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The Global Fund
To Fight AIDS, Tuberculosis and Malaria



BRIDGING THE GAP:

WHY THE EUROPEAN UNION MUST ADDRESS
THE GLOBAL FUND'S FUNDING CRISIS TO TACKLE
THE ESCALATING HIV AND TB EPIDEMICS
IN EASTERN EUROPE AND CENTRAL ASIA





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EXECUTIVE SUMMARY

Despite its tremendous success, the Global Fund to Fight AIDS, Tuberculosis and Malaria is currently facing serious funding gaps. As a result, in December 2011 the Global Fund was forced to cancel its next funding round, leaving recipient countries without the financial support needed to combat their disease epidemics. Furthermore, the funding crisis will leave civil society organisations without the resources needed to hold national governments to account and to create national buy-in to fund disease responses with domestic resources.

Middle-income countries, especially those in Eastern Europe and Central Asia (EECA) with a high burden of TB and HIV, will be particularly vulnerable to this reduction in funding. Countries such as Moldova or the Ukraine have concentrated HIV epidemics, and their Governments are either unable or unwilling to fund their disease response in specific populations. There are even countries within the European Union, such as Romania, that have very high rates of tuberculosis (TB) and are seeing an increase in number of cases. Failing to adequately fund HIV and TB programmes will inevitably contribute to increasing rates of disease and drug-resistance. This will cost lives and cause an enormous drain on the economy due to increased treatment costs and lost productivity.

The world's failure to adequately address the impact of TB and HIV is largely due to a lack of political will and financial commitment. There is an urgent need for greater leadership and accountability on these issues at a regional level. The EU has an unprecedented opportunity to take on this leadership role by stepping in to fill these funding gaps and ultimately saving people's lives.

KEY RECOMMENDATIONS FOR THE EU:

HONOUR existing pledges and scale up support for the Global Fund in the context of the on-going negotiations on the new EU multi-annual financial framework (MFF) 2014-2020 and the 11th European Development Fund (EDF).

ENSURE that one of the three priorities for bilateral and regional cooperation in future Country Strategy Papers tackles societal challenges in EECA.

ENSURE that European Social Fund (ESF) social inclusion activities reaching out to vulnerable groups most at risk (including the Roma community, the homeless, migrants, sex workers, men who have sex with men and injecting drug-users) integrate and mainstream TB and HIV components, from prevention to psycho-social support.

EMBRACE harm reduction as a drug policy principle at the highest political level and actively promote harm reduction through political dialogue with partner countries in EECA and with Russia in particular. The European External Action Service should make full use of its potential to become a progressive force for advancing human rights within the EU's HIV response at global and country levels.

As a board member of the Global Fund:

- **SUPPORT** the revision of the eligibility criteria to ease restrictions on middle-income countries with epidemics concentrated among key populations, particularly where alternative sources of funding are unavailable, and eliminate the rule that 55 percent of funding per year must go to low-income countries.
- Broadly **CONSULT** European citizens and partners on the new funding model and protect the Global Fund's core principles, including country ownership; multi-sectoral partnerships; balance between the regions, diseases and interventions; and transparency and accountability.



BACKGROUND

In January 2012, the world marked the 10-year anniversary of the launch of the most successful global health effort in history — the Global Fund to Fight AIDS, Tuberculosis and Malaria. Since its creation in 2002, Global Fund financed projects have saved 8.7 million lives.¹ In Eastern Europe and Central Asia (EECA), Global Fund supported programmes have diagnosed and treated 340,000 new cases of TB, distributed 590,000 bed nets to protect families from transmission of malaria and currently provide lifesaving antiretroviral treatment (ART) to 24,000 people living with HIV.² However, despite its tremendous success, the Global Fund is currently facing serious funding gaps.

The Global Fund's funding crisis is occurring at a time when there is no viable substitute for the Global Fund in the EECA region. Other donors in the region operate on a far smaller scale than the Global Fund and are often much more restricted in their scope of work. The Global Fund is indeed a unique country driven model where all stakeholders are invited to take part in its national governance body: the country coordinating mechanism (CCM). The Global Fund not only finances programmes to prevent, detect and treat diseases, it also funds civil society organisation (CSO) capacity building, including advocacy work critical for creating an environment in which national governments will transition to funding these live-saving programmes themselves. Indeed, many national governments in the region are still reluctant to support targeted prevention and treatment services for key underserved populations that are most vulnerable to TB and HIV epidemics and are unlikely to fill in the gap left by the Global Fund's changes.³

CANCELLATION OF ROUND 11 FUNDING

In November 2011, due to a variety of reasons that included unfulfilled donor country pledges and a number of key donors failing to make new funding pledges, the Global Fund announced that it was forced to cancel its next funding round (Round 11) and suspend new grants. This was the first time a grant round had been cancelled in the history of the Global Fund. The cancellation of Round 11 funding means no new grants will be disbursed until at least April 2013, essentially leaving countries without the resources needed to aggressively tackle their disease epidemics. **This decision will seriously undermine the inroads we have made against the world's top infectious disease killers.**

TRANSITIONAL FUNDING MECHANISM

In order to address the impact the cancellation of Round 11 would have on existing programmes, the Global Fund created a Transitional Funding Mechanism (TFM) at the end of 2011.⁴ The TFM is solely intended to prevent the disruption of "essential services". It does not allow for scale-up of treatment or for reaching more people, nor does it provide funding for community systems strengthening or advocacy work – two key elements that are essential for building political will nationally to sustain funding for TB and HIV programmes. Furthermore, very few EECA countries⁵ were eligible to apply for the TFM due to changes in eligibility requirements.

1. Global Fund to Fight AIDS, Tuberculosis and Malaria (2012) *Press Release: Global Fund results show broad gains against HIV*, [Online], Available: http://www.theglobalfund.org/en/mediacenter/newsreleases/2012-23-07_Global_Fund_Results_show_broad_Gains_against_HIV/.

2. Global Fund to Fight AIDS, Tuberculosis and Malaria (2012) *Eastern Europe and Central Asia – Grant Portfolio*, [Online], Available: <http://portfolio.theglobalfund.org/en/Region/Index/EECA>.

3. Stuijkyte, R. et al. (2012) *Quitting while not ahead: the Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe and Central Asia*, European Harm Reduction Network.

4. Global Fund to Fight AIDS, Tuberculosis and Malaria (2011) *Press Release: Global Fund board establishes a Transitional Funding Mechanism to replace Round 11 and revises the application and approval process for renewals*, [Online], Available: http://www.theglobalfund.org/en/mediacenter/announcements/2011-12-01_Global_Fund_Board_establishes_a_Transitional_Funding_Mechanism/.

5. In this report, we focus on the following EECA countries due to their high burden of TB and/or HIV: Bulgaria, Estonia, Latvia, Lithuania, Romania (EU member states); Armenia, Azerbaijan, Belarus, Georgia, Moldova, Ukraine (Eastern Partnership Countries); Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan (Central Asian Countries); and Russia.



NEW ELIGIBILITY CRITERIA

New Global Fund eligibility criteria severely restricted middle-income countries from submitting applications to the TFM. In addition to disease burden, the Global Fund used country income categories as a key guidance for deciding where to allocate resources. **Country income, however, does not determine a country's ability to pay for the cost of its disease response and is not an indicator of the number of people who have access to health services.** Moreover, the majority of the world's poor live in middle-income countries. A report by the Center for Global Development has found that the global disease burden has shifted to middle income countries.⁶ In the EECA region more than 95 percent of people living with HIV (PLWH) live in middle-income countries.⁷ The new eligibility policy has meant that many EECA countries are now unable to access resources needed to fight TB and HIV epidemics in their countries, particularly within vulnerable and marginalised populations that have not been prioritized by their own national governments.

In addition to its new eligibility criteria, the Global Fund Board decided that 55 percent of its funding commitments in any given year should be allocated to low-income countries, thus further limiting funding opportunities for middle-income countries. According to the World Bank classification of country income, only two countries in EECA, Kyrgyzstan and Tajikistan, fall into the low-income category, demonstrating the significant effect this criteria will have on the region. Although the 55 percent rule was temporarily suspended at the Global Fund Board meeting in May 2012, if reinstated it would force middle-income countries to cut a quarter of their activities during grant renewals, thereby compromising the quality and scope of activities.

NEW FUNDING MODEL AND FINANCIAL FORECASTS

In November 2011, the Global Fund Board approved a new strategic plan "to become more flexible, iterative and better-informed" in order to increase the impact of its programmes. As part of that process, the Board decided to develop and introduce a "new funding model" to distribute the funds it receives to implementing countries. This new model would replace the existing rounds-based system and would represent an enormous change in the way the Global Fund works. More flexible and predictable funding opportunities are welcomed, however, uncertainties remain as to how any new funding model will protect the Global Fund's core principles of demand-driven and country-owned responses to the diseases.

The new funding model has the potential to radically change the Global Fund. Due to the importance of getting these changes right, discussions must allow enough time to carry out a broad consultation and an effective analysis of the impact of the proposed changes. **Nevertheless, this discussion should not delay the disbursement of available funds to countries facing current funding gaps.**

6. Glassman, A. (2011) 'Global Health and the New Bottom Billion: What Do Shifts in Global Poverty and the Global Disease Burden Mean for GAVI and the Global Fund?', *Center for Global Development*.

7. World Health Organisation: Europe (2012) *Tuberculosis in the European Region*, [Online], Available: <http://www.euro.who.int/en/what-we-do/health-topics/communicable-diseases/tuberculosis>.



THE BURDEN OF TB AND HIV IN EECA COUNTRIES

TUBERCULOSIS:

TB in the European region kills seven people every hour and continues to pose a significant public health threat.⁸ Even more worryingly, failure to adequately fund TB control programmes has led to rising rates of drug-resistant TB. Drug resistance occurs when TB cases are inappropriately managed and treatment is erratic or interrupted, enabling the TB bacteria to resurge. Multidrug-resistant TB (MDR-TB) is a form of TB that does not respond to the standard treatment using first-line drugs and is extremely difficult and up to 100 times more expensive to treat.⁹ **The European region is home to the highest rates of MDR-TB in the world and, with 81,000 MDR-TB cases in 2010 alone, accounts for nearly 20 percent of the global burden.**¹⁰ Preventing the spread of MDR-TB requires a significant scale-up in TB control programmes.

In September 2011, WHO Europe launched its 'Consolidated Action Plan to Prevent and Combat M/XDR-TB' to tackle multidrug and extensively drug-resistant TB in the WHO European Region'. Political commitment to the Plan was demonstrated when all 53 member states fully endorsed it at the WHO Europe Regional Committee meeting in Baku, Azerbaijan; what is lacking is the financial commitment to implement the Plan, estimated to cost US\$ 5.2 billion. Most of the resources needed are expected to be provided by Member States, but WHO Europe identified the Global Fund and the European Commission as key players in filling the funding gap.¹¹

Within EECA countries, the Global Fund has already provided vital resources for MDR-TB drugs, and Global Fund supported programmes treated 16,000 people with MDR-TB in 2010. Global Fund financed projects have also supported laboratory upgrades, improved drug supplies, enhanced disease monitoring, trained service providers and strengthened health systems.¹²

HIV:

Although the global rate of new HIV cases has stabilised and is beginning to decline in many countries, EECA is the only region where the number of new HIV cases continues to rise. In 2011, an estimated 160,000 adults were newly infected with HIV, a rate that is 22 percent higher than in 2005. The number of people dying from AIDS-related causes also continues to rise in EECA. AIDS-related deaths in EECA have increased six fold from 15,000 in 2001 to 90,000 in 2010.¹³

The main route of transmission in EECA is the use of contaminated injecting equipment among people who inject drugs, but sexual transmission is on the rise. Antiretroviral therapy (ART) coverage is low as less than a quarter (23 percent) of those in need have access to treatment. People who inject drugs (PWID) are less than half as likely to have access to ART and face high levels of stigma, criminalisation and harassment, which in turn decrease their ability to seek out health services.¹⁴ Further complicating matters, TB has become the number one killer in the region for people living with HIV, and in turn the escalating HIV epidemic has also increased rates of TB and MDR-TB.

There is strong evidence demonstrating the effectiveness of harm reduction programmes that reduce HIV transmission through interventions such as syringe exchange programmes and provision of substitution treatment and link HIV-positive drug users with health services. However, many governments in EECA countries with the highest burden of drug injecting-led HIV rates have laws in place that directly or indirectly criminalise people who inject drugs and remain unsupportive towards funding harm reduction programmes. There is an urgent need to provide support for community strengthening, advocacy capacity building and work toward the human rights of people who use drugs.

The Global Fund currently provides ART to 24,000 people in the region, offers HIV testing and counselling and is the largest and most important donor for harm reduction services. Between 2002 and 2009, the Global Fund approved an estimated US\$ 430 million for activities targeting people who inject drugs, of which 61 percent went to 22 countries from EECA.¹⁵ That amount is much greater than all other international sources combined.¹⁶ Global Fund supported programmes reached more than half of the estimated PWID population in Armenia, Belarus, Estonia, Ukraine and Uzbekistan in 2010.¹⁷

8. World Health Organisation: Europe (2012) *Tuberculosis in the European Region*, [Online], Available: <http://www.euro.who.int/en/what-we-do/health-topics/communicable-diseases/tuberculosis>.

9. World Health Organisation: Stop TB Department (2008) *Factsheet: Tuberculosis MDR-TB & XDR-TB*, [Online], Available: http://www.who.int/tb/features_archive/drs_factsheet.pdf.

10. World Health Organisation: Europe (2011) *Roadmap to prevent and combat drug-resistant tuberculosis: The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011-2015*, Copenhagen.

11. Ibid.

12. The Global Fund to Fight AIDS, Tuberculosis and Malaria (2011) *Making a Difference: Eastern Europe and Central Asia regional results report 2011*, Geneva.

13. UNAIDS (2012) *Together we will end AIDS*, Geneva.

14. Ibid.

15. Bridge, J, et al, (2012) 'Global Fund investments in harm reduction from 2002 to 2009', *International Journal of Drug Policy*, 4:279-85.

16. Other notable sources since 2002 include bilateral aid from the U.S., British and Dutch governments ranging from \$13 million to \$32 million in total, as well as smaller amounts from sources including the European Commission and the Open Society Foundations.

17. The Global Fund to Fight AIDS, Tuberculosis and Malaria (2011) *Making a Difference: Eastern Europe and Central Asia regional results report 2011*, Geneva.



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THE IMPACT OF GLOBAL FUND FUNDING SHORTAGES IN EECA COUNTRIES

EECA countries' inability to access Global Fund financing has led to increased calls for domestic funding to fill the gap for TB and HIV. In theory, the argument that wealthier countries should pay for their own health programmes makes sense. However, in practice these resources are not being made available and much work is left to be done in terms of creating the political will within countries domestically to fill the gap. Building the capacity of non-state actors in this regard is therefore of utmost importance.

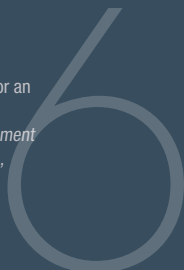
In June 2011, a study published by the Lancet laid out an investment framework for HIV/AIDS that highlighted a list of critical enablers essential to effective HIV programmes.¹⁸ These critical enablers, which are also essential to TB programmes, include community mobilisation, political commitment and advocacy, policy change, stigma reduction, community centred design and delivery of programmes. It is precisely these elements that are required to create an environment in which national governments will make financial and political commitments to tackle these diseases, yet these areas threaten to go unfunded and unsupported in EECA countries due to current Global Fund shortages and the revised Global Fund eligibility criteria that emphasise country income levels.

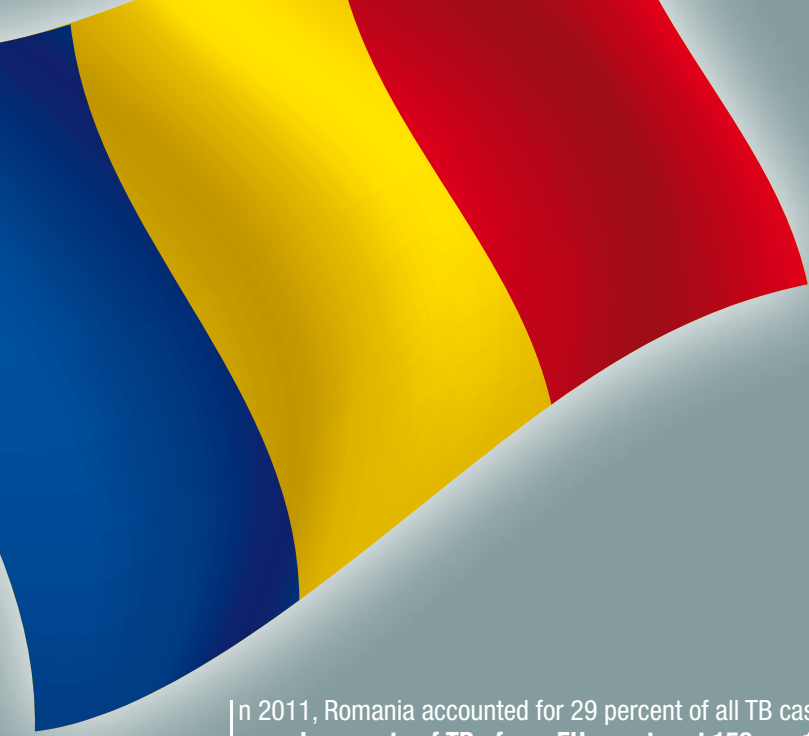
The Global Fund has historically funded civil society strengthening activities including advocacy in EECA countries and has promoted the involvement of TB and HIV civil society organisations at national policy level through its Country Coordinating Mechanisms (CCM). The CCM has helped to build local ownership and participatory decision-making in countries where the voices of civil society were previously left out. Support for community-based organisations and capacity building is needed in order to address the resistance of national governments to providing adequate health programme funding and to sustain programmes over the long run.

The full effects of Global Fund shortfalls are yet to be determined as many of the funding shortages in EECA countries won't go into effect until early 2013. However, there are a number of cases that already demonstrate the dramatic impact the shortfalls will have. In addition to the following case studies, further important examples can be found in the Eurasian Harm Reduction Network's report, "Quitting While Not Ahead: The Global Fund's retrenchment and the looming crisis for harm reduction in EECA" published earlier this year.¹⁹

18. Schwartländer, B. et al. (2011) 'Towards an improved investment approach for an effective response to HIV/AIDS', *The Lancet*, 377: 2031–41.

19. Stuijkyte, R. et al. (2012) *Quitting while not ahead: the Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe and Central Asia*, European Harm Reduction Network.





ROMANIA

In 2011, Romania accounted for 29 percent of all TB cases reported in the EU. **The country has the highest prevalence rate of TB of any EU country at 158 per 100,000, approximately 10 times the rate in the UK and more than 20 times the rate in Germany.**²⁰

Although the number of cases of TB in Romania is dropping overall, a quarter of all cases reported in 2011 were patients that had been treated previously and were re-infected.²¹ This re-infection rate demonstrates the challenges Romania faces in managing TB cases and ensuring patients complete their treatment. Drug shortages and a weak social welfare system have led to rising rates of MDR-TB. For most patients, MDR-TB presents a devastating prognosis as fewer than two out of ten patients with MDR-TB in Romania are cured after receiving treatment for 24 months.²² Even more worryingly, in 2010 Romania reported 20 cases of extensively drug-resistant TB (XDR-TB) – resistance to second-line drugs that develops on top of MDR-TB and is virtually impossible to cure.²³

TB control in Romania is financed by the Ministry of Health and supplemented by a Round 6 Global Fund grant. The grant is implemented by Romanian Angel Appeal (RAA), a local NGO, and provides 30 percent of the TB budget in Romania. The Global Fund supports populations that are underserved by the Romanian Government, reaching the homeless and prisoners, as well as those living in rural areas and the Roma community.

In addition to delivering essential treatment and care interventions, the Global Fund grant ensures an uninterrupted supply of second-line TB drugs. These funds have been used to provide two drugs for MDR- and XDR-TB patients that are not available anywhere else in the country. A reliable and ongoing supply of these drugs is critical to prevent a further increase in drug resistance. Treatment success rates in MDR-TB patients in programmes supported by the Global Fund are consistently over 70 percent, while treatment success rates outside Global Fund financed programmes are around 20 percent.²⁴

20. European Centre for Disease Prevention and Control (2012)
Tuberculosis surveillance and monitoring in Europe 2012, Stockholm.

21. Ibid.

22. Ibid.

23. Ibid.

24. Evidence given by Romanian Angel Appeal in March 2012.



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In line with the recently endorsed 'Consolidated Action Plan to Prevent and Combat M/XDR TB in the WHO European Region', Romania has developed a MDR-TB Action Plan for its National TB Programme, which outlines a comprehensive response to achieve universal access to prevention and treatment of MDR-TB. However, there is growing concern that the country will be unable to implement this Plan due to a lack of funding.

Romania's National TB Programme exists within an already underfunded health care system.²⁵ It has been estimated that the implementation of the national MDR-TB Action Plan from 2012 through 2015 would require an annual budget of US\$ 23 million per year. Approximately US\$ 6 million per year is currently provided to the National TB Programme from the state budget by the Ministry of Health and National Health Insurance House. This budget does not include the cost related to TB and MDR-TB patients' hospitalization, which is estimated to be around US\$ 20 million per year.²⁶

Although the Romanian Government has committed to increase domestic funding for TB control, it is estimated that there will still be a financing gap of US\$ 16 million to implement the country's MDR-TB response in 2013 alone.²⁷ **Romania will not be able to finance scale-up for MDR-TB without ongoing support from donors, including the Global Fund.**

Romania has already felt the effect of funding shortfalls on its HIV programme. After Romania's Global Fund HIV grant ended in 2010, HIV cases increased sharply among people who inject drugs from 3-5 cases during 2007-2009 to 12 cases in 2010 and then to 62 cases in the first nine months of 2011. Reduced funding for prevention services has been identified as one of the factors that led to a jump in cases.²⁸

Silvia Asandi, the General Manager for RAA, pointed out that "Romania's integration into EU brought, along with many positive changes, a severe narrowing of international support for HIV and TB, including from the Global Fund. **Romania's economic status of upper-middle income country does not reflect the real situation of a large category of Romanians who live in extreme poverty and have limited or no access to essential prevention, treatment and care services.**"

25. Romania still spends less on TB control than its neighbours. In 2010, Romania had eight times the number of TB cases as neighbouring Bulgaria but spent half as much on TB control. Stillo, J. (2012) 'Ethnographic analysis of treatment failure in Romania', *IREX.org*, [Online], Available: <http://www.irex.org/sites/default/files/Stillo-%20Final%20Research%20Brief-%20Revised.pdf>.

26. Evidence given by Romanian Angel Appeal in March 2012.

27. Funding gap estimate provided by WHO Country Office Romania

28. Pharris, A. et al. (2011) 'Human Immunodeficiency Virus in injecting drug users in Europe following a reported increase of cases in Greece and Romania, 2011', *Eurosurveillance*, volume 16, issue 48.





BELARUS

In Belarus, the burden of TB remains high despite existing national efforts and government commitment to combat the disease. TB continues to be an important public health issue, and the spread of drug-resistant TB is a major concern.


Belarus is one of WHO Europe's 18 high-priority countries for TB control.²⁹ Belarus is also listed among the 27 MDR-TB high burden countries in the world. According to the most recent drug resistance surveys conducted 2009-2010, more than one third (35 percent) of newly diagnosed TB patients and two thirds (76 percent) of previously treated patients have MDR-TB. These are the highest documented rates in the world. XDR-TB was found in 14 percent of the MDR-TB patients.³⁰

To date the National TB Programme in Belarus has mostly (95 percent) been funded by the public budget with 4.5 percent of funds sourced from external donors, including the Global Fund. The Global Fund supports the National TB Programme with Single Stream of Funding that consolidates TB funding proposals under Round 6 and 9.

29. World Health Organisation: Europe (2007) *Plan to Stop TB in 18 High-priority Countries in the WHO European Region, 2007-2015*, Copenhagen: WHO.

30. Skrahina, A. et al. (2012) 'Alarming levels of drug-resistant tuberculosis in Belarus: results of a survey in Minsk', *European Respiratory Journal*, 39: 1425-1431.





In 2011, due to the alarming levels of MDR-TB in the country, the Ministry of Health recognised the urgent need to scale up diagnosis and treatment of MDR-TB and infection control interventions. The revised estimates of MDR-TB patients resulted in a significant increase in the number of MDR-TB patients the Government needed to target. **It was estimated that the TB budget would need to increase by 200 percent.**³¹

Belarus' MDR-TB response requires procurement of new laboratory equipment, second-line TB drugs and infection control devices, the majority of which are sourced externally. A devaluation of the country's currency by 30 percent made procurement of these interventions even more expensive. The Government recognised that scale-up would not be possible under the existing TB programme and was therefore relying on their Global Fund Round 11 application to supplement their existing TB budget, which was estimated would need to increase by 200 percent.³² The cancellation of Round 11 coincided with an external review of the National TB programme in Belarus in October 2011 that stated that, "M/XDR-TB should be considered a public health emergency in Belarus and preventing and combating it a top priority intervention for the country and the European Region."

Following cancellation of Round 11, Belarus found it was not eligible to apply to the TFM, as the grant application would have been for a scale-up of services that was not permissible under the TFM conditions. Nevertheless, the Government of Belarus has committed to finding the necessary resources to finance the MDR-TB response, and the current Global Fund grant, implemented by the United Nations Development Programme, has been reprogrammed. However, a considerable funding gap for the MDR-TB response in Belarus remains.

It has been estimated that the funding gap in Belarus for the five year period between 2012 and 2016 will be US\$ 16 million per year. US\$ 15 million of this will be needed for second-line treatment of MDR-TB and XDR-TB, US\$ 300,000 for rapid laboratory diagnostics and about US\$ 500,000 for essential patient support programmes to ensure treatment completion.³³

How the funding gap in Belarus will be filled remains uncertain. However, it is clear is that external funding, including Global Fund financing, will be the only way that Belarus will be able to scale up their MDR-TB response to the level required to address the serious trend in drug-resistant TB.

31. Evidence given by WHO Europe July 2012.

32. Ibid.

33. This funding gap is still being confirmed as the country develops their MDR-TB response plan. This is the estimated funding gap as of July 2012.



RUSSIA

HIV rates in Russia continue to rise, from 39,207 newly diagnosed cases reported in 2005 to 62,582 in 2010. Representing a rate of 44 per 100 000 population, **Russia has the highest reported rate of HIV of any country in the European region.**³⁴

The HIV epidemic in Russia is concentrated among marginalised communities, including people who inject drugs and their partners, men who have sex with men, and male and female sex workers. Studies in Russian cities have found an HIV prevalence of 32 to 64 percent among people who inject drugs. A high number of people infected with HIV remain undiagnosed.³⁵

HIV in Russia is fuelled by stigma, discrimination and zero-tolerance drug policies, which prevent the use of opioid-substitution therapy (OST) and limit syringe exchange programmes. **To date the Russian Government has shown little progress towards modifying their drug policies to allow for more effective harm reduction measures.** Non-governmental organisations, funded through the Global Fund, have played a critical role in the delivery of harm reduction services to marginalised groups neglected by Government programmes.

34. European Centre for Disease Prevention and Control (2010) *HIV/AIDS surveillance in Europe 2010*, Stockholm.
35. Holt, E. (2010) 'Russian injected drug use soars in face of political inertia', *The Lancet*, 376: 13–14.



Because Russia is not on the list of the OECD recipient countries, the Russian Government has not been eligible to apply for Global Fund HIV support since 2007. The eligibility criteria were later revised to introduce a so-called NGO exception for countries that are seen as donors (including Russia). Two NGOs in Russia that received support from the Global Fund for harm reduction in Round 3 and Round 5 intended to apply to Round 11 for services to PWIDs. The first, the Open Health Institute (OHI), planned to support 25 HIV prevention programmes covering approximately 21,000 PWID. The other, larger programme, run by the Russian Harm Reduction Network (ESVERO), intended to continue supporting 33 local programmes with approximate coverage of 56,000 PWID per year. On cancellation of Round 11, all harm reduction programmes were at serious risk of closure.³⁶

OHI and ESVERO³⁷ were eligible to apply for funding through the TFM. Both organisations received bridge funding to avoid service disruption between the end of their previous grant and the receipt of TFM monies. However, due to TFM funding restrictions and a funding cap of 40 percent of the previous grant amount, OHI and ESVERO have been unable to scale up any services and have been forced to cut back the regional projects they currently provide.

OHI reported that they have had to cut their HIV prevention projects among sex workers, men who have sex with men and prisoners by half and have put on hold plans to implement projects among migrants and street children. ESVERO has reported serious concerns about having to cut advocacy and community mobilisation efforts, both at the local and country level. A cut in funding for advocacy will pose serious risks for harm reduction programmes in Russia and may reduce the role of civil society in response to HIV as a whole.

The Global Fund remains one of the few international donors providing financial support for HIV prevention programmes in Russia. Domestically, the Russian Government has invested considerable funds in HIV, yet the majority of these funds are used for law enforcement measures, drug supply control and is designated for the procurement of diagnostics and antiretroviral treatment. A body of evidence exists supporting the effectiveness of harm reduction programmes,³⁸ yet in Russia minimal domestic funds have been invested in such programmes that target the most vulnerable populations, and the will of the Russian Government to commit more funding remains low.

36. Evidence provided by OHI July 2012.

37. ESVERO was initially not eligible for the TFM and Bridge funding from the Global Fund, since their Round 5 grant finished in summer 2011, i.e. outside the time framework of the TFM/Bridge funding. However, since most of its supported services managed to operate without funding until 2012, the Global Fund's Board in early March 2012 decided to allow ESVERO to apply to both funding opportunities.

38. Institute of Medicine of the National Academies (2007) *Preventing HIV infection among injecting drug users in high risk countries: an assessment of the evidence*, National Academies Press: Washington.





HOW CAN THE EUROPEAN UNION HELP FILL THE GAP?

Looking at the general climate of austerity in Europe, the European Commission argues that it is currently not in a position to invest more in health programmes in Eastern Europe and Central Asia (EECA). **However, investing in a healthy society is in itself a fundamental goal of economic development and should be more favourably considered by the EU as an appropriate tool for stability and growth in its cooperation policies.** If we consider, for instance, the rising problem of MDR-TB in EECA countries, we know that minimal or delayed action will incur a much greater cost to the EU and countries within the region than acting now.

Cooperation agreements between the EU and EECA countries exist and are supported by financial instruments that fund programmes and projects according to the priorities jointly pre-established in the countries' Action Plans (for Eastern Partnership countries) or regional strategies (for Central Asian countries). Most cooperation agreements mention public health, but practically, very few health projects are implemented on the ground. The ones that are put in place are small-scale projects that receive very little funding.

In order for EU institutions to address a lack of funding for global health programmes in the EECA region, the EU should:

- **ACKNOWLEDGE** the importance of health as a tool for economic, social and human development and honour its commitment in the 2010 Council Conclusions on the EU Role in GloAbal Health by urgently developing, in consultation with civil society, a concrete and time-bound Global Health Programme for Action that duly priorities HIV and TB.
- **HONOUR** existing pledges and scale up support for the Global Fund in the context of the on-going negotiations on the new EU multi-annual financial framework (MFF) 2014-2020 and the 11th European Development Fund (EDF).
- **EXPLORE** new innovative financing mechanisms that could generate additional revenues at EU level and allocate half of the revenues of a Financial Transaction Tax to development including global health programmes.

As Board Member of the Global Fund, the EU should:

- **Agree to quickly INVEST** the new resources available and urgently issue a new Round of applications in order to scale up the response to TB/HIV in the region.
- **SUPPORT** the revision of the eligibility criteria to ease restrictions in middle-income countries with epidemics concentrated among key populations, particularly where alternative sources of funding are unavailable, and eliminate the rule that 55 percent of funding per year must go to low-income countries.
- **Broadly CONSULT** European citizens and partners on the new business model and protect the Global Fund's core principles, including country ownership; multi-sectoral partnerships; balance between the regions, diseases and interventions; and transparency and accountability
- **REAFFIRM** the importance of CSO and community-based organisations in health system strengthening through the new Global Fund strategic plan and ensure meaningful engagement of all country stakeholders.
- **In the new Global Fund funding model, STRENGTHEN** the Targeted Pool for countries with concentrated epidemics in key populations to generate more focused investment in marginalized and highly affected populations and increase funds available for the Targeted Pool.

At the sub-regional level, the EU institutions should:

FOR EU MEMBER STATES WITH A HIGH-BURDEN



OF TB AND/OR HIV ROMANIA, BULGARIA, LITHUANIA, LATVIA, ESTONIA

- Ensure that European Social Fund (ESF) social inclusion activities reaching out to vulnerable groups most at risk (including the Roma community, the homeless, migrants, men who have sex with men, sex workers and injecting drug-users) integrate and mainstream TB and HIV components, from prevention to psycho-social support.
- Ensure that ESF funds are accessible to smaller NGOs and community-based groups that have greater impact on harm reduction and patient support activities.

FOR EASTERN PARTNERSHIP COUNTRIES



BELARUS, UKRAINE, MOLDOVA, GEORGIA, ARMENIA, AZERBAIJAN

- Ensure that one of the three priorities for bilateral cooperation in the future countries' Action Plan tackles a societal challenge (e.g. health, education).
- Prioritise health activities, including through mainstreaming, as a sub-component of all thematic programmes of the Development Cooperation Instrument (DCI) (migration and asylum, investing in people, non-state actors (NSA) and local authorities in development, food security).
- Under the DCI thematic line on NSA and local authorities development, build capacity for a larger number of NSAs working in the field of public health to ultimately push for stronger national leadership in health matters.
- Staff its EU country delegations with social sector officers in charge of health, education and social protection.
- Regularly discuss and document the impact of TB and HIV on the region and the lack of access to healthcare for vulnerable groups in the political dialogue with those countries and at EC inter-service meetings.

FOR THE RUSSIAN FEDERATION



- Embrace harm reduction as a drug policy principle at the highest political level and actively promote harm reduction through political dialogue with partner countries in EECA and with Russia in particular. The European External Action Service should make full use of its potential to become a progressive force for advancing human rights within the EU's HIV response at global and country levels.
- The recent shift from a recipient to donor country, where the Russia Federation is no longer a recipient of bilateral aid of the EU or the GFATM, essentially leaves Russia's marginalised populations on their own. Through political dialogue, the EU needs to encourage Russia to implement evidence-based policies and programmes to tackle the root causes of its HIV and TB epidemics at national level, with a particular focus on the needs of most at risk populations (MARP).
- Provide direct financial and technical support for sustaining harm reduction activities in Russia through support to non-state actors advocating for and implementing harm reduction programs in Russia. Thematic instruments such as the European Instrument on Democratisation and Human Rights (EIDHR) and thematic instruments under the Development Cooperation Instrument (DCI) can be useful complementary tools for projects targeting people who inject drugs.

FOR CENTRAL ASIA



KAZAKHSTAN, KYRGYZSTAN, TURKMENISTAN, UZBEKISTAN, TAJIKISTAN

- Include health as a priority of action in its revised EU-Central Asia Strategy, or mainstream health in other sectors of activity (rule of law, water and environment) in order to tackle Central Asia's highest rates of tuberculosis of the WHO Europe region.
- Sustain funding for the Central Asian Drug Programme (CADAP) and its harm reduction components in the next DCI and expand activities to cover TB control in prisons.
- Invest more resources on capacity building of non-state actors in order to trigger policy change from the bottom up.
- Establish contact with WHO delegations in Central Asia and explore areas of cooperation, especially with regards to the implementation of the WHO EURO Multidrug-resistant TB Action Plan.
- Cooperate with the GFATM on policy and delivery of TB and HIV programmes and request participation in the GF Country Coordination Mechanisms (CCM).





GLOBAL HEALTH ADVOCATES FRANCE AND RESULTS UK are NGOs part of the ACTION network and host the Secretariat of the TB Europe Coalition.

ACTION

is a global partnership of advocacy organizations working to influence policy and mobilize resources to fight diseases of poverty and improve equitable access to health services. ACTION was founded in 2004 as a partnership of civil society advocacy organizations with the shared mission of mobilizing new resources against tuberculosis (TB), a disease that kills one person every 20 seconds. ACTION partners work across five continents in both donor and high burden countries and advocate at the local, national, and global levels.

THE TB EUROPE COALITION

is an informal advocacy network of civil society organisations and individuals that share a commitment to raising awareness of TB and to increasing the political will to control the diseases throughout the WHO Europe region and worldwide.

ACTION

www.action.org



www.tbcoalition.eu



www.ghadvocates.org



www.results.org.uk

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