status of the HIV/AIDS epidemic in Ukraine, and what are the key determinants of the continued growth of the epidemic?
   - What is the current scope of programmes and activities in support of the national AIDS response?

2. Overall Assessment
   - What is the overall assessment of the national AIDS response in Ukraine?
   - What have been the main strengths and achievements of the national AIDS response?
   - What have been the shortcomings and weaknesses of the national AIDS response?

3. Identification of Critical Barriers
   - Are there any critical barriers, external to the national AIDS response, which need to be addressed to enable strategic modifications and strengthen the performance of the programme?

4. Progress towards Universal Access by 2010
   - Are the targets endorsed for Universal Access to prevention, treatment, care and support ambitious and achievable by 2010?

5. Contribution of the Global Fund
   - To what extent has the national AIDS response been supported by the current Global Fund grant contributed to achievements of the National AIDS Programme?

In addition to the areas specified in the TOR, the evaluation team also focused on the cross-cutting issue of human rights.

The main emphasis of the evaluation was on the evaluation of the national response to HIV/AIDS in Ukraine. This emphasis prioritized the activities and time allocations of the Evaluation Team to focus on national level programmes, activities, processes and results. While regional (sub-national) programmes and activities were essential sources of information and data, the evaluation did not purport to conduct a comprehensive evaluation of sub-national responses to HIV/AIDS in Ukraine.

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[11] The Terms of Reference (TOR) for the evaluation were approved at a meeting of the National Coordination Council for the Prevention of the Spread of HIV/AIDS (National Coordination Council) on April 12, 2007. In July 2007, the National Coordination Council was reformed by the Cabinet of Ministers of Ukraine into the Ukraine's National Council for the Prevention of TB and HIV/AIDS (National Council).

2.2 Evaluation methodology

The Evaluation Team set out to conduct a formative programmatic evaluation of the achievements of the national AIDS response. This was oriented towards:

- assessing the achievements of the collective contributions of all partners in Ukraine
- examining programme processes and activities to understand how quality and effectiveness could be improved
- generating recommendations about the direction of the current National AIDS Programme and strategic issues for improvement in the development of a new All-National AIDS Programme

The formative aspect of the evaluation involved the gathering of information during the ongoing implementation of the national AIDS response, including the National AIDS Programmed (2004-2008), with a focus on:

- finding out whether the national AIDS response is being implemented as planned
- identifying any obstacles, barriers or unexpected opportunities that may have emerged
- developing recommendations for adjustments and corrections which can help improve the achievement of key outcomes and impacts.

The Evaluation Team also made extensive use of the following three methods for data collection:

Desk Review

In preparation for the in-country missions, each of the Evaluation team members were provided with a series of background documents and data on the current status of the national response, publications, and information relevant to the specific technical issues. During the in-country missions, a team of national focal points also assisted the Evaluation Team to compile additional documents such as publications, research, reports and other data.

Informant Interviews and Focus-Group Discussions

The primary sources of information for the evaluation were key informant interviews and focus-group discussions. The Evaluation Team met, as necessary, with government officials at the national and regional level, members of the NATIONAL COUNCIL and the regional coordination councils, representatives of NGOs, Global Fund PRs and sub-recipients, and representatives of the civil society, international agencies and donors, and clients of existing programmes and services. Members of the team visited the relevant ministries, research institutions, and service provision sites, including AIDS centres, VCT facilities, clinics, hospitals and other governmental and non-governmental facilities that provide HIV-specific and HIV-related services.

Site visits

To enable the evaluation team to gain a first hand impression not only of the challenges faced but also to assess the local achievements, site visits were also undertaken to select regions.

2.3 Overall Assessment Scale

Importance Scale (for significance of technical areas / issues):

High Features one or more of the following dominant characteristics:

- Essential to national response
- Area / issue represents concerns that warrant priority attention
- Expected to have decisive impact on epidemic

Medium Features one or more of the following dominant characteristics:
- Important, but not intrinsic to national response
- Area / issue represents concerns that warrant moderate attention
- Expected to have significant, but not decisive impact on epidemic

Low Features one or more of the following dominant characteristics:
- Limited importance to national response
- Area / issue does not warrant priority attention
- Not expected to have significant impact on epidemic

Each of the broad technical areas that are covered in the report is assigned a rating of high, medium, or low importance. This scale refers to the overall significance and contribution of a particular technical area / issues to the overall national response to AIDS and its likely relative impact on the epidemic in Ukraine. The importance scale does not characterize performance or reflect progress achieved in these areas.[12]

Progress Scale (for measuring progress and performance of technical areas / issues):

High Features one or more of the following dominant characteristics:
- Excellent progress and outcomes
- Measurable results that have consistently met or exceeded targets
- Programme design and implementation largely consistent with needs
- Minor shortcomings can be quickly and easily overcome
- Programme merits duplication and scale-up

Substantial Features one or more of the following dominant characteristics:
- Strong progress and adequate outcomes
- Some results that have occasionally met targets, and/or significant progress towards targets
- Programme design and implementation partially consistent with needs, some modifications recommended
- Moderate shortcomings to be addressed, requiring limited time and effort

Moderate Features one or more of the following dominant characteristics:
- Adequate progress and some partial outcomes
- Limited progress towards targets
- Programme design and implementation only partially consistent with needs, requires significant revisions and improvement
- Significant shortcomings to be addressed, requiring moderate time and effort

Inadequate Features one or more of the following dominant characteristics:
- Marginal progress and few outcomes
- Insufficient progress towards targets and/or inadequate targets
- Programme design and implementation suboptimal, and largely inconsistent with needs, requires extensive revisions and improvement
- Widespread shortcomings to be addressed, requiring substantial time and effort

Unacceptable Features one or more of the following dominant characteristics:
- Little or no progress and/or negative outcomes

[12] The evaluation maintains that a comprehensive approach that addresses all technical areas is essential to a successful national response to AIDS in Ukraine. A medium or low importance rating should not be misinterpreted as denoting that an area is not a relevant component of the national response.

- No targets and/or inappropriate targets
- Programme design and implementation seriously flawed, and wholly inconsistent with needs, requires wholesale revisions
- Widespread critical shortcomings to be addressed, requiring extensive time and effort

Each of the broad technical areas covered in the report is also assigned a progress rating of high, substantial, moderate, low, or unacceptable. The scale refers to the overall performance or progress achieved in each area against current national plans and programmes (most significantly, current National AIDS Programme and Global Fund Round 1 Programme) and overall imperatives for a successful response to the epidemic. The purpose of assigning such progress ratings is to serve as a benchmark for monitoring future progress in each area, and should not be interpreted as a basis to vindicate or criticize national partners for their performance.

Urgency Scale (for implementation of main recommendations):

Immediate	Requires immediate and priority attention Must be addressed within 3-6 month period
Short-term	Requires short-term attention Should be addressed within 6-12 month period
Mid-term	Requires consistent attention May be addressed within 12 – 24 month period

Each of the main recommendations in the consolidated report (Part 4) is assigned a timeline for its implementation. The scale refers to the relative urgency of a particular recommendation, and the amount of time expected to pursue its implementation. All recommendations in the consolidated report will require special efforts to secure their implementation, and ongoing monitoring to guide their performance.[13] With the exception of the section of the evaluation related to the Global Fund, this report does not specify the responsible parties for specific recommendations, as this is considered to be the prerogative of national authorities in consultation with relevant partners.[14] A more extensive set of recommendations are included in the technical reports on specific issues, which are included as electronic annexes to the consolidated report.

2.4 Components of Evaluation Report

The final evaluation report consists of three components:

Executive Summary and Key Recommendations
The Executive Summary and Key Recommendations constitute Part 1 of the consolidated evaluation report, and are also available as a separate publication in print and electronic formats.

Consolidated Report
The consolidated report includes four parts, including:

Part 1: Executive Summary and Key Recommendations
Part 2: Evaluation Objectives, Focus and Methodology
Part 3: Background Information on Ukraine

[13] A large number of recommendations are classified as 'immediate' as they should be acted upon immediately in order to ensure they are adequately reflected in the new National AIDS Programme (2009-2013), or otherwise merit immediate attention. It is recognized that the reflection of a recommendation in the new National AIDS Programme will not guarantee its successful implementation.

[14] Due to the specific nature of the Global Fund grants, with responsibilities for different roles more clearly defined, these recommendations are addressed to specific parties.

Part 4: National Response to AIDS - Main Findings

The consolidated report is available in print and electronic formats.

Technical Reports

The technical reports provide more detailed background information of the results of the evaluation on specific issues. The full set of technical reports is available only in electronic format, as an annex to the consolidated report.

2.5 Key Evaluation Assumptions

The evaluation planning, methodology and results were based on the following key assumptions:

Link to Development of New All-National AIDS Programme (2009-2013)

The evaluation was designed and implemented as a formative evaluation. It was assumed that the results of the evaluation would be used by the National Council, the Government of Ukraine and other national partners to inform and guide the development of the new National AIDS Programme (2009-2013). However, an ambitious timeline has been set for the development and approval of the new National AIDS Programme. The Evaluation Team encourages the National Council, the Parliament of Ukraine, the Government of Ukraine, and other national partners to make extensive use of the evaluation results during and beyond the process of the development of the new National AIDS Programme in order to improve the outputs and outcomes of ongoing and planned programmes and activities.

Independence of the Evaluation

The Evaluation Team consisted of international technical experts who were not directly involved in current implementation of the current programmes and activities related to AIDS in Ukraine. At the time of the evaluation, several members of the Evaluation Team were staff and/or consultants supported by various international organizations and/or agencies that also maintain representation in Ukraine, including, but not limited to, programmes and agencies of the United Nations, the United States Agency for International Development (USAID), and others. However, these and other members of the Evaluation Team were selected for their individual expertise in relevant technical aspects of the evaluation. During their involvement in the evaluation, it was assumed that these members of the Evaluation Team did not represent their affiliated agencies. It was further assumed that all members of the Evaluation Team maintained an independent approach, and were not guided by preconceived assumptions, or influenced by any party or key informants. During the in-country missions, and in the writing of the evaluation reports, it was assumed that all members of the evaluation team maintained independence and impartiality, and ensured that the evaluation report includes perspectives independent of the perspectives of those who are directly responsible for the implementation of the technical issues being evaluated.

Confidentiality of Information and Sources

Information and data collected by the members of the Evaluation Team during their in-country missions, as well as consultant's debriefing notes, draft reports and detailed evidence notes were shared only among members of the Evaluation Team, and were not for external dissemination, unless specifically authorized by the Team Leader. Any information that was provided to any member on a confidential basis, including the source of such information, will remain confidential.

Attribution

The Evaluation Team felt that attempting to attribute the complex developments in the national response to HIV and AIDS to a single institution or variable was unrealistic. The evaluation does not intend to demonstrate whether the national AIDS response in Ukraine, which consists of a network of interventions embedded in dynamic political and social

systems, was attributable to any single factor. However, the relative influences of key variables were identified and assessed for having contributed to specific outcomes.

Evaluation of Contributions of Specific Individuals
A key principle of the evaluation is to assist Ukraine to scale up positive developments that have emerged from the national AIDS response while attempting to minimize any negative or harmful consequences. The evaluation refrained from the identification and discussion of the contributions of specific individuals, whether positive or negative, except in rare cases where these contributions have had a significant national influence on policies or programme outcomes.

2.6 Areas Covered by the Evaluation

The list of evaluation areas and themes covered by the evaluation represents a comprehensive overview of key components of the national AIDS response. The areas covered in the evaluation are divided into the following three levels, which are listed in detail in the TOR:

Level 1: broad thematic areas

Area 1 - Prevention
Area 2 - Diagnostics, Treatment, Care & Support
Area 3 - Advocacy, Communications & Information
Area 4 - Management, Coordination & Institutional Relations
Area 5 - Planning, Finance and Budgeting
Area 6 - Procurement, Supply Management & Human Resources
Area 7 - Epidemiology and Surveillance
Area 8 - Monitoring & Evaluation

All technical areas were collapsed into these broad thematic areas, with the listing of specific technical areas arranged according to these groups.

Level 2: technical groups

Within the eight broad thematic areas, a total of 26 technical groups were assessed individually, with more specific technical areas incorporated into these broad technical groups.

Level 3: technical issues

Within the 26 technical groups, there were 131 specific technical issues that were addressed by the evaluation, with any other specific technical aspects included into these technical issues. In cases where the evaluation team did not possess relevant expertise or capacity to evaluate a specific technical issue, the Evaluation provided only a brief summary assessment of the issue within the competence of the Evaluation Team.

Global Fund Contribution to the National Response

One member of the Evaluation Team was specifically tasked to conduct the evaluation of Global Fund contribution to the National Response, which was guided by the evaluation questions of the '*Five Year Evaluation of the Global Fund*'.[15] The focus of this component of the evaluation was on the ongoing Global Fund Round 1 grant, with references to the Round 6 grant, where appropriate. Parallel to this specific assessment, all members of the Evaluation Team collected information on the contribution of the Global Fund programmes relevant to specific technical issues. The results of this assessment of the achievements, strengths, shortcomings and weaknesses of the current Global Fund grant supported components of the AIDS response in Ukraine were integrated into the overall evaluation. These results will also be used to meet the

[15] *Five Year Evaluation of the Global Fund,* Study Area 2 - Evaluation of Country Grant Performance and Partnership in 16 Countries.

evaluation needs of the Global Fund Secretariat for an external evaluation of the Global Fund's Round 1 Grant in Ukraine. A summary of the contribution of the Global Fund programmes are included in a separate section of this consolidated report (see 4.19 - Contribution of the Global Fund Grants to the National Response to AIDS). More detailed information about the contribution of the Global Fund programmes is included separately in the technical report on the Global Fund and in the technical reports on other specific issues, which are included as annexes to this consolidated report.

2.7 Selection and Management of the Evaluation Team

The process of selection of members of the Evaluation Team was performed through an open and transparent process. Upon approval of the TOR by the National Council, the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Ukraine, which was responsible for the coordination and administrative management of the evaluation, aimed to identify and engage leading technical experts as members of the Evaluation Team through a search for qualified consultants. The identification of the Team Leader was a key milestone in the assembly of the Evaluation Team. Additional members of the team were recruited by UNAIDS and its cosponsors, under the supervision of the Team Leader, based on recommendations from previous assignments, relevant technical expertise and regional experience. In cases where suitable consultants could not be identified within the timeframe for the in-country phase, special requests were made to the UNAIDS Secretariat and UNAIDS cosponsors to identify and/or support relevant experts from among staff at global or regional offices that could serve as the lead for specific technical issues. The final Evaluation Team included 32 experts, including those members of the team that were affiliated with partner organizations and agencies.

As per the ToR, it was planned that the Evaluation Team would include a group of eight area coordinators for the Evaluation's eight broad thematic areas. However, due to delays in timing of the in-country phase, and need to recruit members of the Evaluation Team for specific technical issues, it was decided to forgo the recruitment of area coordinators.

2.8 Evaluation Phases, Data Collection and Summary of Results

The evaluation was implemented in a series of phases, as outlined in the ToR:

Phase 1 – Inception (April – October, 2007)
Phase 1 involved planning and preparation for the in-country phase of the Evaluation:

- recruitment of the members of the evaluation team
- development of a detailed evaluation matrix
- completion of the desk reviews and development of instruments
- public consultation to ensure awareness, and support for the evaluation among national stakeholders

Phase 2 – In-country mission (October – December, 2007)
Phase 2 featured:

- completion of almost all in-country evaluation missions, including missions by 31 members of the external evaluation team
- a series of four in-country debriefing meetings for members of the evaluation team to highlight key evaluation issues; detailed in-country debriefings for national stakeholders were not undertaken in this phase.
- debriefing notes prepared by members of the evaluation team on technical issues to share with other members of the Evaluation Team, with inclusion of cross-cutting issues, including contributions from the Global Fund and Human Rights implications.

Phase 3 - Preparation of Draft Evaluation Reports (January – July, 2008)
Phase 3 involved the preparation of the first drafts of the technical reports and the consolidated evaluation report. The members of the Evaluation Team completed a series of technical reports for

the issues for which they were responsible. Each of the reports underwent an internal review by at least two reviewers from the UN Joint Team on AIDS in Ukraine, with revisions made by the lead evaluators, as required. Special effort was made to review the technical reports to assess the internal coherence and external correspondence of findings against other existing sources.

The development of the consolidated evaluation report was coordinated by the Team Leader and assisted by a subset of the Evaluation Team. This 'Consolidation Group' met in Kyiv from January 7-11, 2008 to review the key preliminary findings from the in-country missions and the technical reports. The Consolidation Group also developed a series of preliminary conclusions and recommendations related to the overall national AIDS response in Ukraine for inclusion in the consolidated evaluation report. The findings and recommendations in the report were reached by consensus among members of the Consolidation Group. In select cases, decisions on what to include in the consolidated report and the key conclusions and recommendations were based on the majority of view of members of the Evaluation Team, as mediated by the Team Leader. Upon completion of the draft consolidated report, it was also circulated amongst all the members of the Evaluation Team for clarification and comment. The final consolidated evaluation report is not attributable to one or more individual members of the Evaluation Team, and should be interpreted as the consensus view of all members of the Evaluation Team.

During this phase, the preliminary results of the evaluation and the subsequent draft consolidated report were presented at public meetings in Kyiv, on January 28, and June 23, 2008, respectively. These meetings were attended by the Minister of Health of Ukraine, and provided an opportunity for the Team Leader to present the draft results of the evaluation to a broad range of stakeholders, with a focus on those results directly relevant to the process of development of the new National AIDS Programme. The draft version of the consolidated report, as well as copies of the remarks delivered by the Team Leader at these meetings were circulated in Ukrainian and English to over 200 participants in Ukraine via email.

Following these presentations, the draft consolidated report was made available for public feedback. At the request of the Evaluation Team, the draft consolidated report was made available for public comment and feedback for a period of four weeks (from June 23 to July 20, 2008).

Phase 4 – Final Consultations and Completion of Evaluation (August, 2008 – January, 2009)
During Phase 4, all comments and requests for clarification received during the process of public feedback were reviewed by members of the Evaluation Team. In cases where factual errors or other inconsistencies were identified, the appropriate revisions were made to the consolidated report and technical reports. Throughout this process, the Evaluation Team maintained an external and evidence-based approach to support its findings and recommendations, thus preserving the independence of the evaluation results.

The final version of the consolidated evaluation report was reviewed and adopted by the Evaluation Team on January 12, 2009. Upon publication of the consolidated evaluation report, the evaluation is considered to be completed.

2.9 Constraints

The Evaluation Team has identified the following constraints that could be seen as constraints on the scope of this evaluation:

Changing Political Environment
The evaluation was planned and implemented during an unstable political environment in Ukraine, which created moderate challenges for the Evaluation Team. During the period of the evaluation, there were a series of changes of Government in Ukraine, with changes at the level of Vice-Prime Minister for Humanitarian Affairs (who is also Chair of the National Council), and at the level of other senior Governmental representatives. In order to respond to these changes and mitigate risks to the evaluation, several attempts were made to postpone the in-country phase. When the in-country phase was rescheduled for the third time, the Government of Ukraine was again in transition, and the National Council was again in abeyance. During the in-

country missions, the Evaluation Team was unable to meet with some senior Governmental representatives, and some key informants were relatively new. The Evaluation Team was also not successful in formally presenting the preliminary results of the evaluation to the National Council. These factors placed limitations on the ability of the Evaluation Team to draw conclusions about the views and positioning of some informants on key issues covered by the evaluation, and raised questions about the extent to which the results of the evaluation will be thoroughly considered by National Council as the body that requested the evaluation.

<u>Consistency of Approach among Members of Evaluation Team</u>
The evaluation covered an exhaustive number of thematic areas and technical issues. It was not possible to limit the size of the Evaluation Team to a smaller group of experts, who would have been capable of assessing all these technical issues in detail. Most members of the Evaluation Team were responsible for individual technical issues and visited Ukraine for a very short period of time. The team used tools and approaches based on international standards for conducting programmatic evaluations. However, due to the size of the Evaluation Team and the complexity of the issues addressed, it was difficult to ensure consistency of approach and to review the results among all members of the team. As a result, some issues may not have received the attention or technical detail that some stakeholders may feel that they deserved.

<u>Views and Influence of Frequently Cited Parties and Key Informants</u>
The Evaluation Team benefited from excellent cooperation and support from almost all respondents. Due to the large number of members of the Evaluation Team visiting at different times during the in country phase, some respondents were repeatedly approached by different members of the Evaluation Team on different issues. As a result, the views of some key informants were more frequently cited, particular in some of the technical reports. The Evaluation Team made an effort to balance these views, and ensure that the evaluation results were not excessively influenced by views of any party or key informants.

<u>Focus on Global Fund Contribution</u>
Consistent with ToR, one of the foci of the Evaluation was the contribution of the Programmes supported by the Global Fund. The evaluation of the specific contributions of other partners and donor agencies was not intended to be the focus of this evaluation.

2.10 Coordination Role of UNAIDS

At the request of the Ministry of Health of Ukraine and based on the decision of the National Council, the implementation of this Evaluation was coordinated by UNAIDS in Ukraine. UNAIDS was chosen for its mandate and expertise in the coordination of M&E of AIDS. Insofar as UNAIDS is also supporting the National AIDS Programme, UNAIDS insisted that the evaluation be implemented by an Evaluation Team of external experts who are not directly involved in the implementation of the National AIDS Programme in Ukraine. UNAIDS was responsible for coordinating the provision of technical support for the implementation of the evaluation, including planning, logistics and collaboration and follow-up with national counterparts, through the UN Joint Team on AIDS, which includes representatives of all the UN's technical personnel working on HIV and AIDS in Ukraine.

In the absence of a formal evaluation steering committee, the Joint United Nations Team on AIDS (Joint Team), and the Monitoring and Evaluation Working Group (MEWG) under the National Council, served as a de facto steering committee for the evaluation.

The views, conclusions and recommendations in this report and the other evaluation summary reports represent the consensus views of the members of the Evaluation Team. The members of the Evaluation Team, led by the Team Leader, are solely responsible for the views expressed in this publication. The findings of this evaluation should not be taken to represent the views of UNAIDS, its cosponsors or the UNAIDS Secretariat, or any other agency or organization that supported this evaluation.

Part 3: Background Information on Ukraine

3.1 Socio-Economic Profile of Ukraine[16]

Ukraine – is the second largest country in Europe, after the Russian Federation, with an area of 603,700 sq km. The territory from North to South is 893 km, from West to East - 1316 km. Ukraine has ports on the Black sea and the Azov sea. Ukraine borders on the Russian Federation (inland border of 2063 km), Republic of Belarus (975 km), Republic of Poland (542,5 km), Republic of Slovakia (98 km), Hungary (135 km), Romania (608 km) and Republic of Moldova (1194 km).

Map of Ukraine:

Political and Administrative System:
Source: Economist Intelligence Unit

<u>Legal system</u>
Republic. A new constitution was approved by the Verkhovna Rada on June 28th 1996

<u>National legislature</u>
Verkhovna Rada (Supreme Council, or parliament); unicameral assembly of 450 deputies

<u>National elections</u>
September 30th 2007 (parliamentary), October 31st and December 26th 2004 (presidential); next scheduled presidential election in 2010

[16] Sources: http://www.kmu.gov.ua; World Bank

Head of state
President, Viktor Yushchenko, elected in December 2004 and sworn in on January 23rd, 2005

Cabinet of Ministers (State Council)
Prime Minister: Yuliya Tymoshenko
Deputy Prime Minister for Humanitarian Affairs: Ivan Vasyunyk

Key ministers and state agencies (also members of the National Council on HIV/AIDS, TB and Drug Use):
Health: Vasyl Knyazevych
Education & Science: Ivan Vakarchuk
Finance: Viktor Pynzenyk
Interior: Yury Lutsenko
Justice: Mykola Onishchuk
Labour & Social Policy: Lyudmyla Denysova
Family, Youth and Sport: Yuriy Pavlenko
State Prison Department: Vasil Koshchynets
State Committee for Television and Radio of Ukraine: Anatoliy Murakhovsky, a.i.

Administrative divisions
source: http://www.kmu.gov.ua

Ukraine consists of the Crimean Autonomous Republic and 24 regions (oblasts): Vinnytsya, Volyn, Dnipropetrovs'k, Donets'k, Zhytomyr, Zakarpattya, Zaporizhya, Ivano-Frankivs'k, Kyiv, Kirovohrad, Luhans'k, Lviv, Mykolayiv, Odesa, Poltava, Rivne, Sumy, Ternopil, Kharkiv, Kherson, Khmelnytsky, Cherkasy, Chernihiv, and Chernivtsi. The cities of Kyiv and Sevastopol have special status of administrative regions.
Ukraine has 490 districts, 446 cities, 907 towns and 10196 villages.

Demographic and Social Indicators
Source: http://www.kmu.gov.ua; Economist

The population of Ukraine is 46.6 million people. Ukraine has the 5th largest population in Europe (after Germany, Italy, Great Britain, France) and the 21st in the world. Ukrainian population represents 7.3% of population of Europe and 1% of the World population. 68% of Ukrainians live in cities and 32% in rural areas. Almost three million inhabitants live in the capital Kyiv, the largest city in Ukraine.

Population and Demographic Profile	2006
Population, total (millions)	46.6
Major languages:	Ukrainian (official) 67%, Russian 24%, other 9% (includes small Romanian-, Polish-, and Hungarian-speaking minorities)
Major religions:	Ukrainian Orthodox - Kyiv Patriarchate 19%, Orthodox (no particular jurisdiction) 16%, Ukrainian Orthodox - Moscow Patriarchate 9%, Ukrainian Greek Catholic 6%, Ukrainian Autocephalous Orthodox 1.7%, Protestant, Jewish, none 38% (2004 est.)
Adult literacy	99.4%

Economic Indicators:
Source: World Bank

Economic Profile	2006
Poverty headcount ratio at $2 a day (PPP) (% of population)	4.9
Purchasing parity power (PPP) (international dollars)	7,520
Global rank, according to PPP	107th
Income group	Lower middle income
GDP (current US$) (billions)	106.5
GDP growth (annual %)	7.1
GNI per capita, Atlas method (current US$)	1950
Inflation, consumer prices (annual %)	9.1
Foreign direct investment, net inflows (% of GDP)	5.0
Unemployment, total (% of total labour force)	6.8
Unemployment among adults age 15-49 (% of total labour force)	18.2
Monetary Unit	1 hryvnia = 100 kopiykas
Exchange rates (December 31, 2008)	1 usd = 7.70 hryvnias 1 euro = 10.98 hryvnias

Health Indicators:
Source: WHO

Population growth rate	-0.675% (2007 est.)
Birth rate	9.45 births/1,000 population (2007 est.)
Death rate	16.07 deaths/1,000 population (2007 est.)
Infant mortality rate	9.5 deaths/1,000 live births
Life expectancy at birth	total population: 67.88 years male: 62.16 years female: 73.96 years (2007 est.)
Total expenditure on health per capita	427 (Intl $, 2004)
Total expenditure on health as % of GDP	6.5 (2004)

3.2 Epidemiology of HIV and AIDS in Ukraine [17]

The HIV epidemic was first recognized in Ukraine in 1987. Since then, Ukraine has maintained and developed a standardized system for passive surveillance based on confidential name-based reporting of HIV cases in all 27 administrative regions of Ukraine. Based on the data reported under this system, at the end of 2007, 122,674 people had been diagnosed with HIV since HIV surveillance began in 1987, including 122,314 citizens of Ukraine and 360 foreigners. A significant portion of these people are alive and under medical observation at the network of AIDS Centres in Ukraine. At the end of 2007, there were 81,741 people registered with HIV-infection under medical observation (176.2 per 100,000 population), of which 8,944 people were diagnosed with AIDS (19.3 per 100,000 population). Since 1987, 22,424 cases of AIDS had been diagnosed among citizens of Ukraine. 25,318 deaths were officially reported among people living with HIV, including 12,490 AIDS-related deaths, and 12,828 deaths among people living with HIV related to other causes.

3.2.1 Estimated Number of Cases of HIV

The number of officially reported cases of HIV-infection understates the magnitude of the epidemic, as it only includes HIV-infection diagnosed among persons tested at official facilities. Based on the most recent estimates of the Ministry of Health, at the end of 2007, there were 440,000 people [range 255,000–640,000] living with HIV in Ukraine. This is equal to an estimated HIV prevalence of 1.63% among the adult population of Ukraine (age 15-49), indicating that Ukraine has the most severe HIV/AIDS epidemic of any country in Europe or the Commonwealth of Independent States. According to these estimates, only one-fifth of people living with HIV in Ukraine had been tested for HIV and were aware of their HIV status.

The size of the HIV epidemic is steadily increasing, with a growing number of newly diagnosed persons reported every year since 1999. In 2007, 17,687 persons newly diagnosed with HIV-infection were officially reported in Ukraine, the largest number ever reported since the beginning of HIV surveillance in 1987. This represented an annual increase of 10% in comparison to the number of new cases of HIV-infection reported in 2006 (16,094).

3.2.2 HIV infection in Ukrainian Regions

Since 2001, all 27 regions of Ukraine have reported cases of HIV infection. Yet there remains significant diversity of HIV-infection between and within different regions of Ukraine.

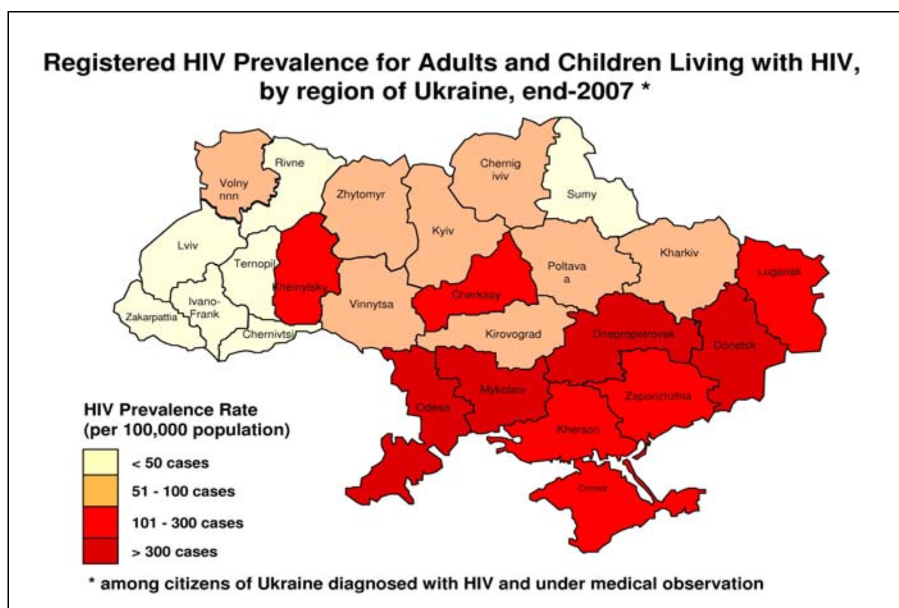
Coverage of HIV Testing at the Regional Level

The number of HIV cases reported is closely related to the number of tests performed and the structure of HIV surveillance within regions. Between regions, significant discrepancies remain in the coverage of HIV surveillance, which is largely determined by the allocations by local government to purchase HIV test kits for all groups of the populations, excluding pregnant women and blood donors (for these populations, HIV test kits are centrally provided by the Ministry of Health). In 2007, 14 of 27 regions provided a proportion of test kits below the national average, suggesting that there may be significant underreporting of HIV among populations most at-risk, particularly in these regions.

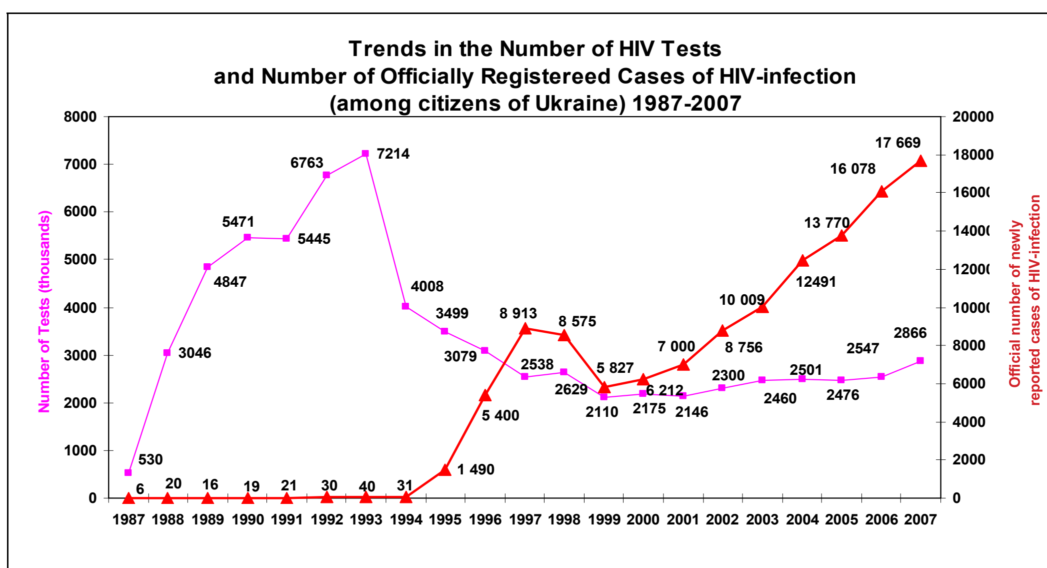
The highest rates of HIV-prevalence have been registered in South-Eastern Ukraine, including: Odessa oblast, Dnipropetrovsk oblast, Donetsk oblast, Mykolayiv oblast, and the city of

[17] The epidemiological data and statistics cited in this section of the report were provided by the Ukrainian AIDS Centre, unless otherwise specified. The data refers to the status of epidemiological indicators as of 31 December, 2007, unless otherwise specified.

Sevastopol, the Autonomous Republic of Crimea, and the capital city Kyiv. At the end of 2007, these seven regions collectively accounted for over 70% of all of the people registered with HIV currently under medical observation in Ukraine. In recent years, there has been a rapid increase of people registered with HIV in central, northern, and western regions of Ukraine. In 2007, 10 of the 27 regions of Ukraine reported an annual increase of 20% or more in the number of people newly reported with HIV, with the highest increases in the Western regions of Ukraine, including Rivne oblast (50.5%) and Zarkarpattia oblast (94.4%), and in the Northern region of Chernighiv oblast (48%). Within regions, the epidemic is concentrated in urban centres, with 78% of people newly diagnosed with HIV in 2007 registered among urban residents.



A significant proportion of the Ukrainian population is tested for HIV on an annual basis. The coverage of HIV testing has remained relatively stable among citizens of Ukraine, with a slight increase in the number of tests performed in recent years. In 2007, 2.86 million tests were performed in Ukraine, an increase of 12% from 2006. Since 1999, the number of newly reported cases of HIV has continued to increase on an annual basis, reaching 17,669 in 2007.



3.2.3 HIV among Blood Donors

The number of HIV tests is not proportionate to the percentage of the population tested for HIV, as persons from some populations are tested repeatedly. There is universal coverage of HIV testing among blood donors. While all donated blood is tested for HIV and contaminated blood discarded, in 2007, HIV surveillance among donors revealed 1,138 donors infected with HIV – equal to an HIV prevalence of 0.17% - significantly higher than in any other European country. In

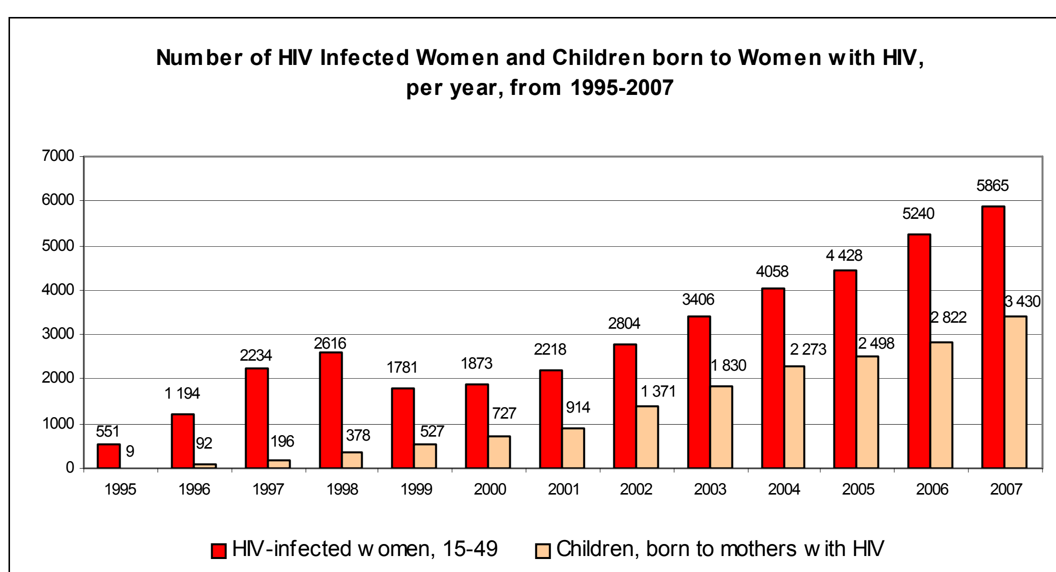
2007, the Ministry of Health reported one case of HIV infection through contaminated blood – believed to be linked to a donor within the period of seroconversion.

Lack of Incidence Data

The number of people newly diagnosed with HIV is not an accurate representation of trends in HIV incidence, as an indeterminate portion of those persons diagnosed with HIV were infected in the last year, with others infected some time in the past. To date, Ukraine has not used laboratory methods such as the detuned assay to estimate incidence, due to the lack of an assay that has been validated among A-subtypes, which are predominant in Ukraine. Yet, the monitoring of HIV incidence remains a critical objective to evaluate progress made towards the goal of reducing the number of new HIV infections and in evaluating the effectiveness of prevention programmes.

3.2.4 HIV among Pregnant Women

Like donors, pregnant women have had significantly higher uptake and more reliable coverage of HIV testing than other groups of the general population in Ukraine. The coverage of voluntary HIV-testing among pregnant women in Ukraine has consistently exceeded 95% in recent years, with the majority of pregnant women undergoing two HIV tests during their pregnancy. The remarkably high coverage of HIV testing among pregnant women also indicates that annual HIV among this population can be used as a reliable proxy for HIV prevalence among adult men and women in the general population. Among pregnant women, HIV prevalence has steadily increased in recent years. In 2007 HIV prevalence among pregnant women was 0.52% – the highest of any country in Europe or Central Asia. Like among other populations that are regularly tested for HIV, there remain significant variations in the prevalence of HIV among pregnant women between regions of Ukraine. In 2007, the lowest levels of HIV prevalence were reported in the Western regions of Chernivetska oblast (0.05%), Zakarpatska oblast (0.08%), and Ivano-Frankivsk oblast (0.09%). In contrast, exceptionally high HIV prevalence was reported among pregnant women in several regions of central and Eastern Ukraine, with three regions reporting HIV prevalence among pregnant women exceeding 1%, including Odessa (1.03%), Kyivska oblast (1.14%) and Mykolaev oblast (1.25%).



3.2.5 HIV among Children and Adolescents

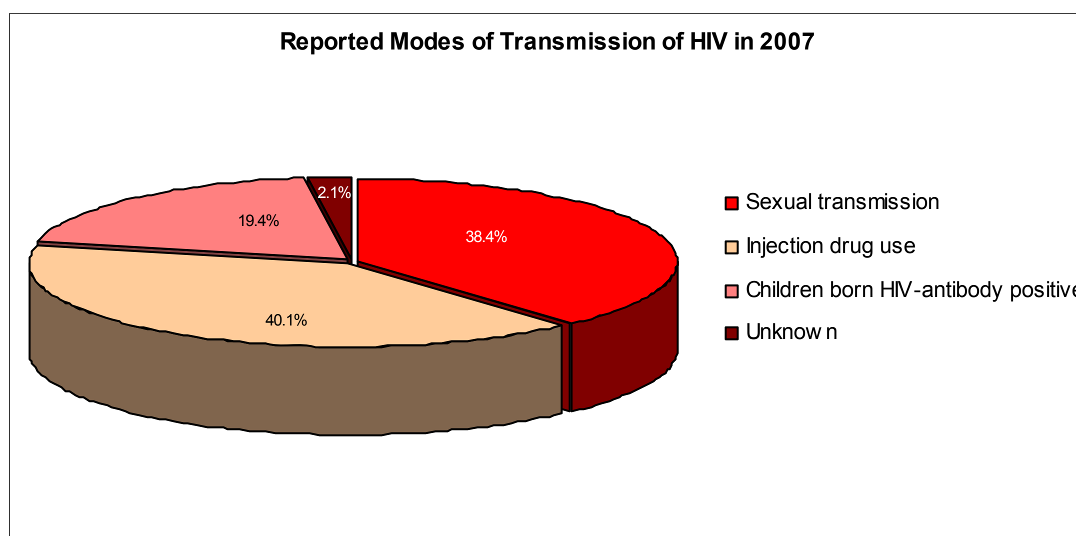
The increase in heterosexual transmission and the growth of HIV among infected women of childbearing age has contributed to the consistent growth of the number of children born to HIV

infected mothers. Consistent with Ukrainian law, the official figures of the Ukrainian Ministry of Health initially include all children born to women with HIV as HIV-positive. While these newborns may initially test HIV-antibody positive, follow-up testing confirms that the majority of these newborns are actually HIV-negative. Newborns that are confirmed to be HIV-negative at 18 months are subsequently removed from the registry of HIV persons under medical observation, but usually remain in the cumulative number of registered HIV cases, leading to inflated figures in the cumulative number of persons diagnosed with HIV.[18] Despite progress in the PMTCT, the total number of children exposed to HIV infection continued to increase. In 2007, 3,430 children were born to women with HIV-infection – an increase of 20% over the previous year. A small but growing number of cases of HIV infection among children under the age of 14 that were infected through injecting drug use and sexual transmission have also been reported.

Proportionately few adolescents and young people aged 15 to 24 years (primarily those engaged in most at-risk behaviours) are officially registered with HIV in Ukraine (e.g. in 2007, they made up 15% of all newly registered case). Behavioural surveillance data suggest that the official figures may be underreported, linked to the low uptake of VCT among these sub-groups. Sentinel surveillance data indicates the HIV prevalence among these sub-groups is higher than indicated by official statistics: HIV prevalence among adolescent male IDUs (aged 15 to 19) was 29% in 2006; among female IDUs – 39%; among adolescent FSWs – 11%; and among young MSM – 4%. Data from behavioural surveillance studies in 2007 indicate significant differences in the vulnerabilities and risk behaviours among male and female MARA.

3.2.6 Sexual Transmission of HIV

Sexual transmission of HIV is increasing rapidly, representing 38.4% of all people registered with HIV in 2007.



These trends indicate the growing shift of the epidemic towards heterosexual transmission. However, the increase in sexual transmission is closely linked to risky sexual behaviour among and with IDUs, and may also be linked to unprotected sex between MSM, sex workers, and their sexual partners. The data from an ongoing study of behaviour among those newly infected with HIV indicates that 20% of those infected through sexual transmission in 2007 reported an IDU as a regular sexual partner in the previous 12 month period.[19] Women in Ukraine, particularly female IDUs and women with sexual partners who engage in high risk sexual behaviour, are increasingly becoming infected with HIV, and women now account for 43.8% of newly reported HIV infections.

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[18] At the end of 2007, the cumulative number of children under the age of 14 that had tested HIV antibody positive was 17,277, of which 5,412 have been confirmed to be HIV-positive. However, only 257 children born in the previous 18 months had their HIV positive diagnosis confirmed in the same period. As a result, the proportion of mother to child transmission in 2007 was not 19.4%, as reported by the Ministry of Health, but 1.8% of all reported HIV cases.

[19] Study on Seroconvertor Behaviour. Unpublished data. International HIV/AIDS Alliance in Ukraine, 2007.

3.2.7 HIV among Patients with Sexually Transmitted Infections and other Groups in the General Population

Among people with sexually transmitted infections (STIs), there is some evidence of a slow but steady increase of HIV. In 2007, there were 791 positive tests of HIV reported among STI patients, an increase of 10% over 2006 (718 positive tests). Serious shortcomings in the coverage and completeness of routine HIV sero-surveillance among patients with STIs make it difficult to accurately monitor HIV incidence among this population. However, sentinel surveillance studies conducted in 2006 in 11 cities of Ukraine indicate the prevalence of HIV among patients with STIs varies from 0% in Lutsk to 5.7% in the cities of Kyiv and Donetsk.

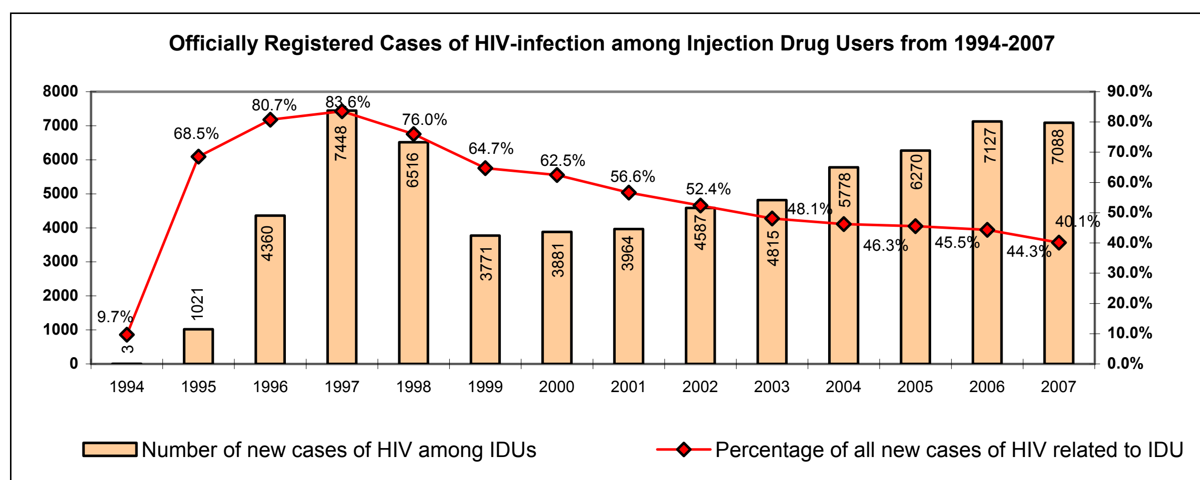
Relatively stable rates of HIV infection have been reported among other groups in the general population that are regularly tested for HIV, including military recruits, prisoners, and patients with clinical indications. Since 2005, the number and percentage of positive HIV tests among people who have been tested anonymously has also been relatively stable. However, as these tests are performed on an anonymous, unlinked basis, it is not possible to disaggregate the number of positive persons from the number of tests.

3.2.8 HIV among Foreigners

In the early years of the HIV epidemic in Ukraine, all foreigners visiting Ukraine for periods over three months were mandatorily tested for HIV, and those that tested positive were deported. However, since the adoption of the Ukrainian National Law on AIDS in 1998, the official policy states that HIV testing of foreigners is voluntary in Ukraine, and deportation is no longer practiced.[20] A small and relatively stable number of tests are conducted among foreigners in Ukraine every year (6,811 tests in 2007).[21] But this testing is characterized by weak provisions to ensure that such tests are performed on a voluntary and confidential basis, as required by law. Since the beginning of the epidemic, 360 cases of HIV were reported among foreigners, including 18 cases reported in 2007.

3.2.9 HIV among Most at-risk Populations

The HIV epidemic in Ukraine remains largely concentrated among MARPs, including IDUs, sex workers, MSM, and sexual partners of these populations. While there are gaps in the coverage and completeness of routine HIV sero-surveillance among these populations, official data indicate that the epidemic continues to increase among IDUs. However, the proportion of IDUs among all newly reported HIV cases is decreasing every year, from 83.6% in 1997 to 40.1% in 2007.



For the first time in recent years, the absolute number of persons newly diagnosed with HIV-infection among IDUs decreased slightly in 2007, from 7,127 cases in 2006 to 7,088 cases in 2007. Sentinel surveillance among IDUs conducted in 2006 indicated that the prevalence

[20] Mostly among foreign students and asylum seekers, who are frequently required to undergo mandatory HIV tests in Ukraine.

[21] Foreigners applying for a Ukrainian visa for a period over three months are still expected to present a certificate indicating that they are HIV-negative.

of HIV-infection among this population was significantly higher than in any other MARP, with HIV prevalence ranging from 18.0% in the city of Sumy to 62.8% in the city of Poltava. The 2007 national HIV estimates indicate approximately 164,000 IDUs living with HIV, representing 41.4% of all adults living with HIV. These data indicate that a significant proportion of IDUs with HIV remain undiagnosed and underreported.

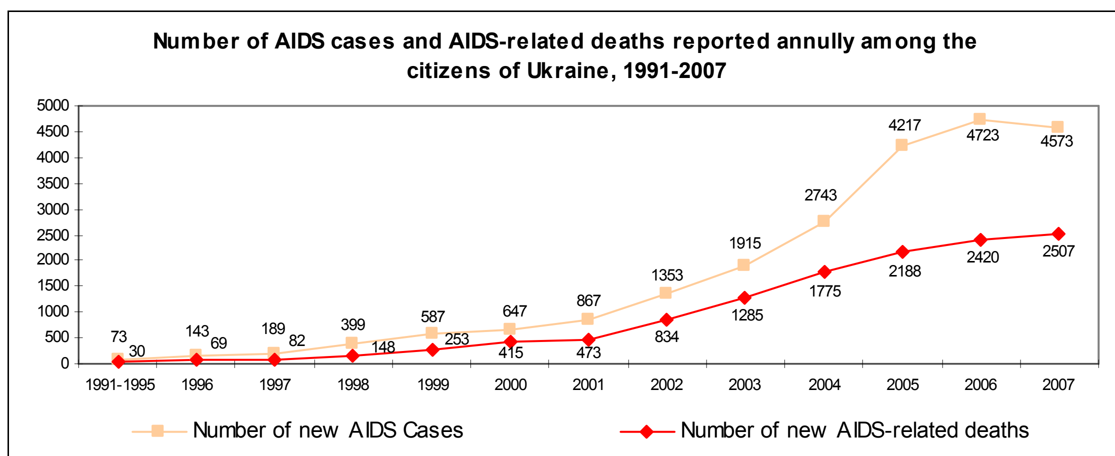
MSM are another population increasingly affected by HIV. In 2007, 48 new cases of HIV infection were officially reported among MSM, representing more than one third of the 158 cases registered among this population since 1987. It is widely suspected that there is significant underreporting of HIV infection related to sex among men, as many cases remain undiagnosed, or are misreported under other exposure categories. The data from sentinel surveillance studies in 2007 indicated that HIV prevalence among MSM in four cities was higher than previously estimated, ranging from 4.4% in the capital city of Kyiv to 23.2% in Odessa. These data suggest that male to male sexual transmission of HIV may be significant, but still largely hidden in Ukraine's HIV epidemic. Additional research is needed to determine what proportion of sexually transmitted HIV infection is related to sexual behaviour of MSM. The 2007 national HIV estimates indicate approximately 41,000 cases of HIV among MSM, representing 10.3% of all adults living with HIV. These estimates suggest that the majority of MSM living with HIV remain undiagnosed and underreported.

Ukraine does not conduct sero-surveillance for HIV among women and men who sell sex. While sex work is no longer prohibited by law in Ukraine, such statistics tend to be unreliable, and difficult to disaggregate from overall number of people living with HIV. Data from sentinel surveillance conducted in 2006 among FSWs indicate a large and growing HIV epidemic among this population, from 4.0% prevalence in Kyiv to 31.0% in Poltava. These data include only FSWs, as male sex workers are difficult to access. HIV prevalence among women engaged in sex work who also inject drugs is significantly higher than among women selling sex who do not inject drugs. Data from Kyiv indicate that HIV prevalence among sex workers who also reported injecting drug use was 5.9% in 2006, whereas HIV prevalence among sex workers who did not report injecting drug use was 3%. These data indicate the significant influence of injecting drug use on the prevalence of HIV among this population. According to the 2007 national HIV estimates, there are approximately 34,200 women living with HIV who are engaged in sex work, representing 8.6% of all adults living with HIV. Additional surveillance data among clients and sexual partners of MARPs and other bridge populations are still lacking in Ukraine.

In the absence of evidence to indicate that sexual transmission in the general population is sustaining the majority of new cases of HIV-infection, the HIV epidemic Ukraine remains classified as concentrated among MARPs.

3.2.10 AIDS Morbidity and Mortality

An increasing number of people have been diagnosed with clinical symptoms and AIDS. The number of newly reported AIDS cases has increased on an annual basis, reaching a 4,723 new AIDS cases in 2006, including 123 pediatric AIDS cases, with a minor decrease to 4,573 new AIDS cases in 2007, including 115 new pediatric AIDS cases.



The cumulative number of reported cases of AIDS in Ukraine from 1987 to the end of 2007 was 22,456. Of these, 22,424 cases were among citizens of Ukraine, including 685 children, and 32 AIDS cases were among foreigners. These figures include cumulative number of 12,511 deaths among persons with AIDS, of which 12,490 deaths were among citizens of Ukraine, including 241 children, and 21 deaths were among foreigners.

At the end of 2007, 8,944 AIDS cases were reported to be currently under medical observation at the network of AIDS Centres in Ukraine. Of these, over three-quarters of all AIDS cases (76.8%) were reported in seven regions of Ukraine, including Donetsk oblast (2,498 cases), Dnipropetrovsk oblast (1,444 cases), Odessa oblast (1,088 cases), Crimea (535 cases), the city of Kyiv (510 cases), Mykolayiv oblast (467 cases), and Kyiv oblast (333 cases). In 2007, there was a marginal decrease in the annual incidence of AIDS cases in Ukraine (9.8 cases per 100,000), with 4,753 new AIDS cases reported, compared with 4,723 new AIDS cases in 2006 (10.1 cases per 100,000). It is unclear whether this decrease in AIDS morbidity is due to a growing number of patients with advanced HIV infection being provided with ART while still at clinical stage III, thus inhibiting clinical progression to AIDS, or whether this indicates a more passive approach to clinical diagnosis and AIDS case registration. In the absence of such evidence, it cannot be concluded that the scale-up of ART is having a genuine impact on the reduction in AIDS morbidity.

AIDS mortality, which is a more reliable indicator of the impact of ART, has continued to increase from 4.6 per 100,000 in 2005 to 5.4 per 100,000 in 2007. Since the beginning of the epidemic, 25,318 deaths were officially reported among people with HIV. 12,490 of these deaths were related to AIDS, including 2,507 deaths in 2007 – the highest number of annual deaths ever reported. An additional 12,828 deaths were reported among persons with HIV related to other causes, including, most significantly accidental death and overdose among IDUs.

TB remains the leading opportunistic infection associated with AIDS morbidity and mortality. As of the end of 2007, 48% of all AIDS cases were diagnosed with active TB disease, including 4,324 patients with pulmonary TB and 923 with extra pulmonary TB. TB is also the leading cause of AIDS mortality, with 53% of AIDS deaths in 2006 associated with TB. TB patients with HIV in Donetsk were found to be almost twice as likely to have drug resistant TB than patients without HIV.[22]

The scale-up of ART for patients with advanced HIV infection was launched in August 2004. At the end of 2007, 7,657 patients were receiving ART, including 908 children. ART is now available in all 27 regions of Ukraine, but over two-thirds of all patients on ART (69%) are concentrated in six regions, including Donetsk oblast (1,417), Odessa oblast (1,009), Dnipropetrovsk oblast (762), city of Kyiv (757), Crimea (705), and Mykolaev oblast (681). The majority of these patients (69%, or 5,268 persons) are provided with ART under the programmes supported by the Global Fund grants, with 31% of patients covered by the state budget.

According to recent estimates, 21,770 patients with advanced HIV were in immediate need of ART at the end of 2007, indicating that ART is currently only covering 35%[23] of those in need. There is a growing trend toward increased coverage of ART, from 21% in 2005 (3,040 persons) to 27% in 2006 (4,777 persons); and 35% in 2007 (7,657 persons). On the basis of gender, data indicates that there is relative equity in access to ART, with coverage among women at 36% in 2006 and 45% in 2007; coverage among men consisted of 23% and 29%, respectively. The large and growing percentage of ART coverage among children (58% in 2006 and 73% in 2007) indicates that children have accelerated access to ART. However, the majority of patients in need of ART still lack access to treatment, including a disproportionately high percentage of IDUs with advanced HIV. As a result, the rapid scale-up of ART has not produced a concomitant decrease in AIDS mortality. On the contrary, AIDS mortality has continued to increase, indicating that the scale of ART scale-up remains insufficient to keep pace with the rate of clinical progression to AIDS and death.

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[22] Dubrovina I., et al., "Drug-resistant TB and HIV in Ukraine: a threatening convergence of two epidemics?" International Journal of TB and Lung Disease 12(7):756–762.

[23] Ukraine: National Report on Monitoring Progress towards the UNGASS Declaration of Commitment on HIV/AIDS. Reporting period: January 2006-December 2007.

Part 4: National Response to AIDS - Main Findings

Section A: Programmes and Services

4.1 Prevention among Most At-Risk Populations

Importance: High
Progress: Moderate

Overview

The HIV epidemic in Ukraine remains concentrated among MARPs, including, most significantly IDUs, sex workers, MSM, MARA, and prisoners who are located in a high-risk environment. Prevention programmes among these populations and their sexual partners play a decisive role in determining the course of the epidemic. Despite remarkable progress made for some of these population groups, the scope, scale, quality and intensity of prevention programmes among MARPs remain inadequate to halt the spread of HIV among these groups and to limit the potential spread of HIV to the general population.

The launch of prevention programmes focused on MARPs began in the mid 1990s, but the rapid scale-up of prevention programmes targeted at specific groups only commenced in 2004 with the advent of the Global Fund grant Programme. At the end of 2007, over 300 governmental and non-governmental organizations were providing prevention services for MARPs. The most significant progress has been made in the scale-up of services for IDUs in all regions of Ukraine. Harm reduction services are being provided for over 140,000 IDUs out of the low estimated number of 325,000 IDUs in Ukraine, with at least some prevention services for IDUs in all regions of Ukraine, with programmes concentrated in larger cities. These services are provided by over 100 NGOs supported by the Alliance under the Global Fund grants, and additional prevention programmes provided by 217 branches of the 'services for young IDUs' under the State Social Services for Families, Children and Youth (SSSFCY).

However, limited progress has been made in scaling-up prevention programmes among sex workers, MSM, prisoners, and MARA. As of the end of 2007, only 21,000 out of the low estimated number of 110,000 FSWs in Ukraine had ever been reached with some form of HIV prevention services between 2004 and the end of 2007. Progress has been seriously inadequate among MSM, where the cumulative number of clients ever reached with prevention services was only 10,000 of the low estimated number of 177,000 MSM in Ukraine. Only 45,000 prisoners out of 130,000 prisoners in Ukraine had ever been reached by an HIV prevention programme between 2004 and 2007. The coverage of the s MARA / MARY is extremely low (in 2007, only 30% of adolescent IDUs aged 10 to 19 years had been reached with HIV prevention programmes).

No prevention programmes exist for male sex workers. Prevention programmes have only recently begun to target the sexual partners of MARPs and MARA, who are the bridge populations that may facilitate the spread of HIV to the general population. Few of the prevention programmes are designed to adequately address overlapping risk behaviours, or gender- and age-specific vulnerabilities and risks.

While Government policy supports prevention programmes among MARPs, the Government is only providing limited financial support and implementing prevention activities among IDUs and prisoners. Prevention programmes for FSWs and MSM are supported almost exclusively by contributions from external donors and implemented by non-governmental and some FBOs, which is not sustainable. There are no national standards for the provision of prevention services among any of MARPs.

At the level of specific project sites, there is little data to demonstrate that these prevention programmes have improved knowledge or translated into safe behaviours among the target

populations, largely due to shortcomings in the site-level monitoring of programmatic outcomes.[24]

At the national level, behavioural surveillance studies provide evidence of significant improvement in the level of knowledge and safe behaviours among MARPs. Some epidemiological evidence suggests that the epidemic may have peaked among IDUs in some regions, albeit at extremely high levels. This evidence suggests that prevention programmes may finally be having an impact on the epidemic. But this evidence also suggests that these programmes were implemented too late and too slowly to control the epidemic when HIV was still nascent among IDUs, sex workers and MSM. The absence of national and regional multisectoral prevention and behavioural change communication (BCC) strategies targeted to people engaging in high-risk behaviour has also greatly hampered progress in this area. There is limited use of integrated prevention service networks and client management approaches to help the clients navigate through barriers to access services for prevention, treatment and care in Ukraine.

Serious gaps remain in the coverage and quality of priority interventions essential to the prevention of HIV among MARPs, including the insignificant coverage of OST among IDUs and almost complete absence of prevention programmes among people living with HIV and their sexual partners. Current harm reduction programmes, focused on needle exchange, are doing little to prevent the transmission of HIV through preloaded syringes, now commonplace among IDUs in many regions in Ukraine. The uptake of current prevention programmes seems to be slowing down. Based on the estimated size of these populations, the majority MARPs who are most vulnerable still are not accessing prevention services on a regular basis.

Numerous barriers still exist to service access, particularly for MARA, ranging from legislative barriers to a lack of health-seeking behaviour among these populations and widespread discrimination. Many prevention programmes for MARPs are neither gender- nor age-specific. Possible entry points for HIV prevention among MARPs are underutilized, for example in the primary healthcare sector, pharmacies and in sexual and reproductive health services. Unless significant improvements are made to enhance the quality and speed of the implementation of prevention programmes for MARPs, it is unlikely that Ukraine will reach its targets for Universal Access to prevention for these populations and have an impact on the epidemic.

Importance / Impact on Epidemic

This is an area of highest importance that is essential to success of the national prevention efforts. The design, scope, coverage and quality of prevention programmes for MARPs will have a decisive influence on future of the HIV epidemic in Ukraine. The frequency of service provision of these prevention programmes will determine whether the epidemic among MARPs is reversed or continues to expand. The comprehensiveness of these programmes will also influence whether the majority of new infections will remain concentrated within these populations, or will shift towards concurrent sexual transmission in the general population, indicative of a generalized epidemic. The current status of programmes and trends in this area suggest that further scale-up of these programmes is already facing a series of critical obstacles. Key obstacles include the lack of capacity to expand the coverage of these services, the lack of a multisectoral prevention strategy, the absence of integrated prevention service networks, and, with the exception of IDUs and prisoners, and the lack of Governmental commitment to financially support and sustain these programmes. If these obstacles are not urgently addressed, there is a credible risk that epidemics in these populations, already unresponsive to current prevention programmes, will continue to deteriorate.

[24] For example, the Alliance does not require its sub-recipients to collect or analyze data that would demonstrate how risk behaviour or the prevalence of HIV has changed over time among clients of its prevention programmes. Such data is essential to demonstrate the effectiveness of prevention programmes at specific sites. Linking such data to the frequency of service provision could also indicate whether clients that access services more frequently indeed report safer behaviours.

Progress

Among all areas of prevention, HIV prevention among MARPs has experienced the most rapid growth, but only moderate progress. Since 2004 there has been commendable progress in mobilization of resources and scale-up of programmes for some MARPs. Extensive networks of non-governmental and governmental organizations providing HIV services for IDUs now exist, and there is increasing local collaboration between these networks in the delivery of prevention services. However, progress has been inadequate to keep pace with the scale and the intensity of the epidemic. In particular, the geographic scope of programmes has been uneven and the coverage of specific populations remains imbalanced.

The Government's lack of commitment to provide resources, support and services for sex workers and MSM and to address the existing financial and administrative barriers to service access for MARA demonstrates an inadequate Government response to address the HIV epidemic in those populations most at-risk. The Government's support for prevention among prisoners is adequate, and is hindered by reluctance to introduce harm reduction and substitution treatment in prisons, even though these interventions are safe, evidence-based, and would have a decisive impact on prevention efforts in this population. Service delivery between Governmental and non-governmental service providers have been poorly coordinated, and in many instances remain non-existent, which represents a serious risk to the sustainability of the prevention programme supported by the Global Fund grants and the viability of overall national prevention efforts.

The design and implementation of HIV prevention programmes in this area are largely consistent with the needs of the populations currently covered. But in order to ensure greater coverage of these populations, and enhance their effectiveness, these programmes require some significant revisions and improvements. For example, many of the prevention services supported by the Alliance and implemented by its sub-recipients have started to provide access to services beyond HIV-specific and other healthcare services, such as psychological, social, legal, vocational training, behaviour change communication and skills building – services which are important to reduce their vulnerability to HIV and maintain their involvement in prevention programmes. However, these services are not specifically targeted at MARA, and the majority of prevention services provided by the SSSFCY do not offer access or referrals to such services. In addition, an outreach component in the SSSFCY services is lacking, even though service-seeking behaviour is very low among these population groups.

Current prevention services often do not reach those most hidden and vulnerable and most at-risk, and are not well-suited to address emerging sub-groups – for example non-opioid/stimulant drug users, or members of the social and sexual network of MARPs. Until recently, the lack of a clear policy to support the implementation of low-threshold OST with methadone has also been a major shortcoming of prevention efforts among IDUs. With the recent approval of OST with methadone, it is hoped that this problem will finally be rectified, but much still depends on how quickly and effectively this policy is implemented with the active support of government officials and medical specialists. All prevention programmes warrant greater consistency of quality and range of basic services among different service providers and sites.

Policies & Regulations

The Government of Ukraine and the Parliament of Ukraine are recognized to have taken momentous positive policy steps to enable prevention programmes among these populations. Ukraine is one of the few countries of the Commonwealth of Independent States (CIS) where there are no national laws or regulations that explicitly prohibit or critically undermine HIV prevention activities among MARPs. Ukraine was the first country in the former Soviet Union to decriminalize male to male sex in 1991; in 1998 Ukraine officially adopted harm reduction as state policy for HIV prevention among IDUs, including

governmental support for needle exchange. In 2006, the Parliament decriminalized sex work, thus removing the last significant legal barrier to HIV prevention among this population.

However, several contradictions still exist in Ukrainian legislation that undermine HIV prevention programmes, including restrictions on access to services for minors and those who are sexually exploited through their involvement in sex work or who require child protection services. Requirements for obtaining consent of a legal representative also represents a serious obstacle for most MARA to access essential prevention services. Mandatory HIV testing of children in shelters, which is common practice, represents a violation of human rights and unjustified in the absence of adequate follow-up services and long-term care options for children who are living on the streets, are using drugs and may be infected with HIV.

Although prostitution is no longer a criminal offence, sex work remains an administrative offence for which the sex workers are liable to be fined. There are frequent reports of police harassment, including demands of free sex in lieu of sex workers paying such fines. These and other cases indicate that the enforcement of protective laws is inadequate to prevent widespread discrimination and exploitation of MARPs.

A large number of other ambiguous governmental regulations at the national and oblast level also precipitate risk behaviour rather than prevent it. These regulations serve to undermine the access of MARP to prevention programmes, and also impairs their outcomes. Some vivid examples include the low maximum quantity of narcotics liable for criminal drug possession, which encourages IDUs to avoid contact with governmental services. Rather than promoting needle exchange and safe use, police harassment of IDUs for possession of a large number of syringes or the risk of arrest for visiting a harm reduction site is more likely to encourage IDUs to share and reuse contaminated syringes.

The lack of a policy supporting harm reduction and substitution therapy in the Ukrainian prison system is not contributing to the prevention of drug use in the prison system, but is likely to facilitate the unrestricted transmission of HIV among prisoners that inject drugs. Similarly, the reluctance of prison authorities to recognize the existence of male to male sex and heterosexual contact in prisons inhibits condom distribution in prisons and thus limits the full implementation of programmes for harm reduction and prevention of sexual transmission among prisoners and detainees.

The existence of such ambiguous legislation and regulations, the absence of clear and supportive prevention and protection policies, oppressive street raids, and the continued violation of the rights of MARPs and MARA, tend to foster mistrust among such groups towards accessing HIV prevention services, particularly those supported by the Government. Weak or discriminatory policies encourage such populations to remain ‘underground’, where risky HIV behaviours are more likely to perpetuate.

Prevention of HIV among ‘vulnerable populations’, as they are defined in Ukrainian laws and policies, is identified as a key component of the Government’s Strategic Concept on HIV/AIDS for 2004-2011 and the National AIDS Programme (2004-2008). The importance of HIV prevention among some population groups engaging in HIV risk behaviour is well defined in these documents, and reflects some of the key international principles of HIV prevention, such as equal access, quality, human rights protection, comprehensiveness (beyond healthcare services), peer-to-peer and outreach, interactive and skills-building approaches in education, health promotion, and self-support. Yet, the Ukrainian National Law on AIDS specifically mentions only support for prevention activities among IDUs, with no reference to the Government’s responsibility to ensure prevention programmes for other MARPs, including most importantly, sex workers, MSM, and other vulnerable groups. The National AIDS Programme includes activities to ‘ensure access for representatives of vulnerable groups to targeted activities and HIV/AIDS/STI prevention programs,’ but does not specify which populations are targeted, or who is responsible for what activities, and how the prevention services provided by NGOs will be sustained and regulated. These

documents often confuse HIV risk behaviour and vulnerability to HIV. These limitations and ambiguity underscore the critical lack of a comprehensive national policy on HIV prevention that specifically indicates support for HIV prevention and behaviour change communication among all populations and groups that engage in high risk behaviour.

Main Recommendations

Immediate:

MR.4.1.1 Ensure that the new National AIDS Programme specifically identifies the importance of HIV prevention among all populations that are most at-risk for HIV-infection and their sexual partners, and other groups that are vulnerable to HIV

Short-term:

MR.4.1.2 Develop a national, multisectoral policy on HIV prevention that explicitly specifies priority support for prevention programmes among MARPs and lines of accountability for its implementation

Medium-Term:

MR.4.1.3 Revise the National Law on AIDS to expand State guarantees to provide prevention services for all MARPs, including minors

MR.4.1.4 Conduct a detailed inventory of Governmental policies, regulations and practices that undermine or inhibit HIV prevention programmes among MARPs, and systematically revise them to eliminate or at least minimize their negative impact

Planning

The process of planning programmes for MARPs has improved greatly in recent years, especially with the establishment of multisectoral coordination mechanisms at various levels, but remains intermittent and ad hoc. This process is hindered by a consistent lack of leadership and ownership from the Government and the absence of clear regulations for governmental-non-governmental and public-private partnerships, as well as for inter-departmental cooperation. Significant achievements include the development of the Road Map, which established a common understanding of a clearly defined package of essential services for each MARP, and the development of the Global Fund Round 6 proposal in 2006, recognized by many national stakeholders as a pivotal process that catalyzed unprecedented collaboration and planning to scale up of prevention programmes. However, the plans and targets elaborated in the Road Map remained largely declaratory, with no measures adopted by the Government of Ukraine to integrate the Road Map into national plans and programmes.

The Round 6 process was more successful in producing concrete results and plans for scaling up prevention programmes for MARPs. The Round 6 process was driven largely by non-governmental and international organizations, with only limited and inconsistent involvement from the Government. Notable exception to this has been growing collaboration between the Ministry of Family, Youth and Sport and the Alliance in planning and coordination of prevention services for young IDUs, which has led to a Memorandum of Understanding on coordination of service provision and development of consistent M&E tools, and some collaboration between the State Department for the Enforcement of Sentences (SDES) and NGOs in the implementation of prevention programmes in the prison system. However, the current Global Fund programmes continue to provide no funding for the prevention services for young IDUs supported by the SSSFCY, thus limiting the scope of coverage and collaboration in this critical area.

Since the Round 6 proposal was approved by the Global Fund in 2007, responsibility for the operational planning for the majority of prevention activities among MARPs rests chiefly with the Alliance as the co-PR of the grant. While the Alliance has developed a strong track-record for the successful implementation of the Global Fund Round 1

programme, it should not be expected to assume lead responsibility for implementation of the majority of prevention programmes for key MARPs in Ukraine, including IDUs, sex workers, MSM, and prisoners in Ukraine. The Global Fund grant is supposed to serve as an addition to existing programmes and services, yet in reality the grant support programme has served as a substitute for the lack of larger national prevention programmes.

Positive prevention among people living with HIV is the exclusive responsibility of the Network as co-PR under the Round 6 grant. The Network has been slow to plan and implement programmes in this area, a problem which is compounded by the absence of positive prevention services for people living with HIV at regional AIDS Centres.

Overall responsibility for prevention activities among MARA remains unclear, although the Ministry of Family, Youth and Sport is providing leadership in this area in partnership with UNICEF. Otherwise, Government involvement is consistently weak in other donor-funded prevention programmes. Similar concerns exist at the subnational level. In some regions, local branches of the Centre of Social Services for Families, Children and Youth provide leadership in governmental coordination of prevention among IDUs and other MARA, in collaboration with other partners. In the case of prevention programmes for other MARPs, however, practical planning and programming is largely determined by local NGO sub-recipients of the Alliance, often without any guidance or involvement from the oblast government or other service providers.

Main Recommendations

Medium-term:

MR.4.1.5 Use the Road Map as the basis for planning the scale-up of prevention services for MARPs

MR.4.1.6 Develop workplans for HIV prevention for different populations as subcomponents to the new National AIDS Programme at the national and oblast levels

MR.4.1.7 Review essential set of services in the Road Map to assure that the needs of MARPs in different settings and sub-groups are addressed, and ensure their implementation across different sites and service providers

MR.4.1.8 Earmark a growing proportion of funding from the Global Fund Round 6 grant for harm reduction services provided by the SSSFCY on a non-tender basis (subject to specific performance requirements)

Financial Resources

Large and growing financial resources have been provided for HIV prevention among MARPs in Ukraine, indicating that prevention programmes for these populations are increasingly receiving much needed attention. The most recent data from the National AIDS Spending Assessments (NASA) indicates a substantial increase of funding for prevention among MARPs, from UAH18M (USD3.5M) in 2005 to UAH41M (USD8.2M) in 2006. However, funding for all prevention services among MARPs in 2006 accounted for only 46% of all prevention expenditures, which is inconsistent with the dominant role of these populations in the HIV epidemic in Ukraine. Despite the increase in funding from government and donor sources, the continued growth of the epidemic in these populations demonstrates that current expenditures remain far short of meeting current needs, and raise serious questions as to how well existing funds are being allocated and used.

Over 80% of funding for these prevention programmes is provided by international or foreign donor sources, most significantly from the Global Fund. The low amount and proportion of Government funding in this area, which includes expenditures at the national and subnational levels, suggests that serious barriers remain to ensure Government support and mid-term sustainability of these programmes.

The proportion of funding for prevention activities among different populations indicates that prevention programmes specifically for IDUs, including harm reduction and substitution therapy, received over 70% of all funding for MARPs. This proportion is consistent with the paramount importance of IDUs. However, the total amount of resources for prevention programmes among other MARPs, particularly MSM and prisoners, FSWs that do not inject drugs, MARA, and people living with HIV, are seriously inadequate and in some cases even non-existent.

Main Recommendations

Immediate:

MR.4.1.9 Ensure that the new National AIDS Programme allocates and earmarks proportionate funding for prevention programmes among MARPs broadly consistent with their role as the source of the majority of new HIV infections

Medium-Term:

MR.4.1.10 Increase the proportion of Government funding for prevention programmes among all MARPs, with the aim of ensuring that programmes, independent of implementation agent, are sustained by government support by 2013

Targets

Targets for prevention programmes among MARPs are largely consistent with international best practices, with high and ambitious targets for Universal Access set to cover the majority of largest MARPs. Targets were set in 2006 as part of the planning to scale up towards Universal Access, and reflect extensive consultation with partners at the national and subnational levels. National targets for MARPs were set according to robust, up-to-date, and scientifically-valid estimates of the size of these populations, and were not limited to the officially registered numbers of these groups, which are considerably smaller and underreported. In particular, targets for IDUs and sex workers aim to reach 60% of the estimated size of these populations by 2010. Targets for MSM and prisoners were slightly lower, at 45% and 50%, respectively. While targets for MARA and especially vulnerable children and adolescents were set at 60%, the estimates of size of these population groups are less robust than for the other MARPs and should be reviewed.

Some stakeholders have expressed concern that the targets for MSM are significantly lower than those of other MARPs, suggesting discrimination and/or weaker support for scaling-up prevention programmes among this population. Given the extremely low level of current coverage of services for MSM, however, the evaluation regards the current target of 45% coverage as ambitious, and it will require unprecedented efforts to reach even this target. Emphasis should be placed on building the capacity of organizations to reach the existing targets, especially for MSM, rather than advocating for increasing targets that are unlikely to be achieved. However, the target for prisoners is considered to be too low as prisoners are easily accessible. There is no reason why the coverage of programmes among prisoners could not be increased to at least 80% in a very short period of time.

Current targets were also based on a robust definition of coverage to include individual clients, and not the number of visits to services (which include repeat visits). The targets also refer to a minimum package of services that includes the provision of information, condoms and/or syringes (as required), access to VCT and referrals to other health and social services.

However, current targets have five serious shortcomings:

I. They do not clearly specify the frequency of service provision for a client to be counted as covered or reached. While it is assumed that the targets refer to the number and percentage of clients that access such services at least once within a period of 12 months, such frequency of coverage is seriously inadequate for all MARPs. In the absence of a clear international expert consensus on the optimal frequency and intensity

of coverage, Ukraine should still adopt a robust national definition of coverage among specific MARP, with coverage for all groups not less than once per quarter.

II. The amount of prevention commodities (number of condoms, syringes, etc.) provided to an individual client during each visit is often insufficient to meet his/her needs, particularly if the client accesses such services on an irregular or infrequent basis.

III. The targets have never been effectively disaggregated at the regional level, so regional or oblast authorities are not able to plan the number of percentage of the national target they are expected to reach within a specific period of time.

IV. Although all of these targets were endorsed by the NC in April 2007, they were never subsequently reflected into the National AIDS Programme (2004-2008) or the new National AIDS Programme currently under development.

V. The targets do not specify referrals or access to HIV treatment, care and support services for people engaging in HIV risk behaviour.

Main Recommendations

Immediate:

MR.4.1.11 Clarify the frequency of coverage separately for each MARP, disaggregated by age and sex

Short-term:

MR.4.1.12 Increase targets for prisoners to at least 80% coverage by the end of 2010

Medium-Term:

MR.4.1.13 Ensure prevention targets are not limited to funding commitments from external donors (Global Fund / USAID, etc.)

MR.4.1.14 Ensure targets include services provided by governmental and non-governmental organizations

MR.4.1.15 Adjust national targets on an annual basis to reflect possible emergence of risk behaviours among different populations, changes in the definition of coverage, and changes in the size of the existing populations (revision of denominator and thus percentage to be covered), as well as realistic progress towards the achievement of targets by all partners [25]

Coverage

The coverage of prevention programmes among IDUs, FSWs, and MSM has improved in recent years, but remains insufficient, particularly for adolescents engaging in risk behaviour. Coverage needs to be substantially and rapidly increased to have a decisive impact on the spread of HIV among these populations. The most notable progress has been made in the coverage of prevention programmes among IDUs, which have been scaled up to include all regions of Ukraine, and now represents one of the largest prevention programmes among IDUs in Eastern Europe. The harm reduction programme coordinated and monitored by the Alliance and primarily supported by the Global Fund grants and additional funding from USAID has cumulatively reached over 140,000 IDUs since 2004 – one of the most substantial achievements in the national response to HIV in Ukraine. The Alliance also maintains a system for ensuring that the coverage reflects the number of individual IDU clients, which is a more accurate standard for monitoring the coverage of programmes than counting the number of client visits. However, IDU coverage under the programme supported by the Alliance remains very limited outside of large oblast capitals, and does not specifically target adolescent IDUs.

Rapid progress is also being made by the ‘services for young IDUs’ to reach young IDUs, which is supported by the SSSFCY. The State Social Services reported over 40,000 IDUs reached with prevention services in 2007. Due to the lack of an integrated monitoring

[25] It is recognized that any such revision has serious implications for targets already agreed in grant agreements with the Global Fund. Where the Global Fund is reluctant to any revision of coverage targets, even if they are based on revised data, then the Global Fund targets would likely remain fixed, even though would risk inconsistency with the revised national targets.

system, double counting of clients between the governmental and non-governmental programmes cannot be excluded. Nevertheless, the cumulative number of clients reached by both of these programmes suggests that coverage may now exceed 180,000 IDUs, or 55% of the low population estimate – indicating considerable progress in just four years.

The coverage of prevention programmes for sex workers, however, is far from meeting current needs. Prevention programmes exist in all regions of Ukraine except for Luhansk, Lutsk, Ternopil and Zhytomyr oblasts, but remain concentrated in large, oblast cities, and focus almost exclusively on FSWs. Recent data indicates that only 41% of sex workers accessed prevention services provided by NGOs in the last month, and 32% have never accessed such services. The cumulative coverage of the existing Global Fund programme is completely inadequate to stop or even slow the transmission of HIV between FSWs and their clients. Prevention programmes among sex workers that are supported by other partners have even lower coverage. There is very limited coverage of sexually exploited children and youth, and FSWs in bars, saunas and hotels. There is almost no coverage among the population of sex workers who migrate to work abroad or in costal resort cities, and of male sex workers. Access to services for the prompt diagnosis and treatment of STIs remains inadequate for sex workers and their clients.

A cumulative number of 45,000 prisoners have been covered by prevention programmes, or 34% of the current number of 130,000 prisoners. Given that all prisoners in Ukraine are easily accessible and in an environment that poses significant risk for HIV infection, such coverage is unacceptably low. The low level of coverage among prisoners indicates the systematic reluctance of prison authorities to implement comprehensive and much needed prevention programmes, such as harm reduction, and the inadequate among of support from the Government and donor sources to scale up prevention coverage in the prison system.

Among MSM, the only sustained prevention programme is also supported by the Global Fund grants, and reports only 10,000 cumulative clients, limited to prevention projects in nine cities. This is equal to coverage of less than 6% of the low population estimate of 177,000 MSM. This current scope and rate of coverage among MSM is too low to have any impact on the epidemic in the population, and suggests a near failure to scale up prevention services for MSM in Ukraine.

The coverage of prevention programmes among adolescents and young people who inject drugs, or young MSM, as well as of those living or working on the streets or in prisons remains extremely low or data is non-existent.[26] Current programmes are doing too little to protect adolescents and young people who, due to their age, biological and social vulnerability, and often higher levels of risk behaviour than their older counterparts, are in need of special attention.

No prevention programmes yet focus on prevention among pre-injectors, despite data showing that non-injecting drug using friends or sexual partners of adolescent IDUs are at high risk of starting to inject drugs. Few, if any, interventions are directed at sexual partners of IDUs, which represents the most critical shortcoming in the quality and efficacy of current prevention programmes among IDUs given the existing evidence of high risk sexual behaviours and high rates of STIs among IDUs.

Main Recommendations

Short-term:

MR.4.1.16 Introduce definition of active (actual) coverage to include only individual clients that have accessed services at least once within a specific period of time, specified for each MARP; the definitions should be informed by

[26] Data supporting this finding has been available for the first time in late 2007 from a secondary analysis of MARA data derived from the behavioural surveillance studies among MARPs, due to the inclusion of larger samples of adolescents into studies, and from a baseline behavioural study among street-based adolescents conducted by UNICEF and the Ukrainian Institute for Social Research.

international evidence of effective minimum frequency of coverage among specific populations and reflecting a consensus among national partners (i.e. IDUs and MARA – at least once per quarter; sex workers, MSM, and prisoners – at least once every six months; other populations – at least once per year)

Medium-Term:

MR.4.1.17 Expand coverage among all programmes to target adult and adolescent IDUs, sex workers, and MSM in smaller cities and towns where there is evidence of risk behaviour, using mobile outreach, and where appropriate, peer driven interventions (PDI)

MR.4.1.18 Change definition of coverage for donor reporting (Global Fund) from cumulative basis to an annual (12 month) basis

Quality of Services

The quality of some prevention services is adequate and consistent with international standards, but the majority of services still require some immediate modifications to increase their quality and efficacy. The basic package for harm reduction and HIV prevention among IDUs is comprehensive and relevant to the complex needs of this population.[27] The quality of harm reduction programmes is largely consistent across different sites and different regions supported by the Alliance and its grant recipients. Programmes supported by the Alliance have not placed adequate emphasis on promoting BCC to promote safer sexual behaviour and consistent condom use among IDUs and their sexual partners, nor on the specific needs of female IDUs and FSWs who are injecting (i.e. referrals to PMTCT services), or adolescent IDUs. The Alliance is implementing internal systems for service quality monitoring of prevention programmes. These systems need to be accelerated and implemented consistently across all sub-recipients, and subject to the results, they may merit expansion to other partners beyond the Global Fund programme.

Among FSWs, the quality of programmes is less consistent, with serious shortcomings in the design of programmes and their intensity. The basic package for HIV prevention among sex workers is largely relevant to the needs of this population.[28] However, at the level of service delivery, there is not a standardized package of interventions that should be accessible to all sex workers.[29] For example, prevention projects supported by the Global Fund and implemented by different sub-recipients provide varying components of the package.

The valuable expertise of sub-recipients and established sex work programmes that have a strong understanding of the needs of sex workers in their city/region is rarely sought by the Alliance to improve the overall programme or share with other sub-recipients.[30] NGOs implementing these projects have limited opportunities to share lessons learned with other service providers, as networks to facilitate horizontal cooperation do not exist.

Several examples exist of sub-standard or poor quality projects and inadequate mechanisms for monitoring the quality of services. Many programmes for sex workers have been developed as an 'add-on' to existing harm reduction projects, which has promoted a bias

[27] The package of services for IDUs includes needle exchange / sterile syringes and disinfectants, community-based and peer-led outreach and education, information and education, access to VCT (referrals and increasingly with onsite rapid testing), referrals to other services, HIV prevention information (brochures), and commodities for prevention of sexual transmission (lubricants and male condoms).

[28] The package of services for sex workers includes community-based and peer-led outreach and education, information and education, access to VCT (referrals and increasingly with onsite rapid testing), referrals to other health and social services, HIV prevention information (brochures), and commodities for prevention of sexual transmission (lubricants and male condoms), as well as access to syringes, as required.

[29] International best practice recommends the following essential health sector interventions for FSWs: behaviour change communication, condoms, VCT, STI diagnosis and treatment and harm reduction for those who inject drugs. In addition, reproductive health and violence prevention interventions as well as vulnerability reduction strategies are recommended as part of a comprehensive response.

[30] One project in Poltava has even been documented by UNAIDS as a model of "best practice."HIV and STI prevention among sex workers in Eastern Europe and Central Asia. (UNAIDS best practice collection) UNAIDS/06.10E". http://data.unaids.org/pub/Report/2006/jc1212-hivpreveasterneurcentrasia_en.pdf

towards sex workers who also inject drugs, often at the expense of other women involved in sex work with different needs.

The number of condoms given to FSWs and the frequency of service provision are totally inadequate to meet the prevention needs of most FSWs. The Alliance reports to have developed a system for monitoring service quality at site level, but there is no evidence that this has resulted in increased number of clients, greater usage of services, or more consistency in quality of services for sex workers across different sites.

In most prevention projects for FSWs, effective and sustainable interventions, such as peer education, quality BCC, reduction of violence and empowerment of sex workers are missing. Programmes also need to focus on promoting consistent condom use with regular and casual sexual partners, as well as with paying clients. Work with sexual partners and commercial clients of FSWs has only recently started, and is limited to select sites and remains at a very small scale.

Projects are not addressing the specific needs for HIV prevention and child protection among minors who are sexually exploited. HIV prevention services for male sex workers as well as transgendered and transsexual sex workers are almost non-existent.

While the use of female condoms was planned under the Global Fund Round 6 grant programme, they are not currently provided to FSWs. Targeted social marketing of female condoms among sex workers is also needed to address barriers to their acceptance and use.

HIV prevention interventions for sex workers need to be expanded in terms of coverage, quality, and provision of comprehensive services, including those outside the health sector (legal, social services, vocational training and skills building) for both female and male sex workers.

Quality of Condoms

In 2007, the Alliance received a large donation of American-made condoms from USAID and began to distribute them to its sub-recipients. These condoms were self-reported by several clients to be of poor quality and have an unpleasant odour. In order to address these concerns, the Alliance conducted laboratory tests on the condoms which indicated that these condoms met all safety and quality requirements. However, client dissatisfaction led to a precipitous reduction in the demand for these condoms, particularly among sex workers. This case is an important lesson in the need for advance planning and consistency of delivery of prevention services and commodities. Similar concerns have been expressed about the introduction of female condoms planned under the Global Fund Round 6 programme.

Once clients are accustomed to a particular standard of prevention commodities, it can be destabilizing to ask them to switch, particularly if the new commodities are unfamiliar or perceived to be of inferior quality. In order to ensure that the number and frequency of client coverage continues to increase, such programmatic changes should be carefully planned through close consultation and focus group testing with clients of the programmes before any new prevention commodity is introduced.

The quality of prevention services for MSM has improved, but remains inadequate to impact and sustain mid-term behavioural change in this population. The minimum package of services, which is outlined in the Road Map and in the service package that is being implemented with support of the Global Fund grants, envisions a comprehensive package of services. In practice, the majority of prevention services for MSM are limited to outreach and health education, condom promotion and the distribution of IEC materials.[31] Services

[31] The package of services for MSM includes community-based and peer-led outreach and education, information and education, access to VCT (referrals and increasingly with onsite rapid testing), referrals to other health and social services, HIV prevention information (brochures), and commodities for prevention of sexual transmission (lubricants and male condoms), as well as access to syringes, as required.

are primarily targeting MSM who self-identify as 'gay'. There are few interventions targeting MSM who do not self-identify but may engage in episodic and high-risk sex, or among young men and boys living or working on the streets. The delivery of services for MSM should ensure the regular provision of comprehensive services like VCT, STI services, as well as individual and group interventions which are still not being offered as part of the standard package of service at all sites. The more frequent use of innovative interventions, such as peer education and internet-based interventions may be more appropriate and effective than just focusing on community outreach to this hidden population. Research has also indicated that lesbian women engage in risk behaviour such as unprotected sex with men and injecting drug use, but these behaviours are not being addressed by current interventions.

Among prisoners, the SDES has made some progress in recognizing the need for HIV prevention programmes and supporting the introduction of HIV education in the prison system. The SDES has received significant support from international partners to design and implement interventions. Yet, the quality of prevention programmes is low and the implementation of these activities remains inconsistent and is difficult to sustain, given that few interventions have been institutionalized. The basic prevention package is very limited,[32] and its provision is often at the discretion of the prison authorities, and is restricted by the inadequate availability of resources. For example, condoms for male to male sex are provided on an irregular basis, and rarely if ever, with adequate or additional lubricant. Some health education services, such as lectures or training via prison loudspeakers featuring messages about HIV are not appropriate vehicles for disseminating information, and are a poor substitute for one-on-one HIV counselling and peer education.

The poor and inconsistent quality of prevention programmes in the prison system is a serious impediment to their impact. An increasing proportion of the prevention services are delivered by the prison staff, but there is no effective system for monitoring the quality of these services. No safe and reliable mechanism exists for prisoners to communicate concerns about poor or inconsistent services. If other governmental authorities have yet to recognize sex workers or MSM as populations for which they are responsible, the SDES has direct and exclusive responsibility to protect the health of prisoners, and for the quality of prevention programmes in the prison system. The reluctance of the SDES to support the implementation of harm reduction programmes, including substitution therapy, despite offers of international assistance to support such interventions, is inconsistent with the needs for HIV prevention in prisons and detention centres. Even VCT, which is one of the few interventions that is strongly supported by the prison authorities, is not accessible to prisoners on a consistent basis. Lacking their own resources to purchase HIV test kits, the majority of prison facilities are dependent on regional health administrations, where such test kits are already in short supply. For the small percentage of prisoners that are covered by prevention programmes, the scope and quality of these programmes is not adequate to have a significant impact on the prevention of HIV transmission among prisoners. HIV prevention has yet to be mainstreamed in probation services, or into pre- and post-release support programmes, and no prevention programmes exist in detention centres. This is important to ensure HIV prevention and support services begin during detention, continue upon release, and that ex-prisoners may access information, prevention commodities and support.

Across the spectrum of prevention programmes for MARPs, special attention needs to be given to ensure the consistent supply of prevention commodities. In late 2007 and early 2008, several problems were reported in the inadequate and inconsistent supply of prevention commodities. In particular, several prevention projects among MSM were without lubricants for extended periods of time. Such shortcomings in PSM can dissuade clients from accessing prevention services on a regular basis, and thus perpetuate risky behaviour.

[32] The package of services for prisoners includes information and education, access to VCT, HIV prevention information (brochures), disinfectants, and commodities for prevention of sexual transmission (male condoms).

Main Recommendations

Short-term:

MR.4.1.19 Revise the definition of minimum package of prevention service for sex workers, MSM, and prisoners to address current shortcomings

MR.4.1.20 Use shortcomings identified in this evaluation as basis for enhancing quality of prevention programmes supported by the Alliance for implementation in Global Fund Round 6, Phase 2 grant

Medium-Term:

MR.4.1.21 Ensure consistent implementation of the minimum package of services across all sites, including governmental and non-governmental service providers, including FBOs

MR.4.1.22 Ensure that each service contact includes on-going and periodic risk assessments and BCC, with intensified risk reduction counselling and active referrals to other services for most vulnerable clients and clients with high risk behaviour, based on a client management approach

MR.4.1.23 Develop specific strategies to address safe sexual behaviour of IDUs and programmes to focus on sexual partners of IDUs and on pre-injectors

MR.4.1.24 Implement social marketing of female and male condoms beyond the activities funded by the Global Fund

MR.4.1.25 Develop standards for quality of all prevention programmes among MARPs, and monitor their implementation

MR.4.1.26 Establish and integrate systems of regular client feedback into service monitoring to better understand clients' needs, preferences and service-seeking behaviour

MR.4.1.27 Establish targeted programmes for adolescents engaging in HIV risk behavior

Outcome / Impact

Data from Ukraine's most recent UNGASS report indicate that prevention programmes among MARPs have made progress in improving knowledge about HIV and promoting safe behaviour, but to date have not made a measureable impact on reducing the number of new infections or halting and/or reversing HIV prevalence.[33] Among IDUs, in 2007 47% correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. The majority of IDUs (>75%) are aware of how HIV is transmitted, including 95% who are aware that HIV is transmitted through the use of shared syringes and needles. The percentage is lower though among adolescent IDUs aged 13 to 19 – only 42% could correctly identify the ways how HIV is transmitted. 84% of IDUs reported the use of sterile injecting equipment the last time they injected, but this does not indicate consistent safe injecting practices. While 79% of adolescent IDUs reported the use of sterile injecting equipment at last injection, when asked about their injecting behaviour over the last month, 30% admitted to have shared needles, 58% to have injected drugs using pre-filled syringes, and 65% to have drawn up their drugs from a common mixing container. The use of pre-filled syringes is of particular concern. Current programmes may be having little impact on prevention of HIV transmission via loaded syringes, as 60% of IDUs reported using syringes that were already preloaded with prepared drugs. Among adolescent IDUs, only 27% reported to always use a condom with their steady partner, 35% with commercial clients, and 36% with casual sexual partners.

There is preliminary evidence that the epidemic may have peaked among IDUs in some regions, but it cannot be established whether these changes are a result of prevention programmes, linked to other changes in the natural progression of HIV infection among this population, changes in sampling methodology of availability of HIV test kits, or other factors. The marginal reduction in the number of newly registered cases of HIV in 2007 is not reliable evidence to suggest that the epidemic among IDUs has peaked. The continued growth in the

[33] Data cited in this section, unless otherwise noted, are from Ukraine: National Report on Monito ring Progress Towards the UNGASS Declaration of Commitment on HIV/AIDS, 2008.

number of newly reported cases of HIV infection among IDUs demonstrates that the current programmes are still not sufficient to arrest the epidemic among this population.

Among women who sell sex, recent data reveal knowledge about HIV to be improving, but still inadequate. In 2007, 47% of FSWs correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. While 86% of FSWs reported condom use with their last sexual partner, only 66% of sex workers reported consistent condom use for vaginal sex with all of their commercial clients, and only 28% for anal sex with all of their clients.[34] Anal sex with clients is particularly widespread among adolescent FSWs (62%). Of particular concern, 39% of FSWs report no condom use with regular clients they 'trust', and 27% report having forgone condom use for extra payment. Despite the existence of prevention programmes, these data indicate that unsafe sexual practices are still common among the majority of FSWs in Ukraine. These risk factors are corroborated by the consistently high prevalence of HIV among FSWs, ranging from 10% to 31% in 2004, from 8% to 32% in 2005, and from 4% to 31% in 2006. These data indicate that the current HIV prevention programmes are having a positive outcome on better knowledge and safe behaviours, but are not having a significant impact on controlling the epidemic among FSWs. There are no behavioural or biological data among clients of FSWs, so there is no reliable indication of the extent HIV transmission from clients to FSWs, or vice versa.

Among MSM, 47% correctly identified modes of transmission of HIV and rejected major misconceptions in 2007, including 93% of MSM that know condom use during each sexual intercourse is a way to reduce the risk of getting HIV. Among adolescent MSM aged 15 to 19 only 40% correctly identified modes of HIV transmission. Of greater concern, as reported in 2007, only 39% of men reported the use of a condom the last time they had anal sex with a male partner, with an even lower percentage reporting consistent condom use with all casual sexual partners. In 2007, 48 new cases of HIV infection were officially reported among MSM, representing over one-third of the all cases officially registered among this population since 1987.[35] Yet, data from sentinel surveillance conducted in 2007 indicates a large epidemic among MSM in Ukraine, with HIV prevalence ranging from 4.4% in the capital of Kiev to 23.2% in the city of Odessa. The low coverage and poor implementation of prevention programmes among MSM is doing little to slow the spread of HIV among this population.

Overlapping risk behaviour can be found among IDUs, FSWs and MSM. Data among MARA show that 19% of adolescent FSWs aged 13 to 19 reported to inject drugs, 45% of them daily; 1.4% of the adolescent MSM aged 15 to 19 stated that they inject drugs, and 24% of the IDU girls told that they had received a reward for providing sexual services (as compared to 3% among IDU boys).

Among prisoners, the level of knowledge is relatively low, but comparable with other MARPs. In 2007, 80% of prisoners correctly replied that condom use is a way to reduce the risk of getting HIV, and 82% correctly reported to be aware of the risk of syringe sharing as a mode of HIV transmission. However, among prisoners that injected drugs in the last 12 months, almost half (46%) reported to have used shared syringes or needles. The vast majority of prisoners (88%) reported sexual contact with other prisoners in the previous six months but 87% of prisoners reported to have never received a condom from any prevention programme. Data from an ongoing cohort study in select prisons did not indicate significant cases of HIV transmission among prisoners inside the prison system, and the number of new annually reported cases of HIV among prisoners has decreased slightly since 2005. Yet, the serious shortcomings of current prevention programmes are doing little to prevent the spread of HIV among prisoners.

There is also limited evidence to demonstrate that these prevention programmes have improved knowledge or safe behaviours among clients of these prevention programmes at the level of specific sites. Due to the shortcomings or absence of site-level monitoring of programmatic outcomes and impacts, it is not possible to link changes in knowledge, safer behaviour or HIV prevalence at the national level to specific prevention programmes. This kind of data is essential to demonstrate the cost effective of specific interventions.

[34] Balakireva, O.N., et. al,"Monitoring the Behaviour of Commercial Sex Workers," Kyiv (2007).
[35] Ministry of Health of Ukraine, et. al, "HIV-Infection in Ukraine, Information Bulletin 28," Kyiv (2008).

Main Recommendations

Medium-Term:

MR.4.1.28 Enhance focus on behaviour change among MARPs, based on a national BCC strategy

MR.4.1.29 Introduce ongoing longitudinal monitoring of outcomes / impact at select individual project sites using standardized tools that can be easily triangulated with second generation surveillance data from national studies

MR.4.1.30 Ensure that all service providers working with MARPs (including MARA) collect an agreed minimum set of data (age, sex, diversity, risk behaviour, new/repeat client, diagnosis, services/commodities provided, referral to other services)

Sustainability

Although funding is increasing for prevention services among MARPs, resources are only adequate to provide short-term sustainability of these programmes. The programme supported by the Global Fund Round 6 grant is planned to continue until mid-2012, and contains minimum resources to scale up and sustain the current package of prevention programmes among IDUs, sex workers, MSM and prisoners to the levels indicated in the grant programme. Prevention programmes among MARPs represent the most important contribution to national prevention efforts, yet they are supported primarily by external donors. No plans exist to ensure the sustainability of these programmes beyond the current support from the Global Fund grants or other donors. Even the resources from the Global Fund grants are inadequate to provide high quality prevention services for all of those that need them, and to expand services to clients and areas that remain poorly covered. Some regional and local NGOs have the capacity to expand their programmes. But with the majority of funding limited to support from the Alliance, these organizations have limited options to expand services beyond the requirements of the Global Fund grant programmes.

Despite the essential importance of these prevention programmes, the Government has demonstrated limited support and ownership for prevention programmes amongst these populations. The Government has not provided funds to support prevention services that are currently being delivered by NGOs. These programmes need to be scaled up and sustained beyond the contributions of external donors. While Government support for ‘services for young IDUs’ is increasing, most of the funds for these services are provided by local governments to support locally government run services. Currently, there are no indications that essential prevention services currently supported by the Global Fund grants will be improved and sustained with greater support from the Government of Ukraine.

The sustainability of these programmes is also threatened by the practice of the Alliance and other donors to pay sub-recipients a significant portion of overall funding to support salaries and overhead costs. The continued growth of these costs represents a risk to the sustainability of these services by raising unit costs and other administrative costs above levels that can be supported by government budgets. Responsibility for this phenomenon ultimately lies with the Government. The Government has neither explored mechanisms for social contracting government resources to NGOs for the implementation of prevention programmes, nor has it make commitments to sustain the majority of prevention programmes that are currently supported by external donors.

Main Recommendations

Short-term:

MR.4.1.31 Systematically assess capacity building needs for prevention among MARPs at all levels and across sectors

MR.4.1.32 Review rates and limits for salaries and other overhead costs within prevention programmes supported by the Global Fund grants and other donors

Model of Service Delivery / Client Orientation

Some models of service delivery among MARPs are consistent with international recommendations, and appropriate for work with populations that are difficult to access through traditional models. Most of the programmes make extensive use of effective intervention models, including community-based outreach and peer education, integrated services and referrals. Many of these services are also designed and delivered with the active involvement of NGOs and representatives of the affected communities. There are also some highly innovative models of service delivery that deserve significant attention and praise. In particular, the Alliance's pilot use of peer driven interventions (PDI) for prevention outreach among IDUs is an excellent example of innovation.[36] Some excellent examples of smaller projects supported by other donors also support client management and comprehensive services. These examples should be sustained and scaled up to other regions and other MARPs.

In contrast, prevention services provided by Government agencies, including the 'services for young IDUs', coordinated by the SSSFCY and the SDES depend largely on a traditional, provider-client model. In this model, IDUs and prisoners are regarded as recipients of services provided by project staff, doing little to use the potential of peer leadership and peer empowerment within the target population to strengthen HIV-prevention efforts or the potential of outreach services. For example, some NGOs working with children who are living or working on the streets have integrated HIV prevention into their set of comprehensive support services. More successful models of service delivery have also used HIV prevention services as a mechanism for integrating other social, legal, vocational and medical services. However, these models are not being implemented consistently across all regions where prevention services are provided. Governmental prevention services also lag significantly behind many NGOs in the implementation of such models.

The majority of prevention services for adult IDUs, FSWs and MSM offer some degree of integrated services, although integrated services do not exist for MARA. The services with the highest degree of integration are available for IDUs through harm reduction programmes supported by the Alliance and its sub-recipients, with a growing list of services available for IDUs through one service provision site.[37] There also has been an increasing emphasis on the provision of client referrals to other health and social services, such as rehabilitation and access to OST. However this is not functioning well for adolescents who inject drugs. Referrals to other services, such as PMTCT services, remain insufficient. The degree of integration in governmental services, such as the 'services for young IDUs', remains limited, and in some sites, non-existent, underscoring both poor planning and also the lack of other services available to IDUs in the majority of government-supported prevention programmes. The degree of integration, coordination and linkages of services among prisoners and MSM remains limited and seriously inadequate.

Client management approaches have been integrated into the programmes for people living with HIV and local referral systems. However, prevention service networks are not adequately integrated to assure a continuum of preventative care. As a result, many people still get 'lost in the system'. This is strongly linked to barriers existing with regard to multisectoral cooperation and sharing of information on clients across sectors, and the overall absence of a clear authority responsible for coordination of prevention among MARPs.

Some of the prevention services for MARPs set good examples for how to design services so that they are acceptable and useful for MARPs. The majority of the prevention and harm reduction programmes were designed specifically to meet the complex needs of IDUs. Rather than viewing IDUs as 'narcological patients,' prevention programmes implemented by the Alliance and some other NGOs view IDUs as 'clients', and design and provide services in order to gain their trust and respect, and based on their needs. In these cases, IDUs are

[36] In early 2008, it was planned to scale-up PDI from 5 to 10 sites, but only among IDUs.

[37] These expanded services now include access to VCT using rapid tests and treatment for STI, which seem to be greatly appreciated by clients and warrant rapid scale-up to other sites and regions.

not expected to accept a standard service or mandatory treatment that may not be acceptable to them. This is most evident in the policy under the Global Fund grant-supported harm reduction programme to provide IDUs with an unlimited number of syringes, if required, or to encourage IDU clients to consider access to substitution therapy where such services are available.

The design of the 'services for young IDUs', based on a drop-in model rather than an outreach model for service delivery, indicates that the Government may be using suboptimal approach to meeting the needs of clients, thus limiting the number of clients and their degree of satisfaction with these services.

A client-oriented approach has also been attempted by some prevention programmes among FSWs, albeit with less success and frequency. As many of the programmes for FSWs were developed as an 'add-on' to existing harm reduction projects, these programmes have not always been appropriate to the prevention needs of FSWs. In sites where programmes were designed to meet the specific needs of FSWs, these programmes have been able to attract and retain women involved in sex work over a long-period of time.

Prevention programmes among MSM face serious obstacles in this area. Few of the organizations providing prevention services for MSM work with adolescent MSM. With only a small number of NGOs involved in the delivery of services for MSM, it will be difficult to ensure client orientation where there is limited organized capacity to implement services. Little client orientation is evident in the prevention programmes for prisoners supported by the SDES.

Service delivery models for prevention among adolescents engaging in high risk behaviour have yet to be developed. The major obstacles are the absence of regulations for service provision for minors, and mechanisms that provide multidisciplinary services, including information and child protection. Currently, interests and attitudes toward at-risk youth differ between professional groups. Groups with specialized training, such as social workers are better accepted by youth and minors than are police, who lack specialized training and often create obstacles that prevent youth from accessing prevention services.

Main Recommendations

Short-term:

MR.4.1.33 Adapt the minimum package of services to address changing dynamics of the HIV epidemic among MARPs; target interventions to reach highest-risk sub-populations on a regular basis, including interventions for young injectors, injectors of amphetamine-type and other (pseudo-ephedrine) stimulants and non-IDUs.

MR.4.1.34 Sustain and expand the coverage of peer driven interventions to include IDUs in all regions by end of 2009

MR.4.1.35 Expand the number and capacity of low threshold facilities, such as crisis and community centres, particularly for MARA, based on a one-stop-shop approach, to increase access to and coverage of services

Medium-Term:

MR.4.1.36 Develop standardized service delivery and integration models for all MARPs

MR.4.1.37 Add substitution therapy as an optional service to all harm reduction sites that meet other licensing requirements by end of 2009

MR.4.1.38 Establish drop-in centres for FSWs to provide them with a safe location to access prevention services, and links to other services to reduce violence and protect their rights

HIV prevention for especially vulnerable children and at-risk adolescents

HIV prevention services in this area include foremost orphans, or children without parental care, disabled children and adolescents, many of the children and adolescents working or

living on the street, including those who are not yet engaging in most at-risk behaviour, those living in temporary and Medium-Term child-care institutions, and those living in so-called "families in crisis". Many of these children and adolescents are more likely to be exposed to HIV infection than their peers living in regular family and social environments. These children and adolescents develop without adequate guidance, role models and supervision of adults, and/or may not have the skills and access to means to protect themselves. In addition, adolescence is a time of experimentation and rapid development, when the influence of peers increases, and behaviours are established which may last well into adulthood. The frequent practice of mandatory HIV testing of children in shelters and psychosocial rehabilitation centres represents a violation of human rights, and does nothing to strengthen efforts for HIV prevention in these institutions. Current regulations also fail to address supplementary care needs arising if a child is confirmed to be HIV positive. There are also a series of legal obstacles and inconsistencies between the National Law on AIDS and the Civil Code that severely limit access of unaccompanied minors to VCT.

The development and scale-up of HIV prevention and harm reduction services for children and adolescents living or working on the streets should be prioritized more than other HIV prevention programmes for children and youth. A significant proportion of MARA live in such high risk environments. As many MARA also spend extended time in temporary and mid-term child-care institutions in Ukraine, HIV prevention should be integrated in training and service programmes for child-care institutions and facilities, such as boarding schools and foster families.

Main Recommendations

Immediate:

MR.4.1.39 Abolish mandatory HIV testing of children in shelters and psychosocial rehabilitation centres

Short-term:

MR.4.1.40 Remove legal obstacles in the HIV law for unaccompanied minors above the age of 14 to access VCT and harmonise the HIV law with the Civil Code of Ukraine

Medium-Term:

MR.4.1.41 Empower local authorities and communities to create protective and enabling environments and safe places for adolescents and young people, particularly in the most severely deprived localities

Inequity of Access / Discrimination

Equity in access to prevention programmes remains a major obstacle among services for MARPs. With the exception of prisoners, existing programmes are only providing equitable access to services for those persons that are most easily reached. It will be a significant challenge to go beyond the 'low hanging fruit' and provide services for those that are most hidden and vulnerable, who despite consistent efforts, are still not reached by existing prevention services.

Sex disaggregated data of prevention programmes suggests that, except for FSWs who also inject drugs, female IDUs face unequal access to harm reduction programmes. Similarly, the absence of prevention programmes for younger and adolescent IDUs and male sex workers suggests that these populations are not priorities for HIV prevention, as they lack any equitable access to HIV prevention programmes.

High threshold requirements for access to substitution therapy also mean that a large portion of IDUs with short-term history of injection and IDUs under age 18 cannot access OST, even if they could benefit from it and also contribute to reducing HIV transmission. In addition, the requirement of having a previous history of two unsuccessful attempts at drug treatment severely limits the number of IDUs eligible for OST. The full scope of such inequities was not

assessed in this evaluation, but needs to be assessed in detail to better appreciate and address these shortcomings.

MARPs are also frequent victims of discrimination, violence, and human rights violations, which also creates serious barriers for them to access HIV prevention services. The most obvious forms of discrimination, such as the legal discrimination or physical harassment of individuals suspected of being HIV-positive, seem to be relatively rare in Ukraine. But this may also be a result of weak or non-existent feedback systems to monitor and respond to such cases of discrimination. Other forms of discrimination and harassment, including negative attitudes towards MARPs from staff and outreach workers, and frequent cases of physical abuse of FSWs and sexual and physical exploitation of street children, are more widespread. These factors seriously undermine trust and access to prevention services, and thereby limit adoption of safer behaviours.

Main Recommendations

Short-term:

MR.4.1.42 Provide mandatory training on sensitivity, stigma and discrimination for all staff of prevention programmes, with a priority training for staff working in direct contact with clients

Medium-Term:

MR.4.1.43 Explore feasibility of setting coverage targets to reach underserved groups and those facing barriers to equitable access to services

MR.4.1.44 Develop and implement zero tolerance policy for discrimination among all providers of HIV prevention services, and monitor its implementation within both health and non-health sectors

Research

The scope and quality of research focused on prevention programmes among MARPs is improving, but remains disproportionately weak given the high importance of this area to the overall national response. The strongest and most representative research has been conducted at the national level as part of the process of UNGASS data collection. In recent years, there has been a positive shift towards integrated behavioural and biological studies for IDUs and MSM – essential to link knowledge and behaviours to trends in HIV infection. This has been augmented by the use of respondent driven sampling (RDS), which represents an ambitious but highly commendable effort to minimize recruitment biases, and to ensure that studies include respondents who may not be reached by existing prevention programmes.

However, important shortcomings remain in the design, dissemination and use of data from these research studies. Few of these studies have included sample sizes large enough that data can be usefully disaggregated and analyzed at the regional level and for the younger age groups (<18). Studies have usually included less than half of Ukraine's regions, providing little information on the status of trends among MARPs in those regions that are not covered. There is little data to suggest that research is also capturing key subpopulations – e.g. young IDUs, non-opiate IDUs, non-street based FSWs, and sexual partners of MARPs (truck drivers, etc.). The results of studies have been exceptionally slow to be released in Ukrainian and English, with subsequent rounds of national studies planned even before the research results from the previous year are available.[38] There are limited examples of how the results of these studies have been used to improve the design and implementation of programmes at the level of project implementation.

[38] In the case of the seroconvertor study in 16 regions of Ukraine, supported by Alliance Ukraine and in collaboration with the Ukrainian AIDS Centre, highly anticipated results from the study have never been disseminated publicly, even two years after the research project was launched.

At the level of specific sites, there is limited evidence to demonstrate that these prevention programmes have improved knowledge or safe behaviours among clients of these prevention programmes. There was only one positive example when the Alliance sub-recipients collected knowledge and behavioural data on programmatic outcomes among new and existing clients of prevention programmes, but the results were never made public, and the collection of this essential data was never continued on an ongoing basis. Such collection and analysis of data should become routine at all prevention sites, whether supported by the Global Fund grants or other sources.

Research with human subjects is regularly conducted without ethics review or written informed consent of the research participants. National guidelines for research and ethics that consider the issue of supplementary care needs of research participants are also lacking.

At the level of specific programmes and projects, there is a consistent lack of expertise in how to design, monitor and analyze data in a scientifically sound manner. Despite the potential international significance of interventions in this area, there are very few research abstracts and scientific papers from Ukrainian researchers that feature the scientific results of prevention work among MARPs in Ukraine. Abstracts from Ukraine that are submitted to international conferences usually feature a review of recent data, without any rigorous analysis using scientific methods. Very few publications in international scientific literature feature HIV research from Ukraine, and those that do are often led by foreign researchers as primary investigators. There are a small but growing number of Ukrainian researchers and practitioners that are involved in collecting, analyzing and disseminating research results. However, Ukrainian expertise remains very limited, particularly outside of Kyiv, in translating the results and recommendations from those studies into improved prevention programmes.

Main Recommendations

Immediate:

MR.4.1.45 Conduct mandatory ethics review of all research studies that involve human subjects, and obtain informed consent for research participants, paying attention to specific ethical issues relating to minors

Short-term:

MR.4.1.46 Prepare inventory of all scientific research studies among MARPs (abstracts, papers, projects) ongoing or conducted in Ukraine last five years, and make database publicly available

MR.4.1.47 Develop agenda for scientific and operational research among MARPs

Medium-Term:

MR.4.1.48 Develop national guidelines on ethics and research, with a particular focus on research among minors and guidance on addressing supplementary care needs of research participants

MR.4.1.49 Require any new / planned research to be coordinated with other national partners through the MEWG

Leadership

The lack of consistent leadership in the area of prevention among MARPs is closely associated with sub-optimal results, fragmented services, and a lack of sustainability. At the national level, responsibility for HIV prevention has been assumed by national and international NGOs, and other partners including bilateral donors, UN agencies, and some representatives of MARPs. Notably absent are representatives of the Government of Ukraine, including governmental representatives from the Cabinet of Ministers, the Ministry of Health, the SDES, and the Ministry of Education. An exception is the leadership and service delivery demonstrated by the Ministry of Family, Youth and Sport and its SSSFCY. However, the role of this Ministry has often been linked to the contributions of individual officials, some of whom have frequently changed, leaving doubts about continuity or greater

leadership by the Government. The Committee on HIV/AIDS and Socially Dangerous Diseases within the Ministry of Health has no expertise or capacity on prevention among MARPs. As a result, there is no national authority in Ukraine to assure the quality of services and programmes, ensure accountability and promote their alignment with overall priorities in the national response to AIDS.

Main Recommendations

Immediate:

MR.4.1.50 Clarify which institution or organ has the authority for planning and coordination of all HIV prevention programmes in Ukraine

Short-term:

MR.4.1.51 Establish regular working group for HIV prevention among MARPs under the National Council to assist and guide this body; working group should include representatives from relevant MARPs, as well as related Government ministries and agencies, NGOs, and international partners

4.2 Prevention among the General Population
Importance: Medium
Progress: Inadequate

Overview

HIV/AIDS awareness and HIV prevention activities among the general population have improved in recent years, but a majority of key groups remain beyond the reach of current programmes. Specific population groups targeted in this programmtic area are young people, school children, students of universities and technical schools, out of school children, uniformed services personnel and recruits, mobile populations, migrants and refugees, and the general population reached through public awareness campaigns and workplace interventions. With a few notable exceptions, the quality and coverage of HIV prevention activities among these populations, and of public information and education programmes, remains low.

According to the National AIDS Programme (2004-2008), HIV awareness and prevention among the general population is a key strategy and priority of the national AIDS response in Ukraine. Beginning in 2004, prevention programmes for various groups in the general population have been scaled up in Ukraine, but at a slow pace and with uneven coverage. The most extensive coverage of basic HIV education and prevention programmes is currently provided for school children, with mandatory coverage of children in grades 5 to 9, and an optional curriculum for children in grades 10 and 11. The majority of HIV education and prevention programmes for specific population groups, such as out-of-school youth, uniformed services, mobile populations, migrants and refugees are fragmented, with great variations in the quality of services provided.
AIDS in the workplace programmes have been piloted among some trade unions and private and public sector employers. Yet, the proportion of enterprises involved and the scope of activities has been very limited.

A national toll-free telephone hotline and website for HIV/AIDS information is of high quality and professionally managed by an NGO. However, the hotline has not been adequately evaluated and relies exclusively on external donor funding. There is no data to indicate if any significant proportion of the general population makes regular or even episodic use of the hotline or the website.

A series of high profile public events, including celebrity charitable events, public marathons, and a historic public concert by Elton John in Kyiv in June 2007 have been essential to promote public attention, and enhance the importance of AIDS in Ukraine. But these events have achieved little to enhance public knowledge of how HIV is transmitted, and have a

negligible effect on reducing stigma and discrimination towards people living with or affected by HIV.

The absence of a national prevention strategy and the acute shortage of resources for prevention services at the national and regional levels are critical shortcomings that undermine the implementation of effective prevention programmes and services in this area.

Importance / Impact on Epidemic

According to the National AIDS Programme (2004-2008), HIV awareness and prevention among the general population is a key strategy and priority of the national response to HIV/AIDS in Ukraine. However, available evidence indicates that the risk factors and behaviours among groups in the general population are not contributing significantly to the spread of HIV in Ukraine. Little data exists to indicate that any significant proportion of subgroups in the general population is directly affected by HIV. However, there is a credible threat that the HIV epidemic may spread beyond MARPs to affect large and concurrent bridge populations, and thus threaten an increasing proportion of the general population of Ukraine – including young people who are not engaged in high risk behaviours.

Primary prevention and public awareness have an essential role in the comprehensive response to the AIDS epidemic in Ukraine, in particular, in promoting accurate public awareness about HIV and AIDS and tolerant attitudes towards people living with HIV, affected by and at-risk of HIV/AIDS. However, with limited resources and an epidemic that remains concentrated among MARPs, primary prevention and public awareness are not the most urgent priorities for the response to the epidemic in Ukraine. Within the range of prevention activities, prevention programmes among the general population are not expected to have a decisive impact in the next five years at reducing the number of new cases of HIV. Nevertheless, current activities aimed at prevention and awareness among the general population, including stigma reduction, are an essential component in the longer term mitigation of impact from HIV/AIDS, and also play a pivotal role in creating a more supportive environment for targeted prevention interventions for MARPs.

Progress

In the area of prevention among the general population, there has been inadequate progress in recent years, and despite some notable exceptions, very few measurable results. In 2007 only 40% of young people knew how to protect themselves against HIV, indicating that Ukraine will fall significantly short of the UNGASS target that by 2010, at least 95 per cent of young people aged 15 to 24 have access to the information and education necessary to develop the life skills required to reduce their vulnerability to HIV-infection. However, several important interventions are producing positive results, such as school-based HIV education and some prevention programmes among the military that have been scaled up to reach a significant proportion of their target populations. The coverage and intensity of these interventions should be further increased while also improving their quality. Other interventions that have been developed at the level of pilot projects, including HIV in the workplace and public awareness campaigns, also have an important role in covering large groups of the general population, and thus should also be scaled up. However, the aim of the majority of prevention programmes in this area should be refocused. These programmes should aim to enhance accurate knowledge about modes of transmission and the means of prevention, promote healthy lifestyles and behavioural change for those at-risk, maintain long-term safe behaviours for those that have already adopted them, and promote tolerance and compassion towards people living with HIV.

There is a high degree of attention given by the President of Ukraine and the Government to HIV prevention in public statements and official strategies. Yet, this has not been translated into sustained campaigns to promote public awareness that would have been implemented with the full support of the Government of Ukraine at either the national or regional levels. Ukraine has yet to implement effective public education interventions, such as regular national awareness

campaigns mandatory on all television channels, or establish an official government internet site with accurate and up-to-date information about HIV and AIDS. The Government has also not pursued innovative means to promote public HIV awareness among the majority of the Ukrainian population, such as the dissemination of HIV information via the national mobile telephone network, consistent public service announcements on radio and television and public advertising (billboards and public transportation), or the consistent integration of HIV awareness campaigns into larger public events such as high-profile sporting or cultural events. Many of the prevention programmes that do exist have limited coverage, suffer from poor design, implementation, M&E, and require extensive revisions and improvement. Insofar as interventions in this area are not the first priority for the national response to AIDS, however, Ukraine has some time to ensure that these programmes are properly developed and enhanced as an essential complement to prevention programmes among MARPs.

Strategy and Targets

In both the Strategic Concept of the Government 2004-2011, as well as in the National AIDS Programme (2004-2008), various groups in the general population are targeted for HIV prevention interventions, including young people, healthcare workers, pregnant women, and the general population. Strategic objectives and action areas are highlighted in these documents, and clearly emphasize the need to intensify HIV prevention for all population groups outlined above. Key principles and methods for service delivery are also specified in these documents, which are consistent with some of the key international principles of HIV prevention. While the overall approach set out in the National AIDS Programme (2004-2008) addresses some of the critical objectives for HIV prevention in the general population, there is no operational plan to translate these policies into interventions and programmes for groups in the general population.

The HIV prevention strategy described in the Road Map, developed through extensive consultations in 2006, is more comprehensive and detailed than the National AIDS Programme, clearly specificing targets and principles for prevention among the general population. The Road Map sets clear objectives and Universal Access targets for prevention in the general population, as well as some operational targets to facilitate the implementation of the strategy. However, the HIV prevention strategy outlined in the Road Map has never been formally integrated into the National AIDS Programme or translated into an implementation plan. This critical shortcoming may be linked to the lack of clarity as to which institution or body has overall national authority for HIV prevention. Neither the National Council nor the Committee in the Ministry of Health has a clear mandate for HIV prevention that includes responsibility for management, coordination, M&E of the prevention activities among the general population. As a result, prevention activities among various groups of the general population are largely uncoordinated, and lack coherent messages, policies and resources to ensure they contribute to a comprehensive national response to HIV.

Main Recommendations

Medium-term:

MR.4.2.1 Develop a national, multisectoral and integrated national strategy for information, education, communication (IEC) and BCC for all population groups to be reflected in the new National AIDS Programme

MR.4.2.2 Use the Road Map as the basis for planning the scale-up of prevention activities for relevant groups in the general population

HIV/AIDS awareness and knowledge in young people

The Government of Ukraine has focused most of its efforts in the area of HIV prevention on providing information and education to young people, mainly in schools, where they are easy to reach in large numbers. Knowledge of HIV/AIDS among young people has increased in

Ukraine in recent years. In 2004, only 14% of young people aged 15 to 24 years could both correctly identify ways of preventing sexual transmission of HIV and rejected major misconceptions, while in 2007, the same indicator was 40%.[39] This progress is largely linked to the efforts to reach young people in primary and secondary schools with HIV prevention information and education, which are funded largely with support from international donors. Extensive support provided for school-based education programmes will cease with the end of the Global Fund Round 1 grant. Achievements in this area are at-risk due the lack of a Government commitment to sustain and enhance these programmes when external funding from the Global Fund and other sources ends.

Consistent with international best practice, HIV prevention in schools has been integrated into wider life-skills-based education (LSBE) programmes. LSBE has been incorporated into the mandatory curriculum for primary and intermediate schools and into the optional curriculum for secondary schools. While the introduction of LSBE into the curriculum represents a significant achievement, capacity building measures lag seriously behind the curriculum, and the number of trained teachers is far short of the coverage needed. The coverage of all types of schools with trained LBE teachers who actually taught the course during the last academic year was only 53% in 2007. There are also concerns about the comprehensiveness of the approach (involvement of parents, school nurses, psychologists, peer education and the wider community), and the quality of teaching.

Another major obstacle to quality HIV education in schools is widespread stigma and discrimination about HIV, MARPs, and people living with HIV within the education sector. This obstacle has been recognized by the Ministry of Education and Science, but HIV in the workplace programmes in the education sector that would address this issue have yet to be implemented.

Data indicates that university and college students are within the most sexually-active age-group in Ukraine (age 20-24). While 23% of young people in this age group report more than one sexual partner per year, only 64% report condom use during last sexual intercourse – the lowest within the age range 15-49. Yet, universities and institutes are currently not involved in any consistent or coordinated HIV prevention activities. Data also indicates that some university and college students also report high risk behaviour, including injecting drug use, sex among men, and episodic sex work. Prevention activities should be enhanced for university and college students to ensure that they have regular access to basic information about HIV, sexual and reproductive health services, and free access to condoms (particularly in student hostels). These services should be based on a peer education approach and a sound referral system to community HIV, health and social services. Where appropriate, universities and colleges should also provide harm reduction services to students who inject drugs, but may be reluctant to visit regular harm reduction programmes due to possible fears of stigmatization.

Several groups of young people who are not in school are especially vulnerable to HIV, but have not been adequately targeted by HIV prevention and education programmes. These include so-called 'bridge populations' of children and young people, including street children, children in child-care facilities and penitentiary institutions, and children of migrants, refugees and other mobile populations. They are especially vulnerable due to their membership of a specific group or subculture, the setting they live in, their limited access to prevention services, their proximity to MARA who are often members of these groups, and to other vulnerability factors. There have been several small projects implemented by governmental organizations, NGOs and FBOs to reach adolescents and young people in out-of-school settings with HIV prevention information and education.

A network of nine local 'resource and training centres' were established under the Global Fund grant programme, focused mainly in priority regions to support, among other areas, HIV prevention and education activities outside school. Under the Global Fund Round 6 grant programme, these centres are gradually being used to provide greater technical

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[39] It is noted that the definition of this indicator changed between 2004 and 2007, so the changes may be more closely related to the revised indicator definition than a genuine change in the level of knowledge among young people.

support and training for local NGOs implementing prevention activities among MARPs. The potential of these centres could be further exploited to perform a much more significant role in systematisation of available resources and coordination of local training programmes, including training for personnel from governmental agencies and institutions.

Another example is the integration of HIV prevention into the work of shelters through capacity building measures supported by UN agencies in cooperation with national NGOs, or HIV prevention that has been mainstreamed into the work of NGOs servicing children and adolescents living or working on the streets. There is also a network of youth-friendly clinics in Ukraine. However this network does not yet reach especially vulnerable adolescents, including MARA, as it is poorly linked to existing outreach programmes among these populations.

No mapping or stakeholder analysis has been conducted of these prevention programmes. These programmes lack a systematic or coordinated approach, and no overall quality assurance system is in place. The minimum package of services defined in the Road Map for these populations has not been implemented and is not adequately taking into consideration the multiple needs of the different sub-groups of these populations, including particularly skills-building, vocational training, and prevention of all forms of abuse and exploitation.

Main Recommendations

Immediate:

MR.4.2.3 Revise the new National AIDS Programme (2009-2013) to specify links and mechanisms of coordination and cooperation of HIV prevention services with wider programmes for social support and development programmes

MR.4.2.4 Revise the new National AIDS Programme to target all schools in Ukraine with adequate teachers and resources to provide HIV prevention for school children of all ages by the end of 2010

Short-term:

MR.4.2.5 Develop standardized protocols for service delivery for these populations, including innovative service delivery models, based on existing experience

Medium-Term:

MR.4.2.6 Increase active (ongoing) coverage of prevention programmes among especially vulnerable children and adolescents to at least 60%

MR.4.2.7 Develop a national programme for HIV prevention in universities and technical schools, to ensure access to information and services for HIV, sexual and reproductive health services, and free access to condoms, based on a peer education approach and a sound referral system to community HIV, health and social services

MR.4.2.8 Strengthen government monitoring and control over public advertising to address and counteract advertising and public message that may promote risky behaviours

Information, Education and Communication for the General Population

While HIV/AIDS awareness among general population should not be a top priority, HIV/AIDS information, education and communication (IEC) for the general population is still an essential component of the national response to HIV/AIDS. In a concentrated HIV epidemic, where the level of awareness of HIV/AIDS among the general population is already high, a comprehensive IEC strategy targeted at the general population helps to create an enabling environment for targeted HIV prevention interventions, especially when emphasis is placed on stigma reduction, skills-building and the promotion of behaviour change.

Activities in this area, however, have been uncoordinated and unsystematic. No overall IEC and BCC strategy exists in Ukraine that could be reinforced in all HIV-related programmes and services. While several mass media campaigns have been implemented targeting youth

and addressing stigma and discrimination with support of celebrities, activities in this area were not sustained, as they were reliant on initiatives from private foundations or international funding. Messages to the public on HIV/AIDS have not been consistent and were not reinforced or developed over time. For example, during Phase 1 of the Global Fund Round 1 grant, the Alliance provided some support for public AIDS education activities. But when these activities were not continued in Phase 2, neither the Government nor other national partners assumed responsibility for sustaining or scaling up IEC activities in this area. In recent years, these activities have produced few measureable results, raising questions about the cost-effectiveness of sustaining these interventions in the absence of a national IEC strategy. The overall approach to HIV awareness and public education remains piecemeal and fragmented, and has failed to produce changes in public attitudes or awareness about HIV, or stimulate community dialogue about the importance of HIV/AIDS.

Quality control of public prevention programmes has also been inconsistent, exercised largely by donors and grant managers for monitoring specific projects and programmes. This has led to the proliferation of IEC/BCC materials of varying quality, and featuring inconsistent aims and messages. Due to the absence of a national strategy for public awareness and prevention, the availability of IEC/BCC materials also varies greatly between regions, with many governmental agencies and NGOs reporting unreliable access to prevention materials, which are always in limited supply. There is frequently duplication of materials developed by different organizations, and critical gaps remain in materials that address gender, age, or level of education, or their availability in different languages.

In 2006, commendable attempts were made by international organizations to develop a national communication strategy for HIV/AIDS. These efforts aimed to coordinate mass media campaigns on HIV/AIDS, adopt a coordinated approach to advocating with the government and the media for free air-time for social advertising, including advertising on private channels, and greater control over counterproductive advertising of risk behaviours and unhealthy lifestyles. These efforts failed, however, primarily due to the inadequate involvement and leadership by the Government.

Since 2007, only two consistent public awareness campaigns have been successfully implemented on Ukrainian television and other media networks. One of the campaigns, 'On the Edge', supported by the Elena Franchuk Anti-AIDS Foundation, features messages of risk and fear that have been proven in international studies to have little impact on promoting safer sexual behaviours. The other campaign, supported by the Ukrainian Media Partnership to Combat HIV/AIDS, features a series of TV and radio clips, and print public service announcements of high quality and are broadcast on an impressive range of state and private media networks.

In 2007, the Ministry of Health conducted its own tender to select a private organization to implement another series of Government sponsored public service announcements. Yet, there has been little coordination between the messages or coverage of these campaigns, underscoring the lack of the government leadership and coordination in this area. Given the extensive experience and capacity of some of the organizations already implementing these campaigns, efforts should focus on the development and coordination of media campaigns implemented by these partners and on the utilisation of evidence-based approaches, rather than trying to develop new initiatives by other partners that may be of dubious quality, or worse, contribute to further proliferation of inconsistent messages.

Since 2003, Ukraine has a well-established national toll-free hotline, which is performing an invaluable function in providing 24 hour access to accurate information about HIV/AIDS. The hotline is linked to a detailed website that logs over 5,000 visitors per month. Calls to the hotline have grown consistently in recent years, with an increasing number of callers of younger age. However, some regional informants expressed concern that neither the hotline, nor the website is known by the general public. There is no data to indicate that any significant portion of the general population is aware of or has used the hotline. The hotline and the website, which are well managed by a Ukrainian NGO with funding from the Global Fund, receive little guidance and no support from the Government of Ukraine.

In light of the established visibility and professional service provided by the hotline, it is not recommended to establish additional hotlines to provide basic information on HIV/AIDS at the regional level. Instead, capacity of the national hotline should be developed and sustained with support from the Government. The hotline should also be better publicized at the local level as a reliable source of general HIV/AIDS information, including for regionally-specific enquiries. However, the Government of Ukraine should develop and maintain a separate national website for HIV/AIDS, featuring official data and the latest information.

Public HIV education initiatives have benefitted from considerable interest and some partnership with the private sector. The private sector has sponsored special events and supported the development and broadcast of public service announcements aimed at condom promotion. However, the lessons learned in this area have not been formally evaluated, and few public-private partnerships have been sustained and developed.

Main Recommendations

Immediate:

MR.4.2.9 Ensure gradual increase of Government support and funding for national hotline in new the National AIDS Programme

Short-term:

MR.4.2.10 Develop a coordinated, multisectoral IEC/BCC strategy that specifies clear targets and messages for public awareness and education campaigns

MR.4.2.11 Focus public awareness and education campaigns where they have a significant outcome – on reduction of stigma and discrimination and behaviour change directed and changing societal norms related to risk behaviour

MR.4.2.12 Government of Ukraine should develop and maintain a national website for HIV/AIDS

Medium-Term:

MR.4.2.13 Ukrainian State Committee for Radio and Television should make issuance / renewal of all broadcast licenses contingent on agreement to provide free airtime for HIV and AIDS quality-assured public service announcements, including during prime-time

Public Activities / Charity and Special Events

Public activities, charitable and special events, such as the Race for Life, International AIDS Memorial Day and World AIDS Day have helped to raise and sustain public attention on HIV in Ukraine. However, these events have often been planned and implemented in an hoc manner, with little continuity between events or across years. For example, the Race for Life charity marathon in Kyiv was one of the highest profile annual public AIDS events in Ukraine from 2001 to 2006, organized by the United Nations, in collaboration with an extensive range of governmental, non-governmental and private sector partners. While the event did not generate significant charitable donations for AIDS, the event was highly successful in mobilizing partners around the only annual public event in Ukraine dedicated to AIDS. It is considered to be a shortcoming of the United Nations in Ukraine to have discontinued this event, and not taken adequate measures to ensure it was maintained by other partners.

Other high–profile public events, such as World AIDS Day concerts organized by Lilia Podkopaeva's Foundation or the high profile public concert by Elton John in Kyiv in June 2007 have been essential to ensure that AIDS remains on the political agenda and a focus of public attention. These events are also recognized for having been successfully conducted independent of external donor or Government funding. In mid-2005, stakeholders made a correct decision to discontinue funding for public events and awareness activities from Phase 2 of the Global Fund Round 1 grant, which has since remained more focused on prevention among MARPs.

More recently there has been a series of exclusive charitable fundraising events in Kyiv hosted by the Network and the Elena Franchuk Anti-AIDS Foundation. These events have been successful in promoting AIDS philanthropy as fashionable, while generating significant resources for special charitable projects. Such events are leading the way for philanthropic giving in Ukraine, and should be sustained on a more regular basis, and organized in other cities in Ukraine. These public activities and special events, however, do not enhance public knowledge about HIV and AIDS, and have little or no impact on behaviour change. These special events suffer from the lack of a national IEC and BCC strategy that would link the currently fragmented action and ensure that messages are clear, consistent and reinforced over time.

In recent years, the Victor Pinchuk Foundation and the Elena Franchuk Anti-AIDS Foundation have also achieved exceptional results in increasing national and international attention to the AIDS epidemic in Ukraine. While not specifically focused on AIDS, the Victor Pinchuk Foundation has hosted the traditional Ukrainian Lunch at the Annual Meeting of the World Economic Forum in Davos, and also used the forum to raise the issue of AIDS in Ukraine. These foundations have also engaged international dignitaries such as Bill Clinton and Kofi Annan. Such informal networks of influential global decision makers can enhance invaluable international attention and support for the national response to AIDS in Ukraine. The Government of Ukraine and other national partners could learn valuable lessons from these Foundations in how to generate and sustain international attention for the AIDS crisis in Ukraine.

Main Recommendations

Immediate:

MR.4.2.14 National partners should agree on at least one national public event for HIV/AIDS that will be held on an annual basis that can be duplicated in cities across Ukraine, to be planned for in the new National AIDS Programme

Medium-Term:

MR.4.2.15 Engage and link public events with official support from existing private sector initiatives such as the "Business Against AIDS" Association, the Global Business Coalition on HIV/AIDS, and the UN Global Compact

MR.4.2.16 Ensure that all messages, slogans and data used in public activities and special events are clear, accurate and reinforced over time, consistent with a national IEC/BCC strategy for AIDS

Migrants and Mobile Populations

Three distinct populations of migrants and mobile populations in Ukraine have needs for HIV information and prevention, each facing different risks and different needs for information programmes and services. Currently, none of these populations have consistent and targeted coverage with any HIV prevention programmes. The programmes that do exist cover only a small percentage of migrants in a limited number of regions, such as Odessa, and are not led or supported by any government agencies or programmes.

The first group of mobile populations consist of approximately 40 million regular visitors, which include all foreigners who cross the borders of Ukraine every year, and an additional 780,000 foreigners that reside permanently in Ukraine. There is no evidence to indicate that the majority of these populations face any elevated risk for HIV infection. Like the general population of Ukraine, this group is in need of basic information about HIV/AIDS in different languages and also require access to prevention services, including VCT and condoms and STI care. Currently, neither information nor prevention services are provided specifically for this group. HIV programmes or targeted information are not available at border crossing points or points of arrival in Ukraine (train and bus stations, airports, sea ports) or provided in places where regular migrants may reside on a temporary basis (hotels, resorts, hostels). However, only a small proportion of this population engages in risk behaviours. Special

attention needs to be given to truck drivers, sailors, and some other categories of mobile workers that may be engaging in high risk behaviour.

There is also growing evidence of sex tourism among regular migrants and visitors, particularly in large cities of Ukraine. Current prevention programmes do not focus on clients of sex workers or sex tourists who may be clients of sex workers in large cities such as Kyiv, Odessa and costal resort cities in Crimea. The lack of universal condom provision in public toilets and hotel rooms throughout Ukraine is a serious shortcoming which could be easily rectified.

The second group are irregular migrants. Ukraine is at the cross-roads of a major route of irregular migration in Eastern and Central Europe. This relatively small population[40] is also considered to be at low-risk for HIV. However, there is evidence that during periods of detainment and pre-deportation, portions of this population can engage in high-risk behaviours, including injecting drug use and sex work. The small size of this population and its controlled access by state authorities makes prevention programmes easy to implement. Yet, there are no targeted or consistent prevention programmes for this population.

The third group includes victims of trafficking – the majority of whom are women who are Ukrainian nationals that were trafficked to a third country. The size of this population remains unknown.[41] Evidence indicates that this population is highly vulnerable to HIV, 11% reported to be engaged in injecting drug use, and up to 70% are involved in sex work. Limited data indicates that HIV prevalence among this group exceeds 4% - almost three times higher than in the general population.

While there have been significant advances in recent years to provide Ukrainian travellers, migrants and temporary workers with access to legal and consular services abroad, these programmes have yet to integrate any information or services for HIV prevention, treatment or support.

The National AIDS Programme (2004-2008) has completely neglected migrants as a target population. The lack of Ukrainian citizenship or residency status makes access to VCT difficult, if not impossible for migrants that want to seek HIV testing. Contrary to Ukrainian law, mandatory HIV testing is still regularly practiced for foreign students and workers.

Main Recommendations

Immediate:

MR.4.2.17 Include migrant and mobile populations, their families and children, as a target population group within the new National AIDS Programme, and as an area of technical support within UNAIDS technical support division of labour for Ukraine

Short-term:

MR.4.2.18 Target migrants and mobile populations with most at-risk behaviours with the respective HIV prevention activities/services

Medium-Term:

MR.4.2.19 Ensure that the State Committee on Nationalities and Migration, Ministry of Interior, State Border Service develop and implement programmes for HIV information and prevention for migrants

MR.4.2.20 Ensure that the Ministry of Foreign Affairs provides consular services for Ukrainian migrants and travellers abroad, featuring basic HIV information and access to local services

MR.4.2.21 Ministry of Culture and Tourism should require that HIV information is made a component of tourism information; all hotels, resorts, hostels and saunas

[40] In 2006, over 1,300 illegal migrants from 27 countries were detained in Ukraine.

[41] Since the year 2000, the International Organization for Migration assisted over 4,500 Ukrainian victims of trafficking to return to Ukraine.

should provide information about HIV/AIDS and STIs, and ensure the adequate availability of free condoms for all clients

Refugees and asylum seekers

The population of refugees and asylum seekers in Ukraine is small, yet it is vulnerable to HIV. Currently no programmes for HIV awareness, prevention, treatment or support specifically target this population. At the end of 2007, there were approximately 2,300 recognised refugees and over 2,200 asylum seekers in Ukraine. Many asylum seekers lack Ukrainian residence permits and therefore cannot access HIV services including VCT, treatment, care and support. All refugees are required by the Immigration Services to be tested for several diseases, including HIV, as part of the refugee status determination procedure, but pre-test counselling and informed consent are rarely, if ever conducted.

Cases of HIV have been reported amongst refugees, but the prevalence is not perceived to be higher than amongst the local population. No reliable data is available on HIV risk behaviour amongst refugees and asylum seekers. Refugees have not been mentioned as a group requiring specific attention in the National AIDS Programme (2004-2008). The only project on HIV and refugees was implemented by UNHCR and UNDP, which involved the development of information booklets and posters on HIV prevention in several languages, and advocacy for human rights and adherence to national legal frameworks. Anecdotal evidence suggests that refugees are denied access to support and treatment services.

Main Recommendations

Immediate:

MR.4.2.22 Integrate needs of refugees and asylum seekers into the new National AIDS Programme

Short-term:

MR.4.2.23 Prohibit mandatory HIV testing of refugees and asylum seekers

Medium-term:

MR.4.2.24 Train all physicians and other health care providers working with refugees in VCT, especially those who take blood for the purpose of refugee status determination to ensure provision of informed consent and quality VCT

MR.4.2.25 Develop HIV/STI prevention peer educators among the respective refugee communities with a culturally sensitive approach

MR.4.2.26 Ensure condoms are easily available for asylum seekers in Temporary Accommodation Centres and places where refugees congregate

HIV prevention for uniformed services

The uniformed services make up a small but stable portion of the general population in Ukraine. They include an estimated 152,000 persons in active military service, 324,000 in the police forces and approximately 32,000 interior forces, and approximately 40,000 in the state border guard service. Limited HIV prevention programmes have been implemented in this area, with significant progress made only in needs assessments, training, and some education interventions among some military personnel and police forces. Most activities have been funded by external partners, and the national budget is covering only basic resources for universal precautions in medical facilities under the Ministries of Defence and Interior, and limited access to HIV testing and counselling. Yet, behavioural surveillance among military personnel indicates frequent risk behaviour among some uniformed services. The number of cases of HIV infection reported among military personnel is small, but has increased in recent years, including those serving in United Nations peacekeeping missions abroad – indicating that this population is at heightened risk for HIV. In recent years, there have also been a small, but consistent number of military conscripts that have been diagnosed with HIV.

No reliable data is available from behavioural or epidemiological surveillance among other uniformed services in Ukraine. However, police forces are considered to play an essential role in success or failure of harm reduction programmes and prevention programmes among sex workers. In regions where local police have been trained under a programme of cooperation with local HIV programmes, such as in Kyiv, the number and percentage of IDUs accessing programmes is reported to be higher. In regions where such collaboration and training do not exist, IDUs frequently report barriers and harassment from local police when visiting harm reduction programmes or even carrying syringes. An active programme for training and education of police on HIV is essential to ensure the forthcoming scale-up of OST. Similar training to ensure synergies between the police and other prevention programmes targeting sex workers, MARA and especially vulnerable children and adolescents also need to be explored on a priority basis.

Main Recommendations

Immediate:

MR.4.2.27 Prevention for uniformed services should be integral part of the new National AIDS Programme 2009-2013, with a dedicated budget to ensure that core activities are supported by domestic resources

Medium-term:

MR.4.2.28 Integrate basic HIV education and prevention into the standard training programme for all uniformed services in Ukraine

MR.4.2.29 Expand the scope and coverage of HIV training programmes for police to focus on officers and departments that are working directly with MARPs, MARA and especially vulnerable children and adolescents

MR.4.2.30 Ensure that all uniformed services who are assigned to serve in international peacekeeping missions get comprehensive training on HIV prevention, and ensure they are covered by HIV prevention and support programme throughout the duration of their service, in collaboration with UN Department of Peacekeeping Operations (DPKO) and consistent with the UN Security Council Resolution 1308 (2000)

HIV prevention in the workplace

Recent projections of the HIV epidemic in Ukraine foresee continued increases in HIV prevalence among the labour force at the same time that Ukraine's population is rapidly declining. While the workplace response to HIV in Ukraine is still in the initial stages, it has already benefitted from the involvement of several international programmes targeted at encouraging workplace initiatives and other forms of employer engagement in the fight against HIV and AIDS. Initial activities undertaken by trade unions and private and public sector employers (including philanthropy, service provision, workplace prevention programs and advocacy) are encouraging, but the number of enterprises involved and the comprehensiveness of activities has been severely limited.

Almost half of Ukraine's workforce is employed in the private sector, yet few private sector enterprises have been targeted for workplace HIV initiatives. However, there are some models of good practice in both private and state Ukrainian enterprises that can serve as case studies in Ukraine and in the region, including, most notably, SMARTwork, 2004; some areas of ILO collaboration, and the exemplary work of the Interpipe Corporation. Multinational companies in Ukraine are also beginning to pay more attention to HIV in the workplace, with leadership and advocacy being provided by the Global Business Coalition on HIV/AIDS and Transatlantic Partners against AIDS.

The concept of corporate social responsibility is also gaining ground in Ukraine, with the UN Global Compact serving as a focal point and making recommendations to create an enabling environment for and supporting establishment of workplace programmes in

Ukraine, which should be integrated with efforts to enhance private sector involvement in HIV programmes.

The coverage and effectiveness to date of HIV workplace programmes has been limited by the absence of clear leadership or strategy in this area. Ukraine's National Association of Business Against AIDS, led by company directors and supported by Transatlantic Partners Against AIDS made some initial progress in uniting business leaders in this area, but has maintained a poor track-record of meetings and follow-up activities. A successful consultative committee on HIV/AIDS prevention in the labour sphere was also established with the consistent involvement of the Ministry of Labour, but ended with the completion of the SMARTwork project.

No Universal Access or other programmatic targets have been endorsed for workplace policies or programs. There is a lack of understanding of the role of workplace HIV policies and programs as part of the national response. The majority of Ukrainian employers are not aware of the existing HIV legislation or their obligations for non-discrimination or non-disclosure of status - 69% of employers believe employees have a legal right to know if a coworker has HIV, and 20% were unaware that it is illegal to dismiss employees because they have HIV.

There has been little or no HIV prevention in the workplace programmes implemented for workers in industries where they may be more vulnerable to HIV infection. Industries such as mining, metallurgy, public transportation (airlines, trains, and buses), trucking, and tourism should be encouraged to establish workplace programmes on a priority basis, particularly as many of these industries are located in regions that have higher levels of HIV prevalence. Similarly, workplace HIV prevention and sensitization programmes for direct service providers and professions in close contact with MARPs, MARA, and especially vulnerable children and adolescents should be prioritised, as they can greatly contribute to the reduction of stigma and discrimination and enhance service access. Particular attention should be paid to the healthcare and education sector, child-care facilities and law enforcement services.

Main Recommendations

Short-term:

MR.4.2.31 Conduct an evaluation of the pilot workplace programmes to guide their future sustainability and scale-up

MR.4.2.32 Integrate a workplace HIV strategy into the national response that reinforces the linkages between workplace prevention and other prevention efforts, with dedicated resources to ensure its implementation

Medium-term:

MR.4.2.33 Focus on positive incentives to engage employers in the response to HIV (i.e. tax incentives for enterprises to provide health promotion activities for their workers, families and communities)

MR.4.2.34 Develop and implement HIV prevention programmes starting in higher prevalence regions, with a focus on industries which are more vulnerable to HIV transmission

MR.4.2.35 Implement mandatory workplace HIV prevention and sensitisation programmes for direct service providers and professions in close contact with MARPs, MARA and especially vulnerable children and adolescents (healthcare and education sector, child-care facilities and law enforcement services)

MR.4.2.36 Rejuvenate the Business Against AIDS forum in Ukraine led by company directors

MR.4.2.37 Revise Ukraine's medium-term forecast of socio-economic development to reflect the impact of the HIV epidemic on key economic indicators, labour productivity and the availability of the workforce

4.3 Voluntary Counselling & Testing and Rapid Testing
Importance: High
Progress: Moderate

Overview

The national system of VCT is one of the most highly developed components of the national response to HIV/AIDS. Having been originally established under the Soviet Union in 1987, the system has been substantially expanded and developed in recent years. Today, there is large and growing coverage of VCT for many groups in the general population, with the number of tests increasing from 2.47M in 2005 to 2.86M in 2007. The majority of these tests are conducted among pregnant women (37%) and blood donors (31%), with uneven and insufficient coverage of MARPs. The National Law on AIDS clearly specifies that all HIV testing is to be done on a voluntary basis, except for mandatory testing among blood and organ samples, and must be accompanied by pre- and post-test counselling. However, the actual coverage and quality of informed consent and counselling remains inconsistent.

The use of rapid testing has been only recently introduced in Ukraine, with particular focus on the use of rapid tests in maternity hospitals for pregnant women presenting for delivery without a previous antenatal HIV test. Beginning in 2006, rapid testing was introduced as point of care (outreach) testing among MARPs. However, the quality and coverage of rapid testing among MARPs remains extremely limited. Implemented by NGOs with support from the Global Fund grants, onsite rapid testing for MARPs has met some opposition from AIDS Centres, who are rightly concerned about the low rates of follow-up for confirmatory tests among persons who initially test positive.

Importance

VCT represents one of the most underused resources in Ukraine's response to HIV. Latest estimates indicate that of 440,000 people living with HIV in Ukraine, only 82,000 people, or less than 20% are under medical observation. This indicates that as many as 350,000 people with HIV in Ukraine have not been tested and may not even know that they are infected with HIV. VCT should ensure that everyone that is tested is also provided with accurate information about HIV, counselling on HIV prevention, risk reduction, and access to condoms.

The use of rapid testing is an essential component of the overall testing strategy in Ukraine that is being slowly scaled up. The use of rapid tests in maternity homes is essential to provide PMTCT for pregnant women with HIV who have not accessed prenatal care and have not been previously tested for HIV, but should also be used in other point of care settings. The provision of rapid testing in outreach settings represents an important opportunity to extend access to VCT for MARPs in low threshold and outreach programmes that otherwise have little or no contact with the health system.

Progress

There has been moderate progress in the national system for VCT in recent years. The number of facilities providing VCT has been increased in recent years, and are now available in all major cities, towns and districts in Ukraine. A comprehensive national protocol for VCT has been endorsed by the Ministry of Health. However, the quality of VCT remains suboptimal, with only AIDS Centres providing consistently high quality counselling and testing. In the majority of other clinical institutions, the majority of tests continue to be done without adequate pre- and post-test counselling. The coverage of frequency of VCT among MARPs, particularly for those of younger age, remains seriously inadequate.

In the area of rapid testing, progress has been very limited, and marked by a lack of leadership from the Ministry of Health. Strong progress has been made with the implementation of rapid testing in all maternity hospitals in Ukraine, but these benefits are limited to expanding testing among a small, but important population of high-risk pregnant women. The National Plan for Scaling-up Rapid HIV Testing, endorsed by the Ministry of Health in February 2007 after significant delays, has still not been implemented. Recent progress has been made to introduce rapid testing for MARPs. However, the introduction of rapid testing among IDUs has not resulted in an increase in the number of newly registered cases of IDUs at AIDS Centres, indicating that serious shortcomings exist in the quality of VCT and referrals for MARP clients provided with rapid testing. The scope of the use of rapid testing among MARPs remains at the level of a pilot programme, and lacks adequate Governmental regulation and support. Serious shortcomings also relate to the registration, validation and quality assurance and quality control of rapid tests in Ukraine.

Key strengths and achievements

Ukraine has over 20 years of experience with HIV testing. There is an established and widespread network of "voluntary HIV counselling and testing" sites, including 214 centres and 'cabinets' for HIV testing and an additional 648 services providing counselling, covering all regions of Ukraine. The relatively high coverage of HIV testing among the general population has increased slightly in recent years. In 2007, more than 2.86 million HIV tests were performed. Coverage of testing among donors is universal, and among pregnant women consistently exceeds 95% - one of the highest rates in the world. Ukraine has also adopted a series of normative documents that regulate VCT in Ukraine, most notably the 2006 VCT protocol, which defines standards for different testing sites and populations. The Ministry of Health has issued an order (No#179, February 2007), to provide a comprehensive Plan of Scaling up Rapid HIV Testing in Ukraine for 2007-2008.

Shortcomings and challenges

Ukraine lacks an overall VCT strategy that specifies what groups of the population should be provided with access to VCT and with what frequency. The current approach to VCT is not consistent with the concentrated nature of the HIV epidemic. National VCT targets have not been established, neither for the population as a whole, nor for specific sub-groups or oblasts. The national VCT protocol does not adequately differentiate between provider initiated, client initiated testing, and diagnostic testing, and inadequate training and monitoring has been provided to ensure its implementation. In 2007, client initiated VCT represented less than 2% of all HIV tests, indicating extremely low uptake of anonymous VCT.

People must often pay out-of-pocket for a client initiated HIV test, in violation of the National Law on AIDS that specifies that all HIV testing is free. There are serious shortcomings in the voluntary nature of testing, with the majority of those tested needing to 'opt out' of being tested, which is difficult to do in practice. High quality pre- and post-test counselling is often only available at AIDS centres, with significant variation in the quality and coverage of counselling among different regions and between facilities within regions. Other health facilities (women's health clinics, blood donation stations) that provide the majority of HIV testing either provide poor quality of pre- and post-test counselling, or do not provide it at all, with post-test counselling often provided only for patients with HIV-positive results.

Stockouts of HIV test kits are common in many regions. In 2005, the National Council recommended regions to provide adequate resources to test 5% of the local population for HIV annually – an arbitrary target that is not reached in many regions. There remain massive disparities between regions in the coverage of HIV testing and the number of new cases

reported, directly linked to varying levels of procurement and use of HIV test kits for key populations from their local budget. As a result, coverage of testing among MARPs, particularly IDUs, as well as patients with STIs and TB, and prisoners, is low and inconsistent.

In the area of rapid testing, the National Plan for Scaling-up Rapid HIV Testing, endorsed by the MINISTRY OF HEALTH in February 2007, has still not been implemented. The use of rapid tests by NGOs since 2007 has unique potential to scale up of access to VCT among MARPs. In regions where rapid testing is being piloted by NGOs among IDU, however, there has not been any significant increase in the number of newly registered HIV cases of HIV among IDUs at AIDS Centres. Pilot sites report less than 50% of clients with reactive results report to the AIDS Centre for confirmatory testing, indicating poor quality of VCT and ineffective referral systems. Urgent revisions are also required in the legal and regulatory framework to support rapid testing by NGOs.

There are serious shortcomings related to registration, validation and quality assurance and quality control of rapid tests in Ukraine. Current regulations do not include requirements for review or evaluation of product performance in country by designated Ukrainian experts or laboratories. The performance of rapid tests used in Ukraine has not been properly evaluated in the settings and among specific populations with various HIV prevalence rates. There is urgent need for a quality assurance programme to ensure and monitor the quality of rapid testing in Ukraine, and a mechanism for confirmation of positive rapid test results, either by a supplemental rapid test or allowing the VCT centres to draw venous blood to forward for confirmatory testing at the AIDS Centre laboratories.

Main recommendations

Immediate:

MR.4.3.1 Develop national VCT strategy as an addendum to the new National AIDS Programme, to focus on increasing quality and availability of VCT for MARPs and other vulnerable groups, including realistic annual targets for specific regions and population groups

MR.4.3.2 Develop national rapid testing strategy as a component to the VCT addendum in the new National AIDS Programme, to focus on accessibility and use of rapid tests in point of care and community settings, ensure the quality of the testing, and ensure confirmatory testing for those with reactive rapid test results

Short-term:

MR.4.3.3 Ensure adequate and uninterrupted procurement and supply of quality HIV test kits on a central basis for all regions of Ukraine, financed by the state budget

MR.4.3.4 Strengthen counselling provided for MARPs through outreach programmes to ensure better follow-up and referrals to AIDS centres

MR.4.3.5 Establish and implement a comprehensive quality assurance programme for rapid and HIV point of care testing in Ukraine

Medium-term:

MR.4.3.6 Launch national campaign to promote access to VCT and awareness of individual HIV status

MR.4.3.7 Ensure mandatory joint professional training programmes for NGO outreach personnel and staff from AIDS Centres to encourage integrated referrals and collaboration in use of rapid tests and follow-up care

MR.4.3.8 Ensure integration of VCT services into medical services for patients at higher risk of HIV, including all STI clinics, TB clinics and narcology clinics

4.4 Laboratory Diagnostics and Patient Monitoring

Importance: High
Progress: Inadequate

Importance

Accurate and reliable laboratory diagnostic services are one of the foundations of Ukraine's capacity to monitor the HIV epidemic in the general population and select groups. The quality of laboratory diagnostic services also provides the basis for medical assessment and treatment decision-making for patients with HIV, and informs prevention interventions for those at-risk for HIV infection. Yet, HIV laboratories in Ukraine often lack adequate policies, resources and conditions to perform this role, and the potential of laboratory staff is undermined by inadequate training and support. Current laboratory infrastructure is barely capable of handling the existing requirements.

To meet future needs will require a massive expansion in HIV testing and a ten-fold increase in the laboratory testing for clinical staging and monitoring of treatment outcomes. Ambitious national targets for counselling and testing and ART cannot be met unless there is a concurrent scale-up of the national laboratory capacity. Laboratories outside of AIDS centres must have the capacity to accurately diagnose common opportunistic infections (particularly TB) and STIs, which will take time. In the interim, the capacity of existing TB and STI laboratories needs to be urgently strengthened to ensure quality TB and STI diagnosis for people living with HIV.

Progress

Senior laboratory staff at the Ukrainian AIDS Centre provide excellent scientific expertise and technical leadership. The scale-up of clinical monitoring services at the laboratories in regional AIDS Centres (viral load and flow cytometry) has enabled scale up of much of the testing essential to scale up of treatment. Some regional laboratories are well equipped and serve as reliable confirmatory laboratories, including for other regions that are still lacking basic equipment, lab facilities and personnel.

Shortcomings and challenges

Widespread shortcomings exist in the quality of laboratory specimens, related to outdated procedures for sample collection using venipuncture with reusable glass syringes and tubes without appropriate labelling or stoppers. This undermines specimen quality, presents serious safety hazards for laboratory personnel, and facilitates carry-over and contamination between samples, thus undermining the reliability of test results.

The complete absence of a functioning system for laboratory accreditation, quality assurance and quality control for any aspect of HIV diagnostic/monitoring services is a critical shortcoming. The majority of HIV tests in Ukraine are performed using test kits from one Ukrainian manufacturer. Yet, the accuracy and reliability of these test kits, or any other test kits and testing algorithms in Ukraine, have never been assessed or validated. Procedures for kit registration are not appropriate and do not ensure that registered products have adequate sensitivity and specificity for use in the Ukrainian setting. Without a system to monitor the ongoing performance of test kits, the accuracy and reliability of HIV-related testing cannot be guaranteed. These problems will not be resolved by the newly created National HIV Reference Laboratory, unless adequate additional support and resources are also provided by the Ministry of Health to implement a comprehensive system for accreditation, quality assurance and quality control on a priority basis at all HIV laboratories throughout Ukraine.

Laboratory personnel are often not considered to be an essential part of the multi-disciplinary teams working in the AIDS Centres, leading to poor understanding among many physicians of the complexities of lab testing, the importance of quality specimens, and the accurate interpretation of laboratory results. Many senior laboratory staff are committed, enthusiastic and well trained in general laboratory disciplines. However, laboratory staff lack opportunities for advanced education and training that is essential to ensure their ability to perform HIV specific testing, especially in aspects related to quality assurance, confirmatory testing, flow cytometry and more advanced molecular technologies such as viral load and DNA PCR. The number of laboratory staff at each AIDS Centre is too small, regulated by the Ministry of Health Order No 33, which is out of date. As a result, many laboratories report extreme staffing shortages and staff burn-out situations, which also undermine the quality and reliability of lab diagnostics.

The regulatory framework, largely under the Ministry of Health, prevents the use of evidence-based approaches to guide decisions and modify/improve practices locally or at a national level. Many regulations are inappropriate, often require years to be approved and implemented, and are highly resistant to revisions that are essential to keep pace with rapid changes in this area.

The system for procurement of laboratory kits, reagents and supplies for HIV testing and clinical monitoring is out of date and poorly managed at the national and regional level. Tendering procedures for laboratory kits, reagents and supplies are flawed, with decisions not reflecting the quality of the products and their appropriateness to the specific tasks. The result is often shortages and gaps in the supply of HIV tests and reagents. Facing a limited selection of suppliers, the Ministry of Health and some regions sometimes purchase outdated HIV test kits and equipment at inflated prices. When most countries now lease expensive laboratory equipment from the manufacturer or supplier, Ukraine has purchased expensive laboratory equipment, which locks them into using specific and sometimes outdated equipment and reagents.

The quality of TB diagnosis is very variable with only few centres of excellence. The diagnosis of extra-pulmonary TB, common among people living with HIV, is poor.

Main recommendations

Immediate:

MR.4.4.1 Establish and implement a comprehensive quality assurance programme for all aspects of HIV related diagnostics, including diagnosis of opportunistic and associated infections (including TB microscopy, culture and drug sensitivity testing) in Ukraine as an essential component of the new National AIDS Programme

MR.4.4.2 Develop a national plan for accreditation and scale-up of the national laboratory capacity, concurrent with targets for VCT and ART in the new National AIDS Programme

Short-term:

MR.4.4.3 Implement widespread revision to the systems for Government registration, procurement and tendering specific to HIV test kits and laboratory equipment to ensure the quality, supply and/or purchase of test kits and other lab equipment that reflects international standards

MR.4.4.4 Fully develop the National HIV Reference Laboratory and make it the lead organization (with regional input) responsible for overall policy and management related to HIV diagnostic services and lab accreditation, and ensure it has adequate resources to perform this role

Medium-term:

MR.4.4.5 Ensure regular multi-disciplinary and professional training opportunities for all laboratory personnel from all AIDS Centres

MR.4.4.6 Shift to mandatory use of only closed, single-use, disposable venous blood collection tubes and storage products

MR.4.4.7 Dried blood spot technologies should be developed, validated and implemented to overcome access issues related to DNA PCR testing

4.5 Blood and Injection Safety, and Post-Exposure Prophylaxis

Importance: High
Progress: Inadequate

Overview

The area of blood safety is proclaimed by the Government of Ukraine as a priority of the national AIDS response. Systems for blood safety are well developed, and continue to receive priority attention and resources. The blood transfusion system in Ukraine is considered to be safe, and relatively well–protected from the risk of HIV infection, with 100% of donated blood tested for HIV. With the large and growing prevalence of HIV in the general population, including among donors, however, it is impossible to exclude the possibility of a very small number of individual cases of HIV transmission through the blood transfusion system – usually related to donors within the seroconversion window period.[42] In 2007, the surveillance system detected 1,138 positive tests among 883,215 tests conducted among donors. To date, there have been reported a total of 21 cases of HIV infection related to contamination of blood and/or blood products, including 2 cases in 2006 and 1 case in 2007.

The number of low-risk volunteer blood donors is insufficient to ensure a safe and adequate blood supply. It is possible to significantly reduce risks by abandoning the current practice of paid donorship and implementing a procedure of regular pool of voluntary low-risk blood donors. The lack of external quality assurance and quality control is also a major shortcoming. In 2006, the percentage of donated blood units screened for HIV in a quality assured manner – a national indicator for HIV/AIDS – was 0%.

Injection safety in medical institutions is accomplished mainly through the use of disposable needles and syringes, along with management of sharp medical waste. There are adequate policies and procedures to ensure the use of disposable needles and syringes in hospitals, clinics and pediatric immunizations centres. There are also procedures for waste management in place with proper disposal of contaminated sharps. However, there are consistent shortages of some disposable commodities in poorer regions, including frequent shortages of disposable needles, syringes, latex gloves, and boxes for disposal of needles. Patients are frequently expected to pay for such supplies out of pocket, or bring their own disposable supplies with them, which comprises the standards for ensuring injection safety.

HIV PEP is available in Ukraine. However, PEP kits are stored and PEP administered only at the regional AIDS Centres. The PEP protocol uses three ARV drugs, rather than two drugs, despite WHO guidelines to the contrary.[43] Medical personnel outside of AIDS Centres have little training or knowledge about PEP for occupational exposure, and there is inconsistent use of PEP following non-occupational exposure to HIV between different regions.

Instead of the universal use of standard precautions in medical facilities, the lack of free and adequate supplies for safe injections and limited access to PEP also perpetuates fears among health workers of nosocomial transmission. These fears can also perpetuate stereotypes about patients at high and low-risk, encourage medical workers to forgo the universal use of standard precautions, and enhance discrimination of patients perceived to be infected with HIV.

Importance / Impact on Epidemic

This is an area of high importance. There is legitimate concern over the level of HIV prevalence among blood donors in Ukraine, which is the highest in Europe.[44] Rare cases of HIV infection through contaminated blood indicates that the safety of the blood transfusion

[42] The seroconversion window period refers to the period of time it takes to develop detectable antibodies to HIV following infection with HIV. In almost all persons, antibodies are produced within 14 weeks after infection occurs. Persons who are tested during the window period may receive a false negative HIV test result, even if they may be infected with HIV.
[43] The two-drug ARV regimen consists of two nucleoside or nucleotide reverse transcriptase inhibitors (NRTIs). HIV/AIDS Treatment and Care: Clinical Protocols for the WHO European Region (2007).
[44] EuroHIV. HIV prevalence in blood donations, 2001-2006; N°76, pp.31-43, Mid-year report (2007).

system is not 100% guaranteed. However, extensive measures already exist to maximize the safety of the blood supply. The extremely small number of cases of HIV infection through contaminated blood or blood products does not represent a significant threat to public health, and pales in comparison to other sources of HIV transmission, including mother to child transmission. There have been three documented cases of HIV in Ukraine related to occupational exposure, but these cases occurred several years prior to the introduction of PEP. As such, injection safety and PEP are not considered to be significant risks, and will not have any measurable impact on the nosocomial transmission of HIV. Nevertheless, the serious shortcomings identified in these areas require attention and effort in order to bring these systems in line with international standards.

Progress

Progress in this area has been inadequate. While progress was made in the earlier years of the epidemic, there has been little progress in recent years. Particularly in blood safety, the lack of a system of quality control and the continued practice of paid donorship are in direct contraction with international guidelines. In the area of injection safety, there has been little progress in recent years to close supply gaps for safe injection equipment. The universal use of standard precautions is not practiced, with many medical personnel instead relying on special precautions for patients known or suspected to be infected with HIV. Despite the need for PEP to be available in all regions and cities in Ukraine, current access to PEP remains limited. These shortcomings need to be addressed at various levels of government and medical institutions, which will require substantial time and effort.

Strengths and Achievements

Blood Safety

Each year, blood collection centres collect and test all donations of blood and blood products for HIV infection. An extensive system for blood safety has been implemented in Ukraine, with over 831,000 blood units tested for HIV in 2006 – which represents 100% coverage. All donors are screened for behavioural and medical risk factors for acquiring HIV infection using standard questionnaires. Consistent with WHO recommendations, 100% of the donated blood units are tested for HIV, viral hepatitis B, viral hepatitis C by enzyme immunoassay (EIA) techniques, using standard operating procedures. There are ongoing training programs for transfusion centre personnel. Plasma is frozen and quarantined for six months before use. The Ministry of Health has expressed its commitment to blood safety as a priority. The current surveillance system seems to be quite effective in detecting cases of HIV among donors (1,138 positive tests among 883,215 tests conducted among donors in 2007).

Injection Safety

For injection safety, there is wide use of disposable needles and syringes in hospitals, clinics and pediatric immunizations centres. There is also a system of waste management in place with proper disposal of contaminated sharps. Treatment standards that address the appropriate use of injections have been drafted. Ongoing training programs exist for personnel involved in administering injections. The Ministry of Health has expressed its commitment to control of infection through injection.

Post-Exposure Prophylaxis

PEP is available and is provided at the AIDS Centres based on the evaluation of the risk for those who had occupational or non-occupational risk of HIV infection. There is an up-to-date national PEP protocol, and adequate training for medical personnel at AIDS centres on how to handle cases of PEP among medical workers, and properly administer PEP. There is an adequate supply of PEP at all AIDS centres to enable access to PEP for medical personnel who need it for cases of occupational accidents, usually within 24-48 hours. No cases of HIV seroconversion were documented in 2005-2006 – indicating that the current PEP programme has been successful in minimizing HIV transmission in cases of occupational exposure.

Shortcomings and challenges

Blood Safety

Despite the Ministry of Health's commitment to blood safety, no single individual or agency has fulltime responsibility for the regulation and administration of the blood transfusion system. No active blood transfusion monitoring system (haemovigilance system) exists to accurately determine the rates of transfusion-transmitted infections. Due to the lack of any system for external quality control of the blood system, the national indicator for blood safety – the percentage of donated blood units screened for HIV in a quality assured manner in 2006 was 0%.

While the Ministry of Health maintains that blood donations are made on a voluntary basis, the majority of blood donors receive payment for donation – a practice which is inconsistent with international recommendations. Some respondents also reported public fears of being infected when donating blood. Combined with the absence of public campaigns to promote a broader-base of low-risk donors, the majority of active blood donors tend to be from a narrow group of regular, repeat donors. Other potential donors, such as family members or friends of patients, and military personnel, sometimes receive pressure to donate blood from during periods of blood shortages. Officials in the blood transfusion service maintain that many regular donors depend on these payments, and thus are motivated to maintain good health or risk loosing their right to donate blood. However, Ukraine has recently been reported to be the country with the highest rate of HIV infection among blood donors in the WHO's European Region. There are also recent documented cases of HIV transmission from blood donors in the seroconversion window period. This is evidence that Ukraine's reliance of a core group of regular, paid donors is not successful, and represents a serious risk to the safety of the blood supply. Recent trends indicate the growing prevalence of HIV among donors, illustrating the urgent need for a regular pool of voluntary low-risk blood donors.

Ukraine faces many of the same structural shortcomings in its blood safety system that are found in some other countries of the former Soviet Union.[45] There is inadequate funding for blood services, which perpetuate poor working conditions and the lack of personnel. The lack of adequate funding is also seen in aging infrastructure, and shortages of basic supplies for equipment, lab diagnostics and infection safety. Medical personnel regularly recommend blood transfusions for patients in exchange for financial gain, even if these procures are not medically justified.

Most significantly, no laboratory quality assurance systems (internal or external) are in use in any blood collection centres.[46] No national agency has quality assurance oversight authority. Only a limited number of HIV test kits have been registered for use in Ukraine, and the test kits currently in use in Ukraine, including for blood safety, have never had performance characteristics validated for use in Ukraine. Although plasma is quarantined for six months before release, waiting for repeat testing of the donor, it was acknowledged that an individual plasma unit may be used in the pharmaceutical industry, even if the donor does not return for follow-up testing.

There are plans to begin HIV PCR testing on donated blood, but these plans lack funding. There is also an artificial belief among some professionals working in the Ukrainian blood system that the use of such PCR systems will add greatly to the safety of the blood supply. However, Ukrainian laboratory experts knowledgeable about PCR testing agree that such testing is expensive, complex and problematic in Ukraine. There are also plans to purchase other expensive equipment for the blood transfusion service, including leukocyte filters and supplies for hemotransfusion viral inactivation. PCR testing and the purchase of other expensive equipment should not be viewed as a panacea solution to the blood safety problem. These plans should not be implemented without first addressing the other basic problems identified above.

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[45] See "Blood Services in Central Asian Health Systems," Global HIV/AIDS Programme, World Bank, May 2008.

[46] The lack of an external system for quality control / quality assurance was responsible for the change of Ukraine's UNGASS indicator for blood safety from 100% in 2006 to 0% in 2008.

Injection Safety

Treatment standards addressing appropriate injection use have not yet been implemented or disseminated. No data on injection practices is available. No assessment or pilot sampling has been performed to survey injection practices in medical or dental facilities or tattoo/acupuncture facilities. The purchase of safe injection equipment is supported by local budgets, so the availability of injection supplies varies widely between regions, depending on the availability of funding. In some hospitals and emergency clinics, needles may be re-used if supplies are inadequate and patients cannot afford to purchase their own equipment. Patients are regularly expected to bring their syringes to clinics and hospitals, which indicates that health system is not providing injection supplies in adequate quantity, or as standard policy. Boxes for the disposal of syringes and other sharp or hazardous medical waste are also reported to be in short supply in some medical institutions. In clinical practices, injections are often given in cases where suitable alternative oral therapies exist. Due to limited availability of combination vaccines, a significant number of childhood immunizations require multiple injections.

Throughout the Ukrainian medical system, there is also poor and inconsistent use of standard / universal precautions. Often medical workers will forgo the standard use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear for work with all patients, which reduce the risk of exposure of the health care worker's skin or mucous membranes to potentially infective materials. On the contrary, medical workers often only use precautions in working with patients known or suspected to be infected with HIV, often in excess to standard / universal precautions and disproportionate to the risk of infection.

Post-Exposure Prophylaxis

The national PEP protocol is outdated and needs revision. PEP kits currently consist of three ARVs, which are prescribed by HIV experts in the AIDS Centres based on the evaluation of exposure risk. While no evidence indicates that a three-ARV combination is more effective for PEP than a two-ARV combination, or vice versa, physicians offer three ARV drugs combination regimen for 28 days. There is almost no availability of PEP outside of AIDS Centres. There are no tools to evaluate adherence to PEP as well as no data on PEP provision and monitoring available at national level. There are reports that some medical personnel have had to pay for PEP or for follow-up medical care out of pocket, as well as reports of discrimination from supervisors or other co-workers, even though there were no documented cases of occupational infection. Currently, PEP is readily available only for health care workers. However, exposure to HIV may also occur in other occupations, including emergency rescue staff, waste-disposal workers, law enforcement personnel and fire-fighters that may be exposed to blood and other potentially infectious body fluids while performing their professional duties.

Services available for PEP following non-occupational exposure to HIV – i.e. for adults who may have been exposed to HIV via sexual or needle-sharing activities, needle sticks outside of occupational settings, trauma, human bites, and sexual assault – remain very limited. While Ukrainian legislation has given extensive and even excessive attention to the criminal liability of people with HIV in cases of HIV transmission, there has been inadequate attention to ensure PEP interventions to prevent HIV infection in these situations. In particular, there is limited knowledge, training and very limited access to PEP in governmental and non-governmental crisis centres that deal with victims of sexual assault.

Main Recommendations

Blood Safety

Short-term:

MR.4.5.1 Establish the blood transfusion service as a separate unit/agency with responsibility and authority for the regulation and administration of all aspects of the blood transfusion system, including blood donation, operating standards, quality assurance and clinical transfusion guidelines

Medium-term:

MR.4.5.2 Establish a system of recruitment of voluntary low-risk blood donors, eliminating paid donors and family/replacement donors, based on international experience on the establishment of an all-volunteer blood donor network before implementing any more expensive purchases of equipment and lab technologies for blood safety

MR.4.5.3 Establish a system of quality assurance for laboratory testing of blood donations, using only properly validated test systems

Injection Safety

Immediate:

MR.4.5.4 Ensure the continuous availability of sterile/disposable injection equipment, even in resource-restricted environments

Short-term:

MR.4.5.5 Perform an assessment or pilot sampling to survey injection practices in medical or dental facilities and tattoo and acupuncture facilities

Post-Exposure Prophylaxis

Short-term:

MR.4.5.6 Revise PEP policy to clarify who is eligible for PEP (occupational and non occupational exposure to HIV), and ensure free provision of PEP

MR.4.5.7 Revise PEP protocol for conformity with WHO recommendations, based on treatment with two ARV drugs

Medium-term:

MR.4.5.8 Ensure at least one clinical centre in every city in Ukraine is trained with adequate personnel and resources to administer PEP

MR.4.5.9 Ensure basic training on infection control and PEP is included in the training programmes and recertification programmes for all medical personnel in Ukraine, and, where appropriate, other occupations (emergency rescue staff, waste-disposal workers, law enforcement personnel and fire-fighters, etc.) who may be exposed to blood and other potentially infectious body fluids while performing their work duties

MR.4.5.10 Ensure collection and analysis of data on PEP on an annual basis

4.6 Medical Care and Treatment

Importance: High
Progress: Moderate

Overview

Since 2004, significant developments have occurred in the provision of medical care and treatment for people living with HIV and AIDS in Ukraine. The number and percentage of people receiving life-saving antiretroviral treatment (ART) increased from 21% in 2005 (3,040 persons) to 27% in 2006 (4,777 persons) and 35% in 2007 (7,657 persons), based on the number of officially registered cases of HIV-infection. Despite the continued increase in the absolute number of patients with AIDS, in 2007 there was the first ever reported decline in newly diagnosed AIDS, from 4,723 cases in 2006 to 4,573 new AIDS cases. There is inadequate evidence, however, to determine whether this decline is associated with the continued scale-up of ART, thus preventing clinical progression to AIDS, or whether AIDS Centres have been more passive in diagnosing AIDS among patients. AIDS mortality remains high and continues to increase, with 2,507 AIDS-related deaths reported in 2007 – the highest number of AIDS deaths since the beginning of the epidemic, indicating that the scale-up of treatment remains inadequate to have an impact on mortality. TB remains the leading opportunistic infection among AIDS patients, with over half of AIDS deaths in 2006 associated with TB.

Importance

This is an area of high importance. The coverage and quality of ART programmes has a decisive influence on AIDS morbidity, mortality and survival, and can also have a direct impact on reducing the transmission of HIV. The extent of coverage of programmes for OST among HIV-negative opiate IDUs can also have a significant impact on reversing the spread of HIV; OST among opiate IDUs with advanced HIV infection can have a significant impact on adherence and survival. The increasing number of people living with HIV that will require medical care and support in coming years represents a significant challenge for the Ukrainian medical system, which is currently ill-equipped to manage a task of such scope and complexity.

Progress

Progress in this area has been moderate. There has been adequate progress in critical areas, particularly in launching the national ART programme. However, there has been slow and limited progress towards reaching agreed national targets, with the majority of adults in need still lacking access to treatment, and extremely limited progress in the implementation of OST. The overall design and implementation of programmes in this area are only partially consistent with current needs, and will require extensive revisions and rapid improvement in order to meet future needs, particularly in decentralizing the provision of ART, implementing methadone-based substitution therapy, and effective prevention, diagnosis and treatment of TB among people living with HIV. There are significant shortcomings to be addressed in this area, requiring extensive time, effort and leadership by the Ministry of Health. These shortcomings include, most significantly, the artificially high price of ART medications procured through the Ministry of Health, widespread illegal out of pocket payments by patients for diagnostic and some medical services, and the lack of integrated, patient-oriented services.

Targets

The overall need for ART treatment was defined in the context of a consultative process of setting Universal Access targets in 2006, when Ukraine took a pioneering role in Eastern Europe in organizing such a process. However, the development of Universal Access targets for ART considered only the needs for treatment among officially registered patients with HIV, thus neglecting the majority of people living with HIV and AIDS who are unaware of their HIV status. The opportunity was missed to define more ambitious targets for non-ART treatment of HIV/AIDS, palliative care, and for concomitant conditions such as viral hepatitis, OST, HIV related TB and others. The targets that were established were specified at the national level, with no subsequent disaggregation of targets at the regional level, or for special settings such as patients in the prison system. Targets for other key aspects of treatment for OST, TB, and palliative care are either non-existent, or limited to the targets that were defined by external sources of funding, such as the Global Fund grant supported programmes.

Main recommendations

Immediate:

MR.4.6.1 Revise treatment and care targets for 2010 (Universal Access) and 2013 (end of the new National AIDS Programme) based on total estimated number of people living with HIV in Ukraine and estimated projections for future growth of the epidemic

MR.4.6.2 Add relevant targets for palliative care, pediatric care, opportunistic infections, OST, TB, viral hepatitis, STIs, and for specific settings, including the prison system

Medium-term:

MR.4.6.3 Empower oblasts to set and revise their own treatment targets as a basis for planning and monitoring regional AIDS programmes

Coverage

The number of people on ART continued to increase rapidly in 2007. However, there was only a small and inadequate increase in the estimated coverage of ART, from 27% in 2006 to 35% in 2007, as the number of patients in need of treatment continues to grow faster than the scale-up of treatment. The methods for calculating of ART coverage, while having improved in recent years, are still based on the officially reported number of patients with HIV, which is not consistent with international recommendations.[47] Several regions that are capable of treating additional patients are not provided with the necessary resources from the Ministry of Health, as these patients were not specified in treatment quotas that were determined earlier. Based on current trends, there is a credible risk that the overall coverage of ART in Ukraine may decrease by 2010, as the number of patients in need of treatment increases faster than the number of new patients on ART.

Conservative projections of future ART needs indicate that at least 80,000 patients will require ART by 2013. However, the current system has struggled to scale up treatment over 8,000 patients, and will not be capable of rolling-out a further ten-fold increase in treatment unless critical shortcomings are addressed. Coverage rates of non-ART and treatment of co-conditions are also difficult to establish, as no accurate needs have been defined. However, among patients with HIV, absolute treatment figures indicate insufficient coverage rates in palliative care, diagnosis and treatment of active TB, and point to almost negligible coverage in treatment of viral hepatitis and drug dependence with OST.

Main recommendations

Immediate:

MR.4.6.4 Provide fast-track access to additional medication and resources to regions that are capable / ready to provide additional patients with ART

Medium-term:

MR.4.6.5 Ensure the Government of Ukraine continues to scale up coverage of ART to at least 80% of those in need of treatment by 2013 (at least 80,000 patients), consistent with Ukraine's international commitments and the National Law on AIDS

Strategic Planning

The Road Map identified key treatment targets. As in other areas, however, plans and targets elaborated in the Road Map have remained aspirational, with no measures adopted by the National Council or the Ministry of Health to integrate the Road Map into the National AIDS Programme. As a result, there is still no strategy or operational plan on how to reach Universal Access to HIV treatment and care. The national and local processes of planning for treatment and medical care are short-term, not driven by treatment needs, but rather by assumptions about available financial and other resources. This approach is inconsistent with the National Law on AIDS that clearly specifies that the Government will provide free treatment for all patients with HIV. There are few operational plans to scale up or sustain services (e.g. OST, or for specific components of programmes supported by the Global Fund grants). Detailed annual operational plans are missing in key areas, including adult and pediatric HIV/AIDS treatment and care, management of TB among patients with HIV, and palliative care. There is no national strategy or plan for hepatitis.

[47] The use of Spectrum to calculate ART coverage in 2007 is recognized as a significant improvement. However, Spectrum is not designed to generate estimates based on the officially reported number of patients with HIV, but rather the total estimated number of persons with HIV, which is considerably higher.

Main recommendations

Immediate:

MR.4.6.6 Clarify the principle of Universal Access to treatment enshrined in the National Law on AIDS, and use it as a basis for ensuring adequate national resources for scaling-up treatment

Short-term:

MR.4.6.7 Develop robust and realistic national and regional scale-up plans to achieve Universal Access to treatment and medical care of HIV and associated conditions, with detailed plans to scale up access and coverage for ART, non-ART medical care (clinical monitoring and opportunistic infection), palliative care, drug substitution treatment, hepatitis, TB, STIs

Opiate Substitution Treatment

Opiate substitution treatment (OST) is safe, effective, and essential to halting the spread of HIV among IDUs in Ukraine. Recent efforts to attract and maintain IDUs in ART have not been highly successful, largely due to the almost complete absence of OST. Yet, overwhelming evidence indicates that OST is essential and effective to improve compliance and adherence to ARV treatment among IDUs with advanced HIV. OST is also essential to break the cycle of HIV transmission between HIV negative and HIV positive IDUs. By the end of 2007, slightly over 500 of the estimated number of 325,000–425,000 IDUs in Ukraine were enrolled in OST, which include only a minority who are HIV negative. At least 60,000 IDUs are believed to be in need of OST, indicating that the current scale of coverage is too small to have any measurable impact on the epidemic. The vast majority of patients are receiving buprenorphine at low dosage, which is considered to be less effective than methadone in retaining patients, and can costs eight times more. The national OST protocols correctly focus on long-term opiate injection drug users, but the inclusion criteria are excessively restrictive. The programme should be expanded to include medium-term opiate IDUs using low threshold services outside narcology clinics.

The State Department of Ukraine for Enforcement of Sentences remains vehemently opposed to the implementation of harm reduction and OST as core components of the HIV prevention programme in the Ukrainian penitentiary system. Despite a direct policy directive from the President of Ukraine and international obligations to support the implementation of harm reduction and OST, SDES has continued to identify regulatory obstacles to the implementation of these much needed interventions. The lack of action by SDES in this area is precipitating the spread of HIV among IDUs in the Ukrainian prison system, and need to be revised immediately.

The importation and use of methadone in Ukraine was only cleared at the end of 2007, following an intervention by the President of Ukraine. The introduction of methadone will enable Ukraine to enroll up to 11,000 opiate IDUs into substitution therapy programmes until 2011 for whom only the minimum external resources have been secured. This leaves a significant gap and no provisions to sustain and scale up this essential intervention. The impact of OST will depend largely on how quickly the coverage of the programme can be expanded, and how accessible and user-friendly the provided services are.

Main recommendations

Immediate:

MR.4.6.8 Include a specific component on the scale-up of substitution therapy in the new National AIDS Programme, clearly specifying treatment needs, available resources, and any resource gaps

MR.4.6.9 Support the implementation of substitution therapy as a core component of the HIV prevention programme in the Ukrainian penitentiary system

Short-term:

MR.4.6.10 Support the implementation of substitution therapy at AIDS centres (as is currently successfully done at the Kyiv City AIDS Centre)

MR.4.6.11 Urgently expand substitution treatment programmes in different settings, based on low-threshold provision of methadone and client friendly service provision, integrated with other medical and non-medical services for IDUs

Medium-term:

MR.4.6.12 Close resource gaps for scale-up of substitution therapy between the current target of 20,000 patients up to 60,000 patients by increasing government funding for OST

MR.4.6.13 Remove restrictive and unnecessary regulations and legislation, preventing access to and scale-up of OST

MR.4.6.14 Ensure robust longitudinal monitoring of outcomes among substitution therapy patients with and without HIV-infection

Decentralization of Services

The current system for the provision of medical care and treatment for people living with HIV is focused on a network of 34 oblast and city AIDS Centres. These AIDS Centres are staffed by specialized medical personnel and exist in parallel to the other health institutions that care for other, non-HIV aspects of medical care, including TB, STIs, narcology and womens' health. Within the framework of existing national regulations, many regions have developed their own local approaches to the provision of ART, leading to stark discrepancies between regions in how the treatment process is organized and the capacity of AIDS Centres. All regions are now equipped with at least one facility for the outpatient treatment of ART, but few of the regions have supported decentralization of medical services beyond the AIDS Centre.

At present, AIDS Centres are not adequately equipped to address all of the medical needs of people with HIV in an oblast or even a large city, which will become significantly larger, more complex and severe in coming years. The limited capacity of the AIDS Centres also represents a serious barrier to access treatment for patients from other cities, or outside these urban centres. Several regions continue to rely heavily on the Lavra Clinic and the Kyiv City AIDS Centre, particularly for the management of more complex cases, leading to excessive and unsustainable demands on the capacity of the Lavra clinic, and perpetuating the lack of clinical capacity and expertise in many regions. Tens of thousands patients with HIV will also require regular clinical monitoring and treatment, which the system is not ready to handle. To date, the excessive reliance on specialized AIDS treatment facilities is inappropriate to support the necessary scale-up of ART and medical care. Only the region of Donetsk Oblast has effectively decentralized the medical care and treatment of patients with HIV/AIDS beyond the oblast AIDS Centre, thus providing an appropriate model for patient care implemented in other cities and at the district level.

It is also essential to improve the medical care and integrated management of patients with HIV in hospitals. Some AIDS Centres have an inpatient ward, but the majority of AIDS centres function as outpatient clinics, relying on the department or hospital of infectious diseases to care for patients with HIV that require hospitalization. Medical personnel working in these in-patient facilities need to be better integrated into the continuum of care for people living with HIV, including access to the specialized training and other benefits entitled to staff working at AIDS centres. Special attention also needs to be paid to ensure that medical specialists that provide outpatient medical care have the right to provide medical consultations with their patients when they are hospitalized.

Main recommendations

Medium-term:

MR.4.6.15 Plan to the systematic decentralization of medical care and treatment services through complementing existing, specialized AIDS Centres by a network of

urban and district-level HIV/AIDS treatment facilities integrated in primary care settings to provide basic HIV/AIDS treatment (including ART) in combination with treatment of co-conditions

MR.4.6.16 Decentralize the provision of HIV medical services, taking into consideration the successful Donetsk Oblast model for decentralization

MR.4.6.17 Integrate the staff at infectious disease wards of hospitals into the system for provision of medical care for patients with HIV, and provide these hospitals with adequate training and support

Treatment Model

The model for the medical care and treatment of patients with HIV/AIDS has not yet been systematically described or standardized, neither for existing specialized AIDS Centres, nor for emerging HIV/AIDS treatment sites in general healthcare settings. The current treatment model needs to be revised in order to optimize the task distribution and collaboration between various members of the treatment team. In some regions, infectious disease specialists appear to be overburdened. However, much of the work that is done by physicians is administrative, involving the scheduling of visits, completion of documentation, and the provision of adherence counselling. The role of nurses and social workers is severely limited, their work underappreciated and their potential role in the treatment and care of patients living with HIV is underused. Their role should be reviewed to have them undertake many of the tasks currently being performed by doctors. There also remain significant differences in the patient load between regions, with physicians in some regions caring for hundreds of patients, while in other regions, full-time doctors are caring a very small number of patients.

With few exceptions in a limited number of regional AIDS Centres, the integral role and expertise of laboratory staff is largely neglected in the multidisciplinary model, with few physicians seeking the support and expertise of relevant laboratory staff in clinical decision making and even in the interpretation of laboratory results.

People living with HIV are not yet systematically involved in the provision of care and the provision of adherence counselling. There are some positive models, including Chas Zhitya Plus at the Lavra Clinic in Kyiv, that demonstrate the essential role that can be performed by NGOs in supporting the treatment and care for patients with HIV.

Main recommendations

Medium-term:

MR.4.6.18 Develop standardized HIV/AIDS treatment models based on optimized task distribution between members of treatment team, realistic staff to patient ratios, and appropriate service integration (nurses, NGOs, lab personnel, social workers)

MR.4.6.19 Develop or revise regulatory documents regarding the structure, resources and functions of the AIDS Centres and their interactions with other vertical systems, including TB, narcological, reproductive health, STIs, infectious diseases, and prison health services

MR.4.6.20 Develop a clear and understandable summary (document) of the model for delivery of HIV medical care and treatment services that clearly outlines the delineation of roles and responsibilities between institutions, and members of the multidisciplinary team that can be read and understood by medical specialists, governmental personnel, health care providers, and patients living with HIV/AIDS

Vertical Services / Integration

The enrollment of patients in medical care and treatment, as well as the efficiency of treatment, is seriously hampered by the highly vertical nature of the medical system in

Ukraine. Patients living with HIV who are also affected by multiple conditions are forced to visit different specialized health services, and often receive uncoordinated or inappropriate treatment and care. For example, existing regulatory barriers prevent the syndromic treatment of syphilis and gonorrhoea at the first entry point in the health system, including at AIDS Centres, contributing to under-treatment or inappropriate self-treatment of STIs, and the extended sexual transmission of HIV. More severe examples exist in narcology or TB, where patients on ART must visit the narcology clinic or TB dispensary on a daily basis for directly observed therapy, even if they are hospitalized with acute immune suppression. Medical specialists and institutions lack adequate knowledge and the mandate to provide integrated care for the complex needs of patients with HIV who have multiple conditions. It is important to include adequate TB infection control measures in HIV care settings through adequate TB screening, diagnosis, treatment and prevention. It is also essential to ensure that all TB patients are regularly provided with VCT for HIV. The association of HIV with drug resistant TB is also of major concern. There is an urgent need to assure that quality assured first and second line anti-TB drugs are universally available and that international standard treatment regimens are adhered to.

Ukraine needs to urgently provide access to integrated treatment and care services, which is more cost-effective, ensure better follow-up, and leads to improved treatment outcomes. Such approaches have already been successfully piloted in select clinics, such as the Kyiv City AIDS Centre, and should be rapidly scaled up to other cities and regions. Some initiatives are also providing integrated care in a continuum, addressing different health and social conditions, hospital and community settings (including home and palliative care), and avoiding loss of patients when moving from between cities, and entering or exiting prisons. A systematic exploration and operational research of these models is essential to the development of appropriate future standards for care and treatment, based on a client-centered approach.

Main recommendations

Immediate:

MR.4.6.21 Specify in the new National AIDS Programme the timeline for the integration of clinical services relevant to HIV, with an urgent priority for integration of TB and narcology services for patients living with HIV

MR.4.6.22 Implement adequate TB infection control in all HIV care and treatment settings

Short-Term:

MR.4.6.23 Ensure Universal Access to quality-assured TB diagnosis, quality-assured first- and second- line anti-TB drugs and TB prevention interventions for all people living with HIV

MR.4.6.24 Ensure access to VCT for HIV in all TB dispensaries and hospitals

Medium-Term:

MR.4.6.25 Overcome the vertical system for health services for patients with HIV by improving structured collaboration at all levels, and promoting the integrated delivery of services; infectious disease specialists should have the training and authority to prescribe and monitor treatment for TB and/or OST, and vice-versa

MR.4.6.26 Strengthen horizontal linkages between HIV-specific services and other services required for comprehensive medical care (including TB, neurology, psychology, primary care, etc.)

MR.4.6.27 Deregulate diagnosis and treatment of all STIs so that all physicians can treat uncomplicated STI cases while maintaining the mandatory reporting of syphilis and gonorrhoea

MR.4.6.28 Implement syndromic management of STIs, including risk reduction counselling and condom provision for all patients with HIV and their sexual partners

Client Orientation

The lack of integrated and comprehensive treatment approaches for patients with HIV/AIDS underscores the general lack of patient orientation of health care services in Ukraine. The majority of health services require patients to exercise initiative and navigate various institutional barriers in order to access care and treatment. The health care system in Ukraine provides few effective provisions for proactive follow-up of patients and treatment outcomes. A disproportionately large number of persons who initially tested HIV positive are never registered under medical observation at the AIDS centre, with significant variation between regions. An excessive number of patients who commence ART either discontinue treatment, or are lost to follow-up, without adequate documentation to explain reasons for such failures. Such patients often face a heightened risk of acute health complications. In a system whose efficacy is based on a system for registration of individual patients, the loss of any patient also represents a significant threat to the future health of these patients. The lack of a patient-centered approach is particularly relevant for OST, which is largely restricted to narcology clinics which are avoided by many IDUs. The threshold for drug users to access effective treatment for drug dependence and HIV/AIDS remains excessively high, as treatment programmes are insufficiently linked with outreach and social support programmes.

Main recommendations

Short-term:

MR.4.6.29 Establish a target for the number or percentage of patients in all regions who are newly diagnosed with HIV and who are successfully placed under medical observation (dispensary list)

Medium-Term:

MR.4.6.30 Improve capacity of services to pro-actively follow-up patients to minimize loss of persons under medical observation, and patients on treatment for ART, treatment for opportunistic infections and/or co-morbidities

MR.4.6.31 Systematically improve patient-centered approach of health care services, particularly for patients with HIV, and lower the threshold of access to such services

MR.4.6.32 Provide services in low threshold settings with emphasis on outreach approaches, particularly for IDUs

Inequity of Access / Discrimination

As specified in the Road Map, ‘Universal Access to treatment must also ensure that all those with advanced HIV infection can access treatment easily and equally, regardless of their occupation, lifestyle, or legal status.’ Yet, access to medical care and treatment remains unequal for persons from different populations and in different regions. IDUs and prisoners face unacceptably low levels of access to ART and other forms of medical care. While active IDUs are estimated to represent one-third of all persons living with HIV, they represent less than 5% of all patients on ART, indicating severe barriers to equitable access to treatment. IDUs also face barriers to access treatment for hepatitis, TB, treatment of STIs and other diseases.

Prisoners living with HIV are easily accessible for diagnosis and treatment, but they also face serious barriers to receive treatment. Most prison facilities lack adequate personnel and facilities to effectively manage the diagnosis and treatment of patients with HIV while protecting the confidentiality of their HIV status. Prisoners have limited access to ART, and the complete exclusion of eligible prisoners from access to OST is neither ethical nor evidence-based.

There are also widespread reports of stigmatization and discrimination of these and other MARPs, such as sex workers and MSM, who are most likely to avoid treatment when faced with discrimination in accessing treatment services. There have been rare cases of migrants

and refugees who have been provided with treatment on an individual basis, but there is no policy that explicitly provides these populations with access to treatment and medical care. Patients with HIV frequently face acute discrimination in accessing life-saving diagnostic and treatment services outside of AIDS Centres, such as in accessing CAT scans, magnetic resonance imaging, and in accessing almost all forms of surgery. These stark inequities demonstrate that barriers to treatment are inconsistent with the concentrated nature of the epidemic, which requires systematic efforts to reach, treat and maintain persons most affected by the epidemic.

Main recommendations

Short-term:

MR.4.6.33 Develop and implement urgent measures to increase access to treatment and care for MARPs, including IDUs, prisoners, sex workers, and MSM as well as for migrants and refugees

Medium-term:

MR.4.6.34 Develop and enforce a zero-tolerance policy for discrimination towards all patients living with HIV, with particular sensitivity given to patients from MARPs (IDUs, sex workers, MSM, prisoners, and others) who are most likely to avoid treatment if they experience discrimination from medical personnel when accessing services

MR.4.6.35 Provide mandatory training on sensitivity, stigma and discrimination for all staff of all treatment programmes, with a priority training for staff working in direct contact with clients

User Fees

In contrast to the majority of medical services in Ukraine, medical services and treatment for patients living with HIV is usually free of charge. However, access to various forms of diagnosis, treatment and care is still limited by official or under-the-table payments for some diagnostic and treatment services. Such payments are most frequently reported for diagnostic procedures, treatment of opportunistic infections, and testing procedures in order to access medical disability. Often, patients with HIV who cannot afford such fees must forgo diagnostic testing. In such cases, preventable or treatable illnesses are not diagnosed. With the exception of the Lavra clinic in Kyiv, and select inpatient facilities at some regional AIDS Centres, it is reported that patients with HIV are frequently expected to pay out of pocket for gloves, syringes, various basic medications and other commodities and services when being hospitalized. User fees, often termed as charitable donations, are frequently reported by HIV positive women for child birth services, with very costly user fees charged for caesarean sections. Such user fees, whether official or under-the-table, are in direct violation of Ukrainian laws, and represent a serious barrier to accessing health care and treatment services for people living with HIV, most of whom cannot afford to pay such user fees.

Main recommendations

Medium-term:

MR.4.6.36 Eliminate official and unofficial fees for all services associated with treatment and care of HIV/AIDS and related conditions, including for diagnostic tests and procedures, OST, medical disability procedures, PEP and other services

MR.4.6.37 Develop and enforce a zero-tolerance policy for all under-the-table payments

Overregulation / Gaps in Regulations

There are frequent examples of overregulation of the provision health services related to HIV/AIDS. Such overregulation restricts the access of persons to treatment services, and

makes it difficult for service providers (physicians, clinics, hospitals) to react quickly and appropriately to changing needs. For example, opioids for OST or for palliative care are frequently unavailable during hospitalization or in home care settings. STI treatment is unavailable at the first point of health provided contact, but only upon referral to an STI clinic. The existing regulatory framework also impedes the availability of suitable (liquid) formulations of OST and the ability to provide OST as take home doses for stable patients. Often, practical administrative decisions cannot be implemented without extensive bureaucratic procedures that are a poor use of human resources and take too much time. For example, the transfer of antiretroviral medication between AIDS Centres usually requires a directive of the Ministry of Health, which must be signed by a Deputy Minister. There are also serious gaps in the regulatory framework. The lack of specific regulations makes it possible to use donated blood without confirmatory testing of the donor at the end of the quarantine period, and prevent the use of standardized quality assurance procedures for HIV laboratory diagnostics.

Main recommendations

Medium-term:

MR.4.6.38 Conduct a comprehensive review and revision of all regulatory frameworks and standards to ensure they are up-to-date, relevant to current priorities, and consistent with international best-practices

MR.4.6.39 Remove legal and regulatory barriers to access opioids for in-patient settings, for palliative and home care, and allow for availability of OST medication in liquid formulation and as take home doses for stable patients

MR.4.6.40 Close gaps in regulatory framework allowing use of blood products without confirmatory testing after quarantine period, and impeding use of external quality assurance procedures for HIV diagnostics

Treatment Guidelines

Ukraine has successfully developed an extensive set of national protocols for HIV/AIDS treatment and care which represents the foundation for evidence-based clinical decision making. The scope and content of these guidelines are largely consistent with the latest WHO clinical protocols for HIV treatment and care guidelines for the European Region. Yet, many stakeholders indicated that the process of development and implementation of these protocols takes too long and is highly bureaucratic, with the Ministry of Health taking excessive amounts of time to provide its endorsement. New protocols do not clearly indicate or specify the changes from previous versions, so users must reread the entire document in order to understand what has changed or been updated.

There is no overall plan for the systematic monitoring of the use of these guidelines and their regular revision. There is also concern as to whether regional HIV/AIDS specialists are competent in the use of these protocols, and what percentage of non-HIV/AIDS specialists in the regions are even aware of their existence. Some protocols appear to have been developed but are not being implemented (e.g. guidelines for the management of TB, palliative care, opportunistic infections, and treatment for pregnant women with HIV). Other key areas of treatment still lack appropriate, up-to-date protocols and standards (e.g. PEP, management of HIV among IDUs, management of HIV/viral hepatitis co-infection, management of STI among patients with HIV). The lack of key protocols and the uneven use of those protocols that do exist indicate that there are severe gaps and inconsistencies in the delivery of up-to-date and evidence-based HIV/AIDS medical services.

Main recommendations

Short-term:

MR.4.6.41 Ensure full availability of guidelines at all levels of care, and enforce their use

Medium-term:

MR.4.6.42 Establish a system for prompt alerts to the health care providers in all regions of changes in treatment and other guidelines and protocols through newsletters, bulletins, email/websites, etc.

MR.4.6.43 Disseminate all guidelines on a regular basis, in print and electronic format, with an introductory section that outlines changes from previous versions

MR.4.6.44 Establish a scientific committee responsible for the development and regular revision of relevant guidelines and protocols, including representatives of national, sub-national and, where appropriate, international experts

Patient Monitoring

The latest data indicate that the one year retention rate for patients on ART in antiretroviral treatment is 78%. However, this data is based on a small cohort of patients on ART. The accurate quality of treatment and care and related rates of adherence and retention are difficult to assess. An effective system of routine monitoring of treatment outcomes for all patients with HIV/AIDS has yet to be developed and implemented. There exists a lack of critical strategic information with regard to ART, but also related to incidence and treatment of opportunistic infections, TB, viral hepatitis, STIs, and OST. The continued improvement of the system for ART monitoring provides an important example of a routine data collection system that can generate process and outcome data that can be used directly for the improvement of treatment quality. Plans have been made to create a patient cohort for in-depth evaluation of Ukrainian treatment standards, but they have yet to be implemented.

Main recommendations

Medium-term:

MR.4.6.45 Develop/improve treatment and care monitoring systems in line with international standards with particular emphasis on monitoring treatment outcomes

MR.4.6.46 Introduce electronic ART monitoring system at facility, regional and national level

MR.4.6.47 Install regular monitoring of gonorrhoea drug resistance and of organisms causing STI syndromes in order to validate treatment outcomes

MR.4.6.48 Support the creation of a cohort of HIV/AIDS patients for in-depth evaluation of Ukrainian treatment standards, based on the enforcement of standards for Good Clinical Practice

Management of Opportunistic Infections

Many of the basic tools for the diagnosis and treatment of opportunistic infections are generally available in Ukraine, and the clinical premises for treatment and diagnoses of OIs are in adequate condition. However, there are serious shortcomings in the accessibility and quality of diagnosis of opportunistic infections. AIDS centres rely on diagnostic facilities in nearby or in other hospitals or departments, which are often difficult to access and available only for additional (out of pocket) payment. Widespread shortcomings relate to the diagnosis of TB, including rapid and reliable culture and drug sensitivity testing, which are generally not available. The diagnosis of extrapulmonary TB is particularly poor, with reports of surgeons refusing to carry out biopsies on people living with HIV. Diagnostic tests for other opportunistic infections, including bronchoalveolar lavage for pneumocystis and molecular tests for viral infections are generally not available either. As a result, the diagnosis of many OIs is based on clinical criteria, which often cannot be confirmed. Discrimination by medical personnel and other barriers exist for patients with HIV to access diagnostic procedures such as endoscopies. No accurate data are available about the incidence of opportunistic infection, and no studies for effectiveness of opportunistic infection treatment are available.

Main recommendations

Immediate:

MR.4.6.49 Ministry of Health to take urgent steps to procure quality-assured essential drugs for opportunistic infection, especially gancyclovir (currently provided by the Alliance), and ensure the adequate and uninterrupted supply of these and other basic medications for the treatment of OIs

Short-term:

MR.4.6.50 Formalize policies for fast, reliable and free access to diagnosis for OIs beyond AIDS centres

Medium-term:

MR.4.6.51 Develop capacity for diagnosis and management of all OIs

MR.4.6.52 Establish at least one national cohort to answer questions about treatment outcomes, weaknesses, special nationwide differences from international results in treatment, and incidence of opportunistic infection to plan future drug requirements

National Reference Centres

The quality of treatment and care services is directly related to technical guidance and oversight. For medical care and treatment of people living with HIV/AIDS, Ukraine has an experienced and professional team at the Ukrainian AIDS Centre that provides strong technical support, coordination and leadership in this area. Other specialized AIDS treatment facilities such as Lavra clinic and the Knowledge Hub provide strong and valuable technical support and mentoring for specific technical aspects of medical treatment, but the roles and responsibilities of these partners are not clearly defined.

Main recommendations

Immediate:

MR.4.6.53 Preserve and enhance the role of the Ukrainian AIDS Centre as the leading technical institution for medical treatment and monitoring of HIV/AIDS or transform its status into a new National AIDS Institute, thus maintaining its key technical expertise

Medium-term:

MR.4.6.54 Transform the function of the Lavra clinic in Kyiv to focus on clinical trials, training, and mentoring of other AIDS Centres, and continue to provide clinical services only for the most complicated patients (i.e. with multiple drug resistance, or on salvage therapy)

MR.4.6.55 Provide substantially more government resources (budget, space and personnel) to enable the Ukrainian AIDS Centre, the Lavra Clinic and the Knowledge Hub to fulfill their roles effectively

Human Resources

The overall number of personnel working in the treatment and care of HIV/AIDS is inadequate to meet future needs, underscored by the absence of a national plan for human resources for HIV/AIDS.

Professional skills and appropriate financial motivation of service providers remain a critical determinant for service quality and treatment success. Ukraine has quickly created some short-term mechanisms to provide specialized HIV/AIDS training for medical workers, enabling them to provide services in a multidisciplinary team. Yet, there remain significant gaps in the standard “in-service” training for HIV/AIDS specialists in important areas, including drug resistance, palliative care, pediatric treatment, laboratory issues, PEP, immunizations for people living with HIV and AIDS, sexual and reproductive health, TB, STIs

and viral hepatitis. While physicians are being "certified" for successful participation in training and retraining programmes, certification and quality control mechanisms still need to be developed for other members of the treatment team. Efforts have been made to initiate a system of ongoing on-the-job mentoring as a continuation of residential medical training, an approach that still needs to be institutionalized.

The current practice of paying a 60% salary bonus to medical personnel working at AIDS Centres perpetuates the myth that working in HIV/AIDS is dangerous, regardless of whether these personnel face occupational hazards, or work directly with hazardous biological fluids. This practice also makes other health personnel in non-AIDS medical institutions less amenable to providing medical services for patients living with HIV, as they may not be entitled to the same level of compensation, and may also undermine the use of universal precautions throughout the Ukrainian health care system.

The generally low financial remuneration of health workers impedes work motivation, favors under-the-table payments and leads to high staff attrition. In light of difficult economic conditions, it is recognized that medical personnel working in AIDS Centres rely on this additional compensation. It is not recommended to abolish these bonuses in the short-term until a long-term solution can be found to ensure all medical personnel are paid a decent wage for their work, without discrimination for work in the area of HIV.

Main recommendations

Short-term:

MR.4.6.56 Develop a comprehensive national human resources plan for HIV/AIDS that reflect accurate needs for scale-up of prevention, treatment, care and support as an annex to the new National AIDS Programme

Medium-term:

MR.4.6.57 Provide adequate training about HIV prevention, care and treatment for all staff in other areas of medical care that are likely to care for people living with HIV (i.e. STI, maternal and child health, TB, etc.)

MR.4.6.58 Require that all graduates from medical, nursing and social work schools have completed a mandatory training programme on HIV/AIDS that demonstrates their competence in a minimum set of HIV/AIDS knowledge and skills

MR.4.6.59 Develop mandatory HIV/AIDS component for all training programmes for recertification of medical personnel

MR.4.6.60 Ensure regular and appropriate coverage of HIV/AIDS in education and postgraduate training for non-HIV/AIDS specialists

MR.4.6.61 Conduct a comprehensive review of policies for payment of salary bonuses for HIV/AIDS, to confirm categories of personnel that are eligible for such a bonus on the basis of occupational risk

Procurement, Supply Management & Stockouts

The reliability of diagnosis and treatment programmes depends on the availability of appropriate resources for testing and treatment. Equipment and supplies essential to the treatment of HIV/AIDS are affected by frequent stockouts, undermining the ability of physicians to make timely and accurate treatment decisions. This is highly relevant to the limited and inconsistent supply of viral load and immunology (CD4) testing, which are essential to make decisions on treatment initiation and monitoring its effectiveness. Stockouts are also frequently reported for commodities needed for safe injections (e.g. latex gloves, syringes), thus jeopardizing the safety of injections for both patients and medical workers. Frequent non-availability of commodities for safe injections have significantly undermined practices for injection safety and hampered adherence to standard precautions. There are also serious limitations in the availability of PEP for medical personnel, with reports that staff have sometimes been required to pay out of pocket for the cost of medication for PEP.

Medical personnel often adopt special precautions for patients with HIV, rather than applying full safety standards for each patient, regardless of HIV status. Stockouts in medications for treatment of patients with HIV/AIDS have been also been reported, albeit less frequently, and mostly relate to non ARVs. Yet, the process of forecasting drug needs and the management of supplies between regions is ad hoc and inconsistent with long-term requirements to scale up ART. Concerns over the quality of medication for ART has received extensive public attention, with particular concern expressed by people living with HIV about governmental purchases of medicines of poor or unknown quality. Particular concerns exist about the procurement of test kits and medications that have not undergone a rigid evaluation or process for quality control.

Main recommendations

Short-term:

MR.4.6.62 Ensure uninterrupted supplies of commodities (including for injection safety)

MR.4.6.63 Enforce adhere to standard precautions in all medical and relevant non-medical settings

MR.4.6.64 Review registration procedures for medication and diagnostics

Drug resistance

The first steps have been made in the establishment of a surveillance system to monitor resistance of HIV to antiretroviral medicines. An initial threshold survey on HIV drug resistance transmission among newly diagnosed patients with HIV indicates that drug resistance level in treatment naive patients is below 5%, indicating that there is no need to revise the content of the first line ART regimen. Awareness about the role and importance of drug resistance, however, is still largely limited to laboratory specialists and has not yet reached the wider clinical, patient and policy making community. This is of particular relevance with regard to identifying early warning indicators at the clinical level, and integrating resources and standards for regular drug resistance surveillance into the national budget and new National AIDS Programme. There is a lack of focus on the early warning signs for drug resistance, including inadequate monitoring of prescribing practice, a high percentage of patients lost to follow-up 12 months after starting ART; patient retention on 1st line ART; ARV drug pick-up; ART appointment keeping; pill count/adherence; and drug supply continuity (stock-outs, shortages).

Timely investments in this area could save millions of hryvnias / dollars in the future, if they are used to ensure that the decisions to change second-line or third-line drugs are accurate and evidence-based. Regular surveys of surveillance of transmission of HIV drug resistance are essential to ensure adequate monitoring of HIV drug resistance prevalence in populations eligible for ART. Such surveys, which have already commenced, should be maintained and expanded before testing of individual patients failing on ART should be offered. In the absence of detailed data about adherence to treatment, drug resistance testing would be inadequate. Capacity of the HIV drug resistance unit at the National Reference Laboratory requires urgent strengthening, including the improvement of working conditions, followed by lab accreditation, development of standard operating procedures and implementation of a quality control and assurance programme.

Main recommendations

Immediate:

MR.4.6.65 Integrate drug resistance surveillance in new National AIDS Programme and budget as part of a comprehensive system for patient treatment monitoring

Medium-term:

MR.4.6.66 Conduct regular population based surveys on HIV drug resistance transmission, monitoring early warning indicators in treatment programs and

cohort studies in sentinel sites to assess effectiveness of ART with resistance testing at a national lab

Clinical and Biomedical Research

Ukraine maintains an extensive medical infrastructure for AIDS, and the majority of patients diagnosed with HIV are under regular medical observation. The large number of treatment-naïve patients and the scope of the treatment scale-up make Ukraine an ideal environment for conducting clinical and biomedical research of national and potentially international significance. Medical research is also essential for monitoring and quality control of clinical programmes, with results that can be compared to other countries and regions. Yet, there is little, if any significant research related to medical care and treatment in Ukraine. The little biomedical research that is being conducted (i.e. genotypic resistance) is being conducted by international partners abroad, using Ukrainian samples.

Despite reports of dedicated resources for HIV/AIDS research from the Ukrainian Academy of Medical Sciences, it was not possible to access a national agenda or research plan for clinical and biomedical research for HIV/AIDS, or review the results of such research. There are no ongoing clinical trials, cohort studies, or other biomedical research being conducted in Ukraine that are having a direct impact on improving or adjusting national treatment protocols, or fast-tracking the introduction of new treatment or new ART agents or combinations. The majority of clinical staff have never received any training in Good Clinical Practice (GCP), and there are few efforts to analyze data or publish results at international conferences or in international scientific journals. Current record keeping makes it difficult to extract clinically significant data for research purposes. The limited and uneven quality of data makes it difficult to compare these data with international studies or results from other countries.

Main recommendations

Short-term:

MR.4.6.67 Start at least one large, multiple-site longitudinal patient cohort to systematically monitor treatment outcomes (ART, treatment of opportunistic infections)

Medium-term:

MR.4.6.68 Ensure at least one clinical staff member from each AIDS centre completes a Good Clinical Practice training programme, and serves as the local focal point for clinical research

MR.4.6.69 Conduct an annual meeting / scientific symposium on clinical care to encourage medical personnel from all Ukrainian regions to present their research findings and review results

MR.4.6.70 Develop a national agenda for scientific and biomedical research for HIV/AIDS

MR.4.6.71 Confirm the HIV/AIDS budget for research of the Ukrainian Academy of Medical Sciences is used to support studies of practical scientific relevance that can be used to improve the diagnosis, treatment and monitoring of patients with HIV

4.7 Non-Medical Care and Support

Importance: Medium
Progress: Inadequate

Overview

A significant range of non-medical care and support services now exists for people living with HIV in Ukraine. The majority of these services are provided by 56 community-based

and NGOs that are coordinated by the Network, with funding from the Global Fund grant-supported programmes. As of the end of 2007, care and support services provided by these organizations had been provided for a cumulative number of 27,500 adults and children. This is equal to coverage of 34% among all persons registered with HIV and under medical supervision, but only 6% of the estimated number of people living with HIV in Ukraine.

Some care and support services for people living with HIV are also provided by Governmental agencies and supported by international organizations.[48] However, no integrated data is available on the number of clients or the frequency of accessing these services. The consistent lack of Government funding and support in this area, particular for services implemented by NGOs, represents a serious barrier to their sustainability.

A growing range of care and support services are also provided by FBOs, such as Caritas and the Orthodox Church, as well as national NGOs such as the Ukrainian Red Cross. These organizations are playing a growing role in providing nursing care, home care, palliative care and psychosocial support to people living with HIV. The care and support services provided by these organizations generally reflect international standards of care, but sometimes lack quality and consistency across different service providers, and are not always coordinated with other services being supported by the Government and the Network.

Given the continued increase in trends among persons newly diagnosed with HIV, serious concern also exists about the capacity to provide any services for the large and growing number of people living with HIV who have never accessed such services, and the difficulty of distinguishing between which clients who should receive services on an essential, or recommended and optional basis.

Importance / Impact on Epidemic

The extensive range of care and support services now available to people living with HIV in Ukraine is a result of advocacy by people living with HIV in Ukraine and rapid scale-up of programme implementation by the Network and its partners – community-based NGOs. Only a small number of these services can be considered essential to have a significant impact on the epidemic and contribute decisively to improving the quality of life of people living with HIV. Some of the services currently provided for people living with HIV are not essential. Faced with a rapid increase in the number of clients, these services need to be reconsidered to ensure equitable coverage and sustainability for the most essential services.

Progress

Prior to 2004, very few non-medical care and support programmes and services for people living with HIV existed in Ukraine. With the introduction of the Global Fund grant programmes, there has been considerable progress in the implementation and scale-up of non-medical care and support programmes and services for people living with HIV existed in Ukraine. The importance of such programmes and services is increasingly well appreciated, and these programmes are producing visible benefits for clients. A range of care and support services are now being implemented in over 50 NGOs in the majority of large Ukrainian cities. Some of these services have produced notable outcomes in improving the quality of life for people living with HIV, particularly in the areas of adherence counselling, care for orphans and vulnerable children, and peer support for people living with HIV and their families.

Most of these services are being successfully coordinated by the Network. Due in part to consistent technical support provided by the Alliance and significant funding from the Global Fund and other donors, the Network has transformed its role as a community-based advocacy group into a national provider of professional care and support services. The planning and delivery of these services have also served as a valuable mechanism for

[48] These include care and support programmes and services supported by UNICEF, Holt International, Mama+, supported by USAID, SUNRISE, and SSSFCY.

enhancing collaboration between governmental and non-governmental organizations in the care and support of people living with HIV.

Despite these achievements, the coverage of care and support services remains extremely low and inadequate to meet the scope and complexity of existing needs. An extensive range of integrated services are currently provided for a very small number of clients at high cost, without adequate focus on essential services for the most vulnerable clients. The majority of persons with HIV most in need – including, most significantly, active IDUs, patients with active TB, prisoners, and chronically and terminally ill patients in need of home and palliative care – have very limited access to these services.

Except for a narrow range of care and support services for children with HIV and their families, there is a systematic lack of Government funding for and involvement in the provision of care and support services for people living with HIV. Instead, the majority of services are funded by the Global Fund grants and implemented almost exclusively by NGOs, which is not sustainable.

The coverage and quality of services, coordinated primarily by the Network and implemented by its sub-recipients, vary significantly between regions, depending on the local capacity of local implementing partners. Variations in the coverage and quality of services are compounded by the consistent lack of Government standards for the provision of such services, and the low level of involvement of the Ministry of Labour and Social Policy that should be the lead Government agency in this area.

Targets

There are few national targets for care and support, and most of the targets that exist are inadequate, lack specificity, and are set by the availability of external funding sources, rather than estimates of actual needs. The weak targets for care and support indicate the low attention that has been given to scaling up of services in this area.

The Road Map includes ambitious targets for care and support, expressed in percentage targets, but these targets were never specified in absolute numbers or translated into national targets or programmes. The Universal Access target adopted by the National Council in April 2007 specifies that 40,700 persons will be provided with care and support services by the end of 2008, with no target specified for 2010. It is recognized that not all people living with HIV need or will use care and support services. However, the target for 2008 is seriously inadequate, representing less than 10% of all people currently estimated to be living with HIV, and less than half of the persons officially reported to be living with HIV and currently under medical observation. The target is an amalgamation of composite targets that were already supported by the Global Fund grants, indicating no plans to further scale up care and support services from other sources, including by the Government of Ukraine. The only national target that has practical relevance for care and support services is indicated in the Global Fund Round 6 grant agreement, and implemented by the Network, in partnership with its sub-recipients. The target for the Round 6 programme is to provide 55,000 people living with HIV with care and support programmes by the end of the grant in 2012.

Main recommendations

Immediate:

MR.4.7.1 Develop national care and support programme or services as component of the new National AIDS Programme, including realistic annual targets in excess of targets already supported by the Global Fund grants

Medium-term:

MR.4.7.2 Annual targets should specify a percentage of persons newly diagnosed with HIV to be offered access to care and support services

Coverage and Frequency

Reliable and up-to-date data on the number of people living with HIV and their families that require care and support services is lacking, including the breakdown by type of services needed and their frequency. Reliable data on the coverage and frequency of Government care and support services are only available from the Ministry of Family and Youth, and Sport for services for children with HIV. Network records indicate that as of the end of 2007, care and support services were provided for over 27,500 adults and children, which represents 34% of all persons registered with HIV (under medical supervision), and only 6% of the estimated number of people with HIV. However, the Network has no effective system to eliminate double counting of clients that are accessing different types of services. The number of persons covered by care and support services includes the cumulative total of clients ever covered with support from the Global Fund programmes (Round 1 and Round 6) since early 2004. The actual coverage of persons currently receiving care and support services is likely to be significantly lower. The Network reported that 8,955 new clients were provided with care and support services in 2007, which is significantly less than half of persons newly registered with HIV in 2007. This indicates that gap in the coverage for such services is expanding rather than narrowing.

Demand for these services will grow even more rapidly in coming years. This will make it impossible for the Network to address the needs of all clients, and increasingly difficult to choose between sustaining services for existing clients and enrolling new clients that may have more acute needs.

The increase in AIDS mortality underscores the importance of palliative care, where the coverage remains small and inadequate. Currently, there are a total of only 442 palliative care beds in 11 oblasts, with an even smaller, but indeterminate portion available to terminal AIDS patients.

The geographic coverage of other services supported by the Network is largely restricted to large cities in 13 oblasts, which include the majority of the regions with the largest number of persons with HIV. Yet, the coverage of services within these regions is concentrated around NGO community centres located in large cities. Many of these centres are not easily accessible, especially for persons from other cities and towns and rural areas, and largely inaccessible for persons from other regions. There is limited capacity among existing NGOs to expand care and support services to reach persons living in small towns and rural areas.

Main recommendations

Immediate:

MR.4.7.3 Include in the new National AIDS Programme plans to provide care and support services in every region of Ukraine by end of 2009, at least for a minimum percentage or number of clients

Short-term:

MR.4.7.4 Include in the new National AIDS Programme a component for palliative care to cover at least 50% of persons projected to need such care by 2010, and growing Government resources for all forms of non-medical care and support

MR.4.7.5 Ensure all service providers, regardless of source of funding, use same definition for clients, coverage and frequency, and ensure reporting of coverage data on quarterly basis

Medium-term:

MR.4.7.6 Develop and implement written policies on how to focus on clients most in need, and encourage graduation of self-sufficient clients out of intensive and high-cost services to make slots available for other clients in greater need

Quality and Relevance of Services

Most non-medical care and support programmes are well intentioned and provide services that are much appreciated by the clients. Yet, in the absence of national standards or guidelines for the provision of social services for people living with HIV, there are serious discrepancies in the quality of facilities and services supported by the Network and those financed from local state budget. The facilities supported by the Network are consistently in better condition, but some do not meet even basic sanitary norms.

Some important training initiatives have been supported through the Global Fund Round 1 grant programme, with the Alliance having provided some support for training in the areas of positive prevention for people living with HIV and palliative care. However, not all staff working in programmes supported by the Global Fund and coordinated by the Network, regardless of HIV status, possess relevant qualifications or have received adequate training to be providing social services. Most of these services are provided by NGOs, which are funded chiefly by the Global Fund grants. Frequently the services supported by NGOs are provided by staff that are themselves living with HIV, which is highly commendable and strongly supported.

Each city should provide access to support and some basic services for people living with HIV. However, community centres in some cities attempt to serve as a 'one stop shop' to address all of the non-medical needs of people with HIV. For example, the Community Centre for People Living with HIV and their families in Kyiv is a positive example of collaboration between the local branch of the Social Services for Family, Children and Youth, the Network, UNICEF, and other partners. But other than the provision of the building, the Centre lacks any sustainable funding from the national government or the city administration to provide or sustain integrated care and support services. Such an approach is neither appropriate nor sustainable, and may even enhance the further isolation and stigmatization of people living with HIV. More emphasis needs to be placed on the sustainable provision of care and support services using government institutions and funding as vehicles for service delivery.

Only a portion of the services currently being provided by projects that are supported by the Global Fund grants are estimated to be essential and deserve further resources and scale-up. These priority services include treatment preparedness counselling, adherence counselling, legal support, and peer education/support groups, and palliative and home care.

Other services are of lower importance, and often variable quality, including care and support related to pregnancy and postpartum, and daycare centres for children living with HIV, and rehabilitation. In light of the high cost and relatively low coverage of many non-essential services, the Network, in close consultation with governmental representatives and based on consultation with clients, should either significantly enhance the quality and consistency of these programmes, and mobilize government funding to sustain such services, or refrain from further scale-up and even consider their discontinuation.

A third category of services are considered to be of little direct benefit to the most urgent needs of clients, and incapable of being sustained. These services include onsite meals for clients, sewing, washing, and ironing services, hairdressing services, and physical education and fitness programmes. Such services should be supported exclusively through volunteer efforts, as is currently done in several organizations, or discontinued, as they represent an inappropriate use of donor funding. Any savings from the discontinuation of these services should be redirected to other, higher priority services for clients most in need, with a focus on regions and large cities where such services do not exist.

Several services that are urgently needed are not currently available to clients in need, or the coverage remains low and quality unknown. These services include home care for chronically ill patients, palliative care for terminally ill patients, care and support for prisoners with HIV, and professional skills building for employment. The provision of such services should be prioritized, as they are essential to ensure quality of life, and will be needed by a rapidly growing number of clients in coming years.

The systematic lack of ‘positive prevention programmes’, including poor access to harm reduction and condom provision at sites supporting care and support services, is a major shortcoming across the spectrum of services supported by the Global Fund grant-supported programmes that is being corrected too slowly. Currently, NGOs provide clients for care and support services with referrals to other prevention services, usually at other project sites and implemented by different NGOs. This approach is ineffective at ensuring that care and support clients have onsite access to prevention programmes, and undermines the principle of the integrated provision of essential services.

The provision of medical disability for patients with advanced HIV by the Medical Occupational Expert Commission (MOEC) is considered highly inefficient, and is in need of wholesale reform. Medical disability for persons with HIV is extremely difficult to access, in part because the members of the MOEC lack adequate knowledge about HIV, the process is very time consuming, and is reported to be discriminatory and stigmatizing for applicants. In cases where is it is provided, the amount of disability is small and inadequate (130 – 500 hrn per month), and the process needs to be repeated every six to twelve months. In light of these widespread shortcomings, the current system will not be capable of meeting growing needs in coming years, as tens of thousands of persons living with HIV will need access to medical disability each year. If recommended changes to the system for medical disability cannot be implemented within 12-24 months, the entire system for medical disability for patients with HIV should be reconsidered.

Main recommendations

Short-term:

MR.4.7.7 Develop categories for all care and support services, based on their impact on quality of life (essential, recommended, and non-essential), and provide governmental and Global Fund resources only for essential and recommended services

MR.4.7.8 Use the Global Fund, Phase 2 planning process to reprioritize targets and funding of the Global Fund grant programme to focus only on essential and select recommended services, with other non-essential services either supported from other sources, or discontinued

MR.4.7.9 Ensure all clients living with HIV are provided with priority access to positive prevention programmes, including free access to condoms and, where appropriate, harm reduction services

Medium-term:

MR.4.7.10 The Network should engage a senior international expert with relevant technical experience as a regular consultant to assist with the ongoing design and implementation of care and support services supported under the Global Fund grant supported programmes

MR.4.7.11 Ensure the development of national standards or guidelines for care and support services in collaboration with the Network and relevant government ministries

MR.4.7.12 Ensure that all staff providing care and support services have relevant qualifications and have completed mandatory training programmes

MR.4.7.13 Make AIDS Centres responsible for the review and issuance of medical disability for patients with HIV, and revise policies for medical disability

Sustainability

At the end of 2007, the majority of care and support services were being supported by the Global Fund grants and implemented by a broad range of NGOs, coordinated by the Network. Most of these NGOs are paying exceptionally high costs for rent, salaries and overhead. With rare exceptions, local governments are neither providing free nor subsidized space for the NGOs to deliver such services, nor are they contributing staff, such as social workers, to assist in the delivery of such services.

During the development of the Global Fund Round 6 proposal, governmental representatives from the Ministry of Health, the Ministry of Family, Youth and Sports, and the Ministry of Labour and Social Policy had little or no involvement in the planning of the services that are now delivered under the current programme. As a result, the services under the Global Fund grant programme were designed largely by the Network in isolation to be self-sufficient, and rely on little governmental regulation, support, or involvement.

In many regions, care and support projects supported by the Network are also topping-up salaries paid to governmental social workers, but at rates that may exceed their official salaries. This has created a situation where governmental social workers sometimes prefer to work for additional salaries paid through the Global Fund grant supported programmes. The high cost of these services, and their mechanism for delivery through NGOs, cannot be sustained in the absence of Government support.

Main recommendations

Short-term:

MR.4.7.14 Provide Global Fund grant resources to support social centres established under the Ministry of Family, Youth and Sports on a non-tender basis (subject to specific performance requirements for the provision of care and support services)

Medium-term:

MR.4.7.15 Local and regional governments should provide office space for free, or heavily reduced rates for NGOs to provide care and support services

MR.4.7.16 Review rates and limits for salaries and other overhead costs within care and support programmes supported by the Global Fund grants and other donors

4.8 Prevention of Mother to Child Transmission & Pediatric Care

Importance: Medium
Progress: High

Overview

Since 2004, outstanding progress has been made in the PMTCT of HIV and the treatment and care of children living with HIV. While the number of pregnant women with HIV continues to increase rapidly – reaching 3,430 in 2007, the coverage of medical prophylaxis for PMTCT has increased to over 92%. The impact of these services is significant – the data of the Ministry of Health indicates that rate of transmission has decreased from 27.8% in 2001 to 7.1% in 2006. While the evaluation considers the accurate rate of mother to child transmission to be slightly higher, the significant reduction in the rate of mother to child transmission is the only UNGASS target that Ukraine has achieved and even exceeded. Despite this progress, a number of obstacles and shortcomings remain, including urgent needs to improve early diagnosis of newborns, and ensure overall coordination and monitoring of the national system for the PMTCT.

In the area of treatment and care, children are regularly provided with preferential access to ART. If only 58% of the estimated number of children in need of ART received it in 2005, by 2007, coverage had increased to over 73%, including over 700 children on ART. 91% percent of pediatric patients are still alive and on treatment 12 months after commencing it. The coverage and quality of diagnosis and treatment of opportunistic infections among pediatric patients is much lower, however, with other obstacles remaining in the areas of laboratory monitoring, the quality and supply of pediatric antiretroviral formulations, and a limited pool of medical specialists with experience in management of pediatric HIV. A number of programmes exist to provide non-medical psycho-social care and support for children and their families, but coverage and quality of these programmes remains sub-optimal.

By the end of July 2007, there were 482 HIV-infected orphans and children deprived of parental care in Ukraine, of which 70% were under custody of the state – equal to almost one-third of all HIV-infected children with established status nationally.

In May 2008, the long-awaited National AIDS Pediatric Centre was opened at OHMADYDT in Kyiv, providing regions with an importance source of clinical support and mentoring.

Importance

The areas of PMTCT and the treatment and care of children living with HIV are of medium importance to the impact on the epidemic. Ukraine has already identified the PMTCT and pediatric treatment as priorities for the national AIDS response. Continued progress in these areas is essential to demonstrating Ukraine's progress in implementing its commitments, but such progress is easily within reach. The scope and quality of the national programme for the PMTCT of HIV, and the speed with which changes are implemented will determine whether Ukraine can eliminate the vertical transmission of HIV by 2010. However, the overall number of pregnant women and children with HIV is relatively small and the vast majority of them are already receiving medical care. The number of children infected with HIV through injecting drug use or sexual transmission is very small, but growing.

Progress

In the area of PMTCT, there has been excellent progress and outcomes, particularly in the high coverage of HIV antenatal testing, and the high, but still suboptimal coverage of comprehensive PMTCT services. The national PMTCT programme is the only prevention intervention in Ukraine that has reached the majority of its target population with a high quality intervention, and also to have made a significant and measurable contribution to prevent HIV among its target population. The reduction of the rate of mother to child transmission and the high rate of adherence and survival among pediatric patients represents achievements that greatly exceed progress in similar areas of adult HIV/AIDS treatment and care.

The design of the programme, including services for the PMTCT that are available at all maternity hospitals in Ukraine, the shift towards highly active antiretroviral therapy (HAART) for optimal prophylaxis, and the establishment of the national pediatric clinical centre are major achievements that are largely consistent with international best practices. Collaboration and coordination between partners is strong, although there is serious lack of consistent leadership and support from the Ministry of Health. Most of the shortcomings that still exist – such as inadequate training, lab diagnostics, lack of sustainability, poor M&E, and PSM – can be overcome if there is an adequate plan and leadership to do so.

Targets

There are clear and ambitious targets for most aspects of PMTCT and pediatric treatment and care. The national target for the PMTCT – to reduce the rate of transmission to less than 2% by 2010 – is an ambitious, yet achievable target for Ukraine, and represents one of the few national targets that are consistent with European countries. The target for pediatric care to ensure that 100% of children in need have access to ART is also an ambitious, yet achievable target. However, few of these targets have been officially endorsed by the national authorities, and many of them lack adequate plans and resources to ensure that they are met. These targets were also specified at the national level, with no subsequent disaggregation of targets at the regional level. The targets for non-medical care and support are more modest, and will not provide adequate coverage for all children with HIV.

Coverage

The coverage of the national programme for PMTCT has consistently exceeded 90%, and is considered to represent Universal Access. However, the continued growth of heterosexual transmission will result in a continued increase in the number of pregnant women with HIV,

and growing needs for PMTCT services. While the system is well-positioned to continue to provide all women with services for PMTCT, it will be an increasing challenge to ensure that PMTCT prophylaxis is provided using HAART – which should be the standard regimen for optimal prevention. It will also be difficult to ensure testing and diagnosis for hard to reach women, including female IDUs, sex workers, migrants, refugees, and homeless persons. Much closer collaboration is needed between mother and child health services, reproductive health services, NGOs and other international organizations that can provide early access to these women who continue to remain at high risk.

In the area of pediatric care and support, ART coverage is higher than for any other population, but current coverage remains short of Universal Access. The Government has made an important commitment to ensure Universal Access to pediatric treatment, and must take decisive measures to ensure that this commitment is kept. In order to increase coverage of those in need of treatment, additional efforts are needed to ensure earlier diagnosis of newborns with DNA PCR, and earlier and more aggressive treatment among children who are failing to thrive. The coverage of non-medical care and support are seriously lacking, with the minority of all children with HIV in Ukraine currently receiving any care and support services.

Decentralization of Services

The current system for PMTCT has been widely decentralized, with all women's consultation clinics providing access to HIV testing and all maternity hospitals in Ukraine having been trained and equipped to provide intrapartum services. This is an excellent model of decentralization, with the quality of services largely consistent across different facilities. However, other aspects of prevention and treatment are less well decentralized. In cases where pregnant women are diagnosed with HIV, they are usually referred to the local AIDS Centre for clinical care, even though treatment and follow-up could be more easily provided at the women's clinics.

The current system for the provision of HIV/AIDS pediatric care and treatment remains highly concentrated within 15 oblast and city AIDS Centres that are providing the majority of pediatric treatment and care. In many other regions, there is very limited experience in providing medical care for children with HIV, so children and their mothers are regularly expected to travel to Kyiv to receive care at the National Pediatric AIDS Centre, which is neither appropriate nor sustainable. With the number of children with HIV continuing to increase, regions need to develop local clinical and laboratory capacity to ensure adequate care can be provided locally.

The other issues are described separately for each of the relevant areas:

Prevention of Mother to Child Transmission

Strengths and achievements

There is a strong political commitment to PMTCT in Ukraine, recognition that a multi-sectoral approach is essential, and strong opportunities for improved collaboration and coordination and for primary prevention activities to reach broad populations. The integration of PMTCT within mother and child health services has been instrumental in the successes achieved to date. OST using methadone is now considered in protocols for PMTCT, acknowledging the need for linkages with harm reduction. The substantial reductions in Ukraine's rate of mother to child transmission (from >25% in 2000 to 7.1% in 2006, according to official statistics of the Ministry of Health) reflects the high coverage of HIV antenatal testing and the high and increasing coverage of ARV prophylaxis among infected women (92.5% in 2007).

An updated protocol for use of HAART (ZDV+3TC+LOP/r) for PMTCT prophylaxis has been approved by the Ministry of Health. The expanded use of HAART in pregnancy for

PMTCT indicates the government's commitment in making progress towards the goal of elimination of mother to child transmission. DNA PCR testing is available in three inter-regional laboratories (Ukrainian AIDS Centre, Odessa AIDS Centre and Simferopol AIDS Centre) since November 2005, with plans to expand to another four inter-regional labs. At the end of the Round 1 Global Fund grant, the Alliance is handing over the responsibility for financing ARV drugs and other commodities for PMTCT to the Ministry of Health. The smooth handover of these activities will be an important milestone, essential to ensure the long-term sustainability and ownership of the national PMTCT programme.

Shortcomings and challenges

The main limitations of the current PMTCT programme relate to management, implementation, and prioritization.

Surveillance
The Ministry of Health has responsibility for M&E of the programme for PMTCT, but has not prioritized this activity. There is duplication in data collection for PMTCT, a lack of coordination of data collected from different sources and a missed opportunity for improving the quality of services.

Monitoring and Evaluation
There is a lack of any quality assurance of data collection. Issues of confidentiality require attention as personal identifiers, including names and addresses, are included in surveillance databases. The current HIV case registration system requires registration of all infants born to HIV-infected mothers. Yet, these infants remain on the registry until they have documented loss of HIV antibodies at around 18 months, regardless if they have a negative DNA PCR tests. Infants who are uninfected according to international surveillance standards remain on the register for unnecessarily long periods, making it difficult to interpret official statistics.

Antenatal HIV screening and medical prophylaxis of mother to child transmission
Problems with government procurement for HIV antibody tests, ART, and lab equipment and reagents have led to supply gaps for pregnant women and children with HIV in various settings, which resulted in some pregnant women with HIV not getting tested and treated on a timely basis. Access to antenatal and PMTCT services for at-risk women have not been prioritised within the current programme, reflecting weak linkages between existing harm reduction, outreach and services for the PMTCT. Poor governmental procurement procedures for drugs and commodities frequently cause interruptions of supply of drugs for prophylaxis, a problem which may intensify when the Government undertakes financing for the PMTCT programme at the end of the Global Fund Round 1 grant. Adherence support for pregnant women is largely provided by NGOs, working in partnership with AIDS Centres, with coverage still extremely limited, and extremely high costs per client. With the introduction of HAART for PMTCT, existing mechanisms for infrastructure, laboratory capacity and follow-up with newborns will not be able to cope with the increased needs. There is inadequate implementation of CD4 monitoring for all pregnant HIV-positive women and children, thus limiting the assessment of eligibility for HAART.

Primary HIV prevention and prevention of unwanted pregnancies in women with HIV
The opportunity for reaching sexually active women with primary HIV prevention messages is missed in pregnancy, as antenatal VCT does not incorporate primary prevention with skills and knowledge about HIV. Attempts are seriously inadequate to reach marginalised women most at-risk with primary prevention interventions. There are weak linkages between PMTCT and harm reduction services, as well as family planning services and STI care, and mechanisms for provision of OST to pregnant women are only now under development. Free contraceptives, including condoms, are not available for women living with HIV at either AIDS Centres or women's health clinics.

Pediatric Diagnosis and Treatment

Strengths and achievements

Since 2004, the pediatric HIV/AIDS Programme in Ukraine has greatly developed and expanded. The treatment programme has expanded to cover approximately one half of the children identified with HIV on ART. Access to viral load and immunology (CD4) testing has become more available for monitoring and following these children, and is far better than among adult patients.

Ongoing efforts to train pediatricians and other pediatric medical staff have improved knowledge and awareness of pediatric HIV. A total of 44 pediatric teams have been trained to date, working in AIDS Centres and orphanages. A postgraduate training curriculum for paediatric HIV management will be developed, and it is planned to introduce a system of training of social workers in social support of HIV-infected children and their families. A variety of other training courses (for between 100-200 people) for pediatricians, general practice pediatricians, nurses and social workers have been carried out, supported by the Alliance, UNICEF and CIDA.

In general, the pediatricians and other members of the care team involved in programs for diagnosis, treatment and care are very dedicated to their work. A long-planned national Pediatric HIV/AIDS Reference/Referral Centre has been recently established at the OHMADYDT hospital in Kyiv, headed by Ukraine's leading pediatric AIDS experts, but only after a personal intervention from the President of Ukraine.

Shortcomings and challenges

Identification of HIV-infected infants
The data on HIV transmission rates and the number HIV-infected newborns are inaccurate and imprecise. Official statistics include all infants born to HIV-positive women as positive until their antibody status is determined at 18 months. This practice is out of date, artificially distorts the number of children with HIV in Ukraine, and is a serious barrier to ensure that HIV positive newborns can access timely treatment, care and support. DNA PCR testing for the diagnosis of the HIV status of babies born to HIV-positive women is not consistently available in all regions. Only 34% of infants born to mothers with HIV were tested by DNA PCR in 2005, 57% in 2006 and 42% as of mid-2007, with substantial regional variation (<20% coverage in some regions, but claimed to be 100% in the City of Kyiv). Infants that have been exposed to HIV who have not had DNA PCR testing are frequently lost to follow-up, so their final status, determined by antibody testing at 18 months, often remains unknown. Primary health care physicians have limited expertise in the recognition of HIV/AIDS symptoms in children, which is likely contributing to delayed diagnosis of HIV-infection in older children and late presentation to specialist services with advanced HIV disease.

Staffing and training of pediatric health care team members
Pediatricians and other health care team members require more practical training in the management of children that are exposed to and infected with HIV. Recent training has been mainly didactic, so skills and knowledge have not been easily transferred into practice. Extensive training in the multidisciplinary team approach to case management is lacking. Medical personnel in the AIDS Centres are not working as a team, with the pediatrician assuming many roles which should be delegated to other members of the team.

Network of pediatric HIV care
There is the lack of an effective network and referral system for HIV pediatric care. Establishing a national referral centre at the National Pediatric Centre in Kyiv is an important step towards addressing this need, but the establishment of the centre will not solve this problem. A system of consultations and referrals from small regional units to

regional AIDS Centres and finally to the national centre should be established and managed. Continuous capacity advancement and training should be implemented on a rigorous basis.

Management of Opportunistic Infections

Major shortcomings exist in the current management of opportunistic infections, most significantly TB, which is one of the most common of opportunistic infections among children with HIV and AIDS. Children with HIV are frequently not diagnosed with TB because classic manifestations more common to adult TB are not present. Diagnostic tests for TB, including reliable culture techniques, sensitivity testing and molecular tests, are generally not available. Diagnostic tests for other opportunistic infections, including bronchoalveolar lavage for pneumocystis and molecular tests for viral infections are generally not available, even at the National Pediatric AIDS Center in Kyiv. Diagnosis, treatment and support for children with other opportunistic diseases, particularly malignancies, are either not available or there is a reluctance on the part of oncologists to be actively involved in the management of these cases.

Strengths and achievements

Non-Medical Care and Support for Infants and Children

The National AIDS Programme provides a commitment to the non-medical aspects of the PMTCT, pediatric care and support. A number of other government programmes also include references to the provision of care and support for children living with HIV.[49]. Services of high quality are also provided by many NGOs, funded largely from the Global Fund grants. However, the coverage of these services remains very limited, and is not sustainable.

It is also planned to introduce a system of training of social workers in social support of children living with HIV and their families. Pediatric adherence programmes have also been recently initiated in some settings, with assistance from NGOs. Day care centres for children living with HIV and their families, offering multidisciplinary support (social workers, psychologists, volunteers, clinicians), have been established in several of the most affected regions of the country, funded by UNICEF and the Global Fund grants and implemented through NGOs.

Shortcomings and challenges

Care and Support Service for Children with HIV

The capacity providing psycho-social support for children living with HIV and their families, including supporting disclosure of infection status within families, remains very limited. Although there are a few NGOs and a small number of day care centres supporting families in large cities in some regions, national coverage remains low. No support groups exist specifically for children and adolescents living with HIV. Existing services are already overburdened and will be unable to cope with the likely increases in the number of cases. Not all NGOs are able to sustain activities once donor funding ends, which creates gaps in service provision and serious disruption to the lives of children and their families that depend on these services.

Care for Orphans and Abandoned Children

The HIV epidemic is increasing demands on the already over-burdened child welfare system in Ukraine. Abandonment of infants born to HIV-infected mothers and their subsequent placement in orphanages (baby houses) is a major problem in Ukraine, although there is no reliable and up to date data on the rate of abandonment (or any trends) among women with HIV who have given birth. Ukraine lacks a coherent strategy

[49] These include the State Programme of Combating Children's Homelessness and Neglect state programme of combating children's homelessness and neglect (2006-2010), the National Programme of Leisure and Health Improvement of Children (up to 2008) and the intersectoral 'Programme on Health of the Nation' (2002-2011)

to prevent abandonment of infants by women with HIV, which is linked to the lack of a strategy for improving access to antenatal and other medical psycho-social care of marginalised or otherwise high-risk pregnant women, who are at elevated risk to abandon their newborn children.

Reliable data does not exist on the number of orphans affected by HIV (i.e. children who may be HIV-negative, but with one or both parents living with HIV), their social care settings (extended family, state-run institutions etc) and access to care and support services. Little efforts are being made to transfer children out of government care into foster families or adoptive families. An unacceptably high proportion of children with HIV live in infectious diseases departments of hospitals on a long-term basis (up to 10%), leading to severe developmental disorders and social dysfunctions. There is high prevalence of psychological and developmental problems among children living with HIV in orphanages, caused by institutionalisation and/or HIV-related nervous system impairment.

Foster care remains under-developed in Ukraine. Although there are no legal barriers to the adoption of orphans living with HIV, to date few children have been adopted.

Access to School and other Child Care Facilities

National laws and other policies of Ukraine guarantee all children with the right to an education and social care, regardless of HIV status. In practice, many families with children living with HIV report cases of discrimination in the Ukrainian school system and other child care facilities. In many regions of Ukraine, access to regular schools and boarding schools among orphans with HIV or without parental care remains extremely limited. There are frequent cases of confidential information about a child's HIV status being compromised within a school. In such cases, parents of other children often demand that the child is removed from the school, demonstrating a basic lack of knowledge about HIV and how it is transmitted. Often, such cases are only successfully resolved through the intervention of a local NGOs, indicating that the Ministry of Education has not provided adequate information and training to school officials on how to manage such cases. If a clear policy and programme to address these issues is not implemented on a priority basis, such issues will be encountered more frequently as the number of school-age children with HIV continues to increase.

Main recommendations

Immediate:

MR.4.8.1 Ensure treatment and care targets for 2010 (Universal Access) and 2013 (end of the new National AIDS Programme) are based on total estimated number of children with HIV in Ukraine, including those diagnosed positive with DNA PCR

MR.4.8.2 Provide universal coverage of DNA PCR for newborns and HAART for PMTCT by end of 2009

Short-Term:

MR.4.8.3 Require regions to set and revise their own targets for treatment, care and support of children with HIV

MR.4.8.4 Designate a single national centre with responsibility for coordinating national programme for the PMTCT

MR.4.8.5 Provide urgent training of pediatric subspecialists, particularly for TB, oncology, neurology and neurosurgery

MR.4.8.6 Ensure pediatric HIV specialists may provide admissions and consultations for any patients that require hospitalization

MR.4.8.7 Train and support pediatric HIV specialists to diagnose and treat patients with active TB

Medium-Term:

MR.4.8.8 Provide access to condoms and other forms of birth control at AIDS Centres and women's health clinics

MR.4.8.9 Develop an effective system for M&E of the national pediatric AIDS programme, which will include a revised definition of HIV status of children based on DNA PCR, as well as outcome measures of management regimens for pediatric patients

MR.4.8.10 Implement a national pediatric HIV management network, and a system for referring patients to the National Pediatric HIV/AIDS Centre in Kyiv

Coverage

Immediate:

MR.4.8.11 Develop robust and realistic national and regional scale-up plans in the new National AIDS Programme to achieve Universal Access to PMTCT (based on the four pillars) and pediatric treatment and medical care

Non-Medical Care and Support for Infants and Children

Medium-term:

MR.4.8.12 Expand coverage and sustainability of day care centres for children with HIV through support from the Government

MR.4.8.13 Develop capacity for sustainable psycho-social support for children with HIV and their families, including support groups for/of HIV-positive children, adolescents, and their families

MR.4.8.14 Develop national strategy for care and support for children with HIV that will ensure coordinated activities of all Ministries involved in the care of HIV-infected children, expand access to foster care and adoption of HIV-infected and affected orphans, support extended families caring for HIV-affected orphans and develop strategies to limit the abandonment of infants by HIV-infected mothers

MR.4.8.15 Develop policy on management of children with HIV in non-medical environment, and implement mandatory training programme for all school directors, nurses, teachers and workers of child shelters and other care facilities about HIV

MR.4.8.16 Develop and implement zero tolerance policy for discrimination on the basis of HIV status in the school system and other child care facilities, and monitor its implementation

Section B: Leadership, Coordination, and Institutional Capacity

4.9 Leadership

Importance: High
Progress: Moderate

Overview

The President of Ukraine has demonstrated exceptional leadership on AIDS. However, the development and implementation of policies and programmes are the primary responsibility of the Parliament of Ukraine and the Government of Ukraine. Based on its recent history of inconsistent engagement in AIDS, it is unclear whether the Parliament of Ukraine will seize the opportunity to influence positively the development of the new National AIDS Programme and monitor its implementation. From the Cabinet of Ministers to key governmental Ministries and agencies, senior levels of the Government of Ukraine have not exercised adequate responsibility in leading or coordinating the national AIDS response. The Parliament and the Government of Ukraine need to rise above the current political obstacles to refocus their commitment to AIDS as a national priority. In particular, the Cabinet of Ministers needs to ensure that the national system for coordination, planning and oversight is operational to ensure an effective national response to the epidemic.

Secretariat of the President of Ukraine

Leadership and political commitment on AIDS in Ukraine has been demonstrated at the highest levels in Ukraine. President Yushchenko has shown exceptional leadership on AIDS, having issued a series of important policy statements and orders on HIV/AIDS. However, the process of follow-up and implementation of these orders by the Government of Ukraine and key ministries has been slow and fragmented. This further underscores that the President's orders on HIV/AIDS have not been matched by concomitant leadership and capacity within the Government of Ukraine and the National Council. The President's meetings with representatives of the Network also represent an invaluable contribution to counteract stigma and discrimination faced by people living with HIV.

AIDS was intermittently considered on the agenda of the National Security and Defence Council in 2006. However, the recent decision to exclude the Minister of Health and other high level officials responsible for AIDS from meetings of the Council may limit attention to the serious implications of AIDS as a threat to national security and demographic stability.

The recent establishment of the Coordinating Council on HIV/AIDS, TB and Drug Addiction under the President of Ukraine provides much needed attention and high-level national leadership on AIDS. In order to minimize the risks of duplication, Ukraine must clarify the roles and responsibilities of the Presidential Council versus other policy development and coordination mechanisms, or risk duplication of functions and continued fragmentation of activities.

Parliament of Ukraine

The Parliament of Ukraine has an essential role in providing the legal foundation for the national response to AIDS. However, in light of successive Parliamentary elections in recent years, there has been a lack of consistent involvement and oversight from the Parliament. The Parliament's Temporary Committee on HIV/AIDS, TB and Drug Addiction has not met since 2006. Since then, most of the contributions of the Parliament of Ukraine have been distinguished by the initiatives of a small number of individual deputies. Some of these deputies are members of the National Council, but it remains unclear how these deputies represent the views of the entire Parliament as a key constituency in the National Council.
AIDS has been given little attention on the agenda of the Parliament, or within relevant committees. The legal status of the new National AIDS Programme requires that it be

reviewed and endorsed by the Parliament of Ukraine as a Law. This provides the Parliament with a special mandate to ensure that the new National Programme is strategic, adequately funded, and responsive to the complex needs of the epidemic.

Cabinet of Ministers

The Cabinet of Ministers' support for HIV/AIDS has been essential to the large and growing contributions of the state budget to HIV/AIDS. The Cabinet of Ministers' Department of Humanitarian Policy has a legal role in analysing the performance of ministries and regions in implementation of the National AIDS Programme. In light of the frequent changes in the Cabinet of Ministers, however, the Government of Ukraine has not exercised consistent attention or involvement with AIDS in recent years. The Cabinet of Ministers has de facto delegated responsibility for the national response to AIDS to the Committee on HIV/AIDS and Socially Dangerous Diseases within the Ministry of Health, and the National Council. Unlike the Cabinet of Ministers, however, neither the Committee nor the National Council has adequate authority and capacity to effectively coordinate the national response to AIDS across different ministries and government agencies. The Cabinet of Ministers has been slow to address recent decrees of the President which ordered the rapid development of the new National AIDS Programme and required a substantial increase in Government funding for AIDS. There are also fragmented and inconsistent approaches to AIDS between different ministries. The Ministry of Health has responsibility to ensure that all patients with HIV/AIDS are provided with access to treatment, consistent with the National Law on AIDS. However, the Ministry of Finance exercises a line-item veto on the budget for the new National AIDS Programme and the state budget that has seriously restricted the ability of the Government of Ukraine to fulfil these obligations. Many key ministries directly involved in AIDS report to the Deputy Prime Minister for Humanitarian Affairs. In light of frequent changes in this position, the Deputy Prime Minister has had limited direct involvement in oversight of the Government's response to AIDS.

Main recommendations

Immediate:

MR.4.9.1 Parliament should conduct a vigilant review of the new National AIDS Programme before it provides its endorsement

MR.4.9.2 Declare AIDS as a leading national health and social priority for the State of Ukraine, and adopt measures to insulate the implementation of Government's commitments on AIDS from future political changes

Short-term:

MR.4.9.3 Assign primary responsibility for the national AIDS response to the Vice Prime Minister for Humanitarian Affairs, and reinvigorate the National Council under his leadership

MR.4.9.4 Clarify the roles and responsibilities for leadership, policy development, coordination and management of the Presidential and National Councils, the Ministry of Health and its Committee on AIDS, and sectoral Ministries

Medium-term:

MR.4.9.5 Conduct regular (at least annual) meetings of the Cabinet of Ministers dedicated to AIDS, with participation of all relevant Ministers[50] to review the implementation of the new National AIDS Programme, based on reports from the Chair of the National Council, and exercise the mandate of the Cabinet of Ministers to generate high level policy decisions and to ensure their implementation across all sectors of Government

MR.4.9.6 Review the implementation of the new National AIDS Programme in annual Parliamentary hearings and use the results to recommend ongoing improvements, including requests for additional funding

[50] Including, Vice Prime Minister for Humanitarian Affairs, and Ministers of Health, Education & Science, Finance, Interior, Justice, Labour & Social Policy, Family, Youth and Sport, State Prison Department, and the State Committee for Television and Radio of Ukraine.

4.10 Coordination

Importance: High
Progress: Inadequate

Overview

Ukraine continues to lack a functional system to ensure coordination of the national AIDS response. Despite the existence of a highly developed architecture for coordination that provides for representation and coordination among governmental and non-governmental partners at the national and subnational levels, these structures have been undermined by frequent political changes, and consistent lack of leadership by the Government. At a time when a strategic national AIDS response is essential to ensure cooperation between all partners, the contributions of various partners, particularly within the Government, remains highly fragmented.

National Council for the Prevention of TB and HIV/AIDS

In May 2005, the National Coordination Council (National Coordination Council) for the Prevention of HIV/AIDS was established by a decree of the Cabinet of Ministers, thus replacing the earlier State Commission on AIDS. The establishment of the National Coordination Council was a strategic decision to establish a high-level national coordinating body to serve as a partnership forum between the Government, civil society, people living with HIV, and international partners. The National Coordination Council was also consistent with the Global Fund's requirements for a CCM, thus enabling the Council's overall mandate as the 'one' body for coordinating the national AIDS response in Ukraine. However, the Cabinet of Ministers later clarified that the National Coordination Council had only an advisory and information sharing role, and was not empowered to perform the function of coordination. In July 2007, its name and status was changed to the National Council for the Prevention of TB and HIV/AIDS (National Council). This expanded the mandate of the National Council to address TB, and added new members with limited capacity and interest in AIDS, but otherwise restricted its role as a coordinating and decision-making authority at the national level.

Despite the weakening of the decision-making authority of the National Council, the architecture of the Council represents a model for a high-level multi-sectoral national forum for coordination on AIDS. The National Council's provision that the Vice-Chair is a representative of people living with HIV is an excellent example of promoting the greater involvement of people living with HIV that has also been replicated in many of the oblast coordination councils. The National Council also includes all other key national constituencies, including domestic and international NGOs, the UN, bilateral donors, and the scientific community. However, the high profile composition of the National Council has also hampered its performance. Since late 2007, the Vice-Prime Minister for Humanitarian Affairs has rarely chaired meetings of the Council, and responsibility for the formation of the agenda has been *de facto* delegated to the Committee within the Ministry of Health. As Government ministries are represented in the Council by Ministers or Deputy Ministers, it has proven difficult to ensure their consistent attendance, creating frequent gaps in the representation of key sectors.

Since its creation in May 2005 and following its re-establishment in July 2007, the National Council has not performed its central role as the overall national authority for the coordination of HIV/AIDS in Ukraine. Except for a short period in 2005-2006 when the National Council, its sub-committees and the Secretariat were functional, the National Council has met only intermittently. Meetings of the Council have focused excessively on the pursuit of additional funding from the Global Fund, most recently for TB. This focus has come at the expense of much needed planning, discussion and guidance for AIDS. Since mid2007, urgent issues such as the development and implementation of the National AIDS Programme, overall national coordination, PSM, human rights, the World Bank loan supported project, guidance to the regional and local coordination councils, and effective

oversight of the current Global Fund grants have not been effectively addressed by the National Council or any other Governmental organ. The inconsistent track-record and narrow focus of the National Council has resulted in lack of the much needed joint planning, priorities-setting and coordination of responsibilities in the development of the new National AIDS Programme. The Council has not guided, monitored or exercised adequate oversight of the large number of complex partners involved in the national response to AIDS.

The performance of the National Council continues to be hampered by weak or non-existent structures to support its role in the development of national policies and recommendations. The sub-committees of the National Council have never functioned to support and guide the decisions of the National Council, and need to be either completely reformed or officially disbanded. The Committee within the Ministry of Heath has been assigned the function of the Secretariat to the Council, but has inadequate capacity and limited interaction with the National Council's constituencies to perform this function.

Ukraine should immediately clarify which body has overall national authority for the coordination of HIV/AIDS. With the recent establishment of a new Presidential Council for AIDS, TB and Drug Addiction, there is a risk of duplication and overlap with the National Council. In order to enhance the capacity of the Council to perform its role as a national forum for coordination on AIDS, its composition needs to be revised and its performance on key issues must be substantially enhanced or otherwise reformed to ensure its functionality. In the absence of a functioning system for coordination, the contributions of various partners, particularly within the Government, will remain highly fragmented.

Regional Coordination Councils

Leadership and coordination is equally important at the oblast, city/town and district levels where services are delivered. The establishment of regional and local coordination councils reflected excellent plans to ensure that coordination structures for AIDS at the national level were replicated in every region of Ukraine. However, the operation of the regional and local coordination councils has been seriously undermined by the consistent lack of support and guidance from the National Council. In some regions, regional authorities have not exercised leadership to ensure the active functioning of these bodies. In the absence of dedicated staff, resources, capacity and guidance from the National Council, the regional and local coordination councils will not be able to fulfil their mandate to develop, coordinate and monitor effective regional and local responses to AIDS.

Sectoral coordination

Several central ministries have been increasingly active in integrating HIV/AIDS in their activities. In part due to the shortcomings of national coordination structures, some ministries and government agencies have initiated their own coordination structures, such as in the Ministry of Education and Sciences. If sector-specific coordination is to be successful, however, each sector still requires a sector-specific plans and resources for AIDS. Currently such plans remain either non-existent or poorly developed and lack adequate resources. In the absence of a comprehensive national AIDS strategy and a functioning National Council, there is a risk that plans and activities of different sectors will remain uncoordinated, duplicative, and have little impact either on the national policy or on the epidemic.

Domestic and international non-governmental organizations

Approximately 200 domestic NGOs working in the field of HIV/AIDS in Ukraine have made an invaluable contribution to the national AIDS response, particularly in the areas of service provision and advocacy. About 30 international NGOs are also involved in HIV/AIDS activities which have helped to establish and develop many of the domestic NGOs and networks. NGOs also manage and implement the majority of activities supported from the Global Fund grants and

other international donors. The majority of 150 regional and local NGOs currently involved in the implementation of the Global Fund grant programmes have consistently demonstrated their capacity as reliable providers of services for prevention, care and support.

Domestic NGOs have also established several networks for the coordination of their policies and advocacy goals, including the Coalition of HIV-Service Organizations, which includes 77 NGOs, the Ukrainian Harm Reduction Network, the Network, and the Alliance's network of over 100 NGO sub-recipients. Since 2005, the group of international NGOs have also demonstrated close coordination on key issues, leading to their active representation in the National Council. However, at the oblast level such mechanisms for effective coordination of NGOs, both domestic and international, are largely ad hoc and seriously inadequate.

External donors

The overall lack of consistent leadership, coordination and planning of the national AIDS response has resulted in programmes that are driven more by external donors than national strategies and priorities. The National AIDS Programme (2004-2008) did not define specific priorities and has not reflected the role, responsibilities and contributions of external donors. As a result, external donors have exercised significant discretion in deciding what programmes and activities they would support, as well as which NGOs would serve as implementing agents. The notable exception has been the Global Fund grants, which are in response to a country-generated grant proposal, and have also served as the de facto basis for guiding the contributions of many external donors.

The lack of donor coordination around a national agenda and weak alignment of M&E requirements among donors has also resulted in frequent duplication of activities. A donor-government working group on aid effectiveness has only recently been established by the Government under the Ministry of Economy. But in the absence of a clear and detailed national strategy, the sub-working group for HIV/AIDS has yet to produce any significant results.

Significant differences remain in policy and programmatic approaches to HIV/AIDS between external donors. For example, USAID has provided extensive support for MARPs and capacity-building activities in heavily affected regions of Ukraine, which has been consistent with concentrated nature of the epidemic. By contrast, the European Commission has frequently advocated for and supported small projects and activities that are focused on youth and the general population, often without sufficient evidence or measurable results. These differences undermine the basis for coordinating the contributions of external donors in support of the national response, and also complicate representation of the bilateral donor constituency in the National Council.

Coordination among Faith-Based Organizations

Since 2006, FBOs have begun to address HIV in a strategic and consistent manner. An inter-confessional dialogue on HIV/AIDS has led to the creation of formal and transparent mechanisms to coordinate policies and activities. The establishment of the Inter-Confessional Council on AIDS has united all major faiths and religious groups in one national structure, and its National Inter-Confessional Strategy on AIDS is an excellent example of how FBOs can unite to overcome differences to make strategic contributions to the national AIDS response. However, local coordinated efforts and collaboration of FBOs with oblast coordinating councils, which are supposed to include FBO representatives, remain limited.

Coordination within the Private Sector

Private companies are recognized as an important partner in the national and regional response. The National and oblast councils have allocated a seat for a representative of the

private sector, but with few results. Some domestic businesses have begun to set up their own charitable foundations. The National Council should make an effort to better integrate these valuable contributions in the national AIDS response.

Coordination within the United Nations System

The UN System plays a high-profile role in advocacy, and the provision of strategic guidance and technical support for the national response to AIDS. UN contributions have been distinguished by recent leadership and engagement of the UN Resident Coordinator in the National Council, and more generally on AIDS issues within the UN. While the volume of resources contributed by the UN agencies is considerably smaller than by other donors such as the Global Fund and USAID, the UN has also played an essential role in mobilizing additional financial resources, including its pivotal role in coordinating the successful coordination of the Global Fund Round 6 grant proposal.

Within the UN system, the UN Theme Group on HIV/AIDS has been refocused on policy and advocacy issues, with technical contributions being addressed by the Joint UN Team on AIDS. The UN's strategic contributions to the national response to AIDS are well summarized in the UN's new Joint Programme of Support (JPS), and efforts are being made to better reflect AIDS in the revised UN Development Assistance Framework (UNDAF).

However, the benefits of closer collaboration within the UN are not visible or understood outside the UN system. UNAIDS continues to be perceived by national and international partners as the UNAIDS Secretariat, rather than the collective contribution of all UN cosponsors to HIV/AIDS. While most stakeholders agree that the UN, and particularly UNAIDS are making valuable contributions, some partners express concern that the UN's proactive role may perpetuate the Government's lack of leadership and ownership. Most national counterparts are unfamiliar with the JPS or the UNDAF, and many misperceive the UN as a donor agency.

Despite progress in recent years, the contributions of individual UN agencies to the national response are still not always well coordinated. The high profile role of the UNAIDS Secretariat is not supported by all UN agencies. Competition for funding between UN agencies persists. Several UN agencies remain focused on the implementation of long-term agency workplans which do not reflect developments in the epidemic or changes in the national response. Some agencies lack the capacity in country to provide adequate technical support in areas where they are designated as lead agency. For example, the World Bank's contributions to AIDS have been very limited beyond support for its loan-supported project, and many national partners are unaware that the World Bank is a UNAIDS cosponsor. Few attempts have been made at country level to adopt common business processes among different agencies, leading to excessive transaction costs for the UN and its national partners. Contrary to the recommendations of the GTT,[51] several UN agencies continue to implement and support individual projects, rather than focusing on building national strategies and programmes and the provision of technical support.

Main recommendations

Immediate:

MR.4.10.1 The Cabinet of Ministers, with support from external donors and national partners, should provide detailed guidance and support to the regional administrations and their Oblast Coordination Council to ensure the timely development of regional AIDS programmes that are well coordinated with the new National AIDS Programme

Short-term:

MR.4.10.2 The bylaws of the National Council should be revised to facilitate representation from Government focal-points of lower operational level that

[51] Global Task Team Report on Improving AIDS Coordination Among Multilateral Institutions and International Donors.

may regularly participate in meetings of the Council and contribute to technical discussions

MR.4.10.3 The National Council should meet regularly (at least quarterly) to generate recommendations to the Cabinet of Ministers and other national partners on policy, overall coordination and to monitor implementation of the National AIDS Programme

MR.4.10.4 National Council should have dedicated secretariat support, which could be provided by the Committee in the Ministry of Health. This would require changing the status, authority and resources of the Committee to serve primarily as the Secretariat to the National Council, and separate this function from its line functions in the Ministry of Health. The Secretariat should report directly to the Chair of the National Council (Vice Prime Minister for Humanitarian Affairs). The Secretariat should continue to support day to day management of the National AIDS Programme, but under the supervision of the National Council. Operational implementation of sectoral AIDS programmes and activities should remain with the relevant line ministries and agencies

Medium-term:

MR.4.10.5 All sectors should develop detailed annual sectoral workplans on AIDS as a complement to the new National AIDS Programme

MR.4.10.6 The National Council should provide guidance and capacity building to all Oblast AIDS Councils to support the process of planning, coordination, implementation and monitoring of oblast AIDS programmes

MR.4.10.7 The National Council should ensure that all national stakeholders (sectors, NGOs, INGOs, FBOs, international agencies, donors) align their contributions to support the new National AIDS Programme

MR.4.10.8 The UN system and all its UNAIDS cosponsor agencies should revise the Joint Programme of Support to focus on the provision of technical support in the implementation of the new National AIDS Programme, and curtail support for small, unsustainable HIV/AIDS projects and activities

4.11 National AIDS Programme

Importance: High
Progress: Inadequate

Overview of National AIDS Programme (2004-2008)

The National AIDS Programme is the key national framework that guides the national response to AIDS in Ukraine. The National AIDS Programme (2004-2008) witnessed a significant increase in annual funding from the state budget far beyond what was originally planned. These increases enabled the scale-up of the coverage of some government services, particularly for VCT, and ART for patients with advanced HIV.

Despite the increase in funding, the National AIDS Programme consistently failed to achieve its key objectives, making progress only in its objective to reduce the level of mother to child transmission of HIV. The programme has been hindered by a series of shortcomings, from the lack of clearly defined responsibilities for management and implementation to the absence of dedicated funding for HIV programmes outside of the health sector. Focused almost exclusively on government contributions, the programme has provided little guidance and support to non-governmental and external partners as to how to make coordinated contributions to the overall national response.

Structural Logic

International best practice in AIDS planning requires that a National AIDS Programme reflects consistent and accurate specification of targets at all different levels of the logical

framework, including targets and indicators of inputs, outputs, outcomes and impacts. The National AIDS Programme (2004-2008) specified only three 'expected results',[52] but it is impossible to establish how any of the 36 planned activities are linked to these results. The Programme also has not contained any specific targets or indicators, and lacked a M&E framework. The format and content of the Programme indicates an overall lack of results-based programming, which is essential for authorities to coordinate interventions and monitor progress between goals, objectives, and activities against clear and evidence-based targets. The expected results from each activity have not been clearly defined or quantified.

The poor and inadequate results of the National AIDS Programme (2004-2008) demonstrate that when results are not logically specified and clearly linked to specific activities, inputs, activities and outputs may contribute little to anticipated results, or lead to results that are not desired.

The National AIDS Programme (2004-2008) has only focused on some of the key target populations for prevention programs, including, most significantly IDUs. However, these programmes have not addressed the main reasons for their vulnerability to HIV, or explained how the interventions address these vulnerabilities. For example, the Programme has declared the aim to "reduce vulnerability to HIV and HIV prevalence rates among vulnerable groups." However, the programme has not specified how the planned activities were to achieve these targets. Several key MARPs have also been conspicuously absent from the programme, including most critically, sex workers, MSM, MARA, and migrants with high-risk behaviours. The omission of these groups in the National AIDS Programme is directly linked to the lack of Government attention and support for programmes among these populations, where the epidemic has continued to grow. In contrast, the proposals and grant agreements that have guided the Global Fund grant-supported programmes have contained a more rigorous analysis of the size of these populations, their prevention needs, and clearly explained how the proposed prevention programmes address needs among IDUs, sex workers, MSM and prisoners.

The National AIDS Programme (2004-2008) also has not specified quantitative and qualitative targets. For example, the goal of reduction of AIDS related deaths is not defined as how many deaths will be avoided, or how many patients require treatment in order to reach this goal. While the Programme states that "by 2011 almost 43 thousand persons will die of AIDS, and over 46 thousand children will be orphaned due to their parents' AIDS-related deaths," the Programme has not explained the anticipated impact of scaling up treatment on reducing AIDS-related morbidity and mortality. Reliable estimates exist of the number of people with HIV in need of treatment, care and support services, but none of these estimates have been specified in the Programme.

The National AIDS Programme (2004-2008) also contained no reliable or evidence-based estimates of future needs for lab diagnostics, palliative care, and non-medical care and support. As a result, it is unclear what percentage of needs was to be covered by the Programme, and what gaps remained. This has made it difficult for external donors to plan where to focus their contributions and what percentage of remaining gaps to cover. The lack of any specific or relevant indicators and targets have also made it practically impossible to monitor and evaluate to what extent the implementation of the Programme has been proceeding as planned, and whether specific activities were contributing to the specified outcomes and impacts.

Finally, the National AIDS Programme (2004-2008) assigned multiple parties to be responsible for the majority of activities. As a result, it is unclear who was responsible for overall implementation of specific activities, and what was to be the role of other partners. Specific roles and responsibilities should be clearly defined in the new National AIDS Programme to enable monitoring of progress and to ensure responsible parties are held accountable for their performance.

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[52] These targets include to: i. stabilize the epidemiological situation in the country by the end of 2008, reduce levels of AIDS morbidity and AIDS-related mortality; ii. reduce levels of HIV risky behavior among youth, especially those aged 15 - 24; and iii. mitigate social tension resulting from HIV/AIDS and decrease its negative impact.

World Bank Funded TB/HIV Loan Project's Role in the National AIDS Programme

Approved in 2002, the World Bank loan-supported project for TB/HIV faced a number of obstacles. The project constantly needed to clarify its focus, and replan its activities so they would be consistent with national priorities and make a contribution to reaching national targets. In this respect, the National AIDS Programme (2004-2008) was not able to provide any clarity of national targets and priorities, or specify which activities were covered by which funding sources and implemented by which partners, or where the loan project should be refocused to make an effective contribution. In some essential areas of the National AIDS Programme, such as strengthening of government infrastructure, the World Bank loan project was specifically identified as the sole source of funding. When the Project encountered implementation problems, some of the essential activities planned under the Project, such as prevention among vulnerable groups or a national IEC campaign, were not delivered or cancelled by the Ministry of Health. The National AIDS Programme provided no mechanism to substitute other sources of government funding to compensate for these shortcomings.

The project also faced a serious of critical implementation barriers. Instead of building sustainable national capacity, the project was managed through a separate Project Implementation Unit (PIU), which created a parallel management structure in the Ministry of Health. The position of project director was repeatedly changed by the Ministry of Health, leading to a lack of understanding about the project's direction and accountability for its performance. The project's procurement procedures were long, complicated, and were a significant factor in the slow pace of implementation. In May 2006, the project was temporarily suspended by the World Bank as a result of the lack of progress and clarity on how it should be restructured. The final results of the project could only be measured in the amount of funds disbursed and the purchase of specific commodities and services, with no measurable link or contribution to national outcomes or impacts.

After many attempts to improve project implementation and performance, including extending the loan closing date for 18 months, the Bank agreed with Government of Ukraine that no additional extension of the project would be provided beyond the end of 2008, given its overall poor performance. The only exception was made to finalize three large contracts with UNICEF for the provision of drugs for opportunistic infections, test kits, reagents and supplies for which an additional extension of 4 months was granted.

Given the very poor performance of the project, the World Bank has rated the project's outcomes and implementation performance as "highly unsatisfactory" in its internal ratings. The ratings for Bank and Government performance are also highly unsatisfactory. The Bank is carrying out an extensive final review of project implementation for the Implementation Completion Report which will be presented to Government for comments by June 2009.

The performance of this loan project illustrated the difficult working environment in Ukraine in the health sector. Unless the Government makes serious improvements in its overall management of the health sector, including the formulation for a coherent national AIDS strategy, the World Bank may be averse to consider support for AIDS under the new National AIDS Programme in the near future. Beyond direct implications for future support from the World Bank, the results of the project may also have serious implications for other donors, who may consider the Government's performance under this project as a potential barrier to sustain or expand their own contributions to AIDS.

Main Recommendations

Immediate:

MR.4.11.1 Revise the new National AIDS Programme to reflects a logical programmatic hierarchy by which objectives of the Programme will be reached, i.e. the programme should specify objectives/aims, expected results, inputs, outputs, outcomes, and impacts so that they are linked with each other

MR.4.11.2 Reflect accurate estimates of persons in need of services, and clearly specify what level of coverage is planned, and any remaining gaps in the new National AIDS Programme

MR.4.11.3 Revise the new National AIDS Programme to specify a minimum set of measurable targets at all levels of indicators (inputs, outputs, outcomes and impacts) and ensure adequate resources to monitor progress against these indicators

MR.4.11.4 Specify a clear distinction of roles and responsibilities for overall management of the National AIDS Programme, as well as the role of lead and supporting organizations for the implementation of specific activities

Medium -term:

MR.4.11.5 Use remaining gaps in the new National AIDS Programme as basis for development of strategy of mobilization of additional resources, only then followed by applications for new contributions from external donors, including any future proposal submissions to the Global Fund

Link to National Obligations and International Commitments

Ukraine has adopted a series of national obligations and international commitments which were not adequately reflected in the National AIDS Programme (2004-2008). Most significantly, the National Law on AIDS clearly specifies state guarantees for the provision of prevention activities, including the availability of free VCT, and harm reduction among IDUs. This Law also specifies that citizens of Ukraine living with HIV are also entitled to free treatment and psycho-social support. Significant international commitments have also been adopted by Ukraine, including the UNGASS Declaration of Commitment, the Political Declaration of the 2006 UN High Level Meeting on AIDS, and the Dublin and Vilnius Declarations. These commitments include the historic commitment to scale up towards Universal Access to prevention, treatment, care and support by 2010.

However, none of these international commitments are explicitly referred to in either the National AIDS Programmes (2004-2008) or the new National AIDS Programme (2009-2013), raising questions about the extent to which Ukraine is committed to implementation of its international commitments on AIDS. Even without referring specifically to Universal Access, even the new National AIDS Programme fails to specify how coverage of essential programmes and services will be scaled up to all those in need, as required by Ukraine's national commitments. This lack of specificity underscores Ukraine's continued inability to reconcile provisions in the National Law on AIDS to guarantee coverage with free and quality services, with the National AIDS Programme, which does not provide adequate resources or mechanisms to ensure the delivery of these services.

Main Recommendations

Immediate:

MR.4.11.6 Ensure consistency between the National Law on AIDS for the state to guarantee the provision of prevention, treatment, and psycho-social support services and the inclusion of relevant targets and resources in the new National AIDS Programme

MR.4.11.7 Specify whether the new National AIDS Programme is aimed at achieving Universal Access, when this will be achieved and for which services

MR.4.11.8 Specify in the new National AIDS Programme reference to and consistency with Ukraine's international commitments, including the UNGASS Declaration of Commitment, Political Declaration of the 2006 High Level Meeting on AIDS, Dublin and Vilnius Declarations and the Paris Declaration on Aid Effectiveness

Priorities

Faced with limited resources and growing needs, Ukraine is not in a position to address all needs for HIV/AIDS. Yet, the National AIDS Programme (2004-2008) has not specified clear priorities to guide the importance of the various aims and related activities consistent with the pattern of the epidemic. For example, the Programme has not specified any hierarchy to the different prevention activities, implicitly suggesting that harm reduction activities under the Programme were equally important to primary prevention programmes in school. In practice, some funding was provided under the Programme for school-based education, even though such programmes are not likely to have a significant impact on preventing HIV transmission. Harm reduction or substitution therapy activities were not funded at all under the Programme, even though these activities could have made a substantial contribution to the prevention of HIV transmission.

In the implementation of the new National AIDS Programme, difficult decisions will need to be made to identify and adjust priorities that are consistent with the changing status of the epidemic. The new Programme should clearly specify the priority areas, activities and funding that will have the most significant impact. For those areas and activities that are specified priorities, but may not be funded fully or in part by the Government, the new National AIDS Programme should still identify which non-governmental and international partners could contribute funding and be responsible for their implementation, in partnership with relevant Government agencies.

Main Recommendations

Immediate:

MR.4.11.9 Specify levels of priorities in new National AIDS Programme (high, medium, low), based on transparent criteria and current evidence, and guide the use of available funding against specific activities, and guide the process of additional mobilization of resources

Process of the Programme Development

The process of development of the new National AIDS Programme, while having improved significantly in recent years, still remains sub-optimal. In the course of the development of the new National AIDS Programme, some stakeholder meetings were held to collect suggestions and review the draft of the concept and the new National AIDS Programme. Particularly in the areas of prevention among MARPs, treatment, care and support, however, it is difficult to accurately plan feasible activities without the active involvement of representatives of these populations and people living with HIV.

The development of the new Programme has been largely coordinated by the Committee on HIV/AIDS and other Socially Dangerous Diseases on an ad hoc basis, with feedback provided by those Government ministries and institutions that expressed a high degree of interest in ensuring that their plans and activities were reflected in the Programme. This precluded the opportunity to ensure synergies between the components of the Programme, and left significant discretion to the Committee to defend the new National AIDS Programme to the Ministry of Finance, including for technical areas in which the Committee is not implementing agent and lack technical expertise. Several stakeholders have also expressed concern that feedback they provided to the Committee was not reflected in the final version of the new Programme.

The National Council did not serve as a forum to conduct a thorough review of the new National AIDS Programme before it was approved by the Cabinet of Ministers. In June 2008, the new Programme was presented to the National Council after it had already been endorsed by the Cabinet of Ministers. Despite widespread concerns about the shortcomings of the document, neither the National Council nor the Committee encouraged extensive public discussion or feedback.

The new National AIDS Programme will have the enhanced legal status of an all-state targeted programme. This presupposes mandatory budget contributions from all levels of Government. Yet, there is limited evidence that regional and district local governance bodies participated in the development of the new programme, as is required by national legislation. Although regional authorities are expected to coordinate their programmes and activities with the new Programme, it will be difficult to use the new programme as the basis for planning and budgeting of their programmes activities.

Main Recommendations

Immediate:

MR.4.11.10 Consider the adoption of an interim programme on AIDS for 2009, leaving more time to develop a more strategic National AIDS Programme for the period 2010-2014, and accurately reflect the invaluable programmatic and financial contributions of the central and local governments to implement of the programme at the regional and local level

Short-term:

MR.4.11.11 Provide extensive assistance to regional governments and their oblast coordination councils to facilitate their development of regional AIDS programmes as a subcomponent to the new National AIDS Programme

Medium-term:

MR.4.11.12 Revise and strengthen the role and performance of the National Council so that it develops, monitors and revises annual operational workplans under the new National AIDS Programme

Financing and Resources

The National AIDS Programme (2004-2008) received resources far in excess of what was originally planned, with substantial increases in annual funding from the state budget provided in 2006, 2007 and 2008, as well as contributions from the Global Fund grant-supported programmes. Despite these increases, the Programme has not been successful in meeting its aims and objectives. While it is impossible to conclude that the suboptimal results of the Programme are directly linked to the inadequate amount of resources, the Programme contained several shortcomings in how funding and resources were planned, implemented and accounted for.

The Programme was not developed on the basis of a full costing exercise of the amount of resources required for optimal programmatic impact. International methodologies for costing of AIDS programmes[53] were not used for the development of the Programme. There was not a clear picture of the total volume of resources required, to what extent the Programme was to cover these needs, what gaps remained in meeting the resource needs and how these gaps were to be filled.

The Programme indicated the possibility to mobilize additional resources from other sources and increase funding in future years. However, it has not specified which were the priority gaps that needed to be filled, which sources of funding be explored, and what revisions to

[53] See, for example 'Resource Needs' from UNAIDS (http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2007/20070925_Resource_needs_methodology.asp), and the 'Goals Model' from the Futures Institute (http://www.futuresinstitute.org/pages/Goals.aspx)

the Programme would be implemented if the missing resources were not mobilized. A majority of the line items in the Programme specified no funding needs or commitments, giving the false impression that these activities were either unimportant or that funding was not needed to ensure their successful implementation.

Mechanisms for financial management in the implementation of the Programme have remained complicated and non-transparent. The Programme has not explained fiduciary issues and procedures in any detail. Several categories of expenses, such as all HIV test kits for VCT, and condoms and syringes for prevention programmes, would be better covered exclusively by the national government in order to ensure economies of scale, and monitoring of regional needs. This is currently impossible, however, due to legal restrictions on the division on expenditures between the national and regional governments in the Budget Code. These obstacles are also not addressed in the new National AIDS Programme, so regional government will again be expected to compensate for the lack of financial support and coordination from the state budget.

The National AIDS Programme (2004-2008) also included few resources to ensure management and coordination. While these costs, as well as costs for salaries and many other administrative expenses are usually covered from other sources and budgets, there is inconsistency between the needs for management and coordination specified in the Programme and the resources available for other sources to meet these needs. For example, the Committee within the Ministry of Health was originally planned to have a staff of 47 full-time personnel and office space within the Ministry of Health. More than one year after the Committee's establishment, it had hired less than 20 staff, and is reluctant to hire more staff for lack of resources and adequate office space. Until adequate financial and administrative resources are provided for management and coordination at the national and regional levels, there is a serious risk that the new Programme will continue to be implemented in a sub-optimal manner.

Main Recommendations

Immediate:

MR.4.11.13 Ensure that all line items in the budget of the new National AIDS Programme include a full and realistic reflection of costs and sources; eliminate any line items lacking a budget

MR.4.11.14 Specify details on financial resource mobilization that indicate which costs will be covered from what budgetary sources (Governmental and donor), and how the Government plans to close any funding gaps

MR.4.11.15 Include details on human resource development that specify how many additional personnel are needed to scale up programmes and services, and how these personnel will be recruited, trained and supported

MR.4.11.16 Include a brief description of fiduciary arrangements including regular auditing of the Programme implementation, in accordance with the national regulations, as an integral component of the new National AIDS Programme

Medium-term:

MR.4.11.17 Ensure that adequate resources for management and coordination are adequately budgeted in the new National AIDS Programme and/or other administrative plans

Use of Strategic Information as Basis for Development of New National AIDS Programme

In comparison to other countries, Ukraine has extensive information on the status of the epidemic, its underlying factors, and the imperatives facing key programmes and services. This 'strategic information' is essential to ensure that the correct strategies are adopted, and to guide current and future programmes and services to have an optimal impact on the epidemic. The current process of planning suggests that available strategic information is not being optimally used to guide the national AIDS response. Reasons may be the lack of

experience in drawing conclusions from strategic information and translating them into practical plans, and the lack of a general lack of commitment to ensure that strategic information is used fully and optimally. Insofar as current and future plans and programmes are not 'evidence-based, they will not have an optimal or even significant impact on the epidemic.

A series of rigorous analyses of the Ukraine's national response to HIV have been completed in recent years, including this evaluation. There is little indication that either the current or the new National AIDS Programme seriously take into consideration and address the key findings or recommendations contained in these analyses. The new National AIDS Programme also does not identify or address the shortcomings of previous programmes.

The preliminary results of this evaluation were presented to a meeting of national stakeholders in January 2008, and the draft evaluation report was released to national partners in June 2008. While there has been extensive review of the draft results of this evaluation by individual Ministries and government agencies, there is little evidence that these results have been used to guide the development and revision of the new National AIDS Programme. There is a serious risk that the critical barriers and shortcomings that have impaired Ukraine's response to AIDS to date will not be resolved in the new National AIDS Programme.

Main Recommendations

Immediate:

MR.4.11.18 Review the results of the evaluation, and prioritize findings and recommendations that are essential for inclusion in the new National AIDS Programme

MR.4.11.19 Conduct an objective self-assessment of the Programme using the HIV/AIDS Strategic Self-Assessment Tool from ASAP[54] and ensure improvement against agreed minimum level threshold ratings for each category

Medium-term:

MR.4.11.20 Review other findings and recommendations of the evaluation to guide the development of national, regional and sectoral workplans for HIV/AIDS

MR.4.11.21 Organise series of mandatory capacity building training programmes on evidence-based planning for key planners and managers at different levels and sectors (National Council, sub-national councils, Ministry HIV/AIDS focal points, etc.)

MR.4.11.22 Accelerate the establishment of the National M&E Unit to support the analysis and use of strategic information

MR.4.11.23 Ensure that any plans or targets for scaling-up coverage of specific services are accompanied by detailed operational plans that identify annual timelines, targets, responsible parties, funding sources, and plans to address and overcome barriers

4.12 Planning, Budgeting and Financing

Importance: High
Progress: Inadequate

Overview

According to the National Law on AIDS and the National AIDS Programme (2004-2008), the Ministry of Health is officially responsible for the management, coordination and prioritization of national AIDS activities and the Ministry of Finance is responsible for distribution of all State funds. The process for budgeting and financing at all levels of government involves the

[54] See the HIV/AIDS Strategic Self-Assessment Tool (SAT) - Guidelines for Evaluating HIV/AIDS Strategies and Action Plans, from the AIDS Strategy and Action Plan (ASAP), a service of UNAIDS based at the World Bank: http://go.worldbank.org/31YTFT9QS0

development of expenditure guidelines based on economic forecasting, the submission of budget requests to financial officials and then negotiations of final budgetary amounts. Amounts budgeted are frequently different from amount of funding that is allocated, which often also differ from the amount finally spent.

Currently, two line items in the state budget specifically support HIV activities. First, the line item for TB, HIV and oncology is administered by the Ministry of Health and supports central procurement of medications and medical supplies, which are then distributed to regional AIDS centres and local medical facilities. The second line item is for TB and HIV services that are supported by joint funding of the World Bank and Government of Ukraine. However, neither of these budget lines capture a significant proportion of government expenditures for AIDS, particularly at the regional and local levels. The lack of a line item in the state budget specific to AIDS makes it difficult to plan and monitor government resources for AIDS.

Equalization grants are also provided by the Central Government to oblast and local governments in support of general government infrastructure and activities. However, these equalization grants do not reflect financial needs specific to AIDS, which are projected to grow rapidly in coming years, particularly at the oblast and district levels. Awarded on the basis of overall projected needs at the regional and local level, decisions about the expenditures and priorities for the use of equalization funds are made at the levels of oblast and local governments. A significant portion of these grants are used to support general programmes such as healthcare and education. Although these programmes may be used to provide HIV-related services, they are not tracked to the HIV-specific lines in the state budget.

The final financing mechanism is the provision of subvention grants that are provided to oblast and local governments under the direction of different State Ministries for specific projects. These grants are usually for a limited amount of time and may include HIV-related activities but are also not tracked with HIV-specific budget line items.

These mechanisms contain systematic shortcomings in the planning, implementation and monitoring of the National AIDS Programme. Within budgetary parameters, implementing agencies at the national and subnational levels should be allowed to make decisions on their programmatic and technical priorities. The implementation of the National AIDS Programme is currently hindered by the lack of a single entity that has adequate authority to move processes forward and hold individuals accountable who prove to be barriers to the implementation of the policies and priorities of the government.

The global financial crisis that emerged in mid-2008 may have serious implications for Ukraine's future capacity to commit the resources envisaged in the new National AIDS Programme. Already lacking adequate funding for AIDS, state and local budgets will be hard-pressed to mobilize adequate funding to address the growing gaps for much needed services.

Strengths and achievements

Under the National AIDS Programme (2004-2008), the Government of Ukraine has significantly increased state expenditures specifically for AIDS from 13.6M UAH (USD2.7M) in 2003 to over 200M UAH in 2008 (USD39M). Large, yet unquantifiable resources are also spent on HIV-related activities by ministries other than the Ministry of Health and by local governments. Significant leadership and progress in programming and funding for AIDS rests at the regional level, with regional and local governments mobilizing their own resources to ensure that services are adequately planned, scaled up and sustained.

The National AIDS Programme is widely recognized at the national and subnational levels as being the framework that sets the programmatic and financial parameters for the national AIDS response. There are clear examples of commitment, leadership and coordination at local levels of government and within the structures of individual ministries to contribute to

and implement the National AIDS Programme. At these levels, prevention activities and medical services are often integrated into existing structures and appear to be part of the spectrum of services provided by health, education and social programmes.

Shortcomings and weaknesses

Many of the shortcomings and weaknesses of the planning, budgeting and finance systems are by-products of Ukraine's large and dynamic government bureaucracy that have a systemic impact on all government programs, and thus are not exclusive to AIDS. There is an overall lack of transparency in the process of budgeting and expenditures of resources. The process of budget setting, negotiation and implementation is perceived by many as a 'black box'. The approach to budgeting and financing for government programmes leaves little room to respond to a rapidly changing epidemic. After the initial budget is set, budget allocations may be renegotiated during the year and final expenditures may be significantly different from the amounts allocated. But there is minimal amount of public consultation or transparency in the process of these ongoing 'adjustments', even with governmental and non-govermental partners at the national and subnational level that are directly affected by these changes. Some budgetary allocations are based on per capita formulas for the delivery of services. Such an approach fails to take into account differing burdens of disease among different populations or regions.

The National AIDS Programme (2004-2008), while comprehensive in its scope and philosophy, has done little to set clear financial priorities, or establish a comprehensive work plan and specific responsibilities. Instead, the National AIDS Programme has assigned multiple parties to be responsible for most of the activities. There have been also significant contributions of existing education, health and social structures to integrated services that are related to, but not specific to AIDS. However, these expenditures have not been indicated in the National AIDS Programme or reflected in government systems for financial monitoring for expenditures related to AIDS.

Ukraine does not require specific budget allocations for all related programmes that provide a critical, yet indirect basis for activities and services related to HIV/AIDS. However, the essential role of this infrastructure is not identified or budgeted for in the overall national AIDS response. For example, the extensive network of narcological clinics does not need to specify total budgetary needs in order to provide testing and counselling for IDUs. Yet, the National AIDS Programme has not considered or reflected these financial needs in order to ensure the network of narcology clinics provides IDUs with access to VCT.

With the exception of the contributions of the Global Fund grants, the National AIDS Programme has also provided little mention of the specific roles or contributions of external partners. Yet, data from 2006 indicates that almost half of all expenditures for AIDS in Ukraine were contributions from external donors. There has also been inadequate reflection of the areas in which external donor support is implemented in partnership with activities that are supported by the Government, such as ART, or as stand-alone efforts, such as prevention among MARPs.

Based on feedback from various ministries, the process for budget prioritization in AIDS – how to determine which activities to fund and which ones to leave without funding, remains unclear. In the absence of identifying clear priorities, the budget of the National AIDS Programme has become the de facto mechanism for prioritisation. Rather than the Programme's priorities determining the budget allocations, the budget allocations have specified the de facto priorities.

The lack of targeted HIV funding has seriously undermined all activities outside of the health sector, particularly in the area of prevention, which remained underfunded or unfunded in the National AIDS Programme. In light of the limited and inadequate state support for AIDS activities outside of the health sector, some government agencies, such as the SDES, have advocated that they require their own independent AIDS programme. This illustrates an

overall lack of coordination within the Government on AIDS, and the inability of the National AIDS Programme (2004-2008) to serve as an adequate mechanism to provide support for national services activities for AIDS, even within the governmental sector.

The inability of the National AIDS Programme (2004-2008) to provide any funding for HIV activities at the subnational level has also undermined programme implementation at the local level, particularly in those regions that lack adequate resources to implement their own activities. As a result, non-health ministries and regional governments have been expected to deliver programmes and activities using their existing infrastructure and other sources of funding, which are never adequate.

Over half of the activities in the National AIDS Programme did not include any funding. Financial support for some of these activities are covered from the existing administrative resources of Ministries and relevant Government agencies. However, the majority of activities in the National AIDS Programme, including all activities for M&E, expanding access to VCT, and HIV education and prevention in the workplace activities were allocated no government funding, even though these activities have large costs, some of which were subsequently covered by external donors.

Even once budget levels have been set, the rate of expenditure of government funds is extremely slow. While the Ministry of Finance is able to provide funds to cover expenditures on a monthly basis, the Ministry of Health has been chronically slow in executing the procurement for medications and test kits that were planned under the National AIDS Programme. As of early November 2007, 11 months into the budget year, only 22% of the state budget for AIDS for 2007 had been spent. This pattern of slow and uneven financial expenditures has a negative impact on assuring the consistent provision of essential commodities. In 2007, this led to acute shortages and delays in the supply of test kits and medical supplies to the regions.

Many regional AIDS Centres suspect they will receive such commodities under the state budget only late in the year. This has forced them to submit artificially modified budget requests to the Ministry of Health to ensure that they have adequate resources to bridge over any period of a gap in the following year. If state funding is not expended by the end of the year, it is transferred back to the State Treasury. Only equipment purchased within a year can be carried over to another year. Otherwise, no system exists for obligating and carrying over unspent funding from one fiscal year to the next – even if the funding was not utilized within a given financial year for objective reasons. This often leads to a rush at the end of the year to push the unspent budget out the door, leading to the excessive and inefficient use of state resources that could have been more rationally used earlier in the year.

Estimates of expenditures for HIV/AIDS indicate that over half of all the expenditures in Ukraine on HIV are out of pocket expenditures of private citizens, or contributions from external donor sources. Although free healthcare for all citizens of Ukraine is a constitutional right, the fact that external donors and individuals living with HIV are paying for a significant portion of their care suggests that the Government of Ukraine is not providing adequate financial resources for covering these services.

The tracking of expenditures is essential in the planning, costing, budgeting, financing and reporting on activities that are specific to HIV/AIDS. The National AIDS Programme is the one national framework that delineates activities, roles and responsibilities at all levels of government. Yet, Ukraine still lacks a transparent system for budgeting, expenditures, monitoring and reporting of programmes and activities that reflects actual needs and implementation under the National AIDS Programme.

Another barrier to efficient planning and budgeting is current legislation and systems for government procurement. As a result of the shortcomings of the current Government procurement process, the Ministry of Health continues to pay more for some of the same commodities (i.e. ART drugs) than is paid through the Alliance, with funding from the Global

Fund. Due to public pressure and the urgent need to expand treatment, however, the Government is trying to budget future costs of ART at the same prices that are currently paid by the Alliance. In the future, if the Government cannot ensure procurement of drugs at the prices they are budgeted, there is a risk of a significant shortfall in the provision of ART drugs, which may represent a critical threat to the implementation of the new National AIDS Programme.

The Ministry of Health was consistently cited by government and non-government officials as providing inadequate leadership, clarity and coordination in the implementation of the National AIDS Programme (2004-2008). Examples of these barriers include the lack of transparency in decision making about which activities are funded, and repeated denial of requests for funding of HIV-specific activities outside of the health sector. The Ministry of Health is the only central government ministry that has received any significant proportion of funding for AIDS under the National AIDS Programme. Yet, the Ministry of Health is also the agency given the role of coordination the implementation of the National AIDS Programme across the Government of Ukraine. Trying to fulfil both roles seems to be a significant conflict of interest.

There are serious shortcomings resulting from a lack of understanding with and low discipline in observing national regulations that specify how the budget has to be planned, developed and implemented. This shortcoming is particularly evident if budget planning is considered as a continuum of decision making arrangements to be made sequentially at the national, regional and district levels. For example, the new National AIDS Programme presupposes extensive financial contributions from the regions. Yet, there has been little effort to engage regional and districts authorities to verify the amount and type of their financial commitments. As a result, the line item in the new National AIDS Programme which assumes contributions from the local budgets is largely an estimate, and cannot be used to require or monitor the adequacy of these contributions. In view of severe restrictions imposed by the Budget Code of Ukraine that specifies what expenditures should be covered by which level of Government, it is necessary to secure consistency and integrity of the process of activity planning and budgeting at all levels of Government.

Finally, although the Ministry of Health has overall responsibility for the development of the National AIDS Programme and its related budget, the Ministry of Finance exercises a de facto “veto” of activities or the amount of funding that it deems to be infeasible or inappropriate to support under the state budget. The Ministry of Finance lacks the technical expertise to appreciate the devastating consequences of such decisions on the development of the epidemic. The current practice represents an excessive level of programmatic control for the Ministry of Finance, and is in direct conflict with other laws of Ukraine that guarantee free access to prevention, VCT, treatment, care and support services. The Ministry of Finance should continue to provide overall budgetary guidance to the implementing ministry. However, the Ministry of Health, in greater collaboration with other Ministries should have the authority to determine technical and financial priorities within the budget that address the imperatives of the epidemic.

Main Recommendations

Medium-term:

MR.4.12.1 Strengthen capacity of central and local authorities on effective use of existing budgeting and financing systems to support the implementation of the new National AIDS Programme

MR.4.12.2 Create a separate line for HIV-specific allocations in the State and local budgets; agencies at all levels of government should adjust related budgeting codes and reporting mechanisms accordingly

MR.4.12.3 Ensure the finance and budgeting needs for AIDS are represented in systemic reforms (such as procurement systems, budget codes, funding formulas, etc.)

MR.4.12.4 Establish a dedicated team with responsibility and authority to conduct routine financial monitoring of HIV/AIDS expenditures at the national level, and provide support to regions to conduct ongoing financial monitoring

4.13 Public Sector Management and Stewardship

Importance: High
Progress: Inadequate

Overview

Management in most government institutions in Ukraine is still characterized by a top-down approach to central planning. This has resulted in extensive bureaucracy with high costs and slow, inefficient management processes. The Government's approach to AIDS is illustrative of how the requirements of the current system, its rules and regulations take precedence over the needs of citizens and the delivery of services. The role of central ministries dominates this hierarchy: regulations are adopted that are often difficult to implement; detailed reports are ordered that are often of little value. These orders often fail to define and monitor results to be achieved. As a result, sub-national governments have little autonomy to make decisions on the basis of local needs and the changing situations.

In the context of the Government's response to AIDS, the bureaucratic system of public management is especially detrimental. The vertically structured systems for planning and implementation within Ministries and between sectors create serious barriers to multi-sectoral collaboration and flexibility that is essential to an effective national response to AIDS.

For effective and efficient implementation, it is essential to provide effective management or "stewardship" by central-level ministries. High quality stewardship is critical if ministries are to guide the transformation of sectoral AIDS programmes and activities into effective services that will have an impact on the epidemic. This requires that the overall approach to governance and management should be refocused to lead, support and empower those who are implementing programmes, and provide incentives instead of sanctions for better performance.

The following findings are based on a brief analysis of performance of the Ministry of Health in public sector management and stewardship of AIDS in the health sector. However, many of these findings are also relevant to public sector management in other sectors and ministries:

Focus on short-term planning and narrow response

The approach to the public sector management of AIDS in the Ministry of Health is dominated by short-term planning and responses. There is little evidence that Ministry has anticipated or responded to the future systemic needs of the epidemic – i.e. how to scale up diagnosis, treatment, care and support from 10,000 to over 80,000 patients in need of ART in the next five years. The Ministry has also yet to articulate how to manage the diagnosis, treatment and care of people living with HIV beyond the network of AIDS Centres at all levels of the health sector.

Internal management

The lack of effective management and strategic guidance is closely associated with the weak emphasis on management skills and programmatic experience. Management of AIDS programmes in the health sector continues to be dominated by medical specialists who have limited experience in public sector management, and little training in results-based planning and management.

Cooperation with other sectors

Due to the multisectoral nature of AIDS, the Ministry of Health needs to enhance its collaboration with partners and institutions outside of the formal health sector and, in particular, with other branches and levels of government. Yet, the location of the Committee

on HIV/AIDS and Socially Dangerous Diseases within the Ministry of Health makes it less likely to engage other government ministries and partners outside of the health sector. Although the authority of the Committee to enhance coordination of the AIDS programme is clearly specified by governmental regulations, counterparts in other sectors and in the NGO sphere express concerns about the commitment and the capacity of the Committee to perform this role. Ongoing coordination of the overall national response across sectors remains poor and ad hoc, and even within different departments of the Ministry of Health.

Vertical structure of health services

Medical services in Ukraine are still organized by narrowly-defined professional specialties. Coordination and integration between medical personnel in different services remains very fragmented (each specialty has its own systems: clinics, management, staff, budgets, etc.). In light of widespread reluctance of many health specialists to care for patients with HIV, these structural barriers make it difficult to mobilize the full potential of the health sector to provide comprehensive services for patients at-risk and living with HIV.

Role of the Ukrainian AIDS Centre

On behalf of the Ministry of Health, the Ukrainian AIDS Centre has demonstrated a strong track-record for management and coordination of most technical issues for AIDS. Despite limitations of its resources and authority, the Ukrainian AIDS Centre has performed its functions well, and consistently provided reliable data and technical guidance for the Ministry of Health and other national partners. However, the Ukrainian AIDS Centre has not paid adequate attention to a series of serious technical shortcomings which are essential to an effective national AIDS response. The lack of strategies and policies for decentralized patient care, accurate projections of future needs for VCT, treatment and care, and poor or non-existent systems for registration and laboratory quality control have not received timely or adequate attention from the Ukrainian AIDS Centre, and require urgent attention and resolution. The division of responsibilities between the Committee on HIV/AIDS and Socially Dangerous Diseases and the Ukrainian AIDS Centre also remain unclear.

Network of Regional AIDS Centres

Since the early 1990s, the network of oblast and city AIDS Centres have attempted to perform all functions for surveillance, diagnostics, treatment, care and coordination at the regional level. The current and future needs for scaling-up diagnosis and treatment services require many of these functions to be decentralized beyond the AIDS Centres. In order to meet this task, AIDS Centres need to quickly refine their role in a manner that will be consistently implemented across different regions of Ukraine. Yet, the AIDS Centres have received little direct support and guidance from the Ministry of Health or the Ukrainian AIDS Centre in how to address these and other urgent tasks.

Quality of services

Many of the shortcomings in the health sector response to AIDS undermine the quality of services. The most urgent problems include the quality of laboratory diagnosis, the quality and sustainability of ART, the management of TB and other opportunistic infections among patients with HIV, and the reliable supply of appropriately-priced, quality test kits and medications. All of these issues are within the direct and exclusive responsibility of the Ministry of Health. In order to fulfill its role as the central organ responsible for the national AIDS response, the Ministry of Health needs to demonstrate that it is aware of these and other urgent issues, and is taking decisive measures to address them and thus improve the quality of services in an effective manner.

Many of these shortcomings originate from systematic shortcomings in the public sector approach to management. Major reforms of the public sector and health system are essential to achieve sustainable improvements in the national AIDS response. However, it would be erroneous to wait for such systemic reforms to proceed before acting to address these issues. The Ministry of Health must pay more serious and consistent attention to management, and act quickly to address these issues, or risk undermining its credibility and the further deterioration of the epidemic.

Main recommendations

Medium-term:

MR.4.13.1 The Ministry of Health should develop a strategy and action plan to improve the response of the health care sector to AIDS, consistent with the new National AIDS Programme

MR.4.13.2 The Ministry of Health and its Committee on HIV/AIDS and Socially Dangerous Diseases should develop its management methods and systems, based on international standards for results based-management and performance; a senior external expert in public sector management should be engaged to provide mentoring within the Committee

MR.4.13.3 Supervision and support of the Ukrainian AIDS Centre by the Ministry of Health should be guided by a joint annual workplan that specifies roles and responsibilities, and includes sufficient resources to achieve planned results

4.14 Procurement and Supply Management

Importance: High
Progress: Unacceptable

Overview

PSM is an essential component of any National AIDS Programme. A comprehensive system for PSM includes every aspect from forecasting future needs to monitoring international prices to obtaining and delivering to the client / patient high-quality level and cost effective goods and services needed to implement effective programs. A large portion of total expenditures for AIDS is used to procure products and services needed for prevention, care and treatment programmes. Products and services to be procured include a wide array of treatment products: tests for HIV diagnosis, laboratory equipment and reagents, prevention products such as condoms and syringes as well as informational materials such as brochures and leaflets, medical supplies, as well as computer equipment for management information systems, and other products, commodities, and services.

Effective and efficient PSM requires a multi-disciplinary approach to issues of legislation, clinical protocols and patient management, laboratory management, logistics and supply management, information/data management, and programme coordination for efficiency and avoidance of duplication. Poor PSM systems and practices can put the entire programme at-risk, whether due to corruption and losses from theft, wastage, destruction from improper handling (e.g. of ARVs), stock-outs, or other problems.

A number of challenges were identified in the area of PSM specific to Ukraine's national AIDS response. There is considerable consensus among officials and partner organizations on where the major problems lie and what must be done to address these issues. There is also a body of evidence supporting the need for significant and urgent reforms in this area. Ukraine's recent accession to the WTO, and public pressure imposed on the Government of Ukraine to support the continued scale-up of treatment, provide opportunities to make substantial changes and improvements to PSM for the national response to AIDS. If these changes are not made on a rapid and thorough basis, there is a serious risk that Ukraine will not be able to further scale up ART to meet the growing national needs, and will risk acute criticism from Ukraine's international and national partners, and, more importantly, from Ukrainian citizens living with HIV.

Strengths and achievements

Some achievements and positive factors exist in the area of PSM, although they are limited compared to the magnitude of the challenges that remain. Positive aspects of the Government's PSM system include a detailed Government Procurement Law which is under development, although it still requires significant revisions. Tender procedures/processes are in place, as stipulated by this law, although these are also in need of revision. Widespread awareness exists among all partners, including Government officials, NGOs and international partners of the seriousness of problems in the area of PSM specific to the performance of the Government of Ukraine, including allegations of corruption and pricing problems. There is also widespread support for the need to improve performance in these areas.

There is a body of reliable evidence that specifies the legislative and structural issues to be addressed, forming a roadmap for where and how the Government needs to make much needed improvements. The Committee on HIV/AIDS and Socially Dangerous Diseases in the Ministry of Heath, if given the mandate, could coordinate issues related to PSM specific to AIDS, and bring urgent attention to PSM problems needing urgent resolution.

Progress has been made in the official registration and importation of methadone, which has previously been a limitation to the implementation of OST. The decentralization in some government systems/processes has created some flexibility in decision-making at oblast and district levels, reducing the negative effects of over-reliance on cumbersome national level procedures.

The Global Fund grant supported programmes have shown that the Alliance, through its own PSM activities and the contracted assistance of a procurement agent (IDA), has been able to successfully manage its PSM systems to ensure a reliable supply of ARVs and other products at reasonable cost. The Alliance has also been able to successfully negotiate and pay reduced world market prices for ARVs and other products. Through the new Global Fund Round 6 grant programme, resources exist for the Network and the Ministry of Health to enhance their PSM capacities. These plans may enable the Alliance to phase out of their support and involvement in some of these areas in future, while Ministry of Health builds its own capacity.

Other partners and programmes have also played roles in PSM-related aspects of the national response, including USAID and WHO's support for technical needs assessments in the area of public procurement; assistance from the Clinton Foundation HIV/AIDS Initiative (CHAI). Other partners have also assisted in the resolution of the difficult issue of methadone registration/importation; and numerous other organizations and individuals are providing technical assistance and advice on PSM problems and potential solutions in Ukraine.

There is also evidence of some coordination and collaboration among partners and organizations involved in the national response, however much more is needed. At the oblast level, officials are conducting much of their own tendering and PSM activities for local AIDS programs, and individual institutions (oblast health department, AIDS Centres) conduct some of their own tendering and buying. Although there are problems with these processes, this decentralized approach allows the oblasts and institutions some flexibility to find their solutions and procure items on their own, avoid stock-outs, and circumvent the slow, bureaucratic PSM processes at national level. In this manner, regions can ensure that their programmes continue to function, even as they await delivery of commodities from the state budget.

Shortcomings and challenges

The most severe weaknesses in PSM were found in Governmental institutions and systems and in related Government policies and regulations. As these systems and policies establish

the overall framework for PSM processes in Ukraine, their shortcomings also affect and impede all other PSM activities in the country. The most significant shortcomings identified in the area of the Government's PSM system fall under the following four categories:

Lack of functioning PSM system

Despite the large and growing scope of the National AIDS Programme, and the growing resources associated with its implementation, the Government of Ukraine lacks a clear policy and responsible body that would manage a national system for PSM for HIV/AIDS commodities and services. Responsibility for various components of the PSM cycle are scattered within the Government between different departments in the Ministry of Health and other institutions at the national and subnational level. As a result, there are no clear lines of accountability. Despite frequent public criticism and high-level political pressure from the President of Ukraine to address some of the most severe issues in PSM, little action has been taken to address these shortcomings and develop a more functional system.

Legislation and legal structures

The Procurement Law is flawed, and tender regulations allow undue influence of a limited number of suppliers and the ability of suppliers to appeal at will. The role of the Tender Chamber is problematic and inappropriate, as it has controversial powers to change tender specifications and reverse tender decisions. The registration system and high registration costs for suppliers of drugs are burdensome. The lack of a sound quality assurance/quality control law and system permit the procurement of products of poor or uncertified quality. Legislation has impeded the importation and distribution of methadone for OST. There are also cumbersome customs regulations delaying and hindering importation of essential drugs and other products.

Bidding processes and prices

Bidding processes_are out of date and overly restrictive. There is limited access to bidding documents, which are only advertised in a small local publication in Ukrainian or Russian. Tender documents are not available on web sites, but must be obtained in person, and bids must also be delivered in person. Lengthy lawsuits which are frequently brought by suppliers that do not win tenders lead to excessive delays in delivery of essential products of one year or more. Inappropriate revisions are made to technical specifications to favour certain goods or suppliers. The annual cycle used by the Ministry of Health for tenders results in systematic delays of up to one year in delivery of goods. While some recent improvements have been reported in the cost of ART drugs procured by the Ministry of Health, prices paid by the Ministry of Health for some ARVs remain significantly higher than the prices of the same drugs procured by the Alliance under the Global Fund grant programmes. Bribes and other improper incentives are influencing procurement decisions at various levels. The excessively high prices being paid by the Ministry of Health for ARV drugs will be unsustainable when the Ministry of Health attempts to scale up of the coverage of ART, as planned in the new National AIDS Programme.

Lack of a national plan or strategy, poor coordination nationwide

The lack of an overall national approach and strategy for PSM hinders progress to ensure cohesion among various institutions and organizations involved in the national AIDS response. Different approaches, procurement rules, procurement plans, and different Ministries in charge (e.g. World Bank vs. other programs) make alignment of PSM systems and activities difficult. The poor quality of data on treatment needs and reliable forecasting estimates results in inadequate planning, and excessive payment for limited quantities of goods and services.

Political situation and structure of health system

Ongoing political instability in Ukraine's government has led to frequent changes of Ministers of Health and other senior officials, and lack of progress or continuity on essential aspects of

HIV/AIDS policy, including PSM. The unclear lines of authority and reporting between national level ministries, departments, AIDS Centres, and oblast health administrations has led to confusion of policies and duplication of efforts. The officials who are to provide oversight of public procurement overlap with each other and have conflicts of interest. With an unclear mandate and limited capacity, the Committee on HIV/AIDS and Socially Dangerous Diseases in the Ministry of Health struggles to achieve its stated objectives. The lack of a clear national system for safe supply chain management across the health system leads to storage and handling problems/inconsistencies.

Even outside of the sphere of Government procurement at the national level, there are several weaknesses in the area of PSM in other AIDS programs. For both the Global Fund grant programmes and the World Bank loan project, many PSM services have been being outsourced to non-Ukrainian entities (Alliance, IDA, UNICEF, UNDP, UNFPA). These approaches may be successful in ensuring a reliable supply of goods and services at reasonable prices, but at the expense of building sustainable national capacity and systems in this area. Procurement delays are sometimes caused by bureaucratic processes of UN agencies, which can be further exacerbated by Government regulations, including customs and registration requirements. The World Bank-imposed Project Implementation Unit structure has been largely ineffective, controversial and caused tensions within the Ministry of Health. Instead of following the national procurement laws, the World Bank project was forced to follow the Bank's procurement rules. Yet, the World Bank was powerless to influence or ensure greater transparency in the bidding process for goods procured under its own TB/HIV loan project.

The Alliance's recent shift towards central procurement of condoms and syringes has created some problems with acceptance and supply management of these commodities at local levels, where these products were previously bought locally and in small lots based on local preferences, albeit at higher prices.

At the oblast level, tendering by health departments and AIDS Centers level often lacks proper procedures and oversight. Despite the move towards decentralization, oblast governments still rely heavily on national-level budget and procurement decisions/actions for their AIDS programs, particularly for ART, test kits, and other laboratory supplies. Some oblast-level data collection and planning appears inconsistent with PSM processes, with oblast health administrations not always well aligned with the needs of their oblast AIDS Centers.

Main Recommendations

Immediate:

MR.4.14.1 Clarify plans and procedures for PSM under the new National AIDS Programme, including a timeline for the Government to address critical PSM shortcomings

Short-term:

MR.4.14.2 Convene an action group of Ministry of Health representatives with key donors and partners to decide on next steps and action plans to make improvements in PSM systems, following agreed recommendations made in this and other evaluations

MR.4.14.3 Institute quarterly PSM meetings for all relevant stakeholders, and greater collaboration and open communication within and between main programmes on PSM process

MR.4.14.4 Include at least two external, independent observers in all meetings of the Tender Committee of the Ministry of Health during tenders related to HIV/AIDS

Medium-term:

Legislation / legal structures / policy:

MR.4.14.5 Invite a team of international lawyers and procurement specialists to work with the Ministry of Health and other Government legal advisors to revise

government Procurement Law for consistency with international best practice principles and WTO requirements, with a focused section on health sector public procurement

Bidding processes / prices:

MR.4.14.6 Develop and publish standard bidding documents, and rules on technical specifications, which may not be altered after they are published by the technical committees

MR.4.14.7 Conduct tenders more than once a year (bi-annual or quarterly), to ensure products can be procured more regularly as programs expand

MR.4.14.8 Ensure tenders are published internationally, in English as well as Ukrainian, and publicly available on websites

MR.4.14.9 Re-instate the appeals review process, which ensures validity of claims before any supplier complaint/appeal in court

MR.4.14.10 Create a global, national and subnational database of prices of ARVs and other drug and laboratory supplies to establish benchmarks and a monitoring tool for Ukraine's procurement of these products

MR.4.14.11 Assist the Ministry of Health to assess where and how inflated prices have continued to be prevalent, and find immediate solutions to this problem, most of which should be part of the legislative improvements

MR.4.14.12 Conduct a detailed review and analysis of all tender awards to date, issued by Ministry of Health as well as the Global Fund and others, products and volumes procured, prices, and suppliers

Lack of a national plan or strategy, poor coordination:

MR.4.14.13 Ensure regular monitoring of all partner contributions toward HIV to have a consolidated inventory of activities, products, donations, etc. to assess gaps and duplications

MR.4.14.14 Conduct a countrywide inventory of drugs, equipment, reagents – itemize which programme is providing what, which equipment is where and how it is being used, where reagents or certain products are lacking or overstocked

MR.4.14.15 Ensure knowledge and skills in PSM are being transferred from international partners (the Alliance, World Response, World Bank, UNICEF, and others) to the Government of Ukraine and other key national partners, including, most significantly, the Network and the Alliance

Structure of health system and inefficiencies:

MR.4.14.16 Conduct an assessment of PSM capabilities at each level and training for those where gaps are identified, beginning with the Committee on HIV/AIDS and Socially Dangerous Diseases which has requested PSM training

MR.4.14.17 Conduct an inventory of oblast-level laboratories for HIV capabilities, including equipment, and produce a laboratory management plan for the HIV programme, including designated reference laboratories for immunology (CD4) and virology (viral load) testing and sample handling plans for sending blood samples and results

Price Negotiation / Lower ARV Prices

In order to sustain and expand access to treatment, the Government must resolve its long-standing problem with over-paying for certain products (especially ARVs). Reports indicate that the Ministry of Health has paid as much as 28 times more for some of the same ARV products than the Alliance paid with funding from the Global Fund grants. For lab tests, the Ministry of Health also reportedly pays much more (e.g. US$20 rather than US$5 per CD4 test) than the Alliance for the same tests. Such high variations in prices indicate that the Government of Ukraine, which is a member of the Clinton Foundation's procurement consortium, has not used its access to this and other reduced-price mechanisms to procure ARVs and laboratory tests at preferential prices. This is highly problematic and unsustainable, especially as the Government has planned to take over responsibility for covering the 6000 ART patients covered under the Global Fund Round 1 grants, as well as supporting the continued scale-up of ART. In order to significantly lower prices for its HIV treatment programme, the Government of Ukraine should consider implementing the

recommendations outlined below, in addition to other recommendations described in the section on PSM.

Main Recommendations

Short-term:

MR.4.14.18 Publicize and make transparent the costs and fees incurred at each stage of the Government PSM process (international procurement, customs clearing, storage and distribution, local agents' margins, user fees to patients, etc)

MR.4.14.19 Partner organizations (e.g. CHAI, WHO, USAID, EC) should work with the Government to develop or obtain a database of ARV and other drug and lab prices available worldwide to use as a benchmark and negotiating tool in adjudicating tenders

Medium-term:

MR.4.14.20 Institute changes in the Government procurement law and tender processes, and open up bidding opportunities to a wider range of suppliers

MR.4.14.21 Explore procurement for ART and select laboratory tests at preferential prices through IDA, CHAI and other sources of preferential pricing for HIV/AIDS commodities

Domestic Production of ARVs

The ARVs currently in use in Ukraine are purchased largely from Indian generic manufacturers and other large multinational firms (as is the case with most countries' HIV/AIDS programmes). Despite the existence of an active local manufacturing base for drugs and health products (albeit in some state of disrepair), there is no evidence of domestic manufacturing of ARVs in Ukraine.

Ukraine is a member of an international consortium called the Technological Network on HIV/AIDS, which aims to achieve self-sufficiency in the research, development, production, and distribution of ARVs and other related medications. Some members of this network (e.g. Brazil, Thailand) have made long-term investments in domestic ARV production to meet their own (large) national needs, thus significantly lowering the cost of treatment. However, Ukraine has never exploited the potential for technical cooperation through this network to explore domestic production of ARVs, perhaps largely due to the relatively small size of Ukraine's local ARV market/demand.

Domestic production of ARVs in Ukraine is not a short-term solution to improving access to ART or saving costs, and may not be a good long-term solution, either. Ukraine's pharmaceutical industry does not appear to be GMP-compliant, nor are the proper quality assurance and quality control mechanisms in place in the country to ensure quality in the production of these complex molecules. As a WTO member, Ukraine would need to acquire licenses from the originator companies to produce the current ARV molecules, or consider issuing a compulsory license, which is a risky and complicated process. All of this would require significant leadership and investment by the Government, which appears unlikely in the short term, and not a priority, given the relatively small size of the domestic market for ARVs in Ukraine, and many other challenges faced by the Government. More immediate savings and efficiencies can be gained by improving PSM processes.

Main Recommendations

Medium-term:

MR.4.14.22 Ukraine may explore long-term local production capacity for ARVs, based on purchase of raw materials from other producers, to supply the domestic market and other markets in the region. However, WTO rules around patents and licensing must be observed

4.15 Human Resource Development

Importance: High
Progress: Moderate

Overview

Strategic planning for human resources needs is essential to anticipate and deliver a growing range and scale of services. Yet, other than the number of personnel in the AIDS Centres, there is a systematic lack of reliable information on the current number and skills of human resources involved in HIV/AIDS activities in Ukraine. The current status of human resources is not centrally monitored, as no system exists to collect and use information on human resources to plan current and future needs.

The key human resources directly involved in the HIV/AIDS response in Ukraine include:
(1) medical personnel providing VCT, treatment, care (e.g. physicians, nurses, lab staff, psychologists);
(2) non-clinical personnel providing prevention and psychosocial support services (e.g. teachers, social workers, NGO outreach workers, lay people, etc.), and
(3) personnel involved in planning and management in prevention, treatment care and support services and/or AIDS programmes at regional and national levels.

To date, no systematic assessment has been undertaken to estimate the number of above-mentioned personnel involved in HIV/AIDS planning, programme implementation and the provision services. According to information provided by the Ukrainian Centre for AIDS Prevention, 369 doctors and 391 medical nurses work in the regional AIDS Centers all over Ukraine. On average, one doctor takes care of 208 HIV-positive persons for clinical follow-up.

With three doctors and almost eight nurses per 1,000 people Ukraine has no shortage of medical personnel. With increasing efficiency and coordination of human resource development efforts it should be possible to support the attainment of Universal Access targets with the provision of an adequate HIV/AIDS workforce.

Currently, the Global Fund grant programmes are the predominant financial source to train clinical and non-clinical/management staff for HIV/AIDS in Ukraine. This support covers the training programs conducted by the Regional Knowledge Hub and the mentoring project initiated under the Lavra Clinic and supported by the Ukrainian AIDS Centre. The state budget does not cover trainings in the field of HIV/AIDS for the NGOs. The monitoring of ongoing training efforts is poor, limited to individual post-training evaluations of knowledge and skills.

Strengths and Achievements

Pre-service education for medical personnel
Teaching of HIV/AIDS-related topics has been integrated in a concrete way in numerous medical specialties. The issues of human rights and patient rights are now addressed in some training programmes.

In-service education for medical personnel
The main achievements in the provision of in-service education and training for medical personnel include the establishment of the Regional Knowledge Hub, the creation of a credit point system and a certificate system, and providing the most appropriate training for physicians, nurses and social workers. This has resulted in the following positive outcomes: (1) consistent training of multidisciplinary teams; (2) training of infectious disease specialists, general practitioners and other specialists in regional medical facilities, cabinets of trust in providing ARV treatment and early diagnosis of HIV/AIDS; (3) establishment of horizontal links between specialists of different specializations

(phthisiatricians, narcologists, specialists in skin and venereal diseases, etc.) to provide comprehensive medical assistance. While the Knowledge Hub was instrumental to scale up treatment in Ukraine, the organizational and managerial set-up was not without problems. The export of a similar Knowledge Hub to St. Petersburg, Russia seems to have created a functioning business model which should be considered to be re-imported.

Training and education of non-medical and management staff
The staff of NGOs working with MARPs and people living with HIV and professional training for social workers and teachers has led to the establishment of (1) NGO personnel with strongly-developed management and outreach skills, (2) knowledge of how to provide socio-psychological assistance for people living with HIV, (3) a core number of teachers training trained in LSBE with a focus on HIV/AIDS, and (4) a limited number of social workers with formal training in HIV/AIDS.

Shortcomings and challenges

There is no clear vision of current and future models for the delivery of HIV/AIDS prevention, treatment and care. For example, it is evident that in the near future AIDS Centres will need to be complemented by at least one layer of decentralized HIV/AIDS treatment services that can integrate HIV/AIDS treatment with other health care services. Due to the lack of such models and a strategic plan, it is impossible to project human resource needs, contributing to the absence of a specific HR component in the new National AIDS Programme.

There is very little standardization and quality control for training that occurs both for medical and non-medical personnel. In particular in the non-medical field, training appears to be organized on an ad-hoc basis, with little follow-up mentoring or monitoring of programmes in place to assess and reinforce how skills are being applied. Certification for trainees only exists with regard to medical training. In the non-clinical field there is little agreement on the basic standards for education (e.g. who is considered as "social worker"). Financial support for in-service training depends largely on external sources. Since 2004, the majority of training for both medical and non-medical personnel has been supported by the Global Fund grant, underscoring the consistent lack of Government support and involvement in this area. Working conditions are not systematically addressed, and there are high rates of turnover and attrition. There is no strategic approach to provide training as part of 'Health Systems Strengthening'. Inadequate attention is paid to health system aspects, such as sustainability, integration of services, establishing new career paths, etc.

Main Recommendations

Immediate:

MR.4.15.1 Develop a human resource development component in the new National AIDS Programme

Medium-term:

MR.4.15.2 Training and professional advancement programmes for educators, medical personnel and social workers involved in the field of HIV/AIDS should specify the number of professionals to be trained for reaching Universal Access to HIV/AIDS services by 2010; additional HIV/AIDS awareness and sensitization training must also be provided for all related professions (police, prison personnel, etc.)

MR.4.15.3 Conduct a systematic analysis of working conditions and measures needed to create more favorable working environments

4.16 Epidemiology & Surveillance

Importance: High
Progress: Substantial

Overview

The epidemiologic characterization of the HIV/AIDS epidemic in Ukraine is fundamental to understanding populations affected and guiding the national programmatic response. Based on available data and extrapolations from these data, Ukraine has the highest adult HIV prevalence in Europe,1.63% of those aged 15-49 years. There were an estimated 440,000 persons in Ukraine living with HIV at the end of 2007. Through the end of 2007, there were 122,314 cases of HIV infection reported to the Ukrainian AIDS Centre, including 17,077 cases among infants exposed to HIV from their mothers. This indicates significant underreporting of HIV-infection, and a large proportion of people infected with HIV who are unaware that they are infected with HIV. The small number of reported cases of HIV among MSM is undoubtedly a gross under-reporting due to the systematic under-ascertainment of MSM risk, due in large part to severe stigma and discrimination toward MSM. A substantial, but not well characterized, number of persons reported to be infected sexually, are the partners of IDUs.

The HIV epidemic in Ukraine is severe and is centered on a large population of very high-risk IDUs. An increasing proportion of new HIV diagnoses are among persons reported to be at sexual risk for infection. It is a priority to better determine how many of these cases are sexual partners of IDUs, and how many are related to sexual transmission networks, either heterosexual or male homosexual. The epidemiologic data should be used to stimulate a heightened national response to this epidemic to better target prevention, care and treatment efforts. The coverage and quality of surveillance in the prison system is seriously inadequate, with cases of HIV among prisoners likely underreported. It is difficult to establish whether prisoners were infected before or after entering the prison system.

Currently, the epidemiologic characterization of the epidemic is provided mainly by the Ukrainian AIDS Centre, based on data received from the oblast AIDS Centres, in close cooperation with other key national and international partners. This data is based on:

- national HIV/AIDS case reporting;
- death case reporting among people living with HIV/AIDS;
- regular HIV testing of certain population groups (about 2.8 million tests in 2007);
- HIV sentinel surveillance in 16 oblasts (IDUs, FSWs, STI patients);
- periodic behavioural surveillance linked to HIV testing (IDU, FSW & MSM);
- specific behavioural surveillance (prisoners, military & youth); and
- special epidemiological studies and surveys.

Strengths and achievements

The staff of the Department of Epidemiology at the Ukrainian AIDS Centre has done a highly commendable job with limited staff and available resources to manage an accurate and up to date national system of HIV/AIDS case reporting, sentinel surveillance and the compilation of national HIV testing data. These efforts have yielded a reasonable epidemiologic picture of the large Ukrainian epidemic that has allowed for prevention, care and treatment efforts to proceed and draw attention to the most pressing areas of this large epidemic.

HIV/AIDS Case Reporting

HIV/AIDS case reporting is regularized throughout Ukraine. As for all HIV/AIDS reporting systems, this system provides a limited picture of the epidemic and is dependent on case detection and registration.

HIV Testing

The centralized nature of HIV testing in Ukraine, especially the concentration of confirmatory HIV testing in just a few centres, allows for the collection and analysis of data from a very large number of tests (over 2.8 million in 2007), with some standardization of methodology. Data are available on testing of blood donors, pregnant women (usually tested twice per pregnancy), clinical patients, STI patients, IDU, anonymous testers, prisoners, persons with multiple sexual partners [although this is a vaguely defined group], military recruits, and partners of HIV-positive persons. While the centralized collection of data about the total number of tests per year is helpful, there are substantial limitations in the way these data are collected and analyzed. Data are usually presented with the number of tests, rather than the number of persons, in the denominator. However, in 2007, HIV-seropositivity was 0.53% among 548,329 first test specimens from pregnant women, clearly indicating a high and increasing prevalence of HIV among pregnant women, which is the most reliable indicator of HIV prevalence in the general population.

Sentinel Surveillance

Since 1997, sentinel surveillance has been conducted among a growing number of key populations that are not well reached through the system for routine HIV surveillance. The implementation and analysis of results of sentinel surveillance have been successfully coordinated by the Ukrainian AIDS Centre and participating oblast AIDS Centres, albeit with significant dependence on external partners for technical support (WHO) and financial assistance (the Alliance). As of 2006, the coverage of sentinel surveillance has been increased to include IDUs, FSWs and STI patients in 12 oblasts. In addition to data from other sources, the current approach to sentinel surveillance provides useful data on trends in HIV prevalence among key populations. The recent introduction of integrated biological and behavioural surveys (IBBS) among some populations is a very positive development, and should be used to standardize and integrate regular approaches to behavioural and sentinel surveillance among these populations who are of primary importance (IDUs, FSW, MSM, prisoners, and their sexual partners). Future plans exist to expand the coverage of IBBS to 16 regions of Ukraine. It is highly commendable that the Government of Ukraine now provides some resources to sustain sentinel surveillance among STI patients. Such support from the Government should be extended to expand the coverage, quality and sustainability of IBBS among other populations who are of primary importance (IDUs, FSW, MSM, and their sexual partners).

Behavioural surveillance

Behavioral surveillance surveys of IDUs and MSM, linked to HIV testing, supported by the Alliance were conducted in 2004, 2006 and 2007. For these surveys, a commendable pilot using respondent driven sampling (RDS) was used for IDUs and MSM. These surveys have provided a wealth of very valuable data that has allowed for more in-depth understanding of the behaviors related to HIV infection and HIV transmission dynamics and networks. Of particular importance was the 2007 MSM survey which identified an HIV prevalence of 11% in a large sample of MSM; these findings indicate a very substantial MSM epidemic in Ukraine that is not measured by HIV case reporting, sentinel surveillance or standard HIV testing.

Special Studies

A variety of special research studies and surveys have been conducted in Ukraine to better understand the epidemic. An ongoing special research study (the “Polaris seroconvertor study”), using a case-control design, is currently being conducted to examine behavioural factors associated with recent HIV infection among IDU and non-IDU; however, the important results of this study have taken too long to be disseminated. Another ongoing study is being conducted among prisoner cohorts in 4 regions of Ukraine in order to determine to what extent HIV transmission inside prison system occurs. A special study on mortality causes among patients with HIV/AIDS was completed in 2007 as well as study on HIV drug resistance transmission among newly diagnosed patients with HIV.

Shortcomings and weaknesses

National HIV/AIDS Case Reporting

The number of staff (epidemiologists, statisticians, data analysts) is inadequate to operate a national HIV/AIDS case reporting system of this scale and complexity. Many of the senior staff in the department of epidemiology are employed by the Institute of Epidemiology and Infectious Diseases. These staff work for the Ukrainian AIDS Centre on a part-time basis, and thus are not fully dedicated, long-term staff of the Ukrainian AIDS Centre. Due to the lack of dedicated staff, there is not an adequate system of review to assure the quality of data collection and management, and conduct much needed data analysis and dissemination.

The information technology demands for a national surveillance system are substantial, but there is not adequate staff or systems focused on this critical area. Inadequate attention to data transfers, storage integrity, and data back-ups at both the national and subnational (oblast) level could result in catastrophic data losses, or worse, leakage of confidential data.

It is thought by epidemiologists working at AIDS Centres that the reporting of diagnosed HIV-positive persons is quite complete, but a focused assessment of the completeness of reporting has yet to be conducted. There remain serious shortcomings in:

- inaccurate categorization by testing codes of some population groups tested for HIV (i.e. prisoners may be reclassified under the testing code for drug users, even though they were tested in prison);
- consistently poor testing, counselling and HIV case reporting practices in the network of government STI clinics;
- significant discrepancies among regions between the number of confirmed HIV-positive lab results and the number of patients officially registered and placed under medical observation (dispensary care), indicating poor and inconsistent follow-up in many regions to encourage patients to be placed under dispensary observation after they are confirmed to be infected with HIV;
- consistent inadequacies in the registration of HIV cases among prisoners.

Sentinel Surveillance

The purpose of sentinel surveillance is to provide a systematic picture, over time of HIV prevalence by risk category and geographic region. The current populations sampled (IDUs, FSWs and STI patients) are reasonable for the Ukraine situation. However, all data for IDU and STI patients should be presented by sex (male, female). The current data also covers only one site in each capital city in a limited number of oblasts, and faces serious obstacles related to recruitment, sample collection and testing, analysis and interpretation of data and use of results. The current sample of sites in 12 oblasts is not unreasonable, but does not provide optimal geographic coverage. Other countries with comparable epidemics conduct sentinel surveillance in most or all regions, MSM, sex workers, prisoners and sexual partners of all MARPs.

HIV Testing

The collection of data on 2.8 million HIV tests per year provides real opportunities to better understand the HIV epidemic. However, a fundamental shortcoming of the collection and management of these data is that the unit of measure is the test, not the person. These data would be of substantially greater value if all data were presented with the number of persons tested as the denominator. This is of particular importance for blood donors and pregnant women. There remain serious shortcomings in:

- the adequate supply of test kits from local budgets for key populations, with significant variation between regions;
- the requirement that local government provide adequate test kits for ensure VCT coverage of 5% of the local population on an annual basis. This is an unjustified requirement has no basis in evidence; however, this requirement should not be

abandoned until a stable national system is implemented to ensure an adequate a reliable supply of HIV test kits for all populations that merit regular, voluntary testing for HIV.

Epidemiologic Investigation
For a country as large and sophisticated as Ukraine, with an HIV epidemic of this scale, there is an inadequate amount of epidemiologic_investigation of HIV/AIDS. There is a marked absence of Ukrainian universities and academic institutions involved in epidemiology, clinical evaluation of HIV/AIDS patients, treatment programme evaluation, interventions, clinical trials, HIV virology and molecular epidemiology. Prospective studies of persons at-risk for HIV infection to determine HIV incidence and related factors, allowing for the development of preventive interventions, would be of particular interest. There are many opportunities to take advantage of international funding to explore these areas while both addressing the HIV epidemic and developing Ukrainian scientific capacity and expertise. Additional benefits would come from the development review bodies for public health and medical ethics and protection of human subjects (institutional review boards and committees for ethical review of research). Data management and analytic capacity would also be enhanced. Several other countries (e.g., Thailand, China, Brazil, South Africa, Uganda) have taken advantage of international interest in cooperative HIV research to develop domestic capacity in these scientific areas.

Epidemiological Estimates
Ukraine has developed a series of up to date national estimates of the HIV epidemic, based on the best available data and internationally-recommended tools and methods. However, the process of developing these estimates has been largely driven by international partners, with growing, but still inadequate leadership and ownership for these estimates by national experts, particularly at the Ukrainian AIDS Centre. These estimates have been generated only for the national HIV epidemic, without the ability to effectively disaggregate estimates at the oblast level. In order to generate more detailed and robust estimates, Ukraine has adequate data and capacity to generate its next set of HIV estimates at the oblast and national level using the software tools EPP and Spectrum.

Data Analysis and Dissemination
The Ukrainian AIDS Centre has performed an exemplary job in the regular validation, analysis and dissemination of HIV/AIDS data. In particular, the HIV Information Bulletin has been published regularly, and contains a large and growing set of reliable and useful data. However, all of the data and each table presented in the bulletin warrant much more detailed analysis and explanation of limitations, trends and significance. There is limited capacity at regional AIDS Centres to generate similar reports at the oblast level. There is also an extensive research and epidemiologic data that is rarely or never analyzed by the staff at the Ukrainian AIDS Centre, or at the oblast level. The regular and in-depth analysis and use of these data is essential to guiding HIV policies and improving programmes, so the full range of non-nominal epidemiological data should also be publicly accessible via the internet.

Ethical Issues
The development of the capacity for epidemiologic and clinical research will require the establishment of appropriate human subjects review committees and capacity. For example, any human subjects research supported with US government resources would require a review by a qualified ethical committee.

International Collaboration
The relatively small number of Ukrainian epidemiologists and scientists who are able to work effectively in English limits the ability of Ukraine to fully participate in the scientific discourse that is an important part of international HIV/AIDS effort. It would be very beneficial to have Ukrainian epidemiologists and scientists fully participate in presenting data at international conferences, interact with international epidemiologic networks, develop study proposals

and publish findings in international scientific journals. The Ukrainian AIDS Centre would benefit from an ongoing collaboration with a centre of excellence in HIV surveillance and epidemiology to allow for bi-directional exchanges of staff to provide technical assistance in Ukraine and to have Ukrainian staff receive training.

HIV Incidence

The determination of true HIV incidence in a population would be the optimal way to monitor the progression of and HIV epidemic and assess the effectiveness of prevention efforts. Unfortunately, there is no simple, reliable way to determine HIV incidence in a national population. There are complex means of estimating HIV incidence on a national level as conducted in Canada and the United States, and there are methods for estimating HIV incidence in discrete population sub-groups from cross-sectional surveys using a serologic testing algorithm for recent HIV seroconversion (STARHS). The specialized nature of these methods requires adaptation to the specific epidemiologic situation in a country. Currently, there are higher priority issues for the Ukrainian AIDS Centre to focus on than embarking on an effort to determine national HIV incidence. However, as methodologies evolve, there should be an ongoing discussion on the appropriate priority and timing of such work in Ukraine. In the interim, the Ukrainian AIDS Centre should prioritize low cost tools for estimating incidence, such as the UNAIDS modes of transmission worksheet.

Main Recommendations

National HIV/AIDS Case Reporting

Medium-term:

MR.4.16.1 Increase staffing of the Ukrainian AIDS Centre Epidemiology Department to allow for more timely and comprehensive reviews of surveillance data

MR.4.16.2 Establish a system of routine, data quality assessments

MR.4.16.3 Hire staff dedicated to support the demands for information technology to support HIV/AIDS surveillance systems

MR.4.16.4 Conduct regular epidemiologic capacity building trainings for staff in oblasts

MR.4.16.5 Provide training for staff on surveillance system quality assurance and monitoring (i.e. training through ECDC)

Sentinel Surveillance

Medium-term:

MR.4.16.6 IBBS and sentinel surveillance should be expanded to all oblasts, and to different sites in large oblasts; this would give “ownership” to the data (and the epidemic) in all oblasts, and depict more accurately trends in prevalence within and between oblasts

HIV Testing

Medium-term:

MR.4.16.7 Present all data with the number of persons tested as the denominator

MR.4.16.8 Present disaggregated data by sex (male, female), and age

MR.4.16.9 Estimate the proportion of the population (by demographic groups) that has been HIV tested (ever and in the past year)

Epidemiologic Investigation

Medium-term:

MR.4.16.10 Expand linkages with academic institutions (Ukrainian and international) for epidemiologic investigations and research to focus on priority research topics

4.17 Monitoring and Evaluation

Importance: High
Progress: Substantial

National Monitoring and Evaluation System for HIV/AIDS

Overview

Adequate information systems are the basis for evidence-informed decision-making regarding the key components of effective national, regional and local responses to HIV and AIDS. This involves the establishment of an overall National M&E (M&E) system that guides the collection, reporting or sharing, and use of data from biological and behavioural surveillance, special research, as well as from programmatic M&E systems – at national and regional levels.

Strengths and achievements

The area of M&E has seen important achievements in Ukraine in recent years, most notably the acknowledgement at national and regional levels of the importance of M&E for evidence-informed policies and programmes. This emerging M&E culture has been driven by the endorsement of the Three Ones principles, which includes the development of components of one national M&E system, as well as of the UNGASS Declaration of Commitment and its associated reporting commitments. In addition, the Global Fund grant supported Round 1 programme, with its emphasis on performance-based funding, has promoted the systematisation of programmatic M&E systems.

The main development of a comprehensive national M&E system has been the formulation and endorsement of a set of national M&E indicators. These indicators facilitated the systematic monitoring of national trends in HIV prevalence and underlying factors, as well as in the national response. The national indicators were the backbone of a first draft National HIV/AIDS M&E Framework and Plan, developed in 2003, but never formally endorsed. The national indicators also formed the basis of Ukraine's comprehensive UNGASS Reports in 2006 and 2008.

The most recent 2008 UNGASS report is the most comprehensive and high quality report ever prepared by Ukraine. The successful development of the report is largely a result of the consistent attention of the M&E Department of the Ukrainian AIDS Centre, which successfully coordinated the development of the report with national and international partners. The report is considered to be a reliable source of data and analysis on the achievements and shortcomings in the national response to HIV/AIDS, and should be used extensively by the National Council and other national and international authorities to plan future contributions and areas of attention. This UNGASS report also represents a model report for other countries in Eastern Europe and beyond.

The Global Fund supported Round 1 programme has made significant contributions to strengthening the national M&E system. The Alliance and other national and international partners have taken the lead in supporting the process of data collection and special surveys for national indicators and the UNGASS reports in 2006 and 2008. Since 2004, the Alliance has also maintained a full-time staff member for coordination, capacity building and support of the national M&E system. In the absence of a governmental National M&E Unit, the Alliance's M&E Team has served as a de-facto national M&E unit, coordinating the collection of national HIV behavioural and programmatic data, and providing extensive funding and support for other national M&E activities.

The Alliance, in close collaboration with UNAIDS and other national partners, have been developing a new National HIV/AIDS M&E Plan, which aims to facilitate the monitoring of the new National AIDS Programme (2009-2013), which still lacks an M&E framework of its own. The Order 106 issued by the Cabinet of Ministers in early 2007 demands a comprehensive M&E framework for the new National AIDS Programme and is thus expected to boost the development of a consolidated national M&E system with a strong support structure, including the establishment of the long overdue National M&E Unit. While the National M&E Unit still does not exist as a formal coordinating structure for M&E, an active national M&E Working Group (MEWG), established in February 2007 under the authority of the National Coordination Council, indicates the interest and involvement of key national stakeholders to better coordinate M&E-related issues.

In addition to the active involvement of non-health sectors in the 2006 and 2008 UNGASS reports, several Ministries have been strengthening their internal M&E systems. While these initiatives do not have a unique HIV/AIDS focus, they include HIV/AIDS-related data, which may contribute to a future National HIV/AIDS M&E System and database. Since 2006, the USAID-financed Health Policy Initiative (HPI) has also provided strong and consistent technical assistance to eight Oblast Coordinating Councils (OCCs) to promote multisectoral collaboration and strengthen M&E on HIV/AIDS.

Shortcomings and challenges

Despite these achievements, one national M&E system is still far away. The main obstacle is the continued lack of a national body with a clear and strong mandate to provide overall guidance and coordination to the national response. Even within the health sector, compartmentalisation between the different departments – e.g. AIDS Centres, STI Dispensaries; TB Dispensaries; Narcology Centres – hampers effective coordination of HIV-related data flows. If the national M&E unit is established within the Committee on TB and HIV Infection/AIDS and Other Socially Dangerous Diseases within the MINISTRY OF HEALTH, as currently planned, it is uncertain whether the Committee can adequately fulfil overall national coordinating functions for M&E within the MINISTRY OF HEALTH, let alone across all sectors, including in the field of surveillance and M&E. The currently inadequate institutional and staffing arrangements, divided between the Ukrainian AIDS Centre and the Alliance, fail to provide a supportive and sustainable environment for effective national coordination in the M&E field.

Although the strengthening of M&E systems in non-health ministries and at the regional level contributes to stronger overall M&E practices, it may further hamper the establishment of one national M&E system, in the absence of clear guidance and coordination. Access to the increasing volume of M&E data remains an obstacle. The establishment of a central, national HIV/AIDS database, comprising key HIV data from different sectors is a priority component of an effective, accessible national M&E system. The initial collection of oblast M&E indicators supported by USAID is a positive development. However, the number and type of these indicators should be significantly reduced before this process is repeated or scaled up to other regions.

Most M&E data-collection is still driven by external reporting requirements from donors and for UNGASS reporting, rather than by the national and local information needs of service providers, programme managers and policy makers. This has resulted in a focus on quantitative data on coverage and service delivery, sometimes replacing more qualitative, operational research, essential for informing the response to HIV/AIDS.

Critical barriers

The lack of government leadership in support of establishing one national HIV/AIDS coordinating body with a clear mandate, and a National M&E Unit to coordinate the

HIV/AIDS-related information flows, is a major obstacle to effective M&E of the national response. The emerging M&E culture needs to be guided and supported by a comprehensive National M&E Plan that focuses on meeting the national and local information needs – rather than merely responding to external reporting requirements.

Another critical barrier is the almost complete lack of government funding for any type of M&E activity, including programmatic M&E or operational research, and special studies or surveys. While the National AIDS Programme (2004-2008) has included M&E-related activities, few, if any have ever received any dedicated Government funding. As a result, the majority of HIV-related M&E developments – particularly within the health field – have been driven by external agendas, such as the reporting to the Global Fund and UNGASS reporting.

Main Recommendations

Immediate:

MR.4.17.1 The Government of Ukraine should ensure that at least 5% of the total funding of the new National AIDS Programme is dedicated for M&E of programmes and services, research needs and the roll-out of a national HIV/AIDS M&E system, with a majority of the funding for these activities to be covered by the Government of Ukraine

Short-term:

MR.4.17.2 The Cabinet of Ministers should establish an adequately staffed National M&E Unit, with a clear mandate to coordinate the National HIV/AIDS M&E system

MR.4.17.3 The National M&E Unit should coordinate the development and implementation of a comprehensive National M&E System and Plan

MR.4.17.4 Review and reduce the type and number of indicators recommended for collection at the oblast level, focusing on essential indicators

Medium-Term:

MR.4.17.5 The Cabinet of Ministers should issue an official Order on the establishment of Regional/Oblast M&E Centres, with mandate for coordinating M&E for HIV/AIDS at the oblast level

MR.4.17.6 The Alliance, the Network and the Ukrainian AIDS Centre should pilot the introduction of a unique identifier code (UIC) within Round 6, Phase 2, which would lead to harmonization of M&E tools and frameworks, and guide the potential introduction of a UIC at the national level

Behavioural surveillance and research

Overview

Social and behavioural research in relation to HIV/AIDS in Ukraine has included regular behavioural surveys – increasingly combined with HIV-prevalence studies – as well as special studies in different sectors (e.g. health, education, and youth) and at different levels (national, regional). To date, these surveys provide the most reliable data that is available on trends in knowledge, attitudes and behaviours, particularly among critically important MARPs; and (indirectly) allow assessing the outcomes and effectiveness of the combined national HIV-prevention programmes and services.

Strengths and achievements

Recent years have seen a positive trend towards regular (biennial) behavioural surveys among key MARP groups, in the context of data collection of the National Indicators. The first two socio-behavioural surveys took place in 2004 and 2006, with separate HIV-prevalence studies among the same MARP groups. In 2007, the first IBBS took

place among a number of key MARP groups, using respondent-driven sampling. The Global Fund grant-supported Round 1 programme has been the driving force behind IBBS. Many other studies have been conducted on different aspects of the HIV epidemic, both at the national and regional levels. Increasingly, different Government sectors get involved in sector-specific studies in the field of HIV/AIDS. The provision of Government resources for national research among youth by the Ministry of Family Youth and Sport is a significant achievement that should be sustained and duplicated in other areas.

National surveys of IDU, FSW and MSM are an essential part of the epidemiologic assessment in Ukraine and should continue. However, special efforts need to be made to ensure greater geographic coverage, and disaggregation of key relevant indicators (oblast, sex, age – including for MARA, and where possible, urban/rural). For example, sample sizes of these national surveys were increased in 2007 to enable analysis of data for adolescents, which were critical to better understand their behaviours, access to services and behavioural determinants.

Shortcomings and challenges

External reporting requirements – most notably in the context of UNGASS and the Global Fund supported programmes – have been the main driving force behind national behavioural surveys and special socio-behavioural studies. As a consequence, research has tended to focus on a limited number of issues, including HIV and behavioural trends, and scope and coverage among MARPs, but to a much lesser extent on the quality of programmes and services provided to MARP groups. This has resulted in research gaps in a number of areas, especially with regard to better understanding the drivers and underlying dynamics of the HIV epidemic in different populations and settings.

To date, most behavioural research has taken place among MARP groups and in regions with relatively high HIV-prevalence rates. However, with HIV rates among MARP groups reaching critical levels in some oblasts, more research is needed on a range of known and potential bridge populations. More in-depth, qualitative studies are needed to better understand the dynamics of sexual cultures, injecting drug use and other risk behaviours in these groups, and especially the motivation underlying these behaviours. There are plans to repeat national IBBS among some MARPs conducted in 2007, using improved methods. In future, there should be a gap of at least two years between such studies to ensure that the studies can capture significant changes over time.

Another field of research to be strengthened involves the effectiveness, cost-effectiveness and sustainability of interventions. Programmatic M&E typically focus on outputs and coverage of presumably “proven successful interventions”, but fails to assess their actual effectiveness and impact.

The quality of socio-behavioural research is often hampered by methodological challenges, such as inadequate sampling techniques, small sample sizes, lack of adequate theoretical frameworks and superficial data analysis. A serious limitation of national surveys is that sample sizes per oblast are too small to provide sufficient basis for reliable disaggregation and use at the oblast level. The geographic coverage of IBBS studies should be scaled up to include a statistically reliable sample in all regions of Ukraine, and also allow for disaggregation of key variables (sex, urban/rural) and sub-populations (MARA).

Access to existing research data is a serious challenge. In the absence of a central database, there is no single, comprehensive overview of the many research projects and studies that take place at national and regional levels. Access to the full details of studies often remains restricted to a limited number group of key people and organizations, while others who have contributed to data collection – including the research population – receive little or no feedback on the results.

In addition to limitations of access, there is a serious gap between the dissemination of information and its actual use in decision making for policy and programme planning. Much research is driven by external agendas, and the results often do not meet the operational information needs of local decision makers at the policy or programme level. Research findings are often ambiguous and fail to translate into "actionable" policy or programmatic solutions. For example, experience with the 2006 UNGASS report have shown the importance of careful reporting and interpretation of national indicators to ensure accurate information on the scope and trends of HIV and the national response. Another common problem is the lack of proper data analysis beyond crude findings. The key challenge remains better coordination of research and the use of research results. This will require the development of national and regional research agendas that provide clear focus regarding research priorities.

Human rights are also an important crosscutting issue in the context of behavioural research, since most studies and surveys focus on marginalised populations that are vulnerable to potential misuse of data. Special attention should be given to informed consent and confidentiality of data. A national Ethical Review Committee should be established to develop and oversee ethical guidelines for HIV/AIDS-related research, with special attention for research among children and adolescents. Furthermore, research populations have the right to be involved in research beyond the data-collection phase – in particular in the dissemination of results and access to data, as well as in the use of research data for decision-making processes on policies, programmes and resource allocation.

Critical barriers

The most critical barrier in the research field is the absence of common research agendas at national and regional levels to coordinate and guide social research to most effectively meet the key information needs and gaps. Another significant barrier is the inadequate access to, and use of social and behavioural research findings to improve and scale up programmes and services. Concrete mechanisms to ensure easy access include a central research database; while proactive information dissemination policies at all levels should facilitate the adequate use of research data by decision makers.

Main recommendations

Immediate:

MR.4.17.7 Include specific resources from the Government of Ukraine for support of research on M&E in the new National AIDS Programme, with the portion of resources increasing on an annual basis in order to ensure sustainability

Short-term:

MR.4.17.8 Develop an annual national research plan, based on national priorities with regard to information needs, with similar plans at the oblast level; use national and regional research agendas to prioritise research projects and studies

Mid-term:

MR.4.17.9 Behavioural surveys should continue to be conducted among MARP groups every two years, integrated with biological surveillance of HIV, as well as key STIs and Hepatitis B and C. Key bridge populations should be included in the next round of IBBS studies to allow early detection of a potential spread to the general population. Existing IBBS studies among other at-risk population groups, such as military personnel and prisoners should be continued each 2-3 years (frequency depending on emerging trends)

MR.4.17.10 Future IBBS studies should aim to maximise coverage to all Ukrainian regions, and increase sample sizes in the most-affected regions in order to allow oblast-level analyses produce statistically significant results, which can guide the oblast-specific responses to HIV and AIDS

MR.4.17.11 The National Council should order the establishment of a National HIV/AIDS Research Database as part of a broader overall national HIV/AIDS database that compiles all available research and studies on HIV/AIDS-related topics. In close collaboration with the MEWG, a National M&E Unit should maintain, update and manage this national database, which should be linked to regional databases and provide easy access to core research data and study reports for all national and regional stakeholders

MR.4.17.12 The National Council should ensure the systematic use of key research findings to inform national and regional HIV/AIDS policies, programmes, as well as resource mobilisation and allocation, and policy and legal advocacy efforts. To this effect, a National M&E Unit, in close collaboration with MEWG and other key stakeholders – should be tasked with the systematic translation of research findings into concrete implications for policies and programmes, specifically the regular update of the National AIDS Programme.

Programmatic Monitoring and Evaluation

Overview

Since March 2004, the Alliance has made considerable contributions to strengthening the systematic M&E of programmes and services – most notably through a computerised management information system (MIS) entitled SYREX. Programmatic M&E by NGOs and government institutions implementing HIV-related programmes and services beyond the Global Fund-support programme has been less systematic, with limited or no harmonisation with other organizations.

Strengths and achievements

The Global Fund supported Round 1 programme, with its strong emphasis on performance-based funding, has been the main driver of more systematic M&E of programmes and services. The most concrete achievement in this area has been the successful development and roll-out of SYREX, which allows systematic tracking of programme inputs, activities and outputs. The Global Fund grant-supported programme has provided ongoing, on-the-job capacity building to the implementing organizations on a range of M&E-related topics.

Shortcomings and challenges

SYREX has taken a long period – almost three years – to develop and roll out, and it continues facing IT problems. Even to date, a number of implementing partners are not properly using, or even refuse to use SYREX, which is unacceptable. This has delayed its effective use for reporting and programme management, and left gaps in the completeness of the Alliance's programmatic data. The availability and accessibility for implementing NGOs to the full SYREX database is still limited. While the Alliance does provide feedback to individual implementing partners on their quarterly progress reports, sharing other M&E data among service providers does not yet take place. As a result, SYREX has so far mostly informed internal management decisions with the Alliance; NGO partners will need additional capacity building to be able to analyse and use the available data for their own purposes of management and programme improvement.

The Global Fund's performance-based funding approach has put pressure on the Alliance and implementing partners alike to show quantitative proof of increased outputs and coverage. For most types of service, these include clients covered from early 2004 until present, thus linking clients that were covered under the ongoing Round 1 grant with the new Round 6 grant. The cumulative coverage figures reported by the Alliance to GFATM tend to overestimate the actual "active" coverage of clients on a yearly, quarterly, or monthly basis. Insofar as Syrex allows the generation of reports for different time ranges, the Alliance and its sub-recipients should use this data to report a more accurate definition of ongoing "active" client coverage. Data on secondary syringe exchange services is also not currently collected by the Alliance, thus leaving out an important aspect of service delivery.

Some implementing partners have expressed concern that SYREX does not adequately focus on information from client feedback and operational research. In addition to specific attention for client-feedback mechanisms at service level, more attention is also needed for monitoring the quality of services in order to better tailor services to the constantly changing needs and requirements of clients. This data is collected in the Alliance's regular monitoring visits, but it is not reflected in SYREX, and not publicly available to other partners, particularly at local level. Another challenge is to better assess the outcomes of GFATM-supported programmes and services in terms of safer behaviours. Service-delivery data from SYREX is not linked to behavioural outcomes among clients at specific sites.

In the Global Fund grant-supported Round 6 programme, cooperation between the two co-PRs, the Alliance and the Network, in the development of a joint project M&E framework has so far been sub-optimal. While Alliance continues using SYREX, building on its current experiences, the Network is still in the process of developing its own M&E tools for reporting by sub-recipients. The programmatic M&E systems and tools introduced to date by the Network are reportedly complex, and not user-friendly. Instead of relying on external M&E assistance that has been 'forced upon' the Network by the Global Fund, the Network would be better served to access practical and consistent M&E support in programmatic monitoring from the Alliance.

Programmatic M&E by Government ministries and other NGOs is characterised by a variety of inconsistent approaches and systems. Most NGOs collect basic data on clients and service provision using reporting tools provided by their donors. Some NGOs have developed their own internal monitoring systems. While some more established NGOs have developed additional quality-assurance systems – sometimes including computerised databases – much of the M&E data remains paper-based and is used for administrative and reporting purposes only. Much of the M&E beyond the scope of the Global Fund grant programmes remains scattered and lacks common standards.

In the Government sector, data collection on service delivery has traditionally been driven by vertical data-collection systems, which are generally focused on reporting. Due to the "compartmentalisation" of Government ministries and departments, the access and use of this M&E data for informing policy and programmatic decisions is very limited. More recently, Ministries and specific departments have started developing new, often computerised, M&E systems, which aim to better assess the outputs and results of the programmes and services provided. There is a risk that the proliferation of different systems will not generate standardized data that can be effectively aggregated to establish levels of coverage or trends.

In addition to the internal M&E challenges mentioned, the overall challenge is better harmonisation of programme M&E approaches and systems: GFATM and other donors tend to develop stand-alone M&E systems and tools for their own project-specific reporting purposes. For example, different definitions of a 'client' and 'coverage' are used by the Alliance and the 'services for IDUs', supported by the State Service for Families, Children and Youth. As a result, the data on IDU coverage among the two programmes cannot effectively be combined. This results in service providers using

different M&E and MIS systems at the same time, or changing from one M&E system to the other with every new donor or project.

Critical barriers

The lack of harmonisation of programme M&E systems and tools is the main barrier to more efficient programmatic M&E. The parallel existence of separate M&E systems (including MIS) for different projects merely serves the information needs of individual projects, rather than being based on a common set of quality standards and priority indicators. This leads to overburdening of service providers, duplication of efforts, inadequate monitoring, and ultimately an inefficient use of funds. To avoid this proliferation of temporary, project-based M&E systems, programmatic M&E should be based on commonly agreed upon quality standards for programmes and service-delivery packages for specific client groups, allowing different service providers and donors alike to use the same core M&E framework and MIS system over time. SYREX could be used as the basis for developing such a more comprehensive, common M&E system.

In the same context, another critical barrier to effective programme M&E is the absence of a UIC, which would allow following up on clients across different service providers in the same geographical region, and get a more complete picture of their actual service needs and use, as well as the impact of these services on knowledge and behaviours.

Main recommendations

Short-term:

MR.4.17.13 The Alliance and the Network should develop and implement an integrated comprehensive project M&E framework and MIS for the GFATM Round 6 project, which builds on the Alliance's achievements and lessons learned with SYREX in the Round 1 project

Medium-term:

MR.4.17.14 The Alliance and the Network's sub-recipients should collect a minimum standard set of ongoing knowledge, behavior and client satisfaction data among new and existing clients to enable the longitudinal monitoring of outcomes and impacts at specific project sites

MR.4.17.15 The MEWG should identify a list of priority topics for operational research that will inform a more effective and efficient implementation of ongoing programme and projects

MR.4.17.16 Other partners providing HIV services (particularly State Service for Families, Children and Youth) should consider using M&E approaches and systems developed within the Global Fund grant supported programme

Section C: Cross-Cutting Issues

4.18 Human Rights

Importance: High
Progress: Inadequate

Overview

In Ukraine, there has been limited progress in addressing human rights issues and protecting the human rights of people vulnerable to and affected by HIV/AIDS. People living with and affected by HIV/AIDS continue to face also pervasive stigma and discrimination, which is a serious impediment to the accessibility and effectiveness of services.

The success of efforts to promote human rights in the context of HIV in Ukraine will depend in large part on Government leadership to prioritise programmatic attention to those most affected by the epidemic, and the allocation of adequate resources to ensure that all partners in the HIV response are supported to build their capacity and perform their necessary role. The Government of Ukraine and the National Council must ensure the costing, budgeting and implementing of programmes to address the underlying human rights barriers to Universal Access, and engage the range of partners necessary for making progress against broader issues related to health, development, rule of law and human rights.

Many of these shortcomings could be addressed through the rapid development and implementation of a national policy to protect MARPs and people living with HIV from stigma and discrimination in all governmental and non-governmental services. However, changes or revisions to laws and regulations will not lead to improvements in human rights if mechanisms are not strengthened to ensure their enforcement.

Strengths and achievements

The National Law on AIDS is recognized as an example of national legislation that contains extensive and commendable provisions for the protection of human rights of people living with HIV, and some other groups affected by HIV/AIDS. Ukraine has removed all explicit legal restrictions or barriers to the implementation of HIV/AIDS progammes and services.
Human rights education campaigns have reached a portion of people affected by HIV in Ukraine. Some report that attitudes are starting to change, particularly amongst youth. Civil society has been monitoring stigma and discrimination, and is working to strengthen its capacity in this area. There are a few emerging examples of people using the courts to address HIV-related human rights violations, and lawyers have been able to secure out-of-court settlements for civil damages in some situations. Most of the legal and regulatory barriers to the implementation of substitution therapy have been overcome.

Shortcomings, weaknesses and critical barriers

Stigma and discrimination remain pervasive
High levels of stigma and discrimination continue to be reported, particularly towards people who use drugs and sex workers, people living with HIV, and young people engaged in high risk behaviour, especially among those living on the street. There are reports of HIV positive children being denied access to education, and those without parental care being kept in infectious disease hospital wards rather than sent to boarding schools. People who inject drugs report being denied HIV services, including antiretroviral treatment, which results in premature death. Women report HIV-related stigma in accessing reproductive health services. Instead of being offered treatment for PMTCT, HIV positive women are often counselled to terminate their pregnancy. There are also reports of HIV positive mothers

being separated from their infants at birth. There is a widespread need for greater awareness and understanding of HIV among the general public in order to counteract myths and promote greater tolerance and understanding towards people affected by HIV/AIDS (e.g. via school education, mass media).

Current regulations require that people newly registered with HIV-infection sign a legal consent form in which they acknowledge their potential criminal liability for the transmission of HIV infection. These consent forms create undue stress and fear among people who have just learned of their HIV status, and have no impact on encouraging safe behaviour. On the contrary, such a requirement may encourage people to avoid contact with AIDS Centres and other services, and thus persist with risky behaviour.

Formal accountability and protection mechanisms are weak

Despite the extensive provisions for the protection of human rights in Ukrainian legislation, they are not being enforced. The Ombudsman's office has limited authority and resources (i.e. ability to request information, produce reports), and a broad mandate which limits specific attention to human rights issues related to AIDS. According to reports from civil society, neither the Ombudsman nor the Public Prosecutor have been responsive to frequent allegations of wrongful arrest of drug users, or police abuse and harassment of sex workers, and MARA. Without a government agency to support pursuit of grievances, people instead report that they fear retaliation, loss of confidentiality, or denial of services if they make formal complaints. If these shortcomings are not dealt with, Ukraine may face a backlog of costly and embarrassing cases in the European Court of Human Rights, filed by Ukrainians who did not receive adequate attention and support in addressing human rights concerns within the Ukrainian system of law and courts.

Prison conditions and law enforcement practices increase vulnerability and impede programmes

Poor prison conditions and abusive police practices increase vulnerability to infection, hamper prevention and treatment efforts, and perpetuate stigma and discrimination against vulnerable populations and people living with HIV.

A public health approach to drug use is urgently needed. While changes to the legal and regulatory framework to enable provision of OST is a major advance, further work needs to be done to sensitise law enforcement and other officials of its benefits and its legality.[55] Criminal law resources should be directed to address the criminal elements of the drug trade, rather than on arrest and harassment of IDUs.

Quality of facilities, treatment and care is uneven

Concerns about quality of diagnostic and treatment services have been frequently noted by people living with HIV, particularly for services outside the capital Kyiv. The lack of integration or coordination between services to manage HIV, TB and drug addiction is undermining both the health and human rights of affected patients. There is an urgent need to implementat and monitor a policy for protection against stigma and discrimination on the basis of HIV infection in all governmental and non-governmental services.

Adolescents face legal barriers to HIV prevention, treatment and care

General civil law provisions enable children to provide independent informed consent to health care from the age of 14, but national AIDS legislation requires parental consent up to age of 18, creating a barrier for independent access to essential services.

Monitoring and Evaluation

Work to measure stigma and discrimination, and track trends over time, needs to be reflected in the national M&E framework. Such data is important to inform programming and understand progress in overcoming the barriers to Universal Access, and realising critical goals outlined in the UNGASS Declaration of Commitment on HIV/AIDS (2001) and 2006 Political Declaration on HIV/AIDS. While the response to HIV is multisectoral and civil

[55] Methadone and buprenorphine were included in the World Health Organization 'Model List of Essential Medicines' in 2005.

society is significantly involved – particularly with regards to the Global Fund grant-supported programmes – accountability for progress ultimately rests with Government of Ukraine.

Main Recommendations

Short-term:

MR.4.18.1 Abolish the requirement for people with HIV to sign a legal consent form in which they acknowledge their potential criminal liability for the transmission of HIV infection

Medium-term:

MR.4.18.2 Revise national laws and regulations to provide clearer protection of human rights for people living with HIV and others affected by HIV

MR.4.18.3 Foster increased awareness and leadership on human rights and HIV among members of Parliament, and also among lawmakers/decision-makers at oblast and city council levels

MR.4.18.4 Ensure that medical workers, educators, police and penitentiary officials at all levels receive training on HIV and human rights, including in the context of HIV as a workplace issue

MR.4.18.5 Implement and monitor policy for stigma and discrimination on the basis of HIV infection in all governmental and non-governmental services

MR.4.18.6 Strengthen the availability and quality of legal services in all regions, and the level of awareness about HIV laws and related human rights among the procurator and courts

MR.4.18.7 Provide greater support for civil society coordination and joint action on human rights monitoring and advocacy

MR.4.18.8 Implement a national policy of zero tolerance for discrimination and breeches of confidentiality among all service providers (governmental and non-governmental) towards vulnerable populations (including refugees) and people living with HIV

4.19 Contribution of the Global Fund Grants to the National AIDS Response

Importance: High
Progress: High

Objectives

The main objectives of this component of the evaluation are to assess the specific value of the contributions of the programmes supported by the current Global Fund grants, and to generate recommendations on how to strengthen the contributions of current and future Global Fund grants. The specific questions related to this objective are:

- What are the key achievements, strengths, shortcomings and weaknesses of the National AIDS Programme in Ukraine financed by the current Global Fund grant?
- What is recommended to ensure the current and future Global Fund grant programmes contribute more effectively to the national AIDS response?
- What have been the strongest determinants of grant performance?
- What forms of technical assistance (duration, intensity, mechanisms) are most associated with successful grant implementation?
- What has been the experience with sustained grant performance to inform other Global Fund applicants and grantees on steps to take during grant implementation?

This summary is based on the evaluation of the achievements and contributions of the Global Fund Round 1 grant, and, where relevant, on the on-going implementation of the Round 6 grant. The Global Fund component of the evaluation covers the period from the

start of the stewardship agreement in 2004, up to the end of 2007. This evaluation comprised of: a review of key Global Fund and PR documents; previous consultant reports related to Global Fund grant implementation; reports from members of the evaluation team covering the technical and management aspects of the evaluation; discussions with key informants in the country, the Global Fund Portfolio Manager and the Director of the International HIV/AIDS Alliance, the Grant Steward for Round 1, based in Brighton, UK.

Overview

The Global Fund grants have made substantial and catalytic contributions towards the national AIDS response in Ukraine. Stakeholders highlighted the impressive progress in programme implementation by the Alliance, which has served as the sole PR (PR) for the Round 1 grant since early 2004. The programme supported by the Global Fund grant effectively contributed to the scaling-up of the overall national response. These contributions are most significant in the areas of access to prevention among IDUs, ART, non-medical care and support, VCT, PMTCT, school-based HIV/AIDS education and building local capacity.

The Global Fund's principle of performance-based funding, with strong focus on accountability, forced the Alliance to ensure timely implementation of activities and implement a systematic monitoring of service delivery and the use of this M&E data for evidence-informed decision making. The impressive performance of the Alliance as a PR demonstrates that direct Global Fund support to civil society PRs can improve the speed of grant implementation and help to mobilize additional implementation capacity.

The implementation of the Global Fund grants have effectively mobilized civil society and has contributed significantly to the strengthening of community systems in the national AIDS response. Support from the Alliance, as PR, was instrumental in the development of the organizational capacity of NGO partners and community-based organizations. For example, the Alliance's support to the Network during the Round 1 grant was a decisive factor in the Network being nominated as co-PR for the Global Fund Round 6 grant. More than 150 national, regional and local NGOs served as sub-recipients of the Round 1 Global Fund grant, providing prevention, care and support services in their communities.

NGO capacity strengthening has also contributed to increased civil society activism, which was instrumental for the recent Presidential decree ordering the immediate availability of methadone and the increased allocation of state budget funding for AIDS. The Alliance and the Network, in their capacity as co-PRs of the Round 6 grant, have more become among the leading implementers and advocates of the national AIDS response in Ukraine.

The Alliance also worked closely with the relevant government facilities and systems for scaling up service delivery, particularly in the area of treatment. Achievements in the delivery of the programme supported by the Global Fund grants would not have been possible without the extensive government infrastructure, which, through this collaboration, has been further strengthened for service delivery.

Despite these achievements, the Global Fund grants continue to face a series of serious challenges and shortcomings:

I. Recent problems encountered with Government's refusal to grant duty-free status to medicines procured under the Global Fund grant programmes is a serious obstacle to their ongoing implementation of these programmes.
II. The lack of national ownership of the Global Fund grants leaves responsibility for implementation of the Global Fund grant-supported programmes in Ukraine largely in the hands of the civil society. To date, the Government has not worked to ensure that the Global Fund grants are aligned and harmonized to meet national goals and objectives.
III. The National Council is not serving as a functioning oversight mechanism for grant implementation. No functioning CCM exists to ensure that the Global Fund grants are being properly implemented.

IV. The Government of Ukraine has not developed plans to ensure the long-term sustainability of the programmes and activities supported by the current Global Fund grants. In the absence of a commitment by the Government of Ukraine to support services provided by NGOs, the majority of services will be incapable of being sustained when the current Global Fund grants come to an end.
V. Internal mechanisms of each of the PRs remain inadequate to mitigate risks and provide effective governance and technical oversight of grants of this size and complexity.
VI. Initial experience with implementation of the Round 6 grant has highlighted a number of serious challenges, some of which are a function of poor planning and inadequate coordination between the PRs.

These and other shortcomings facing the Global Fund grants must be addressed prior to commencement of Round 6, Phase 2 grant, and before Ukraine applies for any new grants from the Global Fund for HIV/AIDS.

Impact on national response

The evaluation found extensive evidence that the Global Fund Round 1 grant has supported the successful implementation of key components of the national response in Ukraine. For example, contributions of the Round 1 grant and its successful management by the Alliance enabled rapid progress in key areas such as ART treatment and PMTCT. Despite this progress, it is too early to conclude that the Global Fund grants have had a singular or decisive impact on reduction of HIV morbidity or AIDS-related mortality.

In the area of prevention among IDUs, there is reliable evidence that the Global Fund Round 1 grant has played a unique role in the significant scaling-up of high quality prevention programmes among IDUs in virtually all regions of Ukraine. As a direct result of the support of the Global Fund, Ukraine now has one of the largest prevention programmes among IDUs in Eastern Europe. Insofar as IDUs remain the MARP in Ukraine, this is one of the most substantial achievements in the national response to AIDS. Even in this critical area, however, there is insufficient evidence that the Global Fund grants have precipitated a change in the course of the epidemic among IDUs.

Progress has been limited under the Global Fund Round 1 grant in scaling-up prevention programmes among other MARPS, such as sex workers, MSM, prisoners and MARA. If the Global Fund grants are to have a significant impact on the epidemic among these key populations, then the quality of services delivered will need to be improved and their coverage expanded.

Status of Global Fund grants in the Ukraine

As of December 2007, the Global Fund Board had approved total funding of US$130,234,332 for Rounds 1 & 6 for HIV/ADS prevention, treatment and care in Ukraine.[56] The implementation of Round 1 grant was initiated in 2003 through a grant agreement with three PRs.[57] In January 2004, the Global Fund suspended the grant agreement due to insufficient progress in programme implementation and due to other management problems. In March 2004, the Global Fund signed an agreement with the International HIV/AIDS Alliance UK to serve as temporary grant steward, responsible for the management of the Round 1 grant implementation. Since October 2005, the Alliance, nominated by the National Coordination Council as the PR, has successfully implemented Round 1, Phase 2, for a total of €55.5M (US$67.2M). This programme represents the largest external contribution to the national AIDS response in Ukraine. Implementation of Phase 2 of the Round 1 grant will end in March 2009 upon completion of the Round 1 grant.

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[56] This includes US$99,121,129 from Round 1, and US$29,649,187 from Phase 1 of Round 6.
[57] The original co-PRs included the Ministry of Health of Ukraine, the United Nations Development Programme (UNDP) and the Ukrainian Fund to Fight HIV Infection and AIDS.

In November 2006, the Global Fund Board approved a second, five-year proposal submitted by the National Council. The "lifetime budget" of the Round 6 proposal is US$151,077,434. However, as per Global Fund regulations, the Global Fund initially committed funds for Phase 1 – the first two years of the proposal period. On 01 August, 2007 the Global Fund Round 6 Phase 1 grant agreements were signed with the two PRs nominated by the National Council for a total of US$29,649,187.

As co-PR of the Round 6 grant, the Alliance in Ukraine signed a direct grant agreement with the Global Fund for US$15,666,166 for Phase 1.[58] The Alliance has the overall responsibility for implementing the Round 6 grant supported activities with the following objectives to:

- ensure sufficient access to integrated prevention, treatment, care and support for vulnerable populations;
- create a supportive environment for a sustainable and efficient response to HIV and AIDS in Ukraine; and
- to monitor and evaluate grant implementation and strengthen the national M&E system.

The Network, as the other co-PR of the Round 6 grant has signed a grant agreement with the Global Fund for up to US$13,983,021 for Phase 1. The Network is mainly responsible for the implementation of activities related to scaling up comprehensive HIV care and treatment, advocacy and community development, and also complements the activities in the areas being implemented by the Alliance.

If the Round 6 grant demonstrates satisfactory performance in Phase 1, measured against agreed targets, the Global Fund may invite the National Council to submit a "Request for Continued Funding" in early 2009. The maximum amount of the Round 6, Phase 2 grant would be US$121,428,247, plus any unused amount from Phase 1, to cover the cost of grant-supported activities in the subsequent three years of the grant supported programme.

Contribution of the Global Fund grants to the National AIDS Response

The Global Fund Round 1 grant has been instrumental in successfully piloting interventions and scaling up access to essential services in the national AIDS response. Some of the most significant contributions include:

(1) Scaling-up access to services

HIV prevention services for MARPs

As of the end 2007, prevention services implemented by sub-recipients reached more than 140,000 IDUs, over 21,000 FSWs, 10,000 MSM and more than 45,000 prisoners.

Antiretroviral treatment, substitution therapy and care:

Key achievements by the end of 2007 included:

- ART has been scaled up to reach more than 7,600 people living with HIV, including 911 children in all 27 regions of Ukraine – a significant improvement from 2004, when only 137 people living with HIV in two regions had access to ART; the majority of these patients (5,268, or 69%) were covered directly with support from the Global Fund Round 1 grant;
- OST with buprenorphine has been implemented in 10 Oblasts for 522 patients;
- Care and support services have been scaled up to reach more than 27,500 people living with HIV, including psycho-social care and ART adherence counselling in 22 oblasts.

PMTCT

PMTCT services were provided by more than 400 medical institutions in regional urban centres and in villages of Ukraine, which reached over 6,000 women; these services helped

[58] Unlike under the grant agreement for the Round 1 grant, which was with the International HIV/AIDS Alliance UK, Round 6 grant agreement is directly with Alliance Ukraine as co-PR.

to expand the coverage of PMTCT and reduce the national rate of transmission among pregnant women.

HIV and AIDS Information
HIV and AIDS information has been provided through school-based education interventions implemented for 8,000 schools, and for the general population through media campaigns supported under Phase 1 of the Round 1 grant. A network of regional resource centres have been established that are providing HIV information, training and support for local service providers. An effective national HIV/AIDS hotline and website have been maintained and developed.

(2) Strengthening national systems and setting implementation standards

National M&E system
The Alliance has been spearheading the development of the National HIV/AIDS M&E Plan, and provides support to the development of the national M&E system, including support for the establishment of a National M&E Unit.

The Alliance took the lead in supporting data collection on national indicators, which were used for Ukraine's UNGASS reports in 2006 and 2008. The Global Fund's performance based funding policy has promoted the systematic monitoring of service delivery and the use of this M&E data for evidence-informed decision making by the PR and the implementing partners.

The Global Fund grant supported programme has also been instrumental in strengthening programmatic M&E practices, especially through the development of SYREX, a monitoring and reporting system used by the majority of the Alliance's sub-recipients. SYREX is a strong candidate for the development of a common national M&E framework for programmatic monitoring, which could be used by the different service providers beyond the lifespan of one project. Under the Round 6 grant, the Alliance continues to provide technical assistance to the further development of both national and programmatic M&E frameworks and systems.

School-based HIV education
The Global Fund Round 1 grant has made significant contributions to achievements in school-based HIV education by funding capacity building of trainers for teachers, the development of evidence-based training and teaching materials, as well as the development of an education-based M&E system.

Multi-disciplinary approach to treatment and care
The Global Fund grants have supported training multidisciplinary teams of doctors, nurses and social workers, which has facilitated cohesive, team-based approaches to treatment, care and support. The grants have also provided support to day centres for HIV positive children and their families, to PMTCT+ projects, as well as grants to NGOs to provide a spectrum of non-medical care and support services for people living with HIV, and to promote treatment adherence.

National technical leadership for surveillance and treatment
Six oblast AIDS Centres and the Ukrainian AIDS Centre were refurbished and equipped to provide technical leadership and to become the national resource and training centres in the areas of surveillance, care and treatment and M&E. A national database for routine epidemiological surveillance was successfully established.

National system for VCT and PMTCT
The Global Fund grants have supported the establishment of infrastructure and enhanced technical skills for the national system for VCT and PMTCT, and served as the main source of funding for programmes in this area. The Global Fund grants provide all the financial resources and support for NGOs that provide VCT services using rapid tests.

Increased availability of technical support in the country

The Global Fund grants have contributed to the training of national staff in the health sector through financial support to the Knowledge Hub for Care and Treatment and to the Ukraine Institute of Public Health Policy. The Alliance provides direct technical support to sub-recipients and has increased the availability of skilled staff for various aspects of prevention, care and support in the government service delivery facilities and among the NGO implementing partners. The Alliance has developed standardized training programmes, conducts training of trainers and has implemented training programmes on project management and development for about 600 participants per year, including participants from a wide and growing range of government and NGO organizations.

Procurement and Supply Management

Transparent procedures for PSM were established by the Alliance, which helped to ‘normalize’ the price of ARVs in an environment where there are significant variances. In 2006, the Ministry of Heath spent 21.6M UAH (USD4.2M) of state funds to purchase ART to meet the needs of 1047 patients. In comparison, the Alliance spent 25.9M UAH (USD5.1M) of Global Fund grant resources to cover the ART needs for 3730 patients. In 2006, the Global Fund grant provided support to three times more patients on ART than did comparable funds provided by the Government of Ukraine. The lower prices paid by the Alliance for ART also had a positive impact on lowering drug prices for ART in Ukraine, which has helped to lower costs for the Ministry of Health.

(3) Strengthened civil society as implementers and as advocates

With the support from the Global Fund grant-supported programmes, the capacity of NGOs was further strengthened as key vehicles for the delivery of essential services for prevention, treatment, care and support. NGO have successfully implemented projects that provide core services and information for MARPs, as well as community centres, clinical and home care programmes that provide essential treatment and care services for people living with HIV. The Global Fund grants currently support over 150 NGOs in the provision of HIV/AIDS services in all regions of Ukraine.

Capacity building of the civil society sector, and in particular of NGO sub-recipients, was a major activity supported by the Round 1 grant. One of the success stories is the development and growth of the Network, which was initially supported by small grants from the Alliance. Under the Round 1 grant, the Network became one of the largest NGO sub-recipients. The Network now serves as a grant maker in its own right as one of two co-PRs of the Round 6 Global Fund grant.

The increase in the number and capacity of NGOs has further strengthened their role as advocates and as watchdogs. At the national and regional levels, Ukrainian NGOs supported by the Global Fund grants are protecting the rights of Ukrainians for access to HIV prevention and AIDS treatment and care, and leading the fight against AIDS-related discrimination and stigma. The Network is a strong champion for increasing access to ART, and serves as a high-profile and effective advocate to support people living with HIV in Ukraine. The recent Presidential decree (No1208/2007) ordering, among other actions, to ensure the immediate availability of methadone for OST, thereby meeting the conditions set by the Global Fund, is largely a result of the tireless efforts of these NGOs.

(4) Strongest determinants of grant performance

A national PR with experience and capacity in grant management

One of the determining factors in the successful implementation of the Global Fund grants was that the Alliance already had a track record in administering grants when it was selected as the PR. The Alliance also possessed considerable organizational and management skills, initially developed through the management of a USAID-funded programme from 2000 to 2004. At the time of its appointment as grant steward, the Alliance already had in place

financial systems, and had an early warning system in place to monitor sub-recipient performance.

The rapid establishment of an effective PSM system

Based on its agreement with the Global Fund as grant steward, the Alliance procured ARV medications directly through IDA, an international non-profit procurement agent. This mechanism was effective, with impressive cost savings over other government ARV procurement systems. Procurement of non-ARV medical goods was sub-contracted to PATH. Local partners such as MSF also provided technical assistance in areas related to ARV treatment and supported the technical and tender review committees.

One of the strongest determinants of success in PSM has been the ability of the Alliance to bring in and use the expertise and track record of international procurement agencies to rapidly establish a special unit for Treatment, Procurement and Supply Management within the Alliance office in Ukraine. The Alliance now has established its own internal national PSM capacity, and received an ‘A‘ rating for its PSM capacity assessment for Round 6.

Performance-based funding

Performance-based funding was the determining factor for setting implementation standards and boosted the development of a strong programmatic M&E system. It forced both the PR and the sub-recipients to meet all major targets and to consistently deliver results. The Alliance managed grant implementation by putting in place an effective model of monitoring the Global Fund grant in the context of the broader national response. It focused on accurately tracking the level of services provided through the use of standardized, relevant and robust indicators.

Forged collaboration between the Government and NGOs

The Global Fund grant has very effectively mobilized the civil society in Ukraine both as PRs and as sub-recipients. The Civil society, in turn, has worked with the relevant government structures and systems for scaling up service delivery. This collaboration has resulted in strengthening existing government infrastructure for service delivery. It has also facilitated the creation of AIDS Service Networks in all regions of Ukraine, comprising of more than 160 organizations and 406 clinics collaborating to ensure the successful implementation of the Global Fund grant supported treatment programme in all regions of Ukraine.

Influenced the policy environment

Since the mid 1990s, civil society in Ukraine has played a decisive role in advocating for greater access to HIV prevention and AIDS treatment and care. This has facilitated the scaling-up of services and focused much-needed attention on the needs of MARPs. With support from the Global Fund grants, the Network has become a strong national voice, advocating for the scale-up of care and support services for people living with HIV and for better management of the national response to the epidemic. These advocacy efforts have drawn attention to corruption as a major barrier to an effective national AIDS response, particularly in the area of public procurement. The Alliance, together with other NGOs, has conducted successful advocacy campaigns reaching top national leaders, including the President, to support policy changes to increase access to OST.

Promotion of transparency through information sharing

The introduction of stakeholders’ meetings during the period when there was no functioning CCM was key to addressing issues related to the grant suspension and the temporary stewardship of the grant. These stakeholder meetings are now used by the PRs as a platform to share grant implementation reports and to discuss implementation related challenges. In the absence of a functioning CCM, these stakeholder meetings are currently the only platform to review the implementation of the ongoing Global Fund grants. Stakeholder meetings do not represent an adequate substitute for the CCM, and thus have no authority for reviewing or approving plans, budgets or programmatic revisions. Yet, they are serving as an effective model for information sharing, and could be used by other programmes and the national response as a whole.

(5) Forms of technical support most associated with successful grant implementation

Technical support to the PR

One of the strongest determinants of grant performance was the direct, timely technical support provided by the International HIV/AIDS Alliance Secretariat in Brighton immediately prior to the stewardship and during the first six months of its role as grant steward. In addition to the technical support organised by the Alliance Secretariat, partners in country were mobilised to provide technical support in specific areas, which facilitated rapid grant implementation.

Technical support to sub-recipients

The Alliance has a proven track record of providing direct, timely technical support to NGOs. Through the Alliance's on-going reporting arrangements with its sub-recipients, they continually assess the sub-recipients capacity and needs and provide them with the appropriate support. The Alliance was pivotal in strengthening the Network by providing them with both technical and financial support. The Network, in turn, trained people living with HIV, social workers, counselors and provided guidance for the formation of local and regional networks. The Ukrainian AIDS Centre, a sub-recipient for Round 1, has also been a key technical partner in designing and developing systems to scale up the provision of ART to people living with HIV. The Global Fund has financed the Knowledge Hub for Care and Treatment in Kyiv to train government health care workers on care and treatment based on a multi-disciplinary care model.

Shortcomings and challenges

Challenges related to operationalization of the Global Fund principles

Principle: '*Support programmes that reflect national ownership'*
Is the Global Fund supported programme part of the national response or a stand alone project?

When the Alliance was selected directly by the Global Fund Secretariat as grant steward in March 2004, grant implementation began under hostile and difficult circumstances.[59] The suspension of the grant when the Ministry of Health was PR affected the Ministry's willingness to accept the programme activities financed by the Global Fund grant as part of the national response to AIDS for which it is legally responsible.

At the same time, the 'CCM' of Ukraine, established in June 2002, was dissolved. In-country stakeholders were consulted on the grant suspension and in the selection of the grant steward. However, the ensuing circumstances were not conducive for the stakeholders, including the UN, to be proactive in ensuring that the Global Fund supported programme was being implemented in a coordinated way as part of the national response. Therefore the country partnership system, comprising of public, private and civil society, as envisaged by the Global Fund, did not exist at the time of initiation of grant implementation. One single constituency, namely the civil society, was given the responsibility for grant implementation.

In mid-2005, during proposal development for Round 1, Phase 2 grant, the Ministry of Health was encouraged to assume the responsibility as a co-PR, responsible for the treatment component of the grant. The de facto refusal of the Ministry of Health to take on this responsibility has resulted in a situation whereby civil society PRs now have the overall responsibility for grant implementation, including for the subsequent Round 6 grant. The continued lack of consistent Government leadership and support has seriously undermined multisectoral national ownership of the Global Fund grants.

The Government's lack of interest and support in the performance of the Global Fund grant is clearly demonstrated by the lack of direct engagement between the Government of Ukraine and

[59] At that time, the CCM of Ukraine, established in June 2002, was dissolved. The country partnership system, comprising of public, private and civil society, as envisaged by the Global Fund did not exist at the time of initiation of grant implementation.

the Global Fund. Despite repeated requests for a meeting, the Chair of the National Council, the Vice Prime Minister for Humanitarian Affairs, has not met with the Global Fund Portfolio Manager during any one of his 10 visits to Ukraine. The serious problems encountered with refusal of the duty-free import of medicines procured under the Global Fund grants as humanitarian aid suggests that the Government may even be undermining the implementation of the Global Fund programme. This issue can only be resolved through engagement and action by the Government of Ukraine and should be done on a priority basis.

The majority of national stakeholders highlighted the Alliance's impressive record of grant implementation, and the invaluable contribution of the Global Fund grants in support of the national response to AIDS, particularly in scaling up access to treatment. As grant steward for Round 1 and now as co-PR for Round 6, the Alliance remains focused on meeting targets and delivering results within a relatively short time frame. The main responsibility of the Alliance and the Network as co-PRs is to ensure timely and successful implementation of the grant, based on the agreement with the Global Fund. The overall responsibility for coordination of the national response remains with the Government of Ukraine – even if this role is not being fulfilled vis-à-vis the Global Fund grants.

The creation of the National Coordinating Council in May 2005 was a positive step towards the coordination of the national programme, including the components of the national response that were supported by the Global Fund. Although it had the right ingredients for a successful national coordination mechanism, the National Coordination Council suffered from a poor and inconsistent record of performance. In July 2007, the National Coordination Council was dissolved and its responsibilities were transferred to the new National Council. However, the continued lack of leadership by the Cabinet of Ministers and the Ministry of Health, frequent changes of Government, a poorly developed national strategy and a non-functioning national AIDS coordinating authority are, according to respondents, the major obstacles to a coordinated national response. The support provided by the Global Fund grants to the implementation of the programme activities were not fully reflected in the National AIDS Programme (2004-2008), even though these grants represent the largest source of external funding for AIDS in Ukraine. Under these circumstances, the Global Fund grants have been implemented as a stand alone programme.

It remains the primary responsibility of the Government of Ukraine and the National Council to ensure that the Global Fund grants are effectively harmonized with the national programme and aligned with contributions of other partners, particularly those from the Government of Ukraine. However, the PRs do not have the capacity or the mandate to compensate for the lack of engagement and support for the Global Fund grants from the Government of Ukraine.

Principle: ***'Pursue an integrated and balanced approach to prevention and treatment'***

The original Global Fund Round 1 proposal envisaged that two thirds of the resources would go to care and treatment and the remaining for IEC activities among the general population, including mass media and education in schools, and a small percentage for prevention among vulnerable groups. The rationale for this allocation of funds was based on synergies with the $60M loan from the World Bank.

Unfortunately, the implementation of World Bank loan-supported project by the Ministry of Health was very slow. With low disbursement rates and innumerable management problems, the prevention activities that were supposed to be implemented by the World Bank project did not materialize. Efforts to rectify this situation were taken by the National Coordination Council during Round 1, Phase 2 grant reprogramming, when more resources were shifted to prevention among vulnerable groups and by including a stronger focus on prevention in the Round 6 grant. This experience demonstrates how the Global Fund grant was responsive to poor implementation of other donor supported programmes activities, which resulted in a more balanced national approach to prevention and treatment than was intended in the original proposal.

Two PRs are now responsible for the implementation of the large and ambitious Round 6 grant. The Alliance is responsible for the implementation of harm reduction and other prevention activities, and the Network responsible for treatment, care and support, and advocacy and community development. This formal division of responsibilities makes the establishment of sound continuum of care and integrated service networks across the Global Fund supported programme even more difficult. In the absence of a national coordination body and of effective local coordination mechanisms, there are already indications that this arrangement is inadvertently resulting in less, rather than more, integration of prevention, care and treatment services. The initial experience with implementation of the Round 6 grant has already highlighted a number of serious challenges which relate to poor planning and inadequate coordination between the PRs.

Principle: ***'The Global Fund actively seeks to complement the finance of other donors and to use its own grants to catalyze additional investments by donors and by recipients themselves'***

The Global Fund grants represent the largest external source of funding for the national response to AIDS in Ukraine. In the absence of other major HIV prevention and AIDS treatment activities and resources, the Global Fund grants also represent the only source of funding for key components of the national AIDS response.

With the exception of current plans to ensure the transfer of 6,000 patients on ART from the Global Fund grant programme to the Ministry of Health, the Government of Ukraine has taken few, if any measures, to strengthen, expand and sustain the programmes and activities supported by the Global Fund grants. The long-term sustainability of essential services can only be assured when activities that are currently supported by the Global Fund grants are sustained and enhanced by the Government of Ukraine.

Ukraine also appears to be experiencing a shrinking donor base for HIV/AIDS. Some donors such as the European Commission justify the reduction of their contributions to AIDS in Ukraine, based on the argument that the bilateral contributions to the Global Fund from its member states is proof of their continued engagement. This goes against the principle of additionality of the Global Fund, which states that 'the Global Fund only finances programs when it is assured that its assistance does not replace or reduce other sources of funding.'[60]

Shortcomings and challenges related to processes and grant management

No national oversight of grant implementation / weak systems for internal governance

Since the dissolution of the National Coordination Council and the establishment of the new National Council, Ukraine has continued to lack a functioning CCM to provide effective oversight of the Global Fund grants and guidance to grant implementation by the PRs. The overall funding approved under both Global Fund grants is large, amounting to a total of US$130M. In the absence of an effective national coordination mechanism, there is no body to take responsibility for ensuring quality assurance and cost effectiveness of implementation of programmes financed by these funds. The PRs and their implementing partners in the governmental and non-government sphere are counting on the additional funding from Round 6, Phase 2 grant (US$121M) to provide continued support for their activities and services.

The Round 6 Conciliatory Group, comprising of the Alliance, the Network, the Coalition of AIDS service NGOs, a Member of Parliament and a representative of the Ministry of Health can at best serve as a mechanism for internal grant coordinating between the PRs. This Group does not meet the membership and governance requirements for CCMs as outlined in the Global Fund policies, and cannot take on any supervisory role due to the inherent conflicts of interest.

[60] How The Global Fund Works. http://www.theglobalfund.org/en/about/how/

Current management mechanisms are also inadequate to provide effective internal governance of each of the Global Fund PRs, albeit for different reasons. The size and complexity of the Alliance's operations in Ukraine, in particular those related to its role as PR, calls for much closer and more frequent supervision particularly of the financial management of grant implementation. To prevent the misuse of funds, the Alliance should establish checks and controls through a local governance mechanism, comprising of members selected through an open and transparent process with specific implementation oversight functions.

The Network is governed by a Coordination Council based in Ukraine that is selected by its members, which has the overall responsibility to oversee the performance of the Network, including the responsibility for the oversight of the Round 6 Global Fund grant. However, the majority of the members of the Network's Coordinating Council consist of senior management and paid staff of the Network, which represents a fundamental conflict of interest. If this current Coordination Council is to be the only mechanism to oversee the grant implementation by the Network, then significant revisions must be made in its membership and in the selection process of the members to avoid conflict of interest and to ensure transparency and accountability in their grant implementation oversight function.

Shortcomings related to assurance of procedures for technical grant management, selection and performance monitoring of sub-recipients

The implementation of the programme based on the Global Fund policy of performance based funding has ensured that the PR has regularly met the targets set in the workplan. The focus therefore is on achieving results to meet quarterly reporting requirements. The need to meet reporting deadlines leaves inadequate time to monitor quality of service delivery. The focus of the grant implementation is principally on achieving coverage targets and not on ensuring the quality of services delivered. Several respondents, including the LFA, raised concerns about the limited systems for quality control of services delivered. While some measures such as ongoing M&E systems and site visits have been implemented by the Alliance to address this issue, these measures may not be adequate to precipitate qualitative improvements in delivery of services across the range of the grant supported activities.

The evaluation recognises that the transparent tender and proposal review procedures introduced by the Alliance have, to some extent, influenced positively the tender procedures for HIV/AIDS programmes by other stakeholders. However, respondents raised concerns on the current practices of both PRs in conducting tenders procedures. The following concerns merit a review of current procedures and the implementation of more rigorous and transparent procedures:

First, there is a risk that current procedures of both PRs could result in the selection of implementing organizations that may not possess the required capacity or expertise to implement specific services. In cases where implementing organizations have an imperfect track record, current procedures may also allow for the reselection of such sub-recipients, due to the lack of other candidates and the overriding need to meet targets. To address these shortcomings, more attention needs to be paid to ensure that all calls for proposals specify a minimum threshold for organizational capacity. More attention also needs to be paid by the LFA to ensure that an adequate number of impartial and technically-qualified experts are present on all tender committees organized by both PRs.

Second, the Alliance is responsible for implementing a wide range of services targeted at vulnerable populations such as MSM, IDUs, and sex workers. Concerns were voiced by respondents about the Alliance's internal technical capacity in all these areas to develop quality calls for proposals, and to put in place criteria for proposal review and ensure the selection of appropriate implementing organizations with the required capacity to implement the component. With less experience and limited technical expertise, the Network is facing even more technical limitations in this area. Both PRs should engage a team of long-term experienced international consultants to provide the required technical support to ensure

that these processes are developed and implemented in a manner that reflects the technically complex and changing needs of their Global Fund programmes.

Third, the tender process for selection of sub-recipients, as currently implemented by both PRs, should be better enforced and documented to ensure that practices are consistent with these procedures. Both the Alliance and the Network should include clearly outline selection criteria for proposals with any Request for Proposals, based on points and minimum scoring requirements. With support from the LFA, impartial and technically-qualified experts on all tender committees must ensure that PR staff does not influence the outcome of tender decisions. The outcomes of all tenders decisions, both positive and negative, should be clearly documented and made publicly available. Unsuccessful tender applicants should have access to information about the rating of their proposal received, and explanations as to why their proposal was not selected. Finally, detailed progress reports on the programmatic and financial performance of all sub-recipient grants should be made publicly available and accessible online, and updated on a regular basis.

The overall transparency of other operational procedures and processes of the PRs also merits further improvement. The Network has introduced a greater degree of transparency through the inclusion of external partners in Network committees that take key policy and funding decisions, and for the hiring of senior staff. This is a commendable approach that should also be considered by the Alliance.

Challenges related to building national PSM system

An area which would have benefited from more attention and support from the Alliance is the Government's PSM system. Consistent with the grant agreement, the Alliance successfully developed its own PSM capacity. The Alliance's PSM system has ensured the regular, cost-effective procurement of drugs, equipment and other commodities that have been essential for the provision of some government services, particularly in the areas of ART, VCT, and PMTCT. However, the Alliance has contributed little to address the systematic and urgent shortcomings in the Government PSM system. While this is not one of the specific targets of the Round 1 grant, this remains a critical shortcoming in Ukraine's future ability to scale up an effective national response to surveillance, treatment and patient monitoring.

The Network, as co-PR for Round 6 grant has declared that it will build PSM capacity in the Ministry of Health. The Network is expected to train and build their PSM team, which will work towards strengthening the PSM unit in the Ministry of Health. But as sub-recipient to the Network, the Alliance will continue to implement the Network's PSM activities. This arrangement is unnecessarily complex, and does not represent an optimal delineation of PR responsibility allocation for PSM under Round 6 grant. Serious concerns also exist whether the Network is capable of meeting its Round 6 targets to build the PSM capacity of the Ministry of Health.

Negative spin-offs from Global Fund resources in the country

A number of respondents expressed concern about the 'brain drain' from the government sector that has been precipitated by the influx of funds through the Global Fund grants. These grants have enabled the PRs to offer better remuneration and other incentives, thus drawing a large number of competent staff away from government entities, which have contributed to further weakening of national capacity.

This could have negative consequences for the long-term sustainability of the Global Fund grant. The Alliance and the Network allocate a significant portion of overall grant funding to support salaries and overhead costs of their own organizations and the operations of sub-recipients. The systematic practice of paying salary-top-ups to government staff for performance of duties that should be part of their regular job description, particularly in the health sector, is problematic. The continued growth of these salary and overhead costs in the NGO sector represents a risk to the sustainability of these services by raising unit costs and other administrative costs, and making it less likely for the Government to contribute to or sustain these services at levels the Government can afford. The focus of the Global Fund

grants on service delivery through civil society sub-recipients further undermines Government capacity, which will impact the sustainability of the programmes when the Global Fund grants come to an end.

Some respondents noted that current responsibilities for management of such a large grant could shift the Alliance's focus from its core mission of supporting community action on AIDS. Although this grant is being implemented through the civil society, the Alliance is under pressure to meet time-bound results, including in areas which were never part of its original mandate, such as PSM. The same applies to the Network, which is currently focusing its time and human resources on building its capacity as PR, with the risk that little time and attention is left for activism and advocacy. According to one respondent, "soon the Network will lose its credibility when advocating for better treatment and support services for people living with HIV when it is responsible for delivering these services."

There are many other issues related to equity of access to services, discrimination and stigma, general violation of human rights, the fight against corruption which need continued focus and activism. Both PRs face inherent conflicts in exercising their roles as advocates for better leadership or improved quality of services when they themselves are coordinating the implementation of national prevention, care and support services.

<u>Initial Performance of Round 6 Grant and Implications for Ongoing Grant Implementation</u>
The initial results of Round 6, Phase 1 indicate that the current grant-supported programme is facing a number of serious, but surmountable challenges. Some targets in the original grant proposal may be overly ambitious, and merit reconsideration to ensure that there are adequate resources and capacity to ensure they are reached in Phase 2. The process of coordination of strategies, services and activities between the Alliance and the Network has been poor – a problem which has been compounded by the lack of effective grant oversight by the National Council. Some roles and functions between the PRs are confused, illustrated by the Network's engagement of the Alliance as a sub-recipient to provide PSM services. The Network has experienced significant management and operational obstacles that raise questions as to its continued capacity as a co-PR. The forthcoming process of development of the Request for Continued Funding for Phase 2 represents an opportunity for national stakeholders to reflect on lessons learned, and conduct significant replanning of the grant for Phase 2. The RCF should focus on a small number of indicators, with greater effort towards reaching a smaller number of ambitious but achievable targets. The National Council should also use the Phase 2 process as an opportunity to review the division of all roles and responsibilities between the co-PRs and their sub-recipients, based on their past performance and core competencies.

Main Recommendations

<u>Addressed to the National Council / Government of Ukraine</u>

Immediate:

MR.4.19.1 The Government of Ukraine should take measures urgently to resolve the issue of duty-free import of medicines as humanitarian aid and ensure that any related problems are addressed on a priority basis in the future

MR.4.19.2 The National Council should lead the process of development of the Request for Continued Funding for Round 6, Phase 2. The proposal development process should be guided by an objective assessment of lessons learned from Phase 1 and a realistic reconsideration of the objectives and targets for Phase 2, including, if necessary, the redefinition of the role and responsibilities of all PRs and sub-recipients

MR.4.19.3 Ensure that the new National AIDS Programme (2009-2013) is well coordinated and that the programmes supported by the Global Fund grants and by other external funders are included as an integral part of the national

response to ensure harmonization and alignment with the national strategies and priorities

MR.4.19.4 Ensure that the development and implementation of the new National AIDS Programme (2009-2013) is well coordinated and that the programmes supported by the Global Fund grants and by other external funders are included as an integral part of the national response to ensure harmonization and alignment with the national strategies and priorities

Short-term:

MR.4.19.5 Ensure that the National Council is truly multisectoral, implements participatory governance procedures and fulfills its core function as a CCM for the Global Fund grants. This is not a choice, but a requirement for oversight of all Global Fund grants. It is recommended that this national coordination mechanism should:

MR.4.19.5.1 have in place Terms of Reference for members and governance procedures for proposal development and for the selection of the PR but most importantly for overseeing the implementation of the grant and for harmonization and alignment of Global Fund supported programme with the national response

MR.4.19.5.2 establish a subcommittee of the National Council that will provide grant oversight. This subcommittee should be chaired by an National Council member and include other relevant stakeholders with technical expertise, but not representatives of the PRs, or sub-recipients, or other partners who may have any conflict of interest

MR.4.19.5.3 provide a review of overall grant performance at regular (quarterly) meetings of the National Council on ongoing Round 6 grant

MR.4.19.5.4 establish a Secretariat to provide administrative support for the functioning of the National Council; the National Council should apply for financial support to the Global Fund to support its running costs with co-financing provided by in-country partners

MR.4.19.5.5 review overall costs within all programmes supported by the Global Fund grants, and review appropriateness of all salary subsidies to government personnel before commencing with the development of the Request for Continued Funding for Round 6, Phase 2

MR.4.19.5.6 hold regular meetings between the Chair of the National Council and the Fund Portfolio Manager to review grant performance and other strategic issues

MR.4.19.5.7 ensure monthly communications between the head of the National Council subcommittee for grant oversight and the Fund Portfolio Manager to review ongoing grant performance issues

MR.4.19.6 Develop a national technical support plan based on a detailed capacity and needs analysis of PRs, sub-recipients and of the relevant stakeholders country wide as well as on a mapping of providers of technical support at the national and regional levels. This plan should include:

MR.4.19.6.1 clearly defined priorities with recommendations on entry points, timelines and specifications of technical support needed at each level

MR.4.19.6.2 a quality assurance plan to monitor the implementation of technical support

MR.4.19.7 Require that the PRs demonstrate that the recommendations addressed to them are being implemented before proceeding with the Round 6, Phase 2 Request for Continued Funding

Medium-term:

MR.4.19.8 The Government of Ukraine must pay serious attention to building the management, financial and PSM capacity of a Government institution as a potential PR candidate for any future Global Fund grant

Addressed to the Alliance and the Network

Immediate:

MR.4.19.9 The PRs take verifiable measures to:

MR.4.19.9.1 ensure that the issues and recommendations included in this evaluation are reviewed with the relevant stakeholders

MR.4.19.9.2 develop a time-bound workplan with clearly defined outputs to address the issues raised and implement the evaluation recommendations for approval by the National Council and the Global Fund. This workplan should include a reporting mechanism to the National Council and relevant stakeholders on its implementation status

MR.4.19.9.3 ensure the provision of high quality technical support to the Government of Ukraine / Ministry of Health to further develop and revise the new National AIDS Programme (2009-2013)

Short-term:

MR.4.19.10 The PRs take verifiable measures to ensure that:

MR.4.19.10.1 tender procedures are technically rigorous and strictly adhered to, and all tender decisions are transparent, and technically and programmatically justified

MR.4.19.10.2 status and progress reports of grant implementation by all sub-recipients are made available online and updated on quarterly basis

MR.4.19.10.3 a policy of zero tolerance to corruption related to all programmatic and managerial aspects be implemented, which must be adhered to by the PRs and all sub-recipients. This policy and any action taken related to this policy should be made public

MR.4.19.10.4 internal governance, management and financial processes of both PRs follow international standards

Medium-term:

MR.4.19.11 The PRs take verifiable measures to ensure:

MR.4.19.11.1 the establishment of national governance mechanism for the Alliance, which includes members who can contribute to the development of the Alliance's overall strategy, provide oversight to financial management and monitor the quality grant implementation

MR.4.19.11.2 a review of the Coordination Council of the Network to ensure it does not include paid staff or consultants but independent technically-competent members, who can contribute to the development of Network's overall strategy, provide oversight to financial management and monitor the quality grant implementation

Addressed to in-country technical partners (UN, USAID, etc.)

Short-term:

MR.4.19.12 Be proactive in the management and provision of technical support to strengthen grant implementation

4.20 Best Practices

One of the most important types of strategic information in a county's response to AIDS is a systematic understanding of which policies, programmes and approaches are working, particularly if they also merit duplication and scale-up. In order to generate such strategic information, a systematic and rigorous approach to evaluation should be used to determine the merit or quality of a specific programme, policy or strategy. As the AIDS epidemic in Ukraine continues to deteriorate, there are regrettably few uncontested examples of best

practices that have been documented to have had a clear and significant impact on the epidemic. The majority of the activities have focused on monitoring of programmes and activities. There has been weak and often non-existent attention to formal evaluation to determine the value or effectiveness of specific policies or interventions. Ukraine has not developed formal criteria for what best practices consist of, and to date there have been only intermittent efforts by international technical partners, such as UNAIDS, to identify best practices in Ukraine.

However, the following is a short summary of some of the key best practices indentified by the external evaluation. It is the opinion of the external evaluation team that these policies, programmes and approaches merit closer attention and possible scale-up and replication as models of 'best practice', both in Ukraine and potentially, where appropriate, in other countries.

i. Political Leadership and Responsibility by the Head of State

The seriousness of the AIDS epidemic is often exacerbated by a lack of political leadership. As described by former UN Secretary General Kofi Annan, 'AIDS represents the greatest leadership challenge of our time.' In response to this challenge, President Yushchenko has demonstrated decisive attention and leadership on AIDS in Ukraine.

In December 2007, President Yushchenko convened an unprecedented national meeting of governmental, non-governmental and international representatives on AIDS in Ukraine. The meeting was characterised by an honest and critical recognition by the President of the potential impact of AIDS on Ukraine's socio-economic and demographic stability. In particular, the President demanded that the national budget reflects all costs that may be required to provide HIV/AIDS-related prevention, treatment, care and support for all those in need. The President also called for a new National AIDS Programme for the period 2009-2013 to be developed and endorsed by the Government of Ukraine. More recently, President Yushchenko was one of the few heads of state to send an official signed statement to the High Level Meeting on AIDS in June 2008, and provide an official endorsement of Ukraine's UNGASS report.

Such attention and political commitment by a Head of State is essential for the development of a national reponse that can more effectively respond to an epidemic of such urgency and proportions. This degree of political leadership is a model of best practice that should be expanded to every level of society, including the Cabinet of Ministers and the Parliament of Ukraine as well as regional leaders of governmental institutions and NGOs.

ii. Leadership and Service Provision by Civil Society

One of the key strengths of Ukraine's response to HIV/AIDS, particularly in the period covered by this report, has been the growing leadership, advocacy, and professional capacity of NGOs in Ukraine, including, in particular, people living with HIV/AIDS.

The Alliance in Ukraine, the largest AIDS organization in Ukraine, and the Network have demonstrated exceptional capacity as professional national partners capable of effectively implementing large and complex HIV/AIDS programmes. Important recognition of this capacity was the decision of the Global Fund to award Ukraine the Round 6 grant of up to $151M, which is now being implemented by the Alliance and the Network as co-PRs. The Network has also been recently profiled as a best practice case study by UNAIDS in 'A Non-Governmental Organization's National Response to HIV.'

Ukrainian civil society organizations have also led the successful national effort to advocate that the Government of Ukraine support the implementation of OST, including methadone therapy, as an effective and evidence-based method for preventing HIV infection among

IDUs. In recognition of civil society's important contributions to the national response, the Government of Ukraine ensured the involvement of national civil society organizations in the National and Regional Councils on AIDS, with persons living with HIV serving as Deputy Chairpersons of these structures, as well as inclusion in the official national delegation to the recent High Level Meeting on AIDS in June 2008. Representatives of civil society are also key partners in the development and implementation of important components of the current and forthcoming National AIDS Programmes. Over 150 Ukrainian civil society organizations are also leaders in the management and implementation of HIV/AIDS services for prevention, treatment, care and support at the local level. The inclusion of civil society participants in meetings held by the President of Ukraine, most recently in December 2007, is further proof of the recognition of their critical role in the national response to AIDS.

iii. Prevention: National Programme on PMTCT

The National Programme on the Prevention of HIV-infection from Mother to Child is the only prevention programme in Ukraine to achieve almost universal coverage of the target population. As noted earlier in this report, beginning in 2003, the coverage of voluntary HIV-testing among pregnant women in Ukraine has consistency exceeded 95%, indicating that pregnant women have had significantly higher coverage of HIV surveillance than any other group in the general population in Ukraine. While there is a consistent increase in the number and percentage of women diagnosed with HIV during pregnancy, the coverage of antiretroviral prophylaxis increased from 9% of women in need in 1999 to over 92.5% in 2007. This programme represents the most rapid scale-up and extensive coverage of any HIV-prevention intervention in Ukraine. Even the practice of testing each pregnant woman twice, which was earlier criticised as an ineffective use of resources, has recently revealed a small but growing number of pregnant women who are seroconverting to HIV infection between their first and second test trimester. This has enabled many of these women, who would have otherwise been missed by the antenatal HIV surveillance system, to still receive ART prophylaxis. The result of this programme has been to significantly lower the rate of mother-to-child transmission from 27.8% in 2001 to 7.1% in 2007, with some sites reaching rates as low as 4%.

The programme has also consistently adopted new approaches to improve outcomes, such as the availability of rapid tests and nevirapine in all maternity hospitals in Ukraine, the pilot implementation of DNA PCR for early diagnosis of newborns, and the recent introduction of HAART as the optimal regimen for PMTCT prophylaxis. Much still needs to be done to lower the transmission from mother to child to rates that are consistent with other European countries and also ensure universal, long-term access to treatment for parents with advanced HIV. Ukraine is determined to ensure that the national PMTCT programme is maintained and further strengthened as a national model of best practice in the field of HIV prevention.

iv. Prevention: High Coverage and Intensity of Harm Reduction Programmes

As the epidemic in Ukraine is still concentrated among MARPs, driven largely by injecting drug use, harm reduction programmes represent the front-line in the prevention of HIV. The National Law on AIDS specifies that the State guarantees 'HIV prevention among persons using injecting drugs, in particular to provide conducive conditions for exchange of used injecting needles and syringes for sterile needles and syringes'.

In order to determine the effectiveness of a harm reduction programme, however, there should be evidence that the programme is providing a significant number of IDUs with access to a minimum package of prevention and support services with regular frequency. High coverage refers to sites where more than 50% of IDUs have been reached by at least one HIV-prevention programme. High intensity refers to the number or percentage of clients who access the service within a specific period of time, ideally within one month. Based on

these criteria, there has not been a comprehensive evaluation of the coverage and effectiveness of harm reduction programmes at multiple sites in Ukraine.
However, one site in Sumy, Ukraine, has been profiled as a best practice case study by UNAIDS in the 'High Coverage Sites HIV Prevention Among IDUs in Transitional and Developing Countries.' The harm reduction programme coordinated by the Alliance and implemented by NGO partners in the field, with funding from the Global Fund, has several sites that are documented to be providing harm reduction programmes with high coverage and intensity. At the majority of these sites, harm reduction programmes offer an expanded package of services, including VCT (including rapid testing), condoms, treatment for STIs, referrals to social services, and limited access to substitution therapy. These expanded services motivate clients to visit these sites on a more frequent basis. There is also some data from these sites that regular or frequent clients practise safer behaviour than new clients who are accessing service for the first time, providing preliminary evidence that these programmes are having an impact on promoting and sustaining behaviours that prevent the spread of HIV.

v. Monitoring of the Coverage Programmes and Their Usage by Clients

Of the key shortcomings of specific programmes or projects worldwide is their frequent inability to identify how many clients are being covered with what services. Data are often limited to recording the number of client visits. At the same time in order to monitor the actual coverage of a programme, it is crucial to have reliable data on what percentage of a target population is using the services, and with what frequency.

In order to address this shortcoming, the Alliance in Ukraine implemented its own computer-based programme for monitoring coverage and use of services in 2005. Called Syrex, this system records the number of client visits and maintains records of all individual clients by means of coding them without requiring confidential personal information. Syrex is now used by over 70 Alliance sub-recipients throughout Ukraine, enabling them to record and report on the number of clients who have used which prevention services and commodities within a given period. Syrex also enables the Alliance to generate reports by region or by target population to monitor the coverage and intensity of service usage at the national level, between regions or at the level of individual service providers.

A new Version 2 of Syrex, which will soon be available publicly as shareware, is now being rolled-out. The new version is more user-friendly and can generate more reports that can be more easily customized by the user organization. Consistent with data from other sources, data from Syrex indicate that current coverage is still too low to have a decisive impact on the HIV epidemic among IDUs at the national level. The data generated by Syrex is also being used to better plan how to close this prevention gap, and mobilise additional resources to provide higher and more frequent coverage of prevention programmes.

vi. Estimations of Size of MARPs

In order to monitor the coverage of services, it is essential to have reliable data on the size of the target population. For MARPs, such data is not available from official statistical sources. In 2005, national partners developed a process to estimate the size of these populations, using internationally recommended methods. Estimates were generated for the size of populations of IDUs, sex workers, and MSM, with low and high ranges, which were subsequently endorsed by the Ministry of Health. The results of these estimates were then used to generate new national HIV/AIDS estimates in Ukraine, and to monitor the coverage of prevention programmes. These figures have also been used by national partners to guide the need for scale-up of programmes and commodities.

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Annex 2: Composite List of Thematic Areas, Technical Areas & Issues

Broad thematic areas (Level 1)	Technical areas (Level 2)	Technical issues (Level 3)
1. Prevention		
	1.1 Most at-Risk Populations	1.1.1 Injecting drug users
		1.1.2. Sex workers
		1.1.3 Prisoners
		1.1.4 Most at-risk adolescents / Most at-risk youth
		1.1.5 Men who have sex with men
		1.1.6 Migrants and Refugees
		1.1.7 Uniformed Services
	1.2. General Population	1.2.1 School-based education, incl:
		- School
		- PTU
		- Institutes and universities
		1.2.2 Education outside school, incl.:
		- Street children
		- Peer to peer
		- Youth organizations
		1.2.3 Workplace
		1.2.4 Gender, women & girls, men & boys
		1.2.5 Medical personnel (incl. universal precautions)
		1.2.6 Prevention of mother to child transmission
		1.2.7 Reproductive health
		1.2.8 Behavioural change communications
	1.3 PSM for Prevention Commodities	1.3.1 Condoms, syringes, etc.
2. Diagnostics, Treatment, Care & Support		
	2.1 Voluntary Couselling and Testing	2.1.1 VCT policy and procedures
		2.1.2 Rapid testing
	2.2 Lab Diagnostics	2.2.1 HIV Serology, incl. test kits
		2.2.2 HIV Virology, incl. test kits
		2.2.3 HIV Immunology
		2.2.4 HIV Resistence

		2.2.5 Lab QA/QC, incl. training
		2.2.6 Blood safety
	2.3 Medical Care	2.3.1 Outpatient care
		2.3.2 Inpatient care
		2.3.3 ART, including PEP
		2.3.4 National ART treatment guidelines and training
		2.3.5 Price reductions and domestic ART production
		2.3.6 Nursing
		2.3.7 Opportunistic infections
		2.3.8 TB/HIV co-infection diagnosis, treatment and management, including MDR TB/XDR TB treatment and management
		2.3.9 Hepatitis co-infection
		2.3.10 Substitution therapy (for positives and negatives)
		2.3.11 STIs and syndromic management
		2.3.12 Pediatric treatment
		2.3.13 Clinical pharmacoloy
		2.3.14 Clinical trials and medical research
		2.3.15 Universal precautions, infection control for HIV, TB, Hepatitis, etc.
	2.4 Medical Commodities	2.4.1 Forecasting, registration, PSM for ART
		2.4.2 Forecasting, registration, PSM for non-ART
	2.5 HIV/AIDS Care	2.5.1 Palliative care & home care
		2.5.2 Psychosocial care & support
		2.5.3 Care for children with HIV
		2.5.4 Care for orphans and vulnerable children
	2.6 HIV/AIDS Support	2.6.1 Medical disability for people living with HIV/AIDS
		2.6.2 Social services for people living with HIV/AIDS
		2.6.3 Rehabilitation for people living with HIV/AIDS
3. Human Rights, Advocacy, Communications & Information		
	3.1 Human Rights	3.1.1 Human Rights
	3.2 Advocacy	3.2.1 Advocacy
	3.3 Information	3.3.1 Electronic information
		3.3.2 Print publications
		3.3.3 Dissemination and use of information (national)

		3.3.4 Dissemination and use of information (subnational)
	3.4 Communications	3.4.1 Campaigns, incl TV & radio
		3.4.2 AIDS special events (WAD, etc.)
		3.4.3 Mass media
4. Management, Coordination & Institutional Relations		
	4.1 Management of NAP	4.1.1 Committee for HIV/AIDS & Socially Dangerous Diseases
		4.1.2 Ministry of Health - NAP management
		4.1.3 Ukrainian AIDS Centre
		4.1.4 GFATM Programme(s)
		4.1.5 Other national management structures
	4.2 Management of Oblast AIDS Programme	4.2.1 Oblast government
		4.2.2 Oblast health department
		4.2.3 Oblast AIDS Centre
		4.2.4 GFATM Programme(s)
		4.2.5 Other sub-regional management structures (municipal, district)
	4.3 Coordination - National-level	4.3.1 NC & Commitees - overall coordination
		4.3.2 Ministry of Health - coordination of NAP
		4.3.3 Other governmental coordination structures
		4.3.4 Non-governmental coordination structures
		4.3.5 Thematic coordination - national development instruments and mainstreaming of HIV/AIDS, etc.
	4.4 Coordination - Sub-national level	4.4.1 Regional coordination councils
		4.4.2 Sub-regional coordination (municipal, district)
	4.5 Instititional relations - National	4.5.1 Cabinet of Ministers
		4.5.2 Presidential administration
		4.5.3 Parliament of Ukraine
	4.6 Instititional relations - Sectoral	4.6.1 Ministry of Health
		4.6.2 Ministry of Family, Youth & Sport
		4.6.3 Ministry of Education
		4.6.4 Department of Corrections
		4.6.5 Ministry of Foreign Affairs
		4.6.6 Ministry of Defence and Interior
		4.6.7 Other National Ministries
	4.7 Instititional relations - Subnational	4.7.1 Work with regions

		4.7.2 Work with municipalities
	4.8 External Relations	4.8.1 NGOs (international / domestic)
		4.8.2 People living with HIV / Greater involvement of people living with or affected by HIV/AIDS
		4.8.3 Faith-based organizations
		4.8.4 Private sector
		4.8.5 Foundations / Philanthropy
		4.8.6 Global Fund to Fight AIDS, TB and Malaria
		4.8.7 United Nations
		4.8.8 World Bank / World Bank loan project
		4.8.9 Bilateral Donors
		4.8.10 Regional coordination structures (CIS, etc.)
5. Planning, Finance & Budgeting		
	5.1 Programe planning, finance & budget	5.1.1 National planning, finance and budgeting
		5.1.2 Oblast planning, finance and budgeting
		5.1.3 Sectoral planning, finance and budgeting
		5.1.4 GFATM planning, finance and budgeting
		5.1.5 World Bank planning, finance and budgeting
		5.1.6 Other planning, finance and budgeting
6. Procurement, Supply Management, and Human Resource Development		
	6.1 National Procurement and Supply Management	6.1.1 PSM for NAP
		6.1.2 PSM for GFATM
		6.1.3 PSM for World Bank project
		6.1.4 PSM for other commodities and services
	6.2 Sectoral / Sub-National PSM	6.2.1 PSM for Oblast AIDS Programme
		6.2.2 PSM for other commodities and services
	6.3 Human Resource Development	6.3.1 Medical education
		6.3.2 Non-medical education
		6.3.3 AIDS training
		6.3.4 Staff support, burn-out
7. Epidemiology and Surveillance		
	7.1 Epidemiology	7.1.1 Reporting
		7.1.2 HIV epidemiology & surveillance
		7.1.3 Clinical epidemiology & surveillance
		7.1.4 TB/HIV surveillance, including anti-TB drug resistance, HIV among TB patients, and HIV

		among drug-resistant TB patients
		7.1.5 PMTCT epidemiology & surveillance
		7.1.6 STI epidemiology & surveillance
		7.1.7 Sentinnel surveillance
		7.1.8 Data entry / QC and validation
8. Monitoring & Evaluation		
	8.1 National M&E Systems	8.1.1 National M&E plan
		8.1.2 National indicators / reporting
		8.1.3 Databases and information management
		8.1.4 National programme monitoring / evaluation
		8.1.5 Oblast M&E
		8.1.6 Sectoral M&E
		8.1.7 Financial monitoring (NASA)
		8.1.8 Behavioural surveillance and other second generation surveillance
		8.1.9 Other research, studies and ethics
		8.1.10 Data use
		8.1.11 GFATM M&E
		8.1.12 World Bank M&E
		8.1.13 Other M&E