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ASSESSMENT OF IMPLEMENTATION OF THE NATIONAL AIDS PROGRAMME FOR YEARS 2009-2013 IN UKRAINE

SYNTHESIS REPORT



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September 2013

**The State Service for HIV/AIDS and Other Socially Dangerous Diseases.
Assessment of the State Program to Ensure HIV Prevention, Treatment, Care, and
Support to HIV-positive People and Patients with AIDS for Years 2009-2013
(the National AIDS Programme) in Ukraine: Synthesis Report
(English original, September 2013).**

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PREFACE

The HIV epidemic in Ukraine remains one of the worst in Eastern Europe and CIS. According to experts, Ukraine is home to 230,000 HIV-positive people; and the prevalence of HIV among adults aged 19 to 49 years is 0.78%. According to official statistics, daily 58 people are diagnosed with HIV, 25 with AIDS, and 10 die from AIDS-related diseases.

The HIV epidemic is characterized by the prevalence of HIV among different groups of the population – especially among high-risk groups, the uneven spread of HIV in the country, the change in the dominant modes of transmission of HIV, and the prevailing infection of people of working age.

During the implementation of the National AIDS Programme for 2009-2013, Ukraine was able to mobilize unprecedented internal and external resources in response to the AIDS threat – many programmes and HIV prevention services are currently implemented in Ukraine. In spite of this, the analysis of the epidemic of HIV infection in Ukraine suggests that the infection has challenged the health system: HIV prevalence rates outpaced its prevention and treatment activities, including antiretroviral therapy to all who need it. Death directly related to AIDS-related diseases has become a real threat to thousands of HIV-positive people in Ukraine and has no signs of slowing down or reaching a peak, which is a threat to social and economic development and demographic stability of the country.

Taking into consideration the continued dependence on external financing and the necessity of strengthening health systems at both national and local levels, it is essential – within the framework of organizing and implementing the HIV response in Ukraine, that the next National Programme is primarily aimed at sustainability and efficiency of the national HIV response.

In March 2012, the National Council on TB and HIV/AIDS at the Cabinet of Ministers of Ukraine initiated the National Assessment of the National AIDS Programme and asked for support of the State Service for HIV/AIDS and other Socially Dangerous Diseases and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Assessment of the current National AIDS Programme will serve as a source of relevant strategic information to develop the new National Programme for 2014-2018.

From July to December 2012 the Assessment Team – consisting of 14 independent national and international experts, conducted a comprehensive evaluation of the National AIDS Programme and assessed the achievements, strengths, weaknesses and challenges facing the national response to the epidemic. The MDG Acceleration Framework (MAF) developed by the United Nations was applied.

The Assessment Team recommends national partners to utilize the results of the present assessment to strengthen the HIV response within the current programmes and during the development of the new Programme for 2014-2018.

On behalf of the Assessment Team, let me express our gratitude to the Government of Ukraine, non-governmental and international organizations, as well as many other key informants who contributed their time, shared their opinions with us, and enabled us to access valuable information sources. Working with you was a great pleasure.

Also, I would like to thank the staff of the UNAIDS Secretariat, the co-sponsor institutions and the experts, who carried out great preparatory work, provided invaluable support to the team, and helped analyze the results and prepare the reports.

The Assessment Team assumes full responsibility for the contents of this document. Another complex and urgent task lies ahead: analyzing and implementing the recommendations. The final impact of this assessment will be determined by the national partners in Ukraine.

Dr. Ronald G. Horstman
Head of the Assessment Team
January, 2013



DEAR COLLEAGUES!

Counteracting HIV/AIDS epidemic has been among the top priorities of social policy in Ukraine. The Government ensures that it is implemented systemically and consistently. In 2009 the National AIDS Programme was first endorsed at the highest legislative level.

The effective strategic planning is impossible without summarizing the results of the work done and conducting an impersonal and independent analysis of national response to the epidemic.

For this reason the State Service for HIV/AIDS and other Socially Dangerous Diseases and UNAIDS have initiated the Assessment of the National AIDS Programme which was conducted with participation of multiple stakeholders. For effective and coordinated work on the Assessment of the National AIDS Programme the State Service for HIV/AIDS and other Socially Dangerous Diseases established a Working Group which consisted of representatives of state institutions, public and international organizations working in the area of HIV/AIDS in Ukraine. The Assessment was performed with participation of leading independent national and international experts, who in detail studied the HIV/AIDS situation in the country, pinpointed the problems and bottlenecks, and proposed effective solutions.

As a result of the Assessment we have a comprehensive detailed report which reflects not only key achievements and progressive steps of Ukraine, but also determines the problem issues which must be addressed. The resulting recommendations have been taken into consideration during the development of the Concept of the National AIDS Programme for 2014-2018 that was endorsed by the Order of the Cabinet of Ministers of Ukraine from May 13, 2013, and also in the development of the Draft National AIDS Programme for 2014-2018.

We express sincere gratitude to all partner organizations that work in the area of counteracting HIV/AIDS in Ukraine for their highly professional and functional approach to conducting the Assessment. Because it is only under the conditions of the well-coordinated joint efforts that we can achieve the set goals and results!

Sincerely,

Head of the State Service for HIV/AIDS and Other Socially Dangerous Diseases of Ukraine

Tetyana Aleksandrina



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Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

United Nations Children's Fund (UNICEF)

Joint United Nations Programme on HIV/AIDS (UNAIDS)

United Nations Development Programme (UNDP)

United Nations Office on Drugs and Crime (UNODC)

Futures Group International, USAID|HIV/AIDS Service Capacity Project in Ukraine

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral
BSS	Behaviour Surveillance Survey
BBV	Blood-borne virus
CMU	Cabinet of Ministers of Ukraine
CD4	Cluster of Differentiation 4
C&S	Care and Support
CDC	Centres for Disease Control and Prevention
CSW	Commercial Sex Workers
CBO	Congressional Budget Office
CIS	Commonwealth of Independent States
EC	European Commission
EU	European Union
FSW	Female Sex Worker
GDP	Gross domestic product
GoU	The Government of Ukraine
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counselling
HBV	Hepatitis B
HCV	Hepatitis C
IDU	Injecting Drug Users
MDG	Millennium Development Goals
MAF	MDG Acceleration Framework
MARP	Most at risk populations
MoH	Ministry of Health
MoJ	Ministry of Justice
MSM	Men who have sex with men
M&E	Monitoring & Evaluation
MSF	Medecins Sans Frontieres
NAP	National AIDS Programme
NCC	National Coordinating Council
NGO	Non-Governmental Organisations
OST	Opiate Substitution Treatment
PLWH	People Living With HIV
PMTCT	Preventing Mother-to-Child Transmission
PWID	People Who Inject Drugs
SEM	Sero-epidemiological monitoring

STI	Sexually Transmitted Infections
TB	Tuberculosis
TG	Transgender
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
UN	United Nations
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WG	Working group

PART I EXECUTIVE SUMMARY

1 EXECUTIVE SUMMARY

In recent years a substantial amount of evidence has been generated and knowledge has been gained about the factors contributing to the inadequate programme response to HIV/AIDS and the lack of impact on the HIV epidemic in Ukraine. However, questions still remain unanswered about the largest contributing factors to the ineffectiveness of the various HIV/AIDS interventions, the sustainability of the programme and inefficiencies in the areas of HIV/AIDS prevention, treatment, care and support. The present assessment of the National Programme to Ensure HIV Prevention, Treatment, Care, and Support to HIV-positive People and Patients with AIDS (hereafter, the National AIDS Programme (NAP) for 2009-2013, carried out on the initiative of the National Council for the Prevention of Tuberculosis and HIV/AIDS, aims to provide further insight into these contributing factors and recommends necessary actions.

The objectives of the assessment are to:

1. Assess the achievements, strengths, shortcomings and weaknesses of the key areas of the NAP, including programmes that are externally funded
2. Identify key bottlenecks, including policies, practices and other structural barriers, and generate strategic, policy and implementation recommendations as to how to improve the impact of the next State AIDS Programme in Ukraine, including strategic guidance for achieving Millennium Development Goal 6
3. Assess the national response efforts from the point of view of their efficiency and sustainability, and to generate recommendations on how to strengthen those within on-going programmes and in the next cycle of the NAP.

The NAP Assessment Team consisted of independent international and national consultants in the main thematic areas, and was steered by the NAP Assessment Working Group. This Group was approved by the National Council and consisted of key stakeholders from the Government, Non-Governmental Organisations (NGO) and UN organisations. The methods used by the consultants were desk reviews, in-depth interviews, group discussions and observation during field visits. The MAF was applied to systematically identify, analyze and prioritize bottlenecks hindering progress towards the MDGs and offering solutions to speed up related processes.

The MAF was endorsed by the United Nations to help accelerate progress at the country level. It promotes solutions to improve policy interventions, drawing upon existing government planning processes and complementing them by identifying actions and actors who could work together. The MAF helps create a partnership with identified roles for all relevant stakeholders to jointly achieve MDG progress, while also improving the mobilization and coordination of efforts and resources contributed by various partners. It is a flexible and strong tool that can be applied in different contexts and can be adapted to different country circumstances. Taking the stakeholders through four systematic steps for each off-track MDG target, the MAF aims to generate shared diagnostics and recommend comprehensive, collaborative and focused actions, based on prioritized 'acceleration' solutions.

The growing HIV epidemic is concentrated mostly in urban 'at risk' populations (MARPs), including injecting drug users (IDU), female sex workers (FSW) and men having sex with men (MSM), and in the penitentiary system, calls for a sustainable and more efficient and effective approach in the near future. With a stabilizing HIV prevalence among IDUs and a decrease in younger users, which is likely due to prevention interventions, an increasing role of the FSW networks in the overall transmission dynamics in Ukraine has been observed. MSM is the most-at-risk population whose epidemic is continuing to expand, and who have a ten times higher likelihood of infection than the general population and expected to represent more than one fifth of all new HIV cases in 2015. Subsets of groups with combined risk characteristics are at the highest risks of HIV infection. The epidemic in prisons is mostly driven by transmission via intravenous drug use. Overall, there is an increasing concern about HIV risks for sexual partners of MARPs.

The National AIDS Programme 2009-2013 and other externally funded programmes have substantially contributed to the increased capacity to respond to the epidemic. The NAP has focused its approach on high-risk population groups and evidence shows that this is having an effect, with prevention programmes delivering initial achievements – particularly among IDUs, and the successful PMTCT programme. This progress can be associated with a three-fold increase in the overall funding level since 2005 and the creative mobilisation of external funding for high-risk groups for prevention, treatment, care and support. Government funding improved even more with a ten-fold increase over the same period.

While the Government concentrates on HIV testing and counselling (HTC), and antiretroviral treatment (ART) and PMTCT, through their expanding country wide network of AIDS Centres and Trust Cabinets, civil society organisation – supported by external donors, focus their interventions on prevention, care and support. Civil society organisations have become strong players and counterparts for the government and synergy between the two have substantiated. Also, Ukraine's HIV/AIDS response should be praised for having made good progress in establishing one coordinating body, one national programme and one M&E system. It is likely that the present division of tasks between government and non-government partners will not be a sustainable solution for the near and long term future provided a prevailing scenario in which external donor funding subsidies and governmental funding priorities do not change. However, there are promising indications of increased political will, and of increasing commitments by the government towards the implementation of donor supported programmes.

Other key successes comprise of the legal framework that has enabled a scaling up of the AIDS response and in granting human rights protection – with restrictions being lifted. Inter alia this has supported the successful increase in treatment services through the nation-wide coverage, the existence of the opioid substitution treatment programme (OST) being the largest in the region – with evidence of effective harm reduction interventions, and the PMTCT programme effectively integrating mother and child services and HIV/AIDS service needs.

The present challenge of Ukraine's response to the HIV epidemic is to build on these strengths and achievements. Despite the successes many challenges and barriers remain. One of those is the priority given to MSM programming, the lack of data on the burden of disease among MSM, and the country ownership of the implementation structures. They represent an unacceptable response to HIV among MSM in Ukraine with insignificant progress, constrained and unmet targets, limited MSM-specific programmes and resources for capacity building.

1.1 GOVERNANCE AND SUPPORT MECHANISMS

1.1.1 Legislation, rules and regulations

Although changes in legislation have supported improved service coverage, state rules still impose regulatory limitations on the national planning exercise for service delivery and do not support a need for results based approach in planning. Therefore, it is recommended that the rules governing *national* planning are revised to enable more response to the population's needs, while in addition allowing evidence from various studies and BSS surveys in the national budget planning process. Establish links with health reform pilots. As for *health sector* rules and regulations, the advice is to reform the key regulations on the narcology register and OST in line with international practice and enforce their implementation in practice and in policy areas. Further amendments are required to legislation to improve the public procurement system for drugs and medical inputs. In addition, reform of the drug policy, enabling fewer incarcerations, eliminating punishment for possession of small amounts of drugs and enabling police to support people who inject drugs to seek for health and social services. Lastly, there is a need to strengthen legislation and its enforcement thus protecting the rights of people engaged in same-sex behaviour.

1.1.2 Policies, strategies and plans

National HIV/AIDS programme strategies should be further aligned and they should focus on HIV

prevention among the most vulnerable FSWs. This includes young and new FSWs, IDUs. There should also be a focus on good practices in IDU services to MSM programming. The NAP will need to develop an integrated socio-medical model that is client centred and includes social workers in specialised services. In addition, for youth a national strategy of healthy lifestyle is to be developed. Other strategies and plans encompass national and region-specific operational plans for eliminating paediatric HIV infections and keeping mothers alive, and a strategy that enables 'hard-to-reach clients', giving them access to care and support services. It furthermore includes analysing and utilising sex and age disaggregated data in planning interventions, and adding population groups at risk of HIV – i.e. prisoners, patients with hepatitis B, hepatitis C, with active TB – in the analysis and planning of coverage with HIV testing.

1.1.3 NAP Organisation

The organisational capacity of the NAP has improved with national coordinating authorities having been legalised and regional (rayon) level coordination bodies having been established, together with an improved synergy between the government and the non-state sector. However, coordination of the national response is still inadequate and characterised by a complex design of the NAP, limited prioritization according to needs, too many implementing agencies, overlapping responsibilities, and inadequate cooperation between national and regional levels compounded by low levels of capacity.

To conduct an effective, efficient and sustainable NAP, its organisation and management can and should be upgraded, starting with improving the overall design of the NAP. There should be an inherent logic between inputs, activities and results, appropriate and measurable targets, funding explicated by activity and source (national, local), and it should contain only priority interventions with a highest potential to help achieve objectives and goals.

Furthermore, the authors of this report recommend enhanced coordination arrangements at the national level and between national and regional levels, with the aim of optimising the number of implementers and eliminating duplications in tasks and responsibilities between National Coordinating Council (NCC), the State Service and the Ministry of Health (MoH), revising functions and developing clear task assignments between MoH, National AIDS Centre, regional health administrations and Regional AIDS Centres, translating National Council decisions into actionable directives issued by the Cabinet of Ministers of Ukraine (CMU), and enhancing the capacities of the national and sub-national councils. Furthermore, the HIV/AIDS NCC and Regional Coordination Councils need to identify the organizations/units in charge of carrying out preventive activities with and for young people 15-24 years, including representatives from high-risk or vulnerable groups. Include representatives of youth organizations into the NCC. All relevant populations of youth should be engaged.

As the government lacks a vision for developing and operating specialised medical and social services with regards to location, purpose and role, rules that expound criteria for developing and establishing (new) specialized services for HIV/AIDS will need to be designed and implemented.

Because the organisation of adequate prevention, treatment, care and support services in the penitentiary system is far behind their equivalent in society and the continuum of care between the two is not guaranteed, the government will need to develop networking, coordination, and cooperation between institutions and staff from the prison administration, prisons and the community.

1.1.4 Human resources

A general finding is that the human resource development and supply capacity hampers NAP implementation, which is due to a lack of strategic vision on the part of the government in terms of poor planning and budgeting at state and local level, as well as a lack of structural/institutional solutions for (re) training that are integrated in the education system. The emphasis should be on developing the human resource capacity through mainstreaming HIV/AIDS, human rights and gender issues and drug dependency in training and re-training programmes within under and post-graduate education, maintaining a focus on integrated services rather than on strengthening the vertical HIV/AIDS care structure with narrowly defined expertise. It should target workers in medical, social, and mental health professions as well as

police and staff of the current penitentiary and justice system.

1.1.5 Monitoring and evaluation

Although substantial progress was made in establishing and consolidating the national M&E system, the system is still not considered adequate, while data/information use generated by this system for planning purposes is moderate. This undermines most efforts in NAP. The solution is to further enhance and make a sustainable M&E system for national and local planning purposes. To make the system sustainable, sufficient financial resources from the national budget need to be provided. Furthermore, one needs to set measurable targets for NAP indicators and logically link those to expected output, outcome and impact. In addition, this report recommends that data collection for NAP indicators should be institutionalised within the routine national statistical system. The system for generating strategic information (performance measurement and impact assessment) that translates into MARP and youth prevention programme strategies should be enhanced. Lastly, the knowledge and skills appraisal of youth should be improved along with the optimization of the SEM system.

1.1.6 Procurement supply management

Procurement and supply-management has been found to be inadequate and causes disrupted supply that hinders service intensity, quality and coverage. The main reasons are insufficient financial allocation and poor planning. Therefore the procurement and supply system should be enhanced, starting with making amendments in the legislation (by MoH) that aim at removing artificial protectionist clauses and opening up the local drug and test kit markets to international competition, and change planning for state procurement of ARVs and CD4 tests from retrospective to prospective, based on direct and proxy indicators of ART need. Furthermore, explore opportunities to delegate procurement of ARVs and diagnostics to the National AIDS Centre, and strengthen the procurement process to prevent stock outs of PMTCT relevant drugs and test kits.

1.2 SERVICE COVERAGE, INTEGRATION AND QUALITY

1.2.1 Coverage, Outreach and Community level interventions

Treatment and testing has been scaled-up with a nation-wide network of AIDS Centres. However, Ukraine still suffers from inadequate coverage of services and outreach to halt a growth in the epidemic. While community level outreach for MARPs is inadequate and critical services like opioid substitution therapy and care and support services are in nascent stages of development, HIV/TB testing and ART coverage are far too low and services are inconsistent, particularly for MARPs.

Coverage is therefore of utmost importance to ensure access for MARPs and other vulnerable groups, by *ensuring early HIV diagnosis, early ART initiation and retention in ART*. First, this can be accomplished through guaranteeing broad involvement of MARPs and bridge groups to HTC services through removal of personal and systemic barriers, the development of individual motivation to receive services, and by introducing the PITC approach into HTC service provision. Second, ensure continuity of service from the stage of involvement in HTC to registration of persons with positive results in care in AIDS centres. ART provision would strengthen prevention results if scaled-up along with further good access to needle exchange and substantial access to OST. Third, as the current scale of OST is not sufficient to enable an increase in ART among MARPs, safeguard OST as a backbone of public (free) narcology services and fund the service from the core budgets with initial national funds for medicine.

Outreach and community mobilisation should be developed and a rigorous outreach strategy should be implemented along with community level interventions. Regarding the latter, incorporate community engagement in peer outreach and service delivery for FSWs, IDUs and MSM, increase the rigor and reach of community-level interventions as standardised approaches for MSM effective interventions, and develop/adapt best practice models used for reaching marginalized and at-risk communities of youth,

and 'hard-to-reach clients' to access care and support. Furthermore, develop palliative & hospice care and hospice at home services regionally. Introduce mobile multi-disciplinary teams and ensure that the new family doctor service staff are trained in working with this group. Apply targeted community mobilisation strategies to improve social capital and ensure availability of confidential services for people living with HIV/AIDS.

1.2.2 Penitentiary health care services

Because there is low coverage of all HIV/AIDS related services in prisons and risks of discontinued health care entering or leaving the system, it will be indispensable in the next NAP to introduce strategies that aim at full access to all essential preventive, treatment and care and support services in the penitentiary system. Adjust all HIV preventive strategies applied in the community to custodial settings by improving scope and quality, use interactive and peer-to-peer approaches, involve community services, and provide information about hepatitis viral transmissions. Furthermore, make condoms, lubricants and disinfectants available in a low threshold manner for all prisoners. Organize screening of hepatitis with pre- and post-test counselling and provide vaccination. Increase the number and quality of VCTs, increase access to ART. Improve the continuation of ARV at the interface of imprisonment and on release. Raise awareness for evidence-based treatment of IDUs, especially OST among management, prison doctors, and nurses. Discuss and introduce evidence-based harm reduction measures. Service integration and client focus

1.2.3 Service integration and client focus

Currently, multiple separate service systems exist at the local level, causing inefficiencies and access barriers. This lack of integration is apparent within the health sector and with the social sector – particularly in relation to HIV/AIDS services. Although PMTCT programmes show that the integration of services is possible, a clear vision on service integration and on placing the client in the centre of attention is yet to be developed. Also a lack of engagement has been observed among key HIV stakeholders in the health sector reform process.

While the MoH should further develop their vision on integrated client-centred delivery mechanisms that also integrate HIV/AIDS and social services into the general health system, HIV stakeholders will need to timely and actively engage in health reform discussions. This active approach should lead to the development of an efficient integrative socio-medical client-centred service model for HIV positive MARPS, youth and other vulnerable groups. The need for integrated services is even more crucial in case external funding for HIV interventions subsides.

Investment in country-based operational research and costing studies on integration of HIV/AIDS services in the health system and revise the draft document on TB/HIV collaborative services are needed. Ensuring that narcological services are included, access to OST at TB hospitals for TB/HIV and TB drug dependent patients is safeguarded, TB and HIV experts are in charge of treatment of TB/HIV patients and ARVs are transferred to medical personnel. Furthermore, roles and responsibilities need to be clearly defined on the diagnosis and management of patients with co-conditions in TB, HIV and narcological services.

For the penitentiary system a detailed strategy needs to be developed and implemented on the management of HIV/AIDS and co-infections (TB, hepatitis, and STIs) associated with the common elaboration of standards, guidelines and protocols.

1.2.4 Quality of Service

Quality standards for HIV/AIDS services, prevention mechanisms, treatments and care services are limited and not enforced. Driving forces include HIV/AIDS stigma & discrimination among health care providers, MoH rules and capacity, and limited financial allocations. Similar issues apply to quality of health care in the penitentiary system.

In order to improve service quality, protocols, standards and guidelines need to be (re)addressed and adequately implemented and monitored. Therefore, evidence-based national standards and guidelines

for MARP programmes need to be developed. MSM-specific approaches would need to be integrated into government and donor protocols. Standards should be reviewed and revised on care and support and PROMS should be integrated into the standards. The introduction of a high-quality, comprehensive systems of internal and external quality control for screening and of test kits, and the control of the safety of blood donation is also recommended. Protocols for PMTCT should be developed, strengthened and implemented with reference to routine HIV testing of male partners of all pregnant women as early in antenatal care as possible, early identification of high-risk pregnant women and integration of OST and other addiction treatment services, an effective case management system that includes interdisciplinary medical and social monitoring, and care for HIV+ women post-partum. Lastly, for improved quality assurance adopt new HTC Guidelines.

1.3 PROGRAM SUSTAINABILITY

A funding gap for the NAP exists and is likely to increase. It is estimated that in 3 years time (2015) the HIV/AIDS programme will require a budget as large as 0.7% of GDP. This represents a 10-fold increase over 2010. Although the government has increased the budget for the National HIV/AIDS response ten times since 2005, overall financial commitments by the government are assessed not to be sufficient for scaling up necessary services. And there are signs that external donors will reduce funding levels and count on structural changes within the health system away from an emergency mode of HIV/AIDS programme operation in which civil society – directly funded by external donors - tries to overcome the gaps in government planning for prevention, care and support services, etc.

Apart from the overall funding gap, the NAP suffers from implementation inefficiencies. Inefficiencies in allocation occur in the previously mentioned low-level governmental participation in essential interventions for MARPs, youth, prisoners, prevention and in social programmes. A productive system of state funding for these services does not yet exist. Systemic inefficiencies in the current input-based mechanisms in the health system and uniform rules applied by the MoH are not cost effective. They cause an unequal distribution of health workers and attenuate the motivation of staff. Technical inefficiencies also exist in testing outcomes (late in clinical stage), late or no treatment or admission and in laboratory monitoring (consuming high volumes of resources). To sustain and scale-up essential services the government will need to increase the allocation of national and local financial resources and decrease programme inefficiencies.

It will be necessary to revise the governments national and local budget in favour of MARPs at the costs of funds for the general public and other activities, and to shift priorities within public funding towards preventive programmes, OST, care and support, condom provision, services tailored to youth and M&E. External funding from the Global Fund and other sources will be necessary to mitigate the epidemic challenges in the medium term, e.g. to cover the gap in ART.

In support, creating favourable conditions for social contracting will facilitate the delivery of public funds for NGO implementation and further assure the sustainable delivery of preventive and care and support services at the community level. This entails that local governments be allowed to legally plan and budget these services and that rules are created that govern their pricing and define the MARPS entitled to receive them.

To resolve systemic inefficiencies, the government will firstly need to amend the rules governing national planning and budgeting and allow them to be adequately responsive to the population's needs, thus enabling results based planning. Moreover, the MoH and other Ministries will need to revise regulations on establishing and financing medical and social service centres using predefined criteria including those on population size and the HIV/AIDS epidemiology.

To resolve technical inefficiencies cost effectiveness and value for money should be improved by decreasing the time between testing and treatment in AIDS Centres. They should develop a strategy on price reduction for life-saving ART and essential laboratory tests, reduce the number of ART regimens for procurement to minimum, and refuse procurement of expensive HIV DR tests.

1.4 POLITICAL WILL AND HUMAN RIGHTS

Two of the main and most profound driving forces behind the inadequate response programme for HIV/AIDS and the lack of impact on the HIV epidemic in Ukraine remain a lack of political will and human rights issues.

The health care system fails to protect human rights and ensure gender equality. Stigma and discrimination regarding HIV/AIDS towards MARPs, PLWHA, and at risk youth within the society, the penitentiary system and among health care providers, together with high levels of masculinity and intolerance to those who fall beyond the socially accepted gender “norms”, create serious barriers to the preventive, treatment and support services needed. Starting within the health system, the government will need to enforce human rights legislation that protects people living with HIV/AIDS and incorporate human rights in the NAP by embracing and advocating a “zero” tolerance approach to discrimination and human rights violations. In addition, they should promote gender equality in the provision of services and information, especially for MARPS and other vulnerable groups. Trans gender persons (especially young and adolescent) should be considered as groups that need protection against discrimination, and integrate services for these groups into programmes targeting IDUs and FSWs. Planning and implementation will need support in terms of monitoring human rights violations/abuses and assessing the level of stigma in the society, among service providers, law enforcement and judiciary work force.

Despite good efforts by the government and recent initiatives by the MoH towards reforming the health system, the report concludes that overall leadership of the HIV/AIDS response remains weak with a lack of political will to profoundly tackle the HIV/AIDS issues in the country. This is apparent within central and local governments and the health sector in general. National and local governments should fully assume their leadership role, and increase and appropriately prioritise financial allocations for the HIV response, and develop and enforce essential legislation, rules and regulations. Without dedicated leadership the implementation of an effective, efficient and sustainable NAP from the top through to community level will remain a dream.

PART II REPORT

2 BACKGROUND AND RATIONALE

The assessment of the National Programme to Ensure HIV Prevention, Treatment, Care, and Support to HIV-positive People and Patients with AIDS (hereafter, the National AIDS Programme [NAP]) for 2009-2013 has been an initiative of the National Council for the Prevention of Tuberculosis and HIV/AIDS (hereafter National Council). The NAP has approached the fourth year and the necessity of the assessment of its implementation is warranted for a number of reasons.

One reason is that in spite of the increase in the availability of resources and the important achievements made by Ukraine in its response to HIV, the HIV epidemic continues to grow with the increasing AIDS related mortality representing a threat to Ukraine's socio-economic development and demographic stability. According to Ukraine's Millennium Development Goals report of 2010 and the numerous statements of the President and the Government of Ukraine, the MDG 6 – to halt and begin to reverse the spread of HIV and AIDS, is the only MDG not to be achieved by 2015 with the only AIDS related target – PMTCT, being achieved so far. Fast, long-term and feasible solutions should be proposed and implemented to strengthen the national HIV response to reach MDG6.

Another reason for the assessment is that the next NAP 2014-2018 has to be informed with up-to-date strategic information.

With the continuous dependency on external funding and the evidenced need to strengthen health and community systems in response to HIV in Ukraine, it is essential that the next NAP is focused on ensuring sustainability and supporting impact oriented national response to HIV. Therefore, the NAP should be assessed across its key programmatic areas across their achievements, strengths, shortcomings and challenges along with focus on their efficiency and financing, capacity and implementation sustainability to suggest most optimal and relevant solutions for the effective HIV response in Ukraine through the on-going state, externally and other funding-supported programmes and the new cycle of the NAP.

In Ukraine, a substantial amount of evidence has been generated and knowledge gained of the factors contributing to the inadequate response to HIV and the lack of impact on the HIV epidemic in Ukraine. This has been gathered through epidemiological surveillance and other studies, various external and internal assessments, reviews, and evaluations – including the Comprehensive External Evaluation of the National AIDS Response 2007-2008, National Operational Plan 2011-2013 and the NAR gap analysis 2010. However, a series of important questions still remain unanswered. What are the biggest contributing factors for the ineffectiveness of various HIV interventions and implementation inefficiencies in the areas of HIV prevention, treatment, care and support?

3 OBJECTIVES

The NAP Assessment has three objectives¹:

1. To assess the achievements, strengths, shortcomings and weaknesses in key areas of the NAP, including the programmes that are externally funded.
2. To identify key bottlenecks, including policies, practices and other structural barriers, and generate strategic, policy and implementation recommendations as to how to improve key outcomes and impacts in the next State AIDS Programme in Ukraine, including a strategic guidance for achieving of Millennium Development Goal 6.
3. To assess the national response efforts from the point of view of their efficiency and sustainability, and to generate recommendations on how to strengthen those within on-going programmes and in the next cycle of the NAP.

The Assessment delivers a report on the main findings and recommendations for increasing effectiveness of the National HIV Response and an Action Plan for accelerating progress on MDG6 for AIDS, revising

¹ Concept Note on the Assessment of the Implementation of the National AIDS Program in Ukraine, February 2012

concrete approaches in the on-going programmes and specific goals, objectives and targets for the new NAP.

The primary beneficiary of the NAP Assessment is the National Council and the Government of Ukraine, while secondary beneficiaries include implementing partners, other than the Government, among those at the local and regional levels, key multi- and bilateral development partners, including most notably the Global Fund, the World Bank, the United Nations, among those UNAIDS and its co-sponsor agencies, USAID, GIZ, EC, and others civil society organizations, CBOs of people living with HIV and other communities like those of people using drugs, MSM, sex workers, youth and others, FBOs, the private sector, charity and other organizations.

4 METHODOLOGY

4.1 COORDINATION

The National Council has approved the establishment of a Working Group and Concept Note for the Planning and Implementation of the NAP Assessment². Technical, administrative and financial support of the NAP Assessment has been provided by UNAIDS in partnership with UNDP and other UN organizations through the Joint UN Team on AIDS.

The Working Group includes representatives of the State Service for HIV and Other Socially Dangerous Diseases, the Ukrainian AIDS Centre, the All-Ukrainian Network of People Living with HIV, the International HIV/AIDS Alliance in Ukraine, UNAIDS Ukraine, WHO Ukraine, UNDP Ukraine, and other partners. The tasks of the Working Group members were to recruit, guide, and monitor the Review Expert Team which consists of International and National experts for key selected thematic sub-areas and a Team Leader. The Working Group supports and assists with the development of an action plan for implementing the proposed recommendations. The Working Group reports to the National Council on the assessment process. The State Services for HIV and Other Socially Dangerous Diseases and the UNAIDS Office in Ukraine have responsibility for day to day management of the assessment process.

The NAP Assessment planning, implementation, and reporting process has been participatory and brought together the efforts of governmental, civil society, private sector, development and other partners.

4.2 THEMATIC AREAS

The broad thematic/programme areas covered by the NAP Assessment reflect the structure the current NAP for 2009-2013 and represent its four main components: 1. Organisational activities, 2. Prevention activities, 3. Treatment, 4. Care and support.

The working Group contracted consultants for each of the following areas: Organisational activities, Sustainability, Human Rights and Gender, Injecting Drug Users (IDU), Commercial Sex Workers (CSW), Men having sex with Men (MSM), prevention of mother-to-child HIV transmission (PMTCT), Youth, Penitentiary System, HIV Testing and Counselling (HTC), Anti Retroviral Treatment (ART), and Care and Support (C&S). The list of these selected thematic sub-areas for the NAP does not include the full range of areas that are covered by the NAP but only those considered by the Working Group that are best capable and crucial for accelerating the progress to meet the MDG #6 targets for AIDS and key targets of the NAP.

Detailed Assessment Reports are available for each of the thematic areas.

4.3 METHODS

The findings are based on:

- a) An extensive desk review of the available recent literature (documents, publications, research reports,

² Ibid.

other data)

- b) In-depth interviews conducted with the key national stakeholders
- c) Site visits.

These findings were triangulated and validated during in-country visits and through extensive consultations with stakeholders. The solutions were identified and the recommendations are based on existing global evidence, where available, as well as informed by the key stakeholders and validated with the key national policy makers.

The assessment methodology used (to the extent possible) the basic approaches of the Millennium Development Goals Acceleration Framework that has been elaborated by the United Nations Development Programme.

A progress scale is used to measure the progress and performance of technical areas / issues. It includes the following categories: high, substantial, moderate, inadequate and unacceptable. The scale refers to the overall performance or progress achieved in each area against the current NAP and overall imperatives for a successful response to the HIV epidemic and achieving MDG#6 for AIDS.

An urgency scale is used for implementation of the recommendations and actions: 3-6 months requiring immediate actions, 6-12 months requiring short-term attention, and 12-24 months requiring consistent mid-term attention.

5 STATUS OF THE EPIDEMIC

5.1 POPULATION

Ukraine experiences the most severe HIV epidemic in Eastern Europe and Commonwealth of Independent States countries. The epidemic is growing. In 2011 21,177 new HIV cases were officially registered (46.2/100,000 population), which is the highest annual number since 1999. The epidemic is concentrated in at risk populations (MARPs), including injecting drug users (IDU), female sex workers (FSW) and men having sex with men (MSM), and has an uneven spread over the country with 77.1% of officially registered HIV cases in urban areas (MoH, 2012³).

5.2 INJECTING DRUGS USERS

Injecting drugs users remain the most affected at risk group by HIV in Ukraine. It is the most populous marginalized group and has the highest prevalence than any other group, maintaining at 21.5%. Over the implementation period of the National AIDS Programme (NAP) 2009-2013, a stabilization of HIV among IDUs was observed. Injecting drug use- associated portion among newly registered HIV cases has reduced from 37% in 2008 to 31% in 2011 (*MoH et al., 2009 MoH et al., 2012*). The unpublished triangulation study conducted in collaboration of multiple institutions, including the Ukrainian AIDS Centre, CDC, Universities of California and Zagreb, links that impact with prevention efforts (*Abdul-Quader et al., 2012*). However, increasing concerns remain over the HIV risk to of sexual partners of IDUs.

5.3 FEMALE SEX WORKERS

Results of a multi-city survey in 2009 estimated an HIV prevalence of 12.9% among FSWs, with prevalence exceeding 25% among FSWs in 4 of the 15 surveyed cities [International AIDS Alliance, 2010]. Recent estimates indicate that there are approximately 70,000 FSWs in Ukraine's urban areas [Berleva, 2010]. Second generation surveillance for HIV over the past few years have shown that FSWs are at high risk and vulnerability in relation to HIV. On average, each FSW in Ukraine has approximately 300 sexual encounters with a paying client each year, and more than 50% of FSWs also have regular sexual partners. Put into

³ Ministry of Health. Newsletter HIV Infection in Ukraine. Kyiv 2012

perspective, there are approximately 21 million sexual encounters between FSWs and clients annually, or approximately 500,000 FSW-client sexual encounters each week.

A key feature of the HIV epidemic among FSWs in Ukraine is the important role of IDU as a risk factor for HIV and thereby accentuating the overall risk of HIV transmission in FSW networks. Overall, approximately 16% of FSWs report injecting drug use, and HIV prevalence is considerably higher among this subset of the population. Therefore, in addition to the risk of sexual transmission of HIV among FSWs, linkage to the HIV epidemic among IDUs continues to fuel the epidemic among FSWs. Recent HIV surveillance data suggest that an increasing proportion of HIV infections in Ukraine are acquired through sexual contact, which is consistent with an important and increasing role of FSW networks in the overall transmission dynamics in Ukraine [Ukrainian AIDS Prevention and Control Centre, 2010].

5.4 MEN HAVING SEX WITH MEN

National sentinel surveillance has identified prevalence at 6.4% (2011) with the most current local prevalence estimates as high as 20.3%. (MOH, 2012) MSM is the only most-at-risk population whose epidemic is continuing to expand. (Abdul-Quader, Kruglov, Rutherford, Salyuk, & Vitek, 2012) MSM in Ukraine have been estimated to be almost 10 times more likely to be HIV-positive than the general population. MSM are expected to become one of the groups with highest potential for HIV infection, with an estimated 60,000 new cases of HIV projected to be attributable to MSM between 2010 and 2015, and representing more than one fifth (22.1%) of all new HIV cases in 2015. (Beyrer, Wirtz, Walker, Johns, Sifakis, & Baral, 2011).

MSM and also male IDU may be misclassified as heterosexual men in the case reporting system (*Abdul-Quader et al., 2012*).

5.5 PRISONERS

HIV prevalence among the prison population varies between 13% and 30%, depending on the source of information (Balakireva, Sudakova et al. 2012) (International HIV/AIDS Alliance in Ukraine 2012). The epidemic in prisons is mostly driven by the transmission through injecting drug use. Approximately 40% of prisoners have used drugs intravenously, in some prisons up to 60%, and in some women's prisons even up to 70-75% according to field visit data.

5.6 PMTCT

Children (~5% of new infections⁴) and pregnant women (~5% of registered HIV-infected persons⁵) comprise a relatively small proportion of the HIV epidemic in Ukraine, and HIV-infected children are not a major driver of subsequent transmission to others. Ukraine's PMTCT programme is of medium importance to the impact on the epidemic and on reaching Millennium Development Goal 6.

5.7 YOUTH

While the proportion of new HIV cases for the age group 25-49 years increases over the years, for recent years a downward trend in the age group specific share of new HIV cases is observed in the group 15-25 years, from 15% in 2007 to 9% in 2011 (MoH, 2012⁶). According to the official statistics in 2011, half of HIV transmission among boys and young men aged 15-24 took place because of injecting drugs (50%), while the majority of girls and young women of the same age contracted HIV through unprotected heterosexual sex (90%) (State Service of Ukraine on HIV/AIDS, 2012).

⁴ Based on an estimated 185 children infected in 2011 (3,938 children born to HIV+ mothers X 4.7% transmission rate), as a percentage of the estimated 3,500 total new infections in Ukraine in 2011.

⁵ Based on 5,527 registered HIV+ pregnant women as a percentage of the 120,148 registered persons living with HIV infection in 2011.

⁶ Ministry of Health. Newsletter HIV Infection in Ukraine. Kyiv 2012

However, young people aged 15-24 years are more affected compared to their counterparts in Western and Central Europe: Ukrainian young women three times as likely and young men twice (USG/Ukraine, 2012).

Among youth, risk of HIV is closely associated with injecting drug use or being the partner of an IDU, and with commercial sex. These risk factors are themselves shaped by determinants of wider vulnerability, including orphanhood and homelessness (Hillis et al, 2012), working or living on the street (Busza et al, 2011), unstable living arrangements, and poor access to health services (Pylypchuk and Marston, 2008).

6 STRENGTHS AND ACHIEVEMENTS

The National AIDS Programme 2009-2013 and other related externally funded programmes have substantially contributed to the increased capacity to respond to the epidemic.

6.1 PREVENTION

Over the past several years there has been a substantial emphasis on targeted HIV prevention for most at risk populations (MARPs). Civil society organisations – mainly with contributions from donor funding, have created a strong system for delivery of preventive services to MARPs, that supplements the public health care system.

Existing non-governmental organisations (NGOs) have been further enhanced and relatively new ones at the local level have gained strengths as well. Moreover, the synergy between government and non-government organisations has enhanced, which is a praiseworthy sign of joint efforts and collaboration directed towards reaching a common goal.

Interventions to reach MARPs have included prevention campaigns as well as outreach programmes, peer support and ARV therapy. Between 2005 and 2011 these services reached 160,000 people who inject drugs (including more than 6,600 people receiving opioid substitution therapy (OST)), 30,000 sex workers, 20,000 men who have sex with men, and 25,000 prisoners⁷. This high-risk group approach has proved to be positive with preventive services rendering initial success, particularly where they reach younger IDUs, being educated to adopt less risky behaviour.

6.2 INJECTING DRUGS USERS

There has been substantial progress in the response to some of the nine UN-recommended service areas for HIV prevention, treatment, care and support among IDUs. Notably this includes nearly reaching the UN recommended annual coverage of syringes, needles, alcohol swabs, condoms and IEC through a combination of methods for increased availability and accessibility to such groups like women, stimulant users, TB patients, and younger injectors. Positive developments are seen in ensuring better access to testing and counselling for HIV, HBV, HCV, also providing STI related services, as well as TB. While condom distribution has continued as an essential element of the basic prevention package, their use in the last intercourse reported by IDUs has not increased though. Opioid substitution therapy (OST) has increased almost 3-fold since the beginning of 2009 but coverage is still not at the levels indicated within the NAP or at the internationally recommended impactful level. Integrative service models to meet multiple health needs of IDUs were initiated in TB clinics (e.g. needle exchange and OST), AIDS centres, narcology clinics and other health settings.

6.3 FEMALE SEX WORKERS

In the past years comprehensive outreach programmes and services were implemented through a network of 40 NGOs with programmes in the large majority of cities in Ukraine. As a result, there has been a substantial scaling-up of service coverage. Whereas in 2007 the estimated coverage was 9% of FSWs,

⁷ Strategic Investments for Impact: Global Fund Results Report 2012. www.theglobalfund.org

this increased to approximately 40% in 2011, meaning 40% of the estimated 70,000 urban FSWs received a basic package of HIV prevention services (outreach, education, condoms and referral to HIV testing and STI treatment services) annually [Abdul-Quader, 2012]. As another composite indicator of coverage, sample surveys indicate that approximately 55% of FSWs know where to undergo HIV testing and have received condoms during the past 12 months. This proportion has remained relatively steady between 2009 and 2011, but represents a substantial increase since 2004 when the estimated coverage was 34% [Abdul-Quader, 2012].

6.4 MEN HAVING SEX WITH MEN

Prevention interventions that are focused on MSM are modestly growing and there is a need to seriously pay attention to prevention among this group. The current scale of coverage is as low as 12% (MOH, 2012), (National Council, 2010), and is by far not enough to address HIV transmission attributable to MSM. There are no data points within the last 5 years that indicate success in the establishment of a sustainable and full-scale programme addressing HIV among MSM in Ukraine.

6.5 PMTCT

The sustained success and continued improvements in coverage with key services of the PMTCT programme in Ukraine over the past decade makes it one of the most successful AIDS response programmes in Ukraine. The programme has achieved high success also relative to other countries. The high-level of political commitment and policy support for eliminating mother-to-child transmission has resulted in scale up and high coverage of HIV testing and of services to prevent mother-to-child transmission. Testing rates for HIV reached 99.2%, ART coverage for HIV positive pregnant at 95.5%. With the establishment of the national paediatric clinical care centre and other activities, access to paediatric ART has been excellent. The programme's pilot tested integrated case management approach contributes to increasing access and interdisciplinary cooperation. (UNICEF Ukraine, 2012).

6.6 PRISONERS

Progress in the responses to HIV/AIDS in the penitentiary system has been achieved especially in offering ARV treatment, prevention, care and support, and training over the last years. However, these efforts are still far below an adequate public health response to the HIV epidemic. The State Penitentiary Service of Ukraine (SPSU) is aware of about only one third of the estimated 20,000 HIV infected prisoners, leaving at least two thirds not followed and treated – and this is likely to be an optimistic estimate. Nevertheless, there is a small but steady increase in the number of patients receiving ARV, mainly due to NGO involvement and the Global Fund. Field observations confirm that the scope and quality of service provision is varied, with remote prisons being worse off and with differentiation between regions.

As NGOs play a crucial role in access to HIV/AIDS related services in prisons, they literally attempt to overcome the gaps in public health care provision. For example, Global Fund supported care and support interventions are now paying for the transportation of doctors from the Regional AIDS Centre (RAC) venue to the prison. Many good linkages seem to depend on the ability of NGOs in communicating and organising them.

Attempts are being made to develop a continuum of care approach in the penitentiary system through collaboration of the Ministry of Health (MoH) and Ministry of Justice (MoJ).

6.7 YOUTH

Clear evidence on the scale and intensity of outputs and their effect is not available, as indicators and the monitoring thereof lack sufficiency. Progress is reported on information and awareness raising campaigns on HIV/AIDS, building tolerant behaviour and other cultural, social, gender and human rights issues, the

involvement of youth in organisation, education institutes having added courses for youth on HIV/AIDS prevention, operational resource centres being opened, coverage of most at risk children and adolescents by preventive programmes. External donors fund most of the activities.

6.8 TESTING AND COUNSELLING

Of the well-developed and government supported system of health care facilities that provide HIV testing and counselling (HTC) in Ukraine, about one in five facilities provide HTC, guarantees territorial access, in particular and for its largest part benefiting HIV-positive pregnant women and their children. For other important groups like MARPs, provision of HTC is still insufficient to ensure early detection of HIV-positive persons and their timely involvement in HIV-related services. During NAP 2009-2013 the annual number of screening tests remained at a similar level (MHC of Ukraine, 2010a, 2011a, and 2012b).

Voluntary counselling and testing (VCT) expanded and enabled more MARPs to know their HIV-status. This has been possible due to the increased use of rapid tests mainly by NGOs – not only office-based but also through mobile units and elsewhere, and support from external donors (*Demchenko et al., 2009, Varban et al., 2012*).

6.9 ART AND OST SERVICES

These services have expanded through the development of the countrywide network of AIDS centres that have primary responsibility for testing, counselling, treatment and caring for HIV patients. The numbers of patients on anti-retroviral therapy (ART) has grown significantly and as of January 1st, 2012 approximately 26,720 individuals were on ART. The number of sites and clients on opioid substitution therapy (OST) is also increasing and first pilot steps are being made to integrate ART and OST treatment and achieve higher treatment adherence rates among IDUs.

The OST programme in Ukraine is the largest in the whole region, and in general there is evidence that harm reduction works. OST is a priority intervention for both HIV prevention and managing opioid dependency in HIV-positives in Ukraine, given that the most prevalent injected drug is opioids and that the majority of IDUs with HIV are opioid users. In late 2010, OST has been explicitly mentioned in legislation for the first time.

6.10 PROGRAM ORGANISATION

Ukraine has managed to have one coordination body, one national programme, and one monitoring and evaluation (M&E) system. This is a major accomplishment. National coordinating authorities have been legislated and through donor assistance regional and rayon level coordination bodies have been established, their capacities developed and a better engagement of government and the non-state sector was embraced. Also, substantial progress was made in establishing and consolidating the national M&E system that generates information about critical epidemiological developments as well as funding flows, monitors the service provision levels, especially those delivered by NGOs. The epidemiological surveillance (routine as well as bio-behavioural) has been improved and better quality data has 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. The availability of comprehensive information has been documented in the *Ukraine Harmonized AIDS Response Progress Report 2012*, which is a rich document with the most up to date results.

6.11 FUNDING

The overall funding situation of the national response has significantly improved. During 2005-2010 total spending levels (from national as well as international sources) almost tripled in nominal terms. The Government of Ukraine (GoU) increased its spending 9.8 fold during the same period and gradually

reduced dependency on external funding from as high as 85% in 2005 down to 40.7- 46.7% in 2009 and 2010 respectively⁸. Allocations from central as well as local budgets grew at an impressive rate averaging an annual growth rate of 62%. Albeit, this growth was not enough to meet the ever growing population needs or further minimize the dependency on external funding.

6.12 POLITICAL ATTENTION

In the past several years political attention to HIV/AIDS issues has increased moderately, with some amendments to legislation being made and new regulations enacted. Progress in some policy areas was more pronounced, i.e. strategic planning, M&E systems and treatment, care & support services. There are promising indications of political will and increasing government commitment towards the implementation of donor supported programmes by the government. Recently the MoH has actively re-signalled political support to HIV/AIDS. However, in some areas the progress has been variable over the years and for some crucial areas, like human rights protection and civil society involvement, the situation has even deteriorated relative to 2007.

6.13 HUMAN RIGHTS

Partners in the National response to HIV/AIDS in Ukraine have begun to recognize the interrelationship between human rights and HIV: while violations of human rights fuel the HIV epidemic and exacerbate its impact on the society, stigma and discriminative behaviour associated with HIV and MARPs undermine the safeguarding of intrinsic human rights values.

Ukraine has developed a strong foundation for protecting the rights of people living with HIV and providing HIV-related medical and social services to those in need - particularly IDUs, mainly with the support of donor-funded projects and advocacy by international organisations. The human rights based approach has been embraced at the highest national level and resulted firstly in declarations (made both at home and abroad) by the nation's leaders, and secondly via advanced legislation and specifically the Law of Ukraine "On Prevention of Spread of Diseases Caused by the Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV" (the HIV Law), which came into effect in January 2011. Thirdly a firm and pro-active position has been taken by the Ukrainian Parliament Commissioner for Human Rights. Finally, work has been underway in human rights advocacy as well as in risk and vulnerability reduction by civil society organisations. This has been welcomed and supported by the international community.

The significant breakthrough in HIV legislation, however, happened against a backdrop of deteriorating human rights' observance in Ukraine, which was noted by Freedom House and Amnesty International. In the context of HIV this concerns the rights of MARPs and explicitly the sexual minorities where three discriminatory legislative acts were initiated. Stigma on same-sex sexual relations is increasing with almost half (46.7%) of Ukrainians thinking that homosexuals should not have the same rights as other Ukrainian citizens (UNDP, 2012).

⁸ Ukraine UNGASS reports 2008, 2010 and 2012. www.unaids.org

7 CRITICAL BARRIERS (BOTTLENECKS)

The strengths of the NAP and related programmes, which has been gradually built up in the last years, together with the many achievements in political support, human rights, programme organisation, prevention, treatment, care and support services for most at risk population groups and vulnerable others, should be the foundation for further improvements of Ukraine's response to the HIV epidemic.

The response still faces many challenges on the road to reaching MDG 6 and aims beyond 2015. The assessment identified critical barriers or bottlenecks that stand in the way of achieving the objectives of the National response. In this chapter they are listed and described. Chapter 8 links these bottlenecks to recommendations for the next National AIDS Program 2014-2018.

7.1 WEAK LEADERSHIP AND PROFOUND SOCIETAL STIGMA, DISCRIMINATION AND INEQUALITY

7.1.1 No engaged leadership means no effective programme

One of the main obstacles to an adequate response to the epidemic is the lack of political will to appropriately tackle HIV/AIDS issues in the country. This is apparent within central and local governments. The political commitment of the central government to HIV/AIDS has been declarative for its largest part. The lack of political will of the government is not only specific to HIV/AIDS, but to the health sector in general, because central government budget allocations for the health sector declined from 3.6% of GDP in 2007 down to 2.9% in 2011. In addition, while close to 91% of public funding for the NAP 2009-2013 was planned to come from the central budget (and 96 % of these funds were allocated to the Ministry of Health), actual spending from the state budget was far behind the NAP plans and in 2009 the Government (national as well as local) allocated 13% less, while in 2010 the funding gap was 34% compared to the financing plans in the NAP law.⁹

The absence of government ownership and leadership has translated into gaps and low levels of response in countrywide, community-level prevention programmes for MARPs, including MSM.

While leading the multi-sector response may be a challenging task for the MoH to handle, there are obvious areas where MoH's political leadership could deliver on the expectations. It seems that political will and/or power within the MoH is not adequate to counteract this inner opposition within the sector and integrate and deliver the services needed to the PLHIV. For example, the integration of TB and HIV services is well known to be one of the most effective ways of concurrently responding to HIV and TB problems, and this issue is purely health sector specific, however this has not occurred yet. Similar challenges are seen with the introduction, scale-up and integration of OST with HIV and TB services.

7.1.2 High level of stigma, discrimination and inequality persists

Stigma and discrimination regarding HIV/AIDS within the society and among health care providers creates important barriers to accessing needed preventive and curative services. Double and triple stigmatization (HIV/AIDS, drug addiction, tuberculosis, homosexual behaviour, etc.) pose particular challenges to MARPs, young people and other vulnerable groups, especially in villages and towns. In addition, high levels of masculinity in the society and intolerance to those who fall beyond the socially accepted gender "norms" trigger access barriers to services.

The central government is passive and does not advance and coordinate the active minimization of stigma and discrimination and promotion of values of diversity and tolerance. Monitoring stigma and discrimination in the society and among service providers towards PLWH and MARPs and youth is absent, while the system of monitoring human rights violations is managed by civil society void of any government involvement.

Furthermore, a gender based approach in servicing and teaching youth is absent, while gender-based

⁹ The World Bank, 2012 Ukraine Public Finance Management Performance Report 2012

monitoring for men and women, boys and girls, as well as transgender is not used to assess the benefits from the NAP.

This translates into an inadequate system of human rights protection, stigma reduction and response to violations/abuse and gender inequality, as well as low levels of capacity of organizations and individuals to provide and demand “judgment-free” services. Mainstream medical and educational professional staffs practice stigma and discrimination against MARPS, youth and PLWHA.

7.2 WEAK GOVERNANCE & SUPPORT MECHANISMS

7.2.1 Legislation, rules and regulations hinder implementation

1. State rules impose regulatory limitations on national planning exercise for service delivery

The State rules for national planning and budgeting as defined by the MoF are not responsive to the population's needs and impose limitations on scaling-up prevention, treatment and care and support services and on making them efficient. Unless these input based regulations are amended and oriented towards results, increasing budget allocations for priority services will face challenges.

National planning and budgeting rules mandate the use of national statistics for planning purposes and do allow the use of datasets including surveys (e.g. BSS survey), size estimation studies, and operational research. Consequently the rich data, which is available through national M&E system, is not requested by planners and is not used effectively and adequately for planning and budgeting based on the actual needs of the population, MARPs, prisoners, youth and other vulnerable groups. As a result in terms of ARV drug procurement, this is planned based on retrospective analysis of those on treatments instead of prospective estimation of those in need. In turn this drives the underestimation for other drugs, test kits and other inputs and causes inadequate delivery of the needed services.

2. Health sector rules create access barriers and drive inefficiencies

MoH rules that govern organizations (see also 6.3.2 systemic inefficiencies) and the delivery of health care services (e.g. HIV diagnosis, registration and placement on ART, see also 6.4) create access barriers which in turn negatively affects quality and drive inefficiencies in terms of time and costs.

Facilities that provide medical services are bound to rigorous unified regulations for these facilities without taking into consideration spread of HIV, which is different in different parts of the country. Consequently some facilities are faced with a significant and growing workload and relative staff shortage, while others are hugely underutilized, which contributes to inefficient use of scarce resources. Furthermore, the state requirements set out for human resources, infrastructure and equipment of these facilities are quite demanding and resource intensive, while limited local budgets are not able to fully satisfy the needs imposed by these regulations and facilities are significantly underfunded. Furthermore, over past four years the capital financing for these facilities has been limited and the supply of necessary diagnostic and laboratory equipment was inadequate, which negatively affected quality of delivered services.

7.2.2 Insufficient Organisation and Management

1. Coordination of the national response is inadequate

The complex design of the NAP with a limited prioritization of critical interventions and with many less effective interventions makes it difficult coordinate. This is compounded by complex institutional arrangements for coordinating and leading the national response with too many implementing entities involved in the programme – forty-eight in total.

The arrangements suffer from overlapping and/or unclear responsibilities and subordination of the entities. Regional AIDS Centres are subordinated to the Regional Health Administrations which has no technical expertise in HIV. Moreover, the two roles of the State Service – being advisory to the National Council and executive for the Cabinet of Ministers via MoH could be conflicting sometimes. Also a weak

relationship exists between the National Council and Oblast (regional) Councils.

The convening power of the MoH is weak and its technical capacity is not adequate to develop such a complex programme. The National AIDS centre has the technical expertise in HIV but has no power and managerial mechanism to introduce innovative approaches in HIV service delivery, or to monitor their implementation.

2. Developing and operating specialised medical and social services lacks vision

For the establishment of new specialized (medical and social) services for PLHIV the government lacks a clear vision in terms of location, purpose and role in the health care system. It has failed (or was not capable) to conceptualize its vision and plan appropriate action to establish these services for PLHIV.

The importance, appropriateness and need for the establishment of facilities that provide social services raises serious doubts. As of today there are only five re-socialization centres for IDU youth and seven centres for HIV positive children and youth funded from local budgets. Similar centres were envisaged in the NAP but implementation was seriously delayed because of various reasons including a lack of political support, lack of funding from local governments, no future strategic vision for these centres, necessary cadre, necessary regulations, etc.

7.2.3 HR development capacity hampers implementation

The main bottleneck in the development of human resources is a lack of strategic vision on the part of the government, which translates into poor planning and budgeting at state and local level. This undermines sustainability and poses risks when donor funding (a primary source for the delivery of training and development) declines.

Presently, most training and re-training is poorly institutionalised and mainly supported by external donor funds. They are offered to social and health care professionals while not fully mainstreamed and integrated within the educational system of the country that delivers under and post-graduate education.

In addition, training on the interaction among drug dependence and infectious diseases is insufficient for penitentiary staff at different levels of the system.

Introducing practical gender issues in education and training programmes is hindered by low levels of capacity.

7.2.4 M&E system not adequate, data use is moderate

Planning and M&E should be inextricably linked. However, the NAP suffers from weak and/or an absence of linkages between its goals, objectives, interventions and targets. This undermines all M&E efforts for NAP, and is deteriorated by the inadequate institutionalization of M&E reporting forms within the national statistical system. In addition, an impact evaluation system is lacking e.g. for FSW programmes.

The latter is resulting in a lower use of M&E data in the national planning processes. There are no mechanisms for using the data that is routinely collected to steer programme evaluation and accountability.

As a consequence, there is insufficient strategic information to guide MARP programme strategies (e.g. FSW and MSM), and it limits the effectiveness of advocacy (e.g. for MSM).

Lastly, the reliability of data for the current SEM system is unsatisfactory. This concerns the coverage with testing, seroprevalence, registration for care and HIV/AIDS morbidity (incidence).

7.2.5 SM is inadequate and causes disrupted supply that hinders service intensity, quality and coverage

Public procurement and supply management is inadequate and causes frequent drug stock-outs. These pose a major risk to those on treatment. The reasons are insufficient financial allocation and poor budgetary planning practices for HIV and TB. Delayed tenders potentially caused by corrupt procurement

practices, together with non sensitivity to the need for an ongoing and sustainable supply of ARV¹⁰ and other commodities like condoms that are difficult to obtain by high-risk youth, test kits and infant formula for proper PMTCT services, etc.

The existing input based mechanism of the centralized public procurement system – instead of a needs-based system – has limitations that affect the quality and quantity of drugs and goods purchased. Moreover, the prices of pharmaceuticals purchased by the government – for example compared to drugs procured under the Global Fund, are often too high, despite the use of tendering in procurement¹¹.

Although the National Council tasked the MoH to lead improvements in PSM to assure continuous and uninterrupted PSM of HIV and TB drugs¹², the situation in 2012 has not changed significantly.

7.3 PROGRAM SUSTAINABILITY AT RISK

Scale-up of quality preventive, curative care and support services in a way that it could be sustainable in a long run is challenged by numerous factors, including:

- Insufficient funding from state budget for necessary inputs: e.g. ARVs, diagnostic test for CD4 count and for viral load, other drugs, preventive commodities, etc.
- systemic limitations in the national planning and budgeting rules, which are normative based and do not take into account population's needs
- interrupted procurement and an insufficient supply of the goods purchased with public funds linked to inefficiencies in central procurement and supply management system the underfunding of health care providers translates into low salaries and low motivation levels for the medical personnel – thus negatively affecting quality of services
- poor links between health care providers and their communities is negatively affecting case detection and treatment adherence rates and resulting in poor treatment outcomes
- Inadequate service quality, etc.

7.3.1 Financial public commitments are insufficient to scale-up services

Although funding levels have increased significantly, one of the main bottlenecks for an adequate response to the epidemic is insufficient financial resources to meet the growing demand for prevention, treatment, care and support.

Based on available projections, by 2015 the total financial needs of the HIV programme is expected to reach as much as 0.3% of GDP. Considering the economic growth and expected increase in state revenues over the coming years, the total financial need for HIV response may reach to 0.7% of Government's total expenditure by 2015¹³. This will be a ten-fold increase of the 2010 public spending on HIV, which would not be feasible unless external funding is provided – at least in the medium term, and with a significant increase in governmental allocations from the state budget. Consequently a significant increase in funding levels from the national budget will be required in a medium to long-term perspective.

Central and local budgets contribute approximately half of the NAP funding. NAP remains significantly reliant on external funding, which provides 40-45% of the needed resources out of which the Global Fund is the most important contributor accounting for 34-37% during 2009 and 2010 respectively. However, Ukraine will have sufficient fiscal space to adequately fund a scaling-up of the required services.

10 Hodgson, I. 2011. *Stock outs: a major threat to HIV treatment in Europe*. www.keycorrespondents.org (Last accessed on August 11th, 2012)

11 Lekhan V, Ruidiy V, Richardson E. Ukraine: Health system review. *Health Systems in Transition*, 2010 12(8):92.

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

13 Calculations by the Assessment Team using <http://www.econstats.com/weo/CUKR.htm> (Last accessed September 5, 2012) and *Aids2031 Costs and Financing Working Group. Costs and Choices: Financing the Long Term Fight Against AIDS*. Washington, DC: Results for Development Institute 2010. p.10.

7.3.2 Inefficiencies characterise implementation

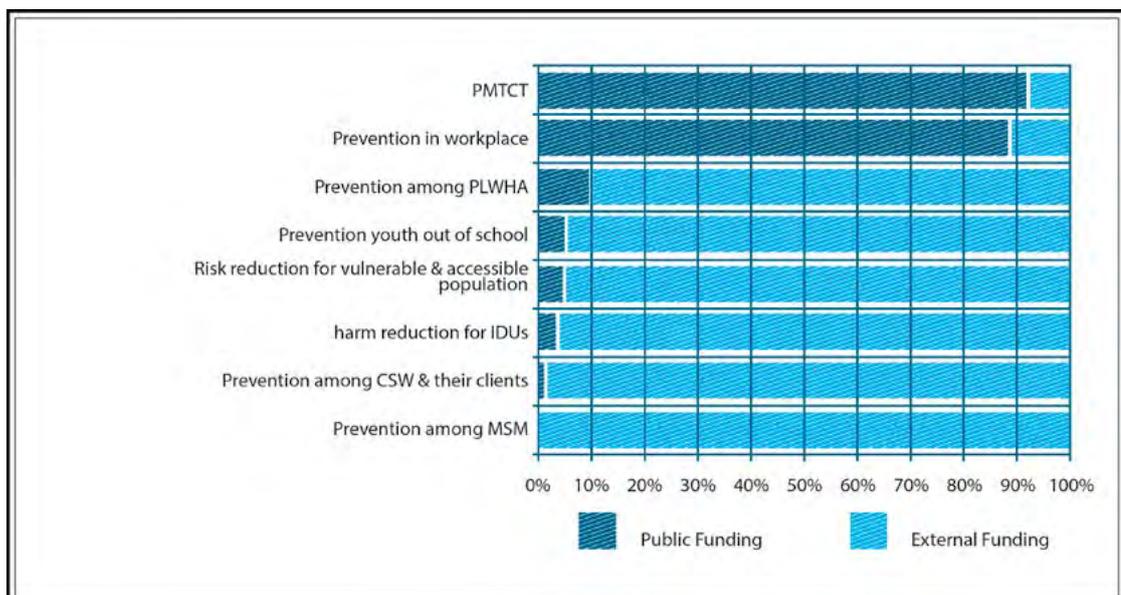
Three types of inefficiencies – i.e. allocation, systemic and technical – are considered important bottlenecks for implementation of an effective response.

1. Inefficient allocation – low government participation in MARPS, youth, prevention and social programmes

In light of the growing financial need and the development of a concentrated epidemic, it becomes important to more effectively use the limited resources and increase allocation efficiency. Considering the epidemiological and programmatic context, where MARPs are primary drivers behind the HIV epidemic and current coverage with the critical preventive interventions are sub-optimal, it is expected that MARPS would receive higher share of funds and the general public less. These concerns, for example, preventive programmes for PWIDs, FSW and MSM programmes, OST services, care and support, and services tailored to youth. However in terms of government spending priorities IDU, CSW and MSM groups marginally receive funds from the government (see Figure 1).

According to NASA¹⁴ around 42% of HIV/AIDS spending is for treatment, less than 5% is for care and support and prevention received only 29% and 27.4% of funds in 2009 and 2010 respectively. At the same time allocations for programme support (which includes planning, coordination, programme management and M&E along with human resource development) consumed around 25-26% during same period. Significant amounts are spent on sustaining the medical infrastructure, which may not be operating at an optimal level and this leaves little resources to fund direct inputs that are so needed for scale-up of quality interventions.

Figure 1 Government spending priorities in prevention 2010

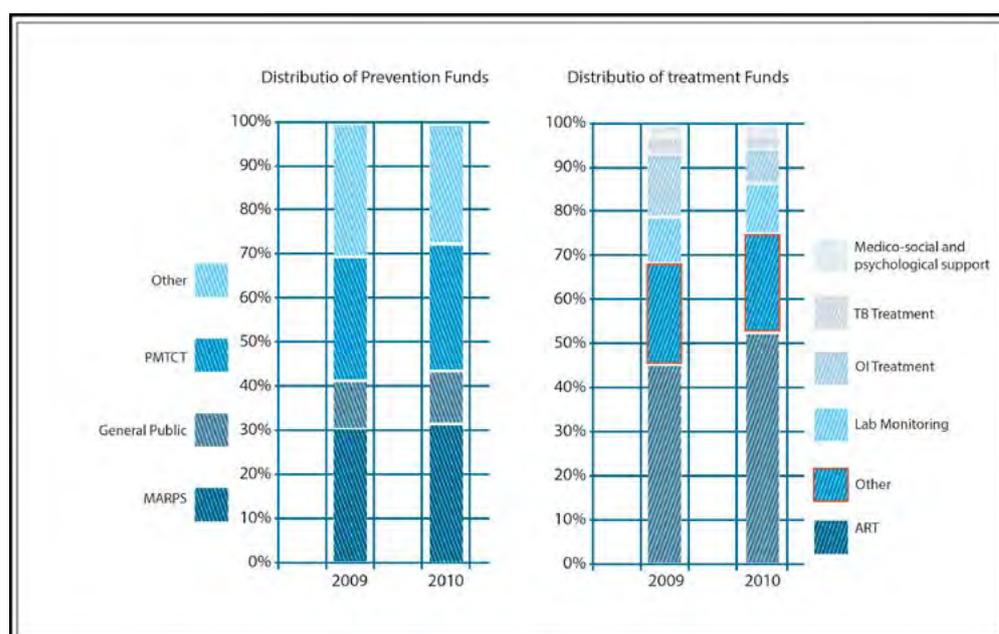


Source: NASA 2009-2010

Questions about allocation efficiency also emerge when looking at spending levels within preventive and curative interventions. For example, only 30% of funds spent on prevention are dedicated to MARPs and the rest is used for PMTCT – 28-29%, prevention among the general public received 11-12% and other undefined activities – 30-27% (see Figure 2). Considering the epidemiological and programmatic context, where MARPs are primary drivers behind the HIV epidemic and current coverage with the critical preventive interventions are sub-optimal, it is expected that MARPS would receive higher share of funds and the general public less.

¹⁴ Ukraine Harmonized AIDS Response Progress Report, International HIV/AIDS Alliance, Kiev 2012.

Figure 2 Distribution of Preventive and Curative Budgets 2009-2010



Source: NASA 2009-2010

2. Systemic inefficiency – input based mechanisms and uniform standards

The health system faces structural impediments that create inefficiencies in the service delivery infrastructure. These impediments stem from *input based mechanisms* and the application of *uniform national standards*.

The input-based mechanisms and rules currently in place neither reflect the health care needs of the population nor take into account regional characteristics of health service provision¹⁵. This situation is further compounded by the legal status of the providers: so-called budgetary institutions, which give them limited rights to make independent managerial and economic decisions¹⁶.

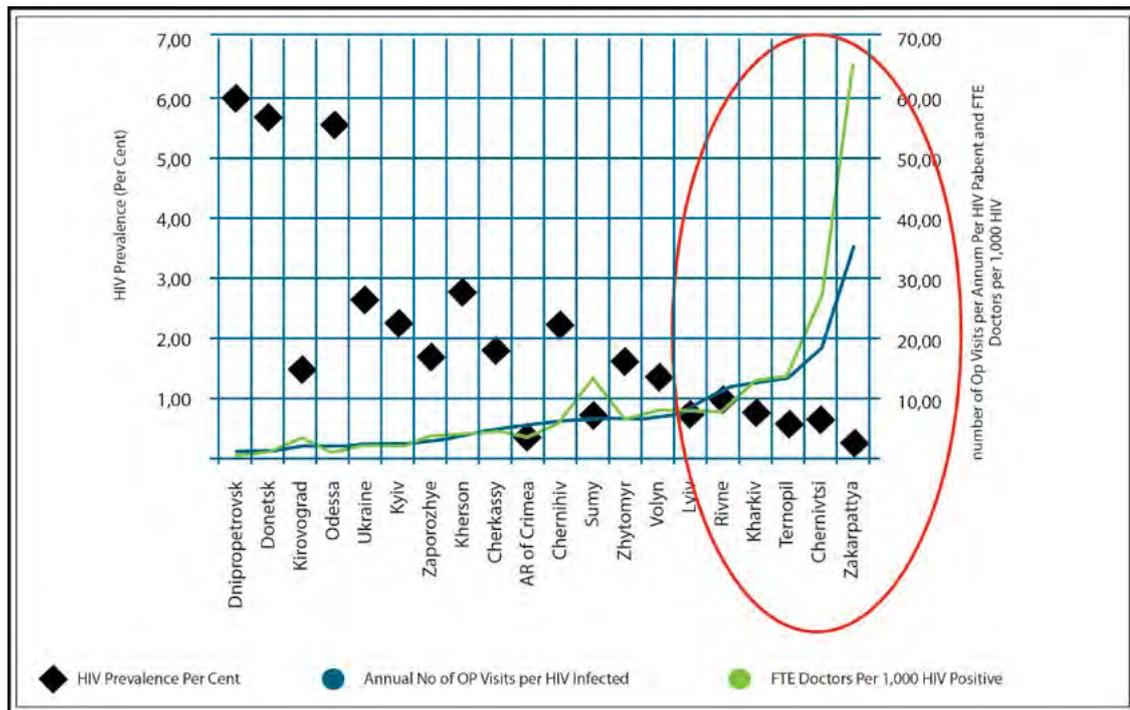
In this way adverse incentives are created for the providers to increase volume of services they deliver or reduce the cost of service delivery and achieve efficiency gains. These adverse incentives operate at the facilitation and system level, and also affect individual provider behaviour. At the facility-level, providers face risks arising from the lack of integrated services for IDU patients that need ART. Poor adherence and dropout of IDUs without OST affects the performance indicators for providers against which they are evaluated. At the individual level medical staff lacks motivation to produce more services, improve quality and treat more patients, above the necessary minimum.

Uniform normative guidelines apply to local AIDS Centres and Trust Cabinets. Due to these standards major inefficiencies occur in the allocation of human resources. Instead of a need based approach, which could help balance staff deployment and reduce costs, the standards applied drive up costs because of surplus staffing in centres that serve areas with low prevalence rates. The crude analysis of the human resource supply across the oblasts (regions), presented in Figure 3, shows the degrees of inefficiency in the supply of physicians relative to HIV prevalence in a given oblast.

¹⁵ Lekhan V, Rudyi V, Richardson E. Ukraine: Health system review. *Health Systems in Transition*, 2010 12(8):92.

¹⁶ Ibid.

Figure 3: HIV Prevalence, Supply of Physicians and Health Service Utilization by PLHIV



Source: Centre for Medical Statistics of the MoH, Letter from 28.09.2012, №MC-01/402

3. Technical inefficiency - testing and treatment

The outcome of testing is not satisfactory but the time currently employed in implementing HIV testing policies consumes a significant volume of resources. Over the past several years Ukraine significantly increased its testing volumes, however the share of cases detected at a late clinical stage (with AIDS or with clinical symptoms of HIV infection) had grown gradually. As only around two third of detected HIV cases receive continuous lab monitoring, the remaining 37% is lost and not followed-up causing further delays in treatment¹⁷. Low levels of testing are also apparent in custodial settings.

Also after testing an inefficient system makes it difficult to engage persons with positive test results in special HIV-related treatment services in AIDS centres. A lack of financial resources for antiretroviral drugs and diagnostics are among the driving forces.

7.3.3 No conducive system for state funding of preventive and social services

Preventive interventions aimed at MARPs as well as at care and support services are primarily funded from external sources – from the Global Fund through NGOs. A sudden reduction in external funding, expected in light of changes occurring within the Global Fund, is assumed to have negative effects and primarily on these interventions among groups most at risk. Consequently, sustainability risks for preventive services for MARPs and care and support services for PLWHA will become prominent without:

- a) A productive environment for financing NGOs out of the state budget. The determinants for this social contracting, i.e. effective contracting of NGOs for the delivery of preventive and social services – are twofold:
 - An appropriate regulatory framework that would facilitate large-scale implementation of NGO contracting countrywide: a. local governments do not have necessary legal framework to plan and budget resources for the delivery of these services, which could be provided by NGOs contracted by a local government b. national regulations do not provide list of and legal definition for MARPS that are entitled to receive social and other services funded out of local budget, and c. the rules

¹⁷ Ukraine Harmonized AIDS Response Progress Report: Reporting period: January 2010 – December 2011. Kiev 2012. <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries>

- and/or guidance for estimation of the need for these services are lacking¹⁸, and d. rules governing estimation of prices for these services do not exist.
 - Economic or societal motivators for NGOs to demand for state funding. As long as Global Fund financing is available the demand for state funding among NGOs will be low and seem largely declarative.
- b) Broadening the focus of the national budget priorities and including preventive interventions among MARPs in the focus of national funding (see 6.3,2,1 on allocation inefficiency).

7.4 INADEQUATE SERVICE COVERAGE, INTEGRATION AND QUALITY

7.4.1 Inadequate scale of services and outreach to halt the epidemic growth

In general, although there are a large number of public and NGO facilities working on HIV prevention and substance abuse, these programmes do not have the scope, quality, intensity and coverage to effectively reach the most hidden and marginalized groups and do not offer convenient services to diagnose or treat HIV and TB.

ART coverage is low, from 13.4% (MSF) to 53% (Govt data), and despite the fact that injecting drug users remain the driving force behind the epidemic, the proportion of IDUs on ART is only 8,3%. The low proportion of active drug users within the number of officially registered HIV patients in need of ARV indicates that these IDUs have limited access not just too antiretroviral treatment but also to health care services in general¹⁹.

The coverage of HIV and TB testing and counselling for MARPs and bridge groups is low and inconsistent²⁰, while the availability of Opioid Substitution Therapy (OST) services is inadequate to meet the needs to facilitate better prevention and treatment outcomes.

Care and support services, while in existence, are in nascent stages of development and not adequate relative to needs.

1. Most at risk adolescents are neglected by the current services that are tailored towards youth.
2. Community level outreach to MARPs and care and support of PLWHA has low coverage and intensity. Few active people who inject drugs have been reached, are motivated and successfully receive preparation for ART and support during ART. The current outreach strategy for FSW constrains programme coverage and intensity. The standardized programme approach does not address the complexity of MSM experience and has challenges engaging diverse MSM. PLWHA have limited access to palliative care, pain relief and hospice care and in rural areas to confidential services, while a care and support strategy is not available for hard to reach clients.

Custodial facilities lack the equivalent of health care that is practiced elsewhere. Prevention activities are limited in number and testing and counselling is often not practiced or of low quality. There is limited access to ART and follow-up. Also, hepatitis infections and STIs are not addressed and treatment and harm reduction measures (including OST) for IDUs and other drug users are absent.

7.4.2 Services hardly integrated and client centred

A clear vision from the MoH on HIV/AIDS service integration is absent, and there is also a lack of engagement in the health sector reform processes from key stakeholders of the HIV/AIDS community. The continuation of a non integrated HIV/AIDS prevention and care system will come under more scrutiny considering the

¹⁸ Official estimates for some groups e.g. IDUs are not reliable or for some groups like MSM they do not even exist. Size estimates, produced using various methodologies, are being used for donor funded projects and the utility of these estimates for state budget allocation is zero, because such estimates are not legally allowed in the national budget planning process.

¹⁹ Médecins Sans Frontières 2012. *Speed up scale-up: Strategies, tools and policies to get the best HIV treatment to more people, sooner*. <http://aids2012.msf.org/2012/speed-up-scale-up/> (Last accessed on August 19th, 2012).

²⁰ USG/UKRAINE Global Health Initiative Strategy, January 2012. www.ghi.gov/documents/organization/191752.pdf

likelihood that international funding for HIV/AIDS activities in Ukraine are expected to decline²¹.

Currently, multiple separate systems provide services and this causes inefficiencies, jeopardising the quality and impact of services.

In terms of lacking 'vertical' integration of services, the vast majority of hospitalized TB patients, contrary to the national ART protocol and WHO recommendations, do not receive ARV drugs. PLHIV are usually referred to TB services for TB diagnosis without follow up instead of integration TB diagnosis in AIDS centres, and OST is not available for IDUs that are on TB or TB/HIV treatment, consequently treatment adherence rates among IDUs is low. Similarly, health care in the penitentiary system is not guided by a comprehensive strategy to address HIV, TB and co-infections (hepatitis and STIs) together.

In terms of the 'horizontal' integration of services, low integration of social aspects in health settings, particularly narcology, HIV and others services, is observed. In addition, there are serious gaps between the penitentiary system and the public health sector. The system operates in relative isolation and lacks inter-sector cooperation with other actors. This affects the quality and volume of services offered to prisoners and imposes limitations on the national response to HIV.

Health sector reform in three oblasts (regions) and the city of Kyiv, which was delayed, and with the exception of Dnepropetrovsk region, do not include any link with the organization and delivery of HIV/AIDS services.

7.4.3 Service quality not guaranteed

In general, MoH rules governing the organization and delivery of health care services that create access barriers negatively affect quality and drive inefficiencies. Quality standards for services, particularly for care, prevention, and treatment are limited or not enforced.

FSW programmes lack sufficient implementation standards, guidelines and management processes, and STI service delivery is inefficient and not evidence-based. For IDUs on ART TB/HIV treatment substitution therapy is not available, resulting in lower adherence to treatment and a high dropout rate. The implementation of MSM-specific services are hindered by formal authorization and uniform rules. In PMTCT, new infections occurring in pregnancy and lactation are increasing and going undetected, while weak follow up systems for HIV+ women postpartum lead to inadequate services and risk of poor health. In addition, the quality of laboratory diagnostics is insufficient as a result of the weak system of quality control at laboratories, registration of test kits and post-marketing control. National recommendations on ART are not aligned with the WHO recommendations, the context of the HIV epidemic and other available resources.

Two driving forces behind the inadequate quality-of-care are *stigma* and *discrimination* among health care professionals, in society and in the penitentiary system.

²¹ Cowley, Peter and Baktygul Akkaziya. September 2012. Feasibility Study: Integration of Services into the Health System of Ukraine. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

8 CONCLUSIONS

The growing HIV epidemic that is concentrated in mostly urban at most-at-risk populations (MARPs), including injecting drug users (IDU), female sex workers (FSW) and men having sex with men (MSM), and in the penitentiary system, calls for a more sustainable, efficient and effective approach in the near future.

With a stabilizing HIV prevalence rate among IDUs and a decrease in younger users likely due to prevention interventions, an increasing role of the FSW networks in the overall transmission dynamics in Ukraine is observed. MSM is the most challenging risk population with a likely expansion towards representing one fifth of all new HIV cases in 2015, while suffering from insignificant progress and limited MSM specific programming. Subgroups with combined risk characteristics are at the highest risks of HIV infection. PMTCT is the only programme area that has sufficiently generated effect. The situation in prisons requires high priority with an epidemic in custodial settings mostly driven by the transmission through injecting drug use. Overall, there is an increasing concern about HIV risks for sexual partners of MARPs and insufficient attention for risky behaviour of youth.

Given these levels and dynamics of the epidemic, the HIV response should further build on the achievements and strength of the current NAP and related programmes and address the factors that are regarded bottlenecks in generating effect, efficiency and creating sustainability. Some of these critical barriers are embedded in the governmental system outside of the health sector others are a direct part of the health care system, in general or in particular related to HIV/AIDS. Bottlenecks in the former relate to problems in legislation, rules and regulations on government financing, input-based planning, (de)centralisation, but also lack of human rights protection enforcement and political will for health care improvements. They all affect the health care system and its reform efforts.

General and HIV/AIDS specific health and social care system bottlenecks deal with insufficient change management of the Ministry of Health (MoH) – although modest positive shifts are observed recently, and Ministry of Social Policy, inappropriate financial allocations and the rigor in the rules applied by MoH. These weak governance and support mechanisms are compounded by profound societal and provider stigma and discrimination. The bottlenecks create other barriers including health system inefficiencies and administrative access barriers, they hinder further service integration efforts, prevent from increasing the scale, intensity and quality of prevention interventions among most-at-risk people and their sex partners, they constrain early testing, diagnosis and prompt treatment without delays, they limit coverage of essential treatment, and they hamper adequate coverage of care and support for people living with HIV/AIDS.

In terms of organisation of the NAP, despite of having the 'three ones' in place, coordination responsibilities are poorly distributed among the different national entities, the design is complex and has a limited results-based orientation (logical framework approach). It also suffers from inadequate cooperation between the national and regional levels. Along with inadequate political will within the government, and weak enforcement of state laws, this obviously creates implementation bottlenecks for the national response and calls for improved coordination through adequate leadership from the highest levels downward.

One of the main concerns is the sustainability of the response to the HIV epidemic. Response efforts in the near future will be confronted with an estimated ten-fold increase in required resources in the period 2010-2015. External donor funding is expected to diminish and government funding at current levels will not be enough, despite the tenfold increase in government allocations since 2005. Implementation inefficiencies furthermore constrain sustainability efforts. National and local authorities will need to create favourable conditions for social contracting mechanisms thus enabling civil society to continue their prevention and social interventions after external donor funding subsidies. Health reform efforts will need to integrate HIV/AIDS services led by a socio-medical model of care for most at risk populations and people living with HIV/AIDS. This model will need to place the client in the centre of care, thus creating trust among clients and reducing access and retention barriers to a minimum.

The new NAP 2014-2018 will provide an excellent platform to address the critical barriers that have been identified in the assessment. The next section elaborates on the recommendations of the assessment, which will need to be translated into concrete actions for the short and medium term.

9 RECOMMENDATIONS (SOLUTIONS)

The recommendations in this chapter are directly linked to the bottlenecks that have been described in Chapter 6. They are expected to guide and support the formulation of the next National AIDS Program 2014-2018 in Ukraine.

9.1 CHALLENGE LEADERSHIP AND REDUCE STIGMA AND DISCRIMINATION

9.1.1 The Ukrainian Government must assume a leading role in HIV/AIDS prevention and care

1. The national government must fully assume a leading role and generate political will among the different stakeholders. Both national government and parliament have to secure adequate attention to HIV/AIDS issues that translates into increased allocation of budgetary resources and improved national stewardship
2. Local governments have to allocate adequate budget financing and better organize delivery of needed services in their localities by trying, as much as possible, to integrate different services within the local health care network, organizing, funding and delivering the needed social services to PLHIV and facilitating better coordination and/or integration between social and health sectors
3. The Ministry of Health has to pay adequate attention to HIV/AIDS related issues and become a better steward and advocate of the national response within the government of Ukraine, as well as with national and international partners. The MoH has to conduct the national procurement of ARVs, drugs and HIV test kits quickie and guarantee a continuous, uninterrupted and sustainable supply of the needed inputs.

9.1.2 Reduce stigma, discrimination and promote gender equality in society and among professionals

In general, reduce stigma, discrimination and gender inequality in society and among professional service providers, including health care staff and law enforcement officers.

1. Protect human rights

- Incorporate a Human Rights based approach in the NAP embracing and advocating for “zero” tolerance to discrimination and Human Rights violations, and provide support and advocacy to promote respect for diversity and tolerance among care providers and the general population. This should be done in order to reduce stigma and protect the rights of people, in particular MARPs²² and PLWHA in society and in custody.
- Enforce Human Rights legislation that protects people living with HIV/AIDS and other vulnerable groups. Provide a prompt response to human rights violations/abuses by implementing monitoring results on the policy level and modifying service delivery mechanisms/structures to ensure their user-friendliness for MARPs and PLHIV
- Implement mechanisms for monitoring human rights violations/abuses as well as assessing level of stigma in the society, among service providers, law enforcement and the judiciary
- Reduce stigma and discriminative behaviour among health care providers via nationwide advocacy and education campaigns and by structurally integrating the appropriate training into curricula. (See also recommendations under HR development, and governance)
- Introduce and sustain courses on drug dependency for graduate and post-graduate specialists of infection diseases, drug dependency, mental health, surgeons, TB specialists and family doctors, as well as nurses, social workers, police and justice system staff. Encourage the involvement of **family** and parents in sex education of young people and in HIV prevention.

²² Taking in to account the negative attitudes in the society towards the rights of MARPs (specifically LGBT and freedom to assemble), central bodies of executive powers may start by openly stating the right LGBT persons to health, education etc.

2. Promote gender equality

- Address gender equality in the provision of services and information, especially for MARPs and other vulnerable groups – taking into account different risk profiles between men and women in Ukraine’s epidemic, who are subject to harassment and discrimination. This also includes adherence to gender equality and “zero” tolerance to GBV in the context of HIV in NAP and design and approval of a HIV Gender Strategy integrated in the NAP 2014-2018.
- Consider TG (especially young and adolescent TG) as groups that need protection against discrimination, and integrate services for these groups into programmes targeting IDUs and CSWs.

9.2 IMPROVE GOVERNANCE & SUPPORT MECHANISMS

9.2.1 Change legislation, rules and regulations that affect HIV/AIDS

1. National

- Revise the rules governing national planning to make them more responsive to population’s needs. This relates to broader government behaviour and public finance management rules. It is therefore of utmost importance that necessary links are established with health reform pilots to enact such changes for the health sector and for HIV/AIDS in particular
- Along the same line, evidence from various studies and BSS surveys should be officially allowed in the national budget planning process to achieve breakthroughs and balance available resources with the population’s health needs
- Reform the drug policy, enabling fewer incarcerations, eliminating punishment for possession of small amounts of drugs and enabling the police to support people who inject drugs to seek healthcare and social services
- Strengthen legislation and enforcement to protect the rights of people engaged in same-sex behaviour. Develop a multi-sector strategy and messaging to combat and/or reverse the passage of anti-gay legislation
- Integrate MSM-specific approaches into government and donor policies.

2. Sector, health

- Reform the key regulations on narcology register and OST in line with international practice and enforce their implementation in practice and policy environment
- The Ministry of Health should initiate amendments in legislation to improve the public procurement system for drugs and medical inputs.

9.2.2 Improve policies, strategies and plans

- Align national programme strategies to focus priorities for HIV prevention to the most vulnerable FSWs, including young and new FSWs
- Apply lessons learned from building support for IDU services to MSM programming
- Within the framework of strengthening policy and overall governance structures for coordination of primary HIV prevention among youth, develop a National Strategy of Healthy Lifestyle of the Youth that integrates issues of HIV/AIDS, drug and alcohol use prevention, reproductive health, sex education, etc.
- Develop a vision and strategy – collaboratively (and agree this with key stakeholders), on the inclusion of social work posts in all specialist services. The lead agent for developing and agreeing on an implementation plan would be the Ministry of Social Policy. Thus, the service model would

shift from medically dominated to a more socio-medical orientation

- Develop, implement, and monitor national and region-specific operational plans for eliminating paediatric HIV infections and keeping mothers alive
- Develop and implement a inter-sector strategy that enables 'hard-to-reach clients' access to care and support services, and which support the development of trust between clients and professionals
- Add population groups at risk of HIV – i.e. prisoners, patients with hepatitis B, hepatitis C, with active TB - in the analysis and planning of coverage with HIV testing for improved access to HIV testing and early HIV treatment and care
- Analyse and utilize sex and age disaggregated data in planning interventions and concentrate on impact of NAP implementation on men, women, boys, girls and TG in reporting progress (assessing share in the benefit generated by NAP).

9.2.3 Improve organisation and management

1. Improve the overall design of the NAP

- Ensuring there is an inherent logic between inputs, activities and results
- Including appropriate measurable targets (see 8.2.5)
- Allocating budget lines explicitly per activity, while indicating the source of funding (national, local budget)
- Including only priority interventions with a highest potential to help achieve objectives and goals
- Working to optimize the number of implementers to facilitate coordination and management, and by streamlining and simplifying implementation arrangements.

2. Enhance coordination arrangements at the national level and between national and regional levels, aiming to:

- Eliminate the duplication and overlap between the roles of NC, the State Service and the MoH
- Revise the functions of and develop clear task assignments between the MoH, National AIDS Centre, regional health administrations and Regional AIDS Centres
- Translate National Council decisions into actionable directives issued by the CMU
- Advance the capacities of the national and sub-national councils.

3. Include representatives of youth organizations into HIV/AIDS National Coordination Council (NCC)

4. NCC and Regional Coordination Councils are to identify organizations/units in charge of carrying out preventive activities with young people aged 15-24. All relevant populations of youth should be engaged, including representatives from high-risk or vulnerable groups

5. Define new rules and/or processes for developing specialized services for HIV/AIDS.

6. For the establishment of services, the following criteria should be considered:

- Clear evidence on the need and appropriateness of new specialised medical or social services exists. Services should have a significant effect on the spread of the epidemic and/or deliver the needed quality services to PLHIV, without further stigmatizing effects.
- There is the chance to scale-up these services within a limited period of time and with an available funding from the national and/or local budgets, and availability of necessary human resources.
- Whenever decisions are made for the establishment of specialised services the government (not the donor supported projects) has to clearly define the role, place and purpose for these services

and should clearly formulate its decision.

- Instead of establishing totally new services, in some instances, adding these services to already existing systems in a health or a social sector should be an option to consider.
 - The rules governing the establishment of a specialized service should allow for innovation and flexibility, thus permitting adaptation to local epidemiological, socio-cultural, budgetary and other contextual factors.
 - New services which are established should delivery quality and effective services to PLHIV in a non-stigmatizing manner, and be tailored and responsive to societal needs and deliver services in a sustainable way.
7. Develop networking, coordination, and cooperation between institutions and staff from prison administrations, prisons and the community.
 8. Revitalise the steady Technical Working Group (TWG) on HIV/AIDS and Prisons (2007-2009).

9.2.4 Develop HR capacity

Challenges in human resource development are linked to broader system issues related to the educational system and human resource production, deployment and motivation/incentives issues, etc. While the government, through health system reforms, will deal with these broader systemic issues, there are possibilities to address some of the challenges within a new NAP, including:

1. Mainstream *HIV/AIDS, human rights and gender issues* in training and re-training programmes

within the under and post-graduate education, using as much as possible, the existing systems for continuous education and development of necessary human resources while having existing central and local funding channels deliver the necessary national financing.

Hereby:

- Maintain a horizontal focus on integrated services rather than strengthening the vertical HIV/AIDS care structure with narrowly defined expertise
 - Structurally integrate appropriate AIDS awareness, gender and stigma and discrimination reducing topics into the training curricula
 - Introduce and sustain courses on drug dependency and interaction with infectious diseases in graduate and post-graduate education
 - Target workers in medical, social, and mental health professions as well as police and staff of the current penitentiary and justice system, and differentiate the training according to level and role
 - Make courses that address human rights and gender issues mandatory.
2. Encourage the involvement of family and parents in sex education of young people and in HIV prevention
 3. Monitor and review employment practices to ensure that staff diagnosed having HIV do not lose their jobs.

9.2.5 Effectuate a sustainable M&E system for national and local planning purposes

In order to contribute to the sustainability of the national M&E system and the use of M&E data by the Government in national and local planning and budgeting processes, the following is recommended:

1. Set measurable targets for the NAP that are directly and logically linked to objectives, goals, expected outcome and impact
2. Institutionalise data collection for the NAP indicators within the national routine statistical system. Provide sufficient financial resources from the national budget in support of M&E activities for the

new NAP

3. For FSW programmes it is important to enhance the system for generating strategic information and translating it into FSW programme strategies. Strategic information should be generated by developing and implementing a system for measuring performance and assessing the impact of FSW prevention programmes
4. Specific youth programmes should revise programme indicators, upgrade their monitoring and evaluation systems, improve knowledge and skill appraisals for youth, and introduce accountability measures for non-performance of the indicators
5. Optimize the SEM system by introducing the renewed coding system, recording and reporting the number of persons undergoing HIV testing, and establishing a system of personal electronic registry for persons testing HIV positive. Allocate a separate code for TB patients tested on HIV.

9.2.6 Enhance procurement and supply management

1. The MoH should make amendments to legislation to improve the public procurement system for drugs and medical inputs. In particular the amendments should aim to remove artificial protectionist clauses and opening up the local drug and test kit markets to international competition
2. Change the planning process for state procurement of ARVs and CD4 tests from retrospective to prospective, based on direct and proxy indicators of ART need
3. Explore an opportunity to delegate procurement of ARVs and diagnostics to the National AIDS Centre
4. Strengthen the procurement process to prevent stock outs of PMTCT relevant drugs and test kits.

9.3 ENSURE SUSTAINABILITY AND EFFICIENCY BY SCALING-UP

9.3.1 Increase finances and scale up essential services

1. Increase the allocation of financial resources to ensure that a core package of preventive and support and care services are sustained for IDUs, and increased for MSM and reaching at least 80% of FSWs, that country ownership and funding is codified for community level interventions that benefit MSM, that primary prevention measures are ensured for lifestyle, and that M&E activities for NAP are adequately funded.
2. Apart from the necessary increase in national and local budgets, external funding from GF and other sources will be necessary to mitigate the epidemic challenges in the medium run

9.3.2 Decrease inefficiencies – change government funding priorities, rules and technical approaches

1. Allocation: The Government's funding priorities need revision because of underfunding and a concentrated epidemic
 - The government will need to consider revising budget allocation in favour of MARPs at the costs of funds for the general public and other miscellaneous activities. Priorities within public funding should shift towards preventive programmes for PWIDs, FSW and MSM, OST, care and support, condom provision and services tailored to youths
 - Establish better mechanisms of collaboration between the MOH and Ministry of Finance for advocacy on resource allocation for ART, and request continued financial support from GF so to cover the gap in ART for the time being
2. Systemic – introduce results based planning and flexible rules

- The MoH with support from the State Service has to amend the rules governing national planning and budgeting, thus allowing improved data collection mechanisms to make planning more responsive to the population's needs
 - The MoH is to revise regulations on establishing and financing of AIDS centres – e.g. capacity linked to population size and HIV/AIDS epidemiology, which would allow for the use of financial and human resources more efficiently – increasing available resources for the procurement of life-saving ART
3. Technical – increase cost effectiveness and value for money
- Develop a strategy for reducing the price of life-saving ART and essential laboratory test which are needed for ART initiation and monitoring of its effectiveness (CD4 and viral load)
 - Reduce the number of ART regimens for procurement to minimum: 2 regimens for 1st line and 2 regimens for 2nd line
 - Refuse the procurement of expensive HIV DR tests, as unnecessary due to low HIV DR prevalence at population level and clear strategy for ART regimens switching recommended by WHO
 - Re-evaluate current testing policies through the lens of technical efficiency and revise testing approaches accordingly in order to find more HIV cases early in the process of infection development
 - Decrease the team between testing and treatment in AIDS Centres.

9.3.3 Create conditions for social contracting

1. The Ministry of Social Policy would need to develop and legislate for effective norms

For “social contracting”, namely define rules that: a) clearly establish/define who the MARPS are that are entitled to receive social and other services funded out of local budget b) help estimate the need for social or support services c) help estimate the cost/budget needed for the delivery of these services. These interventions are expected to facilitate local budget allocation towards social services needed for PLHIV and eventually contracting NGOs to deliver these services

2. Socially responsible businesses and private funds should be involved in service delivery

And provided with incentives to pilot innovate approaches to distributing supplies more effectively to youth.

9.4 IMPROVE SERVICES ACCESS, QUALITY AND INTEGRATION

9.4.1 Aim for integrated client-centred service delivery mechanisms

1. Integrate HIV/AIDS services into the general health system engage in health reform discussions and aim, as much as possible, to assure adequate attention to HIV/AIDS issues when redesigning the organisation of district and oblast (regional) level healthcare services and delivery networks
2. Invest in country based operational research and costing studies to support the future development of policy and programming on integration of HIV/AIDS services in the health system
3. Search for and develop the most efficient integrative social-medical client-oriented service model for HIV positive MARPS, youth and other vulnerable groups, that includes active case finding and intensive throughout support
4. Revise the draft document on TB/HIV collaborative services ensuring that a) narcological services are on board, b) access to OST at TB hospitals for TB/HIV and TB drug dependent patients is ensured, c) TB and HIV experts are in charge of treatment of TB/HIV patients and ARVs are transferred to

medical personnel, d) roles and responsibilities on diagnosis and management of patients with co-conditions in TB, HIV and narcological services are clear

5. Develop for the penitentiary system a detailed strategy on the management of HIV/AIDS and co-infections (TB, hepatitis, and STIs) associated with the common elaboration of standards, guidelines and protocols. Implement this approach.

9.4.2 Ensure access, outreach and community level interventions

Develop rigorous outreach and community level interventions

1. Develop and implement an enhanced outreach strategy for FSW, incorporating community engagement in peer outreach and service delivery.
2. Increase the rigor and reach of community-level interventions as standardised approaches for MSM effective interventions.
3. Develop and implement an integrative social-medical model for HIV-positive PWIDs using different substances (including active case finding and intensive throughout support) (see also 8.4.1).
4. Develop and implement a strategy to enable 'hard-to-reach clients' to access care and support services using the experience of the Alliance pilot project. The strategy should include outreach workers and structures designed to develop trust between clients and professionals (see also 8.2.2)
5. Increase (rapid) testing and counselling services in prisons
6. Develop palliative care, hospice care and hospice at home services regionally including one specific hospice for people co-infected with TB and AIDS
7. Introduce mobile MDTs and ensure the new family doctor service staff are trained in working with this group and develop more services beyond Oblast capitals using targeted community mobilisations strategies to improve social capital and ensure availability of confidential services for PLWHA
8. Design, adapt and scale-up models for reaching marginalized and at-risk communities of youth, through improving outreach of youth-friendly services or strengthening existing services for most-at-risk populations so they increase their skills for working with youngest among their beneficiaries
9. NGO's to support individuals living with HIV and AIDS to speak out to the media and other public events. Also, to support people to become AIDS champions (cf. Elton John)

Ensure timely access to HTC and OST

1. Ensure the broad involvement of MARPs and bridge groups to HTC services through removal of personal and systemic barriers, the development of individual motivation to receive services, and the introduction of PITC approach into HTC services provision
2. Ensure continuity of services provision from the stage of address/involvement in HTC to registration of persons with positive results in care in AIDS centres
3. Establish the OST as a backbone of public (free) narcology services and fund its service from the core budgets with initial national funds for medicine

Introduce full access to all essential preventive, treatment and care and support services in the penitentiary system

1. Adjust all HIV (and other BBV)-preventive strategies applied in the community to custodial settings: improve scope and quality, use interactive and peer to peer approaches, involving community services and provide information about HCV and HBV transmissions
2. Make condoms, lubricants and disinfectants available in a low threshold manner, which allows an easy, decent and discrete access for all prisoners
3. Organize the screening of hepatitis with pre- and post test counselling and provide vaccination

4. Increase the number and quality of VCTs, increase access to ART (including clinical monitoring, staff quality and needs forecasting)
5. Improve continuation of ARV at the interface of imprisonment and on release
6. Raise awareness of evidence-based treatment of IDUs, especially OST among management, prison doctors, nurses by close cooperation with community services providing OST
7. Discuss evidence-based harm reduction measures. Start with existing draft order for needle exchange programmes and extension of condom provision in prisons. Introduce PNSP at least in two selected prisons (women, men)

9.4.3 Improve service quality – (re)address protocols and enforce

Review, (re)design, and adequately implement protocols, standards and guidelines:

1. Support and provide incentives for healthcare institutions, social services, NGOs and their staff to improve quality and work with PWIDs in HIV services and underserved PWIDs groups in including through community mobilisation
2. Develop and implement evidence-based national standards and guidelines for FSW programmes and provide tools and other resources to support implementation
3. Develop and implement evidence-based standards for the management of STIs among FSWs
4. Integrate MSM-specific approaches into government and donor protocols
5. Develop and implement protocols for routine HIV testing of male partners of all pregnant women as early in antenatal care as possible to identify discordant couples, and for starting immediate ARV therapy for all HIV+ members of discordant relationships identified in the context of pregnancy
6. Strengthen protocols for the early identification of high-risk pregnant women and integration of oral substitution therapy and other addiction treatment services into antenatal and maternal services
7. Develop and implement protocols for an effective case management system that includes interdisciplinary medical and social monitoring and care for HIV+ women post-partum
8. Establish a priority indicator to track the survival and immune competence of HIV+ mothers at 18 months
9. Introduce a high-quality comprehensive system of internal and external quality control for screenings and of test kits, and control of the safety of blood donation
10. Adopt new HTC Guidelines
11. Ensure provider-initiated HIV testing for patients with diagnosed viral hepatitis B and hepatitis C to HIV testing policy document and in table 1000
12. Review and revise standards of care and support for implementation and integrate PROMS into the standards
13. Rewrite protocols for the administration of pain relief to meet evidence based practice standards and update relevant medical curriculum to include recent research evidence.
14. Consider TG (especially young and adolescent TG) as groups that need protection against discrimination, and integrate services for these groups into programmes targeting IDUs and CSWs (see also 8.1.2)
15. Ensure gender equality while accessing services especially for vulnerable groups subject to harassment and discrimination (see also 8.1.2)

9.5 NEXT STEPS

9.5.1 Generate NAP action plan

Principle: Preparation of the Action Plan will need to be done in a participatory way with WG members/ stakeholders. Feasibility needs to be verified at every step. Only in that way we can expect the plan to reflect a consensus view that is owned by the stakeholders/implementers.

Approach: Prepare the Action Plan along the lines of the bottlenecks and recommendations as presented in this Consolidated Report. Their categorisation reflects the so-called results chain or performance model.

The model shows the logical sequence from inputs (here called output enablers) to outputs, outcome and impact. The model tries to reflect the cause-effect relationship within the system that comprises the health sector, but also the social, judicial, and financial sectors.

Inputs in such a system are regarded as the conditions that need to be created to make higher results in the chain possible. For example, funds are necessary to purchase and distribute drugs, which - once that has been done properly - will enable health providers to use drugs uninterruptedly and this is likely to increase their quality of services and positively contributes to a healthier population.

While outputs really are the tangible deliverables of the interventions (e.g. higher quality of services, or increased outreach to MARPS), outcome is defined beyond these direct outputs and are considered the effects of the interventions. Outcomes in health sector programmes are denoted as risk behaviour of the target groups (MARPS, prisoners, youth, (pregnant) women, etc.) and their health seeking behaviour. Whereas outputs are programme-based results, outcomes are a population-based result.

Impact is the ultimate change in the health status of the population, usually measured by HIV prevalence and AIDS mortality rates.

Activities in the Action Plan should not only be accompanied by a responsible agency, they should also be accompanied by a list of SMART indicators. If this is done for every action, the final programme will have an M&E plan that enables performance measurement at every stage during implementation.

Each action should also have a financial allocation attached to it. Together with the performance indicators, ideally, the programme can be assessed for its efficiency (cost effectiveness). Because all activities are linked to outputs, and outputs are linked to outcomes and impact - evidence will be generated to 'value money' that is inserted in the National AIDS Program. Probably the Ministry of Finance needs to be consulted to find out whether the current financial system would allow and to what extent adaption needs to be made in the expenditure framework of the government.

For the action plan the following categories are proposed:

1. Leadership
2. Human rights protection and gender equality
3. Governance & Support Mechanisms
 - a. Legislation, rules and regulations
 - i. National level
 - ii. Health sector level
 - b. Organisation
 - i. NAP Organisational design and Coordination
 - ii. Planning & monitoring/evaluation
 1. Policies, planning, strategies
 2. M&E systems
 - c. Human resource development
 - d. Procurement and supply management

4. Sustainability (relates to 'Governance and Support Mechanisms')

a. Finances

1. Government funding
2. External funding
3. Social contracting

b. Inefficiencies

1. Allocate - Govt funding priorities
2. Systemic – MoH rules
3. Technical – testing & treatment

5. Services

a. Integration

b. Access, outreach & community level interventions

c. Quality assurance

REFERENCES

1. Artyukh, O., Balakireva, O., Vasylyashko, I., Patrykeyeva, O., et al. (2010) Health and behaviour patterns among school-aged children in Ukraine within the framework of international project "Health Behavior of School-aged Children (HBSC)", ed. O.Balakireva. UNICEF, Ukrainian O. Yaremenko Institute for Social Studies, Kyiv.
2. Artiuh O., Belonosova N., Varban M., Demchenko I., Kostiuchoch M., Matiyash O., Pivovarova N., Pliusch A. «Investigating Causes Influencing Manifestations of Violence»
3. Alistar SS, Owens DK, Brandeau ML (2011) Effectiveness and Cost Effectiveness of Expanding Harm Reduction and Antiretroviral Therapy in a Mixed HIV Epidemic: A Modeling Analysis for Ukraine. *PLoS Med* 8(3): e1000423. doi:10.1371/journal.pmed.1000423
4. Altice, F. and S. Dvoryak (2012). "PUHLSE Survey Results. Presentation February, 2012
5. Abdul-Quader, A., Y. Kruglov, et al. (2012). "Ukraine HIV Data Synthesis Project. Final Report, May 31, 2012."
6. Analysis of the assessment of regions' implementation of Ukraine MOH orders #102 (of 02.25.2008) and #33 (of 02.23.2000), conducted by the Ukrainian AIDS Centre in summer 2012.
7. Assessment of the performance of the TB and HIV Council at the Council of Ministers of AR of Crimea, oblast, Kyiv and Sevastopol City State Administrations
8. All-Ukrainian Network of PLHIV & International HIV/AIDS Alliance in Ukraine (2011). Open appeal to the President of Ukraine Mr. V. Yanukovich on systematic interventions of government authorities into implementation of the programs aimed at fighting HIV/AIDS supported by international donors dated January 21, 2011
9. AIDSTAR-Two. Men having sex with men in Eastern Europe: Implications of a hidden HIV epidemic. Regional analysis report. USAID, 2010.
10. Alliance. Catalyzing Change through Innovation, Partnerships, and Comprehensive Services. Scaling-Up the National Response to HIV/AIDS through Information and Services (SUNRISE) project 2004-2011. Alliance-Ukraine, 2012.
11. ActionAid (2009) Primary Concern. Action Aid London
12. AIDS Consortium UK How-Is-Care-And Support -Being Addressed In the Global AIDS Responses? AIDS Consortium London. aidsconsortium.org.uk accessed 27/10/12
13. AVERT (online) HIV and AIDS in Russia, Eastern Europe and Central Asia. Accessed 14/10/2012 at <http://www.avert.org/aids-russia.htm>.
14. Audit report 2011, Elena Pinchuk ANTIAIDS Foundation (2011): http://www.antiids.org/files/Financial_statement/ANTIAIDS_Foundation_FS_2011_rus.pdf
15. Balakireva O.N., Bondar T.V. et al 2012, Instructional guidance materials on the operation of centres of social services for at-risk families, children and youth /. - USAID|HIV/AIDS Service Capacity Project in Ukraine.
16. Bordunis T.A., 2011 - Analysis of the legal and regulatory framework on support for children and young people who live and work on the street, homelessness and neglect prevention in Ukraine. - USAID | HIV/AIDS Service Capacity Project in Ukraine.
17. Bobrovsky L., Bokova L., et al. (2011) Ukraine harmonized AIDS response progress report (Reporting period: January 2010 – December 2011): K.: ICF "International HIV/AIDS Alliance in Ukraine", 2012. – 240 p.
18. Berleva, G.O., Dumchev, K.V., et al (2010). Estimation of the Size of Populations Most-at-Risk for HIV Infection in Ukraine in 2009. Analytical Report based on sociological study results. International HIV/AIDS Alliance in Ukraine.

19. Berleva GO, Dumchev KV, Kobyshcha YV, Paniotto VI, Petrenko TV, Saliuk TO, Shvab IA. Analytical report based on sociological study results: Estimation of the size of populations most-at-risk for HIV infection in Ukraine in 2009. Kyiv, Ukraine: ICF International HIV/AIDS Alliance in Ukraine, 2010.
20. Beyrer, Chris, Andrea Wirtz, Damian Walker, Benjamin Johns, Frangiscos Sifakis, and Stefan D Baral. The Global HIV Epidemics among Men Who Have Sex with Men. Washington DC: WHO, 2011.
21. Bailey H, Townsend C, Semenenko I, Malyuta R, Cortina-Borja M, Thorne C 2012. Impact of expanded access to combination antiretroviral therapy in pregnancy: results from a cohort study in Ukraine. Unpublished.
22. Bolshov Y.S, Kosyanchuk M.G., Leshchynsky Y.B., Trofymenko L.V., Shvab I.A. (2012) Monitoring of Behaviours and HIV Prevalence among Men Having Sex with Men as the Second Generation Component of HIV Epidemiological Surveillance (Analytical report upon the results on bio-behaviour research conducted in 2011)(<http://www.aidsalliance.org.ua/ru/library/our/2012/me/msm2011.pdf>)
23. Blatchford, K. and Gash,T. 2012 Commissioning For Success :How To Avoid The Pitfalls of Open Public Services. Institute for Government. London
24. British Council Kyiv. 2012 Social enterprise development project British Council <http://www.britishcouncil.org/ukraine-projects-social-enterprise-development-outline-2012.htm> accessed 27/10/12 <http://www.centreforsocialjustice.org.uk/client/downloads/Couldn't%20Care%20Less%20Report%20WEB%20VERSION.PDF>
25. Budget Code of Ukraine, recent version of 2010, as amended <http://zakon1.rada.gov.ua/laws/show/2456-17>
26. Crago A-L., Rakhmetova A., Shields A. Police violence against sex workers in eleven countries in Europe and Central Asia. In Research for Sex Work: Issue 12. Edinburgh, Scotland: Network of Sex Work Projects, 2010.
27. CDC. "Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services." Morbidity and Mortality Weekly Report 54, no. RR02 (2005).
28. CDC. "Interim Guidance: Preexposure Prophylaxis for the Prevention of HIV Infection in Men who Have Sex with Men." Morbidity and Mortality Weekly Report 60, no. 3 (2011).
29. Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N, et al 2011. Prevention of HIV-1 infection with early antiretroviral therapy. NEJM;365:493-505.
30. Cowley P. and Baktygul A. (2012) Feasibility Study: Integration of Services into the Health System of Ukraine. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc. (Cowley Peter and Baktygul Akkazieva. September 2012. Feasibility Study: Integration of Services into the Health System of Ukraine. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.) (http://www.healthsystems2020.org/files/92804_file_Ukraine_Feasibility_Assessment_FINAL.pdf)
31. Capacity assessment of National TB/HIV Council of Ukraine (July 2009 – June 2010). Analytical report. Kyiv 2010. – USAID| HIV/AIDS Service Capacity Project in Ukraine.
32. CPT (2011). "Report to the Ukrainian Government on the visit to Ukraine carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 9 to 21 September 2009. <http://www.cpt.coe.int/documents/ukr/2011-29-inf-eng.pdf>. Accessed 26 September 2012."
33. Comprehensive External Evaluation of the National AIDS response in Ukraine: Consolidated Report, January 2009.
34. Concept for executive authorities to support the development of civil society in Ukraine, adopted with the CMU Directive as of November 21, 2007, N1035-p, <http://zakon2.rada.gov.ua/laws/>

show/1035-2007-%D1%80

35. Concept of the social service system reform, adopted with the CMU Directive as of April 13, 2007, N178-p, <http://zakon2.rada.gov.ua/laws/show/178-2007-%D1%80>
36. Criteria for the selection of tender proposals regarding the raising of budget funds for social services delivery, approved with the order of the Ministry of Labor and Social Policy (now – Ministry of Social Policy) as of 07.27.2004 N 165, registered with the Ministry of Justice of Ukraine on September 06, 2004, Ref. 1099/9698, <http://zakon1.rada.gov.ua/laws/show/z1099-04>
37. Comprehensive External Evaluation of the National AIDS Response in Ukraine [unspecified author] (2009).
38. Country Report Task Force for the adoption of lists of issues on Ukraine (2012). "Report from: International HIV/AIDS Alliance in Ukraine; Canadian
39. CPT (2011a): Report to the Ukrainian Government on the visit to Ukraine carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 29 November to 6 December 2011; <http://www.cpt.coe.int/documents/ukr/2012-30-inf-eng.htm>
40. CPT (2012). "Preliminary observations made by the delegation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which visited Ukraine from 29 November to 6 December 2011 and response of the Government of Ukraine to three issues raised by the delegation. <http://www.cpt.coe.int/documents/ukr/2012-08-inf-eng.pdf>. Accessed 26 September 2012."
41. Demchenko, I L, et al. Evaluating an Impact from Group Forms of Work under Projects on HIV Prevention among MSM; Operational Survey Brief Results. Kyiv: HIV/AIDS Alliance in Ukraine, 2012.
42. Dvoriak, S., Dumchev, K., Woody, G., Trofimchenko, I., Altice, FL. (2012) Methadone Maintenance Therapy Decreases HIV Seroconversion in Ukraine. Poster Presentation at the International AIDS Conference. July 2012, Washington D.C.
43. Draft National strategy of Ukraine on Narcotic Drugs (until 2020), developed by the State Service of Ukraine for Drug Control and the National Academy of Legal Sciences of Ukraine with support of the International Charitable Renaissance Foundation - <http://narko.gov.ua/komnarko/uk/publish/article/95638>
44. Elo O (team leader). Comprehensive External Evaluation of the National AIDS Response in Ukraine: Consolidated Report, January 2009. UNAIDS Ukraine, 2009.
45. EHRN (2009) Young People and Injecting Drug Use in Select Countries of Central and Eastern Europe. Vilnius: Eurasian Harm Reduction Network.
46. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2011). Annual report 2011: the state of the drugs problem in Europe. Luxembourg: Publications Office of the European Union, 2011
47. EMCDDA and Ukrainian Medical & Monitoring Center of Alcohol and Drugs of the Ministry of Health of Ukraine (2011). "National report on the drug situation (data 2010) for the European Monitoring centre for Drugs and Drug Addiction. [http://www.damonitoring.net.ua/file/NATIONAL%20DRUG%20REPORT\(eng-FIN\).pdf](http://www.damonitoring.net.ua/file/NATIONAL%20DRUG%20REPORT(eng-FIN).pdf). Accessed 27 September 2012."
48. Education and technical development work of the Department for infectious diseases at the NMAPE named after Shupyk <http://kmapo.edu.ua/ua/faculties/fack/rrrrijlkhuiln>
49. Forostynaya, E., and Dumchev, K. (2009). Assessment of accessibility of comprehensive health and social services for injecting drug users (IDUs) in integrative care centers.
50. Finnerti E., Kostenko N., Tripathi V, King E. (2011) Bringing Policy to Practice: Research on the Procedure of HIV Testing among Pregnant Women in Ukraine (http://www.healthright.org.ua/sites/default/files/case_study_report_ukr.pdf)

51. Format for Citations of Documents Annual report 2010, International HIV/AIDS Alliance: http://www.aidsalliance.org.ua/ru/library/our/finalreport/pdf/ar_2010_ukr_preview.pdf
52. FSW as a Factor of Increased Risk of Exposure to HIV”, Operational Survey: Brief Results. Kyiv, Ukraine: ICF International HIV/AIDS Alliance, 2012.
53. Goodwin, R., Kozlova, A., Nizharadze, G., and G. Polyakova (2004) HIV/AIDS among adolescents in Eastern Europe: Knowledge of HIV, social representations of risk, and
54. Grushetsky A. (2012) Monitoring of Behaviours and HIV Prevalence among Sex Workers as the Second Generation Component of HIV Epidemiological Surveillance (Analytical report upon the results on bio-behaviour research conducted in 2011) (<http://www.aidsalliance.org.ua/ru/library/our/2012/me/csw2011.pdf>)
55. Hillis, S., Zapata, L., Robbins, C., Kissin, D., Skipalska, H., Yorick, R., Finnerty, E., Marchbanks, P. and D. Jamieson. (2012) HIV seroprevalence among orphaned and homeless youth: no place like home. *AIDS*. 26(1)105-10.
56. Heijman, Titia, Ronald B Gekus, Udi Davidovich, Roel A Coutinho, Maria Prins, and Ineke G Stolte. “Less decrease in risk behaviour from pre-HIV to post-HIV seroconversion among MSM in the combination antiretroviral therapy era compared with the pre-combination antiretroviral therapy era.” *AIDS*, 2012: 489-495.
57. Heuker, Jose, Gerard J.B. Sonder, Ineke Stolte, Ronald Gekus, and Anneke van den Hoek. “High HIV incidence among MSM prescribed postexposure prophylaxis, 2000-2009: indications for ongoing sexual risk behaviour.” *AIDS*, 2012: 505-512.
58. HIV in Ukraine. Newsletter #37. – State Service of Ukraine on HIV/AIDS and Other Socially Dangerous Diseases; Ukrainian Centre for AIDS Prevention of MOH of Ukraine”; Institute of Epidemiology and Infectious Diseases named after L.V. Hromashevskiyi (National Academy of Medical Sciences of Ukraine)” - M. – 2012
59. Human Rights Council (2008). Eighth session, Agenda item 6, Universal Periodic Review, Report of the Working Group on the Universal Periodic Review, Ukraine, A/HRC/8/45, 3 June 2008
60. HIV-infection in Ukraine. Information bulletins NN 31-38, Kyiv, 2009-2012
61. Harm Reduction International. (2012a) The Global State of Harm Reduction 2012. Edited Claudia Stoicescu. London: HRI. http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf
62. Harm Reduction International (2012b) “Injecting drug use among children and the child’s right to health. London: HRI.
63. http://www.ohchr.org/Documents/Issues/Children/Study/RightHealth/Harm_Reduction_International.pdf
64. HIV/AIDS 2012-2015. Available from: <http://www.euro.who.int/__data/assets/pdf_file/0011/153875/e95953.pdf>, [20 August 2012].
65. HIV/AIDS Legal Network; Eurasian Harm Reduction Network.”
66. Izenberg, J., C. Bachiredy, et al. (2012). “Incidence and impact of police harassment and unofficial detention among HIV-positive individuals recently released from prison in Ukraine. Poster presented at the XIX International Aids Conference July 22 - 27 Washington DC USA.”
67. International HIV/AIDS Alliance in Ukraine (2012). Programme monitoring data for HIV prevention work among key populations 2008-2012 (provided in a set of files)
68. International HIV/AIDS Alliance in Ukraine. “Social Work with People Practicing Same-Sex Relationships. Theory. Methodology. Best Practice.” <http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/lgbt09/zvit.htm>, 2009.
69. International HIV/AIDS Alliance in Ukraine. Behavioural monitoring and HIV infection prevalence among female sex workers as a component of second generation surveillance – Analytical report

- based on results of 2009 survey among FSW. Kyiv, Ukraine: ICF International HIV/AIDS Alliance in Ukraine, 2010.
70. International HIV/AIDS Alliance. Summary Report of ICF "International HIV/AIDS Alliance in Ukraine" on progress in implementing "Support for HIV/AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine" Programme supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (for the first six months of 2011). Kyiv, Ukraine: ICF International HIV/AIDS Alliance, 2011.
 71. ICPS (2012). "World Prison Brief Ukraine. http://www.prisonstudies.org/info/worldbrief/wpb_country_print.php?country=168. Accessed 24. September 2012."
 72. IFSW 2000 Definition of social work <http://ifsw.org/policies/definition-of-social-work/>
 73. Judice, N., Zaglada, O., and R. Mbuya-Brown (2011) HIV Policy Assessment: Ukraine. Washington DC: Futures Group, Health Policy Project. http://ukraine.usaid.gov/sites/default/files/ukraine_policy_assessment_final_7_18_11_acc.pdf
 74. Judice, N., O. Zaglada, and R. Mbuya-Brown. (2011). HIV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project.
 75. Justice J, Drew R, & Lee S 2004. Review of the national program to prevent mother-to-child transmission of HIV/AIDS in Ukraine. The Population Technical Assistance Project & USAID, Available from: < http://pdf.usaid.gov/pdf_docs/PDACA196.pdf>, [20 August 2012].
 76. Justice N 2011. HIV policy assessment: Ukraine, USAID, Available from: <http://ukraine.usaid.gov/sites/default/files/ukraine_policy_assessment_final_7_18_11_acc.pdf>,[20 August 2012].
 77. Joint order of the Ministry for Family, Youth and Sports, MOH, Ministry of Labor and Social Policy as of 09.13.2010 N 3123/275/770 (registered with the Ministry of Justice of Ukraine on October 8, 2010 Ref. 903/18198 "On approving the standards of social services to be delivered to most at-risk populations" <http://zakon2.rada.gov.ua/laws/show/z0903-10>
 78. Kotova V., 2010, HIV positive children: medical care, psychological support, social services, legal protection - UNICEF, State Social Service for Family, Children and Youth. Available at: <http://www.hopeandhomes.org.ua/files/7/b/7b51622-doglyad-infikovani.pdf>
 79. Kiselev, V., Ovcharenko-Fedorov, M., Plevako, O., Polschikova, E., Sira, O., Tilikina, N., Shulga, L (2011). Evaluation of the Models of Secondary Injecting Equipment Exchange among Hard-to-Reach Groups of IDUs. International HIV/AIDS Alliance in Ukraine
 80. Kasianczuk, Maxim G, Lisa Grazina Johnston, Anna V Dovbakh, and Eugeny B Leszczynski. "Risk Factors Associated with Condom Use Among Men Who Have Sex with Men in Ukraine." *Journal of LGBT Health Research* 5 (2009): 51-62.
 81. Kiriazova T., Postnov O., 3, Perehinets I., Neduzhko O. (2012) Association of Injection Drug Use and Late Enrollment in HIV Medical Care in Odessa Region, Ukraine. "HIV in Europe" Copenhagen 2012 Conference: abstract book (<http://www.hiveurope.eu/LinkClick.aspx?fileticket=ckK9ISwZ9vA%3d&abid=115>)
 82. Kryvoruk, A. (2012). "Overview of the state of medical services provision for inmates living with HIV within the penitentiary institutions and detention facilities of the State Penitentiary Service of Ukraine. Power point presentation Kherson, April 2012."
 83. Lillie, T. (2012) Community Mobilization and the Six Programmatic Areas Outlined in the 'Towards an improved investment approach for an effective response to HIV/AIDS'. Rapid Literature Review
 84. Law of Ukraine "On social services", as amended, <http://zakon1.rada.gov.ua/laws/show/966-15>
 85. List of social services to be provided to individuals who face complicated life circumstances and can not overcome them on their own (order as of 09.03.2012 № 537, registered with the Ministry of Justice of Ukraine on September 19, 2012 № 1614/21926, <http://zakon2.rada.gov.ua/laws/show/z1614-12>

86. Maksymenko, E. (2009) Evaluation of Gender Sensitive Approaches to HIV Prevention & Harm Reduction Interventions Among IDUs. ICF International HIV/AIDS Alliance in Ukraine
87. Mimiaga MJ, Safren SA, Dvoryak S, Reisner SL, Needle R, Woody G. (2010) "We fear the police, and the police fear us": Structural and individual barriers and facilitators to HIV medication adherence among injection drug users in Kiev, Ukraine. *AIDS Care*. 2010 Nov;22(11):1305-13.
88. Montaner, J. (2012) Reprogramming of grants in Ukraine away from harm reduction services and to HIV treatment. Letter to the Global Fund August 9, 2012
89. Mburu, G. (2011). "TB and HIV in Ukraine: a wake-up call. <http://blog.aidsalliance.org/2011/04/tb-and-hiv-in-ukraine-a-wake-up-call/>. Accessed 1. October 2012."
90. McNair, Ruth P, and Kelsey Hegarty. "Guidelines for the Primary Care of Lesbian, Gay, and Bisexual People: A Systematic Review." *Annals of Family Medicine*, 2010: 533-541.
91. Martsynovskaya V 2012. Presentation: Prevention of mother-to-child HIV transmission in Ukraine in 2011 PMTCT issues at national and regional levels, Ukrainian AIDS Centre under MoH Ukraine Institute of the infection diseases n.a. Gromashevsky AMS. Unpublished presentation.
92. Martsynovska V.A. (2012) Presentation of the Results of Report "Prevention of HIV MTCT in 2011," Identification of Urgent Problems in PMTCT Sector at the National and Regional Levels
93. MOH of Ukraine, Ukrainian AIDS Prevention and Control Center, SI "Institute of Epidemiology and Infectious Diseases named after L.V. Gromashevsky", at AMS Ukraine, Central Sanitary and Epidemiological Station of the MOH of Ukraine, Kyiv City AIDS Prevention and Control Center (2012). HIV Infection in Ukraine. Information Bulletin № 37. Kyiv.
94. MoH of Ukraine, Ukrainian AIDS Prevention and Control Center, SI "Institute of Epidemiology and Infectious Diseases named after L.V. Gromashevsky", at AMS Ukraine, Central Sanitary and Epidemiological Station of the MOH of Ukraine, Kyiv City AIDS Prevention and Control Center (2009). HIV Infection in Ukraine. Information Bulletin № 31. Kyiv.
95. MOH of Ukraine 2007a. On approval of the clinical protocol on obstetric care "Prevention of mother-to-child transmission of HIV," Order №716.
96. MOH of Ukraine 2012. Ukraine harmonized AIDS response progress report, Reporting period: January 2010- December 2011, UNAIDS. Available from: <[http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_UA_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_UA_Narrative_Report[1].pdf)>, [20 August 2012].
97. MHC of Ukraine (2012) HIV infection in Ukraine: Informational Bulletin No 38 (<http://ukraids.gov.ua/index.php/uk/diyalnist-centru/epidemiologiya/epidnaglyad/rutynnyi-epidnaglyad>)
98. MHC of Ukraine (2012) Report on the Results of Monitoring and Efficiency of Activities to Prevent HIV in Ukraine during 2011
99. MHC of Ukraine (2012) Order No 97 of 9 February 2012 "On Approving National Monitoring Plan and Assessing the Implementation of National Programme for the Prevention of HIV-Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients 2009-2013" (http://moz.gov.ua/ua/portal/dn_20120209_97.html)
100. MOH of Ukraine, Inter-Agency Working Group on the Development of the National Operating Plan. National Operational Plan on AIDS of Ukraine, 2011-2013. Kyiv, Ukraine: Ministry of Health of Ukraine, 2010.
101. MOH Order # 230 as of April 17, 2006 "On establishing a Reference Laboratory under the Ukrainian Centre for AIDS prevention under the MOH of Ukraine" http://moz.gov.ua/ua/portal/dn_20060417_230.html
102. MOH Order # 749 as of October 19, 2009 "On approval and introduction of the education curriculum for training specialists of the "Specialist" Degree in the "Medical Doctor" Qualification at the higher education facilities of the 4th Accreditation Level in specialties "therapeutic operations", "pediatrics"

- and "medicine and prevention operations" http://www.moz.gov.ua/ua/portal/dn_20091019_749.html
103. Nielsen G., Myronyuk, I. External Evaluation of Availability of Services for Diagnosis, Treatment and Case Management of Sexually Transmitted Infections among Most-At-Risk Populations in Ukraine under the Global Fund-Supported Program. International HIV/AIDS Alliance in Ukraine, Nov 2011
 104. Nesheim S, Taylor A, Lampe MA, Kilmarx PH, Fitz Harris L, Whitmore S, Griffith J, Thomas-Proctor M, Fenton K & Mermin J 2012. 'A Framework for Elimination of Perinatal Transmission of HIV in the United States,' *Pediatrics*, vol. 130, iss. 4. Available from: <<http://pediatrics.aappublications.org/content/early/2012/08/28/peds.2012-0194>>, [18 September 2012].
 105. "National program to prevent HIV, provide treatment, care and support for HIV positive people and AIDS patients for 2009-2013". 2011-2013 National operational plan for the Approved by the National TB and HIV/AIDS Council on 07.01.2010.
 106. National Council to Fight Tuberculosis and HIV/AIDS (2010). Proposal to the Global Fund Round 10. (Global Fund's ID: R10_CCM_UKR_H_PF_s1-2_20Aug10_En)
 107. National AIDS Committee. "National Composite Policy Index." 2010.
 108. National Council. "Global Fund Round 10 Application." 2010.
 109. National Council. "Global Fund Round 6 Application." 2006.
 110. National AIDS Trust 2012. HIV social care in England a survey of local funding NAT. London.
 111. National AIDS Programme <http://www.unaids.org.ua/hiv/response/programm>
 112. NEF (2008) Co production A Manifesto for Growing the Core Economy. New Economics Foundation London.
 113. Nash Mir. "One Step Forward, Two Steps Back: Situation of LGBT in Ukraine in 2010-2011." Kyiv, 2011.
 114. Opiyo,P, Yamona,T,Jayne,TS 2008. HIVA and Home Based Health Care. International Journal for equity in health <http://www.equityhealthj.com/content/7/1/8> accessed 13/10/2012
 115. "Organization of implementation of a grant awarded by the Global Fund to Fight AIDS, Tuberculosis and Malaria", approved by the Ukrainian AIDS Centre (order #138-3, 11.01.2011).
 116. Operational information of officially registered HIV-positive Ukrainian citizens: State service of Ukraine on HIV/AIDS and other dangerous social diseases (July 2012): <http://dssz.gov.ua/index.php/uk/operatyvna-informaciya/1067-222>
 117. Open Society Institute (2010). "Making harm reduction work for women: The Ukrainian experience. Assessment in action series. http://www.soros.org/sites/default/files/harm-reduction-women-ukraine_20100429.pdf. Accessed 25 September 2012."
 118. Office of Fair Trading (OFT) 2010 Choice and Competition in Public Services. London
 119. Pylypchuk, R. and C. Marston (2008) Factors associated with sexual risk behavior among young people in Ukraine. *Central European Journal of Public Health*. 16(4): 165-74.
 120. Pohorila, N., Taran, Y., Kolodiy, I., Diyeva, T. (2010). Behavior monitoring and HIV-infection prevalence among injection drug users. Analytical report based on results of linked survey. Kyiv, 2010.
 121. Plan of activities aimed at implementing the Concept of state policy on preventing drug addiction, illicit traffic in narcotic drugs, psychotropic substances and precursors in 2011-2015.
 122. Programme for secondary schools on basic of health: for grades 5-9 2005, "Perun", Kyiv, 48
 123. Pinkham, S. (2010). Women and Drug Policy in Eurasia. Eurasian Harm Reduction Network
 124. Procedure for the development of the social service state standard (approved with the order of the Ministry of Social Policy on 05.16.2012 № 282 (registered with the Ministry of Justice of Ukraine on June 01, 2012 Ref. № 876/21188), <http://zakon2.rada.gov.ua/laws/show/z0876-12>

125. Procedure for the selection of programs (projects, activities), developed by CSOs and creative teams, for the implementation of which financial support is provided, approved with the CMU Directive as of October 12, 2011, N 1049, <http://zakon1.rada.gov.ua/laws/show/1049-2011-%D0%BF>
126. Patient Reported Outcomes Measurement Group (2012) University of Oxford <http://phi.uhce.ox.ac.uk/home.php>
127. Ross, D., Dick, B., and J. Ferguson (eds) (2006) Preventing HIV/AIDS in Young People. Geneva: WHO. http://www.who.int/maternal_child_adolescent/documents/trs_938/en/index.html
128. Richens J., Mircea B. Report of the mission to assess availability of and access to STI services for most at risk and vulnerable populations in Ukraine. WHO Country Office in Ukraine and All-Ukrainian Network of PLWH. Kyiv, Ukraine. 2009.
129. Recommendations from parliamentary hearings on the young people situation in Ukraine “Youth for a healthy lifestyle”, approved by Verhovna Rada enactment #2992-VI of February 3, 2011.
130. Recommendations from parliamentary hearings on: “Legislation and actual child rights situation in Ukraine”, approved by Verkhovna Rada enactment #3189-VI of April 5, 2011.
131. Report on financial expenditures on HIV/AIDS program for 2009, 2010 and 2011, provided by State Service of Ukraine on SDD.
132. Report on the outcome of the legal analysis of the current legislation that governs personnel development in the sphere of HIV-infection/AIDS in Ukraine (project). Ukrainian AIDS Centre, Kiev, 2012
133. Reports on implementation of the National Program on HIV-infection prevention, treatment, care and support for HIV-infected and people with AIDS in 2009-2013. Ukrainian Centre for AIDS prevention under the MOH, 2010 – 2012.
134. Reports on the implementation of Program activities and Program spending in 2009, 2010 and 2011, furnished by the State Service on Social Diseases.
135. Regulations for the tenders to raise budget funds for social services delivery, approved with the CMU Directive as of April 29, 2004, N 559 <http://zakon1.rada.gov.ua/laws/show/559-2004-%D0%BF>
136. Smyrnov, P., Broadhead, R., Datsenko, O., and O. Matiyash (2012) Rejuvenating harm reduction projects for injecting drug users: Ukraine’s nationwide introduction of peer-driven interventions. *International Journal of Drug Policy*. 23(2): 141-7.
137. Schwartlander, B., Stover, J. et al. (2011) towards an improved investment approach for an effective response to HIV/AIDS. *The Lancet*, Volume 377, Issue 9782, Pages 2031 - 2041, 11 June 2011
138. Shields, A. (2009) The Effects of Drug User Registration Laws on People’s Rights and Health: Key Findings from Russia, Georgia, and Ukraine. International Harm Reduction Development Program of Open Society Institute. October 2009
139. Shulga, L., Varban, M. et al. (2010). Research on behaviour and HIV prevalence among injecting stimulant users. Summary of the operational study findings, ICF “International HIV/AIDS Alliance in Ukraine”
140. Shulga, L., Tokar, A., Smirnov A., Dvinskykh, N. (2011) Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users
141. Shulga L., Tokar A., Smirnov A., Dvinskykh N. Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users. Kyiv, Ukraine: ICF International HIV/AIDS Alliance, 2011.
142. Steen R, Vuylsteke B, DeCoito T, Ralepeli S, Fehler G, Conley J, Bruckers L, Dallabetta G, Ballard R. Evidence of declining STD prevalence in a South African mining community following a core-group intervention. *Sex Transm Dis*. 2000 ; 27:1-8.
143. Saxton J, Malyuta R, Semenenko I, Pilipenko T, Tereshenko R, Kulakovskaya E, Adejnova I, Kvasha L

- & Thorne C 2010. 'Previous reproductive history and post-natal family planning among HIV-infected women in Ukraine' *Human Reproduction*, vol.00, iss.0, pp. 1–8.
144. Strategy for sustainable training and continued education of human resources in the sector of HIV-infection / AIDS response in Ukraine (draft). State Service of Ukraine on socially dangerous diseases, 2012.
 145. Sexual activity among school children and homeless adolescents in Russia, Georgia and Ukraine. *Journal of Health Psychology* 9(3): 381-396.
 146. State Penitentiary Service of Ukraine (2009). "Program for HIV Prevention, Treatment, Care and Support to HIV-Infected People and AIDS Patients at the penitentiary institutions and remand prisons of the State Criminal Execution System of Ukraine for 2007–2013 (Approved at the meeting of the State Department of Ukraine for Execution of Sentences on 24.04.2009).".
 147. State Service of Ukraine on Combating HIV/AIDS and other Socially Dangerous Diseases (2012) National Assessment on HIV/AIDS in Ukraine as of Beginning of 2012
 148. State Institute for Family and Youth Development 2009 Summary of the Care and Support component Evaluation research. AUN Power point presentation. Kyiv.
 149. Social Enterprise Europe What is social enterprise. <http://www.socialenterpriseurope.co.uk/pages/what-is-social-enterprise.php> accessed 21/10/12
 150. Social Enterprise London 2011 Spin Out And Deliver. SEL. London
 151. State Service Order # 35 as of March 26, 2012 "On establishing the working group on human resource planning and development in the sector of HIV-infection / AIDS response in Ukraine". <http://dssz.gov.ua/index.php/uk/robochi-grupy/376-vil-snid/grupa-5/oficijni-documenty-5/898-qq>.
 152. Strategy of the social service system reform, adopted with the CMU Directive as of August 08, № 556-p <http://zakon1.rada.gov.ua/laws/show/556-2012-%D1%80>
 153. Strategy of the state policy to enhance the development of civil society in Ukraine and immediate activities of the strategy implementation, adopted with the Decree of the President of Ukraine as of March 24, 2012, № 212/2012, <http://zakon2.rada.gov.ua/laws/show?nreg=212%2F2012&find=1&text=%B3%ED%F1%F2%E8%F2%F3%F2&x=11&y=4>
 154. State Service of Ukraine on Drug Control. ПРОЕКТ НАЦІОНАЛЬНОЇ СТРАТЕГІЇ УКРАЇНИ ЩОДО НАРКОТИКІВ (НА ПЕРІОД ДО 2020 РОКУ) 15.05.2012, accessed at <http://narko.gov.ua/komnarko/uk/publish/article/95638>
 155. I.A.Tovkach. Presentation "Organizational and methodological support for regional AIDS centres" // Meeting of head physicians of AIDS centres, Uzhgorod, September 17-19, 2012.
 156. Taran, Y., Johnston, L., Pohorila, N., and T. Saliuk. (2011) Correlates of HIV risk among injecting drug users in sixteen Ukrainian cities. *AIDS and Behavior*. 15(1):65-74.
 157. Tolopilo, A. and Vlasenko, L. (2008) Drug User Registration: Practices, Consequences, and the Future.
 158. Thorne, C., Semenenko, I., Pilipenko, T., Malyuta, R., and the Ukraine European Collaborative Study Group (2009). Progress in prevention of mother-to-child transmission of HIV infection in Ukraine: results from a birth cohort study. *BMC Infectious Diseases* 2009, 9:40. <http://www.biomedcentral.com/1471-2334/9/40>
 159. Teltschik A., Sakovych O., Poutiainen R., Balakireva O. Adolescent female sex workers in Ukraine – discriminated against and excluded: evidence-based service provision and empowerment. Draft Manuscript. UNICEF, Ukraine, 2012.
 160. Teltschik, Anja, Olga Balakireva, Yuliya Sereda, Tetiana Bondar, and Olena Sakovych. MOST-AT-RISK Adolescents: the evidence base for strengthening the HIV response in Ukraine. Kyiv: UNICEF, 2008.
 161. Tarantino L, Chankova S, Rosenfeld J, Routh S & Preble, E 2011. Ukraine Health System Assessment 2011. USAID. Available from: <<http://www.healthsystems2020.org/content/resource/>

- detail/82461/>, [20 August 2012].
162. Taylor A, Little K, Zhang X 2012. Estimated Perinatal Antiretroviral Exposures, Cases Prevented and Infected Infants in the Era of Antiretroviral Prophylaxis in the US. In: Conference on Retroviruses and Opportunistic Infections. Boston, MA. Abstract T103. Available from: <<http://www.retroconference.org/2012b/PDFs/1000.pdf>>
 163. Thorne C, Semenenko I & Malyuta, R 2012a. Prevention of mother-to-child transmission of human immunodeficiency virus among pregnant women using injecting drugs in Ukraine, 2000–10, *Addiction*, vol. 107, iss. 1, pp. 118-28.
 164. Thorne C, Malyuta R & Semenenko I 2012b. Report on injecting drug use in pregnant HIV-positive women in Ukraine: data from the Ukraine European Collaborative Study and the Cohort Study of HIV-infected childbearing women. Unpublished report.
 165. Thorne C, Semenenko I, Pilipenko T, & Malyuta, R 2009. Progress in prevention of mother-to-child transmission of HIV infection in Ukraine: Results from a birth cohort study, *BMC Infectious Diseases* vol. 9, iss. 40, pp. 1-10.
 166. The Joint UN Programme of Support on AIDS 2012. JPS 2012-2016, UNAIDS Ukraine, Available from: <www.unaids.org.ua/files/JPS_Booklet_.pdf>, [20 August 2012].
 167. The Law of Ukraine 2009. On approval of the State Program to ensure HIV prevention, treatment, care, and support to HIV positive people and patients with AIDS for years 2009-2013, Order № 1026-VI.
 168. Terrence Higgins Trust website information <http://www.tht.org.uk/our-charity/Campaign/Our-social-policies/Stigma-and-discrimination> accessed 13/10/12.
 169. The state HIV-AIDS programme for 2009-13 narrative En. PDF
 170. The PLWA Stigma Index 2009 Give Stigma The Index Finger. GNP and ICW and IPPF and UNAIDS
 171. TOR for Social Contracting, approved with the resolution of the session of the Odessa oblast council on May 20, 2011 № 137-VI, <http://region.odessa.gov.ua/Webpage.aspx?sect=Page&IDPage=35603&id=462>
 172. TOR for the Ministry of Social Policy of Ukraine, as amended, approved with the Decree of the President of Ukraine, as of April 06, 2011, № 389/2011, <http://zakon1.rada.gov.ua/laws/show/389/2011/paran31#n31>
 173. UNAIDS (2003) AIDS Epidemic Update 2003 Geneva: UNAIDS.
 174. UNICEF (2010) Blame and Banishment: The Underground HIV Epidemic Affecting Children in Eastern Europe and Central Asia. Geneva: UNICEF.
 175. Uchtenhagen, A., Schaub, M. (2010). Final Monitoring and Evaluation Report on Opioid Substitution Treatment in Ukraine. Report on 3 rounds of OST monitoring and evaluation in Ukraine. June 08, 2010
 176. UNAIDS. "Comprehensive External Evaluation of the National AIDS Response in Ukraine, Consolidated Report." 2009.
 177. UNAIDS. "Country ownership for a sustainable AIDS response: from principles to practice." 2012.
 178. UNDP. Identification of the Needs of Men who have Sex with Men in Essential HIV/AIDS Prevention, Treatment, Care and Support Services: Summary of the Analytical Report. UNDP Ukraine, 2010.
 179. UNAIDS. 2009b AIDS Palliative Care UNAIDS Geneva
 180. UNAIDS 2009a Comprehensive External Evaluation of the National AIDS response in Ukraine. UNAIDS Kyiv
 181. UNAIDS 2012 Ukraine Harmonized AIDS response Progress Report. UNAIDS Kyiv.
 182. UNAIDS 2010 OutLook Special section State of the AIDS response

183. USAID (2011) HIV Policy Assessment: Ukraine (http://ukraine.usaid.gov/sites/default/files/ukraine_policy_assessment_final_7_18_11_acc.pdf)
184. UNAIDS (2009). "Comprehensive External Evaluation of the National AIDS Response in Ukraine. Consolidated Report. <http://www.unaids.org.ua/hiv/response/programm/evaluation>. Accessed 26 September 2012."
185. UNAIDS (2009). "Comprehensive External Evaluation of the National AIDS Response in Ukraine. Executive Summary and Key Recommendations. <http://www.unaids.org.ua/hiv/response/programm/evaluation>. Accessed 26 September 2012."
186. UNAIDS (2011). "A new investment framework for the global HIV response. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2244_InvestmentFramework_en.pdf. Accessed 23. November 2012."
187. UNAIDS (2012). "2012 Progress reports submitted by countries, Ukraine harmonized Aids response Progress Report <http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/> Accessed 27 September 2012."
188. UNAIDS (2012). "Together we will end AIDS http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/20120718_togetherwewillendaids_en.pdf. Accessed 27 September 2012."
189. UNAIDS 2011a. Countdown to zero. Available from: <http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-elimination-Hiv-Children_en.pdf> [18 September 2012].
190. UNAIDS 2011b. Global HIV/AIDS response: epidemic update and health sector progress towards universal access, 2011. Available from: <http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130_UA_Report_en.pdf>
191. UNAIDS Ukraine 2009. Comprehensive external evaluation of the national AIDS response in Ukraine: Consolidated report, UNAIDS Ukraine. Available from: <http://www.un.org.ua/files/20090522_ee_en_5.pdf>, [20 August 2012].
192. UNDG 2011. MDG acceleration framework: Operational note, United Nations. Available from: <www.undg.org/index.cfm?P=1505>, [20 August 2012].
193. UNICEF Ukraine 2012. PMTCT and improving neonatal outcomes among drug-dependent pregnant women and children born to them in three cities of Ukraine pilot project, UNICEF Ukraine, [20 August 2012].
194. UCSF Global health Sciences 2012 Ukraine Triangulation Updated Analysis Power point for MAF assessment Kyiv
195. Ukrainian AIDS Prevention and Control Center. HIV Infection in Ukraine: Information Bulletin № 33, 2010. Kyiv, Ukraine, 2010.
196. Ukrainian AIDS Center. "National HIV/AIDS Estimates in Ukraine as of beginning of 2012." Kyiv, 2012.
197. Ukrmetrstatstandard (2011) Programme of Inter-Laboratory Comparisons of Screening Results: Antibodies to HIV.
198. Ukrainian Centre for Prevention and Combating AIDS (2010) Information about the Results of Field Visits to Study Reasons of Low Level of Registration of Persons with Positive Result of Tests Conducted by NGOs to Regular Medical Check-up
199. Ukrainian Centre for Prevention and Combating AIDS (2012) Summary of Data for 2011 according to Form No 3-HIV/AIDS "Report on Conducting Consultations due to HIV Testing", Approved by MHC of Ukraine Order No 388 of 11 May 2010
200. Ukrainian Centre for Prevention and Combating AIDS (2012) Summary of Data for 2009-2011 according to Form No 502-3/o "Information about the Results of Sero-epidemic Monitoring of HIV Prevalence," Approved by MHC of Ukraine Order No 587 of 1 December 2004

201. Ukrainian Centre for Prevention of AIDS. Ministry of Health of Ukraine, 2012. National HIV/AIDS Estimates in Ukraine as of beginning 2012. Kyiv
202. United Nations General Assembly Political Declaration on HIV/AIDS, resolution A/RES/60/262, UNGASS 2006, article 20, p3.
203. UK Consortium on AIDS and International Development –Care and Support working group.(2007) What do we really mean by Care and Support ? Progress towards a comprehensive definition. UKConsortium on AIDS and International development. http://www.vso.org.uk/Images/What_Do_We_Mean_By_Care_and_Support_tcm79-21034.pdf accessed 09/10/12
204. United States Government/Ukraine (2012) Global Health Initiative Strategy. <http://www.ghi.gov/documents/organization/191752.pdf>
205. Ukrainian AIDS Centre (2012). Number of people with status of active IDU who are receiving ART in Ukraine as of 01.07.2012 (based on form #56)
206. Ukrainian Centre for Prevention and AIDS MoH, World Health Organization in Ukraine, International HIV/AIDS Alliance in Ukraine and the UN Joint Programme on HIV/AIDS. National HIV/AIDS Estimates in Ukraine as of beginning of 2012. Date of report: April 2012, Kyiv, Ukraine (with extended tables by key populations)
207. Vasylyashko, I. (2010) Efficiency of Introducing the Course “Basics of Health” upon the results of 2009. Management of Education. 240 (inset “Monitoring in education”, 12): 6-16.
208. Viyevskyy, A.M., Zhdanova, M.P., Sidiyak, S. V., Beznogykh, V. S., Hryshchenko, A. I., Lepekha, K. I. , Matveeva-Kukurudz, K. O., Taran, S. P., Turchenko, L. V. , Yudin Y. B. (2011). National Report on Drug Situation (2010 data) for the European Monitoring Centre for Drugs and Drug Addiction and Ukrainian Medical & Monitoring Centre for Alcohol and Drugs of the Ministry of Health of Ukraine. Ukraine. Trends and In-depth Information on Selected Issues. Kyiv, 2011
209. Verkhovna Rada of Ukraine. “Law of Ukraine “On AIDS prevention and social security of population”” 2010.
210. Verkhovna Rada of Ukraine. “The State Program to ensure HIV prevention, treatment, care, and support to HIV-positive people and patients with AIDS for years 2009-2013, No 1026-VI of 19.02.2009.” 2009.
211. van Dommelen L., van Tiel FH., Ouburg S., Brouwers EE., Terporten PH., Savelkoul PH., Morr  SA., Bruggeman CA., Hoebe CJ.. Alarmingly poor performance in Chlamydia trachomatis point-of-care testing. Sex Transm Infect. 2010;86: 355-9.
212. WHO, 2008. Human resources in the sector of HIV / AIDS (healthcare sector workers) in Ukraine.
213. WHO library Comprehensive external assessment of national measures to prevent AIDS in Ukraine: harmonized report (January 2009).
214. WHO (2009). Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence
215. WHO. “Guidelines: prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach.” 2011.
216. WHO/ILO. “Post-exposure Prophylaxis to Prevent HIV Infection. Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection.” 2007.
217. WHO (2010). “Antiretroviral therapy for HIV infection in adults and adolescents. Recommendations for a public health approach, 2010 revision. Geneva, WHO, 2010. http://whqlibdoc.who.int/publications/2010/9789241599764_eng.pdf, Accessed 28 October 2012.”
218. WHO/HTM/TB (2012). “WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders. http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/index.html. Accessed 25 September 2012.”

219. WHO Regional Office for Europe 2011. European Action Plan for
220. Wilson D, et al. (2012) The cost-effectiveness of needle-syringe exchange programs in Eastern Europe and Central Asia: costing, data synthesis, modeling and economics for eight case study countries (unpublished)
221. Wolfe, D., M. P. Carrieri, et al. (2010). "Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward." *Lancet* 376(9738): 355-366
222. Wei, C, A Herrick, HF Raymond, A Anglemyer, A Gerbase, and SM Noar. "Social marketing interventions to increase HIV/STI testing uptake among men who have sex with men and male-to-female transgender women." *Cochrane Database of Systematic Reviews*, 2011
223. WHO. Report of the expert consultation and review of the latest evidence to update guidelines for the management of sexually transmitted infections. World Health Organization, Geneva. WHO/RHR/11.37. 2011.
224. Zhang, L, HZ Qian, ML Blevins, L Yin, Y Ruan, and SH Vermund. "Internet-based behavioral interventions for preventing HIV infection in men who have sex with men (MSM)." *Cochrane Database of Systematic Reviews*, 2011.

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