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OPTIMIZATION OF HIV/AIDS SERVICES WITHIN THE CONTEXT OF HEALTH CARE REFORM IN UKRAINE

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OPTIMIZATION OF HIV/AIDS SERVICES WITHIN THE CONTEXT OF HEALTH CARE REFORM IN UKRAINE

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
CD4+	Cluster of Differentiation 4
FPs	Family Practitioners
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IDU	Injecting Drug Use
LFTs	Liver Function Tests
MARP	Most At-Risk Population
MAT	Medication-Assisted Therapy
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
NGO	Nongovernmental Organization
NAP	National Action Plan
PHC	Primary Health Care
PSM	Procurement and Supply Management
PLWHA	People Living with HIV/AIDS
STD	Sexually Transmitted Disease
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
VHRPT	Very High-Risk Persons for HIV Transmission
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WIRRAL	Test for Syphilis

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EXECUTIVE SUMMARY

In response to a request from the United States Agency for International Development (USAID)/Ukraine Mission, an assessment of the Ukrainian health system was conducted to identify strengths and weaknesses and develop recommendations focusing on HIV/AIDS, tuberculosis (TB), and family planning in 2011. In early 2012, a second assessment was initiated by USAID and the World Health Organization (WHO) to evaluate potential risks and opportunities for the effective delivery of HIV/AIDS services in the context of health care system reform currently underway in Ukraine and identify key performance indicators that could be applied to monitor the performance of contracted providers. The assessment team interviewed a wide range of stakeholders at local, national, and international levels in Kyiv City and in two pilot regions: Vinnytsia and Donetsk oblasts.

The HIV situation in Ukraine is still in transition. HIV prevalence has stabilized at approximately 0.64 in adults aged 15-49 with approximately 21,000 new HIV cases being reported in 2011(Ministry of Health Ukraine 2012). Based on anecdotal evidence and some modeling, it is clear that a significant proportion of the HIV-positive population who need antiretroviral drugs (ARVs) is not getting them for a multiplicity of reasons. These individuals are now at high risk for transmission since their disease is progressing with eventual increases in viral load which increases the probability of transmission.

Simultaneously, yet completely separate from HIV/AIDS activities, health care reform efforts have been underway in Ukraine since 2010 that focus on strengthening primary health care (PHC) and restructuring secondary care levels in Kyiv City and in Donetsk, Dnepropetrovsk, and Vinnytsia Oblasts. Health reforms include the separation of PHC and secondary level care, e.g., establishing PHC centers (instead of polyclinics) with family practitioners (FPs) and moving narrow specialists to secondary care level diagnostic centers (previously these specialists were part of polyclinics). The flow of funding has also changed. PHC centers are now funded by the local and city budgets while secondary level care is funded by oblast budgets. Provider payment mechanisms at the PHC level were changed in 2012 by introducing outcome-oriented mechanisms (performance-based payments) to improve the quality of care through the motivation of health professionals, although none of the currently monitored outcomes are HIV related.

HIV/AIDS service delivery is now structured to treat patients in a "specialized" way; however, the disease process does not need specialization (or specialists) during most of its course. Currently, an HIV-associated patient has all of his or her health needs met by a vertical and "specialized" system, from the patient's initial desire to obtain an HIV test to the patient's end-of-life care. This increases HIV related stigma among the Ukrainian medical community and the general public. The current overly specialized HIV/AIDS care delivery system not only increases the stigma associated with the disease, it provides barriers to medical care as patients have to travel further distances for care they could most often have received at their local PHC center if certain conditions were met.

The over-reliance on "specialization" also has a negative consequence in terms of financing and the overall sustainability and quality of care levels associated with the current HIV/AIDS response. Data from the three AIDS Centers visited during this assessment indicate that there has been a marked stabilization of funding for AIDS Centers in the past five years. The financing of HIV/AIDS prevention and treatment services takes place at national, oblast, and rayon levels in pilot health reform settings according to the following parameters:

- PHC is funded by rayon- and municipal-level budgets
- AIDS Centers and Trust offices are funded by oblast-level budgets
- Most Trust offices currently are funded and managed at rayon level
- HIV/AIDS framework law does not encourage transfer of HIV status information among levels of care

The above-mentioned situation does not result in any incentive (or legal framework) for proper referral of cases from either the PHC level to specialized services (i.e., AIDS Centers and Trust offices) or from specialized services to the PHC level. In sum, the current financing setup of HIV/AIDS care is a disincentive for the integration of HIV services among PHC centers, Trust Offices, and AIDS Centers. As important, there are no current health reform activities that address changes to the financing of HIV/AIDS care that would enable better integration of care.

The literature review and interviews conducted for this evaluation point out that the government of Ukraine has been progressive in terms of financing for HIV/AIDS treatment, especially for much of the care delivered by the AIDS Centers and Trust Offices, and for the distribution of ARVs. However, it is the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and nongovernmental organizations (NGOs) that have been charged with reaching out to very high-risk persons for HIV transmission (VHRPTs)[1]. The assessment revealed that many NGOs that work with MARPs do not trust PHC facilities; therefore, they work directly with AIDS Centers. On the question of how they envisage themselves after Global Fund support ends, many of the NGOs do not have idea plan. Many interviewees predicted that most NGOs active in the HIV/AIDS area will be closed once Global Fund monies are exhausted. Various government health officials were asked the same question about the future sustainability of these NGOs, and several suggested that a mechanism for funding the NGOs is needed and one potential mechanism could be state service provision grants and private organizations in the country.

Many of the NGOs interviewed stated they felt that the Government of Ukraine should take more responsibility in providing funds for MARP-focused activities that NGOs currently provide via a social service provision contract/order. The social provision contract/order mechanism is in place within the Ministry of Science and Education, Youth and Sports. In fact, there are a few precedents where NGOs received funds for their MARP-focused activities through this social service provision. Thus, there are no legislative barriers for NGOs to apply for such a provision, although the procedures are quite complicated and unclear. Much confusion exists about the role, funding, and minimum requirements of the social service provision contract with more than one respondent mentioning that the mechanism is flexible and "there is money to fund it."

In conclusion, the current HIV/AIDS health care delivery system in Ukraine has had many successes and, for the most part, the HIV epidemic is still concentrated and somewhat stable. There are several threats to the system: one is that the many at-risk persons (including VHRPTs like long-term injecting drug users) are still not entering treatment, which would reduce their viral load and thus ability to transmit. Opportunities have been missed, and in the future there will be further missed opportunities to reduce HIV transmission among VHRPTs because of the possible diminishment of Global Fund monies. There are other program design issues that need to be considered as VHRPT needs are often unique and need to be met by more outreach focused care. In addition, current VHRPT focused programs need to be better integrated with narcology centers, TB centers, prisons, etc. Much of the "specialized" care that is currently being delivered by AIDS Centers and some Trust Offices could easily be delivered by the ordinary PHC parts of the system (and by the newly created diagnosis centers where there are no AIDS Centers). Significant cost savings could be realized if these reorientations were to take place. These cost savings could be used to fund needed VHRPT-focused programs in the absence of diminishment of Global Fund monies. This assessment concludes by providing examples of what aspects of current HIV/AIDS services could be delivered by which parts of the health care system using current health care reforms as the template for the examples. In addition, an extensive discussion is offered on what efficiency-gaining tools could be used and the obstacles and opportunities of using such tools to reorient the system.

[1] For the purposes of this discussion, a VHRPT is someone who knows he/she is at serious risk for contracting HIV, continuously engages in risky behavior, or may be HIV positive and not on ARVs or have not yet been clinically staged. For this report, a MARP (whose grouping includes VHRPTs as a subgroup) is defined as someone who exhibits risky behavior (although perhaps not continuously) ,such as the following: (1) occasional intravenous drug use, (2) occasional non-intravenous drug use that resulted in risky unprotected sexual encounters, (3) occasional unprotected commercial sex, and (4) temporary social marginalization.

The assessment team developed a set of recommendations, which include expanding the role for AIDS Centers, Trust Offices, and FPs within the context of current health reforms. It should be noted that the recommendations are categorized according to short- (1–2 years), medium- (2–5 years), and long-term (5+ years) criteria. Key components for any alignment of current health care reform efforts with HIV/AIDS service delivery, confidentiality, and financing needs include expanding the role of AIDS Centers to become more of a mentor/coordinator for PHC HIV efforts and adding a grants organizer/manager for NGO and VHRPT efforts (especially through social service provision contracts).

A draft version of this report was presented and discussed at two round table workshops held July 3 and 4, 2012 in Kyiv to validate the findings of the assessment and discuss the recommendations and next steps with regional and national health sector stakeholders. See Annex C for the workshop agenda and complete list of participants. The more than 35 round table participants hailed from national health institutions, international partners such as UNAIDS, the World Bank, and WHO, as well as regional representatives from Chernigiv, Dnepropertrovsk, Donetsk, Zakarpattia, Cherkasy, Vinnystia, and Kyiv City. Participants validated the findings of this report, and determined the following priorities for national level attention:

1. Address legislative issues related to transferring information on HIV status for clinical purposes
2. Develop guidelines for HIV/AIDS patient management by level with enough flexibility for regional variations
3. Build the capacity of primary care level to address prevention and basic HIV/AIDS care
4. Investigate alternative ways to procure at the oblast level testing and diagnostics materials
5. Add HIV/AIDS indicators to PHC performance incentives
6. Enhance the role of AIDS Centers
7. Leverage social order grants, Social Services and NGOs for outreach services

On July 4, 2012, the Ministry of Health, the State Services on HIV, TB and Other Socially Dangerous Diseases, and local HIV experts agreed to launch a working group for optimizing HIV services. According to Olena Yeshchenko, the Deputy Director of State Services on HIV, TB and other Socially Dangerous diseases, the proposed expert working group will further identify roles and adapt this report's recommendations into action.

1. BACKGROUND

The prevalence of HIV/AIDS in Ukraine is one of the highest in the Commonwealth of Independent States and throughout the European region. Between 1987 and 2011 there were 202,787 cases of HIV infection officially registered among the citizens of Ukraine, including 46,300 AIDS cases and 24,626 deaths from AIDS-related diseases (Ministry of Health Ukraine 2012). In 2011, there were 21,177 new cases of HIV infection that were officially registered. The HIV/AIDS epidemic is characterized as concentrated mostly among those belonging to groups at high risk of infection. Hence, injecting drug use remains the main mode of transmission for HIV (54.4 percent of new cases). A breakdown of epidemics by regions shows that transmission is concentrated in the cities. In 2011, 77 percent of new HIV-infection cases were registered among the urban population (Ministry of Health Ukraine 2012).

Health care reform in Ukraine began in 2010. The goal of the first stage is to test a streamlined model of health care by launching pilot projects in select regions. Full-fledged health care reform is planned for 2013 and the pilot will be completed by the end of 2014. The first three regions selected for testing the new model are Donetsk, Dnepropetrovsk, and Vinnytsia Oblasts. Later in 2011, Kyiv City was added as a reform pilot area. The plan was that the first year of the pilot would be devoted to restructuring the medical network and preparing all the necessary legislative and regulatory adjustments associated with changes in the funding system. A major goal of reform has been achieved in that primary health care (PHC) is now funded by rayon (district)-level funding and, for the most part, has a distinct management structure. Furthermore, a system of diagnostic facilities, which will incorporate much of the specialized care within the former polyclinic system, is being created. Correspondingly, the PHC level is being staffed by family practitioners (FPs) who have undergone either a six-month refresher course or the 18-month original course in family practice. The medium-term vision of health care reform will be to provide an optimized plan for contractual relations between and within a given region and health care facilities. It should be noted, scant information has been given to the public about health reform and there is confusion as to what it actually means.

The Government of Ukraine and many donors recognize that HIV infection is one of the leading health care problems in Ukraine. The situation is threatened by generally unchanging HIV prevalence levels (but unknown incidence levels) and, as reported by numerous injecting drug use (IDU)-focused nongovernmental organizations (NGOs), a substantial number of IDUs who are not being treated due to insufficient availability of substitution maintenance therapy. Because of these HIV threats and the opportunities of ongoing health reform activities, the United States Agency for International Development (USAID)/Ukraine Mission requested a health systems assessment to identify strengths and weaknesses in the Ukrainian health system and develop recommendations focusing on HIV/AIDS, tuberculosis (TB), and family planning themes. The assessment was implemented by the USAID-funded Health Systems 20/20 project. This report represents the second phase of the assessment that evaluated potential risks and opportunities for the effective delivery of HIV/AIDS services in the context of health care system reform currently underway in Ukraine. The second phase also identified key performance indicators that would be applied at the PHC level to monitor the performance of contracted providers.

It is important to assess potential risks and opportunities for the efficient integrated delivery of HIV/AIDS services in the context of the health care system reform. Current health reform efforts are directed toward the PHC level and hospital districts' development. The risk is that specialized services like HIV will lose their capacity and the PHC level will not be ready to pick up HIV/AIDS services. For example, Trust Offices formally belong to the rayon's or oblast's (region's) facilities but technically report to the National AIDS Center. In other words, rayons are paying salaries and maintaining the Trust Office facilities, while the AIDS Center coordinates its services and funds supplies of antiretrovirals (ARV), testing of pregnant mothers, and testing of blood donors. Another example is from the pilot reform oblast of Donetsk, where doctors have been motivated to move from working in Trust Offices to working in PHC centers, yet it is

unclear whether they will continue to receive training and support to offer any HIV services in the PHC centers.

As a result of these and other risks to providing HIV care in an efficient manner and considering current health reform efforts, the World Health Organization (WHO) initiated technical assistance to Zakarpattia Oblast to strengthen HIV testing and counseling (HTC) services. In addition, WHO has developed and piloted provider-initiated testing and counseling guidelines in Odessa Oblast. Both initiatives are implemented with USAID funding. WHO is utilizing a health systems strengthening approach and combining program strengthening with addressing HTC systems more broadly. WHO and USAID believe there is a need to address different HIV services in a systemic way; otherwise, it is not possible to improve the quality or delivery of the services and improve access to HIV services.

In addition, in Zakarpattia WHO initiated an assessment of the Trust Offices network's legal and financial conditions in order to prepare the Trust Offices to become subordinate to the oblast's AIDS Center. Without financial contribution to the rayon's Trust Offices, the AIDS Center has little influence on the Trust Office's performance and the quality of its services. Further, WHO has worked in Zakarpattia Oblast to look at some of the cost-efficiency and financing implications of the current Trust Offices operations in the oblast.

2. OBJECTIVES

The main objectives of this assessment are the following:

- Identify approaches to strengthen and modernize HIV/AIDS services in the context of the health care system reform in Ukraine.
- Explicitly consider rational integration of services
- Develop key performance indicators for oblast-level HIV service providers and the AIDS Center to prepare them for possible contractual relationships with oblast (region) and rayon (district) level governments.

In addition, research instruments address the following:

- Which institution is best positioned to provide what specific HIV services (between AIDS Centers, Trust Offices, and PHC centers; other NGOs doing prevention/outreach to MARPs; and other organizations)?
- What is the best form of ownership (of AIDS Centers and Trust Offices)?
- How should services be contracted, through what mechanism, and who should fund it?
- How can appropriate and effective coordination and referrals among service providers be ensured?
- How can quality services be ensured and sustained?

The scope of this assessment addresses improving the efficiency and effectiveness of HIV/AIDS care within the context of current healthcare reform efforts. While there is opportunity to improve HIV/AIDS care in Ukraine that are not linked to current healthcare reform efforts (for example, improving HIV test integration with current sexually transmitted infections services) these improvements are not within the scope of this evaluation. Another example of the limitations of this assessment is in regards to improving HIV detection and HIV/AIDS treatment options within the Ukrainian penal system. Relatedly, this assessment does not address important systemic topics such as the overall deficit of family practitioners, high levels of HIV stigma in the general population, and overall health care system financing reform.

3. STUDY DESIGN AND METHODOLOGY

To achieve the objectives identified in this assessment, a desk review of existing documents was applied. Based on the documents reviewed, the following hypotheses were proposed:

- General health reform programs have begun to be piloted in three regions (Donetsk, Dnepropetrovsk, and Vinnytsia) and in Kyiv City since 2011; however, HIV/AIDS themes are not included in the health reform program.
- The hierarchy of the HIV/AIDS system is almost strictly "vertical" in nature.
- The role of PHC providers in the provision of HIV/AIDS services is practically nonexistent.
- The role of AIDS Centers and Trust Offices could be optimized based on the WHO assessment in Zakarpattia Oblast.
- Much of the funding specifically targeting MARPs and, most importantly, very high-risk persons for HIV transmission (VHRPTs) is at risk since it currently comes from the Global Fund and that funding may decrease in the medium term.
- A state mechanism should be in place to fund the gaps in HIV/AIDS programming in Ukraine.

To test and investigate the above-mentioned hypotheses in depth, five research tools were developed – all semi-structured questionnaires. These questionnaires were administered to the key informants at the national level and rayon/oblast levels. At the oblast level, focus groups involving local- and regional-level staff were formed, and the same semi-structured research tools were applied within these groups. In total 16 interviews and 6 focus groups were carried out at the national and local/regional levels, and the following types of interviewees were included:

- Five national-level HIV officials from the Ministry of Health (MOH), especially from the State Services on HIV, TB, and Other Socially Dangerous Diseases.
- Roughly 15 oblast-level and municipality-level health administration staff located at institutions such as the Ukrainian AIDS Center (in Donetsk Oblast, Vinnytsia Oblast, and Kyiv City)
- More than 15 PHC facility directors and FPs
- More than 5 AIDS Center directors and Trust Office staff
- More than 15 HIV/AIDS NGO representatives (including from the Rinat Akhmetov Foundation, Alliance Ukraine, and Network of PLWHA)
- Approximately 5 members of bilateral and multilateral international aid organizations (e.g., the Joint United Nations Programme on HIV and AIDS [UNAIDS], WHO, World Bank)

The research tools were extensively discussed with relevant HIV/AIDs experts in Ukraine and also from the region. During the visits of PHC health facilities and AIDS Centers/Trust Offices, the health facility infrastructure and equipment, including laboratories, were shown to the assessment team.

The key informant interviews and focus groups were carried out in Kyiv City and in two regions – Vinnytsia and Donetsk. The rationale for sampling these three localities is that these settings are pilot regions where the process of reforming the health system could begin within the framework of a decree from the National Action Plan (NAP) Economic Reforms Program entitled "Prosperous Society, Competitive Economy, Efficient State for 2010–2014" (#187/2012), which was approved on March 12, 2012. The intention was to test, verify, and investigate the above-outlined hypotheses in these three pilot health

reform settings to develop recommendations on strengthening and modernizing HIV/AIDS services and developing key indicators for monitoring performance of HIV/AIDS services. To obtain an information-rich sample, PHC facilities and NGOs were purposively selected based on regional health administrations' and AIDS Centers' recommendations.

4. FINDINGS

4.1 STEWARDSHIP/LEGISLATION

In 1991 Parliament passed the Law on the Prevention of AIDS and on Social Protection of the Population, and in 1992 the first national program on AIDS prevention was launched in Ukraine. To date, six national programs on HIV prevention, care, and treatment of people living with HIV (PLWHA) have been launched in Ukraine. Within the framework of the fifth national program, an earmarked fund was provided that covered 90 percent of the projected financial requirement for HIV/AIDS prevention and treatment programs (Lekhan et al. 2010). This program received funding from state and local budgets, a loan from the World Bank, and a grant from the Global Fund. AIDS Centers were created throughout the country to carry out epidemiological monitoring and control; clinical and laboratory diagnosis of HIV/AIDS and opportunistic infections; the organization and provision of necessary types of medical, psychological, and social help for PLWHA; and the training of medical staff about HIV/AIDS. However, the interaction between these centers and general health care facilities has been rather weak.

The current (sixth) national program on Prevention, Treatment, and Support for HIV/AIDS Patients (2009–2013) (Law of Ukraine No. 1026-VI, issued February 19, 2009) is a multifaceted program. The current program promotes a complex approach to fighting the epidemic, including the evaluation and monitoring of the epidemic, mass education on HIV/AIDS, primary prevention, and steps on fighting HIV/AIDS among high-risk groups. The sixth national program does the following:

- Creates effective working conditions for public organizations responsible for HIV prevention
- Strengthens the rights of HIV/AIDS patients
- Provides universal access to high-quality care, support, and treatment for HIV patients
- Launches a heroin-substitution program, medication-assisted therapy (MAT), in order to draw IDUs to ARV therapy.

The detailed list of associated legislative documents is provided in Annex A.

In the beginning of 2010, the government of Ukraine started the process of reforming the health system and on March 12, 2012, the president of Ukraine approved a decree from the NAP Economic Reforms Program entitled "Prosperous society, competitive economy, efficient state for 2010–2014" (#187/2012). It includes activities that should be undertaken within the health sector within three pilot regions (Donetsk, Dnepropetrovsk, and Vinnytsia) and (later) Kyiv City. These reforms are mainly directed toward strengthening PHC and introducing new payment mechanisms at the PHC and secondary health care levels. During this assessment, it was revealed that health reforms have launched but are at different stages in all three regions and in Kyiv City (which was subsequently added to the reform sites). The assessment team found that HIV/AIDS services have been left out of scope of current health reforms.

According to the stakeholders interviewed for this study, the official job description of FPs covers a broad range of services, including general internal medicine, pediatrics, obstetrics/gynecology, family planning, reproductive health, TB, HIV/AIDS, health education, and sanitary−epidemiological services. However, the assessment team revealed that that there is a gap between the official job description and the real services

provided by FPs. As one FP reported, one reason for this is, *"…the responsibilities of FPs in the official job description are poorly defined and the required knowledge and skills are not well delineated.*"

Another issue is that the current list of performance-based indicators developed as incentives for FPs does not include any indicators related to HIV ("Procedure about identifying incentives for the volume and quality of work performance by the PHC providers in pilot oblasts", Regulation of Cabinet of Ministers of Ukraine, #209, March 5, 2012). Therefore, there is a need to expand the current PHC reform-based incentive program to include a broader list of performance-based indicators, including HIV/AIDS.

Information sharing within Ukraine is regulated based on several general and public health legislative documents, such as the following:

- Constitution of Ukraine: Article 32
- Law of Ukraine 2 "About Information" (Articles 5, 6, 10, 11, 18–21)
- Law of Ukraine "About Access to Public Information" (Articles 7, 9, 10)
- Law of Ukraine "About Protection of Personal Data" (Articles 4–17, 19–21, 24, 25, 27, 29)
- "A Typical Procedure for the Processing of Personal Data in Databases of Personal Data", approved by the Ministry of Justice of Ukraine № 3659/5 (paragraphs 1.5 - 1.12, 2.1 - 2.5, 3.1, 3.2.), dated December 30, 2011.
- Civil Code of Ukraine (Articles 285, 286)
- Basic laws of Ukraine about public health (Articles 39, 39.1, 40,78)
- Law of Ukraine "On prevention of spread of diseases caused by human immunodeficiency virus (HIV), and legal and social protection for people living with HIV" (Articles 6–9, 11, 13).

Based on these legislative documents the patient has the right to privacy concerning his/her health status, to seek medical assistance including diagnosis, and to receive information about his/her medical examination. More specifically to HIV status confidentiality, Article 6 of the Law of Ukraine "On prevention of spread of diseases caused by human immunodeficiency virus (HIV), and legal and social protection for people living with HIV" outlines that there are "… *results and possible consequences of under-conditions of confidentiality of personal data, including data about the health of individuals…."*

Article 9 of the same law goes on to state the following: *"…registration, record keeping about people living with HIV receiving treatment and epidemiological surveillance of HIV infection are carried out under conditions of confidentiality of personal data, including on health, respect for individual rights and freedoms, certain laws and international treaties of Ukraine ratified by the Verkhovna Rada of Ukraine…."*

The actual result (whether intended or not) of the interpretation of above-mentioned legislation is that AIDS Centers and Trust Offices that are responsible for carrying out HIV testing are not allowed to record, store, use, and disseminate information unless the individual involved allows them to share the information. This inhibits the ability of the health system to offer a rational continuum of care for HIV-positive individuals. However, another statement in the same article in the same law states: "*...procedures for the registration of people living with HIV and those receiving medical treatment are determined by specially authorized central executive body in health….*" According to legislation based in Ukraine, the central executive body in health is the MOH, meaning that there is a possibility to insert some amendments to this law that would allow the sharing of information among PHC providers, AIDS Centers, and Trust Offices.

4.2 SERVICE DELIVERY – A DISCUSSION OF REMAINING VERTICAL OR MOVING TOWARD RATIONAL INTEGRATION

Ukraine's system for addressing HIV/AIDS is generally considered to be somewhat successful due to its rapid start up and commitment from the government, especially in purchasing ARVs (Tarantino et al. 2011). Yet, there are "holes" in the response, as many interviewees reported that only 50–60 percent of those who should be on ARVs are actually on ARVs. Almost all NGO interviewees reported that VHRPT, such as some IDUs, may or may not know their HIV status, but they are not coming in for clinical staging and ARVs if needed. Getting these VHRPTs on treatment is an effective way of reducing HIV transmission through reduction in viral load. Interestingly, a recent WHO, UNAIDS, and Ukrainian State Services report (based on modeling) indicated that although more than 26,000 persons were on ARVs at the end of 2011, this represented only 22 percent of those who actually needed ARVs (Ukrainian AIDS Prevention Center (MOH of Ukraine) and SI "Institute of Epidemiology and Infectious Diseases 2011).

Another point to consider is that the current Ukrainian response to HIV was implemented under a huge epidemiological and societal strain. As occurred in many countries responding to a concentrated epidemic "inching" toward a generalized epidemic in which HIV discrimination was rife, the Ukrainian response to HIV was designed in a very vertical way. This vertical design was necessary in order to make certain that the epidemic was contained to a concentrated setting and that HIV-positive individuals needing ARVs were put on ARVs in a timely fashion.

As the HIV epidemic matures in Ukraine, the health system response to HIV/AIDS needs to mature as well. That maturation can take place by optimizing the health system response whereupon those patients who need specialized HIV/AIDS prevention and treatment delivered through either oblast or city AIDS Centers and Trust Offices receive such services. It should be noted that some Trust Offices provide not only voluntary counseling and testing (VCT), but also provide treatment through first-line ARVs, especially in nonurban areas ("advanced" Trust center). A brief snapshot of how verticalization and specialization has taken hold is indicated by the following current VCT practice:

- A person can choose to go for HIV testing either at a Trust Office within a PHC center or at the oblast/city AIDS Center.
- If a person comes to an FP for a regular check-up or with any disease, and if either the patient or FP has any suspicion of HIV, then the FP has to recommend the patient go to the closest Trust Office for HIV testing, according to the order of MOH of Ukraine № 1141 "About procedure for testing for HIV – infection and quality of research" dated December 21, 2010.

When a patient is referred to a Trust Office for testing, his/her test results cannot be shared with the referring PHC-level physician according to the Law of Ukraine "On prevention of spread of diseases caused by human immunodeficiency virus (HIV), and legal and social protection for people living with HIV" (Articles 6–9,11,13). All interviewed FPs mentioned that *"AIDS Centers don't share any information about HIV-positive patients with the FPs; consequently, the FPs don't know if referred patients went for HIV testing or not, and what his/her status.*" In fact, the Donetsk AIDS Center requested a clarification on this matter from the MOH.

Another good example of how HIV services are delivered in a vertical and specialized manner is shown in Box 4.1. For the most part, once identified as HIV positive, a patient enters the specialized HIV/AIDS care system, whether within the city/oblast AIDS Center or the Trust Offices.

In Vinnytsia Oblast, a patient can get a wide variety of treatment at an oblast AIDS Center, as it has physical therapists, dentists, obstetricians, gynecologists, pediatricians, and other health care providers. In fact, the

Box. 4.1: The Role of Regional AIDS Centers Today

- Provide ARVs
- Monitor HIV-positive patients and the need for ARVs or change in ARVs
- Provide HIV VCT in coordination with on-site Trust Offices
- Provide specialized diagnostic and laboratory investigations
- Meet the vast majority of HIV-positive patient's non-HIV-related medical and dental needs

HIV-positive patient is now separate from the other parts of the health care system; therefore, non-HIV specialists know relatively little about the lives of PLWHA, and the general public is also shielded from HIV-positive individuals. This only reinforces discrimination of PLWHA among the medical community and the general public. The actual physical placement of AIDS Centers on the outskirts of town also reinforces this discrimination, not to mention the inconvenience to the HIV patient who has to travel farther to receive treatment. As an example, one interviewee in Vinnytsia Oblast stated: *"A few days ago my neighbor saw her friend's husband entering an infectious disease doctor's room (at oblast AIDS Center) and I have thought why he is visiting that doctor, he might have some STD or it might be something else."*

Relatedly, PLWHA often have little faith in any healthcare provider, but particularly in the ability of non-HIV specialists to treat even the simplest clinical complaint. PLWHA have been shunted to HIV specialized care since before they were diagnosed HIV positive and went to either the AIDS Center or Trust Offices for an HIV test. Nonetheless, two interviewees mentioned that they know HIV-positive people who go to their FPs for clinical treatment, but do not reveal their HIV status because, as they said, *"I know a couple of cases when an FP's behavior was discriminative toward an HIV-positive patient after he learned about the patient's status."* In another example in Kyiv City, an FP from one of the PHC facilities noted that approximately five PLWHA are registered at her catchment area and she treats them for other conditions, but if they need HIV-related treatment (e.g., refilling ARVs, dealing with complications, or needing lab work), then the patients are referred to AIDS Centers. Most tellingly about the current state of over specialization and verticalization of HIV care in Ukraine, the vast majority of contacts at the three AIDS Centers visited were for non-ARV-enrolled patients.

The inverse means that those patients who do not need specialized HIV/AIDS treatment services should get them at the PHC level. The benefits of reorienting the Ukrainian health system response to HIV as mentioned above are multifold and include a decline of HIV discrimination and a more cost-efficient use of scarce health system resources. An unintended byproduct of the non-integration of HIV prevention and treatment services in Ukraine is the separation of HIV-positive patients (and even patients who are not HIV positive but are at high risk) from the general population.

The crux of the situation is the term "specialized," which can have many meanings in the health system response to HIV. "Specialized" depends on a host of factors and will differ from oblast to oblast, rayon to rayon, PHC to PHC, and even Trust Office to Trust Office. In general terms, "specialization" should include the following parameters: confidentiality, availability of lab and auxiliary services, clinicians' skill, availability of ARVs, and access or knowledge of needed social services. Table 4.1 outlines some of the complexities when considering where to treat HIV-positive patients and those at risk. The table outlines four types of patients (including the setting in which they live) and outlines the realities of seeking treatment and care at various facilities where they are likely to seek care.

TABLE 4.1: Optimizing HIV/AIDS Health Care System in Ukraine

	Rural, Worked Seasonally in City, and had Numerous Sexual Partners	Urban, MSM, HIV-positive, Mild Disease	Urban, IDU, HIV-positive	Periurban, Young, Heterosexual, HIV-positive, Mild Disease
Confidential/no discrimination	PHC No Trust Yes NGOs Yes	PHC Yes AIDS Center/Trust Yes NGOs Yes	PHC No AIDSCenter/Trust partial NGOs Yes	PHC Yes AIDS Center/Trust Yes NGOs Yes
Good lab/auxillary?	PHC No Trust No (except test kits) NGOs No	PHC for HIV screen AIDS Center for CD4+, LFTs, WIRRAL, etc	PHC for HIV screen AIDS Center for CD4+, LFTs, WIRRAL, etc	PHC for HIV screen AIDS Center for CD4+, LFTs, WIRRAL, etc
HIV/AIDS-knowledgable clinicians?	PHC No Trust Sometimes	PHC 18-month FP training - basic HIV care (+/-ARVs) AIDS Center advanced HIV care	PHC Basic HIV care (no ARVs) AIDS Cntr advanced HIV care, but not harm reduction	PHC 6-month refresher training basic HIV care AIDS Center moderately advanced HIV care
Availability of ARVs?	PHC No Trust Sometimes	PHC possible AIDS Center yes	PHC No AIDS Center yes	PHC No AIDS center yes
Knowledge of social services?	PHC No Trust Yes NGOs Yes	PHC Possible AIDSCenter/Trust yes NGOs Yes	PHC no AIDSCenter/Trust partial NGOs Yes	PHC Possible AIDS Center/Trust yes NGOs Yes
Where "specialize"	At testing and staging if positive (Trust/AIDS Center)	At clinical staging and onset of ARVs (AIDS Center) otherwise possible PHC for ARV refill	Go to IDUs, where they congregate, prisons, etc. (NGOs and AIDS Center)	At clinical staging and onset of ARVs (AIDS Center) otherwise PHC for ARV refill

The VHRPT who is an IDU needs specialized care. This type of patient needs outreach and cannot be relied on to come into the AIDS Center, even if he or she knows he/she is HIV positive, as highlighted by one of the NGO representative in Donetsk City. By definition, the needs of VHRPTs are, at a minimum, intensive HIV prevention care and, in many cases, ARVs to reduce their viral load and reduce transmission probability. These are patients whose needs are only partially being met by many NGOs funded by the Global Fund.

There are multiple ways to attempt to increase the efficiency of the Ukrainian HIV/AIDs health care delivery system, and Table 4.2 summarizes the positive and negative aspects of these tools.

TABLE 4.2: Threats, Opportunities, and Needed Funding by Efficiency Change Tool

Tool	Incentives for Proper Care at PHC Centers and Referrals	Contracting Out Services for AIDS and/or Trust Offices	VHRP/Social Order Grants	Legislative/Legal Change
Threats	HIV confidentiality law Different funding source for referral points from PHC (rayon) to AIDS Cntr (oblast) Clinical care training More logistics (more clinics needing HIV test kits and ARV drugs)	Complicated to receive funds from other sources except the state Ownership Taking away power and money	Perception of no money available Perceived as cumbersome with too many minimal standards MARPs may not be favored clients for grants	Often have to go through Council of Ministers Upcoming ellections may make politicians conservative in near term VHRPTs not at top of political constituent list
Opportunities	Less stigma More sustainable Reduces geographical access barriers	Act as training centers Provide other methodological/ consultative support for PHC providers	Mechanism already exists and in use at local level Flexible There is funding for grants available	If oblast- or rayon-level is funding an initiative, legal and political changes less difficult than national-level funding
Additional Funding Needed?	Yes	No	Yes	No

4.3 FINANCING

The over-reliance on "specialization" also has a negative consequence in terms of financing and, therefore, on sustainability and quality of care. In general, a marked stabilization has occurred in the levels of government funding for some AIDS Centers. Those centers visited appeared to be either, at minimum, appropriately staffed and at maximum overstaffed. Some AIDS Centers slightly lacked needed equipment while others were overly equipped. ARV stocks appeared to be good at the AIDS Centers visited. A review of documentation and the interviews conducted revealed that while the Government of Ukraine has been progressive in terms of financing for HIV/AIDS treatment, it has been the Global Fund and NGOs who have been charged with reaching out to VHRPTs. With the potential halt in new funding from the Global Fund after 2016, the government of Ukraine is currently at a crossroads in terms of financing HIV services and has three options:

- Continue with an overly specialized system and devote more governmental resources to VHRPT prevention and treatment efforts through NGOs
- Keep on supporting an overly specialized HIV prevention and care system and do not devote more governmental resources to VHRPT prevention and treatment efforts through NGOS

- Begin to downsize, or at minimum keep the same amount in nominal terms funding for HIV/AIDS and Trust Offices and use any "saved" money from downsizing to enhance funding for VHRPT efforts through NGOs.

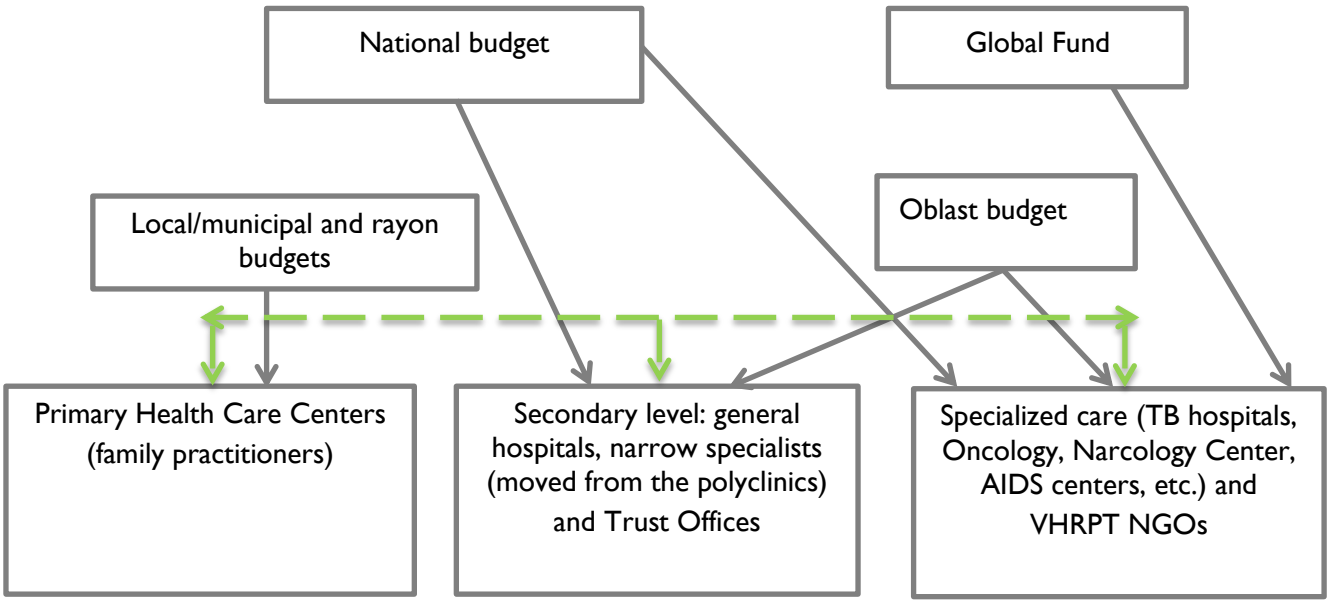
It is important to note that the scope of the Global Fund funding will decrease within the next three years. The second phase of Round 6 HIV for Ukraine (targeting prevention and treatment needs of MARPs) ends in July 2012 and approximately US$100 million will have been spent in the last two to three years, which equals approximately US$35 million per year. Round 10, Phase I has an approximate value of US$30–35 million a year and also is targeting prevention and treatment needs of MARPs and is scheduled to end in December 2013. These figures put the challenges the Ukrainian government faces into perspective.

Because the financing of HIV/AIDS prevention and treatment services are done at national, oblast, and rayon levels, there are opportunities to ascertain what option or mix of options presented above make sense. In fact, Figure 4.1 indicates the challenges and opportunities associated with the current financing of HIV/AIDS care in Ukraine. The gray solid lines in the figure indicate the "compartmentalization" of funding when optimum efficiency would be gained by integrating much more care among the green dashed arrows. In order to promote this rational integration of HIV care, the following should occur:

- Let PHC do more prevention, testing, and basic clinical non-HIV-related care for PLWHA and possibly do some ARV monitoring and refills
- Encourage "specialist" secondary care (i.e., newly created diagnostic centers) to address more complicated HIV/AIDS care (in absence of nearby AIDS Centers)
- Have Trust Offices do VCT in rural settings or where HIV confidentiality is questioned
- Motivate AIDS Centers to not only provide complicated HIV/AIDS care but also oversight and mentoring of the more decentralized HIV/AIDS care system
- Have AIDS Centers become better integrated and provide better integration coordination with other "specialist" centers such as TB centers, narcology centers, and the VHRPT-focused NGO community

In order for the gray arrows and green arrows in Figure 4.1 to exist together, changes need to be made to the HIV/AIDS health care system. An example of these changes were outlined in Table 4.2 according to described efficiency change tools.

Figure 4.1: HIV/AIDS Funds Flow



Moreover, in order to make the Ukrainian HIV/AIDS health care delivery system more efficient and sustainable, change needs to happen. This change will not happen in the abstract; tools must exist that can guide or motivate efficiency changes. These tools mentioned in Table 4.2 are in actuality somewhat dependent on each other. For instance, in Ukraine, incentives for change cannot exist unless some legislative or legal change occurs, as highlighted by an FP in Donetsk Oblast, *"If we get a Prikaz (executive order) to provide treatment for HIV positive patients then we ought to do it."*

As another example, an AIDS Center cannot be contracted out to provide good quality "specialist" care unless the AIDS Center can legally enter into a contract. Currently, governmental tax and the financial monitoring departments preclude the AIDS Centers from entering into contracts as either a supplier or recipient of nongovernmental funding/services. In response, an AIDS Center could be divided into a governmental and an NGO arm with the NGO arm able to receive funding from governmental and non-governmental sources. In fact, nearly all AIDS Centers have created NGOs under their informal supervision to receive funds from various sources other than government so that they can carry out prevention activities because funds from the state budget are limited and not earmarked for such activities. The point is any movement toward making AIDS Centers or Trust Offices a party within a contract necessitates a change in legal status; for example, changing to a communal not-for-profit enterprise similar to the events taking place in Zakrappatia Oblast.

The same concepts hold true for using incentives to motivate PHC centers to take more interest in providing HIV/AIDS prevention and possibly providing treatment services. The current PHC reforms do include a list of eight indicators for which PHC clinics can receive incentives, but none of these indicators are HIV/AIDS related (Procedure about identifying incentives for the volume and quality of work performance by the PHC providers in pilot oblasts, Cabinet of Ministers of Ukraine, March 5, 2012, 209). To change these indicators and still use national funding (which is the current source of incentives for health reform site PHC clinics) a legal change that would have to be approved by the Council of Ministers. This highlights the relationship between the various tools outlined in Table 4.2.

Another good example of where the interrelation of the tools needs to be considered is that PHC efforts in health reform areas are currently being funded by rayon-level budgets while AIDS Centers and Trust Offices are currently (or being planned in the immediate future) funded by oblast-level budgets. This presents difficulties as there is little incentive for proper referrals between PHC and oblast-level AIDS Centers and Trust Offices with specialist care. There are no financial incentive for either level to refer or

take care of patients' needs in a cost-efficient manner. For example, there is no incentive for PHC providers to take care of HIV/AIDS patients or even screen for HIV status in their usual patients because there are no incentive-based performance indicators related to HIV/AIDS in the health reform areas. Not to mention the lack of incentive-based performance indicators in non-health reform areas. From the perspective of rayon-level health finance departments, the current modus operandi would be to redirect the HIV/AIDS patient to oblast-level AIDS Centers/Trust Offices because then oblast-level funding could pay for the patient's needs.

The situation is further complicated in that the funding for specialist care in AIDS Centers and Trust Offices is based, in part, on the number of patients seen. Because of the Soviet Union's legacy of funding by hospital bed or by size of catchment area, the Government of Ukraine has little experience in funding by outputs. In order to reverse this trend, AIDS Centers and Trust Offices need to be incentivized to provide referrals "away" from "specialist" care *in addition to* providing good quality "specialist" care. These incentives need to be interlinked with efforts at the PHC level in order to provide good prevention, positive prevention, and basic treatment services according to agreed-upon definitions of what is non-HIV "specialized care" in the contexts outlined in Table 4.1.

Ideally the AIDS Centers and Trust Offices would achieve a legal status whereby they can enter into a contract with either oblast or rayon governments and they would be encouraged or paid directly for patients to receive appropriate "specialist" care and also would be either encouraged or paid directly to refer patients elsewhere for non-HIV "specialist" care. Relatedly, the PHC centers would need to add incentives (and indicators) that encourage HIV screening and, possibly, for taking care of basic HIV-positive patient needs.

In addition, if AIDS Centers begin to operate more autonomously, they could very well be contracted out by the rayon-level health departments to train PHC practitioners in the provision of HIV/AIDS prevention, screening, basic treatment, and needed social services. This would assist in ameliorating some of the perceived loss of control and power over the HIV/AIDS health care system. The AIDS Centers' role would be that of mentor and overall coordinator, and they could be funded according to these outputs (e.g., # of VCT trainings for PHC workers). In addition, the AIDS Centers' role could easily include distribution of HIV test kits and even a basic ARV drugs to the PHC level with the concurrent transfer of funds from rayon to oblast.

Yet another important example of how the gray arrows in Figure 4.1 are working against the optimizing green arrows is the example of Trust Offices. Currently, Trust Offices are mostly funded by rayon-level funding (receiving some national-level funding for training and test kits). Correspondingly, Trust Offices should integrate follow-up care with PHC levels in the case of HIV-negative individuals, and "specialist" AIDS Center care for PLWHA for initial staging of disease. The current system is irrational in that the Trust Office has little contact with the PHC level for follow up and reinforcement of HIV prevention messages for both HIV negative and HIV positive individuals (positive prevention programs). The lack of contact stems from the fact that the Trust Office is a specialized care center with no clear legal clearance to share HIV status with the PHC level.

A similar argument holds true for the lack of incentives for oblast-funded AIDS Centers to refer patients who currently do not need specialist HIV/AIDS care at the PHC level for a multitude of reasons. Chief among these reasons is the non-transportability of the patient's HIV status among various levels of the Ukrainian health care system, even with the patient's consent. It is perceived from a legal standpoint that a patient's HIV status cannot be shared between various levels of care (e.g., between a PHC or polyclinic and an AIDS Center). Part of this confusion arises from lack of appropriate HIV status disclosure legislation as outlined in section 4.1.

Furthermore, this irrational system is worsened by the fact that there is no financial or contractual incentive for the Trust Office to follow up on HIV-positive patients because they are referred to oblast-funded AIDS Centers (see Figure 4.1). Trust Offices are managerially, legally, and financially obligated to report to polyclinics and hospitals, but methodologically they get support from AIDS Centers. In fact, the

Trust Office, because it receives funding from the rayon level, currently reports to the rayon level, but needs to refer patients to the AIDS Center in order to stage newly diagnosed HIV-positive patients. There is no managerial, financial, or legal precedent for Trust Offices to appropriately refer HIV-tested patients either to PHC (no legal precedent for sharing HIV status) or to AIDS Centers in HIV-positive cases for staging (no singular management structure for referral and absolutely no financial incentive to appropriately refer). The work carried out with WHO in Zakrapattia points to the need for oblast-level AIDS Centers to have some management oversight over Trust Offices in order to ensure appropriate referrals, provide VCT training, and provide AIDS care training in the cases where Trust Offices treat HIV/AIDS patients.

In addition, once AIDS Centers are in a position of managing Trust Offices in their oblast, they could assist rayon-level authorities in optimizing the number and location of needed Trust Offices. In fact, many interviewees noted the overabundance and underfunding of Trust Offices throughout many areas of Ukraine, and their observations have been confirmed by recent research. It is the AIDS Centers who actually have a good handle on the demand for AIDS services oblast-wide and can thus be of assistance in determining the demand for HIV and VCT services across the oblast.

Another example of how interwoven these efficiency gaining tools can be is a description of the relationship between AIDS Centers/Trust Offices and VHRPTs (which exists through NGOs). Although many specialist centers have made great strides in making their centers VHRPT sensitive, there are still threats to access, especially with the potential decrease of Global Fund resources. The dynamic between "specialist" centers and VHRPTs needs to be strengthened. There needs to be an acknowledgement that HIV/AIDS services, especially getting VHRPTs on treatment, needs to "go where VHRPTs go." Indeed, an interviewee from Donetsk Oblast pointed out that the integrated Opioid Substitution Therapy, TB, and HIV Trust Office that exists is very well appreciated and used by clients.

Achieving this will require better integration of HIV/AIDS services in prisons, locations known to be frequented by IDUs, narcology centers, NGOs, and other areas high-risk individuals frequent. One way of accomplishing this would be to establish VHRPT/MARP-sensitive Trust Offices that have significant outreach capabilities. This means these "specialist" AIDS Centers would need to be more proactive and less complacent with treating non-VHRPTs for medical complaints that could easily be handled elsewhere. Many interviewees suggested that AIDS Centers should focus not only on providing mobile VCT services to drug "hot spots" but also on increasing their outreach response to include activities at prisons and concurrent HIV and harm-reduction outreach programs. In addition, HIV education, testing, and needle exchange programs where there is a "one stop" shop for harm reduction and HIV prevention and treatment need to be considered.

Most AIDS Centers are trusted by other government departments and NGOs. They are the natural candidates for acting as liaisons without reach services. These same AIDS Centers and Trust Offices, however, need to have the legal reforms, contractual mechanisms, and incentives to perform these new roles of mentor to PHCs and VHRPT outreach coordinators. Funding must also be considered. Certain legal reforms and governmental decrees are needed to create incentives and contract. Government commitment to broadening the ability of AIDS Centers and Trust Offices to focus on outreach will still be needed even when the aforementioned legal reforms and cost-efficiency tools are in place. Funding allocations should also take into account the needs of many of the VHRPT-focused NGOs in the event that Global Fund support decreases. The social order grant could be an ideal mechanism to support an AIDS Center (one that had its ownership modified or has been divided or had a subsidiary so it could enter into a contract) as a grant coordinating body similar to a Global Fund principal recipient for sub-recipients. These sub-recipients, potentially NGOs or other governmental bodies, could work with the AIDS Center to increase the accessibility of services for VHRPs.

Oblast/city AIDS Centers should have stronger links with the civil society. In particular, AIDS Centers should assist NGOs to source donor, private, or HIV public-private partnership funding opportunities. Perhaps more importantly, AIDS Centers could assist their specialists in getting involved in the formation of areas that may be financed from the state budget within the state social contract. In addition, the regional

AIDS Centers could monitor and evaluate the implementation of activities and projects, both within the framework of the state social contract and under the financing by international organizations.

The AIDS Centers are crucial to the process of health reform in Ukraine butheir role needs to change somewhat and they need to become more efficient. Uniformity existed in all AIDS Centers the authors visited in that all the chairs and secretariats for the HIV/AIDS coordinating boards were active in their oblasts. NGOs and other government partners trust these AIDS Centers, and they are a natural choice to have their role expanded such as outlined above.

4.4 SUMMARY OF OPPORTUNITIES AND THREATS TO HIV/AIDS SERVICE DELIVERY IN CONTEXT OF HEALTH REFORM

The Table 4.3 below provides a summary of the strengths, opportunities, weaknesses and threats to HIV/AIDS service delivery currently.

Table 4.3: Summary of Strengths, Weakness, Opportunities, and Threats to HIV Service Delivery in the Context of Health Reform in Ukraine

Strengths	Weaknesses
• Government commitment to purchasing ARVs • National legislation in place for HIV programming • Wide range of services and care available at AIDS Centers for PLWHA • Family practitioners have performance monitoring indicators under the new health reforms • AIDS Centers have a good handle on the demand for HIV and VCT services across their oblasts • At the oblast level, social grants are in place and some NGOs received funds via this mechanism. At the national level, all the legislation documents were submitted to Verhovna Rada for its approval	• Vertical programming for HIV means most PHC providers don't have strong knowledge of HIV prevention, care, and treatment for PLWHA. • "Specialized" services for HIV leads to a separation of PLWHA from other service levels and fuels stigma and discrimination. • Performance indicators for FPs do not include indicators related to HIV or referral services, thus FPs have no incentive to maintain skills or knowledge of these areas. • Due to legislative interpretation, patient data are not shared between AIDS Centers and Trust Office and the PHC level, which affects the continuum of care for PLWHA. • Only NGOs are reaching VHRPTs, the most vulnerable to HIV infection. • PLWHA distrust providers outside of the AIDS Centers. • AIDS Centers are unable to enter into contracts for services.
Opportunities	**Threats**
• MOH should have executive power to insert amendments to legislation to allow for patient data sharing to improve care • Family practitioners can be trained relatively easily to detect HIV and provide non-ARV-related care to PLWHA in PHC setting, reducing stigma • NGOs have the trust of MARPS and could be used to reach VHRPTs • Social order grants could serve as model for contracting out prevention services to NGOs	• Health reforms do not address HIV programs • Movement toward strengthened PHC services may result in fewer financial and human resources available to serve PLWHA • AIDS Control Programs and AIDS/Trust Centers may be hesitant to decrease the demand for their services • Decreased funding for HIV through donors expected in the near term • Stigma toward PLWHA among FPs still exists

5. KEY PERFORMANCE INDICATORS

Any use of an efficiency change tool will necessitate a priori a list of performance indicators. The following list is indicative of the types of performance indicators by efficiency change tools suggested earlier.

Incentives for PHC level:

- Number of persons tested for HIV who know their HIV status x 100/# of visits at PHC (provided by FP) by quarters and by age groups
- Number of HIV-positive children x 100/total # of children born from HIV-positive mothers at certain period of time
- Number of pre-test and post-test counseling done by FP
- Number of HIV-positive patients receiving appropriate social service referral
- Number of HIV-positive patients receiving routine non-ARV care at PHC level.
- Number of HIV-positive patients receiving first-line ARVs at PHC level.

Contracting out for AIDS Centers and Trust Offices

- Number of health care workers (FPs) at PHC trained on topics such as
    - VCT
    - HIV social support services
    - Recognizing HIV-related illness
    - Recognizing deteriorating status related to HIV
    - Understanding positive prevention
- Number of government health care facilities mentored on a quarterly basis to improve quality of prevention and care for MARPs
- Number of HIV test kits distributed to Trust Offices and PHC centers
- Number of first-line ARVS distributed to Trust Offices and PHC centers

Social order grants

- Number of government health care facilities mentored on a quarterly basis to improve quality of prevention and care for VHRPTs
- Number of VHRPTs reached with information, education and communication messages
- Number of VHRPTs HIV tested on regular basis
- Number of VHRPTs who tested positive and who have been staged
- Number of VHRPTs on ARVs
- Adherence of VHRPTs on ARVS
- Percentage of facilities in localities with at least one HIV/MARPs social worker who either partially or fully worked with NGOs
- Number of HIV products enhancing policy dialogue or service delivery
- Number of products developed by civil society groups and used for advocacy
- Number of volunteers providing social support for HIV-positive people

Legislative changes

- HIV policy harmonized with national health strategy: number of core indicators included in both health and HIV strategies
- Percentage of MAT protocols harmonized with international best practices and/or standards (where standards exist)
- Number of legislative or policy changes affecting HIV confidentiality
- Number of legislative or policy changes encompassing HIV/AIDS indicators into incentive indicators
- Number of legislative changes allowing for legal status change for AIDS control (can enter into contract) or Trust Offices (can be managed by AIDS control)
- Family practice refresher training and original training courses to include X days of HIV/AIDS prevention and treatment training

6. RECOMMENDATIONS

6.1 SUMMARY

In general, it is more cost-efficient and convenient for the patient in terms of accessibility to redirect as many HIV prevention and treatment services away from "specialized" care. Yet as Table 4.1 illustrated, sometimes this cannot be possible. For instance, it would make little sense to redirect the rural patient away from a specialized Trust Office since confidentiality and nondiscrimination in a small village setting may not be possible at a local PHC center. As an FP mentioned in Vinnytsia Oblast, *"Our villages are quite small and people know each other and see who goes where."* Furthermore, it may make little sense to stock a PHC center with HIV testing kits as there may be such little demand and the kits could expire before being used.

Box 6.1: The Potential Role of Regional AIDS Centers

- Stage HIV patients for ARV need
- Provide training to PHC and Trust Offices in ARV drug interactions
- Provide training to PHC and Trust Offices in monitoring immune response in HIV patients
- Act as oblast-wide conduit for HIV-related data
- Give advanced HIV care
- Act as coordinating center for HIV prevention and treatment efforts targeting VHRPTs
- Serve as resource center for HIV-related funding efforts for Oblast
- Serve as procurement agent for VCT test kits and ARVs

In terms of the urban male patient who has sex with men (MSM outlined in Table 4.1), it makes sense to have the FP at the PHC center screen for HIV and also provide much of the nonclinical staging component of AIDS care. In most countries, the routine, non-ARV-related care is taken care of for this type of patient at the PHC level. The FP could easily be made aware of what to look for in terms of ARV drug interactions with other drugs and also what to look for clinically in terms of worsening HIV and/or AIDS status and the role of positive prevention in the patients' lives. In this setting with a fully trained (and not just refresher trained) FP, more HIV prevention and treatment services could be taken care of by the FP, with referral to specialist care for any ARV medication adjustments or scheduled clinical staging whether the patient is on ARVs or not.

The VHRPT patient could have many of his/her prevention needs met at the PHC level. In fact, the PHC level could be of great use in provider-initiated testing and counseling and other screening efforts. This is a similar situation to the urban practitioner who treats the MSM patient mentioned earlier. Also, once tested HIV positive, a patient in this scenario should be clinically staged at specialized care (at onset and at least annually) and referred back to the PHC level if he or she is not on ARVs, but remain at specialized care if

put on ARVs. An FP at a Kyiv PHC facility mentioned that "*currently it is possible to do* [as referenced above] *because the newly trained FPs who just graduated from the medical schools are young and have little stigma to treat such patients for simple conditions as compared to the older retrained doctors, but there should be a legislative base in place.*"

By changing the delivery of HIV/AIDS prevention and treatment services in Ukraine such as suggested above, concurrent positive and negative outcomes will arise. The positives include probable savings to the governmental system so that these funds can be used to assist NGOs in the struggle to bring VHRPTs into the system to get them on ARVs as needed. Another positive would be a reduction in discrimination as more physicians and health care staff treat HIV-positive patients in a PHC setting. Possible negatives include a loss of control by specialists in HIV/AIDS care over all aspects of HIV/AIDS prevention and treatment services. There may be unavoidable clinical errors, but more than likely these would be very limited in number and impact.

In addition, since HIV testing kits (especially for screening purposes) and possibly ARVs are being sent to more places than only HIV/AIDS specialist centers, there are bound to be logistical errors. The HIV test kit/ARV purchasing situation is complicated by the fact that if ARVs are purchased for PHC distribution, they will have to be bought by rayon-level authorities under current PHC reforms, yet rayon-level authorities have never purchased HIV test kits or ARVs; only oblast- or national-level authorities have purchased test kits and ARVs in the past. Nonetheless, oblast-level AIDS Centers could easily function as HIV test kit and ARV distributors for rayon-level funded PHC use (with concurrent payment from rayon to oblast for kits and/or ARVs).

Furthermore, opportunities will be missed because some PHC staff will not be aware of all the social services that are available to HIV-positive persons. Since PHC staff currently do not take care of HIV-positive persons, they cannot be expected to be aware of what social services are available to these individuals. As PHC staff become more accustomed to taking care of HIV-positive individuals, they will become more aware of available social services. It must be remembered though that not every NGO or government facility and its personnel are aware of all social service opportunities available in their operational area. Interestingly, it is the PHC physician who fills out the paperwork for disability (whether HIV related or not), and to increase the PHC physician's responsibility for connecting HIV-positive individuals to HIV-focused social services is only a natural extension of this disability-determining function that PHC physicians currently undertake.

In sum, there is a balance that needs to be achieved by encouraging PHC centers to address non-complicated HIV/AIDS prevention and treatment services, while at the same time ensure a high level of good quality HIV/AIDS care. In other words, the Ukrainian HIV/AIDS delivery care system should not decentralize to such an extent that quality of HIV/AIDS care suffers. At the same time, there is a need for better coordination between outreach services (mainly NGO supplied) and prevention/treatment especially getting VHRPTs on ARVs. AIDS Centers need to be encouraged to act as managers and coordinators of an integrated HIV/AIDS care system. In that way, previously outlined service delivery inefficiencies can be rectified while quality is maintained and better coordination with NGO delivered HIV/AIDS outreach services can be realized.

The assessment team recommends the following actions outlined in the subsection below in order to address the challenges and risks cited above, and to build on the current strengths of the health system and the opportunities presented by the ongoing reforms. These recommendations are addressed to the government of Ukraine but may benefit from development partner support. The assessment team notes that the details behind "how" to implement the below mentioned recommendations are not included at this stage due to the inherent complexities in making change. A coherent next step is to make certain that below recommendations are validated and then certain short and medium term ones are selected for a pilot oblast setting where the details behind "how" to implement the recommendations can be tested.

6.2 SHORT-TERM RECOMMENDATIONS (WITHIN THE NEXT 12 MONTHS)

- Revise the law on confidentiality of information about HIV-positive individuals and develop a draft regulation taking into consideration the aspects of stigma from the patient's side.
- Broaden discussion of efficiency benefits outlined in this paper to include rayon- and oblast-level financial (not health)-focused staff.
- Refine and concretize the responsibilities of FPs, including prevention, positive prevention, recognizing HIV/AIDs-related diseases (Pneumocystis Carina, etc.), drug interactions with ARVs, and when to refer to AIDS Center.
- Discuss and agree on HIV-related incentive indicators with FP and rayon-level health departments so that incentives for HIV testing and prevention can be included using rayon-level funding (instead of national-level funding, which would necessitate more lengthy legal process).
- Review and modify the FP short- and long-term training curriculum after refining responsibilities.
- Continue to support efforts by WHO and others in rationalizing management structure between AIDS Center and Trust Offices.
- Discuss and agree on performance and contracting out indicators with AIDS Centers, Trust Offices, and oblast health departments, including AIDS Center assisting with purchasing of VCT kits, supervision, and monitoring of Trust Offices.
- Document what are the human resource needs associated with changing AIDS Center roles.
- Study in detail state order grants that exist at local levels and make recommendations to simplify the numerous minimum standards that are recommended.
- Develop a document outlining who monitors VHRPT-focused grants, who finances such grants, what are the minimum standards of grant recipients, and what grant topics should be included.
- Once simplified state order grants targeting VHRPTs and working with NGOs are negotiated, work with co-funding from the Global Fund or USAID so that VHRPT-focused grants can be linked to reductions in superfluous "specialist" HIV/AIDS care.
- Prepare all the necessary documents in order to make Trust Offices in urban settings much more MARP and VHRPT sensitive to ensure there is a strong link between outreach and clinical staging/ARV adherence.
- Because current PHC reforms are poorly understood by the public, improve both the patients' and providers' understanding of such reforms.
- Document the benefits and drawbacks of current PHC reform efforts
- Develop and implement a comprehensive incentive based referral system for HIV positive patients and their HIV and non-HIV related medical needs
- Develop /algorithms for addressing HIV positive patient's care taking into consideration patient' wishes, clinical necessity, location of relevant facilities, available ancillary social services, etc.

6.3 MEDIUM-TERM RECOMMENDATIONS (WITHIN THE NEXT TWO YEARS)

- Modify and have approved legal and legislative documents related to the following:
    - Confidentiality of HIV-positive individuals
    - Terms of Reference for FPs
    - HIV-related incentive indicators with FP and oblast health departments
    - Enhanced role of AIDS Center and Trust Offices

    - Performance and contracting out indicators for AIDS Centers, Trust Offices, and PHC centers
    - State order grants for HIV-related topics
- Introduce a revised curriculum that includes enhanced HIV/AIDS topics into short- and long-course FP trainings
- Have FPs carry out preventive, VCT, and treatment of other conditions and receive incentives based on introduced indicators
- Pilot the new VHRPT/MARP-friendly Trust Offices (supervised and managed by AIDS Centers)
- Have one AIDS Center contracted out to manage all HIV/AIDS care for the oblast, including supervising FPs and their prevention/testing services, basic non-ARV care for HIV patients, new MARP/VHRPT-friendly Trust Office, and any other Trust Office in oblast
- Document financial savings from "pushing" nonspecialized HIV/AIDS care to other levels
- Develop incentive indicators so that referrals from Trust Offices of HIV-positive patients for clinical staging are actually captured by AIDS Centers (or advanced Trust Office) for clinical staging and ARVs
- Develop incentive indicators so that referrals from PHC center to AIDS Center for advanced HIV/AIDS care are timely and actually occur
- Develop incentive indicators that would pay AIDS control for treating those cases that actually needed "specialized" care
- Develop and pilot integrated care sites such as narcology centers and AIDS satellite (or advanced Trust Offices)
- Promote through social order grants (and monitored by AIDS Center) outreach activities to prisons, drug use hot spots, etc.

6.4 LONG-TERM RECOMMENDATIONS (WITHIN THE NEXT FIVE YEARS)

- Have FPs do prevention, VCT, treatment of other nonspecific AIDS conditions, and refill or prescribe ARV drugs through incentive-based program
- Develop state order grant to provide funding for NGOs for prevention activities targeting VHRPTs and MARPs
- Develop and implement a social marketing campaign promoting virtues of getting nonspecialist HIV/AIDS care at PHC level
- Continue with PHC reforms
- Train more FPs to increase from the current 1,000 FPs to the needed 3,000
- Roll out nationally some of the activities mentioned in medium-term plan

7. NEXT STEPS

A draft version of this report was presented and discussed at two round table workshops held July 3 and 4, 2012 in Kyiv to validate the findings of the assessment and discuss the recommendations and next steps with regional and national health sector stakeholders. See Annex C for the workshop agenda and complete list of participants. The more than 35 participants hailed from national health institutions,

international partners such as UNAIDS, the World Bank, and WHO, as well as regional representatives from Chernigiv, Dnepropertrovsk, Donetsk, Zakarpattia, Cherkasy, Vinnystia, and Kyiv City. Participants validated the findings of this report, and determined the following priorities for national level attention:

1. Address legislative issues related to transferring information on HIV status for clinical purposes
2. Develop guidelines for HIV/AIDS patient management by level with enough flexibility for regional variations
3. Build the capacity of primary care level to address prevention and basic HIV/AIDS care
4. Investigate alternative ways to procure at the oblast level testing and diagnostics materials
5. Add HIV/AIDS indicators to PHC performance incentives
6. Enhance the role of AIDS Centers
7. Leverage social order grants, Social Services and NGOs for outreach services

On July 4, 2012, the Ministry of Health, the State Services on HIV, TB and Other Socially Dangerous Diseases, and local HIV experts agreed to launch a working group for optimizing HIV services. According to Olena Yeshchenko, the Deputy Director of State Services on HIV, TB and other Socially Dangerous diseases, the proposed expert working group will further identify roles and adapt this report's recommendations into action. Subsequent steps could include developing a feasibility study and action plan for one oblast to carry out select recommendations from this evaluation. This action plan would guide pilot oblast level efforts in optimizing HIV/AIDS service delivery while using some current healthcare reform efforts such as incentive pay and strengthening the role of PHC. The chosen pilot oblast does not necessarily have to be part of the four current healthcare reform sites, since many of the tools used in current PHC reform sites are well documented. Results of such a feasibility study could be used to:

- Inform the newly created working group on hurdles and opportunities for moving forward to implement reforms to the HIV/AIDS response in Ukraine; and

- Guide the implementation of a pilot of integrating HIV/AIDS into PHC and secondary care services, the results of which can be used as a lesson for future roll-out at the national level

ANNEX A: LIST OF HIV/AIDS-RELATED LEGISLATIVE DOCUMENTS

The following documents are available at www.rada.gov.ua.

1. Law of Ukraine "On prevention of spread of diseases caused by human immunodeficiency virus (HIV), and legal and social protection for people living with HIV"
2. Cabinet of Ministers of Ukraine, Regulation № 2026 "On prevention and protection from HIV and AIDS," dated 18.12.98.
3. Order of the Cabinet of Ministers of Ukraine № 120 "On improvement of medical care from AIDS" dated 25.05.2000.
4. Cabinet of Ministers of Ukraine, Ministry of Education and Science of Ukraine, Ministry for Family, Youth and Sports, Penitentiary State Department of Ukraine, Ministry of Labor and Social Policy, Regulation № 740/1030/4154/321/614a "On measures on organization of prevention of HIV transmission from mother to child, health care and social support for HIV-infected children and their families" dated 23.11.2007.
5. Order of the Ministry of Health of Ukraine № 1141 "About procedure for testing for HIV - infection and quality of research" dated 21.12.2010.
6. Guidelines for voluntary counselling and testing for HIV infection (Protocol) approved by the Order of Ministry of Health of Ukraine № 415, dated 19.08.2005.
7. Order of the Ministry of Family, Youth and Sports, Ministry of Labor and Social Policy, Ministry of Health № 3123/275/77 "About provision of social services and standards" dated 13.09.2010:
    - Standard delivery of social services to persons receiving substitution therapy opioid agonists
    - Standard delivery of social services for HIV prevention among people at high risk of HIV infection through sexual contact
    - Standard delivery of social care services and support for people living with HIV/AIDS.

ANNEX B: BIBLIOGRAPHY

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ANNEX C: POLICY ROUNDTABLE MEETINGS

PARTICIPANT LIST

The following individuals participated in the roundtable meetings held July 3 and 4, 2012 to validate the findings of this report and to discuss and agree on priority actions.

Name	Title and Organization
National government	
Oleksandr Tolstanov	Deputy Minister of Health
Olena Yeshchenko	Deputy Director, State Services on HIV, TB, and Other Socially Dangerous Diseases
Natalia Nizova	Director, Ukrainian AIDS Center, Ministry of Health of Ukraine
Alla Scherbynska	Deputy Director, Ukrainian AIDS Center, Ministry of Health of Ukraine
Olena Kolyada	Ukrainian AIDS Center, Ministry of Health of Ukraine
Vitalii Karanda	Ukrainian AIDS Center, Ministry of Health of Ukraine
V. Kolomeichuk	Deputy Head of Maternal and Child Health Department, MOH
Julia Gramotna	Press Secretary, MOH
Pavlo Lisenko	Scientist, Ukrainian Institute of Strategic Research, MOH
Regional and municipal level public sector	
Zhanna Antonenko	Head of M&E Department, Kyiv City AIDS Center
Alexander Yurchenko	Chief Doctor, Kyiv city AIDS Center
Aleksandra Gerashenko	Chief PHC Specialist, Obolonskii Rayon, Kyiv City
Igor Matkovskiy	Chief Doctor, Vinnytsia Oblast AIDS Center
Mikola Matus	Financial and Accounting Unit, Vinnytsia Oblast Health Administration
Mikola Grajdanov	Chief Doctor, Donetsk Oblast AIDS Center
Natalya Malochkina	Head of Treatment Unit, Donetsk Oblast Health Administration
Irina Chukhaleva	Chief Doctor, Dneprpetrovsk Oblast Health Center
Ivan Myronyuk	Chief Doctor, Zakarpattia Oblast AIDS Center
Irina Bandura	Financial Unit of Zakarpattia Oblast Health Administration
Volodymyr Brozhyk	Head, Cherkasy Oblast Health Administration
P. Levchenko	Chief Doctor, Cherkasy Oblast AIDS Center
T. Didenko	Head of Financial and Accounting Unit, Cherkasy Oblast Health Administration
Anatolii Kovalenko	PHC, Cherkasy Oblast Health Administration
Olena Trozenko	Head of M&E Unit, Chernihiv Oblast AIDS Center
Olena Tolilko	Economist, Chernihiv Oblast AIDS Center
M. Deykun	Chief Doctor, Chernihiv Oblast AIDS Center
Sergey Sotnikov	PHC Center, Morgonezskii
Vlodimir Kurita	Lireja NHCR
International Development Partners	
Enilda Martin	Deputy Director, Office of Health and Social Transition, USAID/Ukraine
Paola Pavlenko	Senior HIV/AIDS Advisor, Office of Health and Social Transition, USAID/Ukraine
Tatiana Rastrigina	Senior Project Management Specialist, USAID/UKraine
Charles Vitek	Centers for Disease Control, Ukraine Country Office
Lisa Tarantino	Senior Associate, HS 20/20 Project, Ukraine
Peter Cowley	Senior Health Policy Specialist, HS 20/20 Project, Ukraine
Baktygul Akkazieva	Health M&E Specialist, HS 20/20 Project, Ukraine

Andriy Huk	Chief of Party, USAID's HIV/AIDS Service Capacity Project
Ihor Perehinets	National Professional Officer, Communicable Diseases, WHO Country Office, Ukraine
Yuriy Kobyshcha	National Professional Officer, Strategic Information,WHO Country Office Ukraine
Anna Shakarishvili	UNAIDS Country Coordinator in Ukraine
Alexei Ilnitski	UNAIDS M&E Adviser
Paolo Belli	Country Sector Coordinator, WB/IBRD
NGOs	
Olga Gvozdets'ka	Director, Programme Department, All-Ukrainian Network of PLWH
Anjela Skopenko	Head, Curative Unit, All-Ukrainian Network of PLWH
Sergey Philippovych	Associate Director, Treatment, Alliance Ukraine

ROUNDTABLE MEETING AGENDAS

"Optimization of HIV/AIDS Services in the Context of Health Care Reform"

Policy Roundtable Meeting for Regional Representatives

Lybid Hotel, Kyiv

July 3, 2012

Meeting Objective: To validate the results of the study on *"Optimization of HIV/AIDS Services in the Context of Health Care Reform in Ukraine"* with regional level policy makers and implementers and to identify next steps to implement recommendations.

AGENDA

Time	Topic	Presenter/**Facilitator**
9.30 – 10.00	Meeting Registration	
10.00-10.30	Welcoming Remarks: • Natalia Nizova, Director, Ukrainian AIDS Center • Paola Pavlenko, Senior HIV/AIDS Advisor, Office of Health and Social Transition, USAID/Ukraine	Facilitator: Lisa Tarantino, Team Leader, USAID's Health Systems 20/20 Project, Ukraine
10.30-10.45	"Results of the Study *'Optimization of HIV/AIDS Services within the Context of Health Care Reform in Ukraine'"* • Legislation and Stewardship • Service Delivery • Financing • M&E: Performance Indicators	Peter Cowley, USAID's Health Systems 20/20 Project
10.45–11.00	Discussion and Clarifications	
11.00-11.15	*Coffee Break*	
11:15-11:40	"Current Opportunities and Threats to HIV/AIDS Service Delivery in Ukraine"	Peter Cowley, USAID's Health Systems 20/20 Project
11:40-12:05	"Experiences from Zakarpattia Oblast In Reforming HIV/AIDS Service Delivery"	Ivan Myronyuk, Head of Zakarpattia Oblast AIDS Center
12.05-12:40	"Opportunities to Introduce VCT and MAT into the Family Doctors' Practice"	Andriy Huk, Chief of Party, USAID's HIV/AIDS Service Capacity Project
12.40-13.00	Discussion and Clarifications	
13.00-14.00	*Lunch*	
14.00-15:30	Working Group Discussions	
15.30-16.00	*Coffee-Break*	
16.00-16.45	Presentations of Working Group Findings	
16.45-17.15	Discussion and Clarifications	
17:15-17:30	Concluding Remarks: Lisa Tarantino, Team Leader, USAID's Health Systems 20/20 Project, Ukraine	

"Optimization of HIV/AIDS Services in the Context of Health Care Reform"

Policy Roundtable Meeting

Lybid Hotel, Kyiv

AGENDA

July 4, 2012

Meeting Objective: To use the results of the study on *"Optimization of HIV/AIDS Services in the Context of Health Care Reform in Ukraine"* and the July 3, 2012 meeting findings to agree next steps to implement health reforms aimed to optimize and sustain the delivery of HIV/AIDS services

Time	Topic	Presenter/Facilitator
8.30 – 9.00	Meeting Registration	
9.00-9.15	Welcoming Remarks: Lisa Tarantino, Team Leader, USAID's Health Systems 20/20 Project, Ukraine Oleksandr Tolstanov, Deputy Minister of Health, Ukraine	
9.15-9:45	"Highlights from the Study *'Optimization of HIV/AIDS Services within the Context of Health Care Reform in Ukraine'* and summary of recommendations for national level attention from Day 1*"*	Peter Cowley USAID's Health Systems 20/20 Project
9:45-10:15	Discussion and Clarifications	
10:15-10:30	Coffee Break	
10.30-10.45	HIV Program Integration into Primary Health Care: New Opportunities in the Context of Health Care System Reform	Oleksandr Yurchenko, Head, Kiev City AIDS Center
10.45-11.15	Discussion and Clarifications	
11.15-12.30	Panel Discussion HIV/AIDS Service Integration: Supporting Regional Implementation and Prioritizing National Level Issues • Olena Yeshchenko, Deputy Director, State Services on HIV, TB and other social dangerous diseases • Natalia Nizova, Director, Ukrainian AIDS Center • Ihor Perehinets, National Professional Officer, Communicable Diseases WHO Ukraine • Peter Cowley, Health Policy Specialist, Health Systems 20/20 Project • Baktygul Akkazieva, M&E Specialist, Health Systems 20/20 Project	Facilitator: Lisa Tarantino, USAID's Health Systems 20/20 Project, Ukraine
12.30-13.00	Concluding Remarks • Enilda Martin, Deputy Director, Office of Health and Social Transition, USAID/Ukraine • Olena Yeshchenko, Deputy Director, State Services on HIV, TB and other social dangerous diseases • Natalia Nizova, Director, Ukrainian AIDS Center • Lisa Tarantino, Team Leader, USAID's Health Systems 20/20 Project, Ukraine	
13.00-14.00	*Lunch* *(Followed by Departure of Regional Representatives)*	