Independent review of the Ukraine's Transition Plan 2018-2021

By Center for Health Policies and Studies (PAS Center)

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Executive Summary

This independent review of progress on Ukraine's plan to transition from international to domestic systems by the end of 2021 was commissioned with the aim of "developing detailed recommendations and actions for further strengthening and support. The recommendations are intended to "serve as the basis for a new plan for the institutionalization of the existing mechanism for contracting HIV prevention services for key and vulnerable populations, with a future vision for people living with HIV support services and TB care services incorporation." It was commissioned in response to a 2020 request from the Technical Review Panel (TRP) of the Global Fund to the National Coordination Council on TB and HIV/AIDS. The PAS Center undertook the review, based on the TOR co-defined by the Ukraine's Public Health Center, the Global Fund, and UNAIDS.

The review involved desk review of normative and key programmatic and budget documents, interviews with 28 national and regional stakeholders, 5 virtual focus group discussions with HIV prevention and care and support service providers, and 618 clients of HIV prevention, opioid agonist maintenance therapy and care and support for PLHIV. The review does not factor the impacts of the Russia's invasion that started in February 2022.

Transition Plan

In 2017, Ukraine submitted its Transition Plan '20-50-80' as part of its funding request to the Global Fund which set out a three-year vision and roadmap for moving from international to state management and funding in the following areas: HIV prevention (basic packages), care and support for people living with HIV (PLHIV), and ARV and TB medicine procurement.
At the time, international funding for those areas was managed by the «100% LIFE» (All-Ukrainian Network of PLHIV) and the Alliance for Public Health (APH). The formula, 20-50-80, reflected the benchmarks for state take over of management in 2018-2019-2020, while state funding was to increase in the portions of 0%-50%-80% of funding for basic HIV care and support for people living with HIV and HIV prevention services among three key populations: people who inject drugs, sex workers, and men who have sex with men. Transition planning was an evolutionary process and not just a discrete plan with two subsequent iterations of the original Transition Plan.

The review's report describes in a detail the findings on the Transition Plan progress in the following service areas: HIV prevention (basic packages), care and support for PLHIV, TB support services, and OAMT.

Key findings in relation to review questions

Key findings in relation to 7 review questions posed for the review include:

1. To what extent the provisions of the transition plan "20-50-80" had been implemented by the end of 2021?

Area: HIV prevention (basic packages), and care and support for PLHIV

The normative and regulatory base required for state budgetary allocation and service provision was set in line with the transition milestones, except for the plan to address the VAT taxation on services.
Financial transition has been completed to a significant extent. The state *allocation* was at the level comparable with the Global Fund's support in 2018. Transition accelerated in 2020 when

the state allocated 100% of the estimated budget instead of planned 80%. The levels of funding that reached services was significantly less: 24% of state allocated funds in 2019, 68% in 2020 and 73% in 2021. The causes for underutilization of state allocated funds were linked to the models of payment to contracted services, lower price for services during the tendering competitions, dropped contracts by some services providers and no providers submitting offers to tenders. Strict standardization of key population programming was needed to ensure accountability of services to the state budget. As a result, however, the service packages and costing as they are defined and used in contracts and payment methods are inflexible, prevent tailoring to client needs and contributing to the above-mentioned problem of underutilization.

The transition to state management of state funded services was achieved with certain gaps in procurement, funding, human resources, M&E and information systems. A decentralized procurement model was piloted with the Global Fund support in 2018. In 2019 there was a move to centralized procurement and under-utilization of funds emerged as a problem. The underutilization problem is being studied and solutions have yet to be agreed. In 2019, the PHC set up a new department for managing HIV services for key populations and PLHIV in 2019 and established a set of processes, and procedures. The PHC resourcing of the new additional functions is not sufficient. Moreover, «100% LIFE» and the Alliance for Public Health remain major co-managers of HIV prevention and care and support for PLHIV, with limited participation of PHC in the internationally funded packages of services and technical support. Further conceptual agreement on the roles, responsibilities, resourcing and co-managing of M&E and information systems (e.g., databases) require discussions between the PHC and two other principal recipients and other national stakeholders.

No plans for the state to take on procurement, funding and management of commodities for the prevention services or additional core services for key populations had been made as of the end of 2022.

Area: Opioid agonist maintenance therapy (OAMT)

Three objectives for OAMT in the transition plan have been largely achieved: national goals were set in the State Strategy on HIV, TB and Viral Hepatitis Until 2030 and operational plans; scale up was significant with a 60% increase though not on track for the national goal set for 2025; and a pilot in prison settings started in 2020. Additionally, the state prioritized OAMT in its reforms and the state-guaranteed medical care, i.e. OAMT are organized and paid through the packages of the new agency of National Health Service of Ukraine (NHSU) from the Program of Medical Guarantees starting from 2020. However, as of the end of 2021, these NHSU packages have not significantly increased the anticipated participation of primary care, partly because of unattractive tariffs for service providers and remaining challenges in increased uptake.

The current level of coverage is not sufficient for impact HIV incidence or prevalence among people with opioid dependence. From the perspective of clients surveyed, the quality of OAMT is generally high though there is a problem perceived quality of locally manufactured medicines and better uptake could be achieved with a better reputation of OAMT among people who use drugs, adapting dosage to patients, improved geographical access, easiness of entry and improved behavior and attitudes of staff.

Area: TB support services

Funding and management of TB support services have not been handed over to the state. However, the preparations began before the 2022 war started. A Roadmap for Implementing TB Support Services in a Framework of Transition to State Funding and a package of draft normative

and regulatory documents have been prepared. The government approved the allocation of first state funding for these TB services just before the war. This allocation, however, constituted 8% of the 2021 Global Fund's budget for those services, i.e., below the 30% of the service budget indicated in the funding request to the Global Fund.

Area: State procurement of ARVs and TB medicines, including establishing centralized state procurement

A centralized state procurement agency, the state-owned enterprise, Medical Procurements of Ukraine, has been established. It requires further capacity strengthening. The state budgetary share and procurement role for DS-TB have significantly progressed and, in 2021, nearly all medicines were funded from the state budget. An 8-fold reduction in the cost of ART enabled lower budgetary needs. Since 2018, the state has allocated enough funding to finance ARVs in full in government-controlled areas. In 2021, however, the utilization of state funding was below 20%, and international funding (and procurement primarily through «100% LIFE») was required to fill the gap.

2. What have been the changes that have not been specified in the transition plan?

The Transition Plan anticipated that *local funding* (and international support) would provide support for complementary services of HIV prevention among key populations as the state supports basic prevention packages. No specific commitments or steps, however, were included in the Plan. Local support for HIV prevention has been fragmented, with more examples of progress in supporting social services for people who inject drugs, ex-prisoners, and people living with HIV. These services will remain dependent on centralized state support as local prioritization of the highly stigmatized groups is still unlikely.

Funding of HIV and TB services moved to NHSU, supporting the reforms for optimized delivery of services. HIV and TB service packages were included among the state medical guarantees. Since 2021, the HIV package includes expanded with the partial funding of pre-exposure prophylaxis, or PrEP (free HIV testing and medical care). The state share of HIV and TB diagnostic and treatment services in the penitentiary system progressively increased (70% of ARV budget, which was higher than outside prisons in 2021), though it still depends on international support.

3. To what extend transition planning was fit for purpose from clients and service provider perspectives (including if the transition supported rolling out new and effective approaches and innovations in addition to existing packages and actual and coverage)

Both providers and most clients welcomed state funding and have greater confidence in the HIV prevention and care and support services to be sustained in the future because of systemic state funding. State funding contributes to the de-stigmatization of the services, the people served (key populations and PLHIV). Clients of services though are concerned about the confidentiality of their data (within and outside the health system).

Service providers received significantly less funding after the transition. International funding helped mitigate this challenge as well challenges related to contracting periods. Challenging contractual arrangements, including rigid service regulation were problematic especially for services for key populations which reported underestimated unit cost and impractical, rigid rules about service provision.

The transition led to significant restructuring and consolidation of the service provider market which was turbulent with professional mediation engaged in 8 oblasts/cities. Despite opening the market to for-profit and state-run organizations for providing HIV prevention and care and support for PLHIV, in 2021, all state-funded services were delivered by civil society organizations (CSOs). Moreover, half of the 90 contracts in 2021 were with community-led organizations. Consolidated procurement made it harder smaller CSOs to receive funding directly and they had to partner other larger CSOs to access it. Changes in who delivers services have not always assured quality. Some providers starting to serve new populations face difficulties and require support. Prevention service providers have expressed that they would like to have more dialogue with the PHC.

Service providers and clients report lack of a people-centered approach, particularly in defining frequency and adaptation/ package nuancing of services based on individual needs, as current service regulations, for example, sets the exact number of times for clients can pick up condoms or get counseling or information sessions per year, etc. Clients and providers would also like to add case management or home-delivery of services and ARVs, self-tests, testing for viral hepatitis and syphilis, and access to medications for the liver, other specialists and health services, overdose prevention to the services made available. Service quality has not been sufficiently addressed in the PHC management of services.

3a. Did the transition supported rolling out new and effective approaches and innovations in addition to existing packages?

The transition planning process did not plan to conduct population needs assessment or monitor the context. Transition did not support rolling out innovative services but focused on the continuation and scale up of existing services. The definition of the intervention packages has not been updated since 2019 (though some adaptations took place, e.g. due to the COVID-19 pandemic restrictions, and these were largely relevant to international funding). Mandatory one-size-fits-all packages limited possibilities to make adaptations to people's needs or context. For example, online service provision, which is particularly important for sex workers and MSM, is foreseen as a complementary service; therefore, its financing is expected from elsewhere.

3b. Actual coverage of HIV prevention and care and support for PLHIV

The coverage of key populations increased due to state funding during the transition period.
In 2021, the state services providing basic packages reached 45% of key populations including more than half of the estimated numbers of people who inject drugs, and sex workers but only a quarter of men who have sex with men in the government-controlled territories. Despite progress, the 70% coverage target set for 2020 by the State Strategy on Combating HIV/AIDS, TB and Viral Hepatitis was not achieved.
There are no indicators established for care and support for PLHIV in the State Strategy.

4. Do the legal framework and supporting environment sustain the provision of services / treatment for beneficiaries?

Areas: Basic packages of HIV prevention and HIV care and support for people living with HIV

Five legal acts regulating the service provision, costing and costing methodology and an annual budgetary program set the normative basis and financial framework for state funding. Harm reduction services are recognized in the normative framework for the first time. The budgetary programs are approved annually. They are dependent on the MoH leadership decisions and availability of budgetary funds.

Options for increased sustainability require more extensive discussion and systemic solutions to potentially mirror the "medical guarantee" approach to care, especially for prevention, in the evolving Public Health System. Finally, there will be no sustainability of services without solid, adequately resourced government sector management.

Areas: OAMT, ARV and TB treatments

Care for OAMT, ARV and TB is part of the state medical guarantees. Further sustainability will depend on the state's capacity to procure products. State procurement of ARVs has been problematic. Continued development of procurement capacity in synergy with the clinical planning, forecasting and supply management is a priority.

5. Could the existing M&E be used to identify risks related to transition and how the transition of the M&E functions should happen?

There were gaps in the oversight and coordination. First, the broader stakeholders (for example local stakeholders or broader community of service providers) had limited visibility and involvement. Secondly, oversight and support did not cover all the areas of transition, largely limited to just two: public procurement of services for HIV prevention and care; and support for people living with HIV. Lastly, solutions for greater utilization of the public budget allocation were implemented only partly, despite the challenges well recorded. Some creative solutions were voiced in interviews by the members of the National Council. However, no record is found that those ideas were discussed at the Strategic Working Group.

The National M&E Plan as a main framework for establishing and operationalizing targets established in the State Strategy on HIV, TB and VH 2030 was drafted by the PHC but has not been approved. Similarly, the State Strategy has not been updated to reflect new global HIV targets, and focus on integration of HIV, STI, and viral hepatitis in the new WHO key population guidelines.

PHC systems for gathering information on needs, finding solutions to problems, and assuring quality have yet to be developed. The systems for planning, monitoring and supporting services are fragmented though partners (three leads with different funding sources) of services made efforts to coordinate leveraging the significant know how they had acquired as CSO PRs. In the mid-term, the country (and donors) should be clear and intentional about moving to an integrated system for all HIV prevention and care and support, regardless of funding sources. Service providers and donors should be included in these discussion to factor in their perspectives.

The levels of budgets for M&E for services spent by the civil society principal recipients could help to set milestones for funding this function (or/and outsourcing some elements) within the PHC. The M&E functions within the PHC (and «100% LIFE» and the APH) depend on international funding. They could be co-financed for the needs assessment or capacity building from the budgetary program on public health, which funds the services.

6. What are opportunities to include HIV/TB services in the penitentiary system in the next stage of the transition?

Prison health is under the governance of the Ministry of Justice (MoJ). The penitentiary system works on the sustainability of HIV/TB services. The financial transition of services has been postponed (it was preliminarily planned for U.S. funded services in mid 2022). The outcomes of

MoH-MoJ inter-ministerial discussions on the overall governance of prison health will impact the model and funding of services. If the inter-ministerial discussions decide to proceed with the transfer of penitentiary health to the civilian sector, some HIV and TB services could be offered to be included in the pilot. In the shorter term, the Health Protection Center of the Penitentiary Services should be encouraged to consult partners and develop the package of the documents, costing, and procurement model, like a roadmap developed for the transition of TB support services to state co-funding to set up legal and regulatory systems.

7. What are lessons learned and challenges from the transition from the Global Fund to state financing of HIV services that are relevant for TB and should be combined in the review?

Transition planning for TB services is taking some lessons from the state's takeover of HIV services. For example, a Roadmap of Implementing TB Support Services in a Framework of Transition to State Funding containing normative, financial, procurement, and other steps has been developed through a broad consultation with stakeholders.
The insufficiency of local funding for TB support services informed a decision to go back to centralized state funding for these services and aligning it with the approach for HIV care and support services.
The procurement, payment models, and monitoring approach for TB have yet to be worked out and, based on the lessons from the HIV field, this area requires careful review, engaging service providers, health financing experts, and other stakeholders and experience from international projects.
In the longer term, HIV, TB, and OAMT stakeholders should hold joint discussions on ensuring sustainability, including if a different funding source or operator (e.g., NHSU if its mandate was expanded beyond care to support prevention and non-medical care) should be considered in the future.

Conclusions

Among the Global Fund's EECA applicants[1], Ukraine set the most ambitious formula for the 2017-2020 increase of state ownership of basic HIV prevention services for key populations which is seen globally as being one of the most difficult components of a HIV response to transition to state funding and management. Essential to Ukraine's success was that the 2017 "20-50-80" Plan reflected a consensus commitment for a great state role in HIV and TB programs that mobilized key government, civil society and partners to incrementally build state ownership, particularly community-driven prevention and peer treatment support programming. Its clear benchmarks enabled a unified vision and accountability. Other key conclusions include:

1. **The 20-50-80 Transition Plan, set for 2018-2020, and the PHC's Strategic Working Group have successfully served their purposes.**

2. **Despite not having legal status or a clear accountability mechanism, and evolving over time, the Transition Plan has been a success, with the following critical enablers:**

- A measurable, easy-to-understand and time-bound vision with numeric targets;
- A multistakeholder initiative team including authors of the vision for health reforms;

[1] Based on the scan of the funding requests available at: https://data.theglobalfund.org/documents and Eurasian Harm Reduction Association (2021). Taking stock of budget advocacy efforts in Eastern Europe, South-Eastern Europe and Central Asia. EHRA, Vilnius, Lithuania, 2021

- Strong civil society engagement and investment in increasing buy-in, preparedness to adjust to new procedures and willingness to find solutions as problems came up;
- ART optimization, among other factors, created savings for initial allocation of funds to HIV prevention and care and support services;
- International partner support, especially the Global Fund (and their including the implementation of the Transition Plan as a grant condition, keeping transition on the agenda, funding pilots and flexible bridge support to mitigate challenges during transformations)

3. **The Plan's implementation was possible because of the unique constellation of individuals and factors which might not be replicable in other contexts. Its ambition and approach are unique but can inspire other low-middle income countries.**

4. **The new phase and the radically changed context require rethinking of goals and the approach (for example, discrete-in-time plan, with clear accountability). The ability of the state to allocate increased funds will remain a challenge for years to come, however, this time could be used for testing and finalizing the reformed procurement model with international funding.**

Recommendations for Sustainability Planning by 2025

The review could not set a time-bound plan of sustainability, given the ongoing war and the emergency in the country. Most of the following recommendations will become most relevant in the more stable situation when the country will be able to move from emergency responses to rebuilding its health, social and HIV systems. The conflict and emergency response might require reassessing previous assumptions including on the basic packages of services or acknowledging geographical changes due to people's movement, destruction of infrastructure and living needs.

<u>HIV prevention and care and support for PLHIV</u>

1. Update the MoH regulations on service and their use in the contracts in line with the changed basic needs and cost-effective innovations introduced due to COVID-19 and reflecting the realities of the service provision
   - Care and support services for PLHIV should allow replacing sessions with case management to overcome barriers to care, reducing/increasing the number of interventions in consultation with the client and HIV clinicians. The incentivized packages for people who inject drugs should remain. Services should allow for working with people living with HIV who face more difficulties in developing treatment adherence, including but not limited to support with the ARV delivery for people with mobility difficulties or great distances from HIV care facilities.
   - The prevention package regulations and specifications in contracts should be adjusted to allow a flexible amount of service provision (i.e., providing the commodities nine times a year should become an average recommendation), online service provision, case management, or at least referral support for a stronger cascade of HIV services and linkage to other needs, self-testing for HIV, testing for viral hepatitis, syphilis and overdose prevention, motivation and support for PrEP uptake and addressing sexual and reproductive health and rights.
   - Trans people should be included in the MoH approved list of populations at high-risk for HIV and the prevention service regulation, recognizing it as a key population and committing to transition its funding and management;

- If the packages cannot be defined with the sufficient flexibility for innovation and contextualizing, the MoH and the PHC should plan their regular update.

2. Revise costing, costing methodology, and payment for services, as needed, by using international funding for testing and finding the right balance between accountability and people-centeredness of services.
   - The payment for services should consider a combination of methods using a 'global budget' for the basic services and payment for performance for achieving pre-agreed outcomes;
   - The updated methodology should foresee indexation due to inflation and revisions of the minimum cost of living and factor in the VAT until the public health services are not exempt from VAT;
   - The actual spending on services, prioritizing the prevention services, should be updated, capturing the potential co-coverage of services, if any, from other sources. Differences in costing of interventions and for different populations should be reviewed to set the right balance of incentives and effort needed, not lead to reduced motivation of 'cheaper' populations and interventions.

3. Set a roadmap for integrated planning and management of the national programs of HIV prevention and care and support.
   - Set coverage targets and use the expected coverage for fund allocation (not vice versa). This step would require the PHC to finalize the National M&E Plan for the implementation of the State Strategy on HIV, TB and Viral Hepatitis Until 2030 with annual targets set.
   - Plan for geographical differences and mobility of populations in setting coverage targets, budgets and additional support systems.
   - Identify roles, responsibilities, and synergies in service planning, capacity building, technical support, M&E, and co-funding schemes by the PHC, «100% LIFE» and the Alliance for Public Health. The plan might include outsourcing some functions for capacity building of state services or engaging community monitoring, among other elements.
   - Complete developing the approach to quality assurance that would engage clients, service providers and regional public health institutions;
   - Update the PHC contracts and systems for a nuanced system of verification, technical support, and interventions in case of underperformance or observed misuse of funds, provision of additional training and technical support for new-comers as needed in cooperation with «100% LIFE» and the APH;
   - Set regular (annual) meetings with services providers;
   - The plan should address the long-term of managing systems and databases. The transfer of the Data-Check to the PHC should be completed.
   - The PHC should plan increased funding and human resources for its functions (the ratio between the service cost and management cost in «100% LIFE» and the APH could inform; the management should not be less than 5%).

4. Prepare and pilot the transfer to state procurement of testing and prevention commodities used in HIV prevention, if need be, with international funding.

<u>OAMT</u>

5. Work with NHSU, providers, patient and harm reduction organizations for improved the attractiveness and uptake of the NHSU packages and OAMT services to reach the set targets

for 2025 in the State Strategy on HIV/AIDS, TB, and Viral Hepatitis until 2030. These efforts should address the negative reputation of the quality of locally produced OAMT products among clients, more effective means for referral and motivation from HIV prevention services among people who inject drugs (harm reduction services), and a consultation on the attractiveness of the 2023 tariff that would include primary and private care providers. A dialogue with NHSU is needed on how to monitor and address attractiveness of OAMT among smaller and primary care providers and approach quality assurance of NHSU-funded OAMT (engaging community monitoring as relevant).

TB support services

6. Implement the Roadmap for transition, with revised milestones for 2023-2025, engaging service providers and foreseeing a solid monitoring and learning mechanism to identify the risks and work on solutions. As much as possible, work on its implementation towards building one coherent system for all TB support services funded from all funding sources.

Prison-based HIV prevention, care, and support services for PLHIV and TB services

7. Establish a roadmap for transition, which would include setting up relevant financial and procurement model plans and regulatory documentation for future state funding and management. The process should be consultative, based on the 20-50-80 Transition Plan lessons.

The capacity of pharmaceutical planning and procurement

8. Prioritize efforts in this area in the next cycle. A separate analysis is needed to fully understand the root causes of the challenges and opportunities in the coherent system with clear roles, responsibilities, and resources in the Medical Procurements of Ukraine, the PHC, and other stakeholders. The MoH should do the coordination of this capacity and system building.

Sustainability Plan implementation, oversight, and awareness

9. Use the National Council on TB and HIV/AIDS for the strategic oversight of the processes of building sustainability. More technical, operational discussions ("transition plans", "roadmaps," etc.) would require separate task forces with specific tasks and timelines and co-lead from different partners.

10. Plan for increased awareness of the state taking increased responsibility in the HIV, TB, and OAMT, communicating clearly why those services are essential and prioritized by the state. At a minimum, this should include regular publishing of progress updates actively shared with HIV, TB, public health, and social service communities.

1 Purpose and Methodology

In 2017, Ukraine's National Council on TB and HIV/AIDS adopted a package of documents of its funding request to the Global Fund including the 20-50-80 Transition Plan. This Transition Plan, based on the Cabinet of Ministers-approved *Strategy of Sustainable Response to the TB epidemic, including Resistant Tuberculosis, and HIV/AIDS until 2020*, became a condition of the grant agreement between the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and Ukraine's principal recipients for 2018-2020. The development of a progress report on the implementation of the Transition Plan was included in the funding request to the Global Fund for 2021-2023.

This independent review of the achievement of the Transition Plan outcomes was commissioned in response to a 2020 request from the Technical Review Panel (TRP) of the Global Fund to the National Coordination Council on TB and HIV/AIDS. The TRP's request informed the purpose, and the review questions co-defined by the Public Health Center, the Global Fund, and UNAIDS:

1. To what extent the provisions of the transition plan "20-50-80" had been implemented by the end of 2021?
2. What have been the changes that have not been specified in the transition plan?
3. To what extend transition planning was fit for purpose from clients and service provider perspectives (including if the transition supported rolling out new and effective approaches and innovations in addition to existing packages and actual and coverage)
4. Do the legal framework and supporting environment sustain the provision of services / treatment for beneficiaries?
5. Could the existing M&E be used to identify risks related to transition and how the transition of the M&E functions should happen?
6. What are opportunities to include HIV/TB services in the penitentiary system in the next stage of the transition?
7. What are lessons learned and challenges from the transition from the Global Fund to state financing of HIV services that are relevant for TB and should be combined in the review?

The PAS Center (Moldova) was selected to conduct the review. The UNAIDS Technical Support Mechanism supported the work.

At the initial stage, the review team and the contractors established that transition planning was an evolutionary process, with different versions of documents, varied understanding of what transition planning includes even among key stakeholders, and limited relevance and clarity of some elements reflected in 2017 and 2019 transition planning documents. Therefore, it was agreed to focus mainly on HIV prevention among key populations and HIV treatment for people living with HIV, and areas like opioid agonist maintenance therapy (OAMT).

The review team agreed on the methodology including the list of stakeholders for interviews with the contractors. The PHC staff supported the collection of the information requested. The review involved:

- desk review of normative and key programmatic and budget documents related to areas of the Transition Plan; the Transition Plan updates and reports; national HIV, TB strategic documents and programmatic reports; donor documentation; documentation of the Strategic Working Group under the PHC; and sample contracts with services providers, etc.
- interviews with 25 national stakeholders and 3 regional stakeholders [*see Annex 2*],

- 5 online focused groups with 34 representatives of NGO service providers in selected regions [*see Annex 4 for the summary report*],
- 618 clients of HIV prevention, opioid agonist therapy and HIV treatment support reached through semi-structured interviews (113) and self-administered surveys (505) [*see Annex 3 for the summary report*].

Given the significant size of Ukraine, seven focus regions were chosen to reflect epidemiological and donor investment diversity (regions with and without PEPFAR investments) for the selection of regional stakeholders, service providers and clients for the assessment. The regions were: Dnipropetrovsk, Kharkiv, Lviv, Odesa, Poltava, Zaporizhzhia, and Zhytomyr.

The period of focus for the review was 2018-2021.

The review was initiated in November 2021 and was completed in January 2023. Due to Russia's invasion of Ukraine starting in February 2022, the assessment was put on hold. Its renewal, in June 2022, required revisiting methodology (excluding in-person interviews and focus groups from the methodology; limiting expectations on access to state data; state institutions and in-country stakeholders; and reshaping questions to emphasize the pre-invasion situation), and adjusting the expectation that few specific recommendations on sustainability and donor transition in the changed context are feasible in the changed context. The review did not examine the ongoing changes to services and needs in the emergency response. Furthermore, in parallel to the assessment, the PHC and other stakeholders continued improving management and sustainability of the responses. Changes that took place in 2022 are not fully reflected in the report. One of the limitations of the review is related to the non-government-controlled areas of Donetsk and Luhansk Oblasts, Crimea and Sevastopol where HIV and TB burden is high and which rely on international and foreign support. They were not included in Ukraine's donor transition processes because of their occupation since 2014. Therefore, most data in the report represent government-controlled areas for which the Transition Plan applies and are not inclusive of data on Ukraine's whole territory.

The review team included: Cristina Celan (Manager), Liliana Caraulan (Lead International Consultant HIV/TB until the end of 2021), Raminta Stuikyte (International Consultant[2]), Olena Sinitsyna (national health finance consultant), Elena Nechosina (National Consultant on HIV, TB and Public Health), Oleksandra Iatsura (Lead on Focus Groups and Client Interviews), Andrei Iarovoi (Consultant for Client Interviews) and Maxym Kasianczuk (Consultant on HIV and Sociological Analysis – from July 2022). The review team's effectiveness and availability were significantly affected by the Russia's invasion. The agreement with the contractors was expanded by one member but no further changes to the team were made to ensure the full utility of invested efforts.

Oversight of and support for the assessment was provided by highly resilient teams in PHC, UNAIDS, the Global Fund and the National Council's Secretariat, led by Olga Gvozdetska, Olena Nesterova, Larisa Hetman, Iryna Ivanchuk, Yana Terleeva, and Liudmila Legkostup (PHC); Naira Sargsyan, Natalia Salabai and Raman Hailevich (UNAIDS), Lyubov Kravets and Iryna Koroeva (NC Secretariat); Darren Dorkin, David Kokiashvili, Olga Gordieva (until February 2022) and Nineta Avani (from November 2022, Global Fund).

[2] Raminta Stuikyte serves in the Global Fund's Technical Review Panel (TRP) as its Vice-Chair. The Head of Ethics Office of the Global Fund cleared her participation in this review in August 2021 and defined measures for managing the real, perceived and potential conflict of interest. The report does not represent the TRP position.

2 Transition planning, implementation and accountability

Figure 1: Brief on Ukraine

Population	41.1 million (without Crimea) https://ukrstat.gov.ua/druk/publicat/kat_u/2022/zb/05/zb_Chuselnist.pdf
Income status	Lower-middle income [WB]
Administrative division	27 administrative units (including two fully occupied as of the end of 2021, and two with large portion of the non-government control areas)
Spending on health	7.1% of GDP (2019) 7.7% of general state expenditure (2019) [WHO/World Bank]
HIV epidemic	240,000 people living with HIV [UNAIDS, 2021] 58% of them achieved viral suppression 0.9% prevalence among adults (18-49 y.o.) At national level HIV is concentrated among people who inject drugs (20.9%), sex workers (5.2%), men who have sex with men (4%)
TB epidemic WHO	Eighth largest number of people with MDR-TB globally and one of the largest mortality rates in Europe, while TB incidence is reducing (19% reduction between 2015 and 2020)
Coordination	National Council on TB and HIV/AIDS (it plays the role of Country Coordinating Mechanism), its documentation: https://moz.gov.ua/nacionalna-rada-z-pitan-protidii-tuberkulozu-ta-vilsnid
Global Fund principal recipients	- Public Health Center under the Ministry of Health (PHC), - «100% LIFE» (All-Ukrainian Network of People Living with HIV), - Alliance for Public Health (APH)
Health reform	Involves the development of public health system, reforming health financing and strengthening centralized procurement
Conflict area	Crimea with Sevastopol and parts of Donetsk and Luhansk Oblasts (5.3 million or around 12.8% of the country's population in 2020, before the renewed invasion in 2022, according to the country's funding request to the Global Fund for 2021-2023)

2.1 Establishing the Transition Plan

In 2017, Ukraine significantly increased government spending on its HIV and TB responses: nearly 2 times for HIV[3] and 60% for TB[4] in comparison with the previous year. This increase both compensated for the reduction of international funding and increased the total funding available. For HIV, the total funding increased from US$104.2 million in 2016 up to US$107.8 million in 2017 of which US$46.2 million (42.8%) came from the domestic public budget[5]. The cumulative spending on TB grew from US$38.2 million in 2016 to 41.6 million in 2017, with the government portion reaching 84% (US$35 million) in 2017[6]. Still, Ukraine's response to HIV and TB remained

[3] UNAIDS, global AIDS monitoring, based on GARPR reports, accessed at https://hivfinancial.unaids.org/hivfinancialdashboards.html#

[4] Calculated based on data provided in Ukraine's TB/HIV funding request to the Global Fund for 2018-2020 – Funding Landscape Table, TB Gap Overview.

[5] UNAIDS, global AIDS monitoring, based on GARPR reports, accessed at https://hivfinancial.unaids.org/hivfinancialdashboards.html#

[6] Calculated based on data provided in Ukraine's TB/HIV funding request to the Global Fund for 2018-2020 – Funding Landscape Table, TB Gap Overview.

considerably dependent on the Global Fund to Fight AIDS, TB, and Malaria, the US government, and other donors.

On March 22, 2017, the Cabinet of Ministers approved the *Strategy to ensure a sustainable response to the epidemic of tuberculosis, including chemoresistant, and HIV/AIDS until 2020*[7]. Its adoption was accelerated by the national dialogue on the new funding request to the Global Fund for the allocation period of 2018-2020.[8] The minutes and presentations[9],[10],[11] of this dialogue show the national agreement on the elevated role of the state sector across the national HIV and TB programs including in a greater portion of Global Fund grants managed, and strengthening the responsibility and capacity of the Public Health Center operating together with the two strong principal recipients from the civil society sector, «100% LIFE» (Ukrainian Network of People Living with HIV) and the Alliance for Public Health (APH).

The 2017 Transition Plan '20-50-80' set out a three-year vision and roadmap for moving from international to state management and funding in the following areas: HIV prevention, care and support for people living with HIV, and ARV and TB medicine procurement. At the time, international funding for those areas was largely managed by the «100% LIFE» and the APH. Developed by the National TB and HIV/AIDS Council's working group for the development of the funding request, endorsed by the National Council as Annex 10 to the funding request package, the Transition Plan was not given a status of a legal normative act. However, its implementation became a condition of the grant agreements with the Global Fund to gradual increase state financing. Failure to fulfill it could have resulted in withdrawal of 25% of the grant (nearly US$30 million)[12]. The formula, 20-50-80, was reflected the benchmarks for state take over of management, while state funding was to increase in the portions of 0%-50%-80% of funding for care and support for people living with HIV and basic HIV prevention services among three key populations: people who inject drugs, sex workers, and men who have sex with men.

In Ukraine, transition planning was an evolutionary process and not just a discrete plan. There were two iterations of the original Transition Plan, which was first developed in 2017, then updated in 2018 by the PHC and further readjusted with a progress update in the funding request to the Global Fund in 2020. Based on the records and the interviews conducted, the transition planning (areas and specifics in updated documents referred to the Transition Plan and its workplans) was evolving with changes in the health and PHC leadership and opportunities seen in ongoing health reform. As indicated in Figure 2 below, in 2018, two additional areas were added for planning transition – opioid agonist maintenance therapy and TB support services. The

[7] CoM Regulation of March 22, 2017 № 248-r

[8] MINUTES OF MEETING No. 2 of the Working Group for Development of a Draft Request of Ukraine to the Global Fund to Fight AIDS, Tuberculosis and Malaria to Get Funding for 2018-2020 TB and HIV/AIDS Programmes (hereinafter referred to as GDR) (Annex 35, Ukraine FR to the Global Fund for 2018-2020)

[9] Syvak Oksana, Deputy Minister of Health of Ukraine and Chair of the request development group. Process of preparing Ukraine's request for program funding for 2018-2020 from the Global Fund [*in Ukrainian*]. Presentation for the National council on TB and HIV/AIDS, 18 May 2017

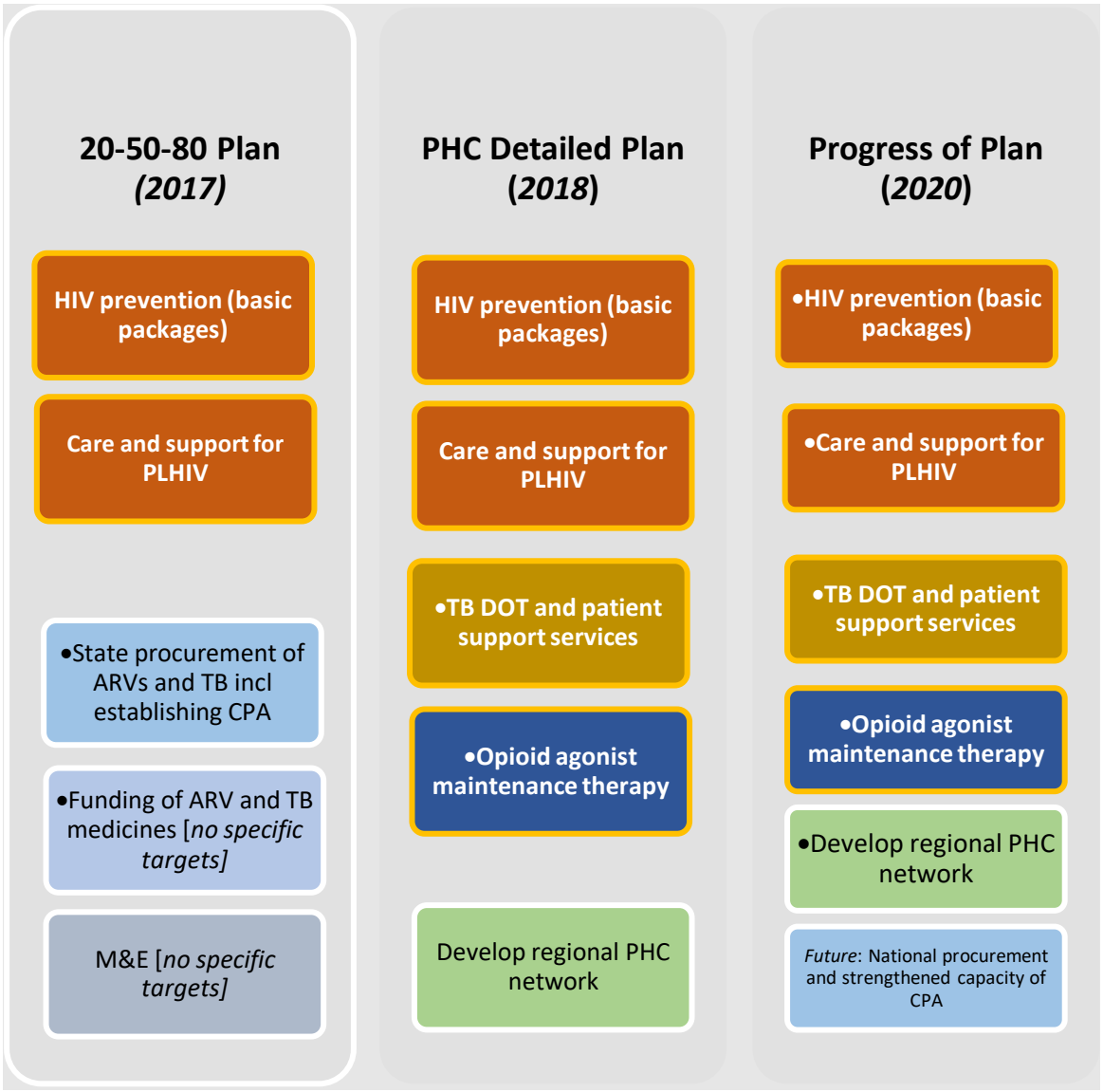
[10] Наталія Нізова, Центр громадського здоров'я як основний реципієнт програми Глобального фонду у 2018-2020 роках, 18 травня 2017 року [Nataliya Nizova. Public Health Center as the principal recipient of the Global Fund programs for 2018-2020, 18 May 2017] [*in Ukrainian*]

[11] Протокол засідання Національної ради з питань протидії туберкульозу та ВІЛ-інфекції/СНІДу 18-05-2017 [Minutes of the Meeting of the National Council on TB and HIV/AIDS, 18-05-2017] [*in Ukrainian*]

[12] Salabai N for the Oversight Committee on Strategic Information Analysis within the GF supported work for the National Council on TB and HIV/AIDS. Analytical note on implementation of the Plan for transition of Services supported by Global Fund programmes to state financing (Plan 20-50-80) (as of the end of 2019 – the first half of 2020) [*undated*]

further parts of the report examine four areas where the transition was foreseen, with the focus on HIV prevention among key populations and care and support for PLHIV.

Figure 2: Areas for increased state ownership in evolving Transition Plan and for this review
The figure presents a simplified overview of HIV, TB and OAMT response areas for increased state ownership. Areas in bold and outlined in yellow are focus of this review. The Progress of Transition Plan was included in the funding request of Ukraine to the Global Fund in 2020.



2.2 Implementation, coordination and monitoring

During the Global Fund grant implementation period, in 2018, in two regions (Poltava and Sumy) procurement of services using international funds for HIV prevention, HIV care and support and TB support through local state institutions was piloted. In July 2018, the National Council on TB and HIV/AIDS[13] charged the Public Health Center with the 'second phase of the implementation of Plan 20-50-80 in 2019'. It decided on a centralized model instead of the decentralized model

[13] MINUTES of Meeting of the National Council on TB and HIV/AIDS, City of Kyiv, 12 July 2018 (signed by Vice-Prime Minister of Ukraine and the Chair of the Council Pavlo Rozenko)

that was piloted, based on analysis presented by the PHC[14]. The areas of work requested by the National Council were: developing and facilitating the establishment of the normative basis for the allocation of state funding and procurement of services by the end of December 2018 including, but not limited to: service regulation development; methodology for defining needs; defining unit costs (tariffs) and the approach to the state budget process; and preparing procurement-related documentation, processes and structures. In the same decision, the National Council asked to revise the regional PHC structures, rules and regulations, though no specific role was set for them in the publicly procured services for HIV prevention, care and support.

In August 2018, the PHC's document, titled 'Detailed 20-50-80 Transition Plan,' outlined the centralized model of service procurement and set out normative work and other steps needed in relation to budget allocation and utilization and state service standards. Unlike the 2017 '20-50-80' Transition Plan, this document addressed TB treatment support in an ambulatory model and the scale up of OAMT including in prison settings as part of the areas of transition.

In 2019, the PHC established a "Strategic working group on issues of ensuring the sustainability of services in the field of combating HIV infection/AIDS and tuberculosis within the framework of the transition to state funding" ("*Стратегічна робоча група з питань забезпечення сталості послуг у сфері протидії ВІЛ-інфекції/СНІДу та туберкульозу в межах переходу на державне фінансування*")[15]. The purpose of this multi-sectoral group was "national coordination and monitoring of the performance of activities within the framework of the implementation of tasks in the transition from funding from international donors to funding from the state budget in the field of combating HIV/AIDS and tuberculosis". In 6 months of its operation in 2019, the Strategic Working Group met 6 times, discussing operational and strategic aspects of public procurement of services of HIV prevention and care and support for people living with HIV (PLHIV). In 2020-2021, it continued less intensively with 3 meetings per year. The initial composition of the Strategic Working Group included: 9 members[16] from the three Principal Recipients of the Global Fund-supported national HIV/TB programs (PHC, «100% LIFE» and APH); two civil society watchdog and capacity building groups (Budget Advocacy School and Institute of Analytics and Advocacy); the National Council's Oversight Commission; the International Renaissance Foundation (which was supporting civil society budget advocacy and initial working groups on health reforms); UNAIDS and; until 2021, a representative of the newly established strategic purchaser of health services in Ukraine, the National Health Services of Ukraine (NHSU). The group was expanded with representatives from the Ministry of Health, USAID and community groups in 2021. Most members played critical role in supporting the PHC with their analysis, addressing challenging issues including mediation in conflict situations and helping to support capacity building and awareness of providers, etc. Already in 2019, the

[14] «Центр громадського здоров'я Міністерства охорони здоров'я України» (ЦГЗ) Виконання зобов'язань України щодо переходу програм Глобального фонду на бюджетне фінансування в 2018 році. Презентація - Віктор Ляшко, Перший заступник Генерального директора [PHC. Fulfillment of Ukraine's obligations regarding the transition of the Global Fund program to budget financing in 2018. Presentation by Victor Liashko, First Deputy of the Director-General] [*in Ukrainian*]

[15] Наказ Державної установи «Центр громадського здоров'я Міністерства охорони здоров'я України» (ЦГЗ) №58-агд от 13.08.2019 Про утворення стратегічної робочої групи з питань забезпечення сталості послуг у сфері протидії ВИЛ-інфекції/СПИДу та туберкульозу в межах переходу на державне фінансування [*PHC Order No.58-agd of 13.08.2019 Regarding the Formation of a Strategic Working Group on Issues of Ensuring the Sustainability of Services in Response to HIV /AIDS and Tuberculosis within the Framework of the Transition to State Funding*] [*in Ukrainian*]

[16] Лист Державної установи (ЦГЗ) від 11.07.2017 № 1337 *[Letter of PHC of July 11, 2017 #1337] [in Ukrainian*]

Strategic Working Group decided to establish sub-groups on TB and prison settings. The review of the minutes of the Strategic Working Group in 2019-2021 found that its deliberations nearly exclusively focused on HIV prevention, care and support. Most other aspects of the Detailed 20-50-80 Transition Plan (like OAMT, NHSU-managed packages of state guaranteed medical care, centralized procurement, Regional PHC development) were not addressed. Hence the Strategic Working Group conducted a partial operational oversight for this Plan, not of the whole Plan.

The PHC regularly provided written updates to the Global Fund on the progress of implementation of the transition (two in 2019, monthly in the first half of 2020 and two 6-month reports in 2020). All the reports are focused on issues related to HIV prevention and care and support for PLHIV (normative, financial, direct implementation, and challenges with solutions).

Similarly, the Oversight Commission of the National Council on TB and HIV/AIDS issued biannual progress analysis which was shared and discussed with the National Council. For example, in 2019 and 2021, the National Council on TB and HIV/AIDS recommended publishing information about the progress of public procurement of services including results of the performance of indicators, normative acts and analysis on the PHC website, in 2021 on the recommendation of the Oversight Commission it recommended including the National Council's and its Oversight Commission members in monitoring visits[17].

The Transition Plan and its progress reports including the achievement of the results are not published on the PHC website, though are reflected in the annual bulletins "HIV infection in Ukraine"[18] and a newly developed portal[19] with info graphics and data on HIV including services taken over by state management and funding. The regional authorities and partners – even some that performed pilots in the Transition Plan were not involved in the discussion and coordination of implementation.

3 HIV prevention and support services for key populations and PLHIV

The transition plan contained a commitment to shift funding and administration systems of HIV prevention services (a basic package for three key populations) and care and support for people living with HIV (PLHIV) from donors to the government. State funding was set to follow benchmarks of funding 0%-50%-80% in 2018, 2019 and 2020. In 2018, a pilot of 20% of prevention basic services was planned with funding from the Global Fund's grant to the PHC. The sections below describe the achievements and lessons learned on several issues including: regulation, funding, service packages, the procurement model, management, and results for these prevention and care services.

3.1 Policy, normative and regulatory work

The overarching policy framework expresses a commitment to provide HIV prevention and care and support services. *The State Strategy on HIV/AIDS, TB and Viral Hepatitis for the Period until*

[17] Рішення Національної ради з питань протидії туберкульозу та ВІЛ-інфекції/СНІДу від 28 січня 2021 року
[18] Available at: https://phc.org.ua/kontrol-zakhvoryuvan/vilsnid/monitoring-i-ocinyuvannya/informaciyni-byuleteni-pro-vilsnid
[19] Accessed at: https://npsi.phc.org.ua/HIV_Monitoring

2030 (the State Strategy)[20] sets the target for the scale of comprehensive HIV prevention services among three key populations: people who inject drugs (PWID), sex workers (SWs) and men who have sex with men (MSM) at 70% coverage based on the estimated size of populations in 2020, 80% in 2025 and 95% in 2030. Care and support for people living with HIV is mentioned explicitly in its overall purpose of the State Strategy, though no specific targets are set.

The legal grounds for state takeover of the responsibility for services were largely established in 2019, with the bulk of work being completed even before the Strategic Working Group was formed. This work included setting service regulations, unit costs, the budgetary basis and budget line through which state would fund it, as well as tendering documentation in synchronicity with finding resources to be allocated for the services.

In June 2019, the Cabinet of Ministers gave a mandate to the Ministry of Health to start the organization of procurement of and allocation of funding for HIV prevention and care and support services[21] in line with the government-approved Concept of Public Health[22].

In July 2019, the MoH approved five normative documents for costing and regulation of the two services which are largely implemented by community-led and other civil society organizations (CSOs). For the first time, harm reduction services were explicitly recognized as part of the national health services outside policy documents. Regulations establishing "procedures for providing services" (i.e., public health standards for services), one for prevention and another for care and support for people living with HIV (PLHIV), were approved by the MoH[23],[24]. Before the approval of the "procedures for providing services", in line with the state budgeting practices, costing methodology to establish the approach to how to calculate the maximum amount for funding needs of those types of services and what this maximum sum includes was approved [25],[26]. Separate unit rates for two service packages (and each intervention included funded by the state) were approved by the MoH in line with the established state service procedures and the

[20] Розпорядження КМУ від 27 листопада 2019 р. № 1415-р «Про схвалення Державної стратегії у сфері протидії ВІЛ-інфекції/СНІДу, туберкульозу та вірусним гепатитам на період до 2030 року» [Cabinet of Ministers of Ukraine Decree dated November 27, 2019, #1415-r "Regarding Approval of the State Strategy of combating HIV /AIDS, tuberculosis and viral hepatitis for the period up to 2030"] [in Ukrainian] https://zakon.rada.gov.ua/laws/show/1415-2019-%D1%80#Text

[21] *[no longer in effect]* Розпорядження КМУ від 12.06.2019 р. № 497 "Деякі питання надання послуг представникам груп підвищеного ризику щодо інфікування ВІЛ та людям, які живуть з ВІЛ" [Cabinet of Ministers of Ukraine Decree of June 12, 2019 No. 497 "Some issues of providing services to representatives of groups at increased risk of HIV infection and people living with HIV"] [in Ukrainian] https://zakon.rada.gov.ua/laws/show/497-2019-п#Text

[22] КАБІНЕТ МІНІСТРІВ УКРАЇНИ РОЗПОРЯДЖЕННЯ від 30 листопада 2016 р. № 1002-р Про схвалення Концепції розвитку системи громадського здоров'я

[23] Наказ МОЗ № 1606 від 12.07.2019 Про затвердження Порядку надання послуг з профілактики ВІЛ серед представників груп підвищенного ризику щодо інфікування на ВІЛ [MoH Order on the Approval of the Procedure for Providing HIV Prevention among Representatives of Groups with Higher Risk for HIV]

[24] Наказ МОЗ № 1607 від 12.07.2019 Про затвердження Порядку надання послуг з догляду та підтримки людей, які живуть з ВІЛ [in Ukrainian] [MoH Order On the Approval of the Procedure for Providing of Care and Support Services for People Living with HIV]

[25] Наказ МОЗ №1556 від 08.07.2019 «Методика розрахунку граничних тарифів на надання послуг з профілактики ВІЛ серед групи підвищеного ризику щодо інфікування ВІЛ» [MoH Order on Methodology for Costing of Ceiling Rates for the Provision of Services of HIV Prevention among the Groups at Higher risk for HIV]

[26] Наказ МОЗ №1556 від 08.07.2019 «Методика розрахунку граничних тарифів на надання послуг з догляду і підтримки людей, які живуть з ВІЛ» [MoH Order on Methodology for Costing of Ceiling Rates for the Provision of Care and Support Services for People Living with HIV]

costing methodologies[27],[28]. The documents were registered in the Ministry of Justice. The Minister of Interior co-signed the key population regulation. These five MoH acts on services and their costing served as the normative basis for contracting and funding services in 2020-2021.

A budget line for the services was included into the existing budget program No2301400 of 2019[29], which funded HIV treatment among other things, and starting from 2020, in a new budget program "Public Health and Measures to Combat Epidemics" (budget program No 2301040)[30]. Notably, procuring public health services is one of five directions of the latter budget program and the only public services procured are the services for key populations and people living with HIV, demonstrating their high prioritization in the development of state public health system. Furthermore, the budget program development, revisions and updates must follow the regulations established by the Ministry of Finance (MoF)[31] requiring annual approval and all approvals and revisions to be agreed with MoF. Hence this work related to budget programs, particularly establishing new budget lines for HIV prevention and care and support of PLHIV, took major concerted inter-departmental preparations and coordination, led by the PHC in coordination with MoH and MoF, while being less visible to all national stakeholders.

3.2 Funding allocation, and spending

The state's allocation for HIV prevention services among key populations and care and support for PLHIV was 0 in 2018, 83.8 million UAH (40% of estimated annual need based on the 2018 budget[32]) in 2019, 207.5 million UAH (100% of estimated annual need) in 2020 and the same amount (100% of estimated annual need) in 2021 (*see details for allocations and spending in* Figure *3*).

These state allocations were based on the actual spending on those packages of services in 2018 within the Global Fund program. In line with the MoH approved methodologies for costing the two services[33],[34], the PHC, with the support of «100% LIFE» for support and care services for PLHIV and the APH for key population programming, collected the amounts and the structure of expenditures (including direct and indirect costs) and the average coverage data from referential service providers.

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[27] Наказ МОЗ №1681 від 23.07.2019 «Граничні тарифи на надання послуг з профілактики ВІЛ серед групи підвищеного ризику щодо інфікування ВІЛ» [MoH Order on Ceiling Rates for the Provision of Services of HIV Prevention among the Groups at Higher risk for HIV] https://zakon.rada.gov.ua/laws/show/z0906-19#Text

[28] Наказ МОЗ №1681 від 23.07.2019 «Про затвердження граничних тарифів на надання послуг, пов'язаних з ВІЛ» [MoH Order on Ceiling Rates for the Provision of Care and Support Services for People Living with HIV]

[29] Наказ МОЗ №411 від 14.02.2019 Про затвердження паспорта бюджетної програми на 2019 рік (2301040) [Order of the Ministry of Health No. 411 of 14.02.2019 On approval of the budget program passport for 2019],

[30] Постанова Кабінету Міністрів України від 27.11.2019 № 1121 Про затвердження Порядку використання коштів, передбачених у державному бюджеті для виконання програми "Громадське здоров'я та заходи боротьби з епідеміями" [Resolution of the Cabinet of Ministers of Ukraine; Order of November 27, 2019 No. 1121 On Approval of the Order for the use of funds provided for in the state budget for the implementation of the program "Public health and measures to combat epidemics"]

[31] Наказ Мінфіна України від 29.12.2002 № 1098 «Про паспорти бюджетних програм» [Order of the Ministry of Finance of Ukraine dated December 29, 2002 No. 1098 "On Passports of Budget Programs"]

[32] Further in the analysis the approach to the estimation of the budget is outlined based on the state methodology of costing services.

[33] Наказ МОЗ №1681 від 23.07.2019 «Граничні тарифи на надання послуг з профілактики ВІЛ серед групи підвищеного ризику щодо інфікування ВІЛ» [MoH Order on Ceiling Rates for the Provision of Services of HIV Prevention among the Groups at Higher risk for HIV] https://zakon.rada.gov.ua/laws/show/z0906-19#Text

[34] Наказ МОЗ №1681 від 23.07.2019 «Про затвердження граничних тарифів на надання послуг, пов'язаних з ВІЛ» [MoH Order on Ceiling Rates for the Provision of Care and Support Services for People Living with HIV]

In 2019, the MoH managed to provide funding for HIV prevention, care and support from the existing resources without the need for additional resources. This was possible because of savings in budgets for HIV product procurement according to former PHC and «100% LIFE» staff as well as the analysis of revisions of the "budget passport" (see also Section 6.3). Thus, optimization of antiretroviral therapy budgets made the first state funding for support services for key populations and PLHIV available. The work was done with incredible speed and synchronicity with state processes. Normally, budget planning starts a year before (i.e., in 2018 for the 2019 financial year) and any allocation requires a justification based on costing and service regulation, which were completed only in July of 2019, while the budget for 2020 in late 2019.

The annual allocations for services were utilized only partially in 2019-2021. The utilization rate started at low 24% of the allocated amounts in 2019 and improved in 2020 and 2021 (68% and 73% accordingly). Thus, the actual amounts reaching services were significantly less than in the previous periods, while the original benchmark for financial transition of 0%-50%-80% was largely achieved in the state allocations as 0%-40%-100%.

The underutilization took place at the stage of tendering and contracting providers (93% of the allocation in 2020 and 79% in 2021 were contracted) and at the stage of providers not being able to claim full budget for their services in line with the result-based financing approach (73% of adjusted in budget planning/contracted amounts were used in 2020 and 93% in 2021)[35].

Underutilization poses risks for the full allocation of funding in the future and is critical to address as, from the state management perspective, it signals low demand. In 2020 and 2021, the mid-year revisions of the budget reduced the allocations planned for HIV services, releasing unused funds for other health demands. Despite underutilization, the unchanged level of the planned allocations for 2021 and 2022 was possible due to the committed leadership at the MoH and the PHC[36].

The value of amounts allocated was lower in comparison with the same sum in 2018 because two aspects were not taken into account in the costing methodology: 1) inflation (indexing of unit rates is allowed in methodologies but was not foreseen in the methodologies for the two HIV services); and 2) the value added tax (VAT) involved for state procured services[37]. The Global Fund grants are not a subject to VAT, and, by extension, service providers do not pay 20% from the Global Fund projects. However, the purchase of public health services is not VAT exempt in Ukraine. The Strategic Working Group[38] and others analyzed the issue and options to move forward but it remains unresolved according to service providers.

The state has yet to fund (and procure) commodities for HIV prevention among key populations including syringes, needles, HIV rapid tests, lubricants. The prevention commodities are funded by the Global Fund, while the APH conducts procurement and supply management. According to two interviews with the state institutions, transferring to state funding, procurement and supply of commodities would create challenges to sustain the current approach to confidential, no ID-based distribution of prevention materials due to state legal provisions.

[35] Based on the analysis of data in Figure 1 and the contracted provider lists.
[36] Interviews with national stakeholders.
[37] Демченко, М. (2020). Аналітична довідка щодо набуття статусу платника ПДВ неприбутковою організацією [Demchenko, M. (2020). Analytical note on VAT payer status by a non-profit organization]
[38] SWG minutes of 11.02.2020, 02.07.2020

Figure 3: State allocation, spending and people served, based on budget data

Data from: Passport of Budget Program No 2301040 for 2019 (amendments on 05.12.2019 and 28.12.2019), 2020 and 2021, and its execution reports for 2019, 2020 and 2021; Passport of Budget Program No 2301400 for 2019 and its execution report.

		2019 (2nd half)	2020	2021
Financial indicators - thousands, UAH				
Allocated amount	*Total*	*83 821*	*207 492,4*	*207 492,4*
	HIV prevention	51 983,8	148 054,3	135 340
	Care and support for PLHIV	31 837,2	59 438,1	72 152,4
Revised allocated after contracting	*Total*		*192 894,4*	*164 152,1*
	HIV prevention		127 686,2	108 928,6
	Care and support for PLHIV		65 208,2	55 223,5
Used amount (% of allocated amount)	*Total*	*19 943,5 (24%)*	*140 091,2 (68%)*	*152 027,3 (73%)*
	HIV prevention	8 435,4 (16%)	90 917,3 (61%)	100 876,00 (75%)
	Care and support for PLHIV	11 508,1 (36%)	49 173,9 (83%)	51 151,30 (71%)
Number of people served (government funded)				
Planned	*Total*	*23'2986*	*355'057*	*314'207*
	HIV prevention	21'1611	305'953	277'199
	Care and support for PLHIV	21'375	49'104	37'008
Revised planned after contracting	*Total*		*306'713*	*287'799*
	HIV prevention		268'573	256'047
	Care and support for PLHIV		38'140	31'752
Implemented (% of planned)	*Total*	*77'933 (33%)*	*302'490 (85%)*	*276'881 (88%)*
	HIV prevention	64'975 (31%)	268'342 (88%)	244'161 (88%)
	Care and support for PLHIV	12'958 (61%)	34'148 (70%)	32'720 (88%)
Budget program No		2301400	2301040	2301040

3.3 State funded service packages

The MoH defined packages of services[39],[40] by engaging national partners and using the WHO/UN guidance as well as previous experience within the Global Fund funded programs. The MoH regulations on "procedures for providing services" establish the definitions, principles,

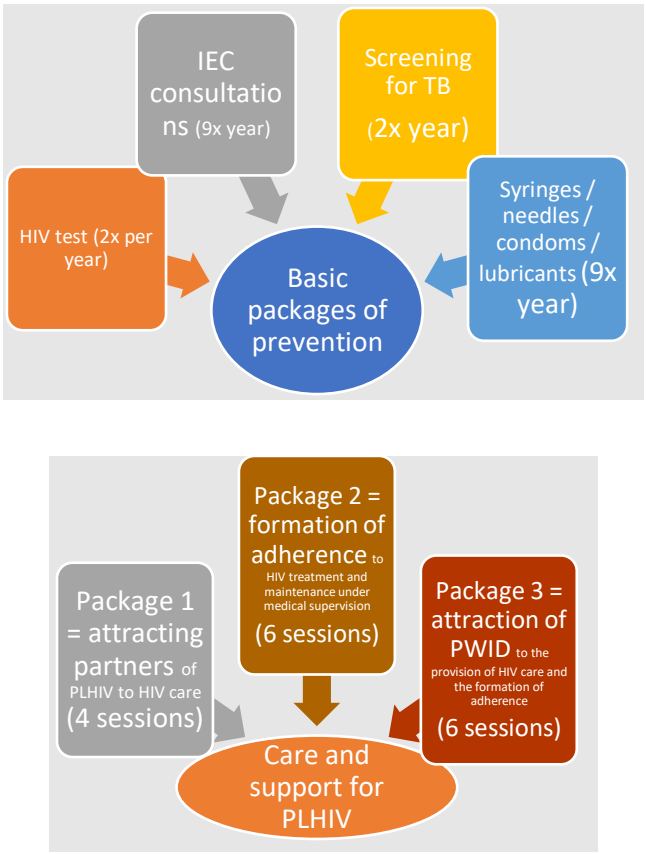
[39] Наказ МОЗ № 1607 від 12.07.2019 Про затвердження Порядку надання послуг з догляду та підтримки людей, які живуть з ВІЛ [in Ukrainian] [MoH Order On the Approval of the Procedure for Providing of Care and Support Services for People Living with HIV]

[40] Наказ МОЗ № 1606 від 12.07.2019 Про затвердження Порядку надання послуг з профілактики ВІЛ серед представників груп підвищенного ризику щодо інфікування на ВІЛ [MoH Order on the Approval of the Procedure for Providing HIV Prevention among Representatives of Groups with Higher Risk for HIV]

approaches, expected results, and details on how such services are provided. It established important principles for both types of services: emphasis on peer support including from key populations, people-centeredness and tailoring to needs, confidentiality (and in case of prevention – also anonymity), non-discrimination, and that they must be evidence-based. Both service regulations describe the packages of services funded by state and the set of additional interventions funded from other sources. The eligibility for providing services is left open for various forms of legal entities including state and private institutions in addition to CSOs.

In the case of prevention, the basic package covered by the state includes four services. In comparison, the open-ended list of other services (which are expected to be funded through local and international sources) is longer with 12 interventions, largely reflecting many services from the WHO's key population guidelines[41] and IDUIT, MSMIT, SWIT. It does not though directly address structural interventions like decriminalization or work to reduce stigma. As shown in Figure 4: State funded packages, based on the MoH service regulations, the basic services are: HIV testing, TB screening, the provision of targeted information, education and counseling (IEC), and distribution of syringes, needles, condoms and lubricants. The basic packages of HIV prevention were shaped to include the basic set of evidence-based services. Two national respondents noted that, for example, HIV case management for key populations is expected to be funded by international sources. Therefore, both state and international partners fund HIV testing, however with different approaches: the PHC funds the regular screening through outreach workers, while the international funding is used for the more-targeted and resource-intense "optimized case finding" (it corresponds partner-assisted referral or index testing, recommended by WHO[42],[43]). The APH data on non-state-funded, complimentary services used shows their high use by PWID with counseling, naloxone and testing for HIV being the most demanded services. For MSM, the most important extra service is HIV testing through "optimized case finding". Condoms and pre-exposure prophylaxis (PrEP) is in high demand.

Figure 4: State funded packages, based on the MoH service regulations



[41] Since then in 2022, the WHO updated the document and in 2022 issued the Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations.

[42] Based on the APH. Optimized case finding as a strategy to improve the HIV care continuum for PWID and their partners, presentation by O.Denisiuk in 2017, available at: https://gallery.mailchimp.com/92222f8f3ad2bfe9c770cf4b0/files/7996b265-1ccc-4c88-8eb1-0134722df4c0/LINKAGES_webinar__Ukraine_presentation.pdf

[43] WHO (2019). Consolidated guidelines on HIV testing services

For care and support services for people living with HIV, three packages are defined with different targets and a set of counseling and motivation sessions, as indicated in Figure 4. While there are no WHO specific standards on how to ensure adherence support, the CDC supported interventions were used for the state defined and supported packages of services. Since 2020, package 1 for reaching partners of PLHIV is no longer covered by state funding because it is supported from other resources and, according to services providers, with a higher rate.

In 2020-2021 Ukraine did not revise the service's regulations, though services reportedly had to adapt significantly to changing basic needs due to the COVID-19 pandemic and reported feedback provided [44].

Providers of both types of services were urged to improve people-centeredness, tailoring the packages to diverse needs and expanding counseling with a case management possibility for some clients in need and keen on getting more support. Based on the assessment, restrictions on adjusting services delivered are set in the MoH approved service regulations that define both packages and general principles of the delivery, the contractual agreement, and the payment model. Therefore, improving people-centeredness would require addressing all elements.

Table 1: Most popular additional services among the state-funded prevention clients

APH data from Syrex for the clients served in 2021; only services reached at least 1% included

Service	*PWID*	*SWs*	*MSM*
Counseling	17%	2%	3%
Naloxone	14%		
Testing for HIV	6%	1%	5%
Other TB service	2%		1%
Case management	1%		
PrEP			1%
Condom			2%

Based on the feedback received, the basic packages for prevention and care and support service packages for PLHIV require expansion in addition to the increased flexibility of the sub-set and frequency of interventions. Case management for more underserved clients was recommended for both prevention and care and support services. For prevention in particular, the packages are seen by providers as very basic, the attractiveness of which is added to greatly by support of other funders. Prevention clients and providers requested greater quantities, quality and variety of prevention commodities, especially condoms and possibilities for more frequent testing for HIV[45]. WHO generally recommends annual retesting of key populations, however, higher frequency of every 3–6 months may be warranted based on individual risks factors and as part of broader HIV prevention interventions[46]. Additional analysis would be needed if more frequent testing would be cost effective and for which sub-groups in Ukraine. Tests for viral hepatitis and syphilis were requested by clients and services for MSM. Overdose prevention and management with naloxone is in high demand and is lifesaving, therefore is an essential service (though not for everyone). COVID-19-related innovations and needs (transportation of ARVs to remote areas and for people with limited mobility; online counseling sessions for key populations; self-tests) were requested to be included in the MoH regulations for the state-funded services and

[44] Based on the five focus group discussions with service providers. The summary report is available as an Annex.
[45] The review could not separate potential bias that the higher costing for the HIV testing intervention (in comparison with other interventions in the basic package) might have influence on the views of service providers.
[46] WHO (2019). Consolidated guidelines on HIV testing services

contracts. While civil society participants are included in various consultations, service providers encouraged involvement of individuals working with clients directly (not only CSO managers).

Trans people and people in prisons are part of the HIV prevention practice in Ukraine and the WHO definition of key populations[47], but they are not mentioned in the ministerial regulations of services. Health (and therefore HIV services) in the penitentiary system are under the stewardship of the Ministry of Justice, therefore regulating services in those settings is outside the current MoH mandate. Trans people, unlike incarcerated people, are not included in the MoH definition of groups at high risk for HIV[48]. The first prevention services for them started in 2016 within Global Fund Project, therefore, in 2017, the understanding of the package needed and strategic data were nascent (and their representative was delegated to the National Council in 2019) but advanced in 2018-2021, giving a strong basis to codify the prevention practice in the future[49].

***From client survey and provider focus groups*: Opportunities for service package improvements**

Care and support for PLHIV:

- The packages do not allow flexibility to be regarded as fully people-centered. According to providers, 6 sessions are not sufficient for many, especially for people who use drugs or people in difficult life situations. Some require more non-lecture type consultations and case management. Assistance for people with limited mobility is not factored in service approaches. There are some who do not need information sessions. Some providers suggested exploring combining the two packages – for PLHIV and for PLHIV-PWID – if a more flexible approach was allowed.
- The package is provided for PLHIV only once without possibility for additional counseling after the "package" is received, which clients and national stakeholders recommended revising.
- For service providers, the package on engaging PLHIV partners was not financially competitive with a parallel donor-funded model. Therefore, it was discontinued, though generally regarded as important.
- Delivering of medicines became a critical service in the context of the COVID pandemic especially in remote areas and has worked well and therefore should be covered by state.

HIV prevention:

- Service providers for the three key populations highlighted the need for "less rigid" and fewer "one-size-fits-all" regulations or/and contractual arrangements of services, allowing nuancing to individual needs and regional specificities – some clients are counselled more frequently in practice and some clients might not show up after few visits, making it artificial to try to deliver them the full package of "2+9" services.
- The three packages are rather basic though highly appreciated. They continued to be heavily complemented by donor programs to make them more attractive for clients and impactful for HIV response, e.g. MSM service providers highlighted the need for HCV/syphilis testing, others for case management for people with greater needs. Clients asked for humanitarian

[47] WHO (2022). Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations

[48] МОЗ наказ 12.07.2019 № 1606 «Про затвердження Порядку надання послуг з профілактики ВІЛ серед представників груп підвищеного ризику щодо інфікування ВІЛ» [Ministry of Health Order of 12.07.2019 No. 1606 "On approval of the Procedure for providing HIV prevention services among representatives of groups at increased risk of HIV infection"]

[49] Interview with national stakeholders.

support, more naloxone, basic medicines for liver, ointments, self-tests, referrals to health specialists (for hepatitis C treatment, neurologist, gynecologist).

- Supplies: Both service providers and clients highlighted the need for increased amounts of syringes and condoms issued based on needs, but, as one provider put it, some individuals might not want to come 9 times for a limited amount of goods. Clients emphasized the need for improved quality, variety of condoms, and overall increased quantities of supplies including naloxone. Some service providers reported experienced of interruptions in supply provision for state-funded services and sometimes solving them through donor-funded programs implemented by the same NGOs. This shows the need for further improved coordination of supply provision and management between the PHC, and APH.

- More frequent and accessible testing. HIV testing is needed more than 2 times for many cases according to providers of all services. Some clients requested adding oral and self-testing and too highlighted wishes for higher frequency. Two providers mentioned that there is an overlap of testing funded by state with other work funded by donors with greater incentives.
- Services for SWs and MSM asked to allow virtual, phone counseling, which is currently included only as a complimentary service in the MoH regulation on services and have become key in the COVID context.

Summary reports of the service clients survey and focus groups with service providers are available as Annexes to this report.

3.4 Funding model

In line with the Transition Plan, in 2018, the PHC piloted contracting of services for HIV prevention, support and care for PLHIV and TB through regional state entities. The pilots developed contracting models, delivered services and even managed to go through local auditing[50]. Nevertheless, after the pilot, the National Council on TB and HIV/AIDS decided on a centralized model of procuring of services. Centralization was expected to bring more predictable, standardized and transparent contracting processes, independent of the political and structural readiness of regional (public) health institutions.

In 2019-2021, the two types of services, the prevention package, and care and support, were procured by the PHC in accordance with the Law on Public Procurement[51]. In line with the requirements of the Law for services, the price of which exceeds 50'000 UAH, the PHC announced open tenders on the ProZorro platform, an open government e-procurement system. Separate tenders are announced for each administrative region and each group to be served (PLHIV, PWID, SWs and MSM) indicating targets, and maximum price for each. Tenders are won by those qualified bidders that propose the lowest price, as per the Law. The invitations for bids can be announced only after the relevant budget lines and procedures are executed.

In 2021, there were 92 contracts with 52 organizations in 25 administrative regions[52]. The state tenders, unlike the Global Fund grants, allowed all types of qualified service providers (for-profit, government and civil society) to apply, however, all organizations contracted in 2021 were from civil society only. In comparison with the pre-transition period, the service provider market has

[50] Interviews with national stakeholders.
[51] ЗАКОН УКРАЇНИ No 922-VIII Про публічні закупівлі (Відомості Верховної Ради (ВВР), 2016, № 9, ст.89)
[52] Based on the PHC data in «*Договори2021_Профилактика.xlsm*» and «*Договори2021_ДІП.xlsm*»

changed, with increased consolidation of service providers, serving more than one population group and/or in more than one region. Organizations, -regional representations of the "100 LIFE", expanded their participation in prevention in some regions (14 out of 67 contracts for prevention). Additionally, there are other key population community-led organizations engaged in service delivery, especially for MSM. Thus, around half of the contracts in 2021 were received by community-based and -led organizations. Not all regions had prevention services contracted by the PHC. In 2021, no contracts were established to deliver services for MSM in Donetsk, Kirovohrad, Sumy, and Zaporizhe and no services for SWs were contracted in Chernihiv.

Over the course of 2019-2021, there were some improvements based on learnings from developing this innovative centralized model, largely coordinated by the PHC's multi-sectoral strategic working group. As the tendering documentation requirements are different and more complex in comparison with donor program requirements, the PHC and other partners invested in improving understanding of the preparatory steps necessary for the potential bidders. The procurement model moved to one contract per oblast, though previously the largest cities had more than one provider. Tender competition allowed new providers to enter the service provider market but also provoked major conflictual situations among CSOs serving key populations, and required professional mediation in Kharkiv, Kherson, Lviv, Mykolaiv, Odesa, Rovno, Zaporozhe (in case of Kyiv mediation has not helped)[53]. In 2020-2021, to stimulate the uptake of state contracts and complementarity, only providers with existing state contracts were eligible for the APH calls for proposals for donor-funded prevention and testing services (though exceptions took place). Still, that did not fully ensure the engagement of some MSM groups with other funding sources where rates and approaches to funding are better.

Because the budget allocations are approved on annual basis in line with the state budget cycle, there is a delay of when tendering procedures could be completed and the selected organization can enter a contract with the PHC for the delivery of services. Therefore, the PHC was supported by the MoH to allow issuing additional contracts at the end of the year for an additional period of one quarter with the organizations that would agree. However, interruptions due to the annual budgeting cycle remain[54].

A major amount of frustration and difficulties related to the procurement model were recorded by this review, however, the review team agreed with the PHC, UNAIDS and the Global Fund not to expand on the model review and recommendations of changes and relevant experience from elsewhere, as alternative models of contracting are already being discussed in parallel with this review. Moreover, the difficulties have been raised extensively in various forums and discussed[55],[56]. In 2021, a separate study was conducted by the think-tank, the Ukrainian

[53] Information from Roman Drozd; relevant meeting reports are available

[54] In the budget report for 2020, the MoH explains the underutilization of funds and invoked flexible procedure as follows: "due to the completion of the tender procedures by the authorized state enterprise at the end of the year, it was not possible to make payments to suppliers after the end of the budget period and medium-term contracts were concluded with suppliers (based on the Law of Ukraine dated 15.12 .2020 No1081-IX "On Amendments to the Budget Code" of Ukraine).

[55] Salabai N. for the Oversight Committee on Strategic Information Analysis within the GF supported work for the National Council on TB and HIV/AIDS. Analytical note on implementation of the Plan for transition of Services supported by Global Fund programmes to state financing (Plan 20-50-80) (as of the end of 2020) [*undated*]

[56] Письмо Національного ЧСЧ-консорціуму No L-1237-110221/MSMPRO, 01.11.2021 «*Огляд проблем щодо надання ключовій групі ЧСЧ послуг із профілактики ВІЛ, догляду та підтримки у зв'язку з ВІЛ за кошти держбюджету та відповідні пропозиції щодо їх вирішення* » [Letter of the National MSM Consortium No. L-1237-110221/MSMPRO, 01.11.2021 "Overview of problems related to the provision of HIV prevention, care and

Healthcare Center (UHC) to inform the discussions on the alternative models for the future[57]. They documented the following difficulties: delay in contract signing, competing on price not quality, lack of flexibility during contract negotiation and signing, wrong incentives in the payment method, non-competitive unit cost, fragmented information systems limiting analysis of HIV continuum of care and achievements, and weak cooperation of services within administrative units.

In addition to the contracting processes and model, providers found it challenging to use the rigid service packages and costing in contracts and the payment method. Prevention service providers raised this issue, while care and support providers are more content with the approaches in part because interventions are less fragmented and costed at satisfactory rates. For example, one information session is 326 UAH, in comparison with 400 UAH per for a sex worker covered with the full basic package of nine visits per year. The recommended frequency of interventions in the MoH regulation for prevention services (e.g. HIV testing twice per year, IEC sessions 9 times per year) was turned into fixed ceilings and packages for each client served in contracts between the PHC and service providers. Their application in bridging contracts at the end of the year and beginning of next year create even more challenges for delivering required interventions in a tight time frame. Rates of the same or similar interventions for different populations and among interventions within the packages differ greatly[58], creating uneven incentives. They are not nuanced to reflect significant investment needed for bringing new clients or more expensive cost in localities with smaller concentration of clients. The rationale for the differences in unit costs between the three key populations and among the packages for care and support for PLHIV is not clear to providers. Providers mentioned challenges of ensuring predictable contracts and regular payments to their staff due to the fragmented schedule and payment systems of state contracts, international donor grants are used to mitigate some of those challenges[59].

3.5 Management

In 2019, the PHC established a special department which, as one stakeholder put it, was the driver of the implementation of transition work for HIV prevention and care, and support for PLHIV. As of the end of 2021, the PHC had 11 dedicated staff members for program management and monitoring of services. It spends 5 million UAH (nearly US$140 thousand)[60] per year for its operations to manage procurement, contracting and contracted HIV prevention and support and care services, which represents 2.5% of the state budget spent on the relevant services. Relevant regulations and processes have been established. The monitoring procedures for state funded services were updated[61],[62].

support services to a key group of MSM at the expense of the state budget and relevant proposals for their solution]

[57] Український центр охорони здоров'я (UHC) (2021). Аналіз моделей закупівлі послуг, пов'язаних з ВІЛ [UHC (2021). Analysis of Models of Procuring HIV-Related Services]

[58] E.g. information session for adherence support is paid 325 UAH, while engaging PWID into HIV care costs less - 299 UAH. Testing of sex workers and MSM costs less than people who inject drugs 73 vs 77 vs 110 UAH, HIV testing is the most expensive service within the prevention package (110 UAH vs distribution of condoms/syringes 5.1 UAH for people who inject drugs). Generally, having different rates is a normal practice and justifiable to reflect the level of effort required.

[59] Focus groups with service providers in August 2022

[60] PHC information

[61] ЦГЗ #33–агд Процедура З проведення моніторингу діяльності надання послуг з профілактики ВІЛ серед груп підвищеного ризику щодо інфікування ВІЛ, 16 серпня 2021

[62] ЦГЗ #34–агд Процедури з проведення моніторингу діяльності надання послуг з догляду і підтримки людей, які живутъ з ВІЛ, 17 серпня 2021

The PHC management covers all the state contracts with providers, however, other complementary packages remain managed by the two CSO principal recipients of the Global Fund, "100 LIFE" and the APH. The actual amounts of those additional budgets and efforts for the complementary packages were not collected therefore, the assessment could not calculate the PHC's portion in the management of key population programming and care and support for PLHIV in Ukraine. As indicated earlier, prevention commodities (condoms, lubricants, syringes, naloxone, etc.) remain funded by international donor projects and procured by the APH to the state-funded services.

The PHC cooperates with other PRs in management of HIV prevention and care and support for PLHIV. For example, a consensus decision was made to terminate one contract after fraud was reported. Similarly, the PHC and Alliance for Public Health jointly agreed on the algorithm for reporting from different modalities of HIV testing services[63]. There is still space for greater synergies: there has been no utilization of APH and «100% LIFE» for onsite monitoring after 2019, nor there has been collaboration to formally exchange reports of monitoring visits[64].

Based on interviews, the PHC is seen as under-resourced for its management functions. The staff conduct procurement of 90 state tenders, organize repeated announcement of tenders until bids are fully placed and completed, and prepare and oversee 92 contracts with modifications - each of which requires a monitoring visit. In comparison with the 11 dedicated employees in the PHC's department dealing with prevention and care and support for PLHIV, the «100% LIFE» alone has twice as much staff for monitoring and strategic information, legal, program management and procurement functions[65]. The PHC salary rates are not competitive with the NGO principal recipients, even with the Global Fund funded top-ups to compensate for low payment levels for state officials[66]. Therefore, the PHC has faced challenges to recruit qualified staff with relevant program experience. High dissatisfaction with the procurement model and practice among prevention providers in particular led to up to 20 inquiries and complains per month. Extra effort was invested to convince providers to apply to tenders. This contributed to burnout of some PHC staff. Moreover, the limited capacity and significant volume of urgent work left little to no time for analytical work and addressing recurrent issues, for example, funding additional services or trying innovative solutions for building capacities or community mobilization for service provision (e.g. in the regions without services).

The transfer of capacity to the PHC in terms of databases for service monitoring has seen limited progress, tapping existing know-how and tools. There are two databases for the services: 1) Syrex developed, administered, and owned by the APH for key population programming; and 2) C++ developed, administered, and owned by «100% LIFE» for support and care for PLHIV.

The services contracted by PHC use the existing databases, following the approaches known to both clients and providers, i.e. in the case of prevention among key populations, there is high confidentiality because of a special a depersonalized client code. The PHC is an advanced user of both databases, getting special access to state-funded service data. Data check (e.g. removing of

[63] PHC &APH (2021). Reporting algorithm for HIV-positive clients identified in the state-funded prevention program and receiving CITI case management support funded by the Global Fund
[64] Interviews with the former PHC manager and APH.
[65] Based on the staff listing on the 100% Life website at: https://network.org.ua/en/our-team/
[66] Interviews with three national stakeholders.

duplications and mistakes that take place during entering of data, cross-checking with the OAMT provider reports on referrals to OAMT) takes place manually.

A 'DataCheck' e-tool was created by «100% LIFE» with donor funding but it has yet to be transferred to the PHC and is expected to replace C++ for care and support monitoring. The two databases, Syrex and C++, are neither integrated with each other, nor are integrated with the main HIV database in Ukraine 'МІС ВІЛ', as they do not have the certification needed for managing protected data. The PHC can manually cross-check clients in C++ (HIV care and support) and 'МІС ВІЛ' because of the same shared client code. Because the PHC does not (co-)own the two databases, it is dependent on the two civil society organizations for modification of the information systems or producing analysis that combines the PHC and APH/"100% LIFE" data. As a result, the PHC does not have a way to directly to see progress on achievement of the State HIV/TB/Hepatitis Strategy's main indicator for key population programming, i.e. the coverage levels of key populations with the *comprehensive* packages of services, which should include both state-funded basic packages and complementary services supported from other sources.

3.6 Results

Coverage

In 2021, the state-funded services reached 45% of key populations, including more than half of the estimated numbers of people who inject drugs (PWID), and sex workers (SWs) and a quarter of men who have sex with men (MSM) in the government-controlled territories in 2021. Hence the 70% coverage target set for 2020 by the State Strategy on Combating HIV/AIDS, TB and Viral Hepatitis was not achieved (the level of achievement of this Strategy's target was 64%). The largest gap is for MSM. The coverage targets set in the state budget program for prevention were lower than in the State Strategy; their level of attainment was 88% in both 2021 and 2022. The coverage with the state services increased significantly during (and despite of) the COVID pandemic.

Cumulatively, during the Transition plan's implementation, organizations contracted by PHC served nearly 80,000 PLHIV with care and support, i.e., 40% of the estimated number in government-controlled territory. In 2021, 100% of PLHIV who received care and support services were on ART, according to the PHC report on the budgetary program. Notably, by design the services are not planned for everyone but targeted to specific sub-populations of people living with HIV, i.e. these that are preparing for initiating ART and/or experiencing difficulties to adhere to treatment, like people who inject drugs. There is no target for the services of care and support for PLHIV in the State Strategy.

Outcomes

For both PWID and MSM there is evidence of significant improvement in the key parameters of the HIV diagnostic and care cascade – getting tested for HIV, enrolling in HIV care, starting ART and achieving viral suppression between 2017/2018 and 2020/2021[67]. Other IBBS parameters

[67] Based on the IBBS data for 2017, 2018 and 2020 and 2021 for PWID and MSM:
Сазонова, Я, Ю. Дукач, Ю (2019). Звіт за результатами біоповедінкового дослідження серед чоловіків, що практикують секс із чоловіками в Україні. Аналітичний звіт за результатами дослідження 2017 року. АРН
Draft of the analytical report on MSM IBBS 2021
І. Тітар, С. Сальніков та ін. (2021). Звіт за результатами Інтегрованого біоповедінкового дослідження 2020 року серед людей, які вживають наркотики ін'єкційним шляхом. ДУ «Центр громадського здоров'я Міністерства охорони здоров'я України». 2021.

stayed relatively stable or insignificantly improved. Additionally, some changes for PWID might be linked to the drug scene changes (e.g. fewer people buy pre-filled syringes but more experienced overdose in 2020 than in 2017).

The HIV care cascade improved between 2017 and 2021. In this period, the portion of diagnosed PLHIV who receive ART increased from 72% to 83% and the share of ART recipients who achieved viral suppression grew from 83% to 93%[68]. In a small sub-set of clients reached through an online survey, half reported achieving suppressed levels of viral load.

Prevention clients reached for this review (n= 453) estimated their ability to prevent HIV due to services at 4.4 (out of 5) and to find out their status at 4.5.

Transition from the clients and providers' perspective

Both providers and most clients welcomed state funding and have confidence in the services to be sustained in the future because of systemic state funding. National stakeholders and services thought that this funding contributes to de-stigmatization of the services, the people served (key populations and PLHIV), and the services especially in relation with state institutions.

Meeting the WHO/UN recommendations for coverage

Ukraine has not achieved the WHO recommended target for coverage (at least 60% of each key population) and the WHO-recommended target for number of needles and syringes distributed. The target for clean injecting equipment that was updated by WHO for viral hepatitis elimination is 300 needles and syringes per person per year. Ukraine reports just 65 syringes distributed per estimated person who inject drugs in 2020 (though this is an increase in comparison with 2018 and 2019)[69]. The MoH regulation on HIV prevention services envisions distribution of 200 syringes per year per client on average in 2022.

"Pre-transition" and "new" clients

There was great continuity of prevention services: the majority of clients that used services in 2018-2019 successfully 'transitioned' to the new era of the state-funded basic packages (see Table 2). Additionally, they additionally attracted new, previously underserved clients. Already in the few months of contracts in 2019, 30,000 people benefited from prevention for the first time since 2018. A significant increase in recruitment of new members is reported for MSM and sex workers who were underserved before the transition process.

Table 2: State-funded services for key populations: 'old' and new clients

Based on the PHC and APH data for government-controlled areas (GCAs) only (provided extracted from Syrex and separate files from APH)

Population	Population size estimate (PSE)	Number of state-funded clients covered by any intervention from the basic package, 2021		Number of pre-transition clients that continued with state services in 2019, 2020 and/or 2021		The number of unique additional clients that were not served before state funding was made available, 2019	
		Number	*% of PSE*	*Number*	*% of PSE*	*Number*	*% of PSE*

Ю. Середа, Я. Сазонова. (2020). Звіт за результатами біоповедінкового дослідження 2017 року серед людей, які вживають наркотики ін'єкційно, в Україні. АРН

[68] PHC data in the national public health monitoring platform, section on the achievement of the 95-95-95 goals for HIV [Моніторинг ВІЛ-інфекції в Україні, ДОСЯГНЕННЯ ЦІЛЕЙ "95-95-95" (ПЕРІОД: З 2017Р. ПО 2021Р.)].

[69] UNAIDS key population atlas, accessed at: https://kpatlas.unaids.org/dashboard

PWID	317'000	169 433	53%	116 364	37%	25 985	8%
SWs	82'300	42 643	52%	27 603	34%	2 232	3%
MSM	161'200	39 681	25%	20 941	13%	2 419	2%

Verification of delivery

Issues of possible overreporting of coverage numbers and gaps in the verification and response systems were raised in several interviews. Globally, there is a strong focus on quantitative coverage indicators for key populations, mirroring the ambitious UNAIDS target of 95% key populations having access to and using combination prevention options by 2025[70]. Like in many other countries, in Ukraine, prevention targets are put into results-based financing schemes which incentivize service providers and staff to achieve as high coverage as possible. On the other hand, generally, prevention services have fewer verification tools because they use depersonalized data for coding clients reached. The discussion on how to improve verification, without giving up of confidentiality and flexibility of services, is neither unique to the transition context (it took place before the PHC took over contracting and funding of the basic packages) nor it is exclusive to Ukraine. The PHC puts significant efforts into the verification of service delivery and has strict provisions in its contracts for cases when verification fails during their monitoring visits or report reviews. Service providers reported anecdotes of their reporting mistakes that led to "unverified" coverage or situations preventing a PHC representative from getting access to clients and therefore not being paid, therefore they see the verification as focused on penalizing providers. At the same time, quality assurance is not prioritized in the PHC management approach. Before the transition, the Global Fund supported the APH to update its management and contracting tools to strike a nuanced balance between the three aspects - the strive for increased coverage of numeric indicators, limitations of verification means and quality assurance. The PHC could utilize this know-how to nuance its own contractual arrangements and monitoring and management systems to establish bonuses and penalties for stimulating quality and adherence to the service regulations. As previously mentioned, increased monitoring and supportive programmatic functions are needed (either in-house or outsourced or a combination of both).

Quality assurance and attractiveness of services

[70] UNAIDS Global AIDS Strategy 2021-2026 End Inequalities. End AIDS.

Quality assurance is an emerging topic where the discussions have begun but have not advanced yet due to other priorities[71], as in part highlighted above.

There are certain areas for improvement from the perspective of clients (Table 3 above), including frequency, more convenient hours and location, greater adaptation of sessions delivered through care and support.

Table 3: Attractiveness of elements of services from the clients' perspective

*Rating from 0 to 5 with 5 being maximum, presented in the order of ranking. This combines feedback received for this assessment from interviewees and online respondents, n=445 for prevention, n=209 for syringes and needles, n=141 for care and support for PLHIV, *services rated only through interviews*

HIV prevention		*Care and support for PLHIV*	
Quality of syringes and needles	4,4	The attitude of the staff, lecturers*	5
Friendly staff, satisfaction with info received	4,3	Felt safe and well at support services	3,6
Quantity of syringes and needles	4,2	Regularity of receiving the services in need	3,5
Felt safe, comfortable to share personal info	4,2	Regular access to outreach, staff	3,5
Regular access to staff	4,2	Ensuring confidentiality of HIV status	3,5
Convenient location / route	4,1	Improved competence for living with HIV	3,4
Convenient working hours	4,0	Convenient hours of operation	3,3
Regularity of receiving the services in need	4,0	Convenient geographical location	3,1
Number of condoms and lubricants received	3,8	Lectures are adapted to needs	3,1
Quality of condoms and lubricants received	3,6	Duration and frequency of sessions	3

See Annex 3 for the summary report of the survey

Clients feel comfortable in services and report friendly staff, good quality and quantity of syringes and needles. At the same time, when asked about state funding nearly every fifth expressed concern about their data being shared outside or within the health system. SWs and MSM were particularly concerned about anonymity. Additionally, 60% of clients report they were not asked for feedback and suggestions how to improve services in 2021.

From the providers perspective (Table 4), they can protect client's data, ensure competent staff and client-friendly hours. However, the particularly challenging areas are innovations and adapting to changing context – the current state approach and support does not enable innovations, as has been highlighted also in the interviews.

Table 4: Provider's view: ability to ensure general quality elements (focus group participants)

Client data protection	81%
Competent and friendly staff	77%
Client-friendly opening hours	73%
Uninterrupted service delivery (in peacetime)	58%
Gathering needs and feedback from clients	50%
Creating a safe space for clients	50%
Geographical availability (incl online services)	27%
Volume and variety of preventive commodities	23%
Frequency of services provision based on demand	15%
Implementation of innovations	4%
Adapting to changing contexts	4%

See Annex 4 for the summary report of the focus group discussions and assessments from the perspective of service providers

[71] ЦГЗ, IFR (2020). Розвиток системи управління якістю програм та послуг в сфері протидії ВІЛ-інфекції в Україні в рамках переходу на державне фінансування. Спільна концепція, Проект для обговорення [Development of the management system for the quality of the program of services in the field of anti-VIL-infection in Ukraine as part of the transition to a sovereign state of finance. Concept, draft for discussion]

4 Opioid agonist maintenance therapy (Substitution maintenance therapy)

Opioid agonist maintenance therapy (OAMT) or substitution maintenance therapy (SMT) has been implemented in the country since 2004 and has been part of the efforts to increase state ownership before the 2017 Transition Plan. Procurement of medicines for OAMT at the expense of the State Budget in 2016 was part of the Global Fund's special requirements[72]. In 2016, around US$1.1 million were allocated by the government within the 2016-2017 budget envelope. In 2017, OAMT medicines were procured by the Ministry of Health[73],[74].

The transition plan of 2017 did not address OAMT but the State Sustainability Strategy did. The iteration of the Transition Plan in 2018 set specific milestones for supporting sustainable implementation of OAMT programs, namely: a) develop national OAMT goals; b) develop scale-up strategy focusing on primary care including through the state guaranteed care packages; and c) introducing OAMT in the penitentiary system.

4.1 National OAMT goals

Targets for OAMT scale up were set in the State Strategy for HIV/AIDS, TB and Viral Hepatitis for the Period until 2030, approved by the Cabinet of Ministers in 2019. Additionally, the Programmatic Committee of the State Council on TB and HIV/AIDS identified specific quantitative targets for 2020, 2021, 2022, and 2023[75]. The implementation plan for the National Strategy on State Drug Policy for the Period Until 2020[76],[77] also foresaw the development of OAMT, and the National Strategy on State Drug Policy highlighted important structural barriers for people to accessing services including the need to reduce stigma of people who use drugs. The Drug Strategy is however not renewed yet.

The planned scale up in the State Strategy for HIV/AIDS, TB and Viral Hepatitis for the Period until 2030 is ambitious in comparison with the baseline, which was 5.5% of the estimated number of people who inject opioids or have opioid dependence in 2020. Over 5 years, the portion of eligible people on OAMT is to increase nearly 3 times to 15% and by 2030 to reach 40%.

A collaborative workplan was developed to operationalize the scale up of OAMT across the administrative areas in 2019-2023[78]. The workplan establishes specific roles for the implementation for the PHC, a Hotline run by expert clients БФ «Надія та Довіра» (Hope and

[72] National Council on TB and HIV/AIDS. Minutes of the meeting (chaired by Rozenko, Vice Prime Minister of Ukraine, Chairperson of the National Council), 16 February 2017, Kyiv [unofficial English translation]
[73] План розвитку програми замісної підтримувальної терапії в 2019 – 2023 роках, 2018
[74] Курпіта, В. Результати впровадження програм Глобального фонду у 2017 році. Accessed https://moz.gov.ua/uploads/ckeditor/документи/Національна%20рада%20з%20питань%20протидії%20туберкульозу%20та%20ВІЛ-СНІД/Матеріали%20засідань/2018/4_Звіт%20ЦГЗ.pdf
[75] The Programme Committee of the National TB and HIV/AIDS Council set the targets of 20,596 clients in 2021, 25,884 in 2022 and 31,172 in 2023 (PHC, Report on the Results of the Implementation of Substitution Maintenance Therapy in 2020 [in Ukrainian: Звіт за результатами впровадження програми замісної підтримувальної терапії у 2020 році], 2021.
[76] Верховна Рада України. Про схвалення Стратегії державної політики щодо наркотиків на період до 2020 року. 2013; https://zakon.rada.gov.ua/laws/show/735- 2013-%D1%80, April 2020
[77] Кабінет Міністрів України. Про затвердження плану заходів на 2019-2020 роки з реалізації Стратегії державної політики щодо наркотиків на період до 2020 року. 2019
[78] План розвитку програми замісної підтримувальної терапії в 2019 – 2023 роках, 2018.

Trust), a people who use drugs network «ВОЛНА» (VOLNA), the Ukrainian Institute of Public Health Policy, and «100% LIFE». Additionally, PEPFAR and UNODC contributed to the workplan.

The scale up planned is insufficient for reducing HIV incidence at the population level and prevalence among people who use opioids and their sexual partners. The WHO's recommendation for impactful coverage is 40%[79]. Different modeling exercises demonstrate that higher coverage with a greater combination of interventions is needed in settings with higher HIV (and HCV) prevalence for reducing incidence and prevalence, especially in higher burden and prevalence regions[80],[81],[82]. Since Ukraine has high HIV prevalence among people who inject drugs (above 20%), therefore higher combination coverage is needed for impact on HIV.

4.2 Scale-up strategy focusing on primary care through the Program of Medical Guarantees (PMG)

Since 2017, OAMT services were scaled up by 60% from 10'189 state-funded clients in 2017 to 16'322 state-funded clients by the end of 2021[83]. As part of health financing reform, in 2018, the Law on Health Services Financially Guaranteed by State for Population was introduced, as was the Program of Medical Guarantees (PMG)[84]. They were applied starting from April 2020 through the new pooled strategic purchaser, National Health Service of Ukraine (NHSU). Opioid agonist maintenance therapy was included as one of the 31 approved packages by the Ministry of Health[85] and, since 1 April 2020, OAMT services are funded by NHSU, while medicines are financed by the Ministry of Health. In 2021, more than 230 providers were contracted to deliver the OAMT service package in all administrative regions under the government control (in occupied territories OAMT was discontinued under the influence of the Russia's legislative ban of OAMT already before the Transition Plan period)[86]. There is a significant level of resilience of the program – despite the war, the NHSU continues to pay for the OAMT packages and, while additional funding was needed from partners for the urgent procurement OAMT medicines, the number of state funded clients increased by 14% to 18'658 as of November 2022[87].

In parallel, important changes took place to improve the regulation of the OAMT services, reflecting its maturity, and making it more aligned with the WHO normative guidance. In 2020, amendments to the ministerial regulation No 200 on Approval of the Order for Delivery of

[79] WHO (2015). Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations

[80] Vickerman P, Martin N, Turner K, Hickman M. Can needle and syringe programmes and opiate substitution therapy achieve substantial reductions in hepatitis C virus prevalence? Model projections for different epidemic settings. *Addiction*. 2012;107(11):1984-95.

[81] Vickerman P, Platt L, Jolley E, Rhodes T, Kazatchkine MD, Latypov A. Controlling HIV among people who inject drugs in Eastern Europe and Central Asia: insights from modeling. Int J Drug Policy. 2014 Nov;25(6):1163-73.

[82] Tan J, Altice FL, Madden LM, Zelenev A. Effect of expanding opioid agonist therapies on the HIV epidemic and mortality in Ukraine: a modelling study. *Lancet HIV.* 2020;7(2):e121-e128

[83] PHC. Information on quantity and other non-personalized features of clients of substitution maintenance therapy (OAT) [in Ukrainian] - monthly bulletins for 2017-2022, accessed at: https://phc.org.ua/kontrol-zakhvoryuvan/zalezhnist-vid-psikhoaktivnikh-rechovin/zamisna-pidtrimuvalna-terapiya-zpt/statistika-zpt

[84] Верховная Рада. Закон Про державні фінансові гарантії медичного обслуговування населення. Відомості Верховної Ради (ВВР), 2018, № 5. https://zakon.rada.gov.ua/laws/show/2168-19#Text

[85] List of NHSU PMG packages for 2020 is available at: https://nszu.gov.ua/vimogi-pmg-2021/likar-2020

[86] https://medicine.rayon.in.ua/news/313433-v-ukrayini-mozhna-proiti-bezkoshtovnu-diagnostiku-i-likuvannia-vil-ta-gepatitiv

Substitution Maintenance Therapy for People with Mental and Behavioral Disorders Resulting from Opioid Use[88] allowed the following:

- private facilities to provide OAMT (at patient cost or through NHSU schemes),
- psychiatrists and not just narcologists to initiate treatment,
- prison settings to practice OAMT and
- reduced daily visits, increased self-administration and the duration of take-home dosages and drug testing among other improvements.

The 2020 OAMT service packages were further revised by NHSU, through a working group involving managers, practitioners, expert patients and other experts of OAMT for the updated 2021 and 2022 PMG packages. The OAMT package includes testing for HIV and viral hepatitis, TB screening, overdose counseling in addition to individual planning and work on opioid use disorder, hence the integration of the services is emphasized. Social case management for OAMT clients through NGOs (valued around US$1.4 million annually[89]) remains funded by the Global Fund through the Alliance for Public Health. The 2022 revised description of the OAMT package explicitly includes provision of information and referral to social and psychological services.

The NHSU's funding rate for OAMT care increased more than 3-fold between 2020 and 2022[90], reaching 6'874 UAH per client per year in 2022 (without the cost of medicines). However, it still might be not fully attractive to all providers (see the Box: Provider's perspective). While this assessment has not managed to get the methodology on how the OAMT package rate was (re)calculated, the head of the NHSU Universal Health Coverage Department at the time confirmed in an interview for the assessment that the initial costing of OAMT and other services was derived from the extensive review of the actual costs and opportunities for optimization in one selected oblast, Poltava, as part of the health financing reforms. The MoH compensated the reduction of income for health facility providers in 2020. Furthermore, the calculation of the cost of OAMT was adjusted to factor in the differences between the essential, fixed costs needed for initiating the type of treatment including meeting the requirement for working with controlled substances and the operational cost, as the original rate was not feasible for smaller sites. The favorable factor allowing the change was the significantly increased NHSU-managed budget, giving fiscal space for expanding health coverage and unit costs.

> **Provider's perspective**: In 2022, a private service provider interviewed decided to engage in a contract with NHSU to move from at-fee-only services to free services for clients. The new NHSU's rate finally covers the main budget lines like the premises and human resources. However, the 2022 payment rate still is not enough to compensate all quality elements of their service. Moreover, their work involves controlled substances and increased attention from law enforcement and control bodies which might discourage others from engaging in OAMT delivery.

The method for payment of the service was changed by NHSU from the general budget to the capitation rate based on clients served, allowing greater planning, accountability and efficiency[91].

[88] MoH Order 27.03.2012 № 200 On the Approval of the Order for delivery of substitution maintenance therapy for people with mental and behavioral disorders resulting from opioid use ["Про затвердження Порядку проведення замісної підтримувальної терапії осіб з психічними та поведінковими розладами внаслідок вживання опіоїдів"] [with the last amendment 16.11.2020]

[89] Based on the budget of the Ukraine's funding request to the Global Fund 2020-2022

[90] The calculation was made using monthly rate comparison, as the first rate in 2020 covered 9 months only.

[91] For 2.5 years, NHSU's two pools of funding were used: initially OAMT was paid from the global budget (which involves paying providers a fixed amount for a certain number of services or a certain period) and later it shifted to

As of the end of 2021, the NHSU packages have not significantly increased the participation of the primary care and private sector in the delivery of this most effective method for management of opioid-related addictive disorders. While the specialized institutions on addictive disorders, HIV and TB continue to be important settings for offering OAMT, the participation of primary care is seen to need further integration, de-stigmatization of both OAMT and its clients, and improvement of geographical accessibility. OAMT is applied in primary care since 2014[92]. At the end of 2021, this level of care constituted one tenth of all state providers and reached 796 clients in 10 regions with state, local funding or at patient cost (see Table 5). However, since the introduction of the NHSU packages in April 2020, fewer sites and regions offer OAMT at the primary care level, though the sites are larger with more people served per institution, some reaching more than 70 clients. Additionally, the PHC register identified 18 private providers at the end of 2021; all of them provided therapy at patient cost.

Table 5: Role of primary care in OAT delivery 2018-2021

	End 2017	*End 2019*	*End 2021*
Primary care sites	17	42	23*
Primary care as % of all sites	9%	19.5%	10.6%
Number of regions	9 regions	13 regions	10 regions
Number of clients (total)	300	801	796
Among them funded by state	*0*	*705*	*769*
Among them funded by the Global Fund grants	*297*	*0*	*0*

**2 facilities did not have clients at the end of 2021.*
Based on the PHC bulletin for 01.01.2018, 01.01.2020, 01.01.2022.
The Institute of Public Health Policy assisted in identifying primary care facilities.

Among OAMT clients surveyed for this assessment, there was a high confidence in the continuation of OAMT because it is funded by state (see more details in the Box).

the capitation rate (set as a fixed amount per patient/capita). The global budget is usually chosen when there is a lack of data in the system. Since the eHealth began operating in Ukraine at the same time as the reform began, funding rates and scope of services were formed based on historical data submitted by providers (hospital data provided in a paper form). The global budget helps to control hospital costs and improve the efficiency of the organization itself because it shifts the economic risk from the purchaser to the health care provider (*Preker, Alexander S.; Langenbrunner, John C.. 2005. Spending Wisely : Buying Health Services for the Poor. Washington, DC: World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/7449*). Per capita funding is needed to distribute limited resources fairly and efficiently so that people receive the same level of funding, regardless of income level or geographic accessibility (WHO/Europe. Funding Health care options for Europe 2020). In doing so, the capitation rate removes the economic incentive to over-deliver services and is better suited to optimize service levels, efficiency, and cost containment. As the system works through new funding mechanisms and collects up-to-date data on actual services and needs provided, payment methods become more sophisticated.

[92] Morozova O, Dvoriak S, Pykalo I, Altice FL. Primary healthcare-based integrated care with opioid agonist treatment: First experience from Ukraine. *Drug Alcohol Depend.* 2017;173:132-138

Client perspective: Clients (21 interviewed and 110 online self-administered survey respondents) were asked to rate the overall quality and different aspects of OAMT service delivery and uptake. Generally, there is relatively high satisfaction with the overall quality of state-funded OAMT, rated at 4.4 in a scale between 0 and 5. Uninterrupted continuity, regularity, opening hours and no additional payment were rated as most satisfactory aspects of OAMT. Among those interviewed, the lowest rating was on the reputation of OAMT in the community of people who use drugs. Geographical access, correct dosage, easy entry into treatment, and friendliness of staff were scored as less satisfactory among online surveys. The recommendations for improvement varied greatly from increased opening hours, availability for those with one hour travel involved, better and just behavior and attitudes of staff towards clients. But the overwhelming majority of recommendations were linked to the problems reported related to the quality of the medicines. The respondents prefer non-Ukrainian products, being given a choice of the manufacturer and reduced or eliminated switches between products from different manufacturers for clients to stay on the same medicines.
See the summary report of the OAMT and other client survey in Annex 3.

State and private sector: A previous community-led assessment in 2020 interestingly did not show major difference between the quality of services in the state facilities and private sector, though data confidentiality is the major reason for choosing private providers among those who could afford it.
Based on *EHRA (2020). Survey of client satisfaction with opioid maintenance therapy services among clients of OMT programs in Kyiv and Kyiv Oblast. Pilot Study Report, accessed at:*

The main area of concern for OAMT clients, overshadowing other issues, is the quality of medications. There is a distrust of the quality of the locally manufactured products, particularly from Kharkiv. In 2019, a batch of locally manufactured buprenorphine was found to have lower concentration than specified[93]. At the meeting of the National Council on TB and HIV/AIDS in August 2019[94], the community representative, chair of their Network VOLNA, Anton Basenko, called on the MoH to require "pre-shipment testing" to the regulatory procurement documents of the OAMT medications. In 2021, the PHC worked with VOLNA to test locally manufactured methadone but VOLNA requested additional tests for quality assurance[95]. There is a perception that the state has a strong preference for local manufacturers because of cost saving and developing local industry. While national experts expressed an opinion that there might have been problems with one or some batches in the past, now the quality of local manufacturers is assured, the client survey demonstrates how widespread the dissatisfaction with the (perceived) quality which has been a problem for several years without a resolution. A service provider interviewed agreed that, even if the quality of local medicines is fine, the perception of clients plays a major role in their satisfaction with the program, and therefore even impacts treatment outcomes and the program's reputation. To solve the problem, the respondents recommended the following options for consideration: to carry out a double-blind study to test the local products abroad (where community would trust the result); to give people a choice of medicines; to allow patients to stay on the same medications and/or allowing a strong system for reported

[93] The evaluation team received the relevant certificate of the lab of pharmacopeia analysis No 693/66719 of 02.07/2019 and the screen copies of the following state institution's DLS decision to prohibit the circulation of that specific medicine.
[94] ПРОТОКОЛ засідання Національної ради з питань протидії туберкульозу та ВІЛ-інфекції/СНІДу, 22 серпня 2019 р. (chaired/signed by Віце-прем'єр-міністр України, голова Національної ради з питань протидії туберкульозу та ВІЛ-інфекції/СНІДу Павло РОЗЕНКО)
[95] Information from Anton Basenko

side-effects and other quality issues through both providers and clients. Harm reduction service providers are engaged in referring clients, however, interviews and focus groups with service providers flagged that this work requires improvements.

Despite the major expansion, coverage is 5.9%[96] and remains significantly below the impactful level and still significantly below the 15% target set by the National Strategy for 2025[97]. A previous analysis highlighted the comprehensive set and ways for improved sustainability including improved attractiveness for clients and service providers[98].

4.3 Introducing OAMT in the penitentiary system

In line with the commitment in the Transition Plan of 2018, OAMT was introduced in the penitentiary system in 2020, following preparatory work by the Health Protection Center of the Ministry of Justice with the support of PHC, the Global Fund and USAID funding. The regulatory framework was laid out by the amended main MoH's OAMT regulation, and the Minister of Justice approving the penitentiary institutions for OAMT pilots[99].

OAMT clients already were to receive their medication if arrested and staying under the competence of the Ministry of Interior (MoI). A joint order by the three ministries – Health, Interior and Justice[100], outlines the path of OAMT clients and roles and responsibilities mirroring the jurisdiction in health system stewardship of closed settings. In the MoI institutions, detainees are brought to health facilities outside the criminal justice system, while for people moving to the establishments of the Ministry of Justice, services are provided on the spot. This joint order has yet to be updated to reflect the introduction of OAMT in the penitentiary establishments.

Before the war, 10 facilities under the State Penitentiary Service of Ukraine (around 10% of all its facilities[101]) provided OAMT including one colony for women. During the war, three penitentiary facilities discontinued treatment due to occupation or evacuation. The reason for piloting in more sites was making sure that people in detention, convicted for lighter and serious crimes could

[96] Calculated based on the estimated number of people with mental and behavioral disorders linked to opioid use of 278 318, cited in PHC, Report on the Results of the Implementation of Substitution Maintenance Therapy in 2020, 2021.

[97] State targets set are 5.5% in 2020, 15% in 2025 and 40% in 2030 according to CoB Decree 27.11.2019 № 1415-p on the approval of State Strategy in the Field of Response to HIV-infection/AIDS, Tuberculosis and Viral Hepatitis by 2030 [Про схвалення Державної стратегії у сфері протидії ВІЛ-інфекції/СНІДу, туберкульозу та вірусним гепатитам на період до 2030 року].

[98] Дворяк, С., Зезюлин, А (2020). Украина: Анализ устойчивости программ поддерживающей терапии агонистами опиоидов в контексте перехода от донорской поддержки к национальному финансированию [in Russian] [Dvoryak, S., Zezyulin A. (2020). Ukraine: analysis of sustainability of maintenance therapy program with opioid agonists in the context of transition from donor to national funding]. Accessed at: https://api.harmreductioneurasia.org/ecb13ff0-23de-4261-b27a-e5c592c25410.pdf

[99] As reported in Иванчук, И (2022). Аналітичний звіт програми ЗПТ в Україні

[100] Міністерство Охорони Здоров'я України, Міністерство Внутрішніх Справ України, Генеральна Прокуратура України, Міністерство Юстиції України. НАКАЗ от 22.10.2012 № 821/937/1549/5/156 Про затвердження Порядку взаємодії закладів охорони здоров'я, органів внутрішніх справ, слідчих ізоляторів і виправних центрів щодо забезпечення безперервності лікування препаратами замісної підтримувальної терапії

[101] In total there were 108 establishments for adults, according to the World Prison Brief with a reference to the State Penitentiary Service of Ukraine as of the beginning of 2022, accessed at: https://www.prisonstudies.org/country/ukraine

have a possibility of OAMT[102]. While the program is short of impactful scale, its strategic implementation in diverse settings will be important for demonstrating its value and feasibility among others to prison staff[103].

5 Tuberculosis support services

Historically, Global Fund assistance for the development of TB support started more recently than for HIV prevention and care and support services for people living with HIV[104]. Ukraine received the first grant for TB only in 2011. Based on the 2015 assessment of transition preparedness, no state ensured benefits were made available to people with TB in Ukraine. Social support for treatment adherence was still fully funded by the Global Fund. The Global Fund grant for 2017-2019 funded TB support through CSOs and provided daily social support for 40% of TB patients. In 2021, TB support services reached 10,235 people with TB and 7,155 people with DR-TB[105].

TB support services are provided to some people with TB and drug resistant forms of TB (DR-TB) and are delivered by NGOs. The main funding source is the Global Fund, with an estimated budget in 2021 of 154.5 million UAH for reaching 10,235 people with TB and 6,695 people with DR-TB. Additionally, the U.S. Government's support, through PATH, provided support to 660 people with DR-TB annually. Furthermore, local budgets contributed financially in 9 regions[106] allocating nearly 7.9 million UAH (approximately 5% of the Global Fund's budget for TB support services) for TB social support. However, data collected by the PHC[107] shows that nearly all regions funded social support in the form of food packages or direct payments to people with TB. Only Sumy and Lviv funded TB support services (i.e. with specialist based services, for example, assessment of needs and support to address them in addition to social aid like food packages and cash transfers) at the amount of 1.5 million UAH.

TB treatment support services have not been fully prioritized in transition planning in 2018-2020. In the 2017 version of the Transition Plan, TB support was not mentioned. However, in 2018-2020, TB treatment support was included in the plans for piloting of a decentralized model of state procurement of services in two oblasts. In 2018, the PHC indicated the need to develop a standard for TB support services and developed projections of state budget needed to cover such

[102] Interview with Mikhail Zlobinets, Deputy Director of the Health Protection Center of the State Penitentiary Services under MoJ

[103] Polonsky M, Azbel L, Wickersham JA, et al. Challenges to implementing opioid substitution therapy in Ukrainian prisons: Personnel attitudes toward addiction, treatment, and people with HIV/AIDS. Drug and Alcohol Dependence. 2015 Mar;148:47-55.

[104] Curatio International Foundation (2015). Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries: Ukraine Country Report

[105] Calculated based on the data of the Global Fund and PATH International support cited in the Центр громадського здоров'я (2021). Дорожня карта впровадження підтримуючих послуг з туберкульозу в рамках реалізації плану переходу на державне фінансування, проект. [PHC (2021). Road map of implementing of supportive TB services in a framework of transition to state funding, draft.] [in Ukrainian]

[106] Dnipropetrovsk, Donetsk, Kyiv, Kirovohrad, Lviv, Sumy, Khmelnytskyi, Cherkasy regions and Kyiv. In 2020, other regions were also funding services (Zaporizhia, Ivano-Frankivsk, Mykolaiv, Kharkiv) but discontinued doing so in 2021.

[107] ЦГЗ (2022). Інформація щодо фінансування соціальних послуг для пацієнтів з туберкульозом за кошти місцевих бюджетів у 2021 році [PHC (2022). Information about funding from local budget of social services for TB patients in 2021] [in Ukrainian] https://docs.google.com/spreadsheets/d/1kI37DjLhs-tPoAxhrFflpJEg5_r9HiD3/edit?usp=sharing&ouid=110947011551771732655&rtpof=true&sd=true

services along with basic HIV prevention packages and HIV care and support for people living with HIV. The projection of the needs for TB support services was higher than for HIV services combined. In response to the PHC analysis, the National Council on TB and HIV/AIDS approved the decision to develop standards, carry out costing, and initiate funding for TB support services along with HIV. However, in practice the steps on TB support services did not materialize. According to stakeholders interviewed, HIV-services were prioritized during the transition implementation because of the significant role and commitment of HIV civil society organizations to support PHC's extraordinary effort to develop the management and financing system under significant time pressure. The TB CSOs and movement developed more recently and so has the partnership between the government and CSOs in the field of TB.

The State Strategy on HIV/AIDS, TB and Viral Hepatitis for the Period until 2030[108] refers to the development of psycho-social services for the achievement of two ambitious targets: the improved treatment outcomes (85% by 2025 and 90% by 2030); and coverage of the ambulatory care of those eligible and in need (95% by 2025 and 100% by 2030). Notably, the development and expansion of the ambulatory model of care has been part of the reforms of TB system taking place in parallel with the '20-50-80' Transition Plan and was incentivized through the NHSU funding methods.

The PHC generated strong evidence on the contribution of TB support services to improving TB treatment outcomes and supporting the TB system reforms shifting and relying on a people-centered model of ambulatory care. In the 2019 and 2018 cohorts of people who received TB support services, 93% of people with DS-TB and 71.3% with DR-TB achieved a positive treatment outcome, i.e., were cured or completed treatment. In comparison, across all people with TB on treatment, this indicator was 77.5% and 49.4% for DS- and DR-TB accordingly. People in treatment who did not receive TB support services were 6.8 times more likely to be lost-to-follow up in case of DS-TB and 3 times in case of DR-TB, while treatment failure was 4.3 times more likely for DS-TB and 1.6 for DR-TB[109].

In 2020, the Ukraine's funding request to the Global Fund for 2021-2023 committed to prioritizing take-over of the TB support services, with the share of state funding to increase from 0% of patients in 2021 to 30% in 2022 and 50% in 2023; and developing a set of normative, costing, resource mobilization and taking other steps to ensure the increase.

In 2021, through a consultative process, a roadmap for transition of TB support services was developed by the PHC. It outlined phased steps for transition, which incorporate lessons learned from the HIV prevention and support service transition:

- Phase 1 (Q4 2021-Q1 2022): Coordination of MoH and other partners, working on standardization of support services, development and assessment of the service delivery models and public consultations. This includes the agreement on dividing competences with the Ministry of Social Policy which is responsible for social services and support.

[108] Розпорядження КМУ від 27 листопада 2019 р. № 1415-р «Про схвалення Державної стратегії у сфері протидії ВІЛ-інфекції/СНІДу, туберкульозу та вірусним гепатитам на період до 2030 року» [Cabinet of Ministries of Ukraine Decree dated November 27, 2019, #1415-r "About endorsement of the State Strategy of combating HIV /AIDS, tuberculosis and viral hepatitis for the period up to 2030"] [in Ukrainian] https://zakon.rada.gov.ua/laws/show/1415-2019-%D1%80#Text

[109] Центр громадського здоров'я (2021). Дорожня карта впровадження підтримуючих послуг з туберкульозу в рамках реалізації плану переходу на державне фінансування, проект. [PHC (2021). Road map of implementing of supportive TB services in a framework of transition to state funding, draft.] [in Ukrainian]

- Phase 2 (2022-2023): The development and approval of relevant legislative and other normative acts, based on expert review of existing legal basis.
- Phase 3 (2022-203): Costing of resources needed including methodology of costing, needs assessment and planning of resources in state budget, accompanying communication campaign, training of providers and establishing the system of quality assurance.

The roadmap is accompanied by draft documentation to support the implementation and facilitation of discussions on the model of service delivery and justification for the funding allocation. Collaboration between state and civil society increased, with a significantly stronger role of people directly affected by TB, *TBpeople Ukraine*, the head of which is the advisor to the Minister of Health. One of the early lessons that the NTP and many other TB stakeholders mentioned is the need for stable TB support from a centralized source, as systemic and continuous funding has proven to be hard to secure. Therefore, the roadmap relies on the national funding sources and not local budgets.

The Ministry of Health of Ukraine with PHC involvement initiated the allocation of UAH 13 million for 2022 under the state budget program No 2301040 "Public health and measures to combat epidemics», which is already funding HIV prevention and support for people living with HIV, for the organization of support for 939 people with TB and 538 people with DR-TB. In February 2022, just before Russia's invasion, the Cabinet of Ministers approved a decision to allocate the funds[110]. The funds have not been released due to the war.

All the stakeholders interviewed highlighted the allocation being ambitious and possible due to collective and strategic lessons learned from HIV processes. However, the amount is short of the 30% of budget indicated by the country in its funding request, as it represents just 8.4% of the TB support service budget in the Global Fund grants in 2021.

The roadmap of activities on development of legislation has yet to materialize, i.e. the development and approval of a description of TB support service, agreeing on the model of procurement and funding of services and relevant costing and contractual arrangements are to be developed. The interviewees highlighted the ongoing despite the war discussions of potential shift of the model and the dialogue with NHSU if services could be contracted by them should the legal acts and funding streams be changed to allow NHSU to contract non-medical (support) services. Back in 2018, documents on transition planning envisioned that NHSU would contract TB support services.

6 Other areas of progress of sustainability and transitioning from donor support

6.1 Local funding for HIV

[110] Повідомлення на офіційному сайті Кабінету Міністрів України «Уряд вніс зміни до порядку використання коштів бюджетної програми «Громадське здоров'я та заходи боротьби з епідеміями» [Post on the Cabinet of Ministry of Ukraine website "Government adopted changes to the procedures of using funds of budget program "Public health and measures to combat epidemics"] [in Ukrainian]

CSO sources show increasing, though fragmented and limited, local funding for HIV prevention, care and support for people who inject drugs and PLHIV and nearly none for sex workers and men who have sex with men. In 2019, 9 regions (local or regional authorities)[111] spent 3.8 million UAH [US$104'000] on the HIV response, reaching nearly 2,300 people who inject drugs and PLHIV. Another analysis[112] shows that CSO-run HIV services received 1.55 million UAH [US$40'000] in 2021. Both analyses have significant limitations and do not reflect all forms of support. For example, the Odessa city procures and funds free syringes through a pharmacy network. Some NGOs receive subsidized premises. At the levels of PHC and the National Council on TB and HIV/AIDS, there is no systemic tracking of all this data that would include all the support available for prevention and care and support for HIV.

Local funding approaches vary greatly and are not systemic. They require creative thinking from CSOs (e.g. crime prevention for serving ex-prisoners and gender violence prevention programs in Poltava). The precedent for the first funding for HIV prevention among sex workers and men who have sex with men was in Lviv achieved in mid-2021. According to multiple interviews and focus groups with prevention service providers, limited progress for those two groups is explained by the fact that that these populations are less likely to be recognized as those in need locally or could be even stigmatized with a decision to serve them feared to be unpopular especially outside larger cities. The service providers shared some good practices at the focus groups. However, outcomes of multiple efforts have been mixed, with annual efforts needed and not always yielding the significant funding needed for service delivery.

Before the war, the PHC and the National Social Service under the Ministry of Social Policy started to draft a methodological guidance for local authorities on the comprehensive package on HIV, TB and viral hepatitis to show what services are needed locally and how to cost them to calculate budgetary needs. Recently, before the invasion, the PHC with partners worked on re-establishing regional population size estimates, which several interviewees highlighted as a right step to support dialogue with authorities on systemic support.

Different interviews with community and government providers highlighted that decentralization reform ('Reform of Local Self-Government and Territorial Organisation of Power'), largely completed in 2021, should give opportunities for a greater role of local authorities in co-financing and supporting services, however, there is a major split in the views among national stakeholders if that is a perspective area, even in the times of peace. There were ideas that the Regional Public Health or local CDC type centers could be better used in local monitoring of services, though the local competences might be limited in HIV and key population programming. The assessment team did not manage to explore the feasibility and way forward for the enhanced regional center's role. In terms of co-funding feasibility, the decentralization reform indeed increased the local revenues which constitute 23% in the consolidated state budget, income of local 'hromada' (local communes). The local budget distribution is uneven, with up to 4-times difference in income per inhabitant between different oblasts. Local budget expenditure for social protection and care increased from 20.7 to 23.7 billion UAH between 2020

[111] Institute of Analytics and Advocacy, International Renaissance Foundation (IRF) (2020). Забезпечення населення медико-соціальними послугами у сфері ВІЛ/СНІД за рахунок коштів місцевих бюджетів

[112] Analysis by БО «Світло надії» conducted through the review of tenders on ProZorro, partner organizations, regional programs identified all funding and extract only those that were funding services, i.e. funding for medications, trainings and general awareness campaigns were excluded. Data is collected for 2019, 2020 and 2021 for HIV, TB and services for penitentiary system and former prisoners.

and 2021. However, in the same period funding for health dropped by more than 40%[113], therefore preliminary local social budgets might have more fiscal space for new interventions than local health budgets.

6.2 HIV (including PrEP) and TB in the Medical Guarantee Program

While HIV and TB medical services were funded earlier, and significant steps were taken to include them in the reforms including: enabling their provision in primary care; decentralizing specialized care; establishing a set of interventions in the protected 'state-guaranteed' items of state budget; and supporting the reforms of moving towards an ambulatory model of TB care, i.e.; and increasing their sustainability.

Since July 2019, the NHSU paid for HIV and TB services as part of the primary care package of the newly established Program of Medical Guarantees (PMG), in accordance with the MOH decree #504[114]. This package is explicitly defined and, like other PMG services, is part of the protected lines in the state budget. HIV rapid testing after unprotected sex for PLHIV partners, MSM, individuals in commercial sex and people who inject drugs, and provider-initiated HIV testing and counseling when the person has symptoms related to HIV, symptom screening/survey for TB and referral for diagnostic, testing for viral hepatitis were all included in primary care. In the following years (2021-2022) those packages did not change significantly, but were further refined, and their coverage rates were indexed. In 2021, the package was supplemented with a service for prevention, diagnosis and early detection of socially dangerous diseases (HIV, tuberculosis including latent tuberculosis infection, hepatitis, sexually transmitted infections, etc.). Examination of TB contact persons and referral for secondary (specialized) and/or tertiary (highly specialized) medical care. Interaction with pediatric TB physician and/or pediatric TB physician on diagnosis and treatment of patients with TB[115]. In 2022, the service was supplemented with an item on identifying individual risk of infectious diseases (tuberculosis, HIV, viral hepatitis, etc.) and non-infectious (cardiovascular, chronic respiratory, cancer, diabetes, etc.), through screening questionnaires, assessment of overall cardiovascular risk, waist circumference, etc.[116] These changes were aimed at integrating government funding for prevention services into the national system, as well as integrating people with HIV/TB into the medical system.

In April 2020, PMG was expanded from primary care only to all levels of care. HIV, TB and OAMT service packages were included in the PMG on primary and specialized levels as a complex care[117].

The packages are reviewed annually by specialized groups involving patients. For example, TBpeople Ukraine's representative used the data collected from a community-led monitoring

[113] Data and analysis is based on Міністерство розвитку громад та територій України. Моніторинг реформи місцевого самоврядування та територіальної організації влади, станом на 10 січня 2022 [Ministry of Development of Communities and Territories of Ukraine. Monitoring of the reform of local self-government and territorial organization of power, as of January 10, 2022] [*in Ukrainian*]

[114] Наказ МОЗ України від 19.03.2018 № 504 "Про затвердження Порядку надання первинної медичної допомоги"

[115] НСЗУ. ВИМОГИ ПМГ 2021**,** https://nszu.gov.ua/vimogi-pmg-2021

[116] НСЗУ. ВИМОГИ ПМГ 2022

[117] Постанова КМ від 5 лютого 2020 р. № 65 Деякі питання реалізації програми державних гарантій медичного обслуговування населення у 2020 році та І кварталі 2021 року

tool, OneImpact, to highlight the need for covering diagnostics and started the dialogue on how stigma of people with TB could be reduced and supported by NHSU in health settings[118].

Since 2021, the HIV package expanded with partial services for pre-exposure prophylaxis (PrEP) - free HIV testing and medical care and management of PrEP[119]. Other costs are funded from international support[120]. The number of people on PrEP has doubled since 2020, reaching 5'711 clients in 2021[121]. The service standard has been approved by the MoH[122].

The changes to funding expanded the number and spectrum of providers. In 2021, the NHSU contracted more than 400 medical facilities for the HIV package. These are AIDS centers, regional and city infectious disease hospitals, multidisciplinary intensive care hospitals, tuberculosis and drug treatment facilities, central district hospitals, and polyclinics, one private provider[123]. Four hundred and thirty (430) more providers were contracted to provide a TB service package at the primary level[124] and 48 providers to provide a TB service package on specialized level[125].

Focus groups of services providers and informants highlighted the remaining challenge of people from vulnerable groups to access the PMG because of the required national ID documents, registration with family doctor, and phone number. There is only indirect data to illustrate the scale of the challenge. An estimated 25-50% of people entering the prison system, where people who use drugs are overrepresented, did not have national ID documents (note that prison health is separate from the general health system and therefore PMG does not work there). Other reasons for avoiding health settings are the anticipated stigma and discrimination. There are positive examples, for example, in Kramatorsk, where a primary care center expanded their services for key populations even more recently during the times of active war. Multiple informants and focus groups highlighted the tendency of former HIV, TB and OAMT centers to hire family doctors to ease access of their clients to primary care.

6.3 ARV and TB medicines and centralized procurement

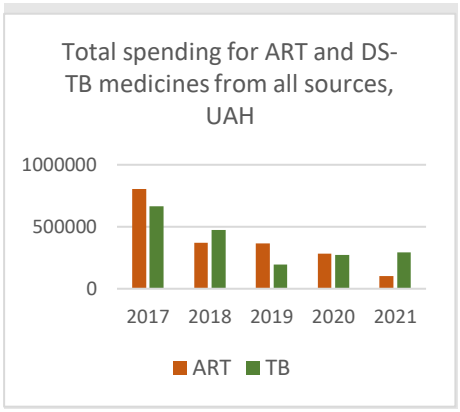
Centralization and capacitating state pharmaceutical procurement (with an increased state share in funding of the essential medicines) were mentioned in the Transition Plan of 2017, however, no details and milestones were established. The Global Fund grant for 2018-2020 supported this work. Before the transition plan, the state had procured portions of HIV, TB, OAMT and other essential medicines using its MoH procurement mechanism and international procurement agencies. The function of state procurement of medicines was consolidated by setting up a centralized state medical procurement agency, the state-owned enterprise, Medical

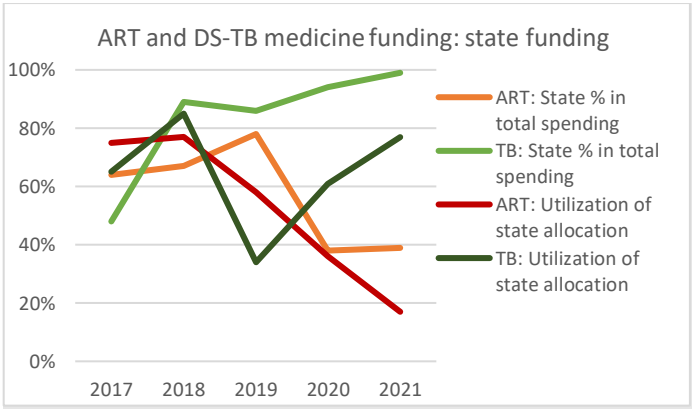
[118] Interview with national informant.
[119] НСЗУ. Специфікації та умови закупівлі медичних послуг, які надаватимуться за Програмою медичних гарантій у 2021 році: ДІАГНОСТИКА, ЛІКУВАННЯ ТА СУПРОВІД ОСІБ ІЗ ВІЛ (ТА ПІДОЗРОЮ НА ВІЛ).
[120] PHC data
[121] Based on the Indicator values of the National Progress Report on Global AIDS Response 2017-2021 (GAM) in ЦГЗ (2022). ВІЛ-інфекція в Україні, інформаційний бюллетень No 53, Київ 2022 [PHC (2022). HIV Infection in Ukraine, Information Bulleting No 53, Kyiv] [in Ukrainian]
[122] Наказ МОЗ України від 05.02.2021 № 189 "Про затвердження Стандартів охорони здоров'я доконтактної та постконтактної медикаментозної профілактики ВІЛ-інфекції"
[123] НСЗУ. Національна служба здоров'я виплатила закладам, що надають допомогу пацієнтам з ВІЛ, понад 291 млн грн
[124] Аптека, news item: https://www.apteka.ua/article/599093
[125] Устинов, О.В. (2020). Допомога хворим на туберкульоз у рамках Програми медичних гарантій За результатами брифінгу НСЗУ від 18.09.2020 р.

Procurements of Ukraine, in 2019 and, from 2020, engaging it in the procurement of antiretrovirals (ARVs), TB and OAMT medicines. The 2020 iteration of the Transition Plan in the funding request to the Global Fund plans further capacitation of the Medical Procurements of Ukraine.

The PHC data shows the more efficient use of resources for antiretroviral therapy and DS-TB treatment but major problems with the utilization of state funding for procuring antiretroviral medicines.

Table 6: Analysis of allocation and spending for ARV and TB medicines by funding sources 2017-2021





Graphs based on PHC data collected, 2022

The cost of ART was reduced more than 8 times between 2017 and 2021 through treatment optimization in line with WHO guidelines and strategic price reduction. The three-year optimization strategy and a revised estimate of needs was developed through a multisectoral approach in cooperation with «100% LIFE». The PHC and the MoH supported the active role of the PLHIV representatives in negotiations and other actions with manufacturers to reduce prices. In 2019, savings for the first line of ARVs amounted to 359 million UAH [in the 2019 rate[126], around US$13.9 million][127]. Those savings were redirected for the first allocation of HIV prevention and care and support services for PLHIV in 2019. Notably, just half of the amount saved would have been sufficient to cover the annual amount needed for HIV prevention and care support.

The share of state funding of TB medications increased from 48% in 2017, before the Transition Plan, to 99% in 2021. For ARVs, since 2018, the state-allocated amounts have been sufficient to fully fund medicines in government-controlled territories. However, the government was not able to absorb funding and therefore its share in spending dropped to just below 40% in 2020 and 2021 after peaking at 78% in 2019 - international support was needed for linking between the state procurement cycles.

6.4 HIV and TB services in the penitentiary system

[126] Average annual exchange rate for 2019 calculated by the National Bank of Ukraine was 100 USD = 2584,56 UAH. Accessed at: https://bank.gov.ua/files/Exchange_r_e.xls

[127] Based on *Kuzin, I., PHC (2020). Ukraine's paths in the process of transition, 17.11.2020, presentation at the event of European Friends of the Global Fund*.

The penitentiary system has its own health system and budget managed by the Health Protection Center (HPC) under the Ministry of Justice (MoJ), thus it has its own pace, successes, and challenges of transition from donor funding.

The '20-50-80' Transition Plan did not address funding and management of services for people in prisons. Nevertheless, the HPC and MoJ shared the notion of the need for increased responsibility, funding from their own budget, and contributing to the Transition Plan that they approved by having a representative in the National Council on TB and HIV/AIDS.

HIV, TB and OAMT services in the penitentiary system are co-financed from the MoJ budget, the Global Fund and other international donors. In 2020-2021, some 70-77% of ARVs were procured from the HPC budget[128] and naloxone was fully funded by the HPC[129]. While HIV diagnostics, ART, TB care and OAMT standards in prisons largely replicate the MoH approved standards (though OAMT is a small pilot), HIV prevention and support and care for PLHIV are different. Prevention and support and care services implemented by CSOs are fully funded by the international donors – the Global Fund and the USAID funded project, "Serving Lives" (only in PEPFAR regions). The USAID 5-year project was finishing in mid-2022 and the CSOs interviewed assessed that the HIV-related testing and some other services supported from the project will have some support from the Global Fund, however, as of the mid-2022, they expected that significant amounts of work would discontinue. The HPC confirmed that they planned to take on some CSO services in 2022, with phased increase in funding in 2023 and 2024. They had no experience in purchasing CSO services but were planning to follow the PHC's model of procurement of prevention and care and support services. The procedures for that purpose were developed within the HPC[130]. The PHC legal office and the HPC are reluctant about the idea of several CSOs that the PHC-funded HIV services for key population and PLHIV could be extended to PLHIV, PWID and MSM who are detained or are serving their sentences in prisons.[131]

Dialogue on revisiting whether the stewardship of the prison health should be changed has been mandated to a joint interdepartmental group of MoH and MoJ, established in 2020[132]. The idea considered is to pilot changes in governance in one region and make conclusions based on that. No specific timelines have been agreed to factor it into planning of donor transition and sustaining of services. The shift in governance would be in line with the WHO's recommendations for a whole-of-government responsibility for prisoner's health and well-being with the MoH providing and being accountable for health services in prisons[133].

[128] Interview with the Deputy Director of HPC of the Penitentiary Services of Ukraine.
[129] FreeZONE. Доступ к услугам по профилактике и лечению ВИЧ и сопутствующих заболеваний в пенитенциарных учреждениях стран региона ВЕЦА. Аналитический отчет 2021 (в рамках проекта «SoS» в сотрудничестве с Alliance for Public Health, 100% LIFE, CAAPL, Eurasian Key Populations Coalition).
[130] Interview with the Deputy Director of HPC of the Penitentiary Services of Ukraine.
[131] Interview with the Deputy Director of HPC of the Penitentiary Services of Ukraine (a PHC representative was present during the interview and confirmed the statement).
[132] Interview with the Deputy Director of HPC of the Penitentiary Services of Ukraine. (the referred Order on the establishment was not found in the online legal search of Verkhovna Rada).
[133] World Health Organization. Regional Office for Europe. (2013). Good governance for prison health in the 21st century: a policy brief on the organization of prison health.

7 Summary analysis based on the review questions

7.1 Lessons learned

Among the Global Fund's EECA applicants[134], Ukraine set the most ambitious formula for the 2017-2020 increase of state ownership of (basic HIV) prevention services for key populations which is globally seen among the most challenging areas during and after donor transition.

In Ukraine, transition planning has been an evolutionary process and not just a discrete plan. There have been three iterations of the original Transition Plan, often referred to as the '20-50-80' Plan which was first developed in 2017, then updated in 2018 by the PHC and further readjusted with a progress update in the funding request to the Global Fund in 2020. Based on the interviews conducted, there is no consensus recollection of what the 20-50-80 Transition Plan is, which version should be called the transition plan or what it includes – some see it as a discrete plan with a specific timeline and focus on HIV prevention and care and support, while others see it as part of the greater sustainability and national ownership process which should evolve while building on achievements and setting new targets for the future. There is a consensus, however, on great ambition and state commitment to systemically co-fund and co-manage services for key populations and HIV care and support.

Based on the records and the interviews conducted, the transition planning (areas and specifics in updated documents referred to the Transition Plan and its workplans) was evolving with the changes in the health and PHC leadership and opportunities seen in the ongoing health reform.

Since 2017, the "20-50-80" Plan reflected a consensus commitment for a great state role in HIV and TB programs which mobilized key government, civil society and partners to incrementally build state ownership, particularly for the HIV community-driven component of prevention and peer treatment support. It helped to have a clear benchmark for visibility and clarity.

The ambition and emergence of the Transition Plan was possible due to a unique constellation of leaders and supportive factors, according to the interviews with the Deputy Minister of Health, former and current staff of Public Health Center, the two Principal Recipients, other members of the National Council, multiple civil society and international partners. These include:

1. Bold reforms were requested by the top leadership of the country, setting the stage for transformative health and health financing reform including the establishment of the Medical State Guarantees with the National Health Service of Ukraine, the national central procurement agency and establishing the concept of 'Public Health' in the health system with leadership of the Public Health Center.
2. The Global Fund's clear communication to the country's leadership on its expectations and its extensive work to support country discussion on meeting those expectations.
3. The leadership of individuals in key government positions including the Deputy Prime Minister who chaired the National Council at the time, and the Acting Minister of Health, and the PHC team.

[134] Based on the scan of the funding requests available at: https://data.theglobalfund.org/documents and Eurasian Harm Reduction Association (2021). Taking stock of budget advocacy efforts in Eastern Europe, South-Eastern Europe and Central Asia. EHRA, Vilnius, Lithuania, 2021

4. Last, and probably most important, the bold push for transition from several civil society and community groups, particularly «100% LIFE» in 2017.

Similarly, the implementation and continued commitment (including the Transition Plan) to the sustainability of the non-medical services that have been traditionally led, funded and managed by civil society organizations would not be possible without:

1. Committed MoH leadership, some of whom were authors and implementers of the Transition Plan;
2. The PHC leadership and staff that established new systems and processes;
3. Adjusted operations of and support from the two CSO principal recipients of the Global Fund, «100% LIFE» and the APH;
4. The accountability mechanism established by the Global Fund with a supportive approach to help bridge gaps during the implementation;
5. Less visible but critical, persistent inter-departmental work with senior officials in the PHC, MoH, MoF and other institutions finding solutions outside the comfort zone of the government system;
6. The supportive CSO, government, UN and private donor partners, largely included in the Strategic Working Group doing work during and outside the meetings including supporting mediation and work with capacity and readiness of civil society and community groups;
7. Utilization of the ongoing health reforms including working with NHSU on improving its support for OAMT work and the new program for public health as will be described further in the report;
8. Local CSO providers taking risks with imperfect solutions with the longer-term view of building state systems for HIV, TB and OAMT.

7.2 Key findings in relation to review questions

Summary analysis and recommendations in relation to 7 questions posed for the review include:

1. To what extent have the provisions of the transition plan "20-50-80" been implemented by the end of 2021?

Area: HIV prevention services and care and support for PLHIV (transfer of management under the milestone targets of 20-50-80, with no state funding anticipated in 2018 with the relevant legal framework)

In summary, the financial transition of the basic packages of HIV prevention services and care and support for PLHIV has been completed to a significant extent. State (MoH) funds are allocated for service delivery. The normative and regulatory base required for state budgetary allocation and service provision was set in line with the milestones for transition planning. The Transition Plan did not address commodities for prevention and funding for them has not been allocated by the state.

The state allocated the amount of funds at the pre-transition funding levels of 2018 (in local currency). Legislative challenges requiring services to pay the VAT remain unresolved. The model for service procurement was chosen after a pilot, in line with the legal requirements. The procurement (and payment) model still does not work well. Therefore, the PHC commissioned a

study of alternative models for procurement within the current legislative framework. Work on the improved model is not completed and will need to be done in synergy with the recent comprehensive amendments of Law No 6364 On Combating the Spread of Diseases Caused by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV and the new Law on Public Health System, the implementation of which is to start on October 01, 2023[135], in line with the continued work on creating the public health system.

The PHC set up a new department for managing HIV services for key populations and PLHIV. Hence the management transfer has been largely achieved. However, resourcing of the new additional functions in the PHC is not sufficient. Further conceptual agreement of the roles, responsibilities, resourcing and co-managing of M&E and information systems (e.g., databases) require further discussions between the PHC and two other principal recipients and other national stakeholders. Another unresolved element in M&E and management is how the state will fund this role. As of mid-2022, no plans for the state to take on procurement and funding of commodities for the services had been set up or implemented. The basic package of prevention services does not cover all the essential core services, which are defined as complementary in the MoH regulation on HIV prevention service provision, and there are no plans on how to increasingly align Ukraine's basic packages with the international recommendations and core client needs.

Area: OAMT (setting national goals, introducing the pilot in the prison settings, and scale up with a focus on primary care)

The three objectives for OAMT in the transition plan have been largely achieved. As planned, OAMT was prioritized in the new Program of State Guarantees through a special NHSU package. The scale-up of OAMT has been significant (60% increase since 2019) but not on track for the 2025 targets set and the WHO recommendations for impact. As of the end of 2021, the NHSU packages have not significantly increased the anticipated participation of primary care, partly because of unattractive tariffs for service providers and remaining challenges in increased uptake. Harm reduction services (HIV prevention among people who inject drugs) are engaged in supporting uptake but its effectiveness requires improvements. OAMT clients report relatively bad reputation of the program and prevalent negative attitudes towards some domestically produced products. The NHSU increased its tariff for 2023.

Area: TB support services

Funding and management of TB support services have not been handed over to the state. However, preparations advanced before the 2022 war started. A roadmap and a package of draft normative and regulatory documents have been prepared. The government approved the first allocation of first funding for these TB services just before the war. This allocation, however, constituted 8% of the 2021 Global Fund's budget for those services, i.e., below the 30% of the service budget indicated in the funding request to the Global Fund.

Area: State procurement of ARVs and TB medicines, including establishing centralized state procurement

The centralized state procurement agency, the state-owned enterprise, Medical Procurements of Ukraine, has been established. It requires further capacity strengthening. If for DS-TB medicines, the state budgetary share and procurement role have significantly progressed, and in 2021, nearly all medicines were funded from the state budget. In the case of antiretrovirals, the 8-time reduction of ART cost enabled lower budgetary needs. Since 2018, the state has allocated

[135] Закон України від 06.09.2022 № 2573-IX Про систему громадського здоров'я

enough funding to finance ARVs in full in government-controlled areas; however, in 2021, utilization of state funding was below 20%, and international funding (and procurement primarily through «100% LIFE») was required to fill the gap.

2. What have been the changes that have not been specified in the transition plan?

Local funding

The Transition Plan anticipated that local funding and international support would provide support for complementary services of HIV prevention among key populations as the state supports the basic packages. No specific commitments or steps, however, were included in the Plan. The local support for HIV prevention has been fragmented, with more examples of supporting social services, notably for people who inject drugs, ex-prisoners, and people living with HIV, and some interventions indicated in the MoH regulations of the services of HIV prevention for key populations, and care and support for PLHIV. The first cases of support for MSM and sex workers were achieved only in 2021 in one oblast. It is vital to continue engaging with the local levels to expand good practices and utilize decentralization-related opportunities for developing social and other services. However, these public health services will remain dependent on centralized state support to ensure equity and recognize limited local prioritization of the highly stigmatized groups. Therefore, at least in the mid-term for the continued transition from donor support, reliance on local budgets will be limited, with some potential for case management and synergetic programs like social reintegration or response to gender-based violence. The state-funded "basic package" will have to expand to include all essential services needed for the impact on the HIV epidemic (and the linked epidemics of viral hepatitis and STIs) funded by the Global Fund and USAID.

Other areas

Funding of HIV and TB services moved to NHSU, supporting the reforms for optimized delivery of services. The HIV and TB service packages were included in the state medical guarantees. Since 2021, the HIV package includes expanded with the partial funding of PrEP (free HIV testing and medical care). Hence, PrEP is part of the state's guaranteed service. The state share of HIV and TB diagnostic and treatment services in the penitentiary system progressively increased (70% of ARV budget, which was higher than outside prisons in 2021), though it still depends on international support. HIV prevention, support, and care for PLHIV continue to depend on international donors. The Ministry of Justice and the Health Protection Center of the Penitentiary Services of Ukraine planned to partially take over funding and management of these services already in 2022, replicating the PHC's procurement model of HIV prevention and care and support services. The plan did not materialize because of the war. In parallel, the Ministry of Justice and the Ministry of Health discuss future governance and the model for the health system in the penitentiary system.

3. To what extent was transition planning fit for purpose from clients and service provider perspectives (including if the transition supported rolling out new and effective approaches and innovations in addition to existing packages and actual coverage)?

Both providers and most clients welcomed state funding and have greater confidence in the services to be sustained in the future because of systemic state funding. This funding contributes to the de-stigmatization of the services, the people served – key populations and PLHIV - and the services, especially in relation to state institutions.

The main remaining concern from the client's perspective is the confidentiality of their data (sharing with other parts of the health system and outside the health system).

Service providers received significantly less funding from the state than they did before the transition (around 73% of the level of the same services in 2018 which was even less in practice due to inflation and VAT applied for state services). Challenging funding and contractual arrangements, including rigid service regulation and application in payment methods, led to underutilization of funding for HIV prevention and care and support. Services for key populations faced more challenges in meeting new detailed regulations and sub-costing and established volumes of services within the basic packages. From their perspective, especially for sex workers, the service cost is underestimated. Other available funding (from international support) helped mitigate the challenges related to contracting periods and lower actual payments to manage their obligations to staff and peer counselors, and payments for premises and other operational costs.

The state tendering system resulted in restructuring and more significant consolidation of the service market. The consolidation led to some providers' growth and openness to take on services outside their "traditional" population or territory. Some smaller CSOs could not receive funding directly and are collaborate with larger providers to be subcontracted for service delivery. From the service provider perspective, the changes in who delivers services have not always assured quality as the tendering decisions are made based on the price offered among providers meeting minimum qualification requirements. Some providers starting to serve new populations face difficulties (for example, reaching the MSM population as they lack knowledge of the specialized dating apps) and require support.

Rolling out new and effective approaches and innovations

Transition planning did not foresee population needs assessment, monitoring the context and did not support rolling out innovative services. In 2019, the definition of the intervention packages was built on existing services and approaches. Online service provision, which is particularly important for sex workers and MSM and has been highlighted in the new WHO consolidated guidance on key populations in 2022, is foreseen as a complementary service; therefore, its financing is expected from elsewhere. The service packages have not been revised after adoption in 2019.

Some service adaptations, especially in 2020 due to the COVID-19 pandemic restrictions, happened in part with international funding. They are yet to be reflected in the MoH service regulations and contracts. Furthermore, the current approach to the detailed regulation and contractual arrangements of service provision moved average indicator values of 2018 to mandatory one-size-fits-all packages, not allowing adaptations to people's needs or context. As a result, service providers and clients report that the services have been less people-centered because of the strictly regulated parameters (frequency, amounts of interventions and commodities, eligibility of PLHIV, etc.). From the service provider and client perspectives, the service packages should be expanded to include additional services, like: case management; home-delivery of services and ARVs; tests including viral hepatitis and syphilis; and access to medications for the liver; consultations with other specialists and health services, overdose prevention. The frequency and quantity of prevention interventions should be increased, including more frequent testing allowed and fewer times for picking condoms. For care and support services of PLHIV, case management should be added to the mix of information and motivation sessions and allow for tailoring to individual needs.

In conclusion, there has been no expansion of existing approaches with new approaches and methods with the state policies and funding. The nature of the government regulations and management highly restrict flexibility of the PHC and the service providers, however, as the very system change to allow systemic funding for non-medical public health services show, in Ukraine changes could be possible if there was will and intentions from state.

Quality has not been sufficiently addressed in the PHC management of services. Service providers, primarily working on prevention, asked to include them better (e.g., engage people directly working in service provision included in working groups like Strategic Working Group, consultation process to update service packages and costing). They requested more counseling opportunities and dialogue with the PHC, suggesting annual sessions for planning and system to support addressing contractual and programming challenges. Those efforts should include various service providers including sub-recipients of the PHC contracted organizations.

Actual coverage

The coverage of services among key populations increased due to state funding during the transition period. In 2021, the state services reached more than half of the estimated numbers of PWID, and SWs but only a quarter of MSM in the government-controlled territories. Since 2019, nearly 40% of the estimated people living with HIV have benefitted from targeted information and motivation sessions to support their treatment adherence.

4. Do the legal framework and supporting environment sustain the provision of services / treatment for beneficiaries?

For the basic package of HIV prevention and HIV care and support for people living with HIV, five legal acts and an annual budgetary program set the normative basis and financial framework for state funding. Harm reduction services are recognized in the normative framework for the first time.

The budgetary programs funding HIV prevention, care, and support for PLHIV are approved annually. Therefore, the sustainability of those services remains dependent on the MoH leadership decisions or availability of budgetary resources.

The options for increased sustainability would require more extensive discussion and systemic solutions that are not specific to HIV services. As the Public Health System continues to be developed, one option would be to consider mirroring the "medical guarantee" approach to care, especially for prevention. The final solutions to ensuring the sustainable provision of care and support would need to be systemic – for HIV, TB, OAMT, palliative care, etc. Thirdly, there will be no sustainability of services without solid government sector management. The human capacity for serving the state procurement management within the PHC should be adequately resourced.

The OAMT, ARV, and TB treatment care are guaranteed services. However, further sustainability will depend on the state's capacity to timely procure products which has been an issue for ARVs. Therefore, a future priority area is the Medical Procurements of Ukraine's continued development of procurement capacity in synergy with the clinical planning, forecasting, and supply management systems.

5. Could the existing M&E be used to identify risks related to transition and how the transition of the M&E functions should happen?

The PHC took the leadership role in the implementation of the Transition Plan. The oversight of the Transition Plan was conducted by the National Council on TB and HIV/AIDS, which established the original Transition Plan in 2017, its Oversight Commission, the Strategic Working Group, and the Global Fund. Different groups had their value added in the oversight. The structures and processes were in place to identify and support the PHC and the National Council of successes and challenges in the transition from donor to state management and funding of procurement of services. Additionally, the Strategic Working Group took a more operational support function, which was particularly important in 2019 and 2020.

However, there were gaps in the oversight.

1) The broader stakeholders had limited visibility and involvement (though the Oversight Commission of the National Council recommended measures for public visibility).
2) Solutions for greater utilization of the public budget allocation were implemented only partly, despite the challenges well recorded in the minutes of the Strategic Working Group, the National Council, and public addresses from service providers. Some creative solutions (e.g., proactive contracting of community building in the regions with no service contracted by the PHC) were voiced in interviews by the members of the National Council. However, no record is found that those ideas were discussed at the Strategic Working Group.
3) The oversight mechanisms focused on two areas of transition – public procurement of services for HIV prevention and care and support for people living with HIV. However, other areas were left outside in the PHC reports to the Global Fund and the Strategic Working Group or the Oversight Commission's reports.
4) As the frequency of the Strategic Working Group is reducing and the review of minutes and two interviews confirm its reduced effectiveness, this group, as it is organized now, might have exhausted its value added.

The National M&E Plan for HIV or HIV, TB and Viral Hepatitis should become the main framework to support the implementation of the State Strategy on HIV/AIDS, TB, and Viral Hepatitis until 2030. It has been drafted by the PHC, but has yet to be approved. One of the functions of the National M&E Plan would be to enable the National Council on TB and HIV/AIDS and other stakeholders to track the achievement of the national prevention targets and demonstrate the role of the implementation of government-funded basic packages. Without the National M&E Plan, the targets set for 2025 and 2030 in the State Strategy are not translated into annual targets for shaping the state allocations and annual targets for state funded services. Furthermore, the Strategy was based on the pre-2020 UN targets for HIV and is yet to reflect the global UNAIDS targets for achieving 95-95-95 and comprehensive targets 2025 or an integrative approach to services set in the 2022 WHO Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Additionally, the current fragmentation of M&E systems limit visibility and the use of data from HIV care and support and prevention services to the continuum of services.

The M&E functions of prevention and care and support for PLHIV have been transferred to the state in part. The PHC has used previous tools and know-how of «100% LIFE» and the APH to build the M&E system of state-funded HIV prevention and care and support for PLHIV. Its focus has been on verification of the delivery of state-funded services. The PHC system for gathering needs, strategic work on identifying and supporting solutions, and quality assurance for these services have yet to be developed. Currently, because international funding continues to support

prevention and care, and support for PLHIV and is managed by «100% LIFE» and the APH, the service monitoring and support systems of the three organizations are fragmented, with the significant know-how built in the CSO PRs. In the mid-term, the country (and donors) should be clear and intentional about moving to an integral system for all HIV prevention and care and support, regardless of funding sources. Service providers and donors should be included in this discussion to factor in their perspectives. As previously highlighted, the PHC needs adequate resourcing to align the capacities of the three key managers of the national programs of HIV prevention and care and support for PLHIV.

Information on the M&E, management and budgets of the civil society principle recipients could help to set milestones how to capacitate this function within the PHC and/or to outsource some elements of it. The M&E functions within the PHC (and «100% LIFE» and the APH) depend on international funding. There is no discussion or plan yet how these functions would be adequately resourced by the state in the future. One of the suggestions is that in the future they could be co-financed for the needs assessment or capacity building from the budgetary program on public health, which funds the services.

6. What are the opportunities to include HIV/TB services in the penitentiary system in the next stage of the transition?

As indicated in Section 6.4, the penitentiary system works on the sustainability of services. The outcomes of MoH-MoJ inter-ministerial discussions on the overall governance of prison health will impact the model and funding of services. If the inter-ministerial discussions decide to proceed with the transfer of penitentiary health to the civil sector, some HIV and TB services could be offered to be included in the pilot. In the shorter term, the HPC of the Penitentiary Services should be encouraged to consult partners and develop the package of the documents, costing, and procurement model, like a roadmap developed for the transition of TB support services to state co-funding to set up legal and regulatory systems. The financial transition of services will be postponed.

7. What are the lessons learned and challenges from the transition from the Global Fund to state financing of HIV services that are relevant for TB and should be combined in the review?

Transition planning of the TB support services is taking certain lessons from the state's takeover of HIV services. For example, the Road map of Implementing TB Support Services in a Framework of Transition to State Funding is developed to plan normative, financial, procurement, and other steps. A broad consultation with stakeholders co-shaped this Road map. The lack of local funding for TB support services with minor exceptions informed the choice of centralized state funding for greater equity and coverage. The procurement and payment models were still to be worked out according to the Roadmap and communication with the PHC. Preliminarily, the services were to be purchased through one civil society manager, which would take over the administration of organizing and sub-contracting of services to other organizations as needed. Based on the lessons from the HIV field, it will be important to carefully review the procurement model and arrangements, engaging service providers, health financing experts, and other stakeholders and experience from international projects in planning costing, indicators for contractual arrangements, the verification, support and M&E systems including the division of labor and co-management of the state and donor-funded services. In the longer term, HIV, TB, and OAMT stakeholders should hold joint discussions on how to ensure greater sustainability, including if a different funding source or operator (e.g., NHSU if its mandate was expanded beyond care to support prevention and non-medical care) should be considered in the future.

8 Conclusions and Recommendations

Despite not having legal status or a clear accountability mechanism, and evolving over time, the Transition Plan has been a success, with the following critical enablers:

- Having a measurable, easy-to-understand and time-bound vision with numeric targets (reminiscent of 3by5 and 90-90-90 by 2020)
- Having a multistakeholder initiative team including authors of the vision for health reforms (including the new public health concept), strong civil society engagement and investment in increasing buy-in, preparedness to adjust to new procedures, and willingness to find solutions as problems came up.
- ART optimization, among other factors, created savings that stimulated initial allocation of funds to HIV prevention and care and support services in 2019.
- International partner support, especially the Global Fund by including the implementation of the Transition Plan as a grant condition, keeping transition high on the agenda, funding pilots, and providing flexible bridge support to mitigate challenges during transformations.

The 20-50-80 Transition Plan inspired processes that built national ownership not only in areas directly addressed in 2017 but even areas that were not mentioned in any iterations.

The Plan's implementation was possible because of the unique constellation of individuals and factors which might not be replicable in other contexts. Its ambition and approach are unique but can inspire other low-middle income countries.

HIV prevention and care and support for PLHIV

The state kept its commitment to allocate sufficient financial resources for community-based services for key populations and PLHIV and achieved a more ambitious benchmark than stated in the Transition Plan.

Significantly less funding reached services: just 24%, 68% and 73% of the funds allocated by state in the respective years from 2019 to 2021. The causes for underutilization were linked to the models of payment, lower price for services during the tendering competitions, dropped contracts by some services providers and no providers submitting offers to tenders. Additionally, the real value of funds was lower due to inflation and VAT taxation on services.

Strict standardization of key population programming was needed to ensure accountability of services to the state budget. As a result, however, the service packages and costing as they are defined and used in contracts and payment methods are inflexible, prevent tailoring to client needs and contributing to the above-mentioned problem of underutilization.

Improved service delivery and greater utilization of state funds will require greater flexibility within the service packages to address the fact that that clients have different needs in different contexts. It will also be necessary to change how the package concept and coverage is used by the PHC for to decide what it will pay for. PHC work to improve the model for procuring services should add give the PHC more flexibility to decide on the right approach for balancing people-centered delivery and accountability. Further building of PHC capacity and management of the national prevention and support programs should be supported, with more staff, and collaborative systems for supportive monitoring, and defining the way forward for PHC to administer a client database. Further pathways for HIV prevention sustainability and increased

state institution capacity should include solutions for state funding of commodities, and quality assurance.

State supported services contributed to: improved HIV diagnostic and care cascades among PWID and MSM; coverage of nearly 50% of the sum of the population size estimates of the three key populations; and engaging new previously unserved clients, however, below the coverage planned in the Strategic Plan and the state budget programs, especially for MSM. Clients and service providers generally viewed the transition positively, however, they did highlight where improvements could be made to service packages, ensuring greater access to services, and improved delivery. SWs and MSM additionally highlighted of preserving anonymity of services in the future.

The impressive progress with HIV prevention's basic packages, HIV treatment support is and will remain fragile. Its annual budgetary approvals depend on leadership in the MoH, the PHC, other government institutions and CSOs.

Transformation came as a result of great investment from all parties – including the PHC staff, service providers and supportive funders among others and great efforts were made to ameliorate negative effects on clients brought about by the changes.

Other areas

Transition of the basic package of prevention for key populations and care and support for people living with HIV catalyzed public discussion and movement towards transition of TB treatment support services and HIV and TB penitentiary services.

TB support services have already taken lessons from the HIV field, while, in 2019, their transition was not prioritized.

During the war, there is little clarity on the next steps for the comprehensive preparations of the roadmap and a set of documentation to support the state ownership and management of those services planned for 2022. There is also less clarity and administrative preparation related to state funding of prevention and care and support services in the future, though the lead state agency is keen to follow the PHC model for contracting CSOs once state funding is available.

The HIV (including PrEP), TB and OAMT packages achieved in the Program of Medical Guarantees (PMG) have a high degree of sustainability, independent of political and context changes because the Law of Ukraine on State Financial Guarantees of Public Medical Services (2168-VIII) which prohibits narrowing the program of medical guarantees, except in cases prescribed by law. These packages contribute to decentralization and efficiencies, however, they have not sparked major extension of the OAMT program to the primary care settings, potentially due to initial low funding rate for OAMT. Additionally, monitoring and support for overcoming barriers for key populations to PMG could be addressed through existing comprehensive services and/or PHC-funded information, education and counseling services. Further coverage of OAMT will not be possible without addressing negative perceptions of the quality of locally manufactured OAMT medications and of the program within the community.

Way forward

The 20-50-80 Transition Plan, set for 2018-2020, and the PHC's Strategic Working Group have successfully served their purposes. The new phase and the radically changed context require

rethinking of goals and the approach (for example, discrete-in-time plan, with clear accountability). The ability of the state to allocate increased funds will remain a challenge for years to come, however, this time could be used for testing and finalizing the reformed procurement model with international funding.

8.1 Recommendations for sustainability planning by 2025, building on the 20-50-80 Transition Plan

The review could not set a time-bound plan of sustainability, given the ongoing war and the emergency in the country. Most of the following recommendations will become most relevant in the more stable situation when the country will be able to move from emergency responses to rebuilding its health, social and HIV systems. The conflict and emergency response might require reassessing previous assumptions including on the basic packages of services or acknowledging geographical changes due to people's movement, destruction of infrastructure and living needs.

<u>HIV prevention and care and support for PLHIV</u>

1. Update the MoH regulations on service and their use in the contracts in line with the changed basic needs and cost-effective innovations introduced due to COVID-19 and reflecting the realities of the service provision
   - Care and support services for PLHIV should allow replacing sessions with case management to overcome barriers to care, reducing/increasing the number of interventions in consultation with the client and HIV clinicians. The incentivized packages for people who inject drugs should remain. Services should allow for working with people living with HIV who face more difficulties in developing treatment adherence, including but not limited to support with the ARV delivery for people with mobility difficulties or great distances from HIV care facilities.
   - The prevention package regulations and specifications in contracts should be adjusted to allow a flexible amount of service provision (i.e., providing the commodities nine times a year should become an average recommendation), online service provision, case management, or at least referral support for a stronger cascade of HIV services and linkage to other needs, self-testing for HIV, testing for viral hepatitis, syphilis and overdose prevention, motivation and support for PrEP uptake and addressing sexual and reproductive health and rights.
   - Trans people should be included in the MoH approved list of populations at high-risk for HIV and the prevention service regulation, recognizing it as a key population and committing to transition its funding and management;
   - If the packages cannot be defined with the sufficient flexibility for innovation and contextualizing, the MoH and the PHC should plan their regular update.

2. Revise costing, costing methodology, and payment for services, as needed, by using international funding for testing and finding the right balance between accountability and people-centeredness of services.
   - The payment for services should consider a combination of methods– a 'global budget' for the basic services, which could be treated as primary care and analog of

NHSU's approach to its funding, and payment for performance for achieving pre-agreed outcomes (e.g., a combination model is used for HIV prevention in Estonia[136])

- The updated methodology (and unit costs) should foresee indexation due to inflation and revisions of the minimum cost of living (in line with the NHSU approach) and factor in the VAT until the public health services are not exempt from VAT;
- The actual spending on services, prioritizing the prevention services, should be updated, capturing the potential co-coverage of services, if any, from other sources. Like in 2019, the MoH and PHC experts could be supported by «100% LIFE» and the APH to bridge potential differences in state and CSO budget concepts;
- Differences in costing of interventions (e.g., for different populations, like lower cost of sessions for HIV-positive people who inject drugs vs. PLHIV sessions or significant difference in the cost of testing vs. distribution of commodities) should be reviewed to set the right balance of incentives and effort needed, not lead to reduced motivation of 'cheaper' populations and interventions.

3. Set a roadmap for integrated planning and management of the national programs of HIV/AIDS prevention and care and support
    - Set coverage targets and use the expected coverage for fund allocation (not vice versa). This step would require the PHC to finalize the National M&E Plan for the implementation of the State Strategy on HIV, TB and Viral Hepatitis Until 2030 with annual targets set.
    - Plan for geographical differences and mobility of populations in setting coverage targets, budgets and additional support systems.
    - Identify roles, responsibilities, and synergies in service planning, capacity building, technical support, M&E, and co-funding schemes by the PHC, «100% LIFE» and the Alliance for Public Health. The plan might include outsourcing some functions for capacity building of state-funded services, engaging community monitoring and improving integration with the M&E for continuum of services, among other elements.
    - Complete developing the approach to quality assurance that would engage clients, service providers and regional public health institutions;
    - Update the PHC contracts and systems for a nuanced system of verification, technical support, and interventions in case of underperformance or observed misuse of funds, provision of additional training and technical support for new-comers as needed in cooperation with «100% LIFE» and the APH to support quality and sustainability of services;
    - Set regular (annual) meetings with services providers for the planning year, including state services and mechanisms for seeking and receiving counseling and support;
    - The plan should address the long-term of managing systems and databases. The transfer of the Data-Check to the PHC should be completed.
    - The PHC should plan increased resourcing of its functions (the ratio between the service cost and management cost in «100% LIFE» and the APH could inform; the management should not be less than 5%).

[136] Kurbatova, A. (2019). Estonia: funding of HIV and drug responses – experiences, mistakes and lessons learned (presentation on behalf of the National Institute for Health Development). UNDP, UNAIDS, and Global Fund global consultation on social contracting

4. Prepare and pilot the transfer to state procurement of testing and prevention commodities used in HIV prevention, if need be, with international funding.

OAMT:

5. Work with NHSU, providers, patient and harm reduction organizations for improved the attractiveness and uptake of the NHSU packages and OAMT services to reach the set targets for 2025 in the State Strategy on HIV/AIDS, TB, and Viral Hepatitis until 2030. These efforts should address the negative reputation of the quality of locally produced OAMT products among clients, more effective means for referral and motivation from HIV prevention services among people who inject drugs (harm reduction services), and a consultation on the attractiveness of the 2023 tariff that would include primary and private care providers. A dialogue with NHSU is needed on how to monitor and address attractiveness of OAMT among smaller and primary care providers and approach quality assurance of NHSU-funded OAMT (engaging community monitoring as relevant).

TB support services:

6. Implement the Roadmap for transition, with revised milestones for 2023-2025, engaging service providers and foreseeing a solid monitoring and learning mechanism to identify the risks and work on solutions. As much as possible, work on its implementation towards building one coherent system for all TB support services funded from all funding sources.

Prison-based HIV prevention, care, and support services for PLHIV and TB services:

7. Establish a roadmap for transition, which would include setting up relevant financial and procurement model plans and regulatory documentation for future state funding and management. The process should be consultative, based on the 20-50-80 Transition Plan lessons.

The capacity of pharmaceutical planning and procurement (mainly for ART and TB treatments)

8. Prioritize efforts in this area in the next cycle. A separate analysis is needed to fully understand the root causes of the challenges and opportunities in the coherent system of medicine and other pharmaceutical product management with clear roles, responsibilities, and resources in the Medical Procurements of Ukraine, the PHC, and other stakeholders. The MoH should do the coordination of this capacity and system building.

Sustainability Plan implementation, oversight, and awareness

9. Use the National Council on TB and HIV/AIDS for the strategic oversight of the processes of building sustainability. More technical, operational discussions ("transition plans", "roadmaps," etc.) would require separate task forces with specific tasks and timelines and co-lead from different partners.

10. Plan for increased awareness of the state taking increased responsibility in the HIV, TB, and OAMT, communicating clearly why those services are essential and prioritized by the state. At a minimum, this should include regular publishing of progress updates actively shared with HIV, TB, public health, and social service communities.

Annex 1: Acronyms

«100% LIFE»	All-Ukrainian Network of People Living with HIV
20-50-80	title of the Transition Plan developed in 2017
APH	Alliance for Public Health
ARVs	antiretrovirals
CPA	Central procurement agency
CSO	civil society organization
DOT	directly observed therapy
DR-TB	drug resistant form of TB
DS-TB	drug susceptible form of TB
EECA	Eastern Europe and Central Asia
HPC	Health Protection Center of the Penitentiary Services of Ukraine
IDUIT	Injecting Drug User Implementation Tool
IEC	information, education and counseling
M&E	monitoring and evaluation
MSM	men who have sex with men
MSMIT	Men who have Sex with Men Implementation Tool
MoF	Ministry of Finance
MoH	Ministry of Health
MoI	Ministry of Interior
MoJ	Ministry of Justice
National Council	National Council on TB and HIV/AIDS
NHSU	National Health Service of Ukraine
OAMT	opioid agonist maintenance therapy (also known as replacement maintenance therapy, opioid substitution therapy, opioid agonist therapy)
PEPFAR	U.S. President's Emergency Plan for Emergency Relief
PHC	Public Health Center
PLHIV	people living with HIV
PMG	Program of Medical Guarantees
PR	principal recipient (of the Global Fund's grants)
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
SW	sex worker
SWIT	Sex Worker Implementation Tool
TB	tuberculosis
UAH	Ukrainian hrivna
UN	United Nations
UNAIDS	Joint UN Programme on HIV/AIDS
UNODC	UN Office on Drugs and Crimes
USAID	U.S. Agency on International Development
US$	US dollars
VAT	value added tax
WHO	World Health Organization
y.o.	years old

Annex 2: List of Informants

In alphabetical order

1. Alona Goroshko, WHO/Europe health financing expert and former Head of UHC Strategy Department of NHSU (2019-mid 2021)
2. Anastasiia Yeva Domani and Natalya Borisovna Zhuravlova, NC members on behalf of trans people [*in writing*]
3. Andrey Chernyshev, NC member on behalf of LGB/MSM, Director of Global Alliance
4. Anton Basenko, NC member on behalf of people who use drugs
5. Denis Klymenko, Co-founder of network of Medical Centres "Alternative" and Medical Centre "Innovation" (Kharkiv)
6. Dmytro Sherembey, Chair of Council of «100% LIFE» (All-Ukrainian Network of People Living with HIV, Deputy Chair of NC
7. Elena Voskresenskaya, Oversight Committee of the National Council on TB and HIV/AIDS, Executive Director of AFEW Ukraine
8. Evgeniy Khanyukov, lead on Prison Health, PHC
9. Iana Terleeva, Head of the TB Department, PHC
10. Ihor Kuzin, Deputy Minister of Health, member of NC, former Deputy and Acting Director General of PHC
11. Iryna Ivanchuk, Head of Mental Health and Addictive Disorders, PHC
12. Jessica Grignon and Volodymyr Chura, USAID
13. Kateryna Mangatova, former Head of the HIV Prevention and Care and Support Department at PHC (until late 2021), now Alliance for Public Health
14. Larysa Hetman, Head of HIV Department, PHC
15. Lesia Tylina, Yulia Petrenko, Lyudmila Pakhucha, Global Fund Local Fund Agent at PricewaterhouseCoopers
16. Lyubomyr Rak, Director General of Center of Lung Health in Lviv region
17. Maria Gudyma, Medical Director of Public Enterprise "Dnipropetrovs'kiy Medical Center of socially significant diseases of Dnipropetrovs'kiy Oblast Council"
18. Maxim Demchenko, consultant in various transition plan implementation tasks and PHC Strategic Working Group member
19. Mikhail Vasilevich Zlobinets, Deputy Director of Health Protection Center of the Ministry of Justice
20. Nataliia Salabai, UNAIDS, former Chair of the NC Oversight Commission (until 2018) and its advisor (2019-2021)
21. Oleksii Zagrebelnyi, Chair of FreeZone and NC member on behalf of ex-prisoner community, Anna Koshkova, FreeZone
22. Olena Kucheruk, International Renaissance Foundation, NC member
23. Olya Klymenko, NC member on behalf of people with TB, Chair of TBpeople Ukraine
24. Pavlo Smyrnov, Associated Director of Alliance for Public Health
25. Roman Drozd, Chair of Regional Committee of the National Council on TB and HIV/AIDS; Director of CSO "Світло Надії" (Light of Hope)
26. Roman Hailevich, UNAIDS Country Director (from 2018), and
27. Sergii Dmitriiev, former Head of Advocacy Department of «100% LIFE»
28. Taras Grytsenko, Advisor to the Minister of Health, former Senior Advisor to the First Deputy Director General Victor Liashko