United States Department of State

Washington, D.C. 20520

FY 2015 Ukraine Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Ukraine.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

Ukraine

Country Operational Plan

(COP) 2015

Strategic Direction Summary

July 29th, 2015

Table of Contents

Goal Statement

PEPFAR-Ukraine has developed a country operational plan whose goal is to increase linkage to and retention in prevention, care, and treatment in high burden regions [1] despite the current geopolitical and economic crisis while also accelerating recently initiated critical reforms in the health care system that are needed for a sustainable epidemic response. United States Government (USG) agencies are working collaboratively with implementing partners, Government of Ukraine (GoU), Global Fund (GFATM), United Nations (UN) agencies, and civil society organizations to achieve these goals.

Vulnerabilities to achieving epidemic control and current targets by mid-2017 include: (1) the war and economic crisis which has drastically reduced GoU resources and ability to address the health needs of the population; (2) significant cuts in Ukraine's current GFATM grant ending in 2017 without anticipated renewal; and (3) severe inefficiencies related to residual corruption and persisting Soviet-era structure and funding of health care services. Major decreases in funding available to both the GoU and GFATM necessitate additional external funding sources for antiretrovirals (ARVs) to avoid increased mortality and ensure epidemic control. After current GFATM reprogramming of all savings to support additional procurement, the GoU requires an additional $10.4 million to purchase ARVs and laboratory tests for planned scale-up of antiretroviral therapy (ART) to 18,000 additional people living with HIV (PLHIV) in 2015. Additional external resources will be needed for a limited number of years to support continued scale-up of ART while system efficiencies and economic growth develop. Health-care reforms have been initiated by the post-Maidan GoU, and external assistance will greatly increase the speed and success of implementation. PEPFAR-Ukraine will assist the design and implementation of changes of policies and systems to improve efficiency and will continue to strengthen human and system capacity. PEPFAR-Ukraine will also assist the GoU to advance other urgently needed reforms and to build technical and financial capacity, especially for transitioning outreach prevention, care, and support services from being predominantly funded by the GFATM to being supported domestically after grant completion in 2017.

Although continuing its primary technical assistance (TA) focus, PEPFAR-Ukraine will temporarily directly support expansion of innovative key population (KP) recruitment and linkage

[1] Ukraine has 27 sub-national regions (24 oblasts; 1 autonomous republic [Crimea] and 2 cities [Kyiv and Sevastopol])

services for an expected two to five years to complement the GoU's ART provision and GFATM HIV direct service delivery due to the critical economic situation. These services will increase the recruitment and retention of PLHIV, especially KP, in the treatment cascade. Given the inability to access Russian-controlled Crimea or the eastern conflict oblasts, these efforts will concentrate in the remaining five highest HIV burden regions (Dnipropetrovsk, Mykolayiv, Odesa, Kherson, and Kyiv City having 58% of estimated PLHIV outside of the conflict zones), and six additional oblasts (Kyiv Oblast, Zaporizhzhya, Cherkasy, Poltava, Chernihiv, and Kirovohrad) with large KPs and 21% of PLHIV. Preliminary modelling by PEPFAR-Ukraine estimates that by mid-2017, ART coverage rates can increase to ~72% coverage among people who inject drugs (PWID) in the five highest burden regions if the technical assistance and targeted testing and linking to care efforts are successful but only if the threshold for ART initiation is changed to 500 and if sufficient ARVs and HIV laboratory tests are procured.

1.0Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Ukraine has a total population of 45.2 million, but conflict with Russia in the past year has significantly affected certain regions, including ones disproportionately affected by HIV. Approximately 2.3 million live in Russian-occupied Crimea and another 3 million in separatist/Russian-occupied portions of the eastern Luhansk and Donetsk regions; over 1 million people from these regions have become internally displaced to other parts of Ukraine. As of 2014, there were an estimated 210,000 PLHIV in Ukraine (0.8% of the population) [SPECTRUM, Ukrainian Center for Disease Control (UCDC)] with the majority of cases among men. Approximately 30% of the PLHIV lived in Crimea (6%) or Luhansk/Donetsk (24%). In 2013, HIV accounted for an estimated 9,742 AIDS-related deaths (1.5% of all deaths) with tuberculosis (TB) causing approximately 50% of all reported deaths among PLHIV. In 2013, 5,229 new cases of TB-HIV co-infection were diagnosed and 2,522 deaths occurred among co-infected individuals.

Ukraine's HIV epidemic remains concentrated geographically with a belt of regions in the South and East disproportionately affected; seven regions, six of which are located in the South and East, account for 2/3 of registered or estimated cases but only 36% of the population. The epidemic is concentrated in KPs with a prevalence of 19.7% among PWID, 7.3% among female sex workers

(FSW), and 5.9% among men who have sex with men (MSM) in 2013 national surveys. Limiting Antigen Avidity (Lag) assay incidence testing of the 2013 Integrated Bio-Behavioral Survey (IBBS) specimens found relatively low incidence rates (0.91% MSM; 0.74% PWID; 0.44% FSW) although identifying several foci with estimated incidence >3% (MSM - Kyiv City, Odesa, and Sevastopol; PWID - Kherson and Ternopil, FSW - Ivano-Frankivsk). Routine program testing and a cohort study suggest an HIV incidence of 1.5% - 2% for PWID nationally, while a cohort study of street PWID suggests subpopulations with substantially higher incidence exist. The HIV prevalence among delivering women was 0.79% in 2013 and has been declining slightly since 2009 [Vitek, 2014]. Female sexual partners of PWID are disproportionately affected and are thought to account for a majority of female PLHIV. However, the route of transmission for ~1/3 of the estimated number of PLHIV is not plausibly characterized and improved data are needed to guide prevention, care, and treatment. An estimated 12,200 new cases of HIV infection occurred in 2014, evidence supports injecting drug use (IDU) still accounts for 20% - 40% of new cases despite marked declines in transmission among PWID.

Political and economic factors pose intense short-term challenges to further scale-up of ART, which reached 65,898 PLHIV (31% of all estimated PLHIV) by end of 2014. Rampant corruption since independence greatly intensified in President Yanukovych's government; this corruption limited economic activity and prevented the emergence of effective procurement and program management. The Russian invasion and war in the East has led to a 20% year-on-year decline in Gross Domestic Product (GDP) by early 2015 with further economic contraction expected this year. The Ukrainian currency has severely devalued, losing nearly 75% of its purchasing power in one year. In 2015, the projected dollar GDP per capita (~$1,900) is expected to be ~50% of 2013. While the replacement of Yanukovych with a reforming, Western-oriented government promises to lead to improved administration and economic growth in the medium-term, intense restructuring of government processes, and successful elimination of residual corruption and excessive post-Soviet bureaucracy is needed in the short-term. Initial efforts to reform procurement in the Ministry of Health (MoH) have already begun, but government procurement of ARV drugs for 2015 suffered from the combined effects of these factors and would have been insufficient to maintain persons currently on treatment. The GFATM, which was purchasing <20% of ARVs, has reprogrammed more than $12 million to cover government ARV procurement shortfalls and other needs through quarter one (Q1) 2016 and allow limited scale-up to ~6,000

additional persons in 2015. However, the GFATM has decreased its funding for the current grant to Ukraine by more than $80 million under the New Funding Model (NFM) and no further savings exist. The conflict in the East has also created over 1 million internally displaced persons (IDP's) coming primarily from Donetsk (HIV prevalence ~1.1%). Displaced PLHIV will require reestablishment of access to services while increased risk behavior among IDPs due to economic and social stress is likely.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	45,309,293		3,236,046		3,429,598		21,194,829		17,557,265		2013
Prevalence (%)		0,8									
AIDS Deaths (per year)	9,742		62		54		2,932		6,694		Spectrum, 2015
PLHIV	210,059		2,630		2,814		86,564		118,050		Spectrum, 2015
Incidence Rate (Yr)		0,03									
New Infections (Yr)	12,185		133		147		5,273		6,631		Spectrum, 2015
Annual births	503,657	1,11									2013
% >= 1 antenatal care visit											
Pregnant women needing ARVs	3,886										
TB cases (Yr)	30,819		293		306		7,345		16,929		2013
TB/HIV Co-infection	6,599	0,01									
Males Circumcised											
Key Populations											
Total MSM*	175,750[2]										*2012*
MSM HIV Prevalence	10,369[3]	5,9									*IBBS,2013*
Total FSW	79,816										*2012*
FSW HIV Prevalence	5,827	7,3									*IBBS, 2013*
Total PWID	310,000						73,000		237,000		*2012*
PWID HIV Prevalence	61,070	19,7					16,400	27%	44,600	73%	*IBBS,2013*
Priority Populations											
Total Prisoners	73,431[4]										
Prisoners HIV Prevalence	2670[5]	5,7									2013

[2] *Analytical report based on the results of the survey "Estimation the size of groups Most-at-Risk for HIV infection in Ukraine" as of 2012– K.: ICF «International HIV/AIDS Alliance in Ukraine», 2012. – P. 48.*
[3] *The estimated number of HIV infections among MSM, 2013*
[4] *Data as of January 1, 2015, State Penitentiary Service not including prisoners in Lugansk and Donetsk oblasts*
[5] Annual *data for 2013, Ukrainian CDC bulletin*

HIV prevalence Sexual partners FSW		7,4[6]									*2010*
HIV prevalence Sexual partners IDUs		8-30									*2007*

6 Grushetsky, Analytical report of the results of biobehavioral survey: monitoring behavior and prevalence of HIV-infection among clients of female sex workers as a component of second-generation HIV surveillance. Kyiv: International HIV/AIDS Alliance in Ukraine.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)											
				HIV Care and Treatment						HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**			**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression in 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	45,309,293	0.8	210,059	139,573			65,898	86.66%	78.1%	2,941,748	31,678	*12,813*
Population less than 15 years[7]	6,665,664	0.08	5,444	2,975			2,700					
Pregnant Women	494,889	0.79	3,886 [15]				3,740			491,385	4,319 [15]	
	Total Population Size Estimate (#)	**HIV Prevalence (%)**		**Reached[8]**	**Linked**	**In[9] care**				**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**On ART**
MSM	175,750	5.9		28,500	138	100				9,381[10]	142	
FSW	79,816	7.3		37,061	124	107				12,392[11]	158	
PWID	310,000	19.7		210,377	1,946	1,453				67,660[12]	2,181	*2,801*
Other group risks				22,397		196				9,528	271	
Prisoners	73,431[13]	5.7 [14]								47,123	2,670	2,812[15]

[8] *Reached, Alliance Annual Program monitoring data for 2014*
[9] *HIV + registered at the AIDS center annual data for 2014*
[10] *MSM tested, Alliance Annual Program monitoring data for 2014*
[11] *FSW tested, Alliance Annual Program monitoring data for 2014*
[12] *PWID tested, Alliance Annual Program monitoring data for 2014*
[13] *Data as of January 1, 2015, State Penitentiary Service not including prisoners in Luhansk and Donetsk oblasts*
[14] *IBBS data 2013, UNODC report*
[15] *Prisoners on ART, Annual data for 2013, State Penitentiary Service*
[15] *The 4,319 includes women who subsequently terminate their pregnancy. The 3,886 represent all of the 4,319 who go to delivery.*

1.2 Investment Profile

Ukraine is a lower-middle income country with gross national income), purchasing power parity adjusted, of $3,960 per capita (World Bank, 2013). Currently, the country is facing a severe macroeconomic crisis: following a period of stagnation in 2012 and 2013 (with growth rates of 0.2 percent and zero in 2012 and 2013 respectively), there was a sharp decline in 2014 by around 7.5-8.0 percent, and the currency weakened by 48 percent against the U.S. Dollar (USD). The fiscal deficit is large, equal to 6.7percent of GDP in 2013 and 10.1 percent of GDP in 2014. The economy prospects in 2015 and 2016 remain grim because of the ongoing armed conflict and humanitarian catastrophe in the East and the grave situation in the financial sector.

The latest detailed HIV expenditure data for Ukraine is available in the draft 2011 National AIDS Spending Assessment (NASA) report [See ***Tables 1.2.1 and 1.2.2. below***.]. The data showed GoU as the major funder of the HIV response (more than 60%), covering most of the clinical care, including 87% ART, 82% PMTCT, and 99% facility-based HIV counseling and testing (HCT/HTC). GFATM covered about 28% of national response costs including > 95% of Medication-Assisted Therapy (MAT) services, KP-targeted combination prevention, and community-based care and support. The remaining 12% costs were shared by other donors, including the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), UN agencies, private foundations, with PEPFAR having the biggest share (more than 4%). Analyzing commodity-specific expenditures, GoU and GFATM were the only funders, with the GoU funding the majority of ARV, HTC, and PMTCT procurements, and the GFATM paying for MAT drugs, rapid HIV tests, and other combination prevention commodities for KPs.

However, due to the growing financial crisis and budget deficit, the GoU has significantly decreased their AIDS financing and respective (estimated) expenditures: from 60% (approximately 60 million USD) in 2011-2012 to 37% (approximately 41 million USD) projected for 2015[16]. [*See Table 1.2.4 below showing the trend of the AIDS spending in 2011-2015 by sources in %*]

The seventh National AIDS Program (NAP) for 2014-2018 was approved as the Law of Ukraine[17] after a one year delay in October 2014, with the 5-year projected budget of 6.38 billion hryvnia (UAH) (or ~$797[18] million USD). It included the planned GFATM HIV Round 10 2014-16 renewal funding, later transitioned into the 2015-2017 NFM grant with the HIV component reduced by 47% (now standing for $92.7 million USD). The GoU (central and local) projected portion, initially planned to cover more than 70% of the total program forecasted costs, significantly lost their purchasing power in USD[19] during 2014-2015. These funding shortfalls are further exacerbated by the persisting GoU practice to underfund the annual AIDS programs by 40 to 60% from the Annual Budget Resolution Law, limiting the allocations to fund only ARVs, PMTCT, and HCT. In 2014[20], only 38% or about $23.3 million USD[21] of the 2014 GoU state[22] AIDS budget projected in the NAP was allocated.

Due to inefficient and corruption-prone MoH procurement processes and severe Hryvna devaluation in 2014, the risk of ARV stock-outs in 2015 became much more serious, compared to the 2014 *ad hoc* minor gaps in the GoU's

[16] Source: the 2013 Report of the Ukraine's State Service on Counteracting Social Diseases on the results of NAP2009-2013 implementation in 2013 and MoH operational data with preliminary state budget AIDS expenditures in 2014 (without local GoU budget)

[17] Law of Ukraine[17] "National State Targeted AIDS Program for 2014-2018", № 1708-VII approved by the Ukrainian Parliament on October 20, 2014

[18] At the 2013, NBU exchange rate was $1 = 8 UAH, when the NAP was developed.

[19] Taken into account Hryvna devaluation against USD based on the average NBU exchange rate in Jan-Mar 2015 ($1=21.67UAH), the total 5 year program budget (with $92.7 million of GF for 2015-17 not changing) may reduce by almost 50% , or approx. $450 million USD

[20] Source: Report on the performance results in 2013 of the State Targeted Program to ensure HIV prevention, care, and support of HIV-infected and AIDS patients in 2009-2013", State Service on Counteracting Socially Dangerous Diseases, website: http://www.dssz.gov.ua

[21] [Source: 2013 State Service Report] 277,478,007 UAH or $23,343,600 USD at the 2014 NBU rate of $1=11.88 UAH

[22] Information on the local budgets spent in 2014 is unavailable as the State Service was disbanded in February 2015.

ARVs, CD4, and VL tests provision when the GFATM supported an emergency procurement. To date, the 2015 risks have been mitigated by using about $5 million of GFATM grant savings to cover the ARV gaps in the 1st quarter of 2015 and re-programming an additional $7.3 million of savings to cover gaps for the rest of 2015 and the 1st quarter of 2016 for the existing ART patients with a slight scale up of 6,000 patients.

Based on the FY'14 Expenditure Analysis (EA), the PEPFAR funding was predominantly TA covering above-site HSS (57%), program management (23%) and Strategic Information (about 8%) areas with limited pilots of direct service delivery for KPs, prevention, and community-based care (up to 12%). To achieve the planned ART scale-up in high burden oblasts through increased access of new HIV-positive KPs to care and increased (re)linkage to care of the lost to follow-up (LTFU) PLHIV, PEPFAR will need to provide additional ARV drugs. Despite the GFATM reallocating savings from currency gains to support additional procurement, an additional $10.4 million will be needed to purchase ARVs and laboratory test kits to allow for planned scale-up of ART by an additional 18,000 PLHIV in 2015.

PEPFAR-Ukraine HSS activities in FY'16 will also complement the resources of the new World Bank health sector loan ($215 million USD for 2015-20). At the national level, the loan will strengthen the establishment of new hospital-based payment systems, e-Health, public health improvement, information and communication campaigns, and MoH capacity building. The loan will also support 8 oblasts, among them 3 of the 11 covered by PEPFAR, to improve prevention, early detection and treatment of cardiovascular diseases and cancer, and oblast health delivery system efficiency.

Table 1.2.1 Investment Profile by Program Area[23]

Program Area	Total Expenditure	% PEPFAR	% GFATM	% GoU*	% Other
Clinical care, treatment, and support	$6,341,486.63	2.6	27.6	66.3	3.5
Community-based care	$3,447,600.27	3	52	27.7	17.3
PMTCT	$2,603,139.13	0	4.8	95	0.2
HTC	$576,920.39	0	0	99	1
VMMC	N/A	N/A	N/A	N/A	N/A
Priority population prevention	$1,761,165.45	0.1	51.3	19.1	29.5
Key population prevention	$8,647,943.78	0.2	93.1	2.6	4.1
OVC	$396,698.57	0	28	44.8	27.2
Laboratory	$7,564,956.24	0	3.3	94.8	1.9
SI, Surveys and Surveillance	$1,745,705.83	0.5	79.5	4.3	15.7
HSS	$18,993,124.20	20	38.2	27.2	14.6
Total	$52,078,740.49**	8.5	41.3	38	12.2

**** GoU is calculated by adding both national and local budget lines***
*****Information for this table came from the 2011 NASA final draft report, shared by the MoH/UCDC. The 2012 NASA draft could not be used as data for PEPFAR costs was incomplete. As such, this is the most reliable snapshot of spending by program area.***

Table 1.2.2 Procurement Profile for Key Commodities (from 2011 NASA)

Commodity Category	Total Expenditure	% PEPFAR	% GFATM	% GoU*	% Other
ARVs	$26,335,103.66	0	13.2	86.8	0
Test kits**	$13.292,255.74	0	4	94	2
Other drugs	$5,158,647.53	0	26.8	71.7	1.5
Lab reagents***	$0	0	0	0	0
Condoms****	$ 678,757.02	0	86.3	8.9	4.8
VMMC kits	N/A	N/A	N/A	N/A	N/A
Other commodities	$6,749,771.25	1.2	24	71.6	3.2
Total	$52,214,535.20****	0.2	13.4	84.2	2.2

**** GoU is calculated by adding both national and local budget lines***

Tables 1.2.1 and 1.2.2 – *Source - MoH/UCDC, most recent and validated draft 2011 National AIDS Spending Assessment report , all amounts in 2011 USD*

*** This category includes rapid tests for HIV among all other types of tests – ELISA, CD4, VL, biochemical and those used for quality control; sterile containers (for sputum collection); reagents*

****Lab reagents are $0 because their cost is included in 'Test kits' category in the Ukrainian budget. There is no way to parse out the separate cost of laboratory reagents.*

*****USG provided condoms as a donation in 2011. However, it is not reflected in the NASA (per methodology) as it was a donation.*

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	N/A				
USAID TB	$4 million USD				
USAID Malaria	N/A				
Family Planning	N/A (*1 M in 2014*)				
NIH					
CDC NCD					
Peace Corps					
DOD Ebola					
MCC					
Private Sector					
PEPFAR Central Initiatives	TBC				
Total					

Table 1.2.4 Estimated national AIDS expenditures in 2011-2015, in % by major sources

Source of funding	2011 Y	2012 Y	2013 Y	2014 Y	2015 Y (forecasted budget)
GoU (state and local)	60%	62%	41%	40%	37%
Global Fund	28%	20%	45%	36%	43%
USG	4%	7%	12%	22%	17%
Others*	8%	11%	2%	2%	3%
Total estimated amount, USD	**100 212 396**	**117,809,213**	**104,474,760**	**66,657,912**	**110,756,388**
Official exchange rate	$1=7.97 UAH	$1=7.99UAH	$1=7.99UAH	$1=11.88 UAH	Average ex rate of Jan-Mar: $1=21.26 UAH

Comments:

* "Others" category includes UN agencies, like UNAIDS, UNDP, UNICEF, other donors, private sector, e.g. private foundations like Clinton/CHAI, IRF (Soros), STOP AIDS Foundation (Pinchuk).

2011: By NASA methodology donors' staff and operations costs were not included.

2012: draft NASA 2012 is to be re-validated by UCDC, its main flaw was incomplete data on USG costs. We used the latest UCDC's version[24] of the 2012 NASA data for all other sources and applied PEPFAR-Ukraine FY'12 average projected outlay in 'Quarterly Report on Obligations and Outlays for PEPFAR Funds in FY'12' ($8,572,302).

2013: We used the 2013 State Service's report[25] on NAP results in 2013, applied PEPFAR-Ukraine FY'13 average projected outlay ($12,753,362) and updated 2013 GFATM grant costs (from GFATM website).

2014: We used the 2014 MoH operational data[26] on state-only AIDS budget costs in 2014, applied PEPFAR-Ukraine FY'14 EA data ($14,728,440) and updated 2014 GFATM grant costs (from GFATM website)

2015: NAP 2015 projected budget in current National Bank of Ukraine (NBU) exchange rate for Jan-Mar 15 ($1=21.26 UAH), NFM grant for 2015, and PEPFAR FY'15 average projected outlay ($19,300,000) were used.

1.3 National Sustainability Profile

The Sustainability Index and Dashboard (SID) analysis of Ukraine's national HIV response was undertaken jointly with key national stakeholders through a series of consultations in February 2015. The results of this analysis identified five elements of the national response that are not sustainable for the country's effective epidemic control: (1) timely and reliable data of national and sub-national financing and expenditures as well as an institutionalized standard process of their collection and analysis; (2) adequate needs assessment, planning, and deployment of human resources for health to maintain and scale-up KP-targeted effective services in prevention, treatment, and care; (3) quality management and improvement systems to ensure effective HIV service delivery and address the biggest losses in the cascade by linking new PLHIV from outreach to clinical care and re-linking and retaining in care LTFU HIV+ clients; (4) adequate and transparent procurement and supply chain management systems to ensure reliable access to quality ART and MAT drugs and laboratory supplies; and (5) reliable and adequate domestic resource allocation and financing based on allocative and technical efficiency analyses.

Based on the discussion with government, the GFATM, UNAIDS, and civil society organization (CSO) stakeholders, areas that demand the greatest attention for sustained epidemic control are: (1) scaling up ART among key and priority populations, and (2) increasing detection of new HIV+ cases and linkage to case management (CM) for those who have dropped out of care. Major challenges include unreliable and inadequate supply of ARVs and tests due to inefficient state health procurement, serious underfunding of the state budget as the main provider of ART commodities and services, and continuing unresolved financial dependence by the government on GFATM resources for critical HIV prevention, care, and support service delivery for KPs. To date, PEPFAR has invested in the areas of: HSS; SI for decision making; limited facility-level quality improvement; and CSO capacity building. However, PEPFAR's achievement of ambitious targets to increase ART coverage in the context of the current economic and financial crisis while improving outreach and CM services will require programmatic redirection.

1.4 Alignment of PEPFAR investments geographically to disease burden

The majority (88%) of PEPFAR expenditures to date have focused on HSS, project management and SI, with HSS representing 57% of expenditures. Above-national and national expenditures comprised 73% of the total expenditures, indicating that the portfolio has been primarily directed at national level TA and capacity building

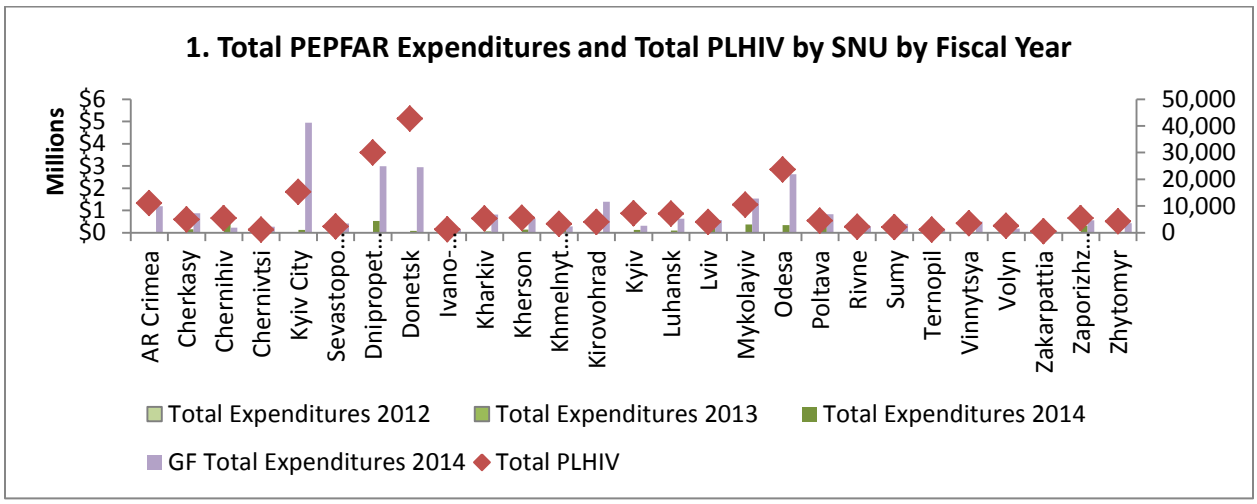
[24] Draft 2012 NASA report with added info on PEPFAR non-disaggregated estimated 12 months outlay can be found in the supplemental docs

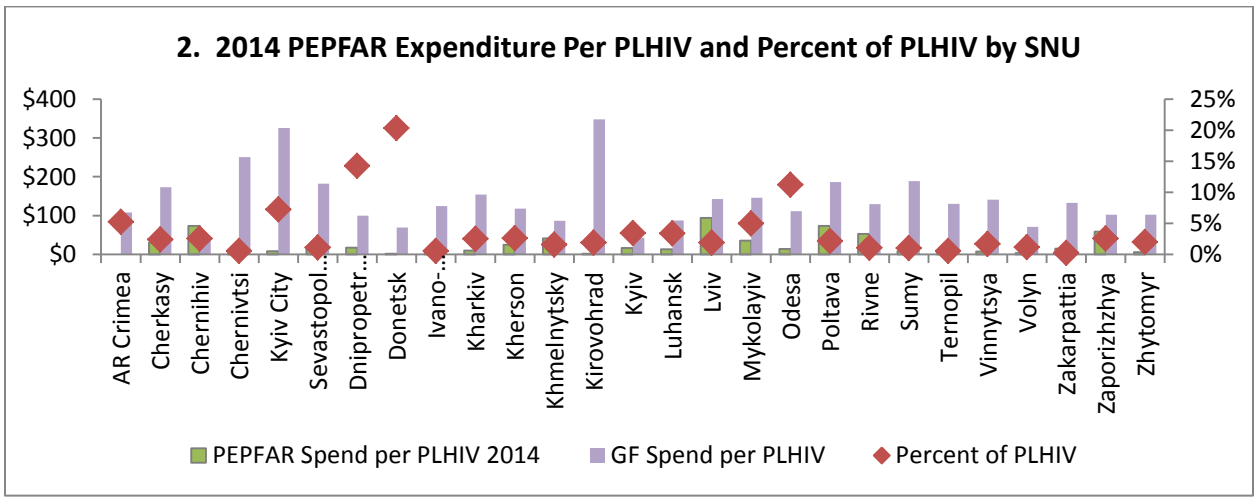
[25] Data from the 2013 State Service report with updated GFATM 2013 spend data and added estimated PEPFAR FY'13 12 months outlay can be found in the supplemental docs

[26] Operational MoH data on the 2014 estimated GoU state budget AIDS expenditures with updated GFATM 2014 spend data and PEPFAR FY'14 EA can be found in the supplemental docs

with a degree of SI, quality improvement, and capacity building support taking place in a few oblasts. Further analysis of the HSS expenditures shows that the majority supported institutional capacity development for improved policies and program development, data use and demand for decision making, epidemiological data modelling at the national and sub-national unit (SNU) level, laboratory strengthening and supply chain management, and infection control in HIV/TB. These investments continue to align with many of the COP 15 core program areas. Several areas, like capacity building in blood safety services, epidemiological data triangulation, and building a national registry of TB patients (e-TB Manager tool) are now considered non-core and will be transitioned during 2015 and 2016.

Tables 1.4.1 and 1.4.2 compare PEPFAR expenditures in 2014 to burden of disease by the SNUs (regions/oblasts). As PEPFAR-Ukraine predominantly provided above-national and national TA on policy and systems improvements that benefit all the SNUs in a fairly equal manner, it would make sense to analyze the PEPFAR expenditure by SNUs/regions data, taking into account the country context where the GoU and the GFATM are the main service delivery providers. The table includes GFATM's expenditures disaggregated by SNU in 2013, but it does not include GoU expenditures as they are not collected by the MoH. PEPFAR and GFATM's expenditures by region in 2013 show a direct correlation between expenditures, PLHIV, and prevalence, with a few exceptions emerging in high burden oblasts such as Dnipropetrovsk and Donetsk. Relatively high expenditures in Kyiv City can be explained by the large number of GFATM sub-grantees based there who were implementing national level projects.





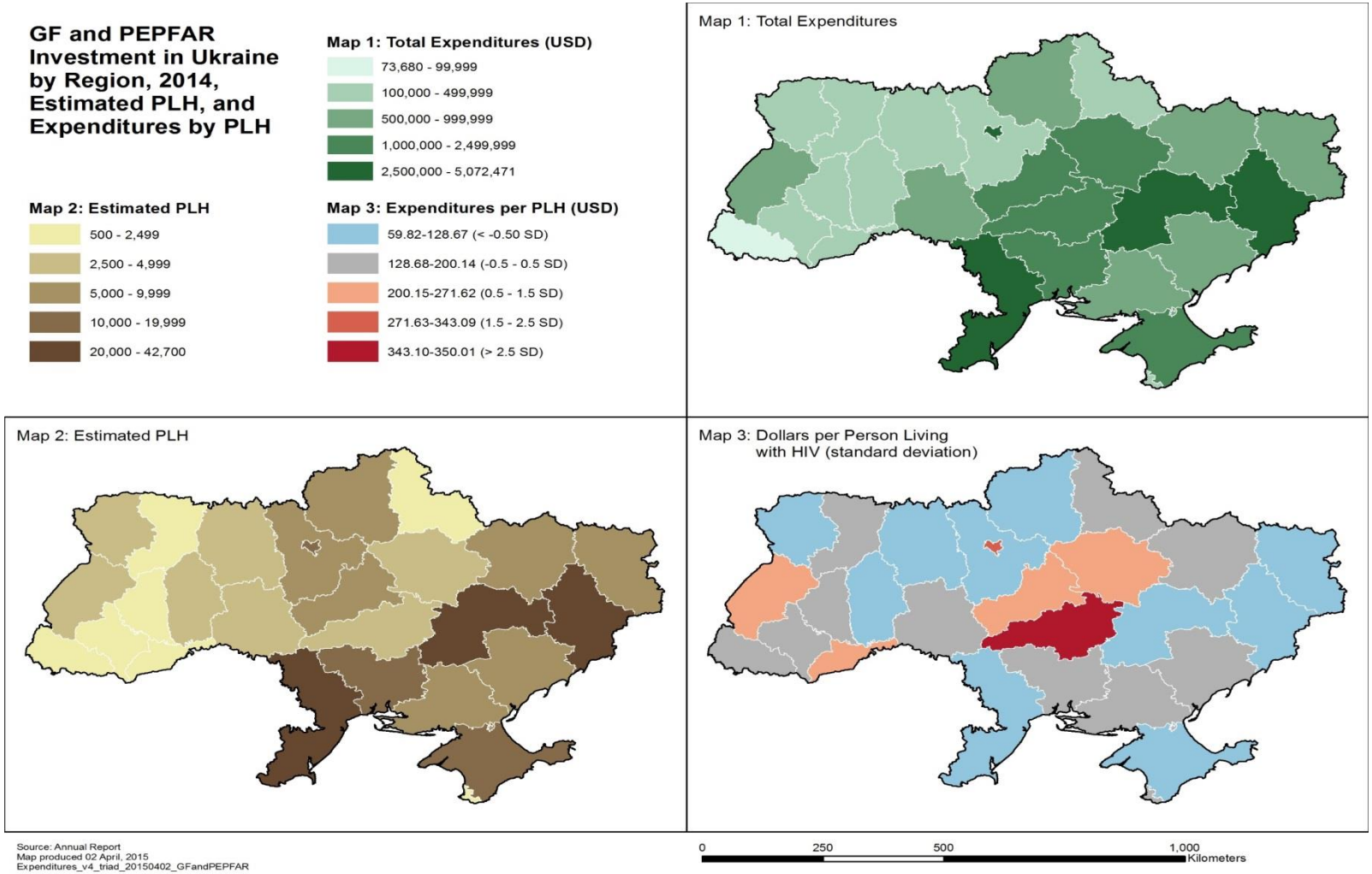
1.5 Stakeholder Engagement

USG engaged with a cross section of national stakeholders including GoU, GFATM and four umbrella civil society and patient advocacy organizations in the context of two national stakeholder meetings on February 3rd and again on February 23rd, 24th, and 27th, 2015. At the national stakeholder meeting on February 3rd, participants assessed the PEPFAR SID. The meeting was facilitated by the UNAIDS Country Director and Measurement and Evaluation (M&E) Advisor and M&E staff from the GoU/UCDC. A cross section of national stakeholders participated in group discussions and reviewed the results of the exercise.

At the meetings on February 23rd, 24th and 27th, USG shared: (1) current epidemiological data and maps; (2) background and requirements for the FY'15 COP; and (3) draft patient pathways that noted leakage of patients at various stages of the clinical cascade. Additionally, the national stakeholder meeting on the 23rd included presentations on epidemiological data and program directions from GoU/UCDC, GFATM, Alliance, and Network. These national stakeholders also provided feedback on: (1) the patient pathway and (2) on priorities for the national program that the USG took into its internal planning meetings on the 25th and 26th. On February 27th, 2015, the USG reported out on its internal core, near- and non-core review process as well as its COP 15 priorities to national stakeholders. The USG also shared a draft of its civil society engagement plan with a request for written feedback a week after the meeting on the 27th. Finally, at the meeting on February 23rd and again on February 27th, the USG team committed to facilitating additional national stakeholder meetings to continue to collectively monitor the national response and to discuss issues of common concern. The next national stakeholder meeting is planned for May 2015.

Since its February 2014 revolution, Ukraine has faced extraordinary political and financial challenges. Ukraine is simultaneously dealing with a Russian invasion, over a million IDPs, and a collapsing economy. The current government is committed to democratic ideals and to undertaking long overdue reforms including those in the health sector. More specifically, GoU has initiated healthcare reforms, and external assistance will advance and the pace and success of implementation. Again, PEPFAR-Ukraine will assist the GoU to move forward with the needed reforms and build technical and financial capacity, especially for transitioning outreach prevention, care and support services (predominantly funded by the GFATM) to be supported domestically in 2017. Please see log frames as it delineates activities focused on data for decision making; increasing financial capacity and transparency. Given current conditions, a partnership is likely not feasible until the country stabilizes both fiscally and politically.

Figure 1.3.2 Total expenditure, PLHIV, and Expenditure per PLHIV by District



2.0 Core, Near-Core and Non-Core Activities

PEPFAR Ukraine carefully reviewed current epidemiological and program data and then mapped gaps and bottlenecks in the HIV cascade of services, particularly core patient pathways, before identifying a set of current and new activities needed to accelerate sustained epidemic control in a concentrated epidemic where the GFATM and GoU provide prevention, care, and treatment services and the USG provides TA to strengthen the national response. PEPFAR-Ukraine mapped six core HIV patient pathways against its current activities as well as GFATM-supported activities with a focus on identifying: (1) areas of the cascade with the greatest leakage of patients; (2) inefficient or unnecessary activities; and (3) opportunities for greater impact before defining its core, near-core, and non-core activities for program implementation. This process identified gaps and bottlenecks including: (1) limited HTC yield with current outreach approaches; (2) challenges to retention in care/support services highlighted by a significant number of drop-outs; as well as (3) a challenging registration process that impedes the uptake of ART services at government facilities.

PEPFAR Ukraine's core and near core activities will focus on addressing the gaps and bottlenecks in the HIV patient cascade through: (1) increasing HTC yield with innovative outreach approaches; (2) promoting evidence-based CM models designed to both return dropouts and link new patients to care and treatment; and (3) strengthening the GoU's ability to provide more client-oriented, quality treatment services. PEPFAR Ukraine will: (1) promote evidence-based peer driven intervention (PDI) models to increase the yield from outreach HTC and (2) provide direct support to expand a peer CM model (Community Initiated Treatment Intervention (CITI) model) with a focus on key and priority populations, especially PWID. In addition, USG will support Quality Improvement (QI) interventions targeted at (1) the GoU's AIDS Centers to address a cumbersome registration process and promote uptake of and retention in care and treatment services and (2) TB and primary health care (PHC) facilities to improve HCT and referrals. A full package of USG activities will be offered in five high-burden oblasts and selectively tailored in six medium-burden oblasts. USG will also continue to work collaboratively with national stakeholders to address protocol and policy barriers at a national level. See Appendix A for a full list of core, near-, and non-core activities as well as transition plans.

3.0 Geographic and Population Prioritization

PEPFAR-Ukraine analyzed epidemiology and program data to identify priority regions and populations on which to focus USG efforts to raise ART coverage for epidemic impact. PEPFAR Ukraine is unable to work in Russian-controlled Crimea or in the conflict zone in eastern Ukraine; these 4 regions contained ~30% of PLHIV. Of the remaining 23 regions, PEPFAR-Ukraine will focus on the five with highest HIV burden (Dnipropetrovsk, Mykolayiv, Odesa, Kyiv City, and Kherson) collectively having 58% of the remaining PLHIV, as well as on an additional six medium burden oblasts (Cherkasy, Poltava, Chernihiv, Zaporizhzhya, Kirovohrad, and Kyiv) with an additional 21% of remaining PLHIV. Current ART coverage in these regions is 30%; additional patients required to reach 80% ART coverage (saturation) in the five high burden oblasts is estimated at 41,419 and for all eleven focus oblasts is 58,072. Odesa has the lowest current coverage for ART (27.1%) among the high burden oblasts and Kirovohrad (21.9%) among all oblasts. The eleven focal oblasts contain an estimated 47,130 HIV-positive individuals from KPs including 34,822 PWID, 9,072 MSM, and 3,097 FSW.

According to the 2013 IBBS, six of the eleven high and medium burden oblasts have an estimated HIV prevalence for PWID that either equals or exceeds the national average of 19.7% [Dnipropetrovsk (31.2%); Kyiv (19.7%); Mykolayiv (31.8%); Odesa (30.2%); Kherson (22.6%); and Cherkasy (19.8%)]. Since injection drug use has been the dominant mode of HIV transmission among PWID and FSW and, indirectly, for sexual partners of PWID, PEPFAR-Ukraine will focus on significantly increasing coverage for this key population. PEPFAR Ukraine has tailored an appropriate mix of core activities within these eleven high and medium burden oblasts (See Appendix A). Estimated ART coverage among PWID in the 5 highest burden regions is 47%; given the country's current political and economic challenges, the PEPFAR-Ukraine team realistically believes it can facilitate the aggressive scale up ART coverage rates to 72%. Achieving this target will be contingent on: (1) success of the TA and targeted testing and linking to care efforts; and (2) the condition that the country receives the requisite number of ARVs and other essential commodities.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Given the recent reductions in GFATM and GoU resources that threaten existing ART coverage, PEPFAR Ukraine worked with partners to refocus USG efforts on raising coverage in KPs, especially PWID, in the priority regions. Current targets reflect initiation of new activities to close gaps in HTC and patient retention in the 11 priority regions with a special focus on the 5 with highest burdens. As Ukraine is considering but has not yet revised guidelines to initiate ART at CD4 500 due to ARV constraints (which have dramatically worsened due to war and economic crisis), these targets are subject to significant upward revision if outside resources for ARV are sufficient to allow national guidelines to be implemented. PEPFAR aims to provide TA to Ukraine to add 4,712 PWID[27] patients on treatment in the 5 priority regions through early 2017[28], with a goal of 17,627 current PWID on ART. This represents an increase in coverage from an estimated 47% as of mid-2013 to 63% (Table 4.1.1 a). Another 2,340 are estimated to be ART eligible increasing coverage to 72%. To reach these targets, PEPFAR Ukraine integrated data on HIV prevalence and self-reported ART use from the 2013 IBBS with Population Size Estimate (PSE) data to estimate current ART coverage and determined that an additional 5,100 PWID in the 5 regions are eligible for treatment under current guidelines. To reach those PWID who had not entered care or who had entered but have been lost to follow-up, PEPFAR Ukraine worked with partners to ascertain interventions, which could most efficiently identify HIV-positive PWID and effectively link them to care and treatment.

The coverage levels in Table 4.1.2 will be achieved through PEPFAR-supported scale-up of innovative activities to increase the yield of HTC among key populations through network driven recruitment, to increase linkage of PLHIV to care through peer case management, and to relink those who have been lost to follow-up. Additional PEPFAR supported QI activities to improve HIV clinical services will limit drop-out from care, but are not reflected in targets in Table 4.1.2.

Current GFATM supported outreach HTC among PWID achieves a ~4% yield and should identify and link 500 ART-eligible PWID in the 5 highest burden regions in 2016. PEPFAR will scale up network peer-driven recruitment into HTC as piloted in Odesa. Scale-up of network recruitment to the 5 highest burden regions (using a conservative estimated yield of 10% rather than the 23% found in Odesa) should link 680 ART-eligible PWID. PEPFAR will support expanded peer case management to link these newly identified PLHIV to regional AIDS centers (RAC); these CM activities have raised successful linkage from prevention to the care services to >80%. Additionally, case management activities at RAC will identify and link an additional 420 ART-eligible PWID who were lost to follow-up (LTFU). These are new activities and no targets exist from previous years. The budget for these activities was calculated from pilot projects of both network recruitment and case management strategies supported by GFATM.

[27] All PWID coverage figures are rounded as they are estimates derived from IBBS and PSE.
[28] Early 2017 was chosen as the next opportunity to measure ART coverage will be the mid2017 IBBS.

While revisions to ART guidelines are being developed that may allow initiation at higher CD4 counts, current ART funding limitations will force extreme prioritization and the targets developed have been limited to the proportion of new PWID reached who will be found to have CD4<350. Challenges will include 1) implementation of network recruitment across new regions; however every region has experience with network recruitment for surveys; and 2) availability of sufficient ARVs for newly identified and linked KP to allow initiation of ART at a CD4 of 350 as currently called for in Ukrainian ART guidelines. A key assumption is that additional external resources will be identified to fund ART scale-up as planned for in the NAP; additional resources that would provide additional ARVs would allow for much more rapid scale-up and would help drive the policy on CD4 count at ART initiation. Data limitations include lack of reliable data from RAC on registered KP due to inability to accurately ascertain risk behavior of patients. Data on KP ART coverage are therefore obtained from IBBS conducted every two years with rounds in mid-2015 and 2017.

Other priority activities to raise ART coverage among PWID include a focusing of QI activities to improve services at RAC to decrease LTFU (~25% cumulatively following registration). These activities will initiate quality improvement at RAC to identify and improve service issues that are responsible for LTFU. These are new activities and no targets exist from previous years. The ART coverage targets set for PWID do not yet include the potential impact of increased retention; therefore, PWID ART coverage achievable may be higher than the 56% projected. Information on the number of KPs lost to follow-up by SNU is part of the baseline data. Challenges will include 1) limited previous QI engagement with RAC in some high burden regions; and 2) availability of sufficient ART for the increased number of KP/PWID retained in care.

Primary TA targets: As a TA program assisting a country with minimal prior PEPFAR service delivery, PEPFAR-Ukraine activities are not well matched to existing Monitoring, Evaluation and Reporting MER indicators. PEPFAR-Ukraine continues to develop custom indicators to better track the impact of its activities. The indicators and targets introduced include ones designed to track a) closing the gaps in the cascade [improved referral by police, transfusion centers, PHC]; b) acceleration of health reform [medical procurement, supply chain, alternative delivery and financing of HIV and MAT services, non-governmental organization (NGO) organizational strengthening]; c) improved pilots of care and support; d) decreased stigma [in prisons and health care settings]; and e) QI and systems building activities to improve services [transfusion centers, RAC (to be developed)]. Current targets reflect activities that are either national in scope (national procurement review and policies) or occurring at selected sites (in priority regions) to provide cost-effective models for dissemination.

The intended impact of these outputs include for a) *cascade gaps:* increased entrance and retention of PLHIV into care due to better HTC and linkage; b) *acceleration of health reform*: increased sustainability of the HIV response by removing inefficiencies and augmenting traditional revenue and delivery sources; c) *care and support pilots*: models for improved retention in services; d) *stigma reduction;* and e) *service QI*: increased entrance and retention of

PLHIV, especially KP, into care due to decreased stigma and improved services in the prison and health care settings.

Table 4.1.1 ART Targets in -Sustained Sub-national Units for Epidemic Control

SNU [Specify SNUs for focus]	Total Est. PLHIV	Current PLHIV on ART (Feb 2015)	Additional patients required for 80% ART coverage	Target current on ART (in Jan 2016)* **	Target for newly initiated in 2015 **
High burden regions					
Dnipropetrovsk	30,000	8,820	15,180	12,512	3,692
Mykolayiv	10,500	4,348	4,052	5,161	813
Odesa	23,600	6,392	12,488	9,069	2,677
Kyiv city	15,200	5092	7,068	6,397	1305
Kherson	5,500	1,769	2,631	2,263	494
Medium burden regions					
Kyiv	7,200	1731	4,029	2,440	709
Zaporizhzhya	5,400	1805	2,515	2,300	495
Cherkasy	5,000	1,151	2,849	1,599	448
Poltava	4,500	1,499	2,101	1,862	363
Chernihiv	5,400	1,485	2,835	1,893	408
Kirovohrad	4,000	876	2,324	1,154	278
Total	**116,300**	**34,968**	**58,072**	**46,650**	**11,682**

'*' target dependent on identification of additional outside resources to purchase ARVs and test kits needed at RACs for scale-up
'' these are not PEPFAR targets but national ones.**

Table 4.1.1.A ART Targets in Sustained Sub-national Units for PWID

SNU [Specify SNUs for focus]	Total Est. PWID PLHIV	Current est. PWID PLHIV on ART	Target new patients added on ART	Target current on ART (in early 2017)*	ART coverage PWID mid 2017
Dnipropetrovsk	12,162	43%	1,769	6,998	58%
Mykolayiv	3,275	48%	166	1,723	53%

Odesa	6,040	62%	1,307	5,054	84%
Kyiv city	4,664	36%	1,396	3,068	66%
Kherson	1,627	44%	74	783	48%
Total	27,769	47%	4,712	17,627	63%

'*' target reflects augmented HTC and linkage to care among PWID supported by PEPFAR and increased eligibility for ART due to increased threshold.

Change from previous targets reflect

1. **Increased ART eligibility due to raising CD4 initiation threshold from 350 to 500**
2. **Yield from network recruitment at 15% (pilot yield was 23%)**

Table 4.1.1.B Additional Likely Impact on ART Targets from Change in Eligibility for ART among PWID Currently Enrolled in Care at AIDS Centers

	Est PWID on ART early 2017 with PEPFAR activities (4.1.1A)	Est ART coverage among PWID (4.1.1A)	Addl PWID initiated on ART from currently registered, newly eligible*	Est total PWID on ART early 2017	Est summary ART coverage among PWID
Dnipropetrovsk	6,998	58%	933	7,931	65%
Mykolayiv	1,723	53%	106	1,829	56%
Odesa	5,054	84%	823	5,876	97%
Kyiv city	3,068	66%	361	3,429	74%
Kherson	783	48%	117	900	55%
Total	17,627	63%	2,340	19,966	72%

- *Additional PWID in care who would be eligible estimated at 12.5% of current active care patients who are not on ART.

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in 5 Highest Burden Regions (2016)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
PWID identified HIV+ in outreach testing	**28,600**	**1120**	**500**
PWID identified through Network PDI recruitment	***13,500***	**1350**	**680**
PWID LTF from care returned via Case Management	***All previously positive***		**420**
Total			**1600**

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

Target Populations	Population Size Estimate (priority SNUs)	Current Coverage (date)	*VMMC_CIRC* (in FY16)	Expected Coverage (in FY16)
NOT APPLICABLE FOR UKRAINE				
Total/Average				

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	**Population Size Estimate (priority SNUs)**	**Coverage Goal (with HVCT)**	**FY16 Target**
[Specify target populations for focus] *Indicator Codes include PP_PREV and KP_PREV.* **PWID (HTC) 5 highest burden regions**	**103,850**	**41%**	**42,000***
Total			

'*' combination of standard GFATM outreach testing (2/3) and enhanced recruitment via networks (1/3). IBBS self-reported HIV testing data on PWID suggests that up to another 20,000 are tested at other venues outside of outreach.

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care, and Treatment

	Estimated # of Children PLHIV (<15)	**Target # of active OVC (FY16 Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC**	**Target # of children tested (FY16 Target)**	**Target # of children on ART**
Odesa	612	12			
Dnipropetrovsk	777	24			
Mykolayiv	272	24			
Kyiv city	396	24			
Chernihiv	140	24			
Kirovohrad	102	12			
Cherkasy	130	24			
Zhytomyr	107	12			
Poltava	116	24			
Lviv	102	12			
Kharkiv	137	24			
Zaporizhzhya	142	24			
Total:	3,034	240			

*OVC service targets include PLHIV aged 15-17 – the category that gets lost to follow-up as they move out of their SNUs for work or study and do not seek medical support or register with a CSO in their new location

Program Area Summaries 4.2-4.10

4.2 Priority population prevention

Although formerly the European country most severely impacted by HIV, Ukraine has made significant progress in slowing the primarily PWID-driven epidemic. Since 2004, Ukraine has optimized external support from GFATM, USG, and other external donors to focus its HIV prevention programs on KPs, including PWID, FSW, and MSM. These HIV prevention programs, bolstered by rapid scale-up of ART by the GoU and GFATM since 2008, have contributed to the stabilization of reported HIV cases since 2012.

To continue on a successful path toward achieving epidemic control in Ukraine, recent analyses of multiple data sources (Vitek, 2014) support PEPFAR Ukraine's emphasis on impactful prevention programming for KPs in high-burden regions. In particular, COP15 activities will involve TA to recruit and retain PWID in evidence-based HIV prevention services, such as needle and syringe exchange, MAT, and early diagnosis and linkage to ART, to further reduce HIV transmission to sexual and injecting partners in the 11 priority regions. With lower GFATM funding, the USG has contributed $1 million worth of condoms for 2014-2017. MAT programs have demonstrated success in decreasing risk behavior but are jeopardized by the planned withdrawal of GFATM financial support by mid-2017; PEPFAR will support pilots of innovative funding and delivery models and continue advocacy for GoU funding despite the economic crisis. In response to the evidence for focal high transmission among MSM in priority regions, PEPFAR will support MSM prevention NGOs to assess risk factors for infection and implement activities to address them.

HIV prevalence within the Ukrainian Armed Forces has historically been less than the general population, yet because of mobility and transfers, significant exposure to commercial sex workers, low condom use, and complex linkages to civilian care, the military remains a unique population. The ongoing conflict in the east has doubled the total military population to more than 250,000. High traumatic injury rates have resulted in a doubling of military blood screening demands to more than 4175 units. The rapid mobilization has exceeded existing HIV screening capacity for military personnel resulting in unscreened individuals in the emergency blood donor pool; increased HIV prevalence within the military may result without prompt intervention.

Recently mobilized military personnel represent a vulnerable population with widely varying educational levels that will receive education on universal precautions to mitigate HIV risk transmission from battlefield trauma. Securing a safe blood supply, universal HIV screening of this rapidly expanded standing military, and supporting effective training of universal precautions for risk mitigation of HIV transmission on the battlefield, focusing specifically on three oblasts with large military populations and corresponding higher HIV prevalence amongst the general population, is a short-term priority over the next two years. PEPFAR will support pilots of innovative funding and delivery models and continue advocacy for GoU funding despite the economic crisis. PEPFAR-Ukraine will support interventions for PWID sex partners and also

support MSM prevention NGOs to assess risk factors for infection and implement prevention activities in response to the evidence for focal high transmission among MSM in priority regions.

4.3 VMMC

Based on existing data and priorities in Ukraine, VMMC is not a PEPFAR-supported program.

4.4 PMTCT

Based on existing data and priorities in Ukraine, PMTCT is not a PEPFAR-supported program.

4.5 HTC

Ukraine estimates that ~67% of its PLHIV population has ever been registered in its HIV care system; thus, a significant proportion of PLHIV are either unaware of their status or have not yet registered at an AIDS Center. Multiple factors—including lack of risk awareness, stigma and discrimination—contribute to shortfalls in the detection and engagement of PLHIV in the HIV care cascade. To achieve epidemic control in Ukraine, concerted efforts must be made to identify previously undiagnosed PLHIV, especially in KPs, and engage them in HIV care and treatment. According to national HTC program data, the overall yield of newly identified HIV-positive individuals from testing at GoU clinical facilities (including PMTCT and blood donation screening) is 1.1%; this proportion is 'artificially' boosted by inclusion of retesting our PLHIV identified in outreach upon presentation to RAC. In comparison, targeting HIV testing to Ukraine's KPs has generated higher HIV-positivity (PWID: 3.2%; MSM: 1.5%; and FSW: 1.3%) (Alliance 2014 testing data); however, increased efficiency of case detection is needed to make rapid gains toward epidemic control. Several new approaches to diagnose PLHIV and link them to care are being planned for COP15. Rapid expansion of HTC services within the military to keep pace with the demands of a doubling of its size in the setting of armed conflict is an opportunity to prevent an otherwise likely increase in HIV rates in this unique population.

PEPFAR Ukraine plans to scale-up an innovative testing model piloted in Odesa to improve testing efficiency and yield in selected high-burden areas and among KPs. When compared to a standard HTC model conducted in 37 stationary and 2 mobile sites in Odesa (positivity of 3.5%), this new network-based model produced substantial gains in HIV yield (positivity of 23.7%) using fewer staff and financial resources (Smyrnov IAS abstract 2015). This innovative model extends existing HTC services by effectively engaging newly identified positives to refer sexual and drug-using partners for targeted and efficient testing. Activities in COP15 related to this network-based model will also evaluate two approaches for additional efficiencies and identify opportunities for scale-up to community outreach and other HIV care settings.

Current governmental regulations restrict HIV testing to healthcare personnel (i.e., physicians and nurses) in clinical settings. PEPFAR-Ukraine will also continue QI activities at primary health care and TB facilities focused on improving facility based HTC and linkage to HIV care at RACs, including expanding HTC beyond confirmed TB cases to TB suspects. Current governmental regulations restrict HIV testing to healthcare personnel (i.e., physicians and nurses) in clinical

settings. To date, however, there are no regulations against HIV self-testing in outreach and community settings. In response to GFATM cuts to outreach-supported HIV testing by healthcare personnel, Alliance has recently developed a niche model of "assisted testing" to enable the continuation of critical outreach testing for KPs in Ukraine. With this method, trained non-healthcare outreach staff will supervise their clients to perform rapid HIV self-tests in community settings. In COP15, PEPFAR Ukraine will support scale-up of this innovative model through ongoing training, QI, and M&E to reach KPs who either fear or experience barriers when accessing health facility-based HCT venues.

Finally, to address concerning levels of stigma and discrimination faced by PLHIV (Stigma report 2014), PEPFAR Ukraine will support stigma-reduction activities in healthcare settings and in the general population. Work in these areas, within HIV care and treatment services, can help to reduce the estimated drop off (33%) between HIV diagnosis and registration in HIV care (Alliance NGO data 2014).

4.6 Facility- and community-based care and support

SPECTRUM modeling estimates that 210,059 persons were living with HIV in Ukraine in 2014. Of these, 139,573 (67%) have registered at an AIDS Center as of Jan 2014 and 104,000 (50%) were considered to be in "active" care by having been seen within the previous 12 months. According to national data, of those registered at the AIDS Center, 25% cumulatively have become "inactive" or lost to HIV care. To work towards the UNAIDS goal of 90% ART coverage by 2020, however, two critical gaps in the HIV care cascade require attention in Ukraine: 1) the drop off between HIV diagnosis and linkage to HIV care (registration); and 2) the loss of PLHIV from active HIV care following registration at an AIDS Center. Efforts to reduce these gaps are needed to achieve coverage goals for ART and viral suppression, especially for KPs and in high-burden geographical areas.

PEPFAR Ukraine will support TA to its national and regional partners in the form of targeted CM activities pioneered by the CITI program (funded by GFATM). COP15 support will target TA in high-burden oblasts to scale-up and further refine CITI's model, which has shown effectiveness in the 1) linkage of PLHIV for registration at AIDS Centers and 2) re-engagement of PLHIV who have been lost from the HIV care system (those without a visit in 12 months).

To date, CITI's approach to linking newly diagnosed PWID to AIDS Centers has been highly effective. In a comparison of regions with CITI CM to those without, linkage to HIV care with CITI is >80% compared with ≤50% without. COP15 TA support will thus focus on the scale-up of CITI -type CM model to include additional key and priority populations (MSM, FSW, and prisoners) in high-burden oblasts.

More recently, to improve retention in HIV care among PWID, CITI case managers began to work with AIDS Center providers to identify registered PLHIV lost to care. Once AIDS Centers contacted those lost to care, CITI case managers were able to re-engage 50% of these patients,

most of whom were PWID, back into care. PEPFAR Ukraine will scale-up this innovative model to the priority oblasts and will also refine and tailor this component of CM for MSM and FSW.

PEPFAR Ukraine will initiate QI activities at RACs in all priority regions to improve patient services and thereby limit dropouts of PWID, especially KPs, from care and treatment. In addition, improved NGO CM models for PLHIV focused on ART adherence that have been developed with PEPFAR-Ukraine support will be scaled up.

4.7 TB/HIV

TB/HIV continues to be a major cause of morbidity and mortality for PLHIV. While HIV testing rates of confirmed TB cases (>85%) and symptomatic TB screening of HIV patients have improved, continued high mortality appears linked to late presentation, delayed initiation of ART, and a high prevalence of MDR-TB. PEPFAR-Ukraine will support improved linkages between the vertical disease treatment programs, monitor rates of 'early' initiation of ART (within 2 months), and initiate focused activities to enhance early initiation of ART.

4.8 Adult treatment

Despite recent gains in scaling up ART for PLHIV in Ukraine, both acute and chronic barriers have the potential to hinder progress towards achieving ART targets and, thus, sustained epidemic control. For 2014, the GoU procured 79% and the GFATM procured 21% of the ARVs for the 65,898 PLHIV on treatment at end-2014 representing 31% coverage of estimated PLHIV. The 2014-2018 National AIDS Plan had envisioned expanding ART coverage by year-end 2015 to 85,698 (41% ART coverage) - an increase of 19,800 on treatment. The steep economic decline and massive currency devaluation resulted in a failure to procure sufficient ARVs for 2015 to maintain current patients on therapy. The government is unable to increase funding above the amount in the national AIDS Plan despite the marked decrease in the purchasing power of the allotted funds. Funding shortfalls also affect laboratory test kits for HIV diagnosis and clinical monitoring. Reprogramming of one-time GFATM grant savings (due to the currency devaluation) towards procurement is underway that will cover ARVs for current patients through early 2016 and limited (6,000 patients) scale-up. However, a request for additional donor support is extant to allow the original scale-up as any further redistribution of GFATM resources will adversely affect critical programming. Given the ongoing political and financial challenges in Ukraine, however, partners at multiple levels are concerned about continuing threats to procurement of ARVs (i.e., stock-outs) and test kits for the next 2-5 years as health procurement reform and returned economic growth stabilize and then reestablish GoU self-sufficiency.

Currently, Ukrainian ART guidelines initiate therapy at CD4 < 350. The MoH has committed to raising the eligibility threshold to CD4 <500, but consistent with WHO guidance on policy development, the concerns of diversion of ART resources away from those with low CD4 has slowed revision. Current ART funding limitations will still ensure that those with CD4 <350 will be prioritized for available ARVs even if the threshold is raised. The availability of sufficient ARVs beyond the amounts envisioned in the NAP would help to guide policy development and would

allow for much more rapid scale-up given the existing number of PLHIV in care and the number anticipated to be reached with expanded recruitment.

According to national cohort data, 87% of all patients initiated on ART in 2012 were retained at 12 months. Summary reporting of all viral loads (VL) done on patients on ARV showed that 78% of specimens had VL<40 copies per mL and another 13% had VL>40 but <1,000 copies/mL giving a total VL rate (<1,000 copies per mL) of 91%. To achieve 90% ART coverage and maintain 90% viral suppression goals, PEPFAR Ukraine will engage in several new TA activities in the priority regions to improve these outcomes among priority populations and in priority regions. Core TA activities for COP15 will include: 1) QI pilots to increase ART uptake and reduce drop-out of patients at AIDS Centers; 2) support to strengthen the national training center and to establish regional training centers to a) improve ART training modules; b) increase numbers of health care workers (including primary care doctors) in ART and HIV management; and c) develop more sustainable decentralized training capacity; 3) establishment of transitional CM pilots to connect HIV-positive prisoners to civilian AIDS Centers upon discharge; and 4) work with the MoH to improve system of commodity procurement and supply chain.

PEPFAR Ukraine will also provide TA to national and regional partners through the cross-cutting activities of laboratory strengthening, SI, and HSS.

4.9 Pediatric Treatment

Based on existing data and priorities in Ukraine, pediatric treatment is not a PEPFAR-supported program.

4.10 OVC

HIV-positive adolescents face extra challenges associated with puberty, in addition to the challenges of accepting their HIV status. At age 15-16, they often move out of their communities to start work or study, and do not register with local CSOs to continue receiving support, which presents challenges for their ART adherence. Mostly coming from socially disadvantaged families, these HIV-positive children do not have the right life skills to manage their economic life. PEPFAR Ukraine will support limited interventions for OVC 15-17 (and caregivers) to provide psychosocial support, support continued adherence to ART, and improve their family economic/personal budgeting skills.

4.11 Laboratory

Laboratory activities are set to: 1) improve key quality management systems; 2) improve laboratory system sustainability; and 3) improve needed staff capacity. Activities center at the national level to strengthen governance of the laboratory network (strengthening of National Reference Laboratory), improvement of critical quality management components (standardizing IQA, introducing EQA and post-release validation for HIV assays, introducing preparation for accreditation to international standards) and development of human capacity in critical laboratory assays, such as point of care CD4 testing. Targets currently are primarily number of persons trained; an accreditation target will be adopted once a Memorandum of Understanding

(MOU) is finalized. As nationally-based activities, these activities do not specifically focus on the priority regions. However, as laboratory services have been developed proportionally to the disease burden, the bulk of staff benefiting work in these regions. Additional details are contained in the log-frames with additional TA also directly provided by PEPFAR-Ukraine staff.

The current armed conflict has highlighted significant gaps in the military blood safety program, for which short-term development of a self-sustaining Quality Assurance/Quality Improvement (QA/QI) program, standardized screening, and decentralization, will ensure this separate blood program keeps pace with civilian national blood safety programs.

4.12 SI

Accurate data and a culture of using data for decision makers are both critical to a sustained successful epidemic response. Current SI targets include both support for country-led activities to obtain and process accurate data (IBBS in 2015, data quality assurance activities, development of an HIV MIS) and development of human capacity to collect, analyze and interpret the data. Additional details are contained in the log-frames with additional TA also directly provided by PEPFAR-Ukraine staff.

4.13 OHSS

PEPFAR-Ukraine will continue to make major investments in building the capacity of CSOs and government institutions, policy change, strengthening Global Fund PRs, and building human capacity. Additional details are contained in the log-frames.

5.0 Program Activities to Sustain Support for Other Locations and Populations

The GoU and the GFATM provide a basic package of HIV services that covers all geographic areas and KPs in Ukraine. Together, they purchase ARVs and diagnostics that underpin the substantial treatment scale-up during the past six years. The GoU has taken major responsibility for procurement of ARVs and diagnostic tests and for advancing PMTCT by integrating HIV testing into prenatal service delivery. The GFATM remains the largest external funder for HIV in Ukraine. Its three Principal Recipients (PRs) cover the major service delivery areas of HTC, behavior change communication, care and support for the chronically ill, support for OVCs, M&E, health information systems, and general HSS. The three PRs have inaugurated their own systems for data collection, analysis, and reporting on prevention, treatment, and care and support services, although to date, no unified HIV MIS has been established as a central repository of data

and information. The GoU supports the equitable delivery of HIV services across the country. The GFATM has adopted a regionalization approach that targets high-burden oblasts in the east and south, although not to the exclusion of other oblasts in the country.

5.1 Package of services in other locations and populations

In its geographic focus and intervention effectiveness analyses, PEPFAR-Ukraine determined that USG-supported activities would no longer continue in two non-priority oblasts – Lviv and Kharkiv – and that stand-alone prevention interventions that insufficiently responded to the cascade of services in both priority and non-priority oblasts would also cease (*see Appendix for a Package of Service chart*). The implementing partners have made arrangements with government social services or with CSOs to support these activities after funding terminates in 2015 or early to mid-2016.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts

Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	***PMTCT_STAT***		
HTC (only sustained ART sites in FY 16)	***HTC_TST***		
Current on care (not yet initiated on ART)	***CARE_CURR-TX_CURR***		
Current on ART	***TX_CURR***		
OVC	***OVC_SERV***		

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

PEPFAR-Ukraine will also end activities that do not require further support because they are finished products (*Table A.3: Transition Plans for Non-Core Activities*). They include stigma and discrimination training curricula, a national HIV drug resistance prevention strategy, an electronic database for monitoring MAT for PLHIV, Pima CD4 analyzer testing, and implementation science studies. The establishment and roll-out of e-TB Manager has also been completed, although UCDC has asked for limited continued programming and support assistance for it. UCDC might also request the addition of a TB stock status module to e-TB Manager.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Strengthen laboratory system for sustainable epidemic control												
1.	Improve capacity for lab proficiency testing and EQA (SS) [N]	Assessment of the existing Ukrainian HIV PT for the CD4 count and VL testing done; Recommendations for improving the EQA/ PT administration and management, including needed trainings provided;	# Mentoring visits; # of labs successfully passed EQA program; #Guidelines, SOPs are published and disseminated # of trainings for laboratory experts conducted	HLAB $100,000	HLAB $200,000	17331 CLSI	II.7. Quality management: Score: 0.8	X		X		X

2.	**Support quality management standards and systems for laboratories**		HLAB	2016	HTXS	2016	HMBL	2016				
			$1,450,000.00	$850,000.00	$25,000.00	$0.00	$100,000.00	$50,000.00				
	ASCP: [N]	Training guidance for participants on the international standards ISO 15189 developed; # of trainings for laboratory experts and laboratory workers; # of lab staff trained	#of laboratories assessed against standards ISO 15189 # of laboratories that increase check-list score and meet accreditation criteria	HLAB $650,000 ($175,000 new)	HLAB $600,000	13268 ASCP	II.5 Human Resources for Health Score: 2.5 II.7. Quality management: Score: 0.8	X		X		X
	Network/CDC: [N]	Guidelines developed and distributed for HIV viral resistance lab diagnostics for lab staff		HTXS $25,000	0	14255 Network/CDC	II.7. Quality management: Score: 0.8					X
	APHL: [N]	---------- Technical input provided to developer of HIV MIS software Laboratory module of HIV Management Information System enhanced		HLAB 800,000 (none new)	HLAB 250,000	12957 APHL	II.7. Quality management: Score: 0.8 III.11 Technical Efficiency	X	-	X	-	X
	AIHA: [N, SN]	---------- 7 blood centers developed QI/QA plans; 7 blood sites implemented quality improvement activities; Quality indicators selected and monitored by pilot sites	Policies and SOPs are developed for TTI testing SOP for equipment validation, reagents/ kits and external controls	HMBL $100,000	HBML $50,000	14219 AIHA	II.7. Quality management: Score: 0.8	X	X	-	-	-

3.	Pilot laboratory management information systems (LB) [N]											
4.	Renovate HIV National Reference laboratory at UCDC [N]	Procurement of design and build contracts initiated	Initiation of renovation project	HLAB $2,000,000	HLAB $358,000			X		X		X
4.	**4.A.** American Society of Microbiology: Increase human capacity for laboratory support of HIV services [N]	3 Trainings on point of care CD4 systems developed and conducted	3 Trainings - HIV VL, HIV serology diagnostics and HIV/Tb co-infection developed and conducted	HLAB $150,000	HLAB $150,000	13168 ASM		X		X		X

6.2 Strategic information (SI)

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Improved data for improved decision making and targeting of PEPFAR interventions												
5.	Support implementation of IBBS and other surveillance efforts			HVSI $1,290,000.00	2016 $795,000.00							
	METIDA [N]	4 IBBS among key population (PWID, FSW, MSM) and bridge group studies are conducted and data on HIV prevalence among key population is collected Regional epidemic modelling (SPECTRUM)	Modes of Transmission study completed with improved ascertainment of modes of transmission among recent cases. Prevention Effectiveness Cohort study completed; Data on intervention	HVSI $1,150,000	HVSI $700,000	14235 METIDA	I. 1. Epidemiological and Health Data Score: I.3. Performance Data Score: IV. 12. Public Access to Information	X				

			effectiveness and PWID incidence collected and analyzed				Score:					
	FOGARTY [N]		Prevention Effectiveness Cohort data analyzed	HVSI $50,000	-	12091 FOGARTY	I.1.Epidemiological and Health Data; Score: 3. Performance Data Score: IV. 12. Public Access to Information Score:				X	
	UCSF [N]	Modes of Transmission study designed and cleared by CDC ADS	MOT study implemented	HVSI $50,000	HVSI $50,000	16718 UCSF	I.1.Epidemiological and Health Data; Score:	X	X			
	PLEDGE [N]	IBBS methodology including study protocol and instruments are developed and approved	IBBS conducted; bio-behavior data is collected; report is endorsed, published and disseminated	HVSI $40,000	HVSI $45,000	13582 HIV PLEDGE	I. 1. Epidemiological and Health Data Score: I.3. Performance Data Score: IV. 12. Public Access to Information Score:	X	X	X	-	-
6.	Develop HIV Management Information System, including identifying clinical outcome indicators to be tracked (Prison settings) Network/CDC	HIV MIS developed and piloted in 3 treatment sites	HIV MIS rolled out in 10 treatment sites	HTXS $600,000	HVSI $300,000	14255 Network/CDC	I. 1. Epidemiological and Health Data Score:			X		X

	[N]											
7.	Support development of an ART training database See Activity #21											
8.	Pilot a surveillance system for rational HIV drug use SIAPS [N]	First round of HIV DUR data collection in two HIV regional facilities and analysis with implementation plan of corrective actions completed	Second round of HIV DUR data collection and analysis completed	HVSI $195,500	HVSI $195,500	14247 SIAPS	II.7. Quality management: Score: 0.8	-	-	X (ART uptake AND retention)	-	X
9.	**Develop online national SI resources**			OHSS 2016 **$106,872.50**	**$73,044.32**	HVSI 2016 **$18,873.38**	**$74,071.22**					
	HIVRiA: National AIDS Program Dashboard creation (obj. 1); Conduct desk review of analytical data on delivery of HIV services in Ukraine, with specific emphasis on key populations [N, SN]	National AIDS Program Dashboard created; Number of regulatory documents developed/ reviewed due to the LEA carried out based on the previous Ukraine's HIV Policy Assessment of 2011.Project`s evidence-based recommendations that are endorsed/ applied by GoU (national/regional/local)	Nat AIDS Dashboard completed and in use. Regional AIDS Dashboards (7) created and in use. Number of regulatory documents developed/ reviewed due to the Project`s evidence-based recommendations that are endorsed/ applied by GoU (national/regional/local)	OHSS $106,872.50	OHSS $73,044,32	13232 HIVRiA	I.3. Performance Data: Score 11.5	X	X	X	X	X
	RESPOND: Develop online national SI resources [N]	National Strategic Information Platform (NSIP) with integrated SI tools developed	National Strategic Information Platform (NSIP) is updated with actual data and available	HVSI $18,873.38	HVSI $74,071.22	12899 RESPOND – Comprehensive KPs	I.1. – Epi and health data, IV.12 – public access to	X	X	X	X	X

		(regional profiles, service mapping, compendium of EBIs, database for HIV service organizations and donors, e-library, M&E Centres on-line offices, etc.	on-line.				information					
10.	METIDA: Support regional data triangulation using routine data [SN]	Preliminary results of Regional triangulation in 6 oblasts collected	The preliminary results are ready for 2 more regions, 6 reports are finalized and presented to decision-makers.	HVSI $100,000	HVSI $100,000	14235 METIDA	I. 1. Epidemiological and Health Data Score:	X	X	X	X	X
11.	**Building capacity within GoU for data and analysis**			OHSS 2016 $312,617.00	OHSS 2016 $0.00	HVSI 2016 $350,000.00	HVSI 2016 $1,235,386.00					
	HIVRiA: NASA validation and institutionalization; investment case phase II [N, SN]	1. NASA methodology finalized and institutionalized within MoH/ UCDC. NASA reports for 2011 and 2012 re-validated and published. 2. Investment Case Phase2 methodology developed. Facility-based information collected 3. # of person-courses completing in-service training within the reporting period (PEPFAR) #= 78	1. Annual NASA reports for 2013 and 2014 produced based on the methodology updated by UNAIDS. Reports used by MoH/ UCDC for (re) programming national AIDS operational plans for 2017 2. IC Phase2 analysis completed and report done. Recommendations discussed with national stakeholders 3. # of person-courses completing in-service training within the reporting period (PEPFAR) #= 85	OHSS: $312,617	HVSI: $885,386	13232 HIVRiA	III.10. Allocative Efficiency 11. Technical Efficiency Score: 4.0; I.3. Performance Data: Score 11.5; II.5. HRH Score: 3.0	X	X	X	X	-
	METIDA: Building capacity within GoU for data and analysis [N, SN]	2 persons M&E specialists at national level trained;	20 regional M&E Units have a capacity of minimum two M&E	HVSI $100,000	HVSI $100,000	14235 METIDA	I. 1. Epidemiological and Health Data	X	X	X	X	X

		20 regional M&E Units have a capacity of minimum two M&E specialists who are well trained in M&E	specialists				Score:					
		Data Quality Assurance Commission meetings Data quality assessment tool for one national indicator piloted in 2 regions Trainings on DQA tool for M&E staff at national level conducted	National DQA implementation plan is developed Data Quality verification tool is finalized 4 data quality/verification visits are conducted	HVSI $250,000	HVSI $250,000	14235 METIDA		X	X	X	X	X

6.3 Health System Strengthening (HSS)

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Favorable environment for improved services accessibility and acceptability												
12.	**Pilot and scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV**	OHSS 2016 $184,978.00 $101,134.00		HMIN 2016 $3,500.00 $0.00		IDUP 2016 $13,500.00 $64,000.00						
	RESPECT: Pilot and scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV by health workers [N, S]	(1) Number of KP and PLWH friendly policies developed; (2) # of medical institutions, that approved KP and PLWH friendly policies (3) # of national standards on waste management approved (4) # of IEM on S&D developed and published (5) # of informational campaigns on S&D run((6) # of trainings/on-site meetings for HCP on KP and PLWH friendly policies conducted	(1) Number of KP and PLWH friendly policies developed; (2) # of medical institutions, that approved KP and PLWH friendly policies (4) # of IEM on S&D developed and published (5) # of informational campaigns on S&D run((6) # of trainings/on-site meetings for HCP on KP and PLWH friendly policies conducted	OHSS $139,978 HMIN $3,500	OHSS 86 134	14254 Stigma and Discrimination	V. 14. Policies, Laws, and Regulations Score:	X	-	-	-	-
	PLEDGE: Pilot and scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV [N, SN]	1) Police guidelines on NSP and Opioid Substitution Therapy (OST) are drafted and shared with key stakeholders	1) Police guidelines on NSP and OST are finalized, printed and disseminated 2) HIV and harm reduction related modules are	IDUP $500 IDUP $5,000 IDUP $3000	IDUP $2,000 IDUP 5,000 IDUP $7000	13582 HIV PLEDGE	V.14. Policies, Laws, and Regulations	X	X	X	X	-

		2) HIV and harm reduction related modules are developed for police professional training and development system 3) Policy and legal review on criminalization of PWIDs is initiated; 4) HIV and human rights related modules are developed for use in prison staff training and development system 5) Assessment of compliance with human rights principles in drug dependence treatment system is initiated; report with recommendations on strengthening human rights compliance as well as on addressing stigma and discrimination is prepared and submitted to the MoH	integrated into police professional training and development system 3) Legal act to abolish criminalization of PWIDs is drafted and submitted to the Government approval; (4) HIV and human rights related modules are integrated into prison staff training and development system (5) Specific policy and legal documents are developed and endorsed to improve compliance with human rights principles including stigma and discrimination in drug dependence treatment facilities of 11 target regions	OHSS $45000 IDUP $5000	OHSS $15000 IDUP $50 000							
13.	**Build organizational capacity to address stigma and discrimination (among health workers, police staff)** RESPECT [SN]	(1) % of HCF that reduced its S&D level; (2) # of HCP who completed Training program on HCT, motivational counselling, prevention/reducin	(1) % of HCF that reduced its S&D level; (2) # of HCP who completed Training program on HCT, motivational counselling, prevention/reducin	OHSS 142,932	OHSS 312,200	14254 Stigma and Discrimination	II. 4. Access and Demand: Score 8.2	X	X	-	-	-

OHSS 2016
$153,417.21 $353,350.68

		g of S&D, UP, PEP, waste management	g of S&D, UP, PEP									
	RESPOND [SN]	Development of the post-graduate HCT curriculum with integrated stigma and discrimination module for health providers	Post-graduate curriculum with stigma and integrated discrimination module for health providers is delivered by post-graduate institutions	OHSS $10,485.21	OHSS $41,150.68	12899 RESPOND – Comprehensive KPs	II. 4. Access and Demand: Score 8.2	X	X	X		
14.	**Conduct stigma reduction activities among health and social workers and educators**		OHSS 2016 $142,932.00 $312,200.00 HVOP 2016 $5,000.00 $10,000.00									
	Peace Corps: Conduct interactive HIV prevention and stigma reduction trainings for health/social workers and educators with focus on stigma reduction towards KPs [S]	Custom Indicator: # of person-courses conducted, with disaggregation by topic (stigma). Annual	Custom Indicator: # of person-courses conducted, with disaggregation by topic (stigma). Annual	HVOP 5,000	HVOP 10,000	14071 Peace Corps	II. 4. Access and Demand: Score 8.2 II.5. HRH Score: 3.0	X	X	X	X	-
	RESPECT: Conduct stigma reduction activities among health workers [S]	(1) % of HCF that reduced its S&D level; (2) # of HCP who completed Training program on HCT, motivational counselling, prevention/reducing of S&D, UP, PEP, waste management	(1) % of HCF that reduced its S&D level; (2) # of HCP who completed Training program on HCT, motivational counselling, prevention/reducing of S&D, UP, PEP	OHSS 142 932	OHSS 312 200	14254 Stigma and Discrimination	II. 4. Access and Demand: Score 8.2	X	X			
15.	Build target group HIV knowledge and skills by promoting healthy behaviors and reducing stigma and discrimination of PLHIV and KPs via Peace Corps community and school-based programs (Near Core) Peace Corps [S]	Contributing to more tolerant attitudes towards KPs in local communities, explaining the importance of issues such as MAT for epidemic control. PP_PREV	Contributing to more tolerant attitudes towards KPs in local communities, explaining the importance of issues such as MAT for epidemic control. PP_PREV	HVOP 20,000	HVOP 35,000	14071 Peace Corps	II. 4. Access and Demand: Score 8.2	X			X	
Strengthen linkages within clinical cascade –focus on prisoners and PWID												

16.	PLEDGE: Improve linkage to AIDS service organizations for prisoners who are released [N, SN, S]	1) Operational research on patients drop outs is completed; report is prepared and used by stakeholders for policy improvement; baseline data is obtained for M&E purposes; (2) At least one SOP is developed and submitted for stakeholders review; (3) Intersectoral coordination and collaboration workshop is held in one target region	(1) SOP on HIV continuum of care is finalized and approved by the SPSU and MOH; (2) At least 150 prison medical staff from 76 prison facilities that are located in 11 target regions are trained on motivational counseling and case management as part of pre-release support programs; (3) At least one intersectoral coordination and collaboration workshop is held in each of 10 target regions; (4) Case management services to link PLHIV who are released from prisons to AIDS services	HBHC $ 10000	HBHC $ 340000	13582 HIV PLEDGE	II.4. Access and Demand	-	X	-	-	-
17.	PLEDGE: Integrate and scale up HIV preventions services into the narcology system [SN, S]	(1) Models of integrated provider initiated HIV testing and counselling, OST and ART services for PWIDs are available in 3 narcology facilities (Kyiv city, Poltava and Kharkiv); (2) # PWIDs are reached with HTC services in narcology; (3) # of PWIDs are provided with ART in narcology;	(1) Workshops to disseminate good practices on integrated models are held in 9 target regions; (2) Model of integrated provider initiated HIV testing and counselling, OST and ART services for PWIDs are available in narcology facilities located in 9 additional target regions;	HVCT $ 35 000	HVCT $130000	13582 HIV PLEDGE	II.4. Access and Demand 7. Quality Management	X	X	X	-	-

		(4) The model is evaluated, case study publication is finalized;	(3) Personnel of additional 9 narcology facilities are trained on integrated HIV services; (4) # PWIDs are reached with HTC services in narcology; (5) # of PWIDs are provided with ART in narcology									
18.	**Improve quality of care and treatment outcomes for Medication Assisted Therapy**			OHSS 2016 $51,940.84	$90,000.00	IDUP 2016 $637,407.50	$676,145.64	HTXS 2016 $100,000.00	$100,000.00			
	HIVRiA: Conduct pilot on OST (MAT) services at the sub-national/ local level. Provide TA on development of the National Strategy on access to HIV prevention services for key populations, with MAT discrete section [SN, S]	Number of pilots on alternative approaches to deliver/finance HIV services developed and launched. (#: 3/ regions)	Number of pilots on alternative approaches to deliver/finance HIV services implemented (#: 5/ regions)	IDUP $137,407.50	IDUP $159,369.30	13232 HIVRiA	II. 4. Access and Demand: Score 8.2 II.7 Quality Management Score 0.8 III.11 Allocative Efficiency Score: 4	X	X	X	X	-
	RESPOND: Pilot integration of MAT services into PHC setting linked to Seven Steps intervention. (Seven Steps is enrolment in MAT services through outreach and case management to develop adherence to these services) and document the model. [S]	Pilos in 2 sites in Poltava and 1 site in Mykolayiv. Document the model.	Final documentation of the model and results of the feasibility study report	OHSS $41,940.84	IDUP $16,776.34	12899 RESPOND – Comprehensive KPs	I. 1. Epidemiological and Health Data Score: I.3. Performance Data: Score 11.5	-	-	-	X	-
	PLEDGE: Improve quality of care and treatment outcomes for Medication Assisted Therapy [N, SN, S]	(1) Multisectoral TWG on OST is functional; (2) Assessment of national clinical protocol for opioid dependence treatment is completed; report	(1) National clinical protocol on opioid dependence treatment is developed, approved, published and disseminated; (2) 50 narcologists are trained;	OHSS $10,000	OHSS $90,000	13582 HIV PLEDGE	II. 4. Access and Demand: Score 8.2 II.7 Quality Management Score 0.8 III.11	-	-	-	X	-

		and recommendations are presented to stakeholders	(3) OST scale-up plans for 11 regions are developed and submitted to local authorities;				Allocative Efficiency Score: 4					
	I-TECH [N, SN]]	MAT training packages for PHCP finalized;	Training of Trainers (TOT) for MAT 100 PHCP trained in MAT	HTXS $100,000	*HTXS $100,000*	12093 I-TECH *TBD I-TECH follow (for 2016)*	II.5. HRH Score: 3.0	-	X	X	X	-
	Alliance MAT [N, SN]]	Note: new mechanism and COP14 funds have still not been released from Congress to agency. Deliverables will be delayed by one year if not released soon. 30 MAT program personnel trained on the last up-to-date clinical standards	Evaluation of ≥ one alternative financing model initiated 55 MAT program personnel trained on the last up-to-date clinical standards Number of sites participating in the QI system # of sites dispensing MAT and ART at the same location nationally Three financially sustainable and cost-effective MAT funding models to inform MAT service on scale-up for the Government of Ukraine identify developed and implemented	IDUP $500,000	IDUP $500,000	17345 Alliance MAT	II. 4. Access and Demand: Score 8.2 II.7 Quality Management Score 0.8 III.11 Allocative Efficiency Score: 4	-	X	X	X	-
Sustainable training facilities and specialized HIV programs for health work force												

19.	**Support training health workers (including primary care doctors) in ART delivery, including CQI**		OHSS 2016 $148,312.00 $114,674.00	HVTB 2016 $7,969.00 $9,142.00		HTXS 2016 $154,852.10 $411,506.80						
	STbCU [S, SN]	HTC_TST TA, HRH-in-Service Training Increased knowledge of PHC providers on TB/HIV and improved referral system between TB and HIV services	HTC_TST TA, HRH-in-Service Training Increased knowledge of PHC providers on TB/HIV and improved referral system between TB and HIV services	HVTB $7969	HVTB $9142	12845 STbCU	II.7. Quality Management Score: 0.8	X	X	X	X	-
	RESPECT [N, SN]	(1)# of training curricula developed (2) # of HCP who completed training programs	(1)# of training curricula developed (2) # of HCP who completed training programs	OHSS $148,312	OHSS $64,674	14254 Stigma and Discrimination	II.5. HRH Score: 3.0	X	-	-	-	-
	RESPOND [SN]	Trainings on ART, and ART/TB, opportunistic infections (OI) and hepatitis are provided by the Ukrainian National Training Center (UNTC) and are covered under the Marketplace voucher system. People trained on ART & ART/TB under the Marketplace voucher system	People trained on ART & ART/TB under the Marketplace voucher system. UNTC training modules are transferred to the Regional Training centers in FY 16. Regional training centers have trainers on ART & ART/TB, OI and hepatitis	HTXS $104,852.10	HTXS $411,506.80	12899 RESPOND – Comprehensive KPs	II.5. HRH Score: 3.0	-	-	X	-	X
	Network/CDC [N]	1 New HIV Clinical Directive developed 1 HIV/OI treatment guidelines developed	4 Trainings in new HIV clinical guidelines conducted	HTXS $50,000	OHSS $50,000	14255 Network/CDC	II.5. HRH Score: 3.0	-	-	X	-	X
20.	**Support regional training centers for HIV services for key populations**	OHSS 2016 $127,426.05 $358,630.10	HVSI 2016 $0.00 $0.00		HTXS 2016 $200,000.00 $200,000.00	HVOP 2016 $300,000.00 $0.00						
	RESPOND [SN]	Regional HIV Training Centers are	Trainings curricula are developed,	OHSS $52,426	OHSS $308,63	12899 RESPOND –	II.5. HRH Score: 3.0	X	X	-	-	-

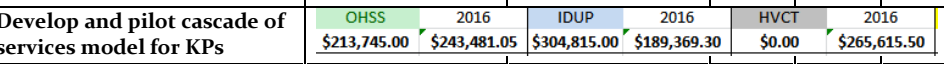
		established and supported in 2 regions. Trainings curricula are developed, trainers trained, trainings conducted, trainees trained	trainers trained, trainings conducted, trainees trained. Training Centers will be established in 2 more regions	.05	0.10	Comprehensive KPs						
	METIDA [N]		15 trainings on providing HIV services for key populations for outreach and case management workers		HVOP #300,000	14235 METIDA	II.5 Human Resources for Health Score: 3.0	X	-	-	-	-
	I-TECH [N]	Training package for TOT on ART training methodologies developed	TOT on ART training methodologies and principles of learning for UCDC staff	HTXS $200,000	*HTXS $200,000*	12093 I-TECH *TBD I-TECH follow (2016)*	II.7 Quality Management Score 0.8 II.5 Human Resources for Health Score: 3.0	-	-	X	-	X
	WHO/CDC [N]	Strengthening M&E capacity working with UCDC on development of the reporting systems for regional HIV centers		OHSS $75,000	OHSS 50,000	13252 WHO/CDC	II.5 Human Resources for Health Score: 3.0	X	X	X	X	X
21.	I-TECH Support development of an ART training database [N]	Adaptation and launch of TrainSMART training database UCDC regional M&E staff trained on the use of TrainSMART;	TrainSMART system handed over from I-TECH to UCDC Web based version launched	HTXS 100,000	*HTXS $100,000*	12093 I-TECH *TBD I-TECH follow in 2016*	II.5 Human Resources for Health Score: 3.0	-	-	X	-	X
Improved data for improved decision making and targeting of PEPFAR interventions												

22.	Network/CDC: Identify clinical outcome indicators for ART and OI treatment [N]	Working group developed outcome Indicators	List of indicators approved	OHSS $30,000	-	14255 Network/CDC	II.3. Performance Data			X		X
23.	**Building capacity within GoU for data and analysis**	OHSS 2016 $186,873.00	HVSI 2016 $241,740.00 $50,000.00	2016 $0.00	HMBL 2016 $100,000.00 $50,000.00							
	HIVRiA: Conduct Legal Environment Assessment (LEA) [N, SN]	LEA carried out based on the previous Ukraine's HIV Policy Assessment of 2011.Project`s evidence-based recommendations that are endorsed/ applied by GoU (national/regional/local)	LEA results discussed with the national stakeholders and a selected number of recommendations are endorsed and auctioned on (at central level/ Cab Min, MoH and sub-national level/ PEPFAR priority oblasts.	OHSS $106,873	OHSS $121,740	13232 HIVRiA	I.3. Performance Data: Score 11.5	X	X	X	X	X
	METIDA [N]	20 new trainees enrolled in the training program for data and analysis The materials for web-based M&E training course developed	The web-based training course on M&E launched	HVSI $50,000	-	14235 METIDA		X	X	X	X	X
	AIHA [N, SN]	5 blood centers pilot sites adopt quality indicators as part of M&E program	Improved blood center M&E reporting form developed and piloted	HMBL $100,000	HMBL $50,000	14219 AIHA	II.7 Quality Management Score 0.8	X	-	-	-	-
	WHO [N]	50 HCW from 25 regions trained on data management; The study protocol for survey on HIV transmitted drug resistance in 8 regions of Ukraine based on WHO Global strategy for surveillance and	50 HCW from 25 regions trained on data management; HIV viral drug resistance surveillance initiated	OHSS $80,000	OHSS $120,000	13252 WHO/CDC	II.5. HRH (Score: 3.0)	X	X	X	X	X

		monitoring of HIV drug resistance developed Improve data availability on burden of HIV/HCV co-infection: initiate analysis of available data on HIV/HCV Data triangulation analysis on co-infection HIV/HCV conducted	Report on the results of HIV/HCV data triangulation analysis disseminated among national stakeholders									
24.	Strengthen M&E capacity and data use efforts of government decision-makers (near core)											
25.	**Support implementation science (near core)**			HVSI $75,164.50	2016 $124,071.22							
	RESPOND: [SN]	Sub-grants to conduct IS studies by research institutions to assess the implementation of adapted international interventions and locally developed interventions; ongoing TA to IS sub-grantees. Study reports are developed and published	IS studies of interventions targeting PWID and PLHIV continue. In-country capacity to implement IS strengthened	HVSI $25,164.50	HVSI $74,071.22	12899 RESPOND – Comprehensive KPs	I.1 – Epi and health data, II.5 – Human resources for health	-	-	-	X	-
	METIDA: [N]	20 new trainees enrolled in the training program; 15 new trainees continue their participation in the program; The materials for	10 trainees (from 2015 cohort) continue their participation in the training program The web-based training course	HVSI $50,000	HVSI $50,000	14235 METIDA	II.5. HRH (Score: 3.0)	X			X	

		web-based training course developed	launched									
26.	**Train health workers in outcome-based decision-making (near core)**		OHSS 2016 **$288,745.00 $292,177.00**			HVSI 2016 **$18,873.38 $98,761.63**						
	HIVRiA: Build capacity of health care managers at the national and sub-national level in evidence-based policy making and oversight [N, SN]	# of person-courses completing in-service training within the reporting period (PEPFAR) #= 60	# of person-courses completing in-service training within the reporting period (PEPFAR) #=85	OHSS $213,745	OHSS $292,177	13232 HIVRiA	II.5. HRH (Score: 3.0) II.7 Quality Management Score 0.8	X	X	X	X	-
	RESPOND: Train health workers in outcome-based decision-making [SN]	"Data demand and use for decision making" (DDUDM) guide developed printed and disseminated among national and regional stakeholders. ToTs for Regional M&E Centers conducted and trainers trained; cascade analysis trainings conducted. DDUDM curriculum is developed and 2 RTCs are provided with training module on DDUDM.	DDUDM trainings conducted by the regional training teams	HVSI $18,873.38	HVSI $98,761.63	12899 RESPOND – Comprehensive KPs	II.5. HRH (Score: 3.0)	X	X	X	X	X
	FOGARTY [N]	2 trainees complete operational research capacity building program	-	OHSS $75,000		12091 Fogarty	II.5. HRH (Score: 3.0)	-	-	-	X	-
Strengthened OD capacity and coordination for improved impact												

27.	**Strengthen organizational capacity for civil society organizations serving KPs**	OHSS $106,872.50	2016 $121,740.53	HVMO $30,000.00	2016 $89,000.00	HKID $20,970.42	2016 $82,301.36	IDUP $26,776.34	2016 $85,841.09	HBHC $41,940.84	2016 $144,027.38	
	HIVRiA: Strengthen the capacity of local partners (NGOs and other non-government partners) which will be able to serve as future TA providers [N, SN, S]	Percentage of improvement in self-assessment scores of partner organizations provided with capacity building activities	Percentage of improvement in self-assessment scores of partner organizations provided with capacity building activities	OHSS $106,872.50	OHSS $121,740.53	13232 HIVRiA	II.5. HRH Score: 3.0 II.7 Quality Management Score 0.8	X	X	X	X	X
	Peace Corps: Strengthen organizational capacity for civil society organizations serving KPs [S]	# of CSOs serving KPs assisted by Peace Corps Response Volunteers to diversify funding sources for services to KPs; # of CSOs serving KPs strengthened by Peace Corps Volunteers # of local CSO projects funded	# of CSOs serving KPs assisted by Peace Corps Response Volunteers to diversify funding sources for services to KPs; # of CSOs serving KPs strengthened by Peace Corps Volunteers # of local CSO projects funded	HVMO $30,000	HVMO $89,000	14071 Peace Corps	II. 4. Access and Demand: Score 8.2	X	X	X	X	-
	RESPOND: Strengthen organizational capacity for civil society organizations serving KPs [S]	Capacity development interventions and business plan development for select number of most viable NGOs including Regional Branches of PLHIV. Improved performance measured by Organizational Performance Index (OPI)	Improved performance measured by Organizational Performance Index (OPI)	HKID $20,970.42 IDUP $16,776.34 HBHC $41,940.84	HKID $82,301.36 IDUP $65,841.09 HBHC $144,027.38	12899 RESPOND – Comprehensive KPs	II. 4. Access and Demand: Score 8.2	X	X	X	X	X
	PLEDGE: Strengthen organizational capacity for civil society organizations serving KPs [SN]	Toolkit for monitoring police policies and practices in promoting accessibility of HIV and harm reduction	At least 50 personnel of CSOs working in harm reduction programs in 11 target regions improved their knowledge and	IDUP $10,000	IDUP $20,000	13582 HIV PLEDGE	V.14. Policies, Laws, and Regulations	-	-	-	X	-

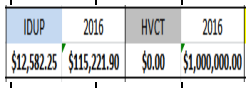
		services for PWIDs is developed, piloted and handed over to CSOs	skills to establish and maintain effective collaboration with police to ensure accessibility of HIV services for PWIDs									
28.	Strengthen coordination of HIV and TB programs											
29.	**Develop and pilot cascade of services model for KPs**											
	HIVRiA: Conduct pilot on improvement patient pathways and cascade of services [SN, S]	1. HIV Client Pathway (across the cascade) for Ukraine developed, in consultation with the key national stakeholders. 2. Number of pilots on alternative approaches to deliver/finance HIV services for KPs developed and launched in one of the PEPFAR priority oblasts. 3. Number of person-courses completing in-service training within the reporting period (PEPFAR) #= 122	Number of pilots on alternative approaches to deliver/finance HIV services implemented in two PEPFAR priority oblasts Number of person-courses completing in-service training within the reporting period (PEPFAR) #= 140	IDUP $274,815 OHSS $213,745	IDUP $159369.30 OHSS $243,481.05 HVCT: $265,615.50	13232 HIVRiA	II. 4. Access and Demand: Score 8.2 II.7 Quality Management Score 0.8 III.11 Allocative Efficiency Score: 4	X	X	X	X	X
	PLEDGE: Develop and pilot cascade of services model for KPs [SN]	Models of effective collaboration and referral schemes involving police to improve accessibility of HIV services for PWIDs are piloted in 3 cities	500 PWIDs are referred by police to community based HIV services; Lessons learned and good practices and experience from the pilots are documented; and	IDUP 30,000	IDUP 30,000	13582 HIV PLEDGE	II. 4. Access and Demand: Score 8.2 V. 15. Planning and Coordination	-	-	-	X	-

			disseminated nation-wide during national conference									
Strengthened Laboratory System for Sustainable Epidemic Control												
30.	**Implement EQA for HIV Rapid Test practices at VCT sites**											
	ASM: [N]	VCT site mentoring and assessment visits initiated Drafts of SOPs developed EQA program developed	Regional laboratory participants undergo in-service training 5 regions initiated EQA program; 5 - 10 sites in each region get site assessment and site mentoring visits 5 - 10 sites in each region successfully pass EQA program	HLAB $150,000	HLAB $400,000	13168 ASM	II.5 Human Resources for Health; II.7 Quality Management III.11 Technical Efficiency	X	X	-	-	-
31.	AIHA: Strengthen blood donation and screening programs [N]	QI/QA plan developed to improve quality and accuracy of testing for pilot sites Donor questionnaire according to EU requirements revised and piloted;	40 blood center professionals trained on monitoring TTI assay performance QI/QA plan to increase percent of successful HIV EQA performance implemented; Internal M&E system for evaluation of TTIs and other testing implemented. Donor education materials according	HMBL $200,000.00 HMBL $100,000	2016 $200,000.00 HMBL $100,000	AIHA 14219	II.7. Quality management	X	-	-	-	-

			to EU requirements are revised and piloted; Inventory management system for blood centers piloted									
	DOD: Strengthen blood donation and screening programs in the military [N]	Improved HIV testing amongst walking blood donation pool in military; develop uniform quality assurance and monitoring in military HIV blood donation program; address probable gaps in linkage to care at civilian AIDS centres	DOD blood safety experts visit and do a technical evaluation of two re-established major blood bank centers and make recommendations. Based on the recommendations, there will be some equipment purchases and reagents to improve the blood supply system of the Armed Forces of Ukraine. Program transition.	HBML $100,000	HBML $100,000	75020 DOD	II.7. Quality Management: Score: 0.8 III.11. Technical Efficiency: Score: 4.0	X	X		X	
32.	AIHA: Strengthen the national blood safety system [N]	Pilot sites assessed against EuBIS inspection checklist; Gaps identified and roadmap to address gaps are developed; Action plan to address identified gaps developed	7 blood centers assessed on progress against EU standards/requirements at CAPA plan based on assessment findings developed	HMBL $50,000	HMBL $0	AIHA 14219	II.7. Quality management	X	-	-	-	-
33.	**Pilot laboratory management information systems**											

34.	**Renovate UCDC laboratory**	See item 4 under lab strengthening										
Improved quality of services and case management for enhanced ART adherence and retention												
35.	RESPECT: Develop and pilot cascade of services model for KPs [SN]	The model is developed to be run in 2 high prevalence oblasts	The model is developed to be run in 2 high prevalence oblasts	OHSS 20 000	OHSS 60 000	14254 Stigma and Discrimination	II. 4. Access and Demand: Score 8.2	-	X	X	-	-
36.	**Pilot and implement case management models for PLHIV focused on ART adherence, IDUs and TB patients**											
	HIVRiA: Conduct pilot on case management models for KPs [N, SN, S]	1. HIV Client Pathway (across the cascade) for Ukraine developed, in consultation with the key national stakeholders. 2. Number of pilots on alternative approaches to deliver/finance case management models for KPs developed and launched in one of the PEPFAR priority oblasts.	Number of pilots on alternative approaches to deliver/finance case management models for KPs Implemented in two PEPFAR priority oblasts	OHSS $213,745	OHSS $243,481.05	13232 HIVRiA	II. 4. Access and Demand: Score 8.2 II.7 Quality Management Score 0.8 III.10 Allocative Efficiency Score: 4	-	X	X	-	X
	RESPOND: [S]	Work with the PLHIV Network to structure and package local interventions; provide sub-grants and TA to select number of NGOs involved in the piloting of	PLHA adhere to ARV, TB treatment and medical services; IS studies are finalized	HBHC $62,911.26 IDUP $8,388.17	HBHC $267,479.42 IDUP $98,761.63	12899 RESPOND – Comprehensive KPs	I.3.- Performance data II. 4. Access and Demand: Score 8.2 III.10	-	-	X	-	X

OHSS	2016	HBHC	2016	IDUP	2016
$213,745.00	$243,481.05	$62,911.26	$267,479.42	$8,388.17	$98,761.63

		PLHA adhere to ARV, TB treatment and medical services; IS studies are conducted					Allocative Efficiency Score: 4					
37.	PLEDGE: Pilot and implement QI models focused on HIV care and treatment in selected regions for KPs [N, S]	# of guidelines, protocols and SOP developed, endorsed; Relevant personnel of 4 prisons are trained to provide quality HIV interventions; HIV response action plans are developed, endorsed and implemented in 4 prisons; (1) HTC sites in 4 prisons received support to provide quality services in line with national standards; (2) # of inmates reached with HTC services;	# of guidelines, protocols and SOP developed, endorsed; Relevant personnel of 50 prisons are trained to provide quality HIV interventions; HIV response action plans are developed, endorsed and implemented in 50 prisons; (1) HTC sites in 50 prisons received support to provide quality services in line with national standards; (2) # of inmates reached with HTC services;	OHSS $96 000	OHSS $95 000	13582 HIV PLEDGE	II.4. Access and Demand 7. Quality Management	X	X	X	-	-
38.	**Use case management approach to identify patients who have dropped out and return them to care**											
	RESPOND: [S]	Piloting Seven Steps to reduce HIV transmission and enroll PWIDs in drug dependence treatment. PWIDs receive HCT and support to finalize their treatment	PWIDs receive HCT and support to finalize their treatment Implementing CITI in two regions (Kherson, Kirovograd) that are not covered under other GF & PEPFAR projects to reach, test & enroll PWID	IDUP $12,582.25	IDUP $115,221.90	12899 RESPOND – Comprehensive KPs	I.3.- Performance data II. 4. Access and Demand: Score 8.2	X	X	X	X	X

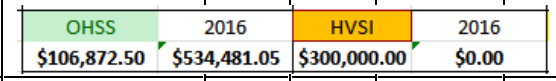
			in care									
	METIDA: Use case management approach to identify patients who have dropped out and return them to care (includes innovative network method to recruit additional PLHIV and link them as well) [N]		In 5 high burden HIV prevalence and 4 medium HIV prevalence regions 1450 patients who have not been seen in past 12 months are returned to care at AIDS centers RNPDI brings in and tests 17,000 PWID CITI links 3,675 new HIV+ PWID to care	-	HVCT 1,000,000	14235 METIDA CITI	II. 4. Access and Demand: Score 8.2	X	X	X	-	-
39.	**Apply QI approach at AIDS Centers to strengthen patient pathway to prevent dropouts**		OHSS 2016 $207,278.15 $1,058,767.00 HTXS 2016 $100,000.00 $500,000.00									
	RESPOND: [SN]	Begin the development of QI Charters in eleven regions, set improvement goals and develop measurement systems	Finalize QI Charters, begin implementation, train mentors and coaches, and test changes	OHSS $157,278.15	OHSS $1,028,767	12899 RESPOND – Comprehensive KPs	II. 4. Access and Demand: Score 8.2 II.5. HRH Score: 3.0 II.7 Quality Management Score 0.8	-	X	X	-	X
	I-TECH: [N]	ClASS Ukrainian reviewers certified 5 AIDS Centers participate in CLASS reviews with UCDC and national reviewers	CLASS reviews continued QI to strengthen HIV services initiated at Odesa, DNP, and Cherkasy AIDS Centers	HTXS $100,000	*HTXS $500,000*	12093 I-TECH *TBD I-TECH follow*	II.5. HRH Score: 3.0 II.7 Quality Management Score 0.8		X	X		X
	AIHA: [N]	Process to confirm referral of HIV reactive blood donors to HIV/AIDS centers and entering into a C&T program piloted; # of potential HIV reactive donors	Process expanded to include reporting of potential donors that have been excluded from donation due to high risk behavior (MSM, IDUs, CSW);	OHSS $50,000	OHSS $30,000	14219 AIHA	II. 4. Access and Demand: Score 8.2		X			

		entered into C&T program at AIDS centers										
40.	RESPOND: Pilot QI interventions to increase yield from facility based HTC and referrals [SN]	Apply QI methodology to improve counseling and testing at the primary health care level and TB facilities. HIV patients are detected in PHC and TB facilities; Cascade service model using QI approach is implemented and documented in Zaporizhzya, Poltava, and Lviv.	HIV patients are detected in PHC and TB facilities using QI methodology in Zaporizhzya, Lviv, and Poltava. If accepted by Oblast health authorities, QI activities will be scaled up.	OHSS - $131,065.13 HVCT - $73,396.47	OHSS - $308,630.10 HVCT - $288,054.76	12899 RESPOND – Comprehensive KPs	II.5. HRH Score: 3.0	X	X	-	-	-
41.	Peace Corps: Support interventions (camps and trainings) for HIV+ youth to provide psychosocial support, adherence promotion, and economic strengthening (OVC) [SN, S]	# of OVC and caregivers benefitting from the program	# of OVC and caregivers benefitting from the program	HKID 30,000	HKID 85,000	14071 Peace Corps	II. 4. Access and Demand: Score 8.2	-	-	X	-	-
42.	**Update clinical protocols for HIV+ children (near core)**											
43.	**Pilot a surveillance system for rational HIV drug use (near core)**											

44.	**Develop pharmacovigilance system for HIV-related drugs (near core)** **SIAPS** [N]	Complete piloting PAIS in 5 regional HIV facilities and develop the PAIS security protocol for the implementation phase. Facilities are: (1) Kyiv City, "Kyiv Lavra AIDS Clinic"/ Nat Academy of Med Sciences, (2) Kyiv Oblast, (3) Chernigiv, (4) Zhytomyr, (5) Vinnytsya	PAIS tool rolled out in PEPFAR priority regions	OHSS $195,500	OHSS $103,500	14247 SIAPS	II.7. Quality management: Score: 0.8	-	-	X	X For TB prevention with isoniazid or cotrimoxazole	X
45.	**RESPOND: Develop QI/QA regulations for HIV/AIDS services (near core)** [N]	Support National QI group QI policy review report; TWG meetings	TWG meetings; regulatory documents on QI/QA developed	OHSS $52,426.05	OHSS $205,753.40	12899 RESPOND – Comprehensive KPs	V.14- Policies, Laws, regulations Score:	X	X	X	X	X
Strengthened national government HIV response through enhanced sustainable financing, budgeting and staffing of National HIV program, Commodity Procurement, and Supply chain												
46.	**Strengthen HIV program planning and budgeting at national and oblast levels**			OHSS $213,745.00	2016 $243,481.00	IDUP $320,617.50	2016 $212,492.40					
	HIVRiA: Provide national and local partners with adequate regional and national data and information. Support the development of RAPS, incl. budget planning and service calculations with targets; TA to the Ministry of Economy on new mechanisms and tools for development/ revision of national and regional AIDS programs (example for any health program); Build capacity of change agent in evidence-based policy making and oversight. [RAPs development, HIV Client	14 Regional/ oblast AIDS programs (RAPs) with costs, targets, KPs intervention packages and budget calculations developed; HIV Client Pathways (Cascade of HIV services) in Ukraine developed and endorsed by the key stakeholders; Number of person-courses completing in-service training	7 priority oblasts are provided with TA to support their RAPs implementation with the focus on achieving higher yield from HTC, referrals, scaled-up ART coverage and returning lost-to-follow up HIV patients into care; Number of person-courses completing in-service training within the reporting period (PEPFAR):	IDUP: $320,617.50 OHSS: $213,745	IDUP: $212,492.40 OHSS: $243,481	13232 HIVRiA	II.5. HRH (Score: 3.0) II.7. Quality Management (Score: 0.8) III. Performance Data: Score **11.5**	X	X	X	X	X

	Pathway development, HIV Prevention in KPs Transition Strategy/ from GF-dependent to country –sustained] [N, SN]	within the reporting period (PEPFAR): 125	115									
47.	**Develop innovative financing and budgeting mechanisms to improve allocative and technical efficiencies in HIV program**			OHSS $117,157.50	2016 $265,626.05							
	HIVRiA: Revise and improve financial mechanisms for provision of HIV services to key population [SN]	Number of alternative resource allocation and financing options for HIV services designed and launched in one of the selected PEPFAR priority regions [prelim: MAT co-financing model in Poltava]	Number of alternative resource allocation and financing options for HIV services implemented in two of the PEPFAR priority regions	OHSS $106,872.50	OHSS $243,481.05	13232 HIVRiA	III.10. Allocative Efficiency 11. Technical Efficiency Score: 4.0	X	X	X	X	-
	RESPECT: [SN]	(1) # of trainings/working groups for PLWH community based organization	(1) # of trainings/working groups for PLWH community based organization	OHSS $10,285	OHSS $22,145	14254 Stigma and Discrimination	V. 14. Policies, Laws, and Regulations	X	X	X	X	X
48.	**Pilot provider payment reforms for HIV, in collaboration with World Bank**											
	HIVRiA: Conduct pilot provider payment models for HIV (Obj 1) [SN]	Number of pilots on alternative approaches to deliver/finance HIV services through new provider payment mechanism	Number of pilots on alternative approaches to deliver/finance HIV services through new provider payment mechanism	OHSS 42,749	OHSS 243,481.05	13232 HIVRiA	III.10. Allocative Efficiency 11. Technical Efficiency Score: 4.0	X	X	X	X	-

		implemented in one of the PEPFAR priority oblasts	implemented in one of the PEPFAR priority oblasts. Policy on provider payment mechanism for the HIV services developed (by MoH and Ministry of Finance)									
49.	**Technical assistance to GOU to ensure HRH capacity in HIV**			OHSS $292,384.08	2016 $439,977.04							
	HIVRiA: Facilitate HRH Strategy development and introduction of relevant changes in the HRH legislation (Obj 3) Support the development of Oblast HIV /AIDS Programs, including HRH planning and training (Obj 3) Define HRH needs for the implementation of alternative mechanisms (rationalization option) of the delivery/financing of HIV services for key populations at the regional level (Obj 3) [N]	National 5-year plan for HRH planning and management aligned with NAP is drafted	National 5-year plan for HRH planning and management aligned with NAP is endorsed; Number of selected regions that have started HRH strengthening plan implementation	OHSS: $213,745	OHSS: $316,525	13232 HIVRiA	II.5. HRH Score: 3.0	X	X	X	X	X
	RESPOND: Technical assistance to GOU to ensure HRH capacity in HIV [N]	Work with the Ukrainian National Training Center (UNTC), Ukrainian Center for Disease Control (UCDC), Regional training Centers to develop resource materials, curricula and trainers on HCT & QI. Training curricula and resource materials on HCT are developed	Training curricula and resource materials on QI and SI are developed.	OHSS $78,639.08	OHSS $123,452.04	12899 RESPOND – Comprehensive KPs	II.5. HRH Score: 3.0	X	X	X	-	X
		See Primary reference above	Transfer TrainSMART;			I-TECH	See primary reference					

		under OHSS 21 ITECH Adapt and launch TrainSMART ART training database	launch web-based version									
50.	**Strengthen commodity procurement and supply chain**											
	SIAPS: 1. Carry out an assessment of the current HIV/AIDS supply chain and develop an implementation plan for key recommendations 2. Support the MoH and UCDC in development and approval of regulations to clarify and streamline distribution and redistribution of Drugs [N]	1. Assessment tools reviewed and optimal selection is made. 2. Mapping of current (re-)distribution of HIV commodities is done. First draft of revised (re-)distribution procedure developed	1. Assessment tool endorsed by national stakeholders (MoH/ UCDC, 3 PRs of the GF grant) and Assessment is carried out in at least 3 PEPFAR priority regions. 2. HIV commodities (re)distribution procedure finalized/ endorsed and in use in PEPFAR priority regions	OHSS: $0 (new activity)	OHSS: $657,856	14247 SIAPS	II.6. Commodity Security and Supply Chain: Score "4"; II.7. Quality management: Score: 0.8	X	-	X	X	X
51.	**Support development of national public health institution to address HIV, TB, and other diseases**											
	Strengthening MoH capacity in national HIV/AIDS policy development, programming [N, SN]	Draft concept of the National Public Health Center (with the HIV and TB policy-making and oversight in its mandate) developed and endorsed by the MoH	Number of regulatory documents developed/ reviewed due to the Project`s evidence-based recommendations that are endorsed/ applied by GoU (national/regional/local)	OHSS: $106,872.50	OHSS 234,481.05	13232 HIVRiA	I.1. Epidemiological and Health Data: (Score: 7.1) II.5. HRH (Score: 3.0) III. 10/11:Allocative and Technical Efficiency: Score: 4.0	X	X	X	X	X
	MOH/TBD		Capacity development of UCDC and strengthening of		OHSS $300,000 HVSI	MOH/TBD	I.1. Epidemiological and Health Data	X	X	X	X	X

			surveillance systems, SI, M&E, Laboratory and management of treatment programs Support activities on development of a strong legislative framework for the NPHI that outlines the roles, responsibilities, authorities of the NPHI to promote effective response to address HIV, TB. 60 Number of person-courses completed trainings in M&E for representatives of UCDC, National Public Health Institute 30 Number of person-courses completed trainings on surveillance system, epidemiology 30 Number of person-courses completed training on management of treatment programs		$300,000		I.7. Human Resources for Health Quality management					
Integrated TB/HIV services												

52.	Complete HIV component of e-Tb manager to be compatible with HIV HIS and joint TB/HIV register											
53.	**Scale up ambulatory care for TB/HIV**											
	STbCU [SN]	TB/HIV ambulatory care treatment model assessed and recommendations presented to partners	TB/HIV ambulatory care treatment model assessed and recommendations presented to partners	HVTB $5,488	HVTB $6,909	12845 STbCU	II.7 Quality Management Score 0.8	-	X	-	X	-
54.	**Strengthen coordination of HIV and TB programs**		OHSS 2016 $64,123.50 $0.00 HVTB 2016 $721,391.63 $933,572.04									
	HTbCU : [SN]	HIV detected within TB patients with further enrolment into treatment; TB detected within HIV patients with further enrolment into treatment; Coverage of PLWH by TB preventive interventions; coverage of TB patients with HIV counseling and testing	HIV detected within TB patients with further enrolment into treatment; TB detected within HIV patients with further enrolment into treatment; Coverage of PLWH by TB preventive interventions; coverage of TB patients with HIV counseling and testing	HVTB $184,935	HVTB $195,851	12845 STbCU	II. 4. Access and Demand: Score 8.2 II.7 Quality Management Score 0.8	X	X	X	X	-
	HIVRiA: Support implementation of HIV-TB interventions through national and regional funding allocations [N, SN]	Number of regional budgets with allocated funding for TB/HIV implementation	Number of regional budgets with allocated funding for TB/HIV implementation	OHSS $64,123.50	HVTB $44,269	13232 HIVRiA	II. 4. Access and Demand: Score 8.2 II.7 Quality Management Score 0.8	X	X	X (uptake and retention)	-	X
	RESPOND: Strengthen coordination of HIV and TB programs [S]	Integrating HIV counselling and testing (HCT) in TB facilities in 6 rayons of Lviv region.	HIV detected within TB patients with further enrolment of them into treatment. Quality improvement QI	HVTB - $31,456.63	HVTB - $123,452.04	12899 RESPOND – Comprehensive KPs	II.5. HRH (Score: 3.0)	X	X	-	-	-

		HIV detected within TB suspects with further enrolment of them into treatment. Quality improvement (QI) change package is developed	change package is developed									
	PLEDGE: Strengthen coordination of HIV and TB programs [N, S]	SOP on HIV/TB collaboration in prison settings is drafted and submitted for the stakeholders review	(1) SOP on HIV/TB collaboration in prison settings is finalized, endorsed, published and disseminated; (2) 50 prison medical personnel are trained on TB/HIV collaboration; (3) Infection control plans are in place in 50 prison facilities	HVTB $5,000	HVTB $70,000	13582 HIV PLEDGE	II.4. Access and Demand 7. Quality Management	X	X	X	-	X
	PATH-CDC:	>85% of TB patients are tested for HIV ; >75% of HIVTB patients are started on ART within 8 weeks	>85% of TB patients are tested for HIV ; >75% of HIVTB patients are started on ART within 8 weeks. Trainings of HCW and monitoring initiated to start most severely ill within 2 weeks	HVTB $500,000	HVTB $500,000	14225 PATH-CDC	V. 15 Planning and Coordination	X	X	X	-	-
Services and systems for emerging risk groups and priority populations												
55.	**Focus prevention services to stop transmission among emerging risk groups (e.g. MSM; discordant couples; sex partners of PWID)**	OHSS 2016 $106,872.50	$48,696.21	IDUP 2016 $183,210.00	$0.00	HVCT 2016 $0.00	$265,615.50	HVOP 2016 $0.00	$164,602.72			
	HIVRiA	Number of	Selection of new/	IDUP	OHSS	13232	II. 4. Access	X	X	-	X	-

	Develop standards/protocols for the provision of HIV services among emerging risk groups (e.g. bridge population and sex partners of PWID) [N, SN]	regulatory documents developed/ reviewed. Selection of draft/ revised standards of services for KPs are endorsed/ applied by GoU (national/regional).	revised standards of services for KPs are piloted in a number of PEPFAR priority oblasts	183,210 OHSS $106,872.50	48696.21 HVCT 265,615.50	HIVRiA	and Demand: Score 8.2 II.7 Quality Management Score 0.8					
	RESPOND: Focus prevention services to stop transmission among emerging risk groups (e.g. MSM; discordant couples; sex partners of PWID) [S]	-	Implementing models based in PDI outreach for sexual partners of PWID and online recruitment for MSM to link them to care. (2 MSM grants, 4 sexual partners grants linked to CITI)	-	HVOP - $164,602.72	12899 RESPOND – Comprehensive KPs	I.3.- Performance data II. 4. Access and Demand: Score 8.2	X	X	-	X	-
56.	RESPOND: Conduct HIV prevention activities in priority populations [S]	Seven Steps intervention targeting PWID and Mpowerment model targeting MSMs are implemented Changes in risk behaviors of PWID and MSM are measured; IS studies report on Mpowerment is prepared and disseminated.	Changes in risk behaviors of PWID are measured; IS studies report on Seven Steps is prepared and disseminated	IDUP $29,358.59 HVOP $41,940.84	IDUP $32,920.54	12899 RESPOND – Comprehensive KPs	I.3.- Performance data II. 4. Access and Demand: Score 8.2	X	X	-	X	-
57.	RESPECT: Identify key HIV-related transmission and service access issues for internally displaced people (IDP) [SN]	# of assessments conducted	# of assessments conducted	OHSS 5 000	OHSS 7 279	14254 Stigma and Discrimination	II. 4. Access and Demand: Score 8.2	-	X	-	-	-

58.	DOD: Develop approaches to battlefield HIV transmission risk mitigation. [SN]	TOT trainings developed for the military medical personnel responsible for the educational and preventive work among the military personnel of different levels; focus on universal precautions and transfusion safety.	Participation of MOD representatives (senior medical officers) for specific HIV medical training or on Blood Safety on the battlefield in the international Conference or training USA. Transition of program.	HVOP 50,000	HVOP 50,000	7250 DoD	III.11. Technical Efficiency; Score: 4.0.	-	-	-	X	-
59.	**DOD:** **Scale up HIV prevention activities among military (near core) [SN]**	Improved access to rapid HIV tests for efficient troop mobilization, with a shift in focus on Kyiv and two other oblasts with higher general HIV prevalence and large military populations. Revised TOT training programs given to the cadets of the Military Medical Academy of the graduation course in order to share their knowledge and provide trainings among military personnel in military garrisons and units.	Higher quality of the HIV-prevention interventions due to revised TOT training programs and up-dated informational materials focused on military sites in 2 oblasts. Delivery of the informational materials with planned HIV prevention messages, provision of materials that are sensitive and appropriate to the target audience's values, needs, and interests; increased awareness, built support for reducing risky behavior.	HVOP 41,346 HVCT $50,000	HVOP 40,000 HVCT $50,000	7250 DoD	III.11. Technical Efficiency: Score: 4.0 II.4. Access and Demand: Score: 8.2.	X	-	-	X	-

7.0 Staffing Plan

PEPFAR-Ukraine conducted its core, near and non-core exercise before evaluating its current budget and staffing pattern. The team determined that there is a need for additional staff to oversee existing and new activities required for adequate program management

under the FY 15 COP, particularly SIMS requirements. However, individuals focused on SIMS monitoring will have their responsibilities embedded in broader position descriptions and responsibilities that address other programmatic needs. The USG-PEPFAR team will provide direct assistance to national stakeholders including the GoU/MoH in the areas of strategic information, lab strengthening and Tb/HIV, among others, in collaboration with implementing partners.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	Pilot and scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV Conduct stigma reduction activities among health and social workers and educators Improve linkage to AIDS service organizations for prisoners who are released Integrate and scale up HIV prevention services into the narcology system Improve quality of care and treatment outcomes for MAT Support training health workers (including primary care workers in ART delivery including CQI) Strengthen coordination of HIV and TB programs Develop and pilot cascade of services model for KPs Pilot and implement case management models for PLHIV focused on ART adherence, IDUs, and TB patients Pilot and implement QI models focused on HIV care and treatment in selected regions for KPs Use case management approach to identify patients who have dropped out and return them to care Support interventions (camps and trainings) for HIV+ youth to provide psychological support, adherence promotion, and economic strengthening (OVC) Focus prevention services to stop transmission	Build target group HIV knowledge and skills by promoting healthy behaviors and reducing stigma and discrimination of PLHIV and KPs via Peace Corp community and school-based programs Strengthen organizational capacity for civil society organizations serving KPs	

	among emerging risk groups (e.g., MSMs, discordant couples, sex partners of PWIDs) Conduct HIV prevention activities in priority populations		
Sub-national level	Building capacity within GoU for data and analysis Pilot and scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV Build organizational capacity to address stigma and discrimination (among health workers, police staff) Improve linkage to AIDS service organizations for prisoners who are released Integrate and scale up HIV prevention services into the narcology system Improve quality of care and treatment outcomes Support training health workers (including primary care workers in ART delivery including CQI)or MAT Support Regional Training Centers for HIV services for key populations Develop and pilot cascade of services model for KPs Strengthen coordination of HIV and TB program Pilot and implement case management models for PLHIV focused on ART adherence, IDUs, and TB patients Apply QI approach at AIDS Centers to strengthen patient pathway to prevent drop outs Pilot QI interventions to increase yield from facility-based HCT and referrals Support interventions (camps and trainings) for HIV+ youth to provide psychological support, adherence promotion, and economic strengthening (OVC) Strengthen HIV planning and budgeting at national and oblast level Develop innovative financing and budgeting mechanisms to improve allocative and technical efficiencies in HIV program Pilot provider payment reforms for HIV in collaboration World Bank Support of national public health institutions to address HIV, TB, and other diseases Scale up ambulatory care for TB/HIV Focus prevention services to stop transmission	Develop online national SI resources Support implementation science Train health workers in outcome-based decision making Strengthen organizational capacity for civil society organizations serving KPs Pilot a surveillance system for rational HIV drug use Scale up HIV prevention activities among military	Conduct general HIV military prevention activities Develop medical and nursing school curricula on stigma and discrimination Develop, implement, and evaluate effectiveness of effective behavioral interventions including for prisoners and MSMs

	among emerging risk groups (e.g. MSMs, discordant couples, sex partners of PWIDs) Identify key HIV-related transmission and service access issues for IDPs Develop approaches to battlefield HIV transmission risk mitigation		
National level	Improve capacity for lab proficiency testing and EQA Support quality management standards and systems for laboratories Support implementation of IBBS and other surveillance efforts Support HIV Management Information System, including identifying clinical outcome indicators to be tracked Building capacity within GoU for data and analysis Pilot and scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV Improve linkage to AIDS service organizations for prisoners who are released Improve quality of care and treatment outcomes for MAT Support training health workers (including primary care workers in ART delivery including Support Regional Training Centers for HIV services for key populations CQI) Identify clinical outcome indicators for ART and OI treatment Strengthen coordination of HIV and TB programs Implement EQA for HIV Rapid Test practices at VCT sites Pilot and implement case management models for PLHIV focused on ART adherence, IDUs, and TB patients Pilot and implement QI models focused on HIV care and treatment in selected regions for KPs Use case management approach to identify patients who have dropped out and return them to care Apply QI approach at AIDS Centers to strengthen patient pathway to prevent drop outs Strengthen HIV planning and budgeting at national and oblast level Technical assistance to GoU to ensure HRH	Pilot laboratory management information systems Renovate HIV National Reference Laboratory at UCDC Support development of an ART training database Pilot a surveillance system for rational HIV drug use Develop online national SI resources Support regional data triangulation using routine data Support implementation science Train health workers in outcome-based decision making Strengthen organizational capacity for civil society organizations serving KPs Strengthen blood donation and screening programs, including in the military Strengthen the national blood safety system Pilot a surveillance system for rational HIV drug use Develop a pharmacovigilance system for HIV drugs Develop QI/QA regulations for HIV/AIDS services	Develop medical and nursing school curricula on stigma and discrimination Develop/distribute national HIV Drug Resistance Drug Prevention Strategy Develop national electronic database to monitor MAT for PLHIV Develop model database (e-TB Manager) for TB management information Facilitate POC CD_4 (Pima) testing

	capacity in HIV Strengthen commodity procurement and supply chain Support of national public health institutions to address HIV, TB, and other diseases Focus prevention services to stop transmission among emerging risk groups (e.g. MSMs, discordant couples, sex partners of PWIDs)		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

HTC	Conduct stigma reduction activities among health and social workers and educators Implement EQA for HIV rapid test practices at VCT sites Pilot QI interventions to increase yield from facility-based HTC and referrals	Strengthen blood donation and screening programs	
Care and Treatment	Identify clinical outcome indicators for ART and OI treatment Improve linkage to AIDS service organizations for prisoners who are released Integrate and scale up HIV prevention services into the narcology system Improve quality of care and treatment outcomes for MAT Support training health workers (including primary care doctors) in ART delivery, including CQI Develop and pilot cascade of services model for KPs Pilot and implement case management models for PLHIV focused on ART adherence, PWIDs, and TB patients Pilot and implement QI models focused on HIV care and treatment in selected regions for KPs Use case management approach to identify patients who have dropped out and return them to care Apply QI approach at AIDS Centers to strengthen patient pathway to prevent drop outs Scale up ambulatory care for HIV/TB Strengthen coordination of HIV and TB programs	Facilitate POC CD4 (Pima) testing	
Prevention	Conduct stigma reduction activities among health and social workers and educators Focus prevention services to stop transmission	Build target group HIV knowledge and skills by promoting healthy behaviors and reducing stigma and	Conduct general military HIV prevention activities

	among emerging risk groups (MSMs, discordant couples, sex partners of PWIDs) Conduct HIV prevention activities in priority populations	discrimination of PLHIV and KPs via Peace Corp-, community-, and school-based programs Scale up HIV prevention activities among military	
OVC	Support local interventions (camps and trainings) for HIV+ youth to provide psychological support, adherence promotion, and economic strengthening (OVC)		
Program/system support	Pilot and scale up implementation of policies designed to reduce stigma and discrimination of KPs and PLHIV Build organizational capacity to address stigma and discrimination (among health workers and police staff) Conduct stigma reduction activities among health and social workers and educators Support Regional Training Centers for HIV services for key populations Support implementation of IBBS and other surveillance efforts Develop HIV Management Information System Identify clinical outcome indicators for ART and OI treatment Build capacity within GoU for capacity for data and analysis Support training health workers (including primary care doctors) in ART delivery, including CQI Strengthen organizational capacity for civil society organizations serving KPs Improved capacity for lab proficiency testing and EQA Support quality management standards and systems for laboratories Strengthen HIV program planning and budgeting at national and oblast levels Develop innovative financing and budgeting mechanisms to improve allocative and technical efficiencies in HIV programming Pilot provider payment reforms for HIV in collaboration with the World Bank Technical assistance to GoU to ensure HRH capacity in HIV Strengthen commodity procurement and supply chain	Support development of ART database Develop online national SI resources Support regional data triangulation using routine data Support implementation science Train health workers in outcome-based decision making Strengthen M&E capacity and data use efforts of government decision makers Strengthen blood donation and screening programs Strengthen the national blood safety system Pilot laboratory management information systems Renovate HIV National Reference Laboratory at UCDC Update clinical protocols for HIV+ children Pilot a surveillance for rational HIV drug use Develop pharmacovigilance system for HIV-related drugs Develop QI/QA regulations for HIV/AIDS services Develop model database (e-TB Manager) for TB management information	Develop medical and nursing school curricula on stigma and discrimination Develop/distribute National HIV Drug Resistance Prevention Strategy Develop national electronic database to monitor MAT for PLHIV Implement and evaluate effectiveness of effective behavior interventions, including for prisoners and MSMs

	Support development of national public health institution to address HIV, TB, and other diseases Strengthen coordination of HIV and TB programs Identify key HIV-related transmission and service access issues for IDPs Develop approaches to battlefield HIV transmission risk mitigation

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Develop medical and nursing school curricula on stigma and discrimination	**Non-core**	$4,500	$0	1	9/2015	The Network of PLHIV developed curricula which were incorporated into existing training programs of medical universities and nursing schools in Lviv & Kyiv.
Develop/distribute National HIV Drug Resistance Prevention Strategy	**Non-core**	$10,000	$0	1	09/2015	The Network of PLHIV developed and distributed the strategy during 2015.
Develop national electronic database to monitor OST for PLHIV	**Non-core**	$25,000	$0	1	03/2016	WHO developed the electronic database during 2015 but activities will continue into 2016 to design a data security system.
Implement and evaluate effectiveness of EBIs including for prisoners and MSM testing	**Non-core**	$72,000	$0	1	12/2015	2 Implementation Science studies will be completed. Reports will be developed and shared with national stakeholders.
Totals	Non-core	$111,500	$0	6		

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$US 4,211,183	**$US 24,008,820**	**$US 28,220,003**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated	
		New	Total
MTCT	Mother to Child Transmission (N/A)	$0.00	$0.00
HVAB	Abstinence/Be Faithful Prevention (N/A)	$0.00	$0.00
HVOP	Other Sexual Prevention	$300,000	$445,000
IDUP	Injecting and Non-Injecting Drug Use	$1,388,026	$1,771,149
HMBL	Blood Safety	$400,000	$400,000
HMIN	Injection Safety	$0.00	$0.00
CIRC	Male Circumcision (N/A)	$0.00	$0.00
HVCT	Counseling and Testing	$2,218,969	$2,529,170
HBHC	Adult Care and Support	$559,249	$686,621
PDCS	Pediatric Care and Support	$0.00	$0.00
HKID	Orphans and Vulnerable Children	$167,301	$188,271
HTXS	Adult Treatment	$2,311,507	$2,416,359
HTXD	ARV Drugs	$0.00	$0.00
PDTX	Pediatric Treatment (N/A)	$0.00	$0.00
HVTB	TB/HIV Care	$1,488,686	$1,633,812
HLAB	Lab	$2,050,000	$2,050,000
HVSI	Strategic Information	$5,164,409	$5,808,437
OHSS	Health Systems Strengthening	$4,852,633	$7,030,642
HVMS	Management and Operations	$3,108,040	$3,260,542

TOTAL	**$24,008,820**	**$28,220,003**

B.2 Resource Projections

The PEPFAR Ukraine team undertook a review process (described elsewhere in this SDS) and identified existing and new core and near core activities needed to accelerate the national response and epidemic control. PEPFAR Ukraine also considered GFATM and GoU spending allocations and plans in determining its geographic focus areas and oblasts. The team subsequently reviewed fiscal data for each existing mechanism and, using OGAC's definition identified excess pipeline that could be applied to COP 15. Finally, budget and management specialists also discussed existing staff and needed positions to undertake the planned COP 15 program and then finalized calculations through two rounds of budget discussions with the interagency team that focused on the: (1) review of the program budget including agency Cost of Doing Business (CODB) and (2) review of budget against earmarks noted in the planning letter.

Additional information developed by PEPFAR Ukraine team at review to clarify SDS objectives and goals:

PEPFAR

Advancing Fast Track Goals

***Through*:**

#1 - Increasing detection, linkage and retention in prevention, care, and treatment

- Focusing in high burden regions for PLHIV
- Increasing ART coverage among PWID

#2 - Accelerating recent start of health care reforms needed for sustainable HIV epidemic control

- increasing the CD4 threshold to <500;
- advancing immediate procurement reform; and
- supporting the government to plan, budget and finance HIV/AIDS services) [acute need to address by 2017]

#3 – Sustaining HIV epidemic control post-2017

Major Shifts from COP 14 to COP 15

COP 14

1. Standalone prevention and minimal treatment cascade focus
2. Broad geographic focus
3. Broad KP and Priority Population focus (MSM, FSW, street youth, and vulnerable populations)
4. Pilots of small quality improvement at TB Centers and Primary Health Centers

COP 15

1. Treatment cascade focus
   a) Increased detection – expansion of network recruiting pilot focused on PWID
   b) Increased linkage to care – peer case management from detection to registration in AIDS centers
   c) Increased relinkage to care – of dropouts from care
2. Focus on 5 priority oblasts, plus 6
3. Focus on PWID and their partners
4. Scale up of QI interventions in AIDS Centers

Linking Goals & Prioritized Activities to Investment Profile

Goal 1

- Improve quality of services and case management for enhanced ART adherence and retention
- Improved data for improved decision making and targeting of PEPFAR interventions (Activities: IBBS, MOT study)
- Strengthen linkages within clinical cascade - focus on prisoners and PWID
- Establish sustainable training facilities and specialized HIV programs for HRH
- Strengthen OD capacity and coordination for improved impact
- Strengthen Laboratory System for Sustainable Epidemic Control
- Integrate TB/HIV services
- Improve services and systems for emerging risk groups and priority populations

Goal 2

- Strengthen national government HIV response through enhanced sustainable financing, budgeting and staffing of National HIV program, Commodity Procurement, and Supply chain
- Strengthen linkages within clinical cascade - focus on prisoners and PWID
- Improve quality of services and case management for enhanced ART adherence and retention
- Improve services and systems for emerging risk groups and priority populations

Goal 3

- Strengthen Laboratory System for Sustainable Epidemic Control
- Improve data for improved decision making and targeting of PEPFAR interventions
- Create favorable environment for improved services accessibility & acceptability
- Strengthen linkages within clinical cascade - focus on prisoners and PWID
- Establish sustainable training facilities and specialized HIV programs for HRH
- Strengthen OD capacity and coordination for improved impact
- Improve quality of services and case management for enhanced ART adherence and retention
- Strengthen national government HIV response through enhanced sustainable financing, budgeting and staffing of National HIV program, Commodity Procurement, and Supply chain
- Integrate TB/HIV services
- Improve services and systems for emerging risk groups and priority populations

Total	$8,878,755	$1,946,792	$8,285,388
New	$6,316,195	$780,443	$1,143,831

Ukraine COP15 Targets by Oblast: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
_Military Ukraine	15,000	-	-	-	-
Avtonomna Respublika Krym	-	-	-	-	-
Cherkas'ka Oblast'	-	-	-	-	-
Chernihivs'ka Oblast'	-	-	-	-	-
Chernivets'ka Oblast'	-	-	-	-	-
Dnipropetrovs'ka Oblast'	-	-	-	-	-
Donets'ka Oblast'	-	-	-	-	-
Ivano-frankivs'ka Oblast'	-	-	-	-	-
Kharkivs'ka Oblast'	1,005	-	-	-	-
Khersons'ka Oblast'	-	-	-	-	-
Khmel'nyts'ka Oblast'	-	-	-	-	-
Kirovohrads'ka Oblast'	-	-	-	-	-
Kyivs'ka Oblast'	480	-	-	-	-
L'vivs'ka Oblast'	1,300	-	-	-	-
Luhans'ka Oblast'	-	-	-	-	-
M. Kyiv	1,913	-	-	-	-
M. Sevastopol'	-	-	-	-	-
Mykolayivs'ka Oblast'	-	-	-	-	-
Odes'ka Oblast'	-	-	-	-	-
Poltavs'ka Oblast'	1,247	-	-	-	-
Rivnens'ka Oblast'	-	-	-	-	-
Sums'ka Oblast'	-	-	-	-	-
Ternopil's'ka Oblast'	-	-	-	-	-
Vinnyts'ka Oblast'	-	-	-	-	-
Volyns'ka Oblast'	-	-	-	-	-
Zakarpats'ka Oblast'	-	-	-	-	-
Zaporiz'ka Oblast'	1,250	-	-	-	-
Zhytomyrs'ka Oblast'	-	-	-	-	-
Total	**22,195**	**-**	**-**	**-**	**-**

Ukraine COP15 Targets by Oblast: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
_Military Ukraine	40,000	-	-
Avtonomna Respublika Krym	-	-	-
Cherkas'ka Oblast'	200	30	53
Chernihivs'ka Oblast'	200	-	68
Chernivets'ka Oblast'	-	-	-
Dnipropetrovs'ka Oblast'	-	-	-
Donets'ka Oblast'	-	-	-
Ivano-frankivs'ka Oblast'	-	-	-
Kharkivs'ka Oblast'	504	-	-
Khersons'ka Oblast'	-	-	-
Khmel'nyts'ka Oblast'	-	-	-
Kirovohrads'ka Oblast'	155	-	34
Kyivs'ka Oblast'	630	-	51
L'vivs'ka Oblast'	150	-	17
Luhans'ka Oblast'	-	-	-
M. Kyiv	1,560	-	34
M. Sevastopol'	-	-	-
Mykolayivs'ka Oblast'	-	-	-
Odes'ka Oblast'	-	-	-
Poltavs'ka Oblast'	305	30	36
Rivnens'ka Oblast'	-	-	-
Sums'ka Oblast'	-	-	-
Ternopil's'ka Oblast'	-	-	-
Vinnyts'ka Oblast'	250	-	34
Volyns'ka Oblast'	-	-	-
Zakarpats'ka Oblast'	-	-	-
Zaporiz'ka Oblast'	-	30	-
Zhytomyrs'ka Oblast'	150	-	18
Total	**44,104**	**90**	**345**

Ukraine COP15 Targets by Oblast: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
_Military Ukraine	-	-
Avtonomna Respublika Krym	-	-
Cherkas'ka Oblast'	-	-
Chernihivs'ka Oblast'	-	-
Chernivets'ka Oblast'	-	-
Dnipropetrovs'ka Oblast'	4,240	-
Donets'ka Oblast'	-	-
Ivano-frankivs'ka Oblast'	-	-
Kharkivs'ka Oblast'	1,400	-
Khersons'ka Oblast'	1,230	-
Khmel'nyts'ka Oblast'	-	-
Kirovohrads'ka Oblast'	1,120	-
Kyivs'ka Oblast'	-	-
L'vivs'ka Oblast'	2,320	-
Luhans'ka Oblast'	-	-
M. Kyiv	1,770	-
M. Sevastopol'	-	-
Mykolayivs'ka Oblast'	-	-
Odes'ka Oblast'	3,170	-
Poltavs'ka Oblast'	-	-
Rivnens'ka Oblast'	-	-
Sums'ka Oblast'	-	-
Ternopil's'ka Oblast'	-	-
Vinnyts'ka Oblast'	-	-
Volyns'ka Oblast'	-	-
Zakarpats'ka Oblast'	-	-
Zaporiz'ka Oblast'	1,510	-
Zhytomyrs'ka Oblast'	-	-
Total	**16,760**	**-**

HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Dark Green Score (17-20 pts) **(sustainable and requires no additional investment at this time)**
Light Green Score (13-16.9 pts) **(approaching sustainability and requires little or no investment)**
Yellow Score (7-12.9 pts) **(emerging sustainability and needs some investment)**
Red Score (0-6.9 pts) **(unsustainable and requires significant investment)**

Sustainability Analysis for Epidemic Control: Ukraine

Epidemic Type: Concentrated
Income Level: Low Middle Income
PEPFAR Categorization: Targeted Assistance
COP 15 Planning Level:

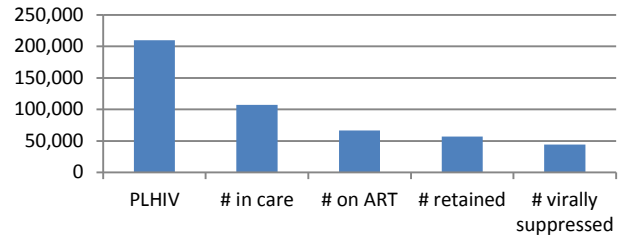
UNSUSTAINED → SUSTAINED

SUSTAINABILITY DOMAINS and ELEMENTS

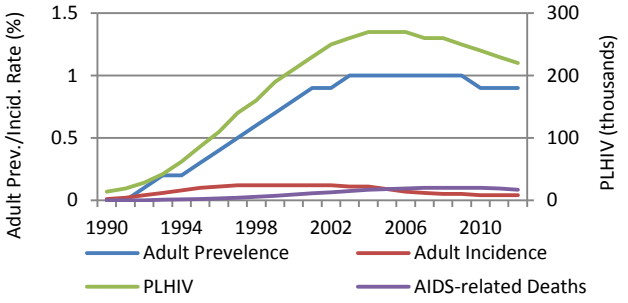
	Score
Institutionalized Data Availability	
1. Epidemiological and Health Data	11.3
2. Financial/Expenditure Data	4.0
3. Performance Data	11.5
Domestic Program and Service Delivery	
4. Access and Demand	8.2
5. Human Resources for Health	3.0
6. Commodity Security and Supply Chain	4.0
7. Quality Management	0.8
Health Financing and Strategic Investments	
8. DRM: Resource Generation	13.0
9. DRM: Resource Commitments	14.0
10. Allocative Efficiency	4.0
11. Technical Efficiency	8.0
Accountability and Transparency	
12. Public Access to Information	10.0
13. Oversight and Stewardship	17.5
Enabling Environment	
14. Policies, Laws, and Regulations	16.0
15. Planning and Coordination	18.0

CONTEXTUAL DATA

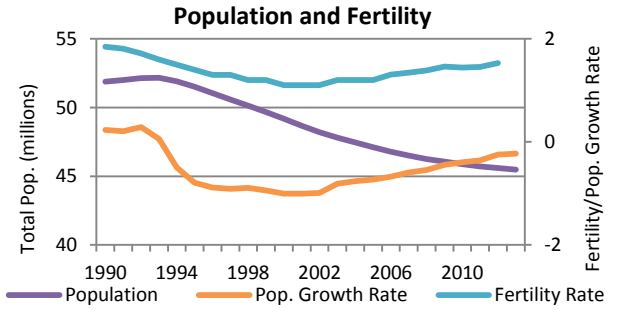
Care and Treatment Cascade



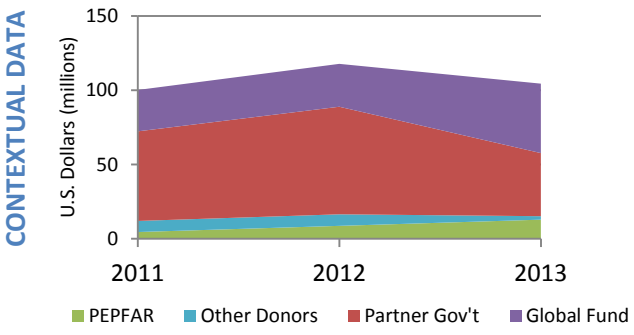
Epidemiological Data



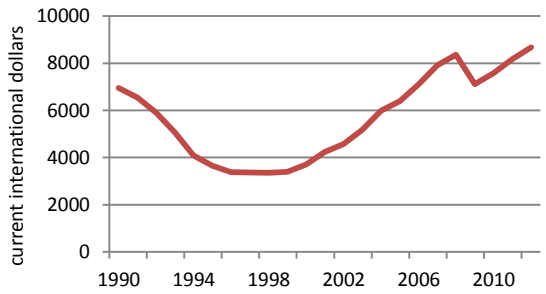
Population and Fertility



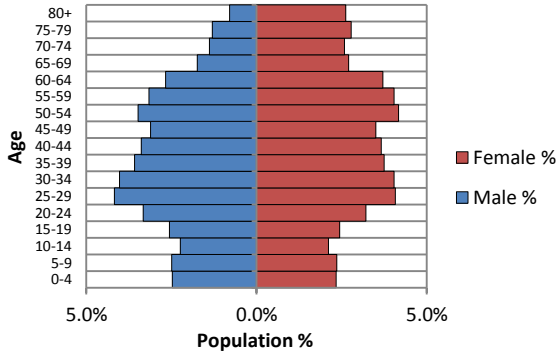
Financing the HIV Response



GNI Per Capita (PPP)



Population Pyramid (2014)



Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

1.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.			**Source of data**	**Notes/Comments**
Q1. **Who leads**: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?	◉ A. Host Country Government/other domestic institution ○ B. External agency with host country government ○ C. External agency, organization or institution ○ D. Not conducted	4.5	Provisions on intersectoral M&E group: http://dssz.gov.ua/index.php/robochi-grupy/355-vil-snid/grupa-2/oficijni-documenty-2 (2) CabMin Order on HIV/AIDS ME System of 2011 and MoH order of Feb 9, 2012; UCDC's instruction on NASA implementation in Ukraine, K-2013	HIV/AIDS epidemiological surveys and/ or surveillance are coordinated by Intersectoral M&E group, which was led by the State HIV/AIDS Service. Routine surveillance is conducted by the UCDC, surveys are done through NGOs mostly with donor funding
Q2. **Who finances**: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?	○ A. 80-100% of the total cost of latest survey was financed by Host Country Government ○ B. 60-79% of the total cost of latest survey financed by Host Country Government ○ C. 40-59% of the total cost of latest survey financed by Host Country Government ○ D. 20-39% of the total cost of latest survey financed by Host Country Government ○ E. 10-19% of the total cost of latest survey financed by Host Country Government ◉ F. 0-9% of the total cost of latest survey financed by Host Country Government	0	In country budget with sources of funding from most recent DHS HIV/AIDS Section, AIS, key population surveys, or other population-based survey (1) USG -NASA - 2011/2012/ M&E line (2) RESPOND - http://zakon1.rada.gov.ua/laws/show/1026-17/paran9#n9	All HIV/AIDS epidemiological surveys are supported by external donors. Salary of epidemiologists is covered only.
Q3. **Comprehensiveness of Prevalence and Incidence Data**: Does Host Country Government collect HIV prevalence and or incidence data?	○ No, the government does not collect HIV prevalence or incidence data ◉ Yes, the government collects (check all that apply): ☑ A. HIV prevalence ☑ Collected by age ☑ Collected for children ☑ Collected by sex ☑ Collected by key population ☑ Sub-national data ☐ Collected every 3 years ☑ Data analyzed for trends ☑ Data made publicly available ☐ B. HIV incidence ☐ Collected by age ☐ Collected for children ☐ Collected by sex ☐ Collected by key population ☐ Sub-national data ☐ Collected every 3 years ☐ Data analyzed for trends ☐ Data made publicly available	2.4	(1) USG -- MoH standard reporting forms and projected incidence through SPECTRUM; (2) RESPOND - Most recent country prevelance and incidence reports (provide citation): http://ucdc.gov.ua/uk/statystyka/epidemiologiya http://ucdc.gov.ua/uk/statystyka/informatsijni-byuleteni/vil-infektsiya http://www.unaids.org/sites/default/files/country/documents//UKR_narrative_report_2014.pdf	Collection of data is made through IBBS surveys funded by international donors. Incidence data was first collected in 2014, but is not done on a routine basis.
	○ No, the government does not collect viral load data ◉ Yes, the government collects viral load data (check all that apply):	2.8	MoH/UCDC HIV Bulletin #41,issued in March 2014: pages 75-77: https://drive.google.com/file/d/0B3u31Ye4	Data are collected at the Regional AIDS Centers on a quarterly basis and sent to MoH/ UCDC M&E Center for aggregation

Q4. **Comprehensiveness of Viral Load Data**: Does Host Country Government collect viral load data?	☑ Collected by age ☑ Collected for children ☐ Collected by sex ☑ Collected by key population ☑ Sub-national data ☑ Collected every 3 years ☑ Data analyzed to understand trends		LQyzOTJIMFlVVGhqdVU/edit	and analysis. It is based on the MoH order # 182 that requires reporting the number of patients who had a VL test and those who have undetectable VL
Q5. **Key Populations**: Does the Host Country Government conduct size estimation studies for key populations?	○ No, the host country government does not conduct size estimation studies for key populations ◉ Yes, the government conducts key population size estimates (check all that apply): ☑ Men who have sex with men (MSM) ☑ Female sex workers ☐ Transgender ☑ People who inject drugs (PWID) ☐ Government finances at least 50% of the size estimation studies ☑ Government leads and manages the size estimation studies	1.6	In country source such as government report: (1) RESPOND http://ucdc.gov.ua/images/info40.doc	(1) NETWORK -These are done by NGOs (Alliance) in the framework of GF grant (2) USG -- there is an GoU intersectoral M&E working group under the CCM. They review and approve IBBS process. Document
	Epidemiological and Health Data Score:	11.3		

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.			**Source of data**	**Notes/Comments**
Q1. **Expenditure Tracking**: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	○ No, it does not have a national HIV/AIDS expenditure tracking system ◉ Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): ☑ A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening ☑ C. Collected sub-nationally ☑ D. Collected annually ☐ E. Data is made publicly available	4	In country source, such as government HIV/AIDS expenditure tracking policy, strategy or SOP: (1) USG - Sources Domain A, Section 1, Q1 CabMin Order on HIV/AIDS ME System of 2011 and MoH order of Feb 9, 2012; UCDC's instruction on NASA implementation in Ukraine, K-2013	This is done in the framework of reporting under the National AIDS program, which is done twice a year. This doesn't include spending for infrastructure, utilities at health facilities, salary for medical staff, etc. This tracking system is not part of the National AIDS program. In addition, Ukraine is doing NASA annually.
Q2. **Quality of Expenditure Tracking**: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others: _____	◉ No, they are not using any international standards for tracking expenditures ○ Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.	0	in country citations for latest NHA, NASA, government expenditure tracking report, global fund new funding model for country (1) USG - Sources Domain A, Section 1, Q1 CabMin Order on HIV/AIDS ME System of 2011 and MoH order of Feb 9, 2012; UCDC's instruction on NASA implementation in Ukraine, K-2013	Lots of data is collected at different levels, but is not agregated and analyzed It is not done according to the international standards.

Q3. **Transparency of Expenditure Data:** Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?	◉ No, they do not make expenditure data available to the public Yes, check the one that applies: ○ A. Annually ○ B. Bi-annually ○ C. Every three or more years	0	In country source of latest expenditure data made available to the public:	Data is available for public, but not systematically collected and requires signigicant effort to be put together for analysis
Q4. **Economic Studies:** Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?	◉ No, they are not conducting special health economic studies for HIV/AIDS ○ Yes, check all that apply: ☐ A. Costing studies or analyses ☐ B. Cost-effectiveness studies or analyses ☐ C. Efficiency studies or analyses ☐ D. Cost-benefit studies or analyses	0	In country reports:	
	Financial/Expenditure Data Score:	**4**		

3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.			**Source of data**	**Notes/Comments**
Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?	○ No, the government does not have an HIV/AIDS service delivery data collection system ◉ Yes, service delivery data are collected/reported for (check all that apply): ☑ A. For HIV Testing ☑ B. For PMTCT ☑ C. For Adult Care and Support ☑ D. For Adult Treatment ☑ E. For Pediatric Care and Support ☑ F. For Pediatric Treatment ☑ G. For AIDS-related mortality	7	HIV/AIDS service delivery HMIS policy/SOP and latest report citation: (1)NETWORK UCDC HIV/AIDS Bulletin, reporting forms under order #180 and 182 (2) RESPOND - http://dssz.gov.ua/index.php/normatyvno-pravovi-akty/2474-nakaz-dssu-vid-15-sichnya-2015-roku-2-pro-zatverdzhennya-planu-mio	Part of this is collected through MoH orders # 180 (epidemiology), 182 (treatment), 612 (PMTCT), 1141 (testing) and other medical statistical forms. Data is collected through M&E system within the GF grant.
Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?	○ No, the government does not routinely analyze service delivery data to measure performance ◉ Yes, service delivery data are being analyzed to measure (check all that apply): ☐ A. Continuum of care cascade, including testing, care, treatment, retention and adherence ☑ B. Results against targets ☑ C. Coverage ☐ D. Site specific yield for HIV testing (HTC and or PMTCT) ☑ E. AIDS-related death rates	3	For each check, in-country source of latest data: (1) USG - MoH Bulletin provides partial analysis [limited or no data on -- continuum of care cascade; retention is partial etc.]	This data is analyzed partially and not systematically. Data is collected from all sires, but there are limitations on quality and accuracy.
Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	◉ No ○ Yes, service delivery data are being: (check all that apply): ☐ A. Collected at least quarterly ☐ B. Collected by age ☐ C. Collected by sex ☐ D. Collected from all clinical sites	0	In country source, such as the latest HMIS report or presentation on HIV/AIDS services: (1) RESPOND - http://ucdc.gov.ua/uk/statystyka/epidemiologiya	Data collection process is very cumbersome, lots of data is collected, but not analyzed and not used for program planning

	☐ E. Collected from all community sites ☐ F. Data quality checks are conducted at least once a year			
Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	○ No, they do not make program performance data available to the public Yes, check the one that applies: ○ A. At least annually ◉ B. Bi-annually ○ C. Every three or more years	1.5	(1) USG - on UCDC website: http://ucdc.gov.ua/uk/diyalnist-centru/monitoring-i-ocinka/informacijni-materialy (2) RESPOND - http://ucdc.gov.ua/uk/statystyka/epidemiologiya	The data which is collected is made public.
	Performance Data Score:	**12**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIVAIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.			**Source of data**	**Notes/Comments**
Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?	(●) This information is not available Check the one answer that best describes the current situation: ( ) A. More than 80% of facilities in high prevalence/burden locations are providing ART. ( ) B. 50-79% of facilities in high prevalence/burden locations are providing ART. ( ) C. 21-49% of facilities in high prevalence/burden locations are providing ART. ( ) D. 20% or less of facilities in high prevalence/burden locations are providing ART.	Q1 Score: 0	In country source, i.e., SIMS, readiness assessments:	ART is provided mostly at specialized facilities - there are about 2566 treatment facilities in Ukraine, 207 out of them provide ART (mostly specialized facilities such as AIDS centers and trust cabinets). However, this question is not quite relevant to Ukraine, because Ukraine is not a service delivery country.
Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?	( ) This information is not available Check the one answer that best describes the current situation: ( ) A. More than 80% of facilities in high prevalence/burden locations are providing Option B+. (●) B. 50-79% of facilities in high prevalence/burden locations are providing Option B+. ( ) C. 21-49% of facilities in high prevalence/burden locations are providing Option B+. ( ) D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.	Q2 Score: 2	In country source, i.e., readiness assessments:	There are 773 facilities providing services to HIV+ pregnant women (according to PMTCT draft protocol). However, this question is not quite relevant to Ukraine, because Ukraine is not a service delivery country.
Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	( ) This information is not available Check the one answer that best describes the current situation: (●) A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites ( ) B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites ( ) C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites ( ) D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites	Q3 Score: 3	In country source, i.e. MOH report: (1) RESPOND - http://ucdc.gov.ua/uk/statystyka/informatsijni-byuleteni/vil-infektsiya	According to national legislation, services can only be delivered through public facilities. Other forms of facilities are not allowed.
Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery	( ) This information is not available Check the one answer that best describes the current situation: ( ) A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites	Q4 Score: 0	Most of services for key populations are NGO-based, in some rare cases local authorities are providing premises/social worker salaries. There is no national protocol on prevention	

sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	○ B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ◉ D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites		national protocol on prevention and policies consistent with internaitonal standards, and thus, there is no finance from the GOU.	
Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%	○ This information is not available Check the one answer that best describes the current situation: ○ A. 80% or more of PLHIV are currently receiving ART ○ B. 50-79% of PLHIV are currently receiving ART ◉ C. 20-49% of PLHIV are currently receiving ART ○ D. Less than 20% of PLHIV are currently receiving ART	Q5 Score 2	In country source, i.e. government annual HIV/AIDS report:	As of November 1, 2014 out of 146 466 PLWH registered at AIDS facilities 63 827 patients were on ART (44%). The estimated number of PLWH in Ukraine is 230 000, bringing ART coverage to 28%.
Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	Check the one answer that best describes the current situation: ○ No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations. ◉ Yes, there are efforts by the government (check all that apply): ☐ educates PLHIV about their legal rights in terms of access to HIV services ☐ educates key populations about their legal rights in terms of access to ☑ National policy exists for de-stigmatization in the context of HIV/AIDS ☑ national law exists regarding health care privacy and confidentiality protections ☐ government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	Q6 Score 1.2	In country source, i.e., government strategy/plan/SOP, HIV/AIDS Human Rights assessment report:	This is reflected in a number of general Laws, e.g. Article 32 of the Constitution of Ukraine (June28, 1996), Criminal Code of Ukraine № 2947-III of 10.01.2002 and Civil Code of Ukraine № 2341-III of 05.04.2001, Article 39-1 of the Fundamentals of Health Care Law of Ukraine N 3611-VI від 07.07.2011, Article 7 of "On Personal Data Protection" Law of Ukraine № 5491-VI of DEc 20, 2012; and specific Laws related to HIV/AIDS: Law of Ukraine # 2861-VI of Dec 23, 2010 "On counteracting transmission of diseases caused by HIV and legal and social protection of people living with HIV"; Law of Ukraine № 1708-VII of Oct 20, 2014 "On Approval of the State Targeted Social Program on Counteracting HIV and AIDS for 2014-2018"; Article 51 and 286 of the Civil Code and Art . 65 of Criminal Code
		Access and Demand Score	**8.2**	

5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Source of data**	**Notes/Comments**
	Check the one answer that best describes the current situation: ◉ This information is not available ○ A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand	Q1 Score: 0		

Q1. **HRH Sufficiency**: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?	○ B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply) ☐ HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand ☐ HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites			
Q2. **HRH Transition**: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	Check the one answer that best describes the current situation: ○ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date ◉ C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date. ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	Q2 Score: 2	In country PEPFAR HRH transition plan and documentation: In Ukraine this is Global Fund-related transition plan, but not PEPFAR. Ukraine's National Cooridnation Council on counteracting TB and HIV/AIDS (perfroming the role of the GF's CCM in the country), Protocol Decision of the meeting on Feb 26, 2015, item # 1/ sub-point 1.4	Transition (from Global Fund-funded to GoU) strategy and draft plan for the MoH/ UCDC has been developed. However, in Ukraine in HIV/AIDS sector we should consider social workers, in particular community-based NGO categories, as well who are part of the service delivery system so far funded through the GF grant. This issues will be included into the Strategy to Ensure Sustainabilityof the TB and HIV programs in Ukraine related to the GF NFM grant of 2015 - 2017, to be developed by the CCM's special Working Group led by UNAIDS and WHO for the CCM's review by July01, 2015
Q3. **HRH Financial reform:** Has financial reform been undertaken in the last 5 years to address government financing of health workers?	Check the one answer that best describes the current situation: ◉ A. No financial reform has been undertaken in the last 5 years to address government financing of health workers ○ B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply): ☐ Wage reform to increase salaries and or benefits of health workers ☐ Increase in budget allocation for salaries for health workers	Q3 Score: 0	In country source, i.e. report on HRH reform or civil service reform:	
Q4. **Pre-Service**: Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	Check the one answer that best describes the current situation: ○ A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☐ content updated for all HIV/AIDS services ☐ updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☐ updated curriculum is problem based/competency based	Q4 Score: 1	SIMS Above Site-SF Tool, "Pre-Service Education" CEE or if other country team knowledge	Some part of donor support trainings have state certificates. Some selected educational institutions updated their curricula within the last 3 years, but others did not.

	☐ updated curriculum includes practicums at high volume clinical/ social services sites ☐ institutions that track students after graduation			
Q5. **In-Service**: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?	Check the one answer that best describes the current situation: ○ A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training. ○ B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented. ○ C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date. ◉ D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.	Q5 Score: 0	Country Team Knowledge; SIMS Inservice Training CEE	Some part of donor support trainings have state certificates
Q6. **HRIS**: Does the government have a functional Human Resource Information System (HRIS) for the health sector?	Check the one answer that best describes the current situation: ◉ A. No, there is no HRIS ○ B. Yes, the government does have a HRIS (check all that apply) ☐ The HRIS is primarily funded by host country institutions ☐ There is a national interoperability strategy for the HRIS ☐ The government produces HR data from the HRIS at least annually ☐ The government uses data from the HRIS for HR planning and management	Q6 Score: 0	national HRIS document or other country team knowledge	There is no information on the training inlcuded in the system. There was an attempt to introduce HRH software within the old system of state human resource management.
Q7. **Domestic funding for HRH**: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?	Check the one answer that best describes the current situation: ◉ This information is not known ○ A. Less than 20% ○ B. 20-49% ○ C. 50-79% ○ D. 80% or more	Q7 Score: 0	In country source, i.e. HRH report, HRIS data: (1) USG -- NASA 2011/2012	In Ukraine Community Health Workers are not part of the service delivery system. At the same time, social workers which are part of the system, should be inlcuded in this question.
	Human Resources for Health Score	**3**		

6. **Commodity Security and Supply Chain:** The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Source of data**	**Notes/Comments**
Q1. **ARV domestic financing**: What is the estimated obligated funding for ARV	Check the one answer that best describes the current situation: ○ This information is not known ○ A. 0-9% obligated from domestic public sources	Q1 Score: 3	Data from NASA, NHA, or Supply Chain management IM: (1) USG Staff - NASA 2011/2012 and (2) RESPOND -	However, in the near future economic crisis and military unrest may have an impact on the provision of ART.

procurement from domestic public revenue (not donor) sources?	○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ◉ D. 80% or more obligated from domestic public sources		http://zakon1.rada.gov.ua/laws/show/1708-18	
Q2. **Test Kit domestic financing:** What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ◉ A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q2 Score: 0	(1) USG Staff - NASA 2011/2012 and (2) RESPOND - http://zakon1.rada.gov.ua/laws/show/1708-18	
Q3. **Condom domestic financing**: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ◉ A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q3 Score: 0	In country source, i.e., NHA, MOH, Condom assessment report: (1) USG Staff - NASA 2011/2012 and (2) RESPOND - http://zakon1.rada.gov.ua/laws/show/1708-18	
Q4. **Supply Chain Plan:** Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	◉ A. No, there is no plan or thoroughly annually reviewed supply chain SOP ○ B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) ☐ Human resources ☐ Training ☐ Warehousing ☐ Distribution ☐ Reverse Logistics ☐ Waste management ☐ Information system ☐ Procurement ☐ Forecasting ☐ Supply planning and supervision	Q4 Score: 0	National supply chain plan/SOP:	
Q5. **Stock:** Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?	◉ A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time ○ B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time ☐ Both public and (if they exist in the country) private storage facilities at central level ☐ Both public and (if they exist in the country) private storage facilities at intermediate level	Q5 Score: 0	In country source, i.e., supply chain assessment report, LMIS data:	This question is not quite relevant, because there is no national supply chain plan in the country. Thus, we had to pick the answer A.

Q6. **Assessment**: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment? (If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)	○ A. No assessment has been conducted nor do they have a system to oversee the supply chain ◉ B. Yes, an assessment was conducted but they received below 80% ○ C. No assessment was conducted, but they have a system to oversee the supply chain that reviews: ☐ Commodity requirements ☐ Commodity consumption ☐ Coordinates procurements ☐ Delivery schedules ○ D. Yes, an assessment was conducted and they received a score that was 80% or higher	Q6 Score: 1	Assesment was conducted by WHO in 2009.	
		Commodity Security and Supply Chain Score 4		

7. **Quality Management:** Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.			**Source of data**	**Notes/Comments**
Q1. **Existence of System**: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?	◉ A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH ○ Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply): ☐ Routinely reviews national HIV/AIDS performance and clinical outcome data ☐ Routinely reviews district/regional HIV/AIDS performance and clinical outcome data ☐ Prioritizes areas for improvement	Q1 Score: 0	In country sources, i.e., QM/QI strategic plan/SOP, QM/QI Assessment Report:	
Q2. **Strategy:** Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?	◉ No, there is no HIV/AIDS-related QM/Q strategy ○ B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years) ○ C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements ○ D. Yes, there is a current HIV/AIDS program specific QM/QI strategy	Q2 Score: 0	QM/QI Strategy document:	
Q3. **Guidelines:** Does national HIV/AIDS	○ A. No, the national practice does not follow current WHO guidelines for PMTCT or ART ◉ B. Yes, the national practice does follow current WHO guidelines for: ☑ PMTCT (option B+)	Q3 Score: 0.8	Current government SOP/technical guidelines for PMTCT and ART:	ART Tech guidelines and SOP: MoH of Ukriane Order №551 of July 12, 2010: Accessed by link: http://ucdc.gov.ua/uk/diyalnist-centru/likuvannya/art; MoH order "Clinical Protocol on ART and medical care for children with HIV " № 182 of April 13,2007 ; Joint Order of the MoH, MinEducation, MinFamily &Youth, Min Soc Policy and State Penitentiary Service N N

technical practice follow current WHO guidelines for PMTCT and ART?	☐ Adult ART ☐ Pediatric ART ☐ Adolescent ART ☐ Test and treat for specific populations			740/1030/4154/321/614a of Nov 23, 2007 approved by MinJustice on Dec 26, 2007 under N 1405/14672: "Instruction on the PMTCT standard operation procedures": http://ucdc.gov.ua/uk/diyalnist-centru/profilaktyka/pvt
Q4. **QI Data use**: Does the host country government monitor and use data for HIV/AIDS quality improvement?	◉ A. No, there is no monitoring for HIV/AIDS quality improvement ○ B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes: ☐ All sites ☐ Use of data to determine quality of program or services ☐ Making recommendations and action plan for mid-course corrections	Q4 Score: 0	In country sources, i.e., report, presentation, or annual plan indicating use of data for quality improvement:	
Q5. **Post-transition:** Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?	◉ A. No, there is no quality monitoring at sites post-transition ○ B. Yes, there is quality monitoring at transition sites. Monitoring includes: ☐ All transition sites ☐ Review of service outcomes ☐ Client feedback on changes in quality ☐ Quality improvement action plan ○ C. PEPFAR/other donors have never supported direct service delivery in the country	Q5 Score: 0	In country sources, i.e., post-transition report or documentation:	There are no post-transition sites in Ukraine yet.
	Quality Management Score	**0.8**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.			**Source of data**	**Notes/Comments**
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	○ A. No, there is no budget line item for HIV/AIDS in the national budget ○ B. Yes, there is an HIV/AIDS budget line item under the Health budget ○ C. Yes, there is an HIV/AIDS program-based budget across ministries ◉ D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 6	In country source, i.e. national budget, budget summary or report for 2014: Budget Law, NAP,	National AIDS Program 2014-2018. The funds of the NAP depend on the annual budget allocations.
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	○ A. No ◉ B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program ○ C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 3	In country source, i.e. national budget, budget summary or report for 2014: Check the Number of the Regulation	Budgetary Code of Ukraine ver. #212-VIII of Mar 02-2015, Article 21 "Development of the Forecasted Budget for the next two after planned bugdet periods", Law of Ukriane 'On State Forecasting and Design of Ukraine's Economic and Social Development Programs', ver. #5463-VI of Oct 16, 2012; Ukraine's Cabinet of Ministers Resolution 'On Approval of the Forecast for the 2013 and 2014 State Budget of Ukraine' #318 of April 5, 2012 . Ministry of Finance fo Ukraine Report on Results of Executed Consoldiated GoU Budget in 2014 (vs. 2013)_of Feb 02, 2015: http://www.minfin.gov.ua/control/uk/publish/archive/main?cat_id=77643
Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	○ Yes ◉ No	Q3 Score: 0	OGAC-provided data sheet (follows tab E) derived from: http://www.mcc.gov/pages/selection/scorecards	
Q4. Domestic public revenue: What was annual	Check the appropriate box for your country's income category: FOR LOW INCOME ○ A. More than 16.4% (i.e. surpasses category mean) ○ B. 14.8%-16.4%, (i.e. 90-100% of category mean) ○ C. Less than 14.8%, (less than 90% of category mean)	Q4 Score: 4	OGAC-provided data sheet (follows tab E) Original Source: IMF Government Finance Statistics	

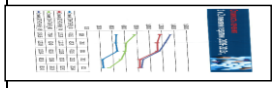
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of GDP in the most recent year available? (domestic revenue excludes external grants)	FOR LOW MIDDLE INCOME ◉ D. More than 22.3% (i.e. surpasses category mean) ◯ E. 20.1-22.3% (i.e. 90-100% of category mean) ◯ F. Less than 20.1% (less than 90% of category mean) FOR UPPER MIDDLE INCOME ◯ G. More than 27.8% (i.e. surpasses category mean) ◯ H. 25.0%-27.8% (i.e. 90-100% of category mean) ◯ I. Less than 25.0% (less than 90% of category mean)			
Score for Domestic Resource Mobilization: Resource Generation:		**13**		
9. **Domestic Resource Mobilization: Resource Commitments:** Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.			**Source of data**	**Notes/Comments**
Q1. Benchmarks for health spending: **African countries:** Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)? **Non-African countries:** Is government health expenditure at least 3 percent of GDP?	◉ A. Yes ◯ B. No	Q1 Score: 5	OGAC-provided data sheet (follows tab E) Original sources: WHO and World Bank	
Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%	◯ A. Less than 10% ◯ B. 10-24% ◯ C. 25-49% ◉ D. 50-74% ◯ E. 75% or Greater	Q2 Score: 7	NASA or NHA data: Financial Gap analysis for GFATM NFM Application, 2014	
Q3. Key population spending: What percent of key population-specific interventions are financed with domestic public and domestic	◯ A. None or information is not available ◯ B. 1-9% ◉ 10-24%	Q3 Score: 2	In country source, i.e., NASA data, national expenditure analysis report: (1) USG - NASA NASA 2011.	Key Groups: PWID, CSW, MSM, Prisoners

financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?	◯ 25-49% ◯ 50-74% ◯ 75% or Greater			
Score for Domestic Resource Mobilization: Resource Commitments:		**14**		

10. **Allocative Efficiency:** The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).			**Source of data**	**Notes/Comments**
Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?	◉ A. No, data are not used annually ◯ B. Yes, data are used annually. Check all that apply: ☐ Epidemiological data are used ☐ Health/service delivery data are used ☐ Financial data are used ☐ There is integrated analysis across data streams ☐ Multiple data streams are used to model scenarios	Q1 Score: 0	In country documentation of strategic plan or annual planning:	
Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?	◯ A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites ◯ B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◉ C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◯ D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◯ E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients	Q2 Score: 3	In country government source, i.e., presentation, GIS data, planning document: the % might be validated upon the sources of information.	Routing reporting forms of the regions to UCDC, Bulletin of the UCDC.
	◯ A. No, there is no system for funding cycle reprogramming	Q3 Score: 1	In country source: policy/SOP: Budget	Budgetary Code of Ukraine ver. #212-VIII of Mar 02-2015; CabMin Resolution № 298 of Mar 17, 2011 "on Approval fo the

Q3.Data driven reprogramming: Do host country government policies/systems allow for reprograming investments based on new or updated program data during the government funding cycle?	◉ B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used ○ C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ○ D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data		Law/Budget Code, Orders of the MoH #	of Mar 17, 2011 "On Approval to the Standard Procedure of using funds envisaged in the State Budget for health programs execution"; MoH Order N 484 of July 10, 2014 "On Re-Distribution of Medicines and Haelth Products procured by the 2013 State Budget"
		Allocative Efficiency Score: 4		

11. **Technical Efficiency:** Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.			**Source of data**	**Notes/Comments**
Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services? (note: full score of five points can be achieved without checking all disaggregate boxes).	◉ A. No ○ B. Yes (check all that apply): ☐ Annually ☐ For HIV Testing ☐ For Care and Support ☐ For ART ☐ For PMTCT ☐ For VMMC ☐ For OVC Service Package ☐ For Key population Interventions	Q1 Score: 0	In country source, i.e., government document, report or presentation: (1) National AIDS Program, 2014-2018 website: http://rada.gov.ua	
	Check all that apply: ☐ Using findings from cost-effectiveness or efficiency studies to modify operations or interventions ☑ Streamlining management to reduce overhead costs ☑ Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling	Q2 Score: 1	In country sources for each checked: publication of tenders (prices), comparison of prices. МоР щквук 1019!!	State Service liquidation - Resolution of the CM, GFATM application - reduced unit costs of the prevention services, reducted prices for ARVs in the national procurement,

Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?	☐ Improving procurement competition ☐ Integration of HIV/AIDS into national or subnational insurance schemes (private or public) ☐ Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact ☐ Geographic targeting in high burden/high yield sites to increase impact ☐ Analysis of expenditure data to establish appropriate range of unit costs			
Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?	○ A. No ◉ B. Yes	Q3 Score: 3	In country source, i.e., national HIV/AIDS expenditure report:	NASA methodology which is adjusted to Ukrainian context.
Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?	Check boxes that apply: ☐ They are not paying for any ARVs ☐ They are not paying for any test kits ☐ They are paying no more than 5% above the international benchmark price for first line ARVs ☐ They are paying no more than 5% above the international benchmark price for test kits	Q4 Score: 0	http://apps.who.int/hiv/amds/price/hdd/Default.aspx	Network will check the prices and compare. Median treatment cost per year, GPRM, USD / Price per tablet, GPRM, USD / Price per tablet, MoH, USD / Difference EFV 40.04 0.11 0.17 55% AZT/3TC 78.62 0.11 0.17 55% TDF/FTC 70.36 0.19 0.41 114% LPV/r 223.13 0.58 0.40 -31%
Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years? Unit cost 2 years ago: $ _____ Current unit cost: $ _____	○ A. No ◉ B. Yes	4	WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/ 	The ARVs prices were reduced within the unit cost, but there is no specific information on the unit cost volumes. In 2011, MoH funded 25,052 ART patients at the cost of aprox. $22,954,384, and in 2013 MoH covered 43790 with $24,294,448, so the rough reduction is from $916.3 per patient per year in 2011 to $554.7 - in 2013 (Data is based on latest MoH/ UCDC's draft 2011 NASA report and MoH HIV Bulletins #39 (reporting for 2011/2012), p.30 and #41 (reporting for 2013), pp.66-67; http://ucdc.gov.ua/uk/
		Technical Efficiency Score: 8		

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.			**Source of data**	**Notes/Comments**
Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)	○ A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) ○ B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) ◉ C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) ○ D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) ○ E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) ○ F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget	Q1 Score: 6.0	OGAC-provided data sheet (follows tab E) Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org)	
Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?	○ A. No, the national HIV/AIDS program progress report or presentation of results is not made public ◉ B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): ☑ On Website ☐ Through any type of media ☑ Disseminate print report or presentation of results	Q2 Score: 4.0	In country source, i.e., last annual national HIV/AIDS progress report or presentation: (1) RESPOND - http://dssz.gov.ua/index.php/operatyvna-informaciya/plany-i-zvity/2191-zvit-pro-rezultati-vikonannya-zagalnoderzhavnoji-programi-zabezpechennya-profilaktiki-vil-infektsiji-likuvannya-doglyadu-ta-pidtrimki-vil-infikovanikh-i-khvorikh-na-snid-na-2009-2013-roki-za-5-rokiv	
	◉ A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically ○ B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply: ☐ On website	Q3 Score: 0.0	In country source, i.e., last HIV/AIDS audit report: Accounting Chamber of Ukraine. Report 2004-2008. Search done by "AIDS" word (CHID in Ukrainian) at the official/ public site of RADA's Accounting Chamber (www.ac-rada.gov.ua): Audit Report (for 2011-2012) on HIV and TB programs implementation (41 pages): http://www.ac-rada.gov.ua/doccatalog/document/16741950/Tuberk	

Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?	☐ Through any type of media ☐ Disseminate print report		ulez_2013.pdf News on the 2009-2013 audit of HIV/AIDS program by RADA's Accounting Chamber, done by 23 April 2014 http://www.ac-rada.gov.ua/control/main/uk/publish/article/16743945 Audit of 2013 and 1st Quarter of 2014 of HIV/AIDS Program of Penitentiary Service: http://www.ac-rada.gov.ua/control/main/uk/publish/article/16744069	See provided links
		Public Access to Information Score:	**10**	

13. **Oversight and Stewardship**: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.			**Source of data**	**Notes/Comments**
Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.	○ A. PEFA assessment never conducted, or data unavailable ○ B. PEFA was conducted and score was below C ○ C. PEFA was conducted and score was C ◉ D. PEFA was conducted and score was B ○ E. PEFA was conducted and score was A	Q1 Score: 3.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	
Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment. Actual scores are ____	Check A or B; if B checked, select appropriate disaggregates: ○ A. PEFA assessment never conducted, or data unavailable ◉ B. PEFA was conducted and score was C or higher for: ☑ (i) Completeness of the financial statements ☑ (ii) Timeliness of submission of the financial statements ☑ (iii) Accounting standards used	Q2 Score: 5.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	
	Check A, B, or C; if C checked, select appropriate disaggregates:		In country source, i.e., reports indicating CSO engagement, policies or	Civil society representatives are

Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?	○ A. No, there are no formal channels or opportunities ○ B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback ◉ C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☐ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☑ Involvement on evaluation teams ☑ Giving feedback through social media ☑ Involvement in surveys/studies ☑ Collecting and reporting on client feedback	Q3 Score: 5.5	SOPs: (1) CCM and former state service as secretariat to CCM . CCM membership, memberships of the workign groups (M&E Group), Stigma Index report, Policy index of the GARP, web-sites of the NGOs, обращение граждан, електронная приёмная граждан. Закон об обращении граждан. http://stigmaindex.org/sites/default/files/reports/Ukraine%20Stigma%20Index_Report2014_ENG.pdf	members of the National HIV/TB Council, which is the country coordination mechanism for HIV
Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society? If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?	○ A. EEI score of 0-0.38; or if no EEI score, there are laws or polices that restrict civil society playing an oversight role ○ B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government ◉ C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight	Q4 Score: 4.0	OGAC-provided data sheet (follows tab E) Data derived from Civicus Enabling Environment Index (civicus.org/eei/)	
		Oversight and Stewardship Score: **17.5**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

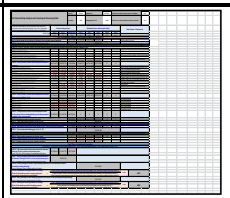
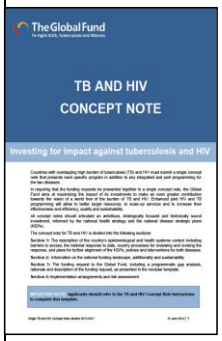
Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. **Policies, Laws, and Regulations:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Source of data**	**Notes/Comments**
Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?	○ A. No, there are no such laws or policies ◉ B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score): ☑ Criminalization of HIV transmission ☐ HIV testing disclosure policies or age requirements ☐ Non-disclosure of HIV status laws ☐ Anti-homosexuality laws ☑ Anti-prostitution legislation ☐ Laws that criminalize drug use, methadone use or needle exchange	Q1 Score: 4.0	In country source, i.e., name of law or policy: (1) Ukraine USAID HIV policy Assessment, NAP Assessment 2013, Criminal Code, Administrative Code. Drug use is not criminalized but storage (dose left) is criminalized.	Whether parental consent required for teeenagers for HIV testing is considered an obstacle. Developers - change questions, classifications, too many different options listed in one question - split into 3 lines teh last one, specifying methadon as a substitution treatement.
Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated? (note: full score of six points possible without checking all boxes)	○ A. No, there are no such policies or laws ◉ B. Yes, there are such policies and laws. Check all that apply: ☑ For people living with HIV ☑ For men who have sex with men ☑ For transgendered persons ☐ For sex workers ☑ For people who inject drugs ☑ For children orphaned or affected by HIV/AIDS ☑ For young girls and women vulnerable to HIV	Q2 Score: 6.0	In country source, i.e., the name of laws and policies: USG - (1) Article 32 of the Constitution; According to the Article 39-1 (2) RESPOND - http://zakon2.rada.gov.ua/laws/show/1972-12 of the Fundamentals of Health Care Law of Ukraine, ; and Law of Ukraine # 2861-VI of Dec 23, 2010 "On counteracting transmission of diseases caused by HIV and legal and social protection of people living with HIV", Chapter 3, Article 13, p. 3.; and (4) According to Art. 132 of the Criminal Code of Ukraine	This is ensured in the HIV law. The Law does not specify the populaitons, but gives the broader categories which include the listed groups. The social order is possible but no practicies for HIV servicing SCOs. The funds used are from local budgets only, not from the central budget.

	☑ For survivors of gender-based violence			
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	○ A. No, there are no special provisions or advantages for CSOs ◉ B. Yes, there are special provisions and advantages for CSOs. Check all that apply: ☐ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☑ Significant tax exemptions for not-for-profit CSOs ☑ Open competition among CSOs to provide government-funded services ☑ Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 3.0	In country source, name of legislation:	Law of Ukraine "On Civic Associations" № 4572-VI of Mar 22, 2012, with changes № 1593-VII of July 4, 2014; Law of Ukraine 'On charity and charitable organizations' № 5073-VI of July 05, 2012 with changes № 1663-VII of Sept 02, 2014 ;
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	○ A. No ◉ B. Yes, there are. Check all below that are included: ☑ A national public health services act that includes the control of HIV ☐ A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 3.0	In country source, name of legislation or policy: USG - Law of Ukraine # 2861-VI of Dec 23, 2010 "On counteracting transmission of diseases caused by HIV and legal and social protection of people living with HIV",	There is a set of policies and legislative documents that regulate HIV service delivery - HIV testing, treatment, prevention, care and support, post-exposure prophylaxis, PMTCT, co-infections and many others
	Policies, Laws, and Regulations Score:	**16**		

15. Planning and Coordination: Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			**Source of data**	**Notes/Comments**
Q1. National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. No, there is no national strategy for HIV/AIDS ◉ B. Yes, there is a national strategy. Check all that apply: ☑ It is multiyear ☑ It is costed ☑ Its development was led by the host country government	Q1 Score: 4.0	In country source, name of current strategy: USG- (1) Law on NAP, 2014-18 (2) RESPOND - http://zakon2.rada.gov.ua/laws/show/1708-18	National AIDS Programs 2014-2018 http://zakon4.rada.gov.ua/laws/show/1708-18

	☑ Civil society actively participated in the development of the strategy			
Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?	○ A. No data-driven prioritization approach was used ○ B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources ◉ C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources	Q2 Score: 4	 ment	
Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?	○ A. No or there is no CCM ○ B. Yes, with conditions ◉ C. Yes	Q3 Score: 2	Global Fund Eligibility List 2014	
Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?	○ A. No, it does not track or map all HIV/AIDS activities ◉ B. the host country government coordinates all HIV/AIDS activities. Check all that apply: ☑ Of Civil Society Organizations ☑ Of private sector ☑ Of donor implementing partners ☑ Activities are tracked or mapped ☐ Duplications and gaps are addressed ☐ Joint operational plans are developed that include key activities of all implementing agencies	Q4 Score: 4.0	In country source, i.e., Coordination data or reports: 	This is done through CCM meetings and a number of thematic working groups on different areas. http://dssz.gov.ua/index.php/nacionalna-rada/komitet-z-refionalnoi-polityky/diyalnist An example of the agenda of the CCM Program Committee meeting of Dec 25, 2014 is presented via hyper link
Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service	○ A. No ◉ B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply: ☑ In advocacy ☑ In programmatic decision-making	Q5 Score: 4.0	In country source for each checked: CabMin Order " On Issues of Councteracting TB and HIV/AIDS № 926, of July 11- 2007 , with ToR of the National Council to counteract TB and HIV/AIDS, with change № 712 of Sep 18, 2013. See the CabMin Order of 2013 in EN via hyper link	Ukraine's National TB and HIV Council (that also performs the function of the GF's CCM) has the national NGOs constituency (represented by the Coalition of HIV-service NGOs), PLHIV constituency (represented by the two PLHIV people as a Vice-Chair and a CCM member), International NGOs constituency (represented by a CCM member, now form AFEW-Ukraine) and faith-based NGOs constituency (represented as CCM memebr by the All-Ukrainian Council of Churches of Ukraine), Ukrainanian Red Cross Organization, trade unions rep. The 27 Regional CCMs repeat the same structure, incl. NGOs and PLHIV as member of both

delivery in the national HIV/AIDS response?	☑ In technical decision-making ☑ In service delivery	CCMs and their standing Working Groups, who plan and monitor implementation of the loacl AIDS programs. See the latest CCM membership of Sep 2013 via hyper link

Planning and Coordination Score:	**18**

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN