

Multicountry Priority Area Terms of Reference Open for Consultation

HIV: Sustainability of Services for Key Populations in Eastern Europe and Central Asia Region

25 October 2017

Priority: Sustainability of services for key populations in Eastern Europe and Central Asia region¹

Upper ceiling Allocation: US\$ 13 M

Max. Number of grants: 1-2

Grant duration: 3 years

Multicountry approach: Based on the Global Fund Board's decision (GF/B36/04) in November 2016 on the Catalytic Investments for 2017-2019 Allocation Period, US\$ 13,000,000 M has been made available to address Sustainability of services for key populations in Eastern Europe and Central Asia region. The amounts and priority areas for Catalytic Investments have been determined primarily by technical partners in consultation with the Global Fund Secretariat, and reflect critical needs that will assist in the delivery of the global plans for HIV, TB, and malaria and the 2017-2022 Global Fund Strategy. Under the recommendation of the Global Fund Board and technical partners, these funds will be allocated through an open and competitive RFP process.

All comments on the draft Terms of Reference should be sent to Christine Kabare, Christine.Kabare@theglobalfund.org by November 15, 2017 midnight CEST time.

Background

The annual number of new HIV infections continues to increase in Eastern Europe and Central Asia (60% increase between 2010 and 2016), indicating sub-optimal quality and coverage of HIV prevention programs. Large gaps also remain along the treatment continuum in the region, with the region not on-track to reach the 90-90-90 targets by 2020. Treatment coverage remains alarmingly low (28%), and less than a quarter of people living with HIV had suppressed viral loads (end-2016). Combining greater targeted domestic investments with greater attention to the provision of services to key populations and the ongoing portfolio of external grants from the Global Fund and other donors are essential to accelerate progress towards targets for Fast-Track and Ending AIDS.

Guiding principles:

The following guiding principles can be used to guide the process of design, selection and implementation of new multicountry grant(s):

- the grant should build on and enhance existing mechanisms for collaboration and partnership between civil society and government, including through CCMs;

¹ The GF definition of the EECA region includes South-East Europe. For the list of eligible countries please refer to www.theglobalfund.org

- the grant should be a model of transparency and inclusivity to enable government and other partners to support and enhance HIV services;
- the grant should strengthen and build on existing regional and cross-border initiatives between civil society and governments in EECA;
- the grant should leverage the potential for real-time networking and sharing of results, including through the innovative use of social media.

Programmatic sub-areas to be addressed by multicountry grant(s) with the overall purpose of accelerating progress on Fast-Track by 2020 and ensuring the sustainability of HIV services for key populations (*an eventual multicountry grant may be confined to one or several sub-areas*):

Sub-area I: Sustainable financing for HIV services for key populations

Rationale: Several countries in EECA, e.g., Belarus, Kazakhstan, Moldova, Ukraine, have already established national and local legislation and mechanisms that enable providers of HIV services for key populations (both non- and for-profit non-governmental organizations) to apply for government funding. However, the accumulated experience remains very limited and the amount and proportion of government funding for HIV services among key populations, including people living with HIV, remains deeply inadequate. The practice of implementing such mechanisms by relevant government departments has been inconsistent, and varies considerably even within a single country. Often the mechanisms to implement this legislation do not exist or are rudimentary.

A new multicountry grant could provide incentives and technical assistance to non-governmental service providers to work with central and local governments to develop and implement new and improved mechanisms for accessing government grants (and/or other type of public funding), to negotiate better terms of work, to establish more sustainable models for government funding. The multicountry grant should enable EECA governments to boost “demand” for this kind of public funding, which will result in better and more predictable support from relevant government sources. This line of work can build on progress that has been achieved so far by “budget advocacy” for HIV prevention among key populations.

In most of countries that are recipients of individual country HIV grants the bulk of HIV prevention services for key populations are financed out of the country’s HIV grant. From one grant to another, the commitment of the recipient country’s government to sustain these services has not materialized over time. The multicountry grant could work in countries with current and pipeline grants from the Global Fund to support advocacy and normative work to develop and implement a mechanism for co-funding (i.e., central/regional/municipal governments and that of the GF) for HIV services for key populations.

Some of HIV services are already covered by compulsory medical insurance (e.g., HIV testing, OST, ART, treatment of TB, of HCV, etc.) but experience varies from country to country. A multicountry project could work in two important dimensions: a) first by supporting actions on gradual expansion of the coverage of the medical insurance of all components that are currently in the “packages of services for key populations” that are financed by the Global Fund, and b) help protect health rights of migrants, including internal migrants, people without proper registrations, people without health insurance policies, and non-citizens whose health rights are violated in many respects.

Success in Sub-area I could be measured by (but should not be limited to):

- Number of mechanisms for receiving government funding and the overall amount that non-government service providers receive each year in each project country to provide HIV services to key populations;
- Instances and amounts (at either national or regional or municipal levels) of co-funding of HIV prevention services for key populations in each project country each year;

- New elements of HIV services that are added to the list of services covered by compulsory medical insurance in each project country.

Relevant activities in Sub-area I may include (but should not be limited to):

- design/revision of a costed standard package of services (commensurate with local market rates in project countries);
- design/revision of relevant local “industry standards” of provision of HIV services to key populations (in locally acceptable formats);
- reaching agreement between relevant municipal/regional government and non-government stakeholders on what’s in the “package” and its cost, etc.;
- building competence of both government and non-government stakeholders in development of relevant ToR for subsidies, grants, etc.;
- capacity building of local government's, health insurance companies, NAP units, central authorities, etc. to organize the planning, implementation, M&E, oversight, control of services financed from local/domestic funding by NGOs;
- sharing pertinent good practices among service providers and authorities in project countries (and beyond);
- Support to patients groups to advocate for appropriate change in medical insurance coverage;
- Setting up and running ARV drug banks (including procuring appropriate level of legal support for ARV drug banks operations);
- Setting up standards for services to be sub-contracted from the medical insurance;
- Support countries with DRG (Diagnosis-related group) services/unit cost calculations to be sub-contracted from the medical insurance funds.

Sub-area II: Sustainable access to affordable ARV drugs and other HIV commodities of assured quality

Rationale: Countries in EECA region continue to pay some of the highest prices for ARV therapy among middle-income countries, while at the same time providing some of the lowest coverage of people on treatment. Expanding ART eligibility based on WHO new recommendations “test and treat” will have significant cost implications for the HIV response in all countries of the region. As EECA countries engage in planning for scaling-up of ARV drugs through domestic sources to end the epidemics, it becomes critical to further reduce the ARV drug prices currently available. ARV price reduction is achievable through harmonizing national regulations in order to meet the supply chain management (PSM) standards, including international procurement mechanisms, promotion of local production and strengthening the national capacity in the area of PSM. Options for pooled procurement of ARV drugs for a group of countries have not been explored, e.g., within Eurasian Economic Union. Similar approaches should be explored for the purchase of other HIV commodities (condoms, harm reduction commodities, HIV test kits, reagents, etc).

Success in Sub-area II could be measured by (but should not be limited to):

- Ratio between median price of products procured and the international median reference value
- Number of countries with national PSM strategy developed and Logistic Management Information System (LMIS) set -up
- Number of countries adopted "treat all" approach
- Amount and proportion of HIV prevention commodities paid for by the government budget

Relevant activities in Sub-area I may include (but should not be limited to):

- Promote the adoption of “test and treat” approach;
- Advocacy for revision and improvement of PSM system regulatory framework;

- Advocacy for development of country unified PSM strategy;
- Support to setting up of a comprehensive single LMIS for quantification and reporting
- capacity development of government and CSOs responsible for different functions of the PSM cycle;
- Capacity building of civil society organisations on monitoring of ARV and other HIV commodities procurement and pricing;
- Supporting and equipping stakeholders with means and skills to negotiate with patent producers, suppliers, and patent-holders

Sub-area III: Reduction of stigma and discrimination of key populations

Rationale: HIV-related stigma and discrimination constitute a major barrier for people living with HIV to accessing HIV prevention, treatment and support. As a result of stigma and discrimination, or fear of it, key populations are reluctant to disclose their status and follow up on the results of testing/survey/medical examinations, even if they have access to services. In addition, there are laws and new attempts in many countries of the region (e.g., Kyrgyzstan, Belarus, Ukraine, Russia, Tajikistan) to reintroduce more severe punishments for drug use and possession of small quantities of illegal drugs and the same for sex work, attempts to criminalize the same sex relationship (often under the pretext of protecting minors), etc. While such legislation does not directly prohibit the provision of HIV prevention services in key populations, it has been proven to be a major barrier to discourage key populations from seeking HIV services. A multicountry grant may equip relevant networks and activists with resources to monitor and intervene when appropriate. One possible type of intervention could be creatively tapping into social media as a driving force behind pertinent social change.

Success in Sub-area III could be measured by (but should not be limited to):

- Attempts to introduce “conservative” legislation that have been successfully blocked;
- Discriminative legislation that has been repealed;
- New legal or normative acts aligning to decriminalization and public health approach in relation to key populations;
- % of PLHIV report friendly attitude in medical facilities.

Relevant activities in Sub-area III may include but should not be limited to:

- Support to civil groups/key population groups to perform watchdog function;
- Supporting country activist groups with resources to pay for expertise, legal support to bring specific cases to courts;
- Advocacy and communication campaigns (e.g. targeting members of parliament, members of national health council, and other relevant bodies) to promote antidiscrimination legislation;
- Media campaigns to sensitize the society and form positive attitude towards PLHIV and other KP;
- Documentation and share of best practices in the field;
- Capacity building of the law enforcement agencies to minimize negative practices towards key populations in the country;
- Trainings for health care workers to minimize discrimination toward KP and PLHIV.

Sub-area IV: Improving efficiency of service delivery models of HIV services for key populations

Rationale: The work on HIV allocative efficiency was only partially implemented in some EECA countries in 2014 - 2016, but all participating countries found it a useful exercise to inform the allocation of national and donor funding. The allocative efficiency of national AIDS programs is questionable. Program efficiency has not been addressed in a consistent manner in the region.

There is little knowledge about how efficient are the service models that are currently on the “market” (accept “self-reported” efficiency.) Most models also appear overpriced.

Improved access to HIV testing services is especially important for key populations at higher risks who face limited access to the public medical facilities that conduct HIV testing. There is an urgent need to remove barriers to enrolment of key populations at higher risk in HIV testing programmes.

Success in Sub-area IV could be measured by (but should not be limited to):

- Proportion of PLH identified through community based HIV services and self-testing and linked to care
- Number of NGOs initiated HTS services for KP at the community level

Relevant activities in Sub-area IV may include (but should not be limited to):

- HIV allocative efficiency studies;
- Evaluation of technical efficiency of current models of HIV services delivered to key populations;
- Collection of evidence on high impact HIV prevention services in EECA with particular focus on transmission in key populations;
- Expansion of different HIV Testing models, including community-based testing allowing the early linkage to HIV care services;
- Integration of HIV testing services into broader health system, including TB, RH, PHC, and STI services;
- Grants to NGOs to prepare necessary documents for HIV testing among key populations and implementation capacity building and HIV counselling and testing services in the country;
- PrEP advocacy (possibly a feasibility study in a group of countries);
- Assessments (e.g., population size, key risk factors, special needs, interaction with HIV services) of new key populations (e.g., transgender).