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Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries

Belarus Country Report

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ACRONYMS

ACP	Anonymous Counseling Points
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Treatment
ARV	Anti Retroviral
BRC	Belarus Red Cross
CCM	Country Coordination Mechanism
CIS	Common Independent States
CSO	Civil Society Organizations
DOTS	Direct Observed Treatment
FSW	Female Sex Worker
GDP	Gross Domestic Product
GF	Global Fund
GNI	Gross National Income
GONGO	Government Organized
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IEHPH	Institute of Epidemiology, Hygiene and Public Health
KP	Key Population
LGBT	Lesbian, Gay, Bisexual and Transgender
MDR	Multi Drug Resistance
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAP	National AIDS Program
NASA	National AIDS Spending Assessment
NGO	Non Governmental Organization
NHAEA	National HIV Allocative Efficiency Analysis
NSEP	Needle and Syringe Exchange Programs
NTP	National TB Program
OST	Opioid Substitution Therapy
PCPY	Per Capita Per Year
PIU	Program Implementation Unit
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSD	Program on Socioeconomic Development
PWID	People Who Inject Drugs
RCC	Rolling Continuation Channel
RCHEPH	Republican Centre for Hygiene, Epidemiology and Public Health
RSPCMT	Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health
RSPCPT	Republican Scientific and Practical Centre for Pulmonology and Tuberculosis
SSF	Single Stream of Funding
STI	Sexually Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
TPSAF	Transition Preparedness and Sustainability Assessment Framework
TRIPS	Agreement on Trade Related Aspects of Intellectual Property Rights
UMIC	Upper-middle income country

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAIDS	United States Agency for International Development
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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EXECUTIVE SUMMARY

Transition Risk Assessment Rationale And Methodology

The Belarus country case study was undertaken in the frame of a research project entitled "Transition from the Global Fund Support and Programmatic Sustainability Research in four CEE/CIS countries", which was commissioned by the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and implemented by Curatio International Foundation (CIF).

Since its foundation in 2002, the Global Fund has invested nearly US$4 billion a year to support programmes addressing these diseases in over 140 countries. Currently the Global Fund measures a country's eligibility for funding in each disease by assessing their disease burden and income. Changes in how the Global Fund allocates resources to recipient countries have important consequences in how countries will continue to conduct previously donor-funded activities. This is particularly relevant for the Commonwealth of Independent States (CIS) and the Central and Eastern European (CEE) region, which are still burdened by fast-growing HIV/AIDS and TB epidemics. Unless the transition from Global Fund support is well planned and effectively implemented, the sustainability of HIV and TB programs in these countries is at risk.

This case study is one among the four studies undertaken in Georgia, Belarus, Bulgaria and Ukraine with a purpose to pilot Transition Preparedness and Sustainability Assessment Framework (TPSAF) and generate prospective evidence to inform an adequate transition planning process from the Global Fund support. The research intends to understand the factors affecting sustainability and to identify the strategic and operational issues required to assure the sustainability of HIV and TB programmes in Belarus.

The TPSAF used in the case study was developed by this research project. The framework allows assessing country readiness for a scenario without Global Fund support by examining the elements that should be in place early on as a country prepares for transition.

For the purposes of this research project, the following definitions of transition and sustainability apply.

Transition is defined as *"the process of moving away from direct donor support by developing mechanisms to manage health programmes, practices or interventions in a sustainable manner through the interaction of internal and external enabling factors".*

Sustainability is defined as *"the capacity of a country to independently manage their disease-specific programmes in the long-term without interruption or compromising quality by developing a sense of ownership and enabled by an adequate internal and external national environment".*

The conceptual framework distinguishes two overarching domains. The external environment is the first domain, which includes political, social and economic environment sub-domains. The external environment includes factors that are outside of the health sector but have an impact on the health response, such as: a country's political and governance structure, economic and social environment, human rights, stigma and discrimination and an enabling environment for civil society.

The second domain is the internal environment, which represents those factors that are specific to the health sector, and has three main sub-domains: governance, inputs to the program and the program itself. All sub-domains are further divided into components that affect the transition and sustainability of public health programs after graduating from donor support. Collectively the components, sub-domains and domains included in the conceptual framework help to unpack the transition and sustainability related issues/areas and present the findings in a well-organized and logical manner.

Finally, by analyzing these external and internal environments, the framework allows to examine a country's readiness and/or identify the steps required to reach the intended outcome, which is

defined as successful transition from Global Fund support to program sustainability. Quantitative and qualitative indicators for each domain and its components were developed to respond to each component of the framework. These indicators have been used to assess possible risk to transition by assigning a range of low risk, moderate risk and high risk and a final score for assessing country risk for the transition.

The assessment utilized mixed methods of data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders from the government or directly working with Global Fund grants, and were identified based on their relationship with the grants as well as through the snow-ball technique, in which interviewees nominate other potential interviewees. The interviewees included government officials, donor representatives, staff from international organizations and civil society members and members of affected communities.

The quantitative and qualitative data arising from case study were triangulated using documentation, conceptualization, coding, and categorizing in line with the conceptual framework domains, sub-domains and components, which allowed us to examine relationships between them and led to major findings that eventually informed the recommendations.

Transition Risk Assessment

Findings presented below are from this country case study and, separately, some general findings, which resonate and align with the results of other studies[1] and lead to more general conclusions from those that are purely country specific. Consequently, the two sets of conclusions are detailed in separate sections. Consequently, the two sets of conclusions are detailed in separate sections. Sustainability Risk Assessment (Table 1 on page 8) summarizes the assessment of Belarus's readiness for transition from GF support, and singles out programme level bottleneck that may impede transition. A summary score of transition risk (42%) indicates that that Belarus is exposed to **medium** transition risk. The scores for each individual domain help identify critical areas that may pose medium to high risk and requires to be addressed during the transition process.

EXTERNAL ENVIRONMENT

Economic development. The Government of Belarus strives to ensure continued and sustainable economic growth. Since 2010 GDP per capita has grown steadily and the share of general Government revenues (excluding grants) to GDP is higher than in upper middle-income countries, posing low risk to transition and sustainability of the Global Fund supported programs.

Political commitment. Despite the economic challenges, stable high share of Government spending on health (around 13%) out of General Government Expenditure along with the relatively high share of Government spending out of total health spending confirm the Government's commitment towards the health sector. If this trend is maintained in the challenging economic environment, there are promising prospects for an easy transition from the Global Fund-supported programs. Nevertheless, unfavorable legal environment hinder effective prevention, treatment, care and support for KP and people living with diseases posing a high risk for transition.

INTERNAL ENVIRONMENT

Financing. The availability of a dedicated budget line for HIV and TB program integrated into the three-year financial plan updated annually and approved by the Government is encouraging. The Public expenditure on HIV program has been increasing since 2012 and the large share (71%) of the national HIV program is funded through the Government budget, although prevention and treatment support and care-related activities remain mostly financed through external resources.

[1] Gotsadze T., Fuenzalida H., et al. Thematic Review on Transition and Sustainability of Global Fund Supported Programs. Curatio International Foundation, 2015 (non published)

The results of the allocative efficiency study of the HIV program have not yet taken into account in the budget planning for national HIV response.

The financing of the TB program is challenging with a 50% gap in the program's funding. Total TB program shows declining trend. Along with decreasing Global Fund support the share of public funding is maintained at only 55%. TB diagnosis, treatment and treatment adherence is largely externally funded.

In summary, the share of program costs Belarus has to take over when the Global Fund support ends for HIV and TB programs remains high. Countries where programs are predominantly government-funded (>95%) found it much easier to assume financial responsibilities at the end of external funding[2]. Therefore, the current level of HIV and TB program financing in Belarus poses a high risk for transition. In order to achieve a positive public health impact with possible financial limitations, the country has to ensure effective coverage of key populations by improving the allocative and technical efficiency of prevention, treatment and care services.

Human Resources: Severe shortages of specialists, geographical imbalances, high turnover and lack of motivation are common features of the Belarusian health care system. The aging of the health workforce, which is most severe in the TB sector, coupled with low salaries of TB medical staff and hazardous work environment, which deter young people from working in the TB field, raises serious concerns. Global Fund-supported trainings for health personnel are not institutionalized into the national education system and the policy for continuous CSO personnel development exists but is rather weak. The availability of well-trained and appropriately distributed human resources is crucial for the programme success. This is even more crucial in a transition scenario due to the importance of continuing care for patients with TB and HIV given the risk for drug resistance[3]. The health workforce system weaknesses described above, puts the transition of HIV and TB programs after the Global Fund support at a medium risk if not addressed accordingly and in a timely manner.

Information Systems. The HIV and TB M&E system is integrated into the national reporting systems, but there is still a room for improvement. The surveillance of the HIV epidemic lacks important indicators and is not adequately analyzed to inform policy makers on priorities within the national HIV program. The 2nd generation surveillance capacity was built with the support of the Global Fund, but remains externally funded. The NTP uses the standardized recording and reporting system, which has been upgraded to accommodate the latest WHO recommendations and additional country needs. Maintaining effective operations of the M&E system after the external funding ends is at a medium risks of sustainability, particularly if the government fails to further enhance its surveillance system, to track program expenditures regularly, to build adequate analytical capacity at national and local levels and to carry out research that informs future policy development and program implementation. Developing and enforcing accountability mechanisms to ensure commitments remain key drivers for sustainability. This requires communicating performance results through the public domain, including reporting expenditure data and targeted activities for key populations. Moreover, most efforts to hold actors accountable are conducted by civil society organizations; therefore, it is crucial to create an enabling environment for civil society organizations to operate[4].

Governance. The Government remains committed to continue the HIV and TB national programs. New national programs are developed and are awaiting the government's approval. The programs' management vary. In the case of HIV, the national management for prevention and treatment is fragmented which limits a coordinated and harmonized prevention and treatment services,

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[2] Gotsadze T., Fuenzalida H., et al. Thematic Review on Transition and Sustainability of Global Fund Supported Programs. Curatio International Foundation, 2015 (non published)

[3] Building Resilient and Sustainable Systems for Health: the Role of the Global Fund, The Global Fund, 2015.

[4] Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio International Foundation, 2015 (non published).

whereas the TB program management is more aligned under the RSPCPT. The Country Coordination Mechanism is well placed within the government and operates effectively, however authorities lacks the vision whether CCM will be maintained after the closure of the HIV and TB grants. There is an evident need to improved the transparency of program -elated financial and performance data. Streamlining the national program governance along with strong coordination function and easy access to program performance information[5] will minimize challenges during transition.

Program. The government's willingness to sustain an effective national response towards HIV and TB epidemic is encouraging. However, in order to achieve a positive public health impact with possible financial limitations, the country has to ensure an effective coverage of key populations by improving allocative and technical efficiency of prevention, treatment and care services. Advancing technical efficiency should be addressed by reinforcing prevention activities, rightsizing of service providers, building linkages between the health sector and non-governmental and social service providers, streamlining patient pathways among TB and HIV service providers and enhancing of follow-up and social support for improved treatment outcomes. Taken together, these measures will mitigate the potential challenges Belarus will face after transition from the Global Fund support.

Organizational Capacity. There are several prerequisites for easy transition and attaining the desired public gains. They are: enhancing the coordination between PR and national program management entities and strengthening the organizational capacity of national program implementers and service providers[6], streamlining of procurement functions to allow the procurement of HIV and TB drugs and commodities at a lower price[7], enhancing M&E and evidence based program planning and implementation are prerequisites for easy transition and attainment of desired public gains.

Overall transition readiness. The assessment of the transition readiness of HIV and TB programs revealed that Belarus faces a medium risk after the Global Fund support ends. An early transition planning addressing the riskiest areas of the HIV and TB programs and systems as well as its effective implementation will allow the country to experience a painless transition and the sustainability of national programs. Given that the first steps initiated by the government for transition planning are commendable and should be seen as a demonstration of government's willingness to sustain an effective national HIV and TB response, it is believed, that a more comprehensive transition plan, outlining detailed steps to be undertaken in each key area of the national HIV and TB programs, would serve as a road map for a smooth and painless transition.

GENERAL RECOMMENDATIONS

Based on the findings of the transition and sustainability assessment discussed in previous chapters, this section provides bold recommendations that can guide the Government and key stakeholders towards an easy transition after external funding ends.

Transition plan. While country is discussing and actively working on the elements of the transition, there is no overall plan governing this process. Adequate conceptualization of and careful planning for the transition would most likely be of benefit.. Other country experiences prove that planned transitions reduce/minimize transition challenges, while rushed transitions cause more problems and undermine sustainability[8]. Therefore, developing time-bound and actionable plans, which have sufficient legal power and adequate indicators to monitor the plan

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[5] Transparency and streamlined accountability: what watchdogs, grant implementers and OIG want, Aidspan, 2015 http://www.aidspan.org/node/3354.

[6] Gotsadze T., Fuenzalida H., et al. Thematic Review on Transition and Sustainability of Global Fund Supported Programs. Curatio International Foundation, 2015 (non published)

[7] Building Resilient and Sustainable Systems for Health: the Role of the Global Fund, The Global Fund, 2015.

[8] Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of global fund supported programs. Curatio International Foundation, 2015

implementation, seem to be necessary first steps for the country to consider. Finally, effective implementation of the plan would also require sufficient resources (human and financial) to achieve transition objectives.

Gradually reducing financial dependence on the Global Fund. Experiences prove that the transition process become smoother and odds for sustainability increases, when the Global Fund's contribution to the national response is not significant, e.g less than 25%[9]. Consequently, the country has to strive to gradually reduce its dependence. The first and most important area for transition to consider is commodity procurement, so that national procurement mechanisms function adequately and allow for such a transition. The most challenging area seems to be transition of preventive interventions, especially those delivered by the NGOs/CSOs, which could be left for the latter phases, provided that sufficient preparatory work is done during the lead-up time to transition date (see CSO contracting for more details).

Many countries give lower priority to prevention compared to treatment. In many instances, the lack of national budget allocation (even with small amounts) has challenged transition and undermined sustainability prospects[10]. While prevention could be last element to be transitioned, it seems important to start developing prevention budget lines/allocations during the transition process, which may eventually drive increased budget allocations when the country stops receiving Global Fund support. in other countries, legally empowered national programs that already reflect a gradual reduction in donor dependence in their budget have often served as an effective instrument in other countries[11].

CSO contracts. The overall legal environment is not conducive for NGO/CSO contracting and the country lacks detailed contracting procedures for CSO contracting in the health sector. Belarus would benefit significantly if these rules/procedures were developed during transition and institutionalized.

A similar situation was observed in the countries that graduated from the Global Fund without having such rules in place and facing transition challenges[12]. Based on other country experiences, such detailed contracting rules/procedures are at least expected to address at least the following: service definition, service pricing and/or methodology to estimate quoted prices, which on one hand helps evaluate the value for money for the submitted bids during tendering/national procurement process and on the other, and most importantly, helps the government to estimate overall program costs for a given disease and adequately budget during the budgeting process; tendering procedures that are aligned with the national procurement laws and regulations; bid evaluation procedures for both quality and value of the bid; procedures for monitoring quality and/or volume of services delivered by CSOs, etc.

Effective national coordination, with or without the CCM as a coordinating body, is essential for effective management of the national response and for implementing the transition process, which leads to sustainability. One of the greatest benefits that the Global Fund has delivered worldwide is creating the space for governments and civil society to jointly engage in the national/global response planning and coordination[13],[14],[15]. In most states CCMs, or similar structures, that formally provide a seat and voice for NGOs/CSOs in the national coordination, have been critical in achieving

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[9] Ibid 8
[10] Ibid 8
[11] Ibid 8
[12] Ibid 8
[13] Spicer N., AleshkinaJ., et al. National and subnational HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice? Globalization and Health 2010, 6:3.
[14] Kapilashramia A., O'Brien O. 2012. The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit? Global Public Health: An International Journal for Research, Policy and Practice Volume 7, Issue 5, 2012.
[15] Duvvury N., Cornman H., Long C. 2005. Participation of Civil Society in Global Governance: Lessons Learned from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. www.icrw.org .

the gains observed globally. Consequently, retaining and/or enhancing effective coordination structures proved to be important in many countries after the Global Fund support[16]. Therefore, it seems important for the country to consider retaining and enhancing the national coordination structure/function, which would allow for continuous NGO/CSO engagement. For such coordination to be effective the production, availability, transparency and easy access to information should be ensured for the development of an evidence-based (or informed) responses.

Enhancing public accountability during and after transition will be critical to assure quality partner engagement e.g NGOs, SCOs, journalists and development partners. This would require the routine production of information describing results of the national response e.g. disease program specific epidemiological and financial expenditure data; the results of program performance, including outcomes and challenges. During transition, the country (perhaps with the Global Fund support) should strive to assure (maybe contractually and/or through legislative action) that this information is not only routinely produced but is also freely accessible for all stakeholders involved, government and civil society alike.

Addressing human resource challenges should be viewed in two parts: a) assuring adequate quantity and re-distribution of the needed human resources and b) continuous education of the professionals involved in the national response – service provision. The latter has been extensively supported by the Global Fund grants, and not only in this country[17]. However, the sustainability of these trainings raise concerns due to the lack of institutionalization achieved during the grant implementation[18]. Consequently, the transition period has to be explicit about what could be achieved, in terms of preparing the necessary human resources and how this function can be institutionalized and eventually funded and delivered by the government. The question of human resources goes well beyond the disease response and results from health sector policies, education policies and the overall socio-economic environment in the country. It also affects the whole health care system of the country. Instead of addressing these challenges as a transition issue, therefore, it is necessary to look at these challenges more holistically and outside of the transition process.

Disease Specific Recommendations

Recommendation # 1: Enhancement of Stewardship and Governance of National Programs

- Ensure the integration of HIV and TB program management, unless MOH envisions different organizational/management arrangements.
- Streamline the legislation - Advocate for the reform of current legislation to decrease stigma and discrimination towards HIV/AIDS and TB; promote enforcement and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support; Revise the state social assistance and benefits legislation by safeguarding the inclusion of PLHIV and TB patients in the eligibility categories; Enforce the policy on collaborative HIV/TB activities, and the collaboration between ministries of Internal Affairs and Health; Reduce the price of government-procured drugs, consider centralizing the ARV drug procurement, or introduce a framework contracting mechanism allowing the decentralized procurement at pre-defined prices. This will allow the government to decrease financial burden of drug procurement after the end of the Global Fund support; Establish fast-track registration with reduced or waived registration fees for WHO-prequalified products.
- Revise guidelines - Develop HIV/TB service collaboration guidelines and enforce compliance; Optimize ARV treatment regimens and develop referral algorithms ensuring continuation of HIV services from identification and prevention to treatment, care and

[16] Ibid 8
[17] Bowser.D., Sparkes.SP., et al. 2013. Global Fund investments in human resources for health: innovation and missed opportunities for health systems strengthening. Health Policy and Planning 2013;1–12.
[18] Ibid 8

support; Improve the effectiveness of TB prevention, diagnostic and treatment services by revising and enforcing protocols ensuring the decrease of in-patient stay and increased responsibility of PHC for treatment and Develop HIV/TB service collaboration guidelines and enforce compliance.

Recommendation # 2: Ensure improved efficiency of current spending, adequate resource allocation for HIV and TB National Program implementation and mobilize domestic and international funding for effective implementation and monitoring of the transition plan.

- Streamline Budgeting process- Prepare budget forecasts and ensure allocations based on technical and allocative efficiency principles. Ensure medium term budgeting of adequate resources for continuation of the HIV prevention, treatment and care activities after the GF funding ends; Ensure medium term budgeting for increased allocation of resources for TB national program that can compensate GF funded share and gradually fill in 50% the programmatic gap as well as ensure adequate funding of TB program from local Government budgets; Carry out detailed analysis of both national programs to determine in which areas technical efficiencies could be realized and consider improvement of allocative and technical efficiency according to the recommendations provided by the WHO; Develop/revise and utilize costing methodology of HIV preventive interventions for budget planning
- Leverage adequate resources for transition plan implementation - Calculate non-programmatic costs of the transition plan implementation and leverage domestic and external resources for its effective implementation and M&E

Recommendation # 3: Streamline service delivery

- Remove access barriers to HIV testing and treatment by strengthening the cooperation between governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services, by improving timely and complete diagnosis, prompt prescription of correct treatment and good adherence to ART; Enhance pre and post test counseling of KPs.
- Improve efficiency of TB treatment by removing duplication of laboratory testing and annual clinical check-ups after the patient is cured; Streamline sputum transportation system.
- Improve TB/HIV testing and treatment.

Recommendation # 4: Ensure adequate supply of human resources and integration of HIV and TB training modules into the continuous medical education system

- Develop HIV/AIDS and TB human resource planning and development strategy.
- Ensure the integration of the HIV and TB training modules into the continuous education systems
- Initiate the integration of the HIV training modules into the undergraduate and postgraduate education systems
- Elaborate a strategy for the training of NGOs

Recommendation # 5: Streamline forecasting, procurement and supply management system

- Develop ARV and TB drug forecasting methodologies and enhance the capacity of respective staff at national, local and facility levels.
- Enforce compliance with drug re-registration procedures.
- Streamline logistics system for timely distribution of commodities procured through GF and public sources.

Recommendation #6: Enhance surveillance systems and build data analysis capacity at national and local levels

- Enhance the HIV surveillance system by introducing WHO recommended indicators.

- Enhance tracking of HIV and TB spending through National Health Accounts and use of data for evidence based planning.
- Provide training in surveillance and M&E data analysis at national, local, and facility levels to ensure evidence based planning and implementation.

Table 1: Summary Risk Assessment Table

H – HIV/AIDS; T- Tuberculosis; B – Both diseases

Component	Disease	Indicator	Risks
External Environment			
Political	B	Existence of political will to prioritize health investments	Stable high Government spending on health, around 13%) out of General Government Expenditure Stable high Government spending out of THE until 2012, a decline was noted in 2013 although remains high (65%)
	B	Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for KP and people living with diseases and strong rule of law	There are legal barriers that hinder effective prevention, treatment, care and support for KP and people living with diseases.
	B	Government ability to contract with CSOs	General regulation allowing CSO contracting is largely absent. Public institutions have no legal right to contract CSOs Detailed rules and procedures for contracting SCO for health service provision DO NOT exist. There are only a few non-governmental NGOs such as Red Cross, and sport associations which receive direct subsidies from the state budget
Economic	B	Favorable economic indicators	GDP per capita growth (annual %) is observed since 2010. Share of General Government Revenues (excluding grants) as % of GDP is more than UMIC mean (30.0) in 2012 year
Internal Environment			
Financing	H	Budgetary commitment to disease	Public expenditure on HIV program has been increasing since 2012. Share of public funding is 71% of total AIDS spending in 2013. There is dedicated budget line for the program integrated in the three year financial plan
	T		Public Expenditure on TB program is decreasing. TB budget is deficient (50% funding gap). Share of public spending on TB is stable and accounts for 55% 2012-2013. There is dedicated budget line for the program integrated in the three year financial plan
	H	Prevention priority	Total public spending on HIV prevention is not increasing. Preventive programs for KP are primarily financed from external sources.
	H	Allocative efficiency	Allocative efficiency study was conducted but has not yet informed budget allocations
	H	Treatment / input financing from public sources	- Case detection/diagnosis mostly financed from TGF - First line ART partially funded by public sources. Second line ART are mostly funded by external sources - Adherence support fully funded from external sources
	T	Treatment / input financing from public sources	- Case detection mostly funded from public sources - FLD funded from public sources, SLDs mostly funded from external sources - Adherence support completely TGF dependent
	H	Prevention financing from public sources	Low Threshold Services (excluding OST) are no funded from public sources, OST mostly financed from TGF grant
Human Resources	H	Sufficient human resources for a disease (quantities, geographic distribution and aging)	Severe shortage of specialists, geographical misbalance, high turnover and lack of motivation are common
	T		With some limitations. Relatively adequate although only 78% of positions are filled. Aging of staff raises serious concerns; low salaries of TB medical staff and hazardous work environment demotivate young people from working in the TB field.
	B	Sufficient human resources for a disease (quantities, geographic distribution and aging)	GF-supported training for health personnel is not institutionalized into the national education system. Policies for CSO personnel development exist but are rather weak. Salaries to the public servants are not covered by the grant except for short term TA
Health Information System	H	Advanced routine statistical reporting fully integrated in the national system	HIV testing, PMTCT, AIDS related mortality, adult and pediatric treatment -partially advanced
	T		TB New and relapse cases, treatment registry, Pediatric treatment- MDR TB, Care and support (including pediatric) – integrated, partially advanced
	H	HIV Second generation surveillance	Rigorous methodology used for IBBS. IBBS Implemented timely (according to NSP); IBBS NOT funded by public sources; PSE NOT funded from public sources
Governance	H		Belarus has government approved NSP for HIV/AIDS covering

		Strong political commitment to diseases	period 2014-2015; New NSP submitted for government's approval; HIV/AIDS NOT prioritized in National Health Strategy Document
	T		Belarus has government approved NTP covering period 2010-2014 and the Action Plan for 2014-2015. New NTP submitted for government's approval. TB is NOT prioritized in National Health Strategy Document
	H	Strong leadership	There is no unit fully responsible for National HIV/AIDS Program. Management of curative and preventive fields is fragmented. Entities responsible for curative and preventive fields are well functioning. Individual leadership is visible
	T		The NTP has a single organizational leader coordinating all types of TB activities in the country. Individual leadership is visible
		Strong coordination mechanisms	The Coordination body is well placed within the government hierarchy to assure adequate national coordination and coordination across different sectors; CSOs have legally determined seat on the national coordination and play significant role. Coordination body functions effectively.
Accountability	B	Program performance results are available and accessible through public domain	Program performance data is publicly available, except Program expenditure data especially for TB.
	B	Enabling Environment for Civil Society engagement [19]	Belarus's EEI for 2013 was 0.41 indicating that there are no laws or policies that restrict civil society playing an oversight role,. In practice civil society is not actively engaged in providing oversight as it is not accepted by the Government
Program			
Service Delivery	H	Treatment	There are increasing numbers PLHIV on ART but rather low coverage. There are gaps from testing to treatment and care cascade. Treatment-adherence outcomes are improving.
	T		Treatment success rates of the new TB cases worsened The percentage of effective treatment of MDR TB cases that started treatment in 2011 and 2012, is only 50.4%
	B	Integrated services	PMTCT is well integrated in maternity care, while TB services still remain as vertical system with limited or no integration into PHC. TB/HIV services are not integrated, but integration with OST services is emerging.
	H	KP reach with preventive services	Coverage of KP with preventive services is increasing but still remains low; Data is based on rigorous IBBS methodology
	B	CSO contracting	Detailed rules and procedures for contracting SCO for health service provision DO NOT exist. There are only few non-governmental NGOs such as Red Cross, and sport's associations which receive direct subsidies from the state budget
Organizational capacity	H	Strong management of the National Disease Program Management Entity (not PR)	Due to the absence of an entity responsible for overall management of HIV/AIDS program its capacity assessment has not been conducted. Relationship between PR and national disease management entity not defined at present due to the absence of such entity. PR manages only GF funding.
	T		Capacity assessment of the National Disease Management entity (Republican Scientific and Practical Centre for Pulmonology and Tuberculosis) is NOT conducted, and staff appraisal is not a regular practice. Although the Entity has sound working relationship with the PR there

[19] http://civicus.org/eei/

			are distinct public agencies.
	B	PSM	TGF-funded procurement is NOT integrated into the national system. Supply chain management is integrated into the national system. NO emergency procurements. Rare stock outs for drugs (not more than once for last year) – mostly due to the weak forecasting National procurement – PAYING MORE than 5% above the international benchmark price
	B	M&E	M&E capacity at government institutions is weak. Although there a lot of analytical reports, they are largely produced by donors and non state actors. The epidemiological data is available and used in NSP/NTP, although M&E data are not always used for program planning and budgeting.
Transition preparedness	H	Transition plan / elements	Legally binding and actionable transition plan does not exist. Plan that includes transition of few elements of the program developed but not yet approved by the government. Transition elements (financial responsibilities) are embedded into the NSP
	T		Legally binding and actionable transition plan does not exist. Plan that includes transition of few components of the program developed but not yet approved by the government. Transition elements (financial responsibilities) are embedded into the NTP
	B	Transition plan characteristics	No
	B	Transition M&E	No
		OVERALL RISK RATING	Medium risk

1. CHAPTER: PURPOSE AND METHODOLOGY

1.1. Purpose

The Belarus country case study was undertaken in the frame of a research project - "Transition from the Global Fund Support and Programmatic Sustainability Research in four CEE/CIS countries", which was commissioned by the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and implemented by Curatio International Foundation (CIF).

Since its foundation in 2002, the Global Fund has invested nearly US$4 billion a year to support programs addressing these diseases in over 140 countries. Currently the Global Fund measures a country's eligibility for funding in each disease by assessing their disease burden and income.

Changes in how the Global Fund allocates resources to recipient countries have important consequences in how countries will continue to conduct previously donor-funded activities. This is particularly relevant for the Commonwealth of Independent States (CIS) and the Central and Eastern European (CEE) region, which are still burdened by fast-growing HIV/AIDS and TB epidemics. Unless the transition from the Global Fund support is well planned and effectively implemented, the sustainability of HIV and TB programs in these countries is at a risk.

Current research seeks to generate prospective evidence to inform adequate transition planning process from the Global Fund support. The research intends to understand the factors affecting sustainability and to identify strategic and operational issues to assure the sustainability of HIV and TB programs.

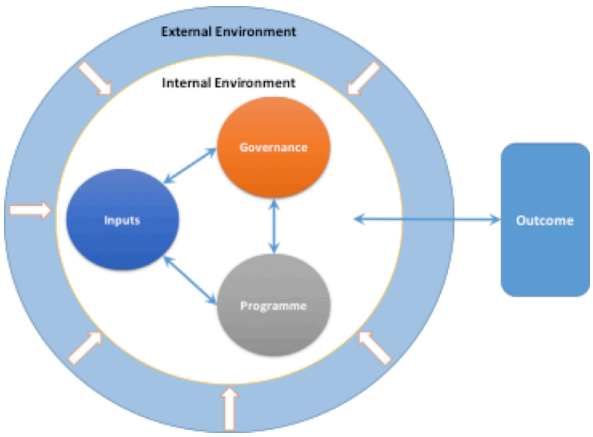
1.2. Methodology

For the purposes of this research project, the following definitions of transition and sustainability apply.

Transition is defined as *"the process of moving away from direct donor support by developing mechanisms to manage health programs, practices or interventions in a sustainable manner through the interaction of internal and external enabling factors".*

Sustainability is defined as *"the capacity of a country to independently manage their disease-specific programs in the long-term without interruption or compromising quality by developing a sense of ownership and enabled by an adequate internal and external national environment".*

Figure 1: Transition Assessment Framework

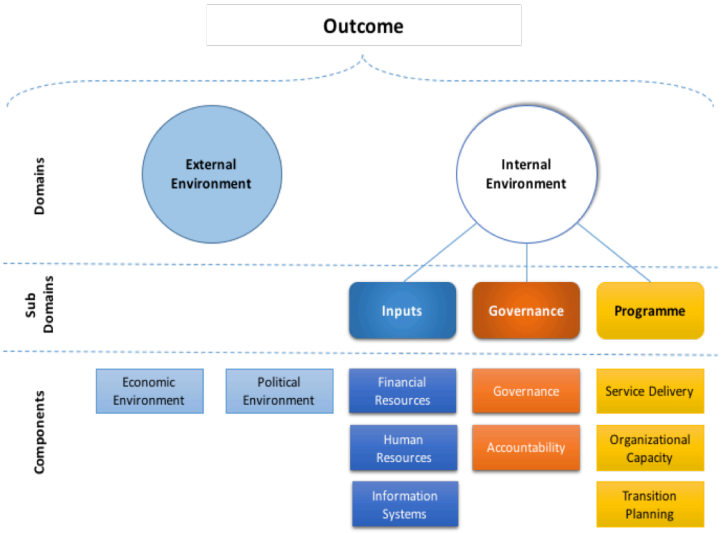


Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. (2015). The road to sustainability: Assessing transition preparedness for a post-Global Fund context. Tbilisi, Georgia: Curatio International Foundation.

The conceptual framework distinguishes two overarching domains (Figure 1). The external environment is the first domain, which includes political, social and economic environment sub-domains. The external environment includes factors that are outside of the health sector but have an impact on the health response, such as: a country's political and governance structure, economic and social environment, human rights, stigma and discrimination, and an enabling environment for a civil society.

The second domain is the internal environment, which represents those factors that are specific to the health sector, and has three main sub-domains: governance, inputs to the program and program itself.

Figure 2: Transition and sustainability assessment components



Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. Gotsadze, T et all (2015). The road to sustainability: Transition Preparedness Assessment Framework. Tbilisi, Georgia: Curatio International Foundation

All sub-domains are further divided into components that affect transition and sustainability of the public health programs after graduating from a donor support (Figure 2). Collectively these components, sub-domains and domains included in the conceptual framework, help to unpack the transition and sustainability related issues/areas and present the findings in a well-organized and logical manner.

Finally, by analysing these external and internal environments, the framework allows us to examine a country's readiness and/or identify the steps required to reach the intended outcome, which is defined as successful transition from Global Fund support to program sustainability.

Table 2: Illustration of the Transition and Sustainability risk assessment framework

Each framework component was operationalized into indicators for each domain and its components. Table 2 illustrates how this tool assesses country readiness for transition.

Program-level bottlenecks that should be addressed

Component	Disease	Indicators	Measurement	Low risk X criteria are met	Moderate risk X criteria are met	High risk X criteria are met	Component Assessment
External Environment							
Internal Environment							
Overall Country Risk Assessment							

General country assessment on readiness for transition

Quantitative and qualitative indicators were developed to respond to each component of the framework. These indicators have been used to assess possible risk to transition byassigning a range of low risk, moderate risk and high risk and a final score for assessing country risk for the transition.

The assessment utilized a mixed method of data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders from the Government or directly working with Global Fund grants, and were identified based on their relationship with these grants as well as through the snowball technique, in which interviewees nominate other potential interviewees. The interviewees included government officials, donor representatives, staff from international organizations, and civil society members, among others.

The quantitative and qualitative data arising from case study were triangulated using documentation, conceptualization, coding, and categorizing in line with the conceptual framework domains, sub-domains and components, which allowed us to examine relationships between them and led to major findings that eventually informed the recommendations.

The research was conducted in four countries CEE/CIS countries Belarus, Bulgaria, Georgia and Ukraine. Country case study findings are collated in a synthesis report that will serve as input to the development of a Global Fund Strategy on Transition and Sustainability and will feed in to the new Global Fund Strategy.

2. CHAPTER: EXTERNAL ENVIRONMENT

2.1. Country Background and Political System

The Republic of Belarus is situated in Eastern Europe and has a population of 9.4 million people (2014), with 75% of inhabitants living in urban area. The country is administratively divided in six regions called "oblasts" (Minsk, Gomel, Grodno, Mogilev, Minsk and Vitebsk), and the city of Minsk as a separate administrative entity. The latter accounts to one-fifth of the country's population. The regions are divided into 121 districts called "rayons", with a population varying between 12,000 to 120,000. Each district has a district council and an administration.

The Republic of Belarus became independent in 1991. The constitution originally adopted in March 1994 was amended through a referendum in November 1996 to expand presidential powers and set up a bicameral parliament - the National Assembly. The last national parliamentary elections were held on September 23, 2012 and the last presidential ballot tok place on December 19, 2010 when the incumbent president, Aleksander Lukashenko, was elected to the third consecutive term. The next parliamentary elections are due in 2016, and the presidential vote is to be held in November 2015.

2.2. Economic Development

The Government of Belarus strives to ensure continued and sustainable economic growth that would promote higher living standards and assistance to the most vulnerable groups[20]. To this end, the Government plans to solve a challenging task of modernising and liberalising the national economy and optimising the country's governance system. The state directly controls most of the country's economy, although private business, including foreign-owned, is expanding progressively. The World Bank ranked Belarus as an upper-middle income country (UMIC) with the Gross National Income (GNI) of US$ 6,730 per capita in 2013.

Table 3: Key Indicators

	2000	2002	2004	2006	2008	2009	2010	2011	2012	2013	2014
Inflation, consumer prices (annual %)	168.6	42.5	18.1	7.0	14.8	12.9	7.7	53.2	59.2	18.3	18.1
GDP per capita (current US$) '000	1,3	1,5	2,4	3,8	6,4	5,2	5,8	6,3	6,7	7,7	8,0
GDP per capita, PPP (constant 2011 international $) '000	7,3	8,1	9,9	12,0	14,5	14,5	15,7	16,6	16,9	17,0	17,3
GDP per capita growth (annual %)	6.1	5.7	12.2	10.7	10.6	0.4	7.9	5.7	1.8	0.9	
GINI index (World Bank estimate)	27.7	30.1	26.3	28.2	27.2	27.7	27.7	26.5			
Revenue, excluding grants (% of GDP)	28.7	26.6	31.4	37.2	38.9	35.3	31.4	29.0	30.0		
GNI per capita growth (annual %)	6.1	5.9	12.2	10.0	10.0	-0.6	8.1	6.8	0.0	-1.1	2.4

[20] United Nations Development Assistance Framework (UNDAF) for the Republic of Belarus for 2011-2015

	2000	2002	2004	2006	2008	2009	2010	2011	2012	2013	2014
GNI per capita, Atlas method (current US$) '000	1,4	1,4	2,2	3,5	5,5	5,6	6,0	6,1	6,4	6,8	7,3
GNI per capita, PPP (current int. US$, 2011) '000	5,8	6,7	8,5	11,0	13,7	13,8	15,1	16,4	16,8	16,9	17,6

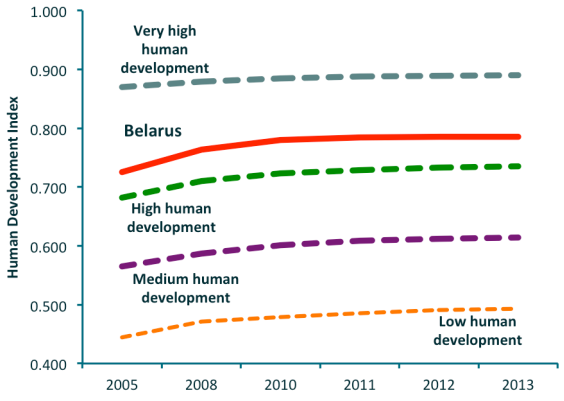
Source: The World Bank Data Base, accessed 30/07/ 2015

Until 2008, the Belarusian economy demonstrated strong growth, but it substantially slowed down in the context of the global economic crisis. Since then the country underwent a period of recurring macroeconomic instability[21]. During 2000-2008, Belarus's GDP grew on average by 8.3% annually (Table 3). Rapid economic growth was driven by a combination of favorable external factors, including strong export demand by key trading partners (the CIS, especially by Russia), underpriced energy imports from Russia, and large trade gains from exporting goods. However, the pace slowed down substantially after the global economic and financial crisis in 2008-2009 and led to lower export demand and reduced access to external borrowing. Growth dropped to 0.2% in 2009. Initial stabilisation gains achieved in 2009 were reversed by expansionary fiscal and monetary policies, including a fast credit expansion under Government-directed lending programs that fuelled a rapid, but short-lived economic recovery in 2010. This improvement came at the expense of a further deterioration of the current account deficit to 15% of GDP in 2010, and heightened pressure on the exchange rate and foreign exchange reserves. After a period of multiple exchanges rates, the Belarusian ruble (BYR) lost close to 70% of its value relative to the US$ and inflation soared to 109% in 2011[22].

As of early 2013, initial macroeconomic stability has been restored. Tight monetary and fiscal policy in late 2011 and through 2012 helped to contain inflation to less than 22% in 2012. The nominal exchange rate stabilised and appreciated modestly in 2012. While the devaluation boosted non-energy net exports in 2011, significant terms of trade gains related to a new favorable energy trade agreement with Russia helped to improve the energy trade balance in 2012. The trade deficit improved from 13.3% of GDP in 2010 to 3% in 2011, and moved into a surplus of 4.6% of GDP in 2012. This in turn eased pressure on the current account, which improved from a deficit of 9.4% by the end of 2011 and to a deficit of less than 3% of GDP in 2012[23].

2.3. Social and Human Development

Figure 3: Human Development Index trend 2005-2013



Belarus ranks high in the Human Development Index **(HDI)** published by UNDP (Figure 3) and it features in the group of countries with high human development, while with regards to life expectancy it falls into the group of countries with medium human development. The country moved from 65th position out of 187 countries several years ago to 53rd position in 2013, thanks largely to the achievements in education[24].

The population of Belarus is declining and ageing. Since 2000 Belarus has experienced a gradual population decline from 10.1 million to 9.5 million in 2012 (Table 4). The decreasing death

[21] Belarus Overview, 2015, World Bank http://www.worldbank.org
[22] Ibid 2.
[23] Ibid 2.
[24] The World Bank Country Strategy

rate and positive migration rate recorded in this period was not enough to reverse the decreasing trend of. The low fertility rate is one of the main factors. Despite a positive increase in recent years, the rate remains below 2.1-children per reproductive age women – e.g. natural replacement threshold.

Table 4: Key Demographic Indicators

	2000	2002	2004	2006	2008	2009	2010	2011	2012	2013	2014
Population, total (million)	10,0	9,9	9,7	9,6	9,5	9,5	9,5	9,5	9,5	9,5	9,5
Population growth (annual %)	-0.3	-0.6	-0.7	-0.6	-0.3	-0.2	-0.2	-0.2	-0.1	0.0	0.0
Life expectancy at birth, total (years)	68.9	68.1	69.0	69.4	70.5	70.4	70.4	70.6	72.0	72.5	

Life expectancy at birth in Belarus is rather low for its level of economic and human development[25] (Table 4). The number of aged people in pension age[26] is stable[27], but the number of people in pre-pension age (40–54 for women and 40–59 for men) grew by 25.8% over the past decade. Taking into account the current burden of pension and health expenditures, aging is becoming an important challenge for Belarus' long-term development[28].

2.4. Other External Factors

Economic activity is likely to contract in coming years due to weak external demand[29]. The war in Ukraine and the economic downturn resulting from the economic sanctions to Russia by Western countries already Belarus economy. After a 1.6% growth in 2014, in January-March 2015real GDP fell by 2 percent year-on-year . On the production side, the decline was driven by the 7.3% contraction of industrial output, after demand from traditional export markets (Ukraine, Russia) fell sharply. The drop more than offset increases in construction, agriculture, and retail trade. Production in all industrial sub-sectors shrank, except for the chemical, petrochemical, and pharmaceutical industry[30].

2.5. Brief Health System Overview

The state-owned Semashko model health system is a legacy from the Soviet Union and is the core of the current Belarus' health system. It ensures universal and free coverage and access to health care, through state-owned facilities, organized hierarchically on a territorial basis[31].

Regulation and governance of the health system remain highly centralized and controlled by ***the*** *Ministry of Health* ***(MOH)***[32], which sets the standards of care and norms for the provision of services. District and regional authorities implement policies and act on the centrally determined priorities within the constraints of their local budgets. Regional and district authorities can apply for more funding or lobby for different priorities to be applied in their area, either through the MOH or their elected representatives in the Government. However, there are no formal channels for seeking inputs from different stakeholders in the policy development and priority-setting process. Local governments work with local health care authorities to purchase services for their population.

[25] Belarus Human Development Report, 2013, UNDP
[26] Belarus did not change the pension age since the soviet times: 55 years for women and 60 years for men.
[27] Between 1989 and 2007, it increased only by 4.4%
[28] Social Protection and Social Inclusion in Belarus, European Commission, 2009
[29] Belarus Economic Update, April, 2015, World Bank http://www.worldbank.org
[30] The World Bank, http://data.worldbank.org/country/belarus
[31] Belarus, Health System in Transition, 2013, European Observatory for Health Systems and Policy, WHO http://www.euro.who.int
[32] Ibid 12.

The Government generously finances the health care system. The health sector is funded primarily by general taxation. Government funding is allocated per capita and per calendar year and it is defined in the Republican Annual Budget, which is then distributed among the oblasts according to their population. According to the latest WHO Health System financing country profile[33] in 2013, public expenditures on health constituted 4% of GDP, while share of health spending in the total government expenditure stood at 13% - both of which data are in line with Europe's upper and middle income countries. At the same time, based on the national income, in absolute terms, public health expenditure remained as low as PPP US$ 388 per capita in 2013 compared to the average in upper-middle income European countries (PPP US$ 564 per capita)[34]. A very small voluntary insurance sector also exists, which is funded by households or employers.

The main set of health care services is available for patients free of charge and there is no system of official co-payments. The bulk of out-of-pocket payments for the population go for purchasing outpatient drugs, except for sick with prevalent chronic conditions such as diabetes, asthma and a few others, including HIV and TB treatment[35].

Highly specialized tertiary care hospitals (including the Republican Scientific and Practical Centre for Pulmonology and TB - RSPCPT) are funded directly from the MOH budget. Hospital funding is estimated on the basis of utilisation of planned budgets and services. Hospitals have no incentive to save, because the would suffer financial consequences as their prospective budgets would be reduced. Primary and secondary services are funded from the oblast and rayon budgets. Tertiary care is cross-subsidised between oblasts when patients from one oblast receive care in another[36].

The health care system is organized in three levels[37]: 1) primary health care (feldsher ambulatory practices) and outpatient clinics (ambulatories) in rural areas, polyclinics in urban areas; 2) secondary care (hospitals and secondary-level polyclinics in oblast and rayon cities); 3) tertiary care (specialized hospitals). Feldshers, general practitioners, district internists and district pediatricians provide primary health care, who do not have a gatekeeping function. At this level the only performance-related indicators are linked to outputs (mass screening, vaccinations, etc.), neither to the outcome nor to the funding. Most health-care facilities are public property and funded by the Government. Some ministries, like the Ministry of Internal Affairs (MIA), and employers (like the railway's) run a parallel system of health-care services and are financed by the respective sectors. These providers are all in the public sector and are managed on a hierarchical basis according to an integrated "command-and-control"-type health system. Individual hospitals, polyclinics, outpatient clinics and FAPs have no real decision-making powers over the capital, staff, or payments, or the types of services offered. Decisions about investments and staff are taken by the regional or the district health care departments, staff level and payment are agreed centrally, and the types of services offered are determined according to norms and standards outlines by the relevant specialist branches in the MOH.

Like most CIS countries, Belarus was left with large overcapacities in the public sector after the demise of the Soviet Union[38]. With growing financial challenges in the health sector, Belarus has managed to reduce some of its overcapacity, moving from 8.3 to 6.8 hospitals and from 1,200 to 1,100 hospital beds per 100,000 population in the period 2000–2009. Still, the number of hospitals and beds remains about 50% higher than in other CIS countries and three times higher than in the European Union - 4.8 hospitals and 83 hospital beds in the CIS and 2.7 hospitals and 52 hospital beds in the European Union in 2009 -, leaving space for further consolidation[39].

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[33] http://apps.who.int/nha/database/CountryProfile/Index/en
[34] Ibid 12.
[35] Ibid 12.
[36] Ibid 12.
[37] Ibid 12.
[38] Ibid 12.
[39] Ibid 12.

Similarly, the sector is overstaffed. Belarus has maintained a large medical workforce since independence, even after adopting the internationally recognized definition of a "practicing doctor" in 2010. In 2011, the MOH employed 32 131 doctors (33.9 per 10 000 population), up from 29 575 (31.2 per 10 000 population) in 2010. The total number of doctors per capita is in line with the average in the EU countries[40]. In 2011 there were 74 064 nurses (78.2 per 10 000 population) and 4 737 midwives (5 per 10 000 population) active in the health-care system. This is considerably higher than in many other CIS countries[41]. However, human resources are unevenly distributed across the country, and there is a shortage in primary care in both rural and urban areas. There are also geographical inequalities in the distribution in rural areas generally, particularly in the regions that are close to the Chernobyl contaminated areas – the shortage of doctors is more pronounced in the Gomel and Mogilev regions. Around 3 000 doctors leave the statutory health system annually – of these around 800 retire, die, or have to leave for health reasons. Internal mobility concerns mainly the flow of more qualified staff from rural to urban areas and from the oblasts to the capital[42].

2.6. The Role of Civil Society Envolvement in Public Service Delivery

Pro-democratic, non-governmental organizations are small, marginalized, and with limited influence inside the country[43]. Civil society organizations (CSO) do not appear to be independent, as they are funded by governmental institutions and align their work with the state's. Therefore, they do not act in the name of protecting the public's interests, but often embody a mechanism for additional governmental control over the society. Their decision-making process does not follow democratic principles, but is designed to implement the state's will, rather than their own. A considerable number of organizations in Belarus do not just work closely with governmental agencies, but are incorporated into them, and depend almost entirely on the will of the political elite. As a result, the space originally meant to be an arena for civil society's activities is vastly incorporated into the state, creating a "hybrid state-public" sector. Financial dependence also plays an important role, although CSOs aspire to receive financial support from sources other than the state's.

The state cooperates willingly with Government-organized NGOs (GONGO), rather than with independent NGOs, for the easier control of their activities and financial flows[44]. Moreover, it allows the state to shift part of its own workload from governmental institutions onto its sponsored organizations and still be able to yield benefits from the work done. As the state is not always able to satisfy the needs of the GONGOs[45] it had created, international funds open up additional opportunities for such organizations. Most of GONGOs receive financial support from internationally-funded projects and programs, including the Global Fund-supported HIV and TB grants, thus there is no mechanism for NGO-contracting in the public sector.

> "In order to get the project registered at the Ministry of Econoy, it took us 3 years and lots of references from different government structures, institutions, parliamentarians".
>
> "Registration of projects/programs financed by international donors is a complicated process that often restricts donors themselves as well as NGOs to apply for".
>
> ***Quotes From Key Informant Interviews***

The number of organizations that solely deal with providing services and avoid the politicization of their activities is growing slowly. Establishing an NGO is a complicated process requiring references

[40] Ibid 12 page 59.
[41] Ibid 12 page 61.
[42] Ibid 12 page 64.
[43] A. Matchanka, "Substitution of Civil Society in Belarus: Government-Organised Non-Governmental Organisations", The Journal of Belarus Studies, 2013.
[44] Ibid 21.
[45] Trade unions, sports associations and Red Cross Society

from governmental institutions and/or representatives of the political elite. Furthermore, in order to use external funding for their operations, NGOs have to register their programs at the Ministry of Economy, which may take from 6 months to 3 years[46].

The country lacks the regulation and the mechanism to contract NGOs. Like most of the former Soviet countries, Belarus has not yet developed a formal mechanism allowing to contract NGOs and CSOs for the provision of publicly-financed services[47].

To support democracy, human rights, and rule of law in Belarus, USAID backs local NGOs to better serve the needs of the society[48]. USAID's support aims to increase the sustainability of local NGOs, enhance their advocacy efforts, promote the sustainable development of professional and local communities, and improve the quality of services delivered by NGOs to the communities and to the general public. Activities include organizational capacity development, specialized training for NGO management, mentoring and peer-to-peer collaboration, in addition to small grants. However, the project/program registration challenges imposed by the Ministry of Economy and described above create barriers to access the funding.

2.7. Human Rights, Stigma and Discrimination

The Constitution and the Criminal Code mainly guide human rights in Belarus. Article 22 of the Constitution[49] of the Republic of Belarus protects rights of all citizens and the Criminal Code prohibits any form of discrimination on the basis of gender, race, nationality, religious or political views, physical or mental disability.

Table 5: Legislations specifying protection for key populations and vulnerable groups [50]

Key Populations	Government	Civil Society
PLHIV	N	N
MSM	N	N
Migrants	N	N
Orphans and vulnerable children	Y	Y
People with disabilities	Y	Y
People who inject drugs	N	N
Prison inmates	N	N
Sex workers	N	N
Transgendered people	N	N
Women and girls	Y	Y
Young people	Y	Y

Source: Thematic report: Stigma and discrimination, 2010

Recent legislative decisions have undermined human rights and reinforced stigma and discrimination. The Government demonstrates limited efforts to enhance the focus of the country's legislation on protecting human rights, and avoiding stigma and discrimination (***The Constitution and the Criminal Code mainly guide human rights in Belarus***. Article 22 of the Constitution of the Republic of Belarus protects rights of all citizens and the Criminal Code prohibits any form of discrimination on the basis of gender, race, nationality, religious or political views, physical or mental disability.

[46] A. Matchanka, "Substitution of Civil Society in Belarus: Government-Organised Non-Governmental Organisations", The Journal of Belarus Studies.
[47] Key Informant Interviews.
[48] USAID in Belarus https://www.usaid.gov/where-we-work/europe-and-eurasia/belarus/civil-society-development.
[49] http://law.by/main.aspx?guid=3871&p0=V19402875e.
[50] Source: "Thematic report: Stigma and discrimination", 2012 progress.

Table 5). Recent changes have created additional barriers and reinforced stigma and discrimination. Specifically:

Criminalization of drug use establishes barriers to services. The Criminal Code of the Republic of Belarus criminalize the possession or the purchase of narcotic drugs, and people who inject drugs (PWID) are subjected to criminal prosecution. The code lacks provisions specifying the minimum dose to possess or to purchase, and imprisonment is the only prosecution option for PWID.

A Presidential Decree ordered the registration of PWID in an electronic database which is used by law enforcement agencies and healthcare organizations. Furthermore, since 2015 it is compulsory to inform law enforcement agencies about all new cases added to the database, while prisons created special units for PWID. The given legal framework creates obstacles to provide harm reduction services in Belarus as outreach workers who are active drug users do majority of work at needle/syringe exchange sites.

A punitive legislation makes it hard to reach sex workers (SW) and it restricts funding for targeted activities. In accordance with the Administrative Code of the Republic of Belarus, sex work is an administrative offence, hence SW are administratively liable and are fined. This regulatory framework not only impedes access to this vulnerable group, but also makes it practically impossible to allocate public funding for this group.

Mandatory testing and compulsory isolation of people with socially dangerous diseases. Law №363-3 of the Republic of Belarus 'On health care' with its changes and amendments prescribes obligatory disclosure of the HIV status when a person seeks medical care and is subjected to compulsory medical examination when status is not known. Law №345-3 on the 'Prevention of socially dangerous diseases, HIV' which entered into force in July 2012, prescribes mandatory HIV testing for a number of professional categories in which a HIV-positive person cannot work or keep on working (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 bill also permits the disclosure of the HIV status upon request by the Ministry of Health or Ministry of Internal Affairs and it promotes compulsory isolation and treatment of individuals with socially dangerous diseases (including HIV and TB). These bills and policies increase stigma and discrimination and create obstables to the provision of HIV-related services and discourage key populations from seeking help and support.

Harm reduction services are not in any way legally defined by the Ministry of Health. It is not clear which harm reduction services are regarded as essential. There is no legal provision about which specialists in which health institutions should provide harm reduction services. The documentation and tools (e.g. data collection for needle-syringe programs, tools for psychosocial assistance, and coordination of multidisciplinary team), which are used by the NGO, are not officially approved by MOH. To date, governmental health care and public health institutions do not participate in the provision of these services. Only a few of them contribute minimally to the provision of harm reduction services by providing premises for the NGO on a discount-fee basis.

The legislative framework provides perverse incentives for TB patients to stay longer in hospitals. TB patients receive a disability benefit that is withdrawn shortly after they are dischanged from hospital, which is very inconvenient for those patients previously working in contact with the public who are not allowed to work during the entire period of their treatment[51].

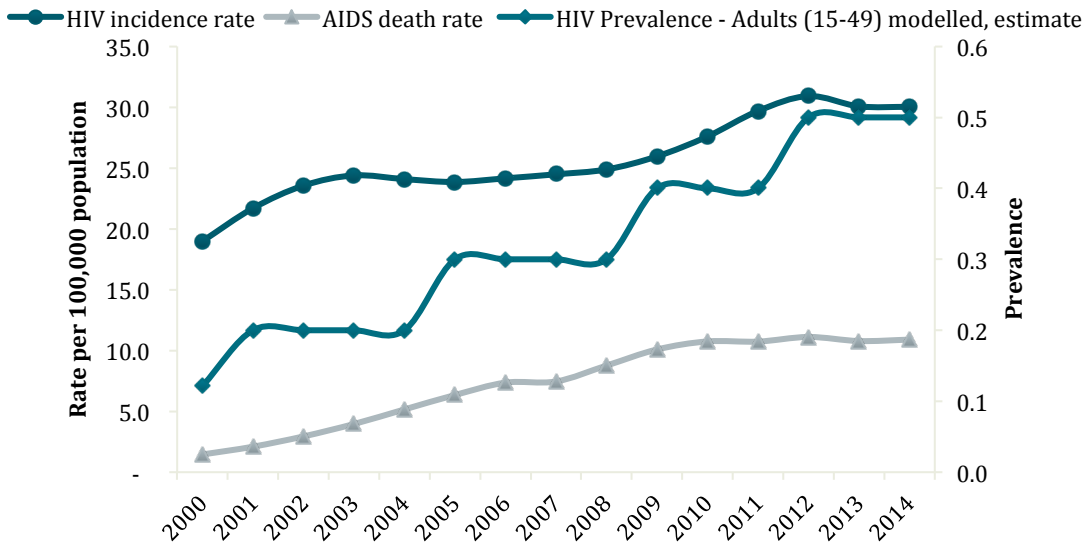
[51] Ministry of Health Order N° 47 issued on 28 April 2010 on "Instructions on mandatory medical examinations of working people and amendments of some resolutions of the Ministry of Health of the Republic of Belarus"

2.8. Epidemiological Characteristics Of HIV and TB

2.8.1. HIV/AIDS

There is no evidence of HIV epidemic improvement in Belarus. HIV epidemic is concentrated among key population (KP) in Belarus. According to UNAIDS estimates, in 2014 HIV prevalence rate reached 0.5 per 100,000 population. UNAIDS also reported that HIV incidence rate increased annually (Figure 4) reaching 30.9 per 100,000 population in 2012. Since then, it has declined slightly to 30.0 per 100,000 population in 2014.

Figure 4: Key HIV Indicators



Source: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx,, accessed on July 27, 2015

Heterosexual transmission significantly prevails over Intravenous Drug Use (IDU) transmission over the last few years. Over the last ten years heterosexual transition of HIV has increased from 50.5% (2004) to 74.2% (2013) - 48.3% among women and 51.7% among men. However, parental transmission shows a declining trend from 56.5% (2004) to 11.7% (2013).

Table 6: HIV prevalence among KP

	2011*	2013**
HIV prevalence among PWID, %	13.3	13.8
HIV prevalence among MSM, %	2.8	4.5
HIV prevalence among FSW, %	2.4	5.8

* 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).

** 2013 IBBS data used for all KPs

Belarus has the highest estimated number of key populations among the 27 countries of the EECA region with 185 000[52] over 9.47 million (1.9% of the 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%)[53,54].

[52] Data based on: preliminary MSM size estimate for 2014 (in Russian), Protocol of the working meeting on size estimates for KP in Belarus (form 7 June 2012, in Russian).

[53] 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.

Notably, HIV prevalence has grown among KP between 2011 to 2013, slightly increasing among PWID and almost doubling among MSM and FSWs (Table 6).

The geographical distribution of the HIV epidemic shows significant differences among the regions. About 80% of all registered cases are reported in teh Gomel oblast, the city of Minsk and in the Minsk oblast (respectively 47.5%, 14.7% and 14% of all cases since 1987)[55]. Belarus is a highly urbanized 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[56].

HIV mostly affects population in the age group of 30-39 years old. The highest growth rate of newly registered HIV infection cases in the period of 2000-2014 has been registered among 30-39 year olds. In this age group the HIV infection rate stands at 430.2 cases per 100,000 people (0.4%), whereas among 25-29 year olds the rate is 240.3 cases per 100,000 people (0.2%). The lowest rate is reported among 15-19 year olds: 9.7 cases per 100,000 people. The morbidity rate has grown from 9.5 to 58.04 cases per 100,000 people among the 30-34 year olds, and from 2.56 to 45.4 cases per 100,000 people between 35 and 39 years old.

The HIV mother-to-child transmission is declining. HIV-infection among pregnant women in Belarus slightly increased from 0.24% in 2007 (256 HIV-positive pregnant women per 103,626 babies born) to 0.27% in 2014[57]. From 1987, when the first case of HIV was registered, to 2014, the 'HIV infection' diagnosis has been confirmed in 245 children born to HIV-infected mothers, 15 of them died. There are a total of 264 HIV infection cases registered among children in the 0-14 age group up until 2014[58].

The most epidemiologically significant group for transmission of HIV infection is PWID. In 2013 the UNAIDS estimated there were 25,000 people living with HIV (PLHIV) in Belarus[59]. According to 2013 IBBS the cities with the highest HIV prevalence were Svetlogorsk (Gomel oblast) with 41.8% and Soligorsk (Minsk oblast) with 16%[60].

2.8.2. Tuberculosis

The TB notification rate declined since 2000 and has remained stable for past few years. After the breakdown of the Soviet Union, in Belarus tuberculosis re-emerged as a public health threat in early '90s. According to the latest WHO estimates for 2013, the TB incidence (new cases and relapses) was 70 per 100,000 population (with a range 62 - 80), which correspond to 6,500 cases per annum (uncertainty range 5,800 - 7,500).[61] As per the country's Vital Registration System (VRS), in 1990 the notification rate (new cases and relapses) was 30 per 100,000 population, and it increased through 1999 to 73 per 100,000 population.

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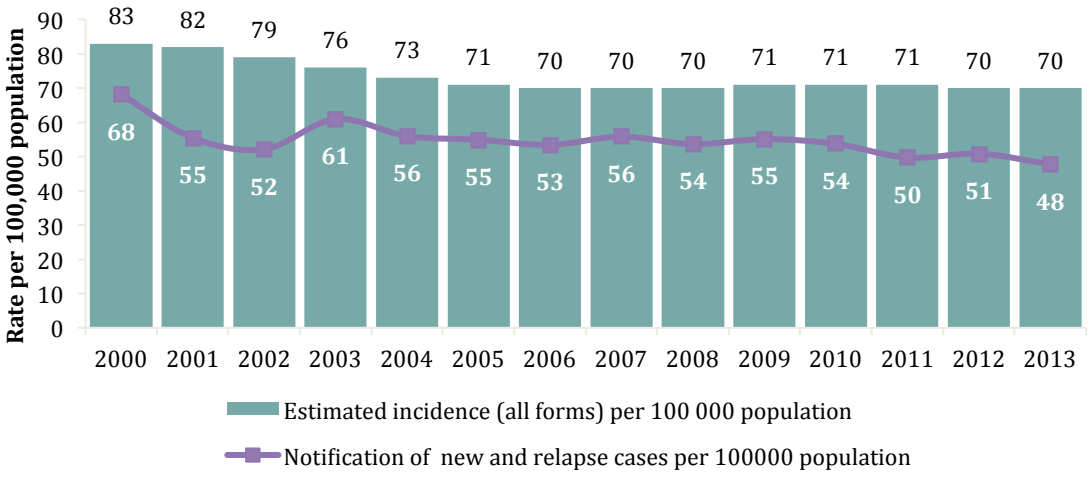
[54] UNDP operational data.
[55] Data of the governmental institution 'Republican Center of Hygiene, Epidemiology and Public Health'.
[56] Data of the governmental institution 'Republican Center of Hygiene, Epidemiology and Public Health'. Operational data about HIV-infection in Belarus as of April 1, 2015 (in Russian).
[57] Data of the governmental institution 'Republican Center of Hygiene, Epidemiology and Public Health'.
[58] Data of the governmental institution 'Republican Center of Hygiene, Epidemiology and Public Health'.
[59] UNAIDS data: http://www.unaids.org/en/regionscountries/countries/belarus/
[60] IBBS for PWID in Belarus, 2013.
[61] Source: WHO, Global tuberculosis report 2014, Key indicators for the WHO European Region, pg. 22.

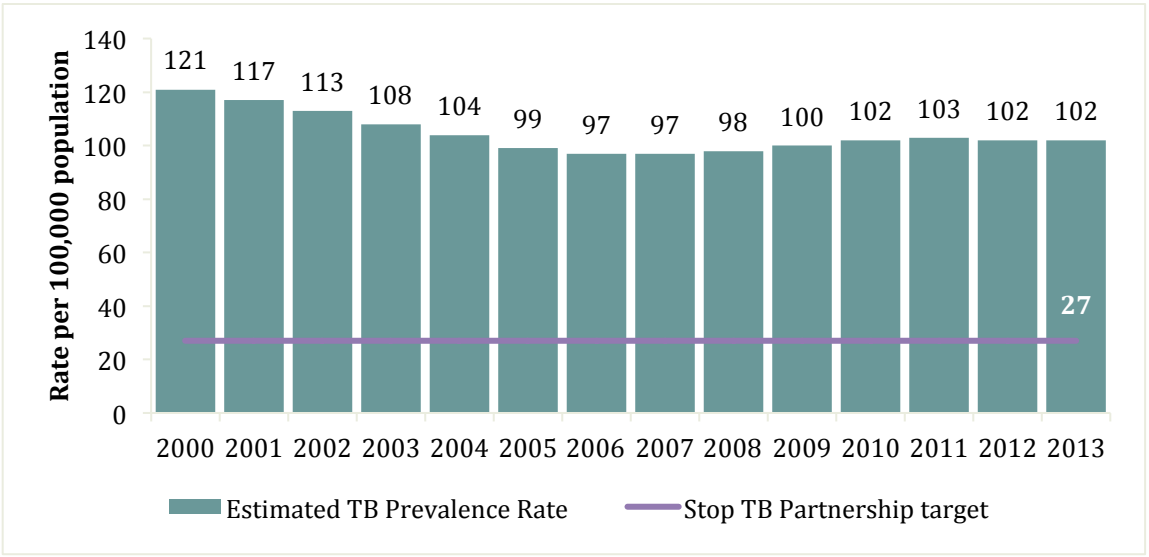
Figure 5: Estimated WHO TB incidence rate and notification of incident TB cases (new and relapse) in Belarus per 100,000 population (1990–2013)



Source: Global Tb Database

Since the year 2000, the notification rate (new cases and relapses) started to decline, and it has remained stable, varying from 50 to 56 per 100,000 populations during 2001 – 2012 (Figure 5).[62] The data for 2013 show a notification rate (new cases and relapses) of 48 per 100,000 population, which correspond to 4,470 cases per annum. The WHO case detection rate also shows the declining trend from 78% in 2009, to 70% in 2011 and 68% in 2013 (Figure 5).

Figure 6: Estimated TB prevalence rate in Belarus, per 100,000 populations (2000–2013)



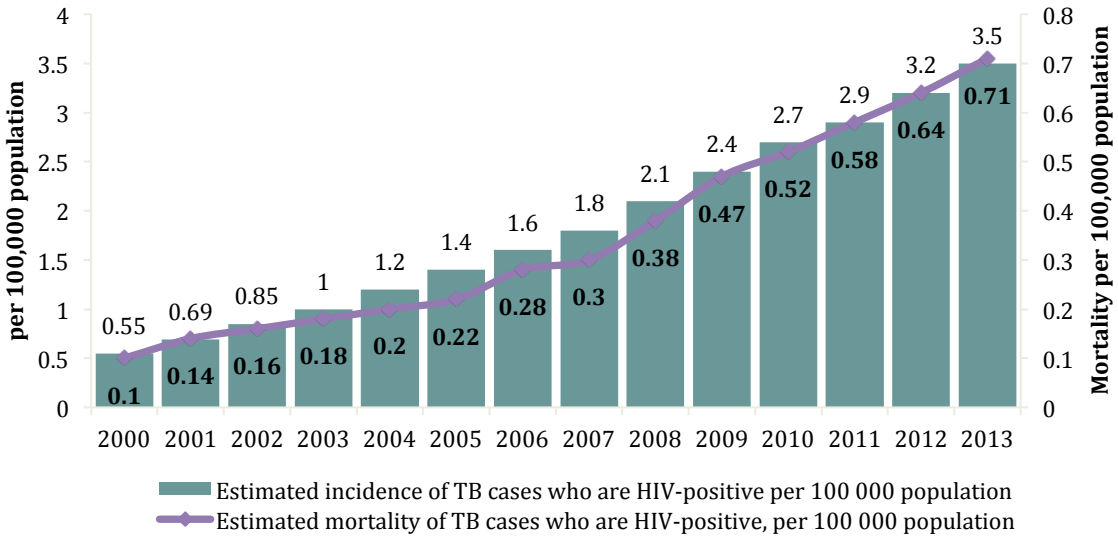
Source: Global TB Database

The majority of TB cases are recorded among economically active age groups and predominantly among the male population. The majority of TB cases are registers among economically active age groups (e.g. 69.1% of new smear positive cases are in age groups between 15 and 54 years old) and among men. In 2013, 72% of all cases (new and relapses) were males (male-to-female ratio was 2.6:1), which is a fact determined by several factors, including risky lifestyle behaviors.

[62] Source: WHO, Global tuberculosis report 2014, Key indicators for the WHO European Region, pg. 22.

There is no data from direct measurement on TB prevalence in Belarus and the only available information comes from WHO indirect estimates. In 2013, the estimated number of prevalent tuberculosis patients was 9,500 (4,900-16,000), equivalent to a rate of 102 (52-168) per 100,000 population (Figure 6). TB prevalence in Belarus sharply increased since 1990 up to 2001 from 54 to 121 cases per 100,000 people. Since then, TB prevalence has slowly declined by 1.1% per year on average. The current prevalence of TB (102 per 100,000 population) is over 3 times higher than the "Stop TB" partnership targeted level of 27 cases per 100,000 populations (half of 1990 level).[63]

Figure 7: Estimated incidence of HIV positive, TB cases and mortality in Belarus, per 100,000 populations (2000–2013)



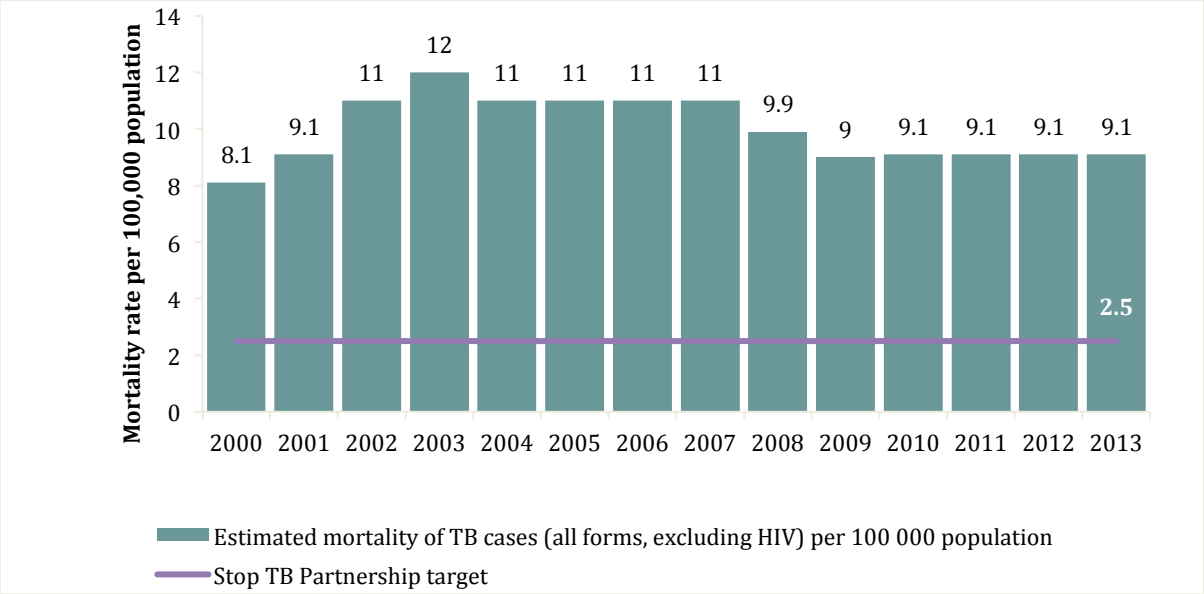
Source: Global TB Database

The prevalence of HIV/TB co-infections is consistently increasing in Belarus. Since 2007, Belarus consistently reported high coverage of HIV testing among TB patients ranging between 93% and 100%, suggesting a representative routine of HIV surveillance among TB patients[64]. The estimated incidence of HIV among TB patients increased on average by 38% annually, whereas estimated mortality among HIV positive TB patients increased on average by 5% annually since 2000.

While TB prevalence and incidence in Belarus has fallen since 2000, the estimated decline in morality is slower, given the high TB case fatality which is due to unprecedented MDR prevalence among new and previously treated cases.

Figure 8: Estimated TB mortality rate (excluding TB/HIV mortality) in Belarus, per 100,000 population (1990–2013)

[63] Source: Belarus TB Epidemiological and Impact Analysis, pg. 20.
[64] Belarus TB Concept Note, 2015



Source: Global TB Database

Estimates for the TB mortality rates are based mainly on the modeling of the Vital Registration System (VRS) data. Thus, in 2000 the TB mortality rate was estimated at 8.1 per 100,000 population. Between 2000 and 2003 the mortality rate gradually increased from 8.1 to 12.0 per 100,000. Since 2004, the mortality rate started to decline and it has remained stable - 9.1 per 100,000 population since 2011 (Figure 8).

The latest available estimates for the TB mortality rate is almost 4 times higher than the "Stop TB" partnership target which aims to halve TB mortality by 2015. Thus, Belarus is far away to achieve the target of 2.5 per 100,000 population[65] (Figure 8).

In comparison with the WHO TB estimated mortality rate, over the last 5 years Belarus' Vital Registration System reported that the TB mortality rate has been decreasing on average by 7.5% annually. As a result, the reported TB mortality rate was 5.8 per 100,000 in 2013, and the most recent preliminary data from VRS for 2014 show a decline to 4.7 per 100,000 – in absolute numbers it means 445 deaths caused by TB.

The MDR TB burden remains high despite existing national efforts to combat the disease. Belarus is listed among the world's top 27 countries with MDT TB high burden[66]. The survey conducted in 2011 about the drug resistance among newly detected and previously treated TB cases indicated a MDR TB rate of 32.3% and 75.6% respectively, which are the world's highest documented rates. XDR TB was found in 11.9% of the MDR TB patients. Thus, it is roughly estimated that 3,100 (2,300 – 4,000) new MDR TB cases occur every year in Belarus[67].

There is an evident progress in reduction of TB incidence in the penitentiary system though it is still five times higher than the rate among general population[68] – The TB incidence in the penitentiary system decreased from 304 per 100,000 in 2008 to 169 per 100,000 in 2014, but it still remains five times higher than the rate among the general population. The main factors are: an insufficient implementation of basic infection control measures in TB prison hospital; high proportion of XDR-TB among inmates; suboptimal treatment outcomes with high rate of lost to

[65] Source: Belarus TB Epidemiological and Impact Analysis, pg. 19.
[66] Ibid 41.
[67] Skrahina A et al. Risk factors for drug-resistant tuberculosis in Belarus: insights from a nationwide survey. June 2012 [submitted for publication].
[68] Belarus TB Concept Note, 2015.

follow-up upon release from the prison; lack of patient-centered approaches to improve adherence to treatment, and low involvement of NGOs.

TB among health care workers follows a general downward trend, yet it remains a serious problem – Over the last five years, the overall number of health care workers detected with TB has decreasing by 53% from 103 health-care workers (including 18 staff from TB facilities) in 2008 to 49 (14 staff working in TB facilities) in 2013. In accordance with the operational research conducted in 2014, the TB notification rate among the health workers in TB facilities was 8.7 times higher than among the general population - 349 and 40 per 100,000 respectively in 2012. From the 109 TB cases among health workers whose treatment results were assessed, 97 (89%) cases were successfully treated.[69]

2.9. Global Grant Overview

2.9.1. HIV/AIDS

Since 2004, the Global Fund has allocated more than US$ 57 million to support the response to HIV in Belarus. This consisted of three grants: US$ 24.1 million in a R3/RCC grant; US$ 18.6 million in a R8 grant and the current Single Stream Funding (SSF) grant of US$ 14.9 million (Table 7). In 2004, the Global Fund HIV Round 3/Rolling Continuation Channel (RCC) Grant was awarded to Belarus to prevent the further spread of HIV through active prevention interventions, specifically those targeting key groups, including PWID, FSWs, youth, MSM, and inmates in penitentiary institutions. The Round 8 Grant was a complementary proposal to the Round 3 RCC HIV Grant with efforts aimed at expanding the coverage of the main vulnerable groups and gradual institutionalization of the prevention and treatment activities. The two grants (R3 and R8) were consolidated into a SSF Grant, which is currently being implemented by UNDP in cooperation with governmental organizations and NGOs, and which continues to target key populations.

Table 7: HIV/AIDS grants

TYPE OF FUNDING	DURATION	AMOUNT (million)
R3/RCC grant	2004-2012	$24.10
R8	2010-2012	$18.60
Single Stream Funding	2013-2015	$14.90
TOTAL	**2004-2015**	**$57.6**

The overall goal of the Global Fund HIV grants in Belarus is to ensure universal access of the key populations in Belarus to HIV prevention, treatment and care, and specifically: i) To prevent further spread of HIV through active preventive interventions and change to less risky behavior, especially among vulnerable population groups, PWID, FSW and MSM; ii) To ensure adequate treatment, care and support for PLHIV, including through health systems strengthening and adherence programs for HIV patients; iii) To create favorable conditions at the national and local level for universal access to prevention, treatment and care.

The key services supported by the Global Fund among key populations include the following:

People Who Inject Drugs: Opioid Substitution Therapy (OST), counseling and testing through Anonymous Counseling Points (ACPs), including mobile ones, access to needle-and-syringe-exchange programs (NSEP), condom distribution, rapid testing for HIV and Hepatitis B and C virus (HBV, HCV), referral services to health-care institutions for essential medical prevention and treatment services, psychosocial support, and provision of targeted information materials.

- **Female sex workers:** Services include VCT (including with provision of the incentive packages), HIV/HVC/HVB, syphilis rapid testing, Sexually Transmitted Infections (STI) testing

[69] Klimuk A, Hurevich H, Harries AD et al. Public Health Action, 2014.

and treatment at health-care institutions, distribution of condoms, lubricants, miramistine, and HIV and related information materials.

- **Men who have sex with men:** VCT services (including with provision of the incentive package), HIV rapid testing, STI testing and treatment at health-care institutions, psychological and counseling support, distribution of condoms, lubricants.

2.9.2. Tuberculosis

The Global Fund has allocated more than US$ 35 million to Belarus to address gaps in the national response to TB (Table 8). This included a US$ 9,244,112 (Round 6) program with the key objective to prevent the further spread of TB among prisoners and homeless people through improvement of the TB case detection rate, enhancement of the quality of TB laboratory diagnostics, provision of quality treatment and social support to TB patients, launch of a second-line treatment of MDR-TB, and improvement of the country's TB surveillance system. The program also promoted the integration of DOTS into the national health care system.

Table 8: TB grants

TYPE OF FUNDING	DURATION	AMOUNT (million)
R6	2007-2010	$9.3
Single Stream Funding	2011-2015	$26.4
TOTAL	**2004-2015**	**$35.7**

The current grant agreement consolidates the goals and activities of the TB program funded under Round 6 and 9 TB proposals and merged into a Single Stream of Funding (SSF) scheme amounting to US$ 26,4 million. The aim is to reduce the burden of TB in Belarus, including by scaling up the management of MDR-TB through the enrollment higher number of patients in second-line treatment. The program had to achieve full integration of the DOTS strategy in the national healthcare system, and support the National TB Program (NTP) in Belarus from 2011 to 2014 by expanding the coverage and scope of the state-supported TB control activities. It also plans to provide training to medical staff and laboratory personnel from national TB control institutions and the general medical network, and it envisages introducing an electronic TB recording and reporting system for collecting and monitoring TB clinical and epidemiological data. Thanks to these funds the country has introduced rapid diagnostic tests for TB detection and implemented the infection control measures and a program to promote adherence to tuberculosis treatment.

The Global Fund rates both active grants as A1

Table 9: Most recent performance rating of GFATM active grants

GRANT NUMBER	GRANT TITLE	COMPONENT	AMOUT $	DURATION	PR	STATUS
BLR-809-G03-H	Ensure Universal Access of the Key Populations in Belarus to HIV Prevention, Treatment and Care	HIV	18,521,619	2010-2012	UNDP	A2
BLR-607-G02-T	Strengthening the Support to Vulnerable Groups and Population at Large under the National TB Control Strategy of Belarus	TB	9,244,112	2007-2010	UNDP	A1
BLR-304-G01-H	Prevention and Treatment of HIV/AIDS in Belarus	HIV/AIDS	24,119,702	2004-2011	UNDP	A2
BLR-S10-G04-T	Strengthening the Support to Vulnerable Groups and Population at Large under the National TB Control Strategy of Belarus and Expanding Access to Quality Diagnosis and Treatment of Drug-Resistant Tuberculosis	TB	26,417,736	2011-2015	UNDP	A1

GRANT NUMBER	GRANT TITLE	COMPONENT	AMOUT $	DURATION	PR	STATUS
BLR-H-UNDP	Ensure Universal Access of the Key Affected Populations in Belarus to HIV Prevention, Treatment and Care	HIV	14,987,574	2013-2015	UNDP	A2

3. CHAPTER: INTERNAL ENVIRONMENT

3.1. Stewardship

3.1.1. Stewardship of national HIV and TB programs

Health care remains as one of the top priorities of country's social policy and it is one of the key components of the Program on Socioeconomic Development (PSD) for 2011-2015[70]. PSD aims to complete the modernization of the health care system as well as to reform the provision and the workforce payment systems[71]. The "Health Care Development Strategy 2020" also sets a program for the development of the health system over the longer term with a focus on introducing cost-effective technologies, increasing investment in health care, and developing human resources, which will help to address weaknesses and gaps in the HIV/AIDS and TB response such as health care staff shortage and turnover, increasing funding for evidence-based cost-effective interventions etc.

HIV and TB related policies are based on technical evaluations and assessments of partner UN agencies and the GF as well as by the epidemiological situation in the country. Interviewees anonymously agreed that HIV and TB policies are based on the analysis of surveillance data, as well as on the findings of the various studies supported by the GF and other partner UN organizations. Close partnership with these organizations ensures the channeling of some politically challenging issues into national programs specifically addressing the diseases.

Despite the Government's efforts to establish an enabling environment for the prevention of socially dangerous diseases, recent legislative changes intensify stigma and discrimination. According to international community, Belarus' new law on the "Prevention of diseases posing a threat to the health of the population" approved in 2011 (resulting the MOH's Order N° 31 of 13 June 2002 on the "Adoption of the list of diseases representing a public health threat") has the potential to increase stigma and discrimination against PLHIV and TB patients (details provided in the respective sections).

Social assistance and social benefit schemes are available for vulnerable groups of population but do not target PLHIV and TB patients. To date, the social protection sector has provided limited social support and care services to HIV and TB patients. Both policy and legislation foresee the provision of various types of financial and in-kind benefits to different vulnerable groups. Important social assistance programs that can potentially target key populations are: financial benefits, food and transportation vouchers, social support/palliative care at home, unemployment benefits. However, PLHIV and TB patients are not included in the list of eligible vulnerable categories. The social benefits eligibility criteria have not been updated over the last decade.

The Ministry of Health is a key player and has sufficient leverage to influence political decisions, though this power is not always used. According to the key informants, the MOH is considered to be a strong actor in the field of HIV and TB assistance, advocating for legislative and/or policy changes, but the MOH is not always ready and/or willing to raise politically sensitive issues when needed be. One of the most recent difficult political decision lobbied by the MOH and

[70] Approved by Decree #136 of 04 January 2011 of the President of the Republic of Belarus.
[71] Health workforce payment systems to be based on workload, qualification level and years of service.

approved by the Ministry of Finance (MOF) was the introduction of food packages for the TB treatment adherence, financed from the public health budget. However, the MOH did not mobilize to include PLHIV and TB patients to the list of eligible categories for social assistance and support in the law on "Social assistance".

3.1.1.1.HIV

The main principles of the Government policy on HIV/AIDS are set out in the National HIV/AIDS Prevention Program (NAP) which reflect commitment to the Millennium Declaration (2000), the 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). At present the country's national response is guided by the current NAP (2011-2015), the third program since the year 2000. The NAP remains the cornerstone and the main thrust for the renewed vision and efforts to combat the HIV/AIDS challenge in the country.

Recent legislative change raises serious concern of the voluntary and confidential nature of the testing procedures as the core principles of global and regional testing guidelines[72]. The National Law on "Prevention of socially dangerous diseases" allows mandatory HIV testing for a number of professional categories and it lists those professional categories whose workers cannot maintain their duties if they had contracted HIV (e.g. surgeons). The law prescribes compulsory HIV testing if a person evades or declines mandatory testing or if there is *"a valid reason to suspect a person has HIV".*

Guidelines are updated and aligned with international and WHO standards. The Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health (RSPCMT) is the key institution responsible for the development/revision of guidelines and approval on behalf of the MOH. The treatment protocol is in line with international standards and recommendations[73]. Most patients in the first line therapy are treated with drugs recommended by WHO although the total number of treatment regimens used in the HIV care remains high (22 regimens). At present, the RSPCMT works on adopting the WHO 2013 ARV treatment guidelines, which are planned to be introduced from 2016.

In 2010, the MOH passed the executive legal act approving the Clinical protocol for OST and another legal act which endorses OST as part of "*Clinical standards of treatment of mental and behavior disorders"*[74]

Stigma and discrimination towards KP among the general population and health professionals remains a challenge. According to the study on the level of tolerance towards people living with HIV[75] which was carried out in 2014, 38.4% of the respondents are not ready to have relationship with PLHIV, 27.6% are against of HIV positive children to study in general schools and 56% think that PLHIV should not be employed.

In 1994 Belarus legalized same-sex sexual relationships. However, lesbian, gay, bisexual and transgender (LGBT) rights in Belarus are still severely limited and homosexuality remains a social taboo. Many Belarusians believe that "homosexuality is a psychiatric illness" and many LGBT persons tend to hide their sexual orientation. Those who "came out" face

> "Stigma and discriminations towards KP is common among population. It is particularly severe among health professionals. Not all doctors want to treat PLHIV".
>
> ***Quote from Key Informant Interview***

[72] HIV treatment and care in Belarus, 2014, WHO
[73] Evaluation of the HIV program review in Belarus, WHO,2014.
[74] Order of the Minister of Health No 1233 from November 16, 2010 "About using opioid substitution treatment for patients with opioid dependence". Republic of Belarus.
[75] "Study of the level of tolerance towards people living with HIV", 2014.

harassment, violence and physical abuse. Stigma and discrimination towards PLHIV is common among health professionals and many physicians resist treating PLHIV when the status is disclosed.

Strong social rejection and stigmatization of key populations may potentially influence/limit the Government's commitment to prioritize prevention activities targeting these groups, beyond the GF support. This may be particularly problematic for MSM: while injecting drug use and sex work are perceived to be the result of underlying social problems, such understanding is missing in the case of MSM, who may face a more moral disapproval by society.

3.1.1.2. Tuberculosis

The National TB Control Program and the Action Plan for the Prevention and Fight against MDR-TB are regularly updated. Tuberculosis control in the Republic of Belarus is guided by the National Tuberculosis Programme (NTP) for 2010-2014[76] and the Action Plan for the "Prevention and fight against MDR-TB in the Republic of Belarus for 2012-2015"[77]. The main objective of the NTP is to ensure the right to health of citizens, as stated in the Constitution of the Republic of Belarus, by preventing and reducing the prevalence of tuberculosis and by improving the epidemiological situation in the country. The key objectives of the national programme for 2009-2014 were: (i) to reduce the mortality rate among TB patients by 1% annually; (ii) to reduce the TB notification rate among the general population by 2% per year; and (iii) to increase the number of actively detected tuberculosis patients by 5% till 2015. The NTP promotes the early detection of the disease and active screening for TB among high-risk groups, it implements measures to reduce TB mortality, and it supports awareness raising activities on TB among the general population and it advocates for an healthy lifestyle.

The main objectives of the action plan for the "Prevention and Fight against MDR-TB in the Republic of Belarus for 2012-2015" are in line with the WHO European Region Comprehensive Action Plan to "Prevent and Combat Multidrug and Extensively Drug Resistant Tuberculosis for 2011-2015". The plan envisages three goals to be reached by the end of 2015 i) to reduce the proportion of MDR-TB patients among previously treated TB patients to 60.8% (down by 20% compared to 2011); ii) to detect 85% of the estimated number of MDR-TB patients, iii) to ensure an efficient and successful treatment of 75% of MDR-TB patients.

Currently, the new National Programme "Tuberculosis" for 2015-2020 is awating approval by the Council of Ministers of the Republic of Belarus. In addition, the New National Comprehensive Strategic Plan to prevent and control MDR-TB for 2015-2020 (NSP) has been finalized and has been submitted to the Government for approval.

The National TB guidelines are aligned with international recommendations[78]. Over the last decade, the Republic of Belarus has significantly strengthened its TB control program based on international recommendations, starting with the introduction of DOTs and further expanding its framework with the implementation of a comprehensive range of approaches. These includes strengthening TB control interventions in the penitentiary system; actively involving primary health care providers in the TB case detection and case management; introducing and scaling up rapid diagnostic techniques for TB and MDR-TB (including rollout of Xpert MTB/RIF); adopting internationally recommended treatment strategies for drug-resistant TB cases; supporting civil society involvement, improving information, education, social mobilization and strengthening adherence to TB treatment. Furthermore, the NTP initiated a number of regulatory documents and guidelines during the implementation of the National TB control programs that were reviewed by international experts and approved by the MOH. These include the performance of the tuberculin

[76] Approved by the Council of Ministers of the Republic of Belarus Order No. 11 on 8.01.2010.
[77] Developed according to the Comprehensive Action Plan to Prevent and Combat Multidrug and Extensively Drug Resistant Tuberculosis in the WHO European Region for 2011-2015, adopted by 61st session of the WHO Regional Committee and approved by the Interagency Council on Tuberculosis on 22.12.2012.
[78] Review of National Tuberculosis Program in Belarus, WHO, 2011

skin testing in children, the organization of the medical care for patients with MDR-TB, the regulation on active follow-up of TB patients from dispensaries, clinical guidelines on organization of TB care in ambulatory settings, clinical guidelines for TB and MDR-TB diagnosis and treatment, and clinical guidelines for monitoring and evaluation of TB control activities in the Republic of Belarus).

The MOH endorsed a policy on collaborative TB/HIV activities: In 2010, the Ministry of Health established a national working group with the aim to draft the national policy for collaborative TB/HIV activities, which was officially endorsed with the MOH Order N° 1217 "On instruction about organization of treatment and care of patients with HIV/TB" dated 11 November 2010. The order states that TB/HIV patients should be treated in TB facilities in consultation with infectious disease specialists responsible for monitoring HIV infection and the prescription of antiretroviral therapy. The order also recommends isoniazid preventive therapy in line with the eligibility criteria for patients, services and providers.

The legislative framework promoting intersectoral collaboration has been strengthened. Joint orders on TB control by the Ministry of Internal Affairs and Ministry of Health promote the collaboration between penitentiary health care department, health care facilities providing TB prevention and care services and civil sector. The joint order also defines procedures for the effective collaboration between these actors and patient referral algorithms.

The MOH revised TB contact investigation policy and approved standard composition of food packages for TB treatment adherence. Most recently the MOH revised a policy on expanding TB contacts investigation and issued an order "On approval of the additional high-calorie food products support for TB patients on ambulatory treatment".

3.1.2. Coordination mechanism

Belarus has two structures focusing on the planning and supervision of the implementation of the HIV and TB response.

The National Multisectoral Council on HIV/AIDS and STI Prevention (NAC), established in 1997, is chaired by the Deputy Prime Minister. The Council is represented by different sectoral ministries and is in charge of reviewing state programs, taking decision on funding and/or legislative changes when required, and discussing challenging and sensitive issues. The NAC has its multisectoral branches at oblast and district local government levels. Unlike the structure at the national level, local NACs allow accept from NGOs.

Country Coordination Mechanism (CCM) – The CCM was established in 2002 and it is has 29 representatives of which 10 from the Government, 5 from multilateral donor organizations, 9 from NGOs, 3 from PLHIV community organizations, and 2 other members. Notably, the majority of the CCM members are represented by organizations specialized in HIV, whilst only 2 members represent TB.

The CCM oversees the comprehensive implementation of the specific project and it ensures the proper coordination among the various sectors as well as the different programs implemented by other external partners. It also monitors the project progress to ensure that the activities are carried out according to the work plan and indicators of programmatic and financial performance are met. It takes the key financial and programmatic decisions and is responsible to address the main problems and challenges related to the project.

> "To improve the quality of work of the secretariat, the CCM decided to request funding from the GF and recruit three individuals fully dedicated for secretariat functions"
>
> ***Quote form Key Informant Interview***

The selected staff of the Institute of Epidemiology, Hygiene and Public Health (IEHPH) in addition to their regular responsibilities serves as the CCM secretariat and is not financed for secretarial function by the Government. The CCM acknowledged the need to strengthen the secretariat through the employment of dedicated staff and decided to establish a small team to serve full time as secretariat. to lift the burden from the staff of the IEHPH, hence

improving the quality of the secretariat performance in future. The new concept note to be submitted to the GF for future funding requests proposes funding of the CCM secretariat from GF resources.

Division of roles and responsibility as well as working relationships between NAC and CCM are not formally defined. There are no formal procedures that govern working relationship between NAC and CCM. According to respondents, the majority of the NAC members also sits in the CCM, thus the members who also sit in NAC automatically channel the recommendations elaborated at CCM to NAC. For example, the issue about social contracting and the introduction of the revisions to the Social Assistance Law as well as revisions to the Law on Local Governance was discussed at CCM and recommendations formulated for consideration by the NAC. Consequently the NAC endorses the respective legislation changes for parliament's approval.

> "There is no formal procedure on the cooperation of the CCM and NAC. As key members of the NAC are also represented on CCM, recommendations ellabrated by the CCM is automatically chanelled to the NAC."
>
> " Some of the regions decided to close NAC as local governments do not see the role of such committee in parallel to CCM".
>
> ***Quotes form Key Informant Interviews***

Nevertheless, the presence of CCM in parallel to NAC resulted in gradual closure of NAC in some regions and districts. Respondents stated that the lack of clarity on the division of functions and modus operandi between these two structures are the key reason for discontinuing NAC's operations at regional level and the disappearance of the platform for advocacy and resolution of challenges related to national HIV and TB response implementation.

CSOs are represented at the CCM oversight committee. Apart from being represented on the CCM, NGOs are also members of the CCM oversight committee, which consists of 7 members out of which 2 members are from non-governmental sector. NGOs consider that there is an enabling environment for their participation in the planning and implementation of HIV and TB national programs.

3.1.3. Program management arrangements

HIV and TB programs are vertical state programs. Significant public health issues, including HIV and TB, are managed and executed through the vertical programs in parallel to the main statutory system. Vertical programs in Belarus are managed and funded directly both by the Ministry of Health (central), the regional and district health authorities (local).

3.1.3.1. HIV

The National HIV Prevention Program, despite being formally managed at the central level, is fragmented and it lacks a single leader coordinating all the HIV activities in the country. The MOH is the central and executive body responsible for the implementation of the governmental policy in the area of HIV and it ensures the coordination between all relevant parties involved in the HIV response. The Deputy Minister of Health who is the Chief State Sanitary Doctor of the Republic of Belarus, coordinates and supervises the performance of the State Sanitary Inspectorate. This consists of the Department of Hygiene, Epidemiology and Public Health in the MOH; the Republican Centre for Hygiene, Epidemiology and Public Health; and a vertical network of sanitary-epidemiological institutions (RCHEPH) (regional, district and zonal centers of hygiene, epidemiology and public health). Each center at national and sub-national level has a separate department on HIV/AIDS prevention. This vertical system coordinates the prevention of HIV and is responsible for implementing and monitoring the state HIV Prevention intervention of the program.

> "Fragmentation of the HIV related services is a major impediment for effective program management".
>
> ***Quote from Key Infornmant Interview***

All the activities related to clinical management of HIV (antiretroviral treatment and ARVs procurement, treatment of opportunistic infections, HIV/TB treatment etc.) are under direct responsibility of the Infectious Diseases Service Department of the MOH, have a separate vertical system of service provision and are headed by another Deputy Minister - First Deputy Minister of Health. Thus, despite being formally managed at the central level, the HIV state program management is fragmented and this hamper the coordinated response.

The Republican Center of Epidemiology, Hygiene and Public Health are considered to be a central agency in the field of HIV/AIDS. As informed by the key informants, the RCHEPH leads the HIV policy dialogue and facilitates state HIV prevention program preparation in a participatory manner by involving national and local authorities, civil society, and health professionals. The RCHEPH is a principal public agency that collects HIV/AIDS data, analysis and plans which require interventions based on the evidence and it accordingly advises the MOH.

The country also has individual public and NGO leaders. According to the key informants, the First Deputy Minister of Health; the Head of the HIV/AIDS department of the Institute of Epidemiology, Hygiene and Public Health; and the Director of the NGO "Positive movement" are leaders in the field of HV/AIDS.

3.1.3.2. Tuberculosis

As mentioned above the National Tuberculosis Programme (NTP) is a vertical program. The MOH is responsible for implementing TB control in the country.

The MOH directly supervises the ***Republican Scientific and Practical Centre for Pulmonology and Tuberculosis*** (RSPCPT) in Minsk, which is the NTP central unit and is responsible for the development and implementation of TB policies and clinical guidelines/protocols as well as monitoring (including surveillance) and evaluating TB control activities countrywide. The RSPCT also supervises the operation of the entire TB network (all TB hospitals and dispensaries at both regional and district level).

The Ministry of Internal Affairs of the Republic of Belarus is responsible for the organization and the delivery of TB treatment in the penitentiary system. The coordinator of the NTP activities in the penitentiary system, the Punishment and Execution Department (PED) of the Ministry of Internal Affairs (MIA), is directly responsible for coordinatingn supervising and funding the TB care and support in penal institutions across the country.

3.1.4. Partnerships

There is a well-established environment encouraging an active participation of a wide range of stakeholders in policy development, implementation and M&E in the field of HIV and TB. One of the key benefits of the GF support was establishing the CCM which creates a platform for information sharing and coordination and it encourages partnership between a wide range of government and non government stakeholders. Interviewed stakeholders perceive the current partnerships as satisfactory. NGOs consider to be actively engaged in program design, implementation and monitoring of HIV national response, whereas the NGO representation in the TB sector is rather limited as there is only one NGO focusing on TB-related service delivery. UN agencies, such as UNDP, WHO, UNAIDS and UNICEF feel comfortable with the partnership arrangements that enables coordination of efforts, funding hence avoid duplications.

3.1.4.1.HIV

Despite the positive experiences between the government and civil society sectors at the service-delivery level, important challenges remain for the sustainability of collaborative partnerships, especially after the GF support ends. To date, one of the important achievements of the GF support has been the development of collaboration and referral linkages between the government and civil society at the service-delivery and facility level. These partnerships are the result of the effective relations established by the PR (UNDP) through its Program Implementation Unit (PIU) at both central and regional level, particularly with the Ministries of Health and Internal

Affairs, and their relevant directorates and departments. In the MOH, these include the National and Regional (Oblast) Centers of Hygiene, Epidemiology and Public Health and their Departments of HIV/AIDS and the Narcology Department. In the MIA, the Department of Drug Control and Fight against Trafficking and the Department of Corrections and its Medical Services section were involved.

"It is less likely that this partnership and collaboration will continue after the GF support ends unless the social contracting mechanism is introduced".

"While we try out best to sustain NGO-provided services, a lot of work remains to be done".

Quotes from NGO Key Informant Interview

Partnerships between the government and HIV-service NGOs established with the GF support is a remarkable and important achievement given the limited experience both sectors had of working together, as well as the limited development of the civil society in Belarus. This collaboration with the Global Fund-supported programme activities have scored a number of relevant goals:

- Governmental institutions have acknowledged the added value of civil society organizations and peer outreach workers in reaching (sub) groups of key populations that would normally not access the existing government services;
- The development of referral mechanisms between NGO and government service providers increased the utilization of both sectors' services;
- To date, the Government-NGO partnership provides the basis for a continuos coordination and collaboration in the (near) future, after the GF support may cease.

The results achieved so far under the NAP was mainly influenced by the close collaboration, partnership, and financial and technical support provided by the UN agencies. Active engagement of WHO and UNAIDS in assessing the effectiveness of AIDS interventions and efficiency of spending largely guided the design of the NAP for 2016-2020. The advocacy efforts of the UN organizations aided the Government to raise sensitive issues and formulate required response.

"With the support of WHO and USAID, a drug resistance survey was conducted in the city of Minsk and countrywide. The results revealed high levels of resistance, which was essential for the revision of the response to MDR-TB in Belarus"

"I participated in international training courses on multidrug-resistant tuberculosis (MDR-TB) at the TB infection control center in Riga, Latvia, where we learnt about the approach to treatment of MDR-TB in Latvia".

Quotes: From Key Informant Interviews

"It was decided to establish the TB patient association. As many TB medical professionals are infected with TB, the association is mostly represented by TB patients from the health sector and housed at the RSPCPT. We try our best to strengthen this NGO and actively engage with the TB-related services, though their capacity remains to be a challenge."

Quote: From Key Informant Interview

Despite the positive experiences between government and civil society sectors at the service-delivery level, the likelihood of continuation of these relationships is at risks when country will move from the GF support. Challenges are likely in the programme implementation and service delivery, as well as in the field of financial support for services delivered by the civil society.

3.1.4.2. Tuberculosis

Contrary to the HIV national program, the existence of partnerships is less evident in the field of TB due to the low number of stakeholders involved. The respondents highly praised the progress achieved in TB control, which was possible through the synergy between the NTP, the implementation of the GF grants, the active support of the WHO and additional funding by United States Agency for International Development (USAID)[79]. Technical assistance provided by the WHO

[79] Funding under the umbrella grant, "Support for tuberculosis control in Belarus, 2007–2009" and "Enhancement of STOP TB Strategy in Belarus, 2010–2013"

in modernizing the National TB Programme has enabled Belarus to benefit from the experience of countries such as Latvia and Estonia, which have WHO collaborating centers on TB and MDR-TB and where clear progress in TB control has been made in recent years. The most important achievements of WHO technical assistance have been the development of clinical guidelines for TB and MDR-TB treatment, the implemention of cohort analyses, the reorganization of TB laboratory network, and the quality assurance with a supranational laboratory in Sweden.

The partnership with the NGO sector is constrained however, due to the lack of CSOs supporting TB related activities. to date, there are only two NGOs involved – the Belarusian Red Cross (BRC) and the Association of TB patients. The role of the BRC in the implementation of the NTP has decreased over the years (details described in the service delivery section). BRC is no longer represented at CCM and is not considered as a sub-recipient of GF TB grant. The Association of the TB patients, the NGO artificially established by the RSPCPT recently, is a member of CCM and is selected as potential sub-recipient of the forthcoming GF funding for TB national program. However, the low capacity of this NGO limits its contribution in the development and implementation of the NTP.

3.1.5. Accountability mechanisms

Belarus regularly provides HIV and TB data to the Global Reporting systems. The government of Belarus ensures regular reporting on HIV and TB data to WHO, UNAIDS, Euro CDC and Stop TB Partnership. Global data bases accessed for the purpose of the given assessment demonstrated completeness of data on key indicators as well as regularity in reporting.

The CCM platform is used for systematic reporting to key stakeholders on the progress achieved in the field of TB and HIV. The CCM meetings are often used to report on the progress of implementation of both, NAP and NTP, to discuss challenges and elaborate remedial actions.

"Implementing agencies regularly report on the implementation progress and discuss problems when faced at CCM meetings"

Quote: From Key informant Interview

Results and findings of both programs, monitoring, evaluation and behavioral studies are readily available on request, although web access remains difficult, with few exceptions, and are not user friendly for non-Russian speakers. For this assessment all reports produced within the M&E framework of both programs were made available to the researchers promptly, but most of them are only in Russian (including GARP) or not placed on web.

The Republican Center of Hygiene, Epidemiology and Public health advises the Ministry of Health on follow-ups based on the available epidemiological and operational data. All respondents anonymously agreed that RCHEPH is the only institution in the field of HIV analysizing data and advising the Ministry of Health on subsequent steps. Likewise the Republican Scientific and Practical Centre for Pulmonology and Tuberculosis is the lead agency recommending the ministry on relevant policy actions regarding TB.

There is no sound evidence of CSOs playing an oversight role by using available data to advocate and demand government's adequate response. Given the legislative and political restrictive environment for CSOs, some key informants said that organizations prefer to keep a low-key profile.

The government-controlled media impedes to secure and maintain public support for NAP and NTP. As described in previous chapter, strict government control over the made sector restricts to raise the level of population information and awareness related to human rights and prevent stigma and discrimination towards key population groups.

3.2. Financing

3.2.1. General health care financing

The Government's commitment to prioritize health care is demonstrated by the high allocation of financial resources to the sector. The Government of Belarus allocates about 6% of GDP to the health sector and health care spending has increased almost six fold per capita between 2000 and

2013. In this period, the level of public health expenditure measured as percentage of total government expenditure fluctuated – recording its lowest level in 2008, with 8.4 % of total government expenditure allocated to the health sector, and its highest in 2010 and 2013 with 13.5 % (Table 10). After a decline between 2000 and 2009, government health spending remained consistently above 13 % between 2010 and 2013. The Government of Belarus has tried hard to keep its share in total health spending at around 70%-78% over last 14 years (Table 11).

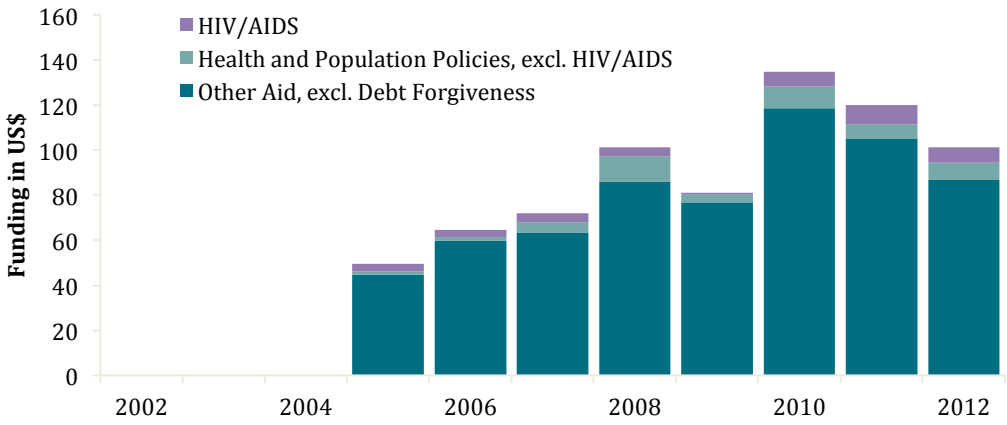
Table 10: Health care financing 2000-2013

	Health expenditure per capita (current US$)	Health expenditure, total (% of GDP)	Health expenditure, public (% of government expenditure)	Health expenditure, public (% of total health expenditure)	Health expenditure, private (% of total health expenditure)
2000	74.7	6.1	10.1	75.5	24.5
2001	82.0	6.6	10.1	71.5	28.5
2002	95.5	6.5	9.8	70.5	29.5
2003	119.5	6.6	10.3	73.8	26.2
2004	156.9	6.6	10.8	74.7	25.3
2005	215.3	6.9	10.5	72.9	27.1
2006	243.5	6.3	9.5	70.2	29.8
2007	304.1	6.4	9.1	69.1	30.9
2008	377.9	5.9	7.9	65.1	34.9
2009	312.6	6.1	8.4	64.0	36.0
2010	322.6	5.6	13.4	77.7	22.3
2011	294.3	4.9	13.0	70.5	29.5
2012	339.0	5.0	13.2	77.2	22.8
2013	462.9	6.1	13.5	65.4	34.6

Source: World Development Indicators. http://data.worldbank.org/indicator accessed on May 30, 2015

The Government of Belarus uses a three-year budget planning cycle. Notably, the health care budget, including the national programs, follows a three-year plan. The MOH submits annually the upcoming fiscal year budget as well as an estimated budget for the next two consecutive years to the Government for approval. This practice allows planning and forecasting the needs of the health budget with a medium-term (three year) perspective.

Figure 9: Aid disbursements, 2002-2012 (US$ million)



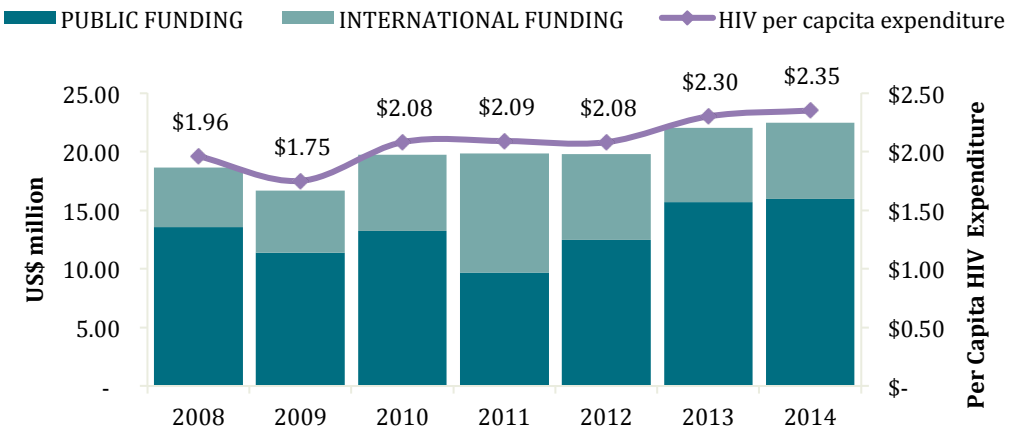
Source: OECD, CRS, 2014.

External funding for the health sector has been declining over the past years, but funding of HIV/AIDS was prioritized. External assistance to Belarus has increased since the mid-2000s and it peaked in 2010 with US$ 134.8 million. Health, population policies and HIV/AIDS accounted for 5.3% to 14.9% of all external assistance (Figure 9). HIV/AIDS has been a key focus and in some years external funding to related programs exceeded those to health and population policies. In 2012, external support for HIV/AIDS amounted to US$ 6.9 million and all other health financing to US$ 7.6 million.

3.2.2. Funding of national hiv program

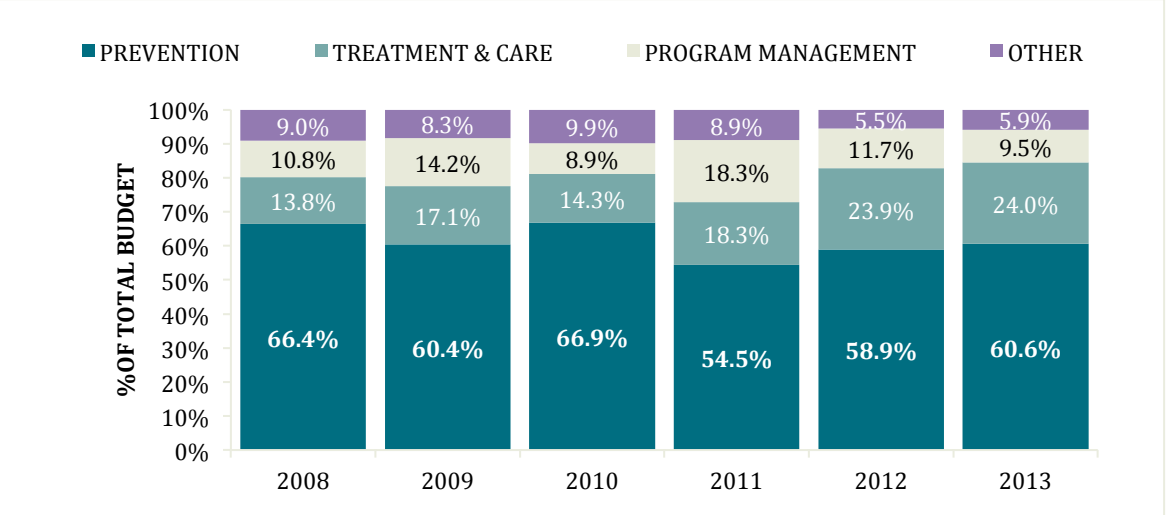
HIV annual expenditure per capita is gradually increasing. Estimated HIV expenditure per capita per year (PCPY) from both national and international sources remained flat between 2010-2012 and accounted to about US$ 2.1 PCPY. Since 2013 there has been an increasing trend and PCPY reached $2.3 and $2.35 in 2013 and 2014 respectively (Figure 10). However, total HIV spending measured as percentage of total health expenditure neither did nor show significant increase and it stayed at level of 0.5%-0. 7% of the total budget between 2008-2013.

Figure 10: HIV National Response Funding by funding sources 2008-2013



The share of domestic funding for the national HIV response has increased in recent years. Activities related to HIV/AIDS in Belarus are funded from the central and local budget, as well as supported by international development partners. Until recently the HIV response has been heavily dependent on foreign aid, with around US$ 20 million invested annually in HIV from both sources (Figure 10).

Figure 11: HIV National Response funding by type of Services



The share of international funding increased from 27% of the total budget in 2008 to 51% in 2011 (with GF support accounting for 96%)[80]. The share of domestic funding increased to 71.1% in 2013 while donor funding decreased to 28.9%[81] (Figure 11).

The government prioritizes the funding of prevention-related activities but these are mostly covered through external resources. The most significant share of the total HIV funding is allocated to prevention-related activities. The most funded HIV-related interventions from domestic public sources[82] are: voluntary, provider-initiated, and mandatory counseling & testing; prevention, diagnosis, and treatment of sexually transmitted infections (STIs); prevention of mother-to-child transmission (PMTCT), including counseling & testing of pregnant women, and delivery practices; blood safety to ensure a safe supply of blood and blood products; outpatient and inpatient opportunistic infections prophylaxis and treatment. Between 2008 and 2013, international donors mainly funded preventive activities for key populations (PWIDs, SW, MSM, prisoners); full supply of antiretroviral medicines; provision of supplementary drugs for opportunistic infections prophylaxis and treatment; supply of tests for specific HIV-related laboratory monitoring; support to upgrade infrastructure, and the provision of new equipment for service provider institutions.

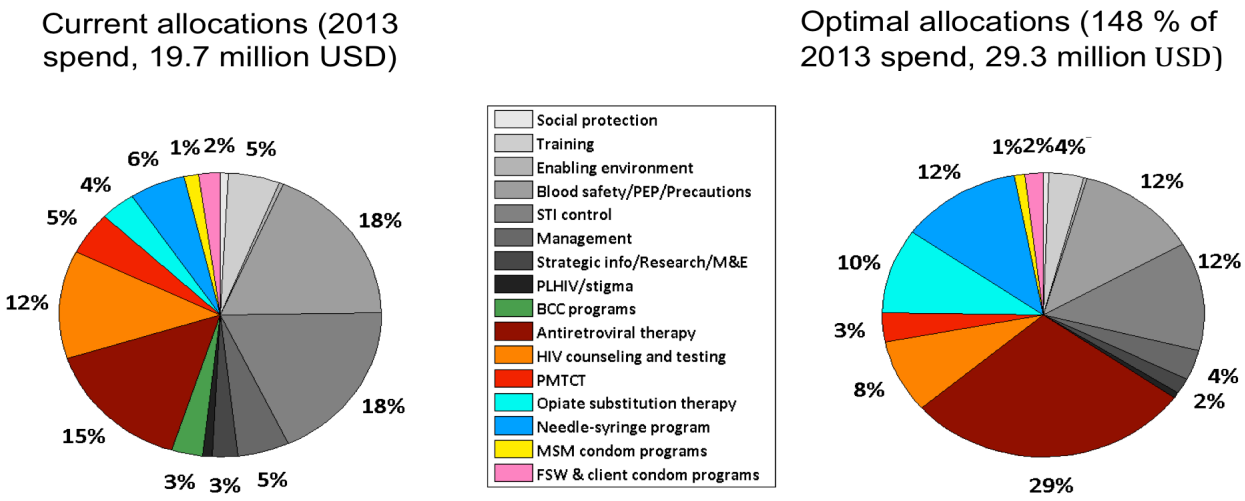
Despite the fact that the funding has increased, current financing is insufficient to maximize the health impact and there is room to optimize the spending. The National HIV Allocation Efficiency Analysis (NHAEA) carried out in 2015 suggests to increase the funding of the national response by 1.5 times to the 2013 funding level[83]. Table 11 below shows the costs per person, as per the 2013 program spending and coverage data.

Table 11: Costs per person reached as determined in the analysis (US$)[84]

Cost per person reached	Belarus	Regional comparison (6 countries including Belarus)			
	2013	Lowest	Highest	Average	Median
FSW programs	$ 88.62	$ 41.66	$ 166.24	$ 102.94	$ 105.35
MSM programs	$ 39.03	$ 23.67	$ 449.13	$ 159.45	$ 71.25
PWID-NSEP programs	$ 101.36	$ 40.90	$ 129.25	$ 109.73	$ 84.11
OST	$ 645.31	$ 431.41	$ 1,645.24	$ 747.36	$ 790.23
PMTCT	$ 4,068.39	$ 738.08	$ 8,905.27	$ 4,616.80	$ 4,267.59
ART	$ 576.48	$ 576.48	$ 2,278.52	$ 1,203.26	$ 1,127.29

The cost per person reached in Belarus are below both the regional average and the median costs for most programs, except those targeting PWID and NSEP. As these costs are not strictly comparable between countries, particularly for prevention programs, as the packages are different, (e.g. higher unit cost may not necessarily mean lower technical efficiency, but may also mean a more comprehensive package), further analysis would be required to determine in which areas technical efficiencies can be increased. The NHAEA recommended ways to optimize HIV allocations for maximum the impacts suggesting the increase of spending for ART, NSP and OST as illustrated in the diagram below (Figure 12).

Figure 12: Comparison of current spending with optimal allocation



3.2.3. Funding Of National Tuberculosis Program

TB care is free in Belarus - TB care is provided free of charge to all patients and exclusively by state-owned health care institutions and facilities with no involvement of private sector. All TB control activities are funded by the state from the national budget.

The TB budget decreased by almost 30% in 2013 compared to 2012, though public share of total funding remained unchanged. Total expenditure on TB as a proportion of total expenditure on health is 2.1%. TB control activities are funded through three main sources: (i) funds from national and local health care budgets which cover operational costs (funding for hospital and out-patient system infrastructures, salaries for staff involved in TB control); (ii) funds from the National Program Tuberculosis which is the main sources for the procurement of diagnostic equipment, drugs, support to refurbishments of TB facilities and some other costs, and (iii) international donor sources with the Global Fund as the main donor in the area of TB control.

Table 12: TB Program funding in million US$, 2012 - 2013

EXPENDITURE CATEGORIES	2012				2013			
	GOV	GF	OTHER EXTERNAL	TOTAL	GOV	GF	OTHER EXTERNAL	TOTAL
TB drugs 1st line	4%	4%		**4%**	6%	0%		**3%**
TB drugs 2nd line	30%	49%		**39%**	57%	64%		**59%**
MDR resistance	0%	5%		**2%**	0%	8%		**3%**
Consumables	46%	16%		**33%**	29%	8%		**19%**
TB Human Resources	3%	4%		**3%**	0%	5%		**2%**
Program management	0%	21%		**10%**	0%	10%		**4%**
TB/HIV	0%	0%			0%	0%		**0%**
Community participation	0%	0%		**0%**	0%	3%		**1%**
IEC	0%	2%		**1%**	0%	0%		**0%**
Other (e.g. specialist care)	16%	0%		**9%**	8%	3%	100%	**7%**
Grand Total	**6.9**	**5.7**	**-**	**12.6**	**4.9**	**3.9**	**0.1**	**9**
% Of total program expenditure	**55%**	**45%**	**0%**		**55%**	**44%**	**1%**	

In 2013, the TB budget decreased by almost US$ 3.6 million compared to 2012 (Table 12). Funding from both the government (US$ 2million) and the GF (US$ 1.76 million) declined. The shrinkage of GF funding is not adequately compensated by the government which aims at maintaining same share (55%) of funding as in previous year (Table 12).

The level of funding by both sources in 2012 for the 1st line TB drugs has not been sustained by the government in 2013 when it took over the responsibility for fully financing these medicines. Despite efforts to obtain figures about unit prices and/or volumes procured locally, the government failed to provide the data. The explanation given was that procuring locally-produced medicines allowed the government to purchase the same volume of drugs with less funding. Given the fact that 75% of total drug spending is on imported medicines, it raises questions on whether the volumes procured through public funding meet the needs.

In addition to the 1st line TB drugs, the government initiated procurement of the 2nd line TB drugs and gradually increased the funding to 33% in 2013. Between 2012-2013 Information, Communication and Education (IEC) related activities received no funding which possibly explains the continuous stigma and discrimination towards TB patients among both the general population and health professionals. The total funding for program management decreased by 30%, which could possibly hamper the program's effectiveness, and it remains funded fully by the GF.

Apart from the medicines, the government also finances ***the*** procurement of consumables and reagents for sputum microscopy. MGIT and LPA Hain laboratory investigations, as well as its share of funding for treatment adherence incentives to patients are gradually increasing.

Table 13: Funding of National TB Control Program, 2013

Financing of TB Control	2013
National TB Budget (million US$)	19.0
Percent funded domestically	26%
Percent funded internationally	24%
Percent unfunded	50%

Source: WHO

Despite the fact that a significant portion of the NTP is alocated by the government, half of the National TB Control Program remains unfunded. The government and external sources cover only half the total NTP budget with 26% and 24% respectively, leaving 50% of the program unfunded (Table 13). About 87% of public funding is allocated for hospital treatment, 12.6% for outpatient treatment and 0.4% for prevention. Imported drugs account for 75% of the medicines budget. The Global Fund additional funding for 1st anti-TB drugs came to an end in 2012 (Table 13).

Despite substantial financial infusions, funding for tuberculosis and other social diseases remains limited. Furthermore, the recent devaluation of the national currency, the Belarusian ruble, made imported equipment, medicines and consumables prohibitively expensive. The salary of health workers involved in TB care remains low and does not reflect the occupational risk. Doctors and nurses lack financial incentives to be involved in TB care and provide high-quality assistance to patients. All of these factors negatively affects the implementation of TB programs and makes it difficult to generate the required public health impact.

The decentralization of TB care funding produces imbalances and it affects the quality of care. TB care at the local level is planned and financed from locally-collected taxes. The different economic development in the various districts creates imbalances in the financial allocation, which eventually affect the quality of care. Greater centralization could allow pooling the resources and distributing them more effectively.

Financial resources available from the public purse in support of NTP are used inefficiently. The WHO evaluation of the NTP[85] highlights an urgent need to increase spending efficiency by restructuring the system and optimizing the use of resources. Specifically:

- *Inefficient interventions* such as mass fluorography screening and enforced treatment are areas where resources could be freed up. Involuntary isolation and treatment should be applied only in exceptional circumstances as they are highly resource consuming from both an economic and epidemiological point of view.
- *Current payment methods promote sub-optimal quality in the of TB services.* Hospitals budgets are based on fixed volumes (number of patients) and there are no incentives to improve the care quality or the treatment of more patients beyond the predefined number. This payment method does not create incentives, at any level of care, to increase the number of detected and successfully treated patients, which are among the NTP's objectives. The doctors optimize their income when they treat exactly the planned number of patients. To fulfill the bed occupancy criteria, patients are hospitalized for unnecessarily long periods, a costly practice which in addition increases the risk of cross-infection because of the poor infection control in TB hospitals. The payment mechanisms for involuntary isolation and treatment are an even stronger incentive to increase the length of stay, because hospitals are paid per patient, per day.

[85] Review of the National Tuberculosis Programme in Belarus, WHO, 2011

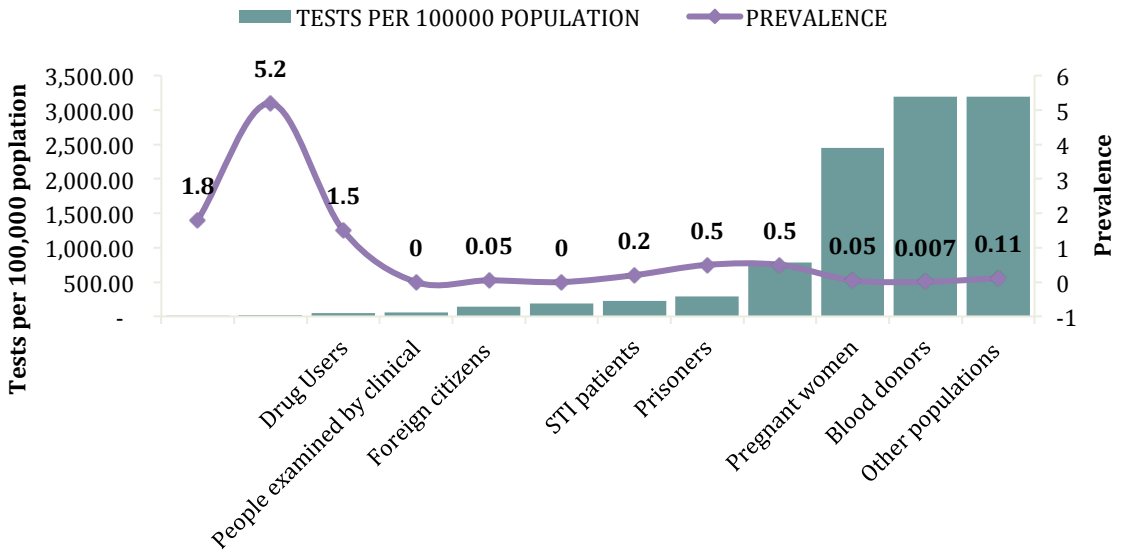
3.3. Service Delivery

3.3.1. HIV

A functioning system of AIDS prevention and control centers operates throughout Belarus, at both regional and national level. Specific treatment and care services are provided by a network of infectious diseases institutions (outpatient and inpatient departments). All other health-related problems are treated in the general health care system.

Coverage of KPs with testing results remains low in the high percentage of undiagnosed people with HIV. A key bottleneck is the low coverage of HIV testing, in particular among high risk groups. The Resolution of the Ministry of Health of the Republic of Belarus #97 of 12 July 2012 "On the establishment of clinical indications for mandatory medical examination of individuals, and on the list of other categories of individuals subject to mandatory medical examination" establishes HIV testing is prescribed in case of pregnancy, STIs, viral hepatitis, IDUs (once a year), as well as for a number of indicator conditions[86] and for prisoners and foreign citizens,

Figure 13: HIV tests vs. prevalence in 2012

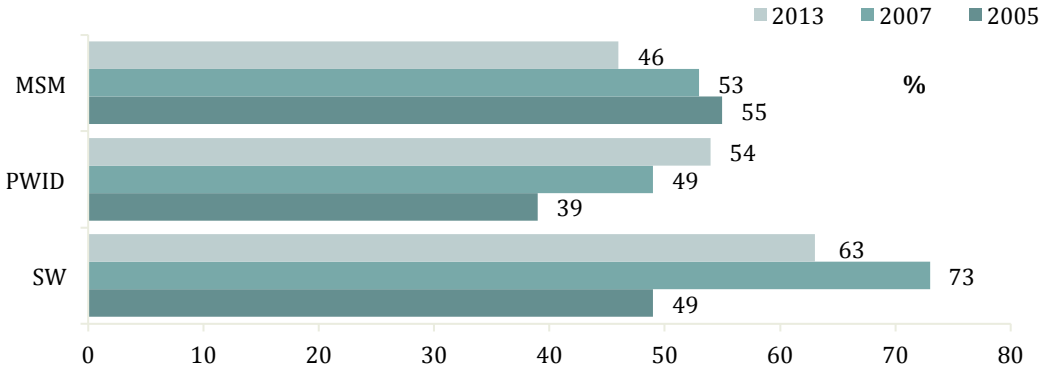


Source: HIV/AIDS Treatment and Care in Belarus – Evaluation Report, WHO, 2014

The number of tests performed annually is around 1 million (over a population 9.5 million) (Figure 13). However, when looking into the categories of people tested, the testing reaching key populations (MSM, IDU and FSW) are either low or not recorded. Figure 13 shows the number of HIV tests in 2012 and the HIV prevalence in the population group tested. In 2014 key interventions[87,88] reached only 26% of KPs hindering further diagnostics and enrolment into care and treatment. National records do not allow disaggregating the numbers of key population groups from those tested for HIV in government facilities and those enrolled on ART.

[86] Resolution of the Ministry of Health of the Republic of Belarus #97 from July 12, 2012 "On the establishment of clinical indications for mandatory medical examination of individuals, and on the list of other categories of individuals subject to mandatory medical examination."
[87] 'Key interventions' mean the following: PWID – coverage at least once a year with syringes, condoms and counseling by outreach worker or a medical worker/psychologist; for MSM and FSW – supply of condoms for at least once a year and counseling by outreach worker or a medical worker/psychologist.
[88] UNDP operational data.

Figure 14: Percentage of KP that have received an HIV test in the last 12 months and who know their results

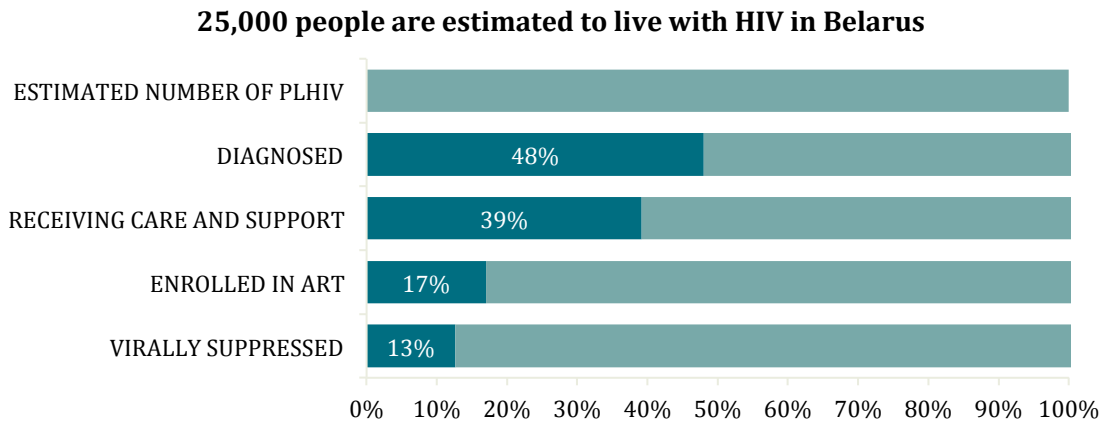


Along with low testing levels there is a serious gap in prevention, counseling and testing high-risk groups. According to the Behavior Sentinel Survey (BSS), only half (54%) of interviewed PWIDs had had an HIV test during the previous 12 months (Figure 14). The percentage of MSMs and SWs who have been tested in the previous 12 months and who know their results decreased by almost 10% since 2007 (Figure 14).

A worrying key problem is that people who are tested positive are then lost to the follow-up test ***before confirming HIV infection***. 75% of clients are lost after the 1st screening test and only 25% perform the confirmatory test after the 1st screening. The target for testing coverage for FSW is set at 15% and at 14% for MSM, without any planned scale up, and is considered very low, like the 23%[89] target for sex partners of PWIDs. The low testing coverage in KPs is also shown in the high percentage of undiagnosed people with HIV. The result is a late diagnosis, hence higher morbidity and mortality, greater economic costs, and increased risk of transmission.

The country has experienced a rapid increase in the number of PLHIV receiving ART. Continuum of the HIV treatment underscores the importance of continued and intensified efforts to reach more people for testing and to make sure that those with the virus receive prompt, regular care and treatment to help them live longer, healthier lives and prevent the spread of HIV. The Republic of Belarus has a decentralized system of providing ART services with the annual increase of access to services for PLHIV. in 2013 there were 343 health care institutions providing ART across the country.

Figure 15: Prevalence based treatment continuum in Belarus 2013



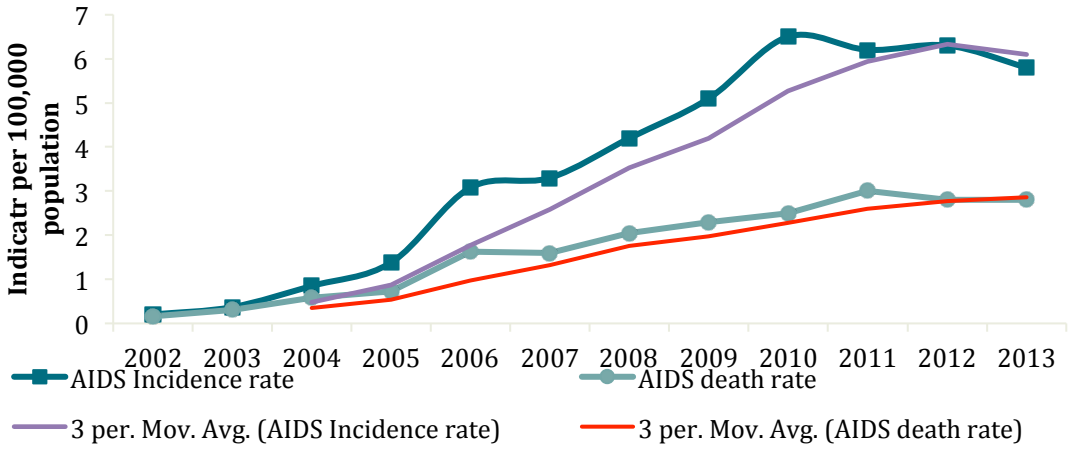
Source: HIV/AIDS Treatment and Care in Belarus – Evaluation Report, WHO, 2014

[89] Evaluation of the HIV program review in Belarus, WHO, 2014.

The treatment cascade presented in Figure 15 shows that the country manages to diagnose 66% of the estimated PLHIV population, out of which only 39% are engaged in care, 22% are enrolled in ART and 14% have suppressed viral load (Figure 15) These data clearly demonstrate that there are weak links from testing to care to ensure that people tested positive for HIV are receive care, meaning that those who have been referred to ART are lost to follow-up.

High rates of lost to follow-up of PLHIV on ART patients. **In 2014** the reported number of patients receiving ART was 5181. The Spectrum data (2014) estimate that about 50% of PLHIV are treated. Furthermore, according to the Infectious Disease Hospital in Minsk, about 120-130 new patients start ART each month and 50 patients of them discontinue the treatment and are lost to follow-up each month[90] (corresponding to a lost to follow-up rate of 10%).

Figure 16: AIDS and AIDS related death rates (3 period moving averages) 2002-2013



Furthermore, the AIDS incidence and AIDS-related death rates were analyzed using three-year moving averages as a proxy for the quality of the treatment outcomes. Figure 16 shows that the incidence rates for AIDS cases are climbing. All of this indicates that the ART treatment is failing to reduce AIDS cases or improve the patient outcomes by reducing AIDS-related deaths. This leaves ground to raise questions about a) the quality of the ART program or b) thee timely and adequate linkages between preventive and curative programs, which have to assure that HIV infections are detected at an early stage of the infection and/or disease, and that patients are timelu enrolled in quality the ART. In order to assess the situation more in depth attempts were made to analyze the time patients would start the treatment as well as lost to follow-up rates, albeit the information system in the country does not collect required data to conduct such analysis.

In summary, there are many barriers to HIV testing and treatment. Challenges exist to scale up the HIV testing and ensur that the number of undiagnosed people with HIV is reduced and people diagnosed with HIV are successfully linked to care and treatment. These include: rapid testing is illegal and not considered a diagnostic tool; the requirement to present a formal ID in order to get an HIV confirmatory test; 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; fear of stigma and discrimination. Furthermore, there is a lack of physicians and medical nurses providing treatment and care (due to the low salary), a lack of social support, and a high personnel turnover. This is resulting in no follow-up on PLHIV who have been registered for HIV care, but do not come for regular check-up; lack of information/misinformation, long queues to visit a doctor etc. These factors create barriers to access to treatment and care and negatively influence adherence. Some services (e.g. HIV testing using blood rapid tests) are provided by health staff employed by NGOs (saliva HIV rapid tests - informal). Insufficient capacity levels in some

[90] Ibid 69.

regions highlights the need to strengthen the cooperation between the governmental institutions working on HIV/AIDS and NGOs to ensure patients' timely access to health and social services, by improving well-timed and complete diagnosis, prompt prescription of correct treatment, and good adherence to ART.

To date, low service coverage has not led to clear results in terms of positive behavior changes and lower HIV rates. The latest IBBS data from November 2013 seem to indicate increasing infection rates particularly among FSWs and MSM, while HIV prevalence is at best stabilizing among PWID. Similarly, while some positive behavior changes are observed especially in the field of safer injection practices – condom use and other safer sex practices remain low among all groups (Table 14).

In order to influence treatment outcomes a multidisciplinary team approach has been introduced. The treatment cascade for Belarus with gaps in the diagnosis, coverage of treatment, and share of people with suppressed viral load highlighted the need for a multidisciplinary approach for the patients' benefit. The MOH issued and enforced an order introducing the multidisciplinary team approach and envisaging the work of peer-consultants, psychologists and social workers together with doctor and nurse. By the end of 2014, 11 peer-consultants worked to increase retention in care and adherence to treatment. However, assistance to PLHIV is still largely 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 the treatment and assistance. The State HIV Prevention Program for 2016-2020 envisages funds from the local budgets to pay psychologists, social workers, and peer-consultants working in multidisciplinary teams.

Table 14: Behavior changes among KP 2005-2013

	2005	2007	2009	2013
Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	34	68	70	54*
Percentage of SWs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	24	50	67	-
Percentage of female and male sex workers reporting the use of a condom with their most recent client1	77	76	70	86
Percentage of PWID who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	61	58	58	
Percentage of injecting drug users reporting the use a condom the last time they had sexual intercourse		59	59	41
Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected		71	87	91
Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	63	56	72	
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	62	67	61	65

*Source: UNIADS Global Report * 2012*

Opioid Substitution Therapy (OST) is available for a limited number of PWIDs. Since 2007, the Ministry of Health has opened 19 OST sites in all oblasts, with the funding from TGF. The OST is provided by governmental health care institutions at city and oblast levels: drug treatment dispensaries and one TB dispensary in the city of Gomel. By the end of 2014, OST services were partly covered from governmental funds, e.g. the staff salaries. The medication was purchased and distributed by the TGF. Overall these sites assist a total of around 1,000 patients. Current coverage is around 5 % of the 18,450 estimated opioid injecting population (the estimated total number is 75,000). This is well below the target set by the WHO/UNODC/UNAIDS (20-40% mid-level, >40%

high)[91]. While there is much higher demand for the service, the lack of narcologists tasked with the provision of OST services limits the increase of targeted population.

The legal security requirements at the OST sites, as well as for safe storing and transportation are excessive and account for 31% of the total OST costs[92]. These high costs for security are not justified as advised by the WHO. The MOH alone is not in a position to review and simplify these legal requirements as they fall under the Ministry of Interior. Due to the excessive security obligations for storing and transportation of methadone, opening new OST sites is seen as unattractive by administrations and staff at TB treatment centers, infectious disease and drug treatment centers, as well as policlinics.

> "In the last years the pattern of drug use in Belarus has changed. Synthetic cannabinoids ("spices") and stimulants (most probably related to amphetamines and mephedrone) are increasingly used. Some of the substances are injected up to 8-10 times daily."
>
> ***Quote: From the Interview of High Government Official***

According to the current legal framework, OST patients are included into a register after they start treatment[93], hence acquiring the same status of illegal drug users who are not in treatment. The inclusion into the register highly stigmatizes OST patients and restricts their chances to find a job because the common practice for governmental institutions is to require proof that one is not on the drug addicts' register.

The lack of legal possibility to receive medications for home use is another other factor making OST less attractive to PWID and detering them from an early approach of the opioid dependence treatment. Even patients who are successful in in treatment, do not use illegal drug for months and years and are socially fully integrated and work cannot have medication for the responsible use at home[94]. Psychosocial support and case management is available in only 2 OST sites out of 19 (11%), all other OST sites provide only medical care.

Harm reduction programs are provided mainly by NGOs and are available on a limited scale. Harm reduction services are provided by NGOs in 26 drop-in and 6 mobile centers across the country. These NGOs have extensive experience in providing a variety of services: needle syringe programs, HIV testing and counseling (HTC), running mobile units, referrals to infectious disease and social services, counseling on adherence to ART, coordination of multi-disciplinary team (nurse, infectious disease specialist, drug treatment specialist, social workers).

The quality of NSP services requires improvement. As per 2014, only 34 syringes were distributed per PWID per year. The mid-level target indicator set by WHO, UNODC and UNAIDS is 100-200 needles/syringes per year[95]. At the same time the NGO indicates that stock-out of injection equipment is experienced, and as a result their harm reduction services loose clients. Harm reduction programs include screening of pulmonary TB among PWID with a 4-item questionnaire. If needed, patients are referred to fluorography in policlinic.

The public health system is engaged in the prevention of Mother-to-Child Transmission (PMTCT). The implementation of measures to prevent vertical transmission of HIV started in 1997 and has constantly improved. The PMTCT strategy is based on the recommendations of WHO and national protocols for treatment of HIV infection. ARV treatment and prophylaxis is offered to HIV positive pregnant women and mothers as well as to children born to HIV mothers and or infected.

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[91] WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. WHO, UNODC, UNAIDS 2012.

[92] M.Petrovich, A.Aleksandrov. "Evaluation of the socio-economic effectiveness of OST programs with methadone on the basis of Gomel oblast (2013)". Minsk. Report presented at the roundtable discussion on the Sustainability of Opioid Substitution Program in Belarus, UNAIDS, March 28, 2014

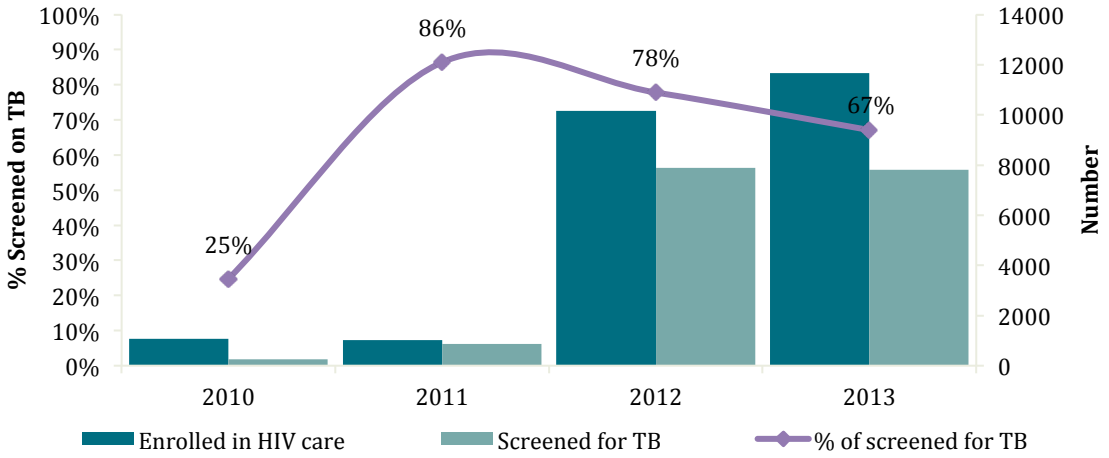
[93] Order of the Minister of Health No 1233 from November 16, 2010 "About using opioid substitution treatment for patients with opioid dependence". Republic of Belarus.

[94] Evaluation of the HIV program review in Belarus, WHO,2014

[95] WHO, UNODC, UNAIDS "Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users" - WHO, UNODC, UNAIDS 2012.

In 2013, 95.9% of HIV infected pregnant women attended an HIV prevention course during the pregnancy and childbirth (in 2012 - 98.1%). In 2013 96.2% of women received drug prophylaxis with three antiretroviral drugs.

Figure 17: Number and percentage of the people enrolled in HIV care and screened for TB during their last visits, Belarus, 2010-2013.



The lack of integration of TB/HIV services creates serious access barriers and impacts treatment outcomes. PLHIV's treatment and care is part of the infectious diseases services. There are HIV outpatient departments in Minsk city and in each of the six oblast infectious disease hospitals. There are also HIV outpatient consulting rooms in polyclinics at district level. The infectious disease specialists working in these facilities are responsible for the regular check-ups of PLHIV, the provision of antiretroviral, isoniazid preventive, and cotrimoxazole preventive therapies as well as the diagnosis and treatment of opportunistic infections.

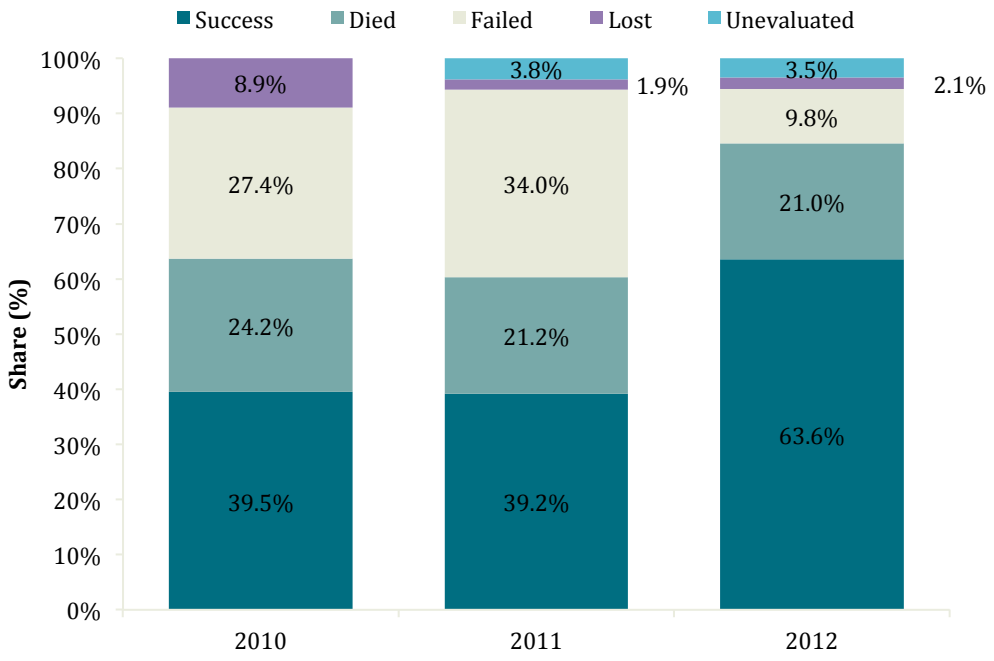
The TB screening is carried out through history-taking and clinical examination at every consultation. Under national guidelines, PLHIV should also have a chest X-ray at least twice a year at the polyclinic. When PLHIV are suspected of having TB during a regular visit with the infectious disease specialist, they are referred to TB services. Communication between these two services is sub-standard.

TB services are the only services legally allowed to diagnose TB, and any investigation carried out elsewhere is not accepted and must be repeated by the TB specialist. Repeated TB investigations in different services lead to diagnostic delays, frequent patient drop-outs, and unnecessary costs. The algorithm for TB diagnosis among PLHIV is not well developed, and available technologies for rapid diagnosis and TB-drug resistant are not used, despite their proven effectiveness in decreasing the high mortality among TB and MDR-TB/HIV patients. Patients are not informed or briefed neither about their risk of developing TB nor about the disease's symptoms and the importance of treatment adherence[96].

In 2013, 67% of PLHIV enrolled in HIV care were screened for TB, down from the 78% TB screening coverage carried out the previous year (2012). However, the absolute number of people enrolled in HIV care tested on TB has significantly improved since 2011 (Figure 17).

Figure 18: Treatment outcomes of HIV/TB patients (2009-2012 cohort)

[96] Review of National Tuberculosis Program in Belarus, WHO, 2011



The National TB Programme 2010–2014 and National HIV Programme 2011–2015 do not have a TB/HIV component and are run separately with their own management and service delivery mechanisms.

This vertical approach could be a serious barrier to access high-quality and timely diagnosis, treatment, and continuos care. In 2013, among all the people newly enrolled in the HIV care, only 6.4% were diagnosed with active TB, out of which only 26.6% received isoniazid preventive therapy (IPT).

3.3.2. Tuberculosis

TB control interventions are delivered through a network of dedicated TB facilities and primary health care services. There are 24 TB hospitals in the civilian system, with a total capacity of 4,605 beds, and one TB hospital in the penitentiary system with 1,860 beds (including 160 beds for MDR-TB patients). In recent years, 740 beds in eight hospitals have been re-assigned to MDR-TB patients. For outpatient care, there are 6 regional (oblast) TB dispensaries, 29 rayon TB dispensaries and 132 TB cabinets with a TB doctor located in general polyclinics, which provide primary health care in urban areas[97]. In rural areas, primary health care services are delivered by general practitioners working in ambulatories (small rural outpatient clinics) and by feldshers (medical assistants) in feldsher ambulatory practices[98]. Both of these services have been involved in TB control since 2002[99]. PHC providers are responsible for identifying people with relevant symptoms, registering them as TB suspects, performing sputum investigations and referring them to the specialized TB service. Diagnosis of TB is established in the specialized TB service units in each peripheral district (rayon) of the country. The diagnosis is identified by direct smear microscopy and complemented by additional clinical and X-ray examinations, and in some cases, through Xpert MTB/RIF investigations.

Unnecessary long hospitalization, widespread use of involuntary isolation and treatment in hospitals along with poor infection control measures in place may be considered as a major

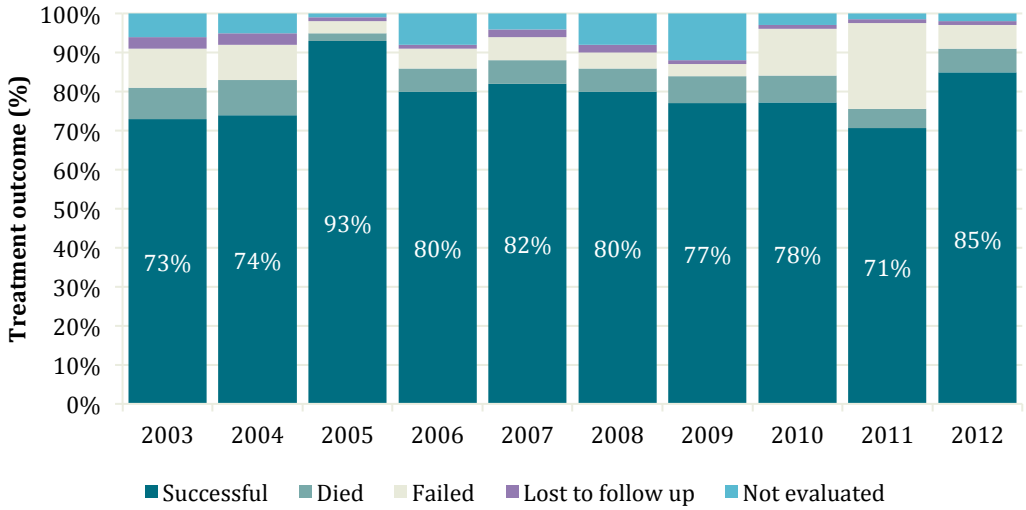
[97] Ibid 72.
[98] Ibid 72.
[99] Ministry of Health Order N° 106 of June 4, 2002 on "Instruction on TB diagnostics in adults".

"In the absence of social support services, compulsory hospitalization is considered a measure to ensure treatment adherence. But lately we managed to find ways for the provision of publicly-funded social support (food products) to the TB patients and the involuntary hospitalization has been significantly reduced"

Quote from Key informat Interview

cause of TB[100]. Patients are usually hospitalized more often and for longer than necessary, partly because the budget allocated to hospitals is based on the number of beds and their occupancy rate. Other reasons claimed are the poor treatment compliance by "difficult" patients outside hospital and the need to offer temporary shelter to "social" patients. As mentioned previously, TB patients receive a disability benefit that is withdrawn shortly after their hospital discharge, which is very inconvenient for those patients previously working in contact with the public who are not allowed to work during the entire period of their treatment[101]. As a result, most of these patients remain in hospital unnecessarily. Some action has already been taken by the National TB Programme, which has submitted a draft order to the Ministry of Health on "Instructions on allowing TB patients to work or study". According to the most recent reports, since 2010 Belarus managed to decrease hospitalizations by 30% (from 1,230 days in 2010 to 430 days in 2014) thanks to enhancement of DOTs at PHC level.

Figure 19: Treatment outcomes in new TB cases, Belarus 2003-2012*



Source: Global TB Database* 2012 data per new definition framework

The TB treatment lacks efficiency. Some patients are referred from one facility to another but are not accompanied by their complete medical records, which means that investigations are repeated unnecessarily and sometimes patients are registered wrongly and the wrong treatment is prescribed. Furthermore, pursuant to Ministry of Health Order N° 106 of 4 June 2002 on the "Improvement of dispensary follow-up and identification of TB patients in the Republic of Belarus", former TB patients are called back for an annual clinical check-up for two years after they have been declared cured. This practice is considered an unnecessary financial burden[102].

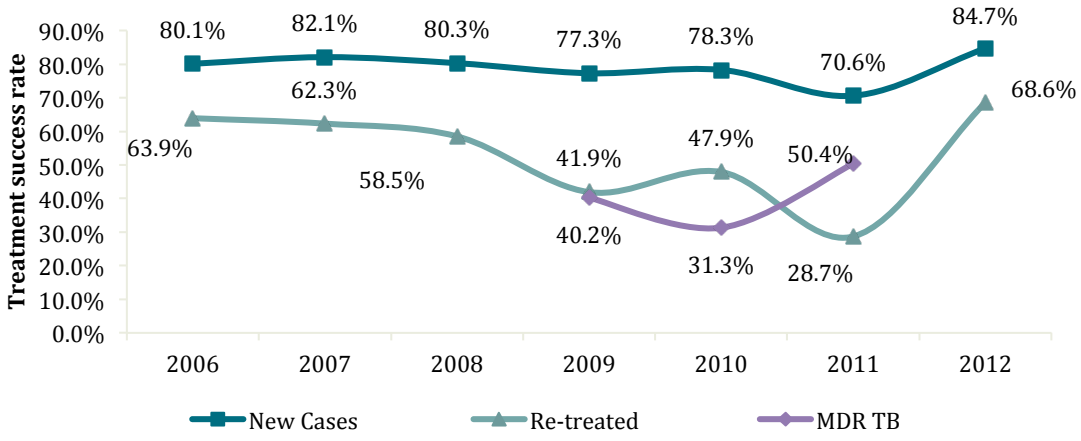
Belarus' treatment success rates of new TB cases has worsened. Between 2003 and 2005 (per former reporting framework) the treatment success rate of new TB cases ranged from 71% to 93%. Since 2005, success rate among new TB cases has decreased, most probably this is related to the increase of MDR TB cases[103].

In 2011 the main reason of the unfavorable therapy outcome was the treatment failure (22%) associated with the high prevalence of MDR among new TB cases. The proportion of cases with lost to follow-up in Belarus is negligible (2%) thanks to the significant improvements in the recent

[100] Review of National Tuberculosis Program in Belarus, WHO, 2011.
[101] Ministry of Health Order N° 47 issued on 28 April 2010 on "Instructions on mandatory medical examinations of working people and amendments of some resolutions of the Ministry of Health of the Republic of Belarus."
[102] Ibid 75.
[103] Ibid 75.

years in the ambulatory DOT treatment and Belarus' law on compulsory isolation and treatment of TB. With the revision of reporting definition framework, the success rate of treatment among new TB cases in 2012 cohort was 85% which is above the average of the WHO European Region which stood at 75.6%. The proportion of patients who died and failed was 6% each.[104]

Figure 20: Trends in treatment success rate among new, retreatment and MDR-TB cohorts, Belarus 2006-2012*



Treatment outcomes among new, retreatment and MDR-TB patients show positive trend. In 2009, 2nd line treatment became available in Belarus. It is expected that the introduction of MDR-TB treatment will gradually reduce the TB epidemic. The rapid change in 2012 in re-treated and new & relapse TB cohorts is related to the transition to the new recording and reporting framework. Although there is obvious positive trend in therapy outcomes for drug susceptible TB, high level of MDR-TB and XDR-TB is still an issue and holds back further improvement.

Treatment success rate of MDR-TB patients remains low. Treatment success rate of MDR-TB patients was quite low in the first two-treatment cohort of MDR patients accounting for 40% and 31% in 2009 and 2010 cohort respectively. Low success rate at the beginning of SLD treatment programs is explained by the fact that in the first cohort, the proportion of patients with severe clinical conditions, with several attempts of unsuccessful treatment with FLD is large, therefore the risks of unfavorable outcomes is high. For the third cohort, in 2011, treatment success rate was 50%, which is slightly higher than regional average, but far below the national target - 75% by 2020 (Figure 20).

While testing coverage of all HIV/TB patients at TB facilities shows a consistently high inclusion of registered cases, testing coverage of people enrolled in HIV care has gradually deteriorated. Since 2007, Belarus consistently reported a high coverage of HIV testing among TB patients, suggesting a routine HIV testing among TB patients. While this is encouraging, TB testing among PLHIV declined from 86.4% in 2011 to 67.1% in 2013.

Belarus shows improving treatment outcomes of all HIV/TB patients. In 2013, among the 1,513 persons newly enrolled in HIV care, 97 (6.4%) were diagnosed with active TB, and 403 (26.6%) received isoniazid preventive therapy (IPT). These are again very low figures, since about 50% of these newly enrolled in HIV care and screened for TB are likely to be eligible for IPT. The coverage of co-infected TB/HIV cases with ARV treatment increased from 29% in 2011 to 76% in 2013. However, it still remains below the WHO target of 100% ART coverage. As for the CPT, in Belarus there is no information related to CPT coverage in the data of National surveillance system. The main achievements in HIV/TB co-infection control are related to: high rate of HIV testing in TB patients, rapid enrollment in ARV treatment of patients with HIV/TB co-infection (from 2011), provision of IPT to PLWH (from 2010), and increase of the treatment success rate of co-infected

[104] Belarus TB Epidemiological and Impact Analysis, pg. 36.

HIV/TB patients (in the 2012 cohort). The main challenges still include obsolete procedures for HIV testing with long lead time to get the final results of HIV status.

The prospects for social protection of TB patients are unfavorable unless the Government takes decisive steps. Forms of social protection are in place in Belarus for TB patients with a formal employment. Sick leave is paid from the social protection funds amounting to 80% of the basic salary during the first week of sickness and 100% from the second week up to a total of six months. This may be adequate for a drug-susceptible TB patient, but not for a MDR-TB patient requiring much longer treatment and care. In these cases, a temporary occupational disability benefit can be requested. TB patients without formal employment do not have any social protection.

TB prisoners are treated in prison TB hospital. The Ministry of Interior has his own health care system, and treats all TB patients in jail at the Republican TB Hospital in Orsha and at the TB women department of Gomel's prison hospital. TB notification and reporting from penitentiary sector is fully integrated into the National electronic TB register. The Republican prison TB hospital has a third-level TB laboratory that is conducting DST to first and second line drugs, participates in the quality assurance system that is organized by National reference laboratory and, since 2014 is equipped with GeneXpert machine.

3.4. Human Resources

3.4.1. General overview of human resource production, deployment and retention

Health workforce shortages are common in Belarus and the country lacks human resource planning and development strategy. Planning for health care personnel is still developed on the basis of norms, and there are policies to redistribute health workers to fulfill these norms (for example, new graduates have to complete a compulsory 2-year work placement in primary care). Howevet, it is still proving difficult to fill posts in less popular medicine branches, and the size of the hospital sector means that there is almost no limit to the number of new specialists that can be absorbed into secondary and tertiary care. Different approaches to health care planning are being explored, but it is likely that norms-based planning will prevail for the foreseeable future. The country lacks a human resource information system which allows forecasting the staff requirements and the implementation of appropriate human resourcing, including the number of staff, specialty, deployment, retention and development.

The education system, largely unchanged from Soviet times, is reacting very slowly to the demands of the market. There are four medical universities in Belarus providing basic medical training for doctors. There is also a separate institution (BelMAPO), which coordinates all postgraduate or continuous medical education for doctors and for some nursing specializations. There are no private institutions in the health education sector. Belarus remains the only country in Europe outside the common European educational space, also known as the Bologna system.

Minimum standards exist for continuous medical education for practicing doctors. Doctors are obliged to follow two 14-day upgrading courses, with a minimum of 80 learning hours, every 5 years. There are also financial incentives to attend updating courses at least at the minimal requirement level.

3.4.2. HV Human Resources

Human resources in the health and NGO sector involved in implementation of the national HIV response have been adequately identified and their capacities strengthened. The human resource capacity in the governmental sector that has been employed in the GF-supported grant includes staff from health facilities, health workforce in prisons, social and psychological services. Some of this staff already had previous experience and capacity to work with key populations, such as staff at Narcological Dispensaries, Dermato-venereological Dispensaries, regional HIV departments and hospitals, medical staff in prisons and detention centers, and social workers. In addition, technical capacity has been strengthened to provide new services, particularly methadone substitution therapy and ARV treatment. In parallel, the human resources in the NGO sector involved in the national HIV response have been estimated to be adequate by the Mid-term

evaluation of the National HIV Response program[105]. While the available workforce has been adequately identified, utilized and strengthened, challenges remain with regards to whether it is sufficient for an effective implementation of the programs.

Shortage of specialists, geographical disbalance, high turnover, and lack of motivation are common in Belarus. There is a lack of physicians and medical nurses providing treatment and care (due to low salary) and a lack of social support. The situation is further complicated by the very high turnover of doctors; the limited "respect" that infectious diseases have (as a specialty) in the professional circles which influences patient-doctor relationship; the patients' lack of trust towards medical professionals. Outside Minsk, there are no infectious disease doctors working on pediatric cases. For example the main Narcological Dispensary OST service point in Minsk serves around 55 patients and is not able to admit more, due to the limited number of medical doctors (Narcologists). The shortage of staff for HIV treatment and a high personnel turnover produce inadequate information or misinformation – there are many examples of people who stopped taking their medicine when they felt better following advices given by informants.

> There is a huge mistrust in the system, personal beliefs, and a general low knowledge of HIV transmission and treatment"
>
> ***Quote: From Key Informant Interview***

Inadequate scale of NGO capacity building trainings. Despite plans of extensive training, some NGOs mentioned challenges with regards to limited capacity building for the staff. This has an obvious negative impact on the services' quality and coverage, while capacity building can also be used as a non-monetary incentive to increase staff motivation. One explanation for the seeming contradiction between the existing training plans and perceived limitations with regard to capacity building by some NGO staff is that not all staff and/or volunteers are effectively participating in the training programs. Hence, additional attention may be given to ensuring capacity-building activities reach all staff and volunteers involved in programme activities.

> "Not all staff members received required training "
>
> ***Quote: From Key Informant Interview***

The Government promotes online/distance learning for sustainable human resource capacity building. The distance learning portal is based on the website of the Belarusian Association of UNESCO Clubs (an NGO) which uses the Moodle platform and it allows training of volunteers and professionals, especially those in remote and rural areas. The main courses developed and offered so far are "Management of prevention programs on HIV / AIDS for youth leaders" and "Access to quality counseling and HIV testing for adolescents and young people at risk". Furthermore, a new online training module on PMTCT has been piloted for Infectious Disease specialists and pediatricians. While these initiatives are commendable, the use of the given mode of human resource capacity building for wide use should be based on thorough analysis of internet access in different parts of the country, a degree of computer literacy among health and NGO staff, as well as the possibilities for formalizing these training courses through the accreditation and inclusion in the CPD/CME system as well as in education institutions.

Training modules developed by the GF grant and/or with other external funding are not yet integrated into the formal education and funding mechanism not defined. The GF grant supported the development and the delivery of a number of training courses, such as VCT and case management courses, coaching of multidisciplinary teams (physician, nurse, psychologist or social worker) for the provision of ART and adherence. However, these modules are still delivered with

[105] The following NGOs are engaged in delivering preventive and support services to key populations: i) well-established larger NGOs with a wide countrywide network, such as the Belarusian Red Cross Association; 2) NGOs with specific experience in the HIV or health field, and strong institutional capacity, such as sub-recipients Positive Movement, Bel-AU and Vstrecha; and iv) local NGOs and community-based organizations with specific experience in working with PWID, sex workers or MSM, such as local organizations of parents of drug users, self-help groups of active and ex-drug users, local chapters of MSM organization Vstrecha, and local NGOs working with sex workers and disadvantaged women.

full financing of the grant, raising sustainability concerns. Furthermore, modules have not yet been integrated into the formal education system for health professionals and continuous professional development of health workers. What is still missing is a mechanism ensuring continuous education of social and NGO sector workforce for the effective delivery of HIV-related prevention.

3.4.3. Tuberculosis human resources

The provision of TB service is severely understaffed, hnce affecting the quality of TB care. In 2011, 78% of the total established positions were filled, albeit with some differences across oblasts (e.g. 97% in Grodno oblast and 59% in Minsk oblast). To compensate for the shortage of staff and create a financial incentive, the Ministry of Health allows TB doctors and nurses to work 1.5 full-time equivalent (FTE). This is an arrangement that allows a fixed budget to be redistributed among fewer staff. National statistics show that, on average, TB doctors work 1.39 FTE and nurses 1.13 FTE and the negative trend in the recruitment of new TB doctors and nurses has not reversed. More than 33% of the staff currently employed is close to retirement. Respondents claim that the lack of young doctors and nurses in the TB care is a consequence of perceived low salaries, which do not compensate for the high risk of TB infection.

To ensure treatment adherence the first steps for TB workers' motivation has been carried out by the Government: the Ministry of Labor and Social Protection determine the medical staff salaries, while the MOH can propose a system of bonuses, including those for occupational hazards. Under the current system, TB doctors and nurses have a maximum of 35 working hours per week compared to the 38.5 hours for all other medical staff and they can retire five years earlier.

TB training modules are integrated into the formal and continuous medical education systems. All four medical schools in Belarus cover TB in the graduate training curricula (with the exception of dentistry), through lectures (16–28 hours) and practical exercises at TB dispensaries (55 hours for primary care doctors and 40 hours for pediatricians). Elective courses on diagnosis of TB and extra-pulmonary TB are also offered during the last year of medical school for therapists and primary health care doctors.

The RSPCPT organizes postgraduate TB specialization and offers on-the-job training for 8–12 laboratory specialists per year, it coordinates quarterly monitoring meetings with the heads of the oblast TB services and it holds annual scientific conferences.

All doctors, including TB doctors, have to renew their practice licenses every five years by accumulating 80 credit hours of continuing medical education organized by the BelMAPO in Minsk. Conferences approved by the Ministry of Health or regional health authorities may also qualify as continuing medical education. Training curricula are revised in collaboration with the National TB Institute every year at university level and every two years at BelMAPO's and they can potentially include necessary updates, for example on rapid TB diagnostic tools.

In-service training is provided by UNDP in order to achieve the Global Fund grant implementation targets. UNDP has two dedicated staff members, one to organize the courses (outsourcing and monitoring) and another to develop the content (working with TB specialists, getting Ministry of Health endorsement). All training curricula have been updated in accordance with the new national guidelines and information gathered from international training.

3.5. Commodity Forecasting, Procurement and Supply Chain Management

3.5.1. General overview of the procurement and supply management system in the health care

***The National Procurement law governs public procurement in the country*.** The legislation of the Republic of Belarus on public procurement consists of the Law "On Public Procurements of Goods, Works and Services" (No. 419- Z of 13 July 2012), plus 77 Presidential decrees, government resolutions, and ministerial decisions (such as ordinances of the Ministry of Health regarding the procurement of medicines). The Law on public procurement establishes a general framework for the supply of goods, services, and services for public aims. As the bill requires bidders (suppliers) to

be registered as a legal entity or a sole proprietor, foreign drug manufacturers can also participate in tenders if they are duly registered as a legal entity in their country.

The legal framework for the registration and quality control of medicines and medical products are continuously enhanced and aligned with international standards. The legal framework for the registration and quality assurance of medical products in Belarus is subjected to a continuous process of alignment with European Union standards. The country has adopted amendments to the Law on Medicines, which simplifies the procedures to register medical products, strengthens the control over the quality of the drugs and it allows price regulation. The new bill foresees the possibility of issuing a perpetual license and it also stipulates that only medications with an international certificate can access the market.

The National Medicines Regulatory Authority comprises two institutions. The Ministry of Health, is responsible for policies, legislative proposals, licensing and inspections and the supply of centrally procured medicines and commodities. The Centre for Examinations and Tests in Health Care is in charge of technical assessments (for drug registration and clinical trials), monitoring (pharmacovigilance, quality control, advertisement) and several inspection functions (good clinical practices (GCP) and good manufacturing practices (GMP)).

The share of Belarus-produced medications on the home market is gradually increasing. The share of locally-produced medicines is expected to reach 50% in monetary terms in 2015. Nevertheless, there are plans to export more as well. Belmedpreparaty is a modern export-oriented public enterprise using high-end pharmaceutical technologies and it holds the GMP certification and quality control of the Pharmaceutical Inspection Convention/Cooperation Scheme (PIC/S), EU and WOS standards. The enterprise manufactures over 350 types of medicines.

The country also applies a pricing policy by which prices of medications are raised only when the new substances cost more than old ones. Prices for medications without foreign components are not raised. The state retains control over prices for 35 medications, out of a list of over 180 titles. Since the country provide all citizens with medicines, the government securesthe local pharmaceutical companies' profitability and replenishes the home market by creating new medications, including the development of generics. The country plans two main approaches to produce the generics included in the essential drugs list for the centralized medicines supply in accordance with the state directives. However, the Belarusian market is expected to suffer from the impact of the ruble's depreciation and the economic instability as the country has becomes ever more reliant on Russian loans to function. Furthermore, the wage growth decided by the government will become unsustainable, threatening to lower domestic consumption. As Belarus is set to become a member of the World Trade Organization (WTO) in near future and will sign the Agreement onTrade-Related Aspects of Intellectual Property Rights (TRIPS), the local pharmaceutical production may as well be negatively affected.

> "We intend to get all domestic manufacturers to raise their output by more than 40% in order to satisfy the domestic demand, including for TB drugs and test systems and secure a rather broad presence on all the export markets."
>
> ***Quote: Key Informant Interview***

Belarus has a centralized and decentralized procurement system for medicines and supplies. For the procurement of medicines, the MOH Decree No. 723 of 18 June 2013 "On Centralization of Public Procurement of Medicines and Clinical Nutrition" is particularly relevant, as it describes the system of public procurements in the healthcare. The decree defines "Belfarmatsiya" (The Public Pharmaceutical Service), a public entity, as the organizer of centralized public procurement of medicines and medical supplies and is directly involved in selecting and contracting suppliers as well as in following up all operations related to shipment, customs formalities, warehousing, and distribution of drugs. The procurement of selected medical supplies is decentralized to local entities.

According to the MoH decree, regional healthcare departments and state organizations subordinated to the MOH prepare plans (forecasts) for the centralized procurement process and have to sumit the requests to "Belfarmatsiya" or regional Farmatsiya enterprises by April 1 of each fiscal year (the latter prepare aggregate requests and submit them to Belfarmatsiya by May 1). Based on the requests, "Belfarmatsiya" prepares a national aggregate application and submits it to the MOH by June 1 of the fiscal year. After the national budget is adopted, the plan of centralized public procurements is approved by the MOH Decree depending on the amount of funds allocated for these purposes.

The centralized procurement will remain for specific important medicines, such as those for treating diabetes, cancer, and tuberculosis. Such procurement is done on a large scale, in bulk and exclusively on a tender basis. This system allows a more cost-effective purchase of needed drugs and it ensures the access to these vital drugs for the population. All pharmaceuticals supplied in this way are free of charge to patients.

The procurement of medicines and commodities financed by the Global Fund is set as a parallel system. UNDP as a Principle Recipient (PR) uses its own procurement rules as per UNDP Procurement Manual. The UNDP Procurement Support Office (PSO) has finalized several Long Term Agreements (LTAs) with procurement agencies and suppliers for products and services frequently used in GFATM-financed programs. To ensure the proper quality and drugs management, the procurement of pharmaceuticals for ART, consumables for testing (including rapid tests for HIV, Hepatitis B and C), consumables for harm reduction programs should be done through the existing UNDP LTAs. LTAs established for the GFATM-financed programs include: i) UNICEF - pharmaceuticals and other medical products including laboratory equipment related to the treatment of HIV/AIDS, Tuberculosis and Malaria; ii) UNFPA: male and female condoms; lubricants (partially); iii) IDA Foundation: 2nd line anti-TB medicines, drugs for ARVT, drugs against opportunistic infections, anti-Malaria drugs, other essential medicines; iv) IMRES: drugs for ARVT, drugs against opportunistic infections, anti-malaria drugs, other essential medicines.

Belpharmacia is responsible for the storage and distribution of government and GF-procured medicines and supplies. State enterprise "Belpharmacia" is responsible for the storage and distribution of all commodities in the country. Storage and distribution fees are fixed for for both publicly and GF-procured drugs and medical consumables. The WHO review team observed that in a few facilities drug storage conditions were inappropriate, including the cold chain for 2nd line drugs, which could create the risk to compromise the quality of the products.

The situation is different with the non-pharmaceutical goods. The main volumes of non-pharmaceutical goods are intended for non-governmental organizations and their sub-recipients located all over Belarus. Those organizations cannot arrange the distribution of health products by themselves, so, in order to ensure an uninterrupted supply of the necessary health products, PR arranges the distribution from the central warehouse, and appropriate funds are budgeted for this purpose.

3.5.2. HIV

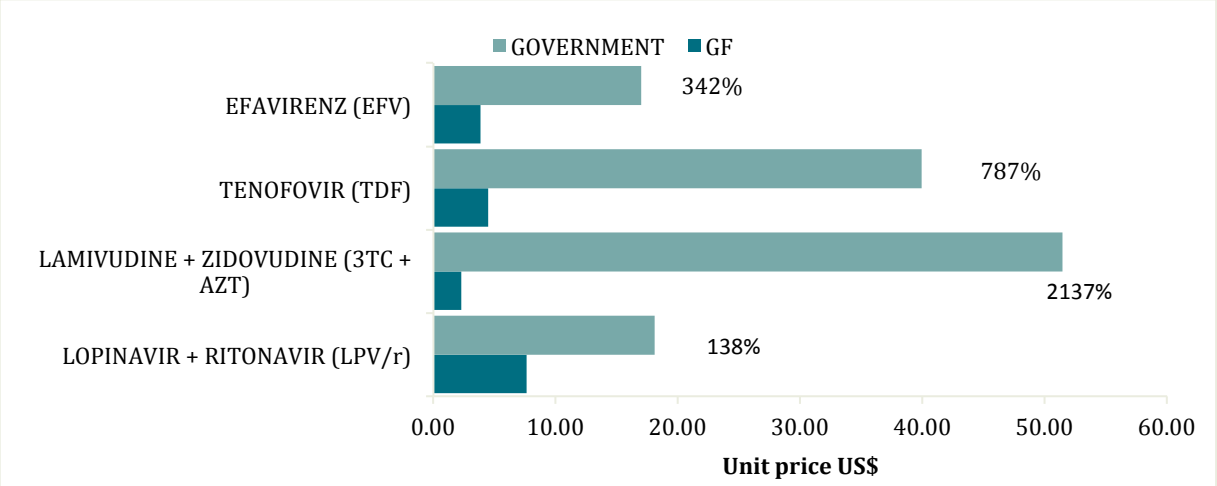
The country lacks a formal methodology for forecasting the ARV drug needs. The Ministry of Health is not involved in the Procurement and Supply Management (PSM) procedures, and limits its involvement to the approval of the annual ARV requirements only. Forecasting in the field of HIV falls under the responsibility of the District Centers of Epidemiology, Hygiene and Public Health. Reports of stock outs were largely due to planning weaknesses at both national and sub-national levels, resulting from the absence of a formalized ARV forecasting methodology[106].

[106] Mid-term Evaluation of the HIV Prevention Programme supported by the Global Fund, EuroHealthGroup, 2014.

Not all ARV drugs recommended by the WHO and national guidelines are registered in the country[107]. At present, there are 19 ARV products registered in the Republic of Belarus. Most of them (16 products) are provided 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. Only few medicines[108] procured through the GF support are registered in the country and non-registered drugs are imported using the so-called 'single entry permit for import' issued by the MOH.

The local procurement of ARV drugs results in higher public spending compared to the cost through the GF procuremen systemt. At the time of the assessment the Government of Belarus procures a share of selected ARV medicines.

Figure 21: Comparative unit prices for key ARV drugs procured by the Government and GF



The price analysis per unit unit for the same medicines purchased by the government and the GF reveals a higher public spending. Dependign on the medicines, price differences vary from 138% to as high as 2,137% (Figure 21). Respondents stated that the option of using the GF drug procurement facility, as alternative to the local procurement, has not been considered at any stage of the transition.

There are logistical challenges in distributing the GF-procured commodities[109]. The mid-term evaluation of the HIV program revealed problems in the distribution of GF-procured commodities. For example, the Anonymous Check Point (ACP) for PWID in Brest had no condoms available. Another ACP for sex workers nearby had plenty of condoms, but it reported that there is currently no mechanism to allow temporary sharing of commodities between ACPs operated by different NGOs for different key populations. The UNDP PIU reports that there is a mechanism on place for redistributing goods between different organizations, but service providers do not always use this in a timely manner. Reportedly, the mechanism is not sufficiently user-friendly, making it difficult to redistribute goods promptly. Hence, it may be necessary to improve the process and raise awareness among the NGOs about it to ensure it is effectively used.

> A mechanism for redistribution of goods between different organizations is in place, but service providers do not always use this in a timely manner
>
> ***Quote: From Key Infornmant Interview***

[107] HIV/AIDS treatment and care in Belarus, Evaluation Report, WHO, 2014.
[108] Lopinavir/ritonavir, oral solution; Lopinavir/ritonavir, tablets, Zidovudine for injection,Methadone, oral solution,Abacavir, oral solution, Ritonavir tablets - Source: UNDP Belarus.
[109] Mid-term Evaluation of the HIV Prevention Programme supported by the Global Fund, EuroHealthGroup, 2014.

3.5.3. Tuberculosis

The TB drug procurement and supply management are compliant with the existing legislation and the National TB Programme guidelines. A total of 124 anti-TB medicines are registered in Belarus (as per 2012). All items are featured on the national essential medicines list.

TB medicines are procured using both centralized and decentralized procurement methods. The procurement of TB drugs is done by the MOH (central procurement of all 1st line and some 2nd line anti-TB drugs) and by the oblast and rayon health authorities (local procurement of quinolones and macrolides), with dedicated personnel in charge of estimating the needs. The central procurement is financed from the MOH budget with the Global Fund and Global TB Drug Facility support. Local procurement is financed from the local budget allocated to oblasts and rayons, which may be difficult to access, causing dangerous delays in procurement.

Delays in the supply of TB drugs were reported due to the lengthy registration procedure. There have been only few occasions in the past when manufacturers did not manage, for various reasons, to supply TB drugs on time. This problem that may be overcome in future by establishing a fast-track registration process with reduced or waived registration fees for WHO-prequalified products imported through the Global Fund and the Global TB Drug Facility. All batches of TB medicines are subjected to quality control by the state control laboratories before entering the distribution system. However, there is concern about the process of re-registration, which is sometimes carried out without enough clinical and bioequivalence/bioavailability data, and authorizations are renewed on the basis of historical data. While it is legally within its powers to do so, the Ministry of Health rarely asks manufacturers to produce these bioequivalence/bioavailability data. Pharma covigilance is conducted through a reporting system by clinicians at all levels. Unfortunately, the reporting of adverse drug reactions is weak and consequently this opportunity to trigger additional checks on the quality of medicines is missed[110].

3.6. M&E and Information Systems

The M&E systems of HIV and TB are fragmented. The M&E systems for HIV and TB are vertically organized and independent. The TB surveillance system is placed at RSPCPT and managed by the M&E unit established in the center, whereas the HIV supervision is the responsibility of the IEHPH. Furthermore, results of the NGO-rendered services as programmatic indicators were reported to the UNDP PIU only until recently.

3.6.1. HIV

According to the WHO assessment of the M&E function, the surveillance system of the HIV epidemic in the country lacks important indicators and is not adequately analyzed to inform policy makers about the priorities within the national HIV program - e.g. 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.. The WHO report 'Evaluation of the HIV program review in Belarus' from November 2014[111] recommends strengthening the surveillance system and ensuring that all relevant data are gathered by one responsible organization. For this purpose, the information system (register) for data collection and reporting was developed within current TGF grant. The HIV register consists of several modules: epidemiological (established, 100% completed, and fully functional); clinical (established, 60% completed); and drug management (in the process of development). The main aim of the register is to gather good quality information to be used for analysis, state reporting, ARVs procurement forecasting etc. The 'owner' of the register is the Republican Centre for Hygiene, Epidemiology and Public Health. The plan for 2015 is to continue improving the HIV-infected

[110] Review of National Tuberculosis Program in Belarus, WHO, 2011.
[111] 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

patient register by including 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).

The 2nd generation surveillance capacity has been built but it remains externally-funded. The HIV surveillance was enhanced with the support of the GF grant, which helped to introduce the 2nd generation surveillance for HIV/AIDS. The country lacks the vision on how to sustanin the 2nd generation surveillance once the external funding from the GF will end.

Belarus tracks AIDS expenditure once every two years. In order to estimate expenditures of the national HIV response, the country uses the National Aids Spending Assessment (NASA) survey, which is carried out once every 2 years and is financed by the GF. The GF support helped to develop the local capacity building for survey planning, data collection, and analysis. Belarus also has sufficient capacity and it produces the National Health Accounts annually financed by the government, which at this point of time does not integrate AIDS sub-account.

Analytical capacity requires improvements. The most recent evaluation of HIV program[112] revealed a lack of analytical capacity in the country. Evidence-based planning is weak, though there are few examples when available evidence informed the political decision on discontinuing some interventions in response to the reduced GF funding.

3.6.2. Tuberculosis

The NTP uses the standardized recording and reporting system, which has been upgraded to accommodate the latest WHO recommendations and additional country needs. In addition to the paper-based TB and MDR-TB registers, Belarus has implemented a web-based, national individualized electronic register for all TB cases. This includes TB patients in the penitentiary system since 2009 and a module for MDR-TB patients since 2012, mostly financed by the Global Fund. The data for all TB and MDR-TB patients are entered into the national electronic TB register at the level of 6 Regional TB facilities (regional M&E units at the regional TB facilities) and the Republican TB prison hospital and are validated on the main program indicators (TB notification, treatment outcomes, etc.) by the Central M&E unit located at the Republican Scientific and Practical Centre for Pulmonology and TB.

4. CHAPTER: ASSESSMENT OF TRANSITION READINESS

This chapter summarizes Belarus' experience in transitioning the program elements; examines the government's readiness to continue, and, where needed, expand activities presently funded through the GF support; and assesseses the country's organizational capacity and country preparation for transition.

4.1. Transition Experience

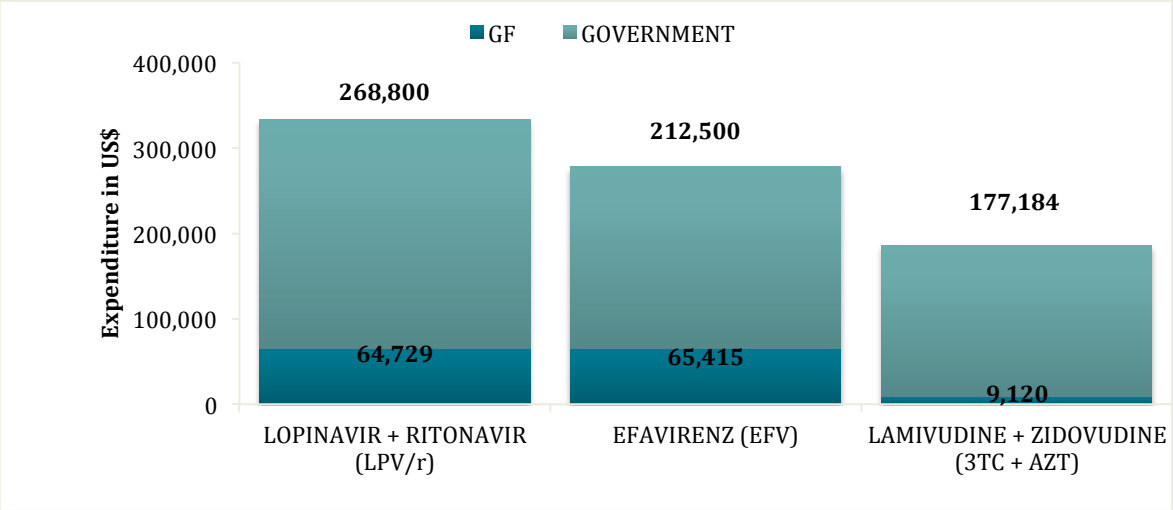
4.1.1. HIV

The Government of Belarus has prepared the ground for an easy and gradual transition while drafting the National HIV Strategy for 2011-2015. The NSP contained the following elements geared towards the transition.

40% of the total budget to purchase of ARV is allocated from the public budget and medicines are procured centrally. Since 2013 the Ministry of Health started to cost-share the expenses for ARVs procurement and planned to gradually increase the allocation of public financing for ARVs (18.3% in 2011 to 24% in 2013).

[112] 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

Figure 22: Cost sharing for the procurement of ARV drugs (2014)



In 2014, the MOH organized the centralized procurement of the ARV drugs and procured three medicines (Figure 22). ARV drugs were added to the annual list of medicines for public procurement and approved by the MOH, and resources accounted in the annual budget. The procedure followed the national procurement law and the contract was awarded to "Farmateh ZAO". The company has registered 3 names of the generic ARV drugs. Procured medicines were stored and distributed using the public supply chain. According to the government, the stakeholders' transition experience was smooth.

The process for consolidating the surveillance and the programatic performance indicator is completed and has integrated the M&E function for almost two years. As described in previous section, the M&E system was fragmented. Surveillance data were collected through a statutory reporting system by the IEHPH, whereas the data on NGO led activities were reported to the PR. In order to consolidate these two information streams, and prepare the ground to integrated the M&E functions before the transition, the IEHPH, jointly with the NGO sector, initiated the development of statutory NGO reporting forms and formalized reporting requirements (forms, frequency, timing and quality standards). The only challenge faced during this process was to encourage NGOs to report on outcome indicators instead of output indicators. Notably, resistance to this change still remains. The consolidated M&E reporting system has been functioning effectively for almost two years now.

> "The consolidation of surveillance and programmatic data was initiated by our institution. The process was held in a participatory manner, where NGO representatives and out staff set together and worked to developstatutory reporting forms and procedures. The only challenge faced was forcing NGOs to include outcome indicators instead of limiting to only output indicators."
>
> ***Quote: From Key Informant Interview***

There are signs of the involvement of the public sector in harm reduction programs. The harm reduction programs, especially NSP, are mainly provided by the NGOs and fully funded from GF resources. More recently, the engagement of the public sector started by ensuring the provision of office space to the NGOs at no cost in selected regions, though this practice has not been formalized and applied to all regions yet.

> "Some local governments expressed their willingness to support NGOs in provision of NSP services by allowing health facilities to provide free office space to NGOs."
>
> ***Quote: From Key Informant Interview***

4.1.2. Tuberculosis

During the last five years, the Government of Belarus has increasingly provided the funding for a significant part of NTP costs. For example, the procurement of 1st line TB drugs, consumables and reagents for sputum microscopy are fully covered by the government which also contributes to

the procurement of 2nd line drugs for MDR-TB patients, to MGIT and LPA Hain laboratory investigations, and is increasing the provision of adherence incentives to patients.

The 1st line TB drugs have been fully covered by the Government since 2012. In 2013 the Government took decisive steps to take over procurement of the 1st line TB drugs from GF. The funding analysis reveals lower resource allocation by the Government compared to previous years when 1st line drugs were procured from both public and GF sources. According to key informants, lower funding allocations were mostly related to the procurement of locally produced medicines, which allowed the Government to fully fund the drug requirement. The Government fostered the production of the 1st line TB drugs locally, enabling smooth transition from GF funding.

> "The decision has been made to intensify production of the 1st line TB drugs to ensure that adequate volume of medicines that meets Belarus market requirements is produced locally.
>
> "Today we are in a position to fully cover country needs."
>
> ***Quotes: From Key Informant Interviews***

The Government has also taken over the costs of culture and DST investigations on solid method, and it covers around half of needs in BACTEC MGIT 960. As per respondents, no particular challenges have been noted during and after transition.

4.2. PROGRAM CONTINUITY

The Government of Belarus ensures the program continuity and aims at expanding the service coverage. Both HIV and TB National programs have been updated for the next five years, the budget forecasts have been prepared, cleared by the local governments and submitted to the Government for approval. Both national programs are part of the National Development Strategy of the Republic of Belarus for 2016-2020. The budgets, though indicative, were developed according to the MOF budget ceiling and rules. Both programs aim at expanding the coverage of target populations with prevention activities, treatment, and care.

Unlike other countries in the CIS, no top-up payments are provided from the GF funding to the public employees engaged in NAP and NTP implementation. Public employees are hired on short-term contract when necessary. Therefore compared to other countries, Belarus is not at risk of loosing qualified staff and their demotivation when GF funding ends. However, salaries in ***GF-financed NGOs are not aligned with the those of public employees,*** which it may impact retention of professionals even if the NGO contracting mechanisms is developed and endorsed.

4.2.1. HIV

The Government of Belarus ensures the program continuity. The new NAP 2016-2020 is being developed through country-wide dialogue involving key national players, international agencies, PLHIV and representatives of key populations. The overall goals of NAP are[113] : to decrease the number of new HIV cases and of AIDS deaths; to create a supportive/enabling environment to address stigma and discrimination and eliminate legal barriers critical to achieve universal access to HIV prevention, treatment and care services.

Achieving these goals is foreseen through: attaining universal access to HIV diagnosis, treatment, care and support (including in the penitentiary system); preventing the spread of HIV in key populations (people who inject drugs, men having sex with men, commercial sex workers, adolescents of risky behavior, prisoners); preventing the morbidity and mortality of HIV-related TB; eliminating the HIV mother-to-child transmission; eliminating HIV transmission within health care settings; ensuring sustainability of the HIV prevention services based on intersectoral and interdepartmental collaboration as well as collaboration with international agencies; developing a

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

national system of monitoring HIV epidemic and evaluation of HIV response; increasing the effectiveness of informational-educational activities on HIV prevention among general population and decreasing HIV-related stigma.

Compared to the targets of the current HIV SSF grant, the coverage of the key 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 the estimated group, in 2015 to 45,000, or 60%, in 2018) and FSW (from the target of 3,500, or 7% of estimated group, in 2015 to 9,000, or 41%, in 2018). The National Program also aim at reaching 40% of MSM by the end of 2020. The new NSP also attempts to address number of weaknesses and gaps identified in the implementation of the current national response.

4.2.2. Tuberculosis

Currently, the new National Tuberculosis Programme for 2015-2020 is in the pipeline and awaiting approval by the Council of Ministers of the Republic of Belarus. In addition, the New National Comprehensive Strategic Plan to prevent and control MDR-TB for 2015-2020 (NAP) is finalized. The latter foresees funding from both, national budget, through the National Programme "Tuberculosis", and international donors.

The strategic goals of the new NAP are: (i) to decrease the TB notification rate by 2% annually by the end of 2020, or by 12% compared to the baseline from 2013; (ii) to decrease the total number of notified MDR-TB patients by 2% annually by the end of 2020, or by 12 % compared to the baseline from 2013; (iii) to ensure successful treatment of 75% of MDR-TB patients by the end of 2015.

There are also additional indicators in the NSP that are in line with WHO's latest policies: (i) to reach at least an 85% treatment success rate in drug susceptible TB, (ii) to achieve the coverage of 95% of sputum positive TB cases with rapid TB laboratory diagnostics and early detection of MDR-TB; (iii) to reduce the average lead time of MDR-TB diagnosis in smear positive TB patients to 7 days country wide; (iv) to cover at least 95% of MDR-TB patients with treatment with 75% treatment success rate among MDR-TB patients, and (v) to achieve 95% coverage with ART and CPT in all registered TB/HIV patients.

4.3. Organizational Capacity

> "CCM meetings are mainly attended by NGOs, less by key government institutions"
> "CCM is just a consultative body… Decisions are just recommendations not always approved by the higher government officials.
> ***Quotes: From Key Informant Interviews***

The CCM is weak CCM and the future is unclear future. Respondents have rated the effectiveness of the Country Coordination Mechanism as sub-standard. It appears that the civil society representatives predominantly attend CCM meeting whereas the attendance of government representatives is considered to be poor. Lacking government representatives, the CCM finds difficult to formulate decisions and when decisions are taken they are not binding for the Government. Essentially, the CCM seems to be purelya consultative body.

Notably, there is no thinking about the CCM's future and there is no vision whether or not there will be a need for a coordination mechanism at all.

Organizational strength and weaknesses of new PR. So far, the GF support to Belarus has been led and implemented by UNDP, but the growing national leadership led to the decision to transfer the Principle Recipient function under NFM to the Governmental Institution - 'Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health' (RSPCMT). Moving the PR from an international organization (UNDP) to a governmental body was initiated mainly to ensure sustainability and country ownership of the planned efforts in the process of transition. The institution was selected and approved as PR by CCM for the new grant (NFM) in March 2015.

Established in 1992, the RSPCMT is a governmental institution subordinated to the Ministry of Health. Decision-making is regulated by the organization's statute and procedures. The RSPCMT consists of following structural divisions: scientific and research, program/project implementation, HR/administrative and support. Currently the RSPCMT employs 137 staff, including infectious disease specialists, epidemiologists, pharmacologists, economists, accountants, and others. A number of commissions function within RSPCMT focusing on procurement, corruption prevention, attestation and qualification. Moreover, RSPCMT is responsible for the licensing of service providers and calculating the paid health services.

In preparation to the planned PR hand over in 2015 the "Capacity Assessment Workshop" was organized with the aim of identifying organizational capacity strengths and weaknesses as well as an informed transition planning.

The RSPCMT has a proven track record for working on international projects in the field of disease research, prophylaxis and health system development. All MOH international projects are expected to be coordinated by the RSPCMT. The RSPCMT has sufficient human resources and good administrative potential for managing and implementing new GF-funded HIV and TB grants to create a new Program Implementation Unit (PIU) which will be headed by the RSPCMT's Deputy Director of Economic Research. The PIU will rely on the institution's existing administrative and financial management systems. Monitoring and reporting under both programs will be integrated into the national automated health reporting systems, which is currently managed by RSPCM.

The RSPCMT also manages the national health account database and produces reports on an annual bases. This increases the opportunity to create sub-accounts for TB and HIV/AIDS and generate adequate funding data to improve the decision-making. Despite high levels in health data, standardization and management, the new PR has limited experience in implementing national health programs of HIV/AIDS and TB, and it lacks the programmatic expertise of working with key populations.

The RSPCMT has no prior experience in on-going management of sub-recipients and in providing funds to non-governmental organizations. Capacity building is being carried out throughout 2015 with the PR's (UNDP) current grant.

Informants reported a weak M&E data analysis capacity at local levels and the need to further enhance the surveillance system. A number of informants raised concerns with M&E and surveillance data analysis capacity at regional and local levels. The local government departments complained that they lack sufficient access to the M&E information and have limited knowledge on the programs' implementation details. Furthermore, there is short supply of trained people at local levels who can analyze surveillance data and plan/recommend corrective measures.

The incomplete set of indicators and weak analytical capacity can potentially impact both evidence-based policy making and implementation. The most recent evaluation of programs carried out by the WHO recommended expanding the set of surveillance indicators (described in the respective sections) which will allow the elaboration of more effective targeting strategies and improve the coverage of target groups with prevention and treatment interventions.

Limited ability to track allocations and report on expenditure. Despite using the NHA, to track HIV/AIDS spending Belarus operates the NASA tool which is a time and resource-extensive exercise and it produces reports once every two years. The situation is further complicated with the analysis of TB national program funding. In order to ensure the sustainability of the financial analysis for the HIV national response, by 2016 the relevant revisions to the national health accounts will be made, and linkages between funding will be allocated thus making possible to reach the key populations reached.

The WHO raises concerns regarding the state procurement process. The most recent survey carried out by WHO in 2011 on the procurement and supply management (PSM) of ARVs aimed at evaluating the changes in regulatory topics and assessing all components of the PSM, from the

central level to the end user. The lack of a formal forecasting mechanism has been identified as one of the main challenges of the public procurement system resulting in short-term stock outs. The WHO mission formulated a number of recommendations regarding regulatory issues, products selection, forecasting and quantification, procurement, quality assurance and receipt, storage and stock management, logistics management information, reporting, monitoring and evaluation[114]. The two major concerns expressed by the WHO regarding the state procurement of ARV and TB medicines were: i) ensuring quality and ii) ensuring low prices. There is no guarantee that procured medications will be confirmed as pre-qualified by WHO.

Continued health workforce shortages coupled with low remuneration weaken the organizational capacity of HIV and TB service providers. There were many complaints about low staffing and low remuneration. The increased coverage targets defined for the SSF grant resulted in an increase of workload and, consequently, staff's dissatisfaction. Furthermore, very low salaries for project staff, including programme managers, social workers, and peer-outreach workers lead to frustration and staff turnover. While it is understood that resources are limited, almost all staff interviewed indicated that the current wages were counterproductive for ensuring a high service quality and coverage. by Respondents indicated as a possible solution the introduction of a performance-based remuneration.

> "The salaries are far below what is needed to sustain a family, especially in the case of (peer) outreach workers, who play a pivotal role in reaching clients and ensuring that the targets are met"
>
> ***Quote: From Key Informant Interview***

NGOs have limited organizational capacity at sub-national levels. Although NGOs appear to have good practical implementation experience, they seem limited in their organizational capacity, e.g. in developing fundraising strategies and ensuring long-term sustainability of their activities. While the GF grant has been supporting the strengthening of institutional capacity through a series of activities by the NGO "Akt", these have not been able to reach all NGOs involved in service delivery to key populations. Larger organizations, including sub-recipients such as Positive Movement, Bel-AU, Vstrecha and the Red Cross demonstrated strong management and implementation capacity, but at the local level many small NGOs have limited institutional capacity and are almost entirely dependent on GF support, while making little or no efforts to mobilize additional resources.

Restrictive regulatory and administrative factors limit a more active engagement of civil society and imporvement of their capacity. As mentioned in previous sections, civil society and community representatives take an active role in formulating and implementating the national response. Nevertheless, a number of factors hamper their development and a more active engagement in the national HIV and TB response. CSO faces difficulties in registrering internationaly-supported projects with the national authorities, a process which limits the NGOs' work and their operational efficiency.

While enhanced collaboration and partnerships between government and civil society have been one of the key achievements of the GF support to Belarus, the development of sustainable partnerships once the Global Fund support will end is one of the key priorities to be addressed. In order for CSOs to be strong partners, they need to further strengthen their institutional capacity.

4.4. Transition Planning

The transition planning has started, some elements have been discussed and specific steps identified, but the shift has not yet been formalized. The GF has clearly communicated to the Government of Belarus the ending of the GF funding by end-2018. In this respected, the transition planning started. Namely:

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

The decision to enhance national ownership of the HIV and TB programs and to transfer its management under the NFM to a governmental institution. As described above, the Government of Belarus decided to transfer the Principle Recipient function under the NFM from UNDP to the governmental institution, 'Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health' (RSPCMT). This institution has been selected and approved as PR for the NFM in March 2015. The shift from an international organization (UNDP) to a governmental body was motivated to ensure sustainability and country ownership within the planned efforts to reach the 100% government funding target for the HIV and TB response in Belarus from 2019.

Enhancement of organizational capacity of the new PR. The Capacity Assessment workshop, dedicated for the assessment of organizational capacity of proposed new PR was held. Potential key challenges that may potentially hamper the continuity of services identified were: lack of procurement experience, limited experience of health products distribution, transportation and absence of the system for monitoring product quality throughout the supply chain, selection and contracting of SRs. To mitigate these weaknesses specific activities are planned for 2015. Particularly:

- To mitigate procurement capacity weaknesses identified during the workshop, WHO, UNDP, MOH and the GF agreed on a transition arrangement. In 2016 UNDP will conduct the procurement of drugs and commodities to guarantee the product price and quality and allow the development of the needed procurement skills withing the new Principal Recipient.
- At the same time, the new PR's procurement capacity will be strengthened in accordance with the Capacity Development Plan, jointly designed by the new PR, MOH, GF and UNDP. The plan includes training on forecasting, supply management, procurement, drug distribution, and patent law. The given arrangement will ensure that, starting from 2017, the new PR will be able to efficiently manage the procurement processes under any modality identified by the Government and the donor in the most efficient and cost-effective manner.
- The sample contract form regulating the relationship between Principal Recipient and SRs complying with TGF requirements has been developed and submitted for CCM consideration.

The creation of an information system for monitoring and forecasting needs for health human resources. The reporting on human workforce has been aligned with the system of the Organization of Economic Co-operation and Development (OECD), the European Office of the World Health Organization, the European Statistics (EURO), the European Statistical Committee (Eurostat) on joint collection of non-financial health statistics "to adapt the program for the registration and planning of human resource needs." The information system of personalized accounting/reporting of human workforce was piloted in 8 institutions in Minsk. However, key informants reported that the MOH has postponed this initiative for unknown reasons and there are no definite plans for scaling it up. Stakeholders plan to continue their advocacy efforts in order to ensure that the country has a well functioning human resource information system that will be used for evidence-based health workforce planning.

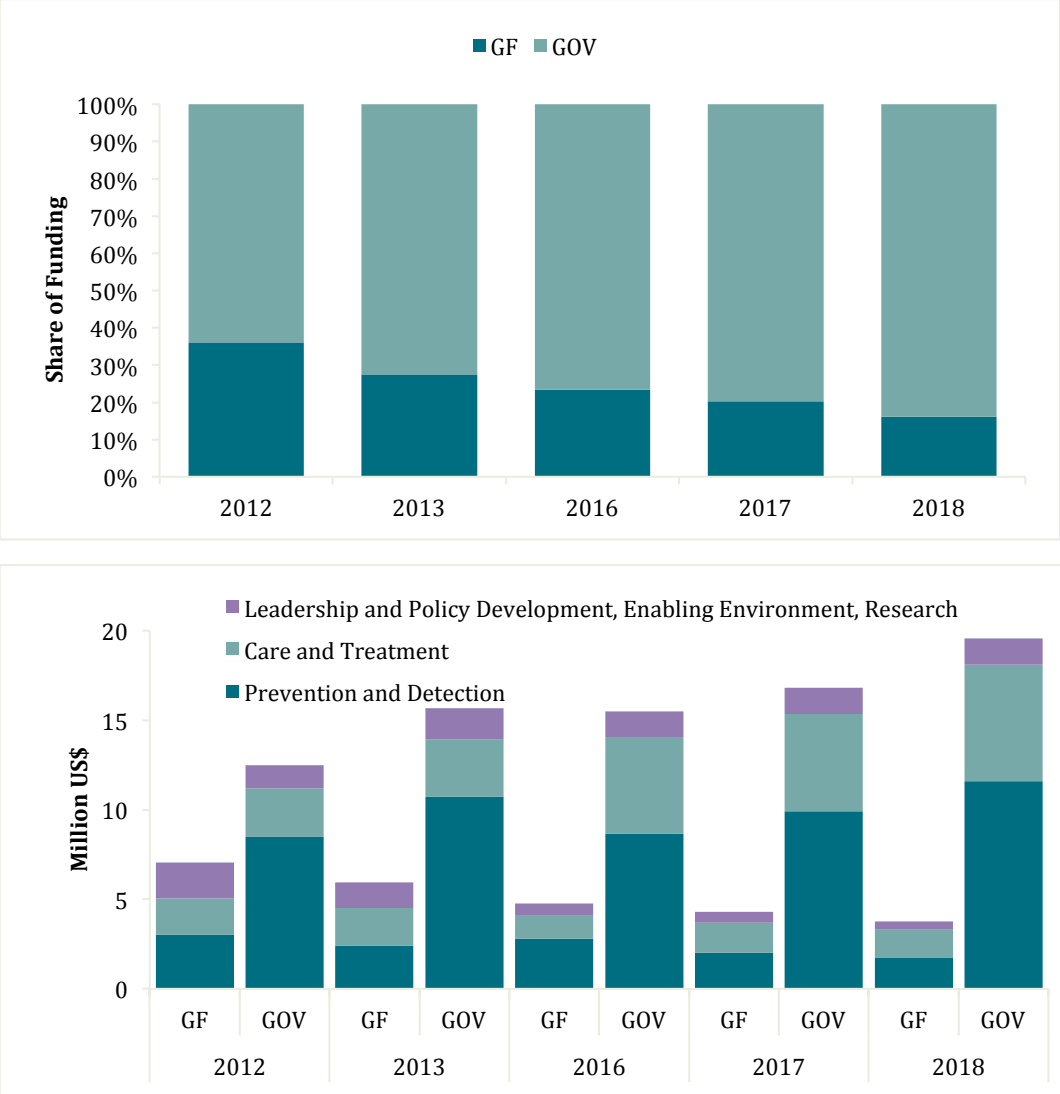
> "The further scale up of the system to nother regions is yet postponed by the decision of the MoH. We continue to advocate for the scale up "
>
> ***Quote: From the Key Infornmant Interview***

4.4.1. HIV

The Government guarantees full funding of all activities by the end of the third year of the new grant (NFM) implementation. The new Concept Note (CN) on HIV submitted to the GF within the frame of the new funding model, is based on the new National HIV/AIDS Prevention Program (NAP) 2016-2020. The Government aims to increase domestic funding of planned intervention from 35% in year one of the new GF grant implementation, to 46% in the second year and 62% in the third

year, and up to 100% from 2019. The funding sources dynamics for NAP for 2016-2018 are presented in Figure 23.

Figure 23: Share of Public Funding in National HIV a Response 2012-2018[115]



Commonly in Belarus, financial planning is performed only on an yearly basis. However the National Development Strategy 2016-2020 defines financial forecasts for all state programs including HIV and TB. The share of government funding gradually increases for prevention, care and treatment, whereas funding for policy development and research remains practically unchanged.

The majority of ARV medicines are procured through GFATM grants. As funding flow from the GFATM tends to decrease and more domestic funding is required for the ART scale-up, ARV procurement mechanisms used within GFATM project can a starting point for the transition and, potentially, also a benchmark for prices using economies of scale of pooled-procurement mechanisms.

Gradual transition to the introduction of the new WHO ARV treatment guideline. According to the National HIV/AIDS protocols, current CD4 count for enrolment to ART is 350. Given that

[115] National HIV Prevention Programme for 2016-2020.

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 change, by 2018 the country will cover with the ART 40% of the estimated number of PLHIV. The plan is to transfer completely to the new ART protocol (CD4≤500 cells) from 2019 and ensure adequate funding from the Government.

The institutionalization of the social contracting for services provided by NGOs and health facilities as well as the mobilization of financial resources. The GF demanded and pushed for promoting social contracting. Respondents acknowledged that if not for the GF advocacy and push for the development of social contracting mechanims, it would have been impossible to motivate governmental structures.

> "The GF pushed us to move on social contracting. Without this pressure it would have been difficult to advance on this".
>
> ***Quote: From Key Informant interview***

Belarus' national budget has never funded prevention activities targeted at key population groups and therefore it lacks the mechanisms of contracting NGOs or setting key populations' services in health care facilities. Consequently, there is neither a mechanism of procuring certain commodity items nor to transfer them onto NGOs for further distribution to clients. To reduce the outlined risks in the first year of transition (2016), the GF will supply most of the funding for targeted prevention programs. During this time the Government plans to finalize the social contracting approach.

While "social contracting" is widely discussed, no formal plan has been developed to outline implementation steps, time lines, responsible entities, and the Government's financial and technical resource requirements for the approval. However, some steps have been taken. Namely:

- The model for a social contracting mechanism was developed with the international organization "ACT" which reviewed the existing legal framework, suggested ways to introduce social contracting and made funding available for a pilot project. The project worked well but the mechanism piloted ignored the need of public funding and the required amendment to add a separate budget line for to social contracting in the Budget Code. This limited the effectiveness of the proposed methodology. Nevertheless, this pilot project raised awareness in the Government and the MOH about the need for a more thorough analysis of the legal base and suggested the changes introduced in the law "On social service " which provides a mechanism for the state social order.
- In 2014 amendments to the Budget Code on financing of the HIV prevention activities (counseling, HIV testing, purchase of consumables) from the local budgets have been introduced by adding a separate budget line for social contracting. The proposed mechanism allows to recruit community social workers as members of the multifunctional teams at local branches of the Institute of Epidemiology, Hygiene and Public Health under the budget line for social contracting, whilst commodities and consumable will be procured from the budget line for drugs and medical consumables;
- The MOH approved new sanitary rules and regulations on HIV / AIDS which define the standard package of HIV prevention services for PWID, MSM and FSW;
- Commodities such as rapid tests, condoms and lubricants were added to the list of medical products for public procurement;
- The MOF approved the introduction of an interdisciplinary team-approach at medical care facilities to improve the ARV treatment adherence and enforce lost to follow-up mechanisms as well as a gradual take over of needle-and-syringe exchange programs. The change will be funded by the local budgets starting from 2016 . So far two regions, Gomel and Brest, allocated funding for 2015-2016 from the local budgets for social contracting, though the recruitement of social workers has not started yet.
- In May 2015 a two-day workshop on social contracting was organised and it was attended by local government representatives, experts in the field of HIV/AIDS, ministries, research institutions and civil society organizations. Participants discussed issues related to social

contracting as well as how to calculate the costs of preventive activities for consequent budgeting purposes.

Stakeholders acknowledge that the given mechanism will not fully compensate the outreach work performed by the NGOs, however it is considered to be the first step to Introduce social contracting in the country. Current legislative changes do not allow the full support of the contracted NGOs, it only ensures funding for outreach workers' salaries and consumables, thus leaving NGO management costs unfunded.

> "This is definitely a step forward. However multifunctional teams will not be able to replace the work performed by the NGOs"
>
> ***Quote: From Key Informant interview***

4.4.2. Tuberculosis

The gradual increase of public funding and procurement of TB drugs and commodities is planned. According to estimates in the Comprehensive (strategic) plan for control of TB and MDR-TB in the Republic of Belarus for 2016-2020, national state budget sources are expected to cover the treatment for: (i) all patients with drug-susceptible tuberculosis, (ii) all MDR-TB patients susceptible to fluoroquinolones and injectable drugs, (iii) partially cover the pre-XDR patients (70%) resistant only to fluoroquinolones or injectable drugs. Besides drug procurement, the Government's co-financing covers other substantial costs related to drugs' storage and distribution, staff and facility operations, as well as clinical investigations for treatment monitoring, drugs for management of side effects of the 2nd line drugs, etc.

Table 15: Share of Public Funding in the National TB Response 2016-2018 for procurement of TB commodities

PROGRAM/	2016		2017		2018		TOTAL	
INTERVENTION/ COMMODITIES	GF	GOV	GF	GOV	GF	GOV	GF	GOV
TB (In Thousand US$)								
Xpert tests	13,000	-	13,000	3,200	9,000	7,900	**35,000**	**11,100**
BACTEC MGIT 960 tests	11,000	11,370	10,000	12,100	9,000	12,650	**30,000**	**36,120**
LPA diagnostics tests	4,400	-	4,400	400	3,500	10,000	**12,300**	**10,400**
Medicines		3,020		3,020		3,030		**9,080**
SUB-TOTAL TB	**28,400**	**14,390**	**27,400**	**18,730**	**21,500**	**33,580**	**77,300**	**66,700**

Since 2007 TB drugs within the GF grants have been supplied by UNDP which has established and implemented a procurement and supply chain management, focusing on quality assurance & risk management, value-for money and cost-effectiveness to support an efficient and sustainable delivery of related programs and projects. The UNDP PSM allows to globally purchase pharmaceuticals and health products through the UN agencies, a wide range of corporate Long-Term Agreements (LTAs) with commercial entities, as well as beyond the UN system and LTAs, if required. Taking the above into account, the NFM will continue using the UNDP procurement mechanism for MDR/XDR-TB drugs during the initial year of implementation in order to ensure sustainability and continuity of the service provision, upon agreement with the MOH, PR and the GF,

Fostering the local production of the test systems is under consideration to ensure the financial sustainability of the high technology laboratory. Although the laboratory network has been substantially strengthened over the last few years and further expansion is planned under the new GF funding, maintenance costs of the high technology lab equipment are not considered in the budget of respective laboratories. This raises concerns about the sustainability of the laboratory capacity. Despite the fact that Xpert MTB/RIF cartridges have been already registered in the country, their cost is 7-8 times higher than the cost of those procured under Global Fund procedures. Taking into consideration this issue, the procurement of cartridges during the period of 2016-2018 is requested under NFM grant and the Government is expected to gradually take over

their procurement from 2017. As a remedial measure, the country initiated the local production of test systems that will reduce the financial burden on laboratory testing. Starting from 2019, Xpert MTB/RIF tests are planned to be procured only under the national budget.

Support for MDR TB treatment adherence to be fully financed by the Government whilst transportation benefits will still be covered by GF. The Introduction of the publicly-financed food packages required preparation of the political platform by the MOH at all government levels involving CCM, NAC, cabinet of ministers and local governments. In order to justify the publicly-fianncing of the packages for treatment adherence a thorough analysis of the weaknesses of the PHC sector was carried out. A pilot project, with the GF's financial backing, was developed to demonstrate the economic benefit of this type of social support. As a result, the Ministry of Health approved the Decree №21 of 18. February 2015 "On approval of the additional high-calorie food products support for TB patients on ambulatory treatment "endorsed also by the Ministry of Finance and Ministry of Social Wellbeing. Three types of food packages have been standardized for TB treatment adherence, especially for MDR TB cases. The decree regulates the terms and conditions of standard food packages distribution: it foresees the support to TB and MDR-TB patients on ambulatory care with high adherence to treatment, patients who receive TB treatment at least for 20 days uninterruptedly. The decre also ensures the allocation of US$20 per patient per month financed through local government's health care budgets. Starting from 2016, incentives in form of food packages will be fully funded from public sources to all eligible patients countrywide.

Financial incentives for health care personnel at the PHC level in support of DOTs strategy has been piloted in selected regions and it will be scale up nationally from 2016. The Government recently piloted in selected regions a new system of bonuses for all health personnel based on the quality of the services provided. Bonuses for TB doctors may increase their basic salary by 20%[116], almost reaching the wage of other tertiary care specialists (e.g. cardiologists). Funding for the incentives has been obtained optimizing the bed capacity and allowing regional and district health authorities to redirect released funds for financial motivation of the PHC staff.

Furthermore, additional bonuses of US$ 0.20 and US$ 0.10 per patient visit are currently paid respectively to nurses and doctors working in TB outpatient facilities under a UNDP-run project in 24 dispensaries using the Global Fund grant. Moreover, in 2011 the Global Fund grant had a budget of US$ 64,000 for staff wages, based on extra hours worked.

To ensure adequate workforce supply of the TB vertical system the political decision has been taken to revise clinical competencies of pulmonologists and TB doctors (phtysiatricians) allowing pulmonologists to treat TB patients. This will enable to fill in the physician shortages in the TB system. Furthermore it was decided to allow "feldsher's" to serve as physician assistants, which would entail training them on how to communicate with and counsel TB patients.

[116] 300,000–500,000 Belarusian roubles (BYR)

INTRODUCTION OF NEW FUNDING MODELS FOR AMBULATORY TB CARE

Traditional funding models for TB care in Belarus are based on financing per occupied TB hospital bed with no established and sustainable funding mechanisms to support patient-oriented ambulatory TB care. In the absence of new funding models, the reduction of the number of TB hospital beds (or average lebth of stay) will release considerable funds which will be withdrawn from NTP in the next fiscal years.

In 2014 the Mogilev pilot project aimed to test, on a very limited scale, a new financial mechanism that would strengthen ambulatory TB care by reallocating funds otherwise dedicated to hospital beds. A working group supported by the WHO has developed guidelines, approved by the Ministry of Health and Mogilev regional health care authorities, that provide additional incentives to PHC staff supervising directly observed therapy.

In the initial phase of the pilot project, 5 TB hospital beds in Mogilev regional TB dispensary have been cut. Saved funds were partially used for the financial incentives to the PHC staff (US$ 1–4 per patient visit). Contracts templates between TB dispensary and primary care nurses (feldshers) were developed and the algorithm on coordination between PHC and TB specialists in the process of discharge from TB hospital was approved. Three patients with drug-susceptible TB and 10 with MDR-TB from rural areas received care under this scheme. According to data provided by the regional TB dispensary, all of the enrolled TB patients have been maintained in treatment from the very beginning of the pilot project introduced in early 2014. In addition, after PHC staff received the incentives, a total amount of US$ 10,270 was saved. Based on this evidence, the Mogilev Regional TB dispensary will expand the project to the Bobruisk and Osipovichi districts in 2015.

5. CHAPTER: CONCLUSIONS AND RECOMMENDATIONS

This section of the report summarizes the findings arising from this country case study and, separately, some general findings, which resonate and align with the results of other studies[117] and lead to more general conclusions from those that are purely country specific. Consequently, the two sets of conclusions are detailed in separate sections.

5.1. Transition and Sustainability Risk Assessment

Table 16 below presents the list of indicators that were used to assess possible risk to transition from GF support. Each indicator has been assessed according to the criteria and has been assigned a score for low risk, moderate or high risk. The component scores are summed up to form a final score of transition risk in a country.

Table 16: Transition Risk Assessment Table

H – HIV/AIDS; T- Tuberculosis; B – Both diseases

Components		Disease	Indicators	Belarus
			External Environment	
Political	**P**	**B**	1. Existence of political will to prioritize health investments **1.1** Increasing trend or stable high share of government spending on health out of General Government Expenditure **1.2** Increasing trend of the share of government spending on health out of Total Health Expenditure (THE)	1.1 Stable high share of Government spending on health (around 13%) out of General Government Expenditure 1.2 Share of Government spending out of THE was stable and high until 2012, decline was noted in 2013 although remains high (65%)
	P	**B**	2 Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for KAP and people living with diseases. 3 Strong Rule of Law	2 There are legal barriers that hinder effective prevention, treatment, care and support for KAP and people living with diseases.
	P	**B**	4. Government ability to contract with CSOs - Existence of general regulation for CSO contracting in the economy 5. CSO contracting is practiced in any sector	4. General regulation allowing CSO contracting is largely absent. Public institutions have no legal right to contract CSOs
				2
Economic	**E**	**B**	1. Favorable economic indicators 1.1 Increasing in GDP 1.2 Increasing or stable high share of General Government Revenues as % of GDP	1.1. GDP per capita growth (annual %) is observed since 2010 1.2. Share of General Government Revenues (excluding grants) as % of GDP is more than UMIC mean (30.0) in 2012 year
				2

[117] Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of global fund supported programs. Curatio International Foundation, 2015

Components		Disease	Indicators	Belarus
			Internal Environment	
			Inputs	
Financing	**F**	**H**	1. Budgetary commitment to disease 1.1. Increasing public expenditure on Disease Specific programs 1.2. Share of public funding in Disease Specific Program budget: 1.2.1. > 75% 1.2.2. 50 – 74% 1.2.3. < 49% 1.3. Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with coasted NSP	1.1 Public expenditure on HIV program is increasing since 2012 1.2 Share of public funding is 71% of total AIDS spending in 2013 1.3 There is dedicated budget line for the program integrated in the three year financial plan
	F	**T**	Budgetary commitment to disease 1.1. Increasing public expenditure on Disease Specific programs 1.2. Share of public funding in Disease Specific Program budget: 1.2.1. > 75% 1.2.2. 50 – 74% 1.2.3. < 49% 1.3. Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with costed NTP	1.1 Public Expenditure on TB program is decreasing. TB budget is deficient (50% funding gap) 1.2 Share of public spending on TB is stable and accounts 55% 2012-2013 1.3 There is dedicated budget line for the program integrated in the three year financial plan
	F	**H**	2 Prevention priority 2.1 Increasing total public spending on HIV prevention for priority groups 2.2 Increasing share of public spending in total spending (donors and Gov.) on HIV prevention for epidemiologically priority groups	2.1 Total public spending on HIV prevention is not increasing. 2.2 Preventive programs for KP are primarily financed from external sources.
	F	**H**	3 Allocative efficiency Existence of allocative efficiency study Allocative efficiency study informs budget allocations	3.1 Allocative efficiency study was conducted in Belarus 3.2 Allocative efficiency study has not yet informed budget allocations
	F	**H**	4 Treatment / input financing from public sources Case detection / diagnostics Drug procurement 4.2.1 First line ART 4.2.2 Second line ART Adherence support	4.1 Case detection/diagnosis mostly financed from TGF 4.2 ARV drug 4.2.1 First line ART partially funded by public sources 4.2.2 Second line ART are mostly funded by external sources 4.3 Adherence support fully funded by external sources

Components		Disease	Indicators	Belarus
	F	**T**	Treatment / input financing from public sources 4.1 Case detection / diagnostics 4.2 Drug procurement 4.2.1 First line drugs (FLD) 4.2.2 Second Line Drugs (SLD) 4.3 Adherence support	1.1 Case detection/ diagnostics is partially funded from public sources 1.2 TB Drugs 1.2.1 FLD funded by the government 1.2.2 SLDs mostly funded through external resources with the small share publicly financed 1.3 Adherence support completely TGF dependent
	F	**H**	4 Prevention financing from public sources 4.1 Funding of Low Threshold Services (excluding OST) from public sources 4.2 Funding of OST services from public sources	5.1 Low Threshold Services (excluding OST) are no funded from public sources 5.2 OST mostly funded from TGF grant
				5
Human Resources	**HR**	**H**	1. Sufficient human resources for a disease (quantities, geographic distribution and aging)	Severe shortage. Shortage of specialists, geographical misbalance, high turnover and lack of motivation are common
	HR	**T**	Sufficient human resources for a disease (quantities, geographic distribution and aging)	With some limitations. Relatively adequate although only 78% of positions are filled. Aging of staff raises serious concerns, low salaries of TB medical staff and hazardous work environment distract young people to work in the TB field.
	HR	**B**	2. Donor supported trainings for health personnel institutionalized in national education system 3. Existence of policy for production/training of CSO personnel (non medical, social service) 4. Donor funded HR salaries aligned with national pay-scale	2. TGF supported training for health personnel are not institutionalized into the national education system 3. Policies for CSO personnel production exist but are rather weak 4. Salaries to the public servants are not covered by the grant except for short term TA
				2
Health Information System	**HIS**	**H**	1. Advanced routine statistical reporting fully integrated in the national system 1.1 HIV testing 1.2 PMTCT 1.3 AIDS related mortality 1.4 Adult treatment 1.5 Pediatric treatment	1.1 HIV testing-integrated, partially advanced 1.2 PMTCT- integrated, partially advanced 1.3 AIDS related mortality – integrated, partially advanced 1.4 Adult treatment- integrated, partially advanced 1.5 Pediatric treatment – integrated, partially advanced
Health Information System	**HIS**	**T**	Advanced routine statistical reporting fully integrated in the national system 1.1 TB New and relapse cases 1.2 TB treatment registry 1.3 Pediatric treatment 1.4 MDR TB reporting 1.5 Care and support (incl pediatric)	1.1 TB New and relapse cases- integrated, partially advanced 1.2 TB treatment registry – integrated, partially advanced 1.3 Pediatric treatment- integrated, partially advanced 1.4 MDR TB reporting- integrated, partially advanced 1.5 Care and support (incl pediatric) – integrated,

Components		Disease	Indicators	Belarus
				partially advanced
	HIS	**H**	2. HIV Second generation surveillance 2.1 Rigorous methodology used for IBBS 2.2 IBBS Implemented timely (according to NSP) 2.3 IBBS Funded by public sources 2.4 PSE funded by public sources	2.1 Rigorous methodology used for IBBS 2.2 IBBS Implemented timely (according to NSP) 2.3 IBBS NOT funded by public sources 2.4 PSE NOT funded from public sources
				3
			Governance	
Governance (Political support, Program leadership, Coordination)	**G**	**H**	1. Strong political commitment to diseases 1.1. NSP with legal and enforceable power in a given country context 1.2. NSP in preparation or without legal and enforceable power 1.3. HIV/AIDS as a priority in National Health Strategy document	1.1 Belarus has government approved NSP for HIV/AIDS covering period 2014-2015 1.2 New NSP submitted for government's approval 1.3 HIV/AIDS NOT prioritized in National Health Strategy Document
	G	**T**	Strong political commitment to diseases 1.1. NTP with legal and enforceable power in a given country context 1.2. NTP in preparation or without legal and enforceable power 1.3. TB as a priority in National Health Strategy document	1.1 Belarus has government approved NTP covering period 2010-2014 and the Action Plan for 2014-2015 1.2 New NTP submitted for government's approval 1.3 TB is NOT prioritized in National Health Strategy Document
	G	**H**	2. Strong leadership 2.1. Legally empowered leading organization to manage given disease program effectively functioning 2.2. Individual leader(s) advocate for disease specific programs	2.1 There is no unit fully responsible for National HIV/AIDS Program. Management of curative and preventive fields is fragmented. Entities responsible for curative and preventive fields are well functioning. 2.2 Individual leadership is visible
	G	**T**	Strong leadership 2.1 Legally empowered leading organization to manage the functioning of the given disease program 2.2 Individual leader(s) advocate for disease specific programs	2.1 The NTP has single organizational leader coordinating all types of TB activities in the country 2.2 Individual leadership is visible
	G	**B**	3. Strong coordination mechanisms 1.1 Coordinating body adequately placed within the government hierarchy and legally empowered within the national Government structure to assure adequate coordination across the sectors 1.2 CSOs have a legally determined seat in the coordinating body 1.3 Coordinating body functions effectively	3.1 Coordination body is well placed within the government hierarchy to assure adequate national coordination and coordination across different sectors; 3.2 CSOs have legally determined seat on the national coordination and play significant role 3.3 Coordination body functions effectively.
				7
Accountability	**A**	**B**	1. Program performance results are available and accessible through public domain: 1.1. EPI data including for KAPs	1.1. EPI data including for KAPs – Available 1.2. Programmatic data and/or reports – Available on request 1.3. Program expenditure data – NOT completely

Components		Disease	Indicators	Belarus
			1.2. Programmatic data and/or reports 1.3. Program expenditure data 1.4. Program M&E reports 1.5. NSP/NTP and other periodic reviews	available 1.4. Program M&E reports – Available 1.5. NSP and other periodic reviews – Available
	A	**B**	2. Enabling Environment for Civil Society engagement [118] 2.1. 0-0.38 – there are law and policies that restrict civil society playing an oversight role 2.2. EEI 0.39 – 0.50 – there are no law and policies that restrict civil society playing an oversight role, but in practice it is not accepted by the Government 2.3. EEI > 0.51-0.76 there are no laws or policies that restrict civil society playing an oversight role, and civil society is actively engaged in providing oversight	Belarus's EEI for 2013 was 0.41 indicating that there are no laws or policies that restrict civil society playing an oversight role, but in practice civil society is not actively engaged in providing oversight as it is not accepted by the Government
				2
			Program	
	S	**H**	1. Treatment 1.1. Increasing coverage (%) trend for ART 1.2. Improving treatment outcome for ART (adherence rate at 12 months)	1.1 Yes increasing numbers of ART but rather low coverage and huge gaps from testing to treatment and care cascade 1.2 Treatment-adherence outcomes are improving
	S	**T**	Treatment 1.1 Improving treatment outcome – success rate for all TB cases 1.2 Improving treatment outcome – success rate for MDR TB	1.1 Treatment success rates of the new TB cases worsened 1.2 The percentage of effective treatment of MDR TB cases that started treatment in 2011 and 2012, is only 50.4%
	S	**B**	2. Integrated services: 2.1 Integrated PMTCT with PHC/Maternity care 2.2 Integrated TB in primary care 2.3 Integrated HIV and TB services	2.4 PMTCT is well integrated in the maternity care 2.5 TB services are still separately standing with limited or no integration into PHC 2.6 TB/HIV are not integrated
	S	**H**	3. KAP reach with preventive services 1.4 Increasing coverage trend of epidemiologically most important KAP with preventive services 1.5 Data based on IBBS studies with rigorous methodology	3.1 Coverage of KAP with preventive services is increasing but yet remains l0w (2 data points 2011 & 2013) 3.2 Data is based on rigorous IBBS methodology
	S	**B**	4. CSOs contracting in health 4.1 Existence of detailed rules and procedures for contracting CSOs for health service delivery (includes medical and other health related social services) 4.2 Government already contracts CSOs for various health service provision	4.1 Detailed rules and procedures for contracting SCO for health service provision DO NOT exist 4.2 There are only few non-governmental NGOs such as Red Cross, and sport's associations which receive direct subsidies from the state budget

[118] http://civicus.org/eei/

Components		Disease	Indicators	Belarus
			using public funds	
				3
Organizational capacity (program management, financial management, contracting, procurement, supply chain management, research and M&E)	**O**	**H**	1. Strong management of the National Disease Program Management Entity (not PR) 1.1. Existence of national program management capacity assessment OR staff performance evaluation practice (at least once in every second year) 1.2. Closely integrated TGF PR and National Program Management	1.1 Due to absence of an entity responsible for overall management of HIV/AIDS program its capacity assessment has not been conducted. 1.2 Relationship between PR and national disease management entity not defined at present due to the absence of such entity. PR manages only GF funding.
	O	**T**	Strong management of the National Disease Program Management Entity (not PR) 1.1. Existence of national program management capacity assessment OR staff performance evaluation practice (at least once in every second year) 1.2. Closely integrated TGF PR and National Program Management	1.1 Capacity assessment of the National Disease Management entity (Republican Scientific and Practical Centre for Pulmonology and Tuberculosis) is NOT conducted, and staff appraisal is not a regular practice. 1.2 Although the Entity has sound working relationship with the PR there are distinct public agencies.
	O	**B**	2. PSM 2.1 TGF funded procurement is conducted using national system 2.2 Supply chain management integrated into the national system 2.3 Low frequency of emergency procurements for drugs (not more than one over for last year) 2.4 Rare stock outs for drugs (not more than once for last year) 2.5 If national procurement – paying not more than 5% above the international benchmark price	2.1 TGF funded procurement is NOT integrated into the national system 2.2 Supply chain management is integrated into the national system 2.3 NO emergency procurements 2.4 Rare stock outs for drugs (not more than once for last year) – mostly due to the weak forecasting 2.5 If national procurement – PAYING MORE than 5% above the international benchmark price
	O	**B**	3. M&E 3.1 Existence of analytical capacity at MoH/main public health agency reflected in availability of analytical reports that are produced with certain periodicity 3.2 Information use for evidence-based program planning and management e.g. NSP/NTP uses recent Epi, programmatic and expenditure data	3.1 Both indicators could be rated as partial. Although there a lot of analytical reports, largely produced by donors and non state actors 3.2 The epidemiological data is available and used in NSP/NTP, although M&E data are not always used for program planning and budgeting
				4
Transition preparedness	**T**	**H**	1. Transition plan / elements 1.1. Legally binding and actionable transition plan exists 1.2. Draft transition plan exists 1.3. Transition elements embedded into the legally empowered national program / NSP	1.1 Legally binding and actionable transition plan does not exist 1.2 Plan that includes transition of few elements of the program developed but not yet approved by the government 1.3 Transition elements (financial responsibilities) are embedded into the NSP

Components		Disease	Indicators	Belarus
	T	**T**	Transition plan / elements 1.1. Legally binding and actionable transition plan exists 1.2. Draft transition plan exists 1.3. Transition elements embedded into the legally empowered national program / NTP	1.1 Legally binding and actionable transition plan does not exist 1.2 Plan that includes transition of few components of the program developed but not yet approved by the government 1.3 Transition elements (financial responsibilities) are embedded into the NTP
	T	**H**	2. Transition plan characteristics: 2.1 Clearly identifies time-bound activities to be implemented during transition 2.2 Clearly outlines roles and responsibilities of a Transition process management 2.3 Incorporates M&E indicators for transition process 2.4 Incorporates budget for transition	Available transition plan: 2.1 Clearly identifies time-bound activities to be implemented during transition 2.2 Lacks the clarity on roles and responsibilities for transition process management 2.3 Does not contain M&E indicators 2.4 Does not have budget
	T	**T**	Transition plan characteristics: 2.1 Clearly identifies time-bound activities to be implemented during transition 2.2 Clearly outlines roles and responsibilities of a Transition process management 2.3 Incorporates M&E indicators for transition process Incorporates budget for transition	N/A
	T	**B**	3. Transition M&E 3.1 M&E is followed 3.2 CSO participates in the transition updates	NO
				2
				Moderate to High risk
			Overall score **(Total max score 76)**	**32 (42%)**

EXTERNAL ENVIRONMENT

Economic development. The Government of Belarus strives to ensure continued and sustainable economic growth. Since 2010 GDP per capita has grown steadily and the share of general Government revenues (excluding grants) to GDP is higher than in upper middle-income countries, posing **low risk** to transition and sustainability of the Global Fund supported programs.

Political commitment. Despite the economic challenges, stable high share of Government spending on health (around 13%) out of General Government Expenditure along with the relatively high share of Government spending out of total health spending confirm the Government's commitment towards the health sector. If this trend is maintained in the challenging economic environment, there are promising prospects for an easy transition from the Global Fund-supported programs. Nevertheless, unfavorable legal environment hinder effective prevention, treatment, care and support for KP and people living with diseases posing a high risk for transition.

INTERNAL ENVIRONMENT

Financing. The availability of a dedicated budget line for HIV and TB program integrated into the three-year financial plan updated annually and approved by the Government is encouraging. The Public expenditure on HIV program has been increasing since 2012 and the large share (71%) of the national HIV program is funded through the Government budget, although prevention and treatment support and care-related activities remain mostly financed through external resources. The results of the allocative efficiency study of the HIV program have not yet taken into account in the budget planning for national HIV response.

The financing of the TB program is challenging with a 50% gap in the program's funding. Total TB program shows declining trend. Along with decreasing Global Fund support the share of public funding is maintained at only 55%. TB diagnosis, treatment and treatment adherence is largely externally funded.

In summary, the share of program costs Belarus has to take over when the Global Fund support ends for HIV and TB programs remains high. Countries where programs are predominantly government-funded (>95%) found it much easier to assume financial responsibilities at the end of external funding[119]. Therefore, the current level of HIV and TB program financing in Belarus poses a high risk for transition. In order to achieve a positive public health impact with possible financial limitations, the country has to ensure effective coverage of key populations by improving the allocative and technical efficiency of prevention, treatment and care services.

Human Resources: Severe shortages of specialists, geographical imbalances, high turnover and lack of motivation are common features of the Belarussian health care system. The aging of the health workforce, which is most severe in the TB sector, coupled with low salaries of TB medical staff and hazardous work environment which deter young people from working in the TB field raises serious concerns. Global Fund-supported trainings for health personnel are not institutionalized into the national education system and the policy for continuous CSO personnel development exists but is rather weak. The availability of well-trained and appropriately distributed human resources is crucial for the programme success. This is even more crucial in a transition scenario due to the importance of continuing care for patients with TB and HIV given the risk for drug resistance[120]. The health workforce system weaknesses dscribed above, puts the transition of HIV and TB programs after the Global Fund support at a medium risk if not addressed accordingly and in a timely manner.

[119] Ibid 98.
[120] Building Resilient and Sustainable Systems for Health: the Role of the Global Fund, The Global Fund, 2015.

Information Systems. The HIV and TB M&E system is integrated into the national reporting systems, but there is still room for improvement. The surveillance of the HIV epidemic lacks important indicators and is not adequately analyzed to inform policy makers on priorities within the national HIV program. The 2nd generation surveillance capacity was built with the support of the Global Fund, but remains externally funded. The NTP uses the standardized recording and reporting system, which has been upgraded to accommodate the latest WHO recommendations and additional country needs. Maintaining effective operations of the M&E system after the external funding ends is at a medium risks of sustainability, particularly if the government fails to further enhance its surveillance system, to track program expenditures regularly, to build adequate analytical capacity at national and local levels and to carry out research that informs future policy development and program implementation. Developing and enforcing accountability mechanisms to ensure commitments remain key drivers for sustainability. This requires communicating performance results through the public domain, including reporting expenditure data and targeted activities for key populations. Moreover, most efforts to hold actors accountable are conducted by civil society organizations, therefore, it is crucial to create an enabling environment for civil society organizations to operate[121].

Governance. The Government remains committed to continue the HIV and TB national programs. New national programs are developed and are awaiting the government's approval. The programs' management vary. In the case of HIV, the national management for prevention and treatment is fragmented which limits a coordinated and harmonized prevention and treatment services, whereas the TB program management is more aligned under the RSPCPT. The Country Coordination Mechanism is well placed within the government and operates effectively, however authorities lacks the vision whether CCM will be maintained after the closure of the HIV and TB grants. There is an evident need to improved the transparency of program -elated financial and performance data. Streamlining the national program governance along with strong coordination function and easy access to program performance information[122] will minimize challenges during transition.

Program. The government's willingness to sustain an effective national response towards HIV and TB epidemic is encouraging. However, in order to achieve a positive public health impact with possible financial limitations, the country has to ensure an effective coverage of key populations by improving allocative and technical efficiency of prevention, treatment and care services. Advancing technical efficiency should be addressed by reinforcing prevention activities, rightsizing of service providers, building linkages between the health sector and non-governmental and social service providers, streamlining patient pathways among TB and HIV service providers and enhancing of follow-up and social support for improved treatment outcomes. Taken together, these measure will mitigate the potential challenges Belarus will face after transition from the Global Fund support.

Organizational Capacity. There are several prerequisistes for easy transition and attaining the desired public gains. They are: enhancing the coordination between PR and national program management entities and strengthening the organizational capacity of national program implementers and service providers[123], streamlining of procurement functions to allow the procurement of HIV and TB drugs and commodities at a lower price[124], enhancing M&E and evidence based program planning and implementation are prerequisites for easy transition and attainment of desired public gains.

Overall transition readiness. The assessment of the transition readiness of HIV and TB programs (Table 16) revealed that Belarus faces a medium risk after the Global Fund support ends. An early

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[121] Transition from the Global Fund support and Programmatic Sustainability: Research in four CEE/CIS countries, Curatio Internataional Foundation, 2015 (non published).

122 Transparency and streamlined accountability: what watchdogs, grant implementers and OIG want, Aidspan, 2015 http://www.aidspan.org/node/3354.

[123] Ibid 98.

[124] Ibid 101.

transition planning addressing the riskiest areas of the HIV and TB programs and systems as well as its effective implementation will allow the country to experience a painless transition and the sustainability of national programs.

5.2. General Recommendations

Based on the findings of the transition and sustainability assessment discussed in previous chapters, this section provides bold recommendations that can guide the Government and key stakeholders towards an easy transition after external funding ends.

Transition plan. While country is discussing and actively working on the elements of the transition, there is no overall plan governing this process. Adequate conceptualization of and careful planning for the transition would most likely be of benefit.. Other country experiences prove that planned transitions reduce/minimize transition challenges, while rushed transitions cause more problems and undermine sustainability[125]. Therefore, developing time-bound and actionable plans, which have sufficient legal power and adequate indicators to monitor the plan implementation, seem to be necessary first steps for the country to consider. Finally, effective implementation of the plan would also require sufficient resources (human and financial) to achieve transition objectives.

Gradually reducing financial dependence on the Global Fund. Experiences prove that the transition process become smoother and odds for sustainability increases, when the Global Fund's contribution to the national response is not significant, e.g less than 25%[126]. Consequently, the country has to strive to gradually reduce its dependence. The first and most important area for transition to consider is commodity procurement, so that national procurement mechanisms function adequately and allow for such a transition. The most challenging area seems to be transition of preventive interventions, especially those delivered by the NGOs/CSOs, which could be left for the latter phases, provided that sufficient preparatory work is done during the lead-up time to transition date (see CSO contracting for more details).

Many countries give lower priority to prevention compared to treatment. In many instances, the lack of national budget allocation (even with small amounts) has challenged transition and undermined sustainability prospects[127]. While prevention could be last element to be transitioned, it seems important to start developing prevention budget lines/allocations during the transition process, which may eventually drive increased budget allocations when the country stops receiving Global Fund support. in other countries, legally empowered national programs that already reflect a gradual reduction in donor dependence in their budget have often served as an effective instrument in other countries[128].

CSO contracts. The overall legal environment is not conducive for NGO/CSO contracting and the country lacks detailed contracting procedures for CSO contracting in the health sector. Belarus would benefit significantly if these rules/procedures were developed during transition and institutionalized.

A similar situation was observed in the countries that graduated from the Global Fund without having such rules in place and facing transition challenges[129]. Based on other country experiences, such detailed contracting rules/procedures are at least expected to address at least the following: service definition, service pricing and/or methodology to estimate quoted prices, which on one hand helps evaluate the value for money for the submitted bids during tendering/national procurement process and on the other, and most importantly, helps the government to estimate overall program costs for a given disease and adequately budget during the budgeting process;

[125] Ibid 98.
[126] Ibid 98.
[127] Ibid 98.
[128] Ibid 98.
[129] Ibid 98.

tendering procedures that are aligned with the national procurement laws and regulations; bid evaluation procedures for both quality and value of the bid; procedures for monitoring quality and/or volume of services delivered by CSOs, etc.

Effective national coordination, with or without the CCM as a coordinating body, is essential for effective management of the national response and for implementing the transition process, which leads to sustainability. One of the greatest benefits that the Global Fund has delivered worldwide is creating the space for governments and civil society to jointly engage in the national/global response planning and coordination[130],[131],[132]. In most states CCMs, or similar structures, that formally provide a seat and voice for NGOs/CSOs in the national coordination, have been critical in achieving the gains observed globally. Consequently, retaining and/or enhancing effective coordination structures proved to be important in many countries after the Global Fund support[133]. Therefore, it seems important for the country to consider retaining and enhancing the national coordination structure/function, which would allow for continuous NGO/CSO engagement. For such coordination to be effective the production, availability, transparency and easy access to information should be ensured for the development of an evidence-based (or informed) responses.

Enhancing public accountability during and after transition will be critical to assure quality partner engagement e.g NGOs, SCOs, journalists and development partners. This would require the routine production of information describing results of the national response e.g. disease program specific epidemiological and financial expenditure data; the results of program performance, including outcomes and challenges. During transition, the country (perhaps with the Global Fund support) should strive to assure (maybe contractually and/or through legislative action) that this information is not only routinely produced but is also freely accessible for all stakeholders involved, government and civil society alike.

Addressing human resource challenges should be viewed in two parts: a) assuring adequate quantity and re-distribution of the needed human resources and b) continuous education of the professionals involved in the national response – service provision. The latter has been extensively supported by the Global Fund grants, and not only in this country[134].However, the sustainability of these trainings raise concerns due to the lack of institutionalization achieved during the grant implementation[135]. Consequently, the transition period has to be explicit about what could be achieved, in terms of preparing the necessary human resources and how this function can be institutionalized and eventually funded and delivered by the government. The question of human resources goes well beyond the disease response and results from health sector policies, education policies and the overall socio-economic environment iin the country. It also affects the whole health care system of the country. Instead of addressing these challenges as a transition issue, therefore, it is necessary to look at these challenges more holistically and outside of the transition process.

5.3. Disease Specific Recommendations

Disease specific recommendations are presented schematically in Table 17 below.

Table 17: Disease Specific Recommendations

[130] Spicer N., AleshkinaJ., et al. National and subnational HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice? Globalization and Health 2010, 6:3.
[131] Kapilashramia A., O'Brien O. 2012. The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit? Global Public Health: An International Journal for Research, Policy and Practice Volume 7, Issue 5, 2012.
[132] Duvvury N., Cornman H., Long C. 2005. Participation of Civil Society in Global Governance: Lessons Learned from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. www.icrw.org .
[133] Ibid 98.
[134] Bowser.D., Sparkes.SP., et al. 2013. Global Fund investments in human resources for health: innovation and missed opportunities for health systems strengthening. Health Policy and Planning 2013;1–12.
[135] Ibid 98.

Recommendation # 1: Enhancement of Stewardship and Governance of National Programs		
	HIV	**TB**
Program Management	Ensure the integration of HIV and TB program management, unless MOH envisions different organizational/management arrangements.	
Legislation and regulation	Advocate for the reform of current legislation to decrease stigma and discrimination towards HIV/AIDS and TB; promote enter enforcement and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support. Revise the state social assistance and benefits legislation by safeguarding the inclusion of PLHIV and TB patients in the eligibility categories. Enforce the policy on collaborative HIV/TB activities, and the collaboration between ministries of Internal Affairs and Health. Reduce the price of government-procured drugs, consider centralizing the ARV drug procurement, or introduce a framework contracting mechanism allowing the decentralized procurement at pre-defined prices. This will allow the government to decrease financial burden of drug procurement after the end of the Global Fund support. Establish fast-track registration with reduced or waived registration fees for WHO-prequalified products;	
	Revision of mandatory testing legislation to allow voluntary testing increased focus on at risk population groups and efficient use of resources. Revision of legislation regulating OST service provision standards. The legislation has to ensure removal of OST initiation barriers and continuous provision of the OST. Enforcement of legislation on NSP service provision to allow expansion of PWID coverage with harm reduction programs.	Revision of the sick leave policy for MDR TB patients and the introduction of social benefits for unemployed TB patients to support treatment adherence. Revision of the legislation to remove all perverse motivations for long hospitalization of TB patients as well as TB hospital funding methodology.
Guidelines	Optimize ARV treatment regimens. Develop referral algorithms ensuring continuation of services from identification and prevention to treatment, care and support.	Improve the effectiveness of TB prevention, diagnostic and treatment services by revising and enforcing protocols ensuring the decrease of in-patient stay and increased responsibility of PHC for treatment.
	Develop HIV/TB service collaboration guidelines and enforce compliance	

Recommendation # 2: Ensure improved efficiency of current spending, adequate resource allocation for HIV and TB National Program implementation and mobilize domestic and international funding for effective implementation and monitoring of the transition plan		
	HIV	**TB**
Budget	Prepare budget forecasts and ensure allocations based on technical and allocative efficiency principles.	
	Ensure medium term budgeting of adequate resources for continuation of the prevention, treatment and care activities after the GF funding ends.	Ensure medium term budgeting for increased allocation of resources for TB national program that can i) compensate GF funded share and ii) gradually fill in 50% the programmatic gap. Ensure adequate funding of TB program from local Government budgets.

Recommendation # 2: Ensure improved efficiency of current spending, adequate resource allocation for HIV and TB National Program implementation and mobilize domestic and international funding for effective implementation and monitoring of the transition plan		
Allocative & Technical Efficiency	Consider improvement of allocative and technical efficiency according to the recommendations provided by the WHO Develop/revise and utilize costing methodology of preventive interventions for budget planning Carry out detailed analysis to determine in which areas technical efficiencies could be realized.	Consider improvement of allocative and technical efficiency according to the recommendations provided by the WHO
Resources for Transition plan implementation	Calculate non-programmatic costs of the transition plan implementation and leverage domestic and external resources for its effective implementation and M&E	
RECOMMENDATION # 3: Streamline service delivery		
	HIV	**TB**
Service Delivery	Remove access barriers to HIV testing and treatment by strengthening the cooperation between governmental institutions working on HIV/AIDS and non-governmental organizations to ensure timely access of patients to health and social services, by improving timely and complete diagnosis, prompt prescription of correct treatment and good adherence to ART. Enhance pre and post test counseling of KPs. Improve HIV/TB testing and treatment.	Improve efficiency of TB treatment by removing duplication of laboratory testing and annual clinical check-ups after the patient is cured. Streamline sputum transportation system. Improve TB/HIV testing and treatment.
RECOMMENDATION # 4: Ensure adequate supply of human resources and integration of HIV and TB training modules into the continuous medical education system		
	HIV	**TB**
Human Resources	Develop HIV/AIDS human resource planning and development strategy. Develop a workforce motivation strategy. Elaborate a strategy for the training of NGOs Ensure the integration of the HIV training modules into the continuous education systems. Initiate the integration of the HIV training modules into the undergraduate and postgraduate education systems	Develop TB human resource planning and development strategy and ensure implementation. Ensure integration of updated TB guidelines in continuous education, undergraduate and postgraduate education systems.
RECOMMENDATION # 5: Streamline forecasting, procurement and supply management system		
	HIV	**TB**
Procurement and supply	Develop ARV and TB drug forecasting methodologies and enhance the capacity of respective staff at national, local and facility levels.	

RECOMMENDATION # 5: Streamline forecasting, procurement and supply management system		
management	Enforce compliance with drug re-registration procedures. Streamline logistics system for timely distribution of commodities procured through GF and public sources.	

RECOMMENDATION #6: Enhance surveillance systems and build data analysis capacity at national and local levels		
	HIV	**TB**
Surveillance and M&E	Enhance the HIV surveillance system by introducing WHO recommended indicators. Integrate HIV/ AIDS spending into the National Health Accounts.	Enhance tracking of TB spending through National Health Accounts and use of data for evidence based planning.
	Provide training in surveillance and M&E data analysis at national, local, and facility levels to ensure evidence based planning and implementation.	

ANNEX 1: LIST OF DOCUMENTS REVIEWED

1 Wilson DP, Yakusik A, Kerr C, Avila C: HIV resource needs, efficient allocation and resource mobilization for the Republic of Belarus. Ministry of Health, Republic of Belarus, March 2013
2 HIV/AIDS treatment and care in Belarus, Evaluation Report, WHO, 2014
3 Resolution of the Ministry of Health of the Republic of Belarus #97 as of 12 July 2012 "On the establishment of clinical indications for mandatory medical examination of individuals, and on the list of other categories of individuals subject to mandatory medical examination
4 Legal and regulatory frameworks for antiretroviral medicines and treatment in selected countries of the Commonwealth of Independent States, A Sub-regional Analytical Report including Belarus, Kazakhstan, Russia, Tajikistan, and Uzbekistan, UNDP, 2014
5 National AIDS Spending Assessment 2008-2011, UNAIDS, http://www.unaids.org/sites/default/files/documents/belarus_2008 2011_en.pdf
6 Optimizing Investments in the National HIV Response of Belarus, DRAFT REPORT, 2015
7 HIV/AIDS Prevention and Treatment in the Republic of Belarus – 3 2013-2015, UNDP
8 GARP 2010
9 GARP 2012
10 GARP 2013
11 GARP 2014
12 NCPI 2012
13 National AIDS Spending Assessment 2008, UNAIDS
14 Optimizing Investments in the National HIV Response of Belarus, UNAIDS, 2015
15 Mid-term Evaluation of the HIV Prevention Programme supported by the Global Fund, EuroHealthGroup, 2014
16 People living with HIV, Stigma Index, Global Network of people living with HIV, 2014
17 The Global Fund New Funding Model and Country Dialogue: Involvement of MSM and Transgender People in Eastern Europe and Central Asia. Eurasian Coalition on Male Health (ECOM), 2015
18 Transition plan for procurement capacity development of the new PR and handover of ARV drug procurement, MOH, UNDP, 2015
19 Roadmap to prevent and combat drug-resistant tuberculosis, The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011-2015, WHO
20 V. Rusovich et al, High time to use rapid tests to detect multidrug resistance in sputum smear-negative tuberculosis in Belarus, Public Health Action, vol 4 no 4 published 21 december 2014
21 Review of the National Tuberculosis Programme in Belarus, WHO, 2011
22 Tuberculosis surveillance and monitoring in Europe, ECDC, WHO, 2015
23 Introducing the Stop TB Strategy in Belarus with a particular focus on taking measures to combat multidrug resistant tuberculosis (MDR-TB), Project Document, UNDP
24 Belarus: Health System Review, Health in Transition, WHO Observatory, 2008
25 National Strategy for sustainable development for the period to 2020 of the Republic of Belarus, Government of Republic of Belarus,
26 Demographic Yearbook Of The Republic Of Belarus, Statistical Book, National Statistical Committee Of The Republic Of Belarus, 2014
27 National Demographic Security Programmen of the Republic of Belarus, 2011 - 2015, Government of Belarus, 2011
28 Law of the Republic of Belarus of on Public Health
29 Belarus Human Development Report 2014
30 A. Matchanka, Substitution of Civil Society in Belarus: Government-Organised Non-

Governmental Organisations, The Journal of Belarusian Studies

31 A. Aliaksandrau et al, Belarus: Time for media reform, policy paper on media freedom in Belarus, 2014

ANNEX 2: LIST OF PEOPLE INTERVIEWED

#	Name	Position and Institution
1	Igor Gayevsky	Deputy Minister of Health, Chief Sanitary Doctor
2	Inna Karaban	Chief Epidemiologist, Deputy Head of the Epidemiology and Hygine Department, MOH
3	Ludmila Jilevich	Deputy Head of the Medical and Preventive Service Organization, MOH
4	Gennady Gurevich	Director of Scientific and Research Institute for Pilmonology and Pthysiology
5	Elena Fisenko	Head of HIV/AIDS Department, Republican Center of Epidemiology, Hygine and Public Health
6	Anna Rusanovich	Epidemilogist, HIV/AIDS Department, Republican Center of Epidemiology, Hygine and Public Health
7	Marina Sacheck	Director, Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health
8	Irina Novik	Deputy Director, Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health
9	Vera Ilyenkova	UNAIDS
10	Olga Otrashenko	Program Coordinator, UNDP
11	Valentin Rusovich	National Professional Officer for Communicable Diseases (TB)
12	Victoria Lozuyk	National Officer, UNICEF
13	Liudmila Trukhan	Positive Movement
14	Oleg Eremin	"Bel Set Anti-AIDS" Non-Commercial Association
15	Inna Lemeshevskaya	Belarusian Red Cross Society
16	Ludmila Rautskya	Head of Pharmaceutical Inspection and Organization of pharmaceutical supplies Department, MoH
17	T. Migal	Deputy Head of the Specialized Medical Care Department, MoH
18	Representatives from regional AIDS centers, local governments and other NGOs	

ANNEX 3: LIST OF KEY INDICATORS

Table 18 Demographic and Social Indicators

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Population, total (thousand)	10,005.0	9,928.0	9,865.0	9,797.0	9,730.0	9,663.0	9,604.0	9,560.0	9,528.0	9,507.0	9,490.0	9,473.0	9,464.0	9,464.0	9,470.0
Population growth (annual %)	-0.3	-0.8	-0.6	-0.7	-0.7	-0.7	-0.6	-0.5	-0.3	-0.2	-0.2	-0.2	-0.1	0.0	0.0
Population ages 0-14 (% of total)	18.6	17.9	17.2	16.6	16.0	15.5	15.2	15.0	14.8	14.8	14.8	14.9	15.1	15.3	15.5
Life expectancy at birth, total (years)	68.9	68.5	68.1	68.6	69.0	68.9	69.4	70.2	70.5	70.4	70.4	70.6	72.0	72.5	
Inflation, consumer prices (annual %)	168.6	61.1	42.5	28.4	18.1	10.3	7.0	8.4	14.8	12.9	7.7	53.2	59.2	18.3	18.1
Poverty headcount ratio at national poverty lines (% of population)	41.9	28.9	30.5	27.1	17.8	12.7	11.1	7.7	6.1	5.4	5.2	7.3	6.3	5.5	
Unemployment, total (% of total labor force) (modeled ILO estimate)	6.4	6.4	6.5	6.4	6.4	6.3	6.2	6.2	6.0	6.1	6.1	6.0	5.9	5.8	

Source: The World Bank Data Base, accessed July 15, 2015

Table 19 Macroeconomic and Health Financing Indicators

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
GDP per capita (current US$)	1,273	1,244	1,479	1,819	2,378	3,126	3,849	4,736	6,376	5,176	5,819	6,306	6,722	7,722	8,040
GDP per capita growth (annual %)	6.1	5.5	5.7	7.8	12.2	10.2	10.7	9.1	10.6	0.4	7.9	5.7	1.8	0.9	
GINI index (World Bank estimate)	27.7	28.3	30.1	29.0	26.3	27.4	28.2	28.8	27.2	27.7	27.7	26.5			
Revenue, excluding grants (% of GDP)	28.7	28.5	26.6	29.3	31.4	33.8	37.2	38.3	38.9	35.3	31.4	29.0	30.0		
GNI per capita growth (annual %)	6.1	5.5	5.9	8.2	12.2	10.3	10.0	8.3	10.0	-0.6	8.1	6.8	0.0	-1.1	2.4
GNI per capita, Atlas method (current US$)	1,380	1,300	1,380	1,630	2,180	2,820	3,520	4,310	5,470	5,590	5,990	6,130	6,400	6,780	7,340
Health expenditure, total (% of GDP)	6.1	6.6	6.5	6.6	6.6	6.9	6.3	6.4	5.9	6.1	5.6	4.9	5.0	6.1	

health expenditure)														
Health expenditure, private (% of total health expenditure)	24.5	28.5	29.5	26.2	25.3	27.1	29.8	30.9	34.9	36.0	22.3	29.5	22.8	34.6
Out-of-pocket health expenditure (% of total expenditure on health)	14.0	18.3	20.5	18.2	17.3	19.9	22.2	23.6	27.5	26.9	19.8	26.6	19.5	31.9

Source: The World Bank Data Base, accessed July 15, 2015

Table 20 Existence of legislations specifying protection for key populations and vulnerable groups

Key Populations	Government	Civil Society
PLHIV	N	N
MSM	N	N
Migrants	N	N
Orphans and vulnerable children	Y	Y
People with disabilities	Y	Y
People who inject drugs	N	N
Prison inmates	N	N
Sex workers	N	N
Transgendered people	N	N
Minors without parental consent		
Women and girls	Y	Y

3