

TB and HIV

Regional CONCEPT NOTE

Investing for impact against HIV and tuberculosis

*IMPORTANT:* Regional applicants, who have been invited to submit a joint concept note for TB and HIV, should use this template.Applicants should refer to the Regional TB and HIV Concept Note Instructions in the platform or on the website to complete this template.

A concept note outlines the reasons for Global Fund investment. It should be based on robust national and regional strategies, and supported by data and information that shows why the proposed approach will be effective. It should clearly prioritize the needs identified at the regional level and the gaps within the broader regional context. It should also describe how implementation of the resulting grant(s) can maximize the impact of the investment, by achieving the greatest possible effect on the health of the people in the region.

The concept note is divided into the following sections:

Section 1: A description of the regional epidemiological situation, health system and other barriers to access, and the various national and regional responses.

Section 2: Information on the regional funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SUMMARY INFORMATION | | | | | | | | | | | | | | | |
| Applicant Information | | | | | | | | | | | | | | | |
| Applicant Name | | | | | Alliance for Public Health | | | | | | | | | | |
| Applicant type | | | | | Regional Organization (RO) | | | | | | | | | | |
| Funding Request Start Date | | | | | July 1, 2016 | | | | Funding Request End Date | | | | June 30, 2019 | | |
| Principal Recipient(s) | | | | | Alliance for Public Health | | | | | | | | | | |
| *If the programs are to be managed as separate grants:* | | | | | | | | | | | | | | | |
| Funding Request Start Date for HIV |  | | | | | | | Funding Request End Date for HIV | | | |  | | | |
| Principal Recipient(s) for HIV | |  | | | | | | | | | | | | | |
| Funding Request Start Date for TB |  | | | | | | | Funding Request End Date for TB | | | |  | | | |
| Principal Recipient(s) for TB | |  | | | | | | | | | | | | | |
| Eligibility Information: Countries\*\* included in the regional application | | | | | | | | | | | | | | | |
| Country | | | | Income Category\* | | Disease Burden\* | | | | Eligibility\* | | | | Focus of application\* | |
| HIV | | | | | | | | | | | | | | | |
| Belarus | | | | UMI | | High | | | | Eligible | | | | Soligorsk | |
| Bosnia and Herzegovina | | | | UMI | | Low | | | | Not Eligible | | | | Sarajevo | |
| Bulgaria | | | | UMI | | High | | | | Not Eligible (NGO Rule only) | | | | Sofia | |
| Georgia | | | | Upper-LMI | | High | | | | Eligible | | | | Tbilisi | |
| Kazakhstan | | | | UMI | | Moderate | | | | Not Eligible | | | | Almaty | |
| Kyrgyzstan | | | | Lower-LMI | | High | | | | Eligible | | | | Bishkek, Osh | |
| Moldova (Republic) | | | | Lower-LMI | | High | | | | Eligible | | | | Beltsi | |
| Romania | | | | UMI | | High | | | | Not Eligible | | | | Bucharest | |
| Russian Federation | | | | HI | | High | | | | HIV-Not Eligible  (NGO Rule only) | | | | St.  Petersburg | |
| Ukraine | | | | Upper-LMI | | High | | | | Eligible | | | | Kyiv, Odesa | |
| TB | | | | | | | | | | | | | | | |
| Belarus | | | UMI | | | | High | | | | Eligible | | | | Soligorsk |
| Bosnia and Herzegovina | | | UMI | | | | Moderate | | | | Not Eligible | | | | Sarajevo |
| Bulgaria | | | UMI | | | | High | | | | Eligible | | | | Sofia |
| Georgia | | | Upper-LMI | | | | Severe | | | | Eligible | | | | Tbilisi |
| Kazakhstan | | | UMI | | | | Severe | | | | Eligible | | | | Almaty |
| Kyrgyzstan | | | Lower-LMI | | | | Severe | | | | Eligible | | | | Bishkek, Osh |
| Moldova (Republic) | | | Lower-LMI | | | | Severe | | | | Eligible | | | | Beltsi |
| Romania | | | UMI | | | | High | | | | Eligible | | | | Bucharest |
| Russian Federation | | | HI | | | | Severe | | | | Not Eligible | | | | St.  Petersburg |
| Ukraine | | | Upper-LMI | | | | Severe | | | | Eligible | | | | Kyiv, Odesa |
| *(Add rows as necessary)* | | | | | | | | | | | | | | | |

\* According to the [Global Fund 2014 Eligibility List](http://www.theglobalfund.org/en/fundingmodel/regionalmulti/eligibility/).

\*\* Mention the tentative list of countries if final list is not available yet.

|  |
| --- |
| Funding Request Summary Table |

Description: C:\Users\agreen\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\2QMQR3C9\MC910217323[1].wmfA funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap tables and modular template.

*IMPORTANT:* A regional application shall only be eligible for funding where the majority (at least 51 percent) of countries included in the concept note are eligible to submit their own request for funding for that same component through a single-country application.

|  |
| --- |
| SECTION 1: REGIONAL CONTEXT |
| This section requests information on the regional context, including descriptions of the TB and HIV disease epidemiology and their overlaps, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions. |

|  |
| --- |
| 1.1 Regional Disease, Health Systems and Community Systems Context |
| With reference to the latest available epidemiological information on TB and HIV, highlight:   1. The current and evolving epidemiology of the two diseases and any significant geographic variations in incidence or prevalence of TB and HIV. Include information on the prevalence of HIV among TB patients and TB incidence among people living with HIV/AIDS. 2. Key populations that may have disproportionately low access to prevention and treatment, care and support services, and the contributing factors to this inequality. 3. Key human rights barriers and gender inequalities that may impede access to health services in the region. 4. The health systems and community systems context in the region (and the countries of this regional application), including any constraints, relevant to effective implementation of the regional TB and HIV programs including joint areas of both programs. 5. Any important regional issues (i.e. epidemiological, health system, community system, human rights or gender issues) that impact on service delivery or health outcomes related to the two diseases. |
| 3-6 PAGES SUGGESTED  HIV and TB Epidemiology in different countries and cities  Eastern Europe and Central Asia (EECA) represents one of the few regions globally where there is a continued increase in the incidence of HIV infection[[1]](#footnote-2). Age-standardized HIV incidence rates per 100 000 population in 2013 were above 15 in Kazakhstan, Kyrgyzstan, Russian Federation and Ukraine[[2]](#footnote-3). Age-standardized HIV prevalence rates per 100 000 population in 2013 were the highest in the region in the Russian Federation and Ukraine (in the interval between 221 and 722 per 100 000)[[3]](#footnote-4). The current estimated number of people living with HIV in the region exceeds 1 500 000 people. The HIV burden in the region is growing constantly showing an increase of 58% in AIDS mortality between 2006 and 2012[[4]](#footnote-5).  Injection drug use was the initial driver of the HIV epidemic while heterosexual transmission has now become widespread in the region[[5]](#footnote-6). Nonetheless substance use remains an important factor, with its control limited by challenges in scaling up harm reduction efforts. It is estimated that 57% of all new HIV infections in Eastern Europe are attributable to the sharing of contaminated needles/syringes by people who inject drugs (PWID)[[6]](#footnote-7).  In Eastern Europe, the rate of diagnosed cases of HIV infection per 100 000 population has increased from 11.7 in 2004 to 22.5 in 2011[[7]](#footnote-8). The prevalence of HIV among PWID in Eastern Europe is above 10%[[8]](#footnote-9).  Very little data is available from countries of the EECA region as to the incidence of HIV among PWID and no data is available for SW and MSM, respectively. Among the 17 countries (59%) that reported such data, HIV incidence in the general population varies widely across the region, from as little as 0.0016 per 100,000 people in Macedonia[[9]](#footnote-10) to as high as 47 per 100,000 people in the Russian Federation[[10]](#footnote-11). The most consistently reported data by countries of the region is that of new HIV infections among PWID, per 1 million population. However, it is important to note that capacity to develop HIV incidence estimates is limited in the region.  HIV prevalence among people from key populations in the EECA region overall is over 23 times that of the general population, as can be seen in Table below, and PWID are approximately 2.5 times more likely to be HIV-positive than SW or MSM, respectively. Among those countries to have submitted reports, the highest HIV prevalence in the EECA region is among PWID in Estonia at 57.9% and as low as 0.0147% among the general population of the FYR Macedonia. The highest reported HIV prevalence among SW is 22.22% in Latvia and 12.96% among MSM in Georgia.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Population Group | No. countries reporting | Estimated Average | Range | | | From | To | | General | 16 (55%) | 0.31% | 0.0147% Macedonia | 1.3% Estonia | | PWID | 23 (79%) | 11.42% | 0% Hungary | 57.9% Estonia | | SW | 20 (69%) | 4.17% | 0.11% Czech Republic | 22.22% Latvia | | MSM | 25 (86%) | 4.31% | 0.5% Albania | 12.96% Georgia | | PWID, SW and MSM combined | 19 (66%) | 7.35% | 0.67% Bosnia and Herzegovina | 21.93% Estonia |   Table: HIV prevalence among general and key populations in the EECA region by countries that reported such data  Just over half of the 29 countries of the EECA region have provided data on the number of people in the general population living with HIV, totalling 407,005. No data has been reported by any country concerning the number of SW or MSM who are living with HIV. Kosovo has the lowest number of general population living with HIV at 84 people, and 2 PWID. In contrast, Ukraine has 232,793 people in the general population living with HIV and Kazakhstan has 13,111 PWID living with HIV.  A similarly grave situation exists for people from key populations in relation to tuberculosis (TB) in the region, which accounts for 5% of the global TB burden. In 2013 there were an estimated 460 000 prevalent TB cases, which is equivalent to 51 cases per 100 thousand population. There were an estimated 38 000 TB deaths among HIV-negative people in the Region, equivalent to 4.1 deaths per 100 thousand population. 24% of all cases (equating to 76,500 people) of multi-drug resistant (MDR) TB in the world were in the EECA region in 2012[[11]](#footnote-12). Eastern European and Central Asian countries continue to have the highest levels of MDR-TB. Such countries as Belarus, Kazakhstan, Kyrgyzstan, Russian Federation, Republic of Moldova, Tajikistan and Ukraine are the countries listed in WHO list of 30 TB or MDR TB high burden counties for 2016–2020.  TB is a leading killer among people living with HIV, and this deadly combination is increasing in the Region. About 17 000 out of an estimated 21 000 HIV patients co-infected with TB were detected in 2013, but only 54% of them received antiretroviral treatment. The percentage of HIV among TB cases increased from 3.4% in 2008 to 7.8% in 2013.  Of an estimated 75 000 MDR-TB cases in the Region in 2013, only 34 945 (46.6%) were diagnosed. The prevalence of MDR among new pulmonary TB cases amounted to 16.9% and was 48% among previously treated cases. Despite the increasing access to treatment with second-line drugs the treatment success rate in 2013 is still low – only 46%.  The vast majority of the TB burden in the Region (85% of TB incidence, 86% of TB prevalence, 90% of the mortality caused by TB and 99.5% of the MDR-TB) occurs in 18 high-priority countries.  Almost all project targeted countries except Bosnia and Herzegovina are high TB burden countries.  According to WHO, the TB/HIV co-infection rate is increasing in the EECA region, with 13,000 people detected with the co-infection in 2012, of which only 62.3% were offered antiretroviral therapy (ART). In addition, the prevalence of HIV among TB cases in the region rose from 3.4% in 2008 to 6.1% in 2012[[12]](#footnote-13).  The Russian Federation and Ukraine together account for over 90% of the reported AIDS cases in the region[[13]](#footnote-14).  In the Russian Federation, as of 2014, HIV prevalence among the general population constituted 494.6 per 100 000, and newly registered cases were 55.6 per 100 000 (in 2013). The geographic distribution of HIV in Russian Federation is rather uneven. The most affected territories are the regions of Samara, Irkutsk, Leningrad, Orenburg, Sverdlovsk (Yekaterinburg), Tyumen, Ulyanovsk, Chelyabinsk, Kemerovo and Kaliningrad, the city of St. Petersburg and the Khanty-Mansi Autonomous District. In these regions, a large reservoir of HIV-infection is still accumulating among PWID and at the end of 2013 between 0.5%-1.5 % of the population were officially registered as HIV-positive. The percentage of HIV positive population in selected cities constitute almost 1% of entire population of St. Petersburg and 1.3% of population of Sverdlovsk oblast. The number of new registered cases was still on the rise in 2014[[14]](#footnote-15).  The main route of HIV transmission in the Russian Federation continued to be injecting drugs with non-sterile equipment. At the end of 2014, 57.0% of all persons with known causes of infection were infected with HIV through injecting drug use. However, since early 2000-s, the increase of new HIV cases due to heterosexual transmission is observed as well.  The prevalence of injection drug use in the Russian Federation was estimated at the level of 274.1 per 100 000 population. Among all the registered PWID, 12.1% were HIV-positive in 2009, HIV prevalence above 20% is found in 13 administrative territories (Chechen Republic, Republic of Buryatia, Kaliningrad, Leningrad, Tver, Ryazan, Orel, Chelyabinsk, Sverdlovsk, Irkutsk, Ulyanovsk, Chita region, and St. Petersburg city). In a survey conducted in St. Petersburg in 2009, 61.1% PWID tested positive. Recent studies conducted in 2014, showed that HIV prevalence is high in other parts of the Russian Federation: 28% in Barnaul, 45% in Perm and 52% in Abakan[[15]](#footnote-16). Overall, the situation is assessed as more favorable in those regions where home-made opiates are predominantly used and heroin is less available[[16]](#footnote-17); oppositely, more HIV-related problems are seen in the regions affected by heroin trafficking from Afghanistan.  HIV prevalence among other populations at risk is less studied, however, the available results showed that it is high also high. The reported HIV-prevalence among female sex workers in 2009 was 4.5%[[17]](#footnote-18). Among MSM, 8.3% were found to be HIV-positive during the bio-behavioral survey in Moscow in 2009. Among prisoners, prevalence of HIV was 6.4% in 2009, most of these people are believed to be PWID and were infected prior to incarceration[[18]](#footnote-19).  Russian Federation ranks 3rd position in the world on MDR-TB burden. MDR-TB case detection rate is extremely low – 15.5 thousand in comparison with 39 thousand of estimated number of MDR-TB cases. Treatment success rate is low both in new cases of susceptible TB – 68%, susceptible retreated cases – 39% and MDR-TB – 40%. Only about 50% TB patients know HIV status. Country doesn’t provide data about access to ART, CPT, IPT[[19]](#footnote-20).  Nowadays Ukraine takes one of the first places among European countries by the number of HIV-positive people. According to the estimated data, as of the beginning of 2015, 218 thousand of HIV-infected people aged 15 years and older have been living in the country. The indicator of HIV prevalence at the age group of 15-49 years made up 0.58% and remains to be one of the highest among countries of Europe and Central Asia. During 1987-2014, 264,489 (excluding data in AR Crimea and Sevastopol city in 2014) cases of HIV-infection were officially registered in Ukraine among its citizens, including 75,577 (excluding data in AR Crimea and Sevastopol city in 2014) AIDS cases and 35,425 (excluding data in AR Crimea and Sevastopol city in 2014) AIDS-related deaths. The HIV/AIDS epidemic in Ukraine is concentrated in cities – in 2014, 76% of new cases of HIV-infection were registered among urban population, while the proportion of newly registered cases of HIV-infection among rural population has been increasing very slowly.  The HIV Prevalence among all key populations is very high and varies from 9% among MSMs to 20% among PWIDs. Levels of HIV-infection among PWID have exceeded the national average in twelve regions of Ukraine including Odesa and Kyiv. The highest levels of HIV prevalence among this group have been registered in the city of Kyiv (20.1%[[20]](#footnote-21)), Odesa region (30.2%[[21]](#footnote-22))[[22]](#footnote-23).  At the present stage of HIV epidemic, the group most-at-risk for HIV-infection, namely men who have sex with men, is becoming more epidemically significant[[23]](#footnote-24).  Tuberculosis still remains the most common AIDS-related disease in Ukraine[[24]](#footnote-25). Ukraine ranks 5th position in the world on MDR-TB burden. But at the same time there is low MDR-TB detection rate – 7.7 thousand in comparison with 13 thousand of estimated cases. MDR-TB treatment success is only 34 %. Mortality rate is high – 13 per 100 thousand population. 20% of newly diagnosed TB patients have HIV. Only 56% of co-infected TB/HIV patients receive antiretroviral therapy, and only 44% - co-trimoxazol prophylaxis. Unfunded National TB Program – 41%[[25]](#footnote-26).  The city of Kyiv is the capital of Ukraine; it has a status of a separate administrative region. It is a metropolis with population of about 3 million people or more than 6% of the total population of the country. In terms of HIV-epidemic, Kyiv has fourth highest HIV prevalence among cities of Ukraine[[26]](#footnote-27). The estimated size of high-risk populations living in Kyiv constitutes a substantially larger percent than the percentage of overall population of Kyiv among the population of Ukraine: 10% of PWID (31300/310000) live in Kyiv, 13% of FSW (10700/80000) and about 21% of MSM (36300/176000)[[27]](#footnote-28). And Kyiv is related to cities with the highest HIV-prevalence rates among PWID - 20.1%[[28]](#footnote-29), the prevalence among FSW of different age groups varies from 1.3 to 8.0%[[29]](#footnote-30), and the prevalence among MSM is on the rise and constituted 17% in 2013[[30]](#footnote-31).  The TB incidence is reported to be lowering and to be substantially lower (43.3 per 100 000) than in some other territories including Odesa. In Ukraine it is 70.5 per 100 thousand population, in Odesa region – 111.2 per 100 thousand population.  Odesa is the city which -- along with Mykolaiv -- has the longest history of HIV epidemic in Ukraine. Currently 20,000 PWID[[31]](#footnote-32) are estimated to live in Odesa with 30.2% of them being HIV-positive[[32]](#footnote-33). The number of FSW in Odesa is estimated as 5 000 persons[[33]](#footnote-34) with HIV prevalence 10,30%[[34]](#footnote-35). The number of MSM in Odesa is estimated as 5 000 persons[[35]](#footnote-36) with HIV prevalence 7,6%[[36]](#footnote-37). Both incidence of TB (111,2 per 100 000) and tuberculosis-related mortality (11,1 per 100 000) according to local statistics are reported to be quite high in Odesa.  HIV epidemic in the Republic of Belarus is in a concentrated stage. The most affected populations are injecting drug users. HIV prevalence in their group increased from 13.7% in 2011 to 14.2% in 2013. Prevalence of HIV infection among other key populations is also on the rise and constituted 6.2% among female sex workers and 5.8% among MSM[[37]](#footnote-38).  HIV prevalence among general population constitutes 142.9 per 100 000. Estimated incidence (based on newly registered cases) increased from 9.1 per 100 000 in 2008 to 19.1 per 100 000 in 2014 mainly due to increased testing and counseling.  Belarus is characterized by an extremely uneven geographical distribution of HIV across the country. The highest prevalence is seen in Gomel oblast (417.9 per 100 000) and Minsk oblast (142.7 per 100 000). Sentinel surveillance conducted in several cities and towns of these two oblasts demonstrate steadily high prevalence of HIV among PWID: Zhlobin, Rechitsa, Svetlogorsk in Gomel oblast and Soligorsk in Minsk oblast[[38]](#footnote-39).  Belarus has the highest estimated number of key populations (KPs) in the EECA region of 27 countries, which is 185,000[[39]](#footnote-40) of 9.47 million (namely 1.9% of population).  Cities with the highest HIV prevalence among PWID according to 2013 IBBS are Svetlogorsk (Gomel oblast) with 41.8% and Soligorsk (Minsk oblast) with 16%[[40]](#footnote-41).  According to the latest WHO estimates for 2013, TB incidence (new cases and relapses) was 70 per 100,000 population (with a range 62 - 80), which correspond to the 6,500 incident cases (uncertainty range 5,800 - 7,500) in absolute number[[41]](#footnote-42). Higher rates of TB and TB mortality in Gomel region is mainly associated with the concentration of HIV epidemics in Gomel region accounting for 53% PLHIV out of total number in the country, and peaking the proportion of TB/HIV in Gomel region to 14%, compared to 5.1% average national TB/HIV rate. Belarus shows low rate of TB detection – 70%. It has extremely high estimated rate of MDR-TB – 34% among new cases and 69% among retreated cases. MDR-TB treatment success is low – 54%[[42]](#footnote-43).  Belarus is one of the 15 high MDR-TB burden countries among the 53 Member States of WHO European region.  In period 2004 to 2011, Bulgaria observed a tendency of increase in the number of HIV cases among injecting drug users. However, since 2012, number of new cases of HIV among PWID started to decline while the number of newly diagnosed HIV cases among MSM group grows. The share of newly registered HIV cases among men who have sex with men has risen to 39% of the annual number of newly registered cases in 2012 and remained at the same level 39% in 2013. Geographical distribution of registered HIV cases indicates that the majority of them are concentrated mainly in large urban areas like Sofia, Plovdiv, Pazardzhik, Varna, Blagoevgrad and Bourgas[[43]](#footnote-44).  Bulgaria is ranking among the 27 high burden MDR countries and among the 6 countries in European Union reporting >20 TB cases per 100 000 habitants. High risk groups are defined as follow: TB and MDR-TB contacts, prisoners, Roma, PLHIV, PWID, refugees and migrants, diabetics, street children and homeless people. Bulgaria limited access to MDR-TB testing – only 45% of retreatment cases – and treatment: 29 MDR-TB patients started treatment from 44 diagnosed with MDR-TB[[44]](#footnote-45).  Bosnia and Herzegovina has the low level HIV epidemic. HIV prevalence among most at risk populations is not exceeding 5%. The main mode of transmission for the period 1986 to 2011 is heterosexual (56.1%), followed by MSM at 21.9 % and PWID at 10.7 %. Recent data show increasing incidence in the MSM population. Despite low HIV prevalence, key stakeholders believe that there are a number of factors that could stimulate the further emergence and spread of the HIV epidemic at any time. Among mentioned factors are following: greater violence to women and increased drug use, prejudice against key populations at risks, vulnerable populations who remain ‘hidden’ and are frightened to use services due to fear of being stigmatized or discriminated, and growing number of migrants and refugees from post-conflict areas[[45]](#footnote-46). Despite the fact, that HIV prevalence among PWID is low across whole country as well as among PWID in Sarajevo, HCV prevalence is relatively high in most cities, and exceeds almost 50% among drug users in Sarajevo[[46]](#footnote-47).  The TB burden in Bosnia and Herzegovina is moderate in comparison with other countries in the World Health Organization European Region. TB prevalence and incidence remain considerably low with the decreasing trend. Multidrug-resistant TB patients, ethnic minorities and Roma populations, prisoners and migrants, and other vulnerable populations living in poor conditions are in the main focus. The tuberculosis co-infection was registered in 26 or 25.2% of persons who developed AIDS and is currently viewed as the key co-infection[[47]](#footnote-48). Bosnia and Herzegovina is not included in the list of high-priority countries. TB case detection is not high – 75%. Low rate of MDR-TB treatment success – 43%. Only 16% of TB patients know their HIV status[[48]](#footnote-49).  Moldova continues to experience a concentrated HIV epidemic among people who inject drugs (PWID - estimated number is 30200), men who have sex with men (MSM - 13500), female sex workers (FSW - 12000) and their clients as well as their sexual partners in the general population. The HIV epidemic is more severe on the left bank of Nistru River, where coverage of prevention programs is lower. There is evidence of spread of the infection in the general population. The estimated HIV prevalence for the right bank of the Nistru River is 0.30% and 1.32% for the left bank. HIV/AIDS is mainly registered among young people of reproductive and economically‐active age, aged 15‐49 – 86.4% of new HIV cases registered in 2014[[49]](#footnote-50).  The bio-behavioral surveys conducted in large cities of Moldova revealed the highest HIV prevalence on Balti (or Beltsi) city. In 2012, prevalence of HIV among PWID in Chisinau was 8.5%, in Balti - 41.8%, in Tiraspol - 23.9%[[50]](#footnote-51). The estimated number of PWID in Balti is 3100 which is 10% of the overall national estimate.  Among commercial sex workers in 2013 it was estimated in Chisinau as 11.6% and in Balti as 21.5%. The number of CSW in Balti 1800 - 15% of the total number for Moldova.  Among MSM in 2013, the prevalence of HIV was in Chisinau 5.4% and in Balti 8.2% with estimated number of MSM mounting to 1200 (about 9% of total)[[51]](#footnote-52).  Thus, the prevalence of HIV is rather high in all key populations in Moldova, and it is the highest in the city of Balti. While the estimated size of all key populations in Balti constituted 9-15% of the national estimates, the percentage of PLWH is currently more than 17% which confirms the necessity of finding new solutions.  Moldova has low case detection rate of TB – 65%. High MDR-TB rate – 24% for new cases and 62% for retreated. Limited access to testing for MDR-TB – only 61% for retreated. Undetected MDR-TB cases: 925 confirmed cases in comparison with 1520 estimated. Low treatment success of MDR-TB – 59%[[52]](#footnote-53).  Rates of new cases of HIV/TB are higher in Balti than in Moldova in general (20,66 vs. 7,38 per 100 000) as well as the TB mortality (18,7 vs. 12,5 per 100 000).  Georgia was categorized as a low-HIV-prevalence country[[53]](#footnote-54); however, more recently[[54]](#footnote-55) it was classified as medium-level along with Kazakhstan and Lithuania. HIV epidemic is predominantly concentrated among people who inject drugs. In 2009, based on the RDS survey conducted on five cities, the number of PWID was estimated as follows: in Tbilisi - 27 107 (23 694-31 532); Gori – 2 989 (2 537-3 570); Telavi – 557 (358-941); Zugdidi - 4 855 (3 945-6 089); Batumi – 5 937 (5 008-7 162)[[55]](#footnote-56). Though the prevalence of injection drug use[[56]](#footnote-57) and the prevalence of HIV among PWID[[57]](#footnote-58) was higher in Batumi, the PWID population is definitely the largest in Tbilisi - the capital. Subsequent estimates[[58]](#footnote-59) show that 38445 of 45000 of total PWID in Georgia, or 85% of them, live in Tbilisi, and the prevalence of HIV among them (5,42%) is higher than in other PWID (about 3%)[[59]](#footnote-60).  While the FSW population is smaller than the PWID one, 60% of it also dwells in Tbilisi (estimated 3910 of 6525) with HIV prevalence 0.6% in Tbilisi and 0.8% in Batumi[[60]](#footnote-61), this might seem to be a clear rise from 0,4% estimated in 2002-06[[61]](#footnote-62); however, the estimates were based on just one HIV-seropositive study participant in Tbilisi and one in Batumi, so no reliable prevalence estimates can be done so far. So, HIV prevalence among FSWs remains low and reached its highest value of 1.9% in 2009[[62]](#footnote-63).  MSM population is distributed across the country differently than the two abovementioned groups: only less than 30% (estimated 5100 of 17215) are found in the capital city Tbilisi[[63]](#footnote-64); and this population seems detached from the PWID as the estimated prevalence of injection drug use among MSM (4.9% -[[64]](#footnote-65)) is similar to that estimated for the five cities population[[65]](#footnote-66). There was an alarming increase in HIV prevalence among MSM, measured by two Bio-BSSs, from 3.7% in 2007 to 6.4% in 2010[[66]](#footnote-67), to 13% in 2012[[67]](#footnote-68) and even higher to 21% according to the unpublished 2015 data. These dangerous trends might be due to high prevalence of syphilis and herpes in MSM population in Georgia found in several surveys[[68]](#footnote-69).  Georgia has limited access to testing for MDR-TB – 61% in retreated cases. Undetected MDR-TB cases – 441 registered in comparison with estimated number 640. Limited access to HIV testing in TB patients. Only 67% of TB patients know their HIV status[[69]](#footnote-70).  Romania. 14 000 people are estimated to be living with HIV in Romania with 12 886 officially registered in 2014[[70]](#footnote-71). Key populations are the driving force of the epidemic and HIV prevalence among them is high – 53.3% is the last IBBS HIV prevalence among PWID[[71]](#footnote-72). National TB program is funded domestically only on 15%%. Low access to testing for MDR-TB – 73% for new cases and 64% for retreated cases and as a result undetected MDR-TB cases. Low MDR-TB treatment success – 34%. Only 69% of TB patients know their HIV status[[72]](#footnote-73).  In most countries of Central Asia, the epidemics are small in absolute numbers but significant in prevalence rate[[73]](#footnote-74). Rates of tuberculosis in Central Asia are extremely high, and even more alarming are the very high rates of multidrug-resistant tuberculosis (MDR-TB) in Kazakhstan, Uzbekistan, Tajikistan and Kyrgyzstan[[74]](#footnote-75).  The Central Asian HIV epidemic has traditionally been assumed to be driven nearly exclusively by drug use; however, HIV prevalence data for FSWs suggest sustained or increasing prevalence in the region[[75]](#footnote-76). The HIV epidemic among MSM is predominantly detached from drug use and is still to be uncovered.[[76]](#footnote-77)  In addition to the universally relevant factors, some studies among PWID analyzed the relationship between HIV and determinants that are particular to local context. For example, a study in Uzbekistan found respondents of Uzbek ethnicity to have higher odds of HIV than their Russian counterparts. However, a study in Estonia found that ethnic Estonians had reduced odds of HIV compared with those of Russian or other backgrounds[[77]](#footnote-78).  Kazakhstan is a country with a concentrated HIV epidemic limited to key high-risk populations (PWID, FSW, MSM and prisoners). The majority (58.3%) of new HIV cases are still registered among PWID[[78]](#footnote-79).  The HIV prevalence is 94.5 per 100 000 population. According to sentinel surveillance, among PWID, 7.9% are seropositive, among FSW – 1,5%, among MSM – 1,2%, among prisoners - 3,9%[[79]](#footnote-80). In Kazakhstan, there is substantial overlap between the sites with the largest number of diagnosed HIV infections, largest number of registered drug users and highest number of heroin seizures[[80]](#footnote-81).  Like in many other countries listed in this narrative, substantial portions of key population dwell in the largest city, Almaty: estimated 11000 of 110940 (10%) PWID live in Almaty, and the prevalence of HIV among them is a bit higher (8.10% vs. 7.9%); estimated 8300 of 19947 (42%) FSW live in Almaty; estimated 4000 of 27890 (14%) MSM live in Almaty.  Despite of high level of TB detection and good treatment results, accessibility of TB diagnostics, country has high level of TB incidence and TB prevalence – accordingly 99 and 127 per 100 thousand population, high rate of MDR-TB – 26% among new TB cases and 58% among retreated cases. Only 76% of co-infected patients receive ARV therapy[[81]](#footnote-82).  In spite of a comparatively low HIV/AIDS burden, Kazakhstan has a high prevalence of multidrug-resistant tuberculosis (MDR-TB)[[82]](#footnote-83). WHO estimates MDR-TB prevalence at 23% in new cases and 55% - in retreatment cases. TB re-emerged as a public health threat in early 1990s, after the breakdown of the Soviet Union, and its burden remains high in Kazakhstan. According to the latest WHO estimates for 2012[[83]](#footnote-84), TB incidence is 137 per 100,000, which is the third highest level among 53 countries of the WHO European Region.  Special population groups, which are considered at high risk of contracting TB and DR-TB, are prisoners, people living with HIV and labor migrants. HIV prevalence among TB patients increased from 0.6% in 2007 to 1.5% in 2011. HIV was not an independent risk factor for MDR-TB; however, HIV-MDR-TB co-infection more likely developed in drug users.  In the selected city of Almaty, the tuberculosis indicators are close to the national levels being slightly more favorable[[84]](#footnote-85).  Kyrgyzstan has a low-prevalence concentrated HIV epidemic with predominant involvement of PWID, MSM and prisoners. Though there are cases of HIV in all the oblasts, the distribution is very uneven[[85]](#footnote-86) and is believed to be influenced by the drug trafficking routes; for example, Jalal-Abad in Kyrgyzstan has reported highest HIV prevalence among PWID at 14% in 2007 compared with a national average of 7.7% which is related to drug trafficking from Afghanistan through Central Asia to the Russian Federation[[86]](#footnote-87). In 2013 the prevalence of HIV among PWID amounted to 12.3%. However, a positive trend is the reduction of HIV prevalence among young (below 25 years old) PWID (from 8% in 2010 to 1.6% in 2013)[[87]](#footnote-88).  HIV prevalence among MSM in 2013 was measured as 13.3%, and this population group is only accessible in Bishkek. Among sex worker, 2.2% were HIV-positive, and among prisoners - 7.6% which was a decline from 13.7% in 2010[[88]](#footnote-89).  Bishkek and Osh cities accommodate 30% of total number of PLHA. The significant number of people representing key populations lives in the selected cities. Estimated number of PWID in Bishkek is 8050 which constitutes 32% of the national estimate, prevalence of HIV among them is 10.90%. As many as 6960 (almost 60%) of MSM are estimated to live in Bishkek with HIV prevalence of 13.30% (which is higher than the national estimates of 6.3%). Female sex workers are a less influential group is Kyrgyzstan; however, 2945 (40%) of them also live in Bishkek.  Kyrgyzstan has limited access to bacteriological diagnostics – only 55% of pulmonary TB have bacteriological confirmation and testing for MDR-TB – only 1267 MDR-TB registered cases in comparison with 1959 estimated cases. At the same time case detection rate is insufficient – 77%. Limited access to MDR-TB treatment; to ARV treatment and co-trimoxazol prophylaxis for co-infected patients[[89]](#footnote-90).  Tuberculosis indicators in Bishkek are more alarming than those for the whole country: tuberculosis-incidence is 118,9 vs. 98,8 per 100 000 and tuberculosis -mortality is 7,3 vs. 6,7 per 100 000.  New, efficient and cost-effective solutions are needed to address the epidemics in the EECA region. The proportion of people with HIV who live in the 200 cities with the highest HIV burden globally is the highest in the EECA region at 38%[[90]](#footnote-91). A city approach has the capacity to address the listed challenges and find sustainable solutions for disease responses that targets high numbers of people with potentially low-cost interventions in a relatively concentrated geographic area and, subsequently, can be adopted by Government institutions and their partners and be progressively funded by the national budget.  **Cities and related activities**  In all regions of the world, cities and urban areas bear a large share of the global HIV and TB burden. Due to health reforms and further decentralisation of tasks to municipalities, city authorities have to take up an increasing number of roles and responsibilities in protecting and caring for their citizens; this is particularly the case in the EECA region, including the push that austerity creates to urbanisation through people seeking income-earning opportunities in either the formal, or informal, sectors.  Starting in 1986, the first Healthy Cities programs were launched in developed countries (i.e. Canada, USA, Australia, many European nations). Today, thousands of cities worldwide are part of the Healthy Cities network and exist in all WHO regions. Evaluations of Healthy Cities programs have proven them to be successful in increasing understanding of health and environmental linkages and in the creation of intersectoral partnerships to ensure a sustainable, widespread program[[91]](#footnote-92).  ASEAN ‘Cities getting to Zero initiative’ is focusing on 13 ASEAN cities and municipal areas — which account for large proportions of HIV burden in their countries (including three in Indonesia) — to catalyze country actions towards the achievement of the 2012 ASEAN Declaration of Commitment: Getting to Zero New Infections, Zero Discrimination, Zero AIDS-related Deaths[[92]](#footnote-93).  The Zero TB Cities Project initiative was formed by Advance Access & Delivery (AA&D) in 2014 to harness growing momentum behind the idea of bringing the global tuberculosis (TB) epidemic into the elimination phase, with a particular focus on local government participation and catalytic successes in multiple locations. To achieve this goal, the Project acts as a platform for association and mutual assistance between comprehensive programs ambitiously tackling TB in all its forms in specific, geographically designed areas. Through this platform, the Zero TB Cities Project creates and shares new resource streams for TB programs at key sites, works to build a knowledge-sharing platform on effective methods for diagnosis, prevention, and treatment of TB, supports the creation of innovative partnerships against TB[[93]](#footnote-94)**.**  The initiative coming from cities to end AIDS in 2030 is shaping into a city movement that united mayors of 28 cities under the Paris Declaration signed on December 1st, 2014. Unfortunately, the EECA region was only represented by one mayor - that of Bucharest - demonstrating the gap in commitment and the need to sensitize municipalities on the issues of HIV, Tuberculosis and the health of key populations within the broader context of sustainable urban development and the integration of health sector strengthening and protection of human rights of all citizens.  The Netherlands, and its capital city, Amsterdam, are at the forefront of implementing progressive policies for drugs and sex work and the mayor of Amsterdam was one of the first to sign the Paris Declaration in 2014. Amsterdam, as participant of a consortium of the 4 big cities of the Netherlands, has introduced a comprehensive policy on coffee shops in order to 1) safeguard the health of drug users by introducing harm reduction, service provision and prevention; 2) prevent criminal acts in production and trade; and, 3) prevent public disorder. Such policies have led to health gains for both key populations through a safer environment and reduced criminal acts[[94]](#footnote-95). In the ‘H-TEAM’ (HIV Transmission Elimination Amsterdam) project multiple stakeholders (including civil society) join forces to curb the rate of new HIV infections in Amsterdam, specifically amongst high risk groups, men-having-sex-with-men (MSM) and migrants. The H-TEAM project combines a range of innovative strategies to raise awareness about the benefits of early HIV detection and treatment, to implement more rapid and widespread testing, and to efficiently link infected individuals to treatment and care and the implementation and evaluation of pre-exposure prophylaxis in high risk MSM. AIDS Foundation East-West (AFEW), a Dutch founded NGO, has extensive experience in working with key populations in EECA and being the linking pin between East and West in exchanging good practices and expertise. AFEW has good examples of interventions to strengthen health systems and to enhance the collaboration between civil society and local authorities.  Similarly, the Swiss NGO Contact Network (Netz) has a 40 years’ experience in drug work and drug policy. It is one of the leading harm reduction organizations in Switzerland, in Europe and in the international context and is well known for its philosophy on development-oriented harm reduction and treatment. The target groups are drug users, including drug using MSM and sex workers. For Switzerland and the world, the breakthrough of the Contact Netz drug policy and drug work culminated in 1986 with the opening of the first safe injection room in the world, located in the Swiss capital, Berne. Contact Netz, together with the City of Berne authorities, was one of the leading forces to develop the four pillar drug policy of Switzerland (prevention, treatment, harm reduction and law enforcement) as a very successful approach to fight HIV/HCV and to facilitate the social (re)integration of vulnerable groups. The relationship between Swiss municipalities – e.g. the City of Berne and Swiss NGOs/CSO’s – e.g. Contact Netz – is based on 'contractual co-operation'. Such 'contractual co-operations' include the financing of sustainable services in HIV prevention, safe injection rooms, work integration, housing, social integration, substitution and security cooperation with the police as well as the participation in the drug commission of the city. The philosophy behind this contractual co-operation model is the theory of 'New Public Management' in which Contact Netz, together with European NGOs, has developed a number of successful regional city platforms responding to the widespread social and health-related problems of vulnerable groups that appear highly concentrated in major urban areas. A good example is the INWORK project: European project of meaningful work and (re)integration programs for marginalised and vulnerable groups such as drug users, homeless people and people with mental health problems[[95]](#footnote-96).  Some cities in the EECA region have demonstrated commitment, and made practical steps, to address HIV and TB in the cities most affected. For example, Tallinn (Estonia) has successfully managed the transition from international to domestic funding of HIV interventions through strong reliance on the city model. Similarly, Prague (Czech Republic) in recent years has managed to achieve a 10-fold increase in the city's budget allocation to PWID programs.  Good practices of AIDS and TB response among key populations exist in the region, for example that of Ukraine. From 2007, the International HIV/AIDS Alliance in Ukraine and its partners from civil society and the government have been developing practical and cost-effective interventions to improve outreach, HIV testing, enrollment and retention in HIV care and treatment for hard-to-reach and high-risk groups such as PWID, commercial sex workers (CSW), and men who have sex with men (MSM). For improving HIV case-finding, Alliance and partners are using peer-driven interventions (PDI), HIV screening with rapid tests in outreach. In addition, implementation of the new intervention called 'risk network PDI' (RNPDI) has improved HIV case-finding from 3% to 25%. Community initiated treatment intervention (CITI) has also been developed by Alliance Ukraine as a short-term rapid linkage from prevention to treatment interventions which facilitate early treatment access for active drug users. Thereafter, CITI Plus aims to not only link positive clients to treatment but to also provide effective adherence support through a combination of community contingency management and community DOTs activities. These interventions in the context of the EECA region are rather an exception than a rule and still have to be adapted for community TB case finding, diagnosis and treatment.  Community systems in the region  NGOs and CBOs are relatively weak throughout the EECA region, especially speaking about advocacy, skills to discuss, negotiate and collaborate with the local authorities, although some countries have an increasing number of competent organisations, usually with links to international NGOs. Throughout the region, there is also a lack of community organisations, or organisations of patients for specific diseases, who can advocate on behalf of those affected. In most instances, communities are not registered and, therefore, are unable to access funding to support self-help initiatives, etc. In some countries, such groups have leaders who have not remained in contact with their community or have been unduly influenced by pharmaceutical companies or pharmacies and, consequently, may become biased. Competition between leaders in communities is also an issue and their battle to access limited resources or contacts with donors.  One of the ways to sustain and develop further the existing key populations groups is the establishment and development of the regional networks of key populations that start to play a more and more significant role in regional and local responses and policies regarding key populations.  There already exists several strong, regional NGO networks and capacity building efforts continue through such groups as ENPUD, SWAN, ECOM, South Caucasus Network, Regional HIV Legal Network and the Eurasian Women’s Network on AIDS (EWNA).  ENPUD strategic priorities are around reducing internal and external stigmatization of people who use drugs; mobilization of partners and resources to improve access of PUD to quality services including ART and OST; improving efficiencies of human rights protection activities including protecting the broken rights on the national and international levels; building the capacity of ENPUD to mobilize communities of PUD.  ENPUD has presence in the following cities: Yerevan, Tbilisi (GENPUD), Soligorsk, Almaty (Temirtau), Bishkek, Beltsi, St. Petersburg, Yekaterinburg, Dushanbe, Kyiv, Odesa.  ECOM's mission is to create favorable conditions to ensure that MSM and transgender people (TG) have access to evidence-based and human rights oriented services in the field of sexual and reproductive health, including HIV. ECOM's strategic priorities include: maintenance of communication system allowing ECOM to work effectively in programmatic and organizational development, and advocacy for MSM and TG-service and LGBT-organizations; capacity strengthening of ECOM's members in implementation of health services for MSM and TG and facilitation of enabling environment for these services; resource mobilization for activities and development of ECOM and its members.  ECOM has presence in the following cities: Almaty (Kazakhstan): Public Fund 'Adali'; Bishkek (Kyrgyzstan): 'Kyrgyz Indigo' and 'Labrys'; Beltsi (Moldova): 'GenderDoc-M' based in Chisinau but working in whole Moldova; St. Petersburg (Russia): 'Action' Center; Dushanbe (Tajikistan): 'Equal Opportunities'; Kyiv (Ukraine): 'Gay Forum Ukraine'.  South Caucasus Network strategic priorities are: contributing to coordinating processes of programs preventing HIV among MSM and TG; mobilization of the civil society HIV prevention among MSM and TG; development of the system of providing all-inclusive service package for MSM in the context of preventing HIV in the South Caucasian region; advocacy of legal processes contributing to the effective response to HIV in the South Caucasian countries; contribute to developing gender-sensitive legal, medical and social services for TG in preventing HIV; practical investigations to gather evidences; development of network cooperation at the national level.  SCN is present in Yerevan (Armenia) - We For Civil Equality NGO, and Tbilisi (Georgia) - Tanadgoma NGO.  Key human rights barriers and gender inequalities that may impede access to health services in the region  Criminalization of behaviors associated with people from key populations continues to be a major barrier to accessing health and related services throughout the region. Even in countries where there is no specific legislation outlawing a particular behavior, people continue to be detained, or imprisoned, regardless.  Also in a number of EECA countries HIV transmission is criminalized.  Although law enforcement training in harm reduction and related issues does sometimes take place, it is very limited in scale and resources and, to-date, appear to have had little practical impact for most people from key populations. A lack of consistent and systematic documentation of such violations of the rights of people from key populations is undermining the efforts of some NGOs and CBOs to address this inequality with the authorities, especially with the judiciary.  Furthermore, access to justice by people from key populations is extremely limited in all countries of the region, either due to cost or due to lack of suitably qualified legal professionals willing to take cases brought by people from key populations. Such inequality in access to legal rights is further exacerbated by the many obstacles put up against people from key populations in obtaining documents necessary to register for health services, including treatment.  A further issue is the sensitivity of communities about speaking directly about a range of issues, such as drug use, sexual activities, sexual orientation and gender identity and, unless approached sensitively, can result in a negative reaction by communities, especially in more conservative areas of Central Asia. Animosity and friction also exists between some key population groups in certain countries of the region, especially between PWID and MSM, and access to the limited resources available.  It is important to note thought that different law enforcement models are applied on the municipal levels and vary based on the levels of awareness of local police about the program implementation in a specific city.  A significant number of people from the Roma community in the region, as well as many economic migrants, are faced with this situation, resulting in high stigmatisation of such people and thereby poor access by them to health services. Internal migration, and internally displaced people who leave areas of conflict or war, suffer additional problems in accessing health services due to a lack of coordination between the key agencies involved, especially interior and health ministries, respectively.  The health systems in the region  Healthcare systems in the region are primarily based on vertical structures and practices of the former Soviet Union, resulting in an institutionalised and musicalized approach that is costly, ineffective and inefficient due largely to poor management and one in which people from key populations are highly stigmatised and discriminated against by healthcare workers who have little, if any, knowledge or understanding of issues such as drug dependence, sexual orientation and gender identity, for example. This is due to the lack of involvement by universities and medical schools in the systematic training of the next generation of service directors, managers and service providers in holistic, evidence-based good practices. As a result, healthcare services are not patient-centred, nor are they community-based and there is no, or very little, consideration as to the quality of care being provided, with most people from key populations excluded from accessing services.  In addition, health services currently available are insular in their approach, unable to be part of a holistic approach in which social services are part of a team providing quality care in the community. Furthermore, in most countries of the region, external funding has strengthened the vertical nature of health programmes, especially for HIV/AIDS and TB, rather than acting as a catalyst for the integration of services in order to save human and financial resources. There is also a lack of health insurance available to people throughout the region, and especially for people from key populations, especially to address 'catastrophic' health expenditures which can cause even greater levels of poverty for the individual and their family members.  A good opportunity to counteract the stubbornness of the national systems are the city-based solutions which provide more horizontal service delivery. There is a range of successful pilots of new healthcare models delivered as part of reform of the healthcare system. A good example would be Komsomolsk town in Ukraine that became a pioneer and a best practice of working with family doctors with the capacity to inform the national level health reform. A strong capacity of cities in piloting new interventions and creating the critical mass for change in the national context must be taken into account.  A crucial factor affecting the ability of health systems to innovate and become more efficient is the lack of partnership in most countries of the region between the Ministry of Health and NGOs. There are some very useful examples where the partnership has worked well, such as Ukraine, Georgia, and Russia, but most other countries either do not have a well-developed NGO sector, or NGOs lack the confidence and the technical capacity to take on a comprehensive partnership with Government entities. Such Government agencies appear more comfortable in using the systems remaining from the former Soviet Union rather than consideration of healthcare delivery to individuals to whom they serve[[96]](#footnote-97).  Again, counteracting some of the national trends, some cities have shown very progressive collaboration models with the civil society in the context of a much more state focused national systems. For example, St. Petersburg in Russia is one of the successful models in developing city level social contracting schemes funded by the municipality. There is a strong capacity in developing collaboration between the municipalities and the civil society in the region that would make the most difference to key populations that reside in this or that locality. This is exactly the way the successful responses have developed in the cities of western Europe. |

|  |
| --- |
| 1.2 National and Regional Disease Strategic Plans |
| With clear references to the current national and/or regional strategic plan(s) and supporting documentation for TB and HIV, briefly summarize the following:   1. The key goals, objectives and priority regional program areas. 2. Implementation to date, including the main outcomes and impact achieved, at the regional level. 3. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed. 4. If applicable, the main areas of linkage to the national / regional health strategy, including how implementation of this strategy impacts relevant disease outcomes.   The applicant can also refer to the technical partners’ regional frameworks or guidance while answering this question. Further, the response to this question should be tailored by the applicant in context of the situation in the region and focus of the application. |
| 2-4 PAGES SUGGESTED  Various strategies and action plans of international organizations and donors already exist for the EECA region as outlined below[[97]](#footnote-98). HIV/AIDS regional strategies: UNAIDS, WHO, EC, Global Fund, PEPFAR In July 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) UNAIDS launched its new initiative with ambitious targets for (1) 90% of all people living with HIV to know their HIV status (90% diagnosed); (2) 90% of all people with diagnosed HIV infection to receive sustained antiretroviral therapy (ART) (90% on HIV treatment); and, (3) 90% of all people receiving ART to have viral suppression (90% suppressed) [[98]](#footnote-99). UNAIDS has recently adopted new strategy for 2016-20. It aims to fast-track AIDS response including by picking up high burden cities as an element of geographical prioritisation within countries.  The Cities Report has been prepared by UNAIDS and released in 2014 providing the data and methods on responding to HIV in cities. Using a Fast-Track AIDS response, cities are called to improve social equality for people affected by HIV and those living with the disease, while also addressing related public health challenges in new and innovative ways to prevent disease[[99]](#footnote-100).  The World Health Organisation (WHO) action plan for HIV/AIDS in Europe, 2012-2015[[100]](#footnote-101), reflects the WHO's global health sector strategy on HIV/AIDS[[101]](#footnote-102) that seeks to halt and begin to reverse the spread of HIV by 2015 and to halt and begin to reverse the incidence of TB in Europe[[102]](#footnote-103). As noted by WHO in 2010, "although globally the number of people newly infected with HIV is decreasing, in eastern Europe and central Asia it continues to rise"[[103]](#footnote-104).  The European Commission (EC) has extended its support in the HIV/AIDS sector to the end of 2016 through a range of funding modalities with support being provided to EU member states, the EU enlargement countries, and countries bordering the EU, as well as the Russian Federation. The focus of the EC Action Plan is on (1) political leadership as an important asset in the fight against HIV/AIDS; (2) the need to address stigma and discrimination, including legal barriers that impede measures to fight HIV/AIDS; (3) HIV/AIDS co-infections such as TB and viral hepatitis, particularly among PWID; (4) treatment as an effective way of preventing HIV; and, (5) the need to stay aligned with regional action frameworks to facilitate synergies and maximise impact[[104]](#footnote-105).  In its 2012-2016 Strategy, 'Investing for Impact', the Global Fund is seeking to be a more effective and efficient funder and to have an impact on health that will result in 10 million lives being saved from 2012 to 2016 and 15 million lives saved since inception of the Fund, together with 140-180 million new infections averted between 2012-2016[[105]](#footnote-106). With regards to the EECA region specifically, the Global Fund’s vision is to stabilize the prevalence and reduce the incidence of HIV and to contain the spread of drug-resistant TB within an environment in which each country develops a self-sustained response to the epidemics.  The GF's specific objectives include the reduction of HIV transmission among PWID by 50%; to increase to, and sustain coverage of, 80% of those in need of ART; to diagnose at least 85% of TB patients, especially multidrug/extensively drug-resistant TB patients; and, to successfully treat at least 90% of patients with drug-sensitive TB and at least 75% of patients notified as having multidrug-resistant TB[[106]](#footnote-107). In this regard, it is noteworthy that the Russian Federation is a major contributor to the EECA disease profile, with the largest HIV epidemic in the region (more than 900,000 persons estimated to be living with HIV/AIDS) and the 11th highest burden of TB and the third highest burden of multidrug-resistant TB in the world.  The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the U.S. Government initiative to help save the lives of those suffering from HIV/AIDS around the world.  PEPFAR is the cornerstone and largest component of the U.S. President’s Global Health Initiative (GHI). GHI is the umbrella that links the efforts of U.S. Government health programming into a unified health strategy. Within the EECA region, PEPFAR focuses its efforts in the Central Asian countries of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, as well as support to Ukraine[[107]](#footnote-108).  PEPFAR in Central Asia concentrates on three strategic priorities: (1) expanding the availability of, and access to, comprehensive HIV/AIDS prevention, treatment and care services for key populations; (2) systematic strengthening of the capacities of institutions, organizations, and individuals to more effectively plan, deliver, and monitor quality services for key populations; and, (3) to build the capacity of public health institutions to collect, analyze, disseminate and utilize data to obtain accurate and complete information about the epidemic, to support policy development, programme planning and implementation, and to improve outreach prevention efforts.  PEPFAR provides technical assistance to build the capacity of host governments and civil society organizations to plan, direct and monitor national HIV programmes, with an emphasis on prevention among key populations, surveillance, testing and counselling, and quality care and treatment[[108]](#footnote-109).  The PEPFAR programme is now in phase 3 (2013-present) and is focused on transparency and accountability for impact, as well as accelerating core interventions for epidemic control.  PEPFAR is investing resources strategically and geographically to reach populations at greatest risk with evidence-based programmes[[109]](#footnote-110), although the provision of NSP remains problematic.  National HIV programs exist in all of the program countries. Very few of the cities have dedicated HIV plans though. Tuberculosis regional strategies The WHO Global TB strategy and targets, post-2015, aims to end the global TB epidemic with targets to reduce TB related deaths by 95% and to cut new cases of TB by 90% between 2015 and 2035 with interim milestones set for 2020, 2025, and 2030. The strategy also seeks to ensure that no family is burdened with catastrophic expenses due to TB and focuses on serving populations highly vulnerable to infection and poor health care access, such as migrants, and to substantively engage with partners within the health sector and beyond, such as in the fields of social protection, labour, immigration and justice[[110]](#footnote-111). The three pillars of the strategy encompass (1) integrated, patient-centred care and prevention; (2) bold policies and supportive systems; and, (3) intensified research and innovation. Of particular note is the focus on systematic screening of contacts and high-risk groups as well as collaborative TB/HIV activities and management of co-morbidities, together with preventive treatment of persons at high risk, and vaccination against TB[[111]](#footnote-112).  In May 2014 the World Health Assembly passed a resolution approving with full support the new post-2015 Global TB Strategy (End TB Strategy). The strategy aims to end the global TB epidemic, with targets to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to ensure that no family is burdened with catastrophic expenses due to TB. It sets interim milestones for 2020, 2025, and 2030.  During the Eastern Partnership Ministerial Conference on TB and MDR-TB (March 30-31, 2015, Riga) the TB Action Plan for the WHO European Region 2016-2020 was discussed and found reflection in the Riga Declaration on Tuberculosis and its Multi-Drug Resistance. Declaration highlights a number of key areas to consider and review, including:  implementing the End TB Strategy and the proposed regional action plan for TB and MDR-TB 2016–2020; targeting and increasing domestic funding towards more patient-centered care at an ambulatory level as a way to avoid hospital-based transmission of the disease and to ensure appropriate patient education interventions, especially for socially vulnerable groups; strengthening and formalizing regional collaboration on TB and MDR-TB at the highest political level across different sectors, including civil-society organizations and communities.  TB Action Plan for the WHO European Region 2016-2020 was endorsed at the 65th session of the WHO Regional Committee for Europe (September 14-17, 2015, Vilnius). The main milestones defined in the TB Action Plan: reduction in the number of TB deaths by 35%, reduction in TB incidence rate by 25%, cure rate in the cohort of patients with MR-TB at least at the level of 75%. The key areas of interventions stipulated by the TB Action Plan:  1. Integrated, patient-centered care and prevention; 2. Bold policies and supportive systems; 3. Intensified research and innovations. The targets and objectives of the new TB Action Plan are aligned with the global End TB Strategy and are built upon the core principles of the Health 2020 Strategy.  Moreover, 20th November 2015 Stop TB Partnership TB Partnership launched of the Global Plan to End TB 2016-2020: The Paradigm Shift. Plan provides a roadmap for the fight against TB for a five-year period. This is the 4th Global Plan since the inception of Stop TB Partnership in 2000.  This plan, based on the End TB strategy, aims to end TB and ‘walks away’ from the limited approach aimed to "controlling" the diseases only. Specifically it speaks about preventing TB, active case finding and contact tracing, focusing attention to key vulnerable and marginalized groups, developing and roll out of new tools, and implementing TB services packages that are comprehensive and work in different type of epidemic and socioeconomic environments. The global TB efforts can become significantly more ambitious and effective by dramatically changing the way TB programs are run. The plan to seeks to achieve the 90-(90)-90 targets: reach at least 90% of all people with TB and place all of them on appropriate therapy—first line, second line and preventive therapy as required; as a part of this approach, reach at least 90% of the key populations, most vulnerable, underserved, at risk populations; achieve at least 90% treatment success for all people diagnosed with TB through affordable treatment services, adherence to complete and correct treatment, and social support.  The Stop TB Partnership was established by the World Health Assembly (WHA) in May 2000 and comprises more than 1,200 organizations, including donors, national and international organizations, governments, NGOs, affected communities, and academic institutions working together to reduce the toll of TB worldwide and ultimately to achieve a world free of TB[[112]](#footnote-113). Its Operational Strategy, 2013-2015, serves as a roadmap for how the Partnership Secretariat, based on its comparative advantages and available financial and human resources, supports the Partnership and contributes to the Global Plan to Stop TB. The strategy has four priorities over the three years that include efforts (1) to facilitate meaningful and sustained collaboration among partners; (2) to increase political engagement by world leaders and key influencers to double external financing for TB from 2011 to 2015; (3) to promote innovation in TB diagnosis and care through TB REACH and other innovative mechanisms and platforms; and (4) to ensure universal access to quality assured TB medicines and diagnostics in countries served by the Global Drug Facility (GDF)[[113]](#footnote-114).  The regional TB project supported by the Global Fund starting 2016 will support the implementation of Global End TB Strategy.[[114]](#footnote-115) Of particular note are the following components of the Strategy, which are reflected in the goal and objectives of the regional proposal:   * Early diagnosis of TB and systematic screening of contacts and high-risk groups; * Collaborative TB/HIV activities; * Political commitment with adequate resources for TB care and prevention; * Engagement of communities, civil society organizations and care providers; * Social protection, poverty alleviation and actions on other determinants of TB; * Discovery, development and rapid uptake of new tools, interventions and strategies; * Research to optimize implementation and impact, and promote innovations.   Further, the regional project is aligned with the three 90-(90)-90 targets of the new Global Plan to End TB 2016-2020: reach 90% of all people who need TB treatment, including 90% of people in key populations, and achieve at least 90% treatment success.  At the national level, the regional project will support achievement of goals, objectives and targets of national TB strategies. Current national strategies and action plans contain targets aiming to reduce TB morbidity and mortality and to improve treatment outcomes. These are expected to be achieved through a number of medical, psychosocial and structural interventions, capacity building, improvement of coordination and other efforts. However, the approach in the plans and strategies is usually nationwide, and, with very few exceptions, they do not address TB epidemics in large cities. While large cities and capitals are usually the ones with largest and central-level TB facilities (hospitals, laboratories, etc.), these are serving patients from the entire country, a region or a number of regions. At the same time, large cities lack their own targeted programs for TB prevention, diagnosis, treatment, care and support, and the funding they receive usually does not take into account the need in additional resources for addressing the factors aggravating TB situation in urban context. This gap will be addressed by the regional project, contributing to successful implementation of national plans.  The recently approved SDGs with specific indicators to be determined in first quarter of 2016 all affect people’s health and wellbeing. SDG 11 specifically looks at urban living and health.  National and City level HIV and TB programs  Belarus State program ‘People’s health and demographic security of Belarus in 2016-2020’ at the moment of concept note submission is present in concept format only. The National HIV/AIDS program 2016-2020 is undergoing approval by the ministries. The program prioritizes access to key HIV services for key populations. Belarus Subprogram “TB prevention” of the state program “People’s health and demographic security for 2016-2020” has been approved by the Council of Ministers on December 2015. Its targets include increased efficiency of treatment of drug-resistant tuberculosis; 90% coverage of patients with MDR-TB risk by rapid diagnosis (bacillary patients, TB/HIV; repeated treatment); 95% coverage of patients with confirmed MDR-TB among new patients; 90% coverage of TB/HIV patients with ART; 100% coverage of MDR-TB/HIV patients with preventive cotrimoxazole treatment; 85% abacillation among new MDR-TB patients 6 months after the start of treatment.  In Soligorsk, there are no city level programs on HIV or TB, but there is a city plan of activities to implement the National programs on HIV and TB for 2011-15. There is a city level coordinating body – Soligorsk rayon coordinating council of HIV and STI prevention, which includes members from local authorities, police, medical staff, NGOs. ARV procurement is conducted at the cost of national budget and the Global Fund similarly as the funding for OST. Needle exchange is funded from the Global Fund grant. In 2014 Soligorsk rayon administration conducted call for proposals for implementers of social support programs for PWID and funding of up to 10 000 USD has been provided to support the work of 2 outreach workers. Currently there is no funding for social contracting from Soligorsk authorities as the Ministry of Finance considered the funding to be not relevant and key populations programs not eligible for social contracting funding.  Bulgaria has been implementing its HIV interventions within the National Programme on Prevention and Control of HIV/AIDS and sexually transmitted infections for 2008-2015. The new program is under development at the moment of Concept Note submission. Sofia City level HIV program has been prepared in the last years, but is still not finished and adopted. The city level HIV coordinating Council has 27 members, 10 of them are NGOS, others represent governmental and municipal agencies, health services, police, etc.  Programs are funded by the Ministry of Health, prevention is funded by a grant from the Global Fund, treatment is funded by the national budget. There is no available data on the level of funding for Sofia specifically.  **Bosnia** and Herzegovina is developing interventions within the ‘Strategy to Respond to HIV and AIDS in Bosnia and Herzegovina 2011-2016’. The City of Sarajevo does not have any HIV/TB programs. The only program is national program supported by the Global Fund and UNDP. Key populations prevention programs in 2014 were funded by the Global Fund. The costs of treatment and procurement of ART in the Federation of Bosnia and Herzegovina, Republic Srpska and the Brcko District is covered by health insurance funds. Three reference centers in Banja Luka, Sarajevo and Tuzla (Clinical Centre University of Sarajevo, Clinical Center University of Banja Luka and Clinical Center University of Tuzla) provide treatment for AIDS patients in the last three decades which is fully covered by the health insurance funds.  Georgia National HIV/AIDS Strategy for 2016 – 2018 prioritizes access to HIV prevention and treatment services for key populations. National TB Strategy on 2016-2020 has been developed and has the goal to stop the spread of TB in Georgia and reduce the TB burden by sustaining universal coverage with quality diagnosis and treatment of all TB patients, including those with M/XDR-TB.TB services are mainly funded by the State TB program. However, Georgia still heavily relies on Global Fund support for funding TB drugs and consumables for lab equipment. There are no city level HIV or TB programs, all HIV and TB programs are centralized. Therefore even data is centralized and in many cases it is impossible to disaggregate city level data from national level data. Most of the funding for HIV in Georgia is coming from the state HIV program (8.17 Million, nearly half of the overall HIV funding in 2014), one third – from the Global Fund, rest – from private sources.  HIV component is included into the State health development program of Kazakhstan for 2016-2020. There are no city level HIV programs in Kazakhstan and no city level Coordinating council. There are episodical meetings of partners on the city level. In 2014 in Kazakhstan republican and local budgets funded 6 910 Million tenge (or around 20 M8llion USD); international organization (including the Global Fund) - 427,26 Million tenge (1.5 Million USD). City budget is funding prevention work, republican – drugs and equipment procurement.  In Kazakhstan, there is an active TB program for 2014-2020. Major participants: the state, external donors, NGOs. Despite of the high level of TB detection and good results in treatment and accessibility of TB diagnosis, the country has a high level of TB incidence and rate. There is no municipal Almaty TB program, all participants work under the approved action plan.  Kyrgyzstan State Program on stabilization of HIV epidemic in the Kyrgyz Republic is covering the period of 2012 – 2016. Kyrgyzstan National Plan on MDR /XDR-TB Control in the Kyrgyz Republic 2013-2016 has the following objectives:  1. Improving of management, coordination, monitoring and evaluation of the National TB Control Program;  2. Control of drug resistance and diagnostics of DR-TB cases (coverage 100% by 2015);  3. Improving TB case management to prevent development of the amplification and DR-TB forms;  4. Treatment of DR-TB cases and increasing of coverage of M/XDR-TB patients up to 85% by 2015;  5. Improving quality of MDR-TB patient treatment to reduce development of XDR-TB, and relapses;  6. Improving infection control at all levels;  7. Increasing participation of PHC and Department of Disease Prevention and Expertise in fight against TB;  8. Advocacy, communication and social mobilization (ACSM) in fight against TB;  9. Enhancing the network of TB control laboratories;  10. National capacity strengthening in terms of fight against drug resistant tuberculosis;  11. Program of social support of the patients with drug resistant tuberculosis (DR-TB) and health workers;  12. Operational research of DR-TB;  13. Improving TB/HIV co-infection management.  At the municipality of Bishkek there functions Coordinating commission on managing health system operating under intersectoral approach which prioritizes the issues of HIV and TB. Most of the activities on HIV prevention for key populations have been funded from the national Global Fund grant, as well as treatment of opportunistic infections and vertical transmission prevention. On annual basis the city budget is funding HIV related activities: needle exchange facilities - 400 000 soms (or around 5 000 USD), IFA laboratory - 700 000 soms (equivalent to 9 000 USD), for procurement of medical drugs for treatment and prevention of opportunistic infections and other medical procurement - 350 000 soms (or 4 600 USD).  Moldova National Program on Prevention and Control of HIV / AIDS and sexually transmitted infections for 2016-2020. National Program on Tuberculosis Control is being prepared for the period of 2016-2020. There is Beltsi municipal program on HIV/AIDS and STI as well as municipal program on TB. There is the city council on HIV/TB composed of representatives of city authorities, medical staff, medical insurance company, police and NGOs. The municipality is funding provision of premises for NGOs working on HIV and TB.  Romania National Public Health Strategy 2014-2020 includes HIV prevention and treatment measures**.** There is Bucharest city council on health and social affairs, which is coordinating a city-funded project on HIV among PWID and other venerable populations (homeless, disadvantaged persons).  Similarly, the Russian Federation does not have a separate HIV/AIDS program and HIV component is included into the State health development program of the Russian Federation for 2014-2020. There exists a Coordinating council on HIV/AIDS working under the Government of St. Petersburg as well as a Coordinating council on TB.  In the Russian Federation, the acting TB programs are the part of the state program "Development of public health protection" approved by the Decree of RF Government dated 15.04.2014 No. 294. TB activities are also reflected in the state program of Saint-Petersburg “Development of public health protection in Saint-Petersburg“ for 2015-2020.  National targeted social program to combat HIV/AIDS for 2014 – 2018 is used in Ukraine. Ukraine National social program against tuberculosis for 2012-2016 has the goal to improve the epidemiological situation by reducing the number of TB patients, reducing morbidity and mortality with TB and TB/HIV co-infection, the spread of MDR TB by implementing public policies based on the principles of universal and equal public access to high-quality prevention, diagnosis and treatment of tuberculosis.  There is Kyiv city level program on HIV prevention and treatment and a dedicated city Coordinating Council on HIV and TB consisting of the city authorities, police, medical staff and NGOs. No municipal funding has been released for AIDS response in Kyiv during the last several years. HIV prevention for key populations is funded through the national HIV grant and ART procurement mainly by the national budget.  There is a city program ‘Health’ for 2015-17 approved of by the Odesa city council. Odesa city coordinating council of prevention of spread of HIV/AIDS, TB and Drug Use has been established since 2011 and is headed by the Deputy Mayor on Humanitarian Issues. Its membership includes local government representatives, AIDS authorities and other medical staff, police, NGOs. In 2014 the city ‘Health’ program released 460 000 hryvnia (around 25 000 USD) on HIV/AIDS. NGOs were funded through the social contracting mechanism by the city budget according to allocation by the city council in the amount of 68 750 hryvnia (or around 3 000 USD).  Existing regional interventions/programs  Eurasian Harm Reduction Network (EHRN) is implementing The Global Fund funded regional program ‘Harm reduction works – fund it!’. The **goal** of the Regional Program is to strengthen advocacy by civil society, including people who use drugs, for sufficient, strategic and sustainable investments in harm reduction as HIV prevention in the region of Eastern Europe and Central Asia. On the regional level, EHRN partners with the **Eurasian Network of People Who Use Drugs** (ENPUD), **UN agencies** and programs (UNAIDS, UNODC, WHO, UNDP), other community networks and regional and international organizations[[115]](#footnote-116). Project activities are implemented in: Belarus, Georgia, Lithuania, Moldova, Kazakhstan and Tajikistan.  A regional network of people living with HIV (ECUO) is implementing The Global Fund supported regional program for advocacy to encourage governments across Eastern Europe and Central Asia to commit to paying for anti-retroviral therapy (ART) and other treatment for HIV. Part of the responsibility of the network, therefore, is to provide tools at the regional and country level for advocates to urge governments to develop plans and set aside budgets to assume the financial responsibility for prevention, treatment and care programs that had been paid for in the past by The Global Fund. Above all this includes the cost of ART. Expanding testing and counselling services around the region is another important component of the ECUO project.  International HIV/AIDS Alliance in Ukraine in partnership with the Steering Committee of TB Europe Coalition, WHO Regional Office for Europe and PAS Center takes part in the activities of an advocacy project for healthcare system strengthening to ensure the efficient control over TB and MDR TB. The project is implemented from January 2016 to December 2018 in Eastern Europe and Central Asia and is focused on reforming the area of tuberculosis treatment and prevention in 11 countries: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan. The project has ambitious objectives to increase political commitment to end TB through regional cooperation and evidence sharing for effective and sustainable transformation of the health systems; and to support countries in implementation of effective, efficient and financially sustainable systems of medical aid delivery to TB patients. Within the key objectives, International HIV/AIDS Alliance in Ukraine in partnership with TB Europe Coalition will ensure the involvement of civil society organizations into the advocacy activities to move to patient-centered model of the delivery of medical aid to TB patients, facilitate sharing best advocacy practices in EECA region to support sustainable high-level advocacy to ensure effective response to TB.  The Global Fund supports regional grant for TB (REP-TB) to leverage high level political commitment, advocacy and sharing experiences among countries especially on health reform and ambulatory treatment of TB/MDR-TB cases.  The joint implementation period of CITIES Platform and TB-RAP programs is 2016-2017; both projects will be implemented in 6 countries of the EECA region, namely in Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova and Ukraine. The main objectives of the program TB-REP:   * to increase the political support in countries for a sustainable transformation of health systems; * the assistance to countries in building an effective model of service delivery in the field of TB with sustainable financing.   During the high level mission within the both projects will be carried out complementary work to increase political commitment to the transformation of health systems of countries for the transition to ambulatory model of health care for people with TB.  The pilot models to assist people affected by TB will be developed and implemented in targeted cities within the project СITIES Platform. It will be a significant contribution to the advocacy at both high-level and bottom-up as part of the TB-REP program. It can also serve as a model for developing country projects to reform the TB service.  In turn, the strong advocacy within TB-REP program and the development of guidelines on the provision of patient- oriented care, financing of services and personnel training in the field of TB will be the basis for a paradigm shift, and as a result - the countries' policy in the field of TB. It can also be used in the development of city models of care for people with TB.  In 2011 UNDP HHD and UNFPA launched a global program to support the design and implementation of municipal action plans on HIV and key populations in large cities. The ‘Urban Health and Justice Initiative’ in partnership with key local stakeholders is supporting the development and implementation of innovative municipal HIV strategies while developing the capacity of key populations to promote and protect their health and human rights. UNDP and UNFPA have supported 26 cities covering five regions to develop innovative Municipal Action Plans addressing the needs of key populations including men who have sex with men, people who use drugs, sex workers and transgender people   * Africa: Abuja (Nigeria): Dar es Salaam( Tanzania), Douala (Cameroon), Kampala (Uganda) Kigali (Rwanda), Lagos (Nigeria), Lusaka (Zambia), Maputo (Mozambique) and Ouagadougou (Burkina Faso) * Asia: Bangkok(Thailand), Chengdu (China), Ho Chi Minh City (Vietnam), Jakarta (Indonesia), Manila (Philippines), Yangon, Mandalay, Pyay, Pathein and Lashio (Myanmar) * Latin America and the Caribbean: Georgetown and New Amsterdam (Guyana), Guatemala City (Guatemala),Porto Alegre (Brazil) and Santo Domingo (Dominican Republic) * Eastern Europe: Belgrade (Serbia) and Odessa (Ukraine).   Implementation to date  On average, less than half of people from key populations have accessed HIV testing and counselling (HTC) services in the 12 months prior to them being interviewed, although key populations are twice as likely to have accessed such services than the general population, as can be seen in Table below. However, some countries in the EECA region have very low levels of HTC access, such as Hungary, Croatia and Bosnia and Herzegovina in particular, whereas a limited number of countries claim to have universal access to HTC for certain population groups, such as Poland among the general population, Hungary for PWID and MSM, and Latvia for PWID. In addition, most countries of the region have not yet adopted the revised WHO guidelines of June 2013 in which a CD4 count of ≤350 cells/mm3 is the point at which ART should be initiated[[116]](#footnote-117).   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Population Group | No. countries reporting | Estimated Average | Range | | | From | To | | General | 16 (55%) | 23.05% | 0.4% Hungary | 100% Poland | | PWID | 24 (83%) | 43.16% | 2% Croatia | 100% Hungary, Latvia | | SW | 21 (72%) | 44.72% | 10.1% Bosnia and Herzegovina | 89.1% Kazakhstan | | MSM | 25 (86%) | 41.74% | 15.45% Montenegro | 100% Hungary | | PWID, SW & MSM combined | 13 (45%) | 45.86% | 15.42% Montenegro | 76.80% Kazakhstan |   Table: Average number of general and key populations who have accessed HTC services in the past 12 months in the EECA region by countries that have reported such data  A total of 238,204 people from the general population are reported by 24 countries of the EECA region (83%) to be accessing ART. This compares with just 9,370 PWID reported by 6 countries (21%) and 3,933 PWID on opioid substitution therapy (OST) to be using ART. One country, Armenia, reported access by 4 SW and 68 MSM to ART.  22 of the 29 countries (76%) of the EECA region reported the distribution of sterile needles/syringes to PWID with the average number distributed at 103.4 sterile needles/syringes per PWID, per year; the median figure was 71 sterile needles/syringes per PWID, per year. Only 4 countries who reported NSP distribution data achieved the WHO, UNODC and UNAIDS recommended quantity of at least 200 sterile needles/syringes distributed to each PWID, per year (the Czech Republic with 201.7; Kazakhstan at 224.00; Estonia at 242.00; and, Kyrgyzstan at 292.00 per PWID, per year). The lowest number of sterile needles/syringes per PWID, per year, was in Serbia at only 16.3[[117]](#footnote-118). |

|  |
| --- |
| 1.3 Joint planning and alignment of TB and HIV Strategies, Policies and Interventions |
| In order to understand the future plans for joint TB and HIV planning and programming, for the region, if applicable, briefly describe:   1. Plans for further alignment of the TB and HIV strategies, policies and interventions at different levels of the health systems and community systems. This should include a description of i) steps for the improvement of coverage and quality of services, ii) opportunities for joint implementation of cross-cutting activities, and iii) expected efficiencies that will result from this joint implementation. 2. The barriers that need to be addressed in this alignment process. |
| 1-2 PAGES SUGGESTED PER COUNTRY  A total of 23 countries (79%) in the EECA region have reported the proportion of TB patients who are living with HIV and 19 countries (66%) have reported the proportion of HIV-positive TB patients who have access to antiretroviral therapy (ART). The proportion of TB patients diagnosed as HIV-positive in the region varies widely from a reported zero (in the Czech Republic, Macedonia and Slovakia) to as high as 20% (in Latvia and Ukraine). ART access by HIV-positive TB patients ranges from a low of 48% (in Ukraine) to claims of universal access in four countries of the EECA region (Albania, Montenegro, Serbia and Slovenia), albeit with relatively low numbers of TB patients receiving such treatment[[118]](#footnote-119).  In the countries of the project that report relevant data highest numbers of HIV positive patients among TB patients is seen in Ukraine (20%), Russian Federation is not reporting the data; most countries have HIV prevalence at the level of 3-5%. HIV treatment coverage is highest in Romania and Georgia at the level of 90%, followed by Belarus, Armenia and Moldova at the level of 70%.  Figure: HIV-positive TB patients and related ART access in countries of the EECA region by project countries that reported such data[[119]](#footnote-120)  There is a need to transition from hospital care model to ambulatory, which requires wider involvement of CSOs in TB services provision. Legal barriers for NGOs involvement in TB treatment support in many countries as well as lack of knowledge/experience among CSOs’ representatives in TB services provision are the reason of insufficient activities of NGOs in TB field including advocacy activities.  There is also a lack of community mobilisation in advocating for quicker and more efficient TB services[[120]](#footnote-121). There is still a lack of integration of services re HIV and TB. There is little contact between HIV and TB specialists about patients. Insufficient standard screening of HIV patients for TB is common in the region. No standard prevention treatment for PLWH for TB.  In order to improve coverage and the quality of services, the following steps must be undertaken and are suggested as part of this program:  - needs assessment, carried out in the beginning of the project to look into factors preventing effective integration of TB/HIV/harm reduction services, and ways to improve coordination and collaboration between actors working on the diseases;  - joint consultations, involving all concerned actors (elected representatives, stakeholders working on the prevention of HIV and TB including harm reduction services, as well as in the fields of care, treatment and support, patient community, law enforcement, and the judiciary) in all project cities, leading to the development of integrated TB/HIV/harm reduction action plans, with relevant indicators and targets. Joint consultations should e conduced regularly throughout project implementation to ensure maximum coverage with services and to address possible quality issues;  - online city platform established and used as a tool to share and promote effective models and best practices for reaching the 90-90-90 objective for HIV and 90-(90)-90 objective for TB in all project cities. The platform should also be used to share action plans developed in project cities, and for tracking progress in implementation of the plans.  The regional project will create a number of opportunities for joint implementation of cross-cutting activities. Collaborative activities lie at the core of the project and are an integral part of all project activities. This means joint implementation of project activities by stakeholders representing TB, HIV and harm reduction areas, as well as city-level policy and decision makers and public officials from health sector, finances, law enforcement and judiciary.  As a result of such joint implementation, the project is expected to bring about sustainable partnerships in the cities covered by the project. Effective communication among the project cities will be happening. By involving all stakeholders, including civil society and community, the project is expected to ensure transparent and accountable policy- and decision-making, program implementation and monitoring and evaluation. Engagement of civil society will also ensure that funding allocated for TB/HIV/harm reduction from municipal budgets will be spent efficiently. |

|  |
| --- |
| SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY |
| To achieve lasting impact against the diseases, financial commitments from national governments and other sources must play a key. Global Fund allocates resources which are far from sufficient to address the full cost of technically sound programs. It is therefore critical to assess how the requested funding fits within the overall funding landscape and how national governments or other donors plan to commit increased resources to the regional disease programs and health sector each year. |

|  |
| --- |
| 2.1 Overall Funding Landscape for Upcoming Implementation Period |
| In order to understand the overall funding landscape of the TB and HIV regional programs and how this funding request fits within that, briefly describe:   1. The availability of funds for each program area and the source of such funding (national governments and/or donors). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund). 2. How the proposed Global Fund investment has leveraged (in case of any existing Global Fund grants) and will leverage resources from national governments and other donors. 3. For program areas that have significant funding gaps, planned actions to address these gaps and raise additional funds.   Please keep your response specific to the aspect of the program for which funding is being requested through this concept note, instead of describing the overall funding landscape for the entire disease programs in the region. |
| 2-3 PAGES SUGGESTED  According to the Global Fund submission by the program countries, the following funding is being secured by the countries for HIV and TB programs in 2013-2017:    \* Not included domestic funds for TB in Kazakhstan, Georgia and Kyrgyzstan; for HIV in Romania, Bosnia and Herzegovina, Bulgaria; and for HIV and TB in the Russian Federation.  *Source: Funding Gap Tables as part of respective country submissions to the Global Fund and data from the Global Fund site regarding previous and current grants*  The diagram demonstrates the anticipated decrease in the Global Fund and other international resources for HIV/TB programs starting 2017 and the stable level of funding from the domestic sources for the same period. In the context of substantial gaps in HIV and TB care cascades and especially among the key populations, the funding decrease for HIV/TB in the coming years needs to be urgently addressed through innovative programmatic and financing approaches.  The funding gap for the provision of a basic package of HIV prevention, care and treatment interventions for PWID, SW and MSM, together with HCV diagnosis, treatment and prevalence monitoring, has been estimated by the Alliance for Public Health based upon a range of factors including (1) the evidence-based interventions recommended by WHO, UNODC and UNAIDS; (2) the estimated size of each key population group in each country, where such data is available; (3) coverage of 60% of each key population group with HIV prevention services as recommended by WHO, UNODC and UNAIDS; (4) the estimated cost of USD 45.23 per PWID, per year, for the provision of sterile needles and syringes, condoms, alcohol pads, HIV rapid blood test, and cost of staff to deliver such interventions; (5) the estimated cost of USD 64.60 per SW, per year, and of USD 51.03 per MSM, per year, for the provision of condoms and lubricant, HIV rapid blood test, and cost of staff to deliver such interventions; (6) the cost of USD 163.63 per PWID, per year, for opioid substitution therapy (OST) and its procurement and distribution; (7) the cost of USD 316.77 per person, per year, for ARV drugs and their procurement and distribution; and, (8) the cost per person, per year, of HCV rapid tests (USD 1.05), HCV treatment (USD 2,270), and HCV prevalence monitoring (qualitative testing) (USD 15).  Adjustments have been made to take into consideration existing Global Fund support to countries of the EECA region. It must be stressed, however, that there are significant gaps in the availability of data, and of reliable data, especially for SW and MSM population size estimates and the coverage of Global Fund supported interventions for key populations in many countries. Therefore, any estimated funding gap must be viewed as conservative, with the likely actual funding required to provide the service coverage needed to impact upon HIV and HCV, respectively, being far higher. In total, the estimated funding gap for PWID, SW and MSM in the entire EECA region is USD 308 million per 1 year, of which USD289 million is needed for countries outside the European Union.  Figure: Funding Gap in HIV, HCV prevention and treatment by Key Populations in the EECA region  In particular, the HIV and HCV needs of PWID constitute over 90% of the funding gap, reinforcing the urgent need for the scaling-up of OST and NSP for PWID in the region, most notably in the Russian Federation. Hence, a major contribution to stopping, and reversing, the HIV epidemic in the region can be made through support to a comprehensive package of harm reduction and associated interventions for PWID in the Russian Federation.  The funding gap in EU countries is far smaller - by a factor of almost 15 - than of non-EU countries of the EECA region. The Russian Federation has by far the largest funding gap of any of the countries, estimated at just over USD 161m, followed by Ukraine with an almost USD 61m gap.  Figure: Funding Gap in HIV, HCV prevention and treatment for Key Populations by country in the EECA region[[121]](#footnote-122)  New funding resources need to be explored in the region to dramatically change the existing situation with coverage of key populations interventions. Cities represent an opportunity to address the most challenging key populations epidemics in the most integrated and comparatively resourced city contexts. |

|  |
| --- |
| SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND |
| This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems. It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The applicant should also provide information on the expected impact and efficiencies achieved from planned joint programming for the two diseases including cross-cutting health systems strengthening as relevant. The modular template (Table 2) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates them with indicators, targets, and costs. |

|  |
| --- |
| 3.1 Programmatic Gap Analysis |
| A programmatic gap analysis needs to be conducted for six to twelve priority modules. These modules should appropriately reflect the regional TB and HIV disease programs in addition to cross-cutting modules such as Health System Strengthening and Community Systems Strengthening.  Complete a programmatic gap table (Table 1) detailing the quantifiable priority module(s) within the funding request. For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.  If applicable, ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 2). |
| * 1. PAGES SUGGESTED – *only for modules that are difficult to quantify*   Despite the leading role of key populations in the development of HIV epidemics in the region, their reach with key services remains critically low. The overall reach with essential HIV prevention services of PWID, Sex Workers and MSM in the program countries is around 10% of the estimated numbers of the groups:    There is a critical need to increase coverage of key populations with HIV and TB services in the project countries.  Different countries have demonstrated different progress towards reaching key populations representatives. The diagram below illustrates the level of coverage of key populations by suggested package of services in the program countries:  City level data is not always available or of sufficient quality and requires additional inquiry. At the same time it may be assumed that national trends are very much the function of the city trends where most of the key populations reside.  Even less developed is the data on key populations HIV care cascade. Based on the overall available data on HIV in the program 8 countries the following aggregated HIV cascade can be developed for the program using 2014 data:  \* no data for Bulgaria  The diagram shows that out of the estimated almost 1.5 Million PLHA only some 260 thousand are receiving ART which is 18% coverage. HIV treatment cascade in 10 project countries shows that major gap exists between number of PLHA linked to care and number of the patients on ART: 811310 PLHA are linked to care, but only 33% of them currently on ART. The more detailed country analysis showed that access to ART varies from 29% in Russia and Kazakhstan to 68% in Georgia.  Substantial gap is seen at the level of HIV treatment access at the project countries strongly led by the accessibility of ART in the cities.  It is well known, that the HIV/AIDS epidemic in the region is still driven by most affected key populations. In average, the share of representatives of key population among all PLHA is 70 percent, where the majority of them are PWID (about 80% of all HIV-infected representatives of key populations). The impact of key populations on the HIV epidemic is differing from country to country: from 16% in Bosnia to 80% in Russia and 87% in Bulgaria.  On the background of overall low access to ART, the access of KP is even cripplingly lower. Only the number of estimated HIV- infected PWID in 10 countries is about 600-800 thousand, while the overall number of ART patients is about 270 thousands.  According to the WHO and other partners assessments, major weaknesses and programmatic gaps in the fight against TB in the EECA region consist in the following: (i) not enough active case finding and contact tracing, including the early TB diagnostic, for key affected population; (ii) low treatment efficiency, increase of MR-TB and repeated treatment cases due to insufficient or low professional work to build adherence to TB treatment, failure to perform full infection control in the places of medical and psychological assistance delivery to TB patients and a very slow transition to the patient-oriented model of health care delivery, including the out-patient one; (iii) weak integration between the HIV and TB services, and limited progress due to post-soviet heritage, vertical structure of health care services; (iiii) insufficient involvement of civil society organizations to the fight against TB due to absence of sustainable financing for NGOs from the budgets of countries/cities (so-called "social mandate") and insufficient coordination with the state sector. (Refusal to conceive a NGO as an equal partner, sometimes sabotage, often stigma). Although, it is scientifically proved that NGOs play significant role in the work of the model for prevention of socially dangerous deceases among the risk groups, as well as they may participate in early TB detection among marginal groups of population that are hard-to-reach for the state sector, take efficient part in support of health care delivery to TB out-patients, contribute in building adherence to treatment.  Health and Community Systems gaps in the project cities  *Almaty, Kazakhstan*  Despite of the high level of TB detection and good results in treatment and accessibility of TB diagnosis, the country has a high level of TB incidence and rate. Treatment retention both for HIV and TB still constitutes a major problem. Low quality of psychological and social follow-up of the patients due to absence of special education, professional knowledge and skills for work with the key affected populations among social workers of the AIDS Center and anti-TB facilities; weak integration between the HIV and TB services – the services “throw over” to each other clients with dual HIV/TB diagnosis trying to avoid responsibility for treatment, complications, mortality rate; high level of stigma linked to HIV, drug use, past imprisonment, etc., from the part of personnel of health care facilities, including the AIDS Center and anti-tuberculosis facilities (patient loses motivation to treatment, does not get required services in full and on time).  *Beltsi, Moldova*  Prevention of HIV among key populations in the city is one of the major problems in AIDS response.  TB problems in the country are linked to the low level of TB detection due to complexities at the diagnostics stage (common queues, stigma from the part of medical personnel), high level of new cases of MR TB, limited access to MR TB testing for repeated treatment, weak detection of MR TB detection and redirecting to repeated treatment, low level of successful treatment (59%) due to low retention, weak integration between the HIV and TB services. General problems of the country affect the TB situation in Beltsy. NGO has built an efficient relationship with the municipal authority. It takes active part in preparation of the city TB program. A new city TB program has been elaborated with a list of activities. But there are not funds for them in the budget. Although the city budget devotes funds for TB and MR TB drugs independently from the program. Also, the NGO is involved in the work for early TB diagnosis among the key affected populations (KAPs), forwarding of clients to health care and prevention facilities, contributes to the system of controlled treatment through nursing of clients at home (delivery of drugs on the basis of the concluded memorandum on cooperation with the tuberculosis dispensary of Beltsy) and its work for building adherence to treatment. Community systems need further strengthening to fully play the role in developing and implementing the city HIV and TB programs and sufficient funding allocation for their implementation.  *Bishkek, Osh, Kyrgyzstan*  Both internal and external migrations are strong in the country. Major cities are Bishkek and Osh. The country has a manual on how to behave with potential TB patients. However, the efforts of the physicians are not sufficient in this field. Due to closed nature of the TB programs for NGOs, TB issues were mainly resolved AIDS-service NGOs among vulnerable groups. Work with general population was not sufficient. Level of stigma towards both HIV and TB patients is very high in the society. The population has a limited access to MDR TB treatment. In the country there are tendencies of imposing religious values which leads to low TB detection among children at early stages. During the last two years a model of TB out-patient treatment has been tested at several Centers for Family Medicine. This model has received positive comments and results. There are still some problems: low quality of PSS due to absence of special education, professional knowledge and skills among social workers for work with the key TB affected populations; weak integration between the HIV and TB services; high level of stigma among medical personnel which leads to the loss of adherence to treatment among patients, patients do not get medical services in full and on time); low level of awareness on TB among wider population.  Although municipal funding is allocated to cover some harm reduction costs, the funding level is not sufficient to cover the city level needs.  *Soligorsk, Belarus*  HIV testing and treatment coverage of key populations remains low. Very little data is available on MSM and sex worker specific HIV cascades. Level of involvement of communities into the decision making on city level remains low. Although there has been a successful experience of social contracting introduction in 2014 in Soligorsk, it has been abolished and further advocacy is needed to prioritize funding of key populations as a target group in social contracting schemes.  TB problems in the country are linked to the low level of TB detection, high level of MR TB among new cases and cases for repeated treatment. Funding shortage of the National TB program makes 31%. There is a high level of MR TB in the country – 34% among new cases and 69% among cases registered for repeated treatment which shows an unsatisfactory infection control and low quality of TB patient treatment. Vertical system of TB and HIV services complicates access to high quality health care services for patients with co-infection. Besides, TB screening is conducted only among the client of the harm reduction programs, other risk groups are not covered; access to health care services for persons from the risk groups is limited also due to absence of social follow-up at the stage of TB diagnostics.  Development and piloting of the project for early TB diagnosis within the risk groups with an active participation of the community representatives in Soligorsk followed by a widening to other regions may solve the problem of the weak TB detection at national level. Establishing cooperation between the two services, development of a network of stations for integrated aid delivery to patients, involvement of primary health and sanitary care in delivery of the services in the field of TB/HIV will increase access to high quality health care for vulnerable groups of population.  *St. Petersburg, Russian Federation*  St. Petersburg demonstrates significant progress in addressing HIV epidemic as compared to other high HIV burden cities of Russia. During the 9 months of 2015 the number of newly registered HIV cases was 3% less than during the same period of 2014. One of the reasons of such achievement is considered to be the well-established algorithm of interactions between NGOs and city authorities supported also by the substantial funding available for the relevant programs in addressing HIV and TB. Nevertheless, there is still a way for the complete transition of the relevant programs to domestic funding. At the moment, many NGOs are formally members of various coordinating bodies together with the relevant authorities at the city and country levels, but they can hardly have meaningful voice there and depend much on the decision makers. Given the changes recently adopted for the legislation in NGO sphere, there is strong need for the development and introduction of new approaches in evaluation of the different projects and programs, modes of practical collaboration, and finally obtaining the sustainable support for the relevant activities, also using the best practices and evidence from other cities and countries participating in this regional proposal.  Delivery of health care to TB patients uses the heritage and approaches employed in the USSR. According to the results of the WHO, the RF is one of the countries of the EECA region with a highest TB burden (third place in the world), MDR-TB case detection rate extremely low – 15.5 thousand in comparison with 39 thousand of estimated number of MDR-TB cases. Treatment success rate is low both in new cases of susceptible TB – 68%, susceptible retreated cases – 39% and MDR-TB – 40%. Only about 50% TB patients know HIV status. State health care facilities have no access for IDUs to perform diagnostics; an extremely weak drug dependency treatment in the anti-TB in-patient facilities, absence of ST, due to which patients leave the departments, they are also discharged with infringements of regime (use of illegal drugs in an in-patient facility); absence of follow-up of IDUs after discharge from an in-patient facility for out-patient treatment, resulting in an increase of MR-TB cases. There are problems with drugs for TB treatment – the list is not complete, prices are groundlessly high (tenders are held by the government). There is a big problem of integration between TB and HIV services.  ***Tbilisi, Georgia***  Community strengthening is the major need in further development of the city level HIV and TB response. Stronger communities need to be involved into the work of the city councils in HIV and TB, conduct advocacy for the services for key popula6tions and especially MSM where the epidemic is still growing, and allocation of the sufficient municipal resources to respond to HIV.  TB hospital base was reduced but still exceeds required number. Hospitalization on non-medical reasons still occurs. Lack of social support for TB patients is the main reason for “social” hospitalization and treatment interruption. A further optimization of hospital capacity is certainly possible due to increase of scope of involvement of primary care providers and community based organizations in TB care. CBOs’ capacity may be used for covering representatives of KAPs with social medical support at ambulatory phase of treatment. Ambulatory care model with the CSOs participation may be developed and piloted in Tbilisi with further extension to all regions of the country. As of today CSOs were involved in TB detection among HIV positive people, other groups were covered with TB screening by health care workers only when visiting clinics. But a group of KAPs with limited access to health care services is not covered with screening for TB. CSOs have an access to this population and can input to early TB diagnostics among risk groups. CBOs can contribute to the transition of existing TB care system to patient-centered TB care aimed at achieving goals of End TB strategy.  *Kyiv, Odesa, Ukraine*  There is substantial gap in HIV status knowledge in the city of Kyiv: only 1 in 3 HIV-positive Kyiv residents knows his/her HIV status (compared to 1 in 2 in Ukraine in general): 10 000 registered HIV positive persons out of over 30 000 estimated PLHA.  Another major issue is the growing HIV epidemic among MSM in Kyiv. MSM is the only key population where HIV epidemic is still developing and is threatening to become a driving force on the city level.  There is significant threat to HIV response sustainability in Ukraine and specifically in Kyiv. As for 2015 ‘zero’ funding has been allocated to HIV prevention and treatment programs.  Taking into account particularities of the city – a great number of immigrants, migrants, citizens without registration, active PWID – there is a necessity to provide early access to reception of complex and free of charge medical examination for TB, as well as creation of simplified conditions for passing TB examination for the mentioned groups of population. Persons without registration in the city of Kiev are practically deprived of access to free of charge TB diagnostics. Besides, representative of risk groups have to wait in line before passing examination in health care facilities. In order to pass a complete examination with the aim to make a diagnosis or its exclusion they have to visit health care facility several times. At this stage the most part of the risk groups are “lost” and fails to pass the complete examination, and therefore, has no access to treatment without a proven diagnosis, remaining a source of infection.  In Odesa a high percentage of TB treatment interruption cases (both newly diagnosed and MR-TB) occurs on the background of high incidence rates and prevalence of all TB forms.  *Sarajevo, Bosnia and Herzegovina*  In December 2015, Global Fund grants awarded to BiH are terminated. By the mid-2016, only core activities will be funded. The government made the commitment to continue supporting the program, but for now, only in the *Transition Plan For Continuation of HIV and AIDS Prevention, Treatment and Care* (2015-2017). Taking into account the experience of other countries where the Global Fund support terminated, situation in BiH is uncertain as well, so low prevalence of HIV can easily become high or severe.  *Sofia, Bulgaria*  Similarly, in Sofia, the planned termination of the Global Fund grant resulted in the risk of cessation of the activities for key populations. Significant share of key populations is based in the city of Sofia. There is a strong need to really ensure the city level funding to cover the core key populations interventions.  Bucharest, Romania  Although the Bucharest municipality is already allocating funding for HIV prevention programs, there is lack of understanding of the cascades for key populations and specific plans to address HIV and TB on municipal levels. Additional inquiry is needed to assess the 90-90-90 status among key populations in Bucharest and plan specific measures to improve it.  TB detection among key populations is low and is not currently addressed as a component of ham reduction interventions. |
| 3.2 Funding Request |
| In order to understand the applicant funding request:   1. Provide a strategic overview of the funding request to the Global Fund, up to the maximum allowable investment amount. Clearly outline the prioritization among different program areas while describing the funding request and any request above this amount. 2. Describe how it addresses the gaps and constraints described in sections 1, 2 and 3.1. 3. Describe the value-add of a regional approach in the context described in section 1 and how it complements, and not duplicates, the existing efforts of national governments and/or other major donors. 4. Describe how the new grant will continue scale up and/or refocus interventions, with reference to the past activities, their outcomes and lessons learned, as described in question 1.2. 5. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact. 6. If support for direct services provision is included in the application, describe why such services cannot be covered by existing grants at country levels when available. Also describe how the proposed interventions will increase sustainability of other (single country) Global Fund investments, if applicable. |
| 4-5 PAGES SUGGESTED  Strategic overview of funding request  Project approach across the cities  The goal of this proposal is the achievement of the UNAIDS and Global Plan to Stop TB of '90-90-90' for HIV and TB key populations in cities of the EECA region through strengthening of health and community systems in the program cities and the development of a Regional City Platform with the twinning and mentoring of cities in Western Europe. This platform provides for the opportunity to share experiences/best practices, development of political leadership among city policy makers, sustainable scale-up of services by developing an enabling environment and a conducive regulatory framework in cities, including sustainable funding to NGO service providers and community organizations/key populations led organizations. Progressive experience of Amsterdam (The Netherlands) and Bern (Switzerland) that have committed to extensively share their developments and expertise within this program are used as successful city response models to key population epidemics and as a source of expertise. Key topics are: development of city service models, policies for key populations and HIV/TB/Hepatitis; political and financial engagement and collaboration between city authorities and NGOs.  Objectives of this proposal are as follows:  Objective 1. To increase knowledge and provide sustainable good practices exchange by the Establishment of the Regional City Platform  The project envisages the development of a web-based City Platform among selected cities for a multi-thematic and integrated key populations policy with concerned actors (elected representatives, stakeholders working on the prevention of HIV and TB including harm reduction services, as well as in the fields of care, law enforcement, and the judiciary). The platform will be seek and develop synergies with the forming of the EECA Community, Rights and Gender (CRG) technical support platform supported by the Global Fund starting 2015 and hosted by the International HIV/AIDS Alliance in Ukraine.  Mechanisms for the development of the Regional City Platform between municipalities so as to engage with governments and thereby receive increased political value will be developed.  Objective 2. Development and implementation of a model for key populations for the '90-90-90’ objective of the HIV and TB response in selected cities of the EECA region  Assessments of municipalities of the selected cities will be conducted in the fields of HIV, TB, harm reduction, prevention, treatment, health and social integration, security in public spaces concerning drug use and sex-working issues. The results of the assessment of the ECUO regional EECA project looking at challenges in transitioning from one stage of cascade to the other that will be conducted in the first half of 2016 will be taken into account. Key populations will be involved into assessments under this program. Findings will lead to the design and implementation of responses, including a mapping of where different key populations gather in each city, compilation and analysis of information on existing services reaching, or accessible to, key populations, the work of NGOs/CBOs, and policies. The situation assessment methodologies on the combinations of services available and the levels of funding for interventions, and the results within the EHRN regional project will be used and resource expertise (persons trained) attracted to the city level assessments and response development.  Activities will contribute to the improvement of municipal monitoring systems to ensure that data collection and reporting mechanisms are tailored to the needs of key populations and that important data is collected and used. This will also result in more integrated monitoring and evaluation of TB and HIV programs. Effective treatment progression models for key populations at the municipality level will be developed, implemented and integrated with major city health and civil society structures strongly relying on working with communities and ensuring their meaningful involvement and leadership in all interventions.  A key activity of the project is to develop and implement practical and cost-effective improvement plans to optimize outreach, early TB case detection, HIV testing, enrollment and retention in TB and HIV care and treatment for hard-to-reach and high-risk groups such as PWID, CSW, former prisoners and MSM in the patient progression path involving both non-governmental and governmental services. Each plan will take into account the specific characteristics and strengths of the risk groups and will be based on harm reduction principles and best practices.  The program will also create synergies between the cities involved, including through developing specific interventions to address the migration phenomena (on drug dealing, drug using and sex work).    Objective 3. Establishing effective partnerships between municipalities and NGOs/CSOs in selected EECA cities. Strengthening community systems to build sustainable response to HIV/TB led by civil society and community organizations  The program pays special attention to building up political leadership among city leaders and policymakers. The initiative seeks to link policy and practice by offering training and further education in support of effective key population policy management. The main objective is to facilitate know-how and build capacities for more effective and sustainable key population policy implementation, the management of key population health programs, drug control policy and security in public spaces. High level advocacy for TB programs among key populations in the cities will be conducted by having the Executive Director and Communities, Human Rights and Gender Technical Officer of the Stop TB Partnership meet with mayors to raise awareness of TB and engage them to develop targeted TB programming.  Exchanging and sharing experiences and best practices of successful models of municipality and NGO/CSO partnership for sustainable drug policies and policies regarding sex work and LGBTI issues in cities will be a core component of this project. Amsterdam and Berne will serve as the models of successful and sustainable cooperation between cities and NGOs/CSOs. Regional examples of successful city responses to HIV and TB among key populations in cities such as Tallinn and Prague will be also be used for the exchange of regionally seeded best practices.  NGOs/CSOs in project cities will be provided with appropriate tools and methods to control budget allocations for key populations in municipal programs and join forces with OSF initiatives on national budget monitoring. Initiatives including the 'International Budget Partnership' will be approached for technical tools and support.  The achievement of social inclusiveness of key populations will be addressed through advocating for the structural involvement of representatives of key populations into social service and labor related mechanisms and initiatives at the municipal level.  *Objective 4. Ensuring sustainable allocations of municipal funding for key population programs in project cities*  The project will develop and adapt effective mechanisms of municipal funding allocation for key population programs in the different cities, especially sustainable city funding to NGO/CBO service providers. It will establish effective mechanisms of collaboration between municipalities and NGOs/CBOs through policy management, contracting and controlling of NGOs/CBOs by municipalities using the examples of Amsterdam and Bern.  The project will exchange and adapt innovative municipality funding approaches (e.g. through employment schemes for key populations with municipalities); develop effective collaboration of the national and municipal key populations agenda, conduct mapping and resourcing advocacy to strengthen city leadership and funding for HIV and TB responses.  The cities agenda in relation to HIV and TB among key populations will be effectively included into the ongoing reforms of national health systems in countries of the EECA region and arrangements made in the context of transitioning from international to domestic funding for prevention, care and treatment of HIV/AIDS and TB.  Attention will be paid to sharing best international practices of public-private partnerships at the city level and private funding for key population programs with the aim to replicate the successful practices in the project cities.  Social impact investments into non-profit organizations, companies and funds with the intention to generate social and environmental impact alongside with a financial return, will be explored. These investments are structured to drive government savings and revenues which are then shared between government, social/non-profit organizations, and investors while filling the gap between societal need and current government and social sector provision.  Inspired by the Swaziland example of a $10 million USD financing from social impact investors to support the scale-up HIV treatment as prevention, International HIV/AIDS Alliance in Ukraine has initiated discussions with like-minded social impact investors and companies, including Gilead Sciences, toward the creation of a social impact development bond aiming at raising the financial capitals required over multiple-years toward ending AIDS and/or eliminating hepatitis C within the territory of a city or municipal government.  Gilead Sciences has expressed interest in partnering with International HIV/AIDS Alliance in Ukraine to provide financial and in-kind support towards the creation of an intermediary, third-sector, platform that would bring social impact investors, city governments and service providers together and help facilitate the design and development of social impact development bonds to end AIDS, TB and eliminate hepatitis C.  *Objective 5. Sharing successful models and popularizing city responses*  The partnership between the cities of the project and potentially other willing to join cities will be framed in the regional city partnership uniting mayors of EECA cities in fight against HIV and TB. We will develop a Kyiv declaration of commitment or joint statement on Paris declaration that can be signed in the last year of the project during a dedicated final event of the project. It will be used as a catalyst of new city initiatives in response to HIV and TB in the region and a sustainable mechanism of generating municipal solutions to emerging health hazards.  Local TV and Radio stations, local newspapers and printed media will be approached to become partners in story telling of the developments in the project.  The BBC and other international news agencies will be approached to become a internatioal partner in documenting the stories and key developments in the project, using the perspectives of mayors, municipal health offices, key populations, civil society. This will facilitate further spread of successful solutions and generate more demand in city health responses.  The project will also develop a handbook of how the municipalities effectively collaborate with NGOs/CBOs to achieve AIDS and TB impact, social integration and security in cities; ongoing sharing of the progress will be made and successful case studies developed.  The annually organized International City Health Conference - a conference for individuals and organisations engaged in the study of, and responses to, structural health issues and health behaviours in the urban environment - will be used as a platform for sharing knowledge and experience of Cities by this project. The organizers have been approached with the offer to host 2018 City Health Conference in Kyiv.  Interesting results from the EECA region will be shared with the Dutch Ministry of Foreign Affairs, UNAIDS, IAS respectively in preparation and participation of the International AIDS Conference 2018 in Amsterdam.  The project will follow the logic of situation assessment in each city, exchange and learning visits to municipalities in Western Europe and best practices in the region, and through adaptation of the most relevant models in the respective cities.  The selected cities selected for the intervention are: Soligorsk (Belarus), Sarajevo (Bosnia and Herzegovina), Sofia (Bulgaria), Tbilisi (Georgia), Almaty (Kazakhstan), Bishkek and Osh (Kyrgyzstan), Beltsi (Moldova (Republic)), Bucharest (Romania), St. Petersburg (Russian Federation), Kyiv, Odesa (Ukraine). Selection of cities for the intervention is based on the following criteria:   * high share (over 0.8%) of key populations among the adult population in the respective country and a concentrated HIV epidemic among the key populations; * high prevalence of HIV/TB in the city, both at the level of the respective country and the region in general. The total share of registered PLHA in the selected cities is over 110,000 persons and constitutes 35% of the overall total registered PLHA in the countries, ranging from 75% in Tbilisi to 7% in Odesa); and, * combination of various city models based on political significance, diverse size, perspective commitment of the mayor and sufficient level of civil society capacity to collaborate with the respective municipality. The letters of commitment from the mayors or mayors’ offices of the respective cities are provided in Annex X.   Cities included in the project have ensured the necessary starting level of municipality commitment to join the project. Municipalities have acknowledged the burdens of the HIV and TB epidemics in their respective cities and confirmed commitment of the municipality to work towards achievement of 90-90-90 global AIDS and TB targets . They also confirmed the intention to collaborate on HIV and TB responses among key populations with the NGO counterparts within the regional cities program to respond to HIV and Tuberculosis epidemics among key affected populations considered for support by The Global Fund.  To ensure sustainability of municipal HIV and TB responses among key populations, the municipalities have confirmed their commitment to cost share harm reduction interventions from municipal budget with the aim to fund a share of project interventions by the end of the project (letters of Commitment provided in Annex X). The municipalities will also develop and implement a social contracting mechanism for NGOs allowing them to apply for and receive municipal funding for HIV and TB responses in the city, by the end of this project.  The municipalities have assigned a dedicated focal point of contact for further implementation of the initiatives.  City specific interventions in addition to the outlined above are described in the following section.  *Almaty, Kazakhstan*  In Almaty AFEW will prioritize uptake of ART and TB treatment and adherence to treatment among PLHIV in the key populations identified. In particular, such activities as patient's Case management system establishment, improving access to Social, psychological and medical services, establishment of self-help group for adherence support at AIDS and TB treatment centers, TB patients’ schools, development of the capacities of local HIV and TB services to improve treatment uptake and adherence and treatment literacy for TB patients are planned.  ECOM has prioritized Almaty as one of its core intervention cities as the destination of in-country migration processes of MSM and transgender (TG) individuals. It will collaborate with Public Fund 'Adali' to conduct the situation assessment and mapping, provide technical support on MSM and TG involvement in municipal coordination structures, support MSM/TG activists in advocacy, documentation, and protection of human rights.  SWAN will partner with sex worker led organizations to deliver training for service providers on rights based programming and the SWIT (Sex Worker Implementation Tool) using the experience and knowledge of the sex worker-led organisations.  Stop TB Partnership experts in local CSOs will be involved as part of the city project implementation group.  It will be created and operate the city Coordination Council for HIV/TB. On the basis of the local university will be developed and implemented a special training for social workers to improve the quality of maintenance TB treatment, at the end of which will be issued certificates of the state sample.  *Beltsi, Moldova*  The municipality and the NGO ‘Youth for the Right to Life’ will jointly implement HIV prevention activities among people who inject drugs, measures to improve prevention and treatment of TB, and work with young people on HIV and Tuberculosis prevention, diagnostics and treatment.  ENPUD has prioritized Beltsi as one of core intervention cities due to the interest raised by the local community group to join the project and the existing background preparatory work to advocate for the local funding allocation for key populations programs. Experience with the NGO ‘Youth for the Right to Live’ and the Union of organizations working on HIV prevention and Harm Reduction include joint achievements in advocacy for naloxone procurement, expansion of OST programs, sustainability of funding for prevention and treatment of HIV and TB through national budget allocations. ENPUD will work to get media coverage of: successful municipal funding allocation for HIV/TB programs, successfully introduce social contracting in the city, and work to prioritize decision making in favor of the relevant services in the city; advocacy for inclusion of the drug user groups into the development and implementation of city HIV and TB programs; public actions to attract attention to the risks of further epidemic development in case no sufficient funding is attracted to HIV and TB responses.  Stop TB Partnership partner SMIT Patient Organization will be involved as city project implementation partner.  In order to improve the provision of assistance for key affected populations with TB it is planned to develop and implement a model which will allow to improve the early diagnosis of TB (providing "green corridor" during the passage of the diagnosis, social support through co-operation of health facilities and NGOs, information work with the medical staff to overcome the stigma and discrimination against patients).  *Bishkek, Osh, Kyrgyzstan*  Activities in Bishkek will be implemented by AFEW Kyrgyzstan. Activities in Osh will be implemented by ‘Anti-AIDS Association’ in Kyrgyzstan and SWAN’s member organization.  Within the project the cities planned:   * Establishment and implementation of the state social order through the Ministry of Health of the Kyrgyz Republic in order to increase financing of NGOs in the Bishkek city from the state budget. * Development and implementation of effective and cost-effective financing mechanisms for programs for the prevention, treatment and care for HIV / TB. * Exchange of experience on the example of cities of Berne and Amsterdam for decision-makers at the cities of Bishkek and Osh in the implementation of progressive policies in relation to harm reduction programs * Building sustainable cooperation between the state, municipalities and non-governmental sector.   ECOM has selected Bishkek as one of the intervention cities due to its being destination of in-country migration processes of MSM and TG individuals and, thus, center of MSM and TG communities to be implemented in partnership with Kyrgyz ‘Indigo’ and ‘Labrys’. ECOM will conduct situational analysis and mapping, provide technical support on MSM and TG involvement in municipal coordination structures, train stakeholders in partnership building and increase MSM/TG-sensitization among partners, train MSM/TG activists in advocacy, documentation, and protection of human rights.  SWAN partnering sex worker led organizations will deliver training for service providers on rights based programming and the SWIT (Sex Worker Implementation Tool) using the experience and knowledge of the sex worker-led organisations.  KNCV-Kyrgyzstan branch and Kyrgyz TB Coalition will become the city partners on TB. It is planned to carry out work aimed at raising awareness about TB (diagnosis and treatment), about the responsibility for their own health and the health of their relatives and people around. The religious leaders and communities should be involved through local administration. For early diagnosis of TB among children in co-operation of health facilities and NGOs will be held outreach with relatives, religious leaders about the importance of identifying TB; maintenance services will be provided at the stage of diagnosis of TB.  The work will also involve NGOs working with the TB, participants of TB-REP program and experts recommended by the Stop TB Partnership who will provide consultancy and partnership support for the implementation of the advocacy component of the СITIES program in Bishkek and Osh.  *Soligorsk, Belarus*  Belset Anti-AIDS’ will be the program partner in Soligorsk. Within the project the planned activities to respond to HIV and TB will prioritize:   * Ensuring access of key populations to pre-test counseling and testing for IHI HIV. * Co-financing of HIV and drug abuse prevention at the workplace with support of industrial enterprises of the city. * Providing psychosocial help and support to the members of key affected populations. * Involving key affected populations and NGO representatives into the decision-making processes through their membership in the interdepartmental HIV prevention council and the working groups to develop and implement HIV prevention measures for 2016-2020 in Soligorsk and Soligorsk district. * Involving peer consultants from among key affected populations to form and support adherence to HIV, drug abuse and Tuberculosis treatment. * Mapping of the situation among MSM and CSW. * Professional training of the representatives of district executive council at the international conferences.   NGO ‘Defeat TB Together’ will become the city partners on TB.  Development and piloting the project for the early detection of TB in high-risk groups with the active participation of communities in Soligorsk with following expansion to other regions could solve the problem with low rate of TB cases detection at the country level. The establishment of cooperation between the two services, the development of integrated network of care for patients, the involvement of primary health care facilities to the provision of services in the field of TB / HIV will expand the access to high quality health care for vulnerable populations. It is planned to involve NGOs in the MPSS for patients on ambulatory treatment phase and work on forming adherence to treatment. The work will also involve NGOs working with the TB, participants of TB-REP program and experts recommended by the Stop TB Partnership who will provide consultancy and partnership support.  *Kyiv, Ukraine*  Alliance for Public Health in Ukraine will prioritize HIV case finding. To achieve this Alliance and city administration will work together to find sustainable solutions to massive HIV testing uptake and HIV case finding through implementing network peer-driven intervention (PDI) methodology, which increases case finding and has been used in GF country project by NGOs, and will be now piloted based in in Kyiv municipal testing facilities for all undergoing HIV testing.  The provision of access to early TB detection for risk groups (immigrants, migrants, people without registration, active IDUs) at the level of primary health care and comprehensive free testing for TB (WGC fluorography, microscopy of sputum for MBT).  ENPUD has selected Kyiv for its joint intervention with the Association of OST of Ukraine to open new OST sites and procure OST drugs with the municipal funding. It is planned to advocate for integration of OST for a range of patient groups into family doctors scheme.  Also, PrEP among MSM will be piloted in Kyiv following self-funded model with research accompanied by WHO and dedicated international professional research partner. This pilot project will have the capacity to develop regional case for MSM PrEP that will be used in other cities of EECA, and will be the first PrEP project in the region.  ECOM has selected Kyiv as one of the four priority cities for their engagement together with Gay Forum Ukraine to conduct situation assessment and mapping, technical support on MSM and TG involvement in municipal coordination structures, training on partnership building and MSM/TG-sensitization of partners, training of MSM/TG activists in advocacy, documentation, and protection of human rights. PrEP intervention advocacy will also be one of the focus areas of ECOM. It will share the results throughout the network and advocate for further adoption of effective and sustainable models in thither cities of the region.  SWAN’s partner organization in Kyiv will provide trainings for service providers based on the SWIT.  *Odesa, Ukraine*  Activities in Odesa will be implemented by NGO ‘Youth Center for Development’. Jointly with the municipality, the following activities have been prioritized: organizing the system of HIV prevention and early detection of HIV and TB among the key populations of Odesa, improving the professional capacities of involved professionals into prevention and treatment work, improving the quality of the provided medical services on HIV and TB.  It will be provided an additional (and complementary to the services within the framework of the GF) psychosocial support for patients (especially IDUs) at the stage of outpatient DOT, including the expanding of access to OST for IDUs, TB patients and providing the DOT based on OST sites.  *Sarajevo, Bosnia and Herzegovina*  Association “Progressive Reinforcement of Organizations and Individuals” (PROI) will prioritize:   * strengthening existing and establishing new effective partnerships between relevant local institutions and CSOs for creating sustainable policies concerning key population at risk; * ensuring sustainable allocations of municipal funding for key population programs; * improving of services for key population including HIV prevention, social services, early detection of HIV, TB and HCV, and access and adherence to ARV, TB and HCV treatment.   *Security House Model* will be applied as main strategy which involves institutions and CSOs in Sarajevo - Public Employment Service; Ministry of Internal Affairs; Centre for Social Work; Municipal Court; Prosecutor's Office; Ministry of Education, Science and Youth; Correctional Institution; Institute for Addiction Diseases, PROI and other CSOs. The main goal of the *Security House Model* is to bring together all actors relevant for creation of successful prevention and resocialization programs for persons at higher risk for HIV, including people who inject drugs, sex workers, prisoners and ex-prisoners, Roma population, youth with criminal behavior. The model not only establishes a direct connection with a variety of services and assistance programs, (educational, labor law, health and social services) but also contributes to harmonization and cooperation within the framework of law enforcement (for example, cooperation between the police, prosecutors and courts).  *Sofia, Bulgaria*  The following activities are planned for Sofia by municipality together with NGO ‘Initiative for Health Foundation’ and the Association "Heath without borders": community assessment and mapping; building up a municipal HIV and TB monitoring system; capacity building and sensitizing among local social and medical personnel; municipal strategic planning; publicity and media involvement; developing and implementing a pilot model for implementation of HIV care continuum services.  *St. Petersburg, Russia*  Due to political constraints for the functioning of the internationally supported initiatives and the scope of HIV and TB epidemics in Russian Federation, it is suggested to involve into the project The Non-Profit Partnership ‘ESVERO’ (Russian Harm Reduction Network), which is the national network organization comprising a wide representation of key affected populations, experts and service providers in the relevant field. Acting as the sub-recipient of the program, ESVERO will establish and lead the Coalition of NGOs including also the St. Petersburg-based ‘Humanitarian Action’ Fund and other civil society actors able to successfully achieve and replicate the program’s outcomes countrywide.  Based on that needs, the Project will be aimed at the following activities involving the NGO specialists, Government authorities and key affected populations:   * Establishment of the Coalition of NGOs for the protection of the rights and interests of key affected populations in the sphere of HIV and TB prevention, treatment, care and support. * Development and introduction of the unified Monitoring and Evaluation System for the essential services for key populations being supported by various sources of funding. The System will comprise the component of actual and adequate services costs estimation necessary for effective budget planning. * Co-funded provision of peer counseling services in HIV/TB prevention for key affected populations in conflict with Law with their further referrals for the relevant medico-social services. * Development of multi-sectoral collaboration and professional improvement of NGO actors through the series of webinars and trainings. Important part of these activities will be devoted to the enhancement of leadership, advocacy and presentation skills among the representatives of key affected populations. It will help in upgrading their active involvement with regional and global events, as well as expanding their representation in the various sub-national networks and coalitions.   Establishment of professional standards for NGO service providers and other representatives acting in HIV/AIDS sphere, as well as promotion of local initiatives at the federal level to address barriers in access of key populations to HIV and TB prevention, treatment and car. Particular attention will be paid to reducing the barriers associated with high stigma and discrimination towards key populations in processing their claims and appeals associated to the implementation of their rights and interests guaranteed by the Law and relevant national and local programs.  Work to strengthen the links between health facilities and NGOs will be carried out with the aim of early detection TB among IDUs and providing social support of IDUs at the ambulatory treatment phase.  Action Center has been selected by ECOM for partnership on situation assessment and mapping, technical support on MSM and TG involvement in municipal coordination structures, training on partnership building and MSM/TG-sensitization of partners, training of MSM/TG activists in advocacy, documentation, and protection of human rights.  NGO ‘E.V.A’ which is a network NGO established to protect the rights of women affected by HIV and other socially significant diseases, has strong partnership with the municipality thanks to which the government is contracting psychological and social services on HIV and TB in St Petersburg from this organization. Its experience will be used to inform the further increase in funding for key populations and learn the successful model to share with other cities of the project.  SWAN partnering sex worker led organizations will deliver training for service providers on rights based programming and the SWIT (Sex Worker Implementation Tool) using the experience and knowledge of the sex worker-led organisations.  *Tbilisi, Georgia*  Concentrated HIV epidemics is especially alarming among Tbilisi MSM with over 25% HIV-positive results among MSM in Tbilisi, according to BSS, 2015. The number is one of the highest in the region.  NGO ‘Tanadgoma-Center for Information and Counseling on Reproductive Health’ is the city implementing partner. Tanadgoma has been working on SRHR issues with key populations (CSW, MSM, PWID) more than 15 years. Tanadgoma has already established partnership relationship with Tbilisi city hall and particularly, with department of health and social services in the city. ENPUD has selected Tbilisi for intervention partnering with Georgian Network of People who Use Drugs (GeNPUD) that is already conducting advocacy work using PUD resources to allocate municipal funding to the PUD services. There is a need to strengthen the community support there.  Tbilisi has developed a following plan within this program:   * creation of action plan for the years 2017, 2018 and creation of transparent scheme of subsidizing NGOs by city hall (social contracting); * development of new innovative guidelines and practical tools for working with key population groups (based on local and international best practices and needs assessment surveys) – guides for outreach work done by community members, guide for consultation etc.; * capacity building and empowerment of communities (MSM, SWs, PWID) in order to make them participate in HIV/TB program planning and implementation including budgeting and M&E (Trainings and workshops, internships of community members at CSOs working in the field etc.); * raising public awareness on HIV and TB in Tbilisi through dedicated activities on specific days (TB day, HIV days etc.) with representatives of communities and city hall officials, infrastructure provided by city hall where IEC materials and condoms will be distributed; * establishment of an NGO coalition including community based NGOs; * creation of promotional video clips and social ads addressing needs and importance of supporting of HIV/TB city initiatives; * training of family doctors, TB clinics and primary health care centers medical personnel on special needs of key populations and how to deal with representatives of KP.   Georgian TB Coalition and the Patients Union are TB partners in the project.  As of today CSOs were involved in TB detection among HIV positive people, other groups were covered with TB screening by health care workers only when visiting clinics. But a group of KAPs with limited access to health care services is not covered with screening for TB. CSOs have an access to this population and can input to early TB diagnostics among risk groups. CBOs can contribute to the transition of existing TB care system to patient-centered TB care aimed at achieving goals of End TB strategy  *Bucharest, Romania*  In Bucharest, Romania, the activities will be implemented by the Direction for Social Assistance of the Bucharest Municipality (DGASMB) and the Romanian Association Against AIDS (ARAS, Asociatia Romana Anti-SIDA). The activities will contribute to the assessment and improvement of the 90-90-90 HIV/TB targets for key affected populations (PWID and other vulnerable populations) which are, and will hopefully be reached with harm reduction interventions implemented by ARAS with support of the Bucharest municipality. Bucharest municipality has already ensured funding for harm reduction interventions since 2013 and it is committed to maintain the support for this intervention. The present project aims to contribute to the development of a sustainable and transparent mechanism of funding for the HIV/TB interventions among the vulnerable populations at the city level. The implementing partners will collaborate in the advocacy activities with Coalition Plus or with EHRN. As a pilot project, the partners will introduce TB active detection among key population and the provision of the services of support for the TB treatment in the existing harm reduction intervention implemented jointly by ARAS and DGASMB and will document the 90-90-90 model implementation through an operational research. The project will document and provide project implementation data as well as research data on TB/HIV intervention to the city counselors and national authorities, with the aim to advocate for the implementation of a coordinated and sustainable mechanism of finding TB/HIV interventions in Bucharest .  How the intervention creates synergies and uses the existing developments  The program will collaborate with the existing regional initiatives and rely upon the resources and expertise and infrastructure developed to date.  EHRN regional project has developed the tools on service monitoring and investment monitoring that will be used during the assessments in the cities of the program. Results of the assessments will also be used for comparing the developed city data to national situation. The program developed models to ensure national resourcing for harm reduction interventions will be used to inform the potential city based solutions. Community support and capacity developed in the national initiatives of EHRN will become an asset to develop the city key populations activists and advocates. National level stakeholders and decision makers will become project advocates for city level resourcing initiatives. The expertise developed on financing options in the national levels will be attracted to extend their expertise to municipal levels.  ENPUD will use its network of representatives which extends to all the project cities except for Sofia. ENPUD will further prioritize the statutory activities such as protection of human rights of PWID in cities and empowerment of PWID to protect their rights. PWID community will be mobilized to support he city level program developments.  ECOM is developing its own regional project where most of this program’s cities are located. The project will contribute to cascading the national achievement for making 90-90-90 for MSM in cities and the recognition of the city gaps in responses to HIV/TB. It will provide the political and advocacy support to the PrEP awareness raising and will accompany the community information sharing on the pilot project in Kyiv. It will also influence municipalities with pragmatic public health language.  SWAN will rely on the representatives that it has in Kyiv, Sofia, Tbilisi, Bishkek, St. Petersburg, and will streamline the project communication with members across the network. Its major focus will be on the meaningfully involvement of SW as project partners in cities, SW led services and clinics. It will prioritize decriminalization of sex work across the city programs.  South Caucasus Network will supply the project with data and resources on MSM and Transgenders in the Caucasus and will advocate for MSM become members in city CCM. It will emphasize human rights, call for addressing discrimination, and gender equality based approaches in the project cities. A specific effort will be made to address the Transgender sex worker in Tbilisi.  Value added of regional approach  Increased urbanization, migration is the growing trend of the modern world. Cities are becoming hubs for the migrants or internally displaced people who are moving to capitals/cities. Cities lack experience in dealing with these groups of society.  At the same time cities are the economic hot spots, they create safe environments for key populations but also for general populations. Also capitals/big cities as example for other cities in countries/region. All the cities are suffering the same problems on health and social inclusion of the target groups and security in the public space (visibility). The exchange of how to resolve these problems, the exchange of how to implement services and what kind of effective drug policy between these cities will be a important learning process. The different dynamics in the different cities how to treat these problems will enforce a process of political pressure in harmonizing drug policy and practice. Hoping that the leading cities of change in the direction of taking over more responsibility and supporting harm reduction within their drug policy and practice will push the others to follow. A leverage can be crated with the regional city platform, not just at country level with the limitations of national (legal) frameworks, but based on the working municipal level processes, models and effective programming solutions.  The models developed will be disseminated between the cities and within the region. In this case the invest of money will have a much higher return on invest as only on a local or national level. The efficiency and the standards of the used instruments, of quality and quantity will rise within the region.  Once having a common attitude, drug policy and work between the cities and the NGOs in the region the power of change in drug policy and the power of getting sustainability for services will grow.  The countries of Eastern Europe and Central Asia have a range of common features in their approach and ability to deliver cost-effective and efficient services for people from key populations and their partners. The countries of the EECA have highly structured and rigid public health systems. Political transition in the early 1990s led to dramatic declines in income, a significant increase in unemployment, and widened income inequities"[[122]](#footnote-123) in the countries of the region, combined with rapidly increasing injecting drug use, especially of opioids. These similarities will be used in the project to develop models that can function well in the existing post-communist power configurations, as well as in similar legal contexts and policies allowing for successful solutions to be cost-effectively replicated in other countries within the region.  Stigma towards, and discrimination of, key populations in the region will be addressed through pragmatic and technical inclusion models that are possible at municipal levels that will allow the effective inclusion of key populations into health and social response programs.  The city approach will overcome the political divide in the region that exists between the pro-Western (those seeking greater integration with the EU and that have signed association agreements) and pro-Russian (Eurasian partnership group and mainly Central Asian countries) national policy orientation, focusing on city policies and health. Working in cities will allow for significant emphasis of public health and social integration and focus on pragmatic and evidence-based solutions for city communities by omitting the national political context.  The synergies to be created between cities involved in this project will develop opportunities for long-lasting partnership. An early warning system as to what is happening around key populations (for example, new drugs entering the market and new associated risks and effective responses, new migration flows and opportunities to effectively address inter-regional migration of key populations and timely provision of services to them) will be established through the Regional City Platform and will function as an efficient internal collaborative mechanism.  PrEP pilot among MSM in Kyiv will be used as a model for further adaptation in the region.  Migration phenomena of key populations related to sex work and drug use in, and within, the cities, and migration routes in the region can only be addressed through a regional initiative. Similarities in solutions offered for city responses through this regional program will facilitate progression of key populations towards the necessary interventions for prevention and care and ease the client care continuum, and provide the systems for improved follow-up and support.  The proposal also adds value to the existing regional efforts supported by the Global Fund on resourcing of harm reduction interventions in the EECA by EHRN. The reinforced city intervention will become a municipal counterpart to the health intervention for key populations at the national level, will reinforce the national funding allocation and will help to establish productive interactions between the local and national budgetary streams to address health issues of key populations.  This project will for the first time address TB in key population groups in an integrated manner with HIV. TB in cities is very much linked to key populations, but also to the poverty pockets, slum dwellers, poor housing. All these specific aspects will be brought to light.  The Regional City Platform will serve as a self-sustainable mechanism through coordination arrangements with one of the cities changing administration and coordination every 2 years. Twinning initiatives with cities of Western Europe will increase awareness of EU policies and strengthen collaboration, paving the way to further funding support from EC neighborhood streams, especially for the cities located in countries with an EU association agreement.  National GF programs as well as other donors will be sensitized and able to use the tools developed by the project and to thereby be in a position to replicate the effective methods in respective national programs. |

|  |
| --- |
| 3.3 Modular Template |
| Complete one modular template (Table 2) based on the funding request outlined in section 3.2. Note that the template allows access to modules that are specifically relevant to TB and HIV components, in addition to modules that are cross-cutting for both diseases. To accompany the modular template, briefly:   1. Explain the rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are cross-cutting for both diseases. 2. Describe the expected and measurable goals and outcomes that address gaps and encourage accelerated impact, referring to evidence of effectiveness of the interventions being proposed. |
| 3-4 PAGES SUGGESTED  The following 7 modules have been selected for this intervention: TB/HIV, Community Systems Strengthening, Health Systems Strengthening – Health Community Workforce/Health Information Systems and M&E/Healthcare Financing/Policy and Governance, Program Management.  Budget distribution between the modules is presented in a diagram below.  The largest funding shares have been allocated to Health Systems Strengthening 4 modules (total of 40% of funding request), TB/HIV module (34% of funding request), and Community Systems Strengthening module (13%).  1. TB/HIV  The activities will contribute to the assessment and improvement of the 90-90-90 HIV/TB targets for key affected populations in the project 12 cities.  At the beginning of the project, needs assessment will be carried out in all project cities, aimed at identifying particular HIV/TB key populations needs in 12 cities. Results of the needs assessment will be reflected in detailed project activities and city HIV/TB improvement plans. Depending on the needs identified, the project will ensure respective training offered to the stakeholders having low level of understanding of TB/HIV/harm reduction, and in the areas where stigma towards people affected by the diseases is particularly strong.  Joint consultations involving all stakeholders and leading to the development of city-level integrated TB/HIV/harm reduction action plans that prioritize the work with key affected populations will be conducted in 12 cities.  Fast-track city approach to HIV and existing models of city-based TB responses will be used.  The cities have suggested a ‘menu’ of interventions and their combinations prioritizing this or another approach based on the particular city needs. The full listing including such activities as:     * development of models to allow massive HIV testing uptake and HIV case finding among key populations, including through implementing network peer-driven intervention (PDI) methodology; * development of models which will allow to improve the early diagnosis of TB (providing "green corridor" during the passage of the diagnosis, social support through co-operation of health facilities and NGOs, information work with the medical staff to overcome the stigma and discrimination against patients); * ensuring access to early TB detection for risk groups (immigrants, migrants, people without registration, active PWID) at the level of primary health care and comprehensive free testing for TB (WGC fluorography, microscopy of sputum for MBT); * establishment of patient's Case management system; * improving access to Social, psychological and medical services; * establishment of self-help group for adherence support at AIDS and TB treatment centers; * TB patients’ schools; * piloting PrEP among MSM in Kyiv following self-funded model with research accompanied by WHO and dedicated international professional research partner. This pilot project will have the capacity to develop regional case for MSM PrEP that will be used in other cities of EECA, and will be the first PrEP project in the region; * Security House Model implementation which involves institutions and CSOs Public Employment Service; Ministry of Internal Affairs; Centre for Social Work; Municipal Court; Prosecutor's Office; Ministry of Education, Science and Youth; Correctional Institution; Institute for Addiction Diseases, and CSOs to bring together all actors relevant for creation of successful prevention and resocialization programs for persons at higher risk for HIV, including people who inject drugs, sex workers, prisoners and ex-prisoners, Roma population, youth with criminal behavior; * development of the capacities of local HIV and TB services to improve treatment uptake and adherence and treatment literacy for TB patients are planned; * development and implementation of a special training for social workers in universities to improve the quality of maintenance TB treatment, at the end of which will be issued certificates of the state sample; * establishment of cooperation between HIV and TB services, the development of integrated network of care for patients, the involvement of primary health care facilities to the provision of services in the field of TB / HIV will expand the access to high quality health care for vulnerable populations. It is planned to involve NGOs in the MPSS for patients on ambulatory treatment phase and work on forming adherence to treatment; * raising awareness about HIV and TB (diagnosis and treatment), about the responsibility for own health.   These activities will be implemented through the sub-grants to the partner NGOs in each of the project cities.  2. Community systems strengthening  In each city the partner NGOs will be involving key affected populations and NGO representatives into the decision-making processes through their membership in the interdepartmental HIV/TB councils and the working groups to develop and implement HIV/TB measures.  Key populations representatives will be involved as peer consultants to form and support adherence to HIV, drug abuse and Tuberculosis treatment.  The key regional key populations networks will implement the following activities in selected cities.  ENPUD has prioritized Beltsi, Kyiv and Tbilisi. In Beltsi it will work advocating for municipal funding allocation in favor of the relevant services in the city and media coverage of successes in this work; advocacy for inclusion of the drug user groups into the development and implementation of city HIV and TB programs; public actions to attract attention to the risks of further epidemic development in case no sufficient funding is attracted to HIV and TB responses. In Kyiv ENPUD will advocate opening new OST sites and procuring OST drugs with the municipal funding as well as for integration of OST for a range of patient groups into family doctors scheme. In Tbilisi advocacy work by PUD will focus on allocation of municipal funding to the PUD services and strengthen the community support.  ECOM has prioritized Almaty, Bishkek, Kyiv, St. Petersburg. It will conduct the situation assessment and mapping among MSM, provide technical support on MSM and TG involvement in municipal coordination structures, support MSM/TG activists in advocacy, documentation, and protection of human rights.  SWAN will partner with sex worker led organizations to deliver training for service providers on rights based programming and the SWIT (Sex Worker Implementation Tool) using the experience and knowledge of the sex worker-led organisations. SWAN will be engaged in Almaty, Bishkek, Kyiv, St. Petersburg.  High level advocacy for TB programs among key populations in the cities will be conducted by having the Executive Director and Communities, Human Rights and Gender Technical Officer of the Stop TB Partnership meet with mayors to raise awareness of TB and engage them to develop targeted TB programming.  These activities will be implemented through subgrants to the regional key populations networks (ENPUD, ECOM, South Caucasus Network, SWAN) and Stop TB Partnership. Subgrant budgets include funds for HIV/TB situation assessment and mapping, technical support on MSM and TG involvement in municipal coordination structures, training on partnership building and MSM/TG-sensitization of partners, training of MSM/TG activists in advocacy, documentation, and protection of human rights, creating video on Video on HIV/TB transmission prevention, Advocacy of the project, which will be implemented locally (working groups, meetings, round-tables, local coordination, office costs and communication costs), TB advocacy visits to each country by Stop TB partnership.  The following activities will be conducted in order to popularize successful multisectoral municipal responses of successful community strengthening:   * development and signing of Kyiv declaration of commitment to combatting HIV/TB in the last year of the project during a dedicated final event; * partnership with international news agencies as well as local print media, TV and Radio stations for story telling of the successful and sustainable municipal responses to HIV/TB in cities; * development of a handbook of how the municipalities effectively collaborate with NGOs/CBOs to achieve AIDS and TB impact, social integration and security in cities; ongoing sharing of the progress will be made and successful case studies developed; * sharing achievements through the annually organized International City Health Conference as well as International AIDS Conference 2018 in Amsterdam.   3. HSS - Health and community workforce  With the aim of establishing effective partnerships between municipalities and NGOs/CSOs in selected EECA cities, the following activities will be conducted:   * Building sustainable cooperation between the state, municipalities and non-governmental sector through training for representatives from Municipalities, NGOs and key populations on developing and adapting effective mechanisms of municipal funding allocation for key populations programs * In some cities - establishment of the Coalition of NGOs for the protection of the rights and interests of key affected populations in the sphere of HIV and TB prevention, treatment, care and support.   Intervention budget includes costs for 1) training for representatives from Municipalities, NGOs and representatives from key populations on developing and adapting effective mechanisms of municipal funding allocation for key populations programs as will as fee and travel costs for international experts for trainings, organized by local SRs; 2) technical support to key populations in each city as well as meetings on policy work for representatives of key populations networks for existing key population networks in selected cities.  4. HSS - Policy and governance  With the aim of strengthening municipalities and civil societies in structural and sustainable responses to HIV/TB in key populations, the following activities will be conducted:   * Exchange of experience on the example of cities of Bern and Amsterdam for decision-makers of 12 cities in the implementation of progressive policies in relation to harm reduction programs * NGOs/CSOs in project cities will be provided with appropriate tools and methods to control budget allocations for key populations in municipal programs; * Technical support to key populations in each city as well as trainings on policy work for representatives of key populations networks and subgrants for existing key population networks in selected cities for coordination and material development.   Intervention budget includes costs for: 1) city’s representatives travel for study visits to Bern or Amsterdam and for participation in the horizontal exchange; 2) organization costs of study visit, horizontal exchange meetings, trainings on policy work; 3) international experts travel, accommodation and fee for horizontal exchange, trainings on policy work and integrated work-meeting preparation and facilitation and counseling conduction; 4) integrated work-meetings and counseling organized in each city by local NGOs.  5. HSS - Health information systems and M&E  With the aim to increase knowledge and provide good practices on municipal responses to key populations HIV/TB epidemics, the project envisages:   * development of a web-based City Platform among 12 cities for a multi-thematic and integrated key populations policy with concerned actors (elected representatives, stakeholders working on the prevention of HIV and TB including harm reduction services, as well as in the fields of care, law enforcement, and the judiciary); * integration of the platform with the forming of the EECA Community, Rights and Gender (CRG) technical support platform supported by the Global Fund; * development of the mechanisms for the Regional City Platform between municipalities so as to engage with governments and thereby receive increased political value; * development and introduction of the unified Monitoring and Evaluation System for the essential services for key populations being supported by various sources of funding.   Budget for this intervention contains funds necessary for: 1) working meetings with stakeholders under the City Platform development (2 regional meetings in Y1); 2) City platform development (in Y1) and support costs (Y2-3); 3)technical support for municipalities to host and use the platform (Costs for meetings, press-conference, round-tables etc. conduction; local coordinator salary, communication costs etc.); 4) meetings for presentations to share about platform functioning locally (one regional meeting per each Y1-Y3); 5) exchange visits between cities (one person from each city per year).  6. HSS - Healthcare financing  In order to ensure sustainable allocations of municipal funding for key population programs in project cities the project will:   * develop and adapt effective mechanisms of municipal funding allocation for key population programs in the different cities, especially sustainable city funding to NGO/CBO service providers; * establish effective mechanisms of collaboration between municipalities and NGOs/CBOs through policy management, contracting and controlling of NGOs/CBOs by municipalities using the examples of Amsterdam and Berne; * exchange and adapt innovative municipality funding approaches (e.g. through employment schemes for key populations with municipalities); develop effective collaboration of the national and municipal key populations agenda, conduct mapping and resourcing advocacy to strengthen city leadership and funding for HIV and TB responses; * the cities agenda in relation to HIV and TB among key populations will be effectively included into the ongoing reforms of national health systems in countries of the EECA region and arrangements made in the context of transitioning from international to domestic funding for prevention, care and treatment of HIV/AIDS and TB; * sharing best international practices of public-private partnerships at the city level and private funding for key population programs with the aim to replicate the successful practices in the project cities; * social impact investments into non-profit organizations, companies and funds with the intention to generate social and environmental impact alongside with a financial return, will be explored.   Intervention budget includes costs for: 1) international consultants’ fee and travel costs for developing and adapting effective mechanisms of municipal funding allocation for key population programs (2 experts, 8 days per city with 1 times travelling per year in Y2-Y3 ) and for establishing effective mechanisms of municipalities and NGOs collaboration through policy management, contracting and controlling of NGO by Municipalities (1 expert, 10 days per city, 1 travel per year in Y2-Y3); 2) innovation seminar for elaborating innovative municipality funding in each of 12 cities with the international experts involvement for facilitation (in Y2); 3) regional horizontal innovative meeting per region - Central Asia and Eastern Europe facilitated by international experts (in Y2 and Y3).  7. Program management  Activities are routine program operating cost relating the PR and two partner organization (CN and AFEW).  Expected measureable outcomes  The ultimate outcome of this program is the improvement of HIV and TB cascades for key populations in the program cities. It is anticipated that as a result of program interventions the resulting improvement of HIV and TB treatment access will be 100% across the program cities against the baseline developed in the first year of the project.  This will be achieved through increased political commitment from the municipalities that will be reflected in developed funding mechanisms to support key populations HIV/TB interventions through social contracting of NGOs. Increased allocations for the related programs will reach at least 20% of the overall funding for key populations programs annually. Relevant funding targets for each city will be established as a result of situation assessment to be conducted in the first year of the project.  These development will be made possible through the activities on health and community systems strengthening, foreseen as part of this program. Modeling of 90-90-90 key populations targets improvements and the technical support to these models’ implementation will inform city level approach development. Integration of HIV and TB prevention and treatment programs and services will help develop synergies for both programs outcomes.  Exchange with Bern and Amsterdam will allow to develop leadership among the municipalities and equip them with the necessary tools and methods to implement change, nurture the culture of genuine collaboration with the civil society in order to improve outcomes of social programs in respective cities. Civil society and especially key populations engagement in the city level program development and dialogue, their structural inclusion into the project from the very beginning will develop capacities of key populations as the drivers of programs on city levels and becoming the key agents of change for key populations health and social initiatives. Support to the regional key populations networks will further develop their capacities for enhanced political weight on both regional and municipal levels.  The following indicator list will be monitored for each of the municipal programs:   * Demonstrated increase at all levels of HIV care cascade at municipality level * Separate indicator for HIV and TB. TB indicator will observe change in HIV testing, and how people are screened for TB. In EECA region there is a tendency of hospitalizing people with drug resistant TB, there should be development in moving to community based treatment for TB * Two or three tire approach of involvement of KAP * Existence of a strategic plan for HIV and TB covering KAP which includes budget lines * Social contracting mechanism in place * The number of social contracts signed on HIV and TB targeting key populations * The number of law enforcement that are sensitized and engaged in the process * Changes in policies and laws and the number of policy dialogues in harm reduction and law enforcement * Advocacy and communication plan – a face of the project – a mayor who stands up * Documentation of best practice in city responses   The project will use annual performance based method to assess its progression and plan the next implementation periods. The participating cities will be judged on their progress against the above indicators which will be linked to the individual city timelines. The cities that will not comply with 60% achievement on the indicators will be excluded from the program. |

|  |
| --- |
| 3.4 Focus on Key Populations and/or Highest-impact Interventions |
| This question is not applicable if all countries included in this concept note are low-income countries. |
| Describe how the requested funding focuses on undeserved and key populations and/or highest-impact interventions, as per the Global Fund’s Eligibility and Counterpart Financing Policy requirement.   1. For the lower-middle-income countries included in the request, describe how the funding requested for those countries focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions. 2. For the upper-middle-income countries and any non-eligible countries included in the request, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions. |
| ½ PAGE SUGGESTED  The program funding 100% focuses on underserved and key populations and highest impact interventions - in all of the program 10 countries and 12 cities. It aims at the achievement of the UNAIDS and Global Plan to Stop TB of '90-90-90' for HIV and TB key populations in cities of EECA region through development of integrated city response models and policies in HIV and TB for key populations; political and financial engagement and collaboration between city authorities and NGOs to implement HIV and TB global targets for key populations in the cities. |

|  |
| --- |
| SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT |
| This section requests information regarding the proposed implementation arrangements for this funding request. Defining the implementation, arrangements for the program including the nominated Principle Recipients (PRs) and other key implementers are essential to ensure the success of the programs and service delivery. For the concept note for TB and HIV, the applicant can nominate one or more PRs, as appropriate given the context. |

|  |
| --- |
| 4.1 Overview of Implementation Arrangements |
| Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:   1. How do the proposed implementation arrangements take into account the regional nature of the investment? 2. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s). 3. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients. 4. If applicable, the type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified. 5. If applicable, how coordination will occur between each nominated Principal Recipient and its respective sub-recipients. 6. How representatives of women’s organizations, people living with the two diseases, and other key populations will actively participate in the implementation of this funding request. |
| 1-2 PAGES SUGGESTED  Project partnership consists of:   * Alliance for Public Health contributing its regional experience, programmatic expertise on key population progression along the treatment cascade and the integration of HIV and TB; * AFEW with expertise on increasing access to health services for HIV, TB and viral hepatitis for key populations in the EECA region utilizing its connectivity of NGO/CBO and governmental sectors, a regional presence in Central Asia, a role with the Amsterdam and City conference, as well as with the AIDS conference in Amsterdam; and, * The Contact Netz contributing expertise on establishing a pragmatic and coherent drug policy on national, county and city levels; on innovative harm reduction interventions on HIV, HCV, night life, substitution, safe injection rooms, social enterprises, housing and cooperation with the police for more security in the public space; on the role in designing municipal and county funding and cooperation approaches to support harm reduction, HIV, TB and viral hepatitis interventions; on the respective actual presence in Bulgaria and Georgia and long-standing former experiences in Central Asia and twinning with the Berne program and experience sharing.   The PR will be the Alliance for Public Health that is based in the region and possesses technical expertise in successful HIV and TB program implementation among key populations. Technical partners and regional NGOs/CBOs value the Alliance’s regional work with key populations. The Alliance positions itself as a regional organization with a proven track record of technical support work and sub-granting. Good examples are the EU-funded project, ‘Broader Introduction of Effective HIV Prevention Strategies Targeting Populations at Most Risk in the ENPI-East Region’, that has provided a firm basis for managing regional-based initiatives as well as the MSM-focused activities conducted with the PEPFAR-funded AIDSTAR Two project, ‘Men having sex with men (MSM) in Eastern Europe: implications of a hidden epidemic’, led by MSH and implemented in the region with the substantial involvement of the Alliance.  SRs will be AFEW and Contact Netz for the delivery of technical support, exchange and guidance on partnership with municipalities and international exchange of the project results through City Health Conference.  Sub-grants will also be provided to the Key populations networks and TB partner. Commitment to work, and letters of support, have been provided by the PWID, CSW and MSM Networks in the EECA region (ENPUD, SWAN, ECOM and South Caucasus Netowrk, respectively). In order to ensure the proper links with TB networks, engagement with Stop TB Partnership and their country level partners will be established.  Partners at the country level will receive sub-grants and will interact with country level CCMs. The following partnerships at the country level are envisaged and will be finalized during the concept note development stage:   * NGO ‘Belset Anti-AIDS’ in Belarus; * NGO ‘PROI’ in Bosnia and Herzegovina; * Initiative for Health Foundation in Bulgaria; * NGO ‘Tanadgoma’ in Georgia; * Public Foundation AIDS Foundation East-West (AFEW) in Kazakhstan; * Public Foundation AIDS Foundation East-West (AFEW) and the AAA Foundation in Kyrgyzstan to work in Bishek and Osh respectively; * Union for HIV Prevention and Harm Reduction in Moldova; * ‘Esvero’, a NGO in the Russian Federation, that will partner with NGO ‘Humanitarian Action’ in St Petersburg; * Romanian Association Against AIDS (ARAS, Asociatia Romana Anti-SIDA) in Bucharest; * Alliance for Public Helath will work in Kyiv and NGO ‘Youth Center for Development’ – in Odesa, Ukraine.   A Steering Board will be established to provide technical and political guidance to the project. It will unite the mayors of the cities, main NGOs/CBOs and regional key population network representatives.  Broader information sharing with other regional projects will be established, especially with the existing programs of EHRN and the prospective project of ECUO. The project will convene an advisory community to keep external stakeholders updated and to receive targeted and effective expert advice on certain thematic issues. The community will unite representatives of other regional organizations and projects, experts in municipal development, and GF board representation from the region.  Key population networks will be involved at the municipality level, the national levels, and regionally.  At the municipality level, key population groups will participate in the situation assessment and will jointly - with local authorities - develop and implement the city plans. At the regional level, key population networks will provide linkages with the national level key population networks, will work in the project steering board as well as take responsibility over certain elements of the program, such as sex work related migration and the continuum of care for inter-city interventions. |

|  |
| --- |
| 4.2 Ensuring Implementation Efficiencies |
| Complete this question only if the Regional Coordinating Mechanism (RCM) / Regional Organization (RO) is overseeing other Global Fund grants. |
| Describe how the requested funding links to existing or planned Global Fund grants.  In particular, from a program management perspective, explain how this request complements (and not duplicates) any human resources, training, monitoring and evaluation, and supervision activities. |
| 1 PAGE SUGGESTED  Alliance for Public Health (Alliance) is implementing [Investing for impact against Tuberculosis and HIV](http://www.theglobalfund.org/en/portfolio/country/grant/?grant=UKR-C-UCDC) program funded by the Global Funds under NFM. Alliance is one of the three Ukrainian Principle Recipients for this program. The program fully focuses on Ukraine HIV and TB interventions and does not reach out to the EECA region or globally. Alliance has served in the capacity of the PR for 3 successive Global Fund programs to Ukraine and has the highest level of performance - A1 rating.  Starting January 2016 Alliance is also implementing TB Regional EECA Project (TB-REP) on Strengthening Health Systems for Effective TB and DR-TB Control. Within the key objectives, Alliance in partnership with TB Europe Coalition will ensure the involvement of civil society organizations into the advocacy activities to move to patient-centered model of the delivery of medical aid to TB patients, facilitate sharing best advocacy practices in EECA region to support sustainable high-level advocacy to ensure effective response to TB.  Alliance will have a dedicated program unit to ensure international management of this program with dedicated staff for management, operations and financial issues. The program unit structure will be designed in such a way as to assure realization of project’s goals and objectives and interlinked with the overall Alliance organization structure. This will help create synergy and use Alliance extensive experience in managing grants both at national and regional level, innovative programs implementation tools to make impact. The programs impact will be maximized through overall operations support relying on high Global Fund standards; coordination of activities in Kyiv and Odesa with the existing Global Fund country grant and their broader exposure to other cities in Ukraine; exchange with the regional TB grant with particular city focus models.  This request is complementary to existing organization human resources, training, monitoring and evaluation and supervision activities and coordinated with the other GF funded programs to achieve synergy of activities with the country HIV teams and country and regional TB activities, and avoid any duplication of functions and/or resources. |

|  |  |  |  |
| --- | --- | --- | --- |
| 4.3 Minimum Standards for Principal Recipients and Program Delivery | | | |
| Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions. | | | |
| PR 1 Name | International HIV/AIDS Alliance in Ukraine | Sector | Not-for-profit |
| Does this Principal Recipient currently manage a Global Fund grant(s) for any of the two disease components or a cross-cutting health system strengthening grant(s)? | | xYes ☐No | |
| Minimum Standards | | Applicant assessment | |
| 1. The Principal Recipient demonstrates effective management structures and planning | | Current structure and management system of the Alliance are aimed at effective and efficient implementation of complex national level programs on HIV/AIDS, TB and other socially dangerous infections. Alliance Governing Bodies consist of General Meeting (strategic body), Board (executive body) and Supervisory Committee (controlling body). Governing Bodies activity is regulated by particular Regulations developed in accordance with the Alliance Bye-Laws, which ensure sound, transparent and effective work of Governing Bodies. Executive Director is the highest official in the organization. Senior Management Team ensures openness and transparency of decision-making process. There is an independent mechanism (staff) for ensuring risk management, compliance and an internal audit, as well as for resolving disputable issues. Organizational structure consists of five departments and independent advisory unit and determines the modes in which the Alliance operates and performs. The Alliance 2013-2010 strategy is based on the organization mission, vision and values, developed into five strategic objectives, which are operationalized in work plans. Alliance has been marked by the Global Fund with the highest rating: A1. | |
| 1. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients) | | Alliance has sufficient capacity and system required for effective management and supervision of sub-recipients activity. In 2013 145 organizations were Alliance sub-recipients (implementing partners) which performed HIV/TB programs. 371 projects were funded for the total sum of 102,337,139 UAH. Alliance ensures continuity of project activities of sub-recipients in all regions of Ukraine by their timely funding. Proper use of the sub-recipients Alliance is regularly confirmed during the annual independent audit. Capacity building of sub-recipients is an integral part of the function of the organization. | |
| 1. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud | | Policies and procedures on governing of the internal control system are implemented in the Alliance. In order to strengthen internal controls over the proper use of funds and fraud prevention Special Policies on risk management and anti-fraud were introduced in Alliance in 2009: Anti-fraud Policy, Conflict of Interests Policy, and Whistle Blowing Policy. The Alliance’s internal control system fosters proper and effective implementation the terms of the grant agreement. The effectiveness of the internal control system is subject of the external and internal audits. By providing positive audit reports the independent auditors regularly confirm that the financial accounting, financial reporting, and internal control systems of the Alliance are developed in accordance with international quality standards and are in full compliance with the regulations and requirements of donors, including the Global Fund. The audit of the Alliance’s financial statements is carried out by company Deloitte, which was approved by the Global Fund. | |
| 1. The financial management system of the Principal Recipient is effective and accurate | | Alliance employees demonstrated professionalism and ability to manage large volumes of funds and grants from various donors, including such as the Global Fund (Round 1, Round 6, first phase of Rounds 9 and 10); European Union; USAID, UN agencies; Foundation Open Society Institute; International HIV/AIDS Alliance (UK) and others. For the last 5 years the average amount, which was under Alliance management exceeded 27 million dollars per year. The financial activities of the year are verified by independent audit that regularly confirms that the financial statements and internal control systems in the Alliance are built in accordance with international quality standards and are fully compliant with the rules and donors, including Global Fund. The correctness of the calculation, tax payments and contributions to different social funds that were made by Alliance and their compliance with the legislation of Ukraine has been repeatedly inspected by state regulatory agencies; no violations were found .All Alliance payments are maintained by Crédit Agricole bank, which has a high rating. This ensures minimum risk for the donor. The system of financial management was highly appreciated by the Global Fund Secretariat. | |
| 1. If applicable, central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products | | All central and regional warehouses engaged into Alliance’s implementation of Grant activities fully comply with requirements on square of facilities and provision of necessary storage conditions. All logistics providers are selected through the bidding process only. Each of 3 groups of logistics providers store cargoes of particular group of medical products procured by the Alliance:   * Liky Ukrainy SJSC – narcotic drugs for OST (2 warehouses of 547 and 1,295 square m). The company is fully licensed by Ukrainian NRA for full-cycle operations with pharmaceuticals, including narcotic drugs; * BaDM (6,150.7 sq.m) and Falbi (9,825.0 sq.m) handles medical products that need special temperature conditions. Both companies are the only GDP certified facilities of this kind in Ukraine. * Diana Luxe Logistics stores cargoes of mass health products, such as condoms, syringes, spirit swabs. The company operates with class A complex of warehouses of 15,000 sq.m total square.   All providers ensure provisions of proper temperature and security control, as well as up-to-date stock management. Alliance’s staff provides regular monitoring of compliance of regional warehousing at partnering NGOs’ with requirements on necessary square and conditions of storage. | |
| 1. If applicable, the distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions | | Alliance fully monitors and controls all operations with turn-over of any goods on the chain central warehouse-final recipient through its management information system (MIS). Among other features, MIS allows constant online tracking of stocks at each link and creating reports on potential deficit. Any charge-off of any goods at regional level is impossible without reported their distribution to final recipients. Plans for distribution of goods are made in advance and given to logistics providers for performing of proper delivery of cargoes. To ensure full responsibility and proper control of movements of all goods, Alliance engages its logistics providers for provision of the whole complex of operations on the way from acceptance of cargoes to central warehouses to delivery to regional recipients. All movements are made in safe, closed and clean vehicles only. | |
| 1. Data-collection capacity and tools are in place to monitor program performance | | The Alliance system of programmatic monitoring includes all elements for getting qualitative data of program performance: unified system of indicators, primary forms, reporting forms, unique identified clients coding, on-line SyrEx database, projects’ rating system. Alliance monitors program performance on regular basis: monitors the data of SyrEx database (on-line), checks the reports (every quarter), monitors the primary documents data, carry out the site visits (twice a year). There are practical manuals on programmatic monitoring system. Every year Alliance provides trainings on programmatic monitoring for sub-recipients. Reliability of program monitoring system of Alliance and data quality was confirmed by independent audits, provided by various donors and their local agents. | |
| 1. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately | | The routine reporting system of Alliance ensures 239,637 people (58.94% of IDUs, 39.92% of CSW, 14.20% of MSM) - the year 2014 coverage of vulnerable groups reached by prevention programs in Ukraine. Alliance is able to report the qualitative data in such scales timely due to standardized system of projects accounting and reporting. The reporting system includes such mechanisms to ensure data quality: unified system of indicators with their description,  standard reporting forms, automatized indicators calculation, control of data entry quality, monitoring of the indicator fulfillment and performance, projects monitoring. | |
| 1. If applicable, implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-region supply chain | | Alliance takes all required measures to control procured medical product quality throughout the in-country supply chain. There is a dedicated staff member responsible for warehouse logistics and coordination of all parties involved. Respected laboratories have been selected on a competitive basis to do the laboratory analysis of procured products (prima facie pharmaceutical products and test-systems). Peculiarities of control over SMT products procured by the Alliance are testing on the entrance point for all qualitative parameters based on approved analytic-normative documentation. Respective tests are done by SE “Central laboratory on medication analysis” which is licensed to work with narcotic drugs. Following requests of WHO “Model of quality assurance system for procurement organizations” and Global Fund TAM on pharmaceuticals quality monitoring, Alliance developed and agreed standard operations procedures on products quality control. | |

|  |
| --- |
| 4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance |
| 1. Describe any major risks in the region and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers’ capacity, and past and current performance issues. 2. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request. |
| 1-2 PAGES SUGGESTED  Project preparation has brought local partners and municipalities on board to express joint interest in program implementation. Letters of support to this fast track cities initiative have been received from the mayors of Yerevan, Soligorsk, Sofia, Tbilisi, Beltsi, Kyiv, Odesa, Amsterdam and Berne; as well as from local authorities of St. Petersburg and the Ministry of Health of Tajikistan. The City of Amsterdam expressed full support to this project.  The UNAIDS Regional Office for the EECA region has provided support in preparation of this EoI and has expressed its willingness to technically support the project in the course of its implementation. The draft of this EoI has been shared by the UNAIDS regional office with all UNAIDS country offices subject to this program and has subsequently received support at the country level.  OSF and EHRN as well as Stop TB partnership have been approached for expert support to the project, shared their expertise at this stage, and confirmed willingness to collaborate in this project.  Local partnerships will enable the program to develop the concept note and seek CCM approval. For example, in Belarus, Ukraine and Bulgaria partners of the project are CCM members. In other countries, such partners as the Ministry of Justice, Ministry of Health, the International Organization for Migration, Ministry of Corrections, Ministry of Labor, Health and Social Affairs will provide an enabling environment for program development.  All AFEW network members have local partners – with which they have longstanding relationships and of which AFEW members have built and strengthened their capacity – in the respective national CCMs.  Certain risks to the project may occur from the restricting policies and approaches exercised by the Russian Federation in regards to key populations health and social programs, including influences in other countries in the region. It is anticipated that city approach chosen for this project will minimize these potential political risks and focus on municipal pragmatic health and social interventions.  Risks about sustainability of the project parts especially on the full-funding at the end of the project through the municipalities. |

|  |
| --- |
| CORE TABLES, ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE |
| Before submitting the concept note, ensure that all the core tables, eligibility requirements and endorsement of the concept note forms listed below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so. |

|  |
| --- |
| Endorsement of the concept note |
| The Global Fund requires evidence of endorsement of the final concept note by all RCM members (or their designated alternates) / RO representative.  A representative of each PR must sign off on the funding request by:   * RCMs: at the bottom of the endorsement sheet confirming that they endorse the concept note and are ready to begin grant-making and implementation. * ROs: submitting a letter confirming they endorse the Concept Note and are ready to begin grant-making and implementation. A template of this letter is not provided. |

|  |  |
| --- | --- |
| Endorsement of the concept note by CCMs | |
| 1. For each country included in the concept note, attach a signed letter from the national CCM Chair or Vice-Chair, confirming endorsement of this regional funding request. If available, attach the minutes of the CCM meetings, at which the CCM agreed to endorse the funding request submitted. List these documents in the RCM endorsement form or in the Concept Note Development and PR Selection Processes form for ROs. | |
| 1. List any countries included in the concept note where there is a CCM, but for which there is no CCM endorsement and explain the reasons for the lack of such endorsement. For these countries, describe how the RCM / RO will obtain support from in-country partners to implement the proposed interventions and address any operational and legal challenges to program implementation. | |
| Country | Description |
|  | 1 PAGE SUGGESTED |
| 1. If any of the countries included in the funding request have no CCM, please attach a signed letter of endorsement from an existing national mechanism. If no endorsement has been provided, explain the reasons for the lack of such endorsement. For these countries, describe how the RCM / RO will obtain support from in-country partners to implement the proposed interventions and address any operational and legal challenges to program implementation. | |
| Country | Description |
|  | 1 PAGE SUGGESTED |

|  |  |
| --- | --- |
| Core Tables / Documents | |
| ☐ | Table 1: Programmatic Gap Table(s) |
| ☐ | Table 2: Modular Template |
| ☐ | Table 3: List of Abbreviations and Annexes |
| ☐ | RCM Eligibility requirements Form / RO Concept Note Development and PR Selection Processes form |
| ☐ | Endorsement of Concept Note Form, including endorsement letters from CCM of each country that forms a part of the regional application |

1. DeHovitz, J., A. Uuskula, and N. El-Bassel, The HIV epidemic in Eastern Europe and Central Asia. Curr HIV/AIDS Rep, 2014. 11(2): p. 168-76.

   Kazatchkine, M., Drug use, HIV, HCV and TB: major interlinked challenges in Eastern Europe and Central Asia. J Int AIDS Soc, 2014. 17(4 Suppl 3): p. 19501. [↑](#footnote-ref-2)
2. Murray, C.J., et al., Global, regional, and national incidence and mortality for HIV, tuberculosis, and malaria during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet, 2014. 384(9947): p. 1005-70. [↑](#footnote-ref-3)
3. Global Report: UNAIDS Report on the Global AIDS Epidemic 2013. Geneva: UNAIDS, 2013. 2013; Available from: <http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf> [↑](#footnote-ref-4)
4. WHO. Figures talk: HIV/AIDS in the WHO European Region. Copenhagen, WHO Regional Office for Europe, 27 November 2013. 2013; Available from: <http://www.euro.who.int/__data/assets/pdf_file/0006/235599/WAD-Fact-sheet-Eng.pdf> [↑](#footnote-ref-5)
5. DeHovitz, J., A. Uuskula, and N. El-Bassel, The HIV epidemic in Eastern Europe and Central Asia. Curr HIV/AIDS Rep, 2014. 11(2): p. 168-76. [↑](#footnote-ref-6)
6. UNAIDS. Global report. UNAIDS report on the global AIDS epidemic 2013. 2013; Available from: <http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf> [↑](#footnote-ref-7)
7. DeHovitz, J., A. Uuskula, and N. El-Bassel, The HIV epidemic in Eastern Europe and Central Asia. Curr HIV/AIDS Rep, 2014. 11(2): p. 168-76. [↑](#footnote-ref-8)
8. Jolley, E., et al., HIV among people who inject drugs in Central and Eastern Europe and Central Asia: a systematic review with implications for policy. BMJ Open, 2012. 2(5). [↑](#footnote-ref-9)
9. UNAIDS. AIDSInfo Online Database, Ibid. [↑](#footnote-ref-10)
10. Europe., E.C.f.D.P.a.C.W.R.O.f. HIV/AIDS surveillance in Europe 2011, in Stockholm: European Centre for Disease Prevention and Control. 2012, in, DeHovitz J, Uuskula A, El-Bassel N. The HIV Epidemic in Eastern Europe and Central Asia. Curr HIV/AIDS Rep, Springer Science & Business Media, DOI 10.1007/s11904-014-0202-3, New York, 2014, p4. [↑](#footnote-ref-11)
11. WHO. Global Tuberculosis Report 2013. 2013; Available from: <http://www.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf> [↑](#footnote-ref-12)
12. WHO Regional Office for Europe. Tuberculosis in the European Region. Fact sheet. 2012; Available from: <http://www.euro.who.int/__data/assets/pdf_file/0006/244743/Fact-sheet,-Tuberculosis-in-the-WHO-European-Region-Eng.pdf> [↑](#footnote-ref-13)
13. Kazatchkine, M., Drug use, HIV, HCV and TB: major interlinked challenges in Eastern Europe and Central Asia. J Int AIDS Soc, 2014. 17(4 Suppl 3): p. 19501. [↑](#footnote-ref-14)
14. Федеральный научно-методический центр по профилактике и борьбе со СПИДом Информационный бюллетень № 39 " ВИЧ-ИНФЕКЦИЯ". Available from: <http://www.hivrussia.org/files/bul_39.pdf>

    Федеральный научно-методический центр по профилактике и борьбе со СПИДом. Справка ВИЧ-инфекция в Российской Федерации на 31 декабря 2014 г Available from: <http://www.hivrussia.org/files/spravkaHIV2014.pdf> [↑](#footnote-ref-15)
15. К. Ерицян, М. Корнилова, В. Одинокова. ОТЧЕТ ПО РЕЗУЛЬТАТАМ ДОЗОРНОГО БИО-ПОВЕДЕНЧЕСКОГО ИССЛЕДОВАНИЯ ПО ВИЧ-ИНФЕКЦИИ СРЕДИ ПОТРЕБИТЕЛЕЙ ИНЪЕКЦИОННЫХ НАРКОТИКОВ В ГГ. АБАКАН, БАРНАУЛ, ВОЛГОГРАД, ПЕРМЬ, НАБЕРЕЖНЫЕ ЧЕЛНЫ. ESVERO. Москва, 2015 [↑](#footnote-ref-16)
16. Национальный доклад Российской Федерации о ходе выполнения Декларации о приверженности делу борьбы с ВИЧ/СПИДом. 2010; Available from: <http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/russia_2010_country_progress_report_en.pdf> [↑](#footnote-ref-17)
17. Национальный доклад Российской Федерации о ходе выполнения Декларации о приверженности делу борьбы с ВИЧ/СПИДом. 2010; Available from: <http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/russia_2010_country_progress_report_en.pdf> [↑](#footnote-ref-18)
18. Национальный доклад Российской Федерации о ходе выполнения Декларации о приверженности делу борьбы с ВИЧ/СПИДом. 2010; Available from: <http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/russia_2010_country_progress_report_en.pdf> [↑](#footnote-ref-19)
19. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-20)
20. IBBS 2013. [↑](#footnote-ref-21)
21. IBBS 2013. [↑](#footnote-ref-22)
22. Ukraine harmonized AIDS response progress report. Reporting period: January, 2012 – December, 2013. 2014. [↑](#footnote-ref-23)
23. Ukraine harmonized AIDS response progress report. Reporting period: January, 2012 – December, 2013. 2014. [↑](#footnote-ref-24)
24. Ukraine harmonized AIDS response progress report. Reporting period: January, 2012 – December, 2013. 2014. [↑](#footnote-ref-25)
25. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-26)
26. Юрченко, О., et al., Розвиток епідемії ВІЛ-інфекції та картування послуг у сфері ВІЛ/СНІД серед представників груп найвищого ризику у м. Київ, in Інформаційний бюлетень – липень 2015 року. 2015, Київський міський центр профілактики та боротьби зі СНІДом. [↑](#footnote-ref-27)
27. Berleva, G.O., et al., Analytical report of the results of research “Evaluation of number of most at risk populations for HIV in Ukraine”. 2012, ICF “International Alliance in Ukraine”: Kyiv. [↑](#footnote-ref-28)
28. IBBS 2013. [↑](#footnote-ref-29)
29. Моніторинг поведінки та поширення ВІЛ-інфекції серед жінок, які надають сексуальні послуги за винагороду, як компонент епіднагляду за ВІЛ другого покоління: аналіт. звіт за результатами біоповедінкового дослідження 2013 року / Балакірєва О.М., Бондар Т.В., Середа Ю.В. та ін. 2014, К. : МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні». p. 144 с. [↑](#footnote-ref-30)
30. Моніторинг поведінки та поширеності ВІЛ-інфекції серед чоловіків, які практикують секс із чоловіками, як компонент епіднагляду за ВІЛ другого покоління: аналіт. звіт за результатами біоповедінкового дослідження 2013 року / Большов Є.С., Касянчук М.Г., Трофіменко Л.В. 2014, К.: МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні». p. 96 с. [↑](#footnote-ref-31)
31. Berleva, G.O., et al., Analytical report of the results of research “Evaluation of number of most at risk populations for HIV in Ukraine”. 2012, ICF “International Alliance in Ukraine”: Kyiv. [↑](#footnote-ref-32)
32. Моніторинг поведінки та поширення ВІЛ-інфекції серед споживачів ін’єкційних наркотиків як компонент епіднагляду за ВІЛ другого покоління: аналіт. звіт за результатами біоповедінкового дослідження 2013 року / Балакірєва О.М., Бондар Т.В. та ін. 2014, К.: МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні». p. 181 с. [↑](#footnote-ref-33)
33. Berleva, G.O., et al., Analytical report of the results of research “Evaluation of number of most at risk populations for HIV in Ukraine”. 2012, ICF “International Alliance in Ukraine”: Kyiv. [↑](#footnote-ref-34)
34. Моніторинг поведінки та поширення ВІЛ-інфекції серед жінок, які надають сексуальні послуги за винагороду, як компонент епіднагляду за ВІЛ другого покоління: аналіт. звіт за результатами біоповедінкового дослідження 2013 року / Балакірєва О.М., Бондар Т.В., Середа Ю.В. та ін. 2014, К. : МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні». p. 144 с. [↑](#footnote-ref-35)
35. Berleva, G.O., et al., Analytical report of the results of research “Evaluation of number of most at risk populations for HIV in Ukraine”. 2012, ICF “International Alliance in Ukraine”: Kyiv. [↑](#footnote-ref-36)
36. Моніторинг поведінки та поширеності ВІЛ-інфекції серед чоловіків, які практикують секс із чоловіками, як компонент епіднагляду за ВІЛ другого покоління: аналіт. звіт за результатами біоповедінкового дослідження 2013 року / Большов Є.С., Касянчук М.Г., Трофіменко Л.В. 2014, К.: МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні». p. 96 с. [↑](#footnote-ref-37)
37. Национальный отчет о достигнутом прогрессе в осуществлении глобальных мер в ответ на СПИД. Республика Беларусь. Отчетный период: январь 2013 г. ― декабрь 2014г. 2015. [↑](#footnote-ref-38)
38. Национальный отчет о достигнутом прогрессе в осуществлении глобальных мер в ответ на СПИД. Республика Беларусь. Отчетный период: январь 2013 г. ― декабрь 2014г. 2015. [↑](#footnote-ref-39)
39. UNAIDS. Global report. UNAIDS report on the global AIDS epidemic 2013. 2013; Available from: <http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf> [↑](#footnote-ref-40)
40. UNAIDS. Global report. UNAIDS report on the global AIDS epidemic 2013. 2013; Available from: <http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf> [↑](#footnote-ref-41)
41. WHO. Global Tuberculosis Report 2013. 2013; Available from: <http://www.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf> [↑](#footnote-ref-42)
42. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-43)
43. Republic of Bulgaria country progress report on monitoring the 2013 political declaration on HIV/AIDS. 2014; Available from: <http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/BGR_narrative_report_2014.pdf> [↑](#footnote-ref-44)
44. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-45)
45. APMG Report of the Independent Evaluation of the HIV/AIDS Programme in Bosnia and Herzegovina. 2014 [↑](#footnote-ref-46)
46. Valerio Baćak, Zoran Dominković. Behavioral and Biological Surveillance Study among Injection Drug Users in Bosnia and Herzegovina, 2012: A Respondent-Driven Sampling Survey [↑](#footnote-ref-47)
47. Bosnia and Herzegovina COUNCIL OF MINISTERS. RESPONSE RESPONSE TO HIV/AIDS IN BOSNIA AND HERZEGOVINA 2011–2016 STRATEGY. [↑](#footnote-ref-48)
48. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-49)
49. Republic of Moldova progress report on HIV/AIDS: January – December 2014. 2015. [↑](#footnote-ref-50)
50. Republic of Moldova progress report on HIV/AIDS: January – December 2014. 2015. [↑](#footnote-ref-51)
51. Republic of Moldova progress report on HIV/AIDS: January – December 2014. 2015. [↑](#footnote-ref-52)
52. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-53)
53. Monitoring the Declaration of Commitment on HIV/AIDS: Georgia Country Progress Report. 2010; Available from: <http://data.unaids.org/pub/Report/2010/georgia_2010_country_progress_report_en.pdf> [↑](#footnote-ref-54)
54. Platt, L., et al., HIV epidemics in the European region: vulnerability and response. 2015: World Bank Publications. [↑](#footnote-ref-55)
55. Estimating the Prevalence of Injection Drug Use in Five Cities of Georgia. 2009; Available from: <http://bemonidrug.org.ge/wp-content/uploads/2014/07/Estimating-the-Prevalence-of-Injection-Drug-Use-in-Five-Cities-of-Georgia.pdf> [↑](#footnote-ref-56)
56. Estimating the Prevalence of Injection Drug Use in Five Cities of Georgia. 2009; Available from: <http://bemonidrug.org.ge/wp-content/uploads/2014/07/Estimating-the-Prevalence-of-Injection-Drug-Use-in-Five-Cities-of-Georgia.pdf> [↑](#footnote-ref-57)
57. Chikovani, I., et al., Prevalence of HIV among injection drug users in Georgia. J Int AIDS Soc, 2011. 14: p. 9. [↑](#footnote-ref-58)
58. Estimating the Prevalence of Injection Drug Use in Georgia. 2012. [↑](#footnote-ref-59)
59. Estimating the Prevalence of Injection Drug Use in Georgia. 2012. [↑](#footnote-ref-60)
60. Chikovani, I., et al., HIV risk and prevention behaviors among Female Sex Workers in two cities of Georgia. 2014. [↑](#footnote-ref-61)
61. Platt, L., et al., HIV epidemics in the European region: vulnerability and response. 2015: World Bank Publications. [↑](#footnote-ref-62)
62. Bio-behavioral surveillance surveys among female sex workers in Georgia, Tbilisi, Batumi 2008–2009. . 2013; Available from: <http://curatiofoundation.org/wp-content/uploads/2015/09/72.pdf> [↑](#footnote-ref-63)
63. Population Size Estimation of Men Who Have Sex with Men in Georgia. 2014; Available from: <http://curatiofoundation.org/wp-content/uploads/2015/09/255.pdf> [↑](#footnote-ref-64)
64. Bio-behavioral surveillance surveys among men who have sex with men in Tbilisi, Georgia 2010. . 2010; Available from: <http://curatiofoundation.org/wp-content/uploads/2015/09/166.pdf> [↑](#footnote-ref-65)
65. Estimating the Prevalence of Injection Drug Use in Five Cities of Georgia. 2009; Available from: <http://bemonidrug.org.ge/wp-content/uploads/2014/07/Estimating-the-Prevalence-of-Injection-Drug-Use-in-Five-Cities-of-Georgia.pdf> [↑](#footnote-ref-66)
66. Bio-behavioral surveillance surveys among men who have sex with men in Tbilisi, Georgia 2010. . 2010; Available from: <http://curatiofoundation.org/wp-content/uploads/2015/09/166.pdf> [↑](#footnote-ref-67)
67. HIV risk and prevention behavior among Men who have Sex with Men in Tbilisi, Georgia. Bio-behavioral surveillance survey in 2012. 2012; Available from: <https://www.researchgate.net/publication/275349803_HIV_risk_and_prevention_behavior_among_Men_who_have_Sex_with_Men_in_Tbilisi_Georgia._Bio-behavioral_surveillance_survey_in_2012> [↑](#footnote-ref-68)
68. Bio-behavioral surveillance surveys among men who have sex with men in Tbilisi, Georgia 2010. . 2010; Available from: http://curatiofoundation.org/wp-content/uploads/2015/09/166.pdf

    HIV risk and prevention behavior among Men who have Sex with Men in Tbilisi, Georgia. Bio-behavioral surveillance survey in 2012. 2012; Available from: <https://www.researchgate.net/publication/275349803_HIV_risk_and_prevention_behavior_among_Men_who_have_Sex_with_Men_in_Tbilisi_Georgia._Bio-behavioral_surveillance_survey_in_2012> [↑](#footnote-ref-69)
69. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-70)
70. Dec. 2014 , Comp M&E INBI Prof. Matei Bals. [↑](#footnote-ref-71)
71. UNODC IBBS 2010, Nationa Report on drugs, NAA, 2012. [↑](#footnote-ref-72)
72. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-73)
73. Kazatchkine, M., Drug use, HIV, HCV and TB: major interlinked challenges in Eastern Europe and Central Asia. J Int AIDS Soc, 2014. 17(4 Suppl 3): p. 19501. [↑](#footnote-ref-74)
74. Schluger, N.W., et al., Tuberculosis, drug use and HIV infection in Central Asia: an urgent need for attention. Drug Alcohol Depend, 2013. 132 Suppl 1: p. S32-6. [↑](#footnote-ref-75)
75. Baral, S., et al., HIV among female sex workers in the Central Asian Republics, Afghanistan, and Mongolia: contexts and convergence with drug use. Drug Alcohol Depend, 2013. 132 Suppl 1: p. S13-6. [↑](#footnote-ref-76)
76. Wirtz, A.L., et al., Uncovering the epidemic of HIV among men who have sex with men in Central Asia. Drug Alcohol Depend, 2013. 132 Suppl 1: p. S17-24. [↑](#footnote-ref-77)
77. Jolley, E., et al., HIV among people who inject drugs in Central and Eastern Europe and Central Asia: a systematic review with implications for policy. BMJ Open, 2012. 2(5). [↑](#footnote-ref-78)
78. Республика Казахстан. Национальный доклад о достигнутом прогрессе в осуществлении глобальных мер в ответ на СПИД. Отчетный период: 2014. 2015; Available from: <http://www.unaids.org/sites/default/files/country/documents/KAZ_narrative_report_2015.pdf> [↑](#footnote-ref-79)
79. Республика Казахстан. Национальный доклад о достигнутом прогрессе в осуществлении глобальных мер в ответ на СПИД. Отчетный период: 2014. 2015; Available from: <http://www.unaids.org/sites/default/files/country/documents/KAZ_narrative_report_2015.pdf> [↑](#footnote-ref-80)
80. Jolley, E., et al., HIV among people who inject drugs in Central and Eastern Europe and Central Asia: a systematic review with implications for policy. BMJ Open, 2012. 2(5). [↑](#footnote-ref-81)
81. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-82)
82. Van den Hof, S., et al., Converging risk factors but no association between HIV infection and multidrug-resistant tuberculosis in Kazakhstan. Int J Tuberc Lung Dis, 2013. 17(4): p. 526-31. [↑](#footnote-ref-83)
83. WHO. Global Tuberculosis Report 2013. 2013; Available from: <http://www.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf> [↑](#footnote-ref-84)
84. Анализ заболеваемости туберкулезом в Республике Казахстан. 2010; Available from: <http://2010-2013.iwep.kz/index.php?newsid=129> [↑](#footnote-ref-85)
85. Кыргызская Республика. Страновой отчет о достигнутом прогрессе в осуществлении глобальных мер в ответ на ВИЧ-инфекцию за 2014 год. 2015; Available from: <http://www.unaids.org/sites/default/files/country/documents/KGZ_narrative_report_2015.pdf> [↑](#footnote-ref-86)
86. Jolley, E., et al., HIV among people who inject drugs in Central and Eastern Europe and Central Asia: a systematic review with implications for policy. BMJ Open, 2012. 2(5). [↑](#footnote-ref-87)
87. Кыргызская Республика. Страновой отчет о достигнутом прогрессе в осуществлении глобальных мер в ответ на ВИЧ-инфекцию за 2014 год. 2015; Available from: <http://www.unaids.org/sites/default/files/country/documents/KGZ_narrative_report_2015.pdf> [↑](#footnote-ref-88)
88. Кыргызская Республика. Страновой отчет о достигнутом прогрессе в осуществлении глобальных мер в ответ на ВИЧ-инфекцию за 2014 год. 2015; Available from: <http://www.unaids.org/sites/default/files/country/documents/KGZ_narrative_report_2015.pdf> [↑](#footnote-ref-89)
89. Data 2014. WHO TB countries’ profiles // <http://www.who.int/tb/country/data/profiles/ru/> [↑](#footnote-ref-90)
90. <http://www.unaids.org/sites/default/files/media_asset/JC2687_TheCitiesReport_en.pdf> [↑](#footnote-ref-91)
91. <http://www.who.int/healthy_settings/types/cities/en/> [↑](#footnote-ref-92)
92. <http://www.asean.org/archive/documents/19th%20summit/ASEAN_Declaration_of_Commitment.pdf> [↑](#footnote-ref-93)
93. <http://www.advanceaccessanddelivery.org/our-approach> [↑](#footnote-ref-94)
94. <http://www.amsterdam.nl/gemeente/organisaties/organisaties/sites/project_1012/1012/aanpak/beleid/> [↑](#footnote-ref-95)
95. [www.inworkproject.eu](http://www.inworkproject.eu) [↑](#footnote-ref-96)
96. G. Shaw. Situation Assessment and Strategic Direction for the prevention to care and treatment of HIV/AIDS, TB and viral hepatitis among Key Populations in Eastern Europe and Central Asia (EECA) 2016-2018 - prepared for International HIV/AIDS Alliance in Ukraine, 2015. [↑](#footnote-ref-97)
97. G. Shaw. Situation Assessment and Strategic Direction for the prevention to care and treatment of HIV/AIDS, TB and viral hepatitis among Key Populations in Eastern Europe and Central Asia (EECA) 2016-2018 - prepared for International HIV/AIDS Alliance in Ukraine, 2015. [↑](#footnote-ref-98)
98. Joint United Nations Programme on HIV/AIDS (UNAIDS). 90-90-90 An ambitious treatment target to help end the AIDS epidemic. Geneva, UNAIDS, 2014 (<http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf>, accessed 07 January 2015). [↑](#footnote-ref-99)
99. The Cities Report. UNAIDS, 2015: <http://www.unaids.org/sites/default/files/media_asset/JC2687_TheCitiesReport_en.pdf> [↑](#footnote-ref-100)
100. World Health Organisation. European Action Plan for HIV/AIDS 2012-2015. WHO Regional Office for Europe, Copenhagen, 2011 (<http://www.euro.who.int/__data/assets/pdf_file/0011/153875/e95953.pdf>, accessed 06 January 2015). [↑](#footnote-ref-101)
101. World Health Organisation. Global health sector strategy on HIV/AIDS 2011-2015. Geneva, WHO, 2011 (<http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf>, accessed 07 January 2015). [↑](#footnote-ref-102)
102. WHO. European Action Plan for HIV/AIDS 2012-2015, Ibid. [↑](#footnote-ref-103)
103. WHO. European Action Plan for HIV/AIDS 2012-2015, Ibid. [↑](#footnote-ref-104)
104. European Commission. Commission Staff Working Document: Action Plan on HIV/AIDS in the EU and neighbouring countries: 2014-2016. Brussels, European Commission, 14 March 2014, Document SWD(2014) 106 final (<http://ec.europa.eu/health/sti_prevention/docs/ec_hiv_actionplan_2014_en.pdf>, accessed 13 January 2015). [↑](#footnote-ref-105)
105. The Global Fund To Fight AIDS, Tuberculosis and Malaria. The Global Fund Strategy 2012-2016: Investing for Impact. Geneva, GFATM, 2012 (<http://www.theglobalfund.org/documents/core/strategies/Core_GlobalFund_Strategy_en/>, accessed 12 January 2015). [↑](#footnote-ref-106)
106. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Turning the Tide Against HIV and Tuberculosis: Global Fund Investment Guidance for Eastern Europe and Central Asia. Geneva, GFATM, 2014 (English language version: <http://www.theglobalfund.org/documents/publications/other/Publication_GlobalFundInvestmentEECA_Guidance_en/>, accessed 19 January 2015; Russian language version: <http://www.theglobalfund.org/documents/publications/other/Publication_GlobalFundInvestmentEECA_Guidance_ru/>); Framework (only available in English): <http://www.theglobalfund.org/documents/publications/other/Publication_GlobalFundInvestmentEECA_Framework_en/>) [↑](#footnote-ref-107)
107. <http://www.pepfar.gov/countries/index.htm>, accessed 2 February 2015. [↑](#footnote-ref-108)
108. U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). Partnership to Fight HIV/AIDS in the Central Asia Republics (undated), (<http://www.pepfar.gov/documents/organization/199559.pdf>, accessed 2 February 2015). [↑](#footnote-ref-109)
109. <http://www.pepfar.gov/about/strategy/index.htm>, accessed 2 February 2015. [↑](#footnote-ref-110)
110. World Health Organisation. WHA approves Post-2015 Global TB Strategy and Targets, Geneva, 19 May 2014 (<http://who.int/tb/features_archive/globaltb_strategy/en/>, accessed 07 January 2015). [↑](#footnote-ref-111)
111. World Health Organisation. The End TB Strategy: Global strategy and targets for tuberculosis prevention, care and control after 2015. Geneva, WHO, December 2014 (<http://who.int/tb/post2015_TBstrategy.pdf>, accessed 07 January 2015). [↑](#footnote-ref-112)
112. Stop TB Partnership. Operational Strategy 2013-2015. Geneva, WHO, 2012 (<http://www.stoptb.org/assets/documents/about/OperationalStrategy2013-2015.pdf>, accessed 07 January 2015), p7. [↑](#footnote-ref-113)
113. Stop TB Partnership, op. cit. [↑](#footnote-ref-114)
114. World Health Organisation. The End TB Strategy: Global strategy and targets for tuberculosis prevention, care and control after 2015. Geneva, WHO, December 2014 (<http://who.int/tb/post2015_TBstrategy.pdf>, accessed 30 December 2015). [↑](#footnote-ref-115)
115. <http://www.harm-reduction.org/projects/regional-program-harm-reduction-works-fund-it> [↑](#footnote-ref-116)
116. WHO. Consolidated ARV guidelines. Geneva, WHO, June 2013, <http://www.who.int/hiv/pub/guidelines/arv2013/art/statartadolescents/en/> (accessed 11 June 2015). [↑](#footnote-ref-117)
117. G. Shaw. Situation Assessment and Strategic Direction for the prevention to care and treatment of HIV/AIDS, TB and viral hepatitis among Key Populations in Eastern Europe and Central Asia (EECA) 2016-2018 - prepared for International HIV/AIDS Alliance in Ukraine, 2015. [↑](#footnote-ref-118)
118. G. Shaw. Situation Assessment and Strategic Direction for the prevention to care and treatment of HIV/AIDS, TB and viral hepatitis among Key Populations in Eastern Europe and Central Asia (EECA) 2016-2018 - prepared for International HIV/AIDS Alliance in Ukraine, 2015. [↑](#footnote-ref-119)
119. Source: <http://www.who.int/tb/country/data/profiles/en>, accessed 01 December 2014 [↑](#footnote-ref-120)
120. G. Shaw. Situation Assessment and Strategic Direction for the prevention to care and treatment of HIV/AIDS, TB and viral hepatitis among Key Populations in Eastern Europe and Central Asia (EECA) 2016-2018 - prepared for International HIV/AIDS Alliance in Ukraine, 2015. [↑](#footnote-ref-121)
121. Analysis by International HIV/AIDS Alliance in Ukraine prepared for G. Shaw. Situation Assessment and Strategic Direction for the prevention to care and treatment of HIV/AIDS, TB and viral hepatitis among Key Populations in Eastern Europe and Central Asia (EECA) 2016-2018 - prepared for International HIV/AIDS Alliance in Ukraine, 2015. [↑](#footnote-ref-122)
122. UNICEF. A decade of transition, Regional Monitoring Report, No.8. Florence: UNICEF Innocenti Research Center; 2001. [↑](#footnote-ref-123)