

**Ukraine**

**Country Operational Plan**

**(COP) 2017**

**Strategic Direction Summary**

March 16, 2017



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## 1.0 Goal Statement

In 2016, Ukraine achieved added >13,000 patients onto antiretroviral therapy (ART) despite war, economic challenges, and resistance from anti-reformers. Key stakeholders, including the National Center for Public Health (NCPH) and civil society, have set ambitious targets for 2018 ART scale-up towards the UNAIDS Fast Track Targets. In support, PEPFAR-Ukraine's Country Operational Plan (COP) 2017 goals are to:

- ❖ Rapidly expand ART through support to the NCPH for: (1) scale-up with PEPFAR-supported antiretrovirals (ARVs) to 15,000 new patients (2) implementation of comprehensive HIV guidelines; and (3) decentralization, differentiated services, multi-month scripting, regimen optimization, and Test and Start.
- ❖ Ensure rapid uptake of ART through:
  - ❖ Expansion of HTS among key population (KP) groups; large-scale expansion of effective modalities (provider-initiated testing and counseling (PITC), index testing).
  - ❖ Promoting demand creation among KPs.
- ❖ Improve linkage and retention through targeted KP operational research and refining case management models.
- ❖ Ensure high viral load suppression through improved retention and adherence activities.
- ❖ Foster innovations throughout the clinical cascade.

COP 2017 innovative changes include: (1) introducing network-based HIV testing services (HTS) recruitment among men who have sex with men (MSM); (2) piloting network-based HTS using point-of-care recency assays to link recently infected persons who inject drugs (PWID); (3) case management models addressing mental health to increase linkage and retention; and (4) new testing modalities to increase yield.

PEPFAR-Ukraine will continue to improve ART coverage and services in the five highest and six medium HIV burden regions that contain ~70% of estimated persons living with HIV (PLHIV) in government controlled areas (GCA) of Ukraine. In COP17, the program will expand activities to GCA Donetsk (ranked fourth in estimated PLHIV).

With PEPFAR support, ART coverage in GCA Ukraine is projected to increase from 36% at end-FY16 to 64% by end-FY18.

To achieve these targets, PEPFAR-Ukraine shifted resources towards increased case-finding and linkage through support of PITC in health care facilities, index testing, and expanded KP network recruitment based on low ART coverage among KPs, but high projected coverage among

previously diagnosed PLHIV by 2018. Additional resources will improve retention and adherence support.

Despite permissive guidelines, providers are not yet implementing Test and Start given previous prolonged ARV shortages and ingrained attitudes favoring delayed initiation, especially for PWID. Current major bottlenecks include the need to reorient providers and patients towards the benefits of early ART initiation while addressing systems issues limiting or delaying treatment access. Forthcoming national guidelines will provide a comprehensive approach to HIV testing and treatment consistent with WHO standards; Ukraine will need significant support in implementation. To ensure KPs benefit, PEPFAR-Ukraine activities will prioritize development of HTS and linkage activities for PWID and MSM in collaboration with community and civil society organizations. Close review of partner performance continues to guide programs as evidenced by ongoing improvements in network-based PWID recruitment based on reviews.

Overall, PEPFAR COP17 investments accelerate achievement of service targets leading to rapid ART scale-up while continuing to catalyze key reforms in legislation, finance, procurement systems, and organizational capacity to provide long term sustainability.

## 2.0 Epidemic, Response, and Program Context

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### 2.1 Summary statistics, disease burden and country profile

Since 2014, conflict with Russia has significantly affected certain regions with HIV burdens. As of 2016, the Ukraine State Statistics Service estimates total Ukraine's population as 42.6 million, excluding Crimea and Sevastopol. Approximately 2.3 million people 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 2016, there were an estimated 224,000 PLHIV in Ukraine, all ages (0.9% of the 15 – 49 year old population) [SPECTRUM, Ukrainian Center for Disease Control (UCDC), May 2016] with the majority of cases among men<sup>1</sup>. Approximately 23% of estimated PLHIV live in Crimea (5%) or Luhansk/Donetsk (18%). In 2015, HIV accounted for an estimated 8,846 AIDS-related deaths (1.5% of all deaths in Ukraine in 2015) with tuberculosis (TB) causing approximately 65% of all reported deaths among PLHIV. In 2015, 4,787<sup>2</sup> new cases of TB-HIV co-infection were diagnosed and 1,789<sup>2</sup> 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 ~50% of estimated cases but only 31% 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%

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<sup>1</sup> PEPFAR/Ukraine used 2016 SPECTRUM Estimates but new national targets, which will be available later in the calendar year, will be based on 2017 SPECTRUM estimates.

<sup>2</sup> No data are available from Russian-occupied Crimea and non-government controlled parts of Donetsk/Luhansk.

among MSM according to the 2015 Integrated Bio-Behavioral Survey (IBBS). PEPFAR in-house estimates suggest that ~192,000 of the 224,000 PLHIV (SPECTRUM 2016) in Ukraine live in GCA. Case reporting data show 132,945 (69%) of these PLHIV registered at an AIDS Center in GCA as of Jan 2017; thus, ~60,000 PLHIV either remain unaware of their status or have not yet registered at an AIDS Center. The 2015 IBBS suggests that 30,000 – 35,000 HIV-positive PWID and at least 10,000 HIV-positive MSM are unaware of their status.

An estimated 16,713 new cases of HIV infection occurred in 2016. Evidence supports that injecting drug use (IDU) still accounts for 20% - 40% of new cases despite declines in transmission among PWID and with MSM transmission increasing in recent years. 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 is being completed. LAG testing of case-reporting specimens from Kyiv City in 2013 found the highest incidence (2%) among MSM.<sup>3</sup> 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. Female sexual partners of current or former PWID are disproportionately affected. Preliminary data from the Modes of Transmission study found that standardized risk assessment elicited IDU risk from 45% and MSM history from another 18% of a sample of recently registered cases as compared with data on the same patients from the standard reporting at registration of 36% and 6% respectively.

The response to the epidemic in Ukraine focuses on KP prevention programs and an expansion of ART. Harm reduction continues to be a key component of the national HIV prevention strategy. 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. The Government of Ukraine (GOU) supports laboratory commodities for HTS with near-complete coverage of pregnant women, blood donors, and TB patients, but limited coverage for HTS at other clinical facilities. The combined efforts of the NCPH, civil society, GFATM, and PEPFAR prevented stock-outs and supported an increase of ~14,000 patients during calendar year 2016, with 74,780 PLHIV (38% of est. PLHIV) on ART in GCA Ukraine as of Jan 1, 2017.

In the past year, progress has been made on several of the economic and political factors that have limited 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. The Russian-supported war in the East caused Ukraine's gross domestic product (GDP) per person to decline from \$4,400 in 2013 to <\$2,100 in 2016. Slow

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<sup>3</sup> Simmons R, et al. HIV Incidence Estimates Using the Limiting Antigen Avidity EIA Assay at Testing Sites in Kiev City, Ukraine: 2013-2014. PLoS One. 2016 Jun 8;11(6):e0157179. doi: 10.1371/journal.pone.0157179.

economic growth resumed in 2016 with estimated per person GDP forecast at \$2,250 in 2017.<sup>4</sup> Intense continued efforts to restructure government processes and eliminate major residual corruption and bureaucracy continue to be needed. The post-Maidan governments have included reformers with current strong support of the Ministry of Health's reform efforts by the prime minister; however, powerful residual vested interests and new populist political forces continue to slow critical changes.

However, major progress was made in funding and efficiency of GOU in HIV/AIDS procurements and in improving the management structure for public health programs, including HIV/AIDS. Procurement for ARVs and laboratory commodities was transferred to international agencies for the period 2016 – 2019 to avoid a previously inefficient and corrupt GOU process; these procurements in 2016 produced unit-prices similar to GFATM/PEPFAR standards with substantial cost-savings. In December 2016, after intense advocacy from civil society and NCPH, the GOU budget for HIV procurements increased 2.5 fold. Intense advocacy from civil society with manufacturers on pricing and patent protection succeeded in obtaining very favorable pricing, including for generic Atripla and dolutegravir (DTG). Further intense advocacy and bureaucratic work enabled these medications to be included into planning for procurement and use, even though they are not yet registered in Ukraine. The NCPH, supported by WHO and PEPFAR, has succeeded in ensuring consensus that all ART procurements use optimized ART regimens, predominantly generic Atripla in 2016, and for all new patients. After requiring PEPFAR support in COP16 to cover anticipated stockouts of ARVs during calendar year 2017, these successes have improved the ability of the GOU to support existing patients, extend support to patients receiving Emergency Commodities Fund (ECF) and COP16 ARVs, provide limited scaleup, and provide adequate laboratory commodities in 2018. PEPFAR-Ukraine continues to support pharmaceutical procurement system and supply chain management reform.

Ukraine is drafting a new GFATM grant proposal for 2018 – 2020. Civil society and the NCPH intend to ensure that ambitious targets for ART scaleup, aligned with COP17 targets, are included in the proposal and explicitly supported by the GOU. The proposal will include requests for continued support for the ~25,000 patients currently on GFATM-procured ARVs; this step will allow GOU resources to support all ART patients in 2018 previously supported by GOU or PEPFAR (through ECF and COP16) and to extend ART for an additional 8,000 patients outside of PEPFAR priority regions.

Other policy issues are also helping set the stage for improving coverage. Ukrainian ART guidelines issued in December 2015 were permissive for initiating all PLHIV, especially for certain subgroups including PWID, onto ART at any CD4 while otherwise prioritizing PLHIV with CD4<500. The Ministry of Health (MOH) is leading completion of new comprehensive guidelines for HIV prevention, care, and treatment which will include recommendations for pre-exposure prophylaxis (PrEP), 'Test and Treat', differentiated service delivery, multi-month scripting, and a

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<sup>4</sup> IMF. World Economic Outlook Database, October 2016.  
<https://www.imf.org/external/pubs/ft/weo/2016/02/weodata/index.aspx>

de-emphasis on CD4 testing; their release for public discussion is anticipated in April 2017. COP17 activities involve support for comprehensive technical assistance to treatment facilities for implementation of the guidelines, including supportive mentoring and monitoring, training in new guidelines including development of Test and Start practices, and improvement of procedures and policies at regional and facility levels.

**Table 2.1.1 Host Country Government Results**

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	42,590,879		3,150,511	7	3,343,782	8	2,220,062	5	2,343,937	6	17,502,425	41	14,030,162	33	Ukraine State Statistic Service, data as of January 2016 (excludes Crimea and Sevastopol) <a href="http://database.ukrcensus.gov.ua">http://database.ukrcensus.gov.ua</a> Assessed on Jan 5, 2017
HIV Prevalence (%)		0.9													Ukraine Spectrum, 05/16/2016, data for 2016 (15-49 both sex)
AIDS Deaths (per year)	8,846														Ukraine Spectrum, 05/16/2016, data for 2016
# PLHIV	224,028		1,480	1	1,630	1	9,663	4	3,345	1	93,560	42	114,351	51	Ukraine Spectrum, 05/16/2016, data for 2016 (includes Crimea and Sevastopol)
Incidence Rate (Yr)		0.07													Ukraine Spectrum, 05/16/2016, data for 2016 (15-49 both sex)
New Infections (Yr)	16,713		183	1	195	1	2,133	13	1,158	7	5,478	33	7,566	45	Ukraine Spectrum, 05/16/2016, data for 2016 (includes Crimea and Sevastopol)
Annual births	411,781														Ukraine State Statistic Service, data for 2015 (excludes Crimea, Sevastopol and temporarily occupied territories) <a href="http://database.ukrcensus.gov.ua">http://database.ukrcensus.gov.ua</a> Assessed on Jan 5, 2017
% of Pregnant Women with at least one antenatal clinic visit	~97%														Proxy data: 97.6% of pregnant women were tested for HIV in 2015, HIV in Ukraine Bulletin No45, page 101
Pregnant women needing ARVs	2,962														UCDC Bulletin No45, p.101
Orphans (maternal, paternal, double)	NA														
Notified TB cases (Yr)	24,131														UCDC 2015, <i>New cases only</i> , excluded Crimea and Sevastopol, TB-2015 Statistical tables, Table N031; <a href="http://ucdc.gov.ua/pages/diseases/tuberculosis/surveillance/statistical-information">http://ucdc.gov.ua/pages/diseases/tuberculosis/surveillance/statistical-information</a> Assessed on Jan 5, 2016

% of TB cases that are HIV infected		19.8																UCDC 2015, excluded Crimea and Sevastopol, TB-2015 Statistical tables, Table No32; <a href="http://ucdc.gov.ua/pages/diseases/tuberculosis/surveillance/statistical-information">http://ucdc.gov.ua/pages/diseases/tuberculosis/surveillance/statistical-information</a> Assessed on Jan 5, 2016
% of Males Circumcised	N/A																	
Estimated Population Size of MSM*	186,700																	Analytical Report. Estimation of the Size of Populations Most-at-Risk for HIV Infection in Ukraine as of 2014 based on the results of 2013 survey. International HIV/AIDS Alliance in Ukraine
MSM HIV Prevalence		8.5																IBBS 2015
Estimated Population Size of FSW	73,850																	Analytical Report. Estimation of the Size of Populations Most-at-Risk for HIV Infection in Ukraine as of 2014 based on the results of 2013 survey. International HIV/AIDS Alliance in Ukraine
FSW HIV Prevalence		7																IBBS 2015
Estimated Population Size of PWID	341,500																	Analytical Report. Estimation of the Size of Populations Most-at-Risk for HIV Infection in Ukraine as of 2014 based on the results of 2013 survey. International HIV/AIDS Alliance in Ukraine
PWID HIV Prevalence		21.9																IBBS 2015
Estimated Size of Priority Populations (Sexual partners of PWID)	121,916																	Estimate based on IBBS 2015 (35.7% of PWID reported that they have non-IDU sexual partner)
Estimated Size of Priority Populations Prevalence (Sexual partners of PWID)		15																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 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression\*

Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year			
	Total Population Size Estimate (#)	HIV Prevalence <sup>5</sup> (%)	Estimated Total PLHIV <sup>1</sup> (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	45,102,927 42,590, 879	0.5	224,000	132,942	74,780	33	89	2,344,741 <sup>6</sup>	17,066	14,027
Population less than 15 years	6,494,293	0.05	3,110		2,432	78				
15-24 year olds	4,563,999	0.3	13,008		N/A					
25+ year olds	31,532,587	0.65	207,910		N/A					
<b>Key Pop</b>										
MSM	186,700	8.5	15,870	4,126	1,111	7				
FSW	73,850	7	5,170	3,774	2,792	54				
PWID	341,500	21.9	74,789	36,646	24,680	33				
Priority Population (Partners of PWID)	121,916	15	18,287	3,968	1,756	10				

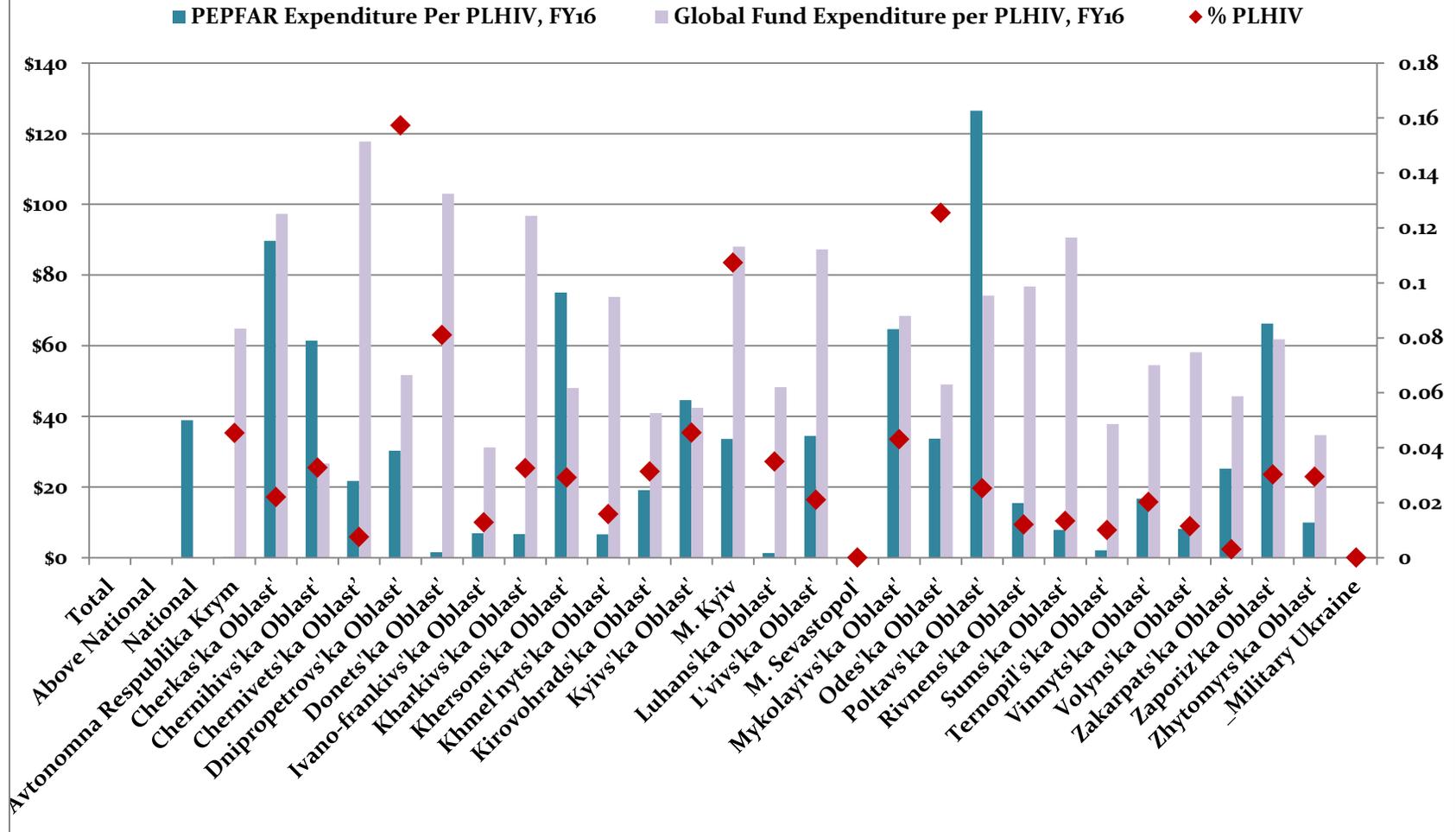
\*These should be national data, if the data do not exist, PEPFAR data may be used if relevant.

Estimates for testing, treatment, retention and suppression for key and priority population groups (below grey line) should only be included if reliable data exists.

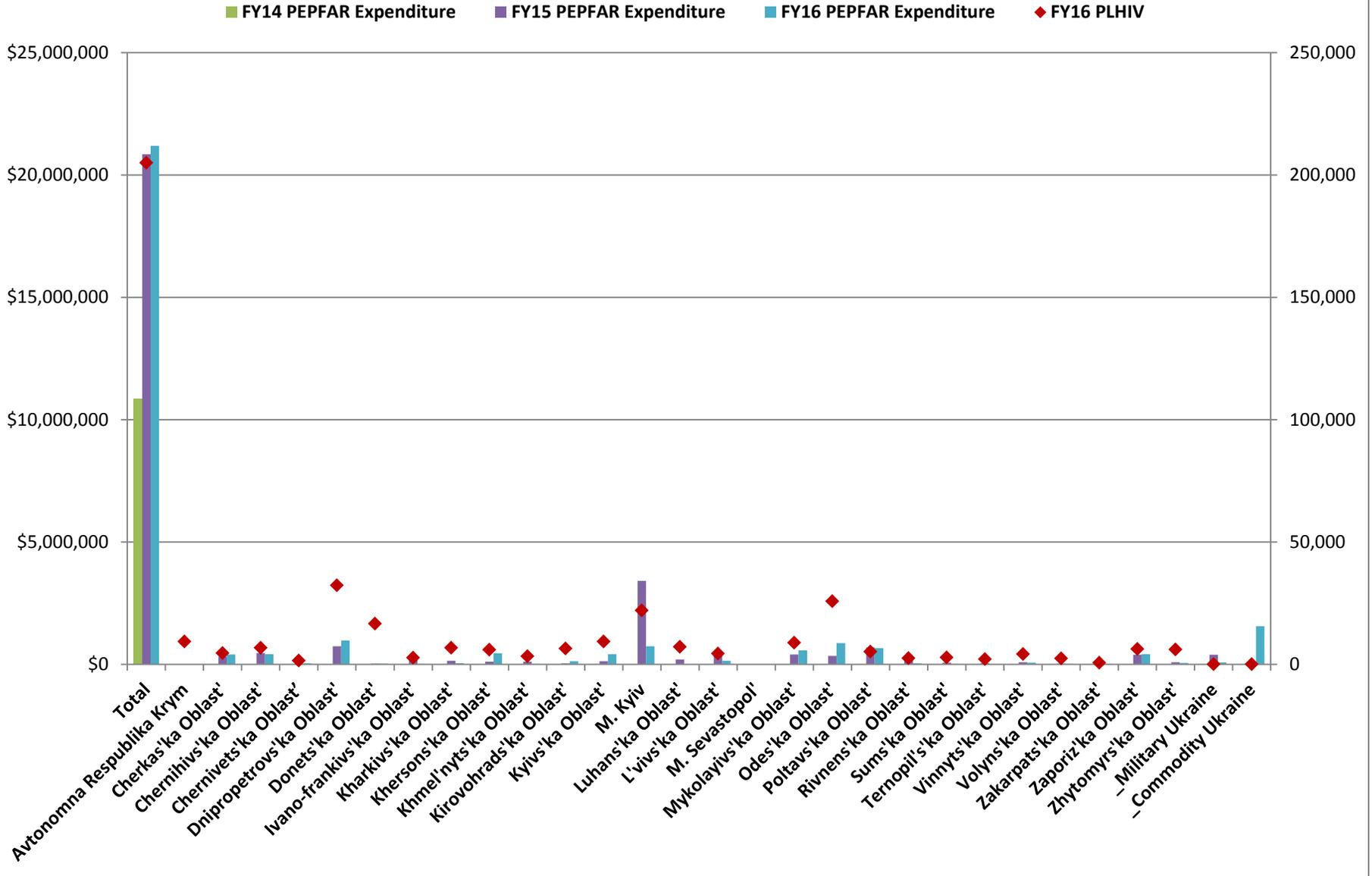
<sup>5</sup> Spectrum, May 2016 estimates

<sup>6</sup> Data for 2015

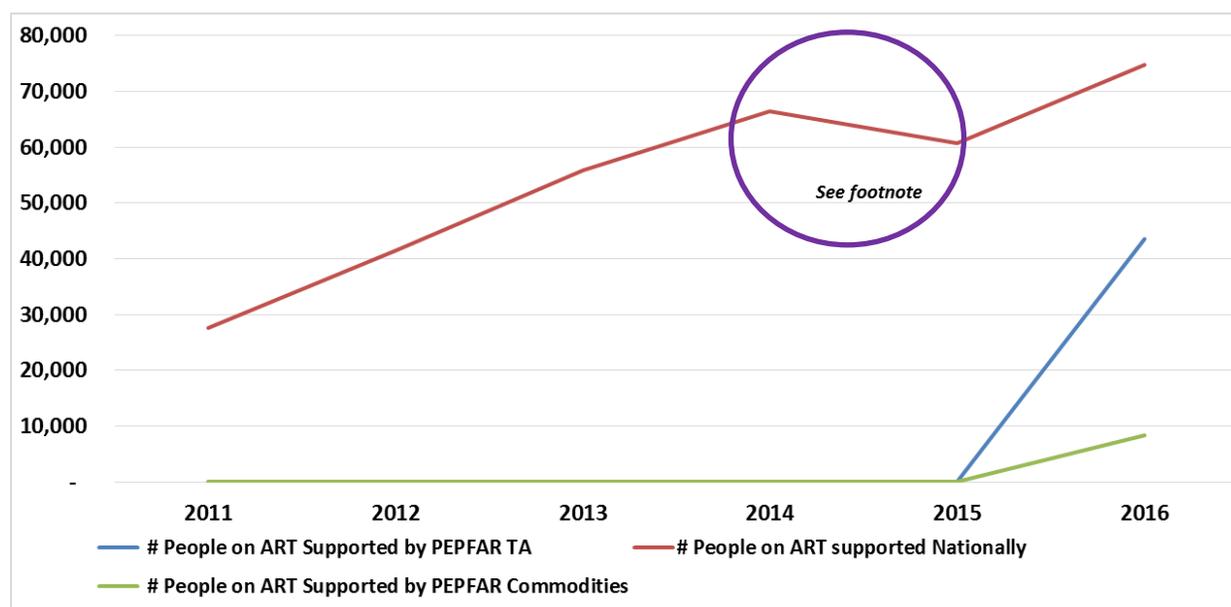
## FY 2016 PEPFAR and Global Fund Expenditures per PLHIV and % PLHIV, by SNU



## Total PEPFAR Expenditures and Total PLHIV (FY14-FY16), by SNU



**Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment**



*\*The decline in 'People on ART' from end 2014 to end 2015 is artifactual as it reflects the inability to report from non-government controlled areas (non-GCA) beginning in 2015. During 2015, >6,000 net new patients were added on ART within GCA Ukraine.*

## 2.2 Investment Profile

In 2014, GFATM, together with PEPFAR, became the largest funding source for Ukraine's HIV response. A severe national currency devaluation over two years of economic and social crisis and war in the East (National Bank of Ukraine rates: \$1 equaled 12 Ukrainian hryvnia (UAH) in 2014, 22 in 2015, and 26 UAH in 2016) caused a sharp drop of the GOU's share of HIV expenditures from \$31.7 million in 2014 to \$15.1 million total in 2016. In 2016, the estimated total expenditure was ~\$80 million; the GFATM contributed \$39.5M (51%); PEPFAR - \$20.8M (29%); and the central GOU - \$15.1M (20%), whereas the local GOU budgets and other (domestic and international) sources were around \$5 to \$7 million. The GOU's funding structure has not changed; the state budget covers ARVs and lab commodities, including rapid HIV tests for pregnant women and blood donors, while the local GOU budgets cover baby milk formula for PMTCT, and health facilities staff and operational costs.

In December 2016, the GOU successfully passed an increased budget for HIV, an increase of 2.5 fold, to purchase approximately 63 percent of Ukraine's ARV requirements. In addition, under pressure from civil society organizations (CSOs) supported by donors and the new MoH leadership, the GOU budgeted for the procurement of medication-assisted treatment (MAT). GFATM and PEPFAR through USAID will need to continue commodities support and supply chain technical assistance to ensure scale up in order for Ukraine to meet its national targets, as

the country is still facing a period of financial crisis and severe budget constraints due to the ongoing conflict in the East

Ukraine's three year GFATM New Funding Model grant finishes in December 2017, with about \$30.5 million budgeted for 2017. HIV and TB Commodities<sup>7</sup> account for 59% of the total grant (~ \$79M). The biggest share is for ARV drugs (\$10.2 M in 2016 and \$8M in 2017), while the rest is for multidrug-resistant (MDR)-TB drugs (\$25M). GFATM also provided \$3.7 million in emergency ARVs via the United Nations International Children's Emergency Fund (UNICEF) to cover gaps in the non-controlled government areas (NCGA) of Lugansk and Donetsk in 2016 and the first half of 2017. In December 2016, the GFATM provided an additional \$4,300,000 in HIV emergency funding for these territories for July 2017 – June 2018.

For 2018-2020, the GFATM allocated \$71 million for Ukraine's HIV program, with \$10.5 million earmarked for Donetsk and Luhansk NGCAs. A full review HIV application from the country needs to be submitted for approval to the GFATM by May 23, 2017. The GOU has to co-fund at least 40% of the total amount. Another condition for releasing HIV funds is the development and approval of a new national TB program for 2017-2021. The catalytic HIV funding portion comprises \$3.9 million for activities with high KP impact, \$2.3 million for tackling human rights barriers to health services, and \$2 million supporting Resilient and Sustainable Systems for Health in data systems/ generation and use. For the release of catalytic funding the GOU has to match funds on a 50:50 basis.

The GFATM and PEPFAR remain the dominant providers of outreach prevention and care and support for key and priority populations. In the last two years, PEPFAR has become the largest funding source for strategic information (SI), HIV research and surveillance, and health system strengthening (HSS) activities covering training of facility-based and community-based health care staff. To address the government's need to resume responsibility for prevention, care, and support activities, PEPFAR has worked jointly with UNAIDS and GFATM to help the MoH develop a National HIV and TB Transition and Sustainability Strategy for 2017-2020, with an Action Plan based on the Fast-Track Initiative/the 90-90-90 targets. The Sustainability Strategy, with the draft Action Plan, was submitted to the Cabinet of Ministers of Ukraine in the summer of 2016. Due to the changes in the MoH leadership, the documents were re-routed for all of the key Ministries' review/ clearance. The Cabinet of Ministers is expected to approve it by April 2017.

**Note:**

Please note that Table 2.2.1 and 2.2.2 contains the most recent information available. Ukraine/MoH NPHC is currently undertaking a 2015 National AIDS Spending Assessment (NASA) exercise and tables will be updated when results are made available. The Table 2.2.5 entitled GOU and donor funding was calculated by PEPFAR/Ukraine, based on available operational data from MoH/ NPHC and the GFATM principal recipients (PRs).

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<sup>7</sup> GFATM procures ARVs, MAT, MDR-TB drugs, opportunistic infection drugs, and rapid diagnostic tests.

**Table 2.2.1 Annual Investment Profile by Program Area<sup>8</sup> (2014 data)**

<b>Program Area</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% GOU<sup>9</sup></b>	<b>% Other</b>
Clinical care, treatment and support	32,389,790	0.1	50.5	47	2.4
Community-based care, treatment, and support <sup>10</sup>					
PMTCT	1,159,141	0	8	80	12
HTS	2,245,260	0.2	28.6	47.7	23.5
VMMC	N/A	N/A	N/A	N/A	N/A
Priority population prevention <sup>11</sup>	463,372	0	43.6	9.2	47.2
Key population prevention	7,619,819	0.7	83	4	12.3
OVC	676,344	8.1	62.3	9.9	19.7
Laboratory <sup>12</sup>					
SI, Surveys and Surveillance	2,631,445	42	32.3	0.5	25.2
HSS <sup>13</sup>	2,428,059	54.5	11.5	0	34
<b>Total</b>	<b>86,107,837</b>	<b>11,735,752</b>	<b>36,263,132</b>	<b>31,705,000</b>	<b>6,358,953</b>

**Table 2.2.2 Annual Procurement Profile for Key Commodities, 2015\***

<b>Commodity Category</b>	<b>Total Expenditure</b>	<b>% PEPFAR (ECF)</b>	<b>% GF</b>	<b>% GOU</b>	<b>% Other</b>
ARVs	\$27,164,424	23	37	40	n/a
Rapid test kits	\$67,127	0	58	42	n/a
Other drugs	n/a	n/a	n/a	n/a	n/a
Lab reagents	\$4,598,390	23	17	60	n/a
Condoms	\$699,831**	100	0	0	n/a
Viral load commodities	\$2,804,517	29	37	34	n/a
VMMC kits	n/a	n/a	n/a	n/a	n/a
MAT	\$1,189,008	0	100	0	n/a
Other commodities (lubricants)	\$860,384**	100	0	0	n/a
<b>Total</b>	<b>\$37,383,681</b>				

\* Information for this table came from the 2015 operational data of MoH/ NPHC and PRs, and USG/ ECF 2016 expenditure report

\*\*Donation from the USAID DELIVER project in 2015 (21,207,000 pcs of condoms and 9,751,000 pcs of lubricants)

<sup>8</sup> Information for this table came from Ukraine's GARP 2016 Report with a summary of National AIDS Spending Assessment for 2014 and the 2014 National Funding Matrix shared by the MoH/National Public Health Center. This is the most recent NASA report giving a plausible snapshot of 2014 spending by program areas taking into its limitations: it does not include Crimea, Donetsk and Lugansk regions; its methodology does not allow to have granular enough data for the PEPFAR program spending categories. All amounts in USD, 2014 using NBU currency exchange rate for 2014: \$1 USD: 11.89UAH

<sup>9</sup> GOU part consists of state (incl. credits) and local government budget lines

<sup>10</sup> It could not be parsed out of the NASA 2014 spending program areas on clinical care and treatment

<sup>11</sup> It is comprised of two lines in NASA 2014 NFMATRIX: post-exposure prophylaxis (PEP), and pre-exposure prophylaxis (PrEP) for sero-discordant couples. Prevention for prisoners can't be parsed out of the broad category entitled as 'Addendum items/Non-core global/Other'.

<sup>12</sup> It could not be parsed out of the NASA 2014 spending program areas on clinical care and treatment

<sup>13</sup> HSS is represented only by the "Critical enablers: Policy dialogue, Stigma Reduction" category in NASA 2014 NFM and may under-report the actual total HSS spending, as it may also be diluted in a broad NFM category "Addendum items/Non-core global/other"

**Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration**

<b>Funding Source</b>	<b>Total USG Non-PEPFAR Resources</b>	<b>Non-PEPFAR Resources Co-Funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
USAID MCH					
USAID TB	\$3.6 Million in FY17 (\$4 M in FY18)				
USAID Malaria					
Family Planning					
NIH	\$0				
CDC (Global Health Security)	\$0				
Peace Corps					
DOD Ebola					
MCC					
<b>Total</b>					

**Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP**

<b>Funding Source</b>	<b>Total PEPFAR Non-COP Resources</b>	<b>Total Non-PEPFAR Resources</b>	<b>Total Non-COP Co-funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
Other PEPFAR Central Initiatives	\$1,116,205 (SAMHSA + MARTAS)					<ul style="list-style-type: none"> <li>To support SAMHSA in-country activities (see strategy in supporting documents)</li> <li>This study, which will be nearing its end in FY18, evaluates the implementation of an intervention to more effectively link patients with newly identified HIV infection to HIV care services</li> </ul>
<b>Total</b>	<b>\$1,116,205</b>					

**Table 2.2.5: GOU and donor funding for the national response in 2014-2018**

	2014 (NASA)	2015	2016	2017 (projected)	2018 (projected)	Source
Partner Gov't	\$31,705,000 37%	\$16,894,675 22%	\$15,094,650 20%	\$31,537,037 37%	35,000,000 36%	2015 and 2016 state GOU budget (MoH operational data), NBU exchange rate: 1 USD to 21.8 UAH in 2015, to 24.3 UAH in 2016, and to 27 UAH in 2017
PEPFAR	\$11,735,752 13%	\$20,853,409 27%	\$21,162,033 29%	\$37,608,888 38%	\$37,629,296 38%	2014, 2015, 2016 EAs; 2017: COP'16 budget; 2018: COP'17 planning level
Global Fund	\$36,263,132 42%	\$39,464,846 51%	\$38,069,442 51%	\$30,657,416 31%	25,678,813 26%	GFATM PRs and staff (2015 incl. Emergency Fund for Donbas: \$3,686,121; 2016- PRs draft reports to GF/LFA), new 2018-2020 allocation*
Other international	\$4,125,123 5%	tbc	n/a	n/a	tbc	NASA-2015 is in the process, 2018: AHF, Pinchuk Foundation
Other domestic	\$2,233,830 3%	tbc	n/a	n/a	n/a	NASA-2015 is in the process
<b>Total:</b>	<b>86,107,837</b>	<b>77,212,930</b>	<b>74,326,125</b>	<b>99,803,341</b>	<b>98,308,109</b>	

\* 2018-2020 new HIV allocation: 70,836,441 (annual: 23,612,147 + 2,066,666 = 25,678,813), catalytic HIV=6.2 mln + GOU 6.2, min 25% of GOU co-fund required: \$30mln

### 2.3 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) 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 SID also recognized three vulnerabilities: private sector engagement, commodity security and supply chain, and quality management. Under current regulations, HIV testing and treatment services are provided in the government facilities only, limiting the role of private clinics. There are a few emerging not-for-profit clinics, which will be run by PLHIV Networks in Poltava and Kyiv. They plan to combine mainstream primary health care and critical HIV services like PITC and ART dispensing. PEPFAR-Ukraine is providing technical assistance (TA) to modify regulations that currently restrict HIV service provision to the government sector to allow private and not-for-profit sectors to contribute to the scaling-up and decentralization of service provision, ultimately increasing access for clients. PEPFAR-Ukraine is also providing technical and legal assistance for local governments to subcontract services to non-governmental organizations (NGOs), and capacity building for the NGOs to be able to obtain contracts. 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).

Although the GOU continues to face economic and political instability, it committed to increasing the budget for ARVs and to procuring MAT in December 2016. While PEPFAR/Ukraine procured approximately \$8M in HIV ARVs and lab products through the ECF after a GOU request, the request from the GOU has declined significantly as it plans to increase its share of funding for ARVs in 2018 to approximately \$25 million to cover 63% of ART patients. PEPFAR and the GFATM financial support for commodities will continue for 2018, with the GFATM to cover 27 percent (controlled and uncontrolled territories) and PEPFAR to cover 10 percent of the 2018 target of 141,782 ART patients.

GOU currently relies on international procurements through United Nations agencies (UNICEF and United Nations Development Programme (UNDP)) which were successful at decreasing the price of ARVs per patient by almost one-half in a period of two years in conjunction with the optimization of ART regimens as well as receiving better prices. However, Ukraine is expected to transition to a national procurement agency by March of 2019. The GOU, with United States government (USG) TA, has developed legislation to establish this agency within the context of overall health financing system reform. Continued TA is necessary to ensure it is launched and has the capacity to resume procurement for the country. PEPFAR-Ukraine continues to provide TA to the MoH to establish the National Drug Procurement Agency and help build its capacity for effective and transparent procurements at the national and local level in PEPFAR-supported regions.

In 2016, PEPFAR-Ukraine also supported the national supply chain system assessment, which identified numerous challenges, including inefficient and outdated supply planning, delivery and stock management. The assessment report corroborated the very low SID-2016 rating in the Commodity Security and Supply Chain domain (2.5 out of 10 max). USG will provide technical assistance to the MoH to implement key recommendations from the report to improve the reliability and efficiency of key HIV commodities procurement and supply management, as well as assist in the design of a Logistics Management and Information System (LMIS).

The GOU began implementation of an ART optimization strategy based on WHO recommendations. This has improved treatment through standardization and simplification of ART regimens, including the use of one tablet a day regimens comprised of less toxic and more efficacious drugs. Implementation of ARV optimization will lead to decreased spending on expensive lopinavir (LPV)/ritonavir (rtv) regimens and increase the number of PLHIV on treatment. Implementation of alternative approaches for MAT financing, co-payment by patients and contribution from local authorities will also address these gaps. 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). Also, as some USG mechanisms come to an end in 2017, quality improvement (QI) teams will be institutionalized within the GOU structures. Laboratory quality management continues to be a priority area of PEPFAR-Ukraine TA and new HIV clinical guidelines are expected to address the need to bring the country's laboratory processes and practices in line with international/WHO standards.

In late 2016, with strong USG support and technical assistance, the GOU established the NCPH which subsumed UCDC, which was the governmental leader of the national HIV response. This new entity will oversee the HIV and TB responses allowing for greater integration in historically vertical services. The mandate for the NCPH includes direction of other major public health programs including hepatitis B and C, STIs, and eventually non-communicable diseases. PEPFAR Ukraine continues to strengthen organizational and technical capacity at NCPH through direct cooperative agreements and through TA provided by implementing partners. Near term PEPFAR support for the NCPH will be needed to build staff capacity and to contribute to the sustainability (Indicator 9.1) of the national response.

Most importantly, in 2016, the MOH, under the aegis of the Acting Minister of Health, initiated the process of reforming the entire health system to become more service oriented and customer focused. In 2017, health reform priorities include a change in payment models for primary care, increased hospital autonomy, the development of a basic benefit package, and the introduction of a health insurance model with the launch of the National Health Service. HIV, TB, MAT, and sexually transmitted infection (STI) services still need to be integrated at the primary care level. The USG will provide TA to the development of the basic benefits package to include HIV and HIV/TB services. PEPFAR-Ukraine will also work on human resources for health (HRH) reform to allow for task-shifting and sustainable scale up. The sustainability of the national response for HIV is closely linked to the success of these broader reforms.

#### **2.4 Alignment of PEPFAR investments geographically to disease burden**

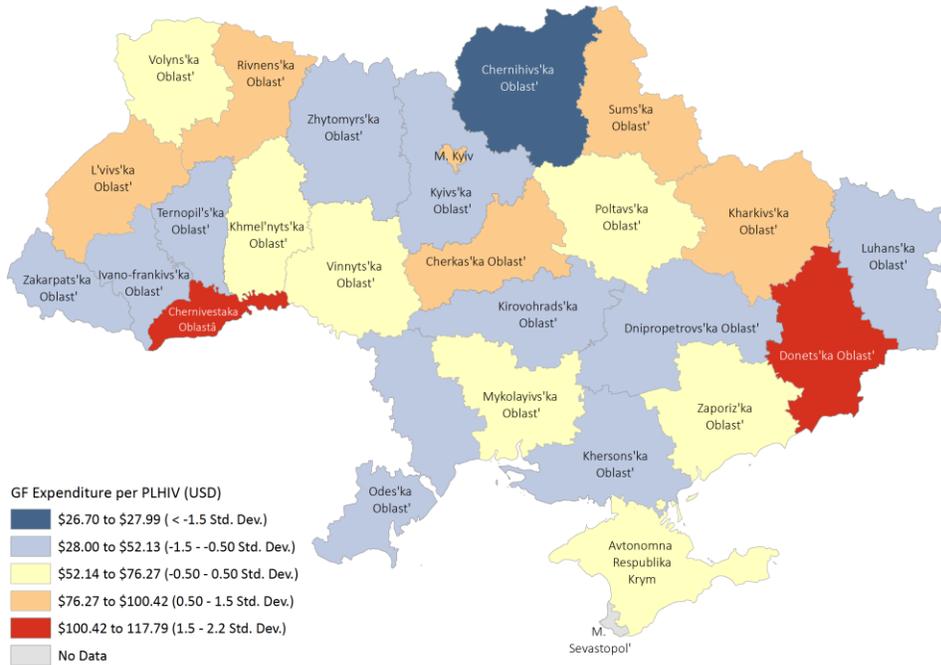
As noted by the tables below, PEPFAR direct funds to the oblasts (districts) and areas of the country that have the highest HIV burden, although Kyiv misleadingly appears overfunded due to the national institutions based there. GFATM funding also generally follows a pattern of funding oblasts with a higher burden of PLHIV. For COP17, PEPFAR/Ukraine will focus additional resources and activities on Donetsk GCA (which currently appears to have a very low investment) in addition to the 11 high and medium burden oblasts that the program committed to focusing on with the COP 15 pivot. With this change, PEPFAR/Ukraine will further align investments with the regional (district) disease burden and complement GFATM's efforts to support activities in the NGCA of Donetsk.

**Figure 2.4.1 (2016 PEPFAR and GFATM data)**

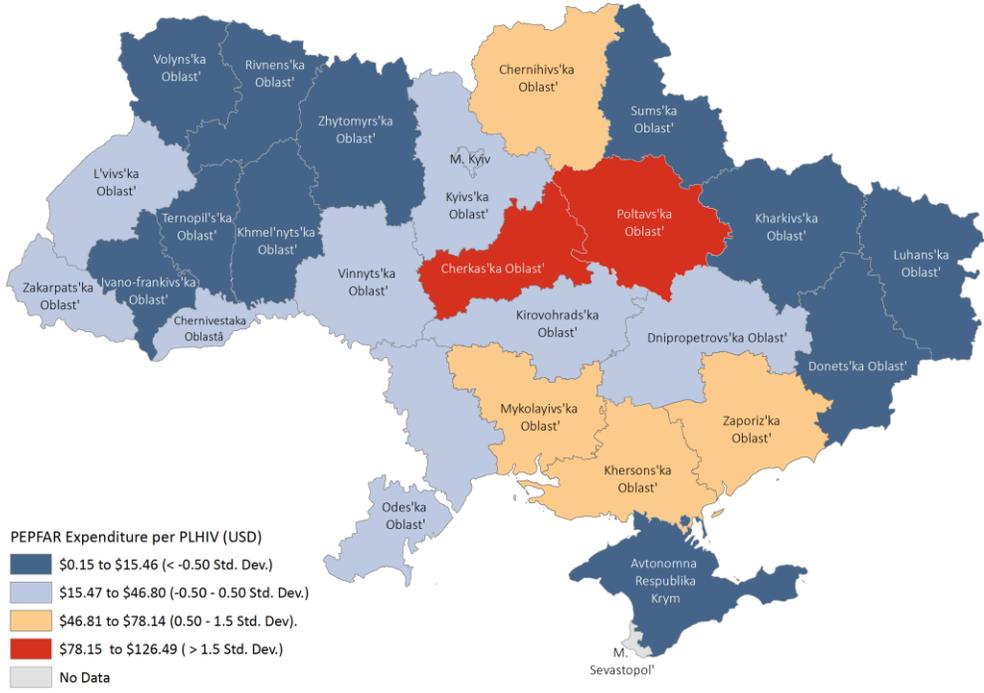
**PLHIV by Region**



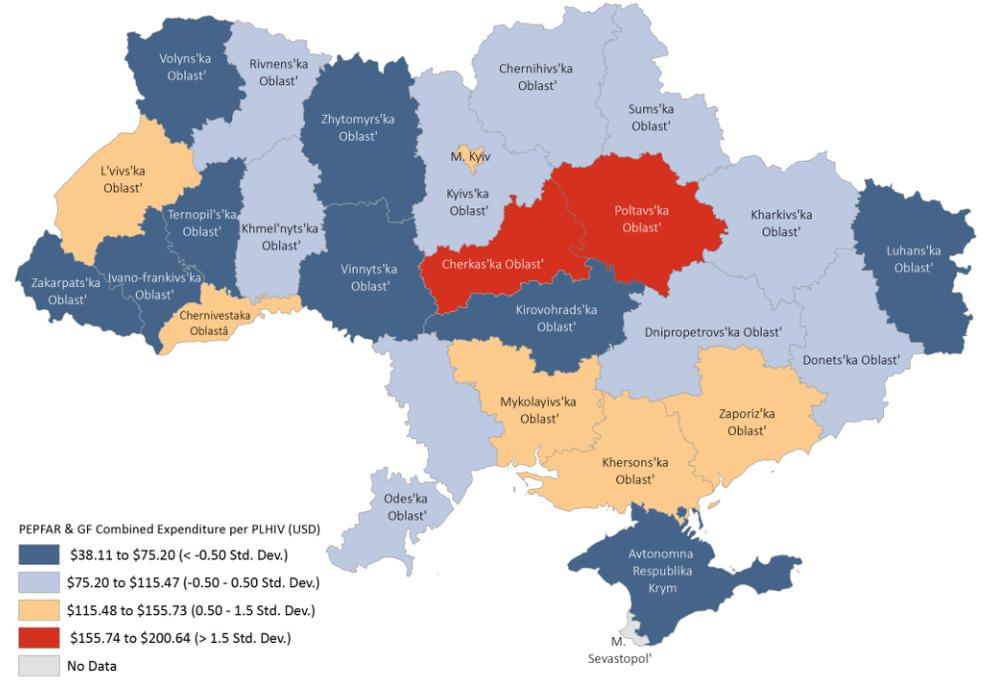
**Global Fund Expenditure per PLHIV by Region**



### PEPFAR Expenditure per PLHIV by Region



### PEPFAR & Global Fund Combined Expenditure per PLHIV by Region



## 2.5 Stakeholder Engagement

PEPFAR/Ukraine organized a joint national stakeholder meeting with both GFATM and UNAIDS on January 25<sup>th</sup>, 2017. Notes, audio recordings, and Power Point presentations are available at the site noted below and was shared with participants. The meeting brought together national and local (e.g., oblast/district) stakeholders from different parts of the country including the GOU, CSOs, multilateral organizations, and external donors at a key point in COP 16 development. Key objectives for the meeting included a discussion on the GFATM application modality and contents for the GFATM concept note (CN), and the PEPFAR COP process and how to harmonize activities and funding resources to deliver maximum programmatic impact for the national response.

The morning sessions focused on the GFATM CN and the country committed to submitting a full application. However, this requires a detailed transition plan and a commitment to ensuring sustainability. Finally, the GFATM PRs committed to innovative approaches to address the need to increase and retain the numbers of PLHIV in the HIV clinical cascade.

The afternoon was devoted to the development of the PEPFAR COP and how to harmonize planning and activities for the COP with the GFATM CN. The USG team shared epidemiological data. The team also identified key program gaps and potential solutions to address gaps and scale up the numbers of individuals on treatment. The meeting relied on a panel and discussion format to solicit feedback from meeting participants. After the DCMM meeting, the draft SDS and data pack were shared with national stakeholders and they were given four days' time to provide feedback prior to the materials being submitted to other program stakeholders.

The USG PEPFAR team has also consistently shared quarterly PEPFAR Oversight and Accountability Response Team (POART) monitoring and program results via presentations with national stakeholders over the last year. In addition, USG staff meets almost weekly with other national stakeholders, including GOU/NCPH and UNAIDS representatives, and hold periodic calls with GFATM to ensure coordination on key technical and program issues. The USG PEPFAR team is also providing technical input and assistance to the GOU and other national stakeholders developing the GFATM CN, which will be submitted for review in May 2017.

Dropbox/Website for National Stakeholder meeting can be found at:

**<https://www.dropbox.com/sh/qntibfyu61fw8wb/AACzz9g2thBcEFFkK4ql5wR7a?dl=0>**

## 3.0 Geographic and Population Prioritization

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**Progress towards epidemic control:** Despite strong headwinds, Ukraine achieved substantial improvements in ART coverage and especially ART policy in 2016 as post-revolution reforms continued to make incremental progress. Shortfalls from 2015 procurements threatened stockouts in first half of 2016 but the arrival of ECF-procured drugs allowed for progress in scaling up ART in H2 2016 in PEPFAR regions. By Q4 of FY 16, estimated ART coverage in PEPFAR 11 scale-up oblasts averaged ~36 % with a range of 20% in Kirovograd<sup>14</sup> to 60% in Mykolaiv. Intense coordinated advocacy from national stakeholders produced major policy improvements in 2016, including the following:

- 2.5 fold increase in GOU funding for HIV commodities. This funding is available in 2017 to procure ARVs for use in 2018; PEPFAR contributions to commodity procurement will decrease beginning in COP 17.
- GOU is projected to fund ~8,000 + patients of MAT drugs for the first time following advocacy and a GFATM condition precedent. Further increases in financing for MAT are still needed to support scale-up for epidemic impact.
- Establishment of a NCPH within the MOH – an entity with a broad mandate for public health that is organized on the foundation of the UCDC in overt recognition of the capacity built through PEPFAR and GFATM technical assistance.
- ARV manufacturer concessions especially around Atripla and DTG allowing for decreased reliance on expensive branded ARVs, extension of one-pill-a-day regimens, and introduction of new highly effective ARVs.
- Acceptance by national stakeholders of procurement of only optimized regimens for new patients regardless of the source of funding (GOU, GFATM, PEPFAR).

By end-2017, the country expects to have 108,000 individuals on treatment and, by end-2018, Ukraine will be back on track to meet UNAIDS Fast Track target goals with 142,000<sup>15</sup> individuals on ART. While scale up will continue to progress towards epidemic control, only Mykolaiv is expected to scale up to reach saturation at the end of FY18. In the next year, the national program will need to shift its strategic focus to identifying new HIV-positive individuals in order to meet the 2018 treatment target as the proportion of previously diagnosed PLHIV not on ART rapidly decreases. In addition, the country faces several key hurdles to further scale up treatment including 1) building a consensus among the patient and provider communities on the benefits of immediate initiation of ART for all; 2) increasing the capacity for delivering ART through further decentralization and more efficient service delivery; and 3) further and sustained increase in GOU capacity to procure ARVs for full Fast Track coverage.

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<sup>14</sup> Kirovograd has administrative and structural challenges that will require intensive support in COP 17; direct PEPFAR technical assistance to treatment centers began in Q4 FY16. Additionally, the PLHIV size estimate for this region is likely to decrease when official SNU estimates are available.

<sup>15</sup> These projections include >10,000 ART patients in non-GCA Donetsk and Luhansk supported by GFATM; they do not include patients in the Autonomous Republic of Crimea/Sevastopol supported by Russia.

PEPFAR/Ukraine is supporting the country's efforts to address these issues. The country is expected to complete and roll out new HIV guidelines in 2017, and USG will support the implementation of the guidelines with an emphasis on education and support of providers and patients, including activities to create demand for quality HIV services among patient communities. PEPFAR activities will support development of differentiated services in the HIV care delivery system and support accelerated decentralization of ART provision. Additionally, PEPFAR activities will support education on optimization, continued reform in procurement processes, and additional advocacy to ensure adequate GOU resources.

The optimization of ART regimens is allowing the GOU to support greater numbers of individuals. In procurements with 2016 resources from GOU, GFATM, and PEPFAR (COP 16), regimens for new patients exclude branded LPV and are centered on generic Atripla with introduction of low cost DTG and generic atazanavir as alternates for specific situations. While the average annual cost of ARVs for new patients was ~\$320 under the procurement with 2015 ECF funds, the projected cost, using pricing available to Ukraine, is expected to fall to ~ \$150 with the COP16 procurements. Similar prices within the GOU procurements and the increase in GOU funding will allow the GOU to provide ARVs for patients initiated on ECF and COP16 procured ARVs during 2018 and allow for modest additional scale-up with GOU ARVs outside of PEPFAR scale-up regions. Ukraine is currently developing a new CN for funding from GFATM for 2018-2020 which envisages continued short-term support of ARVs for patients currently on GFATM-procured drugs. Continued progress towards progressive substitution of highly effective alternates for LPV for existing patients should allow the GOU to extend support to all patients at UNAIDS Fast Track coverage levels by 2020, with only modest increases from current GOU funding levels.

***Data for prioritization decisions and associated yields for epidemic control:*** PEPFAR-Ukraine reviewed epidemiology and program data to assess the program's progress in the priority regions and in populations originally selected in COP 15 for focused USG efforts. Data included 1) program data on GFATM-supported KP prevention services including HTS 2) GOU data on new/cumulative PLHIV in care, number on ART and retention on ART, reported mortality; 3) GOU data on HTS; 4) national 2016 SPECTRUM on incidence, prevalence, and mortality estimates; 5) KP population size estimates (PSE) and data from 2015 KP integrated bio-behavioral surveys (IBBS); and 6) recently published studies on HIV prevalence, incidence, and transmission in Ukraine. Ukraine still does not have validated subnational estimates of PLHIV but official estimates that are accepted by oblasts are expected to be available by end-2017 and will be derived under the national monitoring and evaluation (M&E) working group in collaboration with oblast level M&E staff using SPECTRUM and modified Asian Epidemic Model (AEM) models. In the interim, for COP planning, PEPFAR continues to use SNU estimates derived using a multiplier-based method apportioning national SPECTRUM estimates using four indicators (two PMTCT screening and two case reporting) available from robust routine reporting for all oblasts. The 2016 SPECTRUM estimate of PLHIV in Ukraine is 224,000 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 192,000 was obtained by eliminating Crimea's estimate and

decreasing Donetsk and Luhansk estimates by 50%. In addition, PEPFAR/Ukraine reviewed annual progress report (APR), quarter 4 (Q4) POART data, and preliminary FY17 quarter 1 (Q1) results and recommendations in refining program focus and activities for greater impact in COP2017.

***Geographic focus:***

***Expanded priority districts for saturation:*** In COP 17, PEPFAR-Ukraine program proposes to expand its geographic focus to the GCA of Donetsk. The GCA of Donetsk has a PLHIV burden that would be fourth on the list of PEPFAR scale-up oblasts. GOU HIV care delivery capacity was severely impacted by the conflict with the dominant clinical and laboratory facilities being located in areas seized by Russian-supported forces (Donetsk oblast and city AIDS centers). Chief of Mission (COM) directives now allow for USG travel within GCA Donetsk<sup>16</sup> and the embassy encourages agencies to increase support activities within the GCA. Additionally, this extension would complement GFATM-supported treatment activities in NGCA Donetsk, helping to achieve both epidemic impact and ethical parity.

***GCA of Donetsk:*** As of January 2016, per the Ukraine State Statistics Service, Donetsk was estimated to have 4,252,260 people in both its GCA and NGCA. SPECTRUM estimates suggest that there are 33,200 PLHIV and PEPFAR/Ukraine's estimates assume that approximately half of those are in GCA Donetsk. GCA Donetsk received limited ECF ARVs which are being used for rapid initiation of new patients; however, estimated ART coverage with only ECF drugs will plateau at ~42%. With shifting of limited quantities of COP 16 ARV drugs and inclusion within COP17 activities, ART coverage can be extended to >12,000 patients (est. coverage ~75%) by end-FY 18.

As a result of adding GCA Donetsk to PEPFAR/Ukraine's priority districts, the program will focus on the six regions with the highest HIV burden (Dnipropetrovsk, Mykolayiv, Odesa, GCA Donetsk, Kyiv City, and Kherson) and continue to work in six additional medium burden oblasts (Cherkasy, Poltava, Chernihiv, Zaporizhzhya, Kirovohrad, and Kyiv), with an estimated 78% of the PLHIV in the country and 79% of newly reported HIV cases in 2016. These twelve focal oblasts collectively contain an estimated 57,000 HIV-positive PWID, 11,000 HIV-positive MSM, and 3,000 HIV-positive FSW.<sup>17</sup>

The 2016 program review confirmed that the team should continue to support an increased focus on three regions: Kyiv City, Odesa, and Dnipropetrovsk (especially Krivy Rih). These regions account for ~80,000 (42% of the estimated PLHIV in GCA Ukraine with only ~22% of the population). As such, the program will continue to focus on hot spots like Krivy Rih and support activities for Kyiv and other cities such as Odessa that recently joined UNAIDS Fast Track Cities Initiative (FTCI). Unlike COP 16, program activities will continue to support scale up of services to

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<sup>16</sup> Security precautions apply within 20 miles of the line of contact which increase with proximity. Most large treatment sites (with the exception of Mariupol) are outside of this zone.

<sup>17</sup> Based on 2015 IBBS results and 2016 PSE by oblast

FTCI cities through existing PEPFAR implementing partners and activities planned under PEPFAR annual operational plans rather than under parallel or separate processes.

***FTCI Update:*** Kyiv has ~2.8 million inhabitants and ~22,000 estimated PLHIV. However, Ukraine's capital city was historically viewed as a politically challenging place to implement HIV programs. Mayor Valery Klitchko committed to the UNAIDS FTCI in April 2016. In addition to PEPFAR support, the city has secured private funding from the Pinchuk Foundation to provide an additional 1,700 courses ARVs from April 2017 through end-2018 to facilitate the scale up of individuals on treatment. The city has also adopted a strategic plan to reach its targets and has placed data on a public website to facilitate transparency. Kyiv has also served as a model to other cities including Odessa. As of January 1, 2017, Kyiv has ~ 6693 on ART and will add ~ 6287 net new individuals by end-2018 resulting in approximately 60% coverage by end-2018 which will keep the city on track to reach its Fast Track treatment goals by 2020.

### ***Populations that PEPFAR/Ukraine will prioritize:***

#### **Population Focus:**

Age and gender: Ukraine's epidemic overwhelmingly affects adults over 25 years old. Case reporting data indicates that only 5.7% of 12,893 adult cases in 2015 were 15 – 24 years of age; SPECTRUM also estimates that <6% of adult cases are <25 years old. In both case reporting and modelling, the proportion in this age group has steadily decreased over the past decade. Among KPs, there is some divergence in trends. While both PWID and FSW IBBS surveys since 2009 have shown a progressive decline in HIV prevalence among individuals 15 – 24 years old, the 2015 IBBS found an increase in HIV prevalence among MSM 15 – 24 years old. SPECTRUM estimates that 45% of PLHIV are female. As of January 2016, 47% of ART patients were female and females accounted for 50% of the 8,303 patients started on ECF ARVs in 2016.

KPs: PEPFAR-Ukraine continues to emphasize improving services to limit transmission among KPs. While case reporting data suggests that heterosexual transmission has been increasingly dominant since 2007, available data suggests that KPs continue to play a major role. The PEPFAR-supported Modes of Transmission study surveyed >2,000 recently registered adult PLHIV; a standardized risk assessment found that among males, 45% and 18% reported IDU and MSM risk respectively, compared to 36% and 6% for these same patients per the case reporting system. These data suggest that PWID and MSM represent a majority of recently registered PLHIV; a significant proportion of the remaining cases are likely to have been sexual partners of KP, especially of current or former PWID.

Transmission among MSM is of increasing concern. The 2013 IBBS showed MSM to have the highest estimated incidence (by LAg testing) among KP; a similarly high incidence among MSM was reported from LAg testing of registered cases in Kyiv in 2013-14. In the 2015 IBBS, MSM, both <25 years old and 25+ showed increased HIV prevalence compared with the 2013 IBBS; among KPs, MSM had, by far, the lowest proportion knowing their HIV diagnosis or on ART.

Accordingly, PEPFAR-Ukraine will continue to focus on significantly improving linkage for PWID and increasing activities to reach and link MSM to care. Current network based recruiting of PWID will be modified to improve enrollment into case management (CM) and linkage to care. Based on promising results from a pilot study, PEPFAR-Ukraine will begin piloting network recruiting using recency tests to identify and link newly infected PWID to care and treatment as part of the program's efforts to more effectively curtail HIV transmission. For additional activities, please see sections 4 and Appendix A.

**Expected Results of refinement in prioritization:**

Achievement of the COP17 targets will raise coverage for the PEPFAR scale-up oblasts to 60% - 75%. Discussions with stakeholders indicate that these ambitious targets represent an upper limit of absorptive capacity within this timeframe and will require intensive combined efforts to address potential bottlenecks. The expansion of priority oblasts to Donetsk in COP 17 (including use of ~1,000 courses of COP16 ARVs in Donetsk) will allow continued scale-up in Donetsk after ECF ARVs are fully prescribed; this expansion will not slow efforts to reach 80% ART saturation in the other 11 PEPFAR priority oblasts with the timely availability of COP17 ARVs. Currently, GFATM supports activities in the NGCA of Donetsk and has earmarked funds to continue its support to the NGCA under the new CN that the country will submit in May 2017. Donetsk has historically had the highest burden of HIV. Successful control of the epidemic in Ukraine will require addressing Donetsk, particularly given its proximity to the war zone in eastern Ukraine and the potential to backslide on recent gains of the national program towards the UNAIDS Fast Track goals if the high numbers of PLHIV in this oblast are not given greater access to treatment in the next two years.

Continued PEPFAR-Ukraine efforts to focus on services for KPs should mitigate anticipated issues affecting recruitment and retention for KPs and allow for continued scale-up according to the ambitious targets developed with NCPH and civil society partners.

**Table 3.1 Current Status of ART saturation**

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained				
Scale-up Saturation (Mykolaiv oblast)	4.3% (#8,820)*	5 256	1	1
Scale-up Aggressive (11 Priority Oblasts)	68.7% (#140,900)*	47 609	10	11
Sustained commodities	27% (#55,280)	13 651	14	13
Central Support				

**Background for Calculations:**

\* Total PLHIV/% of all PLHIV for COP17:

Scale-up Saturation:  $8\ 820$  (Mykolaiv oblast est PLHIV) /  $205\ 000$  (total Ukraine est PLHIV)  $\times 100 = 4.3\%$

Scale-up Aggressive:  $140\ 900$  (11 priority oblasts est PLHIV) /  $205\ 000$  (total Ukraine est PLHIV)  $\times 100 = 68.7\%$

**# Current on ART:**

Taken from data pack, Tab Assumption Input, Column L (Host country data)

# of SNUs - Please see SDS Table A.1 for reference

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

**Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts\***

Entry Streams for ART Enrollment	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly initiated on ART (APR FY 18) TX_NEW
<b>Adults</b>			
TB Patients	(5,761)	(945)	
Pregnant Women			
VMMC clients			
Key populations**	<b>43,476</b>	<b>2,695</b>	<b>2,156</b>
Priority Populations**	<b>76,733</b>	<b>6,396</b>	<b>4,917</b>
Other Testing			
<b>TOTAL new adult cases (PEPFAR testing augmentation)</b>	<b>120,209</b>	<b>9,091</b>	<b>7,073</b>
Total new cases start ART from status quo testing efforts		(13,541)	<b>11,510</b>
Previously diagnosed and/or in care			<b>22,376</b>
<b>TOTAL all efforts</b>		<b>(22,632)</b>	<b>40,959</b>

\*PEPFAR/Ukraine testing target calculation assumes that within 12 priority regions, 13,541 cases would be newly registered in FY18 through “status quo” testing activities without additive effect of PEPFAR site-level technical assistance, based on 2016 UCDC-reported case registration rates. It also assumes 11,510 of those newly identified individuals would start ART (90% new registered surviving, 85% among them starting ART). PEPFAR/Ukraine testing targets in bold therefore represent an augmentation to the status quo, and are based on specific testing modalities and focus populations. New on treatment targets in bold reflect all treatment-naïve patients who would start ART in facility sites reached with PEPFAR ART-related technical assistance.

**\*\*Key Populations includes PWID, MSM, and prisoners reached with a mix of targeted facility and community testing modalities; Priority Populations include adults reached with facility index testing, PITC in select settings, and voluntary counseling and testing (VCT)**

**\*NB:** Table 4.1.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts is not required for the Ukraine program as it has no VMMC investments

<b>Target Populations</b>	<b>Population Size Estimate (scale-up SNU)</b>	<b>Coverage Goal (in FY18)</b>	<b>FY18 Target</b>
KP_PREV PWID* 12 scale-up oblasts	210,600	18%	38,526
KP_PREV MSM* 3 scale-up oblasts	54,900	4%	2,000
<b>TOTAL</b>	<b>265,500</b>	<b>15%</b>	<b>40,526</b>

\* **NB:** GFATM is the primary donor in Ukraine for prevention for KP

<b>SNU</b>	<b>Estimated # of Orphans and Vulnerable Children</b>	<b>Target # of active OVC (FY18Target) OVC_SERV</b>
Dnipropetrovsk		50
Odessa		50
M. Kyiv		10
Kyiv		10
Mykolayiv		40
Chernihiv		50
Kirovohrad		60
Zaporizhzhya		10
Kherson		30
Poltava		40
Cherkasy		50
<b>TOTAL</b>		<b>400</b>

## **Program Area Summaries 4.2-4.10**

### **4.1 Targets for scale-up locations and populations**

SPECTRUM modeling estimates that 224,000 PLHIV in Ukraine in 2016; PEPFAR estimates that ~192,000 of these live in GCA. To achieve 90-90-90 targets in Ukraine, PEPFAR has defined 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.”

### **4.2 Priority population prevention**

Ukraine has made significant progress in slowing its primarily PWID-driven HIV epidemic. Since 2004, the country has used external support primarily from GFATM 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 from 2008 – 2014, contributed to a stabilization of reported HIV cases since 2012 with declining HIV prevalence among PWID and FSW in IBBS through 2015.<sup>18</sup> COP 17 activities are designed to complement the GFATM's outreach prevention services (such as needle and syringe exchange) which covered ~ 62% of PWID, 50% of FSW, and 18% of MSM in 2015.

In addition to the lowest rates of prevention coverage, MSM had an increasing HIV prevalence in the 2015 IBBS (8.5%; 2015 IBBS) with increases among both MSM younger and older than 25 years, and had the highest incidence rate in LAg testing of 2013 IBBS samples. IBBS demonstrated very low rates of knowledge of HIV status (28%) and linkage to treatment (7%).

COP17 will support formative research to assess the underlying factors driving the high rates of transmission amongst KPs sub-groups in order to develop targeted prevention interventions, and create demand for prevention services such as PrEP, MAT and condoms. PEPFAR COP17 funds will also support MSM prevention NGOs to link MSM into prevention services and HTS through internet and network-based approaches. Other major complementary COP17 activities are described under HTS; NGOs will recruit PWID and MSM for HIV testing services using network and social media recruiting to increase early diagnosis and linkage to ART and further reduce HIV transmission to sexual and injecting partners. Participants will also receive KP-appropriate prevention messaging.

Condoms: Because of lower GFATM funding under the NFM, the USG contributed ~56M condoms for 2014-2017 to a GFATM PR.

MAT: MAT programs demonstrated success in decreasing risk behavior in Ukraine. MAT is reaching 9,214 clients at 174 sites as of Jan 1, 2017. The program is being transitioned to the government program for commodities during 2017-2018, with GOU funding for 2018 projected to assume all current clients. PEPFAR will support pilots of innovative funding and delivery models and continue advocacy for GOU funding for MAT to allow for expansion through increased GOU funding, local support; and co-pay options for MAT. There will be improved access to MAT through QI of MAT services to allow for more efficiency, through models to increase MAT provision for stabilized patients through local pharmacies, and through efforts to improve existing pilots providing MAT in primary care.

PrEP: MSM populations in Kyiv City and Odesa had incidences of 5% and 4% respectively in 2013 IBBS LAg testing; preparedness surveys indicate significant desire for PrEP. COP16 Kyiv FTCl funds (once awarded) will develop a pilot of PrEP which includes frequent testing (including self-testing) and rapid availability of ART. COP17 funds will extend PrEP within Kyiv and Odesa cities. Additionally, a pilot PrEP activity will be implemented by METIDA for MSM based on current MSM-friendly HTS sites and Kyiv AIDS center. METIDA will report 500 MSM newly enrolled on oral PrEP. The forthcoming comprehensive HIV protocol will have recommendations on PrEP

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<sup>18</sup> slight increase in HIV prevalence among PWID in 2015 IBBS is felt to represent deliberate changes in sampling methodology to decrease sampling of PWID already in care as discussed during COP16

initiation for different categories of patients: MSM, discordant couples and PWID. NPHC will pilot PrEP for MSM in PEPFAR oblasts and in non PEPFAR oblasts using GF funds. PrEP will be initiated on the basis of AIDS centers and targets will be set for AIDS centers.

**Military:** As mobilized military personnel have been shown to have higher HIV rates, PEPFAR also supports a standardized HIV prevention program for 30,000 soldiers and new recruits, including the distribution of 300,000 condoms obtained from Alliance. Prevention activities will be scaled up in two oblasts (Odesa and Mykolaiv) and the Anti-Terrorist Operation (ATO) zone that are higher HIV prevalence and have large, mobile, and expanding military populations. Additional TA will strengthen military HIV and anti-stigma & discrimination policies, develop a sustainable Ukrainian military-led comprehensive HIV awareness and prevention program that supports the National Guard, and build capacity for military medical personnel. A patient tracking system will be developed to document referral to civilian AIDS centers and track military ART coverage rates. Policy changes include the addition of 'active military personnel' as a vulnerable population for the upcoming GFATM proposal and addition of a Ministry of Defense (MOD) representative to the National AIDS Council.

**Prisons:** High levels of IDU and syringe sharing were reported within a prison-based IBBS. Fewer than 12% of PLHIV identified in IBBS reported being aware of having HIV. Another 40% are diagnosed during incarceration. PEPFAR will support the Ministry of Justice to introduce MAT and a package of HIV prevention services within pre-trial detention centers and prisons.

#### **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**

PEPFAR in-house estimates suggest that ~192,000 of the 224,000 PLHIV (SPECTRUM 2016) in Ukraine live in GCA. Case reporting data show 132,945 (69%) of these registered at an AIDS Center in GCA as of Jan 2017; thus, ~60,000 PLHIV either remain unaware of their status or have not yet registered at an AIDS Center. The 2015 IBBS suggests that 30,000 – 35,000 HIV-positive PWID and at least 10,000 HIV-positive MSM are unaware of their status.

To achieve epidemic control by rapidly scaling up ART through Test and Start and adequate availability of ARVs, intensified efforts are needed to identify PLHIV who currently do not know their status, particularly in hard-to-reach KP sub-groups, and engage them in HIV care and treatment. Current testing strategies are insufficient in reach and yield to identify the numbers of new PLHIV needed to reach treatment targets. In addition, the drop off between HIV screening in outreach or at HCF and linkage to HIV care (registration), especially for KPs, is also limiting.

Multiple factors—including lack of risk awareness, perceptions of treatment efficacy and access, testing policies, and stigma and discrimination—contribute to these gaps in the HIV care cascade.

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 retesting PLHIV identified and referred from KP outreach. Current GFATM-supported KP 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 yet participating in HTS programs.

PEPFAR's emphasis is on HTS programming for KPs and sexual partners of PLHIV in 12 high-burden regions which contain most of the undiagnosed KPs. Major directions for the PEPFAR – Ukraine program will be large-scale expansion of pilots of innovative HTC models to efficiently increase reach and yield, especially KPs. These include dramatically scaling up PITC at HCF, and expanding index-based testing of partners. KP and partner testing will be especially important for reaching individuals without clinical manifestation of illness who would not otherwise be found in clinical facilities.

#### ***Network-based KP recruiting:***

**PWID:** Many of the undiagnosed PWID can be reached with HTS via PEPFAR network-based recruiting as demonstrated in the recruitment from March - November 2016 of 15,074 PWID for testing which revealed 3,026 HIV-positive individuals, including 2,184 (14.5% of tested) newly identified. This testing compares favorably in yield to a standard outreach HTS model (positivity of 3.5%) and uses fewer staff and financial resources. PEPFAR is also supporting increased case management (CM) to link identified HIV-positive individuals to HIV care and treatment. Additional work is needed to improve CM services as inadequate rates of linkage to CM (50%) and of initiation of care (23%) and treatment through CM were found in initial implementation in 2016. Feedback from CMs suggests that both patient misperceptions of risk/benefit of ART and current system issues in treatment sites (including access limitations, delays, pre-existing ARV shortages, and needs for multiple clinical and laboratory examinations) play a role.

**MSM:** 2015 IBBS data found that only 28% of HIV+ MSM knew their HIV status and suggested that >5000 undiagnosed HIV+ MSM live in Kyiv City and Odesa. In FY2016 and 2017, PEPFAR Ukraine piloted an MSM HTS project, using social media platforms to connect and link MSM to HTS and care. Of ~2,500 MSM reached through online and in-person counseling, only 46% were tested with a 5% yield. This innovative strategy shows promise in reaching harder-to-reach MSM, however more information is needed to increase efficacy. PEPFAR will conduct qualitative research to better understand factors preventing MSM from accessing HTS and HIV care and treatment services. In Kyiv city, PEPFAR will adapt the optimal case finding (OCF) network-based recruiting of MSM with COP16 FTCl resources and support continued implementation with COP17 resources. COP17 resources will also develop additional improved testing and linkage activities for MSM in Kyiv, Odesa, and Dnipro.

## **QI:**

PEPFAR Ukraine is also supporting QI activities at ART sites in 7 regions to ensure better linkage through improved services, including referrals for PLHIV identified by HTS at HCF to AIDS Centers where they can be confirmed and offered care and treatment; the new ART mechanism will assume support of QI activities during 2017-18.

**Index testing:** Index testing, while a component of OCF, is not a routine component of HTS. Through a PEPFAR Ukraine pilot in 2016, partner testing proved successful in reaching PLHIV with unknown status. Approximately 1.1 partners per index client were identified, with an 11% yield among partners tested, and 75% linkage to AIDS centers. PEPFAR will expand index testing to ART sites in the 12 PEPFAR-focus regions.

## **PITC:**

Currently PITC is not commonly practiced in most facilities outside of TB and AIDS centers. In FY 2016, PITC was piloted by PEPFAR Ukraine in select medical facilities in four oblasts. Of the 2133 patients tested, 528 (25%) were seropositive. This activity may be especially useful in reaching significant numbers of PLHIV with longer-standing infections who have not previously sought or who have dropped out from HIV specialty services. Additional ongoing pilots will help delineate the optimal balance of criteria (age, facility type, risk) to be employed for wider implementation. PEPFAR will rapidly scale-up PITC in COP17 to identify un-diagnosed PLHIV through primary care, in-patient care, and specialized health services, linking them to HIV care and treatment.

## **Prison Settings:**

Fewer than 12% of PLHIV in prison are aware of having HIV and another 40% are diagnosed during incarceration. HTS services and linkage to care will be expanded in select prisons within PEPFAR-focus regions. Currently, testing in prisons is ad hoc. USAID will provide TA to make testing in pre-trial detention centers and prisons routine and systematic. USAID will ensure that all prisoners are tested upon entry to the prison system and are offered testing according to international guidelines throughout their incarceration and again at release. In addition, USAID will ensure that all HIV+ prisoners are offered ART.

## **Stigma and Discrimination:**

PEPFAR Ukraine will also continue to support stigma reduction activities in healthcare settings. Work in these areas can help to reduce the estimated drop off (33%) between HIV diagnosis and registration in HIV care. Despite progress in recent years, KPs in Ukraine still experience significant self-stigmatization, as well as stigma and discrimination from communities, families, law-enforcement officials and health center staff (medical and non-medical staff), hampering successful maintenance of healthy behaviors and reducing health-seeking behavior. Perceived, internalized, anticipated and experienced stigma present barriers to seeking care, preventing people from being tested, and if positive, seeking treatment. Continuing to address stigma and

discrimination can help to reduce the estimated drop off (33%) between HIV diagnosis and registration in HIV care.

PEPFAR Ukraine will continue to support stigma reduction activities in healthcare settings, by building upon and expanding current approaches to measure, document and mitigate stigma and discrimination while identifying new innovative models to reduce self-stigmatization and stigma and discrimination – stemming both from HIV status and from identification with any KP group. The Stigma Index will measure progress towards addressing stigma and discrimination and self-stigmatization.

### ***Military:***

The Department of Defense (DOD) will procure, distribute, and provide TA for the use of 70,000 HIV rapid test kits (RTKs) to support Ukraine Armed Forces' (UAF) improved routine HIV testing of all mobilized soldiers and new recruits; move to regular routine testing of the current standing army; and ensure 100% linkage to civilian ART centers. Testing and counseling will be conducted at Territorial Military Clinical Centers. HIV RTKs will be delivered and distributed among three Operations Districts with focus on Southern Operation Command (Odesa and Mykolaiv) and Eastern Operations Command (Dnipropetrovsk).

### ***Policies:***

Current governmental regulations restrict performance of diagnostic HTS to qualified medical personnel in clinical settings. TA for the development of new clinical guidelines has focused on removing barriers to diagnostic testing in non-clinical settings by non-medical personnel and on developing an accreditation process for these personnel. The new guidelines, expected to be finalized by FY 2018, are reported to provide fundamental policy changes that will facilitate expansion of HTS. These include community testing using trained certified non-medical personnel, expansion of PITC, acceptance of verbal consent, and promotion of the expanded use of rapid tests, including emphasizing confirmation based on two rapid tests, including support for self-testing. Changes to Ukrainian laws will be needed; draft changes to legislative acts have been developed.

### ***Partner performance management:***

Ongoing review of partner data for network-based HTS and Community Initiated Treatment Initiative (CITI) model implementation in FY Q2-Q4 among PWID tracked issues with low entry into CM and linkage to clinical care. Site visits and collection of additional data indicate these issues are not primarily related to partner performance but, as noted above, are due to a combination of physical/systems access issues and perceptions of low utility of ART among the population. Improved coordination of implementer and QI activities at ART sites to address access is being developed; case managers will initiate CM meetings held at the regional health facilities, AIDS centers (rather than in the community) to address the region-specific issues and structural barriers. CM teams will work with ART sites to strengthen coordination and tracking of

PWIDs to better understand and address gaps in achieving linkage and treatment initiation targets. Other enhancements to the CITI model envision intensive case engagement such as motivation counselling, education on treatment literacy, transportation to appointments, providing food packages for PWID who register and initiate ART, and consistent follow up via telephone calls and texting. Improved messaging regarding the benefits of early ART initiation will be also developed within a new implementing mechanism (IM) initiated in COP17.

In COP16, during the PEPFAR-supported QI process, health care and NGO service providers identified system-based barriers to HIV care and implemented local solutions to address those barriers, while using cohort analysis of HIV patients in the cascade of care and run charts to measure change. The continuous quality improvement (CQI) approach resulted in improvements that will support COP17 activities such as use of data for decision making at facility level, improved skills at local and oblast level to critically identify issues and solutions, and linking community and facility service providers. COP17 activities will build upon this work by addressing critical issues identified through CQI. Based on the assessment of program results, COP17 resources will also support activities to increase demand for prevention services including PrEP, condoms, and MAT.

### ***Commodities:***

Commodity issues critical to HTC include large shortfalls in the GOU procurement of diagnostic test kits in previous years. Historically, the GOU procured all enzyme-linked immunosorbent assay (ELISA) test kits used for most HTS at HCF and for confirmation of all PLHIV, and RTKs 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, especially in late 2015 and H1 2016. COP 2017 includes a request for 110,000 RTKs to support PEPFAR-funded PITC and index testing and to ensure adequate availability at additional key HCF in PEPFAR priority regions. PEPFAR-Ukraine continues to support pharmaceutical procurement system and supply chain management reform. Though close in price, there is a slight difference in the prices of test kits purchased by two vendors as one vendor only provides the product while the other vendor's price includes additional laboratory materials.

## **4.6 Facility- and community-based care and support**

SPECTRUM modeling estimates that 224,000 persons were living with HIV in Ukraine in 2016. PEPFAR estimates that ~192,000 live in GCA. Of these, 132,945 (69%) had registered at an AIDS Center as of Jan 2017 and ~80% of these were considered to be in "active" care defined as having been seen within the previous 12 months. To work towards 90% ART coverage by 2020, improved care services and support are needed to decrease the loss of PLHIV following registration at an AIDS Center along with activities to re-engage the ~27,000 PLHIV who are no longer in active care.

PEPFAR supports targeted CM activities that re-engage PLHIV who have been lost from the HIV care system (those without a visit in 12 months). Case managers worked with AIDS Center providers to identify registered PLHIV lost to care. In early implementation of reengagement by AIDS Healthcare Foundation (AHF) CM, approximately half of lost to follow up (LTFU) were located by contact from AIDS Centers staff; case managers re-engaged ~50% of these patients back into care. CITI reports similar rates of reengagement of re-contacted LTFU patients, most of whom were PWID.

PEPFAR will conduct a situational analysis addressing challenges, barriers, and solutions for improved utilization of case managers, including peers, within GOU HIV services. Case managers will be a link between facility and community based services – providing social support necessary to link them to testing, treatment and care services, track LTFU, and provide tailored support to enhance adherence and retention in care.

Linking post-release prisoners to treatment, care, and support will improve treatment retention among this population. Case managers will support post-release prisoners with pre-release counseling, and will link them with HIV treatment services in upon release.

#### **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. USG regions now have joint TB/HIV plans on improving TB/HIV case management and coordination of services, which are approved by regional orders. PEPFAR will support improved linkages between the vertical disease treatment programs and encourage and monitor rates of early initiation of ART (within 2 months). A monitoring system has been implemented within the GOU system; preliminary results from 2016 indicate a 58% initiation rate of ART within 2 months. With PEPFAR technical assistance, Ukraine adopted an ambitious target to increase this to 90% within 2018 – 2020.

## 4.8 Adult treatment

Despite serious constraints on the availability of GOU procured ARVs in 2016, Ukraine added >13,000 patients onto ART (22% scale-up) largely due to ECF-supported ARVs. Building on recent progress, key stakeholders, including the NCPH and civil society, have set ambitious targets for 2018 ART scale-up towards Ukraine's UNAIDS Fast Track Targets. COP17 activities are designed to complement GFATM and GOU resources in attaining the ambitious 2018 goals; these activities include TA to support implementation of improvements in ART policies and services and procurement of additional ARVs and laboratory commodities to support an additional 15,000 new ART patients.

After requiring PEPFAR support in COP16 to cover anticipated stock-outs of ARVs during calendar year 2017, several successes have improved the ability of the GOU to support existing patients, extend support to patients receiving ECF and COP16 ARVs, and provide additional scale-up in 2018. Procurement for ARVs and laboratory commodities was transferred to international agencies for the period 2016 – 2019; these procurements in 2016 produced unit-prices similar to GFATM/PEPFAR standards with substantial cost-savings. In December 2016, intense advocacy from civil society and NCPH succeeded in increasing the GOU requested budget for HIV procurements by 2.5 fold. Intense advocacy from civil society with manufacturers on pricing and patent protection succeeded in obtaining very favorable pricing including for generic Atripla and DTG. The NCPH, supported by WHO and PEPFAR, has succeeded in ensuring that all ART procurements use optimized ART regimens, predominantly generic Atripla in 2016 and forward for new patients.

Ukraine is drafting a new GFATM grant proposal for 2018 – 2020. Civil society and the NCPH intend to ensure that ambitious targets for ART scale-up, aligned with COP17 targets, are included in the proposal and explicitly supported by the GOU. The proposal will include requests for continued support for the ~23,000 patients currently on GFATM-procured ARVs; this will allow GOU resources in 2018 to support all ART patients previously supported by GOU or PEPFAR (through ECF and COP16) and to extend ART for an additional 8,000 patients outside of PEPFAR priority regions.

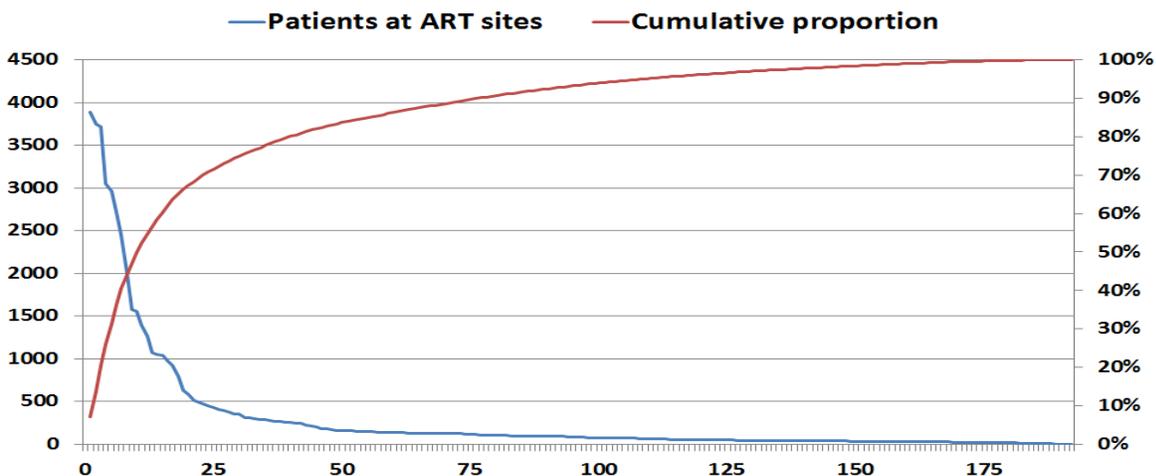
Other policy issues are helping set the stage for improving coverage. Ukrainian ART guidelines issued in December 2015 were permissive for initiating all PLHIV, especially for certain subgroups including PWID, onto ART at any CD4 while otherwise prioritizing PLHIV with CD4<500. Comprehensive new guidelines are expected for review in mid-2017; current drafts reportedly include explicit recommendations for rapid ART initiation for all PLHIV, differentiated services, and multi-month scripting. COP17 activities involve support for comprehensive technical assistance to treatment facilities in implementation of the guidelines, including supportive mentoring and monitoring, training in new guidelines including development of Test and Start practices, and improvement of procedures and policies at regional and facility levels.

Improving coverage will require major increases in the accessibility of treatment. Although ART is provided at >280 HCF in GCA Ukraine, treatment is concentrated at the regional AIDS centers and a small number of large affiliates; within the 12 PEPFAR regions, 25 of 192 ART sites (12 oblast AIDS centers and 13 large affiliates) care for nearly 40,000 (71%) of ART patients. Within these 25 sites, the average number of ART patients per provider can exceed 800. In some regions, significant numbers of ART patients have been shifted to non-HIV-specialty-care infectious disease providers in other sites. COP17 resources will assist with implementing differentiated and improved services and task-shifting as well as further decentralization to additional sites outside of the HIV specialty care system.

According to the most recent national cohort data, 86% of all patients initiated on ART in 2015 were retained at 12 months with ~1/2 of LTFU due to mortality. LTFU in cohorts with greater ART duration declines with an overall weighted retention rate of >90%. COP17 resources will support improving adherence activities to maintain or improve retention indicators as large numbers of PLHIV, especially PWID, begin ART.

In 2016, 49,497 patients on ART for >6 months had VL testing; 90.4% had VL<1,000. Shortages of VL commodities prevented full coverage but supplies are adequate for 2017. COP17 resources will support improved adherence activities to help ensure continued high adherence and VL suppression, including initiating HIV drug resistance (DR) surveillance.

### Distribution of ART patients at ART sites in 12 PEPFAR focus regions, Ukraine Jan 2017



#### 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 NPHI data as of 1/1/2017, 2,848 HIV-positive children were on ART and 45 children who have been diagnosed as HIV+ are not on ART. Most OVC in Ukraine come from socially and economically disadvantaged families and many of the children are orphaned by the epidemic. These HIV-positive children do not have sufficient skills to manage their economic life and many of them experience difficulties in socialization, often related to their caregiver's fear of societal stigma and discrimination. PEPFAR Peace Corps promotes adherence to ART among OVC through promoting socio-emotional support for the families, strengthening family bonds and life skills, reducing stigma and self-stigma, promoting healthy behavior, and through increasing financial literacy. Caregivers also receive training on status disclosure, ART-adherence, (self) stigma-reduction, 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 NPHI estimates, the number of children living with HIV aged 15-17 represents less than 15% of HIV infected children (<18).

Based on the success of the OVC-related PEPFAR activities and the increase of outreach (FY16 Q4 – 249 OVC; FY17 Q1 – 273 OVC reached), PEPFAR will continue growing the program. All current and planned OVC activities only take place in PEPFAR-focus regions.

#### **4.11 Addressing COP17 Technical Considerations**

##### *Prevention and care services for under 30 year olds:*

The HIV epidemic in Ukraine primarily affects individuals over 30 years of age. The average age of PWID in IBBS studies continued to rise and reached 34 years in the 2015 study. HIV prevalence among PWID and FSW <25 years old continues to fall. However, among MSM, including those <25 years old, HIV prevalence rose in the 2015 IBBS; MSM also had the highest incidence among KPs in limited antigen incidence testing from the 2013 IBBS. PEPFAR-Ukraine is therefore orienting resources towards MSM, including younger MSM.

##### *Increased testing yield and improving testing modalities:*

PEPFAR-Ukraine analysis identified the need to substantially increase entry of undiagnosed PLHIV into the care cascade to meet 2018 treatment targets. Accordingly, expansion of innovative and development of improved testing modalities was prioritized as described in section 4. 6.

##### *Improved retention and viral suppression:*

Although retention and viral suppression have been strong areas of achievement within the ART program, additional activities are being supported through COP17 resources (as described in 4.8) in order to strengthen the system while large numbers of ART patients are initiated under less stringent selection.

*Support of a sustainable, quality service delivery model:*

Ukraine's HIV service delivery model is rapidly evolving with the anticipated expansion to service delivery outside of the HIV specialty system and with health-care reform, including changes in the finance for primary and specialty care. COP17 resources will provide technical assistance to HIV service delivery sites within and outside of the HIV specialty care system and will help guide health reform to improve sustainable support for improved HIV services.

**Program Area 4.12: Commodities**

The country did not experience stock-outs in 2016 due to an additional procurement via GFATM. There is a risk of stock-outs in Q1 2017 due to late State procurements for 2016 (procurement was only launched at the end of 2016). However, the country conducted negotiations with UNICEF to have partial deliveries to avoid treatment interruption.

The government plans to distribute all PEPFAR purchased ARVs and lab commodities to PEPFAR- assisted areas. The additional needs in non-PEPFAR focus oblasts will be covered through the GFATM. The country has an established system in order to monitor the distribution of State-procured commodities, GFATM procured commodities, and PEPFAR procured commodities separately, and to ensure that commodities do not expire.

Currently, it is estimated that only 59% of people with HIV are aware of their infection. In order to close the gap, particularly among KPs with the lowest coverage and highest risk, self-testing has been proposed as an innovative way to contribute to this effort. Based on WHO recommendation to start self-testing, the Centers for Disease Control and Prevention (CDC) will pilot a project to implement self-testing in PEPFAR-assisted areas. Oral Quick RTKs will be procured for piloting this self-testing model.

DOD will procure, distribute, and provide appropriate technical assistance for HIV RTKs in order to support UAF's critical need to improve routine HIV testing of 100% of mobilized soldiers and new recruits, move to regular routine testing of current standing army, and ensure 100% linkage to civilian ART centers. HIV RTKs will be delivered and distributed among three Operations Districts with focus on Southern Operation Command (Odesa and Mykolaiv) and Eastern Operations Command (Dnipropetrovsk). Testing will be realized through activities of testing and counseling cabinets of Territorial Military Clinical Centers.

NCPH is committed to distributing PEPFAR procured RTKs to PEPFAR-assisted areas. In addition, they have further committed to distributing the amount of RTKs needed to meet HTC targets to PEPFAR assisted facilities. This will be done in cooperation between NCPH and oblast

health authorities. Further, rapid HIV SD Bioline test kits will be procured locally through Alliance for Public Health to perform HIV assisted rapid testing by NGOs as part of the optimized HIV case-finding model for PWIDs and their partners in social risk networks. These RTKs will assist in reaching the HTC\_TST annual targets for PWIDs and for MSMs in PEPFAR-assisted areas.

The MAT project, implemented by Alliance for Public Health, plans to have 250 MAT patients receive methadone treatment by prescription from local pharmacies. This intervention will decrease medical staff load at MAT sites and is more convenient for clients. According to Ukrainian regulations, in order to receive MAT medications in a pharmacy by prescription, patients need to demonstrate that they are not taking illegal substances for 6 months. Urine tests from Step Drug of Abuse rapid tests Intec will be used to test 250 MAT patients for illegal substances (opioids, benzodiazepines, amphetamines methamphetamines, barbiturates) once a month over 6-month period.

#### **4.13 Collaboration, Integration, and Monitoring**

The PEPFAR-Ukraine team has leveraged a strong interagency working relationship over the last few years to ensure coordination amongst USG agencies and their implementing partners as well as with external stakeholders, including GFATM and its principal recipients, as well as UNAIDS. Last December, the MOH indicated that it will take a greater role in coordinating all partners involved in the national HIV response. In recent years, government and stakeholder driven coordination has yielded needed results for the national program (e.g. preventing ARV stock outs) and the collaboration has deepened to focus on technical issues that need to be addressed to scale up the numbers of individuals in the HIV clinical cascade with the recent focus on UNAIDS 90-90-90 Fast Track goals.

- a. *Strengthened cross technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MOH;*

PEPFAR-Ukraine technical resources are shared across agencies with increased cross-agency input into design of new procurements. In addition, technical capacity is shared with the GFATM and MOH with USG-supported technical experts (both locally employed staff and partner-supported) participating in the GFATM grant proposal development working groups and MOH technical working group. Joint collaboration with other USG agencies and external stakeholders have resulted in the following activities and strengthened HIV prevention/testing and treatment services

- Jointly mapped HIV clinical cascade with GOU, CSOs, and donors to note challenges and to address them. The PEPFAR-Ukraine team noted losses in treatment centers and initiated QI and other activities to promote retention. These strategies are being revised in COP 17 to be more impactful.
- Jointly prevented ARV stock outs to ensure continued treatment scale up.

- Jointly discussed how to increase HIV testing yield with GFATM and national stakeholders. Introduced OCF in COP 15/COP 16 and are seeing increased yields while refining COP 17 strategy to provide stronger linkage and retention.

- The PEPFAR/Ukraine team actively ensures linkage between a United States Agency for International Development (USAID) mechanism working on MAT policy (i.e. Deloitte) and a CDC mechanism focused on advocacy for MAT. Also, Substance Abuse and Mental Health Services Administration (SAMHSA) staff has been working with both agencies to strengthen the impact of USG efforts.

*b. Strengthening Implementing Partner (IP) management and monitoring and the implementation of innovative strategies across the cascade, in a timely manner, to improve impact within shorter time periods;*

Implementing Partner performance will be managed systematically using a multi-faceted approach, to facilitate timely performance improvements. Activity managers will continuously engage with implementing partners, meeting at least quarterly, to stay abreast of issues impacting performance as they arise. Each quarter the inter-agency team will share IP narrative reports among the USG team; analyze project data to assess progress towards reaching targets prior to each POART call; and review expenditure trends and pipeline. Every six months agency leads will assess overall IP performance, and develop remediation plans if required.

*c. Improved integration of key health system interventions, including HRH and laboratory (VL) activities, across the cascade; and*

PEPFAR continues to support strengthening of HIV clinical care training through strengthening regional training centers to a) improve ART training modules; b) increase numbers of healthcare workers (including primary care doctors) in ART and HIV management; c) develop more sustainable decentralized training capacity; and d) train nurses to be able to assume increased HIV clinical responsibilities as envisaged under new clinical guidelines. PEPFAR will continue to make major investments in building the capacity of CSOs and government institutions, policy change, strengthening GFATM PRs, and building human capacity.

PEPFAR-Ukraine provides direct technical assistance to increase VL capacity. A high-level PEPFAR laboratorian is on the laboratory working group and participates in strategic planning with the HIV National Reference Laboratory. Working with GOU, PEPFAR-Ukraine has mapped current viral load equipment capacity and regions requiring capacity support as scale-up occurs. Using this mapping, the NCPH is negotiating with suppliers with agreements that supplied an additional VL platform in Cherkasy in 2016 and commitments to provide an additional 8 VL platforms. VL test kit availability is adequate for full testing of both ART and pre-ART patients.

*d. Improving efficiencies of service delivery through improved models of care delivery across community and facility sites.*

PEPFAR Ukraine resources will support development of improved service delivery at HCF providing HIV care through QI activities and other technical assistance. The experience of increased decentralization of ART provision will be studied to identify and disseminate best practices and ways of overcoming common barriers. Expansion of a USG-supported HIV Management Information System (MIS) system to facilitate analysis of data on cascade and quality of care indicators will continue with extension beyond major oblast HIV care facilities and transition to GOU support. A laboratory module will be added to increase the utility to HCF.

New efforts will also include qualitative data collection to inform the design of activities to improve provision of testing, linkage, and adherence, especially for KPs.

## 5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

### 5.1 Targets for attained and sustained locations and populations

#### Standard Table 5.1.2

Table 5.1.2 Expected Beneficiary Volume Receiving Commodities in Central Support Oblasts\*

Sustained Support Volume by Group		Expected result APR 17	Expected result APR 18
Current on ART	<i>TX_CURR</i>	3,773	N/A

\**TX\_CURR* for APR17 in this table is specific only to patients on PEPFAR funded ARVs in 14 non-priority oblasts. These patients would have started ART beginning in 2016-early 2018, with ARVs purchased through an ECF request approved as part of COP15/FY16. During Q1-Q2 FY18, the GOU will take over funding ARVs for these patients, and therefore no commodity-focused Central Support targets are set for FY18. During FY18, an estimated 2,341 patients in 13 non-priority oblasts are expected to transition to GOU supported-ARVs; GCA Donetsk would be a priority oblast and the ARVs for ~1,432 patients expected to be on PEPFAR-funded ARVs there would also likewise transition to GOU-funded ARVs. A total of ~18,000 patients on PEPFAR-funded ARVs, in priority and non-priority oblasts combined, would transition to GOU support in FY18.

### 5.2 Priority population prevention

Outside of PEPFAR's scale-up oblasts, GFATM funds HIV prevention programs on KPs, including PWID, FSW, and MSM, with minor support from regional/local governments.

#### **MAT:**

National level TA and advocacy are likely to have beneficial effects for MAT programs outside of scale-up regions.

### **5.3 VMMC**

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

### **5.4 PMTCT**

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

### **5.5 HTC**

PEPFAR-Ukraine will work with the groups drafting the application for the new GFATM grant for 2018-2020 to encourage support of additional testing strategies with higher efficacy (such as network based KP recruiting, PITC, and index testing) in the non-scale-up regions.

#### ***Policies:***

Successful development of the new clinical guidelines and legislative changes, as described in 4.5, will facilitate expansion of HIV testing and HTS in non-scale-up regions.

### **5.6 Facility- and community-based care and support**

Not applicable

### **5.7 TB/HIV**

Not applicable

### **5.8 Adult treatment**

#### ***Policies:***

Successful development of the new clinical guidelines and continued national level laboratory technical assistance as described in 4.9 and 4.13, will facilitate expansion of ART and VL support in non-scale-up regions.

### **5.9 Pediatric Treatment**

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

### **5.10 OVC**

Not applicable, OVC activities only take place in scale up locations.

### **5.11 Establishing service packages to meet targets in attained and sustained districts**

Not applicable given absence of attained or sustained regions.

### **5.12 Commodities**

As noted there are no attained or sustained regions.

The country did not experience stock-outs in 2016 due to an additional procurement via Global Fund. There is a risk of stock-outs in H1 2017 due to late State procurements for 2016 (procurement was only launched at the end of 2016). However, the country conducted negotiations with UNICEF to have partial deliveries to avoid treatment interruption. Going forward, there are currently no concerns regarding ARVs and VL commodities in non-scale-up regions, through FY2018, assuming GFATM approval of the new grant proposal. Some limitations in rapid test kits may exist in these regions as these are predominantly purchased by local health administrations.

The government plans to distribute all ARVs and lab commodities to PEPFAR- assisted areas purchased with PEPFAR resources in COP16 and onwards. The additional needs in non-PEPFAR focus oblasts will be covered through the GFATM and GOU resources. The country has an established system in order to monitor the distribution of State-procured commodities, GFATM-procured commodities, and PEPFAR-procured commodities separately, and to ensure that commodities do not expire.

As noted in section 4.12, HIV RTKs for the military will be delivered and distributed among three scale- up Operations Districts with focus on Southern Operation Command (Odesa and Mykolaiv) and Eastern Operations Command (Dnipropetrovsk). They will also be delivered in Kharkiv which is a sustained region.

### **5.13 Collaboration, Integration, and Monitoring**

Not applicable given absence of attained or sustained regions.

## **6.0 Program Support Necessary to Achieve Sustained Epidemic Control**

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### **6.1 Critical Systems Investments for Achieving Key Programmatic Gaps and 6.2 Critical Systems Investments for Achieving Priority Policies**

**Three programmatic gaps:** 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 remain essential for achieving 90-90-90 and sustained epidemic control in Ukraine for 2017-2018.

**Gap 1 Health commodities insecurity** has moderately decreased since last year. Ukraine continues to face a period of financial crisis and severe budget constraints due to ongoing conflict in the Eastern region of the country. However, in December 2016, the GOU successfully passed a 2.5-fold increased budget for HIV, which should cover ~63 percent of Ukraine's ARV

requirements. The GFATM and PEPFAR will need to continue commodities support and supply chain technical assistance to ensure scale up to meet Ukraine's national targets..

The GOU needs additional programmatic and managerial capacities for health procurement planning and administration. The GOU currently lacks the capacity to transparently procure at best international prices and ensure rational pharmaceutical and supply chain management. Quantification of commodity needs is heavily influenced by the availability of funds, rather than need, and a LMIS is needed to track stocks in facilities. Historically, corrupt interests controlled public procurements, resulting in inflated prices and lower treatment coverage. However, under legislation enacted in late-2015, international agencies (UNICEF and UNDP) purchase HIV commodities for MOH. By 2019, Ukraine plans to establish and procure through an independent National Drug Procurement Agency. The GOU, with USG technical assistance, has developed legislation to establish this agency within overall health financing system reform; continued assistance is necessary to ensure the agency's successful launch and functioning. In 2016, civil society organizations convinced the GOU to allocate funding to purchase MAT medications for the first time: 13 million UAH (appr. 500,000 USD) for use in 2017 and 17 million UAH for 2018.

To maximize procurement with limited government financing for HIV commodities, the NCPH started a progressive optimization of ART regimens for new patients, with WHO and USG technical assistance and support from civil society in negotiating favorable pricing for ARVs. This is increasing use of one tablet a day regimens and availability of newer highly effective drugs while decreasing spending on expensive branded LPV/rtv regimens, thereby increasing both treatment quality and availability. Implementation of alternative approaches for MAT financing, co-payment by patients and contribution from local authorities will also address these gaps.

**Gap 2: Lack of Detection, Linkage, and Retention in Care of PLHIV/Key Populations.** Ukraine still lacks adequate capacity to detect, link, and retain PLHIV/KPs in care. Only 59 percent of estimated PLHIV know their status and are enrolled in care as of January 1, 2017. Of these, only 56 percent are receiving ART, of whom ~90 percent are virally suppressed. PWID remain a KP for transmission, and large subgroups remain difficult group to find, link, and retain in HIV care. Against a backdrop of increasing HIV rates, MSM have the lowest rate among KPs of HIV diagnosis and treatment.

The first system barrier reflects incomplete and fragmented services leading to low detection and retention. Ukraine needs additional efficient strategies to augment standard outreach in detection and linkage of PWID, their sexual partners, and MSM. Case management coverage remains inadequate and expensive to support PWID referral, enrollment, and retention. No unified patient tracking system between NGOs, primary and specialized health centers, and AIDS Centers exists to reduce dropout between screening and registration; moreover, AIDS center procedures to enroll and retain patients require further standardization and streamlining. Limited MAT is provided in drug rehabilitation centers with small numbers of additional sites at AIDS and TB facilities, but is generally unavailable in primary health care centers, district hospitals, and non-existent in prisons. To increase testing and yield, scaling up PITC, including

partners' and couples' testing at specialized (TB, drug rehabilitation, STI, family planning/reproductive health (FP/RH)) and primary care clinics, and improvement of OCF/CITI for PWID and MSM will increase detection of PLHIV and expanded will improve linkage to care. CDC's Treatment mechanism and USAID's new mechanism will work in collaboration with local NGOs to facilitate linkage, ART initiation and retention, with CDC focusing on improving clinical care in treatment facility-based sites and USAID improving services in community-based settings and CM models. Piloting of network-based recruitment using recency testing to link recently infected individuals to care may help treat individuals with high transmission risks.

Innovative service delivery models, including differentiated services and dispensing 3-6 month supplies of ART, will improve retention and adherence. Development of improved adherence activities will also decrease loss to follow-up.

A lack of a public health approach to HIV service delivery is a serious barrier to scaling up HTS and treatment services for KPs. The current system prioritizes specialized and high threshold care, rather than primary or preventive care. HIV services are over-medicalized with only specialized physicians providing diagnostic HTS and treatment. Predominantly externally funded NGOs currently perform prevention, care, and support services, with government planning gradually to assume responsibility for prevention services. The government, in partnership with NGOs and with USG support, is working to establish standards and certification for HIV outreach, prevention, support, and care services.

Insufficient funding for HIV, HIV/TB, and MAT commodities and services also result from inefficiencies in resource utilization. Local social services administrations have started to contract NGOs for non-clinical, social care services; however, regulatory and institutional barriers still exist. The removal of these barriers will allow for health authorities to contract NGOs for outreach prevention, HTS with rapid tests, case management, and retention services.

The lack of a unified HMIS system to track patients through the continuum of care and appropriate analysis of data for decision making continue to present considerable barriers for achieving 90-90-90 targets. Data analysis and use remain substandard, and multiple, parallel HMIS systems require additional improvements in quality control and interoperability. A unified HMIS will be expanded in all key oblasts including Donetsk and will be supplemented with a laboratory module. Additional data on key populations and official SNU estimates of PLHIV are needed. The NCPH will assume leadership of the biennial IBBS surveys in 2019 and will require capacity strengthening to undertake these activities.

**Gap 3: Unreformed Health System and Its Impact on HIV Services.** The healthcare system in Ukraine still follows a Soviet model that de-emphasizes a public health approach. Post-independence reforms to Ukraine's health system have been characterized by timid steps and frequent retreats; however, in mid-2016, healthcare reform gained political commitment and started advancing. This commitment included the approval of a health care financing system reform concept, developed with USG support. In 2017, health reform priorities include a change

in payment models for primary care, increased hospital autonomy, the development of a basic benefit package, and the introduction of a health insurance model with the launch of the National Health Service. These changes are designed to have resources follow service provision rather than unused infrastructure and should support improved efficiency and sustainability of the system, including HIV services. Better integration or co-location of HIV, TB, MAT, and STI services at the primary care level is needed. The USG TA will support development of a 'basic benefit package' to include HIV and HIV/TB services.

The lack of commitment by national and regional governments, including the Ministry of Finance, to fully fund national and local HIV/AIDS programs was a system barrier identified in COP'16. As mentioned earlier, the GOU increased funding for ARVs and commodities and have committed to continue the treatment of all PEPFAR patients that start ART in 2016 and 2017. However, additional resources will be needed to cover other HIV services needed for effective epidemic control. Financial incentives for providers to provide critical HIV services and increase the number of patients are needed. The planned health finance reforms and expected payment system that will be based on the number of patients will help to address this gap.

Another important systems barrier is strong remaining stigma and discrimination surrounding key populations and PLHIV, including self-stigma. A new USAID mechanism will build on successful interventions to reduce stigma in health care facilities in pilot sites and expand this work to all the PEPFAR-supported regions.

Progress has been made on coordination of HIV and TB services, especially in regions which received USG technical assistance. HIV testing rates of confirmed TB cases (>95% of patients know their status) and symptomatic TB screening of HIV patients have improved. The new USAID HIV-TB mechanism will address this gap by continuing to improve coordination and increase the timely (within 8 weeks) initiation of ART for TB/HIV patients as called for by the new national targets.

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

In Table 6.3 Excel workbook includes all other system investments proposed for COP. See Appendix C

## 7.0 Staffing Plan

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The Ukraine PEPFAR team, after pivoting in COP 15 to the new PEPFAR 3.0 goals and guidelines and further refining and concentrating its resources towards achieving the UNAIDS 90-90-90 targets in focus oblasts in COP 16, plans to leverage COP 17 resources to realize the full outcomes of these programming decisions. COP 17 is designed to enhance the treatment cascade in Ukraine – particularly among PWID – and to continue critical health systems strengthening, laboratory, and care and treatment activities.

The PEPFAR interagency team has analyzed current staffing requirements in light of the COP 17 budget envelope and target planning environment. The team took into account multiple variables that could affect staffing needs in the FY 18 implementation year: continued scale-up of test and start activities, the implementation cycles of different agencies that lead to non-alignment with the federal fiscal year, potential impacts that could be intuited from a potential hiring freeze or “2 for 1” attrition policy, available space at the embassy, front office and management counselor inputs, core activities, Site Improvement Through Monitoring System (SIMS) visits, and the proper balance between PEPFAR staff, partner funding, and project implementation needs.

As a result, staffing decisions reflect the identified priority of “staying the course” and accelerating efforts to implement currently approved priorities in COP 16, which are reflected and further refined in COP 17. PEPFAR Ukraine is not requesting additional full time equivalent (FTE) staff in COP 17. However, one term-hire is requested to support laboratory activities, including national laboratory renovation for the Ukraine NPHC. This position is further described below.

Taking into account the activities approved in COP 16 and proposed for COP 17, the additional effort to support Kyiv Fast Track Cities Initiative, and the shift to more service delivery and the purchase of ARV commodities, the PEPFAR Ukraine Team is still very lean compared with the workload required. However, structural changes were made in COP 16 that, when fully implemented in FY 17, will provide efficiencies and specific support for key activities including QI, SI and Care and Treatment. These structural changes included reducing supervisory span of control within CDC to provide more oversight to locally-employed technical staff, prioritizing health reform and procurement assistance for the GOU, adding support staff and a technical SI expert to the PEPFAR Coordinator’s Office, and enhancing both SI and Treatment capacities across the interagency team.

### **VACANT POSITIONS**

There are currently 4 vacant positions in the PEPFAR Team, and we are expecting a new Limited Non-career Appointment (LNA) PEPFAR Coordinator in FY 17 or early FY 18.

### **Care and treatment (LES)**

CDC was approved in COP 16 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 position has been approved at post, and is expected to be filled by June 2017. This position is a key treatment program technical advisor to the Ukraine MOH, partners

and NGOs in the implementation of treatment programs and activities. This position is critical to implement SIMS visits for treatment sites.

#### **Care and Treatment Medical Officer**

PEPFAR – This position has been filled. The incumbent will arrive at post on July 1, 2017. The incumbent is a current CDC employee, Medical Officer, and a o-6 Commissioned Corps Officer, with extensive experience overseas working on treatment issues in PEPFAR. This position will cost 10% to HVMS and the rest to HTXS, and will be supervised and paid from CDC resources.

#### **SI Specialist (interagency, based in PEPFAR Coordinator's Office)**

PEPFAR – This United States Direct Hire (USDH) position was approved in COP 16, and has been approved at post by the front office. Interviews have been conducted and we expect the position to be filled by June 2017. This position supports the major planned expansion of SI-related activities which 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 reside in CDC technical supervision and Cost of Doing Business (CODB) costs, as 10% HVMS and 90% HVSI. The position will integrate with interagency and Office of the Global AIDS Coordinator (OGAC) for SI-related activities at post.

#### **Health Reform Advisor (USAID)**

This position was approved in COP 16 as a Sustainability Analyst. With the rapid pace of health reform efforts in Ukraine, including in health finance, USAID repurposed a long term vacancy to a two-year US Personal Services Contractor (PSC) position with an option to extend up to one year. The Health Reform Advisor will cost 100% to OHSS. The Advisor will lead efforts to support the GOU health reform agenda, including key reforms in health finance and e-health. With a comprehensive health management information system (HMIS) planned for the country, the position will serve as PEPFAR's point person in ensuring the system is designed to meet public health data needs.

#### **Procurement Specialist (USAID)**

The PEPFAR-Ukraine Procurement and Supply Chain (PSM) Specialist (approved in COP 16), a two-year US PSC 100% costed out to OHSS, will serve as the interagency specialist for USG-supported commodities and also coordinate USG PSM activities with NCPH, UN agencies, and the GFATM PRs 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 Coordinator and LES Program Assistant**

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. Hiring for this position was delayed in COP 16 given the hiring freeze but expected to onboard in COP 17. This position will cost 100% to HVMS and will be budgeted under Department of State (DoS). The Ukraine PEPFAR Team requires strategic planning and coordination across an expanding interagency team, which currently includes six agencies, to ensure key deliverables. There is also a growing need to ensure agencies closely monitor program impact through increased reporting requirements and intensified partner management in all quarters. Strategic planning across the interagency team and with national stakeholders is also intensified during the preparation of the annual COP, particularly given the increasingly narrow window and sequential nature of COP preparation. In addition, there are routine coordination needs for program planning and implementation to effectively respond to OGAC and front office ad hoc requests.

### **NEW POSITIONS**

#### **Laboratory Specialist (LES)**

Ukraine HIV laboratories are a critical part of achieving the 90-90-90 targets. In both process and policy, HIV laboratories in Ukraine require ongoing high level technical assistance in order to continue evolving towards international best practices. In addition to a large amount of assistance coordinated through our laboratory implementing partners, the GOU has identified the final location for the planned renovation of the HIV Reference Laboratory as part of the NCPH, and preparation has begun in earnest to get this project off the ground. This will require additional assistance in laboratory technical assistance support as the senior laboratory specialist will be increasingly required to devote a substantial portion of her time to the laboratory renovation project. CDC proposes to hire a term hire laboratory specialist (24 to 36 months) who can sit in current CDC space and provide support for laboratory programs and the renovation project to ensure recent gains are not lost and progress continues in HIV laboratories in Ukraine. This position will cost 10% to HVMS and 90% to HLAB.

#### **SAMHSA**

SAMHSA, through the Headquarters Operational Plan (HOP), placed a full time USDH regional Substance Abuse Specialist in Ukraine in 2016 and approved one LES assistant/specialist for a period of five years. No funding will be provided through the COP for these two positions, the primary purposes 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.

### **STAFFING OUTLOOK**

At present, the team is operating efficiently and poised to expand with critical vacancies being filled in FY17. The team is comprised of technical staff and managers, with a low number of administrative

positions. LE staff comprises nearly 80% of all fully PEPFAR-funded positions, and occupy leadership roles in the interagency.

Although 47 individuals at post “touch” PEPFAR in some way, there are 31 staff that spend at least 50% of their time on PEPFAR and 25 who spend 100% of their time on PEPFAR. Of those 25 staff, 5 (20%) are USDH and 20 (80%) are LES.

The Ukraine PEPFAR interagency team has a matrix approach to cross-cutting issues. A specific example is the interagency SI technical working group where core activities take place across agencies but are coordinated in a team approach. The addition of a Strategic Information (SI) advisor to the PEPFAR Coordinator’s Office (PCO) will further enhance this. The interagency team maintains a fluid approach to problem solving and communication through regular meetings and ad hoc information exchange.

**Site Monitoring (SIMS)** in Ukraine will take about 17% of staff time (4% increase from COP 16), and 80% of SIMS ME staff time. This does not include time spent on webinars, trainings, and meetings related to SIMS. The team must incorporate 118 SIMS visits in the coming year, which is a two-fold increase from 2016.

Enhanced partner management practices, the increase of SIMS site visits, and the expansion into Donetsk will require careful management to maximize the benefits from increased oversight and coverage without an adverse impact on staff efficiency. Synthesizing team staffing needs with work requirements to create an effective mix of priority activities is an important priority for PEPFAR Ukraine in COP 17, so that the team remains relatively lean yet achieves its objectives.

### **Cost of Doing Business (CODB)**

CODB in COP 2017 is 15% of the total planning envelope. The team is using applied pipeline aggressively in order to manage funds conservatively. Much of the CODB pipeline in COP 17 emanates from vacant positions that went unfilled in early FY 17. Those positions will be filled in late 2017 but cost savings will be realized from unpaid salaries and benefits. CODB for COP 17 will increase 5% over COP 2016. Cost savings were identified in non-ICASS administrative costs for CDC and USAID. However, in FY 18, there will be increases in International Cooperative Administrative Support Services (ICASS) costs. Additionally, the PCO will have a significant increase in staffing costs to cover the startup (i.e. purchase of new furniture, appliances for housing etc.) and relocation of the planned Department of State’s (DoS) Limited Non-Career Appointment (LNA) Foreign Service Officer (FSO). This change is in line with S/GAC’s efforts to integrate all PEPFAR Coordinator positions within the DoS globally across country programs rather than to have them seconded to DoS from other USG agencies. SIMS-related travel did increase; however, some of the increase was offset by reducing the numbers of people going on some visits (one versus two staff), and designing co-visits as an interagency to get maximum efficiency. Ukraine CODB costs are optimized and are not expected to increase significantly in the near term, unless the staffing footprint is enlarged.

# APPENDIX A

**Table A.1 - SNU Prioritization**

PLHIV estimates	SNU	COP15 Prioritization	APR16 Achievement	COP16 Prioritization	Expected Achievement By APR17	COP17 Prioritization	COP17 Target (APR18)
32240	Dnipropetrovs'ka Oblast'	Scale-up Agg	35.4%	Scale-up Agg	51%	Scale-up Agg	74%
25720	Odes'ka Oblast'	Scale-up Agg	37.6%	Scale-up Agg	49%	Scale-up Agg	69%
22000	M. Kyiv	Scale-up Agg	27.0%	Scale-up Agg	38%	Scale-up Agg	59%
16600	Donets'ka Oblast' (GCA)	(Sustained Com)	35.0% (*)	Sustained Com	47%(*)	Scale-up Agg	75%
9320	Kyivs'ka Oblast'	Scale-up Agg	35.7%	Scale-up Agg	49%	Scale-up Agg	68%
9300	Avtonomna Respublika Krym	Not Supported	#N/A	Not Supported	#N/A	Not Supported	#N/A
8820	Mykolayivs'ka Oblast'	Scale-up Sat	59.6%	Scale-up Sat	64%	Scale-up Sat	82%
7160	Luhans'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	21%	Sustained Com	#N/A
6720	Chernihivs'ka Oblast'	Scale-up Agg	29.0%(*)	Scale-up Agg	37%(*)	Scale-up Agg	52%
6680	Kharkivs'ka Oblast'	Central support	#N/A	Sustained Com	33%	Sustained Com	#N/A
6420	Kirovohrads'ka Oblast'	Scale-up Agg	19.4%	Scale-up Agg	28%	Scale-up Agg	40%
6200	Zaporiz'ka Oblast'	Scale-up Agg	37.7%	Scale-up Agg	46%	Scale-up Agg	68%
6040	Zhytomyrs'ka Oblast'	(Sustained Com)		Sustained Com	29%	Sustained Com	#N/A
5980	Khersons'ka Oblast'	Scale-up Agg	37.8%	Scale-up Agg	45%	Scale-up Agg	61%
5180	Poltavs'ka Oblast'	Scale-up Agg	37.6%(*)	Scale-up Agg	45%(*)	Scale-up Agg	57%
4520	Cherkas'ka Oblast'	Scale-up Agg	38.3%(*)	Scale-up Agg	44%(*)	Scale-up Agg	77%
4320	L'vivs'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	38%	Sustained Com	#N/A
4140	Vynnyts'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	40%	Sustained Com	#N/A
3240	Khmel'nyts'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	40%	Sustained Com	#N/A
2740	Sums'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	28%	Sustained Com	#N/A
2640	Ivano-frankivs'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	27%	Sustained Com	#N/A
2460	Rivnens'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	43%	Sustained Com	#N/A
2340	Volyns'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	53%	Sustained Com	#N/A
2060	Ternopil's'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	33%	Sustained Com	#N/A
1540	Chernivets'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	34%	Sustained Com	#N/A
620	Zakarpats'ka Oblast'	(Sustained Com)	#N/A	Sustained Com	47%	Sustained Com	#N/A
0	Military Ukraine	Mil		Mil		Mil	

(\*)PEPFAR/UKRAINE will not report results for Chernihiv, Cherkasy, Poltava, Donetsk associated with USAID/RESPOND at the end of FY17 because that mechanism is not working in those oblasts. However, expected end of FY17 calculations were made for these oblasts in order to have a baseline for target setting for the additional regions the CDC treatment mechanism would cover in FY18.

**Table A.2 ART Targets by Prioritization for Epidemic Control**

<b>Prioritization Area</b>	<b>Total PLHIV</b>	<b>Expected current on ART (APR FY 17)</b>	<b>Additional patients required for 80% ART coverage</b>	<b>Target current on ART (APR FY18) TX_CURR</b>	<b>Newly initiated (APR FY 18) TX_NEW</b>	<b>ART Coverage (APR 18)</b>
Attained						
Scale-Up Saturation (Mykolaiv Oblast)	8 820	5 655	1401	7 215	2 281	82
Scale-Up Aggressive (Other 11 Priority oblasts)	140 900	64 315	48 405	93 633	38 678	66
Sustained commodity						
Central Support						
Commodities (if not included in previous categories)						
<b>Total</b>	<b>149 720</b>	<b>69 970</b>	<b>49 806</b>	<b>100 848</b>	<b>40 959</b>	<b>67</b>

## APPENDIX B

### B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$2,868,457	\$34,873,585	\$37,742,042

Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	0
HVAB	Abstinence/Be Faithful Prevention	0
HVOP	Other Sexual Prevention	498,253
IDUP	Injecting and Non-Injecting Drug Use	1,707,673
HMBL	Blood Safety	503,779
HMIN	Injection Safety	0
CIRC	Male Circumcision	0
HVCT	Counseling and Testing	4,118,446
HBHC	Adult Care and Support	767,433
PDCS	Pediatric Care and Support	0
HKID	Orphans and Vulnerable Children	112,746
HTXS	Adult Treatment	6,794,175
HTXD	ARV Drugs	2,605,290
PDTX	Pediatric Treatment	0
HVTB	TB/HIV Care	791,699
HLAB	Lab	3,021,101
HVSI	Strategic Information	4,992,709
OHSS	Health Systems Strengthening	6,255,374
HVMS	Management and Operations	2,704,907
<b>TOTAL</b>		<b>34,873,585</b>

### B.2 Resource Projections

The Team used a variety of inputs to formulate its COP 2017 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 were used. The lump-sum budgeting portion of the PEPFAR Budget Allocation Calculator (PBAC) and the Expenditure Analysis (EA) were particularly useful resources. Agencies focused on attaining goals rather than “budget sharing,” and thus specific activities have been resourced appropriately. CODB relied on a review of prior year costs with FY 2018 projected increases based on budget analysis by agency and embassy financial specialist

## APPENDIX C – Table 6

### Section 6.o Tables: Program Support Necessary to Achieve Sustained Epidemic Control

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Table 6.1.1 Key Programmatic Gap #1: Commodity Insecurity												
One treatment standard on TOD developed/adapted	Outcomes expected after 3 years of investment (FY19)	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)	90-90-90 1,2,3	Activity budget for above-site (included in total budget)	explanation (if needed)
1. [Governance] Lack of institutionalized and professionalized national/ sub-national entities for health procurement management and administration	A Transition Action Plan for state med procurement developed and endorsed by GoU/ MoH. <i>Key assumption: political will and reformist MoH team are in place</i>	To be awarded in July 2017	An endorsed action plan for national drugs procurement beyond March 2019 developed and shared for key stakeholders discussion (From 2015 till March 2019, the state MoH procurement, incl. HIV, TB, HepC, is done via International Org-ns, UN + Crown Agents )	Copy of endorsed Final Action Plans for national drugs procurement (with date finalized)  Copy of endorsed Final Transition Action Plans for state med procurement produced (with date finalized)	TA to the MOH to establish procurement, optimize pharmaceutical sector financing and transition from international agencies to national entity;	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5	1,2,3	[REDACTED]	
	A legal framework and transition action plan for drugs procurement and storage in PEPFAR focal regions developed and endorsed by MoH/ regions	To be awarded in July 2017	A Legal Framework for HIV and MAT drugs procurement and delivery/storage at the regional and local/facility level developed and endorsed by key stakeholders	Copy of Legal Framework for HIV and MAT drugs procurement and delivery/storage at the regional and local/facility level endorsed by stakeholders (with date finalized)  Copy of Legal framework and transition action plan endorsed by MOH (with date finalized)	Support the development of the selected regional health procurement entities	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5	2	[REDACTED]	
	2 local procurements of HIV drugs and health commodities in PEPFAR focal regions are piloted using the state e-procurement Prozzoro system	To be awarded in July 2017	1 tool for HIV drugs and health commodities developed and included into the state e-procurement Prozzoro system	Number of tools for HIV drugs and commodities developed and included in the state e-procurement Prozzoro system;  Number of Local Procurements piloted via Prozzoro system in PEPFAR focal regions	TA to MOH to establish e-procurement system	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5	1,2,3	[REDACTED]	
	Military procurement system that interacts with MoH		Strategy developed for self-sufficient long-term HIV testing commodities procurements by the Armed Forces without need for long-term PEPFAR support. [Added by DOD 2/22]		TA to Medical department of Ministry of Defense to improve collaboration with MoH	OHSS	\$35,000	Prevention for the military, Follow-on	8. Commodity Security and Supply Chain: 2.5	1	35,000	

2. [Financing] Lack of adequate government financing and misallocation of existing resources for critical HIV prevention and care commodities	10% percent reduction in stock-outs in PEPFAR focal area facilities NB (Baseline will be established by project)	To be awarded in July 2017	5% percent reduction in stock-outs in PEPFAR focal area facilities	Stock-out rate by facility	Advocacy for increased procurement and supply of quality generic drugs	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5	2,3	[REDACTED]	
	Optimized regimens adopted to reduce costs	National ART optimization strategy based on WHO recommendation developed  National ART procurement plan reflects optimized regimens	Tools to review ART regimens for appropriateness, drug combinations developed and piloted at regions  80% of projects sites implementing ART optimized regimens  Reduction of LPV/rtv regimens from 36% to 29%  Increase DTG from 0% to 4%	# of Tools/SOPS developed and piloted  % of projects sites implementing ART optimized regimens  % reduction of use of LPV/RTV	ART optimization strategy development, implementation and monitoring  Activity: NPHI Treatment team conduct monitoring visits to the ARTs site to review ART regimens	HTXS	\$260,000	CDC Treatment Mech	6. Service Delivery: 5.0	2,3	\$260,000	
	Central and local government procured MAT and prevention services for KPs in 10 PEPFAR-supported regions	10 rayon/city local budgets in 5 PEPFAR-supported regions allocated money for - MAT sites and/or prevention services for KPs	Central government and 12 rayon/city local budgets in 7 PEPFAR-supported regions allocated money for MAT and prevention services-KPs	# of staff in local GoU administrations and CSOs trained in planning and costing MAT and KP prevention services  # of regions procuring MAT  # of rayon/city allocated budgets for MAT and/or prevention services;  Oblast and local/ city councils decisions documented; Project PMEP reports	Advocacy and TA to the MOH and regions to develop/ change regulations to procure MAT and prevention commodities. Training the regional and local administration staff and local NGOs to plan and cost MAT and prevention services through local budgeting process and advocating its approval by the local councils.	IDUP	\$245,000	HSS-SHARe	8. Commodity Security and Supply Chain: 2.5	1,2,3	\$245,000	

	Better access to MAT medications in pharmacies in cities where project sites are operating is ensured.  Out of patients' pockets MAT prescription practices implemented and MAT take-home dose practices are implemented at Project sites.	MAT medications are available by prescription from 3 pharmacies at cities where project sites are operating  Co-payment MAT models implemented in 4 project sites  MAT take-home dose model is implemented in 6 project sites	MAT medications are available by prescription at 5 pharmacies in cities where project sites are operating  MAT take-home dose are implemented in 9 project sites	# of pharmacies where MAT medications are available by prescription  # of project sites practicing co-payment MAT models  # of MAT sites with take-home doses	Advocate for better access to MAT medications in the pharmacies.  Expand out of patients' pockets MAT prescription practices and MAT take-home dose practices	IDUP	\$40,000	MAT APH	8. Commodity Security and Supply Chain: 2.5	2,3	\$40,000	
	Action plan for pooled funding from oblasts/MoH and other ministries for drugs procurement developed and endorsed by GoU/MoH	To be awarded in July 2017	TWG on state drugs procurement reforms set up and operational.  Options for financing of national drugs procurement developed and endorsed for key stakeholders	TWG mtgs decisions documented.  Copy of endorsed options for financing of national drugs procurement.  Copy of action plan for pooled funding from oblasts/MoH and other ministries (with date finalized).  Project PMEP reports	TA to MOH and oblasts to develop pooled funding for procurement;	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5	2,3	[REDACTED]	
	Co-payment schemes for MAT developed and implemented in 8 PEPFAR-supported regions	Alternative approach for MAT financing (co-funded by the local budget and patients) developed and implemented in 7 pilot cities and 1 district in 4 PEPFAR-supported regions	Co-payment MAT models scaled-up in 3 more PEPFAR-supported regions (up to 7) based on the pilot results	# of regions/districts implementing MAT co-funding models	Analyse the results of MAT co-funding models and provide options to the local health administrations for revising the local MAT provision	OHSS	\$85,000	HSS-SHARe	11. Domestic Resource Mobilization: 6.7	3	\$85,000	
3. [Supply Chain] Lack of rational pharmaceutical management and supply chain system	1. National Essential Medicine List adopted that includes approved-ARVs-Non-PEPFAR activities.				USAID anti-corruption funding within mechanism.	USAID-Non-PEPFAR						
	50 procurement specialists trained on evidence-based quantification and supply-planning developed.	To be awarded in July 2017	National Supplies Chain Assessment completed and actionable recommendations endorsed by MoH	Copy of endorsed National Supplies Chain Assessment (with date finalized).  Number of procurement specialists trained	TA to MOH and oblast health administrations to properly quantify commodities	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5	1,2,3,	[REDACTED]	

	LMIS piloted in 1 selected PEPFAR-supported region	To be awarded in July 2017	Draft LMIS designed and tested in 1 selected PEPFAR-supported regions	Operational LMIS endorsed by MOH (with date finalized)  Number of regions with piloted LMIS	Development and piloting of LMIS	[REDACTED]	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain: 2.5	1,2,3,	[REDACTED]	
TOTAL							\$1,865,000				\$1,865,000	

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

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)	90-90-90 1,2,3	Activity budget for above-site (included in total budget)	explanation (if needed)
2.1 Incomplete and fragmented services leading to low yields and retention [HR and Service Delivery]	Optimized case finding models institutionalized (recommended for paractical implementation by Center for Public Health) to detect PWID and their sexual partners	Pilot new OCF recruitment strategy in 3 regions  5% increase in proportion of new (+) among all HIV screened cases  OCF/CITI NGOs participated at least monthly in regional CQI Multidisciplinary teams meetings at ART sites	Expand new OCF recruitment strategy in 10 regions  10% increase in proportion of new (+) among all HIV screened cases  Model for identification of recently HIV infected persons piloted in 1 site  ART info materials for PWID developed and available on OCF/CITI sites	HTC_TST and HTC_TST positive MER 2.0 indicator  KP_PREV MER 2.0 indicator  # of OCF/CITI NGOs meetings with regional CQI Multidisciplinary team  % increase in proportion of new (+) among all HIV screened cases	Implement optimized case finding for PWID focused on active recruitment of HIV positive and their risk/social networks  Activity: OCF recruitment strategy modification: increase number of coupons for risk network  OCF identification of recent HIV infection using recency test  OCF/CITI NGOs collaboration with regional CQI Multidisciplinary teams working on at ART sites  Development of ART information materials for PWID	[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery: 5.0 9. Quality Management: 3.2	1,2,3	[REDACTED]	
	Use CITI case management approach to identify patients who have dropped out and return them to care (includes innovative risk network to recruit add'l PLHIV and link them as well)  23 NGOs in 12 pilot regions implemented CITI case management approach to link them to care	To be awarded in April 2018	60% of OCF new positives enrolled in CITY  60% eligible of OCF LFTU enrolled in CITI  80% CITI clients registered as HIV+ patients at a facility  80% CITI clients starting ART	MER indicators:  % clients registered as HIV+ patients at facility  % clients starting ART  % of client"s drop outs in CITI  incentivized model  % clients starting ART in CITI	Enhancement of CITI case management linkage, retention and viral suppression for PWID  Pilot model for incentivized retention (points, transportation cards)  Network based recruitment using recency testing to identify initial seeds  Development of motivation packages to support ART initiation and adherence  OCF/CITI modification for MSM   Designing of a cloud based mobile data collection and tracking application	[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery: 5.0 9. Quality Management: 3.2	1,2,3	[REDACTED]	

	<p>Implementation of innovative models to improve retention and adherence</p> <p>100% of supported sites have in 12 pilot regions implemented optimized dispensing services</p> <p>100% of supported sites in 12 pilot regions have implemented at least two innovative models from pilots</p>	<p>Optimized ART dispensing practices: dispensing 3-6 month supply for ART implemented at 50% pilot sites</p> <p>30% of supported ART sites have functional QA/QI system in place</p> <p>At least one innovative model is implemented in 50% of pilot sites</p>	<p>Optimized ART dispensing practices: dispensing 3-6 month supply for ART implemented at 80% pilot sites</p> <p>80% of supported sites have functional QA/QI system in place</p> <p>At least two innovative models are implemented in 80% of pilot sites</p>	<p>% of supported ARTs sites have a system QA/QI system in place</p> <p>% of supported ARTs sites that implemented optimized dispensing services</p> <p># of innovative models implemented in % of pilot sites</p>	<p>Implementation of QA/QI activities to improve ART services at regions</p> <p>Optimization of dispensing practices services for PLHIV, improved appointment and notification systems</p> <p>Development of improved adherence activities to minimize LTFU, prioritization of patients for ART</p> <p>Implementation of innovative service delivery models</p> <p>NPHI monitoring/mentoring visits to ART sites</p>	HTXS	<p>170,000 (site level)</p> <p>150,000 (site level)</p> <p>400,000 (site level)</p> <p>250,000 (site level)</p>	CDC Treatment Mech	<p>6. Service Delivery: 5.0</p> <p>9. Quality Management: 3.2</p>	1,2,3	\$0	
	<p>Knowledge transferred from best international practices for local capacity</p> <p>100% of pilot sites piloted at least one innovative service delivery models which will be proposed by ICAP</p>	<p>Action plans to pilot innovative service delivery models developed</p> <p>On-site mentoring visits conducted</p> <p>Workshop on best ART international practices conducted</p> <p>35 participants trained on ART international practices</p>	<p>Development of 3 pilot "one stop" model of integrating HIV/TB/MAT services for PWID</p> <p>4 TeleECHO sessions linking less-experienced providers with subject matter experts via video and teleconference conducted</p> <p>60 % of health care providers linked with ART subject matter experts via video teleconference</p>	<p># of "one stop" model pilots of integrated HIV/TB/MAT services for PWID implemented</p> <p># of TeleECHO sessions</p>	<p>Development of pilot innovative service models with pilot sites</p> <p>Development of action plans to implement innovative service delivery models</p> <p>Mentoring visits to pilot site by ICAP experts to mentor on innovative models implementations</p> <p>Workshop on best ART international practices</p> <p>TeleECHO sessions prepared for health care providers</p>	HTXS	<p>240000 (40 K is from applied pipeline)</p>	ICAP	<p>6. Service Delivery: 5.0</p> <p>9. Quality Management: 3.2</p>	2,3	\$240,000	
	<p>Communication strategy tailored for specific KP groups are piloted in 6 high-burden PEPFAR-focus regions.</p>	<p>To be awarded in October 2017</p>	<p>Completion of a communication strategy to enhance KP knowledge of and demand for early ART initiation and prevention services designed, based on formative research.</p>	<p>Copy of completed communication strategy (with date finalized)</p> <p># of pilot regions with a communication strategy</p>	<p>Increase and sustain demand for high quality treatment and prevention services among KP</p>	[REDACTED]	[REDACTED]	[REDACTED]	<p>6. Service Delivery: 5.0</p> <p>9. Quality Management: 3.2</p>	1,2	[REDACTED]	
	<p>25% of prisons in focal regions comprehensive package of HIV, TB, HCV, and MAT prevention, care and treatment services for PLHIV and other at-risk detainees and incarcerated persons pre- and post-release.</p>	<p>To be awarded in October 2017</p>	<p>A comprehensive package of HIV, TB, HCV and MAT prevention, care and treatment services for PLHIV and other at-risk detainees and incarcerated persons pre- and post-release designed and validated by MOJ</p>	<p>Copy of endorsed outline of comprehensive services packages</p> <p># of prisons delivering comprehensive package of service</p>	<p>Strengthen HIV, TB, HCV, and MAT services for KPs and PLHIV in pre-trial detention centers and prisons and ensure their continuity after release</p>	[REDACTED]	[REDACTED]	[REDACTED]	<p>6. Service Delivery: 5.0</p> <p>9. Quality Management: 3.2</p>	2,3	[REDACTED]	

Staff in 50% MoJ detention settings in PEPFAR focal regions successfully implementing comprehensive package of services	To be awarded in October 2017	Staff in 25% MoJ detention settings in PEPFAR focal regions successfully implementing comprehensive package of services	% of medical and social staff in pre-detention and prison facilities in PEPFAR-supported regions trained to provide integrated HIV, MAT, HCV, and TB services	Build the capacity of medical and social service staff of the Ministry of Justice to provide comprehensive HIV, TB, HCV, and MAT services	[REDACTED]	[REDACTED]	[REDACTED]	7. Human Resources for Health: 6.0	2,3	[REDACTED]	
40% of primary and 85% of specialized Health Care Facilities (STI, TB, Narcology) implementing PITCs in all (6) high-burden areas supported by PEPFAR	14 primary and 10 specialized HCF developed, adopted and implemented PITCs in 9 pilot cities and 8 districts	Pilots completed, analyzed, and inform local AIDS plans for scaling up PITC at primary and specialized HCF in the 5 high-burden PEPFAR-supported regions	# of local administrations that introduced PITC in primary care and specialized (TB, STI, narcology) clinics.  # of planning, costing and managing tools for introducing and providing PITC in primary and specialized HCFs for the local GoU administrations	Analyze results of piloted local planning, costing, and management mechanisms for integrating PITCs in STI, TB, narco clinics, and PHC. Provide planning, costing and management tool-kits for PITC for local administrations, disseminate at the regional level and nationally.	HVCT HVTB	190000 48,000	HSS-SHARe	6. Service Delivery: 5.0	1	\$238,000	
PITC and partner testing are implemented in 12 PEPFAR-focus regions.	To be awarded in October 2017	PITC and partner testing are implemented in 9 PEPFAR-focus regions.	HTC_TST and HTC_TST positive  # of regions implementing PITC and partner testing	PITC and partner testing are scaled up in high-burden oblasts.	[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery: 5.0	1	[REDACTED]	
Development of appropriate SOPs to enroll and retain patients				ATA to develop SOPs at the facility level- SOPS spell out specific procedures for facilities to deliver services for patients- RESPOND that was doing this in COP'16; finished in December 2017		\$0	RESPOND- (ending)	9. Quality Management: 3.2	N/A	\$0	
Introduction and Scale up of MAT in PHC and prisons				TA to introduce and scale up MAT in prisons PLEDGE ended in Dec 2016	[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery: 5.0	N/A	\$0	

<p>MAT activities of all stakeholders are coordinated at the national level</p> <p>70% MAT medications are procured at the expense of GoU to sustain MAT patients formerly supported by GFATM and to scale up access to MAT</p> <p>MAT scale-up targets in frames of National HIV/AIDS prevention program 2019-2023 are established in accordance with WHO recommendations</p> <p>Successful advocacy efforts allowed improve access to MAT</p> <p>MAT scale-up integrated into National HIV/AIDS Prevention Program.</p>	<p>4 meetings of MOH MAT WG organized</p> <p>50% MAT medications have been procured at the expense of GoU Budget to take over MAT patients formerly supported by GFATM</p> <p>SIMS: 100% of light green &amp; dark green scores</p> <p>Clinical guidelines and standards on TOD are in use in the capacity of technical medical documentation.</p>	<p>4 meetings of MOH MAT WG organized</p> <p>60% MAT medications have been procured at the expense of GoU Budget to take over MAT patients formerly supported by GFATM</p> <p>30% of estimated number of PWID are set as an MAT target for National HIV/AIDS prevention program 2019-2023</p> <p>SIMS: 90% of light green &amp; dark green scores</p> <p>100% of light green &amp; dark green scores</p>	<p># of meetings of MOH MAT WG organized/facilitated</p> <p>% MAT procurement at expense of GOU budget to take over MAT patients formerly supported by GFATM</p> <p>% of estimated number of PWID are set as an MAT target for National HIV/AIDS prevention program 2019-2023</p> <p>Above site level CEE A_7_01</p>	<p>Support to MOH MAT WG</p> <p>Advocate for MAT procurement at expense of GOU budget to take over MAT patients formerly supported by GFATM</p> <p>Advocate for MAT scale-up in frame of National HIV/AIDS Prevention Program 2019-2023</p> <p>SIMS. Advocacy to MAT.</p> <p>Development/adaptation of clinical guidelines on treatment of opioid dependency (CG on TOD)</p>	IDUP	\$40,236	MAT APH	6. Service Delivery: 5.0	2,3	\$40,236	
<p>Patient tracking system developed.</p> <p>HIV data to national systems from all PEPFAR regions and 85% of clinics</p>	<p>HIV MIS is operating in 3 regions</p>	<p>HIV MIS is operating in 12 regions and 2 National Clinics</p>	<p># of regions where HIV MIS is operating</p> <p># of National Clinics where HIV MIS is operating</p>	<p>Development of unified HMIS system for patient tracking</p> <p>Coordination and support for HIV MIS development, roll-out and maintenance in 12 regions (PEPFAR priority regions +Vinnitsa) and 2 National level clinics</p>	HVSI	\$0	Network	13. Epid &Health Data: 5.7	1,2,3	\$0	
<p>Training data base (TrainSMART) is operated by NPHI and in use for planning of training activities nationwide</p>	<p>One training data base supported and implemented at NPHI</p> <p>80% of trainings performed by regional training centers are registered in TrainSMART</p>	<p>One training data base supported at NPHI</p> <p>100% trainings performed by Regional training centers are registered in TrainSMART</p>	<p># of training data bases supported</p>	<p>Technical support for training data base (TrainSMART) implementation at NPHI</p>	OHSS	\$100,000	I-TECH	13. Epid &Health Data: 5.7	1,2,3	\$100,000	
<p>600 patients in need are supported through the National HIV Hotline in terms of their access to HIV testing, treatment, other HIV services, related legal issues</p>	<p>200 patients supported through National HIV Hotline on HIV testing, treatment, legal issues</p>	<p>400 patients supported through the National HIV Hotline on HIV testing, treatment, legal issues</p>	<p># of patients who received support through the National HIV Hotline</p> <p># of KP patients received support through the National HIV Hotline</p>	<p>Support for patients to access HIV testing, treatment, other HIV services through the National HIV/AIDS Hotline</p>		\$0	Network	6. Service Delivery: 5.0	1,2,3	\$0	

	Further pilot and roll-out evidence-based adherence interventions targeted at PLHIV, PWID, and TB/HIV co-infected patients				Implementation of financially-sustainable and cost-effective MAT models to scale-up MAT service It is a REPETITION of MAT activity above, in GAP 1/Commodity	IDUP	\$0	HSS-SHARe	6. Service Delivery: 5.0	2,3	\$0	
	12 MAT Project Sites with MAT QI instruments adopted for routine use to improve quality of care and treatment outcomes in MAT Project sites	One set of MAT QI instruments developed /adapted and piloted	MAT QI instruments adopted for routine use in 8 project sites	# of MAT QI instruments developed/adopted and tested  # of MAT sites where MAT QI instruments adopted for routine use	Development/adaptation, piloting of MAT QI tools  Adoption/implementation of MAT QI tools into routine practice of MAT sites	IDUP	\$50,000	MAT APH	6. Service Delivery: 5.0	2,3	\$50,000	
2.2 Lack of a public health approach to HIV service delivery [Governance]	Oblast level Public Health Centers established with clear responsibilities in the HIV, TB and MAT areas in 75% of PEPFAR-supported regions	PHC established in one region (Kyiv)	PHCs established in five regions with political will	# of Regional level Public Health Centers established;  # of PHC staff trained;	Support development and capacity building of selected regional public health centers to address HIV, TB, and other diseases	OHSS	\$250,000	HSS-SHARe	2. Policies & Governance: 4.6	1,2,3	\$250,000	
	Legislation passed that allows for task shifting of HTS, referrals, and dispensing to non-physicians	Draft guidelines for implementation of task-shifting mechanisms developed for public discussion	Legislation changes on task shifting of HIV testing and referral services to non-physicians prepared and adopted by MoH	# of legislation changes prepared and adopted  Copy of legislation changes (with date finalized)	TA to MoH, National PHC to develop legislation for task-shifting of HTS, referrals to non-physicians	OHSS	\$65,000	HSS-SHARe	2. Policies & Governance: 4.6	1,2,3	\$65,000	
	National QI/QA framework developed	CIASS assessments performed in 6 high burden PEPFAR priority regions  One National Stakeholders meeting to discuss/disseminate CIASS findings/recommendations	CIASS assessments performed in 6 PEPFAR medium priority regions  One National Stakeholders meeting to discuss/disseminate CIASS findings/recommendations	# of PEPFAR regions where CIASS assessments were performed  # of stakeholder meetings conducted to discuss/disseminate CIASS findings/recommendations	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  Support for CIASS in the PEPFAR priority regions	HTXS	\$150,000	I-TECH	2. Policies & Governance: 4.6	1,2,3	\$150,000	
	HIV DR national surveillance system implemented in 12 PEPFAR pilot oblasts	Protocol on HIVDR surveillance developed  TWG on development HIVDR surveillance system organized	HIVDR survey conducted  Draft tools for HIV DR surveillance system developed	HIVDR routine surveillance system implemented	Strengthen national surveillance of HIV Drug Resistance in Ukraine  Implementation of routine HIV DR surveillance system	HVSI	\$150,000	CDC/WHO	13. Epid & Health Data: 5.7	2, 3	\$150,000	
					Activity 4- Development of QI/QA national regulations for HIV/AIDS services	OHSS	\$0	RESPOND- Completed and transferred to MOH and integrated into a post-graduate education program	2. Policies & Governance: 4.6	N/A	\$0	

2.3 Lack of appropriate financing mechanisms to support and sustain public and NGO HIV service deliver [Financing]	National and oblast-level budgets based on 90-90-90 strategy developed and funding disbursed for all critical services for KP and PLHIV in 80% of PEPFAR-supported regions	New Ukraine's HIV-TB grant application to GF is successfully developed on Fast Track and Test&Start strategies, endorsed by key partners, and submitted to the GF.  2017 GoU state budget allocate funds to critical HIV services, covering at least 50% of ART need.  Local budgets in 7 regions increased funds by 20% for community-based critical HIV services	2018 GoU state budget allocate funds to critical HIV services, covering at least 63% of ART needs.  Local budgets in 7 regions increased funds by 30% for critical HIV services	A new HIV-TB application to GF developed and submitted (with date submitted)  Amount of GoU (state and local) budget allocated for HIV services	TA and advocacy to MOH and oblasts to revise AIDS plans based on 90-90-90 and Test&Start, and disburse funding. Support and facilitate optimization of resource planning and allocation using 3 funding sources: GoU/ central and local budgets, new GF HIV-TB grant for 2018-2020, and PEPFAR.	OHSS HVSI	150,000 120,000	HSS-SHARe	11. Domestic Resource Mobilization: 6.7, 12. Tech and Allocative Efficiencies: 6.2	1,2,3	\$270,000	
	80% of PEPFAR-supported regions use national health subvention (annual allocation) to fund HIV services. This subvention should include mandated funding for HIV and other services.	50% of local authorities receiving project TA increase investments in HIV	75% of local authorities receiving project TA increase investments in HIV	% Oblast and City health (and HIV) budgets includes critical HIV services  % increase in budgets allocated to critical HIV services	TA and advocacy to local health administrations to use health budgets to plan and fund critical HIV services	OHSS	\$85,000	HSS-SHARe	11. Domestic Resource Mobilization: 6.7, 12. Tech and Allocative Efficiencies: 6.2	1,2,3	\$85,000	
	80% of PEPFAR-supported regional state administrations contract qualified NGOs for prevention, outreach, care, and support services.	7 local government administrations contract NGOs to provide HIV services to KPs through social contracting or other mechanisms	Social contracting guidelines, based on pilot results, implemented in 14 district administrations in 7 regions	# of local government administrations that used social contracting or other mechanisms for funding community-based HIV services	Analyze results of piloted contracts of local GoU with NGOs for KP HIV service provision. Based on the pilot results, develop and provide toolkits for planning, costing and managing the social contracts for HIV services by NGOs for dissemination and scale up at the regional level and nationally.	OHSS	\$30,000	HSS-SHARe	11. Domestic Resource Mobilization: 6.7	1	\$30,000	

	More cost effective case management models adopted in 10 PEPFAR-supported regions	Planning, costing and organization mechanisms for PLHIV case management model developed and introduced in selected local districts in 7 PEPFAR-supported regions	Planning, costing and organization models for case management for PLHIV documented, endorsed by MoH/ NPHC and disseminated at the regional level and nationally	# of planning, costing and organization mechanisms for PLHIV case management developed;  # of local GoU administrations that approved and introduced case management models  # of PEPFAR-supported regions who adopt cost effective case management models	Document and legalize the planning, costing and organization mechanisms for PLHIV case management by the local administrations in local budgeting process  Develop recommendations for dissemination and roll-out.	OHSS	\$50,000	HSS-SHARe	6. Service Delivery: 5.0	2,3	\$50,000	
	All critical services are included and funded in the national AIDS program and 7 regional AIDS plans of PEPFAR priority regions	National partners equipped with recommendations on most cost-effective interventions and models of HIV service provision  2017 GoU state budget allocates funds to critical HIV services, covering at least 50% of ART needs.  Local budgets in 7 regions increased funds to 20% for critical HIV services	Action plans for 4 regions' allocation of resources for optimal mix of services to achieve the biggest long term impact on the local HIV epidemic developed. Activities will be costed for one city and 2 regions.	Report of the Investment Case II study;  Amount of budget allocated for HIV services	Support to MoH/ NPHC to develop and implement action plans of optimized allocation for HIV at national and regional level based on Investment Case II results and piloted new funding mechanisms (provider PBF, social contracting, clients co-financing and PPP)	OHSS  HVCT	85,000 25,000	HSS-SHARe	11. Domestic Resource Mobilization: 6.7	1,2,3	\$110,000	
2.4 Lack of a unified HMIS system and appropriate analysis of data for decision making [Barrier 4-M&E /Information]	Linked HMIS to track patients through the continuum of care	To be awarded in April 2018	HIV MIS is operating in 13 regions (including Donetsk oblast) and 2 National Clinics	# of regions where HIV MIS is operating	Develop unified HIV Management Information System, including clinical outcome indicators to be tracked  HIV MIS expansion at the non-occupied territories of Donetsk Oblast	[REDACTED]	[REDACTED]	[REDACTED]	13. Epid & Health Data: 5.7	1,2,3	[REDACTED]	
	Lab. Module is integrated component of HIV MIS		One lab module is developed and operational	# of lab modules developed and operational	Support for the development and implementation of Lab module	[REDACTED]	[REDACTED]	[REDACTED]	13. Epid & Health Data: 5.8	1,2,3	[REDACTED]	

	National operator takes responsibility of HIV MIS on behalf of the GoU. HIV MIS is supported at the central level. HIV MIS is properly maintained (hardware and software) and managed. Technical support for the data analysis, decision making and dissemination of information is ensured.	To be awarded in April 2018	Regulations authorizing HIV MIS official use in healthcare institutions all over Ukraine are developed and approved  HIV MIS is functional and operated by the National operator	Regulations authorizing HIV MIS official use in healthcare institutions all over Ukraine are developed/ approved  HIV MIS on behalf of the GOU operational (date of handover)	Support for the National HIV MIS Operator at the central level including maintenance (hardware and software), management and operations, communication, technical support for the data analysis, decision making and dissemination of information.	[REDACTED]	[REDACTED]	[REDACTED]	13. Epid &Health Data: 5.8	1,2,3	[REDACTED]	
	Evaluation findings are presented to the TWG and action plan developed how to address HIV MIS system limitations for further HIV MIS improvements	To be awarded in April 2018	One protocol on HIV MIS evaluation in 12 pilot regions developed and approved  One report on HIV MIS evaluation in 12 pilot regions developed	# of protocols on HIV MIS evaluation in 12 pilot regions developed and approved  # of reports on HIV MIS evaluation in 12 pilot regions developed	HIV MIS Evaluation in 12 pilot regions	[REDACTED]	[REDACTED]	[REDACTED]	13. Epid &Health Data: 5.8	1,2,3	[REDACTED]	
	HIV MIS is aligned/integrated with/to National e-Health strategy	To be awarded in April 2018	HIV MIS is aligned/integrated with/to National e-Health strategy	HIV MIS is aligned/integrated with/to National e-Health strategy (through demonstration of signed planning documents)	Support for the integration of HIV MIS into the National e-Health strategy	[REDACTED]	[REDACTED]	[REDACTED]	13. Epid &Health Data: 5.8	1,2,3	[REDACTED]	
	HIV MIS utilized in accordance with operational procedures. Better access to and improved quality of services ensured through information analysis and data driven decision making in PEPFAR regions.	To be awarded in April 2018	Operational procedures/local protocols on HIV MIS utilization to ensure better access and improved quality of services through information analysis and data driven decision making are developed in 5 regions	# of regions where operational procedures/local protocols on HIV MIS utilization to ensure better access and improved quality of services through information analysis and data driven decision making are developed	Support for the development of the operational procedures/local protocols on HIV MIS utilization to ensure better access and improved quality of services through information analysis and data driven decision making	[REDACTED]	[REDACTED]	[REDACTED]	9. Quality Management: 3.2	1,2,3	[REDACTED]	

<p>Partner notification models working in 90% of project supported sites</p> <p>SOPs on patient notification developed</p> <p>Partner notification models implemented in 12 PEPFAR regions</p>	<p>To be awarded in April 2018</p>	<p>Health care providers at ART sites trained to implement partner notification strategy</p> <p>SOPs on partner notification developed</p> <p>Partner notification models piloted in 3 project regions</p>	<p>% of project supported sites where notification models are in use</p> <p>Development and approval of SOPs for patient notification models</p> <p># of regions where patient notification is in use in accordance with officially approved standardized procedures</p>	<p>Implementation of the partner notification strategy in the PEPFAR ART sites</p> <p>Capacity development in health care provider on utilization of different models of partner notification</p>	<p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>13. Epid &amp; Health Data: 5.7</p>	<p>1,2,3</p>	<p>[REDACTED]</p>	
<p>M&amp;E staff at regional levels have the capacity to generate and analyze population estimates that correspond to the cascade of services and KPs</p>	<p>Institutionalization of DQA with development of appropriate tools</p>	<p>Tool for core ART indicators to be verified within DQA activities at the regional levels</p>	<p>SI activities transitioned to NPHI</p>	<p>Support DQA at all levels (DQA commission, development and roll-out of DQA tools and standards, DQA visits)</p> <p>Number of DQA visits conducted to the regions</p> <p>Number of joint visits by METIDA and NPHI team to the regions</p>	<p>HVSI</p>	<p>\$0</p>	<p>METIDA</p>	<p>9. Quality Management: 3.2</p>	<p>1,2,3</p>	<p>\$0</p>	
<p>M&amp;E staff at regional levels have the capacity to generate and analyze population estimates that correspond to the cascade of services and KPs</p>	<p>Tool for core ART indicators to be verified within DQA activities at the regional levels</p>	<p>SI activities transitioned to NPHI</p>	<p>Number of DQA visits conducted to the regions</p> <p>Number of joint visits by METIDA and NPHI team to the regions</p>	<p>Support DQA at all levels (DQA commission, development and roll-out of DQA tools and standards, DQA visits)</p>	<p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>9. Quality Management: 3.2</p>	<p>1,2,3</p>	<p>[REDACTED]</p>	
<p>M&amp;E staff at regional levels have the capacity to generate and analyze population estimates that correspond to the cascade of services and KPs</p>	<p>M&amp;E Staff with ability to collect, analyze, interpret data</p>	<p>Simple Treatment Monitoring Application tool (STMA) updated with new reports added on ART patients including PEPFAR patients as well</p>	<p>Trainings for NPHI on Economic evaluations</p>	<p>Number of adapted aggregated reports in STMA tool according to PEPFAR M&amp;E treatment reporting</p> <p>Support HIV surveillance activities in Ukraine to analyze HIV cascades leaks</p> <p>integration of STMA tool with the Medical Information System (MIS)</p> <p>Development of Economic evaluations training package</p>	<p>HVSI</p>	<p>\$0</p>	<p>METIDA</p>	<p>13. Epid &amp; Health Data: 5.7</p>	<p>1,2,3</p>	<p>\$0</p>	

	M&E staff at regional levels have the capacity to generate and analyze: HIV prevalence in the region, number of persons on ART, KP population size estimates that correspond to the cascade of services and KPs and mapping of KP services	M&E staff at regional levels have the capacity to generate and analyze population estimates that correspond to the cascade of services and KPs	M&E course for universities on public health epidemiology and implementation science developed  M&E course integrated in curricular for universities	Maps for visualisation used by NPHI for ART services mapping, MAT sites	Number of maps developed by NPHI  Develop online courses in M&E, and data analysis including analysis of the treatment cascades for KPs  Conduct HIV Epidemic modeling using AEM and SPECTRUM at the regional levels  Development of maps for the visualization of the prevention and treatment service coverage among key population	HVSI	\$0	METIDA	13. Epid & Health Data: 5.7	1,2,3	\$0	
	M&E staff at regional levels have the capacity to generate and analyze population estimates that correspond to the cascade of services and KPs	Protocol for study to identify barriers to ART access for CSW approved	Study to identify barriers to start ART conducted and results presented to the national stakeholders	Study conducted and results disseminated among national stakeholders	Qualitative study to identify barriers to ART access for CSW as FTCI	HVSI	\$0	METIDA	13. Epid & Health Data: 5.7	2	\$0	
	IBBS study conducted by NPHI team, data analyzed and disseminated to national stakeholders	To be awarded in April 2018	Plan for IBBS study developed with timeframe, milestones, procurement		TA to the NPHI for IBBS 2017 study preparation, part of procurement  Trainings for NPHI team to prepare for IBBS study	[REDACTED]	[REDACTED]	[REDACTED]	13. Epid & Health Data: 5.7	1,2,3	[REDACTED]	
TOTAL							\$8,040,829				\$3,479,928	

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	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)	90-90-90 1,2,3	Activity budget for above-site (included in total budget)	explanation (if needed)
3.1 To date, lack of an approved health reform strategy. [Governance] SOME PROGRESS: PH Concept approved, Health Financing Reform Concept approved	MoH Department of Public Health, National Public Health Center are fully staffed and trained with approved budget to address HIV, TB and other public health challenges	Key PH system entities (MOH DepPH, NPHC) staff are equipped with knowledge and skills in PH  Financing options for Public Health at the central and local levels, consistent with the decentralization and health system reforms, developed for public discussion	Nat PH Center fully staffed and trained with approved budget, with clear mandate in HIV/AIDS program areas.  Financing options for national and regional Public Health systems agreed by the national stakeholders and endorsed by MoH and MoFinance	# of NPHC staff trained in PH programming, financing and org development;  Financing options for PH, incl. HIV and TB services, drugs and commodities developed and documented.	Support development and capacity building of the MoH Department of Public Health, National Public Health Center, selected regional PH centers to address HIV, TB, and other public health challenges	OHSS	200,000	HSS-SHARe	2. Policies & Governance: 4.6 7. HRH: 6.0	1,2,3	\$200,000	

<p>Increased National Public HealthCenter/ NPHC leadership of SI activities (including IBBS and HIV DR surveillance) and laboratory services:</p> <p>NPHC conducted IBBS in 2019</p> <p>NPHI conducted HIV DR surveillance in 2020</p>	<p>Creation of TWG for developing the HIV SI Plan</p> <p>Draft of national HIV SI Plan developed and agreed</p> <p>Action plan for IBBS study developed together with METIDA project</p> <p>Training module on HIV IBBS data analysis developed</p> <p>Tools for monitoring of early warning indicators (EWI) of HIVDR developed</p>	<p>Protocol for assessment of national M&amp;E system developed</p> <p>Protocol for IBBS 2019 developed</p> <p>National HIVDR Strategy developed</p> <p>Gap analyses and recommendations based on the results of HIV Epidemiological surveillance prepared</p>	<p># of coordination meetings with stakeholders on HIV SI plan development</p> <p># of TWG meetings on preparation to national M&amp;E system assessment</p> <p># of trainings for the national TWG on supporting the national M&amp;E assessment</p>	<p>Support capacity development of NPHI to increasingly lead response and introduce reforms in strategic information and laboratory services</p> <p>Development of HIV SI Plan</p> <p>Preparation for IBBS study</p> <p>Analysis and utilization of HIV BBS data</p> <p>Trainings on HIVDR testing</p> <p>Development of proficiency testing and external quality assessment (PT/EQA) programs for: HIV RT; CD4; HIV VL</p>	<p>HVSI</p> <p>HVSI</p>	<p>\$400,000</p> <p>\$160,000</p>	<p>CDC NPHI</p>	<p>2. Policies &amp; Governance: 4.6</p>	<p>1,2,3</p>	<p>\$560,000</p>	
<p>Basic HIV, TB, MAT, and STI services integrated, including at the primary health care level, in 80% of PEPFAR-supported regions</p>	<p>Planning, costing and management mechanisms developed and applied to implement integrated care services packages at 13 sites in pilot districts/cities</p>	<p>Planning, costing and management mechanisms for integrating HIV, TB, MAT services for KPs in the specialized (ART, TB, STI, narcology) and primary care clinics are documented and disseminated for local and national partners to inform NAP and local HIV plans for 2018 and 2019</p>	<p># of documented planning, costing and management mechanisms for integrated KP services at the local district and facility level, endorsed by MoH/ NPHC.</p> <p># of local/ district sites where integrated care services packages implemented</p>	<p>Analyze 7 regional pilots results on planning, costing and management mechanisms for integrating HIV, TB, MAT services for KPs in the specialized (ART, TB, STI, narcology) and primary care clinics. Inform national AIDS Program and local HIV action plans for 2018 and 2019</p>	<p>OHSS</p>	<p>50,000</p>	<p>HSS-SHARE</p>	<p>6. Service Delivery: 5.0</p>	<p>1,2,3</p>	<p>\$50,000</p>	
<p>Civil society-developed strategic advocacy plan implemented for 4 policies/legislation related to health care reform AND</p> <p>2 policies/legislation adopted as result of civil society advocacy efforts.</p>	<p>To be awarded in October 2017</p>	<p>Civil society-developed strategic advocacy plan implemented for 2 policies/legislation related to health care reform</p>	<p>Joint oblast and local/ city administration and council meetings with CSOs, documented.</p> <p>Press-events, round-tables, national and local media coverage - documented.</p> <p># of strategic advocacy plans implemented</p> <p># of policies/ legislation adopted</p>	<p>Civil society advocates for improved access to quality and effective health services</p>	<p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>6. Service Delivery: 5.0</p>	<p>1,2</p>	<p>[REDACTED]</p>	

	A guaranteed essential PHC package of services, including HIV services, developed and implemented in PEPFAR-supported regions	HIV testing services included in the primary health care State Guaranteed Benefits Package in the legislative drafts endorsed by MoH	Costing and Financing options for inclusion of critical HIV services (rapid testing, referrals and ART dispensing) into the State Guaranteed Benefits Package at the primary care level developed and disseminated for national discussion	# of costing and financing options for inclusion of critical HIV services into the SGHP (primary care) developed  Copies of endorsed legislative drafts	TA assistance to develop costing and financing options of and advocacy for inclusion of HIV critical services (RT, referrals, ARV dispensing) into the State Guaranteed Health Benefits Package at the primary care level.	OHSS	\$0,000	HSS-SHARe	2. Policies & Governance: 4.6; 6. Service Delivery: 5.0	1,2,3	\$50,000	
	HIV NRL and regional HIV labs staff implemented and passed international standards ISO 15189	Gap analysis of current policies, processes or procedures at HIV NRL conducted  Steering committee responsible for writing policies, processes and procedures for each element (Quality System Essential established)	≥80% laboratory staff accomplished required trainings for ISO 15189 preparation  90% of documents on procedures and processes developed and ready for accreditation	% of laboratory staff accomplished tests with satisfactory scores  SIMS CEEs for QMS scores are at least light green	TA to HIV NRL and regional labs staff on step wise preparation for accreditation on ISO 15189	HLAB	\$170,000	ASCP	10. Laboratory: 6.2	1,2,3	\$170,000	
	100% of all pilots labs completed SLIPTA assessment	100% of 12 regional pilot labs completed SLIPTA assessment  Lab staff for 12 regional lab trained on use of EQA panels  SOPS for EQA panels developed	100 % of 12 labs increase SLIPTA stars at least by one SLIPTA vs baseline assessment  EQA panels developed and distributed to all 12 pilot sites	# of laboratories implementing step wise laboratory continuous quality improvement program (SLIPTA)  EQA panels developed and distributed to all pilot sites	Trainings for HIV labs professional on SLIPTA tool  Institutionalization of the QMS for lab professionals	HLAB	80,000  130,000	ASCP	10. Laboratory: 6.2	1,2,3	\$210,000	
	80% of pre-service institutions using curricula on quality management for lab specialties	Curricula on quality management evaluation for laboratory specialties in routine use in Ukrainian pre-service training institution(s)	One curricula on quality management evaluation for laboratory specialties developed	# of pre-service institutions using curricula on quality management for laboratory specialties	Development of curricula on quality management evaluation for laboratory specialties  Development of the training modules on Quality Management for laboratory specialties for pre-service curricula	HLAB	\$70,000	ASCP	10. Laboratory: 6.2	1,2,3	\$70,000	

	QMS system implemented in 11 sites at the blood centers  11 blood centers piloted system to improve linkage to ART services and close communication gap between blood centers and AIDS centers	To be awarded in April 2018	Trainings for 11 pilot sites laboratory staff on 12 QMS elements completed with ≥80% satisfactory scores  Proposal on Blood Safety CIMS reviewed by MOH and action planned developed  Blood Safety CIMS national system implemented  Blood Centers staff trained on CIMS system use at 11 pilot sites	# of labs successfully completed QMS assessments	Preparation of the blood centers to transition to EU Directives for international and national certification.  Blood centers QMS assessment  Assessment and proposal for national Blood Computer information systems, CIMS system modification for national use  Trainings for health care providers for CIMS system use	[REDACTED]	[REDACTED]	[REDACTED]	10. Laboratory: 6.2	1,2	[REDACTED]	
TOTAL							\$1,960,000				\$1,810,000	

Table 6.2.1: Test and START												
Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)	90-90-90 1,2,3	Activity budget for above-site (included in total budget)	Explanation (if needed)
1. Lack of guidelines and policies  [Governance]	Comprehensive HIV guidelines and protocols that include a TEST and START approach developed and institutionalized	Completed roll out of the Test and START guideline through trainings by end of year 1  50% of PEPFAR supported sites implemented TEST and START Policy	Continued implementation of Test and Start guideline  90% of PEPFAR supported sites implemented TEST and START Policy	# of project facilities offering TEST and START	Rollout and implementation of TEST and START guideline (same day initiation of treatment)  Training of TOTs and 12 regional trainings on TEST and START	HTXS	210,000 (site level)	CDC Treatment Mech	2. Policies & Governance: 4.6; 6. Service Delivery: 5.0	1,2,3	\$0	
	Development of SOPs that streamline enrollment and reflect a TEST and START approach	Comprehensive HIV care and treatment national guideline reviewed by WHO experts  Development and distribution of Tools and SOPs supporting implementation of Test and Start strategy	All PEPFAR supported facilities to have SOPs and Tools on Test and Start implementation  At least one quarterly visit pilot oblasts done with WHO expert  Two trainings on ART by WHO international experts	SIMS (Availability of tools and SOPs supporting Test and Start)  # of WHO and NPHI Treatment team joint visits to the ART sites	Advocacy for adoption and implementation of comprehensive HIV care and treatment national guideline (Test and Start)  Trainings for NPHI Treatment team by WHO experts on ART, Test and Start  TA to NPHI on innovative service delivery models implementation  WHO and NPHI Treatment team joint mentoring visits to ART sites	HTXS	\$200,000	CDC/WHO	2. Policies & Governance: 4.6; 6. Service Delivery: 5.0	1,2,3	\$200,000	

	100% of supported sites have in 12 pilot regions implemented at least two models of best care/ treatment international practices including Test and Treat  100% of supported sites have reduced LPV/rtv containing regimens	2 work-shops on the best care and treatment international practices conducted  Curricula on HIV/co-morbidities clinical trainings for physicians developed/revised  35 clinical trainings on HIV/co-morbidities for 875 physicians conducted  SIMS: ≥ 90% of light green & dark green scores	3 additional work-shops on the best care and treatment international practices conducted  35 clinical trainings on HIV/co-morbidities for 875 physicians conducted  SIMS : ≥ 90% of light green & dark green scores SIMS	# Of work-shops/trainings on the best care and treatment international practices conducted  #of curricula on HIV/co-morbidities clinical trainings for physicians developed/revised  #of clinical trainings on HIV/co-morbidities for # physicians conducted  SEEs Above-site level	Dissemination of the best care and treatment international practices including Test and Treat strategy  Support to implementation of ARV care and treatment around optimized regimens of ART	HTXS	\$290,000	I-TECH	6. Service Delivery: 5.0	1,2,3	\$290,000	
	ARV dispensing expanded to PHCs and NGOs in 80% PEPFAR-supported regions	Planning, costing and organization mechanisms for ARV dispensing at primary care level and in a community-based setting developed and tested in one NGO and 2 PHCs	Lessons learned from planning, costing and organization of ARV dispensing in PHC and community-based settings documented and disseminated at the local/regional level and nationally for scale-up	# of local legislative and organizational changes for ARV dispensing at PHC and in community-based settings developed and implemented;  # of planning, costing and organizational tools for ARV dispensing at PHC and in community-based settings designed, tested and endorsed by local GoU/ MoH  Project PMEP reports	TA to the local state administrations and MoH/ NPHC to change/ develop regulations for planning, costing and organization of ARV dispensing through PHCs and in community-based setting (NGOs)	OHSS	\$0,000	HSS-SHARe	2. Policies & Governance: 4.6; 6. Service Delivery: 5.0	2,3	\$50,000	
2. Lack of financial resources that would allow for significant expansion of HIV services  [Financing]	National partners are equipped with evidence-based financial data for annual budgeting process based on Test-&Start approach.	Test & START approach costed and shared with key stakeholders	Key Test & START costing results -incorporated in the budgeting process and used for preparation of NAP	National 2018 AIDS Program budget and regional/local 2018 AIDS plan budgets developed based on Test-&Start costs calculations.	National level costing of Test and START conducted and results used for preparation of a new HIV-TB GF application for 2018-2020	OHSS	\$0,000	HSS-SHARe	14. Fin/Expenditure Data: 6.3	1,2	\$50,000	
	Simplified regimens under a new protocol				cross reference 6.1.1, financing activity					2		
	Demand and supply of quality generic drugs as cost-effective alternative to expensive brands				cross reference 6.1.1, financing activity					2,3		

	Capacity built at national and oblast level for quantification of commodities				cross reference 6.1.1, supply chain activity					1,2,3		
	5- Patient co-payment schemes related to TEST and START designed and tested	postponed in response to the MoH/ NPHC's request based on the national SHers' consultations			Activity 5: TA to develop regulations and design and test co-payment scheme related to ARV provision	OHSS		HSS-SHARe	2. Policies & Governance: 4.6			
3. Lack of human resource requirements that will be needed under TEST and START approach (Health Workforce)	National partners are equipped with data on human resource needs required for TEST and START approach implementation	Empirical analysis of human resource requirements for TEST and START to determine a gap and develop recommendations for HRH rationalization conducted	HRH rationalization options rolled out in 3 regions and endorsed nationally.  HRIS institutionalized by means of E-health model.	Report of the empirical analysis of HR requirements for Test and START with recommendations of HRH rationalization options;  HRIS module developed and incorporated into the e-health system of the MoH	Based on estimates for HR needs for Test&Start in 3 regions, support 7 focal regions in quantification and planning of HR for HIV in 2019 and 2020, using task-shifting models. Finalize and institutionalize HRIS	OHSS	180,000	HSS-SHARe	7. Human Resources for Health: 6.0	1,2,3	\$180,000	
	2- Passage of legislation that would allow for an appropriate deployment of staff (repeal of order 33)	MoH Order #33 repealed in Sept 2016			cross reference 6.1.2 governance							
	3- State Penitentiary Services will develop a human resource plan for HIV service delivery in the prison system with a public health approach 2/14/2017 State Penitentiary Service is disbanded and transitioned to the Ministry of Justice in October 2016				Activity 3: TA to SPS to develop HR plan for service delivery			[REDACTED]	7. Human Resources for Health: 6.0			
TOTAL							\$980,000				\$770,000	

Table 6.2.2: New and efficient service delivery models												
Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)	90-90-90 1,2,3	Activity budget for above-site (included in total budget)	explanation (if needed)

1. Regulatory barriers for a high quality, less expensive patient-centered HIV service system [Governance]	Protocols and guidelines changed to reflect 90-90-90 strategy developed and implemented	Comprehensive HIV management guideline and legislation changes to implement 90-90-90 strategy developed	Comprehensive HIV management guideline and legislation changes to implement 90-90-90 strategy approved.  Trainings to roll-out of the new guidelines conducted in 7 regions	# of regulations to implement 90-90-90 strategy developed and endorsed by MoH/NPHC.  # of oblast and local health administrations and health providers staff trained on new regulations.	cross reference 6.1.2, governance activity  TA and support to the MoH TWG to develop comprehensive HIV management guidelines and prepare legislation changes, including the design of regulations for partner notification/ index testing of sexual partners of KP and self-testing for hard-to-reach KP.	OHSS	\$50,000	HSS-SHARe	6. Service Delivery: 5.0	1	\$50,000	
	Expanded PHC, that include HIV service delivery developed and implemented	Policy and program options for HIV service delivery at the PHC developed for national discussion	Lessons learned shared with MOH for dissemination.  HIV related KPIs for PHC payment system developed and tested in 2 selected PEPFAR-supported regions	Nat PHC meetings with regional AIDS centers documented results of options discussion.  Options for HIV service provision at PHC documented.  # of PEPFAR-supported regions with HIV related KPIs for PHC payment system developed and tested	TA to develop and support implementation of an integrated and expanded primary health care service package that includes HIV critical services.  Support reforms of PHC provider payment system (to include HIV in the performance variable) in the two focal regions, in collaboration with the MoH and other donors	OHSS	\$65,000	HSS-SHARe	6. Service Delivery: 5.0	1,2,3	\$65,000	
	Innovative and sustainable MAT models are piloted  MAT best practices described and handed to CPH for further implementation in other non PEPFAR regions	Protocols on piloting of innovative and sustainable MAT models are developed and approved by CDC	3 MAT sites piloted innovative and sustainable MAT models  1 report on innovative and sustainable MAT models MAT models is published	# of CDC approved piloting protocols on innovative and sustainable MAT models  # of MAT sites piloted innovative and sustainable MAT models  # of published reports on innovative and sustainable MAT models	Designing and piloting of innovative and sustainable MAT models including MAT in PHC settings, post-discharge practices and dispensing of methadone solution with mechanical dosing devices	IDUP	\$120,000	MAT APH	6. Service Delivery: 5.0	2,3	\$120,000	
	Results of pilot PrEP model analysed  Best practices developed and used by GoU to scale PrEP for MSM nationally	To be awarded in April 2018	Protocol for MSM PrEP developed and approved  NPHI Treatment team approve action plan for pilot MSM PrEP model	# of MSM receiving PrEP	Pilot PrEP models for MSM: community and facility based models  Training for physicians on understanding MSM risks, counseling high risk clients and improving PrEP effectiveness	[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery: 5.0	2,3	[REDACTED]	

	25% of identified policy bottlenecks in analysis resolved	To be awarded in October 2017	Completed analysis of regulatory, policy and financial barriers within MoJ completed	# of policy bottlenecks resolved (copies of regulation changes, etc)  Copy of final analysis	Improve and develop MOH and MOJ evidence-based policies and regulations for expansion of integrated HIV, TB, and HCV programs for pre-trial detainees, prisoners and ex-prisoners, and ensure that they are included in national strategies and budgets	[REDACTED]	[REDACTED]	[REDACTED]	2. Policies & Governance: 4.6	1,2,3	[REDACTED]	
2. Inadequate recruitment and sub-optimal task assignments for HIV health providers, case managers, and PHC health providers [Human Resources]	General practitioners trained to diagnose, test, and treat, and refer patients				cross reference 6.1.2 governance		0		7. Human Resources for Health: 6.0 6. Service Delivery: 5.0	1,2,3		
	Models for local funding of case management through health facility/oblast health budgets implemented in 6 PEPFAR-focus regions.  Models to provide community-based support for ART adherence implemented in 4 PEPFAR-focus regions.	To be awarded in October 2017	Completed situational analysis addressing challenges, barriers and solutions for improved utilization of social workers/case managers, including peers, into primary health care, specialized centers, and ART treatment sites.  Models to provide community-based support for ART adherence implemented in 4 PEPFAR-focus regions.	HTC_TST and HTC_TST positive TX_NEW TX_RET  Copy of situational analysis (with date finalized)  # of regions implementing community-based support models  # of regions implementing local funding of case management models	Scale up models to increase people who know their HIV status, are linked to care and treatment, and retained in care and treatment	[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery: 5.0	1,3	[REDACTED]	
	Non-infectionist physicians have capacity to deliver ART	RESPOND will end by Sep2017			Train health workers, including primary health care doctors, in ART delivery, including CQI		\$0	Respond ending	7. Human Resources for Health: 6.0	2,3		
	Routine standardized HIV testing on regular intervals and pre or post deployment, and upon demobilization ensuring 100% linkage for mil PLHIV to civilian AIDS centers for treatment	Develop confidential military HIV tracking system to document referral to civilian AIDS centers	Update existing standardized mandatory HIV testing policy (1 mandatory HIV test for active duty every 3-5 years). Strengthen anti-stigma and discrimination HIV military policy		Support HIV military policy development	OHSS  NB: This is a site level activity and has targets associated with it in the TBB tab of the PBAC	\$90,970	TBD				\$0

3. Laboratory procedures create unnecessary testing and inadequate number of viral tests available [Barrier 3: Laboratory]	EQA/PT guidance, SOPs for HIV NRL and regional labs are in use in 6 labs.	Policies on Quality Management Systems developed  3 labs pilot participating in EQA for HIV viral load passed PT program	Policies on Quality Management Systems endorsed  3 additional labs pilot participating in EQA for HIV viral load passed PT program	Policies on Quality Management Systems developed  # of labs participating in EQA for HIV viral load passed PT program  #of protocols on EQA for HIV viral load developed	Development of Quality Management Systems Policy  Improve capacity for lab proficiency testing and EQA for HIV related tests  Development of EQA/PT guidance, SOPs for HIV NRL and regional labs  Development of the protocol for EQA for HIV viral load	HLAB	\$180,000	CLSI	10. Laboratory: 6.2	1,2,3	\$180,000	
	CD4 tests will only be conducted at ART initiation to establish baseline.	National Proficiency Testing (PT) program for CD4 count developed  One management tool for HIV NRL developed	National Proficiency Testing (PT) program for CD4 count endorsed  One additional management tool for HIV NRL developed	# of labs passed Proficiency Testing (PT) program for CD4 count  # of SOPs, management tool for HIV NRL developed	POC PIMA relocation from the existing sites for sites remote areas  Implementation of the POC services for KP  Development of SOPs, management tools for HIV NRL	HLAB	\$70,000	ASM	10. Laboratory: 6.2	1,2,3	\$70,000	
	New WHO HIV testing algorithm is implemented.  Testing procedures aimed at ART enrollment are optimized  How do you measure "optimized"?	Monitoring tool developed to track the effectiveness of new HIV testing algorithm  5 labs using monitoring tool for HIV testing algorithm effectiveness  One report with data analysis developed	7 labs use monitoring tool for HIV testing algorithm effectiveness  One report containing data analysis developed	# of the monitoring tools developed to track the effectiveness of new HIV testing algorithm  # of labs using monitoring tool for HIV testing algorithm effectiveness  # of reports containing data analysis developed	TA for HIV NRL in implementation of WHO new HIV testing algorithm.  Optimize testing procedures aimed at ART enrollment	HLAB	\$70,000	APHL	10. Laboratory: 6.2	1,2,3	\$70,000	
TOTAL							\$1,685,970				\$985,970	

Table 6.3 Other Proposed Systems Investments												
Systems Barrier/ Gap	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)	90-90-90 1,2,3	Activity budget for above-site (included in total budget)	explanation (if needed)
Finance												
Governance												

Develop and implement policy reform around PWID, including needle and syringe access programs for prisoners.		Harm reduction, including OST, available for prisoners				[REDACTED]	[REDACTED]	[REDACTED]	2. Policies and Governance 4.6	N/A		
Stigma and discrimination of KP and PLHIV, incl. self-stigma, is a barrier for uptake of and retention in care.	10% decrease in level of stigma caused by fear of being HIV infected amongst healthcare providers who were trained on Stigma and Discrimination	To be awarded in October 2017	Pilot 5 trainings on KP-competency and stigma/ discrimination/ violence mitigation using adapted curriculum for at least 200 healthcare providers	KP Competent Curriculum completed.  # of person courses of curriculum carried out  % decrease in level of stigma amongst health care providers	National HIV Stigma Index Survey report 2018 (vs. 2010, 2013, 2016) carried out; health providers trained; advocate for policy change	[REDACTED]	[REDACTED]	[REDACTED]	2. Policies and Governance 4.6	1,2,3	[REDACTED]	
HRH - Systems/Institutional Investments												
Lack of HRH capacity in HIV and broader public health. Outdated training programs	Finalize institutionalization/ evaluate the sustainability of the new PH course and Flagship Health Financing course	Post-graduate course on PH and Health System/Health Finance developed and incorporated into standard educational curricula of 3 Ukrainian higher educational institutions	3 higher educational institutions implemented post-graduate courses	# of Ukrainian educational institutions that institutionalized and implemented Health Financing and Public Health courses	PH and Health Systems/ Health Financing post-graduate courses are approved by MoH, MoEducation and run in 3 Ukrainian Education Institutions	OHSS	\$170,000	HSS-SHARe	7. HRH 6.0	1,2,3	\$170,000	
	Training Evaluation Framework and Tools (TEFT) are in use in NPPI	One training curricula on TEFT developed  1 training on TEFT conducted  25 participants from regional Training centers trained on TEFT evaluation	Evaluation by NPPI using TEFT tool conducted  One additional training curricula on TEFT developed	# of training curricula on TEFT developed  #of trainings on TEFT for CPH, UCFM and other experts conducted	Technical support for Training Evaluation Framework and Tools (TEFT) implementation to NPPI	HTXS	\$150,000	I-TECH	13. Epid & Health Data: 5.7	1,2,3	\$150,000	

	CPH100% of staff from training unit completed clinical mentorship  The web-based distance learning platform/virtual Training Center launched on CPH web site	25 specialists trained on clinical mentorship  110 clinical mentor visits to ART sites performed  1 web-based distance learning platform/virtual Training Center launched	25 additional specialists trained on clinical mentorship  110 additional clinical mentors visits to ART sites performed  1 additional web-based distance learning platform/virtual Training Center supported	# of specialist trained on clinical mentorship  # of clinical mentors visits to ART sites  # of web-based distance learning platform/virtual Training Center launched/ supported	Establishment and development of the institute of clinical mentorship in CPH  Develop and launch web-based distance learning platform/virtual Training Center	OHSS	\$230,000	I-TECH	7. Human Resources for Health: 6.0 6. Service Delivery: 5.0	1,2,3	\$230,000	
	Clinical trainings on HIV/ART for nurses are organized  100% of medical nurses trained at HIV clinical management trainings dispensing ARVs for clients	One HIV/ART Training curricula for Nurses developed  2 HIV/ART Trainings for nurses conducted	One additional HIV/ART Training curricula for Nurses developed  3 additional HIV/ART Trainings for nurses conducted	# of HIV Training curricula for Nurses developed  # of HIV Trainings for nurses conducted	Development of curricula and provision of clinical trainings on HIV/ART for nurses.  Building faculty capacities in the area of HIV clinical management for nurses	HTXS	\$200,000	I-TECH	7. Human Resources for Health: 6.0 6. Service Delivery: 5.0	1,2,3	\$200,000	
	Activities of Stakeholders in the development of new medical technology documentation (guidelines, protocols, standards) needed for treatment optimization and implementation of new service delivery models are coordinated at the national level	4 meetings of the National Treatment working group are conducted	4 additional meetings of the National Treatment working group are conducted	# of meetings of the National Treatment working group	Coordination of Stakeholders at the national level in terms of development new medical technology documentation (guidelines, protocols, standards) needed for treatment optimization and implementation of new service delivery models	HTXS	\$0	Network	7. Human Resources for Health: 6.0	1,2,3	\$0	No new funds for COP17. Mechanism Funded in COP16 and will function through March 2018
	100% of all healthcare professionals in 12 regions have sufficient qualifications to operate HIV MIS	700 healthcare professionals from HIV MIS sites are trained on computer literacy and on usage of HIV MIS	300 healthcare professionals from HIV MIS sites are trained on computer literacy and on usage of HIV MIS	# of persons/courses trained on computer literacy and on usage of HIV MIS	Trainings on computer literacy, on usage of HIV MIS for staff of HIV MIS sites and advanced trainings on HIV/AIDS treatment	HVSI	\$0	Network	7. Human Resources for Health: 6.0	1,2,3	\$0	No new funds for COP17. Mechanism Funded in COP16 and will function through March 2018
	Health care providers/infectionists trained to initiate ART, managed patients with co morbidities in PEPFAR priority regions	200 healthcare professionals trained in advanced clinical management of HIV and co-morbidities	200 additional healthcare professionals trained in advanced clinical management of HIV and co-morbidities	# of healthcare professionals trained on advanced clinical management of HIV and co-morbidities	On-line/phone mentorship for physicians on the treatment of OI and other HIV/AIDS treatment issues	HTXS	\$0	Network	7. Human Resources for Health: 6.0	1,2,3	\$0	No new funds for COP17. Mechanism Funded in COP16 and will function through March 2018
Inst & Org Development												
Lack of HIV and TB coordination and integration	Improved linkages for HIV and TB referrals and coordination.	PEPFAR activities will be implemented starting from April 2017 (COP17).	Assessment conducted and activities aimed on establishing effective coordination between TB and HIV services are adjusted to address the revealed gaps and barriers.	TB_STAT TB_ART	Oblasts assessment, capacity building for medical providers on TB/HIV case management, establishing robust supportive supervision system aimed at continuous quality improvement of TB/HIV case detection and management (2nd and 3rd "90"s)	HVTB	300,000	Challenge TB	6. Service Delivery: 5.0	1,2,3	\$0	

Lack of NPHI capacity in Research, Data Visualization, and M&E	NPHI staff wrote research protocols without TA	Trainings materials on research protocols and manuscripts preparation developed	2 trainings on research protocol development & manuscripts preparation conducted	# of trainings on research protocol development & manuscripts preparation conducted	Conduct trainings on research protocol design & manuscripts preparation	HVSI	\$65,000	UCSF	13. Epid &Health Data: 5.7	1,2,3	\$65,000	
Lack of NPHI capacity in Research, Data Visualization, and M&E	NPHI staff updated NPHI website with HIV data visualization figures: HIV prevalence, KP size, ART treatment, number of ART patients, number of MAT patients	Training package for data visualisation developed	2 data visualization courses for NPHI staff conducted	# of data visualization courses conducted	Conduct data visualization courses for NPHI staff	HVSI	\$50,000	UCSF	13. Epid &Health Data: 5.7	1,2,3	\$50,000	
Lack of NPHI capacity in Research, Data Visualization, and M&E	NPHI M&E team developed list of M&E indicators to be collected from regions to track implementation of Test and Start	Training package for M&E courses developed for NPHI use 1 TOT for NPHI conducted	12 CH staff members trained in M&E, SI	#of CPH staff trained in M&E, SI	Conduct short term M&E, SI courses for NPHI at UCSF	HVSI	\$130,000	UCSF	13. Epid &Health Data: 5.7	1,2,3	\$130,000	
Develop and pilot cascade of services model for KPs		PWID and PLHIV enter the cascade of services from first and secondary of health care				OHSS	0	RESPECT ends in September 2017	6. Service Delivery: 5.0	N/A		
Integrate and scale up HIV prevention services into the narcology clinics		HTC yield of PWIDs increased and PWIDs have access to prevention services, including MAT				[REDACTED]	[REDACTED]	[REDACTED]	6. Service Delivery: 5.0	N/A		
Laboratory												
Lack of lab strategy	Laboratory Policies implemented at HIV National Reference Lab and 12 regional labs	Laboratory Policy developed by TWG NPHI institutes laboratory policy and strategy developed for HIV rapid tests	90% of 12 pilot sites successfully passed EQA program	# of community testing sites enrolled and successfully passed EQA	Support of EQA for HIV rapid tests done by providers at community level Support for the development of Laboratory Policies and Strategies for NPHI	HLAB	\$60,000	ASM	10. Laboratory: 6.2	1,2,3	\$60,000	
Lack of legislation for HIV testing by lay providers	HIV testing by lay providers is officially recognized and 22 NGOs in 12 PEPFAR regions implemented HIV testing	National frameworks developed allowing to recognize HIV Testing performed by lay providers as a medical testing	National frameworks endorsed allowing to recognize HIV Testing performed by lay providers as a medical testing	# of regulations/ national framework documents developed allowing to recognize HIV testing performed by lay providers as a medical testing	Provide TA for NPHI on implementation TEST and START strategy, HIV self-testing management Development of Framework institutionalize HIV testing by lay providers	HLAB	\$70,000	ASM	10. Laboratory: 6.2	1,2,3	\$70,000	
Need for NRL reconstruction	Report for NRL assessment analyzed and action plan to address gaps developed	Assessment tool for NRL assessment developed	NRL assessment performed	#of assessment tools for NRL assessment developed Report for NRL assessment released	Support for NPHI and contract HDR Architecture to provide an assessment of the HIV/AIDS National Reference Laboratory	HLAB	\$70,000	APHL	10. Laboratory: 6.2	1,2,3	\$70,000	

Lack of capacity at regional and national labs	Staff of 100% of regional and national labs are utilizing HIV testing algorithms, laboratory management and quality assurance practices	35 representative from national labs trained on HIV testing algorithm	12 regional labs used new testing algorithm in practical work	# of trainings on HIV testing algorithms conducted	Trainings on HIV testing algorithms, laboratory management and quality assurance	HLAB	\$10,000	APHL	10. Laboratory: 6.2	1,2,3	\$10,000	
Lack of strategy/framework for Public Health Lab	Public Health Lab Strategy/framework document is officially approved	One Strategy/framework document on Public Health Lab Strategies/planning developed	One Strategy/framework document on Public Health Lab Strategies/planning endorsed	# of strategy/framework documents on Public Health Lab Strategies/planning developed	Public Health Lab Strategy/framework document development	HLAB	\$20,000	APHL	10. Laboratory: 6.2	1,2,3	\$20,000	
Development of laboratory Policy and Strategy for NPHI	Public Health laboratory network organised  PHL network scheduled quarterly meetings	2 trainings aimed at the laboratories network capacity building performed	2 additional trainings aimed at the laboratories network capacity building performed	# of laboratories network capacity building activities implemented	Build capacities of Public Health Laboratories network	HLAB	\$100,000	APHL	10. Laboratory: 6.2	1,2,3	\$100,000	

Strategic Information

Lack of/ low capacity within GoU for data and analysis.	NASA institutionalized at MOH/NPHC and implemented annually without international TA; MOH/NPHC is able to analyse NASA results for AIDS program review and adjustments	NASA Electronic tool piloted and institutionalized at NPHC.	NASA electronic tool developed and tested.  NASA electronic tool transferred to the MoH/NPHC.	NASA tool is fully institutionalized under NPHC umbrella.  # of staff in NPHC, PH Department of MoH trained in utilizing and analysing NASA for the AIDS program review and adjustments	TA provided to analyse NASA results for AIDS program review and adjustments  Support to institutionalize NASA electronic tool for national use.	HVSI OHSS	85,000 100,000	HSS-SHARe	14. Financial/Expenditure Data 6.3 7. HRH 5.0	1,2,3	\$185,000	
Lack of capacity and use of data visualization	Specific visualizations created/published by NPHI team at the NPHI website, at 12 AIDS regional centers websites	To be awarded in April 2018	25 person trained on data visualisation  Data visualisation training package developed  Data visualization improved and supported	# of trainings for data visualization  # of visualizations published on NPHI site	Training for NPHI on Data visualization	[REDACTED]	[REDACTED]	[REDACTED]	13. Epi and Health data 5.7	1,2,3	[REDACTED]	
	Develop online national SI-resources. COMPLETED in COP16.		National online HIV-Resource portal created at UCEDEG/NPHC. Achieved by October 2017			HVSI OHSS	0	RESPOND and HIVRIA will complete this work by October 2017.	13. Epi and Health data 5.7	N/A		

Systems Development

TOTAL							\$2,260,000				\$1,610,000	

							<b>Total Site and Above Site Funds (Column H)</b>		<b>\$15,811,699</b>		<b>Total Above Site Funds (Column M)</b>		<b>\$10,429,928</b>
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