Interim Report
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Tracking Global HIV/AIDS Initiatives and their Impact on the Health System in Ukraine

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GLOBAL HIV/AIDS INITIATIVES NETWORK

The Global HIV/AIDS Initiatives Network (GHIN) is a network of researchers established in 2006 that aims to track the effects of the major global HIV/AIDS initiatives:

- The World Bank's Global HIV/AIDS Programme including the Multi-country AIDS Programme (MAP)
- The Global Fund to Fight AIDS, TB and Malaria (GFATM)
- The United States President's Emergency Plan for AIDS Relief (PEPFAR).

The Members of the Network are researching the country effects and inter-relationships of these initiatives at national and sub-national levels. This network builds on two earlier studies: the Tracking Study, led by the London School of Hygiene and Tropical Medicine (2003-2004) and the System-Wide Effects of the Fund (SWEF) Research Network (since 2003) coordinated by the Partners for Health Reformplus project.

GHIN countries undertaking 2-4 year studies include: Angola, Benin, China, Ethiopia, Georgia, Kyrgyzstan, Malawi, Mozambique, Peru, South Africa, Tanzania, Uganda, Ukraine, Vietnam and Zambia. The Network is facilitating comparative work across these countries and will synthesise research findings.

Researching the national and sub-national effects of global HIV/AIDS initiatives at the country level

For further information on the Network, please visit our website:
http:/www.ghinet.org./
Alternatively please contact: Neil Spicer, neil.spicer@lshtm.ac.uk or Aisling Walsh, aislingwalsh@rcsi.ie, or any of the individual country researchers listed on the GHIN website.

Additional copies of this report can be found at:
http:/www.ghinet.org./

Table of Contents

Acknowledgments

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Executive Summary

- In July 2006 the School of Public Health and the School of Social Work of the National University 'Kyiv-Mohyla Academy' started implementing the Ukrainian part of a three-year international research project 'Tracking global HIV/AIDS initiatives and their impact on health systems'. The partners in this project are the London School of Hygiene and Tropical Medicine and the Royal College of Surgeons in Ireland. The project is financed by the Open Society Institute (OSI) in New York. The study forms a part of the *Global HIV/AIDS Initiatives Network* (GHIN): http://www.ghinet.org/.
- The aim of this stage of the research is to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) HIV/AIDS grants in Ukraine in three case study regions (Kyiv, Odessa and L'viv) including the effects on scale up of HIV/AIDS programmes; quality of care of HIV/AIDS services; human resources for HIV/AIDS programmes; coordination of HIV/AIDS programmes; and access to HIV/AIDS services.

Key findings of the study include:

Scale up of HIV/AIDS programmes

- The numbers and types of HIV/AIDS services have expanded substantially between 2004 and 2007; interviewees largely attribute this to the GFATM HIV/AIDS grant, which represented 44% of total HIV/AIDS funding in 2006. The vast majority of organisations delivering HIV/AIDS services receive resources from the GFATM grant either directly or indirectly (in the case of the latter, resources received through other GFATM recipients).
- The numbers of NGOs providing HIV/AIDS-related services has increased substantially since the introduction of the GFATM HIV/AIDS grant. While some NGOs existed before this date many respondents indicated that without the GFATM grant most NGOs would not exist.
- Secondary data show that client numbers have increased substantially in the three case study regions between 2004 and 2006 including clients receiving prevention services, ARV treatment, care and support and substitution therapy, as well as HIV/AIDS information materials. The facility survey confirms that client numbers have increased in key areas in this period: ARV treatment, HIV testing, post exposure prophylaxis and substitution therapy. National-level data also show substantial scale up.
- However, interviewees stressed that resources are insufficient to meet growing demand from HIV/AIDS-related services despite the fact that many service providers receive funding from multiple donors.
- Expansion of HIV/AIDS services and their coverage has been much more limited outside key priority (high HIV prevalence) regions such as Kyiv and Odessa as well as outside large cities in those and other regions.
- The process for distributing GFATM resources to different sub-recipients is subject to some criticism including: perceived lack of transparency about how priorities are set and projects/organisations are funded; regional priorities are seen as not corresponding with national priorities; distrust of large regional organisations that distribute resources to service providers; closed bidding competitions seen as favouring a limited number of organisations, and open bidding competitions are perceived as unfair (personal connections with Principal Recipient staff are believed to increase the chance of receiving a grant); complex procedures for obtaining grants.
- Interviewees identified a number of barriers to scaling up HIV/AIDS services in the three case study regions including: lack of professionalism among HIV/AIDS service organisation staff; a lack of commitment among some HIV/AIDS service organisations; ineffective monitoring and reporting systems; problems delivering outreach harm reduction services (needle/syringe exchange) due to harassment of drug user clients and service providers by the police; insufficient information about the activities of GFATM-funded HIV/AIDS services.

Quality of care

- The vast majority of service providers indicated that the services they provide to clients are of high quality. Similar patterns are apparent among services within the three case study regions and among government and NGO services.
- These patterns accord with clients' accounts of their satisfaction with HIV/AIDS-related services provided by government and nongovernmental organisations in the three regions: the vast majority were satisfied or very satisfied.
- Service providers and sub-national government and NGO stakeholders described GFATM support as having a positive impact on their organisations including: increased financing, personnel training and the supply of ARVs; improvements in organisations' management; better systems of reporting and monitoring and evaluation; improvements in quality of care; the development of new programmes and services together with improved availability of treatment, medications and technical resources; scale-up in numbers of clients; enrolment of new staff and improved staff skills.
- Qualitative data suggest clients' perceptions of the quality of care received from NGOs is often more positive than government services, although this relates largely to client-provider relations rather than technical quality of care. Aspects of NGO working practices valued by clients include informality and lack of bureaucracy, and that staff were attentive, sympathetic and non-discriminating.
- Two thirds of personnel of HIV/AIDS service organisations who were interviewed during the study stated that their organisation had a system in place for evaluating clients' satisfaction levels. The data suggest that monitoring client satisfaction is more common among NGOs than government services. Conversely, a minority of clients recalled having had their satisfaction level evaluated by an HIV/AIDS service organisation.

Human resources for HIV/AIDS programmes

- Most government and NGO service providers felt staffing levels were sufficient to carry out present activities.
- Staffing levels were seen as having increased among NGOs, and to a limited extent government service providers; a common practice among NGOs is to recruit former-clients as staff.
- Workloads increased, but for most respondents increases were not substantial.
- The vast majority of service providers received some training in HIV/AIDS-related activities.
- Government and NGO service providers felt motivated working in their facility or organisation; factors that motivated workers included feeling their work was valuable, empathy with clients, career opportunities and financial incentives.
- Most service providers indicated they had received some financial incentives for working with HIV/AIDS clients. However, the GFATM grant does not fund these incentives.

Sub-national coordination of HIV/AIDS programmes

- Sub-national HIV/AIDS coordination councils, a condition of, but not funded by the GFATM grant, have been created in Kyiv, Odessa and L'viv. Councils consist of representatives of government institutions and NGOs.
- The functions of HIV/AIDS coordination councils include promoting the coordination of local programmes, developing strategic plans and evaluating activities.
- The GFATM Principal Recipient the International HIV/AIDS Alliance in Ukraine funds regional coordinators in priority regions (including Kyiv and Odessa) whose roles include promoting more effective coordination between GFATM sub-recipients.
- In Odessa activities of the regional coordination council were evaluated by interviewees as effective in promoting local coordination. Opinions of Kyiv respondents about the effectiveness of the coordination council were mixed, and there were only negative comments about the L'viv coordination council, which was seen as a formality, and was ineffective. Some respondents perceived the councils as artificial since they were seen as imposed by external donors.
- Several factors inhibited the effectiveness of these councils: indifference and traditional management approaches among government agencies; the inability of representatives of NGOs to effectively lobby their ideas; high turnaround of council members; the absence of financial incentives for council members; limited representation of all interested parties; limited NGO capacity; the political situation in different regions in terms of whether those in power have an interest in HIV/AIDS.

- Nearly half of clients interviewed indicated they had been referred to their current service or had heard about it through another HIV/AIDS organisation; a high proportion had heard through peers. Referrals were most common in Kyiv and Odessa, while in L'viv most clients find out about services primarily through peers. Data suggest that NGOs are more active in referring clients and they cooperate between each other more than government organisations. Coordination between HIV/AIDS service organisations appears to be strongest in Odessa among the study regions, in Kyiv they appear to coordinate less, and there is very limited coordination in L'viv.
- The vast majority of service providers indicated their organisation refers clients and receives clients from other HIV/AIDS organisations. A lower proportion of clients indicated that they had been referred between services. This suggests that client referrals are practised, but on an ad hoc basis.
- A common electronic monitoring database is used across International HIV/AIDS Alliance-managed HIV/AIDS projects (GFATM and USAID SUNRISE grants); service providers enter common indicators onto a partially automated system that also enables them to manage service delivery and commodity distribution.
- There are some examples of projects run jointly by multiple organisations and other forms of coordination including provision of premises to NGOs by state institutions, information exchange, joint events and NGO volunteers working on joint projects based at government medical institutions.
- Interviewees suggested that a number of developments have promoted improved coordination between HIV/AIDS services: the creation of International HIV/AIDS Alliance in Ukraine regional coordinator posts; the introduction of strategic planning at the regional level through coordination councils; and the establishment of the Coalition of HIV Service NGOs, an organisation that works in Kyiv and Odessa. Inhibiting factors include bureaucracy, fragmentation and complexity of the health system, and the disengagement of some governmental institutions.

Access to HIV/AIDS services

- An indicator of access is whether services have to refuse clients, and similarly whether clients feel they have been refused a service. Data suggest that only a minority of clients are refused services.
- Service providers and clients evaluated the overall accessibility of services: data suggest different perspectives between providers and clients. The vast majority of service providers rated their organisation as highly accessible; clients were far more critical about levels of service access, with a high proportion rating a service highly or fairly inaccessible despite the fact they were using it.
- The most important household/community barriers from clients' perspectives are: stigmatisation of HIV/AIDS and limited knowledge of HIV/AIDS risk factors/symptoms. Key institutional/programmatic barriers are: limited workers, poor quality service provision and lack of equipment.
- Clients indicated that the stigmatisation of HIV/AIDS by their communities was the most important barrier to using HIV/AIDS services since this risked them becoming known as HIV positive, or a drug user or sex worker which are also stigmatised activities.

Chapter 1. Introduction

1.1 Background

Before 2004 Ukraine's HIV/AIDS policies and programmes mostly consisted of political speeches and negative public messages about the new infection, and sporadic HIV testing against a background of limited financing of treatment and support for people living with HIV/AIDS (PLWHA). National programmes were approved, but were not implemented or evaluated, and there was a pompous and empty launch of a 'Year to Fight HIV/AIDS' in 2002. While progressive national legislation protecting the rights of PLWHA was passed in 1998 and extended in 2001, which in general corresponds to international standards[1], it was not always respected and it was sometimes openly violated.

This began to change in 2004 when the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) provided funding for a programme 'Overcoming the HIV/AIDS epidemic in Ukraine', implemented by an international NGO, the International Alliance for HIV/AIDS in Ukraine. Ukraine received a $92M first round Global Fund grant to implement the programme that covers four areas: 1) treatment, care and support of people living with HIV/AIDS; 2) further development and expansion of preventative services aimed at population groups most vulnerable to HIV/AIDS, namely injecting drug users (IDUs), female commercial sex workers (CSWs), men having sex with men (MSM) and prisoners; 3) creation of a positive environment through educational and informational events and advocacy; 4) monitoring and evaluation [2].

The implementation of the Global Fund programme led to an increase in the volume of medical and social services for PLWHA and people in high risk groups. For example:

- By 2007 4,060 people [3] (compared to 65 in 2003) received HAART therapy;
- 4,487 HIV-positive pregnant women (beginning of 2004) received ARV to prevent the spread of HIV from mother to foetus and during labour;
- 436 IDUs received substitution therapy (the first programmes for substitution therapy started in 2005);
- Groups most vulnerable to HIV infection received preventative services and information materials: over 110,000 IDUs; over 15,000 female CSWs; over 29,000 prisoners;
- 406 medical institutions in all regions of Ukraine received drugs and other medical supplies financed by the GFATM [4].

The Ukrainian government also has a loan from the World Bank for implementing a project 'Monitoring of Tuberculosis and HIV/AIDS in Ukraine'. Implementation of this project started in 2003 and it was anticipated that by the end of 2007 the Ukrainian government (the Ministry of Health) would have used $60M for tuberculosis and HIV/AIDS programmes. However, in 2006 the loan was suspended due to slow use of funds, and resumed only in 2007.

[1] Rudiy V. Legislation of Ukraine in area of fight with HIV/AIDS: State of art and ways of improvement - Kyiv, 2004. 187 p. (p. 77).
[2] Global Fund Observer (GFO). – N 33. – 2004. - 18 October.– Available from: www.aidspan.org/gfo/archives/newsletter.
[3] Global Fund to Fight AIDS, TB and Malaria 2007b ARV Factsheet.
[4] http://www.aidsalliance.kiev.ua/ru/gfund/meetings/10stakeholders_meeting/10SHM_Ukr_final.ppt

Other organisations also have active HIV/AIDS programmes in Ukraine. These include:

- USAID;
- Swedish SIDA;
- UNICEF;
- UNAIDS;
- The international NGO 'International Renaissance Foundation' (Soros Foundation);
- The international NGO 'Transatlantic partners against AIDS',
- Clinton Foundation supporting a programme 'Initiatives to resist HIV/AIDS';
- The Elton John AIDS Foundation;
- The National Red Cross Committee.

1.2 Study tracking global HIV/AIDS initiatives and their impact on health systems

In July 2006 the School of Public Health and the School of Social Work of the National University 'Kyiv-Mohyla Academy' started implementing the Ukrainian part of a three-year international research project 'Study tracking global HIV/AIDS initiatives and their impact on health systems'. The partners in this project are the London School of Hygiene and Tropical Medicine and the Royal and College of Surgeons in Ireland. The project is financed by the Open Society Institute (OSI) in New York. The study forms a part of the *Global HIV/AIDS Initiatives Network* (GHIN): http://www.ghinet.org/

There are several stages to the study:

Stage 1 August - November 2006: *Preparatory stage* – contacting key stakeholders; policy and programmatic document review; interviewing national stakeholders; preparation of a situation report (Semigina *et al.* 2007: http://www.ghinet.org/downloads/ukraine.pdf).

State 2 December 2006 - December 2007: *Regional case studies baseline* - collection of data in three case study sites: Kyiv, Odessa and L'viv through policy and programmatic document review; analysis of secondary data; semi-structured interviews with local stakeholders; semi-structured interviews with providers of government medical and nongovernmental social services for HIV/AIDS; semi-structured interviews with clients of HIV service organisations; a facility survey of organisations funded by the GFATM grant; analysis and interpretation of data; preparation of the report and dissemination of results.

Stage 3 December 2007 - January 2008: *National data collection* – policy and programmatic document review; interviewing national stakeholders.

Stage 4 February - July 2008: *Regional case studies follow up* – focused collection of data in Kyiv, Odessa and L'viv through a policy and programmatic document review; analysis of secondary data; semi-structured interviews with local stakeholders; semi-structured interviews with providers of medical and social services; semi-structured interviews with clients of HIV-service organisations; a facility survey of organisations funded by the GFATM grant; analysis and interpretation of data.

Stage 5 August-December 2008: *Advocacy and dissemination* - analysis and interpretation of data collected during previous stages of the study; preparation, publication and distribution of a final study report; preparation of briefing sheets and policy briefs; holding national events including a press conference; preparation of papers for scientific journals; participating in global advocacy and dissemination events and outputs as part of the *Global HIV/AIDS Initiatives Network*.

This report presents results of Stage 2 of the study.

Chapter 2. Research Aims and Methods

2.1 Research aim and objectives

The aim of Stage Two of the 'Study tracking global HIV/AIDS initiatives and their impact on health systems' was to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) HIV/AIDS grant in Ukraine in three case study regions: Kyiv, Odessa and L'viv including the effects on scale-up of HIV/AIDS services, health systems capacity (quality of care, human resources and sub-national coordination) and equitable access to HIV/AIDS services.

The broad goal of the 'Study tracking global HIV/AIDS initiatives and their impact on health systems' is to provide reliable research findings on the effects of global HIV/AIDS initiatives (GHIs) to inform decisions made by government policymakers and practitioners, international agencies and nongovernmental organisations in Ukraine.

The selection of research sites was determined by the epidemiological contexts and levels of GFATM-financed activity. Kyiv and Odessa are so-called priority regions where the GFATM grant was invested substantially. L'viv is within a so-called non-priority region where the official statistics indicate low levels of HIV/AIDS transmission, and few services are supported by the GFATM. However, there exists a relatively developed public sector in this region, and given the geographical position of L'viv on the border with Poland it was decided to include the city to provide an opportunity to compare priority and non-priority regions in terms of identifying the influence of the GFATM on the development of HIV programmes.

The study has the following objectives:

Scale up of HIV/AIDS programmes

- To assess levels of scale-up of HIV/AIDS programmes in the three study regions;
- To explore key factors enabling and inhibiting scale up;

Quality of care of HIV/AIDS services

- To examine perceptions of the quality of care of GFATM-financed HIV/AIDS services;
- To identify aspects of services that clients considered important in terms of quality;
- To assess whether and how HIV/AIDS service organisations evaluated client satisfaction;

Human resources for HIV/AIDS programmes

- To explore perceptions of the adequacy of staffing levels among GFATM government and nongovernmental sub-recipients;
- To assess the effects of the GFATM on staffing levels, staff workloads, training and motivation;

Coordination of HIV/AIDS programmes

- To describe the functions and composition of sub-national HIV/AIDS coordination councils;
- To assess the effectiveness of sub-national HIV/AIDS coordination councils and identify factors enabling and inhibiting sub-national coordination;
- To examine levels and forms of coordination between HIV/AIDS services;

Access to HIV/AIDS services

- To assess level of accessibility of governmental and nongovernmental GFATM-financed services;
- To identify key household/community and institutional/programmatic barriers to accessibility from clients' perspectives.

2.2 Data collection methods

Mixed quantitative and qualitative research methods were adopted to collect data during the second stage of the study, namely:

- Review of relevant policy and programmatic documents;
- Analysis of secondary data including data generated by the GFATM Principal Recipient the International HIV/AIDS Alliance in Ukraine;
- Semi-structured interviews with local stakeholders including representatives of public and nongovernmental organisations working in the field of HIV/AIDS;
- Semi-structured interviews with clients of HIV service organisations;
- Self-completed facility tools undertaken by providers of government medical and NGO social services for HIV/AIDS.

Research instruments were developed collaboratively by Ukrainian, London and Dublin researchers, and were piloted in Kyiv in late 2006. The field research in Kyiv, Odessa and L'viv was carried out in January through to March 2007 by field researchers from the School of Public Health and School of Social Work at the Kyiv Mohyla Academy. All respondents were fully informed about the nature of the research and provided verbal or written consent to participate in the study.

2.3 Description of the sample

The sample was based on all active HIV service organisations in Kyiv, Odessa and L'viv which provide services to PLWHA or provide HIV/AIDS prevention services to marginalised groups that consented to participate in the research. Purposive and snowball methods was used to identify stakeholders participating in the study. Random sampling was employed in carrying out the frontline provider and client interviews. Details of interviews are as follows:

Local government and nongovernmental stakeholders (N=72): representatives of governmental and nongovernmental organisations including managers of services receiving GFATM grants, representatives of regional departments of state administrations (including officials from the Department of Family, Youth and Sports Affairs, healthcare departments and education departments at municipal and regional levels) and regional NGOs that are members of coordination councils. Table 1.1 summarises the number of interviewees by type of organisation.

Table 1.1 Breakdown of stakeholders by city and organisation type

	Kyiv	Odessa	L'viv	Total
Government organisations	2	5	3	10
State administration	4	1	3	8
Nongovernmental organisations	4	7	4	15
Nongovernmental service provider managers	20	12	7	39
Total	**30**	**25**	**17**	**72**

Frontline service providers (N=88): personnel working directly with clients from governmental and nongovernmental HIV/AIDS organisations funded by the GFATM grant. Table 2.2 summarises the numbers of interviewees by region, organisation type and interviewees' genders.

Table 2.2 Breakdown of service providers interviewed by organisation type, region and gender

	Kyiv	Odessa	L'viv	Total
Organisation type				
Government medical service providers	18	10	4	32
Nongovernmental social care service providers	28	19	9	56
Gender				
Female	28	19	6	53
Male	18	8	7	33
Total	46	29*	13	88

* 2 unrecorded

Clients of HIV/AIDS service organisations (N=93): clients using prevention, treatment and care services provided by government and nongovernmental organisations funded by the GFATM grant. Table 2.3 summarises the numbers of client interviewees by region, organisation type and gender.

Table 2.3 Breakdown of clients interviewed by organisation type, region and gender

	Kyiv	Odessa	L'viv	Total
Organisation type				
Government medical service providers	16	13	1	30
Nongovernmental social care service providers	29	16	18	63
Gender				
Female	23	5	4	32
Male	22	24	15	61
Total	45	29	19	93

Facility survey (N=12): a self completed form filled out by twelve organisations receiving GFATM funding including AIDS centres and other government healthcare providers and NGOs. Table 2.4 summarises the numbers of facilities by region and organisation type.

Table 2.4 Breakdown of facility surveys completed by organisation type and region

	Kyiv	Odessa	L'viv	Total
Organisation type				
Government medical service providers	2	3	2	7
Nongovernmental social care service providers	3	2	0	5
Total	5	5	2	12

2.4 Difficulties and limitations of the study

The study has a number of difficulties and limitations. It is believed that service providers and managers' sensitivities about their organisations' working practices, and as previous studies have highlighted, institutional cultures that lack transparency, influenced their willingness to reflect on negative as well as positive aspects of their work, despite individuals being assured that their comments would not be attributed to them, and they would not be identified in any study outputs.

The number of clients interviewed was relatively low due to considerable difficulties recruiting participants who are highly marginalized and practise behaviour criminalized by the state. The survey was not able to elicit the perspectives of individuals not using HIV/AIDS services due to particular recruitment difficulties: interviewees were recruited through GFATM-financed service providers. All interviews were conducted in private spaces to maintain confidentiality: particular care was taken to ensure clients' HIV positive status was not revealed through being interviewed. Hence the study does not claim to be widely representative of the views of all PLWHA and risk groups within the study sites, nor more broadly across Ukraine.

The facility survey was problematic to administer. Sensitivities around providing routinely collected activity and financial data among managers and administrators of GFATM-financed government and nongovernmental organisations meant that it was not possible to systematically conduct the survey in the three study sites: only twelve organisations agreed to participate in this part of the study. Indeed, some stakeholders interviewed indicated that incomplete and/or inaccurate record keeping is common among government and nongovernmental organisations, which explained the lack of willingness to allow the field researchers either to directly access records or in many cases to provide data. Most organisations employed a number of parallel information systems relating to different aspects of their activities including client interventions, commodity management, human resources and financial flows. Individual organisations used different computer-based and paper-based information systems in parallel, each with a different format. This made it difficult and time consuming to extract data from their records for the purpose of completing the facility survey form, especially for busy, under-paid staff. Hence, while twelve facility surveys were completed some data were missing from completed forms.

Chapter 3. Context

3.1 Epidemiological context

Kyiv

Kyiv, with a total population of 2.7 million, is ranked seventh among the 27 administrative regions of Ukraine in terms of the prevalence of HIV (134.6 per 100,000 of population cumulative in 2006). Between 2002 and 2004 the HIV incidence increased from 15.93 per 100,000 to 23.79, which is equivalent to two new HIV cases a day. By 2005 3,438 HIV cases were registered in the city including 374 AIDS patients (Ministry of Health of Ukraine, 2005), and 97 people had died of AIDS-related illnesses. In 2006 alone 1,146 new HIV cases were registered in the city (38.9 per 100,000 of population against 29.2 nationally)[5].

HIV/AIDS prevalence is highest among injecting drug users (IDUs), although there is increasing concern that the disease is spreading to people of reproductive age who do not inject drugs. Of the 3,438 officially registered people with HIV in Kyiv clinics, 3,155 are IDUs (73%), and the majority of people with HIV in the city are 20-29 years old (63.5%). Although most PLWHA are male, this trend is changing: in 1987 the percentage of women registered as HIV positive was 23%; by 2004 the proportion had risen to nearly 47%. In 2005 506 children born to HIV positive mothers were enrolled in clinics, although most were taken off the records after their HIV status was determined as negative. The general indicator of vertical transmission of HIV from mother to child is 17.52%.

Odessa

Odessa region is ranked fourth in terms of the HIV among the 27 administrative regions of Ukraine in terms of prevalence (56.1 per 100,000 of population against 29.2 nationally), and second by level of spread: in 2006 7,857 people with HIV were registered at clinics (a prevalence of 326.7 per 100,000 of population compared to 133.5 nationally in 2006). The region has land and sea borders with Moldova, Romania, Bulgaria and Turkey. International drug transportation routes pass through Odessa and the region has a large number of resorts which attract high numbers of tourists seasonally. Both of these factors contribute to the high rate of increase of HIV/AIDS in the region.

As of January 2006 7,857 people with HIV had been registered by clinics, 905 of them as AIDS patients. Between 1987 and 1994 small numbers of new HIV cases were registered annually (between five and twelve), which were in most cases transmitted heterosexually. Since 1999 annual rates of inflection have increased dramatically, largely among IDUs, although the number of HIV infected pregnant women increased sharply (the proportion of HIV positive people who were pregnant women in Odessa region was considerably higher than national average: 0.62% and 0.30% respectively at the beginning of 2006). There has also been a steady increase in the number of cases of transmission through heterosexual intercourse (23% in 1996, 34% in 2004 and 38% in 2005). The largest number of HIV cases in Odessa region in 2005 was registered among 18-24 year olds (16%) and 25-49 year olds (60%).

L'viv

Since 1987 1,423 people have been registered with HIV in the L'viv region (55.5 per 100,000 people). The cities with highest HIV prevalence are Boryslav (230.7), Chervonograd (188.9), Sambor (76.0), L'viv (68.9) and Striy (71.6). In 2006 242 people were diagnosed with HIV for the first time (9.4 per 100,000 people compared to 34.5 nationally), including 104 people with AIDS (4.06 per 100,000 people compared to 12.09 nationally). By January 2007 875 HIV positive people were registered in clinics in the region including 141 people with AIDS. A total 106 people died of AIDS-related illnesses in the region according to official figures, including 36 people in 2006. The majority of HIV infections, 70.5% in the region compared to 60.7% in 2005, resulted from injecting drug use, and 66.1% of people infected were male, and 73.7% of HIV cases were registered among 20-39 year old people. By the beginning of 2006 the number of children born to HIV positive mothers was growing (119 since 1987); nine children were diagnosed as HIV positive including three with AIDS.

[5]Epidemiological Situation in Kyiv http://www.aidsalliance.kiev.ua/ru

3.2 HIV/AIDS programmes in Kyiv, Odessa and L'viv

Kyiv

HIV/AIDS control and treatment in the city of Kyiv comes under the 'Program to prevent the spread of HIV infection in Kyiv, to provide support and treatment to PLWHA in 2006-2008'[6]. Its priorities are to focus on risk groups, preventative work among young people, prevention of vertical transmission, and provision of treatment, care and support. The programme is led by state organisations (the health and education departments and the youth department of the Kyiv city administration). NGOs are involved in the programme's implementation.

The programme is chronologically divided into two stages. The strategic direction of Stage I (2006-2007) was a full-scale information and education campaign aimed to increase the ability of the municipal community to deal with the negative impacts of the HIV/AIDS epidemic; and Stage II (since 2008) focused on the creation of an effective interagency system to provide medical care and social protection to PLWHA. In general, the programme's priorities are as follows:

- formation of a supportive environment for PLWHA;
- preventing further spread of HIV in Kyiv;
- overcoming stigma and discrimination towards PLWHA;
- medical care for PLWHA;
- care and support for PLWHA;
- preventative work among high risk groups.

The Programme defines the following as high risk groups: IDUs, female CSWs, MSM and people with multiple sexual relations. It is also particularly concerned with the protection of children. It aims to include the traditional state medical institutions as well as NGOs that work in the field of HIV/AIDS.

Odessa

In Odessa HIV/AIDS policy is defined by a regional 'Programme to prevent HIV/AIDS infection and to support and treat HIV positive people and people with AIDS for 2004-2008'[7]. The tasks of the Programme are not dissimilar to those of the national programme, although they do not include scientific research.

The programme is coordinated through the Odessa regional coordination council. This was created as a body within the Department of Healthcare of the regional state administration. Its role is to coordinate the activities of the Programme, which covers a number of departments of the regional administration: healthcare, education and science, family affairs and youth, culture, physical culture and sports, press and information and the adolescent affairs service. It also encompasses Odessa regional state television and radio broadcasting company, the state epidemiological service (SES) of Odessa region, the department of the Ministry of Internal Affairs of Ukraine in the Odessa region, and the regional Red Cross.

The Odessa regional Programme differs from the programmes in Kyiv and L'viv in that it provides strict allocation of financing for each activity in the Programme every year. However, this means that certain activities are not funded: for example, monitoring programmatic activities and any activities carried out by NGOs. Unlike the Kyiv programme, there is no strategic monitoring or evaluation of tasks or activities.

L'viv

The L'viv regional 'Programme for prevention of HIV infection, help and treatment of PLWHA in 2004-2008'[8] resembles the national Programme, but without a scientific research and development component. Services are largely provided by state institutions and governmental bodies. NGOs are mostly involved in information and education activities. Unlike the Kyiv programme, there is no strategic monitoring or evaluation of tasks or activities.

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[6]Рішення Київради від 9 березня 2006 р. No 161/3252 «Про затвердження Програми по запобіганню поширенню ВІЛ-інфекції в м. Києві, забезпеченню допомоги та лікування людей, які живуть з ВІЛ/СНІДом, на 2006 – 2008 роки».
[7]Обласна Програма забезпечення профілактики ВІЛ-інфекції, допомоги та лікування ВІЛ-інфікованих і хворих на СНІД на 2004-2008 роки, затверджена рішенням обласної Ради від "20 " жовтня 2004 р. No 505-IV.
[8]Програма забезпечення профілактики ВІЛ-інфекції, допомоги та лікування ВІЛ-інфікованих і хворих на СНІД на 2004-2008 роки у Львівській області, затверджена Розпорядженням Голови львівської обласної державної адміністрації від 17 листопада 2004 року No 927

Chapter 4. Sub-National HIV/AIDS Service Scale Up

4.1 Introduction

The GFATM grant represents a high proportion, 44%, of total HIV/AIDS funding in Ukraine nationally in 2006[9], suggesting the grant has the potential to have a substantial impact of HIV/AIDS programme scale up. The GFATM HIV/AIDS grant funds government medical institutions and NGO social services to provide services for PLWHA and their family members, preventative services for vulnerable groups including injecting drug users (IDUs) and sex workers (SWs), as well as preventative services to general population in the study regions of Kyiv, Odessa and L'viv. This chapter describes patterns of HIV/AIDS service scale up in the three study regions and explores key factors enabling and inhibiting scale up. Data are elicited from secondary sources and from the facility survey conducted as part of this research among sampled GFATM sub-recipients.

4.2 Scale up of GFATM-supported services nationally and in the study regions

In 2004 HIV/AIDS services were under developed in Ukraine due to limited financing, although small scale HIV testing, ARV therapy and needle/syringe exchange services existed in some regions, primarily funded by different international donors. By 2007 the number of HIV/AIDS services had expanded considerably, as had the types of services. Table 4.1 indicates how the range of different HIV/AIDS services expanded between 2004 and 2007.

Government and nongovernmental interviewees widely attribute the scale up of HIV/AIDS services nationally and within the study regions to GFATM funding which became available in 2004. Indeed, almost all organisations directly or indirectly receive financing or resources from the GFATM (indirect receipt of resources means an organisation received resources though other government or nongovernmental recipients)[10],[11],[12],[13]. GFTAM sub-recipients include government healthcare providers, primarily specialist AIDS centres, that deliver medical services including HIV testing and treatment, prevention of vertical transmission and treatment of opportunistic infections, while NGOs supported by the GFATM focus on social care including harm reduction (needle/syringe exchange and drugs detoxification), condom distribution and support for PLWHA. Other government services provide a range of HIV/AIDS-related interventions funded by the GFATM including drugs (narcology) centres, STI (dermato-venerology) centres and tuberculosis hospitals.

One interviewee explained:
With the arrival of the Global Fund, if the therapy was available to about 130 people in all of Ukraine before, at present there are thousands of these people who have an opportunity to extend their lives, and makes the quality of their lives better.

Another interviewee suggested:
If before we had 30% HIV-positive children born to our HIV infected mothers, by the end of this pilot project and up until present we've been able to keep this number at stable 7%. We've gone from 30% down to 7%.

[9]Excluding out-of pocket expenses (International HIV/AIDS Alliance in Ukraine, 2006)
[10]Funding recipients at the national level include the All-Ukrainian Network of PLWHA; the International Renaissance Foundation, the Ukrainian Centre for Prevention and Fighting AIDS of the Ministry of Health of Ukraine; the Foundation for the Prevention of Chemical Dependency and AIDS; the Programme of Adequate Technologies in Healthcare (PATH); Regional Information Centre for Care and Treatment of HIV/AIDS in Eurasia; AIDS Foundation East-West; the All-Ukrainian Association for Harm Reduction.
[11]International HIV/AIDS Alliance in Ukraine: Annual Report for 2004. – Kyiv, 2005. – 40 p.
[12]International HIV/AIDS Alliance in Ukraine: Annual Report for 2005. – Kyiv, 2006. – 52 p.
[13]Міжнародний Альянс з ВІЛ/СНІД: три роки в Україні. Звіт за підсумками діяльності. - [Цит. 2006, 12 грудня]. - Доступний з: http://www.aidsalliance.kiev.ua/cgi-bin/index.cgi?url=/ua/gfund/index.htm.

In 2004 the number of HIV/AIDS service organisations in the three case study regions was limited to the AIDS centre in Kyiv, the municipal AIDS centre in Odessa and a department within an infectious hospital within L'viv. By the 2007 an extensive number of institutions and organisations exist that provide HIV/AIDS services. In particular the numbers of NGOs providing HIV/AIDS-related services has increased substantially since the introduction of the GFATM HIV/AIDS grant in Ukraine in 2004. While some NGOs existed before this date many respondents indicated that without the GFATM grant most NGOs would not exist. Figure 4.1 illustrates how levels of funding of GFATM sub-recipients have increased between 2004 and 2006 in Kyiv, Odessa and L'viv.

Table 4.1 Key HIV/AIDS services in case study regions (beginning of 2004 and 2007)

	Kyiv		Odessa		L'viv	
	2004	2007	2004	2007	2004	2007
Voluntary HIV-testing	+	+	+	+	+	+
ÄRV treatment for adults	-*	+	-	+	-	+
ÄRV treatment for children	-	+	-	+	-	-
Prevention of vertical transition	-	+	-	+	-	-
Substitution therapy*	-	+	-	+	-	-
Needle/syringe exchange	+	+	+	+	+	+
Hospice care	-	-	-	-	-	-
Medical treatment: opportunistic infections	+**	+	+**	+	-	+
Non-medical (social) support	-	+	-	+	-	-
Social care in public centres	-***	+		+	-	-
Day centre for HIV-positive children	-	+	-	+	-	-

Sources: Interviews conducted in 2007; International HIV/AIDS Alliance in Ukraine: Annual Report for 2004; International HIV/AIDS Alliance in Ukraine: Annual Report for 2005; Міжнародний Альянс з ВІЛ/СНІД: три роки в Україні. Звіт за підсумками діяльності. - [Цит. 2006, 12 грудня]. - Доступний з: http://www.aidsalliance.kiev.ua/cgi-bin/index.cgi?url=/ua/gfund/index.htm.

* Buprenorphine

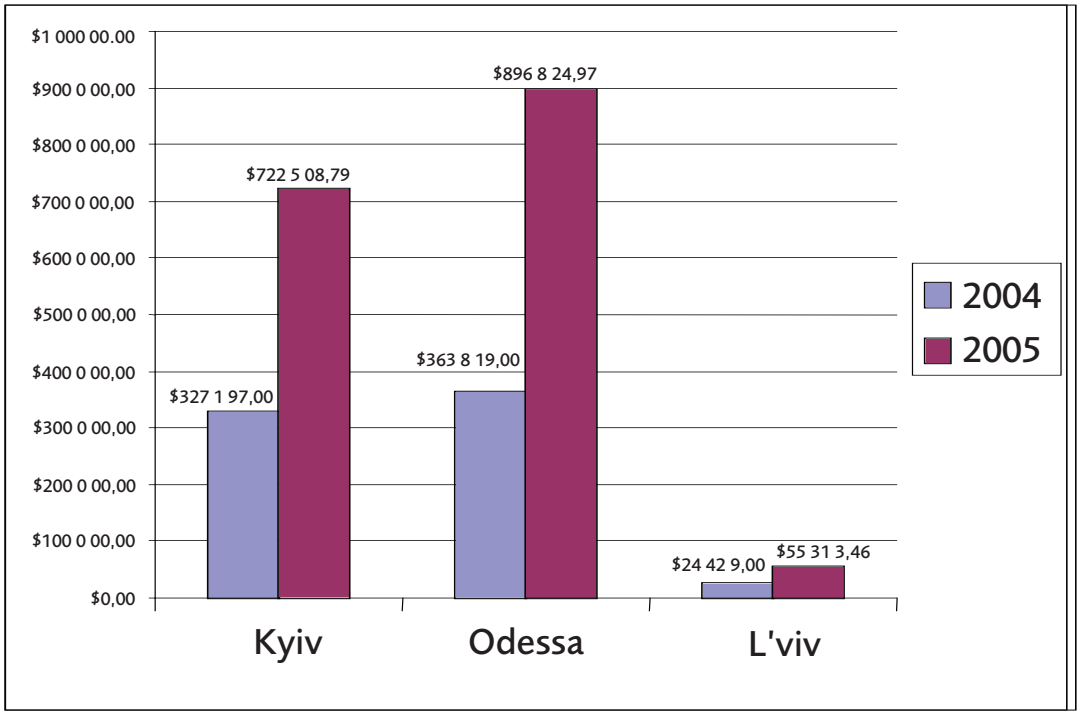
** The service was provided at an extremely low scale in 2004

*** Started mid-2004

In addition to providing grants to sub-recipients the GFATM grant directly funds the procurement of commodities and equipment for distribution to service providers. Commodities include: ARV drugs, post exposure prophylaxis drugs, OI drugs, PMTCT drugs, substitution therapy (Buprenorphine), needles/syringes, condoms, baby milk formulas. Equipment includes: laboratory equipment including refrigerators and other materials, HIV testing equipment including viral load equipment, general medical equipment, office equipment and some capital costs such as building repairs. Secondary data point to scale up in the procurement and distribution commodities and equipment. The case study regions received the following amounts for medications and milk formulas (a means of preventing vertical transmission caused by breastfeeding) in 2005: Kyiv $131,623; Odessa $301,550, L'viv $7,125[14]. Despite these volumes of commodities, as Chapter 7 suggests, shortage of commodities was nominated as one of the most important barriers to using services by clients and providers.

[14] International HIV/AIDS Alliance in Ukraine: Annual Report for 2005

Figure 4.1 GFATM sub-grants 2004 to 2005 years in Kyiv, Odessa and L'viv



Source: International Alliance HIV/AIDS in Ukraine

4.3 Scale up of client numbers receiving HIV/AIDS services

Secondary data suggest that the number of clients receiving HIV/AIDS services has increased substantially in the three study regions between 2004 and 2006, including clients receiving prevention services, ARV treatment, care and support and substitution therapy. Table 4.3 summarises these data. Data elicited from the facility survey also indicates that the numbers of clients receiving ARV treatment, HIV testing, post exposure prophylaxis and substitution therapy have increased in this period in Kyiv, Odessa and L'viv (Table 4.4). In L'viv most of the services for clients of HIV/AIDS service organisations were introduced only in 2006 when the GFATM-supported programme started in the region. Social marketing and advocacy activities have also increased in all three regions. In Kyiv the distribution of information materials went up from 30,037 units in 2004/5 to 127,973 in 2006. In Odessa the number of information materials distributed went up 4.6 times over the same period of time, although in L'viv it decreased 5.8 times. Advocacy activities also expanded to a certain degree: for example, 14 advocacy events took place in 2004-2005 in Odessa, and in 2006 the number was 61. At the same time the number of trained advocacy specialists also increased[15].

[15]International HIV/AIDS Alliance in Ukraine 2007

Table 4.3 Total client numbers: key HIV/AIDS services in Kyiv, Odessa and L'viv

Services	Number of clients receiving services by the end of the period					
	Kyiv		Odessa		L'viv	
	2004/ 2005	2006	2004/ 2005	2006	2004/ 2005	2006
Preventative services	7843	23139	11214	28536	782	4305
Substitution therapy	-	240	-	99	-	-
Care and support	1111	2862	989	4658	29	221
ARV treatment	232	301	373	374	-	-

Source: International HIV/AIDS Alliance in Ukraine

Secondary data also point to substantial levels of scale up at the national-level. Only 255 people were receiving ARV therapy as of April 2004 in Ukraine as a whole; by the end of 2006 there were 4,600 people receiving ARVs nationally[16]. Table 4.5 presents national indicators of scale up of client numbers relating selected service areas and client groups.

Table 4.4 Client numbers: selected HIV/AIDS services in Kyiv, Odessa and L'viv

Services	Number of clients receiving services in the period								
	Kyiv*			Odessa			L'viv		
	2004	2005	2006	2004	2005	2006	2004	2005	2006
Testing: express analysis			587						
Testing: PCR			248						
Testing: ELISA			17,612		198	579			
Testing: immunoblot			924						
Testing: CD-4			2,163		100	456			
ARV treatment	18		250		56	147			4
Substitution therapy			47						
PEP	68		52	5	11	14			4

[16] Global Fund to Fight AIDS, TB and Malaria ARV Factsheet (2007)

Table 4.5 Selected national indictors of GFATM-financed HIV/AIDS service scale up

	2004	2007*
ARV treatment	255	3,720
PMTCT	1,324	4,487
IDUs receiving prevention services	10,612	110,407
SWs receiving prevention services	1,068	15,459
IDUs receiving substitution therapy (not ARV)	65	343
Numbers of condoms distributed for free	245,189	3,830,177
PLWHA receiving care and support services	402	20,699
Number of children living with and/or affected by HIV receiving care and support services	32	2,853

Source: International HIV/AIDS Alliance in Ukraine (2007)
* As of January 2007

4.4 Limitations and problems of scaling up HIV/AIDS services

Despite substantial levels of scale up in the coverage of HIV/AIDS services interviewees stressed that resources are insufficient to meet growing demand, despite the fact that many service providers receive funding from multiple donors. A number of service areas are absent such as palliative care, and some key services remained limited in scope, notably Methadone substitutive therapy which until recently has been restricted by Ukrainian drugs laws. As the tables above suggest the expansion of different service areas and the numbers of clients receiving services has been more limited in L'viv than the other two study regions since it is not a designated priority region. Moreover, most of the HIV/AIDS services are concentrated in large cities; this makes it difficult for a large number of potential clients living outside major cities to access services[17].

The process for distributing GFATM resources to different sub-recipients was criticised by many interviewees. Problems include:

- perceived lack of transparency about how priorities are set and projects/organisations are funded;
- regional priorities are seen as not corresponding with national priorities;
- distrust of large regional organisations that distribute resources to service providers;
- closed bidding competitions which are seen as favouring a limited number of organisations;
- open bidding competitions are perceived as unfair (individuals with personal connections to Principal Recipient staff are believed to have a greater chance of receiving a grant);
- complex procedures for obtaining grants make it difficult for some less established organisations to apply.

Interviewees identified a number of additional barriers to scaling up HIV/AIDS services across the three case study regions including:

- Limited professionalism among some HIV/AIDS service organisation staff;
- Limited commitment among some HIV/AIDS service organisations;
- Ineffective monitoring and reporting systems;
- Problems delivering outreach harm reduction services (needle/syringe exchange) due to harassment of drug user clients and service providers by the police;
- Insufficient information about the activities of GFATM-funded HIV/AIDS services.

[17]The Directory of Organizations Working in the Field Of HIV/AIDS. – Available from: http://www.aidsalliance.kiev.ua/cgi-bin/index.cgi?url=/en/library/our/aidsdirectory/index.htm.

4.5 Summary

- The numbers and types of HIV/AIDS services have expanded substantially between 2004 and 2007; interviewees largely attribute this to the GFATM HIV/AIDS grant, which represented 44% of total HIV/AIDS funding in 2006. The vast majority of organisations delivering HIV/AIDS services receive resources from the GFATM grant either directly or indirectly (in the case of the latter, resources received through other GFATM recipients).
- The numbers of NGOs providing HIV/AIDS-related services has increased substantially since the introduction of the GFATM HIV/AIDS grant. While some NGOs existed before this date many respondents indicated that without the GFATM grant most NGOs would not exist.
- Secondary data show that client numbers have increased substantially in the three case study regions between 2004 and 2006 including clients receiving prevention services, ARV treatment, care and support and substitution therapy, as well as HIV/AIDS information materials. The facility survey confirms that client numbers have increased in key areas in this period: ARV treatment, HIV testing, PEP and substitution therapy. National-level data also show substantial scale up.
- However, interviewees stressed that resources are insufficient to meet growing demand from HIV/AIDS-related services despite the fact that many service providers receive funding from multiple donors.
- Expansion of HIV/AIDS services and their coverage has been much more limited outside key priority (high HIV prevalence) regions such as Kyiv and Odessa as well as outside large cities in those and other regions.
- The process for distributing GFATM resources to different sub-recipients is subject to some criticism including: perceived lack of transparency about how priorities are set and projects/organisations are funded; regional priorities are seen as not corresponding with national priorities; distrust of large regional organisations that distribute resources to service providers; closed bidding competitions seen as favouring a limited number of organisations, and open bidding competitions are perceived as unfair (personal connections with Principal Recipient staff are believed to increase the chance of receiving a grant); complex procedures for obtaining grants.
- Interviewees identified a number of barriers to scaling up HIV/AIDS services in the three case study regions including: lack of professionalism among HIV/AIDS service organisation staff; a lack of commitment among some HIV/AIDS service organisations; monitoring and reporting systems are ineffective; problems delivering outreach harm reduction services (needle/syringe exchange) due to harassment of drug user clients and service providers by the police; and insufficient information about the activities of GFATM-funded HIV/AIDS services.

Chapter 5. Quality of Care

5.1 Introduction

This chapter discusses perceptions of the quality of care delivered by GFATM-funded HIV/AIDS services based on data from the service provider, client and government and NGO stakeholder interviews. The aspects of services that clients considered important in terms of quality are reviewed, and data on the extent to which HIV/AIDS service organisations evaluated client satisfaction are presented.

5.2 Perceptions of quality of care

The vast majority of service providers (85/88) indicated that the services they provided to clients were of high quality ('above average' or 'maximum'); similar patterns are apparent among services within the three case study regions and among government and NGO services (Table 5.1). These patterns accord with clients' accounts of their satisfaction with HIV/AIDS-related services provided by government and nongovernmental organisations in the three regions: the vast majority (82/93) were 'satisfied' or 'very satisfied' (Table 5.2). This compares favourably to a recent Ukrainian survey into clients' experiences of healthcare where 90% of clients evaluated quality of health services as 'relatively low' and 'extremely low' (UNDP, 2003). This suggests that clients' experiences of HIV/AIDS services may be better than those of healthcare generally in Ukraine.

Table 5.1 Service providers' perceptions of quality of care

	Minimum	Less than average	More than average	Maximum
Overall	1	1	25	57
Kyiv	0	1	17	27
Odessa	0	0	4	23
L'viv	1	0	4	7
Government medical service	1	0	6	22
NGO social service	0	1	19	35

Sample size: N=88

Service providers and sub-national government and NGO stakeholders described a number of ways in which GFATM financing had impacted positively on their organisations' ability to deliver better quality services. The most important effects include:

- improved supply of ARVs;
- additional and better trained personnel;
- scale-up in numbers of clients;
- improvements in organisations' management, which have become more mission-oriented, more strategic in their planning and have adopted better systems of reporting, monitoring and evaluation;
- the development of new programmes and services together with improved availability of treatment, medications and technical resources;

While few clients were aware of how services had changed over time, those that were pointed to several improvements including: improved staff skills; increased cooperation between government and NGO services, and that government service providers 'had become kinder' than they were previously. A client interviewed at the Kyiv AIDS centre stated that number of wards had recently increased, services were provided more promptly, technical resources had improved, and number of medications that could be received free of charge had increased.

Table 5.2 Clients' satisfaction with HIV/AIDS services

	Very dissatisfied	Dissatisfied	Average	Satisfied	Very satisfied
Overall	0	2	3	21	61
Kyiv	0	1	2	11	25
Odessa	0	1	1	7	20
L'viv	0	0	0	3	16
Government medical service	0	1	2	7	19
NGO social service	0	1	1	14	42

Sample size: N=87

Qualitative data elicited from the client survey reveal how clients' perceptions of the quality of care they received from NGOs tends to be more positive than their perceptions of government services, and that this relates largely to client-provider relations rather than technical quality of care per se. Clients saw the way NGO HIV/AIDS organisations provided services in *'... an informal and confiding atmosphere'* as important, as was the absence of bureaucracy. Many respondents noted that they were attracted to services that made information available and those that gave them an opportunity to socialise with people who had similar problems. Some clients said that they liked the less top down 'equal-to-equal' principle adopted by NGOs, especially those who employed staff who were ex-clients. Some respondents liked NGO employees' attitudes towards them, which they characterised as attentive, sympathetic and non-discriminating. Conversely clients tended to be more critical of government medical institutions providing HIV/AIDS services; staff were seen as authoritarian and working practices as lacking transparency. One interviewee said: *'We are not allowed to leave the territory of the Centre even though we don't have any infectious diseases. And they give no explanations'*.

Similarly NGO service providers explained that an important aspect of the quality of the services they delivered relates to their working practices and how they interact with clients. Illustrating this view an NGO interviewee said: *'Nongovernmental organisations are more tolerant, more mobile, more flexible and not bound by all those norms'*. Respondents noted that employees of NGOs were often motivated to provide quality care because they understood their needs. NGO respondents suggested that the poor quality of care provided by government institutions stemmed from limited government budgets resulting in low wages making it difficult to recruit skilled personnel.

5.3 Systems for evaluating client satisfaction

Two thirds of personnel of HIV/AIDS service organisations who were interviewed stated that their organisation evaluated clients' satisfaction levels. One respondent indicated their organisation did not evaluate satisfaction levels, and nine respondents were not aware whether their organisation adopted such a form of monitoring. Organisations in Kyiv (34/40) and L'viv (9/11) are the most active in monitoring satisfaction levels, with a somewhat smaller proportion in Odessa (20/27). The data suggest that monitoring client satisfaction is more common among NGOS (46/50) compared to government services (17/28). Methods of evaluating client satisfaction include:

- individual and focus group interviews;
- books of proposals, comments and complaints;
- testimonials of relatives;
- evaluation forms at group meetings,
- staff and management soliciting clients' impressions and feedback on activities;
- clients filling in a Dependency Index survey allowing them to indicate how they feel their situation has improved and their satisfaction with services.

Nevertheless only 33/93 clients recalled having had their satisfaction level evaluated by an HIV/AIDS service organisation; 28 of these clients were using nongovernmental social services and five were using government medical institutions. Nineteen respondents responded that the organisation they were using had not performed such evaluations. The majority were not able to answer the question.

5.4 Summary

- The vast majority of service providers indicated that the services they provide to clients are of high quality. Similar patterns are apparent among services within the three case study regions and among government and NGO services.
- These patterns accord with clients' accounts of their satisfaction with HIV/AIDS-related services provided by government and nongovernmental organisations in the three regions: the vast majority were satisfied or very satisfied.
- Service providers and sub-national government and NGO stakeholders described GFATM support as having a positive impact on their organisations including: increased financing, personnel training and the supply of ARVs; improvements in organisations' management; better systems of reporting, monitoring and evaluation; improvements in quality of care; the development of new programmes and services together with improved availability of treatment, medications and technical resources; scale-up in numbers of clients; enrolment of new staff and improved staff skills.
- Qualitative data suggest clients' perceptions of the quality of care received from NGOs is often more positive than government services, although this relates largely to client-provider relations rather than technical quality of care. Aspects of NGO working practices valued by clients include informality and lack of bureaucracy, and that staff were attentive, sympathetic and non-discriminating.
- Two thirds of personnel of HIV/AIDS service organisations who were interviewed during the study stated that their organisation had a system in place for evaluating clients' satisfaction levels. The data suggest that monitoring client satisfaction is more common among NGOs than government services. Conversely, a minority of clients recalled having had their satisfaction level evaluated by an HIV/AIDS service organisation.

Chapter 6. Human Resources

6.1 Introduction

The GFATM programme in Ukraine funds NGO sub-recipients to recruit social workers to provide HIV/AIDS services, but not for government sub-recipients to increase their healthcare staff. This chapter presents survey data on perceptions of the adequacy of staffing levels among GFATM government and NGO sub-recipients, the effects of the GFATM on staffing levels, staff workloads, training and motivation. Data are derived from the service provider questionnaire survey and the facility survey.

6.2 Staffing levels

Service providers were asked whether staffing levels were adequate to provide current volumes of services: overall, 70% of respondents indicated that there were sufficient staff (responding 'maximum' or 'more than average'). Similar patterns were revealed irrespective of the region or organisation type (government or NGO services). Table 6.1 summarises these data.

Service providers were also asked whether they believed staffing levels had increased since the GFTAM commenced funding their organisation (Table 6.2). A high proportion of respondents working for NGOs indicated staff numbers had changed significantly reflecting the fact that the GFATM grant can be used to recruit additional social workers. Conversely, government HIV/AIDS service providers are not able to recruit additional medical staff with GFATM funding: this is reflected in the data. A common practice among NGOs is to recruit ex-clients, and this had allowed them to expand their workforce. An interviewee suggested:

The Global Fund significantly influenced human resources. This is a part of organizational policy. The salary is increasing on 10 per cent annually, and we have personnel who are former clients. These people were able to show their worth. Now they are helping to other people and earning their living.

Table 6.1 Staffing levels in HIV/AIDS service organisations: service provider perceptions about whether staffing levels are sufficient

	Minimum	Less than average	More than average	Maximum
Overall	3	18	26	23
Kyiv	2	8	12	10
Odessa	1	8	10	8
L'viv	0	2	4	5
Government medical service	1	5	13	8
NGO social service	2	13	13	15

Sample size: N=70

Table 6.2 Staffing levels: service provider perceptions about whether staffing levels had increased since the inception of the GFATM

	Changed significantly	Limited change	No change
Overall	23	14	9
Kyiv	7	3	5
Odessa	14	8	2
L'viv	2	3	2
Government medical service	4	4	6
NGO social service	19	10	3

Sample size: N=46

6.3 Workloads

The data suggest that staff workloads have increased since receiving support from the GFATM HIV/AIDS grant: the majority of service providers responding indicated that they had experienced some increase in their workloads, and some reported their workloads had increased significantly (Table 6.3). Increased workloads reflect scale up in numbers of clients receiving services as well as increases in administrative workloads. Illustrating this point an interviewee said: *'With the Global Fund programme we have financing, we have resources, we have a large scale of drugs and so we have many patients. That's why the workload increased proportionately'*.

Table 6.3 Service provider perceptions about whether workloads have increased since the inception of the GFATM

	Significant increase	Some increase	No change
Overall	4	20	7
Kyiv	2	7	6
Odessa	2	9	1
L'viv	0	4	0
Government medical service	2	5	2
NGO social service	2	15	5

Sample size: N=31

6.4 Staff training and qualifications

The Principal Recipient, the International HIV/AIDS Alliance has placed considerable emphasis on training, including arranging and conducting training sessions for, and organising experience sharing meetings among, GFTAM sub-recipients. During 2005, for example, the Alliance organised 32 training sessions and seminars in Ukraine: 950 people participated in training including employees of NGOs, representatives of target groups, doctors, psychologists, representatives of local authorities, journalists and others. In addition, the South-Ukrainian Training Centre to Prevent HIV/AIDS has been working with the support from the Alliance and the international NGO the International Renaissance Foundation, and training for various target audiences in the regions funded by the GFATM[13].

The survey suggests that the receipt of training is widespread: the vast majority, 76/83 interviewees participating in the study, indicated that they had received training in the last twelve months. Similar patterns were apparent among both government and nongovernmental staff and across the three case study regions. As a stakeholder suggested: *'The Global Fund provided a lot of training, so now staff can use methods and implement new services'*.

Topics of training include providing medical and preventative advice to risk groups/HIV/AIDS patients, VCT, ART and the prevention of vertical transmission. Table 6.4 summarises the type of training received by government and NGO staff. The data suggest that staff of NGOs are also receiving training to improve their knowledge of activities normally carried out by government medical services; namely VCT and ARV treatment in addition to their core activities.

Table 6.4 Training received by HIV/AIDS service providers

	Government medical service	NGO social service	Overall
HIV/AIDS advice	8	17	25
VCT	8	16	24
ARV treatment	7	15	22
Vertical transmission	10	10	20
Tuberculosis	6	8	14
Substitution therapy	3	12	15
Adherence counselling	2	15	17

Sample size: N=84

6.5 Staff motivation and incentives

Results of the study suggest high motivation levels among employees of HIV/AIDS service organisations. The majority of service providers responding indicated that they had 'maximum' motivation working for their organisation; the data suggest that high levels of motivation exist among both government and NGO workers across the three case study regions (Table 6.5).

[13]2005 Annual Report of International HIV/AIDS Alliance in Ukraine. – Available from: http://www.aidsalliance.kiev.ua/ru/library/our/finalreport/pdf/report_2005_ua.pdf

Table 6.5 Staff motivation among HIV/AIDS service organisations

	Minimum	Less than average	More than average	Maximum
Overall	2	4	13	48
Kyiv	1	3	8	24
Odessa	1	1	3	13
L'viv	0	0	2	11
Government medical service	2	3	4	15
NGO social service	0	1	9	33

Sample size: N=67

NGO respondents suggested a number of factors that increased their motivation to work at an HIV/AIDS service organisation including:

- Working at the organisation was an opportunity to help others. The following views of interviewees illustrate this perspective: *'desire to help and save lives'*; *'desire to protect their rights'*; *'service and help for people with a problem'*; *'help of equal to an equal'*; and *'desire to improve quality of life and health of HIV-positive people'*;
- Interviewees had personal involvement in the problem in that they were HIV positive or had experience of drug use. For example, service providers suggested their motivation was high because of: 'personal experience'; 'knowledge of the problem from within'; *'as a former injecting drug users and being HIV-positive - with a wife and children - I don't want someone else to suffer through this'*; and *'I am an ARV patient myself and know the problem from within'*;
- The presence of relatives or friends affected by HIV/AIDS motivated some service providers. For example, an interviewee said they were motivated because *'my friends died'*;
- Working at the organisation was an opportunity to grow professionally and personally. Interviewees suggested that they were motivated by *'creative self-realisation'*; *'it's a career opportunity'*; *'an opportunity to grow professionally'*; and *'interest in work'*;
- A feeling of satisfaction that their work had had positive results. For example interviewees said: *'real positive work results'*; *'this is my favourite job'*; and *'work is effective'*;
- A sense that they directly benefit from the service, for example financial incentives received or they are able to use an organisation's services themselves.

Representatives of governmental organisations mentioned incentives such as: *'professional obligation'*; *'interest to issue/topic/work'*; *'opportunity for improvement/professional carrier'*; *'opportunity to deliver correct and truthful information'*.

While an important motivation among the staff of NGOs in particular is their personal involvement in issues related to HIV/AIDS interviewees also indicated that they received a range of incentives including monetary bonuses and expenses. Table 6.6 summarises the different forms of incentives received by HIV/AIDS workers: these are not funded by the Global Fund grant.

Table 6.6 Types of incentives for HIV/AIDS workers

Type of incentive	Number of respondents*
Monetary bonuses	43
Re-imbursement of job related expenses	28
Education/training	20
Accommodation	17
Transport subsidies	8
Child care subsidies	8
Health insurance	7
Access to loans	7
Other	2

* Interviewees could nominate multiple responses

6.6 Summary

- Most government and NGO service providers felt staffing levels were sufficient to carry out present activities.
- Staffing levels were seen as having increased among NGOs, and to a limited extent government service providers; a common practice among NGOs is to recruit former-clients as staff.
- Workloads increased, but for most respondents increases were not substantial.
- The vast majority of service providers received some training in HIV/AIDS-related activities.
- Government and NGO service providers felt motivated working in their facility or organisation; factors that motivated workers included feeling their work was valuable, empathy with clients, career opportunities and financial incentives.
- Most service providers indicated they had received some financial incentives for working with HIV/AIDS clients. However, the GFATM grant does not fund these incentives.

Chapter 7. Sub-National Coordination

7.1 Introduction

In common with other former Soviet Union countries the Ukrainian health system consists of vertical structures responsible for specific diseases and population groups. HIV/AIDS services are delivered through a discrete system of national, regional and municipal AIDS centres. Other disease areas also have separate structures including tuberculosis, STIs (dermato-venerology) and drugs treatment (narcology). Such a system creates poor coordination between healthcare providers, duplication and inefficiency (Drew and Purvis, 2005). Multi-sectoral HIV/AIDS coordination structures at the national and sub-national level are a new development promoted by the GFATM programme. This section describes the functions and composition of these structures, assesses their effectiveness and identifies factors enabling and inhibiting sub-national coordination. Data are derived primarily from semi-structured interviews with sub-national government and NGO stakeholders. The section then examines coordination between HIV/AIDS services based on data from client and service provider interviews.

7.2 Sub-national HIV/AIDS coordination structures: functions and composition

The GFATM HIV/AIDS programme in Ukraine aims to promote the improved coordination of HIV/AIDS organisations as well as supporting productive dialogue between different sectors involved in HIV/AIDS programmes. The creation of national, regional and local coordination councils is one stipulation of the GFATM grant (although GFATM funds were not made available to establish the councils), as is promoting the active engagement of NGOs, especially those that represent the interests of PLWHA in decision making in the field of HIV/AIDS at the national and sub-national level.

Regional and municipal coordination councils were created to coordinate local activities of government and NGO HIV/AIDS service providers with the aim of reducing local competition between HIV/AIDS organisations, to set local priorities for HIV/AIDS activities and to develop prevention, treatment and care programmes.

Kyiv

There is a Municipal Coordination Council (MCC) in Kyiv established to carry out the decree of the State Administration for the City of Kyiv[19]. It is a working body that coordinates activities of local executive bodies, enterprises, institutions, international organisations, and NGOs including PLWHA and religious organisations that work in Kyiv. The Council aims to form and effectively carry out a common programme for HIV/AIDS, to consolidate the use of funds and to improve the system of monitoring and evaluation in the field of HIV/AIDS prevention. The MCC includes 19 representatives of government and nongovernmental organisations, although the membership has changed considerably over time, and is led by the Deputy Head of the State Administration for the City of Kyiv. The new MCC was created in 2006 in accordance with the decree of the State Administration for the City of Kyiv[20].

An inter-sector working group (IWG) was created based at the MCC. Its main functions include technical support, information exchange, developing the Programme of Counteracting the HIV/AIDS Epidemic with the aim of increasing its efficiency, and coordinating the activities of local authorities, individual departments, offices and NGOs. Activities of IWG were generally perceived by interviewees as positive[21].

[19]Number 1361 (26.07.2005). Розпорядження Київської міської державноїх адміністрації від 26.07.2005 No 1361 «Про утворення Київської міської координаційної ради з питань запобігання поширенню ВІЛ-інфекції/СНІДу».

[20]Розпорядження Київської міської державної адміністрації «Про внесення змін до розпорядження Київської міської державної адміністрації від 26.07.2005 No 1361» від 05.12.2006 No 1726.

21Стан епідемії ВІЛ/СНІДу в Києві та аналіз заходів протидії. Ситуаційний аналіз / Балакірєва О., Бочкова Л., Бєлова І., Шендеровський К., Жилка Н. та ін.- К., Вид-во Раєвського, 2006. - 136с.

A number of coordination councils also function in certain districts of Kyiv. Stakeholders noted that most of these councils were initiated and led by NGOs, although in some cases by state services.

Odessa

There are both regional (oblast) and municipal coordination councils in Odessa. The regional council is a consultative body based at the department of healthcare of the regional state administration. Forty representatives of different organisations and authorities are members of the regional coordination council. These include representatives of the departments of the regional state administration: the healthcare department, education and science, family affairs and youth, culture, physical education and sports, press and information, adolescence service, and the Odessa regional state TV and radio company, the regional state sanitary and epidemiological service (SES), the Odessa regional department of the Ministry of Internal Affairs of Ukraine, the Odessa regional office of the state department for execution of punishments of Ukraine. The regional office of the Red Cross is also represented on the council[22] . The council is led by the head of the healthcare department of the regional state administration. Nearly half of the members of the Council are NGOs.

Official functions of the council include regular evaluation of the regional HIV/AIDS programmes, and proposing changes in the direction and volume of financing to different activities within the programme and coordinating HIV/AIDS service providers. Using the information provided by the council on how the Programme is being carried out and its recommendations as to adjustments to activities and volumes of financing, the regional state administration considers and submits proposals to the regional council for consideration. Having considered the proposals at the permanent deputy commissions, the regional council makes necessary additions and changes to the Programme. There is also an IWG in Odessa - a working body of the regional coordination council which includes representatives of different departments and structures. The tasks of this group are to develop HIV/AIDS programmes in the Odessa region including an annual plan of work for the coordination council and to monitor the implementation of decisions.

L'viv

L'viv has a regional HIV/AIDS coordination council, which, according to interviewees has a minimal role in forming policies.

Global Fund regional coordinators

The round one GFATM HIV/AIDS grant Principal Recipient the International HIV/AIDS Alliance in Ukraine, has also created its own system to promote coordination: regional coordinators. Such positions were introduced in the priority (high HIV-prevalence) regions in central, eastern and southern Ukraine including Odessa and Kyiv city/region. There is no coordinator in L'viv which is not a priority region. Regional coordinators' roles include attempting to improve coordination among local government and other state institutions, and to increase effectiveness of work within GFATM-supported projects run by government medical services and NGOs[23]. The role involves organising and taking part in the process of strategic planning of HIV/AIDS activities at the regional level, initiating situation analyses in a region if required, participating in the work of regional and city HIV/AIDS coordination councils, and in the development of regional policies for prevention of HIV/AIDS and STIs among target groups. According to interviewees this direct intervention by the Alliance is gradually improving coordination at the sub-national level. In Odessa interviewees indicated that the regional coordinator had been effective in mapping HIV/AIDS organisations, priority setting and supporting the implementation of work. As a result, according to respondents, *'... they [service providers] don't duplicate each other any more; everybody has their own niche…'*.

[22]Одеська обласна Програма забезпечення профілактики ВІЛ-інфекції, допомоги та лікування ВІЛ-інфікованих і хворих на СНІД на 2004-2008 роки, затверджена рішенням обласної Ради від 20 жовтня 2004 р. No 505-IV, [Цит. 2006, 12 грудня]. - Доступний з: http://oda.odessa.gov.ua/Main.aspx?sect=Page&IDPage=8067&id=1

[23]Інформація взята з новин Міжнародного Альянсу з питань ВІЛ/СНІДу, доступний на сайті http://www.aidsalliance.kiev.ua/cgi-bin/index.cgi?url=/ua/announcements/0006

7.3 The effectiveness of regional and city coordination structures

According to several government and NGO interviewees a key effect of GFATM support has been the establishment of the regional and municipal-level coordination councils, which have had some impact in terms of improving coordination between HIV/AIDS service organisations and increasing NGO engagement in sub-national decision making. Nevertheless, government and NGO stakeholders had different views on the effectiveness of HIV/AIDS coordination councils. While most respondents suggested that the creation of these coordination mechanisms has had a positive effect on the coordination of government and NGO HIV/AIDS services, others suggested the municipal coordination councils were less effective than the regional councils, which were established earlier. One interviewee, for example said:

...[the municipal] coordination council... they are more occupied with relationships between themselves than with any kind of work. I participated in meetings once... but sorry, I don't have enough spare time to engage in chatting there'.

Moreover, some study respondents perceived these structures as 'artificial' because they were seen as being imposed by an external donor which reduced local ownership of the structures.

Kyiv

Some stakeholders from governmental institutions indicated they were confident that the Kyiv MCC was working well and its activities were effective in establishing closer cooperation between governmental and nongovernmental organisations. However, representatives of NGOs tended to be more critical when evaluating the activities of coordination councils. An NGO interviewee suggested that whilst the Kyiv MCC involved a lot of discussions it had little impact on the day-to-day work of their organisation:

Quite often the work of the coordination council goes according to the plan: generalized, summarized, praised, criticized, outlined the first one and now waiting for the next meeting according to the plan, or when instructions are passed down or a hearing at the Supreme Council takes place or something in the government. And again - met, reported, and then everyone is back to his own work.

Odessa

In Odessa many respondents were positive when evaluating the activities of the regional coordination council because meetings were seen as effectively tackling problems, and clear tasks are assigned to members. In addition to regular meetings, round tables, forums and open sessions were held. According to interviewees, since the beginning of the implementation of the GFATM programme Odessa has managed to improve the system of cooperation between governmental and nongovernmental organisations. For example, an interviewee said:

... cooperation of governmental and non-governmental organizations used to remind me of that story when everybody is pulling a blanket on himself and there are zero results and everybody is still cold. But since 2003 we've managed to establish a system of very good, close cooperation with nongovernmental organisations, to coordinate the directions.

According to study respondents Odessa's peculiarity is that they also have a regional coordination council for HIV/AIDS, tuberculosis, drug abuse and homelessness which is led by the head of the regional state administration which is interested in the issues that the council works with, and which has a positive influence on the work of the Council.

L'viv

According to respondents' views the L'viv coordination council is a formality and it does not play any significant role in practice.

7.4 Factors inhibiting the effectiveness of sub-national coordination mechanisms

Based on the analysis of government and NGO stakeholder interviews, the following factors appear to inhibit the activities of coordination councils:

- Indifference of government agencies about the activities of coordination mechanisms. Because the initiative to establish coordination councils originated from NGOs (which especially it is true for Kyiv and L'viv);
- Many organisations, including healthcare departments, are not prepared to be open and discuss issues publicly;
- Inability of representatives of NGOs to effectively lobby their ideas and proposals through decisions of coordination councils. This is the opinion of representatives of NGOs, especially in Kyiv, who suggested that NGOs have not been involved in politics before, hence they do not have experience of influencing the political agenda;
- Turnaround of members who represent different organisations within councils. Officials who are members of coordination councils are either elected or are nominated by elected officials, hence they change quite often; this was seen by interviewees as negatively impacting on the coherence of HIV/AIDS policies and programmes;
- Absence of financial incentives for members of coordination councils. Members are not paid to attend;
- Councils lack representation of all interested parties. For example, not all HIV/AIDS NGOs' interests are taken into account. An interviewee explained: *'Bureaucrats need a certain number of people to form a committee. So they include those whom they already know'*.
- The work of coordination councils depends to a considerable degree on the political situation in a region and those who will be in power, and their interest in solving the problem of HIV/AIDS in the region. An interviewee explained:

To my regret, the work of our councils depends on the political situation. A new chief again, and the council members changed to a certain degree, but as of today, if we talk of the time since August 2006, we can see very active support from the political leaders of the region, we see their high interest, we see specific steps and readiness to make political decisions. We think it's very important.

7.5 Coordination between organisations delivering HIV/AIDS services: client referrals

Each Ukrainian HIV/AIDS organisation specialises in a specific area of activity underlining the importance of effective cooperation between organisations. Data on how organisations refer clients to another serves as an indicator of effectiveness of such cooperation. Clients responding to the survey were asked how they found out about the service they are currently using. A high proportion indicated that they had either been referred or informed by another organisation (nearly 50%) or they had been informed by a peer, suggesting that a certain system of referrals and information exchange between organisations exists. According to clients, the referral system is the most developed in Kyiv and Odessa, while in L'viv the majority of clients find out about services through personal contacts. Also, clients believe that the referral to government medical institutions is better than to NGOs (Table 7.1).

Table 7.1 Where clients found out about the HIV/AIDS service organisation they are currently using

	Referral from another service	Informed by another service	Mass media	Informed by peer	Other
Overall	31	13	10	30	24
Kyiv	21	6	3	14	8
Odessa	9	6	7	9	12
L'viv	1	1	0	7	4
Government medical service	19	8	9	5	7
NGO social service	12	5	1	25	17

Sample size: N=93

The survey also suggests that clients tend to have good knowledge of different government and NGO HIV/AIDS organisations. Out of 93 respondents only twelve did not name at least one other organisation that provided HIV/AIDS services (in Kyiv eight respondents could not name any organisations, in Odessa and L'viv two clients in each city were unable to nominate another HIV/AIDS organisation). Levels of awareness of tuberculosis organisations was lower among study participants (22/93 respondents could name a tuberculosis organisation reflecting the low number of tuberculosis organisations in the country). Respondents' opinions suggest that there is quite high awareness among clients about different HIV/AIDS organisations, and that these organisations have been effective in promoting themselves. However as the following section suggests, clients have a number of other problems relating to limited knowledge of HIV/AIDS and HIV/AIDS services.

All but one respondent among service providers who gave responses to the question about referring clients to other organisations said that their organisation practised it. The data suggest that clients are more frequently referred between state institutions or NGOs, as well as AIDS centres, tuberculosis and narcological clinics than to private organisations providing HIV/AIDS services including private hospitals, clinics or laboratories. Compared to other regions HIV/AIDS service organisations in Kyiv refer their clients to private institutions more often. Representatives of NGOs refer their clients to other NGOs, AIDS centres and narcological clinics more often than state medical organisations do; and less frequently to state or private hospitals, clinic and laboratories. Data suggest that that NGOs are the most active in referring clients and they cooperate between each other more than medical organisations do. However, representatives of NGOs in Kyiv and L'viv explained that the system of referrals is imperfect; there is competition between certain NGOs, and in L'viv organisations monopolise certain areas (for example, a single charity foundation works with female SWs, and there is the only one organisation working with prisoners in the city). The situation in Odessa is different; the majority of organisations refer clients to other organisations and some organisations sign formal agreements on client referral with other organisations.

7.6 Common HIV/AIDS service monitoring database

A common electronic database of clients is used by almost all organisations participating in the survey since it is a condition of receiving GFATM funding. According to interviewees the introduction of the common reporting system across GFATM and USAID SUNRISE grantees provides an opportunity to accurately track a large number of services and interventions of HIV/AIDS service organisations in a coordinated way.

Until recently sub-recipients' reports were submitted in word processor format and data were compiled by the International HIV/AIDS Alliance IT department. With an increase in the number of organisations supported by both the GFATM grant and the UNAID SUNRISE programme the need to introduce a common system with unified activity indicators was recognised, including indicators of client coverage with HIV/AIDS programmes that avoided double-counting clients. The database SyrEx was introduced to register clients of HIV/AIDS programmes that was installed at the Alliance, and sub-grantees and other grant recipients enter indicators quarterly that reflect their activities onto a spreadsheet. Completing and downloading standard format forms into the database is automatic and hence much more efficient. The database also allows HIV/AIDS service organisations to register consultations and referrals for testing on a daily basis which enables them to keep daily track of services provided and manage commodities received and distributed to each client.

Nevertheless it should be noted that this system only covers the HIV/AIDS services funded by the GFATM and USAID programmes: similar systems are not adopted by other donor and government HIV/AIDS programmes where separate reporting systems exist whereby service providers pass data vertically to a central government agency or donor agency. In contrast the Alliance system enables services to manage service delivery and commodity distribution.

7.7 Joint HIV/AIDS projects

There are some examples of projects run jointly by multiple organisations. For example, in Kyiv the State Social Service for Families, Children and Youth is carrying out a joint harm reduction project with NGO HIV/AIDS services. Interviewees saw this as a positive development. One interviewee said about this harm reduction programme:

All programmes are being implemented together with nongovernmental organisations. We, on our part, pay wages to workers, pay for utilisation of syringes, for production of... clients' cards that are issued by participants of the project, transportation - gasoline, drivers' wages. We pay for the production of information materials and provide premises. On their part, nongovernmental organisations provide specialists, cover expenses for syringes, condoms, sterile tissues, necessary medications, vitamins. This is the contribution of nongovernmental organisations at the expense of donors.

Cooperation between HIV/AIDS organisations in Kyiv commonly consists of joint projects and events. In general, government stakeholders evaluated cooperation between organisations positively while representatives of NGOs stress the fact that there is limited cooperation with government organisations, and indeed between NGOs themselves. For example, one interviewee said: *'... a referral system exists but there is no active cooperation'*. Other interviewee explained:

To be honest, we do their job that they are supposed to do themselves, and then they just report. They do help us but to a less degree than when they report that they've done such an enormous job. On the other hand, if help is needed, they help.

According to respondents coordination between HIV/AIDS service organisations in Odessa takes a number of forms including client referrals, provision of premises to NGOs by state institutions, information exchange, joint events and NGO volunteers working on joint projects based at government medical institutions. Interviewees suggested that the coordination of HIV/AIDS services is under developed in L'viv: every organisation has a monopoly in a certain sphere such as working with the specific group of clients. Where coordination exists this is largely due to personal and family connections between the directors of different organisations.

7.8 Factors enabling and inhibiting effective coordination between HIV/AIDS services

The survey revealed a number of factors enabling effective coordination between HIV/AIDS services including:

- the introduction of regional coordinators by the International HIV/AIDS Alliance in Ukraine;
- the creation of the organisation the Coalition of HIV Service NGOs which works in Kyiv and Odessa to promote coordination between HIV/AIDS organisations;
- and the introduction of strategic planning at the regional level in order to determine priorities and plan work programmes.

Respondents suggested an inhibiting factor is the bureaucracy, fragmentation and complexity of the system of services, and the disengagement of some governmental institutions. For example one interviewee said:

There is competition between governmental structures too, only in a bit different perspective. Governmental structures are trying to get rid of some work. For example, there is a board meeting. And my colleague from the department of adolescence affairs says "ah, it's none of our business, we don't have to do this; it is a job for the criminal police for adolescence affairs".

7.9 Summary

- Sub-national HIV/AIDS coordination councils, a condition of, but not funded by the GFATM grant, have been created in Kyiv, Odessa and L'viv. Councils consist of representatives of government institutions and NGOs.
- The functions of HIV/AIDS coordination councils include promoting the coordination of local programmes, developing strategic plans and evaluating activities.
- The GFATM Principal Recipient the International HIV/AIDS Alliance in Ukraine funds regional coordinators in priority regions (including Kyiv and Odessa) whose roles include promoting more effective coordination between GFATM sub-recipients.
- In Odessa activities of the regional coordination council were evaluated by interviewees as effective in promoting local coordination. Opinions of Kyiv respondents about the effectiveness of the coordination council were mixed, and there were only negative comments about the L'viv coordination council, which was seen as a formality, and was ineffective. Some respondents perceived the councils as artificial since they were seen as imposed by external donors.
- Several factors inhibited the effectiveness of these councils: indifference and traditional management approaches among government agencies; the inability of representatives of NGOs to effectively lobby their ideas; high turnaround of council members; the absence of financial incentives for council members; limited representation of all interested parties; limited NGO capacity; the political situation in different regions in terms of whether those in power have an interest in HIV/AIDS.
- Nearly half of clients interviewed indicated they had been referred to their current service or had heard about it through another HIV/AIDS organisation; a high proportion had heard through peers. Referrals were most common in Kyiv and Odessa, while in L'viv most clients find out about services primarily through peers. Data suggest that NGOs are more active in referring clients and they cooperate between each other more than government organisations. Coordination between HIV/AIDS service organisations appears to be strongest in Odessa among the study regions, in Kyiv they appear to coordinate less, and there is very limited coordination in L'viv.
- The vast majority of service providers indicated their organisation refers clients and receives clients from other HIV/AIDS organisations. A lower proportion of clients indicated that they had been referred between services. This suggests that client referrals are practised, but on an ad hoc basis.
- A common electronic monitoring database is used across International HIV/AIDS Alliance-managed HIV/AIDS projects (GFATM and USAID SUNRISE grants); service providers enter common indicators onto a partially automated system that also enables them to manage service delivery and commodity distribution.

- There are some examples of projects run jointly by multiple organisations and other forms of coordination including provision of premises to NGOs by state institutions, information exchange, joint events and NGO volunteers working on joint projects based at government medical institutions.
- Interviewees suggested that a number of developments have promoted improved coordination between HIV/AIDS services: the creation of International HIV/AIDS Alliance in Ukraine regional coordinator posts; the introduction of strategic planning at the regional level through coordination councils; and the establishment of the Coalition of HIV Service NGOs, an organisation that works in Kyiv and Odessa. Inhibiting factors include bureaucracy, fragmentation and complexity of the health system, and the disengagement of some governmental institutions.

Chapter 8. Access to GFATM-Financed HIV/AIDS Sservices

8.1 Introduction

Access to services implies not only the existence of services but a range of household/community level barriers including geographical and economic barriers, clients' knowledge of HIV/AIDS services and social barriers such as stigmatisation of HIV/AIDS, drug use and sex work; and institutional/programmatic barriers including the availability of resources including commodities and equipment, staff numbers and incentives, staff attitudes, service quality and organisation and coordination between services. Based on the service provider and client surveys this chapter considers overall levels of access to HIV/AIDS services from providers and clients' perspectives, and identifies the most important household/community and institutional/programmatic barriers to accessing HIV/AIDS services.

8.2 Overall indicators of HIV/AIDS service access

An indicator of access is whether services refuse clients, and similarly whether clients feel they have been refused a service. Tables 8.1 and 8.2 present providers' and clients' perspectives on refusals; both sets of data suggest that only a minority of clients are refused services. However most problems with providing services appear to be among organisations of L'viv where one third of providers noted that clients might not receive help they needed, while in Kyiv and Odessa it is one fifth (Table 8.1). This is most likely due to the fact that L'viv is a relatively new region supported by the GFATM grant and therefore does not have a developed network of HIV/AIDS service organisations.

Table 8.1 HIV/AIDS services accepting all clients presenting: providers' perspectives

	Accept all client who present	Refuse some clients
Overall	69	16
Kyiv	36	7
Odessa	24	5
L'viv	9	4
Government medical service	26	4
NGO social service	43	12

Sample size: N=85

Service providers and clients were asked to evaluate the overall accessibility of services (Tables 8.3 and 8.4). The data reveal substantially different perspectives between providers and clients. The vast majority of service providers rated their organisation as being highly accessible to clients; conversely clients were far more critical about levels of service access, with a high proportion rating a service highly or fairly inaccessible despite the fact they were using it. The most critical were clients of Kyiv HIV/AIDS service organisations; in L'viv clients' opinions were more divided, and in Odessa clients were more inclined to be positive about accessibility of services (Table 8.4). Moreover, clients of NGO services evaluated accessibility of services higher in general than clients of government institutions. In order to better understand these patterns, the follow section explores the relative importance of household/community and institutional/programmatic barriers to access from providers and clients' perspectives.

Table 8.2 Clients' perspectives on whether they have ever been refused an HIV/AIDS-related government or NGO service

	Have never been refused a service	Have been refused services
Overall	67	17
Kyiv	33	6
Odessa	17	10
L'viv	17	1

Sample size: N=84

Table 8.3 Providers' perspectives on their HIV/AIDS service organisation's overall level of accessibility

	Very inaccessible	Fairly inaccessible	Moderate	Fairly accessible	Very accessible
Overall	33	15	8	16	19
Kyiv	23	9	3	6	2
Odessa	4	5	2	5	13
L'viv	6	1	3	5	4
Government medical service	10	11	3	1	5
NGO social service	23	4	5	15	14

Sample size: N=91

8.3 Household/community and institutional/programmatic factors of HIV/AIDS service accessibility

The survey assessed clients' views on the relative importance of different barriers to accessing HIV/AIDS services. Table 8.5 summarises clients' perceptions of the most important barriers, and provides a breakdown by clients using government and NGO HIV/AIDS services. The most important household/community barriers are: stigmatisation of HIV/AIDS and limited knowledge of HIV/AIDS risk factors/symptoms. Key institutional /programmatic barriers are: limited numbers of workers, poor quality service provision and lack of equipment (implying testing equipment).

Clients indicated that the stigmatisation of HIV/AIDS by their communities undermined their abilities to use HIV/AIDS services since this risked them becoming known as HIV positive, or a drug user or sex worker, which as also stigmatised activities. One client, for example, said a significant problem is: *'...the hostile attitude of the community'*; another client explained: *'...fear of HIV status being made known and violation of confidentiality'* are important barriers to using services. A related problem is the criminalisation of injecting drug use and sex work and policing of these activities which represents a barrier to HIV/AIDS service use since police frequently intercept drug users or sex workers, including these who try to use HIV/AIDS-related services. These findings accord with a previous study that suggested that in Ukraine there is high intolerance towards PLWHA among people, including among people aged 15-24 years[24].

Table 8.5 Key barriers to accessing government and NGO HIV/AIDS services: clients' perspectives

Access barriers	Number of clients*
Overall	
Stigma: fear of being identified as HIV+ through using the service	32
Limited knowledge of risk factors/ recognition of symptoms	26
Insufficient number of workers	24
Poor quality service provision	24
Shortage of necessary equipment needed to provide services	23
Clients using government services	
Shortage of necessary equipment needed to provide services	15
Insufficient number of workers	14
Service is located too far away	13
Limited knowledge of risk factors/ recognition of symptoms	12
Poor quality service provision	12
Clients using NGO services	
Stigma: fear of being identified as HIV+ through using the service	22
Limited knowledge about eligibility	15
Limited knowledge of risk factors/ recognition of symptoms	14
Insufficient number of workers	13
Shortage of necessary medicines	13

*Factors having 'strong' or 'very strong' impacts on clients' abilities to utilise the service they are *currently* using
Sample size: N=93

[24]*Andruschak L, Bochkova L, Dovbakh H, Muravsky O, Saldana V and Scherbinska A. 2006* National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS. Kyiv.

The data suggest limited knowledge of HIV/AIDS among clients - in terms of knowledge of risk factors /symptoms and eligibility to use services (especially among users of NGOs) - is a relatively important factor influencing utilisation of HIV/AIDS services. Indeed, previous studies in Ukraine reveal limited understanding of HIV/AIDS among IDUs, SWs and young people, although higher levels of awareness are apparent among prisoners and MSM[25]. The Ukrainian GFATM grant supports HIV/AIDS awareness programmes through the mass media, leaflets/booklets and other materials distributed by GFATM sub-recipients, posters displayed in public spaces and lessons at primary and secondary schools about sexual health and HIV/AIDS. Nevertheless Ukrainian stakeholders suggested that insufficient preventive work of this nature has been conducted, especially among children and young people.

A high proportion of clients perceived staff shortages as an important barrier to using services, although this view contradicts service providers' views that staffing levels are sufficient for delivering services. Stakeholders indicated that human resources problems reflect low salaries among government health staff resulting in retention problems and significant labour migration from rural to urban areas resulting in the closure of rural health facilities. Imbalances in the availability of healthcare services and staff in urban and rural areas are documented previously[26]. Whilst governmental health workers may receive an additional supplement (including health insurance) from local government budgets, the GFATM HIV/AIDS grant allows NGOs but not government organizations to recruit new staff (see Chapter 6 of this report). This is reflected in the survey data that suggest that a higher proportion of clients using government HIV/AIDS services than NGO services perceive human resources as a barrier to service use.

Poor quality service provision was another key barrier to HIV/AIDS service use perceived by clients, albeit primarily among government rather than NGO service users. Indeed, as suggested in Chapter 5 of this report, while quantitative data suggest most clients are satisfied with HIV/AIDS services, qualitative data suggest clients are more critical of the quality of government than NGO providers, although this relates to client-provider relations rather than technical quality of care. This accords with a recent survey into experiences of healthcare generally where 90% of clients evaluated quality of health services as 'relatively low' and 'extremely low'[27].

Clients also saw shortages of equipment and medicines are further barriers to access. Indeed, as Chapter 4 suggests despite substantial new funding for HIV/AIDS services from the GFATM, according to interviewees, resources are insufficient to meet growing demand. For example, a manager of an NGO explained that the organisation finds it difficult to balance providing high-quality interventions to individual clients against trying to meet increasing need in the city. An added problem is the practice of some government health staff selling medicinal drugs to drug dealers leading to shortages, a practice that stakeholders described as commonplace.

The data point to some regional variations in patterns of access from the perspectives of clients. In Kyiv the most important factors were: insufficient number of workers; organisation's location being too far away; lack of information about the presence of services; clients find it difficult to communicate their needs to service providers. In Odessa the main barriers according to clients include: stigmatisation of HIV/AIDS; shortages of equipment; poor quality services; insufficient number of workers. In L'viv clients emphasised: shortages of medicines; lack of information about the presence of services; they had limited awareness of their eligibility to use services.

[25] *Andruschak L, Bochkova L, Dovbakh H, Muravsky O, Saldana V* and *Scherbinska A. 2006* National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS. Kyiv.
[26] Lechan V., Rudiy V. (Eds) 2005 Main directions for the further development of health system in Ukraine *Kyiv*
[27] UNDP 2003 Power of Decentralization: Ukraine Human Development Report.

8.4 Summary

- An indicator of access is whether services have to refuse clients, and similarly whether clients feel they have been refused a service. Data suggest that only a minority of clients are refused services.
- Service providers and clients evaluated the overall accessibility of services: data suggest different perspectives between providers and clients. The vast majority of service providers rated their organisation as highly accessible; clients were far more critical about levels of service access, with a high proportion rating a service highly or fairly inaccessible despite the fact they were using it.
- The most important household/community barriers from clients' perspectives are: stigmatisation of HIV/AIDS and limited knowledge of HIV/AIDS risk factors/symptoms. Key institutional/programmatic barriers are: limited workers, poor quality service provision and lack of equipment.
- Clients indicated that the stigmatisation of HIV/AIDS by their communities was the most important barrier to using HIV/AIDS services since this risked them becoming known as HIV positive, or a drug user or sex worker which as also stigmatised activities.