



BRIDGING THE GAP

HOW THE EUROPEAN UNION
CAN ADDRESS THE FUNDING CRISIS
FOR TB AND HIV PROGRAMMES
IN EASTERN EUROPE AND CENTRAL ASIA



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ACKNOWLEDGEMENTS

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We would also like to thank the following people for their assistance in compiling information for the case studies:

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ACRONYMS

ACSM	Advocacy, Communication and Social Mobilisation	Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
AIDS	Acquired Immune Deficiency Syndrome	HIV	Human Immunodeficiency Virus
ASHMC	Agency for the Support of Civil Society	MDR-TB	Multi Drug-Resistant Tuberculosis
ART	Anti-Retroviral Therapy	NEP	Needle Exchange Programme
CADAP	Central Asian Drug Action Programme	NFM	New Funding Model
CSO	Civil Society Organisation	NGO	Non-Governmental Organisation
DCI	Development Cooperation Instrument	OST	Opioid Substitution Therapy
EC	European Commission	PWID	People Who Inject Drugs
EECA	Eastern Europe and Central Asia	TB	Tuberculosis
EIDHR	European Instrument for Democracy and Human Rights	TFM	Transitional Funding Mechanism
ERDF	European Regional Development Fund	WHO	World Health Organisation
ESF	European Social Fund	XDR-TB	Extensively Drug-Resistant Tuberculosis
EU	European Union		

EXECUTIVE SUMMARY

This report is the second publication in a series where we examine funding shortages for TB and HIV programmes in Eastern Europe and Central Asia (EECA).¹ The first publication, “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” explored the cancellation of the Global Fund to Fight AIDS, Tuberculosis and Malaria’s eleventh funding window in 2011 and how this left some countries without the financial support needed to aggressively combat their disease epidemics. This report builds on our previous publication by analysing three cases studies to demonstrate the continued impact of TB and HIV in the region and to show the effects of international donor aid diminishing in middle-income countries. The current situation for TB and HIV programmes in the region remains serious. These diseases urgently require sustained political and financial support from both domestic and international sources, including regional level aid from the European Union.

The Global Fund to Fight AIDS, TB and Malaria, historically the largest international donor for TB and HIV programmes in the EECA region, has adopted a New Funding Model (NFM) that will significantly reduce the amount of support available for middle-income countries. This includes support to civil society organisations that deliver TB and HIV services and are essential to creating environments where national governments are held accountable for properly addressing the health needs of their citizens. A Global Fund modelling of funding allocations under the NFM indicated that just three percent of total resources would be allocated to EECA.² This represents a 50 percent decrease compared with what was previously available.³

International donors increasingly use countries’ national income status to gauge eligibility for aid funding. However, income status does not reflect the number of people who are able to access health services. In the EECA region, only two countries qualify as low-income according to the World Bank’s country income classification: Tajikistan and Kyrgyzstan. While economic development has lifted many of the countries in the region to middle-income status, decreases in poverty and health inequalities have not been achieved at the same rate.

Most of the world’s at-risk populations for diseases like TB and HIV live in middle-income countries.⁴ The EECA is no exception: TB remains a significant public health problem and the region accounts for a quarter of the world’s drug-resistant TB cases. In addition, it is the only region in the world where the rate of new HIV infections is still increasing, in part because of concentrated HIV epidemics among vulnerable groups that are under-served by their national governments. This also raises key questions around human rights and access to health services.

The argument that wealthier countries should pay for their own health programmes makes sense, but the political will to deliver services to vulnerable populations is often absent, effectively abandoning tens of thousands of people. Donors seeking to make inroads against TB and HIV cannot ignore middle-income countries in the greater European region. Similarly, European Union institutions cannot turn a blind eye to these cross-border health threats occurring both on their doorstep in countries such as Azerbaijan and Albania, and within the European Union itself in countries like Romania. The consequences for the EU are particularly evident with TB, whose economic burden to the EU is already estimated at €5.9 billion a year.⁵

There is an urgent need for the international community to re-focus its attention to financing health programmes and to supporting civil society organisations in the EECA region.

1. 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.

2. The funding simulation was carried out in January 2013, and it should be noted that the parameters used to model funding allocations may change after agreement of the final model by the Global Fund Board.

3. Eurasian Harm Reduction Network (2013) *The Global Fund’s New Funding Model: What it Might Mean for You and Your Country*, EHRN.

4. Glassman, A. et al. (2012) *Global Health and the New Bottom Billion: How Funders Should Respond to Shifts in Global Poverty and Disease Burden*, Center for Global Development.

5. Diel, R. et al. (2013) ‘Costs of tuberculosis disease in the EU – a systematic analysis and cost calculation’, European Respiratory Journal, [Epub ahead of print].

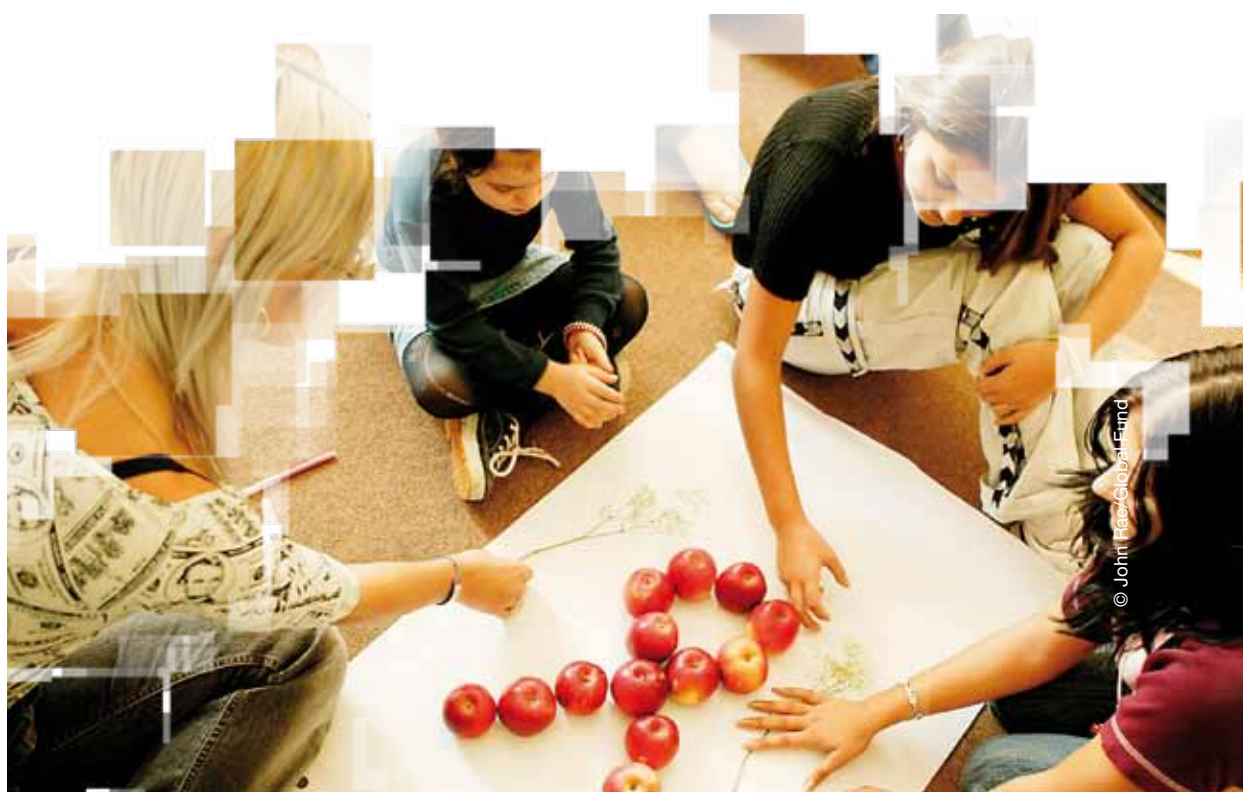
THIS REPORT, THEREFORE, MAKES THE FOLLOWING
RECOMMENDATIONS FOR THE EUROPEAN UNION INSTITUTIONS TO:

- **SCALE UP** their contribution to the Global Fund to €450 million for 2014-2016;
- **ADOPT** a holistic approach to EU differentiation policy⁶ that determines aid eligibility based on multi-dimensional causes of poverty, eliminating country-income thresholds;
- **EARMARK** at least 20 percent of the Development Cooperation Instrument (DCI) for health and basic education;
- **DEVELOP** an action-oriented Global Health Programme for Action with time-bound targets in consultation with civil society;
- **BUILD CAPACITY** of health civil society organisations to enhance participatory decision-making processes, hold national governments to account and help shape inclusive national health agendas through the DCI Civil Society Organisations and Local Authorities thematic programme;
- **ALLOCATE** at least 50 percent of the new revenues produced by the European Financial Transaction Tax to development cooperation, including global health programmes, and explore other innovative financing mechanisms that can generate additional revenues at EU level.

IN ADDITION, THIS REPORT RECOMMENDS THE GLOBAL FUND SHOULD:

- **RE-EVALUATE** country eligibility criteria based on income to make allowances for affected EECA countries, acknowledging that country income is not always a useful indicator for access to health services or health inequalities within a country;
- **INCREASE** the proportion of resources available to the EECA region, recognising the future economic burden drug-resistant TB will pose if there is a failure to tackle it aggressively today and knowing that abandoning support for HIV and harm reduction programmes has human rights implications for key populations that are most at risk.

6. The European Union's policy of 'differentiation' guides the EU's development policy and determines its allocation of aid by setting eligibility criteria that differentiates between the needs and capacities of developing countries.



BACKGROUND

In this report we return to examining the funding gaps for TB and HIV programmes in Eastern Europe and Central Asia (EECA). Our previous report on the region, "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", was first published in September 2012 and depicted the challenges many EECA countries faced in the aftermath of the Global Fund to Fight AIDS, Tuberculosis and Malaria's cancelled 11th funding window.

Since then, available funding for TB and HIV programmes continues to be limited, with many donors, including the Global Fund, diminishing their support to middle-income countries. This is occurring at a time when adequate 'phasing out' of aid has not occurred and there simply are no other funding alternatives for TB and HIV programmes. Domestic support has also been lacking as many governments in the region are often unable or unwilling to support targeted prevention and treatment services for vulnerable populations who are most affected by the TB and HIV epidemics.

This report presents three case studies – Azerbaijan, Albania and Romania – that outline continuing challenges in the fight against TB and HIV and make the case for a regional response to these epidemics by the Global Fund and European Union institutions.

THE GLOBAL FUND AND IT'S NEW FUNDING MODEL

To date, the Global Fund has been one of the most successful global health efforts in history. Since its creation in 2002, Global Fund supported programmes have saved 8.7 million lives. In EECA, programmes financed by the Global Fund have detected and treated more than 380,000 cases of TB and at least 64,000 people living with HIV are currently receiving life-saving antiretroviral therapy (ART).⁷

In November 2011, the Global Fund Board approved the 'Global Fund 2012-2016 Strategy', which aimed to increase the impact of its programmes by becoming "more flexible, iterative and better-informed". A year later, in November 2012, this translated into the adoption of a New Funding Model (NFM) that dramatically changes the way the Global Fund invests. The NFM was designed to incorporate the lessons learned from the Global Fund's previous rounds-based system of funding. The rounds-based system has been in use since the Global Fund's launch in 2002 and was the subject of growing criticism. Complaints included that the rounds-based system was "unnecessarily complex and resource intensive requiring huge amounts of time and money at country level to draft proposals that were mostly not approved".⁸

Under the NFM, the Global Fund seeks to offer better 'value for money' and will direct resources to where they are most needed and can have the biggest impact. In addition, the NFM aims to give grant applicants more flexibility in terms of timing and when they can apply for funds as well as more predictability in terms of levels of funding available while also encouraging countries to express full demand. The full implementation of the NFM will begin in late 2013, although there has been the opportunity for some countries to apply for funding as early or interim applicants.

Significantly, as a result of the shift in focus to where resources are most needed and can have the biggest impact, some countries will now be eligible for much less funding than was previously the case.

Eligibility of funds is determined by the Global Fund's 'Eligibility, Counterpart Financing and Prioritisation' policy. A list of eligible countries is updated annually to reflect changes in income level and disease burden. Countries that are eligible (at the beginning of 2013 there were a total of 126 countries) are placed into four categories or country bands:⁹

- Band 1: Lower income, high burden – (29 countries, 53% funding share)
- Band 2: Lower income, low burden – (20 countries, 7% funding share)
- Band 3: Higher income, high burden – (17 countries, 31% funding share)
- Band 4: Higher income, low burden – (60 countries, 10% funding share)

On the surface, this rationale appears to make sense. It seems logical to direct resources to countries that struggle the most to finance their own health programmes. However, the vast majority of WHO European Region countries will be categorised into Band 4 despite the fact that many of these countries disproportionately suffer from high burdens of drug-resistant TB and where the number of new HIV infections continues to increase within key vulnerable and marginalised populations. **The new band classification means that the EECA will receive just three percent of total Global Fund resources – translating to 50 percent less funding than was previously allocated.**¹⁰

7. Global Fund to Fight AIDS, Tuberculosis and Malaria (2013) Grant Portfolio, [Online: <http://portfolio.theglobalfund.org/en/Home/Index>].

8. Eurasian Harm Reduction Network (2013) *The Global Fund's New Funding Model: What it Might Mean for You and Your Country*, EHRN.

9. Global Fund to Fight AIDS, Tuberculosis and Malaria (2012) 'Evolving the Funding Model', *Twenty-Eighth Board Meeting*, GF/B28/02.

10. Eurasian Harm Reduction Network (2013) *The Global Fund's New Funding Model: What it Might Mean for You and Your Country*, EHRN.



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EU DIFFERENTIATION POLICY

The European Union (EU)'s policy of 'differentiation' guides the EU's development policy and determines its allocation of aid by setting eligibility criteria that differentiates between the needs and capacities of developing countries.¹¹ This is particularly relevant as the EU has a seat on the Board of the Global Fund and, as a member, has the ability to influence the Global Fund's eligibility criteria which determine the amount of resources available to middle-income countries.

Differentiation has long characterised the EU's development policy but was significantly reinforced in 2011 with the adoption of the European Commission (EC)'s 'Agenda for Change' Communication.¹² The proposal, endorsed by EU Member states in May 2012,¹³ made differentiation a key feature of EU development strategy and has considerably altered modalities and the allocation of EU aid to developing countries. The 'Agenda for Change' stresses that countries whose economies are already on a path for sustained growth or are able to generate their own resources are excluded from receiving grant-based bilateral aid. It describes how EU aid will be concentrated in countries with the highest need and where it can have the greatest impact.¹⁴

The 'Agenda for Change' also envisions new forms of development partnership for countries that have graduated from aid, aiming to create relationships that are based on exchange and mutual interests. Yet how these partnerships will be implemented remains vague. Without appropriate 'phasing out' of existing aid or identifying and securing alternative financing, 'graduate' countries can experience a collapse of funding for health and other development sectors.

The differentiation principle will be applied to EU financial instruments for external action during the period 2014-2020 and will have major consequences for how EU aid is allocated. The new eligibility criteria (needs, capabilities, commitments and performance, and potential impact of EU aid) will increase the amount of EU aid allocated to low income and fragile states. At the same time the criteria will make countries that individually make up more than one percent of the world's GDP, such as China and India, and upper-middle-income countries, such as Kazakhstan, ineligible for EU bilateral aid. However, these criteria do not take into account that country income is not an indicator of the number of people who have access to health services. This form of GDP-based graduation fails to recognise that the majority of the world's poorest people continue to live in middle-income countries and that these countries continue to make up the majority of the global disease burden.¹⁵

11. Historically, the EU applied different instruments for development cooperation to different countries and regions, in particular to African, Caribbean and Pacific countries. The 'European Consensus on Development' (2005) defined differentiation as a necessity (art. 57) and set out specific criteria for aid allocation, notably needs and performance (art. 23).

12. Communication from the European Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, 'Increasing the Impact of EU Development Policy: an Agenda for Change', 13 October 2011.

13. Council conclusions, 'Increasing the Impact of EU Development Policy: an Agenda for Change', 3166th Foreign Affairs Council meeting, Brussels, 14 May 2012.

14. Chapter 4 – Differentiated Development Partnership.

15. Glassman, A. et al. (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.

THE BURDEN OF TB AND HIV IN THE EUROPEAN REGION

TB

Tuberculosis remains a significant problem worldwide and the WHO European Region is no exception. **In the WHO European Region, 360,000 people develop TB every year.** Although estimates indicate that overall TB rates in the region have been falling at a rate of about five percent per year since 2000, **40,000 in the region people continue to die from the disease every year.**¹⁶ TB is also closely linked with HIV as individuals living with HIV are 30 times more likely to develop TB, and the disease continues to cause a quarter of all AIDS-related deaths.

TB continues to threaten public health in the region due to a failure to adequately fund TB care and control programmes over the past two decades. In addition, an absence of investment in TB research and development has resulted in a lack of new tools to fight TB. These failures have led to rising rates of drug-resistant TB.

Drug-resistant TB occurs when TB cases are inappropriately managed and treatment is erratic or interrupted. This was particularly the case with the collapse of public health systems that accompanied the fall of the Soviet Union. Multidrug-resistant TB (MDR-TB) is a particularly virulent strain of the disease that is resistant to the two most powerful first-line anti-TB drugs. MDR-TB is much more expensive to treat, and the drugs for MDR-TB are more toxic with severe side-effects.

In 2012, there were an estimated 74,000 MDR-TB cases in the WHO European Region.¹⁷ **The region makes up 13 percent of the global population but accounts for nearly a quarter of the global MDR-TB burden.** Fifteen of the 27 high MDR-TB burden countries worldwide are located in the European Region. These include five EU Member states: **Romania, Bulgaria, Estonia, Lithuania and Latvia.**

These statistics are alarming given the increased treatment costs for MDR-TB. TB treatment in the 'new' EU Member states costs €2,600 for a standard case of TB compared to €24,000 for MDR-TB. In the wealthier EU Member states it costs €7,800 to cure a standard case of TB and €55,000 for MDR-TB. **It is conservatively estimated that economic cost of TB in the EU amounts to €5.9 billion per year.**¹⁸

In response to the rising rates of drug-resistant TB, WHO Europe launched a '**Roadmap to prevent and combat drug-resistant tuberculosis**'.¹⁹ Although the plan was fully endorsed by all 53 Member states in 2011, political and financial will to implement the plan has been lacking. Within the Plan, **WHO Europe also singled out the European Commission as a key player in financing the response to drug-resistant TB in the region.**

In a globalised world with increasing amounts of travel due to business and tourism, as well as the freedom of movement for people within the EU, the challenge of responding to drug-resistant TB is enormous. **TB does not respect borders, and any efforts made to make a significant impact against this disease must be regional and trans-national.** This is where the EU can play a vital role. European institutions must recognise that TB and MDR-TB are cross-border threats that require regional political leadership from the EU.

16. World Health Organization (2013) *Global TB Control Report 2013*, Geneva: WHO.

17. Ibid

18. Diel, R. et al. (2013) 'Costs of tuberculosis disease in the EU – a systematic analysis and cost calculation', *European Respiratory Journal*, [Epub ahead of print].

19. WHO 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: WHO Regional Office for Europe.



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HIV AND HARM REDUCTION

There is no doubt that the past decade has seen significant improvements in HIV care and control, especially in terms of advances in treatment and improving access to antiretroviral treatment (ART). Despite these successes, little progress has been made in terms of stopping new infections and the number of AIDS-related deaths in much of the wider European Region.

While the rate of new HIV cases is declining in most parts of the world, this is far from the case in EECA. New HIV infections increased from 130,000 in 2001 to 140,000 in 2011.²⁰ AIDS-related deaths have also been on the rise. Deaths in the region increased 21 percent between 2005 and 2011 from 76,000 to 92,000. UNAIDS estimated there are currently 1.4 million people living with HIV in the region today. Strikingly, only a quarter of the people eligible for ART are receiving it.²¹

One of the key drivers of the HIV epidemic in the region is people who inject drugs (PWIDs). Rates are high among this population as PWIDs are far less likely to have access to or are willing to seek treatment. **This is a result of high levels of stigma, criminalisation and harassment, which decrease the ability of PWIDs to seek out health services.**²²

Harm reduction efforts have been shown to reduce the risk of HIV transmission for PWIDs through interventions such as the provision of clean injecting equipment via needle and syringe exchange programmes or the provision of substitution treatment. **Of the 30 countries in EECA, 11 have low coverage of needle and syringe programmes, four of which are within the EU: Latvia, Lithuania, Poland and Romania.**²³ Despite clear evidence that these interventions have significant beneficial impacts, many governments continue to oppose funding or even allowing harm reduction programmes.²⁴

Although the political will to mobilise investments for harm reduction interventions is lacking in many countries, some action is being taken. WHO Europe recently launched the ‘**European Action Plan for HIV/AIDS 2012-2015**’, which calls for accelerated action, stronger political commitment, increased investment and a comprehensive response to HIV/AIDS in the region.²⁵

THE IMPACT OF DIMINISHING AID TO MIDDLE-INCOME COUNTRIES

Donors using national income levels as criterion for cutting aid to middle-income countries represents a worrying trend. While the past decade has seen many countries transition from low- to middle-income status, their new classification does not take into account widespread levels of poverty and growing inequalities within middle-income countries. **Of the top ten countries contributing to global poverty, only four are low-income.**²⁶ Income classification also fails to reflect that collectively middle-income countries account for the majority of all TB and HIV cases worldwide: **Eight out of ten of the highest TB burden countries are middle-income and only 30 percent of HIV-positive individuals live in low-income countries.**²⁷

Many argue that as countries move to middle-income status, they should pay for health programmes themselves. **However, this argument ignores the fact that national health expenditure, in addition to financial constraints, depends on political will.** Many governments in the EECA region are unwilling to prioritise health programmes and fail to recognise the importance of investing in health, in particular when it comes to funding programmes for vulnerable and socially excluded groups.²⁸ This is where the role of external donors, including the Global Fund and the EU, have a vital role to play in reaching populations that are neglected by their own governments.

The Global Fund has ambitious targets for reducing the global burden of TB and HIV, but it cannot achieve these if it does not invest in middle-income countries. The arrival of the Global Fund’s NFM heralds an uncertain period for many EECA countries. **A Global Fund simulation conducted in January 2013 indicated that just three percent of total resources would be allocated to EECA; this represents a 50 percent decrease compared with what was previously available.**²⁹

20. UNAIDS (2012) *Regional Factsheet 2012: Eastern Europe and Central Asia*.

21. Ibid

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

23. UNAIDS (2012) *Regional Factsheet 2012: Eastern Europe and Central Asia*.

24. McLean, S. (2012) *HIV, Drug Use and the Global Fund: Don’t Stop Now*, Hove: International HIV/AIDS Alliance.

25. WHO Europe (2011) *European Action Plan for HIV/AIDS 2012-2015*, Copenhagen: WHO Regional Office for Europe.

This dramatic decrease is frightening given that 15 out of the 27 high MDR-TB burden countries in the world are in the WHO European region. Additionally, while rates of new HIV infections have been falling on a global level, they continue to rise in the EECA region. With the Global Fund limiting support available to countries in the region because of their higher-income and relatively lower disease burden (Band 4) status and other donors such as USAID pulling out, there are serious concerns for future financing of TB and HIV programmes and for the people affected.

As recently as November 2012, the European Commission recognised that stigma and discrimination remain a real problem in Europe directed at people living with HIV/AIDS. It made clear that it is aware it drives people away from seeking help and care and fuels an increase in HIV transmission.³⁰ A similar story can be applied to TB, where stigma and a general lack of awareness are known to stop people from accessing the treatment they need.

The Global Fund has been critical in fighting this stigma, providing services to key marginalised groups in the EECA region. In December 2012, a group of 18 networks and NGOs from the region expressed their concerns about the Global Fund scaling back its support to the region, remarking that where people living with the diseases have traditionally been criminalized and excluded, the Global Fund has pushed for their human rights and full inclusion.³¹

The real impact of the changing donor landscape in the region remains to be seen. However, there is legitimate worry about what such a transition will mean for people affected by TB and HIV. The following case studies illustrate the importance of ensuring sustained funding in order to eliminate TB and HIV as serious public health threats.

26. Glassman, A. et al. (2012) *Global Health and the New Bottom Billion: How Funders Should Respond to Shifts in Global Poverty and Disease Burden*, Center for Global Development.

27. Glassman, A. et al. (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.

28. Eurasian Harm Reduction Network (2013) *The Global Fund’s New Funding Model: What it Might Mean for You and Your Country*, EHRN.

29. Ibid

30. European Commission (2012) *The Fight Against HIV/AIDS by the EU*, MEMO/12/929.

31. Garmaise, D. (2012) ‘EECA NGOs Express Concerns About Recent Developments at the Global Fund’, Aidspace.



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AZERBAIJAN

In Azerbaijan, the burden of TB remains worryingly high. Especially alarming are the rates of multidrug-resistant TB (MDR-TB). The most recent data available estimates that 11,000 people in Azerbaijan develop TB every year and of these nearly a quarter have drug resistant strains.³² **Azerbaijan is listed as one of 27 high MDR-TB burden countries in the world and has the third highest MDR-TB rate in the world.**³³

The rising rates of drug resistance in Azerbaijan are of particular concern and require an aggressive and sustained response. Although the Azeri Government has been increasing funding for its national TB budget, **the WHO has described political support for the National Tuberculosis Programme as “suboptimal”.**³⁴

A large amount of funding for TB care and control has come from external sources. The Global Fund is a key financier of TB related components and programmes in Azerbaijan. Since 2006, the Global Fund has provided almost \$23 million for the treatment of TB and MDR-TB in Azerbaijan, a figure that is expected to reach \$33 million by 2015.³⁵ Global Fund financing has been used to improve case detection and diagnosis, ensure quality treatment, and manage the spread of drug-resistant TB. Grants have also been successfully used to support vulnerable and at-risk populations, including prisoners, internally displaced persons and people living with HIV.

USAID has also provided significant support to Azerbaijan and has worked in collaboration with both the Ministry of Health and Ministry of Justice. Together with the Ministries and other national partners including CSOs, USAID has helped modernize TB reporting and patient tracking, has developed TB clinical practice guidelines, and has helped train doctors.

Despite having received significant levels of international financing in the past, international assistance for health programmes is decreasing. This is mainly due to the country's large oil reserves, which resulted in a rapid economic boom that increased GDP from around \$7 billion in 2003 to \$67 billion just under a decade later,³⁶ moving Azerbaijan from lower-middle-income to upper-middle-income status.³⁷ Consequently, USAID and World Bank support will both be phased out of the country by the end of 2013.³⁸ The Global Fund will continue to deliver funding through existing grants until the end of 2015. However, under the New Funding Model Azerbaijan is classified in Band 4 (higher income, low burden) and, as a result, it is highly unlikely that the country will receive anywhere near the same level of financial support once current grants come to an end.

Azerbaijan must scale up its response and recognise that its TB problem needs to be resourced

32. WHO (2012) *Global Tuberculosis Control Report 2012*, Geneva: World Health Organisation.

33. WHO Europe (2012) *Tuberculosis country work summary: Azerbaijan*, Copenhagen: WHO Regional Office for Europe.

34. Ibid.

35. WHO Europe (2012) *Review of Tuberculosis Prevention, Control and Care in Azerbaijan*, Copenhagen: WHO Regional Office for Europe.

36. World Bank (2013) *World Development Indicators: Azerbaijan*, The World Bank Group.

37. World Bank (2013) *Country and Lending Groups*, The World Bank Group.

38. The Global Fund to Fight AIDS, Tuberculosis and Malaria (2013) *Diagnostic Review of Global Fund Grants to the Republic of Azerbaijan*, GF-OIG-13-007.



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domestically, but this is unlikely to occur without strong calls from domestic CSOs and stakeholders. The Global Fund has historically funded CSOs in Azerbaijan, yet this funding is also coming to an end. CSOs centre their work around TB care and control and carry out advocacy, communication and social mobilisation (ACSM) activities which help to hold the Azeri Government accountable and address resistance to funding health programmes. CSOs also build trust within communities, particularly among the most marginalised and vulnerable, in order to reduce stigma and improve TB case finding and treatment adherence.

To maximise the potential of civil society, greater financial support must be given to CSOs working in the country. While health is currently not a priority area for the EU delegation in Azerbaijan, there is strong potential for the EU to engage with and financially support CSOs who are actively working on health, and TB.

With external donors leaving en masse over the next few years, the future of TB care and control in Azerbaijan remains uncertain. The Azeri Government has the capacity to address the TB situation and aggressively scale up its response to MDR-TB. **What is missing is the financial and political commitment to take the place of external funding sources such as the Global Fund. Civil society must be supported in both their programmatic and advocacy activities to ensure the Azeri government increases its own investments in fighting TB.**



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ALBANIA

Albania remained somewhat sheltered from the HIV/AIDS epidemic through much of the 1980s and into the early 1990s. However, with the collapse of Communist rule in 1992 much in the country began to change, including the relaxation of restrictions on freedom of movement. As a consequence, Albanians were exposed to many more sexual and behavioural risk factors associated with HIV/AIDS.

HIV rates in Albania have been on the rise since the fall of Communism. Although total figures are relatively low on a population level, **rates are high among key marginalised and most-at-risk populations, including people who inject drugs (PWIDs).** Rates of drug use in Albania have been increasing since the early 1990s and with them, so have rates of HIV.³⁹ PWIDs are more likely to engage in high-risk activities such as sharing used drug equipment, having unprotected sex with unknown or multiple partners and selling sex to buy drugs.

Harm reduction programmes have been proven to mitigate risk among PWIDs including needle exchange programmes (NEPs) and the provision of opioid substitution therapy (OST). It is therefore vital that harm reduction programmes receive the necessary support in Albania. Without them, the risk of HIV transmission for PWIDs and other vulnerable groups, such as sex workers, will remain unacceptably high. CSOs have proven their ability to carry out such programmes,⁴⁰ and yet, **despite substantial evidence for their effectiveness, existing harm reduction efforts have been fragmented and do not receive sufficient levels of funding from the Albanian Government.**⁴¹

The Albanian Parliament recently approved its ‘National Drugs Strategy 2012-2016’, which raises the issue of harm reduction,⁴² indicating that there is some awareness of its importance. In practice, however, there is only one agency funded by the Albanian Government that provides grants for CSOs: the Agency for the Support of Civil Society (ASHMC). ASHMC does not provide funding for harm reduction or NEPs. **There is no other national body that provides support for CSOs delivering harm reduction programmes.**⁴³

Albanian law has also been a considerable barrier to carrying out harm reduction programmes. While the law does not restrict NEPs from operating, it does little to facilitate or encourage them. **Many police officers impede NEPs by interpreting needle distribution as “facilitation of drug intake and use” and, on occasion, keeping NEP staff from carrying out their work or even incarcerating them.**⁴⁴

39. Boci, A. (20 13) *Is Albania Getting to Zero HIV Infection Among Injecting Drug Users?: Implications of loss of new funding opportunities for Harm Reduction programmes in Albania*, Eurasian Harm Reduction Network.
40. Aksion Plus (2013) OST treatment in Albania.
41. Ibid
42. European Monitoring Centre for Drugs and Drug Addiction (2013) *Country overview: Albania*, Lisbon: EMCDDA.
43. Boci, A. (20 13) *Is Albania Getting to Zero HIV Infection Among Injecting Drug Users?: Implications of loss of new funding opportunities for Harm Reduction programmes in Albania*, Eurasian Harm Reduction Network.
44. Ibid



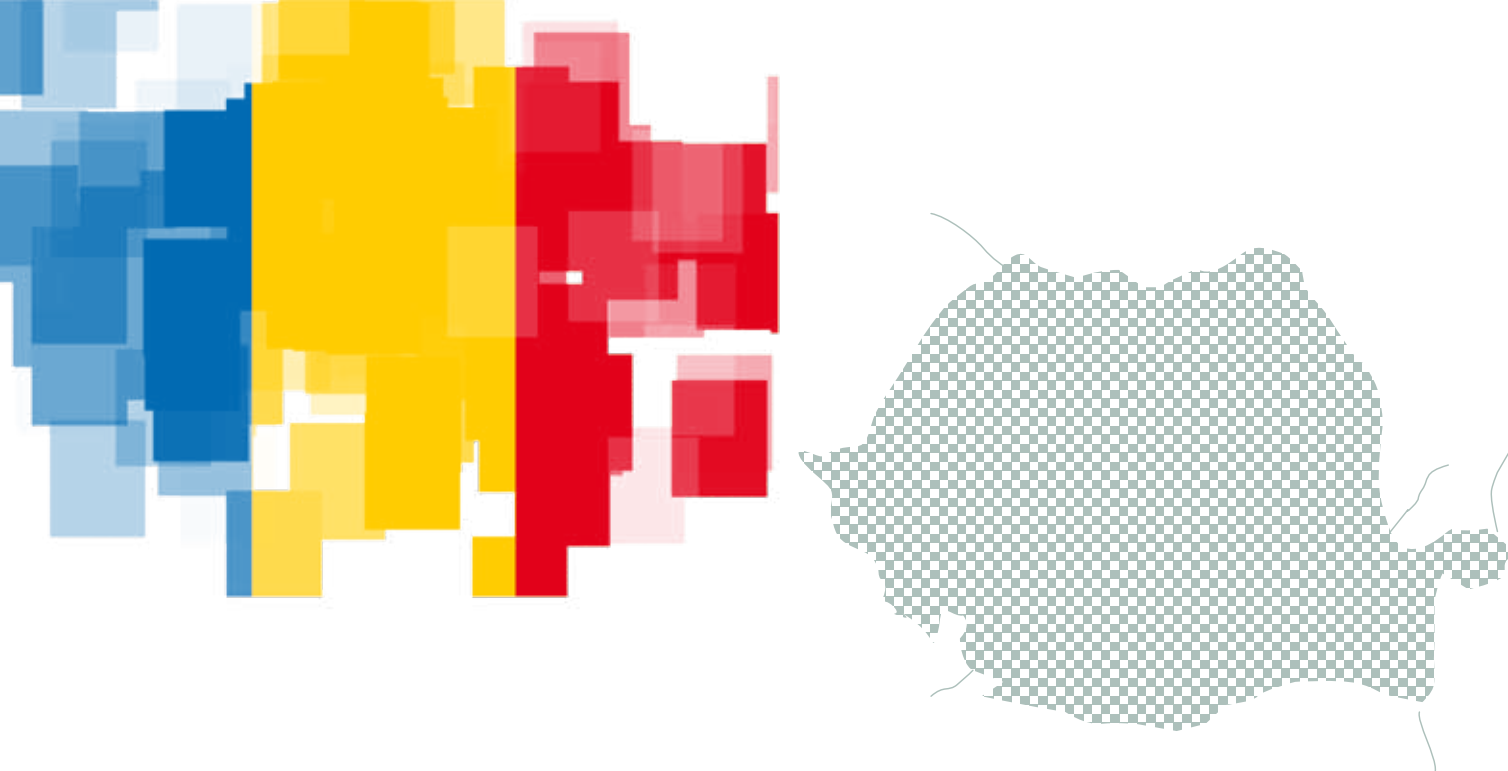
In the past, support from external donors has allowed CSOs to deliver much needed harm reduction programmes. However, as of March 2012, the four NGOs that were providing NEPs for PWIDs are no longer receiving funds. Certain NEPs are currently only surviving through the volunteer work of a select few who are only able to provide small scale and disjointed interventions.⁴⁵ Given that Albania has graduated from lower- to upper-middle-income country status, it is even less likely that they will receive support from external donors that have been so important in the past.

International agencies, including UNICEF, UNFPA and the Open Society Foundation, have been instrumental in funding HIV intervention programmes for at risk groups. However, at least for the 2013 fiscal year, these agencies are not planning on supporting harm reduction programmes in Albania.⁴⁶ The Global Fund, which has given considerable support to vulnerable groups at high risk of HIV transmission, is also unlikely to continue funding at levels similar to the past.

Without financial support for CSOs to carry out harm reduction programmes, many vulnerable populations will be at a heightened risk for HIV infection. This is particularly true given the slow response from the Government. It is paramount that the EU delegation in Albania uses the political and human rights country dialogues to ensure that harm reduction programmes are supported by the Albanian Government.

45. Boci, A. (20 13) *Is Albania Getting to Zero HIV Infection Among Injecting Drug Users?: Implications of loss of new funding opportunities for Harm Reduction programmes in Albania*, Eurasian Harm Reduction Network.
46. Ibid





ROMANIA

Romania is one of WHO Europe's 18 high priority countries for TB. **In 2011, Romania accounted for 27 percent of all TB cases within the EU.** Romania has particularly low levels of treatment success, with previously treated patients making up nearly a quarter of all TB cases. This is especially worrying as patients who have been previously treated for TB are much more likely to develop drug resistance. In Romania, 19 percent of previously treated cases are now multidrug-resistant.⁴⁷

A lack of resources combined with deep-rooted stigma have made fighting TB in Romania incredibly difficult. Stigma often prevents individuals with TB symptoms from seeking health services, meaning they are not diagnosed and do not receive treatment. Even when TB patients are treated, only three quarters of Romanian TB patients successfully complete their treatment. This figure is much lower for those with drug-resistant TB: **only 16 percent of MDR-TB patients are successfully treated after 24 months—one of the lowest rates in the world.** By comparison, the average for the entire WHO European Region is 49 percent.⁴⁸

The Romanian National TB Programme is severely underfunded. The National TB Programme was supposed to receive €10 million in domestic funding for 2013 but was only allocated €4 million – a small fraction of the resources needed to respond to its TB epidemic. In October 2012, the Romanian Government approved a national plan to fight MDR-TB and committed to spend €5.75 million in 2013 responding to drug-resistant TB. However, the Romanian Parliament failed to allocate the budget necessary and, to date, the plan remains unfunded.

The Global Fund grant to Romania provides drugs used to treat MDR-TB and XDR-TB (extensively drug-resistant TB, resistance that develops on top of MDR-TB). The drugs provided through the Global Fund are not available through any state-funded treatment. Global Fund financed treatment successfully treats 70 percent of MDR-TB patients – much higher than state-funded treatment, which has just a 16 percent success rate due the local pharmaceutical industry not producing the drugs needed and regulations preventing the Ministry of Health from purchasing drugs from the WHO's Global Drug Facility.

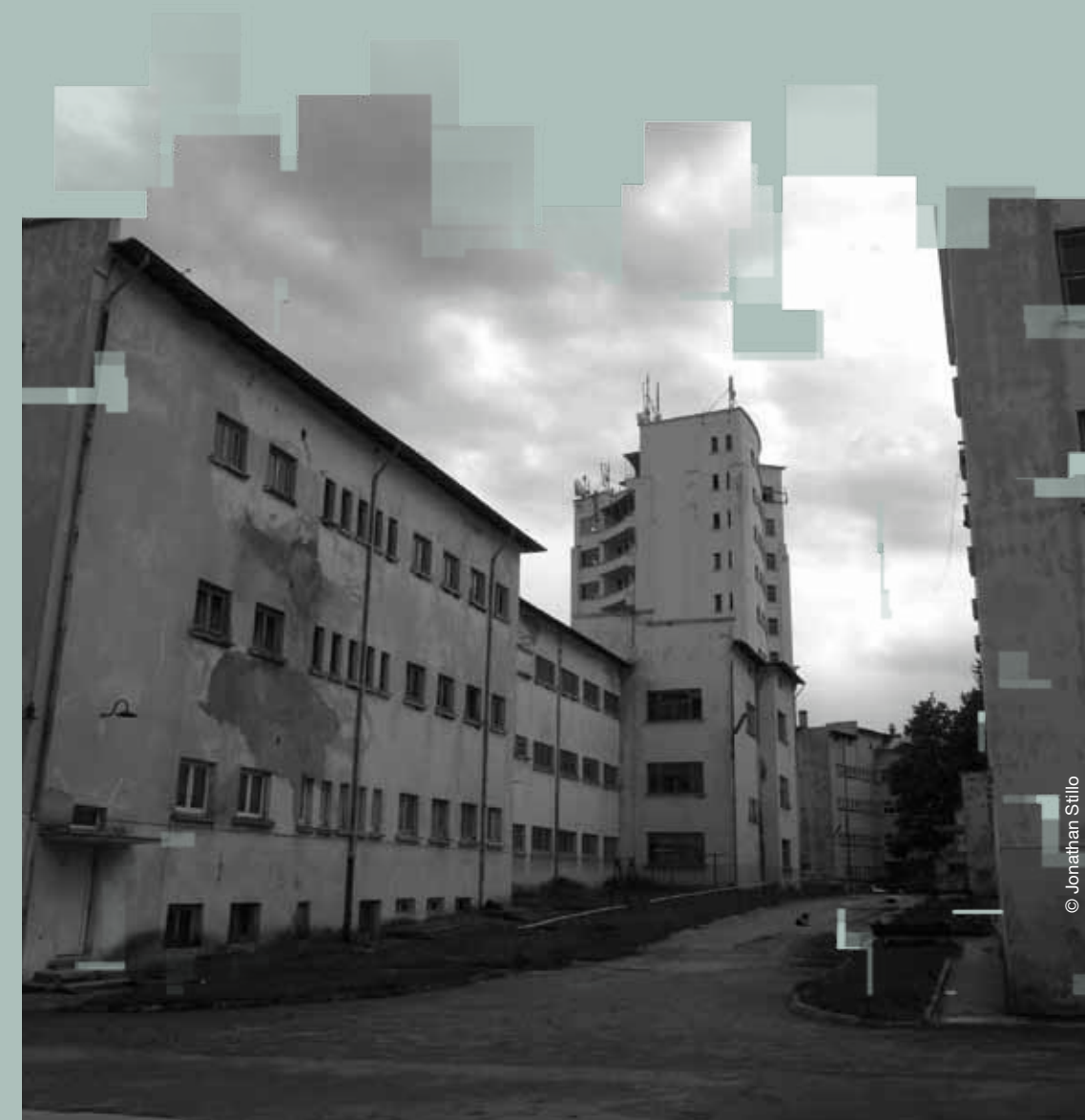
47. European Centre for Disease Prevention and Control/WHO Regional Office for Europe (2013) *Tuberculosis Surveillance and monitoring in Europe 2013*, Stockholm: European Centre for Disease Prevention and Control.

48. Ibid

Romania's current Global Fund grant is supposed to continue to ensure an uninterrupted supply of MDR and XDR-TB drugs as previous grants have done. However, due to changes in local legislation, the drugs have not been allowed to enter the country, leaving Global Fund supported patients facing drug stock-outs or having to opt for the lower quality state-funded treatment. Even with the Global Fund grant, the drugs provided only cover a small proportion of individuals with drug-resistant TB, and a **scale-up in funding is desperately needed in order to aggressively tackle drug resistance.**

Dr Mihaela Stefan, TB Monitoring and Evaluation Officer of the Romanian Angel Appeal Foundation, explained that every day she hears of more patients who develop extensively drug-resistant TB and no longer respond to any of the treatments available in Romania. Dr Stefan recalls the story of a 29-year-old woman with XDR-TB who weighed a mere 36kg and her left lung had lost two thirds of its function. Romanian doctors told her she could not be treated with drugs available in Romania. Dr Stefan explained, ***"She was lucky as her mother works in Italy and so she was able to go to Milan to ask the doctors to treat her there."***

Romania must step up its domestic response to TB. **However, increased global travel that allows diseases such as TB and drug-resistant TB to spread more easily demonstrates that Romania's TB epidemic is not simply a national issue. TB is a cross-border health issue that will require a regional response and cannot be left to countries to deal with independently.** The EU must recognise that tackling TB and responding to drug resistance will require strong political leadership at the EU level.





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RECOMMENDATIONS

Investing in a healthy society is a key determinant of poverty eradication and sustainable development. As the EU global health strategy recognises, health is a crucial factor for improving social justice and equality.⁴⁹ Strengthening health systems should therefore remain at the centre of EU policies and bilateral assistance due to the important role it plays in furthering key EU development goals.

Many EECA countries provide evidence that GDP-based graduation is not an indicator of strong social policies and functioning healthcare services. The reinforcement of the differentiation principle within both the Global Fund's New Funding Model and the EU development agenda not only poses a threat to health achievements made in many of middle-income countries, it can also lead to a financing vacuum for donor dependents TB and HIV programmes with disastrous consequences for the region's citizens. Considering the rapid increase in rates of drug-resistant TB and the continuing rise in new HIV infections and AIDS-related deaths in the region, the EU finds itself in a dangerous position. **The EU has two options: to adequately fund the fight against TB and HIV or to ignore these diseases at its own peril and risk a greater public health emergency.**

While we all agree that countries should ultimately bear the primary responsibility for financing their own health systems, many EECA governments lack the financial capacity or political will to deliver adequate health services to their populations. Even when countries have the resources to do so, lack of prioritisation, corruption or unwillingness to tackle diseases that primarily affect marginalised groups have kept TB and HIV high on the list of public health threats.

We therefore call on the EU to provide the economic and political assistance needed to support the transition process towards ownership of national health responses. This can be done through existing cooperation agreements and financial instruments and must include capacity strengthening of local civil society and their role in shaping the national and regional health agendas. Finally, as the largest international donor for TB and HIV in the region, we also make key recommendations to the Global Fund.

49. Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, The EU Role in Global Health, 31 March 2013

IN ORDER TO ADDRESS THE FUNDING SHORTAGES FOR TB AND HIV PROGRAMMES IN THE EECA REGION, EUROPEAN UNION INSTITUTIONS SHOULD:

- **SCALE UP** their contribution to the Global Fund to €450 million for 2014-2016, given Global Fund activities strongly align with EU development objectives and given its track record of promoting and supporting human rights in the region;
- **ADOPT** a holistic approach to differentiation based on multi-dimensional causes of poverty, eliminating country-income thresholds. This approach should be based on in-depth analyses of present and future country needs and should take into account poverty, inequality and vulnerability levels; access to social protection and services and other deprivations indexes; and national trends and policies being implemented by national governments;
- **EARMARK** at least 20 percent of the Development Cooperation Instrument (DCI) for health and basic education;
- **DEVELOP** an action-oriented Global Health Programme for Action with time-bound targets in consultation with civil society;
- **BUILD CAPACITY** of health civil society organisations to enhance participatory decision-making processes, hold national governments to account and help shape inclusive national health agendas through the DCI Civil Society Organisations and Local Authorities thematic programme;
- **ALLOCATE** a significant share of the new revenues produced by the European Financial Transaction Tax to development cooperation, including global health programmes, and explore other innovative financing mechanisms that can generate additional revenues at EU level;
- **FACILITATE** transition of countries that have 'graduated' from EU aid by strengthening local non-state actors' capacity to advocate for better national health responses from the bottom-up;
- **INCLUDE** health and social sector issues in bilateral political and human rights dialogues with EECA countries.

AS A BOARD MEMBER OF THE GLOBAL FUND, THE EUROPEAN COMMISSION SHOULD:

- **SUPPORT** the development of new eligibility criteria to make exceptions for middle-income countries by focusing on, for example, trends in disease prevalence and access to prevention and treatment, especially in key affected populations;
- **CONTRIBUTE** to the definition of mechanisms for the allocation of Global Fund funding prioritising interventions to address vulnerable groups' needs in higher income countries;
- **REAFFIRM** the importance of CSOs and community-based organisations in health systems by enhancing participation in the development of Global Fund concept notes and in Country Coordinating Mechanisms.

IN ADDITION, THIS REPORT RECOMMENDS THE GLOBAL FUND SHOULD:

- **RE-EVALUATE** country eligibility criteria based on income to make allowances for affected EECA countries, acknowledging that country income is not always a useful indicator for access to health services or health inequalities within a country;
- **INCREASE** the proportion of resources available to the EECA region, recognising the economic burden drug-resistant TB will pose if there is a failure to tackle it aggressively, and knowing that abandoning support for HIV and harm reduction programmes has human rights implications for key populations that are most at risk.



AT THE SUB-REGIONAL LEVEL, THE EUROPEAN UNION INSTITUTIONS SHOULD:



FOR EU MEMBER STATES WITH A HIGH-BURDEN OF TB AND/OR HIV (Bulgaria, Estonia, Latvia, Lithuania, Romania):

Via structural funds, which are intended to narrow the development disparities among EU member states and regions, the EU has the opportunity to reduce health inequalities that continue to exist within its territory. On the basis of the Common Strategic Framework 2014-2020, which clearly identifies health investments within both the European Social Fund (ESF) and the European Regional Development Fund (ERDF) as key in promoting social inclusion and combating poverty, we call the European Commission to:

- Raise specific health issues in the preparation and review of the National Strategic Reference Framework and in the annual country-specific recommendations of TB and HIV in high-burden countries in order to help prioritise health investments under the ESF and the ERDF;
- Ensure that 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 greatest impact on harm reduction and patient support activities.



FOR EASTERN PARTNERSHIP COUNTRIES (Armenia, Azerbaijan, Belarus, Georgia, Moldova, Ukraine):

These countries, to differing extents, have expressed their interest in building closer relations with the EU and are undertaking political, economic and social reform in this direction. We urge the EU to use its political relations and financial instruments with these countries to:

- Ensure that at least one of the three priorities for bilateral cooperation addresses social sector issues such as health and education;
- Staff its EU country delegation 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 political dialogues, human rights dialogues and at EC inter-service meetings.



FOR THE RUSSIAN FEDERATION:

The recent shift from a recipient to donor country and its graduation to a high-income country essentially leaves Russia's marginalised populations on their own. We therefore urge the EU to:

- Encourage Russia, through political and human rights dialogue, to implement evidence-based policies and programmes to tackle the root causes of its HIV and TB epidemics at a national level, with a particular focus on the needs of the most at risk populations;
- 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;
- Provide direct financial and technical support for sustaining HIV, TB and harm reduction activities in Russia through the support of non-state actors advocating for and implementing programmes in Russia. Thematic instruments such as the European Instrument on Democratisation and Human Rights (EIDHR) and thematic instruments under the DCI can be useful complementary tools for projects targeting vulnerable groups.



FOR CENTRAL ASIA

(Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan):

- Revise the EU-Central Asia Strategy to include health as one of its main priorities, or mainstream health in other sectors of activity (rule of law, water and environment);
- 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;
- Reinforce relations between EU and WHO delegations in Central Asia to ensure improved cooperation, especially with regards to the implementation of the WHO Europe's 'Roadmap to prevent and combat drug-resistant tuberculosis';
- Cooperate with the Global Fund on policy and delivery of TB and HIV programmes and request EU delegations participation in the Global Fund Country Coordination Mechanisms.



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.EU

WWW.RESULTS.ORG.UK