The Global Fund
To Fight AIDS, Tuberculosis and Malaria

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or mala

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

SUMMARY INFORMATION			
Applicant Information			
Country	**Belarus**	**Component**	**HIV**
Funding Request Start Date	**01.01.2016**	**Funding Request End Date**	**31.12.2018**
Principal Recipient(s)	**Governmental Institution 'Republican Scientific Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health' (RSPC MT)**		

Funding Request Summary Table

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

SECTION 1: COUNTRY CONTEXT

1.1 Country Disease, Health and Community Systems Context

a. Epidemiology of the disease

As of January 1, 2015 the Republic of Belarus has 17,522 registered HIV infection cases; the number of people registered and living with HIV (PLHIV) equals 13,527 people; the infection rate is 142.9 cases per 100,000 people[1].

The UNAIDS estimated number PLHIV in the Republic of Belarus constituted 25,000 in 2013[2]. According to the routine surveillance data, HIV incidence rate in 2014 has increased in comparison to previous years (1,196 in 2011; 1,533 in 2013) [3]. Although the overall estimated HIV prevalence remains the same, there is no evidence of the HIV epidemic improvement in the Republic of Belarus.

HIV epidemic in Belarus is characterized as concentrated with low prevalence among general population (0.4%, 2013) and higher rates among the key affected populations (KAPs), particularly among people who inject drugs (PWID,13.8%, 2013[4]).

HIV-infection among pregnant women in Belarus as indicator of HIV in the general population has slightly increased from 0.24% in 2007 (256 HIV-positive pregnant women per 103,626 babies born) to 0.27% in 2014, keeping within 0.22% and 0.3% during this period[5]. This supports the statement about the focused stage of the epidemic with potential to grow to the general population.

The geographic distribution of the HIV epidemic shows remarkable differences among the regions. Majority of HIV cases are concentrated in Gomel oblast, the city of Minsk and Minsk oblast (47.5%, 14.7% and 14% respectively of all cumulative cases since 1987). About 80% of all registered cases are in these oblasts[6]. Belarus is highly urbanised country with three quarters of population residing in cities. Six cities of the country – Minsk, Pinsk (Brest oblast), Gomel (Gomel oblast), Zhlobin (Gomel oblast), Svetlogorsk (Gomel oblast), Soligorsk (Minsk oblast) – are home to about 30% of the country's population and 55% of all registered HIV cases in Belarus[7].

In general, the most HIV-infected age group is 30-39 year olds: their HIV infection rate is 430.2 cases per 100,000 people (0.4%) of the age group. The HIV infection rate among 25-29 year olds is 240.3 cases per 100,000 people (0.2%) of the age group. The lowest HIV infection rate is among 15-19 year old adolescents: 9.7 cases per 100,000 people of the age group.

The highest growth rate of newly registered HIV infection cases in 2000-2014 is in the 30-34 and 35-39 age groups: the morbidity rate has grown from 9.5 to 58.04 cases per 100,000 people of the 30-34 y.o. age group, and from 2.56 to 45.4 cases per 100,000 people of the 35-39 y.o. age group. The number of newly registered HIV infection cases among 25-29 year olds has grown significantly for

[1] Data of the Governmental Institution 'Republican Center of Hygiene, Epidemiology and Public Health'. Can be accessed in Russian through Belarus online AIDS portal // http://www.aids.by
[2] UNAIDS data: http://www.unaids.org/en/regionscountries/countries/belarus/
[3] Data of the Governmental Institution 'Republican Center of Hygiene, Epidemiology and Public Health'.
[4] IBBS for PWID in Belarus, 2013
[5] Data of the Governmental Institution 'Republican Center of Hygiene, Epidemiology and Public Health'.
[6] Data of the Governmental Institution 'Republican Center of Hygiene, Epidemiology and Public Health'.
[7] Data of the Governmental Institution 'Republican Center of Hygiene, Epidemiology and Public Health'. Operational data about HIV-infection in Belarus as of April 1, 2015 (in Russian).

the last 2 years: to 46.6 cases per 100,000 people of the age group; this could be associated with the intensified HIV injection-based transmission in Minsk City in 2014.

The Republic of Belarus has been identifying the growing significance of sexual transmission of HIV since 2004. In 2013, over 85% of the newly registered HIV infection cases were reportedly associated with unprotected sexual contact[8]. In 2014 this percentage decreased to 77.4. At the same time, homosexual contacts reportedly accounted for 2.8-2.9% of the newly registered HIV infection cases in 2013-2014, but it is likely to be underreported due to stigma around homosexual relationships.

Among male population aged 15 and older HIV is 1.5 times more prevalent than among women of the same age: 139.9 and 93.6 cases per 100,000 people respectively. Highest HIV prevalence is among men of 30-39 year old: 516.0 cases per 100,000 people (0.5% of the age group).

An increased number of HIV-positive women of reproductive age has led to an increase in the number of children born to HIV-positive mothers. From 1987 until January 1, 2015 HIV-positive mothers have delivered 2,788 children including 275 children born in 2014. Throughout the entire observation period, the 'HIV infection' diagnosis has been confirmed in 245 children born to HIV-infected mothers, 15 of them died. There are 264 HIV infection cases registered among children in the 0-14 age group[9]. However the number of the first-time identified HIV-positive pregnant women has decreased by 1.2 times by 2014. In 2014, the risk of the mother-to-child HIV transmission has been reduced to 1.9%.

b. Key populations

Belarus has the highest estimated number of key populations (KPs) in the EECA region of 27 countries, which is 185,000[10] of 9.47 million (namely 1.9% of population). According to the 2013 sentinel surveillance, the highest HIV infection rate is among people who inject drugs (PWID) (13.8%), female sex workers (FSW) (5.8%), and men having sex with men (MSM) (4.5%). Key populations have disproportionately low access to prevention and treatment services. In 2014 only 26% of KAPs were reached by key interventions[11][12] which hinders further diagnostics and enrolment to care and treatment. National records do not allow segregating the numbers of key population groups from those tested for HIV in government facilities and those enrolled on ART.

The most epidemiologically significant group for transmission of HIV infection are PWID. Highest HIV prevalence among PWID is observed in Minsk city and oblast and Gomel oblast. Cities with the highest HIV prevalence according to 2013 IBBS is in Svetlogorsk (Gomel oblast) with 41.8% and Soligorsk (Minsk oblast) with 16%[13].

FSW constitute another high-risk group with HIV-prevalence at 5.8%. Sub-group among FSW most affected by HIV are FSWs that use drugs. HIV prevalence in this group is significantly higher – 13.4% according to 2013 IBBS. The share of FSW that use drugs has increased from 10.1% in 2006

[8] Data of the Governmental Institution 'Republican Center of Hygiene, Epidemiology and Public Health'.
[9] Data of the Governmental Institution 'Republican Center of Hygiene, Epidemiology and Public Health'.
[10] Data based on: preliminary MSM size estimate for 2014 (in Russian), Protocol of the working meeting on size estimates for KAP in Belarus (form 7 June 2012, in Russian).
[11] Under 'key interventions' the following are meant: PWID – coverage at least once a year with syringes, condoms and counseling by outreach worker or a medical worker/psychologist; for MSM and FSW – coverage at least once a year with condoms and counseling by outreach worker or a medical worker/psychologist.
[12] UNDP operational data.
[13] IBBS for PWID in Belarus, 2013.

to 22.4% in 2013 and may be a further contributing factor to HIV growth among FSW. The highest HIV prevalence among FSW according to 2013 IBBS is found in cities of Svetlogorsk (Gomel oblast) with 22%, Minsk with 8% prevalence and Gomel with 6.7%[14].

HIV prevalence among men who have sex with men (MSM) is 5.8%, with highest prevalence recorded in Svetlogorsk (Gomel oblast) with 16.6% and Vitebsk with 8.5%[15].

Notably, HIV prevalence has grown in key populations groups between 2011 to 2013, slightly increasing among PWID and almost doubling among MSM and FSWs.

	2011[16]	2013[17]
HIV prevalence among PWID, %	13.3	13.8
HIV prevalence among MSM, %	2.8	4.5
HIV prevalence among FSW, %	2.4	5.8

c. Key human rights barriers and gender inequalities that may impede access to health services

Addressing human rights barriers and gender inequalities is crucial in the national response to HIV/AIDS. The intersection of various forms of discrimination (HIV-status, gender, drug use, sexual orientation etc.) deepens social inequalities, increases the burden of HIV on key populations, and dramatically influences the trajectory of the epidemic. Despite governmental commitment to HIV response and willingness to take over funding of significant part of HIV related services, there are legal barriers compromising access to appropriate and quality HIV services for key populations:

- *PWID: criminalization of PWID*. Criminal Code of the Republic of Belarus regulated that possession or purchase of narcotic drugs is a crime, and people who inject drugs are subject to criminal prosecution. There are no provisions in the Criminal Code specifying a minimum drug dose to possess or to purchase, and the only prosecution option for PWID is imprisonment. Presidential Decree №6 'On urgent measures to combat illicit trafficking of drugs' came into legal force 1 January 2015. The document toughens criminal responsibility for illegal drug trade, introduces administrative sanctions for drug use; the repeated consumption of drugs within a year after administrative sanctions for such offences were imposed as well as drug abuse in public places or at work will be punishable by up to two years of the limitation of freedom. This Decree also created a single electronic database of PWID, that is used by law enforcement agencies and healthcare organizations. Also since 2015 it is compulsory to transfer information on all new cases of registration with narcological institutions from healthcare facilities to law enforcement agencies. In order to implement the Decree since 2015 in prisons special units were created for imprisonment of PWID. This legislation creates barriers to provide harm reduction services as majority of work at needle/syringe exchange sites is done by outreach workers who are active drug users.

- *FSW*: punitive legislation towards sex workers. In accordance with the Administrative Code of the Republic of Belarus, female sex workers are prosecuted for an administrative offence: they become

[14] IBBS for FSW in Belarus, 2013.
[15] IBBS for MSM in Belarus, 2013.
[16] National Report on the Progress in Global Measures in Response to AIDS (on implementation of Political Declaration on HIV/AIDS): Reporting Period 2012-2013. – Minsk, 2014 (in Russian).
[17] 2013 IBBS data used for all KAP groups.

administratively liable and pay fines. This regulatory framework not only impedes access to this vulnerable group, but also makes it practically impossible to allocate public funding for the arrangements targeted at this group.

- *PLWH:* criminalization of unintentional HIV-transmission, with risk of imprisonment. According to Law #363-3 the Republic of Belarus 'On health care' with its changes and amendments, once a person contacts medical professionals, he/she becomes subject to obligatory disclosure of his/her HIV-positive status and subject to compulsory medical examination. The National Law № 345-3 'Prevention socially dangerous diseases, HIV' came in force on July 2012, allows mandatory HIV testing for a number of professional categories and lists professional categories, which cannot maintain their duties if a person lives with HIV– e.g. surgeons. The law allows compulsory HIV testing if a person evades or declines mandatory testing or if there is 'a valid reason to suspect a person has HIV…'. The law states that disclosure of status is allowed upon request by the Ministry of Health, Ministry of Internal Affairs and compulsory isolation and treatment for socially dangerous diseases (including TB) can be forced upon an individual. This law raises serious concern of the voluntary and confidential nature of the test procedures as the core principles of global and regional testing guidelines and recommendations.

These laws and policies increase stigma and discrimination, and create barriers to providing HIV-related services and discourage key populations from seeking services.

Moreover, there are a number of legislative barriers impeding efficient organization of the HIV infection treatment and care processes.

- Barriers in receiving state funding by HIV-service non-governmental organisation (NGOs): social contracting mechanism is not used because of certain legal barriers in transferring local funds to NGOs.

- The regulatory framework on prevention, treatment, care, social and psychological support to people living with HIV (PLHIV) does not fully comply with the changed epidemiological HIV situation in Belarus:

A) there is a sophisticated, time consuming and expensive HIV confirmation algorithm (2 enzyme immunoassay tests to be confirmed by immunoblotting), which means two visits to the lab if the first test is positive, two blood tests, and no rapid tests are used;

B) an epidemiologist is responsible for crisis counselling after HIV-positive test, and then refers the patient to infectious disease physician, which leads to the loss of patients (25% of the diagnosed PLHIVs residing in Belarus are not included into the treatment and support program);

C) there is no regulatory framework on collaboration between NGOs and the public sector to organize rapid HIV testing at NGOs.

d. The health systems and community systems context in the country

Health systems

Healthcare system of the Republic of Belarus supports response measures in the sphere of HIV/AIDS. This section describes the system of healthcare from the point of view of six functions (structure elements) of the system of healthcare according to the concept scheme suggested by WHO: Administration and management; Human resources in healthcare; Medical goods and technologies; Information on healthcare; Funding of healthcare; Providing services.

Administration and management:

Particularly significant public health issues, including HIV and TB, are tackled in Belarus through vertical programs managed and executed in parallel to the main statutory system. Thus, there is State HIV Prevention Program developed for 5-years' time interval. The current one is for 2011-2015. This Concept Note is being developed to support new State HIV Prevention Program for 2016-2020.

Vertical programs in Belarus are managed and funded directly both by the Ministry of Health (central) the regional and district health authorities (local).

The Ministry of Health is the central and executive body responsible for implementation of the governmental policy in the area of HIV and should ensure coordination between all relevant parties involved in HIV response. Deputy Minister of Health, Chief State Sanitarian of the Republic of Belarus is appointed as National Coordinator of State HIV Prevention Program. This person is the head of the State Sanitary Inspectorate consisting of the Department of Hygiene, Epidemiology and Public Health in the MoH; national-level organization: the Republican Centre for Hygiene, Epidemiology and Public Health; and vertical network of sanitary-epidemiological institutions: regional, district and zonal centres of hygiene, epidemiology and public health. Each centre including national-level has Department on HIV/AIDS Prevention. This vertical coordinates the prevention of HIV and is responsible for implementation and monitoring of State HIV Prevention Program (NAP).

However, all activities of the NAP related to clinical management of HIV (antiretroviral treatment and ARVs procurement, prevention and treatment of opportunistic infections, HIV/TB activities etc.) is direct responsibility of Infectious Diseases Service having separate vertical and headed by another Deputy Minister - First Deputy Minister of Health.

Thus, even being formally managed at the central level, NAP has no single leader coordinating all types of HIV activities in the country. This weakens HIV response in general and resulted in patients loss over the treatment cascade.

Funding of healthcare:

In 2011 overall expenses for healthcare amounted to 5.3% from GDP, which corresponds to the share of per capita expenditure for healthcare on PPP at the amount of $793 (which corresponds to respective indicator for CIS, but is lower than that for European region on the whole, that made up 8.3% from GDP according to data for 2010)[18]. The larger part of the expenditure is from the state budget. The key sources of budget revenues are enterprises rather than deductions from employees' payroll. This is the specific feature of the Belarusian healthcare system that reflects the nature of the country's economy as a whole: as it is mostly not privatized, the profits or revenues from local enterprises go through local budgets and are consolidated (as non-target) at the national level. Ministry of Health is the agency consolidating the resources at the national level, it also performs the function of a third-party payer for tertiary care and vertical programs (for example, on fighting TB and HIV/AIDS), conducted in the interests of the entire population. Overall structure of budget allocation for healthcare is determined by the Ministry of Health and the Ministry of Finance in accordance with the orders of the President of the Republic of Belarus and the Parliament of the Republic of Belarus. Then the decisions on the budget go down to the local level for implementation. Thus funding of the vertical programs – like on HIV and TB – depends on the overall economic situation in the country and budgeting of healthcare system.

Until recently the HIV response in Belarus has been heavily dependent on foreign aid, with around

[18] Belarus: Health System Review. – Health Systems in Transition. – Vol. 15 No 5, 2013.

$ 20 million invested annually in HIV. If in 2008-2011 the percentage of international funding has increased from 27% of the total budget in 2008 to 51% in 2011 (of which 96% were from TGF)[19], NASA results for 2012-2013 showed that domestic funding share increased up to 71.1% in 2013 with donors funding 28.9%.

This funding level is not sufficient to maximise health impact. National HIV Allocative Efficiency Analysis was performed for Belarus in 2015 (UNAIDS, WB, UNDP, and TGF) suggesting to increase 1.5 times the 2013 funding level. Recommendations on how the country can optimize allocation of HIV funding for maximum health impacts, suggested the increase in ART, NSP and OST, illustrated in the diagram below[20].

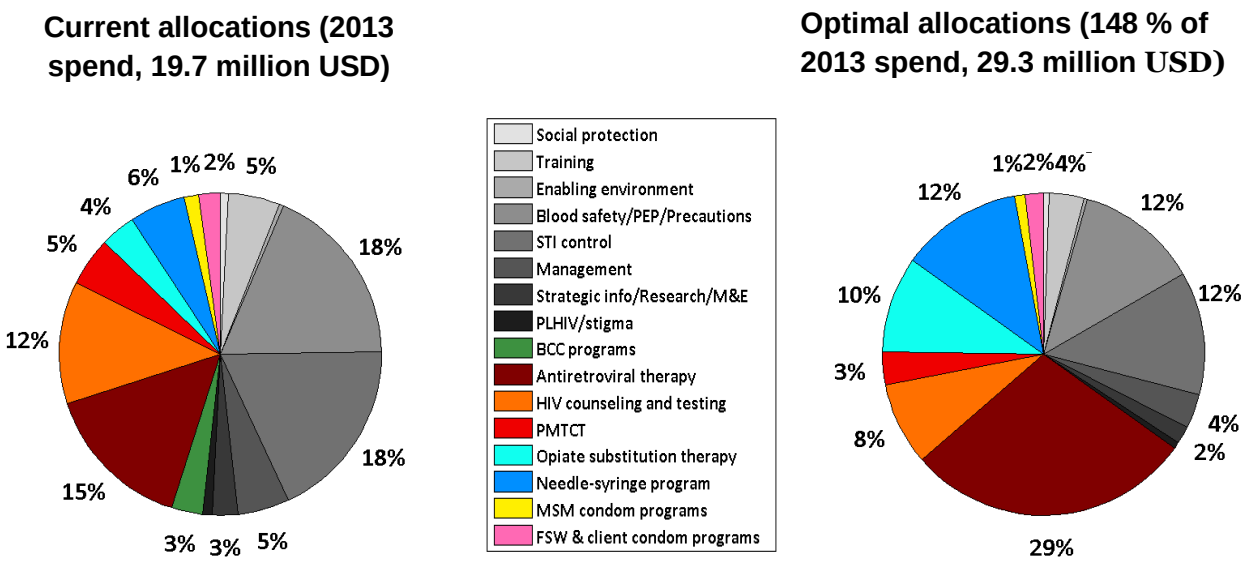


Figure 1: Comparison of current spending with optimal allocation of 200% of current prevention and treatment spending (equivalent to 148 % of total current spending).

Ensuring implementation of the activities of the State HIV prevention program is carried out with the funds of the state budget as well as with the funds from external technical assistance by international organizations, primarily TGF.

Human resources in healthcare:

The issues of the human resources policy are reflected in the Strategy for the Development of Health Care in the Republic of Belarus to the year 2020; Program of activities of Belarus' Government for 2011-2015 approved by the Council of Ministers of Belarus (resolution № 216 as of 18.02.2011). Building up human resources for the health system is one of the priority areas of cooperation between the MoH of Belarus and the WHO for the period 2008-2015. The main challenges in human resources in Belarus comprise lack of an efficient strategy:

1) on forecasting and human resources (HR) strategic planning. Lack of an HR personifying information system, which would allow the forecasting of staffing requirements and the implementation of appropriate human resourcing including the number of staff, their specialty, level

[19] D. Wilson, A. Yakushik, C. Kerr, C. Avia. HIV resource needs, efficient allocation and resource mobilization for the Republic of Belarus. – March 2013.
[20] Optimizing Investments in the National HIV Response of Belarus. Draft report. April 2015 // World Bank, TGF, UNAIDS, UNPD.

of training. There is a surplus of specialists against the deficit of general practitioners. Because of inefficient planning, the number of doctors outweighs the number of nurses; in 2007 there was a disproportion between doctors and nurses of 1:2.4 against the recommended 1:4). Non-clinical staffs like social workers are not taken into account at all. This particularly impacts on the quality of the assistance rendered to patients with HIV and TB as the service delivery model at present requires more attention from nurses, and provision of social and psychological support.

2) on education and training of human resources. The system of education, training and retraining of doctors and nurses both on pre-service and post-graduate levels does not ensure sufficient clinical practice. Task shifting from doctor to nurse and/or non-clinical workers is not envisaged by training programs. The contents of training programs do not always meet the existing requirements.

3) on distribution of personnel as the need may be. Ineffective system of monetary and non-monetary incentives does not facilitate the attraction, motivation and retention of an appropriate health workforce. Despite the increase in the salaries of health workers, the income level of health workers is lower than in other economic sectors (industry, agriculture). This results in an outflow and imbalance of personnel both from certain areas of health care and from particular geographical areas. Human capacity to address the health needs of PLHIV is very limited. There are lack of physicians and medical nurses providing treatment and care (due to low salary) and lack of social support. Thus, there is no follow up on PLHIV who have been registered for HIV care, but do not come for regular checkup.

In such context it is important to create multidisciplinary teams for HIV treatment and ensure the availability of human resources (physicians, medical nurses, social workers) who provide HIV treatment and care services for PLHIV through for instance considering task shifting if necessary.

Medical goods and technologies:

An evaluation was conducted by WHO in 2011 on procurement and supply management (PSM) of ARVs (February 2011) with the aim of evaluating changes in regulatory topics and assess all components of PSM from the central level to the end user. A number of recommendations were formulated following this mission in relation to regulatory issues, product selection, forecasting and quantification, procurement, quality assurance and receipt, storage and stock management, logistics management information, reporting, monitoring and evaluation[21].

Since 2013 the Ministry of Health started to cost-share expenses for ARVs procurement through state procurement procedures. The Ministry of Health of the Republic of Belarus organized the first centralized procurement of the ARV drugs in 2013. The procurement contract was awarded to Farmateh ZAO. The company has registered 3 names of the generic ARV drugs; however, it operated as an applicant during the registration process. And the manufacturer of the drugs is Hetero Labs Ltd. that supplies medications to Farmateh ZAO for packaging in blisters / individual packaging.

The Republic of Belarus organizes centralized procurement of the ARV drugs. Both, government and local budgets are allocated for that. Accordingly, pursuant to the legislation of the Republic of Belarus, this type of procurement is qualified as the public procurement. The public procurement procedure is regulated by Law #419-3 of the Republic of Belarus 'On public procurement of goods (works, services)' dated July 13, 2012. The Ministry of Health operates as a customer when organizing public procurement of the ARV drugs. The procurement managing unit is

[21] HIV/AIDS treatment and care in Belarus // WHO Europe, January 2014.

'Belpharmatsiya' RUP (The Public Pharmaceutical Service), which is directly involved in selecting and contracting suppliers as well as in all follow-up operations related to shipment, customs formalities, warehousing, and distribution of drugs.

There are two major concerns regarding state procurement: 1) ensuring quality and 2) ensuring low prices. The price of drugs might be higher compared to prices, which are negotiated by TGF with the suppliers, and procurement is done through voluntary pooled procurement (VPP). There is no guarantee that procured medications will be confirmed as pre-qualified by WHO.

The Ministry of Health does not fully involve into all processes of PSM, and its involvement is more restricted by getting forecast data from the National AIDS Center making procurement and delivering drugs to the National AIDS Centre. The forecasting methodology is not formalized.

Stock-outs happen and are handled by redistributing drugs from other regions, but delays in disbursement of ART to clinics are reported. A few cases were reported of paediatric ART use for adults because of stock-outs of adult formulations, and of patients receiving a part of a triple therapy regimen in situations of stock-outs.

Today there are 19 ARV products registered in the Republic of Belarus. Most of them (16 products) are distributed by suppliers who have drug patents issued by the Eurasian Patent Organization. As a result, the equivalent generic drugs cannot be imported into the Republic of Belarus without violating the intellectual property rights of the patent owner.

There are no valid patents for the 13 ARV products currently prescribed in the treatment regimen to the HIV-positive patients residing in the territory of the Republic of Belarus. However, only 3 of these drugs have been registered in the Republic of Belarus as of January 2015.

The Law 'On public procurement of goods (works, services)' does not have any restrictive rules in relation to the country of registration of the potential bidders of the procurement procedure. The bidders shall only be registered as a legal entity or a sole proprietor. Therefore, foreign drug manufacturers can also bid if they are duly registered as a legal entity in their country.

Law #161-3 of the Republic of Belarus 'On medicines' says that the medicines circulated in the Republic of Belarus shall be duly registered. In addition, the law provides for a number of cases in which medicines having no registration in the Republic of Belarus are allowed to be imported and used. One of such cases is importing the non-registered medicines 'intended for treatment of the limited contingents of patients with rare pathologies, for liquidating the consequences of natural disasters, catastrophes, epidemics, and those imported as foreign non-repayable aid if there are documents proving registration of the medicines in the country of origin'. In this case, the supplier of the unregistered drug can apply to the Ministry of Health to issue a permit for a single entry of the drug.

In 2015, the work on standardizing procedures for reporting at all levels (conducting a working meeting of the infectious service experts and on-site training) will be completed.

The methodology on forecasting the need for antiretroviral drugs will also be finalized and approved. It will be used for compiling applications on antiretroviral drugs procurement and will be included in the orders of the Ministry of Health of the Republic of Belarus as regards the development of technical specifications for procurement

Information on healthcare:

Surveillance of the HIV epidemic in the country lacks important indicators and is not adequately

analysed to inform policy decisions on priorities within the national HIV program (i.e. CD4 count at diagnosis, number of people in care (in care and not on ART yet and in care and on ART and with suppressed viral load), as well as more data on key populations, HIV prevalence etc.). Policy decisions should be driven by a thorough analysis of strategic key information on HIV surveillance and monitoring of HIV treatment and care. The latest recommendations regarding strengthening surveillance system and collection of indicators is described in WHO report 'Evaluation of the HIV program review in Belarus', November 2014[22].

HIV response in the country would benefit from strengthening the surveillance system and ensuring that all relevant data is gathered in/by one responsible organization. With this purpose information system (register) for data collection and reporting was developed within current TGF grant. HIV register consists of several parts: epidemiological (established, 100% completed and fully functional now); clinical (established, 60% completed); and drug management (not established yet, in the process of development). The main aim of the register is to gather information of good quality to be used for analysis, state reporting, ARVs procurement forecasting etc.

The 'owner' of the register is Republican Centre for Hygiene, Epidemiology and Public Health.

In 2015, it is planned to continue improving the HIV-infected patient register. This includes inputting all data on the patients receiving treatment into the clinical part of the register; inputting all data on the HIV-positive status patients but not receiving treatment into the clinical part of the register; developing a drug management module for the ARV drugs (drug inventory of the national, oblast, and rayon levels).

Providing services:

HIV-related health services for PLHIV and KAPs are mainly provided by health care facilities. The Republic of Belarus has a decentralized system of providing ART services with the annual increase of access to services for PWLH; in 2013 there were 343 health care institutions providing ART in the country. Specific treatment and care services are provided by network of infectious diseases institutions (HIV outpatient rooms and departments, Infectious diseases hospitals). All other health issues are addressed through the health care system on general basis. Some services (i.e. HIV testing using blood rapid tests) are provided by health staff employed by NGOs or by NGOs staff (saliva HIV rapid tests). Insufficient capacity levels in some regions demonstrate the necessity to strengthen cooperation between the governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services, by improving on timely and complete diagnosis, prompt prescription of correct treatment and good adherence to ART.

Linkage to care after a reactive result by community-based organizations is the weakest part of the programs (i.e. in one project, only 30% of people with a positive HIV test were known to have taken a confirmatory test and accessed care). Testing programs/activities should have clear linkage to care pathways identified and support established to ensure that people testing positive for HIV are linked to care. Prevention activities for key populations are only provided by local NGOs. The Government does not have finalized social contracting mechanisms to provide funding to NGOs working with key populations.
Coverage of HIV testing, in particular among populations most at risk, is low. Targeting mainly young people during previous years resulted in a serious gap in prevention, counselling and testing of

[22] Evaluation of the HIV program review in Belarus'. - WHO, November 2014 // http://www.euro.who.int/__data/assets/pdf_file/0010/273295/HIV-Programme-Review-in-Belarus.pdf?ua=1

groups most at risk. The low testing coverage in KAPs is also reflected in the high percentage of undiagnosed people with HIV, which in turn results in late diagnosis and consequently higher morbidity and mortality, higher economic costs and increased risk of transmission. There are many barriers to HIV testing, showing the challenges that exist to scale up HIV testing and ensuring that the number of undiagnosed people with HIV is reduced and people diagnosed with HIV successfully linked to care and treatment:

- rapid testing is illegal and not considered a diagnostic tool;
- to get an HIV confirmatory test people are asked for formal ID;
- geographical barriers as tests are performed only in some towns in Belarus;
- limited outreach testing that focuses on PWID and partners of PWID;
- reported stock-outs of HIV tests in summer months;
- fear of stigma and discrimination.

In order to ensure earlier diagnosis of PLHIV, testing programmes need to be designed to reach people most at risk. Measures need to be taken to ensure an enabling environment for testing.

The MoH order introducing multidisciplinary team approach and envisaging work of peer-consultants, psychologists and social workers together with doctor and nurse was issued and in force. By the end of 2014, 11 peer consultants worked to increase retention in care and adherence to treatment. However, delivery of assistance to PLHIV is still based on the doctor-patient principle where only medical assistance is provided, the role of the nurse is minimal and civil society does not actively participate in the delivery of treatment and assistance to PLHIV.

Peer consultants can help with accepting the diagnosis, linkage to care, improving adherence and retention in care, which will ultimately influence treatment outcomes at individual and community level. Treatment cascade for Belarus with gaps in the diagnosis, coverage of treatment and percentage of people with suppressed viral load shows a need for a multidisciplinary approach for the benefit of the patients.

State HIV Prevention Program for 2016-2020 envisages mobilization of funds from the local budgets for payment for work of psychologists, social workers and peer consultants working in multidisciplinary teams.

Community systems

Community involvement is critical for HIV response in key populations driven HIV epidemic. With TGF program starting from 2004 civil society organisations and key populations organisations have been supported to develop and implement HIV response programs.

NGOs have been the major implementers of HIV prevention progrms for KAP. In particular, NGO ‘Positive movement’ together with its partners in regions have been working with PWID, ‘Belarus Association of UNESCO’ with FSW and NGO ‘Vstrecha’ with MSM. All of the organisations and their partners have representatives of KAP involved as project managers or outreach workers.

Community representatives take part in high-level policy process around HIV in Belarus including through membership in CCM. Nevertheless, a number of limiting factors exist in community systems in Belarus, in particular:

- CSO envisage difficulties in registration of international support projects with national authorities. This limits operational efficiencies and created dependencies from official process;

- Social contracting mechanism has not been finalised for healthcare and not used in Belarus leaving NGOs fully internationally funded;

- CSO and key population groups strongly depend on international funding, and in Belarus donor context – on TGF funding;

- high levels of stigma towards representatives of key population groups is still observed from the general population;

- there is a lack of leaders among key population groups and need for development of new community representatives to serve as effective advocates for the needs of key populations.

The issues listed above are addressed in the proposed project.

1.2 National Disease Strategic Plans

The legal framework and health policies demonstrate country's political commitment to respond to HIV epidemic, including activities related both to HIV/AIDS issues and general health policy perspectives. The main principles of the Government policy on HIV/AIDS are set out in the National HIV/AIDS prevention Program (NAP) and reflect strong commitment to the Millennium Declaration (2000), Declaration of Commitment on HIV/AIDS (2001), the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia (2004) and the new Political Declaration on HIV/AIDS (2011). The first NAP in Belarus was developed for 2000-2005; the current NAP is for 2011-2015. NAP remains the cornerstone and the main thrust for the renewed vision and efforts to combat the HIV/AIDS challenge.

a. Goal and strategy

The submission of the current HIV Concept Note falls at the development of the new National HIV/AIDS Prevention Program (NAP) 2016-2020. The new NAP 2016-2020 is being developing through wide country dialogue involving key national players, international agencies, PLHIV and representatives of key affected populations; and is a basis for the current proposal in terms of suggested activities, service packages, coverage indicators and unit costs.

Overall goals of NAP 2016-2020 are[23]:

- to decrease number of new HIV cases;
- to decrease number of AIDS deaths;
- to create a supportive/enabling environment to address stigma and discrimination and legal barriers critical to achieve universal access to HIV prevention, treatment and care services.

The priority objectives are as follows:

- achieving universal access to HIV diagnosis, treatment, care and support including penitentiary system;
- prevention of HIV spread in key affected populations (people who inject drugs, men having sex with men, commercial sex workers, adolescents of risky behaviour, prisoners);
- prevention of morbidity and mortality of HIV-related TB;
- elimination of HIV mother-to-child transmission;
- elimination of HIV transmission within health care settings;
- ensuring sustainability of HIV prevention services based on intersectoral and interdepartmental collaboration as well as collaboration with international agencies;
- development of National system of monitoring HIV epidemic and evaluation of HIV response;
- increasing effectiveness of informational-educational activities on HIV prevention among general population and decreasing HIV-related stigma.

Expected outcomes of the program implementation, by 2020:

[23] Concept of the National HIV Prevention Programme for 2016-2020 (Draft, translated into English).

- to cover 80% of patients from the estimated number of people living with HIV in need of treatment with combined ARV therapy;
- to reduce the risk of mother-to-child HIV transmission to 1%;
- to ensure 100% testing of donor blood with application of NUT-technologies using ELISA and PCR methods;
- to ensure 100% TB screening of people from high infection risk groups and referral of those in need of treatment to TB healthcare institutions;
- to expand coverage of the high infection risk population groups with HIV prevention services in line with the approved standards:
  PWID – up to 60% of the estimated number
  FSWs – up to 20% of the estimated number[24]
  MSMs – up to 18% of the estimated number[25];
- 90% referral of people from high HIV risk groups, who contacted HIV prevention service delivery points and are in need of treatment, to healthcare institutions;
- to cover up to 80% of school children and students with HIV prevention programs based on life skills.

If compared to the targets of the current HIV SSF grant, the coverage of the key affected populations under the NSP for 2016-2020 with TGF support will be sufficiently increased for PWID (from the target of 25,680 or 30,7% of estimated group size in 2015 to 45,000 or 60% in 2018) and FSW (from the target of 3,500 or 7% of estimated group size in 2015 to 9,000 or 41% in 2018).

At the same time, planned increase of coverage among MSM is not that high and is planned from the target of 4,200 or 7% of estimated group size in 2015 to 12,500 or 21% in 2018. This is caused by the few reasons:

- country Context. Experiencing high level of stigma from the decision makers, this group is not considered by the government as priority group to be addressed with HIV prevention. This makes it difficult to plan allocation of government resources for this group within the NAP;
- income Level. In accordance to the recent analysis, income level of MSM allows for buying condoms and not to depend on support services. However IBBS in 2013 shows that only 62.8% of MSM used condom during the last sexual contact;
- due to above reasons, government funding for MSM within the NAP could hardly be significantly increased and approved by the decision makers.

National Program will aim at reaching 40% of MSM by the end of 2020.

Share of government funding of majority of services suggested under this Concept Note will be gradually increased from 35% in year 1 of its implementation, followed by 46% and 62% in years 2 and 3, and up to 100% take over by the end of year 3 of implementation of the current grant. This will be in line with and supported by the National HIV Prevention Program for 2016 – 2020.

One of the priorities is to finalize development of the social contracting mechanism for it to be a fully tested and efficient tool for implementation of preventive measures by 2016 to ensure efficient provision of services, sustainability of preventive measures addressed to the vulnerable population groups and to transfer all functions previously financed by TGF to the government.

b. Implementation to date

Service delivery to date is analysed in terms of access to low-threshold services and treatment cascade.

HIV prevention services for key populations are implemented with TGF support by NGOs/CBOs. In 2014 coverage with key interventions was: PWID – 29,783 (39.7% of estimated PWID population),

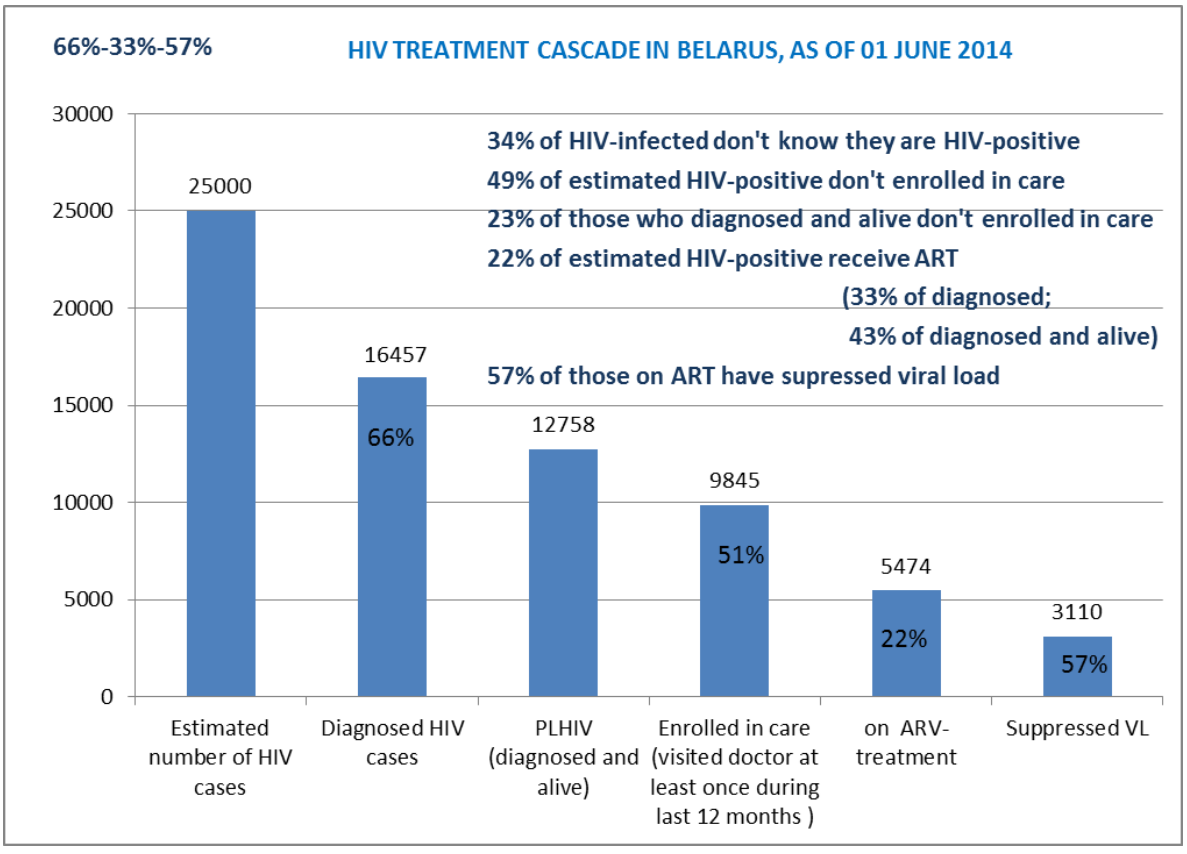
[24] Based on the revised in April 2015 estimate for FSW at the level of 22,000 FSW (previously – 50,000 FSW), the target will be increased to 40%.
[25] The target is planned to be revised to 40%, based on the discussions as part of the national dialogue prior to the submission.

FSW – 5,719 (11.4%), MSM – 4,795 (7.9%), OST was provided to 1,083 PWID, and ART to 6,064 PLHA (24% of estimated PLHA).

This coverage effort is likely to contribute to behavioural changes among key population groups captured by IBBS. IBBS demonstrates reductions in risk behaviour: among PWID percentage of those who used sterile syringe at last injection increased from 70.94% in 2007 to 90.9% in 2013, among FSW condom use during the last sexual intercourse increased from 75.93% in 2007 to 81.8% in 2013)[26]. However, among MSM condom use in last sexual intercourse with a man decreased from 66.78% in 2007 to 62.8% in 2013.

Around 1 million of tests are conducted annually in Belarus, but the majority are recorded among blood donors (302,131), pregnant women (231,584) and other populations like military, job testing, ministry of internal affairs testing (287,060)[27]. Programmatic data by current TGF PR UNDP shows that 11,299 HIV tests were conducted within the program for key populations in 2014 (testing coverage of 6% of estimated number of key populations), among PWID – 7,862 tests (10.5% of estimated number of PWID), among MSM – 1 830 tests (3% of estimated number of MSM), among FSW – 1 607 tests (3% of 2014 estimated number of FSW). Those numbers show very low coverage of KAPs with HIV testing. At the same time 2013 IBBS shows higher access to testing among key populations groups at 55.7% for PWID, 63.4% for FSW and 62.1% for MSM**.** Lack of national monitoring system which will track key populations access to diagnostics does not allow to make proper estimation on accessibility of HIV testing for key populations groups.

The estimated treatment cascade continuum below shows some of the challenges and gaps of treatment and care in Belarus.



[26] IBBS among PWID and FSW Reports in Belarus, 2013.
[27] HIV/AIDS treatment and care in Belarus: Evaluation report. – WHO. – January 2014.

Analysing the cascade, the following conclusions are made. Testing programmes/activities don't have clear linkage to care pathways identified and support established to ensure that people testing positive for HIV are linked to care. Human capacity to address the health needs of PLHIV is very limited. There are lack of physicians and medical nurses providing treatment and care (due to low salary), lack of social support, high personnel turnover. This is resulting in (i) no follow up on PLHIV who have been registered for HIV care, but do not come for regular check-up; (ii) lack of information/misinformation, (iii) long waiting in queue to visit a doctor etc. This creates barriers to access to treatment and care and negatively influence adherence. 24% of PLHIV who diagnosed and alive are not in HIV care, 22% of estimated number of PLHIV (out of 25,000) receive ART and only 12% of all infected have suppressed viral load. It means that only 12% of 25,000 individuals living with HIV in mid-2014 were getting the full benefits of the treatment they need to manage their disease, keep virus under control and thus, have low chance to transmit HIV to others.

Nevertheless, it is fair to say that the current NAP 2011-2015 has demonstrated significant progress in the HIV response, particularly in increasing ART coverage (1.6 fold increase in 2013 comparing to 2011), increasing state spending for HIV programs (from 48.7% in 2011 to 71.1% in 2013). During NAP 2011-2015 number of new AIDS cases decreased by 8.4% (5.4 cases per 100,000 population) and there was decrease in HIV mortality (2.8 cases per 100,000 in 2013 comparing to 6.2 in 2011). In spite of significant progress, the number of new infections continues to grow, because access to HIV testing, treatment and care, especially among key populations, remains limited.

c. Limitation and lessons learned

It is necessary to further develop the social contracting mechanism for effective and complete transition of the preventive arrangements under funding from public sources by late 2018. The existing National HIV Preventive Program for 2011-2015 does not envisage providing subsidies to NGOs for them to deliver social services and introduce social projects, which is the main obstacle to implement the state social contracting in HIV-related prevention, care, and support.

In addition to zero funding allocated in the National HIV Prevention Program for the social contracting, the implementation constraints are as follows: a small number of applications submitted to the state social contracting bids, which can partially be explained by the lack of awareness of the NGOs on the bidding and contract award procedure; lack of communication and feedback between NGOs and the government bodies launching bids; lack of interagency collaboration on delivering the services that involve more than one government bodies; difficulty to comply with the requirements and procedure for granting subsidies to NGOs for them to provide social services and implement social projects; imperfection of the bidding procedure to select the implementing agency for the state social contracting (sophisticated bid evaluation system).

It is planned that the government agencies and NGOs being financially supported by TGF will directly focus their efforts on tackling the above obstacles in 2016-2018 in order to address the existing problems and to minimize the risks of ensuring sustainability of prevention activities.

The NAP 2016-2020 will be based on the main outcomes and lessons learnt from NAP 2011-2015 reflected in the Concept of NAP 2016-2020 and conclusions and recommendations of evaluations conducted by the WHO, TGF/UNDP, UNAIDS etc. During NAP 2011-2015 implementation there were a number of assessments and evaluations aiming to identify strengths and weaknesses and improve national HIV/AIDS response. The following **achievements/strengths** have been identified:

- NAP 2011-2015 is well-designed, highly focused on key populations; the mix of interventions provided meets the standards for interventions proven to be effective for HIV prevention

among key populations;

- Development of coordination, collaboration and referral linkages between government and civil society at the service delivery and facility level, as well as at higher management levels at the district (rayon), regional (oblast), and national levels;
- Effective approaches of working with PLHIV and KAPs; NGO staff, peer outreach workers and volunteers make specific efforts to identify and reach specific subgroups of sex workers, PWID and MSM, who are often more hard-to-reach and may have particularly high HIV risk;
- Increase of government funding for ARVs (from 18.3% in 2011 to 24% in 2013);
- Substantial HIV treatment scale-up (ART coverage increased by 38% in 2013 compared to 2011);
- Strong and outspoken civil society organizations, inclusion of civil society and KAPs to planning and implementation of HIV-related activities;
- Strong coordination of efforts – functioning CCM, one agreed HIV/AIDS program that provides the basis for coordinating the work of all partners; one national HIV/AIDS coordinating multisectoral authority; one agreed HIV/AIDS national monitoring and evaluation (M&E) system;
- Considerable progress in PMTCT;
- Commitment of the government to scale up OST program and gradually transfer OST funding to the government.

In spite of these significant achievements a number of **weaknesses and gaps** were identified and going to be addressed in the next NAP 2016 - 2020:

- Lack of sustainability of government-civil society partnerships and comprehensive service delivery to key populations;
- Insufficient coverage and utilisation of HIV prevention services compared to size estimations of key populations resulted in low impact on HIV transmission among KAPs and spread of HIV epidemic;
- Lack of political will in the lead of the national HIV response, not only in terms of financial resource allocations, but also to ensure continuing partnerships with civil society organisations to deliver comprehensive service packages to all key populations;
- Low coverage of HIV testing, in particular among most at risk populations;
- Insufficient enrolment and retention in HIV care and ART;
- Lack of harm reduction programs, including low OST coverage;
- Lack of integrated services, including collaboration between HIV clinics and NGOs, TB hospitals and narcologists;
- High level of stigma and discrimination that hinder access of PLHIV and KAPs to medical and social services;
- Shortage of human resources and high staff turnover;
- Lack of coordination between HIV and TB services, thus, low capacity to fully address the needs of co-infected patients.

d. Linkage of the Program with the national health strategy

The stated objectives for the health system include improving the health of the population, reducing morbidity and mortality rates, and improving average life expectancy levels. The aim is to achieve

this by improving the quality of health care provided as well as its accessibility to the whole population[28]. Although noncommunicable diseases pose the greatest health burden, HIV and tuberculosis (TB) are the main communicable disease challenges to population health. Effective HIV/AIDS response will contribute to achieving overall objectives of the health system.

Health care has remained one of the top priorities in the social policy of Belarus and is one of components of the Program on Socioeconomic Development (PSD) for 2011-2015 (approved by Decree #136 of 04 January 2011 of the President of the Republic of Belarus). PSD is implemented by five-year plans; and the focus of 2011-2015 is to complete modernization of health care through introducing more enterprise, initiative and energy to the system. This will include reforms to provider and health workforce payment systems. The remuneration of health workers should now also take into account workload and other features as well as qualification level and years of service.

The Strategy for the Development of Health Care in the Republic of Belarus to the year 2020 also sets out a program for the development of the health system over the longer term. The priorities included in the Strategy – using cost-effective technologies, increasing investment in health care, developing human resources policy etc. – will help to address weaknesses and gaps in HIV/AIDS response (health care staff shortage and turnover, increasing budget for NAP 2016-2020, using evidence-based cost-effective interventions etc.).

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

2.1 Overall Funding Landscape for Upcoming Implementation Period

According to WHO estimates, in 2011 total expenditure on health accounted for 5.3% of GDP, which equated to a per capita expenditure at PPP of $793 per capita[29]. The vast majority of this spending came from the state budget. WHO estimated that health expenditure accounted for 13% of total government expenditure in the same year (WHO, 2013). WHO estimates show that health expenditure as a share of GDP in Belarus – at 5.6% in 2010 – is below the EU average of 9.9%, and the WHO European Region average of 8.3%, and level with the CIS average of 5.7%. In terms of PPP, according to WHO estimates, Belarus has the highest per capita health expenditure in the CIS, after the Russian Federation. This reflects the political priority given to health care in Belarus, but it also indicates that the current organization of care, which is quite similar to the organization of care under the prior Semashko system, absorbs considerable resources. The system is primarily funded through the public sector and, according to WHO estimates, the share of health expenditure from public sources as a percentage of total health expenditure was 70.7% in 2011, which is higher than in neighbouring Lithuania or Poland and considerably higher than in any other country of the CIS, the average for which was 56.6% in 2010. Such public spending has been maintained despite severe fiscal shocks.

Social health insurance has not been introduced in Belarus, and the national health system is mainly funded by the state through general taxation (there are no earmarked taxes or other contributions specifically for health funding) and some out-of-pocket payments, which are usually made in order to purchase pharmaceuticals and for limited private services. The central government sets national health priorities, regional and district administrations oversee the organization and funding of primary and secondary care at the local level. The Ministry of Finance is responsible for collecting financial resources for health care The Ministry of Health has overall responsibility for the health system

[28] Richardson E, Malakhova I, Novik I, Famenka A. Belarus: health system review. Health Systems in Transition, 2013, 15(5):1–118 (http://www.euro.who.int/__data/assets/pdf_file/0005/232835/HiT-Belarus.pdf?ua=1)
[29] Belarus: Health System Review. – Health Systems in Transition. – Vol. 15 No 5, 2013.

(including delivery and planning of health care).

Activities related to HIV/AIDS in Belarus are funded from the national and local budgets, as well as supported by international development partners.

NASA findings show that total annual investments in national AIDS response from both public and international funding sources in Belarus has remained relatively stable and accounted for about $20 million annually. The biggest share of HIV/AIDS investments between 2008 and 2013 was supported by the public budget (73% in 2008; 67% in 2010; 71% in 2013). Average annual public spending was $12.6 mln. Estimated HIV expenditure per capita from public and international funding sources accounted for about $1.39 in 2010; $1.02 in 2011; $1.32 in 2012 and $1.65 in 2013.

Despite quite stable participation of the government in HIV/AIDS response, overall sustainability of national AIDS response during last years was also related to external support. There are certain areas of HIV response funded exclusively by donors: support to NGO in their work with key affected populations (PWID, MSM, FSW). TGF remained a major external donor in national AIDS response between 2008 and 2014, which enabled major gains in access to HIV prevention, treatment, care and support. The share of TGF in total annual HIV funding sources accounted for 96% of total international funding sources. Besides technical support and contribution of UN agencies (UNAIDS, WHO, UNICEF), no other external funding for HIV/AIDS control is anticipated for the coming years. UN agencies orient their support primarily to technical assistance for development and adjustment of national guidelines (treatment, surveillance and other), development of the next cycle of the National Strategy, building capacity of national specialists and do not duplicate TGF support.

In 2013, according to the results of the first HIV Allocative Efficiency Analysis in Belarus, country optimized the allocation of HIV funding for maximum health impacts: reallocated funds from HIV prevention for general population to antiretroviral treatment and HIV prevention among key affected populations.

In 2014 HIV Allocative Efficiency Analysis (Optima) was updated with recommendations which laid in the basis of NAP 2016-2020 budget formulation. According to the Optima results, at least 2 times increase of current funding together with optimal allocation of resources (ART, HIV TC, NSP, OST) is required to influence the HIV epidemic in the country. Additionally, the interventions previously supported solely through TGF grants - HIV prevention activities focused at key affected populations - are taken by the government starting 2016 (the government share in these activities will be as follows: 2016 – 35%, 2017 – 46%, 2018 – 62%, 2019-2020 – 100%). Thus, despite the fact that government will increase NAP 2016-2020 funding 2.5 times compared to current budget, planned government expenditure on HIV/AIDS activities in 2016-2020 may be insufficient.

This funding request aims at addressing significant gaps in government funding (e.g. prevention programs for MSM, PWID, FSW; ARV treatment; community systems strengthening) in order to obtain an effective national HIV response and ensure smooth take over to the government after 2018.

2.2 Counterpart Financing Requirements

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	☒Yes ☐ No	
ii. Minimum threshold government contribution to disease program (low	☒Yes ☐ No	

income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)		
iii. Increasing government contribution to disease program	☒Yes ☐ No	

The NAP 2016-2020 is a real game-changer in terms of the governmental investment. It envisages a planned, rapid and scaled transitioning of the financial responsibilities to the government. The funding sources dynamics for NAP for 2016-2018 is presented below. Data for 2013 is based on real spending, estimated spending for 2016-2018 is based on actual government spending for HIV in 2013 adjusted to the changes in total spending for Health Sector and gradual transfer of HIV program from TGF financial support to the government. Details of calculations and 2012-2013 GARPR provided in Annex 14.

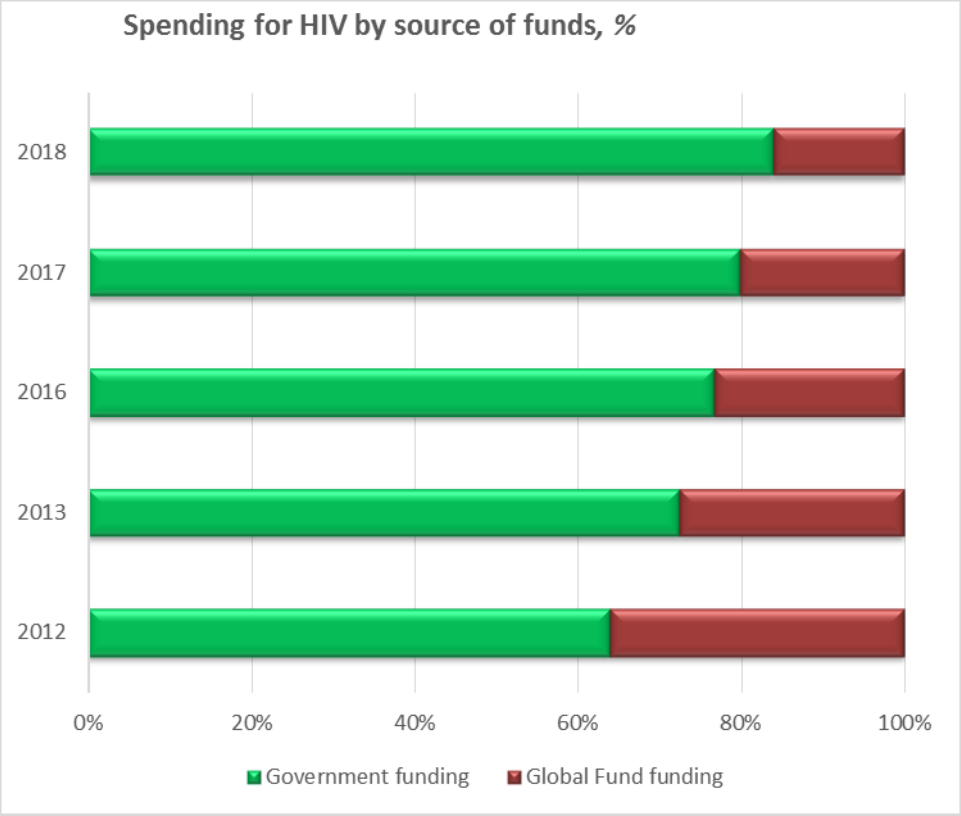


Figure 2. Funding sources dynamics for NAP for 2012-2018.

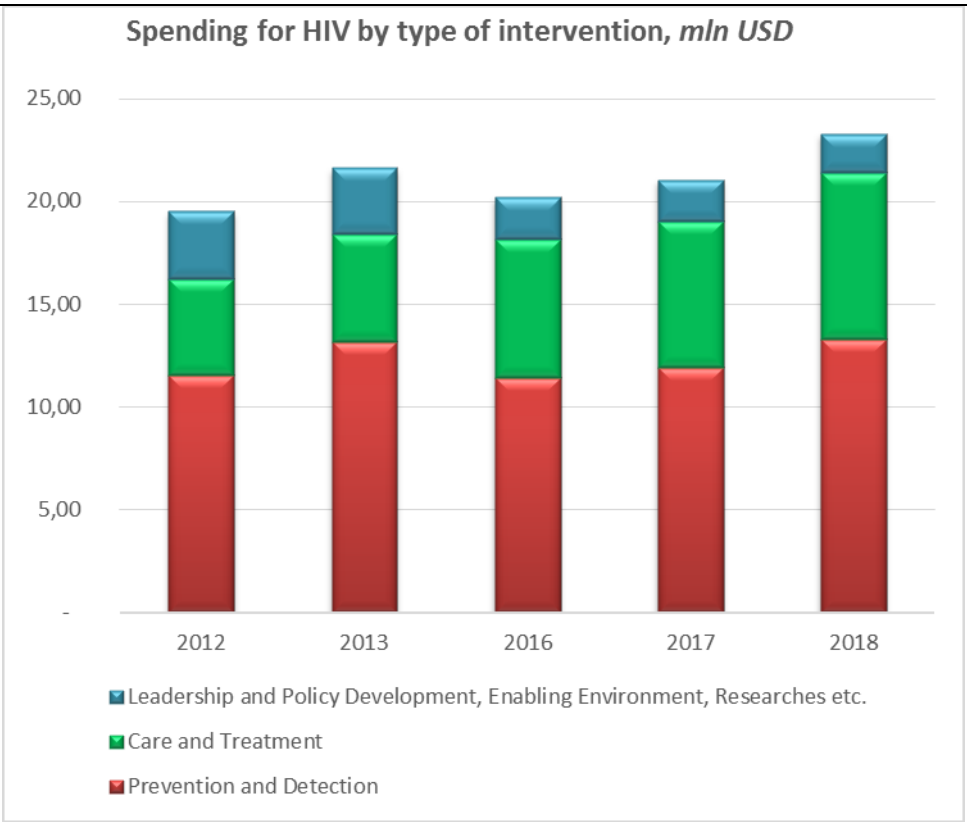


Figure 3. Program components shares for NAP for 2012-2018.

Type of intervention	2012		2013		2016		2017		2018	
	GF	GOV	GF	GOV	GF	GOV	GF	GOV	GF	GOV
Prevention and Detection, *mln USD*	3,02	8,49	2,42	10,73	2,79	8,67	2,02	9,91	1,73	11,59
Care and Treatment , *mln USD*	2,02	2,72	2,09	3,19	1,34	5,40	1,66	5,45	1,60	6,50
Leadership and Policy Development, Enabling Environment, Research etc. , *mln USD*	2,00	1,27	1,44	1,75	0,62	1,41	0,61	1,44	0,42	1,47
Total	**7,04**	**12,47**	**5,95**	**15,68**	**4,74**	**15,49**	**4,28**	**16,79**	**3,74**	**19,55**

The transition has been planned with risk minimising strategies for program implementation and feasibility assessment which led to the following arrangements.

In 2016 the government will not allocate funding for service delivery for key populations due to absence of social contracting and dedicated budget forecasted for 2016. Meanwhile the national resources will be used to procure shares of certain commodities – syringes and oral rapid HIV tests respectively. The governmental contribution in procurement in 2016 will make up $45,000.

In 2017 the government will fund through social contracting or based on Centres of Hygiene and Epidemiology (if 2016 piloting successful) 50% of the planned national target service delivery and 75% of commodities costs for all commodity items. The overall amount to be allocated by the

government to reach 2017 targets will be $1,155,000.

In 2018 the government will procure all commodities and also cover 75% of service delivery costs for HIV prevention among PWID and FSW and 50% for MSM. The funding allocated by the government in 2018 will be $2,026,000.

All testing costs for non-NGO-based testing will occur with the government. This will support the accomplishment of HIV-testing indicator for all key populations groups.

OST related costs (staffing, administration, rent, etc.) will be paid by the government. Methadone procurement throughout the project will be conducted with TGF funding.

ART funding will be used for procurement of new courses only. An increase from 6,064 in early 2015 to over 10,000 ART patients is envisaged. Governmental funding directed towards this will occur at the level of $8,125,000 in the course of 2016-2018.

The relevant funding request is being put into the calculations supporting the National Program for 2016-2020. The expenditures will be tracked using the national health accounts. The data will be used for reporting to TGF.

The potential risk with tracking of this expenditures lies with currently limited ability to track allocations of HIV routine testing and ART to key populations groups and thus claim the funding as supporting this project. It is anticipated that by 2016 the relevant revisions to the national health accounts will be made and linkages between funding allocated and key populations reached will become possible.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

3.1 Programmatic Gap Analysis

Analysis of programmatic gaps was conducted based on recommendations received during WHO evaluation mission (report of the evaluation mission ‘HIV/AIDS treatment and care in Belarus’, January 2014:; (b) Mid-term evaluation of the HIV infection prevention program funded by TGF (February 2014); (c) UNAIDS report drafted within the framework of the process of determining the new targets for achieving universal access to HIV infection treatment by 2020; (d) analysis of cascade of services on HIV infection treatment and care; (e) analysis of the current HIV infection epidemiological situation, especially in the vulnerable groups (see section 1.1), as well as (f) results of the analysis of the national dissemination of resources in the sphere of counteracting HIV infection (OPTIMA). According to the data received in Belarus there have been identified programmatic gaps that have determined key priority modules:

- Low level of coverage by HIV testing in key affected populations (PWID, MSM, FSW).

- Insufficient level of enrolment and patient retention in the programs of care.

- Insufficient coverage by ART.

- Lack of harm reduction programs including low level of OST.

- Lack of integrated services including cooperation between clinics for HIV positive and NGOs, TB hospitals and narcologists.

- Insufficient level of target coverage of key affected groups by preventive services.

- Insufficient sustainability of interaction (partner relations) between state and non-governmental organizations in providing complex services to most vulnerable groups (implementation of the mechanism of behavioral sentinel surveillance is limited).

The quantifiable programmatic analysis was done for the number of interventions in the priority ‘service’ and ‘enabling’ modules, which contribute mostly to the objectives and goal of the Concept

Note. The following priority modules were selected for programmatic gap analysis: Prevention programs for people who inject drugs (PWID) and their partners, Prevention programs for MSM and TGs, Prevention programs for sex workers and their clients, Treatment, care and support, HIV/TB.

(1) **HIV testing.** The programmatic gap in HIV testing and counselling for KAPs includes laboratory screening in the health facilities and rapid testing provided through NGOs within the prevention services. It is expected that changes in national legislation on HIV testing algorithm will be approved in 2015 and HIV testing in health care facilities will include rapid HIV testing as first screening test as recommended by WHO.

(a) 44% of estimated group of **PWID** is planned to be covered by HIV testing by the end of 2018 **(**NAP 2016-2020). TGF grant will contribute to the total size group coverage as 16% in 2016 decreasing to 6% in 2018, which, together with domestic funding will give total coverage of PWID who received an HIV test and who know the results up to 44% in 2018 (which is 73% of PWID covered by HIV prevention package). Share of domestic funding supported coverage will gradually increase from 4% in 2016 to 38% in 2018.

(b) For 2016-2018 25% of the total estimated **FSW** will be offered HIV testing. 11%, 7% and 4% will be covered through the Global Fund grant and from 3% to 20% of FSWs will be tested on the basis of functional groups at the HIV/AIDS prevention departments, other organizations funded by national budget. Thus, separate budget line (domestic funding) to cover HIV prevention services for KAPs including HIV testing in particular will be foreseen in the NAP 2016-2020. In 2019-2020 all expenses to cover HIV testing among FSWs will be covered by the domestic funding according to the above mentioned approach.

(c) The Global Fund allocation for **HIV testing for MSM** will cover 4.40%, 4.35% and 4.17% of estimated population of MSM in 2016, 2017 and 2018 respectively, with 9.10%, 9.65% and 11.46% government coverage of this group during 2016-2018 (using the same approach as for FSWs – see above). This will give total coverage of MSM by HIV testing in 2016, 2017 and 2018 as 13.50%, 14.0% and 15,63% respectively. It is planned that in 2019-2020 MSM will receive HIV testing within services for general population (HIV testing and STIs management and control) and will be covered by domestic funding planned in the NAP 2016-2020 by NGOs using social contracting mechanism.

(2) **Opioid Substitution therapy.** The OST programmatic gap is planned to be covered by domestic funding accordingly to the NAP 2016-2020 from 15% in 2016 to 27% in 2018, while Global Fund grant will cover OST drug procurement for all of these patients. National target for OST coverage is to reach 41% of estimated number of people who inject opioids representing 10% coverage of estimated number of PWID by 2020.The requested funding will be used in 2016-2018 to procure methadone, to repair and equip 3 new MMT (methadone medication therapy) wards. Expansion of the MMT program in 2016-2018 will be supported by the operation of the 20 existing MMT wards and 3 new additional MMT wards to be launched (23 wards in total). Taking into account the available resources for increasing the number of clients it will be enough to have the operating points (23 points of OST) for the specified coverage (41%). It is planned to procure methadone fully at the expense of the government budget starting from 2019.

(3) **HIV prevention programs for key populations.** These priority modules include interventions developed for and aimed to reach PWID, MSM and FSW.

(a) Programmatic gap of the **HIV prevention program for PWID** in 2016-2018 will be covered by TGF grant as 40%, 25% and 15% in 2016, 2017 and 2018. Together with 0%, 25% and 45% coverage from domestic funds, it provides total coverage (60% for 2018) of the national targets for this population group.

(b) Programmatic gap of the **HIV prevention program for FSW** in 2016 -2018 of the NAP 2016-2020 will be covered by TGF grant (gradual decrease of share from 27% in 2016 to 10% in 2018) and increase of domestic funding from 0% in 2016 to 31% in 2018 will allow reaching 41% coverage of total FSW population and full coverage of the national targets for 2018. In 2019-2020 all expenses for HIV prevention services for FSWs will be covered by the government.

(c) Programmatic gap of the **HIV prevention program for MSM** in 2016, 2017 and 2018 of the NAP 2016-2020 that will be covered by domestic resources - 0%, 4% and 10.4%; and by TGF grant - 11%, 11% and 10.4%, which gives reaching the national coverage targets of the National HIV Prevention Programme: 11%, 15% and 20.8% in 2016, 2017 and 2018. It is planned that by 2020 the national coverage target will reach 40% of estimated MSM population. In 2019-2020 HIV prevention services for MSM will be covered by the government through active collaboration with NGOs using social contracting mechanism. Strong social rejection and stigmatization of key populations influences government commitment to prioritizing this group.

(4) **Treatment, Care and Support - ART.** TGF allocation for the ARV treatment programme will cover 10%, 14% and 15% in 2016, 2017 and 2018 accordingly of the estimated number of PLHIV, contributing to the national targets. During participation of the country in regional initiative on re-targeting universal access to HIV treatment new treatment targets were identified to be included in the NAP 2016-2020. It is based on the approach to measure coverage of ART as percentage of PLHIV on treatment from the estimated number of PLHIV in need of ART, and envisage gradual shift to the WHO 2013 HIV guidelines and towards 'Treatment as Prevention'.

3.2 Applicant Funding Request

The programmatic and financial gap analysis demonstrate the need for increased support to the national HIV epidemic response. The state-funded National Program 2016-2020 can only partly address the identified gaps.

This Concept Note is aimed at partial filling of the national HIV response gaps. Aim of this project is the containing the HIV epidemics and reduction of HIV-related morbidity and mortality in Belarus. Due to the concentrated character of the epidemic, PWID, FSWs and MSM HIV prevention and access to care interventions are prioritised. Due to the low coverage of ART, HIV treatment interventions are included with prioritised access for key populations groups.

The Concept Note builds on the implementation experience of TGF HIV programs in Belarus of Round 3 and Round 8 and the increasing national response. It acknowledges the need for increased national ownership of the HIV response program and the need for the development of national capacities and leadership to take full responsibility for and control of HIV/AIDS. It builds service delivery approaches in low-threshold and high impact interventions that are integrated and delivered in order to ensure care continuum for the most affected groups in the areas where these risk groups are concentrated and where risks of HIV are the highest.

This project also acknowledges the complicacies that exist for civil society in Belarus and the limitations that have been posed by recent legislations of Belarus for health and social interventions for PWID and MSM. To address these, the project suggests advocacy and civil society strengthening interventions to improve implementation environment for health interventions for key populations.

The following four strategic priorities shape the project approach.

Strategies

1. Development of national capacities and transitioning of programs to the national funding

Thus far Round 3 and Round 8 HIV programs in Belarus have been led and implemented by UNDP. Growing acknowledgement of the need to develop national capacities and leadership in HIV response have been demonstrated by the Republic of Belarus in its policies and targets as well as in implementation arrangements envisaged in this project.

The draft Concept of the National HIV Prevention Program for 2016-2020 is aiming at achieving the ultimate breakthrough in AIDS response and focuses on key vulnerable populations. It sets targets of universal access to services and commits national contribution at the level of about $51 Million over 2016-2018.

Growing national leadership has resulted in the decision for enhanced national ownership of the HIV program and transfer of its management under NFM to the Governmental Institution 'Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health' (RSPC MT). This Center is currently coordinating national health accounts and standards and is becoming the national coordinating body of international programs within the Ministry of Health. Therefore, the program transition to the management of this Center will allow to integrate key populations focused programs of HIV response to the national health accounts and further develop national system of HIV response.

Certain functions that require enhanced capacity development with the Center will be subject to intensive technical support throughout 2015-2016 and will be supported by transitory international arrangement. For example the procurement of health products will be initially conducted in 2016 with the assistance of UN family of organisations to guarantee products price and quality, and allow for the needed procurement capacities to be established with the new Principal Recipient.

Targets within this project are aligned with the national targets while program approaches and calculations have been unified.

Transitioning arrangements will be approached through:

1) covering shares of procurement of commodities by the national program starting from 2016;
2) piloting in 2016 of a model of stationary NSP and outreach based in state Centers of Hygiene and Epidemiology with prospectively considering their funding in 2017 and even more in 2018;
3) covering through social contracting starting 2017 shares of sub-grant costs either implemented by NGOs or by the Centers of Hygiene and Epidemiology if the pilot is successful.

Gradual transfer of the national funding obligations is envisaged within the project with phased approach. Initially selected procurement will be taken over in 2016, with all the service delivery funded by this project and full coverage of the program starting from 2019.

2. Support to integrated services for key populations

Low coverage of key populations with basic HIV prevention services, low access to HIV and ART as services for key populations, lack of data on service access for key groups and lack of integrative services reduce the program effectiveness. The given program focuses on addressing these gaps through low threshold and civil society led programs, integrated targets for key interventions, and integrated implementation arrangements.

Outreach services by civil society organisations form the core of the implementation approach. Increased coverage by key interventions is 1.5 times for PWID, 1.6 times for FSWs and 2.6 times for MSM. The outreach also serves as the entry point for HIV screening with oral rapid tests that are supervised by outreach workers. These specially trained outreach workers will also perform the role of case managers and provide the necessary follow up for the patients screened positive, for further diagnostics and enrolment to ART. This low threshold, integrated and continued support will allow

substantially improving client reach, case finding and linkage to care while increasing coverage with the key interventions.

Due to funding restrictions the coverage of key populations with HIV prevention interventions remains low for FSWs and MSM. It is anticipated that national coverage targets for these groups will be increased.

HIV/TB integration is provided through early detection and increased access to diagnostics in the respective patient groups. In particular, all project clients will have TB screening through questionnaires and further referred to x-raying if needed. All TB patients will be offered HIV testing with rapid tests in the medical facilities for HIV diagnostics and follow up.

3. Regionalisation and focus on the concentrated epidemic areas

This strategy will be achieved through:

- regional priorities. Project has revised the regional priorities and re-located delivery points against the greater concentration of HIV and key populations. All key populations interventions are following the epidemic priorities working in the regions most affected by the epidemic.

  Meanwhile there are difficulties in fully establishing the regional program priorities due to the lack of sub-national data about key populations size estimates. Gaps in data about key populations sub-regional numbers will be addressed through regional size estimation research planned in 2016.

- fast-track cities. The program will intensively work in 6 cities with epidemic concentration: Minsk, Svetlogorsk, Pinsk, Gomel, Zhlobin, Soligorsk, which will coordinate responses for all key populations and establish collaboration and dialogue with the municipalities through the advocacy campaign on awareness raising and ensuring local commitment. Project delivery sites for key populations in the cities will be based in comprehensive community centres that also do outreach and have mobile ambulances at their disposal for full and efficient coverage of the urban area.

- mobile solutions. Less intensive approach is offered with geographic spread to reach key populations that reside in remote areas. Mobile units will be used by PWID, MSM and FSWs programs to reach remote areas.

4. Support to key populations destigmatisation and inclusion into public health mainstream

The National Program acknowledges high levels of stigma from the general population towards groups with highest HIV risks. Legal barriers to service delivery have been introduced by recent Presidential decree criminalising drug use. Administrative offence foreseen by Belarus Administrative code serves as impediment for service delivery. NGOs are not funded by the government due to lack of respective regulatory framework. This hinders the development of national public health response among key populations.

This project works to reduce these barriers:

- campaign to improve social images of key population groups is envisaged throughout the project life. It will be based upon public health and human rights principles and will be implemented by the national NGO network; it will also address the criminalization issues and advocacy to legislation change in respect to PWID, FSW;

- social contracting mechanism will be finalised in order to be introduced in the project starting from 2017. NGO 'Act' will make the necessary assessment, development and advocacy steps to promote social contracting and ensure resource allocation for NGOs with TGF investment phasing out;

- advocacy for increased national commitments in response to HIV among key populations will be conducted by NGOs and new Principal Recipient. In particular, the campaign above will address the need to revise the national targets for key populations coverage and fully encompass high-impact interventions like OST in the national program targets.

Based on these four strategic priorities three strategic objectives have been identified for this project:

1. To scale up the delivery of evidence-based, integrated and regionally prioritised package of HIV prevention and treatment services to key populations groups at risk of or affected by HIV.

2. To build national capacities to fully uptake the programmatic and financial responsibility of HIV response in Belarus.

3. To strengthen community systems to ensure relevant, human rights and public health based, sustainable and integrated HIV response measures for key affected populations.

The objectives are reflected in 9 modules. Rationale for module selection and outline of activities under each module are presented in the following section.

Above allocation funding is requested for this program. Above allocation funding is requested to develop capacities of PWID program to extend its reach up to 60% (target of the national program) through introduction of innovative peer-driven intervention approach (PDI) that uses the networks of drug users to reach to the hardest-to-reach subpopulations of PWID.

3.3 Modular Template

Gap analysis has identified the greatest programmatic and financial gaps in interventions for key populations, OST access and HIV treatment. In particular, 100% gap for HIV prevention services for 2016 for PWID (including OST), FSWs and MSM, 76% gap in ART (coverage calculated as percentage of people receiving ART from the estimated number of people with HIV). OPTIMA is suggesting the need for substantial increase in ART and OST coverage as well as interventions for PWID.

Five service modules have been selected with respective interventions to address this gap: modules on PWID, MSM, FSWs, TB/HIV, Treatment and care. The logic between the modules prioritises treatment cascade for key populations: service outreach and HIV prevention activities are integrated with HIV/TB screening and follow-up case management for those tested positive. Treatment for HIV to be covered within this project will be used for newly detected PLHA from key populations. It is planned that the government will gradually uptake program delivery in 2016 and funding 50% of service delivery costs for PWIDs and FSWs and 25% for MSMs in 2017 to 75% for PWIDs and FSWs and 50% for MSMs in 2018. Government will start with procurement of commodities (syringes and rapid HIV tests) in 2016 and will fully fund commodities procurement in 2018.

Based on the situation analysis, enabling environment is critical to HIV program success in Belarus. A number of legal barriers to access for key populations exist in Belarus. Until now, the government has not been funding focused HIV prevention interventions for key populations. New Principal Recipient from the government will address some of the policy barriers, but will require capacity building in certain areas, and particularly procurement and supply management (PSM) and subgranting. The existing monitoring system does not allow tracking access of key populations to HIV testing and ART. This context led to the selection of four enabling environment modules: HSS PSM, HSS M&E, CSS, Management and governance.

Project will allow improving existing treatment cascade and reducing HIV morbidity and mortality. Particularly it aims (i) to expand testing among key affected populations; (ii) to improve linkage to care; (iii) to develop adherence to ART and retention in care by a doctor, (iv) to increase ART coverage. The interventions in service modules will allow 4,000 patients increase in access to ART. Due to introduced case management in the key populations projects, at least 65% of the anticipated increase in new ART patients will occur through key populations groups.

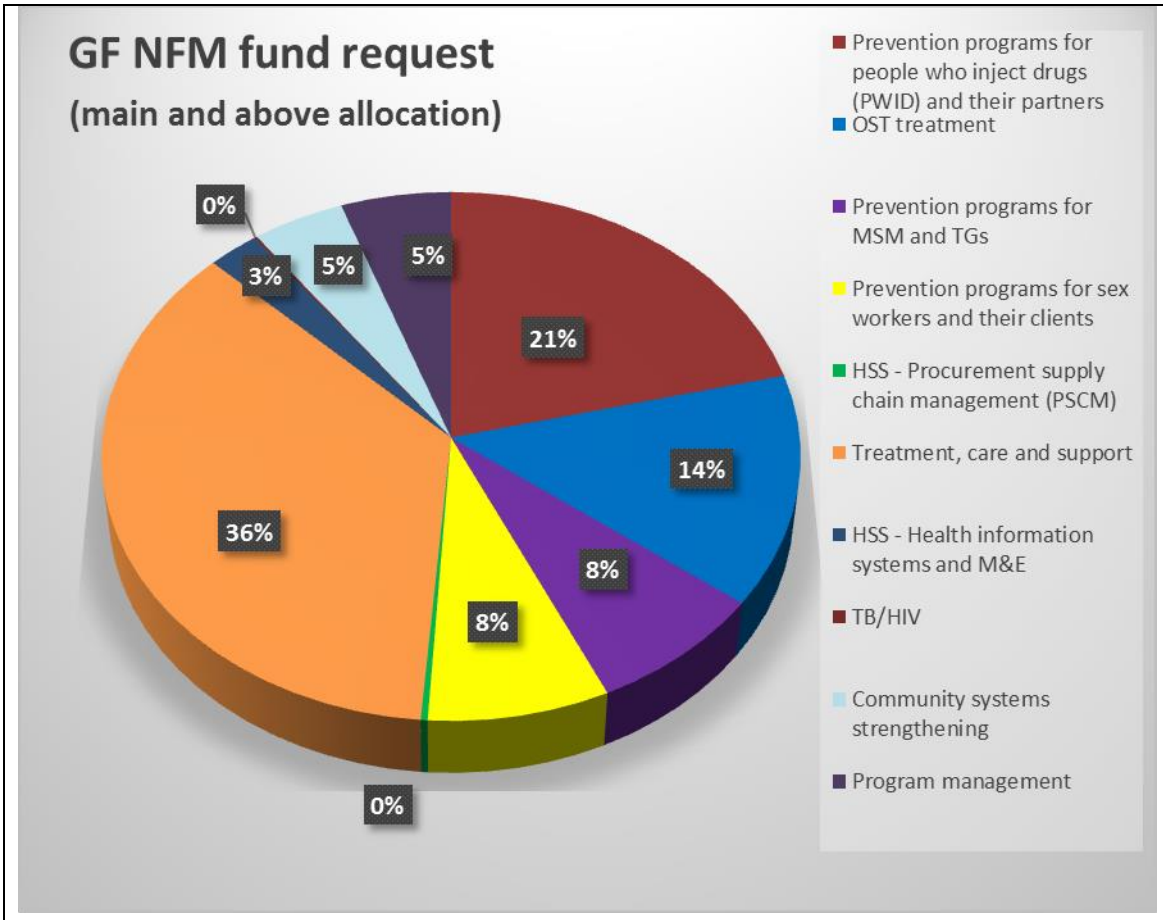


Figure 4. TGF NFM fund request (main and above allocation).

Service delivery modules attract the greatest share of funds – 87%.

PWID module covers HIV prevention and OST measures, as well as prevention among sexual partners of PWID. This module share is 35% in overall program budget.

Intervention coverage is 30,000 in 2016, 37,000 in 2017 and 45,000 in 2018. The funding share to be covered by GF funding is declining from 98% in 2016 to 41% in 2018 and all funding is expected to be fully provided by government in 2019.

Regional prioritisation of interventions will start from 2016, with 50% of coverage occurring in Gomel oblast. Most activities will occur in the most affected cities with greatest number of PHLA and registered PWID. Regional estimates of PWID will be provided by the size estimation study in 2016; its results will be used to further adjust programmatic reach.

Models of delivery are: community centers (in most affected by HIV and drug use cities: Minsk, Svetlogorsk, Pinsk, Gomel, Orsha), outreach, and mobile clinics (23 towns). Service delivery based in healthcare facilities – Centers of Hygiene and Epidemiology – will be piloted in 2016. This model will be scaled up if found to be effective.

Minimal package of services includes:

- syringe distribution and exchange (150 syringes per PWID per year),
- condom distribution (43 per PWID per year),
- consultation,
- testing with oral rapid HIV tests provided by social or outreach workers, covering about 40% of

PWID reached,

- case management for HIV-positive PWID provided by outreach worker who is involved in NSP and HIV rapid testing.
- questionnaire TB screening and referral to x-ray.

Motivational packages for new PWID will be provided to facilitate client increase. Peer-driven intervention using a chain-referral mechanism is suggested as a strategy to increase coverage. Due to lack of funds it has been suggested in the above allocation.

Rapid HIV testing for sexual clients of HIV-positive PWID will be conducted (for 14% of tested clients, based on IBBS 2013 HIV-prevalence among PWID).

In terms of OST funding, TGF will only procure methadone. It is planned that the coverage of OST will increase to 2,800 at the end of 2016 and 4,900 at the end of 2018. Opening of 3 new OST sites is planned to make this increase in OST coverage possible.

MSM and transgender module takes 8% of the overall program budget. NGO 'Vstrecha' is implementing MSM programs throughout Belarus. MSM programmes operate in 6 oblast cities (Brest, Minsk, Mogilev, Vitebsk, Gomel, Grodno) and 7 in regions: Bobruisk, Zhlobin, Lida, Mozir, Svetlogorsk, Orsha, Polotsk through contracting coordinator, outreach worker, doctor and psychologist in each site.

Minimal package of services includes:

- condoms and lubricants distribution (52 condoms per MSM per year),
- STI testing and treatment (10% of MSM reached),
- rapid testing for HIV (40% of MSM reached),
- case management for HIV-positive MSM,
- psychological counselling.

For the closed groups of MSM that at first do not wish to get in contact with NGOs the following strategies of reach are planned: hotline and Skype counseling; Internet-counseling on websites for MSM contacts, counseling in geo-social networks (using mobile telephones), advertising on the most popular with MSM sites through using banners, support to a specialized internet-portal. 2014 annual coverage makes up 4,795 and an increase is planned every year to reach 6,600 in 2016, 8,700 in 2017, and 12,500 in 2018 (2.6 times increase from the 2014 coverage level). TGF funding will cover 6,600, 6,525, and 6,250 in 2016-2018 years respectively and the rest will be covered by government.

FSW module budget share is 8%. Starting 2006 Belarus Association of UNESCO (BelAU) has been involved as TGF program implementer. BelAU sub-contract Red Cross and women's NGOs, in small towns direct contracting is happening. In 2014 annual coverage is 5,719 FSWs (including FSWs who are injecting drugs). Two mobile clinics will be used: one in Minsk and surrounding highways, one for the overall country operations (to be procured). The following package of services will be provided:

- condom and lubricant distribution (218 condoms per FSW per year),
- counselling,
- testing for HIV (40% of FSWs reached) and

- case management for HIV-positive FSWs.

New coverage will be assured through 1 new mobile clinic to be procured under allocation.

ART and adherence module (36% of funding requested from TGF). Expansion of treatment will prioritise access of key populations and at least 65% of the patients newly enrolled into ART will be representatives of the key populations.

According to the National HIV/AIDS protocols, current CD4 count for enrolment to ART is 350. Given that approximately 3,000 people living with HIV in Belarus have CD4=350-500 cells, it is planned to make a gradual transition to implement the WHO recommendations (2013) to start ART at the rate of CD4≤500 cells. To do so, the national HIV infection treatment protocols will be updated. According to this transition, ART will additionally cover 2,620 new patients including some patients with CD4≤500 cells in 2016, and consequently ART will additionally cover 3,700 new patients in 2017, and 4,100 new patients in 2018. Therefore, by 2018 the country will cover with ART 40% of the estimated number of PLHIV. It is planned to completely transfer to ART introduced at CD4≤500 cells starting from 2019. The Spectrum software program has been used to estimate the number of people living with HIV who have CD4≤350 cells and who will need ART in 2016-2018, as well as the number of new patients to be covered by ART annually. It is planned that the grant will cover the procurement of the first-line treatment ARV drugs recommended by the WHO for the new patients annually, including some patients with CD4≤500 cells. Other patients who need ART will be treated with the drugs procured at the expense of the government budget**.**

Adherence support will be provided in 10 cabinets (8 cities with oblast level) by infectious diseases outreach workers hired by 'Positive movement' NGO.

Palliative home care will be introduced in 7 cities with the highest number of the HIV/AIDS patients in late stages of HIV (Svetlogorsk, Gomel, Rechitsa, Zhlobin, Minsk, Soligorsk, and Pinsk). Integrated services will include psychological support, medical and social services, as well as training for relatives and volunteers to render basic home-based medical and social assistance and support to PLHIV. This area of work is very important since home-based palliative care to the HIV/AIDS patients is currently provided only by NGOs (the Sisters of Mercy of the Belarusian Red Cross). Public funding can be allocated from domestic sources in the future once the public social contracting arrangements will be in place.

HIV/TB module

HIV screening among TB patients is planned as part of the project. Annually 5,000 rapid tests for HIV will be procured within this project to screen TB patients for HIV and provide necessary follow up.

All key populations reached will be screened for TB through questionnaires and referred to x-rays if necessary.

Gradually increasing funding for these modules will come from NAP. Belarus Network Against AIDS will work in the cities with the highest prevalence rates and coordinate activities of key populations service providers. This will optimise the resources and will lead to productive regional dialogues on HIV programs and expenditure and necessary funding from the local governments.

Enabling environment modules: CSS, M&E, PSM, program management (13% of requested allocation budget).

Preparation of Social contracting for HIV by 'Act' NGO is a critical intervention to ensure transitioning from TGF to the national funding. The following activities are envisaged to make this social contracting possible:

- analysis of legislation and preparation of changes in the law on charity to allow contracting of governmental funds to NGOs and transferring procured commodities for the government to

NGOs;

- finalising and adapting in legal acts the package of services for key populations that would be used for calculating the national investment in HIV prevention among most-at-risk populations;
- sensitizing local governments and communities about the need to invest into HIV response among key populations;
- development of mechanisms to allow accumulation of additional funds for NGO-based prevention work, e.g. establishment of local foundations to resource HIV prevention interventions form local budgets and private donors.

Campaign to remove legal barriers to access to services among key populations will be conducted throughout the project life. The campaign includes bus tour, press-conferences and round tables (details provided in Annex 15).

Improved data quality and research are envisaged as part of M&E module. In particular, IBBS for all key populations is planned for 2017. Research on regional size estimation of key populations groups is planned at the very beginning of project implementation in 2016.

National formular for registration of HIV positive persons and treatment is envisaged in 2016 allowing to improve operational data and forecasting capacity.

Changes in system for national records on HTC and ART will allow for tracking key populations. To simplify HIV testing procedure the MoH is updating Sanitary norms and regulations. Updated procedure envisages using HIV rapid-tests as first screening tests instead of one ELISA including possibility to perform HIV tests by non-medical staff based on NGOs. Key affected populations like PWID, MSM, FSW and their sexual partners are designated as groups where HIV testing with rapid tests should be the first choice.

PSM capacities will be developed with the new Principal Recipient through training, on-site support, procedure development and exchange visits. This will allow creating the necessary procurement capacities with the new Principal Recipient and enabling rapid, quality and value for money procurement of commodities and drugs for the program, starting from 2017.

Expected outcomes, impact and targets

As a result of the implementation of the activities within the module the following coverage of key populations groups will be achieved:

Estimated size	Target group		2016	2017	2018
75000	PWID	**Target reach of PWID**	**30000**	**37000**	**45000**
		% from estimated PWID	40%	50%	60%
60000	MSM	**Target reach of MSM**	**6600**	**8700**	**12500**
		% from estimated MSM	11%	15%	21%
22000	FSW	**Target reach of FSW**	**5900**	**7500**	**9000**
		% from estimated FSW	27%	34%	41%
	OST	**Target reach OST**	**2800**	**3850**	**4900**
25000	ART	**Target reach ART**	**7500**	**8500**	**10260**
		% from estimated PLHA	30%	34%	41%

As a result of this increased HIV prevention and treatment efforts, HIV prevalence rates among all key populations groups are expected to stabilise or decrease and AIDS mortality per 100,000

population is to drop from 2.9 in 2014 to 2 in 2018.

3.4 Focus on Key Populations and/or Highest-impact Interventions

By means of the present Concept Note the funding request for Belarus, categorized as an upper-middle income country, focuses 100% of the budget on key affected populations and/or high impact interventions. The request is structured around 9 modules encompassing 5 service delivery modules and 4 enabling environment modules.

All the interventions in the modules aim to ensure the continuum of care through the delivery of most effective and high impact services for key affected populations. The interventions allow filling the gaps of the National HIV Program indicated in the programmatic gap analysis.

Totally, the service modules will spend over 86% of the 3-year Global Fund budget, with two modules (Treatment, care and support; Prevention programs for PWID) containing more than 70% of the total funding for the modules and have the highest impact on HIV epidemic.

The service interventions are all focused on key affected populations. 100% of HIV prevention services aim at PWID and their sexual partners, MSM and FSW. The chosen HIV prevention services are evidence-based high impact interventions and will be implemented considering country's context including regional differences.

The funding request for ART care and support interventions focuses only on procurement of the first-line ARV drugs for the new patients annually, including some patients with CD4≤500 cells.

The enabling environment modules are aiming at protecting the human rights of the key affected groups and provide for advocacy for access to high quality services for those groups. The expected outcomes from the interventions under these modules would enable the scale-up of sustainable services for these KAPs.

The proposal is based on Strategic Investment Guidance from Technical Partners and focuses on interventions that have been previously implemented in the country. These interventions proved to be effective in addressing the needs of KAPs and PLHIV and bringing the HIV/AIDS epidemic under control.

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

Belarus has the national health system funded by the national budget for most of services (with the exception of a number of paid diagnostics, e.g. for sexually transmitted infections), provided free at the point of use. Primary and secondary healthcare is resourced from the regional budgets; highly specialised care is funded from the national budget. Policy development is centralised with limited or no participation from the hospital or district levels, which acts according to centrally developed priorities within their local budgets[30]. Proportion of the local taxes and revenues are sent to the national budget, from which the Ministry of Health receives its allocations which are used to fund specialized programs like HIV/AIDS and Tuberculosis.

The procedure of state programs formulating, financing and control of implementation are determined by the Government of the Republic of Belarus (Resolution of the Council of Ministers dated 07.03.2013 г. №152). State HIV Prevention Program is approved by the Council of Ministers of the Republic of Belarus; the main customer of the State Program is the Ministry of Health, the main coordinator is the Republican Centre for Hygiene, Epidemiology and Public Health. All implementers of the State Program (13 Ministries and departments, local executive authorities)

[30] Belarus: Health System Review. – Health Systems in Transition. – Vol. 15 No 5, 2013.

submit the form of the state report on execution of the State Program to the Republican Centre for Hygiene, Epidemiology and Public Health on a yearly basis. Based on the submitted reports and on information from GIU GFATM regarding the work of civil society organizations within the framework of international technical assistance project, the Ministry of Health submits the progress report on implementation of the State program to the Ministry of Economy, Ministry of Finance and the Council of Ministers. This progress report also includes the assessment of efficiency of expenditures from republican and local budgets, implementation of the planned activities and achievement of targets set.

The funding requested under this project is in line with the draft Concept of National HIV Prevention Program for 2016-2020 under development at the time of this submission. All activities are coordinated and complementary, implementation approach and costing are unified and in line with the national targets for 2016-2020.

The Principal Recipient for this program is Governmental Institution 'Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health' (RSPC MT).

The Principal Recipient has been selected following by the established procedure for Principal Recipient selection,[31] by the decision of the national CCM on 24 March 2015. Two organisations have applied to become the Principal Recipient – the NGO 'Positive movement' and Governmental Institution 'Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health'. Based on the agreed application rating system, 119 points have been awarded to the 'Positive Movement' and 124 – to the RSPC MT. During voting for PR on AIDS, out of 20 voting CCM members, 11 supported nomination of RSPC MT, 8 voted against, 1 abstained. Based on the results of anonymous voting procedure RSPC MT has been elected to become the PR[32]. The same Principal Recipient has been selected for the Tuberculosis proposal with unanimous support.

The civil society Principal Recipient has not been supported due to anticipated difficulties that may occur with project registration with national authorities and following limitations in operations due to complicated civil society operations regulations in the Republic of Belarus.

The sub-recipient civil society organisations will play a major role in the project implementation. Representatives of key population groups are involved in management and implementation of projects with these NGOs. All the civil society SRs involved in the implementation of the current grant have strong track record in program implementation and are expected to continue their roles in the new project. The sub-recipients have been identified through open call for proposals and selected by the specifically formed working group – on October 9, 2014 and further approved by CCM:

- NGO 'Act'
- NGO 'Belarus Anti-AIDS Network '
- NGO 'Positive Movement'
- NGO 'Vstrecha'
- NGO 'Belarus Association of UNESCO'
- Belarus Red Cross Society

Sub-recipients NGO 'Positive Movement' and NGO 'Belarus Association of UNESCO' will also work with sub-sub-recipients. In most cases local implementation for key populations' service delivery will

[31] Procedure for Selection of the Principal Recipient(s) of the grant of the Global Fund to Fight AIDS, Tuberculosis and Malaria within New Funding Model approved by the Deputy Minister of Health of Belarus Gayevsky (in Russian).

[32] Protocol of CCM meeting No 48(2) of CCM meeting as of March 24, 2015 (in Russian).

be arranged through direct contracting of local implementing staff, with coordination and administrative support from the sub-recipient head office.

Special international contract form regulating relationship between Principal Recipient and SRs complying with TGF requirements has been developed and provided for consideration of CCM. The coordination between Principal Recipient and Sub-recipients is envisaged through dedicated management staff with the Principal Recipient to manage SRs, programmatic and financial reporting, bi-annual working meetings.

Representation of key populations groups has been assured via membership of groups in concept note development group, involvement in respective NGOs part of the national dialogue around submission, and via CCM membership.

The Principal Recipient of the Round 8/9 HIV/TB program in Belarus, UNPD, will be supporting capacity building for the new PR during 2015 and 2016. Due to the lacking health procurement capacity with the newly appointed PR identified during Capacity Assessment workshop, which took place 31 March – 1 April 2015, procurement function for health products will be performed by UNDP during 2016, while in parallel arrangements made for full transfer of procurement functions and budgets to the new Principal Recipient starting 2017 or 2018. UNDP will be a sub-recipient for health procurement in 2016.

4.2 Ensuring Implementation Efficiencies

Currently Belarus is the recipient of TGF HIV/TB grant under Round 8/9 with UNPD implementing the Principal Recipient function. The program ends in December 2015.

In order to support the Belarus CCM integrated approach to oversight of TGF grants, an oversight commission consisting of seven members from the CCM and other constituencies, as well as working groups on key populations, have been formed by CCM on March 24, 2015[33].

TB request is being submitted by Belarus to TGF simultaneously with the HIV/AIDS request. The dialogue around both submissions has been inclusive and part of the same dialogue process with strong involvement of both the existing Principal Recipient and the newly selected Principal Recipient to ensure informed transition of existing programs.

The same Principal Recipient has been recommended by CCM for TB request as for the HIV request which will allow ensuring sufficient level of program coordination.

Principal Recipient RSPC MT Deputy Director on Economic Research is responsible for both HIV and Tuberculosis program development and will head program implementation unit upon its establishment. Program implementation unit will work on both HIV and Tuberculosis programs. It will rely upon the existing administrative and finance management systems of the Principal Recipient and the developed capacities specifically involved for programme implementation unit by the RSPC MT. Monitoring and reporting under both programs will be integrated into the national automated health reporting accounts that are currently managed by RSPC MT and with the existing finance reporting mechanisms.

There is no overlap between the activities proposed under the HIV and Tuberculosis grants. The integration of programs occurs at the level of early detection of HIV among TB patients and TB screening of groups vulnerable to HIV.

[33] Protocol of CCM meeting No 48(2) of CCM meeting as of March 24, 2015 (in Russian).

4.3 Minimum Standards for Principal Recipients and Program Delivery			
PR 1 Name	**Governmental Institution 'Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health' (RSPC MT)**	**Sector**	**Government**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☐Yes ☒No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		RSPC MT is a governmental institution established in 1992, subordinate to the Ministry of Health (MoH). Decision making is regulated by its Statute and organizational procedures. Organizational structure consists of sub-divisions: scientific and research, implementation and project, HR/administrative and support. 137 staff are currently employed by RSPC MT (including infectious disease specialists, epidemiologists, pharmacologists, economists, accountants, and others). A number of commissions function within RSPC MT: procurement, corruption prevention, attestation and qualification. MoH on competitive basis allocates its funding through contract to the Center which, in turn, contracts other Health Organizations. Licensing, calculation of paid services is also part of RSPC MT portfolio. The RSPC MT has a proven track record for working on international projects in the field of disease research and prophylaxis, health system development. It is supposed, that all international projects of MoH will be coordinated by the Centre. Director of the Centre is appointed by the Minister of Health of Belarus. Three deputy directors appointed by the director are: on scientific work, on economic research and information. RSPC MT has no prior experience of managing TGF grants or collaboration with TGF	
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-		RSPC MT has a proven track record with financial management of program/grant budgets. It has experience of handling financial reporting of sub-	

recipients (and relevant sub-sub-recipients)	recipients following written rules and mechanisms. RSPC MT has no prior experience of on-going management of sub-recipients and providing funds to non-governmental organisations. This capacity is subject to development during 2015 by the PR of the current grant. RSPC MT has potential to manage international grants (including sub-recipients management): in 2015 a unit for evaluation of international cooperation and international projects in the field of health care was introduced in the structure of the Center
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The Center has a Commission established by the order of its head on counteracting corruption and prevention of corruption in the Center. The financial statements of the RSPC MT are audited by annual financial audit by the Ministry of Health, Ministry of Finance and Treasury
4. The financial management system of the Principal Recipient is effective and accurate	Overall budget of RSPC MT in the last financial year made up $ 1,352,921. The RSPC MT has written policies and procedures related to the financial management function: the financial management functions are approved by the organization in accordance with the requirements of national legislation. RSPC MT has 2 accounts in 'Belinvestbank': budget and non-budget. For foreign currency transfers the relevant foreign currency account is opened. The electronic system 'Client-bank' is used with a system of cryptographic protection of information. There is a double signature system in place. The RSPC MT has controls in place for preparation and approval of transactions/ payments and for banking arrangements. The organization has clearly defined financial management and accounting functions following written rules and procedures. It uses financial management and accounting IT System 1C: Enterprise.
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The RSPC MT follows public procurement rules and procedures: the Public Procurement Act Presidential Decree of 31 December 2013 № 590 'On some issues of public procurement of goods (works, services)'; Resolution of the Council of Ministers of the Republic of Belarus of 15.03.2012 № 229 'On improvement of relations in the field of procurement of goods (works, services)'. The RSPC MT does not have an experience for procurement of health products, pharmaceuticals or diagnostic products, except for limited experience of

	procurement of 7 biological microscopes in 2014. For medical goods procurement the Center will use the procedure of centralized procurement approved by the MoH, through 'Belpharmacia' and 'Belmedtechnics' enterprises, or through UN agencies. The organization has potential to establish Procurement unit and systems and if required, this structure can be created by order of the head of the organization. The RSPC MT uses an IT system for recording, tracking and reporting procurement information – the financial accounting in the organization is fully automated. The procurement function is segregated: the Organization has specialized Planning and Procurement Management Commission. In the Center's warehouse, an automatic fire alarm system is installed. The physical guarding of the premises is outsourced to the respective Department of the Ministry of Interior of the Republic. The RSPC MT has experience in forecasting the use of health products, pharmaceuticals or diagnostic products: it deals with the clinical and economic analysis; it is involved in the development and annual revision of the National Drug Formulary and the Republican form of medical products.
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	Distribution of health products is regulated by the decrees of MoH. RSPC MT has limited experience of health products distribution and transportation and the respective systems are not in place
7. Data-collection capacity and tools are in place to monitor program performance	The Center is a coordinator of the system for monitoring and evaluation of the indicators related to public health and the performance of healthcare organizations (in the whole country and by region). It also performs the evaluation of the effectiveness of the government programs. The RSPC MT has IT system for reporting of M&E data. The Center is responsible for data entry in the republican information-analytical system 'Healthcare'; medical registers about disease incidence; information systems about infectious and parasitic diseases. The RSPC also provides data to local authorities, healthcare organizations, and educational facilities. The RSPC MT currently has no TGF program specific system of programmatic monitoring. It has the capacity to use the Round 9 PR developed tools for monitoring, including unique identifier coding system, SyrEx database for tracking key population clients,

	approaches and procedures for monitoring visits
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	RSPC MT has operational Monitoring and Evaluation system, as well as broad experience in monitoring the public health situation in Belarus. The RSPC MT participates in the strategic planning of healthcare development in the country. The organization is involved in a wide range of activities in the M&E field. The Center also reports on indictors related to public health and performance of healthcare organizations. The institution maintains registers and databases about various diseases in the country. The center has IT systems for monitoring and evaluation, as well as mechanisms to collect and verify data from lower reporting levels. The organization has departments responsible for monitoring and evaluation. The Center lacks specific expertise in relation to the monitoring and evaluation of national HIV and Tuberculosis programs
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	RSPC MT has limited experience of health products distribution and transportation and has no systems for monitoring product quality throughout the supply chain

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance

The transitory arrangements for NFM require high levels of financial commitment from the national budget. In particular, the national contribution of $11 M over the period of 2016-2018 (covering service delivery costs and commodity costs) is expected as counterpart financing of this project for key populations related work in order to reach the national targets. Belarus national budget funding has never before been directed towards key populations groups focused HIV prevention programs and the mechanisms of contracting NGOs for this work or setting key populations' services in health care facilities still have to be developed, piloted and adjusted. No mechanism of procuring certain commodity items and their transfer to NGOs for further distribution to clients is currently in place.

The following risks related to the launch of Social Contracting Mechanism were determined:

- the approval procedure of the Budget Code of the Republic of Belarus, including changes enabling possibility to procure goods and services from NGO for work with the key affected populations, is not yet finalized.

- the endorsement and approval procedures for State HIV Prevention Program, envisaging financing of prevention activities from the local budget by Social Contracting Mechanism, are not yet finalized.

To reduce the above risks transition period of 2016 is planned whereby most of funding for focused prevention programs will be sourced by TGF. During this time the government will finalise the social contracting approach that will allow it to fund NGOs and add to the existing procurement formular the commodity items for focused HIV prevention programs. Dedicated advocacy effort to promote social contracting of NGOs by the Government is part of the agenda proposed by SR 'Act' NGO in this project. Governmental Principal Recipient that will start oversight of key populations program implemented by experienced NGOs will develop national capacities and expertise to develop and

implement key population programs as well as integrate them in national health accounts.

New Principal Recipient – although with high levels of capacities in health data, standardisation and management – has limited experience in implementing national health programs and specifically HIV/AIDS, no programmatic expertise of work with key populations, and very limited experience in health procurement. It is also a national entity controlled by the Ministry of Health and subject to national health regulations. These factors contribute to programmatic and health procurement quality risks, as well as to certain risks related to governmental regulations of key populations related policies.

Efficiencies in procurement of ART especially in the context of growing procurement role of national budget, constitute another risk for national program implementation. WHO has been reporting higher costs of drugs and lack of quality assurance as major concerns regarding the state procurement of ARVs.

To mitigate these risks, for the initial implementation period of 2016 health products procurement will be conducted by UNDP to ensure quality and price of the products. Capacity building for program implementation, sub-recipient management and health products procurement with the new Principal Recipient will be conducted by UNPD according to the capacity development plan, starting from 2015.

In order to improve the quality of the antiretroviral drugs procurement the following measures are envisaged:

- registration of the used drugs and the control of their quality at the stages of registration procedures, their quality control in procurement and supply on a regular basis, regardless of a producer (a national, foreign producer). For this purpose there is a set of procedures specified by the legal acts;

- in case of the procurement of antiretroviral drugs without registration in the Republic of Belarus, including also the generic production, according to the mechanisms of the United Nations agencies (or the similar) a procurement condition should be the availability of the prequalification of the WHO production sites as a criterion for admitting to procurement procedures;

- to monitor the quality of the used drugs in prescribed manner (submission of reports in case of adverse reactions, identification of the inadequate quality of drugs);

- while preparing technical specifications for the procurement, a main criterion should be qualitative characteristics of the procured drugs in terms of their compliance with the accepted standards, rather than the parameters of cost.

Legislation on key populations has substantially limited the capacities of NGOs to work with key populations. The government is voicing concerns over the high numbers of key populations groups and the need to reduce them in Belarus which may occur in the future key populations size estimation reports. Low levels of national target coverage of key population groups with growing incidence of HIV – FSW at 40% and MSM at 18% – poses risks for further escalation of HIV.

To improve the environment of project implementation a campaign toward reduced stigma of representatives of key populations and profiling the work of civil society organisations has been planned by Belarus Anti-AIDS Network as part of this project. It will work towards improved social image of key population groups and form demand for health interventions for those most at risk of infection throughout Belarus society. Increase of national coverage targets for key populations groups is one of the objectives of the campaign.

Inflation and other economic risk factors caused by unstable political situation in the bordering Ukraine and Russian Federation and devaluation of national currency pose a risk to the program

implementation. In 2014 Belarus rouble lost 49% of its value. Due to high level of integration of Belarus trade into Russian market, longer term economic downturn is expected. This may decrease the capacity of Belarus government to fund vertical programs, including HIV/AIDS, and weaken the country's ability to conform to its commitment against growing national targets and reach stabilising impact on the developing epidemic.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

- x Table 1: Financial Gap Analysis and Counterpart Financing Table
- x Table 2: Programmatic Gap Table(s)
- x Table 3: Modular Template
- x Table 4: List of Abbreviations and Annexes
- x CCM Eligibility Requirements
- x CCM Endorsement of Concept Note