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

SYNTHESIS REPORT

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Synthesis Report

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DISCLAIMER

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALOS	High Average Length of Stay
ART	Antiretroviral Therapy
CCM	Country Coordination Mechanism
CF	Conceptual Framework
CSO	Civil Society Organization
DOT	Direct Observed Treatment
DST	Drug Susceptibility Testing
ECDC	European Center for Disease Control
EEI	Enabling Environment index
FLD	First Line Drugs
GARPR	Global AIDS Response Progress Reporting
GDP	Gross Domestic Product
GGE	General Government Expenditure
GGR	General Government Revenues
GHSPIC	Georgia Health and Social Projects Implementation Centre
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioral Surveillance
KP	Key Populations
LIC	Low Income Country
LMIC	Lower Middle Income Country
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MDR-TB	Multi Drug Resistant Tuberculosis
MoH	Ministry of Health
MPH	Ministry of Public Health
MSM	Men who have Sex with Men
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Disease
NCDCPH	National Center for Disease Control and Public Health
NFM	New Funding Modality
NGO	Non-Governmental Organization
NSEP	Needle and Syringe Exchange Programs
NSP	National Strategic Plan

NTP	National Tuberculosis Program
OST	Opioid Substitution Therapy
PEP	Post Exposure Prophylaxis
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PR	Principal Recipient
PSE	Population Size Estimation
PWID	People Who Inject Drugs
SDG	Sustainable Development Goals
SLD	Second Line Drugs
STI	Sexually Transmitted Infections
SW	Sex Worker
TA	Technical Assistance
TB	Tuberculosis
TGF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
TERG	Technical Evaluation Reference Group
THE	Total Health Expenditure
TPAF	Transition Preparedness Assessment Framework
TRP	Technical Review Panel
UCDC	Ukrainian Center for Disease Control
UHC	Universal Health Coverage
UMIC	Upper Middle Income Country
XDR-TB	Extensively Drug Resistant Tuberculosis

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EXECUTIVE SUMMARY

INTRODUCTION

The goal of the synthesis report is to examine the experience of four middle-income EECA countries – Belarus, Bulgaria, Georgia and Ukraine – that have received grant support from the Global Fund and, in the near future, will have to prepare for transition out of Global Fund assistance in a way that assures the financial and programmatic sustainability of their TB and HIV responses. The synthesis report presents the main findings from this assessment and elaborates recommendations for the country actors. These countries share important similarities and can serve as examples for other comparable countries in the region, or with analogous backgrounds, in planning for transition. Finally the synthesis also aims to inform the Global Fund's strategy development process, especially for the area of transition and sustainability.

For the purpose of this study, sustainability is defined as "the capacity of a country to independently manage its disease-specific programs in the long-term without interruption or compromising quality by developing a sense of ownership, enabled by an adequate internal and external national environment". However, before reaching sustainability, countries will necessarily experience a transitional period, during which they set the foundations for durable continuity for donor supported programs. Therefore, assessing transition readiness is the primary goal in this four-country review. We define transition 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 (outside of the health sector) enabling factors".

The case studies were conducted through a literature review as well as through the collection of primary and secondary data guided by the Transition Preparedness Assessment Framework (TPAF) which allows to examine a country's transition readiness towards program sustainability and identify the areas that need to be attended during transition planning and implementation.

A number of limitations were encountered when conducting the research, which are summarized below: a) The synthesis report is the result of four case studies that represent the realities of each of the countries. As such, the findings may not be translatable to all contexts, which limits their generalizability. General findings have been collected across all countries, which may be relevant to other countries with similar contexts. At the same time, specific findings may be useful for other countries as lessons learned. b) Different country teams conducted the initial case studies. The use of local teams ensured that the researchers knew TPAF and the country context and thus were able to provide robust results. Nonetheless, the diversity of individuals used for TPAF implementation may have had an effect on interpretation of overall results. c) Finally, there were some limitations in terms of some comparable data availability for across the four countries for the entire 2000-2014 assessment period.

EPIDEMIOLOGICAL TRENDS

Epidemiological analysis demonstrates that while there are challenges to control HIV/AIDS and TB spread significant public health gains have been achieved by the national programs over the past decade. The magnitude of the HIV epidemic differs among the countries, with Ukraine having Europe's most severe HIV epidemic while other countries yet face low HIV

prevalence, mainly concentrated among key populations (KP). The countries observed a declining trend of HIV rates in most KP, with the exception of Men who have Sex with Men (MSM); HIV infected patients are now diagnosed earlier and the rate of late diagnosis has fallen, albeit slightly; and, most likely, timely diagnosis has also helped to ensure timely enrollment into Anti Retroviral Treatment (ART). ART expansion led to stabilized, and in some countries even reduced AIDS related mortality.

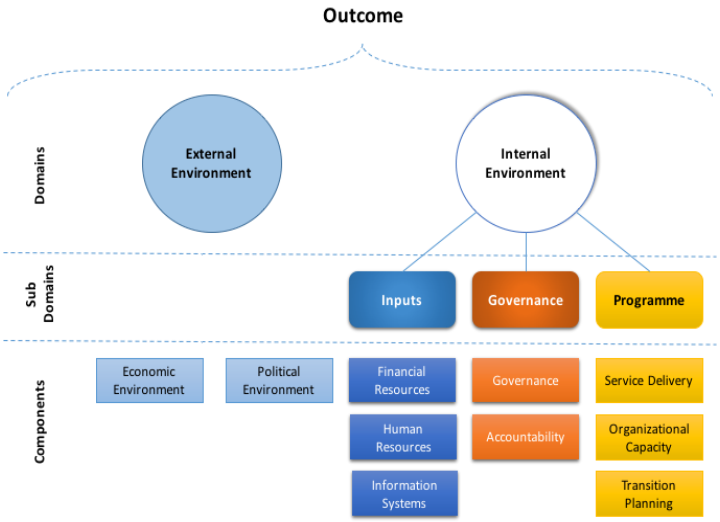
Tuberculosis remains an important public health challenge in the EECA region as well as in the four countries studied. Progress in TB diagnosis, treatment and care is also obvious, although some challenges remain to be tackled and require further attention. Improved TB programs most likely led to declining TB prevalence, incidence and notification rates. Improved treatment success rates for both sensitive and MDR cases are also notable, along with declining TB related mortality, etc. While progress is visible, the national TB programs still require significant strengthening if these countries are to meet the Stop TB targets.

In light of these findings, it would be prudent to claim that part of these gains could be attributed to Global Fund investments. Therefore, sustaining and even expanding these gains as the countries move towards the post-Global Fund era is extremely important.

The four countries have received funding for HIV and TB from the Global Fund since 2003. The Global Fund grant portfolio differs between countries in terms of grant duration, target areas and principal recipients. From now all four countries have at least two years to plan and implement transition from Global Fund support, with a few exceptions, such as the Bulgaria HIV program, closing at the end of 2016.

CASE STUDY FINDINGS

Figure 1: Transition preparedness assessment framework's components



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

This section of the report synthesizes findings of the four country case studies, which are based on the Transition Preparedness Assessment Framework (TPAF). The TPAF includes two main domains, the external and internal environment further subdivided into relevant sub-domains and components. The main findings of the synthesis are presented according to each component (Figure 3).

EXTERNAL ENVIRONMENT

The external environment is subdivided into the economic and political environments, both of which are essential components for successful transition from external support. An

enabling economic environment is crucial for sustained and/or increased and predictable domestic investments in health and, especially, for the successful transition of externally funded programs. This component was assessed by analyzing annual GDP growth trends in the countries and the share of General Government Revenue (GGR) as a percentage of GDP. The assessment revealed that environment in Bulgaria, Georgia and Ukraine are somewhat more conducive for smooth transition compared to Belarus. Though all countries need to pay attention to certain areas that require further improvement during transition.

The political environment as an enabling factor for an adequate transition of HIV and TB programs has been assessed by analyzing the following: 1) the existence of **political will to prioritize health investments** within the government's budget; 2) the **existence of laws, regulations and policies** that make possible prevention, treatment and care service delivery for KP and people living with the diseases and the ability of the government to enforce these laws; 3) and the **existence of mechanisms within the government to enable CSO/NGO contracting** for the delivery of various services funded out of state or local budgets.

The political will to prioritize health investments was assessed using two indicators: a) the share of government spending on health out of the General Government Expenditure (GGE) and b) the share of public spending out of the Total Health Expenditure (THE). By assessing these indicators, we can conclude that there is an adequate political will to invest in health in Belarus and Bulgaria, Georgia is lagging compared to others, while Ukraine, although spending comparable share on health is experiencing decline in health investments.

Another important factor for transition, particularly for HIV services, is a well elaborated legal framework that is adequate to protect the rights of key affected populations and to deliver preventive, curative and care service, including those delivered by NGOs/CSOs. However, the mere existence of such a legal framework will not be sufficient unless mechanisms are in place to uphold/enforce these laws. Assessment shows that Bulgaria has no legal barriers and Ukraine appears to have the least legal impediments after Bulgaria. However in both countries anti-discrimination laws have not been always effectively enforced to safeguard the human rights of vulnerable social and ethnic groups. In the case of Georgia, criminalizing laws against drug users and the inadequate scale of needle exchange programs in a country with high rates of People Who Inject Drugs (PWID) are seen as barriers to access preventive HIV services, which creates risks to transition. Worryingly, legal barriers in Belarus are widespread, which puts KP at higher risk and will most likely hinder transition, especially for the services being funded by the Global Fund and focused on KP.

The third area of assessment for the political environment is the ability of the government to contract SCO for all sectors through the existence of legal frameworks, rules and procedures, or by demonstrating that they currently do this effectively. The assessment revealed that general regulations allowing the governments to contract with CSOs is favorable in three out of four studied countries (Bulgaria, Georgia, Ukraine). Belarus is particularly behind in these two areas, which increases the overall risk arising from the political environment compared to the other three countries. The government's ability of contracting CSOs for HIV and TB service provision is assessed later in the document.

INTERNAL ENVIRONMENT

The internal environment encompasses the enabling factors, directly related to the health sector/programs and has been divided into the following sub-domains: a) inputs; b) governance; and c) the program (Figure 3).

INPUTS

Inputs are the resources that are available for the HIV and TB programs. These are subdivided into components that include: (i) financial resources, (ii) human resources and (iii) health information systems (Figure 3).

Without dedicated ***financial resources*****,** it would be difficult for any program to survive. Resources should be predictable and proportional to the disease burden in the country. However, available resources are strongly related to the economic environment and political will. Financial resources were assessed by examining the budgetary commitment and financial dependence on donor/external funding for both diseases, and by looking at the prioritization of investments for preventive and treatment interventions, especially for epidemiologically important population groups.

Countries demonstrate an increasing trend in expenditure for both diseases with dedicated budget lines. However, financial dependence on external support is still significant, which may pose risks to transition and sustainability of the programs unless gradually reduced.

Public spending on HIV prevention activities in all four countries was low, ranging between 41% (Georgia) to 71% (Belarus). When looking at the preventive services that reach KP, the dependency on external donor funding is high. These program components face the greatest sustainability risk during transition. Each country has prioritized HIV and TB treatment related interventions for public investments and is taking steps to reduce treatment dependence on the Global Fund.

The availability of adequately trained and distributed ***human resources*** is important for program success and long-term sustainability. This component was measured by assessing the availability of sufficient human resources, the institutionalization of donor-supported trainings; the existence of policies to train NGO/CSO personnel; and the alignment of donor funded salaries and top-ups with the national pay scale.

All countries with exception of Belarus reported sufficient numbers of HIV personnel. In the case of TB, all four countries reported limitations concerning the number of TB professionals, their low salaries and aging of the staff.

Serious concerns were reported with regards to the lack of institutionalization of Global Fund supported trainings into national education systems, raising questions whether they would continue after the grants ended. Belarus and Ukraine have partially integrated training modules developed through the Global Fund grant in continuous education systems, while in Georgia and Bulgaria these trainings lack institutionalization. Challenges are expected in re/production of CSO cadres in all countries. Countries differ significantly in terms of donor funding salary alignment and top-ups. In Belarus HR salaries are fully covered by the national budget, in Georgia Global Fund funded salaries are aligned with the national pay scale, while in Bulgaria and Ukraine salaries funded by the Global Fund are the main motivation factor and are significantly higher than public salaries.

Quality, timely, adequate and reliable data is an essential part of sustaining HIV and TB programs. This component was assessed by evaluating the integration of comprehensive routine statistical reporting in the national health information system(s) for both diseases, as well as by evaluating HIV second generation surveillance mechanisms i.e. the quality and rigor of the methodology used, funding sources and integration of the data in the national reporting.

Countries to some degree advanced their health information systems and collect necessary information that can be used in program evaluation and/or intervention planning, albeit these achievements were not without limitations. Nevertheless, it seems possible the remaining limitations to be address during well planned transition, with the exception of analytical capacity limitations that could remain for a while due to structural limitations of the education and public sector employment. With regards to HIV second-generation surveillance, Belarus, Georgia and Ukraine use rigorous methodologies for Integrated Biological and Behavioral Surveillance (IBBS), which is implemented in a timely manner. In the case of Bulgaria, methodological challenges do not allow to generalize the findings. The greatest risk to health information systems seems to arise from the current dependence on external funding for IBBS and Population Size Estimation (PSE) studies and the unavailability of state funding for this research. Special attention has to be paid to tracking program expenditures, particularly for TB.

GOVERNANCE

The governance sub-domain is sub-divided into governance-specific components that includes all of the actors and institutions involved at the organizational level and steering the HIV and TB programs and the factors fostering accountability, which is an important to ensure that organizational level is fulfilling their roles and commitments (Figure 3).

Appropriate **governance** is the cornerstone of any program. This component was assessed by looking at three indicators: a) political commitment (non-financial), as revealed by well elaborated, disease-specific National Plans with sufficient legal power to drive national budgetary allocations and disease programs that are given adequate priority in the national health sector strategy; b) strong institutional and individual leadership of the disease programs (not PR); and c) an appropriately placed and well-functioning coordination mechanism within country governance structures.

At the time of this study, most of the countries were in the process of preparing or had recently approved **disease specific strategic plans**. Government-approved national HIV and TB programs existed in Belarus and Bulgaria. Furthermore, Bulgaria embarked on development of the new HIV and TB national strategies for 2016-2020. A new HIV/AIDS prevention, treatment, care and support National Program (2014-2018) has been approved by the law in Ukraine, while a new national TB program (2015-2018) is under development. Out of the four studied countries, Georgia is the only one where NSP/NTP existed but lacked sufficient legal power.

The study examined the institutional leadership of the disease programs, and revealed varying degrees of **institutional and individual leadership effectiveness**. Mainly, with the exception of two occasions (Bulgaria HIV & TB and Georgia HIV), institutional leadership for disease program was either lacking or not effective. Therefore, all programs, with the exception of Georgia TB, relied mostly on individual leaders to advocate and lead the national response.

Ability of the CCMs to conduct their activities was measured by looking at their **placement and legal empowerment** within the government hierarchy; the participation of CSOs; and how effectively they functioned. While all CCMs effectively engage NGOs/CSOs, they have not had solid legal foundations within the sovereign legislation and therefore are not well placed within the national governance structure to ensure coordinated, multi-sectorial responses to HIV and TB epidemics. With exception of Belarus and Georgia, the CCMs did not function effectively.

Transparency and easy access to epidemiological and program performance data is critical to assure adequate **accountability** in a county and allow interested stakeholders to engage in program monitoring/oversight, thereby ensuring that government commitments are held. The transparency of information to the public was measured by looking at the availability of epidemiological data on KP, and regular production and dissemination of program reports, expenditure data and other reviews in an easily accessible form to the public. Ukraine demonstrated the most positive results. Bulgaria showed the weakest results since it has no formal rules and mechanisms to disseminate program results. Georgia and Belarus have data available on KP, but other information is partial or unavailable. Particularly worrisome is the absence of program expenditure data in Belarus, Bulgaria and Georgia. This is especially relevant for TB programs, while for HIV the countries are requested to carry out such assessment biennially.

Enabling Environment Index was used to measure the country environment for civil society, for which Bulgaria showed highest score, followed by Ukraine and Georgia. Belarus demonstrates the lowest overall EEI score, primarily due to non-conducive governance environment for NGOs/CSOs.

PROGRAM

This sub-domain is sub-divided into three components: (i) service delivery; (ii) organizational capacity; and (iii) transition planning (Figure 3).

Service delivery is measured through treatment coverage and outcomes; the integration of existing disease services into general services, such as PHC; the coverage of KP with preventative services; and the ability to sub-contract CSOs specifically for health (prevention and care) service delivery.

In the case of HIV, ART **coverage and treatment adherence** rates are improving in all countries. Georgia is the only country in Eastern Europe that has universal access to ART using their network of health facilities and demonstrated >90% coverage among those who are diagnosed and eligible for treatment. Belarus, Bulgaria and Ukraine also show an increasing trend for both ART coverage and treatment outcome, but the coverage rates still remain low in Belarus and Ukraine. Treatment success rates for all cases of TB are improving in all countries except Ukraine, which are mostly associated with ineffective treatment programs. Treatment outcomes for MDR TB cases are improving but remain low in all countries.

The process of **service integration** for both TB and HIV is ensured in Georgia, but remains sub-optimal in Belarus and Bulgaria. In Ukraine TB/HIV services are not yet integrated but close to emerge. There are no regulations that describe and direct the collaboration between TB, HIV and primary health care facilities, or NGOs that provide support to people living with HIV (PLHIV). Consequently, the lack of service integration has negative implications on the expansion of HIV testing coverage and treatment.

Coverage of KP with preventive services show increasing trend across the countries. HIV testing coverage has improved in Bulgaria, Georgia and Ukraine, but at different paces. Safe practices among PWID improved in Georgia and Ukraine, while safe sex practices in other KP deteriorated in Georgia and partly in Belarus and improved in Ukraine and Bulgaria.

C**SO contracting** in the health sector is lacking in all countries albeit legal environment for CSO contracting seems conducive and most countries, except Belarus, contract CSOs for the provision of social services.

ORGNAIZATIONAL CAPACITY

The organizational capacity differs from the one described in under the governance component in the previous section and looks at organizational capabilities of the national entity responsible for disease program management by looking at: program management; financial management; contracting; procurement-supply chain management; and research, monitoring and evaluation areas.

Of the four countries, Bulgaria demonstrates a positive example where assessments of the MoH as the PR of the Global Fund grants are regularly conducted and the PR and national disease program management are fully integrated because of being the same entity. The lack of integration of National HIV and TB program and grant management is identified in Belarus, Georgia and Ukraine. The absence of a centralized public entity with overall planning and oversight responsibilities in Belarus, Georgia, and Ukraine raises sustainability risks after transition from Global Fund support.

Like the program management, procurement and supply chain management are core areas for an effective TB and HIV response. While **supply management systems** are fully integrated into national systems (except in Ukraine), procurement in Belarus, Bulgaria and Ukraine and in some instances Georgia will most likely face challenges after Global Fund support ends if the following weaknesses are not addressed during the transition process: Enhancement of country capacity in forecasting and allowing sufficient buffer stocks (all countries); The lack of integration of the Global Fund grant procurement into national procurement systems (Belarus, Bulgaria Ukraine); National procurement legislation restricting international procurement (Belarus); Noncompliance with drug registration requirements; The absence of drug quality control mechanisms (in all countries); The lack of price regulation mechanisms (Belarus, Ukraine).

TRANSITION PLANNING

A direct measure of forward thinking for HIV and TB programs currently receiving external funding in any country is the ability to plan the take-over of responsibilities both at the programmatic level and in terms of funding. Three out of the four countries studied do not have plans in place. In the case of Belarus, there is no transition plan approved by the government, although plans for some elements to be transitioned are developed and do specify time-bound activities to be implemented over coming years. These plans lack clarity on roles and responsibilities during the transition process, such as who will lead the response and who will take over specific activities. At the same time, they do not include measureable indicators to track progress and most importantly, they do not include a budget, making it difficult to evaluate the resources that will be necessary for transition.

CONCLUSIONS AND RECCOMENDAITONS

This assessment allows decision-makers and country stakeholders to prioritize areas that need to be addressed during transition planning through national/sub-national consultative process. The transition plan should be a prioritized action plan to take over responsibilities to ensure the long-term sustainability of the programs.

The assessment of the transition preparedness should be made by component where colors guide the action. The components highlighted in green entail lower risk. These components could be maintained at current or higher levels, but given the lack of risk they do not necessarily need to be included in the transition plan. Components with moderate risk (in a yellow zone) need to be included in the transition plan, but primarily for monitoring purposes; in case the risks increase, action should be taken. The areas highlighted in red require higher levels of attention and prioritization. These components warrant inclusion in the transition plan along with risk mitigating activities and after prioritization and after giving full consideration to contextual factors. In order to account for context, the stakeholders should look at prioritization through a feasibility lens for a given country by examining importance of a given component to sustainability and implementation feasibility. Clear steps to address these areas should be developed early on with clear milestones from the start to adequately measure progress over time and clear responsibilities for implementation have to be assigned and adequate resources and time for their implementation should be allocated.

As the findings show, there are several challenges to sustainable transition in the countries. However, taking epidemiological lens and recognizing importance of KP as key drivers of the epidemics, mostly for HIV/AIDS, it becomes important to first draw conclusions around transition challenges affecting these population groups. Challenges that affect KP could be separated into structural and supply side related.

From structural challenges legal barriers (at times criminalizing KP activity) along with societal norms, believes and stigma are most likely working together and preventing legal changes to occur in a country. Consequently, both seem to be major impediment for the national programs and requires active advocacy and education on a national and at times from a supranational level (see arrow box on the top). Also, both these factors most likely prevent elected and/or appointed politicians from advocating for interventions focused on KP and as a result during a political/budgetary process these groups are not prioritized. Most likely this is the reason why past advocacy efforts have not led to budgetary allocations for KP-focused interventions in the studied countries. Therefore, in the environment where public funding for preventive and care activities focused on KP is not available, these activities still depend on external - Global Fund support and therefore pose the biggest challenge to sustainable transition. These groups being drivers of HIV/AIDS and TB epidemic and unless adequate national resources are secured, public health gains achieved by the countries could evaporate after transition.

The study also noted that NGOs/CSOs are the critical service providers for preventive and care services for KP. However, without having national budgetary resources, it seems that governments are not rushing into developing NGO contracting mechanisms that is an absolute prerequisite to replace external funding with the national one and for keeping NGOs/CSOs continuously engaged in a service provision to KP. All of these seems to place KP-related transition challenges into a vicious cycle, which is hard to break. Consequently, transition is challenged and future sustainability of the national responses is undermined, unless this vicious cycle is timely addressed. To overcome these challenges it is critical to: a)

continue with **national / supranational advocacy** and educational efforts aimed at reducing public resistance/stigma, enacting legal changes decriminalizing certain activities, reducing legal barriers to services and facilitating national budget allocations; b) developing and enacting **NSP that has sufficient legal power to drive national investments** for KP-focused interventions; and c) developing and implementing rules that **clearly define the steps required for NGO/CSO contracting.** While prevention in KP 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 and aided transition[1].

Another set of transition challenges emerges from supply side factors, which could be sub-divided into two parts. The first is weak or inadequate surveillance and program monitoring, which produces inadequate data for decision-making and for national program planning. This challenge is further layered by lack of, or inadequate sovereign transparency requirements for the information produced with public funds. Lack of information (epidemiological, programmatic or financial) emerges as a major barrier significantly limiting advocacy potential that could be mounted by civil society groups, external partners and/or other stakeholders, like journalists. Consequently, another vicious cycle emerges, which on one hand negatively affects national program/response planning and on the other imposes impediments for effective public/civil society engagement with the government, as they are not enabled to identify problems and advocate governments for the necessary changes. While critical/essential data and information production (even if it is of limited quality) is completely donor dependent, sustainable transition faces even a greater risk. Consequently, three critical needs emerge: a) **improving quality/reliability of the surveillance information** during or before transition; b) **timely shifting funding responsibility for data generation and analysis** onto governments, or alternatively securing longer-term external funding for critical information reproduction; and c) **assuring data** (epidemiological, programmatic and financial) **transparency and accessibility to public**. All of this would certainly help national planning and public accountability.

Another supply challenge relates to human resource development in general. **Addressing human resource challenges** should be viewed in two parts: a) assuring an adequate quantity and re-distribution of the necessary human resources; and b) continuous education for the professionals involved in the national response – service provision. 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. Therefore, it may be slightly less feasible to accomplish. **Alternative models could assure scalable delivery of the necessary trainings and at a lower cost** by using technology innovations available on the market.

Effective national coordination, with or without a CCM, is essential for effective management of the national response and for implementing the transition process, which leads to sustainability. It seems important for the country to consider retaining and enhancing the national coordination structure/function, which would allow for continuous

[1] Gotsadze T., Fuenzalida-Puelma HL., Chkhatarashvili K., Chikovani I., Tabatadze M. Transition and sustainability of Global Fund supported programs: Synthesis report of selected country case studies and reviews. Curatio International Foundation, Tbilisi 2015.

NGO/CSO engagement. In addition it would be critical to **assure effective management of national programs** that implies both institutional arrangements that allow for legal powers for the lead agency to influence the implementation of national programs, and individual leadership within such agencies.

Finally, countries remain heavily reliant on the Global Fund to finance necessary drugs and other consumables-commodities. Therefore, **gradually reducing financial dependence on the Global Fund** is critical. The first and **most important area to consider for transition is commodity procurement**, so that national procurement mechanisms function adequately. Secondly, **planning for more aggressive service integration** may also create efficiency gains and so increase the resources needed to financially sustain country programs.

"In development work, including global health, there have been a lot exits but not many successful transitions."

Mark Dybul, Executive Director of the Global Fund

CHAPTER 1. INTRODUCTION

Since it was established in 2002 the Global Fund has provided funding to support countries' responses to HIV, TB and malaria, and currently spends nearly US$4 billion a year in over 140 countries[2]. However, the economic crisis of 2008 and the subsequent difficulties in raising funds for development assistance for health highlighted the need for countries to be prepared for a scenario of decreasing aid[3]. At the same time, economic growth in several countries in the 'South' has moved them from low-income to middle-income status and enabled them to contribute more to their social programs from national budgets. As a result, these countries are able to sustain their disease-specific programs in the near future, particularly in a post-2015 scenario, where countries must maximize their resources to ensure they meet the health-related needs of their population and Sustainable Development Goal (SDG) targets.

The goal of this synthesis report is to examine the experience of four middle-income EECA countries – Belarus, Bulgaria, Georgia and Ukraine – that have received grant support from the Global Fund and, in the near future, will have to prepare for transition out of Global Fund assistance in a way that assures the financial and programmatic sustainability of their TB and HIV responses. Guided by the Transition Preparedness Assessment Framework (TPAF) developed by the authors, which is detailed elsewhere[4], the synthesis report presents the main findings from this assessment in the four selected countries and elaborates recommendations for the country actors. It also aims to inform the Global Fund's strategy development process, especially for the area of transition and sustainability.

The objective of transitioning from donor support is ensuring the sustainability of the programs/national responses. For the purpose of this project, we define sustainability as "the capacity of a country to independently manage its disease-specific programs in the long-term without interruption or compromising quality by developing a sense of ownership, enabled by an adequate internal and external national environment[5]". However, before reaching sustainability, countries will necessarily experience a transitional period, during which they set the foundations for durable continuity for donor supported programs. Therefore, assessing transition readiness is our primary goal in this four-country review. We define transition 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 (outside of the health

[2] Global Fund to fight AIDS, Tuberculosis and Malaria. (2015a). About the Global Fund. Available at: http://www.theglobalfund.org/en/about/

[3] IHME. (2014). Institute for Health Metrics and Evaluation. Financing Global Health 2013: Transition in an Age of Austerity. Seattle, WA. http://www.healthdata.org/sites/default/files/files/policyreport/2014/FGH2013/IHMEFGH2013Overview.pdf

[4] 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.

[5] External environment are those factors outside of the health sector.

sector) enabling factors". This report synthesizes the main results from the transition readiness assessments arising from the four case study countries, using the TPAF to present the main findings and reach general conclusions and recommendations that could inform successful transition.

The report is divided into five main sections, starting with an introduction to the report, followed by a brief explanation of the methodology used. Chapter 3 sets the stage in the countries by providing brief information on the main epidemiological trends for HIV and TB and the grants that these countries have received from the Global Fund. Chapter 4 presents the main findings from the case studies by assessing how far the external and internal environments enable transition. Chapter 5 serves as a discussion of main opportunities and challenges in the four case study countries. The report ends with Chapter 6, which provides general conclusions and recommendations for transition to programmatic sustainability. Detailed findings of the four countries can be found in the respective country case study reports, which are available upon request from the Global Fund.

CHAPTER 2. METHODOLOGY

2.1 COUNTRY CASE STUDIES

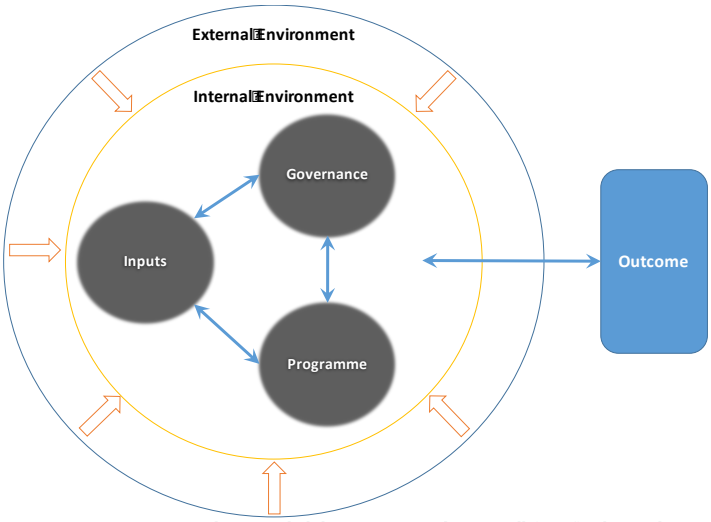
This synthesis report examines four middle-income economies in the EECA region, with Georgia and Ukraine being classified as lower-middle-income countries and Belarus and Bulgaria as upper-middle income countries[6]. The four countries have received funding for HIV and TB from the Global Fund since 2003. Their relatively low HIV burden, successes in reducing TB rates and middle-income country status makes them useful case studies to understand which factors should be in place for sustainable transition of these programs. These countries share important similarities, due to their geographical location and income levels, they can serve as examples for other comparable countries in the region, or with analogous backgrounds, in planning for transition.

The case studies were conducted through a literature review as well as through the collection of secondary and primary data (through in-depth interviews), guided by the Transition Preparedness Assessment Framework (TPAF) detailed below.

2.2 TRANSITION AND SUSTAINABILITY ASSESSMENT FRAMEWORK

The Transition Preparedness Assessment Framework was developed and piloted in the studied countries and is published in a separate report. TPAF seeks to guide the assessment of enabling and limiting factors related to transition in order to identify the key elements that should be addressed during transition planning and implementation before ceasing external support.

Figure 2: Transition Preparedness Assessment Framework



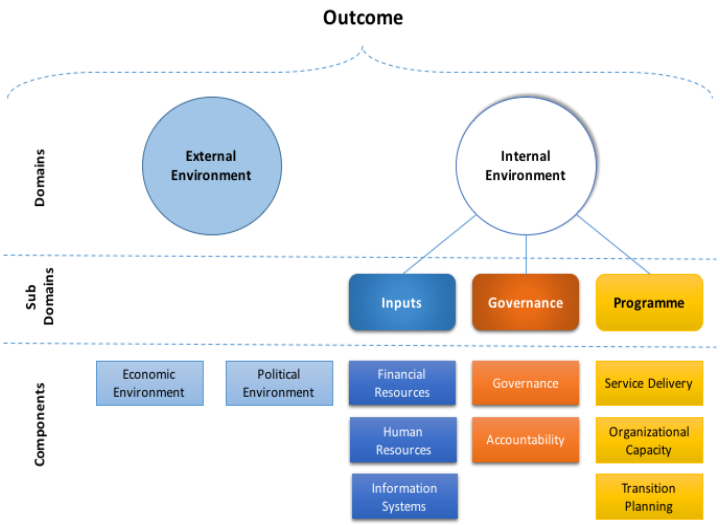
Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. Gotsadze, T et all (2015). The road to sustainability: Transition Preparedness Assessment Framework. Tbilisi, Georgia: Curatio International Foundation.

The framework is divided into two general domains (see Figure 2). The external environment is so named because it encompasses the elements outside of the health sector, including the political and economic environment. The internal environment, which is further sub-divided into three sub-domains (inputs, governance and program), represents the factors within the health sector. As Figure 1 shows, these elements are in close interaction and collectively they lead to the expected

[6] World Bank (2015). Country Groups. Available at: http://econ.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20421402~menuPK:64133156~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html#Uppermiddleincome

program outcome(s) of improved health of people affected by the program. Therefore, **successful transition from Global Fund support to program sustainability has to assure that public health gains achieved through the Global Fund support are either retained or expanded**.

Figure 3: Transition preparedness assessment framework's 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 of the TPAF are further divided into components affecting transition and the sustainability of the public health programs (Figure 3). Collectively, the components, sub-domains and domains included in the framework, help to unpack sustainability related issues / areas that need to be addressed during transition, and help to present the findings in a well-organized and logical manner.

Finally, by analyzing these external and internal environments, their domains and components, the framework allows us to examine a country's transition readiness towards program sustainability and identify the areas that need to be attended during transition planning and implementation.

Table 1: Illustration of the Transition and Sustainability risk rating[7]

Low risk – >85%	Dark Green Score, sustainable and requires no additional investment at this time
Moderate to Low risk – 70-85%	Light Green Score, approaching sustainability and requires little or no investment
Moderate risk - 50-69%	Dark or Light Yellow Score, emerging sustainability and needs some investment
Moderate to High risk - 36-49%	
High to Moderate risk – 25-35%	Dark or Light Red Score, unsustainable and requires significant investment
High risk – <25% red	

Each component of the framework was operationalized into indicators (qualitative and quantitative) for each domain/sub-domain, which are described in detail in the following sections. The indicators were converted into numerical values, so that each component was scored. A risk category was assigned to each component according to the overall scores. To define a country's overall risk, scores for each category were summarized and aggregated,

[7] Modified from PEPFAR's HIV/AIDS Sustainability Index and Dashboard

based on the percentage of scores accumulated for all domains/sub-domains/categories. Table 1 illustrates how these indicators, when summarized, help to assess country readiness for transition and/or sustainability.

This framework was operationalized into tools that were used during the country fieldwork for data collection and are available from elsewhere[8]. Both quantitative and qualitative data arising from the desk review, in depth interviews and secondary quantitative data were triangulated and informed indicator measurement, using conceptualization, coding, and categorizing in line with the conceptual framework domains, sub-domains and components. This allowed us to examine relationships, leading to major findings and eventually informing the recommendations.

2.3 LIMITATIONS

A number of limitations were encountered when conducting the research, which are summarized below:

- This synthesis report is the result of four case studies that represent the realities of each of the countries. As such, the findings may not be translatable to all contexts, which limits their generalizability. General findings have been collected across all countries, which may be relevant to other countries with similar contexts. At the same time, specific findings may be useful for other countries as lessons learned.
- Different country teams conducted the initial case studies. The use of local teams ensured that the researchers knew TPAF and the country context and thus were able to provide robust results. Nonetheless, the diversity of individuals used for TPAF implementation may have had an effect on interpretation of overall results. This was addressed by working with all teams pre- and post-fieldwork to ensure that information was collected and presented in a coherent manner across the teams, and that they were reporting and interpreting information in the same way.
- The assessment findings were validated with the country stakeholders, however in the case of Bulgaria, it was not possible to share and receive feedback on the assessment results within the report production period. Therefore the Bulgaria TPA findings may not reflect the country stakeholders' views.
- Finally, there were some limitations in terms of data availability for some countries, which is the result of the particular contexts. This means some comparable data across the four countries was not available for the entire 2000-2014 assessment period. This was a particular challenge in the case of Bulgaria. However, this was not a major limitation and has not affected the overall results of this synthesis report. The data, whenever possible, was taken from international databases and compared with the national data that we were able to access, and quantitative data was complemented with qualitative data. Data limitations have been highlighted whenever relevant in the report.

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

CHAPTER 3. SETTING THE STAGE

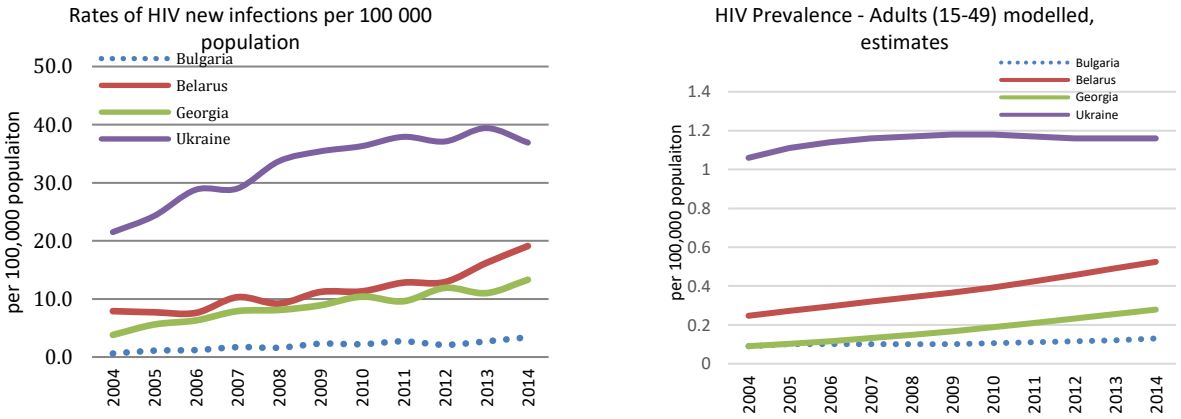
The four studied Eastern European and Central Asian (EECA) countries share important similarities due to their backgrounds as Eastern Block states. This background and its relationship to transition will be addressed further when we discuss the external and internal environment in more details. However, as a necessary first step, in this section we discuss the context in which the Global Fund began to provide funding for HIV/AIDS and TB in these countries and how epidemiological trends have evolved since. Details on the disease-specific programs will be addressed in the next chapter.

3.1 EPIDEMIOLOGICAL TRENDS

This section provides a general overview of the main epidemiological trends in the four EECA countries for HIV and TB from the year 2004 until 2014. The data demonstrates how these two diseases have evolved, partly due to the Global Fund's support. However, it should be noted that there are variations in the availability, quality and reliability of data, especially those related to key populations (KP), which imposes some limitations to our analysis.

HIV and AIDS: The overall national prevalence of HIV in all studied countries remains low (see Figure 3 right), with the exception of Ukraine, where it is above 1%. However, a low national prevalence often masks a higher HIV prevalence and incidence rates in certain geographical areas and/or among key populations at higher risk, due to limitations in reaching risk populations and large numbers of people who do not know they are infected or do not seek health care. According to case study reports, there are significant variations in HIV epidemics between and within the countries[9].

Figure 4: HIV new infections and Adults prevalence rates (estimates) per 100,000 population, 2004-2014



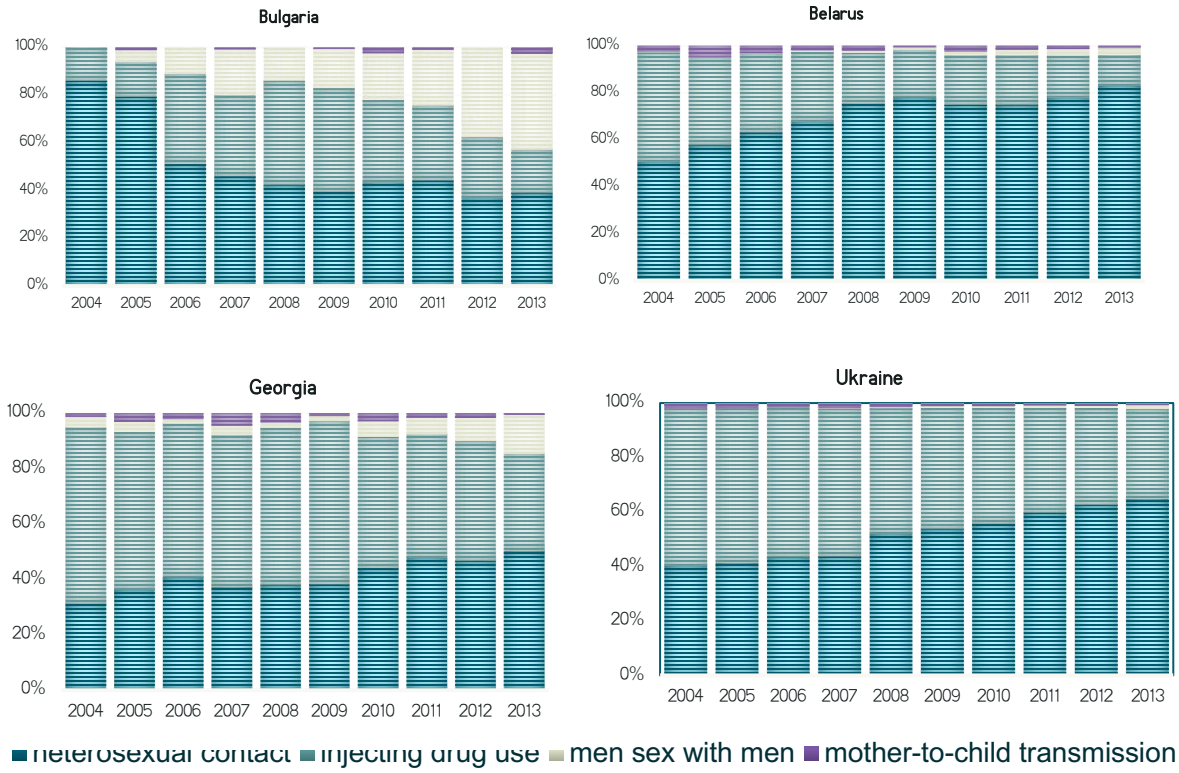
Source: European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2014 (left) and Source: UNAIDS. AIDSinfo, 2014. Available at: http://www.aidsinfoonline.org for Bulgaria indexmundi (right).

Adult HIV prevalence stabilized in Ukraine over the period of 2004-2014, while in other countries it is still growing. This can inter alia be attributed to the provision of comprehensive, focused prevention and harm-reduction services to the most affected

[9] Country case studies

groups over the last few years, which led to a continuous decrease in HIV transmission among people who inject drugs (PWID), and the stabilization of the HIV epidemic in Ukraine[10]. In this country the number of officially registered new adult HIV cases started to decline in 2014, when it accounted for 44.8 per 100,000 population[11]. However, adult HIV prevalence and rates of newly detected HIV cases seem to be on rise in the other studied countries. After Ukraine, Belarus and Georgia detect higher rates of HIV infected, while Bulgaria shows the lowest rate, reaching a maximum in 2014 (2.9 per 100,000 population) that is far below than the average of new HIV rates in EU member states (5.7 per 100,000 population)[12]. This data shows that, in three out of four countries, the epidemiological situation is still challenging, infection continues to spread and stabilization has not been achieved, with the exception of Ukraine. Even for the latter, the HIV prevalence has stabilized at considerably higher level than in the other three countries.

Figure 5 Main route of HIV transmission in studied countries, 2004-2013[13]



There is a change in the way infection spreads in these countries. The data about modes of transmission presented in Figure 5 allows us to identify the most important population groups epidemiologically. Most new HIV cases are still attributed to heterosexual

[10] Gotsadze, T., Transition from global fund support and programmatic sustainability research in four CEE/CIS countries: Ukraine Case Study, 2015

[11] Ibid 9

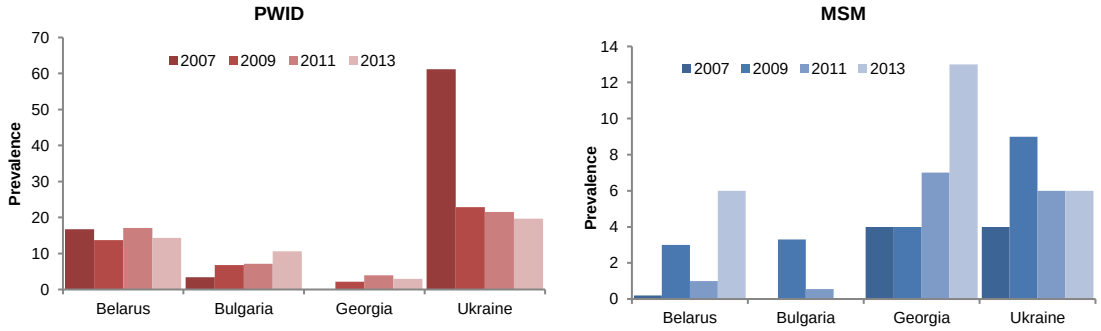
[12] Tabatadze, M., Transition from global fund support and programmatic sustainability research in four CEE/CIS countries: Bulgaria Case Study, 2015

[13] Source: European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013.

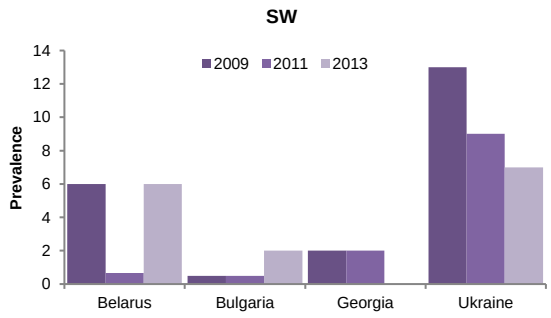
transmission, with an increasing share noted in Belarus, Georgia and Ukraine. This transmission includes both infection transmitted by Sex Workers (SW) and through bridge populations i.e. sexual partners of high-risk groups e.g. PWID. Transmission through injection among PWID, once a leading cause of new HIV cases in Eastern European countries, still accounts for a sizable share, although it has declined over the past decade. HIV prevalence among this risk group is stable in Belarus and Georgia, whereas a significant decrease has been noticed in Ukraine. This is probably the result of efforts made by countries that were largely supported by the Global Fund to implement effective harm reduction programs among PWID. The only country where the HIV prevalence continues to grow among PWID is Bulgaria (Figure 6).

The share of new infections among Men who have Sex with Men (MSM) is growing in Bulgaria[14] and Georgia, while in Belarus and Ukraine this mode of transmission still accounts for a small portion of all newly diagnosed cases (Figure 5). The epidemiological importance of MSM in Bulgaria and, to a lesser extent, in Georgia is similar to that seen in most European countries[15], where MSM is the only key population group with increasing transmission rates and growing prevalence. This suggests that targeting preventive and curative interventions at MSM is necessary, since efforts thus far were not sufficient to contain the infection spread in this group.

Figure 6: HIV prevalence among PWID, MSM and SW, 2007-2013



Source: UNAIDS. AIDSinfo, 2014. Available at: http://www.aidsinfoonline.org



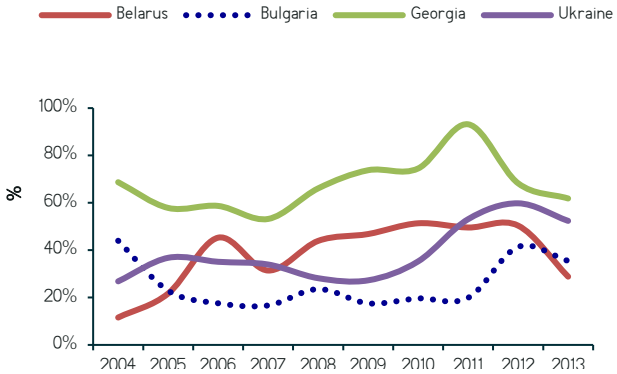
Transmission through SW seems to be under control in all countries, as demonstrated by stable or declining prevalence among this group with the exception of Bulgaria, possibly due to effective preventive programs among this group (see Figure 6). These epidemiological changes are also supported by Integrated Biomarker and Behavior Surveillance (IBBS) studies among key populations. The studies' findings

[14] Data for Bulgaria is only for 2009 and 2011. 2011 data raises concerns

[15] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013

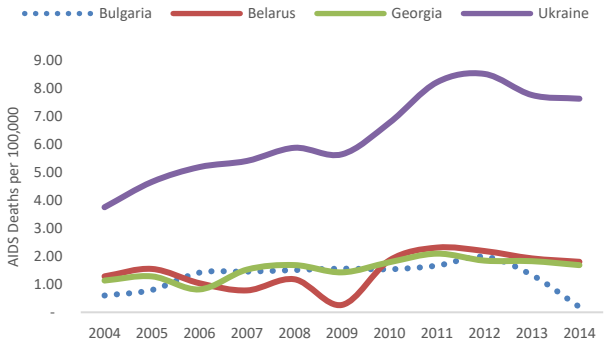
indicate a stable or declining prevalence among PWID in Belarus and Ukraine, a growing prevalence among MSM in Belarus, Georgia and Ukraine, and a stable picture in Bulgaria. The latter could be the attributed to lack of data or the lack of adequate research in this hard to reach population group, as IBBS data among MSM in Bulgaria (Figure 6) contradicts with the trends in main route of transmission (Figure 5).

Figure 7: Share of AIDS cases among newly diagnosed HIV positive patients, 2004-2013



Early diagnosis of HIV infection leading to early initiation of ARV treatment offers better treatment outcomes and reduces HIV transmission risks. Georgia demonstrates the highest share of AIDS cases among newly diagnosed HIV cases, indicating remaining weaknesses in the timely detection/testing of risk groups. In 2013, 60% of detected HIV cases were at the stage of AIDS, while in Belarus and Bulgaria these rates were around 20% (see **Figure 7**). Among the four countries, Bulgaria maintained the lowest share throughout the years (not including the spike in 2012), indicating a better uptake of HIV testing by population. Nevertheless, since 2012 all countries demonstrate improvements in HIV detection at an early stage of infection, which could be seen as a positive development, albeit not yet a fully satisfactory one.

Figure 8 AIDS related death rates per 100,000 population



Source: European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2014

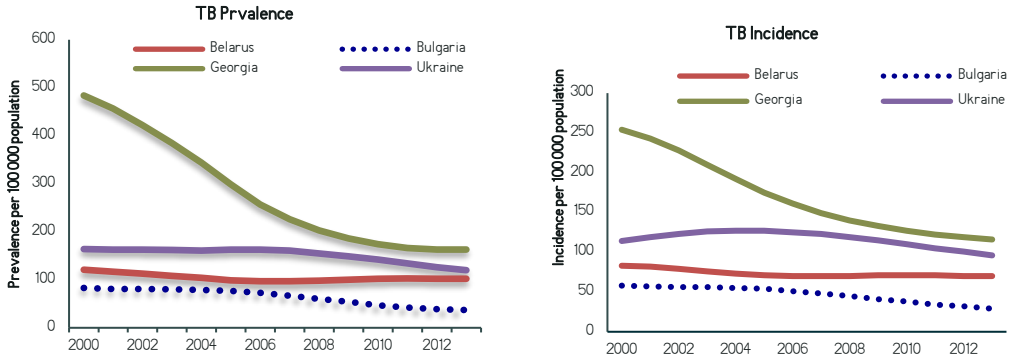
The death rate from AIDS has stabilized over the past couple of years and since 2013 reveals a declining trend, which is mostly notable in Bulgaria. This may be attributed to a significant expansion of ART treatment in all countries, which has most likely improved health outcomes for people with HIV.

Tuberculosis

Tuberculosis remains an important public health challenge in the EECA region as well as in the four study countries. As shown in **Figure 9**, TB prevalence and incidence in the four countries has declined since 2000. Georgia has demonstrated the most progress in reducing

both TB prevalence and incidence; however, it still remains one of the top 5 countries in terms of MDR-TB incidence rates in the region[16].

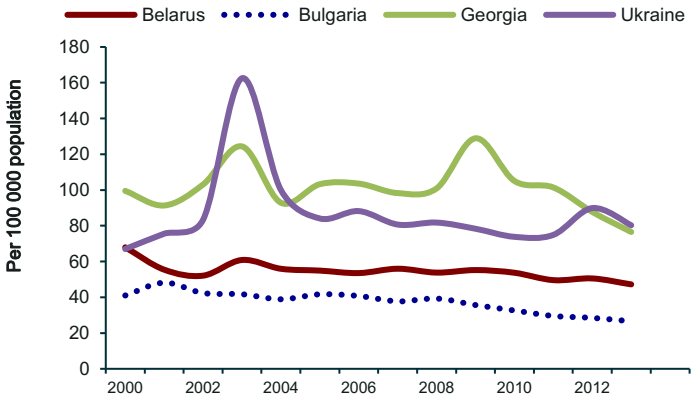
Figure 9: Estimated TB incidence and prevalence per 100,000 population, 2000-2013



Source: World Health Organization, Tuberculosis data, 2014. Available at: http://www.who.int/tb/country/data/download/en/

Of the four case study countries, Bulgaria shows the lowest prevalence and incidence rates for TB, but is still among the 18 high priority countries for tuberculosis in the WHO European region, because it reports more than 20 cases per 100,000 population[17].

Figure 10: Estimated notification rate of all TB cases per 100,000 population, 2000-2013



Source: World Health Organization. Tuberculosis data, 2014. Available at: http://www.who.int/tb/country/data/download/en/

TB notification rates of new and relapse cases varies among the studied countries. The notification rate is highest in Georgia, followed by Ukraine, while Belarus and Bulgaria have lower rates. There is a declining trend observed in Belarus and Bulgaria that may reflect a true reduction in the spread of the disease. Bulgaria, which has achieved significant reductions in TB notification, could become a low TB incidence country by 2018, according to the ECDC definition (notification rate <20/100 000 population)[18].

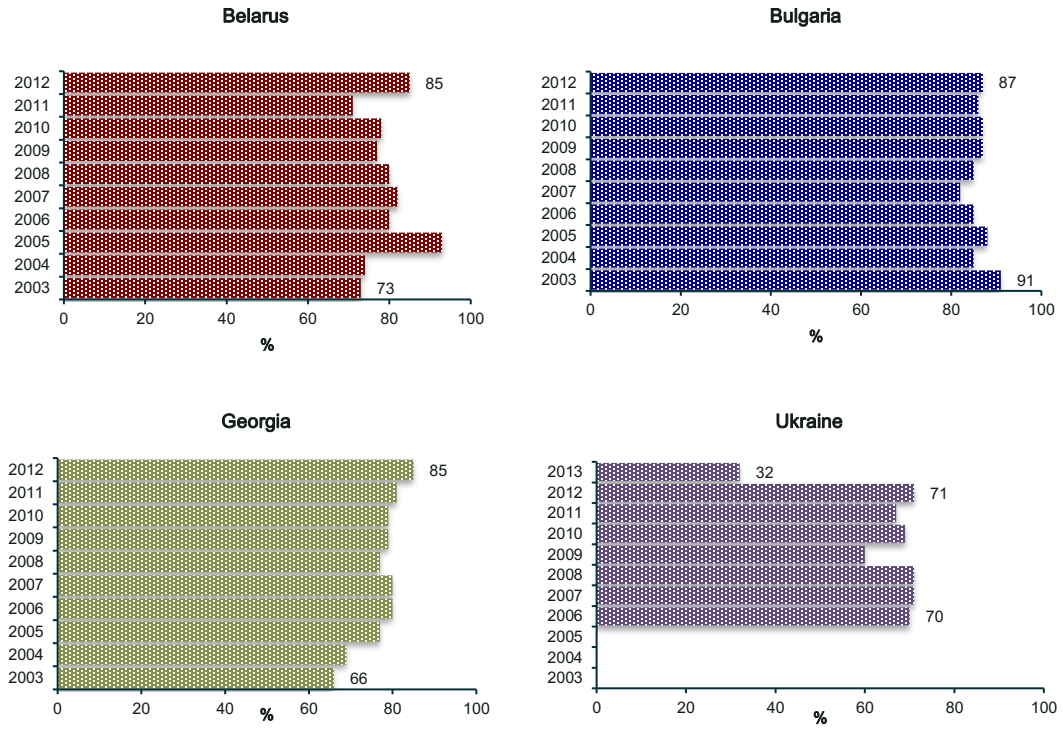
During the last decade significant progress has been achieved in Belarus, Bulgaria and Georgia in TB treatment success rates (see Figure 11). Ukraine reveals little progress; indeed, in 2013 a sharp decline in treatment success rates was noted there, most likely due to inadequate treatment provision, which varies from place to place.

[16] WHO (2014). Global Tuberculosis Report. Available at: http://www.who.int/tb/publications/globalreport/en/

[17] WHO (2014) Tuberculosis Bulgaria Country profile. Available at: https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHOHQReports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=BG&LAN=EN&outtype=html

[18] Tuberculosis surveillance and monitoring in Europe 2015

Figure 11: Treatment success rate for all new and relapse cases (%), 2003-2013

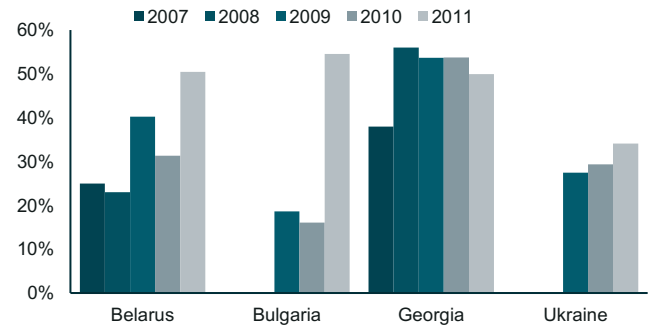


Source: World Health Organization. Tuberculosis data, 2014. Available at: http://www.who.int/tb/country/data/download/en/

Despite achieving important gains, Georgia remains one of the 27 countries in the world with the highest MDR-TB rates. A 2010 national drug resistance survey in Bulgaria also found that the original estimates for Bulgaria were exaggerated, with a total of 27 MDR cases for 2013 representing 2% of the new cases notifyed and 12.8% of retreatment cases. MDR-TB prevalence is also an issue in Ukraine, which ranges from 5.3% to 28.9% in different regions of the country.

Figure 12 shows the MDR-TB treatment success rate as measured 24 months after the initiation of second line treatment. For the latest year available (2011), Belarus, Bulgaria and Georgia show success rates of around 50%-55%. Georgia reveals a relatively stable trend with little volatility between years. However, Belarus and Bulgaria have gradually improved MDR management and, as a consequence, have reached the levels seen in Georgia. Ukraine demonstrates the lowest rate (34%), although with increasing trend.

Figure 12: Treatment success rate for MDR-TB patients

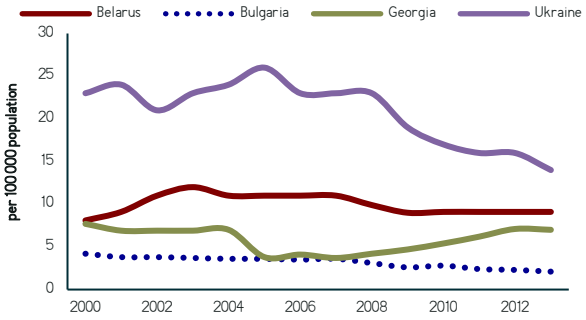


Regarding HIV/TB co-infection, Georgia reports 2.1% HIV prevalence among TB cases, with a 63% treatment success rate. Co-infection is a serious problem in Ukraine, with 19.6% of TB patients reportedly HIV positive in 2013. In Bulgaria, HIV prevalence among notified TB cases remains low: in 2013, out of 1932

notified TB cases, only 0.2% were diagnosed with HIV.

The main achievements in HIV/TB co-infection control are related to: the high rate of HIV testing in TB patients, rapid enrollment in ARV treatment[19] and improvements in treatment success rates.

Figure 13: Estimated TB mortality rate (all forms, excluding HIV) per 100,000 population, 2000-2013



The TB death rates reveal a declining trend in Ukraine and Bulgaria. The mortality rate for Belarus is stable at 9.1 per 100,000 population. However, this data does not correspond with data from the Belarus Vital Registration Statistics, which reports 5.8 deaths per 100,000 in 2013. Georgia has shown some fluctuations in TB mortality rates, showing a sharp decrease in 2005 followed by an increase in 2012. This is most likely due to inaccurate cause of death reporting in the country. It should be noted that Ukraine, Belarus and Georgia have not met the Stop TB partnerships' target to halve TB mortality by 2015.

SUMMARY OF EPIDEMIOLOGICAL TRENDS

The magnitude of the HIV epidemic differs among the countries, with Ukraine having Europe's most severe HIV epidemic while other countries yet face low HIV prevalence, mainly concentrated among key populations (KP). The epidemiological data presented in this section indicates that while some challenges still remain and HIV infection is still spreading without being brought under control, significant public health gains have been achieved by the national HIV programs over the past decade. Namely, countries observed a declining trend of HIV rates in most KP, with the exception of MSM; HIV infected patients are now diagnosed earlier and the rate of late diagnosis has fallen, albeit slightly; and, most likely, timely diagnosis has also helped to ensure timely enrollment into ART, which has been expanded significantly. ART expansion probably has led to stabilized, and in some countries even reduced AIDS related mortality. In light of these findings, it would be prudent to claim that part of these gains could be attributed to Global Fund investments, as it was the primary funder for preventive services, especially targeted at KP, for testing services and, in some countries, even for ART (more details on Global Fund investments are provided in Table 3 on page 25).

Progress in TB diagnosis, treatment and care is also obvious, although some challenges remain to be tackled and require further attention. Improved TB programs most likely led to declining TB prevalence, incidence and notification rates. Improved treatment success rates for both sensitive and MDR cases are also notable, along with declining TB related mortality, etc. While progress is visible, the national TB programs still require significant strengthening if these countries are to meet the Stop TB targets.

[19] Country case studies

In conclusion, public health gains resulting from the Global Fund investments are obvious. Therefore, sustaining and even expanding these gains as the countries move towards the post-Global Fund era is extremely important for the Fund.

3.2 GLOBAL FUND COUNTRY GRANTS

To address HIV and TB epidemics, countries started applying for Global Fund grants in 2003/2004. Below, we briefly present an overview of Global Fund support for the two diseases in the four countries. The Global Fund grant portfolio differs between countries in terms of grant duration, target areas and principal recipients (Table 3 on page 25).

Table 2: Selected Characteristics of Global Fund grant portfolio in studied countries

Country	Active Grants (years)		Applied for new Funding Model	Principle Recipient(s) for active or new grants
	HIV	TB		
Belarus	2015	2015	Yes	MoH/ RSPCMT
Bulgaria	2015*	2018	No	MoH
Georgia	2015	2016	Yes	MoH/NCDCPH
Ukraine	2017**	2015	Yes	UCDC, AUA, AUN

All of the studied countries have active HIV and TB grants until the end of 2015, with the exception of Bulgaria (TB) (Table 2). Since Belarus, Ukraine and Georgia are eligible for the new funding mechanism (NFM), they applied for new funding that will cover their programmatic needs until 2018. It is expected that HIV/TB funding will be made available to Ukraine beyond the year 2017 as well.

With a GNI of 4692 US$ per capita in 2013, Bulgaria has been upgraded to UMIC according to the World Bank classification, and currently falls in the "Band 4" (high income, low incidence) group of the Global Fund's NFM classification. However, the Bulgarian government only learned that Global Fund funding for the HIV program would end in 2015 after the 31st Board meeting in March 2014. However, the political and economic crises of 2012-2014 resulted in frequent changes in the government and at the Ministry of Health level, which caused delays in program implementation and led to unspent funds. Due to these difficulties and the fact that they lagged behind preventive service delivery targets for KP, which placed at risk the smooth transition of these activities onto the national budget, Bulgaria was granted a one year no-cost extension until the end of 2016 for the HIV grant only, because a 2015-2018 grant for TB was underway. Due to the short notice, Bulgaria was unable to plan a transition process adequately. However, the extension of the HIV grant now allows some, albeit limited, time for transition. Since Global Fund support for the TB program continues until 2018, the government will have a couple more years to gradually increase its commitment for TB control and secure the long-term sustainability of effective interventions in the TB field.

Countries used several approaches to manage Global Fund supported grants (Table 2). In Belarus, the UNDP has taken the lead for HIV/AIDS and Tuberculosis, serving as Principal Recipient (PR) for all grants. However, under the NFM application, the Government of Belarus decided to transfer the PR function from UNDP to the public institution subordinated to the MoH – the "Republican Scientific-Practical Center of Medical Technologies and Informatization, Management and Economy of Public Health" (RSPCMT). The shift from an international organization (UNDP) to a governmental body was motivated

by sustainability and country ownership concerns, within planned efforts to reach 100% government-funding for the HIV and TB response starting from 2019.

In the case of Bulgaria, the Ministry of Health was in charge of all grants. This has been instrumental, as it empowered the government to liaise with all actors supported from grant proceeds and kept national entities responsible for HIV and TB programs in the driver's seat.

Whilst Georgia changed PRs frequently, these were largely changes in legal entities, while the people managing the Global Fund grants remained the same and moved from the Government entity – the GHSPIC (Georgia Health and Social Projects Implementation Center) – to a national NGO – the Global Projects Implementation Center – and thereafter to the NCDCPH, although some people were lost during the last transition.

In the case of Ukraine, whilst government PRs were changing, the International HIV/AIDS Alliance and All Ukrainian Network of PLWHA were the longest non-governmental players in the HIV/AIDS field. The TB grant, which had been granted fairly recently in 2011, went through different management teams and PRs. Once the lack of close linkages between non-governmental PRs and national program managers was eventually recognized, the last grants for HIV/AIDS and TB had both government and NGO PRs. The transfer of the PR function to the Ukrainian Center for Disease Control (UCDC) in 2012 was an important development with the potential to lead to sustainability, provided that the time under the grants is used effectively to develop and maintain adequate capabilities within the institution, and that UCDC has the necessary legal support and is adequately empowered to improve the functionality of the national programs.

SUMMARY OF THE GRANT PORTFOLIO

All four countries have at least two years to plan and implement transition from Global Fund support, with a few exceptions, such as the Bulgaria HIV program, closing at the end of 2016. Having the MoH as a PR in all countries is a step forward that may allow the governments to lead the transition process and ensure HIV and TB program sustainability after Global Fund support ends.

Table 3 Global Fund supported HIV and TB Grants

Country	Grant Disease Focus	Grant Number	Main Objectives	Grant Dates	Amount Disbursed /committed	Principle Recipient	Performance Indicator	STATUS
Belarus	HIV	BLR-304-G01-H	Prevention and treatment of HIV/AIDS in Belarus	2004-2011	$ 24,119,702	UNDP	A2	Closed
		BLR-809-G03-H	Ensure universal access to HIV prevention, treatment and care among KP	2010-2012	$18,521,619	UNDP	A2	Closed
		BLR-H-UNDP		2013-2015	$15,250,470	UNDP	A2	Active
	TB	BLR-607-G02-T	Reduce the burden of TB by scaling up the management of MDR-TB. Providing trainings to health staff, improve TB recording and reporting systems and diagnostics.	2007-2010	$9,244,112	UNDP	A1	Closed
		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	2010-2015	$26,390,029	UNDP	A2	Active
Bulgaria	HIV	BUL-202-G01-H-00	Prevention and Control of HIV/AIDS	2004-2015	$49,646,567	MoH	B1	Active
	TB	BGR-T-MOH	Reduction of TB prevalence by 6 % by 2017	2015-2018	$6,357,362	MoH	NA	Active
		BUL-809-G03-T	Strengthen the National Tuberculosis program in Bulgaria	2010-2015	$8,219,450	MoH	B1	Active
		BUL-607-G02-T	Improve the Tuberculosis Control in Bulgaria	2007-2013	$17,374,789	MoH	A2	Closed
Georgia	HIV	GEO-202-G01-H-00	Diagnosis, ART and adherence services for PLWHA. Harm reduction services, including needle/syringe distribution and OST. Prevention services for KP, including psychosocial care and support services.	2004-2009	$14,363,254	GHSPIC	A1	Closed
		GEO-H-GPIC	Sustaining and scaling up existing national responses for implementation of effective HIV/AIDS prevention activities, improving survival rates of people with advanced HIV infection by strengthening treatment and care intervention in Georgia	2011-2015	$24,446,874	GPIC (NCDCPH from 2014)	A1	Active
	TB	GEO-405-G03-T	Expansion of DOTS Implementation in Georgia	2005-2011	$6,410,351	GHSPIC	B1	Closed
		GEO-607-G05-T	Bridging the gap in the management of drug-resistant tuberculosis in Georgia	2007-2011	$9,192,634	GHSPIC	NA	Closed
		GEO-607-G06-H	Bridging the gap in the management of drug-resistant tuberculosis in Georgia	2005-2011	$8,047,101	GHSPIC	B1	Closed
		GEO-411-G11-T	Expansion of DOTS Implementation in Georgia	2011-2013	$2,596,750	GPIC	NA	Closed
		GEO-T-GPIC	Sustaining universal access to quality diagnosis and	2011-2014	$9,357,503	GPIC	A2	Closed

		GEO-T-NCDC	treatment of all forms of TB including M/XDR-TB	2014-2016	$15,396,763	NCDCPH	A2	Active
Ukraine	HIV/TB	UKR-C-UCDC	Investing for impact against Tuberculosis and HIV	2015-2017	$4,302,539	UCDC	B1	Active
		UKR-C-AUN		2015-2017	$60,406,308	AUN	NA	Active
		UKR-C-AUA		2015-2017	$68,799,281	AUA	NA	Active
	HIV	UKR-607-G06-H	Support for HIV/AIDS Prevention, Treatment and Care for the Most Vulnerable Populations in Ukraine	2007-2012	$51,809,686	AUA	A2	Closed
		UKR-607-G05-H		2007-2012	$78,025,021	AUN	A1	Closed
		UKR-102-G04-H-00	Overcoming HIV/AIDS epidemics in Ukraine	2004-2008	$99,224,887	AUA	B1	Closed
		UKR-102-G01-H-00			$452,948	UNDP	NA	Closed
		UKR-102-G02-H-00	Ensuring Treatment, Care and Support for People with HIV/AIDS, Reduction of the Negative Consequences of the HIV/AIDS Epidemic and Development and Implementation of the System for Controlling the HIV/AIDS Epidemic	2003-2008	$541,682	UCSDD	NA	Closed
		UKR-011-G10-H	Building a sustainable system of comprehensive services on HIV prevention, treatment, care and support for MARPs and PLWH in Ukraine	2012-2014	$5,282,149	UCDC	B1	Closed
		UKR-011-G09-H			$54,136,669	AUN	A1	Closed
		UKR-011-G08-H			$64,731,185	AUA	A1	Closed
	TB	UKR-913-G11-T	Reducing the TB burden in Ukraine through expanding and enhancing access to high quality TB services	2013-2015	$30,464,308	UCDC	B1	Active
		UKR-911-G07-T		2011-2013	$29,601,181	FDU	A1	Closed

Source: The Global Fund (2015). Grant overview. Available at: http://www.theglobalfund.org/en/portfolio/country/

CHAPTER 4. SYNTHESIS OF COUNTRY STUDIES

This section presents the synthesis of the four country case studies with the use of the TPAF. The data presented below is taken from these four case studies unless otherwise specified.

As previously mentioned, the four case study countries share a comparable political past as post-Soviet/Eastern Block states, which has had an effect on how their health systems were organized, funded and how services were delivered. Moreover, three out of four countries have recently undergone or are undergoing major political and/or military crises, namely:

Bulgaria, the EU member and upper-middle-income country with population of 7.2 million, has recently experienced turbulent political changes in the government that have resulted in five different Ministers of Health since 2012, which obviously has had a negative impact on all health programs managed by the ministry. Characterized as an upper-middle-income country, it has been plagued by economic instability due to the political crises of the past five years.

Georgia, classified as a lower-middle-income country, has a population of 3.7 million with high unemployment rates and a significant amount of internally displaced people (IDPs) due to different armed conflicts since 1991, including the recent Russian military offensive in 2008.

Ukraine, a lower-middle-income country with 45.49 million inhabitants, is also the second largest country among post-Soviet states after Russia. The recent and ongoing military crisis in the East of the country, and the seizure of Crimea by Russia, has affected more than five million people and caused political instability, which has negatively affected the country's economy and its immediate prospects.

The republic of Belarus, which is an upper-middle income country with population of 9.5 million, has regained macroeconomic stability following the economic crisis of 2008 and is developing progressively, albeit with limited democratic reforms.

In this section we attempt to synthesize the four country case studies using the framework presented on Figure 2 on page 13, which is based on the TPAF and includes two main domains, the external and internal environment, which are further subdivided into relevant sub-domains and components. The findings related to the outcomes i.e. public health gains, were presented earlier. The main findings of the synthesis are presented according to each component (see Figure 3 page 14). In addition, Annex 1 provides summarized findings for each component and its measurement indicator based on the TPAF.

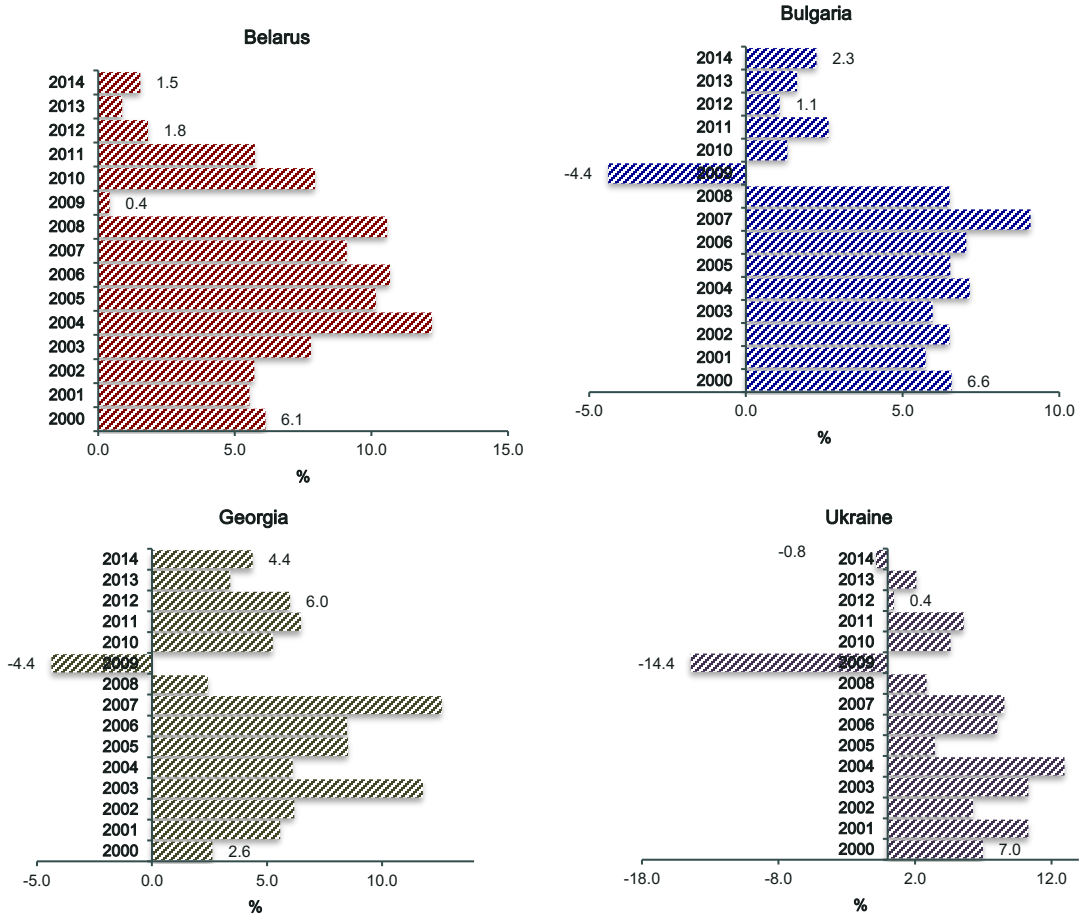
4.1 EXTERNAL ENVIRONMENT

The external environment is subdivided into the economic and political environments, both of which are essential components for successful transition from external support.

4.1.1 ECONOMIC ENVIRONMENT

An enabling economic environment is crucial for sustained and/or increased and predictable domestic investments in health and, especially, for the successful transition of externally funded programs. This component was assessed by analyzing annual GDP growth trends in the countries and the share of General Government Revenue (GGR) as a percentage of GDP.

Figure 14: Real GDP per capita growth (annual %) in the four countries



Source: World Bank. World Development Indicators, 2015. Available at: http://data.worldbank.org/indicator

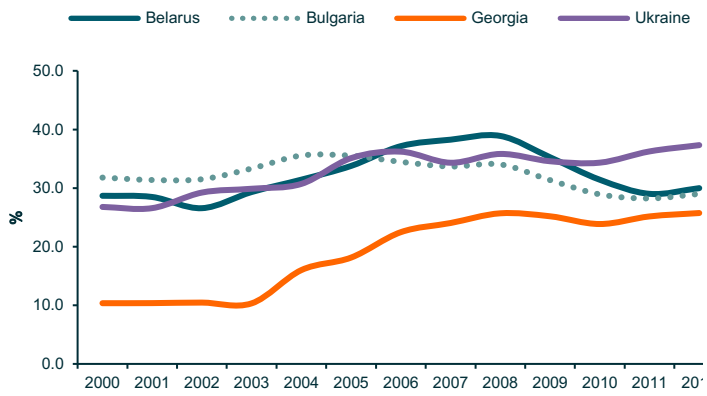
As Figure 14 shows, the four countries were significantly affected by the economic crisis of 2008. However, in recent years GDP per capita growth has been favorable in Belarus, Bulgaria and Georgia. Belarus and Bulgaria experienced significant drops in 2012 but now have respective GDP growth rates of 1.5% and 2.3% annually. Ukraine has experienced a decline in economic growth, falling from 0.2 in 2013 to -0.8% in 2014, primarily due to the armed conflict and political instability. The prospects for 2015 are even worse, with an anticipated 11% decline in GDP[20]. All of this indicates that three out of four countries have a

[20] IMF Statement on Discussions with Ukraine on the Second Review under the Extended Fund Facility Arrangement. Press Release No. 15/457 October 3, 2015. Last accessed on October 20th, 2015. https://www.imf.org/external/np/sec/pr/2015/pr15457.htm.

more conducive macroeconomic environment that could facilitate transition away from the Global Fund.

GGR as a percentage of GDP (see figure 11) serves as a proxy indicator of the fiscal resources available to the government. Ukraine has experienced a significant increase in GGR from 26.8% in 2000 to 36.3% in 2012.

Figure 15: Share of General Government Revenue (excluding grants) as a percentage of GDP in the four countries



Source: World Bank. World Development Indicators, 2015. Available at:

Bulgaria and Belarus experienced a tiny increase over the same period. But among the four countries, Georgia had the fastest growth rate (15.3%) over the same period. Such growth was most likely determined by the very low GGR levels (10.4%) observed in 2000. However, this growth was not sufficient to reach the levels seen in other studied countries. Lower GDP per capita and a lower share of GGR relative to GDP (25.7%) means that Georgia has relatively lower financial capacity compared to other countries in our sample. Increasing and/or stable GGR relative to GDP indicates that the governments were able to secure stable or growing financial resources (compared to previous years), which could provide an enabling environment for transition and eventual sustainability.

SUMMARY OF COMPONENT ASSESSMENT: These indicators show that when analyzing the economic environment (measured as the economic growth and the ability of the governments to collect revenue) independently of other country factors, Belarus, Bulgaria and Georgia have a positive economic backdrop which can allow for an appropriate transition of the HIV and TB funded-activities from the Global Fund onto national budgets. Ukraine has shown a positive trend in the share of general government revenue but this is hindered by the armed conflict that it is currently experiencing, which has had detrimental effects on economic growth. This situation puts Ukraine in a different position compared to other countries in our sample, and requires close monitoring.

4.1.2 POLITICAL ENVIRONMENT

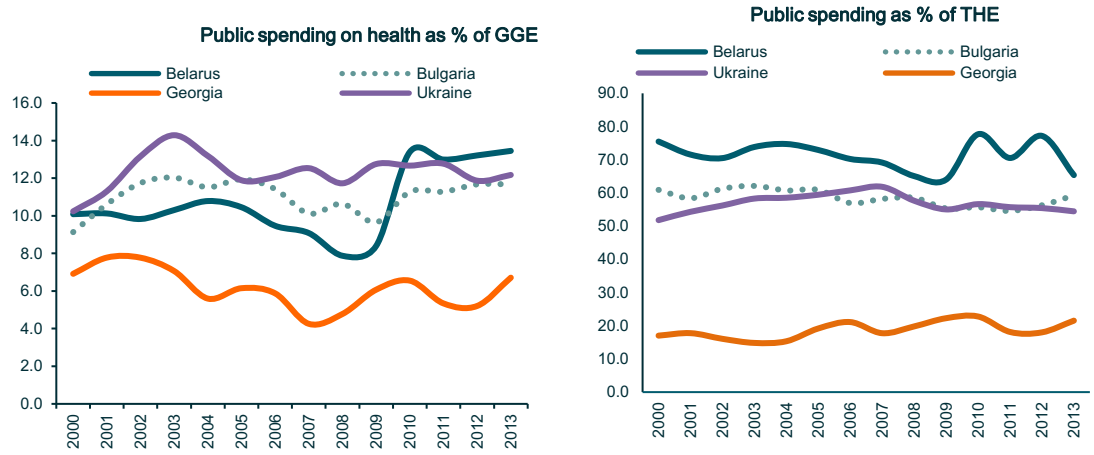
Transition and ultimately the sustainability of disease programs require adequate political support/will to ensure that health investments are prioritized and sustained by the Government. The political environment as an enabling factor for an adequate transition of HIV and TB programs has been assessed by analyzing the following: the existence of political will to prioritize health investments within the government's budget; the existence of laws, regulations and policies that make possible prevention, treatment and care service delivery for KP and people living with the diseases and the ability of the government to

enforce these laws; and the existence of mechanisms within the government to enable CSO/NGO contracting for the delivery of various services funded out of state or local budgets.

a. Prioritization of health investments

The political will to prioritize health investments was assessed using two indicators: a) the share of government spending on health out of the General Government Expenditure (GGE) and b) the share of public spending out of the Total Health Expenditure (THE).

Figure 16: Public spending on health as % of general government expenditure and health expenditure as % of total health expenditure, 2000-2013



Source: World Bank. World Development Indicators. 2015. Available at: http://data.worldbank.org/indicator

As shown in Figure 16 (left), in 2013 Belarus, Ukraine and Bulgaria spent comparable shares of the state budget on health (13.5%, 12.2% and 11.7% respectively). Georgia was the lowest spender among the studied countries, as the share of state budget spent on health ranged between 4.3-6.7%, depending on the year. Decline was observed in 2011-2012 with increase in 2013. The suggested levels of budgetary spending on health for Belarus, Ukraine and Bulgaria are well above LMIC average for 2008-2012 (6.74%)[21], while Georgia is comparable to the levels seen in other LMIC countries. Ukraine experienced deterioration to economic challenges in 2013-2014. Figure 16 (right) describes the share of public spending on health as a percentage of total health expenditure (THE). The figure shows that Belarus maintains the highest share of public financing for health, placing little burden on the population and non-state sector. Belarus is followed by Bulgaria and Ukraine. Georgia has the lowest share, and places the greatest burden for health care financing on its population.

b. The existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for KP and people living with diseases

Another important factor for transition, particularly for HIV services, is a well elaborated legal framework that is adequate to protect the rights of key populations and to deliver preventive, curative and care service, including those delivered by NGOs/CSOs. However,

[21] http://data.worldbank.org/data-catalog/health-nutrition-and-population-statistics Accessed on October 20, 2015

the mere existence of such a legal framework will not be sufficient unless mechanisms are in place to uphold/enforce these laws.

Table 4 Non-discrimination laws and regulations specifying protection for key populations and vulnerable groups

	KEY POPULATIONS / Respondent Sector	PLHIV	MSM	Migrants	Orphans and vulnerable children	People with disabilities	People who inject drugs	Prison inmates	Sex workers	Transgendered people	Minors without parental consent	Women and girls	Young people
Bulgaria	Government	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
	Civil Society	Y	Y	n. a	Y	Y	N	Y	N	Y	Y	Y	Y
Belarus	Government	N	N	N	Y	Y	N	N	N	N	n. a	Y	Y
	Civil Society	N	N	N	Y	Y	N	N	N	N	n. a	Y	Y
Georgia	Government	Y	N	N	N	Y	Y	N	N	N	n. a	N	Y
	Civil Society	Y	N	N	N	N	N	Y	N	N	n. a	Y	N
Ukraine	Government	Y	Y	Y	Y	Y	Y	Y	Y	N	n. a	Y	N
	Civil Society	Y	N	N	Y	Y	N	N	N	N	n. a	Y	N

Source: Thematic report: Stigma and discrimination. ECDC special report

Table 5 Existence of laws that criminalize key affected populations, 2014

Type of laws	Belarus	Bulgaria	Georgia	Ukraine
HIV restrictions on entry, stay or residence	Y	N	N	N
Laws criminalizing any aspect of sex work	Y	N	N	Y
Laws that criminalize same-sex sexual activities between consenting adults	N	N	N	N
Laws that specifically criminalize HIV non-disclosure, exposure or transmission	Y	N	Y	Y

Based on responses from government officials and members of civil society, Table 4 displays the existence of non-discriminatory laws for different key population groups, while Table 5 describes the laws that exist in these countries that continue to impose legal barriers on KP. As the tables show, and collected qualitative data underlines, Bulgaria has no legal barriers to the provision of effective prevention, treatment and care for KP and people living with the diseases. Among other case study countries, Ukraine appears to have the least legal hinders after Bulgaria. However in both countries anti-discrimination laws have not been always effectively enforced to safeguard the human rights of vulnerable social and ethnic groups.

In the case of Georgia, criminalizing laws against drug users and the inadequate scale of needle exchange programs in a country with high rates of PWID are seen as barriers to access preventive HIV services, which creates risks to transition. Worryingly, legal barriers in Belarus are widespread, which puts KP at higher risk and will most likely hinder transition, especially for the services being funded by the Global Fund and focused on KP.

Furthermore, people living with HIV and TB patients are not considered vulnerable groups and sex work is criminalized, which not only makes it difficult to ensure that these groups are not being discriminated but also prevents the allocation of resources for targeted

activities out of the state budget. Beyond the legal challenges, MSM are also highly stigmatized in these societies, except in Bulgaria.

In all of the case study countries, CSOs under the Global Fund grants are playing an important role in delivering prevention and care services for HIV and TB infected people.

c. Government ability to contract with CSOs

The third area of assessment for the political environment is the ability of the government to contract civil society organizations for all sectors[22] through the existence of legal frameworks, rules and procedures, or by demonstrating that they currently do this effectively.

Table 6 CSO contracting legislation and mechanisms, 2014

Type of laws	Belarus	Bulgaria	Georgia	Ukraine
Regulation allowing NGO/CSO contracting	No	Yes	Yes	Yes
Contracting mechanisms	No	Yes	Yes	Yes

Belarus lacks general regulations that allow for NGO / CSO contracting (not only in health), and there is little evidence of government interaction with NGOs. However, general legislation in Bulgaria, Georgia and Ukraine do allow for NGO/CSO contracting for the provision of various services.

SUMMARY OF COMPONENT ASSESSMENT: The three areas of political environment – i) the prioritization of health investments; ii) the existence of laws to protect KP; and iii) the government's ability to contract CSOs – provide insights into the political context in the countries that will facilitate or impede a successful transition from Global Fund support. By assessing these indicators, we can conclude that there is good political will, expressed as investments in health in Belarus and Bulgaria. Ukraine although spend comparable share on heath out of state budget, experienced decline in in recent years. Georgia is lagging compared to others. We find that there has been a slight increase in funding for health as a percentage of public expenditure. This is important since it not only demonstrates the current commitment to fund health, but also indicates the level of motivation to understand the value of investing in health programs in the long-term.

The ability to contract CSOs is another factor related to the political environment, as it facilitates targeting KP with adequate services, which are usually provided by CSOs/NGOs. In the studied countries we observe that while funding for health is adequate (except in Georgia and with risk in Ukraine), there is a lack of regulations and/or adequate enforcement of laws protecting KP and/or contracting CSOs for service provision. Belarus is particularly behind in these two areas, which increases the overall risk arising from the political environment compared to the other three countries.

Analysis of the political environment highlights the importance of focusing efforts during transition on legislative barriers/impediments, by working with the governments and, where possible, introducing necessary legislative changes in a timely manner. This work may also require more active engagement with other actors in the countries, such as UNDP

[22] For the political commitment the framework looked at general laws, not health sector specific. The latter ones are more thoroughly evaluated under the program domain of the framework.

and other UN agencies on the ground, which are better placed to work with host governments and advocate for legislative amendments/changes. Unless the behavior of certain KP is decriminalized, it may not be possible to drive national budgetary allocations for these groups, which would pose challenges to smooth transition and negatively affect sustainability. Supportive legislation alongside an enabling legal environment for CSO contracting for publicly financed services will aid the continuation of NGO/CSO engagement in national disease responses after the end of Global Fund support.

4.1.3 SUMMARY FINDINGS OF EXTERNAL ENVIRONMENT DOMAIN

The results of the external environment assessment revealed that the environment in Bulgaria, Georgia and Ukraine is somewhat more conducive for a smooth transition than in Belarus. Nevertheless, all countries need to pay attention to certain areas that require further improvement during transition.

Table 7: Summary of T&S risk assessment for External Environment

Component	Indicators	Belarus	Bulgaria	Georgia	Ukraine
Economic	Favorable economic indicators				
Political	Existence of political will to prioritize health investments				
	Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for KP and people living with diseases				
	Government ability to contract with CSOs				

Belarus, Bulgaria and Georgia have a positive economic environment, which can allow for the appropriate transition of HIV and TB funded-activities from the Global Fund onto national budgets. However, the armed conflict in Ukraine has had a detrimental effect on economic growth in the country, thus putting Ukraine in a different scenario than the other three countries. There is an adequate political will to invest in health in Belarus and Bulgaria, Georgia is lagging compared to others, while Ukraine, although spending comparable share on health is experiencing decline in health investments. Existence of laws that criminalize key populations noted in Belarus, followed by Georgia. Bulgaria has no legal barriers and Ukraine appears to have the least legal hinders after Bulgaria. However in both countries anti-discrimination laws have not been always effectively enforced. This may potentially hinder national budgetary allocations for these groups, and will possibly pose challenges to smooth transition and hinder sustainability. General regulations allow the governments to contract with CSOs in three out of the four studied countries (Bulgaria, Georgia, Ukraine).

4.2 INTERNAL ENVIRONMENT

The internal environment encompasses the enabling factors directly related to the health sector/programs. For assessment purposes, and following the program cycle logic, the internal environment has been divided into the following sub-domains: a) inputs; b) governance; and c) the program. The summarized results for each of these sub-domains can be found in Annex 1, but in this section we will try to unpack more details of the sub-domains for the internal environment by looking at its components (see Figure 3 page 14).

4.2.1 INPUTS

Inputs are the resources that are available for the HIV and TB programs. These are subdivided into components that include: (i) financial resources, (ii) human resources and (iii) health information systems.

4.2.1.1 FINANCIAL RESOURCES

Without dedicated financial resources, it would be difficult for any program to survive. Resources should be predictable and proportional to the disease burden in the country. However, available resources are strongly related to the economic environment and political will (as described earlier). Under inputs, financial resources were assessed by examining the budgetary commitment and financial dependence on donor/external funding for both diseases, and by looking at the prioritization of investments for preventive and curative interventions, especially for epidemiologically important population groups.

a. Budgetary commitment to the disease programs

Table 8: Sources of HIV program financing, 2013-2014[23]

Country (year)	Years	Government	Global Fund*	Other Donors
Belarus	2011	51.0%	49.0%	n.a
	2012	63.0%	37.0%	n.a
	2013	71.0%	29.0%	n.a
	2014	71.0%	29.0%	n.a
Bulgaria	2011	51.0%	49.0%	n.a
	2012	63.0%	37.0%	-
	2013	74.0%	26.0%	-
	2014	67.0%	33.0%	-
Georgia	2012	28.0%	67.0%	5.0%
	2013	32.0%	58.0%	10.0%
	2014	48.0%	42.0%	10.0%
Ukraine	2012	52.4%	44.4%	3.2%
	2013	55.8%	40.4%	3.8%
	2014	66.7%	29.2%	4.2%

** The data from Georgia and Belarus beyond Global fund includes funding from other donors as well.*

Initially we looked at HIV/AIDS spending for the years when data was available. Our findings, which arose from case studies and are detailed in Table 8, reveal that government spending, especially in HIV/AIDS programs, grew steadily over the past years in all studied countries and partly replaced donor funding. Nonetheless, even in 2013 and 2014 these programs were significantly dependent on external financial support. Georgia received 52% of its funding from donors, with the largest amount provided by the Global Fund, followed by Bulgaria (33%). The smallest share of external funding was obtained by Belarus and Ukraine in 2014 (29% each).

[23] Country case studies

Table 9: Sources of TB program financing, 2012-2014 [23]

Country (year)		Government	Global Fund*	Other Donors
Belarus	2012	55.0%	45.0%	-
	2013	55.0%	44.0%	1.0%
Bulgaria	2012	62.0%	38.0%	-
	2013	82.0%	18.0%	-
	2014	80.0%	20.0%	-
Georgia	2012	50.9%	42.8%	6.3%
	2013	53.8%	41.0%	5.1%
	2014	56.7%	38.3%	5.0%
Ukraine*	2011	NA	NA	NA
	2012	NA	NA	NA
	2013	81.6%	15.7%	2.7%

** Does not take into account other donor funding*

The financing of TB programs, as detailed in Table 9, was more variable than HIV. In Belarus and Georgia, close to 40% or more funding for NTP is from external sources, while in Ukraine and Bulgaria only 15% and 20% of NTP needs respectively are supported by external sources.

While the share of donor/external funding in total health expenditure could be marginal in the studied countries, HIV and TB programs seem to be heavily dependent on external support. For example, in Ukraine, donor funding accounts for only 0.2-0.3% of total health spending. But these resources are important for funding ART, HIV preventive services and TB treatment. The government has committed to increasing funding until the end of Global Fund support and taking over full responsibility for funding by 2018. However, the tense political environment makes fulfillment of this promise difficult. For this year, the funding gap in the HIV response is projected to be 25%, which could become wider if external funding continues to decline. This is exacerbated by the severe depreciation of the national currency against the US$. In Ukraine, the Global Fund also continues to finance second-line TB drugs for MDR-TB, equipment and consumables for laboratory diagnostics, patient incentives for adherence, as well as other monitoring and training activities. Finally, all of the studied countries, except Ukraine, maintain dedicated budget lines for both HIV and TB programs expenditure in the Medium Term Expenditure Framework (MTEF) or in national budgets, which helps to drive national allocations based on costed National Strategic Plans (NSPs).

Table 10: Financing of HIV and TB National Programs

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Increasing public expenditure on Disease Specific programs	HIV	Yes	Yes	Yes	Yes
	TB	No	Yes	Yes	No
Share of public funding in Disease Specific Program budget	HIV	50 – 74%	50 – 74%	< 49%	50 – 74%
	TB	50 – 74%	>75%	50 – 74%	≥ 75%
Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with costed NSP	HIV	Yes	Yes	Yes	No
	TB	Yes	Yes	Yes	No

Table 10 summarizes the financing of national HIV and TB programs across all of the studied countries. Countries demonstrate an increasing trend in expenditure for both diseases with dedicated budget lines. However, financial dependence on external support is still

significant, which, unless it is gradually reduced, may pose risks to transition and the sustainability of the programs.

b. Allocative efficiency

Table 11: Allocative efficiency

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Existence of allocative efficiency study	HIV	Yes	No	Yes	Yes
Allocative efficiency study informs budget allocations		No	No	No	No

Donors are trying to reduce financial dependence alongside health needs, and so have supported allocative efficiency studies in Belarus, Georgia and Ukraine. However, to date the study results have failed to inform national budgetary decisions and/or drive efficiencies (Table 11).

c. Prevention priority

The TPAF selected the dependence of preventive activities on external support as one of the most sensitive indicators for transition. The findings are summarized in Table 12. Case studies discovered that state spending on HIV prevention activities in all four countries was low, ranging around 50%. However, these expenditures included spending on blood safety, PMTCT and testing on HIV, Sexually Transmitted Infections (STIs) and Post Exposure Prophylaxis (PEP).

Table 12: Public funding of Prevention interventions

Indicators	Belarus	Bulgaria	Georgia	Ukraine
Increasing total public spending on HIV prevention for priority groups	No	No	No	No
Increasing share of public spending in total spending (donors and Gov.) on HIV prevention for epidemiologically priority groups	No	No	No	No

When looking at the preventive services that reach PWID, MSM, SW and other KP, the dependency on external donor funding increases even more, revealing that these program components face the greatest sustainability risk during transition. Unless this is adequately addressed, it may negatively affect the infection spread in a concentrated epidemic setting. However, adequately addressing this challenge requires a comprehensive approach that ranges from removing/reducing structural-legal and societal barriers to driving budgetary allocations in the state budget and enabling CSOs/NGOs to deliver these services through national contracting.

d. Treatment financing from public sources

The adequate financing of diagnosis, treatment and care services is an important component of healthy HIV and TB programs, which can help to sustain public health gains in the long-term. Therefore, the case studies closely examined the dependence of these services on external support in order to evaluate transition preparedness. The summarized findings are presented in **Table 13**.

Table 13: Treatment / input financing from public sources

Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
HIV	Case detection / diagnostics	Ⓟ	Ⓟ	Ⓟ	Ⓟ
	Drug procurement - First line ART	Ⓟ	Ⓟ	Ⓟ	Ⓟ
	Drug procurement -Second line ART	Ⓟ	⃠	⃠	Ⓟ
	Adherence support	⃠	⃠	⃠	⃠
TB	Case detection / diagnostics	Ⓟ	Ⓟ	Ⓟ	Ⓟ
	Drug procurement - First line drugs	©	©	Ⓟ	Ⓟ
	Drug procurement -Second line drugs	⃠	⃠	⃠	Ⓟ
	Adherence support	⃠	⃠	⃠	⃠

Legend: Fully Covered © Partially Covered Ⓟ Not Covered ⃠

In the case of HIV, the government of Belarus committed to a cost-sharing program for ARVs with the Global Fund that started in 2013. By 2014, 40% of the total budget for ARVs came from the government. While the Global Fund still funds adherence support, the public financing schemes have already been developed and public funding has been ensured, starting from 2016, to fully replace adherence costs that are fully funded by the Global Fund. Belarus has fully covered first-line drugs for TB since 2012, as well as the costs of culture and DST (Drug Susceptibility Testing) investigations, although second line TB drugs and drugs for MDR TB are still fully covered by Global Fund resources.

In Bulgaria, the government partially covers the costs of first line ART and the costs of case detection and diagnosis. Second line ART medicines and adherence support is still dependent on external funding. TB treatment with first line drugs is fully procured by the public budget. Basic TB diagnostic tests are publicly funded but the Global Fund pays a significant amount for laboratory testing, with the state only covering the cost of reagents and materials for solid media and culture on solid media. Second line drugs for MDR/XDR are procured out of Global Fund resources. Food vouchers as incentives for MDR-TB treatment adherence are paid out of grant proceeds.

Georgia is the only country in the Eastern European region that has maintained universal access to ART, but drugs are still largely paid from the Global Fund grant. The government's contribution towards ART adherence is zero, and is fully reliant on Global Fund resources. Global Fund grants are the only source for procurement of first line TB drugs for 2014-2016. The procurement is conducted through the global drug facility using a direct procurement mechanism. Starting in late 2015, the government has committed to cover the costs of first line TB drugs. However, there is no financing for outreach services and case detection in the government's TB control program. The Global Fund grant is currently financing incentives for DOTs, for MDR-TB and XDR-TB patients. These incentives include transportation costs for patients who are below or at the poverty line.[24]

In Ukraine, the government partially covers the costs of diagnosis and treatment whilst ART adherence interventions fully rely on external funding. The government also funds the majority of costs for the central procurement of drugs, diagnostics and supplies, blood

[24] There is a state grading system "means testing system" in Georgia, which evaluates the poverty of the household based on a questionnaire and observation. The grading system defines who belongs to the "below the poverty line" rate, i.e, is eligible for the state social support

safety, and treatment, while donors and local budgets fund other HIV/AIDS services. Drugs for TB are partially funded by the government and procured through a national competitive bidding mechanism. Apart from these financial dependencies, the inefficient use of available public resources is observed in these countries, which increases the pressure on the budget and poses further challenges to sustainability (see Table 14).

Table 14: Other challenges to financial sustainability

Disease	Challenge	Belarus	Bulgaria	Georgia	Ukraine
HIV	Testing	Inefficient	Efficient	Efficient	Inefficient
	Treatment initiation criteria of CD4 count ≤500 cells/mm	To be introduced 2016	Introduced	Introduced	To be introduced 2016
	Optimization of treatment guidelines	Not planned	n.a	In process	Not planned, but piloted for emergency procurement
	Treatment monitoring approaches	Inefficient	n.a	Inefficient	Inefficient
	Treatment continuum	Inefficient	n.a	Inefficient	Inefficient
TB	Overcapacity of TB hospital beds	Yes	Yes	No	Yes
	High Average Length of Stay	Yes	Yes	No	Yes
	TB in-patient treatment reimbursement methods create perverse incentives for long ALOS	Yes	Yes	Partially	Yes

The regulations guiding HIV testing in Belarus and Ukraine do not ensure the targeting of KP; rather, an increasing number of tests have been administered to the groups of population with low prevalence rates. The introduction of new WHO ARV treatment guidelines puts an additional burden on the restricted public resources. While Bulgaria and Georgia have already introduced new treatment guidelines, Belarus and Ukraine scheduled the introduction starting from 2016. Obviously countries that only partially cover treatment costs from public purse will find difficult to accommodate additional resource needs for the implementation of the new WHO guidelines. Furthermore, the large number of ARV treatment regimens observed in all countries, the absence of decisive action from the governments for optimization (except Georgia), and the lack of treatment adherence monitoring and the follow up mechanisms (in Belarus, Bulgaria, Ukraine) are signs of systemic inefficiencies that cause the inefficient use of financial resources.

In the TB sector, key obstacles for efficient use of available public resources include the overcapacity of TB hospital beds observed in Belarus and Ukraine, and the regulation of hospital based TB treatment with the reimbursement mechanisms, which serves as a perverse incentive for long hospitalizations, This makes adequate financing of the disease response in these countries even harder.

SUMMARY FINDINGS OF FINANCIAL RESOURCES: Each country has prioritized HIV and TB treatment related interventions for public investments and is taking steps to reduce treatment dependence on the Global Fund. However, while the transition steps to replace donor funding for treatment with national resources are visible, a more aggressive pace might be warranted for transitioning funding for drugs, diagnostics and other consumable onto national budgets. This approach may afford additional time and resources to be spent

on services that are mostly donor dependent and face numerous barriers to be easily transferred onto national funding, such as preventive services for KP, especially for HIV. Finally, when planning for transition it is also important to highlight the reduction of inefficiencies, which could help to generate the necessary national resources and could possibly aid transition.

4.2.1.2 HUMAN RESOURCES

Human resources include service providers delivering prevention, treatment and care/support services to HIV and TB affected individuals. The availability of adequately trained and distributed human resources is important for program success and long-term sustainability. This component was measured by assessing the availability of sufficient human resources for both diseases, which includes provider to population ratios, distribution and age-structure of the workforce. This was also assessed by measuring the following: the institutionalization of donor-supported trainings (i.e. continuous professional development) in national education systems; the existence of policies to train NGO/CSO personnel; and the alignment of donor funded salaries and top-ups with the national pay scale.

a. Sufficient human resources

Bulgaria, Georgia and Ukraine all reported sufficient numbers of HIV personnel in the semi-structured interviews, which were validated by using national statistical data. The only exception was Belarus, which reported severe shortages of specialists, misdistribution and high turnover. In the case of TB, all four countries reported limitations concerning the number of TB professionals, their low salaries and aging of the staff as the major challenges, while the numbers were reported to be overall acceptable (Table 15).

Table 15: Inputs - Human Resources

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Sufficient human resources for a disease	HIV	Severe Shortage	Sufficient	Sufficient	Sufficient
	TB	Shortage	Shortage	Shortage	Shortage
Donor supported trainings for health personnel institutionalized in national education system	Both	Partially integrated	Not Integrated	Not Integrated	Partially integrated
Existence of policy for production/training of CSO personnel	Both	Exists but weak	Does not exist	Does not exist	Does not exist
Donor funded HR salaries aligned with national pay-scale	Both	Not applicable	Not aligned	Aligned	Not aligned

b. Donor supported trainings

Serious concerns were reported with regards to the lack of institutionalization of Global Fund supported trainings into national education systems, raising questions whether they would continue after the grants ended.

Training modules developed with the help of the Global Fund grant and/or with other external funding are not yet fully integrated into the formal education system in Belarus. To respond to human resources challenges, the government has developed a number of

strategies. Doctors are required to undertake minimum continuous medical education every five years. The government has also prioritized the training of human resources working on HIV by developing capacity building plans and even distance learning programs for providers based in remote or rural areas. However, trainings developed through Global Fund funding have yet to be integrated into the formal education system and funding mechanisms defined. In the case of TB, training modules are integrated into the formal continuous medical education system.

In 2012, the Bulgarian government approved the National Qualification Framework for adopting the European qualification framework for lifelong (continuous) education.[25] Extensive training for medical staff on new technologies, drugs and treatment for HIV and TB were organized through Global Fund funding; however, these trainings have not been institutionalized into the formal continuous education system so far.

Like Bulgaria, training modules for HIV and TB developed by the Global Fund are not integrated into the formal education system in Georgia. Trainings on HIV and TB related issues are fully funded by Global Fund grants and by USAID for the TB program, which ended in 2015.

In Ukraine, doctors are required to attend postgraduate training every five years. In-service training is fully funded by the State but is provided by a limited number of institutions, which creates access barriers. Donor supported trainings for both programs are partially integrated into the postgraduate training program.

All of this indicates that, once Global Fund support ends, continuous education programs in these countries will face challenges, which may negatively affect treatment quality and therefore treatment outcomes.

c. CSO training policy

Policies to train CSO personnel are available in Belarus, where there are programs to train all staff working in the national HIV response. However, these policies are weak, do not reach all staff and volunteers and are mainly externally funded. In Bulgaria, there have been no efforts made to involve civil society in trainings on organizational development or technical capacity building. The trainings were offered through Global Fund grants but these have decreased in the past years. There is no policy for the production or training of CSO personnel in Georgia either. In Ukraine, there is no policy for continuous CSO personnel development. Instead, NGOs have formed coalitions and alliances that develop training initiatives implemented for and by NGOs themselves with external funding. These are mostly targeted at NGO staff, NGO social workers and NGO psychologists (Table 15).

d. Donor funded HR salary alignment with national pay-scale

Countries differ significantly in terms of donor funding salary alignment and top-ups. It is common that Global Fund grants finance HR salaries and top-ups in almost all of the studied countries. The only exception is Belarus, where HR salaries are fully covered by the national

[25] Medical University Pleven. http://www.mu-pleven.bg/index.php?option=comcontent&view=article&id=2721:the-implementation-of-the-bologna-process-in-bulgaria&catid=296&Itemid=639&lang=en accessed June 22, 2015

budget. Georgia stands out from the remaining two countries where Global Fund funded salaries are aligned with the national pay scale. In Bulgaria and Ukraine salaries funded by the Global Fund are the main motivation factor and are significantly higher than public salaries. Employees from the public sector also receive top-ups from Global Fund grants, which in a few cases are 5-10 times higher than public salaries. NGOs working with Global Fund grants also receive higher salaries than those in the public health sector, but these are comparable to the salaries in a non-government sector, which is mainly supported by donors (Table 15).

SUMMARY OF FINDINGS FOR HUMAN RESOURCES: All of this indicates that after graduation from Global Fund support challenges are expected to emerge for production/re-production of adequately trained health and NGO/CSO cadre. Most likely, it will not be possible to sustain current training efforts due to the lack of institutionalization of Global Fund supported trainings and knowledge dissemination. These challenges in donor-funded trainings are not only relevant to the countries in this report and/or to the Global Fund, but they also have greater implication for other countries and donors alike[26]. Moreover, it may not be possible to tackle these problems during a transition period, due to the structural barriers observed in the countries: i.e. the lack of state requirements for continuous education for health care personnel; the absence of an adequate cadre of trainers in established training institutions; the lack of state support/funding for these trainings, etc. To achieve sustainability, it seems essential to remedy these challenges with the help of well thought through mechanisms, which could potentially act on a supranational level and use modern technologies as opposed to tackling challenges on a country-by-country basis. It will be critical to make the mechanisms developed for these purposes self-sustainable and scalable to assure long-term sustainability.

4.2.1.3 HEALTH INFORMATION SYSTEM

"Knowing your epidemic" is a critical precondition for adequate national response planning and implementation. National health information systems collect and generate data to support program and resource planning, and contribute to evaluating program outcomes and impacts. Quality, timely, adequate and reliable data is an essential part of sustaining HIV and TB programs. Therefore, this component was assessed by evaluating the integration of comprehensive routine statistical reporting in the national health information system(s) for both diseases, as well as by evaluating HIV second generation surveillance mechanisms i.e. the quality and rigor of the methodology used, funding sources and integration of the data in the national reporting. The findings are summarized in Table 16 below.

Table 16: Inputs – Health Information System

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Advanced routine statistical reporting fully integrated in the	HIV	Integrated, partially advanced	Integrated, partially advanced	Integrated, partially advanced	Integrated, partially advanced

[26] Vujicic M., Weber SE., Nikolic IA., Atun R., Kumar R. 2012. An analysis of GAVI, the Global Fund and World Bank support for human resources for health in developing countries. Health Policy Plan. (2012) 27 (8): 649-657. doi: 10.1093/heapol/czs012.

national system	TB	Integrated, partially advanced	Integrated, partially advanced	Integrated, advanced	Integrated, partially advanced
HIV Second generation surveillance:					
Rigorous methodology used for IBBS	HIV	Yes	No	Yes	Yes
IBBS Implemented timely (according to NSP)		Yes	No	Yes	Yes
IBBS Funded by public sources		No	No	No	No
PSE funded by public sources		No	No	No	No

a. Advanced routine statistical reporting fully integrated in the national system

A data system is considered to be advanced and fully integrated when disease related epidemiological data is well disaggregated and epidemiological and programmatic data is fully integrated into the national statutory statistical reporting system. For HIV, this means that data is disaggregated by region, target population, gender, age, route of transmission and type of service (including HIV testing, PMTCT, AIDS related mortality, adult and pediatric treatment, etc.), and integrated into the routine reporting system.

For TB, this means data disaggregation (age, gender, geography, population types), including TB new and relapse cases, TB treatment registry, pediatric TB and MDR-TB treatment and reporting and care and support (including pediatric care). The four countries reported relatively well functioning information systems, albeit with partial integration for both diseases.

In Belarus, HIV and TB are vertical units that are separated from the rest of health care system and therefore they have their own, program-specific information flows. The HIV surveillance system lacks important indicators and is not fully adequate to inform policy and/or program decisions within the national HIV program due to lack of critical data e.g. on CD4 count at diagnosis, data on key populations, etc. NTP uses a standardized recording and reporting system, which combines paper based TB and MDR-TB registers with a web-based individualized register for all TB cases, primarily funded by the Global Fund. The systemic limitations of these systems are compounded by the HIV program's weak analytical capacity, which was described in a recent evaluation report[27], although there are a few examples when the available evidence informed the policy decision on discontinuing some interventions in response to reduced GF funding.

In Bulgaria, the institutional framework for HIV surveillance seems more or less adequate; however, some weaknesses need to be addressed during a well-planned transition. Namely, the country lacks or has inadequate critical information necessary to assess its program effectiveness and make respective, evidence-informed changes during program planning. On the other hand, the TB surveillance system is both paper-based and digital, and delivers adequate information. However, TB surveillance is characterized by descriptive rather than inferential analysis, which highlights the institutional capacity limitations.

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

In Georgia, the routine surveillance systems for both diseases are relatively well developed and integrated in comparison to other countries. However, despite well set targets, indicators and the use of baseline data, monitoring and evaluation of the national response was a frequent challenge due to the lack of a clearly designated entity responsible for these functions. In 2013, this challenge was addressed and a monitoring and evaluation unit was established under NCDCPH, composed of experts from governmental and non-governmental organizations. Areas that need further improvement are the disaggregation of collected data and further clarification of the functions of different entities engaged in collecting and analyzing routine surveillance and programmatic information.

GEORGIA: The HIV routine surveillance system is relatively well developed and provides basic data to monitor the HIV situation, although the data is not disaggregated by age, gender, geographical allocation etc. Since 2002, Georgia has also systematically collected second-generation surveillance information, which allows the KP's status to be tracked and responded to accordingly. IBBS studies and other operational research is fully funded by external donors (TGF, USAID); no other source of funding for those surveys have been identified yet once the GF will discontinue funding.

Ukraine has made important progress in establishing and consolidating a national monitoring and evaluation system that generates information about critical epidemiological developments and funding flows, and monitors the service provision levels, especially those delivered by NGOs. However, there are no national-level HIV/TB co-infection indicators, and evidence-based policy-making is still a challenge in the country.

b. HIV second generation surveillance

With regards to HIV second-generation surveillance, Belarus, Georgia and Ukraine use rigorous methodologies for Integrated Biological and Behavioral Surveillance (IBBS), which is implemented in a timely manner. However, neither IBBSs nor the Population Size Estimate (PSE) studies, which are necessary to derive critical information for adequate program planning for KP, were funded from public sources. In the case of Bulgaria, there are serious problems in HIV second-generation surveillance, as the IBBS is conducted through convenience sampling and population size estimations are based on expert opinion, which may lead to methodological bias and may lower the external validity for generalizing study findings to the entire population. Furthermore, given that the IBBS and PSE study reports are not in English, the ability to involve international experts for quality assurance and peer-review is also limited.

SUMMARY OF FINDINGS FOR INFORMATION SYSTEMS: Countries to some degree have advanced their health information systems and collected the necessary information that can be used in program evaluation and/or intervention planning, although these achievements were not without limitations. Nevertheless, it seems possible to address the remaining limitations during a well planned transition, with the exception of analytical capacity limitations, which could remain for a while due to structural limitations in education and public sector employment. The greatest risk to health information systems seems to arise from the current dependence on external funding for IBBS and PSE studies and the unavailability of state funding for this research. Therefore, to minimize transition risk and assure that critical epidemiological and programmatic data is available after transition, it seems vital to start transitioning funding responsibilities onto the government for these

important research/surveillance activities. Special attention has to be paid to tracking program expenditures, particularly for TB.

4.2.1.4 SUMMARY OF SUB-DOMAIN ASSESSMENT

An assessment of current inputs for both diseases in the four countries reveals a mixed picture (Table 17). While in Belarus, Bulgaria and Georgia overall public expenditure for HIV and TB is increasing, there is still inadequate investment in prevention services targeted at priority groups, which makes these investments dependent on donor support and poses risks to transition and sustainability.

Table 17: Summary of T&S risk assessment for Inputs

	Disease		Belarus	Bulgaria	Georgia	Ukraine
Financing	HIV	Total				
		Prevention				
		Treatment				
	TB	Total				
		Treatment				
HR	Both					
Information System	HIV					
	TB					

Belarus, Bulgaria and Georgia have a positive economic environment, which can allow for an appropriate transition of the HIV and TB funded-activities from the Global Fund onto national budget. Political instability in Ukraine puts the country in a different situation. The four countries, however, have made important improvements in providing access to treatment with first-line drugs for HIV and TB, which in some cases have transitioned from Global Fund funding. In Ukraine, however, current difficulties hinder the prioritization of HIV and TB treatment, as shown by stagnant public expenditure for the diseases and the misalignment of budget/resource allocation with NSP priorities.

Of these findings, the major concern for transition is the inadequate attention to funding prevention services, which are largely delivered by NGOs/CSOs in all countries. The provision of prevention services is directly related to the NGO/CSO contracting, which was discussed earlier and is also elaborated later in the report. If public funding is not available for prevention, care and support services and CSOs are not in place (or substituted), then there is a danger that these activities will be left behind after the donor support ceases. The reduction of the scale and scope of preventive interventions poses risks to the public health gains already achieved through Global Fund support. Similarly, the provision of adequate care and support services, which are usually delivered by NGOs/CSOs, is critical to achieve better treatment adherence and outcomes for ART and TB, which also leads to reduced mortality among affected communities. Therefore, sustainable transition requires the allocation of public financing towards these activities coupled with appropriate mechanisms for NGO/CSO contracting (unless other means of service delivery are developed) and capacity building. This is a challenge in each studied country, and requires timely attention.

Health human resource availability, distribution and aging are broader, structural health systems issues and are not only related to HIV and AIDS. The authors questioned if transition planning for HIV and AIDS programs are appropriate entry points for dealing

with the problems of such structural magnitude, when taking into the account expertise and technical capabilities of the Global Fund's country teams. However, the authors felt that two areas: a) on-job trainings for continuous education (where they exist), and b) the alignment of Global Fund supported salaries or salary top-ups with the national pay scale require immediate attention for sustainable transition. The authors also felt that developing/institutionalizing such trainings in a country during transition may not be feasible. Instead, establishing a supranational (i.e. regional) initiative to develop on-line training courses for health workers and NGOs/CSOs on various topics could be a medium-term solution for addressing training needs during and after transition.

The integration and routine production of essential data/information, which is critical not only for adequate program/intervention planning and evaluation, but also for stakeholder engagement in advocacy efforts, seems to function relatively well in the studied countries. The major challenges expected as a result of transition relate to IBBS studies and information about KP i.e. PSE studies. Two issues seem important here: a) these studies are still fully dependent on donor support, but need to be funded by the governments and should become an indefinite part of surveillance activities prior to transition; and b) while seeking public financing for this work, it is also necessary to increase methodological rigor, perhaps through better methodological guidance issued globally and/or better quality assurance mechanisms in the country.

4.2.2 GOVERNANCE

The governance sub-domain is sub-divided into governance-specific components that include all of the actors and institutions involved at the organizational level and steering the HIV and TB programs, and the factors fostering accountability, which is an important precondition to ensure that the organizational level fulfills its roles and commitments (see Figure 3 on page 14). Table 20 on page 48 schematically presents the findings for each indicator across all four studied countries.

4.2.2.1 GOVERNANCE

Appropriate governance is the cornerstone of any program. This area was assessed by looking at three indicators: a) political commitment (non-financial), as revealed by well elaborated, disease-specific National Plans with sufficient legal power to drive national budgetary allocations and disease programs that are given adequate priority in the national health sector strategy; b) strong institutional and individual leadership of the disease programs (not PR); and c) an appropriately placed and well-functioning coordination mechanism within country governance structures.

a. Strong political commitment to HIV and TB

The Global Fund has conducted a transition and sustainability review of the countries that have already transitioned from Global Fund support[28]. The review showed that countries with strong leadership that acknowledges importance of communicable diseases within the national development priorities, and government approved disease programs/strategies

[28] Gotsadze T., Fuenzalida-Puelma HL., Chkhatarashvili K., Chikovani I., Tabatadze M. Transition and sustainability of Global Fund supported programs: Synthesis report of selected country case studies and reviews. Curatio International Foundation, Tbilisi 2015.

(or strategic plans) with sufficient legal power to drive national budgetary allocations, were better placed to deliver satisfactory results after transition from Global Fund support. Therefore, political commitment to the diseases was measured by the existence of a National Strategic Plan (NSP) for each disease with sufficient legal power[29], the prioritization of HIV/AIDS and TB in the national health strategy document, and financial planning.

Table 18: Governance - Strong political commitment to diseases

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
NSP/NTP with legal and enforceable power in a given country context	HIV	Yes*	Yes*	No	Yes*
	TB	Yes*	Yes*	No	No
NSP/NTP in preparation or without legal and enforceable power	HIV	Yes	Yes	Yes	n.a
	TB	Yes	Yes	Yes	Yes
HIV/AIDS as a priority in National Health Strategy document	HIV	No	Yes	Yes	No

** NSP/NTP till the end of 2015*

At the time of this study, most of the countries were in the process of preparing or had recently approved disease specific strategic plans. Government-approved national HIV and TB programs, covering the period 2010-2015, guide national HIV and TB response in Belarus and Bulgaria. Furthermore, Bulgaria embarked on the development of new HIV and TB national strategies for 2016-2020. A new HIV/AIDS prevention, treatment, care and support National Program (2014-2018) has been legally approved in Ukraine, while a new national TB program (2015-2018) is under development. Out of the four studied countries, Georgia is the only one where NSP existed but lacked sufficient legal power.

b. Institutional and individual leadership

The evidence from countries that have already transitioned from the Global Fund suggests that those countries where government institutions are strongly engaged in program management during Global Fund grant implementation have greater capacity to manage a disease specific national response after transition[30]. Therefore, our study examined the institutional leadership of the disease programs, and revealed varying degrees of institutional and individual leadership effectiveness. On the whole, save on two occasions, institutional leadership of the disease programs was either lacking or ineffective (see Table 19). Therefore, all programs, except Georgia's TB program, relied on individual leaders to advocate and lead the national response.

[29] An agreement between two or more legally empowered (within a given sovereign country) parties on the national disease plan that can be enforced in a given sovereign state either by law, decree and/or through other legal instruments.

[30] Gotsadze T., Fuenzalida-Puelma HL., Chkhatarashvili K., Chikovani I., Tabatadze M. Transition and sustainability of Global Fund supported programs: Synthesis report of selected country case studies and reviews. Curatio International Foundation, Tbilisi 2015.

Table 19: Governance – Strong leadership

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Legally empowered leading organization to manage given disease program effectively	HIV	No	Yes/not effective	Yes	No
	TB	Yes	Yes/not effective	No	No
Individual leader(s) advocate for disease specific programs	HIV	Yes	Yes	Yes	Yes
	TB	Yes	Yes	No	Yes

Belarus has a well empowered national TB institution and strong leaders for both diseases. A single public organization directs the TB response and is empowered to supervise the entire TB network in the country. However, for HIV/AIDS no entity is fully responsible for the national HIV response. Consequently, the institutions involved in HIV/AIDS service planning and delivery report to different units at the central level, leading to fragmentation and hindering a coordinated response.

In Bulgaria, a single public entity – the *Directorate for the Management of Specialized Donor-Funded Programs* – within the Ministry of Health manages the Global Fund's grants for both diseases. However, effective operation of the directorate is hampered by frequent changes in the Ministry of Health due to political turmoil. While the head of the directorate advocates for domestic resource mobilization and the sustainability of NGO engagement in the national HIV and TB control response, without political support from the MoH these efforts are not fully delivering expected results.

In Georgia, the situation is completely different. While Georgia does not have a single structure responsible for the HIV/AIDS response, different public agencies share specific responsibilities with regards to the national program and coordinate their efforts. As for TB, the *National Centre for Tuberculosis and Lung Disease* (NCTBLD) serves as the lead institution for managing the program, but it has very limited legal powers and fully depends on the MoH to develop and adopt the necessary regulations to facilitate the national response. The sheer range of public and private sector facilities delivering specialized TB services complicates the situation further. Due to legislative and institutional weaknesses, the entire TB response lacks adequate institutional leadership, which is frequently voiced by stakeholders involved.

Finally, in Ukraine, while the institutions responsible for leading the national response were found to be weak due to overall weaknesses in the country's legislative and regulatory environment, individual leaders do play a significant role, which most likely determined the achievements of the national programs.

c. Appropriately placed and well-functioning coordination mechanism within the governance structure of a country.

Country Coordination Mechanism (CCMs) were also found to be an important legacy of the Global Fund supported programs, which weaken or disappears after transition, largely because they lack a legal basis/institutionalization[31]. Therefore, the ability of the CCMs to conduct their activities was measured by looking at their placement and legal

[31] Ibid 30

empowerment within the government hierarchy; the participation of CSOs; and how effectively they functioned.

Table 20: Governance – Coordination Mechanism

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Coordinating body adequately placed within the government hierarchy and legally empowered within the national Government structure to assure adequate coordination across the sectors	Both	Yes	Yes?	Yes?	No
CSOs have a legally determined seat in the coordinating body		Yes	Yes	Yes	Yes
Coordinating body functions effectively		Yes	No	Yes	No

To meet the Global Fund's grant requirements, countries are required to establish a CCM in order to ensure the broad representation of various government, non-government, private, religious and community representatives and stakeholders. In practice, the CCM's legal powers, the role, performance, and operational dynamics varies slightly between countries (Table 20).

In Belarus, two structures coordinate and supervise the HIV and TB response. In addition to the CCM, which is housed in the Ministry of Health, the National Multisectoral Council on HIV/AIDS and STI Prevention (NAC) reviews programs, makes decisions on funding and takes legislative initiatives. The NAC has several local branches and allows for NGO participation. However, although the members of the NAC and CCM are frequently the same, there are no provisions for to divide roles and responsibilities between institutions or in working relations. As a result, several local NACs stopped operations due to the lack of clarity on the division of functions, resulting in the disappearance of a platform for advocacy and the resolution of challenges related to national HIV and TB response implementation on the local level.

Ukraine established a national coordination mechanism, but under recent administrative reforms the National Council was demoted from the Cabinet of Ministers (Deputy Prime Minister) to the level of the MOH. These reforms also adversely affected the work of the regional councils. Some regions moved the regional coordination committees from the Governor's office to the regional Health Departments. Thus the country lost the platform at national and regional levels for adequate coordination and effective implementation of multi-sectoral responses to HIV and TB, but maintained CSO representation and engagement in the coordination bodies that remained.

Similarly, in Bulgaria and in Georgia the CCM is housed in the Ministry of Health and is entrusted with the political leadership, coordination and evaluation of national programs for both diseases. However, CCMs housed at the sectoral ministry level lack the legal power to assure adequate coordination across the sectors.

Overall, the CCMs were found to have good CSO participation. However, with the exception of Belarus and Georgia, the CCMs did not function effectively.

4.2.2.2 ACCOUNTABILITY

Transparency and easy access to epidemiological and program performance data is critical to assure adequate accountability in a county and allow interested stakeholders to engage in program monitoring/oversight, thereby ensuring that government commitments are held. All of this could contribute to successful transition and could lead to sustainability. Civil society actors usually place accountability demands on programs, but they can only keep program managers and government representatives accountable to the society/community if they have an enabling environment. Accountability has been measured by examining the availability and accessibility of epidemiological and program performance results in the public domain, and by looking at the *Enabling Environment for Civil Society* engagement in countries. The findings are briefly presented in Table 21 and discussed in detail below.

a. Program performance results are available to the public

Transparency and open data allow decision-makers to make evidence-based decisions, and allow actors at the local and national levels to hold the government accountable for the services they deliver and the money they spend. The transparency of information to the public was measured by looking at the availability of epidemiological data on KP, and the regular production and dissemination of program reports, expenditure data and other reviews in an easily accessible form to the public (Table 21).

Table 21: Accountability - Program performance results are available and accessible through public domain

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
EPI data including for KAPs	Both	Yes	No	Yes	Yes
Programmatic data and/or reports		Partly	Partly	Partly	Yes
Program expenditure data		No	No	No	Partly
Program M&E reports		Yes	No	No	Yes
NSP/NTP and other periodic reviews		Yes	No	Partly	Yes

In this component, Ukraine demonstrated the most positive results by making data on KP available in the public domain as well as regularly publishing M&E program reports and reviews. However, program expenditure data was incomplete.

Bulgaria showed the weakest results since it has no formal rules and mechanisms to disseminate program results. There is limited data for disease programs on the national websites or accessible through public domain, particularly on KP. Other data such as expenditure data, CCM minutes, and program reports are only available upon request. Like other countries in the region, Bulgaria is required to submit information to UNAIDS' global reporting system and to Euro CDC, but in most public databases the critical indicators were missing or incomplete by year. Consequently, the lack of internationally comparable data, which should be available from international data sources, along with very limited information available within the country, significantly limited this analysis and raised concerns about the availability of and uninterrupted access to critical information for national stakeholders. All of this imposes limitations on our analysis and on any advocacy

efforts national stakeholders should be able to mount. Georgia and Belarus have data available on KP, but other information is partial or unavailable.

Particularly worrisome is the absence of program expenditure data in Belarus, Bulgaria and Georgia that will track financial allocations to the priority and effective interventions and/or population groups during and after Global Fund support. This is especially relevant for TB programs in the studied countries. The main challenge observed is the absence of demand for and availability of TB expenditure-tracking tools. This is unlike HIV, where national AIDS expenditure tracking tools are utilized and countries are requested to carry out this assessment biennially.

b. Enabling environment for civil society engagement

Table 22: Accountability - Enabling Environment for Civil Society engagement[32]

Countries	Socio-economic	Socio-cultural	Governance	EEI
Belarus	0.60	0.55	0.23	**0.41**
Bulgaria	0.62	0.49	0.66	**0.61**
Georgia	0.51	0.46	0.50	**0.50**
Ukraine	0.60	0.54	0.55	**0.56**

Source: CIVICUS. Available at: http://www.civicus.org/eei/

To measure the country environment for civil society, we relied on the Enabling Environment Index (EEI), which uses secondary data from 109 countries and measures governance, socio-cultural and socio-economic conditions that have an effect on the ability of citizens to participate in civil society. EEI is measured from 0 (least enabling) to 1 (most enabling)[33].

The index includes informal civil society groupings as well as civil society organizations. As Table 22 shows, Belarus demonstrates the lowest overall EEI score of 0.40, primarily due to the non-conducive governance environment for NGOs/CSOs. Bulgaria shows the highest EEI score among four countries (0.60), where civil society is actively engaged in providing oversight. In Ukraine, an EEI score of 0.56 also indicates that a good enabling environment for civil society work exists in the country. An example of this was the co-drafting of a law by a group of citizens called 'Patients of Ukraine' with the government to ensure that national drug procurement is conducted through international organizations in order to make the best use of resources.

4.2.2.3 SUMMARY OF GOVERNANCE SUB-DOMAIN ASSESSMENT

The governance component in the four countries was assessed with the help of indicators covering: political support, program leadership, effective coordination mechanisms, and accountability (see Annex 1 for more details). Particular challenges in the governance sub-domain include:

[32] When EEI is up to 0.38 it indicates there are law and policies that restrict civil society playing an oversight role, between 0.39 and 0.5 it shows that there are no law and policies that restrict civil society playing an oversight role, but in practice it is not accepted by the Government and index between 0.51-0.76 shows that civil society is actively engaged in providing oversight.

[33] The Global average for EEI was 0.55 in 2013, with New Zealand being highest scoring country – 0.87 and Democratic Republic of Congo lowest – 0.26. Source: http://civicus.org/eei/ Accessed on October 21st, 2015

- The lack of a legally binding NSP or NTP in some countries to drive national budget allocations for the disease program and especially for priority interventions;
- The absence of an entity within the government structure with a clear, legal mandate to effectively manage HIV or TB programs and deliver results;
- While all CCMs effectively engage NGOs/CSOs, they have not had solid legal foundations within the sovereign legislation and therefore are not well placed within the national governance structure to ensure coordinated, multi-sectorial responses to HIV and TB epidemics. This risk is paired with the weak performance/functionality of the CCMs in some countries. CCMs are at risk of disappearing after the end of Global Fund support, which has happened in a number of countries that have already transitioned from Global Fund support[34].

Table 23: Summary of T&S risk assessment for Governance

Disease	Belarus	Bulgaria	Georgia	Ukraine
Governance				
Accountability				

Regarding accountability, Ukraine stands out from other countries by having a good enabling environment for civil society engagement, maintaining rich performance data and offering stakeholders easy access to the required information. Bulgaria has the highest rating in terms of CSO enabling environment, as reflected in its high EEI score, but fails to ensure the availability and transparency of information.

4.2.3 PROGRAM

This sub-domain is sub-divided into three components: (i) service delivery; (ii) organizational capacity; and (iii) transition planning. These components allow evaluation of the sub-domain in more detail, as described below.

4.2.3.1 SERVICE DELIVERY

This component seeks to help us understand how the program currently functions and its relationship with the transition. As such, service delivery is measured through treatment coverage and outcomes; the integration of existing disease services into general services, such as PHC; the coverage of KP with preventative services; and the ability to sub-contract CSOs specifically for health (prevention and care) service delivery.

a. Treatment coverage and outcomes

HIV: ART coverage and treatment outcomes are improving in all countries (Table 24). Georgia is the only country in Eastern Europe that has universal access to ART using their network of health facilities. At the end of 2013, the country demonstrated >90% coverage among those who are diagnosed and eligible for treatment. A spectrum-generated estimate suggests that in 2013, Georgia met 80% of the treatment needs, which is the universal access threshold defined by WHO but is not yet in line with the 90-90-90 call by UNAIDS.[35] Compared to previous years, 2012-2013 showed an improvement in survival/retention

[34] Ibid 30
[35] Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

among patients initiating ART. The 12-month retention indicator grew from 79% (2011) to 85% (2013).

Table 24: Service Delivery - Treatment

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Increasing coverage (%) trend for ART	HIV	Yes	Yes	Yes	Yes/Low
Improving ART treatment outcome (adherence rate at 12 months)		Yes	Yes	Yes	Yes
Improving treatment outcome – success rate for all TB cases	TB	Yes	Yes	Yes	Yes/Low
Improving treatment outcome – success rate for MDR TB		Yes/Low	Yes	Yes/Low	Yes/Low

Belarus, Bulgaria and Ukraine also show increases in both ART coverage and treatment outcomes, but coverage rates still remains low in Belarus and Ukraine. Both countries experience weak linkages of testing to treatment and care pathways to ensure that people tested positive for HIV receive treatment and the necessary care. The main challenge to accessing ART is the large number of tests necessary to initiate ART, which creates both financial, geographic and time barriers. These barriers are further layered by the mandatory requirement to provide personal identification documents to register for treatment, which undermines patient confidentiality.

TB: Treatment outcomes among new, retreatment and MDR-TB patients show positive trend in Belarus. The success rate of treatment among new TB cases in the 2012 cohort was 85%, which is above average for the WHO European Region, and 69% for retreated cases. Although there is an obvious positive trend in treatment outcomes for drug susceptible TB, the treatment success rate of MDR-TB patients remains low. The high level of MDR-TB and XDR-TB is still an issue and holds back further progress.

Bulgaria demonstrates positive results in TB treatment outcomes i.e. treatment success rates for both susceptible and MDR TB. The TB treatment success rate for all notified TB cases has been stable at over 80% for the last few years. Introducing quality MDR treatment resulted in a substantial increase in the MDR TB success rate, although the treatment success rate for retreating TB cases has declined.

In Georgia, the success rate for new cases and relapses was 85% in 2012. The MDR-TB cases who began treatment in 2011 had a 50% success rate, while the cumulative success rate for XDR-TB cases between 2008-2011 was 29,5%. The recent GLC mission report notes great concern that the current system for MDR-TB in Georgia is no longer adequate, and serious changes are needed to improve the situation and to try and bring MDR-TB under control[36].

Ukraine has low treatment success rates for new TB patients. Over the past 10 years, the TB (new pulmonary and extra pulmonary) treatment success rate is around 70%. Low treatment success rates are mostly associated with the high prevalence of TB among new MDR TB cases, the inadequate provision of medication, violations of standards, challenges to treatment adherence mainly due to alcohol and drug abuse, and a high level of co-infection with TB and HIV. According to the WHO report, treatment failure and losses to follow-up (11% each in 2012) are the main indicators of the ineffective treatment component of the program. As for MDR TB, Ukraine has gradually improved the diagnosis

[36] GLC European Region Consulting Mission: PMDT in Georgia, 17-20 July, 2014, Final Report.

and enrolment of MDR TB cases in treatment. During 2009-2013, the number of MDR TB cases almost tripled. 87.4% of these cases have been enrolled in treatment. According to the WHO, this success is explained by the introduction of modern diagnostics methods - although the percentage of effective treatment of MDR TB cases that started treatment in 2011 and 2012 is only 34.9%.

b. Integration of existing services into general services

Following WHO's guidance[37],[38] and after transition from the Global Fund, service integration was seen by some countries as a way to increase the efficiency of vertical programs and improve focus/benefits for patients[39]. Consequently, we looked at the current dynamics and degree of integration of HIV and TB services in the studied countries through different lenses (Table 25). We found that PMTCT is well integrated into PHC and/or antenatal care in all countries.

Table 25: Service Integration

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Integrated PMTCT with PHC/Maternity care	Both	Yes	Yes	Yes	Yes
Integrated TB in primary care		Yes/ Limited	Yes/ Limited	Yes	No
Integrated HIV and TB		No	Yes/	Yes	No

In the case of Belarus, the lack of integration of TB and HIV services, creates barriers to access and has a negative impact on treatment outcomes. TB control interventions are delivered through a network of dedicated TB facilities and primary health care services. PHC providers are responsible for identifying people with relevant symptoms, registering them as TB suspects, performing sputum investigations and referring them to specialized TB services. TB diagnosis is carried out in the specialized TB service units in each peripheral district (rayon) of the country.

In Bulgaria, HIV and TB services are not well integrated. Only a few NGOs provide integrated services to KP, and those that do usually specialize on one single key population group. Importantly, legally TB diagnoses should be done by TB services, and if diagnosis is conducted elsewhere this must be repeated. This leads to diagnostic delays, possible patient dropouts and increases unnecessary costs. Furthermore, the algorithm for TB diagnosis among PLWHA is not well developed, while technologies for rapid diagnosis of TB are lacking. Although national TB services are delivered by a wide range of organizations – including specialized public hospitals, a laboratory network, civil society organizations,

[37] WHO 2008. Integrated Health Services - What and Why? Technical Brief No.1, May 2008. http://www.who.int/healthsystems/technical_brief_final.pdf

[38] Montenegro H., Holder R., Ramagem C., Urrutia C., Fabrega R., Tasca R., Salgado O., Alfaro G., Gomes MA.: Combating Health Care Fragmentation through Integrated Health Service Delivery Networks in the Americas: Lessons Learned. the Journal of Integrated Care, Volume 19, Issue 5, October 2011.

[39] Gotsadze T., Fuenzalida-Puelma HL., Chkhatarashvili K., Chikovani I., Tabatadze M. Transition and sustainability of Global Fund supported programs: Synthesis report of selected country case studies and reviews. Curatio International Foundation, Tbilisi 2015.

general practitioners and patronage nurses – TB integration into the primary health care still remains quite limited.

TB/HIV services function well in Georgia but are hampered by discrimination against HIV patients in some regions. There is also an initiative to scale-up HIV testing, which is a significant weakness in the country, by linking it with the Hepatitis C virus elimination program, which would simultaneously test for HIV in all patients/individuals. Combining these two testing programs is expected to be relatively cost-effective and may improve HIV detection rates. There is progressive integration of TB services into PHC, however, certain concerns arise with a high share of private PHC providers engaged in TB care, which lack adequate motivation to provide the appropriate care.

In Ukraine, TB/HIV services are not yet integrated but are expected to emerge soon. There are no regulations that describe and direct the collaboration between TB, HIV and primary health care facilities, or NGOs that provide support to PLHIV. This results in the development of local orders at the regional level that do not cover every aspect of TB/HIV collaboration and/or do not take into consideration the role of PHC facilities. The potential of NGOs to provide TB/HIV patient support is not fully realized. Specifically, the mobile primary healthcare points operated by NGOs, which provide screening for STI, HIV and Hepatitis C Virus among vulnerable groups, are not significantly involved in coordinated TB/HIV care efforts, including TB screening and follow up for co-infected patients. It is important to note that Ukraine has made significant efforts to integrate OST sites into the structure of the existing health care system. TB services are still separate, and have little or no integration into PHC.

c. Coverage of KP with preventative services

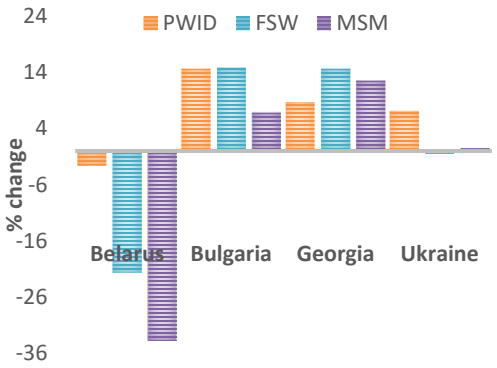
All four countries show increasing rates of KP coverage with preventative services (Table 26). However, in Belarus and Ukraine, this coverage remains low.

Table 26: Service Delivery – KP reached with preventive services

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Increasing coverage trend of epidemiologically most important KAP with preventive services	HIV	Yes/Low	Yes	Yes	Yes/Low
Data based on IBBS studies with rigorous methodology		Yes	No	Yes	Yes

The available data for measuring KP coverage with preventive services is mostly based on program targets, but not on estimated population sizes in all four countries and/or adequate IBBS data. Therefore, we used a number of indicators measured by IBBS surveys to analyze the progress achieved in covering key population groups with preventive services.

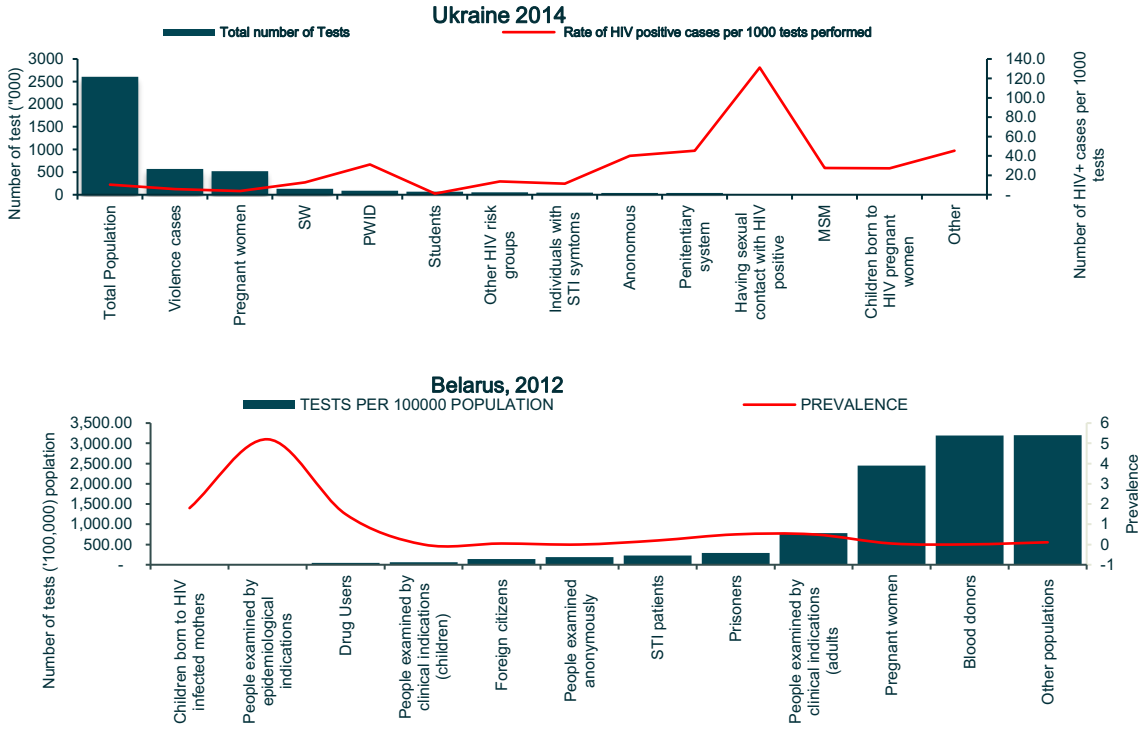
Figure 17: Change in HIV testing coverage among KP, 2009-2013



Notably, Bulgaria, Georgia and Ukraine show improved HIV testing coverage of KP, with the exception of Female Sex workers (FSW) in Ukraine (Figure 17). Positive changes in coverage vary between countries and among key populations, ranging between 7%-15%. Bulgaria has the highest improvement in HIV testing coverage expansion for PWIDs and FSWs (15% each group); however, this information has to be treated with caution, due to the lack of rigor of IBBS methodology used in this country.

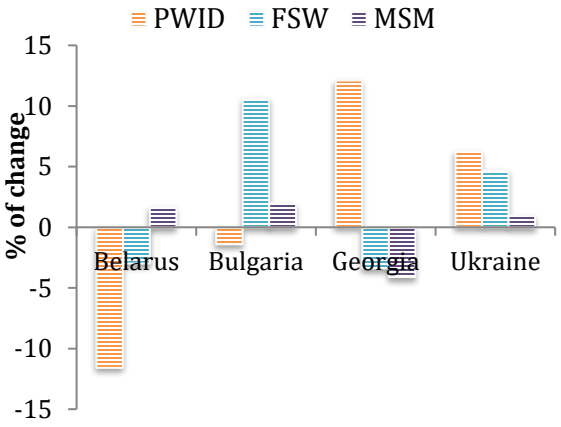
Belarus is the only country where HIV testing has declined for all KP. HIV testing for FSW also deteriorated in Ukraine between 2009-2013, while its testing coverage of MSM is insignificant (0.5%) (Figure 17). While the number of HIV tests performed annually is increasing in Belarus and Ukraine, the coverage of HIV testing of particular population groups at risk still remains low, as demonstrated on Figure 18.

Figure 18: Rate of HIV positive cases per 1000 tests performed



Belarus and Ukraine failed to target the most important population groups, which results in a high level of undiagnosed HIV cases and/or late diagnosis, as confirmed by the share of AIDS cases among newly reported cases in Ukraine and HIV prevalence in Belarus.

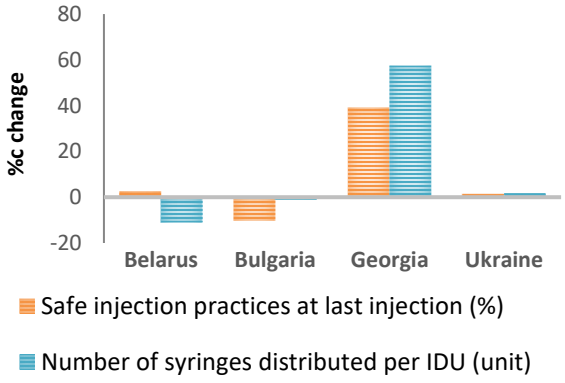
Figure 19: Change in safe sex behavior at last intercourse among KP, 2010-2014[40]



While the improved coverage of KP with HIV testing in Bulgaria and Georgia is commendable, it is not always followed by safer sex behavior. Safe sex behavior during the last intercourse, as measured through IBBS studies, deteriorated in the past couple of years among PWID in both countries, and amongst FSW and MSM in Georgia. In Belarus, safe sex behavior of PWIDs and FSWs worsened, whilst MSM improved. Safe sex behavior in Ukraine is improving among all KP, although at different speeds (Figure 19).

PWIDs, the most affected population group in Georgia, show a tangible improvement in safe injection practices (48% in 2011 and 87% in 2014), which correlates with the increased number of syringes distributed to them in the same period (Figure 20).

Figure 20: Change in safe injection practices among PWID (%), 2011-2014



The average number of syringes distributed per injecting drug user decreased in Belarus and Bulgaria, which had a destructive effect on the improvement of save injection practices among PWID, particularly in Bulgaria (Figure 20).

Ukraine reported an improvement in testing of PWID, albeit to a lesser extent than in Georgia.

d. CSO contracting in health sector

A considerable amount of HIV prevention interventions targeting KP are implemented by CSOs but are exclusively funded by the Global Fund in all of the studied countries, whilst CSO engagement in provision of TB services is limited.

The overall legal environment allowing CSO contracting for publicly financed social services differs from country to country. Nevertheless, none of these countries has yet developed rules and procedures for CSO contracting in the health sector (Table 27), which, if left unaddressed, may hamper the continuation of CSO provided services after the end of Global Fund support.

[40] The share of sex workers who reported that a condom was used with their last client

Table 27: CSO contracting in health sector

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Existence of detailed rules and procedures for contracting CSOs for health service delivery	Both	No	No	No	No
Government already contracts CSOs for various health service provision using public funds		No	No	No	No

In 2003, amendments to the Social Services Act were adopted in Bulgaria to allow NGOs to provide social services and to apply for funding from the state and municipal budgets. However, CSO contracting has not yet been practiced in the health sector, and the country lacks detailed rules and procedures for CSO contracting in health service delivery.

Even though Bulgaria may develop rules and procedures for CSO contracting in the foreseeable future, CSOs lack the capacity to provide integrated services, which would be important for receiving state funding in a competitive environment. CSOs are less active in the field of TB. Under the Global Fund programs, initial steps were taken to establish effective networking between CSOs and TB medical personnel to strengthen efforts for TB case detection and TB screening among at-risk groups, and to improve TB treatment adherence. Acknowledging these challenges, some NGOs recently started diversifying their mission to be able to deliver a spectrum of services to different target groups, which would eventually increase their fundraising opportunities and possibly contribute to their sustainability as well.

In Ukraine, a general regulation allowing CSO contracting exists and detailed tender procedures for CSO contracting are available in the social sector. The government already contracts CSOs to provide social services using public funds, but this is not yet practiced in the health sector due to the absence of the necessary rules, regulations and procedures allowing the procurement of publicly financed health care services from civil society organizations. The partnership between the government and CSOs in the field of TB is less developed than in HIV/AIDS. Historically, TB was mainly addressed by the health sector in Ukraine, and therefore attracted less interest from the non-governmental sector. NGOs engaged in HIV/AIDS service provision have started to address TB related issues, although on a limited scale. In the health sector, and for HIV and TB services in particular, CSO service provision is still largely dependent on foreign donor funding.

In Georgia, the government already contracts CSOs to provide social services using publicly administered funds (provided by the Global Fund), but it lacks the skills for developing technical specifications for the procurement of health services. CSO capacity especially at the community level in HIV filed is rather weak compared to the capacity of NGO/CSOs at the national level. Presence of civil society in TB is rather limited; there is only one active organization “Georgia TB patients union”, which is umbrella to 11 smaller NGO’s. This Union was heavily supported by USAID funded TB project that is coming to an end.

The overall legal environment is not conducive for NGO/CSO contracting in Belarus and the country lacks detailed contracting procedures for CSOs in the health sector. Only a few NGOs such as the Red Cross and sport’s associations receive direct subsidies from the state

budget. In general, public institutions have no legal right to contract CSOs. Given the restrictive CSO environment, the capacity of the civil sector is limited, especially in TB. It is less likely that CSO contracting for publicly financed health services will be allowed in the country in foreseeable future if this is not addressed at the supra-national level.

SUMMARY OF SERVICE DELIVERY: For both diseases, treatment coverage and treatment outcomes are gradually improving but still remain low. In the case of HIV, ART coverage and treatment adherence rates are improving in all countries, although coverage rates still remain low in Belarus and Ukraine. Both countries experience structural barriers and weak linkages between testing, treatment and care pathways to ensure that people tested positive for HIV receive timely treatment and care.

Treatment success rates for all cases of TB are improving in all countries except Ukraine, which has low treatment success rates for new TB patients, which are mostly associated with ineffective treatment programs. Treatment outcomes for MDR TB cases are improving but remain low in all countries.

The process of service integration for both TB and HIV is ensured in Georgia, but remains sub-optimal in Belarus and Bulgaria, while not yet existent in Ukraine. Consequently, the lack of service integration has negative implications on the expansion of HIV testing coverage and treatment.

The coverage of KP with HIV testing has improved in Bulgaria, Georgia and Ukraine – although at different paces – but has not improved in Belarus. While HIV testing coverage is increasing in Georgia and Bulgaria for all KP and in Ukraine for PWIDs, it is not followed by any quality counseling that impacts upon KP behaviors.

CSO contracting in the health sector is lacking in all countries, although legal environment for CSO contracting seems conducive and most countries, except Belarus, contract CSOs for the provision of social services. Therefore, the lack of detailed rules and procedures for CSO contracting in publicly financed health care services needs to be tackled. If countries fail to take decisive steps in this direction, it may pose a challenge to the continuation of preventive services, which are currently delivered by NGOs and CSOs and financed by Global Fund grants. Furthermore, the availability of a contracting mechanism may not be sufficient without building the capacity of the NGO/CSO sector with adequate knowledge and skills to comply with public procurement rules.

4.2.3.2 ORGANIZATIONAL CAPACITY

For the purpose of this study, the organizational capacity has been assessed by looking at the following: program management; financial management; contracting; procurement-supply chain management; and research, monitoring and evaluation areas (see Annex 1 for more details). The organizational capacity analysis looks at the organizational capabilities of the entity responsible for disease program management. A summary of the findings is briefly presented in Table 28 below.

a. Strong management of the disease program

Management of the national disease program was measured by evaluating the existence of a national program management capacity assessment or staff performance evaluations, as well as the relationship between Global Fund PRs and national program management.

Difficulties in this area are strongly correlated with those identified in the governance component.

Table 28: Organization Capacity – Management of disease program

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Existence of national program management capacity assessment or staff performance evaluation practice (at least once in every two years)	HIV	No	Yes	No	No
	TB	No	Yes	No	No
Closely integrated TGF PR and National Program Management	HIV	No	Yes	Yes	No
	TB	Yes	Yes	No	No

Of the four countries, Bulgaria is a positive example where assessments of the MoH as the PR of the Global Fund grants are regularly conducted, and the PR and national disease program management are fully integrated (since they the same entity).

In Belarus, Ukraine and Georgia, however, the National HIV and TB programs and grant management are not integrated. The absence of centralized public entities with an overall planning and oversight function raises sustainability risks after transition from Global Fund support.

b. Procurement and supply chain management

Procurement and supply chain management are also core areas for an effective TB and HIV response. Country findings show that the procurement of medicines and commodities financed by the Global Fund is conducted through a parallel system in most cases, except Georgia.

Georgia benefits from having public entities as the PR of Global Fund support, which allowed national procurement rules and procedures to be applied to the purchase of HIV and TB? equipment, medicines and supplies under the Global Fund grants.

In case of Bulgaria, although the MoH is the PR of the Global Fund, procurement under the HIV and TB grants takes place through parallel systems.

Table 29: Organization Capacity - Procurement and supply management

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
TGF funded procurement is conducted using national system	Both	No	No	Yes	No
Supply chain management integrated into the national system		Yes	Yes	Yes	No
Low frequency of emergency procurements for drugs (not more than one over for last year)		Yes	Yes	Yes	Yes
Rare stock outs for drugs (not more than once for last year)		Yes	Yes	Yes	Yes
If national procurement – paying not more than 5% above the international benchmark price		Yes	No	No	Yes

In Belarus and Ukraine, where the responsibility for procurement through the grant lies with non-public institutions (UNDP in case of Belarus and 2 CSOs in Ukraine), the procurement of goods is performed in parallel to the national procurement system using international procurement rules and procedures aligned to Global Fund procurement requirements.

BELARUS: UNDP as the PR uses its own procurement rules. The UNDP Procurement Support Office has finalized several Long Term Agreements with procurement agencies and suppliers for products and services frequently used in GFATM-financed programs. Only a few drugs procured through with Global Fund support are registered in the country, while non-registered drugs are imported using the so-called 'single entry permit for import' issued by the MoH.

BULGARIA: The MoH procures all drugs financed by the Global Fund in accordance with the Public Procurement Act through local tenders. Waivers are granted for drugs not registered in the country. TB first line drugs not registered in the country are procured directly from the Global Drugs Facility.

GEORGIA: All ART and anti-TB drugs are procured through the Global Fund mechanism and are exempted from registration thanks to a waiver issued by the MoLHSA.

UKRAINE: CSO PRs procure HIV and TB drugs funded by the Global Fund.

Notably, the majority of medicines procured with TGF resources for both programs are not registered and are imported using special waivers (e.g. in Georgia, Bulgaria, Belarus). These medicines are not included in national essential drug lists. While this does not pose a problem while medicines are procured using Global Fund resources, it may make it harder for the government to procure high quality drugs after transition unless they are included in list of medicines used by public procurement.

In every country except Ukraine, supply chain management uses either the national supply and logistics system or a direct delivery system handled by the supplier. Ukraine utilizes a parallel supply management system due to the ineffectiveness of the national system.

Countries perform well in terms of procurement planning, demonstrating few or no emergency procurement and medicine stock outs. Ukraine had to make emergency procurements in 2015 for the internally displaced individuals from the conflict zone, which was hampered by delays in approving a new framework law allowing public procurement through international organizations.

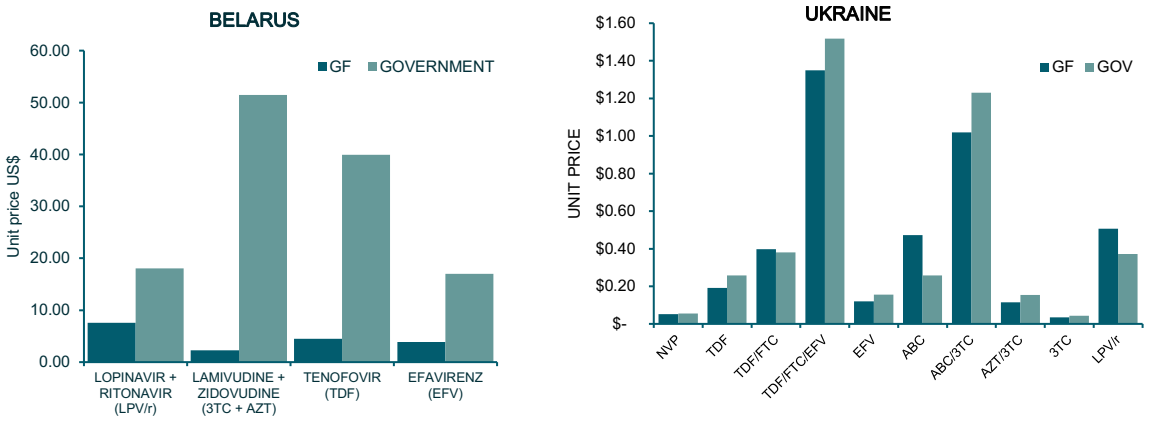
Table 30: Challenges in national procurement and supply management systems

Challenges	Belarus	Bulgaria	Georgia	Ukraine
Consumption based forecasting	Yes	n.a	Yes	Yes
Absence of drug quality control system	Yes	Yes	Yes	Yes
Price regulation	No	Yes	No	No

The governments in these countries are gradually taking responsibility for financing drug and supply procurement, utilizing national procurement systems. The number of WHO and development partner-led assessments carried out in these countries highlights weaknesses in national procurement systems such as weak drug forecasting practices, the poor quality of procured medicines and tests, and the lack of rules mandating generic medicine procurement. The study shows that none of these countries has well-established drug quality control systems in place (Table 30).

A comparison of both procurement practices revealed that local procurement of ARVs results in higher public spending than the mechanism used by the Global Fund grant. This poses a challenge during transition.

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



Georgia and Bulgaria were found to not be paying more than 5% above the international benchmark price, which shows that they are doing well in negotiating competitive prices for goods and commodities. Ukraine and Belarus currently pay significantly above international price benchmarks (Figure 21). To resolve this issue, in Ukraine the MoH has revised the national procurement law to allow for direct procurement from international organizations to ensure competitive prices and eliminate corruption[41]. In Belarus, our analysis reveals higher public spending, with price differences varying between 138% and 2,137% for different medicines.

c. Monitoring and evaluation capacity

Finally, the study also assessed the monitoring and evaluation capacity of the MoH and national institutions responsible for program planning and management, which, because of its importance for national response management, is an important element of organizational capacity.

Table 31: Organization Capacity – Monitoring and Evaluation

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Existence of analytical capacity at MoH/main public health agency reflected in availability of analytical reports that are produced with certain periodicity	Both	Moderate	Moderate	Limited	Moderate
Information use for evidence-based program planning and management e.g. NSP/NTP uses recent Epi, programmatic and expenditure data		Partly	Partly	Partly	Partly

M&E units responsible for specific disease program monitoring and evaluation are placed at public institutions in all four countries and produce reports with at a certain regularity. These reports are mainly available in local languages and are largely descriptive, lacking analysis necessary to guide disease program planning. Furthermore, the staffing of these

[41] Gotsadze, T. (2015). Transition from the Global Fund support and programmatic sustainability research in four CEE/CIS Countries: Ukraine country report. Tbilisi: Curatio International Foundation.

units are adequate in Bulgaria and Georgia, but seemed to be sub-optimal in Belarus and Ukraine, especially for TB program monitoring. The capacity building of these units has largely been dependent on Global Fund support, and was mostly targeted at national level – ignoring the need for sub-national capacity building. Moreover, the majority of M&E staff are either fully funded from grants or receive salary top-ups, except in Georgia and Belarus.

BELARUS: The most recent evaluation of the HIV program revealed a lack of analytical capacity in the country. Evidence-based planning is weak.

BULGARIA: National HIV and TB M&E is governed by the Directorate for Public Health and Management of Specialized Donor-Funded Programs at the MoH. The Directorate has set up a separate M&E Unit with sufficient capacity for data analysis; however, data analysis is limited only to the indicators requested for Global Fund PF, GARPR and ECDC reporting.

GEORGIA: While Georgia has well-established health information systems and an M&E unit, its analytical capacity requires enhancement to regularly practice evidence based planning.

UKRAINE: While the analytical capacity of M&E is sufficient, findings in evidence-based policy-making are only used to a limited extent.

In Belarus, the monitoring and evaluation systems for TB and HIV are fragmented due to the separate vertical systems for treating these diseases. The TB program lacks integrated surveillance and program performance indicators, including those for NGO led activities. In the case of HIV, surveillance and programatic performance indicators have been integrated already. NGO reporting forms have been included in the statutory reporting system and integrated HIV M&E system for almost two years. The most recent evaluation of both disease programs in Belarus identified the lack of analytical capacity at the national and sub-national levels as a key challenge that restricts evidence based planning in the country. However, there are a few examples where the available evidence informed political decisions to discontinue some interventions in response to reduced funding from the Global Fund.

Bulgaria's institutional capacity for robust HIV surveillance and M&E is inadequate, and most importantly, the country has been left without valid benchmarks to assess program effectiveness and optimize future programming. At present, a separate M&E Unit with sufficient capacity for data analysis is functional at the MoH. However, data analysis is limited only to the indicators requested for grant performance reporting, GARPR and ECDC reporting. TB surveillance is more oriented towards descriptive rather than inferential analysis. More in-depth analysis exploring risk factors and group-segregated analytical studies would have generated the evidence on which TB national policy and programming should be built.

In Georgia, a M&E unit was established in 2013, supported by a specific working group composed by government and non-governmental experts that focuses on identifying and addressing issues in M&E processes. This working group is tasked with critically assessing the system, identifying data flow gaps and developing recommendations[42]. Importantly, data analysis is viewed as weak for both diseases and the MoH is not seen as using HIV and TB surveillance data for decision-making. This is exacerbated by the fact that, while the

[42] Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

AIDS Centre takes these functions voluntarily for HIV, it is unclear who is explicitly tasked to perform these functions for TB.

Important progress has been made in Ukraine in establishing and consolidating a national monitoring and evaluation system, generating epidemiological information, as well as funding flows and service provision levels, including those delivered by the NGOs. It is a common practice in all sectors of the country to use official statistics for planning purposes. Similar to other sectors, the MOH only uses data from routine surveillance for annual, which often results in the underestimation of annual service requirements and commodity needs, and in shortages of funds and commodities for effective implementation of the national TB and HIV/AIDS response. This practice undermines the comprehensiveness of the data generated by national M&E for both diseases and reduces national capacity for adequate planning and disease response.

SUMMARY OF ORGANIZATIONAL CAPACITY: The absence of a centralized public entity with overall planning and oversight responsibilities in Belarus, Georgia, and Ukraine raises sustainability risks after transition from Global Fund support.

While supply management systems are fully integrated into national systems (except in Ukraine), procurement in Belarus, Bulgaria and Ukraine and in some instances Georgia will most likely face challenges after Global Fund support ends if the following weaknesses are not addressed during the transition process:

- The lack of integration of the Global Fund grant procurement into national procurement systems (Belarus, Bulgaria Ukraine);
- National procurement legislation restricting international procurement (Belarus);
- Noncompliance with drug registration requirements and inclusion of the Global Fund procured medicines and consumables into the list of drugs and items subject to national procurement (Belarus, Bulgaria, Ukraine);
- The absence of drug quality control mechanisms (in all countries);
- The lack of price regulation mechanisms (Belarus, Ukraine).

M&E units responsible for specific disease program monitoring and evaluation are placed at public institutions in all four countries and produce regular reports that lack the quality of analysis that should guide respective disease program planning. In Belarus and Georgia, the M&E structures remain fragmented, parallel systems for HIV and TB, and in the case of Georgia functions and responsibilities of respective institutions are not well/clearly defined. Overall, analytical capacity in all studied countries is largely lacking, which poses a challenge to effective disease program planning and implementation during and after Global Fund support.

4.2.3.3 TRANSITION PLANNING

A direct measure of forward thinking for HIV and TB programs currently receiving external funding in any country is the ability to plan the take-over of responsibilities both at the programmatic level and in terms of funding. In this area, elements such as the existence of a legally binding plan with clear time-bound activities and a dedicated budget for transition were assessed for both diseases.

This was the area where none of the countries scored well. In the case of Belarus, Bulgaria and Ukraine, steps have been identified for transition, but they have not been developed into a transition plan or as a part of the national program.

Table 32: Transition preparedness

Indicators	Disease	Belarus	Bulgaria	Georgia	Ukraine
Transition plan / elements:					
Legally binding and actionable transition plan exists	HIV	No	No	No	No
	TB	No	No	No	No
Draft transition plan exists	HIV	No/Few elements	No	No	No
	TB	No/Few elements	No	No	No
Transition elements embedded into the legally empowered national program / NSP/NTP	HIV	Yes	No	No	No
	TB	Yes	No	No	No
Transition plan characteristics:					
Clearly identifies time-bound activities to be implemented during transition	HIV	n.a	n.a	n.a	n.a
	TB	n.a	n.a	n.a	n.a
Clearly outlines roles and responsibilities of a Transition process management	HIV	n.a	n.a	n.a	n.a
	TB	n.a	n.a	n.a	n.a
Incorporates M&E indicators for transition process	HIV	n.a	n.a	n.a	n.a
	TB	n.a	n.a	n.a	n.a
Incorporates budget for transition	HIV	n.a	n.a	n.a	n.a
	TB	n.a	n.a	n.a	n.a
Transition M&E	***Both***	n.a	n.a	n.a	n.a
M&E is followed		n.a	n.a	n.a	n.a
CSO participates in the transition updates		n.a	n.a	n.a	n.a

Belarus, in response to the Global Fund's communication about the termination of funding by the end of 2018, started a transition planning process. Some important elements necessary for transition have been identified and embedded in the legally approved national plans/strategies, and therefore implementation of selected activities is already underway. However, Belarus lacks a comprehensive vision for transition that clearly identifies critical, time-bound activities, outlines roles and responsibilities, incorporates monitoring and evaluation indicators and allocates sufficient budgetary resources for its implementation. Planned and/or implemented transition elements are described in more detail in the text box on the next page.

In Bulgaria, transition planning was limited due political instability over past three years. The country began developing a transition plan in 2012, but did not finalize it. However, the government has recently intensified its planning for HIV program transition in 2015 by developing an ambitious plan expressed in the no-cost extension proposal to the Global Fund, which envisages major transitions taking place in 2016 when the Global Fund grant ends. However, no visible actions had been taken by June 2015, and civil society groups expressed skepticism whether the transition objectives would be achieved. This is partly due to the fact that the Global Fund sustainability study was conducted in May-June 2015,

when there were only a few months left to achieve the goals of the plan. Nor were any steps taken to ensure the gradual and smooth transition of the TB program.

In Georgia, discussions about the transition from the Global Fund support started in early 2014, when the New Funding Modality (NFM) was introduced and the government received an official letter from the Fund about the changed funding conditions and the willingness to pay requirement. The first state document to mention that the government should assume the financial responsibility to gradually take over the Global Fund program was the Georgian Healthcare System State Concept 2014 – 2020. While Georgia has yet not begun the transition process, it has started to develop the national disease specific strategies and concept notes for HIV and TB programs according to Global Fund requirements, following the WHO's review of the programs. The commitment to develop detailed transition plans for both diseases is included in the concept notes, and the development of these documents will start from 2016.

Ukraine has started transition planning by discussing some of the elements necessary for take-over, but specific steps have not been formalized yet, and the continued provision of services for KP is an important concern. For HIV, initial steps have included the following: evaluating the HIV program to inform the optimization of public funding; developing an HIV investment case; identifying the effectiveness of HIV services; and optimizing treatment regimens for emergency ARV procurement, etc. UNAIDS and USAID have also expressed willingness and are supporting the development of a transition plan.

SUMMARY OF TRANSITION PLANNING: Three out of the four countries studied do not have plans in place. In the case of Belarus, there is no transition plan approved by the government, although plans for some elements to be transitioned are developed and do specify time-bound activities to be implemented over coming years. These plans lack clarity on roles and responsibilities during the transition process, such as who will lead the response and who will take over specific activities. At the same time, they do not include measureable indicators to track progress and most importantly, they do not include a budget, making it difficult to evaluate the resources that will be necessary for transition.

The Global Fund has clearly communicated to the Government of Belarus the ending of the GF funding by the end of 2018. In this respect, the transition planning has started the following:

- **Building program management and procurement capacity:** To enhance national ownership of the HIV and TB programs, the decision was taken to transfer its management from UNDP to a governmental institution. In this regard, the new PR's capacity has been assessed and steps to strengthen it have been planned with clear roles and time frame.
- **Building procurement capacity:** To mitigate the new PR's procurement capacity weakness, an agreement has been reached with the Global Fund that, in 2016, UNDP will remain responsible for the procurement of drugs and commodities and allow the development of the PR's procurement capacity in accordance with the Capacity Development Plan, which was jointly designed by the new PR, MOH, the Global Fund and UNDP. The plan includes training on forecasting, supply management, procurement, drug distribution, and patent law. This 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. Commodities such as rapid tests, condoms and lubricants were added to the list of medical products for public procurement.
- **Institutionalization of social contracting** for services provided by NGOs and the mobilization of financial resources has been another element of the transition preparedness addressed by the country. The model for a social contracting mechanism has been developed and piloted. In 2014, amendments were introduced to the Budget Code on financing HIV prevention activities (counseling, HIV testing, purchase of consumables) from the local budgets by adding a separate budget line for social contracting. The introduction of an interdisciplinary team-approach at medical care facilities to improve ARV treatment adherence, enforce lost to follow-up mechanisms and gradually take over needle-and-syringe exchange programs was approved. The change will be funded by the local budgets starting from 2016. So far, two regions, Gomel and Brest, have allocated funding for 2015-2016 from the local budgets for social contracting, although the recruitment of social workers has not started yet.
- **A new regulation on the standard package of HIV prevention services** for PWID, MSM and FSW is approved;
- **Enhancement of TB treatment adherence:** The introduction of publicly financed food packages required the preparation of a political platform by the MOH at all government levels, involving the CCM, NAC, Cabinet of Ministers and local governments. In order to justify public financing of the packages for treatment adherence, a thorough analysis of the weaknesses of the PHC sector was carried out. A pilot project, with the Global Fund's financial backing, was developed to demonstrate the economic benefits of this type of social support. As a result, the Ministry of Health approved Decree №21 of 18 February 2015 "On the approval of additional high-calorie food products support for TB patients on ambulatory treatment", which was also endorsed by the Ministry of Finance and the Ministry of Social Wellbeing. Three types of food packages have been standardized for TB treatment adherence, especially for MDR TB cases. The decree also ensures the allocation of US$20 per patient per month, financed through local government's health care budgets. Starting from 2016, incentives in the form of food packages will be fully funded from public sources to all eligible patients countrywide.
- **Support of DOTs strategy:** Financial incentives for health care personnel at the PHC level in support of DOTs strategy has been piloted in selected regions and will be scaled up nationally from 2016. The funding for the incentives was obtained by optimizing bed capacity and allowing regional and district health authorities to redirect released funds.
- **TB Human Resources:** To ensure an adequate workforce supply to the TB system, it was decided to revise the clinical competencies of pulmonologists and TB to allow pulmonologists to treat TB patients. This will enable them to fill in the physician shortages in the TB system. Furthermore, it was decided to allow "feldshers" to serve as physician assistants, which would entail training them on how to communicate

4.2.3.4 SUMMARY FINDINGS OF PROGRAM SUB-DOMAIN ASSESSMENT

In this report the program is characterized as the level where disease-specific activities are rolled-out, drugs and supplies are procured and distributed, and program activities and results are effectively monitored and evaluated. It also examines country readiness for transition by looking at transition planning.

Table 33: Summary of T&S risk assessment for Program

	Disease	Belarus	Bulgaria	Georgia	Ukraine
Service Delivery	HIV				
	TB				
Organizational Capacity	Both				
Transition preparedness	HIV				
	TB				

The findings revealed that Bulgaria and Georgia are doing relatively well in terms of service delivery in both programs, which is not the case for Belarus and Ukraine (Table 33).

Out of the four countries, Bulgaria has stronger national capacity to assume programmatic and financial responsibilities after transition. This might also be the case for Belarus, where the evaluation of program management activities, and the interaction between the PRs and the national program management, will improve with the appointment of the new government PR. However, Georgia is still lagging behind in its TB program management, which has meant that the PR is managing the Global Fund grant and is responsible for the disease surveillance component separately from the general TB response. The situation in Ukraine is more problematic, as it has weak organizational capacity and procurement and supply chain management has not been integrated into the national system.

The capacity to use evidence for decision-making, specifically planning and budgeting, needs to be strengthened in all of these countries. Procurement also needs strengthening in all countries. Although the situation in Georgia is more positive, mechanisms should be put in place to ensure the transparency of the procurement process and that countries do not pay significantly higher prices for drugs and commodities compared to international price benchmarks.

Of particular relevance for transition is the ability of these countries to plan for transition early on and include it within their HIV and TB programs. The absence of legally binding plans[43] developed in close collaboration with all key government and non-governmental stakeholders in these countries could make national resource allocations after the end of external funding difficult.

[43] An agreement between two or more legally empowered (within a given sovereign country) parties on the transition plan that can be enforced in a given sovereign state either by law, decree and/or through other legal instruments.

CHAPTER 5. CONCLUSIONS AND RECOMMENDATIONS

These case study findings provide a general overview of the readiness of these countries to transitioning away from the Global Fund. As mentioned previously, the evaluated domains, sub-domains and relevant components were assessed separately in order to identify the challenges that can be addressed for each of the diseases. However, these components are closely interrelated, as confirmed by our case study findings. Table 34 summarizes the level of risk for transition for each of these components in the four countries. This assessment allows decision-makers and country stakeholders to prioritize areas that need to be addressed during transition planning through national/sub-national consultative process. The transition plan should be a prioritized action plan to take over responsibilities to ensure the long-term sustainability of the programs. Therefore, the use of the TPAF makes it easier to spotlight and agree on clear next steps through national dialogue and consensus. The assessment of the transition preparedness should be made by component and not by domains or sub-domains. In this sense, the components highlighted in green have shown progress prior to transition and entail lower risk. These components could be maintained at current or higher levels, but given the lack of risk they do not necessarily need to be included in the transition plan. Components with moderate risk (in a yellow zone) need to be included in the transition plan, but primarily for monitoring purposes; in case the risks increase, action should be taken. Alternatively, some additional activities could be planned if stakeholders decide to do so through a consultative process.

Table 34: Transition assessment visualization for the four countries

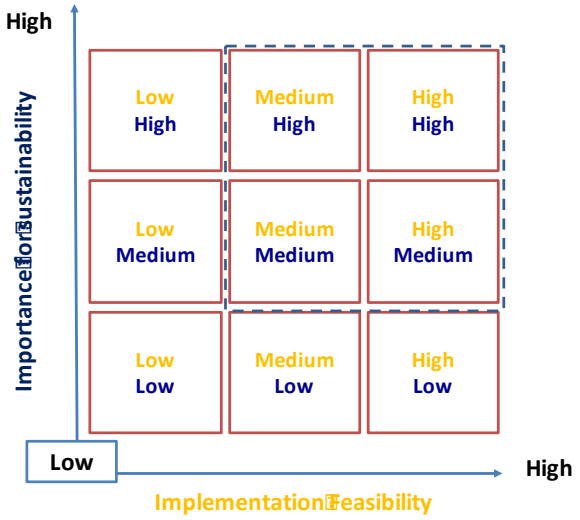
Domain/Sub-domain/Component	Belarus	Bulgaria	Georgia	Ukraine	Component Assessment
External Environment					
Political					
Economic					
Internal Environment					
Inputs					
Financing					
HR					
HIS					
Governance					
Governance					
Accountability					
Program					
Service delivery					
Organizational capacity					
Transition preparedness					
Overall country risk assessment	Moderate to High risk	Moderate to High risk	Moderate to High risk	High to moderate risk	

The areas highlighted in red require higher levels of attention and prioritization. These components warrant inclusion in the transition plan along with risk mitigating activities, after prioritization and full consideration of the contextual factors. In order to account for context, stakeholders should prioritize components by examining their importance to sustainability and their implementation feasibility. Clear steps to address these areas should be developed early on, with clear milestones from the start to adequately measure progress over time. Clear responsibilities for implementation should

also be assigned, and adequate resources and time should be allocated to their implementation.

Our overall scoring method shows that Belarus, Bulgaria and Georgia are at a moderate to high-risk for effective transition, while Ukraine is at a high to moderate risk. However, each country has components that are at moderate to high risk or high-risk, and deserve attention during transition planning and implementation. In order to select the components that have to be prioritized during transition planning, we suggest the organizational framework presented in Figure 22. This framework could be helpful during national consultations that should be informed by the findings of TPAF. However, the selection and prioritization of components to be addressed during transition, have to be based on a) their importance to sustainability (blue) and b) their implementation feasibility (yellow) within the timeframe afforded for transition. Obviously, if all the components are discussed by the stakeholders and mapped on the framework, those with higher importance and higher implementation feasibility have to be considered i.e. shaded quadrant in the upper-right hand side. This will help stakeholders identify WHAT needs to be done, but further discussions are warranted to identify HOW these activities have to be carried out. Therefore, we will now try to unpack the issues that may inform the HOW question for these discussions.

Figure 22 Framework for transition planning



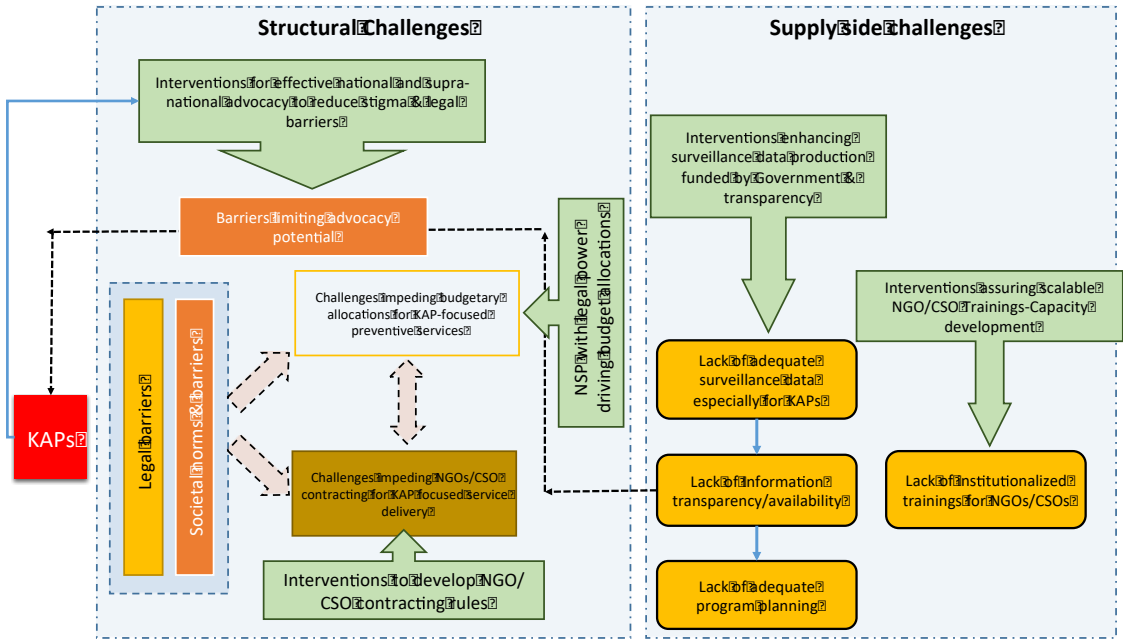
As the findings show, there are several challenges to sustainable transition. However, since an epidemiological perspective highlights the importance of KP as key drivers of the epidemics, mostly for HIV/AIDS, it is important to draw conclusions about the transition challenges that affect these population groups. Consequently, Figure 23 attempts to visualize and link study findings around KP by separating them into structural and supply side related challenges.

Structural challenges include legal barriers, which at times criminalize KP activity, along with societal norms, beliefs and stigma that are most likely working together and preventing legal changes. Consequently, both seem to be major impediments to national programs and require active advocacy and education at the national, and at times supranational levels (see arrow box on the top). Moreover, both factors most likely prevent elected and/or appointed politicians from advocating for interventions focused on KP; as a result, these groups are not prioritized during the political/budgetary process. Most likely, this is the reason why past advocacy efforts have not led to budgetary allocations for KP-focused interventions in the studied countries. Therefore, in an environment where there is no public funding for preventive and care activities focused on KP, these activities still depend on external/Global Fund support and pose the biggest challenge to sustainable

transition. These groups are drivers of the HIV/AIDS and TB epidemic, and unless adequate national resources are secured, public health gains achieved by the countries could evaporate after transition.

Obviously, this challenge is not unique to these countries and has been observed in other parts of the world where the Global Fund[44],[45] plays key roles in funding services for key population groups. We have also noted that NGOs/CSOs are the critical service providers for preventive and care services for KP. However, without the national budgetary resources, governments are not rushing into developing the NGO contracting mechanisms that is an absolute prerequisite to replacing external funding with the national funding, and for keeping NGOs/CSOs continuously engaged in service provision to KP. All of these puts KP-related transition challenges in a vicious cycle, which is hard to break. Consequently, transition and the future sustainability of the national responses will be undermined unless the vicious cycle is addressed in a timely manner. Looking at this situation three potential solutions, reflected in Figure 23, come to mind. Namely, it will be critical to: a) continue with **national and, possibly supranational, advocacy** and educational efforts aimed at reducing public resistance/stigma, enacting legal changes decriminalizing certain activities, reducing legal barriers to services and facilitating national budget allocations; b) developing and enacting **NSP that has sufficient legal power to drive national investments** for KP-focused interventions; and c) developing and implementing rules that **clearly define the steps required for NGO/CSO contracting** (see box arrows on the left hand side of Figure 23).

Figure 23: Critical transition challenges affecting KP-focused interventions



[44] McCoy, D., Chand, S. And Sridhar, D. (2009). Global health funding: how much, where it comes from and where it goes. Health Policy and Planning, 24, 407-17.

[45] Oomann, N, Bernstein, M and Rosenzweig, S. (2007). Following the funding for HIV/AIDS: a comparative analysis of the Global Fund and World Bank MAP in Mozambique, Uganda and Zambia. Center for Global Development, HIV / AIDS Monitor, 2007 Oct 10. [98]. Available at: http://www.popline.org/node/199919#sthash.qwuwwClB.dpuf

While prevention in KP could be the last element to be transitioned, it is 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 and aided transition[46].

Another set of transition challenges emerges from supply side factors, which could be sub-divided into two parts (see **Figure 23**). The first is weak or inadequate surveillance and program monitoring, which produces inadequate data for decision-making and for national program planning. This challenge is compounded by the lack of, or inadequate, sovereign transparency requirements for the information produced with public funds. The lack of information – epidemiological, programmatic or financial – emerges as a major barrier, significantly limiting potential advocacy that could be conducted by civil society groups, external partners and/or other stakeholders, like journalists. Consequently, another vicious cycle emerges, which hinders national program/response planning and impedes effective public/civil society engagement with the government, as civil society is unable to identify problems and advocate for the necessary changes. While critical/essential data and information production (even if it is of limited quality) is completely donor dependent, sustainable transition is even more at risk. Consequently, three critical needs emerge: a) **improving the quality/reliability of surveillance** information during or before transition; b) **shifting funding responsibility for data generation** and analysis onto governments in a timely manner, or alternatively securing longer-term external funding for critical information reproduction; and c) **assuring data** (epidemiological, programmatic and financial) **transparency and accessibility to public**. Over the past decade, many development agencies have imposed data transparency requirements on the countries they support and have requested donor-supported data to be made available and easily accessible in the public domain. Therefore, embarking on a similar path may be an option for the Global Fund to consider, while providing grant financing during transition period. All of this would certainly help **national planning** and **public accountability.**

Another supply challenge relates to human resource development in general (for both HIV and TB programs), but KP-focused interventions obviously also includes NGO/CSO trainings. We have noted that this activity is mainly externally funded and not well institutionalized. **Addressing human resource challenges** should be viewed in two parts: a) assuring an adequate quantity and re-distribution of the necessary human resources; and b) continuous education for the professionals involved in the national response – service provision. The Global Fund has supported continuous education in several countries[47], not only those included in this study. However, the sustainability of these trainings raises concerns due to the lack of institutionalization achieved during the grant implementation[48]. Consequently, the transition period has to be explicit about what could be achieved in terms

[46] Ibid 38

[47] 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.

[48] Ibid 98.

of preparing the necessary human resources and how this function can be institutionalized, 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 entire health care system. Therefore, while this is a critical area for sustainable transition, it may be slightly less feasible than the ones discussed earlier, and definitely requires attention during the transition process. Alternative models for human resource reproduction have to be considered beyond conventional ones. **Alternative models could assure scalable delivery of the necessary trainings and at a lower cost** by using technology innovations available on the market.

Effective national coordination, with or without a CCM, 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 a space for governments and civil society to engage jointly in national/global response planning and coordination[49],[50],[51]. In most states, CCMs, or similar structures, formally provide a seat and voice for NGOs/CSOs in the national coordination, and have been critical in achieving the gains observed globally. Consequently, retaining and/or enhancing effective coordination structures is important in many countries after the Global Fund support[52]. 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 of and easy access to information should be ensured**.

Our analysis has also identified other important areas for consideration during transition planning. Namely, current governance arrangements will require thorough consideration. Therefore, in addition to enhanced national coordination it would be critical to **assure effective management of national programs**. Effective management in this case encompasses both institutional arrangements that allow for legal powers for the lead agency to influence the implementation of national programs, and individual leadership within such agencies. The capability of national program managers (institutions and individuals) could also be the source of significant transition risks. Capturing these risks with the help of TPAF and increasing governments' awareness about these challenges may lead to transition activities to remedy the situation.

Finally, we have noticed that countries remain heavily reliant on the Global Fund to finance necessary drugs and other consumables-commodities. Therefore, **gradually reducing financial dependence on the Global Fund** is critical. Some countries already have plans to reduce dependence on the Global Fund, most likely at the request/push of the Fund itself. However, the actual pace of reduction on external funding seems slow, relative to the

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[49] 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.

[50] 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.

[51] 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 .

[52] Ibid 98.

economic strength of these countries. The experience of other countries[53] show that timely reduction in Global Fund dependence, at least regarding commodities, makes the transition process smoother and increases the odds of sustainability – particularly when the GF contribution to the national response is not significant, i.e. less than 25%. Consequently, the country has to strive to gradually reduce its dependence on external support. The first and **most important area to consider for transition is commodity procurement**, so that national procurement mechanisms function adequately. Secondly, **planning for more aggressive service integration** may also create efficiency gains and so increase the resources needed to financially sustain country programs.

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

ANNEX 1: TRANSITION RISK ASSESSMENT TABLE – FOUR COUNTRY FINDINGS

H – HIV/AIDS

T – Tuberculosis

B – Both diseases

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
			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 1.1. Share of Government spending out of THE was stable and high until 2012, decline was noted in 2013 although remains high (65%)	1.1. The share of Government spending on health out of General Government Expenditure is increasing 1.2. The share of government spending on health out of THE is increasing.	1.1 The share of Government spending on health out of General Government Expenditure is low, decline was noted in 2011-2012 with increasing trend in 2013 1.2. The share of government spending on health out of THE is increasing.	1.1. Stable high government spending on health around 12% out of total General Government Expenditure, albeit deterioration noted due to economic challenges emerging in 2013 -2014. 1.2. Stable share of Government spending on health out of THE
	P	**B**	2 Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for KP and people living with diseases. 3 Strong Rule of Law	2 There are legal barriers that hinder effective prevention, treatment, care and support for KP and people living with diseases.	2. Legislation in Bulgaria does not create barriers to HIV and TB programs 3. Laws are not effectively enforced to protect KP	2. Restrictive drug policy, no legal basis for the needle exchange activities create certain barriers for HIV program. Legally not regulated sex work is considered as hindering factor.	2. There are no major legal barriers that hinder effective prevention, treatment, care and support for KP and people living with diseases. 3. Laws are not effectively enforced and administratively

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
					from discriminations	3. Laws are not effectively enforced to protect KP from discriminations	some KP face challenges when accessing services
	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	4.General regulation allowing CSO contracting exists 5. CSO contracting is practiced in social sector	4. General regulations allowing CSOs contracting exist 5. CSO contracting is practiced in social sector	4. General regulation allowing CSO contracting exists 5. CSO contracting is practiced in social sector
				2	**5**	**4**	**4**
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 Share of General Government Revenues (excluding grants) as % of GDP is more than UMIC mean (30.0) in 2012 year	1.1. GDP per capita growth (annual %) is observed since 2010 Share of General Government Revenues (excluding grants) as % of GDP is slightly higher than UMIC mean (29.0) in 2012 year	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 LMIC mean (25.7) in 2012 year	1.1 GDP per capita decrease (annual %) is observed in 2014 due to armed conflict 1.2 Share of General Government Revenues (excluding grants) as % of GDP is more than LMIC mean (37.3) in 2012 year
				2	**2**	**2**	**1**
Internal Environment							

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
			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	1.1 Public Expenditure on HIV program is increasing 1.2 The share of public spending on HIV accounted for 66% of total AIDS spending in 2013 1.3 There is dedicated budget line for the program integrated in the national budget. Costed NSP not yet approved as of June 2015, however multiyear financial plan incorporates previous NSP.	1.1 Public expenditure on HIV program is increasing 1.2 The share of public spending on HIV accounted for 46% of total AIDS spending 2014 1.3 There is a dedicated line in MTEF and aligned with NSP	1.1 Public expenditure on HIV program is NOT increasing. Political will is lacking in prioritization of HIV/AIDS Program during resource allocation. The budget of the health sector has been increased by 10% in 2014 in response to NGO's aggressive lobbying, however additional funding has been redistributed to other state programs by the MOH leaving HIV unattended 1.2 Share of public funding is approximately 44% of total AIDS spending in 2014 1.3 Budget lines exists but NOT aligned with NSP needs
	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%	1.1 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	1.1 Public Expenditure on TB program is increasing 1.2 The share of public spending on TB accounted 80% of total TB spending in 2014 1.3 Costed TB program – approved. There is dedicated budget line	1.1 Public expenditure on TB program programs is increasing 1.2 The share of public spending on TB accounted 56.7% of total TB spending in 2014 1.3 There is a dedicated line in MTEF and aligned with NTP	1.1 Public expenditure on TB program is NOT increasing. Political will is lacking in prioritization TB Program during resource allocation. The budget of the health sector has been increased by 10% in 2014 in response to NGO's aggressive lobbying, however additional

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
			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		for the program integrated in the National budget and multiyear financial plan.		funding has been redistributed to other state programs by the MOH leaving TB unattended 1.2 The biggest share (47.7%) of total NTP expenditure is covered through central and local budget sources in 2013, whereas external funding accounts for only 19%. 1.3 Ukraine has never performed detailed calculation of all TB activities and estimation of a total budget
	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. 2.1 Preventive programs for KP are primarily financed from external sources.	2.1 No public spending on HIV prevention for priority groups (PWIDs, SWs. MSM) has been reported 2.2 While share of public spending out of total HIV spending on prevention remains stable, public spending on HIV prevention for priority groups (PWIDs, SWs. MSM) has not been reported	2.3 Total public spending on HIV prevention for priority groups not increasing 2.4 Share of public spending in total spending for priority groups not increasing	2.1 Overall spending on HIV prevention is not increasing. 2.2 Preventive programs for KP are primarily financed from external sources. Budget for preventive activities has been decreased over the last couple of years

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
	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	3.1. There are no allocative efficiency studies conducted in Bulgaria	3.1 Allocative efficiency study was conducted in Georgia. OPTIMA study proved that allocations in NSP and new CN are efficient in terms of possible impact. 3.2 The study was done in parallel with the NSP and CN development, so the study has not informed the allocations just proved they were right.	3.1 Allocative efficiency study was conducted in Ukraine 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 4.1 Adherence support fully funded by external sources	4.1 Case detection / diagnostics is partially funded from public sources 4.2 ARV drugs are fully funded by public sources 4.2 Adherence support services are limited and fully funded by the TGF	4.3 Case detection and diagnostics are partially funded from public sources 4.4 ARV drugs 4.4.1 First line ART partially funded by public sources 4.4.2 Second line ART-fully funded by TGF 4.5 Adherence support is fully funded by TGF	4.1 Case detection/diagnosis mostly financed from TGF 4.2 ARV drugs 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 from external sources
	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	4.1 Case detection/ diagnostics is partially funded from public sources 4.2 TB Drugs 4.2.1 FLD funded by the government 4.2.2 SLDs mostly funded through external resources with the small	4.1 Case detection /diagnostics is partially funded from public sources. Considerable volume of laboratory work is dependent on TGF 4.2 TB drugs 4.2.1 FLDs completely	4.1 Case detection /diagnostics is partially funded from publics sources 4.2 TB Drugs: 4.2.1 FLD-partially funded from public source 4.2.2 SLD/MDR-XDR-fully funded from TGF	4.1 Case detection mostly funded from public sources 4.2 TB Drug 4.2.1 FLD funded from public sources 4.2.2 SLDs mostly funded from external sources 4.3 Adherence support completely TGF dependent

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
			(SLD) 4.3 Adherence support	share publicly financed 4.3 Adherence support completely TGF dependent	funded from public sources 4.2.2 SLD funded from TGF funds. Though there is a well-evidenced intent of the Government to take over the SLD starting from 2018. 4.3 Adherence support services (for MDR TB patients and for underprivileged TB patients, and children with TB) are completely TGF dependent.	4.3 Adherence support - partially covered from public sources	
	F	**H**	5 Prevention financing from public sources 5.1 Funding of Low Threshold Services (excluding OST) from public sources 5.2 Funding of OST services from public sources	5.1 Low Threshold Services (excluding OST) are not funded from public sources 5.2 OST mostly funded from TGF grant	5.1 Low threshold services are not funded from public sources 5.2 OST services are funded from public sources on a co-payment basis.	5.1 Low threshold services are not funded from public sources 5.2 OST services are mostly funded by public sources on a co-payment basis. There are challenges, i.e. psycho-social component is not included.	5.1 Low Threshold Services (excluding OST) are not funded from public sources 5.2 OST mostly funded from TGF grant
				5	**5**	**5**	**3**
Human Resources	**HR**	**H**	1. Sufficient human resources for a disease (quantities, geographic distribution and aging)	Severe shortage of specialists, geographical misbalance, high turnover and lack of motivation	Sufficient. Inadequacy of human resources for HIV was not raised by stakeholders, or noted in	Sufficient. Inadequacy of human resources for HIV was not raised by stakeholders, or	Sufficient. Inadequacy of human resources for HIV was not raised by stakeholders, or noted in any publications. However,

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
				are common	any publications. However, downsizing of HIV staff is expected after the GF ends.	noted in any publications.	downsizing of HIV staff is expected after the GF ends.
	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.	With some limitations. There is a lack of TB professionals; aging of staff raises serious concerns; uneven geographic distribution of TB HR was noted by majority of stakeholders; low salaries of TB medical staff and hazardous work environment distract young people to work in the TB field.	With some limitations. There is a lack of TB professionals; aging of staff raises serious concerns; uneven geographic distribution of TB HR was noted by majority of stakeholders; low salaries of TB medical staff and hazardous work environment distract young people to work in the TB field.	With some limitations Relatively adequate although only 87% 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. TGF supported trainings for health personnel are not institutionalized in national education system 3. The policy for production/training of CSO personnel does not exist; 2. TGF funded salaries are not aligned with national pay-scale	3. TGF supported trainings for health personnel are not institutionalized in national education system 4. The policy for production/training of CSO personnel does not exist; 5. TFG funded salaries are aligned with the national pay-scale	1 TGF supported some trainings (especially for HIV) have been institutionalized into the national education system 2 Policies for CSO personnel production exist but are rather weak 3 TFG funded salaries are not aligned with the national pay-scale and are significantly higher
				2	**3**	**3**	**3**

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
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	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 Electronic database prevails; disaggregation is limited	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	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, partially advanced	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, partially advanced	1.1 TB new and relapse cases-integrated, advanced 1.2 TB treatment registry – integrated, advanced 1.3 Pediatric treatment-integrated, advanced 1.4 MDR TB reporting-integrated, advanced 1.5 Care and support (incl. pediatric) – integrated, advanced	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, partially advanced

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
					1.1 Both- electronic and paper-based reporting system; TB laboratory, particularly National Reference Laboratory uses paper-based reporting. TB reporting follows WHO R&R standards		
	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	2.1 IBBSs lack rigorous methodology 2.2 IBBSs have not been conducted since 2012 2.3 IBBS NOT funded from public sources 2.4 PSE lacks rigorous methodology and NOT funded from public sources	2.1 Rigorous methodology used for IBBS 2.2 IBBS Implemented timely (according to NSP) 2.3 IBBS NOT funded from public sources 2.4 PSE NOT funded from public sources	2.1 Rigorous methodology used for IBBS 2.2 IBBS Implemented timely (according to NSP) 2.3 IBBS NOT funded from public sources 2.4 PSE NOT funded from public sources
				3	**2**	**4**	**3**
			Governance				
Governance (Political support,	**G**	**H**	1. Strong political commitment to diseases 1.1. NSP with legal and enforceable power in a given country context	1.1 Belarus has government approved NSP for HIV/AIDS covering period 2014-2015 1.2 New NSP submitted for government's approval	1.1 Does not exit 1.2 NSP to Control HIV/STIs in Bulgaria is in preparation 1.3 HIV/AIDS is prioritized in	1.1 Does not exist 1.2 NSP exists, however without legal and enforceable power 1.3 HIV/AIDS is prioritized in National health strategy	1.1 Ukraine's parliament approved the Law on HIV/AIDS covering period 2014-2018 (alternative to NSP)

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
Program leadership, Coordination)			1.2. NSP in preparation or without legal and enforceable power 1.3. HIV/AIDS as a priority in National Health Strategy document	1.3 HIV/AIDS NOT prioritized in National Health Strategy Document	national health strategy document	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	1.1 NTP with legal and enforceable power exists; 1.2 N/A 1.3 TB is prioritized in National Health Strategy document	1.1 Does not exist 1.2 NTP has no enforceable and legal power 1.3 TB is prioritized in National health strategy document	1.1 Country develops a new National Program for the period of 2015-2018 awaiting Government's approval (under the leadership of UCDC).
	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. 2.1 Individual leadership is visible	2.1 There is a legally empowered leading organization, however it does not seem to be very effective. 2.2 2.2 HIV/AIDS has an individual leader advocating for HIV program	2.3 MoLHSA's health department is responsible for overall management of all health programs including HIV/AIDS. National CDC and National AIDS center are legally empowered leading organizations to manage Preventive and Curative fields respectively. Both entities are affectively functioning 2.4 HIV/AIDS has an individual leader	2.1 There is no entity fully responsible for the national Disease program. Following reorganization the management responsibilities are not transferred to other entity due to its absence (the entity should be formed at MoH). Ukrainian AIDS center is legally empowered but complexities of public management impose significant limitations on

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
						(National AIDS center) advocating for HIV program	its powers. Functioning is with some limitations 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 Individual leadership is visible	2.1 There is a legally empowered leading organization, however it does not seem to be very effective. 2.2 Yes, there is an leader advocating for disease specific program	2.1 There is no effectively functioning legally empowered leading organization 2.2 TB program Individual leader is not visible	2.1 Ukrainian AIDS center is legally empowered but complexities of public management impose significant limitations on its powers. 2.2 Individual leaders exist but less visible then in TB
	G	**B**	3. Strong coordination mechanisms 3.1 Coordinating body adequately placed within the government hierarchy and legally empowered within the national Government structure to assure adequate coordination across the sectors 3.2 CSOs have a legally determined seat in the coordinating body 3.3 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.	3.1. Coordinating body is well placed within the government hierarchy to assure adequate national coordination and coordination across different sectors - established by the ordinance of the Council of Minister 3.2. CSOs have legally determined seats in the coordinating body. 3.3. Coordinating body effectiveness is not adequate - not all decisions are documented and considered by the	3.1 Coordination body (CCM) is well placed within the government hierarchy to assure adequate national coordination and coordination across different sectors – established by the Government resolution; 3.2 CSOs have legally determined seats in Coordination body 3.3 Coordination body functions effectively	3.1 Coordination body is not 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 functionality is rather weak and not very effective, especially since resent restructuring.

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
					government and other players		
				7	**6**	**6**	**3**
Accountability	**A**	**B**	1. Program performance results are available and accessible through public domain: 1.1. EPI data including for KP 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	1.1. EPI data including for KP – Available 1.2. Programmatic data and/or reports – Available on request 1.3. Program expenditure data – NOT completely available 1.4. Program M&E reports – Available 1.5. NSP and other periodic reviews – Available	1.1. Epi data including for KP – NOT available through public domain (though that data are available on external websites (WHO, UNAIDS, ECDC)) 1.2. Programmatic data – partially available 1.3. Expenditure data are not accessible through public domain and not readily available upon request 1.4. M&E reports – NOT available (can be obtained upon request) 1.5. NSP reviews are not available through public domain	1.1 EPI data including for KP - Available 1.2 Programmatic data and/or reports – partially available 1.3 Program expenditure data - NOT available 1.4 Program M&E reports - NOT available 1.5 NSP and other periodic reviews – partially available	1.1. EPI data including for KP – Available 1.2. Programmatic data and/or reports – Available 1.3. Program expenditure data – NOT completely 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 [54]	Belarus's EEI for 2013 was 0.41 indicating that there are no	EEI for Bulgaria for 2013 was 0.61. There are no	EEI for Georgia for 2013 was 0.50. There are no law and	Ukraine's EEI for 2013 was 0.56 indicating that there are no

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

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
			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	laws or policies that restrict civil society playing an oversight role,. However in practice civil society is not actively engaged in providing an oversight as it is not accepted by the Government	laws or policies that restrict civil society playing an oversight role and civil society is actively engaged in providing oversight	policies that restrict civil society playing an oversight role, but in practice it is not accepted by the Government.	laws or policies that restrict civil society playing an oversight role, and civil society is actively engaged in providing oversight
				2	**2**	**2**	**4**
			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 1.1 Treatment-adherence outcomes are improving	1.1 There is an increased coverage trend for ART 1.2 ARV treatment outcomes are improving.	1.3 There is an increased coverage trend for ART 1.4 ARV treatment outcomes are improving.	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

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
	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 1.1 The percentage of effective treatment of MDR TB cases that started treatment in 2011 and 2012, is only 50.4%	1.1 Overall TB treatment outcome success rate is improving. 1.2 MDR TB treatment success rate is improving	1.3 Overall TB treatment outcome success rate is improving. 1.4 MDR TB treatment success rate is low	1.1 Over the past 10 years sensitive TB treatment success rate is around 70% 1.2 The percentage of effective treatment of MDR TB cases that started treatment in 2011 and 2012, is only 34.9%
	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	2.1 PMTCT is well integrated in the maternity care 2.2 TB services are still separately standing with limited or no integration into PHC 2.3 TB/HIV are not integrated	2.1 HIV testing for pregnant women are integrated into PHC 2.2 TB integration in primary care is limited 2.3 There is no or minimal integration of HIV and TB services	2.1 HIV testing for pregnant women is integrated in PHC 2.2 TB is integrated in primary care but there are challenges 2.3 HIV/TB services are integrated, but not well coordinated especially in regions	2.1 PMTCT is well integrated in the maternity care 2.2 TB services are still separately standing with limited or no integration into PHC 2.3 TB/HIV services are not integrated but close to emerge even integration with OST services
	S	**H**	3. KP reach with preventive services 3.1 Increasing coverage trend of epidemiologically most important KP with preventive services 3.2 Data based on IBBS studies with rigorous methodology	3.1 Coverage of KP with preventive services is increasing but yet remains l0w (2 data points 2011 & 2013) 3.2 Data is based on rigorous IBBS methodology	3.1 Coverage of KP with preventive services is increasing 3.2 IBBSs do not apply rigorous methodology	3.1 Coverage of KP with preventive services is increasing 3.2 Data based on IBBS studies with rigorous methodology	3.1 Coverage of KP with preventive services is increasing but yet remains low (2 data points 2011 & 2013) 3.2 Data is based on rigorous IBBS methodology
	S	**B**	4. CSOs contracting in health services 4.1 Existence of detailed rules and procedures for	4.1 Detailed rules and procedures for contracting SCO for health service provision DO NOT exist 4.2 There are only few non-	4.1. Detailed rules and procedures for contracting CSOs for health service delivery DO	4.1 Detailed rules and procedures for contracting CSOs for health service delivery DO NOT exist	4.1 Detailed tender procedures for CSO contracting is available in social sector NOT for health sector

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
			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 using public funds	governmental NGOs such as Red Cross, and sport's associations which receive direct subsidies from the state budget	NOT exist 4.2 Government already contracts CSOs for health service provision using public funds. MoLSP has contracted some CSOs for social services. Medical (clinical) service provision is not allowed without medical license	4.2 Government already contracts CSOs to provide social services using public funds	4.2 Government already contracts CSOs to provide social services using public funds, but this is not practiced yet for health services
				3	**5**	**6**	**3**
Organizational capacity (program management, financial management, contracting, procurement, supply chain management,	**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. 1.1 Relationship between PR and national disease management entity not defined at present due to the absence of such entity. PR manages only GF funding.	1.1 Assessment of the MoH as TGF program PR is conducted 1.2 1.2 TGF PR and national program management fully integrated	1.3 Capacity assessment not conducted OR staff performance evaluation not practiced in National Disease Program Management entities 1.4 National Program Management and TGF PR are closely integrated as the Entity responsible for HIV/AIDS prevention and control serves as a PR	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 PRs and national disease management entity not defined at present due to the absence of such entity. PRs manage only GF funding.
	O	**T**	Strong management of the National Disease Program Management Entity (not PR) 1.1. Existence of national program	1.1 Capacity assessment of the National Disease Management entity (Republican Scientific and Practical Centre for Pulmonology and	1.1 Assessment of the MoH as TGF program PR is conducted 1.1 1.2 TGF PR and national program	1.2 There is no entity empowered to manage national TB program, therefore its capacity assessment has not been conducted	1.1 Due to absence of an entity responsible for overall management of HIV/AIDS program its capacity assessment has not been conducted.

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
research and M&E)			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	Tuberculosis) is NOT conducted, and staff appraisal is not a regular practice. 1.2 Although the Entity has sound working relationship with the PR they are distinct public agencies.	management fully integrated	1.3 Relationship between PR and national disease management entity not defined at present due to the absence of such entity. PR manages GF funding and responsible for disease surveillance component of the National TB Program.	1.2 Relationship between PRs and national disease management entity not defined at present due to the absence of such entity. PRs manage only GF funding.
	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	2.1 TGF funded procurement is conducted using national system 2.2 Supply chain management is fully integrated into the national system 2.3 NO emergency procurements were reported 2.4 NO stock outs were reported 2. 5 Limited access to the data about unit prices for drugs and test kits	2.1 TGF funded procurement is conducted using national system 2.2 Supply chain management is fully integrated into the national system 2.3 NO emergency procurements were reported 2.4 NO stock outs were reported 2.5 Paying NOT MORE than 5% above the international benchmark price	2.1 TGF funded procurement is NOT integrated in the national system 2.2 Supply chain management is NOT integrated into the national system 2.3 Low frequency of emergency procurements for drugs reported in 2013 2.4 Stock outs for drugs (not more than once for last year) NOT detected 2.5 If national procurement – PAYING MORE than 5% above the international benchmark price

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
	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	3.1 There is a moderate analytical capacity at public sector 3.2 Collected data, though not completely accurate, is used for evidence-based program management	3.1 There is limited analytical capacity. Analytical reports are not produced by public sector 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	3.1 Both indicators could be rated as partial. Although there a lot of analytical reports in Ukraine, 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	**7**	**4**	**1**
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	A separate transition plan for HIV will not be developed due to time limitation (Bulgaria will graduate from TGF support for HIV program by end of 2015). Transition will be incorporated into HIV new State program	1.1 Legally binding and actionable transition plan does not exist 1.2 There is no draft for the transition plan but there is a deadline when it should be developed and thinking is in place. 1.3 Transition elements (financial responsibilities) are embedded into the NSP, although the latter is not legally empowered	1.1 Legally binding and actionable transition plan does not exist 1.2 There is no draft of the transition plan but there are steps identified, although not formalized, for its development 1.3 Transition elements (financial responsibilities to cover ART by 2018) are embedded into the National HIV/AIDS program (HIV/AIDS law)
	T	**T**	Transition plan / elements 1.1. Legally binding and	1.1 Legally binding and actionable transition plan	1.1 Legally binding and actionable transition	1.3 Legally binding and actionable transition plan	1.1 Legally binding and actionable transition plan

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
			actionable transition plan exists 1.2. Draft transition plan exists 1.3. Transition elements embedded into the legally empowered national program / NTP	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 1.1	plan does not exist 1.2 There is no draft of the transition plan 1.2 National program for 2016-2020 includes transition of funding of certain program elements	does not exist 1.4 There is no draft of the transition however there is discussion regarding the plan and a deadline when it should be developed is set. 1.5 Transition elements (financial responsibilities) are embedded into the NSP, although the latter is not legally empowered	does not exist 1.2 There is no draft of the transition plan but there are steps identified, although not formalized, for its development 1.3 Transition elements (financial responsibilities) are embedded into the National TB program
	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	N/A	N/A	N/A
	T	**T**	Transition plan characteristics: 2.1 Clearly identifies time-bound activities to be implemented during transition	N/A	N/A	N/A	**N/A**

Components		Disease	Indicators	Belarus	Bulgaria	Georgia	Ukraine
			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				
	T	**B**	3. Transition M&E 3.1 M&E is followed 3.2 CSO participates in the transition updates	NO	N/A	N/A	N/A
				2	**0**	**0**	**0**
				Moderate to High risk	Moderate to High risk	Moderate to High risk	High to Moderate risk
			Overall score (Total max score 76)	**32 (42%)**	**37 (49%)**	**36 (47%)**	**26 (33%)**

Explanation of the risk assignment methodology

For each component percentages are calculated based on total scores possible and the amount of scores earned and respective colours are assigned:

- Low risk = Green - ≥70%
- Moderate risk = Yellow - 36-69%
- High risk = Red – ≤35%

For Overall Country Risk Assessment similar calculations are used and the following colours are assigned:

- Low risk = Dark Green - >85%
- Moderate to Low risk = Light Green - 70-85%
- Moderate risk = Dark yellow - 50-69%
- Moderate to High risk = Light yellow - 36-49%
- High to moderate risk = Light red – 25-35%
- High risk = Dark red – <25%

Component		Belarus	Bulgaria	Georgia	Ukraine	Component Assessment
Political	Max score	6	6	6	6	12
	Country score	2	5	4	4	8
	Country score rate	33%	83%	67%	67%	75%
Economic	Max score	2	2	2	2	4
	Country score	2	2	2	1	3
	Country score rate	100%	100%	100%	50%	75%
Inputs: Financing	Max score	14	14	14	14	28
	Country score	5	5	5	3	8
	Country score rate	36%	36%	36%	21%	29%

Inputs: HR	Max score	6	6	6	6	12
	Country score	2	3	3	3	6
	Country score rate	33%	50%	50%	50%	50%
Inputs: HIS	Max score	6	6	6	6	12
	Country score	3	2	4	3	7
	Country score rate	50%	33%	67%	50%	58%
Governance: Governance	Max score	10	10	10	10	20
	Country score	7	6	6	3	9
	Country score rate	70%	60%	60%	30%	45%
Governance: Accountability	Max score	4	4	4	4	8
	Country score	2	2	2	4	6
	Country score rate	50%	50%	50%	100%	75%
Program: Service delivery	Max score	10	10	10	10	20
	Country score	3	5	6	3	9
	Country score rate	30%	50%	60%	30%	45%
Program: Organizational capacity	Max score	8	8	8	8	16
	Country score	4	7	4	1	5
	Country score rate	50%	88%	50%	13%	31%
Transition preparedness	Max score	10	10	10	10	20
	Country score	2	0	0	0	0
	Country score rate	20%	0%	0%	0%	0%
Overall score	Max score	76	76	76	76	
	Country score	32	37	36	25	
	Country score rate	42%	49%	47%	33%	