



Dr. Mark R. Dybul
Executive Director of the Global Fund to Fight AIDS Tuberculosis and Malaria

Dear Dr. Dybul,

With this letter we, the undersigned organizations representing civil society including organizations representing communities of people living with HIV, most vulnerable populations, and non-governmental HIV/TB service organizations from Eastern Europe and Central Asia (EECA), would like to congratulate you on your recent appointment as the new Executive Director of the Global Fund. We hope that your deep knowledge of program implementation related to the effective treatment and prevention of AIDS, TB and malaria in resource limited settings will ensure that the Global Fund stays global and invests in strengthening the civil society.

At the same time we would like to bring to your attention a number of our concerns related to probable consequences of the recent developments in the Global Fund policies and reforms, which may have a negative impact on the ability of EECA region to sustain programs targeting most at risk populations (MARPs).

EECA is home to the world's fastest-growing HIV epidemic. No other region in the world has experienced the epidemic so strongly and consistently concentrated among people who inject drugs (PWID) and their sexual partners.¹ In 2010 42% of newly diagnosed HIV cases in EECA were reportedly acquired through injecting drug use.² HIV prevalence among PWID is nearly 10% in most countries of the region with some rising to over 70%.² However the access of PWID in the region to life saving services remains unacceptably low - only 10% of PWID in Eastern Europe and 36% in Central Asia have access to needle-syringe programmes (NSPs). In most countries access to opioid substitution treatment (OST) is limited and not funded by the governments². Access to ART in the region is the second lowest in the world with only 23% of people in need of ART receiving it at the end of 2010.³

The region's TB epidemic, closely entwined with that of HIV, is another major health challenge in the European region. According to WHO, TB treatment success rates have continuously

¹ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2010. Stockholm: European Centre for Disease Prevention and Control; 2011.

² Latypov A, Bidordinova A, Khachatryan A. Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality. EHRN, 2012.

³ Donnell D et al. Antiretroviral Therapy and HIV Transmission Partners in Prevention Study. Lancet, 2010, 375(9731):2092–2098.

decreased, falling from 72% and 50% in 2005 to 69% and 48% in 2010 among new and previously treated TB cases respectively. TB is the leading cause of death among people living with HIV in the region, yet not all HIV-positive people with TB are offered ART, and systems to support integrated TB and HIV treatment—particularly for people who use drugs—remain poorly developed.

The Global Fund's direct involvement to date has been the key reason that the number of needle-syringe programs increased steadily after 2002. In 2003, a total of 213 needle-syringe exchange programs reportedly existed across 25 EECA countries,⁴ and just seven years later there were more than eight times that number in Ukraine alone.⁵ The Global Fund's beneficial influence has often been very clear: in several EECA countries (e.g. Belarus, Kazakhstan and Tajikistan), OST pilots were first introduced within the implementation of the HIV prevention programs supported by the Global Fund. The Global Fund supported not only syringes and medicines, but also programs to reduce stigma, mobilize communities, and build the service and advocacy capacity essential to the establishment of sustainable, nationally supported programs. In a region where PWID have traditionally been criminalized and excluded, the Global Fund pushed for their human rights and full inclusion.

However recent developments at the Global Fund such as: the cancellation of Round 11; introduction of 55% rule; the restructuring of the Global Fund Secretariat (including disbanding the Civil Society Partnerships Team); and finally the introduction of the New Funding Model, which seems to put MARPs in middle income countries (MIC) at potential risk of no more prevention, treatment, care and support as national governments are still reluctant to support targeted prevention and treatment services for MARPs, or to fill in the gap that will come about if the Global Fund abruptly retreats from the region of EECA. In EECA only two countries, Kyrgyzstan and Tajikistan are still classified as low income. The political will of most national governments to respond adequately to HIV and TB epidemics by investing in scale-up of evidence and human rights-based HIV and TB services for MARPs is limited.

With this letter we request that while operationalizing the Global Fund's strategy, managing the Global Fund Secretariat and introducing the New Funding Model, you take into account a set of recommendations from a group of civil society and community based organizations from EECA:

- It must be made explicit that interventions and programmes funded within the NFM must include relevant aspects of community systems strengthening, SOGI and GES and that services for MARPs are not de-prioritised in applications to the indicative funding pool.
- Civil society representatives must be fully involved in the Concept Note development stage and all other stages of proposal development within the NFM. Clear procedures and mechanisms, which will ensure their meaningful involvement, should be developed in direct consultation with civil society and community groups.

⁴ Aceijas C, Hickman M, Donogoe MC, Burrows D, Stuikyte R. Access and coverage of needle and syringe programmes (NSP) in Central and Eastern Europe and Central Asia. *Addiction* 2007; 102(8):1244-50.

⁵ Ministry of Health of Ukraine, Ukraine harmonized AIDS response progress report. Reporting period: January 2010- December 2011", Kyiv – 2012.

- It must be made explicit how non-CCM and Regional Proposals will be addressed and funded within the NFM.
- The TB allocation percentage should be increased to a minimum of 20% to reflect the changing paradigm of the TB response and the growing menace of MDR-TB and TB/HIV co-infection.
- The Targeted Band must be preserved and expanded beyond the proposed 10% and it must be made explicit that Critical Enablers such as stigma reduction, gender equality, community mobilisation, legal environment, HCSS, social protection, gender-based violence etc. will be funded as part of a comprehensive MARPs package.
- As the NFM prioritizes proposals based on National Strategic Plans (NSP), countries' NSPs must be evaluated for human rights and investment in MARPs.
- The Global Fund Board must preserve and expand the "NGO Rule" to cover all three diseases or eliminate the OECD DAC list eligibility filter.
- The 55% rule should be eliminated as it would reduce funding available through existing grants in most MICs with concentrated HIV epidemics even while limiting their opportunities to obtain new funding.⁶
- The access of MICs, especially those with concentrated epidemics, to Global Fund resources should not be lower than it was prior to the Global Fund funding crisis. Three of the top five countries with the highest HIV burdens are middle income and eight of the ten countries with the highest TB burdens are middle income. In fact, only 30% of HIV-positive people lived in LICs in 2009.⁷
- The Civil Society Department's responsibility for supporting civil society engagement should be re-instituted within the Global Fund Secretariat.
- Civil society representatives and organizations should be involved in the development and revision of the Global Fund documents, which are used by the countries as guidelines to support the development of their applications (like harm reduction, CSS, HIV and human rights info notes and other relevant documents).

The Global Fund's decision to reduce funding availability based on country income ignores the fact that income is not the determining factor for the availability of HIV and TB services for MARPs; rather, the decisive factor is political will. With few alternate funding sources available, there is the risk of the growth of the region's concentrated HIV epidemic, and loss of the many gains made in the last decade with Global Fund support.

The Global Fund and donor governments must recognize that given its large concentrated epidemic among people who inject drugs, who are highly stigmatized, further investments in EECA are the most strategic choice. Donors have an ethical and moral imperative to maintain funding to desperately needed HIV and TB programs in the region and facilitate a gradual transition towards funding of MARPs from national sources.

⁶ Policy Brief: The Global Fund 55% rule: why it needs to be revoked. EHRN, 2012

⁷ Glassman A, Duran D, Sumner 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? CGD working paper 270. Washington, D.C.: Center for Global Development, p. 2.

We look forward to working together with the Global Fund towards ensuring that evidence and rights based programming, decision making and practices remain the driving principles of the response.

Sincerely yours,

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