

*IMPORTANT NOTE:* Applicants should refer to the Standard Concept Note Instructions to complete this template.

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

A concept note is divided into the following sections:

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

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

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

Section 4: Implementation arrangements and risk assessment.

Investing for impact against HIV, tuberculosis or malaria

STANDARD

CONCEPT NOTE

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| SUMMARY INFORMATION |
| Applicant Information |
| Country | Kosovo/CCM | Component  | HIV/AIDS |
| Funding Request Start Date  | 1 July 2015 | Funding Request End Date  | 31 December 2017 |
| Principal Recipient(s)  | Community Development Fund (CDF) |

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| Funding Request Summary Table  |

![Description: C:\Users\agreen\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\2QMQR3C9\MC910217323[1].wmf]()A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

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| SECTION 1: COUNTRY CONTEXT  |
| This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.  |

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| 1.1 Country Disease, Health and Community Systems Context  |
| With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight: 1. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.
2. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.
3. Key human rights barriers and gender inequalities that may impede access to health services.
4. The health systems and community systems context in the country, including any constraints.
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| 2-4 PAGES SUGGESTED Epidemiological situationKosovo is characterised by low prevalence of HIV infection among both the general public and key populations. No worrying epidemic dynamics have been observed over the last several years. The recent 2014 IBBS studies confirmed low prevalence of HIV in all the key populations[[1]](#footnote-2). HIV prevalence among MSM in Pristina was 2.3%, and HBV prevalence - 4.6%. No PWID were infected with HIV in Pristina and Prizren. Prevalence of HBV for Pristina was 5% and for Prizren was 2.5%, and HCV[[2]](#footnote-3) prevalence - 31% (Pristina) and 20% (Prizren). No FSW tested positive for HIV, infectious HBV or secondary Syphilis in Ferizaj. TB incidence in Kosovo is 47/100,000 but HIV prevalence is very low among TB patients (1 HIV positive case was registered in testing services provided 300 TB patients under the current GFATM TB grant).Higher prevalence of HIV is observed in all neighbouring countries. The factors contributing to low prevalence of HIV in Kosovo have not been analysed. One possible factor that may have contributed to Kosovo’s low HIV prevalence is the high prevalence of male circumcision. According to the recent (2013-2014) Kosovo Multiple Indicator Cluster Survey[[3]](#footnote-4) the percentage of men aged 15 to 49 who report having been circumcised is 91.5%. This rate is even higher (96.1%) among Roma, Ashkali and Egyptian communities. Apart from this there are no other significant factors that could explain lower HIV prevalence than in neighbouring countries, relatively low alcohol use may be another factor but there is no evidence to support this argument. The recent IBBS studies demonstrate relatively high prevalence of risk behaviour in key populations, which presents a risk of swift deterioration of the epidemic situation in case HIV is introduced in KP communities. Thus according to 2014 IBBS study in Ferizaj only 23% of FSW always carry a condom. 33% agreed to sex without condom last time more money was offered. 38% of FSW did not use condom during the last vaginal sex with a client, and only 33% reported always using condom with clients in the past month. Only 25% of FSW used condom during the last sex with non-paying sexual partner. 67% reported their regular sexual partners also having sex with other women. There is an overlap between SW and drug use, and 22.4% of FSW in Ferizaj reported using drugs prior to sexual intercourse with clients. Only 3.5% reported never using alcohol. Only 52% of surveyed FSW in Ferizaj had ever tested for HIV infection. Only 28% of those who ever tested for HIV did that in the last 12 months (only 14% of all respondents).MSM are a highly mobile population with 55% reporting traveling outside of Kosovo and 90% traveling outside of Pristina in the past 12 months. 27% of those who travelled abroad reported having anal sex without a condom during their travel. Anal sex without a condom is even more common during in-country travel - 38% of those who travelled outside of Pristina reported unprotected anal intercourse during their travel. Only half of MSM who had sex with women in the past 12 months used condom. 69% of MSM reported always using condoms during anal sexual intercourse in the past 12 months. All of the conducted IBBS studies are characterised by limited generalizability of findings due to either small sample size (2011 study) or the limited geographic coverage of the study (2014 study). 2014 IBBS studies among PWID, MSM and FSW incorporated key population size estimates in two municipalities for PWID, one municipality for MSM, as well as expert opinion based best guess estimates of sex workers population. Although the findings from Pristina and Prizren for PWID and from Pristina for MSM have been extrapolated to the whole population of Kosovo, the extrapolation method was weak and may have led to significant overestimates of key population sizes. Additional studies are required in other to estimate population sizes in other municipalities not covered by IBBS study.According to the Multiple Indicator Cluster Survey[[4]](#footnote-5) only 37.4% of the population of Kosova live in urban areas. This should be taken into account in extrapolations of key population size estimates, as the prevalence of drug use in rural areas is believed to be significantly lower than in urban areas of the country. The experts working with KPs suggest that the estimates presented by IBBS implementing agency should be significantly reduced. Thus 12000 and 3000 have been proposed as more realistic estimates for PWID and FSW respectively. Wildt (2012) in her recent review of SW industry in Kosovo, suggests that the IBBS estimate of 6342 should be halved to arrive at a more realistic estimate based on the expressed opinions of experts and interviewed FSW.Having considered the above it has been decided that mid range estimates for 9 most populated municipalities of Kosovo will be used as denominator for the proposed programme. In case of PWID, IBBSS-defined prevalence of HIV in Prizren (the second largest municipality) was used as extrapolation index to obtain population size estimates for the 9 selected municipalities. For MSM the IBBSS-defined mid-range prevalence estimate of 3.5% in adult male population has been applied to the 9 selected municipalities. And for FSW the denominator estimate is based on the sex work prevalence estimate in adult female population derived from expert opinion estimates of FSW population sizes. Key populations and access to services There are HIV prevention interventions in place for PWID, MSM and FSW. The outreach and service delivery modality for FSWs is least defined. The current level of coverage is difficult to establish due to insufficient reliability of population size estimates. However there is a clear need to improve coverage of key populations both geographically and in terms of specific segments of KPs. Current coverage of needle and syringe services may be as low as 23%[[5]](#footnote-6), and less than 100 people access MMT services. Current coverage of MSM is about 5% of the estimated population. Although about 7% of FSW have access to STI services, the spectrum of services is very limited, and the existing outreach capacities do not allow for any significant increase in the service coverage. The existing HIV prevention services require standardisation and tighter quality assurance measures. The existing bio-behavioural data do not allow for accurate understanding of the effectiveness of the existing interventions in regards to behavioural patterns in PWID population. Thus although 2011 survey suggested that ‘in comparison to the first surveillance wave carried out in 2006, statistically significant increases in the proportion of IDUs who ever tested for HIV and who reported using sterile injecting equipment at most recent drug injecting episode were observed in 2011’, the study also found three times increase in HCV prevalence in the observed period. This may suggest that the prevention programmes did not pay sufficient attention to some of the specific risks of infection transmission associated with the use of injecting water or procedures involved in the preparation and sharing of the drug. BCC strategies require better elaboration to address the specific risks and vulnerabilities faced by the key populations. Detection of HIV requires improvements. 2013-2014 MICS has found that only 15.5% of women and 31% of men aged 15 to 49 know where they could get tested for HIV. Only 0.7% of women and 1.4% of men have been tested for HIV in the last 12 months and know their results. Only a small proportion of key populations have been tested so far. Only 14% of FSWs in Ferizaj, 23% of PWID in Pristina, 16% of PWID in Prizren, and 36% of MSM who participated in the recent IBBSS have tested for HIV in the last 12 months. Although VCT is available for pregnant women, testing is not available in antenatal clinics, not actively promoted by health care workers, and utilisation of the service is very limited. According to 2013-2014 MICS results, 97.8% of women aged 15 to 49 with a live birth in the last two years were attended during their last pregnancy that led to a live birth at least once by skilled health personnel. 81.1% of women in the same category gave urine and blood samples during the last pregnancy that led to a live birth. 99% of women in this category had their most recent live birth delivered in a health facility. 97.4% of women stay in the health facility for 12 hours or more after the delivery. At the same time only 3.6% of women reported that they received counselling on HIV during antenatal care. And only 2.1% reported that they were offered and accepted an HIV test during antenatal care and received their results. The majority of women aged 15-49 could not correctly identify all three means of MTCT of HIV. These data indicate both the need and good opportunities for promotion of HIV testing among pregnant women with consequent linkages to PMTCT for those who tested positive for HIV infection. Although all of identified PLHIV who require treatment for HIV infection (currently onlyn14 people) do access ART, they faced severe treatment interruptions leading to immune response irregularities identified through CD4 testing. The buffer stocks of ARV medicines are currently introduced in order to eliminate the risk of stock-outs but further improvements in the PSCM system are required. 60% of people who were tested positive for HIV have been lost to follow up. 28 people are currently receiving HIV care through the national PLHIV association (KAPHA). The involvement of PLHIV in defining HIV service delivery as well as linking people to care and ensuring retention is limited.Key populations face multiple challenges in accessing health services. Human rights and gender issuesKosovo is characterised by highly stigmatised society attitudes towards PLHIV and key affected populations. 2013-2014 MICS has found that only 6.2% of women and 8.2% of men aged 15 to 49 express accepting attitudes on all four questions concerning people living with HIV[[6]](#footnote-7). More information on stigma and discrimination related challenges can be found in the recent WHO review of Kosovo HIV programme. Gender inequalities and gender-based violence are common among disadvantaged populations and particularly affect young women and girls residing in rural and suburban areas. Violence also constitutes a significant risk factor for FSW. According to Wildt (2015) more than half of them experience violence, predominantly from clients, who demand particular types of sex, including group sex and sex without condom. Women do not recourse to law enforcement when they encounter violence due to fear of arrest. This clearly demonstrates the detrimental effect of FSW criminalisation on their access to essential services as well as protection of their human rights. Criminalisation of same-sex relationships have similar implications for MSM and the development of HIV prevention and care interventions for this population. Health systems and community systemsProcurement and supply chain management systems require further strengthening including the development of better planning and risk management. Detection of HIV is not sufficiently strategic. Very small share of KPs tested. No systematic testing of pregnant women. IBBS: fewer than 20% of PWID received HIV counselling and testing services in the past 12 months, only 41% of PWID in Pristina and 27% in Prizren knew where to get free and anonymous test for HIV. Quality of MMT, IEC/BCC work should be improved. KP’s representation is weak and no networks of KPs or patients’ associations. PLHIV association lacks clear agenda and strategy.  |

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| 1.2 National Disease Strategic Plans  |
| With clear references to the current national disease strategic plan(s) and supporting documentation (include the name of the document and specific page reference), briefly summarize:1. The key goals, objectives and priority program areas.
2. Implementation to date, including the main outcomes and impact achieved.
3. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.
4. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.
5. For standard HIV or TB funding requests[[7]](#footnote-8), describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.
6. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.
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| 4-5 PAGES SUGGESTEDThe National HIV Strategic Plan The Ministry of Health and other relevant governmental departments continue elaborating the national strategic plan (NSP) related to HIV infection. The plan is based on the recently approved National Health Strategy as well as the previous National Strategic Plan for HIV 2009-2013. As there was no sufficient progress in the development of new HIV strategy close to the time of Concept Note submission, a WHO mission was commissioned in 2014 to review the previous strategic plan and to provide recommendations for the expedient development of 2015-2019 NSP by the strategy development team and other relevant stakeholders. The mission concluded that “the goal, key strategic issues, and specific strategic objectives are as relevant in 2014 as they were at the time they were written”[[8]](#footnote-9). Although the National HIV plan is not yet fully costed, the objectives and priority areas have already been agreed. These areas, their funding by the government, and the prospects of their funding by the government are discussed below. Objective 1: Reducing the risk of HIV infection among KAP:1.1. HIV prevention programmes for PWID;1.2. HIV prevention programmes for FSW;1.3. HIV prevention programmes for MSM.Only a proportion of infrastructure and personnel costs associated with the delivery of MMT services at public health facilities is covered by the government under this objective. A growing contribution of the government towards the costs of methadone is expected during the programme implementation. Objective 2: Reducing the risk of HIV infection among other vulnerable groups and the general population:2.1. Integration of HIV and STI prevention programmes in the framework of formal education core curriculum;2.2. Development of programmes to prevent HIV/STI among vulnerable groups through education and informal education activities; 2.3. Development of programmes for prevention of HIV/STI through education and informal education activities specific to each vulnerable group;2.4. Promotion and distribution of condoms to vulnerable groups;2.5. Developing programmes that promote and encourage HTC.The government will most likely support the activities in the education system targeting segments of the general population. Funding of specific activities targeting underserved ethnic minorities and vulnerable rural women and girls is less likely. Objective 3: Strengthening the capacity for quality HIV/AIDS prevention, diagnosis, treatment and care:3.1. Development of programmes to expand the use and improve the quality of HTC services;3.2. Strengthening prevention of mother to child transmission of HIV infection (PMTCT);3.3. Blood safety programme: systematic testing of blood (and blood derivatives) for HIV and other infections;3.4. Ensure safe working environment for the prevention of HIV infection in health care facilities and other working environments;3.5. Diagnostic and laboratory support;3.6. Regular supply of ARV medicines;3.7. Strengthening the system of control and STI treatment;3.8. Care and support for chronically ill.The government will cover or partly cover most of the activities under this objective including blood safety measures and laboratory HIV testing. Testing for HIV for marginalised populations in the community settings will not be prioritised given the budget limitations.Objective 4: Improving the quality of life for PLHIV:4.1. Continuing the work of the care and support centre for PLHIV, their relatives and partners;4.2. Development and distribution of IEC materials targeting specific information needs of PLHIV; including web portal and telephone line for PLHIV;4.3. Advocacy, lobbying and mass media campaigning to reduce stigma and discrimination against PLHIV;4.4. On-going ART.Most of the activities under this objective (apart from the clinical care) are not covered by the governmental budget. Objective 5: Strengthening the Monitoring and Evaluation system of HIV/AIDS:5.1. Establishment of an efficient system for Monitoring and Evaluation.Although prioritised in the new strategic plan, the development of effective M&E system is unlikely to be sufficiently funded in the immediate future. Objective 6: Strengthening the legal and institutional framework in the field of HIV/AIDS:6.1. Develop policies on HIV and AIDS that are in full compliance with international standards and recommendations;6.2. Providing sufficient funds by the MOH and other relevant partners to ensure the sustainability of all services for HIV and AIDS;6.3. Providing an efficient system for regular supply of ARV medicines, test kits and other laboratory supplies;6.4. Providing an effective coordination system between institutions/organisations working on HIV/AIDS.Policy development activities performed by the governmental structures does not require significant investment and will likely be covered from the state budget. It should be noted that although advocacy is mentioned in this section of the national plan, the community control over HIV programme implementation will not be funded through the state channels in line with the nature of this activity. WHO HIV Programme Review mission[[9]](#footnote-10) identified five key strategic areas which need to be addressed to achieve the overall NSP 2009-2013 goal:1. Strengthening the information and knowledge base for an evidence-informed response:
	1. Address the issues of HIV case under-reporting, especially by private clinics that carry out HIV tests;
	2. Specifically target strong societal stigma and discrimination against key populations;
	3. Improve monitoring and evaluation of programmes through introduction of automated management information systems, as well as ongoing qualitative operational research;
	4. Continue periodical IBBSS among key populations and other national surveys such as the sentinel HIV prevalence survey among women attending antenatal care, and population based studies.
2. Strengthening of the institutional frameworks and organisational and technical capacity of Government and civil society organisations to develop and implement effective HIV/AIDS policies, programmes and services in a coordinated manner:
	1. Strengthen the coordination capacity of MoH;
	2. Improve overall capacity of all stakeholders to actively participate in HIV/AIDS response.
3. Strengthening the legislative, policy and financial basis for effective implementation of the national response:
	1. Develop resource mobilisation strategies (transitional arrangements);
	2. Direct legislation, policies and resource allocation to support a sustainable response;
	3. Address service delivery barriers:
		1. Weak PSM practices resulting in shortage and stock-outs of essential health products;
		2. Legislative barriers to easy service access such as criminalisation of sex workers and drug users;
		3. Management and organisational barriers (inability to manage a complex system of vertical programmes;
		4. Stigmatisation from primary health care workers;
		5. Low government spending on health.
4. Improving the comprehensiveness and quality of programmes and services, to meet the prevention, care, support and treatment needs of those at risk or affected by HIV/AIDS:
	1. Reiterate the role of the public health sector in provision of comprehensive package of services to the key populations.
5. Scaling up the coverage of key populations at risk and those affected by or vulnerable to HIV and AIDS with key programmes and services:
	1. More efforts to ensure planned interventions are targeted at hard to reach key populations;
	2. Population specific prevention services to reach at least 80% of those at risk of acquiring HIV infection;
	3. After reaching these populations, trust must be built to ensure that all (or almost all) of those reached will agree to HIV test; for marginalised populations, any interaction with mainstream health service providers can be perceived as dangerous, so outreach workers usually have to build trust over a number of meetings, encouraging a meaningful knowledge of HIV status that leads to improved health outcomes;
	4. HIV testing (and an immediate result) is available, appropriate, affordable, accessible and attractive enough to at least 80% of people from key populations;
	5. Counselling and peer support with accompanied HIV testing to minimise loss to follow-up;
	6. For those who test HIV positive, there is linkage to appropriate, affordable, accessible and user-friendly treatment, care and support options, including ART as needed;
	7. For specific key populations including PWID, adherence support is provided to assist with ongoing engagement with HIV care and (in particular) with ART;
	8. Secure, effective, supportive pathways exist from HIV testing to ongoing treatment, care and support.
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| SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY  |
| To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.  |

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| 2.1 Overall Funding Landscape for Upcoming Implementation Period |
| In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe: 1. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).
2. How the proposed Global Fund investment has leveraged other donor resources.
3. For program areas that have significant funding gaps, planned actions to address these gaps.
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| 1-2 PAGES SUGGESTED In the upcoming implementation period the Global Fund is expected to remain the main source for funding for HIV related interventions. Contribution of the government is expected to be more significant than in the previous years. It should be noted though, that the recently developed National HIV Strategic Plan have not been costed, and the presented contribution is the result of official consultation with various governmental departments involved in the response to HIV epidemic regarding realistic estimates of their respective budgets in 2015 - 2017. The governmental funding is expected to cover the following areas of the national strategic plan:* Safety of donor blood – fully covered by the government;
* Antiretroviral treatment and treatment for opportunistic infections – fully covered by the government;
* Partial support to MMT services offered by the public health facilities;
* HIV prevention intervention (including HIV testing and counselling) in penitentiary institutions;
* Limited contribution to HIV counselling and testing and laboratory testing for treatment monitoring;

Apart from the government there are very few agencies planning to offer their modest contributions towards the national response to HIV/AIDS, the most significant being UNFPA, which is contributing towards peer education related to HIV prevention and sexual and reproductive health (SRH), social marketing, condom procurement, community education sessions, theatre-based education, media campaigns and other activities targeting the general population. Historical and planned UNFPA contributions are as follows: 2012 - $584072013 - $1529102014 - $1938772015 - $70000 - $1000002016 - $70000 - $1000002017 - $70000 - $100000WHO has contributed to policy related activities as well as participation of local specialists in international conferences in the following amounts:2012 - $1489;2014 - $3106.In 2014 WHO has also conducted the reviews of the National HIV programme and the national HIV strategic plan with the budget of $40000. These activities were part of the global agreement between the Global Fund and WHO. There are no current WHO budget allocations for 2015-2017.  UNICEF’s last contribution of $10,000 has been provided in 2012. No specific key population activities are covered by external agencies. The following essential areas of the response to HIV infection are not covered by any of the domestic or external funding sources:* Focused HIV prevention activities among PWID (apart from procurement of methadone and administration of MMT programmes by the public health facilities), MSM, FSW, vulnerable women and girls, migrants and ethnic minorities;
* Community based detection of HIV infection in KAPs;
* Community-based care and support for PLHIV;
* Significant proportion of expenses related to implementation of MMT programmes;
* Bio-behavioural surveillance, estimates of the key population sizes, and formative studies to inform the design of HIV prevention and care interventions.

The proposed programme will cover these gaps during the programme implementation period. The programme policy development and advocacy group will work closely with the relevant governmental structures in order to ensure increasing engagement of the government in HIV prevention among the key populations.  |

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| 2.2 Counterpart Financing Requirements  |
| Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.1. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.
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| Counterpart Financing Requirements | Compliant? | If not, provide a brief justification and planned actions |
| 1. Availability of reliable data to assess compliance
 | [ ]  Yes [ ]  No |  |
| 1. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)
 | [ ] Yes [ ]  No |  |
| 1. Increasing government contribution to disease program
 | [ ]  Yes [ ]  No |  |
| 1. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.
2. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.
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| 2-3 PAGES SUGGESTEDGovernmental contribution towards the response to HIV infection has been steadily growing over the last several years. Several governmental departments have specific budget allocations associated with HIV interventions. These include: * Ministry of Health;
* Infectious disease clinic;
* Prison health department;
* National institute of public health;
* Blood transfusion centre;
* Methadone maintenance centres;
* Ministry of culture, youth and sports;
* Ministry of internal affairs and
* Ministry of education, science and technology.

Between 2012 and 2014 the government invested €1,503,204 in HIV related infrastructure and activities, which represents a modest increase over the previous period. The planned allocation for the next three years is 20% larger than the allocation for the last three year and constitutes €1,869,403. Although the national HIV strategic plan has not been costed and this work is ongoing, the projections utilised in this Concept Note are based on detailed consultations conducted by the National HIV Programme Coordinator with the responsible managers of the relevant governmental departments and have high degree of reliability. Discussions between stakeholders (including the relevant governmental departments) regarding the increase in condom and methadone procurement by the government are ongoing. The government is also expected to commit to provide necessary supplies and infrastructure support for the functioning of laboratory equipment utilised to determine the effectiveness of treatment. The proposed programme, through its Programme Advocacy Group (PAG) will monitor budget allocations for HIV and advocate for the fulfilment of governmental commitments. |

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| SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND |
| This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems. It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs. |

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| 3.1 Programmatic Gap Analysis  |
| A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant’s funding request. Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant’s funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.  |
| * 1. PAGES SUGGESTED – *only for modules that are difficult to quantify*

The programmatic gap analysis tables demonstrate that the need in outreach and HIV prevention service targeting the key affected populations is significantly greater than what is included in the proposed programme. Budget limitations dictated inclusion of only very basic service combinations mainly limited to distribution of most essential prevention commodities as well as quality behavioural change communication. The programme also prioritises the detection of HIV infection in order to ensure timely access to care and support of those who need these services and the follow-up referrals and linkages to the emerging PLHIV community support structures. The proposed coverage of key populations is not optimal (about 40% for MSM and FSW), but represents realistic targets given the limited capacity of implementation partners as well as environmental restrictions. The targets have also been affected by the recent significant increase in the available key population estimates. One important remaining gap is availability of services to sexual partners of PWID and clients of FSW, including HIV testing and counselling. According to 2011 IBBS, 74.1% of PWID in Kosovo were sexually active, about a quarter (27.1%) of these had multiple sexual partners. Sexual partnerships with people who are not injecting drug users are common. More effective detection of HIV requires testing of sexual partners of the key affected populations.Apart from the main HIV prevention and detection activities directly related to service delivery and analysed in the programmatic gap analysis tables, there is a range of important activities, which are more difficult to quantify. These relate to PSCM module as well as Removal of legal barriers to access. Despite the limited financial resources allocated to these, they will play a significant role in ensuring the success of direct interventions targeting key affected populations. The investment required for these activities mostly relates to personnel (advocacy, legal and HIV technical), as well as modest expenses required to conduct essential stakeholder consultations and think tanks for the development of solutions, regulations and policies. The proposed programme does not contain resources required to catalyse and support the development of community groups, networks, and small local service delivery units. It is expected that as a result of proposed programme implementation the need for such developments will become more articulate and will allow for the development of more focused funding proposals to support this area.  |

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| 3.2 Applicant Funding Request  |
| Provide a strategic overview of the applicant’s funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.  |
| 4-5 PAGES SUGGESTED Goal: Maintaining the low prevalence of HIV and improving the quality of life of affected people through the improved cascade of HIV prevention and care servicesObjectives:1. To improve access of key populations to quality HIV prevention and care services;The programme will expand the coverage of essential HIV services targeting key affected populations. Utilisation of a mobile service delivery unit and introduction of a network of local peer educators in new sites will allow for expanding geographic coverage. Innovative coverage strategies (peer driven interventions and secondary service delivery) will allow for reaching the underserved and more marginalised segments of the key affected populations. The quality of service delivery will be improved through participatory development and rollout of structured behaviour change communication, shifting the focus of BCC from distribution of printed IEC materials to structured verbal communication between the service providers and clients; adjustment of services in accordance with in-depth understanding of risk factors associated with various stages of drug preparation, distribution and consumption; development and application of risk management measures related to procurement and supply chain management; introduction of patient monitoring and treatment quality control etc. 2. To improve detection of HIV and facilitated access to care and treatment;The programme will strengthen promotion and improve availability of HIV testing and counselling for key affected populations in the community settings. The policy development and advocacy group will work with the relevant regulatory and health authorities in order to design and implement a strategy for promotion of universal HIV testing of pregnant women and people with signs and symptoms of medical conditions that could indicate HIV infection.The programme will contribute to strengthening of the continuum of prevention and care services by linking testing to HIV prevention, care and treatment services (including PMTCT) through supporting the development of necessary regulations and effective referral mechanisms. Treatment retention and effectiveness will be improved through the development of patient associations and introduction of treatment quality monitoring by PLHIV organisations, as well as through strengthening of laboratory capacity to monitor the treatment effectiveness. The programme advocacy group will work the relevant agencies to promote the development and rollout of national treatment protocols. 3. To create supportive environment for sustainable HIV/AIDS response.The programme will introduce an organised policy development and advocacy function shared between the key civil society stakeholders and collaborating closely with the relevant governmental structures. The function will be performed by the Programme Advocacy Group (PAG) consisting of the representatives of PLHIV, KAPs, and service providers facing legal, regulatory or cultural barriers to the development of effective interventions. The programme will collaborate with the existing technical assistance mechanisms in order to develop and strengthen the essential community systems and engage the associations and networks of PLHIV and KPs and other stakeholders in addressing stigma and discrimination restricting the development of HIV prevention and care services.The programme will support introduction of effective client registration and service delivery monitoring software, essential bio-behavioural monitoring, KP size estimates in areas of high concentration of KPs, and formative studies required to ensure the relevance and effectiveness of provided services.Module 1. Prevention programmes for people who inject drugs (PWID) and their partnersThe programme will aim to involve the majority of PWID in Kosovo in quality HIV prevention and care. Taking into account unavailability of reliable nation wide estimate of PWID population size, the initial phase will include strengthening of the current services in the existing intervention sites as well as measuring PWID populations in other areas with significant concentration of PWID. Strategic outreach and the delivery of essential combination of HIV prevention and care services will be eventually provided in all areas of high concentration of PWID. During Year 1 of the programme outreach will be intensified and coverage consolidated in the sites with available programmes and estimates of key population sizes. Additional studies including mapping of areas with high concentration of KPs and KP size estimates will be conducted during Year 1 and will direct further geographic expansion to all areas of high concentration of KPs in Years 2 and 3 of the programme. Engagement of peers in secondary service delivery, motorised mobile service delivery unit, and peer driven interventions (PDI) are the main strategy to increase the coverage. Each of the PDI interventions is expected to establish contacts with at least 150 new clients within the first 6 months of implementation. PDI will be directed at reaching the underrepresented segments of PWID including women who inject drugs, younger PWID, as well as users of substances other than heroin (including Methadone and ATS).The proposed coverage denominator relates to the areas with existing harm reduction services for PWID (Pristina, Prizren, and Gjilan) as well as to several other municipalities where introduction of services is planned starting from Year 2 of the programme. Sufficiently reliable PWID population size estimates exist for Pristina and Prizren only. For other municipalities it is proposed to assume that prevalence of injecting drug use is similar to that of Prizren, the second largest municipality. Extrapolation of Prizren prevalence to the third site where the current programme is implemented (Gjilan), as well as to other six most populous municipalities of Kosovo (Peja, Mitrovica, Ferizaj, Gjakova, Vushtrri and Podujeva) gives a working denominator for the 9 target municipalities of 8918[[10]](#footnote-11). The programme aims to reach 3400 PWID by the end of 2015 with strengthened and quality controlled service combination, 4500 PWID in 2016, and 5350 in 2017. The coverage targets are based on the estimate of PWID population in 9 sites with the highest concentration of PWID. The coverage targets for 2017 may need to be adjusted based on the actual results of the size estimation studies, which will be conducted in the first half of 2016. The offered essential combination of services for PWID will include: 1. Supply of appropriate types of injecting equipment (including syringes required by injecting users of Methadone[[11]](#footnote-12) – 5ml and 10ml). Studies to explore the feasibility of introduction of Low Dead Space injecting instruments have been included under Module 7 (Health Information Systems and M&E);2. Behaviour change communication work with clients through structured verbal interaction and (where relevant) distribution of quality printed IEC materials developed with participation of [prospective] clients. Verbal interaction between frontline outreach staff and service providers will be prioritised and regulated by well-structured protocols prescribing the methods (including individual and group sessions as well as peer-based communication), thematic spectrum, regularity, and key contents of such communication; 3. Opioid substitution maintenance treatment to prevent HIV transmission by reducing injection frequency and to improve the quality of life of PWID. A range of activities will be implemented to improve the quality of MMT services (including termination and replacement of the Methadone prescription practice leading to unsafe injecting of Methadone[[12]](#footnote-13), to promote MMT, to address misconceptions regarding this treatment, and to eliminate stock-outs of the substitute medication and treatment interruption; Coverage of MMT services will be significantly improved as a result of strengthened service delivery and demand generation. The programme will aim to engage 150 people in MMT programme in Year 1 of the programme implementation, followed by further enrolment of new clients in new programme locations with further coverage increase to 200 and 250 patients by the end of 2016 and 2017 respectively. Further increase in MMT coverage is expected due to the increased involvement of the government.4. Referrals to STI testing and condom distribution to prevent sexual transmission; 5. Ensuring access to and support of ART. Activities related to this service include community-based access to HIV testing and counselling, the development of operational guidance under Module 8 (Removing legal barriers), the development of PLHIV organisations and peer-support networks, as well as adherence support and treatment monitoring performed by civil society organisations and community groups under the Module 5 (Treatment and care); 6. HIV testing and counselling. Wherever possible the actual counselling and testing rather than referrals will be provided in the community settings and as early as possible in the relationship between the client and service delivery organisation; 7. Psychosocial support.The programme will introduce adjustments to MMT service delivery models in line with recommendations of recent reviews[[13]](#footnote-14) and stakeholder consultations. The activities will include: * Strategic promotion of MMT services with involvement of patients in thorough analysis of benefits, identification of risks and development of risk management recommendations;
* Revision of MMT admission criteria and operational procedures in order to increase service uptake and retention;
* Better integration MMT with other available harm reduction services including MMT promotion as a component of routine outreach work, access to drop-in facilities with essential hygiene services, strengthened psychosocial support, and introduction of comprehensive case management approach;
* Development and introduction of service adjustments catering for female clients of MMT;
* Advocacy to improve registration of patients and service delivery in all facilities including private clinics; alignment of databases;
* Replacement of ineffective methadone prescription system previously introduced in Prizren;
* Supporting creation of MMT patient association and development of immediate plans focusing on service quality improvements;
* Development and introduction of code of conduct for personnel involved in MMT services;
* Negotiating with public health authorities the introduction of performance-based incentives for personnel of governmental health facilities providing MMT services (as part of the strategy to increase the uptake of services);
* Supplying essential equipment to the public health facilities delivering MMT services in Pristina, Gjakova and Gjilan (refrigerators, tables, methadone dispensers, partitions, and IT equipment) as part of the strategy to increase uptake and retention in MMT programme).

Complementary services will be also provided in order to attract and retain clients and address their essential needs. These may include: basic health care, testing for viral hepatitis[[14]](#footnote-15) and treatment referrals, screening clients for tuberculosis with subsequent referrals for diagnostics, reproductive health services, legal support, livelihood development, and humanitarian aid. The implementing agencies will explore partnerships and additional sources of funding and in-kind contributions in order to scale the delivery of these complementary services. Several service improvements, such as introduction of TB screening of PWID in harm reduction programmes, will not require significant resources and can be done through procedural adjustments and development and introduction of simple screening protocols. Please note that distribution of alcohol swabs and sterile water has been removed from the main allocation and placed under the above allocation calculations. This has been done in order to increase the quantities of injecting instruments available to programme clients to sufficient levels in line with WHO/UNAIDS/UNODC recommendations in order to increase utilisation of sterile instruments. It has been concluded that distribution of alcohol swabs and sterile water in the current programme has not been effective, as only about 2 to 5% of all injections are currently conducted with sterile water distributed by harm reduction programmes. The programme will also introduce specifically designed measures to ensure proper disposal of used injecting equipment.The description of service package with the annual quotes of commodities and services per client are included in the budget assumptions. Price reductions are assumed and will be sought for injecting equipment and other prevention commodities. Module 2. Prevention programmes for MSM and TGsIn Year 1 the programme will focus on improvement of the outreach strategy (focused on the involvement of peers in client recruitment and secondary service delivery, development of more robust guidance and tools for service delivery, consolidation of coverage in Pristina (the only site where sufficiently reliable estimates of the target population are available) and other settlements where CSGD is currently operating. Size estimates in areas with the highest concentration of MSM will be conducted in the beginning of Year 2 of the programme[[15]](#footnote-16). Service improvements will focus on:* expanding the geographic area of service delivery through utilisation of a motorised mobile unit circulating along the predetermined roots covering settlements with high concentration of MSM;
* the development of thorough BCC guidance covering recommended communication techniques, thematic spectrum as well as the essential contents;
* strengthening the outreach strategies and service delivery models through the introduction of secondary service delivery and better use of the modern ICT technologies[[16]](#footnote-17).

The upgraded service combination will include the following services: 1. BCC work with clients through structured verbal interaction; 2. Distribution of condoms and lubricants; 3. Referrals or delivery of STI testing and treatment; 4. Ensuring access to and support of ART; 5. HIV testing and counselling; 6. Psychosocial support;7. Legal support services in collaboration with dedicated lawyers and human rights protection organisations.For the purposes of target setting midrange of all estimates included in 2014 IBBS study is taken (2796 for Pristina) and extrapolated to other proposed programme sites at 3.5% of adult male population. The estimate for the 9 sites is 13432 MSM. The programme will aim at reaching 40% of the estimate (5373 people) by the end of 2017. Module 3. Prevention programmes for sex workers and their clientsIn Year 1 the programme will focus on improvement of the outreach strategy (focused on the involvement of peers in client recruitment and secondary service delivery, as well as more structured (albeit informal) relationship with the gatekeepers, health workers - e.g. gynaecologists - and law enforcement), design of a more appropriate combination of services, consolidation of coverage in Ferizaj (the only site where services are currently provided to FSW), as well as conducting size estimates in areas with high concentration of SWs. Intensive consultations with FSW will be used to design the most appropriate service combinations and delivery models. References for potential peer outreach workers provided by the team of Utrecht University will be contacted and utilised for peer service delivery. In order to increase geographic coverage of services the programme will utilise two outreach strategies: outreach managed from a stationary office, as well as outreach by a motorised team. The latter will utilise the Mobile service delivery unit, which will be shared with other SRs. The mobile solution has been chosen to avoid multiplication of stationary service delivery platforms given resource limitations and the limited numbers of prospective clients. The indicative schedule for Mobile unit operations includes five different routes each covering several settlements where sex work has been well documented: * Pristina – Mitrovica – Skenderaj – Drenas (Gllogoc);
* Pristina – Gracanica – Gjilan – Kaminica;
* Pristina – Klina – Istog – Peja;
* Pristina – Malisheva – Rahovec – Gjakova;
* Pristina – Podujeva.

Advocacy will have to focus on legal provisions for the mobile clinic operations as well as negotiation of acceptable working model with the local law enforcement structures. There will need to be a dialogue with the police and other stakeholders. The units can also offer fee-based VCT services to general public, which may bring the necessary income to service delivery organisation but also make the service more discreet and not exclusively associated with criminalised or marginalised key populations.The upgraded service combination will include the following services: 1. Behaviour change communication work with clients through structured verbal interaction and distribution of quality printed IEC materials developed with participation of [prospective] clients[[17]](#footnote-18); 2. Condom distribution[[18]](#footnote-19); 3. Referrals or delivery of gynaecological services and STI testing and treatment; 4. Ensuring access to and support of ART; 5. HIV testing and counselling; 6. Psychosocial support, prevention and management of client violence towards SW;7. Legal support services in collaboration with dedicated lawyers and human rights protection organisations. The current number of FSW who access STI diagnosis and treatment services is less than 500. A combination of peer involvement, mobile service delivery and PDI interventions is expected to bring the number of clients to about 1000 clients in 2015, 1500 in 2016 and 1900 by the end of the programme. The available estimates of FSW population sizes in the six most populous municipalities of Kosovo are based on expert opinions and cannot be used as reliable denominators. It is suggested that these estimates are utilised without extrapolation to the national population. The total midrange estimate for the six municipalities (Pristina, Prizren, Gjakova, Peja, Mitrovica and Ferizaj) is 2575. Applied to adult female population of these municipalities as well as those located on the routs of the mobile service delivery unit, 0.9% index gives an estimate of 4586 SW on the territory, which will be covered by the programme. The expected coverage of 1900 constitutes about 40% of the estimated denominator. These figures may require adjustments should more accurate estimates of FSW population size become available. Thus if we accept that the available expert estimates are doubling the likely population size, as suggested by Wildt, the proposed target will exceed 80% of the estimate, which Wildt suggested as more realistic. Module 4. Prevention programmes for migrants, vulnerable women and girls, and underserved ethnic minoritiesApart from the three key populations included in the first three modules above the programme also includes interventions targeting prisoners, migrants, vulnerable women and girls, and underserved ethnic minorities - Roma, Ashkali and Egyptian (RAE). These groups are characterised by specific vulnerability factors such as temporary displacement or increased mobility, engagement in experimentation with drugs and occasional transactional sex, low level of education/literacy, extreme poverty, and gender based discrimination. These vulnerability factors are particularly acute in suburban areas, small municipalities and villages, and this is where the programme will focus its activities targeting these populations. The population of migrants also include men from diaspora who are reported to create a peak season for FSW, when they returning in summer and winter holidays[[19]](#footnote-20). The activities targeting RAE communities will reach people aged 15 to 49 and will focus in Lipjan, Ferizaj, Fushe Kosove, Obiliq, South Mitrovica, Gjakova, Istog, Peja and Klina municipalities. The activities targeting vulnerable women and girls will reach people aged 15 to 24 and will focus in Decan, Kacaniku, Kaminica, Skenderaj, Shtimje and Viti. The proposed interventions for these populations are limited to the detection of HIV infection, which also includes basic awareness raising through pre and post-test counselling, distribution of printed IEC materials as well as structured group communication, as well distribution of limited amount of condoms. Services for prisoners (1380 clients per year) include HIV, HBV and HCV testing, study visits of programme personnel to other sites where the similar work is well organised, as well as production and distribution of printed IEC materials[[20]](#footnote-21). It is assumed that further development of MMT, piloting needle and syringe services, distribution of condoms, and behaviour change counselling will be covered from governmental funding sources. In Year 1 the programme will focus on improvement of the outreach strategy (focused on the involvement of peers in client recruitment and secondary service delivery, as well as conducting qualitative explorations of risk and vulnerability factors). The programme will utilise two outreach strategies for these populations: outreach managed by local nongovernmental organisations (including women organisations), which will be identified on a competitive basis, as well as outreach by a motorised team[[21]](#footnote-22) (limited to HIV testing and other services provided at relevant events such as European Testing Week and World AIDS Day. The service will focus on detection of HIV and raising the awareness of clients. Appropriate communication strategies will be designed with active participation of prospective clients. The programme will also ensure linkages to HIV care and support for those tested positive. The implementing agency will explore partnerships and seek additional support in order to enable the expansion of the spectrum of available services (such as condom distribution, and development and dissemination of printed IEC materials). The programme will collaborate closely with the Ministry of Diaspora in order to develop and utilise appropriate communication targeting migrants, mainly seasonal workers departing and returning from their working assignments abroad. These activities will be based on operational studies exploring risks, vulnerabilities and promising BCC strategies targeting migrant workers. Services are most likely to be located in the airport, visa services, and may include promotion of voluntary HIV testing as part of the departure and arrival routines. Module 5. Treatment, care and supportCare and support services for PLHIV will be based on the Kosovo Association of People Living with HIV/AIDS (KAPHA). The activities will include the delivery of essential care services, engagement in advocacy, as well as in treatment quality monitoring and policy development. Specifically the programme includes: * Involvement of PLHIV peer supporters in the case management of PLHIV to facilitate access to pre-art care. Linkages and clear referral mechanisms between organisations administering HIV tests and KAPHA or local initiative groups of PLHIV activists;
* Involvement of PLHIV (KAPHA or local initiative groups of PLHIV activists) in monitoring of treatment quality, admission procedures, as well as access to psychosocial and other support required to enrol and successfully retain in treatment; These activities also relate to access to the required opportunistic infection diagnosis and treatment irrespective of the source of funding or medicines;
* Involvement of PLHIV activists with support from the programme advocacy officers in issues related to procurement and supply chain management and control over functioning of risk management mechanisms designed to ensure uninterrupted supply of ARV and other necessary health products taking into account the projected uptake of new patients;
* Involvement of PLHIV (KAPHA or local initiative groups of PLHIV activists) in monitoring of treatment quality, admission procedures, as well as access to psychosocial and other support required to enrol and successfully retain in treatment;
* Universal screening of PLHIV for Tuberculosis. The required laboratory testing is covered by the governmental funding;
* Development of psychosocial support and counselling algorithms and protocols to be utilised by peer support workers;
* Negotiating and reaching agreements among stakeholders regarding the roles of civil society organisations and PLHIV community in the delivery of psychosocial support and other services including identification of potential patients and the overall comprehensive case management including supporting access of PLHIV to the required outpatient and in-patient care;
* Essential humanitarian aid to clients (personal hygiene supplies and basic nutrition support);
* Advocating for the development of national protocols for the treatment of HIV-infection incorporating the role of PLHIV organisations in treatment monitoring and quality assurance.

Module 6. HSS: Procurement and supply chain management (PSCM) The programme will exercise robust PSCM standards and procedures in order to ensure timely and uninterrupted supply of the required health products. In addition to that the programme implementation partners and the advocacy group will work closely with the Ministry of Health procurement and other relevant department in order to support further improvements in the MOH PSCM system. Specifically the programme includes the following: * Procurement of health products required for the implementation of the proposed programme including HIV prevention commodities; rapid HIV, HBV, HCV and syphilis tests; laboratory equipment for treatment monitoring; methadone dispensers; and methadone;
* Working with the MoH for the handover of the remaining methadone procurement to the government;
* Exploration of more effective strategies to procure the essential HIV prevention and detection commodities, including:
	+ Continue explorations and negotiations with potential suppliers of free-of-charge condoms for distribution among the key populations (including UNFPA);
	+ Optimise the spectrum of procured injecting equipment to include the required proportion of larger volume syringes (5ml and 10ml) in accordance with the needs of clients;
	+ Continue to explore possible reductions in the costs of procured HIV and other testing kits.
* Work closely with the Ministry of Health and other relevant agencies in order to develop a risk management strategy to ensure uninterrupted procurement of essential medicines including ARV medicines and opioid substitutes. The risk management policies and procedures will include appropriate provisions for defining the buffer stocks, factoring for projected treatment expansion, avoiding delays associated with customs formalities, as well as storage and distribution of health products. The PR will explore the possibilities of a longer-term agreements with suppliers with phased supply of the medicines not to overburden the limited storage capacity of PR/SRs.

The existing stock of methadone is sufficient for the first year of the programme. It is assumed that the next supply of methadone will be at least partially procured by the Ministry of health. The PR and other programme stakeholders will work closely with the Ministry in order to ensure the optimal procurement and supply parameters. In particular, phased supply of the medicine will be negotiated with supplier in order to avoid expiration of methadone and not to overburden the limited storage facilities.Module 7. HSS: Health information systems and M&EThe programme will improve monitoring and evaluation of service delivery in order to support the progression of clients throughout the service continuum, avoid duplication, ensure accurate tracking of intervention progress and facilitate routine reporting. The plan incudes procurement of international TA and training of implementing partners in order to develop and introduce a system for client registration and service delivery monitoring.A range of studies will be conducted in order to assess feasibility and inform implementation of interventions, and verify the targets. These include:* Studies to establish feasibility of introduction of Low Dead Space injecting equipment;
* Regular monitoring of the drug scene and other contextual factors affecting the key populations in order to expediently adjust interventions; This can be performed through light qualitative explorations among clients, as well as through introduction of regular reports by frontline service providers on any observed changes;
* Regular collection of data regarding the preferred types of injecting instruments in order to inform procurement;
* Regular consultations with prison health and social workers regarding any significant contextual changes and the progress of HIV prevention and care; interventions;
* Analysis of Naloxone availability and obstacles and development of solutions;
* Key population size estimates (nationwide or in a selection of high concentration settlements);Situation assessment in prison system to establish the need for introduction of needle and syringe programmes and design the programmes if required.

Module 8. Removing legal barriers to accessAn important feature of the proposed programme is a strong advocacy and policy development component supporting the Objective 3. Most of the advocacy activities (including those related to community systems strengthening and improved policy and governance) are included under module 8 (Removing legal barriers to access). The advocacy component will be managed by a strong team of specialists based in the offices of PR and SRs involved in the areas of work, whose success heavily relies on policy and advocacy developments. The team (the Programme Advocacy Group - PAG) will develop and implement an advocacy plan, which is indicatively explained below. The key areas of policy and advocacy work include:* Legislation analysis and promotion of improvements enabling better access to essential HIV prevention, care and treatment services for KPs and PLHIV; This work will include the analysis of Kosovo’s commitments related to EU accession, antidiscrimination legislation, and identify any conflicts between various branches of legislation affecting key populations including sex workers, MSM and PWID. Based on the analysis of national and international legislative frameworks a clearer definition differentiating various aspects of trafficking of humans and transactional sex will be offered and incorporated in the operational policies and standard practice of law enforcement officers, health care workers and other stakeholders affecting access of key populations to essential HIV prevention and care services;
* Development and promotion of operational policies and standard procedures to ensure the required level of service uptake and retention;
* Development of community systems and community involvement in service monitoring and quality assurance;
* Improving awareness of essential principles and interventions of HIV prevention, care and treatment among key stakeholders including but not limited to health care workers and law enforcement personnel. Instead of small scale training activities targeting limited numbers of health care workers and police staff, the programme will focus on the development and rollout of codes of professional practice, as well as introduction of essential information in the official curricula of professional training;
* Legal analysis and negotiations with law enforcement and other essential stakeholders of the operations, routes and schedules of service delivery units including the motorised mobile unit;
* Development of community based organisations, including PLHIV networks and peer-support groups with clear role in supporting access to quality care and treatment;
* Establishment of prison programme advisory council comprising the front-line workers and possible former prisoners with clear ToR designed to monitor the development and implementation of interventions as well as to represent interests and channel/defend the essential needs of clients.

The programme will design and introduce a BCC module related to prevention and management of overdose among PWID. The advocacy group will conduct necessary legal analyses and backup piloting of Naloxone distribution among clients. Due to funding limitations this intervention has been budgeted in the above allocation. OD management education and Naloxone distribution may be included as a component of Peer-Driven Intervention (PDI), which will be determined at the detailed planning stage of PDI. The programme also includes efforts aimed at strengthened provider initiated detection of HIV among pregnant women and patients of clinical facilities with signs and symptoms of medical conditions that could indicate HIV infection, including TB. These efforts will concentrate on the development of policies and procedures required to enable and promote universal testing of pregnant women and symptomatic patients. Improvement of testing protocols should also include a range of other populations recommended for provider initiated testing in the recent HIV programme review by WHO. Together with community-based testing in KPs, provider initiated testing will allow for timely detection of newly introduced HIV infection.  |

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| 3.3 Modular Template  |
| Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:1. Explain the rationale for the selection and prioritization of modules and interventions.
2. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.
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| 3-4 PAGES SUGGESTEDThe selection of modules supports the implementation of programme objectives. Modules 1 (PWID), 2 (MSM), 3 (FSW) and 4 (other vulnerable populations) relate to both Objective 1 and Objective 2, as apart from outreach and delivery of HIV prevention services to key populations and proxy key populations they also include measures designed to ensure timely detection of HIV among these population group. Interventions related to improved detection of HIV in key affected populations and other vulnerable population groups, as well as interventions to ensure expedient progression of PLHIV to requited care and treatment, are placed under the relevant prevention modules. Module 5 (PLHIV) relates to Objective 2 in terms of improving access to and retention in care, as well as to Objective 3, as it includes the development of operational policies (such as treatment protocols) and community-based treatment quality and adherence support and monitoring systems. Modules 6 (PSCM), 7 (M&E), and 8 (Advocacy) support the implementation of Objective 3. The selected composition of modules will allow for building of the effective continuum of HIV prevention, care and treatment services through improved outreach to key populations at risk, active promotion of HIV testing leading to timely detection of HIV and expedient access to community-based and clinical care. Strengthening of treatment monitoring will allow for utilisation of HIV prevention potential of antiretroviral treatment. Uninterrupted supply of optimised quantities of adequate HIV prevention commodities and the overall improvements in functioning of national PSCM systems (Module 6) will play an important role in the effectiveness of HIV prevention, detection and care services. The advocacy agenda (Module 8) will allow for introduction of policies and regulations supporting the development and delivery of essential HIV prevention and care services. And the research and monitoring component (Module 7) will improve the understanding of the risk factors and needs of the key populations and allow for better focusing of interventions.  In addition to the areas of work directly related to the above modules, the proposed programme contains additional components that will strengthen the overall national response to HIV epidemic. It will advocate for and contribute to the development of improved policies and procedures related to access to HIV testing and counselling for pregnant women with appropriate links with PMTCT interventions. Capacity development and stigma related sensitisation will improve functioning of health and community workforce, as well as service delivery within the health system.Expected impact and outcomes of the programmeHIV prevention:The programme will allow for keeping the current low prevalence of HIV infection if key affected populations[[22]](#footnote-23). This will be achieved through the increase in coverage and supporting low risk behavioural choices. The coverage increase will be achieved through the increased number of outreach workers and secondary peer service providers, introduction of motorised service delivery unit, as well as utilisation of PDI as a means of reaching the underserved segments of the key populations. The significant increase in the number of distributed syringes (from the current 25 syringes per person per year to 100) will improve access of PWID to sterile injecting equipment. The programme will also completely reconceptualise the approach to behaviour change communication (BCC) through shifting fro ineffective distribution of printed IEC materials to well structured, focused verbal communication, designed in close collaboration with the clients and covering all the essential areas of HIV and associated risks and vulnerabilities as well as a range of other issues of significance to the key populations (such as overdose prevention and management and prevention of violence towards female sex workers). The proposed combination of HIV prevention services is expected to reduce prevalence of high-risk behaviours, which will be verified by bio-behavioural studies planned for 2017. The programme aims to ensure that by 2017 85% of PWID, MSM and FSW adopt behaviours lowering their risk of HIV transmission. This is measured by the following three HIV prevention outcome indicators:* Percentage of PWID reporting the use of sterile injecting equipment the last time they injected (current HIV grant 2014 target - 80%; 2014 IBBS result - 82%; 2017 target - 85%);
* Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (2014 target - 85%; 2014 IBBS - 66%; 2017 target - 85%;
* Percentage of SW reporting the use of a condom with their most recent client (2014 target - 85%; 2014 IBBS - 62%; 2017 target - 85%.

HIV Detection and access to care:The programme will improve detection of HIV in the key populations, mainly PWID, MSM and FSW as a result of increased intervention coverage, active promotion of community-based HIV testing, and increased availability of rapid tests. The PAG will collaborate with the MoH to improve HIV testing among pregnant women. The programme will design functional mechanisms to ensure access of identified people with HIV to the required care and treatment. Supportive environment for sustainable response: The activities included in modules 6, 7 and 8 will contribute to: * optimisation of legislative and regulatory frameworks as well as increasing governmental commitment to support effective HIV prevention and care interventions targeting PLHIV and other key populations;
* strengthening of PLHIV and KP engagement in advocacy, service development and quality assurance, as well as facilitation of timely movement of clients through the continuum of services;
* better capacity to align interventions with risk factors and other parameters of KP situation and context, monitor service delivery, as well as impact and outcomes of interventions.

Additional gains expected from the funding requested above the allocation amountDue to the funding limitations several interventions and activities have been removed from the main allocation and placed in the additional requested allocation. These include the following: 1. Several essential studies required to accurately estimate the size of MSM and PWID populations and plan further scale-up of the required interventions, to monitor the behaviours and infection prevalence among MSM, and to inform the design of interventions among prisoners and underserved ethnic minorities:
	1. MSM and PWID population size estimation;
	2. Study on HIV, STI, HCV prevalence and behavioural surveillance among MSM;
	3. Operational research among prisoners and RAE;
2. Design and production of printing materials for PWID, MSM, FSW. Although the programme prioritises structured verbal BCC, participatory design of quality printed materials can strengthen the impact of IEC work with the key populations. Combination of verbal and printed communication can increase the outcome of HIV prevention interventions;
3. HIV prevention activities among prisoners including rapid HIV, HBV and HCV tests, design and production of printed information materials, as well as study visits for health personnel of penitentiary institutions. This additional investment would complement the committed governmental contribution towards HIV work in prisons and increase the effectiveness of the interventions;
4. Overdose (OD) prevention training and piloting of OD prevention and management with Naloxone. Given the high prevalence of OD in Kosovo, as well as the prevalence of collection drug use, this life saving intervention targeting PWID is of high significance;
5. Alcohol swabs and sterile water for injections. The quantities of alcohol swabs and sterile water bottles distributed by NSPs within the current Global Fund grant are suboptimal and do not impact on the reduction of harms associated with injecting drugs. Given the frequency on injecting, in order to achieve impact the number of distributed swabs and sterile water bottles would need to be twice the amount of distributed syringes. This required amount of commodities has been included in the above allocation, as it represented significant increase in cost over the current allocation. Distribution of injecting equipment was prioritised over the distribution of alcohol swabs and sterile water;
6. VCT counsellor for MSM to improve the quality of counselling and testing;
7. Specific TA support for PDI introduction among MSM and SW. The main allocation includes one TA episode and would require combining all the three KPs in PDI preparation activity. Funding the additional activities included in the above allocation would enable more KP specific, intensive and focused design of PDI interventions;
8. HBV testing for PWID and MSM (due to low prevalence of HBV in these groups);
9. One additional press conference / public event per year. Funding these would complement similar activities included in the main allocation and strengthen the advocacy component of the programme.
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| 3.4 Focus on Key Populations and/or Highest-impact Interventions |
| This question is not applicable for low-income countries. |
| Describe whether the focus of the funding request meets the Global Fund’s Eligibility and Counterpart Financing Policy requirements as listed below:1. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions.
2. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.
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| ½ PAGE SUGGESTEDThe proposed programme fully focuses on key affected and underserved populations including PLHIV, PWID, MSM, FSW, prisoners, as well as vulnerable young women and girls, migrants, and underserved ethnic minorities (Roma, Ashkali and Egyptian). The latter are characterised by certain specific vulnerability factors such as temporary displacement or increased mobility, engagement in experimentation with drugs and occasional transactional sex, low level of education/literacy, extreme poverty, and gender based discrimination. E.g. 12% of RAE women aged 15-49 were first married or in union before age 15 and 43% of women aged 20-49 were first married or in union before age 18. RAE communities are also characterised by significantly lower awareness of HIV and stronger HIV related stigma[[23]](#footnote-24). For these latter groups the programme focuses on the detection of HIV infection and essential prevention communication. Apart from the delivery of essential HIV prevention and care services to PLHIV and KAPs, the Concept Note includes a range of highest-impact interventions. The programme’s advocacy agenda (Objective 3) is designed to lift barriers to the broader disease response and create conditions for improved service delivery through: * Legal and technical analyses of factors impeding the rollout of effective HIV prevention interventions among FSW;
* Development of regulatory framework for introduction of mobile service delivery units;
* Enabling timely clinical monitoring through strengthening of the capacity of the national reference laboratory;
* Improved PSCM through introduction of risk management strategy.

 In addition the programme enables roll-out of new technologies that represent global best practice such as:* Scaled use of rapid HIV testing technologies to improve detection of HIV among the key affected populations;
* Strengthened outreach efforts based on peer-driven methods and designed to reach out to the underserved segments of the key populations;
* Piloting the overdose prevention and management activities with the use of Naloxone.
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| SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT |
| 4.1 Overview of Implementation Arrangements |
| Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe: 1. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).
2. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.
3. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.
4. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.
5. How representatives of women’s organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.
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| 1-2 PAGES SUGGESTEDThe proposed implementation arrangement is similar to the current HIV grant. Only one PR is nominated to manage the implementation of the proposed programme. The size of the programme makes it impractical to introduce more than one principal recipient. As the current PR (CDF), which is selected as PR for the proposed Concept Note implementation, is a civil society organisation, the role of civil society in the development of concept note and the implementation and oversight of the grant is secured by the proposed arrangements.For the implementation of certain activities within the HIV grant supported by the Global Fund, the PR shall rely on its current sub-recipients (SRs). The sub-recipients to implement specific projects among KAPs have been identified and selected in transparent, competitive, and based on a list of certain criteria that included technical merit, programmatic experience, geographical areas of functioning, achievements demonstrated in the past, sound financial and M&E systems in place, availability of key staff and procedures, etc. in early stages of the R7 GF HIV grant. Due to lack of experienced organizations with specific focus on HIV prevention among key affected populations, but also due to investments made in development of capacities of implementing agencies, the PR will consider the continuation of grant management with current sub-recipients. In order to ensure that the SRs are effective and efficient in delivering services to KPs in need, the PR will assess current performance of nominated SRs, conduct assessment of services provided and capacities and systems relevant to carry out the specific scope of work, before concluding a Grant Agreement. Four areas of capacity are assessed: program management, financial management, procurement and M&E. A standard checklist is used for each of the technical areas. Annex 11 provides the sub-recipient capacity assessment forms. (Capacity assessment templates attached to CDF Operations Manual).Once the CCM approves the selection of a specific SR, and (if relevant) the conditions set by the PR as a result of the SR capacity assessment are met, a sub-grant agreement is signed between the PR and the SR. The sub-grant agreement contains the terms and conditions that specify the contractual obligations between the PR and SR. The following key documents guiding the Any changes to the terms and conditions of the sub-grant agreement between PR and SR should be agreed by the two parties, and corresponding amendments should be made to the sub-grant agreement. The SRs, which will be responsible for the delivery of services and for implementation of advocacy agenda, represent and employ PLHIV and other key populations. Most of the proposed activities (service design, promotion and implementation including the development of BCC protocols; reaching out to underserved subpopulations of KAPs; participation in advocacy analysis, consultation and dialogue, operational studies; establishment of patient monitoring and treatment quality control mechanisms) require direct involvement of PLHIV and other key affected populations. Several local women’s organisations will be involved on a competitive basis to implement activities targeting vulnerable women and girls.  |

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| 4.2 Ensuring Implementation Efficiencies  |
| Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants. |
| Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.  |
| 1 PAGE SUGGESTEDThe proposed programme is a continuation of the existing HIV grant and will not overlap with it. It will be implemented in parallel with Global Fund supported TB related activities. Given the insignificant overlap between HIV and TB epidemic in Kosovo, there is no overlap between the areas of work associated with HIV and TB grants, and no overlap between the implementation partners. The personnel directly involved in HIV programme implementation are not involved in implementation of TB programme. Neither they perform overlapping functions. There are four CDF general staff (executive director, finance, procurement, and IT managers) involved in management of both HIV and TB activities and in line management of HIV and TB personnel. Their time allocations are split between two grants in accordance to their involvement. The two programmes share office rent and administrative costs proportionately to the number of staff involved in the implementation of each of the programmes.  |

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| 4.3 Minimum Standards for Principal Recipients and Program Delivery  |
| Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions. |
| PR 1 Name | Community Development Fund - CDF | Sector | NGO |
| Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)? | ☐Yes ☐No |
| Minimum Standards  | CCM assessment  |
| 1. The Principal Recipient demonstrates effective management structures and planning

The Community Development Fund (CDF) is a local NGO that commenced its activities in November 1999, when it was established in partnership with the Soros Foundation/Open Society Institute. On 8 October 2000, the CDF was registered as a local, non-profit NGO with Public Benefit Status to carry out a community development programs through small-scale community investments. So far, CDF has implemented programs funded by World Bank, USAID, Swiss Government, Canadian Government, UNDP, Kosovo Government and the GFATM. The PR has sufficient number of skilled, professional and experienced staff to manage the program. In October 2011 the PR established respective Program Implementation Units. The HIV PIU is comprised of HIV Program Manager (Senior Management Staff) and Middle Management Staff that includes: HIV procurement officer, HIV financial officer, HIV program assistant, HIV M&E officer, VCT coordinator, HIV Logistic/Driver, and Technical Support Staff who assists in day-to-day work: HIV financial assistant and HIV M&E assistant.The highest governing body of the PR is the Board of Directors, having ultimate responsibility for the policies and financial affairs of the CDF. The Executive Director is appointed (or removed) by the Board of Directors. The Executive Director proposes the internal organizational plan and the employment policies of the Foundation to the Board for approval. The day-to-day activity of the Fund is managed by the Executive Office, headed by the Executive Director, who coordinates relations and consultations with the CDF Board, and acts as secretary and a non-voting member of the Board. Executive Director is responsible for overall management of the CDF, including management of the staff.In his/her day-to-day work Executive Director works closely with Senior Management Staff that includes: 2 Program Implementation Units managers (HIV and TB respectively), 1 Procurement and Administration manager, 1 Finance Manager, and 1 MIS officer. | The PR demonstrates effective management structures and planning- The PR has sufficient number of skilled, professional and experienced staff to manage the program [including staff for functional tasks such as Procurement and Supply Chain Management (PSM), monitoring and evaluation (M&E) and Finance].- PR shows effective organizational leadership, with a transparent decision-making process.- Staff of key functions at the PR has relevant technical knowledge & health expertise for HIV/AIDS. |
| 1. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)

Once the CCM endorses the selection of a specific SR, and (if relevant) the conditions set by the PR as a result of the SR capacity assessment are met, a sub-grant agreement shall be signed between the PR and the SR. The sub-grant agreement contains the terms and conditions that specify the contractual obligations between the PR and SR. The SR becomes responsible for implementation of the sub-grant agreement that includes timely implementation of the work-plan and budget, submission of the required programmatic and financial reporting, monitoring and supervision of service delivery under the agreement, participation in meetings and other means of communication with the PR, etc. Similar terms and conditions shall be applicable to SSRs. The PR shall monitor the implementation of the sub-grant agreements by the SRs focusing on work-plan implementation, achievement of targets, budget utilization, and the quality of services. The PR will utilize different means of oversight and monitoring the SR performance, such as: desk review and verification of periodic reports and documentary evidence; regular monthly meetings with all SRs; monitoring visits to SR service delivery sites; and review of programmatic and financial reports. The PR will carry out regular field monitoring visits to the SRs with the purpose to observe the quality of services offered by the SR, and to verify the quality of data reported by the SR in periodic reports. For this purpose, the PR undertakes planned as well as ad-hoc visits to the SRs. Each of the SRs is visited at least once a month; nevertheless the actual frequency of monitoring visits undertaken by the PR for any given SR depends on the experience of a particular implementing organization, results of previous monitoring visits, quality of submitted reports and achievement of planned indicators. The PR M&E Officer is primarily responsible for implementing the monitoring visits; nevertheless, other PR staff, e.g. the PR Manager, the Financial and Procurement Officer, conducts monitoring visits as appropriate. Staff of the partner organizations, members of the CCM HIV working group, LFA, and other relevant stakeholders can also take part in monitoring visits. When reviewing the reports, the PR pays attention to the following:* Completeness, consistency and quality of the provided reports and supporting documents;
* The reasons for programmatic under/over-achievement
* Utilization of the budgeted costs, including reasons for under/over-utilization;
* Conformity with the national legislation;
* Eligibility of expenses; presence of any ineligible expenditure (not approved whether by the PR and/or Global Fund due to non-compliance of rules and regulations).

SRs must submit to the PR reports that are complete, accurate, signed and stamped. Only complete and accurately filed SR reports are approved by the PR. The PR shall follow up with the SRs on any issues identified during monitoring and the review of reports.In addition, all program supplies distributed to SR’s, and MoH (beneficiaries) are properly logged. This includes all items distributed to organizations, community groups, or individuals. All fixed assets are tagged with identification numbers which corresponds to the fixed asset register / inventory sheet / warehouse inventory log. | *Provide a brief description*PR exercises sufficient oversight over sub-recipients to safeguard both financial and physical assets.- PR has the ability to provide or contract for capacity-building to ensure timely and quality program implementation |
| 1. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud

The PR conducts internal control in order to prevent and detect misuse or fraud, and get an assurance that funds provided by GF are utilized: in line with the approved work plan, expected targets and the approved budget; in line with established Financial Management procedures and Global Fund standards; following generally accepted accounting principles; in line with the legal requirements of Republic of Kosovo; with valid and credible documentation that is properly kept in SR’s files.The PR shall request and expect from SRs to provide appropriate documents to support all expenses incurred by them during program implementation (e.g. personnel, program or administrative expenses). Evidence of appropriate authorization must be provided for all expenses accompanied by copies of invoices and receipts. Inability to provide necessary documents shall constitute ineligible expenses, and in such a case the SR shall be compelled to reimburse the PR.The PR shall document findings from desk verification and on-site monitoring visits, share the concerns identified during visits with the relevant SR and LFA, and establish an action plan with timeframe for corrective action. Financial monitoring visits to SRs will be also utilized to identify technical support needs and to mentor relevant staff in financial issues. | *Provide a brief description*The internal control system ensures that the PR adheres to policies and procedures consistently.- The internal control system supports compliance effectively with the related grant agreement to be proposed (evidence of the operation of the internal control is verified during grant management).- To be checked during grant management: external auditors and other third-party assurance providers are selected and assigned duties in accordance with Global Fund guidelines. |
| 1. The financial management system of the Principal Recipient is effective and accurate

Accounting policies are defined in guidelines specifying the accounting treatment for particular financial transactions while at the same time disclosing the underlying rationale. They constitute basic principles designed to ensure that the accounting records are complete, relevant, and reliable, and that the accounting practices are followed consistently from one period to another, so that financial reporting is comparable. Cash basis accounting method is utilized for project-specific reporting. It means that in the accounting of the Program, the effects of transactions and other events are recognized when they are paid. On top of that all contracts are entered into the management information system (MIS) when signed and the same amount credited to a vendor account.CDF employs specific software to generate the internal and external financial reports (further referred to as MIS). A chart of accounts has been developed for use with the computerized CDF cash based accounting system. The aim of this system is to categorize the transactions of the program into relevant accounts to be able to assist in the process of:* controlling expenditure;
* gathering information for reporting purposes, and
* analyzing accounting information for the production of the Financial Monitoring Reports (FMR).

The MIS is tailored to generate the financial reports to different donors. The system can generate detailed financial reports for any period of time, such as:* General Ledger Account Summary;
* Statement of Sources and Uses of Funds;
* Enhanced Financial Reports;
* Bank Book Report,
* Cash Book Report.

Financial Officer is responsible for generating the periodic financial reports due to reporting schedule.All reports generated from the system are subject to various updates which will include information about the detailed budget activity and expenditure category for each transaction depending upon the grant agreements’ requirements signed with donors: in case of grant extensions or reprogramming /budget revisions, or other changes imposed by the donor, system is updated. The accounting records are maintained in the software system in a way that prevents any unauthorized and improper corrections (unauthorized subsequent amendments of transactions). Any necessary corrections are made in a manner that permits the correction to be distinguishable and identifies the individual who made it. | *Provide a brief description*- PR has an accounting system in place that can correctly and promptly record all transactions and balances making clear reference to the budget and work-plan of the grant agreement.- PR manages all transactions and transfers to suppliers and sub-recipients in a transparent manner to safeguard financial and physical assets.- To be checked during grant management: The PR monitors actual spending in comparison to budgets and work-plan and investigates variances and takes prompt action. |
| 1. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products

Some of the key elements necessary to ensure that medical products actually reach the intended user are adequate storage and distribution systems. However, currently the storage and distribution of pharmaceutical products is done at MoH warehouse. It is most likely that the pharmaceutical products could be distributed directly in Central Pharmacies of Regional Hospitals due to better and more acceptable physical conditions for storage and better structure of professional human resources for drug management. It may even be possible to use private facilities and distribution networks run by commercial companies if public health facilities are not maintained up to a standard.Before medical products are procured the CDF will verify if the storage space for the products fulfills minimum international standards of good-storage practices i.e. that he space is adequate with respect to volume as well as quality of space (clean, dry, not subject to excessive heat or light, cold chain areas available if needed, all storage areas free of rodents and facilities are secure). Storage areas should be assessed using international and Kosovo Medicine Agency guidelines. The PR will verify if all storage facilities and personnel use the FEFO (first-expiry, first out) system when products have different expiry dates and the FIFO (first-inventory, first out) system for products with the same expiry date.In addition, CDF staff will ensure that there is no stock-out or overstock of the warehouse with inventory. The efficient stock management must take into account, without limiting to it, the following:* Economic order quantity is the order quantity that minimizes total inventory holding costs and ordering costs.
* Safety inventory (also called buffer inventory) represents a level of extra inventory that is maintained to mitigate risk of [stock outs](http://en.wikipedia.org/wiki/Stockout) due to uncertainties in supply and demand.
* Storage capacity of the MoH Central Warehouse which could affect the size of the order.
* Storage conditions as set by the Kosovo Medicine Agency in accordance with Kosovo Law Nr.2003/26 on Medicinal Products and Equipment.
* Product market demand.
 | *Provide a brief description*The storage capacity is appropriate in condition (including ventilation), equipment, and size for the type and quantity of products to be stored.- There is sufficient trained staff at central and regional level to manage stock.- The facilities are properly secured against theft and damages.- The facilities are equipped with a temperature monitoring and controlling mechanism. |
| 1. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions

There are inventory and information collection systems at each distribution and treatment site sufficient to monitor consumption rates and prevent diversion, stock outs and expired products; and if the inventory and information collection systems are not sufficient, it may be necessary to use grant funds to develop a computerized inventory and information collection system. Distribution and inventory management systems should include a mechanism to trace by batch number the patients to whom ARVs and other sensitive drugs are distributed in the event the product is recalled. The distribution network should be evaluated to ensure that there will be a constant supply of medicine. The supply chain management is based on the pull system where distribution is demand driven. However, it is necessary to identify significant challenges in distribution: * Lack of adequate roads, including seasonal problems like flooding and excessive snowing;
* Areas of internal conflict.

Once products arrive, it is important to use the inventory and information collection system to monitor forecasts with actual consumption rates. Only by monitoring this information can stock-outs be avoided and continuous supply of medicine guaranteed. It is also important for the programme to do periodic oversight and control every six months, of all points in the distribution chain. This will confirm that information is being accurately reported and help to prevent diversion of valuable commodities. | *Provide a brief description*- There is a distribution plan for supplies, dispatches and transportation.- The security measures for transportation are defined and the equipment and transportation conditions are adequate.- There is sufficient trained staff to manage distribution and delivery activities.- There is a logistics-management nformation system (LMIS) with requisition and stock-reporting tools in place to anticipate and minimize risk of stock-outs (incl. accurate forecasting and timely ordering). |
| 1. Data-collection capacity and tools are in place to monitor program performance

The routine data collection system implemented by CDF relies on data collected from the SRs and is based on a list of indicators determined by the Performance Frameworks for the two grants, as well as a list of additional internal indicators that are used by the PR for monitoring whether the programmatic activities implemented by the SRs are on track and/or corrective actions are needed. The routine data collection system is based on SR reporting on monthly, quarterly and semi-annual basis. Please refer to the chapter on SR management (Chapter 4) for more details on SR reporting. A robust data quality assurance system is implemented by CDF in order to ensure accuracy and reliability of programmatic data and consists of the following elements: * Verification of quarterly and semi-annual progress reports of sub-recipients by M&E officers of the PR. Verification of the internal logic of the reported data (e.g. cumulative numbers exceed those for the period, etc.), as well as consistency of the reported data with the M&E plan, work plan, budget and procurement plan;
* Review of primary documentation submitted by the SRs in support of their monthly reports: procurement forms, receipts and trainings participants’ lists, minutes of meetings, training evaluations, and other relevant documentation;
* Regular monthly field visits and ad-hoc visits to SRs allow to assess the quality of workplan implementation by the SR, as well as quality of data reported by the SRs in the last quarterly report.
* Monthly meetings with sub recipients to discuss planned activities, past performance and progress to-date, as well as necessary changes in implementation;
* Review of substantial deliverables such as manuals produced, guidelines, training materials, IEC materials, etc.
 | *Provide a brief description*- The monitoring and evaluation (M&E) system defines relevant indicators for routine monitoring of activities/interventions that are aligned to the goals and objectives of the program in question.- Adequate mechanism and tools are in place to report accurate and quality assessed data from the sub-sub-recipient / sub-recipient to the PR level.- Applicable for high-impact / TERG countries: Program Reviews are planned during the implementation period and National program reviews are conducted with involvement of partners on a regular basis. |
| 1. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately

Data collected through routine monitoring system is used by the PR for the following purposes:* To assess program implementation; estimate whether the program is on track and / or corrective actions are needed; to approve / revise / revisit future plans accordingly;
* To provide feedback and guidance to the SRs on their programmatic activities;
* To report to the GF / CCM / other external stakeholders on the programs’ progress up to date.
 | *Provide* *a brief description*The routine reporting system/ Health Management and Information System(HMIS) for public-sector facilities has a coverage of at least 50 percent, andthere is a costed plan to improve coverage to 80 percent.- The relevant HIV indicators have clear definitions- The routine reporting system / HMIS has a data-assurance mechanism in placethat annually verifies data. |
| 1. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain
 | *Provide a brief description* There is no qualified staff to manage/oversee quality assurance activities.(c) There is a plan for quality monitoring activities throughout the in-country supply chain, including quality control.(d) The World Health Organization "Model Quality Assurance System for Procurement Agencies (MQAS)" serves as guidance.(e) The entity has Standard Operating Procedures (SOPs) for key processes in place and revises the SOPs when necessary. |

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| 4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance |
| 1. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers’ capacity, and past and current performance issues.
2. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.
 |
| 1-2 PAGES SUGGESTEDThe delivery of the proposed programme can be influenced by a number of risks with various degrees of significance, which require mitigation measures.As recommended in the portfolio analysis and to increase the impact of the programme, all coverage indicators have been increased to ensure effective HIV prevention and timely detection of HIV among the programme clients with robust referrals to care. Recently conducted estimates of key population sizes have also called for introduction of more ambitious targets. The programme also includes activities aimed at additional vulnerable populations including migrants, underserved ethnic minorities, and vulnerable women and girls in rural areas. The significant increase in coverage will be achieved through introduction of innovative outreach strategies such as PDI, utilisation of a mobile service delivery unit, and greater engagement of peers in secondary service delivery. Implementation partners will require technical support to develop necessary capacities to implement these new approaches. Although the programme includes some limited amount of international TA, additional support may be required through one of the existing TA mechanisms complementing the Global Fund activities. The increased focus on quality assurance, which includes community monitoring of service delivery and thorough revision of several interventions including BCC and MMT will facilitate the planned increase in coverage, as well the planned access to qualified legal analysis. Another risk mitigation strategy that is considered by the PR is competitive engagement of additional implementation partners in new geographic areas of programme implementation. Geographic expansion of service delivery to marginalised populations will require building improved relationships with law enforcement and other significant stakeholders to ensure sufficient understanding and endorsement of interventions at the local level. National response to HIV and the current HIV programme supported by the Global Fund experienced severe supply disruptions, which have lead to interruptions in antiretroviral as well as methadone maintenance treatment, as well as wastage of medicines. Although these challenges have been analysed, and the involved parties have taken remedial action, certain improvements are still required in the organisation of PSCM cycle. Risk management strategy needs to be developed and introduced by the Ministry of health and the programme implementers have already agreed to support the government in the design of such strategy. Among the other things the strategy will include more detailed instructions regarding the buffer stock calculations, alignment of procurement plans with the projected increase in the number of patients, phased supply of medicine to eliminate the risk of expiration, as well as emergency procurement mechanisms. PSCM related technical assistance is currently being provided to the PR, which is further reducing the significance of this risk factor. Another risk is the limited number of potential implementing partners on the ground and lack of their capacity for delivering high quality services. Regarding in-field service provision PR relies mostly on a few NGOs, which sometime demonstrate suboptimal performance, but absence of competition does not allow selecting appropriate implementing partners that could provide high quality services. This risk will be mitigated through supporting activities on development of community-based organizations, including PLHIV networks, PWID/MMT patients’ organisations, and other peer-support groups for their meaningful engagement in HIV service provision and advocacy efforts for ensuring timely delivery of quality services. Limited involvement of the government in the programme implementation presents another challenge. The only PR is an NGO and most of the programme activities are NGO-based. This risk can be considered of low impact as it does not directly influence outcomes of the current Program, but is crucial in terms of further sustainability of GF-supported services on HIV prevention and care. This risk will be mitigated by gradual takeover of services under the current grant by the government structures. The government is already supporting treatment of HIV and opportunistic infections, contributing to HIV services in penitentiary institutions and MMT services and is currently considering increased supply of condoms for HIV prevention purposes. The programme advocacy group will follow up on these commitments and will keep sustainability issue on programme’s advocacy agenda. There are risks associated with introduction of specific interventions such as those related to service delivery to criminalised populations, limitations associated with introduction of Naloxone, as well as challenges involved in the necessary licensing of mobile service delivery units for provision of health services. These will be addressed by the advocacy group, which will conduct the necessary legal analyses and engage in a constructive dialogue with relevant governmental agencies on the development of adequate solutions. High turnover of staff and limited incentives and poor working conditions can impact on the programme effectiveness. The programme contains a modest contribution towards improving the situation in public health facilities involved in the delivery of MMT. The implementing agencies will seek opportunities for professional development of frontline service providers.  |

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

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

1. Prevalence in key populations may be underestimated. The 2014 IBBS studies were conducted only in Pristina municipality for MSM, in Ferizaj for FSW, and in Pristina and Prizren for PWID. The study participants have been recruited through organisations providing HIV prevention services to key populations, thus segments of key populations which are not exposed to HIV prevention interventions were underrepresented in the studies. [↑](#footnote-ref-2)
2. HCV prevalence is a biomarker of sharing injecting equipment and paraphernalia and is an indication of the PWID network’s vulnerability to HIV infection. The 2011 IBBS study (Behavioural and biological surveillance study on HIV among IDU in Kosovo 2011. Technical report. Pristina, 2011) has found 96 people with HCV in an RDS of 205 PWID – a prevalence rate of 47%. [↑](#footnote-ref-3)
3. The Kosovo Agency of Statistics. 2014. 2013-2014 Kosovo Multiple Indicator Cluster Survey, Key Findings. Prishtinë/Priština, Kosovo: The Kosovo Agency of Statistics. [↑](#footnote-ref-4)
4. The Kosovo Agency of Statistics. 2014. 2013-2014 Kosovo Multiple Indicator Cluster Survey, Key Findings. Prishtinë/Priština, Kosovo: The Kosovo Agency of Statistics. [↑](#footnote-ref-5)
5. These calculations are based on mid range prevalence estimates [↑](#footnote-ref-6)
6. People (1) who think that a female teacher who is HIV-positive and is not sick should be allowed to continue teaching, (2) who would buy fresh vegetables from a shopkeeper or vendor who is HIV-positive, (3) who would not want to keep secret that a family member is HIV-positive, and (4) who would be willing to care for a family member with AIDS in own home. [↑](#footnote-ref-7)
7. Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB. [↑](#footnote-ref-8)
8. Dave Burrows, Aram Manukyan, Mirza Musa. Review of the HIV National Strategic Plan in Kosovo, October 2014. [↑](#footnote-ref-9)
9. WHO (2014) Review of the HIV Programme in Kosovo. Copenhagen. [↑](#footnote-ref-10)
10. Application of the same extrapolation technique to the total country population gives a nationwide estimate of PWID population of **13808**. This may be an overestimate as we extrapolate from predominantly urban to predominantly rural areas and prevalence of injecting drug use is likely to be lower in rural locations. [↑](#footnote-ref-11)
11. 28.7% of PWID reported injecting Methadone in 2011 IBBS sample. [↑](#footnote-ref-12)
12. Schardt S. (2013) Methadone maintenance treatment in Kosovo: Assessment report. P. 14. [↑](#footnote-ref-13)
13. Schardt S. (2013) Methadone maintenance treatment in Kosovo: Assessment report. [↑](#footnote-ref-14)
14. HCV testing is included in the main allocation and HBV testing – in the above allocation. [↑](#footnote-ref-15)
15. Due to funding limitations these studies are included in the above allocation. [↑](#footnote-ref-16)
16. The implementing partners will seek additional funding to enable the development of ICT-based communication tools. [↑](#footnote-ref-17)
17. Production of printed IEC materials is included in the above allocation. Production of visual materials to be distributed through internet-based social network will also be explored. MICS report suggests that the use of mass media (23-42% among 15-49 year old) is much lower than the use of the internet (95-97% among 15-24 year old). [↑](#footnote-ref-18)
18. Distribution of lubricants is included in the above allocation. [↑](#footnote-ref-19)
19. Wildt, R. (2012). *Preliminary study on sex trafficking and prostitution market dynamics in Kosovo.* [↑](#footnote-ref-20)
20. All these services are included in the above allocation. [↑](#footnote-ref-21)
21. This will utilise the mobile service delivery unit shared with the other key populations. [↑](#footnote-ref-22)
22. The impact target is to retain the prevalence in PWID, MSM and FSW below 5%. The 2014 prevalence rates established by IBBS studies are 0% among PWID and FSW, and 2.3% among MSM. Although these data relate to a limited number of municipalities (Pristina for MSM, Ferizaj for FSW, and Pristina and Prizren for PWID), they allow for concluding that the nationwide prevalence in HIV in al these groups is most likely below 5%. [↑](#footnote-ref-23)
23. MICS, P. 15 [↑](#footnote-ref-24)