EURASIAN HARM REDUCTION NETWORK
ЕВРАЗИЙСКАЯ СЕТЬ СНИЖЕНИЯ ВРЕДА

The Global Fund's New Funding Model:

What it Might Mean for You and Your Country

Policy Brief

March 2013

Eurasian Harm Reduction Network

The Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programs, groups of people who use drugs (PUD) and their allies from across 29 countries of Central and Eastern Europe and Central Asia (CEECA) who work to advocate for the universal human rights of people who use drugs in order to protect their lives and health. EHRN's mission it is to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and well-being, whilst protecting human rights at the individual, community and societal level.

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1. Executive summary

Recipients of the Global Fund in Eastern Europe and Central Asia (EECA) have serious reservations about the new funding model (NFM) being launched by the Global Fund in 2013. HIV and TB epidemics continue to grow across the region and people living with and / or affected by the 3 key diseases (i.e. HIV/AIDS, TB and Malaria) experience persistent health and human rights challenges. Yet, based on allocation criteria developed by the Global Fund, most countries in the region have been placed in the lowest-priority eligibility category, which means they will have access to fewer funds and more restricted opportunities through the NFM.

The consequences are potentially dire for people in need in the region, especially the community and civil-society groups which provide critical services for them. The Global Fund is frequently one of the biggest (often only), source of funding for such services.

The following recommendations focus on some key issues in regards to the components and implementation of the NFM. All of these are based upon the actual concerns expressed by advocates and affected communities in the region:

1. Communities must be involved in all aspects of monitoring the NFM's roll out, including the transition phase.
2. Better information about the NFM needs to be made more widely available. The Global Fund should identify approaches to raise awareness about the NFM. These should be simple and clear to all partners in each country, including civil society and community groups which are implementing programmes at a community and grassroots level.
3. The Global Fund must be more directive and clear with regards to participation in country dialogues and expected outcomes. The Global Fund should clarify who is involved and in what capacity. All processes should be monitored to ensure meaningful participation by all country-level stakeholders (including MARPs).
4. Greater flexibility should be integrated into all NFM allocation formulas and decisions, and not just those of Country Band 4. They should take account of the barriers and experiences in EECA and other Middle Income Countries (MICs).

   In particular:

   - The Global Fund should develop and use new allocation criteria that do not automatically restrict funding for middle-income countries and those classified as 'low burden.'
   - The 'ceilings' that are currently a key part of the NFM structure should be reconsidered.
   - The Global Fund should provide sufficient flexibility in regards to 'disease split.'

   All of these steps are needed in order to allow full expression of need

5. The Global Fund should clarify exactly how the incentive funding stream will work and how countries (particularly) in Country Band 4 can access it. All countries should have equal access to money via this stream, not just 'easy' ones that are being rewarded. As a first step towards addressing imbalances in access, the Global Fund should review the incentive funding stream midway through the first three-year NFM cycle.

2. Methodology

The research for this policy brief was conducted during February 2013. It consisted of three main elements: a literature review; a questionnaire and then, semi-structured interviews. The literature review included publications identified through a Web-based search, as well as documents (e.g. PowerPoint slides), which were presented and disseminated at meetings that were organised to discuss the Global Fund's new funding model (NFM).

The questionnaire was drafted by the Eurasian Harm Reduction Network (EHRN) and was distributed to key Global Fund stakeholders at both, a global and country level (in four places: Armenia, Georgia, Moldova and Uzbekistan). Semi-structured interviews were also conducted by telephone with several stakeholders.

Those contacted with regards to the questionnaire and / or an interview included: representatives from the Global Fund Secretariat; technical agencies providing international guidance on HIV and TB issues; civil society and community groups. Interviews were conducted in either English or Russian.

Focus Countries

EHRN selected four countries in Eastern Europe and Central Asia (EECA) for targeted attention during the research: Armenia, Georgia, Moldova and Uzbekistan. They were selected because:

i) they all face challenges with regard to financial support for HIV and TB responses;

ii) they all rely significantly on Global Fund support to meet these challenges;

iii) they are all, currently, eligible for Global Fund support, and

iv) they are all placed in the lowest-priority NFM eligibility category (known as Country Band 4). Being in Band 4 places them in the worst position regarding access to Global Fund funding (including when compared with their eligibility for Round 11).

Despite this focus, the observations and information apply across most of the rest of EECA.

Aims and Objectives

This report has three primary objectives:

i) To explain to civil society representatives the basic components of the NFM.

ii) To summarize observations about the NFM, including concerns and opportunities which were identified during the research.

iii) To help support advocacy efforts, especially among civil society and community groups whilst providing the Global Fund with relevant recommendations. These are intended to help it address the concerns of civil society with regards to the NFM.

This publication is intended primarily for Global Fund stakeholders at country level in EECA, although many of the issues discussed have a much broader relevance as the Global Fund restructures its overall grant making system.

These brief aims are to provide as much basic information as possible which is simple, clear and concise. More details, along with comprehensive background information on the NFM can be found on the Global Fund website.[1]

[1] See www.theglobalfund.org/en/activities/fundingmodel/.

3. What is the New Funding Model (NFM)?

3.1 Background

In November 2012, the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) adopted a new funding model (NFM) that aims to change how it invests.

The development of the NFM was a main priority of the Global Funds 2012-2016 Strategy, which the Board approved in the previous year.

The NFM will replace the 'rounds-based' funding model that has been used since the Global Fund was launched more than a decade ago. That model faced increasing criticism for many reasons, including the fact that it was not as efficient or cost-effective as it should be or could be. Critics said, amongst other things, that the former funding model was unnecessarily complex and very resource intensive requiring huge amounts of time and money at country level, to draft proposals that were mostly not approved.

Another major criticism centred on the fact that, even when grants were awarded, it could take several months and up to a year or more for agreements to be signed, during which time countries were deprived of funds and unable to implement services to people in need.

The NFM was designed to offer increased *'value for money'* for both, the implementing countries and donors. That objective, which is a tenet of the Global Fund's new five-year strategy, means that the Global Fund and its partners should direct resources to where they are most needed and can have the biggest impact. As a result, decisions will place even greater emphasis on data and evidence regarding such need and impact.

According to the Global Fund, the main principles of the NFM are as follows:

- Greater alignment with country schedules, context and priorities.
- Focus on countries with the highest disease burden and lowest ability to pay, whilst keeping the portfolio global.
- Simplicity for both implementers and the Global Fund.
- Predictability of process and financing levels.
- Ability to elicit full expressions of demand and reward ambition.

3.2 The NFM in action: key information about the model

It's difficult to argue with the theories and principles regarding the NFM! - Who would oppose efforts to make the Global Fund processes more simple and predictable with better aligned country priorities, based primarily (if not exclusively) on evidence? The most important questions are based upon how it will work in practice...

The Global Fund has attempted to explain the mechanics of the NFM to a wide, diverse range of stakeholders over the past several months.

As of February 2013, the following core elements and steps appear to be the most relevant:

Eligibility

Eligibility for Global Fund support through the NFM will continue to be determined by the Eligibility, Counterpart Financing and Prioritization (ECFP) policy, which the Global Fund Board approved in May 2011. This policy identifies which countries are eligible for Global Fund support including the kind of support they can expect to receive. The eligibility list is updated annually to reflect changes in income level and disease burden.

At the beginning of 2013, a total of 126 countries were eligible to receive at least some type of support from the Global Fund.

Applicants must show that their proposed programmes will also attract financial support from the government; this requirement is known as `counterpart financing'. There are some important exceptions including: i) proposals for multi-country grants (also known as regional grants) and ii) proposals that are submitted independent of a country coordinating mechanism (CCM), also known as 'non-CCM' proposals.

Proposal Development

Proposals are to be developed through a process that, the Global Fund is calling **country dialogue**. The Global Fund says this is *"designed to be an inclusive process that provides a platform for all stakeholders to have their voices heard."* [2] Therefore, participants in this dialogue should include representatives from all sectors that the Global Fund considers to be 'partners', including government, civil society, and communities living with and affected by HIV, TB and Malaria.

The country dialogue process should result in a **concept note**. This document is not supposed to be a lengthy, comprehensive application. Instead, it should include a request for a specific amount of funding, whilst summarizing the country context, planned activities and interventions. Ideally, the concept note will be based upon the countries' national strategic plans (NSPs) for programming associated with the three diseases.

However, the Global Fund has said that, only 'robust' NSPs should serve as the basis for Global Fund proposals. One of its goals in the overall NFM structure is to support countries in developing strong NSPs.

The concept note should be sent to the Global Fund Secretariat for review. If needed, the Secretariat will work with country partners to improve the concept note to a high level of quality before sending it to the Global Fund's Technical Review Panel (TRP) - The independent group that evaluates all Global Fund proposals and submits recommendations regarding funding to the Board.

One of the major changes in the NFM is that the TRP will engage directly with applicants. After receiving the concept note, members of the panel will work with country stakeholders to develop a more in-depth and formal programme proposal based upon it. The Global Fund calls this collaboration the 'iterative process.'

The Secretariat and Global Fund Country Teams are expected to be involved during this stage as well. According to representatives from the Global Fund Secretariat, the concept note will "require that applicants document stakeholder involvement in the application development process, particularly efforts made to meaningfully engage key populations."[3]

A finalized proposal will then be presented to the Global Fund Board for approval. The proposal should be 'disbursement-ready.' This means that funds can start flowing to countries soon after approval. All proposals are expected to be designed to cover a three-year period.

Availability of Funds

Donors can and do contribute to the Global Fund at any time. For the purposes of planning, the Global Fund relies on a ***replenishment*** process in which, it solicits pledges from donors for the following three-year period. The most recent process will end with an announcement in October 2013 regarding the total amount pledged by donors for the period from 2014 through to 2016. This amount is what the Global Fund will have available to fund all Global Fund programmes during that upcoming period. As a result, the overall reach and scope of the NFM will depend upon the results of the replenishment.

In the NFM, the Global Fund will use a series of formulas to allocate programming resources. The goal is to indicate in advance a 'range' of how much money each country is eligible to receive over each three-year period associated with a replenishment cycle. The first step will be to divide available resources across the three diseases. The initial allocation by disease will be based on the Global Fund's historical 'split' which was until now,

[2] As cited in questionnaire submitted by a representative from the Global Fund Secretariat in February 2013.
[3] As cited in questionnaire submitted by a representative from the Global Fund Secretariat in February 2013. **Note:** The term 'key populations' in this explanation is a synonym for another commonly used term: most-at-risk populations, or MARPs. Both refer to people who use drugs, sex workers and men who have sex with men, among other populations.

52% of money for HIV, 32% for Malaria, and 16% for TB. According to Mark Dybul, the Global Fund Executive Director, these proportions will only apply for the period of transition to the NFM. This will be revisited prior to the full implementation of the NFM in 2014."[4] Also according to the Global Fund Secretariat countries will have flexibility within the NFM to shift resources across diseases, although if they shift more than 10%, this will trigger a review at the Secretariat before it is approved.

The next step will involve another formula that places all eligible countries into one of four categories, which the Global Fund calls ***country bands.***

The two criteria that determine a country's band are 'disease burden', and 'ability to pay'.

Disease burden is based on prevalence (the proportion of the total number of cases to the total population) and the 'ability to pay' is based on a country's national income per capita. The amount of resources allocated to each band will then be further divided amongst all the countries in it.

The four bands are as follows:[5]

Band 1: Lower income, high burden - (29 countries, 53% funding share)	**Band 3:** Higher income, high burden - (17 countries, 31% funding share)
Band 2: Lower income, low burden - (20 countries, 7% funding share)	**Band 4**[6]**:** Higher income, low burden - (60 countries, 10% funding share)

As of early February 2013, it had not yet been formally decided in which band all the eligible countries would be placed.

At that time, it was expected that 18 EECA countries would be eligible for Global Fund support in the future, and would thus, seek money through the NFM. Of those, nearly all - (i.e. 15) were expected to be grouped in Band 4, with one - (i.e. Ukraine) potentially in Band 3 and two others (Kyrgyzstan and Tajikistan) in Band 2.[7] The Global Fund plans to review the composition of the bands and revise allocation criteria (including allocation of total resources across diseases) at the start of each three-year allocation period.

Another important point about the bands is that countries will be placed in one band only, irrespective of any differences in regards to disease burden and across the three different diseases. Each country will be able to make its own decisions about how to 'split' its Global Fund money among the identified three diseases. However, applicants will need to explain their reasons for allocating funds in a way that does not reflect the needs associated with these three diseases.[8]

Types of Funding

Two types of funding will be made available through the NFM. The main type is called ***indicative funding***. This refers to a range of money available for each country over a three-year period. The amount is determined in advance through the allocation formula. The Secretariat will inform each applicant of its indicative funding range during the country dialogue process.

The other type of funding is called ***incentive funding.*** This refers to money that the Global Fund sets aside in a reserve fund. Applicants are required to compete for money provided through this source. The money is available

[4] As cited in a letter from Global Fund Executive Director Mark Dybul to 18 networks and NGOs from EECA. February, 2013. It is worth noting that, as this report was being finalized, the Global Fund announced funding decisions related to the NFM transition phase (see Section 3.3 of this report). According to information made available to the Global Fund on the 28th February, the 'disease split' for both new and existing funds for the 2013 -2014 period will be: 55% to HIV/AIDS, 27% to Malaria and 18% to TB.

[5] The distribution of countries and percentage of funding shared among bands, as presented in this table, is in accordance with GF/SIIC05/02, Annex 1. The Global Fund has said changes could be made prior to the full roll-out of the NFM in the second half of 2013.

[6] The term 'targeted pool' was often used to refer to Band 4 when the Global Fund was developing the NFM in 2012. That term is rarely used now and instead 'Band 4' is more common parlance.

[7] The other 15 EECA countries expected to be eligible for new funding in the transition are: Albania, Armenia, Azerbaijan, Belarus, Bulgaria, Georgia, Kazakhstan, Kosovo, Latvia, Lithuania, Moldova, Romania, Russia, Turkmenistan and Uzbekistan. Source: Global Fund document - "Eligibility list for new funding in the transition – 2013", March 2013.

[8] As cited during an interview with a Global Fund Secretariat respondent on 22nd February 2013.

to 'reward' countries that show evidence of high-quality programmes which have substantial impact. The money a country receives from this source is additional to the total it can receive through indicative funding.

The Global Fund has not designated the target percentage of all available funding that it will reserve for incentive funding. It will certainly be far smaller than indicative funding, perhaps 10% of the overall amount for each three-year funding cycle.

When Can Countries Apply?

As of February, 2013, the Global Fund had yet to specify timelines and deadlines for applications through the NFM. As noted below (in Section 3.3), some applicants will get new money in 2013. For at least one-half of countries, new funding will be available starting from early 2014. Based on signals from the Global Fund Secretariat, it is expected that funding decisions will be made on a quarterly basis (i.e. four times a year).

3.3 Implementation schedule

The NFM will be implemented in stages. The first stage, which the Global Fund is calling the 'transition phase', will continue through much of 2013. One element of that stage involves what are called 'early applicants'. This group consists of a small number of applicants (whom are) invited by the Global Fund to test the model. A second element of the transition phase involves what the Global Fund is calling 'interim applicants'. Only selected components of the NFM will be applied and instead, funding made available will largely be provided for renewal and extension of existing grants.

Both early and interim applicants have to meet at least one of the following three criteria:

i. They are considered by the Global Fund to be significantly underfunded.
ii. They face service disruption in 2013 and through part of 2014 (e.g., regarding availability of antiretroviral drugs).
iii. They are considered by the Global Fund to be 'well positioned' for making an impact.[9]

The Board has also said that selected participants should be diverse in areas which include size, geography, capacity and type of proposal. This means that at least one proposal needs to be either regional in nature or not submitted by a CCM.

The Global Fund announced the names of the early and interim applicants on 28th February 2013. There were a total of nine early applicants, of which, three are regional proposals including one focused on HIV in EECA.[10, 11]

The total number of interim applicants is 47; of these five are from EECA.[12] Based upon communications with the Global Fund Secretariat, the following EECA countries could be at risk of severe interruptions to HIV essential services by Q3 of 2014: Albania, Kazakhstan, Kosovo, Moldova and Russia. To address the potential risks of interruptions to services these countries are included in the list of interim applicant countries to the NFM, with the exception of Kazakhstan since it is no longer eligible for new HIV funding. Belarus was also included as an interim applicant for TB programming.

[9] Aidspan, Global Fund Observer Newsletter, Issue 210: 25th February 2013.

[10] According to a Global Fund press release dated 28th February 2013, the following six countries were selected to be early applicants: the Democratic Republic of the Congo, El Salvador, Kazakhstan, Myanmar, the Philippines and Zimbabwe. Approximately $393 million in total will be reserved for early applicants for the 2013 - 2014 transition period. Of that, $248 million in indicative funding is available for the six countries; $29 million in incentive funding (is potentially available to those six countries) and $116 million is available for the three regional proposals.

[11] According to GFO Newsletter Issue 2011 "The three regional initiatives were not named in the information made public by the Global Fund at the time of the launch. However, Board Members were informed that the initiatives, and the components for which they can apply, are as follows: the Regional Artemisinin Resistance Initiative (Malaria); the Eurasian Harm Reduction Network (HIV); and the Regional Malaria Elimination Initiative in Mesoamerica and Hispaniola (Malaria).

[12] According to a Global Fund press release dated 28th February 2013, a total of about $1.5 billion will be made available to interim applicants for the 2013 - 2014 transition period. Of the 47 interim applicants, five are from EECA. The indicative funding amounts available to those five countries are as follows: Albania ($100,000 for HIV); Belarus ($1 million for TB); Kosovo ($300,000 for HIV); Moldova ($8 million for HIV); and Russia ($5 million for HIV).

Country	Interim HIV programs ($M)	Interim TB programs ($M)
Albania	0,1	
Belarus		1
Kosovo	0,3	
Moldova	8	
Russia	5	

It is important to mention here that, of the total funding the Global Fund will make available to interim applicants, only $174 million or 11.5% will go towards TB. This has raised significant concerns within the TB society.

As noted elsewhere, new money will be available in 2013 but only for early and interim applicants. The earliest opportunity for all other eligible applicants to obtain new funding is in 2014. The list of EECA countries eligible for new funding in the transition can be found in Annex 1 of this document.

The Global Fund plans to monitor the transition phase and has communicated its wish for affected communities to be involved in this monitoring. Lessons learned from the transition phase will be used to finalize the model before it's fully implemented. That will take place after the Replenishment Conference in September 2013, when the Global Fund will have more substantial information about the amount of funding it can disburse through 2016.

4. Cause for Apprehension: The NFM's Implications for Middle-Income Countries and MARPs in EECA

The Global Fund has stated that the NFM will offer new, improved opportunities for support to partner countries. However, it appears that, there could be fewer and more restricted opportunities for countries and people in need in EECA. All but two of the 18 countries in the region (i.e. the Kyrgyz Republic and Tajikistan) expected to be eligible for Global Fund support are classified as middle-income countries (MICs). Of these 16 countries, only Ukraine is not expected to be placed in Country Band 4. Priority recipients under the NFM are countries classified as low income. As a result, far fewer resources will be made available to MICs overall.

The Global Fund has said that its main reason for focusing on low-income countries is that they have less 'ability to pay' because they are poorer. However, indicators related to per capita income have limited value in identifying which countries have the greatest needs. They cannot and do not reflect the fact that about three-quarters (75%) of the world's poorest people live in just five countries, all of which are currently classified as middle income.[13] In addition, three of the five countries with the highest burden of HIV are MICs.[14] Absolute TB burdens are concentrated among MICs as well. For example, two MICs (India and China) currently account for almost 40% of all TB cases. About 60% of worldwide cases of multi drug-resistant TB (MDR-TB) are in just four countries, all of which are MICs: India, China, Russia and South Africa.[15] Despite these absolute burdens, most MICs are expected to be placed in Country Band 4.

From an EECA perspective, it is of note that 15 out of the 27 high MDR-TB burden countries in the world are in the region.[16] EECA is also the only region where HIV prevalence continues to rise.[17]

Another important point with regard to EECA is that HIV and TB epidemics in most of the region's countries are concentrated among MARPs. In many of those countries, governments may have sufficient resources to provide services but are often unwilling to do so because of legal, social and institutional discrimination against members of those populations. In such cases, 'ability to pay' is a very meaningless indicator. Funding decisions cannot be based solely on such an indicator or even on others, in relation to standard public health (i.e. disease burden). Human rights challenges are the main obstacle and these challenges must be taken into account by the Global Fund when determining funding access and availability.

Advocates from EECA and elsewhere raised such concerns throughout 2012, as the Global Fund was developing the NFM. Partly in response to this advocacy pressure, the Global Fund is developing a separate allocation methodology for Band 4 countries. One anticipated outcome will be the allocation of a fixed amount of funding to countries in this category to address MARPs and/or other 'special interventions'. [18]

'Another difference from the other bands is that the allocation formula for Band 4 would take into account a country's overall population, not just disease burden in absolute numbers. The reason cited for this decision is that data on the number of MARPs in a country can be difficult to obtain (due to them being `hard to reach'). According to the Global Fund, overall population size is considered "the most relevant proxy for the size of MARPs".[19] Among the expected beneficiaries of this special condition are smaller countries with a high MDR-TB burden,[20] several of which are in EECA.

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[13] Summers, T (2012). Where Did All the Poor People Go? As cited on the website of the Global Health Policy Center of the Center for Strategic and International Studies (CSIS). Online: www.smartglobalhealth.org/blog/entry/where-did-all-the-poor-people-go/. According to Summers, "Half the world's poor live in India and China (mainly India), a quarter live in other MICs (especially Pakistan, Nigeria, and Indonesia), and the remaining quarter live in low-income countries (LICs)."

[14] 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? CGD Working Paper 270. Washington, D.C.: Center for Global Development, p. 2

[15] World Health Organization, Global Tuberculosis Report 2012

[16] Tuberculosis in the WHO European region: WHO Fact Sheet 2012.

[17] As noted on the UNAIDS website: www.unaids.org/en/regionscountries/regions/easterneuropeandcentralasia/

[18] As cited in a Global Fund PowerPoint presentation dated 22nd January 2013.

[19] As cited in a Global Fund PowerPoint presentation dated 22nd January 2013.

[20] As cited in a questionnaire submitted by a representative from the Stop TB Partnership Secretariat in February 2013.

The effects of these special conditions were not entirely clear as of the end of February 2013. According to a Global Fund simulation reviewed in January 2013, Country Band 4 would receive 10% of overall Global Fund resources in the first NFM cycle.[21] The same simulation indicated that just 3% of total resources would be allocated to EECA; a share that represents a 50% decrease compared with what was previously available. Both percentages could change by the time the NFM is fully launched in late 2013. However, it is disappointing that the starting point represents a decline compared with historical Global Fund allocations. With its high rates of MDR-TB, increasing HIV prevalence and deplorable human rights environment, EECA needs a significantly greater share to ensure that even the basic needs for people living with / affected by HIV and TB are addressed.

[21] As cited in a Global Fund PowerPoint presentation dated 22nd January 2013.

5. The EECA Perspective: Other Concerns about the NFM

Although the Global Fund (in response to external concerns) has undertaken certain measures to minimise the potential negative impact of the NFM in regards to MARPs, it seems likely that countries and people in need (in EECA) will not benefit (as concluded in Section 4 above). Based on what has been announced about the NFM as of mid-February, there is a significant likelihood that the region will be further ignored and excluded from Global Fund support.

Listed below are summaries of key concerns raised about the NFM to date. Most of them were cited during research by advocates both within and outside the region, including representatives of communities living with HIV and TB at country level (in Armenia, Georgia, Moldova and Uzbekistan). Information and observations from the Global Fund have been noted as well, where relevant.

1. There is a lack of awareness about the NFM within countries, organisations and communities that depend on Global Fund support in EECA. Research indicates a limited understanding of the rationale behind the NFM, as well as the key components of it including eligibility criteria and resource allocation. Many important Global Fund implementers including principal recipients, sub-recipients and sub-sub-recipients have reportedly received little, if any, information about it. As a result, many country-level stakeholders are unsure of how the NFM's application might affect their countries and the communities that they represent. For example, a respondent from Moldova, after a presentation about the NFM, said that: "At times the information was overwhelming and confusing."[22] An NGO respondent from Georgia stated: "Having read different materials about the NFM, I could not understand what this model is about... I looked through many different documents but still, I couldn't understand the NFM."[23] And a third of respondents from Georgia said something similar: "The model is complicated... It is hard to understand."[24]

2. The NFM's country dialogue process is unclear. The NFM places a huge amount of responsibility on 'country dialogue' and has said that, it expects it to be an "inclusive" and multi-stakeholder process. However, there is little indication of what that entails including who takes responsibility for the organization of such a process and how it should be structured. Many observers assume that the CCMs will control this process. This is of concern because CCMs in many countries (including much of EECA), do not effectively engage with or even include representatives from MARPs. The CCMs are in fact, frequently hostile towards MARPs and refuse to propose funding which meets their disease-specific programming needs. A response from Armenia highlighted many of the concerns from around the region, as follows:

> *"Theoretically it all looks good but in practice CCMs can decide who they'd like to involve....[The] participation of SR [sub-recipient] and SSR [sub-sub-recipient] organisations in the country planning process, and in the development of a concept note, followed by application is very important. These organisations know best, the needs and concerns of the populations they work with and can provide information to assess the impact of funding / projects on communities."*[25]

3. The NFM places 'ceilings' on available support. By announcing indicative funding amounts in advance, the Global Fund is placing an artificial 'ceiling' or top level on available support. Whilst countries are able to plan more efficiently because they know what they can expect from the Global Fund, these ceilings are also of concern because they may limit a country's ability to apply for the amount of money it truly needs. In such cases, 'full expression of demand' (a longstanding guiding principle of the Global Fund) cannot be sought or met.

Ceilings could limit the success of interventions in EECA, given the chronic unmet need in most of the region's countries. A respondent from the Stop TB Partnership Secretariat stressed the organisation's concern about the impact of such limits on TB responses: "If countries are allocated a fixed amount per disease, this will limit their ambition as well as capabilities for scale up. This is particularly evident for TB, which is 90% dependent on the

[22] As cited during an interview with a representative from WHO in Moldova, on 12th February 2013.
[23] As cited during an interview with a representative from an NGO in Georgia on 14th February 2013.
[24] As cited during an interview with a representative from an NGO in Georgia on 11th February 2013.
[25] As cited during an interview with a representative from an NGO in Armenia on 15th February 2013.

Global Fund for external financing."[26] This respondent's comment is especially relevant to EECA in light of the rising epidemic of TB and MDR-TB in the region.

4. Global Fund support will be reduced in most of EECA due to the NFM's allocation and eligibility criteria. Critical services provided by NGOs and community groups will be the first to lose funding. All respondents, from the four target countries, expressed concern about the impact of the NFM related funding cuts on comprehensive service delivery, especially for MARPs. As the following quotes indicate, most were extremely worried about the impact on services and activities that are generally provided by community-based groups and other local civil society organisations in relation to treatment adherence support, legal aid and human rights advocacy. The Global Fund is often one of the biggest (sometimes only) sources of funding for such services.

> *"The government is likely to prioritize treatment and the first services to be downsized or closed would be those implemented by NGOs and community organisations. These include harm reduction services and OST [opioid substitution treatment] which are only supported by the Global Fund. Funding is also likely be cut (or abolished) for capacity building of communities and civil society organisations, along with advocacy components and psychosocial support for PLHIV and IDU [injecting drug user] communities."*[27]

> *"Supporting people receiving treatment and helping them to adhere to treatment is extremely important. These services (provided by NGOs) ensure quality of treatment and adherence to treatment. If Global Fundfunding is cut after the transition to the NFM, the country may decide that it's necessary to use this money to ensure supply of ARV [antiretroviral] drugs, thus, care and support services provided by NGOs will be decreased or denied...This, in turn, will affect the quality of treatment. In our work, we observe that PLHIV are not always completely prepared for antiretroviral treatment and so, their adherence to treatment should be improved; in doing this, their motivation to be adherent must be supported."*[28]

> *In half of the harm reduction sites supported by the government, Global Fund resources are used to procure injecting equipment and to pay outreach workers' salaries. Without this Global Fund money, these sites cannot offer a NSP and they will have far fewer experienced staff to work with clients. In that, the work will be much less effective.*
>
> — As cited during an interview with a representative from an NGO in Uzbekistan on 8th February, 2013.
>
> *The government is not ready to fund all services currently provided with Global Fund support right now.*
>
> — As cited during an interview with a representative from an NGO in Georgia on 11th February, 2013.
>
> Evidence from elsewhere in the region draws attention to the concerns noted above by the Uzbekistan and Georgia respondents. According to a respondent from Armenia, shortfalls in Global Fund support in 2012 had the following consequences:
>
> *The budget for was reduced by more than 25%. At the same time indicators did not change and we couldn't increase salaries to motivate our project staff... [There is] no funding for expanding services, capacity building or personnel training... We do not have any other donors.*
>
> — As cited during an interview with a representative from an NGO in Armenia on 15th February, 2013.

Some respondents also raised a similar but slightly different concern. Alignment with national strategic plans is likely to place even more decision-making power with government agencies. One respondent stated: "If a country has the option to decide it is likely to reduce whatever it determines to be 'non-essential' activities. Countries will maintain those 'life-saving' activities which should be funded with or without Global Fund support [e.g. Treatment for HIV and TB]."[29]

[26] As cited in a questionnaire submitted by a representative from the Stop TB Partnership Secretariat in February 2013.
[27] As cited during an interview with a representative from an NGO in Moldova on 13 February 2013.
[28] As cited during an interview with a representative from an NGO in Uzbekistan on 8 February 2013.
[29] As cited during an interview with a representative from an NGO in Georgia on 11 February 2013.

The comments above highlight the potentially serious impact of a restrictive NFM. In EECA and elsewhere, the wide range of services and activities offered by local community and civil society groups are considered to be essential elements of effective treatment, care and support for people living with and affected by HIV and TB; and as endorsed by leading international agencies including the World Health Organization (WHO), Joint United Programme on HIV/AIDS (UNAIDS) and the Stop TB Partnership.

The Global Fund acknowledges that the level of funding might go down for countries in Band 4. It hopes to limit the negative impact by working to make investments more strategic. According to respondents from the Secretariat, this means that the Global Fund will strengthen its internal capacity to review concept notes carefully and request that proposals allocate sufficient money for community systems strengthening (CSS) and other services that are important to communities and MARPs. At the same time, it will refuse to accept proposals that fail to focus extensively on such critical interventions in an adequate manner.[30]

5. The Global Fund's use of national income and disease burden as the only two main allocation criteria is a 'blunt tool' that cannot truly indicate where the greatest needs are. For one thing, as noted by a respondent from Uzbekistan: "National economic indicators are statistically average indicators which do not always reflect the real situation, including one in the health sector especially when talking about villages."[31] Health systems in many EECA countries have limited capacity and resources. Governments are often unable to provide sufficient support to improve them.

Moreover, countries' income per capita is used to determine 'ability to pay.' This is an imprecise method. In some EECA countries, governments actually have sufficient funding to support comprehensive programming across the three diseases. However, many are unwilling to do so. This is especially true in countries where HIV and TB epidemics are concentrated amongst MARPs. Instead of using money to help people in need, they stigmatize and discriminate against them, whilst denying access to health and social care services. The consequences can be seen in figures such as those reported by the WHO: i.e. only 23% of people eligible for ARVs in the region are receiving it; a rate that is half of that in sub-Saharan Africa.[32]

Disease burden also has significant limitations as a viable indicator. The Global Fund considers 'high burden' only in regards to national disease prevalence. That both masks and ignores the realities and needs of countries with concentrated epidemics, such as in EECA. Currently high and continually rising HIV and TB prevalence among sex workers, men who have sex with men (MSM) and people who use drugs (PUD) present major public health crises which are devastating communities across the region.

Both of these criteria ultimately fail to be viable or valid in EECA. Neither takes account of the human rights violations and abuses that leave MARPs bereft of services, whilst further widening the inequality gap within society. Whether governments are unable or unwilling to pay, the consequences are extremely damaging for people living with or at risk of HIV and TB. Many find it difficult, if not impossible to obtain adequate services and support, especially in the public sector and structural violence is commonplace. In most places of the region, Global Fund money has provided an essential lifeline in recent years.

[30] As cited during an interview with a Global Fund Secretariat respondent on 22nd February, 2013.

[31] As cited during an interview with a representative from an NGO in Uzbekistan on 8th February, 2013.

[32] Macolini, M. HIV Still Spreading in Post-Soviet Countries, Mostly in Drug Injectors. International AIDS Society, 8th September, 2012. Online: www.iasociety.org/Default.aspx?pageId=5&elementId=14710

6. Recommendations

The recommendations listed below are intended to help the Global Fund to address the concerns noted in Section 5 above. The focus should be on creating a NFM which helps ensure that Global Fund support reaches as wide a range of individuals in need as possible, especially MARPs and others affected by HIV and TB in EECA.

1. Communities must be involved in all aspects of monitoring the NFM's roll out. It is important, in the short term, that the NFM's transition phase be closely monitored by civil society organisations and communities of people living with and affected by the diseases. Participants from EECA must be involved; this will help them identify problematic issues early on and develop strategies (particularly with regard to advocacy), to respond to those challenges.

The following demand from a recent communities' consultation is worth repeating and supporting:[33]

> Community leadership and participation in the monitoring of all aspects of the transition to the NFM are essential for scrutinizing the process, assessing the impact and determining successful approaches. To ensure and strengthen community engagement, independent community-led monitoring mechanisms must be put in place. Communities will lead and take responsibility in these efforts. Technical and financial support must be provided for these mechanisms in order to carry out this critical watchdog function.

2. Improved information about the NFM should be made available. The message from EECA respondents is straight-forward! Most have, at least, heard about the NFM but they do not understand it, including what it might mean to their organisations, their countries and the people they serve. ***The Global Fund should identify approaches to raise awareness about the NFM which are simple and clear to all partners in every country.*** One essential step is to have enhanced information made available as soon as possible and to ensure that it reaches partners at all levels in every country. A major priority should be that, this information is written in plain language and organised so as it is accessible to civil society and community groups.

3. The Global Fund must be more directive and clear with attention to participation in country dialogues and the expected outcomes.

At a minimum, it should:

- Clarify exactly who should be involved and in what capacity, including participants from civil society and communities.
- Provide capacity-building support to representatives from civil society and communities, to ensure they are able to participate effectively.
- Clarify processes and procedures around the concept note, with the goal of ensuring that all stakeholders have influence over its development and finalization.
- Put in place mechanisms to monitor country dialogue processes in all countries and which take action when MARPs and communities are excluded from meaningful participation.

4. Greater flexibility should be accorded all NFM allocation formulas and decisions; not just that of Country Band 4 and which, takes account of real life obstacles and experiences in EECA and other MICs. In particular:

- ***The Global Fund should develop and instigate new allocation criteria that do not automatically restrict funding for middle-income countries and those classified as 'low burden'.*** National income and disease burden should be just two of several considerations, i.e. not the only ones, by which the Global Fund determines eligibility and potential available funding. Among the additional indicators should be those related to trends in disease prevalence; access to and uptake of prevention and treatment services, especially by MARPs; and governments' inclination (based on historical trends) to provide

[33] Communities Statement released at the conclusion of the Communities Consultation on the New Funding Model, 25th - 26th January 2013 in Amsterdam, the Netherlands.

resources and support based on evidence and need. Sufficient information exists for such indicators to be developed and applied quite quickly. They should be added to the list of NFM criteria by the time the NFM is fully launched in late 2013.

- ***The 'ceilings' that are currently a key part of the NFM structure should be reconsidered.*** Such limits restrict applicants' ability to seek 'full expression of need' which is a core Global Fund principle. The Global Fund must recognize and respond to the clear evidence from EECA which shows that MARPs (and other people living with and affected by HIV and TB) are being widely discriminated against in many ways, i.e. socially, legally and in terms of access to health services. The Global Fund has played a critical role in engaging and supporting such communities and civil society groups. This must not only continue but must also increase. Support should not be withdrawn otherwise epidemics will further escalate amongst the most vulnerable, at risk populations, which will increase the disease burden of many countries.
- ***The Global Fund should provide sufficient flexibility with regard to 'disease split'.*** This is especially important when considering TB. Allocating funding based upon historical disease splits is not a good policy and the proportions should be reconsidered after the period of transition to the NFM. Otherwise it could limit what the Global Fund can and should do in its future responses to the disease; this is more important than ever since MDR-TB is becoming more prevalent. Countries with major, under-resourced TB epidemics should be able to command a comprehensive means of support from the Global Fund and for that the appropriate level of funds for TB counteraction should be available within NFM.

5. The Global Fund should clarify exactly how the incentive funding stream will work and how countries specifically in Country Band 4 can access it. Many of the research respondents do not understand the incentive funding stream. As one noted: "[I am] not sure how the incentive funding will work for our region and how the countries will be able to finance their full quality demand. Again, more work needs to be undertaken in ensuring that instructions are clear and simple."[34]

As such, the incentive funding reserve should be used judiciously and carefully. The idea of 'rewarding' countries for good behaviour and excellent performance may be appealing but this approach disadvantages societal contexts that are more difficult and complicated, as in much of EECA. The Global Fund should consider ways to reach those countries because the need for incentives to improve HIV, TB and Malaria programming is particularly great. They need prodding that could be accompanied by additional money through the incentive funding stream. This is different from 'rewarding', but the impact may be positive nonetheless.

As a first step toward addressing these potential imbalances of access, the Global Fund should review the incentive funding stream midway through the first three-year NFM cycle. Decision-making processes and procedures should then be revised, if necessary, to ensure that all countries (not just the easy ones) have adequate opportunities to acquire this additional funding.

[34] As cited in a questionnaire by a representative from an NGO in Moldova, received on 22nd February 2013.

ANNEX 1: EECA countries eligible for new funding in the transition - 2013[35]

Country/Economy	Component	Income Category	Disease Burden	Eligible for Funding
Albania	HIV	Upper-LMI	Low	Yes
Albania	TB	Upper-LMI	Low	Yes
Albania	Malaria	Upper-LMI	Low	Yes
Albania	HCSS	Upper-LMI	N/A	Yes
Armenia	HIV	Upper-LMI	High	Yes
Armenia	TB	Upper-LMI	High	Yes
Armenia	Malaria	Upper-LMI	Low	Yes
Armenia	HCSS	Upper-LMI	N/A	Yes
Azerbaijan	HIV	UMI	High	Yes, targeted only
Azerbaijan	TB	UMI	Severe	Yes
Azerbaijan	Malaria	UMI	Moderate	Not eligible
Azerbaijan	HCSS	UMI	N/A	Yes
Belarus	HIV	UMI	High	Yes, targeted only
Belarus	TB	UMI	High	Yes, targeted only
Belarus	Malaria	UMI	Low	Not eligible
Belarus	HCSS	UMI	N/A	Not eligible
Bulgaria	HIV	UMI	High	Yes, targeted only, NGO rule[36]
Bulgaria	TB	UMI	High	Yes, targeted only
Bulgaria	Malaria	UMI	Low	Not eligible
Bulgaria	HCSS	UMI	N/A	Not eligible
Georgia	HIV	Upper-LMI	High	Yes
Georgia	TB	Upper-LMI	Severe	Yes
Georgia	Malaria	Upper-LMI	Moderate	Yes
Georgia	HCSS	Upper-LMI	N/A	Yes
Kazakhstan	HIV	UMI	Moderate	Not eligible
Kazakhstan	TB	UMI	Severe	Yes

[35] Based on the Global Fund document "Eligibility list for new funding in the transition – 2013", March 2013. The list does not apply to grant renewals.

[36] "NGO rule" applies to upper-middle income countries (UMICs) not listed on the OECD's DAC list of ODA recipients which are eligible to submit HIV/AIDS applications for funding provided that the government of the relevant country does not receive any funding, and that certain other requirements are met.

Country/Economy	Component	Income Category	Disease Burden	Eligible for Funding
Kazakhstan	Malaria	UMI	Low	Not eligible
Kazakhstan	HCSS	UMI	N/A	Yes
Kosovo	HIV	Upper-LMI	Low	Yes
Kosovo	TB	Upper-LMI	Low	Yes
Kosovo	Malaria	Upper-LMI	Low	Yes
Kosovo	HCSS	Upper-LMI	N/A	Yes
Kyrgyzstan	HIV	LI	High	Yes
Kyrgyzstan	TB	LI	Severe	Yes
Kyrgyzstan	Malaria	LI	Moderate	Yes
Kyrgyzstan	HCSS	LI	N/A	Yes
Latvia	HIV	UMI	High	Yes, targeted only, NGO rule
Latvia	TB	UMI	High	Yes, targeted only
Latvia	Malaria	UMI	Low	Not eligible
Latvia	HCSS	UMI	N/A	Not eligible
Lithuania	HIV	UMI	High	Yes, targeted only, NGO rule
Lithuania	TB	UMI	Severe	Yes
Lithuania	Malaria	UMI	Low	Not eligible
Lithuania	HCSS	UMI	N/A	Yes
Republic of Moldova	HIV	Lower-LMI	Moderate	Yes
Republic of Moldova	TB	Lower-LMI	Severe	Yes
Republic of Moldova	Malaria	Lower-LMI	Low	Yes
Republic of Moldova	HCSS	Lower-LMI	N/A	Yes
Romania	HIV	UMI	High	Yes, targeted only, NGO rule
Romania	TB	UMI	High	Yes, targeted only
Romania	Malaria	UMI	Low	Not eligible
Romania	HCSS	UMI	N/A	Not eligible
Russian Federation	HIV	UMI	High	Yes, targeted only, NGO rule
Russian Federation	TB	UMI	Severe	Not eligible
Russian Federation	Malaria	UMI	Low	Not eligible

Country/Economy	Component	Income Category	Disease Burden	Eligible for Funding
Russian Federation	HCSS	UMI	N/A	Not eligible
Tajikistan	HIV	LI	High	Yes
Tajikistan	TB	LI	Severe	Yes
Tajikistan	Malaria	LI	Moderate	Yes
Tajikistan	HCSS	LI	N/A	Yes
Turkmenistan	HIV	UMI	Low	Not eligible
Turkmenistan	TB	UMI	High	Yes, targeted only
Turkmenistan	Malaria	UMI	Low	Not eligible
Turkmenistan	HCSS	UMI	N/A	Not eligible
Ukraine	HIV	Upper-LMI	High	Yes
Ukraine	TB	Upper-LMI	Severe	Yes
Ukraine	Malaria	Upper-LMI	Low	Yes
Ukraine	HCSS	Upper-LMI	N/A	Yes
Uzbekistan	HIV	Lower-LMI	High	Yes
Uzbekistan	TB	Lower-LMI	Severe	Yes
Uzbekistan	Malaria	Lower-LMI	Moderate	Yes
Uzbekistan	HCSS	Lower-LMI	N/A	Yes

EURASIAN HARM REDUCTION NETWORK
ЕВРАЗИЙСКАЯ СЕТЬ СНИЖЕНИЯ ВРЕДА

Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programs and their allies from across 29 countries in the region of Central and Eastern Europe and Central Asia (CEECA). Together, we work to advocate for the universal human rights of people who use drugs, and to protect their lives and health.

The Network unites over 350 institutional and individual members, tapping into a wealth of regional best practices, expertise and resources in harm reduction, drug policy reform, HIV/AIDS, TB, HCV, and overdose prevention. As a regional network, EHRN plays a key role as a liaison between local, national and international organizations. EHRN ensures that regional needs receive appropriate representation in international and regional forums, and helps build capacity for service provision and advocacy at the national level. EHRN draws on international good practice models and on its knowledge about local realities to produce technical support tailored to regional experiences and needs. Finally, EHRN builds consensus among national organizations and drug user community groups, helping them to amplify their voices, exchange skills and join forces in advocacy campaigns.

Since 2008 EHRN hosts the Civil Society Action Team (CSAT) in CEECA. CSAT is a civil society-led global initiative that coordinates, brokers and advocates for technical support to civil society organizations implementing or seeking grants from the Global Fund to Fight AIDS, TB and Malaria.

Become an EHRN Member: EHRN invites organizations and individuals to become part of the Network. Membership applications may be completed online at:
www.harm-reduction.org/become-a-member.

Eurasian Harm Reduction Network (EHRN)
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