The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Turning the Tide Against HIV and Tuberculosis

Global Fund Investment Guidance for Eastern Europe and Central Asia

Acknowledgement

In order to ensure that the views of a variety of stakeholders were represented in the development of this Eastern Europe and Central Asia Investment Guidance, the Global Fund held a number of broad and inclusive consultations and dedicated workshops on what might be the objectives and principles of a differentiated approach to fight HIV and TB in the region, and how these could be achieved. Participants included Global Fund Board Members from the EECA region and other constituencies, Secretariat staff, representatives of regional and international partners, donors, and technical agencies as well as community representatives. The final draft of this investment guidance was also shared with various members of the Global Fund Technical Review Panel for their input. The Global Fund would like to thank all the participants for their constructive engagement and input to these discussions and for the many subsequent reviews of the draft guidance document.

We would especially like to express our sincere gratitude to Aleksandr Glyadyelov, the photographer, for giving us permission to use his pictures throughout this document. All copyrights remain his.

List of abbreviations

EECA	Eastern Europe and Central Asia
GLC	Green Light Committee
LI	Low income
LMI	Lower-middle income
PEPFAR	President's Emergency Plan for AIDS Relief
SMART	Specific, measurable, achievable, realistic and time-bound
UMI	Upper-middle income
WHO	World Health Organization

Turning the Tide Against HIV and Tuberculosis

Global Fund Investment Guidance for Eastern Europe and Central Asia

Vision, goals and targets

The Global Fund's vision for the Eastern Europe and Central Asia region is to **stabilize HIV incidence and contain the spread of drug-resistant TB**.

To this end, the Global Fund will aim to contribute to the following goals within the current allocation period:

- To reduce HIV transmission among people who inject drugs by 50%.
- To increase to and sustain coverage of 80% of those in need of antiretroviral (ARV) therapy.
- To diagnose at least 85% of TB patients, especially multidrug/extensively drug-resistant-TB patients.
- To successfully treat at least 90% of patients with drug-sensitive TB and at least 75% of patients notified as having multidrug-resistant TB.

Global Fund resources

US$679.5 million is available for the allocation period 2014-2016. Implementation is expected to cover the period 2014-2017.

Principles

Alignment with existing Global Fund and partner strategies and action plans.

Differentiation for and ownership of country-specific approaches.

Objectives				
	1. Enhance access to comprehensive harm reduction services for people who inject drugs, including in prisons.	**2. Promote universal access to ARV therapy with special focus on key populations.**	**3. Promote universal access to timely and quality diagnosis of all forms of TB, including multi/extensively drug-resistant TB.**	**4. Promote universal access to quality treatment of all forms of TB, specifically multi/extensively drug-resistant TB.**
Actions	Scale up access to the comprehensive package of harm reduction interventions. Support quality community-based services. Share and roll out best practice service models.	Scale up access to ARV therapy and support treatment retention and adherence. Ensure uninterrupted supply of quality-assured medicines. Ensure early HIV diagnosis, linkage to treatment and continuum of care for key populations.	Expand the use of new diagnostic technologies. Ensure proper internal and external quality assurance systems in TB laboratories. Improve tracing and management of TB and multi/extensively drug-resistant TB contacts and infection control.	Ensure uninterrupted supply of quality-assured medicines. Implement patient-centered approaches for improving treatment outcomes. Address TB/HIV co-infection through integrated care and joint strategies.
Enablers	• Develop national investment frameworks for impact, sustainability and transition processes. • Strengthen TB and HIV information systems, surveillance and monitoring and evaluation program. • Strengthen TB and HIV procurement and supply chain management systems. • Strengthen advocacy efforts for HIV and TB control, including revision of regulatory frameworks for harm reduction. • Reform health and financing systems to apply sustainable patient-centered TB services, based on outpatient case management and appropriate patient support.			

Differentiated approach, sustainability and co-financing targets

	Low-Income (LI)	Lower Low-Middle Income (Lower LMI)	Upper Low-Middle Income (Upper LMI)	Upper Middle-Income (UMI) + High Disease Burden	No Longer Eligible for New Global Fund Financing
Counterpart financing	Minimum threshold: 5%	Minimum threshold: 20%	Minimum threshold: 40%	Minimum threshold: 60%	N/A
Harm reduction	• Not less than 50% of Global Fund HIV programming is dedicated to the provision of and advocacy for harm reduction and linkage of key populations to care. • All countries develop and implement SMART plans for gradual transfer of harm reduction services to domestic sources of funding.				
HIV prevention, treatment, diagnosis and adherence support	• Global Fund programs maximize prevention coverage, linkage and retention in care of key populations. • Prevention among key populations to be included in national AIDS programs and gradually transferred to domestic or alternative sources of funding. • All countries develop and implement SMART plans for the transfer of ARV therapy provision and adherence support services to domestic sources of funding.				
	• Minimum 30% funding for ARV therapy, lab services and adherence support to be covered by domestic or alternative sources, before end of current allocation. • Elimination of mother-to-child transmission to be transferred to domestic or alternative sources of funding before end of current allocation.	• Minimum 60% funding for ARV therapy, lab services and adherence support to be covered by domestic or alternative sources, before end of current allocation.	• ARV therapy funding from Global Fund prioritizes treatment initiation and scale up among key populations. • Minimum 75% of funding for existing ARV therapy patients, lab services and adherence support to be covered by domestic or alternative sources, before end of current allocation.	• ARV therapy funding from Global Fund only for treatment initiation and scale-up among key populations. • All funding for existing ARV therapy patients, lab services and adherence support to be covered by domestic or alternative sources, before end of current allocation.	• Funding for ARV therapy, lab services and adherence support to be covered by domestic or alternative sources, before end of current grants.
TB treatment, diagnosis and adherence support	• Diagnostic and treatment for susceptible TB in all countries is covered by domestic or alternative sources of funding. • Not less than 10% of Global Fund funds should be programmed for TB/HIV collaborative activities and other co-morbidities. • National multidrug-resistant TB expansion plans, including transition to domestic financing, are developed or reviewed for appropriate targets and endorsed by Green Light Committee.				
	• Minimum 30% funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current allocation.	• Minimum 50% funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current allocation.	• Minimum 75% of funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current allocation.	• All funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current allocation.	• All funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current grants.
Sustainability	• Limited incentives and pay for performance to governmental service providers to be gradually transferred to domestic or alternative sources of funding. • All countries to improve regulatory framework for nongovernmental organizations financing and develop social contracting mechanisms. • All countries to submit sustainability plans with concept note or within first year of new funding allocation.				• All countries required to implement transition plans.

Turning the Tide Against HIV and Tuberculosis

Global Fund Investment Guidance for Eastern Europe and Central Asia

Introduction

Since 2002, the Global Fund's investments in the Eastern Europe and Central Asia (EECA) region have contributed to considerable progress in combating HIV and TB, developing enabling environments and strengthening health and community systems. These successes would not have been possible without the close collaboration of the Global Fund, implementing countries and partners, including technical agencies, private firms and nongovernmental organizations. Nevertheless, EECA continues to face serious challenges and is now the region with the highest rate of HIV growth and the highest levels of multidrug-resistant TB in the world.

Building upon *Investing for Impact: Global Fund Strategy 2012-2016*, the Strategy, Investment and Impact Committee and the Global Fund Board are currently developing a coherent framework to describe the Global Fund's engagement strategy in different country contexts, including the Global Fund's approach to supporting countries in their transition towards a self-sustained response to the three epidemics. This "development continuum" framework is expected to be discussed by the Global Fund Board in 2015.

Linked to this work, and with the opportunity created by the launch of its new funding model, the Global Fund, in collaboration with a wide range of stakeholders, has embarked on the development of a *Global Fund Investment Guidance for EECA* for the 2014-2016 allocation period.[1] The aim of this guidance is to recommend strategic priorities for contributing to sustainable impact on HIV/AIDS and TB in the region and thereby help reverse the tide of the epidemics.

In EECA, the Global Fund has allocated US$679.5 million[2] for the financing of programs for 2014 and beyond. While there continue to be large resource gaps within the region, this volume of funding, if invested with a clear focus on high-impact activities and key populations, has the potential to greatly contribute to reducing the burden of the epidemics on the region's population. By integrating sustainability considerations in all investment decisions, countries can also ensure that the gains are preserved, even after Global Fund support is no longer available.

Principles

The *Global Fund Investment Guidance for EECA* and its subsequent implementation are guided by two overarching principles:

- **Alignment:** The investment guidance aims to align with partner policies, action plans, strategies, and disease-specific targets.[3] The targets underline the desire to coordinate with and complement the disease-control priorities set by partners, building on evidence-based demand articulated by countries.
- **Differentiation and ownership:** The Global Fund recognizes that different countries have markedly different profiles and therefore needs. The investment guidance has been designed to provide general guidance for countries on investment priorities in the region, but with the understanding that countries will need to develop differentiated, country-specific approaches for their implementation.

It is important to underline that the interventions, actions and enablers which are explicitly recognized in the EECA Investment Guidance are those which are specific to the region. Without these, success against TB and HIV in EECA cannot be achieved. As such, there are a number of other disease program elements and enablers "such as health and community systems strengthening, human rights and gender" which are not explicitly mentioned here. Their omission from this guidance does not signal that they are any less of a priority for the Global Fund. On the contrary, it is taken as given that such elements will be incorporated into Global Fund programming and will continue to receive funding, as before, provided there is sufficient evidence base for their need in a particular setting.[4]

Epidemiological profile of the region

HIV/AIDS

According to the World Health Organization (WHO), the EECA region has the fastest-growing HIV epidemic globally, with significant increases in mortality from AIDS. The number of people living with HIV in EECA has increased by 860,000 to 1.3 million between 2001 and 2012.[5] In the latter half of that period, (between 2006 and 2012), reported deaths among people with AIDS increased by 58 percent.[6]

Specific key populations which are at higher risk of HIV exposure and infection are: people who inject drugs and their sexual partners, men who have sex with men, sex workers, prisoners and migrants. People who inject drugs are at particular risk in Eastern Europe and it is estimated that 57 percent of all new HIV infections are attributable to the sharing of syringes and needles.[7] Although the epidemic remains concentrated among people who inject drugs, sexual transmission among this group and their partners, as well as sex workers and their partners, is rapidly gaining prominence as well.[8]

There are three key factors accounting for the continued spread and high mortality rate of HIV in EECA.

- **HIV testing and counseling among key populations remains insufficient, which leads to delayed diagnosis of HIV infections and late treatment initiation.** According to WHO, in 2012, 50 percent of new HIV infections were diagnosed with CD4 cell counts below 350/mm^3 and 30 percent with CD4 cell counts of 200/mm^3 or lower.[9] Varying levels of treatment quality and inconsistent adherence to treatment further contribute to the problem.
- **Inadequate coverage of prevention measures and antiretroviral (ARV) therapy results in the continued rise of HIV and AIDS cases.** Despite significant efforts to increase the number of HIV-positive patients on treatment, it is estimated that across EECA only 35 percent of people eligible for HIV treatment are receiving ARV therapy.[10] Treatment among people who inject drugs in the region is particularly low; even though this population comprises 62 percent of those living with HIV, only 22 percent of people who inject drugs receives ARV therapy.[11]
- **Access to harm reduction services - including opioid substitution therapy and needle and syringe exchange programs - remained limited,** despite the fact that these interventions are key to reducing the transmission of HIV among people who inject drugs and their sexual partners. In 2010, only 10 percent of people who inject drugs in Eastern Europe and 36 percent in Central Asia had access to needle and syringe exchange programs.[12]

Tuberculosis

In 2012, approximately 353,000 new TB cases and 35,000 TB-related deaths were reported in Europe, most of them in EECA. Although TB incidence has fallen at an average rate of 5 percent per year over the last decade, EECA continues to account for 5 percent of the global TB burden.

The particularly alarming aspect of EECA's TB profile is the fact that this is the region with the highest levels of multidrug-resistant TB in the world. In 2012, 24 percent of the global multidrug-resistant TB burden was reported in EECA[13] and 15 of the 27 countries worldwide with a high burden of multidrug-resistant TB are found in this region. Some countries present multidrug-resistant TB among more than 35 percent of new TB cases and more than 60 percent of re-treatment TB cases.[14]

There is also an increasing TB/HIV co-infection rate in the region. According to WHO, almost 13,000 out of an estimated 19,000 TB patients co-infected with HIV were detected in 2012 and only 62.3 percent of them were offered ARV therapy. The prevalence of HIV among TB cases increased from 3.4 percent in 2008 to 6.1 percent in 2012.[15]

The primary factors contributing to this disease profile are:

- **Diagnostic capacity across the region remains limited.** As a result, in 2012, less than half (44 percent) of the estimated number of multidrug-resistant TB patients were diagnosed.[16]

- Access to multidrug-resistant TB treatment has been scaled up three-fold compared to 2011, but the **treatment success rate for people with multidrug-resistant TB is insufficient.** Only 49 percent of multidrug-resistant TB cases were successfully treated in 2012. Adherence to a long, difficult treatment is a major obstacle.[17]
- While WHO recommends that, where possible, patients with multidrug-resistant TB should be treated using ambulatory or community-based care, **hospitalization for multidrug-resistant TB is almost universal in EECA.** This is problematic because many hospitals across the region suffer from poor infrastructure, lack of modern equipment, lack of infection control, and understaffing, and ultimately contribute to further spread of drug-resistant TB. Likewise, outpatient services face serious challenges to ensuring continuity of care and access by socially vulnerable groups.

Vision, goals and targets

The Global Fund's vision for the EECA region is to stabilize the prevalence and reduce the incidence of HIV and to contain the spread of drug-resistant TB. The aim is to ensure that EECA will no longer be the region with the highest rate of HIV growth and the highest levels of multidrug-resistant TB in the world.[18]

To this end, the Global Fund's fight against HIV and TB in the region will aim to contribute to the following goals within the current allocation period:

- To reduce HIV transmission among people who inject drugs by 50 percent.
- To increase to and sustain coverage of 80 percent of those in need of ARV therapy.
- To diagnose at least 85 percent of TB patients, especially multidrug/extensively drug-resistant TB patients.
- To successfully treat at least 90 percent of patients with drug-sensitive TB and at least 75 percent of patients notified as having multidrug-resistant TB.

Objectives and actions

Based on EECA epidemiological patterns, investment priorities in the region will be focused on four complementary pillars. The following section outlines the strategic actions that the Global Fund will support, as well as the expectations for transitioning the funding for these components from the Global Fund to domestic or alternative sources.

1. **Enhance access to comprehensive harm reduction services for people who inject drugs, including those in prisons.** The Global Fund supports the implementation and scale-up of access to the comprehensive package of high-quality harm reduction interventions to all people who inject drugs, including those in prison.[19] The desire is that all countries in the region will improve their regulatory frameworks and integrate harm reduction components into their national drug policies, allowing for the necessary scale-up of comprehensive harm reduction services, including those provided through the community. To achieve this, the Global Fund would like to see sharing and progressive rollout of best-practice service models and it expects countries to program at least 50 percent of Global Fund HIV support for the provision of and advocacy for harm reduction and linkage of key populations to care.

   At the same time, all countries, irrespective of income level, should ensure that SMART *(specific, measurable, achievable, realistic and time-bound)* plans – which allow for the gradual transfer of harm reduction services (including opioid substitution therapy) to domestic funding – are developed and implemented.

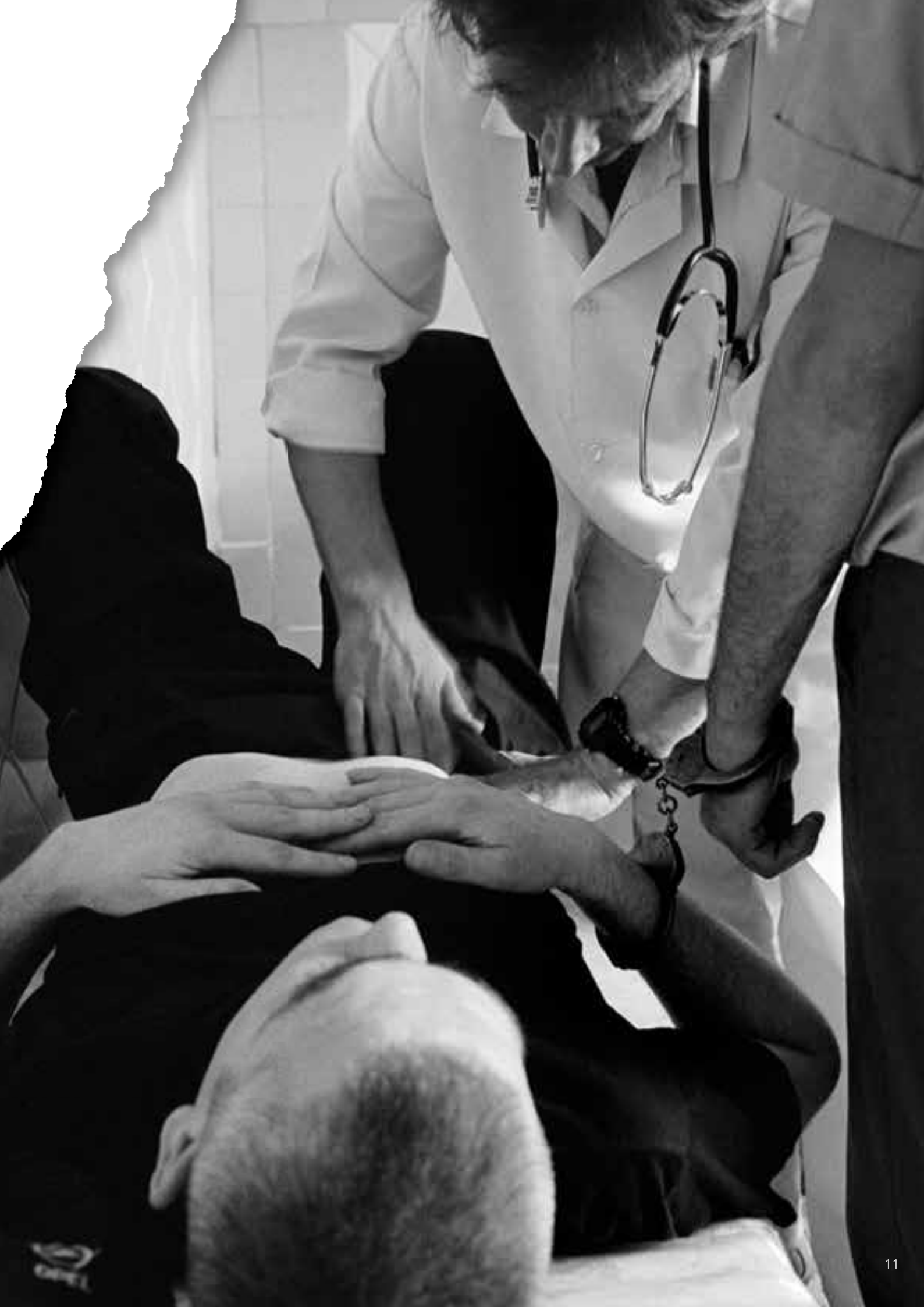
2. **Promote universal access to ARV therapy, with special focus on key populations (people who inject drugs, men who have sex with men, sex workers and prisoners)** – All HIV-positive patients who are eligible for treatment should have access to timely and quality diagnosis and referral services as well as access to treatment. To this end, the Global Fund will support proposals which prioritize efforts to scale up effective treatment and adherence services and clearly outline mechanisms for ensuring an uninterrupted supply of quality-assured medicines consistent with WHO-recommended regimens and the use of fixed-dose combinations. They should also outline quality services which contribute to ARV therapy scale-up, encompass laboratory services for HIV-positive patients, diagnostics and treatment for TB and other opportunistic infections, and drugs to counter adverse reactions to ARVs.

   Clearly, making progress on early treatment initiation will not be possible without improved prevention coverage among key populations, early HIV diagnosis through expanded voluntary testing and counseling services and an effective linkage system between community-based and facility-based services. The Global Fund therefore expects that proposals will maximize prevention coverage (>60 percent) of key populations (men who have sex with men, sex workers, and people who inject drugs) and outline mechanisms for better linking the prevention, diagnosis, treatment and care components.

   The Global Fund expects to see strong prevention programs, emphasizing integrated approaches to prevention and treatment, including targeted prevention packages, increased access to HIV testing, early ARV therapy initiation and retention into quality care programs. Within this continuum, the Global Fund will prioritize funding for treatment initiation among key populations and prisoners, while expecting to see a gradual transfer of patients to government programs. At the same time, the Global Fund expects that prevention among key populations will be included in national AIDS programs and funding for ARV therapy, laboratory equipment and services, and adherence support will be gradually transferred to domestic or alternative sources. To this end, SMART plans of transition, outlining this process, should be submitted to the Global Fund.

3. **Promote universal access to timely and quality diagnosis of all forms of TB, including multi/extensively resistant TB** – All patients with symptoms of TB, including hard-to-reach and high-risk groups such as migrants, the homeless and prisoners, should have access to timely and quality diagnosis, referral services and treatment. To this end, the Global Fund will orient its investment to further strengthening TB laboratories with new diagnostic technologies, standardizing laboratory methods, and strengthening quality-assurance schemes for all levels of diagnostic testing. Moreover, the Global Fund will support proposals which outline approaches to intensified TB case finding, tracing and management of TB and multi/extensively drug-resistant TB contacts and infection control; in countries with large migrant populations, approaches to improving the regulatory framework for dealing with TB diagnosis and subsequent referral among this population will be prioritized.

   The Global Fund's expectation is that funding for lab reagents and consumables, as well as the maintenance of the equipment and services, will be transferred to domestic or alternative sources before the end of the current allocation/grant.



4. **Promote universal access to quality treatment of all forms of TB, including multi/extensively drug-resistant TB** – The Global Fund will contribute to universal access to TB treatment by supporting proposals with ambitious scale-up plans which clearly outline the mechanisms for ensuring an uninterrupted supply of quality-assured medicines, consistent with WHO-recommended regimens, and patient-centered support services to enhance treatment outcomes. This includes shifting to ambulatory or community-based treatment and introducing essential improvements to TB control services and systems to reduce the further spread of multidrug-resistant TB. In addition, wherever epidemiologically justified and programmatically feasible, we recommend that countries include the following elements in their proposals:

   - extending treatment plans to include prisons and patient follow-up after release;
   - addressing the issue of migrants, particularly provision of services and overcoming the legal and political barriers to effective prevention and treatment for migrants;[20]
   - programming not less than 10 percent of Global Fund financing for TB/HIV collaborative activities and other co-infections.

   The Global Fund expects that, irrespective of income levels, appropriate treatment with quality-assured drugs for susceptible TB in all countries will be covered by domestic or alternative sources of funding. With this in mind, Global Fund support should be oriented toward covering the gap in treatment of drug-resistant TB and patient-centered approaches for improving treatment outcomes for all forms of TB, including adherence support. At the same time, each country's multidrug-resistant TB expansion plan, with technical support from the Green Light Committee (GLC), should outline an increased investment by government in the provision of multidrug-resistant TB treatment and patient support.

Transition of salaries and top-ups

In order to ensure long-term sustainability of the programs currently financed by the Global Fund, the goal is to ensure that funding for human resources be transferred to either government funding or alternative mechanisms. This applies to both salaries and top-ups to public and civil servants, as well as staff working in and for non-governmental organizations. Where limited human resource costs, including salaries and top-ups, remain funded by the Global Fund, countries should plan to transition these costs to performance-based incentive schemes.

The Global Fund would like to ensure that supported programs take a responsible, gradual approach to transitioning human resource costs. In light of this, country transition plans should outline how funding for human resource costs will be shifted to government or alternative sources of funding, and how countries will improve their regulatory frameworks for nongovernmental organization financing and development of social contracting mechanisms.

Enablers

The following enablers will support the implementation of the above-mentioned investment objectives and actions:

- **Develop national investment frameworks for impact, sustainability and transition processes** – Countries should develop national investment frameworks based on their national programs and budgets in order to ensure that domestic and external resources are invested strategically, maximizing their catalytic potential in order to achieve the greatest impact possible. Such frameworks "promote the scale-up of optimally effective, rights-based responses, enhance equity and inclusiveness and overcome barriers for populations most in need of services".[21] The development of national investment frameworks can also be used to broker collective agreements on transitioning program elements covered by the Global Fund to domestic funding and thus form the basis of sustainability and transition plans across the region.

  While preserving and strengthening key features of the Country Coordinating Mechanism policy such as civil society and private sector participation, Country Coordinating Mechanisms should increasingly ensure that they serve as the link between Global Fund grants and other health and development programs, including government- and donor-funded programs. The Global Fund sees Country Coordinating Mechanisms as being in a unique position to integrate Global Fund-supported activities into national health systems and health financing reforms and promote patient-centered approaches.

- **Strengthen TB and HIV information systems, surveillance and monitoring and evaluation program** – The Global Fund's new funding model and the development of national investment frameworks provide an appropriate forum for stimulating dialogue, with ownership from key policy-makers. However, such dialogue must be based on robust national data on epidemic trends and key populations (e.g. population size estimates and estimated needs for services), which supports the development of a programmatic and financial gap analysis and leads to the prioritization of investments. To this end, it is necessary to strengthen the quality and availability of national data, establish baseline data for key populations, increase the accuracy of population estimates, and review and improve the quality of services and define packages with unit costs which can be subsequently absorbed by national funding. WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the President's Emergency Plan for AIDS Relief (PEPFAR) and others working with countries have already initiated such efforts.

- **Strengthen the TB and HIV procurement and supply chain management systems** – To ensure the sustainability of procurement and supply management systems beyond the life of Global Fund grants, system strengthening initiatives are required. Currently, 10 out of 18 EECA countries receiving grants are fully or partially dependent on the Global Fund for the procurement of ARV drugs. Additional efforts are needed to strengthen national procurement systems in order to improve domestic capacities for procurement of pharmaceuticals and other health products and to facilitate the transition away from reliance on Global Fund-supported procurement mechanisms. Support will also be provided to ensure that treatment guidelines are aligned with the latest available evidence-based guidelines, product selection supports treatment adherence, sustainable price reductions are achieved, and that the system responds to the needs of the programs.

- **Strengthen advocacy for effective HIV and TB control, including revision of regulatory frameworks for harm reduction** – To support the implementation of policy and system changes, the Global Fund will continue developing and adapting its advocacy agenda with EECA governments and partners.

Priority advocacy topics include:

- The need to remove legal barriers for the efficient functioning of prevention and treatment activities. This particularly applies to repressive drug policies, insufficient respect for the rights of people who inject drugs in seeking health care, and unavailability of harm reduction services.
- The need to involve key populations in decision-making processes.
- The need to ensure that the quality of programs is maintained and continues to improve after transitioning to domestic funding.

- **Reform health and financing systems to apply sustainable patient-centered TB services, based on outpatient case management and appropriate patient support** – To ensure better outcomes in TB treatment and prevention, it is necessary to improve TB care delivery models across the region, primarily by strengthening links across levels of care and types of providers, and shifting away from hospital-based to ambulatory or community-based care. The three key enablers to achieve this goal are:
  - review the role of primary health care in TB case finding and case holding and strengthen the referral system.
  - introduce multidisciplinary patient-centered approaches, which often extend beyond the traditional health system's boundaries and involve rigorous actions by other public services (such as social services) and non-state and community actors.
  - change from input-based to performance-based financing and contracting, and promote modern methods of payment.

  The Global Fund is committed to ensuring that the effect of the reform of the TB services on the staff employed by these institutions is minimized. To this end, the Global Fund will work with countries to ensure that a gradual transition plan for human resource costs and social support is put in place.

Resources

The Global Fund has committed US$679.5 million to the region for the period 2014-2016, which is available for the implementation period of 2014-2017. Of this, US$649 million is from new funding model allocations and the remaining US$30.5 million is for the implementation of commitments for those countries and components which are no longer eligible for funding under the new funding model. The largest funding allocation within the region is to Ukraine (28 percent), followed by Uzbekistan (10 percent) and Georgia (9 percent). (For further details, see graph on page 16.)

Overall, the EECA region is getting 188 percent of the aggregate "fair share" of funding, based on global disease burden and ability to pay.[22] This is essentially explained by the historical comparatively higher success rate of EECA countries under the previous rounds-based funding model. Given the Global Fund's efforts to ensure that funding is focused on the low-income, high-disease burden countries, future funding in EECA, based on similar levels of replenishment, could be significantly lower.

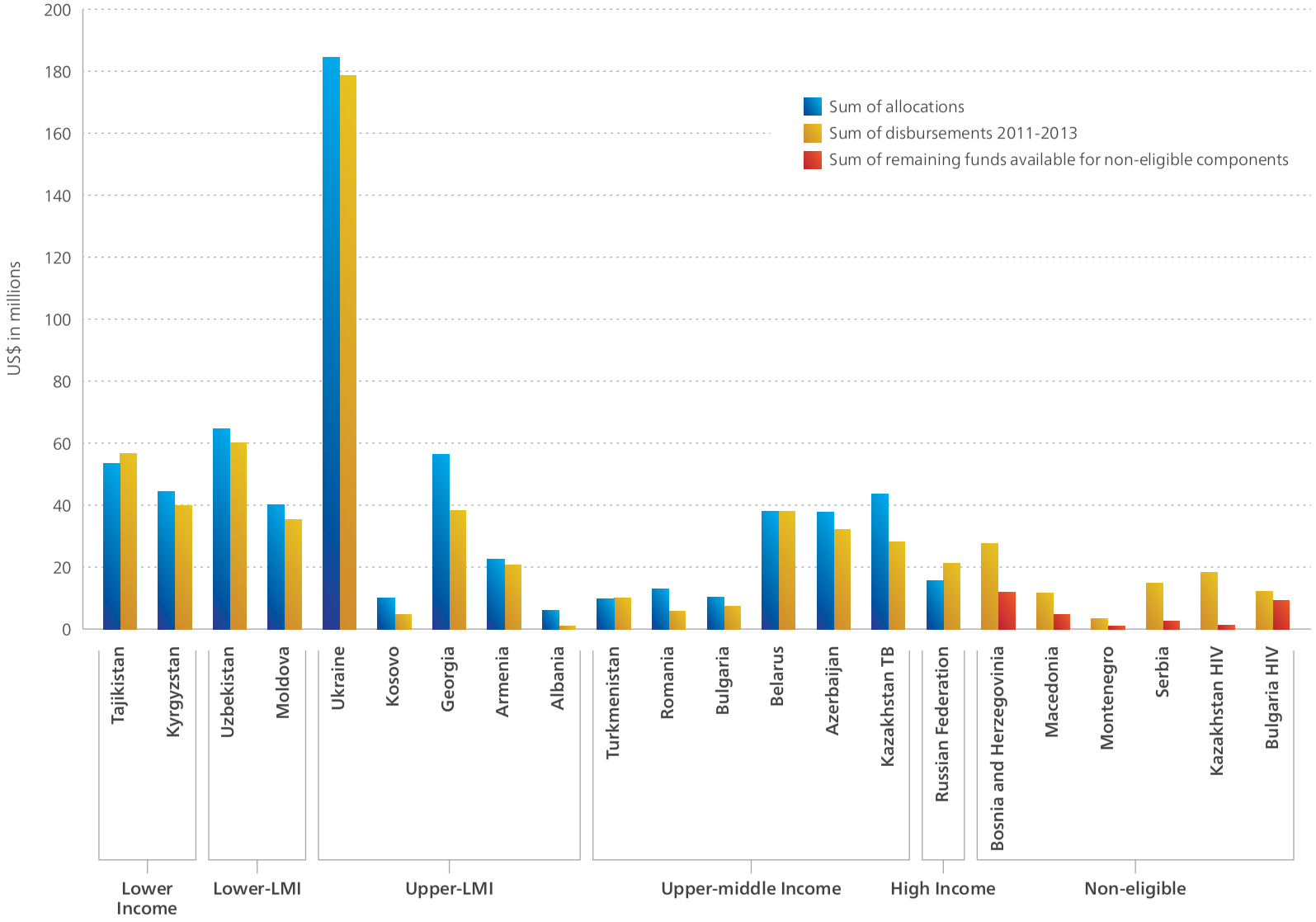
Monitoring

The implementation of this guidance note will be monitored annually through data collected from grants' regular reporting and, if necessary, on an ad hoc basis from in-country implementers. The Global Fund will aim to minimize the reporting burden on countries by coordinating with partners to obtain needed data. At the same time, the Global Fund will make the annual progress updates widely and transparently available to all stakeholders and will engage in discussions to adjust or accelerate the approach if necessary.

Conclusion

The Global Fund Investment Guidance for EECA is an ambitious yet realistic approach to programming Global Fund resources in the region. However, it will not achieve its goals in isolation. It is only through effective long-standing partnership at the country and regional levels, beginning with leadership of the countries and supported by the collective determination of all stakeholders, that the vision of stabilizing the HIV growth rate and containing the spread of drug-resistant TB can be realized.

Global Fund Disbursements 2011-2013 vs New Funding Model Allocations



New funding model allocation amount EECA: **US$649 million**
Remaining funds available for non-eligible components: **US$30.5 million**
Disbursements 2011-2013: **US$665 million**

Endnotes

1 The funding available for the 2014-2016 allocation period will be implemented within the 2014-2017 timeframe.

2 This figure includes US$649 million under the new funding model, plus US$30.5 million available to countries no longer eligible as of January 2014.

3 The targets of the regional Investment Guidance are aligned with partner disease-specific targets and plans such as: The European action plan for HIV/AIDS 2012–2015; The UNAIDS new framework "Treatment 2015" to accelerate action in reaching 15 million people with antiretroviral treatment by 2015; The EECA of PLHIV (ECUO) plan for sustained universal access to ART in the region; The WHO Stop TB Strategy (including the pipeline 'Post-2015 Strategy'); The Global Plan to Stop TB 2006 - 2015; Roadmap to Prevent and Combat Drug-Resistant Tuberculosis: The Consolidated Action Plan to Prevent and Combat M/XDR-TB in WHO European Region 2011-2015; Follow up of the 2004 Dublin Declaration and 2011 Political Declaration on HIV/AIDS; Follow up of the 2007 Berlin Declaration on tuberculosis and 2011 Beijing Declaration on public health and health systems strengthening.

4 Guidance and information notes on health systems strengthening, community systems strengthening, human rights, community and gender, and other key considerations in HIV and TB programs are available under the new funding model section of the website: http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

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6 WHO. Figures talk: HIV/AIDS in the WHO European Region. 27 November 2013. http://www.euro.who.int/__data/assets/pdf_file/0006/235599/WAD-Fact-sheet-Eng.pdf

7 Global report. UNAIDS report on the global AIDS epidemic 2013. UNAIDS, 2013. http://www.unaids.org/en/resources/campaigns/globalreport2013/globalreport

8 HIV/AIDS surveillance in Europe 2012. ECDC, 2013. http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/publications/2013/hivaids-surveillance-in-europe-2012

9 Figures talk: HIV/AIDS in the WHO European Region, 2012. Halting and reversing the spread of HIV by 2015 are at stake; 2013. http://www.euro.who.int/__data/assets/pdf_file/0006/235599/WAD-Fact-sheet-Eng.pdf

10 Figures talk: HIV/AIDS in the WHO European Region, 2012. Halting and reversing the spread of HIV by 2015 are at stake; 2013. http://www.euro.who.int/__data/assets/pdf_file/0006/235599/WAD-Fact-sheet-Eng.pdf

11 Harm Reduction Network. http://www.harm-reduction.org/issues/drug-use-and-hiv

12 Mathers, B.M, et al., HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage, 2010. http://www.harm-reduction.org/sites/default/files/pdf/HIV%20prevention%2C%20treatment%20and%20care%2C%202010%2C%20National%20drug%20and%20alcohol%20research%20centre_0.pdf

13 In 2012, there were an estimated 76,500 MDR-TB patients in EECA. World Health Organization. Global Tuberculosis Report 2013. Geneva: WHO, 2013. WHO/HTM/TB/2013.11. http://www.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf?ua=1

14 Testing coverage for resistance to second line drugs almost doubled in 2012 compared to 2011 in the region, however it remains at a very low level (9% of MDR-TB cases). Nevertheless, this allowed detection of 381 cases of extensively drug-resistant tuberculosis (XDR-TB). Tuberculosis surveillance and monitoring in Europe 2013. Stockholm, European Centre for Disease Prevention and Control, and Copenhagen, WHO Regional Office for Europe, 2013. Available at: http://www.euro.who.int/__data/assets/ pdf_file/0004/185800/Tuberculosis-surveillance-and-monitoring-in-Europe-2013.pdf

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16 Tuberculosis in the WHO European Region, Factsheet 2014. http://www.euro.who.int/__data/assets/pdf_file/0006/244743/Fact-sheet,-Tuberculosis-in-the-WHO-European-Region-Eng.pdf

17 Tuberculosis in the WHO European Region, Factsheet 2014. http://www.euro.who.int/__data/assets/pdf_file/0006/244743/Fact-sheet,-Tuberculosis-in-the-WHO-European-Region-Eng.pdf

18 It must be noted that a major contributor to the EECA disease profile is the Russian Federation, with the largest HIV epidemic in the region (more than 900,000 persons estimated to be living with HIV/AIDS) and the 11th highest burden of TB and the third-highest burden of multidrug-resistant TB in the world. However, this Investment Guidance addresses countries which are eligible for Global Fund financing under the new funding model. Nevertheless, the hope is that the implementation of sound, evidence-based approaches will have a spillover effect on those countries which are no longer going to receive Global Fund support. This is also applicable to most of the southeast European countries, where the TB situation, especially multidrug-resistant TB, seems to be less of a concern and the HIV situation remains under control with relatively low incidence in key populations (essentially men who have sex with men).

19 WHO, UNODC, UNAIDS, Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2012. http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf

20 Reference made to the minimum package for cross-border TB control and care in the WHO European region. Wolfheze consensus statement.

21 UNAIDS "Smart Investments", 2013.

22 The minimum required level forms part of the qualitative criteria approved by the Board. Its purpose is to allow a graduated reduction to the funding levels of disease components that have received funding at levels above the original allocation amount adjusted for external financing under the allocation methodology, or which have an existing grants pipeline greater than its original allocation amount adjusted for external financing.

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