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Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries

Ukraine Country Report

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Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCM	Country Coordination Mechanism
CIS	Common Independent States
CMU	Cabinet of Minister of Ukraine
CSO	Civil Society Organizations
DALY	Disability-Adjusted Life Years
DOT	Direct Observed Treatment
EU	European Union
FDI	Foreign Direct Investment
FSW	Female Sex Workers
GBV	Gender Based Violence
GDP	Gross Domestic Product
GOU	Government of Ukraine
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
KP	Key Populations
OST	Opioid Substitution Therapy /Medication Assisted Treatment
MDR	Multi Drug Resistant
MOF	Ministry of Finance
MOH	Ministry of Health
MSF	Medicines Sans Frontières
NAP	National Aids Program
NC	National Committee
NGCA	Non-Government Controlled Areas
NGO	Non-Governmental Organization
NSP	Needle and Syringe Exchange Program
NTP	National TB Program
OC	Oversight Committee
ODA	Official Development Assistance
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV/AIDS
PWID	People Who Inject Drugs
SES	Sanitary Epidemiological Service
SPSU	State Penitentiary Service of Ukraine
SS	State Service on HIV/AIDS and Other Socially Dangerous Diseases
TB	Tuberculosis
TFR	Total Fertility Rate
TPSAF	Transition Preparedness and Sustainability Assessment Framework
UAH	Ukrainian Hryvnia
UCDC	Ukrainian Center for Disease Control
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHI	Voluntary Health Insurance

WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

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Table of Contents

EXECUTIVE SUMMARY	1
TRANSITION RISK ASSESSMENT RATIONALE AND METHODOLOGY	1
TRANSITION RISK ASSESSMENT	2
1. CHAPTER: PURPOSE AND METHODOLOGY	12
1.1. PURPOSE	12
1.2. METHODOLOGY	12
2. CHAPTER: EXTERNAL ENVIRONMENT	14
2.1. COUNTRY BACKGROUND AND POLITICAL SYSTEM	14
2.2. ECONOMIC DEVELOPMENT	14
2.3. SOCIAL AND HUMAN DEVELOPMENT	15
2.4. OTHER EXTERNAL FACTORS	16
2.5. BRIEF HEALTH SYSTEM OVERVIEW	17
2.6. THE ROLE OF CIVIL SOCIETY INVOLVEMENT IN PUBLIC SERVICE DELIVERY	20
2.7. HUMAN RIGHTS, STIGMA AND DISCRIMINATION	22
2.8. EPIDEMIOLOGICAL CHARACTERISTICS OF HIV AND TB	24
2.8.1. HIV/AIDS	24
2.8.2. TUBERCULOSIS	28
2.9. GLOBAL FUND GRANT OVERVIEW	30
2.9.1. HIV/AIDS	30
2.9.2. TUBERCULOSIS	32
3. CHAPTER : INTERNAL ENVIRONMENT	32
3.1. STEWARDSHIP	32
3.1.1. STEWARDSHIP OF NATIONAL HIV AND TB PROGRAMS	32
3.1.2. COORDINATION MECHANISM	34
3.1.3. PROGRAM MANAGEMENT ARRANGEMENTS	36
3.1.4. PARTNERSHIPS	37
3.1.5. ACCOUNTABILITY MECHANISMS	40
3.2. FINANCING	41
3.2.1. GENERAL HEALTH CARE FINANCING	41
3.2.2. FUNDING OF THE NATIONAL HIV PROGRAM	44
3.2.3. FUNDING OF NATIONAL TUBERCULOSIS PROGRAM	48
3.3. SERVICE DELIVERY	49
3.3.1. HIV	49
3.3.2. TUBERCULOSIS	58
3.4. HUMAN RESOURCES	61
3.4.1. GENERAL OVERVIEW OF HUMAN RESOURCE PRODUCTION, DEPLOYMENT AND RETENTION	61
3.4.2. HIV HUMAN RESOURCES	63
3.4.3. TUBERCULOSIS HUMAN RESOURCES	65
3.5. COMMODITY FORECASTING, PROCUREMENT AND SUPPLY CHAIN MANAGEMENT	66
3.5.1. GENERAL OVERVIEW OF PROCUREMENT AND SUPPLY MANAGEMENT SYSTEM IN THE HEALTH CARE	66

3.5.2.	HIV	68
3.5.3.	TUBERCULOSIS	70
3.6.	M&E AND INFORMATION SYSTEMS	71
3.6.1.	HIV	71
3.6.2.	TUBERCULOSIS	72
4.	CHAPTER: ASSESSMENT OF TRANSITION READINESS	73
4.1.	TRANSITION EXPERIENCE	73
4.2.	PROGRAM CONTINUITY	73
4.2.1.	HIV	74
4.2.2.	TUBERCULOSIS	74
4.3.	ORGANIZATIONAL CAPACITY	74
4.4.	TRANSITION PLANNING	77
4.4.1.	HIV	78
5.	CHAPTER: CONCLUSIONS AND RECOMMENDATIONS	80
5.1.	TRANSITION AND SUSTAINABILITY RISK ASSESSMENT	80
5.2.	GENERAL RECOMMENDATIONS	89
5.3.	PROGRAM SPECIFIC RECOMMENDATIONS	91
ANNEXES:		96
ANNEX 1:	LIST OF DOCUMENTS REVIEWED	96
ANNEX 2:	LIST OF PEOPLE MET	98
ANNEX 3:	LIST OF KEY INDICATORS	101

EXECUTIVE SUMMARY

Transition Risk Assessment Rationale and Methodology

The Ukraine country case study was undertaken in the frame of a research project entitled “Transition from the Global Fund Support and Programmatic Sustainability Research in four CEE/CIS countries”, which was commissioned by the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and implemented by Curatio International Foundation (CIF).

Since its foundation in 2002, the Global Fund has invested nearly US\$4 billion a year to support programmes addressing these diseases in over 140 countries. Currently the Global Fund measures a country’s eligibility for funding in each disease by assessing their disease burden and income. Changes in how the Global Fund allocates resources to recipient countries have important consequences in how countries will continue to conduct previously donor-funded activities. This is particularly relevant for the Commonwealth of Independent States (CIS) and the Central and Eastern European (CEE) region, which are still burdened by fast-growing HIV/AIDS and TB epidemics. Unless the transition from Global Fund support is well planned and effectively implemented, the sustainability of HIV and TB programs in these countries is at risk.

This case study is one among the four studies undertaken in Georgia, Belarus, Bulgaria and Ukraine with a purpose to pilot *Transition Preparedness and Sustainability Assessment Framework (TPSAF)* and generate prospective evidence to inform an adequate transition planning process from the Global Fund support. The research intends to understand the factors affecting sustainability and to identify the strategic and operational issues required to assure the sustainability of HIV and TB programmes in Ukraine.

The TPSAF used in the case study was developed by this research project. The framework allows to assess country readiness for a scenario without Global Fund support by examining the elements that should be in place early on as a country prepares for transition.

For the purposes of this research project, the following definitions of transition and sustainability apply.

Transition is defined as “*the process of moving away from direct donor support by developing mechanisms to manage health programmes, practices or interventions in a sustainable manner through the interaction of internal and external enabling factors*”.

Sustainability is defined as “*the capacity of a country to independently manage their disease-specific programmes in the long-term without interruption or compromising quality by developing a sense of ownership and enabled by an adequate internal and external national environment*”.

The conceptual framework distinguishes two overarching domains. The external environment is the first domain, which includes political, social and economic environment sub-domains. The external environment includes factors that are outside of the health sector but have an impact on the health response, such as: a country’s political and governance structure, economic and social environment, human rights, stigma and discrimination and an enabling environment for civil society.

The second domain is the internal environment, which represents those factors that are specific to the health sector, and has three main sub-domains: governance, inputs to the program and the program itself. All sub-domains are further divided into components that affect the transition and sustainability of public health programs after graduating from donor support. Collectively the components, sub-domains and domains included in the conceptual framework help to unpack the transition and sustainability related issues/areas and present the findings in a well-organized and logical manner.

Finally, by analysing these external and internal environments, the framework allows to examine a country's readiness and/or identify the steps required to reach the intended outcome, which is defined as successful transition from Global Fund support to program sustainability. Quantitative and qualitative indicators for each domain and its components were developed to respond to each component of the framework. These indicators have been used to assess possible risk to transition by assigning a range of low risk, moderate risk and high risk and a final score for assessing country risk for the transition.

The assessment utilized mixed methods of data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders from the government or directly working with Global Fund grants, and were identified based on their relationship with the grants as well as through the snow-ball technique, in which interviewees nominate other potential interviewees. The interviewees included government officials, donor representatives, staff from international organizations and civil society members and members of affected communities.

The quantitative and qualitative data arising from case study were triangulated using documentation, conceptualization, coding, and categorizing in line with the conceptual framework domains, sub-domains and components, which allowed us to examine relationships between them and led to major findings that eventually informed the recommendations.

Transition Risk Assessment

Findings presented below arise from this country case study and, separately, some general findings, which resonate and align with the results of other studies¹ and lead to more general conclusions from those that are purely country specific. Consequently, the two sets of conclusions are detailed in separate sections. Sustainability Risk Assessment (Table 1 on page 8) summarizes the assessment of Ukraine readiness for transition from GF support, and singles out programme level bottleneck that may impede transition. A summary score of transition risk (33%) indicates that that Ukraine is exposed to **high to moderate** transition risk. The scores for each individual domain help identify critical areas that may pose medium to high risk and requires to be addressed during the transition process.

EXTERNAL ENVIRONMENT

Economic development: The recent political turmoil, ongoing military actions and the annexation of Crimea have negatively affected Ukraine's economy and are perceived to have a lasting effect. Stable high government spending on health, which was around 12% of total General Government Expenditure, started to deteriorate due to the economic challenges that emerged in 2014. If this trend is maintained, Ukraine will face challenges during transition from Global Fund support.

Political commitment: The share of government spending on health out of General Government Expenditure started to deteriorate due to economic challenges emerging in 2013 -2014, albeit the share of government spending on health out of the total health expenditure. There are no legal barriers that hinder effective prevention, treatment, care and support for KP and people living with diseases, however anti-discrimination laws have not been always effectively enforced to safeguard the human rights of vulnerable social and ethnic groups.

INTERNAL ENVIRONMENT

Financing: The government's commitment to fund the national HIV and TB response looks less promising at present. Although the share of public expenditure on HIV and TB program is increasing, it is at a slow pace and remains largely dependent on external funding. The political will to prioritize the HIV/AIDS program during resource allocation is lacking, and underfunding of national disease specific programs is common. In summary, the share of program costs Ukraine has

¹ Gotsadze T., Fuenzalida H., et al. Thematic Review on Transition and Sustainability of Global Fund Supported Programs. Curatio International Foundation, 2015

to take over when the Global Fund support ends for HIV and TB programs remains high. Countries where programs are predominantly government funded (>95%) found it much easier to assume financial responsibilities after the end of external funding². Therefore, the current level of HIV and TB program financing in Ukraine poses a high risk for transition. In order to achieve a positive public health impact with possible financial limitations, the country has to ensure effective coverage of key populations by improving the allocative and technical efficiency of prevention, treatment and care services.

Human Resources: Geographical imbalance, staff turnover and a lack of motivation are common features of the Ukrainian health care system. The ageing of the health workforce, which is most severe in the TB sector, coupled with the low salaries of TB medical staff and hazardous work environment which deter young people from working in the TB field, raises serious concerns. Global Fund supported trainings for health personnel are not fully institutionalized in the national education system, and there is policy for continuous education of CSO personnel. These systemic weaknesses put the transition of HIV and TB programs after Global Fund support at high risk, if they are not addressed accordingly and in a timely manner.

Information Systems: The HIV and TB M&E system is integrated into national reporting systems, but there is still room for improvement. The 2nd generation surveillance capacity was built with the support of the Global Fund, but remains mostly externally funded. Maintaining the effective operation of the M&E system after external funding ends is at a medium level risk if the government fails to further enhance its surveillance system, track program expenditures regularly, build adequate analytical capacity at national and local levels and carry out research that informs future policy development and program implementation.

Governance: The government remains committed to the continuation of the HIV and TB national programs, although the new national TB program is still awaiting government approval. The management of national HIV and TB programs faces challenges following the liquidation of the State Service of Ukraine on HIV/AIDS and Other Socially Dangerous Diseases. Following reorganization, the MOH failed to establish/assign the national program management responsibility to respective divisions in the ministry. UCDC is legally empowered but the complexities of public management impose significant limitations on its powers and operations.

Ukraine had a functioning national coordination mechanism, but recently the National Council mandate was shifted down from the Cabinet of Ministers to the level of the MOH. As a result of the recent restructuring of the overall national coordination system, erosion of the traditional HIV/TB governance and coordination resulted in reduced political commitment and disappearance of HIV and TB from the government's and the MOH's policy agenda. Streamlining national program governance, strong coordination and easy access to program performance information³ will minimize challenges during transition.

Program: In order to achieve a positive public health impact despite possible financial limitations, the country has to ensure effective coverage of key populations by improving allocative and technical efficiency of prevention, treatment and care services. Advancing technical efficiency should be addressed by reinforcing prevention activities, rightsizing service providers, building linkages between the health sector and non-governmental and social service providers, streamlining patient pathways among TB and HIV service providers and enhancing of follow-up and social support for improved treatment outcomes. Taken together, these measures will mitigate the potential challenges Ukraine will face after transition from Global Fund support.

² Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of global fund supported programs. Curatio International Foundation, 2015

³ Transparency and streamlined accountability: what watchdogs, grant implementers and OIG want, Aidspace, 2015
<http://www.aidspace.org/node/3354>

Organizational Capacity: There are several prerequisites for easy transition and attaining the desired public gains. They are: enhancing coordination between PR and national program management entities and strengthening the organizational capacity of national program implementers and service providers; streamlining procurement functions to allow the procurement of HIV and TB drugs and commodities at a lower price; and enhancing M&E and evidence based program planning and implementation.

Transition preparedness: Since Ukraine has made little to no effort to gradually transfer responsibilities to the government for particular program elements, its transition experience is limited and, where available, is not positive. Due to cutbacks in the Phase 1 HIV GF grant of Round 10, prevention activities were reduced in size, and the government has not taken over funding of the remaining services. Whilst there was neither a formal mechanism allowing the government to finance preventive services, nor a government approved standard list of preventive services for KPs, this was a missed opportunity to facilitate and initiate the required policy and regulatory changes and safeguard adequate funding. Within the frames of NFM prevention, service packages for different KP groups have been further optimized. At present, minimum service packages, comprising of 3-4 services only, are offered to KP, which apparently limits the effectiveness of preventive programs. Furthermore, funding for case management (социальное сопровождение) substantially decreased through NFM, which caused massive NGO staff redundancy at the national and local levels (around 30%-35%.) The government share of funding for ARV medicines increased, although due to the procurement problems, the government failed to meet expectations.

The only positive experience of transitioning program element is that most OST sites established at narcological institutions have dedicated staff for psychosocial care (social workers and/or psychologists) who are employees of the health care facility and are paid from regular facility budgets. Likewise, social workers are deployed at AIDS and TB centers.

In summary, Ukraine faces High to Moderate risk of transition. Given that at present the government and other key stakeholders are over-occupied by immediate emergency challenges, the first steps initiated by the government for transition planning are commendable and should be seen as a demonstration of government's willingness to sustain an effective national HIV and TB response. It is believed, that a more comprehensive transition plan, outlining detailed steps to be undertaken in each key area of the national HIV and TB programs, would serve as a road map for a smooth and painless transition.

RECOMMENDATIONS

GENERAL RECOMMENDATIONS: Based on the findings of the sustainability assessment discussed in previous chapters, this section provides bold recommendations that can guide the Government and key stakeholders towards an easy transition after external funding ends.

- **Transition plan:** While the country is discussing and actively working on the elements of the transition, there is no overall plan governing this process. Adequate conceptualization of and careful planning would most likely be of benefit. Other country experiences prove that planned transitions reduce/minimize transition challenges, while rushed transitions cause more problems and undermine sustainability⁴. Therefore, developing time-bound and actionable plans, which have sufficient legal power and adequate indicators to monitor plan implementation, seem to be necessary first steps for the country to consider. Finally, effective implementation of the plan would also require sufficient resources (human and financial) to achieve transition objectives.
- **Gradually reducing financial dependence on the Global Fund:** Experience prove that the transition process become smoother and odds for sustainability increase when the Global

⁴ Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of global fund supported programs. Curatio International Foundation, 2015

Fund's contribution to the national response is not significant, i.e. less than 25%⁵. Consequently, the country has to strive to gradually reduce its dependence. The first and most important area for transition to consider is commodity procurement, so that national procurement mechanisms function adequately and allow for such a transition. The most challenging area seems to be transition of preventive interventions, especially those delivered by NGOs/CSOs, which could be left for the latter phases, provided that sufficient preparatory work is done during the lead-up time to transition date (see CSO contracting for more details).

- Many countries give lower priority to prevention compared to treatment. In many instances, the lack of national budget allocation (even with small amounts) has challenged transition and undermined sustainability prospects⁶. While prevention could be last element to be transitioned, it seems important to start developing prevention budget lines/allocations during the transition process, which may eventually drive increased budget allocations when the country stops receiving Global Fund support. In other countries, legally empowered national programs that already reflect a gradual reduction in donor dependence in their budget have often served as an effective instrument⁷.
- **CSO contracting:** The overall legal environment is not conducive to NGO/CSO contracting, and the country lacks detailed contracting procedures for CSO contracting in the health sector. Ukraine would benefit significantly if these rules/procedures were developed during transition and institutionalized. A similar situation was observed in countries that graduated from the Global Fund without having such rules in place and facing transition challenges⁸. Based on other country experiences, such detailed contracting rules/procedures are at least expected to address the following: service definition; service pricing and/or methodology to estimate quoted prices, which helps evaluate value for money for the submitted bids during tendering/national procurement process and, most importantly, helps the government to estimate overall program costs for a given disease and adequately budget during the budgeting process; tendering procedures that are aligned with the national procurement laws and regulations; bid evaluation procedures for both quality and value of the bid; procedures for monitoring quality and/or volume of services delivered by CSOs, etc.
- **Effective national coordination,** with or without the CCM as a coordinating body, is essential for effective management of the national response and for implementing the transition process, which leads to sustainability. One of the greatest benefits that the Global Fund has delivered worldwide is creating the space for governments and civil society to jointly engage in national/global response planning and coordination^{9,10,11}. In most states CCMs, or similar structures, that formally provide a seat and voice for NGOs/CSOs in national coordination, have been critical in achieving the gains observed. Consequently, retaining and/or enhancing effective coordination structures proved to be important in many countries after Global Fund support¹². Therefore, it seems important for the country to consider retaining and enhancing the national coordination structure/function, which would allow for continuous NGO/CSO engagement. For such coordination to be effective, the production, availability, transparency and easy access to information should be ensured for the development of evidence-based (or informed) responses.

⁵ Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of global fund supported programs. Curatio International Foundation, 2015

⁶ Ibid 5

⁷ Ibid 5

⁸ Ibid 5

⁹ Spicer N., Aleshkina J., et al. National and subnational HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice? *Globalization and Health* 2010, 6:3

¹⁰ Kapilashramia A., O'Brien O. 2012. The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit? *Global Public Health: An International Journal for Research, Policy and Practice* Volume 7, Issue 5, 2012

¹¹ Duvvury N., Cornman H., Long C. 2005. Participation of Civil Society in Global Governance: Lessons Learned from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. www.icrw.org

¹² Ibid 5

- **Enhancing public accountability** during and after transition will be critical to assure quality partner engagement i.e. NGOs, SCOs, journalists and development partners. This would require the routine production of information describing results of the national response i.e. disease program specific epidemiological and financial expenditure data; the results of program performance, including outcomes and challenges. During transition, the country (perhaps with Global Fund support) should strive to assure (maybe contractually and/or through legislative action) that this information is not only routinely produced, but is also freely accessible for all stakeholders involved, government and civil society alike.
- **Addressing human resource challenges** should be viewed in two parts: a) assuring adequate quantity and re-distribution of the needed human resources; and b) continuous education of the professionals involved in national response service provision. The latter has been extensively supported by Global Fund grants, and not only in this country¹³. However, the sustainability of these trainings raise concerns due to the lack of institutionalization achieved during grant implementation¹⁴. Consequently, the transition period has to be explicit about what could be achieved in terms of preparing the necessary human resources, how it can be achieved, and how this function can be institutionalized, funded and delivered by the government. The question of human resources goes well beyond the disease response, and results from health sector policies, education policies and the overall socio-economic environment in the country. It also affects the whole health care system. Instead of addressing these challenges as a transition issue, therefore, it is necessary to look at these challenges more holistically and outside of the transition process.

PROGRAM SPECIFIC RECOMMENDATIONS

RECOMMENDATION # 1: Enhancement of Stewardship and Governance of National Programs

- Improve coordination function at national and local levels for better programmatic planning, budgeting, implementation and M&E. Plan for maintaining a new CCM secretariat and ensure that adequate funding is guaranteed from MOH budget.
- Ensure participatory process for Transition Plan development, implementation and monitoring and evaluation by enhanced partnerships between government and non-government sectors and active engagement of all stakeholders in transition planning, implementation and M&E of transition process.
- Build National Program Management capacity at MoH (Department of Public Health) and UNDCD.
- Revise current legislation to decrease stigma and discrimination towards HIV/AIDS and TB. Particularly, revise/elaborate the state social assistance and benefits legislation by safeguarding the inclusion of PLHIV, key population and TB patients in the eligibility categories.
- Enforce the policy on collaborative HIV/TB activities, as well as ensure collaboration between the Ministries of Internal Affairs and Health.
- Elaborate legislation allowing distribution and redistribution of drugs from and between Oblasts and Rayons in order to decrease treatment interruptions
- Renew mapping of Development Partner programs and their alignment in support of the transition plan implementation.
- Maintain partnership with CSOs by developing CSO contracting mechanisms and continuous COS capacity building.
- Optimize ARV treatment regimens and develop referral algorithms that ensure the continuation of services from identification and prevention to treatment and care

¹³ Bowser.D., Sparkes.SP., et al. 2013. Global Fund investments in human resources for health: innovation and missed opportunities for health systems strengthening. Health Policy and Planning 2013;1-12

¹⁴ Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of global fund supported programs. Curatio International Foundation, 2015

- Revise and enforce protocols that ensure a decrease in in-patient stay and increase the responsibility of PHC for treatment.
- Ensure the transparency of achievements in the field of HIV and TB through improved access and provision of sufficient information to the public for the decrease of stigma and discrimination.

RECOMMENDATION #2: Ensure improved efficiency of current spending, adequate resource allocation for HIV and TB National Program implementation and mobilize domestic and international funding for effective implementation and monitoring of the transition process.

- Prepare national and regional budget forecasts and ensure allocations based on technical and allocative efficiency principles. Ensure medium term budgeting of adequate resources for continuation of HIV prevention, treatment and care activities after GF funding ends as well as ensure medium term budgeting of adequate resources for TB national program at national and local levels that can i) compensate GF funded share and ii) gradually fill the programmatic gap. In addition, the MoH may consider to define and legislate the range of per capita allocation per year for local budgets along with revised possible share of spending for outpatient and in-patient care. HIV and TB national program budgets should reflect a multi-sectoral approach. Even though HIV and TB programs currently are vertical programs under the MOH, program budgets should list all relevant activities funded by other line ministries. The government of Ukraine can be advised to advocate that each ministry has HIV and TB specific budget lines in its budget.
- Ensure allocative efficiency. Consider improving allocative and technical efficiency of both national programs according to the recommendations provided by the WHO, WB and other technical research studies. Carry out a detailed analysis to determine in which areas technical efficiencies could be realized. Develop and utilize costing methodology of HIV preventive interventions for budget planning. For TB national program Improve effectiveness of TB prevention, diagnostic and treatment services through strengthening the role of the PHC sector and modification of funding methodology for in-patient treatment
- Leverage resources for transition plan implementation. Calculate the non-programmatic costs of the transition plan implementation, and leverage domestic and external resources for effective implementation of the plan and M&E

RECOMMENDATION # 3: Streamline service delivery

- Expand coverage of PWIDs with harm reduction programs by allowing alternative delivery models of NSP service provision and with OST by revising legislation that hinders OST service provision and ensure its enforcement. Ensure implementation of the Prevention Service Strategy
- Remove barriers to HIV testing and treatment through strengthening cooperation between governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services, by improving timely and complete diagnosis, prompt prescription of correct treatment and good adherence to ART.
- Develop a patient-centered care model oriented to ambulatory care of all TB and MDR TB cases, and initiate implementation of TB facility rightsizing by closing small inefficient facilities.
- Revise legislation to remove all motivation factors for long hospitalization of TB patients as well as TB hospital funding methodology. Include TB hospitals in general health care reform aiming to institute new performance-based funding mechanisms. The available resources obtained as results of cost-efficiency measures should be re-invested in TB control to cover urgent needs for ambulatory care (TB prevention, diagnosis, patient support, treatment follow-up and adherence, social contracting, incentives for TB and PHC staff as well as additional layers etc.).
- Improve the efficiency of TB diagnostic services by revising the respective legislation on obligatory fluorography screening among professions with little impact on spread of airborne infection, and focus better on well-defined risk groups in line with WHO

recommendations; rationalize the laboratory system and improve sputum transportation logistics; continuously improve laboratory quality insurance.

- Update and introduce TB diagnosis, treatment and prevention protocols in accordance with the latest international standards to ensure access to relevant diagnostic tools and use of adequate treatment regimens (including adequate dosage) and isoniazid preventive treatment in evidence based dosage and duration.

RECOMMENDATION # 4: Ensure adequate supply of human resources and integration of HIV and TB training modules into the continuous medical education system

- Develop HIV/AIDS human resource planning and development strategy and elaborate a work force motivation strategy. Ensure the integration of HIV training modules in continuous education systems and consider gradual integration of these training modules into undergraduate education system. Elaborate a strategy for continuous NGO training.
- Review TB human resources plan and task profiles of staff in line with projected changes. Consider merging of two existing separate specialties of pulmonology and TB specialist into one (respiratory disease specialist), including pre- and post-graduate education and specialization. Increase the salaries (incentives) for TB staff (physicians and nurses) and primary care staff involved in TB care at the cost of TB bed reduction (consider using savings from cost-efficiency measures).

RECOMMENDATION # 5: Streamline forecasting, procurement and supply management system

- Develop an ARV drug forecasting methodology that allows sufficient buffer stocks according to international standards and revise TB drug forecasting methodology. Consequently build responsible staff capacity in drug forecasting methodology.
- Build the procurement capacity at local levels for transparent and competitive procurement practices
- Develop a Drug Management module in e-TB manager to improve the distribution and redistribution procedure at all levels.
- Improve stock management capacity at Oblast levels.

RECOMMENDATION #6: Enhance surveillance systems and build data analysis capacity at national and local levels

- Provide training in surveillance and M&E data analysis at national, local and facility levels to ensure evidence based planning and implementation.
- Build staff capacity in utilization of e-TB manager.
- Elaborate methodology for TB expenditure tracking and ensure regular utilization and ensure regular tracking of HIV/ AIDS spending.

RECOMMENDATION #7: Ensure NGO capacity development to ensure sustainability

- Establish NGO “Consulting body” to support NGOs in diversification of their income sources and diversification of service provision range.
- Build NGO capacity in Management, Proposal writing, Advocacy, Resource Mobilization, Strategic planning etc.
- With active involvement of local NGOs, perform a financial mapping exercise and assist/guide NGOs to tap resources.
- Perform a more detailed analysis of existing legislation in government NGO support mechanisms and advocate/promote respective changes.

Table 1: Summary Risk Assessment Table

H – HIV/AIDS; T- Tuberculosis; B – Both diseases

Component	Disease	Indicator	Risks
External Environment			
Political	B	Existence of political will to	Stable high government spending on health around 12% out of total General Government Expenditure, although a deterioration

		prioritize health investments	was noted due to economic challenges emerging in 2013 -2014. Stable share of Government spending on health out of THE
	B	Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for KP and people living with diseases and strong rule of law	There are no legal barriers that hinder effective prevention, treatment, care and support for KP and people living with diseases. However, laws are not effectively enforced and administratively some KPs face challenges when accessing services
	B	Government ability to contract with CSOs	General regulation allowing CSO contracting exists and detailed tender procedures for CSO contracting is available in social sector.
Economic	B	Favorable economic indicators	GDP per capita decrease (annual %) was observed in 2014 due to armed conflict. Share of General Government Revenues (excluding grants) as % of GDP is more than LMIC mean (37.3) in 2012 year
Internal Environment			
Financing	H	Budgetary commitment to disease	Public expenditure on HIV program is NOT increasing. Political will is lacking in prioritization of HIV/AIDS Program during resource allocation. The budget of the health sector was increased by 10% in 2014 in response to NGOs' aggressive lobbying, however additional funding has been redistributed to other state programs by the MOH, leaving HIV unattended. Share of public funding is approximately 44% of total AIDS spending in 2014. Budget lines exist but NOT aligned with NSP needs
	T		Public expenditure on TB program is NOT increasing. Political will is lacking in prioritization TB Program during resource allocation. The budget of the health sector was increased by 10% in 2014 in response to NGOs' aggressive lobbying, however additional funding has been redistributed to other state programs by the MOH, leaving TB unattended. The biggest share (47.7%) of total NTP expenditure is covered through central and local budget sources in 2013, whereas external funding accounts for only 19%. Ukraine has never performed a detailed calculation of all TB activities and estimation of a total budget
	H	Prevention priority	Overall spending on HIV prevention is not increasing. Preventive programs for KP are primarily financed from external sources. The budget for preventive activities has been decreased over the last couple of years
	H	Allocative efficiency	Allocative efficiency study was conducted in Ukraine but has not yet informed budget allocations
	H	Treatment / input financing from public sources	Case detection/diagnosis mostly financed from TGF. First line ART partially funded by public sources. Second line ART are mostly funded by external sources. Adherence support fully funded from external sources
	T	Treatment / input financing from public sources	Case detection mostly funded from public sources. FLD funded from public sources, SLDs mostly funded from external sources. Adherence support completely TGF dependent
	H	Prevention financing from public sources	Low Threshold Services (excluding OST) are no funded from public sources, OST mostly financed from TGF grant
Human Resources		Sufficient human resources for a disease (quantities, geographic distribution and aging)	Sufficient. Inadequacy of human resources for HIV was not raised by stakeholders, or noted in any publications. However, downsizing of HIV staff is expected after the GF ends.
	T		With some limitations Relatively adequate although only 87% of positions are filled. Aging of staff raises serious concerns, low salaries of TB medical staff and hazardous work environment distract young people to work in the TB field.
	B	Sufficient human resources for a disease (quantities, geographic distribution and aging)	TGF supported some trainings (especially for HIV) have not been institutionalized into the national education system. Policies for CSO personnel production exist but are rather weak. TFG funded salaries are not aligned with the national pay-scale and are significantly higher
Health Information System	H	Advanced routine statistical reporting fully integrated in the national system	HIV testing, PMTCT, AIDS related mortality, adult and pediatric treatment -partially advanced
	T		TB New and relapse cases, treatment registry, Pediatric treatment-MDR TB, Care and support (incl pediatric) – integrated, partially advanced
	H	HIV second generation surveillance	Rigoris methodology used for IBBS, IBBS implemented timely, IBBS and PSE not funded from public sources
Governance	H	Strong political commitment to diseases	Ukraine has parliament approved Law on HIV/AIDS covering period 2014-2018 (alternative to NSP)
	T		Country develops a new National Program for the period of 2015-2018 , which is awaiting Government's approval (under the leadership of UCDC).
	H	Strong leadership	There is no entity fully responsible for the national Disease

			program. Following reorganization of State Agency the management responsibilities are not transferred to other entity due to its absence (the entity should be formed at the MOH). UCDC is legally empowered but the complexities of public management impose significant limitations on its powers. Individual leadership is visible.
	T		Ukrainian AIDS center (UCDC) is legally empowered but the complexities of public management impose significant limitations on its powers. Individual leaders exist but are less visible than in HIV.
		Strong coordination mechanisms	The Coordination body is not well placed within the government hierarchy to assure adequate national coordination and coordination across different sectors. CSOs have legally determined seat on the national coordination and play a significant role. Coordination body functionality is rather weak and not very effective, especially since recent restructuring.
Accountability	B	Program performance results are available and accessible through public domain	Program performance data is publicly available, except Program expenditure data especially for TB.
	B	Enabling Environment for Civil Society engagement ¹⁵	Ukraine's EEI for 2013 was 0.56, indicating that there are no laws or policies that restrict civil society playing an oversight role, and civil society is actively engaged in providing oversight
Program			
Service delivery	H	Treatment	There are increasing numbers PLHIV on ART but rather low coverage. There are gaps from testing to treatment and care cascade. Treatment-adherence outcomes are improving.
	T		Over the past 10 years, the sensitive TB treatment success rate is around 70%; The percentage of effective treatment of MDR TB cases that started treatment in 2011 and 2012 is only 34.9%
	B	Integrated services	PMTCT is well integrated in maternity care, while TB services still remain as vertical system with limited or no integration into PHC. TB/HIV services are not integrated, but integration with OST services is emerging.
	H	KP reach with preventive services	Coverage of KP with preventive services is increasing but still remains low (2 data points 2011 & 2013); Data is based on rigorous IBBS methodology
	B	CSO contracting in health	Detailed tender procedures for CSO contracting is available in social sector NOT for health sector. Government already contracts CSOs to provide social services using public funds, but this is not practiced yet for health services
Organizational capacity	H	Strong management of the National Disease Program Management Entity (not PR)	Due to the absence of an entity responsible for the overall management of the HIV/AIDS program, its capacity assessment has not been conducted. Relationship between PRs and national disease management entity not defined at present due to the absence of such an entity. PRs manage only GF funding.
	T		Due to the absence of an entity responsible for the overall management of TB program, its capacity assessment has not been conducted. The relationship between PRs and national disease management entity is not defined at present due to the absence of such entity. Non-government PR manages only GF funding.
	B	PSM	GF funded procurement is NOT integrated into the national system. Supply chain management is NOT integrated into the national system. Low frequency of emergency procurements for TB drugs while for HIV most recent emergency procurement was held in 2015. Stock outs for drugs (not more than once for last year) NOT detected. National procurement PAYING MORE than 5% above the

¹⁵ <http://civicus.org/eei/>

			international benchmark price .
	B	M&E	M&E capacity at government institutions is weak. Although there a lot of analytical reports in Ukraine, they are largely produced by donors and non state actors. The epidemiological data is available and used in NSP/NTP, although M&E data are not always used for program planning and budgeting.
	H	Transition plan / elements	Legally binding and actionable transition plan does not exist,. Albeit there are steps identified for transition plan development, but yet not formalized. Transition elements (financial responsibilities to cover ART by 2018) are embedded into the National HIV/AIDS program (HIV/AIDS law).
	T		Legally binding and actionable transition plan does not exist,. Albeit there are steps identified for transition plan development, but yet not formalized. Transition elements (financial responsibilities) are embedded into the National TB program
	H	Transition plan	NA
	T	characteristics	NA
	B	Transition M&E	NA
OVERALL RISK RATING			High to Moderate Risk

1. CHAPTER: PURPOSE AND METHODOLOGY

1.1. Purpose

The Ukraine country case study was undertaken in the frame of a research project entitled “Transition from the Global Fund Support and Programmatic Sustainability Research in four CEE/CIS countries”, which was commissioned by the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and implemented by Curatio International Foundation (CIF).

Since its foundation in 2002, the Global Fund has invested nearly US\$4 billion a year to support programmes addressing these diseases in over 140 countries. Currently the Global Fund measures a country’s eligibility for funding in each disease by assessing their disease burden and income.

Changes in how the Global Fund allocates resources to recipient countries have important consequences in how countries will continue to conduct previously donor-funded activities. This is particularly relevant for the Commonwealth of Independent States (CIS) and the Central and Eastern European (CEE) region, which are still burdened by fast-growing HIV/AIDS and TB epidemics. Unless the transition from Global Fund support is well planned and effectively implemented, the sustainability of HIV and TB programs in these countries is at risk.

Current research seeks to generate prospective evidence to inform an adequate transition planning process from Global Fund support. The research intends to understand the factors affecting sustainability and to identify the strategic and operational issues required to assure the sustainability of HIV and TB programmes.

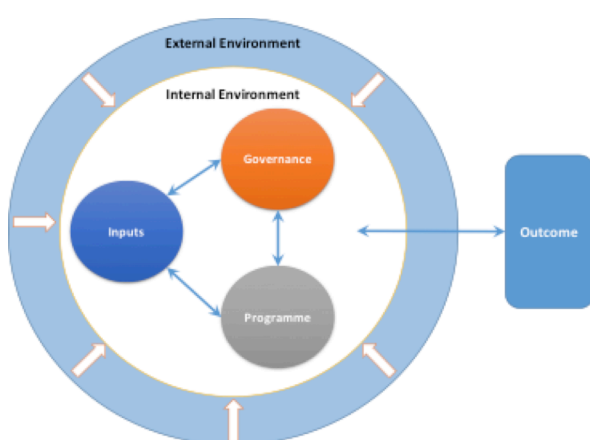
1.2. Methodology

For the purposes of this research project, the following definitions of transition and sustainability apply.

Transition is defined as “*the process of moving away from direct donor support by developing mechanisms to manage health programmes, practices or interventions in a sustainable manner through the interaction of internal and external enabling factors*”.

Sustainability is defined as “*the capacity of a country to independently manage their disease-specific programmes in the long-term without interruption or compromising quality by developing a sense of ownership and enabled by an adequate internal and external national environment*”.

Figure 1: Transition & Sustainability Assessment Framework

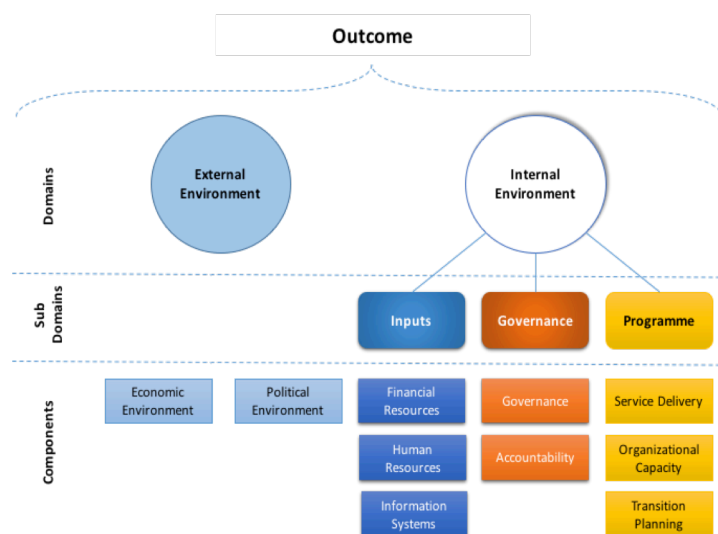


Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. (2015). The road to sustainability: Transition Preparedness Assessment Framework. Tbilisi, Georgia: Curatio International Foundation.

The conceptual framework distinguishes two overarching domains (Figure 1). The external environment is the first domain, which includes political, social and economic environment sub-domains. The external environment includes factors that are outside of the health sector but have an impact on the health response, such as: a country’s political and governance structure, economic and social environment, human rights, stigma and discrimination and an enabling environment for civil society.

The second domain is the internal environment, which represents those factors that are specific to the health sector, and has three main sub-domains: governance, inputs to the program and the program itself.

Figure 2: Transition and Sustainability assessment components



Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. Gotsadze, T et al (2015). The road to sustainability: Transition Preparedness Assessment Framework. Tbilisi, Georgia: Curatio International Foundation

All sub-domains are further divided into components that affect the transition and sustainability of public health programs after graduating from donor support (Figure 2). Collectively the components, sub-domains and domains included in the conceptual framework help to unpack the transition and sustainability related issues/areas and present the findings in a well-organized and logical manner.

Finally, by analysing these external and internal environments, the framework allows us to examine a country's readiness and/or identify the steps required to reach the intended outcome, which is defined

as successful transition from Global Fund support to program sustainability.

Table 2: Illustration of the Transition and Sustainability risk assessment framework

Each framework component was operationalized into indicators for each domain and its

Program-level bottlenecks that should be addressed

Component	Disease	Indicators	Measurement	Low risk	Moderate risk	High risk	Component Assessment
				X criteria are met	X criteria are met	X criteria are met	
External Environment							
Internal Environment							
Overall Country Risk Assessment							

General country assessment on readiness for transition

General country assessment on readiness for transition

components. Table 2 illustrates how this tool assesses country readiness for transition.

Quantitative and qualitative indicators were developed to respond to each component of the framework. These indicators have been used to assess possible risk to transition by assigning a range of low risk, moderate risk and high risk and a final score for assessing country risk for the transition.

The assessment utilized mixed methods of data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders from the government or directly working with Global Fund grants, and were identified based on their relationship with the grants as well as through the snow-ball technique, in which interviewees nominate other potential interviewees. The interviewees included government officials, donor representatives, staff from international organizations and civil society members and members of affected communities.

The quantitative and qualitative data arising from case study were triangulated using documentation, conceptualization, coding, and categorizing in line with the conceptual framework domains, sub-domains and components, which allowed us to examine relationships between them and led to major findings that eventually informed the recommendations.

The research was conducted in four countries CEE/CIS countries: Belarus, Bulgaria, Georgia and Ukraine. The country case study findings are collated in a synthesis report that will serve as input to the development of a Global Fund Strategy on Transition and Sustainability and will feed in to the new Global Fund Strategy.

2. CHAPTER: EXTERNAL ENVIRONMENT

2.1. Country Background and Political System

Ukraine is a country in Eastern Europe with a total area of 603,628 km², making it the largest country entirely in Europe after Russia.

Ukraine is a republic, governed by executive (the Cabinet of Ministers (CMU) and the President), legislative (the Verkhovna Rada, or Parliament), and judicial branches.

Constitutional changes enacted in 2010, including giving the President greater power to dismiss the Parliament, have resulted in a greater concentration of power within the presidential administration. The country is further governed by 24 oblasts (regions) and two cities with special status (Kiev and Sevastopol). The oblasts are divided into 490 districts (rayons). Within the rayons are municipalities (cities and villages). The President appoints administrators in the oblasts and rayons.

Ukraine gained independence after the collapse of the Soviet Union in 1991. The “Orange Revolution” in 2004 occurred, in part, as a response to dissatisfaction with economic situation and Ukraine’s political institutions. However, the government that came to the power after “Orange Revolution” was not able to overcome internal divisions and bring about lasting economic improvements. In February 2014, President Victor Yanukovych was expelled by pro-Euro-Atlantic members of parliament after he used the security forces to crack down on public protests and his attempt to tighten ties with Russia. Petro Poroshenko was elected to replace him in May 2014. After Yanukovych was unseated, Russia annexed the Autonomous Republic of Crimea and pro-Russian separatists increased their efforts to destabilize the eastern part of the country (Donetsk and Lugansk oblasts), where war is currently taking place, fuelled with Russian support.

Ukraine joined the World Trade Organization in 2008 and the EU’s Eastern Partnership in 2009. In 2015 Ukraine signed an Association Agreement with the EU.

The 2014 political crisis, which escalated into a military conflict in Eastern Ukraine, has affected more than five million people, resulting in a deterioration of the humanitarian situation in the country. The vulnerability and emergency needs of the population are expected to rise further, as the ongoing armed confrontation, lack of supplies and restriction of movements continue. Today the situation remains highly unstable. Some territories in the Donetsk and Lugansk oblasts are under the control of the Ukrainian government, while others have become part of the non-government controlled areas (NGCA).

2.2. Economic Development

The rapid marketization and hyperinflation that followed independence caused severe socioeconomic hardship in Ukraine. While there was some stabilization in the economy after 2000, and even growth from 2003–2007, the global economic downturn has hit the Ukrainian economy hard and the country has sought assistance from the IMF and World Bank. Ukraine experienced a decline in GDP of around 15 percent in 2009 (World Bank) but since then the economy has improved, reaching around 2 percent annual GDP per capita growth by year 2013 (Table 3). However, the current military conflict in eastern Ukraine, which affects not only political stability and people but also economic output of the country, offers bleak prospects for the country’s economic performance over the coming years.

Recent political turmoil, ongoing military actions and the annexation of Crimea have negatively affected Ukraine’s economy and are perceived to have a lasting effect. Political change and economic instability caused several negative developments by the end of 2014: GDP

had fallen by 8%; the inflation rate reached 24.9% (the highest level in the last 14 years); and the national currency devalued by 300%, causing dramatic cutbacks in spending on health, education and social protection. Due to the armed conflict in the east of the country, military expenditures grew to 4% of GDP, while national bank reserves depleted twofold. 2 million jobs disappeared over the course of 2014. 20% of Ukraine's industrial potential is in the non-controlled territories, 50% of which has been destroyed.

Table 3: Key Indicators

	2000	2002	2004	2006	2008	2009	2010	2011	2012	2013	2014
GDP per capita (current US\$)	636	879	1,367	2,303	3,891	2,545	2,974	3,570	3,855	4,030	3,082
GDP per capita growth (annual %)	7	6.3	13	8	2.9	-14.4	4.6	5.6	0.4	2.1	-0.8
GINI index (World Bank estimate)		29.1	28.9	29.7	26.6	26.4	24.8				
Revenue, excluding grants (% of GDP)	26.8	29.2	30.7	36.2	35.8	34.6	34.3	36.3	37.3		
GNI per capita growth (annual %)	6.6	6.6	12.8	7.5	3.5	-15.5	5.3	5.5	4.8		-0.3
GNI per capita, Atlas method (current US\$)	700	790	1,270	1,950	3,22	2,840	22,990	3,110	3,500	3,760	3,560

Source: The World Bank Data Base, accessed May19, 2015; * 2002

According to official statistics, income inequality remained moderate, with a Gini coefficient of about 0.25 registered in 2012.¹⁶ About 11.2% of population is in extreme poverty as their expenditures were below 900 UAH (USD 112) per month in 2012.¹⁷

2.3. Social and Human Development

Non-communicable diseases (NCD) and chronic conditions comprise the bulk of mortality in Ukraine, especially among working age males. The risk of dying from circulatory system diseases (CSD) and cancer is much higher in Ukraine than the EU-average.

In addition, Ukraine has the highest mortality rate from infectious diseases in the entire WHO European Region, followed by Russia and Eastern European countries. HIV/AIDS and Tuberculosis account for 90 percent of all deaths from communicable diseases in Ukraine. HIV/AIDS accounts for 2.19 percent and 3.62 percent and TB accounts for 1.04 percent and 1.48 percent of deaths and disability-adjusted life years (DALY) in Ukraine respectively.

High adult morbidity and mortality, especially among the working age population, followed by the changing age and gender structure of the population have significant economic and social consequences. The Ukrainian labor pool is shrinking due to both emigration and high mortality among the working age population – a situation now exacerbated by the military conflict. Population projections indicate that the male and female working age population (aged 15 to 59) has already begun to decline as a share of the total population, and will continue to do so far into the future, taking into account the current population's growth rate, fertility rate, and mortality rates. Premature deaths among wage-earners and skilled workers can affect negatively not only household incomes but also the country's economy as a whole. The declining share of working age adults due to high mortality and the increasing proportion of elderly people could further hurt the economy unless new mechanisms are developed to attract and retain older workers.

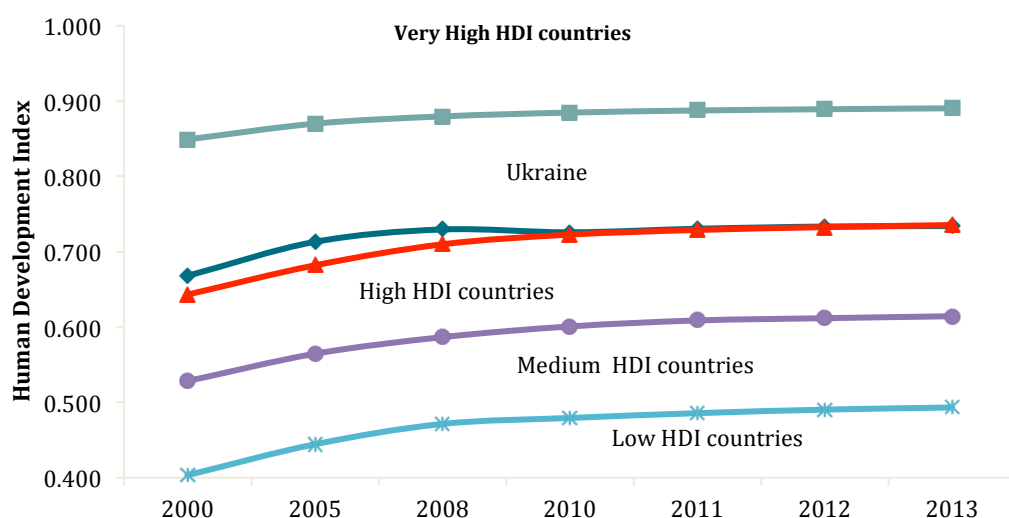
The gender gap has already led to a high proportion of single women and widows in the northern regions of Ukraine. Cultural, linguistic and religious differences already exist in Ukraine between the eastern and the western parts. Differentials in fertility, mortality, population growth, in different regions and among social and ethnic groups could also further exacerbate existing

¹⁶ The World Bank. Report No: PAD939, February 10 2015.

¹⁷ Extreme relative poverty is measured as percentage of individuals with total expenditure per adult equivalent below 60% of median; US\$ 5 per day poverty line comparison is used.

disparities. In the short term, the decline in Ukraine's population may imply lower overall health expenditure. However, in the long run, with ageing, these will be offset by a rise in demand for health services¹⁸.

Figure 3: Human Development Index trend 2005-2013



Ukraine ranks high in terms of the Human Development Index. According to the UNDP Human Development Index (HDI) (Figure 3), the country belongs to that group of countries with high human development. The country maintained 65th position out of 187 countries between 2012-2013.

2.4. Other External Factors

The armed conflict occurred on the territory most affected by HIV and TB, and resulted in a deterioration of the national HIV and TB response. The south-eastern regions of Ukraine, including Donetsk and Lugansk, have always been the areas most affected by HIV and have the highest prevalence of HIV in Ukraine, (644.5 per 100,000 population). 25% of all registered PLHIV (33 000), 25% of PLHIV on treatment (13 000) and the biggest population of PWID (45 000) live/d in Donetsk and Lugansk region.

According to the Ukraine Centers for Disease Control (UCDC), as of April 2015, a total of 1,304 PLHIV moved from Donetsk and Lugansk NCGA to other regions of Ukraine. However, the majority of PLHIV (13, 938) continue to follow up with AIDS facilities in the NGCA. Among them 6,610 patients receive ART. An additional 200 HIV infected people who are eligible to start ART are currently on the waiting list, unable to initiate treatment due to shortages of ARV medications. HIV testing decreased by 30% in the non-controlled territories, and the OST program was ceased for 800 clients.

Based on information received directly from AIDS centers in the NGCA, it is expected that interruptions in ARV treatment will happen in August. There is also a serious threat of discontinuation of essential HIV commodities and services (e.g. for HIV diagnostics and monitoring) that will negatively affect treatment effectiveness and outcomes. The last shipment of HIV treatment commodities to the NGCA (procured by the All Ukrainian Network of People living with HIV under the 2015-2017 GFATM Grant) took place in February 2015. Since then, the further delivery of HIV supplies and commodities has become increasingly difficult and dangerous, relying on risky delivery modalities using various forms of informal arrangements to pass numerous security check-points. The stocks of drugs available in Donetsk and Lugansk will expire by August 2015 and put more than 8,000 people who are currently receiving ARV treatment

¹⁸ An avoidable tragedy: Combatting Ukraine's Health Crisis, Lessons from Europe, World Bank, 2009

and PMTCT prophylaxis at risk of interruptions in treatment, progression to AIDS and death as well as new cases of children infected through MTCT. In addition, there is a real risk of development of resistant forms of virus that would pose a further threat to public health in the NGCA and in Ukraine overall.

The delivery of drugs and health products to the NGCA is particularly challenging. Deliveries of any government-funded health, education, social or other services, including supplies of medications, to the NGCA have been suspended since March 2015 following the passage of a new law that considers the NGCA in parts of Donetsk and Lugansk regions to be “occupied territories”. ART sites in the NGCA have ARV medications stocks only until August 2015. There are also reports from the NGCA indicating stock outs of HIV test kits, including for pregnant women, as well as reports of an increased number of deliveries among women with an unknown HIV status. The conflict has also resulted in increased gender based violence and sexual assaults¹⁹.

Compared to PLHIV, TB patients residing in NGC territories have sufficient supplies of TB medicines until the end of the year. As informed by UCDC due to the buffer stock of TB drugs, the country has sufficient stocks of medicines until the end of the year, and annual TB medicine stocks were delivered to these the government controlled territories through MSF (an international NGO) prior to any further deterioration of security.

2.5. Brief Health System Overview

The Ukrainian health system has preserved the fundamental features of the Soviet Semashko system against a background of other changes, which are developed on market economic principles. Ukraine has extreme decentralization in the health system in comparison with the classic Soviet model. Health facilities are now functionally subordinated to the Ministry of Health, but managerially and financially they are accountable to the regional, rayon and local self-government entities, which has constrained the implementation of health policy and fragmented health financing.

The regulation and policy development of the health system is shared between the MOH, the President and Cabinet of Ministers, and Parliament. The Ministry of Health (MOH) is responsible for providing data and information for setting national health policy priorities, and for the planning and management of the health system. The President and Cabinet of Ministers determine how the health system is organized, given the policies that the administration sets forward. Parliament determines health care budgets and financing, and directs the Ministry of Finance’s (MOF) funding allocations to oblasts and rayons. The Ministry of Economy also advises this process; new legislation may be introduced by the MOH to Parliament, and may be a result of a collaborative, working group process. The President may also provide emergency legislation to the Parliament for its consideration. In practice, the Office of the President and the Prime Minister have the ability to wield a great deal of influence over draft MOH legislation.

So far the MOH has not exerted its stewardship function properly in a decentralized environment. During the deep economic and fiscal crisis of the 1990s, the ownership and management of health facilities were devolved to local authorities²⁰. In terms of financing, at present approximately two thirds of total government expenditure on health is channeled through local governments, and one third through central Ministries, including the MOH. In the new decentralized environment, the MOH should have developed the role of planner, coordinator, and evaluator of health services’ standards and performance, while local authorities at regional, city, district, and community levels should have assumed the role of implementing actors. Instead, the former has continued to impose extremely detailed input-based “norms” (on personnel, infrastructure, etc.) on all individual facilities, and has focused mainly on procuring inputs such as

¹⁹ UNAIDS brief, 2015

²⁰ There are three tiers of local governments in Ukraine: the top tier has 24 oblasts (regions), the Autonomous Republic of Crimea, and two cities with special status: Kyiv and Sevastopol; the second tier has 488 rayons (or districts) and approximately 177 cities; the third tier consists in 12,000 small towns, settlements and villages.

drugs for the national programs, while the latter have acted to a great extent in isolation, working with numerous isolated facilities and without clear mandates in terms of service standards and results.

The Ministry of Health plays a regulatory role in the Ukrainian health system at the national, regional and district levels. The Ministry is responsible for the accreditation of all health facilities regardless of ownership, but this is more of a formality than a tool for improving the quality of services. Similarly, standardization efforts through the development of clinical guidelines and protocols have been ongoing, but they are not generally evidence-based, and their efficacy has not been monitored. Since 2007, improving the quality of health care has become a more systematic activity and there is a department in charge of assessing the quality of health care services.

The transition from centralized financing to its extreme decentralization is the main difference in the health system in comparison with the classic Soviet Semashko model. Although no fundamental reform has taken place, many changes in the health sector have been initiated and often realized since independence, although most of them were oriented not towards meeting the health needs of the population but towards solving organizational problems in the health sector. User fees have been introduced to mobilize additional resources, and sickness funds and Voluntary Health Insurance (VHI) have begun to develop. To reduce government expenditure in circumstances where there was an acute shortage of funds, the stock of hospital beds was cut by a third. The government also laid the legal basis and introduced measures to drive institutional reform of the health sector (for example, to reorient the system towards primary care and introducing family medicine). It also introduced specific quality guarantees for health services (the licensing of medical practice, accreditation of health facilities, standardization of clinical practice).

Health care expenditure in Ukraine is low and has not increased significantly as a proportion of GDP since the mid 1990s. Expenditure cannot match the constitutional guarantees of access to unlimited and free care. Although prepaid schemes such as sickness funds are growing slowly, out-of-pocket payments account for 37.4% of total health expenditure.

Government funding for health has been maintained in line with that of countries at similar levels of socio-economic development. However, it is mainly used to maintain the current extensive delivery system at its minimal level of functionality. In 2013 government (central and local) health expenditure accounted for 12.2 percent of total consolidated budget expenditures, or approximately 4.2 percent of GDP. Most government health financing comes from general taxation, and it is allocated according to inputs and mainly to cover recurrent costs (over 95 percent of total costs)²¹. Compensation for individual doctors and nurses is mainly through salaries, which reflect seniority and level of specialization. Overall, the current financing mechanisms create inertia and discourage interventions that enhance efficiency, while opportunities to take advantage of less invasive technologies, new standards of care and more dynamic service modalities are lost.

Although there has been considerable decentralization in the system, in most other respects the system remains largely unreformed. Decentralization has meant deconcentration of functional and managerial powers at the regional and sub regional level. Regional and local health directorates are responsible for health facilities in their territory and are functionally subordinated to the Ministry of Health, but managerially and financially they are accountable to regional and local self-government. Only the State Sanitary-Epidemiological Service and the State Pharmaceuticals Quality Control Inspectorate, each with relevant facilities at the different levels of administration, remain fully centralized and vertically subordinated to the Ministry of Health. Consequently, while the Ministry of Health formally takes the lead in developing health policy, implementation is constrained.

²¹ For example, the funding public hospitals receive is allocated according to line-item budgeting, and for each item such as energy, staff, etc. the total amount the hospital receives is dependent on their beds and bed days. Staff numbers are associated with beds based on national "staffing norms".

Decentralized management of the system impedes the implementation of plans developed at the national level, and there is no central health planning agency. Approaches to capacity planning have remained almost unchanged since Soviet times. The mechanisms currently in place neither reflect the health care needs of the population nor account for the regional characteristics of health service provision. There is also little incentive for the rational use of resources or cost control over health facilities, which are predominantly funded from the national budget and with out-of-pocket payments.

Ukraine has an extensive health care infrastructure despite the rapid reduction in the number of beds that took place in 1997–1998, in response to a severe economic crisis. Ukraine has an oversized, inefficient, hospital sector, in terms of both beds and the number of hospitals. Yet their service delivery capacity is extremely limited. Ukraine has 2,200 hospitals, 8,300 polyclinics, and over 400,000 hospital beds in the public sector²², about 40 percent more beds per capita than the WHO European Region average. This hospital infrastructure was built on the assumption that every small territory should be self-sufficient in terms of health care (each oblast, municipality, and rayon), which was probably correct in times of bad communication and poor transport (and low input costs), but is now less justifiable both in terms of catchment population and investment optimization.

Moreover, such large hospital infrastructure is quite inefficient. For example, in 2013 the average length of stay in hospitals in Ukraine was 11.8 days, which is not a result of different medical needs, but rather linked to the perverse incentives embedded in the system (e.g. paying hospitals according to the number of beds and bed days creates an incentive to increase the length of a patient's stay, even if it is not medically necessary).

The service delivery capacity of this large hospital infrastructure is extremely limited. Small inpatient facilities, such as municipal (city) and rayon (district) hospitals, and municipal mono-profile hospitals (TB, STD, etc.) represent about 75% of hospital beds providing only inpatient services. Oblast (regional level) hospitals, specialized clinical and diagnostic centers of national research institutes form the remaining 25 percent of hospital beds (WHO-Euro, 2014)²³. Hospital polyclinics and rayon hospitals provide both primary and specialized care, while oblast and city hospitals haphazardly provide a mix of chronic care and specialized and super-specialized treatment for a number of medical specialties. Because of chronic lack of investment and other constraints, very few medical facilities are able to provide complex medical care (for example, modern cardiac surgery or cancer treatment). Furthermore, unsatisfactory sanitary conditions are found most often in rural areas. The lack of systematic updates on the condition of medical facilities and the minimal financing of capital costs in the state health system are the two main reasons for the lack of planning in the prospective development (construction, renovation) of medical facilities. The Ukrainian health system has also consistently encountered severe difficulties with the supply and maintenance of existing technological equipment.

Traditionally, primary care in Ukraine has been provided within an integrated system by district internists and pediatricians employed by state polyclinics. In 2000 the transition to a new model of primary care based on the principles of family medicine began. Family doctors/general practitioners (GPs) make up a third (32.9%) of all primary care physicians. They work at family medicine polyclinics or in appropriate polyclinic departments, and the overwhelming majority of family doctor/GP facilities and departments are located in rural areas (70%).

The inpatient system is a hierarchical system organized into three levels. The first (lower) level is that of rural hospitals providing basic inpatient facilities. The second (middle) level is the true foundation of the system. Secondary inpatient care is provided in central district and municipal

²² By comparison, Spain, a country with similar population, has approximately 150,000 beds and yet substantially more hospital activity.

²³ WHO - Regional Office for Europe, 2014, European Observatory on Health Systems and Policies, (draft) Ukraine HiT Summary. Previous version from 2005 is available at: <http://www.euro.who.int/data/assets/pdf/file/0010/98893/E84927sum.pdf>.

multi-profile hospitals, children's hospitals, specialized clinics (dispensaries), and specialized hospitals, which are located and governed at this organizational level. The third (higher) level is that of regional and supra-regional specialization provided by regional hospitals, diagnostic centers and specialized clinics, and specialized clinical and diagnostic centers at the national research institutes of the Ministry of Health and the National Academy of Medical Sciences. These were originally designed to provide highly specialized medical care to patients with the most severe and complicated conditions, but there has been some blurring of the lines between secondary and tertiary care levels.

The number of medical human resources per capita has increased gradually since 1990, but this does not reflect a growth in the number of medical personnel so much as a decline in the total population, as the absolute number of doctors has been falling. At the same time the medical workforce is ageing rapidly, as new graduates choose to work outside the state health system or seek opportunities abroad. The key staff shortages are in rural areas and in primary care, which has a high turnover. The number of nurses has fallen much more rapidly due to low wages and the low status of nursing, and limited possibilities for professional development. This trend is witnessed throughout the Commonwealth of Independent States (CIS), and runs counter to developments in EU countries.

The core challenges for Ukrainian health care therefore remain the ineffective protection of the population from the risk of catastrophic health care costs and the structural inefficiency of the health system. High levels of out of pocket payments (OOPs) create a barrier to access health services for the poor and generate catastrophic expenses for those seeking urgent care, or for those affected by chronic diseases who need to purchase medicines.

The current government has ambitious plans for significant health system reform not only to improve health outcomes in Ukraine, but also in reaction to economic imperatives to rationalize the system. Outside of improving the quality and accessibility of key health services, the reforms intend to change the budgetary model of the health system in order to eventually transition Ukraine's health system to a social health insurance model. The priorities of health reform include: health financing reform, redefining the structure of health service delivery and granting autonomy to health facilities. While the key reform directions have been announced, implementation has not yet been initiated and the time frame is largely unknown. The way forthcoming reports may affect sustainability of HIV and TB programs is difficult to predict.

2.6. The Role of Civil Society Involvement in Public Service Delivery

Ukraine is regarded by international organizations as having the freest and most vibrant civil society among CIS countries²⁴. Levels of civil society development in Ukraine approximate the levels of new EU member states. According to the Unified State Register of Enterprises and Organizations of Ukraine (USREOU), the number of CSOs increased in recent years. Non-governmental actors include provider associations, NGOs and other civil society organizations, and the media. Provider associations are grouped by specialty and vary in size and services for members. As of October 1, 2013, there were 76,575 public associations; 288 creative unions and other professional associations; 14,729 charitable organizations and 1,483 self-organized bodies.

New laws regulating the activities of public associations, charitable organizations, and foundations came into force²⁵ ***in 2013.*** While the overall sustainability of the CSO sector did not change significantly in 2013, there were some positive developments in the legal environment, financial viability, advocacy, and public image of the sector. In 2013, two relevant laws came into force: the Law on Public Associations and the Law on Charity and Charity Organizations, which regulate the activities of public associations, charitable organizations, and foundations.

²⁴ CSO Sustainability Index For Central And Eastern Europe And Eurasia 17th edition - June 2014

²⁵ CSO Sustainability Index For Central And Eastern Europe And Eurasia 17th edition - June 2014

- *The new Law on Public Associations enables public associations to conduct economic activities to accomplish their statutory objectives.* Since January 1, 2013, public associations have been able to choose to use simplified taxation systems, paying single taxes at a flat rate of 3 percent to 10 percent of their incomes without paying income tax or VAT. Legal entities that make donations to CSOs are eligible for a 4 percent tax deduction. Individuals are also eligible for tax deductions. However, neither legal entities nor individuals use these opportunities in practice due to ambiguities in the regulations and burdensome procedures.
- *The new Law on Public Associations simplified conditions and procedures for registering public associations.* Previously, forty-two founders were needed to start a national public association; now just two persons can found any public association. The registration period was reduced from thirty to seven working days and is now free. In addition, the restriction that an organization can operate only in the territory of its registration was lifted; now any CSO can engage in activities in any region of Ukraine.

Since 2013, public authorities have increasingly promoted CSOs' engagement in service provision. In 2013, the Ministry of Social Policy introduced a legislative change allowing CSOs to compete for social service contracts and adopted relevant tender procedures (evaluation methodology for application evaluation etc.). Some cities and regional capitals have introduced grant competitions for CSO projects financed by the local budgets. CSOs increasingly use various fundraising methods to attract public funding. However, local authorities do not have the resources to fund these social contracts or handle these competitions.

Institutional development of CSOs, including the establishment of strategic plans, rules and procedures of internal management, democratic governance, and annual reporting ***remains a priority for most international technical assistance programs operating in Ukraine.*** Although organizations conduct strategic planning, few CSOs apply it in their day-to-day work. At the same time, reductions in personnel hinder CSOs' capacities to plan their activities strategically. CSOs thus often change their planned activities, even while they remain aligned to their missions, as stipulated in their by-laws. In 2013, donor organizations paid more attention to the internal management of organizations. Donors require written internal management policies and procedures from CSOs seeking institutional support. Organizations that have undergone organizational audits now better understand the need for and benefits of internal management rules. At the same time, the development of management policies and procedures are beyond the capacity of small CSOs.

The financial management of CSOs has improved. USAID's new emphasis on providing direct funding to CSOs has forced leading CSOs to undergo external audits of their management and financial systems. As a result, more CSOs now understand the importance of proper and continuous financial management, which requires transparent procedures and systems. In addition, more CSOs include financial statements in their annual reports.

CSO advocacy has improved dramatically since 2013, although advocacy at local levels is challenged by the lack of CSO skills for engaging in public policy and the unwillingness of local governments to cooperate with them. CSOs actively participated in a campaign to finalize the Association Agreement between Ukraine and the EU. CSOs had access to new channels to influence policy making. The Coordinating Council for Civil Society Development under the president became a platform for CSO representatives to interact directly with public officials and endorse decisions. The Human Rights Commissioner at the Supreme Council (the Ombudsman) created a civic platform through which CSOs develop human rights agendas for further consideration. The Cabinet of Ministers established a Board of Heads of Civic Councils to serve as a unified platform for all civic councils in Ukraine. It held nineteen meetings with the government during the year to exchange information and provide policy recommendations. However, not all civic councils are involved in such cooperation. In 2013, CSOs launched advocacy campaigns at the national level in new and surprising sectors. A law banning smoking in public places was adopted as a result of a strong public awareness campaign organized by a coalition of health CSOs. Advocacy at the local level is more difficult. Local CSOs are less skilled at engaging in public policy. Moreover, local authorities are not keen to cooperate with CSOs to promote civil rights through new policies and regulations. In

addition, community bylaws often do not ensure citizen participation in local self-government or contain provisions that are difficult for citizens to fulfill²⁶.

CSO service provision is still largely dependent on foreign donor funding. As a result, CSOs follow donor priorities and requirements rather than constituents' needs and demands. Service provision is more visible and successful at the local level, while more policy work takes place at the national level.

The number of publications and overall media coverage of CSO activities has increased significantly. Mass media highlighted the work of CSOs focused on HIV/AIDS, charity, and business development. Although publications vary in quality, there are now fewer negative publications. For example, reporting on charity-related fraud was replaced with stories about the positive impact of charitable organizations and foundations. The media regularly reports on health care issues, and displays a relatively high level of technical ability to report on the sector.

2.7. Human Rights, Stigma and Discrimination

Table 4: Existence of legislations specifying protection for key populations and vulnerable groups

Key Populations	Government	Civil Society
PLHIV	Y	Y
MSM	Y	N
Migrants	Y	N
Orphans and vulnerable children	Y	Y
People with disabilities	Y	Y
People who inject drugs	Y	N
Prison inmates	Y	N
Sex workers	Y	N
Transgendered people	N	N
Women and girls	Y	Y
Young people	N	N

Source: TheOSTic report: Stigma and discrimination, 2010

There is no specific framework anti-discrimination law in Ukraine but there are significant legal measures to protect PLHIV against discrimination, as well as specific antidiscrimination measures and stigma reduction efforts outlined in labor, healthcare, and education sector regulations.

Ukraine has developed a strong foundation for protecting rights, however policies are not effectively or consistently implemented (Table 4). The legal and regulatory review carried out by USAID in 2011 confirmed that Ukraine has developed a strong foundation for protecting the rights of people living with HIV and providing HIV-related medical and social services to the population of Ukraine—particularly IDUs—with the support of international organizations and donor-funded projects. As nearly every key informant pointed out, “implementation, coordination, and collaboration are often left to individual personalities and the interests of those involved.”

Gaps and barriers in HIV policy implementation in Ukraine include the following: a lack of detailed mechanisms, such as operational guidelines or standards, to support the implementation of HIV laws and regulations; inadequate strategic planning or a lack of detail in implementation plans; insufficient resources mobilized to implement the laws and regulations; and a lack of awareness and acceptance of legal protections for vulnerable groups among key stakeholder groups, including law enforcement, local government, and healthcare providers.

²⁶ For instance, in Kirovohrad, 2,000 signatures must be collected to initiate a public hearing, and 9,000 signatures are needed to introduce a local initiative.

Although the country has made progress in enhancing non-discriminatory legislation, which creates enabling legal environment for effective HIV/AIDS program implementation, PWIDs, SWs and the TG population still face legal barriers to access required services. Namely:

- ***Stigma and discrimination*** - Ukrainian law prohibits discrimination based on HIV status, protects patient confidentiality, and guarantees equal rights for people living with and affected by HIV. However, these protections do not extend to some vulnerable groups, and no enforcement mechanisms or systems exist to support these populations in exercising their legal rights.
- ***Criminalization of unintentional HIV-transmission.*** A separate article of the Criminal Code of Ukraine (art. 130) specifically provides for punishment with up to 8 years imprisonment for exposure to risk of HIV-transmission or unintentional HIV-transmission.
- ***Criminalization of PWIDs.*** MOH Order #634 from July 2010 led to a significant decrease of drug “thresholds” and criminalized opioid drug users by 20 times, compared to the previous edition of the MOH Order on regulated “drug threshold amounts”.
- ***The decriminalization of sex work*** paved the way for an active national response. However, the lack of anti-discrimination provisions for FSW and administrative responsibility contributes to abuses of power on the part of law enforcement officers, leading to obstacles to service delivery and use²⁷. As a result, program implementation and service delivery remain complicated. Another gap in policies relates to the GBV response. There are strong national laws prohibiting sexual violence in Ukraine, but there is almost no attention to GBV within national HIV and AIDS policies and programs. There are also no clinical management guidelines for services to GBV survivors²⁸, thus further limiting support to FSWs who frequently experience violence.
- ***Inefficient anti-discrimination legislation and initialization of homophobia and transphobia*** - There are no effective mechanisms to protect people from discrimination on the basis of sexual orientation and gender identity (SOGI) in Ukraine. The anti-discrimination law adopted in 2012 omits SOGI from its list of non-discriminatory bases. According to current legislation, the parenting and reproductive rights of LGBT (lesbian, gay men, bisexual and transgender people) are also restricted and denied. Moreover, there are attempts to institutionalize homophobia and transphobia in Ukrainian legislation. The draft law on so called homosexual propaganda, which introduces criminal liability with a penalty of up to 5 years imprisonment for mentioning homosexuality in the public sphere or conveying of any type of information related to lesbians, gays, bisexual, and transgender people, was approved on its first reading in 2012.
- ***Prohibition for PLWH to adopt children*** - MOH order #479 prohibits the adoption of children by HIV-positive people with a B20-B24 diagnosis.
- ***Inaccessibility of HIV-positive women to assisted reproductive technologies*** - MOH order #579 includes HIV infection (B20-B24) in the list of medical counter-indications for treatment of female infertility with assisted reproductive technology methods with public funds.
- ***Inefficient opioid substitution treatment (OST) regulation*** - A key legislative order for the regulation of OST implementation, MOH Order #200, led to discrimination against patients, inadequate measures for medical staff and regulations that were against international and national practices of effective SMT implementation. A revised draft of MOH Order #200 was published for public discussion in January 2014 but had not yet been adopted.
- ***Discriminatory Provisions for Migrants*** - The Law on HIV provides for the expatriation of HIV-positive migrants if their behavior subjects the health, rights and interests of citizens of Ukraine to risk.

²⁷ National Report on Monitoring Progress Towards the UNGASS Declaration of Commitment on HIV/AIDS Reporting period: January 2008–December 2009.

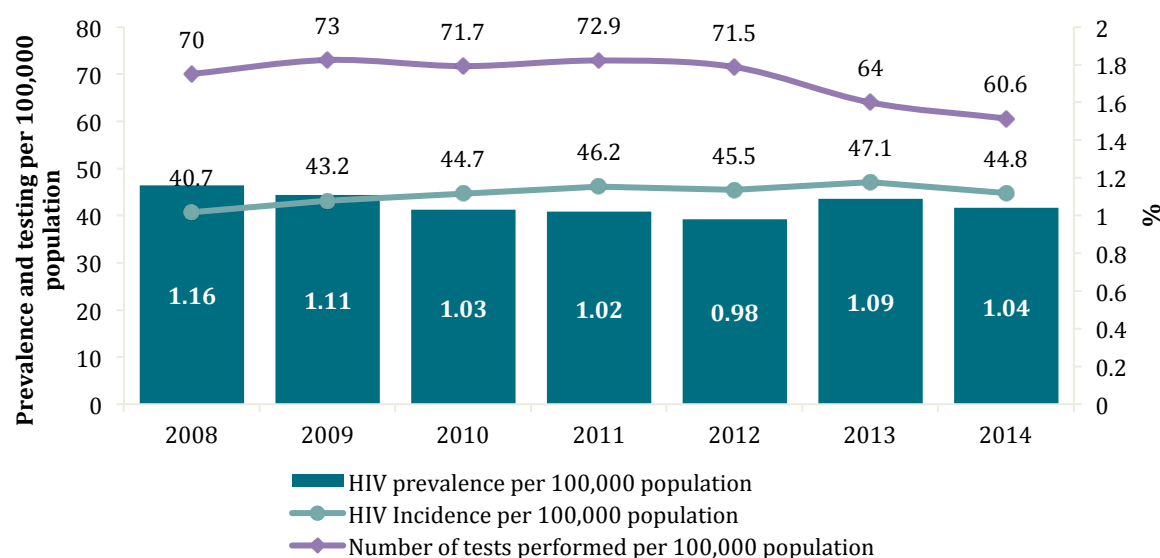
²⁸ Judice, N., O. Zaglada, and R. Mbuya-Brown, HIV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project, 2011.

2.8. Epidemiological Characteristics of HIV and TB

2.8.1. HIV/AIDS

Ukraine suffers from the most severe HIV epidemic in Eastern Europe and Commonwealth of Independent States countries (CIS). The current status of the HIV epidemic in Ukraine is associated with i) the stabilization of the epidemic and the wide spread of HIV among various populations most at risk of infection, ii) the uneven spread of HIV infection in different regions of the country, iii) the shift in dominant routes of HIV transmission, and iv) the fact that HIV mainly affects the working age population. During 1987-2014 Ukraine officially registered 264,489 HIV infection cases among Ukrainian citizens, including 75,577 AIDS cases and 35,425 AIDS-related deaths (except Crimea)²⁹.

Figure 4: HIV Dynamics

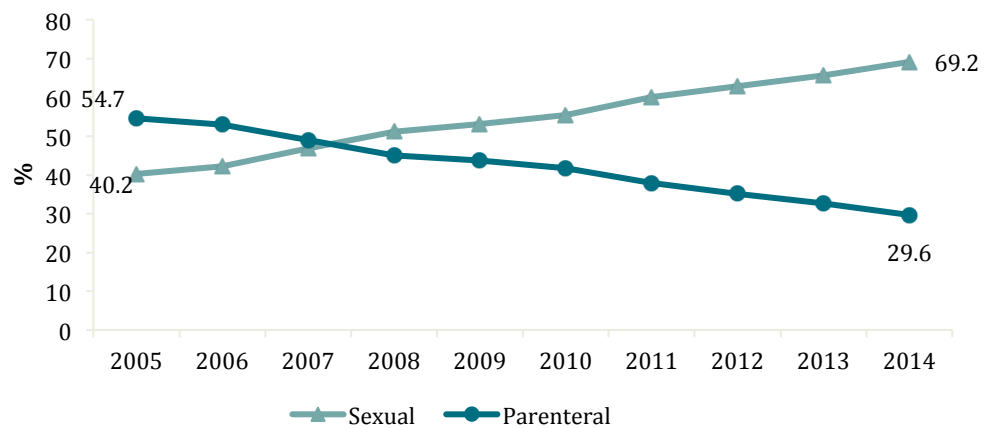


Significant progress has been achieved in the fight against HIV/AIDS. This can inter alia be ascribed to the provision of comprehensive, focused prevention and harm-reduction services to the most vulnerable groups over the last few years, which led to a continuous decrease in HIV transmission among people who inject drugs, and the stabilization of the HIV epidemic in Ukraine.

The number of officially registered new HIV cases started to decline in 2014, when it accounted for 44.8 per 100,000 population. (Figure 4).

Figure 5: Main transmission routes

²⁹ HIV epidemic in Ukraine, Information Bulletin #43, UCDC, 2015



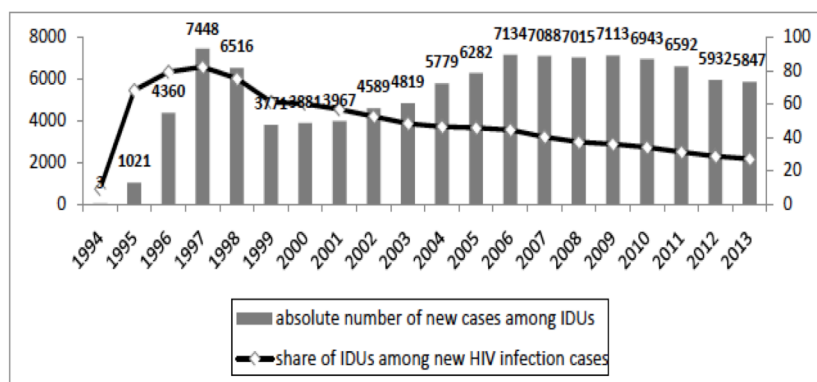
Source: UCDC, 2015, InforOSTion Bulletin #43

New cases of HIV-infection are mostly present in the age group 25-49 years. Its proportion has been gradually increasing from 63.8% in 2009 to 67.0% in 2013. In addition, the male to female ratio of reported new HIV cases has remained unchanged at 55: 45 since 2009. The proportion of young people aged 15-24 years among the newly reported cases of HIV has been gradually increasing in recent years, from 12% in 2009 to 67% in 2014.

The primary mode of transmission has changed from injecting drug use to heterosexual sex. From 1995 to 2007 HIV transmission through drug injection had dominated in Ukraine, typically through injecting drug use. Since 2008 HIV transmission has shifted towards the sexual transmission route, mainly heterosexual. In 2014 the proportion of HIV transmission through sexual contacts (including mother-to-child HIV transmission) reached 69.2%, while the proportion of parenteral transmission of HIV through injecting drugs declined to 29.6% (Figure 6). Besides these key affected groups, sex workers and men who have sex with men are other groups that are becoming more epidemiologically significant. From 2005 to 2013 the number of officially registered new cases of HIV-infection among MSM rose to 262. The number is assumed to be significantly underestimated, as these men tend to keep their sexual orientation secret.

The “new wave” of HIV infections through heterosexual sex appears to be a result of risky sexual behaviors of PWID and their sexual partners.

Figure 6: Officially registered HIV cases among PWID, 1994-2013³⁰

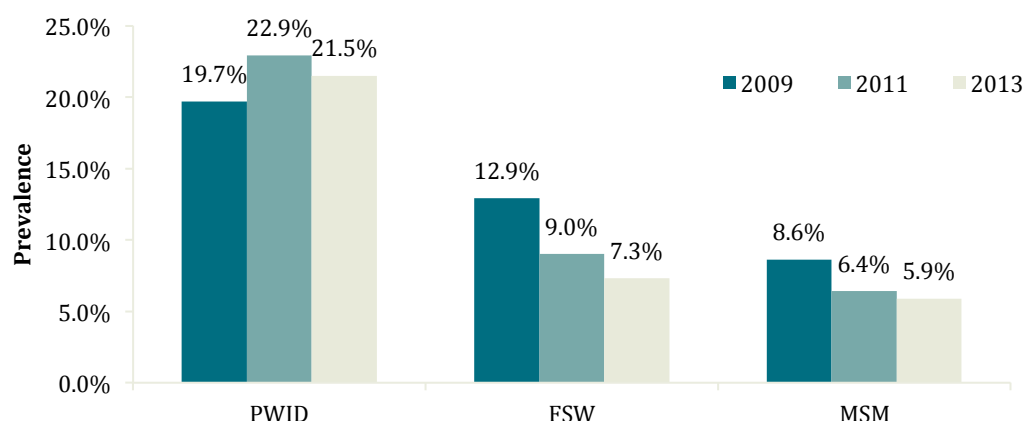


Between 1999 and 2006, the number of PWID among new HIV infection cases increased in parallel with an annual decrease in the proportion of PWID among the total number of new HIV cases (Figure 6). Furthermore, between 2006 and 2013, there has been a clear decrease in the number of registered new

³⁰ Good Practices in Europe, WHO, 2014

cases of HIV among PWIDs, as well as a continuing decrease in the proportion of PWIDs among the total number of new HIV cases.

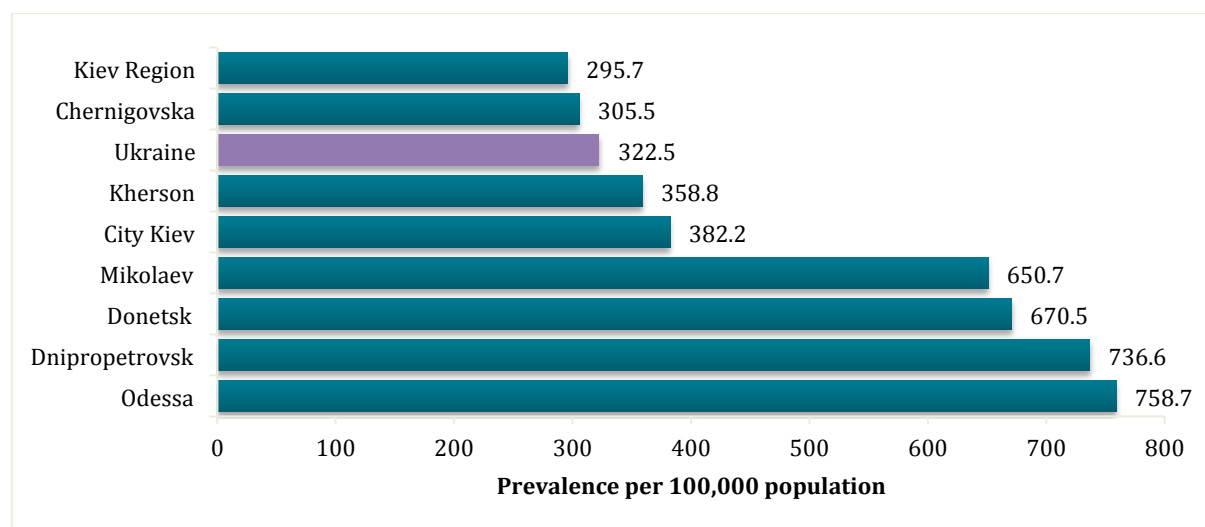
Figure 7: HIV prevalence among KP, 2009-2013³¹



One major achievement, however, is that over the past couple of years, ***HIV prevalence among PWID has started to decline*** (Figure 7).

HIV prevalence among Men who has sex with Men (MSM) is estimated at 5.9%, and remains relatively small compared to other key populations, totaling no more than 0.4% of all HIV cases in the country, even though the number of cases continue to rise.

Figure 8: Highest Prevalence Regions³²



Source: UCDC, 2015, InforOSTion Bulletin #43

HIV prevalence among Female Sex Workers (FSW) is also declining. Of particular note is the fact that HIV among FSW appears to be highest in cities with the highest incidence of HIV among PWID (Figure 8). As per 2011 BBS, the HIV prevalence among those FSW who had reported never using drugs was 6% nationwide, whereas the prevalence rate was 32% among FSW who reported ever using drugs but not in the past year, and 41% among FSW who reported injecting drugs within

³¹ Good Practices in Europe, WHO, 2014

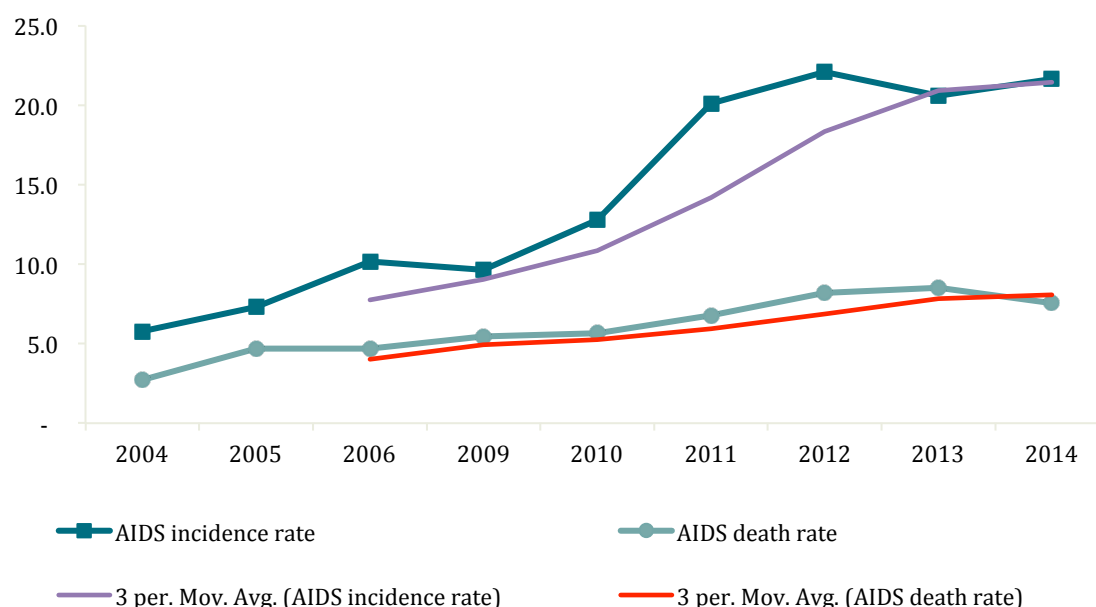
³² Source: UCDC, 2015, Information Bulletin #43

previous year. Consequently, there appears to be a direct link between injecting drug use, FSW and the higher prevalence of HIV in Ukraine³³.

The highest HIV prevalence is registered in 8 regions with 40% of estimated PLHIV (100,000)³⁴. The highest rates were registered in the southeastern regions of Ukraine, including Odessa region, Dnepropetrovsk region, Donetsk region, Nikolayev region, the city of Kiev, Kherson region, Chernigovska and Kiev regions. The western regions have low and medium levels of HIV infection (Figure 8). The HIV/AIDS epidemic in Ukraine is mostly concentrated in cities. In 2013, 77 percent of new cases of HIV infection were registered among the urban population, while the proportion of newly registered cases of HIV-infection among the rural population has been increasing rather slowly (from 21.0% in 2009 to 23.0% in 2013).

According to the most recent size estimates for key populations at risk of HIV, which were published by the UCDC at the end of 2012, the total number of PWID in Ukraine is 310,000 with more than 40% located in Kiev city, Odessa, Donetsk and Dnepropetrovsk oblasts³⁵. The 2011 bio-behavioral survey sample of PWIDs was primarily males between 15 to 49 years of age, with an average age of 33 years. The sample was older than previous surveys, with longer injecting histories suggesting an aging of this population; in 2008, 42% of PWIDs had injected for 11 years or longer, while in 2011 53% injected for 11 years or longer.

Figure 9: AIDS incidence and AIDS Death rates



Source: UCDC, 2015, Information Bulletin #43

AIDS incidence and AIDS death rates exhibit an increasing trend (Figure 9). Whereas prior to 2013, AIDS incidence increased annually and reached 22.1 per 100,000 populations, it declined to 21.6 in 2014. A similar trend is observed in the case of AIDS death rates, however the three period average trend shows that the decrease observed between 2013-2014 did not reverse the trend of these indicators. Nevertheless, based on the data provided, it can be concluded that the speed in AIDS death rate increase (average annual increase 0.44) is slower than the AIDS incidence rate (average annual increase 1.44).

³³ Ukraine HIV Data Synthesis Project: Final Report, UCSF/CDC, 2013.

http://www.aidsalliance.org.ua/ru/library/our/2012/me/msm_en_2011.pdf

³⁴ Ukraine Concept Note, 2014

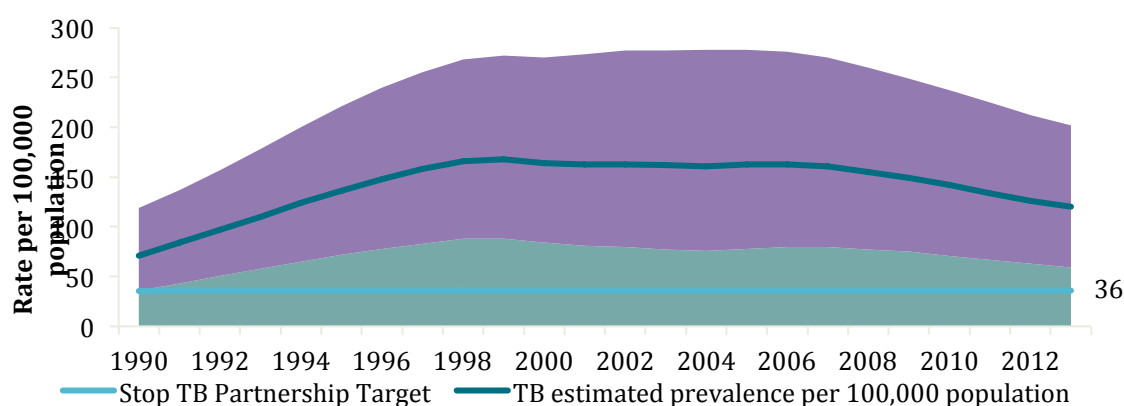
³⁵ Abdul-Quader, A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project. Draft Final Report, September 13, 2012.

2.8.2. Tuberculosis

Ukraine is reported to have one of the highest TB prevalence rates in Europe. In 2014 Ukraine was, for the first time, cited as being one of the top five countries with the highest MDR TB burden in the world³⁶.

TB prevalence in Ukraine sharply increased between 1990 and 1999 from 71 to 168 cases per 100,000 (Figure 10). In the period 2000 – 2007, the decline of TB prevalence was negligible. After 2008 TB prevalence steadily contracted, with a -4.3% mean annual rate of change. In 2013, the estimated number of prevalent tuberculosis patients in Ukraine was 54,500 (27,000-91,000), which is equivalent to a rate of 120 (59-202) per 100,000 population and is three times higher than the Stop TB partnership targeted level of 36 cases per 100,000 population (half of 1990 level).

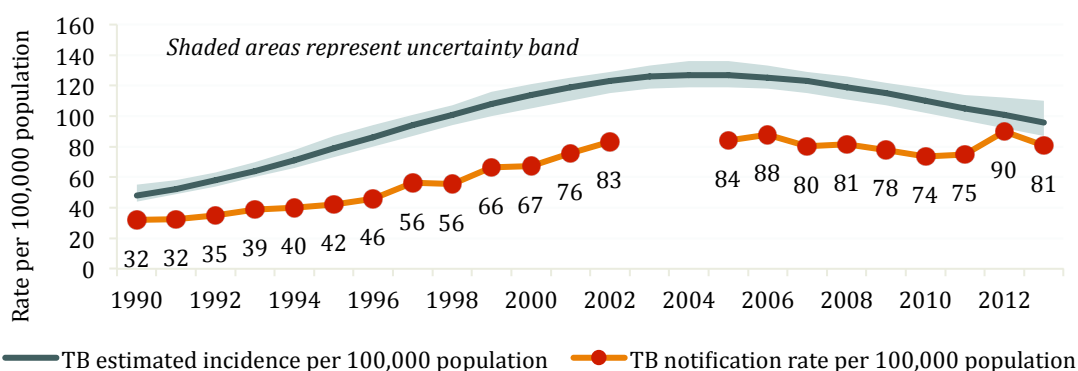
Figure 10: Estimated TB prevalence rate in Ukraine, per 100,000 population (1990–2013)³⁷



Data source: Global TB database

The TB incident rate shows a declining trend. There were an estimated 44,000 incident cases of TB (uncertainty range 39,000-50,000), equivalent to a rate of 96 (87-110) per 100,000 population in 2013. TB incidence sharply increased from 48 in 1990 to 127 per 100,000 population in 2004. This increasing trend in TB incidence stopped in 2004 and reversed starting from 2007. The mean annual rate of decline between 2007 and 2013 in Ukraine was 3.3% (Figure 11).

Figure 11: Estimated TB incidence rate and notification of incident TB cases (new and relapse) in Ukraine, per 100,000 population (1990–2013)



³⁶ "India, China, Russia, Pakistan and Ukraine have 60% of all MDR-TB cases", - From presentation: The End TB Strategy, Role of WHO in supporting implementation of the new global strategy, - by Dr. Mario Raviglione, Director of Global TB Programme

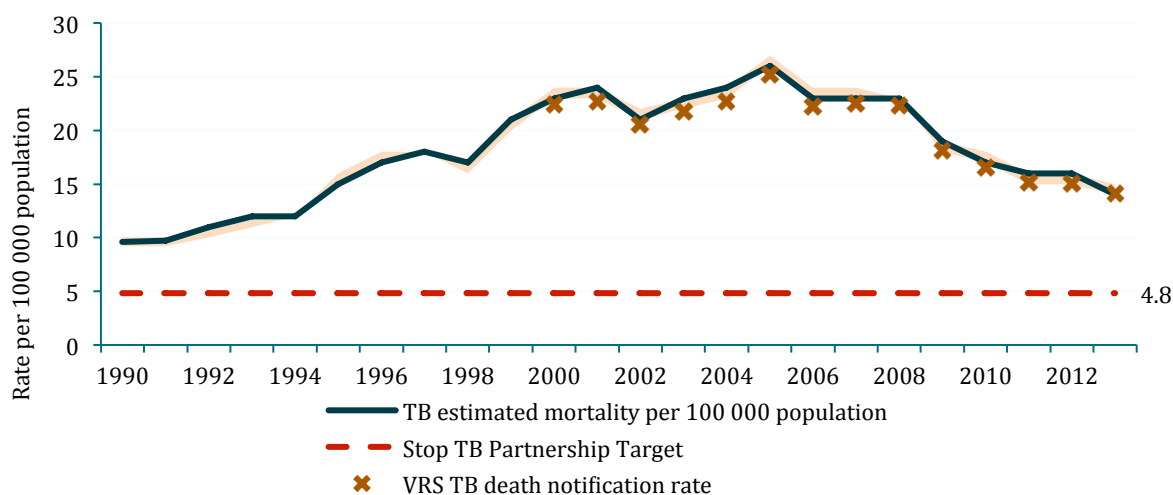
³⁷ Arax Hovhannesian, Ina Motrich and Andrei Dadu , Tuberculosis Epidemiological Impact Analysis, 2015, Ukraine

Data source: Global TB database

TB notification rates have improved. During the last eight years the number of notified TB cases (all forms) increased from 41,254 cases (equivalent to 88.0 per 100,000) in 2006 to 48,134 (106.4 per 100,000) cases in 2013. The average rate of increase in notification rates of all TB cases within 2006-2013 was 3.0% annually, although the TB notification rate varies across geographic regions and settings. The reason for such variation could be the true difference of TB burden and different levels of access to quality health care and the capacity to detect TB. According to national statistics, in 2013 the lowest rate of new tuberculosis cases was recorded in Kharkov oblast (44.7/100,000), while in Kherson, Odessa and Dnepropetrovsk oblasts the new TB notification rate was above 90/100,000 – more than twice as high as in Kharkov. 4.5% of all new TB cases in 2013 were among intravenous drug users, ranging from 0% (Zakarpats'ka and Cernivci regions) to 14.5% in Donetsk oblasts. A fitted regression model explains only 13% of variability of TB, indicating no correlation between IV drug-use and the TB burden.

MDR prevalence is also one of the risk factors of TB burden driving the TB epidemic upwards. According to routine surveillance results, the percent of MDR among notified new TB cases ranged between 5.3% in Ivano-Frankovsk and 28.9% in Kherson.

Figure 12: Estimated TB mortality rate (excluding TB/HIV mortality) in Ukraine, per 100,000 population (1990–2012) ³⁸



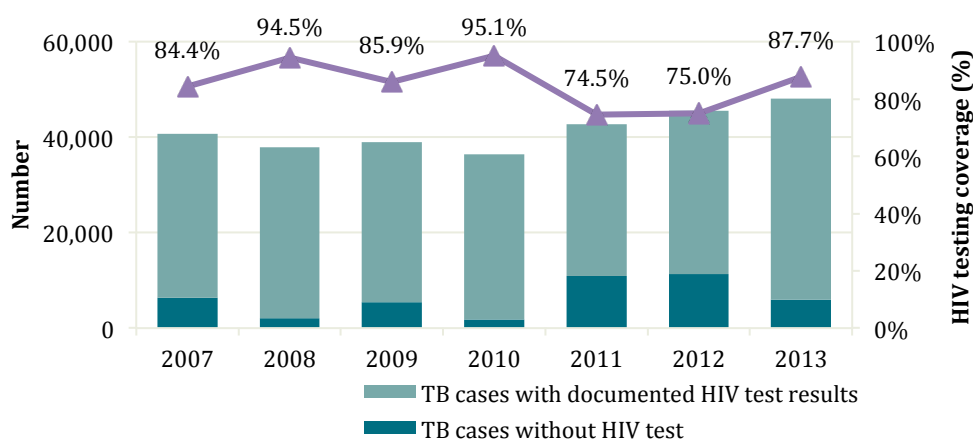
Data source: Global TB database

Ukraine is far away from achieving the Stop TB partnership targeted reduction of TB mortality. Estimates of TB mortality for Ukraine are based on Vital Registration System data.³⁹The mortality rate increased sharply from 9.6 to 26.0 per 100,000 in the period 1990 - 2005. Starting from 2006, the mortality trend in Ukraine reversed with an average annual reduction rate of -7.2% (Figure 12). In 2013 estimated mortality was 14 per 100,000. Despite such an impressive decline, the current mortality rate in Ukraine is about 3 times higher than the Stop TB partnership target, which is to halve the 1990 TB mortality rate by 2015.

Figure 13: Notified TB cases by documented HIV test results, and HIV testing coverage, Ukraine 2007-2013

³⁸ Shaded areas represent uncertainty band of WHO estimated TB mortality. Horizontal dashed line represent Stop TB Partnership target of 50% reduction in TB mortality rate by 2015 compared to 1990

³⁹ Global TB database



Data source: Global TB database

The notable increase in HIV/TB co-infections reflects the growing burden of the HIV epidemic in the country, which is expected to drive the TB epidemic upwards. According to routine surveillance data, the proportion of HIV/TB co-infections between 2007 and 2013 increased on average by 22% annually. In 2013, 19.6% of TB patients with documented HIV test results were HIV positive (Figure 13). Such a notable increase in HIV/TB co-infections reflects either the growing burden of the HIV epidemic in the country, or results from improved TB/HIV collaboration. The TB/HIV co-infection rate in Ukraine ranges from 2.4% (Zakarpats'ka region) to 31.7% (Donetsk region), according to 2013 routine surveillance data.

2.9. Global Fund Grant Overview

2.9.1. HIV/AIDS

Since 2003, the Global Fund has allocated more than USD 487.7 million to support the response to HIV in Ukraine. The country's **Round 1 HIV grant**, which was implemented by the UK International HIV/AIDS Alliance and is in the final stages of close-out, strengthened the national response to the epidemic by improving the quality and significantly increasing the availability and accessibility of antiretroviral treatment for people living with HIV. It also expanded prevention coverage aimed at most-at-risk populations, including injecting drug users, female sex workers, men who have sex with men, prisoners and at-risk youth. The Alliance and a national network of PLHIV, comprising some 150 sub-recipients, implemented interventions aimed at encouraging safe behavior and reducing the risk of HIV and other sexually transmitted infections, as well as reducing the stigmatization of and discrimination against people living with HIV.

In 2007, Ukraine received further Global Fund support to strengthen both the prevention and treatment of HIV and AIDS. Prevention activities, which as of 2009 included opioid substitution therapy and the treatment of opportunistic infections, have come under a **Round 6 grant** to the International HIV/AIDS Alliance in Ukraine. Alliance Ukraine and over 100 sub-recipients work to reduce HIV transmission and AIDS-related illness and death in Ukraine through interventions focused on the most-at-risk populations.

The program, which was implemented by the International HIV/AIDS Alliance in Ukraine (as distinct from its sister organization in the UK), aimed to ensure universal access to HIV prevention services, focusing in particular on injecting drug users, female sex workers, men who have sex with men, prisoners, street children and vulnerable young people up to 24 years of age. Scaled-up harm reduction and other prevention services are now available to vulnerable populations, including hidden and stigmatized groups. Program implementers created a supportive environment for a sustainable and efficient response to HIV and AIDS in Ukraine, as well as strengthening the national monitoring and evaluation system to measure the effectiveness of their interventions.

Table 5: HIV/AIDS grants

Grant Number	Period	Budget US\$	Principle Recipient	Rating
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UKR-102-G02-H-00	Ensuring Treatment, Care and Support for People with HIV/AIDS, Reduction of the Negative Consequences of the HIV/AIDS Epidemic and Development and Implementation of the System for Controlling the HIV/AIDS Epidemic	2003 2005	0.5	Ukraine Center for Socially Dangerous Disease Control (UCDC)/MOH	NA
UKR-102-G03-H-00	Reducing the Risk of HIV-Infection among Vulnerable Groups		0.5	UNDP	NA
UKR-102-G04-H-00	Overcoming HIV/AIDS epidemics in Ukraine	2004 2009	99.2	International HIV/AIDS Alliance in Ukraine (Alliance)	B1
UKR-607-G05-H-00	Support for HIV/AIDS Prevention, Treatment and Care for the Most Vulnerable Populations in Ukraine	2007	78.0	International HIV/AIDS Alliance in Ukraine (Alliance)	A1
UKR-607-G06-H-00		2012	51.8	All Ukrainian Network of PLWH (Network)	A2
UKR-011-G08-H	Building a sustainable system of comprehensive services on HIV prevention, treatment, care and support for MARPs and PLWH in Ukraine	2012	64.7	International HIV/AIDS Alliance in Ukraine (Alliance)	A1
UKR-011-G09-H		2014	54.1	All Ukrainian Network of PLWH (Network)	A2
UKR-011-G010-H			5.3	Ukraine Center of Disease Control (UCDC)/MOH	B1
UKR-C-AUA		2015	68.6	International HIV/AIDS Alliance in Ukraine (Alliance)	NA
UKR-C-AUN	Investing for impact against Tuberculosis and HIV	2017	60.4	All Ukrainian Network of PLWH (Network)	NA
UKR-C-CDC			4.3	Ukraine Center of Disease Control (UCDC)/MOH	NA
TOTAL			487.4		

The second of Ukraine's Round 6 HIV grants aimed to provide universal access to treatment care and support services to people living with HIV and those affected by the disease. Implemented by the All Ukrainian Network of People Living with HIV/AIDS and over 50 sub-recipients from both government and civil society, the program financed by this grant supports expanded antiretroviral treatment, social support, palliative care and associated programs for marginalized populations; diagnosis and management of TB/HIV co-infections; the expansion of drug adherence counseling; psychosocial support and care for people living with HIV; and the expansion of coverage to reach more people living with HIV with a focus on injecting drug users.

The **Round 10** HIV grants aimed to address the needs of MARPs and PLWHA and other people most affected by the HIV epidemic by scaling-up and ensuring equitable access to comprehensive HIV prevention, treatment, care and support; strengthening health systems for sustainable solutions; and strengthening community systems that enable needs-based and cost-effective interventions. The Phase 2 proposal of the Round 10 grants took into account the changing country context and epidemic trends and was aligned with the National HIV/AIDS Program 2014-2018 (NAP). The strategic strengths of the NAP were to address both medical, social and community services and promote the integration and decentralization of HIV/AIDS services. In line with goals of the NAP, the main priorities for Phase 2 were to expand prevention services and scale-up treatment, care and support services; emphasize the stewardship role of the government; effectively decentralize social and medical services; ensure equity and a strong community voice; and develop adequate mechanisms for quality assurance and M&E. Program implementation was conducted on a 'dual track' basis. There were three Principal Recipients, including two non-governmental organizations – the International HIV/AIDS Alliance in Ukraine (Alliance) and the All-Ukrainian Network of People Living with HIV/AIDS (Network) – and one governmental organization, the newly created Ukrainian Center for Disease Control (UCDC). The alliance was primarily responsible for prevention activities and OST program implementation. The Network provided care and support activities, coordinated efforts to reduce stigma and discrimination, and worked with communities on system strengthening. UCDC was in charge of overall coordination, health system strengthening, and facility-based service provision.

In 2014 Ukraine applied for the New Funding Mechanism and received a grant of 133.3 million USD for the period 2015 – 2017. The grant aims to reduce TB and HIV/AIDS-related morbidity and mortality in Ukraine through: **scaling up equitable access** to high quality TB and HIV prevention, treatment, care and support with a focus on **key populations**; supporting **continuum of care and treatment cascade**; catalyzing/supporting *critical enablers* for **health care reform** and **community system** strengthening, changes in TB, HIV and TB/HIV **integrated service** delivery and **decentralization**; and **supporting** sustainable **environment** for the delivery of services by the end of the programme.

2.9.2. Tuberculosis

Ukraine received the first TB grant during Round 9 in 2011 in the amount of US\$ 29,601,181 (PHASE 1) for the period of 2011-2013, with the specific objectives of preventing multidrug-resistant TB, improving treatment effectiveness, institutionalizing the training and retraining of health care workers, and improving laboratory diagnosis.

Table 6: HIV/AIDS grants

Grant Number		Period	Budget US\$	Principle Recipient	Rating
UKR-911-G07-T	Reducing the TB burden in Ukraine through expanding	2011 2013	29.6	Foundation for Development of Ukraine	A1
UKR-913-G11-T	and enhancing access to high quality TB services	2013 2015	30.5	Ukraine Center of Disease Control (UCDC)/MOH	B1
TOTAL			60.1		

The Foundation for Development of Ukraine, a private Ukrainian foundation, is the Principal Recipient for the US\$103.5 million Round 9 grant on TB. This five-year grant was signed in early 2011, with the goal of contributing to reducing the TB burden through expanding and enhancing access to high quality TB services. The MOH National TB Program is a major sub-recipient for this grant.

The plan to achieve the stated objectives involves building national TB program management capacities at central and regional levels; consolidating the laboratory structure and introducing external quality analysis; strengthening provision of DOTS (the basic package that underpins the Stop TB Strategy) supported by case management and outreach; rolling out internationally approved treatment for multidrug-resistant TB; and systematic human resource management and introduction of TB-relevant content in courses for TB specialists and primary health care physicians. This program will benefit the vulnerable and the poor, which are the populations most at risk of TB. Phase II of the same grant was approved in 2013 and will be closed end of December 2015.

While the Foundation for Development of Ukraine “Akhmatov Fund” was a Principal Recipient for Phase I of the grant, for Phase II the CCM decided to transfer the PR function to the UCDC, which can be considered as a first step towards sustainability.

3. CHAPTER : INTERNAL ENVIRONMENT

3.1. Stewardship

3.1.1. Stewardship of national HIV and Tb programs

3.1.1.1.HIV

A new HIV/AIDS prevention, treatment, care and support National Program has been approved. In October 2014, the Law of Ukraine "On Approval of the National Programme on HIV prevention, treatment, care and support for HIV and AIDS for 2014-2018", was approved. **Importantly 21 regions have developed their regional plans.** With the help of PEPFAR supported projects, 21 regions developed regional programs for HIV/AIDS prevention treatment and care,

although only a few (three) regions managed to allocate local resources to support regional program implementation.

New HIV legislative progress facilitates improved access of KP to prevention and treatment services. The new HIV law adopted by the Verkhovna Rada of Ukraine (the parliament) in December 2010 and the Partnership Framework signed by the US Government (USG) and cabinet of Ministers of Ukraine (CMU) in February 2011 are important steps in harmonizing Ukrainian policies around HIV. The new law provides clearer and more specific definitions of medical services and the rights and responsibilities of clients and healthcare providers than the previous law. The HIV Law provides the foundation upon which access to services could be improved, including the scale-up of critical OST and needle and syringe exchange programs (NSP) and other services for KPs that have historically faced significant legal and regulatory barriers in Ukraine. Ukraine's new HIV law opens a path to future expansion of the HIV response in Ukraine, especially HIV prevention and treatment services for KPs.

Ukraine has made progress in aligning national treatment guidelines to WHO recommendations. In 2014 Ukraine adopted WHO's new treatment guideline (2013 "CD4 -500") which was planned to be introduced in 2015. However due to financial challenges faced by the program, the introduction of the new treatment guideline has been temporarily postponed to 2016.

The parliament has adopted a new Law "On implementing programs of the Global Fund to Fight AIDS, Tuberculosis and Malaria in Ukraine"⁴⁰, which exempts goods and services from value added taxes and is expected to make it possible to save and redirect substantial funds into buying other goods and services as part of the TGF program. In addition, the law allows Ukrainian AIDS Center, as a government institution and primary recipient of the Global Fund grant, to conduct procurement according to international standards.

Standards for social services were developed and adopted⁴¹ by the government, which guides the delivery of social support activities. As prevention activities are not yet fully funded by the GF, due to reduced GF funding for the years 2013-2017, the number of types of services defined in standard social service packages has been reduced from seven to four. Importantly, these packages no longer include informational material.

An HIV prevention policy for the penitentiary system was approved and implemented in Ukraine for 2009-2013, and a new one is under preparation. In order to pursue the National Programme for the Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients for 2009–2013, a relevant sectoral programme for penitentiary institutions – the Programme to Ensure Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients in Penitentiary facilities and Remand Prisons of the State Criminal Execution Service of Ukraine for 2007-2013 – has been developed and is currently being implemented. A new program for 2016-2018 is under preparation. Changes in the management of the penitentiary Health Department hindered the development of the new program. Key challenges for the implementation of this sectoral programme include: insufficient funding, lack of specialists, shortages or delayed procurement of medicines and consumables, shortages of informational material and individual protection means, unregulated cooperation with partners and finally the lack of recognition of HIV risk behaviors among prisoners.

While Ukraine has made strong progress in improving the HIV policy environment, major challenges remain. Political instability continues to cause frequent staff changes at the highest levels of government, making it difficult to maintain policy reform momentum.

⁴⁰ Verkhovna Rada The Law #4999-VI, from June 21, 2012

⁴¹ Joint decree of the Ministries: Ministry of Family, Youth and Sports, Ministry of Social Policy and Ministry of Health No.: 3123/275/770 from 13.09.2010 "Standards for social service provision for KAPs". <http://zakon2.rada.gov.ua/laws/show/z0903-10>

3.1.1.2. Tuberculosis

A new National TB Program is under preparation. The National TB Program for the years 2012-2014 was approved by the government in October 2012. This is the second national program developed in Ukraine. At present, the new National Program for the period of 2015-2018, which was developed under the leadership of UCDC, is awaiting the government's approval.

The UCDC is charged with the control of HIV and other socially dangerous diseases and performs traditional NTP functions in relation to TB control: management, strategic planning, coordination, supervision, regular information and feedback, training, and monitoring and evaluation.

Ukraine has made progress in aligning National TB guidelines to WHO recommendations. Over the last couple of years, Ukraine has significantly strengthened its TB control program based on international recommendations, starting with the introduction of DOTs and further expanding its framework by implementing a comprehensive range of approaches, including: strengthening TB control interventions in the penitentiary system; actively involving primary health care providers in TB case detection and case management; and introducing and scaling up rapid diagnostic techniques for TB and MDR-TB (including the rollout of Xpert MTB/RIF). At present, treatment strategies for drug-resistant TB cases are under preparation. Nevertheless, MOH order N 327 of 15.05.2014, which requests extensive obligatory fluorography screening among professions with little impact on the spread of airborne infection, must be aligned with WHO active case finding recommendations. The guide for laboratory quality control for microbiological investigation of *M.tuberculosis* has not yet been finalized, approved and implemented at all levels of the laboratory network.

3.1.2. Coordination mechanism

Ukraine had a functioning national coordination mechanism, but recently the National Council mandate was shifted down from the Cabinet of Ministers (Deputy Prime Minister) to the level of the MOH. The National Coordination Council on HIV/AIDS under the Cabinet of Ministers of Ukraine (CMU) was established in 2005, but it was reorganized into the National Council (NAC) to Fight Tuberculosis and HIV infection/AIDS

(NAC) in July 2007 under the Prime Minister's office. The NAC provided cooperation between state institutions and non-governmental organizations⁴² and operated through quarterly or more frequent meetings. The NAC had broad multisectoral representation from a variety of ministries, NGOs, academia, religious organizations, and the PLHIV community. Several key informants noted that other ministries, such as the MOIA and the MOES, sent different representatives every time and that the representatives were not actively engaged in proceedings. With the exception of the former Ministry of Youth and Sports (MoYS), the participation of other ministries was characterized by key informants as "sporadic, ineffective, and low-level."

"The participation of key government structures was not adequate. Often ministries sent different representatives who were not empowered to speak on behalf of the ministry, but rather take notes and deliver messages back to the ministry. The most active always were NGOs. Sometimes we joked that NC was established only for NGOs..."

Quote: From Key Informant Interview

- **The NAC facilitated the work of Committees on Programme Affairs and Regional Policies** – A number of committees were created in 2010 by a decision of the NAC in order to improve the quality its draft decisions, to engage more stakeholders into its operations, and to harmonize the activities of the above-mentioned working groups. Members of the NAC headed these committees. The composition of the NAC's committees was set up based on a cross-sectoral approach, with the representation of NGOs. The committees operated through meetings.

⁴² Report on the Council activities of 2013

- ***An Oversight Commission (OC) for Global Fund financed projects was created*** in 2011 to supervise implementation of the Global Fund grants. It operates through meetings and supervisory field visits, organized according to an action plan. The OC will continue to operate beyond the expiration of its mandate until the NAC under the MOH is formed and new elections are organized.
- ***Collective decision-making agencies were established in the oblasts (districts) of Ukraine under the Governor's office.*** 27 Regional Councils were set up in 2005 – 2006 and operate as consultation and advisory bodies, through quarterly or more frequent meetings. They include representatives of the different organizations involved in the HIV/AIDS response in each region, including religious organizations and service providers. The Deputy Chair typically represents the CSO or PLHIV community. Oblast and rayon councils function with little or no support from the National Council, but some oblasts have been actively supported by donor-funded projects. Key informants also noted that the success of the coordination council varies according to the strength of NGO presence and the leadership of government participants.

“The regional coordination council is a very useful, helpful mechanism for collaboration and coordination as well as for addressing problems. The effectiveness of these councils varies by region and mostly depends on the individuals involved and/or NGOs”

Quote: From Key Informant Interview

In order to ensure the ongoing activities of the National Council on Tuberculosis and HIV/AIDS in Ukraine, a National Council Secretariat was created. In 2011 the State Service on Combatting HIV/AIDS and Other Socially Dangerous Diseases⁴³ (SS) was established. Its functions included serving as a secretariat for the functions assigned by the Cabinet of Ministers of Ukraine on prioritization and implementation of the national policies on TB and HIV/AIDS; consolidating the use of funds; promoting coordinated activities by state agencies, international and non-governmental organizations; and monitoring and overseeing TB and HIV/AIDS programmes and activities. The major functions of the Secretariat included organizational, methodological and technical provision of activity of the National Council, Committee on Programme Affairs, Committee on Regional Policies, and the Commission on Oversight of Development of Proposals, Negotiations and Implementation of Programmes. As such, it was funded by the GF grant.

As a result of the recent restructuring of the overall national coordination system of the country, the erosion of the traditional HIV/TB governance and coordination resulted in reduced political commitment and the loss of HIV and TB from government's and MOH's policy agenda.

- With the recent government restructuring efforts, the CMU decided to optimize the number of councils and committees under its authority, resulting in the shift of the NC to the MOH, although this decision has not yet been formalized. The last two CCM meetings were held in February and June 2015, in which the GF Grant Agreement was discussed at the request of the GF representatives, followed by discussions about the operability of the CCM and the preparation of the transition plan.
- Following the first initiatives of the new government to optimize the number of State Agencies in the public sector, the State Service on Combatting HIV/AIDS and Other Socially Dangerous Diseases was liquidated and the decision taken to move its functions to one of the departments of the MOH. However, due to frequent management change at MOH and its delayed organizational restructuring, the question of how to coordinate Public Health and HIV/ TB is under consideration for the 2nd year already. In response to the GF's request, a small part of secretariat was moved from SS to the MOH and continues to be fully funded through the grant.

⁴³ Approved by the Law of the President of Ukraine # 1085/2010 as of December 9, 2010 as a central agency of executive power, Decree # 441 on “Provisions for the State Service on Combatting HIV/AIDS and Other Socially Dangerous Diseases

"Some regions where we work shifted the regional committees from Governor's office to the regional health departments, which will affect the multisectoral planning and will make difficult to lobby decisions"

Quote: From Key Informant Interview

- The CMU decision also had a significant impact in the work of the regional councils. According to key informants, some regions moved the regional committees from Governor's office to the regional Health Departments.

In summary, the following conclusions can be made: the country lost the platform at national and regional levels for adequate coordination for effective implementation of multisectoral responses to HIV and TB.

3.1.3. Program management arrangements

The Ministry of Health of Ukraine is responsible for National HIV/AIDS and TB program development and oversees implementation. However changes to the MOH administration, its structural reorganization and the preparation of a large package of important health reforms weakened the MOH's functionality in the area of TB and HIV/AIDS.

As a result, the MOH's leadership has continued to be weak. Despite the challenges involved in a multi-sector response, there are obvious areas where the MOH's political leadership could deliver on expectations.

"The Ministry does not react immediately to the needs of HIV and TB programs"

« The reorganization of the ministry is slow. None of the departments of the MOH are charged with the functions that the State Service had after its liquidation»

«HIV/AIDS seems no longer to be a priority for the Government and the ministry»

Quote: From Key Informant Interview

Furthermore, according to key informants the MOH lacks the capacity and professional staff to react promptly to new realities and challenges. There is a general opinion among stakeholders that HIV/AIDS and TB programs lost the government's attention, and that they are no longer high on the MOH's or the government's political agendas.

As mentioned above, ***the former State Service of Ukraine on HIV/AIDS and Other Socially Dangerous Diseases managed program implementation, coordinated monitoring and evaluation and was responsible for national, GF and global reporting.*** No dedicated department was established at the MOH to inherit these functions following the SS's liquidation. In its absence, UNAIDS coordinates the donor response to HIV. The coordination of the TB response is left to international implementing partners.

Ukrainian Center of Disease Control (UCDC) organizes and delivers specialized health care services, provides methodological support to organizations in the health sector involved in HIV and TB response, tracks implementation of program activities, collects and finalizes reports submitted by program implementers through the state surveillance system and is responsible for reporting to the CMU, MOH and international community. The capacity of UCDC has been strengthened over the years.

Recent administrative reforms introduced by the Government have also affected the Sanitary Epidemiological Service (SES). Although the SES is currently being liquidated, it is unclear which structure/entity in the health sector will assume its functions. There are discussions about creation of the Institute of the Public Health on the basis of the UCDC, which will take over the responsibility for policy development, surveillance and monitoring of non-communicable and communicable diseases including HIV/AIDS and TB. However, stakeholders expressed their concerns about UCDC's ability to assume new responsibilities and also effectively manage the national HIV and TB programs.

The provision of health services in the State Penitentiary Service of Ukraine is fragmented. The health care of detainees in police custody is in the responsibility of the MOH through Public Health agencies, while prison health care is responsible for detainees in pre-trial centers and sentenced prisoners. This implies that coordination is critical to ensure continuity of treatment.

3.1.4. Partnerships

The environment encouraging active participation of wide range of stakeholders in policy development, implementation and M&E was well established in the field of HIV and TB, but it has deteriorated since the change of the government. One of the key benefits of GF support was

the establishment of the NAC, which created a platform for information sharing, coordination and partnership between a wide range of government and non-government stakeholders. However, interviewed stakeholders perceive current partnerships as being sub-standard. NGOs and development partners are still

actively engaged in program design, implementation and in monitoring the national HIV response, while the MOH and other government institutions have become less involved. Although they understand that the MOH has competing priorities on its agenda, stakeholders want to see decisive steps from the MOH to resolve the outstanding challenges and prevent any further deterioration in the epidemic situation in the country.

The partnership between development partners and NGOs is exemplary. A wide range of development partners involved in HIV and TB programs in Ukraine have effective partnerships with NGOs. However, in the absence of coordination and guidance from the MOH, development partners are following their original programmatic plans – even though they understand that, amidst a changing environment and planned reforms, the resources available could be used more effectively.

«MOH has to be more responsive to the problems HIV program faces at present. If the MOH will not be able to resolve drug procurement problems asap, it will result in ARV treatment interruption »

«The MOH has to be more active. We do understand that MOH is in the process of organization development, but with the liquidation of the State Service, their function has not been transferred to the ministry. There is no unit that can take a stock of problems faced during the implementation and address them accordingly»

Quote: From Key Informant Interview

Text Box 1: Government and CSO partnership to resolve procurement related challenges

Patients -co-authors of the Law on Procurement

«This is the first precedent in which patients are the co-authors of the law, and try to help the country find effective tools for solving problems in the purchase of medicines. We reviewed the existing legislation and proposed necessary changes to the laws that will save thousands of lives»

International experience indicates that when countries that lack well-functioning public procurement systems involve international organizations in the purchase of medicines with public funds, they create a number of advantages both for patients and for the health care system, and make budget savings. This is proven in many transition countries such as Moldova, Armenia, Azerbaijan, Georgia, as well as several countries in Africa, Asia and South America. Through this kind of a mechanism, such countries ensure the on-time delivery of effective, safe and quality medicines and budget savings.

In order to allow the efficient use of scarce public resources and ensure the timely delivery of vitally important medicines in Ukraine, the “Patients of Ukraine” CF together with “Arzinger” LF have prepared and brought to the Ministry of Health a draft law of Ukraine “On ensuring drugs procurement through international organizations through the state budget”. The draft law was developed in a few weeks with the participation of qualified lawyers and CSOs, and takes into account worldwide experience of the involvement of international organizations in public procurement procedures in the field of medicine.

The law will not only help to eliminate corruption from drug procurement, but will also provide lifesaving drugs for patients with HIV/AIDs, tuberculosis and other diseases, and vaccines for children. The draft law provides for the transfer of state procurement of drugs and vaccines to international organizations such as WHO and UNICEF. The explanatory note to the law states that it has the following benefits: reducing the supply chain of medicinal products (many drugs are purchased by international organizations under direct contracts with manufacturers, which allow them to get the best price and quality assurance); providing high-quality procurement through strict requirements that apply to drugs; providing speedy purchases through procurement by pre-qualified international organization; eliminating corruption risks related to the procurement of drugs by the Ministry of Health of Ukraine; procurement according to transparent and open rules and procedures of international organizations; and the ability to purchase drugs at low prices due to the large volume of purchases carried out by international organizations and through long-term framework agreements with suppliers.

3.1.4.1.HIV

The development of the new national program was carried out in a participatory manner ensuring the participation of stakeholders from the central and regional executive authorities, national and international NGOs. The Concept Note prepared for GF funding was agreed with the Ukrainian Regions.

A wide representation of stakeholders is ensured in the CCM oversight committee and other technical working groups. The members of the National M&E Group include representatives of international and national organizations and research companies. National reports are largely prepared based on the results of bio-behavioral surveys carried out by NGOs, and with the active involvement of CSO professionals who possess information about hard-to-reach groups of the population.

At the regional level, NGOs fulfill a vital role as watchdogs to monitor the oblast government’s role in addressing HIV, implementing integral HIV programs, and advocating for patients whose rights may have been violated. In some regions, NGOs have built strong relationships with the government and with health facilities. In other regions, these relationships are strained, and NGOs face obstacles to providing services or protecting the rights of PLHIV.

Civil society plays a key role in shaping the commitment of top leaders via high-level meetings, meetings of stakeholders, advocacy campaigns and the exchange of official correspondence. NGO representatives have been involved in all phases of government policy development. NGO

representatives, specifically, PLHIV, LGBT and HIV-service organizations members of the National TB and HIV/AIDS Council and its working bodies (the Committee for Regional Policies; the Committee on Programmatic Issues; the Commission for the Supervision of Application Development, Negotiations and Implementation of Programs Implemented with funds of the Global Fund to Fight AIDS, Tuberculosis and Malaria).

In addition, CSO representatives have access to financial and technical support to implement HIV activities through grants from international donor organizations. Such financial and technical support from donor institutions is mostly aimed at ART and OST, care and support, prevention among vulnerable groups, community mobilization and advocacy. The viability of such projects is low and there are no mechanisms to secure the sustainability of civil society organizations beyond the assistance period. Consequently, according to key informants, given the reduction of the scope of financial and technical assistance from donor organizations for such activities, the number of clients of these programs will decrease and the quality of their services will go down.

The government regularly solicits input from the public and concerned stakeholders, although the government appears to be more responsive in areas where donors and NGOs are active or where other groups are organized. National government data, budgets, and goals are publicly available and communicated to stakeholders. The MOH website and other government websites post much of this information in a timely manner, although not always in a form that is user-friendly to non-specialists.

Civil society, including provider groups, NGOs, and the media, provides a watchdog function over health providers and institutions in the way they deliver services. Public and concerned stakeholders through community health committees in Ukraine have opportunities to meet with health managers to raise issues about performance. For example, recently reported stock outs of ARVs highlighted the ability of patients to effectively express their needs in a manner that should produce a desired response at the national level⁴⁴.

3.1.4.2. Tuberculosis

The CCM enables wide public participation. The participation of representatives of a wide cross-section of the public in the development of proposals, implementation of government policies, consolidated spending of funds and monitoring of TB programs is provided through the CCM membership, through Local (regional/municipal/district) TB and HIV/AIDS councils and Intersectoral working groups established with the MOH.

The partnership of the Government and CSOs in the field of TB is less developed compared to HIV/AIDS. Historically TB was mainly addressed by the health sector in Ukraine, and therefore attracted less interest from

development partners and the non-governmental sector, as reflected in the absence of external funding. According to key informants, key stakeholders only recognized the importance of TB as a key public health problem in relation to HIV/TB co-infection. NGOs engaged in HIV/AIDS service provision started to address TB related issues, although on a limited scale. Ukraine received the first GF grant only in Round 9, which came into effect in 2012 and facilitated a more active partnership between government institutions and CSOs, and also mobilized development partners to contribute to the national TB response.

The first grant for TB was awarded by the GF only in 2012. In the absence of targeted external funding for TB, NGOs were less interested being engaged in TB. Gradually the interest in TB has grown, but not sufficiently to counterbalance HIV/AIDS interests.

Quote: From Key Informant Interview

Nevertheless, civil society organizations played a proactive role in drafting the National TB Program and developing its activities. CSO were represented in the working group for elaborating the National Program and submitted written proposals after holding wide public consultations. National and international NGOs were also involved in the development of the

⁴⁴ Ukraine Health System Assessment, USAID, 2011

Concept alongside stakeholders from the central executive authorities. The Concept was agreed with Ukrainian Regions.

Although CSOs started to be more actively involved in TB policy formulation, their influence is limited compared to those involved in the field of HIV/AIDS. Limited representation, paired with relatively shorter experience in the TB field, limits their ability to be more vocal and leverage support for the changes needed.

3.1.5. Accountability mechanisms

Ukraine regularly provides HIV and TB data to global reporting systems. The government of Ukraine ensures regular reporting on HIV and TB data to WHO, UNAIDS, Euro CDC and Stop TB Partnership. Global databases demonstrate the completeness of Ukraine's data on key indicators and the regularity of its reporting (up until 2012).

The CCM platform is used for systematic reporting on the progress achieved and challenges in the field of TB and HIV to key stakeholders. CCM meetings are often used to report on the progress of implementation of both NAP and NTP, to discuss challenges and to elaborate remedial actions, although it has been weakened lately.

UCDC updates surveillance data on a monthly basis, which is available electronically on the web, and also publishes annual HIV surveillance reports.

The results and findings of program monitoring, evaluation and behavioral studies are readily available and easy to access on the web and in print, except of some reports, which are not user friendly for non-Ukrainian speaking individuals. For the purpose of this assessment, all types of reports produced within the M&E framework of both programs were made available to the researchers promptly, but most of them were only available in Ukrainian, limiting our ability to fully explore the documents.

The media is actively engaged in reporting the challenges faced during the implementation of NAP, but is less aggressive on NTP implementation challenges, stigma and discrimination.

Electronic and printed media aggressively highlight issues related to shortage of ARV medicines, funding and procurement related issues, thereby defending the rights of PLHIV. However, issues related to TB prevention and treatment, along with population information and awareness related to human rights and the prevention of stigma and discrimination, receive less attention.

CSOs actively utilize their oversight function. CSOs regularly perform analysis of different topics related mostly to HIV/AIDS, organize meetings and discussions with a wide range of stakeholders, reach out to the media and organize public gatherings to lobby issues and defend the rights of their constituencies.

Text Box 2: NGO Oversight

MOH Order #200 on Medication Assisted Treatment (OST) MOH, dated 27/03/2012, imposed a requirement of "2 unsuccessful drug treatment attempts before patient is enrolled into OST", which consequently restricted a patient's easy access to OST services.

In 2013 Alliance Ukraine actively started to advocate for necessary changes in Order #200. Alliance Ukraine, together with partners on OST, tried several different approaches, ranging from dialogue with the MOH to initiating a court case against it. A large number of patients, with the Alliance's legal support, submitted petitions to Ukrainian governmental institutions, including the MOH, the Ministry of Justice, and the Administration of the President. As a result, the MOH issued Order #218, which revoked the requirement for "2 unsuccessful attempts of treatment" as a precondition for a patient to enroll in OST.

3.2. Financing

3.2.1. General health care financing

The government's commitment to prioritize the health sector has deteriorated since 2014.

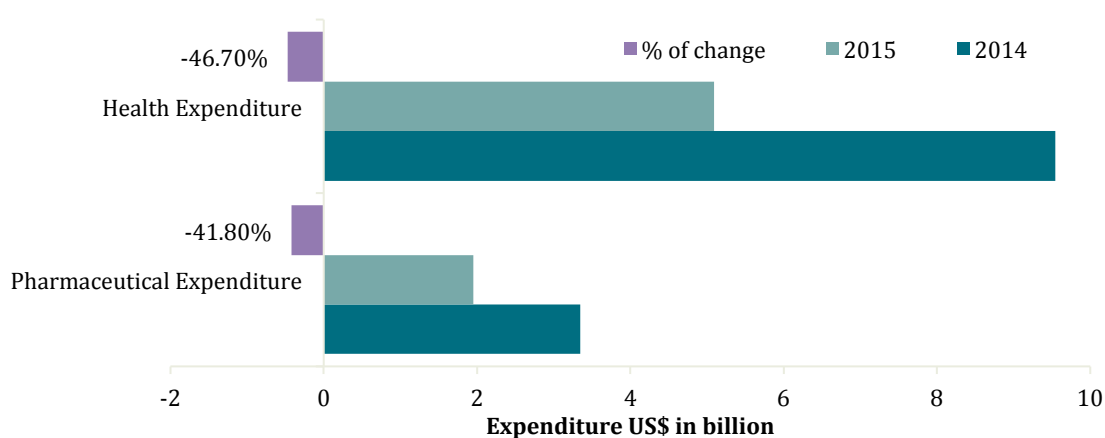
Health expenditure as a share of total government expenditure increased in the period of 2000-2013, with the lowest level of spending recorded in 2008 and 2012 (11.7% and 11.9% respectively), and the highest level of health expenditure reported in 2010 (12.8%). After the decrease in 2012, health expenditure increased to 12.2% in 2013 (for annual data refer to ANNEX 3).

Table 7: Health care financing 2000-2013

	2000	2007	2008	2009	2010	2011	2012	2013
Health expenditure per capita, PPP (constant 2011 international \$)	214.2	509.9	557.4	565.0	599.3	607.4	634.2	686.7
Health expenditure, total (% of GDP)	5.6	6.4	6.6	7.8	7.8	7.3	7.5	7.8
Health expenditure, public (% of government expenditure)	10.2	12.5	11.7	12.8	12.7	12.8	11.9	12.2
Health expenditure per capita (current US\$)	35.6	194.4	251.3	197.2	231.4	261.8	289.8	312.7
Health expenditure, public (% of total health expenditure)	51.8	61.8	57.7	55.0	56.6	55.7	55.4	54.5
Health expenditure, private (% of total health expenditure)*	48.2	38.2	42.3	45.0	43.4	44.3	44.6	45.5
Out-of-pocket health expenditure (% of total expenditure on health)	44.1	34.7	39.4	42.0	40.5	41.5	41.8	42.8

Source: World Development Indicators. <http://data.worldbank.org/indicator> accessed on May 30, 2015

Figure 14: Expenditure Projections⁴⁵ 2014-2015



Due to the economic downturn, the depreciation of the national currency and the tense political situation in the country, funding of the health sector has shrunk since 2014. Compared to previous year, the total budget for the health sector decreased by almost 47%, and budget allocations for pharmaceutical expenditure declined by 42% in 2015. According to informants, the budget was decreased for almost all sectors in favor of defense-related spending.

Apart from the budget decline, the Public Finance Management (PFM) system in Ukraine has persistent weaknesses, which prevent good performance and

We lobbied hard for health sector budget increase in 2014 by organizing protest actions, talking on media, TV, meeting with parliamentarians, which resulted in budget increase, however the MOH used additional resources to fund other state programs and no penny was allocated for HIV/AIDS”.

Quote: From NGO representative's Interview

⁴⁵ Ukraine Pharmaceuticals and Healthcare Report Q3 2015

undermine spending efficiency and better expenditure outcomes⁴⁶. Rules defined by the MoF require the use of national statistics for budget planning purposes. However, these rules do not yet recognize data derived from the improved national M&E system, such as size estimation studies, BSS surveys, from other operational research work, etc. Consequently this kind of data is not demanded by planners and is not used effectively.

The political will to prioritize HIV/AIDS and TB Programs during resource allocation is lacking. The budget of the health sector was increased by 10% in 2014 in response to NGOs' aggressive lobbying. However, the MOH distributed the additional funding to other state programs, leaving HIV and TB unattended (Table 8).

Table 8: Resource allocation to State Programs

State Program	% Of need covered	State Program	% of need covered	State Program	% of need covered
Pediatric Oncology and oncohematology	100%	TB	34%	Transplantation	24%
Multiple Sclerosis	97%	HIV/AIDS	34%	ART	22%
Cardio Vascular Diseases	61%	Hepatitis	34%	Adult Oncology	14%
Immunization	54%	Reproductive Health	29%	Nephrology	10%
UN Convention	50%	Diabetes mellitus	28%	Implants	2%
Blood Donors	42%	Hemophilia	26%		

The disconnect between policy objectives and recurrent budget allocation does not allow for planning of the service volumes that the population needs. Instead, it only focuses on the infrastructural, human resource and capital inputs that have to deliver these services. This disconnect is further aggravated by the poorly developed budgeting norms (for inputs and for funding allocation) established by the government or by line ministries. Uniform norms developed by the MOH across the country regulate the establishment of AIDS centers by local government, their staffing etc. Such rules drive recurrent and capital budget allocations from local budgets. But since the spread of infection is different in different localities, these uniform rules create huge inefficiencies.

While funds are spent at the local level, decision-making authority does not rest with local governments, which leads to a misalignment of administrative and financial responsibilities at the local and regional levels. Local administrations have very little discretion in allocating funds and administering programs. Decision-making, including facility-level budgeting, is subject to a rigid vertical structure of input norms imposed by ministerial orders.

Healthcare facilities find themselves at the frontline of this “mismatch” between available resources and service delivery mandates, absorbing the resulting unfunded costs and, where possible, shifting them on to the patients. Administrators need not only to present their budgets, respecting impossible norms, but also find a way to provide the actual services within their budget envelopes⁴⁷. Private households' expenditure, mainly patients' OOPs at the point of service delivery, accounted for 3.26% of GDP in 2012 (the latest available data). This was equal to 42.8% of total health expenditures (Table 7 on page 41), according to Household Budget Surveys conducted that year, while pharmaceuticals and other medical appliances are primarily financed by households (at a level of approximately 90 percent). These high levels of OOP can cause catastrophic levels of health expenditure for those who seek care, and/or prevent households from seeking care. For example, according to a 2011 household survey, 22.6 percent of those who needed to buy medicines were not able to get them, primarily for affordability reasons, while the concentration

⁴⁶ The World Bank, 2012 *Ukraine Public Finance Management Performance Report 2012*

⁴⁷ Ukraine HIV Program Efficiency Report, World Bank

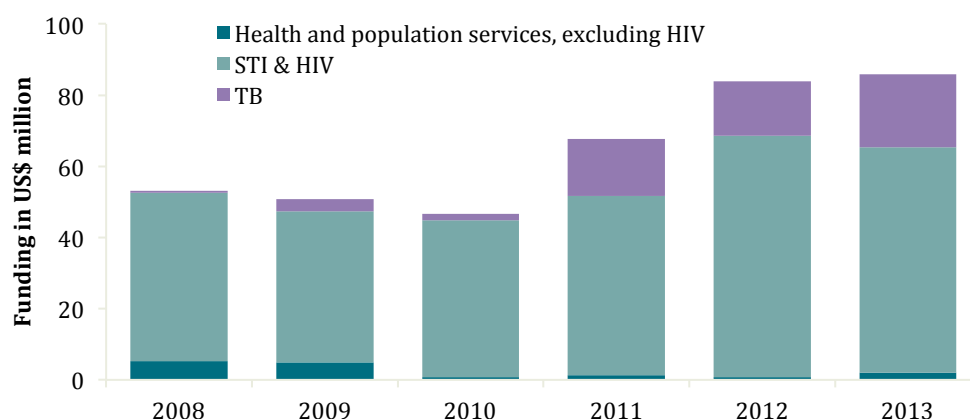
index for the utilization of inpatient services was 0.21, signaling a severe inequality in utilization of hospital services in favor of the rich. Among the poorest 40 percent of households, 10.2 percent reported spending more than 25 percent of their total non-food expenditure on health⁴⁸.

Ukrainian laws guarantee free ART, treatment of TB and of opportunistic infections, as well as the accessibility and appropriate quality of HCT services (including anonymous testing, the provision of preliminary and follow-up consulting services, and ensuring of the safety of testing for client and provider).

Flaws in the public procurement system limit fair and open competition, thereby undermining value for money⁴⁹. Protectionist rules reflected in the laws promote locally manufactured products over imported ones, which sometimes undermines the quality of products procured by the government. Facilities are required to use locally produced HIV test kits that are of poor quality and a source of inefficiencies, but most importantly negatively affect the quality of testing services, as noted earlier. Furthermore, procurement rules that limit competition drive-up the costs of inputs (ARVs, HIV test kits, etc.). Through open international bidding the cost of ARVs, test kits, etc. could be significantly lower, as we have seen for the commodities purchased with the TGF grant. Consequently with the same amount of financial resources, Ukraine has the opportunity to purchase more inputs necessary for treatment, which could increase the efficiency of public funds and treat and care for more PLHIV.

External funding of the health sector increased from 2011 to 2013, prioritizing the funding of HIV/AIDS. External assistance to Ukraine increased from 2011 and peaked in 2013 at 85.9 million USD. 74% of total external assistance in 2013 was allocated to HIV/AIDS, and 24% to TB (Figure 15).

Figure 15: Aid Disbursements, 2002-2012 (US\$ millions)



Donor funding accounts for only 0.2–0.3 percent of total health spending in Ukraine. Donors are important contributors to antiretroviral therapy (ART) and TB treatments in the health system, and often provides support through local NGOs and civil society organizations. Key bilateral donors that work in Ukraine and provide programming related to HIV/AIDS and TB include USAID, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), the Swedish International Development Agency (SIDA), and the Swiss Agency for Development and Cooperation (SADC). Other important donors include the International Alliance for HIV/AIDS, the Clinton Foundation, and the Soros Foundation. Additionally, international organizations such as WHO and other UN agencies provide key technical assistance to the MOH.

It will be difficult to ensure the sustainability of specialized programs of public health significance without rationalizing the health system and using resources more efficiently. Financial sustainability and improved resource use within the entire health system and the

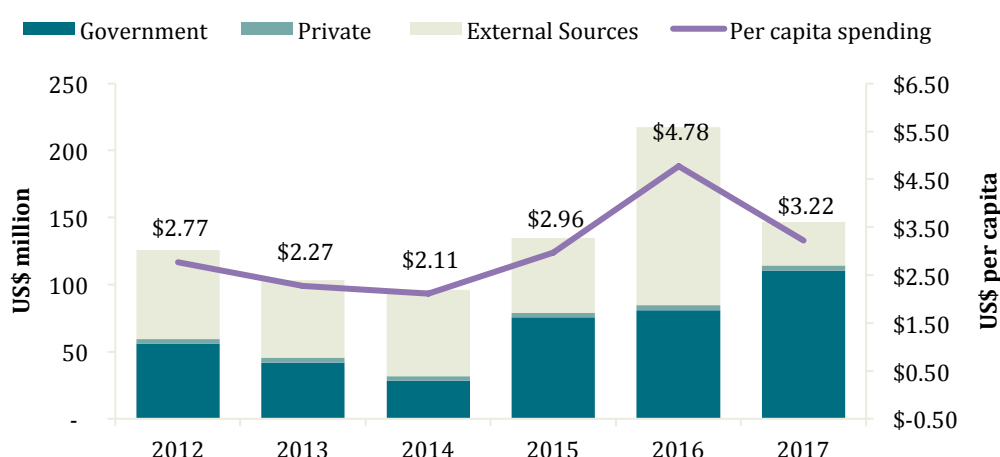
⁴⁸ The rest (0.2 percent of GDP) is constituted by private insurance contributions.

⁴⁹ Sustainability of HIV/AIDS Response, 2012, UNAIDS

HIV/AIDS or TB systems are related. Without rationalizing the health system and a corresponding freeing up resources, specialized programs of public health significance would continue to rely on donor funding or remain underfinanced, thereby perpetuating threats to sustainability. On the other hand, efficiency in HIV/AIDS, TB, and other specialized programs depends on the effective integration of these services in the general health care system. Parallel service delivery systems for specialized programs create a considerable cost burden on the country's health financing, as well as coordination and management problems.

3.2.2. Funding of the national HIV program

Figure 16: HIV National Response Funding by funding sources (actual and forecasted) 2012-2017⁵⁰

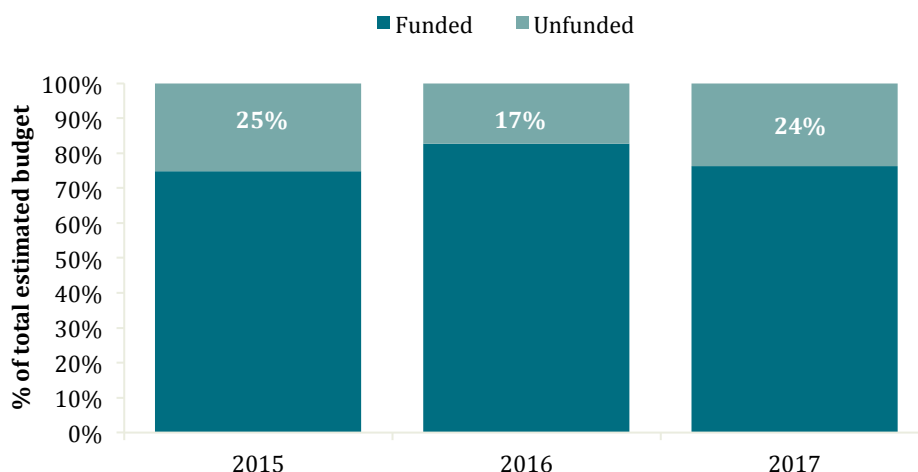


The government's commitment to fund the national HIV/AIDS response looks less promising. Estimated total HIV expenditure per capita per year (PCPY) from public and international funding sources up to the year 2014 decreased (Figure 16). While an increase is projected for years 2015 - 2016, PCPY is planned to decrease again in 2017.

The share of domestic funding in the national HIV response increased in 2015 and will maintain this pace in the coming years, but the total HIV budget will start to decrease due to fading external support. Activities related to HIV/AIDS in Ukraine are funded from national and local budgets, in addition to support from international development partners. Starting from 2014, the government increased its funding plans further until the end of GF support by taking over full funding responsibility from year 2018 (Figure 15), as declared in NFM GF concept note. However the prospects of fulfilling this commitment are slim given the tense political environment in the country. Therefore the forecasted budget increase has to be treated with caution, especially in relation to the share of domestic funding.

⁵⁰ NFM GF, 2014

Figure 17: Funding Gap of HIV National Response 2015-2017

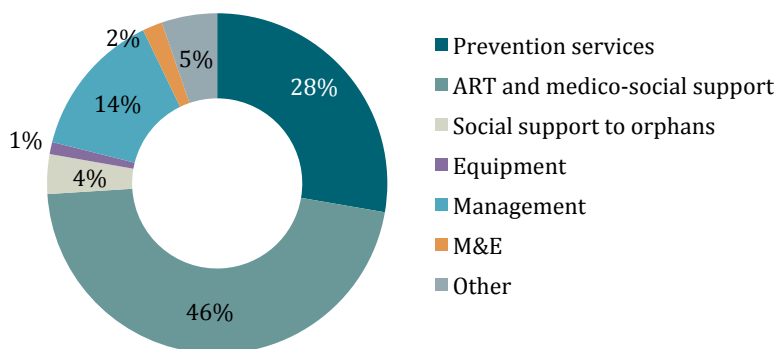


Apart from declining external support and decreased domestic funding, Ukraine's national HIV/AIDS response will suffer from an increased funding gap. As reported in the NFM GF concept note, the estimated funding gap will vary from 17% to 25% in the years 2015-2017. There is a severe risk of the gap widening after 2017 if external funding declines and the government's ability to allocate more resources is not guaranteed.

Inadequate funding and the inefficient use of national and local resources allocated to HIV/AIDS prevention, treatment, care and support services will have a further negative impact on the effectiveness of the national response. There is often a disconnect between national laws and policies and the budget allocations, which often undermines the Ukrainian law on HIV/AIDS that guarantees free access to HIV prevention, HCT, treatment, care and support services. At the same time, the MOH lacks the financial authority to establish broader collaboration with other ministries. These factors complicate the MOH's ability to plan for the future and develop concrete strategies to mitigate the effects of HIV/AIDS. According to key informants, although the MOH is responsible for the development and implementation of the NAP and its respective budget, the MOF resists funding activities that it considers unnecessary and/or should not be supported by the national budget. These decisions are apparently made in the absence of sufficient technical expertise. Moreover, the crucial problems that create barriers in effectively combatting HIV/AIDS epidemics are the permanent lack of financing of services for PLHIV and the ineffective use of local budget funds allocated to HIV/AIDS.

The severe depreciation of the national currency further increases the gaps in public funding of the program. The share of public funding of the national HIV response was calculated at an exchange rate of US\$ to local currency US\$ 1= 8.1 UAH. However, the national currency depreciated by 300% in 2015 (US\$1 = 24UAH), which resulted in severe financial resource shortages (19 million US\$) in the ARV procurement budget. The negative implications of currency depreciation are less evident in GF funded activities, as the exchange rate was set at US\$1=15.83 UAH by the GF.

Figure 18: HIV/AIDS funding by type of intervention, NASA, 2012 (US\$ millions)



The liquidation of the State Services for Socially Dangerous Diseases resulted in the abolition of tax exemption procedures for GF funded commodity procurement, and severely affected the volume of ARVs to be procured in 2015. The authority for issuing tax exemption letters was delegated to the SS, but since its liquidation the MOH has failed to take decisive steps to transfer this function to the SS's successor. Since almost half of the budget for the national AIDS program (Figure 18) is for ARVs, the lack of action on behalf of the MOH has resulted in fewer funds available for the procurement of medicines and commodities.

Another significant concern for Ukraine's public health system is the serious lack of sufficient government funding for targeted preventive interventions among KPs. Similarly, the government service delivery network does not have active outreach mechanisms for the targeted groups. Active outreach work with targeted preventive services among the KPs is mostly carried out by NGOs, with external financial assistance. There is no formal contracting mechanism to sustain these critical NGO-implemented with government budget funding support.

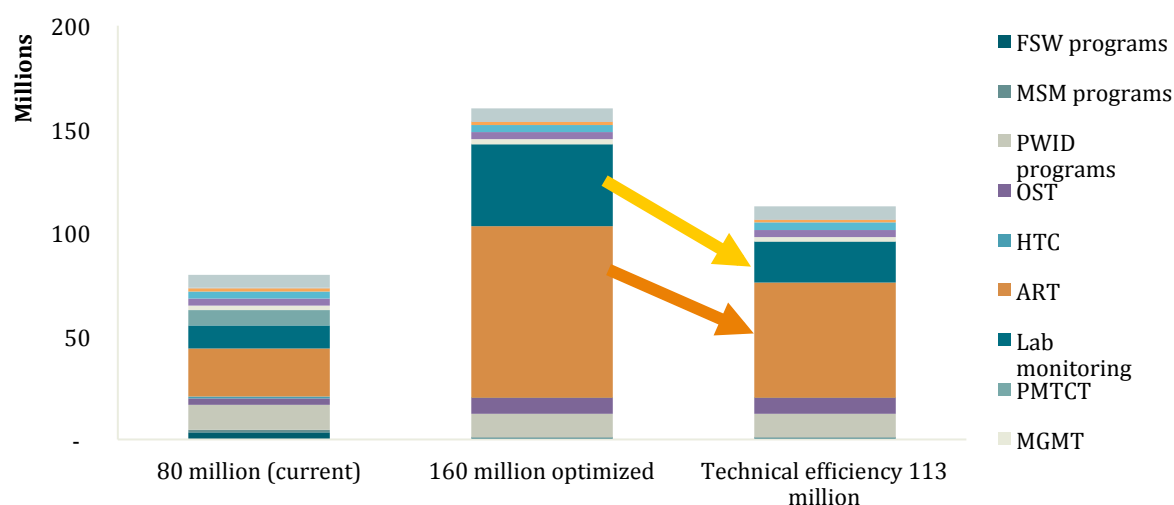
"Due to the abolition of the State Service, we no longer get tax exemptions on medicines and commodities, thus in 2015, we are left with 13% less funding to procure ARVs"

Quote from Key Informant Interview

The rules for HIV diagnosis, registration and placement on ART, which were developed by the MOH, create administrative access barriers to care, increase time and cost, drive inefficiencies and adversely affect health outcomes. MOH regulations unnecessarily delay the placement of eligible PLHIV on ART due to expanded clinical evaluation of health conditions by referral to "narrow" specialists and by waiting for laboratory tests. The recommendations of the national clinical protocol on ART exceeds the financial capacity of the government to provide ART and laboratory tests. National clinical protocols for ART include an unnecessarily high number of possible ART regimens: 38 regimens for 1st line ART and 48 for the 2nd line. These norms, which have been developed by experts without considering their budgetary implications and/or their impact on the delivery of services, have most likely caused more challenges instead of solving problems.

Current funding is insufficient to maximize the health impact and has room to optimize spending. The World Bank Allocative HIV Efficiency Analysis (NHAEA) performed in 2014-2015 suggests two ways to achieve national targets with less money, by combining allocative and technical efficiency (Figure 19).

Figure 19: Proposed HIV Investment Case, World Bank, 2014-2015



The costs per person reached in 2014 and the forecasts for 2015-2016 presented in Table 9 below demonstrate that the costs per person reached⁵¹ in Ukraine are below the regional average and median costs for most programs. Notably, a unit cost decrease is planned for 2015-2016 by reducing the number and type of services per prevention package.

Table 9: Costs per person reached established in the analysis (USD)⁵²

Cost per person reached	Ukraine*		Regional comparison (6 countries including Belarus)			
	2014	2015-2016	Lowest	Highest	Average	Median
FSW programs	\$ 33.18	\$ 25.26	\$ 41.66	\$ 166.24	\$ 102.94	\$ 105.35
MSM programs	\$ 30.66	\$ 19.35	\$ 23.67	\$ 449.13	\$ 159.45	\$ 71.25
PWID programs	\$ 28.84	\$ 14.48	\$ 40.90	\$ 129.25	\$ 109.73	\$ 84.11

*Source: Alliance Ukraine, presentation for Sustainability Forum, 2015

Since these costs are not strictly comparable between countries, particularly for prevention programs where the packages are different (i.e. a higher unit cost may not necessarily mean lower technical efficiency, but could also mean a more comprehensive package), further analysis would be required to determine in which areas technical efficiencies could be realized.

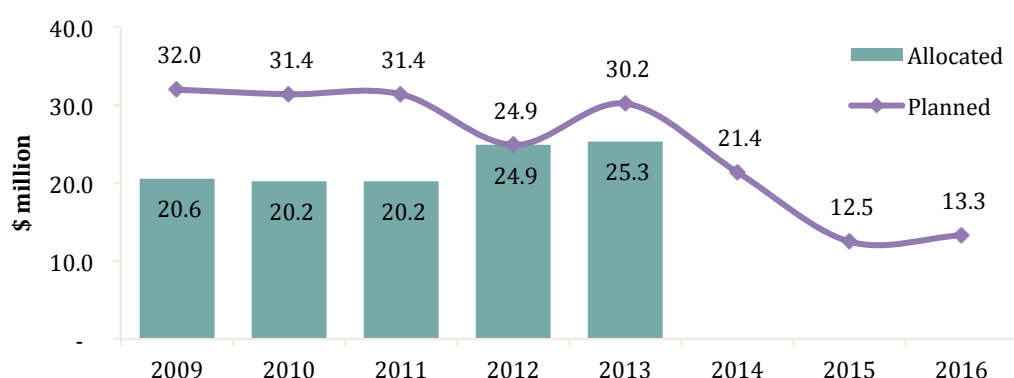
With current changes in the international HIV financing landscape and the anticipated reduction in Global Fund financing, it is expected that the last two years of the Ukraine National AIDS Strategy will require increasing domestic resources, or more efficient implementation of the same services. This leaves Ukraine with approximately two and a half years to develop and implement a transition strategy in order to meet its growing HIV response financing challenge. An external evaluation of the National AIDS Program conducted in 2009 identified a number of severe inefficiencies in the implementation of the HIV response, including: i) low coverage of HIV services; ii) the inadequate scope of services; iii) a large variation in the quality of service provided; and iv) high costs of service delivery (as described in following sections).

⁵¹ Costs include the distribution of commodities to each person, the development of IEC materials and their distribution and the costs for HTC and STI services. Commodities include 170 sterile needles/syringes and alcohol wipes at USD12 per person, per year; 25 (for PWID)/350 (for FSW) condoms per person at USD 1/14 per person, per year; 40% of key population annual coverage of HTC costs at USD 0.3 per person, per year; and 40% (for PWID)/80 (for FSW) of annual coverage cost of STI at USD 0.6/1.2 per person, per year.

⁵² Optimizing Investments in the National HIV Response of Belarus. Draft report. April 2015 // World Bank, TGF, UNAIDS, UNPD.

3.2.3. Funding of national tuberculosis program

Figure 20: Planned and allocated financing for the NTP from the state budget for 2012-2016 years

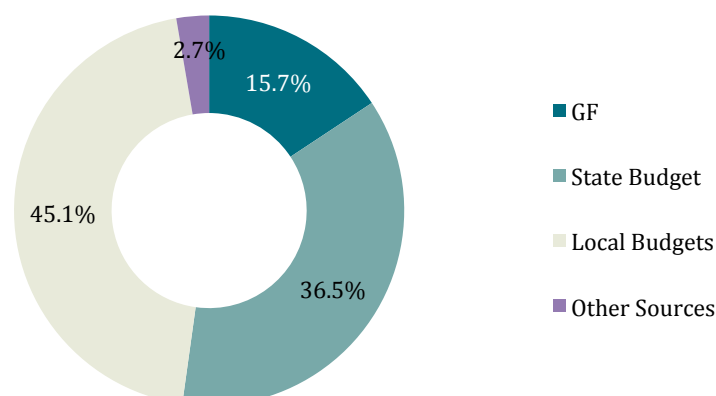


The NTP budget does not account for all funding sources and public commitments are not always met. The NTP 2012-2016⁵³, the third national program of Ukraine, includes funding under the round 9 grant of the Global Fund to Fight Tuberculosis (hereinafter – GF), but does not take into account other funding sources such as USAID (Chemonics, MSH, SIAPS) and others (Figure 20). The Government always fails to allocate the full funding stated in the national program, as demonstrated in Figure 20. Since 2009, the Government has failed to allocate sufficient resources for the implementation of planned NTP activities.

Ukraine has never performed a detailed calculation of all TB activities and total budget estimate, which would have shown funding levels from all funding sources and by activities, and the budget deficit. The World Health Organization developed a corresponding tool⁵⁴ to calculate the budget for all TB activities, but this has not yet been utilized.

Budget deficits mostly affect the procurement of first and second line TB drugs, equipment for rapid TB diagnostics and consumables. The underfunding of budget line for 1st and 2nd line TB drugs was mainly justified by the need to utilize the large remainder of anti-TB drugs from the previous year, which had been procured from the Global Drug Facility (combined anti-TB drugs) through GF funding. Since only 21.0 million USD was budgeted for second-line anti-TB drugs for patients suffering from MDR-TB in 2013, this amount was not enough considering the growth of MDR-TB cases in the country. This example shows how it is important to review the budget of the NTP each year and to adjust it according to the epidemiologic data and other changes, so that it meets the real needs and is used to optimum effect.

Figure 21: Sources of NTP funding, 2013



⁵³ Law of Ukraine dated 16.10.2012 No. 5451-IV, <http://zakon2.rada.gov.ua/laws/show/5451-17>

⁵⁴ <http://www.who.int/tb/dots/planningbudgetingtool/en/>

Ukraine will remain dependent on partner support for a number of priority interventions⁵⁵.

According to the 2013 NTP expenditure analysis, the biggest share of total NTP expenditure is covered through central and local budget sources, whereas external funding accounts for only around 19% (Figure 21). At the moment, the GF grant covers procurement of second-line TB drugs for MDR TB cases which are not yet funded by the public purse, equipment and consumables for laboratory diagnostic techniques, patient incentives for adherence support and other key NTP activities such as monitoring / supervision and training. Since the government is not yet in a position to ensure full funding of all TB cases in the country, Ukraine will still remain dependent on external resources.

The Government may improve funding levels by ensuring allocative and technical efficiencies in service provision. In-patient (hospital) treatment of TB continues to play an important role in TB case management in Ukraine, as the vast majority of TB patients are hospitalized for treatment for different periods of time, depending on the form of disease by infectious status and resistance profile. The current capacity of TB hospitals is highly excessive and requires substantial optimization and downsizing. The WHO has suggested rightsizing the hospital sector, optimizing diagnostic services and moving TB treatment from hospital to PHC level as a strategy for ensuring efficiency in public spending.

3.3. Service delivery

HIV/AIDS and TB services are administered through vertically structured systems funded through the MOH. The National AIDS and TB Centers implement the nation's response to the respective diseases. The vertical nature of these systems protects their autonomy and funding. However, the two centers do not communicate well with each other and do not coordinate well with PHC, thus limiting access to testing and treatment.

NGOs provide essential outreach, prevention, and supportive services. However, these services are not integrated (or formally connected via a contract) with the government health care system. It is believed by respondents that a closer connection would improve the effectiveness of service delivery.

3.3.1. HIV

The volume, quality and intensity of prevention interventions are still insufficient to stop the spread of HIV among KPs. A functioning network of 40 AIDS prevention and control centers and 737 Trust Points (Kabinet Dovira) exists in Ukraine⁵⁶. These national and oblast AIDS centers are the health system's primary agent for delivering HIV/AIDS testing and treatment services. Outreach and prevention services are often provided by donor- and local government-supported NGOs, where available. A national lab network provides diagnostic lab services. Fragmentation, limited accountability, variable reporting by medical institutions, and discrepancies between declared and actual services exist at the local levels (Semegina et al., 2007). The state budget covers the majority of costs for the central procurement of drugs, diagnostics and supplies, blood safety and treatment, while other HIV/AIDS services (care and support, harm reduction, work with vulnerable groups and advocacy) are funded by donors and oblast and local budgets.

The vast majority of prevention efforts in Ukraine (especially those aimed at KPs) have remained the responsibility of a variety of NGOs working with, and under, the International HIV/AIDS Alliance in Ukraine (Alliance) and the All Ukrainian Network of PLHIV Network. Their activities include substitution treatment, education, provision of condoms, needle exchange, STI testing, etc. While many NGO-led prevention efforts have been of high quality, they are not available in all oblasts or rayons. The government's role in prevention has been minimal, and Ukraine's lack

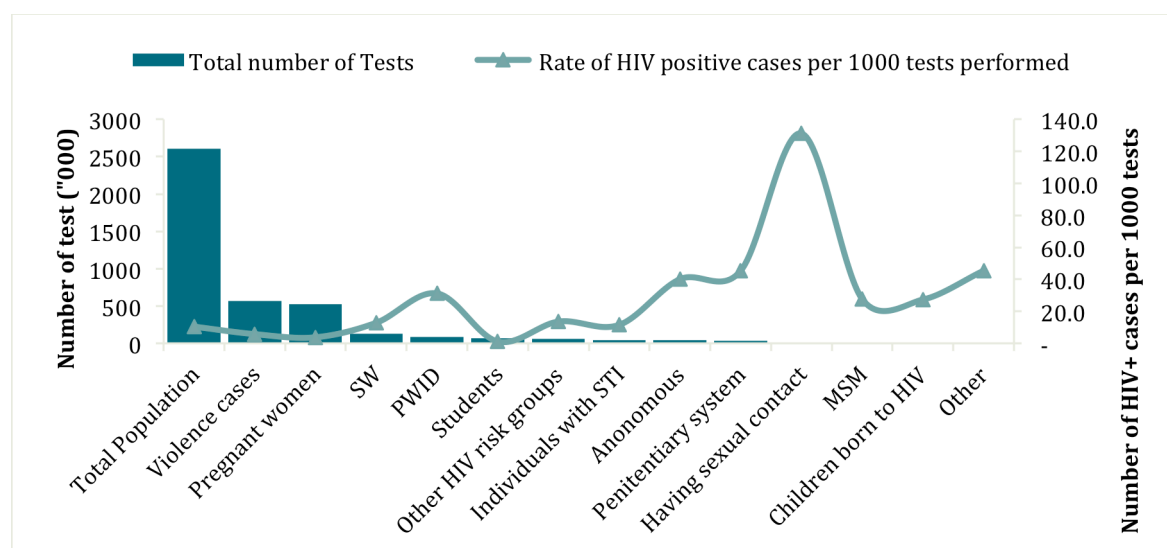
⁵⁵ Extensive review of TB prevention, control and care in Ukraine, WHO, 2015

⁵⁶ National report on monitoring progress towards the UN General Assembly Special Session (UNGASS) declaration of commitment on HIV/AIDS. 2010

of a strong, viable public health system inhibits their ability to respond in the way other AIDS-affected countries have.

Some success has been achieved in reducing transmission via PWID as a result of education programs, needle exchange, and substitution therapy (which remains limited in scope and very politically sensitive). UNAIDS has documented that implementation of evidence-based harm reduction programming have reduced the HIV incidence among people who inject drugs in Ukraine, and Ukraine's experience has become a UNAIDS best practice⁵⁷. Yet despite the progress achieved in Ukraine, a number of weaknesses have also been identified, as described below.

Figure 22: Rate of HIV positive cases per 1000 tests performed, 2014



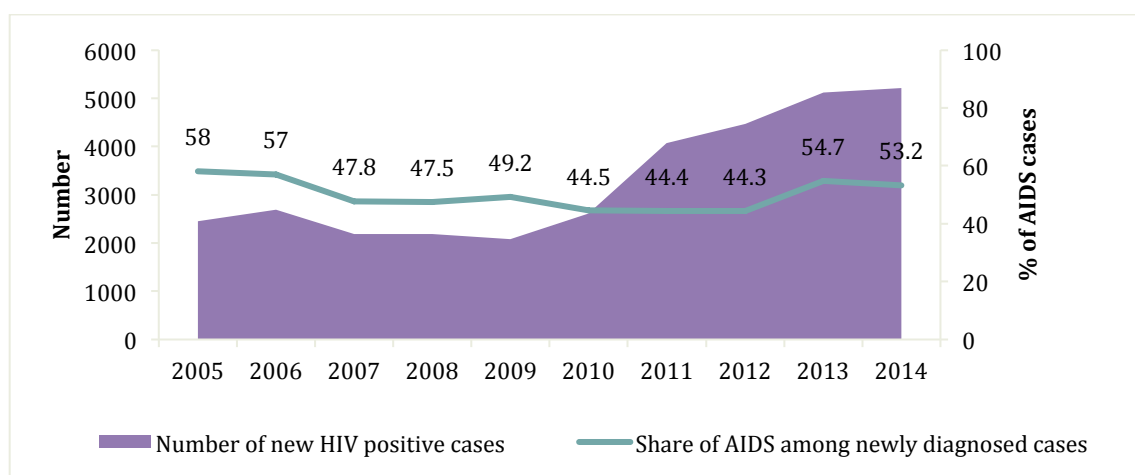
Source: UCDC, Information Buletin #43, 2014

The low coverage of KPs with testing results in a high percentage of undiagnosed people with HIV. While the number of tests performed is increasing, the low coverage of HIV testing, in particular among populations most at risk (KP), is the key bottleneck to the HIV problem.

In 2014, 2.6 million HIV tests were performed among different groups of the population. However, when looking into the categories of people tested, a low proportion of testing reaches key populations (MSM, IDU and FSW). Figure 22 shows the number of HIV tests performed (in thousand) in 2014 and the number HIV positive cases recorded per 1000 tests by population group. This figure clearly demonstrates the low coverage of KPs, especially PWIDs and MSMs even though the HIV detection rate is quite high in those population groups. In summary, Ukraine fails to target the most important population groups, which results in a high level of undiagnosed HIV cases and/or late diagnosis, as confirmed by the share of AIDS cases (53.2%) among newly reported cases (Figure 22).

⁵⁷ UNAIDS, 2010

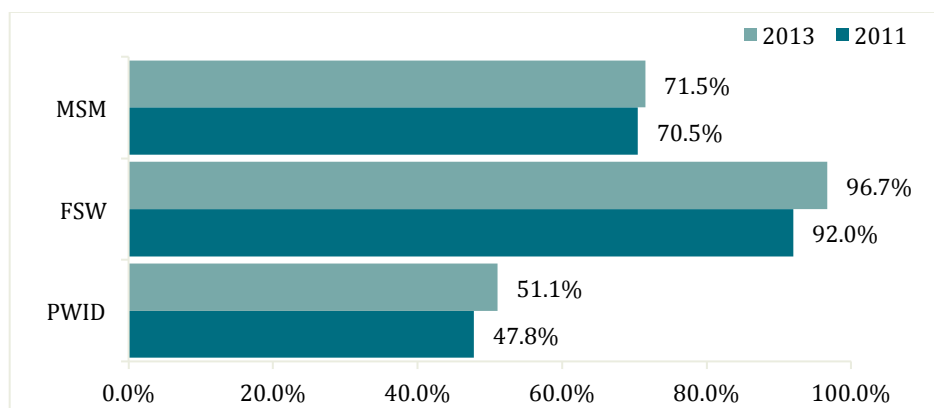
Figure 23: Share of AIDS new cases among first time diagnosed PLHIV, 2005-2014



The low coverage of KPs is also confirmed by BBS, 2013. According to bio-behavioral surveys conducted in 2013, the percentage of people who have been tested for HIV in the last 12 months and know their results still remains low among groups most-at-risk for HIV-infection, except for FSW – 63,1% (59% in 2011). In 2013 that indicator accounted for 42,8% among PWIDs (35,7% in 2011) and 38,3% among MSM (37,8% in 2011) (Figure 23).

The coverage of clients with a minimum package of preventive services is uneven among different KPs. According to the Alliance’s operational data, in 2014 63.5% of the total estimated PWID population was reached with minimum prevention package of services, whereas the coverage is much lower among FSW (46.3%) and MSM (16.2%).

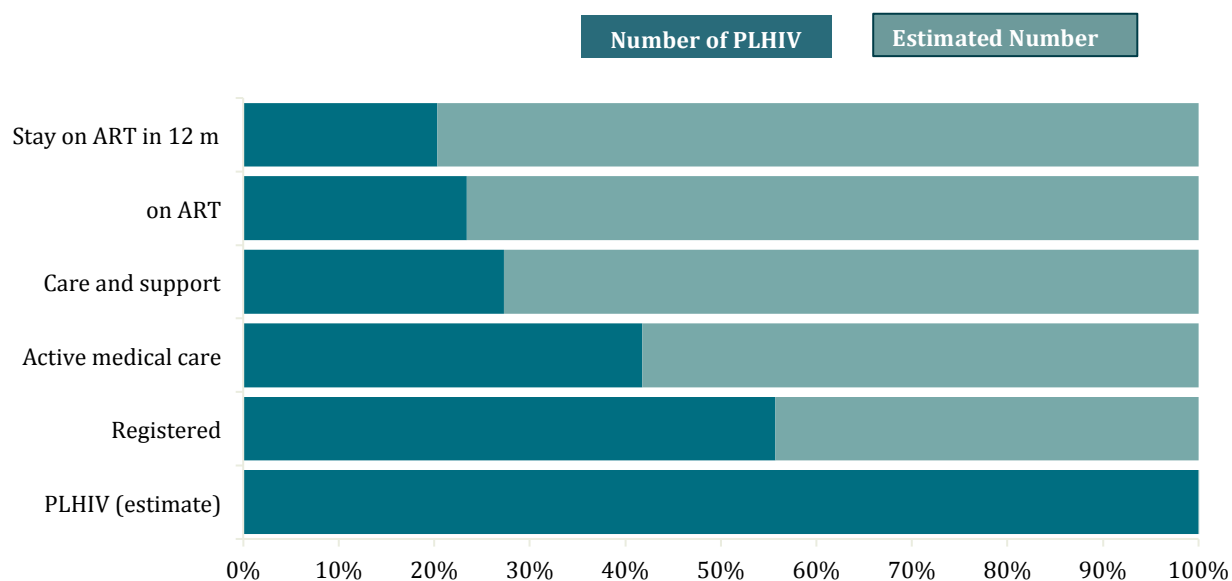
Figure 24: Condom use during last sexual intercourse by KPs, 2011-2013



While PWID coverage with preventive activities is higher compared to other risk groups, the most dangerous sexual behavior is observed among PWIDs. Prevention programmes for people most-at-risk of HIV-infection and their sexual partners play a crucial role in determining the further development of the HIV epidemic. In 2013 the percentage of people who reported condom use during their last sexual intercourse was 51,1% of PWIDs (47,8% in 2011), 96,7% of FSWs (92,0% in 2011), and 71,5% of MSMs (70,5% in 2011) (Figure 24). Therefore, the most dangerous sexual behavior is observed among PWIDs, which makes it important to take efforts to rapidly increase the coverage level, scale and quality of prevention interventions among this group.

The country has experienced a rapid increase in the number of PLHIV receiving ART, but the HIV treatment continuum underscores the importance of continued and intensified efforts to reach more people with testing, and to make sure that those with the virus receive prompt, ongoing care and treatment to help them live longer, healthier lives and prevent the spread of HIV to others

Figure 25: Prevalence based treatment continuum, 2013

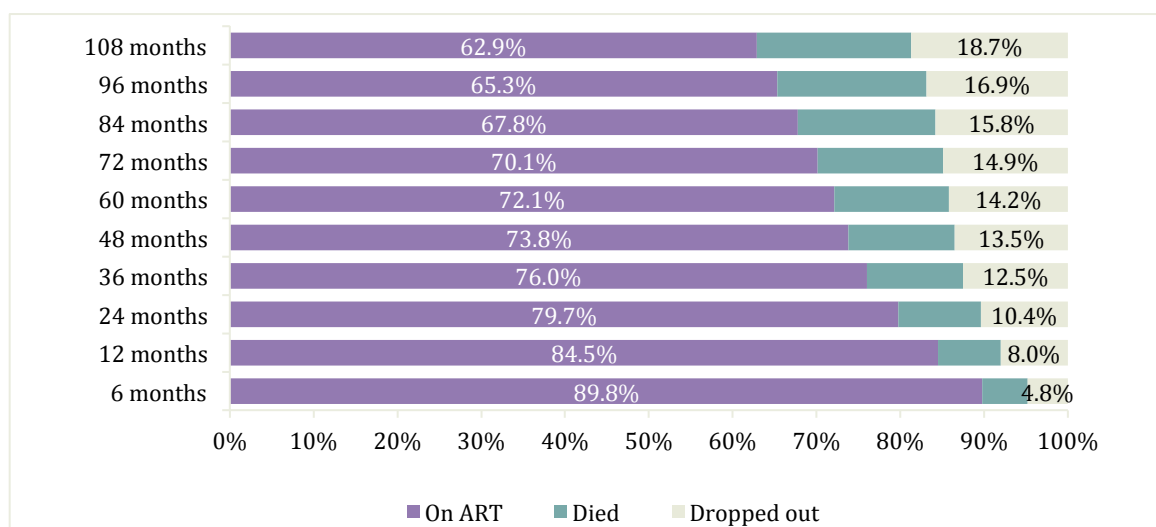


Source: Alliance, 2014

The treatment cascade presented in Figure 25 shows that the country manages to diagnose only 56% of the estimated PLHIV population, out of which only 42% are engaged in care⁵⁸, 27% receive care and support, 23% are enrolled in ART and 20% stay on ART for 12 months (Figure 25). This data clearly presents that there are weak linkages of testing to care pathways to ensure that people tested positive for HIV receive care, meaning that those who have been referred to ART are lost to follow-up.

Retention in treatment is high but decreases over the time. Generalized data of the PLHIV on ART cohort analysis for the period August 2004 to December 2012 showed that 84,5% of people who initiated ART in cohorts continued receiving it after 12 months of treatment (minimum survival rate), 7,8 % of people died within a year after initiation of treatment and 8% of people interrupted ART mainly for non-medical reasons (Figure 25). The main reasons for that are the late initiation of ART and low adherence to treatment. 64% of people who started ART in 2004-2005 are still alive and on antiretroviral therapy within 8 years of treatment (Figure 26).

Figure 26: ART retention, all cohorts, August 2004- December, 2013



⁵⁸ Undergoes testing at least once a year

The USAID funded “Patient Pathway”⁵⁹ analysis demonstrates that not all PLHIVs are registered for HIV care; not all who register for HIV care once, come for regular check ups or are seen at least once a year; not all who access care regularly and are eligible for ART have access to ART; and not all who start ART continue it.

Barriers in the transmission of information without patient consent hamper the ability of NGOs to follow-up. Under the current law on HIV, the transmission of information by health workers to social workers and NGOs that provide care and support services is only possible based on client’s written consent. This creates obstacles in reaching PLHIV who have not given written consent and dropped out of treatment.

The confidentiality of PWID personal data, as well as the need for informed consent, is regulated by MOH Order #110 on keeping primary accounting/reporting documentation at health care facilities. Comprehensive patient assessment protocols are part of the national ‘Clinical Guidelines on Antiretroviral Treatment in HIV-positive Adults and Adolescents’, which was approved by MOH Order #551 on 12 July 2010, and by the ‘Procedure of Treatment of HIV-positive Individuals Who Are Injecting Drug Users’, approved by MOH Order #476 on 19 August 2008, respectively⁶⁰.

Restrictions to accessing ART for PWID include the large number of tests and laboratory analysis required before the administration and initiation of ART. In addition, PWID must provide personal identification documents, such as a passport, in order to register with an ART site. Most PWID do not have such papers and, consequently, are unable to access ART. Such requirements are included in the ‘Procedure of Treatment of HIV-positive Individuals Who Are Injecting Drug Users’, which was approved by MOH Order #476 on 19 August 2008.

As a result, only about half of PLHIV are known to the health system and are enrolled in care and treatment services. Such inadequate coverage can contribute to the further spread of infectious diseases such as HIV. There is a need to revise existing collaboration mechanisms with civil society organizations and other state social services in order to ensure regular contacts and support for PLHIV to receive care and life-saving therapy.

Access to opioid substitution therapy (OST) has been aggressively rolled out and is free. The provision of OST services began in 2005 and is available free-of-charge to patients/clients through government/NGO partnerships. As of January 2015, OST is provided in all 27 administrative units of Ukraine across 270 sites to 8,407 patients, of whom about 90% are taking methadone substitution therapy, according to the operational report of the Ukrainian AIDS Center⁶¹. Since 2007 the number of patients on OST increased almost 16-fold and the number of sites has gradually increased from 10 (2007) to 270 (2014).

Most OST sites are integrated into the existing health care system and infrastructure, and are mainly funded from existing governmental budgets. Such sites include not only specialized drug dependence treatment (narcological) facilities, but also TB dispensaries, AIDS Centers, infectious disease hospitals and polyclinics. OST sites have good practices, professional staff and a multidisciplinary approach. They include links to HIV and TB management, and best practice models of integrated care (IC) for patients with drug dependence, HIV infection and TB. 83 sites provide integrated services for 67,6% of OST clients⁶². OST is provided on the basis of narcological dispensaries, and is also integrated into care for other facilities such as AIDS centers, TB dispensaries, maternity wards in selected regions and general practice health facilities. An operational NGO network provides psychosocial services and advocates for OST to be scaled up and improved at different levels.

⁵⁹ Patient Pathway Analysis, USAID, 2015, Draft not published yet

⁶⁰ Good practices in Europe, WHO, 2014

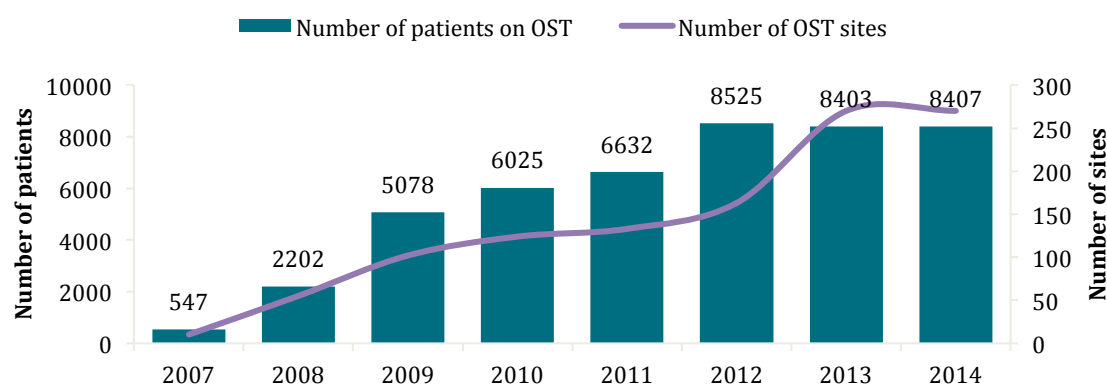
⁶¹ Ministry of Health of Ukraine, statistics on substitution therapy, available online: <http://ukraids.gov.ua/index.php/uk/statystyka/profilaktyka/zamisna-pidtrimuvalna-terapiya>

⁶² Emilis Subata, Substitution Maintenance Treatment in Ukraine, 2013

While some OST sites are quite well integrated into existing health care institutions (HCI) and are less dependent on external funding, most still rely on external donor funding not only for medications, but also for remuneration for OST staff. Pending public procurement of OST medications and subsequent potential cuts of donor funding for salaries may reduce the motivation of health care institutions and staff to work with PWID and restrict access to OST.

Despite the increase of sites and the number of PWID on OST, coverage still remains very low compared to demand (Figure 27). The MOH's support for OST was one of the most important conditions of the current scale-up, as the approval of clinical protocols and improved legal regulation⁶³ of OST served created a supportive environment. Nevertheless, important restrictions to treatment stipulated in the Order #200 limited patients' access to OST. In 2013 Alliance Ukraine was actively involved in the advocating for necessary changes to the Order. Attempts were made to improve access of PWID to OST by removing the unnecessary requirement of 2 unsuccessful drug treatment attempts before a patient is enrolled.

Figure 27: Number of clients enrolled in OST, 2007-2014



Source: UCDC

As a result, the MOH issued Order #218, which revoked the requirement by the previous order of 2 unsuccessful attempts of treatment as a condition for a patient to enter OST. Thus PWID can access OST directly as a first treatment option, which is in line with WHO Guidelines (2009).⁶⁴ Despite these efforts, however, less than 3% of the estimated 250,000 opioid drug users in Ukraine access OST services⁶⁵.

MOH regulations allow physicians to write prescriptions for Buponephrine (BPN) (up to 10 days) to stable patients for home use, although this is only practiced in selected regions. Similarly the possibility to purchase liquid **methadone in vials (20 mg) from pharmacies by prescriptions from physicians allows stable patients to travel with family** or on business if needed.⁶⁶ Ivano-Frankovsk is the only site in the country where patients can receive MTD by prescription on the regular basis and so could move geographically, albeit at their own expense.

Links between OST sites in the country have been established which increase the mobility of OST clients. With medical documents from their OST site, they can now continue OST in other sites.

⁶³ Order of MOH from 2012 03 27 Nr 200

⁶⁴ Guidelines for Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, WHO, Geneva, 2009. <http://www.who.int/substanceabuse/publications/opioiddependenceguidelines.pdf>

⁶⁵ Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010-December 2011, Kyiv, 2012.

⁶⁶ Ibid 62.

Another important achievement is the joint order⁶⁷ of MOH, the Ministry of Internal Affairs and the State Narcological Service, which outlines procedures for cooperation between different entities and grants continuity of OST for patients who are placed in detention facilities for a short period of time. Under this regulation, custody staff bring an arrested patient to an OST site every day. While this is an important regulation, execution requires enforcement, as noted in the report on “Substitution Maintenance Treatment in Ukraine”.

Psychosocial support is integrated in most OST sites. As noted by the same report, most OST sites at narcological institutions. Staff for psychosocial care (social workers and/or psychologists) are integrated into the health care facility’s staff lists and are paid from regular facility budgets. In facilities where psychosocial staff are not integrated, psychosocial assistance is provided through NGOs.

The retention of PWID on OST is high as demonstrated by the assessment. Continuous monitoring for OST and analysis of best practices for scale-up was requested by MOH Order #161⁶⁸. To address this request, the ICF International HIV/AIDS Alliance in Ukraine supported a three-phase assessment of OST effectiveness⁶⁹, which found that client retention was high. In phase one, 83% were retained at six months and 75% at 12 months⁷⁰. During phase two, 92% of Buprenorphine patients were retained over six months. In phase three, 76% of Methadone patients were retained after 18 months. Statistically significant changes in client status and behavior during a 6 month treatment period were observed: a 75% reduction in the use of opioids, cannabis and poly-drug use in the last 30 days; general health improved (50% increase); patients reported 65% less depression, anxiety, aggression and suicide attempts; all HIV risk behaviors were reduced, most dramatically related to injecting risk (up to 82% reduction), but less so for sexual behaviors and tattooing; Illegal income and criminal activity during the last 30 days declined by 70%-90%; and social integration increased (the number of working days per month doubled). According to the monitoring report, the feasibility, safety and effectiveness of OST was equally good in all phases, with no difference between Buprenorphine and Methadone⁷¹.

Registration in the national registry prevents client enrollment in treatment. Health care and law-enforcement sectors from the government to regions and local levels still lack constructive cooperation in defining and working together towards common goals, such as improved public health and welfare, reduced drug addiction amongst the prison population, the suppression of illicit drug markets and the reduction of the demand for illicit drug use. Most of the challenges and barriers for further increased access to OST still have a legal nature.

Nevertheless, challenges and barriers in scaling-up and maximizing the effects of OST still prevail. Despite impressive progress in the implementation of OST in Ukraine, there are still many challenges and barriers that may prevent further scaling-up and maximizing of OST’s beneficial effects in preventing HIV and TB epidemics. Most of the challenges and barriers are inherent in the remnants of post-soviet legal norms, attitudes, phobias against controlled medications, including towards the medical use of MTD or BPN. There is a lack of national consensus on OST and commitment to procure OST drugs, and no approved costing methodology. OST drugs are not yet included in the national drug registry.

⁶⁷ Oder 22.10.2012 for the procedures for cooperation to grant the continuity of OST program

⁶⁸ Наказ МОЗ України від 13.04.2005 № 161 «Про розвиток та удосконалення замісної підтримуючої терапії для профілактики ВІЛ/СНІДу серед споживачів наркотиків» <http://www.moz.gov.ua/ua/portal/dn20050413161.html> (Order of the Ministry of Health of Ukraine of 13.04.2005 № 161 “On the development and improvement of substitution therapy for HIV / AIDS prevention among people who inject drugs”).

⁶⁹ Uchtenhagen, A., Schaub, M., Final Monitoring and Evaluation Report on Opioid Substitution Treatment in Ukraine: outcomes from 3 phases of research. Research Institute for Public Health and Addiction associated with Zurich University a WHO Collaborating Centre, June 08, 2010.

⁷⁰ Дворяк С.В., Оцінка ефективності програм замісної підтримувальної терапії бупренорфіном в Україні / Дворяк С.В., Штенгелов В.В./Всесвіт соціальної психіатрії, медичної психології та психосоматичної медицини. – 2009. – Т.1. №1 (1). (Dvoryak S.V. Evaluation of program effectiveness of substitution therapy by buprenorphine in Ukraine/Dvoryak S.V. Shtengelov V.V./The universe of social psychiatry, clinical psychology and psychosomatic medicine, 2009. – Т.1 №1 (1).

⁷¹ Ibid

So far OST is not available in Penitentiary Institutions. WHO recommend that patients in OST should have a possibility to continue pharmacological treatment in prisons, alongside other treatment options. Those who are willing to start OST after incarceration should be able to do it in prisons.⁷² Although OST services are allowed by prison regulations, in reality no such services are actually available for prison inmates. It is also too expensive to transport opiate dependent prisoners to OST sites located in the community every day, and therefore no OST provision is yet available⁷³.

Needle and Syringe Programs (NSP) are an essential part of a package of services for PWID. In Ukraine, NSP is supported as a part of the core package of services within the GFATM program, and the number of participating sites is growing. In 2013 the number of syringes for every injecting drug user distributed through NSP was 77,03. This indicator slightly increased from 2011, when the number of distributed needles/syringes was 75,3.

In the recent years, NSP has also become accessible through pharmacies. Among PWID

PWID so far tried to avoid approaching governmental treatment institutions, because their names are put into the dispensary register. This information is not confidential and could be disclosed under the requirement of law-enforcement agencies. Persons, whose names are on the registry, are more stigmatized, compared to those, who are not recorded”.

Quote: from Key Informant Interview

respondents of the 2011 Alliance BBS, 47% reported receiving free needles and syringes during the last 12 months from NSP programs (45% male and 53% female PWID), whilst 69% of PWID (72% male and 60% female PWID) reported buying needles and syringes. PWID who were clients of NGOs received more

free services during the last 12 months. Nearly all (95%) of PWID who were clients of NGOs received needles and syringes free of charge, while 39% purchased needs and syringes. The average cost is 0.5 – 1.00 UAH per syringe (6 to 12 USD cents) depending on the size and producer.

IBBS 2011 also shows that 95.5% of the target population of PWID reported using sterile injecting equipment the last time they injected drugs; the data does not provide details, however, about the source of the sterile injecting equipment⁷⁴. Analysis of data related to needle/syringe sharing from IBBS 2011 also shows that such sharing was not a regular practice during the previous 30 days. However, according to IBBS 2011, 56.2% of PWID who never used a used needle/syringe also reported receiving an injection with a ‘pre-filled syringe’, leaving open the possibility that such PWID were undertaking such injections with contaminated equipment even though they believed that such equipment was unused⁷⁵.

Since 2010, legislative Order #188 has provided heavy sanctions against PWID who are in possession of extremely minute quantities of illicit drugs, such as the residue remaining in a use needle or syringe. This has resulted in many PWID refusing to exchange their used needles/syringes at NSP sites due to fear of police action against them for possession of quantities of drugs above those provided for in Order #188.

⁷² Health in prisons. A WHO Guide to the Essentials in Prison Health, WHO, Copenhagen, 2007.

<http://www.euro.who.int/data/assets/pdf/0009/99018/E90174.pdf>

⁷³ Europe: Good Practices, WHO, 2014, p-77

⁷⁴ Balakiryeva, O.M., Bondar, T.V., Sereda, Yu.V., and Sazonova, Ya.O. Analytical Report: Behaviour Monitoring and HIV Prevalence among Injecting Drug Users as a component of Second Generation Sentinel Surveillance (based on results of the 2011 bio-behavioural survey). International HIV/AIDS Alliance in Ukraine & the Olexander Yaremenko Ukrainian Institute for Social Research, Kiev, 2012.

<http://www.aidsalliance.org.ua/ru/library/our/2012/me/iden2011.pdf>

⁷⁵ Balakiryeva, O.M., Bondar, T.V., Sereda, Yu.V., and Sazonova, Ya.O. Analytical Report: Behaviour Monitoring and HIV Prevalence among Injecting Drug Users as a component of Second Generation Sentinel Surveillance (based on results of the 2011 bio-behavioural survey). International HIV/AIDS Alliance in Ukraine & the Olexander Yaremenko Ukrainian Institute for Social Research, Kiev, 2012. <http://www.aidsalliance.org.ua/ru/library/our/2012/me/iden2011.pdf>

Text Box 3: Good Practice in Ukraine's Harm Reduction Program⁷⁶

Many harm reduction services at the grassroots level around the world experience difficulties in implementing services caused by law enforcement agencies and other agencies of local government administration because of their respective lack of awareness and understanding of harm reduction, and the reasons why such services are being provided to individuals and groups that some parts of the national legislation consider to be criminals, such as drug users and sex workers.

A key finding from Ukraine is the usefulness of local agreements between local police, local government administration and NGOs undertaking service delivery for key populations. These written agreements outline the activities to be undertaken, the locations involved and the respective roles and responsibilities of all the signatory parties in order to ensure that interventions are unimpeded by local government agencies.

Integrated service delivery has been modestly practiced in Ukraine and requires improvement and expansion. TB/HIV, TB/HIV/OST, NSP/HIV/TB joint points of delivery need to be scaled up (details are provided under the TB section).

Poorly integrated services for PLHIV result in fragmented services that do not address patients' major health issues. Newly developed normative regulations on TB/HIV should include greater

"TB doctors are not interested to know about AIDS treatment and which drugs are used. They do not even know how TB and ARV drugs interact."

Quote: From Key Informant Interview

comprehensive integration of services, including access to OST for TB/HIV and TB drug-dependent in-patients. They should not limit access of PLHIV to TB diagnosis and treatment, and should be more specific in suggesting mechanisms for better collaboration. TB experts in hospitals should work in close collaboration with HIV experts, and should discuss, initiate and monitor ART for patients receiving TB treatment. ARVs from AIDS centers should be provided to the medical personnel of TB hospitals, rather than exclusively provided directly from AIDS Centers to patients. Regulations should also support the integration of services on the premises of narcological facilities, in order to ensure HIV and/or TB diagnosis, management and monitoring of drug dependent patients. Monitoring of data on services for TB/HIV/Drug dependent patients should be introduced into TB, HIV and Narcological services. It is important to meaningfully involve PLHIV in the process of developing new regulations to integrate the services they need.

Current legislation allows links between health and social services, but it is not flexible enough to allow the deployment of community social workers. MOH Decree #30 gives space to deploy social workers in health care facilities, which is welcomed by Maternities, OST clinics and AIDS centres. However the qualification requirements set by the legislation, such as higher education in social science, can prevent health facilities from deploying former members of key populations as social workers, even though they are proven to operate more effectively than public social workers.

The PMTCT program is integrated into existing maternal and child health care services, and is supervised by the Department of Health Care for Mothers and Children, with close collaboration from HIV/AIDS-specific services. Access to voluntary counseling and testing is available in antenatal clinics for all pregnant women. HIV testing is free of charge and is included in the routine package of antenatal screening tests, including syphilis and viral hepatitis, with an 'opt-out' strategy. HIV enzyme-linked immunosorbent assay (ELISA) screening tests are performed in laboratories, with confirmation testing in seven referral laboratories. HIV screening is performed twice during pregnancy. Positive results are confirmed by two ELISA tests, while a western blot is used if ELISA results are inconclusive.

Antenatal testing is provided with informed consent, and the right of women to refuse the HIV test is discussed during counseling. Midwives and obstetricians, who ideally have undertaken a special

⁷⁶ Europe: Good Practices, WHO, 2014

counseling training course, conduct pre-test counseling. Women with positive tests are referred to a specialist within their local AIDS center, where they receive post-test counseling, including information on the laws pertaining to HIV-positive individuals in Ukraine and how to prevent the transmission of HIV to partners and infants. Women are encouraged to invite their partners for HIV counseling and testing. Women who have not received antenatal care and arrive in labor are offered rapid HIV testing (using Multispot HIV-1/HIV-2 rapid test kits): this strategy has been implemented nationally since 2003.

The responsibility to provide of HIV prevention, treatment and care services to people in prison is divided between the All Ukrainian Network of PLHIV and the Alliance of Ukraine. The Network is responsible for ensure access of prisoners to ART. The Alliance of Ukraine has little direct work inside of prisons, but instead actively works on innovative approaches to HIV prevention, treatment and care for people on remand from prison who are required to register with local police on a regular basis. Furthermore, the Alliance and its local NGO partners implemented a peer-to-peer strategy for HIV prevention in prisons, which is now implemented by the Network. Volunteers are trained in HIV prevention techniques, such as condom and lubricant use, distribution of IEC materials, etc., which are then distributed by the volunteers. This is in addition to the basic health services provided by the Prison Department inside of each prison.

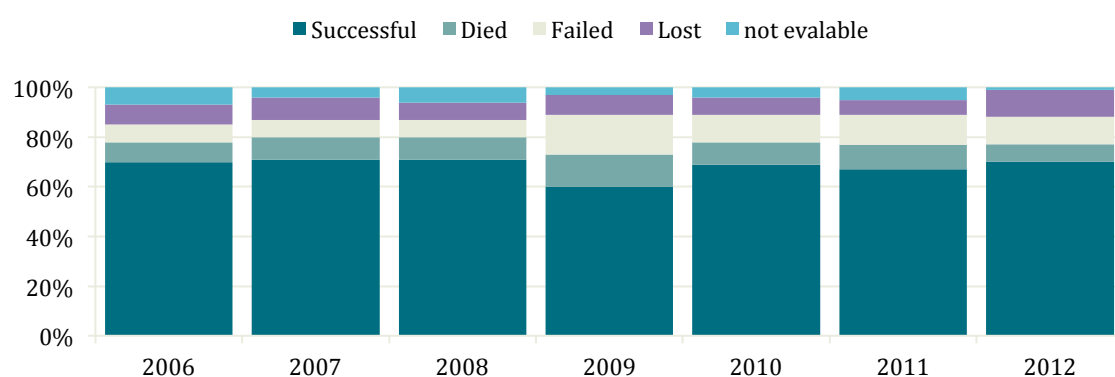
Social services in HIV prevention, care and support for PLHIV are provided by regional NGOs and CBOs. Close cooperation between local NGOs and health care facilities allows for the provision of effective medical and social services in the area of HIV/AIDS, and increases the adherence of patients to particular services.

3.3.2. Tuberculosis

Ukraine has vertical TB services that require hospitalization in specialized hospitals. During the last 5 years, the number of TB beds was reduced by 17% from 25,329 in WHAT YEAR? to 21,701 in 2013. In total, there were 80 TB dispensaries with 15,174 TB beds, 36 TB hospitals for adults with 5,255 TB beds, 3 TB children hospitals with 250 TB beds and 89 sanatoriums with 12,128 TB beds in 2013. The average length of stay in Ukraine is 91 days for adult patients and 81 days for children. The ALOS significantly varies between the regions from 117 days Zaporizhje to 67 in Zhitomir for adults, and from 164 days in Zaporizhje to 38 days in Ternopol for children.

At present the TB sector is mostly oriented towards in-patient service provision. Most TB services are provided in an in-patient setting. The role of outpatient clinics, especially of the PHC sector, is limited. Therefore the involvement of other specialists such as social workers, psychologists and/or visiting nurses for key populations is largely absent in the public sector, and psychosocial services are mostly provided by the NGO sector. Although some pilot projects promote an enhanced role for the PHC sector in TB prevention and treatment, there is no formal mechanism for contracting primary care nurses or social workers to carry out directly observed treatment (DOTs) for TB patients at an outpatient level. Only the Red Cross Society of Ukraine is empowered to contract nurses and social workers for effective implementation of the DOTs strategy, and these activities are fully funded by the GF grant.

Figure 28: Results of treatment of new TB (pulmonary and extra pulmonary) cases, 2006-2012

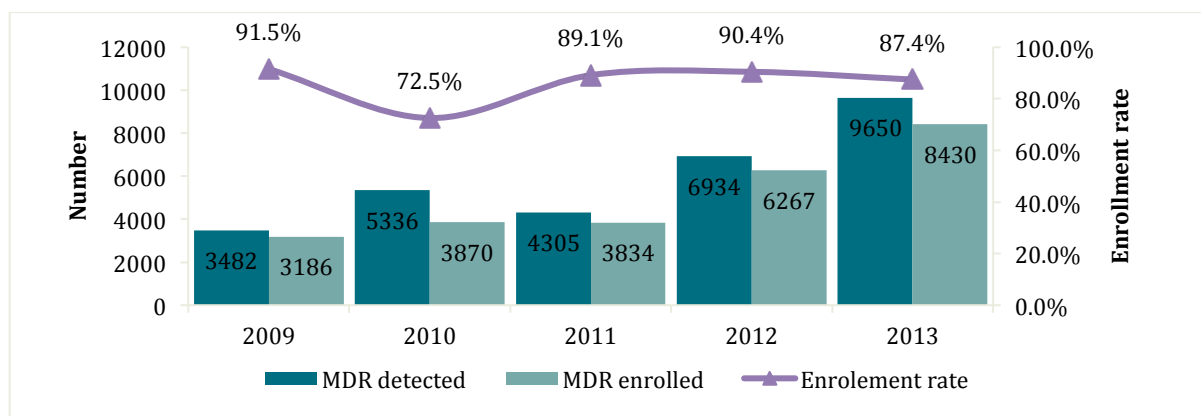


Ukraine has low treatment success rates among new TB patients. Over the past 10 years, the TB (new pulmonary and extrapulmonary) treatment success rate is around 70%, with the exception of 60% in 2009. Low treatment success rates are mostly associated with the high prevalence of TB among new MDR TB cases, inadequate provision of medication, violations of standards, adherence and TB treatment, alcohol and drugs, and a high level of co-infection of TB / HIV related diseases. According to WHO, treatment failure and lost to follow-up (11% each in 2012) are the main indicators of ineffective treatment.

The treatment regimens made available to patients in Ukraine vary greatly from place to place. According to WHO protocols, TB treatment with first-line drugs may consist of a daily or a three times per week pill regimen (WHO 2010: 30). However, the treatment regimens made available to patients in Ukraine vary greatly from place to place. In out-patient treatment, medical staff may implement one of a number of protocols, ranging from offering a patient daily therapy under medical supervision in the clinic office (DOTS) to distributing several days' worth of medication to a patient or to a patient's family member to be taken home and self-administered. Non-integrated TB clinics are frequently closed on weekends, meaning that patients on a daily pill regimen who are unable to take medication home to self-administer over the weekend will experience an interruption in their treatment on a weekly basis. In integrated treatment facilities, where co-infected patients receive treatment for HIV, TB, and addiction in the same facility, patients are required to report to the medical facility daily, even on weekends.

Unnecessarily long hospitalization periods, combined with the widespread use of involuntary isolation and treatment in hospitals with poor infection control measures, are considered to be a major cause of TB and especially of MDR cases. Patients are usually hospitalized more often and for longer than necessary, partly because the budget allocated to hospitals is based on the number of beds and their occupancy rate. Other reasons claimed are poor compliance with treatment by "difficult" patients outside hospital, and the need to offer temporary shelter to "social" patients. Family doctors' lack of motivation to serve TB patients further supports an argument for prolonged hospitalization.

Figure 29: Treatment success rates among new TB cases and recurrent MDR TB, 2002-2012

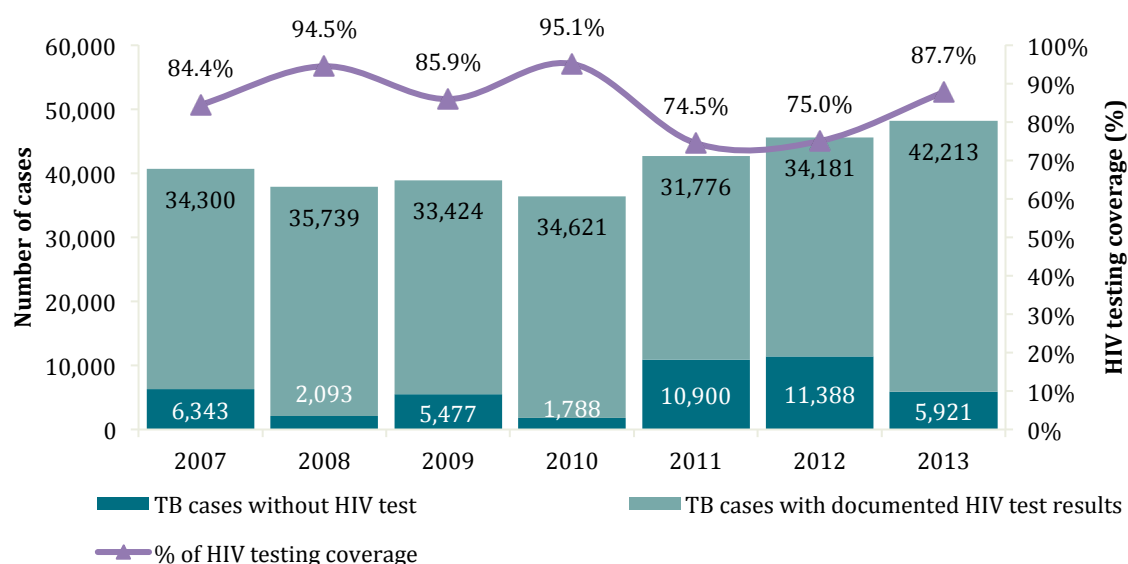


Data source: Global TB database

Ukraine has gradually improved the diagnosis and enrolment of MDR TB cases in treatment. Since 2009, the number of MDR TB cases almost trebled, reaching 9,650 in 2013. 87.4% of these cases have been enrolled in treatment (Figure 29). According to WHO, success is explained by the introduction of modern methods of diagnostics. The percentage of effective treatment of MDR TB cases that started treatment in 2011 and 2012, is only 34.9%.

Low-adherence to treatment is seen as a symptom of patients' larger social and psychological problems; such patients are placed in hospitals involuntarily.⁷⁷ Many doctors reported that those with the worst records of adherence are usually former prisoners and/or persons affected by alcohol and drug addiction. These patterns of addiction are, in turn, taken as indicators of unresolved psychological illness that makes successful treatment impossible. In the absence of social or psychological support, the only option considered for ensure adherence to treatment is hospitalization in a closed TB ward. Often coercive treatment is proposed too soon, after the patient has failed to comply with very restrictive, non-patient-friendly forms of drug administration.

Figure 30: Notified TB cases by documented HIV test results, and HIV testing coverage, Ukraine 2007-2013



Data source: Global TB database

The TB/HIV health services are provided by two separate systems in Ukraine: the TB Department and AIDS Centers. The TB facilities and AIDS Centers at the oblast level have attempted to address co-infected TB/HIV individuals attending the two services through the simplest possible referral mechanism.

Every 8th TB patient in ten is tested for HIV (Figure 30). **This indicator could have been higher if there were not a significant variability in the integration of TB/HIV services across the country.** Coordinated care is more likely to be available at the central level or in oblast centers, and much less likely to be available at the rayon level. At the oblast level and their main cities, TB facilities have access to an infectious disease specialist onsite, and AIDS Centers have access to a TB specialist, although the mechanism for this access and the frequency of visits vary. Some remote rayons and towns do not provide sufficient access to TB/HIV co-infection services, such as CD4 count, viral load, ART and Opioid Substitution Therapy (OST). Often patients need to travel to the oblast center for HIV testing, which results in delays in diagnosis and treatment. Additionally, limited access to services at the rayon level contributes to default during the outpatient phase of TB treatment when patients leave oblast city center TB dispensaries to move to more remote towns.

The use of rapid tests for HIV in TB patients during the outpatient treatment phase is very limited. This may be due to health care providers' lack of capacity in terms of pre- and post-

⁷⁷ Jennifer J. Carroll, Barriers to Treatment Adherence in Ukrainian Tuberculosis Control Programs, 2013

counseling or their lack of understanding of the advantages of rapid testing in the effective management of TB/HIV co-infected patients and the improved impact on patient outcomes. In many sites, this is attributed to the fact that TB institutions are not part of the GF programs that supply express-tests and provide training to the personnel.

NGO potential in providing TB/HIV patient support is not fully realized. Specifically, the mobile primary healthcare points provided by NGOs, which provide screening for STI, HIV and Hepatitis C Virus among vulnerable groups, are not significantly involved in coordinated TB/HIV care efforts, including TB screening and follow up for co-infected patients.

There are no regulations that describe and direct the collaboration between TB, HIV and primary health care facilities, or NGOs that provide support to people living with HIV (PLHIV). This results in the development of local orders at the regional level that do not cover every aspect of TB/HIV collaboration and/or do not take into consideration the role of PHC facilities.

Barriers to care exist for patients in the diagnosis and treatment of TB/HIV. These include difficulty in obtaining necessary diagnostic tests (cost, transportation, and difficulty accessing multiple sites), lack of patient knowledge or inaccurate understanding, fear of stigma and discrimination at health care facilities, and lack of access to substitution treatment onsite at inpatient TB and HIV sites. Barriers also exist to the continuity of care including ART and completion of TB treatment after discharge from inpatient facilities, especially for patients from smaller towns.

The prospects for the social protection of TB patients are unfavorable if the Government does not take decisive steps. Ukraine Red Cross Society (URCS) promotes patient adherence to TB treatment. URCS provides DOTS to a limited number of patients in their homes. In addition, it also periodically provides incentive packages that may include food, counseling, and/or vouchers for transportation or other necessities. Patients who are deemed to be at high-risk of treatment default are referred from the TB treatment cabinet to URCS for at-home follow-up. No state ensured benefits are made available to TB patients in Ukraine. Social support for treatment adherence is only provided by URCS and fully funded by the GF grant.

TB prisoners are treated in Prison TB hospitals. The Ministry of Interior has his own health care system, and all TB patients are treated in specialized TB hospitals. In prisons, TB patients can be transferred from peripheral colonies to TB hospitals (just to check CD4, or to complete diagnosis, etc.), which means that non-TB patients could potentially be exposed to contracting TB or cross-infection. In prisons, TB patients are not treated during their prolonged stay in the so called “quarantine” zone of TB prison-hospitals, which can last up to 14 days. Importantly, the concept of “preterm release” for patients with TB stimulates them to not undergo treatment. Moreover, courts do not consider, or do not know, whether people who have been arrested have TB, which can often mean that TB patients under arrest remain in unsuitable settings for a long time. Ex-prisoners suffering from TB are not prepared well, not transferred appropriately, not accompanied, often not encouraged to continue their treatment in civil TB institutions.

3.4. Human Resources

3.4.1. General overview of human resource production, deployment and retention

Health workforce shortages and aging are common in Ukraine, and the country lacks a human resource planning and development strategy. The lack of a strategic planning process for human resource allocation, coupled with the normative-based human resource allocation system currently in effect, hinders the efficient delivery of TB and HIV/AIDS service delivery and the appropriate allocation of health cadres. Planning for health care personnel is still developed on the basis of norms. While there are policies to redistribute health workers to fulfill these norms, filling posts in less popular branches of medicine (like epidemiology and TB specialists) proves difficult. Different approaches to health care planning are being explored, but it is likely that norms-based planning will prevail for the foreseeable future. The country lacks a human resource information system that could allow for the forecasting of staffing requirements and the implementation of appropriate human resourcing, including the number of staff, specialty,

deployment, retention and development. The lack of a strategic planning process for human resource allocation at the central level of the MOH, coupled with the normative-based allocation of human resources, affects both the efficient delivery of TB and HIV/AIDS service delivery and the appropriate allocation of health cadres. Official guidance on human resource planning for HIV/AIDS care stipulates that planning should be based on actual needs as determined by the epidemiological situation rather than on population size alone. However, this guidance is at odds with the current health facility financing system, which allocates fixed line-item budgets that do not allow facility managers any flexibility in staffing expenditure⁷⁸.

At the same time, the health workforce is aging, as new graduates choose to work outside the state health system or seek opportunities abroad. While a high proportion of TB specialists (more than half in some regions) are close to or beyond retirement age, the specialty is not a popular choice among new graduates as it involves higher occupational risk and work with socially difficult patients⁷⁹.

The deficiency of the human resources allocation process affects patient loads for TB and HIV/AIDS service providers. There are significant differences across regions in patient loads per health worker for TB and HIV/AIDS services: in some areas, infectious disease physicians are overburdened, while nurses, social workers, and laboratory physicians are underutilized. Unfilled staff vacancies for infectious disease specialists (particularly for TB) are typically draw the most attention in such situations.

Relatively low government salaries are a barrier to the provision of efficient services to KP and provide many opportunities for corrupt practices to take place for people to access health and other services in a timely manner. For example, the average monthly salary of a nurse in Ukraine is in the region of US\$100, which is insufficient to cover the average cost of living in the country. In addition, nurses are often used by doctors and health care facilities to process paperwork rather than to undertake medical-related service delivery with patients for which nurses have received training. This results in service delivery being low, relatively costly and inefficient. Often, nurses working in government-run health care facilities also work part time for NGO supported services to earn for living.

Poor working conditions in health facilities are consistently cited as the main factors that discourage health professionals to join or remain in the public health sector. Poor social conditions and infrastructure in rural areas make posts there difficult to fill. New graduates posted to rural or remote areas as part of their two-year service requirement (for state sponsored students only) typically leave their posts as soon as they fulfill the requirement. In Kiev and other big cities, the availability of alternative, better-paid occupations is widely perceived to draw health workers away from the health care system. A medical doctor with the highest qualifications and a specialization that is among the best paid usually does not earn more than US\$300 a month, including bonuses and additional payments.

There is no real health workforce motivation system. The public health system continues largely to rely on Soviet practices of remunerating health care workers using fixed salary scales, which are based primarily on the length of experience. Salaries do not reflect the patient load or any service quality indicators linked to individual provider or facility performance. As a result, the current system does not provide monetary incentives for health workers to improve the quality, efficiency, or quantity of their work. The budgets of individual health facilities have a line item for salaries, and managers do not have the flexibility to allocate savings from other budget areas (e.g., facility maintenance) to staff remuneration. Nevertheless, some exceptions exist. For example, facility managers can raise the salaries of workers with hazardous working conditions and for surgeons, based on the quantity and complexity of their work. Such raises must fit within the salary fund provided by their line-item budgets, and are limited to a certain percentage of base salary.

⁷⁸ Ukraine Health System Assessment, 2012, USAID

⁷⁹ Review of the National Tuberculosis Programme in Ukraine, 2011, WHO

Additional remuneration, which can reach up to 50 percent of base salary, is granted for increasing the amount of work by substituting for a missing worker (which is important in understaffed facilities) or an increase in the catchment population served. Some cadres can receive bonuses for working long shifts, performing complex duties, excellent achievements, or for being on-call at home. Those working in AIDS centers and TB dispensaries receive a bonus percentage pay increase due to the potentially hazardous nature of working with infectious disease. Bonuses for achievements related to performance efficiency or quality are extremely rare, due to chronic lack of funding, and are typically not awarded in a transparent manner⁸⁰.

The education system is largely unchanged from Soviet times, and is reacting very slowly to the demands of the market. Higher medical education is provided by 18 state medical universities and faculties, which are evenly distributed around the country in 16 regional centers and in the capital of the Crimean Autonomous Republic. In addition, four private institutions, which are all licensed and accredited, provide higher medical education. The state institutions are funded and supervised by the MOH and the Ministry of Education, and maintain accreditation and education licenses. The MOH and MOE develop and approve syllabuses and model curricula for medical education, which individual institutions can change to a limited extent.

Curricula revisions are conducted every five years by expert working groups, and are then approved by the MOH. However, evidence-based medicine is not yet grounded in university curricula for medical education. One of the reasons is that there is no mechanism for the timely modification of pre-service curricula to respond to updates in national clinical guidelines, which often results in discrepancies between the norms and what is actually being taught to students. The number of students admitted to medical education is based on both the estimated needs of the population for different medical specialists and the state's economic potential, and is supervised by the MOH. It is unclear to what extent this process involves a strategic review of the population's health needs (including regional-level analyses) to identify priority specialties for pre-service training and to provide additional incentives for students to choose these areas for their specialization.

As part of continuing medical education, doctors should attend postgraduate training every five years. In-service training for doctors is provided by three institutions of higher education, which dedicated primarily to this type of training and fully funded by the state budget. Only students from institutions that are not under the MOH pay fees.

The shortage of adequately trained managers is recognized by MOH and the government as one of the main obstacles to implementing health care reforms. Addressing this shortage is one of the key strategies to develop the health sector. In response, an 18-month degree program in health care management, which was developed with EU technical assistance, was introduced in all three post-graduate medical education institutions. However, the combined training capacity of the institutions offering this program is still insufficient to meet needs.

Employees of the public sector receive salary top-ups from GF grants. Salary top-ups are common in Ukraine. As reported by key informants, salary top-ups vary depending the position of and particular tasks assigned to a public employee. There are a few cases when salary top-ups are 5-10 times higher than public salaries. Eventually when external funding ends, this practice may lead to the demotivation of public employees and difficulties in staff retention.

3.4.2. HIV human resources

The salaries of HIV service staff in NGOs are mostly paid by GF grants and are significantly higher than salaries in the public sector. According to key informants, NGO staff salaries are almost 3-4 times higher than public employees in the health sector. For example, an NGO social worker earns about 3,000 – 4,000 UAH, whereas a social worker in the state social services receives a salary of 1000-1500 UAH, depending on the professional category. In financial terms work, with

⁸⁰ Ukraine Health System Assessment, 2012, USAID

the NGO is more attractive than in public sector, which often is a reason why public sector employees, notably from the health sector, have dual occupations, working part time for the public sector and part time for an NGO. The consequences of such arrangements on the quality of services provided has not been evaluated.

The shortage of health professionals in the penitentiary system severely affects HIV/AIDS service provision. The sharp decrease of health workforce in prisons undermines service quality. According to respondents, staff have little motivation to work in difficult environments with low pay. In the absence of infectious disease specialists, internists are requested to manage HIV positive patients. In order to mitigate these challenges, UCDC assigns district HIV specialists (180 specialists in total) to visit prisons for testing, counseling, diagnosis and treatment prescription with GF financial support. While this approach seems to be an appropriate short-term solution, no decisive steps are planned to find effective medium and long-term solutions to the problem.

“Staff motivation is extremely low due to difficult work environment and low salaries. Only those new graduates agree to work in our system who failed to get employed in civil sector”.

Quote: From Key Informant Interview

HIV/AIDS is only partly institutionalized within in-service medical education. Four National HIV/AIDS Training Centers provide such training in the country. These centers enable national certification and accounting of trained providers, they have insufficient capacity to meet the HIV service provision needs that have been decentralized to sub regional levels. Providers in the AIDS centers have received, by and large, adequate in-service training and mentoring on HIV service provision. However, this is not the case with family doctors and other PHC workers, as HIV prevention, treatment, care, and support has not been mainstreamed in family medicine in Ukraine, and pre-service training in HIV/AIDS is largely considered to be inadequate.

The training of social workers at NGOs and at the AIDS centers is supported by different donor organizations using different curricula that do not allow for uniform certification of those who are trained. Moreover, monitoring of training results is limited to individual post-training evaluations of knowledge and skills. In addition, the scarcity of specialists with training in epidemiology, biostatistics, and M&E has been identified by several assessments as an impediment for the HIV/AIDS response⁸¹. Recently, the Alliance has introduced distance courses for social workers to build their capacity and skills. Furthermore, an on-line course on serving most at risk adolescents has been introduced by an NGO called “Ukrainian Institute of Social Research”, with the financial support of development partners.

Capacity building activities for NGOs and their social workers are mostly implemented by NGOs. Alliance Ukraine has established 11 resource centers throughout Ukraine to increase the capacity of local NGO staff to better serve their clients. These resource centers are mostly located within existing NGO partner organizations. Furthermore, Alliance Ukraine also runs selective courses using on-line platforms and provides certified basic and advance courses. Alliance has also developed and delivered trainings on sexual and reproductive health to NGO social workers and psychologists, thereby increasing the availability of, and FSW access to, SRH interventions. While all these efforts are encouraging, sustaining these training activities depends on the funding available.

Although the state Pedagogical University offers a one year training to social workers in “case management”, access is denied to community social workers. According to program requirements, the applicant for such training should possess a higher education degree, which apparently is not a case for community social workers (peer outreach workers).

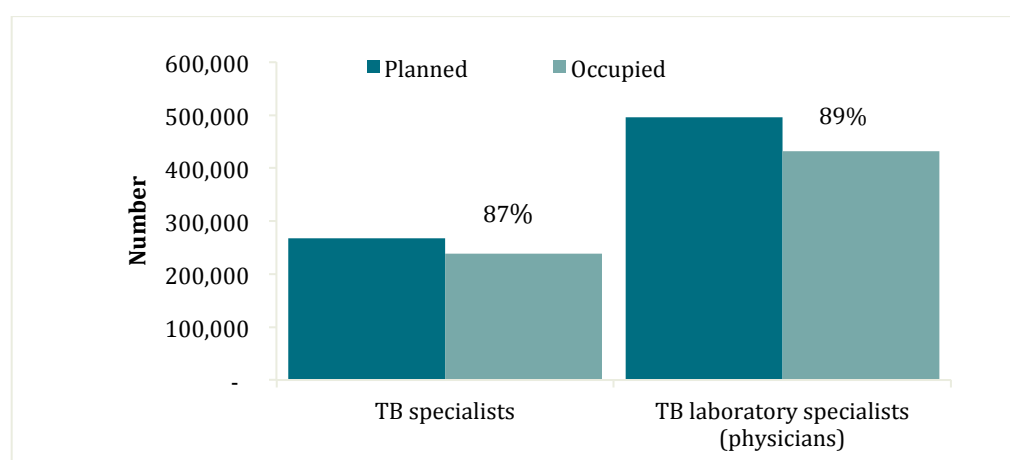
Around 30 international NGOs that have been involved in the HIV/AIDS response during the past decade have helped to organize and build the capacity of many local NGOs and networks.

⁸¹ Ukraine Health System Assessment, 2012, USAID

NGOs perform the majority of their activities with financing from Global Fund grants and other international donors. Most NGOs at the oblast and local levels implement programs financed by Global Fund grants. They have demonstrated an increased capacity as the providers of prevention, care, and support services. Local NGOs have also created several networks to coordinate their advocacy strategies and goals, including the Coalition of HIV-servicing Organizations; the Ukrainian Harm Reduction Association; the All-Ukrainian Network of People Living with HIV, and the Alliance Ukraine network, which includes over 100 sub-recipient NGOs. Since 2005, a group of international NGOs has also demonstrated close cooperation in key areas, which resulted in their efficient representation in the National Council. However, at the oblast level, such mechanisms for efficient cooperation between both local and international NGOs are in most cases irregular and inefficient, according to the international expert assessment. The legally declared governmental leverage to support HIV/AIDS response in Ukraine is mostly unused, because there is mechanism that would regulate social assignments for NGOs to provide certain services funded from the state budget.

3.4.3. Tuberculosis human resources

Figure 31: HR in TB sector



Staff shortages in the TB sector are prominent in Ukraine. Historically, health professionals have less respect for TB specialty, which, coupled with their low willingness to be deployed in the sector, results in continuous staff shortages. According to official data, only 89% of TB specialists and 87% of TB Laboratory specialists positions were filled in in 2014 (Figure 31).

The low motivation of TB specialists hampers staff retention in the TB sector. Although the payroll is the main cost (57% of total annual budget) of the TB hospital budget, salaries for TB physicians and nurses are too low and uncompetitive to attract sufficient young doctors and nurses. For example, the starting monthly salary for a young doctor just after receiving his specialization as a TB specialist is UAH 2,500 (USD 100), and for a nurse working at a TB facility is UAH 2,100 (USD 84). Furthermore, there is no system of professional insurance and/or hazard payments for those TB professionals who acquire TB. Aggression at the work place from hospitalized patients with alcohol and drug addiction also poses challenges for retaining staff in TB care.

TB specialists provide TB services only. Two main specialists, Pulmonology and TB specialist (Physiatry), are registered in Ukraine. These specialists are trained at the same Medical Universities/Institutes with the same undergraduate curricula, but in practice these are two independent specialists. In the case of suspected TB, pulmonologists refer patients to TB specialists, although respondents note that the lack of sufficient TB knowledge among Pulmonologists presumably results in the late diagnosis of TB cases. The existing post-graduate specializations and qualification approval (so called categories – second, first and highest categories) are different for both specialties. Pulmonology as a specialty is perceived to be more attractive to young physicians.

Insufficient knowledge of contemporary TB prevention and treatment protocols is another underlying cause of TB epidemics. Lots of progress in building the capacity of TB

“Knowledge on several topics like childhood TB, TB management in special situations (example with TB and pregnancy) is very limited”.

Quote: From Key Informant Interview

specialists in key aspects of TB and the MDR-TB control program has been noted in the past couple of years, but in many cases their level of knowledge in TB management still remains insufficient. In addition, there is lack of training for communication with difficult patients and management of TB/HIV cases.

Management staff have low capacity. The lack of managerial staff capacity and the absence of supportive supervision has been named as one of the main challenges by key informants. The introduction of supportive supervision, which should gradually replace the more traditional command and control style of supervision, is considered to be a priority by respondents. Building management capacity in the modern principles of TB management and in communication skills development were also recommended as priority aspects to be addressed within NTP implementation.

While the undergraduate program includes DOTs, post-graduate education programs remain outdated. TB is part of the undergraduate and post-graduate education system, and is also included in the continuous professional development program. However, these courses are outdated and require urgent revision in line with international standards and WHO recommendations.

3.5. Commodity Forecasting, Procurement and Supply Chain Management

3.5.1. General overview of procurement and supply management system in the health care

The Framework Law on Public Procurement regulates public procurement in Ukraine.

Ukraine's Law on «Public Procurement Process» is dated 10.04.2014 No 1197-VII⁸². In addition to the framework law, a number of by-laws regulate public procurement process in Ukraine. A draft law has been developed to enable amendments to the Procurement Law with a view to improving the procurement system, allowing framework contracts and regulating the use of online procurement processes and procedures⁸³. Public procurement legislation mandates a the winner of a competitive tender to provide a license that entitles it to engage in the type of activity that is required to allow execution of the procurement contract⁸⁴. Non-residents (the foreign nationals) may not hold such a license, since licensing legislation states that only Ukrainian nationals may hold medical products import/wholesale licenses⁸⁵.

Several barriers restrict the affordability of medicines. Almost no TRIPS-flexibilities are implemented under Ukrainian law, and a variety of TRIPS-plus provisions are incorporated in the Ukrainian Patent Law and the Law on Medicines. The market authorization of medicines is complicated and takes approximately 1.5 years, which delays the launch of generic medicines upon patent expiry. There is also no internal or external international benchmarking mechanism for medicine prices. MOH procurements of ARV in previous years were possible only with participation of local distributors, as non-residents (manufacturers) could not overcome the regulatory obstacles and meet the terms and conditions of MOH's bidding requirements. These barriers hamper competition among ARV and TB suppliers in Ukraine and can negatively influence access to treatment by keeping the price of available drugs higher than they would be if the generic version were registered for use in Ukraine⁸⁶.

Quality control of medications (including ARVs and TB drugs) imported into Ukraine is regulated by the Law on Medicines⁸⁷. Article 17 of the law stipulates that medications registered in Ukraine can be imported if they have a quality certificate issued by the manufacturer. At the end of 2008, the State Inspectorate on the Quality Control of Medications was granted the authority to

⁸² <http://zakon4.rada.gov.ua/laws/show/1197-18/print1389885658732185>.

⁸³ <http://goo.gl/BkvQcu>.

⁸⁴ Part 3 Article 40 of the Law No 1197.

⁸⁵ Paragraph 2 Item 1.3 The Licensing Conditions for the Medicinal Products Import, paragraph 2 item 1.2 The Licensing Conditions for the Medicinal Products Retail/Wholesale

⁸⁶ Ukraine Health System Assessment, 2011, USAID

⁸⁷ Law of Ukraine on Medicines, from April 4, 1996 of No. 123/96-BP, Last edition from 20-10-2014

execute state control over the quality of medications imported to Ukraine. If an imported medication already has a Good Manufacturing Practices (GMP) certificate provided by an agency such as the U.S. Food and Drug Administration, it passes following visual quality control alone, since the certificate already indicates an adequate level of quality. If the certificate is absent, the medication goes through a double control process, consisting of visual and laboratory quality control. The procedures for laboratory control of medications are under development. Executing laboratory control for each shipment of medication requires considerable resources in terms of time, money, and specialists. The MOH has issued its own series of orders to control drug quality.

Responsibility for quality control rests with the State Inspectorate for Quality Control of medical goods, which is the central body of executive power. The actions of this body are directed and coordinated by the CMU through the MOH. Current regulations define cases when state registration of a certain medical product may be cancelled, suspended for a defined period, or withdrawn from the market and its circulation limited or prohibited. They also outline procedures for handling cases in which a product adversely affects or poses risks to human health — whether detected during manufacturing or during use. The regulations also address inconsistency in marking and the low quality and effectiveness of a product compared with that declared by the State Inspection for Quality Control of Medical Products. The procedure for notifying adverse effects is established, but it does not always work effectively due to a lack of training, fear of receiving reduced supplies of medications in the next period and unwillingness to do the necessary paperwork⁸⁸.

The Ukrainian Tax Code provides VAT exemption for the sale of medical products allowed for production and use in Ukraine and registered in the state register of medical products. Medicines procured through GF funding also benefited from the provisions of this law. Until recently, Procurement Agents (PRs) obtained a tax exemption letter from the State Service of Socially Dangerous Diseases. Since the liquidation of the State Service, however, no mechanism has yet been elaborated to allow for the exemption of all medicines procured through the GF.

The MOH is responsible for arranging procurement through tendering for centralized state purchases to support targeted state programmes. The existing system of centralized purchasing of pharmaceuticals is disliked by health care facilities, agencies and monitoring institutions, because the Ministry of Health purchases and distributes drugs without taking into account regional demand regarding the type and volume of drugs needed. Moreover, the prices of the purchased pharmaceuticals are often too high, despite the use of tendering in procurement⁸⁹. National counterparts, including those in the higher level of the Government, have noted weaknesses in the procurement performance and have tried to address those at the National Council level, which tasked the MOH to lead improvements in PSM to assure continuous and uninterrupted PSM of HIV and TB drugs⁹⁰.

In response to procurement system challenges, the MOH initiated a further revision of the framework law on procurement to allow direct procurement from international organizations such as UNICEF, GLC, the GF, etc. The framework law was submitted to parliament for approval in May 2015. Approval of this law will allow the MOH to procure ARV and TB drugs at competitive prices from respective international organizations and use its limited financial resources more effectively.

To ensure that the right medicines are procured, the MOH initiated a revision of the essential drug list. Up until recently, public procurement in the health sector was mainly guided by the national drug list. According to respondents, this list was not aligned with national clinical guidelines, and the mechanism for revising the list was not transparent. In 2015, therefore, a working group was established under the MOH tasked with developing a new national drug list,

⁸⁸ Ukraine Health System Assessment, 2012, USAID

⁸⁹ Lekhan V, Rudyi V, Richardson E. Ukraine: Health system review. Health Systems in Transition, 2010; 12(8):92.

⁹⁰ Ukraine 2010, The Round 10 Proposal for HIV/AIDS for the Global Fund. www.theglobalfund.org

which will be aligned with national/international clinical guidelines and protocols. It was hoped that the updated list would be approved shortly and used for annual public procurement, although changes in the management of the ministry may potentially delay required approval.

The procurement of medicines and commodities financed by the Global Fund is set as a parallel system. PRs use their own procurement rules and practices aligned with GF procurement requirements.

3.5.2. HIV

The National AIDS Center is responsible for forecasting, monitoring and utilizing ARVs at the national and regional levels. The MOH approved a methodology for estimating the need for ARVs in 2010. It states that regional healthcare authorities and the National AIDS Center are authorized to make arrangements for implementing and ensuring the compliance of subordinate healthcare facilities during the process of estimating need for ARV drugs. The estimation system, as currently defined, involves a one-time annual centralized procurement of ARVs. Therefore, regional authorities are asked to project the ART needs for each patient for 12 months, including the expected number of new patients. Oblasts have to send their requests for ARVs to the National AIDS Center in the first half of the preceding year. The large time lag between estimating needs and the delivery of drugs introduces makes it likely that the initial needs estimations are wrong. The prevalent opinion among key informants was that the planning mechanism is ineffective and that the drugs received are often not the drugs requested.

In addition, there is no legal provision for keeping a buffer stock of ARVs to ensure the continuity of

treatment in case of delays in procurement and distribution. According to informants, a variety of shadow measures for redistributing drugs among facilities are employed by providers in an attempt to prevent shortages and stock outs.

The supply, storage, and transportation of HIV drugs, test kits, and consumables are organized according to the Schedule of Distribution. Supplies and commodities are supplied directly to regional AIDS Centers. The Reference Laboratory is responsible for distributing test kits and equipment procured via the state budget to HIV/AIDS reference laboratories. “Ukrvaksyna” State Enterprise is responsible for the delivery of test kits, and “Ukrmedpostach” State Enterprise is responsible for the delivery of ARVs. Interviews revealed a prevailing opinion among providers that the existing system of HIV-related drugs and consumables supply is unclear and inconvenient. State procurements and distribution of products are not clearly defined in terms of delivery.

Disruptions in the supply of ARVs procured by the MOH restrict access to ART for PLHIV. In the absence of publicly procured ARVs in 2014 and 2015, due to delays in approval of new

Procurement Law, the GF allocated an additional 4 million USD to the “All Ukrainian Network of PLHIV” (PR) for the purchase of required ARVs. The Network has already organized emergency procurements twice in 2015 (in the first and third quarters), in the total amount of USD 5 million, to ensure the continuity of ART for PLHIV who are on treatment until the first quarter of 2016. As a result of negotiations with the suppliers that were initiated and conducted by the Network, the suppliers provided free ART worth about \$2.4 million.

“The forecasting methodology for ARVs requires improvement. There is a large time lag between forecasting and the actual receipt of medicines, which apparently affects the calculation of needs for the next year. Often the ARVs received are not the ones required. Furthermore there is no formal mechanism that allows the redistribution of medicines between districts and regions.

At present, when there is an emergency and people move from Lugansk and Donetsk to Dnipropetrovsk, there was a need to improve supply of ARVs to this region. In the absence of a formal mechanism and a “buffer stock”, informal mechanisms have been used to mobilize the required volumes of ARVs from various regions and supply Dnipropetrovsk.”

Quote: Key Informant Interview

“Ukraine fails to meet targets (number of people on ART) stipulated in the NAP and GF funding proposal due to the delays in procurement of ARVs. As the MOH has not yet initiated procurement, GF transferred additional funds to us for the purchase of ARVs which allows to have a minimum stock of ARVs till the end of this year”.

Quote: from Key Informant Interview

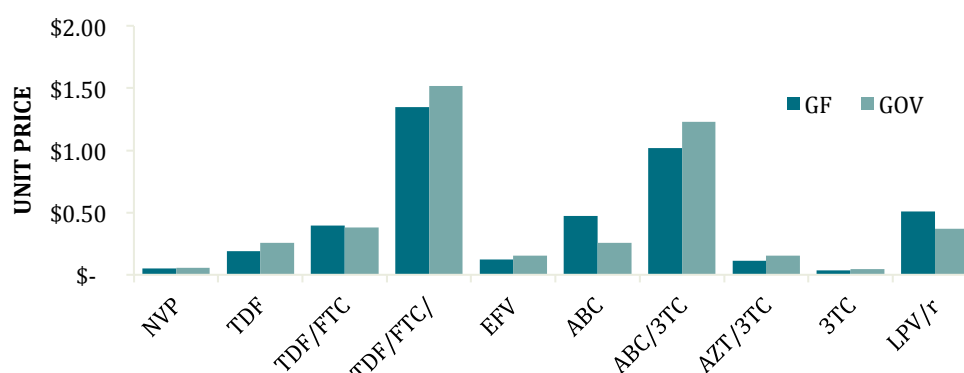
There is a concern among health professionals and patients about the quality of procured and distributed medicines and diagnostics, the unpredictability of the supply of medicines needed for long-term treatment of HIV/AIDS and the risk of drug resistance in case of treatment interruption.

The lack of integration between distribution, procurement and finance makes it difficult to set priorities in product release. The replenishment of supplies only once a year provides very limited flexibility for stock re-adjustments based on patient needs or changed regimens. This can result in the continued prescription of regimens that are no longer suitable, due to stock limitations.

The Global Fund approved emergency funding for the procurement of ARVs for the government non-controlled territories. The last shipment of HIV treatment commodities to the NGCA, which was procured by the All Ukrainian Network of People living with HIV under the 2015-2017 GFATM Grant, took place in February 2015. The stocks of drugs available in Donetsk and Lugansk will expire by August 2015, which puts more than 8,000 people who are currently receiving ARV treatment and PMTCT prophylaxis at risk of interruptions in treatment, progression to AIDS and death as well as new cases of children infected through MTCT. Therefore, In June 2015 the GF approved an emergency allocation to UNICEF to ensure the rapid procurement and distribution of ARV drugs to NGCA.

Flaws in the public procurement system limit fair and open competition, thereby undermining value for money. The protectionist rules reflected in the laws promote locally manufactured products over imported ones, which sometimes undermines the quality of products procured by the government. The facilities are required to use locally produced HIV test kits that are of poor quality and a source of inefficiencies, but most importantly negatively affect the quality of testing services. Furthermore, procurement rules that limit competition drive-up the costs of inputs (ARVs, HIV test kits, etc.). Through open international bidding, the cost of ARVs, test kits, etc. could be significantly lower, as we have seen for the commodities purchased with the GF grant (Figure 32).

Figure 32: Comparative unit prices for key ARV drugs procured by the Government and GF, 2014



Source: All Ukrainian Network of PLHIV

A comparative analysis of unit prices for ARV medicines procured through GF and MOH clearly indicates the inefficiency of public procurement. With the same amount of financial resources, Ukraine has the opportunity to purchase more inputs necessary for treatment, which could increase the efficiency of public funds and treatment and care for more PLHIV.

Ukraine is in a position to allow more funding for ART if the procurement legislation is streamlined to allow the purchase of generics instead of brand medicines and the optimization of treatment regimens. The All Ukrainian Network of PLHIV has performed an informal analysis of the possible cost savings in case generic ARVs are procured and concluded that the government can save about USD 8 million (Table 10), which could be used for further expansion of access to ART of PLHIV. In addition, the procurement of ARVs is further complicated by the large number of treatment regimens used in Ukraine. Optimizing treatment regimens would obviously diminish relatively small-scale procurements and give more leverage to the government for obtaining better price

deals from suppliers. However, the respondents interviewed were confident that existing treatment regimens are well grounded in the needs of PLHIV.

Table 10: Potential savings when generic ARVs are procured

International nonproprietary name	Presentation, dosage	USD
Abacavir	tabl., 300 mg	\$ 640,711.97
Abacavir/Lamivudine	tabl., 600 mg/ 300 mg	\$ 212,308.62
Abacavir	Solution for oral administration, 20 mg/ml	\$ 127,476.67
Darunavir	tabl., 600 mg	\$ 643,632.84
Lopinavir/Ritonavir	tabl., 200 mg/ 50 mg	\$ 5,245,868.87
Lopinavir/Ritonavir	tabl., 100 mg/ 25 mg	\$ -31,824.20
Lopinavir/Ritonavir	Solution for oral administration, 80 mg/ 20 mg - 1 ml	\$ -142,378.40
Raltegravir	tabl., 400 mg	\$ 267,460.00
Ritonavir	tabl., cap., 100 mg	\$ 39,691.26
Tenofovir+Emtricitabine+Efavirenz	tabl., 300 mg/ 200 mg/ 600 mg	\$ 1,466,392.44
Etravirine	tabl., 100 mg	\$ 104,615.28
TOTAL SAVINGS		\$ 8,573,955.34

Source: All Ukrainian Network of PLHIV

3.5.3. Tuberculosis

According to the most recent assessment of the national TB program, there is a need to improve the forecasting and supply management of TB drugs. An evaluation of the Ukraine TB program by the WHO Regional Office for Europe in 2010 highlighted challenges in substandard supply chain management and stock maintenance practices below the regional level. As a result, erratic availability of locally purchased anti-TB drugs led to unsatisfactory treatment outcomes and an increase in MDR-TB. However, since then some improvements have been noted in the continuous supply of the country with TB medicines.

Drug selection for procurement is based on existing national treatment guidelines and WHO recommendations. In general, first-line drugs (FLD) for TB are financed by the state budget and procured through a competitive bidding mechanism. Fixed-dose combination products are available only if FLD and is supplied/granted by the Global TB Drug Facility.

Despite the fact that the MOH has not yet initiated procurement of TB medicines for the year 2015, the health system has sufficient drugs. As explained by a key informant, this was possible due to two reasons: i) an overestimation of drug needs; and ii) the availability of a 12 month buffer stock, which allows the system to have a continuous supply of medicines. **While it is encouraging**

"According to the legislation, the state supplies are to be conducted once per year with 100% annual stock+100% annual reserve for TB drugs"

Quote: from Ukraine Concept Note, 2014

that no treatment breakdown is foreseen due to delayed procurement, concerns remain about the lack of capacity and effective methodology for drug forecasting.

Furthermore, delivery is made to the facilities at once, and national regulations do not allow for the movement of drug stocks from one region to another when needed. As a result, regions experience stock-outs of essential TB medicines, including Rifampicin and lack of specific SLD for many diagnosed patients. In addition, interruption in the supply of laboratory consumables remains a bottleneck, according to informants. **In summary, the supply system does not allow for adequate reaction to problems as they arise, as it is not flexible enough to fill in the gaps rapidly.**

While it is believed that some of these problems will be addressed by the e-TB Manager program, a web-based system that provides comprehensive information about patient case management, including pharmaceutical management information resolution of the challenges mentioned above, would require revision of the regulatory environment and building human resource capacity.

All procurement activities related to pharmaceuticals and medical products within the Global Fund program are in full compliance with the requirements of the Global Fund and national legislation, and constitute a parallel system. Thus, all TB and ARV drugs are WHO pre-qualified (or ERP approved) and produced in GMP certified facilities.

3.6. M&E and Information Systems

The UCDC is responsible for M&E of HIV and TB programs. In 2009 an M&E Unit was established as a structural division at UCDC, which was responsible for Monitoring and Evaluation of Implementation of Programme Activities in Response to the HIV/AIDS Epidemic (UC M&E) and ensuring organizational and methodological support and coordination of the processes of M&E data collection, analysis and presentation. Regional Centers for Monitoring and Evaluation of Implementation of Programme Activities in Response to the HIV/AIDS Epidemic (RC M&E) were established and are functioning within the AIDS Centers.

Substantial progress has been made in establishing and consolidating the national M&E system, though room for further improvement remains. Substantial progress has been made in establishing and consolidating the national M&E system, which generates information about critical epidemiological developments and funding flows, and monitors service provision levels, especially those delivered by NGOs. Epidemiological surveillance (routine as well as bio-behavioral) has been improved, and better quality data have emerged about the HIV spread and about epidemic drivers. Data availability has enhanced national capabilities to monitor epidemic developments, identify achievements as well as shortcomings and plan or take necessary corrective measures. USAID performed a systems assessment that showed robust and well-implemented data collection and reporting systems and did not identify any major gaps in data management systems. Data verification shows excellent data quality.

Nevertheless, there still remain weaknesses that have to be addressed. Namely, the M&E systems of the health and penitentiary system are not yet integrated; state funding is insufficient; the number of staff deployed at UCDC M&E unit and their salaries are low in comparison to the workload; the capacity of staff at regional levels requires enhancement, etc.

Evidence based policy-making remains a challenge. It is a common practice in all sectors of the country use official statistics data for planning purposes. Similar to other sectors, the MOH only uses data from routine surveillance for annual planning, which often results in the underestimation of annual services and commodity needs, and results in shortages of funds and commodities for effective implementation of the national TB and HIV/AIDS response. This practice undermines importance of comprehensive data generated by national M&E and reduces national political support for this rather functional system. Public officials at national and local levels do not possess a sufficient level of results-oriented management culture or understanding of the importance of monitoring and evaluation.

“As long as there is no relevant national need for information and no funding for extremely important M&E activities, the availability of information for monitoring and planning of national response may suffer negative impact in case of donor support absence”.

Quote: From Key Informant Interview

Although routine surveillance is publicly funded, 2nd generation surveillance and M&E remains dependent on external sources. Furthermore, M&E specialists who are responsible for monitoring GF funded grants at UCDC are financed through GF resources. Therefore, the sustainability of the above-mentioned achievements is the main concern of national stakeholders.

3.6.1. HIV

One of the best-developed components of the M&E system is the system of routine epidemiological surveillance, which is almost fully funded from the state budget and uses new international approaches and recommendations. In general, the country's achievements in M&E have been well recognized, especially with the introduction of a specially developed database to monitor the provision of HIV services to most-at-risk populations, which uses unique identifier

codes to prevent the double-counting of individuals and enables better assessment of service coverage. The software allows for real-time reporting to the GF, and is used by more than 150 non-governmental organizations in Ukraine (as well as groups from Belarus, Kazakhstan, Kyrgyzstan, Malaysia and Tajikistan)⁹¹. The availability of data has significantly enhanced national capabilities to monitor epidemic developments, identify achievements as well as shortcomings and plan or take necessary corrective measures. The availability of comprehensive information has been well documented in the Ukraine Harmonized AIDS Response Progress Report 2012, which is a rich document with the most up to date results. However, some major challenges still remain, which are discussed later in this report.

Another well-established source of data for M&E is programme monitoring of NGO project activities, in particular related to the implementation of Global Fund grant programmes with the financial support of the “All-Ukrainian Network of PLWH” and the ICF “International HIV/AIDS Alliance in Ukraine”, as well as bio-behavioral, epidemiological, economic and other studies and evaluations. These components of the M&E system apply up-to-date methodological approaches and tools and are characterized by the high quality of data, according to the results of external quality audits and data verification by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Ukraine regularly collects and analyses data on HIV expenditure. Although the SS was responsible for such research in 2014, after that body was liquidated the UCDC for the first time implemented National AIDS Spending Assessment (NASA)⁹², which was extensively utilized during the preparation of the concept note for the new GF funding modality.

The country lacks a unified register of PLHIV. The coding system used by health providers and NGOs differ, which limits the integration of parallel registers. The WHO, UNICDC and UNAIDS recommend a Unique Identifier Code (UIC), based on a range of numbers and /or letters that keeps the name, address and other key personal information of the individual PLHIV confidential whilst allowing service providers to identify the individual for whom interventions are being delivered. In Ukraine, three UIC systems are operational: a) Alliance Ukraine and its partners use a system with 8 symbols based on a client’s personal information to register people in HIV prevention programs; b) the “All Ukrainian Network of PLHIV” uses a system that is automatically generated from the client’s full name to register people in treatment, care and support programs; while c) AIDS Centres use a client’s full name, based on the data in their national passports, to register HIV positive persons to receive ART.

3.6.2. Tuberculosis

The NTP uses a standardized recording and reporting system, which has been upgraded to accommodate the latest WHO recommendations, although it has shortcomings. The current TB information system is a paper-based system and has limited capacity to manage information on TB cases, products, and reporting requirements. It demonstrates problems with the regularity and accuracy of reports from different levels of the TB network and does not support effectively M&E. The lack of information for both effective day-to-day and strategic decision making, including TB program planning, budgeting, forecasting, and supply planning is another shortcoming of the system. Furthermore, there is no coordination between parallel data collection and the reporting streams of the Ministry of Health and State Penitentiary System.

A new e-TB Manager system was recently introduced. To mitigate the challenges of the current TB information system, a new e-TB manager has been designed and piloted which incorporates requirements of the National TB Program in close collaboration with UCDC and USAID/SIAPS project and was adapted to comply with national requirements for personal data management. Notably, the system received official certification and was approved by the MOH as the official TB information system. The user’s manual and SOPs were developed and approved. The system allows the collection and use of data analysis for decision-making, management of pharmaceuticals,

⁹¹ Strategic Investments for Impact: Global Fund Results Report 2012. www.theglobalfund.org

⁹² Data not yet publicly available

quantification and inventory management. Staff have been trained, and final institutionalization of the system is planned by end of 2015.

Ukraine has no national-level TB/HIV co-infection indicators⁹³. Co-infection indicators differ by region and do not allow for comparison and analysis at the central level. Data for local indicators are collected sporadically and may remain unanalyzed, while any conclusions are not always brought to the attention of the oblast health administration.

Unlike HIV/AIDS, no system for regular TB expenditure monitoring has been introduced yet.

4. CHAPTER: ASSESSMENT OF TRANSITION READINESS

This chapter summarizes Ukraine's experience in transitioning program elements; examines the government's readiness to continue and, where needed, expand activities presently funded through GF support; and assesses the country's organizational capacity and preparation for transition.

4.1. Transition Experience

Since Ukraine has made little to no effort to gradually transfer responsibilities to the government for particular program elements, its transition experience is limited and, where available, is not positive.

- Due to cutbacks in the Phase 1 HIV GF grant of Round 10, prevention activities were reduced in size, and the government have not taken over funding of the remaining services. Whilst there was neither a formal mechanism allowing the government to finance preventive services, nor a government approved standard list of preventive services for KPs, this was a missed opportunity to facilitate and initiate the required policy and regulatory changes and safeguard adequate funding.
- Within the frames of NFM prevention, service packages for different KP groups have been further optimized. At present, minimum service packages, comprising of 3-4 services only, are offered to KP, which apparently limits the effectiveness of preventive programs.
- Furthermore, funding for case management (социальное сопровождение) substantially decreased through NFM, which caused massive NGO staff redundancy at the national and local levels (around 30%-35%).
- The government share of funding for ARV medicines increased, although due to the problems described above, the government failed to meet expectations.

The only positive experience is that most OST sites established at narcological institutions have dedicated staff for psychosocial care (social workers and/or psychologists) who are employees of the health care facility and are paid from regular facility budgets. Likewise, social workers are deployed at AIDS and TB centers.

Transition experience in TB is lacking as Ukraine only received the first GF grant in 2012.

4.2. Program Continuity

In the absence of a comprehensive national health strategy in Ukraine, diseases are usually addressed within the framework of separate national programs, such as the programs on TB and HIV. In general, health care in Ukraine is much more focused on treatment, while prevention – an important component in HIV and TB programs – is hardly addressed. This causes a high financial burden on the health care system due to the use of relatively expensive secondary and tertiary levels of care, and causes a fragmentation that prevents services from becoming integrated and client-centered.

⁹³ TB/HIV Co-Infection Services Gap Analysis in Ukraine, USAID, 2014

Although the government acknowledges the need to reform the health sector, it has not taken any decisive steps to introduce system wide reforms, but rather has limited its efforts to pilots.

4.2.1. HIV

The NAP 2009-2013 demonstrated significant progress in the HIV response, particularly in expanding ART coverage and increasing state spending for HIV programs. During NAP implementation, a certain stabilization of the epidemic was been observed, namely, in decreasing the HIV growth rates, decreasing the share of new infections in 15-24 age group, and a sixfold decrease in mother-to-child transmission rates. Despite significant progress, however, the number of new infections continues to grow, while access to treatment and care, especially among KPs, remains limited, which means that HIV mortality rates are still high.

The new NAP 2014-2018 was developed through countrywide dialogue involving key national players, international agencies, PLHIV and representatives of the key populations. The NAP 2014-2018 is based on the main outcomes and lessons learnt from NAP 2009-2013, as reflected in the assessment of the implementation of the National AIDS Program 2009-2013. The overall goal of NAP 2014-2018 is to decrease HIV/AIDS morbidity and mortality through ensuring sustainable and accessible service delivery in the field of prevention, diagnostics, treatment, care and support for PLHIV. Priority areas include: i) HIV prevention with a focus on KPs, which anticipates a transmission to state funding after the end of GF support (planned from 2017); ii) a significant increase in ART coverage, with 118,000 patients on ART (compared to current level of 55,784), with government funding for the total ART need by 2018; iii) strengthening the laboratory potential for HIV testing and ART monitoring (CD4, viral load tests, HIV drug resistance); iv) care and support services for PLHIV, with an anticipated transmission to state funding in 2017. The NAP 2014-2018 does not contain specific activities related to TB/HIV co-infection. Coinfection is only addressed as a part of the care and support service package, which contains social worker consultations on TB/HIV issues, referrals to medical institutions, and assistance in receiving access to medical services.

4.2.2. Tuberculosis

The National TB Program 2012-2016 (NTP) has an overall goal of mitigating the TB epidemic situation by focusing on TB morbidity and mortality, TB/HIV coinfection and MDR-TB through ensuring high-quality TB prevention, diagnostics and treatment services. The implementation of the program is ongoing. The NTP prioritizes i) improvement in the quality of laboratory services for TB diagnostics; ii) provision of up-to-date treatment of MDR-TB cases with appropriate patient support to ensure adherence; iii) strengthening the links between civilian and penitentiary TB services; iv) intensifying case finding and DOT support; and v) strengthening capacities for program management, coordination, monitoring and evaluation.

The Government plans to initiate preparation of the new NAP 2017-2021 in early 2016, which will be based on the findings of the joint Global Fund-USAID-WHO-World Bank assessment mission in 2013⁹⁴.

4.3. Organizational Capacity

The uncertain state of the CCM and its unclear future: The effectiveness of the Country Coordination Mechanism has been rated as sub-standard by respondents, due to the reorganization process that is described in the previous section. At present, immediate action is required to decide where to place the CCM and who should chair it. It is hoped that, with the appointment of the new Minister of Health, the decision will be made in the nearest future, which would allow for the effective resolution of challenges currently faced by both national programs. Since this immediate problem remains unresolved, no thinking has yet taken place regarding the CCM's future.

⁹⁴ Key recommendations form the Joint Global Fund-USAID-WHO-World Bank Mission. Phase II TB grant negotiation in Ukraine. May 2013

The State Service for Socially Dangerous Diseases has been liquidated, and no proper unit has been yet established within the Ministry of Health to assume its functions, which are the responsibility for countering socially dangerous diseases and ensuring the sustainability of services. This limits stakeholders' coordination and cooperation with the MOH.

Key stakeholders have the capacity and opportunity to advocate for health issues and participate effectively with public officials in establishing policies and plans for health services⁹⁵. However, this varies significantly according to the disease/health issue in question, and is clearly stronger where there is donor backing and interest (specifically in the area of HIV/AIDS). Civil society, technical experts and health service users have the capacity/opportunity to use, analyze and provide feedback to the government on health sector goals. The MOH hosts a number of disease or health issue-specific working groups comprising technical specialists and relevant stakeholders, such as provider associations and patients groups.

Organizational strength and weaknesses of PRs: So far GF support to Ukraine have been led and implemented by three PRs: the UCDC (public entity), and two NGOs (The All Ukrainian Network of PLHIV and Alliance Ukraine). While all three PRs have the capacity to effectively manage program implementation, they may face challenges with planned reforms in the health sector as well as with the end of GF funding. The key challenges are outlines in the Table 11 below.

Table 11: PR possible challenges

PR	Current weaknesses	Future Key Challenges
UCDC	<ul style="list-style-type: none"> Funding gaps, uncertain GoU funding Cumbersome funds flow mechanism through Treasury slows UCDC's ability to pay on time UCDC lacks the authority for final decision making and implementation in HIV and TB areas The organization cannot make decisions independently, because of dependence on the MOH Lack of administrative management oversight relationship between UCDC and regional AIDS and TB Centers 	<ul style="list-style-type: none"> Possible reorganization of Sanitary Epidemiological Services may require a merger of this service with UCDC. The UCDC reform process may negatively impact national HIV and TB program implementation Lack of financial independence (over-reliance on donors for funding) Human resources gaps (due to lack of funding, GoU salary levels), loss of some experienced staff
All Ukrainian Network of PLHIV Alliance Ukraine	<ul style="list-style-type: none"> High dependence on donor funding (85%-90%, mostly through GF) 	<ul style="list-style-type: none"> Absence of well defined strategic vision for sustainability Lack of funding for the continuation of HIV prevention services and risk to lose staff at the community level Absence of mechanism to win government contracts High NGO staff salaries compared to public sector, will limit the government's ability to compensate through social contracting mechanism

The human resources for health (HRH) policy is being addressed and regulated by a number of different legislative and regulatory documents, but none of them provides the integrated strategic HRH approach or methods needed to implement a HRH policy in health care. The main weaknesses in HRH, which are relevant for both the HIV and the TB sectors, are the government's lack of strategic vision, which leads to poor planning and budgeting at national and local levels; the weak sustainability of HRH training programs (most activities are funded by external donors); the failure to institutionalize training on many HIV/AIDS and TB issues in the state system of medical

⁹⁵ Ukraine Health System Assessment, USAID, 2011

education, leading to low motivation of medical specialists to participate in such trainings; and the extremely high number of secondary and tertiary health specialists compared to the acute need for personnel in primary health care, which makes health care services high-threshold, thus contributing to low HIV and TB detection rates.

Inefficient public procurement practices: Inefficient public procurement practices at the national and local levels limit the effective implementation of TB and HIV national response. Transparency is needed in the pharmaceutical sector, in terms of prices in particular, so that effective policies and advocacy/accountability efforts can be implemented by the state and civil society, and their impact monitored accordingly.

The central M&E unit at UCDC has insufficient power, which paired with poor funding, staff shortages and increased staff workloads weakens UCDC's ability to effectively monitor implementation of national HIV and TB programs. If funding and staffing levels remain unchanged, it will be difficult to maintain the M&E specialists currently deployed at UNDCD through grant funding.

With Global Fund grants PRs have established systems for quality data collection and reporting on prevention, treatment, care and support services. The PRs have built their capacity in conducting quality analysis of gathered information, which is used to inform and improve program activities. However, there is no general health management information system (HMIS) nor specific HIV MIS in Ukraine, except in some pilot areas. It appears that the future of HMIS initiatives will be determined by decisions related to the development of HIS as part of the planned health care reforms. Therefore, at present, most epidemiology, counseling and testing, screening, diagnostics, treatment, PHHP inventory and care and support data are contained in different information flows. Since different entities are responsible for these flows, it is very difficult to track patients throughout the various service providers. The mostly paper-based data collection system increases the workload of health care personnel, leading to lower data quality and complicating data analysis.

Informants have highlighted weak M&E data analysis capacity at local levels and the need to further enhance the surveillance system. Concerns about M&E and surveillance data analysis capacity at regional and local levels have been raised by a number of informants.

Limited ability to track allocations and report on expenditure for the national TB program. Whilst the capacity for tracking expenditure of the national HIV/AIDS program has been established, UCDC does not possess the methodology or the knowledge to monitor NTP expenditures.

Lack of continuous support to clients: An overview of the main agencies responsible for each key component in the HIV/AIDS sector highlights the current lack of continuum of support for key populations, starting from an individual's first contact with an outreach worker or health care facility whether it is operated by an NGO or a Government agency, or a combination of the two. The relative lack of PWID access to ART is one key indicator of the inability of the current labor division to support KP in accessing critically important components in the continuum of care for HIV/AIDS prevention, treatment and care in Ukraine (Table 12).

Table 12: Division of roles and responsibilities in the HIV/AIDS response⁹⁶

PREVENTION	CARE & SUPPORT	TREATMENT
Alliance Ukraine	The All Ukrainian Network of PLHIV	Government of Ukraine
Key Populations	PLHIV (general and Key Populations)	PLHIV (general and Key Populations)
Outreach, Drop-in Centers, Health facilities, NSP sites, pharmacies, drug treatment sites	AIDS centers	AIDS centers

⁹⁶ Europe: Good Practices, WHO, 2014

UIC - anonymity	UIC – more formal disclosure of personal data	No coding
Prevention	-	-
Rapid tests	Registration support	Confirmatory test
		Dispensing ART
Adherence support through case managers	Adherence support	Dispensing of treatments for Opportunistic infections
TB/HIV co-infection support through case managers	TB/HIV co-infection support	-
OST and ART support	-	OST and ART support
Viral Hepatitis support	Viral Hepatitis support	-

Deficient coordination between central and regional mechanisms in the management and financing of AIDS Centers leads to an ineffective use of financial and human resources. A network of regional AIDS Centers delivers services that are legally independent of the national Ukrainian AIDS Center. Regional AIDS Centers are funded and supported by local budgets and have resources for excessive recruitment of personnel. The MOH has very limited resources for procuring ARV drugs and laboratory tests, which it distributes from the national to the regional levels, and thereafter to the local level. The Ukrainian AIDS Center provides methodological supervision for the services, but has limited power to introduce new approaches to service delivery. In order to introduce new forms of, or approaches to, service delivery, which, in many cases, require additional resources or structural changes, the UCDC must seek support from local health administrations and coordinate its efforts with the MOH at the national level. The UCDC can suggest changes to the Order of the MOH on staffing, but cannot regulate human resource issues directly. A lack of clarity regarding the distribution of tasks between the national AIDS Center and the State Services confuses matters further. There is a need to develop a new Human Resource Strategy for HIV and TB services, taking into consideration health care reform, the integration of services, and revised roles, responsibilities and subordination functions.

Less integration and coordination is observed between TB and HIV services. TB and HIV services are provided by two separate vertical systems, which lead to HIV and TB services being highly fragmented for the patient. The level of integration and coordination differs from region to region and mostly depends on the political will of health departments of regional/district/city state administrations as well as on the initiatives of local communities and health services providers.

Limited NGO organizational capacity at sub-national levels. Although NGOs appear to have good practical technical and implementation experience, community level NGOs have limited organizational capacity, e.g. in developing fundraising strategies and ensuring the long-term sustainability of their activities. While the current PRs have been supporting institutional capacity strengthening for NGOs, they still lack knowledge and skills. Many small NGOs are entirely dependent on GF support, while making little or no efforts to mobilize additional resources.

A sustainable partnership between Government and NGOs is not yet formalized. While enhanced collaboration and partnerships between government and civil society have been one of the key achievements of GF support to Ukraine, the development of sustainable partnerships between government and civil society beyond the end of Global Fund support is one of the key priorities to be addressed.

4.4. Transition Planning

While transition planning has been initiated – and some elements of transition have been discussed and specific steps identified – it is not yet formalized. A clear message on the ending of GF funding at the end of 2017 has been clearly communicated by the GF to the government of Ukraine on a number of occasions. A special forum dedicated to the sustainability of GF supported programs has been organized jointly by the MOH and GF with wide stakeholder representation.

The current dependence on external development aid, particularly GF, concerns all key stakeholders in the country. All are cognizant of the need to move away from sole reliance on external resources. While thinking about transition planning has begun and some elements have

been elaborated, key stakeholders in the country are mostly pre-occupied by resolving the current problems faced in the provision of services to key population groups. Nevertheless, the sections below briefly describe the first steps taken in preparation for the transition process.

4.4.1. HIV

Transition planning initiatives in HIV/AIDS sector are grouped into three categories: i) Investment case, ii) Strategies for service continuum and iii) NGO sustainability, as described below:

Investment case:

- ***To optimize public funding and improve allocative efficiency, a study on HIV Investment case has been prepared.*** The HIV Investment case, using the OPTIMA tool, has been supported by the WB, which provides guidance to the Government on the areas/services where investment of resources will ensure desired public health impact.
- ***UNAIDS, jointly with USAID funded projects, intends to support an HIV/AIDS technical efficiency study.*** This research is seen as complementary to the HIV Investment Case, which will inform resource investment decisions and identify areas for further improvement.
- ***The effectiveness of HIV/AIDS services has been assessed and gaps/weaknesses identified.*** USAID supported a Patient Pathway Analysis, which maps the weaknesses at each stage of HIV/AIDS service delivery for each type of KP.
- ***The patient organization prepared draft procurement law.*** For the first time in Ukraine's history, a patient organization prepared a draft procurement law enabling the public procurement of drugs through international organizations. The law will allow for the more efficient use of public resources by procuring quality medicines at a lower cost.
- ***A USAID funded project supports the refinement of procurement and supply chain management systems***
- ***UNAIDS and USAID will support the development of a transition plan***
- ***Optimization of treatment regimens introduced for emergency ARV procurement grant.*** In preparation of the proposal for emergency funding, UNICEF together with national stakeholders initiated the optimization of ARV treatment regimens and decreased the number down to 7. Although stakeholders believe that Ukraine should maintain a variety of regimens, the experience with emergency grant is expected to generate stakeholder willingness to revisit their opinion.
- ***PEPFAR completed an HIV sustainability index exercise,*** which identified priority weaknesses and will be used for programmatic planning purposes.

Strategies for service continuum:

- ***Development partners and NGOs support the development of regional HIV/AIDS plans.*** Starting from 2014, support has been provided to almost all high burden regions in Ukraine to develop regional HIV/AIDS plans. This was an opportunity to ensure that the regions improve the effectiveness of HIV/AIDS service delivery and plan adequate financial resources. However, only a few regional plans have been approved so far.
- ***A strategy has been developed to ensure the access of key population groups to prevention services for 2014-2018.*** The working group at the former State Service for Socially Dangerous Diseases developed a strategy to ensure the access of key population members to prevention services in 2014-2018, which was approved with the Orders of the State Service in January and in May (new version) 2015. The strategy defines the main areas to implement the government policy of Ukraine to ensure the access of populations vulnerable to HIV within the national targeted social HIV/AIDS prevention program for 2014-2018. The strategy also defines the list of key preventive services for each type of key population (the names of services, key populations and responsible authorities). While the strategy is a framework document defining "what" should be achieved, it lacks a detailed implementation plan that elaborates funding and service provider contracting mechanisms, with a particular emphasis on HIV service NGOs, the introduction of "prevention" as a separate type of services, and the establishment of an enabling legal environment for

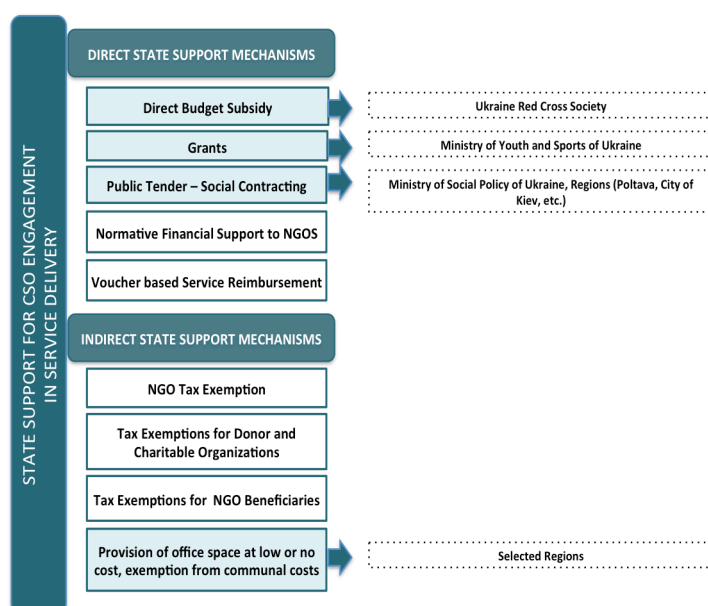
strategy implementation, along with a clearly defined time schedule and responsible entities.

- **UCDC developed a training strategy.** UCDC has gained valuable experience and developed important relationships and capacity in conducting TB and HIV trainings for health workers. UCDC plans to build on these strengths by providing many more of these much-needed trainings for health workers around the country, and to become an important, nationally and internationally recognized Ukrainian Training Institution for HIV, TB and other health topics. For this purpose, a detailed analysis of UCDC capacity has been carried out and a training strategy developed that outlines possible sources of funding, topics of trainings, areas for UCDC capacity development and a detailed, time bound action plan covering the period 2014 – 2015. However, the complicated political environment, coupled with frequent changes in the MOH management, have hampered implementation of the action plan.
- **The Alliance pilots models of OST co-financing** that should inform possible investments in OST.
- **Considerations are given to limit NSP to most vulnerable PWIDS.** Stakeholders are considering options for limiting NSP services to the most vulnerable and disadvantaged PWID, while allowing the better off to purchase injection equipment at pharmacies.

NGO sustainability:

- **An assessment of NGO capacity needs for technical assistance and potential sources for leveraging government funding has been completed.** In 2014, Alliance Ukraine carried out a thorough analysis of NGO capacity that identified needs for further technical assistance and analyzed the legislation that allows mobilization of public resources through social contracting. Based on the key findings of the assessment, recommendations have been elaborated and shared with the CSO sector. The assessment clearly stipulates the challenges faced by NGOs and provides guidance on how to resolve them.
- **Sustainability and Opportunities: an assessment of HIV service NGO financial sustainability experience** was completed in 2015. The report provides all the possible funding mechanisms for NGO-led social services utilized in different countries. Examples of the state funding mechanisms available and piloted/used in Ukraine are presented in Figure 33 below.

Figure 33: State support mechanisms piloted/used in Ukraine



- **Social contracting is only practiced in selected regions.**

There are a few good examples of social contracting practiced in Kiev and Poltava as well as in other regions, where local governments contracted NGOs for social service provision.

- **Indirect government support mechanisms are tested and operational in selected regions.** With advocacy efforts from the local NGOs, local government initiated the allocation of office spaces to NGOs at a symbolic cost.

- **Methodological guidelines have been developed**

for HIV service prevention sustainability. Methodological recommendations were developed in 2014 within the framework of the Political Sustainability Project with the financial support of

ICF “International HIV/AIDS Alliance in Ukraine (Alliance-Ukraine)”, and were widely shared with NGOs

- **Social entrepreneurship** is gaining popularity in Ukraine, according to the All Ukrainian Network of PLHIV. This form of activity is mainly targeted to labor therapy (especially for drug-dependent people or commercial sex workers), social rehabilitation, and implementation of the new mechanisms to solve relevant social problems etc.

5. CHAPTER: CONCLUSIONS AND RECOMMENDATIONS

This section of the report summarizes the findings arising from this country case study and, separately, some general findings, which resonate and align with the results of other studies⁹⁷ and lead to more general conclusions from those that are purely country specific. Consequently, the two sets of conclusions are detailed in separate sections.

5.1. Transition and Sustainability Risk Assessment

Table 13 below presents the list of indicators that were used to assess possible risks to transition from GF support. Each indicator has been assessed according to the criteria and has been assigned a score for low risk, moderate risk or high risk. The component scores are summed up to form a final score of transition risk in a country. To summarise, there is a high to moderate risk of transition for GF financed HIV and TB programs.

Table 13: Risk Assessment Table

H – HIV/AIDS; T- Tuberculosis; B – Both diseases

Components		Disease	Indicators	Country result
External Environment				
Political	P	B	1. Existence of political will to prioritize health investments 1.1 Increasing trend or stable high share of government spending on health out of General Government Expenditure 1.2 Increasing trend of the share of government spending on health out of Total Health Expenditure (THE)	1.1. Stable high government spending on health around 12% out of total General Government Expenditure, albeit deterioration noted due to economic challenges emerging in 2013 -2014. 1.2. Stable share of Government spending on health out of THE
	P	B	1 Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for KP and people living with diseases. 2 Strong Rule of Law	2. There are no legal barriers that hinder effective prevention, treatment, care and support for KP and people living with diseases. 3. Laws are not effectively enforced and administratively some KPs face challenges when accessing services
	P	B	4. Government ability to contract with CSOs - Existence of general regulation for CSO contracting in the economy 5. CSO contracting is practiced in any	4. General regulation allowing CSO contracting exists 5. CSO contracting is practiced in social sector

⁹⁷ Gotsadze T., Fuenzalida H., et al. Thematic Review on Transition and Sustainability of Global Fund Supported Programs. Curatio International Foundation, 2015

Components		Disease	Indicators	Country result
			sector	
				4
Economic	E	B	1. Favorable economic indicators 1.1 Increasing in GDP 1.2 Increasing or stable high share of General Government Revenues as % of GDP	1.1 GDP per capita decrease (annual %) is observed in 2014 due to armed conflict 1.2 Share of General Government Revenues (excluding grants) as % of GDP is more than LMIC mean (37.3) in 2012 year
				1
Internal Environment				
			Inputs	
Financing	F	H	1. Budgetary commitment to disease 1.1. Increasing public expenditure on Disease Specific programs 1.2. Share of public funding in Disease Specific Program budget: 1.2.1. > 75% 1.2.2. 50 – 74% 1.2.3. < 49% 1.3. Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with costed NSP	1.1 Public expenditure on HIV program is NOT increasing. Political will is lacking in prioritization of HIV/AIDS Program during resource allocation. The budget of the health sector has been increased by 10% in 2014 in response to NGO's aggressive lobbying, however additional funding has been redistributed to other state programs by the MOH leaving HIV unattended 1.2 Share of public funding is approximately 44% of total AIDS spending in 2014 1.3 Budget lines exists but NOT aligned with NSP needs
	F	T	Budgetary commitment to disease 1.1. Increasing public expenditure on Disease Specific programs 1.2. Share of public funding in Disease Specific Program budget: 1.2.1. > 75% 1.2.2. 50 – 74% 1.2.3. < 49% 1.3. Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with costed NTP	1.1 Public expenditure on TB program is NOT increasing. Political will is lacking in prioritization TB Program during resource allocation. The budget of the health sector has been increased by 10% in 2014 in response to NGO's aggressive lobbying, however additional funding has been redistributed to other state programs by the MOH leaving TB unattended 1.2 The biggest share (47.7%) of total NTP expenditure is covered through central and local budget sources in 2013, whereas external funding accounts for only 19%. 1.3 Ukraine has never performed detailed calculation of all TB activities and estimation of a total budget
	F	H	2 Prevention priority 2.1 Increasing total public spending on HIV prevention for priority groups 2.2 Increasing share of public spending in total spending (donors and Gov.) on HIV prevention for epidemiologically priority groups	2.1 Overall spending on HIV prevention is not increasing. 2.2 Preventive programs for KAP are primarily financed from external sources. Budget for preventive activities has been decreased over the last couple of years

Components		Disease	Indicators	Country result
	F	H	2 Allocative efficiency Existence of allocative efficiency study Allocative efficiency study informs budget allocations	3.1 Allocative efficiency study was conducted in Ukraine 3.2 Allocative efficiency study has not yet informed budget allocations
	F	H	3 Treatment / input financing from public sources Case detection / diagnostics Drug procurement 3.2.1 First line ART 3.2.2 Second line ART Adherence support	4.1 Case detection/diagnosis mostly financed from TGF 4.2 ARV drugs 4.2.1 First line ART partially funded by public sources 4.2.2 Second line ART are mostly funded by external sources 4.3 Adherence support fully funded from external sources
	F	T	Treatment / input financing from public sources 4.1 Case detection / diagnostics 4.2 Drug procurement 4.2.1 First line drugs (FLD) 4.2.2 Second Line Drugs (SLD) 4.3 Adherence support	4.1 Case detection mostly funded from public sources 4.2 TB Drug 4.2.1 FLD funded from public sources 4.2.2 SLDs mostly funded from external sources 4.3 Adherence support completely TGF dependent
	F	H	5 Prevention financing from public sources 5.1 Funding of Low Threshold Services (excluding OST) from public sources 5.2 Funding of OST services from public sources	5.1 Low Threshold Services (excluding OST) are not funded from public sources 5.2 OST mostly funded from TGF grant
				3
Human Resources	HR	H	1. Sufficient human resources for a disease (quantities, geographic distribution and aging)	Sufficient. Inadequacy of human resources for HIV was not raised by stakeholders, or noted in any publications. However, downsizing of HIV staff is expected after the GF ends.
	HR	T	Sufficient human resources for a disease (quantities, geographic distribution and aging)	With some limitations Relatively adequate although only 87% of positions are filled. Aging of staff raises serious concerns, low salaries of TB medical staff and hazardous work environment distract young people to work in the TB field.
	HR	B	2. Donor supported trainings for health personnel institutionalized in national education system 3. Existence of policy for production/training of CSO personnel (non medical, social service) 4. Donor funded HR salaries aligned with national pay-scale	1 TGF supported some trainings (especially for HIV) have been institutionalized into the national education system 2 Policies for CSO personnel production exist but are rather weak 3 TGF funded salaries are not aligned with the national pay-scale and are significantly higher
				3

Components		Disease	Indicators	Country result
Health Information System	HIS	H	1. Advanced routine statistical reporting fully integrated in the national system 1.1 HIV testing 1.2 PMTCT 1.3 AIDS related mortality 1.4 Adult treatment 1.5 Pediatric treatment	1.1 HIV testing-integrated, partially advanced 1.2 PMTCT- integrated, partially advanced 1.3 AIDS related mortality – integrated, partially advanced 1.4 Adult treatment- integrated, partially advanced 1.5 Pediatric treatment – integrated, partially advanced
Health Information System	HIS	T	Advanced routine statistical reporting fully integrated in the national system 1.1 TB New and relapse cases 1.2 TB treatment registry 1.3 Pediatric treatment 1.4 MDR TB reporting 1.5 Care and support (incl pediatric)	1.1 TB New and relapse cases- integrated, partially advanced 1.2 TB treatment registry – integrated, partially advanced 1.3 Pediatric treatment- integrated, partially advanced 1.4 MDR TB reporting- integrated, partially advanced 1.5 Care and support (incl pediatric) – integrated, partially advanced
	HIS	H	2. HIV Second generation surveillance 2.1 Rigorous methodology used for IBBS 2.2 IBBS Implemented timely (according to NSP) 2.3 IBBS Funded by public sources 2.4 PSE funded by public sources	2.1 Rigorous methodology used for IBBS 2.2 IBBS Implemented timely (according to NSP) 2.3 IBBS NOT funded from public sources 2.4 PSE NOT funded from public sources
				3
			Governance	
Governance (Political support, Program leadership, Coordination)	G	H	1. Strong political commitment to diseases 1.1. NSP with legal and enforceable power in a given country context 1.2. NSP in preparation or without legal and enforceable power 1.3. HIV/AIDS as a priority in National Health Strategy document	1.1 Ukraine has parliament approved Law on HIV/AIDS covering period 2014-2018 (alternative to NSP)
	G	T	Strong political commitment to diseases 1.1. NTP with legal and enforceable power in a given country context 1.2. NTP in preparation or without legal and enforceable power 1.3. TB as a priority in National Health Strategy document	1.1 Country develops a new National Program for the period of 2015-2018 awaiting Government's approval (under the leadership of UCDC).
	G	H	2. Strong leadership 2.1. Legally empowered leading organization to manage given disease program	2.1 There is no entity fully responsible for the national Disease program. Following reorganization the management responsibilities are not transferred to other entity due to its

Components		Disease	Indicators	Country result
			effectively functioning 2.2. Individual leader(s) advocate for disease specific programs	absence (the entity should be formed at MoH). Ukrainian AIDS center is legally empowered but complexities of public management impose significant limitations on its powers. Functioning is with some limitations 2.2 Individual leadership is visible
	G	T	Strong leadership 2.1 Legally empowered leading organization to manage the functioning of the given disease program 2.2 Individual leader(s) advocate for disease specific programs	2.1 Ukrainian AIDS center is legally empowered but complexities of public management impose significant limitations on its powers. 2.2 Individual leaders exist but less visible than in TB
	G	B	3. Strong coordination mechanisms 3.1 Coordinating body adequately placed within the government hierarchy and legally empowered within the national Government structure to assure adequate coordination across the sectors 3.2 CSOs have a legally determined seat in the coordinating body 3.3 Coordinating body functions effectively	3.1 Coordination body is not well placed within the government hierarchy to assure adequate national coordination and coordination across different sectors; 3.2 CSOs have legally determined seat on the national coordination and play significant role 3.3 Coordination body functionality is rather weak and not very effective, especially since recent restructuring.
				3
Accountability	A	B	1. Program performance results are available and accessible through public domain: 1.1. EPI data including for KAPs 1.2. Programmatic data and/or reports 1.3. Program expenditure data 1.4. Program M&E reports 1.5. NSP/NTP and other periodic reviews	1.1. EPI data including for KAPs – Available 1.2. Programmatic data and/or reports – Available 1.3. Program expenditure data – NOT completely available 1.4. Program M&E reports – Available 1.5. NSP and other periodic reviews – Available
	A	B	2. Enabling Environment for Civil Society engagement ⁹⁸ 2.1. 0-0.38 – there are laws and policies that restrict civil society playing an oversight role 2.2. EEI 0.39 – 0.50 – there are no laws and policies that restrict civil society playing an oversight role, but in practice it is not accepted by the Government 2.3. EEI > 0.51-0.76 there are no laws or policies that restrict civil society playing an oversight role, and civil society is actively engaged in providing oversight	Ukraine's EEI for 2013 was 0.56 indicating that there are no laws or policies that restrict civil society playing an oversight role, and civil society is actively engaged in providing oversight
				4

⁹⁸ <http://civicus.org/eei/>

Components		Disease	Indicators	Country result
			Program	
Service Delivery	S	H	1. Treatment 1.1. Increasing coverage (%) trend for ART 1.2. Improving treatment outcome for ART (adherence rate at 12 months)	1.1 Yes increasing numbers of ART but rather low coverage and huge gaps from testing to treatment and care cascade 1.2 Treatment-adherence outcomes are improving
	S	T	Treatment 1.1 Improving treatment outcome – success rate for all TB cases 1.2 Improving treatment outcome – success rate for MDR TB	1.1 Over the past 10 years sensitive TB treatment success rate is around 70% 1.2 The percentage of effective treatment of MDR TB cases that started treatment in 2011 and 2012, is only 34.9%
	S	B	2. Integrated services: 2.1 Integrated PMTCT with PHC/Maternity care 2.2 Integrated TB in primary care 2.3 Integrated HIV and TB services	2.4 PMTCT is well integrated in the maternity care 2.5 TB services are still separately standing with limited or no integration into PHC 2.6 TB/HIV services are not integrated but close to emerge even integration with OST services
	S	H	3. KP reach with preventive services 3.1 Increasing coverage trend of epidemiologically most important KAP with preventive services 3.2 Data based on IBBS studies with rigorous methodology	3.1 Coverage of KP with preventive services is increasing but yet remains low (2 data points 2011 & 2013) 3.2 Data is based on rigorous IBBS methodology
	S	B	4. CSOs contracting in health 4.1 Existence of detailed rules and procedures for contracting CSOs for health service delivery (includes medical and other health related social services) 4.2 Government already contracts CSOs for various health service provision using public funds	4.1 Detailed tender procedures for CSO contracting is available in social sector NOT for health sector 4.2 Government already contracts CSOs to provide social services using public funds, but this is not practiced yet for health services
				3
Organizational capacity (program management, financial management, contracting, procurement, supply chain management, research and M&E)	O	H	1. Strong management of the National Disease Program Management Entity (not PR) 1.1. Existence of national program management capacity assessment OR staff performance evaluation practice (at least once in every second year) 1.2. Closely integrated TGF PR and National Program Management	1.1 Due to absence of an entity responsible for overall management of HIV/AIDS program its capacity assessment has not been conducted. 1.2 Relationship between PRs and national disease management entity not defined at present due to the absence of such entity. PRs manage only GF funding.
	O	T	Strong management of the National Disease Program Management Entity (not PR) 1.1. Existence of national program management capacity assessment OR staff performance evaluation practice (at least once in every second year) 1.2. Closely integrated TGF PR and National Program Management	1.1 Due to absence of an entity responsible for overall management of HIV/AIDS program its capacity assessment has not been conducted. 1.2 Relationship between PRs and national disease management entity not defined at present due to the absence of such entity. PRs manage only GF funding.

Components		Disease	Indicators	Country result
	O	B	2. PSM 2.1 TGF funded procurement is conducted using national system 2.2 Supply chain management integrated into the national system 2.3 Low frequency of emergency procurements for drugs (not more than one over for last year) 2.4 Rare stock outs for drugs (not more than once for last year) 2.5 If national procurement – paying not more than 5% above the international benchmark price	2.1 TGF funded procurement is NOT integrated in the national system 2.2 Supply chain management is NOT integrated into the national system 2.3 Low frequency of emergency procurements for drugs reported in 2013 2.4 Stock outs for drugs (not more than once for last year) NOT detected 2.5 If national procurement – PAYING MORE than 5% above the international benchmark price
	O	B	3. M&E 3.1 Existence of analytical capacity at MoH/main public health agency reflected in availability of analytical reports that are produced with certain periodicity 3.2 Information use for evidence-based program planning and management e.g. NSP/NTP uses recent Epi, programmatic and expenditure data	3.1 Both indicators could be rated as partial. Although there a lot of analytical reports in Ukraine, largely produced by donors and non state actors 3.2 The epidemiological data is available and used in NSP/NTP, although M&E data are not always used for program planning and budgeting
				1
Transition preparedness	T	H	1. Transition plan / elements 1.1. Legally binding and actionable transition plan exists 1.2. Draft transition plan exists 1.3. Transition elements embedded into the legally empowered national program / NSP	1.1 Legally binding and actionable transition plan does not exist 1.2 There is no draft of the transition plan but there are steps identified, although not formalized, for its development 1.3 Transition elements (financial responsibilities to cover ART by 2018) are embedded into the National HIV/AIDS program (HIV/AIDS law)
	T	T	Transition plan / elements 1.1. Legally binding and actionable transition plan exists 1.2. Draft transition plan exists 1.3. Transition elements embedded into the legally empowered national program / NTP	1.1 Legally binding and actionable transition plan does not exist 1.2 There is no draft of the transition plan but there are steps identified, although not formalized, for its development 1.3 Transition elements (financial responsibilities) are embedded into the National TB program
	T	H	2. Transition plan characteristics: 2.1 Clearly identifies time-bound activities to be implemented during transition 2.2 Clearly outlines roles and responsibilities of a	N/A

Components		Disease	Indicators	Country result
			Transition process management 2.3 Incorporates M&E indicators for transition process 2.4 Incorporates budget for transition	
	T	T	Transition plan characteristics: 2.1 Clearly identifies time-bound activities to be implemented during transition 2.2 Clearly outlines roles and responsibilities of a Transition process management 2.3 Incorporates M&E indicators for transition process Incorporates budget for transition	N/A
	T	B	3. Transition M&E 3.1 M&E is followed 3.2 CSO participates in the transition updates	N/A
				0
				High to Moderate risk
			Overall score (Total max score 76)	26 (33%)

EXTERNAL ENVIRONMENT

Economic development: The recent political turmoil, ongoing military actions and the annexation of Crimea have negatively affected Ukraine's economy and are perceived to have a lasting effect. Stable high government spending on health, which was around 12% of total General Government Expenditure started to deteriorate due to the economic challenges that emerged in 2014. If this trend is maintained, Ukraine will face challenges during transition from Global Fund support.

Political commitment: The share of government spending on health out of General Government Expenditure started to deteriorate due to economic challenges emerging in 2013 -2014, albeit the share of government spending on health out of the total health expenditure. There are no legal barriers that hinder effective prevention, treatment, care and support for KP and people living with diseases, however anti-discrimination laws have not been always effectively enforced to safeguard the human rights of vulnerable social and ethnic groups.

INTERNAL ENVIRONMENT

Financing: The government's commitment to fund the national HIV and TB response looks less promising at present. Although the share of public expenditure on HIV and TB program is increasing, it is at a slow pace and remains largely dependent on external funding. The political will to prioritize the HIV/AIDS program during resource allocation is lacking, and underfunding of national disease specific programs is common. In summary, the share of program costs Ukraine has

to take over when the Global Fund support ends for HIV and TB programs remains high. Countries where programs are predominantly government funded (>95%) found it much easier to assume financial responsibilities after the end of external funding⁹⁹. Therefore, the current level of HIV and TB program financing in Ukraine poses a high risk for transition. In order to achieve a positive public health impact with possible financial limitations, the country has to ensure effective coverage of key populations by improving the allocative and technical efficiency of prevention, treatment and care services.

Human Resources: Geographical imbalance, staff turnover and a lack of motivation are common features of the Ukrainian health care system. The ageing of the health workforce, which is most severe in the TB sector, coupled with the low salaries of TB medical staff and hazardous work environment which deter young people from working in the TB field, raises serious concerns. Global Fund supported trainings for health personnel are not fully institutionalized in the national education system, and there is policy for continuous education of CSO personnel. These systemic weaknesses put the transition of HIV and TB programs after Global Fund support at high risk, if they are not addressed accordingly and in a timely manner.

Information Systems: The HIV and TB M&E system is integrated into national reporting systems, but there is still room for improvement. The 2nd generation surveillance capacity was built with the support of the Global Fund, but remains mostly externally funded. Maintaining the effective operation of the M&E system after external funding ends is at a medium level risk if the government fails to further enhance its surveillance system, track program expenditures regularly, build adequate analytical capacity at national and local levels and carry out research that informs future policy development and program implementation.

Governance: The government remains committed to the continuation of the HIV and TB national programs, although the new national TB program is still awaiting government approval. The management of national HIV and TB programs faces challenges following the liquidation of the State Service of Ukraine on HIV/AIDS and Other Socially Dangerous Diseases. Following reorganization, the MOH failed to establish/assign the national program management responsibility to respective divisions in the ministry. UCDC is legally empowered but the complexities of public management impose significant limitations on its powers and operations.

Ukraine had a functioning national coordination mechanism, but recently the National Council mandate was shifted down from the Cabinet of Ministers to the level of the MOH. As a result of the recent restructuring of the overall national coordination system, erosion of the traditional HIV/TB governance and coordination resulted in reduced political commitment and disappearance of HIV and TB from the government's and the MOH's policy agenda. Streamlining national program governance, strong coordination and easy access to program performance information¹⁰⁰ will minimize challenges during transition.

Program: In order to achieve a positive public health impact despite possible financial limitations, the country has to ensure effective coverage of key populations by improving allocative and technical efficiency of prevention, treatment and care services. Advancing technical efficiency should be addressed by reinforcing prevention activities, rightsizing service providers, building linkages between the health sector and non-governmental and social service providers, streamlining patient pathways among TB and HIV service providers and enhancing of follow-up and social support for improved treatment outcomes. Taken together, these measures will mitigate the potential challenges Ukraine will face after transition from Global Fund support.

⁹⁹ Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of global fund supported programs. Curatio International Foundation, 2015

¹⁰⁰ Transparency and streamlined accountability: what watchdogs, grant implementers and OIG want, Aidsplan, 2015
<http://www.aidsplan.org/node/3354>

Organizational Capacity: There are several prerequisites for easy transition and attaining the desired public gains. They are: enhancing coordination between PR and national program management entities and strengthening the organizational capacity of national program implementers and service providers; streamlining procurement functions to allow the procurement of HIV and TB drugs and commodities at a lower price; and enhancing M&E and evidence based program planning and implementation.

Transition preparedness: Given that the government and other key stakeholders are over-occupied by immediate emergency challenges, the first steps initiated by the government for transition planning are commendable and should be seen as a demonstration of government's willingness to sustain an effective national HIV and TB response. It is believed that a more comprehensive transition plan, outlining detailed steps to be undertaken in each key area of the national HIV and TB programs, would serve as a road map for a smooth and painless transition.

5.2. General Recommendations

Based on the findings of the sustainability assessment discussed in previous chapters, this section provides bold recommendations that can guide the Government and key stakeholders towards an easy transition after external funding ends.

Transition plan: While the country is discussing and actively working on the elements of the transition, there is no overall plan governing this process. Adequate conceptualization of and careful planning would most likely be of benefit. Other country experiences prove that planned transitions reduce/minimize transition challenges, while rushed transitions cause more problems and undermine sustainability¹⁰¹. Therefore, developing time-bound and actionable plans, which have sufficient legal power and adequate indicators to monitor plan implementation, seem to be necessary first steps for the country to consider. Finally, effective implementation of the plan would also require sufficient resources (human and financial) to achieve transition objectives.

Gradually reducing financial dependence on the Global Fund: Experience prove that the transition process become smoother and odds for sustainability increase when the Global Fund's contribution to the national response is not significant, i.e. less than 25%¹⁰². Consequently, the country has to strive to gradually reduce its dependence. The first and most important area for transition to consider is commodity procurement, so that national procurement mechanisms function adequately and allow for such a transition. The most challenging area seems to be transition of preventive interventions, especially those delivered by NGOs/CSOs, which could be left for the latter phases, provided that sufficient preparatory work is done during the lead-up time to transition date (see CSO contracting for more details).

Many countries give lower priority to prevention compared to treatment. In many instances, the lack of national budget allocation (even with small amounts) has challenged transition and undermined sustainability prospects¹⁰³. While prevention could be last element to be transitioned, it seems important to start developing prevention budget lines/allocations during the transition process, which may eventually drive increased budget allocations when the country stops receiving Global Fund support. In other countries, legally empowered national programs that already reflect a gradual reduction in donor dependence in their budget have often served as an effective instrument¹⁰⁴.

CSO contracting: The overall legal environment is not conducive to NGO/CSO contracting, and the country lacks detailed contracting procedures for CSO contracting in the health sector. Ukraine would benefit significantly if these rules/procedures were developed during transition and institutionalized.

¹⁰¹ Ibid 99

¹⁰² Ibid 99

¹⁰³ Ibid 99

¹⁰⁴ Ibid 99

A similar situation was observed in countries that graduated from the Global Fund without having such rules in place and facing transition challenges¹⁰⁵. Based on other country experiences, such detailed contracting rules/procedures are at least expected to address the following: service definition; service pricing and/or methodology to estimate quoted prices, which helps evaluate value for money for the submitted bids during tendering/national procurement process and, most importantly, helps the government to estimate overall program costs for a given disease and adequately budget during the budgeting process; tendering procedures that are aligned with the national procurement laws and regulations; bid evaluation procedures for both quality and value of the bid; procedures for monitoring quality and/or volume of services delivered by CSOs, etc.

Effective national coordination, with or without the CCM as a coordinating body, is essential for effective management of the national response and for implementing the transition process, which leads to sustainability. One of the greatest benefits that the Global Fund has delivered worldwide is creating the space for governments and civil society to jointly engage in national/global response planning and coordination^{106,107,108}. In most states CCMs, or similar structures, that formally provide a seat and voice for NGOs/CSOs in national coordination, have been critical in achieving the gains observed. Consequently, retaining and/or enhancing effective coordination structures proved to be important in many countries after Global Fund support¹⁰⁹. Therefore, it seems important for the country to consider retaining and enhancing the national coordination structure/function, which would allow for continuous NGO/CSO engagement. For such coordination to be effective, the production, availability, transparency and easy access to information should be ensured for the development of evidence-based (or informed) responses.

Enhancing public accountability during and after transition will be critical to assure quality partner engagement i.e. NGOs, SCOs, journalists and development partners. This would require the routine production of information describing results of the national response i.e. disease program specific epidemiological and financial expenditure data; the results of program performance, including outcomes and challenges. During transition, the country (perhaps with Global Fund support) should strive to assure (maybe contractually and/or through legislative action) that this information is not only routinely produced, but is also freely accessible for all stakeholders involved, government and civil society alike.

Addressing human resource challenges should be viewed in two parts: a) assuring adequate quantity and re-distribution of the needed human resources; and b) continuous education of the professionals involved in national response service provision. The latter has been extensively supported by Global Fund grants, and not only in this country¹¹⁰. However, the sustainability of these trainings raise concerns due to the lack of institutionalization achieved during grant implementation¹¹¹. Consequently, the transition period has to be explicit about what could be achieved in terms of preparing the necessary human resources, how it can be achieved, and how this function can be institutionalized, funded and delivered by the government. The question of human resources goes well beyond the disease response, and results from health sector policies, education policies and the overall socio-economic environment in the country. It also affects the whole health care system. Instead of addressing these challenges as a transition issue, therefore, it is necessary to look at these challenges more holistically and outside of the transition process.

¹⁰⁵ Ibid 99

¹⁰⁶ Spicer N., Aleshkina J., et al. National and subnational HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice? *Globalization and Health* 2010, 6:3

¹⁰⁷ Kapilashramia A., O'Brien O. 2012. The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit? *Global Public Health: An International Journal for Research, Policy and Practice* Volume 7, Issue 5, 2012

¹⁰⁸ Duvvury N., Cornman H., Long C. 2005. Participation of Civil Society in Global Governance: Lessons Learned from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. www.icrw.org

¹⁰⁹ Ibid 99

¹¹⁰ Bowser D., Sparkes S.P., et al. 2013. Global Fund investments in human resources for health: innovation and missed opportunities for health systems strengthening. *Health Policy and Planning* 2013;1-12

¹¹¹ Ibid 99

5.3. Program Specific Recommendations

Program specific recommendations are presented schematically as follows:

RECOMMENDATION # 1: Enhancement of Stewardship and Governance of National Programs

	HIV	TB
Coordination	<ul style="list-style-type: none"> Improve coordination function at national and local levels for better programmatic planning, budgeting, implementation and M&E. Finalize reorganization of the MOH and assign TB and HIV responsibilities to respective unit Ensure active engagement of all stakeholders in transition planning, implementation and M&E of transition process. Plan for maintaining a new CCM secretariat and ensure that adequate funding is guaranteed from MOH budget. 	
Program Management	<ul style="list-style-type: none"> Based on the UCDC capacity assessment findings, elaborate a detailed plan for UCDC management capacity building and ensure its implementation with the assistance of USAID and other development partners. 	
Partnership	<ul style="list-style-type: none"> Enhance the partnership between government and non-government sectors for coordinated service provision, transition planning and implementation and M&E of transition implementation. Ensure the active participation of key stakeholders in various thematic groups to be established depending on the needs outlined in the transition plan. Renew mapping of Development Partner programs and their alignment in support of transition plan implementation. Maintain partnership with CSOs by developing CSO contracting mechanisms and continuous COS capacity building. 	
Legislation and regulation	<ul style="list-style-type: none"> Revise current legislation to decrease stigma and discrimination towards HIV/AIDS and TB Revise/elaborate the state social assistance and benefits legislation by safeguarding the inclusion of PLHIV and TB patients in the eligibility categories. Enforce the policy on collaborative HIV/TB activities, as well as ensure collaboration between the Ministries of Internal Affairs and Health. Elaborate legislation allowing distribution and redistribution of drugs from and between Oblasts and Rayons in order to decrease treatment interruptions. 	
Guidelines	<ul style="list-style-type: none"> Optimize ARV treatment regimens Develop referral algorithms that ensure the continuation of services from identification and prevention to treatment and care. 	<ul style="list-style-type: none"> Revise and enforce protocols that ensure a decrease in in-patient stay and increase the responsibility of PHC for treatment.
Accountability	<ul style="list-style-type: none"> Ensure the transparency of achievements in the field of HIV and TB through improved access and provision of sufficient information to the public for the decrease of stigma and discrimination. 	

RECOMMENDATION # 2: Ensure improved efficiency of current spending, adequate resource allocation for HIV and TB National Program implementation and mobilize domestic and international funding for effective implementation and monitoring of the transition plan

	HIV	TB
Budget	<ul style="list-style-type: none"> Prepare national and regional budget forecasts and ensure allocations based on technical and allocative efficiency principles. Ensure medium term budgeting of adequate resources for continuation of prevention, treatment and care 	<ul style="list-style-type: none"> Ensure medium term budgeting for increased allocation of resources for TB national program at national and

	<p>activities after GF funding ends. Define and legislate the range of per capita allocation per year for local budgets to ensure adequate funding of program from local government budgets</p>	<p>local levels that can i) compensate GF funded share and ii) gradually fill the programmatic gap. Define and legislate the range of per capita allocation per year for local budgets along with revised possible share of spending for outpatient and in-patient care.</p>
Allocative Efficiency	<p>Consider improving allocative and technical efficiency according to the recommendations provided by the WHO, WB and other technical research studies. Develop and utilize costing methodology of preventive interventions for budget planning. Carry out a detailed analysis to determine in which areas technical efficiencies could be realized. Develop an adequate social contracting mechanism (for NGOs) to ensure the effective implementation of preventive and outreach activities. Explore further opportunities for co-financing of some services</p>	<p>Consider improving allocative and technical efficiency according to the recommendations provided by the WHO Improve effectiveness of TB prevention, diagnostic and treatment services through strengthening the role of the PHC sector and modification of funding methodology for in-patient treatment Refine TB prevention, diagnostics and treatment algorithms</p>
Resources for Transition plan implementation	<p>Calculate the non-programmatic costs of the transition plan implementation, and leverage domestic and external resources for effective implementation of the plan and M&E</p>	

RECOMMENDATION # 3: Streamline service delivery

HIV

TB

Service Delivery	<ul style="list-style-type: none"> Remove barriers to HIV testing and treatment through strengthening cooperation between governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services, by improving timely and complete diagnosis, prompt prescription of correct treatment and good adherence to ART. Expand coverage of PWID with OST by revising legislation that hinders OST service provision and ensure its enforcement. Expand coverage of PWID with harm reduction programs by allowing alternative delivery models of NSP service provision. Ensure implementation of the Prevention Service Strategy 	<ul style="list-style-type: none"> Revise legislation to remove all motivation factors for long hospitalization of TB patients as well as TB hospital funding methodology. Develop a patient-centered care model oriented to ambulatory care of all TB and MDR TB cases, and initiate implementation of TB facility rightsizing by closing small inefficient facilities. Include TB hospitals in general health care reform aiming to institute new performance-based funding mechanisms. The available resources obtained as results of cost-efficiency measures should be re-invested in TB control to cover urgent needs for ambulatory care (TB prevention, diagnosis, patient support, treatment follow-up and adherence, social contracting, incentives for TB and PHC staff as well as additional layers etc.). Improve the efficiency of TB diagnostic services by revising the respective legislation on obligatory fluorography screening among professions with little impact on spread of airborne infection, and focus better on well-defined risk groups in line with WHO recommendations; rationalize the laboratory system and improve sputum transportation logistics; continuously improve laboratory quality insurance. Update and introduce TB diagnosis, treatment and prevention protocols in accordance with the latest international standards to ensure access to relevant diagnostic tools and use of adequate treatment regimens (including adequate dosage) and isoniazid preventive treatment in evidence based dosage and duration.
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RECOMMENDATION # 4: Ensure adequate supply of human resources and integration of HIV

and TB training modules into the continuous medical education system

	HIV	TB
Human Resources	<ul style="list-style-type: none"> • Develop HIV/AIDS human resource planning and development strategy. • Elaborate a work force motivation strategy. • Elaborate a strategy for training NGOs. • Ensure the integration of HIV training modules in continuous education systems. • Initiate the integration of HIV training modules into undergraduate and postgraduate education systems. 	<ul style="list-style-type: none"> • Review human resources plan and task profiles of staff in line with projected changes. • Merge the two existing separate specialties of pulmonology and TB specialist into one (respiratory disease specialist), including pre- and post-graduate education and specialization. • Increase the salaries (incentives) for TB staff (physicians and nurses) and primary care staff involved in TB care at the cost of TB bed reduction (consider using savings from cost-efficiency measures).

RECOMMENDATION # 5: Streamline forecasting, procurement and supply management system

	HIV	TB
Procurement and supply management	<ul style="list-style-type: none"> • Develop an ARV drug forecasting methodology that allows sufficient buffer stocks according to international standards. • Build staff capacity in drug forecasting methodology. • Elaborate by-laws to enable implementation of public procurement through international organizations. • Build the procurement capacity at local levels for transparent and competitive procurement practices. 	<ul style="list-style-type: none"> • Revise TB drug forecasting methodology for publicly procured medicines. • Build staff capacity in drug forecasting methodology • Develop a Drug Management module in e-TB manager to improve the distribution and redistribution procedure at all levels. • Improve stock management capacity at Oblast levels.

RECOMMENDATION # 6: Enhance surveillance systems and build data analysis capacity at national and local levels

	HIV	TB
Surveillance and M&E	<ul style="list-style-type: none"> • Provide training in surveillance and M&E data analysis at national, local and facility levels to ensure evidence based planning and implementation. • Ensure regular tracking of HIV/AIDS spending. 	<ul style="list-style-type: none"> • Provide training in surveillance and M&E data analysis at national, local and facility levels to ensure evidence based planning and implementation. • Build staff capacity in utilization of e-TB manager. • Elaborate methodology for TB expenditure tracking and ensure is regular utilization.

RECOMMENDATION # 7: Ensure NGO capacity development to ensure sustainability

	HIV	TB
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Surveillance and M&E	<ul style="list-style-type: none">• Establish NGO “Consulting body” to support NGOs in diversification of their income sources and diversification of service provision range.• Build NGO capacity in Management, Proposal Writing, Advocacy, Resource Mobilization, Strategic planning etc.• With active involvement of local NGOs, perform a financial mapping exercise and assist/guide NGOs to tap resources.• Perform a more detailed analysis of existing legislation in government NGO support mechanisms and advocate/promote respective changes.
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ANNEXES:

ANNEX 1: LIST OF DOCUMENTS REVIEWED

1. Ukraine National Report on Monitoring Progress Towards the UNGRASS Declaration of Commitment on HIV/AIDS, January 2006-December 2007;
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ANNEX 2: LIST OF PEOPLE MET

№	ИМЯ ФАМИЛИЯ	УЧЕРЕЖДЕНИЕ	ПОЛОЖЕНИЕ	КОНТАКТНАЯ ИНФОРМАЦИЯ
1	Alexander Kvitashvili	МОН	Minister of Health	
2	Паола Павленко	USAID	Старший советник по вопросам ВИЧ/СПИДа Офиса здравоохранения в Украине	info@stbcu.com.ua clerman@usaid.gov
3	Сакович Елена	UNICEF	Руководитель проектов профилактики ВИЧ среди молодежи	osakovych@unicef.org
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ANNEX 3: LIST OF KEY INDICATORS

Table 14 Demographic and Social Indicators

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Population, total (thousand)	49,175.8	48,683.8	48,202.5	47,812.6	47,451.6	47,105.1	46,787.7	46,509.3	46,258.2	46,053.3	45,870.7	45,706.1	45,593.3	45,489.6	45,362.9
Population growth (annual %)	-1.0	-1.0	-1.0	-0.8	-0.8	-0.7	-0.7	-0.6	-0.5	-0.4	-0.4	-0.4	-0.2	-0.2	-0.3
Population ages 0-14 (% of total)	17.5	16.8	16.2	15.6	15.1	14.7	14.3	14.1	13.9	13.9	13.9	14.0	14.2	14.5	14.7
Life expectancy at birth, total (years)	67.9	68.3	68.3	68.2	68.2	68.0	68.1	68.2	68.3	69.2	70.3	70.8	70.9	71.2	
Inflation, consumer prices (annual %)	28.2	12.0	0.8	5.2	9.0	13.6	9.1	12.8	25.2	15.9	9.4	8.0	0.6	-0.3	12.2
Poverty headcount ratio at national poverty lines (% of population)								12.7	7.1	5.8	8.8	7.8	9.1	8.4	
Unemployment, total (% of total labor force) (modeled ILO estimate)	11.6	10.9	9.6	9.1	8.6	7.2	6.8	6.4	6.4	8.8	8.1	7.9	7.5	7.9	

Source: The World Bank Data Base, accessed July 15, 2015

Table 15 Macroeconomic and Health Financing Indicators

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
GDP per capita (current US\$)	636	781	879	1,049	1,367	1,829	2,303	3,069	3,891	2,545	2,974	3,570	3,855	4,030	3,082
GDP per capita growth (annual %)	7.0	10.3	6.3	10.3	13.0	3.5	8.0	8.5	2.9	-14.4	4.6	5.6	0.4	2.1	-0.8
GINI index (World Bank estimate)			29.05	28.66	28.93	29.02	29.65	29.56	26.64	26.44	24.82				
Revenue, excluding grants (% of GDP)	26.8	26.6	29.2	29.9	30.7	35.1	36.2	34.3	35.8	34.6	34.3	36.3	37.3		
GNI per capita growth (annual %)	6.6	11.9	6.6	10.7	12.8	3.5	7.5	8.6	3.5	-15.5	5.3	5.5	4.8		-0.3
GNI per capita, Atlas method (current US\$)	700	730	790	980	1,270	1,540	1,950	2,570	3,220	2,840	2,990	3,110	3,500	3,760	3,560
Health expenditure, total (% of GDP)	5.6	5.7	6.3	6.9	6.6	6.4	6.4	6.4	6.6	7.8	7.8	7.3	7.5	7.8	
Health expenditure per capita (current US\$)	35.6	44.3	55.0	72.7	90.4	117.5	147.0	194.4	251.3	197.2	231.4	261.8	289.8	312.7	

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Health expenditure, public (% of government expenditure)	10.2	11.3	13.2	14.3	13.2	11.9	12.1	12.5	11.7	12.8	12.7	12.8	11.9	12.2	
Health expenditure, public (% of total health expenditure)	51.8	54.3	56.2	58.3	58.6	59.5	60.8	61.8	57.7	55.0	56.6	55.7	55.4	54.5	
Health expenditure, private (% of total health expenditure)	48.2	45.7	43.8	41.7	41.4	40.5	39.2	38.2	42.3	45.0	43.4	44.3	44.6	45.5	
Out-of-pocket health expenditure (% of total expenditure on health)	44.1	41.8	40.4	38.7	38.6	37.5	36.3	34.7	39.4	42.0	40.5	41.5	41.8	42.8	

Table 16 Existence of legislations specifying protection for key populations and vulnerable groups

Key Populations	Government	Civil Society
PLHIV	Y	Y
MSM	Y	N
Migrants	Y	N
Orphans and vulnerable children	Y	Y
People with disabilities	Y	Y
People who inject drugs	Y	N
Prison inmates	Y	N
Sex workers	Y	N
Transgendered people	N	N
Women and girls	Y	Y
Young people	N	N

Source: Thematic report: Stigma and discrimination, 2012 progress