

Ukraine

Country Operational Plan

(COP) 2016

Strategic Direction Summary

June 17th, 2016

Table of Contents

Goal Statement

1.0 Epidemic, Response, and Program Context

- 1.1 Summary statistics, disease burden and epidemic profile
- 1.2 Investment profile
- 1.3 Sustainability Profile
- 1.4 Alignment of PEPFAR investments geographically to burden of disease
- 1.5 Stakeholder engagement

2.0 Core, near-core and non-core activities for operating cycle

3.0 Geographic and population prioritization

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

- 4.1 Targets for scale-up locations and populations
- 4.2 Priority population prevention
- 4.3 Voluntary medical male circumcision (VMMC)
- 4.4 Preventing mother-to-child transmission (PMTCT)
- 4.5 HIV testing and counseling (HTS)
- 4.6 Facility and community-based care and support
- 4.7 TB/HIV
- 4.8 Adult treatment
- 4.9 Pediatric Treatment
- 4.10 OVC

5.0 Program Activities in Sustained Support Locations and Populations

- 5.1 Package of services and expected volume in sustained support locations and populations
- 5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

- 6.1 Critical systems investments for achieving key programmatic gaps
- 6.2 Critical systems investments for achieving priority policies
- 6.3 Proposed system investments outside of programmatic gaps and priority policies

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

Appendix A- Core, Near-core, Non-core Matrix

Appendix B- Budget Profile and Resource Projections

Appendix C- Systems Investments for Section 6.0

Appendix D- Kyiv City Fast Track Initiative (FTCI) with associated activities/targets

Appendix E- Additive Commodities and associated treatment targets by oblast and site level

Appendix F- Custom Indicators

Appendix G- Above Site Milestones

Goal Statement

Despite war, economic collapse, and bitter resistance from corrupt interests, Ukraine made progress against HIV in 2015 by initiating critical procurement reforms and achieving 10% scale-up of ART. To accelerate further progress in Ukraine, maximize implementation of ‘test and start’, and achieve sustainable epidemic control, PEPFAR-Ukraine’s overarching goals are to

- Catalyze reforms in treatment guidelines, service delivery models and protocols, and critical health service systems to support sustainable operations
- Introduce innovation at all stages of the clinical cascade to increase initiation (detection, linkage, initiation) and effectiveness (retention, viral suppression) of ART, especially for PWID, and
- Provide critical temporary commodity and service support to overcome key bottlenecks to scale-up while Ukraine undergoes political, economic, and health service reform

Building on the recent Government of Ukraine (GoU) policy change to initiate ARVs at $CD4 \leq 500$, PEPFAR-Ukraine is supporting development of comprehensive HIV guidelines incorporating ‘test and start’ recommendations for release in 2016. PEPFAR-Ukraine partners are catalyzing key reforms in legislation, financing models, and procurement systems to support HIV services. PEPFAR-Ukraine is supporting service improvements in the five highest HIV burden regions (Dnipropetrovsk, Mykolayiv, Odesa, Kherson, and Kyiv City [a new UNAIDS Fast-Track City]) and six medium-burden oblasts (Kyiv Oblast, Zaporizhzhya, Cherkasy, Poltava, Chernihiv, and Kirovohrad) that contain ~78% of estimated PLHIV and ~90% of HIV-positive PWID in non-conflict areas.

Innovative changes include (1) optimized case finding to increase HTS among PWID not reached by GFATM outreach; (2) increased case management to effectively link PLHIV to treatment; (3) new models for testing of partners and HCF patients; and (4) quality improvement at ART sites to promote greater initiation and retention in treatment.

A key bottleneck continues to be limited availability of ARVs and laboratory commodities due to the collapse of GoU purchasing power. In close cooperation with GoU, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and civil society, PEPFAR-Ukraine is using key ART commodity procurements through USG central funding to enable scale-up for epidemic control and incentivize further optimization of GoU and GFATM ARV procurement efficiency; increased efficiency in 2017 procurements should allow both maintenance of existing patients and expansion of coverage to patients added through PEPFAR scale-up in 2016.

Estimated ART coverage in the 11 priority regions is projected to increase from 32% (Jan 2016) to 47% (Jan 2017) with PEPFAR technical assistance and ARVs purchased by GFATM and ECF (2015). A commodity request is forthcoming from the GoU to allow scale-up in 2017 in the 11 priority regions; an additional 20,000 patients on ART would raise estimated coverage to ~60% by 2018.

To ensure PWID benefit, PEPFAR-Ukraine activities will target adding approximately 4,700 PWID to ART over 2016-2017; with projections of additional PWID initiating therapy through GFATM outreach, improved services and new eligibility guidelines, estimated coverage can reach 60% by end 2017.

To increase fiscal efficiency, the program will design mechanisms through a collaborative, interagency process in 2016. The program will add a treatment mechanism and staff member to support implementation of new HIV clinical guidelines.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Ukraine has a total population of 45.1 million, but conflict with Russia since 2014 has significantly affected certain regions with HIV burdens. 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 are internally displaced within Ukraine. As of 2015, there were an estimated 223,000 PLHIV in Ukraine (0.9% of the 15 – 49 year old population) [SPECTRUM, Ukrainian Center for Disease Control (UCDC)] with the majority of cases among men. Approximately 30% of estimated PLHIV live in Crimea (6%) or Luhansk/Donetsk (24%). In 2014, HIV accounted for an estimated 8,939 AIDS-related deaths (1.4% of all deaths) with tuberculosis (TB) causing approximately 50% of all reported deaths among PLHIV. In 2014, 4,885¹ new cases of TB-HIV co-infection were diagnosed and 1,994¹ deaths were reported among co-infected individuals.

Ukraine's HIV epidemic remains geographically concentrated 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 ~60% of estimated cases but only 37% of the population. The epidemic is concentrated in (KP) with a prevalence of 21.9% among PWID, 7.0% among female sex workers (FSW), and 8.5% among men who have sex with men (MSM) in 2015 Integrated Bio-Behavioral Survey (IBBS). Limiting Antigen Avidity (Lag) assay incidence testing from the 2013 IBBS found relatively low incidence rates (0.91% MSM; 0.74% PWID; 0.44% FSW) although identifying estimated incidence >3% among MSM in Kyiv City, Odesa, and Sevastopol, PWID in Kherson and Ternopil and FSW in Ivano-Frankivsk; Lag testing of 2015 samples will be done this year. 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 0.8% in 2014 and has been declining slightly since 2009 [Vitek, 2014]. Female sexual partners of current or former PWID are disproportionately affected. 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,

¹ No data are available from Russian-occupied Crimea and non-government controlled parts of Donetsk/Luhansk.

and treatment. An estimated 10,561 new cases of HIV infection occurred in 2015. Evidence supports injecting drug use (IDU) still accounts for 20% - 40% of new cases despite declines in transmission among PWID.

The response to the epidemic in Ukraine focuses on KP prevention programs and an expansion of ART. Coverage with GFATM-supported prevention packages and HIV testing in 2015 was 62% of estimated PWID, 50% of FSW, and 18% of MSM with HIV testing coverage of 44%, 37%, and 14% respectively. GoU supports laboratory commodities for HTS with near-complete coverage of pregnant women and blood donors and partial coverage for HTS at other clinical facilities. Coverage with ART has continued to increase despite severe procurement shortfalls for drugs for 2015. The combined efforts of the UCDC, civil society, GFATM, and PEPFAR prevented stockouts and supported an increase of ~6,000 patients with 60,753 PLHIV (32% of all estimated PLHIV) on ART in government controlled areas of Ukraine as of Jan 1, 2016. Progress was made on adoption of key policies in 2015. In December, new ART guidelines were issued recommending ART initiation for most patients at a CD4 of 500 cells/ml and at any CD4 level for certain groups including PWID. The MOH is leading development of new comprehensive guidelines for HIV prevention, care, and treatment which will include a 'test and treat' recommendation and a de-emphasis on CD4 testing; release is anticipated in late 2016 due to needed legally prescribed steps. Harm reduction continues to be a key component of the national HIV prevention strategy.

Political and economic factors pose intense short-term challenges to further scale-up of HTS and ART. Prior to the 2014 Maidan civil movement, endemic corruption under President Yanukovich limited economic activity and maintained ineffective procurement and program management. Since 2014, the Russian-supported war in the East has led to severe economic contraction and a 70% currency devaluation with a decline in Ukraine's GDP per person from \$4,400 in 2013 to \$2,100 in 2015.² Economic growth resumed in Q4 of 2015 with 1% growth forecast for 2016. The new Western-oriented government includes many reformers but powerful residual vested interests have slowed critical changes; intense efforts to restructure government processes and eliminate major residual corruption and bureaucracy continue to be needed for further progress. Initial efforts to reform procurement in the Ministry of Health (MoH) have begun to produce results; ARV and TB commodity procurements were successfully outsourced to international agencies for 2016 - 2019, simplifications were made to product registration requirements, and the development of a government approved essential drugs list in a data-based more transparent manner was initiated. However, ARV and laboratory commodity procurement remains severely constrained. While the GoU has maintained the budget allocation under the National AIDS Plan (NAP) for HIV commodity procurement in Ukrainian currency, the purchasing power has decreased by two-thirds from ~\$30 million in 2013 to ~\$10 million in 2016. Improvement in prices for antiretrovirals have occurred due to international procurement and shifting to 80% use of

² IMF. World Economic Outlook Database, October 2015. Report for Ukraine
[https://www.imf.org/external/pubs/ft/weo/2015/02/weodata/weorept.aspx?sy=2012&ey=2020&scsm=1&ssd=1&sort=country&ds=.&br=1&pr1.x=47&pr1.y=10&c=926&s=NGDP_R%2CNGDP_RPCH%2CNGDPD%2CNGDPDPC%2CPPPGDP%2CPPPPC&grp=0&a=](https://www.imf.org/external/pubs/ft/weo/2015/02/weodata/weorept.aspx?sy=2012&ey=2020&scsm=1&ssd=1&sort=country&ds=.&br=1&pr1.x=47&pr1.y=10&c=926&s=NGDP_R%2CNGDP_RPCH%2CNGDPD%2CNGDPD%2CNGDPDPC%2CPPPGDP%2CPPPPC&grp=0&a=)

generics; however, local patent protections and registration requirements limit further price improvements. Projected procurement from GoU resources for 2017 at average GFATM prices for Ukraine would maintain treatment for ~40,000-45,000 of the persons expected to be on treatment by end-2016. The GFATM grant³ is projected to purchase ARVs to cover ~21,000 - ~24,000 patients in 2017.

The GoU (UCDC) is working intensely with PEPFAR-Ukraine, GFATM, WHO, and other partners to develop further procurement efficiencies. These efficiencies include 1) optimization by national and WHO experts in April 2016 of recommended regimens for existing and new ART patients to allow use of equivalently effective regimens to those currently protected by patents; 2) expedited registration of generic products to allow recommended regimens to be implemented; 3) expedited development of documents to allow newly recommended regimens to be purchased this year. The GoU will also be requesting ARV support from PEPFAR's Central Funding to allow for scale-up within the priority regions using the new optimized regimens. UCDC leadership has committed to using requested USG central funding resources for scale-up rather than maintenance of existing patients. UCDC believes the efficiencies being developed through this process can produce sufficient savings to enable GoU procurement of adequate ARVs to extend maintenance of treatment in 2017 to patients started on treatment in 2016. Additional resources for procurement from the GoU are also the object of intense advocacy by civil society but have been unsuccessful to date in the current budgetary situation.

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	42,759,661		3,308,129		3,507,830		19,663,706		16,279,996		Ukraine State Statistic Service, data as of January 2015 (excludes Crimea and Sevastopol) http://database.ukrcensus.gov.ua Assessed on Feb 10, 2016
HIV Prevalence (%)		0.9									Spectrum, 2015 (15 – 49 year olds)
AIDS Deaths (per year)	8,939		79		66		3,120		5,700		Spectrum, 2015,
# PLHIV	223,481		2,850		3,060		97,000		121,000		Spectrum, 2015 (includes Crimea and Sevastopol)
Incidence Rate (Yr)		0.024									Spectrum, 2015 – Data for 15+ only
New Infections (Yr)	10,561		204		216		4,300		5,650		Spectrum, 2015
Annual births	465,882	1.03									Ukraine State Statistic Service, data

³ The current GFATM grant ends in 2017 and the GFATM had previously indicated that no further grants would be available; recently the GFATM has indicated that a new grant may be available but with a further restricted funding ceiling.

										for 2014 (excludes Crimea, Sevastopol and temporarily occupied territories) http://database.ukrcensus.gov.ua Assessed on Feb 10, 2016
% of Pregnant Women with at least one ANC visit	>95%									Official 2015 data pending
Pregnant women needing ARVs	2,991									Unpublished data, UCDC, 2015, excluding Crimea and Sevastopol
Orphans (maternal, paternal, double)	NA									Although 83,716 orphans are registered with Ukrainian government, separate data are not available for HIV-related orphans; the proportion of these is small.
Notified TB cases (Yr)	25,543		230		243		7,638		17,432	UCDC 2014, <i>New cases only</i> , excluded Crimea and Sev., TB-2014 Statistical tables, Table No20; http://ucdc.gov.ua/pages/diseases/tuberculosis/surveillance/statistical-information Assessed on Feb 10, 2016
% of TB cases that are HIV infected	4,885	19								UCDC 2014, excluded Crimea and Sev., TB-2014 Statistical tables, Table No32; http://ucdc.gov.ua/pages/diseases/tuberculosis/surveillance/statistical-information Assessed on Feb 10, 2016
% of Males Circumcised	N/A									
Estimated Population Size of MSM*	186,700									Population size estimates for high risk groups in Ukraine, AIDS Alliance, 2013
MSM HIV Prevalence	8.5									Preliminary data, IBBS 2015
Estimated Population Size of FSW	73,850									Population size estimates for high risk groups in Ukraine, AIDS Alliance, 2013
FSW HIV Prevalence	7.0									Preliminary data, IBBS 2015
Estimated Population Size of PWID	341,500									Population size estimates for high risk groups in Ukraine, AIDS Alliance, 2013
PWID HIV Prevalence	21.9									IBBS 2015
Estimated Size of Priority Populations	127,038									Rough estimate based on IBBS 2015 (37.2% of PWID reported that they have non-IDU sexual partner)

(Sexual partners of PWID)											
Estimated Size of Priority Populations Prevalence (specify)	15.1										IBBS 2015
<i>*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.</i>											

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)

			HIV Treatment and Viral Suppression				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	45,102,072 ⁴ 42,759,661 ⁵	0.5	223,481 ⁶	60,753 ⁷	84.5% ⁸	90.8% ⁹	2,347,915 ¹⁰	15,869 ¹¹	6,385 ¹²
Population less than 15 years	6,815,959 ¹³	0.09	5,905 ¹⁴	2,415 ¹⁵					
Pregnant Women	~415,000 ¹⁶	0.75% ¹⁷	2,991 ¹⁷				397,459	1432 ¹⁸	1,369 ¹⁹
MSM	186,700²⁰	8.5²¹	15,870	1,032	NA		25,802²¹		
FSW	73,850	7.0	5,170	2,021	NA		27,568²¹		
PWID	341,500	21.9	74,789	19,520	NA		149,473²¹		
Partners of PWID	127,038²²	15.1	19,183	1,841	1,841		81,812		

⁴ Total Ukraine population 2014 including Crimea and Sevastopol, used as denominator for HIV prevalence

⁵ Total Ukraine population 2015 excluding Crimea and Sevastopol, accessed at www.ukrcensus.gov.ua

⁶ SPECTRUM, UCDC, 2015 – includes Crimea and Sevastopol and non-government controlled areas of Donetsk and Luhansk.

⁷ Data for January 1, 2016, UCDC <http://ucdc.gov.ua/uploads/documents/85ec49/2be0f86f844813170dofdda8048c4b9e.pdf> No data from Crimea, Sevastopol and non-government controlled areas of Donetsk and Luhansk.

⁸ Data from UCDC Bulletin No43, p.46 for cohort analysis of PLHIV who initiated ART in 2013 after 12 months on ART

⁹ Based on summary data for all VL done on patients on ART – 78.2% <40 and 12.6% 40-<1000 copies per ml in 2014, UCDC Bulletin No43, p.108. Some patients may have had more than 1 VL in this period.

¹⁰ UCDC M&E data for 2015, Unpublished

¹¹ UCDC data for Jan-Dec 2015, page 3, accessed at: <http://ucdc.gov.ua/uploads/documents/83da57/ad7be360047af62096fc4ffa31035f4c.pdf>

¹² Calculation based on UCDC ART data for January 2016 and January 2015, Donetsk and Luhansk uncontrolled territories excluded

¹³ Population <15, 2015, excluding Crimea, accessed at www.ukrcensus.gov.ua

¹⁴ SPECTRUM, UCDC, 2015

¹⁵ Data for January 1, 2016, UCDC <http://ucdc.gov.ua/uploads/documents/85ec49/2be0f86f844813170dofdda8048c4b9e.pdf> No data from Crimea and Sevastopol and non-government controlled areas of Donetsk and Luhansk.

¹⁶ Final birth data is still pending; approximately 415,000 – 420,000 births occurred in government-controlled areas.

¹⁷ This represents all identified HIV-infected women delivering in 2015, including 1432 women newly found to be HIV-infected on PMTCT screening as well as 1559 women already registered at AIDS centers.

¹⁸ Unpublished data 2015, provided by UCDC M&E department, Mar 25, 2016. This represents HIV-positive women newly detected in pregnancy screening.

¹⁹ 95.6% women initiated ART in prenatal care.

²⁰ All estimates for population size for high risk groups done in 2013 by AIDS Alliance

²¹ All risk groups estimates based on IBBS 2015 (only preliminary results for MSM and FSW as of February 2016)

²² Rough estimate based on IBBS 2015 among PWID (37.2% reported having non-IDU sexual partner)

²³ Data represents outreach testing in GFATM prevention projects; self reported data on testing in last 12 months from 2015 IBBS suggests significantly greater proportions of all 3 risk groups are being tested, presumably through other venues than outreach.

1.2 Investment Profile

The GFATM has been the largest external funder of Ukraine's HIV response, providing support since 2004 and becoming the largest funding source in 2015. Total HIV/AIDS expenditures in 2015 were preliminarily estimated at ~\$87 million; the GFATM contributed \$39.5M (45%); PEPFAR - \$20.8M (24%); the central GoU - \$16.9M (19%); and local GoU budgets the remainder. The GoU in 2016 will procure ~49% of ARVs and HIV tests for pregnant women and blood donors, while the local GoU budgets cover health staff salaries and facility operational costs.

The 2015-2017 GFATM New Funding Model grant for Ukraine is \$134M, with most funds front-loaded during the first two years (2015 - 2016). Commodities²³ account for 59% of the total grant (~ \$79M), the biggest shares of which are for ARV drugs (\$35M) and for MDR-TB drugs (\$25M). In 2015, the GFATM provided \$3.7M in emergency ARVs to UNICEF to cover gaps until the end of 2016 in non-controlled government areas in Lugansk and Donetsk.

The GFATM and PEPFAR remain the dominant providers of prevention, care, and support services for key and priority populations. GFATM and PEPFAR activities are aligned, especially in SI, quality improvement, optimized case finding and linkage to services, support to CSOs, and procurement. IBBS and training activities previously supported by the GFATM have shifted to PEPFAR support before eventually being assumed by the government.

Failure of the GoU to procure MAT is a shared GFATM and PEPFAR concern. Since 2005, the GFATM has procured all MAT for Ukraine. By the end of 2017, the country will have 9,600 patients on substitution therapy, all supported by the GFATM which had previously planned no support past 2017. However, the GFATM is now discussing an option with the CCM for release of \$4M to purchase MAT if the GoU releases \$1M for it.

To address government's failure to assume responsibility for prevention, care, and support activities, PEPFAR works jointly with UNAIDS, GFATM, and the MoH in a multi-sector technical working group to develop a National Transition and Sustainability Action Plan based on the draft Strategy of HIV and TB Response, 2020 that is currently being developed by MoH and UCDC with PEPFAR support. It will be presented to the Cabinet of Ministers of Ukraine for consideration in Q2 2016.

Note:

Please note that Table 1.2.1 and 1.2.2 are most recent information that is available. Ukraine is currently undertaking a NASA exercise and tables will be updated when results are made available. Tables 1.2.3 and 1.2.4 use 2015 data. The table entitled GoU and donor support was calculated by PEPFAR/Ukraine based on available data for 2015.

²³ GFATM procures ARVs, MAT, MDR-TB drugs, opportunistic infection drugs, and rapid diagnostic tests.

Table 1.2.1 Investment Profile by Program Area²⁴

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.

Available 2015 data: GoU and Donor funding for the national response

	2013	2014	2015	2016 (projected)	2017 (projected)	Source
Partner Gov't	\$42,834,652	\$26,663,165	\$16,894,675	\$15,187,617		2015 central gov't state budget with exchange rate of NBU 1 usd to 21.8447. 2016 NBU 1 usd to 24.3
PEPFAR	\$12,536,971	\$14,728,446	\$20,853,409	\$20,853,409		Expenditure analysis for 2014 & 2015 and draft NASA report for 2013
Global Fund	\$47,013,642	\$38,151,056	\$39,464,846	\$38,869,642	\$9,011,531	GFATM PRs and GFATM staff (budgeted for 2015: \$35,778,725 plus Emergency Fund for Donbas: \$3,686,121)
Other Donors	\$2,089,495					TBD
Private Sector						TBD
Out of Pocket						TBD

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT						
DREAMS						
DREAMS Innovation						
DREAMS Test & Start – Men						
VMMC						
Viral Load						
Other PEPFAR Central Initiatives	\$541,771					
Other Public Private Partnership						
Total	\$541,771					

1.3 National Sustainability Profile

The Sustainability Index and Dashboard (SID) analysis was undertaken jointly with key national stakeholders (GoU, UNAIDS, GFATM, and national and regional CSOs) through a consultation in December 2015. The analysis identified three strengths – planning and coordination, civil society engagement, and public access to information -- all under the Governance, Leadership, and Accountability domain. The MoH has developed a five-year National AIDS Plan with full stakeholder participation and an active supportive CCM. The MoH established health financing, public health, pharmaceutical management, HIV testing and treatment, and HIV/TB sustainability technical working groups to address policy, management, and technical aspects of the national response. CSOs provide most prevention, care, and support services in Ukraine, while also supporting strategic information, health management information systems, research, procurement, and advocacy. However, CSO's long-term existence is threatened by likely reductions of GFATM assistance after 2017. The GoU recently passed a law establishing transparent e-procurement procedures, and by April 2016, most government tenders will use this national system. Additionally, Ukrainian legislation now mandates the procurement of all public-sector pharmaceutical commodities, including HIV and TB products, through reputable international organizations.

The SID recognizes three vulnerabilities: private sector engagement, commodity security and supply chain, and quality management. Although legislation does not bar national and sub-national governments from procuring private-sector medical services, there is no previous experience. PEPFAR-Ukraine is providing TA to regional governments to subcontract services to private businesses or NGOs. In addition, PEPFAR-supported NGOs now receive TA to develop business plans and several of them are now applying for low-interest social entrepreneurship loans. These interventions address indicators on innovative sustainable financing models (Indicator 4.2) and on allowing private health providers to compete for government services (Indicator 4.3).

The MoU now procures less than half of required ARVs and test kits and has not established a logistics management information system (LMIS). Addressing NAP scale-up targets, PEPFAR-Ukraine in 2015 procured \$10.4M in HIV products through the ECF after a GoU request; the GoU plans to submit an additional request in 2016 to meet scale-up requirements. PEPFAR financial support for commodities should continue temporarily until Ukraine has sufficient resources to purchase needed commodities. PEPFAR-Ukraine is providing TA to the MoH to increase efficiency by optimizing regimens, further shifts to generics, identifying optimal medicines for a unified National Essential Medicines List, and encouraging framework contracting. It also plans to invest in an LMIS design. These interventions address ARV and test kit domestic spending (Indicators 8.1 and 8.2) and assurance of appropriate ARV stock levels (Indicator 8.6).

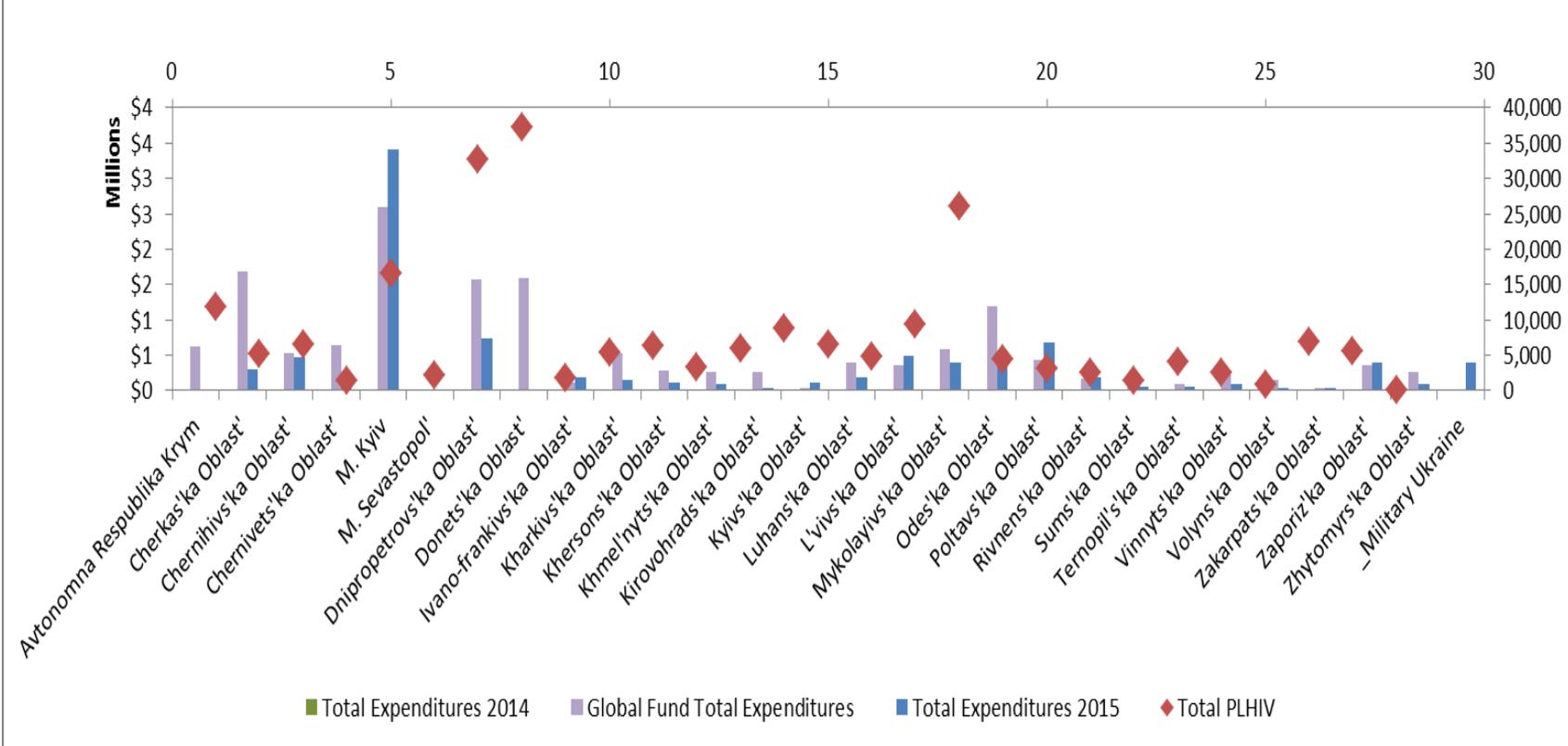
The SID identifies quality management as a vulnerability, noting that the government lacks budget lines for quality management, a data system to track performance improvement, and oversight provision to ensure continuous quality improvement (QI) in HIV services. PEPFAR-Ukraine will pilot HIV performance-based budgeting and programming (Indicator 9.1), roll out a national HIV Management Information System that collects data on HIV program indicators (Indicator 9.3), and establish regional QI teams for HIV health facilities in selected regions (Indicator 9.5). QI teams have been institutionalized through health administration orders in some regions and national institutionalization is under consideration. Laboratory quality management is a priority area of PEPFAR-Ukraine technical assistance.

A National Public Health Institute (NPHI) is being established by the MoH and will subsume UCDC, which currently is the governmental leader of the national HIV response. PEPFAR Ukraine continues to strengthen organizational and technical capacity at UCDC; PEPFAR support of the new NPHI will be needed for sustainability (Indicator 9.1).

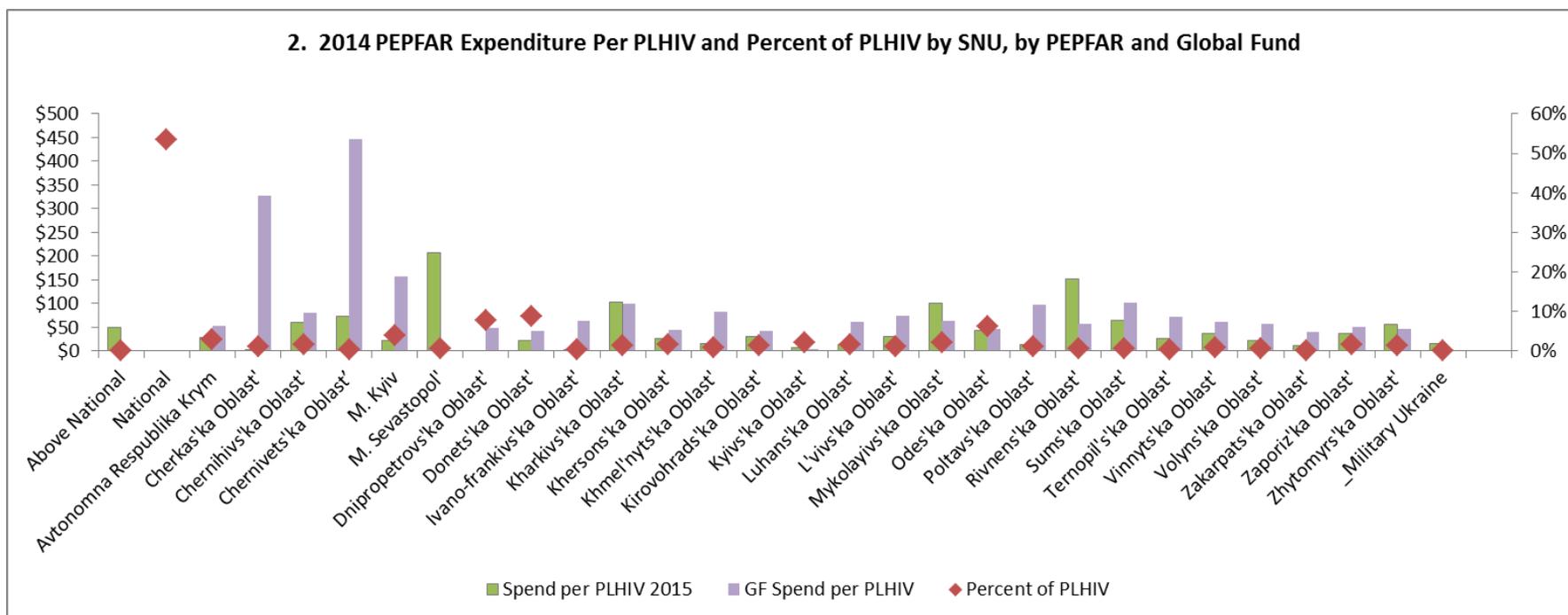
1.4 Alignment of PEPFAR investments geographically to disease burden

As noted by the tables below, both PEPFAR and GFATM direct funds to the oblasts and areas of the country that have the highest HIV burden, although Kyiv misleadingly appears overfunded due to the national institutions based there. Additionally, the results do not illustrate the current pivot as expenditure data reflects COP 14. More specifically, for COP 15 and 16, PEPFAR/Ukraine will focus resources and activities on 11 high and medium burden oblasts, which will further align investments with current disease burden.

1. Total PEPFAR Expenditures and Total PLHIV by SNU by Fiscal Year, for PEPFAR and Global Fund



2. 2014 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU, by PEPFAR and Global Fund



1.5 Stakeholder Engagement

PEPFAR/Ukraine engaged national stakeholders including the GoU, CSOs, multilateral organizations and external donors at key points in COP 16 development.

National Stakeholder meeting #1 – Sustainability Index and Dashboard (SID)

PEPFAR-Ukraine convened a national stakeholder meeting in December 2015 facilitated by UNAIDS and GoU representatives to discuss the SID tool. PEPFAR-Ukraine invited representatives of umbrella CSOs and regional representatives from organizations that work with PWID, MSM and other key populations. SID results and results from a GFATM sustainability assessment were discussed at a national stakeholder meeting in January 2016 and in a national working group developing Ukraine's transition and sustainability plan.

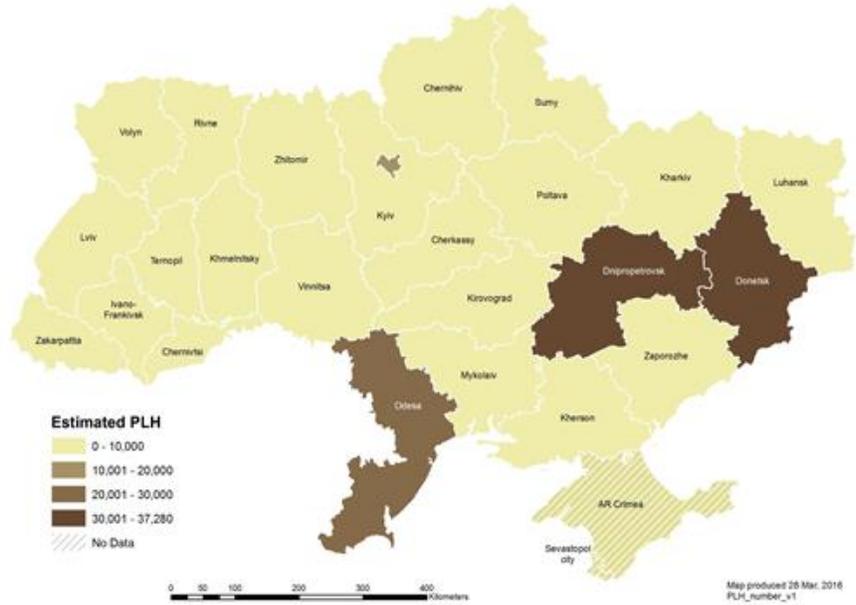
National Stakeholder meeting #2 – COP 16 planning in context of National AIDS Program

In January 2016, PEPFAR-Ukraine held a national stakeholder meeting for joint COP planning with representatives from the MoH; UCDC, State Penitentiary Service; CSOs; UNAIDS, UNODC; and GFATM. All stakeholders made presentations. The meeting provided a forum for engagement on epidemiological data, successful activities to scale up, and current gaps and bottlenecks in reaching epidemic control. A variety of stakeholders from the GoU, multilateral organizations, and CSOs presented perspectives on topics such as epidemiological data; activities to address clinical cascade gaps; and stigma and discrimination in health care facilities. The meeting also focused on civil society engagement and presented PEPFAR-specific programmatic data (APR results; indicators; targets; and expenditure analysis data). PEPFAR-Ukraine shared all presentations and the civil society engagement plan. PEPFAR-Ukraine requested written feedback on the engagement plan from CSOs but has not received any. The discussions and engagement influenced programmatic priorities and directions for COP 16.

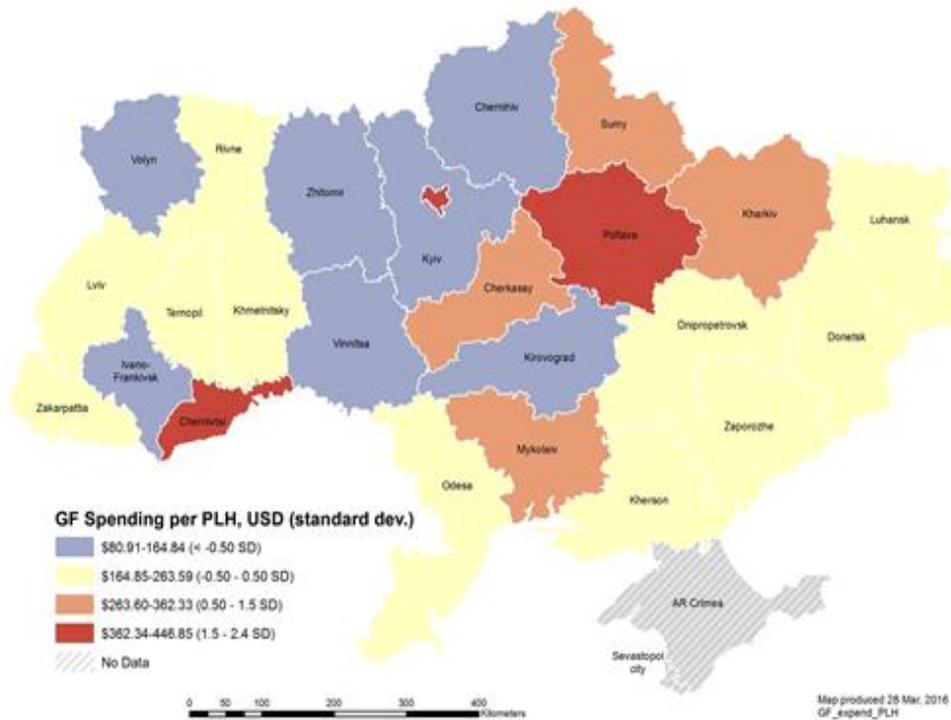
Gender Assessment –In December 2015, two consultants carried out PEPFAR's gender assessment, interviewing a cross-section of national stakeholders including representatives from key population groups (PWID and MSM). The consultants presented the report to stakeholders in late December and at the January stakeholder meeting. PEPFAR-Ukraine also considered the results and recommendations in developing COP 16.

Figure 1.4.2 Total expenditure and PLHIV by District

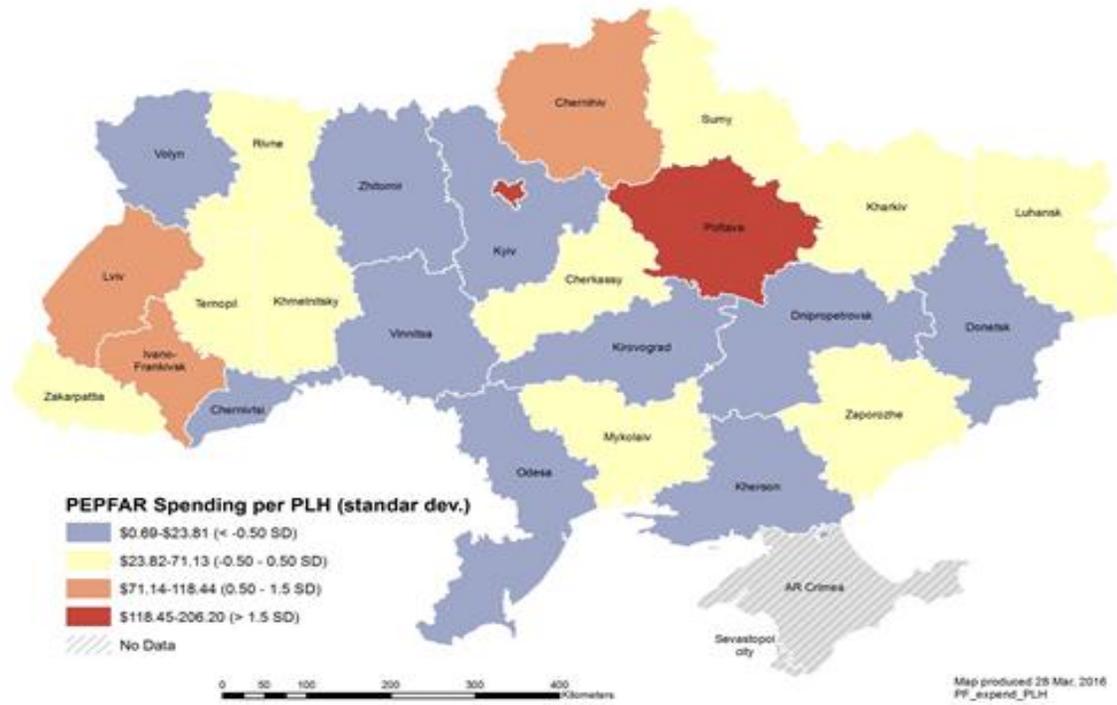
Estimated Number of PLH by Oblast
Ukraine | March, 2016



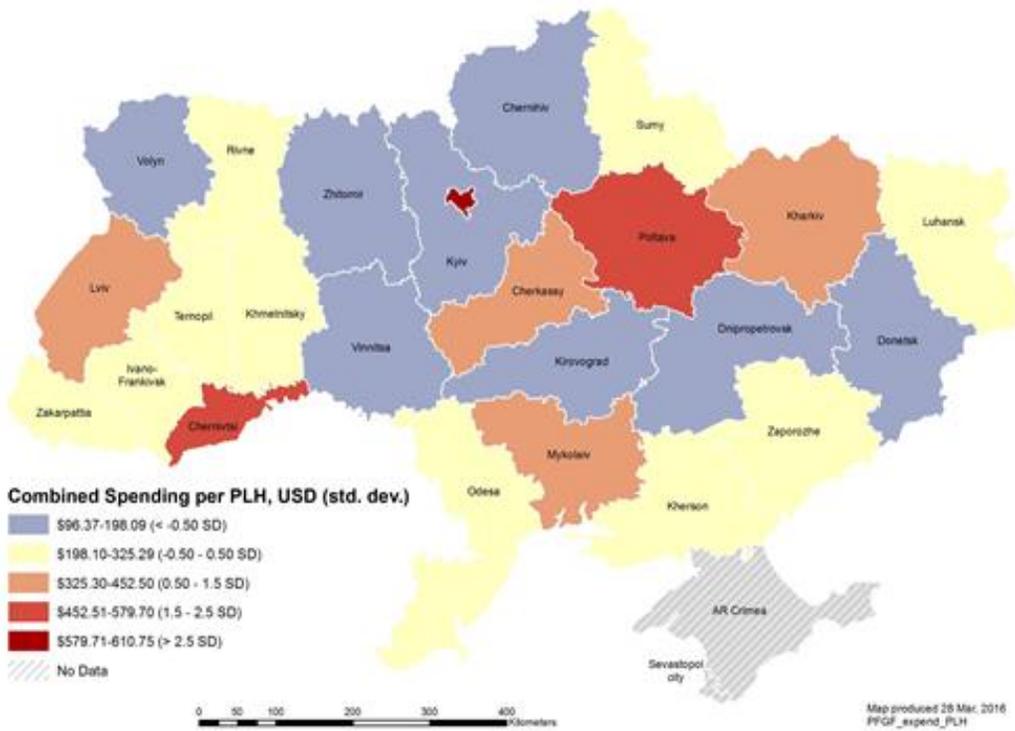
GF Expenditures per PLH by Region



PEPFAR Expenditures per PLH by Region



COMBINED PEP/GF Spending per PLH



2.0 Core, Near-Core and Non-Core Activities

In COP 15, PEPFAR Ukraine reviewed epidemiological and program data and mapped gaps and bottlenecks in the HIV services cascade before identifying activities needed to accelerate epidemic control in 11 high and medium burden oblasts. For COP 16, PEPFAR-Ukraine reviewed the COP 15 core, near and non-core decisions and considered changes vis-à-vis the results of recent SID 2.0 and SBOR exercises and evaluated activities in light of: (1) expected impacts on numbers of PLHIV in the cascade and strengthening local technical capacity for a sustainable response; (2) priority given the results of the SID 2.0 and SBOR exercises; (3) comparative advantage of the USG over other national stakeholders; and (4) ability to transition the activity to the government or other party.

The team also considered whether new activities were needed to further accelerate results and impact. To that end, the program will support the GoU's planned COP funds request for additional commodities to increase treatment coverage in the 11 priority oblasts. PEPFAR-Ukraine will also support Kyiv City in participation in the UNAIDS 90-90-90 Fast-Track Cities Initiative (FTCI) by supporting existing activities and adding new targeted activities, particularly to bolster MAT services and increase treatment coverage. Core, near and non-core activities for COP 16 are delineated in Appendix A.

3.0 Geographic and Population Prioritization

Data for prioritization decisions: PEPFAR-Ukraine reviewed epidemiology and program data to identify priority regions and populations selected last year for focused USG efforts to raise ART coverage for epidemic impact. Data included 1) program data on GFATM-supported KP prevention services including HTS and updated KP population size estimates (PSE) and preliminary data from 2015 KP integrated biobehavioral surveys (IBBS); 2) GoU data on new/cumulative PLHIV in care, number on ART and retention on ART, reported mortality; 3) GoU data on HTS; and 4) national 2015 SPECTRUM on incidence, prevalence, and mortality estimates. Ukraine does not yet have validated subnational estimates of PLHIV; these will be derived this year under the national M&E working group using available modelling tools (SPECTRUM and modified AEM). In the interim, PEPFAR is using SNU estimates derived using a multiplier-based method involving generating estimates using two PMTCT screening and two case reporting indicators with subsequent averaging. The SPECTRUM estimate of PLHIV in Ukraine is 223,000 including Crimea and portions of Donetsk and Luhansk oblasts occupied by Russian-supported forces. An in-house working estimate for total PLHIV in GoU-controlled territories of 188,000 was obtained by eliminating Crimea's estimate and decreasing Donetsk and Luhansk estimates by 50%.

Gap for epidemic control: Currently, the estimated gap for achieving 90% of PLHIV in government controlled areas [GCA] knowing their status is ~42,000 and the gap for 80% on ART treatment is ~90,000. The total amount of funding needed for epidemic control was estimated at

\$113,000,000 under an ideal allocation and optimized scenario²⁵; this represented a gap of \$33,000,000 from available HIV financing in 2013 prior to the collapse of GoU purchasing power and decrease in the GFATM grant. The starkest current gap is funding for ARVs and laboratory commodities but critical gaps may occur for funding for KP prevention and MAT after the GFATM grant ends.

Using current best prices for ARVs in Ukraine procured by the GFATM of ~\$270 - \$300 per patient-year, a total of ~\$40 - 45 million would be needed to support 80% coverage with ART. The GoU is able to allocate ~\$10 million for ARV procurement for use in 2017 with ~\$9 million additional planned by GFATM. The GoU, GFATM, PEPFAR, civil society and other stakeholders are working intensely to optimize regimens to decrease average ARV pricing; a national workshop will be held in early April with WHO expert support. The GoU is preparing a request for funding from PEPFAR's central funding to partially address remaining gaps for priority oblasts once more clearly defined after the optimization exercise.

Geographic focus: PEPFAR Ukraine is unable to work in Russian-controlled Crimea or in the conflict zone in eastern Ukraine; these 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) with an estimated 91,000 PLHIV, representing 55% of the PLHIV in the 23 regions, and on six additional medium burden oblasts (Cherkasy, Poltava, Chernihiv, Zaporizhzhya, Kirovohrad, and Kyiv) with ~23% of PLHIV. Current ART coverage (Jan 2016) in these regions is estimated at 32%; additional patients required to reach 80% ART coverage (saturation) for all eleven focus oblasts is 64,000. Kherson has the lowest current ART coverage (29%) among the high burden oblasts and Kirovohrad (17%) among all 11 oblasts. The eleven focal oblasts contain an estimated 52,000 HIV-positive PWID, 8,400 HIV-positive MSM, and 2,600 HIV-positive FSW.²⁶

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 ART coverage for this key population with an appropriate mix of core activities within the eleven focus oblasts (See Appendix A); COP15 funded activities have begun implementation in the past several months. Recent 2015 IBBS data highlighted the challenge of attaining high coverage in PWID and necessitated recalibration of targets. The estimate of ART coverage among PWID in the 2013 IBBS was ~40%; methodological changes to sampling were introduced in 2015 to decrease the likelihood of oversampling PLHIV registered in AIDS centers. The 2015 survey succeeded in reaching a subpopulation of PLHIV with significantly lower coverage by prevention services, especially HIV testing. Among PWID who knew their HIV status prior to the study in 2015, the proportion on ART was similar to 2013; however, those who had not been tested had no opportunity to receive care and treatment, resulting in an overall much lower estimated ART coverage. The 2015 methodology may have oversampled PWID lacking services. In Odesa, the

²⁵ World Bank. HIV Allocative Efficiency Analysis in Ukraine 2015.

²⁶ Based on preliminary 2015 IBBS results by oblast as of Mar 29, 2016

estimated number of PLHIV PWID on ART from 2015 IBBS ART coverage (2%) and 2014 PSE was only 200, while the Odesa AIDS center reported >250 known active PWID on ART; it is likely that the number of PWID receiving ART who are not classified as PWID is substantially higher. While the 2015 IBBS demonstrated that subpopulations of PWID with less access to HTS need to be reached, it also demonstrated that a network-based approach could link these individuals to testing; such network-based activities were recently initiated by PEPFAR-Ukraine.

In the 11 priority regions, ART coverage among PWID was estimated at 33% by averaging the 2013 and 2015 survey results. Given the country's current political and economic challenges, the PEPFAR-Ukraine team realistically believes it can facilitate scale up of ART coverage to ~39% by end-2016 and then more rapidly to ~60% by the end of 2017 as PEPFAR interventions and recently approved guidelines for 'test and treat' increasingly have effects. Achieving this target is contingent on: (1) success of the TA, testing and linkage to care efforts; and (2) availability of adequate ARVs and other essential commodities.

Additional data analysis and political developments support an increased focus on three regions: Kyiv City, Odesa, and Dnipropetrovsk (Kriviy Rih). These regions account for >75,000 (45% of the estimated PLHIV in non-conflict regions with only ~ 24% of the population.

Kyiv City and the Fast Track City Initiative: With ~2.8 million inhabitants and ~17,000 estimated PLHIV, Ukraine's capital city has one of Ukraine's largest HIV epidemics but has been viewed as a politically challenging place to implement HIV programs. In February 2016, Mayor Valery Klitchko stated a desire to join the Fast Track Cities Initiative to eliminate HIV/AIDS as a public health threat by 2030. Preliminary review of data suggest that linking an additional ~5,000 HIV-infected PWID and ~2,000 HIV-infected MSM to ART will be critical to a successful action plan for Kyiv.

Odesa Oblast and reformist leadership: With 2.4 million inhabitants and ~26,000 estimated PLHIV, Odesa has been heavily affected by HIV since Ukraine's epidemic began. While many strong NGO programs were implemented, political factors have inhibited optimal HIV programming. Under the recently appointed reformist governor (Mikheil Saakashvili) and deputy governor (Maria Gaidar), opportunities for more rapid reform have appeared.

Dnipropetrovsk Oblast and Kriviy Rih: Dnipropetrovsk (DNP) is the second most populous oblast (3.3 million) and has had the second largest HIV epidemic (estimated 33,000 PLHIV) behind only Donetsk. Review of epidemiologic data suggests that more than half of the burden in DNP is concentrated in Kriviy Rih, a city of ~650,000. Outreach testing of 5,385 PWID in Kriviy Rih in 2015 had a yield of >14% vs 2% among 16,433 PWID tested in the rest of the oblast. Kriviy Rih testing identified >60% of HIV-positive PWID found in DNP oblast and ~23% of the total HIV-positives found in outreach testing of >149,000 PWID in all of Ukraine. Seroprevalence in PMTCT testing in Kriviy Rih in 2015 was 5.5% vs <1% in the rest of the oblast. Similarly, FSW (whose HIV risk remains heavily due to IDU) had a seroprevalence on outreach testing in Kriviy Rih of 6.2% vs 1.0% in the rest of DNP. The number of PLHIV registered in AIDS centers in Kriviy Rih is higher than in DNP

city, even though DNP city has 1 million inhabitants. The seroprevalence among PWID in Krivy Rih is unknown as IBBS surveys are conducted only in capital cities of each oblast. Given the outreach and PMTCT testing, the PWID seroprevalence is almost certainly much higher than the 40% HIV prevalence recorded among PWID in DNP city in the 2015 IBBS. As Krivy Rih is therefore not represented in the PWID component of SPECTRUM modelling for Ukraine, current total national and regional estimates of PLHIV and PWID PLHIV are likely underestimates.

[REDACTED]

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

PEPFAR has responded to the challenge of achieving 90-90-90 targets by defining program goals to be “to increase linkage to and retention in prevention, care, and treatment in high burden regions while also accelerating recently initiated critical reforms in the health care system that are needed for a sustainable epidemic response.” This adjustment required simultaneous refocusing on support of services and pilots to raise coverage with prevention, care, and treatment, especially among PWID, while intensifying support for sustainable reforms, such as improved procurement. COP16 targets reflect continued expansion of new activities started with COP15 funding to close gaps in HTS and patient enrollment and retention into care and treatment.

Priority/key population prevention: Targets for KP_Prev predominantly reflect the targets for a network based recruitment for HTS and linkage for sexual and injecting partners of PWID in priority oblasts. The activity also provides prevention services to the participants. The network activity initiated field operations in February 2016. Targets were derived from the experience of a pilot network activity in Odesa and are based on the expected yield from recruiting HIV-positive PWID (‘seeds’). The network based activity complements GFATM prevention work that reaches ~60% of estimated PWID. In addition, targets for KP_Prev reflect a set of prevention activities for MSM in Kyiv City and Odesa that were identified as MSM ‘hotspots’ in Lag testing of 2013 IBBS samples; activities include outreach through social networks and the internet with linkage to testing and case-managed referral to services. These are newly begun activities and there are no results yet to compare with targets. PP_Prev targets reflect activities to reach partners of PLHIV and PWID partners with prevention services including HTS and linkage for HIV-positive clients.

HTC

HTC_TST targets were set for 4 related sets of activity. The largest proportion reflects technical assistance to the testing services at the ART treatment sites and linkage after testing positive; targets are based on 2015 testing data. The second largest proportion reflects direct support of the new network-based recruitment for HTS for sexual and injecting partners of PWID. These targets

were based on experience from the pilot. Activity budgets were calculated from the pilot projects of both network recruitment and case management approaches supported by GFATM. The activity complements the GFATM-funded outreach HTC testing for PWID. In the 5 highest priority regions, estimated coverage of PWID with outreach testing in 2015 ranged from 39% - 62% (mean 51%); if half of the persons tested through the network recruitment activity are PWID who would not otherwise have been tested, then mean coverage will be 59%. The third largest proportion reflects technical assistance to the military testing program to ensure HIV testing for 100% of all mobilized troops and to increase routine HIV testing amongst existing soldiers and officers. The fourth set of activities is reflected in a small percentage of the HTC_TST targets to be achieved via testing in prisons.

Facility- and community-based care and support

Targets for KP_MAT reflect technical assistance to MAT sites through a recently begun project; they represent additional patients who will be placed on MAT using GFATM-procured commodities. To date, no results have been generated to compare with the established targets.

Adult treatment

Adult treatment targets for PWID require using alternative data sources from the GoU routine reporting systems.

PWID: Program activities are intended to raise coverage among PWID; however, routine reporting of PLHIV on ART cannot adequately capture PWID due to mis-ascertainment. IBBS surveys that are conducted every 2 years do capture self-reported ART data that seem to accurately reflect the experience of the respondents (from VL testing in Lag survey); however the representativeness of the surveys for the entire PWID population for the treatment coverage indicator is dependent on location of the survey sites (although prevalence data was not significantly affected). Coverage data for PWID also requires estimation of PWID populations; Population Size Estimate (PSE) exercises are done every 2 years following the IBBS which provides a portion of the inputs needed with the others derived from program data.

Anticipated treatment target coverage for early 2017 and 2018 among PWID as measured through future IBBS studies is estimated using the current level of self-reported antiretroviral coverage from IBBS studies and projections of the flows of PWID onto treatment. For current coverage, PEPFAR integrated data on HIV prevalence and self-reported ART use obtained in the 2013 IBBS and 2015 IBBS studies with PSEs developed for PWID in 2012 and 2014 respectively, and then averaged the ART coverage estimates to account for different methodologies. Projections of the flows of PWID into the treatment system were developed from (1) routine outreach (using current testing coverage, yield, and linkage), (2) network based recruiting (using extrapolated data from the pilot study and regional indicators), (3) re-linking of dropouts back to AIDS Centers (from pilot work done under GFATM); as well as (4) an estimation of the number of PLHIV under active care that are undiagnosed PWID who will be newly eligible for ART. These flows were adjusted for the new December 2015 guidelines that make PWID eligible for ART at

any CD4 (flows 1-3) and most PLHIV eligible at a CD4 of 500 currently; further adjustment was made for 'test and treat' eligibility that is being incorporated into new guidelines to be released by end 2016 (flow 4). Targets for flows 1-3 can be monitored from M&E of the network based recruitment and case-management activity. These are newly begun activities and there are no results yet to compare with the established targets.

Achieving improved ART coverage among PWID will also require improved access to HTS to PWID presenting from non-outreach settings (e.g. primary and specialized health facilities), and improved services through QI and treatment TA for all PWID within ART treatment sites for initiation of care and treatment and targeted support for improved adherence.

Through these activities, PEPFAR aims to add ~3,200 PWID²⁷ patients on ART treatment in the 11 priority regions through early 2017²⁸, with a goal of ~20,800 current PWID on ART; another 5,500 PWID are projected to be added onto ART through early 2018 as these programs mature. Another 5,900 PWID are estimated to be already registered at AIDS Centers and are now potentially ART eligible under the new ART guidelines. These flows increase potential ART coverage among PWID by early 2018 to 61%. (Table 4.1.1a).

However, extending ART to these individuals will also require 1) adequate ART availability to remove the need for clinical triaging of treatment; 2) technical assistance with implementation of the recent guidelines for a CD4 threshold of 500, and 3) technical assistance with completion and implementation of new guidelines currently under development that incorporate a test and treat philosophy. Because resources for ART commodities (ARVs, CD4 and VL test kits) currently come from a national health budget under financial stress, outside resources for ARVs and commodities are temporarily needed for achievement of national treatment targets. The MoH is currently developing guidelines that incorporate decreased or no CD4 testing after initial evaluation. Resources for service delivery come from regional health budgets; achieving these coverage targets will require innovation in service delivery and health financing reform.

Additional challenges for achieving higher ART coverage among PWID include inadequate availability of MAT to buttress adherence measures. Currently, the GFATM is procuring MAT to cover an estimated 9,600 patients (increased from 8,512 patients as of 1/1/2016). The lack of incentives for MAT providers to cover additional patients will slow scale-up, but PEPFAR technical assistance partners believe sufficient additional clinical services can be arranged to support 9,600 patients. Efforts to link additional PWID to ART services should rapidly consume additional MAT 'slots' as they are added. Additional slots will require alternative funding for more MAT medications, including local government and client cost share, and PEPFAR partners are implementing activities to pilot these alternatives. During 2016, PEPFAR proposed to procure sufficient MAT medications to support 1,000 patients in Kyiv City to support more rapid expansion of ART among PWID.

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.

All PLHIV: With the provision of USG supplied ART commodities, resulting ART coverage estimates will be calculated at the regional level and monitored using GoU reported PLHIV on ART and estimates of the number of PLHIV per region. Currently these SNU PLHIV estimates are in-house PEPFAR estimates but development of approved SNU PLHIV estimates has been judged a priority by the national M&E Working Group. GoU treatment results will be monitored by USG partners providing technical assistance to ART treatment sites. Current monitoring can quantify patients placed on ART from GoU sources which are tracked separately; while attribution of the remaining ART patients between GFATM and ECF is not possible on the individual level, reliable data on product delivery can approximate the relative contributions. Based on the delivery schedules for antiretrovirals being delivered in 2016, ART coverage in the 5 highest priority oblasts should increase from ~32% as of 1/1/2016 to 47% with over ¾ of the scale-up being due to PEPFAR antiretrovirals and the remainder due to GFATM.

TBHIV: TBHIV targets for testing are derived from the number of TBHIV patients found in the regions where PEPFAR supports TBHIV activities.

OVC Targets: USG-supported activities to support OVC and to lower stigma and discrimination are set based on the number of HIV-infected children living in regions where PC volunteers are able to work.

Primary TA targets: As a TA program assisting a country with minimal prior PEPFAR service delivery, PEPFAR activities remain only partially matched to existing Monitoring, Evaluation and Reporting MER indicators.

PEPFAR adopts MER indicators where possible and develops 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 from health facilities to AIDS Centers, improved registration and enrollment after HIV testing in AIDS Centers, increased proportion of PLHIV started on ART]; (b) acceleration of health reform [medical procurement, supply chain, alternative delivery and financing of HIV and MAT services, 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. 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 HTS 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 delivery 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.

Two important cross-cutting activities for PEPFAR with outputs expected in 2016 are development of (1) a transition and sustainability plan; and (2) development of new comprehensive HIV service guidelines. In collaboration with the GFATM and PRs, PEPFAR is supporting the development of a national HIV Sustainability Strategy 2020 and Action Plan; Cabinet of Ministers approval is expected in Q2 CY 2016 after which PEPFAR will support its implementation in the high burden oblasts. PEPFAR is also supporting a national comprehensive review of HIV service guidelines (a 'protocol' covering prevention, testing, laboratory diagnosis and monitoring, care, support, treatment, and other services); development of the new protocol that includes a 'test & treat' recommendation, decreased CD4 usage, and other improvements is underway with issuance expected in late 2016 after passage of legally prescribed steps. Other output measures for PEPFAR TA activities have been organized around the SBOR process and are included in the SBOR section.

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

SNU	Total PLHIV	Current on ART (Jan 1, 2016)	Expected on ART, end 2016	Est cov'g end CY2016	Target New on ART (APR FY17) PEPFAR TX_NEW	Target Current on ART (APR FY17) PEPFAR TX_CURR*	Expected on ART end FY2017 (PEPFAR, GOU, GF)	Est. ART coverage end FY2017 (PEPFAR, GOU, GF)
High burden regions								
Dnipropetrovsk	32,760	9,940	15,845	48%	6,496	11,236	22,341	68%
Mykolayiv	9,420	4,783	5,355	57%	629	1,079	5,984	64%
Odesa	25,980	7,918	11,478	44%	5,409	7,966	16,887	65%
Kyiv city	16,560	5,021	8,968	54%	3,479	5,301	10,754	65%
Kherson	6,360	1,852	2,650	42%	878	1,330	3,528	55%
Medium burden regions								
Kyiv	8,720	2,338	4,185	48%	539	1,943	4,724	54%
Zaporizhzhya	7,000	1,923	2,539	36%	955	1,355	3,494	50%
Cherkasy	5,160	1,387	2,037	39%	715	1,175	2,752	53%
Poltava	4,520	1,623	2,173	48%	605	975	2,778	61%
Chernihiv	6,440	1,629	2,283	35%	719	1,153	3,002	47%
Kirovohrad	5,940	1,006	1,591	27%	367	796	1,958	33%
Total	128,860	39420	59104	46%	20,791	34,309	78,202	61%

*TX_CURR target includes a) patients expected to initiate in FY17 through PEPFAR scale-up and b) patients maintained who originally initiated treatment in 2016 through PEPFAR ECF.

Table 4.1.1a ART Targets* among PWID in Scale-up Sub-national Units for Epidemic Control

SNU	Total estimated PWID PLHIV	Estimated current (end 2015) on ART from IBBS studies	Estimated expected on ART, end 2016	Est cov'g end CY2016	Estimated expected on ART, end 2017**	Est projected cov'g, end 2017
High burden regions						
Dnipropetrovsk	14,520	4356	5401	37%	9,607	66%
Mykolayiv	2,436	1035	1339	55%	1,632	67%
Odesa	10,836	3468	3909	36%	6,382	59%
Kyiv city	6,660	1499	2,083	31%	4,036	61%
Kherson	1,722	646	660	38%	932	54%
Medium burden regions						
Kyiv	3,358	588	764	23%	1,592	47%
Zaporizhzhya	5,184	2748	2951	57%	3,416	66%
Cherkasy	1,457	510	612	42%	900	62%
Poltava	1,035	279	362	35%	575	56%
Chernihiv	2,337	526	589	25%	749	32%
Kirovohrad	2,970	1931	2069	70%	2,351	79%
Total	52,515	17586	20739	39%	32,172	61%

Table 4.1.1b ART Targets in Sustained: Commodities Sub-national Units*

SNU	Target Current on ART (APR FY17)
	PEPFAR TX_CURR
Chernivtsi	51
Donetsk	1432
Ivano-Frankivs	60
Kharkiv	199
Khmelnitskiy	310
Lviv	280
Luhansk	81
Rivne	286
Sumy	115
Ternopil	51
Vinnitsia	201
Volyn	250
Zakarpattia	62
Zhytomyr	395
Total	3773

*Maintaining patients on treatment in Q4FY17-Q1FY18 among group initiating treatment in 2016 through PEPFAR ECF.

Table 4.1.2 Entry Streams for PWID Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV	Identified Positive	Newly initiated on ART (by end 2016)
Adults			886
Global Fund outreach			
Optimized case finding and CITI			2,267
PWID in care but not yet on ART			*
Total			3,153

** No contribution from the pool of PWID in care but not on ART currently (the majority of whom are not identified as active PWID by AIDS center records) was estimated for this component for new on ART in CY2016. The full contribution (estimated ~5,900 eligible) was allocated for CY2017 due to 1) new guidelines for 'test and treat' for PWID not yet operationalized at local level; 2) adequate ARVs for major scale-up arriving over next 6 months, so limited scale-up before last quarter of this year, and 3) 'test and treat' not yet in guidelines for general population (PWID who are not currently identified as PWID by AIDS centers would not be currently considered eligible for ART if CD4>500).

Table 4.1.2a Facility-based Entry Streams for Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)	Newly Identified Positive (APR FY17)	Newly Initiated on ART (by end 2017)
Adults			
AIDS Center and ART site testing*	50,035	3,085	18,099*
Prisoners***	1200	33	95**
Total	51,235	3,118	-

*Facility testing target includes all PLHIV entering facilities for testing and would be inclusive of a) PWID identified through OCF /CITI, b) partner referral efforts / index testing initiated by providers or by NGOs co-located within/proximate to facilities. Priority populations include sexual partners of PWID and PLHIV. Newly initiated on ART is high compared to testing target (sites where PEPFAR is funding testing TA activities and also treatment).due to large numbers of registered HIV+ patients not yet on treatment, expected to initiate ART in FY17.

**Prison activity will also link previously identified positives to care.. Recently released prisoners initiating treatment to be reported as custom indicator

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
KP_PREV (PWID)	184,400	17%	31,140
KP_PREV (MSM)	41,300	8%	3,146
PP_PREV (sexual partners of PLHIV and PWID)	14,800	19%	2,774
Total	240,500	15%	37,060

Table 4.1.5 Targets for OVC and Linkages to HIV Services

Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target) OVC_KNOWNSTAT*
9856 nationally		
Cherkassy	32	
Chernihiv	32	
Dnipropetrovsk	32	
Kherson	32	
Kirovohrad	32	
Kyiv Oblast	32	
Kyiv city	32	
Mykolaiv	32	
Odesa	32	
Poltava	31	
Zaporozhe	31	
TOTAL	9856 nationally	350

4.2 Priority population prevention

Ukraine has made significant progress in slowing the primarily PWID-driven HIV epidemic. Since 2004, the country has used external support from GFATM and the USG 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.

Achieving epidemic control will require addressing the estimated ~60,000 PLHIV in government-controlled areas [32% of estimated PLHIV as of Jan 2016] who are not registered in care and ~29,000 PLHIV who are registered but are no longer in active care. PEPFAR's emphasis is on prevention programming for KPs and sexual partners of PWID and PLHIV in 11 high-burden regions. COP 16 activities will recruit 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. Because of lower GFATM funding, the USG contributed ~56M 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 end-2017; PEPFAR will support pilots of innovative funding and delivery models and continue advocacy for GoU funding for MAT. PEPFAR is supporting MSM prevention NGOs to link MSM into prevention services and HTS through internet and network-based approaches. PEPFAR also supports a standardized HIV prevention program for all mobilized military and new recruits, as this population has proved to have higher HIV rates, perhaps suggesting rapid mobilization includes a significant number of PWID not previously recognized.

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 ~68% of the PLHIV population in the government-controlled areas have ever been registered in the 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 and stigma and discrimination—contribute to shortfalls in the detection and engagement of PLHIV in the HIV care cascade. To achieve epidemic control, efforts must be made to identify previously undiagnosed PLHIV, especially in KPs, and engage them in HIV care and treatment. Current governmental regulations restrict performance of HTS to qualified health personnel in clinical settings. Technical assistance will focus on removing regulatory barriers to testing of partners of PLHIV and PWID in non-clinical settings and by non-clinical personnel.

The overall yield of newly identified HIV-positive individuals from testing at GoU clinical facilities is 1.1%, a proportion that is boosted by inclusion of retested PLHIV identified in outreach. GFATM supported outreach provided assisted self-testing to an estimated 44% of PWID, 37% of FSW, and 14% of MSM in 2015. However, declining yields suggest that the GFATM outreach testing of these KPs, many of whom are established prevention clients, will not be successful in reaching many who are not participating in HTS programs. These people can be reached with a network intervention. In March 2016, PEPFAR Ukraine piloted an innovative testing model to improve testing efficiency and yield in the priority oblasts among PWID. When compared to a standard HTS model (positivity of 3.5%), this new network-recruiting model produced substantial gains in HIV yield (positivity of 23.7%) using fewer staff and financial resources. PEPFAR is also supporting increased CM to link identified HIV-positive individuals and previously untested PWID to HIV care and treatment.

PEPFAR Ukraine is also supporting QI activities to ensure better linkage through improved referral processes for HIV-positive individuals identified by HTS at HCF to AIDS Centers where they can be confirmed and offered care and treatment. PEPFAR activities are also supporting pilots of (1) improving HTS for partners of PLHIV after passive referral by the index patient and

(2) introducing widespread testing with RT for patients of primary HCF in high-prevalence regions. The yield from the pilot testing exceeded 20%, especially in the highest burden area of Krivy Rih; paired with increased linkage interventions, this activity may be useful in reaching significant numbers of PLHIV who have not previously sought or who have dropped out from HIV services.

PEPFAR Ukraine will also support stigma reduction activities in healthcare settings and in the general population. Work in these areas can help to reduce the estimated drop off (33%) between HIV diagnosis and registration in HIV care.

Rapid expansion of HTC services within the military occurred to keep pace with the doubling of its size in the setting of armed conflict but has been limited by a significant commodities gap. PEPFAR Ukraine is providing TA to support the expanded testing. The urgent gap in HIV RTKs will be addressed through short-term procurements to ensure 100% of mobilized troops are screened. Although military regulations require mandatory referral of positives to civilian PHC, technical assistance for case management and a secure patient tracking database will be adapted, if possible, from an existing data base, such as the Alliance CITI system, to ensure this occurs.

Commodity gaps critical to HTC include large shortfalls in the GoU procurement of diagnostic test kits. Historically, the GoU procured all ELISA test kits used for most HTS at HCF and for confirmation of all PLHIV and also RTs used at government HCF. Laboratory procurement is given lower priority in GoU than procurement of medications and the shortfalls in procurement have led to shortages of RTs at government HCF and ELISAs for screening and confirmation.

4.6 Facility- and community-based care and support

SPECTRUM modeling estimates that 223,000 persons were living with HIV in Ukraine in 2015. PEPFAR estimates that ~188,000 live in government-controlled areas. Of these, 127,377 (68%) had registered at an AIDS Center as of Jan 2016 and ~77% were considered to be in “active” care by having been seen within the previous 12 months. To work towards 90% ART coverage by 2020, however, two critical gaps in the HIV care cascade require attention: (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. While adherence to ART has been high (>85% at 12 months), increased adherence efforts will be needed as planned interventions rapidly increase the number of ART patients, especially among PWID.

Through its CITI model, PEPFAR is now supporting an expansion of targeted CM activities that link PLHIV for registration at AIDS Centers and re-engage 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. In pilot activities to relink patients lost to follow-up, CITI case managers worked 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 support will expand CM to larger numbers of PWID, especially those identified by network recruiting and from activities to re-link dropouts from care. In addition, improved NGO CM models for PLHIV focused on ART adherence that have been developed with PEPFAR support have been scaled up; ~83% of PLHIV on ART receive care and support services. PEPFAR has begun supporting CM with social workers for MSM in Kyiv City, one of the MSM 'hot spots.' PEPFAR is also conducting QI activities at 113 (100%) of ART treatment sites in 7 of the 11 priority regions to improve patient services and thereby limit dropouts from care and treatment.

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 will support improved linkages between the vertical disease treatment programs and encourage and monitor rates of early initiation of ART (within 2 months).

4.8 Adult treatment

Procurement for ARVs and laboratory commodities has been transferred to international agencies to avoid a previously inefficient and corrupt process. New Ukrainian ART guidelines issued in December 2015 raised the CD4 threshold for initiation of ART to 500 with ART recommended for certain subgroups, including PWID, at any CD4. A coalition of stakeholders including UCDC, PEPFAR, GFATM, and civil society acted in concert to avoid stock-outs and achieved ART scale-up to >6,000 patients in 2015 despite acute political and economic obstacles.

For 2014, the GoU procured 79% and the GFATM procured 21% of the ARVs for ~66,000 PLHIV on treatment at end-2014 representing 31% coverage of estimated PLHIV. The 2014-2018 National AIDS Plan (NAP) had envisioned expanding ART coverage by year-end 2015 to ~86,000 and by end-2016 to 105,000. 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 was unable to increase funding above the amount in the NAP 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 covered ARVs and allowed for limited scale-up. However, additional donor support will allow further scale-up as any additional redistribution of GFATM resources will adversely affect critical programming.

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%. Introduction of electronic tools for case information by PEPFAR partners at almost all AIDS Centers will allow monitoring of VL suppression on a cohort basis by 2017.

To achieve 90% ART coverage and maintain 90% viral suppression goals, PEPFAR will provide TA to improve outcomes among priority populations. Core TA activities for COP16 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 healthcare 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 the system of commodity procurement and supply chain.

PEPFAR is also conducting QI activities at 113 (100%) of ART treatment sites in 7 of the 11 priority regions to improve patient services and thereby limit dropouts of KPs, especially PWID, from care and treatment. 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

Based on UCDC data, as of 1/1/2015 there were 9,856 children with HIV-positive status under medical supervision in Ukraine; while most are children born to HIV-positive mothers, whose status had not been confirmed yet, this total includes 3,036 confirmed HIV-infected children. As of 1/1/2016, 2,761 HIV-infected children were on ART. Most OVC in Ukraine come from economically disadvantaged families and some are orphaned by the epidemic; these HIV-positive children do not have sufficient skills to manage their economic life. PEPFARs promote adherence to ART among OVC along with strengthening family bonds, life skills, healthy behavior, and financial literacy. Caregivers receive training on status disclosure, ART-adherence, effective communication with their children, socio-emotional support, and financial literacy.

PEPFAR does not fund pediatric care and treatment. However, PEPFAR OVC activities link with activities from other institutions including a national reference pediatric clinic, AIDS Centers, and NGOs. PEPFAR will support linkages of OVC to HIV services through the “Network of PLHIV,” which has developed local-level programs to engage OVC into HIV-services. The percentage of OVC that will age out of these programs is low. Based on UCDC estimates, the number of children living with HIV aged 15-17 was 390, representing less than 15% of HIV infected children (<18).

4.11 Laboratory

Laboratory activities focus on measures 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. Current targets include number of persons trained; an accreditation target will be adopted once a Memorandum of Understanding (MOU) on a SLMTA-like activity is finalized. Since they are based nationally, 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. 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, decentralization, and provision of a blood screening platform will ensure this separate blood program keeps pace with civilian national blood safety programs.

Viral load capacity: PEPFAR-Ukraine is providing direct technical assistance to manage viral load capacity. A high-level PEPFAR laboratorian is on the working groups developing new laboratory guidelines including WHO recommendations for de-emphasis of CD4 testing and rational use of VL. Working with GoU, PEPFAR-Ukraine has mapped current viral load equipment capacity (sufficient under current utilization) and regions requiring capacity support as scale-up occurs. Current capacity suffers from inadequate quantities of laboratory commodities, which will be addressed through requested central support.

4.12 SI

Improvements to the national HIV SI system are being driven by the goal of meeting European Union standards under the Partnership Agreement. Current SI targets include 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. Expansion of a USG-supported HIV MIS system will enable collection and analysis of granular HIV testing and clinical data along the cascade of HIV care. The next round of IBBS among risk groups is scheduled for early 2017; the survey for PWID will include an additional study site in Krivy Rih to better evaluate HIV prevalence in this key city. HIV related estimates via modelling, including calculations of the size of risk groups, will be supported. Other PEPFAR SI activities will target data quality assessment and sustainability of SI activities through continuous training for local M&E personnel.

In line with PEPFAR gender analysis recommendations, a study assessing risk factors for HIV among newly identified young HIV positive pregnant women will be developed. Assessment of HIV/HCV burden among HIV positive patients as a key mortality factor among PLHIV on ART will be performed, and HCV surveillance activities will be initiated by the WHO country office. The WHO Global HIV drug resistance surveillance strategy will also be supported in the country. Additionally, HIV facility-based QI activities will incorporate ongoing data collection, data analysis and service mapping that will guide programmatic decisions. PEPFAR will build capacity

within UCDC for the National AIDS Spending Assessment (NASA), and (HIV/AIDS technical and allocative efficiency at the regional level.

4.13 OHSS

PEPFAR 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.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

The GoU and GFATM provide basic packages of HIV services for all regions and KPs in Ukraine and have historically purchased sufficient ARVs and diagnostics to achieve 2014-18 National AIDS Plan treatment targets. The GoU has taken major responsibility for procurement of ARVs and diagnostic tests. In 2013, for example, the GoU purchased 82 percent of national ARV requirements. However, because of the economic downturn, the government will only purchase 49 percent of ARVs needed in 2016 for the national target of 86,491 patients; GFATM (30 percent) and USG (21 percent) procurements are covering the difference. The GFATM remains the largest external funder for HIV, responsible for 45 percent of National HIV/AIDS Program expenditures in 2015. Its 2015-2017 grant totals \$134M with 59 percent for commodities. The GFATM is the country's sole purchaser of MAT. GFATM's three Principal Recipients (PRs) support HTS, BCC, care and support, support for OVCs, M&E, MIS, and general HSS. PEPFAR invested \$1.2M in 2015 to cover PR training costs, an area previously supported by the GFATM. The three GFATM PRs have their own systems for data collection, analysis, and reporting on prevention, treatment, and care and support services. The GFATM has adopted a regionalization approach targeting high-burden oblasts in the east and south without exclusion of other oblasts.

5.1 Maintenance package of services in other locations and populations

PEPFAR-Ukraine terminated its stand-alone prevention programs for most-at-risk adolescents, MSM, male prisoners, and PWID; programs were transferred and sustained by a social work association and GFATM PRs Alliance and Network. It also ended prevention programs for most-at-risk adolescents and male prisoners and a pilot of HIV testing for suspected TB cases in primary health care centers in Lviv. Prison sector, law enforcement, and drug rehabilitation activities in Kharkiv will end in June 2016.

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

PEPFAR-Ukraine will end activities not requiring further support because they have finished products (*Table A.3: Transition Plans for Non-Core Activities*). These include strategic

information instruments and platforms transferred to national and regional health authorities and finalized policies, regulations, guidelines, etc. handed over to the government and other relevant parties. The MoH developed an HIV/TB National Transition and Sustainability Strategy and Implementation Plan endorsed by the CCM and submitted to the Cabinet of Ministers for approval. PEPFAR-Ukraine provided technical assistance to and participated in the plan's development and will align its activities as possible.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

The top three programmatic gaps in the clinical cascade are: Commodity Insecurity; Lack of Detection, Linkage, and Retention in Care of PLHIV/Key Populations; and an Unreformed Health System and Its Impact on HIV Services. Overcoming these three gaps is essential for achieving 90-90-90 and sustained epidemic control.

Gap 1: in 2013, the GOU purchased approximately 82 percent of Ukraine's ARV requirements, demonstrating its commitment. However, because of the conflict in the East and the declining economy (70 percent reduction of purchasing power of Ukraine's currency), the country can now only pay for half of the ARVs needed to reach its national targets. For Ukraine to meet its national targets, the GFATM and PEPFAR will temporarily need to continue their current support of increased volumes of commodities and supply chain technical assistance.

The first systems barrier refers to commodity insecurity and reflects government shortcomings to transparently procure at best international prices. Historically, corrupt interests controlled public procurements, resulting in inflated prices and lower treatment coverage. However, recent legislation mandates that international agencies purchase health commodities for MOH with UNICEF designated as the procurement agent for ARVs until 2019, at which time Ukraine will have inaugurated an independent National Drug Procurement Agency. However, the government has not yet developed legislation to establish this agency. In addition, oblasts are legally constrained from buying ARVs and MAT because funding for these is envisaged in the national budget by the 2014-2018 AIDS Program Law.

The second systems barrier refers to lack of adequate government financing and misallocation of existing resources for critical HIV prevention and care commodities. Currently, there is an absolute scarcity of government funds to purchase needed commodities. In addition, the government procures some high-cost ARVs due to patent-protected market positions and allows an excessive number of drug regimens. The government does not prioritize buying MAT currently and relies on the USG and GFATM to furnish large quantities of test kits, condoms, and other prevention/diagnostic items.

The third system barrier refers to a lack of a rational pharmaceutical management and supply chain system. National and subnational authorities use multiple lists to procure drugs; drug selection committees, whose members were commonly influenced by vested pharmaceutical

interests, have chosen drugs without accounting for costs or effectiveness. Quantification of commodities is based on the availability of funds, rather than need, and a logistic management information system (LMIS) has not yet been designed to track stocks in facilities.

Gap 2: Ukraine still lacks systems to adequately detect, link, and retain PLHIV/key populations in care. Overall, only 67 percent of estimated PLHIV know their status and 52 percent are enrolled in care. Of these, only 61 percent are receiving treatment, of which ~90 percent are virally suppressed. PWID remain a key population for transmission, but are a difficult group to find, test, and retain in care with resulting low rates of treatment coverage.

The first system barrier reflects incomplete and fragmented services leading to low detection and retention. Ukraine lacks appropriate strategies to augment standard outreach in detection of PWID and their sexual partners and lacks adequate case management to support referral, enrollment, and retention. No unified patient tracking system between NGOs, specialized health centers, and AIDS Centers exists to reduce dropout; moreover, facility procedures to enroll and retain patients require further standardization and streamlining. Limited MAT is provided in drug rehabilitation centers, but is generally unavailable in primary health care centers, district hospitals, and non-existent in prisons.

The second system barrier pertains to lack of a public health approach to HIV service delivery. The current system prioritizes specialized care, rather than primary or preventive care. HIV services are over-medicalized with only specialized physicians providing post-test counseling. Externally funded NGOs undertake prevention, care, and support services with, to date, little government willingness to assume responsibility; the government has also failed to establish normative standards and certification for HIV outreach, prevention, support, and care services.

The third system barrier refers to deficient financing mechanisms to support public and NGO HIV service delivery. Insufficient funding for HIV, HIV/TB, and MAT commodities and services heavily results from resource utilization inefficiencies. Further GFATM funding remains uncertain and the National AIDS Program could face multiple severe challenges if funding is substantially reduced. Even with imminent funding reductions, most GFATM-supported NGOs have not developed business plans and alternative revenue streams. Because of legal barriers, government health authorities have not contracted NGOs to provide HIV services, but to a limited extent social service departments have contracted NGOs to provide social work services.

The fourth system barrier is lack of a unified HMIS system and appropriate analysis of data for decision making. Additional data on key populations and official SNU estimates of PLHIV are needed. Data use analysis and use remain substandard, and multiple, parallel HMIS systems require additional improvements in quality control and interoperability.

Gap 3: The healthcare system in Ukraine still follows a Soviet model that de-emphasizes a public health approach. A comprehensive healthcare reform proposal still lacks sufficient political commitment to advance.

The first system barrier is failure by the MoH to produce an approved health reform strategy and implementation action plan due to vested interests in the Cabinet of Ministers and the National Parliament and blockage of MoH leadership. HIV, TB, MAT, and STI services remain un-integrated at the primary care level, the government has just started developing an essential package of services to include HIV and HIV/TB components; performance-based payment systems for healthcare facilities and providers remain unrealized.

The second system barrier refers to a lack of commitment by national and regional governments, including the Ministry of Finance, to fully fund national and local HIV/AIDS programs. The government eschews funding of MAT and KP prevention, care, and support services. HIV health providers, including primary care providers, lack financial incentives to provide critical HIV services and increase the number of patients.

The third system barrier is lack of appropriate drug selection and procurement mechanisms. Historically, there have been non-transparent procurement systems at the national and oblast level and multiple procurement lists that contain inappropriate and over-priced drugs. In addition, the government procures sub-optimal drug regimens.

Table 6.1.1 Key Programmatic Gap #1: Commodity Insecurity

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of institutionalized and professionalized national/ sub-national entities for health procurement management and administration [Governance]	1. [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
	2. [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
	3. [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
	4. [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
	5. Military procurement system that interacts with MoH	Activity 5: TA to military medical system to improved collaboration with MoH			pipeline	Military Prevention
Lack of adequate government financing and misallocation of existing resources for critical HIV prevention and care commodities [Financing]	1. [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
	2. [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery: 5.6
	3. Central government and regions will procure MAT and prevention commodities	Activity 3: Advocacy and TA to the MOH and oblasts to procure MAT and prevention commodities	IDUP	\$132,541	HSS-SHARe	8. Commodity Security and Supply Chain: 2.5
	4. [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
	5. Co-payment schemes introduced and operational	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5

		Activity 5: TA to develop and pilot co-payment system	OHSS	\$255,000	HSS-SHARe	11. Domestic Resource Mobilization: 6.7
Lack of rational pharmaceutical management and supply chain system [Supply Chain]	1. [REDACTED] 2. [REDACTED] 3. [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5
TOTAL				\$2,237,541		

Table 6.1.2 Key Programmatic Gap #2: Lack of Detention, Linkage, and Retention in Care of PLHIV/Key Populations

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Incomplete and fragmented services leading to low yields and retention [HR and Service Delivery]	1. Optimized case finding models institutionalized to detect PWID and their sexual partners 2. Pilot and scale-up PITCs in primary and specialized facilities (STI, TB, Narcology) 3. Development of appropriate SOPs to enroll and retain patients 4. [REDACTED] 5. Further pilot and roll out evidence-based adherence interventions targeted at PLHIV, PWID, and TB/HIV co-infected patients 6. Improved quality of care and treatment outcomes for Medication Assisted Therapy (MAT)	Activity 1: Implement Optimized case finding for PWID focused on active recruitment of HIV positive and their risk/social networks	HVCT	\$750,000	METIDA	6. Service Delivery: 5.6 9. Quality Management: 3.2
		Activity 2: TA to oblasts and health facilities to pilot and scale-up PITCs	HVCT	\$247,785	HSS-SHARe	6. Service Delivery: 5.6
		Activity 3: TA to develop SOPs at the facility level. SOPS spell out specific procedures for facilities to deliver services for patients		\$200,000.00	RESPOND	9. Quality Management: 3.2
		[REDACTED]		[REDACTED]	[REDACTED]	6. Service Delivery: 5.6
		Activity 5: Development of unified HMIS system for patient tracking	HVSI	\$500,000	Network	6. Service Delivery: 5.6, 9. Quality Management: 3.2
		Activity 6: Implementation of financially sustainable and cost-effective MAT models to scale-up MAT service	IDUP	\$100,000	MAT Alliance for Public Health	6. Service Delivery: 5.6, 9. Quality Management: 3.2

		Activity 7: Implement Community Initiated Treatment Initiative (CITI) for PWID focused on case management, community support, link to care and short term adherence support	HVCT	\$750,000	METIDA	6. Service Delivery: 5.6, 9. Quality Management: 3.3
Lack of a public health approach to HIV service delivery [Governance]	<ol style="list-style-type: none"> Oblast level Public Health Centers established with clear responsibilities Legislation passed that allows for task shifting of HTS, referrals, and dispensing to non-physicians National QI/QA framework developed 	Activity 1: Support development of selected regional public health centers to address HIV, TB, and other diseases	OHSS	\$140,000	HSS-SHARe	2. Policies & Governance: 4.6
		Activity 2: Advocacy for adoption and implementation of comprehensive HIV care and treatment national guideline (Test and Start)	OHSS	\$180,000	CDC WHO	2. Policies & Governance: 4.6
		Activity 3: CIASS assessments (service delivery capacity with QA/QI elements) to foster country-owned, sustainable, high quality prevention, detection and treatment programs Support quality monitoring activities at the ARTs sites	HTXS	- \$1,400,000	ITECH new mechanism	2. Policies & Governance: 4.6
		Activity 4: Development of QI/QA national regulations for HIV/AIDS services	OHSS	\$109,578	RESPOND	2. Policies & Governance: 4.6
		Activity 5: Strengthen national surveillance of HIV Drug Resistance in Ukraine	OHSS	\$180,000	CDC WHO	13. Epid & Health Data: 5.7
		Activity 6: TA to develop legislation for task-shifting to non-physicians	OHSS	\$70,000	HSS-SHARe	2. Policies & Governance: 4.6
		Activity 7: TA to update military HIV policy focusing on standardized HIV testing, anti-stigma, and anti-discrimination	OHSS	pipeline	Military Prevention	2. Policies & Governance 4.6
		Lack of appropriate financing mechanisms to support and sustain public and NGO HIV service deliver [Financing]	<ol style="list-style-type: none"> National and oblast-level budgets based on need developed and funding disbursed for all appropriate services Oblasts use national health subvention (annual allocation) to fund HIV services. This subvention should include mandated funding for HIV and other services. Oblast Health Administrations contract qualified NGOs for prevention, outreach, 	Activity 1: TA and advocacy to MOH and oblasts to revise AIDS plans based on need and disburse funding	OHSS IDUP	\$312,353 \$132,541
Activity 2: Develop innovative financing and budgeting mechanisms to improve allocative and technical efficiencies in HIV program	OHSS HVSI			\$213,838 \$175,000	HSS-SHARe	

	<p>care, and support services</p> <p>4. NGOs with diversified funding sources that enable them to continue servicing KPs</p> <p>5. Introduction of more cost effective case management models</p> <p>6. All critical services are included and funded in the national and in priority regions' AIDS plans</p>	Activity 3: TA and advocacy to use health subventions for critical HIV services	OHSS	\$180,000.00	HSS-SHARe	11. Domestic Resource Mobilization: 6.7
		Activity 4: TA and advocacy in seven regions to contract NGOs for service provisions	OHSS	\$208,235	HSS-SHARe	11. Domestic Resource Mobilization: 6.7
		Activity 5: Capacity building of NGOs for resource mobilization	OHSS	\$182,629	RESPOND	11. Domestic Resource Mobilization: 6.7
		Activity 6: Pilot and implement case management models for PLHIV focused on ART adherence, IDUs and TB patients	OHSS HVCT	\$252,367 \$35,000	HSS-SHARe	11. Domestic Resource Mobilization: 6.7, 12. Tech and Allocative Efficiencies: 6.2
Lack of a unified HMIS system and appropriate analysis of data for decision making [Barrier 4-M&E /Information]	<p>1. Linked HMIS to track patients through the continuum of care</p> <p>2. Institutionalization of DQA with development of appropriate tools</p> <p>3. M&E Staff with ability to collect, analyze, interpret data</p> <p>4. M&E staff at regional levels have the capacity to generate and analyze population estimates that correspond to the cascade of services and KPs</p>	Activity 1: Develop unified HIV Management Information System, including clinical outcome indicators to be tracked	HVSI	\$500,000	Network	6. Service Delivery: 5.6
		Activity 2: Support HIV surveillance activities in Ukraine to analyze HIV cascades leaks	HVSI	\$100,000	METIDA	13. Epid &Health Data: 5.7
		Activity 3: Support DQA at all levels (DQA commission, development and roll-out of DQA tools and standards, DQA visits)	HVSI	\$100,000	METIDA	9. Quality Management: 3.2
		Activity 4: Develop online courses in M&E, and data analysis including analysis of the treatment cascades for KPs	HVSI	\$114,000	METIDA	13. Epid &Health Data: 5.7
		Activities 5: Conduct HIV Epidemic modeling using AEM and SPECTRUM at the regional levels	HVSI	\$100,000	METIDA	13. Epid &Health Data: 5.7
		Activities 6: IBBS 2017 + 2 new studies on risk factors for HIV among young women and study on HIV/HCV burden)	HVSI	\$1,400,000	METIDA	13. Epid &Health Data: 5.7
		TOTAL				\$7,679,028

Table 6.1.3 Key Programmatic Gap #3: Unreformed Health System and Its Impact on HIV Services

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
To date, lack of an approved health reform strategy. [Governance]	<ol style="list-style-type: none"> Establishment of a National Public Health Institute (NPHI) Increased NPHI leadership of SI activities (including IBBS and HIV DR surveillance) and laboratory services. Basic HIV, TB, MAT, and STI services integrated at the primary health care level in five high burden oblasts A guaranteed essential package of services, including HIV services, developed and implemented in 5 high burden oblasts TA to HIV NRL and regional HIV labs staff to implement international standards ISO 15189; Preparation for lab accreditation based on SLMTA tool Development of the training modules on Quality Management for laboratory specialties for pre-service curricula Implementation of the QMS at the blood centers, improve linkage to ART services and close communication gap between blood centers and AIDS centers 	Activity 1: Support development of national public health institution to address HIV, TB, and other diseases	OHSS	\$130,000	HSS-SHARe	2. Policies & Governance: 4.6
		Activity 2: Support capacity development of NPHI to increasingly lead response and introduce reforms in strategic information and laboratory services	OHSS	\$300,000	CDC MOH	2. Policies & Governance: 4.6
		Activity 3: TA for integrated HIV and TB-related services at PHCs	OHSS	\$75,000	HSS-SHARe	6. Service Delivery: 5.6
		Activity 4: TA input around HIV critical services into main activity supported by World Bank	OHSS	\$25,000	HSS-SHARe	2. Policies & Governance: 4.6 ; 6. Service Delivery: 5.6
		Activity 5: TA to HIV NRL and regional labs staff on step wise preparation for accreditation on ISO 15189;	HLAB	\$350,000	ASCP	10. Laboratory: 6.2
		Activity 6: Trainings for HIV labs professional on SLMTA tool. Activity 7: Institutionalization of the QMS for lab professionals.				
	Activity 5: Preparation of the blood centers to transition to EU Directives for international and national certification.	OHSS	\$0 Funding for this activity has been reduced. Funds in the amount \$ 150, 000 allocated for ARTs	AIHA	9. Quality Management: 3.2	
Lack of total funding and appropriate funding	<ol style="list-style-type: none"> An inter-ministerial committee that includes both MOH, MOEDT, and MOF established that reviews a budget based on HIV/AIDS and MAT needs and finances it 	Activity 1: Advocacy to establish inter-ministerial committee jointly with UNAIDS and GFATM	OHSS	\$20,000	HSS-SHARe	11. Domestic Resource Mobilization: 6.7

[Financing]	<p>accordingly</p> <ol style="list-style-type: none"> 2. Medical subvention (grant allocation) from the national level to SNUs that adequately fund HIV services and MAT 3. Adequate sub-regional budget allocations that support HIV and MAT services 4. MOF and MOH support performance based financing and co-payment mechanisms in the HIV sector 	Activity 2: cross reference with 6.1.2 financing activity #2				
		Activity 3: cross reference with 6.1.2 financing activity #1				
		Activity 4: Pilot provider payment reforms for HIV, in collaboration with World Bank	OHSS	\$20,000	HSS-SHARe	ii. Domestic Resource Mobilization: 6.7
Lack of appropriate drug selection and procurement mechanisms for HIV commodities	<ol style="list-style-type: none"> 1. International procurement of drugs through 2019 with a transition to government procurement through a national drug procurement agency 2. Introduction of e-procurement 3. Essential medicines list produced and implemented 4. New protocol with optimized regimes developed 	Activity 1: cross reference 6.1.1, governance activity #1				
[Supply chain]		Activity 2; cross reference 6.1.1, governance activity #4				
		Activity 3: cross reference 6.1.1, supply chain activity #1				
		Activity 4: cross reference 6.1.1, financing activity #2				
TOTAL				\$900,000		

6.2 Critical Systems Investments for Achieving Priority Policies

Table 6.2.1 Test and Start						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of guidelines and policies [Governance]	<ol style="list-style-type: none"> Comprehensive HIV guidelines and protocols that include a TEST and START approach developed and institutionalized Development of SOPs that streamline enrollment and reflect a TEST and START approach Non-medical personnel and nurses have authority to engage in HIV testing and counseling and dispense ARVs ARV dispensing expanded to PHCs and NGOs 	Activity 1: cross reference 6.1.2, governance activity #1				
		Activity 2: cross reference 6.1.1, financing activity #2				
		Activity 3: cross reference 6.1.2, governance activity #3				
		Activity 4: TA to change regulations and pilot ARV dispensing through NGOs and PHCs	OHSS	\$170,000	HSS-SHARe	2. Policies & Governance: 4.6; 6. Service 6.2
		Activity 5: Provide TA for NPHI on implementation TEST and START strategy, HIV self-testing management	HLAB	\$150,000	ASM	10. Laboratory: 6.2
Lack of financial resources that would allow for significant expansion of HIV services [Financing]	<ol style="list-style-type: none"> Requirements and costs calculated for TEST and START approach Simplified regimens under a new protocol Demand and supply of quality generic drugs as cost-effective alternative to expensive brands Capacity built at national and oblast level for quantification of commodities Patient co-payment schemes related to TEST and START designed and tested 	Activity 1: TA to MOH to calculate costs related to TEST and START	HVSI	\$100,000	HSS-SHARe	14. Fin/Expenditure Data: 6.3
		Activity 2: cross reference 6.1.1, financing activity #2				
		Activity 3: cross reference 6.1.1, financing activity #1				
		Activity 4: cross reference 6.1.1, supply chain activity #2				
		Activity 5: TA to develop regulations and design and test co-payment scheme related to ARV provision	OHSS	\$50,000	HSS-SHARe	2. Policies & Governance: 4.6
Lack of human resource requirements that will needed	<ol style="list-style-type: none"> Empirical analysis of human resource requirements for TEST and START conducted Passage of legislation that would allow for 	Activity 1: Conduct an empirical analysis of the human resources required to conduct TEST and START	OHSS	\$50,000	HSS-SHARe	7. Human Resources for Health: 6.3

under TEST and START approach [Health Workforce]	an appropriate deployment of staff (repeal of order 33) 3. [REDACTED]	Activity 2: cross reference 6.1.2 governance #3				
		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	7. Human Resources for Health: 6.3
TOTAL				\$270,000		

Table 6.2.2 New and efficient service delivery models

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP ¹⁶	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Regulatory barriers for a high quality, less expensive patient-centered HIV service system [Governance]	<ol style="list-style-type: none"> 1. Protocols and guidelines changed to reflect new service delivery models developed and implemented. 2. Protocols define stable patients as those with undetectable viral load or based on simple clinical criteria 3. Expanded PHC, that include HIV service delivery developed and implemented 	Activity 1: cross reference 6.1.2, governance activity #1				
		Activity 2: cross reference 6.1.1, financing #2				
		Activity 3: TA to develop and implement an integrated and expanded primary health care service package that include HIV critical services			[REDACTED]	
Inadequate recruitment and sub-optimal task assignments for HIV health providers, case managers, and PHC health providers [Human Resources]	<ol style="list-style-type: none"> 1. General practitioners trained to diagnose, test, and treat, and refer patients 2. Introduction, then increase number, of social workers/case managers, including peers, into primary health care, specialized centers, and ART treatment sites 3. [REDACTED] 4. Health workers and managers have capacity to use data for decision making 5. Non-infectionist physicians have capacity to deliver ART 6. 100% linkage to civilian care from military HTC program 	Activity 1: cross reference 6.1.2 governance #3				
		Activity 2: cross reference 6.2.2 governance activity #3				
		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	7. Human Resources for Health: 6.3
		Activity 4: Train health workers and managers in outcome based decision making	HVSI	\$328,733	RESPOND	7. Human Resources for Health: 6.3

		Activity 5: Train health workers, including primary health care doctors, in ART delivery, including CQI	HTXS	\$182,629	RESPOND	7. Human Resources for Health: 6.3
		Activity 6: Expand military case management program	HVCT	pipeline	Military prevention	7. Human Resources for Health 6.3
Laboratory procedures create unnecessary testing and inadequate number of viral tests available [Barrier 3: Laboratory]	<ol style="list-style-type: none"> 1. New testing protocols reduce number of CD4 tests. 2. CD4 tests will only be conducted at initiation to establish baseline. 3. New protocols streamline the number of diagnostic tests needed for enrollment 	Activity 1: Improve capacity for lab proficiency testing and EQA for HIV related tests Development EQA/PT guidance, SOPs for HIV NRL and regional labs	HLAB	\$150,000	CLSI	10. Laboratory: 6.2
		Activity 2: Provide TA for HIV NRL in implementation of WHO new HIV testing algorithm, streamline the number of diagnostic tests needed for ART enrollment	HLAB	\$200,000	APHL	10. Laboratory: 6.2
		Activity 3: Development of management tool for HIV NRL on HIV POC technologies, implementation of the POC services for KP	HLAB	\$150,000	ASM	10. Laboratory: 6.2
TOTAL				\$911,362		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Finance							
	Pilot provider payment reforms for HIV, in collaboration with World Bank	1,2	Financial support guaranteed for an essential package of services including HIV services in five high burden oblasts	\$30,000	OHSS	HSS-SHARe	11. Domestic Resource Mobilization 6.7
	Develop innovative financing and budgeting mechanisms to improve allocative and technical efficiencies in HIV program	1,2,3	Cost-efficient service models adopted in regions		OHSS	HSS-SHARe	12. Technical and Allocative Efficiencies 6.2
	Strengthen HIV program planning and budgeting at national and oblast levels	1,2,3	All critical services are included and funded in the national and in priority regions' AIDS programs		IDUP OHSS	HSS-SHARe	11. Domestic Resource Mobilization 6.7 12. Technical and Allocative Efficiencies 6.2
Governance							
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	2. Policies and Governance 4.6
	Pilot scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV and enroll clients into cascade of services		Policies adopted that reduce stigma and discrimination to facilitate the enrollment of KP and PLHIV into the cascade of services	\$49,545	OHSS	RESPECT	2. Policies and Governance 4.6

HRH - Systems/Institutional Investments							
	Technical assistance to GoU to ensure HRH capacity in HIV	1,2,3	GoU and priority regions have costed HRH strategies and implement them to reach 90-90-90	\$335,294	OHSS	HSS-SHARe	7. HRH 6.3
Inst & Org Development							
	Strengthen coordination of HIV and TB programs	1,2	Regional AIDS programs have activities focused on HIV/TB and system of referrals of HIV and TB are instituted in priority oblast	\$35,000	HVTB	HSS-SHARe	6. Service Delivery 5-56
	Improve linkages for HIV and TB referrals and coordination	1,2,	Effective coordination between TB dispensaries and AIDS Centers	\$195,851	HVTB	STBCu	6. Service Delivery 5-56
	Develop and pilot cascade of services model for KPs	1,2,3	PWID and PLHIV enter the cascade of services from first and secondary of health care	\$322,041	OHSS	RESPECT	6. Service Delivery 5-56
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery 5-56
Laboratory							
	Development of laboratory Policy and Strategy for NPHI	1,2,3	NPHI institutes laboratory policy and strategy	\$100,000	HLAB	APHL	10. Laboratory 6.20
Strategic Information							
	Building capacity within GoU for data and analysis	4	NASA institutionalized in MOH and implemented annually without international TA; MOH is able to carry out efficiency studies	\$115,558	HVSI OHSS	HSS-SHARe	14. Financial/Expenditure Data 6.3 12. Technical and Allocative Efficiencies 6.2
	Develop online national SI resources	1,2,3	Data visualization improved and supported	\$74,071	HVSI	RESPOND	13. Epi and Health data 5-7
Systems Development							
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	9. Quality Management 3-4

TOTAL			
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*Reference Appendix C for a list of activity types that fit in each category.

7.0 Staffing Plan

The Ukraine PEPFAR team, after pivoting in COP 15 to the new PEPFAR 3.0 goals and guidelines, continues to refine its program activities, budget, and staffing in COP 16 to meet priority country and PEPFAR objectives. COP 16 is designed to enhance the treatment cascade in Ukraine – particularly among PWID – and to continue critical health systems strengthening, laboratory, and project oversight activities.

In light of complex challenges of matching COP cycle planning to funding implementation realities and country-specific requirements, the PEPFAR Ukraine team met early in the planning process to discuss staffing alignments that would further pivot objectives and, of particular focus this year, Test and Start. Decisions were further informed by the core/near/non-core exercise and the development of the FSW and PBAC. As a TA country, staffing priorities reflect the two main activities of site monitoring and technical assistance.

Further clarifications to the COP requirements were brought to light in Bangkok during the COP review. After learning that \$8.8 million in funds would be available to purchase drugs for Ukraine, the priorities shifted to staffing up a model that will ensure adequate monitoring and QA that is required in a DSD context with existing and five planned new staff. The analysis of SIMS visits required (national level) and reporting necessitated a shift in PEPFAR-Ukraine’s approach to the staffing, which heretofore had focused on maintaining an extremely lean profile. The team needs to substantially bolster its SI capacity, in light of increased SIMS, EA, and POART requirements that have been enhanced as part of the pivot, and new indicators and DSD monitoring as a part of the increased funding package. CDC has filled its full-time LES SI Advisor position, and has also filled its LES SI Program Specialist position. USAID has hired an EFM Quality Improvement and Communications Specialist who analyses quality improvement data and develops and tracks treatment cascade indicators.

Given the relatively small team size of PEPFAR Ukraine, realigning and adding positions impacts other team members more directly than may be the case in larger teams with broader duties and a deeper bench of specialized positions. Level of effort analysis revealed that staff spend most time on core rather than near core or non-core activities. Thus, consideration was given to 1) care and treatment, 2) sustainability, and 3) PEPFAR team coordination in country.

Care and treatment (LES)

CDC is requesting to add one technical Program Specialist, an LES MD, to lead Care and Treatment activities. This position will cost out at 80% to HTXS and 20% HVMS owing to grants management responsibilities. This skill set is currently missing from team technical staff and will be an important link to building care and treatment capacity in Ukraine. This position is the treatment program technical advisor to the Ukraine Ministry of Health, partners and non-governmental organizations (NGOs) in the implementation of treatment programs and activities. HTXS increased 100% over COP 15.

Care and Treatment USDH

PEPFAR –Ukraine is increasing its support to Ukraine for a continued major expansion of antiretroviral treatment to achieve epidemic control. This support includes a) commodity support for increased scale up of treatment to new patients; b) temporary commodity support for maintenance in CY 2017 of patients started on ART by GoU and through an ECF request; c) awarding of a new mechanism to provide increased staff and logistics support to the Ukrainian Center for Disease Control to provide TA in ART regimen optimization and service provision to treatment sites; d) support from a central ART TA mechanism to provide training and mentoring to existing national level treatment experts and the unit of treatment specialists described in c). The provision of ARVs and treatment TA will necessitate SIMS visits focusing on treatment CEEs to >200 ARV treatment sites. This major expansion of ART-related activities will require high level in-country technical input and coordination of the activities that will be best provided by a dedicated USDH treatment expert. This position will cost 10% to HVMS and the rest to HTXS, and will be supervised and paid from CDC resources.

SI USDH (interagency)

PEPFAR –Ukraine is significantly increasing its support to Ukraine for a continued major expansion of antiretroviral treatment to achieve epidemic control and is continuing its ‘pivot’ to increasing patient detection and linkage to care, while maintaining a broad portfolio of activities designed to improve the capacity for a sustainable response. The complexity is increased by having a mix of easily quantifiable targets (such as direct treatment targets for PLHIV reached with PEPFAR-supplied ARVs) and difficult to quantify targets which cannot be directly measured easily but instead require integration of data and inference (such as coverage of PWID with treatment). The increased support and complex targets are creating a significant increase in required SI outputs for the overall program as well as from multiple agencies; these outputs are required to adequately provide integrated data analysis and interpretation to multiple OGAC stakeholders. This major expansion of SI-related activities requires high level in-country technical work and coordination of agency SI/M&E activities that will be best provided by a dedicated USDH strategic information expert. This position will sit in the PCO but CDC will oversee technical supervision and CODB costs, as 10% HVMS and 90% HVSI. The position will integrate with interagency and OGAC for SI-related activities at post.

Sustainability Analyst (USAID)

USAID has repurposed a long term vacancy to a two-year US PSC position with an option to extend up to five years. Originally slated to be a Health Economist, the position will now be a Sustainability Analyst, a PSC, which will cost out 100% to OHSS. The Sustainability Analyst will monitor national and sub-national government program and financial investments in PEPFAR-supported activities, track the implementation of the HIV Transition and Sustainability Plan, and act as PEPFAR’s point person for the implementation of the Kyiv Fast Track Cities Initiative.

Procurement Specialist (USAID)

The PEPFAR-Ukraine Procurement and Supply Chain (PSM) Specialist, a two-year US PSC 100% costed out to OVHS, will serve as the interagency specialist for USG-supported commodities and also coordinate USG PSM activities with UCDC, UN agencies, and the GFATM Principal Recipients to quantify and develop supply plans for HIV commodities to Ukraine. The PSM specialist will closely monitor the stock levels of all HIV commodities, included those sourced by PEPFAR, and alert the PEPFAR interagency partners about the undersupply or stock out of specific products. The incumbent will track the supply of non-optimized and optimized regimens in HIV treatment sites by source of supply. In addition, s/he will provide expert advice to the PEPFAR partners and national stakeholders about (1) the establishment of an independent health procurement agency that will purchase HIV commodities and (2) the capacity of regions and districts to purchase harm reduction commodities, such as condoms and needles/syringes.

PEPFAR Team Coordination

The PEPFAR Coordinator position will remain a PSC position under USAID until the State LNA position is at post, and will cost 100% to HVMS. The team identified a need for, and approved, an LES Program Assistant for the PEPFAR Coordinator, in order to help organize the growing and increasingly complex program and team environment in Ukraine. This position will also cost 100% to HVMS and will be budgeted under State. The Ukraine PEPFAR Team requires coordination throughout the year with increased reporting and data reviews such as quarterly POART calls, APR/SAPR, SIMS/DATIM but coordination is intensified during preparation of the annual Country Operational Plan. In addition, there are routine coordination needs for program implementation such as organizing partner meetings; coordinating with other national stakeholders and responding to OGAC and front office ad hoc requests.

SAMHSA

SAMHSA, through the HOP, will place a full time USDH regional Substance Abuse Specialist in Ukraine in 2016 along with one LES assistant for a period of three years. No funding will be provided through the COP for these two positions the primary purpose of which will be to advance the uptake of MAT, establish an Addiction Technology Transfer Center, and address associated policy challenges in close coordination with the broader USG PEPFAR/Ukraine team.

The Ukraine PEPFAR Team has no vacancies at this time deemed critical to achieving its targets. The repurposed and newly requested positions listed above should be on board by end of calendar year 2016, if not earlier. When fully staffed, the team footprint will increase approximately 38% overall and approximately 25% for core staff (FTE, 100% PEPFAR funded). In all, the team will have 44 individuals “touching” PEPFAR activities in one way or another, with 26 core FTE.

The team has an acceptable level of CODB and management relative to technical and programmatic staff. Out of 31 total and proposed FTE, only 4 PEPFAR-funded are purely administrative support, and 6 are management. There is excellent LES/USDH balance, with 69% of staff LES, and 6 LES staff in leadership positions. There are clear opportunities for career advancement for most LES.

Cost of Doing Business (CODB)

CODB in COP 2016 will increase nearly 100% over COP 2015. The primary driving factors in this increase are: 1) addition of 3 new USDH positions; 2) addition of 2 new LES positions; 3) filling 6 vacancies; 4) Peace Corps volunteer costs have been reinstated for volunteers returning to Ukraine for the first time since 2014; 5) increased meetings and travel for more SIMS visits (national level, 300+ sites, an increase of 200%); and 6) general increases year over year including training, staff onboarding, ICASS, equipment for new staff, and partner/CS/NGO engagement. Travel costs are also increasing due to required training and PCS moves. Because of the dynamic environment in Ukraine leading to rapidly shifting priorities and activities for the PEPFAR Team, predicting future CODB costs in out-years is not possible. It is safe to assume, however, that CODB will continue to rise each year to some extent as costs for staff, travel, training, and office space continue to increase year over year.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<ul style="list-style-type: none"> -Scale up implementation of policies and practices designed to reduce stigma and discrimination of KP and PLHIV -Conduct stigma reduction activities among health and social workers in primary health care centers and other health facilities -Improve linkage to AIDS service organizations and MAT services for HIV positive prisoners who are newly released -Integrate and scale up HIV prevention services into the drug rehabilitation system -Improve access to, quality of care, and treatment outcomes for MAT -Support training health workers (including primary care workers in ART delivery including CQI) - Strengthen cross referrals and coordination of HIV, MAT, and TB programs - Implement and expand cascade of services model using QI methodology for PLHIV and KPs - Scale up case management models for PLHIV focused on ART, MAT, and TB adherence in NGOs - Use patient tracking methods to identify patients who have dropped out and return them to care - Strengthen prevention services for key and priority populations such as PWID,MSMs, discordant couples, and sex partners of PWIDs) - Conduct HIV prevention activities in key and priority populations -Training for primary health care doctors for HIV and TB referrals -Develop standard operation procedures to conduct HTC services in prisons -Pilot and scale up PITC in primary and specialized facilities -Ensure that appropriate government health facilities, including primary health care facilities, employ social workers/case managers to assist TB and HIV patients - Improve linkage to MAT, TB, and AIDS service organizations 	<ul style="list-style-type: none"> -Build target group HIV knowledge and skills by reducing stigma and discrimination of PLHIV and KPs and promoting healthy behaviors via Peace Corp community and school-based programs -Close communication gap Between blood centers and AIDS centers to ensure bilateral information exchange on primary identified PLWH - Develop guidelines for lab staff on HIV viral resistance diagnostic -Modes of Transmission study -Strengthen blood screening for TTIs in blood centers 	<ul style="list-style-type: none"> -Support regional data triangulation using routine data -Facilitate POC CD4 (Pima) testing

for prisoners who are released

-Support integrated HIV, MAT, TB, and STI at the primary health care level

-Ensure routine testing of prisoners upon admission and pre-release, and as desired during length of stay

-Ensure prisoners receive combination prevention interventions

-Ensure State Penitentiary Services augment medical services through access of AIDS Center personnel

-Ensure reduction of testing visits for stable HIV patients

-Apply QI at AIDS Centers and ART sites to strengthen patient pathway to prevent dropouts

- Scale up QI interventions to increase yield from facility based HTC and referrals

-Apply QI methodology to improve counseling and testing at the primary health care level and TB facilities

-Support interventions (camps and trainings) for HIV+ children and youth and their care givers to provide psychological support, adherence promotion, family and economic strengthening (OVC)

Strengthen organizational capacity for civil society organizations serving KPs

-Improve quality of care and treatment outcomes for MAT

-Support training health workers (including primary care workers in ART delivery including CQI)

-Implement Optimized Case Finding (OCF) and Community Initiated Treatment Initiative (CITI) for PWID focused on peer navigation, outreach case management and community support to achieve TEST and START, linkages to care, ART adherence.

-Use case management approach to identify patients who have dropped out and return them to care

-HIV epidemic modeling using AEM and SPECTRUM at the regional level

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Sub-national level	<ul style="list-style-type: none"> -Build capacity within GoU for data and analysis - Pilot scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV 	<ul style="list-style-type: none"> -Develop online national SI resources -Train health workers in 	<ul style="list-style-type: none"> -Support implementation science -Regional AIDS dashboard transferred

<ul style="list-style-type: none"> - Build organizational capacity to address stigma and discrimination (among health workers, social workers) -Strengthen coordination of HIV and TB programs-- Focus prevention services to stop transmission among emerging risk groups (MSM, discordant couples, sex partners of PWID) -Integrate and scale up HIV prevention, testing, and referral services and MAT into the drug treatment system - Improve quality of care and treatment outcomes - Support inclusion of primary care workers in ART and MAT delivery - Support Regional Training Centers for HIV providers and family doctors -Establish Public Health Centers in up to three focal regions - Implement a cascade of services model for KPs and PLHIV - Strengthen coordination of HIV, MAT, and TB programs - Implement case management models for PLHIV focused on ART adherence - Support the implementation of Regional AIDS Plans at oblast level and selected rayons - Improve linkages for HIV and TB referrals and coordination and scale up ambulatory care for TB/HIV - Implement prevention services to stop transmission among key and priority populations (e.g. MSMs, discordant couples, sex partners of PWIDs, prisoners) - Strengthen organizational capacity for civil society organizations serving KPs -Expand a surveillance system for rational HIV drug use -National AIDS dashboard created and in use -Prison medical and social work staff are trained on pre-release counseling - Strengthen organizational capacity for civil society organizations serving KPs to improve ability to effectively receive government and private sector funding -Implement PDI models to identify and recruit sexual partners of PWID and online recruitment for MSM -Establish sub-national drug procurement units -Capacity building conducted for quantification and supply 	<ul style="list-style-type: none"> outcome-based decision making - Support regional data triangulation using routine data - Support innovative financing and budgeting mechanisms to improve HIV, TB, and MAT programs -In-service training courses in evidenced based policy and oversight completed -Capacity raised of NGOs to provide HIV management and budget support to regions and districts -Pilot alternative approaches to manage and finance HIV services -Develop national 5 year plan for HRH -National Supply Chain assessment completed -Tracking of early initiation HIV positive TB patients on ART implemented -Tools adapted for quantification and supply planning -Framework contracting for multi-year purchasing of HIV, MAT, and TB products initiated -National AIDS dashboard created and in use -Plan for transitioning within two years to EU standards for blood safety activities 	<ul style="list-style-type: none"> to GoU -Building capacity within GoU for data and analysis (NASA tools developed and populated) -TB/HIV ambulatory care treatment model assessed -Prevention Effectiveness Cohort study
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- planning
- Sub-national governments commission HIV, TB, and MAT medical/social services
 - Scale up MAT services in primary health care centers and other appropriate health facilities
 - Strengthen referral network between HIV, TB, and MAT services
 - Diversify funding sources for NGOs engaged in prevention, care, and support services
 - Financial support guaranteed for an essential packages of services including HIV services in five high oblast
 - HIV National Management Information System roll out
 - DQA Commission at regional levels; Adoption of DQA tools

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
National level	<ul style="list-style-type: none"> -Support the development of a Logistics Management Information System to track HIV, TB, and MAT -Prison system routine purchase of HIV commodities -Support policies to introduce MAT into prison and pre-trial detention centers -Support the establishment of a National Drug Procurement center - Technical assistance to GoU to ensure HRH capacity in HIV - Technical assistance to a pharmacovigilance system for HIV and TB drugs - Develop/distribute national HIV Drug Resistance Drug Prevention Strategy -Develop national QI/QA regulations for HIV/AIDS services -Capacity building conducted for quantification and supply planning - Support innovative financing and budgeting mechanisms to improve HIV, TB, and MAT programs 	<ul style="list-style-type: none"> -Finalize an essential medicines list that includes MAT, TB, and HIV commodities with a preference for generic products -Support the establishment of the National Public Health Institute -Develop national clinical guidelines on MAT -Tools adapted for quantification and supply planning -Technical assistance to the MOH to have framework contracting for multi-year purchasing of HIV, MAT, and TB products initiated -Conduct high level diplomacy to support continuation of Global Fund support at sufficient levels 	<ul style="list-style-type: none"> -Develop online national SI resources - Scale up implementation of policies designed to reduce stigma and discrimination of KP and PLHIV -Pilot a surveillance system for rational HIV drug use - Support implementation science -National AIDS dashboard transferred to GoU -Building capacity within GoU for data and analysis (NASA tools developed and

- Support health subvention from national to oblast level that contains a mandated HIV and TB earmark
- Support legislation that defines a clear division of national and sub-national responsibilities for HIV and TB under decentralization
- Advocacy for MOF to support performance based financing and co-payment mechanisms
- Ensure government purchases adequate number of viral load tests
- Development of comprehensive HIV care and treatment national guidelines (Test and Start)
- HIV National Management Information System roll out
- Conduct ART treatment practice improvement activities, including QI at ART treatment sites
- Provide TA on ART related issues both nationally and regionally in ART sites where ART is given currently and under health care reform (AIDS centers, trust cabinets and other treatment sites)
- Provide TA to develop national guidelines, protocols on regimen optimization, prioritization of patients for ART under conditions models for innovative antiretroviral service delivery, models for antiretroviral service delivery for key populations
- Study HIV patients outcome data including use of increasingly available electronic registers to identify systemic issues associated with outcomes of HIV patients in AIDS centers, polyclinics, TB care settings and other settings
- Advocacy work to ensure procurement of MAT medications from GoU/local/regional budgets
- IBBS among key population (PWID, FSW, MSM) and bridge group on HIV prevalence
- Study Assessment of HIV prevention effectiveness among PWID with DBS testing for measuring incidence
- Study among young HIV+ women and their partners conducted
- Data for Cohort treatment cascade collected
- DQA Commission at national; Adoption of DQA tools at the national level
- Improve capacity for lab proficiency testing and EQA
- Support quality management standards and systems for laboratories
- Support NRL in HIV testing strategy and algorithm validation
- Develop a model essential package of services that includes HIV services
- Introduce e-procurement of HIV and TB commodities by new government purchasing entity
- Optimize lab system
- Develop on-line national SI resources
- Train health workers in outcome based decision making
- populated)
- Investment Case Phase II completed
- LEA completed
- Police guidelines on OST, NST, and harm reduction materials finalized for law enforcement and prison services
- Develop standards plus protocols for provision of HIV services among bridge populations

based on Consolidated WHO guidelines for HIV testing services.

-Support NRL in guidance on implementation of the POC applications; Development strategy for management Self-Testing programs

-Improve capacity for lab proficiency testing and EQA

-Support implementation of IBBS and other surveillance efforts

-Improve quality of care and treatment outcomes for MAT

-Support Regional Training Centers for HIV services for key populations

-Development of financially sustainable and cost-effective MAT funding models to inform MAT service on scale-up for the GoU

-Technical assistance to the National MAT working group under the MOH and support to the coordination of MAT activities on the National level are ensured

-Train SMART for use in UCDC and NPHI

-QA with CIASS instruments are continued to strengthen HIV services at Odesa, DNP, and Cherkasy Oblasts, other prioritized regions

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

	Core Activities	Near-core Activities	Non-core Activities
HTS	<ul style="list-style-type: none"> - Strengthen cross referrals and coordination of HIV, MAT, and TB programs - Implement and expand cascade of services model using QI methodology for PLHIV and KPs -Develop standard operation procedures to conduct HTC services in prisons -Pilot and scale up PITC in primary and specialized facilities -Ensure routine testing of prisoners upon admission and pre-release, and as desired during length of stay -Ensure reduction of testing visits for stable HIV patients - Strengthen coordination of HIV, MAT, and TB programs - Scale up QI interventions to increase yield from facility-based HCT and referrals -Apply QI methodology to improve counseling and 	<ul style="list-style-type: none"> Close communication gap between blood centers and AIDS centers to ensure bilateral information exchange on primary identified PLWH - Develop guidelines on clinical use of HIV viral resistance diagnostics -Strengthen blood screening for TTIs in blood centers 	<ul style="list-style-type: none"> Facilitate POC CD4 (Pima) testing

testing at the primary health care level and TB facilities

-Implement PDI models to identify

and recruit sexual partners of PWID and online recruitment for MSM

-Integrate and scale up HIV prevention, testing, and referral services and MAT into the drug treatment system

-Training for primary health care doctors for HIV and TB referrals

-Prison system routine purchase of HIV commodities

-Legislation passed and operationalized for task shifting (HTC, referrals, and ARV dispensing) for non-physician health personnel

-Modes of Transmission study

	Core Activities	Near-core Activities	Non-core Activities
Care and Treatment	--Comprehensive guidelines and developed that support TEST and START and new delivery models	-Train health workers in outcome-based decision making	-Support implementation science
	-Improve linkage to AIDS service organizations and MAT services for HIV positive prisoners who are newly released	- Support innovative financing and budgeting mechanisms to improve HIV, TB, and MAT programs	-Regional AIDS dashboard transferred to GoU
	-Improve access to, quality of care, and treatment outcomes for MAT	-Tracking of early initiation HIV positive TB patients on ART implemented	-TB/HIV ambulatory care treatment model assessed
	-Support training health workers (including primary care workers in ART delivery including CQI)	-Support the development of a Logistics Management Information System to track HIV, TB, and MAT	-Pilot a surveillance system for rational HIV drug use
	- Strengthen cross referrals and coordination of HIV, MAT, and TB programs	-Develop new treatment protocol with optimized regimens and diagnostic testing (increase provision of ARV supplies to clients from one month to 3-6 months)	-Develop standards plus protocols for provision of HIV services among bridge populations
	- Implement and expand cascade of services model using QI methodology for KPs	-Finalize an essential medicines list that includes MAT, TB, and HIV commodities with a preference for generic products	
	- QI/QA national regulatory documents developed	-Tools adapted for quantification and supply planning	
	-Apply QI at AIDS Centers and ART sites to strengthen patient pathway to prevent dropouts	- Build target group HIV knowledge and skills by reducing stigma and discrimination of	
	- Scale up QI interventions to increase yield from facility based HTC and referrals		
	- Scale up case management models for PLHIV focused on ART, MAT, and TB adherence in NGOs		
- Use patient tracking methods to identify patients			

<p>who have dropped out and return them to care</p> <ul style="list-style-type: none"> -Ensure that appropriate government health facilities, including primary health care facilities, employ social workers/case managers to assist TB and HIV patients -Support integrated HIV, MAT, TB, and STI at the primary health care level <p>Ensure State Penitentiary Services augment medical services through access of AIDS Center personnel</p> <ul style="list-style-type: none"> -Integrate and scale up HIV prevention, testing, and referral services and MAT into the drug treatment system - Improve quality of care and treatment outcomes - Support inclusion of primary care workers in ART and MAT delivery - Support Regional Training Centers for HIV providers and family doctors - Implement a cascade of services model for KPs - Strengthen coordination of HIV, MAT, and TB programs - Implement case management models for PLHIV focused on ART adherence - Scale up QI approach at AIDS Centers to strengthen patient pathway to prevent drop outs - Improve linkages for HIV and TB referrals and coordination and scale up ambulatory care for TB/HIV -Expand a surveillance system for rational HIV drug use -Prison medical and social work staff are trained on pre-release counseling - Technical assistance to a pharmacovigilance system for HIV and TB drugs - Develop/distribute national HIV Drug Resistance Drug Prevention Strategy 	<p>PLHIV and KPs and promoting healthy behaviors via Peace Corp-, community-, and school-based programs</p>
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	Core Activities	Near-core Activities	Non-core Activities
Prevention	-Scale up implementation of policies and practices designed to reduce stigma and discrimination of KP	-Develop national clinical	- Scale up implementation of policies designed to reduce

and PLHIV

-Conduct stigma reduction activities among health and social workers in primary health care centers and other health facilities

- Build organizational capacity to address stigma and discrimination (among health workers, social workers)

-Integrate and scale up HIV prevention services into the drug rehabilitation system

-Integrate and scale up HIV prevention, testing, and referral services and MAT into the drug treatment system

- Strengthen prevention services for key and priority populations such as

PWID,MSMs, discordant couples, and sex partners of PWIDs)

- Conduct HIV prevention activities in key and priority populations

-Ensure prisoners receive combination prevention interventions

- Implement prevention services to stop transmission among key and priority populations (e.g. MSMs, discordant couples, sex partners of PWIDs, prisoners)

-Scale up MAT services in primary health care centers and other appropriate health facilities

-Diversify funding sources for NGOs engaged in prevention, care, and support services

-Support policies to introduce MAT into prison and pre-trial detention centers

guidelines on MAT

stigma and discrimination of KP and PLHIV

-Police guidelines on OST, NST, and harm reduction materials finalized for law enforcement and prison services

-Prevention Effectiveness Cohort study

OVC	Core Activities	Near-core Activities	Non-core Activities
Program/system support	<p>-Support local interventions (camps and trainings) for HIV+ children and youth and their care givers to provide psychological support, adherence promotion, family and economic strengthening (OVC)</p> <p>Behavioral surveys and size estimation for most-at-risk adolescents (age group 10-19 years) at the local level in 5 high burden regions.</p>		

-Conduct stigma reduction activities among health and social workers and educators	
-Strengthen organizational capacity for civil society organizations serving KPs	
-Support legislation that defines a clear division of national and sub-national responsibilities for HIV and TB under decentralization	
- Support innovative financing and budgeting mechanisms to improve HIV, TB, and MAT programs	
-Support health subvention from national to oblast level that contains a mandated HIV and TB earmark	-Optimize lab system
-Advocacy for MOF to support performance based financing and co-payment mechanisms	-Plan for transitioning within two years to EU standards for blood safety activities
-Ensure government purchases adequate number of viral load tests	- Support regional data triangulation using routine data
-Support the establishment of the National Public Health Institute	

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP	Estimated Funding in COP	# of IMs	Transition End date	Notes
-Support implementation science	Non-core	16	17			
-Regional and National AIDS dashboard transferred to GoU	Non-core					
-Building capacity within GoU for data and analysis (NASA tools developed and populated)	Non-core					
-TB/HIV ambulatory care treatment model assessed	Non-core					
- Scale up implementation of	Non-core					

policies designed to reduce stigma and discrimination of KP and PLHIV

-Pilot a surveillance system for rational HIV drug use Non-core

-Investment Case Phase II completed Non-core

-LEA completed Non-core

-Police guidelines on OST, NST, and harm reduction materials finalized for law enforcement and prison services Non-core

-Develop standards plus protocols for provision of HIV services among bridge populations Non-core

-Facilitate POC CD4 (PIMA) testing Non-core o o

-Prevention Effectiveness Cohort Study Non-core o o

Totals o o

APPENDIX B

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
4,784,253	32,824,635	37,608,888

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated (New Funding Only)
MTCT	Mother to Child Transmission	0
HVAB	Abstinence/Be Faithful Prevention	0
HVOP	Other Sexual Prevention	7,493
IDUP	Injecting and Non-Injecting Drug Use	355,082
HMBL	Blood Safety	3,296
HMIN	Injection Safety	0
CIRC	Male Circumcision	0
HVCT	Counseling and Testing	2,971,797
HBHC	Adult Care and Support	391,142
PDCS	Pediatric Care and Support	0
HKID	Orphans and Vulnerable Children	195,288
HTXS	Adult Treatment	3,175,356
HTXD	ARV Drugs	8,800,000
PDTX	Pediatric Treatment	0
HVTB	TB/HIV Care	706,599
HLAB	Lab	2,752,734
HVSI	Strategic Information	4,041,199
OHSS	Health Systems Strengthening	6,626,506
HVMS	Management and Operations	2,798,143
TOTAL		32,824,635

B.2 Resource Projections

The Team used a variety of inputs to formulate its COP 2016 planned spending. Resources were projected based on partner feedback and prior year spending required to reach indicators and objectives. Primary data tools including the PBAC and SBOR were used. The lump-sum budgeting portion of the PBAC and the EA were particularly useful resources. Agencies focused on attaining goals rather than “budget sharing,” and thus specific activities have been resources appropriately. CODB relied on a review of prior year costs with 2016 projected increases based on budget analysis by agency and embassy financial specialists.

APPENDIX C

Systems Investments for Section 6.o

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A

Laboratory

Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services

Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents an supplies, travel and transport, building rental and utilities will not be included

APPENDIX D Kyiv Fast Track Cities Initiative (FTCI) Central (non-COP) funding and activities

Kyiv Fast Track Cities Initiative (FTCI)

Kyiv City has been one of the most heavily affected regions of Ukraine with an HIV epidemic currently estimated at 22,000 PLHIV. On April 6, Kyiv City's mayor, Vitaly Klitschko, signed onto the UNAIDS Fast Track City Initiative and the city has begun mapping current resources and identifying gaps with stakeholders. The Kyiv City Coordination Council will begin drafting the city's strategy in May. On the basis of current epidemiological and programmatic information, PEPFAR-Ukraine has identified ongoing activities that could help more rapidly attain FTCI targets and achieve epidemic control in Kyiv City; these activities are proposed to be augmented. Development of the Kyiv City strategy will include finalization and incorporation of PEPFAR activities.

Activities:

The estimated PWID population size in Kyiv is large (32,000) with a high HIV prevalence (22%, 2015 IBBS); HIV testing and linkage to treatment rates are currently low with an estimated >5,000 HIV-infected PWID unaware of their status and unlinked to care. Network recruiting activities for PWID (OCF) will be augmented, with an anticipated target of 3,000 additional PWID tested and 240 additional PWID begun on ART. Access to MAT is currently extremely low in Kyiv with ~800 patients (~3% coverage). A MAT mechanism will enhance efforts to support increased provision sites, including another large site in eastern Kyiv ('Left Bank') and primary care facilities; increased advocacy for provision of MAT by local authorities will occur along with procurement of 500 patient-year courses to more rapidly increase coverage.

The estimated MSM population size in Kyiv is large (24,000) with a high HIV prevalence (15%, 2015 IBBS) and incidence (limited antigen (Lag) incidence testing 2013 IBBS); HIV testing and linkage to treatment rates are low. A network based recruiting activity will be developed and initiated for MSM, resulting in an additional 2,000 MSM tested. Additionally a pilot PrEP activity will be developed and implemented for MSM based on current MSM-friendly HTS sites.

Preliminary data indicates that SW are currently accessing HIV testing at moderately high rates; although prevalence in Kyiv remains low (1.5% 2015 IBBS), those testing positive have very low levels of ART initiation; identification of the barriers and development of a proposed activities to enhance access will be undertaken.

The new CDC treatment technical assistance mechanism will enhance planned support to Kyiv ART sites and develop a model for same day initiation of ART while also trying to enhance partner recruitment for HTS by practitioners.

An additional 1,000 patient-year courses of optimized ART regimens will be procured to ensure that the additional PLHIV detected and linked to care through the augmented activities described above will be able to be initiated on ART

USAID contributions to the FTCTI will augment activities that are currently being undertaken by its IPs. These activities take place at the municipality, city district, community, and facility levels and represent technical support for governance, sustainable financing and resource mobilization, human resources for health (HRH), pharmaceutical management, NGO capacity building, detection and linkage to care, and stigma and discrimination. Major activities include assistance for HIV management, including quantification, procurement planning, and development of an electronic Logistics Management Information System. Governance technical assistance activities include revising the Municipal AIDS Plan, policies encouraging the registration of HIV+ IDPs and other non-residents in the Kyiv City AIDS Center, and assessing the organizational needs for the Municipal Public Health Center. Financial management activities encompass implementation of cost-efficient service delivery models, promoting Municipal Health Authority subcontracts of HIV services to NGOs, and training district health authorities in managing HIV funding. HRH activities include training of PHC and other health facility providers in ART, HTC, and HIV/TB. Community-based activities incorporate TA for NGOs to generate their own funds and receive government subcontracts as well as motivational counseling, testing, and referrals for MSM and sexual partners of PWID and PLHIV. Facility level interventions include linking PHC and specialized healthcare facility case managers to NGO outreach workers; assisting PHCs and specialized facilities to manage and budget for counseling, testing and referral activities; and developing local protocols for stigma and discrimination. The USAID IP now working in two city districts in Kyiv City will expand its activities to four districts.

PEPFAR USG Implementing Partner	Activity	Goals	Expected Funding	Targets (as applicable)
Deloitte/HIV Reform in Action	Develop plan for MAT and harm reduction commodity procurement	City procurement mechanism developed and operational.	\$25,000	
	Training in managing decentralized HIV funding	Funding for city HIV activities successfully disbursed and expended.	\$20,000	
	Revise Municipal AIDS Plan and annual budgets based on FCTI targets	Municipal AIDS Plan and annual budgets regularly reviewed and revised.	\$50,000	
	Organizational needs assessment for municipal	Organizational plan for Municipal Public Health	\$20,000	

	Public Health Center completed and action plan developed	Center and Action Plan developed and implemented.		
	Kyiv City subcontracts NGOs for prevention, care, and support services through social contracting. Organizational capacity of CSOs/NGOs in Kyiv City to request and receive government funding strengthened	NGOs undertaking prevention, care, and support services receive subcontracts from the city and successfully complete their activities.	\$30,000	
	Policies to facilitate HIV+ IDPs into treatment and care developed	Policies to facilitate HIV+ IDPs into treatment and care developed and successfully implemented. Results are documented.	\$10,000	
	Cost-efficient service models implemented in Kyiv City	Cost-efficient service models implemented and adopted.	\$40,000	
	Case management mechanisms linking case managers in PHCs and specialized health facilities to NGO outreach workers	Case managers in PHCs and specialized health facilities recruited and are actively linking patients to care.	\$45,000	
	Policy on how to ensure that HIV+ non-official residents can access HIV services developed	Policy that accesses HIV+ non-official residents to care implemented.	\$10,000	
	TA to Kyiv City to plan, budget, and implement PITC services in PHCs and specialized health facilities in 2 additional districts	Kyiv City plans, budgets, and implements PITC services in PHCs and specialized health facilities in two additional city districts.	\$40,000	
MSH/SIAPS	Quantification for HIV commodities and supply planning and training undertaken	HIV commodity quantifications used to forecast and order products.	\$60,000	
	Piloting LMIS	LMIS reports used to supply HIV facilities at max-min stock levels.	\$100,000	

Pact/RESPOND	Sexual partners of PLHIV and PWID tested and counseled and linked to care	Sexual partners of PLHIV and PWID tested and counseled and linked to care.	\$40,000	90% CARE_NEW
	Motivational counseling, testing, and referral for MSMs	Motivational counseling, testing, and referral mechanisms for MSMs implemented and results documented.	\$146,000	
	Social enterprise/alternative funding for NGOs	Revenues generated from social enterprise activities are used to cover NGO costs.	\$30,000	
	Training 100 PHC doctors and health workers on ART, HTC, and HIV/TB	100 PHC doctors and health workers on ART, HTC, and HIV/TB trained.	\$60,000	
All-Ukrainian Network of PLHWA/ RESPECT	SOPs developed for stigma and discrimination in additional health sites	Stigma and discrimination SOPs in additional sites fully operational.	\$5,000	
Alliance for Public Health/ METIDA	OCF for PWID	<ul style="list-style-type: none"> Active case finding and increased linkage to treatment for the large number of HIV-infected PWID not in care (estimated ~5,000) 	\$130,000	3,000 KP_PREV
	Modify OCF for MSM	<ul style="list-style-type: none"> Active case finding and linkage to treatment for MSM <p>Make programmatic decisions relying on the data how well target populations (PWID&MSM) are being reached with individual and/or small group level interventions</p>	\$120,000	2,000 KP_PREV
Alliance for Public Health/ METIDA	Identifying barriers and means to improve access to ART for SW	Collect and analyze information on existing barriers in order to better plan and	\$50,000	

		organize programmatic activities aimed to improve linkage to ART for the high proportion of HIV-infected SW currently not accessing ART		
CDC/ TBD ART mechanism	Monitoring and mentoring of providers to ensure optimal implementation of new ART protocols, including development of model for approaching or achieving same day initiation of ART	<ul style="list-style-type: none"> •Design, test and adopt viable and sustainable models for implementation of new treatment protocols •Build capacity of healthcare providers conducting the same day initiation of ART Ensure implementation of the test and treat strategy at the site level	\$100,000	
	Pilot/continue practitioner improvement of partner referral	<ul style="list-style-type: none"> •Collect and analyze information about the yield of HTC and the effectiveness of HTC interventions while identifying PLHIV •Use programmatic data to improve referral patterns and increase HTC yield 	\$50,000	HTC_TST 100 10% yield
Alliance for Public Health	PREP pilot among MSM	<ul style="list-style-type: none"> •Develop needed normative documents for a PrEP pilot •Pilot PREP at MSM friendly HTC sites Analyze programmatic data and develop recommendations on PREP strategies in MSM	\$100,000	PrEP_ New target 100

Alliance for Public Health/MAT	Increasing integration of MAT into primary health care – support for SOPs and implementation Support new site Advocacy and assistance with policy	<ul style="list-style-type: none"> •Design, pilot and adopt viable MAT models including those in primary healthcare settings •Advocacy for MAT scale up including opening of new MAT site(s) •Support adoption of local regulations creating enabling environment for MAT provision Improve quality of integrated services provided at the MAT sites	\$100,000	KP_MAT 500
	MAT procurement limited	<ul style="list-style-type: none"> •Plan and perform procurement of MAT medications needed to support MAT scale up •Advocate for MAT procurement for the expense of municipal budget Support planning	\$50,000	
USAID/Chemonics	Procure add'l 1,000 courses of ART		\$170,000	
Additional ART commodities				
TOTAL			\$1,601,000	

APPENDIX E Additive Commodities

Background:

As of January 1st, 2016, Ukraine had 235 ART sites (including 7 cabinets [offices] of the Odessa City AIDS center but not including sites located on temporarily occupied areas of Donetsk and Luhansk regions). The national program also had 58,758 individuals on ART and an overall ART coverage rate of approximately 31% (based on denominator of estimated number of PLHIV) as of January 2016. Currently, the national program provides ART and associated commodities through funding from the Government of Ukraine (GoU); the GFATM; and, in the current fiscal year, through an Emergency Commodity Fund (ECF) request from PEPFAR.

In April 2016, the USG team updated its previous COP 16 SDS to identify \$3,400,000 USD of funds to be redirected to the purchase of commodities for the scale up of ART to approximately 20,000 individuals that are identified HIV + and awaiting treatment as the country moves towards implementation of WHO test and start recommendations. However, in late April and early May as Ukraine moved forward with its efforts to optimize existing ART drug regimens, national partners (GoU, civil society, multilateral donors) jointly reviewed and agreed on an emerging gap that indicated existing patients would experience a shortfall in ARV commodities for FY 2017.

As background, the MoH's UCDC and national stakeholders have been actively driving regimen optimization, which is designed to maximize coverage, based on WHO guidance to markedly improve cost effectiveness. However, GoU funding for ARVS in 2016 is capped by the Ministry of Finance (MoF) at a national currency equivalent of ~\$10.2 M USD and, given the ongoing economic crisis and the devaluation of the local currency, the GoU's purchasing power has also decreased. For 2017, GFATM will cover 26,000 existing patients and is committed to buying optimized regimens. Additionally, GFATM covered 7,200 in non-government controlled areas in 2016 and may do so again through the end 2017. And, implementation of regimen optimization will begin in the second half of 2016. GoU will cover 43,000 patients for Q1 and Q2 and the savings from optimization will cover Q3. However, a commodities gap will emerge in Q4 (see the chart below for specific details). This gap will require ~\$6.2 M for antiretroviral drugs and an additional ~\$800,000 for laboratory commodities for 2017 to cover the GoU patients in Q4. In addition, \$3.4M in savings will be used to procure commodities for initiating treatment for an additional ~20,000 patients during CY 2017.

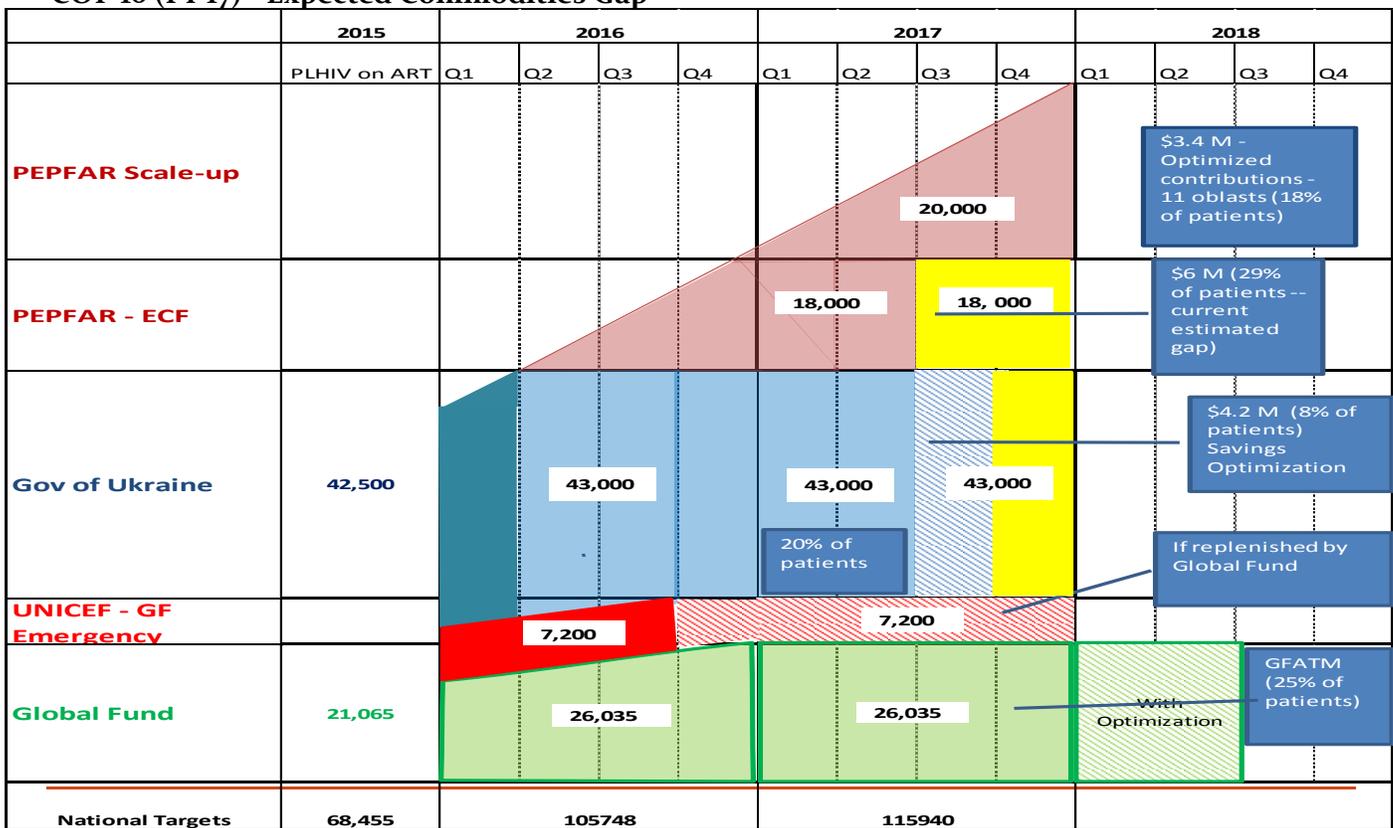
In early-May 2017, the US Department of State's Office of the Global AIDS Coordinator (S/GAC) agreed to provide an additional \$7,000,000 USD towards the purchase of drugs and commodities. As such, the USG PEPFAR program will make a total of 10.4 M USD available for drugs and commodities through an existing USG mechanism to ensure: (1) coverage for 43,000 patients that would be impacted by ARV shortage and that GoU's savings from optimization will not be able to cover; (2) to continue coverage for 18,000 patients that the GoU was to assume from PEPFAR's current ECF support; and (3) to help scale up ART to approximately 20,000 individuals who are HIV+ and in need of treatment. In brief, drugs provided under COP 16 will be used for sustaining and expanding ART

coverage, particularly in geographic regions where the burden of PLHIV and PWID is highest, as part of a broader strategy to reach epidemic control.

PEPFAR Monitoring, Evaluation and Reporting (MER) Targets:

Direct service delivery (DSD) targets have been assigned to the Ministry of Health’s (MoH) Ukrainian Centers for Disease Control (UCDC). For COP 16, UCDC will report quarterly on four targets that assess treatment scale up and the quality of treatment services including: (1) TX_NEW (quarterly); (2) TX_CURR (quarterly); (3) TX_RET (annually); and (4) TX_PVLS (annually). In addition, TA targets will be determined and assigned to USG implementing partners that are providing technical assistance to UCDC for scaling up and for ensuring quality of treatment services. A treatment TWG visit will be arranged and results shared with key stakeholders.

COP 16 (FY 17) - Expected Commodities Gap



APPENDIX F Custom (Internal Project) Indicators & Targets

OU-Level SUMMARY

Indicator	Agency (IM)	FY17 Target
HTC_TST	USAID/RESPECT/non prison; CDC/METIDA	34340
TX_NEW	USAID/RESPECT/non prison; USAID/RESPECT/prison; USAID/RESPOND(CITY in Kherson); USAID/RESPOND (Proportion TX_NEW/CARE_NEW); CDC/METIDA	4130
TX_CURR	USAID/RESPECT/prison; USAID/RESPOND	38221
CARE_COM	USAID/RESPECT/non prison; USAID/RESPECT/prison; CDC/METIDA	4282
CARE_NEW	USAID/RESPECT/non prison and RESPECT prison; USAID/RESPOND	277
PP_PREV	DOD; PC	100200
Number of cases of clients' referral HCPs from pilot HCFs to Trust cabinets in order to perform HIV HTC	USAID/RESPECT/non prison	1200
Number of HIV-positive individuals retained on ART 3 months after the release	USAID/RESPECT/prison	215
Number of HIV-positive individuals referred to programs providing services for the clients with substance disorders	USAID/RESPECT/prison	120

Number of HIV (+) positive patients linked to MAT	CDC/Alliance	326
Number of HIV (+) positive patients linked to ART	CDC/Alliance	1352

FY17 CUSTOM/Internal Indicators - Indicator/agency/ breakdown

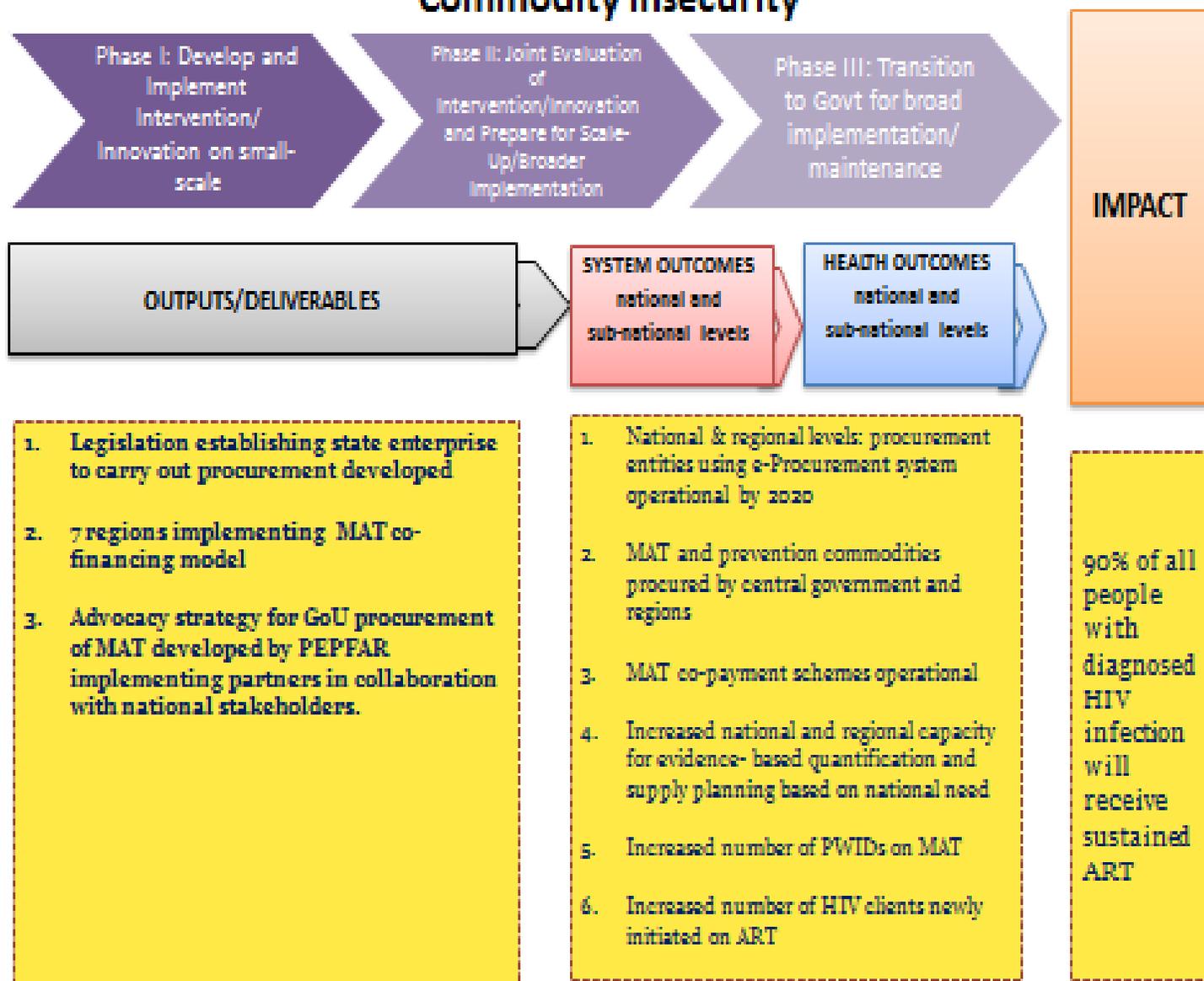
Indicators	Agency (by IM)	FY17 Target
HTC_TST	USAID/RESPECT/non prison	1200
HTC_TST	CDC/METIDA	33140
TX_NEW	USAID/RESPECT/non prison ; USAID/RESPECT/prison	145
TX_NEW	USAID/RESPOND QI; USAID/RESPOND(CITI in Kherson); USAID/RESPOND(Proportion TX_NEW/CARE_NEW)	1775
TX_NEW	CDC/METIDA	2210
TX_CURR	USAID/RESPECT/prison	140
TX_CURR	USAID/RESPOND	38081
CARE_COMM	USAID/RESPECT/non prison; USAID/RESPECT/prison;	1520
CARE_COMM	CDC/METIDA	2762
CARE_NEW	USAID/RESPECT/non prison and RESPECT prison	277
CARE_NEW	USAID/RESPOND	90%
PP_PREV	PC	200
PP_PREV	DOD	100000
Number of cases of clients' referral HCPs from pilot HCFs to Trust cabinets in order to perform HIV HTC	USAID/RESPECT/non prison	1200

Number of HIV-positive individuals retained on ART 3 months after the release	USAID/RESPECT/prison	215
Number of HIV-positive individuals referred to programs providing services for the clients with substance disorders	USAID/RESPECT/prison	120
Number of HIV (+) positive patients linked to MAT	CDC/Alliance	326
Number of HIV (+) positive patients linked to ART	CDC/Alliance	1352

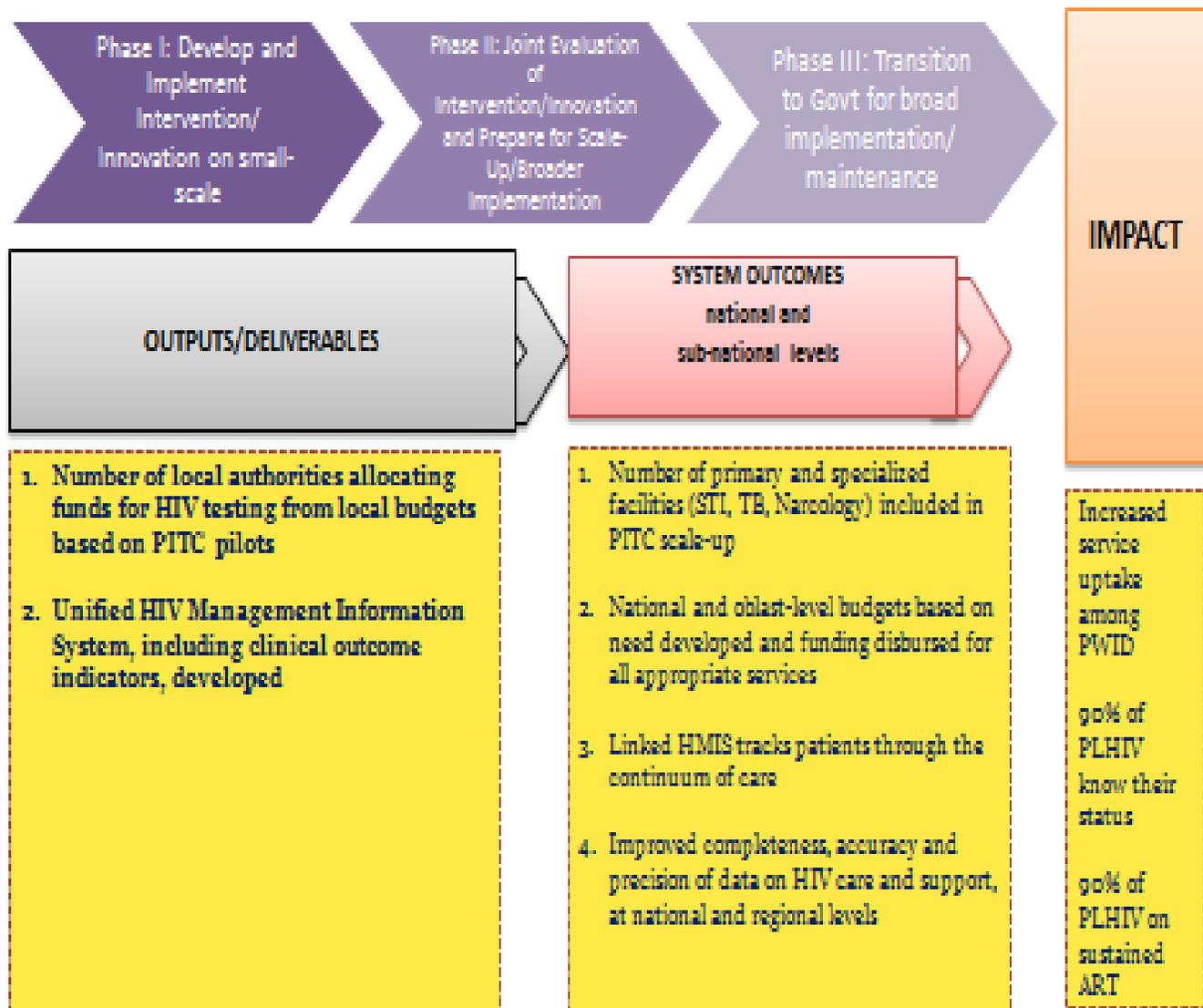
APPENDIX G Above Site Milestones

The following above site milestones were agreed on by the PEPFAR/Ukraine team and headquarters staff at the COP 16 review in Bangkok.

Deliverables for Quarterly Monitoring for Programmatic Gap #1: Commodity Insecurity



Deliverables for Quarterly Monitoring for Programmatic Gap #2: Improving Detection, Linkage, and Retention of PLHIV/Key Populations



Deliverables for Quarterly Monitoring of Adoption and Implementation of Test & Start

