UKRAINE HARMONIZED AIDS RESPONSE PROGRESS REPORT

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Virus
ART	Antiretroviral therapy – use of prescribed drugs against HIV infection
CL	Confidence Limit
CSW	Commercial Sex Workers
FCSW	Female Commercial Sex Workers (women providing sexual services for a reward)
GFATM, Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users
LGBT	Lesbian, gay, bisexual and transgender people
M&E	Monitoring and Evaluation
M&E Centre	Ukrainian Centre for Monitoring and Evaluation of Program Implementation on Combatting HIV-infection/AIDS
MoH	Ministry of Health of Ukraine
MSM	Men who have sex with men
National AIDS Program	National Program to Insure Prevention of HIV Infection, Treatment, Care and Support for HIV Infected Persons and AIDS Patients in 2009-2013
National Report	Ukraine's Harmonized Progress Report on National Response to the HIV/AIDS Epidemic (this paper)
NCPI	National Composite Policy Index
NGO	Non-governmental Organisation
PLHA	People Living with HIV/AIDS
SES	Sentinel Epidemiological Surveillance
SMT	Substitution Maintenance Therapy
State Service on Social Diseases of Ukraine	Ukraine's State Service on Combatting HIV-infection/AIDS and Other Socially Hazardous Diseases
STI	Sexually Transmitted Infection
Ukrainian AIDS Centre of the MoH of Ukraine	State Agency "Ukrainian Centre for Prevention and Control of AIDS" of the Ministry of Health of Ukraine
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing for HIV
WHO	World Health Organization

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SECTION I. STATUS AT A GLANCE

During the 2011 UNGASS meeting the country participants voted unanimously to adopt a new Political Declaration that includes new commitments and bold new targets. The new Declaration is based on two previous Political Declarations: Declaration of Commitment of HIV/AIDS (2001) and Political Declaration on HIV/AIDS (2006).

UN member states committed to following targets:

Reduce sexual transmission of HIV by half by 2015;

Reduce HIV transmission among people who use injecting drug by 50% by 2015;

Insure prevention of new cases of HIV in new-borns by 2015;

Increase the number of people with access to vital antiretroviral therapy to 15 million;

By 2015 reduce TB deaths among people living with HIV by half;

Reduce lack of funding to fight AIDS at the global level and adopt measures to increase annual funding to combat AIDS to 22-24 billion USD by 2015; acknowledge that investing in fight against AIDS is a matter of joint responsibility.

The Political Declaration evidently reflects the dire need to scale up access to HIV services for populations with high risk of HIV infection, e.g., men having sex with men, injecting drug users and sex workers.

The Political Declaration aims to eliminate gender inequality, violence and gender-based discrimination; and also address the needs of women and girls. All of these targets need to be implemented immediately.

In 2012 Ukraine in the framework of evaluating progress in reaching Millennium Development Goals: Tracking progress on HIV/AIDS by 2015 submits to the UNAIDS Secretariat the Harmonized National Report for 2010-2011 on Implementing Resolutions of the "Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS" (2011), Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia (2004) and WHO, UNAIDS and UNICEF joint reporting tool "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector" (hereafter – 2012 National Report).

It is the most comprehensive and full review of the HIV/AIDS response, which comprises of 56 indicators, recommended for all UN member states.

Six indicators are not relevant for Ukraine, as they do not reflect the epidemic registered in the country:

 # 1.6 "Percentage of young people aged 15- 24 who are HIV infected" - because such indicator is not relevant for Ukraine as it does reflect the epidemic registered in the country.

Indicator of HIV prevalence among youth helps appropriately estimate trends in countries with growing generalized HIV epidemic fuelled by the heterosexual rout of transmission. For countries with HIV epidemic concentrated in populations most at risk of HIV infection such indicator contains less useful information.

According to current data of the Ministry of Health of Ukraine by the end of 2011 prevalence of HIV among pregnant women in Ukraine is under one per cent, which corresponds to the UNAIDS recommended definition of concentrated epidemic of HIV infection. As a result in the 2010-2011 Report Ukraine presents HIV prevalence rates based on epidemiological data collected among injecting drug users, persons engaged in commercial sex, men having sex with men, i.e., populations most at risk of HIV infection which currently remain the driving force behind the epidemic in the country.

Data collected as a result of routine epidemiological surveillance of pregnant women in gynaecology offices demonstrates that in 2011 in Ukraine 0.47% of pregnant women among primarily diagnosed patients tested positive for HIV. At the same time, epidemiological situation in five regions of Ukraine calls for concern, where such indicator is considerably higher compared to the average in the country, namely 1.08% in the Dnipropetrovsk region; 0.87% in Mykolayiv region; 0.84% in Odessa region; 0.80% in Donetsk region; and 0.78% in Kyiv region.

 # 7.2 "Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months" - because such indicator is not relevant for Ukraine as it does not reflect the epidemic registered in the country.

Currently Ukraine is experiencing a concentrated HIV epidemic, whereas such indicator is used only in countries with a generalized epidemic fuelled by the heterosexual rout of transmission and helps estimate the level of HIV prevalence among women affected by physical or sexual violence.

 # 1.18 "Migrants: condom use", # 1.19 "Migrants: HIV testing", # 1.20 "Migrants: HIV prevalence" – because such indicators are not relevant for Ukraine. Such indicators are applied to migrants coming from countries with a generalized HIV epidemic. Currently there are no registered cases of large scale migration to Ukraine from countries with a generalized epidemic; individual cases of HIV infection among foreign nationals, e.g., students, do not affect the epidemic's development in Ukraine.

 # 3.10 "Number and percentage of infants born to HIV-infected women assessed for and whose infant feeding practices were recorded at DTP3 visit" – such indicator is not relevant for Ukraine, as the national strategy program for prevention of vertical transmission of HIV from mother to child aims to entirely exclude breast feeding of new-borns born to HIV positive mothers. Children born to HIV positive mothers are supplied with breast milk substitute, financed by local budgets. Counselling of HIV positive mothers on feeding the new-borns is organized in the framework of current normative and legislative documents by medical staff of the AIDS Centers, reproductive health facilities (e.g., maternity hospitals, gynaecology offices, centers for family planning, etc.)

The following five indicators are relevant for Ukraine, however currently there are no reporting and accounting forms which would enable to collect the data under such indicators:

 # 4.4 "Percentage of health facilities dispensing ARV that experienced a stock-out of at least one required ARV in the last 12 months [disaggregated by sector (public, private)" - such indicator is relevant for Ukraine, however there are no available reporting and accounting forms to help collect data under such indicator. In the framework of Round 10 it is planned to develop and implement in some regions an electronic toolkit; and from 2014 reporting on the indicator will be collected on the national level.

 # 5.3 "Number and percentage of adults and children newly enrolled in HIV care who start on treatment for latent TB infection (isoniazid preventive therapy) among the total number of adults and children newly enrolled in HIV care over a given time period" - such indicator is relevant for Ukraine, however currently there are no available reporting and accounting forms to help collect data under such indicator. In Ukraine prevention with Isoniazid is prescribed to patients based on medical indicators, according to Methodology Guidelines on Improving Medical Care for HIV Infected Persons and AIDS Patients as approved by the MoH of Ukraine Decree # 344 dd. 15.12.2000, regardless of the time of enrolling into follow up care. As a result data on prevention activities using Isoniazid in HIV infected patients is available for all HIV infected persons, without separation for patients newly enrolled into follow up care.

 # 5.4 "Number and percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit among all adults and children enrolled in HIV care in the reporting period" - such indicator is relevant for Ukraine, however currently there are no available reporting forms to help collect data under such indicator.

 # 7.6 "Number of adults and children with HIV actively enrolled in HIV care in 2011". Such indicator is relevant for Ukraine, however currently there are no available reporting and accounting forms to help collect data under such indicator. It is necessary to develop and implement an electronic registry system of visits to HIV care facilities to measure such indicator.

 # 7.7 "Percentage of adults and children enrolled in HIV care who were screened for hepatitis C" - is relevant for Ukraine, however currently there are no available reporting forms to help collect data under such indicator.

As a result in the 2012 National Report Ukraine does not provide data under eleven indicators.

Some of the indicators in the 2012 National Report were calculated based on available data from existing statistical sources. To calculate other indicators special sociological and epidemiological studies were carried out among the general public and HIV vulnerable populations.

With aim to insuring quality research and opportunity for comparative analysis of the situation in different countries, data collection was organized based on standard techniques, recommended by the UNAIDS Global AIDS Response Progress Reporting (2012).

A) Inclusiveness of stakeholders in the report-writing process

To insure timely development of the 2012 National Report the National Council to Fight Tuberculosis and HIV-infection/AIDS approved a list of targets and indicators, spheres of responsibility for stakeholder organizations and deadlines in its decision dd. 13.12.2011.

Government Organization "Ukrainian Center to Control and Prevent AIDS of the MoH of Ukraine (hereafter - Ukrainian AIDS Centre of the MoH of Ukraine) was selected as organization responsible for developing of the 2012 National Report.

The State Service of Ukraine on Combatting HIV-infection/AIDS and Other Socially Hazardous Diseases (hereafter – Ukrainian State Service on Social Diseases) manages the process of development and submission of the 2012 National Report, and coordinates the process of indicator approval by the central government agencies of executive power and Government of Ukraine.

Following three central government agencies of executive power approve values for indicators: the Ministry of Health of Ukraine (MoH of Ukraine) - Ukrainian State Service on Social Diseases, Ministry for Education and Science, Youth and Sports of Ukraine (Ministry for ESYS of Ukraine) and State Penitentiary Service of Ukraine.

State agencies of executive power carry first and foremost responsibility for supporting monitoring and evaluation in the field of HIV/AIDS. According to the Law of Ukraine "On Combatting Spread of Diseases Caused by the Human Immune Deficiency Virus (HIV) and Legislative and Social Protection of the Nation" (2010) the Ministry of Health of Ukraine - as a central agency of executive power in the field of health care, has a special responsibility to support inter-departmental coordination of measures to fight HIV infection.

The ICF "International HIV/AIDS Alliance in Ukraine" directly supported development of the 2012 National Report in the framework of Program "**Support** for **HIV** and AIDS Prevention, Treatment and Care for Most **Vulnerable** Populations in **Ukraine" financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria;** with support from the WHO Country Office in Ukraine; Working Group on Monitoring and Evaluation under the National Council to Fight Tuberculosis and HIV-infection/AIDS provided technical assistance.

Records and results of the 2012 National Report represent a joint opinion of a wide range of stakeholders engaged in national response to HIV/AIDS in Ukraine, supported by the Government of Ukraine.

According to the recommendations presented in the UNAIDS guidelines the 2012 National Report had been developed and discussed at stakeholder and partner meetings. Values of specific indicators were reviewed by experts of governmental, non-governmental and international organizations. According to the UNAIDS recommendations each national indicator and draft of the 2012 National Report were presented for review and approval during meetings of the Working Group on Monitoring and Evaluation with participation from representatives of central agencies of executive power, civil organizations, international and bi-lateral organizations, including networks of people living with HIV.

Draft of the 2012 National Report was disseminated among all members of the Working Group on Monitoring and Evaluation. Comments and recommendations of the working group members were considered in the process of finalization of the 2012 National Report. The final draft of the report was submitted by the Ukrainian AIDS Centre of the MoH of Ukraine during the open Stakeholders' Forum on March 21, 2012. The Forum welcomed over 80 participants.

The final draft of the 2012 National Report was reviewed and approved at the meeting of the National Council to Fight Tuberculosis and HIV-infection/AIDS on March 29, 2012. Following this decision the Ukrainian and English copy of the report was forwarded to the UNAIDS Secretariat (Geneva).

B) The status of the epidemic

Ukraine is experiencing the most severe HIV epidemic in Eastern Europe and the CIS countries. The current status of the epidemic is associated with wide spread of HIV among various populations,

first of all populations most at risk of infection; uneven spread of HIV infection in different regions of the country; shift in dominant routs of HIV transmission; HIV affects mainly population of the working age.

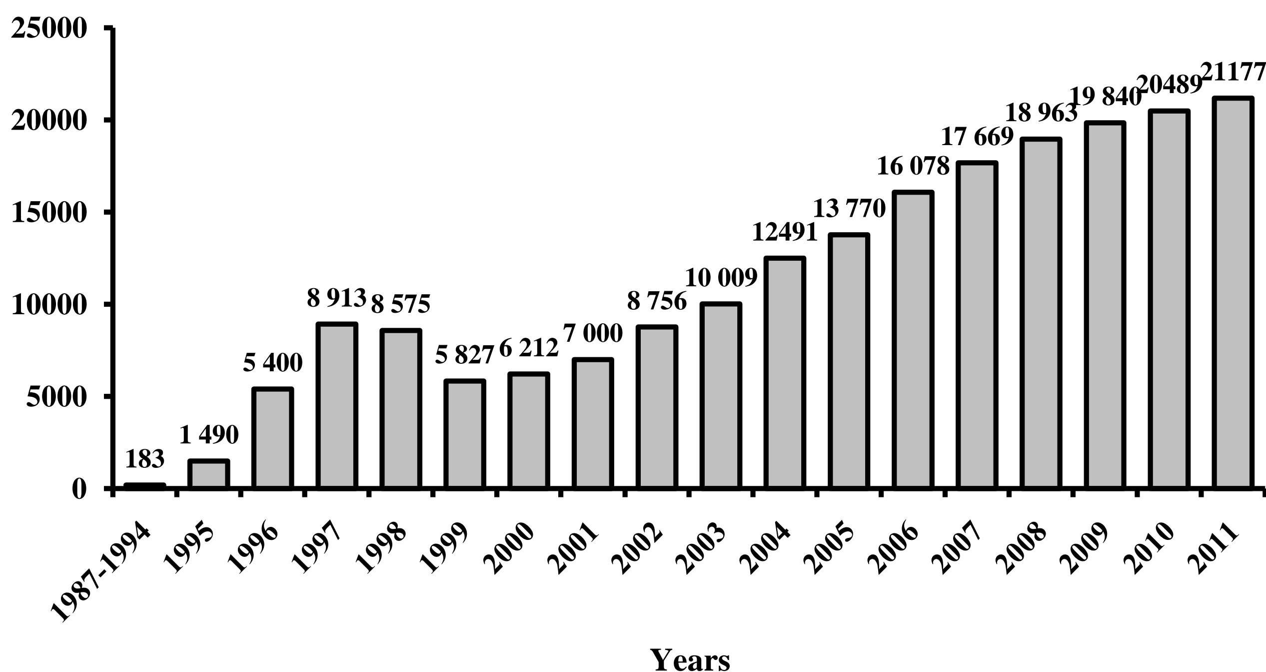
In 1987-2011 Ukraine officially registered 202,787 HIV infection cases among Ukrainian nationals, including 46,300 AIDS cases and 24,626 AIDS related deaths.

The HIV epidemic continues to develop: starting from 1999 the number of new HIV cases remains on the rise. In 2011 Ukraine officially registered 21,177 new cases of HIV infection (46.2 per 100 thousand population) – this is the highest indicator value, registered from the time when HIV surveillance was first introduced in 1987 (Picture 1).

In some regions the epidemic is concentrated in the cities – in 2011 77.1% of new HIV cases were registered among the urban population, at the same time an increase in new HIV cases among the population in the country regions is very low, however its numbers continue to rise (e.g., from 2007 till 2011: 21.8%; 21.0%; 21.0%; 23.5%; 22,9%, respectively).

In respect to age and gender groups new HIV cases are usually registered in people aged 25 to 49, the proportion of this particular group continues to increase (e.g., from 2007 till 2011: 62,8%; 62,5%; 63,8%; 64,8%; 66,3%, respectively); the proportion of men tends to decrease (e.g., from 2007 till 2011: 56,2%; 55,4%; 55,1%; 56,4%; 54,5%, respectively).

However, in the last period of years HIV incidence rates have shown a sustainable tendency to decrease among 15 to 25 year olds within the overall number of first registered cases of HIV infection (e.g., from 2007 till 2011: 15%; 13%; 12%; 11% and 9%), which may indicate stabilization of the HIV epidemic in general as a result of a shift in behaviour to less risky by the young people.



***Picture 1**. History of officially registered new HIV cases among Ukrainian nationals by years, 1987-2011*

In 2009-2011 Ukraine has experienced a minor decease in the number of screening tests for HIV: 3,350, 3,278 and 3,318 thousand respectively. According to the sero-epidemiological monitoring data in the past three years HIV prevalence among the Ukrainian nationals is on a decrease: 1.11%, 1.03% and 1.02%, respectively.

In 2009-2011 HIV care indicators have shown a tendency to increase: 54.5%, 60.6%, 62.7%, respectively, however the HIV care coverage indicator remains insufficient (i.e., under 70%). Consequently one third of HIV positive individuals identified as a result of sero-epidemiological surveillance are not covered by HIV and clinical care (e.g., did not receive a test result, do not wish to enrol into medical care and so on), these patients remain source of infection which continues to drive the HIV epidemic.

The number of officially registered HIV infection cases reflects the number of carried out tests for antibodies to HIV and the structure of testing in the regions. In regions with limited access to testing, especially for people from most at risk populations, the registered number of HIV cases may be significantly underestimated (e.g., Zakarpattya region, Ivano-Frankivsk region, Volyn region, Zaporizhzhia region and Donetsk region).

In 2009-2011 the number of HIV tests among injecting drug users (code 102) and HIV prevalence rates have shown a tendency to decrease: 13.34%, 12.31%, and 11.39% respectively. In regard to patients with diagnosed sexually transmitted infections (code 104) – HIV prevalence rates remain practically stable: 1.51%, 1.25% and 1.45%, respectively. At the same time the number of tests provided to persons with multiple unprotected sexual encounters (code 105) is experiencing a slight increase: 39, 49 and 57 thousand tests respectively, bearing in mind that HIV prevalence under such indicator is on a decrease: 1.96%, 1.77% and 1.60%.

It is worth considering data on HIV prevalence in respect to regions among patients with codes 104 and 105. For example, highest indicators under code 104 (i.e., patients with diagnosed sexually transmitted infections) were registered in the Odessa region (3.54%) and lowest - in Zakarpattya region (0.14%) compared to 1.45% average prevalence rate in the country.

Under code 105 (i.e., persons with multiple unprotected sexual encounters) only 35 tests were carried out in Sevastopol and 68 in the Poltava region. As a result, small numbers of tests under such code do not allow to measure HIV prevalence rates. Compared to the average HIV prevalence rate in Ukraine of 1.60% under the code 105, highest rates had been registered in Kyiv (5.52%) and the lowest in the Zakarpattya region (0.27%).

In the past years the testing system operating in Ukraine includes testing donors and pregnant women using test kits procured with financial support from the state budget; the general population is tested with test kits, procured with support from the local budgets. When analyzing the proportion of tests carried out with support from the local budgets compared to the overall number of tests – there are significant geographic variations in indicator values. Highest rates are registered in the Chernigiv region, Zakarpattya region, Kherson region, Cherkassy region and Donetsk region, the lowest rates are recorded in the Poltava region, Vinnitsa and Khmelnitsky regions and Autonomous Republic of Crimea.

However it is more informative to analyze not just the proportion of tests carried out with support from the local budgets in general, but also proportion of tested most at risk populations which remain the driving force behind the epidemic in Ukraine. Using this criterion as a guideline – the lowest rates were registered in the Cherkassy region, Mykolayiv region, Chernigiv region, Khmelnitsky and Lugansk regions; the highest rates were recorded in the Zakarpattya region, Ivano-Frankivsk region, Volyn region, Zaporizhzhia region and Donetsk region.

It is assumed that HIV prevalence rates among pregnant women registered at the gynaecology offices appropriately reflect HIV prevalence level in the general population as well as tendencies for epidemic's development. Also pregnant women as a sampling group are representative for analyzing epidemiological situation among the sexually active proportion of the population. Based on the primary testing result (code 109.1) in 2011 HIV prevalence rate among pregnant women in Ukraine was 0.47% (e.g., from 2007 till 2011: 0.52%; 0.55%; 0.55%; 0.48%; 0.47%, respectively).

When analyzing regional indicators, following tendencies show: in 2011 the indicator varied significantly – from 0.02% in the Zakarpattya region to 1.08% in the Dnipropetrovsk region. The indicator was high in the so called priority regions of Ukraine: Mykolayiv region, Odessa region, Donetsk region and Kyiv and Kirovograd regions (e.g., 0.87%; 0.84%; 0.80%; 0.79% and 0.63%). This data supports the hypothesis that in some regions of Ukraine the HIV epidemic could establish itself the general population.

A series of international studies suggest that to minimize risks associated with blood transfusion, careful selection of donors remains a more effective means of ensuring donor blood safety compared to HIV testing. Also medical staff often recommend patients to have a blood transfusion for an extra charge, even though it is not medically viable, which further increases risk of HIV infection.

Currently Ukraine has 23 registered cased of HIV infection via transfusion of infected blood and blood products. The average rate of HIV prevalence among primary blood donors (code 108.1) in the country was 0.16% (from 2007 till 2011: 0.17%; 0.18%; 0.20%; 0.18%; 0.16%, respectively).

Regions with traditionally high levels of HIV prevalence have the poorest quality of pre-test counselling delivered by the Blood Transfusion Service, HIV infection rates among one-time donors in the Mykolayiv region is 0.51%, in Odessa region – 0.46%, in Dnipropetrovsk region – 0.35%, in Chernivtsy region – 0.33%, in Kherson region – 0.32%, it is suspected that these regions do not provide pre-test counselling at all.

There are recorded cases of HIV infection among registered blood donors in the Autonomous Republic of Crimea, Vinnitsa region, Dnipropetrovsk region, Donetsk region, Zaporizhzhia region, Lugansk region, Mykolayiv region, Odessa region, Sumy region, Ternopil region, Kherson region, Khmelnitsky region, Chernigiv region and the city of Kyiv. This indicates that there is no system in place to prevent HIV infection during blood transfusion and transfusion of blood products and components, and there is a need for new effective methods of donor selection to eliminate donors who engage into HIV related risky behaviours.

In Ukraine each day 58 persons were diagnosed with HIV, 25 persons were diagnosed with AIDS, and 10 patients died of AIDS related diseases – 2011 official statistics say.

The number of AIDS patients in country continued to increase up to and including 2006. In 2007 first minor decrease in AIDS morbidity was registered (from 10.1 per 100 thousand population in 2006 to 9.8 per 100 thousand population in 2007). In 2008-2009 these indicators were at 9.5 and 9.7 per 100 thousand population, however in 2010 and 2011 the indicator increased to 12.8 and 20.1 per 100 thousand population respectively. The rise in AIDS morbidity in 2010-2011 may be somewhat explained by the effect of the MoH Decree # 551 dd. 12.07.2010 "On Approving Clinical Protocol for Antiretroviral Therapy in Adults and Adolescents" which defined AIDS according to the WHO clinical staging of HIV infection (2006) and included such diagnosis as "pulmonary tuberculosis" as well as "extra-pulmonary tuberculosis".

It should be noted that in the past years there are increasing numbers of HIV infected persons identified based on clinical symptoms. Based on the results of sero-epidemiological surveillance in 2011 over 22% of all HIV positive results were identified in patients tested based on clinical symptoms. In some regions this indicator is significantly higher.

In 2011 in Ukraine HIV infection and AIDS were simultaneously diagnosed in 4,076 cases (over 44%) out of 9,189 new AIDS cases registered within the reporting year; and 5 113 patients in HIV care were diagnosed with the IV clinical stage of AIDS.

Tuberculosis continues to be the most wide spread AIDS related disease in Ukraine; it is diagnosed in 5,745 cases (62.5%) out of 9,189 new AIDS cases.

Analysis of the HIV epidemic in Ukraine demonstrates that the infection weighs heavy on the country's health care system – the speed of HIV epidemic development surpasses the efforts to control and treat the infection, including provision of antiretroviral therapy (ARV) to all eligible patients.

Death from AIDS related diseases has become a real threat for thousands of HIV infected people in Ukraine: in 2011 3,736 patients died of AIDS related diseases, including 22 children. The highest mortality rates were registered in the Donetsk region – 5 cases, in the Dnipropetrovsk region – 4 cases, two cases in the Autonomous Republic of Crimea, Zhytomyr region, Odessa region, Poltava region, and Khmelnitsky region, one case each in the Kharkov and Zaporizhzhia region.

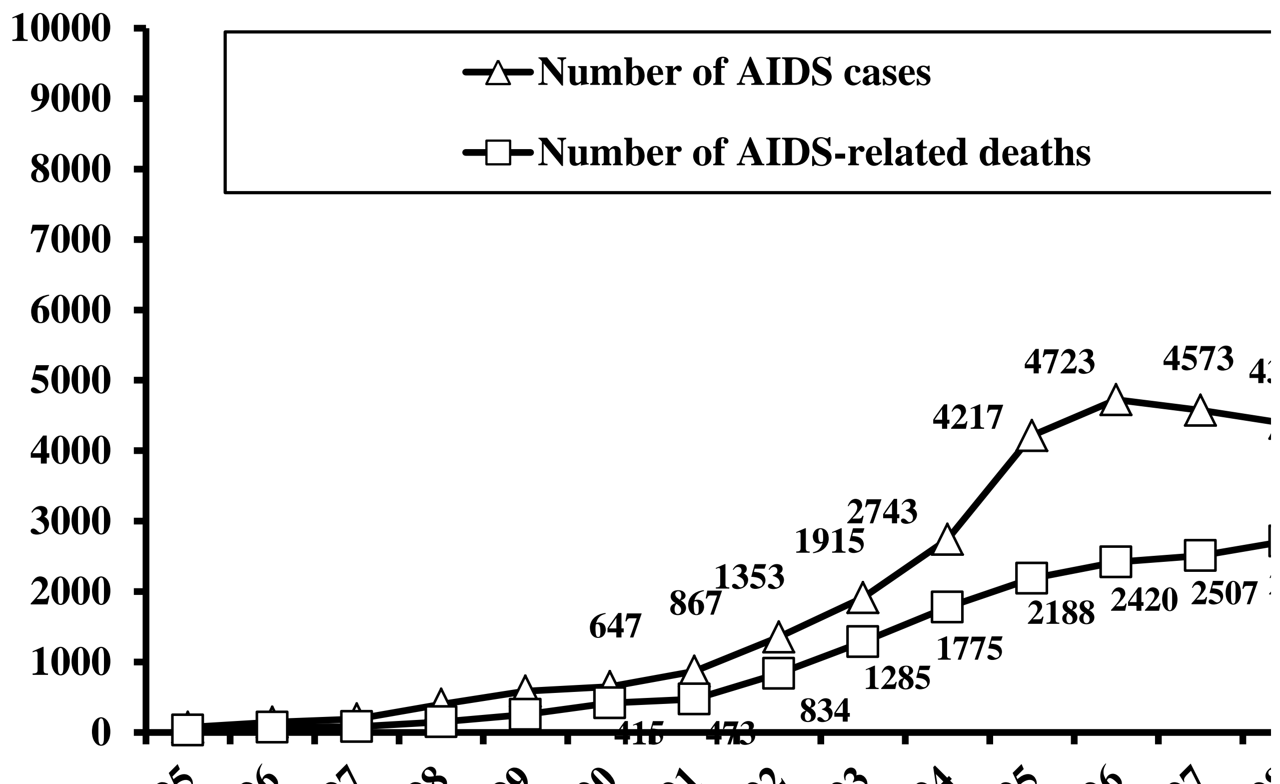
In 2011 AIDS mortality increased compared to the previous years, now it comes up to 8,2 per 100 thousand population; in the previous years it was estimated at 4,6; 5,2; 5,4; 5,8; 5,6; 6,8 per 100 thousand population respectively.

Active injection drug users still have limited access to clinical measures as a result of restricted availability of substitution maintenance therapy resulting in low ARV adherence.

As of 01.01.2012 Ukraine has 120,148 Ukrainian nationals in HIV care in health care facilities (264.3 per 100 thousand population), including correction facilities of the State Penitentiary Service of Ukraine, out of which 18,751 patients diagnosed with AIDS (41.2 per 100 thousand population).

Just as before there are significant variations in HIV prevalence in relation to regions of Ukraine. Highest HIV prevalence rates according to the official registry system, are recorded in Southern and Eastern regions of Ukraine: Dnipropetrovsk region, Donetsk region, Odessa region, Mykolayiv region, the city of Sebastopol and also in the Autonomous Republic of Crimea (e.g., 605.9-361.6 per 100 thousand population); prevalence rates in these regions are significantly higher compared to the country average of 264.3 per 100 thousand population as of 01.01.2012.

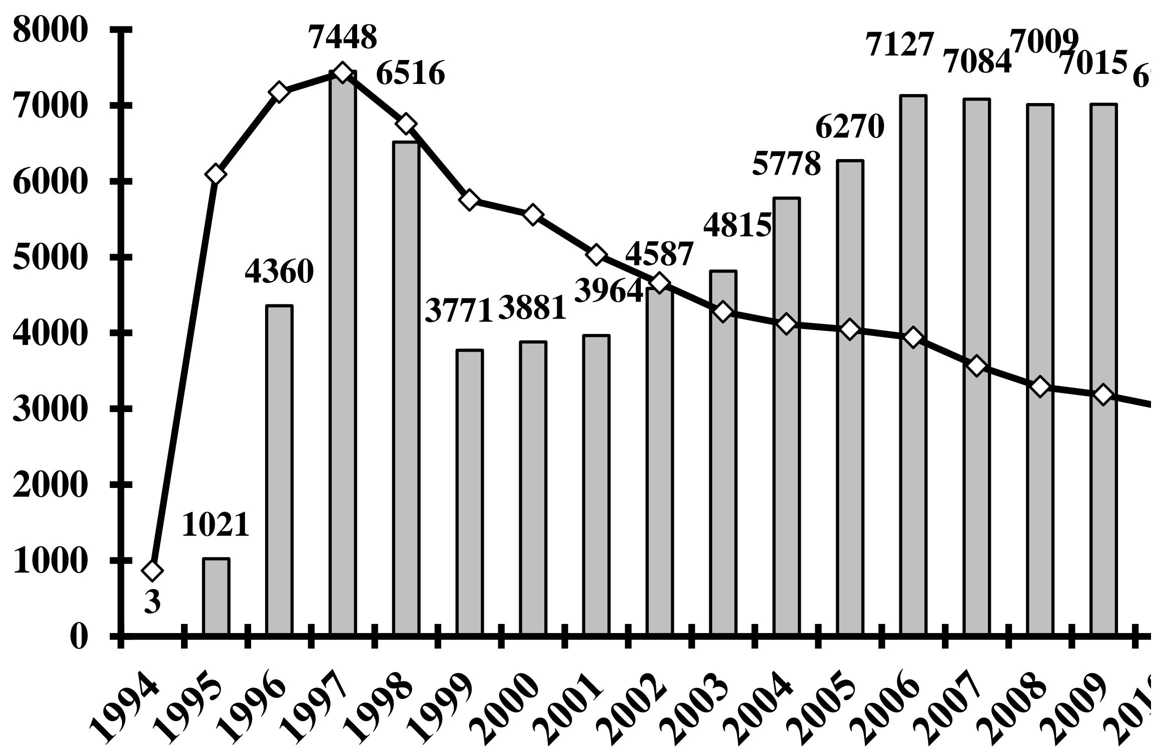
From 1995 until and including 2007 parenteral way of HIV transmission dominated – usually through injecting drug use. In 2008 for the first time starting from 1995 there had been a shift in routs of HIV transmission from parenteral to sexual. In 2011 the number of persons infected as a result of unprotected sexual encounters increased to 49%, while injection drug use was estimated at 31%.



***Picture 2**. Number of new AIDS cases and AIDS related deaths among Ukrainian nationals (1991-2011)*

An increase in transmission of HIV and the increasing number of HIV-infected women of child-bearing age caused a gradual increase in the number of infants born to HIV-infected mothers; in 2011 their proportion was estimated at 19%. Although these infants initially test positive for HIV antibodies, as a reaction to mother's antibodies, most of them are HIV-negative. New-borns with a negative HIV-status should be expelled from HIV care at the age of 18 months and over. Although Ukraine is experiencing a fall in mother-to-child HIV transmission, the overall number of children with confirmed HIV status continuous to increase. As of 01.01.2012 there are 2,722 in HIV care with confirmed HIV diagnosis, including 752 children with AIDS, and 6,735 children with unconfirmed HIV.

It is worth noting that between 1999 and 2006 the absolute number of injecting drug users (IDUs) among new HIV infection cases increased in parallel with an annual decrease in proportion of IDUs among the total number of new HIV cases. The past years (2006–2011) have demonstrated a clear tendency of decrease in the absolute number of registered new HIV cases among injecting drug users; as well as a tendency of decrease in proportion of IDUs (Picture 3).



***Picture 3**. Officially registered HIV infection cases in IDUs by years*

Men who have sex with men (MSM) as a group continue to be at high risk of HIV infection. Between 2005 and 2011, an annual increase in absolute number of new HIV cases in the group was officially registered: 20, 35, 48, 65, 94, 90, and 143. One may assume that the number of HIV infection cases resulting from sexual relations between men is greatly underestimated.

Ukraine does not register HIV infection cases among female commercial sex workers (FCSW). However, data of sentinel epidemiological surveillance indicates a broad and growing epidemic in the population.

In Ukraine HIV infection remains concentrated in the most at risk populations, first and foremost – IDUs. Statistics suggest that the new wave of HIV infection via sexual rout of transmission is directly caused by risky sexual behaviour of IDUs and their sexual partners. High rates of HIV prevalence among pregnant women signal further rapid development of the epidemic among the general population.

C) The policy and programmatic response

HIV/AIDS prevention is organized in Ukraine based on the UNAIDS "Three Ones" key principles: One agreed HIV/AIDS Action Framework (e.g., National Program to Fight HIV/AIDS in 2009–2013); One National AIDS Coordinating Authority (e.g., National Council to Fight Tuberculosis and HIV-infection/AIDS); One agreed country level Monitoring and Evaluation System (e.g., National M&E System).

Ukraine has a national strategy to combat HIV/AIDS, which was approved as Law and remains mandatory for implementation by all branches of power, the strategy affects society in general and each

Ukrainian national in particular. These activities are carried out by the State in close cooperation with civil society and international organizations at national and local level; the State annually increases finding of essential activities.

The State defined priority directions in combatting HIV/AIDS in Ukraine include strengthening HIV/AIDS prevention, provision of HIV/AIDS treatment for patients in need, upholding human rights of people living with HIV and encouraging public's tolerant attitude towards people with HIV. Ukraine supports these activities through the Law of Ukraine "On Prevention of Spread of Diseases Caused by the Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV" which came into effect in January 2011. The Law harmonises relations between the human rights requirements and public health needs, insures comprehensive and full concrete implementation of the harm reduction strategy, and supports development of public-private partnership needed for provision of effective response to spread of HIV infection.

In 2007 Committee on Combatting HIV-infection/AIDS and Other Socially Hazardous Diseases (hereafter – Committee) was created as agency of governance, designed to insure inter-departmental and intersectoral cooperation in implementing government policy to fight HIV/AIDS.

In 2011 the Committee was dissolved as a result of administrative reform and replaced by the State Service on Combatting HIV-infection/AIDS and Other Socially Hazardous Diseases (approved by the Law of President of Ukraine # 1085/2010 as of December 9, 2010 as a central agency of executive power). On April 8, 2011 the President of Ukraine approved Decree # 441 on "Provisions for the State Service on Combatting HIV-infection/AIDS and Other Socially Hazardous Diseases".

Key tasks of the Ukrainian State Service on Social Diseases:

Present suggestions on developing state policy in the field of HIV infection/AIDS and other socially hazardous diseases;

Implement state policy in the field of HIV infection/AIDS and other socially hazardous diseases;

Develop suggestions to strengthen legislative and normative base in the field of HIV infection/AIDS and other socially hazardous diseases

Implement government control over upholding legislation in the field of HIV infection/AIDS and other socially hazardous diseases;

Develop and manage projects aimed at implementing national and other programs in the field of HIV infection/AIDS and other socially hazardous diseases;

Coordinate activities of other state agencies in the field of HIV infection/AIDS and other socially hazardous diseases;

Monitor morbidity rates for HIV infection/AIDS and other socially hazardous diseases;

Register HIV infected persons and AIDS patients among Ukrainian nationals, foreign nationals, persons without citizenship who permanently reside in Ukraine or temporarily reside in the country on legal grounds;

Perform functions of the National Council Secretariat, according to the Ukrainian Cabinet of Ministers Decree, with no additional funding from the state.

The State Service is a high level agency with a wide decision-making authority which signal political adherence of the highest echelons of power to defining directions in combatting HIV infection/AIDS as one of the priority spheres of the state policy.

The Ukrainian State Service on Social Diseases is a working agency in the framework of the country coordination mechanism (i.e., the National Council to Fight Tuberculosis and HIV-infection/AIDS). The National Council is an advisory and counselling agency under the Cabinet of Ministers of Ukraine.

The National Council has 31 members, including 11 members (35%) from the civil society: academia, AUCO "All-Ukrainian Network of People Living with HIV", TB patients and people affected by TB, national and international civil society organizations, private sector, trade unions. One of three of the National Council deputies is a representative of civil society.

The government sector is represented by managing administration of the central agencies of executive power. Participation from representatives of the administration in the operation of the National Council promotes more efficient decision making, however it requires a high level of organization of activities, namely quality development of document drafts and other materials

submitted for review, timely distribution of materials and feedback. All interested parties can participate in the National Council meetings.

Key functions of the Secretariat include development of action plans and reports of the National Council, development of agenda and materials for the National Council meetings, technical support for preparation and organisation of the Council meetings, timely provision of essential materials to the National Council members, printing materials, developing decision drafts and meeting minutes, developing agendas and materials for meeting of the National Council committees and Supervisory Commission, informing the public on the activities of the National Council, publishing National Council documents on the web site of the Ukrainian State Service on Social Diseases, and so on.

Currently Ukraine has the following mechanism of coordination of activities in the field of HIV/AIDS:

1) Collective decision making agency at the national level. The National Coordination Council to Fight HIV-infection/AIDS was set up under the Cabinet of Ministers of Ukraine (CMU) on May 15, 2005 (Decree # 352).

In 2007 the Council was reorganized into the National Council to Fight Tuberculosis and HIV-infection/AIDS (CMU Decree # 926, as of July 11, 2007).

The National Council is a permanent intersectoral counselling and advisory agency under the Cabinet of Ministers of Ukraine designed to manage intersectoral coordination in the field of HIV/AIDS and Tuberculosis. The National Council also acts as a country coordination mechanism as required by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The National Council comprises of 31 members (with a women/men ratio of 35% to 65%). In regard to representation of different sectors, women represent the PLHA community, national NGOs, central and local agencies of government, National Parliament, donor organizations. Women-members of the National Council actively pursue issues on advocacy, stigma and discrimination, and gender equality.

The National Council reviews policy developments in the field of HIV/AIDS and TB, including implementation of the National HIV/AIDS and TB Programs, GF grants (acts as Country Coordination Mechanism in Round 1, 6, 9, 10). The National Council operates through quarterly or more frequent meetings.

2) Collective decision making agencies at the regional level. Twenty seven Regional Councils to Fight Tuberculosis and HIV/AIDS (hereafter – Regional Councils) were set up in 2005–2006 in all of Ukraine's regions. Regional Councils were set up under the Council of Ministers of the Autonomous Republic of Crimea, regional city state administrations, Kyiv city and Sebastopol city administrations to operate as counselling and advisory agencies. Composition of the Regional Councils and the Councils' targets reflect the composition and targets of the National Council. The Councils operate through quarterly or more frequent meetings.

3) Collective working agencies to develop draft decisions at the national level

a) Thirty ad hoc and permanent expert working groups (hereafter – working groups) represent different spheres of HIV/AIDS and Tuberculosis control in Ukraine. Working groups operate under ministries which are represented in the National Council including 15 working groups under MoH, and other working groups under the Ministry for Education and Science, Youth and Sports of Ukraine, State Penitentiary Service of Ukraine and so on; working groups comprise of representatives of the government, international and domestic organizations, and other experts. Working groups operate through meetings.

b) Committees of the National Council on program issues and regional policy. Committees were created in 2010 with aim to improving quality of draft decisions of the National Council, to engage more stakeholders into the operations of the national Council, harmonize activities of working group mentioned above. Members of the National Council head Committees of the National Council. The composition of the National Councils Committees is set up based on the intersectoral approach. Operate through meetings.

c) Supervisory Commission for the Global Fund Supported Projects. The Commission was created in 2011 to supervise implementation of the Global Fund grants. Operates through meetings and supervisory field visits, organised according to the action plan.

4) Permanent Secretariat aims to insure operation of the collective agencies at the national level (i.e., the Ukrainian State Service on Social Diseases performs National Councils' Secretariat functions, organizes meetings of the National Council and its Committees and cooperates with the regional councils).

All mentioned agencies work as a public service through organization of working meetings and assemblies. Most activities on organization of activities, communication, and implementation of decisions were performed by the Secretariat in 2005-2006 (the Secretariat was set up in the framework of the **USAID** | **HIV**/AIDS Service Capacity project (USCP) implemented by the Futures Group).

It is evident that Ukraine has a multilevel system of intersectoral and inter-departmental cooperation between multiple partners which operate at the national and regional levels. Main task for the future is to insure the system's sustainable and efficient operation.

D) Indicator data in an overview table.

Table 1. Values of the National Report indicators.

Targets and indicators	Indicator value	Indicator origin
Target 1. Reduce sexual transmission of HIV two fold by 2015		
1.1 Percentage of (%) young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission *	39,9%	Political Declaration, Dublin Declaration
1.2 Percentage (%) of young women and men aged 15-24 who have had sexual intercourse before the age of 15	6,7%	Political Declaration
1.3 Percentage (%) of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	9,7%	Political Declaration
1.4 Percentage (%) of women and men aged 15-49 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse*	63,9%	Political Declaration
1.5 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their result	12,4%	Political Declaration
1.6 Percentage (%) of young people aged 15-24 who are HIV infected *	Indicator not relevant to our country	Political Declaration
1.7 Percentage (%) of commercial sex workers reached by HIV prevention programs	61,2%	Political Declaration, Dublin Declaration
1.8 Percentage (%) of female and male sex workers reporting the use of a condom with their most recent client	92,0%	Political Declaration, Dublin Declaration, Joint Tool
1.9 Percentage (%) of sex workers who received an HIV test in the last 12 months and who know their result	58,5%	Political Declaration, Dublin Declaration, Joint Tool

1.10 Percentage (%) of sex workers living with HIV	9,0%	Political Declaration, Dublin Declaration, Joint Tool
1.11 Percentage (%) of men having sex with men reached by HIV prevention programs	53,1%	Political Declaration
1.12 Percentage (%) of men reporting the use of a condom the last time they had anal sex with a male partner	70,5%	Political Declaration, Dublin Declaration, Joint Tool
1.13 Percentage of men having sex with men who received an HIV test in the last 12 months and who know their result	37,8%	Political Declaration, Dublin Declaration, Joint Tool
1.14 Percentage (%) of men having sex with men living with HIV	6,4%	Political Declaration, Dublin Declaration, Joint Tool
1.15 Percentage (%) of health facilities that provide HIV testing and counselling services	6,9%	Joint Tool
1.17 Percentage (%) of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	92,4%	Joint Tool
1.18 Percentage (%) of migrants from countries with a generalized HIV epidemic who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse	Indicator not relevant to our country	Dublin Declaration
1.19 Percentage of migrants from countries with a generalized HIV epidemic who received an HIV test in the last 12 months and who know their result	Indicator not relevant to our country	Dublin Declaration
1.20 Percentage (%) of migrants with HIV infection	Indicator not relevant to our country	Dublin Declaration
1.21 Percentage (%) of inmates with HIV infection	13,6%	Dublin Declaration
Target 2. Reduce HIV transmission among people who inject drugs two fold by 2015		
2.1 Number of syringes distributed through specialized needle and syringe programs per injecting drug user per year	75,3	Political Declaration, Dublin Declaration, Joint Tool
2.2 Percentage (%) of injecting drug users reporting the use of a condom the last time they had sexual intercourse	47,8%	Political Declaration, Dublin Declaration, Joint Tool
2.3 Percentage (%) of injecting drug users reporting the use of sterile injecting equipment the last time they injected	95,5%	Political Declaration, Dublin Declaration, Joint Tool
2.4 Percentage (%) of injecting drug users who received an HIV test in the last 12 months and who know their result	35,7%	Political Declaration, Dublin Declaration, Joint Tool

2.5 Percentage (%) of injecting drug users living with HIV	21,5%	Political Declaration, Dublin Declaration, Joint Tool
2.6 (a) Estimated number of opioid users (injection and non-injection)	Estimated number of injection opioid users: 250 000	Joint Tool
2.6 (b) Number of people on opioid substitution therapy (OST)	6 632	Joint Tool
2.7 (a) Number of needle and syringe program (NSP) sites (including pharmacies with free distribution of needles and syringes)	1 667	Joint Tool
2.7 (b) Number of substitution therapy (OST) sites	133	Joint Tool
Target 3. By 2015 eliminate cases of HIV transmission from mother to child and significantly reduce HIV related maternal mortality		
3.1 Percentage (%) of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	95,5%	Political Declaration, Dublin Declaration, Joint Tool
3.2 Percentage of infants born to HIV-infected women who received an HIV test within 2 months	55,3%	Political Declaration, Joint Tool
3.3 Mother-to-child transmission of HIV (modelled)	Mother-to-child transmission of HIV based on national methodology: 4,7% (2009)	Political Declaration
3.4 Percentage (%) of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	99,2%	Joint Tool
3.7 Percentage (%) of infants born to HIV-infected women receiving antiretroviral (ARV) prophylaxis for prevention of mother-to-child transmission (PMTCT) during pregnancy and labour (early transmission frequency at the age of six weeks) **	99,1%	Joint Tool
3.10 Number and percentage of HIV-exposed infants who are exclusively breastfeeding at DPT3 visit	Indicator not relevant to our country	Joint Tool
3.13 (a) Percentage (%) of HIV-positive pregnant women who were injecting drug users	3,5%	Joint Tool
3.13 (b) Percentage (%) of HIV-positive pregnant IDU women who received OST during pregnancy	7,3%	Joint Tool

3.13 (c) Percentage (%) of HIV-positive pregnant women IDU receiving antiretroviral (ARV) prophylaxis for prevention of mother-to-child transmission during pregnancy	65,3%	Joint Tool
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015		
4.1 (b) Percentage (%) of eligible adults and children who enrolled on antiretroviral therapy, currently receiving treatment people in HIV care estimate number	 69,9% 24,9%	Political Declaration, Dublin Declaration, Joint Tool
4.2 Percentage (%) of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	82,3%	Political Declaration, Joint Tool
4.2 (a) Percentage (%) of injecting drug users with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	73,2%	Joint Tool
4.2 (c) Percentage (%) of adults and children with HIV still alive and known to be on antiretroviral therapy 60 months after initiating antiretroviral therapy during 2006	70,8%	Joint Tool
4.2 (d) Percentage (%) of injecting drug users with HIV with HIV still alive and known to be on antiretroviral therapy 60 months after initiating antiretroviral therapy during 2006	61,7%	Joint Tool
4.4 Percentage (%) of health facilities dispensing ARV that experienced a stock-out of at least one required ARV in the last 12 months [disaggregated by sector (public, private)]	Indicator is relevant to our country, however there is no available data to measure the indicator	Joint Tool
4.5 Percentage (%) of people with HIV infection who already need antiretroviral treatment at the time of diagnosis	40,0%	Dublin Declaration, Joint Tool
Target 5. Reduce two fold TB related mortality in people living with HIV by 2015		
5.1 Percentage (%) of estimated HIV-positive incident TB cases that received treatment for TB and HIV	35,7%	Political Declaration, Dublin Declaration, Joint Tool

5.3 Number and percentage of adults and children newly enrolled in HIV care who start on treatment for latent TB infection (isoniazid preventive therapy) among the total number of adults and children newly enrolled in HIV care over a given time period	Indicator is relevant to our country, however there is no available data to measure the indicator	Joint Tool
5.4 Number and percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit among all adults and children enrolled in HIV care in the reporting period	Indicator is relevant to our country, however there is no available data to measure the indicator	Joint Tool
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries		
6.1 Domestic and international AIDS spending by categories and financing sources	2009: 509 446 463 UAH 2010: 578 340 208 UAH	Political Declaration, Dublin Declaration
Target 7. Critical Enablers and Synergies with Development Sectors		
7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)	Attachment 2 to Report	Political Declaration, Dublin Declaration
7.1 (c) European Centre for Disease Prevention and Control additionally: the National Composite Policy Index (NCPI) (HIV infection/AIDS)	Attachment 2 to Report	Dublin Declaration
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Indicator not relevant to our country	Political Declaration
7.6 Number of adults and children with HIV enrolled in HIV care	Indicator is relevant to our country, however there is no available data to measure the indicator	Joint Tool

7.7 Percentage (%) of adults and children enrolled in HIV care who were screened for hepatitis C	Indicator is relevant to our country, however there is no available data to measure the indicator	Joint Tool

** Millennium Development Goal Indicator*

*** Countries should track the percentage of infants on ARV. In case it cannot be done, the countries should report percentage of infants who initiated ARV therapy. Data should correspond to the national protocol on ARV prophylaxis in the postnatal period.*

SECTION II. OVERVIEW OF THE AIDS EPIDEMIC

HIV prevalence and AIDS mortality remains one of the hardest social and economic burdens affecting the demographic situation in the country and exerting significant pressure on the health care structures.

According to official statistics currently Ukraine has 200,000 registered HIV infected persons, almost 25,000 patients died of AIDS related diseases. In 2011 the network of specialized clinical facilities registered over 1,700 new cases of HIV, compared to 580 cases ten years back in 2001.

HIV epidemic mainly concentrates among IDUs, FCSW and their sexual partners and also among MSM. Sentinel epidemiological study of HIV organized in the framework of integrated bio-behavioural research in 2011 among most at risk populations presents following results: 21.5% (43.8%- 2.5%) IDUs, 9.0**%** (38.2% 1- 0%) FCSW and 6.4 % (20.0% – 1.4%) MSM are infected with HIV. High HIV prevalence rates among FCSW are explained by the fact that women IDUs actively engage in commercial sex, which contributes to the HIV epidemic in the country.

Large scale IDU fuelled epidemic of HIV began to develop in Ukraine back in 1995; most of IDUs remain sexually active as a result HIV spread via the sexual rout of transmission continues to increase. As the epidemic spreads from predominantly men IDUs to their sexual partners, as a result increasing the proportion of HIV infected women. According to the official statistics in 2011 percentage of HIV positive women in HIV care was 45.0% compared to the overall number of patients in HIV care.

Unprotected sex between MSM contributes to a minor increase in proportion of new HIV cases in the country (under 1% among HIV infection cases with determined rout of transmission). However, official statistics could underestimate the real rate of HIV transmission within the group which remains stigmatized. 2011 sentinel research data suggests that the rate of HIV prevalence in Ukraine among MSM is 6.4%. However, regional analysis demonstrates that the indictor varies significantly from 0% in Poltava to 20.0% in Donetsk.

It is assumed that HIV prevalence rates among pregnant women registered at the gynaecology offices appropriately reflect HIV prevalence level in the general population as well as tendencies for epidemic's development. Also pregnant women as a sampling group are representative for analyzing epidemiological situation among the sexually active proportion of the population [UNAIDS/WHO, 2000]. Based on the primary testing result (code 109.1) in 2011 the average HIV prevalence rate among pregnant women in Ukraine was 0.47% (e.g., from 2007 till 2011: 0.52%; 0.55%; 0.55%; 0.48%; 0.47%, respectively).

However, regional 2011 indicators vary significantly – from 0.02% in the Zakarpattya region to 1.08% in the Dnipropetrovsk region. The indicator was high in the so called priority regions of Ukraine: Mykolayiv region, Odessa region, Donetsk region and Kyiv and Kirovograd regions (e.g., 0,87%; 0,84%; 0,80%; 0,79% and 0,63%). This data signal a sub-epidemic in a country with high HIV prevalence caused by social and economic factors.

Nevertheless, from 2006 the epidemic continues to decrease, as a result of implementing a series of comprehensive activities aimed to curb HIV in particular among IDUs.

In 2006 compared to 2005 HIV prevalence in the country increased by 16.8%, and in 2011 compared to 2010 it increased only by 3.6%; official statistics signal a decrease in HIV epidemic development and in growth rate of HIV morbidity.

Also in parallel with annual increase in the number of HIV infected persons, there is a positive trend in reduction in officially registered HIV infected persons aged 15-24: from 2,775 in 2005 to 1,907 in 2011. Along with a reduction in new HIV cases among young people aged 15-24, HIV morbidity among the group also decreased in the reporting period. Reduced spread of HIV and decreasing rate of

development of the epidemic according to new figures on HIV prevalence among youth seem to indicate stabilization of the epidemic in the country. However official statistics do not reflect the real rates of HIV prevalence for adolescents and youth from the risk populations (e.g., IDUs, CSW, and MSM) – as HIV continues to actively spread in these groups.

Many young people from risk populations have limited access to prevention and treatment services provided by the government and civil society organizations because such services are mostly targeted at over 25s.

Indicator 1.6. "Percentage of young people aged 15-24 who are HIV infected"

There is no data collected to measure HIV prevalence in young people aged 15-24.

The indicator is utilized in countries with a generalized epidemic; it helps relatively correctly estimate trends in HIV epidemic development when the epidemic is fuelled by the heterosexual rout of transmission.

However, for countries with HIV epidemic concentrated in populations most at risk of HIV infection such indicator is less reliable for analyzing epidemic's development.

Ukraine has a concentrated HIV epidemic: in the end of 2011 HIV prevalence among adult population was estimated at 0.95% and among pregnant women HIV prevalence was under one per cent, according to the Ukrainian Ministry of Health current statistics. In the 2012 National Report Ukraine submits HIV prevalence data based on sentinel epidemiological surveillance studies organized among injecting drug users, female commercial sex workers, men having sex with men, i.e., populations most at risk of HIV which currently fuel the epidemic in the country.

It is evident that the official statistics do not reflect the real scale of the HIV/AIDS epidemic in Ukraine, including the real number of people infected with HIV. Official statistics register the number of persons tested positive for HIV and officially registered in the national registry of HIV patients. Many more Ukrainians may be infected with HIV, but are not aware of their status.

Updated HIV/AIDS estimates for Ukraine suggest that at the start of 2012 there were 216,977 thousand people aged 15-49 infected with HIV. This estimate differs from official statistics on the number of people aged 15-49 in HIV care in specialized health care facilities (e.g., 106,225 HIV infected patients as of start of 2012). This means that only 49% or each second person living with HIV in Ukraine was tested for HIV and are aware of their positive HIV status.

These estimates came as a result of the latest national review of the HIV/AIDS situation in Ukraine in 2012. Many domestic and international organizations engaged in monitoring HIV/AIDS epidemic in Ukraine made a contribution to defining these estimates, which came as part of the global HIV/AIDS prevalence estimates in 2012.

These estimates will be used to forecast the number of HIV infected persons in need of treatment, care and support.

From 1997 Ukraine together with routine epidemiological surveillance is introducing up-to-date methodologies of epidemiological surveillance, namely second generation epidemiological surveillance for HIV.

Results of sentinel epidemiological surveillance studies for 2011 demonstrate high rates of HIV infection among at risk populations.

Indicator 1.10 (FSW) "Percentage of female sex workers who are living with HIV"

In 2011 HIV prevalence among FWS was measured based on blood test results using rapid test-kits, performed in 25 geographic units.[1] Study covered with tests 4,816 persons. HIV prevalence rate among FSW was 9.0% (c.i. 8.18 – 9.82%).

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[1] *Sentinel epidemiological surveillance of HIV infection organised in the framework of integrated bio-behavioural study "Monitoring the Behaviour and HIV Infection Prevalence among FCSW as Component of Second Generation Epidemiological Surveillance of HIV". The study was carried out by the Kyiv*

Please see **Table 2** for data on HIV prevalence reflecting regional differences in some cities. Donetsk, Kyiv, Poltava and Khmelnitsky traditionally have higher HIV rates compared to other cities. In Lugansk, Uzhhorod and Kharkiv there are no HIV cases detected among FSW.

Table 2. HIV prevalence among FCSW based on 2011 research data

City	Number of tests	HIV prevalence, (%)	Confidence limit
Donetsk	283	38,20	29,70 – 48,40
Kyiv	274	23,70	17,00 – 30,50
Poltava	152	23,03	16,33 – 29,72
Khmelnitsky	147	17,09	11,00 – 23,17
Kirovograd	147	13,33	7,84 – 18,81
Odessa	297	13,07	9,24 – 16,90
Cherkassy	136	12,60	4,40 – 20,60
Kherson	199	9,43	5,37 – 13,49
Ivano-Frankivsk	149	9,20	4,56 – 13,84
Dnipropetrovsk	276	6,51	3,60 – 9,43
Mykolayiv	294	6,21	3,46 – 8,97
Lviv	196	5,82	2,55 – 9,09
Zhytomyr	150	5,31	1,72 – 8,90
Rivne	149	4,80	1,37 – 8,23
Zaporizhzhia	193	4,50	1,60 – 8,40
Simferopol	298	3,34	1,30 – 5,38
Lutsk	136	2,53	0,00 – 5,16
Ternopil	150	2,00	0,00 – 4,24
Vinnitsya	148	1,56	0,00 – 3,56
Chernigiv	150	1,00	0,00 – 4,50
Sumy	147	0,90	0,00 – 2,70
Chernivtsy	145	0,52	0,00 – 1,70
Lugansk	150	0	-
Uzhhorod	148	0	-
Kharkiv	300	0	-

It is more likely that FCSW were infected via injecting drug use. HIV prevalence among FSW, more appropriately defined as IDUs[2] in relation to their behaviour practices (hereafter – FCSW-IDUs) is 40.5% (c.i. 35.77% – 45.23%), compared to HIV prevalence in non-IDU FCSW of 6.4% (c.i. 5.64% – 7.16%).

HIV prevalence in a group of FCSW aged over 25 was 3.6%; ≥ 25 year olds – 14.6%.

2007-2011 research data shows variations in HIV prevalence among FCSW in the regions (please see Table 3 and 4).

Table 3. Results of sentinel surveillance in female commercial sex workers in 2007 and 2009 (2008)[3]

City	2007			2009 (2008*)		
	HIV prevalence in all FCSW, %	HIV prevalence in FCSW under 25, %	HIV prevalence in non-IDU FCSW	HIV prevalence in all FCSW, %	HIV prevalence in FCSW under 25, %	HIV prevalence in non-IDU FCSW
Donetsk	32,2	38,4	13,3	39,0	40,0	32,0

International Sociology Institute in cooperation with the Ukrainian Centre for Prevention and Control of AIDS under the MoH of Ukraine and NGOs with financial support from the ICF “International HIV/AIDS Alliance in Ukraine”. RDS and TLS methodologies were used within the study.

[2] FCSE who reported using injection drugs at least once in the last 12 months

[3] Sentinel surveillance results from cities with epidemiological surveillance organized in 2007 and in 2009 (2008) were used to compare data on HIV prevalence

Lutsk	11,8	10,5	2,7	0*	0*	0*
Mykolayiv	26,0	23,5	22,1	24,0*	3,3*	11,5*
Poltava	28,0	27,6	14,5	19,3	9,5	6,1
Simferopol	10,0	14,3	3,8	25,0	18,8	6,7
Kherson	7,0	10,4	3,5	11,08	6,8*	2,9*

Table 4. Comparative results of sentinel surveillance in female commercial sex workers in 2010 and 2011

City	2010			2011		
	HIV prevalence in all FCSW, %	HIV prevalence in FCSW under 25, %	HIV prevalence in non-IDU FCSW	HIV prevalence in all FCSW, %	HIV prevalence in FCSW under 25, %	HIV prevalence in non-IDU FCSW
Donetsk	36,0	11,8	15,1	38,2	14,3	4,0
Lutsk	10,0	0	6,3	2,3	1,6	2,3
Mykolayiv	-	-	-	6,2	0	4,4
Poltava	10,0	4,3	0	23,0	5,3	18,4
Simferopol	9,0	-	9,0	3,3	5,3	4,1
Kherson	7,0	6,0	3,6	9,4	4,5	4,9

Women-IDUs in Ukraine actively engage in commercial sex, which results in high HIV prevalence in female commercial sex workers. However, in regard to the danger of epidemic’s generalization, the rout via which female commercial sex workers acquired the virus is irrelevant as the women continue to pose a risk of infection to clients.

Indicator 1.14 (MSM) “Percentage of men having sex with men who are living with HIV”

Integrated bio-behavioural study among MSM was organized in 27 cities of Ukraine[4]. Proportion of HIV infected MSM in the general sample was 6.4 % (c.i. 2.4 – 10.4 %).

Table 5. Sentinel surveillance results for men having sex with men (2011)

City	Number of tests	HIV prevalence, (%)	Confidence limit
Donetsk	400	20,0	14,5 – 25,7
Odessa	400	16,1	1– 23,1
Zhytomyr	150	10,9	2,4 – 23
Lugansk	200	9,6	2,1 – 21,2
Khmelnitsky	150	8,0	4 – 11,7
Sebastopol	150	7,3	4 – 11,7
Kyiv	400	6,9	4 – 10,1
Lviv	250	6,8	3,5 – 10,6
Ivano-Frankivsk	150	6,4	1 – 14,8
Vinnitsa	150	6,1	2,2 – 10,6
Sumy	200	5,6	1,7 – 10
Kherson	250	5,5	2,9 – 8,9
Uzhhorod	150	5,3	1,6 – 9,6
Zaporizhzhia	200	4,9	2,5 – 7,2
Dnipropetrovsk	350	4,8	2,3 – 7,9
Kharkiv	300	4,8	2,3 – 7,3

[4] Sentinel epidemiological surveillance of HIV infection organised in the framework of integrated bio-behavioural study “Monitoring the Behaviour and HIV Infection Prevalence among MSM as Component of Second Generation Epidemiological Surveillance of HIV”. The study was carried out by the Centre for Social Expertise of the Sociology Institute under the Academy of Sciences of Ukraine in cooperation with the Ukrainian Centre for Prevention and Control of AIDS under the MoH of Ukraine and NGOs with financial support from the ICF “International HIV/AIDS Alliance in Ukraine”. The study utilised RDS and TLS methodologies.

Kirovograd	150	3,6	1 – 9,1
Lutsk	150	3,3	0 – 3,9
Cherkassy	250	2,9	1,3 – 4,7
Simferopol	200	2,7	1,2 – 4,7
Chernivtsy	150	2,6	0,2 – 6,6
Kryvyi Rig	150	2,0	0 – 5,6
Mykolayiv	400	2,0	0,05 – 4
Rivne	150	1,7	0,5 – 3,5
Ternopil	150	1,4	0,4 – 2,8
Chernigiv	150	1,4	0,4 – 2,9
Poltava	200	0	0

HIV prevalence in MSM over 25 was 4.2%; ≥ 25 years of age – 7.8%.

The 2011 official data suggests that among new registered HIV cases MSM is only 0.7% (143 persons).

Considering that the sentinel surveillance results do not reflect the official statistics, i.e., research demonstrates high HIV prevalence in MSM, including regions with traditionally low HIV rates, HIV epidemic affecting MSM groups needs to be monitored more closely and with more frequency.

Indicator 1.21 "Percentage of inmates with HIV infection"

In 2009 second generation surveillance was used for the first time to study HIV prevalence among inmates. Results show that in 2009 HIV prevalence among inmates was 15% (c.i. 13% – 17%).

In 2011[5] the HIV prevalence study was organized again in the same correction facilities using methodology and sampling sizes of the previous study. In that period of time HIV prevalence rates remained practically the same: 13.7% (c.i. 11.8% – 15.6%).

Proportion of HIV positive inmates in penitentiary facilities reflects the number of incarcerated injecting users. In 2011 HIV prevalence among inmates with history of drug use was 22.9% (c.i. 19.5% – 26.7%), among inmates with no history of drug use: 8.1% (c.i. 6.0% – 10.5%).

These results adequately reflect official statistics, namely sero-epidemiological study results which defined HIV prevalence among inmates at 10.4%. The 2011 study of HIV and inmates did not define confidence limits because research each site engaged a sample of 50 respondents.

Table 6. HIV prevalence in correction facilities (2011)

Region/Oblast	Site	Number of tests	Percentage of HIV positive respondents
Autonomous Republic of Crimea	#1	50	52,0
	#2	50	8,0
Donetsk region	#1	50	10,0
	#2	50	6,0

[5] *Sentinel epidemiological surveillance of HIV infection organised in the framework of integrated bio-behavioural study "Monitoring the Behaviour and HIV Infection Prevalence among Inmates as Component of Second Generation Epidemiological Surveillance of HIV". The study was carried out by the CSO "Ukraine's Yaremenko Institute for Social Research" in cooperation with the State Penitentiary Service of Ukraine in close partnership with the Ukrainian Centre for Prevention and Control of AIDS of the MoH of Ukraine, with technical support from the UN Office on Drugs and Crime (UNODC). The study was organised in 24 correction facilities (including four penitentiaries for women) and two penal colonies. Study's sample – 1,300 respondents.*

Mykolayiv region	#1	50	8,0
	#2	50	16.0
Kharkiv region	#1	50	26,0
	#2	50	12,0
	#3	50	0,0
Cherkassy region	#1	50	14,0
	#2	50	10,0
Odessa region	#1	50	22,0
	#2	50	34,0
	#3	50	16,0
Poltava region	#1	50	2,0
	#2	50	2,0
	#3	50	2,0
Zhytomyr region	#1	50	8,0
	#2	50	14,0
Lugansk region	#1	50	2,0
	#2	50	6,0
Lviv region	#1	50	10,0
	#2	50	4,0
Ternopil region	#1	50	32,0
	#2	50	0,0
Chernigiv region	#1	50	40,0

HIV prevalence among inmates over 25 was 6.4%; among inmates ≥ 25: 17.3%. HIV prevalence in women was three fold higher (33.0%) compared to HIV prevalence in men (10.1%), the variance is explained by the fact that the proportion of women was greater than proportion of men.

Indicator 2.5 (IDU) "Percentage of injecting drug users who are living with HIV"

HIV prevalence among IDUs was measured based on blood test results using rapid test-kits, performed in 26 geographic units. Study covered with tests 9,069 persons. HIV prevalence rate among IDUs in 2011 was 21.5% (c.i. 20.6 – 22.8). In 2008 and 2009[6] HIV prevalence rate was 22.9% (c.i. 21.9% – 23.9%)[7].

Data presented in Table 7 reflects clear geographic variations in HIV prevalence in IDUs. Mykolayiv, Dnipropetrovsk and Chernigiv traditionally have high HIV rates. Lowest HIV prevalence in IDUs was registered in Chernivtsy, Sumy and Uzhhorod. In 2011 HIV prevalence in male IDUs was 20.8%, and in women IDU – 23.6%.

Table 7. HIV prevalence in IDUs based on 2011 research data

City	Number of tests	HIV prevalence, (%)	Confidence limit
Mykolayiv	500	43,8	25,1 – 45,9
Dnipropetrovsk	499	41,3	28,1 – 39,2
Chernigiv	349	37,5	27,2 – 38,9
Khmelnitsky	350	34,9	28,7 – 40,4
Odessa	500	31,6	27,9 – 36,4
Lviv	250	30,8	21,7 – 34,1

[6] Sentinel epidemiological surveillance of HIV infection organised in the framework of integrated bio-behavioural study "Monitoring the Behaviour and HIV Infection Prevalence among IDUs as Component of Second Generation Epidemiological Surveillance of HIV". The study was carried out by the CSO "Ukraine's Yaremenko Institute for Social Research" in cooperation with the Ukrainian Centre for Prevention and Control of AIDS under the MoH of Ukraine and NGOs with financial support from the ICF "International HIV/AIDS Alliance in Ukraine".

[7] Indicator was calculated in SPSS with weights designed by age exported from RDSAT.

Donetsk	501	28,5	16,6 – 25,5
Bila Tserkva	299	27,8	18,5 – 37,4
Poltava	350	27,7	17,1 – 28,4
Cherkassy	356	25,8	21,4 – 31,0
Kherson	351	25,6	23,1 – 34,2
Zhytomyr	350	22,3	14,9 – 23,1
Simferopol	500	20,8	18,8 – 26,4
Lutsk	352	19,6	13,7 – 23,5
Ivano-Frankivsk	250	18,8	11,3 – 22,4
Kyiv	508	18,1	17,4 – 33,1
Vinnitsa	350	16,0	9,2 – 16,9
Kirovograd	350	11,4	4,9 – 13,2
Kharkiv	353	10,2	5,3 – 12,0
Rivne	350	9,7	6,1 – 12,6
Ternopil	200	9,5	8,7 – 24,9
Zaporizhzhia	200	6,5	2,0 – 10,4
Lugansk	251	6,0	1,1 – 3,9
Chernivtsy	200	5,5	1,3 – 6,6
Sumy	350	4,9	2,1 – 6,7
Uzhhorod	200	2,5	4,0 – 2,6

Presented data indicates that HIV rates among IDUs remain significantly high. However, there are some positive changes in regard to HIV prevalence in the group.

UNAIDS and WHO guidelines suggest that HIV prevalence in younger age groups adequately represents the level of new infection cases. Also it is recommended to define trends in new HIV infection cases based on data from respondents with reported drug use over a 2 year period. HIV infection rates in this at risk population age < 25 years old was 7.1%; ≥ 25 years old: 24.4%.

Compared data from 2007, 2009 (or 2008 depending on the year of the study in a particular city) and 2011 indicates some positive developments in HIV epidemic among IDUs. In regard to identifying this trend in young IDUs and those who were just initiated into drug use in some cities – the trend is unclear, as a result of a small number of respondent from such group in each site (please see Table 8 and 9).

Table 8. Comparing research results of sentinel surveillance studies in injecting drug users (2007 and 2009) (2008)

City	HIV prevalence in all IDUs		HIV prevalence in IDUs with reported drug use under 2 years		HIV prevalence in IDUs under 25	
	2007	2009 (2008*)	2007	2009 (2008*)	2007	2009 (2008*)
Mykolayiv	42,5	55,2	8,2	0	21,3	22,5
Odessa	55,2	36,8*	50	21,4*	53,1	33,3*
Donetsk	41,4	33,2*	31,3	12,5*	30	9,1*
Kherson	31,6	26,7*	34,3	10,3*	32,4	20*
Simferopol	42,8	25,1	22,1	25	44,1	37,5
Poltava	24,4	23,7*	22,6	7,7*	22,2	18,2*
Kyiv	12,7	23,2	-	0	14,6	4,8
Dnipropetrovsk	16,4	22,7	-	14,3	-	15,2
Cherkassy	26	12,1	6,3	9,7	12,8	13,3
Kharkiv	17,3	10,6*	9,1	3,9*	5,3	1,4*

Table 9. Results of sentinel surveillance studies in injecting drug users (2011)

City	HIV prevalence in all IDUs	HIV prevalence in IDUs with reported drug use under 2 years	HIV prevalence in IDUs under 25
Mykolayiv	43,8	17,6	27,3
Odessa	31,6	6,4	3,4
Donetsk	28,5	0,7	3,6
Kherson	25,6	0,9	13,5
Simferopol	20,8	8,6	9,0
Poltava	27,7	0,0	4,5
Kyiv	18,1	0,0	9,5
Dnipropetrovsk	41,3	6,3	16,1
Cherkassy	25,8	0,0	5,8
Kharkiv	10,2	4,6	2,4

Results obtained as a result of sentinel surveillance in 2011 indicate stabilization of the epidemic in injecting drug users and reflect routine epidemiological surveillance results in IDUs. However, this at risk population is most affected by HIV and remains the driving force behind the HIV epidemic in Ukraine.

Indicator 4.2 "Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy" in 2011: 82.29%

Percentage of adults and children with HIV/AIDS still alive and known to be on treatment 12 months after initiation of antiretroviral therapy 12 months after initiation of the antiretroviral therapy in period from 01.01.2011 to 31.12.2011 is 82,29 % (5,993 patients out of 7,282 patients who initiated therapy in the 2010 cohort continue to get treatment).

Those who do not get treatment in 12 months after initiation of therapy in the 2010 cohort include 576 deceased patients and 713 patients lost to follow up due to different reasons.

Data from current departmental statistical Form # 57 (Table 3000) for accounting and reporting monitoring of HIV/AIDS treatment process, of the Ministry of Health of Ukraine "Reports on Adults and Children Initiating ART in a Cohort and Getting Treatment during 6, 12, 24 and 36 Months (January-December 2011)" 2010 cohort, was used to measure the indicator.

Ukraine launched large scale ART provision to AIDS patients and HIV infected persons in August 2004 in the framework of Program "Overcoming HIV/AIDS Epidemic in Ukraine" financed by the Global Fund in six of the country's regions. By 2008 ART treatment was gradually scaled up to all 27 regions of Ukraine. As of 01.01.2012 17 % of patients were getting treatment with support from the Global Fund (Round 6) and 83% with support from Ukraine's state budget.

From the time of initiation of ART in the country Ukraine significantly raised the professional level of doctors providing support to patients in treatment, improved the legislative base and technical support provision to the AIDS Centers. By 2009 these changes resulted in incremental increase in the indicator value (e.g., 2007: 77.6%, 2008: 82%, and 2009: 85%). However, growing numbers of patents in need of treatment significantly outstretch increasing financing of the National AIDS Program and strengthened capacity of the Ukrainian AIDS Centers. Not all HIV patients are reached by ART, support of antiretroviral therapy is insufficient which in 2011 resulted in the indicator's decrease (e.g., 2010: 84%, 2011: 82, 3%).

Key reason for dropping out from ART treatment in the first 12 months from its initiation in the 2004-2007 cohorts was the patient's death (i.e., death caused by late initiation of ARV), starting from the 2008 cohort patients are usually lost to follow up due to various reasons, usually non-medical.

The current situation calls for improving strategy of treatment delivery, namely decentralization of antiretroviral therapy provision, rapid scale up of substitution maintenance programs and introduction of efficient prevention programs, diagnostic and treatment of Tuberculosis in people living with HIV.

Indicator 4.2 (a) "Percentage of injecting drug users with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy "in 2011: 73.24%

Percentage of injecting drug users with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy in period from 01.01.2011 to 31.12.2011 is 73,24 % (1,051 patients out of 1,435 patients who initiated therapy in the 2010 cohort continue to get treatment).

This indicator was measured based on current data provided by the regional AIDS centers, based on information from the primary accounting Form # 510-3/o "Journal for Registration of Patients on ART in a Medical Facility". There are no accounting forms to measure such indicator at the national level. The 2010 cohort of IDU patients did not collect data on reasons for dropping out of therapy.

Considering that Ukraine reports this indicator for the first time, there is no comparative data from the last year.

Percentage of injecting drug users with HIV/AIDS on treatment 12 months after initiation of antiretroviral therapy is significantly lower compared to the corresponding indicator for all people in need of ART. This calls for strengthening cooperation between health facilities and civil society organizations, insuring timely and full access to medical services, nurturing and supporting ART adherence in IDUs and further scale up of SMT programs in Ukraine.

Indicator 4.2 (c) "Percentage of adults and children with HIV still alive and known to be on antiretroviral therapy 60 months after initiating antiretroviral therapy" in 2011: 70.77%

Percentage of adults and children with HIV still alive and known to be on antiretroviral therapy 60 months after initiating antiretroviral therapy in period from 01.01.2011 to 31.12.2011 is 70,77 % (1,433 patients out of 2,025 patients who initiated therapy in the 2006 cohort continue to get treatment).

Among patients lost to follow up 60 months after initiation of therapy in 2006 325 patients died and 267 patients dropped out from the program due to various reasons.

Data from current departmental statistical Form #57 (Table 3000) for accounting and reporting monitoring of HIV/AIDS treatment process, of the Ministry of Health of Ukraine "Reports on Adults and Children Initiating ART in a Cohort and Getting Treatment During 6, 12, 24 and 36 Months (January-December 2011)" – 2006 cohort, was used to measure the indicator.

From the time of initiation of ART in the country Ukraine significantly raised the professional level of doctors providing support to patients in treatment, improved the legislative base and technical support provision to the AIDS Centres. In 2011 these changes resulted in growing indicator values (in the 2006 cohort) compared to 2009 (in the 2004 cohort: 65%) and 2010 (the 2005 cohort: 68%).

Indicator 4.2 (d) "Percentage of injecting drug users with HIV with HIV still alive and known to be on antiretroviral therapy 60 months after initiating antiretroviral therapy" in 2011: 61,71%

Percentage of injecting drug users with HIV with HIV still alive and known to be on antiretroviral therapy 60 months after initiating antiretroviral therapy in period from 01.01.2011 to 31.12.2011 is 61,71 % (448 patients out of 726 patients who initiated therapy in the 2006 cohort continue to get treatment).

This indicator was measured based on current data provided by the regional AIDS centers, based on information from the primary accounting Form # 510-3/o from the "Journal for Registration of Patients on ART in a Medical Facility". There are no accounting forms to measure such indicator at the national level. The 2010 cohort of IDU patients did not report reasons for drop out from therapy.

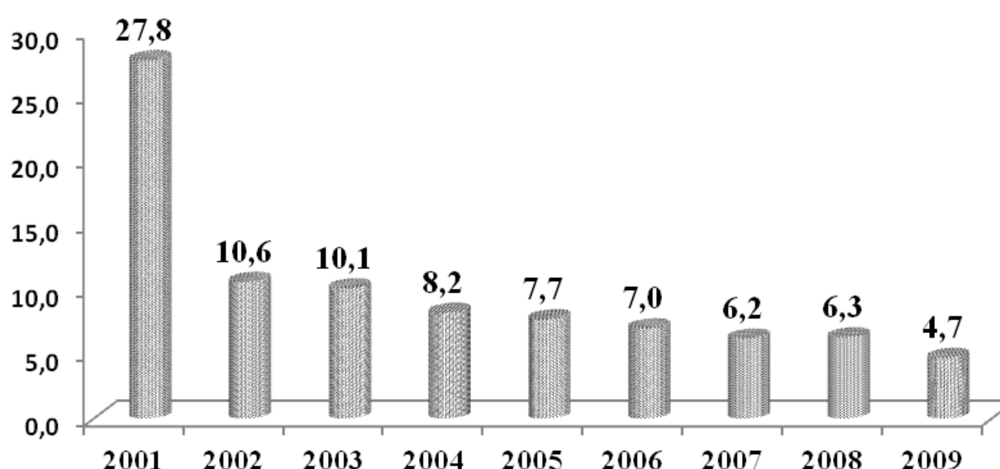
Considering that Ukraine reports this indicator for the first time, there is no comparative data from the last year.

Percentage of injecting drug users with HIV/AIDS on treatment 60 months after initiation of antiretroviral therapy is significantly lower compared to the corresponding indicator for all people in need of ART. This calls for strengthening cooperation between health facilities and civil society organizations, insuring timely and full access to medical services, nurturing and supporting ART adherence in IDUs and further scale up of SMT programs in Ukraine.

Indicator 3.3 "Mother-to-child transmission of HIV"

Implementation of the National Strategy Program for Prevention of HIV Transmission from Mother to Child (hereafter – PMTCT) remains the only intervention in Ukraine to reach most of the target population with quality services, resulting in significant reduction in level of mother to child transmission of HIV.

Starting from 2001 Ukraine advanced in PMTCT reduction, proportion of HIV transmission cases from mother to child decreased six fold: from 27,8% in 2001 to 4,7% in 2009.



Picture 4. HIV transmission from mother to child in Ukraine over time, %

In 2009 3,857 infants were born to HIV positive mothers, out of this number 169 children were diagnosed with HIV using serological method virus detection (e.g., enzyme immunoassay and immune dot blot test) performed at the age of 18 months; 3,447 children tested negative for HIV were released from care; 241 children are have unconfirmed HIV status due to lack parents' permission to perform tests, death of a child with undetermined HIV status and changing a place of residence.

In 169 HIV infected children 150 infants (88.8%) received ARV prophylaxis, 155 children (91.7%) were bottle-fed immediately after birth.

Analysis of PMTCT activities in HIV exposed infants shows that 129 (76,3%) of women received ARV prophylaxis, including 17 women (13,2%) only during labour. 152 (89,9%) pregnant women gave birth spontaneously (through the birth canal), 15 women (8,9%) received a scheduled C-section, 2 women (1,2%) had an unplanned C-section (based on medical indicators). 9,0% of HIV infected pregnant

women were using drugs during pregnancy, 12,4% of women were in III and IV clinical stage of HIV at the time of labour.

To reach a 2% rate of HIV transmission from mother to child as defined by the National Program to Insure Prevention of HIV Infection, Treatment, Care and Support for HIV Infected Persons and AIDS Patients in 2009-2013 and UNAIDS Target 3 “Eliminate vertical transmission of HIV and significantly reduce AIDS-related maternal mortality by 2015” it is necessary to strengthen epidemiology monitoring of HIV infection in children born to HIV positive mothers, which will help obtain more essential information on risk factors currently affecting HIV transmission from mother to child in Ukraine and develop effective measures to prevent vertical transmission of HIV in the country.

SECTION III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The strategy to combat HIV/AIDS is a priority of the state policy on health and social development in Ukraine. The Government of Ukraine has accepted a number of strategic commitments and, together with international and non-governmental organizations, is applying greater effort to meet them and to overcome the HIV epidemic in the country.

This section describes Ukraine's achievements in the implementation of Millennium Development Goals, aimed to reduce and slow down the spread of HIV/AIDS by 2015, on the basis of indicators identified for the main areas of HIV/AIDS response:

Target 1. Reduce sexual transmission of HIV by 50% by 2015;

Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015;

Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths;

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015;

Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015;

Target 6. Reach a significant level of annual global expenditure (US$ 22-24 billion) in low- and middle-income countries;

Target 7. Critical Enablers and Synergies with Development Sectors;

Target 1. Reduce sexual transmission of HIV by 50% by 2015

Indicator 1.1 "Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission"

In 2011 percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was 39.9%[8]. This indicator was constructed on the basis of responses to five questions.

No significant difference in the values of this indicator depending on sex distribution of the youth population were identified in 2011: 37.7% of female respondents and 42% of male respondents correctly identified ways of prevention the sexual transmission of HIV and knew, how HIV was not transmitted. Among young people aged 15-19 years this indicator amounts to 35.2%, and in the 20-24 years age group it was 47.5%, but this difference is statistically insignificant. Among women aged 15-19 years the indicator value was 38.9%, and in the 20-24 years age group it was 36.9% (as in the case with men, this difference is not statistically significant). At the same time, it should be noted that the 1.1 Indicator value in the National Reports on Follow Up to the Declaration of Commitment on HIV/AIDS for 2006-2007 and 2008-2009 amounted to 40%.

As far as the type of settlement (urban/rural) is concerned, there are some inessential and statistically insignificant differences in the responses. For instance, 41.5% of urban respondents could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission, compared to 36.6% of respondents residing in rural areas.

Analysis of these responses indicates at a rather low awareness level of young people about specific ways of preventing transmission of HIV and about routes through which HIV infection is not transmitted.

88.7% of interviewed young people (88.8% of women and 88.7% of men) knew that the risk of HIV transmission could be reduced by having sex with only one uninfected partner who had no other partners. A certain difference in responses to the question about this way of preventing transmission of

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[8] *Results of the national representative sociological survey of the population of Ukraine aged 15-49 years, conducted by the CSO Analytical Center 'Socioconsulting' from 23.11.2011 till 05.01.2012. Total number of surveyed people was 2003 respondents in all territorial and administrative regions of Ukraine (AR Crimea, 24 oblasts and cities Kyiv and Sevastopol) and in all types of settlements.*

HIV was observed in different age groups of female respondents: 86.1% (15-19 years) and 90.6% (20-24 years), correspondingly, which indicated the need to strengthen prevention activities, primarily among students.

Condom use every time they had sex as a way of prevention sexual transmission of HIV was mentioned by 88.2% respondents irrespective of their sex. Similar to the previous question, women from 15-19 years age group gave less correct answers to this question that women aged 20-24 years: 84.3% versus 88.8% correspondingly. In 2009 this indicator value amounted to 91%, which means that there is certain decline in the level of awareness of this way to prevent transmission of HIV.

84.4% of respondents agreed to the statement that a healthy looking person could have HIV (82.8% of women and 85.9% of men). In 2009 the value of this indicator was 84%.

The statement that a person can be HIV infected if he/she would drink from the same glass with a HIV infected person was recognized as false by 72.8% of respondents (72.4% of women and 73.1% of men). The survey results demonstrate certain differences in answers both among men and women of the 15-19 years age group, and of the 20-24 years age group. It should be also noted that in 2009 the portion of young people, who recognized this statement as false was slightly lower – 66%.

Only 62.9% of respondents (59.7% of women and 64.3% of men) disagreed with the statement that a person could become HIV infected through shared use of a lavatory, swimming pool or sauna with someone who is HIV infected. In 2009 the portion of individuals who gave correct answer to this question was 65%.

So, we can state that the value of this indicator has not changed since 2007 and still remains at the level of 40%. It should be noted, that within implementation of the provisions of Declaration of Commitment on HIV/AIDS the target value of this indicator was 95 to be achieved in 2010. Taking the above mentioned into consideration, there is a need to conduct information and educational campaigns at the national level, especially for young people, to increase their awareness in the area of HIV prevention.

Indicator 1.2 "Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15"

In 2011 percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 was 6.7%[9] (representativeness error for this indicator was 2.6%).

Value of this indicator for men was 10.2%, and for women – 3.0%; among men aged 15–19 years – 12.0% and aged 20–24 years – 8.9%; among women aged 15–19 years – 4.6% and in the age of 20–24 years – 1.9%. Some respondents tried to give socially desirable answers, diminishing the number of their sexual partners and did not admit that they had casual or commercial sex, or quite to the opposite, exaggerated their sexual experience. The latter was more characteristic for young men.

As far as the type of settlement of respondents is concerned, there was no significant difference in their responses. So, 6.4% urban residents and, correspondingly, **7.4%** rural residents aged 15–24 years said that they had had sexual intercourse before the age of 15.

In 2007 the value of Indicator 1.2 amounted to 5.0%, and in 2009 – 2.4%. It should be noted, that in 2009 the methodology of asking about the sexual debut was somewhat changed. In 2007 an interviewer asked a respondent directly (at an eye-to-eye interview), while in 2009 and 2011, taking the highly sensitive nature of these question into account, the questionnaire with a section with questions about sexual practices was handed to the respondents to be filled individually (without participation of the interviewers). On the one hand, it became an efficient method to prevent respondents' refusals to participate in the survey; while on the other hand, the use of this method resulted in a certain disruption of logic in the answers provided by respondents.

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[9] *Results of the national representative sociological survey of the population of Ukraine aged 15-49 years, conducted by the CSO Analytical Center 'Socioconsulting' from 23.11.2011 till 05.01.2012. Total number of surveyed people was 2003 respondents in all territorial and administrative regions of Ukraine (AR Crimea, 24 oblasts and cities Kyiv and Sevastopol) and in all types of settlements.*

Many respondents were discontented with very sensitive questions. Respondents often refused to fill these sections of the questionnaire even individually, or felt ashamed to provide answers to these questions to the interviewer.

Anyway, it should be noted that efforts to develop the culture of sexual relationships among adolescents and young people before they become sexually active is an important activity area to prevent HIV infection.

Indicator 1.3 "Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months"

In 2011 percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months was 9.7%[10]. A significant reduction of the value of this indicator compared to 2009 – 15% and 2007 – 14% is observed.

According to the respondent's answers, women were almost three times less likely to have more than one sexual partner than men – 4.6% versus 14.9% correspondingly. Almost similar difference was documented in 2009 - 7% and 23% correspondingly.

The largest proportion of men and women, who had more than one sexual partner, was in the 20–24 years age group. The value of this indicator among men aged 20–24 years was 30.9%, and among men aged 15–19 years – 21.6%, and in the 25–49 years age group – 10.3%. Among women aged 20–24 years this indicator amounted to 5.0%, and in the 15–19 years age group – 3.7% and among women aged 25–49 years – 4.6%.

As far as the type of settlement (urban/rural) of respondents is concerned, the observed differences in answers were inessential and statistically insignificant. The value of Indicator 1.3 among urban residents was 9.9%, and among rural residents – 9.2%.

Thus, young men of the 20-24 (30.9%) and 15-19 (21.6%) age groups were the most sexually active. That is why there is need to focus more on the men from these very age groups to cover them with specialized prevention programs.

Indicator 1.4 "Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse"

In 2011 percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse was 63.9%[11].

Among men the value of this indicator was 68.2%, and among women – 50.0%. Among men aged 15–19 years and 20–24 years, this indicator value was almost identical and amounted to 85.2% and 85.4%, correspondingly, and in the 25–49 years age group it was lower and amounted to 50.7%.

Among women aged 25–49 years the value of this indicator was 50.0%. The sampling size to perform reliable statistical calculation of this indicator among women aged 15–19 years and 20–24 years turned out to be not representative. As far as the type of settlement (urban/rural) of respondents is concerned, there were significant differences in the responses. The value of this indicator among urban residents was lower than among rural residents – 61.2% and 70.9%, correspondingly.

In 2007 the value of Indicator 1.4 was 72.0%, and in 2009 – 61.0%. Presumably, in 2007 somewhat overstated estimates were obtained taking the sensitivity of this question into account. And, on the contrary, the data received in 2009 and 2011 reflected the real situation more accurately thanks to the use of tools that allow for better taking the sensitivity of this issue into consideration.

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[10] Results of the national representative sociological survey of the population of Ukraine aged 15-49 years, conducted by the CSO Analytical Center 'Socioconsulting' from 23.11.2011 till 05.01.2012. Total number of surveyed people was 2003 respondents in all territorial and administrative regions of Ukraine (AR Crimea, 24 oblasts and cities Kyiv and Sevastopol) and in all types of settlements.

[11] Results of the national representative sociological survey of the population of Ukraine aged 15-49 years, conducted by the CSO Analytical Center 'Socioconsulting' from 23.11.2011 till 05.01.2012. Total number of surveyed people was 2003 respondents in all territorial and administrative regions of Ukraine (AR Crimea, 24 oblasts and cities Kyiv and Sevastopol) and in all types of settlements.

In 2009 – 2011 the values of Indicator 1.4 remained at practically the same level of 61.0% and 63.9%; the difference of values is statistically insignificant and the representativeness error is 6.9%.

Indicator 1.5 "Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results"

In 2011 percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results was 12.4%.

This indicator was constructed on the basis of a national sociological representative survey of the population of Ukraine aged 15-49 years. Total number of the surveyed people was 2,003 in all territorial and administrative regions of Ukraine and in all types of settlements. In 2011 the values of Indicator 1.5 had very significant statistical difference compared to 2009 – 13.1% and to 2007 – 15.,5% due to implementation of a higher quality research with the better developed question sections, which helped to better identify the respondents' understanding of the survey questions compared to previous surveys.

The question to respondents whether they received an HIV test in the past 12 months was asked immediately after an 'introductory' question if they were tested for HIV in their life at all. Also, some 'control' questions were included in the survey to clarify when exactly the respondents were tested for HIV.

Knowledge of HIV status is critically important to protect oneself and prevent infecting other people, as well as to make decision about initiation of treatment.

Since 1998 the control over the spread of HIV infection in Ukraine has been performed on the basis of voluntary testing of all population groups. It was in 1998 when Ukraine adopted a new edition of the Law on AIDS, which, in particular, declared the principle of an informed choice to undergo testing for HIV, which is in compliance with international legislation on human rights and the WHO guidelines.

In December 2010 the applicable Law of Ukraine was amended and it was adopted in the new edition that, in particular, envisaged ensuring the state guarantees, namely, with respect to "availability and adequate quality of testing to detect HIV infection, including anonymous testing, with the provision of pre- and post-test counselling, as well as ensuring safety of testing for the individual being tested and for the personnel that performs it".

In 2005, in order to improve voluntary counselling and testing for HIV, the Ministry of Health (MoH) of Ukraine issued a number of documents that improved the efficiency of use of resources that were available in the country, to prevent the spread of HIV, to expand availability of voluntary counselling and testing for HIV infection (hereinafter to be referred to as VCT) for different population groups in each territorial and administrative region.

In 2009, pursuant to the objectives and activities of the National Program for the Prevention of HIV-infection, Treatment, Care and Support for People living with HIV and AIDS Patients for 2009-2013, the MoH of Ukraine approved the Strategy of Improving the System of HIV Counselling and Testing and Standardized Laboratory Diagnostics, and in 2010 the MoH of Ukraine issued an order to approve the list of diseases, symptoms and syndromes, with which the patients are offered voluntary counselling and testing services when they seek for medical assistance at the health care facilities regardless of their subordination and levels of health services being provided. To date VCT is a key component of prevention, treatment, care and support programmes for HIV-infected people and AIDS patients. The country has a well-established network of 761 'trust rooms' and drop-in centers that provide VCT services.

In 2011, according to the survey results, the percentage of individuals aged 15–49 who received an HIV test in the last 12 months and who know their results was 12,4%, including 15.0%, among women and 9.8% among men, urban residents 13.6% and rural residents – 9.7% . The higher testing rate among women compared to men is explained by the fact that all pregnant women who visit antenatal clinics are offered to undergo an HIV test on a voluntary basis. For example, in 2010 the HIV testing coverage of pregnant women in Ukraine was 97.5%. The higher testing rate among urban residents compared to the rural ones is explained by a better developed infrastructure. The highest quality VCT services are provided by AIDS Prevention Centers located in the cities.

The value of this indicator among the citizens of Ukraine aged 15-19 years was 11.2%, aged 20-24 years – 16.0%, and aged 25- 49 years – 11.8%.

Among women aged 15-19 years the value of this indicator was 13.0%, aged 20-24 years – 22.5%, and aged 25-49 years – 13.6%. The value of this indicator in the 20-24 years age group is significantly different due to the fact that the largest number of pregnant women is in this very age group.

Among aged 15-19 the value of this indicator was 9.6%, aged 20-24 years – 9.5%, aged 25-49 years – 10.0% (the difference is statistically insignificant).

Comparison of the data obtained in the sociological surveys with the official statistics data indicates that the data of sociological surveys are overstated. This can be related to the fact that sometimes respondents provided 'socially desirable' answers. At the same time, the data demonstrated a rather high level of HIV testing among general population in 2011.

Indicator 1.7 "Percentage of female sex workers reached with HIV prevention programmes"

In 2011 percentage of female sex workers reached with HIV prevention programmes was 61.2%[12]. In 2007 the value of this indicator was 69.0% and in 2009 - 59%.

The indicator was constructed on the basis of FSW answers to two questions: "Do you know where you can go if you wish to receive an HIV test?" and "In the last twelve months, have you been given condoms?" The value of this indicator among FSW aged 25 years and older compared to FSW younger than 25 years differs by almost 10% and amounts to 65.0% and 55.0% correspondingly.

The survey results demonstrated that 91.1% of FSW know where to go for HIV testing, while in 2009 this indicator was 89%. Percentage of FSW who are younger than 25 years and who know where to go for HIV testing is smaller in comparison with female sex workers aged 25 years and older – 88.3% versus 92.9%, correspondingly.

64.2% of FSW reported that they had obtained condoms in the last twelve months, while in 2009 this percentage was 61.0%. As well as in the previous survey, certain age differences have been observed. The value of this indicator among FSW who were younger than 25 years was 59.2%, and among their colleagues older than 25 years – 67.3%.

In 2011 HIV and STI prevention services were provided by 54 NGO in all regions of Ukraine. Every client was offered a basic package of services. In September 2011 implementation of these projects using the model of "Peer Driven Intervention" was successfully completed in seven cities of Ukraine.

At the same time, according to the program monitoring data the actual level of FSW coverage with prevention services is significantly lower compared to the survey data, but it grows annually. So, in 2007 the proportion of FSW covered with prevention programs was 9%, in 2008 – 15%, in 2009 – 36%, in 2010 – 37% and in the end of 2011 it amounted to 40.3%[13].

Thus, on the basis of bio-behavioural studies that were conducted in recent year and of the program monitoring data, certain positive dynamics in the growth of coverage of FSW with prevention programs is being observed.

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[12] The indicator was constructed on the basis of survey of commercial sex workers (CSW) aged 14 and more years in 25 administrative and territorial units of Ukraine within and integrated bio-behavioral study "Behavioral Monitoring and HIV Prevalence among CSW as a Component of Second Generation Surveillance of HIV" conducted from June 7 till November 9, 2011. The study was implemented by Kyiv International Institute of Sociology in cooperation with the Ukrainian AIDS Prevention Center at the MoH of Ukraine and NGOs, with financial support provided by the ICF International HIV/AIDS Alliance in Ukraine. The survey was conducted with the use of TLS (19 cities, 3,603 respondents) and RDS (7 cities, 1,402 respondents) methods. The survey sample was 5,005 respondents.

Indicators for the cities in which the RDS methodology was used, were calculated with the RDSAT software, and indicators for the cities in which the TLS methodology was used were calculated with the SPSS software with the use of weighs that adjust the size of points in the sample; the final national indicator was constructed as a mean value of regional indicators weighed against the size of the sample applied in the cities.

[13] According to the data from SyrEx database, provided by the ICF International HIV/AIDS Alliance in Ukraine.

Indicator 1.8 "Percentage of female sex workers reporting the use of a condom with their most recent client"

In 2011 percentage of female sex workers reporting the use of a condom with their most recent client was 92.0%[14]. According to 2009 data this indicator was 89.1% and in 2007 – 86.2%, which demonstrates a positive growth rate of this indicator. The survey results indicate that there was no significant difference in the distribution of answers by age. 93.6% of respondents younger than 25 years reported the condom use with their most recent client and 91.0% of respondents in the age group of 25 years and older gave the same answer.

The respondents mentioned the following reasons why they did not use condom with their most recent client: in 42.7% of cases the client insisted that condoms should not be used; 21.3% of women believed that would be paid more for sexual services without using a condom; 14.3% – never thought that condom use was necessary; 13.7% of FSW did not have condoms at hand; 12.7% of women did not like to provide sexual services with the use of condoms; 9.9% reported that condom use decreases the sexual pleasure; 9.6% were intoxicated with alcohol or drugs.

According to the survey results, 73.2% of respondents, who provided vaginal sex services in the recent 30 days, reported that they used condoms every time. As anal sex is considered most risky in terms of HIV infection, a special attention should be paid to the frequency of condom use when these sex services are provided.

The survey results demonstrated that 69.7% of respondents, who provided anal sex services in the recent 30 days, reported that they used condoms every time.

At the same time, according to the survey, 59.2% of FSW reported that they would never agree to provide sexual services without the condom use. Every one in five FSW (22.4%) would agree to sex without a condom with a permanent client whom they know well; 16.4% were ready to sex without condoms for extra payment; and 13.8% of FSW said that they would agree to an unprotected sex with a permanent client, whom they trust.

So, more than half of FSW (59.2%) express their firm conviction that they would never provide sex services without a condom. This means that indicator "use of a condom with a most recent client" does not fully facilitate to the detection of FSW with risky sexual behaviour. Condom use with the most recent client can be 'compensated' by the failure to use it in the next sexual contact.

Thus, even with the growing percentage of FSW, who reported the use of a condom with their most recent client, the unsafe sexual behaviour is still practiced by this target group and there is a need to further implement prevention activities in this group.

Indicator 1.9 "Percentage of female sex workers who have received an HIV test in the past 12 months and know their results"

In 2011 percentage of female sex workers who have received an HIV test in the past 12 months and know their results[15] was 58.5%[16].

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[14] The indicator was constructed on the basis of survey of commercial sex workers (CSW) aged 14 and more years in 25 administrative and territorial units of Ukraine within and integrated bio-behavioral study "Behavioral Monitoring and HIV Prevalence among CSW as a Component of Second Generation Surveillance of HIV" conducted from June 7 till November 9, 2011. The study was implemented by Kyiv International Institute of Sociology in cooperation with the Ukrainian AIDS Prevention Center at the MoH of Ukraine and NGOs, with financial support provided by the ICF International HIV/AIDS Alliance in Ukraine. The survey was conducted with the use of TLS (19 cities, 3,603 respondents) and RDS (7 cities, 1,402 respondents) methods. The survey sample was 5,005 respondents.

Indicators for the cities in which the RDS methodology was used, were calculated with the RDSAT software, and indicators for the cities in which the TLS methodology was used were calculated with the SPSS software with the use of weighs that adjust the size of points in the sample; the final national indicator was constructed as a mean value of regional indicators weighed against the size of the sample applied in the cities.

[15] It is typical for Ukraine that paid sex services are mostly provided by women. A group of male sex workers in Ukraine is rather small, closed and hard-to-reach to conduct a research. That is why in this and other indicators, it is women who are meant, when there is a reference to commercial sex workers.

[16] The indicator was constructed on the basis of survey of commercial sex workers (CSW) aged 14 and more years in 25 administrative and territorial units of Ukraine within and integrated bio-behavioral study "Behavioral Monitoring and HIV Prevalence among CSW as a Component of Second Generation Surveillance of HIV" conducted from June 7 till November 9, 2011. The study was implemented by Kyiv International Institute of Sociology in cooperation with the Ukrainian AIDS Prevention Center at the MoH of Ukraine and NGOs, with financial support provided by the ICF International HIV/AIDS

This indicator helps to evaluate the progress in implementation of HIV counselling and testing programs for female sex workers, the need to further implement prevention programs for FSW and the progress in reducing the rates of HIV infection in this target group. In 2009, percentage of commercial sex workers, who received an HIV test in the past 12 months and know their results, was 59%. However, comparison of 2011 indicator data with the previous years is not valid, because in 2011 most regions (25) of the country were included in the sample for the first time (in 2009, the survey was conducted in 15 cities of Ukraine).

Starting from 2005 behavioural studies related to HIV/AIDS in the world, as well as in Ukraine, have been using the new methods to reach the hard-to-reach groups that today are recognized to be the most efficient methods to study the behaviours of FSW and other vulnerable groups. These methods include Respondent-Driven Sampling (RDS) and Time-Location Sampling (TLS).

According to the results of survey among commercial sex workers, the testing coverage of the younger age group (under 25 years) in 25 regions of the country was somewhat lower than of the older age group (25 years and older) and amounted to 56.7% (in 2009 – 56.0 %). The value of this indicator for FSW aged 25 years and older was 59.6% (in 2009 – 61.0%).

A significant proportion of FSW, who have received an HIV test in the past 12 months and know their results, is probably related to the increased level of coverage of the risk groups representatives with voluntary counselling and testing for HIV (VCT) services. Today VCT is a key component of prevention, treatment, care and support programs for HIV infected people and AIDS patients. The country has a well-established network of 761 “trust rooms” and drop-in centers that provide VCT services.

One of the instrumental factors that contribute to the indicator of HIV testing is a rather broad use of rapid tests among most-at-risk populations that are being performed by local NGOs.

In 2011 HIV and STI prevention services were provided by 54 NGOs in all regions of Ukraine. These NGOs provided a basic package of services which is mandatory for all clients of harm reduction programs. In September 2011 HIV and STI prevention projects for FSW using the “Peer Driven Intervention” model were successfully completed. These projects were implemented by regional NGOs in seven cities of Ukraine.

The proportion of commercial sex workers covered with a comprehensive package[17] of HIV prevention services in the past 12 months was 40.3 % (28,224 people) of estimated number of 70,000 people.

Besides, the results of bio-behavioural studies that were conducted in the several recent years provide the grounds to speak about positive trends in the behaviour change in these groups for a safer behaviour, and, subsequently, to hope that the trend towards reduction of HIV prevalence in this group would become sustainable.

Indicator 1.11 “Percentage of men who have sex with men reached with HIV prevention programmes”

In 2011 the coverage indicator for men, who have sex with men was 53.1%[18], in 2009 – 63% and in 2007 - 50%.

Alliance in Ukraine. The survey was conducted with the use of TLS (19 cities, 3,603 respondents) and RDS (7 cities, 1,402 respondents) methods. The survey sample was 5,005 respondents.

Indicators for the cities in which the RDS methodology was used, were calculated with the RDSAT software, and indicators for the cities in which the TLS methodology was used were calculated with the SPSS software with the use of weighs that adjust the size of points in the sample; the final national indicator was constructed as a mean value of regional indicators weighed against the size of the sample applied in the cities.

[17] A comprehensive package of HIV prevention services for FSW offered by the regional NGOs is aimed to meet the specific needs of this target group and includes the following services: 1) distribution of disposable materials, such as male/female condoms, lubricants, antiseptics of local action, pregnancy tests, other hygienic and disinfecting means; exchange or distribution of syringes for FSW, who are injecting drug users; 2) distribution of information materials; 3) counseling provided by social workers, health care workers and other specialists, as well as peer counseling; 4) targeted referral of the clients to other specialized projects, organizations and facilities, as well as case management; 5) voluntary counseling and testing for HIV, diagnostics of STIs and testing for viral hepatitis; 6) referral to free treatment of STIs, etc.

[18] The indicator was constructed on the basis of survey of men who have sex with men (MSM) in 27 administrative and territorial units of Ukraine within and integrated bio-behavioral study “Behavioral Monitoring and HIV Prevalence among Men

However, a direct comparison of these indicators with the previous years would not be valid, because in 2011 it was the first time when 27 administrative and territorial units of Ukraine (27 cities) were included in the sample, while in 2009 such study was conducted only in 14 cities of Ukraine.

Among MSM aged under 25 years the indicator value was 57.2%, among MSM aged 25 and older – 50.2%. No difference between these age groups was observed.

Positive answers to the question "Do you know where you can go if you want to receive an HIV test?" were given by 88% of the interviewed MSM. Among MSM aged under 25 years the percentage of positive answers was 84.5%, while among MSM aged 25 and older – 90.4%.

Positive answers to the question "Have you received condoms in the past 12 months" were given by 56.2% of the surveyed MSM. Among the representatives of this risk group aged under 25 years a positive answer was given by 60.9% of respondents and in the group aged 25 years and older – 52.9% respondents.

In 2011, HIV prevention among men who have sex with men was performed by 18 non-governmental organizations in 11 oblasts under coordination and overall management of the Alliance-Ukraine (in Dnipropetrovsk, Donetsk, Zaporizhzhia, Mykolayiv, Odessa, Kharkiv, Kherson, Khmelnitsky, Cherkassy and Chernivtsy oblasts, in the cities of Kyiv and Sevastopol and AR Crimea).

According to the program monitoring, coverage of MSM with prevention services is growing, even though it is much lower than was estimated by the survey. So, in 2007 the proportion of MSM reached with services was 3%, in 2009 – 8%, in 2009 – 13.5% and in the end of 2011 – 20.1%[19].

The program monitoring data demonstrate the dynamic growth of MSM coverage with prevention programs. However, on the basis of epidemiological data, it is obvious that the existing level of coverage of this vulnerable group is insufficient to ensure a sustainable impact on the epidemic.

Indicator 1.12 "Percentage of men reporting the use of a condom the last time they had anal sex with a male partner"

In 2011 percentage of men reporting the use of a condom the last time they had anal sex with a male partner was 70.5%[20]. In 2009 the value of this indicator was 64% and in 2007 - 39%, which is an evidence of growth of this indicator.

Among MSM aged under 25 years the value of this indicator is 68.9%, while among MSM aged 25 years and older – 71.6%.

An analysis of condom use frequency is more illustrative in terms of safer behaviour. According to the interviews with MSM, who answered a qualifying question, 49.8% of respondents always (in 100% of cases) used condoms when they had anal sex with other men in the past 30 days. This indicates to the fact the MSM still widely practice risky behaviour which may lead to HIV infection spread.

On the one hand, the value of this indicator had grown since 2009 confirming the efficiency of prevention programs among MSM. On the other hand, it should be noted that this indicator does not reflect the consistency of condom use with regular or casual male partners, while the survey data confirm the difference between sustainable sexual practices and the actual behaviour at the recent anal sex. The indicator also does not give an idea about the use of a condom with female sexual partners.

Who Have Sex with Men as a Component of Second Generation Surveillance of HIV" conducted from July 29 till October 26, 2011. The study was implemented by Kyiv International Institute of Sociology in cooperation with the Ukrainian AIDS Prevention Center at the MoH of Ukraine and NGOs, with financial support provided by the ICF International HIV/AIDS Alliance in Ukraine.

The survey was conducted with the use of RDS (respondent driven sample) method. Total survey sample was 5,950 respondents.

[19] According to the data from SyrEx database, provided by the ICF International HIV/AIDS Alliance in Ukraine.

[20] The indicator was constructed on the basis of survey of men who have sex with men (MSM) in 27 administrative and territorial units of Ukraine within and integrated bio-behavioral study "Behavioral Monitoring and HIV Prevalence among Men Who Have Sex with Men as a Component of Second Generation Surveillance of HIV" conducted from July 29 till October 26, 2011. The study was implemented by Kyiv International Institute of Sociology in cooperation with the Ukrainian AIDS Prevention Center at the MoH of Ukraine and NGOs, with financial support provided by the ICF International HIV/AIDS Alliance in Ukraine.

The survey was conducted with the use of RDS (respondent driven sample) method. Total survey sample was 5,950 respondents.

Indicator 1.13 "Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results"

In 2011 percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results was 37.8 %.

The indicator represents a group of men who have sex with men that have received an HIV test in the past 12 months and know their results, and allows estimating the need for further implementation programs to ensure access to counselling and testing for HIV among MSM.

In recent years an ever growing number of new HIV infections among the representatives of this group has been registered in Ukraine. Starting from 2005 the behavioural studies related to HIV/AIDS in the world, as well as in Ukraine, have been using the new methods to reach the hard-to-reach populations that today are recognized to be the most efficient methods to study the behaviours of MSM and other vulnerable groups. These methods include Respondent-Driven Sampling (RDS) and Time-Location Sampling (TLS).

In 2011, percentage of men who have sex with men, that have received an HIV test in the past 12 months and know their results, was 37.8 %[21], in 2009 – 43.0%. Among MSM aged under 25 years the value of this indicator was 36.2 % (in 2009 – 43 %), among MSM aged 25 and older – 38.9 % (in 2009 – 44.0%).

However, it would not be incorrect to directly compare this indicator with the values obtained in the previous years, as in 2011 the sample included all 27 regions of the country for the first time (in 2009 the survey was conducted in 14 cities of Ukraine).

Analysis of subnational indicators demonstrates a wide range of their levels – from 12.5 % in the city of Chernigiv to 66.9 % in Uzhhorod. The lowest indicator values were obtained in the cities of Chernigiv, Zaporizhzhia, Lutsk, Kirovograd and Kharkiv, and the highest – in the cities of Uzhhorod, Mykolayiv, Cherkassy and Odessa. Compared to 2009 the indicator level grew in Uzhhorod, Cherkassy, Odessa, Simferopol, Donetsk and Lugansk.

Table 10. Dynamics of the indicator "Percentage of MSM that have received an HIV test in the past 12 months and know their results"

	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results		
Cities	2007	2009	2011
Uzhhorod	-	30	66,9
Mykolayiv	80	88	62,4
Cherkassy	10	33	59,2
Odessa	-	50	53,9
Kyiv	31	62	51,0
Kryvyi Rig	-	-	50,3
Simferopol	22	12	45,6
Donetsk	29	18	41,8
Sevastopol	-	-	39,4
Ternopil	-	-	38,5
Poltava	-	47	37,6
Vinnitsya	-	-	37,5

[21] The indicator was constructed on the basis of survey of men who have sex with men (MSM) in 27 administrative and territorial units of Ukraine within and integrated bio-behavioral study "Behavioral Monitoring and HIV Prevalence among Men Who Have Sex with Men as a Component of Second Generation Surveillance of HIV" conducted from July 29 till October 26, 2011. The study was implemented by Kyiv International Institute of Sociology in cooperation with the Ukrainian AIDS Prevention Center at the MoH of Ukraine and NGOs, with financial support provided by the ICF International HIV/AIDS Alliance in Ukraine.
The survey was conducted with the use of RDS (respondent driven sample) method. Total survey sample was 5,950 respondents. The inclusion criteria were based on the answer to the question on whether the respondent had anal sex with other men in the last 6 months (since January 2011).

	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results		
Cities	2007	2009	2011
Chernivtsy	-	-	36,9
Sumy	-	-	36,5
Lviv	-	56	33,9
Rivne	-	-	33,5
Kherson	7	54	31,7
Lugansk	19	21	24
Zhytomyr	-	-	23,2
Ivano-Frankivsk	29	47	22,8
Dnipropetrovsk	9	21	20,2
Kharkiv	-	28	19,7
Kirovograd	-	-	19,5
Lutsk	-	-	16,6
Zaporizhzhia	-	-	15,9
Chernigiv	-	-	12,5

Proportion of men who have sex with men, covered with a comprehensive package of services to prevent HIV in the past 12 months is 20.1% (19,130 people) of the estimated number of 95,000 people.

The share of MSM covered with testing is significantly higher among the clients of NGOs that provide services to MSM and amounted to 61.2% in 2011 compared to 29.9% among those who were not clients of non-governmental organizations. The highest quality voluntary counselling and testing for HIV in accordance with the National Protocol is provided by AIDS Prevention Centers. Recently rapid tests for HIV among most-at-risk groups have been introduced in Ukraine. A significant difference in the level of testing coverage among the clients of NGOs that provide services to MSM and those, who are not clients of such organizations, demonstrates the efficiency of rapid test use for hard-to-reach higher risk groups.

In 2011 HIV prevention activities among men who have sex with men were implemented by 18 non-governmental organizations in 11 oblasts under coordination and overall management of the Alliance-Ukraine (in Dnipropetrovsk, Donetsk, Zaporizhzhia, Mykolayiv, Odessa, Kharkiv, Kherson, Khmelnitsky, Cherkassy and Chernivtsy oblasts, in the cities of Kyiv and Sevastopol and AR Crimea).

At the same time, MSM still practice risky behaviours that lead to further spread of HIV infection in the country.

Indicator 1.15 "Percentage of health care facilities that provide HIV testing and counselling"

In 2011 percentage of health care facilities that provide HIV testing and counselling was 21.1 %.

The number of health care facilities that offer their premises to provide HIV counselling and testing services is 1,712. Total 8,110 health care facilities can provide VCT services in Ukraine.

The source of this information is operational data of regional AIDS Prevention Centers that were collected by 01.01.2012 and represent the number of health care facilities in the regions that submit reports by the Form № 3-HIV/AIDS. Besides, information from the State Facility "Medical Statistics Center of the MoH of Ukraine" was analyzed in relation to the total number of health care facilities in the system of the MoH of Ukraine by 31.12.2011 and of sectoral health care facilities and private clinics by 31.12.2010.

Indicator 1.17 "Percentage of women, who had access to antenatal care, who were tested for syphilis at their first visit to antenatal care service"

Elimination of congenital syphilis and vertical transmission of HIV are the key goals of the global health system by 2015. It implies an active integration of syphilis screening and treatment programs for pregnant women with the program for the prevention of mother-to-child transmission of HIV.

Percentage of women, who had access to antenatal care, who were tested for syphilis at their first visit to antenatal care service was 92.1% in 2009 and 92.4% in 2011.

The data about the number of tests for syphilis in pregnant women are collected by the State Facility “Medical Statistics Center of the MoH of Ukraine” under the official statistical Form №21.

So, the numerator includes the number of pregnant women who received a test for syphilis at their first visit to antenatal clinic. In 2011 457,434 women were tested. The denominator includes the data about total number of pregnant women, who turned to antenatal clinics in 2011, and its value amounted to 495,250 women.

Serology test of pregnant women for syphilis is included in the list of standard laboratory tests to be performed when a pregnant woman is registered at an antenatal clinic for the first time. According to the Order № 417 of the MoH of Ukraine as of 15.07.2011 “On Organization of Outpatient Obstetric and Gynaecological Service in Ukraine”, the first test for syphilis should be done for a pregnant woman at registration, and the second – on the 29-th week of gestation.

Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015

Indicator 2.1 "Number of syringes distributed through specialized needle and syringe programs per injecting drug user per year"

Number of syringes distributed per one injection drug user through needle and syringe exchange programs was 75.3 in 2011.

Ukraine remains among countries in the concentrated stage of HIV epidemic among groups with high risk of HIV, key of them are IDUs, CSWs, MSM and prisoners. Prevention programs play a key role in determination of epidemic process development in these groups.

Prevention programs among IDUs have reached certain progress in upgrading the level of knowledge about HIV-infection and safe behaviour formation. In 2011, 95.5% of IDUs reported the use of sterile injecting equipment during the last injection, but this still does not imply regular safe injecting practices.

Despite gradual decrease in the share of IDUs among persons with HIV, HIV-infection prevalence in IDUs, as before, remains the highest if compared with other risk groups.

One of the key programs on HIV prevention among IDU are harm reduction programs, which allow to reduce the risk of infection in this group and limit potential spread of HIV among sexual partners of IDU and general population. An important stage in implementation of harm reduction strategy is to motivate injecting drug users to disinfect injecting equipment, to refuse from sharing needles and syringes and to use only sterile needles and syringes.

Needle exchange sites (NES) allow to provide IDU with sterile injecting equipment and to establish stable contacts with representatives of this risk group. NES, just like harm reduction program, is a “low-threshold” service – a client has to provide minimum information about him/herself in order to participate in the program, all services are free of charge, and location of the site is, as a rule, convenient for visiting, etc. Significant decrease in HIV, hepatitis B and C transmission among injection drug users can be reached by exchange of used syringes for new ones for small amount of money or for free.

As of January 1, 2012, there are 1 667 sites of needle and syringe exchange program (NSEP)[22] in Ukraine (including pharmacies, where it is possible to receive needles and syringes free of charge), which operate in 27 regions of Ukraine. The average number of syringes distributed per one injecting drug user within needle and syringe exchange programs was **75.3** in 2011. During 2011, 81 non-governmental organizations provided HIV preventing services for injecting drug users in all regions of Ukraine. Level of IDU coverage with comprehensive HIV prevention services, provided by NGOs on sites, in 2011 made 54.14 % (157 011 individuals) from the estimated number (290 000 individuals).

An important task of NES in harm reduction program is the removal of used needles and syringes from the turnover in IDU environment. Public organizations’ prevention from collecting the syringes used and suspension of used syringes exchange programs for IDU played negative role due to out-of-

22 Needle and syringe exchange programs are any programs, which provide access to sterile tools and their further safe utilization via stationary or mobile exchange programs and/or via pharmacies, where this equipment or tools can be received free of charge.

date and incomplete legislation, which regulates storage, utilization and destruction of medical wastes procedures and requires obligatory disinfection of syringes used from the side of controlling agencies – if compared with 2010, 1 081 413 syringes less were collected in 2011.

Indicator 2.2 "Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse"

In 2011 percentage of injecting drug users, who reported that they used a condom during the last sexual intercourse was 47.8%[23]. In 2009 this indicator was 48%, i.e. it has not changed for 2 years.

In 2011 this indicator among women made 46.7%, and among men – 48.2%. Among IDUs under 25 this indicator was 58.3%, and among IDUs over 25 – 45.6%. This difference was also observed in 2009 – 53% against 47%.

Safer sexual behaviour among IDUs is the most important, as persons injecting drugs, can transmit HIV-infection into the general population through sexual route of transmission.

56.8% of respondents always used a condom (in 100% cases) in the last three months (90 days) during sexual intercourse with casual sexual partner, 10.8% never used a condom, and 32.4% used a condom with different level of frequency.

It can be stated, that the sexual route of HIV transmission among IDUs and their sexual partners remains a threatening factor in the spread of HIV-infection among both, risk groups and general population.

Indicator 2.3 "Percentage of IDUs, reporting the use of sterile injecting equipment the last time they injected"

Percentage of IDU, who reported that the use of sterile injecting equipment during the latest injection in the last month was 95.5%[24] in 2011. In 2007 this indicator was somewhat lower and made 84%, in 2009 – 87%. Positive dynamics is observed in comparison with 2007, the indicator increased by 11.5% and by 8.5% in comparison with 2009.

In 2011 this indicator among women was 95.7%, among men – 95.5%, if compare with 2009, the difference was in favour of men – 84% against 89% respectively.

In 2011 this indicator among IDUs under 25 was 94.6%, whereas among IDU over 25 – 95.7%. According to 2009 data, Indicator 2.3 among IDU under 25 was 89%, and among IDU over 25 – 87%.

At the same time the survey demonstrated that 57.8% of respondents received/bought an injection from the syringe, which was already filled, in the last 30 days. Also 7.9% of respondents confirm, that they injected with a syringe that had been already used by another person.

Besides that, 12.2% of respondents indicated, that in the last 30 days they at least once (with different frequency) gave or sold their needle or syringe to another person after injection.

To the question, how often in the last 30 days they filled the syringe with already prepared drug from the shared container, 22.5% of respondents indicated constant filling, 37.5% of respondents filled with different level of frequency and 40.1% have never filled.

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[23] Calculations of this indicator were based on the results of the survey conducted among injecting drug users (IDUs) in 26 administrative-and-territorial units of Ukraine in the framework of integrated bio-behavioural survey "Monitoring the behaviour and HIV-infection prevalence among IDU as a Component of Second Generation HIV Epidemiological Surveillance", which was conducted during June 3-October 24, 2011. The survey was carried out by the Ukrainian Institute for Social Studies named after O.O. Yaremenko in collaboration with State Institution "Ukrainian AIDS Center of the Ministry of Health of Ukraine" and NGO, with financial support from International HIV/AIDS Alliance in Ukraine.
The sampling was implemented using RDS (respondent driven sample) method – the sampling which is directed by respondents. The survey sample was 9069 persons (6578 men and 2491 women).

[24] The indicator was calculated based on the results of the survey among injecting drug users (IDUs) in 26 administrative-and-territorial units of Ukraine within integrated bio-behavioural survey "Monitoring the Behaviour and HIV-infection Prevalence among IDUs as a Component of Second Generation HIV Epidemiological Surveillance", conducted during June 3-October 24 of 2011. The study was carried out by Ukrainian Institute for Social Studies named after O.O.Yaremenko in collaboration with State Institution "Ukrainian AIDS Center of the Ministry of Health of Ukraine" and NGO, with financial support from International HIV/AIDS Alliance in Ukraine.
The sampling was implemented using RDS (respondent driven sample) method – the sampling which is directed by respondents. The survey sample was 9069 persons (6578 men and 2491 women).

Taking into account the data indicated and not considering high percentage of sterile injection equipment use during the last injection, we can state risk behavioural practices among IDUs. Thus, the need in the coverage of this group with high-quality harm reduction programs and expand the substitution maintenance treatment programs remains urgent.

Indicator 2.4 "Percentage of injecting drug users, who received an HIV test in the last 12 months and who know their result"

Percentage of injecting drug users, who received an HIV test in the last 12 months and who know their result was 35.7% in 2011.

This indicator allows to evaluate the progress in implementation of HIV counselling and testing programs among injecting drug users, need in further access of this target group to VCT programs. Awareness of HIV status is crucially important for own protection and for prevention of infecting other people as well as taking decision about treatment.

Since 2009 all regions have been included into the survey to identify the percentage of IDUs tested for HIV in the last 12 months and are aware of their test results. Peculiarity of 2011 study is involvement of regions, which are conventionally considered to "second wave" regions, i.e. regions, where the prevalence of HIV-infection is lower than in other regions, according to official data. Besides, in 2011 the respondents were proposed to be tested not only for HIV, but also for Hepatitis C.

Percentage of IDUs, tested for HIV in the last 12 months and who know their test results, was 35.7 %[25] in 2011. In 2009 this indicator was 26.0%. Increase in Indicator 2.4 value in 2011 is mostly associated with increase in risk groups representatives' coverage with HIV voluntary counselling and testing. At the moment VCT is a key component of prevention, treatment, care and support programs for people living with HIV/AIDS.

One of the efficient factors, which allowed increasing the value of HIV testing indicator, is rather wide use of rapid tests among risk groups representatives, implemented on sites by NGOs. Level of IDUs coverage with comprehensive package of HIV prevention services[26] was 54.1% (157 011 individuals) from the estimated number (290 000 of individuals) in 2011.

During 2011, 81 non-governmental organizations provided HIV prevention services to injecting drug users in all the regions of Ukraine. Besides provision of basic package of services, NGOs had possibility to work with separate hard-to-reach subgroups of IDU, using several innovative models: "Peer Driven Intervention", "HIV prevention in Stimulant Drugs Users through the Change of Individual Behaviour at Group Level", "Street Nurses in Harm Reduction Projects". In September, 2011 innovative intervention on counselling for the sexual partners of IDUs was launched. The project aims at teaching sexual partners with communication techniques and provision of knowledge and skills on reduction of HIV-infection and STD risk.

Despite gradual decrease of the share of IDUs in structure of people with HIV, HIV prevalence among IDU remains, as before, the highest, in comparison with other risk groups.

Among separate IDU groups, indicator value is: 34% among men and 40 % among women. This difference is probably explained by the fact that women undergo testing more often during pregnancy. In 2009 the difference was significant: 25% among men and 29 % among women.

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[25] Indicator on the share of injecting drug users, who received an HIV test in the last 12 months and know their results, was calculated based on the results of the survey among injecting drug users (IDUs) in 26 administrative-and-territorial units of Ukraine within integrated bio-behavioural survey "Monitoring the Behaviour and HIV-infection Prevalence among IDUs as a Component of Second Generation HIV Epidemiological Surveillance", conducted during June 3-October 24 of 2011. The study was carried out by Ukrainian Institute for Social Studies named after O.O.Yaremenko in collaboration with State Institution "Ukrainian AIDS Center of the Ministry of Health of Ukraine" and NGO, with financial support from International HIV/AIDS Alliance in Ukraine.

The sampling was implemented using RDS (respondent driven sample) method – the sampling which is directed by respondents. The survey sample was 9069 persons (6578 men and 2491 women).

The study was held in a form of "tet-a-tet" interview accompanied by HIV and Hepatitis C testing (with rapid tests).

[5]Comprehensive package of services for IDUs includes the following activities: distribution and exchange of syringes, alcohol swabs and/or condoms at stationary, street and mobile needle exchange sites through outreach work, voluntary HIV counselling and testing with rapid tests, STDs diagnostics, counselling on HIV-infection and drug use, which is provided by a social worker, trained within the program, as well as provision of information regarding other prevention and treatment programs, which are being implemented in the region (substitution treatment programs, ARV treatment), etc.

In 2011 this indicator among IDUs under 25 was 34.9%, among IDUs over 25 – 35.9%. The same trend was observed during recent years – 23% and 32% in 2007, and 22 % and 28 % in 2009 respectively. It can be assumed, that older IDU are more often covered with prevention programs and have more co-infections, which is ground for medical observation.

Indicator 2.6 (a) "Estimated number of opiate users (injection)"

Estimated number of opiate users (injection) in 2011 was 250,000 individuals.

Drug use gradually transformed into serious social problem and, in the first place, due to the high risk of HIV-infection and other viruses transmitted through the blood. In Ukraine these are injecting drug users, who are the primary risk group for becoming HIV infected. HIV epidemic, caused by injecting drug users, as a rule spreads faster, than the epidemic, where primary route of transmission is sexual.

Estimated number of injecting drug users allows evaluating the scale of required prevention programs and evaluating the progress achieved in implementation of HIV prevention programs among IDUs.

Calculations of Indicator 2.6 value (a) were based on the data on the estimated number of IDUs in Ukraine in 2011, which was received in each region according to the results of behavioural studies.[27] The share of IDUs, who used drugs within the last 30 days, was identified for each region with further calculation of the number of injection opiate users according to maximal and minimal evaluations.

Only injection opiates were considered in calculation of estimated number of opiates users, taking into account the fact that the study was carried out only among individuals, who inject drugs. According to medical statistical data, non-injection opiates use is not wide-spread in Ukraine, although there is no data on the number of non-injection opiate users.

Indicator 2.6 (b) "Number of people on opioid substitution therapy at all OST sites»

The number of people on opioid substitution therapy amounted to 6 632 individuals in 2011. In 2007 this indicator made 547 individuals, in 2009 – 5 078 individuals.

Use of substitution maintenance therapy in treatment of patients with injection opioid addiction syndrome is the most effective healthcare tool in reduction of injection drug use. Besides that, SMT provides ensures support in provision of other diseases treatment, including HIV-infection, TB and viral Hepatitis.

This indicator demonstrates adherence and progress, which was reached in treatment of injecting opiate users, as well as reduction in the probability of HIV infection among persons injecting drugs.

SMT program continues to operate in 27 regions of Ukraine within 133 healthcare establishments.

As of January 1, 2012, 6 632 patients received access to SMT. Among them 5 828 patients received SMT with methadone and 804 patients with buprenorphine. Almost 45% (2 967) SMT patients are HIV-positive, among them 931 received ART, 1 201 patients had TB and 3 700 individuals had Hepatitis B and/or C.

Grant agreements on medical and psycho-social support of SMT patients, supported by International HIV/AIDS Alliance in Ukraine, are implemented by 34 NGOs, that collaborate with healthcare institutions (psycho-neurological and narcological clinics, AIDS Centers, TB clinics and infectious diseases hospitals, city and district hospitals), in which SMT sites operate.

Since October 1, 2011 the number of integrated care centers has increased if compared with the previous period (from 8 to 34), which allowed to introduce multidisciplinary model of follow-up of

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[27] Indicator on the share of injecting drug users, who received an HIV test in the last 12 months and know their results, was calculated based on the results of the survey among injecting drug users (IDUs) in 26 administrative-and-territorial units of Ukraine within integrated bio-behavioural survey "Monitoring the Behaviour and HIV-infection Prevalence among IDUs as a Component of Second Generation HIV Epidemiological Surveillance", conducted during June 3-October 24 of 2011. The study was carried out by Ukrainian Institute for Social Studies named after O.O.Yaremenko in collaboration with State Institution "Ukrainian AIDS Center of the Ministry of Health of Ukraine" and NGO, with financial support from International HIV/AIDS Alliance in Ukraine.

The sampling was implemented using RDS (respondent driven sample) method – the sampling which is directed by respondents. The survey sample was 9069 persons (6578 men and 2491 women).

The study was held in a form of "tet-a-tet" interview accompanied by HIV and Hepatitis C testing (with rapid tests).

program participants with injection opiate addiction, double (drug addiction and HIV) or triple diagnosis (drug addiction, HIV and TB) at the sites.

Integrated care centers for SMT patients operate in Mykolayiv, Sumy, Poltava, Vinnitsa, Ivano-Frankivsk, Kherson, Odessa, Zaporizhzhia, Rivne and Ternopil regions, as well as in the cities of Kyiv and Sevastopol and AR Crimea.

Due to the projects of medical and psycho-social follow-up of SMT patients it became possible to improve reintegration and resocialization indicators. Thus, according to the data from NGOs, which implement SMT projects, about 30% of patients were employed due to participation in SMT program, almost 3% started studying, over 16% of patients renewed their family relationships, about 5% created families and over 2.5% of patients had children.

Another important outcome of SMT projects is that average income from participants'' illegal activities significantly decreased during this period of time, and percentage of patients brought to justice decreased by several times. In particular, crime rate, related to participation in illegal drug turnover among those enrolled in SMT programs, dropped 7 times, other crime rates (thefts, etc.) –4 times (results of 400 clients of methadone programs interviewing in 13 healthcare institutions).

Despite certain achievements in reintegration of SMT patients, there is need to improve medical services and especially psycho-social follow-up of SMT patients, search for new ways to upgrade psychological and social work, training of specialists, working with SMT clients, as well as everybody involved in SMT program in Ukraine – law enforcement bodies, journalists, representatives of executive body, etc.

Indicator 2.7 (a) "Number of needle and syringe program sites (including pharmacies with free distribution of needles and syringes)"

Number of needles and syringes program sites (including pharmacies with free distribution of needles and syringes) made 1667 in 2011.

Needle and syringe programs are one of the most effective interventions in HIV prevention among IDUs. This indicator evaluates availability of proper access to sterile needles and syringes.

Needle and syringe programs are any programs which provide access to sterile equipment and its further safe utilization through stationary or mobile exchange programs and/or pharmacies, where this equipment can be received free of charge.

Indicator 2.7 (b) "Number of substitution therapy sites"

The number of sites for opioid substitution therapy was 133 in 2011. In 2009 this indicator was 144.

Substitution maintenance treatment is highly effective for changing injecting behaviour, which affects the risk of HIV infection in IDUs. Besides, SMT promotes better access to ART, increases adherence and decreases mortality. SMT also ensures essential support for provision of treatment of other diseases, including HIV-infection, TB and viral Hepatitis.

The indicator demonstrates adherence and progress, which was achieved in treatment of opiate users, as well as reduction in HIV-infection risk in persons injecting drugs.

Substitution maintenance treatment program continues to operate in 27 regions of Ukraine at 133 healthcare institutions. As of January 1, 2012, 6 632 patients have received access to SMT. The smallest amount (1-2) of SMT sites operates in Zakarpattya, Kyiv, Ternopil, Kharkiv and Chernivtsy regions, as well as in the city of Sevastopol. The biggest amount of SMT sites operates in Donetsk, Poltava, Mykolayiv and Dnipropetrovsk regions as well as in AR of Crimea. In the other regions 3-7 sites operate.

The highest number of injecting drug users, who receive SMT services, is in the cities of Kyiv and Sevastopol (164 and 105 clients per 1 site respectively), the smallest (less than 30 clients) – in Vinnitsa, Ivano-Frankivsk, Lviv, Rivne, Kharkiv, Cherkassy and Chernigiv regions. On average, 1 SMT site covers 50 injection opiate users with SMT services.

The largest share of injecting drug users receiving SMT is men. Average proportion of men and women on SMT countrywide equals 4:1.

Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths

Indicator 3.1 "Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission"

The percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission was 94.7% in 2010, and 95.5% in 2011.

The system of data collection and reporting on the measures to prevent mother-to-child transmission of HIV (also referred to as PMCT) was established and functions in Ukraine since 2004. This made it possible to monitor actual rather than estimated utilization of various antiretroviral treatment schemes for HIV-positive women to prevent mother-to-child transmission of HIV.

Therefore, the numerator includes the total number of HIV-positive pregnant women who received any antiretroviral treatment regimen, which was 3,635 in 2010, and 3,763 – in 2011.

The denominator includes the data on the total number of HIV-positive pregnant women who kept their pregnancy, which was 3,828 in 2010, and 3,939 – in 2011.

In Ukraine, pregnant women receive antiretroviral treatment only in public sector clinics. Standards of ARV prophylactic treatment of HIV-positive pregnant women and birthing mothers are set in the National clinical protocol on obstetric care "Prevention of mother-to-child HIV transmission", approved by the Order of the Ministry of Health of Ukraine No. 716 as of November 14, 2007.

The coverage of HIV-positive pregnant women with antiretroviral treatment to reduce the risk of mother-to-child transmission of HIV from 1999 through 2007 has increased from 9.0% to 92.5%; in 2008 this indicator value ranged from 94.5% to 95.5%.

The following regimens were used in Ukraine during 2010 and 2011:

Table 11. Antiretroviral treatment regimens for HIV-positive women to prevent mother-to-child transmission of HIV

#	Indicators	2010	%	2011	%
1	The number of HIV-positive women who kept their pregnancy.	3,828	100	3,939	100
2	The number of HIV-positive pregnant women, who received ARV treatment, of the total number HIV-positive women who kept their pregnancy.	3,625	94.7	3,763	95.5
2.1	including: ARV treatment on medical grounds prior and during pregnancy	629	16.4	810	20.6
2.2	APV prophylaxis during pregnancy	2,710	70.8	2,782	70.6
	including: with one ARV drug	553	14.4	247	6.3
	with two ARV drugs	176	4.6	105	2.7
	with three ARV drugs	1,981	51.8	2,430	61.6
2.3	ARV prophylaxis during delivery (single-dose nevirapine)	286	7.5	171	4.3
3	The number of HIV-positive pregnant women who did not receive ARV treatment	203	5.3	176	4.5

During the period from 2008 – 2011 one could also observe gradual reduction of the number of HIV-positive pregnant women, who only received a single dose of nevirapine during labour as antiretroviral prophylaxis: 277, 240, 286, and 171 correspondingly. This is the evidence of the use of more ARV prophylaxis regimes.

Indicator 3.2 "Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth"

This indicator measures progress in the extent to which infants born to HIV-positive women are tested within the first two months of life.

WHO recommends providing early virological testing of infants for HIV as soon as possible to guide clinical decision-making at the earliest possible stage of HIV infection in children.

In Ukraine, in line with the Clinical Protocol on the treatment of opportunistic infections and HIV-associated diseases in children living with HIV/AIDS, approved by the Order of the Ministry of Health of Ukraine No. 206 of April 07, 2006, the first PCR DNA testing of babies, born to HIV-positive mothers, should be conducted within 1-2 months of birth, and the second testing – at the age of 3-5 months.

Until 2011 statistical reporting on PMTCT in Ukraine included the data only on the number of conducted examinations to identify the presence of HIV genetic material in the children's blood samples by using PRC DNA methodology (one, two and three tests) regardless of the child's age and terms of testing. Percentage of infants, born to HIV-positive women, and covered with one-time PCR DNA testing was 75.0% in 2008 and 70.0% in 2010.

In order to improve the system of record-keeping and reporting in the area of PMTCT in Ukraine, in 2011 they have calculated the indicator "Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth" for the first time ever using methodology, suggested by the reporting guidelines on the Political Declaration on HIV/AIDS. The indicator value was **55.3%**.

The nominator includes the number of infants, born to HIV-positive women, who were tested for HIV within two months of birth using Early Infant Diagnosis (EID) methodology (RCR DNA). In 2011 its value was 2,176 children.

The denominator includes the data on the total number of living children, born to HIV-positive women. In 2011 this value reached 3,938 children.

According to research results, the indicator value 3.2 (55.3%) has the following distribution: children with positive results of PCR DNA testing – 1.4% (54 children), with negative results – 53.8% (2,118 children), with unidentifiable results, or samples were discarded by the lab – 0.1% (4 children). Disaggregation of the data by testing results cannot ensure their representativeness in terms of the level of mother-to-child transmission due to low coverage of children, born to HIV-positive women, with HIV testing during the first two months of life.

Therefore, in Ukraine in 2011 only about half of infants, born to HIV-positive mothers, were tested for HIV by means of the nationally recognized EID methodology to determine their HIV status. Low value of this indicator may point to systemic weaknesses in the provision of virological labs with necessary test-kits to perform PCR testing.

Indicator 3.4 "Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status"

HIV antibody testing of pregnant women is one of important components of programmes for prevention of mother-to-child HIV transmission, which is conducted to identify a woman's serological status, and – in case of its positive result – to provide a woman with counselling, medical assistance and prophylactic antiretroviral treatment to prevent infection in the future child.

The percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status, makes up 99.2% in 2011.

In line with the methodology, suggested in the Joint Reporting Tool of WHO, UNICEF and UNAIDS for Monitoring and Reporting on the Health Sector Response to HIV/AIDS, this indicator includes all HIV-

positive pregnant women attending antenatal care in 2011, regardless of the timing of HIV diagnosis, including before pregnancy.

The data on the number of HIV tests conducted among pregnant women are collected by the State Facility "Centre for Medical Statistics of the Ministry of health of Ukraine" (reporting form #21).

Therefore, the nominator includes the number of pregnant women who have been tested for HIV and received their results; in 2011 there were 491,328 of such women.

The denominator includes the data on the overall number of pregnant women attending antenatal care, which in 2011 made up 495,250 women.

According to current regulations, the testing of a pregnant woman for HIV is only made upon her informed consent. The recommendation is to get tested twice: during registration at the antenatal clinic, and immediately prior to delivery. They have been implementing comprehensive prevention measures to reduce the levels of MTCT in Ukraine since 1999, while in 2001 the State Program on the Prevention of Mother-to-Child Transmission of HIV was launched. It was found that the coverage of pregnant women with routine testing for HIV in Ukraine since 2008 ranges within 95-99%.

Of particular interest is the fact that against the increase of the total number of HIV-positive pregnant women in 2008 – 2011, one can observe gradual reduction of the number of women with HIV-positive status, newly diagnosed during pregnancy during labour and delivery and during the post-partum period – 3,933 (80.0%) in 2008; 3,928 (74.4%) in 2009; 3,424 (67.2%) in 2010; and 3,057 (55.3%) in 2011.

Table 12. Dynamics of cases of HIV infection in pregnant women

Indicators	2008	2009	2010	2011
Total number of HIV-positive pregnant women	4,916	5,281	5,099	5,527
including: The number of pregnant women known to be HIV positive before pregnancy	983	1,353	1,675	2,470
The number of pregnant women, newly identified as HIV positive during pregnancy, labour, delivery, or during the post-partum period	3,933 (80.0%)	3,928 (74.4%)	3,424 (67.2%)	3,057 (55.3%)

Of all women, who learned about their HIV-positive status while attending antenatal care, during labour and delivery, or during the post-partum period in 2011 (3,057 women), HIV was diagnosed within 12 weeks of pregnancy in 23.4% (1,071) of women; in the period of 12 – 26 weeks in 26.9% (1,231) of women; after 26th week of pregnancy – in 12.3% (562) of women; during labour and delivery – in 3.7% (171) of women; and after delivery – in 0.5% (22) of women.

Therefore, 4.2% of HIV-positive pregnant women were not tested to HIV antibodies before delivery and labour, and consequently did not receive necessary ARV prophylaxis. In 2010 this value constituted 7.7%. According to special epidemiological studies, in 70-80% cases these pregnant women belong to populations most at risk for HIV.

Indicator 3.7 "Percentage of infants born to HIV-positive women receiving antiretroviral (ARV) prophylaxis for prevention of mother-to-child transmission (PMTCT)"

Percentage of infants born to HIV-positive mothers receiving ARV prophylaxis to reduce the risk of mother-to-child transmission is generally high throughout Ukraine: 98.3% in 2008; 98.4% in 2009; 98.0% in 2010; and 99.1% in 2011.

This indicator is calculated against the data, collected by the current system of record-keeping and reporting in the area of PMTCT in Ukraine, which operates since 2004.

The numerator includes the number of infants born to HIV-positive women receiving ARV prophylaxis to reduce the risk of mother-to-child transmission, which in 2011 made up 3,904 children.

The denominator includes the data on the total number of living children, born to HIV-positive women. In 2011 this value reached 3,938 children.

Standards of ARV prophylaxis among infants, born to of HIV-positive women, are set forth in the National clinical protocol on obstetric care “Prevention of mother-to-child HIV transmission”, approved by the Order of the Ministry of Health of Ukraine No. 716 as of November 14, 2007.

According to this protocol, measures of PMTCT should be applied to all infants born to HIV-positive mothers.

The following regimens were used in Ukraine during 2010 and 2011:

Table 13. Antiretroviral treatment regimens for infants to prevent mother-to-child transmission of HIV

#	Indicators	2010	%	2011	%
1	Total number of living children born to HIV-positive women	3,881	100	3,938	100
2	The number of infants born to HIV-positive women receiving ARV prophylaxis to reduce the risk of mother-to-child transmission	3,803	98.0	3,904	99.1
2.1	including: one ARV dug, 7 days	2,913	72.9	3,079	78.2
	one ARV drug, 28 days	383	9.6	244	6.2
	three ARV drugs, 7 days / 28 days	507	12.7	581	14.7
3	The number of infants born to HIV-positive women, who did not receive ARV prophylaxis	78	2.0	34	0.9

Indicator 3.13 (a) “Percentage of HIV-positive pregnant women who inject drugs”

In line with the methodology, suggested in the Joint Reporting Tool of WHO, UNICEF and UNAIDS for Monitoring and Reporting on the Health Sector Response to HIV/AIDS, the indicator «Percentage of HIV-positive pregnant women who inject drugs” measures the percentage of HIV-positive women, who have been using drugs actively during pregnancy. In Ukraine in 2011 this indicator makes up **3.5%**.

The nominator includes the number of HIV-positive pregnant women who have been injecting drugs actively during pregnancy, and in 2011 there were 151 women of this kind.

The denominator includes the data on the total number of HIV-positive women, whose pregnancies resulted in deliveries or abortions; in 2011 this group consisted of 4,351 women.

Before 2011 Ukrainian statistical reporting in the area of PMTCT did not take into account the status of active IDU among pregnant women; it only included the data on the number of pregnant women with parenteral mode of HIV transmission (that is, through injecting use of narcotic substances). The share of such women among the overall number of HIV-positive pregnant women was 7.3% in 2008; 7.1% in 2009; and 6.4% in 2010.

In 2011 the data to calculate Indicator 3.13(a) was obtained within the framework of overall improvement of the system of record-keeping and reporting on PMTCT.

HIV-positive pregnant women who are IDU still remain extremely hard-to-reach group for various interventions to prevent mother-to-child transmission of HIV. It is well-known that injection of narcotic drugs and other psychoactive substances always goes hand in hand with stigma and discrimination, so it forces the patients to conceal this fact. In this connection, real prevalence of active injecting drug users among HIV-positive pregnant women can be much higher. Such situation limits opportunities for timely provision of necessary PMTCT services, substitution maintenance therapy, as well as other medical, social and preventive programmes for HIV-positive pregnant women who actively inject drugs.

Indicator 3.13 (b) "Percentage of HIV-positive pregnant women – IDU, who received substitution maintenance therapy during pregnancy"

The percentage of HIV-positive drug using pregnant women, who received substitution maintenance therapy during pregnancy, was 5.5% in 2009 and **7.3%** - in 2011.

The nominator includes the number of HIV-positive pregnant women on substitution maintenance therapy during pregnancy (16 women in 2010, and 29 women in 2011).

The denominator includes the number of HIV-positive drug using pregnant women attending antenatal care. In 2010 there were 288, and in 2011 – 395 women of this kind.

The indicator 3.13 (b) is calculated on the basis of operative data of the Ukrainian AIDS Centre of the Ministry of Health of Ukraine within the framework of overall improvement of the system of record-keeping and reporting on PMTCT. The obtained data confirm the low coverage of HIV-positive pregnant women, who are injecting drug users, with substitution maintenance therapy.

It was found that the majority of women with active opioid dependency continue using drugs during pregnancy, thus putting their own health and that of their future children at risk. This situation requires active scale-up of access of pregnant IDU, particularly those who are HIV positive, to substitution maintenance therapy, rehabilitation programmes, and services of socio-psychological support.

Indicator 3.13 (c) "Percentage of HIV infected pregnant and birthing women, who are IDUs and who were receiving ARV-prophylaxis to reduce the risk of mother-to-child transmission of HIV during pregnancy"

Percentage of HIV infected pregnant and birthing women, who are IDUs and who were receiving ARV-prophylaxis to reduce the risk of mother-to-child transmission of HIV during pregnancy was **65.3%** in 2011.

The numerator includes the number of HIV infected recently confined women, who are IDUs who were receiving ARV-prophylaxis to reduce the risk of mother-to-child transmission of HIV during pregnancy; in 2011 there were 228 such women.

The denominator includes the number of HIV infected women, who are IDUs, whose pregnancy resulted in birth in 2011 – 349 women.

Indicator 3.13 (c) is being constructed on the basis of operational data of the Ukrainian AIDS Prevention Center at the MoH of Ukraine within the framework to improve the registration and reporting system in the area of PMTCT.

The obtained data indicate a low level of coverage of HIV infected pregnant women, who are IDUs, with antiretroviral prophylaxis to reduce the rate of vertical transmission of HIV. This category of patients has a limited access not only to antiretroviral therapy, but to health services in general. Taking the scale of HIV spread among injecting drug users in Ukraine into account, there a need to unify approaches to the organization of procedures for providing substitution maintenance therapy for drug users with opioid dependence. It will ensure the quality of therapy and provide an opportunity to develop adherence among HIV infected injecting drug users to antiretroviral therapy, and will facilitate to the prevention of further spread of HIV infection in this population group.

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015

Indicator 4.1 (b) "Percentage of eligible adults and children currently receiving antiretroviral therapy"

In 2011, percentage of eligible adults and children who were receiving antiretroviral therapy was 69.89% (in absolute figures – 26,720 people on ART among 38,230 people who were undergoing regular medical check-ups, who had medical indicators for antiretroviral therapy).

Ukraine ensures equal access to treatment for both women and men, which is confirmed by the fact that in 2011 percentage of ART coverage of HIV infected women was 70.52% (treatment is provided to 12,911 women of 18,307 women eligible for ART), and, correspondingly for men this indicator value was 69.31% (13,809 men of 19,923).

A significant ART coverage of children – 94.26% (2,268 of 2,406 children eligible for ART) confirms that priority access for children in need of such treatment has been ensured.

This indicator was constructed on the basis of a temporary sectoral statistics and reporting form for the monitoring of HIV/AIDS treatment № 56 (Table 1000) of the Ministry of Health of Ukraine entitled "Report on Provision of Antiretroviral Therapy to HIV Infected People and AIDS Patients by 01.01.2012".

Comparison of this indicator with the data for the previous years is impossible due to the changes in the methods of its construction.

In spite of a significant growth in the number of patients on ART, the rate of scaling-up the antiretroviral treatment program for HIV infected people lags behind the rate of growth of people in need of ART, which is explained by the limited funding. Insufficient ART coverage of HIV infected people in need of it indicates the need to urgently mobilize the efforts of public and non-governmental sectors to ensure universal access to diagnostics, treatment, care and support for people, living with HIV and AIDS.

Indicator 4.2 "Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy"

Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy in the reporting period from 01.01.2011 till 31.12.2011 was 82.29% (5,993 patients continue receiving treatment of 7,282 patients, who started treatment in the cohort in 2010).

Among those, who discontinued treatment 12 months after its initiation in the cohort in 2010 – 576 patients died and 713 patients discontinued treatment due to different reasons.

This indicator was constructed on the basis of a temporary sectoral statistics and reporting form for the monitoring of HIV/AIDS treatment № 57 (Table 3000) of the Ministry of Health of Ukraine entitled "Reporting on adults and children, who started ART in the cohort and continue treatment 6, 12, 24 and 36 months after its initiation for January-December 2011", 2010 cohort.

A large-scale provision of ART to people living with HIV and AIDS in Ukraine started in August 2004 within the program "Overcoming HIV/AIDS Epidemic in Ukraine" financed by the Global Fund in 6 regions of the country. Gradually, by 2008 the ART had been introduced in all 27 regions of Ukraine. By 01.01.2012 17% of patients were receiving treatment with the Global Fund support (Round 6 funding) and 83% were treated at the expense of the State Budget of Ukraine.

The process of ART introduction in the country contributed to a significant improvement of professional skills of health care workers that follow up patients on treatment, to the improvement of the legislative and regulatory framework, material and technical support to AIDS Prevention Centers. As a result, a gradual growth of this indicator was observed till 2009 (2007 – 77.6%, 2008 - 82%, 2009 – 85%). At the same time the rate of funding for the National Program and capacity of AIDS Prevention Centers lag behind the rate of growth of the number of patients in need of treatment. ART coverage of HIV infected people and their follow up are insufficient and in 2010 the value of this indicator somewhat declined (2010 – 84%, 2011 – 82.3%).

Death on ART (which was related to late initiation of ART) was among the main reasons to discontinue ART during the first 12 months after initiation of treatment in the 2004-2007 cohorts; starting from 2008 ART was mostly discontinued due to different reasons, primarily non-medical ones.

Today there is a need to improve the strategy of treatment service provision, namely, to decentralize provision of antiretroviral treatment, to quickly scale up the substitution maintenance therapy, as well as efficient tuberculosis prevention, diagnostics and treatment programs for people living with HIV.

Indicator 4.2 (a) "Percentage of IDUs living with HIV known to be on treatment 12 months after initiation of antiretroviral therapy"

Percentage of IDUs living with HIV known to be on treatment 12 months after initiation of antiretroviral therapy in the reporting period from 01.01.2011 till 31.12.2011 was **73.24%** (1,051 patients continue treatment of 1,435 people, who started treatment in the 2010 cohort).

This indicator was constructed on the basis of operational information received from the regional AIDS Prevention Centers on the basis of primary reporting form №510-3/o "Registration log for patients on ART at the health care facility". There are no reporting forms to calculate this indicator on the national level. Data about the reasons for discontinuation of treatment among IDUs in the 2010 cohort are not collected.

This indicator was calculated on the basis of data about active injecting drug users and people on substitution maintenance therapy, who comprise 19.7% of the overall 2010 cohort.

As soon as Ukraine it reporting by this indicator for the first time it is not possible to compare it with the previous data. Percentage of IDUs living with HIV, who remain on treatment 12 months after initiation of antiretroviral therapy, is significantly lower than the same indicator for all people on ART. It confirms the need to strengthen cooperation between health care facilities and non-governmental organization to ensure a timely and full access to health services and to develop and support adherence to ART among IDUs, as well as to ensure the further scaling up of the SMT programs in Ukraine.

Indicator 4.2 (c) "Percentage of people living with HIV/AIDS known to be on treatment 60 months after initiation of antiretroviral therapy"

Percentage of people living with HIV/AIDS known to be on treatment 60 months after initiation of antiretroviral therapy in the reporting period from 01.01.2011 till 31.12.2011 was **70.77%** (1,433 patients continue treatment of 2,025 people who started treatment in the 2006 cohort).

Among those who discontinued treatment 60 months after its initiation in the 2006 cohort – 325 people died and 267 discontinued treatment due to different reasons.

This indicator was constructed on the basis of a temporary sectoral statistics and reporting form for the monitoring of HIV/AIDS treatment № 57 (Table 3000) of the Ministry of Health of Ukraine entitled "Reporting on adults and children, who started ART in the cohort and continue treatment 6, 12, 24 and 36 months after its initiation for January-December 2011", 2006 cohort.

The process of ART introduction in the country contributed to a significant improvement of professional skills of health care workers that follow up patients on treatment, to the improvement of the legislative and regulatory framework, material and technical support to AIDS Prevention Centers. As a result, a gradual growth of this indicator was observed in 2011 (in the 2006 cohort) compared to 2009 (in the 2004 cohort - 65%) and 2010 (in the 2005 cohort - 68%).

Indicator 4.2 (d) "Percentage of IDUs living with HIV/AIDS known to be on treatment 60 months after initiation of antiretroviral therapy"

Percentage of people living with HIV/AIDS known to be on treatment 60 months after initiation of antiretroviral therapy in the reporting period from 01.01.2011 till 31.12.2011 was **61.71%** (448 patients continue treatment of 726 patients who started treatment in the 2006 cohort).

This indicator was constructed on the basis of operational information received from the regional AIDS Prevention Centers on the basis of primary reporting form №510-3/o "Registration log for patients on ART at the health care facility". There are no reporting forms to calculate this indicator on the national level. Data about the reasons for discontinuation of treatment among IDUs in the 2006 cohort are not collected.

An adequate monitoring of antiretroviral therapy was started in 2008, and that is why all people who became HIV infected through injecting drug use and started therapy in 2006 and who comprise 35.9% of the total 2006 cohort were included in the calculation of this indicator.

As soon as Ukraine it reporting by this indicator for the first time it is not possible to compare it with the previous data. Percentage of IDUs living with HIV, who remain on treatment 60 months after initiation of antiretroviral therapy, is significantly lower than the same indicator for all people on ART. It confirms the need to strengthen cooperation between health care facilities and non-governmental organization to ensure a timely and full access to health services and to develop and support adherence to ART among IDUs, as well as to ensure the further scaling up of the SMT programs in Ukraine.

Indicator 4.5 “Percentage of people living with HIV, who were in need of ARV-therapy at the moment when they were diagnosed”

In 2011, percentage of people living with HIV, who were in need of ARV-therapy at the moment when they were diagnosed in Ukraine, was 39.98%. This indicator was constructed on the basis of statistical reporting forms related to HIV/AIDS approved in the beginning of 2005.

In the reporting period, 21,177 people with the newly diagnosed HIV infection (regardless of the infection stage) were taken in the follow-up in Ukraine in 2011, including 4,391 people with an advanced HIV infection and 4,076 people with AIDS; total 8,467 people with the late stages of HIV infection. So, in 2011 the percentage of people in need of ART at the moment of diagnosis was 39.98%.

Significant difference in the rates of HIV epidemic still exists between the regions and within the regions of the country. The number of officially registered HIV infections correlates with the number of tests for antibodies to HIV and the testing structure in the regions.

Analysis of HIV antibody testing rates in the regions of Ukraine demonstrated that in 2011 there were significant regional variations in the proportions of tests funded from the local budgets (without taking into account tests among blood donors and pregnant women that are being funded from the state budget). In 2011 the total percentage of tests funded from the local budgets in the total number of tests was 40.5%, while in AR Crimea this indicator amounted only to 27.1%, in Poltava oblast – 21.8% and in the city of Sevastopol – 34.6%.

The registered number of HIV infections in the regions with limited access to testing, especially for most-at-risk populations, can be significantly lower than the actual number (Zakarpattya, Ivano-Frankivsk, Volyn, Zaporizhzhia and Donetsk oblasts), but a large number of HIV infected people will be detected due to the presence of clinical manifestations of the disease. Overall, in the country almost 25.0%, or one in four confirmed cases of HIV infection (without blood donors and pregnant women) were diagnosed on the basis of clinical indications. In some regions this indicator is even higher: for example, in Sevastopol it exceeds 35.0%, in AR Crimea – almost 32.0% and in Poltava oblast – 27.0%.

In 2011, percentage of people in need of ARV-therapy at the moment of diagnosis in the regions of the country varied from 78.17% in Ivano-Frankivsk oblast to 14.29% in Zakarpattya oblast.

Table 14. Percentage of people in need of ARV-therapy at the moment of diagnosis in Ukraine in 2011

Regions	Number of new HIV infection cases	Number of AIDS cases	Number of advanced HIV infection cases	Percentage of people in need of ART at the moment when they were diagnosed
Ivano-Frankivsk	142	21	90	78.17
AR Crimea	1,077	59	504	52.27
Poltava	464	94	120	46.12
City of Kyiv	1,269	281	298	45.63
City of Sevastopol	241	62	47	45.23
Odessa	2,080	410	523	44.86
Dnipropetrovsk	3,447	900	613	43.89
Lugansk	715	106	200	42.80
Kherson	716	102	204	42.74
Zhytomyr	458	86	105	41.70
Zaporizhzhia	523	101	111	40.54

Donetsk	3,994	802	696	37.51
Khmelnitsky	279	53	50	36.92
Kyiv	831	212	93	36.70
Kharkiv	565	124	83	36.64
Chernigiv	481	70	95	34.30
Chernivtsy	106	11	25	33.96
Mykolayiv	1,132	32	347	33.48
Ternopil	149	24	23	31.54
Cherkassy	494	107	46	30.97
Vinnitsya	372	94	19	30.38
Sumy	202	28	30	28.71
Lviv	493	129	12	28.60
Volyn	280	63	13	27.14
Kirovograd	358	75	14	24.86
Rivne	246	25	26	20.73
Zakarpattya	63	5	4	14.29
Total for Ukraine	21,177	4,076	4,391	39.98

Timely diagnostics and provision of adequate ARV therapy have a decisive impact on the indicators of mortality of AIDS-related diseases and on indicators of survival of HIV infected people, and can also directly influence the values of HIV prevalence.

Today ART is available in all 27 regions of Ukraine. However, ART coverage is insufficient to meet the needs of ever growing number of new patients who are in need of treatment.

Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

Indicator 5.1 "Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV"

In 2010, by the end of reporting period percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV was **35.73%.** The data are provided for 2010 due to the lack of data about the number of incident TB cases among HIV infected people in Ukraine in 2011.

This indicator was constructed on the basis of primary reporting forms № 025/o "Medical card of an outpatient client" and №510-3/o "Registration log for patients on ART at the health care facility", as the reporting form is now being reviewed by the MoH of Ukraine, and on the basis of information provided by the WHO Office in Ukraine.

In 2010 antiretroviral therapy was provided to 2,144 HIV infected people with incident TB, who already started tuberculosis treatment. According to the WHO European Regional Office, in 2010 an estimated number of HIV positive incident TB cases in Ukraine was 6,000 people (5,000 to 7,100 people).

In 2007–2010, a number of activities aimed at early detection of TV cases among HIV infected people and to ensure adequate treatment for them, including screening for TB with the Global Fund support was implemented in Ukraine. In 2010 a new "Clinical Protocol for Antiretroviral Therapy of HIV Infection in Adults and Adolescents" was adopted. It identifies tuberculosis as an indication to initiate antiretroviral therapy. It is recommended to start ART 2-8 weeks after the beginning of TB treatment. As a result, the value of this indicator grew from 21% in 2008 to 35.73% in 2010.

Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries

Indicator 6.1 "Domestic and international AIDS spending by categories and financing sources"

Data to construct this indicator were obtained from a 2011 research to evaluate national expenditures on response to HIV epidemic in Ukraine in 2009-2010. This research was based on the methodology of National AIDS Spending Assessment, (NASA), which was for the first time adapted to the situation in Ukraine. The applied methodology preserved key features of NASA thus ensuring consistency and interrelation of these approaches. The research was conducted by the Ukrainian AIDS Prevention Center and regional AIDS Centers. Technical support to the research was provided by the ICF International HIV/AIDS Alliance in Ukraine and UNAIDS.

The research results confirm that Ukraine's dependence on the external funding sources for the implementation of HIV epidemic response in 2009 and 2010 remained at the level of the previous years. Almost 41% of all expenditures on epidemic response are covered at the expense of external sources, with the Global Fund being the major donor (around 34% and 37% of the total amount of expenditures in 2009 and 2010 correspondingly).

Table 15. Expenses Structure by Funding Sources

Funding Source	2009		2010	
	Hryvnias[28]	% of the total amount of expenses	Hryvnias	% of the total amount of expenses
State and local budgets	296,429,784	58.2%	302,150,330	52.2%
International sources	207,489,037	40.7%	269,960,680	46.7%
Including the Global Fund	172,001,388	33.8%	213,254,552	36.9%
Non-governmental sources	5,527,643	1.1%	6,229,198	1.1%
Total expenses	509,446,464	100.0%	578,340,208	100.0%

Table 16. Expenses Structure by Activities

Activities	2009		2010	
	Hryvnias	% of the total amount of expenses	Hryvnias	% of the total amount of expenses
Prevention	148,292,952	29.1%	158,415,454	27.4%
Treatment	211,176,121	41.5%	241,546,154	41.8%
Care and support	21,373,565	4.2%	29,093,793	5.0%
Administrative activities	128,603,826	25.2%	149,284,807	25.8%
Total	509,446,464	100.0%	578,340,208	100.0%

An expected reduction of external funding increases the relevance of the need to review the strategy for financial support to the epidemic response activities, both in terms of amounts of funds allocated for these activities, and in term of prioritization of areas to finance.

Data of epidemiological surveillance and behavioural studies indicate that today HIV infection epidemic in Ukraine does not demonstrate any stable trends towards reduction of its spread. Under the conditions of limited resources and the growing needs it is necessary to clearly identify priorities and to allocate funds to such areas where they will bring most benefits and make the largest impact on the epidemic development.

[28] Here and further on the absolute values in Ukrainian Hryvnias are rounded to integers (without kopecks) to ease the perception of information.

In the process of development of a new national targeted program of response to HIV epidemic in Ukraine it will be necessary to envisage the introduction of mechanisms for a gradual reduction of dependence on external funding and to ensure support to the most efficient models for the organization of prevention, treatment, care and support services.

Distribution of total expenses by the activity areas and funding sources is presented in the Tables below.

Annexes to this report include the National Funding Matrix in which the epidemic response activities correspond to the classifier of spending categories used in the NASA methodology.

Certain changes were entered into the activity classifier during the process of adapting the NASA methodology. In particular, it was taken into consideration that the comprehensive HIV epidemic response activities in Ukraine have certain logical structure that was defined, *inter alia*, by the current National Targeted Program for 2009-2013. This very structure is reflected in the classifier with the distribution of four key groups of activities that include: prevention, treatment, care and support, and administrative activities. Besides, the classifier of funding sources reflects the actual representation of specific organizational structures in the sphere of HIV epidemic response in Ukraine.

Table 17. Structure of Expenses on Prevention Activities, by Funding Sources

Funding sources for prevention activities	2009		2010	
	Amount in Hryvnias	% of the total amount of expenses on prevention	Amount in Hryvnias	% of the total amount of expenses on prevention
State funding sources, total	79,220,191	53.4%	76,462,135	48.3%
State budget funds (without external loans)	32,218,950	21.7%	39,510,593	24.9%
State budget funds (including external state loans)	758,516	0.5%	351,627	0.2%
Local budgets	46,128,781	31.1%	36,234,098	22.9%
State budget sources not split into categories	113,944	0.1%	365,818	0.2%
Non-governmental funding sources, total	754,233	0.5%	1,132,708	0.7%
Households	201,102	0.1%	282,672	0.2%
Non-profit enterprises, institutions and organizations	38,874	0.0%	17,617	0.0%
Commercial enterprises, institutions and organizations	216,593	0.1%	606,252	0.4%
Non-governmental funding source that are not specified above	297,664	0.2%	226,167	0.1%
International funding sources, total	68,318,528	46.1%	80,820,611	51.0%
The United States Government	2,428,579	1.6%	2,663,726	1.7%
Governments of other countries	4,379,178	3.0%	4,799,632	3.0%
The Global Fund	53,267,438	35.9%	64,676,091	40.8%
UN agencies	4,591,495	3.1%	4,576,546	2.9%
Other multilateral agencies	121,274	0.1%	4,309	0.0%
International non-profit organizations and charitable funds	3,491,746	2.4%	3,808,894	2.4%
Other international funding sources	38,818	0.0%	291,414	0.2%
Total expenses on prevention	148,292,952	100.0%	158,415,454	100.0%

Table 18. Structure of Expenses on Treatment Activities, by Funding Sources

Funding sources for treatment activities	2009	2010

	Amount in hryvnias	% of the total amount of expenses on treatment	Amount in hryvnias	% of the total amount of expenses on treatment
State funding sources, total	180,702,861	85.6%	178,944,126	74.1%
State budget funds (without external loans)	129,894,539	61.5%	111,836,701	46.3%
State budget funds (including external state loans)	4,343,139	2.1%	1,989,329	0.8%
Local budgets	44,368,167	21.0%	62,694,883	26.0%
State budget sources not split into categories	2,097,017	1.0%	2,423,213	1.0%
Non-governmental funding sources, total	584,818	0.3%	389,606	0.2%
Households	156,730	0.1%	101,417	0.0%
Non-profit enterprises, institutions and organizations	413,284	0.2%	187,790	0.1%
Commercial enterprises, institutions and organizations	1,776	0.0%	71,443	0.0%
Non-governmental funding source that are not specified above	13,029	0.0%	28,957	0.0%
International funding sources, total	29,888,441	14.2%	62,212,422	25.8%
The United States Government	740,771	0.4%	1,119,874	0.5%
Governments of other countries	0	0.0%	33,052	0.0%
The Global Fund	28,286,723	13.4%	59,276,004	24.5%
UN agencies	509,894	0.2%	1,333,229	0.6%
International non-profit organizations and charitable funds	351,053	0.2%	450,263	0.2%
Total expenses on treatment	211,176,121	100.0%	241,546,154	100.0%

Table 19. Structure of Expenses on Care and Support Activities, by Funding Sources

Funding sources for care and support activities	2009		2010	
	Amount in hryvnias	% of the total amount of expenses on care and support	Amount in hryvnias	% of the total amount of expenses on care and support
State funding sources, total	4,396,666	20.6%	7,645,346	26.3%
State budget funds (without external loans)	3,060,928	14.3%	5,374,105	18.5%
State budget funds (including external state loans)	1,335,738	6.2%	1,665,041	5.7%
Local budgets	0	0.0%	606,200	2.1%
Non-governmental funding sources, total	1,447,204	6.8%	1,716,745	5.9%
Households	936,607	4.4%	1,114,361	3.8%
Non-profit enterprises, institutions and organizations	510,597	2.4%	601,089	2.1%
Non-governmental funding source that are not specified above	0	0.0%	1,295	0.0%
International funding sources, total	15,529,696	72.7%	19,731,702	67.8%
Governments of other countries	82,288	0.4%	749	0.0%
The Global Fund	14,082,284	65.9%	18,068,315	62.1%
UN agencies	156,751	0.7%	0	0.0%
International non-profit organizations and charitable funds	1,106,295	5.2%	1,521,780	5.2%
Other international funding sources	102,078	0.5%	140,858	0.5%
Total expenses on care and support	21,373,565	100.0%	29,093,793	100.0%

Table 20. Structure of Expenses on Administrative Activities, by Funding Sources

Funding sources for administrative activities	2009	2010

	Amount in hryvnias	% of the total amount of expenses on administrative activities	Amount in hryvnias	% of the total amount of expenses on administrative activities
State funding sources, total	32,110,067	25.0%	39,098,723	26.2%
State budget funds (without external loans)	511,969	0.4%	664,883	0.4%
State budget funds (including external state loans)	0	0.0%	817,160	0.4%
Local budgets	31,397,691	24.4%	37,361,530	25.0%
State budget sources not split into categories	200,407	0.2%	255,150	0.2%
Non-governmental funding sources, total	2,741,388	2.1%	2,990,139	2.0%
Households	775,187	0.6%	2,789,698	1.9%
Non-profit enterprises, institutions and organizations	650,257	0.5%	140,580	0.1%
Commercial enterprises, institutions and organizations	1,264,467	1.0%	24,117	0.0%
Non-governmental funding source that are not specified above	51,477	0.0%	35,744	0.0%
International funding sources, total	93,752,371	72.9%	107,195,945	71.8%
The United States Government	3,606,298	2.8%	15,579,140	10.4%
Governments of other countries	1,317,190	1.0%	2,674,354	1.8%
The Global Fund	76,364,943	59.4%	71,234,143	47.7%
UN agencies	4,506,201	3.5%	8,054,129	5.4%
Other multilateral agencies	343,427	0.3%	1,448,904	1.0%
International non-profit organizations and charitable funds	5,293,470	4.1%	4,704,352	3.2%
Other international funding sources	597,396	0.5%	971,504	0.7%
International commercial organizations	1,723,447	1.3%	2,529,419	1.7%
Total expenses on administrative activities	128,603,826	100.0%	149,284,807	100.0%

Target 7. Critical Enablers and Synergies with Development Sectors

Indicator 7.1 "National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)" - Annex 2 to the National Report

Indicator 7.1 (c) "European Center for Disease Control and Prevention; additionally: National Composite Policy Index (for HIV/AIDS) - Annex 2 to the National Report

SECTION IV. Best Practices

In 2010-2011 Ukraine continued to introduce best practices and innovative approaches towards HIV prevention, care and support for people living with HIV/AIDS, supporting favourable environment and developing policies aimed at successful implementation of country strategies to fight HIV/AIDS.

Political leadership and responsibility of the Head of State

In the reporting period the Head of State, President of Ukraine Viktor Yanukovich and Ukraine's Government invested serious effort into fighting HIV/AIDS epidemic in the country. On December 23, 2010 the Parliament of Ukraine adopted the new wording for the Law of Ukraine "On Combatting Spread of Diseases Caused by the Human Immune Deficiency Virus (HIV) and Legislative and Social Protection of the Nation"; the law overturned a series of discriminative provisions introduced the previous legislation, defined substitution maintenance therapy as one of the key interventions in HIV prevention among injecting drug users, cleared some definitions and so on.

Joint efforts from the government and civil society sector supported by international organizations helped secure significant financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria in Round 10 amounting to over 300 million USD for 2012-2016, which will help support HIV prevention programs for most at risk populations, strengthen the health care structures and system of treatment provision, care and support for people living with HIV/AIDS.

For the past seven years implementation of the Global Fund grant continues to be hindered by differences in grant utilization practices defined by the national legislation which differ from the Global Fund and international procedures regulating the grant process. According to Ukrainian legislation charity aid delivered to Ukraine with financial support from the Global Fund is subject to taxation. Procedures employed to declare products procured with support from the Global Fund were too time consuming which jeopardized the procurement schedule defined according to the needs. The Ministry of Health of Ukraine with support from the Cabinet of Ministers developed and submitted to the Parliament Draft Law "On Introducing Amendments to the Tax Code of Ukraine on Placing Duties on Operations Related to Utilization of the Global Fund to Fight AIDS, Tuberculosis and Malaria Grants in Ukraine", under the law GF financing will be exempt from taxation and simplified procedures on customs registration will be used for GF procured products.

Civil society and international organizations deeply concerned by the critical situation around the substitution maintenance therapy which occurred in 2010, failure to fulfil goals of the National Program to Insure Prevention of HIV Infection, Treatment, Care and Support for HIV Infected Persons and AIDS Patients in 2009-2013 and GF supported programs appealed to the country's political leadership to take immediate action. The appeal was reviewed by Ukraine's Prime Minister who requested the central agencies of executive power to insure scale up of substitution maintenance programs, support introduction of liquid formulas, study best international practices and strengthen coordination of activities between government agencies, civil society organizations and international organizations.

Strengthening cooperation between civil society organizations and government agencies

Strong leadership, advocacy efforts and professional attitude demonstrated by the civil society organisation in the past two years significantly strengthened national response to HIV/AIDS in Ukraine. The All-Ukrainian Network of People Living with HIV/AIDS and International Charitable Foundation "International HIV/AIDS Alliance in Ukraine" in cooperation with the regional offices and partner organizations proved their ability to effectively implement HIV/AIDS programs. The Global Fund to Fight AIDS, Tuberculosis and Malaria recognized this ability by providing to Ukraine a five year Round 10 Grant of over 300 million USD to be implemented by the Alliance Ukraine and PLHA network as co-recipients.

Civil society organizations also remain key partners in developing and implementing essential components of the National Program to Insure Prevention of HIV Infection, Treatment, Care and

Support for HIV Infected Persons and AIDS Patients in 2009-2013. Over 150 non-governmental organizations provide services on prevention; care and support to HIV affected populations at the local level.

Care and support services are an integral part of care provision for HIV positive patients; care provision includes medical and non-medical components. In Ukraine medical services are supported by the network of health facilities, including specialized facilities (e.g., Centers to Control and Prevent AIDS) and general facilities (e.g., counselling and testing sites in policlinics and hospitals). However, for many patients non-medical services remain unavailable. In the framework of GF supported programs grant principle recipients in close cooperation with grass roots organizations, government agencies and international experts developed a package of social services. The package includes social, psychological services, judicial advice, referral services to medical facilities and partner organization, support for treatment adherence, provision of food packages and hygiene products. The Ukrainian government developed and approved standards for social service delivery. Financial support schemes were tested to insure continuous provision of social services. In 2011 46,000 clients (36% out of all registered patients) received a comprehensive package of services. Ukraine aims to scale up access to services and reach 80% of clients.

Mentor support program

Experts and program clients provided good feedback on the peer mentoring program piloted by the ICF “International HIV/AIDS Alliance in Ukraine” in partnership with in the Odessa city “Partner” CSO in 2010. Four more organizations initiated mentor program implementation in 2011. The program was adapted to Ukrainian needs based on the Metro Safe project, developed and implemented by the London based charity Metro Centre (UK).

The mentor and mentee meet during 4-5 months in the framework of the mentor support program to establish continuous one on one contact; the program is designed to raise HIV awareness among MSM, alter sexual practices, change attitude to HIV infection and health in general. Under the program a mentor meets one mentee once every two weeks at any time convenient to work for 2-3 hour on ten clearly structured modules:

“Module 0: Introduction”
“Module 1: Basic awareness of safer sexual practices”
“Module 2: Share your story”
“Module 3: Self-esteem”
“Module 4: Drug and alcohol use”
“Module 5: Being gay”
“Module 6: Partnership”
“Module 7: Facing the problem”
“Module 8: Social role and responsibility/Imagining the worst”
“Module 9: Goal setting”

Changes in behaviour, skill, awareness and attitude towards one’s health is tracked down in four stages using the BASK questionnaire (i.e., Behaviour, Attitude, Skills and Knowledge) in the framework of the Module 0, 5 and 9 and also six months upon the program completion.

Evaluation of the mentor support program showed that it presents clearly defined data on HIV, STI, and ways of transmission of infection, prevention and treatment. Also the program strengthens community development by investigating key problems faced by the community. The program directly engages volunteers and helps develop the NGO’s volunteer movement, and what is more important by utilizing a one on one approach it is possible to measure the program impact on each client which makes the project unique compared to the current prevention programs running in Ukraine.

Questionnaire result obtained at different stages of project implementation show substantial changes in behaviour, attitude, skills and knowledge of mentees. Clients of the Kyiv city "Gay Alliance" NGO raised the average level of attitude, skills and knowledge from 55.7% to 93.6%. Lesser, but nevertheless vital changes were registered in the Network's clients in Kryvyi Rig: from 79.9% to 89.2%. During the fourth survey the mentees were offered to take a rapid HIV test. All 22 clients engaged in two mentor programs agreed to take the test. None of the clients tested positive for HIV which is a key achievement of the program.

Feedback from program participants:

Mentors:
"I review the modules not just with the mentees, but friends. Because having clear knowledge on the subject makes their life safer."
"It was important for me convince the client to practice protected sex. I think I managed to succeed."

Mentee: "The trainings helped me understand why I do what I do and how important it is to have safer behaviour practices and take personal responsibility."

Currently there are plans to implement the program in all of Ukraine's regions.

HIV prevention in commercial sex workers using the peer driven intervention model

In 2010 the ICF "International HIV/AIDS Alliance in Ukraine" piloted a "Peer Driven Intervention" project on HIV prevention in commercial sex workers. The model was developed by US sociologists in 1980 and proved its efficiency in reaching injection drug users (IDUs).

Prevention work using the model aims to:
Reach new groups of CSWs;
Study the group's characteristics;
Get information on CSW's needs in particular services;
Analyze behaviour patterns of the target group using the model's research component;
Raise HIV awareness in reached CSWs and provide quality services on HIV/STI counselling and testing.

The program was successfully realized by the Alliance Ukraine implementing partners in Kyiv and Simferopol, and in 2011 the program was scaled up to seven more regional projects. Projects were launched in March 2011. Implementing NGOs in Kyiv, Kirovograd, Kharkiv, Sebastopol, Rivne, Poltava, Nikopol provided prevention services, quality education, information materials and HIV and STI testing for CSWs. Projects were completed in September 2011. The activities reached 2,701 women engaged in sex work. In January 2012 five new PDI projects "Peer Driven Interventions: Secondary Coverage" were launched for implementation in the current program year.

The project helped local NGOs to reach new sub-populations of CSW, including sex workers working from apartments and other hard to reach places; girls aged 14-18; and also sex workers working through the Internet. More than half of project clients were under 25 – this sub-population is most vulnerable to HIV and STI. Other project manages to engage CSWs as volunteers to disseminate prevention information within their social circle and recruit new clients.

Feedback from one of the project clients:

Has the project changed me? – I think it did. I reviewed my priorities and attitude to my sex life, I became more careful in my sex life, always use protection, I try to find out beforehand who the client is, I reviewed by attitude towards men. It is very useful to have a talk one on one and get education, after

that you want to reach new highs, rise from your rock bottom; you grow aware of the consequences. You start thinking about what you tried to ignore, even though you realized that it was there.

Project client (Poltava)

Developing gender sensitive approaches towards HIV prevention in women who use drugs

In 2011 with support from the US Agency for International Development (USAID) five NGOs launched a pilot project “HIV Prevention in Women IDU”.

The project aims to introduce effective harm reduction methods for women who use injection drugs and improve their life according to their personal standards. The project focused on gender roles and gender socialisation processes within the culture of drug use and in society in general without promoting gender stereotypes and in particular gender stereotypes associated with women IDUs. The project supported trainings on gender issues which remain new territory for most Ukrainians, promoting awareness on gender issues among service delivering organizations, which helped correct working techniques employed by NGOs and as a result improve service delivery to women IDU.

The project supported activities to scale up access to harm reduction programs for women. Activities aimed to satisfy the women’s need in harm reduction related to drug abuse and alleviate barriers to HIV prevention and other services. All project components were designed to be acceptable to women from a practical and emotional point of view and delivered in a respectful and sensitive manner.

Project components:

1. Combination of structured education activities, namely weekly peer to peer activities with volunteers, monthly trainings and support for peer to peer volunteers; secondary exchange of syringes;
2. Short term child care;
3. Case management for women IDUs;
4. Supporting safe emotional and physical environment;
5. Changing policies in service delivery to women IDUs.

Improved quality of service delivery resulted in growing number of visits from women IDUs, better awareness, and higher motivation to engage in safer drug use and sexual practices. In regard to the positive impact of gender sensitive programs, NGO staff mostly sited increasing numbers of women clients and visits from women clients. NGO staff also mentioned improved trust relations between the organization and women clients, better understanding of the clients’ needs, women clients demonstrated more demand for services, the number of gender sensitive services increased (e.g., a special day for visits from women, outreach rout designed to cater for women’s needs), better understanding of gender sensitive approach by the organization’s staff, improved quality and quantity of counselling sessions and services delivered by the NGO.

Adoption of HIV positive children: breaking the stereotypes

Each year in Ukraine 11% of HIV positive mothers give up their new-borns for adoption; each year around 500 HIV positive infants enter state run orphanages. These children have limited access to care and support, poor adherence to HAART, inadequate sexual education and much lower chances of being adopted into a loving family compared to HIV negative children.

Activities supported by the All Ukrainian PLHA Network in the framework of the Children Plus project help provide continuous support to HIV positive children in state run orphanages in nine regions of Ukraine; also project provides a new scheme for placing HIV positive children into families. Activities include finding and training potential adopted parents willing to adopt HIV, working with the child before s/he enters an adopted family and providing comprehensive social support.

The project focuses on supporting close cooperation and coordinating referrals between government agencies (e.g., Service for Adoption and Care for Children, Centers for Social Services for Family, Children and Youth) legally responsible at national and regional level for placing children into adopted families. Experts analyzed factors determining adoption of HIV positive children; developed a general sociological profile of adopted parents; studied basic profiles of HIV positive children; analyzed the motives of adopted parents and key problems which adopted families and parents face in the first six months of adoption.

Educating and training of the government agencies staff, including seminars, field visits and individual interviews helped encourage tolerant attitude towards HIV positive children, break stereotypes associated with these children and finally provide them with a right to a loving family. As a result of project activities random adoptions turned into a system and 106 children found a new home. Results of the "Children Plus" project may be extended to other countries in Eastern Europe.

Community mobilization to strengthen antiretroviral therapy provision at national level

In the last decade Ukraine significantly progressed in ART provision. About 83% of ART is provided with support from the state budget, other patients are treated with financing from the Global Fund. Unfortunately the state does not fulfil its obligations in regard to ART provision. For several years the National AIDS Program was underfinanced by 50%.

The All Ukrainian PLHA Network in cooperation with the State Service for HIV/AIDS and other stakeholders joined advocacy efforts to correct the situation. The organizations collected data on stock outs from around Ukraine, forwarded letters of concern to regional and national government agencies and raised the issue at meetings with officials at different levels. These activities culminated in a national campaign "Help to Survive". Campaign aimed to secure full financing of ART programs in 2012, as vital component of the National AIDS Program. The information and advocacy campaign was launched with a press conference, following the press conference campaign organizers sent 2,000 post cards to high ranking officials, including the President of Ukraine, MPs, ministers, ambassadors, heads of international organizations and missions. The post cards were signed by children asking for help to them and their families to get vitally important treatment. The campaign was highly popular with the media. As a result of advocacy efforts the President of Ukraine instructed the Prime Minister to insure full financing of medicine procurements for HIV positive patients in the framework of the 2012 budget. To support the President's decision the PLHA Network placed bill board signs with an appeal to the members of parliament to insure financing of the National AIDS Program in the 2012 budget. As a result the 2012 budget allocated 64% more funds for antiretrovirals compared to 2011. This will help reach 80% more patients. Advocacy campaigning proves that the voice of patients can be heard by the President and Parliament and community can influence decision making at the highest echelons of power.

Monitoring and Evaluation: National M&E Plan

Project "Best Practices in Integrated Care Provision to IDUs"

Provision of integrated care for patients with double or triple diagnosis (e.g., HIV/drug abuse and HIV/drug abuse/TB) remains priority direction for the National AIDS Program (2009-2013). Gained experience in running sites with integrated care provision called for scale up of sites. The Clinton Foundation with financial support from the WHO Country Office in Ukraine in cooperation with a charity "Public Health" (Kryvyi Rig) launched in 2010 a project on experience exchange in integrated care provision for IDUs. The project runs at the municipal Psychiatric and Neurological Dispensary in the Kryvyi Rig City and receives visits from members of multidisciplinary teams from all over Ukraine.

The basic program for visits included two working days and could be modified depending on the needs and requests of the participants. Members of multidisciplinary teams could directly participate in sites practical activities (e.g., administer and register medicines, make records, communicate with the patients, review interesting cases); they also could communicate with the members of the local multidisciplinary team who made presentations about their work and participated in discussions.

From November 2010 till July 2011 sixteen medical doctors, 11 medical nurses, 11 social worker and three psychologists (in total 41 staff) working in Narcology Dispensaries, Psychic and TB Dispensaries, AIDS Centers, city and central regional hospitals and policlinics in 21 regions of Ukraine underwent training.

Key modules focused on the following issues:

Organizing operations of the center for integrated care at a health facility and inter-departmental cooperation (e.g., planning activities, indicators, staff support and so on);

Functions of the Narcology Doctor (e.g., patients' visits, dosing, standard situations, open hours, working with accounting and reporting forms and so on);

Functions of the Infections Doctor (e.g., ART prescription, CD4 tests, viral load tests, determining the need for treatment);

Functions of the TB Doctor (e.g., detecting TB cases in SMT program clients, medical support, provision of substitution therapy at the TB Dispensary);

The role of the psychologist: provision of counselling services and psychotherapy;

The role of the social worker: evaluation of patients' social needs, support of services provision, keeping records;

IT manager: presentation of data base for service delivery, protection of personal data;

Functional role of the NGO in coordinating operations of the center for integrated care;

At the integrated care center the team of visiting specialists was especially impressed by the methadone administration system, involving two medical nurses. The system helps to speed up the process of methadone administration, insures improved control over consumption of medicines and reduces inaccuracies in keeping records.

The team of visiting specialists highly marked the system of continuous treatment provision during hospitalization of SMT clients to other health facilities, including clearing methadone delivery issues, directly supplied by the Pharmacia Pharmacy.

The team discussed practices of methadone dosing and providing support to difficult patients who abuse alcohol and stimulants. Most specialists agree that such patients should not be dismissed from the program but require extra services and attention (e.g., counselling, hospitalization and so on).

In June 2011 the program for experience exchange was presented at the National SMT Conference. Feedback from project participants heightened the interest in the exchange program and the number of specialists interested in studying the center's operations, especially experts from western and central Ukraine who previously did not engage in the exchange program.

SECTION V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

Ukraine is experiencing the most severe HIV epidemic in Eastern Europe and the CIS countries. The current status of the epidemic is associated with wide spread of HIV among various populations, first of all populations most at risk of infection; uneven spread of HIV infection in different regions of the country; a shift in dominant routs of HIV transmission; HIV affects mainly population of the working age. HIV epidemic in Ukraine currently may be defined as concentrated.

HIV prevalence rates and AIDS related mortality continue to grow each year. However, first signs of reduction in the epidemic's development had been detected, epidemic tends to stabilize, and fewer new HIV infection cases are registered in IDUs resulting in reduction in scale of the HIV epidemic.

Currently Ukraine has sufficient human, financial and technical resources to support effective programs on prevention, treatment, care and support to curb HIV. Prevention of mother to child transmission of HIV and insuring safety of donor blood serve as examples of successful program implementation.

It is vital to have political support, control over implementation of legislation designed to protect human rights especially in populations most at risk of HIV. New wording of the ADIS Law adopted in December 2010 is expected to provide such legislative support. The Law operates within traditions of international legislation and regulates activities in prevention, treatment, care and support required to promote effective measures to curb HIV infection and provide social and legal protection of people living with HIV infection.

Active civil society involvement remains another essential component of success. In the framework of implementation of the Grant provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria grant, the All-Ukrainian Network of People Living with HIV/AIDS and ICF "International HIV/AIDS Alliance in Ukraine" in cooperation with over 150 grantee NGOs from 2007 till now provide prevention, care and support services to vulnerable populations in Ukraine, which insured the country's eligibility for Round 10 GF Grant.

Until now most prevention interventions in populations most at risk of HIV were supported by international donor organizations and implemented by civil society and some faith based organizations, practically without control or support from the government. However, quality and scale of priority interventions improved. Domestic teams of experts developed basic packages of prevention services for populations most at risk of HIV infection based on WHO recommendations. The package includes distribution of sterile syringes, information materials, pre-test counselling for HIV infection, including with rapid tests, distribution of condoms, STI treatment, referral services to other medical and non-medical facilities depending on the need. These services are currently available in all 27 administrative regions of Ukraine. It is evident that prevention intervention in injection drug users, who remain most at risk of HIV in Ukraine, resulted in lower infection rates in the country.

Voluntary counselling and testing for HIV is the most developed component of national activities to curb AIDS. VCT continues to reach with services growing numbers of populations, however there are variations in reaching MARPs and efforts to reach vulnerable populations remain inadequate.

Under the 2010 MoH Decree the Ukrainian Center to Control and Prevent AIDS starting from 01.01.2011 collects data on counselling and testing for HIV infection.

Data analysis for 2011 shows following trends: obstetrics-gynaecology services provided most pre-test counselling services (32.6%), other health facilities (e.g., region and city hospitals, multi-functional clinics, Sanitary and Epidemiological Services etc.) provided 24.7% of pre-test counselling services, Blood Transfusion Services (24.0%) and AIDS Services (21.4%). Data demonstrates that most tests are performed in pregnant women and donors of blood, organs, biological materials, cells, and body fluids, i.e., within the general population.

For the first time since implementation of VCT Ukraine supported evaluation of delivery of counselling and testing services. Data suggests that in three years of implementation of programs on strengthening VCT strategy and standardizing laboratory testing for 2009-2013 (2009 MoH Decree) the projects failed to reach with VCT services a 60% coverage rate of populations most at risk of HIV. Risk populations remain uncovered by the specialized services (e.g., Narcology, Tuberculosis and STI facilities), State Penitentiary Service of Ukraine, Centers for Social Services for Family, Children and Youth and NGOs.

Despite the fact that VCT provision employs a developed infrastructure of facilities, especially in big cities of Ukraine, coverage with VCT services remains insufficient. It should be stressed that only AIDS Centers provide continuous quality VCT services to all populations, including people from most at risk populations.

To support implementation of the National Program to Insure Prevention of HIV Infection, Treatment, Care and Support for HIV Infected Persons and AIDS Patients in 2009-2013 (Law of Ukraine # 1026-IV, dd. 19.02.2009) in regard to scaling up access to free of charge HIV testing for different populations the Ukrainian AIDS Center of MoH of Ukraine monitors scale up of Anonymous Testing Sites (i.e., Dovira Offices) at the city district level.

As of 01.01.2012 the number of health facilities providing VCT services as defined by the decrees of health departments under regional state administrations totals 761 facilities, including 49 facilities in the framework of regional and city AIDS Centers and 712 other facilities which provide counselling and testing services for HIV infection.

As of 01.01.2012 26,720 patients receive ART, including with support from the state budget – 22,216 patients (83.1%). Also in penitentiary facilities 822 patients receive ART with support from the Round 6 GF financed program. In total 27,542 patients receive antiretrovirals in Ukraine.

Despite the fact that injecting drug users remain the driving force behind the epidemic in Ukraine, the proportion of IDUs on ART is only 8,3% (the indicator does not include patients on ART and substitution maintenance therapy). Low proportion of active drug users within the number of officially registered HIV patients in need of ARV (10.3%, or 1,187 patients) indicates that this population has limited access not just to antiretroviral therapy but also to health care services in general.

As of 01.01.2012 a total of 38,230 patients are in need of ART. 11,510 patients including 138 children are eligible for antiretroviral therapy but do not receive treatment (statistics include only those patients who are in HIV care and registered in the System for Treatment Monitoring).

Treatment of HIV patients employs comprehensive schemes, including various medical, non-medical and psychological services. In 2011 8,740 patients were treated for opportunistic infection and HIV related diseases with medicines procured with support from the World Bank loan and GF Round 6 Grant.

With aim to scaling up access to antiretroviral therapy for HIV infected patients at the city district level the Ukrainian AIDS Center insures organizational and technical support for health facilities to decentralize ART provision. Currently ART is available at 125 regional level health facilities and two health facilities at the national level.

The All-Ukrainian Network of People Living with HIV/AIDS[29], William J. Clinton Foundation and AIDS Healthcare Foundation[30] provided support to the city district Anonymous Testing Sites (i.e., Dovira

[29] In the framework of Program "Support for HIV and AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine" supported by the Global Fund Round 6.

Offices) to deliver quality medical services on ART at the Autonomous Republic of Crimea, Vinnitsa region, Dnepropetrovsk region, Donetsk region, Ivano-Frankivsk region, Mykolayiv region, Poltava region, Odessa region, Lugansk region, Kherson region, Khmelnitsky region and the city of Kyiv.

As of 01.01.2012 70,093 HIV infected patients received palliative care in health facilities (56,616 patients at AIDS Centers and 13,477 at other health care facilities), including 2,066 HIV patients who received hospice care (1,292 at AIDS Centers and 774 at other health care facilities).

AIDS Centers in 12 regions have 370 in-patient beds, including 21 beds for children (in 5 AIDS Centers) and 70 hospice beds (in 10 AIDS Centers).

Considering high likelihood of stigmatization of vulnerable populations within the general health care system and unwillingness of at risk populations to seek medical help, lack of in-patient beds in all regional AIDS centers significantly limits access to in-patient specialized medical care, including hospice care for HIV patients.

[30] In the framework of project “Scaling Up Access to Treatment by Providing ARV Therapy at Anonymous Testing Sites (i.e. Dovira Offices)”

SECTION VII. MONITORING AND EVALUATION ENVIRONMENT

(a) An overview of the current monitoring and evaluation (M&E)

Ukraine has achieved significant progress in demonstration of certain signs of establishment and development of one M&E system to monitor the national response to HIV epidemic (SS M&E) However, ensuring its real content and making it fully functional still remain a task for the future.

One of the best developed components of SS M&E is the system of routine epidemiological surveillance that provides data to monitor the trends of epidemic process development. This system is almost fully funded from the state budget and uses the operational standards that were developed long before the beginning of HIV epidemic in Ukraine.

Another well-established source of data for M&E is the program monitoring of NGO activities, in particular related to the implementation of the program financed through the Global Fund grant, as well as biobehavioral, economic and other studies and evaluations. These components of the M&E system apply up-to-date methodological approaches and tools and the results of this activity organically complement the data of routine sero-epidemiological monitoring. However, the data collected with the use of such methods are often not trusted by the government officials, who give their preference to official statistics. Considering such attitude of decision-makers and the fact that these activities are funded from international sources, its sustainability and further development is rather unlikely in view of reduction of such funding in the long run.

Challenges to the development of SS M&E are not specific to the system of M&E of HIV epidemic and response activities, but they rather characterize the management culture and traditions in the country in general. Despite all these difficulties, in 2010-2011 certain positive developments occurred in the area of M&E.

Key achievements in this period included:

Approval of two legal and regulatory documents on the development of the SS M&E:

Resolution of the Cabinet of Ministers of Ukraine No. 1349 'On the Single System of Monitoring and Evaluation of the Effectiveness of Measures Aimed at Preventing the HIV Epidemic Spread' as of December 28, 2011, which, in particular, approved the Provisions on the Single System of Monitoring and Evaluation of the Effectiveness of Measures Aimed at Preventing the HIV Epidemic Spread (Provisions on SS M&E);

Order of the MoH of Ukraine No. 97 'On Approval of the National Plan for Monitoring and Evaluation of the Implementation of the National Program for Prevention, Treatment, Care and Support for HIV-infected People and AIDS Patients for 2009-2013'.

Existence of these documents opens the prospects for further development of SS M&E, especially on the subnational level. Provisions on SS M&E provide definitions of key terms and establish areas of responsibilities for the key players in the public sector in the area of M&E. The National M&E Plan provides a framework of indicators for monitoring of national epidemic response and is a 'role model' to develop subnational M&E plans. It is envisaged that the National M&E plan will be developed separately for each next national targeted program in the area of HIV and will ensure feedback in the system of management of such programs.

The development of regional M&E systems within the National Program implemented with the Global Fund financial support provided in Round 6:

M&E divisions have been included in the organizational structure of 27 regional AIDS Centers, and in 21 centers they have at least one full-time M&E position;

Employees of M&E centers were trained at the workshops and training seminars on M&E and today have a significant intellectual capacity to ensure further development of the subnational M&E systems.

Implementation of a pilot research to evaluate expenses with the use of the national methodology that meets international standards in this area:

the research was conducted on the national and subnational levels with the involvement of the public, civil society and international institutions;

The research results can be used as an entry point for other studies, in particular, for the evaluation of economic efficiency and evaluation of impact of individual programs and projects on the epidemic.

(b) Challenges faced in the implementation of a comprehensive M&E system

In general the SS M&E development is characterized with individual initiatives and successes on the national and regional levels, but there is still the lack of a comprehensive approach and understanding of the essence and content of M&E as the instrument for public governance.

One of the recommendations of the Comprehensive External Evaluation of the National Response to the HIV/AIDS Epidemic in Ukraine in 2008 was to create the National M&E Unit as an extremely important component to ensure future progress in the establishment of the SS M&E. In the end of 2009 the Ukrainian Center for Monitoring and Evaluation of Implementation of Program Activities in Response to HIV/AIDS Epidemic (UC M&E) was established as a structural division of the Ukrainian AIDS Prevention Center. It has the responsibilities to ensure organizational and methodological support and coordination to the processes of M&E data collection, analysis and presentation. However, UC M&E is not an independent organizational unit and cannot coordinate M&E development activities because it does not have respective authorities needed to convey all information flows into the single M&E system. So, the issue of ensuring coordination of all national efforts in the area of M&E of HIV epidemic response in the country still remains relevant.

Development of "M&E culture" as a program cycle component and instrument of the state policy is still mostly dependent on the influence of external factors, such as:

а) national commitments of Ukraine related to regular reporting by the indicators of achieved targets envisaged in the UN declarations and other international documents;

б) Financing within the Global Fund programs (Rounds 1, 6 and 10) on the basis of their efficacy and a related need to demonstrate the results related to the achievement of targets.

In spite of the fact that these external factors still stimulated the creation and development of certain mechanisms of M&E, they were mostly oriented towards compliance with the external requirements to reporting, and not towards meeting the internal information needs. Focus on data collection with the aim to prepare reports that is dominating in the administrative and command paradigm of public governance, often results in the formalization of the process, concentration of attention on the activity and output indicators, resulting in the increased paper work and production of data that will be obviously unfit for use in order to improve the policies and programs.

So, internal information needs of the country are still waiting for their clear articulation by service providers and decision makers. Such articulation of interests, in particular by public sector, can become a real impetus for the development of SS M&E.

A long-term existence of M&E practice that is independent in relation to actual information needs created a situation, in which a great amount of the accumulated data remains unused, and the lack of coordination of research activities in the sphere of HIV leads to the duplication of their directions, goals and obtained results.

However even if there is a need to use these data, often it is rather problematic in spite of the fact that individual databases were established at different levels and in different sectors. One of still relevant recommendations of the Comprehensive External Evaluation of 2008 is to create the national database of the M&E of HIV infection and epidemic response activities, which would contain key data about the epidemic, the national and regional response activities, results of ad-hoc research, etc.

So, the key obstacle to the full introduction of the SS M&E is:

Lack of internal public demand to the provision of information to be used in public governance in order to improve policies and programs, to ensure the efficiency of use of financial resources, to achieve the declared goals related to the commitment on epidemic response.

Other barriers to the development of SS M&E are just the consequences:

de-jure existence of the single coordination structure on M&E and its de-facto inability to perform coordinating functions;

practically complete lack of state funding of M&E activities;

imperfect legal and normative acts that regulate the M&E activities;

Lack of knowledge management strategy and a complicated access to the accumulated data.

(c) Remedial actions planned to overcome the challenges

An expected reduction of the external funding amounts increases the actual need to review the strategies and policies for the organization of HIV epidemic response in Ukraine. Under conditions of limited resources and growing needs the need to correctly identify priorities and channel resources to the activities that can potentially lead to the largest impact on epidemic process becomes ever more pressing. As a consequence, a breakthrough of vision can happen and the demand for quality data to ensure the result oriented management will be clearly articulated on the government level.

In such conditions further development of the SS M&E becomes possible, and, in particular, will include:

coordination of activities of all partners in the area of M&E on the basis of consolidated national M&E plan that meets the real information needs of the country and takes into account the external obligations of the country related to international reporting;

review of authorities and responsibilities of the national M&E unit, legal and normative formalization of its status, as well as respective steps to create M&E units at the subnational level;

development and introduction of the guiding documents in the area of M&E of HIV epidemic response including: knowledge management policy, national agenda of HIV research, methodological guidelines and protocols for research and evaluation, etc.;

Development and governmental support of a certified course on M&E, further development of human capacity oriented to the improvement of capacity of M&E specialists to create information products of an adequate quality to meet the information needs for the organization of efficient response to HIV epidemic in Ukraine.

(d) Highlight, where relevant, the need for M&E technical assistance and capacity-building

A significant share of capacity development needs is beyond the system of M&E *per se* and is related to the general conditions in which this system is functioning. These conditions include a morally out-dated management system that is based on the command and control approach and does not envisage existence of M&E as its integral component. Another example is the common practice of planning oriented at the process, which is also far from the principles of M&E and results oriented management.

The existing M&E system has the following key technical support needs:

development of strategic documents, in particular, M&E and knowledge management policies;

implementation of a comprehensive mapping of existing information flows in the area of HIV epidemic response in Ukraine and conducting the analysis of the information exchange system in order to identify duplication or gaps in this system;

development of a concept of electronic medial registry in the area of HIV;

development of a concept of external information policy of Ukrainian AIDS Center, in particular, the concept and terms of reference for the creation and functioning of the national information portal on the issues of HIV infection and epidemic response activities;

Development of a comprehensive, multi-module training course on M&E and provision of support for its implementation.

ANNEX 1 CONSULTATION/PREPARATION PROCESS FOR THE COUNTRY PROGRESS REPORT ON MONITORING THE FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS

1)	Which institutions/agencies made an input into completing indicator forms?	
	National Council on Combatting Tuberculosis, HIV infection/AIDS and Other Socially Hazardous Diseases under the Ministry of Health of Ukraine	No
	b) State Service of Ukraine on Combatting HIV-infection/AIDS and Other Socially Hazardous Diseases	Yes
	c) Ukrainian Center for Prevention and Control of AIDS under the Ministry of Health of Ukraine	Yes
	d) ICF “International HIV/AIDS Alliance in Ukraine”	Yes
2)	With inputs from the central agencies of executive power:	
	Ministry of Health of Ukraine	Yes
	Ministry for Education and Science, Youth and Sports of Ukraine	Yes
	Ministry of Foreign Affairs of Ukraine	Yes
	State Penitentiary Service of Ukraine	Yes
	Civil society organizations:	
	AUCO “All-Ukrainian Network of People Living with HIV/AIDS”	Yes
	ICF “International HIV/AIDS Alliance in Ukraine”	Yes
	Private: Futures Group International	Yes
	UN family organizations	Yes
	Bi-lateral organizations: USAID	Yes
	Other:	
	Crimean Republican “Center for Prevention and Control of AIDS”, Regional Centers to Control and Prevent AIDS, Kyiv City Center to Control and Prevent AIDS, Municipal Agency “Odessa City Center to Control and Prevent AIDS”	Yes
3)	Was the report reviewed in a large scale discussion forum?	Yes
4)	Are the research results stored centrally?	Yes
5)	Is the data available for open discussion?	Yes
6)	Responsible for submission of the National Report and follow-up:	

Name/Title: Database manager Yevgeniy Shyder
Data: March 31, 2012

Signature:

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ANNEX 2: NATIONAL COMMITMENTS AND POLICY INSTRUMENT (PART A)

NCPI Respondents

[Indicate information for **all** whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]

NCPI - PART A *[to be administered to government officials]*

Organization Names/Positions	Organization Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]					
		A.I	A.II	A.III	A.IV	A.V	A.VI
State Service of Ukraine on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases	Tetiana Alexandrina, Head	+	+	+	+	+	+
State Service of Ukraine on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases	Olena Yeschenko, Deputy Head	+	+	+	+	+	+
State Service of Ukraine on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases	Maryna Zelenska, HIV/AIDS Counteraction Office Chief	+	+	+	+	+	+
Ministry of Education and Science, Youth and Sports	Svitlana Fitsaylo, Main Specialist at the General and Pre-school Education Office	+	+		+		
Ministry of Social Policy	Victoriya Sanovska, Social Services Office Deputy Chief - Social Technologies Implementation and Social Work Section Head	+	+	+	+		
State Service for Youth and Sports	Igor Khohych, Youth Policy and Communications Department Director	+	+		+		
State Penitentiary Service	Anatoliy Kryvoruk, Treatment and Prevention Work Section Head at the Healthcare, Medical and Sanitary Assistance Office	+	+		+	+	
SE "Ukrainian AIDS Center of the MoH of Ukraine"	Nataliya Nizova, Director	+	+		+	+	+
SE "Ukrainian AIDS Center of the MoH of Ukraine"	Alla Scherbinska, Deputy Director	+	+			+	
SE "Ukrainian AIDS Center of the MoH of Ukraine"	Olexandr Zhyginas, acting Head of Ukrainian Center for Monitoring and Evaluation of Programme Performance Measures against HIV-infection	+	+		+		+

Add details for all respondents.

NCPI - PART B *[to be administered to civil society organizations, bilateral agencies, and UN organizations]*

Organization Names/Positions	Organization Names/Positions	Respondents to Part B [indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	B.V
Bulah Lada	Kyiv city branch of the All-Ukrainian Charitable Organization "All-Ukrainian Network of People Living with HIV/AIDS", Executive director	+	+	+	+	+
German Olena	Mykolayiv regional civil youth movement "Penitentiary initiative", Director	+	+	+	+	+
Dovbakh Anna	ICF "International HIV/AIDS Alliance in Ukraine", Associate Director: policy and partnership	+	+	+	+	+
Kudelia Denys	ICF "Vertikal", President	+	+	+	+	+
Kurpita Volodymyr	AUCO "All-Ukrainian Network of People Living with HIV/AIDS", Executive Director	+	+	+	+	+
Stefanishyna Olga	CF " Advisory Community Council on Issues of Access to Treatment in Ukraine" (UCAB), *Executive Director*	+	+	+	+	+
Stryzhak Olena	Cherkasy regional branch of the AUCO "All-Ukrainian Network of People Living with HIV/AIDS" , Head of the Board	+	+	+	+	+
Sultanov Mirzakhid	UN Office on Drugs and Crime, HIV/AIDS Advisor in Ukraine and Moldova	+	+	+	+	+
Tarasova Tetyana	UNICEF in Ukraine, HIV/AIDS Project Manager					+

Add details for all respondents.

[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

Yes	No

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

IF YES, what was the period covered *[write in]*: 2009-2013

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.
The National Program to Ensure Prevention, Treatment, Care and Support for Those Living with HIV and AIDS (hereinafter referred to as the "National Program") was passed by the Verkhovna Rada of Ukraine as a law for the period of 2009-2013. In pursuance of the National Program line ministries (in particular the Ministry of Education and Science, Youth and Sports, the State Penitentiary Service) developed sectoral programs and regional support programs for each oblast of Ukraine. There are the following major differences of the National Program, as compared to the previous five programs: higher status as the Law of Ukraine; larger funding from the state and local budgets; Greater number of National Program implementers and respective funding breakdown.

IF YES, complete questions 1.1 through 1.10; ***IF NO***, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[write in]*:

The state employer of the National Program is the Ministry of Health of Ukraine (hereinafter referred to as the "MoH") that ensures the overall coordination and control over its implementation.

The National Program implementers that have provisioned funding from the state budget are the State Penitentiary Service, the Academy of Medical Science of Ukraine, the Ministry of Education and Science, Youth and Sports, the National Academy of Sciences of Ukraine, the Ministry of Defence, and the Ministry of Social Policy.

At the regional level the National Program implementers are local state administrations that envision funding from the local budgets for its implementation.

Furthermore, the execution of various activities under the National Program is shared, without separate funding, between the Ukrainian State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases, the Ministry of Finance, the Ministry of economy, the Ministry of Justice, the Ministry of Internal Affairs, and other governmental authorities and institutions.

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military/Police	Yes[31]	No	Yes[32]	No
Transportation	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young People	Yes	No	Yes	No
Other [write in]:	Yes	No	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?
Activities under the National Program are funded from the Global Fund project (Rounds 6 and 10), other charitable programs, and international technical assistance projects in addition to the state and local budgets.

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes[33]	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes[34]	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[35] - persons detained at penal institutions; those unprisoned; waifs and homeless citizens, primarily children, including those from families in difficult life circumstances, etc.	Yes	No
SETTINGS		

[31] Among military personnel only.
[32] Among military personnel only, funded by the Ministry of Defense.
[33] The National Program objectives define migrants as one of the risk groups exposed to HIV, though without any special activities provisioned.
[34] Pregnant women.
[35] Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees)

Prisons	Yes	No
Schools	Yes	No
Workplace	Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the **country** [write in]**?**

KEY POPULATIONS
The key populations for primary HIV prevention are as follows: youth, in particular pupils, those employed, military personnel, population at large (those covered by mass-media and social advertisement); The key populations for prevention among representatives from high-risk groups are as follows: injecting drug users; persons detained at penal institutions; those unprisoned; commercial sex workers; migrants[36]; waifs and homeless people; children, including those from families in difficult life circumstances; Men having sex with men. The key populations for prevention among those living with HIV are as follows: HIV-positive pregnant women, birthing mothers and new-born babies; HIV-positive persons; Key populations for specific prevention activities: Blood donors; Persons who contacted biological liquids at risk of HIV.

1.5. Does the multisectoral strategy include an operational plan?

Yes	No

[36] The National Program mentions migrants as a target population in a pro forma manner, yet in fact no special prevention activities are provisioned.

1.6. Does the multisectoral strategy or operational plan include:

Formal programme goals?	Yes	No
Clear targets or milestones?	Yes	No
Detailed costs for each programmatic area?	Yes	No
An indication of funding sources to support programme implementation?	Yes	No
A monitoring and evaluation framework?	Yes	No

1.7. Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
(Both national and international) civil society organizations took a pro-active part in drafting the National Program and developing its activities, being represented in the working group elaborating the National Program, submitted written proposals with wide public consultations held. Also NGOs and charitable organizations were included into the National Program as co-implementers, in particular the principal beneficiaries under the Global Fund projects, i.e. the International HIV/AIDS Alliance in Ukraine and the All-Ukrainian Network of PLWH.

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No	N/A

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No	N/A

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A

2.1. IF YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
Sector-wide approach	Yes	No	N/A
Other [write in]:	Yes	No	N/A

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)		
HIV impact alleviation	Yes	No
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No
Reduction of stigma and discrimination	Yes	No
Treatment, care, and support (including social security or other schemes)	Yes	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No
Other[write in below]:	Yes	No

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No	N/A

The "Social and Economic Impact from HIV/AIDS in Ukraine" survey was jointly conducted by the World Bank and the Ministry of Health of Ukraine with the participation of the UN Joint Program on AIDS and the International HIV/AIDS Alliance in Ukraine. The survey assesses short- and mid-term (2004-

2014) impacts from HIV/AIDS and incorporates policy recommendations. The level of enforcement of the said recommendations was evaluated in the previous report (2010).

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	5

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc.)?

Yes	No

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?[37]

Yes	No

5.1. Have the national strategy and national HIV budget been revised accordingly?

Yes	No

5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of Current and Future Needs	Estimates of Current Needs Only	No

5.3. Is HIV programme coverage being monitored?

Yes	No

IF YES, is coverage monitored by sex (male, female)?

Yes	No

IF YES, is coverage monitored by population groups?

Yes	No

IF YES, for which population groups?
Age, gender
Briefly explain how this information is used:

[37] The Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, ref. no. A/RES/65/277 dated June 10, 2011.

This information is used for the purpose of planning the needs in services, in particular in treatment, for the purpose of budgeting and procuring antiretroviral medications to treat opportunistic infections.

Is coverage monitored by geographical area?

Yes	No

IF YES, at which geographical levels (provincial, district, other)?
Regional level. At the regional level the monitoring at the level of districts and cities is carried out.
Briefly explain how this information is used:
This information is used for the purpose of planning the needs in services and treatment, considering regional specifics, for the purpose of ensuring the availability of medications for treatment and laboratory diagnostics, and budgeting.

5.4. Has the country developed a plan to strengthen health systems?

Yes	No

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
In 2011 Ukraine launched another phase of the healthcare system reform[38], which provisions introducing new approaches in the healthcare sector, enforcing quality standards, changing the system of healthcare establishments funding by means of the healthcare services request. The said reform will have a positive impact on the healthcare sector and on the response to HIV/AIDS in particular.

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:

[38] The Law of Ukraine "On Amending the Ukraine's Law Fundamentals as to Improving Healthcare Services" and the Law of Ukraine "On the Procedure to Reform the Healthcare System in the Regions of Vinnitsya, Dnipropetrovsk and Donetsk, and in the City of Kyiv".

It can be stated that the Three Ones Principles are implemented in a consistent manner in Ukraine, i.e. there is one coordinating body (National TB and HIV/AIDS Council), one strategy (the National Program to Ensure Prevention, Treatment, Care and Support for Those Living with HIV and AIDS) and one monitoring and evaluation system (the Regulation was approved with the Cabinet of Ministers of Ukraine Resolution no. 1349 "On the Unified System to Monitor and Evaluate Activities Targeted at the HIV Epidemic Spread Prevention" dated December 28, 2011). The governmental and non-governmental sectors share the views concerning the challenge and the strategy of response to the HIV epidemic in Ukraine. In pursuance of the National Program, sectoral strategies by all the types of services and detailed by-region disbursement computations were elaborated. Drafting the National and Regional Operational Plans for 2011-2013 widely involved representatives from governmental authorities, healthcare establishments, social services and the public, which turned out to be an innovative approach to planning, enabled "bottom-upwards" problem determination and provided for the real engagement of service providers into the planning process. An important achievement is Ukraine's submission of an application for Round 10 of the Global Fund and winning the funding. The National Strategic Action Plan on HIV Prevention among Children and Youth from Most-at-risk and Vulnerable Populations and Care and Support for Children and Youth Affected by the Problem of HIV/AIDS" was developed. The National Strategy of Trilateral Cooperation in Response to HIV/AIDS in Labour for 2012-2017 is being drafted. Over the recent years the State has given greater priority to the treatment of PLWH. As a result, the epidemic incidence rates have reduced several times. Financial expenses made on arrangements in response to HIV/AIDS in 2009-2010 were assessed.
What challenges remain in this area:
The strategic planning process is on the right track, yet there is always some room for improvement. Delays in getting the final findings of the Comprehensive External Evaluation (they were provided in the middle of 2009 only), unfortunately, made it impossible to fully avail of its recommendations in the planning of the National Program (the latter was drafted in 2008 and approved in early 2009). The financial crisis doesn't allow for the necessary funding of all the areas within the response to HIV/AIDS, which results in the insufficient scope and magnitude of prevention programs, in particular among the population at large, in terms of increasing the level of awareness concerning HIV and forming safe behaviour. Given no funding by the State, prevention activities become possible only through attracting external funds, in particular under the Global Fund projects. The strategy on programs and services maintenance following the Global Fund financing completion has not been developed yet. There is a need to carry out the Comprehensive External Evaluation of the National Program performance.

Descriptive part to Section A1. Strategic Plan.

It can be stated that the Three Ones Principles are implemented in a consistent manner in Ukraine, i.e. there is one coordinating body (National Council on Counteraction to TB and HIV/AIDS), one strategy (the National Program to Ensure Prevention, Treatment, Care and Support for Those Living with HIV and AIDS) and one monitoring and evaluation system (the Regulation was approved with the Cabinet of Ministers of Ukraine Resolution no. 1349 "On the Unified System to Monitor and Evaluate Activities Targeted at the HIV Epidemic Spread Prevention" dated December 28, 2011).

In order to achieve effective performance under the selected strategy, the key implementers of the National Program elaborated sectoral strategies by all the types of services with detailed by-region disbursement computations, and oblast programs, taking into account regional specifics of the epidemics.

With a view of determining particular activities, needs in services and technical assistance, and determining the problem "bottom-upwards", each region of Ukraine developed its Regional Operational Plan for 2011-2013. The innovative approach to regional planning enabled actual involvement of social services providers and wide engagement of representatives from governmental authorities, healthcare establishments and the public.

The National Operational Plan became the foundation for Ukraine's application for Round 10 of the Global Fund to Fight AIDS, TB and Malaria. The application development involved representatives of all the stakeholders from the governmental and non-governmental sectors.

The governmental and non-governmental sectors share the views concerning the challenge and the strategy of the response to the HIV epidemic in Ukraine. Planning and joint decision-making on particular steps are ensured through open discussions and working groups. In general, cross-sectoral coordination is available through the National Coordination Council and respective regional councils.

One of the main challenges reported by the majority of respondents is that activities of the National Program are largely underfunded from the state budget. The financial crisis doesn't allow for the necessary funding of all the areas within the response to HIV/AIDS, which results in the insufficient scope and magnitude of prevention programs, in particular among the population at large.

Given no funding by the State, prevention activities become possible only through attracting external funds, in particular under the Global Fund projects.

Furthermore, developing the strategy on programs and services maintenance following the Global Fund financing completion remains to be an issue on the agenda.

All in all, according to experts' assessments, Ukraine's efforts in planning the strategy of the response to the HIV/AIDS epidemic in 2010-2011 tend to enhance.

Year	Score
2011	7
2009	6
2007	5
2005	4
2003	4

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?
Government ministers

Yes	No

Other high officials at sub-national level

Yes	No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

Yes	No

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
In the address to the UN General Assembly on June 08, 2011,[39] the President of Ukraine V.F. Yanukovych fully endorsed the new Getting to Zero UNAIDS 2011-2015 Strategy, the Global Zero Action Plan to prevent new infections among children by 2015 and keeping their mothers alive, and the new Political Declaration of the High-Level Meeting. In December 2010 the new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" was passed, which establishes more forward-looking and advanced conditions for introducing programs and services in response to HIV/AIDS. The support of the National TB and HIV/AIDS Council, officials from the Ministry of Health, the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases throughout the development and working-out of Ukraine's application to the Global Fund (Round 10) enabled attracting funds and proved the readiness and capacity of the Ukrainian AIDS Center to become the Principal Recipient under the Global Fund project. The President of Ukraine V.F. Yanukovych ordered the Prime-minister M.Ya. Azarov to allocate funds for the procurement of medications for HIV-positive people in full in 2011. The Head of the State also ordered the Government to account for HIV-positive people's needs in medications while drafting the State Budget for 2012 and take all the necessary measures to deliver medications to those in need. In 2010 central executive authorities underwent complete reforming. Subsequently, the majority of ministries, committees and services were liquidated or re-shuffled. Still, the response to HIV/AIDS is a high-level priority in Ukraine and, therefore, a dedicated governmental body, the State Service on

[39] http://www.president.gov.ua/news/20313.html

Counteraction to HIV/AIDS and Other Socially Dangerous Diseases, was established. Unlike the previous authority, the Committee, the State Service has a higher status, greater powers and a wider organizational chart. The Commission to Supervise the Preparation of Applications, Negotiations and Implementation of Programs Financed by the Global Fund to Fight AIDS, TB and Malaria was set up at the National TB and HIV/AIDS Council. The UNESCO Moscow Office Director Dendev Badarch expressed his gratitude to the minister of education and science, youth and sports Dmytro Tabachnyk for arranging and holding the international round-table on prevention awareness-raising and policies related to HIV in the education system (on November 10-11, 2011) which engaged representatives from international organizations and UN agencies, ministers of education from Central Asia and Eastern Europe countries, and the non-governmental sector. Within the framework of Ukraine's preparation to EURO-2012 large-scale information campaigns on prevention, in particular "Red Card", "Fair Play", "Give no Chance to AIDS", etc., are held. In general, the preparation to EURO-2012 involved a lot of athletes and famous persons into information campaigns on HIV prevention and tolerant attitude formation. The year 2012 was announced to be the year of sports and healthy lifestyle.[40]

2.1. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?

Yes	No

IF NO, briefly explain why not and how HIV programmes are being managed:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
IF YES, what is his/her name and position title? Rayisa Bogatyriova, Vice-prime-minister of Ukraine, Minister of Health of Ukraine		
Have a defined membership?	Yes	No
IF YES, how many members? 30		

[40] The Cabinet of Ministers of Ukraine Resolution no. 360-r "On Measures to Prepare and Hold in Ukraine the Year of Sports and Healthy Lifestyle in 2012" dated April 27, 2011.

Include civil society representatives?	Yes	No
IF YES, how many? 10		
Include people living with HIV?	Yes	No
IF YES, how many? 2		
Include the private sector?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes	No	N/A

IF YES, briefly describe the main achievements:
Representatives from international and non-governmental organizations are included as members of all the working groups established at the Ministry of Health of Ukraine and the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases and take an active part in their activities. The Public Council was established at the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases to study the public opinion, provide for wide discussions of resolutions and draft regulations. The implementation of the Global Fund Round 10 project in collaboration of three principal recipients from various sectors, namely the Ukrainian AIDS Center (governmental sector), the All-Ukrainian Network of PLWH and the International HIV/AIDS Alliance in Ukraine (non-governmental sector), is an example of tight cooperation. The Commission to Supervise the Development of Applications, Negotiations and Implementation of Programs Financed by the Global Fund to Fight AIDS, TB and Malaria was set up at the National TB and HIV/AIDS Council. There are representatives from international and non-governmental organizations among the Commission members. Experts from international and non-governmental organizations are engaged into the external assessment of state programs. Non-governmental organizations largely contribute to non-admission of services interruption, especially in case of antiretroviral therapy. Non-governmental organizations advocate, on a permanent basis, the reduction of prices on antiretroviral medications procured from the state budget. Tight cooperation between governmental bodies and non-governmental organizations has been created to implement prevention programs and to attract grant funds. There are qualitative advancements in partnerships at the regional level thanks to the activities of HIV/AIDS coordination councils. The culture and skills of HIV/AIDS monitoring and evaluation are well-developed among

international and non-governmental organizations owing to their experience from the implementation of numerous programs and projects.
What challenges remain in this area:
Although in general non-governmental partners stick to the general strategy, in some cases there is insufficient coordination of activities of international and non-governmental organizations, which leads to duplication in their activities at the operational level. Recently it happened that non-governmental organizations had greater opportunities to develop their capacities and acquire experience in the management of large programs and projects (e.g., the projects under Global Fund Rounds 1 and 6), compared to respective state-run institutions. As a consequence, there has been a certain staff drain from state-run institutions to non-governmental organizations, and it is difficult to reverse this trend. There is insufficient involvement of, and interaction with, private businesses. There are positive, yet rare, examples of cooperation (O. Pinchuk Foundation, R. Akhmetov Foundation) that provide important, though focused, assistance. There is a need to improve the mechanism of interaction between the governmental sector and non-governmental organizations at the local level in particular regions of Ukraine, and at the level of districts and towns. There are weak capacities of local non-governmental organizations, in particular at the level of small towns and rural areas. The mechanism of the social request for services of non-governmental organizations at expense of the state budget is yet to be introduced. Some state-run entities still fail to incorporate into their operations positive experience and best international practices offered by international and non-governmental organizations, in particular in terms of monitoring.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

0%

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other	Yes	No

supplies		
Technical guidance (through activities of program and regional committees)	Yes	No
Other [write in below]:	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?

Yes	No

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

Yes	No

IF YES, name and describe how the policies / laws were amended
In December 2010 the Verkhovna Rada of Ukraine passed the new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV".
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
In order to ensure the full-fledged functioning of the new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV", one has to bring by-law regulations to compliance with it. This process requires certain time and experts' involvement. In order to exempt from taxation procurements under the Global Fund project, the relevant draft Law of Ukraine was developed (to be considered in 2012).

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:

In the address to the UN General Assembly on June 08, 2011,[41] the President of Ukraine V.F. Yanukovych fully endorsed the new Getting to Zero UNAIDS 2011-2015 Strategy, the Global Zero Action Plan to prevent new infections among children by 2015 and keeping their mothers alive, and the new Political Declaration of the High Level Meeting.

In December 2010 the new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" was passed, which establishes more forward-looking and advanced conditions for introducing programs and services in response to HIV/AIDS.

The support of the National TB and HIV/AIDS Council, officials from the Ministry of Health, the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases throughout the development and working-out of Ukraine's application to the Global Fund (Round 10) enabled attracting funds and proved the readiness and capacity of the Ukrainian AIDS Center to become the Principal Recipient under the Global Fund project.
The President of Ukraine V.F. Yanukovych ordered the Prime-minister M.Ya. Azarov to allocate funds for the procurement of medications for HIV-positive people in full in 2011. The Head of the State also ordered the Government to account for HIV-positive people's needs in medications while drafting the State Budget for 2012 and take all the necessary measures to deliver medications to those in need.
At the backcloth of harshly limited resources the State has clearly defined priorities for funding from the state budget: HIV diagnostics, ART, mother-to-child transmission prevention, post-contact prevention.

A great achievement against the background of the economic crisis was procuring ART medications from the state budget. In 2012 the state budget provisions 305 mln. UAH for the response to HIV/AIDS or almost 90 mln. UAH more than in 2011.

Recent biddings for ART medications procurement from the state budget resulted in the procurement of medications at prices reduced by 25%. In 2012 these savings will allow the state budget to provide necessary medications to more than 5,000 extra HIV-positive people. In addition, medications will be procured under Global Fund Round 6. Thus, more than 13,000 extra patients will be reached with treatment. As of the end of 2011, ART medications were received by approximately 25,000 people.

Ukraine proves its utmost commitment to substitution maintenance therapy programs and has the most advanced legal framework in this realm, as compared to other CIS countries. In December 2010 the new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" was passed. According to it, one of the state guarantees established by it is the use of substitution maintenance therapy with a view of preventing HIV among drug users.

In 2010 central executive authorities underwent complete reforming.[42] Subsequently, the majority of ministries, committees and services were liquidated or re-shuffled. Still, the response to HIV/AIDS is a high-level priority in Ukraine and, therefore, a dedicated governmental body, the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases, was established. Unlike the previous authority, the Committee, the State Service has a higher status, greater powers and a wider organizational chart.

The Commission to Supervise the Development of Applications, Negotiations and Implementation of Programs Financed by the Global Fund to Fight AIDS, TB and Malaria was set up at the National TB and

[41] http://www.president.gov.ua/news/20313.html
[42] The Decree of the President of Ukraine no. 1085/2010 "On Streamlining the System of Central Executive Authorities" dated December 09, 2010, the Decree of the President of Ukraine no. 441/2011 "On the Issue of the Ukrainian State Service on Counteraction of HIV/AIDS and Other Socially Dangerous Diseases" dated April 08, 2011.

HIV/AIDS Council.
What challenges remain in this area:
Despite high-rank officials' declarations on the priority of the response to the HIV/AIDS epidemic, this sector remains to be underfunded. Reforming the system of governmental authorities is accompanied by certain organizational complications, including frequent changes in the top management of the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases (3 heads in 2 years), the protracted staffing of the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases, human resource development. Yet, it should be noted that, in general, the execution of the state strategy of the state policy hasn't been significantly affected by the reform. The State Social Service for Family, Children and Youth was liquidated in course of the reform of the system of governmental authorities.[43] The functions on prevention that used to be performed by this Service were divided between three executive agencies (the Ministry of Education and Science, Youth and Sports; the Ministry of Social Policy; the State Service for Youth and Sports); these structures are still being formed and interaction between them is being arranged. Professional managers experienced in the response to HIV/AIDS have low motivation to work at governmental authorities and state-run institutions. A low priority is given to the problem of HIV/AIDS in programs of political parties.

Descriptive part to Section A2. Political Support and Leadership

The response to the HIV/AIDS epidemic had been acknowledged as one of the priorities of the State in the healthcare sector, which is continuously re-confirmed by the high-rank officials.

In the address to the UN General Assembly on June 08, 2011,[44] the President of Ukraine V.F. Yanukovych fully endorsed the new Getting to Zero UNAIDS 2011-2015 Strategy, the Global Zero Action to prevent new infections among children by 2015 and keeping their mothers alive, and the new Political Declaration of High Level Meeting.

In December 2010 the new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" was passed, which establishes more forward-looking and advanced conditions for introducing programs and services in response to HIV/AIDS. The provisions of this Law allows for the full-fledged support to substitution maintenance therapy programs and, thus, Ukraine has the most advanced legal framework in this realm, as compared to other CIS countries.

The support of the National TB and HIV/AIDS Council, officials from the Ministry of Health, the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases throughout the development and working-out of Ukraine's application to the Global Fund (Round 10) enabled attracting

[43] The Decree of the President of Ukraine no. 1085/2010 "On Streamlining the System of Central Executive Authorities" dated December 09, 2010.
[44] http://www.president.gov.ua/news/20313.html

funds and proved the readiness and capacity of the Ukrainian AIDS Center to become the Principal Recipient under the Global Fund project.

In 2010 central executive authorities underwent complete reforming. Subsequently, the majority of ministries, committees and services were liquidated or re-shuffled. Still, the response to HIV/AIDS is a high-level priority in Ukraine and, therefore, a dedicated governmental body, the State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases, was established. Unlike previous authority, the Committee, the State Service has a higher status, greater powers and a wider organizational chart.

At the backcloth of harshly limited resources the State has clearly defined priorities for funding from the state budget: HIV diagnostics, ART, mother-to-child transmission prevention, post-contact prevention. A great achievement against the background of the economic crisis was procuring ART medications from the state budget. In 2012 the state budget provisions 305 mln. UAH for the response to HIV/AIDS or almost 90 mln. UAH more than in 2011.

As for problems, experts point at objective factors, namely the overall deficit of budgetary funds and organizational complications that arose from reforming the system of executive authorities.

All in all, experts agree that in the reporting period Ukraine demonstrates rather high level of political support and leadership in actions within the response to the HIV/AIDS epidemic.

Year	Score
2011	7
2009	6

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	Yes[45]	No
Men who have sex with men	Yes[46]	No
Migrants/mobile populations	Yes[47]	No
Orphans and other vulnerable children	Yes[48]	No
People with disabilities	Yes[49]	No
People who inject drugs	Yes[50]	No

[45] The Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV"

[46] The Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" prohibits discriminations based on people's belonging to populations with higher risk of exposure to HIV, the Law of Ukraine "On Approving the National Program to Ensure Prevention, Treatment, Care and Support for Those Having HIV and AIDS for 2009-2013" defines men having sex with men as one of the most-at-risk populations.

[47] The Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" prohibits discriminations based on people's belonging to populations with higher risk of exposure to HIV, the Law of Ukraine "On Approving the National Program to Ensure Prevention, Treatment, Care and Support for Those Having HIV and AIDS for 2009-2013" defines migrants as one of the most-at-risk populations.

[48] The Concept of Children's Rights Protection, the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV".

[49] The Law of Ukraine "On the Fundamentals of the Social Protection of the Disabled in Ukraine".

[50] The Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" prohibits discriminations based on people's belonging to populations with higher risk of

Prison inmates	Yes[51]	No
Sex workers	Yes[52]	No
Transgendered people	Yes	No
Women and girls	Yes[53]	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

Does the country have a general (i.e., not specific to HIV-related discrimination) law on nondiscrimination?

Yes	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
There is no specific framework anti-discrimination law in Ukraine, although over the recent years discussions concerning its adoption have been taking place. However, some Laws of Ukraine directly prohibit discrimination by various features, namely:
The Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" prohibits discrimination based on person's belonging to the populations with higher risk of exposure to HIV.
The Law of Ukraine "On Approving the National Program to Ensure Prevention, Treatment, Care and Support for Those Living with HIV and AIDS for 2009-2013" defines certain populations at risk of exposure to HIV, in particular men having sex with men, migrants, injecting drug users, people providing sexual services for remuneration. Thus, in accordance with the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV", the provisions on discrimination prohibition apply to the said populations.
The Concept of Children's Rights Protection and the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" prohibits discrimination of children, regardless their status (in particular, orphanage) and health condition.
The Law of Ukraine "On the Fundamentals of the Social Protection of the Disabled in Ukraine" prohibits discrimination of people with limited capabilities, regardless of disease that caused the disability.
The Criminal Enforcement Code of Ukraine prohibits discrimination of people serving a sentence, in particular at penal institutions.
The Law of Ukraine "On Ensuring Equal Rights and Opportunities for Women and Men" prohibits

exposure to HIV, the Law of Ukraine "On Approving the National Program to Ensure Prevention, Treatment, Care and Support for Those Having HIV and AIDS for 2009-2013" defines injecting drug users as one of the most-at-risk populations.

[51] The Criminal Enforcement Code of Ukraine.

[52] The Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" prohibits discriminations based on people's belonging to populations with higher risk of exposure to HIV, the Law of Ukraine "On Approving the National Program to Ensure Prevention, Treatment, Care and Support for Those Having HIV and AIDS for 2009-2013" defines persons providing sexual services for remuneration as one of the most-at-risk populations.

[53] The Law of Ukraine "On Ensuring Equal Rights and Opportunities for Women and Men".

gender-based discrimination.

Briefly explain what mechanisms are in place to ensure these laws are implemented:
The legislation doesn't set forth clear-cut mechanisms to counteract discrimination. In the event of discrimination, a person has the right to appeal to a court.

Briefly comment on the degree to which they are currently implemented:
Under the said legal acts the anti-discrimination provisions are applied as the general principle.

2. Does the country have laws, regulations or policies that present obstacles[54] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes	No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[55][write in below]:	Yes	No

Briefly describe the content of these laws, regulations or policies:

[54]These do not necessarily have to be HIV-oriented policies and laws. These can be policies, laws and regulations that impede or complicate access to HIV prevention, treatment, care and support. In the country reports for the previous years, among other, the following examples were given: "laws criminalizing same-sex relationships", "laws criminalizing possession of condoms or equipment for drug usage", "vagrancy laws", "laws preventing import of generic medications", "policies preventing dissemination and storage of condoms in prisons", "policies preventing access of non-nationals to ART", "criminalization of transmission and exposure to HIV", "inheritance laws /relevant women rights", " laws prohibiting provision of information and services on sexual and reproductive health for youth", etc.

[55] In addition to the listed, the vulnerable populations may include those considered as populations at higher risk of exposure to HIV at the local level, according to the available data (including (in the alphabetical order) bisexual pesons, clients of commercial sex workers, indigenous population, internal migrants, prisoners, and refugees).

Briefly comment on how they pose barriers:

IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes	No

IF YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	Yes	No
Avoid commercial sex	Yes	No
Avoid inter-generational sex	Yes	No
Be faithful	Yes	No
Be sexually abstinent	Yes	No
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No
Other [write in below]:	Yes	No

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes	No

2.1. Is HIV education part of the curriculum in:

Primary schools?	Yes	No
Secondary schools?	Yes	No
Teacher training?	Yes	No

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?

Yes	No

2.3. Does the country have an HIV education strategy for out-of-school young people?

Yes	No

Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?

Yes	No

Briefly describe the content of this policy or strategy:
The content and tools to implement the awareness-raising strategy are established according to the target populations. The content and scope of training on HIV in general schools are established in the standards on primary and complete general education. The content of awareness-raising campaigns among the population at large (in particular through mass-media, social advertisements, etc.) is defined for each campaign and is approved by a wide circle of stakeholders. For instance, within the framework of Ukraine's preparation to EURO-2012 large-scale information campaigns on prevention, namely "Red Card", "Fair Play", "Give no Chance to AIDS", etc., were launched. In general, the preparation to EURO-2012 involved a lot of athletes and famous persons into information campaigns on HIV prevention and tolerant attitude formation. The national healthy lifestyle logo, the "Constitution of a Healthy Human Being" and special awareness-raising programs were developed.

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

 Check which specific populations and elements are included in the policy/strategy

	IDU [56]	MSM[57]	Sex workers	Customers of Sex Workers	Prison inmates	Other populations [58] [write in]
Condom promotion	+	+	+	+	+	other population
Drug substitution therapy	+					
HIV testing and counseling	+	+	+	+	+	other population
Needle & syringe exchange	+					
Reproductive health, including sexually transmitted infections prevention and treatment					+	other population
Stigma and discrimination reduction	+	+	+	+	+	other population
Targeted information on risk reduction and HIV education	+	+	+		+	
Vulnerability reduction (e.g. income generation)						

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?

Very Poor										Excellent
0	1	2	3	4	0	6	7	8	9	10

Since 2009, what have been key achievements in this area:
HIV prevention was declared as the major priority in the state policy, and all the key line ministries are involved in the implementation of prevention programs. ***Primary prevention*** is based on the principles of a healthy lifestyle and family values. The national healthy lifestyle logo, the "Constitution of a Healthy Human Being" and special awareness-raising programs were developed. The year 2012 was announced to be the year of sports and healthy lifestyle.[59] For instance, within the framework of Ukraine's preparation to EURO-2012 large-scale information

56 IDU = People who inject drugs
57 MSM = men who have sex with men
58 Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection
(e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)
59 The Cabinet of Ministers of Ukraine Resolution no. 360-r "On Measures to Prepare and Hold in Ukraine the Year of Sports and Healthy Lifestyle in 2012" dated April 27, 2011.

campaigns on prevention, namely “Red Card”, “Fair Play”, “Give no Chance to AIDS”, etc., were launched. In general, the preparation to EURO-2012 involved a lot of athletes and famous persons into information campaigns on HIV prevention and tolerant attitude formation.

At the local level there is an understanding of the importance of prevention programs; thus, the local budgets find opportunities to allocate funds for awareness-raising activities.

The issue of HIV prevention has been integrated into the education process.

In spite of the lack of funding from the state budget, teachers are trained on HIV/AIDS prevention for compulsory school subject “Basics of health” and optional lessons with senior pupils, and publications with guidelines were provided for their work.

The Ministry of Education and Science, Youth and Sports controls, on a permanent basis, the quality of HIV prevention studies at educational institutions and the level of teachers’ training and qualifications; a special focused Order was issued by the Ministry.

There are continuous activities carried out with a view of forming a tolerant attitude towards HIV-positive people. The Ministry of Education and Science, Youth and Sports jointly the Network of People Living with HIV prepared trainers on tolerant attitude to HIV-positive children formation to conduct trainings for teachers and heads of educational institutions from each oblast.

Focused prevention among high-risk populations is carried out under the Global Fund project.

Lower HIV incidence rates have been traced among IDUs over the recent years, in particular thanks to NGOs’ activities.

In all the regions of Ukraine strong cooperation with non-governmental organizations implementing prevention programs at penal institutions is aligned. Certain standards and requirements to such cooperation have been set forth with some positive achievements already available.

The magnitude of substitution maintenance therapy for HIV prevention among drug users has been expanded greatly.

Prevention programs for IDUs under harm reduction strategies have been functioning in a stable way

What challenges remain in this area:

Primary prevention:

There is no budgetary funding for prevention programs, in particular those implemented in the realm of education.

There is largely insufficient financing of science in terms of studying and introducing innovative prevention programs.

The coverage of HIV/AIDS problems by mass-media, especially by commercial ones, doesn’t suffice to provide for the necessary scope of prevention programs.

Focused prevention:

Prevention programs for IDUs insufficiently account for the changed HIV transmission way, i.e. from IDUs to their sexual partners. The coverage of IDUs’ sexual partners with prevention programs is

low.

There are changes in the operation of social services arising from reforming the system of governmental authorities.

The scope and magnitude of prevention programs among MSM and those implemented in prisons are insufficient.

There is the red-tape attitude of some state-run entities to certain types of prevention activities, namely SMT and harm reduction programs.

There is no appropriate strategy on blood donation and infection control.

Has the country identified specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?
They are determined within the framework of the National Program, sectoral and regional programs in pursuance of it, and in the National and Regional Operational Plans.

IF NO, how are HIV prevention programmes being scaled-up?

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young People	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC[60] on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination	1	2	3	4	N/A

60 IEC = information, education, communication

Reduction					
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other[write in]:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:

HIV prevention was declared as the major priority in the state policy, and all the key line ministries are involved in the implementation of prevention programs.

Primary prevention is based on the principles of a healthy lifestyle and family values.

The national healthy lifestyle logo, the "Constitution of a Healthy Human Being" and special awareness-raising programs were elaborated.

The year 2012 was announced to be the year of sports and healthy lifestyle.[61]

For instance, within the framework of Ukraine's preparation to EURO-2012 large-scale information campaigns on prevention, in particular "Red Card", "Fair Play", "Give no Chance to AIDS", etc., were launched. In general, the preparation to EURO-2012 involved a lot of athletes and famous persons into information campaigns on HIV prevention and tolerant attitude formation.

At the local level there is an understanding of the importance of prevention programs; thus, the local budgets find opportunities to allocate funds for awareness-raising activities.

The issue of HIV prevention has been integrated into the education process.

[61] The CMU's Resolution no. 360-r "On Measures to Prepare and Hold in Ukraine the Year of Sports and Healthy Lifestyle in 2012" dated April 27, 2011.

In spite of the lack of funding from the state budget, teachers are trained on HIV/AIDS prevention for compulsory school subject "Basics of health" and optional lessons with senior pupils, and publications with guidelines were provided for their work.

The Ministry of Education and Science, Youth and Sports controls, on a permanent basis, the quality of HIV prevention studies at educational institutions and the level of teachers' training and qualifications; a special focused Order was issued by the Ministry.

There are continuous activities carried out with a view of forming a tolerant attitude towards HIV-positive people. The Ministry of Education and Science, Youth and Sports jointly the Network of People Living with HIV has held trainings for heads of educational institutions from each oblast.

Focused prevention among most-at-risk populations is carried out within the framework of the Global Fund project.

Lower HIV incidence rates have been traced among IDUs over the recent years, in particular thanks to the activities of NGOs.

In all the oblasts of Ukraine tight cooperation with non-governmental organizations implementing prevention programs at penal institutions has been aligned. Certain standards and requirements to such cooperation have been set forth with some positive achievements already available.

The magnitude of substitution maintenance therapy for HIV prevention among drug users has been expanded greatly.

Prevention programs for IDUs under harm reduction strategies have been functioning in a stable way.

What challenges remain in this area:

Primary prevention:

There is no budgetary funding for prevention programs, in particular those implemented in the realm of education.

The local advocacy of allocation of payable learning hours for optional programs is insufficient.

There is a lack of social ads, visual promotion and awareness-raising programs on a healthy lifestyle.

There is largely insufficient financing of science in terms of studying and introducing innovative prevention programs.

The coverage of HIV/AIDS problems by mass-media, especially by commercial ones, doesn't suffice to provide for the necessary scope of prevention programs.

Focused prevention:

Prevention programs for IDUs insufficiently account for the changed HIV transmission route, from IDUs to their sexual partners. The coverage of IDUs' sexual partners with prevention programs is low.

There are changes in the operation of social services arising from reforming the system of governmental authorities.

The scope and magnitude of prevention programs among MSM and those implemented in prisons

are insufficient.

There is the red-tape attitude of some state-run entities to certain types of prevention activities, namely SMT and harm reduction programs.

There is no appropriate strategy on blood donation and infection control.

Descriptive part to Section A4. Prevention

As experts have it, the greatest concerns arise from the performance under prevention programs in Ukraine, as compared to performance in other areas. The new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" and the National Program to Ensure Prevention, Treatment, Care and Support for Those Living with HIV and AIDS for 2009-2013 define prevention as a priority for the state policy. Prevention programs are based on the principles of a healthy and moral lifestyle, spiritual values and responsible behavior in sexual relationships. All the key line ministries are engaged in the implementation of prevention programs.

The National Program incorporates a prevention component comprised of several constituents, namely:
Primary HIV prevention;
Prevention among most-at-risk populations;
Prevention among HIV-positive persons:
Specific prevention measures (donorship safety and post-contact prevention).

The experts point out that prevention programs are implemented in all the said areas, yet the greatest concerns arise from ***primary HIV prevention,*** given no state budget funding for activities provided for by the National Program.

Despite the absence of funding, one should mention certain achievements:

The issue of HIV prevention is integrated into the education process, the quality of the studies is controlled on a permanent basis.

At the local level there is an understanding of the importance of prevention programs; thus, the local budgets find opportunities to allocate funds for awareness-raising activities.

The year 2012 was announced to be the year of sports and healthy lifestyle[62], the national healthy lifestyle logo, the "Constitution of a Healthy Human Being" and special awareness-raising programs were elaborated.

Within the framework of Ukraine's preparation to EURO-2012 large-scale information campaigns on prevention, in particular "Red Card", "Fair Play", "Give no Chance to AIDS", etc., were launched.

Prevention among most-at-risk populations is implemented thanks to the financing by the Global Fund and a valuable contribution by non-governmental organizations. These prevention programs will be continued in the following two years (2012-2013), as endorsed by the Round 10 Global Fund grant.

In the reporting period prevention programs for IDUs under harm reduction strategies functioned in a stable way. Lower HIV incidence rates have been traced among IDUs over the recent years, in particular owing to NGOs' activities.

[62] The Cabinet of Ministers of Ukraine Resolution no. 360-r "On Measures to Prepare and Hold in Ukraine the Year of Sports and Healthy Lifestyle in 2012" dated April 27, 2011.

The scale of substitution maintenance therapy for HIV prevention among drug users has been expanded greatly.

Still, experts point out that prevention programs for IDUs insufficiently account for the changed HIV transmission route, from IDUs to their sexual partners. The coverage of IDUs' sexual partners with prevention programs is low.

In all the oblasts of Ukraine tight cooperation with non-governmental organizations implementing prevention programs at penal institutions is aligned. Certain standards and requirements to such cooperation have been set forth with some positive achievements already available.

The implementation of positive (among PLWH, mother-to-child-transmission) and specific prevention activities are held at a high level and receive relevant funding from the state budget. The vertical transmission rate has reduced down to 4.7%.

As for the general assessment of country's efforts in the implementation of prevention programs, experts were almost unanimous in the opinion that there was no appropriate financing for prevention programs, though their scores differed drastically, depending on the official viewpoint of the institution they represented. Thus, the combined index on prevention programs for 2010-2011 is lower than a year ago.

Year	Score
2011	5
2009	6
2007	5
2005	4
2003	4

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

If YES, Briefly identify the elements and what has been prioritized:
HIV diagnostics; Medical follow up, necessary laboratory tests; Free-of-charge access to ART for patients; Access to the diagnostics and treatment of opportunistic infections; Social and psychological support Palliative and hospice assistance; HIV mother-to-child transmission prevention programs; Providing information on living with HIV; PLWH's access to reproductive health services.

Briefly identify how HIV treatment, care and support services are being scaled-up?

At the political level all the necessary conditions for the implementation of treatment, care and support for PLWH were established. Treatment, care and support for PLWH are the major objectives of the National Program for 2009-2013. Yet, at the operational level complications occur; they are related to public procurement procedures and lead to delays in treatment scale-up.

To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counseling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Pediatric AIDS treatment	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other [write in]: Reproductive health services for discordant pairs Hospice assistance	1	2	3	4	N/A

Does the government have a policy or strategy in place to provide social and economic support to

Yes	No

people infected/affected by HIV?

Please clarify which social and economic support is provided:
According to the new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" passed on December 23, 2012, the State guarantees the social protection of PLWH and their family members and the provisioning of PLWH with healthcare and social services. So, PLWH, in addition to the rights and freedoms of a human being and a citizen, are also entitled to: 1) compensation for losses associated with the restriction of their rights resulting from the disclosure or release of information on their positive HIV status; 2) free-of-charge provisioning with ART medications and drugs for opportunistic infections treatment under the procedure established by the central executive authority in charge of health. Monthly financial allowance from the state is assigned to HIV-positive children and children who suffer from a disease caused by HIV. In the event that a disability is established, a person living with HIV has the right to a pension, as provided for by the law.

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?

Yes	No	N/A

Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?

Yes	No	N/A

IF YES, for which commodities?
There is a regional mechanism for the management of procurement of some types of goods, i.e. condoms, medications for opportunistic infections treatment. Theoretically, ART medications can be procured at the regional level, although in practice, due to many reasons, they are not. Substitution therapy medications may not be procured at the regional level.

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?

Very Poor										Excellent
0		2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:

Over the recent years the State has given greater priority to the treatment of PLWH. As of the end of 2011, ART medications were received by approximately 26,000 people. A great achievement against the background of the economic crisis was procuring ART medications from the state budget. In 2012 the state budget provisions 305 mln. UAH for the response to HIV/AIDS or almost 90 mln. UAH more than in 2011. Recent biddings for ART medications procurement from the state budget resulted in the procurement of medications at prices reduced by 25%. In 2012 these savings will allow the state budget to provide necessary medications to more than 5,000 extra HIV-positive people. In addition, medications will be procured under Global Fund Round 6. Thus, more than 13,000 extra patients will be reached with treatment. More than 40,000 patients are to receive ART medications in 2012. Ukraine proves its utmost commitment to substitution maintenance therapy programs in practice and has the most advanced legal framework in this realm, as compared to other CIS countries. In December 2010 the new wording of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV" was passed. According to it, one of the state guarantees established by it is the application of substitution maintenance therapy with a view of preventing HIV among drug users. The vertical transmission rate has reduced down to 4.7%. The project on HIV-positive women's safe conception is being implemented in Ukraine. Significant progress has been traced in the expansion of the magnitude of treatment at penal institutions: As compared to 2010, the coverage with ART at penal institutions nearly doubled. Penitentiary system medical staff has sufficient capacities and experience for prescription of ART and treatment as such, for ART planning, laboratory test systems; medications and tests are procured. A number of ART schemes for penal institutions increased (7 schemes are planned). The process of treatment of HIV-positive prisoners' opportunistic infections improved thanks to the target procurement of medications for this category of people (while earlier medications used to be planned for procurement and procured for all the prisoners). A 60-bed infectious disease ward for treatment of HIV-positive people from penal institutions was commissioned in Donetsk region. Another 80-bed ward is to be launched in Zhytomyr oblast in 2012. There has been an essential decision to improve the healthcare servicing and ensure continuous SMT for HIV-positive prisoners, as the following joint orders is at the final stage of approval: MoH, the State Penitentiary Service – on the procedure of interaction of healthcare establishments, penal institutions and pretrial detention centers in medical follow-up, laboratory support and ART. MoH, Ministry of Internal Affairs, Ministry of Justice, State Drug Control Service – on the procedure of institutions interaction in ensuring uninterrupted SMT. The healthcare reporting system at penal institutions was brought to compliance with the requirements of the Ministry of Health.
What challenges remain in this area:
The insufficient coverage with ART is related to the insufficient funding of both ART medications, laboratory support of HIV-positive people and coverage of HIV-positive IDUs with substitution therapy programs.

There is a deficit of funds for procuring sufficient amounts of medications for opportunistic infections treatment, and, thus, these expenses are covered mostly by patients.

Complicated bureaucratic procedures for procurements from the state budget, and untimely budgetary funding sometimes lead to delays in the delivery of medications.

There are cases of delays in the state budget procurement of systems for HIV testing and laboratory monitoring of HIV-positive persons.
There is a need to advance the governmental procurement of ART medications, test systems, etc., to avert cases of deficits in medications.

Requirements of financial institutions that inspect healthcare establishments with regard to planning and using medications make it impossible to fully solve the issue of forming a buffer stock of ART medications against possible delays in procurement or delivery.

Laboratories equipment requires material and technical support, given an increase in the number of patients receiving ART. Yet, the funding for these expenses doesn't increase proportionately.

There is a need to intensify activities on forming adherence to ART.

There is a need to improve and introduce, on a large-scale basis, the integrated approach to healthcare and social services for HIV-positive IDUs.

Substitution maintenance therapy programs envision the funding for the procurement of medications only, without any allocations for patients' social support.

The National Program activities implemented by the State Penitentiary Service were underfunded by 13% as against the planned target.

Given the continuously increasing number of HIV-positive people at penal institutions, the system of execution of penalties lacks due laboratory equipment, and lacks medical personnel experienced in HIV issues.
Laboratory equipment in the system of execution of penalties is insufficient.

5.1 Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No	N/A

5.2 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

5.3 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

5.4 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

5.5 IF YES, what percentage of orphans and vulnerable children is being reached?

20 %

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
The previously launched initiatives and programs aimed at solving problems of orphans and other vulnerable children are continued. The National Strategic Action Plan on HIV Prevention among Children and Youth from Risk Groups and Populations Vulnerable to HIV, Care and Support for Children and Youth Affected by the Problem of HIV/AIDS.
What challenges remain in this area:
There is a need to expand the scope and magnitude of comprehensive programs for street children which are targeted, inter alia, at preventing HIV.

Descriptive part to Section A5. Treatment, Care and Support.

Over the recent years, at the backcloth of the state budget deficit, the State has given greater priority to the treatment of PLWH. As of the end of 2011, ART medications were received by approximately 26,000 people.

A great achievement against the background of the economic crisis was procuring ART medications from the state budget. In 2012 the state budget provisions 305 mln. UAH for the response to HIV/AIDS or almost 90 mln. UAH more than in 2011.

Recent biddings for ART medications procurement from the state budget resulted in the procurement of medications at prices reduced by 25%. In 2012 these savings will allow the state budget to provide necessary medications to more than 5,000 extra HIV-positive people. In addition, medications will be procured under Global Fund Round 6. Thus, more than 13,000 extra patients will be reached with treatment. More than 40,000 patients are to receive ART medications in 2012.

Significant progress has been made in the enlargement of treatment at penal institutions.

As compared to 2010, the coverage with ART at penal institutions nearly doubled, and a number of ART schemes for penal institutions will increase (7 schemes are planned). The penitentiary system medical staff has sufficient capacities and experience for prescription of ART and treatment as such, for ART planning, laboratory testing systems; medications and tests are procured.

The process of treatment of opportunistic infections among HIV-positive prisoners improved thanks to the target procurement of medications for this category (while earlier medications used to be planned for procurement and procured for all the prisoners).

A 60-bed infectious disease ward for treatment of HIV-positive people from penal institutions was commissioned in Donetsk region. Another 80-bed ward is to be launched in Zhytomyr oblast in 2012.

Still, experts point out that the existing coverage with ART is insufficient. This relates, primarily, to the insufficient funding of both ART medications and the laboratory support of HIV-positive people, and, secondly, to the low coverage of HIV-positive IDUs with substitution therapy programs, and the insufficient adherence to ART.

There is a deficit of funds for procuring sufficient amounts of medications for opportunistic infections treatment, and, thus, these expenses are covered mostly by patients.

Laboratories equipment requires material and technical support, given an increase in the number of patients receiving ART. Yet, the funding for these expenses doesn't increase proportionately.

Experts highlight systemic problems in general governmental procurement procedures, in terms of medical goods procurement in particular, which leads to interruptions in deliveries of medications and test systems.

Complicated bureaucratic procedures for the state budget procurement and untimely budgetary funding sometimes leads to delays in deliveries of medications.

There is a need to improve and introduce, on a large-scale basis, the integrated approach to healthcare and social services for HIV-positive IDUs. Substitution maintenance therapy programs envisage the funding for the procurement of medications only, without any allocations for patients' social support.

There are some problems in the penitentiary system. In particular, the National Program activities implemented by the State Penitentiary Service were underfunded by 13% as against the planned target.

Given the continuously increasing number of HIV-positive people at penal institutions, the system of execution of penalties lacks due laboratory equipment, and lacks medical personnel experienced in HIV issues.

In general, experts point at a large progress in the implementation of treatment, care and support programs in the reporting period.

Year	Score
2011	8
2009	6

VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?

Yes	**In Progress**	No

Briefly describe any challenges in development or implementation:
Officials from governmental agencies do not possess a sufficient level of results-oriented management culture and understanding of monitoring and evaluation.

IF YES, years covered [write in]:

2012-2013

IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	**Yes, some partners**	No	N/A

Briefly describe what the issues are:
Representatives from governmental authorities, international and non-governmental entities apply different approaches to selecting denominators of some indicators (a total number of PLWH, IDUs, FSW, MSM, etc.). Representatives from governmental authorities and state-run entities insist on using official statistics, while those from international and non-governmental organizations suggest using survey-based estimates. There are some deviations in views on the depth and means of detailing the indicators (e.g., the age-group breakdown). The relevance of certain indicators raises doubts.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	**No**
IF YES, does it address:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	**No**
A data dissemination and use strategy	Yes	**No**
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	**Yes**	No
Guidelines on tools for data collection	**Yes**	No

3. Is there a budget for implementation of the M&E plan?

Yes	In Progress	**No**

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

%

4. Is there a functional national M&E Unit?

Yes	In Progress	No

Briefly describe any obstacles:
It is possible to define organizational and institutional obstacles faced by the national M&E Unit in its activities as follows: the insufficient scope of unit's powers; lack of personnel; overload with other tasks having nothing common with monitoring and evaluation.

4.1. Where is the national M&E Unit based?

In the Ministry of Health?	Yes	No
In the National HIV Commission (or equivalent)?	Yes	No
Elsewhere *[write in]*? Treatment and Prevention Institution SE "Ukrainian Center for AIDS Prevention"	Yes	No

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Permanent Staff [Add as many as needed]			
Head	1		Since 2009
Regional monitoring and evaluation system development specialist	1		Since 2009
Database specialist	1		Since 2009
Surveys specialist	1		Since 2009
Routine epidemiological surveillance specialist	1		Since 2009
Epidemiological monitoring system improvement specialist	1		Since 2009
Epidemiologist		2	Since 2009
Assistant	1		Since 2009
	Fulltime	Part time	Since when?
Temporary Staff [Add as many as needed]			

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

Briefly describe the data-sharing mechanisms:
There are certain traditions of M&E data exchange between principal partners. The data exchange among governmental institutions is ensured by means of sending information requests. Requests are drawn up in the name of the Ukrainian State Service on Counteraction to HIV/AIDS and Other Socially Dangerous Diseases or the Ukrainian AIDS Center. As the need may be, the order is executed by the National TB and HIV/AIDS Council. Data exchange with international and non-governmental organizations is also ensured through sending requests and getting information upon their consent.
What are the major challenges in this area:
The mechanism of information and data exchange between various partners hasn't been formalized; it should be incorporated into the monitoring and evaluation system.

Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes	No

Is there a central national database with HIV- related data?

Yes	No

IF YES, briefly describe the national database and who manages it.
The national database Devinfo is being developed and filled with data. UNICEF is responsible for database development and maintenance, while Monitoring and evaluation Unit is in charge of data input.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above	**Yes, but only some of the above**	No, none of the above

IF YES, but only some of the above, which aspects does it include**?**

The database contains numerical values of all the Monitoring and evaluation National Plan indicators, including information on key populations and geographical coverage with services.

6.2. Is there a functional Health Information System[63]?

At national level	Yes	No
At subnational level	Yes	No
IF YES, at what level(s)? *[write in]*		

7. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?

Yes	No

8. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Other [write in]: Official data release for information and results demonstration.	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
Ukraine has rather a well-developed monitoring system, in particular the system to collect, analyze and use statistical information. Yet, it should be stressed that the system of evaluation is by far less advanced.

9. In the last year, was training in M&E conducted

At national level?	Yes	No
IF YES, what was the number trained: 9 persons		
At subnational level?	Yes	No
IF YES, what was the number trained 99 persons (from all the regions of Ukraine)		
At service delivery level including civil society?	Yes	No
IF YES, how many? Inaccessible information		

9.1. Were other M&E capacity-building activities conducted other than training?

Yes	No

[63] For example, the one ensuring regular transmission of data collected at healthcare establishments at the district level upwards to the national level, just as the analysis and use of data at various levels.

IF YES, describe what types of activities
Organizational and methodical support is provided to regional monitoring and evaluation units, in particular by means of providing guidelines. Monitoring visits are made to regional monitoring and evaluation units, in particular for the purpose of consultations provision and advocacy of their interests among local authorities. Participation in conferences and other national and international events on monitoring and evaluation. Office appliances and computer hardware were purchased to back the operation of monitoring and evaluation units.

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
The Cabinet of Ministers of Ukraine approved the Resolution no. 1349 "On the Unified System to Monitor and Evaluate Activities Targeted at the HIV Epidemic Spread Prevention" dated December 28, 2011. There is rapid regional monitoring and evaluation system development: in 2009 monitoring and evaluation units operated in 11 oblasts only, while during the following two years such units were set up in all the 27 regions of Ukraine. The inter-agency approach was introduced thanks to the work of the group on monitoring and evaluation.
What challenges remain in this area:
The national and regional monitoring and evaluation plans require further elaboration. There is no in-depth scrutiny of monitoring and evaluation data for the purpose of further managerial decision-making. There is insufficient level of staffing with monitoring and evaluation personnel and its training, especially beyond the capital. As a rule, monitoring and evaluation functions are defined as additional ones. Thus, the system of monitoring and evaluation is not developing as a full-fledged and independent entity. Regional monitoring and evaluation units have insufficient equipment and supplies. The funding of necessary surveys is insufficient. The monitoring of NGOs' activities has to be improved.

Descriptive part to Section A6. Monitoring and Evaluation.

According to experts, in the reporting period the monitoring and evaluation system was consistently developing.

The regional monitoring and evaluation units emerged in all the regions of Ukraine with the collection of the regional indicators having been aligned. The national monitoring and evaluation plan is still being developed; a number of bio-behavioural surveys are held with international reports drawn up. The inter-agency approach was introduced thanks to the work of the monitoring and evaluation group.

The Cabinet of Ministers of Ukraine approval of the Resolution no. 1349 “On the Unified System to Monitor and Evaluate Activities Targeted at the HIV Epidemic Spread Prevention” dated December 28, 2011, was acknowledged by experts as the main achievement in the realm of monitoring and evaluation.

The experts reported the insufficient level of staffing with monitoring and evaluation personnel and its training, especially beyond the capital. As a rule, monitoring and evaluation functions are defined as additional ones. Thus, the system of monitoring and evaluation is not developing as a full-fledged and independent entity.

There is no in-depth scrutiny of monitoring and evaluation data for the purpose of further managerial decision-making.

Necessary surveys are primarily funded under the project supported by the Global Fund and other international projects without any disbursements from the state budget.

The overall score for monitoring and evaluation remains to be at the level of the previous report.

Year	Score
2011	7
2009	7
2007	3
2005	3
2003	3

ANNEX 3. NATIONAL COMMITMENTS AND POLICY INSTRUMENT (PART B)

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

I. CIVIL SOCIETY INVOLVEMENT[64]

GARP To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
Civil society plays the key role in shaping commitment among lead managers via high-level meetings, meetings of stakeholders, advocacy campaigns and exchange of official correspondence. NGO representatives have been involved in all phases of government policy development. NGO representatives, specifically, PLWH, LGBT and HIV-service organisations are among members of the National TB and HIV/AIDS Council and its working bodies (the Committee for Regional Policies; the Committee on Programmatic Issues; the Commission for Supervision of Application Development, Negotiations and Implementation of Programmes Implemented with funds of the Global Fund to Fight AIDS, Tuberculosis and Malaria). In September 2011, a Public Council was established with the State Service of Ukraine for Countering HIV Infection/AIDS and Other Socially Dangerous Diseases (the State Service of Ukraine for Social Diseases); it united among its members the representatives of 27 NGO organizations. The mission of the Council is to provide for citizen participation in the managing of government matters, the exercising of public control over State Service of Ukraine for Social Diseases' operations and to take into account the public opinion during the formulation and implementation by the State Service of its statutory assignments. A greater number of NGO representatives are of opinion that public involvement is of predominantly formal nature and hence, has almost no effect on the efficiency of government policy implementation or scope of public funds earmarked to counteract HIV infection. The principal achievements related to civil society involvement in this direction are: A revision of the Law of Ukraine to Counteract HIV Infection/AIDS Epidemics in Ukraine (1991) initiated; also, participation in the development of changes in that piece of legislation and support to the adoption of changes by the Verkhovna Rada of Ukraine. Consequently, the Law of Ukraine No. 2861-VI to Change the Law of Ukraine on Prevention of Acquired Immune Deficiency Syndrome (AIDS) and on Social Protection of the Population was adopted on 23 December 2010. The new law introduced a new name for the law to counteract HIV infection/AIDS epidemics changing it into the Law on Counteraction to Propagation of Diseases Conditioned by the Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV the new version of which came into force as of 15 January 2011. One special feature of the Law is Clause 3 of Article 14 according to which "*no discrimination against an individual based on availability of HIV infection in such individual or his/her belonging to groups with*

[64]Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

increased HIV risks shall be allowed".

Owing to a proactive involvement of the civil sector, Ukraine was able to receive the GFATM grant within Round 10 Grant on the AIDS component to implement its Programme of Development of a Viable System of Comprehensive Services on HIV/AIDS Prevention and Treatment and Care After and Support to Vulnerable Groups and PLWH.

The advocacy campaign on the allocation of funds for ARV medications procurement from the national budget. In 2011, owing to activities of the All-Ukrainian Charitable Organization "All-Ukrainian Network of People Living with HIV/AIDS" and the Advisory Community Council on Issues of Access to Treatment in Ukraine (UCAB) Charitable Fund it became possible to convince government officials in the need for 100% funding of treatment of HIV/AIDS patients. The initiated public action *Help to Survive!* resulted in the winning of President of Ukraine's sympathy towards the need for financing the procurement of medicines for HIV-infected individuals in 2011 and 2012 100% from the national budget. Thanks to that, the national budget provision for the treatment of HIV/AIDS patients has doubled.

Advocacy measures of the civil society had an impact on the motioning of legislative initiatives aimed at lowering discrimination against such group with high risk of HIV infection as MSM as well as people living with HIV for consideration of the Parliament. Specifically, advocacy appeals of the All-Ukrainian Union "Council of LGBT Organisations of Ukraine", the draft law No. 8487 effectively banning "*any discrimination in the employment area on the grounds of […] HIV/AIDS status […] or sexual orientation*" has been registered with the Verkhovna Rada of Ukraine.

Owing to advocacy activities of gay community organisations (in particular, of the All-Ukrainian Charity Organisation "Gay Forum of Ukraine"), the State Statistics Service of Ukraine issued in July 2011 an official statement to notify discontinuation of statistic records of 'homosexuals', underage included, in Ukraine.

Active advocacy measures taken by non-governmental organisations (in particular, of the All-Ukrainian Union "Council of LGBT Organisations of Ukraine", the All-Ukrainian Association of Public Organisations "Ukrainian Helsinki Union for Human Rights", the ICF "International HIV/AIDS Alliance in Ukraine", the AUCF "Coalition of HIV-Service Organisations") have complicated prospects of outrageously wretched draft Law of Ukraine No. 8711, of 20 June 2011, to Change Certain Legislative Acts (As Regards the Protecting of Children's Rights to Safe Information Environment) being adopted by the Verkhovna Rada of Ukraine. It should be noted that the draft law that suggests implementation of criminal responsibility for 'propaganda of homosexualism' and 'the cult of homosexualism' in Ukraine, if adopted, would render impossible a considerable proportion of information outreach measures on HIV infection prevention among MSM and that, with a view that it has not been scrapped from the agenda, its final rejection by the Parliament will require further efforts from the civil society.

Owing to proactive position of the civil society, a meeting between the Executive Director of the Global Fund to Fight AIDS, Tuberculosis, and Malaria Michael Kazachkin, the Prime Minister of Ukraine, the Minister of Public Health Protection of Ukraine and National TB and HIV/AIDS Council members took place in January 2012.

Owing to proactive position of the civil society on HIV/AIDS problems actualization, the State Service of Ukraine for Countering HIV Infection/AIDS and Other Socially Dangerous Diseases, the central body in charge of government anti-HIV/AIDS policy implementation was officially established in late 2010 (President of Ukraine Decree No. 1085, of 9 December 2010, on Optimisation of the System of Central Executive Bodies).

Active steps taken by non-governmental organisations have resulted in the implementation of standards of provision of social services to counteract HIV infection epidemics approved by the Joint Order of the Ministry of Ukraine for Family, Youth and Sports, the Ministry of Labour and Social Protection No. 3123/275/770, of 13 September 2010, to Approve Standards of Provision of Social Services to Risk Groups Representatives (registered with the Ministry of Justice of Ukraine on 8 October 2010 under No. 903/18198). The total of five standards have been approved: (1) Standard of the Provision of Social Services of Care and Support for People Living with HIV/AIDS; (2) Standard of the Provision of Social Services on HIV Infection Prevention Among People with High Risk of HIV through Sexual Transmission; (3) Standard of the Provision of Social Services to Patients with Concurrent TB and HIV Infection; (4) Standard of the Provision of Social Services to Patients with Triple (HIV infection/Tuberculosis/Addiction to substances) Diagnosis; (5) Standard of the Provision of Social

Services to Individuals on Opioid Substitution Maintenance Therapy.

GARP To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society representatives been involved in the planning and budgeting process for the National Strategic Planon HIV or for the most current activity plan (e.g. attending planning meetings and reviewingdrafts)?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

Civil sector representatives are involved in the planning and budgeting of the National (and local) plans and actions.

The participation of representatives of the wide public in development of proposals, implementation of government policies, consolidated spending of funds and monitoring of HIV programmes implementation is provided through the introducing of public representatives into the membership of:

- National TB and HIV/AIDS Council and its working bodies,
- Local (regional/municipal/district) TB and HIV/AIDS councils,
- Intersectoral working groups established with MoH.

E.g., the National Programme for Prevention, Treatment, Care and Support for HIV-infected People and AIDS Patients for 2009–2013 was developed with involvement of national and regional public organizations and intersectoral working groups.

Nevertheless, the government does not fully account for public proposals in its planning of national and local budget on HIV. The Programme budget is executed at less than 50% and NGOs have no practical effect on either its performance or supervision.

GARP To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

The national HIV strategy?

LOW					HIGH
0	1	2	3	4	5

The national HIV budget?

LOW					HIGH
0	1	2	3	4	5

The national HIV reports?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

a). The National Strategy:

The majority of measures taken by the civil society have been included into the National Strategy; however, this is only true for those measures funded from GF's grants through the principal recipients.

Measures by the civil sector performed outside the GF funding have not been included in the National Strategy.

b). The National budget on HIV includes only budget provisions for measures implemented within the GF grants.

The National Strategy does not provide for national-level funding of NGOs. There is no specific mechanism of counter-HIV measures implementation by NGOs at the expense of government funds.

c). Civil society representatives proactively participate in writing national reports. The major reports are being largely prepared based on results of bio-behavioural surveys carried out by NGOs. Target groups for such surveys are mostly composed of clients of such NGOs.

National reports are most often prepared with involvement of civil society professionals possessing information about hard-to-reach groups of the population.

The 2009 National Report of Ukraine on the Follow-up to the Declaration of Commitment on HIV/AIDS was prepared and discussed during the meeting of stakeholders and partners. The Report was presented and approved at the meetings of the Working Group for Monitoring and Evaluation with participation of representatives of the central executive bodies, international and bilateral organisations, also of the All-Ukrainian Network of People Living with HIV.

GARP To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

Developing the national M&E plan?

LOW					HIGH
0	1	2	3	4	5

Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					HIGH
0	1	2	3	4	5

Participate in using data for decision-making?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

a) The Provisions of the Unified Monitoring and Evaluation System were approved by the Decree of the Cabinet of Ministers of Ukraine of 28.12.2011; the National M&E Plan was approved by the Order of the MoH of Ukraine of 09.02.2012 (the Order has been submitted to the Ministry of Justice of Ukraine for official registration). The documents were developed with active participation of public representatives, in particular, of the National M&E Group members.

б) On 09.04.2009, the Ukrainian Centre for Monitoring and Evaluation of the Performance of program actions to counteract HIV-infection/AIDS was established. On 30.01.2010, an intersector working group on monitoring and evaluation of the efficiency of performance of programme actions to

counteract HIV-infection/AIDS has been established by order of the MoH of Ukraine.

The National M&E Unit and the National M&E Group operate with support from international institutions. Public representatives take an active part in the activities of the national M&E group.

The members of the National M&E Group include representatives of international and Ukrainian organisations, research companies.

Some NGO representatives are of opinion that National M&E Group activities are to a certain degree dependent on the support from international institutions. Hence, there is no actual feeling that its outputs are the national product.

c) It should be noted that self-organising efforts of individual risk groups in Ukraine have led to the establishment of coordinating structures that are involved, both generally and at the level of individual experts, in the process of monitoring and evaluation of measures of response to HIV infection epidemic in Ukraine. This can be said, first and foremost, about the Standing Reference Group on LGBT Community and MSM-Service Projects (SRG Ukraine), an expert and advisory body that has been active for five years in Ukraine. Similar bodies are being established also at the local level (e.g., there is a Standing Reference Group on LGBT Community and MSM-Service Projects in Donetsk Oblast).

GARP To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

Participation of the civil sector is both considerable and multifaceted ranging from delivery of services to policy-making. Representatives of PLWH and LGBT/MSM communities are the most active while CSWs are more passive ones.

There is an opinion among experts that civil sector representation is related not to community category but rather to the lobbying of interests of HIV-service organisations financed by the Global Fund. More than 100 NGOs obtained grants from the AUCF “All-Ukrainian Network of PLWH” for implementation of care, support and treatment programmes in Ukraine; more than 100 NGOs received grants from the ICF “Alliance-Ukraine” for implementation of HIV prevention programmes in Ukraine.

While community mobilisation (risk groups and PLWH) is one of the new activities in Ukraine, the following organisations have been already registered (legalized) and are now actively involved in the delivery of prevention, care and support services and/or making of respective policy: the All-Ukrainian Charitable Organization “All-Ukrainian Network of People Living with HIV/AIDS” (PLWH community); the All-Ukrainian League Charitable Organisation “Legalife” (CSW community); The All-Ukrainian Public Organization “The Association of Substitution Maintenance Therapy Participants of Ukraine” (the community of SMT clients); AUCO “Spilnota”; ICF “Vertikal”; the ICF “Club House Federation” (IDU community); Public ex-Prisoner Organisation “Podolannya”; the All-Ukrainian Union “The Council of LGBT Organisations of Ukraine”; the All-Ukrainian Public Organisation “Gay Alliance Ukraine”; the All-Ukrainian Public Organisation “Gay Forum of Ukraine”; the All-Ukrainian Charitable Organisation “Tochka Opory” (LGBT community/ MSM group) and 34 more LGBT organisations.

In April 2011, a Coalition to Counter Discrimination (CCD) was established in Ukraine; as of 1 March 2012, the Coalition unites some 26 NGOs. The Coalition sees one of its tasks in the overcoming of health-status (specifically, HIV status)-based discrimination in Ukraine.

Representation of religious and rehabilitation organisations is at the weakest; herewith one has to note that individual confession organisations and institutions aim at working with representatives of certain risk groups. E.g., one of the statutory objectives of the charitable institution - The Metropolitan Andriy Sheptytskyi Hospital with the Curia of L’viv Archdiocese of the Ukrainian Greek Catholic Church mentions *“the provision of social help, protection and assistance […] to sexual minorities”*.

It shall be also necessary to provide for more active involvement of the business sector, trade union movements, unions and coalitions.

GARP To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society able to access:

Adequate financial support to implement its HIV activities

LOW					HIGH
0	1	2	3	4	5

Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
Civil society representatives have access to financial and technical support of their actions against HIV exclusively within the context of assistance granted by international donor organisations (the Global Fund, the USAID, the Renaissance Foundation, GIZ and other). Such financial and technical support from donor institutions is mostly aimed at ART and SMT, care and support, prevention among vulnerable groups, community mobilization and advocacy. The viability of such projects is low and there is no mechanisms to secure sustainability of civil organizations beyond the assistance period. Consequently, in conditions of permanent reduction of the scope of financial and technical assistance from donor organisations for implementation of above measures the number of clients of their programmes will decrease and the quality of their services will go down. Civil organizations have no developed fundraising and social entrepreneurship skills. The financial and technical assistance is almost not accessible at the level of smaller towns and local communities.

GARP What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations				
People living with HIV	<25%	25-50%	51-75%	>75%
Men who have sex with men	<25%	25-50%	51-75%	>75%
People who inject drugs	<25%	25-50%	51-75%	>75%
Sex workers	<25%	25-50%	51-75%	>75%
Transgendered people	<25%	25-50%	51-75%	>75%
Testing and Counselling	<25%	25-50%	51-75%	>75%
Reduction of Stigma and	<25%	25-50%	51-75%	>75%

Discrimination				
Clinical services (ART/OI)*	<25%	25-50%	51-75%	>75%
Home-based care	<25%	25-50%	51-75%	>75%
Programmes for OVC**	<25%	25-50%	51-75%	>75%

*ART = Antiretroviral Therapy; OI=Opportunistic infections

**OVC = Orphans and other vulnerable children

GARP Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2011?

VERY POORLY										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:

1. In 2010, Ukraine developed and submitted its application for Global Fund Round 10 grant under on AIDS Component. The three key recipient organisations were identified, two of them representing the non-governmental sector (the AUCF “All-Ukrainian PLWH Network” and the ICF “International HIV/AIDS Alliance in Ukraine”) and one more being a public institution (the Ukrainian Centre for Prevention and Response to AIDS with the MoH of Ukraine). A component to enhance community systems was specifically outlined in the Programme.
2. On 03.11.2010, the Cabinet of Ministers of Ukraine adopted a decree “to provide for public involvement in the making and implementing of government policy” that approved the Procedure of Public Consultations on Issues of Government Policy Making and Implementation. The act also decreed the establishment of public councils with each individual Executive body. Such councils are platforms for dialogue between the government and the non-governmental sector. The Public Council was established with the State Service of Ukraine for Countering HIV Infection/AIDS and Other Socially Dangerous Diseases (in September 2011), and the membership in the Public Council with the Ministry of Public Health Protection of Ukraine was updated in October 2011.
A mechanism of National Council on Response to TB and HIV/AIDS member rotation has been implemented.
Operations of intersectoral working groups active in the field of counteraction to HIV continue; new groups are established and composition of the existing ones is updated.
Thanks to the meetings held with MoH representatives, members of the UCAB (the association of patients with the most socially dangerous pathologies for the protection of their interests) were included in the working groups of the MoH of Ukraine in charge of public procurement of ARV and anti-TB medications in 2012 as well as in the Coordination Council of the MoH of Ukraine on matters of OkhMatDyt National Specialised Clinic operation (the structural organization of the OkhMatDyt Children Clinic includes the Centre for Treatment of Children with HIV/AIDS and their parents).

What challenges remain in this area:

There is no system for civil society contracting for the delivery of services.
The system of government support to NGOs is lacking.
There is a mismatch between the national and regional levels of cooperation between the public and the non-governmental sector.
The performance of the National TB/HIV Council as a platform for forging consensus between the civil society and government structures is insufficient.
The decision-making process remains ‘closed’ from the civil society, particularly at the regional level.
The budgeting and fund disbursement is insufficiently transparent.
Public organisations have no casting votes in the National TB/HIV Council, which makes their participation in the Council rather formal.
The greater portion of services provided by the civil society is concentrated on the level of regional centres and bigger cities.
The scope, quality and intensity of HIV-prevention measures among the most vulnerable groups of population remain insufficient to effectively prevent HIV from spreading in these groups or limit its potential expansion onto the general population.

Narrative to the civil society involvement section

In 2010-2011 the civil society continued playing a considerable role in the making and the implementation of the government policy to counteract HIV infection/AIDS. The main forms of participation were the following:

- At the national level: public representation in the National Council on Response to TB and HIV/AIDS (the Nation's Coordination Mechanism), its standing committees and commissions (the Committee for Regional Policies; the Committee for Programme-based Activities; the Supervisory Commission. At the regional level the public is represented in local TB/HIV-infection/AIDS councils and in the working groups established with such councils;
- Public involvement in the work of intersectoral working groups (e.g., nearly 16 such groups related to counteraction to HIV/AIDS have been established with the MoH; of these, the Intersector Working Group on Issues of the Delivery of HIV/AIDS and TB-related Social Services to Vulnerable Groups of Population merits a special mention);
- Activities of public councils with the Executive bodies, e.g., the Public Council with the State Service of Ukraine for Countering HIV Infection/AIDS and Other Socially Dangerous Diseases established in September 2011 (it is still premature to evaluate its progress to date);
- Meetings between stakeholders;
- Advocacy campaigns;
- Official exchange and working meetings with government representatives from the Executive.

In theory, the public has ample possibilities to become involved in government policy-making and implementation processes. Yet the respondents also mention existing drawbacks the majority of which have been already mentioned by experts in the previous 2009 report, namely:

Formal nature of public participation in the work of the National TB/HIV Council related to the lack of casting vote for the public in the decision-making process;

The insufficiently transparent process of budgeting and funds allocation. Failure to account for public proposals while planning the national and local budgets on HIV;

Impossibility for the public to impact funds disbursement or oversee funds spending;

The 'restricted' nature of the decision-making process that makes it inaccessible for the civil society, particularly, at the regional level;

Under-representation of high-risk groups in the National and regional TB/HIV Councils;

Underperformance of the National TB/HIV Council as the platform for consensus between the civil society and the government;

Low levels of public involvement, particularly of those representing high-risk groups, at the level of small towns and districts;

Poor representation of religious and rehabilitation organisations, the business sector, trade union movements, associations and coalitions;

Lack of NGO support by the State;

The National Strategy does not include NGO activities, financed from sources other than the Global Fund;

Public representation is mostly linked to representing interests of HIV-service organisations rather than those of the community itself. Operations of the former are predominantly financed from donor funds and, in particular, by the Global Fund;

NGOs' dependence from funds coming from the only source (most of the time it is the Global Fund) attests to insufficient viability and sustainability of such organisations and their activities in the event of funding terminated by the donor;

The National Monitoring and Evaluation System's operability depends on technical assistance from non-governmental organisations (support to the National M&E Group and the National M&E Unit).

NGOs' fundraising and social entrepreneurship capacities are either non-existent or poorly developed;

NGOs' operation is mostly focused at the level of Oblast centres and big cities with smaller towns and districts being practically cut from accessing the services;

NGOs have no access to financial and technical assistance at the level of small towns/districts.

The content of the above listed issues preventing more active involvement of the civil society in counteraction to HIV/AIDS in Ukraine largely repeats the situation of 2008 and 2009. However, despite the barriers the civil society was able to contribute to the making and subsequent implementation of the national policy as well as to the solving a range of issues to enhance accessibility and improve quality of services in the field of HIV counteraction. The principal achievements related to the civil society involvement in this direction have been:

A revision of the Law of Ukraine to Counteract HIV Infection/AIDS Epidemic in Ukraine (1991) initiated; also, participation in the development of changes in that piece of legislation and support to the adoption of changes by the Verkhovna Rada of Ukraine. Consequently, the Law of Ukraine No. 2861-VI to Change the Law of Ukraine on Prevention of Acquired Immune Deficiency Syndrome (AIDS) and on Social Protection of the Population was adopted on 23 December 2010. The new law introduced a new name for the law to counteract HIV infection/AIDS epidemic changing it into the Law on Counteraction to Propagation of Diseases Conditioned by the Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV the new version of which came into force as of 15 January 2011. One special feature of the Law is Clause 3 of Article 14 according to which "*no discrimination against an individual based on availability of HIV infection in such individual or his/her belonging to groups with increased HIV risks shall be allowed".*

Owing to proactive position of the civil society on HIV/AIDS problems actualization, the State Service of Ukraine for Countering HIV Infection/AIDS and Other Socially Dangerous Diseases, the central body of the Executive in charge of government anti-HIV/AIDS policy implementation was officially established in late 2010 (President of Ukraine Decree No. 1085, of 9 December 2010, on Optimisation of the System of Central Executive Bodies).

Owing to a proactive involvement of the civil sector, Ukraine was able to receive the GFATM grant within Round 10 funding on AIDS component to implement its Programme of Development of a Viable System of Comprehensive Services on HIV/AIDS Prevention and Treatment and Care and Support to Vulnerable Groups and PLWH.

In 2011, owing to activities of the All-Ukrainian Charitable Organization "All-Ukrainian Network of People Living with HIV/AIDS" and Charitable Fund "Advisory Community Council on Issues of Access to Treatment in Ukraine" (UCAB) it became possible to convince government officials in the need for 100% funding of treatment of HIV/AIDS patients. The initiated public action *Help to Survive!* resulted in the winning of President of Ukraine's sympathy towards the need for financing the procurement of medicines for HIV-infected individuals 100% from the national budget in 2011 and 2012. Thanks to that, the national budget provision for the treatment of HIV/AIDS patients has doubled.

Advocacy measures of the civil society had an impact on the motioning of legislative initiatives aimed at lowering discrimination against such group with high risk of HIV infection as MSM as well as people living with HIV for consideration of the Parliament. Specifically, advocacy appeals of the All-Ukrainian Union "Council of LGBT Organisations of Ukraine", the draft law No. 8487 effectively banning "*any discrimination in the employment area on the grounds of […] HIV/AIDS status […] or sexual orientation*" has been registered with the Verkhovna Rada of Ukraine*.*

Owing to advocacy activities of gay community organisations (in particular, of the All-Ukrainian Charity Organisation "Gay Forum of Ukraine"), the State Statistics Service of Ukraine issued in July 2011 an official statement to notify discontinuation of statistic records of 'homosexuals', underage included, in Ukraine.

Active advocacy measures taken by non-governmental organisations (in particular, of the All-Ukrainian Union All "Council of LGBT Organisations of Ukraine", the All-Ukrainian Association of Public Organisations "Ukrainian Helsinki Union for Human Rights", the ICF "International HIV/AIDS Alliance in Ukraine", the AUCF "Coalition of HIV-Service Organisations") have complicated prospects of outrageously wretched draft Law of Ukraine No. 8711, of 20 June 2011, to Change Certain Legislative Acts (As Regards the Protecting of Children's Rights to Safe Information Environment) being adopted by the Verkhovna Rada of Ukraine. It should be noted that the draft law that suggests implementation of criminal responsibility for 'propaganda of homosexualism' and 'homosexualism cult' in Ukraine, if adopted, would render impossible a considerable proportion of information outreach measures on HIV

infection prevention among MSM and that, with a view that it has not been scrapped from the agenda, its final rejection by the Parliament will require further efforts from the civil society.

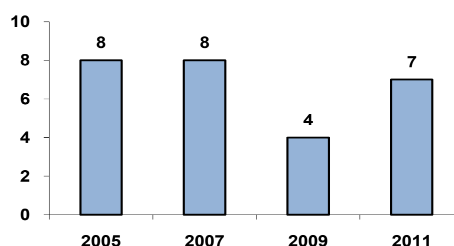
Owing to proactive position of the civil society, a meeting between the Executive Director of the Global Fund to Fight AIDS, Tuberculosis, and Malaria Michael Kazachkin, the Prime Minister of Ukraine, the Minister of Public Health Protection of Ukraine and National Council on Response to TB and HIV/AIDS members took place in January 2012.

Active steps taken by non-governmental organisations have resulted in the implementation of standards of provision of social services to counteract HIV infection epidemics approved by the Joint Order of the Ministry of Ukraine for Family, Youth and Sports, the Ministry of Labour and Social Protection No. 3123/275/770, of 13 September 2010, to Approve Standards of Provision of Social Services to Risk Groups Representatives (registered with the Ministry of Justice of Ukraine on 8 October 2010 under No. 903/18198). The total of five standards have been approved: (1) Standard of the Provision of Social Services of Care and Support for People Living with HIV/AIDS; (2) Standard of the Provision of Social Services on HIV Infection Prevention Among People with High Risk of HIV Contraction through Sexual Transmission; (3) Standard of the Provision of Social Services to Patients with Concurrent TB and HIV Infection; (4) Standard of the Provision of Social Services to Patients with Triple (HIV infection/Tuberculosis/Addiction to substances) Diagnosis; (5) Standard of the Provision of Social Services to Individuals on Opioid Substitution Maintenance Therapy.

The Provisions of the Unified Monitoring and Evaluation System (Cabinet of Ministers of Ukraine Decree of 28.12.2011) and the National M&E Plan (MoH of Ukraine Order of 09.02.2012) were developed and approved with involvement of NGO representatives.

Thanks to the meetings held with MoH representatives, members of the UCAB (the association of patients with the most socially dangerous pathologies for the protection of their interests) were included in the working groups of the MoH of Ukraine in charge of public procurement of ARV and anti-TB medications in 2012 as well as in the Coordination Council of the MoH of Ukraine on matters of OkhMatDyt National Specialised Clinic operation (the structural organization of the OkhMatDyt Children Clinic includes the Centre for Treatment of Children with HIV/AIDS and their parents).

The evaluations of efforts to enhance the civil society role made by civil society experts in this reporting period were higher than in 2009 (please see Picture. 5). However, the indicator is somewhat lower than in 2005 and 2007.



Picture. 5. Evaluation of efforts aimed at increasing civil society involvement. 2005, 2007, 2009 and 2011 (based on expert opinion polls).

II. POLITICAL SUPPORT AND LEADERSHIP

2.1. GARP Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes	No

IF YES, describe some examples of when and how this has happened:
The involvement of representatives of PLWH communities and other key population groups in the process of government policy-making and national programme implementation in the HIV area has been predominantly at the national level, e.g.: Development of the National Strategy for 2009-2013; national expenditures planning. Development of regional operational plans. The work of committees and working groups on response to HIV. Experts are, however, skeptical in their evaluations of government's readiness to hear vulnerable group representatives. There are one or two PLWH representatives among the National TB/HIV Council members. Under the Rules of Procedure of the National Council, the Council Chair shall have four deputies one of them being a representative of a public organization of people living with TB or HIV/AIDS (upon agreement).

III. HUMAN RIGHTS

3.1.1. GARP Does the country have non-discrimination laws or regulations which specify protections for
specific key populations and other vulnerable subpopulations?
Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

3.1.2. GARP Does the country have a general (i.e., not specific to HIV-related discrimination) law on nondiscrimination?

Yes	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

In spite of the absence of a single general piece of legislation against discrimination, a number of regulations do expressly provide for the prohibition of discrimination.
E.g., the prohibition of discrimination is envisaged in Article 24 of the Constitution of Ukraine: "Citizens shall enjoy equal constitutional rights and freedoms and shall be equal under the law. There may not be privileges or limitations on grounds of race, skin color, political, religious or other convictions, sex, ethnic or social origin, ownership status, place of residence, language or other." Sadly, the above language in the Principal Law is not abreast of the challenges of today as it does not warrant effective protection from discrimination on the broadest possible grounds. For example, Article 24 of the Constitution does not mention such grounds for discrimination of relevance for the Ukrainian society as sexual orientation or disability.

In April 2011, a Coalition to Counter Discrimination (CCD) was established in Ukraine that as of 1 March 2012 has united some 26 NGOs. The Coalition sees as one of its objectives the elimination of discrimination in Ukraine on the list of 22 grounds, among them health status, HIV status, sexual orientation and gender identity. The Coalition has developed a draft Law of Ukraine on Protection from Discrimination. There are plans to suggest the bill for consideration of subjects of legislative initiative for the purpose of its further official motioning for consideration of the Parliament.

1. There is a legal prohibition of discrimination of HIV-positive individuals on the ground of their status in Ukraine.
The Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV:
Article 14, Cl. 3: 'Any discrimination of a person on the grounds of HIV availability shall be prohibited. Discrimination shall be construed to mean action or inaction that directly or indirectly creates limitations or divests a person of his/her proper rights or degrades his/her human dignity on the basis of one or more grounds related to actual or possible availability of HIV or gives grounds for referring such person to groups of increased risk of HIV'.
2. A number of documents in Ukraine envision prohibition of discrimination in the employment area, moreover, the National Programme of HIV Prevention provides for measures aimed at overcoming discrimination at the work place, though without showing the planned allocation amount:
Section II. Prevention Measures: 'The providing for development of programmes of HIV/AIDS prevention at the work place for the purpose of avoidance of discrimination of HIV-infected persons in the area of labour relations; the carrying out of monitoring in this area'; 'The preparing and the providing for implementation of HIV/AIDS at work prevention techniques; also elimination of discrimination outbreaks in the area of labor relations.'
The Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV (new 2010 version):
Article 16: 'Dismissal or refusal from employment of individuals living with HIV on the ground of their HIV-positive status or limitation of the rights of their relatives on the above ground shall be prohibited.'
Draft Labour Code of Ukraine (currently at the public hearings stage):
Volume One. General Provisions. Chapter 1. Main Provisions. Article 4. Prevention of Discrimination in the Employment Area: 'Any discrimination in the area of employment, in particular, the breach of the equal rights and possibilities principle or direct or indirect limitation of the rights of employees depending on suspected or actual HIV/AIDS pathology shall be prohibited.'
MoH Order No. 457, of 01.06.2009, to Approve the Action Plan of the Ministry of Education and Science of Ukraine to Implement the National Programme of HIV Prevention, Treatment, Care and Support of HIV-Infected and AIDS Patients for 2009 through 2013:
Clause 1.4 of the Action Plan: 'To supervise compliance with HIV/AIDS legislation in the employment area as regards the overcoming of discrimination of HIV-infected persons; to provide for implementation of on-the-job HIV/AIDS prevention techniques as well as to overcome manifestations of discrimination in the employment area.'

3. Discrimination of PLWH by health care services providers is legally prohibited in Ukraine.
The Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV (new 2010 version):
Article 16: 'Any refusal from admittance of individuals living with HIV on the ground of their HIV-positive status or limitation of the rights of their relatives on the above ground shall be prohibited.'

4. Discrimination of PLWH in the area of pre-school and school education is legally prohibited in Ukraine.
Article 16. of the Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV (new 2010 version).
The Order of the MoH, the MES, the MFYS, the State Department of Corrections and the Ministry of Labour No. 740/1030/4154/321/614a, of 23.11.2007, on Measures of Organising Prevention of HIV Mother-to-Child Transmission, Medical Care and Social Support of HIV-infected Children and Their Families:
The Instruction to the Procedure of Health and Social Care Delivery to HIV-infected Children, Clause 6.1: 'HIV-infected children shall attend pre-school, secondary, specialized and higher educational institutions of 1st through 4th accreditation levels on general grounds.'

5. The importance of implementation of measures of enhanced tolerance to PLWH is determined and provided for in Ukraine by a range of regulations.
The Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV (new 2010 version):
Article 4, Clause 1, Subclause 13: 'The State guarantees the enforcement of a consistent policy aimed at forming tolerant attitude towards people living with HIV.'
Article 4, Clause 1, Subclause 14: 'The State guarantees the implementation of information activities aimed at forming tolerant attitudes among the population towards, and avoiding discrimination of people living with HIV.'

Law of Ukraine No. 1026-VI to Approve the National Programme of HIV Prevention, Treatment, Care and Support of HIV-infected persons and AIDS Patients for 2009 through 2013:
Section II. Preventive Measures: 'To contribute to the forming of tolerant attitude to HIV-infected persons and AIDS patients'. Planned financing at UAH700 thousand from the GF grant. 'Provision of informational and education activities on issues of tolerant attitude towards HIV-infected children.' Planned financing at UAH5,000 from the national budget.
MoH Order No. 452, of 25.06.2009, to Approve the Action Plan to Implement the National Programme of HIV Prevention, Treatment, Care and Support of HIV-infected persons and AIDS Patients for 2009 through 2013:
Clause 6.3 of the Action Plan: 'To contribute to the forming of tolerant attitude towards HIV-infected and AIDS patients in cooperation with non-governmental organizations.'

6. The importance of implementation of measures of enhanced tolerance to risk groups is determined and provided for in Ukraine by a range of regulations. However, the National Programme does not mention the amount earmarked to fund the measures.
Law of Ukraine No. 1972-XII, of 12.12.1991, the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV (new 2010 version):
Article 4, Clause 1, Subclauses 13 and 14 (please refer to Box 7 in this Form).
Law of Ukraine No. 1026-VI to Approve the National Programme of HIV Prevention, Treatment, Care and Support of HIV-infected and AIDS Patients for 2009 through 2013.
Section II. Preventive Measures: Carrying out measures aimed at overcoming manifestations of discrimination on the part of employees of public health, labor and social protection authorities against

risk group representatives.'

MoH Order No. 452, of 25.06.2009, to Approve the Action Plan to Implement the National Programme on HIV Prevention, Treatment, Care and Support of HIV-infected persons and AIDS Patients for 2009 through 2013:
Clause 6.4 of the Action Plan: 'To provide for the execution of measures aimed at overcoming manifestations of discrimination on the part of employees of public health, labour and social protection authorities against risk group representatives.'

7. In Ukraine, laws and MES orders warrant the inclusion of the issue of tolerant attitude to PLWH into the school curricula.
Law of Ukraine No. 1972-XII, of 12.12.1991, the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV (new 2010 version):
Article 4, Clause 1, Subclause 6: 'The State guarantees the inclusion of issues on inadmissibility of discrimination of such individuals [PLWH] and on the need of forming a tolerant attitude towards these through respective curricula for secondary, vocational and higher educational institutions.'

MoH Order No. 457, of 01.06.2009, to Approve the Action Plan of the Ministry of Education and Science of Ukraine to Implement the National Programme on HIV Prevention, Treatment, Care and Support of HIV-Infected and AIDS Patients for 2009 through 2013:
Clause 4.2 of the Action Plan: To introduce an optional training course on HIV/AIDS prevention for the youth in secondary educational institutions.
Clause 4.5 of the Action Plan: To contribute to the forming of tolerant attitude towards HIV-infected persons and AIDS patients. To provide for informational and educational work on matters of shaping tolerant attitude towards HIV-infected children.

9. In Ukraine, the Ministry of Education and Science of Ukraine has included topics of tolerant attitude towards PLWH in the curricula of advanced training courses for pedagogical staff.
MoH Order No. 457, of 01.06.2009, to Approve the Action Plan of the Ministry of Education and Science of Ukraine to Implement the National Programme of HIV Prevention, Treatment, Care and Support of HIV-Infected and AIDS Patients for 2009 through 2013
Clause 3.6. of the Action Plan: To include the course on the Forming of Tolerant Attitude To HIV-positive Children into the System of Pre-School and School Education in the System of Advanced Training of Pedagogical Staff of Pre-School and Secondary Educational Institutions and Educational Managerial Staff.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:
A range of laws are in need of review to make them compliant with the Law of Ukraine No. 1026-VI to Approve the National Programme of HIV Prevention, Treatment, Care and Support of HIV-infected and AIDS Patients for 2009 through 2013. There are no bylaws aimed at the enforcement of the new (as of 23.12.2010) version of the Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV.

Briefly comment on the degree to which they are currently implemented:
It appears to be quite challenging a task to practically enforce the norms against discrimination envisaged in the new version of the anti-HIV law in absence of adopted bylaws. The legislation per se is barely able to change anything as the very legal culture and legal consciousness need to be changed. According to public opinion polls, a mere 3% of residents in Ukraine believe in due process and unbiased, uncorrupted courts. Hence, a new version of the anti-HIV law will hardly change anything if there is no one to comply with legal norms.

3.2. GARP Does the country have laws, regulations or policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No

3.2.1. GARP IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[43]*[write in]*:[65]	Yes	No

Briefly describe the content of these laws, regulations or policies:
Medical assistance for ART administration is delivered on a territorial principle. Pursuant to internal regulations of the correctional facilities and Code of Criminal Procedures norms, a syringe is the prohibited item that renders impossible the implementation of syringe exchange programmes on the territory of such facilities. There exists also the ban to the handing over of medications, ART medicines included, which creates additional problems with the shaping and the supporting of propensity and further complicates treatment and delivery of care and support services. There is no legislative framework in place that would regulate continuation of substitution therapy in conditions of MIA and correctional facilities. This leads to disruptions in the treatment regimen already at the stage of temporary detention facility. Insufficient SMT programmes scale up has been due, in particular, to the lack or improper quality of orders issued by regional Public Health Departments, also because of the absence of medication distribution schedules and fixed pharmacy units; non-compliance with MoH orders as to the number of SMT patients and the absence of prescription-based distribution of medications. An outdated and incomplete legal regulatory framework that regulates the medical waste storage and disposal procedure together with the requirement of mandatory disinfection of used syringes imposed by supervisory authorities hampers activities of civil organizations related to the collection of used syringes. In the last 12 months the syringe collection rate saw a dramatic drop from 4,714,163 units in 2010 to 3,632,750, in 2011. The new version of MoH of Ukraine Order No. 188/2000, of 29.07.2010, to Approve the Tables of Small, Big and Particularly Big Dimensions of Drug Substances, Psychotropic Substances and Precursors Found in Illegal Turnover provides for a considerable increase of the acetylated opium threshold that brings into effect criminal responsibility in Ukraine. Because of that, the level of criminalization of opioid consumers grew 20 times; the number of syringes returned for exchange dwindled twice thus

[65]Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection

(e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees).

leading to erosion in efficiency of prevention programmes for IDUs. The problem with recognizing medications, medical products and lubricants purchased abroad by the Alliance and the PLWH Network to prevent and treat HIV/AIDS and TB cases in Ukraine in furtherance of respective agreements with the Global Fund remains high on the agenda. A group of six members of parliament has submitted for consideration of the Verkhovna Rada of Ukraine a scandalous draft Law of Ukraine No. 8711, of 20 June 2011, to Change Certain Legislative Acts (on the Protection of the Rights of Children to Safe Information Environment) that suggests imposition of criminal responsibility for 'the propaganda of homosexualism' and 'the cult of homosexualism' in Ukraine. If adopted, the bill will effectively disallow a considerable proportion of information outreach measures of HIV prevention among MSM/LGBT.
Briefly comment on how they pose barriers:
Limitation of access to ART, increased criminalization of IDU environment, deterioration of the performance of prevention programmes (in particular, the syringe exchange ones); stigmatization of drug users.

3.3. GARP Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	No

Briefly describe the content of the policy, law or regulation and the populations included.

3.4. GARP Is the promotion and protection of human rights explicitly mentioned in any HIV policy or
strategy?

Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
The Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV (new 2010 version): issues of propaganda and human rights protection have been defined in Section III. The Rights and Social Protection of Individuals Living with HIV and Their Family Members. Article 13. The right of individuals living with HIV to information. Protection of information about HIV-positive status of an individual from publication and third-party disclosure. Article 14. The equality under the law and the prohibition of discrimination of individuals living with HIV and those belonging to groups with increased risks of HIV. Article 16. Protection of the right to work and other social rights of individuals living with HIV, their relatives and nearest people. Article 17. Making good for the damage inflicted on the health of individual in the event of his/her infection with HIV. Article 18. Rights of parents of children infected with HIV and children suffering from HIV-conditioned diseases. Article 19. State support of HIV-infected children and children suffering from HIV-conditioned diseases. Article 15. Other rights of people living with HIV.

3.5. GARP Is there a mechanism to record, document and address cases of discrimination experienced by

people living with HIV, key populations and other vulnerable populations?

Yes	No

IF YES, briefly describe this mechanism
Neither the Criminal Code of Ukraine nor the Code of Administrative Offences of Ukraine explicitly provide for any responsibility for discrimination, and this is a serious hindrance to bringing to responsibility officials or other persons guilty of discrimination offence. Meanwhile, there is an implicit responsibility for discriminatory acts envisaged in Article 161 of the Criminal Code of Ukraine. Clause 1 of the above article mentions, among other grounds for criminal responsibility, "*a direct or indirect limitation of rights or establishment of direct or indirect individual privileges for citizens based on race, skin colour, political, religious or other convictions, sex, ethnic and social origin, ownership status, place of residence, language or other characteristics*". Nevertheless, there have been only isolated cases of efficient use of the Article in the judicial practice in Ukraine because of a range of practical barriers to its implementation. Such a mechanism is envisioned in the criminal and administrative law system. Documenting and accounting are being done by NGOs on an ad hoc basis. There are no special accounting/documenting facilities provided by government institutions. A number of projects to document discrimination cases and provide protection to persons on a case-by-case basis are implemented on the national level (e.g., projects Liga "Legalife" and "Our World"). The Know Your Rights manual containing the Section on Health Protection. Legal Protection of the Rights of AIDS Patients has been published.

3.6. GARP Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

	Provided free-of-charge to all people in the country		Provided, but only at a cost	
Antiretroviral treatment	Yes	No	Yes	No
HIV prevention services66	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?

[66]Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV
prevention in the workplace, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of motherto-
child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention
and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers,
school-based HIV education for young people, universal precautions in health care settings..

The priority has been given to the following HIV-vulnerable groups:
For testing and counseling: to pregnant women (despite the fact that all have access to free-of-charge services).
HIV-prevention services: first of all, to IDUs; then to FSWs and MSMs.
ART delivery: to PLWH; first of all, to children.
Care and support in relation to HIV: to PLWH; first of all, to children.

3.7. GARP Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	No

3.7.1. GARP In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	No

3.8. GARP Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:

Legal regulations do not provide for either limited or privileged access to services; in particular, this is envisioned in the new (as of 23.12.2010) version of the Law of Ukraine No. 1972-XII, 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV.
However, there is no equal access to these in reality as prisoners and IDUs have only limited access.
The National Strategy for 2009-2013 envisages the work with high-risk group representatives; however, it fails to account for all the key population groups (there is no mention of women having sex with women and transgender individuals).

3.8.1. GARP IF YES, does this policy/strategy include different types of approaches to ensure equal access
for different key populations and/or other vulnerable sub-populations?

Yes	No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

Article 4 of the Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV (the new 2010 version) sets out government guarantees of:

- Prevention of HIV infection spread among injecting drug users of psychotropic substances through programmes for rehabilitation of such individual and harm reduction programmes that, inter alia, envisage administration of substitution maintenance therapy to individuals suffering from the substance addiction as well as creation of conditions for the exchange of used syringes and needles for sterile ones with subsequent recycling of the former (Cl. 8);
- Free access to services preventing HIV infection transmission from HIV-infected pregnant

women to their new-born children (Cl. 11);

- Implementation of a consistent policy aimed at the shaping tolerant attitude towards individuals who belong to groups with increased risk of HIV and to people living with HIV (Cl. 13);
- Social protection of people living with HIV and their family members; also provision of necessary health care and social services to people living with HIV (Cl. 15).

The National Strategy for 2009-2013 envisages a set of prevention, treatment and organisation measures as well as measures to care for and support HIV-infected persons and AIDS patients, specifically:

Provision of free access to advice and free-of-charge HIV-tests to the population and, first of all, to young people and risk group representatives;

Stepping-up of prevention measures among risk group representatives (IDUs; individuals serving their term at correctional facilities; those released from serving term; individuals engaged in prostitution; migrants; individuals without home or shelter, particularly, children (also from families with complicated life conditions) etc.);

Broader access for IDUs, particularly, HIV-infected, to substitution maintenance therapy and rehabilitation programmes;

Provision of HIV-infected persons and AIDS patients with antiretroviral therapy;

Provision for the treatment of HIV-infected and AIDS patients with opportunistic and associated diseases;

Coordination of palliative support delivery to HIV-infected and AIDS patients;

Delivery of social services and provision of social and psychological support and non-medical care to HIV-infected persons and AIDS patients;

Granting legal advice to HIV-infected persons and AIDS patients.

3.9. GARP Does the country have a policy or law prohibiting HIV screening for general employment
purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	No

IF YE,S briefly describe the content of the policy or law:

Cl. 2, Article 6 of the new version of the line Law of Ukraine on HIV/AIDS states, 'The testing of individuals 14 or more years of age shall be carried out on a voluntary basis.'

In spite of HIV tests being voluntary in Ukraine, there are overt or silent HIV tests used for some employment or service options (regular military service, police etc.)

3.10. GARP Does the country have the following human rights monitoring and enforcement mechanisms?

Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No

Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No

IF YES on any of the above questions, describe some examples:

In spite of the negative answer to Question a) provided in comments, the experts generally recalled the existence of the judicial system in general, the Ombudsman and activities of human rights organisations.

3.11. GARP In the last 2 years, have there been the following training and/or capacity-building activities:

Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[67]?

Yes	No

Programmes for members of the judiciary and law enforcement[68] on HIV and human rights issues that may come up in the context of their work?

Yes	No

3.12. GARP Are the following legal support services available in the country?

Legal aid systems for HIV casework

Yes	No

Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	No

3.13. GARP Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other [write in]: Raising public awareness on HIV/AIDS issues in schools and pre-school facilities to reduce stigmatisation and discrimination of HIV-positive children within the system of pre-school and secondary school education.	Yes	No

3.14. GARP Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you
rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:

67 Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008).
68Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labor court judges or commissioners.

1. A new version of the Law on HIV has been adopted that is specifically targeted at: Legal protection of people living with HIV and their nearest ambience (this is reflected not only in the new name of the Law but also in a number of its articles); Counteraction to discrimination against PLWH and representatives of groups with increased risk of HIV infection; Securing the right of access to HIV infection prevention, treatment, care and support. Nevertheless, the experts also comment on a certain declaratory nature of the language of that law that is related to the lack of proper mechanisms of their enforcement. 2. Carrying out a survey into the level of PLWH stigmatisation as part of a global initiative in various walks of life (labour relations, medical services, family and inner circle relations, educational area, self-stigmatisation). 3. Implementation of projects on protection of rights of vulnerable group representatives with support from the European Commission.
What challenges remain in this area:
Lack of systemic work in absence of its institutionalization Difficult situation at the local level; rights violations High stigmatisation levels in smaller towns and villages Absence of a mechanism to reveal rights violation cases and penalize health care institutions for failure to deliver proper medical services to PLWH (diagnosis and treatment should be fully financed from the national budget) Absence of a national authority responsible for the monitoring of such activity Corruption in the public procurement system Criminalisation of drug addicts Inaccessibility/discontinuation of SMT and TB treatment Administrative persecution for prostitution; a draft law has been recently registered with the Parliament that aims at enhancing responsibility for prostitution; there is also another draft law, to Change Certain Legislative Acts (on Protection of the Right of Children to Safe Information Environment), that envisages criminal responsibility for the 'propaganda of homosexualism.'

3.15. GARP Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you
rate the effort to implement human rights related policies, laws and regulations in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
Owing to the efforts of the civil society, it has been possible to secure extra budget allocations for the procurement of ART medicines Adoption of the new version of the Law on HIV
What challenges remain in this area:
Dishonesty and corruption of the judicial system and law enforcement agencies; tortures in the police. Breaches of rights of participants in harm reduction and substitution maintenance therapy programmes (also by medical personnel). Disclosure of information about HIV status and HIV morbidity rates; unauthorized collection of such information by government authorities. In spite of the adopting of some progressive pieces of legislation in the HIV sphere, the situation with rights observance has deteriorated since the change of government in 2010.

NARRATIVE TO THE HUMAN RIGHTS SECTION

The citizens of Ukraine are guaranteed their rights and freedoms by the principal law of Ukraine, the Constitution of Ukraine. Article 6 of the Constitution guarantees the equality of civil constitutional rights and freedoms, the equality of citizens under the law as well as the absence of privileges or limitations on grounds of race, skin colour, political, religious or other convictions, sex, ethnic and social origin, ownership status, place of residence, language or other.

While there is no special anti-discrimination legislation in Ukraine, there exists a range of different laws and legal regulations with anti-discriminatory provisions.

The year 2010 witnessed one of the most prominent events in the context of protection of rights of people living with HIV and their inner circle and implementation of anti-discrimination policy regarding these. On December 23, 2010 changes were introduced to the principal legislative act that regulates the rights of HIV-infected persons and AIDS patients, the one On prevention of Acquired Immune Deficiency Syndrome (AIDS) and on Social Protection of the Population. Changes were made even to the name of the law to make it read: the Law on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV. The name of this improved piece of legislation as well as a whole range of its articles underscore the need for not only social but also legal protection of people living with HIV and their relatives.

The most important changes in the new version of the Law as regards the observance of human rights have been the following:

The discriminatory and stigmatizing provision in the previous law that covered special responsibilities of people living with HIV, like ‘diplomatic missions and consulates of Ukraine may issue visas for entry in Ukraine to foreign nationals and persons destitute of citizenship rights arriving in Ukraine for the period in excess of three months subject to presentation by such persons of a documentary proof of their negative HIV infection status’ has been cancelled;

The right of people living with HIV to participate in assistive reproduction technology programmes has been envisaged in case of prevention of HIV transmission from the parents to their would-be child (Art. 10);

The section dedicated to rights and social protection of people living with HIV and their family members was drastically changed; specifically, measures to regulate the confidentiality of information on HIV status of individual, the right of people living with HIV to be provided with respective goods and services necessary for HIV treatment and prevention, the right to free-of-charge provision of medicines necessary for HIV treatment, protection of the employment rights of people living with HIV etc. have been envisioned.

The Law treats discrimination as action or inaction that directly or indirectly creates limitations or divests a person of his/her proper rights or degrades his/her human dignity on the basis of one or more grounds related to actual or possible availability of HIV or gives grounds for referring such person to groups of high risk of HIV infection (Cl. 3, Art. 14). Article 16 imposes prohibition of PLWH discrimination by medical services providers and in the field of pre-school land school education. Both this Law and departmental and interdepartmental orders of Central executive bodies provide for inclusion of the issue of tolerant attitude towards PLWH in the curricula of schools and advanced training courses for pedagogical staff.

At the same time, there are certain issues with practical enforcement of such anti-discrimination legislative provisions:

A number of laws need to be reviewed to be compliant with the Law of Ukraine No. 1026-VI to Approve the National Programme on HIV Prevention, Treatment, Care and Support of HIV-infected and AIDS Patients for 2009 through 2013.

There are no bylaws aimed at the enforcement of the new (as of 23.12.2010) version of the Law of Ukraine No. 1972-XII, of 12.12.1991, on the Prevention of the Spread of Diseases Conditioned by Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV.

The level of legal culture and legal consciousness among the population is insufficient; there is also distrust towards the judicial system of Ukraine among the population.

The access of representatives of key population groups to the prevention, treatment, care and support services is complicated because of existing regulatory barriers and practices:

Medical assistance to ART is delivered based on a territorial principle.

Internal regulations of correctional facilities and provisions of the Criminal Procedural Code both prohibit the using of syringes thus disallowing implementation of syringe exchange programme on the territory of such facilities. There is also the prohibition of handing over medications, ARVs included, which creates additional problems with fostering and supporting adherence, further complicates treatment and use of care and support services.

There is no legal regulatory framework that would regulate substitution therapy continuation in MIA's and correctional facilities; this leads to disruption of the treatment process already at the stage of temporary detention facility.

Insufficient scale up of SMT programmes has been due, in particular, to the lack or insufficient quality of orders issues by regional PHPD, also to the lack of medication distribution schedules and attached pharmacy units as well as to non-compliance with MoH orders regarding the number of SMT patients and the absence of prescription-based distribution of medications.

An outdated and incomplete legal regulatory framework that regulates the medical waste storage and disposal procedure together with the requirement of mandatory disinfection of used syringes imposed by supervisory authorities hampers activities of civil organizations related to the collection of used syringes. In the last 12 months the syringe collection rate saw a dramatic drop from 4,714,163 units in 2010 to 3,632,750, in 2011**.**

The new version of MoH of Ukraine Order No. 188/2000, of 29.07.2010, to Approve the Tables of Small, Big and Particularly Big Amounts of Drug Substances, Psychotropic Substances and Precursors Found in Illegal Turnover provides for a considerable increase of the acetylated opium threshold that brings into effect criminal responsibility in Ukraine. Because of that, the level of criminalization of opioid users grew 20 times; the number of syringes returned for exchange dwindled twice thus leading to erosion in efficiency of prevention programmes for IDUs.

The problem with recognizing medications, medical products and lubricants purchased abroad by the Alliance and the PLWH Network to prevent and treat HIV/AIDS and TB cases in Ukraine in furtherance of respective agreements with the Global Fund remains high on the agenda.

A group of six MPs has submitted for consideration of the Verkhovna Rada of Ukraine a scandalous draft Law of Ukraine No. 8711, of 20 June 2011, to Change Certain Legislative Acts (on the Protection of the Rights of Children to Safe Information Environment) that suggests imposition of criminal responsibility for 'the propaganda of homosexualism' and 'the cult of homosexualism' in Ukraine. If adopted, the draft law will effectively disallow a considerable proportion of information outreach measures of HIV prevention among MSM/LGBT.

That way, having analysed expert responses, one may conclude that it is IDUs and prisoners who have the biggest problems with access to services.

Parallel to considerable progress made in the legal regulatory framework in respect of the protection of the rights of people with HIV, the experts draw attention to the following issues that remain unresolved:

Lack of systemic work in absence of its institutionalization

Difficult situation at the local level; rights violations

High stigmatisation levels in smaller towns and villages

Absence of a mechanism to reveal rights violation cases and penalize health care institutions for failure to deliver proper medical services to PLWH (diagnostics and treatment should be fully financed from the national budget)

Absence of a national authority responsible for the monitoring of such activity

Corruption in the public procurement system

Criminalisation of drug users

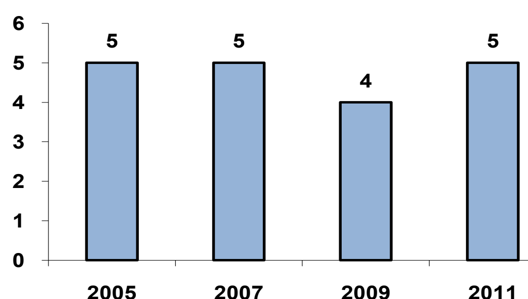
Inaccessibility/discontinuation of SMT and TB treatment

Administrative persecution for prostitution; a draft law has been recently registered with the Parliament that aims at enhancing responsibility for prostitution

Initiatives to introduce criminal responsibility for the 'propaganda of homosexualism': a draft law to Change Certain Legislative Acts (on Protection of the Right of Children to Safe Information Environment).

Governmental institutions have no experience with recording, documenting and reviewing cases of discrimination against people living with HIV and key groups of population. Such activities are performed by NGOs on an ad hoc basis. E.g., a number of projects to document discrimination cases and provide protection to persons are implemented on the national level (e.g., projects of Liga "Legalife", "Our World" and other).

Experts' evaluation of the efforts made in 2011 to practically implement the existing policy, legislation and regulatory provisions were generally higher than in 2009. The 2011 evaluation is similar to those made in 2005 and 2007.



Picture. 6. Evaluation of efforts aimed at practical implementation of the existing policy, legislation and provisions. 2005, 2007, 2009 and 2011 (based on expert opinion polls)

Hence, notwithstanding the adoption of anti-discrimination legislative provision and the broadening of the rights and freedoms of people living with HIV and their close circle, practical enforcement of such policies still drags behind. Some experts mention a deterioration of the situation with observance of human rights since 2010.

The issues in this area include:

- Dishonesty and corruption of the judicial system and law enforcement agencies,
- Tortures in the police,
- Breaches of rights of participants in harm reduction and substitution maintenance therapy programmes (also by medical personnel),
- Disclosure of information about HIV status and HIV morbidity rates; unauthorized collection of such information by governmental authorities.

IV. PREVENTION

4.1. GARP Has the country identified the specific needs for HIV prevention programmes?

Yes	No

4.1.1. GARP To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to...				
	Strongly disagree	Disagree	Agree	Strongly agree	**N/A**

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	**N/A**
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject Drugs	1	2	3	4	N/A
HIV prevention for out-of-school young People	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counselling	1	2	3	4	N/A
IEC[69] on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination Reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young People	1	2	3	4	N/A
Universal precautions in health care Settings	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

4.2. GARP Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?

Very poorly										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
Prevention projects have been included in the application for Global Fund Round 10. Minimum service packages for IDUs, FSWS, and MSM have been identified. Implementation of harm reduction programmes that envisages motivation of risk group representatives to HIV testing has allowed a considerable improvement of HIV detection rates among IDUs, FSWs and street children. Years of joint efforts to overcome HIV epidemics secured a sustainable trend in the stabilization of epidemiological situation and the reduction of morbidity rates among the population in Ukraine. The official data of the Ukrainian Centre for AIDS Prevention and Control with the MoH of Ukraine attest to almost quadruple reduction of the infection prevalence rate on the national scale since the beginning of Global Fund's programmes implementation by the Alliance. When the number of new registered HIV

[69]IEC = information, education, communication

cases in 2004 was 2,482 more compared with the previous year, the nation-wide growth in 2011 was only 687 new cases. The trend became possible, first of all, due to the impact on the population groups most vulnerable to HIV infection: IDUs, FSWs, and MSM. Results of routine and sentinel epidemiological surveillance confirm the considerable effect of prevention programmes on HIV prevalence among IDUs. The absolute majority of newly diagnosed HIV cases among IDUs stabilized at the 2006 level and has been showing a decreasing trend since 2009. The proportion of HIV-positives persons among IDUs has been on a steady decline since 2006, when the indicator was at 16.5%, to 11.3% in 2011. One most characteristic achievement to mention would be the suspension of epidemic growth rate among recent IDUs. It is this subgroup that indicates at HIV morbidity indicator. As results of the recent integrated bio-behavioural survey show, the HIV prevalence indicator for the subgroup of IDUs with up to three-year experience of drug use has decreased more than five times from 29.9% in 2004 to 5.5%, in 2011. The annual median HIV morbidity indicator for the IDU group fluctuates at 2% level.
What challenges remain in this area:
Absence of government institutions that would be in charge of prevention programmes implementation in risk groups. Lack of coordination between the public and the civil sectors. Implementation of prevention programmes via non-governmental sector (civil organizations) for funds from donor organisations attests to their poor viability and sustainability after donor funding is terminated. While the government declares its prevention efforts in the system of school education, such prevention measures are mostly limited to lecturing activities that are hardly the most efficient ones. There are no signs of State's involvement in the work with risk groups. Criminalisation of drug abuse. Lack of budget financing or stability of prevention programmes. Absence of professional training for social workers from the target groups.

NARRATIVE TO THE PREVENTION SECTION

Specific needs in the area of HIV prevention have been outlined in the National Programme for Prevention, Treatment, Care and Support for HIV-infected People and AIDS Patients for 2009–2013. HIV-prevention services to high-risk groups, particularly to IDUs, FSW, MSM and prisoners are provided by NGOs, mostly from grants of the Global Fund.

The experts outlined the following main progresses in the area:

Prevention projects have been included in the application for Global Fund Round 10 on the AIDS Component;

Standards of provision of social services to counteract HIV infection epidemic approved by the Joint Order of the Ministry of Ukraine for Family, Youth and Sports, the Ministry of Labour and Social Protection No. 3123/275/770, of 13 September 2010, have been adopted, and minimum service packages for IDU, CSWs and MSM have been identified in these;

Implementation of harm reduction programmes that envisioned motivation of risk group representatives to HIV testing has allowed a considerable improvement of HIV detection rates among IDUs, FSWs and street children;

There are signs of stabilization of the situation with HIV epidemics and a reduction of infections rates among the population of Ukraine. In experts' view, this has been due to the impact on the population groups most vulnerable to HIV: IDUs, FSWs and MSM;

Effective since 2009 there is a trend towards reduction of HIV morbidity among IDUs, which is further confirmed by routine and sentinel survey data;

Epidemic growth rates among recent IDUs with up to three-year experience of drug use have been suspended.

Civil society experts are of opinion that the implementation of prevention programmes within the reporting period allowed providing access to such prevention components as blood safety, harm

reduction for IDUs, HIV-related counselling an testing, prevention of HIV mother-to-child transmission, HIV prevention among PLWH, reproductive health protection services (also for STDs), lowering risks of HIV transmission among MSM and FSWs.

Prevention components that still remain insufficiently accessible for the population are: propaganda of condom use; HIV prevention among the young people who do not attend school; on-the-job HIV prevention; awareness-raising and educational campaigns on issues of risk level mitigation; reduction of stigmatization and discrimination; reduction of risks for sexual partners from the key groups of the population; educational activities on AIDS matters among the school pupils; universal measures of HIV prevention at medical assistance delivery.

Unlike the 2009 expert opinion poll results, this year's responses have estimated the prevention measures on condom propagandas as inaccessible for the majority of those in need of it. At the same time, prevention measures related to HIV counselling and testing, harm reduction for IDUs, risk mitigation for MSM and FSWs, and reproductive health protection services have been deemed more accessible for the majority of those in need of these as opposed to 2009.

According to respondents, the barriers to prevention programmes implementation in Ukraine include:

Lack of governmental institutions in charge of prevention programmes implementation among risk groups;

Lack of proper coordination between the public and the civil sectors;

Poor viability of prevention programmes implemented by NGOs for funds from donor organisations;

Declaratory nature and inefficiency of prevention programmes in the system of school education;

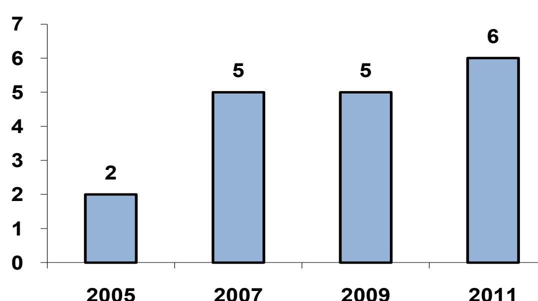
No prevention activities are carried out among risk groups by government institutions;

Criminalisation of drug users complicates access to clients;

Lack of budget financing or sustainability of prevention programmes;

Lack of professional training for social workers from among the target groups.

This year's efforts of HIV prevention programmes implementation have obtained the highest scores from the experts (compared with other reporting periods; please refer to Picture. 7).



Picture. 7. Evaluation of efforts aimed at HIV prevention programme implementation. 2005, 2007, 2009 and 2011 (based on expert opinion polls).

V. TREATMENT, CARE AND SUPPORT

5.1. GARP Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

IF YES, Briefly identify the elements and what has been prioritized:
Within the reporting period, standards of provision of social services to counteract HIV infection epidemic approved by the Joint Order of the Ministry of Ukraine for Family, Youth and Sports, the Ministry of Labour and Social Protection No. 3123/275/770, of 13 September 2010, have been adopted, as follows: Standard of the Provision of Social Services of Care and Support for People Living with HIV/AIDS; Standard of the Provision of Social Services on HIV Infection Prevention Among People with High Risk of HIV Contraction through Sexual Transmission; Standard of the Provision of Social Services to Patients with Concurrent TB and HIV Infection; Standard of the Provision of Social Services to Patients with Triple (HIV infection/Tuberculosis/Addiction to substances) Diagnosis; Standard of the Provision of Social Services to Individuals on Substitution Maintenance Therapy with Opioid Agonists. On 25.02.2010, the State Department of Ukraine for Corrections approved the Methodical Recommendations to the Provision of Social Care and Support Services to PLWH Staying in Correctional Facilities. The following documents have been developed and await approval: Standard of Provision of Social Services to HIV-Infected Children Orphans and Children Destitute of Parental Care. Standard of Primary Prevention of Tuberculosis, Risky Behaviour Towards Sexually Transmitted Infections, Including HIV Infection and Other Dangerous and Particularly Dangerous Infectious Diseases Among Children and Young People in Risk Groups. The main priorities of these documents include: early beginning of ART; forming and supporting of adherence to ART and medical services in general; support of families with children and prisoners (counselling, retrieval of documents, food packages, and referral to health care facilities). The Standards cover the most HIV-vulnerable groups of population (people with high risk of sexually transmitted infections, PLWH, AIDS/TB patients, triple-diagnosis AIDS/TB/IDU) patients; people receiving maintenance therapy) and aim at providing continuity of prevention, medical, social, legal, social and economic and information services to vulnerable groups of population. At preparing the Country Application for Financing within the framework of Global Fund round 10, the needs calculation was made on the basis of the above standards. Treatment of HIV patients is performed based on clinical protocols approved by the MoH. A new clinical protocol of antiretroviral therapy of HIV infection in adults and adolescents (MoH Order No. 551, of 12.07.2010) was approved in 2010. The protocol gives clear recommendations to medical staff as to the diagnosing of the clinical phase of HIV infection in patients, the scope of examination and treatment required in each individual case with application of various combinations of available modern antiretroviral medications. One of the experts drew attention to the fact that social services standards are little known and hence, poorly implemented.

Briefly identify how HIV treatment, care and support services are being scaled-up?
The network of ART facilities has been expanded to include not only AIDS Centres but also TB dispensaries and central district hospitals. The government complies with the commitments it has assumed and provides treatment (15,000 individuals in 2010 and more than 20,000, in 2011). The broadening of treatment possibilities is being done in a non-uniform way and depends on the amount of allocations from the national budget. The scope of treatment services is being broadened owing to a twofold increase in the financing from the national budget as well as to funds from Global Fund Round 10. As of 01.01.2012, there were 27,542 individuals receiving Art in Ukraine; of these: 22,216, for funds from the national budget; 4,504, for funds from the GF Round 6 within the scope of implementation of the Programme to Support HIV and AIDS Prevention, Treatment and Care for the Most Vulnerable Populations in Ukraine. 822 individuals receive the treatment in correctional facilities for funds from the GF Round 6. Care and support projects are currently implemented exclusively by NGOs for funds from local donors. In 2011, care and support services were available to some 40,000 individuals. Consequently, the expansion of care and support services happens owing to activities of non-governmental organisations. Medical institutions are increasingly conscious of the great benefits brought by NGO activities and begin to actively collaborate with NGOs. Social services for family, children and youth, territorial social welfare centres, war veteran councils, and specialized public social support centres are the key social service providers among public institutions nationwide. However, their scope of work lacks specific HIV-related services; e.g., the Kyiv Social Services for Family, Children and Youth has been seeing its budget on a steady decrease since 2009, which renders impossible any broadening of the scope of service it provides.

5.1.1. GARP To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree Strongly	Agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for	1	2	3	4	N/A

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree Strongly	Agree	N/A
occupational exposures to HIV					
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other[write in]:	1	2	3	4	N/A

5.1.2. GARP Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you
rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

VERY POORLY										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
The coverage of patients with ART and TB treatment services increased Almost a hundred-per cent coverage of children with ART reached Treatment accessibility enhanced owing to the twofold increase in ART sites The Care and Support Component included in the service package for PLWH Accessibility of care and support services in regions increased Despite progress achieved with increased budget allocations for ARV medicine procurement in late 2011, a range of issues arose throughout the year that affected the quality of life of PLWH. Tender procedures on procurement of ARV medicines were carried out of schedule, which led to their ill-timed supply to regions and from here, to disruptions in the treatment of patients. Disruptions were registered with IFA testing services, also among the pregnant women, and with CD4 diagnosis. Also, the lack of milk formulas and ARV medications for new-borns took place.
What challenges remain in this area:
Individual risk groups to HIV (IDUs, CSW and prisoners) continue being beyond the scope of treatment programmes. Issues with treatment services accessibility remain highly relevant for remote regions, smaller towns and villages. Care and support services are not in the range of services provided by public institutions. There are disruptions with therapy and problems with inaccessibility of hepatitis diagnosis and treatment, particularly in correctional facilities. The public procurement legislation is far from perfect.

5.2. GARP Does the country have a policy or strategy to address the additional HIV-related needs of
orphans and other vulnerable children?

Yes	No

5.2.1. GARP IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

5.2.2. GARP IF YES, does the country have a national action plan specifically for orphans and vulnerable
children?

Yes	No

5.2.3. GARP IF YES, does the country have an estimate of orphans and vulnerable children being reached
by existing interventions?

Yes	No

5.2.4. GARP IF YES, what percentage of orphans and vulnerable children is being reached?

%

NARRATIVE TO THE TREATMENT, CARE AND SUPPORT SECTION

The Constitution of Ukraine guarantees free-of-charge health care support for all the citizens in the country. The National Strategy for HIV for 2009-2013 provides for effectuation of a set of treatment measures, specifically as regards the provision of HIV/AIDS patients with antiretroviral therapy pursuant to standards and clinical protocols approved by the Ministry of Public Health Protection of Ukraine. In 2010, a new clinical protocol for antiretroviral therapy of HIV infection in adults and adolescents (MoH Order No. 551, of 12.07.2010), was adopted. The protocol gives clear recommendations to medical staff as to the diagnosing of the clinical phase of HIV infection in patients, the scope of examination and treatment required in each individual case with application of various combinations of available modern antiretroviral medications.

The procurement of ARV medicines is done for funds from the national budget and the Global Fund. The government complies with the commitments it has assumed and provides treatment to those who needs it (15,000 individuals in 2010 and more than 20,000, in 2011).

As of 01.01.2012, there were 27,542 individuals receiving Art in Ukraine; of these:

22,216, for funds from the national budget;

4,504, for funds from the GF round 6 within the scope of implementation of the Programme to Support HIV and AIDS Prevention, Treatment and Care for the Most Vulnerable Strata in Ukraine.

822 individuals receive the treatment in correctional facilities for funds from the GF round 6.

Care and support projects are currently implemented exclusively by NGOs for funds from local donors. Consequently, the expansion of care and support services happens owing to activities of non-governmental organisations. In 2011, care and support services were available to some 40,000 individuals. Social services for family, children and youth, territorial social welfare centres, war veteran

councils, and specialized public social support centres are the key social service providers among public institutions nationwide. However, their scope of work lacks specific HIV-related services.

Within the reporting period, standards of provision of social services to counteract HIV infection epidemic approved by the Joint Order of the Ministry of Ukraine for Family, Youth and Sports, the Ministry of Labour and Social Protection No. 3123/275/770, of 13 September 2010, have been adopted. On 25.02.2010, the State Department of Ukraine for Corrections approved the Methodical Recommendations to the Provision of Social Care and Support Services to PLWH Staying in Correctional Facilities. The main priorities of these documents include: early beginning of ART; forming and supporting of adherence to ART and medical services in general; support of families with children and prisoners (counselling, retrieval of documents, food packages, and referral to health care facilities).

The Standards cover the most HIV-vulnerable groups of population (people with high risk of sexually transmitted infection, PLWH, AIDS/TB patients, triple-diagnosis AIDS/TB/IDU) patients; people receiving maintenance therapy) and aim at providing continuity of prevention, medical, social, legal, social and economic and information services to vulnerable groups of population.

The following documents have been also developed and await approval: the Standard of Provision of Social Services to HIV-Infected Children Orphans and Children Destitute of Parental Care; the Standard of Primary Prevention of Tuberculosis, Risky Behaviour Towards Sexually Transmitted Infections, Including HIV Infection and Other Dangerous and Particularly Dangerous Infectious Diseases Among Children and Young People in Risk Groups.

The National Strategic Action Plan for HIV Prevention Among Children and Youth in Risk Groups and Vulnerable to HIV, Care and Support of Children and Youth Affected by HIV/AIDS Issues was adopted in 2010 (approved by the National Council on Response to TB, HIV/AIDS on 25.05.2010).

The key achievements in the area of improved access to treatment, care and support have been, as follows:

Owing to civil sector efforts and advocacy campaigns, it became possible to actualise the problem of shortage of ARV medications. Thanks to the above activities, the President of Ukraine issued a respective commission order to the Government in late 2011 to secure 100% the need for ARV medications among those in need of such treatment. National budget allocations on treatment (ART) nearly doubled.

Budget savings allowed for lowering prices on ARV medications. Additional procurement of medicines for HIV-infected was carried out.

Prospects of broadening of treatment services thanks to the funds available from Global Fund round 10.

The network of ART facilities has been expanded to include not only AIDS Centres but also TB dispensaries and central district hospitals. The number of ART-providing sites has doubled.

Standards of social services adopted.

Collaboration between health care institutions and NGOs as regards the delivery of treatment, care and support services improved.

Coverage of patients with ART and TB treatment services increased.

Almost a hundred-per cent coverage of children with ART reached

The Care and Support Component included in the service package for PLWH

Accessibility of care and support services in regions increased

In spite of greater treatment coverage overall, it is being done in a non-uniform way and depends on the amount of allocations from the national budget. A range of issues arose throughout 2011 that affected the quality of life of PLWH:

Disruptions in ARV medicines supply within the scope of the national programme led to disruptions in the treatment of patients. That was due to ill-timed handling of ARV medication procurement procedures. Disruptions were also registered with IFA testing services and with CD4 diagnosis. Also, the lack of milk formulas for new-borns took place.

Experts draw attention to the following systemic problems affecting accessibility of treatment, care and support services:

Individual risk groups to HIV (IDUs, CSW and prisoners) continue being beyond the scope of treatment programmes;

Lack of access to hepatitis diagnosis and treatment, particularly in correctional facilities;

The public procurement legislation is far from perfect;

Issues with late HIV diagnosis and with accessibility of treatment services in remote regions, smaller towns and villages remain high on the agenda;

Not all prisoners have access to services or are able to receive them in full;

Care and support services are not in the range of services provided by public institutions.

Problems with access to treatment, care and support services are relevant for prisoners, injecting drug users, female sex workers, children orphans raised in public educational institutions, disabled persons living in public welfare homes, people with physical disabilities affecting their ability to move, children and adolescents living in the street, victims of violence (irrespective of sex), low-income individuals, persons destitute of citizenship rights or without ID, illegal migrants and adolescents.

IDUs and FSWs demonstrate both subjective personal barriers to access the services (distrust in the public health system in general; fear of being 'recorded'; failure to comprehend one's belonging to the IDU/FSW group) and systemic reservations (unsuitable working hours of health care facilities; their remote location far from the place of stay or residence; lack of residence permit; shortage of medicines that leads to preferential treatment of 'trouble-free' patients).

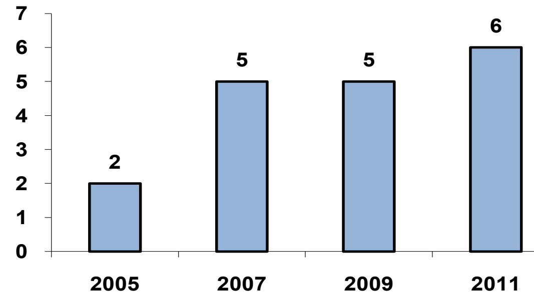
Access problems for migrants, particularly, for illegal ones, are related to the lack of residence permit, language barriers and are due to the medicine accounting and reporting system in place in Ukraine.

For prisoners, the access to treatment, care and support services is hampered by the closed nature of the correctional system overall as well as by the lack of statistically reliable data and sufficient amount of medicines and distrust in the support system.

As in the previous report from 2009, experts have noted that within the reporting period the majority of those in need could access paediatric HIV treatment and post-contact prevention facilities. The respondents amended this year's list of available treatment, care and support components with early diagnosis of HIV among new-borns; HIV counselling and testing for TB patients; social and psychological support of PLWH and their family members; supervision of TB situation at facilities where HIV-related treatment and care are delivered; TB-prevention therapy among HIV-infected; TB screening of HIV-infected persons; and post-natal ART for women.

The experts keep deeming inaccessible/not fully accessible: antiretroviral therapy (particularly for TB patients); cotrimoxazole prevention among HIV-infected persons; on-the-job care and support; on-the-job treatment services for PLWH; dietary support; prevention therapy to prevent TB spread among PLWH; treatment of the most widespread HIV-related pathologies.

Efforts made to implement HIV-related treatment, care and support programmes scored higher in 2011 (Picture. 8).



Picture. 8. Evaluation of efforts aimed at implementation of HIV-related treatment, care and support programmes. 2005, 2007, 2009 and 2011 (based on expert opinion polls).

ANNEX 4: GOVERNMENT EUROPEAN SUPPLEMENT TO THE NATIONAL COMMITMENTS AND POLICY INSTRUMENT (PART A)

Political Leadership

The report from the last round of monitoring the Dublin Declaration suggested taking a different approach to measuring political leadership than the traditional focus on issues such as the presence or absence of national strategic frameworks and AIDS coordinating authorities. The report identified measures that would provide a better assessment of political leadership:

The extent to which relevant and effective policies are in place, including policies related to populations and/or interventions that may lack widespread political support in the country (e.g. the provision of harm reduction services in prisons, the provision of ART for undocumented migrants).

The extent to which HIV prevention funding is prioritized towards those subpopulations that are most affected by HIV in a country.

The extent to which essential programmes are delivered at scale, even if they lack widespread political support.

The extent to which countries are providing ART coverage for key populations, particularly people who inject drugs, men who have sex with men, migrants and prisoners.

1. Are relevant and effective policies in place that demonstrate political leadership in the response to HIV?

Yes □ No □

If Yes, briefly describe (i.e. 100-200 words) the key policies that demonstrate political leadership?

The key national policy priorities have been set out in the National Programme for Prevention, Treatment, Care and Support for HIV-infected People and AIDS Patients (hereinafter, 'the Programme') approved by the Verkhovna Rada of Ukraine for 2009–2013. In compliance with the National Programme, ministerial institutional programmes (specifically, by the Ministry of Education, Science, Youth and Sports and the State Penitentiary Service) as well as regional programmes in each region of Ukraine have been developed. The Contracting Authority under the Programme is the Ministry of Health (hereinafter, 'the MoH') in charge of overall coordination and oversight of its performance. Activities of various sectors and stakeholders are coordinated by the National Tuberculosis and HIV/AIDS Council.

2. Is the country's prevention funding prioritized for those populations most affected by the epidemic?

Yes □ No □

If Yes, identify the populations in priority order:

	Second category: PLWH - treatment provision.
	People who inject drugs
	Men who have sex with men
	Migrants
	Prisoners
	Sex workers
	Other:

3. Are measures in place to ensure that relevant and effective programmes (e.g. prevention, treatment, care and support for key populations such as people who inject drugs, men who have sex with men, migrants and prisoners) are delivered at the scale required to provide significant coverage, even if those programmes lack widespread political support?

Yes □ No □

If Yes, briefly describe (i.e. 100-200 words) those measures? Please provide evidence and/or examples that these measures are having a positive impact on coverage.

Prevention among the risk groups is implemented at the expense of Global Fund Project resources owing to substantial contributions by NGOs. These prevention programmes will continue within the two coming years (2012 and 2013) at the expense of the Global Fund Round 10 grant.

Prevention programmes among IDUs on harm reduction have been regularly implemented throughout the reporting period. The infection level among IDUs has decreased within the last years, also owing to involvement of NGOs.

The scope of substitution maintenance therapy implementation has been substantially increased to prevent HIV infection among drug users.

Nevertheless, the experts point out that prevention programmes for IDUs insufficiently take into account the change in HIV infection transmission route - from IDUs to their sexual partners. Low coverage of IDUs sexual partners with prevention programmes.

List any programmes that have limited political support and why.

4. Is antiretroviral therapy readily available for the following populations?

People who inject drugs

Yes □ No □

If No, why not?

Migrants (generally)

Yes □ No □

If No, please explain:

Undocumented migrants (specifically)

Yes □ **No** □

If No, why not?

Prisoners

Yes □ No □

If No, please explain?

Role of Civil Society

1. To what extent were efforts being made in the past year to increase civil society participation in the HIV response?

1 to 5 (1 being lowest and 5 being highest)

① ② ③ ***④*** ⑤

Please provide concise examples (i.e. 100-200 words) of efforts made to increase civil society participation.

Representatives of international organizations and NGOs have been included as members and actively participate in activities of the National and regional TB and HIV/AIDS councils and of all working groups set up with the MoH and the State Service for Social Diseases.

To research public opinion and carry out public discussion of decisions and draft regulations, a Public Council has been established with the State Service for Response to HIV/AIDS and Other Socially Dangerous Diseases.

One good example of in-depth interaction could be the implementation of the Global Fund Round 10 project in collaboration with three key beneficiaries belonging to different sectors, namely the public sector represented by the Ukrainian Centre for AIDS Prevention and Control and the non-governmental sector represented by the All-Ukrainian Network of PLWH and the International HIV/AIDS Alliance in Ukraine.

A Commission to oversee development of applications, the process of negotiations and implementation of programmes executed with money from the Global Fund to Fight AIDS, Tuberculosis and Malaria has been established with the National Tuberculosis and HIV/AIDS Council. The Commission includes representatives of international and non-governmental organisations.

Experts from international organisations and NGOs are involved into carrying out external assessment of national programmes.

Close cooperation between governmental institutions and NGOs for the purposes of prevention programmes implementation and grant funds involvement has been established.

2. To what extent is civil society able to access adequate financial support to implement its HIV activities?

1 to 5 (1 being lowest and 5 being highest)

① ② ③ ***④*** ⑤

3. To what extent is civil society able to access adequate technical support to implement its HIV activities?

1 to 5 (1 being lowest and 5 being highest)

① ② ③ ④ ***⑤***

4. What level of involvement do key risk populations (e.g. people who inject drugs, men who have sex with men, sex workers, migrants and/or prisoners) have in governmental, HIV-related policy design and programme implementation?

1 to 5 (1 being lowest and 5 being highest)

① ② ③ ***④*** ⑤

5. To what extent has civil society contributed to strengthening the political commitment of top leaders and the formulation of national policy?

1 to 5 (1 being lowest and 5 being highest)

① ② ③ ***④*** ⑤

6. To what extent have civil society representatives been involved in the planning and budgeting process for the national response to HIV?

1 to 5 (1 being lowest and 5 being highest)

① ② ③ ***④*** ⑤

7. Should the involvement of civil society in the national response to HIV be strengthened and/or expanded?

Yes □ No □

If Yes, how could it be strengthened and/or expanded and what difference would it make in the response?

There is a high-level NGO involvement in processes of HIV/AIDS policy shaping and

implementation. It is necessary to support the existing initiatives.

National Spending on HIV Prevention

This section of the European Supplement to the NCPI is designed to assess a country's financial commitment to HIV prevention, including detailed information on the funding for targeted interventions among people who inject drugs, men who have sex with men and sex workers.

Note: Countries that use the National AIDS Spending Assessment (NASA) to provide this data to UNAIDS as part of Global AIDS Response Progress reporting do not need to submit any additional data; ECDC will use the data reported to UNAIDS for monitoring the Dublin Declaration. Countries that do not complete the NASA should complete this section of the European Supplement to the NCPI.

The national government should submit the existing financial data that it uses to track total prevention spending as well as funding for targeted interventions among key populations (e.g. people who inject drugs, men who have sex with men, migrants, prisoners). Ideally, the financial data would be for the last complete year that it is available.

If the data on total prevention spending is broken down into additional sub-categories – needle and syringe programmes, opioid substitution therapy, condom social marketing, etc. – the national government is strongly encouraged to provide that information.

If the financial data is disaggregated by source (e.g. national government, provincial/state/local government, commercial sector, civil society), the national government is encouraged to provide that information as well.

1. Provide a concise summary of the data on national spending on HIV prevention.

National expenditures on HIV/AIDS epidemic prevention are being increased every year. The 2009 expenditures amounted to 509.4 million UAH, and those of 2010 equalled to 578.3 million UAH.

2. Is additional information being submitted in an attachment?

Yes □ No □

If Yes, what is the name of the attachment?

National Funding Matrix

3. If you are not providing data for this indicator, please explain why. For example, data is not collected on this issue or it is not considered useful in the country context.

Prevention Response

1. 'Is treatment as prevention' considered to be part of your country's prevention efforts?

Yes □ No □

If No, please explain briefly why not.

If Yes, please indicate if any of the following approaches are used in your country:

Yes	Serodiscordant couples

	Pre-exposure prophylaxis (PrEP)
Yes	Post-exposure prophylaxis (PEP)

Provide a brief summary (i.e. 100-200 words) of any applicable policy, strategy and/or programme related to 'treatment as prevention'.

In recent years in conditions of national budget deficit the State gives increasingly greater priority to the treatment of PLWH. As of end of 2011, around 26 000 receive ARV medications.
Treatment, care and support programs envision components, as follows:
HIV infection diagnostics
Case follow-up; necessary laboratory tests
Access to ART (free of charge for patients)
Access to diagnostics and treatment of opportunistic infections
Social and psychological support
Palliative and hospice support
Mother-to-child HIV transmission prevention programs
Dissemination of information about living with HIV
PLWH' access to reproductive health services.

One considerable achievement in economic crisis conditions is the provision of funds from the national budget to compensate antiretroviral medications procurement expenditures. More than 305 million UAH have been earmarked in the 2012 national budget on measures to counteract HIV infection/AIDS – more than 90 million UAH in 2011.

The most recent antiretroviral medication public procurement tender resulted in the procurement of the medicines at prices 25% lower; the savings will allow for the provision of necessary medicines at the expense of the national budget to more than 5 thousand additional HIV-infected persons in 2012. Moreover, the medications will be procured also within Global Fund Round 6. Thus, more than 13 thousand additional patients will receive treatment. Plans for 2012 envisage the provision of ART to more than 40 thousand patients.

2. Did government and/or civil society conducted any evaluations of prevention projects and programmes in your country during the last two years?

Yes □ **No** □

If Yes, were these evaluations conducted by?

Government □ Civil society □ Both □

If Yes, please provide a brief summary of the most important and/or most useful prevention evaluations conducted during the past two years. If possible, please include some basic information on: 1) the project/programme that was evaluated (e.g. target population, objective of the intervention, coverage); 2) the key findings (positive and negative) from the evaluation; and 3) how the findings were used. You may also include an attachment with additional information if it helps explain the work.

3. Is additional information being submitted in an attachment?

Yes □ **No** □

If Yes, what is the name of the attachment?

Migrants

Please note that the term 'migrants' is being used in a broad context in this indicator. For example, it can include immigrants, undocumented immigrants, mobile/transient populations, ethnic minorities and/or other relevant populations.

1. Are migrants considered an important sub-population in the national response to HIV?

Yes □ **No** □

If Yes: a. Do government and civil society use the term migrant to identify a specific population in the national response to HIV?

Yes □ No □

b. Are other terms used to identify this same population?

Yes □ **No** □

If Yes, list the other term(s).

C. How is the term migrant defined in your country?

An immigrant is a foreign national or an individual without citizenship who has obtained the immigration permit and arrived in Ukraine for full-time residence or, while staying in Ukraine on legal grounds, has obtained the immigration permit and stayed in Ukraine as the full-time resident[70].

A 'migrant worker' is a national of the Contracting Party who has been allowed by another Contracting Party to stay on its territory for the performance of paid work[71].

A refugee is an individual who is not the national of Ukraine and because of having reasonable grounds to doubt becoming the victim of persecution on grounds of race, confession, national origin, nationality (citizenship), membership in a certain social group or political convictions stays beyond the country of his/her national origin and is not able to enjoy the protection by that country or is not willing to enjoy such protection due to the above doubts or, having no nationality (citizenship) rights and staying beyond the country of his/her previous permanent residence is not able or unwilling to return to such country for reasons of the abovementioned doubts[72].

D. Is data available on the total number of migrants in your country?

Yes □ No □

If Yes, what is the overall size of the migrant population?

Statistical recording of external migration processes is performed. E.g., in 2011 the external migration growth rate made 17,096 persons (with the total of 31,674 arriving in, and 14,588 leaving the country); the 2010 increase was at 16,133 persons (33,810 arrived in, and 14,667 left the country).

E. Is disaggregated data collected on the migrant population (e.g. country of origin, health issues)?

Yes □ **No** □

If Yes, what disaggregated data is collected?

If No, why is disaggregated data not collected?

2. Are migrants specifically mentioned in your country's national strategic plan for HIV and AIDS?

[70] Law of Ukraine on Migration

71 European Convention on the Legal Status of Migrant Workers ratified by Law of Ukraine No. 755-V, of 16 March 2007.

72 Law of Ukraine on Refugees and Individuals In Need of Additional or Temporary Protection.

Yes □ No □

If Yes, please provide a brief summary (i.e. 100-200 words) of the context.

The 'migrants' are formally determined in the National Programme as the key vulnerable group for HIV infection prevention; however, it does not actually provide for any special measures regarding this group.

If No, why not?

3. Is there evidence that HIV disproportionately affects migrants in your country?

Yes □ **No** □

If Yes, please provide a brief summary of the evidence.

4. Is there evidence that migrants are disproportionately represented in any of the following key populations?

People who inject drugs	Yes □	**No** □
Men who have sex with men	Yes □	**No** □
Prisoners	Yes □	**No** □
Sex workers	Yes □	**No** □
Other:	Yes □	**No** □
Other:	Yes □	No □

5. What barriers do migrants face in accessing HIV prevention, treatment and care services in your country?

Please provide a brief summary of the barriers

Not defined.

6. How do legal status, laws and policies affect migrants' access to HIV prevention, treatment and care services in your country?

Please provide a brief summary of the issues.

The migrants can access medical care services on general grounds.

7. Is progress in your country's response to HIV among migrants monitored?

Yes □ **No** □

If Yes, please provide a brief summary of how progress is monitored.

8. Are indicators used to monitor progress in your country's response to HIV among migrants?

Yes □ **No** □

If Yes, please provide a brief overview of the indicators and the relevant data sources.

If Yes, what are the data sources for the indicators?

9. Are there targeted prevention programmes for migrants in your country?

Yes □ **No** □

If Yes, please provide a brief summary of the programmes.

10. Does your country have data on the uptake of HIV testing among migrants?

Yes □ **No** □

If Yes, please provide a brief summary of the data.

11. Does your country have data on access to ART among migrants?

Yes □ **No** □

If Yes, please provide a brief summary of the data.

12. Are migrant communities involved in the policy/programming response in your country?

Yes □ **No** □

13. Do you have any HIV-related programmes for migrants in your country that are considered particularly useful and/or effective that could be seen as a 'best practice'?

Yes □ **No** □

If Yes, please provide a brief summary of the programme(s). You may also include an attachment with a description of the programme(s).

14. Is additional information being submitted in an attachment?

Yes □ **No** □

If Yes, what is the name of the attachment?

People who Inject Drugs

This section is designed to collect data on two important aspects of the HIV response among people who inject drugs: The coverage of essential HIV-related services and needle-sharing behaviour. Specifically, national governments are encouraged to provide data on the following topic areas:

- Proportion of people who inject drugs who are regularly reached by needle and syringe programmes
- Number of syringes distributed to/obtained by people who inject drugs
- Proportion of opioid injectors in OST

• Percentage of people who inject drugs who report needle sharing

Further information on the EMCDDA measures is available at the following link on their website: http://www.emcdda.europa.eu/themes/key-indicators/drid Examples of data from these measures are also available on the EMCDDA website: http://www.emcdda.europa.eu/stats11/hsrtab5a and http://www.emcdda.europa.eu/stats11/hsrfig1

Similar measures are also recommended on pages 11-12 of the WHO/UNODC/UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users (IDUs).

It is important to note that the updated set of Global AIDS Response Progress (GARP) indicators from UNAIDS replaced the previous coverage indicator for people who inject drugs with one that measures the 'number of syringes distributed per person who injects drugs per year by needle and syringe programmes'. This indicator is similar to the EMCDDA indicator mentioned above: 'Number of syringes distributed per IDU per year'.

If EMCDDA has data on these indicators for your country and/or you provided data to UNAIDS as part of 2011 GARP reporting, you do not need to resubmit that data for Dublin monitoring. (Countries that participate in the ECDC-sponsored M&E workshop on 25-27 January 2012 will receive a report of any data on their countries held by EMCDDA.)

1. If neither EMCDDA nor UNAIDS has data from your country for the following indicators, please provide a concise summary of any available country data for each of them:

• Proportion of people who inject drugs who are regularly reached by needle and syringe programmes

• Number of syringes distributed to/obtained by people who inject drugs

• Proportion of opioid injectors in OST

• Percentage of people who inject drugs reporting needle sharing

National governments may submit any existing data that is relevant to the indicators on programme coverage for and behaviour among people who inject drugs. Where appropriate, it would be useful to know essential background details, including the numerator and denominator, the data collection methodology and tool(s), the age and sex disaggregation, where the data was collected, why the data was collected and when the data was collected.

2. Is additional information being submitted in an attachment?

Yes □ No □

If Yes, what is the name of the attachment?

Men who have Sex with Men

This section of the European Supplement to the NCPI is designed to collect data on coverage of HIV prevention programmes among men who have sex with men (MSM).

Although coverage data on this population for this has been collected through previous rounds of UNGASS reporting, there have been concerns about the value of the data, particularly in the European region. The existing indicator is composite in nature and considers a person to be covered by a prevention programme if they have received condoms in the last year and know where to get an HIV test, which many experts believe to be insufficient measures. Despite reservations about this indicator, no credible alternative has yet been proposed or accepted by the international community.

In 2010, the European MSM Internet Survey (EMIS) was conducted with more than 180,000 respondents from 38 countries[73].

[73] For more details of EMIS and to access copies of EMIS reports see http://www.emis-project.eu/ .

This survey considered:

• HIV negative MSM to be covered by HIV programmes if they were quite or very confident to get an HIV test AND had been reached by MSM-specific HIV prevention in the last 12 months AND had not had unprotected anal intercourse in the last 12 months because of non-availability of condoms.

• HIV positive MSM to be covered by HIV programmes if they had monitored their HIV infection in the last six months AND had been reached by MSM-specific HIV prevention in the last 12 months AND had not had unprotected anal intercourse in the last 12 months because of non-availability of condoms. For countries with available EMIS data available2, ECDC Is proposing to use this data3 for Dublin reporting in 2012.

For countries with available EMIS data available[74], ECDC Is proposing to use this data for Dublin reporting in 2012[75].

1. Do you agree with ECDC to using EMIS data on coverage of prevention programmes among men who have sex with men for your country in the 2012 Dublin report?

Yes □ No □

If No, please explain why not.

2. Do you have additional data available on coverage of HIV programmes for men who have sex with men in your country?

Yes □ No □

If Yes, please provide a brief summary (i.e. 100-200 words) of the please briefly explain and present this data.

3. Is additional information being submitted in an attachment?

Yes □ No □

If Yes, what is the name of the attachment?

National Report Indicator No. 1.11

Prisons

1. Are free condoms available in prisons in your country?

Yes □ No □

If Yes, are they available in: Some prisons □ Most prisons □ **All prisons** □

2. Is opioid substitution therapy available in prisons in your country?

Yes □ **No** □

If Yes, is it available in: Some prisons □ Most prisons □ All prisons □

If Yes, can prisoners initiate opioid substitution therapy in prison?

Yes □ **No** □

3. Are needle and syringe programmes available in prisons in your country?

Yes □ **No** □

If Yes, are they available in: Some prisons □ Most prisons □ All prisons □

4. Is mandatory HIV testing done in prisons in your country?

Yes □ **No** □

If Yes, is it done in: Some prisons □ Most prisons □ All prisons □

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[74] Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, the former Yugoslav Republic of Macedonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine and the United Kingdom.

[75] If you need more details of the data available specifically for your country from EMIS that will be used by ECDC for Dublin reporting, please contact Teymur Noori at ECDC on Teymur.Noori@ecdc.europa.eu

5. Is Hepatitis C testing done in prisons in your country?

Yes □ **No** □

If Yes, is treatment available for prisoners who test positive?

Yes □ **No** □

If Yes, please provide a brief summary (i.e. 100-200 words) of treatment options, including how and where they are delivered.

Treatment, Care and Support

1. Does your country have policies, laws and/or regulations recommending ART for people living with HIV?

Yes □ No □

If Yes, please indicate when the policy, etc. was adopted and briefly explain (i.e. 100-200 words) why it was adopted.

The National Programme for Prevention, Treatment, Care and Support for HIV-infected People and AIDS Patients; treatment protocols approved by MoH orders.

If No, please explain how decisions are made (e.g. what criteria are used) to determine if a person living with HIV is eligible for ART.

According to treatment protocols[76] based on laboratory tests data and compliance with protocol criteria. Protocols are reviewed and updated on a regular basis.

2. Are there vulnerable and/or marginalized populations who have more difficulty accessing HIV treatment, care and support services?

Yes □ No □

If Yes, please provide a brief response that identifies the populations who have more difficulty accessing treatment, care and support services.

There exist certain difficulties with providing access for all HIV-positive IDUs in need of ART for the reason of insufficient adherence. To minimise the problems, substitution maintenance therapy is applied and support is provided pursuant to the standard requirements[77].

Stigma and Discrimination

1. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes □ **No** □

If Yes, briefly describe this mechanism (i.e. 100-200 words).

2. Does the country have a policy or law prohibiting HIV screening for general employment purposes?

Yes □ No □

If Yes, briefly describe this policy or law.

[76] MoH of Ukraine Order No. 551, of 12.07.2010, to Approve the Clinical Protocol for Antiretroviral Therapy of HIV Infection in Adults and Adolescents.

[77] Order No. 476, of 19.08.2008, to Approve the Treatment Protocol of HIV Positive Individuals who are Injection Drug Users

Law of Ukraine on the Prevention of the Spreading of Diseases Caused by Human Immunodeficiency Virus (HIV) and the Legal and the Social Protection of People Living with HIV does not directly prohibit the screening procedure but actually guarantees the right of individual to seek quality HIV counselling and testing, including anonymous.

3. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes □ No □

If Yes, briefly describe these programmes.

Law of Ukraine on the Prevention of the Spreading of Diseases Caused by Human Immunodeficiency Virus (HIV) and the Legal and the Social Protection of People Living with HIV prohibits discrimination of human based on availability of HIV infection or his/her belonging to a group with increased risk of HIV infection. Discrimination means action or inaction that directly or indirectly creates limitations, deprives the person of his/her rights or dishonours him/her based on one or more characteristic features that relate to actual or possible HIV infection or give grounds for referring the individual to groups with increased risk of HIV infection.

Combined Reporting

For this round of monitoring the Dublin Declaration, the data collection process has been combined with Global AIDS Response Progress reporting, which was previously known as UNGASS reporting.

1. Is this combined approach an improvement over previous processes?

Yes □ No □

If Yes, briefly explain (i.e. 100-200 words) how the new approach is better.

No comments

If No, briefly explain why not and identify ways that it could be improved.

No comments

2. Please rank the amount of effort your country expended in previous rounds of Dublin and UNGASS reporting.

(0 being the least effort and 10 being the most effort)

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ **⑧** ⑨ ⑩

3. Please rank the amount of effort your country expended in this round of combined reporting.

(0 being the least effort and 10 being the most effort)

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ **⑧** ⑨ ⑩

ANNEX 5. CIVIL SOCIETY EUROPEAN SUPPLEMENT TO THE NATIONAL COMMITMENTS AND POLICY INSTRUMENT 2012 (PART B).

Political Leadership

The report from the last round of monitoring the Dublin Declaration suggested taking a different approach to measuring political leadership than the traditional focus on issues such as the presence or absence of national strategic frameworks and AIDS coordinating authorities. The report identified measures that would provide a better assessment of political leadership:

• The extent to which relevant and effective policies are in place, including policies related to populations and/or interventions that may lack widespread political support in the country (e.g. the provision of harm reduction services in prisons, the provision of ART for undocumented migrants).

• The extent to which HIV prevention funding is prioritized towards those subpopulations that are most affected by HIV in a country.

• The extent to which essential programmes are delivered at scale, even if they lack widespread political support.

• The extent to which countries are providing ART coverage for key populations, particularly people who inject drugs, men who have sex with men, migrants and prisoners.

Are relevant and effective policies in place that demonstrate political leadership in the response to HIV?

Yes	No

If Yes, briefly describe (i.e. 100-200 words) the key policies that demonstrate political leadership.

Is the country's prevention funding prioritized for those populations most affected by the epidemic?

Yes	No

If Yes, identify the populations in priority order:

People who inject drugs

Men who have sex with men

Migrants

Prisoners

Sex workers

Other:_____________________________

Other:_____________________________

Are measures in place to ensure that relevant and effective programmes (e.g. prevention, treatment, care and support for key populations such as people who inject drugs, men who have sex with men, migrants and prisoners) are delivered at the scale required to provide significant coverage, even if those programmes lack widespread political support?

Yes	No

If Yes, briefly describe (i.e. 100-200 words) those measures? Please provide evidence and/or examples that these measures are having a positive impact on coverage.

Prevention programs. Prevention programs for IDUs (in particular harm reduction programs), FSWs, MSM and prisoners are financed through non-governmental organizations under the Global Fund projects.

Increasingly more clients are covered by such programs, and there are indications of lower epidemic rates in the population of IDUs.

As of December 31, 2011, performance target indicators were over-fulfilled. During the second

half of the year 2011 large number of new clients were reached, i.e. 23,671 IDUs, 4,865 CSWs, 5,161 MSM, 7,926 prisoners and 6,090 street children.

Over July 01 - December 31, 2011, 42,624 VCTs for HIV were held, while the number of screening tests for STIs reached 78,417. During this period there were 26,363 visits made to mobile clinics with 7,696,919 condoms distributed. Performance indicators as of December 31, 2011, are given in the table below.

Performance indicators	Target	Actual
Number of IDUs reached*	-	157,011
Number of CSWs reached*	-	28,224
Number of MSM reached*	-	19,130
Number of prisoners reached*	-	25,497
Cumulative number of street children reached	-	54,387
Cumulative number of VCT for HIV held	320,000	405,389
Cumulative number of screening tests for STIs held	320,000	480,151
Cumulative number of visits to mobile clinics	130,000	162,589
Cumulative number of condoms distributed	54,817,50 0	67,544,311
Number of clients receiving SMT	-	6,632
*Coverage indicators for the last twelve months are given as of December 31, 2011.		

In 2011 a large portion of representatives from vulnerable populations were reached with prevention services: 157,011 IDUs (54 % of the estimated number); 28,224 CSWs (40 % of the estimated number); 19,130 MSM (20% of the estimated number); 25,497 prisoners (18% of the total number of prisoners). 54,387 children deprived of parental care were reached with prevention activities under the Program.

List any programmes that have limited political support and why.

Substitution therapy programs have limited political support. Experts point out that there is an impact from the neighbouring country (Russia) policy on SMT.

Syringe exchange programs in prisons.

Prevention programs among FSWs and MSM, since there is no governmental authority in charge.

The limited funding of prevention programs for prisoners causes insufficient coverage of prisoners. In 2011 there were 25,000 prisoners reached with prevention services, while the 2011 target indicator “share of prisoners and those detained who are reached with prevention services (%)” under the National HIV/AIDS Program is 40% or approximately 60,000 persons.

The limited political support of care and support programs in the penitentiary system.

Programs in response to HIV/TB co-infection.

4. Is antiretroviral therapy readily available for the following populations:

People who inject drugs

Yes	No

If No, why not?

Men who have sex with men

Yes	No

If No, why not?

Migrants (generally)

Yes	No

If No, why not?

ART is accessible for officially registered migrants only. However, there is a large number of bureaucratic hindrances. This either delays migrants' beginning ART or makes it impossible at all.

Undocumented migrants (specifically)

Yes	No

If No, why not?

The principle of healthcare establishments funding in Ukraine allows for providing healthcare services to citizens of Ukraine who are officially registered within its territory. In Ukraine there is no mechanism of ART services provision to unregistered migrants.

Prisoners

Yes	No

If No, why not?

ART is provided at penitentiary establishments within the framework of the Global Fund programs only. The needs in the therapy by far exceed the capacity of the State Department for the Execution of Sentences to meet them. In some establishments HIV prevalence among prisoners reaches 30%, which is far higher than the HIV prevalence rates in other vulnerable populations. There are problems with diagnostics and treatment of co-infections.

In general, current penitentiary system isn't yet ready for due implementation of programs in response to HIV/AIDS.

The state of affairs with diagnostics at penitentiary establishments is better, though relevant treatment is a challenge.

Role of Civil Society

Does the country have an organization or mechanism that promotes on-going interaction between government, people living with HIV, civil society and the private sector for implementing HIV-related strategies and programmes?

Yes	No

What percentage of the national expenditure on HIV was spent on activities implemented by civil society in the past year?

0%.

The National Strategy for 2009-2013 envisions state budget allocation for the procurement of test systems, medications and laboratory equipment for diagnostics. Thanks to the allocations from municipal budgets, some medical goods are procured, wages of the medical staff are paid and utility bills of the AIDS centers are covered. No funds from the state budget are assigned for programs implemented by the civil society.

As of now, the social request mechanism has been developed in Ukraine; it is realized through the development and execution of social projects in response to HIV/AIDS funded from the budget

and other sources by means of making social contracts (there are examples of the social request mechanism introduced in the oblasts of Odessa and Mykolayiv).

Should the involvement of civil society in the national response to HIV be strengthened and/or expanded?

Yes	No

If Yes, briefly describe how could it be strengthened and/or expanded and what difference it would make in the response?

The involvement of civil society in the national response to HIV can be strengthened and expanded in the following ways:

promoting greater acknowledgement of civil society representatives' experience, expertise and knowledge in matters related to planning the national response to HIV/AIDS;

ensuring public access to forming the state policy and to information on strategic issues;

ensuring public engagement in the work of key working groups on the government procurement of antiretroviral medications (this process was already launched in 2012 thanks to the efforts of the Ukrainian Community Advisory Board (UCAB));

monitoring the execution of the National Strategy on HIV/AIDS for 2009-2013;

ensuring the development of another National Strategy on HIV/AIDS for 2013-2017 with broad layers of the population engaged;

involving members of the public into the development of the national budget on HIV;

involving members of the public into the work of key task forces on budgeting and budget allocations, medication quality control (working groups at the State Ethics Committee of Ukraine, at the State Expert Center, and at the State Medications Service);

introducing representatives of all the vulnerable populations into the National TB and HIV/AIDS Council, which will enable defending the interests of these populations in a more reasoned manner and foster shaping and implementing balanced and client-oriented policies within the framework of the response to HIV;

introducing representatives of PLWH and other vulnerable populations into the local TB/HIV councils. Currently, their participation is noticeable at press-conferences, round-tables and working meetings. However, they should be enabled to lobby the interests of the vulnerable populations, have an impact on resolutions of the TB/HIV councils and incentivize the governmental bodies in the context of the response to the HIV epidemic.

The state has been continuously taking actions to ensure the public engagement in the national response to HIV, although their scope and magnitude are yet insufficient.

Prevention Response

Does the country have a policy or strategy to promote preventive health interventions for key risk populations?

Yes	No

For each of the following sub-populations – people who inject drugs, men who have sex with men, sex workers, migrants from high prevalence countries and prisoners – does the policy/strategy include the following elements?

Condom promotion	Yes	No
Drug substitution therapy	Yes	No
HIV testing and counseling	Yes	No
Needle and syringe exchange	Yes	No
Reproductive health, including STI prevention and treatment	Yes	No
Stigma and discrimination reduction	Yes	No

What have been the key policy/strategy achievements in this area in the last two years? *Please provide a brief summary (i.e. 100-200 words) of the achievements.*

Thanks to the implementation of activities under the National Strategy on HIV/AIDS, improvement of legislation on HIV (primarily the adoption of the new wording of the law on AIDS in 2010 that covers key issues of the implementation of prevention activities, particularly syringe exchange and substitution therapy programs), the development of a number of provisions to enhance counselling and testing for vulnerable populations, Ukraine has managed to attain certain positive trends in terms of the response to the HIV epidemic, namely:

to reduce the HIV incidence rate,

to reduce the mother-to-child HIV transmission rates,

to increase the coverage of the target populations with treatment, care and support programs.

In 2010 the international "Red ribbon" award was received by 2 Ukrainian non-governmental organizations - NGO "Penitentiary Initiative" (for the effective model of comprehensive services provision to prisoners living with HIV at 6 underfunded prisons in Ukraine) and NGO "Club "Svinatok" (Donetsk city) – the first Ukraine organization established and managed by HIV-positive people and drug users. This precedent became a catalyst in terms of setting up other organizations for this population in Ukraine.

At the same time, experts point at some drawbacks: there is an extremely narrow prevention component in the activities of healthcare establishments, as their efforts are targeted at "emergency therapy", i.e. acting when patients have to be saved already. Among TB prevention activities within healthcare establishments only fluorography is being mentioned.

What are the remaining policy/strategy challenges? *Please provide a brief summary of the achievements.*

A number of regulations that hamper applying the policies (the Order of the Ministry of Health of Ukraine (MoH) on the minimum residual amounts of drug substances or the MoH's Orders on methadone distribution).

Officials' reluctance in the introduction of effective prevention programs in prisons.

No clear-cut state policy in the promotion of condoms.

No migrant-target activities.

No legislative regulation providing for syringe exchange and substitution therapy activities in prisons.

The National Strategy represents the incomplete list of vulnerable populations.

Criminalization of drug users. No state budget funding for the activities of NGOs implementing prevention programs.

The majority of people in need in the country, including key risk populations (e.g. people who inject drugs, men who have sex with men, sex workers, migrants from high prevalence countries and prisoners), have access to:

Harm reduction for people who inject drugs:	Yes	No
HIV testing and counselling:	Yes	No
Prevention for people living with HIV:	Yes	No
Risk reduction for men who have sex with men:	Yes	No
Risk reduction for sex workers:	Yes	No
Risk reduction for migrants from high prevalence countries:	Yes	No
Risk reduction for prisoners:	Yes	No

'Is treatment as prevention' considered to be part of your country's prevention efforts?

Yes	No

If No, please explain briefly why not.

Despite the option "yes" taken, experts point at the absence of clear-cut state policy in this field. The MoH finances the procurement of test systems and ARV medications, which can be interpreted, to a certain extent, as the introduction of the "treatment as prevention" principle. One of the experts noted that HAART is prescribed predominantly at the fourth stage of the disease, which perhaps depicts the "life extension" approach rather than prevention.

If Yes, please indicate if any of the following approaches are used in your country:

Serodiscordant couples	Yes
Pre-exposure prophylaxis (PrEP)	Yes
Post-exposure prophylaxis (PEP)	Yes

Provide a brief summary (i.e. 100-200 words) of any applicable policy, strategy and/or programme related to 'treatment as prevention'.

Discordant pairs. The pilot project "Ensuring the Access of HIV Discordant Pairs to Services on the Exercise of HIV-Positive People's Reproductive Rights in Ukraine in 2010-2011" was implemented through the Zakarpattya AIDS Center with the technical assistance from ICF "Network of People Living with HIV" financed by the Global Fund to Fight AIDS, TB and Malaria Grant. In two years (2010-2012) the project covered 11 regions of Ukraine, cities in the AR of Crimea and in the regions of Kharkiv, Mykolayiv, Lviv, Lugansk, Odessa, Rivne, Poltava and Donetsk, the Kryvyi Rig district and the city of Kyiv. 70 HIV discordant pairs had an opportunity to undergo medical examination, get primary counselling on family planning and make a final decision on conception. For the first time ever, the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV", effective as of January 2012, sets forth the HIV-positive citizens' access to assisted reproductive technologies, yet only subject to prevention of HIV transmission from parents to a would-be child

(Article 10, Clause 2).

Post-contact prevention has been in place in Ukraine since 2004. There are standards for actions and help in case of both contacts at a work-place and non-occupational contacts (e.g., in case of raping). The Ministry of Health of Ukraine ensures free-of-charge post-contact prevention for those in need by means of the centralized procurement of ARV medications for these purposes.

The State guarantees equal access to post-contact prevention services for persons with high risk of contacts with HIV while performing professional duties, in the event of sexual violence and in other cases, with relevant counselling services provided under the procedure approved by the authorized central executive body in charge of healthcare (Article 4 of the Law of Ukraine "On Counteracting Diseases Caused by the Human Immunodeficiency Virus (HIV), and the Legal and Social Status of People Living with HIV").

Did government and/or civil society conduct any evaluations of prevention projects and programmes in your country during the last two years?

Yes	No

If Yes, were these evaluations conducted by?

Government	Yes
Civil society	Yes
Both	Yes

If Yes, please provide a brief summary of the most important and/or most useful prevention evaluations conducted during the past two years. If possible, please include some basic information on: 1) the project/programme that was evaluated (e.g. target population, objective of the intervention, coverage); 2) the key findings (positive and negative) from the evaluation; and 3) how the findings were used. You may also include an attachment with additional information if it helps explain the work.

1. In 2011 the International HIV/AIDS Alliance in Ukraine summarized the 5-year USAID Scaling-up the National Response to HIV/AIDS through Information and Services (SUNRISE) Project in its volume "Catalysing Changes through Innovations, Partnerships and Comprehensive Services". The Project implementation made it possible to increase the magnitude of interventions and achieve the coverage of 60% in 9 most affected regions of Ukraine. As a result, the HIV incidence rates have largely decreased in these regions: from 27.4% in 2004 down to 1.2% in 2010, which indeed has decelerated the epidemic spread tempo.

http://www.aidsalliance.org.ua/ru/news/pdf/sunrised/sunrise_ukr_for_web.pdf

2. Bio-behavioural surveys among IDUs titled "Monitoring the Behaviour and HIV-infection Prevalence among IDUs as a Component of Second Generation HIV Epidemiological Surveillance" were held in Ukraine in 2007, 2008/2009 and 2011. The survey findings depicted lower HIV incidence rates among IDUs having a drug use record of less than three years. Although the findings obtained didn't directly evidence the effectiveness of prevention programs among IDUs, such hypotheses were given in course of discussions of the findings.

Is additional information being submitted in an attachment?

Yes	No

If Yes, what is the name of the attachment?

Migrants

Please note that the term 'migrants' is being used in a broad context in this indicator. For example, it can include immigrants, undocumented immigrants, mobile/transient populations, ethnic minorities and/or other relevant populations.

Are migrants considered an important sub-population in the national response to HIV?

Yes	No

If Yes:

a. Do government and civil society use the term migrant to identify a specific population in the national response to HIV?

Yes	No

b. Are other terms used to identify this same population?

Yes	No

If Yes, list the other term(s).

c. How is the term migrant defined in your country?

There are permanent or temporary, mainly labour, migrants.

1. A person who lives in a locality/country different from the one where s/he was born.
2. A person who works in a locality/country where s/he permanently resides.

d. Is data available on the total number of migrants in your country?

Yes	No

If Yes, what is the overall size of the migrant population?

The 2001 census showed that in Ukraine there were 5.3 mln. people who were born beyond its territory, most often in other republics of the former Soviet Union, given the long history of the common state. The majority of them came into Ukraine before 1991. Yet, 1.2 mln. people are immigrants to modern Ukraine. These are mostly repatriates, including former deportees and political prisoners, who returned to their historic homeland.

Numbers of labour emigrants are estimates based on surveys. The widest one among them was held by the State Statistics Committee in 2005 and showed that labour migration abroad is practiced by 1.5 mln. people or by more than 5% of the employable population.

There is no data on internal migration. Still, it has a large scale, especially in terms of commuting migration of rural citizens in areas of big urban and industrial centers and that for longer distances, mostly to the capital.

e. Is disaggregated data collected on the migrant population (e.g. country of origin, health issues)?

Yes	No

If Yes, what disaggregated data is collected?

Various data is collected on permanent, or resettlement, migration, i.e. age, gender, citizenship, country of origin, etc.

As for labour migration, these are data from versatile surveys.

If No, why is disaggregated data not collected?

Are migrants specifically mentioned in your country's national strategic plan for HIV and AIDS?

Yes	No

If Yes, please provide a brief summary (i.e. 100-200 words) of the context.

The National Program refers to the word "migrants" only once, in the descriptive part, and in the context of the overall list of the most-at-risk populations:

"The major Program objectives are as follows:

… prevention measures are .... strengthening prevention measures among representatives of the most-at-risk populations (injecting drug users; persons detained in penal institutions; those released from the prison; those engaged in prostitution; **migrants**; waifs and homeless citizens, primarily children, including those from families in difficult life circumstances, etc.)"

Prevention, treatment, care and support services for migrants are financed neither by the state budget nor by the Global Fund grants under the National Program.

If No, why not?

There were no data evidencing that the Ukrainian migrants were one of the populations most exposed to HIV, when the National Action Plan for 2009-2013 (National Program to Ensure Prevention, Treatment, Care and Support for Those Having HIV and AIDS) was developed.

In order to find out a HIV prevalence rate among Ukrainian labour migrants and an impact of their sexual behaviour on the HIV status, the bio-behavioural survey among Ukrainian labour migrants "Monitoring the Behaviour and HIV-infection Prevalence among migrant workers as a Component of the Second Generation HIV Epidemiological Surveillance" was held in Ukraine for the first time in 2010-2011.

Subsequent to the survey findings, the HIV prevalence rate among the Ukrainian citizens having a record of employment abroad reached 2.6%. Rather high HIV prevalence rate among labour migrants was caused by persons from populations with high risk of HIV, i.e. injecting drug users, commercial sex workers and persons who used to be imprisoned. This allows to state that it is inaccurate to consider labour migrants as a bridge group, i.e. a population fostering the spread of HIV/AIDS.

There were no surveys held with regard to other groups of migrants in the context of the response to HIV/AIDS in Ukraine.

Is there evidence that HIV disproportionately affects migrants in your country?

Yes	No

If Yes, please provide a brief summary of the evidence.

Is there evidence that migrants are disproportionately represented in any of the following key populations?

People who inject drugs	Yes	No
Men who have sex with men	Yes	No
Prisoners	Yes	No
Sex workers	Yes	No
Other:__________________________	Yes	No
Other:__________________________	Yes	No

What barriers do migrants face in accessing HIV prevention, treatment and care services in your country?

Please provide a brief summary of the barriers.

Such barriers may be faced by illegal migrants and refugees, since the access of these categories to healthcare services is hampered due to a number of reasons: a language barrier, a legal status, unawareness of one's rights and opportunities, the lack of money, discrimination by particular medical staff members, etc. Still, there are only 2,400 refugees in Ukraine, and fewer than 1,000 illegal migrants

were detained at the frontier last year. A half of them are citizens of post-USSR states who enjoy the right of visa-free border crossing and can easily leave the territory of Ukraine after an unsuccessful attempt of getting into a Western country. There is an insignificant number of illegal migrants having the so-called "migration risk" thanks to the persistent and long-lasting work on establishing border crossing and immigration controls.

How do legal status, laws and policies affect migrants' access to HIV prevention, treatment and care services in your country?

Please provide a brief summary of the issues.

In fact, there are no appropriate migration policies to integrate migrants into the Ukrainian society, which may hamper foreigners' access to the needed services.

Is progress in your country's response to HIV among migrants monitored?

Yes	No

If Yes, please provide a brief summary of how progress is monitored.

In 2002 and 2005 behavioural surveys among bridge groups (migrants inclusive) were held upon request of the ICF "International HIV/AIDS Alliance in Ukraine".

In 2010-2011 the bio-behavioural survey among Ukrainian migrant workers "Monitoring the Behaviour and HIV-infection Prevalence among migrant workers as a Component of Second Generation HIV Epidemiological Surveillance" was held upon request of the ICF "International HIV/AIDS Alliance in Ukraine" with its findings still being summarized.

Are indicators used to monitor progress in your country's response to HIV among migrants?

Yes	No

If Yes, please provide a brief overview of the indicators and the relevant data sources.

If Yes, what are the data sources for the indicators.

Are there targeted prevention programmes for migrants in your country?

Yes	No

If Yes, please provide a brief summary of the programmes.

Does your country have data on the uptake of HIV testing among migrants?

Yes	No

If Yes, please provide a brief summary of the data.

Does your country have data on access to ART among migrants?

Yes	No

If Yes, please provide a brief summary of the data.

Are migrant communities involved in the policy/programming response in your country?

Yes	No

If Yes, please provide a brief summary of the extent of their involvement.

Do you have any HIV-related programs for migrants in your country that are considered particularly useful and/or effective that could be seen as a 'best practice'?

Yes	No

If Yes, please provide a brief summary of the programme(s). You may also include an attachment with a description of the programme(s).

Is additional information being submitted in an attachment?

Yes	No

If Yes, what is the name of the attachment.

Prisons

Are free condoms available in prisons in your country?

Yes	No

If Yes, are they available in:

Some prisons	Yes
Most prisons	Yes
All prisons	Yes

Is opioid substitution therapy available in prisons in your country?

Yes	No

If Yes, is it available in:

Some prisons	Yes
Most prisons	Yes
All prisons	Yes

If Yes, can prisoners initiate opioid substitution therapy in prison?

Yes	No

Are needle and syringe programmes available in prisons in your country?

Yes	No

If Yes, are they available in:

Some prisons	Yes
Most prisons	Yes
All prisons	Yes

Is mandatory HIV testing done in prisons in your country?

Yes	No

If Yes, is it done in:

Some prisons	Yes
Most prisons	Yes
All prisons	Yes

Is Hepatitis C testing done in prisons in your country?

Yes	No

If Yes, is treatment available for prisoners who test positive?

Yes	No

If Yes, please provide a brief summary (i.e. 100-200 words) of treatment options, including how and where they are delivered.

Treatment, Care and Support

Does your country have policies, laws and/or regulations recommending ART for people living with HIV?

Yes	No

If Yes, please indicate when the policy, etc. was adopted and briefly explain (i.e. 100-200 words) why it was adopted.

The Constitution of Ukraine guarantees free-of-charge healthcare for all the citizens of Ukraine.
The National Strategy on HIV for 2009-2013 allows for a comprehensive set of treatment activities, in particular for providing antiretroviral therapy to people living with HIV/AIDS as per the standards and clinical protocols approved by the Ministry of Health of Ukraine.
The Ministry of Health of Ukraine drafts, approves and systematically reviews the HIV antiretroviral therapy clinical protocol for adults and teenagers. In 2010 a new HIV antiretroviral therapy clinical protocol for adults and teenagers was approved with the MoH's Order no. 551 dated July 12, 2010. This latter incorporates clear-cut recommendations for physicians as to diagnosing patients' clinical stage of HIV and determining the scope of testing and treatment with various combinations of available modern antiretroviral medications required in each particular case. In 2010 the recommendation on mandatory treatment start in case of CD4 below 350 was introduced.

If No, please explain how decisions are made (e.g. what criteria are used) to determine if a person living with HIV is eligible for ART.

Are there vulnerable groups who have more difficulty accessing HIV treatment, care and support services?

Yes	No

If Yes, please provide a brief response that identifies the groups who have more difficulty accessing treatment, care and support services.

- Prisoners;
- IDUs;
- Children-orphans who are brought up at state-run educational institutions;
- The disabled who live in state-run social care institutions;
- The disabled having limited moveability;
- Children and teenagers living in the street;
- Victims of violence (irrespective of gender);
- Low-income people;
- People having no citizenship or merely no documents, illegal migrants;
- Teenagers.

Injecting drug users and commercial sex workers face complications while accessing HIV-targeted treatment, care and support services due to subjective (mistrust to the healthcare system at large, fear of being put on official records, unawareness of one's belonging to the population of IDUs/FSWs) and systemic barriers (inconvenient open hours of healthcare establishments, their remoteness from places of living or residence, no official residential registration with governmental authorities, and the deficit of medications under which preference is given to well-off patients).
Migrants, especially illegal ones, face obstacles because of no official residential registration with governmental authorities, language barriers, etc., and the currently effective medication accounting system.
Prisoners suffer from the situation when the system is closed in general, there are no statistically valid data, the healthcare system is generally mistrusted, and there is no sufficient amount of medications. Not all the prisoners have access to the services and receive them in a full-fledged manner.
Small towns and villages are typically affected by the problems of late diagnostics and the need to come to regional centers for treatment.

Combined Reporting

For this round of monitoring the Dublin Declaration, the data collection process has been combined with Global AIDS Response Progress reporting, which was previously known as UNGASS reporting.

Is this combined approach an improvement over previous processes?

Yes	No

If Yes, briefly explain (i.e. 100-200 words) how the new approach is better.

The combined approach makes it possible to harmonize the national reporting, eliminate variances in highlighting the civil society's position concerning particular issues, elaborate and add up some components.

If No, briefly explain why not and identify ways that it could be improved.

The drawback of such reporting is that the amount of information requested is too large. Great complications are faced while gathering it, which, in some cases, causes experts' pro forma or subjective responses unconfirmed by actual data and affects the quality of information received.

Furthermore, the content of the questions isn't always interpreted by all the respondents in the same way, which complicates summarizing replies to them.

It is difficult for experts to answer "yes" or "no" in some cases.

Sometimes in their comments experts doubt the accuracy of the answers provided.

Please rank the amount of effort your country expended in previous rounds of Dublin and UNGASS reporting. *(0 being the least effort and 10 being the most effort)*

0	1	2	3	4	5	6	7	8	9	10

Please rank the amount of effort your country expended in this round of combined reporting.

(0 being the least effort and 10 being the most effort)

0	1	2	3	4	5	6	7	8	9	10

ANNEX 6. NATIONAL FUNDING MATRIX FOR 2009-2010

Reporting period:	2009
Reporting cycle:	Calendar year
Amounts reported in:	**Local currency** (Ukrainian hryvnia, UAH)
Average Exchange Rate for the year	7,79 local currency to USD

AIDS Spending Categories	TOTAL (Local Currency)	Financing Sources														
		Public Sources					International Sources						Private Sources			
									Multilaterals							
		Public Sub-Total	Central / National	Sub-National	Dev. Banks Reimbursable (e.g. Loans)	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL (Local Currency)	509 446 462	296 429 783	165 686 385	123 230 375	5 101 655	2 411 368	206 891 641	12 554 304	9 764 341	172 001 387	464 702	12 106 906	6 125 038	2 080 232	2 069 626	1 975 180
1. Prevention (sub-total)	116 550 139	67 436 608	32 035 974	34 528 173	758 516	113 944	48 556 844	5 067 458	3 930 795	37 910 696	129 174	1 518 721	556 687	85 793	201 102	269 792
1.01 Communication for social and behavioral change	2 109 464	911 892	99 312	812 581			1 156 019	310 556		784 640		60 824	41 553		28 289	13 264
1.02 Community mobilization	0	0					0						0			
1.03 Voluntary counseling and testing (VCT)	13 994 101	13 123 497	3 264 659	9 488 561	370 276		843 836	70 100	94 722	45 718		633 296	26 768	1 717	6 791	18 260
1.04 Risk-reduction for vulnerable and accessible populations	2 293 648	1 252 340	1 227 072	12 726	12 541		1 041 308			997 788		43 521	0			

1.05. Prevention - Youth in school	224 093	59 233		59 233			162 240	61 548		3 700		96 992	2 620		720	1 900
1.06 Prevention - Youth out-of-school	5 329 556	386 882	25 136	361 746			4 932 911	2 619 333	1 230 167	686 663		396 748	9 764	7 376	2 388	
1.07 Prevention of HIV transmission aimed at people living with HIV	984 931	104 412	57 191	47 221			849 999	4 455	258 969	559 657		26 918	30 520		25 000	5 520
1.08 Prevention programmes for sex workers and their clients	4 030 725	234 445	154 714	75 429	4 303		3 796 279	141 615		3 654 664			0			
1.09 Programmes for men who have sex with men	3 799 351	4 781	4 539	242			3 794 570	1 237 454		2 556 966		150	0			
1.10 Harm-reduction programmes for injecting drug users	26 966 873	1 319 414	298 800	1 020 614			25 590 658	83 650	91 810	25 120 525	121 275	173 399	56 800		56 800	
1.11 Prevention programmes in the workplace	4 126 955	3 363 898	460 996	2 892 574	1 249	9 080	699 587		670 000	21 689	7 899		63 469		56 203	7 266
1.12 Condom social marketing	22 667	0					22 667			22 667			0			
1.13 Public and commercial sector male condom provision	131 816	26 200		24 760	1 440		100 546		25 772	74 775			5 070		5 070	
1.14 Public and commercial sector female condom provision	0	0					0						0			
1.15 Microbicides	0	0					0						0			
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	0	0					0						0			
1.17 Prevention of mother-to-child transmission	41 860 164	38 569 355	22 535 017	15 583 356	350 495	100 486	3 273 310	538 749	1 559 356	1 160 994		14 211	17 499	14 466	3 033	
1.18 Male Circumcision	0	0					0						0			
1.19 Blood safety	6 500 536	6 214 807	3 472 546	2 737 884		4 378	0						285 729	62 134	13	223 582
1.20 Safe medical injections	0	0					0						0			
1.21 Universal precautions	0	0					0						0			
1.22 Post-exposure prophylaxis	1 770 174	1 753 179	435 992	1 298 974	18 212		99			99			16 896	100	16 796	
1.98 Prevention activities not disaggregated by intervention	73 099	16 500		16 500			56 599			56 599			0			

1.99 Prevention activities not elsewhere classified	2 331 988	95 773		95 773			2 236 215			2 163 552		72 663	0			
2. Care and Treatment (sub-total)	200 021 295	164 604 560	130 302 279	27 862 125	4 343 139	2 097 017	34 855 724	4 581	666 645	33 061 502	0	1 122 995	561 011	1 776	167 437	391 798
2.01 Outpatient care (sub-total)	157 576 580	134 635 390	110 344 599	19 465 125	3 993 377	832 289	22 770 192	0	323 184	21 416 042	0	1 030 966	170 998	1 776	134 675	34 547
2.01.01 Provider- initiated testing and counseling	2 161 739	2 008 641	369 097	1 201 411	36 583	401 550	109 675			109 675			43 423		40 811	2 612
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	27 122 839	26 129 256	18 439 722	3 852 357	3 494 239	342 937	898 295		323 184	559 511		15 600	95 288	1 776	88 551	4 961
2.01.03 Antiretroviral therapy	99 994 773	85 292 012	74 242 500	10 866 351	148 131	35 030	14 700 220			14 700 220			2 540		2 540	
2.01.04 Nutritional support associated to ARV therapy	48 613	0					48 613			39 192		9 422	0			
2.01.05 Specific HIV-related laboratory monitoring	23 271 958	19 644 927	17 137 895	2 139 836	314 423	52 772	3 624 258			3 334 193		290 065	2 773		2 773	
2.01.06 Dental programmes for PLHIV	76 642	74 022	20 170	53 852			2 620			2 620			0			
2.01.07 Psychological treatment and support services	2 091 011	12 700		12 700			2 051 337			2 051 337			26 974			26 974
2.01.08 Outpatient palliative care	1 318 452	190	110	80			1 318 262			608 062		710 200	0			
2.01.09 Home-based care	0	0					0						0			
2.01.10 Traditional medicine and informal care and treatment services	0	0					0						0			
2.01.98 Outpatient care services not disaggregated by intervention	1 490 555	1 473 643	135 106	1 338 537			16 912			11 232		5 680	0			
2.01.99 Outpatient Care services not elsewhere classified	0	0					0						0			
2.02 In-patient care (sub-total)	29 142 578	27 777 431	19 126 456	8 048 421	349 762	252 792	1 320 138	0	186 710	1 133 428	0	0	45 009	0	22 055	22 955
2.02.01 Inpatient treatment of opportunistic infections (OI)	26 479 995	25 122 258	19 125 096	5 496 209	248 161	252 792	1 312 728		186 710	1 126 018			45 009		22 055	22 955

2.02.02 Inpatient palliative care	200 470	193 060	1 360	191 700			7 410			7 410			0			
2.02.98 Inpatient care services not disaggregated by intervention	0	0					0						0			
2.02.99 In-patient services not elsewhere classified	2 462 113	2 462 113		2 360 512	101 600		0						0			
2.03 Patient transport and emergency rescue	4 180 309	119 356	1 200	118 156			3 735 244			3 704 957		30 287	325 709			325 709
2.98 Care and treatment services not disaggregated by intervention	3 895 906	21 343		21 343			3 874 563			3 874 563			0			
2.99 Care and treatment services not-elsewhere classified	5 225 921	2 051 040	830 024	209 080		1 011 936	3 155 586	4 581	156 751	2 932 512		61 742	19 295		10 707	8 588
3. Orphans and Vulnerable Children (sub-total)	5 274 805	3 126 254	2 455 307	670 947	0	0	1 222 651	0	0	1 032 756	0	189 895	925 900	0	925 900	0
3.01 OVC Education	0	0					0						0			
3.02 OVC Basic health care	0	0					0						0			
3.03 OVC Family/home support	0	0					0						0			
3.04 OVC Community support	0	0					0						0			
3.05 OVC Social services and Administrative costs	0	0					0						0			
3.06 OVC Institutional Care	0	0					0						0			
3.98 OVC services not disaggregated by intervention	0	0					0						0			
3.99 OVC services not-elsewhere classified	5 274 805	3 126 254	2 455 307	670 947			1 222 651			1 032 756		189 895	925 900		925 900	
4. Program Management and Administration Strengthening (sub-total)	53 529 556	11 374 665	343 941	10 895 068	0	135 656	39 390 173	2 474 542	3 341 781	30 710 713	252 018	2 611 120	2 764 718	1 399 964	735 975	628 779
4.01 Planning, coordination and programme management	508 913	48 200	25 304	22 896			339 420	284 820	54 600				121 293	121 293		
4.02 Administration and transaction costs associated with managing and disbursing funds	19 533 065	3 546 741	410	3 546 331			15 984 148	904 615	138 440	14 194 380	81 246	665 467	2 176	17	34	2 125

4.03 Monitoring and evaluation\	376 474	10 000		10 000			366 474	49 281	18 891	298 303			0			
4.04 Operations research	0	0					0						0			
4.05 Serological-surveillance (Serosurveillance)	0	0					0						0			
4.06 HIV drug-resistance surveillance	0	0					0						0			
4.07 Drug supply systems	0	0					0						0			
4.08 Information technology	1 905 553	19 589		19 589			1 885 963	1 100		1 874 158		10 706	0			
4.09 Patient tracking	0	0					0						0			
4.10 Upgrading and construction of infrastructure	20 093 818	6 983 710	318 227	6 529 827		135 656	10 470 289	363 251	102 672	8 477 727	170 772	1 355 868	2 639 819	1 278 654	734 511	626 654
4.11 Mandatory HIV testing (not VCT)	0	0					0						0			
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0					0						0			
4.99 Program Management and Administration Strengthening not-elsewhere classified	11 111 733	766 425		766 425			10 343 878	871 476	3 027 178	5 866 145		579 079	1 430		1 430	
5. Incentives for human resources (sub-total)	127 046 640	49 752 827	547 847	49 204 980	0	0	76 011 733	4 645 734	1 297 205	63 740 705	83 511	6 244 577	1 282 080	592 699	11 412	677 969
5.01 Monetary incentives for human resources	119 669 777	49 628 427	547 847	49 080 580			68 918 608	4 612 216	660 700	58 114 114	83 511	5 448 066	1 122 743	476 374		646 369
5.02 Formative education to build-up an HIV workforce	95 461	36 266		36 266			27 595	1 157		26 438			31 600			31 600
5.03 Training	7 187 274	82 134		82 134			6 977 404	32 361	636 505	5 512 027		796 511	127 737	116 325	11 412	
5.98 Incentives for Human Resources not specified by kind	94 127	6 000		6 000			88 127			88 127			0			
5.99 Incentives for Human Resources not elsewhere classified	0	0					0						0			
6. Social Protection and Social Services (excluding OVC) (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

6.01 Social protection through monetary benefits	0	0					0						0			
6.02 Social protection through in-kind benefits	0	0					0						0			
6.03 Social protection through provision of social services	0	0					0						0			
6.04 HIV-specific income generation projects	0	0					0						0			
6.98 Social protection services and social services not disaggregated by type	0	0					0						0			
6.99 Social protection services and social services not elsewhere classified	0	0					0						0			
7. Enabling Environment (sub-total)	3 528 724	48 478	0	48 478	0	0	3 452 446	361 989	138 414	2 556 664	0	395 379	27 800	0	27 800	0
7.01 Advocacy	0	0					0						0			
7.02 Human rights programmes	0	0					0						0			
7.03 AIDS-specific institutional development	0	0					0						0			
7.04 AIDS-specific programmes focused on women	0	0					0						0			
7.05 Programmes to reduce Gender Based Violence	0	0					0						0			
7.98 Enabling Environment and Community Development not disaggregated by type	0	0					0						0			
7.99 Enabling Environment and Community Development not elsewhere classified	3 528 724	48 478		48 478			3 452 446	361 989	138 414	2 556 664		395 379	27 800		27 800	
8. Research excluding operations research which is included under (sub-total)	3 495 305	86 392	1 037	20 604	0	64 751	3 402 070	0	389 500	2 988 352	0	24 218	6 843	0	0	6 843
8.01 Biomedical research	0	0					0						0			
8.02 Clinical research	0	0					0						0			
8.03 Epidemiological research	913 221	21 641	1 037	20 604			891 580			891 580			0			

8.04 Social science research	0	0					0						0			
8.05 Vaccine-related research	0	0					0						0			
8.98 Research not disaggregated by type	0	0					0						0			
8.99 Research not elsewhere classified	2 582 084	64 751				64 751	2 510 490		389 500	2 096 772		24 218	6 843			6 843

Reporting period:	2010
Reporting cycle:	Calendar year
Amounts reported in:	**Local currency** (Ukrainian hryvnia, UAH)
Average Exchange Rate for the year	7,94 local currency to USD

AIDS Spending Categories	TOTAL (Local Currency)	Financing Sources														
		Public Sources					International Sources						Private Sources			
									Multilaterals							
		Public Sub-Total	Central / National	Sub-National	Dev. Banks Reimbursable (e.g. Loans)	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL (Local Currency)	578 340 208	302 150 330	157 386 282	137 955 552	3 158 116	3 650 381	268 989 176	26 870 525	13 963 905	213 254 553	1 453 213	13 446 981	7 200 702	1 673 316	4 288 148	1 239 238
1. Prevention (sub-total)	128 468 433	70 256 859	39 331 322	30 407 108	351 627	166 802	57 310 481	6 207 816	4 565 273	43 779 030	4 309	2 754 053	901 092	380 277	282 672	238 143
1.01 Communication for social and behavioral change	6 338 475	1 709 772		1 709 772			4 612 803	3 673 178		776 979		162 646	15 900		3 923	11 977
1.02 Community mobilization	0	0					0						0			
1.03 Voluntary counseling and testing (VCT)	12 144 641	11 827 011	1 651 735	10 016 960	110 110	48 206	315 096		795	136 629		177 673	2 534	2 534		

1.04 Risk-reduction for vulnerable and accessible populations	1 649 444	94 021	49 098	17 401	17 533	9 990	1 552 896	69 085	26 152	1 035 788		421 870	2 527		150	2 377
1.05. Prevention - Youth in school	109 949	93 442		93 442			15 475			15 475			1 032		1 032	
1.06 Prevention - Youth out-of-school	5 168 504	289 801	139 997	149 804			4 814 549	1 490 706	2 279 204	1 006 855		37 784	64 153	63 402		752
1.07 Prevention of HIV transmission aimed at people living with HIV	1 867 293	186 405	64 086	102 118		20 202	1 645 888	1 662		1 571 037		73 189	35 000		35 000	
1.08 Prevention programmes for sex workers and their clients	4 960 329	81 078	243	80 835			4 879 251	29 050		4 850 201			0			
1.09 Programmes for men who have sex with men	4 123 749	2 597		2 597			4 119 052	510 745		3 608 306			2 100		2 100	
1.10 Harm-reduction programmes for injecting drug users	29 953 986	1 165 366	25 513	1 139 293		560	28 703 620	131 481	84 291	26 753 457	4 309	1 730 081	85 000		85 000	
1.11 Prevention programmes in the workplace	3 027 952	2 496 028	51 456	2 428 758	3 452	12 363	380 221	144 818	211 500	18 136		5 767	151 702		151 452	250
1.12 Condom social marketing	25 186	0					25 186			25 186			0			
1.13 Public and commercial sector male condom provision	181 492	21 828	2 642	18 686	500		159 664		33	159 631			0			
1.14 Public and commercial sector female condom provision	0	0					0						0			
1.15 Microbicides	0	0					0						0			
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	0	0					0						0			
1.17 Prevention of mother-to-child transmission	46 434 045	42 961 225	33 575 103	9 164 633	146 075	75 414	3 326 960	143 738	1 936 518	1 230 170		16 534	145 859	139 878	3 981	2 000
1.18 Male Circumcision	0	0					0						0			
1.19 Blood safety	7 810 160	7 355 605	3 185 406	4 114 707	55 426	67	59 380			59 380			395 175	174 353	34	220 788
1.20 Safe medical injections	0	0					0						0			
1.21 Universal precautions	0	0					0						0			
1.22 Post-exposure prophylaxis	1 429 528	1 429 418	416 433	994 454	18 532		0						110	110		

1.98 Prevention activities not disaggregated by intervention	2 383 312	513 334	169 611	343 723			1 869 978		26 780	1 843 198			0			
1.99 Prevention activities not elsewhere classified	860 389	29 926		29 926			830 463	13 352		688 601		128 510	0			
2. Care and Treatment (sub-total)	224 936 908	155 324 937	111 891 763	38 608 876	1 989 329	2 834 969	69 269 122	266 154	1 333 229	66 473 471	0	1 196 269	342 849	71 443	132 993	138 414
2.01 Outpatient care (sub-total)	184 289 074	136 030 296	103 535 992	30 376 973	1 583 203	534 128	48 039 979	33 862	883 054	45 986 940	0	1 136 123	218 799	71 113	91 639	56 048
2.01.01 Provider- initiated testing and counseling	2 549 758	2 283 882	361 990	1 678 772	36 821	206 298	233 935		7 100	205 862		20 973	31 941		31 941	
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	10 610 176	8 002 831	3 615 714	3 324 552	911 637	150 928	2 529 561	810	875 954	1 576 280		76 518	77 783	1 263	59 698	16 822
2.01.03 Antiretroviral therapy	131 464 691	96 747 541	75 705 312	20 597 431	439 656	5 143	34 668 180	33 052		34 571 113		64 016	48 970	48 970		
2.01.04 Nutritional support associated to ARV therapy	51 383	0					51 383			51 275		107	0			
2.01.05 Specific HIV-related laboratory monitoring	31 387 090	25 903 371	22 115 144	3 460 501	181 322	146 404	5 462 839			5 187 756		275 082	20 880	20 880		
2.01.06 Dental programmes for PLHIV	102 007	97 267	7 000	64 962		25 305	4 740			4 740			0			
2.01.07 Psychological treatment and support services	2 864 765	15 000		15 000			2 810 539			2 810 539			39 226			39 226
2.01.08 Outpatient palliative care	1 776 892	800	120	680			1 776 092			1 090 233		685 860	0			
2.01.09 Home-based care	0	0					0						0			
2.01.10 Traditional medicine and informal care and treatment services	0	0					0						0			
2.01.98 Outpatient care services not disaggregated by intervention	3 477 313	2 974 603	1 730 711	1 230 076	13 767	50	502 709			489 143		13 567	0			
2.01.99 Outpatient Care services not elsewhere classified	5 000	5 000		5 000			0						0			
2.02 In-patient care (sub-total)	18 762 828	16 982 757	8 275 148	7 666 541	406 126	634 943	1 718 352	0	450 175	1 268 176	0	0	61 719	330	9 778	51 611

2.02.01 Inpatient treatment of opportunistic infections (OI)	16 709 975	15 112 373	7 894 212	6 207 843	375 375	634 943	1 535 883		450 175	1 085 708			61 719	330	9 778	51 611
2.02.02 Inpatient palliative care	266 297	260 897	11 247	249 650			5 400			5 400			0			
2.02.98 Inpatient care services not disaggregated by intervention	0	0					0						0			
2.02.99 In-patient services not elsewhere classified	1 786 556	1 609 487	369 689	1 209 048	30 750		177 069			177 069			0			
2.03 Patient transport and emergency rescue	8 542 431	96 098	283	95 815			8 424 646	155 927		8 268 719			21 687			21 687
2.98 Care and treatment services not disaggregated by intervention	6 252 367	177 729		177 729			6 074 638			6 074 638			0			
2.99 Care and treatment services not-elsewhere classified	7 090 208	2 038 057	80 340	291 819		1 665 898	5 011 507	76 364		4 874 998		60 146	40 644		31 576	9 068
3. Orphans and Vulnerable Children (sub-total)	8 864 137	5 988 502	5 159 852	828 650	0	0	1 792 850	0	0	1 604 872	0	187 977	1 082 785	0	1 082 785	0
3.01 OVC Education	0	0					0						0			
3.02 OVC Basic health care	0	0					0						0			
3.03 OVC Family/home support	0	0					0						0			
3.04 OVC Community support	0	0					0						0			
3.05 OVC Social services and Administrative costs	0	0					0						0			
3.06 OVC Institutional Care	0	0					0						0			
3.98 OVC services not disaggregated by intervention	0	0					0						0			
3.99 OVC services not-elsewhere classified	8 864 137	5 988 502	5 159 852	828 650			1 792 850			1 604 872		187 977	1 082 785		1 082 785	
4. Program Management and Administration Strengthening (sub-total)	54 930 860	9 507 023	595 362	7 906 950	817 160	187 551	42 467 932	6 886 384	5 956 657	27 033 685	209 240	2 381 966	2 955 905	146 194	2 773 901	35 809
4.01 Planning, coordination and programme management	38 240 223	3 524 007	31 212	3 492 795			34 502 431	5 191 190	3 649 023	23 501 864	207 072	1 953 282	213 784	122 094	76 658	15 032

4.02 Administration and transaction costs associated with managing and disbursing funds	2 406 807	65 847		65 847			2 340 960		2 288 578	52 382			0			
4.03 Monitoring and evaluation\	813 430	9 300		9 300			804 130	24 816	19 056	760 259			0			
4.04 Operations research	0	0					0						0			
4.05 Serological-surveillance (Serosurveillance)	0	0					0						0			
4.06 HIV drug-resistance surveillance	0	0					0						0			
4.07 Drug supply systems	0	0					0						0			
4.08 Information technology	1 513 283	67 061		67 061			1 441 085	745 398		695 687			5 137		1 560	3 577
4.09 Patient tracking	0	0					0						0			
4.10 Upgrading and construction of infrastructure	11 472 794	5 592 553	564 150	4 023 692	817 160	187 551	3 146 867	924 981		1 791 034	2 168	428 684	2 733 375	24 100	2 692 075	17 200
4.11 Mandatory HIV testing (not VCT)	0	0					0						0			
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0					0						0			
4.99 Program Management and Administration Strengthening not-elsewhere classified	484 323	248 255		248 255			232 459			232 459			3 609		3 609	
5. Incentives for human resources (sub-total)	152 703 663	60 925 201	384 563	60 147 178	0	393 460	89 865 042	11 437 859	715 591	71 346 521	834 653	5 530 418	1 913 420	1 075 402	13 681	824 337
5.01 Monetary incentives for human resources	141 227 474	60 761 702	384 563	59 983 678		393 460	79 226 233	11 013 425	4 722	63 231 104	450 292	4 526 691	1 239 540	524 540		715 000
5.02 Formative education to build-up an HIV workforce	385 608	52 181		52 181			232 322	2 761	700	228 861			101 105			101 105
5.03 Training	10 478 593	103 824		103 824			9 801 993	421 531	710 169	7 427 073	384 361	858 859	572 776	550 862	13 681	8 233
5.98 Incentives for Human Resources not specified by kind	611 988	7 494		7 494			604 494	143		459 483		144 868	0			

5.99 Incentives for Human Resources not elsewhere classified	0	0					0						0			
6. Social Protection and Social Services (excluding OVC) (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.01 Social protection through monetary benefits	0	0					0						0			
6.02 Social protection through in-kind benefits	0	0					0						0			
6.03 Social protection through provision of social services	0	0					0						0			
6.04 HIV-specific income generation projects	0	0					0						0			
6.98 Social protection services and social services not disaggregated by type	0	0					0						0			
6.99 Social protection services and social services not elsewhere classified	0	0					0						0			
7. Enabling Environment (sub-total)	5 498 583	40 442	0	40 442	0	0	5 456 026	1 663 640	285 892	2 131 218	212 528	1 162 748	2 116	0	2 116	0
7.01 Advocacy	0	0					0						0			
7.02 Human rights programmes	0	0					0						0			
7.03 AIDS-specific institutional development	0	0					0						0			
7.04 AIDS-specific programmes focused on women	0	0					0						0			
7.05 Programmes to reduce Gender Based Violence	0	0					0						0			
7.98 Enabling Environment and Community Development not disaggregated by type	0	0					0						0			
7.99 Enabling Environment and Community Development not elsewhere classified	5 498 583	40 442		40 442			5 456 026	1 663 640	285 892	2 131 218	212 528	1 162 748	2 116		2 116	

8. Research excluding operations research which is included under (sub-total)	2 937 624	107 367	23 420	16 348	0	67 599	2 827 722	408 673	1 107 262	885 754	192 483	233 550	2 535	0	0	2 535
8.01 Biomedical research	0	0					0						0			
8.02 Clinical research	0	0					0						0			
8.03 Epidemiological research	713 088	16 248	401	15 848			696 840			696 840			0			
8.04 Social science research	0	0					0						0			
8.05 Vaccine-related research	0	0					0						0			
8.98 Research not disaggregated by type	0	0					0						0			
8.99 Research not elsewhere classified	2 224 535	91 118	23 019	500		67 599	2 130 882	408 673	1 107 262	188 914	192 483	233 550	2 535			2 535

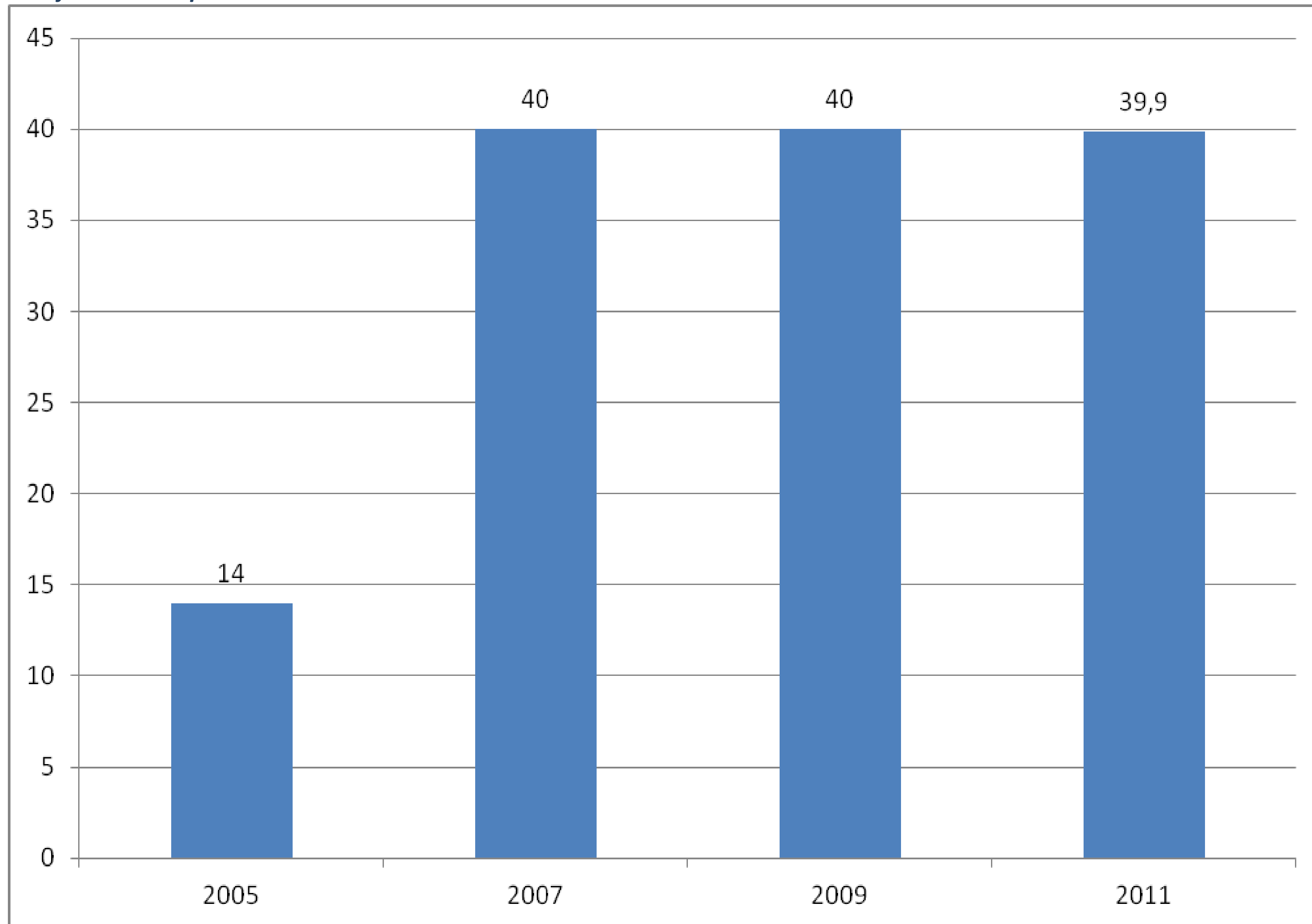
ANNEX 7. INDICATOR RARIONALE AND INDICATORS OVER TIME

RATIONALE 1.1. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission

	Total	Men			Women			City population	Country region residents
		All age groups	Aged 15-19	Aged 20-24	All age groups	Aged 15-19	Aged 20-24		
Percentage of respondents aged 15-24 years who gave the correct answer to all five questions	39.9%	42.0	35.2	47.5	37.7	38.9	36.9	41.5	36.6
Numerator: number of respondents aged 15-24 years who gave the correct answer to all five questions	220	119	44	75	101	42	59	156	64
Percentage of respondents who gave a correct answer to Question 1 "Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?"	88.7%	88.7	84.8	91.8	88.8	86.1	90.6	88.3	89.7
Numerator: number of respondents aged who gave a correct answer to Question 1	489	251	106	145	238	93	145	332	157
Percentage of respondents who gave a correct answer to Question 2 "Can a person reduce the risk of getting HIV by using a condom every time they have sex?"	88.2%	89.4	88.8	89.9	86.9	84.3	88.8	89.1	86.3
Numerator: number of respondents aged who gave a correct answer to Question 2	486	253	111	142	233	91	142	335	151
Percentage of respondents who gave a correct answer to Question 3 "Can a healthy-looking person have HIV?"	84.4%	85.9	80.8	89.9	82.8	84.3	81.9	82.4	88.6
Numerator: number of respondents aged who gave a correct answer to Question 3	465	243	101	142	222	91	131	310	155

	Total	Men			Women			City population	Country region residents
		All age groups	Aged 15-19	Aged 20-24	All age groups	Aged 15-19	Aged 20-24		
Percentage of respondents who gave a correct answer to Question 4 "Can a person get HIV by sharing a glass of water with someone who is infected?"	72.8%	73.1	72.0	74.1	72.4	71.3	73.1	76.3	65.1
Numerator: number of respondents aged who gave a correct answer to Question 4	401	207	90	117	194	77	117	287	114
Percentage of respondents who gave a correct answer to Question 5 " Can a person get HIV by sharing a toilet/swimming pool/sauna with someone who is infected? "	62.1%	64.3	65.6	63.3	59.7	61.1	58.8	43.9	39.4
Numerator: number of respondents aged who gave a correct answer to Question 5	342	182	82	100	160	66	94	165	69
Denominator Number of respondents	551	283	125	158	268	108	160	376	175

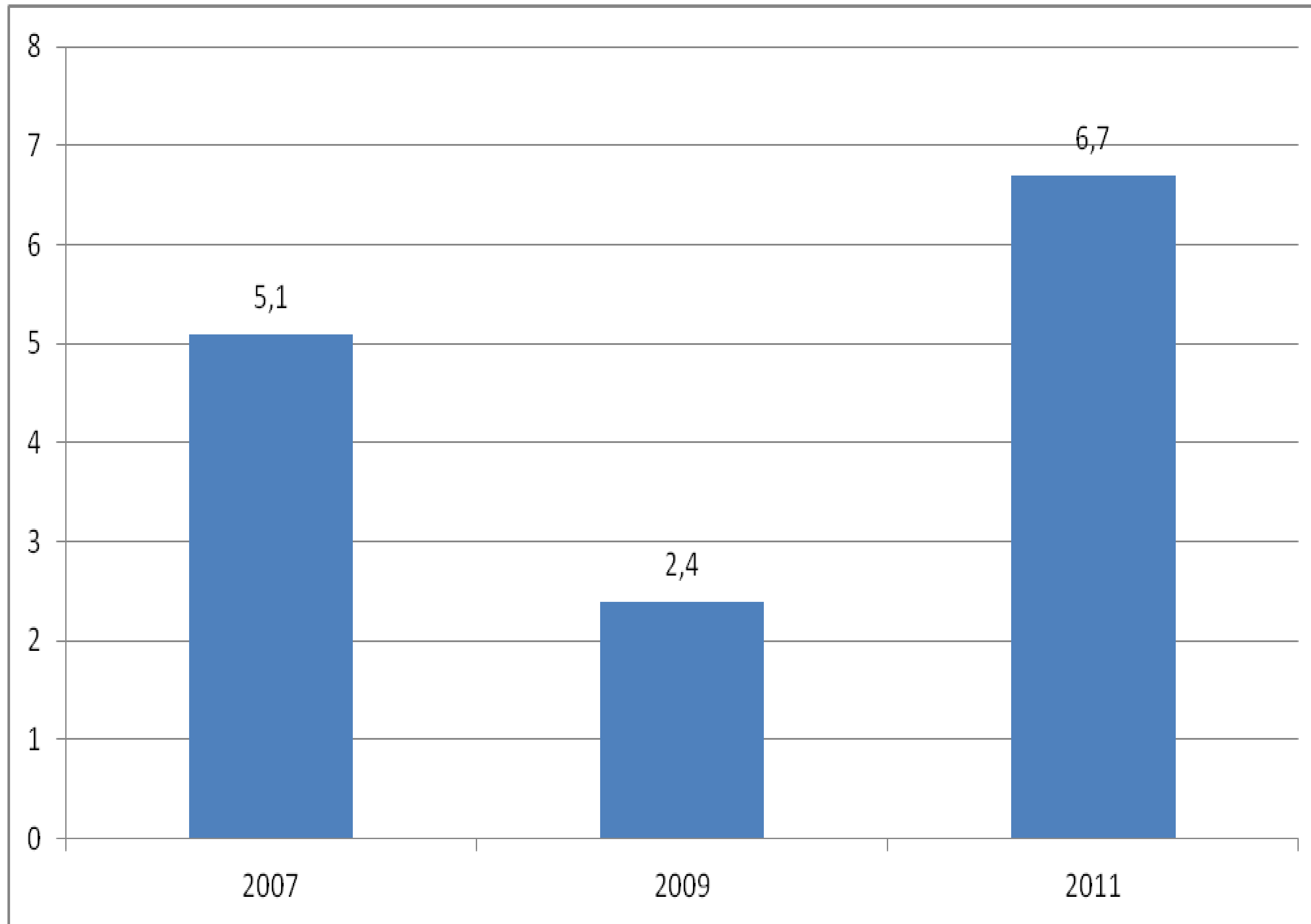
INDICATOR OVER TIME 1.1 Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission



RATIONALE 1.2 Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years

	Total	Men			Women			Urban population	Country region residents
		All age groups	Aged 15-19	Aged 20-24	All age groups	Aged 15-19	Aged 20-24		
Percentage of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15	6.7%	10.2	12.0	8.9	3.0	4.6	1.9	6.4	7.4
Numerator: number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15	37	29	15	14	8	5	3	24	13
Denominator number of respondents	551	283	125	158	268	108	160	376	175

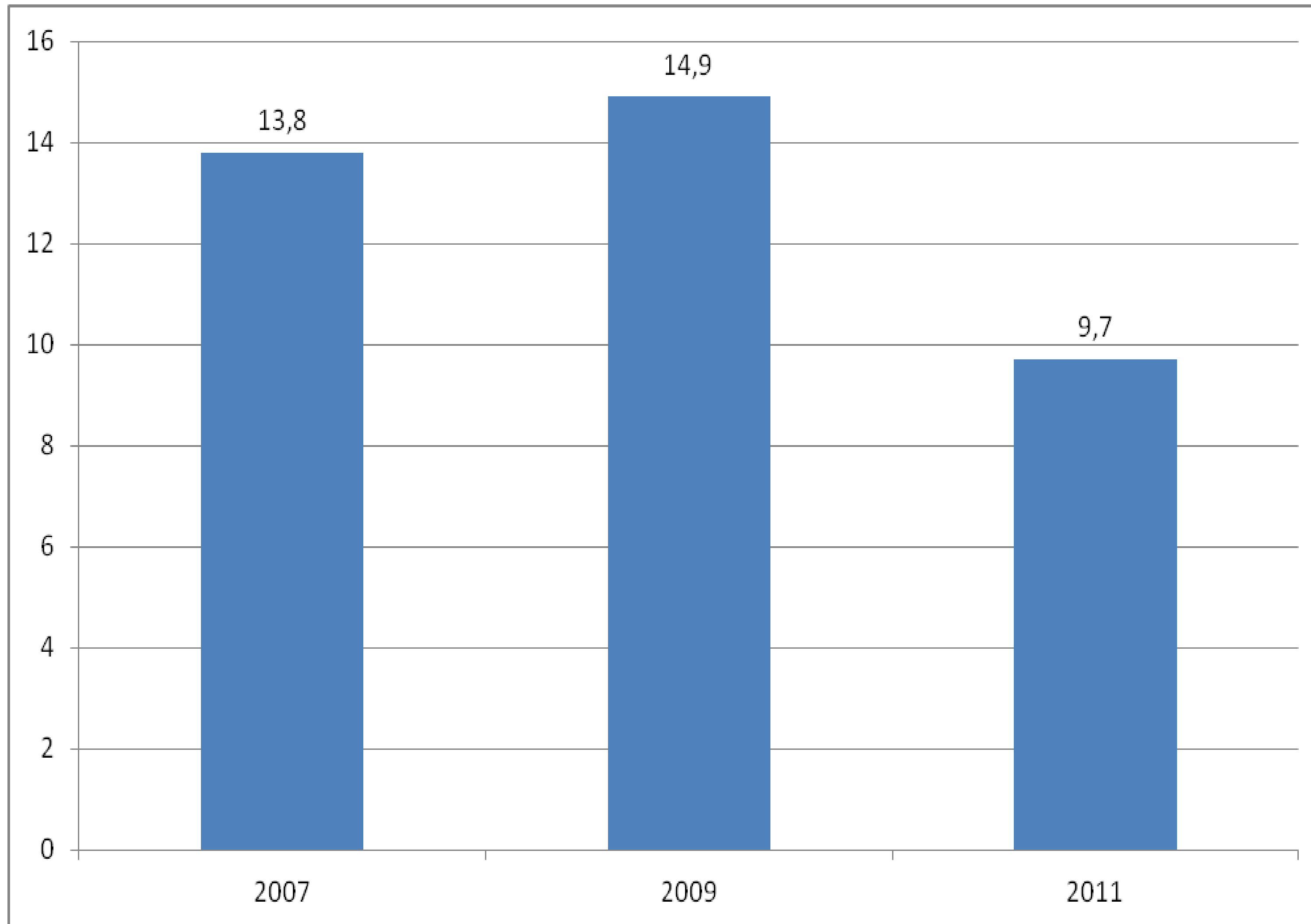
ICATOR OVER TIME 1.2 Percentage of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years



RATIONALE 1.3 Percentage of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

		Total				Men				Women	Urban population
		All age groups	Aged 15-19	Aged 20-24	Aged 25-49	All age groups	Aged 15-19	Aged 20-24	Aged 25-49		
Percentage of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	9.7%	14.9	21.6	30.4	10.3	4.6	3.7	5.0	4.6	9.9	9.2
Numerator: number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	194	148	27	48	73	46	4	8	34	139	55
Denominator number of respondents	2003	995	125	158	712	1008	108	160	740	1405	598

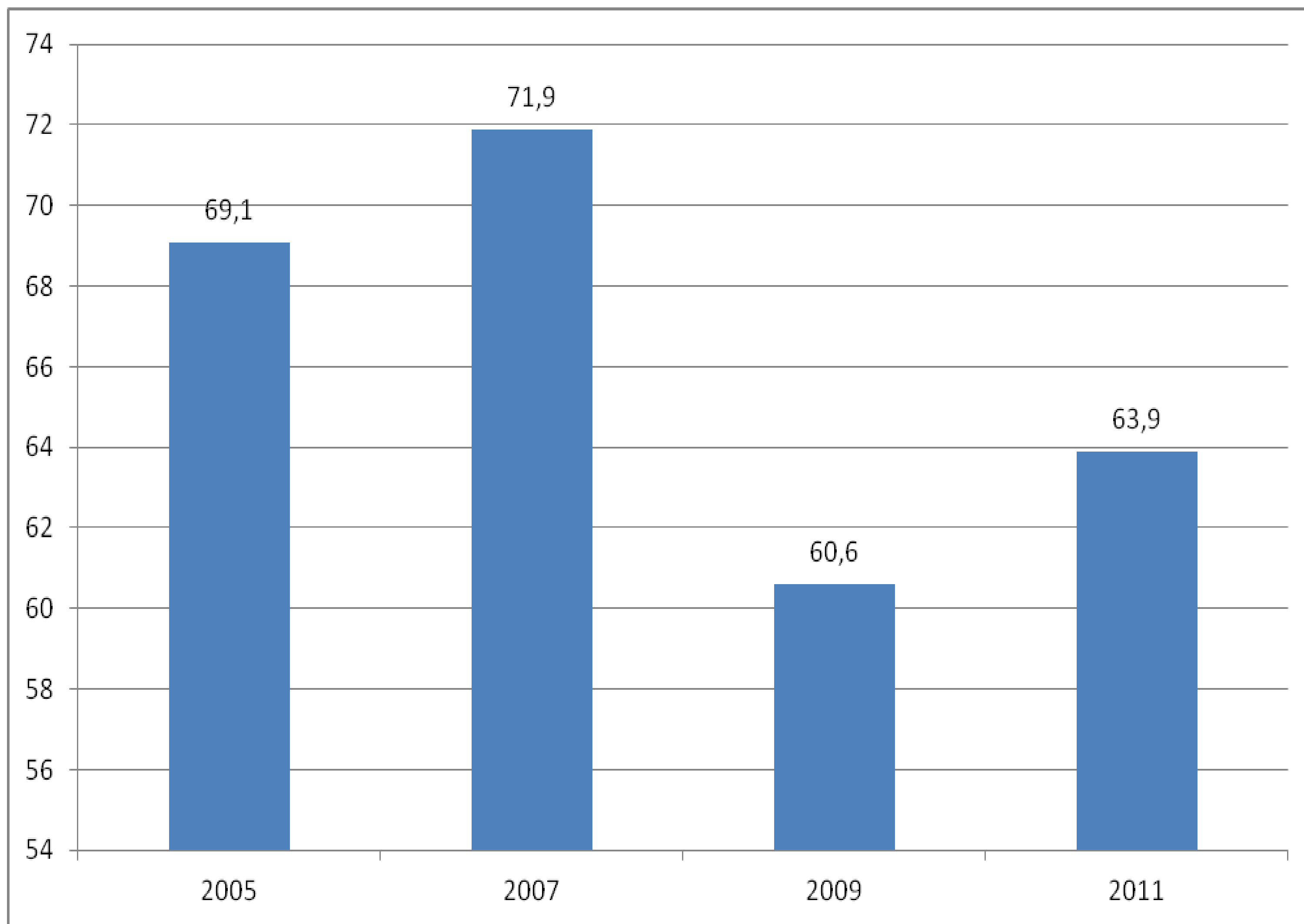
INDICATOR OVER TIME 1.3 Percentage of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months



RATIONALE 1.4 Percentage of women and men aged 15-49 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse

	Total	Men				Women				Urban population	Country region residents
		All age groups	aged 15-19	aged 20-24	aged 25-49	All age groups	aged 15-19	aged 20-24	aged 25-49		
Percentage of women and men aged 15-49 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse	63.9%	68.2	85.2	85.4	50.7	50.0	75.0	37.5	50.0	61.2	70.9
Numerator: number of women and men aged 15-49 who had more than one partner in the past 12 months and reported the use of a condom during their last sexual intercourse	124	101	23	41	37	23	3	3	17	85	39
Denominator: number of respondents	194	148	27	48	73	46	4	8	34	139	55

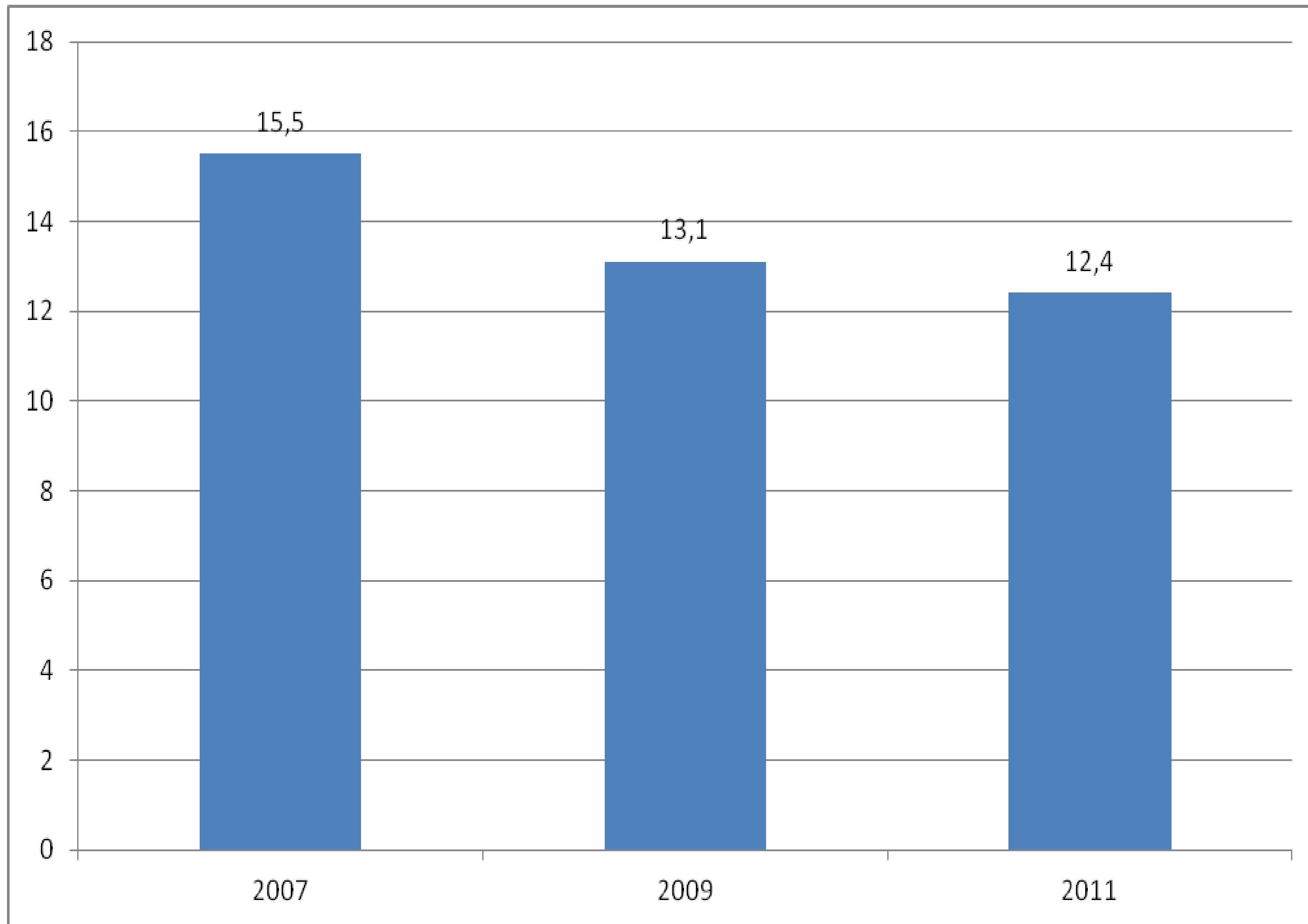
INDICATOR OVER TIME 1.4 Percentage of women and men aged 15-49 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse



RATIONALE 1.5 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their result

	Total	Men				Women				Urban population	Country region residents
		All age groups	aged 15-19	aged 20-24	aged 25-49	All age groups	aged 15-19	aged 20-24	aged 25-49		
Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their result	12.4%	9.8	9.6	9.5	10.0	15.0	13.0	22.5	13.6	13.6	9.7
Numerator: number of women and men aged 15-49 who received an HIV test in the last 12 months and who know their result	249	98	12	15	71	151	14	36	101	191	58
Denominator: number of respondents	2003	995	125	158	712	1008	108	160	740	1405	598

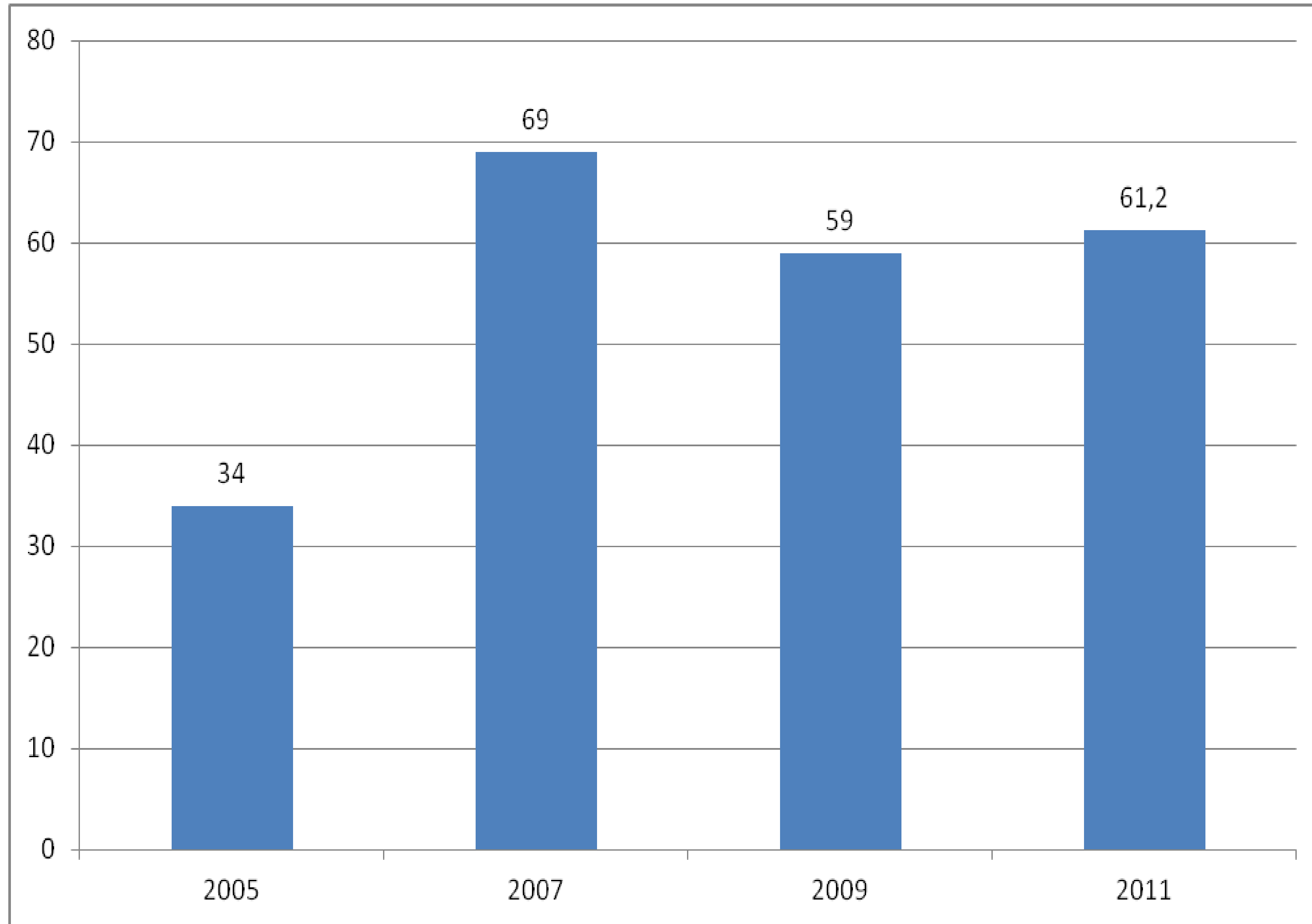
INDICATOR OVER TIME 1.5 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their result



RATIONALE 1.7 Percentage of commercial sex workers reached by HIV prevention programs

	Total	Women		
		All age groups	Aged <25	Aged 25+
Percentage of female commercial sex workers who responded “yes” to both questions	61.2%	61.2	55.1	65.0
Numerator: number of female commercial sex workers who responded “yes” to both questions	3061	3061	1037	2028
Percentage of female commercial sex workers who responded “yes” to Question 1 “Do you know where you can get tested for HIV?”	91.1	91.1	88.4	93.0
Numerator: number of female commercial sex workers who responded “yes” to Question 1	4562	4562	1662	2901
Percentage of female commercial sex workers who responded “yes” to Question 2 “Did you receive condoms in the last 12 months (e.g., through information and education programs or projects, syringe exchange points, counseling centers, centers for social services for family, children and youth, during information campaigns, etc.)?”	64.2	64.2	59.3	67.5
Numerator: of female commercial sex workers who responded “yes” to Question 2	3214	3214	1116	2104
Denominator: overall number of sampled female commercial sex workers	5005	5005	1881	3120

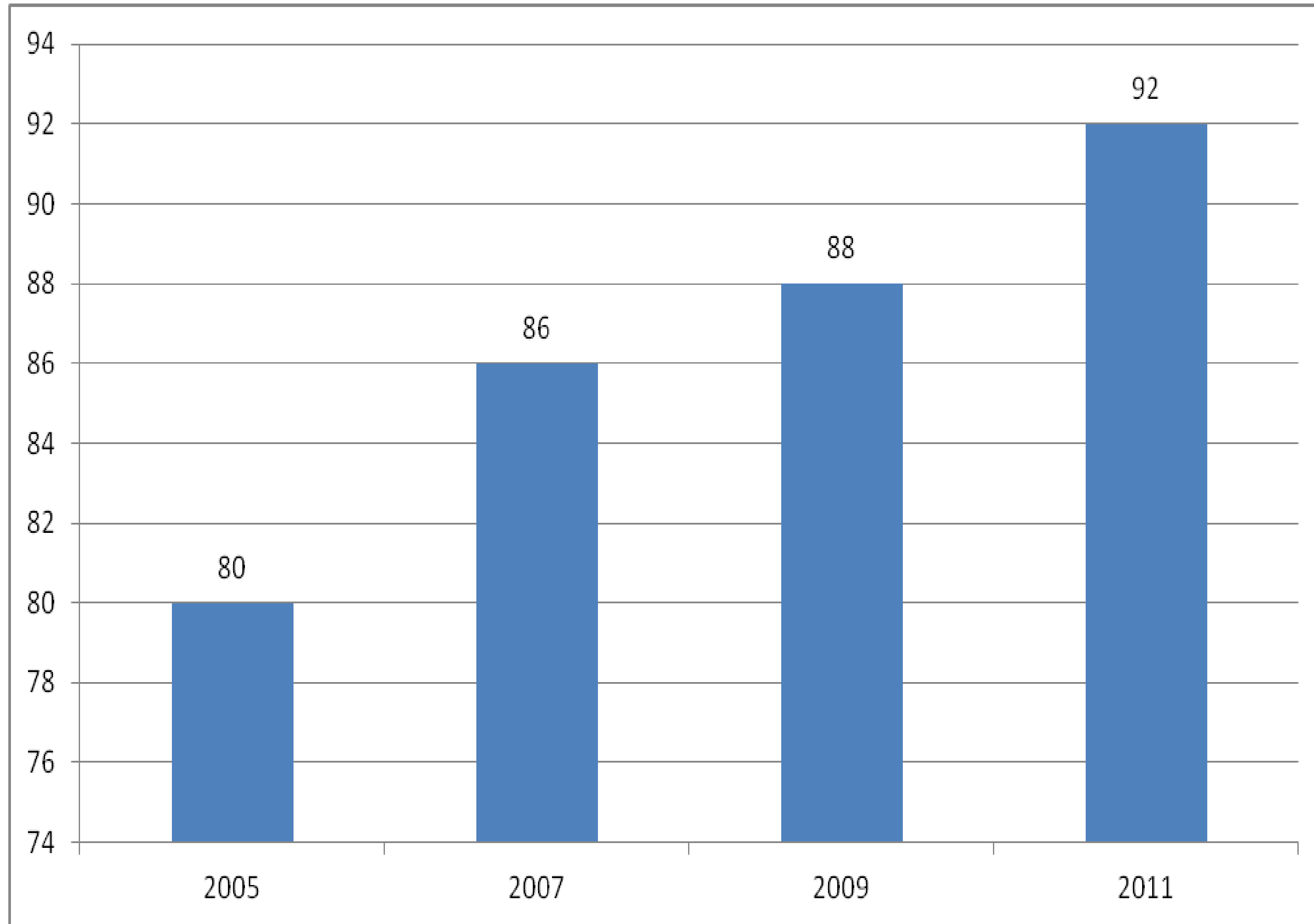
INDICATOR OVER TIME 1.7 Percentage of commercial sex workers reached by HIV prevention programs



RATIONALE 1.8 Percentage of female sex workers reporting the use of a condom with their most recent client

	Total	Women		
		All age groups	Aged <25	Aged 25+
Percentage of female sex workers reporting the use of a condom with their most recent client	92.0%	92.0	93.6	91.0
Numerator: number of female sex workers reporting the use of a condom with their most recent paying client	4603	4603	1761	2838
Denominator: overall number of sampled female commercial sex workers	5005	5005	1881	3120

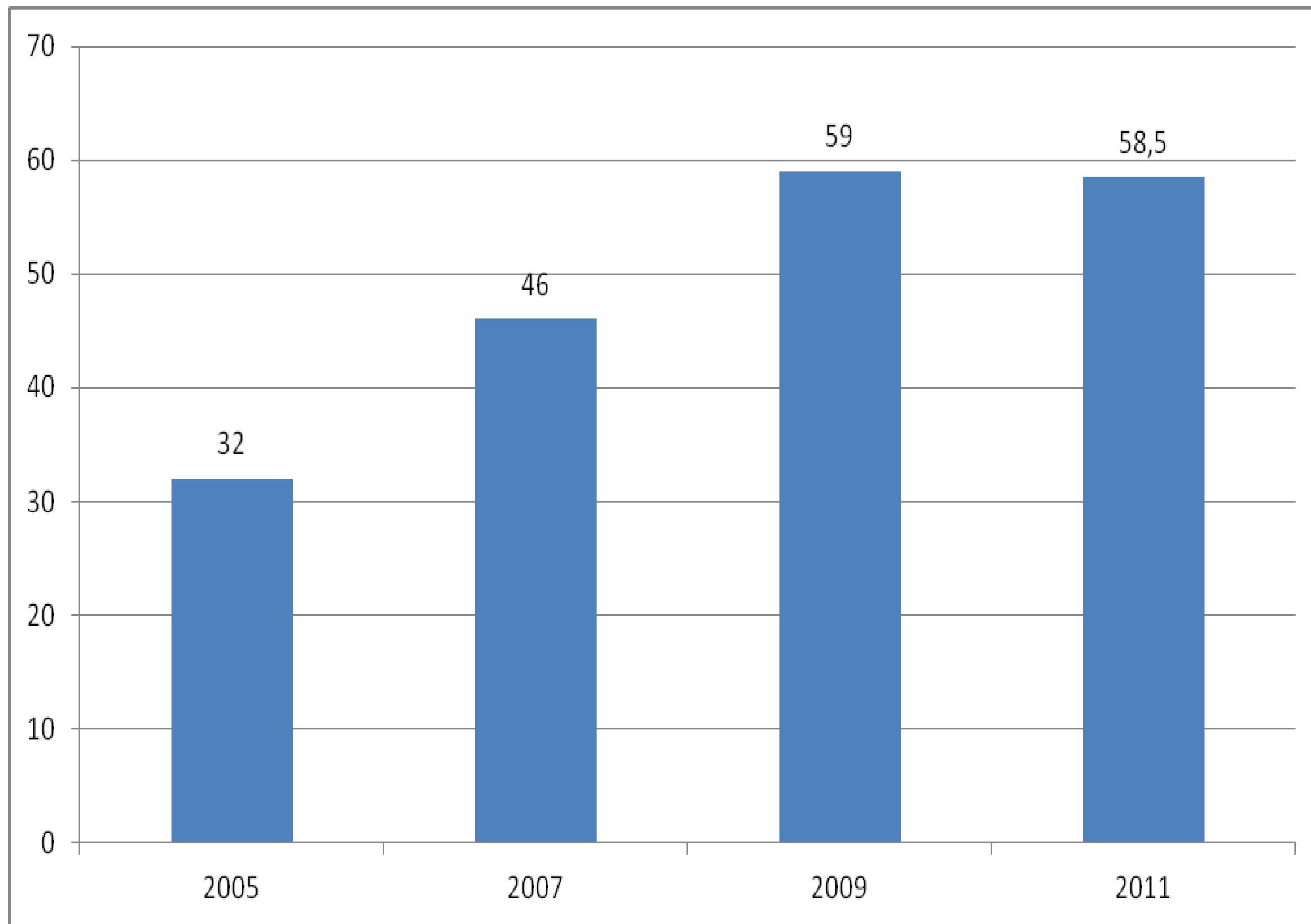
INDICATOR OVER TIME 1.8 Percentage of female sex workers reporting the use of a condom with their most recent client



RATIONALE 1.9 Percentage of sex workers who received an HIV test in the last 12 months and who know their result

	Total	Women		
		All age groups	Aged <25	Aged 25+
Percentage of sex workers who received an HIV test in the last 12 months and who know their result	58.5%	58.5	56.8	59.7
Numerator: number of sex workers who received an HIV test in the last 12 months and who know their result	2929	2929	1069	1864
Denominator: overall number of sampled female commercial sex workers	5005	5005	1881	3120

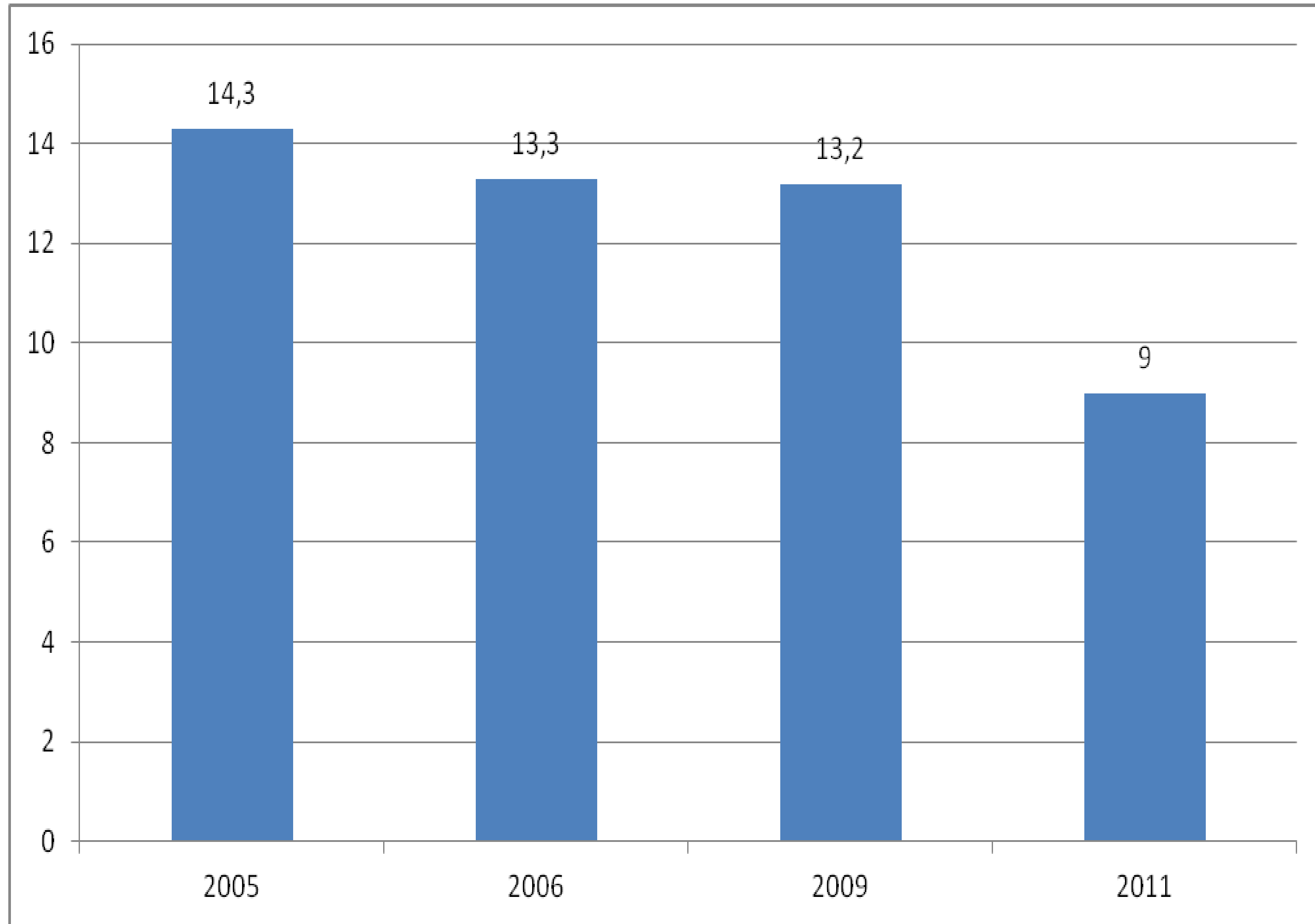
INDICATOR OVER TIME 1.9 Percentage of sex workers who received an HIV test in the last 12 months and who know their result



RATIONALE 1.10 Percentage of sex workers living with HIV

	Total	Women		
		All age groups	Aged <25	Aged 25+
Percentage of sex workers living with HIV	9.0%	9.0	3.1	13.0
Numerator: number of female commercial sex workers who tested positive for HIV	435	435	58	383
Denominator: overall number of sampled female commercial sex workers	4816	4816	1863	2949

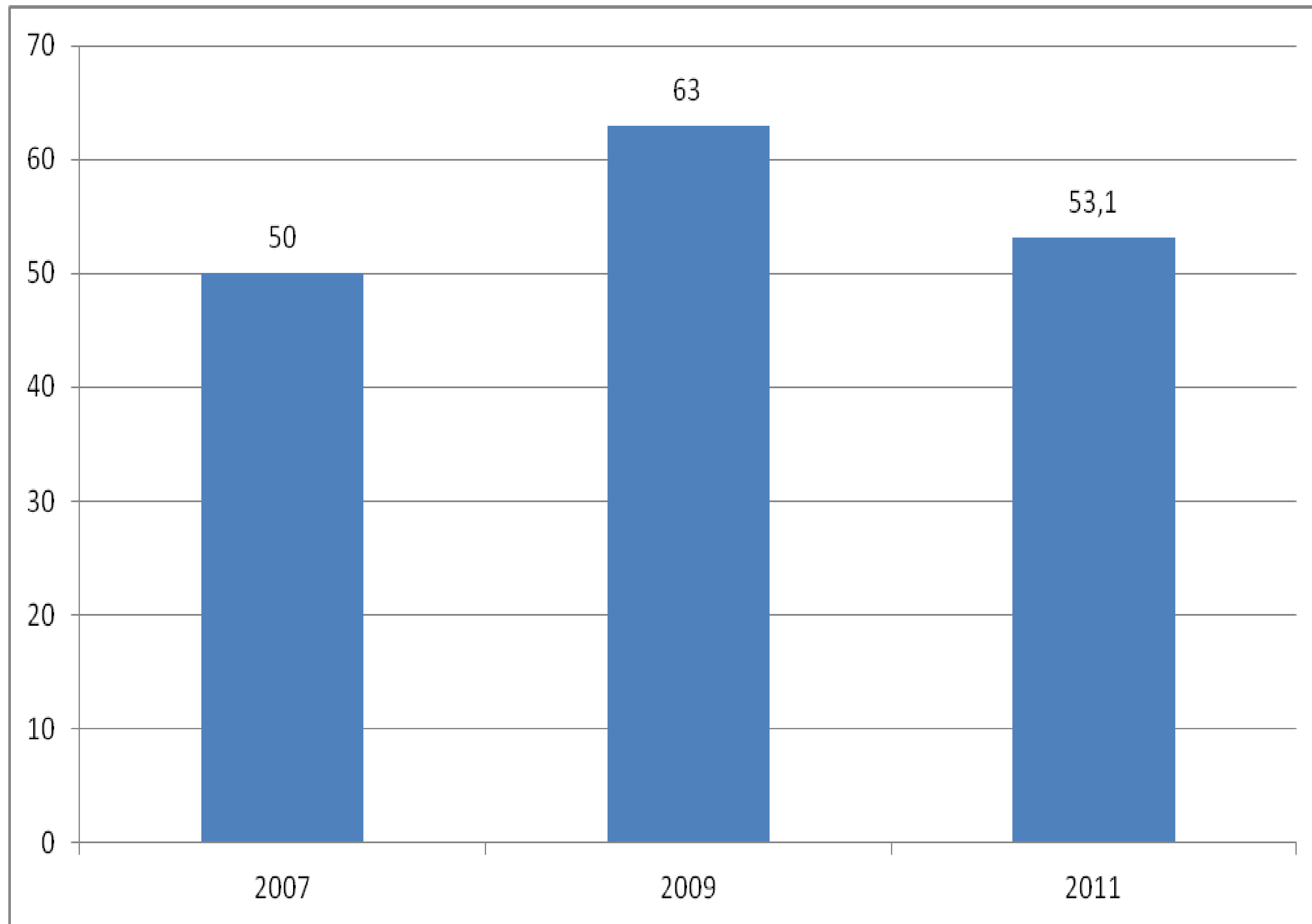
INDICATOR OVER TIME 1.10 Percentage of sex workers living with HIV



RATIONALE 1.11 Percentage of men having sex with men reached by HIV prevention programs

	total	aged <25	aged 25+
Percentage of men having sex with men who responded “yes” to both questions	53.1%	57.2	50.2
Numerator: number of men having sex with men who responded “yes” to both questions	3160	1399	1761
Percentage of men having sex with men who responded “yes” to Question 1 “Do you know where you can get tested for HIV?”	88.0	84.5	90.4
Numerator: number of men having sex with men who responded “yes” to Question 1	5237	2065	3172
Percentage of men having sex with men who responded “yes” to Question 2 “Did you receive condoms in the last 12 months?”	56.2	60.9	52.9
Numerator: of men having sex with men who responded “yes” to Question 2	3343	1489	1854
Denominator: overall number of sampled men having sex with men	5950	2443	3507

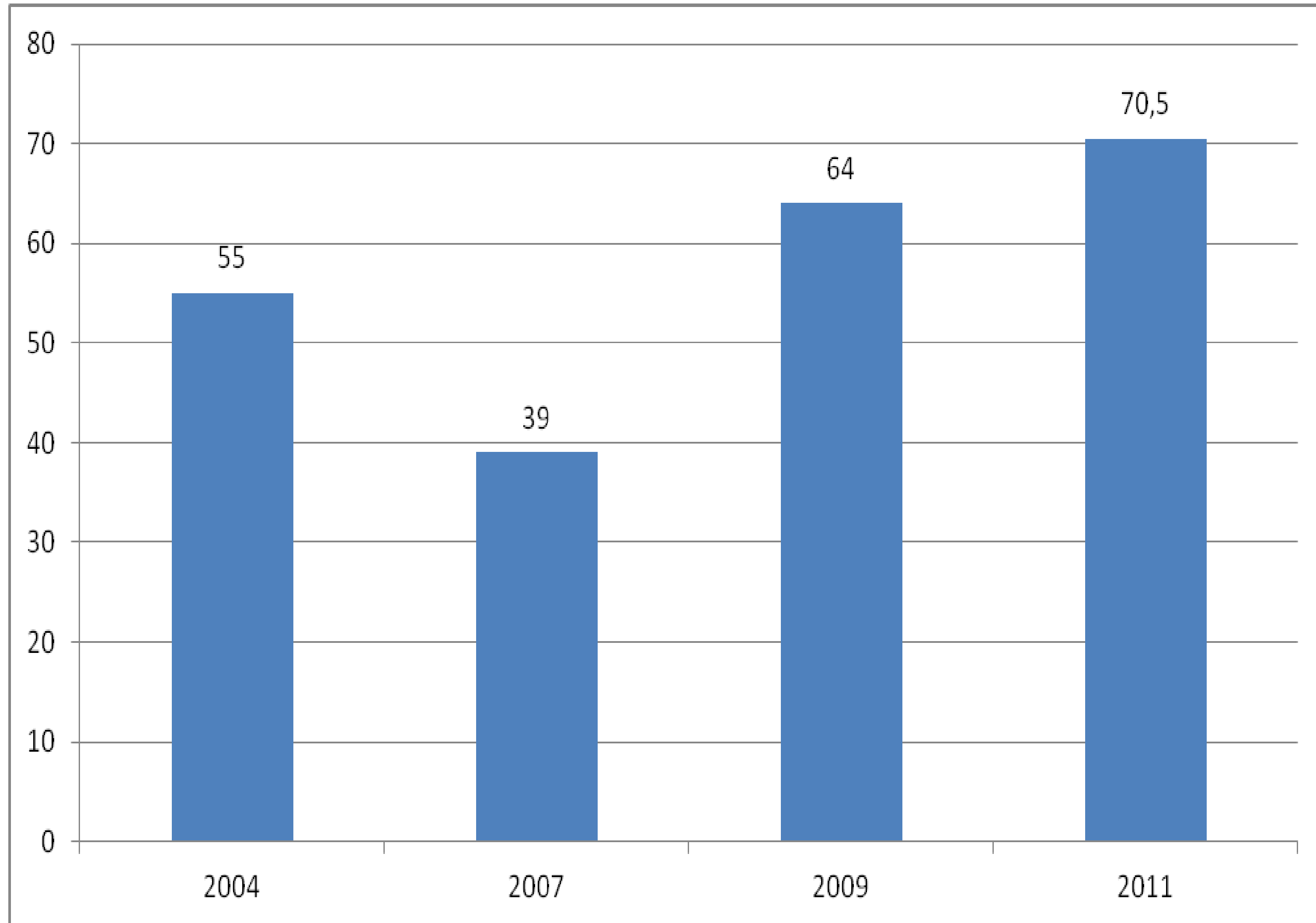
INDICATOR OVER TIME 1.11 Percentage of men having sex with men reached by HIV prevention programs



RATIONALE 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

	total	Aged <25	Aged 25+
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	70.5%	68.9	71.6
Numerator: number of men reporting the use of a condom the last time they had anal sex with a male partner	3884	1534	2350
Denominator: number of men reporting the use of a condom the last time they had anal sex with a male partner in the last 6 months	5508	2226	3282

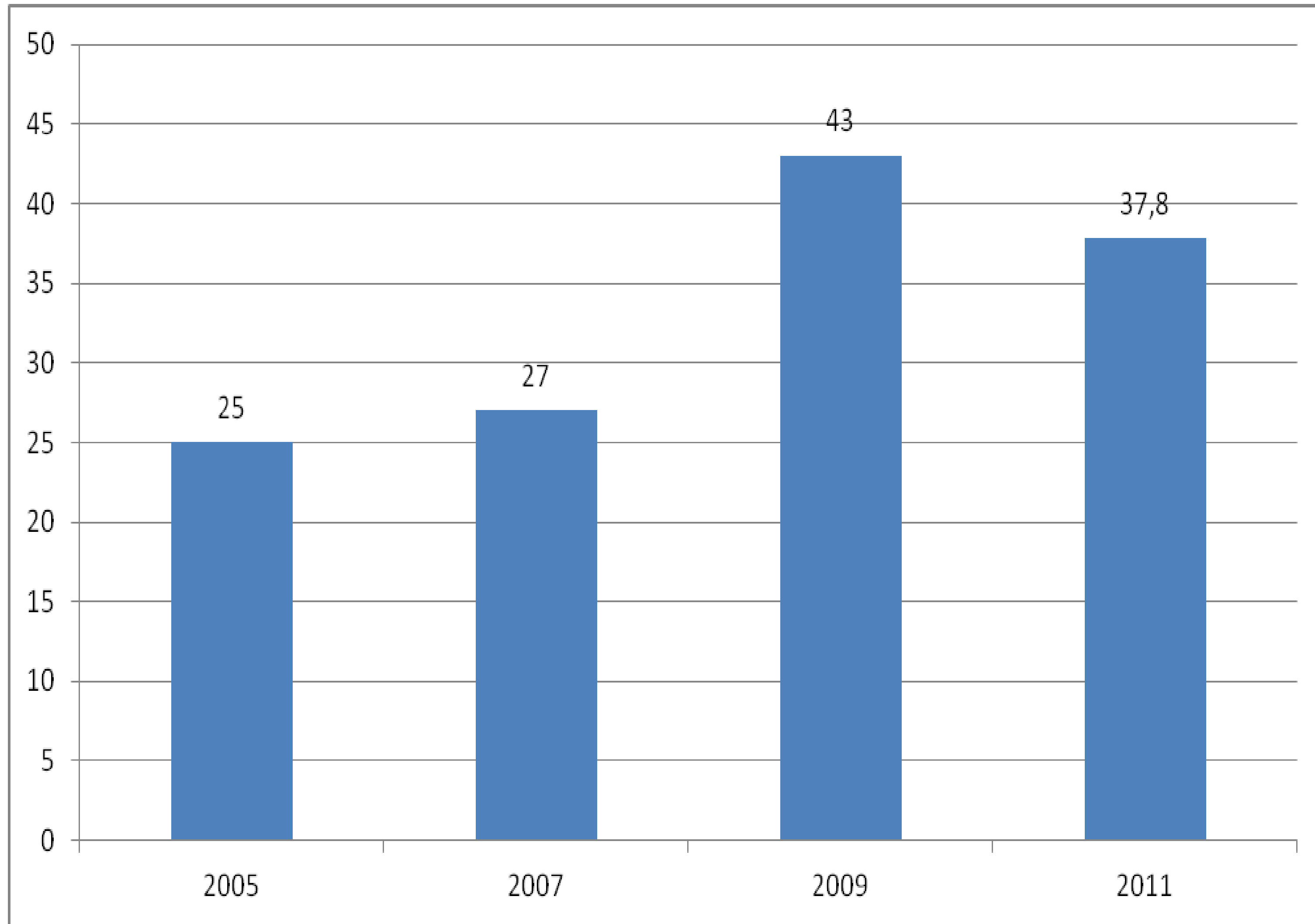
INDICATOR OVER TIME 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner



RATIONALE 1.13 Percentage of men having sex with men who received an HIV test in the last 12 months and who know their result

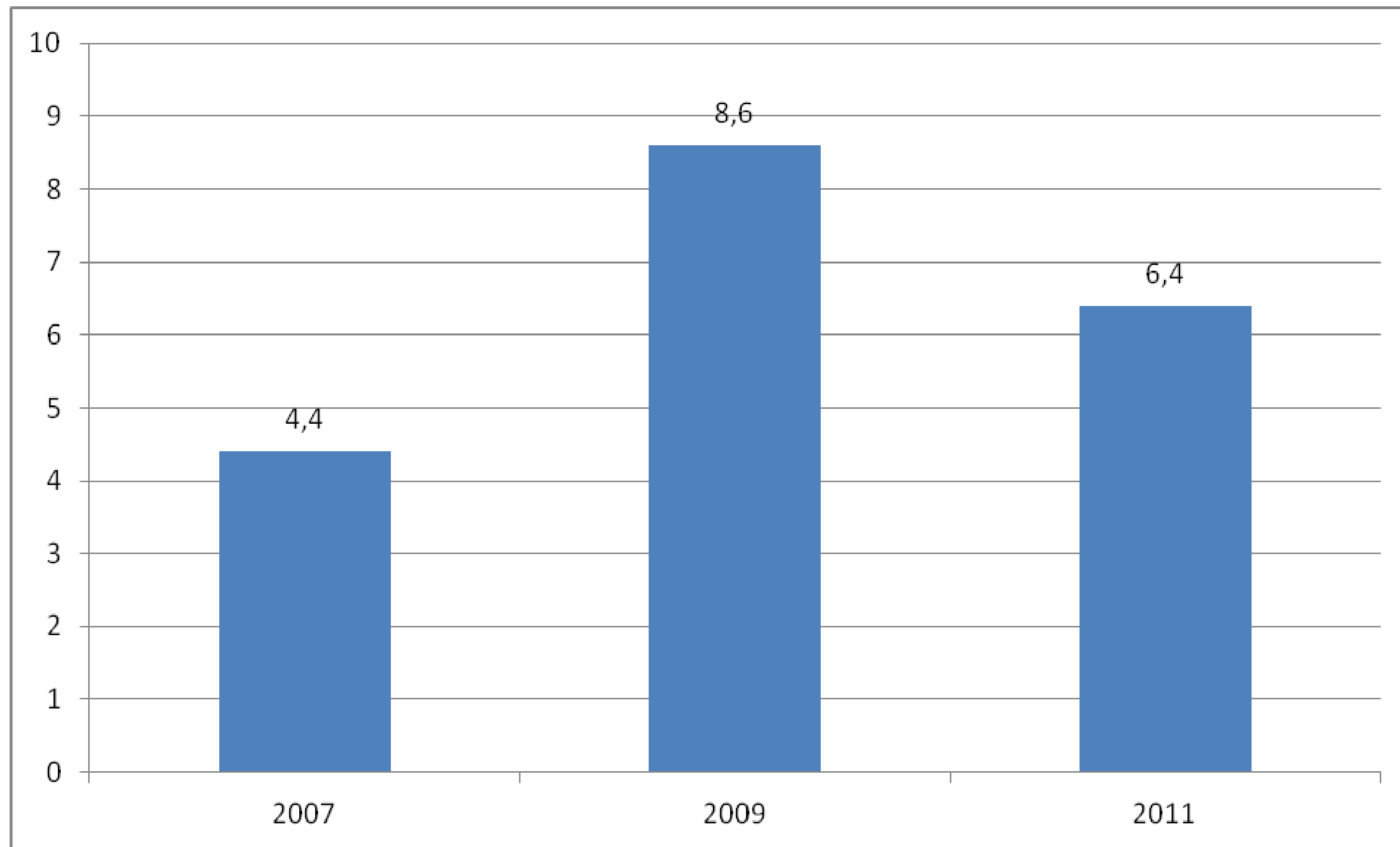
	total	Aged <25	Aged 25+
Percentage of men having sex with men who received an HIV test in the last 12 months and who know their result	37.8%	36.2	38.9
Numerator: number of men having sex with men who received an HIV test in the last 12 months and who know their result	2249	884	1366
Denominator: overall number of sampled men having sex with men	5950	2444	3506

INDICATOR OVER TIME 1.13 Percentage of men having sex with men who received an HIV test in the last 12 months and who know their result



RATIONALE AND INDICATOR OVER TIME 1.14 Percentage of men having sex with men living with HIV

	total	Aged <25	Aged 25+
Percentage of men having sex with men living with HIV	6.4%	4.2	7.8
Numerator: number of men having sex with men who tested positive for HIV	378	103	275
Denominator: overall number of men having sex with men who were tested for HIV	5950	2444	3506



RATIONALE AND INDICATOR OVER TIME 1.17 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit

	total
Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	92.4%
Numerator: number of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	457434
Denominator: overall number of women accessing antenatal care (ANC)	495250