Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM
ROLLING CONTINUATION CHANNEL

The Applicant named below is invited to apply to the Global Fund to Fight AIDS, Tuberculosis and Malaria for additional financing for up to six years in regard to the interventions targeted in the expiring grant indicated below. This avenue to receive funding is called the Rolling Continuation Channel and the accompanying '**Guidelines for Proposals**' further explain the application content and process.

Different to the 'Rounds' channel of funding, open to all Applicants, this Proposal Form may only be completed by Applicants who qualify to receive an invitation to apply for this additional financing.

Importantly, the Rolling Continuation Channel is specifically offered to Applicants with strong performing grants. Within their proposal, the Applicant is required to demonstrate that the proposal's goals and objectives will contribute to demonstrate the potential for impact on the relevant epidemic and show sustainability. This should be an important focus of your planning and proposal development.

The rationale for the Rolling Continuation Channel and its purpose is fully explained in the Guidelines for Proposals. Please read these carefully, as they provide all the information required to complete this application.

Applicant Name	**COUNTRY COORDINATING MECHANISM TO FIGHT AIDS AND TUBERCULOSIS**
Country/countries	**BULGARIA**
Component	**HIV/AIDS**
Expiring Grant Number	**BUL-202-G01-H-00**
Applicant Type	**CCM**

How to complete this form

PROPOSAL FORM SECTIONS

REQUIRED ATTACHMENTS

A. **Targets and Indicators Table** *(for performance based funding evaluation during the proposal term)*

B. **Preliminary List of Pharmaceutical and other Health Products**

C. **Membership and Proposal Endorsement details of Coordinating Mechanism** *(If you applied in Round 7 for different component(s), you still need to complete this Attachment to show proposal endorsement.)*

+ **Detailed Proposal Budget**

+ **Detailed Work plan**

A checklist of all annexes to be attached to the Proposal Form is provided at the end of section 5 of this Proposal Form.

1. **Before you start** - Ensure that you have all documents that accompany this form:
   - The Guidelines for Proposals for 'Rolling Continuation Channel' applications;
   - A complete copy of this Proposal Form; and
   - A complete copy of Attachments A, B and C to this Proposal Form.

2. **Read the accompanying** Rolling Continuation Channel **Guidelines for Proposals** before completing this Proposal Form.

3. Further guidance for completing specific sections is also included in the Proposal Form itself, printed in *blue italics*. In some questions, indications are given as to the recommended maximum length of the answer to guide the overall maximum length expected for a completed application.

4. To **avoid duplication of effort**, we recommend that you make maximum use of existing information (e.g., national health sector development plans, country evaluations of disease impact and/or sustainability, national monitoring and evaluation frameworks, situation analyses of strengths and weaknesses of the existing responses to the disease(s), and documents written to report to the Global Fund on existing grants and/or work supported by other donors/funding agencies).

5. **Complete the Checklists** at the end of section 5 of the Proposal Form to ensure that you are submitting a complete application.

6. **Attach all documents** requested throughout the Proposal Form **including** a **detailed** budget, work plan, and all documents you are requested to annex to the proposal.

7. Consult our "Frequently Asked Questions" link at: http://www.theglobalfund.org/en/apply/rcc/documents/faq/ In addition, examples of proposal budgets with a good level of detail and that are included on our Round 7 website may assist you to prepare your Rolling Continuation Channel Detailed Proposal Budget (section 5.1).

1 Proposal Overview

1.1 General information on proposal

Proposal title
PREVENTION AND CONTROL OF HIV/AIDS IN BULGARIA

Currency in which the proposal is submitted

*Please check only **one** box below. **Please note that you must use this same currency throughout the whole Proposal Form**.*

☐ US$ **OR** ☒ Euro

1.2 Summary of funding request

Please fill in the amount requested for each year of the proposal term below. This amount must be the same as the totals of the corresponding budget summary by cost category in table 5.3.

Table 1.2 – Total funding summary

Total funds requested over proposal term						
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
5 578 095	5 945 544	6 494 312	5 429 859	4 734 671	4 239 333	32 421 815

1.3 Contact details for enquiries by the Global Fund

*Please provide full contact details for two authorized persons **who will be** readily accessible to the Global Fund for technical or administrative clarification purposes for approximately **two months** following the deadline for submission of proposals, as set out on the cover page of this Proposal Form.*

Table 1.3 – Contact details for enquiries by the Global Fund

Contact Details for Enquiries on the Applicant's Proposal after Submission		
	Primary contact	**Secondary contact**
Name	Dr. Tonka Varleva	Prof. Hristo Taskov
Title	CCM Secretary and Director of Prevention and Control of AIDS, Tuberculosis and STIs Directorate	CCM Second Vice-chair and Vice-chair of the Expert Board on HIV/AIDS/STIs Prevention at the Ministry of Health
Organization	Ministry of Health	National Center of Infectious and Parasitic Diseases
Mailing address	Bulgaria 1000 Sofia 5 Sveta Nedelia Sq	Bulgaria 1000 Sofia 26, Yanko Sakazov blv.
Telephone	+359-2-9301-243 +359-2-9301-274	+ 359 2 943 30 75 + 359 2 843 21 75
Fax	+359-2-9301-274	+ 359 2 944 28 75
E-mail address	tvarleva@mh.government.bg	taskov@ncipd.org
Alternate e-mail address	tvarleva@gmail.com	hristotaskov@gmail.com

1 Proposal Overview

1.4 Overview of Applicant's proposal

Provide a brief summary *(maximum two pages)*:

(a) of the overall strategy of this proposal including: the main goals, objectives, and planned outcomes and outputs to be achieved through the additional funding requested, specifying the main beneficiaries (including target populations and their estimated number) and the main geographic area(s) targeted by this proposal;

(b) as to whether the **main** interventions targeted in this proposal represent a continuation and scale-up of the same interventions targeted in the expiring grant or, as relevant, a change in scope to include a broader package of interventions; and

(c) of how the overall strategy of this proposal contributes to both reducing overall mortality and morbidity, and to the achievement of the Millennium Development Goals.

The **overall goal** of this rolling continuation proposal is to contribute to the decrease of HIV incidence rate and to improve the quality of life of people living with HIV by:

Increase from 37% in 2007 to at least 60% in 2014 the coverage of most-at-risk groups with targeted, sustained and evidence-based HIV prevention interventions in order to reduce the risk of acquiring or transmitting the HIV infection.

Increase from 33% in 2007 to at least 75% the coverage of voluntary testing and counselling services provided to the most-at-risk groups in order to increase the proportion of HIV-infected people who know their status.

To this effect, the ***overall proposal strategy*** will focus on *three broad aspects* of the national response: a) *Sustainability and national ownership*; b) Scaling up *coverage*, and providing *continuity* of access to *comprehensive, high-quality* programmes and services tailored to the specific needs of most-at-risk groups; and c) Provision of professional care and support services for PLHIV to improve the quality of their life.

The proposal seeks to contribute to the overall goal of the National AIDS Strategy 2008-2015 through the attainment of the following specific objectives: 1) To create a ***supportive environment*** for an effective and sustainable national response to HIV/AIDS in Bulgaria; 2) To strengthen the ***evidence base*** for a targeted and effective national response to HIV and AIDS; 3) To expand the accessibility, coverage and quality of ***VCT*** services as an entry point to prevention, care, support and treatment services, with a special focus on the key most-at-risk groups; 4-9) Objectives 4-9 focus on reducing the specific vulnerabilities and scaling up the ***coverage***, and guaranteeing ***continuity*** of access to ***comprehensive, high-quality*** programmes and services tailored to the specific needs and priorities of the key most-at-risk groups: 4) Injecting drug users (IDUs); 5) Roma population; 6) Sex workers; 7) At-risk youth; 8) People living with HIV (PLHIV); and 9) Men who have sex with men (MSM);

Proposal objectives are:

OBJECTIVE 1: To create a supportive environment for a sustainable national response to HIV/AIDS in Bulgaria

OBJECTIVE 2: To strengthen the evidence base for a targeted and effective national response to HIV and AIDS

OBJECTIVE 3: To scale up coverage of testing and counselling services provided through the low-threshold VCT network with a focus on most-at-risk groups

OBJECTIVE 4: To reduce HIV vulnerabilities of IDUs by scaling up population coverage of a comprehensive package of prevention interventions

OBJECTIVE 5: To reduce HIV vulnerabilities of most-at-risk Roma people (aged 15-25 years) by scaling up population coverage of community-based prevention and referral services

1 Proposal Overview

OBJECTIVE 6: To reduce HIV vulnerabilities of female and male sex workers by scaling up population coverage of comprehensive package of prevention interventions

OBJECTIVE 7: To reduce HIV vulnerabilities of at-risk youth (aged 15-24 years) by scaling up coverage of comprehensive youth-friendly programmes and services

OBJECTIVE 8: To improve the quality of life of people living with HIV/AIDS (PLHIV) by guaranteeing universal access to treatment, care and support

OBJECTIVE 9: To reduce HIV vulnerabilities of MSM by scaling up population coverage of a comprehensive package of prevention interventions

Planned Outcomes and Outputs **–** This rolling-continuation proposal focuses on strengthening the national and local/municipal systems needed for a ***sustainable national response*** by applying the *lessons learned* to date in the expiring grant, and integrating them in national and local legislation, policies, plans, and programmes and services.

Implementation of the proposal will take a ***phased approach*** that will first focus on 1) ***Expanding coverage, comprehensiveness and quality*** of key programmes and services for MARP groups that have *proven their effectiveness* under the current, expiring grant; and subsequently focus on 2) Systematically establishing and strengthening a ***supportive environment*** that will guarantee local ownership and sustainability of the national response to HIV/AIDS. This involves strengthening the meaningful involvement (including sustained allocation of Government human and financial *resources*) of all key government sectors at the national and especially the *municipal* level, as well as strengthening ***partnerships*** between Government, civil society and the private sector.

Main beneficiaries: estimated number of most-at-risk groups in need of key services in 2007

Injecting drug users – 19,800
Men who have sex with men – 62,191
Young Roma people (aged 15-25 years) identified as most-at-risk IDU, MSM, SW, partners of IDU, SW and MSM; ex-prisoners, mobile people – 42,350
Prisoners – 11,058
Sex workers – 7,720
At-risk youth (aged 15-24 years) – 74,954
People living with HIV (PLHIV) – 4,184

Main geographic areas targeted by this proposal:

Analysis based on epidemiological data for the last three years to December 2007 shows delineation of four groups of regions based on the concentration of the epidemic.

(d) Regions with very high cumulative incidence* - Sofia and Plovdiv (3.5 to 6.06 per 100 thousands)
(e) Regions with high cumulative incidence - Varna, Sofia-region, Yambol, Bourgas, Stara Zagora, Blagoevgrad, Vidin, Haskovo and Rousse (1.33 to 1.88 per 100 thousands)
(f) Regions with medium cumulative incidence - Targovishte, Dobrich, Razgrad and Kyustendil (0.17 – 0.70 per 100 thousands)
(g) Regions with low cumulative incidence - Sliven, Gabrovo, Silistra, Pernik Pazardzhik, Montana, Vratza, Lovech, Veliko Turnovo, Pleven, Kardzhali and Shumen (less than 0.17 cases per 100 thousand)

Main interventions targeted in this proposal represent a continuation and scale-up of the interventions targeted in the expiring grant

* ** Average cumulative incidence of new diagnosed HIV cases per 100 000 population in 2005-2007*

1 Proposal Overview

This proposal has a phased approach, focused on ***scaling up*** successful programmes and services by expanding them to geographic areas that have been estimated as both with high cumulative HIV incidence and consentration of risk factors; as well as by increasing coverage of existing services and strengthening their quality and client-orientedness, as well as intensifying proactive outreach work and peer approaches.This scale up is expected to be facilitated by the proposal's equally important focus on building in ***sustainability*** by strengthening the involvement and ownership of Government sectors and institutions, especially at the municipal level. In this context, the proposal aims to build capacity and work closely with key institutions in all the biggest municipalities (centres of 28 regions) in the country. The planned scale up is important for all key components of the expiring grant – VCT services, programmes and services for PLHIV, sex workers, IDUs, MSM, Roma population, at-risk youth – and is expected to be sustained by the explicit focus on creating an overall supportive environment through building institutional and technical capacity in all sectors, strengthening legislative and policy frameworks and other approaches to ensure sustainability. The combined focus on scaled-up coverage and sustainability is considered to lead to synergistic effects, which will make a considerable contribution to a real impact on HIV trends.

The expiring grant contributed substantially to the achievement of the goals of the National Strategy and Program for Prevention and control of HIV/AIDS/STIS 2001-2007. It has been designed bulding on and scaling up interventions of the current National AIDS Program and the in line with the new National AIDS Sratrategy 2008-2015. This alignment will expand the national response and will and will icrease the potential of the country in achieving the MDG by reducing vulnerabilities of groups most at risk, providing contributing to a better quality of life of PLHIV, diminishing HIV-related morbidity and mortality.

1.5 Technical Assistance provided during proposal preparation

*Please check the applicable box(es) if you received any technical assistance during preparation **of this proposal** for the sections set out below. Indicate which organization(s) or individuals (if any) provided assistance, and over what duration this was provided.*

Table 1.5 – Technical assistance for proposal preparation

Section	Name of organization(s) or individuals providing assistance and type of assistance provided	Duration of technical assistance
☒ Sections 1 to 3B	UNAIDS National Program Advisor provided review and feedback on the sections UNAIDS Country office supported translation of documents	5 days
☒ Proposal Strategy Section 4	Joost Hoppenbrouwer Consultancy provided review and comments on the proposal UNAIDS Epidemiology and Impact Evaluation Department Geneva provided technical assistance on Estimation and Projections of the epidemic using Workbook, EPP models UNAIDS National Program Advisor Mrs. Manoela Grozdanova provided technical assistance to the proposal development process	10 days 2 days 30 days
☐ Proposal Budget Section 5		

1.6 Previous Global Fund grants/proposals recommended for funding

*Please provide **specific details of (ii) amounts expended under existing Global Fund grants for the same disease as targeted in this proposal** (by Round) as **at 30 September 2007**. For more detailed information, see the Guidelines for Proposals, section 1.6.*

1 Proposal Overview

Table 1.6.1 – Previous Global Fund same disease financial support

Same Disease Component as targeted in this Proposal Form	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 30 September 2007	Total cumulative amount already expended (by the PR and SRs) under prior Global Fund grants as at 30 September 2007
Round 1		
Round 2	13 778 487	11 304 968
Round 3		
Round 4		
Round 5		
Round 6		
Total	13 778 487	11 304 968

*Where relevant to the goals and objectives of this proposal, also identify any **existing HSS or Integrated** components (e.g. HIV/TB) in the table below.*

Table 1.6.2 – Previous Global Fund HSS and other financial support

HSS or Integrated	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 30 September 2007	Total cumulative amount already expended under prior Global Fund grants as at 30 September 2007
Round 1		
Main disease targeted		
Round 2		
Main disease targeted		
Round 5		
Main disease targeted		
Total		

2 Income Level Eligibility Questions

2.1 Eligibility Requirements linked to World Bank Income Level Classification

In the table below, please identify the World Bank income level classification for your country. This information may be found at the following link: Web link to World Bank Income Level Data

***Applicants should complete only** those questions in this section 2 that are identified in the "Next Steps" column below as relevant to their income level classification.*

Country Name	World Bank income level classification	Date	**Next Steps**
	Low-income	1 July 2006	➔ *Go straight to **section 3A**, Applicant Type*
Bulgaria	Lower-middle income	1 July 2006	➔ *Complete **both** sections 2.2 and 2.3, and **then go to section 3A***
	Upper-middle income	1 July 2006	➔ *Complete sections 2.2 and 2.3 **and** 2.4, and then go to section 3A*

2.2 Counterpart financing and greater reliance on domestic resources

Indicate in the table below the extent of domestic 'counterpart financing' being contributed to support the national response for the disease targeted in this proposal. Indicate, first, the resources requested in this proposal (Line A), and then domestic resources other than those requested in this proposal (Line B).

➔ *For definitions and details of **counterpart financing** requirements, see the Guidelines for Proposals, section 2.2.*

Important notes:

1. *The field "Total requested from the Global Fund" in table 2.2.1 below must equal the budget request in section 1.2, section 5 and the budget breakdown by cost category in table 5.3.*

2. ***Amounts included in line A and line B in the tables below should be in figures not percentages.***

Table 2.2.1 – Counterpart financing

Financing sources ⬇	**Counterpart Financing calculation over proposal term** *(same currency as in section 1.1)*					
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**	**Year 6 estimate**
Line A ➔ Total requested in this proposal **[from table 5.3]**	5 578 095,2	5 945 544,1	6 494 311,7	5 429 859,3	4 734 671,3	4 239 333,4
Line B ➔ Amount of country counterpart financing	5 922 079	6 310 098	7 020 734	8 647 488	9 301 246	10 446 378
Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %	51.50%	51.49%	51.95%	61.43%	66.27%	71.13%

2 Income Level Eligibility Questions

2.3 Focus on poor or vulnerable populations

Lower-middle income and Upper-middle income countries must demonstrate a focus on poor or **vulnerable population groups**. Proposals may focus on both population groups but **must** focus on at least one of the two population groups.

Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these population groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal.
(Maximum half a page.)

The target groups of this RCC proposal are:

Injecting drug users (IDUs)
Men who have sex with men (MSM)
Young Roma people (aged 15-25 years)
Prisoners
Female and male sex workers (SWs)
At-risk youth (aged 15-24 years)
People living with HIV (PLHIV)

The target groups were identified on the evidence base for

- Increasing number of new HIV infections consequently increasing HIV prevalence confirmed by cross-sectional surveillance studies
- Potential for development of concentrated epidemics due to behaviors identified as drivers of the epidemic
- Vulnerabilities related to geographical distribution of HIV cases pertaining to bridging populations that can contribute to the transmission of the HIV infection
- Overlap of vulnerabilities of risk behaviors in target groups are IDUs as follows: MSM, young Roma men, Prisoners, F&M sex workers (and their partners), at-risk youth, PLHIV
- Vulnerabilities related to low social, health and economic status and internal and external mobility.
- Regular needs assessment performed as part of outreach work of service providers

These groups were identified through a broad national consultative process in 2007 when 9 round tables were organized on national level in order to evaluate the strengths, weaknesses, opportunities and threats of the interventions implemented within the framework of the National Action Plan for Prevention and Control of HIV/AIDS and STIs (2001-2007). Future policies and strategies in the areas of HIV prevention, testing, treatment, care and support to ensure impact and sustainability of the national response were major subject of the round tables. More than 240 people participated actively in consultative process representing key stakeholders in the country:

- governmental institutions (ministries, state agencies, commissions)
- health and social care providers
- representatives of the academic sector
- civil-society organizations actively involved in implementing the national HIV/AIDS response
- international and bilateral organizations
- representatives of most-at-risk groups and PLHIV

This proposal will continue to provide comprehensive quality HIV prevention, care and support services to the hard-to-reach groups primarily by civil society organizations. Major successful strategy to increase coverage and effectiveness of interventions is the participation of the target groups through:

- implementation of activities by community-based organizations as SRs of the grant
- referral to and provision of services by key community members through peer-driven activities
- consensus – building forums to support policy development and strategic planning
- participatation in executive and consultative bodies at national level. PLHIV in particular have 2 representatives in CCM and 1 in the Expert Board on HIV/AIDS at the Ministry of Health
- participation in wuality assurance of service provision through mechanisms to monitor client satisfaction.

2 Income Level Eligibility Questions

2.4 Upper-middle income high disease burden minimum thresholds

Upper-middle income countries must also demonstrate that they **currently face** a high national disease burden.
➔ *Countries falling under the 'small island economy' lending eligibility exception as classified by the World Bank/ International/Development Association are exempt from meeting this requirement*.

Confirm that the Upper-middle income country targeted in this proposal is **currently** facing a high **national disease burden**, as defined by data from WHO.

3A Eligibility of Country Coordinating Mechanism

From July 2005, the Board of the Global Fund has mandated that CCM, Sub-CCM and RCM Applicants must continue to comply with six minimum eligibility requirements to remain eligible to submit proposals. Annex 1 to this Proposal Form lists all of these requirements and some Applicants will need to complete Annex 1. Please read on to see if this is relevant to your application.

This section requests information as to how, as a Coordinating Mechanism Applicant, your proposal has been prepared in a manner which is compliant with these important minimum eligibility requirements.

3A.1 Coordinating Mechanism compliance history

Table 3A.1 – Applicant's history of Coordinating Mechanism compliance

Global Fund record of application history		Your Next Steps
☒	Applied in Round 6 or Round 7 **and** determined as being compliant with the minimum eligibility requirements.	***Complete section 3A.2 and sections 3A.3 and 3A.4 below.***
☐	Did not apply in Round 6 or Round 7 **or** determined non-compliant with the minimum eligibility requirements.	***Instead of completing this section 3A, complete all of Annex 1 to this Proposal Form*** *(refer to page 40).*

3A.2 Changes in Coordinating Mechanism's operations compared to last application

Describe any changes in the Coordinating Mechanism's rules of procedure; or the sectors represented on the Coordinating Mechanism; or the representative selected by a sector; or the main operations of the Coordinating Mechanism since submission of your Round 6 application to the Global Fund. In particular, describe if new processes have been adopted to manage conflicts of interest; or oversee the work of implementation partners. If there are changes in sectors represented on the Coordinating Mechanism, or in the representative for a particular sector, the Coordinating Mechanism must show how the sector itself made a transparent selection of their representative.

If there are any changes, these must be described in detail below and you must attach documented evidence of how the Coordinating Mechanism continues to meet requirements numbered 1 to 6 in Annex 1 to this Proposal Form.

Since Round 6 when CCM Bulgaria was qualified as eligible, there were no general changes in the sector proportion and representatives of the CCM. According to the CCM Terms of Reference, members can have either full-voting or observer status. The full members are members by appointment or members by election. According to article 5 of the CCM Terms of Reference (Annex 1 – CCM Bulgaria ToR), the appointed members of the CCM participate by virtue of their employment and the elected members are elected by the constituency of the non-governmental organizations working with the main target groups of Program "Prevention and Control of HIV/AIDS" on a quota basis for a period of three years. The structure and sectors represented in Bulgarian CCM up to now are as follows:

1. Governmental sector with 14 representatives, which are 38% of the Committee
2. Non-governmental sector with 23 representatives, which are 62 % of the Committee. The non-governmental sector includes the following constituencies:
- Academic/Educational sector – 7 representatives (19 %)
- Non-governmental/Community-Based Organizations - 10 representatives (27%)
- Multilateral/Bilateral Organizations - 5 representatives (13 %)
- People living with HIV/AIDS – 1 representative

The only changes occurred up to now are:
1. A new member was invited as an observer with the decision taken on the work meeting of CCM on 30.01.2008. The new observer is the Chair of the most popular nongovernmental organizations, representing the intravenious drug users in Bulgaria "Hope-Sofia". It will be very usefull for the CCM to include directly in its work and decision making process the feedback from the

representative of the key affected people in Bulgaria (Annex 11 – Minutes from the CCM meeting on 30.01.2008)

2. The representave of the people affected by tuberculosis, nominated in 2006 by the constituency of TB patients in 2006 was resigned by his own request. CCM Bulgaria decided to initiate a new process for election of member, who will represent the people affected by TB
3. During the CCM working meeting on 30.01.2008 CCM members decided to invite a representative from the business sector, who will be nominated by the pharmaceutical organizations related to the ARV drugs in Bulgaria (Annex 11 – Minutes from the CCM meeting on 30.01.2008)
4. Two members by law were changed because of the new persons appointed to the position of UN Resident Representative in Bulgaria and Deputy Minister of Finance.
5. The Mission Director of USAID and the representative of an IDUs' organization (Foundation *Hope-Sofia*) participate in CCM meetings as observers. According to CCM Terms of Reference, they do not have voting obligation and did not sign attachment C to the current proposal.

3A.3 Summary of PR(s) identified in this proposal

Topic Area	Yes or No	If no, explain why not
Are the Principal Recipient(s) identified in section 4.8.1 of this proposal from a different entity than the Chair and Vice Chair of the Coordinating Mechanism.	**No**	If no, **you must attach as an annex to your proposal,** the Coordinating Mechanism's current policy to mitigate potential and actual conflicts of interest. Annex 1 – ToR of CCM Bulgaria Annex 2 – Statements of conflict of interests Annex 3 – Minutes from the CCM meeting on 01 August 2006 A second Vice-Chair from the non-governmental sector was elected to avoid a conflict of interest between the Principle Recipient and the CCM Chair and/ or Vice-chair (Art. 6.4 from the CCM Terms of Reference). The second Vice-Chair chairs the CCM meetings in situations where there is a potential conflict of interest. He is a representative of the academic sector and serves for a period of three years after the election (Annex 3 – Minutes from the CCM meeting on 01 August 2006)

3A Eligibility of Country Coordinating Mechanism

3A.4 Country-driven, coordinated and multi-sector approach to proposal development

To be eligible to submit a proposal under the Rolling Continuation Channel, Coordinating Mechanism Applicants (CCM, Sub-CCM and RCM) must also provide evidence that they have complied with the proposal specific minimum eligibility requirements (which comprise a sub-set of the six minimum eligibility requirements). These minimum requirements are those listed as Requirements 3(a), 3(b), 4(a) and 5(a) in Annex 1 to this Proposal Form, at page 40.

Applicants are requested to review these minimum requirements carefully, and then provide detailed answers to the questions set out in the text box below.

3A.4.1 If you are proposing to <u>continue/scale up some or all of the interventions</u> from the expiring grant, describe in detail the transparent process that the Coordinating Mechanism followed in order to ensure that:

(a) a broad group of stakeholders (including Coordinating Mechanism and non-CCM stakeholders) have been involved in evaluating the appropriateness of the interventions; and

(b) the decision to continue these interventions was made after discussion among the broad group of stakeholders consulted.

Applicants are reminded that they must also attach documentation (as numbered annexes to their proposal) to provide evidence of the transparent, broadly inclusive processes they adopted and describe below to develop this proposal. ➔ *Refer to the Guidelines for Proposals for a list of minimum documents, section 3A.4.1.*

The process for designing and planning of the RCC proposal was a substantial part of the strategic planning process for the new National Strategy and Action Plan for HIV/AIDS. The preparation started in October 2007 with conducting 9 (nine) round tables for SWOT analysis of the key areas of the national HIV/AIDS response with the participation of 241 people.

The results from these discussions and feedback from the participants were the basis for the national AIDS strategy development and for the designing of the interventions described in the current proposal for RCC (Annex 16 – Web-site announcements for strategic planning in HIV/AIDS).

Also there was a clear and transparent procedure initiated by the CCM Bulgaria for preparing of small proposals to be included into the country's proposal.An expert working group was established for preparation of the RCC project proposal with an order of the Minister of Health in December 2007 (Annex 12- Order No 15-3584/15.12.2007) The RCC invitation letter and all documents were translated into Bulgarian and uploaded on 3 official web-sites – these of the National AIDS Committee, Ministry of Health and Program Prevention and Control of HIVAIDS in January 2008, also in the UNAIDS Bulgaria e-bulletin for ensuring a broad inclusion of the stakeholders (Annex 10 - Invitation for small proposals development). CCM Bulgaria members designated to the appointed expert working group to prepare a clear procedure and criteria for evaluation and inclusion of small proposals into the consolidated country RCC proposal. (Annex 11 – Minutes from CCM meeting on 30.01.2008). This decision was implemented and the documents were also uploaded on web-sites, mentioned above. (Annex 13 – Published procedure and criteria for small proposals).

25 small proposals were submitted from 17 nongovernmental organizations, 1 state agency and 2 academic institutions. Some of the organizations had prepared more than one small proposal. (Annex 15 – Cover Letters of the small proposals). The small proposals were evaluated by the expert working group (Annex 17 – Minutes from the working group evaluation of small proposals).

A broad discussion meeting was organized with the stakeholders who have sent small proposals and the expert working group members in Sofia on 22.03.2008. The proposals were presented and discussed in detail with all participants during the meeting. It is important to stress on the fact, that the small proposals presented the real inclusion of the non-governmental organizations working at local level in Bulgaria. At the meeting there were participants from 10 local non-governmental organizations from different towns of Bulgaria, only 3 NGOs working in Sofia and a representative of the State agency for Child protection. After the broad discussions the acceptable proposals were included into the country's proposal and presented to the all CCM members via email. (Annex 18 – Minutes from the work meeting with stakeholder for discussing the small proposals).

3A Eligibility of Country Coordinating Mechanism

3A.4.2 **If you are also proposing <u>new interventions</u> or <u>where a new/additional PR is proposed</u>**, describe in detail the transparent process that the Coordinating Mechanism followed to ensure that:

(a) a broad group of stakeholders (including Coordinating Mechanism and non-CCM stakeholders) were involved in the documented and broadly inclusive process to solicit submissions (for new interventions or a new PR) and review these for possible integration into this Rolling Continuation Channel proposal; and

(b) the decision of whether to include new interventions, or select a new or additional PR, was made after these submissions were received, transparently evaluated and discussed by the Coordinating Mechanism.

Applicants are reminded that they must also attach documentation (as numbered annexes to their proposal) to provide evidence of the transparent, broadly inclusive processes they adopted and describe below to develop this proposal. ➔ *Refer to the Guidelines for Proposals for a list of minimum documents, section 3A.4.2.*

The expansion of HIV prevention interventions among men who have sex with men was included as a separate objective of this RCC proposal rather than continuing as part of Objective 3 (VCT services) from the expiring grant. The rationale behind this is based on the following:

In 2006 UNAIDS supported small pilot project focusing on HIV prevetion among MSM visiting gay bars in Sofia. The results from this pilot project were presented to the members of the CCM and the need for more scaled and focused work with MSM was clearly identified. During the meeting agreement was reached that HIV prevention work among MSM community should be expanded by both active inclusion of MSM in the planning and implementation of prevention activities and by strengthening the capacity of the existing NGOs of MSM and supporting the establishment of new MSM NGOs

The results from the Integrated Biological and Behavioural Surveillance survey in 2007 indicated that HIV prevalence in the group is between 0.99 and 2.65%;

Data from the national HIV registry which indicates that the share of HIV infected men is 73% which suggest the potential of a hidden epidemic among MSM;

Outcomes from the Round table on HIV prevention interventions among MSM, conducted in October 2007, with the active participation of MSM community representatives which clearly identified the need to scale up prevention activities to ensure coverage of services; to design and implement interventions tailored to the specific needs and priorities of the target group; and to actively involve representatives of MSM to ensure the provision of effective client-friendly services;

Outcomes from a discussion meeting between some of the CCM members and representatives from the MSM group in December 2007, to discuss in detail current epidemiological and programmatic context and priorities for future action;

Outcomes of the transparent and participatory procedure, opened by CCM Bulgaria, to solicit small proposals to be integrated in the country RCC proposal, where the MSM group was again identified as a priority target group to be targeted with specific services.

➔ *After completing this section,* ***go to section 3B.***

3B Membership and Proposal Signature

3B.1.1 Leadership of the Coordinating Mechanism

Identify below the requested information regarding the Chair and Vice Chair of the Coordinating Mechanism.

Table 3B.1.1 – Coordinating Mechanism leadership information

	Chair	1st Vice-Chair	2nd Vice-Chair
Name	Mrs. Emel Etem	Prof. Radoslav Gaydarski	Prof. Hristo Taskov
Title	Deputy Prime Minister and Minister of Disaster Management Policy	Minister of Health	Deputy Director
Organization	Council of Ministers	Ministry of Health	National Center of Infectious and Parasitic Diseases
Sector represented	Government	Government	Academic
Mailing address	Bulgaria 1000 Sofia 1 Dondukov Blv.	Bulgaria 1000 Sofia 5 St. Nedilya Sq.	Bulgaria 1000 Sofia 26 Yanko Sakuzov Blv.
Telephone	+ 359 2 940 27 20	+ 359 2 930 11 01	+ 359 2 943 30 75
Fax	+ 359 2 988 26 44	+ 359 2 981 06 27	+ 359 2 944 28 75
Main e-mail address	e.etem@government.bg	minister@mh.government.bg	taskov@ncipd.org

3B.1.2 Summary of sector representation on the Coordinating Mechanism

Please note ➔ to be eligible for funding, Coordinating Mechanism Applicants must demonstrate evidence of membership of people living with and/or affected by the disease(s). Where stigma is an issue, the level of information required is explained in the Guidelines for Proposals. Also, it is recommended that the membership of the Coordinating Mechanism comprise a minimum of 40% representation from non-governmental sectors. ➔ *Refer to the Guidelines for Proposals section 3B.1 and the Coordinating Mechanism Guidelines.*

Table 3B.1.2 – Summary of Coordinating Mechanism members

Summary of Membership of Coordinating Mechanism	
Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal.	
Sector Representation	**Number of members representing the sector**
☒ Academic/educational sector	7
☒ Government	14
☒ NGOs/community-based organizations	10
☒ People living with and/or affected by HIV/AIDS, tuberculosis or malaria	1
☐ Private sector	

3B Membership and Proposal Signature

☐	Religious/faith-based organizations	
☒	Multilateral and bilateral development partners in country	5
☐	Other *(please specify):*	
	Total Number of Members	37

3B.1.3 Coordinating Mechanism proposal endorsement

Coordinating Mechanism members must endorse this proposal to confirm their support, as representatives of the sector they represent. **Coordinating Mechanism endorsement is demonstrated by each member signing Attachment C in the final column once all membership information has been completed in that attachment**.

Please note ➔ The **original** (not photocopied, scanned or faxed) **signatures of the Coordinating Mechanism members** must be provided in **Attachment C**. The minutes of the Coordinating Mechanism meeting at which the proposal was considered and endorsed must be **also be attached** as an annex to this proposal.

4 Proposal Strategy

Proposal Strategy

The Rolling Continuation Channel is specifically offered to Applicants who have strong performing grants that have demonstrated impact or potential for impact on the relevant epidemic and show sustainability. The Applicant's strategy for their Rolling Continuation Channel proposal should similarly focus on planning for achievement of impact and sustainability within the national disease prevention and control program.

Where **national disease specific prevention and control plan(s) exists**, Applicants are encouraged to attach these documents to their proposal and then use the questions in this section 4 to highlight key areas of the plan/other documents for review.

➔ *For more information on the requirements of this section, please refer to the Guidelines for Proposals, section 4.*

4.1 Requested proposal term

Please fill in the proposal term start date (based on the former grant's expiration date) and the end date (up to a maximum of six years).

Table 4.1 – Proposal term

	From	To
Month and year:	01 January 2009	31 December 2014

4.2 Key changes in the stage, type or dynamics of the disease

Comparing the strategy and interventions of this proposal to those in the Coordinating Mechanism's earlier proposal for the expiring grant, describe **the main** changes in the **stage, type or dynamics** of the disease, including any changes in the most **affected population group(s)**. For key changes identified indicate whether this change has led to changes in the approach taken in this proposal.

Applicants are requested to specifically comment on current trends in mortality and morbidity impact indicators within the populations targeted in this proposal, and the assessed contribution of the expiring grant towards more favorable trends in those indicators. *(Maximum of one page.)*

Since 2004, with the implementation of the Global Fund grant in Bulgaria, there have been several major improvements in terms of surveillance evidence on the stage, type and dynamics of the HIV infection.

- Establishment and expansion of the National Second Generation HIV Surveillance System, which is designed to track in parallel biological and behavioural trends among the groups most-at-risk
- Active motivation and referral of most-at-risk groups to use Voluntary HIV Counselling and Testing services; rapid scale-up of the provision of VCT services through a network of stand-alone centres, mobile medical units, drop-in centres for IDUs
- Implementation of nationwide campaigns for promotion of HIV testing and counselling, including anonymous and free-of-charge VCT services

These efforts made it possible to intensify HIV case finding and resulted in increased case detection rates, particularly through VCT services.

Furthermore, focused efforts to collect epidemiological evidence on HIV prevalence and behavioural evidence on the drivers of the epidemic, were successful in

- Better understanding epidemiological patterns of the spread of HIV in different sub-groups of the population and geographical distribution by country regions
- Estimating the HIV epidemic as of 31 December 2007 and projecting the epidemiological trends to 2015.

Since 1986 till 2007, a cumulative total of 814 HIV cases were registered in the Bulgaria, of which 180 developed AIDS till 2006. The annual number of newly registered HIV cases increased from 49 cases in 2000 to 125 cases in 2007. The increased annual number of newly detected cases is due to the active provision of specific services to the groups most at risk (including HIV counseling and testing) through the implementation of Program "Prevention and Control of

HIV/AIDS . Up to December 2007, registered HIV cases are concentrated mainly in four of the 28 country districts: Sofia, Plovdiv, Bourgas and Varna.

- For the period 1986-2007, a total of 109 HIV cases in the injecting drug use category have been registered in the country, of which 99 only in the period 2004-2007. It is evident that the activities of Program "Prevention and Control of HIV/AIDS", the NGOs working with IDUs in 10 country regions and 18 HIV VCT centres have contributed to finding of a significant number of IDUs living with HIV.
- For the period 1986-2007, a total of 63 HIV cases of the homo-/bisexual category have been registered in the country, of which 36 only in the period 2004-2007.
- The average percentage of people who are still alive 12 months after initiation of ARV therapy in the 2001 and 2002 cohorts is 85%, while for the 2004 and 2005 cohorts it is 86.6%. Regarding 24-month survival, the results in the 2001-2003 cohort was 73%, which increased to 85% in the 2004-2007 cohort.

Tendencies in the last years

Since the beginning of the GF-funded program in 2004 and the implementation of a robust Integrated Biological and Behaviour Surveillance (IBBS) and programmatic HIV preventive activities, it was possible to detect new tendencies in the stage and dynamics of epidemic (Table 2). A major tendency is the onset of concentrated epidemics among IDUs in the two largest cities – Sofia and Plovdiv. Average HIV prevalence among IDUs in Bulgaria has risen more than seven times – from 0.97% in 2004 to 7.29% in 2007. The abolishment of the 'single dose' article in the Penal Code, which criminalized the simple possession of drugs, had negative influence on HIV prevention activities in this group.

The male-to-female ratio of registered HIV infections for the period 1986-2006 is 2:1, which implied that a large number of them are in the homo-bisexual transmission category. IBBS surveys in 2007 indicated that the HIV prevalence in this group is between 0.99% and 2,65%. In 2005, 30% of men receiving ARV treatment were MSM. Data analysis identified the need to perform back-calculation on HIV prevalence among MSM. Results were 0.99% in 2004, and 1.6% in 2007, and confirmed the expert opinion the potential development of a concentrated epidemic, which has been not recognized. The WORKBOOK method 2007 was used to estimate the number MSM HIV cases and their share of among all estimated people living with HIV – 23%.

Dynamic tendencies are seen in the group of young Roma men. Annual IBBS activities in this group started in 2005. Results on HIV prevalence were 2,67% in 2007. HIV cases are concentrated mainly in Plovdiv. It should be highlighted that this is a heterogeneous group and the majority of HIV cases are due to mixing injecting drug use and male-to-male sexual behaviour.

Though surveillance surveys in prisons showed 0.38% HIV prevalence in 2007, the annual number of newly registered has increased 7.4 times (from 5 cases in 2004 to 37 in 2007). It should be noted that in 2007, 19 HIV cases were found through the provision of anonymous VCT services only in the prison in Plovdiv, and all of them a history of injecting drugs. It is expected that this tendency will continue and will reflect the tendencies among IDUs and MSM in the country.

The rate of annual increase of HIV incidence in the adult population (15-49 years) in the country was higher in the period 2002-2004 (68%-50% annual increase), and slowed down after 2004 to reach annual rate of increase of 7% in 2007. This is explained with the implementation of the Round 2 GF grant, which made it possible to rapidly scale-up HIV prevention activities in the groups most-at-risk.

Dynamics of the HIV epidemic among most-at-risk groups

GROUP	2004		2007		Prevalence Increase
	HIV Prevalence	Number*	HIV Prevalence	Number*	
IDUs	0.93%	184	7.287%	1 443	7.84
MSM	0.994%	557	1.603%	883	1.61
SW	0.412%	44	0.368%	38	0.90

YRM	0.029%	3	2.666%	241	80.33
Prisoners			0.379%	40	
Low Risk	0.029%	1 092	0.034%	1 256	1.17

*calculation with Workbook-method 2007, (UNAIDS 2007)

The potential for impact of services provided by the GF-funded Program, and especially the community-based approach, is evidenced by the knowledge and behavioural changes over time tracked through IBBS since the beginning of the program in 2004 to 2006. People from the most-at-risk groups who have received an HIV test and know their results have increased more than twofold, and knowledge results on HIV transmission and prevention has increased nearly threefold.. There is 51% increase in the percentage of IDUs who report the use of sterile injecting equipment. Condom use with most recent client among sex workers remains significantly high – 95.63% (Annex 21 - Bulgaria UNGASS Progress Report 2008).

There is a substantial increase in the percentage of people living with HIV, who are still on treatment 12 months after initiation of ARV therapy (from 87.09% in 2004 to 93.75% in 2006).

Estimates of the number of people living with HIV by geographical regions and population groups were performed with the use of the WORKBOOK estimation package, and with the technical support of UNAIDS. Additional demographic and mortality data to 2015 were obtained through the SPECTRUM ver. 3.14 estimation and projection model.

Estimates show that 68% of the people living with HIV in 2007 come from the groups most-at-risk. Largest shares among these HIV infections take IDUs and MSM.

Summary of key changes in the stage, type and dynamics of the epidemic

1. Increase in HIV prevalence among injecting drug users
2. Identification of the epidemiological situation among MSM
3. Delineation of groups in multiple risk
   - Young Roma people – IDU, MSM, SW
   - Prisons – IDU, MSM
   - Vulnerable children and youth
4. Delineation of 4 groups of country regions according to the of spread of HIV infections and risk factors (see Figure 1.)
   - Regions with very high cumulative incidence* and high-risk factors**
   - Regions with high cumulative incidence* and high-risk factors**
   - Regions with medium cumulative incidence* but high-risk factors**
   - Regions with low cumulative incidence* and low-risk factors**– rest of the country.

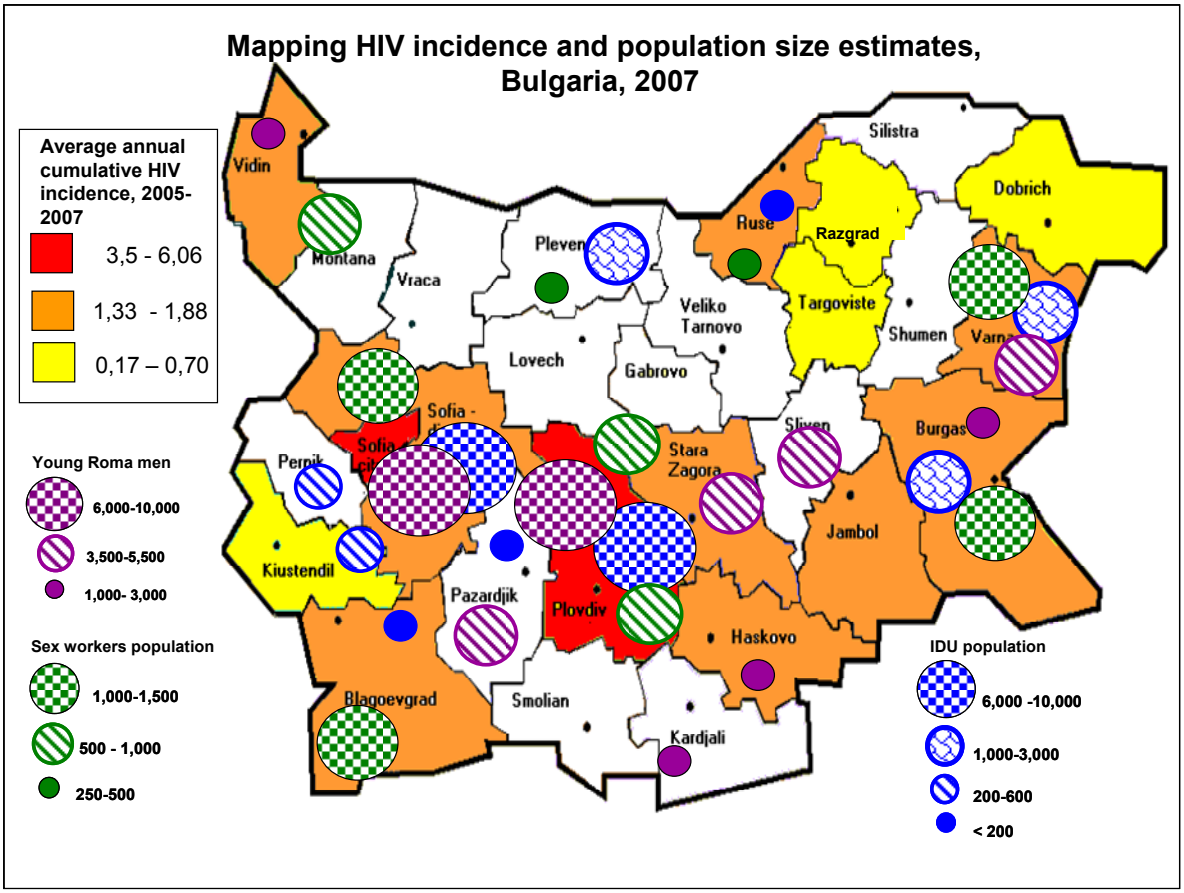
** Average cumulative incidence of new diagnosed HIV cases per 100 000 population*
*** The risk of the region is identified by the overlapping the size of the vulnerable groups, transport corridors, tourist aria, border entry point etc.*

Key conclusion: In order to reduce the number of new HIV cases there is a need to:

- Scale-up and expand the scope of high-quality services
- Intensify intervention among groups contributing to the spread of the infection
- Improve STIs surveillance and link it with HIV surveillance
- Strengthen systems for surveillance of bridging populations between the groups most-at-risk and the general population

4 Proposal Strategy

Figure 1. Mapping HIV incidence and population size estimates, Bulgaria, 2007 (Annex 28)



4.3 Current national program context

4.3.1 Epidemiological and disease-specific background relevant to your country

In the table below: **(i)** identify the total population of the country **and (ii)** provide current estimates of the stage of the disease (prevalence rates) in the listed population groups where the groups are applicable to your national epidemiological framework, and where there is existing available data.

The 'source of estimate' (final column in the table below) may be from recent published estimates of UNAIDS or WHO (as relevant to the disease component of this proposal), but may also be published national estimates or statistics.

Table 4.3.1. – Estimated disease prevalence within key population groups

Population	Estimated population size Estimated HIV prevalence (%) Estimated number of PLHIV	Year of estimate	Source of estimate
(i) Total country population	7,679,290	2006	National Statistical Institute
(ii) Current estimates of the following population groups:			
Total people – estimated HIV prevalence *(adults and children)*	0.054%	2007	Spectrum ver. 3.14

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Population	Estimated population size Estimated HIV prevalence (%) Estimated number of PLHIV	Year of estimate	Source of estimate
Total estimated number of people living with HIV *(adults and children)*	4,184	2007	Spectrum ver. 3.14
Estimated number of women living with HIV >15 years	932	2007	Spectrum ver. 3.14
Estimated number of pregnant women living with HIV	35	2007	Spectrum ver. 3.14
Estimated number of children (0-14 years) living with HIV	13	2007	Spectrum ver. 3.14
Estimated number of AIDS related deaths per year	32	2007	Spectrum ver. 3.14
Estimated number of orphans (0-17 years)	N/A	N/A	N/A
Injecting drug users – estimated population size (15-49 years)	19,800	2007	Expert estimation
Injecting drug users – estimated HIV prevalence (15-49 years)	7.287%	2007	Workbook method 2007
Estimated number of Injecting drug users living with HIV (15-49 years)	1,443	2007	Workbook method 2007
Sex workers – estimated population size (15-49 years)	10,429	2006	0.55 % of total female population
Sex workers – estimated HIV prevalence (15-49 years)	0.368%	2007	Workbook method 2007
Estimated number of Sex workers living with HIV (15-49 years)	38	2007	Workbook method 2007
Men who have sex with men – estimated population size (15-49 years)	55,069	2006	3 % of total male population
Men who have sex with men – estimated HIV prevalence (15-49 years)	1.603%	2007	Workbook method 2007
Estimated number of Men who have sex with men living with HIV(15-49 years)	883	2007	Workbook method 2007
Prisoners – total population size (>15 years)	10,271	2007	Ministry of Justice
Prisoners – estimated HIV prevalence (15-49 years)	0.034%	2007	Workbook method 2007
Estimated number of Prisoners living with HIV(15-49 years)	1,256	2007	Workbook method 2007
Young Roma men most-at-risk – estimated population size (15-25 years) Plovdiv, Sofia	9, 025	2007	Expert estimation
Young Roma men most-at-risk – estimated HIV prevalence (15-24	2.666%	2007	Workbook method 2007

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Population	Estimated population size Estimated HIV prevalence (%) Estimated number of PLHIV	Year of estimate	Source of estimate
years)*Plovdiv, Sofia			
Estimated number of young Roma men most-at-risk living with HIV (15-24 years) Plovdiv, Sofia	241	2007	Workbook method 2007
Low-risk population – estimated population size (15-49 years)	3,653,166	2007	Remaining population in Workbook method 2007
Low-risk population – estimated HIV prevalence (15-49 years)	0.034%	2007	Workbook method 2007
Low-risk population living with HIV(15-49 years)	1,256	2007	Workbook method 2007
Total number of PLHIV in need of ARV therapy	336	2006	Spectrum ver. 3.14
Annual number of new people in need of first-line ARV therapy	146	2007	Spectrum ver. 3.14
Number of people receiving ARV therapy	221	2007	Spectrum ver. 3.14
Other: *(identify)*			

* HIV prevalence data was obtained through the Integrated Biological and Behavioural Surveillance surveys, conducted among young Roma men in Sofia and Plovdiv in 2007.

4.3.2 National disease specific planning framework

Describe how the country's disease specific planning frameworks** have evolved since submission of the proposal relevant to the expiring grant, to support national efforts to prevent and control the disease.

Comment on factors including (but not limited to):

(a) how the national plans have been amended to take into account changes in the disease profile and the current epidemiological status *(from sections 4.2 and 4.3.1 above)*;

(b) whether, and in what ways, a broad range of national, regional and local health sector stakeholders (including the public, private, and NGO sectors and communities affected by the disease) have been included in the evolution of the national/country disease prevention and control plan(s); and

(c) how national planned outcomes *(e.g., the number of people identified as needing treatment by 2015)* have been determined, having regard to strengthened experience in key service provision, and the increasing availability and predictability of national, bilateral and multilateral financing.

** Plans which may be described, depending on in-country circumstances include: the disease prevention and control initiatives set out in the National Health Sector Development Plan; a National Disease Control Strategy or Plan; a poverty reduction strategy paper; sub-sector policies relevant to the proposal *(e.g. national or sub-national human resources policies, or norms and standards)*; and the National Monitoring and Evaluation Plan *(health sector, disease specific, or other)*.

Where such plans exist, they should be attached to the proposal to assist proposal review

(a) The guiding principles in the national HIV/AIDS response were identified through the Situation and Response Analysis conducted in the period 1998-2000 with the support of UNAIDS. The results became the evidence base for the design of the National Strategy and Action Plan for Prevention and Control of HIV/AIDS and STIs (2001-2007). It set forth the overall HIV specific needs and priorities for action. While the government political and financial commitment to the national HIV/AIDS policies increased significantly over the years, there were programmatic gaps in terms of unmet prevention needs. Since 2004, with the additional financial resources of the Global Fund grant on HIV, Bulgaria has been successful in introducing and implementing the strategic

framework for HIV prevention among the groups most-at-risk, including development of institutional framework, infrastructure and capacity for service delivery.

(b) The National Programme for Prevention and Control of HIV/AIDS and STIs (2008-2015), which is currently finalized, is designed to build on the existing efforts and achievements and ensure system strengthening and sustainability of the national response. Future priorities for action were identified through a broad national consultative process conducted in October-November 2007 with the participation of all relevant stakeholders. There were a series of National Round Tables to assess the effectiveness of implemented interventions and identify strengths and gaps for the period to 2007. The goals of the new National Programme for Prevention and Control of HIV/AIDS and STIs (2008-2015) are to reduce the number of new HIV infections and improve the quality of life for people living with the disease.

(c) The National Programme incorporates an integral and balanced approach, including comprehensive prevention, diagnosis, treatment, care and support services. It

- takes into account lessons learned
- outlines the implementation of evidence-based interventions
- points out provision of services tailored to the needs of key target groups.
- aims at scale-up and expansion of the scope of high-quality services
- sets forth the quality improvement and system strengthening in terms of epidemiological surveillance and monitoring and evaluation
- aims at decentralization of management and control of service delivery, including financial flows for civil society initiatives and community-based programmes
- seeks to ensure overall health system strengthening and sustainability of service provision over time
- strengthens mechanisms to ensure adequate and predictable financing over time, including through strong government and local ownership.

The main interventions and outcomes were planned as part of the development of the national strategy for 2008-2015. To this end in 2006 the Central Unit for Integrated Biological and Behavioural Surveillance at the National Centre of Infectious and Parasitic Diseases iniatiated a comprehensive process to estimate and project the HIV epidemic in the country through the use of UNIADS-recommended WORKBOOK and SPECTRUM packages for low and concentrated epidemics. Estimations and projections of the HIV epidemic in the general population and most-at-risk groups were technically supported by UNAIDS.

Results for HIV prevalence among IDUs, young Roma men and sex workers for 2004, 2005, and 2006, obtained by the Integrated Biologcal and Behavioural Surveillance (IBBS) surveys, were input in the WORKBOOK method 2007. Regarding HIV prevalence among MSM, a back-calculation method was used based on HIV prevalence among MSM in 2007 form the IBBS survey and data on the share of MSM on ARV treatment fron the national HIV-patient register. Results from the WORKBOOK method 2007 were used for identifying the estimated number of people living with HIV in each of the most-at-risk groups and estimated HIV prevalence in the genral population.

The estimated HIV prevalence in the general population, country demographic data from the National Statistical Institute and the registered annual number of patients on ARV treatment for each year (2000-2007) were input into the SPECTRUM model version 3.14. This model package was used for estimation and projection of the number of people living with HIV, the annual number of new HIV infections, the number of people in need of ARV treatment, the number of AIDS deaths, and the number of HIV-infected pregnant women and children (Table 4.3.2).

The SPECTRUM model version 3.14 was further used to identify the unmet needs of ARV treatment as a deficit from the total number of people in need of treatment and the number of people that are expected to be provided with free ARV treatment through predictable increase of the forecast financial resources in the state budget.

All results was analysed in combination of regular programmatic and qualitative data collected through the implementation of the expiring GF grant, and consequently used to guide planning the scale and coverage of main interventions; identify key priorities in terms of target groups, key services to be provided, and geographical deployment of services according to the epidemiological patterns and risk assessment.

Table 4.3.2. Projections of disease prevalence in the total country population and in key risk groups population group without interventions in 2014

Population	Value	Year of estimate	Source of data
Total country population	7,996,300	2014	Spectrum ver. 3.14
Total people – estimated HIV prevalence *(adults and children)*	0.143%	2014	Spectrum ver. 3.14
Total estimated number of people living with HIV *(adults and children)*	11,400	2014	Spectrum ver. 3.14
Estimated number of women living with HIV >15 years	2,893	2014	Spectrum ver. 3.14
Estimated number of pregnant women living with HIV	90	2014	Spectrum ver. 3.14
Estimated number of children (0-14 years) living with HIV	26	2014	Spectrum ver. 3.14
Estimated number of AIDS related deaths per year	270	2014	Spectrum ver. 3.14
Injecting drug users – estimated population size (15-49 years)	19,800	2014	Expert opinion
Injecting drug users – estimated HIV prevalence (15-49 years)	22.29%	2014	Calculation*
Estimated number of Injecting drug users living with HIV (15-49 years)	4,414	2014	Calculation*
Sex workers – estimated population size (15-49 years)	10,429	2014	0.55 % of female population
Sex workers – estimated HIV prevalence (15-49 years)	1.127%	2014	Calculation*
Estimated number of Sex workers living with HIV (15-49 years)	118	2014	Calculation*
Men who have sex with men – estimated population size (15-49 years)	57,496	2014	3 % of male population
Men who have sex with men – estimated HIV prevalence (15-49 years)	4.904%	2014	Calculation*
Estimated number of Men who have sex with men living with HIV(15-49 years)	2,700	2014	Calculation*

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Prisoners – total population size (>15 years)	**10,650**	**2014**	**Expert opinion**
Prisoners – estimated HIV prevalence (15-49 years)	**1.161%**	**2014**	**Calculation***
Estimated number of Prisoners living with HIV(15-49 years)	**124**	**2014**	**Calculation***
Young Roma people most-at-risk – estimated population size (15-25 years)	**42,350**	**2014**	**Expert estimation**
Young Roma people most-at-risk – estimated HIV prevalence (15-24 years)*	**8.155%**	**2014**	**Calculation***
Young Roma people most-at-risk – estimated population size (15-25 years)	**736**	**2014**	**Calculation***
Low-risk population – estimated population size (15-49 years)	**3,653,166**	**2014**	**Remaining population**
Low-risk population – estimated HIV prevalence (15-49 years)	**0.105%**	**2014**	**Calculation***
Low-risk population living with HIV(15-49 years)	**3,842**	**2014**	**Calculation***
Total number of PLHIV in need of ARV therapy	**2,624**	**2014**	**Spectrum ver. 3.14**
Annual number of new people in need of first-line ARV therapy	**711**	**2014**	**Spectrum ver. 3.14**
Number of people receiving ARV therapy	**2,362**	**2014**	**Spectrum ver. 3.14**
Total number of PLHIV in need of ARV therapy	**262**	**2014**	**Spectrum ver. 3.14**

*Estimates for the HIV prevalence among young Roma people were calculated by the Workbook method, 2007, using data form the Integrated Biological and Behavioural Surveillance surveys, conducted among young Roma men in Sofia and Plovdiv in 2007.

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4.3.3 Common funding mechanism arrangements (only where relevant)

*This section only requests information from Applicants if funding requested in this proposal is **intended to be contributed through a common funding mechanism,** such as a Sector-Wide Approach (SWAp), basket or pooled funding arrangement (whether at a national, regional or the health sector level).*

(a)	Is part or all of the additional funding requested in this proposal intended to be contributed through a common funding mechanism? *(Note ➔ streamlined administrative arrangements such as procuring medicines through pooled procurement arrangements are not considered a 'common funding mechanism' for the purposes of this question).*	☐ Yes ➔ *complete this section* ☒ No ➔ *go to section 4.4*

(b) If only part of the funding requested in this proposal will be contributed into the common funding mechanism, please explain the rationale for such an approach?

N/A

(c) **Provide an overview of the common funding mechanism and the way it functions**. In your response, identify development partners who are part of the common funding mechanism and their respective level of financial contribution (in percentage terms) to the common funding mechanism. *(Note ➔ Documents describing the functioning of the common funding mechanism should be provided as an annex to your proposal to enable a review of the governance and operational arrangements. These documents may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*

N/A

(d) Have funds from the expiring grant been managed through a common funding mechanism to date? If yes, explain the outcome of the latest evaluation of the common funding mechanism's processes. **In particular, Applicants should fully explain any adverse outcomes and/or lessons learned, and what actions were taken to respond to these findings**. *Note ➔ Attach, as an annex to your proposal, the most recent audit or other external assessment of the programmatic and financial operations of the common funding mechanism.*

N/A

(e) Describe the Applicant's assessment (**including by reference to any criteria used during the assessment process**) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal **and** ensure effective supervision of the work that is proposed. *Note ➔ Where relevant, provide details of any changes in financial controls or management arrangements that have been agreed with the common funding mechanism to ensure that the funding (if approved) will be used in a **transparent, efficient and timely manner**.*

N/A

(f) Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by (or will serve as additionality to) resources currently or planned to be available to the common funding mechanism. *Note ➔ If the common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for interventions specific to achieving impact in respect of disease targeted in this proposal during the proposal term.*

N/A

4.4 Overall Country Disease Prevention and Control Needs Assessment

The outputs and outcomes planned to be achieved under this proposal (as a scale-up of the interventions under the expiring grant, or, as relevant, the introduction of a broader package of interventions) **should be based on an analysis of program and financial gaps in national plans/programs/strategies to prevent and control the disease**.

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Applicants should follow these steps to complete section 4.4 and 4.5:

Step 1 **Section 4.4.1** requests Applicants to identify gaps in the main "key service" (program) areas targeted by this proposal, and the **level of additional coverage that is requested through this proposal**. *This is a summary of the main needs only. Applicants must still describe the specific interventions/activities planned under this proposal (in section 4.6) and the targets and indicators that are proposed to evaluate performance during the proposal term (in the 'Targets and Indicators Table', Attachment A)*.

Step 2 **Section 4.4.2** requests Applicants to describe any health systems strengthening strategic actions ('**HSS Strategic Actions**') that are essential to ensure that the planned outputs and outcomes of this proposal will be achieved, **and to identify how much support for these actions is requested in this proposal**. HSS Strategic Actions are more fully discussed in the Guidelines for Proposal (section 4.4.2). *This section also requests information on other current and planned levels of support for the same HSS Strategic Actions.*

Step 3 **Section 4.5** requests Applicants to identify the country's **overall disease specific financial needs** to prevent and control the disease. **Thus 'Line A' in table 4.5 should include both program and essential disease specific health systems needs. All other lines in the table should also include both program and health systems needs if these are essential to the national disease prevention and control plan.** *This is a summary of the financial needs only. Applicants must provide a detailed budget request by disease component (within section 5) and summarize this request in table 1.2.*

Note ➔ *Depending on absorptive capacity (whether actual or increased capacity to be developed through this proposal or other support), an Applicant's proposal may plan to respond to the whole of the needs identified in the "key services", or only part of the needs/gaps identified.*

Step 4 In section 4.6, Applicants should fully describe the specific interventions/activities which are included in this proposal to ensure that the programmatic needs targeted by this proposal are fully met.

See the Guidelines for Proposals, sections 4.4 and 4.5, for further explanation.

4.4.1 Key Service Needs Assessment

4.4.1 Overall Key Service national program needs assessment
(a) Based upon an existing Health Sector Strategic Plan**, describe below the country's overall disease specific prevention and control needs in terms of '*people in need of key services*', commenting on at least five of the major 'people in need of key services' areas.
*** If there is no existing Health Sector Strategic Plan (or equivalent), Applicants are requested to respond to this question by reference to an analysis of national/regional goals, together with analysis of disease surveillance data and target group population estimates for relevant prevention and control strategies as described in section 4.3.1.*
The target groups of the national HIV/AIDS policy were identified through the Situation and Response Analysis conducted in the period 1998-2000 with the support of UNAIDS. The results became the evidence base for the overall design of the National Strategy and Action Plan for Prevention and Control of HIV/AIDS and STIs (2001-2007). It set forth the overall HIV specific needs and priorities for action. While the government political and financial commitment to the national HIV/AIDS response increased significantly over the years, there were programmatic gaps in terms of unmet prevention needs. Since 2004, with the additional financial resources of the Global Fund grant on HIV, Bulgaria has been successful in implementing the strategic framework for HIV prevention among the groups most-at-risk, including development of infrastructure and capacity for service delivery, implementation of targeted interventions, provision of complementary services and significantly expanding covergae. The National Programme for Prevention and Control of HIV/AIDS and STIs (2008-2015) draft is designed to build on the existing efforts and achievements and ensure system strengthening and sustainability of the national response. The goals of the National Programme for Prevention and Control of HIV/AIDS and STIs (2008-2015) are to reduce the number on new HIV infections and improve the quality of live of people living with the disease. The National Programme incorporates an integral and balanced approach, including comprehensive prevention, diagnosis, treatment, care and support services. It outlines the implementation of lessons learned and

evidence-based interventions, scale-up and expansion of the scope of high-quality services, and provision of services tailored to the needs of key target groups.

Needs assessment was performed through a broad national consultative process in October-November 2006 and five key programmatic areas were identified as priorities:

Low-threshold VCT services for groups most-at-risk (IDUs, MSM, prisoners, SW, at-risk young Roma people and most at risk youth)

Comprehensive low-threshold outreach programmes for groups most-at-risk to implement Behavioural Change Communication (IDUs, MSM, prisoners, SW, at-risk young Roma people and most vulnerable youth)

Provision of accessible and affordable ARV treatment for people living with HIV (PLHIV)

Provision of accessible Opioid Substitution Treatment for IDUs (OST)

Care and support for the groups most-at-risk and PLHIV

The size of the group of heroin addicts in Bulgaria is estimated to be in the range of 20,000 and 30,000 in 2006, of which around 80% are injecting drug users. In 2006, around 4,000 of the IDUs were on either on opioid substitution treatment, or on other drug dependence treatment, or had left the country for work and treatment. The abolishment of the 'single dose' article in the Penal Code in 2004, had negative influence on HIV prevention activities and the number of IDUs in prisons rose to around 1,000 in 2006. The Round 2 Global Fund grant made it possible annually to reach with regular prevention services 36% of IDUs most-at-risk who were not in treatment and detention institutions. This is the major group contributing to the increase in the number of new HIV cases. The number of new HIV infections among IDUs are estimated to reach 1/3 of all new HIV infections. Behavioural data for 2006 indicates still low percentage of IDUs who avoid sharing injecting equipment. Therefore, this proposal aims at scaling-up the coverage of comprehensive harm-reduction programmes to 80% annually in 2015.

The integrated biological and behavioural survey among MSM in 2006 helped shed some light on the patterns contributing to HIV transmission in the group. Results for 2007 indicate that the HIV prevalence in this group is between 0.99% and 2.65 %. The WORKBOOK application was used to estimate the share of MSM living with HIV to be 23% of the total estimated number of people living with HIV. Behavioral data collected in 2006 further points out HIV-related risks as 58.3% of the respondents had anal sex with a non-regular partner in the last 1 month. Of those who had non-regular partners in the last 6 months, only 25.6% reported consistent condom use. 18.6% reported having had male commercial sex partners in the last 6 months, and 45.7% of MSM reported having sex with a female partner in the last 6 months. Epidemiological and behavior data clearly identify MSM as a high-priority group for targeted research and intervention. Available data on programmatic response to HIV among MSM is still scarce and suggest that the prevention needs of group have been partially addressed in large urban areas as the capital city of Sofia and covered around 2% of the MSM population considered at higher risk. This proposal particularly aims at strengthening entry points to comprehensive prevention services for this group and annual coverage with regular services of at least 30% of those in need.

As a result of specific socio-cultural and economic characteristics and associated marginalisation, the Roma population makes up a disproportionately high proportion of most-at-risk groups, including IDUs, male and female sex workers, MSM, prison inmates and (particularly vulnerable) young people. The risk of HIV infection among Roma is further exacerbated by their social exclusion and lack of access and/or use of health, educational and social services. Special community-based programmes among Roma people will continue to be implemented to ensure accessibility of HIV prevention programmes and services to the Roma population, whose cultural and socio-economic marginalisation make them particularly hard to reach. This proposal aims to ensure that one third of young Roma at-risk will be reached on annual basis with consistent counseling, motivation, referral and mediation to services provided for most-at-risk populations.

Prisoners are also a group with overlap of vulnerabilities exacerbated by unhealthy living conditions, violence and homosexual activities which are common to men-only settings. The successful example of rapid scale-up of voluntary anonymous HIV counseling and testing services will be used as entry point to other face-to-face interventions to implement behavioural change communication. Main approach will be the cooperation with the civil society organizations, VCT

staff and use of peer educators to reach about 60-70% of the prison population at the end of the proposal term.

The size of the group of women and men who offer sex paid services is estimated between 12-15 000. Around 7-9 000 of them have been identified as most-at-risk and in need of low –threshold outreach services based on analysis of epidemiological and programmatic data. Through HIV prevalence in this group is estimated to be low, sex workers are a bridging population for HIV transmission from other most-at-risk groups to the general population. According to regular assessment performed by outreach teams works throughout the country, around one third of sex workers are young Roms women and men. Surveillance surveys showed that between 5 and 7% inject drugs. Factors influencing sex work are mainly poverty, unemployment. Current level of coverage with services of the group most-at-risk is close to 60%. This proposal aims both to expand annual coverage to 80% and to intensify interventions at the individual level.

Young people in Bulgaria from 15 to 24 years are 1 024 9472. A significant part of them (approximately 16%) do not complete secondary school. According to data of the Ministry of Education about 77 000 of young people age 15-19 are not enrolled in education, and 4189 orphans and vulnerable children live in institutions3. Several recent studies of among youth confirm their vulnerability to HIV, with increasing number of young people with sexual debut under 15; increasing number of sexual partners; inadequate knowledge on HIV/STIs, high pregnancy rate among the 15-19 years old girls. The propolsal will specifically focus on primary HIV prevention among subgroups of young people at higher HIV risk, such as droups out, children in institutions, street children, delinquent youth, heavy alcohol and marihuana users.

The cumulative numer of officially registered PLHIV in Bulgaria is 803 at of 31.12.2007. 369 as of them are registered in the the HIV/AIDS treatment departments/sectors, 221 receive ARV therapy. It was estimated through SPECTRUM Ver.3.14 that in 2007 the real number of PLHIV is 4172 and it will increase till 11 348 people in 2014.Through the progress of HIV epidemic in Bulgaria it is assumed that the number of patients on therapy will reach 2362 in 2014. With the increasing of HIV incidence and the disease far going more people will need palliative care. It is projected that the number of people in need will be 323 in the end of 2014. Hospices and home based care have to be established for these people. The number of HIV positive pregnant women in Bulgaria in 2007 is 35. It will reach 90 women in 2014 that have to be provided with PMTCT. Ever more and more PLHIV need professional psychological and social support. Till 2014 the people in need of psychological support will be 6986 and PLHIV in need of social support will be 830.

[2] The data from National Statistical Institute, 31.12.2006

[3] Data from the State Agency for Child Protection, February, 2008

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(b) **People in Need of Key Services targeted by this proposal**

Complete table 4.4.1 to illustrate the main (but not only) 'people in need of key services' **that will be targeted by this proposal**.

Please note:

(i) **complete Part A** of table 4.4.1 for up to three of the **main** (not only) 'people in need' key services that are continuing from the expiring grant;

(ii) **where relevant, complete Part B** of table 4.4.1 for up to three of the main 'people in need' key services that are new (representing a scope change) compared to the expiring grant;

(iii) each of lines A, B, C and D for each 'key service' in table 4.4.1 should contain quantitative information in regard to 'needs' and 'people' to be reached; and

(iv) this gap analysis should guide the completion of the 'Targets and Indicators Table' (the framework by which performance will be evaluated according to the Global Fund's performance based funding criteria) required under section 4.6. *Please note ➔ the Targets and Indicators Table should have a greater number of performance and impact measurement indicators than simply the key services covered in table 4.4.1, as these.are only the 'main' key service areas.*

Specify below additional information (if any) you believe relevant concerning the groups and/or areas or regions targeted and any assumptions including target size of the population groups.

The estimated target size of the populations in need of key services in 2007 is:

Injecting drug users – 19,800
Men who have sex with men – 62,191
Young Roma people (aged 15-25 years) identified as most-at-risk IDU, MSM, SW, partners of IDU, SW and MSM; ex-prisoners, mobile people – 42,350
Prisoners – 11,058
Sex workers – 7,720
At-risk youth (aged 15-24 years) – 74,954
People living with HIV (PLHIV) – 4,184

Main geographic areas targeted by this proposal:

Analysis based on epidemiological data for the last three years to December 2007 shows delineation of four groups of regions based on the concentration of the epidemic.

(a) Regions with very high cumulative incidence[4] - Sofia and Plovdiv (3.5 to 6.06 per 100 thousands)
(b) Regions with high cumulative incidence - Varna, Sofia-region, Yambol, Bourgas, Stara Zagora, Blagoevgrad, Vidin, Haskovo and Rousse (1.33 to 1.88 per 100 thousands)
(c) Regions with medium cumulative incidence - Targovishte, Dobrich, Razgrad and Kyustendil (0.17 – 0.70 per 100 thousands)
(d) Regions with low cumulative incidence - Sliven, Gabrovo, Silistra, Pernik Pazardzhik, Montana, Vratza, Lovech, Veliko Turnovo, Pleven, Kardzhali and Shumen (less than 0.17 cases per 100 thousand)

IMPORTANT INSTRUCTIONS FOR THE COMPLETION OF TABLE 4.4.1 ON THE FOLLOWING PAGE

Refer to the M&E Toolkit when completing this table for information on "key services" (termed "service delivery areas" in the M&E Toolkit).

Importantly – table 4.4.1 (Part A and Part B) is only for the main 'key people in need' services (e.g. provision of medicines delivered to people) and not a table for Applicants to also identify human resource and other HSS needs. These needs should be included in Table 4.4.2.

Only complete table 4.4.1 after reviewing the Guidelines for Proposals.

[4] * *Average cumulative incidence of new diagnosed HIV cases per 100 000 population in 2005-2007*

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PART A: Interventions continuing and scaling-up from the expiring grant

Continuing Key Service 1 – continuing	Actual		Targeted						
Provision of low-threshold free HIV testing and counselling by VCT centres, mobile medical units, and drop-in centres with focus on most-at-risk and poor populations	2006	2007	2008	2009	2010	2011	2012	2013	2014
A: People in need of key services *(from national or, where relevant, regional annual plans)*	175,129	174,885	175,436	173,188	171,036	168,976	167,007	165,149	163,423
B: Extent of need already planned to be met under existing/future funding *(This figure **must take into account** all planned resources, domestic and external, including Global Fund grants for the same disease, and all as yet undisbursed Phase 2 potential amounts)*	26,366	56,880	63,793	17,640 (10%)	22,274 (13%)	27,280 (16%)	42,671 (26%)	72,534 (44%)	93,949 (57%)
C: Expected annual deficit in 'key service' needs	148,763	118,005	111,643	155,549	148,761	141,696	124,336	92,615	69,474
D: Extent of total need covered by this proposal				67,265 (39%)	74,699 (44%)	82,803 (49%)	73,903 (44%)	48,717 (29%)	30,129 (18%)

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Continuing Key Service 2 – continuing	Actual		Targeted						
Provision of a package of comprehensive low-threshold outreach services to reach with BCC most-at-risk populations	2006	2007	2008	2009	2010	2011	2012	2013	2014
A: People in need of key services *(from national or, where relevant, regional annual, plans)*	170,600	167,509	164,908	161,265	157,522	153,883	152,945	152,242	151,460
B: Extent of need already planned to be met under existing/future funding *(This figure **must take into account** all planned resources, domestic and external, including Global Fund grants for the same disease, and all as yet undisbursed Phase 2 potential amounts)*	37,578	61,254	64,260	6,721 (4%)	6,334 (4%)	5,948 (4%)	15,482 (10%)	30,088 (20%)	50,101 (33%)
C: Expected annual deficit in "key service" provision	133,022	106,255	100,648	154,544	151,187	147,936	137,463	122,154	101,359
D: Extent of need covered by this proposal				56,909 (35%)	64,215 (41%)	64,702 (42%)	56,514 (37%)	49,101 (32%)	40,556 (27%)

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PART B: New interventions that alter the scope of the expiring grant - but which are still in line with the broader package of interventions to which the expiring grant was contributing. ➔ ***Applicants are strongly encouraged to refer to section 4.4.1 of the Guidelines for Proposals*** *(at page 14)* ***before completing this table.***

Key Service 1 – new	**Actual**		**Targeted**						
Provision of opioid substitution treatment for IDUs	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: People in need of key services *(from national or, where relevant, regional annual, plans)*	19,800	19,800	19,800	19,800	19,800	19,800	19,800	19,800	19,800
B: Extent of need already planned to be met under existing/future funding *(This figure **must take into account** all planned resources, domestic and external, including Global Fund grants for the same disease, and all as yet undisbursed Phase 2 potential amounts)*	2,000	2,000	2,178	2,570 (13%)	3,260 (16%)	4,100 (21%)	4,940 (25%)	5,930 (30%)	6,920 (35%)
C: Expected annual deficit in "key service" provision	17,800	17,800	17,622	17,230	16,540	15,700	14,860	13,870	12,880
D: Extent of need covered by this proposal				400 (2%)	700 (4%)	850 (4%)	1,000 (5%)	1,000 (5%)	1,000 (5%)

Key Service 2 – new	**Actual**		**Targeted**						
Case management of people most-at-risk and PLHIV	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: People in need of key services *(from national or, where relevant, regional annual, plans)*	15,456	15,884	16,638	17,016	17,398	17,773	18,176	18,549	18,999
B: Extent of need already planned to be met under existing/future funding *(This figure **must take into account** all planned resources, domestic and external, Global Fund grants for the same disease, and all as yet undisbursed Phase 2 potential amounts)*	0	0	0	0	0	0	1,050 (6%)	2,275 (12%)	2,958 (16%)
C: Expected annual deficit in "key service" provision	15,456	15,884	16,638	17,016	17,398	17,773	17,125	16,274	16,041
D: Extent of need covered by this proposal				1,445 (8%)	2,056 (12%)	2,725 (15%)	2,506 (14%)	2,137 (12%)	1,813 (10%)

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4.4.2 Strategic actions to strengthen health systems

As explained at the start of section 4.4, certain '**HSS Strategic Actions**' may be essential (dependent on country specific contexts) to ensure achievement of the outputs and outcomes targeted by this proposal, including where there is a planned scale up or scope change compared to the expiring grant. These HSS Strategic Actions may include actions to improve grant performance, address current or anticipated barriers, and/or support and sustain expansion/scale-up of interventions to prevent and control the disease.

The Global Fund therefore strongly encourages Applicants to include in their proposal a request for support of relevant HSS Strategic Actions which are coordinated with the national disease control strategy.

Before completing this section, Applicants should refer to the Guidelines for Proposals, section 4.4.2, where significantly greater detail is provided on HSS Strategic Actions supported.

4.4.2 Complete table 4.4.2 below to describe, for up to five main actions:

(a) the **HSS Strategic Actions** that are **essential to achieve the planned outputs and outcomes of this proposal** and therefore the broader disease prevention and control plans at the national level;

(b) **how the actions link to the planned program work during the proposal term** and **address** key points in regard to current or expected challenges *(including those arising due to the injection of the additional funding requested in this proposal)* arising in the health system; and

(c) **other support currently available or planned/anticipated for the same actions**.

Ensure that the HSS Strategic Action(s) is/are consistent with (where one exists) the national Health Sector Development Plan/Strategic Plan and its time frame. *(Ensure you provide this Plan as an annex to the proposal as requested in section 4.3.2).*

To clearly demonstrate the link requested in (b) above, Applicants should relate proposed HSS Strategic Actions to disease specific goals and their impact indicators. ***Refer to information on possible indicators for HSS actions in the Guidelines for Proposal at section 4.4.2.*** *(Where only one strategic action is proposed, Applicants must explain the rationale behind this decision with reference to the guidance provided in the Guidelines for Proposals.)*

Copy and repeat the table for up to five HSS Strategic Actions.

Revised Table 4.4.2A – Summary of essential HSS Strategic Actions requested in this proposal

4.4.2A Summary of funding requested for HSS Strategic Actions in this proposal

In the table below summarize, by year, the total funding requested for HSS Strategic Actions in this proposal for this disease component. *This will be the sum of the 'Funding Request' for each year for each HSS Strategic Action included in this disease component, as detailed in part B of table 4.4.2 (**on the following page, copied for up five HSS Strategic Actions**). Applicants are reminded that they must ensure that the overall funding needs (table 4.5) include both program and essential disease specific health systems needs to ensure that the financial gap analysis reflects all available, planned and required resources.*

Total funds for essential HSS Strategic Actions requested over proposal term						
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
861 601	815 477	921 232	1 034 758	963 019	736 292	**5 332 380**

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Action 1	*(Description of the HSS Strategic Action, the health systems constraints/capacity issues it responds to, and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)* ***Governance*** **Strategic action: Strenghtened leadership, coordination and partnership for HIV prevention at local level and development of quality-assurance systems for HIV/STI prevention, treatment, care and support services provided** 1) The main responsible governmental body for public health prevention at local level is the *Regional Inspectorate for Public Health Protection and Control* (RIPHPC), which is a key structure of the Ministry of Health. There are 28 all over the country . During the expiring grant, RIPHPCs, together with NGOs addressing most-at-risk groups, played a key role in conducting second-generation sentinel surveillance. In addition, VCTs cabinets have been established and are operating in 12 RIPHPCs, which is one of the key sustainability strategies for VCT. RIPHPCs **need restructuring and institutional strenghtening** to better **accomplish their role** as key institutions with the mandate to provide local leadership in the field of the HIV/TB/STI surveillance, monitoring and evaluation, strategic planning and policy development. In this context, a key action of this RCC proposal is to strengthen the capacity of RIPHPC staff at both health promotion and epidemiology departments in strategic planning; HIV and STI prevention and control; health programme management; M&E; surveillance; advocacy; resource mobilisation; community development and outreach; specific knowledge and skills to work and communicate with most-at-risk groups (Annex 22 - *Institutional Framework for AIDS/TB/STIs prevention and control in Bulgaria*). 2) Scale-up of the Municipal AIDS Offices into Municipal AIDS/TB/STIs Committees with clearly defined roles, responsibilities, structure, management arrangements, with well defined statute, mission, lines of authority and subordination in relation to other bodies of the executive power at local level, and their capacity strengthening for HIV/TB/STIs prevention policy, advocacy and strategic planning. 3) Harmonisation of existing, and development of new legislation and regulatory documents in the health-care and social sector, education, justice, internal affairs, media, NGOs at national and local level in relation to HIV/STI prevention, treatment care and support, human rights, stigma and discrimination, suche as: Harmonization between the Public health law and the Law on municipal budgets in order municipal funds to be allocated for local HIV prevention activities; Change in Educational Legislation to ensure access of in-school youth to LSBSHE. Change of legal age for HIV testing from 18 to 15 or 13 years without parental concent; Change in the legislation criminalising single dose drug possession; 4) Development and introduction of standards, technical and methodological guidelines, standard operational procedures and other regulation on national, sectoral and local level related to the prevention and control of HIV and STIs. 5) Introduction of quality-assurance systems for the services provided for HIV/STI prevention, treatment, care and support. 6) Strengthening of partnership and coordination between state institutions and NGOs at the municipal level, through their involvement in Local AIDS/ TB/ STIs Committees and by strengthening the roles and capacities of RIPCPHs.

A: Describe below, through 'key words' *(refer to the Guidelines for Proposals at page 16)*, the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term.

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6

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Capacity of the staff in 5 RIPHPC in the field of surveillance, monitoring and evaluation, strategic planning and policy development in HIV/STI prevention and control strengthened and operational	Capacity of an additional staff in 7 new RIPHPCs in the field of surveillance, monitoring and evaluation, strategic planning and policy development in HIV/STI prevention and control strengthened and operational	Capacity of an additional staff in new 8 RIPHPC in the field of the surveillance, monitoring and evaluation, strategic planning and policy development in HIV/AIDS and STI prevention and control strengthened and operational	Capacity of an additional staff in new 8 RIPHPC in the field of the surveillance, monitoring and evaluation, strategic planning and policy development in HIV/AIDS and STI prevention and control strengthened and operational	Staff in all 28 RIPHPC in the field of the surveillance, monitoring and evaluation, strategic planning and policy development for HIV/AIDS and STI prevention and control strengthened and operational	Staff in all 28 RIPHPC in the field of the surveillance, monitoring and evaluation, strategic planning and policy development for HIV/AIDS and STI prevention and control strengthened and operational
3 Local AIDS/TB/STIs Committes established	New 5 Local AIDS/TB/STIs Committes established	New 2 Local AIDS/TB/STIs Committes established	AIDS/TB/STIs Committes established and operational	AIDS/TB/STIs Committes established and operational	AIDS/TB/STIs Committes established and operational
HIV related legislation updated, harmonised and in place	HIV related legislation updated, harmonised and in place	HIV related legislation updated, harmonised and in place	HIV related legislation updated, harmonised and in place	HIV related legislation updated, harmonised and in place	HIV related legislation updated, harmonised and in place

B: Identify below (in summary only) the amount requested in this proposal for HSS Strategic Actions. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget.)*

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
118 923	201 017	224 428	191 405	171 170	95 335

C: Describe below other current and planned/anticipated support for this action over the proposal term.

*In the left hand column below, please identify the name of **other sources** of HSS strategic action support (including from existing Global Fund and other donor grants/loans etc). In the other columns, please provide information on the type of outputs/outcomes.*

Name of supporting stakeholder ↓	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as section 1.1)*	**Expected outputs/outcomes from existing and planned support**
Government	2008-2015	90 000	Quality-assurance systems for HIV/STI prevention, treatment, care and support services established and operating
Other Global Fund Grants with HSS elements			
Other: *(identify)*			

Other: *(identify)*			
Other: *(identify)*			
Other: *(identify)*			

Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 2	*(Description of the HSS Strategic Action, the health systems constraints/capacity issues it responds to, and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)* ***Human Resources*** **Strategic action:** ***Building capacity of service providers, NGOs, governmental and municipal authorities*** **1) Service provider capacity building** 1.1 Assessment of the overall needs and qualification requirements of professionals and service providers in different sectors including health and social sectors, education, internal affairs, justice, media and NGOs and others for the provision of HIV/AIDS prevention, treatment care and support services. 1.2 Analysis of the quality and content of the existing basic and post-graduate curricula and qualification programmes, including knowledge and skills building of health-sector workforce, social workers and key educational specialists . 1.3 Development and adoption of educational standards, programmes and materials for HIV/STI prevention, diagnostics, treatment, care and support services, based on an analysis of existing educational programmes. 1.4 Integration of the HIV educational programme into existing educational programmes of (specialised) professional schools, universities and colleges, postgraduate and continuing professional education entities. 1.5 Development and adoption of medical standards on HIV/AIDS and STIs; 1.6 Training of staff in existing service-delivery points in client- and time-friendly free-of-charge STI diagnosis and treatment. **2) Capacity strengthening of NGOs** With the support of the expiring grant a lot of technical capacity has been built among NGOs working with SWs, IDUs, Roma community and at-risk youth. At the same time, however, no financial resources were allocated for strengthening NGOs' *institutional* capacity. As a result, many NGOs working in HIV prevention are weak and primarily depend on funding by the GF. Hence, the current proposal aims to systematically strengthening the institutional capacity of NGOs working with IDUs, Roma, SWs, at-risk youth and PLHIV. Special efforts and attention will tbe given to MSM NGOs. This is expected to strengthen self-sustainability of NGOs and their ability to attract funding from other donors. **3) Capacity strengthening of government and municipal insititutions** Another key capacity building area involves municipal staff providing AIDS/TB/STIs-related health and social services tailored to the specific characteristics and needs of IDUs, Roma, SW, at-risk youth and PLHIV.

A: Describe below, through 'key words' *(refer to the Guidelines for Proposals at page 16)*, the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term.

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Educational standards, programs and materials for HIV and STIs prevention,	Medical standards for HIV/AIDS and STIs adopted	HIV educational programme incorporated into existing educational programs for	Professionals and service providers of HIV/AIDS prevention, treatment care	Professionals and service providers of HIV/AIDS prevention, treatment care	Professionals and service providers of HIV/AIDS prevention, treatment care

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diagnostics, treatment, care and support services developed Staff in existing service delivery points trained in client- and time-friendly free-of-charge STI diagnosis and treatment	Staff in existing service-delivery points trained in client- and time-friendly free-of-charge STI diagnosis and treatment	service providers Trained staff in client- and time-friendly free-of-charge STI diagnosis and treatment empowered and operational NGOs working with most-at-risk groups institutional capacity built	and support services educated by the introduced educational programs Trained staff in client- and time-friendly free-of-charge STI diagnosis and treatment operational NGOs capacity built	and support services educated by the introduced educational programs Trained staff in client- and time-friendly free-of-charge STI diagnosis and treatment operational NGOs self-sustainable	and support services educated by the introduced educational programs NGOs self-sustainable

B: Identify below (in summary only) the amount requested in this proposal for HSS Strategic Actions. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget.)*

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
99 157	89 887	44 820	44 360	19 982	24 737

C: Describe below other current and planned/anticipated support for this action over the proposal term.

*In the left hand column below, please identify the name of **other sources** of HSS strategic action support (including from existing Global Fund and other donor grants/loans etc). In the other columns, please provide information on the type of outputs/outcomes.*

Name of supporting stakeholder ↓	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as section 1.1)*	**Expected outputs/outcomes from existing and planned support**
Government	2008-2015	185 000	Strengthened capacity of service providers, NGOs, national and local institutions involved in HIV prevention and control
Other Global Fund Grants with HSS elements			
Other: *(identify)*			
Other: *(identify)*			
Other: *(identify)*			

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Action 3	*(Description of the HSS Strategic Action, the health systems constraints/capacity issues it responds to, and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)* **Strategic Action: M&E** **Development and implementation of integrated multisectoral national HIV/AIDS and STIs M&E system** One of the challeges of Universal Access identified during a broad consultation process in 2006 was the delay in the establishment of the National HIV/AIDS Monitoring & Evaluation System. Currently, the GF M&E Unit performs many key M&E roles and functions. The expiring grant has allowed the generation of strategic information in the area of behavioural surveillance; national UNGASS reports were developed and submitted using the existing M&E system, but a national M&E data collection and dissemination *system* and *unit* are yet to be established Due to the process of major restructuring of primary health care and hospital privatisation, the existing system of surveillance/reporting of STIs was abolished. The constantly increasing number of private clinics has led to a further deterioration of the STI-reporting system. In this context, the current RCC proposal plans to support: the following 1) Design and participatory development of national M&E framework and plan for HIV and STIs, including guidelines, standard operational procedures, forms. 2) Establishment of the national HIV and STIs M&E, surveillance, strategic planning and policy development unit at the National Centre for Infectious and Parasitic Disease (NCIPD), which is the institution responsible for collecting information on communicable diseases and data dissemination to all stakeholders. The current proposal will support the development of a national information system for HIV/STIs at the national and local level, as well as the establishment of a national HIV/AIDS and STI database. 3) Establishment of the regional HIV/STI M&E, surveillance, strategic planning and policy development units at the Regional Inspectorates for Protection and Control of Pubic Health (RIPCPH), in close collaboration with the Local AIDS/TB/STIs Committees. 4) Strengthening the M&E capacity of the National M&E Unit and of key national and local stakeholders. 5) Integration of HIV/STIs/TB Information systems in the National Health Information System. The current GF programme will support an operational survey of the national HIV/STIs M&E needs of all key stakeholders and will adapt data collection and dissemination tools accordingly. The project proposal will support regular *follow-up BBS* among IDUs, MSM, sex workers, prisoners, Roma and the general population 15-49. Thus, the Programme will provide a major contribution to the collection of second-generation surveillance data for the National HIV/AIDS/STIs M&E system and database, allowing the identification of trends over time. This proposal includes a number of *operational research studies* on the specific risks and vulnerabilities of the beneficiaries of the project (IDUs, drug users in prisons; MSM; sex workers; Young people at higher HIV risk, PLHIV, as well as a number of studies to explore potential drivers of HIV risk among other groups, currently not included as key target groups, such as mobile populations. All these studies will contribute to a stronger basis for an evidence-informed national response, and will be used for purposes of national priority setting, (national and international) resource mobilisation and strategic planning.
A: Describe below, through 'key words' *(refer to the Guidelines for Proposals at page 16)*, the planned	

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outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term.					
Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
1.Establishment of the national HIV and STIs M&E, surveillance, strategic planning and policy development unit at 3 M&E regional units in 3 RIPHPC 2. Development of national M&E framework and plan for HIV and STIs, including guidelines, standard operational procedures, forms. 3. Strengthening of the national and regional M&E units capacity and the M&E capacity of key national and local stakeholders.	1.Establishment of 5 additional M&E regional units in 5 RIPHPC 2. Continuation of development and piloting of national M&E framework and plan for HIV and STIs, including guidelines, standard operational procedures, forms. 3.Strengthening of the national and regional M&E units capacity and the M&E capacity of key national and local stakeholders	1.Establishment of 5 additional M&E regional units in 5 RIPHPC 2 .Integration of the HIV/STIs/TB (M&E) Information systems in the National Health Information System 3. Strengthening of the national and regional M&E units capacity and the M&E capacity of key national and local stakeholders	M&E regional units established and operational 2. Strengthening of the national and regional M&E units capacity and the M&E capacity of key national and local stakeholders 3. The National M&E system providing strategic information to decision makers	M&E regional units established and operational 2. Strengthening of the national and regional M&E units capacity and the M&E capacity of key national and local stakeholders 3. The National M&E system providing strategic information to decision makers	The National M&E system operational and providing strategic information to decision makers

B: Identify below (in summary only) the amount requested in this proposal for HSS Strategic Actions. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget.)*

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
382 915	334 571	402 196	554 918	586 072	426 156

C: Describe below other current and planned/anticipated support for this action over the proposal term.

*In the left hand column below, please identify the name of **other sources** of HSS strategic action support (including from existing Global Fund and other donor grants/loans etc). In the other columns, please provide information on the type of outputs/outcomes.*

Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term *(same currency as section 1.1)*	Expected outputs/outcomes from existing and planned support
Government	2005-2018	215 000	The National M&E system operational and providing strategic information to decision

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			makers
Other Global Fund Grants with HSS elements			
Other: *(identify)*			
Other: *(identify)*			
Other: *(identify)*			
Other: *(identify)*			

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Action 4	*(Description of the HSS Strategic Action, the health systems constraints/capacity issues it responds to, and linkages to this proposal – **not more than half a page for each HSS Strategic Action**)* **Service delivery** **Strategic action: Improved client-friendly STI services** Currently, Bulgaria faces major challenges with diagnosis and treatment of STIs, since: • Due to the increasing number of private STI clinics there is major underreporting of STI cases; • STI treatment is not covered by the National Health Insurance Fund; • Not all STIs are diagnosed according to the recommended diagnostic tests and procedures; • There is no external quality control of the laboratories providing tests for syphilis, chlamydia, and gonorrhoea. At a time when the main focus of HIV/AIDS programmes in the country is on reducing STI prevalence among key population groups at risk (primarily sex workers and MSM) and affiliated groups (particularly clients and regular partners of sex workers), they do not have sufficient access to client-friendly services. As a result, STI-prevention measures among most-at-risk groups and the general population remain ineffective. Venereological services in Bulgaria are provided at Dermatovenerological Dispenseries, private STI clinics and by some NGOs funded by the GF or other donors. The expiring grant has integrated STI diagnosis and treatment in three VCT centres and 9 mobile medical units (MMUs). The current proposal will scale up STI counselling, testing and treatment through the following strategies: 1) Establishment and scale up of free of charge, low-threshhold service points with appropriate working time and friendly client-oriented health staff; 2) Increased number of MMUs; as well as moving from individual MMUs usage by NGOs to the shared usage at regional level to be coordinated and managed by the Regional Inspectorates of Pubic Health Protection and Control (RIPHPC) in order to ensure more cost-effective utilisation of existing MMUs and improve regional and local service coverage for all groups at risk. 3) Special training programmes for STI specialists in existing STI facilities to enhance their capacity and skills on counselling and client-friendly STI services for MARP groups. In places where scale up cannot be provided by MMUs, special financial arrangements and incentives will be offered to existing STI specialists to provide free-of-charge and time-accessible STIs services or support of part-time working stationary STIs established/rented in the area of respective Roma community. 4) Equipment of one laboratory for STI diagnosis with modern (PCR) equipment; 5) Introduction of laboratory and external quality control, as well as lab study standartization. 6) Client-friendly service delivery points for providing free of charge STIs counselling, diagnosis and treatment, as well as HIV testing, counselling and commodities (condoms, lubricants) will be equipped and operational at local level. Client-friendly service-delivery points will be located in already existing health-care facilities such as Dermatovenerological Dispensaries (DVD), Mobile Medical Units, VCT centres, STIs cabinets in polyclinic and/or hospitals, depending on the specific local situation and availability of existing service providers. 7) Regional Inspectorates of Pubic Health Protection and Control (RIPHPC) will coordinate, monitor and support this procces. Client-friendly services and providers will increase coverage for STI services and consequently, bring about reductions in STI prevalence among key population affected.

A: Describe below, through 'key words' *(refer to the Guidelines for Proposals at page 16)*, the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term.

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6

Free-of-charge, low-threshold service points with appropriate working time and friendly client-oriented health staff established MMUs that provide STIs diagnosis and treatment established	Free-of-charge, low threshold service points with appropriate working time and friendly client-oriented health staff established MMUs that provide STIs diagnosis and treatment operational client and time friendly free of charge STI diagnosis and treatment services provided to people in need from most at-risk-groups	Free-of-charge, low threshold service points with appropriate working time and friendly client-oriented health staff established MMUs that provide STIs diagnosis and treatment operational client and time friendly free of charge STI diagnosis and treatment services provided to people in need from most at-risk-groups	Free-of-charge, low threshold service points with appropriate working time and friendly client-oriented health staff established MMUs that provide STIs diagnosis and treatment operational client and time friendly free of charge STI diagnosis and treatment services provided to people in need from most at-risk-groups	Free-of-charge, low threshold service points with appropriate working time and friendly client-oriented health staff operational MMUs that provide STIs diagnosis and treatment operational client and time friendly free of charge STI diagnosis and treatment services provided to people in need from most at-risk-groups	Free-of-charge, low threshold service points with appropriate working time and friendly client-oriented health staff operational MMUs that provide STIs diagnosis and treatment operational client and time friendly free of charge STI diagnosis and treatment services provided to people in need from most at-risk-groups

B: Identify below (in summary only) the amount requested in this proposal for HSS Strategic Actions. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget.)*

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
260 606	190 002	249 787	244 076	185 796	190 064

C: Describe below other current and planned/anticipated support for this action over the proposal term.

In the left hand column below, please identify the name of ***other sources*** *of HSS strategic action support (including from existing Global Fund and other donor grants/loans etc). In the other columns, please provide information on the type of outputs/outcomes.*

Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term *(same currency as section 1.1)*	Expected outputs/outcomes from existing and planned support
Government	2008-2015	345 000	Improved client-friendly STI services
Other Global Fund Grants with HSS elements			
Other: *(identify)*			
Other: *(identify)*			

Other: *(identify)*			
Other: *(identify)*			

4.4.3 Risks and capacity issues arising from HSS Strategic Action support

➔ *Applicants are strongly encouraged to refer to the Guidelines for Proposals at section 4.4.3 for further information before completing this section. Specifically, Applicants should refer to the explanation of 'risks or implications' for sub-question (a) below at page 17 of the Guidelines for Proposals.*

(a) Describe your consideration of any risks or implications arising from the provision of the requested additional support for the HSS Strategic Actions included in this proposal.

The following potential risks and implications arising from the proposed HSS strategic actions have been identified:

Strategic action: Strenghtened leadership, coordination and partnership for HIV prevention at local level and development of quality-assurance systems for the services provided for HIV/STI prevention, treatment, care and support

There is minimal risk related to the delegation of the administration and coordination of local HIV activities funded by the GF to the Regional Inspectorates for Public Health Protection and Control (RIPHPC) due to the fact that they are local structures on direct sub-ordination of the Ministry of Health.

Another potential minimal risk is related to the lack of professional communication in some regions between NGOs and the RIPHPC staff. This will be addressed through intensive networking at local level and strengthening the capacity of RIPHPC staff . This will help RIPHPC to better **accomplish their role** as key institutions with the mandate to provide local leadership in the field of the HIV/STI surveillance, monitoring and evaluation, strategic planning and policy development.

Strategic action: *Building capacity of Human Resources*

There is a minimal risk because the Ministry of Health has committed to support the services of comprehensive ARV treatment for PLH with HAART. An example is that currently, the Ministry of Health is using national funds to purchase 100% of ARV medications and to pay for personnel who provide ARV treatment to PLH. *The potential risk is that the integration of* HIV educational programme into existing educational programmes of professional schools, universities and colleges, postgraduate and continuing professional education providers may take longer time than planned due to the need to make individual agreements with all educational providers since they are independent bodies. The proposed mitigation strategy is the plan to develop priority list of specialists that need to be addressed first and to follow phased approach.

Strategic action: Development and implementation of integrated multisectoral national HIV/AIDS and STIs M&E system

Minimal risk, since M&E is a priority strategic area included in National AIDS Strategy (2008-2015). National AIDS Strategy (2008-2015) plays an important role in ensuring that the national response to the epidemic is executed within the framework of the Three One´s initiative. The National HIV/AIDS/STIs M&E system will lead to greater integration of HIV and STIs surveillance into overall surveillance of infectious diseases, thus will contribute to overall improvement of the surveillance of the infectious diseases in the country.

Strategic action: Improved client friendly STI services and STI reporting

Minimal risk, since client-friendly service-delivery points will be located in already existing health-care facilities such as Dermatovenerological Dispensaries (DVD), Mobile Medical Units, VCT centres, STIs cabinets in polyclinic and/or hospitals, depending on the specific local situation and availability of existing service providers and this will ensure their sustainability.

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(b)	**Applicant Capacity for Health Systems Strengthening Issue identification** Describe below how the Applicant is ensuring that they have, or are developing and/or strengthening, their capacity in regard to their level of understanding of health systems needs and linkages (including identification of strengths, weaknesses, treats and opportunities) to disease specific prevention and control plans and interventions. Applicants should describe if there have been any changes in their relative capacity over the term of the expiring grant.

The following strategies are planned to develop and strengthen the capacity of the CCM Bulgaria with regard to understanding better health-systems needs and linkages to HIV and STIs prevention and control plans and interventions.

CCM capacity-building trainings will be organised on M&E; on linkages between HIV/AIDS programmes and health systems; health system strategic planning; health programme monitoring and management; stigma and discrimination; human rights. This will improve the capacity of the CCM members to identify problems and opportunities in the health system that are relevant to the national plans for prevention and control of the HIV/STIs.

The CCM members will be involved in the development of the national M&E system and framework. This will substantially increase their capacity to understand and identify priority needs, weaknesses and strengths of information systems and M&E in the field of HIV/AIDS/STIs in the wider context of health. The Project will further support capacity building of key stakeholders (Government, CSOs and private sector) in data collection, analysis, and dissemination.

Partnership and lobbying meetings with stakeholders, National Assembly representatives and business sector on linkages between the health health system will be also conducted.

One of the main strengths in the capacity of the CCM achieved over the term of the expiring grant is the partnership and good collaboration developed between the Ministry of Health as a Principal Recipient and the local authorities and the NGOs working for the programme in the field of HIV/AIDS. The partnership agreements were signed between the Minister of Health and 19 mayors, where the Programme Prevention and control of HIV/AIDS was implemented and they were sensitised on the issues related to the HIV/AIDS prevention and vulnerable groups.

4.4.4	**Health Systems Strengthening cross-cutting issues**	
(a)	Did you also submit a proposal in response to the Round 7 call for proposals that was approved by the Global Fund Board at its 16th Board meeting in China in November 2007?	☐ Yes ➔ *complete this section* ☒ No ➔ *go to section 4.5*
(b)	**If yes to (a)**, are there any cross-cutting HSS Strategic Actions integrated in this proposal that will benefit any component included in the Round 7 proposal?	
(c)	**If yes to (b)**, provide below a short description of the relevant component(s) in the Round 7 proposal and how the HSS Strategic Actions in this proposal will benefit achievement of the outputs and outcomes targeted in the Round 7 proposal.	
(d)	If relevant, provide a detailed justification (*with clear information on direct linkages to this proposal)* for those cross-cutting HSS Strategic Actions in this proposal which you believe should still be funded even if some or all of the Round 7 proposal is not recommended for funding. *(**Two page maximum**, including summary details of relevant actions and budget amounts. Also ensure that the budget amounts for HSS Strategic Actions are clearly indicated in the detailed budget required in section 5 for this component.) Refer to the Guidelines for Proposals, section 4.4.4 for additional guidance.*	

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4.5 Overall Country Financial Needs Summary

4.5.1 Overall Disease Specific Financial Needs Assessment

Based on an analysis of the national goals and objectives for preventing and controlling the disease, **describe below** the overall disease specific financial needs. Include information about how this costing has been developed (e.g., through costed national strategies, Medium Term Expenditure Framework [MTEF] or other basis).

As described in step 3 under section 4.4, such analysis should recognize any required investment in essential disease specific HSS Strategic Actions.

Also summarize the overall financial need in table 4.5 in Line A.

The costing of needed budget allocations is made upon the previous expentidure framework and the analisys and estimation of the current HIV prevention needs.

4.5.2 Current and planned sources of funding

(a) **Domestic Sources**

Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to the disease targeted in this proposal. Please also explain the process of prioritization of such funding to ensure that resources are utilized efficiently and on a timely basis (e.g., explain if there are significant available in-country resources, such as HIPC [Heavily Indebted Poor Country] debt relief or other such resources which are available to support disease prevention and control strategies, and how these resources are being efficiently used).

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line B.

The planned financial contributions from national and local sources for the period 2009-2014 are

expected to grow from 50 to 70 % of the total resources needed. For that period the state funding will fully cover the ARV treatment and monitoring, blood safety and testing, Since 2014 it is planned the state budget to finance the entire needs of the national response to HIV/AIDS

(b) **External Sources**

Describe current and planned financial contributions anticipated from all relevant external sources relating to the disease targeted in this proposal (including, based on section 1.6, existing grants from the Global Fund and any other external donor funding).

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line C.

Besides the funds that are committed and are planned to be allocated by UN agencies present in Bulgaria for up to 2009 other possible external financial contributions could be expected from the European Union Funds and Programmes

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4.5.3 Overview of Financial Gap

In table 4.5, Line E, provide a calculation of the gap between the estimated overall need (Line A, table 4.5) and **current and planned available resources for this component** (Line D, table 4.5).

*This table is a summary **only** of overall funding gap. Applicants must provide a detailed budget (see section 5) to identify the amount requested in this proposal.* ***Note*** ➔ Depending on absorptive capacity (whether actual or increased capacity to be developed through this proposal or other support), an Applicant's proposal may plan to respond to the whole of the needs identified in the "key services", or only part of the needs/gaps identified. Questions in section 4.8 focus more fully on absorptive capacity.

4.5.4 Additionality

Describe how Global Fund resources received will be additional to existing and planned/anticipated resources, and will not substitute for such sources. Explain plans to ensure that this additionality will continue for the proposal term.

Global fund resources in respect to total financing for prevention and treatment is provided for to be around an average of 40 % for the whole period of the Proposal, where 48 % during the first year will be decreased gradually to 29 % for the last year.

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Table 4.5. Financial contributions to national response

Financial gap analysis *(EUR)*									
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned**		**Estimated/Forecast**				
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs	**5 222 156**	**4 972 717**	**7 466 440**	**11 734 796**	**12 255 642**	**13 515 046**	**14 077 347**	**14 035 917**	**14 685 711**
Domestic source **B1**: Loans and debt relief (*provide donor name*)									
Domestic source **B2**: National funding resources	2 657 018	2 562 352	5 120 595	5 922 079	6 310 098	7 020 734	8 647 488	9 301 246	10 446 378
Domestic source **B3:** Private Sector contributions (national)									
Total of Line B entries ➔ Total current & planned domestic resources	**2 657 018**	**2 562 352**	**5 120 595**	**5 922 079**	**6 310 098**	**7 020 734**	**8 647 488**	**9 301 246**	**10 446 378**
External source **C 1**: All current & planned Global Fund	2 234 239	2 110 882	2 088 078						
External source **C 2** (*UN*)	330 899	299 482	257 768	234 622					
External source **C3** (*provide donor name*)									
External source **C4**: Private Sector grants/ contributions (International)									
Total of Line entries C ➔ Total current & planned external resources	**2 565 137**	**2 410 365**	**2 345 845**	**234 622**					
Line D ➔ Total current and planned resources ➔ (i.e. Line D = Line B Total +Line C Total)	**5 222 156**	**4 972 717**	**7 466 440**	**6 156 701**	**6 310 098**	**7 020 734**	**8 647 488**	**9 301 246**	**10 446 378**
Line E ➔ Total Unmet need (Line A – Line D) -	**0**	**0**	**0**	**5 578 095**	**5 945 544**	**6 494 312**	**5 429 859**	**4 734 671**	**4 239 333**

The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed. The Global Fund also recognizes that in meeting figures in forward years may be indicative and not confirmed but must still be included on the basis of reasonable projections in reliance on existing and past practices. Please mark the indicative amounts with an asterisk (*) in the table above where this applies.

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4.6 Detailed Proposal Strategy

This section describes the strategy of the Rolling Continuation Channel proposal based on its continuation of strengths from the expiring grant's goals and objectives and changes (including a possible scale-up and/or change of scope) arising from identified implementation gaps, weaknesses and/or changing contextual factors from the original proposal. The concepts of scale-up and scope change in a Rolling Continuation Channel proposal are further defined at both Part A.2 (pages vi and vii) and sections 4.6.3 to 4.6.5 (pages 22 to 24) of the Guidelines for Proposals. **Applicants are strongly recommended to only proceed to complete section 4.6 below after a full review of this information**.

➔ *Applicants are reminded that Rolling Continuation Channel is specifically offered for strong performing grants, where the Applicant can demonstrate that the proposal has, or has the potential to have, impact in regard to the national disease prevention and control program, and for sustainability. This should be an important focus of your planning and proposal development.*

In support of this section, all Applicants must submit :

1. A **Targets and Indicators Table** ➔ This is included as **Attachment A** to the Proposal Form and comprises the framework upon which **program performance and impact** will be evaluated during the program term according to the Global Fund's performance based funding criteria.

   *When preparing this table, **please ensure that the proposed outcomes are consistent with the key service program needs analysis** in section 4.4 **and consistent with** measurement of impact related to the overall proposal goals, although it is recognized that Attachment A may have more service delivery areas than the number of 'people in need of key services' identified in section 4.4.* All targets should be measurable and identify the current baseline. For definitions of the terms used in this table, see the 'Explanatory Note' provided on the first sheet in 'Attachment A' (Targets and Indicators Table) to the Proposal Form. For further guidance, Applicants should also refer to the latest 'Attachment' to the PR's grant agreement with the Global Fund for the expiring grant.

2. A detailed **Work Plan** ➔ which must meet the following criteria:

   (a) *Structured along the same lines as the proposal strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.*

   (b) *Covers the first three years only of the proposal term and is:*
   - ***i. detailed for year 1, with information broken down by quarters; and***
   - ***ii. indicative for years 2 and 3,** with information at least half yearly.*

   (c) ***Consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above and the planned outputs/outcomes set out in section 4.4.2 (HSS Strategic Actions).*

4.6.1 Planned Service Delivery Areas and Specific Interventions

Referring to your overall needs assessment in section 4.4 above, provide a detailed description of the proposal's objectives, service delivery areas and planned interventions/activities you have identified in the 'Targets and Indicators Table' (Attachment A to your proposal), and how these will contribute to overall impact in regard to the disease. Also include areas of synergy between the three diseases if any are included in this proposal's strategy.

*The information below should be **no longer than two pages**, and Applicants should provide **detailed quantitative information in Attachment A** ('Targets and Indicators Table') **to this Proposal Form**. Where actions to strengthen health systems are planned, Applicants are required to provide descriptive information at section 4.4.2.*

OBJECTIVE 1: To create a supportive environment for a sustainable national response to HIV/AIDS in Bulgaria

The main focus of Objective 1 is to ensure sustainability of the national response to HIV/AIDS in the following main areas:

1. Institutional frameworks and partnerships at the national and local level;
2. Legislative and policy frameworks and strategic planning
3. Sustained resources – human, financial and material resources

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Objective 1 is primarily aimed at guaranteeing the sustainability of the implementation of the National HIV/AIDS Response and Policy in Bulgaria and will contribute to the overall strengthening of the health system.

SDA 1.1: HSS: Governance and institutional framework development

The main purpose of the activities under this Service Delivery Area is to develop and officially endorse an overall institutional framework, with clearly defined roles and responsibilities of key Ministries, municipalities and civil society organizations in the response to HIV/AIDS at the national and local level

Activity 1.1.1: Strengthen the National AIDS Coordinating Body in Bulgaria

This main activity is crucial for the enhancing of the government ownership and will focus on the establishment of an effective National AIDS Committee with clear and officially endorsed roles and responsibilities, and formalized multisectoral membership. The Ministry of Health has the leading role in the national response to HIV/AIDS prevention and control, and under this activity the participatory approach will be used for all sectors to be equally involved and their roles and responsibilities to be described in the amended and officially endorsed Terms of Reference of the National AIDS Committee. The role of the National AIDS Committee will be officially endorsed in the Decree of the Council of Ministries. The Directorate for Prevention and Control of AIDS, Tuberculosis and STIs at the Ministry of Health will have the important role in this process of the real involvement of all key stakeholders. The key sector that will be included is the business sector and this was one of the key lessons learned from the previous grant, supported by the Global Fund.

Activity 1.1.2: Strengthen the role of the Municipal Authorities in the field of HIV/AIDS prevention

Strengthening the municipal authorities in order to be really involved in the institutional framework and in the funding mechanisms for HIV/AIDS prevention at local level. Bulgaria has already gained an experience in the field of the local strategic planning under the project BUL/98/005 supported by the UNDP Bulgaria and established Local AIDS Committee and at the same time under the GF grant 10 Local AIDS Coordinating Offices were established on an office-based model within the municipalities. The key lesson learned is to enhance the municipal role in the coordination and funding mechanism through the scale-up of the Local AIDS Offices into Local AIDS/TB/STIs Committee with the involvement of all sectors at local level – municipal administration, police officers, media representatives, NGOs, local structures of other governmental institutions, Regional Inspectorates for Public Health Protection and Control etc. In the first year at least 3 Local AIDS Offices will be scaled-up into Local AIDS/TB/STIs Committee in Sofia, Plovdiv and Varna. Their roles and responsibilities will be included in the Government Decree for the National AIDS Committee and they will represent the Committee at local level.

Activity 1.1.3: Enhancing the capacity of the Regional Inspectorates for Public Health Protection and Control (RIPHPC)

The main responsible governmental body for public health prevention at local level is the Regional Inspectorate for Public Health Protection and Control, which is a key structure of the Ministry of Health. Their number is 28 in all over the country. Under the expiring grant, the Regional Inspectorates for Health Protection and Control played very important role in the conducting of second generation sentinel surveillance in close collaboration with the nongovernmental organizations, working with vulnerable groups in Bulgaria. And in 12 of them are established Voluntary Counseling and Testing Centers. The key lesson learned is to enhance the capacity of the Regional Inspectorates for Public Health protection to take the leadership role at local level in the field of the surveillance, monitoring and evaluation, strategic planning and policy development in HIV/AIDS and STI prevention and control. The first year this will be piloted in at least 5 RIPHPC in the biggest cities like Sofia, Plovdiv, Varna, Burgas through establishment of AIDS/TB/STIs Units.

The abovementioned activities will empower and strengthen the existing Public Health – client friendly settings to provide free of charge prevention services in the field of HIV/AIDS, diagnosis and treatment of STIs

This will be done through enhancing the institutional framework at all level with special focus on regional level and the involvement of RIPHPC to control the services delivered and to support all existing settings at local level to provide qualitative service. It is essential also to develop a strategy for ensuring of financing mechanisms for the established drop-in centers, needle and syringes exchange programs, Mobile Medical Units, VCT centers, STIs cabinets, MMT, social services, hospice structures, home-care based services etc. It is essential to collaborate all efforts on local level to work together and in a proper manner.

SDA 1.2:HSS: Strategic planning and development of a coherent legislation framework

The main purpose of the activities under this Service Delivery Area is ensure an adequate legislative base, policies, strategic plans, technical guidelines and standards in all sectors that will enable an effective response to HIV/AIDS.

Activity 1.2.1: Development and officially endorsed sectoral HIV/AIDS plans in the key Ministries

It is essential for the national response to HIV/AIDS to include as more as possible key ministries which have very important role in the national policy for HIV/AIDS prevention. This will be done through the sectoral approach and after defining the roles of the ministries, they will be involved in gradual manner in the process of strategic planning and financing of the sectoral HIV/AIDS plans. The first year under this activity the main focus will be put on Ministry of the Interior, the Ministry of Justice and the Ministry of Labour and Social Policy, because they are the essential ministries related to the prevention work with vulnerable groups in Bulgaria. The close work with the Ministry of Finance will be also one of the main activities. The second year the work will continiue with the rest of the Ministries or other governmental agencies. Also during the third year an analysis will be made for the approach used and the results achieved under the sectoral HIV/AIDS Plans.

Activity 1.2.2: Development and officially endorsed municipal HIV/AIDS plans in key municipalities

One of the strengths of the Program Prevention and Control of HIV/AIDS is that partnership has been established with the 19 municipalities where the activities are implemented. While the partnership has been a positive result, it still needs to be scaled-up with the Involvement of more key stakeholders and especially of the Regional Inspectorates for Public Health Protection and Control.

Activity 1.2.3: Improvement of the legislative framework to support the national response to HIV/AIDS

The strengthening of the legislation framework will guarantee the achievements of all national and regional efforts in the field of HIV/AIDS prevention, treatment and control. Many of the factors related to the effective multi-sectoral policies development and implementation, harmonization between the government and municipal policies, ensuring financial sustainability and social protection will be improved through the amendments in the existing normative documents.The analysis and the experience from the expiring grant showed that there is a need for change in key legal documents. The first year emphasis will be put on the Public Health Law, the Penalty Code, the Antidiscrimination Law, and for development of a new regulation for adopting of Medical standards for consulting, prevention and treatment of HIV/AIDS. All efforts under the other objectives for legislation change will be supported also under Objective 1.

SDA 1.3: HSS: Human resources

The main purpose of the activities is to strengthen an adequate management and institutional capacity in key institutions and organizations in order to achieve sustained resources for the efficient implementation of their roles and responsibilities in the field of HIV/AIDS prevention and control

Activity 1.3.1: Strategic actions for building adequate human resources in the field of HIV/AIDS

It is essential to analyze the quality and content of the existing basic and post-graduate curricula and qualification programs, including knowledge and skills building in health work force, social workers, key educational specialists and etc. An assessment of needs and determination of qualification requirements of experts and service providers in different sectors will be performed and the efforts will be focused on the partnership with the universities for upgrading curricula to be introduced to meet the requirements for qualification of specialists needed in the field of HIV/AIDS. The first yer it is planned to upgrade 2 different curricula and to pilot them.

Activity 1.3.2: Institutional capacity building of the NGOs, working for HIV Prevention among groups at most risk

The goal of the activities is to build institutional capacity of the NGOs, working in the field of HIV/AIDS in Bulgaria in important areas as fund raising, lobbying and advocacy; human rights protection, community development and outreach; specific knowledge and attitudes on the vulnerable groups etc. A knowledge hub will we established and will implement the key activities related to design special programs and to provide trainings for the NGOs.

Activity 1.3.3: Resource mobilisation

It is essential to work in two important directions to promote the establishment of a specific budget line for HIV/AIDS-related interventions in place in Ministry of Finance and key other Government ministries and to develop and implement effective strategies for resource mobilisation for the national response to HIV/AIDS in the Government sector, private sector, as well as local and international donors

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SDA 1.4: HSS: Administration, monitoring and evaluation

Activity 1.4.1: Administration of services at regional level – related to the work of 10 Local AIDS Managers
Activity 1.4.2: Administration of activities at national level – related to the overall coordination of the implementation of the objective 1
Activity 1.4.3: Monitoring and supervision –related to the supervision of the coordinating offices and key structures at local level

SDA 1.5: Supportive environment: Program Management

Activity 1.5.1. Program management and monitoring of the objectives implementation – related to the activities implemented by the Program Management Unit to enhance its capacity for coordination of the Program.

OBJECTIVE 2: To strengthen the evidence base for a targeted and effective national response to HIV and AIDS

Currently, the main roles and responsibilities related to the monitoring and evaluation of the situation and the national response to HIV/AIDS are being carried out by to the Directorate for Prevention and Control of AIDS, Tuberculosis and STIs at the Ministry of Health. The Directorate is responsible for collecting, processing and analyzing all data from routine HIV/AIDS surveillance, national HIV and AIDS registries, and data for the provision of ARV therapy. Another part of the key roles and functions is attributed to the Monitoring and Evaluation Unit for GF-funded programmes. The unit is in charge of collection, processing and analysis of data from the information system for programmatic reporting and monitoring of organizations, which are sub-recipients of GF grants. The current proposal will further contribute to strengthening the overall system, organizational, human and other capacities at the national and regional level by gradually building-on GF-programme capacities under the expiring grant and expanding the scope of work to meet the need of one national HIV/AIDS M&E system.

This objective is aimed at the achievement of the following key outputs:

- Adequate institutional support structures for surveillance and M&E in place, including a National Unit for M&E and Strategic Planning, with effective links to existing statistics and information-management institutions; and a clear division of M&E-related mandates, roles and responsibilities;
- Strengthened M&E Capacity among key stakeholders – implementers, policy makers and project managers
- National M&E Plan and Framework, specifying protocols, guidelines and mechanisms for data collection (national indicators; programmatic M&E; (operational) research); data reporting and sharing; data analysis; information dissemination and services; and the strategic use of M&E data in planning and programming;
- National HIV/AIDS information systems established and maintained;
- Integrated Biological and Behavioural Surveillance (IBBS) study implemented among key MARP groups on a biennial basis;
- National research agenda developed, including operational research in key areas of programme and service delivery.

SDA 2.1: HSS: Infrastructure

Activity 2.1.1: Establishment of national units for surveillance, M&E and strategic planning
National unit for surveillance and National unit for M&E and strategic planning will be established and operating at the National Centre of Infectious and Parasitic Diseases through building-on and expanding the roles and functions of the M&E and surveillance units established within the expiring GF grant.

Activity 2.1.2: Staged establishment of regional units for HIV/TB/STI surveillance and M&E
During the first year, 3 regional units will be established in the Regional Inspectorates for Public Health Protection and Control (RIPHPC) in Sofia, Plovdiv and Varna. Localisation of the regional units is based on the need to closely monitor the epidemiological and programmatic context in the regions identified as highest priority. During the second year, 5 new regional units will be established in the RIPHPC in Bourgas, Stara Zagora, Blagoevgrad, Ruse and Yambol. During the third year, 5 more units will be established in regions to be identified according to the epidemiological context and operational research results to identify priority regions.

Activity 2.1.3: Strengthening the national HIV/STI reference laboratories

The National HIV Reference laboratory will be renovated and an STI National reference laboratory HIV National reference laboratory will be established. Regular external quality control on laboratory testing for HIV/STIs will be performed.

SDA 2.2: HSS: Human resources

Activity 2.2.1: Recruitment of personnel for the National units for surveillance, M&E and strategic planning

Personnel with specific roles and capacities will be recruited for the National central unit HIV/STI surveillance and patient monitoring unit: 3 epidemiologists, 2 statisticians, 2 data managers and 1 technical assistant; and for the National unit for M&E and strategic planning: 2 M&E specialists, 2 sociologists, 1 data manager, 1 economist, 3 data operators. The National Unit for M&E and strategic planning will be established on the basis of the M&E unit for GF programs.

Activity 2.2.2: Recruitment of personnel for the regional units for Surveillance and M&E

Staff will be recruited for each regional unit, which will include 1 epidemiologist, 1 M&E officer and 1 technical assistant. After Year 4 of the proposal, they will be reemployed by RPHI.

Activity 2.2.3: Recruitment of additional personnel for national STI reference laboratories

Additional supportive staff will be recruited for the National STI Reference Laboratory for the first 2 years: 1 biologist, 2 laboratory technicians.

Activity 2.2.4: Surveillance and M&E human capacity development

Main human capacity development activities include provision of technical assistance and training at the national and regional level in the areas of epidemiology, surveillance, programmatic M&E, information system operation, data entry and validation, data storage and data transfer. In order to maintain and improve qualifications, opportunities to attend international conferences and meetings will be provided.

SDA 2.3: HSS: Information system & Operational research

Activity 2.3.1: Development of national HIV/AIDS M&E plan

Working groups will be established to develop national guidelines, forms and operating procedures for data collection, storage and analysis. A one-day National Consensus Meeting will be conducted, at which the National Monitoring and Evaluation Plan will be presented and the responsibilities of individual stakeholders for the plan's implementation will be agreed.

A Quality Assurance system for data collection and verification will be developed and implemented. Regular supervision will be provided to validate data records and provide continuous on-the-site training of the regional surveillance and M&E units.

Activity 2.3.2: Upgrade and maintenance of national information systems for HIV surveillance and M&E

DAtasets for the 3 disease components (HIV/TB/STI) will be gadually integrated in one information system at the National Centre for Health Informatics and linked to the National surveillance system for other communicable diseases. Technical assistance will be provided for surveillance data analysis and preparation of annual surveillance report.

Activity 2.3.3: Conduct regular surveillance surveys and Operational Research to provide evidence base for planning and management

Skills-building workshops will be organized for medical specialists and outreach workers/ interviewers participating in biological and behavioural surveillance. Integrated Biological and Behavioural Surveillance will be conducted among key populations most-at-risk: annually for IDUs, and biannually for other groups. Special qualitative studies & operational researches will be conducted too. External assessments on effectiveness of interventions among the different groups will contribute to and ensure the evidence base for policy development and program adaptation

SDA 2.4: Administration, monitoring and evaluation

Activity 2.4.1: Administration of activities at regional level

Regular visits will be conducted for monitoring, supervision and quality assurance of activities performed by NGOs among the target groups.

Activity 2.4.2: Administration of activities at national level

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OBJECTIVE 3: To scale up coverage of testing and counselling services provided through the low-threshold VCT network with a focus on most-at-risk groups

This proposal will continue to support and strengthen the established low-threshold VCT network through the country. The prevention resources for counseling and testing will continue to be targeted to those whose behaviors place them at an increased risk of HIV infection. The overall strategy is to enlarge the access to counseling and voluntary HIV testing services in both low-threshold VCT centers and in the rest public and private health care units where all at–risk sexually active people will be encouraged to be counseled and tested for HIV. Most HIV test is currently performed in the public and the private health care sector and collaboration with serviice providers is an essential element of this strategy.

Several crosscutting strategies must be implemented to achieve enlargement of access to counseling and voluntary HIV testing services in health care units and in the existing VCT centers and Mobile medical units;

- To increase the capacity to offer counseling and voluntary HIV testing services through the Health care facilities and low-threshold VCT network throughout the country.

- Ensure access to counseling and voluntary testing services to everyone of the population in need of these services, especially people belonging to the vulnerable groups, migrants, unemployed young people, people with lack or gaps in their health insurances, people with low income profile.

- Increasing of information, education and communication activities for general population and vulnerable group especially prisoners in HIV/AIDS prevention

SDA 3.1: Prevention: Testing and Counseling

Activity 3.1.1: Provision of client-initiated HIV testing and counselling in VCT centres

HIV counseling and testing will remain client-centered and will continue to be provided in way that addresses the group of most risk of our community to increase the acceptance and delivery of testing services in at most at risk communities. We will continue to utilize new rapid testing technology in aim to enable testing in VCT centers and in nontraditional settings – such as drop-in centers, street outreach programs and to provide screening test results during initial client encounters, so that client do not have to revisit for test results. With the purpose to increase the motivation of at-risk individuals to know their HIV status and decrease perceived barriers to HIV testing we envisage to participate uniting with the other objectives in improvement surveillance to assess specific vulnerable population's risk and testing behaviors. We will continue to develop, implement and evaluate models of integrating STD and HIV counseling and testing.

Activity 3.1.2: Provision of HIV testing and counselling services in prisons

We envisage continuing and maximizing the ensuring access to counseling and voluntary HIV testing services for prisoners by external provider of VCT services

Activity 3.1.3: Provider-initiated HIV testing and counselling serivces in health facilities

To achieve the goal to ensure counseling and voluntary HIV testing services to everyone who need it we will continue to work with health departments, public and private health care providers in order to increase the proportion of providers who routinely provide VCT to patient with another STD, to patient with TB and to all who are with medical conditions indicative of HIV disease. In aim to ensure high quality of counseling and testing services we will develop guidance and medical standart operating procedures on HIV counselling and testing for HIV in health care facilities. Enhancement of education activities in aim to increase provider recognition of primary HIV infection and awareness of other medical conditions that may be indicative of HIV disease in order to promote appropriate and timely HIV testing.

SDA 3.2: Prevention: Condom distribution

Activity 3.2.1: Condom distribution

Most common sexual activity that takes place in penal institution is sex between men. We envisage procuring condoms teller machines for mail prison units. In this way we will ensure distribution of free-of-charge condoms to the prisoners in any time. Condoms and lubricants will be distributed during outreach

activities also.
Condoms will be promoted through peer educator activities, educational session and printing materials.

SDA 3.3: Prevention: BCC - community outreach

Activity 3.3.1: Mass media

Promotion of VCT services will continue to be done particularly through targeted messages mainly on TV during national AIDS campaigns. The toll-free information line, which has been established under the program, will be maintained.

Activity 3.3.2: BCC - community outreach

Education is one of a cornerstone of HIV prevention in prison. VCT teams will continue to provide educational session about HIV/AIDS on a regular basis. The prisoners and prison staff will be informed about HIV/AIDS and about ways to prevent HIV transmission with special emphases on the risks of transmission within the prison environment and to the needs of prisoners after release. Prisoners and staff will participate in development of educational materials. Written materials will be appropriate for the educational level of the prison's population. In view of the importance of peer education provided by prisoners themselves they will be trained and iinvolved in disseminatinon of information and providing support for risk reduction. Peer education will be one of the most effective components of efforts to prevent the spread of HIV infection among inmates.

Activity 3.3.3: Provision of a package of effective HIV prevention services through outreach activities among IDU in prisons

Prisoners on methadone maintenance prior to imprisonment are able to continue this treatment in prison. The next year a pilot project in Prison in Sofia will be implemented aimed to provide methadone maintenance treatment to inmates in correctional unit of the prison.. Needle distribution also will be introduce as a pilot project in Prison in Sofia. Peer educators will be involved in educating other prisoners because HIV transmission in penal institution often is a result of illegal practices Like injecting drug use.

SDA 3.4: Administration, monitoring and evaluation

Activity 3.4.1: Administration of activities at regional level

We envisaged implementing model of administration of the activities at regional level through Regional Public Health Institutes subordinated to the Ministry of Health. Activities will include coordination and facilitation at regional level, prevention and networking activities. They will collect generalize and submit information to the Ministry of health

Activity 3.4.2: Administration of activities at national level

Management and administration of the Objective 3 at national level will ensure coordination of all activities and ongoing evaluation and feedback to service providers and sub-recipients.

Activity 3.4.3: Continuous monitoring and supervision of the provision of testing and counselling services to ensure quality

Regular supervision and monitoring visits at least once a year will ensure evaluation of activities and evaluation of quality of VCT services provided.

OBJECTIVE 4: To reduce HIV vulnerabilities of IDUs by scaling up population coverage of a comprehensive package of prevention interventions

Organization and management of comprehensive community-based outreach work with IDUs: experience from the current grant has proven the appropriate selection of the 10 municipalities with the largest populations of IDUs in the country of more than 90% of the total IDU population in Bulgaria. The different approach in this proposal will be the delineation of the level and intensity of the HIV prevention services in different geopgraphical regions: 1) Plovdiv and Sofia – high-coverage and intensity of interventions as there is concentrated HIV epidemic in both city IDU populations, 2) scaling-up the services in the high-risk cities of Varna, Bourgass, Pleven, Kyustendil and Blagoevgrad , and 3) continuing the services in the cities of Rousse, Pernik and Pazardzhik. We will continue partnership between the Ministry of Health as

Principal Recipient and the NGOs as the organizations, directly working and providing HIV services to the target population.

SDA 4.1.: Prevention: BCC - community outreach

Activity 4.1.1: Provision of a package of effective HIV prevention services through outreach activities among IDUs

Tthe experience and lessons learned from the expiring grant have shown that community-based outreach work, actively involving the target population is very important for reaching and scaling up coverage among IDUs. Though, outreach work is not HIV prevention service by itself it is essential for creating an enhancing setting for the successful implementation of all effective HIV prevention efforts among IDUs.

Activity 4.1.2: Procurement, distribution and exchange of needles, syringes and sterile injection kits

NSEP will take place in drop-in centres, mobile outreach units and by professional outreach teams working in the community of IDUs. Special attention will be given to the use of peer leaders/"gate keepers" for secondary distribution of clean injecting equipment and NSEP.

Activity 4.1.3: Procurement and distribution of free condoms to reduce risk sexual behaviour among IDUs

The results of IBBS/SGS study during last 4 years show that risky sexual behavior is essential and independent factor for HIV transmission among Bulgarian IDUs and the low condom use among them is a significant danger for rapid spread of HIV epidemic among them as well as for further transmission to the general population. Therefore, we are planning a considerable scale-up of the condom distribution and the coverage with those services among IDUs.

Activity 4.1.4: Provision of information, education and counseling to reduce high-risk HIV behaviour

As the ultimate target is to change the risky for HIV transmission sexual and injecting behaviours among IDUs, the provision of adequate behaviour-change oriented IEC is essential for the overall project success. The IEC activities will be provided by the outreach teams and will take place on individual and/or group format on the street and in the drop-in centres.

Activity 4.1.5 Peer-driven HIV prevention among IDUs

As a highly marginalized group, the IDUs in a great extent rely on information and support between themselves and are very reluctant to accept information and advise from outside. The use of peer educators/gatekeepers for distribution and exchange of needles/syringes and provision of IEC was started in the expiring grant and now, it is planned to scale it up and to use the natural IDU networks of information and support to promote sustainable positive change in their risky sexual and injecting behaviours.

Activity 4.1.6: Training of outreach workers

We intend to continue the process of professional capacity building in the field of outreach work with IDUs for HIV prevention. It will be in two directions: 1) education and training of new outreach workers and 2) continuous education and training of special skills.

Activity 4.1.7: Administration of community outreach services for IDUs

From the start of the expiring proposal, the M&E component was always regarded as a major part of the HIV prevention activities and it represents a combination of: 1) routine reporting system, 2) on-site visits – routinely and also for problem solving and - 3) IBBS as a major tool for programmatic progress evaluation. This is one of the greatest program achievements and will be kept and further developed in the current proposal.

SDA 4.2: Testing and Counseling

Activity 4.2.1: Provision of low-threshold HIV counselling and testing services (VCT)

The ambitious target of the new proposal is to significantly scale-up the provision of HIV counseling and testing services to IDUs and at the end of the project we should test at least 80% of the total IDUs population for HIV at least once every 12 months. This ambitious target will be reach by means of: increasing the human capacity in medical staff, careful utilization of the resources of the existing VCT cabinets, the drop-in centres and the MMUs, as well as larger scale of procurement of rapid HIV tests.

Activity 4.2.2: Provider-initiated counseling and testing (PICT) in drug-dependance treatment programs

Another direction of scaling of the HIV testing and counseling services for IDUs will be the inclusion and reporting of the HIV testing and counseling that happens outside the framework of the community-based outreach work with street IDUs with the ever increasing population of IDUs who are on substitution or other

specialized drug-free treatment (both in- and out-patient), in different institution such as prison and probation, or in contact with other social services. Here, the basic approach will be more active provider-initiated counseling and testing (PICT) that should result in high coverage in the range of 90+% of these IDU populations and in high percentage of returned and known HIV results.

SDA 4.3: Prevention: Opioid Substitution Treatment

Activity 4.3.1: OST for IDUs in extreme dependency and hard to reach with standard educational programs Roma people, hard-to-reach populations, HIV Infected IDUs

Opioid substitution therapy (OST) is a pharmacological approach to the treatment of opioid dependence in which the illegal opioid drug (mainly heroin) is replaced by orally administered opioid medicine (methadone, slow-release morphine (Substitol), and buprenorphine), for which there is cross-tolerance and cross-dependence aiming at preventing and cure of the opioid withdrawal syndrome after stopping the use of heroin. The general idea of the current proposal is to focus on provision of methadone maintenance treatment (MMT) as a form of OST to the most marginalized and most-at-risk IDU populations that would not be covered by mainstream of OST provided in the framework of National Program for development of network of MMTs. In our view, these MAR IDU populations include: 1) IDUs in prison system, and 2) IDUs in Roma neighborhoods.

Activity 4.3.2: Opioid Substitution Treatment

OST will be especially important as it is expected that app. 80% of OST (total number of 8000 people at the end of the proposal period) will be provided outside the framework of the current proposal.

SDA 4.4: Prevention: STI diagnosis and treatment

Activity 4.4.1: Diagnosis of sexually transmitted and blood-borne infections

The STIs and especially the ulcerous ones such as syphilis and genital herpes are a very strong factor for increased vulnerability of IDUs towards the HIV infection that was underestimated so far in the prevention efforts and activities supported by the current GF program. The STIs screening and diagnosis will be provided in a comprehensive network of Mobile Medical Units (MMUs), drop-in centers and user-friendly STI clinics.

Activity 4.4.2. STI Treatment

free-of-charge treatment for syphilis and genital herpes will be provided in a comprehensive network of Mobile Medical Units (MMUs), drop-in centers and user-friendly STI clinics.

SDA 4.5: Care and support: Case management of people most-at-risk

Activity 4.5.1: Case management of IDUs most-at-risk and HIV infected IDUs

Case management is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by IDU clients with multiple, complex problems and risk-reduction needs. CM is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or reinfection. As a hybrid of HIV risk-reduction counseling and traditional case management, CM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors.

Priority for CM services will be given to HIV seropositive IDUs having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and reinfection. For HIV seropositive IDUs, CM involves the coordination of primary and secondary prevention interventions in close collaboration with all other relevant services, institutions and organizations.

SDA 4.6: Supportive environment: Stigma reduction in all settings

Activity 4.6.1: Legislative changes to address barriers to effective HIV prevention activities

It is clear from our experience that the abolishment of the so called “single dose” article in the Bulgarian Penal Code in 2004 without proper replacement with other legislative text that is protecting IDU who is not otherwise involved in criminal activities from being criminally prosecuted had led to very unfavorable changes in the setting for the HIV prevention activities among IDUs to the extent that there is a certain danger that this will effectively ruin the effectiveness of those efforts. So, in this proposal is planned a carefully developed and

implemented strategy for political lobbying and promotion of appropriate legislative change in the Penal Code that will be in help for the HIV prevention among IDUs.

Activity 4.6.2: Advocacy for stigma and discrimination reduction

sustained efforts in the form of mass media campaigns, working meetings and conferences with the participation of leading political figures, together with top managers/representatives from the police, prosecution, courts and other institutions both on national and regional levels aiming at supporting positive environment for successful implementation of HIV prevention activities among IDUs.

SDA 4.7: Administration, monitoring and evaluation

Activity 4.7.1: Head office administration

The experiences and lessons learned from the expiring grant call for continuation of the current organizational and management structure of the component "Prevention of HIV among IDUs".

Activity 4.7.2: Continuous monitoring and supervision to ensure quality of service provision

OBJECTIVE 5: To reduce HIV vulnerabilities of most-at-risk Roma people (aged 15-25 years) by scaling up population coverage of community-based prevention and referral services

As a result of specific socio-cultural and economic characteristics and associated marginalisation, the Roma population makes up a disproportionately high proportion of MARP groups, including IDUs, male and female sex workers, MSM, prison inmates and (particularly vulnerable) young people. The risk of HIV infection among Roma is further exacerbated by their social exclusion and lack of access and/or use of health, educational and social services.

While the proposed project components focusing on HIV prevention, care and treatment for MARP groups (IDUs, sex workers, MSM, PLHIV, at-risk youth) aim to maximise coverage of services and programmes among the entire MARP population, a special Roma component has been added to ensure accessibility of these programmes and services to the Roma population, whose cultural and socio-economic marginalisation make them **particularly hard to reach**.

In this regard, **coordination** with the other components (objectives) is particularly important. There are essential linkages between prevention activities provided under Objective 5, such as BCC specifically tailored to the needs of the Roma population and service utilisation provided for this target group under other objectives. HIV counselling and testing will be provided by specialists from VCTs through *mobile medical units* (MMU) (Objective 3). While Roma teams will provide accompanying and referral, extended STI services from the existing health system will provide testing and treatment. The effective mechanism for referral and case management for Roma IDUs will be supported by needle-and-syringe exchange programmes (NSEP), methadone-maintenance treatment (MMT), drop-in centres, VCT and condom and lubricants provision under Objective 4. Mobilised families of Roma IDUs will have meetings with the local Objective 4 teams. The vast majority of sex workers and MSM (predominantly heterosexual) covered under this objective will not be reached by Objective 6 and MSM Objective as far as they are "hidden" and stay away from the commonly used venues and outdoor scenes. In those Roma communities where brothels exist, specialists from Objective 6 (Sex Workers) will be supported by the Roma team to provide their regular HIV and STI counselling. A communication procedure will be developed between prison services (under Objective 3) and local services (including NGO/community based service providers) from the place where Roma ex-inmate is going to live. The local expert who provides regular supervision of the Roma team will also provide special sessions on cultural sensitivity for the medical staff from the existing health system and other objectives delivering low threshold HIV/STI services for the targeted Roma population. Roma adolescents (12 – 15 years old) will be trained in HIV/STI/sex education based on life skills development under this objective and will be not covered by Objective 7 with LSBHE. Organisational development of Roma organisations to ensure sustainability and fundraising knowledge will be provided under Objective 1. Activities under this objective will be carried out in close cooperation with others local structures such as General Practitioners, RIPCPH, other health programmes and the Municipality. In this way, synergy will be ensured and duplication will be avoided.

Continued operation of teams of Roma community workers and specialists as well as of community based health and social centres are necessary to ensure success of BCC interventions.

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SDA 5.1: Prevention: BCC - community outreach

Activity 5.1.1 Outreach work for provision of HIV/STI counselling, motivation and referral to other HIV prevention services

Implementation of regular outreach activities to provide counselling on HIV/STI/safe sexual and injecting practices, condom promotion and distribution of educational materials, motivation and active referral for HIV testing and STI treatment for adolescents (15-25 years old), ex-inmates and mobile men and women

Activity 5.1.2 Distribution of free-of-charge condoms to the people from Roma community

This service is planned to cover up to 70% of the needs of SW, MSM. This new intervention is justified by the need to strongly support for risk reduction in sexual behaviour, especially under the new procedures of case management which include twice per month follow up of risk reduction behaviour.

Activity 5.1.3 HIV/STI/sexual education based on life skills development for 12-15 years-old Roma (boys and girls)

HIV/STI education based on social skills development at appropriate age (12-15 years-old) will be a strong intervention for empowerment of young Roma people as well as achievement of positive change in community norms.

Activity 5.1.4 Printing and distributing informational materials

Development of informational materials on 4 topics: 1.HIV/AIDS; 2. Condoms, 3. Where, how and why to test for HIV? 4. STI – When and where should one look for healthcare? Informational materials will be distributed by outreach-worker teams as part of regular activities to provide counselling, referral and support.

Activity 5.1.5 Capacity building of Roma peer educated on HIV/STI prevention among MSM based on life skills development

Specially designed training provided by specialists and cultural mediators for prevention of HIV/AIDS/STI and strengthening of leadership skills of informal leaders in the MSM groups in Roma community was proved to be an effective mechanism for sustainable change in knowledge, group norms and risk-avoiding behaviour. .

Activity 5.1.6 Supportive environment - service delivery points

Community centres provide facilities for large package for community interventions. Mobile units will ensure geographical expansion of affordable services for people in need. Community based STI treatment facilities will be established in the 10 cities of intervention.

Activity 5.1.7 Administration of activities at regional level

These funds are provided for autonomous management of office and service delivery premises as well as management of local teams.

Activity 5.1.8 Exchange of experience and capacity building service delivery

One annual meeting for representatives of all service providers under Objective 5;; capacity building in specialists in HIV/STI prevention education and strengthening of leadership skills for MSM informal leaders as well as work with families of IDUs.

SDA 5.2 Care and support: Case management of people most-at-risk

Activity 5.2.1. Case management of people most-at-risk

Case-management and referral mechanisms to key health and social services – including (mobile) VCT, STI diagnosis and treatment, harm reduction programmes (incl. NSEP, MMT). About 20% represent most-at-risk peopl (MSM, SW, IDUs) and from 50% to 80% of them will be reached through regular consultations on the basis of case management, accompanying to VCT, etc.,

SDA 5.3 Prevention: Testing and counselling

Activity 5.3.1: Provision of HIV testing and counselling services

Services will be provided to: MSM, IDUs, female and male sex workers, partners of MSM, IDUs, sex workers, ex

prison inmates, patients with STIs, young men aged 15-25, migrant labourers. This service was successful in revealing newly appeared HIV infection cases and this work should expand in all country regions. Extended outreach work will be ensured by purchasing of one vehicle for each Roma NGOs.

SDA 5.4 Prevention: STI diagnosis and treatment

Activity 5.4.1 STI Testing and medical examination

The existing outreach work for motivation and accompanying for STI counselling and testing should expand beyond the population covered by the expiring grant to reach subgroups at certain risk from the Roma community in all country regions.

Activity 5.4.2: Provision of low-threshold STI treatment services

It is planned that the number of service delivery points and medical staff for STI treatment will be increased to provide larger coverage to people in need.

SDA 5.5 Administration, monitoring and evaluation

Activity 5.5.1: Continuous monitoring of supervision to ensure quality of service provision

Regular supervision and annual monitoring visits will ensure evaluation of activities and a high level of coordination and the continuous high quality of services provided. Management and administrative costs for strategy planning and M&E under this Objective.

Activity 5.5.2: Administration activities at national level

OBJECTIVE 6: To reduce HIV vulnerabilities of female and male sex workers by scaling up population coverage of comprehensive package of prevention interventions

In view of the fact that Bulgaria is situated in a region with an increasing HIV epidemic as well as high rates blood- and sexually transmitted infections (STIs), effective measures are needed to be taken to avoid the further spread of HIV/STIs. Especially vulnerable to HIV/STIs are women and men with high-risk sexual behaviours and those in marginalised social conditions. Experiences of working with these marginalised groups have proven the effectiveness of outreach work and peer-driven interventions.

The issue with HIV prevalence, low social status, discrimination, marginalisation etc is still topical for the country. Reasons include: limited access to HIV prevention and treatment services: low hygienic and educational culture; low social status; unsafe sex practices; drug use, including unsafe practices such as sharing of needles and syringes; low educational level about the risks and prevention of HIV/STIs and blood-transmitted infections due to high mobility of some women; ongoing economic crisis

The group of men and women, who offer sex services in Bulgaria is between 12-15,000. The data is collected mainly by experts' evaluation and observation of the outreach teams, working for the Programme.

This target group could be described: 1) by types of offered sexual services: VIP and escort; on advertisement:outdoors; indoors, students and girls in high school; by sex: women, men , offering sex services, MSM (very often this group is also covered by the outreach teams, who offer them counselling and materials)and transsexuals; by ethnic belonging: Bulgarians, Roma, Turkish, UNC, others; and finnaly by drug use: Using drugs – by injecting or by other ways – inhalants and nasal, and not using drugs

All of them are people in "need", but the most results would be achieved if the groups of the outdoor and indoor sex workers and students, selling sex are covered. They are about 60-70% of the whole group or about 7000-9000. One third of them are Roma and about 5% of them are intravenous drug users. Currently the outreach workers cover as many as 60% of the target group – 4200 to 5400.We could aim at increase with about 20% from those who are covered now, by a continuing financing, which will ensure coverage of some distant regions, work with new municipalities and eventually better coverage of North Bulgaria

Reasons to work with this group would be connected to their own high vulnerability; the higher number of (possible) risky contacts with the general population; and their close relationships to other groups at risk (IDUs, homeless people, criminals). It is planned to continue all interventions implemented under the Objective 6 of the expiring proposal. We will follow the same focus like up to now:

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DA 6.1: Prevention: BCC - Community outreach

Activity 6.1.1: Outreach counselling and motivation of the target group to use preventive services.

Lessons learned from the expiring grant have shown that community outreach work has proven its effectiveness among the target group of Sex workers. Visiting the clients of the Programme on the places they live and work and providing them number of services(save sex materials, counselling,guidance, etc.) is essential for effectively reaching and scaling up coverage among sex workers.

Regular mapping and flexibility in relation to changes in the work place of the target group leads to including different and new subgroups like partners /those are pimps, managers, guards and etc/ of sex workers and clients of sex workers. Although it will be difficult to work directly with many of the clients we will try to define the exact way or strategy to cover them – with special information materials or with consultation if it possible.

Activity 6.1.2: Condom and lubricant distribution

Our practice shows that the distribution of safer sex materials (condoms, lubricants) is one of the most efficient approaches in HIV/STIs prevention among vulnerable groups. Especially when it is combined with outreach work and specialized consultations in the field. Although the results from the surveillance show that high percentage of SWs use condoms often they are under the pressure of clients to do not use. That's why we need to focus on support them avoiding risk sexual behaviour by using condoms and lubricants .

Activity 6.1.3: Distribution of safe drug use materials

Distribution of safe drug materials as part of outreach work is very effective way of prevention of HIV among drug users . Distribution of safe drug materials is usually combined with specialized consultation informational materials and relevant referral to specific services for drug users in the filed.

Activity 6.1.4: Peer education

Lessons learned up to now are that there are a lot of Sex workers whose are not reached by the Programme and peer educators and gate-keepers sometimes have better access to unreached clients. Involving peer educators in the work of the teams is like a logical step after the peer training workshops. One of the main goals of training peer educators is to motivate Sex workers to use health and prevention services and reduce of HIV/STI infection

Activity 6.1.5 IEC material and campaigns

The results of Second generation surveillance show there is a change in positive way in behaviour of the target group. To continue the work by up to now and to have good BCC results we need to develop and provide adequate IEC materials for our clients. Offered information should include the specific of the target group. It is necessary that the face to face consultation for increasing clients' skills and knowledge in the health and social spheres go together with distributing educational materials. It will ensue in easier and long term memorizing of key information on different topics among the sex workers.

Activity 6.1.6 Regional administration of service provision

Nowadays there are working eight teams of outreach workers on the territory of Bulgaria. It is advisable to use already built structure and trained workers who have the potential to cope with the planning extension. About the better coverage it is planed to have analysis of the actual situation in region in the country that is not covered by the Objective. In reference to already working NGOs is good to be done analysis of the capacity of every organisation and after that to be planned taking on new members and/or raising the salaries and engagement of the outreach workers.

Activity 6.1.7 Sharing experience and training to improve qualification

Because of the specific outreach work among Sex workers (mobility of the group, different type of people they meet-pimps, police, etc.; frequent change of places they visit, night shifts, etc.) it is necessary to be flexible and to keep the quality of providing services and low level of professional "burn out" and high level of team atmosphere. That's why this type of activity is very important and directed mainly to the out-reach teams - their following education, regular meetings for change experience, work on supporting their regular supervision meetings.

SDA 6.2: Prevention: Testing and counselling

Activity 6.2.1: Provision of low-threshold HIV counselling and testing services

Some of the main characteristics of the target group is that they are very marginalized and often are in unequal economical position. Usually they do not have possibility to use generally accessible health services social skills and attitudes regarding health care and usually they do not have possibility to use generally accessible health services. Often there is a lack of social skills and attitudes regarding health care too. That is a reason to believe that the presence of low-threshold services for sex workers will be very useful. It will make the HIV prevention more effective among the target group and as a result will improve the public health in general

For providing the needs of target group for HIV/STI counselling and testing mobile medical units will continue their regular work in time and places suitable for the clients. There sex workers will receive motivation for using services, counselling and testing by medical team.

SDA 6.3: Prevention: STI diagnosis and treatment

Activity 6.3.1 .Provision of low-threshold services for STI diagnosis and treatment

As it was mentioned most of the sex workers are marginalized and often are in unequal economical position. Providing to them STI diagnosis and treatment by low-threshold services will make the STI prevention more effective among the target group and as a result will improve the public health in general.

Provision of STI diagnosis services through regular use of mobile medical units and guidance to Public Medical clinics. Increasing the motivation and supporting the access to specialised medical services and medical care.

SDA 6. 4: Care and support: Case management of people most-at-risk

Activity 6.4.1 Provision of specific services to the target group

It is foreseen extending the activity with starting of a new intervention - "case management" and new service "low threshold centre" and continuing work. As a part of work in the "low-threshold" centre we will provide - Case management of clients from target group /SW/ with most at risk behaviour. Provision of regular individual or group psychosocial support to clients PLHIV or with high risk behaviour, and/or motivation for proper adherence to the prescribed treatment; counselling for risk avoidance with respect to sex and injecting practices; healthy lifestyle education including mediation to increase the use of the services provided by the health system. The case management of each individual will be carried out by a specialist – psychologist or social worker.

SDA 6.5.: Supportive environment: Stigma reduction in all settings

Activity 6.5.1 Conducting workshops for representatives of institutions

Our experience from the expiring grant have shown that involving representatives from municipal level, Police officers, medical specialists, etc. in discussions and participation in specialized trainings help to reducing the stigma above the target group.

We aim to develop effective collaboration mechanisms with Police authorities and officers at the national and municipal level to create a supportive environment for the implementation of HIV-prevention interventions among marginalised populations that are particularly vulnerable to HIV (including IDUs, sex workers, Roma population, street children). Also to work for creation a supportive environment including stigma reduction, easier access to specific services, special education.

SDA 6.6.: Administration, monitoring and evaluation

Activity 6.6.1. Head office administration

In relation to the future development of the objective it is good to save the same structure of the objective. it includes: Long term consultant and Programme assistant

The long term consultant leads the work meetings, participate in the common discussions, analysis for the implementing the program and if it is necessary, seeks and offers decisions to overcome the current issues; support the director of the Program; works on criteria for choosing sub-recipients; Consult and control of the regional teams; Control the implementation of activities, meeting deadlines and quality; chooses short term consultants and define their tasks and etc. The Programme assistant support all activities of LTC.

Activity 6.6.2 Monitoring and supervision

Conducting regular and ad-hoc visits to implementing partners in view of monitoring, supervision and quality assurance of service provision, as well as situation analysis and staff selection in new geographical regions where program activities will be expanded

OBJECTIVE 7: To reduce HIV vulnerabilities of at-risk youth (aged 15-24) by scaling up coverage of comprehensive youth-friendly programmes and services

All interventions under Objective 7 of the expiring proposal will continue to be supported both by the National Program for HIV/AIDS and STIs Prevention and Control 2008-2015 and by this RCC proposal.

Key service-delivery areas addressing mainstream youth such as: Behaviour-change communication (BCC), life-skills-based sexual and HIV education (LSBSHE) and peer education, Supportive environments (municipal and school policy development) will continue be developed under the National Programme.

The RCC proposal will basically concentrate on subgroups of young people at higher HIV risk, like drops out, children in institutions, street children, delinquent youth and young people with health risky behaviours. It is important to notice that HIV prevention interventions for roma children continue to be planned under the Roma Objective. The mainstream youth will be addressed only through a national communication strategy.

Overall, the interventions aim to build capacity in existing structures in order to guarantee their sustainability after the RCC project expires.

SDA 7.1: Prevention: BCC: Community outreach - peer education

Main activities in this field include peer-education activities by and for out-of-school youth in the age of 10-19 who are at higher risk of HIV.

Under the expiring grant at-risk young people, such as drops out, children in institutions, delinquent children, children with disabilities etc. were addressed through peer education under municipal projects developed and implemented by municipal teams of all 13 pilot municipalities after strategic planning based on situational analysis. Different interventions tailored to reach different subgroups of at risk youth have been piloted in each municipality. Three excellent models of municipal Youth clubs already exist – in Veliko Turnovo, Bourgas and Varna – which have been established and/or supported through these municipal projects. Another best practice is the Youth club of the Consultative Centre of Health and Future Foundation in Pernik, established with technical support from the Youth Objective of the expiring proposal, and financial support of UNICEF.

This proposal will select and support 22 existing structures in the 22 (out of 28) regional centres of Bulgaria – one in each municipality (like Regional Inspectorates for Public Health Protection and Control, or Municipal Youth Structures, supported by the State Agency for Youth and Sport, or Drugs Prevention Information Centres, or a local NGO – sub-recipient of another objective of the proposal, or some other structure) in order to establish a Youth club of peer educators in each regional centre. The proposal will avoid establishing new structures; instead, the focus will be on training and strengthening the capacity of at least one adult (professional) from an existing structure and to use space in this structure for Youth club meetings. The clubs will be created gradually in the groups of regions, defined by the epidemiological analysis of concentration of HIV infection all over the country.

Activity *7.1.1. Situational analysis and mapping of at-risk youth subgroups' settings in each municipalities*

The Youth clubs activities will be planned on situational analysis and mapping of at-risk-youth setting in each municipality. The selected adult will work with one program expert and already trained under the expiring grant peer educators in order to identify, map the settings, assess and analyse the needs of subgroups of out-of-school young people.

Activity 7.1.2. Community outreach through peer education out-of-school

Further, the teams of the clubs will plan interventions and address certain subgroups with complex activities including correct information, individual counseling, condoms, educational materials and group peer educational sessions throughout community outreach. Peer educational teams will promote voluntary counseling and testing services among at-risk youth. They will motivate at-risk youth to test for HIV and will refer to VCT centres for STIs management if needed.

Activity *7.1.3. Qualification enhancement and experience exchange*

Every year special trainings and follow ups will be organised for 1 or 2 professional, supporting each club.

Activity *7.1.4. Summer schools for peer educators*

Every year at least 4 peer educators of each Youth club will be recruited from schools and universities (if there are

any) as well as from at-risk youth subgroups. They will be trained on national or regional levels according the UNFPA and Harvard University standards for Peer Education, adopted in Bulgaria.

Activity 7.1.5: Administration of services

it is to be implemented by 14 NGO or municipality centers in the 14 regions and will cover the coordination of the outreach activities , collecting and processing of the primary data, preparing the reports

SDA 7.2: BCC: Mass media

Activity 7.2.1 Communication strategy development

A communication strategy will be developed in the first year of this proposal, and piloted in the second year.

Activity 7.2.1. Mass media campaigns

At least one campaign on HIV prevention, condom promotion and stigma and discrimination reduction will be launched every year. The messages will be tailored to different age and segments of the youth group and disseminated through different channels.

Activity.7.2.3. Condom promotion and distribution

Condom-promotion activities will take place among mainstream youth; while Condom distribution will be done among at-risk youth. Over 750 000 condoms will be distributed among young people every year through peer educators.

SDA 7.3.: Care and support: Support for orphans and vulnerable children

A process of change is going into the Bulgarian institutions for orphans and vulnerable children aimed to reduce the number of institutions and to reorganise them as well as to support foster families to take care of children. More than 4000 children5, aged 7-18 live in 86 institutions for children all over the country. (Source: State Agency for Child Protection).The analysis has showed that on the one hand the changes are quite slow in the moment and on the other – the professionals in institutions are not trained to provide life skills based sexual and HIV education (LSBSHE) and youth friendly counseling and testing.

Activity 7.3.1: Training of professionals taking care for children in institutions

Activities in this field will comprise the provision of comprehensive care and support, including life-skills-based sexual and HIV Education (LSBSHE) and youth-friendly services for orphans and vulnerable children in institutions. It would be reasonable and sustainable to build capacity of the personnel of these institutions, because even after the reform, when the children will be organised in smaller settings, the need of trained professionals will be even higher. At least 2 social workers from institutions for orphans, delinquents and juvenile criminals will be trained to provide LSBSHE. Training and follow up will be provided for 30 professionals annually.

The medical specialists (at least 1 in every institution) will be trained to provide youth friendly services and referral to VCT for HIV testing and STIs management. Every year 30 professionals will be trained and supported. The institutions to start with are situated in the areas with highest HIV and STI s prevalence. All the activities will be coordinated with the State Agency for Child Protection.

SDA 7.4: Supporting environment: Advocacy for legislation change

Activity 7.4.1. Advocacy for legislation change for ensuring access of young people in schools to LSBSE

One of the main strengths of the Objective 7 of expiring proposal is the capacity build in the sphere of life skills based sexual and HIV education (LSBSHE) and peer education (PE) – trained teachers, school counselors, school medical professionals, peer educators in and out of school and LSBSE and PE IEC materials. At the same time one of the basic weakness of Youth Objective is lack of access of Bulgarian children to comprehensive life skills based sexual and HIV education in school. In the context of the expiring project (2004-08) 152 pilot schools offer comprehensive sexual health education (at least 30 hours) as an elective subject. The national coverage, however, is rather low.

Although the trained teachers, directors of pilot schools and municipal educational authorities are highly motivated to participate in the process, the national educational system does not have a sustainable answer to the need of young people of comprehensive sexual health and HIV education.

[5] Data are from the State Agency for Child Protection

The main activity in this area is advocacy for legislative change. The new RCC proposal aims to implement a range of advocacy interventions to change the existing legislation and ensure access for all students to life-skills-based sexual education in school

Activity 7.4.2. Advocacy for legislation change for changing legal age for HIV testing of young people without parental consent from 18 to 15 year

Other serious weakness of the system is the legal age for HIV testing of young people without parental consent, which is 18 years old according to Bulgarian Health Law. Thus, advocacy actions are planned to lower the official consent age for HIV testing to15 or 13 years.

SDA 7.5: HSS: Information system & Operational research

Activity 7.5.1. Knowledge attitude and behaviour (KAB) survey among 15-49 years

Nationwide KAP surveys for 15-49 years old – representative for five age groups (15-19, 20-24, 25-29, 30-49) – will be carried out twice during the 6-year period of project implementation.

Activity 7.5.2: Maintenance of web based system for monitoring and evaluation of peer education activities

An M&E system will be developed and implemented to monitor the provision of peer-education activities and their impact among young people.

SDA 7.6. Administration, monitoring and evaluation

Activity 7.6.1: Administration at national level

Management and administration of the Objective 7 at national level will ensure coordination of all activities and ongoing evaluation and feedback to service providers and sub-recipients.

Activity 7.6.2: Monitoring and supervision visits

Regular supervision and monitoring visits at least once a year will be organised for evaluation of quality of services addressing the at-risk youth needs.

OBJECTIVE 8: To improve the quality of life of people living with HIV/AIDS (PLHIV) by guaranteeing universal access to treatment, care and support

The National HIV/AIDS Strategy incorporates the provision of comprehensive services to ensure free-of-charge SRV treatment, AIDS-related diseases, prevention of mother-to-child transmission of the HIV infection, post-exposure prophylaxis of the health care providers, and universal precautions.

The Global Fund grant will continue contributing to meet the needs for universal access to treatment and care of PLWHA through 3 strategies:

- Strengthening the health-care system for provision of accessible and affordable follow-up and ARV treatment for all PLWHA in need
- Development and implementation a system for integrated provision of medical and social services for care and support of PLWHA at municipality level
- Reducing HIV/AIDS stigma and discrimination against PLWHA by health care workers

The implementation of these strategies is structure around the following core service delivery areas and main activities:

SDA 8.1: HSS: Infrastructure

Activity 8.1.1: Ensure easy access to follow-up , ARV treatment and monitoring trough expanding current sectors for treatment and establishing new

As of the end of 2007, 369 patients were on treatment and follow-up in the four HIV/AIDS treatment centers. Due to the increasing number of patients in need of ART and monitoring, and in order to facilitate the access of PLHIV to treatment and care services, 2 new sectors and CD4 laboratories will be established for the first 3 years. According to the needs and number of patients, the existing sectors will be expanded. In order to meet the increased number of patients demanding palliative, 3 hospices will be opened gradually in different country regions.

SDA 8.2: HSS: Human resources

Activity 8.2.1: Training of health staff to provide treatment and care to PLHIV

The estimated number of patients on follow-up and ART will rise from 531 in 2008 to 7,164 in 2014. This will increase the demand for medical specialists providing care and treatment to PLHIV. Therefore, 56 medical doctors and nurses will be gradually trained in the first 3 years, and 80 more in the next 3 years. To meet the increasing demand for palliative care, health care workers will be trained to provide the service. In order to implement good international practices, external consultants will be invited in the development guidelines and training courses for the health care staff.

SDA 8.3: Treatment: Prophylaxis and treatment for opportunistic infections

Activity 8.3.1: Provision of high-quality treatment and prevention of OI among PLHIV

This proposal will continue to contribute to the improvement of quality of life of PLHIV through support to treatment services for opportunistic infections. The proposal is intended to cover only costs for procurement of necessary medicines, while all other costs will continue to be covered with national resources.

SDA 8.4: Care and support: Care and support for chronically ill

Activity 8.4.1: Develop professional case management services to provide care and support to PLHIV

At present, psychologists and social workers are not part of the staff of HIV/AIDS treatment departments. The current RCC proposal will contribute to recruit at least one psychologist in each HIV/AIDS treatment sector. In addition, at least 1 social worker should be recruited to provide social support, referral, and accompanying to health care facilitiesfor provision of medical care to PLHIV. To ensure the provision of additional home care for PLHIV in need of the service, professional groups will be established including at least 1 medical nurse and 1 social worker.

Activity 8.4.2: Scale up support services for PLHIV provided by NGOs and self-support groups

At present, three NGOs representing self-support groups in Sofia and Varna, provide a supportive environment to PLHIV through organizing training workshops and social events. This proposal will continue to financially support these NGOs. Due to the increasing number of PLHIV in different country regions, it is planned to motivate and strengthen new self-support groups in the other 4 towns where treatment sectors operate: Plovdiv, Pleven, Bourgas and Stara Zagora.

SDA 8.5: HSS: Information system & Operational research

Activity 8.5.1: Strengthen recordkeeping systems for health facilities providing follow-up and ARV treatment

As of the end of 2007, implementation of electronic database information system on treatment of HIV/AIDS patients, and management of ART medication was introduced in the Hospital of Infectious Diseases in Sofia. Two operators have been trained in data entry. The further development of this system requires the recruitment and training of 5 more data entry operators until the end of 2011. Starting from 2013, the operators will be recruited by the Hospitals of Infectious Diseases hosting the HIV/AIDS treatment departments.

SDA 8.6: HSS: Strategic planning and development of a coherent legislation framework

Activity 8.6.1: Development and update of legal documents related to treament and care to PLHIV

With a view of standardising and regulating of the provision of treatment and care for PLHIV, existing medical standards, guidelines, operational procedures and training materials will be updated and new ones will be developed in additional areas. Furthermore, guidelines and HIV specific legislative framework will be developed for confidentiality of the information, disclosure and shearing of HIV status, data protection, storage and transfer.

SDA 8.7: Supportive environment: Stigma reduction in all settings

Activity 8.7.1: Reduce HIV/AIDS stigma and discrimination against PLHIV by health care workers

The issue about the stigma and discrimination against PLHIVA **by the health care workers** will be integrated into the existing national system for human rights protection. To further reduce stigma and discrimination, specific topics and toolkits on HIV stigma and discrimination on will be introduced in the curricula of medical universities and colleges, post-graduate and vocational education programmes for medical

specialists.

SDA 8.8: Administration, monitoring and evaluation

Activity 8.8.1: Head office administration

Management and implementation of activities under this objective will be strengthened and administered by an objective manager, a technical assistant and short-term consultants. The office will be located in the National Centre of Infectious and Parasitic Diseases. Remuneration of the staff and costs for office management will be covered by the present proposal during the first 4 years only.

Activity 8.8.2: Continuous monitoring of supervision to ensure quality of service provision

The quality of the provision treatment care and support services will be continuously monitored through collecting standardized information from the service providers. Regular local supervision will be carried out. For the purpose of situational analysis and ongoing needs assessment, operational research will be conducted. Monitoring, estimation and projection results will be published annually. Working and study visits in other countries are planned to exchange experience on the issues of care and treatment for PLHIV.

Objective 9: To reduce HIV vulnerabilities of men who have sex with men (MSM) by scaling up population coverage of a comprehensive package of prevention interventions

MSM remain hard-to-reach and data about them are scarce. Therefore, in the first year, operational research has to be conducted. Results will be used to identify the stratification within the group, map the geographical distribution of group and sub-groups, to Identify factors and risk behaviours contributing to the transmission of the HIV infection and other STIs. These surveys will provide the evidence base for the design, implementation and expansion of quality service delivery to the MSM group.

The existence and involvement of NGO network implementing outreach activities among MSM is an important prerequisite for conducting. Currently, there is only one active organization situated in Sofia - Foundation “Queer”. To present, they have implemented activities mainly in the area of MSM human rights protection, and have no practical experience with the provision of specific preventive services. Therefore, other priority strategy under this objective is the development and establishment of institutional and implementation framework that will enable effective and client-friendly service delivery to MSM. There is a clear need to develop human and institutional capacity and national guidelines for provision of services tailored to the needs of the target group.

From the second year on, activities under this objective will be centred around the design and implementation of effective and client-friendly services, including HIV prevention, care and support and active referral to existing health services. First, effective communication channels will be developed through websites, other targeted media messages and outreach work in order to motivate MSM and their partners to use HIV prevention services. Concurrently, it is necessary to develop adequate infrastructure for service delivery, e.g. establishment of MSM-friendly service delivery points, STI testing, diagnosis and treatment services as well as initiate interventions at the individual level through case management of those most-at-risk.

To expand the coverage of services and guarantee their high-quality, the third main strategy of this objective is to build adequate supportive environment and mobilise financial, human and infrastructural resources. Enhancement of political commitment and advocacy for legislative changes are planned to reduce stigma and discrimination and to increase overall public acceptance of the human rights of MSM. Campaign activities and involvement of eminent MSM persons to go openly in public are also recognized as effective interventions in this key area. It is envisaged that the private sector will be actively involved in order to raise funds through cost-return strategies, i.e. advertising in MSM web-sites.

SDA 9.1: HSS: Information system & Operational research

Activity 9.1.1. Conduct operational research to provide evidence base for the design and implementation of services to MSM

In the first year, operational research is planned to identify the stratification within the group; to map the geographical distribution of the group and sub-groups and places for outreach work; to identify factors and risk behaviours and design specific services to reduce the vulnerability of MSM to HIV/STIs. Operational research will be supported by an MSM organization as additional activity to the regular outreach work for HIV prevention among MSM. During the third year another operational research for interim assessment of effectiveness of implemented interventions among MSM will be conducted.

SDA 9.2: HSS: Service delivery

Activity 9.2.1: Development of national guidelines, operational procedures and tools for provision of effective and quality services tailored to the needs of MSM

During the second year of the project national guidelines, operational procedures and tools will be printed to guide and unify the implementation of services by different providers to the group of MSM. Printed materials will be used as well for needs assessment, HIV/STI consultation, social support, peer education and other know how directions.

SDA 9.3: Supportive environment: Strengthening of civil society and institutional capacity building

Activity 9.3.1: Establishsment of new and selection of existing NGOs to provide specific HIV prevention services to MSM

Conduct expert visits for situation analysis, support to establishsment of new and/or selection of existing NGOs to implement acitivies in 5 municipalities: Sofia, Plovdiv, Varna, Bourgas and one to be identified from activity 1.

Activity 9.3.2: Training of public health staff, NGO staff and peer educators to provide specific HIV prevention services to MSM

Conduct training of 10 trainers in aspects of service provision for HIV prevention among MSM by international trainer experienced in the work with the target group. Training materials in specific aspects will be developed and adapted for service delivery among MSM. Conduct training of public health staff, NGO staff and peer educators to provide specific services for HIV prevention among MSM

SDA 9.4: HSS Infrastructure

Activity 9.4.1: Provision of services through low-threshold centres for MSM

In the second and third year, respectively 3 and 2 pilot MSM-friendly centres will be established as service delivery points for provision of low-threshold services.

SDA 9.5: Prevention: BCC - community outreach

Activity 9.5.1: Reach MSM with HIV prevention messages through web-sites and other targeted media

Support to the most-frequented MSM web-site and development of online counselling on HIV/STI/safe sex topics. Leaflets and other informational materials on HIV/STI/risk behaviour topics will be developed specifically targeting MSM. The informational materials will be distributed by outreach-worker teams as part of regular activities to provide counselling, referral and support.

Activity9.5.2: Outreach counselling and motivation of the target group to use preventive services

Implementation of regular outreach activities by NGOs to provide a package of services including counseling on HIV/STI/safe sexual practices, condom and IEC distribution, safe sex materials, motivation and active referral for HIV testing and STI treatment. Target will be reached also through the use of MSM peers to provide counselling and education on risk reduction strategies.

Activity 9.5.3: Condom and lubricant promotion and distribution

Procurement of condoms will be distributed during outreach activities. It is planned that during each contact for service provision 3 condoms and 1 small package of lubricant will be distributed to each MSM.

Condoms will be promoted also through campaign activities. This new intervention is justified by the need of strong support for risk avoiding sexual behaviour.

Activity 9.5.4: Regional administration of service provision

The activities are carried out by NGOs responsible for community outreach coordination, primary data collection and analysis, reports preparation in 3 municipalities.

SDA 9.6: Prevention: Testing and Counseling

Activity 9.6.1:. Provision of low-threshold HIV counselling and testing services

HIV counselling and testing services will be provided to the target group through regular use of mobile medical units and stand-alone VCT centres as service delivery point.This service will be successful in revealing newly

appeared HIV infection cases.

SDA 9.7: Prevention: STI diagnosis and treatment

Activity9.7.1: Provision of low-threshold services for STI diagnosis and treatment

Comprehensive medical services for examination, diagnosis and treatment of STI will be provided to MSM through regular use of mobile medical units and stand-alone VCT centres as service delivery points.

SDA 9.8: Care and support: Case management of people most-at-risk

Activity 9.8.1: Provision of specific services for case management of people most-at-risk

Professional counselling on social and psychological aspects, including mediation to increase the use of services for MSM will be provided by the health system. It will include also referral and accompanying of the clients to such services.

SDA 9.9: Supportive environment: Stigma reduction in all settings

Activity 9.9.1: Conducting workshops for representatives of institutions

Organization and conducting a workshop with representatives of State Commission for Protection Against Discrimination and health care institutions to identify areas of possible cooperation in the field of stigma and discrimination issues and acceptance of MSM human rights, and establishment of mechanisms to address rising issues

Activity 9.9.2: Actively involve the private sector in order to raise funds

Conduct operational research to identify effective cost-return strategies, i.e. advertising in MSM web-sites.

Activity 9.9.3:. Implement campaign activities

The Program will participate in the development of National communication strategy in the part for MSM and will support the organization and conducting of MSM-oriented events and national AIDS information campaigns with specific messages to address stigma and discrimination.

SDA 9.10: Administration, Monitoring and Evaluation

Activity 9.10.1: Conducting regular and ad-hoc visits to implementing partners in view of monitoring, supervision and quality assuranceof service provision

Regular supervision and annual monitoring visits will ensure evaluation of activities and a high level of coordination and the continuous high quality of services provided.

4 Proposal Strategy

Analysis of planned interventions – Scope and Scale Considerations

4.6.2 Incorporation of lessons learned into this proposal

Describe below:

(a) the **strengths** of the expiring grant that have facilitated successful implementation and strong grant performance to date (e.g. PR management, implementation capacities of partners, procurement and supply management strategies). Summarize how the strategy of this proposal continues and builds upon these key strengths;

(b) how this proposal **addresses and resolves weaknesses or bottlenecks** encountered during implementation of the expiring grant (e.g. in regard to PR management and Coordinating Mechanism oversight, implementation capabilities of partners, etc.**). **Where there have been issues in implementation capacity, ensure that in this section** (or in the response to section 4.8) **the Coordinating Mechanism describes how capacity issues have been addressed in this proposal to ensure strong performance** (including through, where relevant, the selection of new/additional PR(s) from appropriate sectors – whether public sector, civil society, for profit sector, or otherwise)**; and**

(c) if relevant, how other lessons learned (outside of the expiring grant) have been incorporated into this proposal.

*(**Applicants may find it useful to refer to, for example, feedback from the Global Fund at the time of receiving notice of their qualification for the Rolling Continuation Channel, the most recent 'Progress Updates and Disbursement Requests' from a Principal Recipient, or the 'Grant Scorecard' published by the Global Fund after a grant has completed Phase 1 when commenting on grant implementation issues).*

Among **many strengths** of the expiring grant that have facilitated successful implementation and strong grant performance to date the following stand out:

1) Improved service delivery and coverage of most at risk groups with key prevention services like community outreach programs, harm reduction programs, condom and lubricants promotion and distribution, low threshold services, including VCT, mobile medical units.

With the expiring grant support the following service delivery points were established and strengthened: 5 low-level centres for IDUs ; 7 health-social centres in the Roma community; 14 mobile medical units; establishing and functioning of 20 VCT network throughout the country; VCT in all the prisons in the country; 5 key Departments for HIV treatment renovated and refurbished; three centres of psychic and social support for HIV/AIDS people, their relatives and partners supported

2) Technical capacity among the civil society to provide services for MARP has been strengthened. More than 50 civil society organizations (CSOs) were directly contracted by the MoH for the execution of the GF program.

3) Political commitment and leadership of the Government were backed up by increasing annual allocations from the national budget spent on free ARV treatment provision and blood safety and HIV testing.

4) Coordinated multisectoral partnership and involvement of civil society in the national AIDS policy formulation, monitoring and evaluation is achieved through the high representation of the non-governmental sector and affected communities in the CCM.

5) The National HIV/AIDS policy is aligned with the Country Development Plans through inclusion of HIV/AIDS prevention and control policy in the key strategic documents of the country (The National Health Strategy, The National Strategic Reference Framework 2007-2013)

6) PR management capacities were enhanced by the establishment of the Directorate for Prevention and Control of AIDS/TB and STIs within the Ministry of Health. This lead to strengthening the activities and empowering the entire network of stakeholders working for HIV prevention. In the process expiring grant implementation the capacity of the other departments of the MoH in the area of health programme management were also strengthened.

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The key service delivery areas and interventions in the RCC proposal are planned and building on already existing structures, services, networks, partnerships, coordinating and participatory decision making mechanism. The key strengths of the expiring grant will guarantee the successful implementation of the RCC proposal.

Key weaknesses and bottlenecks encountered during implementation of the expiring grant **and planned actions to address and resolve these:**

1) Insufficient coordination of HIV activities at local level. Vertical management between the PR and the local NGOs as well as weak and sometimes non-existing operational coordination of HIV activities at municipal level lead on the one hand to high administrative burden at central government level and on the other hand insufficient involvement of local authorities in the HIV response. The RCC plans to address this with the support for the delegating the management and coordination role of local HIV programs to the RIPCPH and the establishment of Local AIDS committees that will be responsible for local policies implementation.

2) The National HIV/AIDS/STI Monitoring & Evaluation System is still not established. This is one of the key actions that will be addressed under objective 2: "*To strengthen the evidence base for a targeted and effective national response to HIV and AIDS"* and health system strengthening.

3) The abolishment of "single dose drug possession" article of the Penal Code lead to the rapid increase of HIV infection among IDUs. This will be addressed through: advocacy and lobbing actions for legislation adjustment, introducing new services like opioid substitution therapy and scaling up low threshold services in both mobile and stand alone centers.

4) Services provided by NGOs are totally depended on the GF funding. This will be addressed in several ways 1) through allocation of funds from the key ministries and municipalities to support NGOs activities and 2) building the institutional capacities of the NGOs 3) resource mobilization strategy development and implementation

5) Lack of qualitative operational researches that will allow better understanding of the attitudes and behaviors driving the HIV epidemic This will be addressed by planning and conducting several qualitative operational researches that can be a base for development and tailoring the effective HIV prevention activities.

6) Existing Stigma and discrimination among general population as well as among health care professionals towards PLH and other marginalized groups is still relatively high. This will be addressed through: specially tailored media campaigns, advocacy activities and professional trainings

7) Based on the expiring grant it is recognized that the most at risk groups could be served better when individual case management for follow up of risk reduction behavior, maintenance of treatment and/or substitution therapy and referral to relevant health services. The introduction of individual case management is planned in the RCC. The strong participation of the target group in all stages of planning, implementation, monitoring and evaluation during the expiring grant proved to be a successful strategy and will be further strengthened.

8) Develop a coherent framework of national and local legislation, policies, strategic plans, technical guidelines and standards in all sectors that will enable an effective response to HIV/AIDS. This will ensure the sustainable mechanism for financing of the nongovernmental sector through different budget mechanisms.

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4.6.3	Continuation of Expiring Grant's strategy	
(a)	Does this proposal continue the same objectives, same service delivery areas, and same focus and range of interventions as the expiring grant (without any changes to program scope or scale)?	☐ Yes ➔ *answer (b) below and go to section 4.6.6* ☒ No ➔ *go to section 4.6.4*
(b)	If yes, describe how the continuation of the original proposal's implementation strategy is the most effective approach to achieve sustained disease specific health outcomes and impact consistent with the national plan. *Applicants should support this explanation by referring to technical, disease trend and managerial factors.*	
N/A		

4.6.4	Program scale adjustments in this proposal	
	This section requests a description of any planned change in the scale of interventions within this proposal as compared to the expiring grant's strategy. *(In this context, a 'scale-up' of interventions should be used by Applicants to categorize a significant increase in the outcomes of planned interventions. Examples of programmatic 'scale up' include: a significant increase in: the number of people with advanced HIV infection receiving ARV treatment, or number of ITNs distributed to people at risk, or the number of facilities with adequate staffing per level to enable an efficient and effective implementation of DOTS.)* ➔ ***Refer to the Guidelines for Proposals for further information.*** ***Applicants are advised that any proposed reduction in the scale of interventions/services in this proposal compared to the expiring grant would need to be supported by clear and objective information on the reasons for this change.*** *(Examples may include the availability of resources from an alternative source to replace some portion of the interventions from the expiring grant).*	
(a)	Does this proposal include a significant planned scale adjustment (whether a scale up or a reduction in interventions) compared to the expiring grant's planned focus and outcomes?	☒ Yes ➔ *answer question (b) below* ☐ No ➔ *go to section 4.6.5*

(b)	**If yes to (a) above**, describe the planned scale adjustments. Provide logical and technical justification as to why this change will create more effective and sustained strategies for greater health outcomes and impact. *Examples of reasons for a change in the scale of interventions include: a changed country context, changing disease patterns, synergies between the diseases, changes in evidenced-based interventions and knowledge and increased coverage.) Applicants are strongly encouraged to include a diagram or map to explain expansion-focused interventions where relevant.* ➔ ***Refer to the Guidelines for Proposals*** *(page 22)* ***for further information.***
The IBBC data and estimation and projection of HIV epidemic in Bulgaria (Workbook) show clear need to scale up the interventions, planned in this proposal, in the following aspects: 1. The recent development of epidemic figured out one hidden vulnerable population – men who have sex with men (MSM). Due to stigmatization of these behaviours, the epidemiological data till the beginning of GF expiring grant did not illuminate definitely the fact that 2 to 1 ratio of HIV infected men to women is a result of MSM practices. The experts' hypothesis that there is a hidden prevailing MSM mode of HIV transmission was verified by the results of the IBBS data from the 2007. A significant number of HIV infected MSM have been detected and this is the reason to scale up this RCC proposal with **one new objective: *To reduce HIV vulnerabilities of men who have sex with men (MSM)by scaling up population coverage of a comprehensive package of prevention interventions***	

2. Increase in coverage and provision of comprehensive higher-quality preventive services, care and support for the most at risk groups is also planned in this proposal through introducing new service delivery areas and interventions and their intensity adjustment based on the grouping of the regions in the country, based on the their HIV epidemic.
   - Scaling up population coverage with comprehensive HIV prevention programmes for most at risk groups
   - Better focusing and tailoring of different SDAs and interventions due to the delineation of 4 groups of regions prioritized by the concentration of HIV epidemic;
   - Providing case management for most-at-risk and HIV-infected IDUs, Roma youth, SWs and MSM to influence behaviour change at individual level;
   - Offering opioid substitution therapy for most at risk IDUs;
   - Establishing new service delivery points like low-threshold centres for SWs in 5 country regions;
   - Scaling up community-based peer-driven outreach in IDUs, SWs, MSM and at-risk youth groups;
   - Establishing hospices and home based care for PLH;
   - Providing of low threshold services for STIs diagnosis and treatment.
   - Scaling up HIV counselling and testing through enhancing both provider- and client-initiated counselling and testing.

3. The third major aspect of scaling up interventions in this RCC proposal is strengthening of management and monitoring and evaluation mechanisms at national and regional levels:
   - All 28 Regional Inspectorates of Public Health Prevention and Control will be gradually involved in IBBS as well as in overall management mechanism at local level.
   - Coordination, harmonization and networking between different objectives at local level is planned to be improved though networking strengthening and brother involvement of key stakeholders in decision making, focused in establishing of local AIDS/TB/STIs Committees.
   - Institutional framework of key line ministries with clear roles and responsibilities in relation to HIV prevention activities will be strengthened
   - New funding mechanism for community-based activities are planned to be established under RCC proposal for channelling and coordination of national funds from central to regional and community levels.
   - HIV/AIDS monitoring and evaluation system at all levels will be built on at all levels of national health care system.

The sustainable and evidence based outcomes will be achieved through the well established mechanisms both for funding and sharing of responsibilities at all levels and sectors involved in the national response.

4.6.5 Program scope change planned in this proposal

As set out in the Guidelines for Proposals, program scope change is possible for Rolling Continuation Channel proposals where the planned scope change facilitates the introduction of a broader package of interventions to which the expiring grant is contributing. (Examples of reasons for a change in scope may include: a changed country context, changing disease patterns, synergies between the diseases, changes in evidenced-based interventions and knowledge and increased coverage.) *However, proposals which are determined by the Global Fund to be materially different from the expiring grant (e.g. propose different overall goals, different overall objectives, etc.) are not supported under the Rolling Continuation Channel. Such proposals should be submitted under the Rounds based channel.*

For increased information on scope change, Applicants are strongly encouraged to refer to section 4.6.5 of the Guidelines for Proposals.

(a)	Does this proposal include a proposed change in scope as compared to the expiring grant's scope?	☐ Yes ➔ *answer question (b) below* ☒ No ➔ *go to section 4.6.6*

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(b)	**If yes to (a)**, describe below the planned scope change below as compared to the expiring grant's strategy *(e.g. describe the new 'key service' coverage areas and planned interventions/activities)*. Provide logical and technical justification as to why the planned scope change is a priority to ensure the creation of more effective and sustained strategies for greater health outcomes and impact.
N/A	

4.6.6 Interrelationships and dependencies on other support for the national program

➔ *Refer to the Guidelines for Proposals, section 4.6.6 (page 25) for further information before completing the following questions.*

(a) **Other proposals which have impacted the scope and/or scale of the expiring grant**

Describe whether (and if so, to what extent) any other proposal(s) submitted to the Global Fund after the start date of this expiring grant already involves a scale-up of the interventions in the expiring grant, or a scope change to the expiring grant. **If there is any overlap between this proposal and earlier proposals to the Global Fund, Applicants should clearly explain why this proposal is asking for support for the same 'key services' or interventions, and why this is not a request for duplicative funding.**

N/A

(b) **Linkages to other Global Fund proposals**

Describe any specific interrelationship or dependency between this proposal and the interventions targeted in: (i) any existing Global Fund grant; or (ii) a Round 6 or Round 7 proposal submitted to the Global Fund and not yet signed/approved (as relevant). *A dependency includes, for example, one proposal providing the framework for treatment interventions, and the 'interdependent' proposal containing, for example, a significant proportion of the medicines required to ensure that the treatment interventions can be achieved.*

Applicants are encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants *(including 'Phase 2' amounts anticipated to become available).* ***The reason(s) why a Round 7 grant remains unsigned at the time of submission of this proposal should also be explained in detail****.*

N/A

(c)	Describe any major bottlenecks in current performance towards achievement of the disease specific national plan *(as supported by these other Global Fund grants and/or all other financial sources)*, and if so, what steps are being taken in-country to resolve these challenges?
N/A	

(d)	**Only if relevant**, indicate whether any part of the request for funding in this proposal arises from the discontinuation of support from another source? If so, explain the reason why that source of funding is no longer available.
N/A	

Private Sector Contributions

4.6.7 Private Sector contributions

(a) If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions *(whether financial or non-financial)* anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs.

➔ *Refer to the Guidelines for a* ***definition of Private Sector*** *and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.*

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N/A

(b) Referring to the population group(s) that will be the focus of the Private Sector co-investment partnership, identify in the table below the annual amount of the anticipated contribution. (For non-financial contributions, please attempt to provide a monetary value if at all possible, and at a minimum, a description of that contribution).

Size of population group that is the focus of the Private Sector contribution ➔								
Refer to the Guidelines for Proposals for examples on 'Contribution Description' *** Add extra rows below to identify each main Private Sector contributor*		**Contribution Value** *(same currency as selected in section 1.1)*						
**** Private Sector Contributor Name**	**Contribution Description** *(in words)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**

Planning for Sustainability and Impact

For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.8.

4.6.8 Potential for sustainability

(a) **Strengthening national capacity and processes**

Describe how this proposal makes an important contribution to the strengthening and/or further development of national systems and institutional capacity (including the capacity of the public, private and NGO sectors, and communities affected by the disease(s). Refer to country evaluation reviews, if available.

This proposal has a specific focus on building in and working towards sustainability in all its objectives of the Program and for the sustainability in the national response to HIV/AIDS. Objective 1 "*To create a supportive environment for an effective and sustainable national response to HIV/AIDS in Bulgaria"* has the crucial role in creating and strengthening supportive institutional frameworks and systems – including partnerships between Government, municipal authorities, civil society and private sector, as well as institutional capacity and human resources for the national response to HIV/AIDS. In addition, the key output will be establishment of supportive legislative, policy and strategic planning frameworks at the national and municipal level. The proposal aims to achieve:

Financial Sustainability - the mechanisms and approaches will be introduced to increase the level of state funding for HIV prevention for the most-at-risk groups through development, implementation and financing of sectoral ministerial plans for HIV/AIDS prevention; implementation and financing of municipal prevention programs and improvement of the legislation, related to HIV/AIDS at all level. It is important to ensure the specific budget line for HIV/AIDS-related interventions in place in the Ministry of Finance and other key Government ministries in order to increase gradually the government commitment and budget allocations. The real involvement of the municipalities in financing and supporting the nongovernmental organizations with premises is already started under the expiring grant and will be scaled-up under the RCC proposal. Nowadays the Bulgaria Government works closely with the German colleagues to reduce the prices of ARV drugs in the country and the region.

Officially endorsed mechanisms for coordination and multisectoral cooperation **-** this will be achieved in different aspects between all stakeholders at all level – governmental sector, municipal authorities and civil sector. A strong emphasis will be put on establishing and rolling out a National Surveillance and M&E System, in which all key stakeholders from government and civil society will participate. The sustainability will be achieved through strengthening M&E Capacity among key stakeholders – implementers, policy makers and project managers

NGO sector sustainability – the main focus will be put on the strengthening of the institutional and managerial capacity of NGOs through training of the key staff in fund raising, lobbying and advocacy; human rights protection,

community development and outreach; specific knowledge and attitudes on the vulnerable groups etc. This will

enhance the capability of the NGOs to attract funding and to deliver high quality services.

HIV/AIDS and STIs Services sustainability will be the main result of the abovementioned outputs of the RCC Proposal.

The main strategies for the implementation of all interventions under the Proposal are:

- To involve and strengthen the existing health care structures and
- To coordinate the efforts between national and local levels, government, municipal, civil and private sectors

This is the way to resolve many of the obstacles defined in Bulgaria Country Report for scaling up the National HIV/AIDS Response towards Universal Access to prevention, treatment, care and support (Annex 23) and to ensure sufficient involment of all sectors related to HIV/AIDS and sustainability in the initiatives of the community-based organizations providing services to the most-at-risk groups in Bulgaria.

(b) **Alignment with Broader Developmental Frameworks**

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative and the Millennium Development Goals.

Also include an overview of any links to international initiatives, e.g. as the WHO/UNAIDS 'Universal Access Initiative' or the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities, or the 'Roll Back Malaria Global Strategic Plan').

The main objectives and priorities of Programme "Prevention and Control of HIV/AIDS", funded by GF, are incorporated in a range of national strategies, programmes and documents, which encompass health, demographic, economic and social aspects of contemporary national policy. Some of them are: the *National Program for Prevention and Control of HIV/AIDS and STIs (2008-2015);* the National Health Strategy 2007-2013 (draft) ; Joint Memorandum on Social Inclusion between the EC and Bulgaria; the National Demographic Strategy 2006-2020; the National Child Strategy 2008 – 2018, supporting the National Programme for Control of Drug Abuse and others.

The continuation of the GF Programme will significantly contribute to the achievement of the Millenium Development Goals and other global Initiatives– the Three Ones, implementation of the UNGASS declaration and the Universall access to care, treatment of support.

4.6.9 Evidence of impact/potential for impact

For the questions below, the concept of 'impact' refers to whether there is clear evidence of impact on the relevant disease epidemic or influence of planned interventions on disease prevalence, incidence, mortality and/or averted infections. In order to demonstrate impact on the relevant disease, the program may require increased coverage to reach a greater proportion of the population in need with care and support, treatment and prevention services. In addition, planning for impact will require an impact measurement system to capture monitoring and evaluation measures. Refer to the Guidelines for Proposals, section 4.6.9 for more information.

(a) **Potential for demonstrating impact**

How will the additional support provided by this proposal increase the capacity of the country to demonstrate that its national disease strategy will have, or has the potential to have, a measurable impact on the burden of the disease (whether expressed in terms of overall morbidity and/or mortality and/or averted infections).

As an integral part of the National Programme for Prevention and Control of HIV/AIDS and STIs 2008-2015, the RCC proposal will contribute to a significant increase of coverage of most-at-risk population with comprehensive prevention services.

Analysis of the development of the epidemic in the last five years showed that the annual HIV incidence rate increased in 2002 – 2003 (68-50% annual increase), slowed down after 2004 and reached annual rate of increase of 7% in 2007. This could be explained by the implementation of expiring grand that made possible rapid scale-up of HIV prevention activities among most-at-risk groups. The projection of the epidemic modeled by the UNAIDS estimation packages Workbook and Spectrum 3.14 clearly outlined that the trend of the epidemic would turn down in the third year of the RCC proposal. This proposal will contribute to a better quality of life of PLHIV, diminishing HIV-related morbidity and mortality.

The potential for impact of planned services is evidenced by the knowledge and behavioural changes over time tracked from the beginning of the expiring proposal till the moment through IBBS and other surveys. People from the most-at-risk groups who have received an HIV test and know

their results have increased more than twofold, and knowledge on HIV transmission and prevention has increased nearly threefold. There is 51% increase in the percentage of IDUs who report the use of sterile injecting equipment. Condom use with most recent client among sex workers remains significantly high – 95.63% (citation Bulgaria UNGASS Progress Report).A substantial increase in the percentage of people living with HIV, who are still alive and on treatment 12 months after initiation of ARV therapy is observed (from 87.09% in 2004 to 93.75%).

Current RCC proposal funds will contribute of national health system strengthening. The proposal allocate funds for structural and capacity building on national and local level - National M&E system, PIPHPC and community based organizations development .

(b) **Impact Measurement Systems (IMS)**

Describe the in-country systems and organization(s)/team(s) that evaluate potential for health impact, determine country impact measurement indicators, and track/monitor achievements towards national goals.

In your description, comment on the strengths and weakness(s) of the IMS (e.g., health information systems, surveys, mortality registration, and community registers), and solutions integrated into this proposal to overcome challenges and finance gaps to effectively report on performance and impact indicators over the proposal term.

Note ➔ **If there has been a recent national/external evaluation of the IMS, describe the main findings**.

The National M&E system strengthening is a key area of the health system and priority in the National HIV/AIDS/STIs Strategy. The operational comprehensive M&E system will generate data and channel information to guide, evaluate and adjust the National response to the dynamic of the epidemic. National M&E unit will gather information related to all GF impact and outcome indicators, the National HIV/AIDS/STIs program indicators as well as UNGASS, MDG and ECDC required indicators and other international commitments.

(c) **Linking M&E activities under this proposal to the National IMS**

Describe how the data relating to measuring performance and impact in regard to this proposal will be accurately collected, collated and reported by implementing partners to the Applicant, the Global Fund and the body responsible for national monitoring and evaluation.

In your description also explain how this proposal seeks to: (1) use, to the extent that they exist, existing country systems for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing; and (2) achieve greater harmonization and alignment of partners to country cycles in regard to procedures for reporting, budgeting, financial management and procurement.

The data related to measuring performance and impact in regard to this proposal will be accurately collected, collated and reported by implementing partners to the PR, the Global Fund and the National M&E unit through the establishment of the AIDS/TB/STIs Imformation system and the establishment and capacity development of the national and regional M&E units located respectively in the NCIPD and 28 RIPHPCs.

The current proposal will use the existing national systems for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing in the manner done in the expiring grant.

(d) **M&E Systems Strengthening plans**

By reference to the '*M&E Systems Strengthening Tool*' (describe, in a summary format only, how this proposal incorporates a plan to overcome any capacity gaps in the PR(s) and SR(s) M&E systems to ensure that M&E activities in this proposal will be effectively linked to the National IMS framework to finance relevant gaps *(as contemplated above).*

In particular, Applicants should comment on how gaps and potential/actual bottlenecks identified that are relevant to this proposal will be managed or mitigated during the proposal term. Budgetary implications arising from this assessment should be included in the budget information required in section 5. ***Note ➔ The Global Fund recommends that between 5 to 10% of this proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.***

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One of the challenges of Universal Access identified in 2006 was the delay in the establishment of the National HIV/AIDS Monitoring & Evaluation System.
The existing bottleneck in the M&E system will be managed and mitigated by the following key actions:
1) Participatory development of national M&E framework and plan for AIDS/TB/STIs
2) Establishment of the national and regional AIDS/TB/STIs units
3) Development of a national information system and AIDS/TB/STIs and database.
4) Strengthening the M&E capacity of key national and local stakeholders.
5) Integration of HIV/STIs/TB Information systems in the National Health Information System.

This proposal plans to conduct a number of *operational research studies* on the specific risks and vulnerabilities of the beneficiaries of the project (IDUs, drug users in prisons; MSM; sex workers; Young people at higher HIV risk, PLHIV, as well as a number of studies to explore potential drivers of HIV risk among other groups, currently not included as key target groups, such as mobile populations. All these studies will contribute to a stronger basis for an evidence-informed national response, and will be used for purposes of national priority setting, national and international resource mobilisation and strategic planning.

4.7 Program and Financial Management

In this section, Applicants should describe their proposed implementation arrangements and if there are any changes from the expiring grant's management plan. See the Guidelines for Proposals, section 4.7, for more information.

Table 4.7: Nominated Principal Recipient(s)

(a) Indicate if the existing Principal Recipient(s) (PR(s)) will change (e.g. adding an additional PR or replacing the current PR)?	☐ **Yes** *Answer (b) and (c) below before question 4.8*
	☒ **No** *Go to question 4.8*

If there is/are any new PR(s), Applicants are requested to complete the box below.

(b) **Responsibility for implementation**				
Name of new Principal Recipient(s)	**Sector**	**Name of Contact person**	**Address, telephone, fax numbers and e-mail address of contact person**	**Is the new PR replacing an existing PR ? Yes/No?**

(c) Describe the rationale for the proposed change(s) to PR arrangements. Also include a detailed description of the transparent, documented process utilized to select the PR(s) based on objective documented criteria, as this is required to ensure compliance with Coordinating Mechanism minimum requirement 4(a) in Annex 1 to this Proposal Form (and in Annex 1 to the Guidelines for Proposals).

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4.8 Factors influencing implementation capacity

4.8.1 Principal Recipient capacities

Describe the respective technical, managerial and financial capacities of each PR in this proposal (continuing and new) to manage and oversee implementation of the proposal (or their proportion) having regard to the proposed changes in scale and/or scope identified in section 4.6.

What plan(s) exist to strengthen the PR(s)' capacity to absorb these changes into their implementation management framework, and ensure strong performance? Please also discuss any anticipated barriers to strong performance, and how they will be addressed, referring to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

Currently, the Principal Recipient has already established an adequate capacity to manage the expiring Grant financed by the Global Fund grant management in the five major areas as follows:

1) With regard to Financial Management & Systems, the Principal Recipient has ensured:

- A well-established organizational structure for financial management and reporting, as well as documented roles and responsibilities for the management of Global Fund resources
- Very well-prepared and motivated staff at the Financial Management and Reporting Unit in the Program Magement Unit, supported on a daily base from the MoH „Budget and Accounting" Directorate;
- Specialized software moduls for financial management and procurement and supply management, that operated effectively and this allow to control the funds disbursed to the numerous sub-recipients under the Program
- Mechanisms are in place to manage properly all financial documents under the requiremens of the Global Fund
- Strict and properly documented rules and procedures are in place for costing and detailed budgeting; the budget includes breakdowns for each Sub-recipient under the Programme;
- Mechanisms are in place for regular inventories of tangible assets acquired from Programme funds, as well as an adequate level of insurance;
- Efficient mechanisms are in place to hire an independent auditor for the annual financial audit of the Principal Recipient and Sub-recipients; in addition, external control on the GF Grant management is exercised by the National Audit Office and the Public Internal Financial Control Agency;

2) With regard to Institutional & Programmatic Capacity, the Principal Recipient has ensured:

- The Minister of Health is the authorized representative of the Principal Recipient, and the Ministry of Health Secretary General is responsible for administrative control on the Programme which ensures political support . A well-established mechanism for signing the Grant Agreement, adoption of the Agreement by Parliament and promulgation in the Official Gazette is in place.
- The Program Management Unit works in close cooperation with the key bodies like Expert Boards, National Committee and Agencies related to the national policy in HIV/AIDS;
- Detailed job descriptions of the key PMU staff is in place (Annex …… – PMU Roles and responsibilities) and also operational procedures were developed for communication with Sub-recipients and rules for annual plans and budgets;
- Coordination of programme activities with other national, regional and international initiatives implemented in the country;

3) With regard to the Sub-recipients managent

- In place is an effective management capacity of the PR to evaluate the sub-recipients under the GF grant, to provide training and build on technical support to improve their capacity to provide better quality of services;

- PR gained experience in establishment and using of management system that assured control over the sub-recipients and allow transparent partnership and support between the SRs and the PR;
- Mechanisms and experience in carrying out the regular supervision of Sub-recipients in order to ensure the quality of services provided to target groups

4) With regard to Procurement and Supply Management, the Principal Recipient has ensured:

- A well-established division responsible for Global Fund Grant supplies working in close cooperation with the „Investment Policy" Directorate under the Ministry of Health which is in charge of procurement and supply under the National Programme for prevention and control of AIDS and STIs;
- An experience gained in contracting and procurement management under the Public Procurement Act, including tools to implement the VAT exemption according to the Grant Agreement with the Global Fund and this is very important strength of the department in delivering to Sub-recipients centrally procured goods and health products
- Well-established mechanisms for product quality assurance at the lowest procurement prices;
- A well-established Procurement Management Information System for Global Fund grant resources;
- Sufficient storage facilities for the storage of drugs and medical consumables at all levels of the chain of distribution

5) With regard to Monitoring and Evaluation, the Principal Recipient:

- Monitoring and Evaluation Unit within the PMU is responsible for coordinating the M&E efforts under the Programme
- The M&E unit has experience in the collection and analysis of data on programme progress, including well-established mechanisms for reporting and flow of information at various levels;
- The PR developed various registration and reporting tools in place which guarantee confidentiality and informed consent in the provision of specific services and carrying out surveillance research;

4.8.2 Sub-Recipient information

(a)	Are the majority of sub-recipients (SR(s)) **from the expiring grant,** continuing their roles and responsibilities in this proposal?	☒ **Yes** ➔ *answer question 4.8.3* ☐ **No** ➔ *answer (b) before completing question 4.8.3*

(b) **If no**, explain why, and for new SR(s) who will either receive a substantial proportion of the funding for this proposal or will be involved in funding to sub-sub-recipients:

(i) describe the **transparent** process by which new SRs were identified **and the criteria** that were applied in the identification process.

(ii) summarize the past implementation experience of these new SRs

4.8.3 Sub-Recipient capacities

What plans exists to strengthen the capacity of the major SR(s) to absorb the continuing and/or expanded responsibilities under this proposal, and ensure strong performance? Please also discuss any anticipated barriers to strong performance, and how they will be addressed, referring to any evaluations by the existing PR(s) of SR capacities (e.g., capacity-building needs, staffing and training requirements, etc.).

Under the RCC proposal the important role for ensuring strong performance is put on the NGOs technical and managerial capacity building. During the last years sub-recipients working under the expiring Grant were supported in all aspects by the Principal Recipient in order to provide better quality services for the most at risk groups. It is planned that the RCC proposal will support NGOs sub-recipients to continue scaling-up interventions. Objective 1 specificallyl focus on training of key NGO staff in the field of fund raising, lobbying and advocacy; human rights protection. It is planned also to improve local coordination between all stakeholders that will further enhance networking and reduce barriers to access to services for most-at-risk groups. This will be achieved with the effective involvement of the Regional Inspectorates for Public Health Protection and Control.

4 Proposal Strategy

Applicants should carefully read the Guidelines for Proposals at section 4.9 and section 4.10 before completing the questions below.

4.9 Procurement and supply management (PSM) of health products

4.9.1 Overview of extent of change to PSM arrangements		
(a)	Does this proposal involve the procurement and supply management of a significant quantity of any medicines or other key health products? ➔ *Refer to the Guidelines for Proposals, section 5.3 (cost categories) for a definition of 'health products'.*	☐ **No** ➔ ***Go directly to the budget section*** *(section 5)* ☒ **Yes** ➔ *answer question (b)*
(b)	**If yes to (a)**, does this proposal give rise to **any change(s)** in the **roles and responsibilities** for the procurement and supply management of health products in comparison to the expiring grant?	☒ **No** ➔ ***Complete section 4.9.2*** *and then* ***go to section 5 and Attachment B*** *(detailing quantities and unit costs for health products)* ☐ **Yes** ➔ ***Go to section 4.10*** *before completing* ***section 5*** *and* ***Attachment B***

4.9.2 PSM of health products for continuing PR(s) involving a scale-up of ongoing activities

Describe:

(a) how implementation arrangements relevant to this proposal have been planned to ensure *(including, as relevant, plans to obtain necessary additional technical assistance, training or other capacity building assistance)* that continuing PR(s) have sufficient capacity to absorb the increased responsibilities in respect to the PSM of health products for the planned scale-up; and

(b) the extent to which the ongoing procurement and supply management of health products under this proposal will be coordinated with other procurement and supply management actions in support of the national disease prevention and control program to ensure greater impact on the disease.

Continuing PR - There are no significant newly introduced responsibilities for the PSM of health products and the PR has a sufficient capacity to continue the implementation of procurement and supply management of health products without additional technical assistance

➔ **For continuing PR(s) where there is no significant newly introduced responsibility for the PSM of health products**, **complete section 5 and Attachment B** *(see section 5.4.1).*

➔ **For new PRs and/or where a continuing PR's responsibilities are newly/significantly extending into the PSM of health products**, **complete section 4.10 to describe the revised PSM arrangements** before completing **section 5 and Attachment B.**

4.10 PSM of health products – New PR(s) and/or newly introduced PSM activities

This section should be completed where this proposal targets interventions which introduce significantly altered arrangements to those under the expiring grant, whether those changes arise from:

(a) **New PR or key sub-recipient** ➔ this proposal identifies an additional (or replacement) PR or sub-recipient whose responsibility it is to undertake a substantial proportion of the PSM of health products; or

(b) **Scope change** ➔ this proposal is targeting a broader package of interventions to which the expiring grant is contributing, in circumstances where these interventions include the PSM of health products as a new or significantly increased focus during implementation.

4 Proposal Strategy

4.10.1 Amended roles and responsibilities for PSM of health products

In the table below, describe the planned roles and responsibilities for procurement and supply management of health products under this proposal. *(For example, the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is PR for this grant application.) If a function is planned to be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health Department of Disease Control, or Ministry of Finance, non-governmental partner, technical partner).*	In this grant application what is the role of the organization responsible for this function? *(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).*	Indicate if there is need for additional staff or technical assistance
Procurement policies & systems			☐ Yes ☐ No
Quality assurance and quality control of pharmaceuticals			☐ Yes ☐ No
International and national laws (patents)			☐ Yes ☐ No
Coordination			☐ Yes ☐ No
Management Information Systems (MIS)			☐ Yes ☐ No
Product selection			☐ Yes ☐ No
Forecasting			☐ Yes ☐ No
Procurement and planning			☐ Yes ☐ No
Storage and Inventory management			☐ Yes ☐ No
Distribution to other stores and end-users			☐ Yes ☐ No
Ensuring rational use			☐ Yes ☐ No

4.10.2 Procurement capacity

(a)	Will procurement and supply management of medicines and other health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient(s) or will sub-recipients also conduct procurement and supply management of these products?	☐ PR(s) only ☐ SRs only ☐ Both

(b) For each new organization planned to be involved in the procurement of medicines and other health products, provide details of the current volume of medicines and other health products procured on an annual basis in the table below. *Use the "tab" button on your computer to add extra rows at the bottom of the table if more than four new organizations will be involved in **procurement**.*

Organization Name	Total value of medicines and other health products procured during last financial year *(In same currency as in section 1.2 of this proposal)*

4.10.3 Coordination Capacity
Describe the extent to which ongoing procurement and supply management of health products under this proposal will be coordinated, to the extent possible and appropriate having regard to country contextual considerations, with other procurement and supply management actions undertaken in support of the national disease prevention and control program.

4.10.3 Coordination Capacity
Describe the extent to which ongoing procurement and supply management of health products under this proposal will be coordinated, to the extent possible and appropriate having regard to country contextual considerations, with other procurement and supply management actions undertaken in support of the national disease prevention and control program.
The Program Management Unit (PMU) is responsible for the management, control, and coordination of the chain of supplies, utilizing the structure and existing information system of the Principal Recipient and the applicable legislation in the field of the Public Procurement of Republic of Bulgaria in narrow collaboration with the National Program for Prevention and control of HIV/AIDS.

4.10.4 Supply management (storage and distribution)		
(a)	Will the same organization as in the expiring grant provide the supply management (storage and distribution) functions for medicines and other related health products during the proposal term?	☐ Yes *➔ continue to question below* ☐ No *➔ continue to question below*
(b)	**Indicate** which types of organizations will be involved in the supply management of medicines and other related health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below.	☐ National medical stores or equivalent ☐ Sub-contracted national organization(s) *(specify which one(s) below)* ☐ Sub-contracted international organization(s) *(specify which one(s) below)* ☐ Other: *(specify below)*
(c)	Describe each organization's current **storage capacity** for medicines and other related health products, and indicate how a possible scaling up of interventions and increased requirements under this proposal will be transparently and effectively managed.	
(d)	Describe each organization's **current distribution capacity** for medicines and other related health products. In your response, indicate how any increased responsibility for distribution of medicines and other health products under this proposal will be managed, and potential challenges addressed. In addition, provide an indicative estimate of the percentage of the country and/or population covered by procurement and supply management services under this proposal, and the relative percentage increase (if any) this represents on existing distribution arrangements for the nominated distribution partners.	

4 Proposal Strategy

4.10.5	**Pharmaceutical products selection** Do you plan to utilize national standard treatment guidelines ('STG') that comply with the World Health Organization's ('WHO') STG during the proposal term? **If not**, describe below the STG that are planned to be utilized, and the rationale for their use. In section 5.4.1, Applicants are requested to complete **'Attachment B' to this Proposal Form** on a per disease component basis to provide more detail on the STG, and also the expected prices for medicines.

5 Proposal Budget

5. Proposal Budget - Overview and general guidance

In this Section 5 Applicants must provide specific information on their funding request (as summarized in table 1.2).

Applicants should prepare their budget information in the following order:

1. **prepare a detailed proposal budget** (section 5.1);
2. from that detailed budget, **prepare a summary by Service Delivery Area** (section 5.2);
3. from that detailed budget, **prepare a summary by cost category** (section 5.3); and
4. **then** provide details about key budget assumptions (section 5.4).

Funding to be contributed through a common funding mechanism
If part or all of the funding requested is to be contributed through a common funding mechanism *(relevant for Applicants who completed section 4.3.3)*, **Applicants must:**

(a) compile the Budget information in sections 5.1 to 5.3 on the basis of the anticipated use, attribution, or allocation of the requested funds only within the common funding mechanism (that is, not the total combined funds in the common funding mechanism); **and**

(b) provide, **as an annex to your proposal**, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request in a covering page to that plan.

5.1 Detailed Proposal Budget

A detailed budget covering the proposal period must be attached as an annex to your proposal.

The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

The Detailed Proposal Budget *should meet the following criteria. (Please refer to the Guidelines for Proposals, section 5.1):*

*(a) It should be **structured along the same lines as the Proposal Strategy**—i.e., reflect the same goals, objectives, service delivery areas and activities which can build towards impact on the disease.*

(b) It should cover the full term of the proposal, and:
- *(i) be **detailed for year 1, year 2 and year 3**, with financial information broken down by **quarters for the first year, and at least half yearly for the second and third years**; and*
- *(ii) provide summarized information and assumptions for the balance term of the proposal period (years 4, 5 and 6).*

*(c) It should state all key assumptions, including those relating to **units and unit costs (avoid using lump-sum amounts)**, and should be consistent with the assumptions and explanations included in section 5.4.*

*(d) It should be integrated with the detailed **Work Plan** for year 1 and indicative Work Plan for year 2 and 3 (please refer to section 4.6).*

(e) Details and costs of HSS Strategic Actions should be clearly identified.

*(f) It should be **consistent** with other budget analysis provided elsewhere in the proposal, including those in this section 5.*

5 Proposal Budget

For tuberculosis and HIVAIDS components only:

Multi-drug-resistant tuberculosis	
Does the proposal request funding for the treatment of multi-drug-resistant tuberculosis?	☐ Yes
	☒ No
If yes, Applicants are reminded that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Thus ➔ Applicants should also ensure that for each year of the proposal term, an amount equivalent to US$ 50,000 should be transparently budgeted for in the Detailed Proposal Budget (this section 5.1) for contribution towards fees incurred by the Green Light Committee. *Applicants should note that this money must be reserved for the Green Light Committee and can not be transferred for other implementation activities.*	

5 Proposal Budget

5.2 Summary of Detailed Proposal Budget by objective and service delivery area

Please provide a breakdown of the annual budget by service delivery area (SDA) derived from your detailed proposal budget (section 5.1). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). Totals should be provided in this table both for each Year (vertical total) and for each SDA (horizontal total). **The totals requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.3 (budget breakdown by cost category) and with the amounts entered should be indicated in table 1.2.**

Revised Table 5.2: Budget breakdown by objective and service delivery area

		Budget breakdown by SDA *(EUR)*						
Objective Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
1	**OBJECTIVE 1: To create a supportive environment for a sustainable national response to HIV/AIDS in Bulgaria**	**654 618**	**651 193**	**652 716**	**602 938**	**551 359**	**482 477**	**3 595 300**
1	SDA 1.1: HSS: Governance and institutional framework development	90 760	193 988	219 315	183 735	168 614	86 562	942 973
1	SDA 1.2: HSS: Strategic planning and development of a coherent legislation framework	43 041	19 592	19 838	18 790	6 821	19 618	127 700
1	SDA 1.3: HSS: Human resources	126 264	61 271	25 946	32 569	10 047	10 967	267 064
1	SDA 1.4: Administration, monitoring and evaluation	65 343	64 812	64 134	42 539	40 862	40 862	318 553
1	SDA 1.5: Supportive environment: Program Management	329 211	311 530	323 483	325 304	325 015	324 467	1 939 010
2	**OBJECTIVE 2: To strengthen the evidence base for a targeted and effective national response to HIV and AIDS**	**683 146**	**456 735**	**620 657**	**513 187**	**510 210**	**447 499**	**3 231 433**
2	SDA 2.1: HSS: Infrastructure	279 472	68 821	74 317	92 033	79 590	0	594 233
2	SDA 2.2: HSS: Human resources	209 380	209 538	264 349	250 101	207 691	273 262	1 414 322

5 Proposal Budget

		Budget breakdown by SDA *(EUR)*						
Objective Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
2	SDA 2.3: HSS: Information system & Operational research	165 703	139 501	231 514	121 051	172 782	124 088	954 638
2	SDA 2.4: Administration, monitoring and evaluation	28 591	38 875	50 476	50 002	50 148	50 149	268 241
3	**OBJECTIVE 3: To scale up coverage of testing and counseling services provided through the low-threshold VCT network with a focus on most-at-risk groups**	**886 701**	**755 174**	**782 062**	**585 200**	**391 066**	**441 377**	**3 841 580**
3	SDA 3.1: Prevention: Testing and Counseling	612 365	555 896	606 725	448 850	249 322	304 057	2 777 215
3	SDA 3.2: Prevention: Condom distribution	145 207	52 305	56 490	44 842	47 378	42 641	388 862
3	SDA 3.3: Prevention: BCC - community outreach	63 599	82 434	57 273	30 938	30 938	30 938	296 121
3	SDA 3.4: Administration, monitoring and evaluation	65 529	64 539	61 575	60 570	63 428	63 741	379 382
4	**OBJECTIVE 4: To reduce HIV vulnerabilities of IDUs by scaling up population coverage of a comprehensive package of prevention interventions**	**771 963**	**889 853**	**1 002 732**	**863 898**	**775 417**	**707 138**	**5 011 001**
4	SDA 4.1: Prevention: BCC - community outreach	512 693	494 527	538 150	407 038	329 858	272 660	2 554 926
4	SDA 4.2: Prevention: Testing and Counseling	24 129	29 914	32 193	31 318	27 880	20 500	165 935
4	SDA 4.3: Prevention: Opioid Substitution Treatment	123 586	254 751	314 007	314 802	311 121	311 121	1 629 388
4	SDA 4.4 : Prevention: STI diagnosis and treatment	37 614	39 935	47 080	40 692	33 741	30 089	229 151

5 Proposal Budget

		Budget breakdown by SDA *(EUR)*						
Objecti ve Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
4	SDA 4.5: Care and support: Case management of people most-at-risk	32 273	37 574	40 096	40 096	40 096	40 096	230 229
4	SDA 4.6: Supportive environment: Stigma reduction in all settings	15 339	10 993	9 459	8 692	7 813	8 608	60 903
4	SDA 4.7: Administration, monitoring and evaluation	26 329	22 159	21 748	21 260	24 909	24 065	140 469
5	**OBJECTIVE 5: To reduce HIV vulnerabilities of most-at-risk Roma people**	**625 120**	**662 084**	**757 238**	**575 434**	**502 277**	**482 447**	**3 604 600**
5	SDA 5.1: Prevention: BCC - community outreach	479 173	432 090	424 791	349 946	328 630	289 957	2 304 587
5	SDA 5.2: Care and support: Case management of people most-at-risk	50 986	85 272	124 802	20 531	17 433	28 690	327 714
5	SDA 5.3: Prevention: Testing and counseling	18 734	26 029	34 388	28 084	25 374	20 314	152 923
5	SDA 5.4: Prevention: STI diagnosis and treatment	40 182	89 222	141 429	145 045	98 936	111 639	626 453
5	SDA 5.5: Administration, monitoring and evaluation	36 046	29 471	31 829	31 829	31 904	31 846	192 924
6	**OBJECTIVE 6: To reduce HIV vulnerabilities of female and male sex workers by scaling up population coverage of comprehensive package of prevention interventions**	**591 150**	**640 975**	**726 278**	**545 951**	**461 918**	**389 929**	**3 356 201**
6	SDA 6.1: Prevention: BCC - community outreach	494 515	544 001	620 969	444 512	371 698	306 297	2 781 992
6	SDA 6.2: Prevention: Testing and Counseling	50 327	52 258	54 178	53 340	51 667	49 993	311 763

5 Proposal Budget

		Budget breakdown by SDA *(EUR)*						
Objective Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
6	SDA 6.3: Prevention: STI diagnosis and treatment	11 775	15 746	20 660	17 725	12 504	7 722	86 133
6	SDA 6.4: Care and support: Case management of people most-at-risk	6 872	7 739	8 455	8 358	4 033	3 936	39 393
6	SDA 6.5: Supportive environment: Stigma reduction in all settings	3 221	1 772	1 913	1 913	1 913	1 913	12 646
6	SDA 6.6: Administration, monitoring and evaluation	24 440	19 460	20 102	20 102	20 102	20 067	124 273
7	**OBJECTIVE 7: To reduce HIV vulnerabilities of at-risk youth and adolescents (aged 10-19) by scaling up coverage of comprehensive youth-friendly programs and services**	**581 007**	**638 233**	**632 285**	**561 395**	**442 460**	**355 020**	**3 210 400**
7	SDA 7.1: Prevention: BCC – community outreach	308 130	337 897	429 914	400 614	247 090	200 893	1 924 538
7	SDA 7.2: Prevention: BCC - Mass media	143 898	134 230	96 118	86 500	86 500	86 500	633 747
7	SDA 7.3: Care and support: Support for orphans and vulnerable children	28 919	39 040	29 740	29 740	24 448	21 802	173 690
7	SDA 7.4: Supporting environment: Advocacy for legislation change	44 738	34 512	29 399	0	0	3 835	112 484
7	SDA 7.5: HSS: Information system & Operational research	5 113	48 573	2 556	2 556	42 437	2 556	103 792
7	SDA 7.6: Administration, monitoring and evaluation	50 209	43 981	44 557	41 984	41 984	39 433	262 148
8	**OBJECTIVE 8: To improve the quality of life of people living with HIV/AIDS (PLHIV) by guaranteeing universal access to treatment, care and support**	**545 305**	**861 716**	**810 260**	**793 142**	**752 614**	**666 962**	**4 430 000**

5 Proposal Budget

		Budget breakdown by SDA *(EUR)*						
Objecti ve Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
8	SDA 8.1: HSS: Infrastructure	239 069	356 619	245 195	313 908	313 908	313 908	1 782 605
8	SDA 8.2: HSS: Human resources	57 827	57 919	121 912	118 078	81 393	17 123	454 252
8	SDA 8.3: Treatment: Prophylaxis and treatment for opportunistic infections	51 785	79 995	127 851	127 849	127 849	127 849	643 177
8	SDA 8.4: Care and support: Care and support for chronically ill	57 262	95 093	141 105	152 522	152 522	152 522	751 026
8	SDA 8.5: HSS: Information system & Operational research	18 057	25 461	26 990	13 938	13 529	14 347	112 322
8	SDA 8.6: HSS: Strategic planning and development of a coherent legislation framework	23 392	5 982	10 737	2 018	1 508	1 508	45 145
8	SDA 8.7: Supportive environment: Stigma reduction in all settings	62 311	201 822	95 584	25 156	23 519	1 841	410 234
8	SDA 8.8: Administration, monitoring and evaluation	35 602	38 825	40 885	39 674	38 386	37 864	231 237
9	**OBJECTIVE 9: To reduce HIV vulnerabilities of MSM by scaling up population coverage of a comprehensive package of prevention interventions**	**239 086**	**389 580**	**510 083**	**388 715**	**347 350**	**266 485**	**2 141 300**
9	SDA 9.1: HSS: Information system & operational research	10 226		10 226	0	0	0	20 452
9	SDA 9.2: HSS: Service delivery		2 122		0	0	0	2 122
9	SDA 9.3: Supportive environment: Strengthening of civil society and institutional capacity building	15 421	4 900	3 680	3 680	3 680	3 680	35 041

5 Proposal Budget

		Budget breakdown by SDA *(EUR)*						
Objective Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
9	SDA 9.4: HSS Infrastructure		38 134	49 926	33 165	33 165	33 171	187 561
9	SDA 9.5: Prevention: BCC - community outreach	169 581	281 792	344 263	256 204	215 750	130 992	1 398 582
9	SDA 9.6: Prevention: Testing and Counseling	4 847	10 552	22 527	22 521	22 521	22 521	105 488
9	SDA 9.7: Prevention: STI diagnosis and treatment	8 736	19 022	40 618	40 614	40 614	40 614	190 217
9	SDA 9.8: Care and support: Case management of people most-at-risk	1 513	4 094	8 698	8 698	8 698	12 586	44 288
9	SDA 9.9: Supportive environment: Stigma reduction in all settings	12 258	9 503	9 128	3 668	3 668	3 668	41 893
9	SDA 9.10: Administration, monitoring and evaluation	16 505	19 460	21 017	20 166	19 255	19 255	115 657
Total requested from the Global Fund:		**5 578 095**	**5 945 544**	**6 494 312**	**5 429 859**	**4 734 671**	**4 239 333**	**32 421 815**

5 Proposal Budget

5.3 Summary of Detailed Proposal Budget by Cost Category

In table 5.3 ***on the following page***, provide a breakdown of the annual budget by cost category *derived from your Detailed Proposal Budget (section 5.1).*

Please note:

(a) Guidance on the budget categories and the expenses falling within each category is provided in the **Guidelines for Proposal** section 5.3.

(b) The total requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.2 (breakdown by 'service delivery area').

(The "Total funds requested from the Global Fund" must also be consistent with the amounts entered in table 1.2 relating to this component.)

5 Proposal Budget

Table 5.3 – Budget breakdown by cost category

	Breakdown by cost category *(EUR)*						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
Human resources	1 845 213	2 287 444	2 741 031	2 247 932	1 879 287	1 723 048	**12 723 955**
Technical Assistance	117 086	42 182	42 221	28 285	33 149	38 212	**301 134**
Training	471 818	575 294	534 571	470 182	376 532	360 727	**2 789 124**
Health products and health equipment	1 093 796	1 122 988	1 074 995	810 174	696 117	494 500	**5 292 570**
Medicines and pharmaceutical products	180 315	294 285	412 263	400 187	394 381	373 297	**2 054 729**
Procurement and supply management costs	17 363	19 100	20 247	20 861	20 247	21 720	**119 538**
Infrastructure and other equipment	810 915	299 018	215 743	133 432	87 225	4 936	**1 551 269**
Communication materials	318 752	302 439	229 734	148 256	146 576	139 462	**1 285 219**
Monitoring & Evaluation	91 511	124 083	78 782	74 237	115 210	76 858	**560 682**
Living Support to clients/target populations	58 441	60 089	76 467	58 239	74 559	65 280	**393 075**
Planning and administration	430 848	525 699	637 150	536 869	441 162	474 711	**3 046 439**
Overheads	142 037	292 922	431 108	501 205	470 227	466 582	**2 304 081**
Other: *(To be further defined to meet national budget planning categories)*							, 0
Total funds requested from Global Fund	**5 578 095,2**	**5 945 544,1**	**6 494 311,7**	**5 429 859,3**	**4 734 671,3**	**4 239 333,4**	**32 421 815**

5 Proposal Budget

5.4 Key budget assumptions

The Detailed Proposal Budget (section 5.1) should contain all key budget assumptions. Below, Applicants are requested to highlight their budget assumptions for years 1, 2 and 3 in relation to three key areas.

5.4.1 Medicines and other health products and equipment

Applicants must complete Attachment B to this Proposal Form *(Preliminary List of Pharmaceuticals and other Health Products)* ***to provide details of the budget assumptions for years 1, 2 and 3 in respect of health products (including consumables), medicines, health equipment and services directly tied to procurement and supply management of health products.***
Please note that unit costs and volumes must be consistent with the information reflected in the detailed component budget. If prices from sources other than those specified below are used, a rationale must be included.

(a) **Provide a list (by generic product name) of medicines** to be used in years 1, 2 and 3-, and identify which essential medicines list those medicines are included, and whether WHO's standard treatment guidelines are being followed. **See also section 4.10.5 above**.
(Please complete table B.1 in Attachment B to the Proposal Form.)

(b) **Identify the average cost per person per year (or average cost per treatment course) for these medicines**. *If available, provide the cost per patient including all other costs, beyond the cost of medicines.*
(Please complete table B.2 in Attachment B to the Proposal Form.)

(c) Provide **the total cost** of medicines by therapeutic category for all other medicines to be used over years 1, 2 and 3. It is not necessary to itemize each product in the category.
(Please complete table B.2 in Attachment B to the Proposal Form.)

(d) Provide a list of other health products (e.g., condoms, diagnostics, hospital and medical supplies), health and non-health equipment, and services directly tied to procurement and supply management. Unit costs are requested for Health Products (i.e., consumables).
(Please complete tables B.3 and B.4 in Attachment B to the Proposal Form.)

Information on appropriate unit costs is available in the Guidelines for Proposals, section 5.4.1.

Provide any additional information on unit costs below.

Product packages per person per year:

PACKAGE {5A} for treatment of STI	person/year	6.84 €
PACKAGE {12} for treatment of OI	person/year	139.58 €
PACKAGE {1} for safe injecting drug use	person/year	0.28 €
PACKAGE {2} for safe drug use (other than injecting)	person/year	0.20 €
PACKAGE {3} for safe sex	person/year	17.12 €
PACKAGE {4} for blood collection	person/year	0.60 €
PACKAGE {5B} for diagnostic/med.consumables for STI	person/year	7.69 €
PACKAGE {5C} for diagnostic/med.consumables for STI/MSM	person/year	6.96 €

For more information see the attached Procurement Plan & Attachment B.

5.4.2 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first three years, to what extent human resources spending will strengthen health systems' capacity at the client/target population level, and how these salaries will be sustained after the proposal period is over. ***(Maximum of half a page.)***

(Useful information to support the budget includes: a diagram/organigram of the PR; a list of proposed positions showing title, function and planned annual salary; and proportion (in percentage terms) of time that will be allocated to the work under this proposal. Please attach such information as an annex to your proposal and indicate the appropriate annex number.)

In order to achieve program goals and objectives PR appointed high level professionals - programmatic, technical and administrative, dedicated to the accomplishment of all programmatic activities. All human resources

costs have been budgeted taking into consideration the average salaries for each professional level (Annex 24 -)

The human resources costs and capacity development for health and social specialists in existing facilities will strengthen the health system capacity and skills on counseling and client-friendly services for most at risk groups. Another key capacity building area involves municipal staff providing AIDS/TB/STIs-related health and social services tailored to the specific characteristics and needs of IDUs, MSM, Roma, SWs, at-risk youth and PLHIV. Thus the investment in human resources during RCC proposal will contribute to providing high quality client friendly HIV prevention, treatment and support services to people in need and contributing to improved health outcomes, better survival and quality of life for PLHIV, reduced vulnerability of most at risk groups. The PMU key staff will be appointed as a part of the established Directorate Prevention and control of AIDS, TB and STIs within the Ministry of Health starting in year 3 of RCC proposal duration.

The current proposal aims to systematically strengthen the institutional and human resources capacity of NGOs working with IDUs, MSM, Roma, SWs, at-risk youth and PLHIV. This is expected to ensure self-sustainability of NGOs and their ability to attract funding from other donors.

5.4.3 Other key expenditure items

Explain the rationale for how other expenditure categories which form an important share of the budget (e.g., infrastructure and other equipment; communication materials; or planning and administration), have been budgeted for the first three years.
(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)

Quality indicators are projected on the base of the planned number of interventions, the target groups' number, the necessary number of materials and medical consumables, destined to reaching risk groups according to a determined frequency for specific groups and the planned number of examinations of each one of the groups.

According to the standards into force for offering medical consumables to representatives of risk groups product packages for intravenous drug addicts, for safe sex, for blood collection, for STI diagnostics, etc. are standardized, valued and attached to the Procurement Plan.

When forming **value indicators** is considered the following:

- Within the prices per unit of goods and services isn't included the amount to be paid for taxes and duties that is provided to be funded by the State budget;
- An average value of STI and OI treatment course is determined on the bases of the values reported by Health establishments for the previous year;
- In order to keep the requirements of the Public Procurement Law to select goods and service suppliers on the basis of competition it is provided the deliveries to be realized in a centralized way by the Ministry of Health and to be given for the Sub-recipients needs afterwards. This is the reason why the relative share of the expenses allocated in the governmental sector exceeds significantly the funds planned for Health Facilities and for NGOs;
- For the first year current sale prices are set and for the second and the third year an inflation is foreseen respectively of 10% and 8% regarding the previous year, as according the official statistical data of the National Institute of Statistics the inflation in Bulgaria for 2007 has been 12,5%. The value reported for the past year sets a record and is almost twice bigger than the inflation in 2006;
- The activity of the outreach workers under all components is valued on the bases of the number of contacts with vulnerable people. The foreseen scheme of payments represents a premise for stimulating outreach workers to achieve a bigger number of persons;
- The work of doctors doing medical examinations of people in vulnerable situation that do not have as a whole Health insurance is valued on the basis of actual prices, paid by the National Health Insurance Fund for the examinations of people having their insurance. Same refers to the nurses' and laboratory assistants' work for collection and examination of blood samples;

A significant relative part of the common expenses represent the expenses for Human resource and Trainings. Due to insufficient funds for Health issues, at the present moment the State finances only the most urgent and pressing needs, related to treatment and for activities such as creating National System for Control, Monitoring and Assessment, training of medical specialists and outreach workers among risk communities, prevention and information of the society for the HIV/AIDS problem the State budget provides no funds.

5 Proposal Budget

5.4.4 Financial Support for Coordinating Mechanism operations	
Does the applicant intend to apply for funding of CCM, RCM, Sub-CCM operations? *Details on the availability of such funding are provided in section 5.4.4 of the Guidelines for Proposals, and Applicants should refer to these before completing this section.*	☐ Yes *provide details below* ☒ No *Go to the checklist for annexes to your proposal*
If yes, please specify the amount requested and describe how the amount complies with the **time limitation** and **funding categories available**, as explained in section 5.4.4 of the Guidelines for Proposals. **Applicants must ensure that the amount requested is included in the Detailed Proposal Budget** (section 5.1) **in a separate identifiable budget line**.	

CHECKLIST OF ANNEXES TO BE ATTACHED TO YOUR PROPOSAL

The table below provides a list of the various annexes that should be attached to the proposal after completing sections 4 and 5. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Sections 3A and 3B: Applicant eligibility information and proposal endorsement		**Annex Number to your proposal**
3A.3	Conflict of interest policy of the Coordinating Mechanism where the Chair and/or Vice Chair from the same entity as a nominated PR.	Annex 1 - CCM Bulgaria Terms of Reference Annex 2 - Statements on conflict of interest management, signed by CCM members Annex 3 – Minutes from CCM meeting on 01.08.2006
3A.4.1 and 3A.4.2	Documentation relevant to the minimum requirements for eligibility and changes in the Coordinating Mechanism and the proposal's scale and/or scope from the expiring grant.	Annex 4 - Order of the CCM Bulgaria Vice-Chair for election of new members Annex 5 - Procedure for election of new CCM members from the constituency of the non-governmental organizations Annex 6 – Minutes from the working group reviewing of nomination made by non-governmental organizations in 2006 Annex 7 – Invitation letters to the NGOs to nominate new representatives for CCM members Annex 8 – Email Messages from the NGOs, participated in the nomination process in July 2006 Annex 9 – Notification letters to the NGOs for the results after the nomination process for new CCM members Annex 10 – Invitation for proposal development Annex 11 – Minutes from CCM meeting on 30.01.2008

CHECKLIST OF ANNEXES TO BE ATTACHED TO YOUR PROPOSAL

		Annex 12 – Order for working group Annex 13 – Procedure and criteria for small proposals Annex 14 – Emails to stakeholders sent by CCM members Annex 15 – Cover letters from the stakeholders sent small proposals Annex 16 – Web-site announcements for strategic planning in HIV/AIDS Annex 17 – Minutes from the working group evaluation of small proposals Annex 18 – Minutes from the work meeting with stakeholder for discussing the small proposals Annex 19 – CCM invitation for nominationof alternative PR Annex 20 – Minutes from CCM meeting on 26.03.2008
3B.1.3	List of members of the Coordinating Mechanism as signed by those members to confirm endorsement of the proposal.	**Attachment C**
Section 4: Proposal Strategy		**Annex Number to your proposal**
4.	National disease specific prevention and control plan (or equivalent), if one exists.	Annex 26 – Bulgaria National HIV/AIDS Response 2001-2007 Annex 29 – Bulgaria National HIV/AIDS Strategy 2008-2015 Draft
4.3.2	Documentation relevant to the national disease program context.	Annex 21 – Bulgaria UNGASS Report 2008 Annex 22 – Institutional Framework for AIDS/TB/STIs Prevention and control in Bulgaria Annex 23 Bulgaria Country Report for Scaling Up the National HIV/AIDS response towards Universal Access Annex 27 – National System for Surveillance, Monitoring and Evaluation Annex 28 – Mapping HIV incidence and population size estimates, Bulgaria 2007
4.3.3(c) *(**only** if common funding*	Documentation describing the functioning of the common funding mechanism.	

CHECKLIST OF ANNEXES TO BE ATTACHED TO YOUR PROPOSAL

mechanism)		
4.3.3(d) *(**only** if common funding mechanism)*	Most recent audit report or assessment of the performance of the common funding mechanism.	
4.6	**A completed 'Targets and Indicators Table' Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
4.6	**A detailed Work Plan** (quarterly information for the first year, and indicative information for the second and third years).	Annex 30 – Detailed Work Plan for Year 1, Year 2 and Year 3
Section 5: Component Budget		**Annex Number to your proposal**
5.1	**Detailed Proposal Budget**	Annex 31 - Detailed Proposal Budget
5.1 *(if HSS strategic actions are included – see section 4.4.2)*	Details and costs for cross-cutting HSS amounts (if not clearly identifiable from the detailed component budget).	
5.1 - 5.3 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	
5.4.1 *(and section 4.10.5)*	Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3).	**Attachment B** and Procurement Plan
5.4.2	Human resources costs.	Annex 24 – PMU Bulgaria Organizational Structure Annex 25 – PMU Roles and Responsibilities
5.4.3	Other key expenditure items.	
Other relevant documents attached by Applicant (including for Annex A if applicable to the Applicant's CCM eligibility status/application history, s.3A.1)**:**		**Annex Number to your proposal**

ANNEX 1 – Coordinating Mechanism MINIMUM ELIGIBILITY REQUIREMENTS

***Please note that the following sections follow the order set out in the document entitled 'Clarifications on CCM Minimum Requirements' at**: http://www.theglobalfund.org/en/apply/rcc*

Principle of broad and inclusive membership	
Requirement 1 ➔ Selection of non-governmental sector representatives (a) Provide evidence of how the Coordinating Mechanism members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, or religious and faith-based organizations),* have been selected by their own sector(s) based on a **documented**, **transparent** process **developed within their own sector**. *Please indicate below (via the check-box below) which documents are relied on to support the Applicant's statement of compliance with this requirement **AND** attach as an annex the documents showing **each sector's transparent process** for Coordinating Mechanism representative selection, and **each sector's** meeting minutes or other documentation recording the selection of their current representative.*	
Documentation relied on to support compliance with Requirement 1	**Identify which annex to this proposal contains these documents**
☒ Selection criteria for each sector developed by each respective sector	Annex 1 - CCM Bulgaria Terms of Reference Annex 4 - Order of the CCM Bulgaria Vice-Chair for election of new members Annex 5 Procedure for election of new CCM members from the constituency of the non-governmental organizations Annex 6 – Minutes from the working group reviewing of nomination made by non-governmental organizations in 2006 Annex 7 – Invitation letters to the NGOs to nominate new representatives for CCM members
☐ Minutes of meeting(s) at which the sector transparently determined its representative	
☐ Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	
☒ Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	Annex 8 – Email Messages from the NGOs, participated in the nomination process in July 2006
☐ Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the Coordinating Mechanism	
☒ Other: *(please specify):*	Annex 9 – Notification letters to the NGOs for the results after the nomination process for new CCM members Annex 3 – Minutes from the CCM meeting on 01.08.2006

(b) Please briefly summarize how the information provided within the annexes listed above satisfies Requirement 1.

In July 2006 the Secretariat of CCM initiated a transparent and documented process for election of new CCM members from the non-governmental organizations. According to the procedure 28 NGOs working with vulnerable groups, 3 NGOs working with PLHIV and 5 NGOs working with young people were invited and took part in the nomination process. All organizations and groups responded to the invitation and each ranked three representatives as 1st, 2nd and 3rd place and were elected 5 new members of CCM, who was approved as full members of CCM on the CCM work meeting dated 01 August 2006 (Annex 3 – Minutes from CCM meeting on 01.08.2006). The elected members are appointed for 3 yearly period and are as follows: a representative of the organizations, working with IDUs; representative of the organizations, working with Roma community; a representative of the organizations, working with sex workers; a representative of the organizations, working with young people; a representative of the people living with HIV/AIDS. (Annex 1 – CCM Bulgaria Terms of Reference). The election process was also applied within the TB patients and one representative was approved as a member also during the CCM Meeting on 01.08.2006, but he resigned by his own will in 2007. CCM Bulgaria decided to start procedure for election of people affected by TB again.

All of the abovementioned organizations were informed about the results from the procedures and for the organizations ranked at first place (Annex 9 - Notification letters to the NGOs for the results after the nomination process for new CCM members).

Principle of involvement of persons living with and/or affected by the disease(s)

Requirement 2 ➔ People living with and/or affected by the disease(s).

Describe the involvement of people living with and/or affected by the disease(s) in the Coordinating Mechanism. *(Importantly, Applicants submitting HIV/AIDS and/or tuberculosis components must clearly demonstrate representation of this important group. Please carefully review the Global Fund's 'Clarifications on CCM Minimum Requirements – Round 7' document before you complete this section.)*

Two of the members of CCM Bulgaria are people living with HIV/AIDS - one of them was nominated in 2002 when CCM was constituted according to the requirements of GFATM and represents NGOs working with people affected by the disease. The other represents people living with HIV/AIDS and in July 2006 was elected within the constituency of the non-governmental organizations, working with people affected by the HIV/AIDS (Annex 6 – Minutes from the working group reviewing of nomination made by non-governmental organizations in 2006).

The representative of the people living with tuberculosis, nominated by the constituency of TB patients in 2006 was resigned by own request.

Principle of transparent and documented proposal development processes (Requirements 3, 4 and 5).

As part of the eligibility screening process for proposals, the Global Fund will review supporting documentation setting out the Coordinating Mechanism's proposal development process, the submission and review process, the nomination process for Principal Recipient(s), as well as the minutes of the meeting(s) where the Coordinating Mechanism decided on the elements to be included in the proposal and made the decision about the Principal Recipient(s) for this proposal. We will also review how, during the program term, the Coordinating Mechanism will oversee implementation.

Please describe and provide evidence of the applicant's documented, transparent and established processes to respond to each of the 'Requirements' set out below:

Requirement 3(a) ➔ Process to solicit submissions for possible integration into this proposal.

ANNEX 1 – Coordinating Mechanism MINIMUM ELIGIBILITY REQUIREMENTS

CCM Bulgaria is responsible for ensuring a broad stakeholder input in the development of the proposal according to Art. 10.3 of the CCM Terms of Reference (Annex 1 - CCM Bulgaria Terms of Reference).

The proposal development and submission procedures are laid out in Art. 10.3.1; 10.3.2., and 10.3.3. Keeping to these procedures, on the meeting held on 30 January 2008 (Annex 11 - Minutes from CCM meeting on 30.01.2008), CCM approved all procedures related to the proposal development process for RCC.

All stakeholders were publicly invited to take part in the proposal development process for RCC applying. The invitation was announced on the website of the National Committee for Prevention of AIDS and STIs at the Council of Ministers (www.ncaids.government.bg), on the website of Program "Prevention and Control of HIV/AIDS", website of the Ministry of Health (www.mh.government.bg) and on the electronic bulletin of UNAIDS Bulgaria (http://www.unaids-bulgaria.org). (Annex 10 – Invitation for small proposals development). All of the application documents received by the CCM Bulgaria were translated into Bulgarian and uploaded on the abovementioned web-sites in both languages (Bulgarian and English). The CCM Members took decision to designated to the expert working group established to prepare the documents (annex 12 –Order for RCC working group) to develop transparent criteria and procedure for the small proposals to be included into the country's proposal (Annex 13 – Procedure and criteria for small proposals). The announced deadline for proposal was 01 March 2008.

Also the elected members of CCM informed by email the organizations, that they represent in the CCM about the process to solicit submissions of small proposals. After that the email messages were forwarded to the CCM Secretary (Annex 14 – Emails to stakeholders sent by CCM members)

Requirement 3(b) ➔ Process to review submissions received by the Coordinating Mechanism for possible integration into this proposal.

As a result from the open and clear procedure for possible integration into the Bulgarian Country Proposal for RCC, twenty-five small proposals were received. They were sent by 1 governmental, 2 academic and 17 non-governmental organizations (Annex 15 – Cover letters from the stakeholders sent small proposals). Some of the organizations presented more than one small proposal, that is why the number of proposals is 25, but the number of senders is 20. 14 of the organizations are not members of CCM Bulgaria (73 % of the proposals submitted).

The working group designated by CCM Bulgaria to prepare the criteria and procedure for the reviewing and evaluating the proposals, conducted a meeting on 10.03.2008 for evaluating the all received proposals (Annex 17 – Minutes from the working group evaluation of small proposals). A broad discussion meeting with all stakeholders and experts from the working groups and the small proposals was conducted on 22.03.2008 in order to present and discuss the small proposals. (Annex 18 – Minutes from the work meeting with stakeholder for discussing the small proposals). All CCM Members were informed about the reviewing process of the small proposals received and evaluated through sending of the minutes from the discussion via email.

Requirement 4(a) ➔ Process to nominate the Principal Recipient(s) for proposals.

According to the CCM Bulgaria Terms of Reference there is in place a clear procedure for nominating of Principal Recipient (art. 10.6). The procedure was fully kept. In the case of requesting continued funding, the existing PR was automatically re-nominated as PR, but CCM Bulgaria also gave opportunity if there are alternative suggestions for Principal Recipient to give them in written form before the CCM meeting when proposal was reviewed and endorsed (Annex 19 – CCM invitation for nomination of alternative PR). These rules are described in the article 10.6.3 and 10.6.4 of the Terms of Reference. An invitation was uploaded on the official web-site of the

National AIDS Committee to invite the stakeholders to give written suggestions for alternative Principal Recipient until 26.03.2008 (Annex 19 - CCM invitation for nomination of alternative PR).

There were no alternative suggestions for PR and the existing PR was approved from all of the CCM members by simple majority voting during the last CCM meeting (Annex 20 - Minutes from CCM meeting on 26.03.2008).

Requirement 4(b) ➔ **Process to oversee/review** program implementation by the Principal Recipient(s) during the proposal term.

CCM has firm regulations regarding the overseeing the implementation of programs funded by the Global Fund. They are laid out in Art. 10.9 of the CCM Terms of Reference and precisely in Art. 10.9.2. (Annex 1 – CCM Bulgaria ToR)

Since the CCM establishment (2002), the reports on program and financial implementation of Program "Prevention and Control of HIV/AIDS", the reports on the procurement plan implementation, the reports on the selection of sub-recipients, as well as all other documents relevant to the implementation are presented and approved during the CCM meetings. The Principle Recipient submits a copy of Disbursement Requests and Quarterly Progress Updates and Annual Performance Reports of the Program.

Requirement 5(a) ➔ **Process to ensure the input** of a broad range of stakeholders, including Coordinating Mechanism members **and non-CCM members**, in the proposal development process.

The coordination of the proposal development process was assigned by the CCM Bulgaria to the expert working group (Annex – Order for RCC working group) established at the Ministry of Health. The technical development was assigned to experts in the field of prevention and control of HIV/AIDS, program management, and working with vulnerable groups. Out of them 5 are CCM members. All of the procedure for invitation to solicit small proposals, evaluation, broad discussion and inclusion were performed in accordance with the GF requirements. Only 3 of the received small proposals were evaluated as unacceptable according to the procedure and evaluation criteria (Annex 17 – Minutes from the working group - evaluation of small proposals).

The other proposals were presented in details and discussed with the stakeholders on 22.03.2008 (Annex 18 – Minutes from the work meeting with stakeholder for discussing the small proposals) and the proposals were included into the country's proposal. The minutes and evaluation scores were presented to the CCM members before the work meeting on 26.03.2008 via email. (Minutes from CCM meeting on 26.03.2008)

Requirement 5(b) ➔ **Process to ensure the input** of a broad range of stakeholders, including Coordinating Mechanism members **and non-CCM members**, in grant oversight processes.

All of decisions related to oversight the implementation of the GF Grant, taken during the CCM meetings are published on the web-site of the Ministry of Health. Principle Recipient published the Annual reports on the web-site of the Program Prevention and Control of HIV/AIDS. Except this, all copies of the annual Audit Reports are available for each Member of CCM Bulgaria for receiving upon request from the Program Management Unit Staff.

ANNEX 1 – Coordinating Mechanism MINIMUM ELIGIBILITY REQUIREMENTS

3A.4.6 Principle of effective management of actual and potential conflicts of interest	
Requirement 6 ➔ Are the Chair **and/or** Vice Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal?	☒ Yes ☐ No

If yes, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex**.

CCM has a procedure for management of potential conflict of interest, approved in its Terms of Reference, as well as regulations for ethical behaviour, laid out in Article 9 of the CCM Terms of Reference (Annex 01 CCM Bulgaria ToR). Various possible situations are described, in which each CCM members could have potential conflict of interest (Art. 9.4). In case of potential conflict of interest a written notification is submitted to the Chair or to the Secretary, who examines the potential conflict of interest and determines the actions required to avoid the conflict (Art.9.5 and Art.9.6). In the situation where the Chair and/or Secretary have a conflict of interest, the situation will be examined by two CCM officers who do not have a conflict of interest.

If any CCM member fails to notify the Committee of an existing or a potential conflict of interest, there are procedures which are described in Article 9.9. All CCM members approve the rules of ethical behaviour and the procedures on conflict of interest management, signing a Statement of conflict of interest, attached as part of the CCM Terms of Reference (Annex 2 – Statements on conflict of interest management, signed by CCM members).

To avoid a conflict of interest between the Principle Recipient and the CCM Chair and/ or Vice-chair a second Vice-Chair is elected from the non-governmental sector (Art. 6.4 from the CCM Terms of Reference). The second Vice-Chair chairs the CCM meetings in situations where there is a potential conflict of interest. He is a representative of the academic sector nominated by the representatives from the nongovernmental organizations and has up to 3-year mandate after election (Annex 3 – Minutes from CCM meeting on 01 August 2006).

HIV/AIDS Attachment A to the Proposal Form

Program Details

Country:	
Disease:	
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
	To contribute to the decrease of HIV incidence rate
	To improve the quality of life of people living with HIV

Impact and outcome Indicators	Indicator formulation	initial Baseline (baseline as in expiring grant)			new Baseline for this RCC proposal (i.e. latest available information)			Targets						Comments*
impact	% of injecting drug users who are HIV infected													
impact	% of MSM who are HIV infected													
impact	% of young Roma men who are HIV infected													
impact	% of adults aged 15-49 who are HIV infected													
impact	% of young women and men aged 15-24 who are HIV infected													
impact	% of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy													
outcome	% of injecting drug users reporting the use of sterile injecting equipment the last time they injected													
outcome	% of injecting drug users reporting the use of a condom the last time they had sex with non-regular partner													
outcome	% of men reporting the use of condom the last time they had anal sex with a male partner in the last 6 months													
outcome	% of female sex workers reporting the use of a condom with the last client													

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

	Objective description	Comments
1	OBJECTIVE 1: To create a supportive environment for a sustainable national response to HIV/AIDS in Bulgaria	
2	OBJECTIVE 2: To strengthen the evidence base for a targeted and	
3	OBJECTIVE 3: To scale up coverage of testing and counselling services provided through the low-threshold VCT network with a focus on most-at-risk groups	
4	OBJECTIVE 4: To reduce HIV vulnerabilities of IDUs by scaling up population coverage of a comprehensive package of prevention interventions	
5	OBJECTIVE 5: To reduce HIV vulnerabilities of most-at-risk Roma people	
6	OBJECTIVE 6: To reduce HIV vulnerabilities of female and male sex workers by scaling up population coverage of comprehensive package of prevention interventions	
7	OBJECTIVE 7: To reduce HIV vulnerabilities of at-risk youth and adolescents (aged 10-19) by scaling up coverage of comprehensive youth-friendly programmes and services	
8	OBJECTIVE 8: To improve the quality of life of people living with HIV/AIDS (PLHIV) by guaranteeing universal access to treatment, care and support	
9	OBJECTIVE 9: To reduce HIV vulnerabilities of MSM by scaling up population coverage of a comprehensive package of prevention interventions	
10		
11		
12		
13		
14		
15		

Impact and outcome Indicators		Indicator formulation				initial Baseline (baseline as in expiring grant)			new Baseline for this RCC proposal (i.e. latest available information)			Targets						Comments*
						Value	Year	Source	Value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	
Objective / Indicator Number	Service Delivery Area	Indicator formulation	Baseline (if applicable)			Targets for year 1 and year 2					Annual targets for years 3, 4, 5 and 6				Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5	Year 6					
1.1; 2.1	HSS: Human resources	Number of people trained in management, M&E, surveillance and strategic planing	239	2007	please select…	156	224	163	275	245	247	192	100		Y	N	Y - cumulative annually	
3.1; 4.1; 5.1; 6.1; 7.1; 9.1	Prevention: Testing and Counseling	Number of people from the most-at-risk groups receiving voluntary testing and counselling services	44,030	2007	Programmatic progress reports	33,962	84,905	38,789	96,973	110,083	116,574	121,251	124,079		N	N	Y - cumulative annually	
3.2	Prevention: BCC - community outreach	Number of prisoners reached through outreach work and peer-driven activities to educate and motivate for a positive change of behaviour	1,186	2007	Programmatic progress reports	1,626	4,066	1,883	4,706	5,363	4,224	3,056	1,857		Y	N	Y - cumulative annually	
4.2	Prevention: BCC - community outreach	Number of contacts with IDUs for basic HIV/AIDS counselling motivation and referral to use services	16,556	2007	Programmatic progress reports	25,386	63,466	24,422	61,056	60,588	46,560	30,912	17,568		Y	N	Y - cumulative annually	
4.3	Prevention: BCC - community outreach	Number of IDUs reached with comprehensive outreach HIV prevention services	4,960	2007	Programmatic progress reports	2,116	5,289	2,035	5,088	5,049	3,880	2,576	1,464		Y	N	Y - cumulative annually	
4.4	Prevention: BCC - community outreach	Number of IDU peer educators trained to provide basic HIV/AIDS counselling , motivation and referral to use services	10	2007	Programmatic progress reports	15	40	45	50	55	60	65	70		Y	N	Y - over program term	
4.5	Prevention: Opioid Substitution Treatment	Number of people enrolled in OST	1,650	2007	Patient records	2,560	2,970	3,240	3,960	4,950	5,940	6,930	7,920		Y	N	Y - over program term	
5.2	Prevention: BCC - community outreach	Number of young Roma people reached with comprehensive HIV prevention services	9,717	2007	Programmatic progress reports	5,427	13,568	5,618	14,044	14,555	10,069	7,846	5,443		Y	N	Y - cumulative annually	
5.3	Prevention: BCC - community outreach	Number of contacts with young Roma people for basic HIV/AIDS counselling motivation and referral to use services	19,434	2007	Programmatic progress reports	43,418	108,544	44,942	112,355	116,438	80,549	62,772	43,545		Y	N	Y - cumulative annually	
5.4	Prevention: BCC - community outreach	Number of Roma peer educators trained to provide basic HIV/AIDS counsello\ing , motivation and referral to use services	138	2007	Programmatic progress reports	50	200	100	200	205	210	210	210		Y	N	Y - cumulative annually	
6.2	Prevention: BCC - community outreach	No of SW peer educators trained to provide basic HIV/AIDS counseling, motivation and referral to use services	34	2007	Programmatic progress reports	20	40	20	40	40	40	40	40		Y	N	Y - cumulative annually	
6.3	Prevention: BCC - community outreach	Number of sex workers reached with comprehensive HIV prevention services	3,694	2007	Programmatic progress reports	1,819	4,547	1,902	4,754	4,961	3,445	2,756	2,067		Y	N	Y - cumulative annually	
6.4	Prevention: BCC - community outreach	Number of contacts with sex workers for basic HIV/AIDS counselling motivation and referral to use services	25,861	2007	Programmatic progress reports	47,293	118,232	49,443	123,607	128,981	89,570	71,656	53,742		Y	N	Y - cumulative annually	
7.2	Prevention: BCC - community outreach	Number of youth peer educators trained to provide services, motivation and referral for HIV prevention services	170	2007	Programmatic progress reports		98		108	112	112	112	112		Y	N	Y - cumulative annually	
7.3	Prevention: BCC - community outreach	Number of staff from institutions for orphans and vulnerable children, trained to provide life skills based sexual and HIV education	0	2007	Programmatic progress reports		60		60	50	50	40	35		Y	N	Y - cumulative annually	
8.1	HSS: Human resources	Number of medical specialists and profesionals trained to diagnose, provide ARV treatment, care and support to PLHIV	3	2007	Programmatic progress reports	16	39	16	39	40	40	28	28		Y	N	Y - cumulative annually	
8.2	Treatment: Antiretroviral treatment (ARV) and monitoring	Number of people recieving ARV treatment	221	2007	Patient records	203	405	282	565	876	1,287	1,818	2,362		Y	N	Y - cumulative annually	
9.2	Prevention: BCC - community outreach	Number of MSM reached with comprehensive HIV prevention services	No data available		please select…	610	2,440	1,268	3,622	4,775	5,896	4,367	1,725		Y	N	Y - cumulative annually	
3.3; 4.6; 5.5; 6.5; 7.4; 9.3	Prevention: BCC - community outreach	Number of free condoms distributed to most-at-risk groups	887,046	2,007	Programmatic progress reports	1,693,900	3,387,800	1,529,552	3,059,104	2,957,432	2,318,312	2,057,108	1,237,604		Y	N	Y - cumulative annually	
4.7; 5.6; 6.6; 8.3; 9.4	Care and support: Case management of most-at-risk and HIV-infected people	Number of people receiving case management	0	2007	please select…	434	1,445	822	2,056	2,725	2,506	2,137	1,813		Y	N	Y - cumulative annually	
	Please Select…				please select…										Y	N	Y - over program term	
	Please Select…				please select…										Y	N	Y - over program term	
	Please Select…				please select…										Y	N	Y - over program term	