Global Fund Observer

NEWSLETTER

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In the last year, in programs supported by the Global Fund, the number of people receiving antiretroviral therapy was up 20%; the number of malaria bednets distributed rose 25%; and the number of TB cases detected and treated increased by 9%. The Fund released the 2014 numbers on 1 December.

Ghana's Health Service spent some $3.8 million of a Global Fund grant on faulty condoms procured in a tender that was riddled with fraud, the Office of the Inspector General has found. In

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Aidspan's analysis of what accountability means in the context of global health cooperation was published in December by Globalization and Health.

9. PRESS RELEASE: Aidspan releases first-ever documentary, "I didn't want to bring shame on my family": growing up gay in Ghana

Aidspan, the independent watchdog of The Global Fund to Fight AIDS, TB and Malaria, is pleased to announce the release of its first-ever documentary film, "I didn't want to bring shame on my family": growing up gay in Ghana. The film is being released on December 1, 2014, to coincide with the global celebration of World AIDS Day.

ARTICLES:

1. NEWS: Numbers of people reached and services provided continues to rise

David Garmaise 11 December 2014

Global Fund releases end-2104 numbers

The number of people receiving anti-retroviral therapy through programs supported by the Global Fund reached an estimated 7.3 million by the end of 2014, a 20% increase over a year earlier. A total 450 million insecticide-treated nets to prevent malaria were distributed, up 25% over 2013's total of 360 million. The number of TB cases detected and treated rose from 11.2 million a year ago to 12.3 million at the end of 2014, a 9% increase.

Other key results numbers announced by the Fund on World AIDS Day, 1 December, show year-on-year increases ranging from 4% to 38%. See the table for details.

The Numbers			
Cumulative results for programs to which the Global Fund contributed			
	RESULTS TO DECEMBER 2014	RESULTS TO DECEMBER 2013	YEAR-TO-YEAR CHANGE
No. of people receiving ART	7.3 million	6.1 million	+ 20%
TB smear-positive cases detected and treated	12.3 million	11.2 million	+ 9%
MDR-TB cases treated	150,000	108,908	+ 38%

No. of condoms distributed	4.9 billion	4.5 billion	+ 9%
No. of HIV counseling and testing sessions conducted	390 million	306 million	+ 27%
No. of malaria ITNs distributed	450 million	360 million	+ 25%
Structures covered by IRS	55.0 million	48.3 million	+ 14%
Malaria cases treated	470 million	390 million	+ 21%
HIV behavioral change communications	450 million	412 million	+ 9%
No. of women receiving PMTCT treatment	2.7 million	2.4 million	+ 13%
Care and support services provided	27.0 million	24.6 million	+ 10%
Care and support for OVC	7.2 million	6.9 million	+ 4%
Treatment for STIs	21.0 million	19.6 million	+ 7%
People treated for TB/HIV	11.0 million	9.4 million	+ 17%
Person episodes of training for health or community workers	15.6 million	14.9 million	+ 5%

In a news release accompanying the announcement of the results, the Global Fund said that the numbers "show significant movement towards common milestones in HIV response, articulated well in a study recently released by UNAIDS that calls for fast-tracking the HIV response to end the epidemic by 2030." The news release also noted the accelerated efforts against malaria and progress in the response to TB.

[This article was first posted on GFO Live on 11 December 2014.]

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2. NEWS: Ghana should repay $3.8 million to Global Fund in faulty condom deal

Lauren Gelfand 11 December 2014

Tender for more than 120 million condoms was riddled with fraud -- and the goods were bad

Ghana's Ministry of Health spent some $3.8 million of a Global Fund grant on faulty condoms procured in a tender that was riddled with fraud, the Office of the Inspector General has found. In addition to developing a plan to recover the funds, the Secretariat will be placing all purchasing for Ghana under the pooled procurement mechanism and requiring greater oversight by the local fund agent.

The investigation report published on 11 December confirmed that the procurement of 128 million male condoms purchased for the Ghana Health Service between 2010 and 2013 were "substandard, over-priced and bought through a non-competitive tender process involving forged documents".

The tendering process was flawed from the outset, according to the report. Advertised only locally for a very short time period, the bid was whittled down to a single source with the immediate disqualification of two other bidders. An evaluation by the Ghana Central Tender Board was not reviewed, making the process decidedly untransparent.

Only a month after the bid was approved, the MoH agreed to a 35% per unit cost increase -- an increase worth nearly $1 million over what had been a fixed-price contract that was ostensibly not subject to adjustments. According to the investigation, there is no evidence that the supplier, Global Unilink, provided the Ghana Health Service with documentation including market-pricing data to justify the price increase.

Moreover, the tender was predicated on the provision of falsified documents. Global Unilink provided misleading information related to where the condoms were manufactured, including a falsified manufacturer's certificates that declared the condom manufacturer was WHO-certified.

This led to the other major problem: the condoms were of decidedly inferior quality. The investigation confirmed that the supplier did not source the product from a WHO-certified manufacturer, as it had been contracted to do. The purchased prophylactics did not meet WHO specifications or standards, even though the samples submitted during the tender for quality tests did come from a WHO-certified manufacturer. What this means is that quality condoms were provided for testing and low-quality ones supplied for use.

These quality issues came to light when end users reported that they burst too easily, did not contain enough lubricant and, according to one Ghanaian media report, were not big enough.

Why the Ghana Health Service failed to continue to carry out quality control tests on the Be Safe condoms remains to be seen; going forward, Aidspan understands from the Global Fund Secretariat: "the Secretariat will provide the Ghana Food and Drug Authority with advance notice of the dispatch

of critical health products and commodities procured for Global Fund programs from whatever source. The LFA will verify the quality testing has been conducted before distribution."

Other safeguards have been put in place, specifically related to the procurement of health products and commodities for Ghana. Since 2012, Ghana has been enrolled in the pooled procurement mechanism and global drug facility, meaning that ARVs, HIV test kits, drugs and diagnostic kits for malaria and TB drugs are all now procured by the Global Fund on Ghana's behalf. The MoH is now only responsible for the procurement of products such as gloves and cotton swabs.

The Secretariat should pursue the recovery of the full $3.84 million spent on the faulty condoms -- funds that Ghana itself has since 2013 been seeking from the supplier, Global Unilink, according to Ghanaian media reports.

A majority of the faulty condoms remain undistributed, stored in an MoH warehouse that, itself, has been subject to major scrutiny for the poor quality and conditions. In one Ghanaian media report, the facility was described as having a leaky roof and poor temperature controls -- less than ideal conditions even at the best of times. The condoms are to be withdrawn and destroyed by the MoH and Ghana Health Service in line with "international procedural and environmental regulations" -- whether this will happen is unclear.

Ghana has a generalized HIV prevalence rate of under 2% but within certain key populations, including commercial sex workers and men who have sex with men, the rate is considerably higher. Results from a demographic and health survey supported by the Global Fund should be published in 2015: the best way to determine whether there has been an increase in infection rates. It will not, however, be possible, to make any causatory inference that a spike in infections is due to the use of these problematic prophylactics.

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3. NEWS: Nigeria meets counterpart financing requirement

Tunde Akpeji 11 December 2014

Nigeria has met its counterpart financing requirement for malaria as well as for a joint HIV-TB concept note as required by the terms of the new funding model. The West African country is one of the largest beneficiaries of the NFM, allocated more than $1 billion for 2014-2017.

The government will commit some $460 million over five years to a massive malaria prevention campaign, to emphasize activities in high-priority states identified in coordination with the National Malaria Control Program (NMCP). An additional government commitment of $40 million per year has been approved by legislators to support the HIV response.

New domestic financing requirements, known as Willingness to Pay, are a hallmark of the NFM as it shifts Global Fund resources towards those countries with the highest disease burdens and the least ability to pay. Nigeria, the most populous country in sub-Saharan Africa, is also its largest economy according to revised gross domestic product (GDP) figures released by the Nigerian government in April.

Nigeria submitted its concept note for malaria in June, and it has cleared the Technical Review Panel, Aidspan understands from the country coordination mechanism (CCM). A joint concept note for HIV/TB was submitted in August. Both concept notes are expected to proceed to grantmaking in early 2015.

Although Nigeria has earned decent grades for its grant implementation in the past, a new approach was envisioned in both concept notes, with an emphasis on shifting resources and responsibilities to states -- especially high-burden states -- rather than maintaining centralized responsibility. This will allow a more tailored complement of activities to be carried out in different states, based on population demographics, disease burden and capacity of the health system in each state. Already six states have been designated as sub-recipients and will maintain those roles in the 2014-2017 allocation period. These changes will also afford the national control programs for HIV and malaria to do more oversight, monitoring and evaluation and less program implementation. There will be no change to the CCM role.

The existing private-public sector partnership known as the Affordable Medicines Faculty- malaria has been integrated into Nigerian malaria activities so that, going forward, the country will be able to use Global Fund grants to co-subsidize ACT therapies for pediatric and adult use.

The program continues to face challenges, however, as access has been compromised in areas where high demand has yet to be met with an increased supply. Some of the downsides of the AMFm in Nigeria -- including hoarding and distorted pricing -- remain, according to a source within the CCM.

Nigeria's new holistic approach to Global Fund grant management also extends to its management of risk, both programmatic and fiduciary. All principal and sub-recipients are required to develop and seek approval for risk management plans as a condition of disbursement. This includes the NMCP, which was found to have engaged in a series of fraudulent transactions for airline transactions. It is expected to reimburse some $50,000 to the Fund prior to grantmaking, Aidspan understands.

But while Nigeria is working to evolve the way it implements grants, the overarching context in which stakeholders engaged in the HIV response are working makes some of the activities, and policies, particularly challenging. Legislation was passed in early 2014 making it a crime to be gay, and provides harsh penalties for organizations found to be working on gay issues. This is not supposed to extend to health services, but the reality is far more complicated (see article here).

Within the CCM there is still tremendous opposition to allowing men who have sex with men, people who inject drugs and other members of key populations to have a voice in the decision-making and oversight of Global Fund grants. They say that because the legal statutes are indicative of the will of the Nigerian people, they have no choice but to adhere to the law and thus distance themselves from the very people the grant monies are supposed to be assisting.

The Fund says that it will continue with an engagement approach launched in 2014 through the grantmaking process, which included the establishment of a secretariat for key affected populations to manage engagement with the rest of the CCM. This has helped, thus far, to ensure that the priorities expressed by the CCM were aligned with those identified by the key populations.

It is anticipated that more technical assistance to key populations will be provided during grantmaking, and through the entire implementation cycle. How to ensure better representation of key populations in the CCM, however, remains to be seen.

According to CCM Spokesperson, Emmanuel Abi Couson said “for [foreign entities] to come and say they should be at the highest decision-making body then you are asking too much. That is our stand as far as Nigeria is concerned because we cannot go against the law of the land.”

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4. NEWS: Mauritania, the Global Fund and the discreet inclusion of the gay community in the HIV response

Robert Bourgoing 11 December 2014

In a shaded courtyard of a non-descript building just on the outskirts of Nouakchott, a group of young men sits in comfortable repose. It's a group with no official name, only the whispered identity of an MSM: a man who has sex with men. One by one they get up to sit on an overturned bucket

and tell the most intimate details of their lives. They are providing anonymized responses to two employees of the NGO SOS Pairs Educateurs as part of Mauritania's first Integrated HIV Bio-Behavioral Surveillance (IBBS) survey since 2007.

The data collected by the IBBS survey will help the national AIDS commission, SENLS, to develop its concept note for some $32 million allocated by the Global Fund to Mauritania under the new funding model (NFM).

A first data collection in seven years will clarify the state of the disease and its response in the Islamic republic, both within the general population and those groups most exposed to the risks of infection: groups like commercial sex workers, prisoners, members of the security forces and truck drivers who

travel the length of the West African corridor or across the northwestern deserts of the Sahel. Other high risk groups include economic migrants, sailors and the fishing industry.

But it's the men who have sex with men who are the hardest to reach, even for the survey, in this very conservative society. "It's impossible to say the word homosexual in public," explains Fatimata Ball, who represents people living with HIV on the Mauritanian country coordinating mechanism (CCM). Ball is one of just two people in Mauritania who appear bare-faced when they talk about their HIV-positive status. With her head held high she daily battles discrimination on behalf of her fellow citizens living with the disease, and the taboos that complicate everything -- especially anything to do with homosexuality.

"They're [considered] horrible people who we shouldn't engage with -- not even to shake their hands because for 40 days afterwards, your prayers will be worth nothing," she says, shaking her head ruefully.

A 'foreigner problem'

Officially, Mauritania is one of 11 countries worldwide where being gay is punishable by death. In reality, this penalty has not been applied against anyone since 1987.

Conventional wisdom is that the country is not nearly as harsh in its perception of homosexuality as countries like Iran, or even southern neighbor Senegal. And Fatimata Ball is quick to say that religion -- Mauritania practices a very strict interpretation of Sunni Islam -- doesn't bear all the responsibility. "We've got the big religious leaders who are saying that, even if Islam condemns these practices, these are human beings who have the right to treatment," she says. "But what they're not doing is saying it publicly: not on the radio, or in the newspapers, or even during their sermons. They're not saying it so people can hear, and so people aren't frightened."

The silence is an advantage to the people working on the frontlines as well. "We don't want to make noise around our work; our society doesn't like too much buzz," says Jibril Sy, president of SOS Pairs Educateurs, which has been working quietly in the gay community since 2001. "When we started our

work, we knew that it would be a bad strategy to attack the law," he says. "So we have really taken the angle of right to health, which works here. No matter who you are, even if you're a stranger, Mauritanians believe you have a right to health."

Most don't, however, believe that HIV is a 'Mauritanian thing' but rather an uninvited import from neighboring countries, carried by people who fled Senegal or the Gambia to become refugees here. They think that those foreign elements are also responsible for the introduction of homosexuality into Mauritanian culture, reflecting their disharmony with the way things really are. According to Amadou Seye Ndiaye, himself of Senegalese origin, "if you behave normally, you should have no problems. But these new guys, they are bringing us trouble. They dress up in women's clothings, they wear makeup, and they get married -- like in Senegal."

Ndiaye is a self-styled representative of the Nouakchott gay community, in which he says he knows about 400 people -- incuding about 100 Mauritanians. Among them are many who use his home as sort of a drop-in center. It is here that SOS Pairs Educateurs are carrying out their survey, and it is here that Yacoub and Ahmed (not their real names) explain how the gay community in Nouakchott is changing.

"There are a lot of men in Mauritania who have sex with other men, but we are very, very discreet. We can be the masters of ceremony at weddings and celebrations of birth but beyond that, we try not to attract attention," says Ahmed. "But the Senegalese, they are very provocative, very daring. And it shows, and it shocks, and it causes a lot of people to revolt against them."

Leaving the shadows behind, and being heard

"More and more we see gay men coming and asking for services from civil society," says Aliou Diop of SOS Pairs Educateurs. What this means, according to Diop, is that if the state is allowing groups like his to respond, it's that the state understands that the national response must accommodate all of the different needs. And the needs are growing, according to the preliminary results of the survey, which have yet to be made public, the HIV infection rate in the gay community is on the rise, likely to substantially exceed the 5% infection rate recorded in 2007.

Nothing proves the importance of reacting to an epidemic before it spreads beyond a concentrated population to the general population than a rise in infections, but Jibril Sy says there are very few, if any, activities being carried out across the country. This is due to the challenges that followed a damning Office of the Investigator General report from 2009. Suspension of the grant meant a loss of direction and ultimately resulted in very little effort to target prevention activities to one of the communities that needed them most.

The new funding model (NFM) is providing Mauritania with a previously unanticipated opportunity: to wipe the slate clean and demonstrate its new capacity for risk management while also changing its strategy, and its approach, to HIV. This means a bigger ask -- some $11 million -- for innovative new programs that put key populations at the heart of the response. But even this is not without challenges because even condom distribution has to be done covertly, through people who volunteer (PDF - 600 Kb - p. 16) to keep the products hidden in their homes.

Saving face or saving lives

How to encourage men who rely on the shadows to step into the light, to risk harassment, arrest and discrimination remains the unanswered question. Senegalese expat Madieng says it's about coming together as a community. "If we're in a bloc, we will have a strong coalition, with a strong leader who knows the problems and can speak on our behalf," he says. "It is up to us to help ourselves; we can't wait until society accepts us -- we just want to be left in peace and treated like human beings."

But another sign of the disconnect between the new arrivals and the indigenous community is revealed with Yacoub and Ahmed's almost immediate rejection of the idea. "We don't think that coming together will serve any purpose, because we are fine just helping each other. We don't have any specific problems that require us coming together, forming an association, being represented by some guy," they say.

For now, some short-term plans are in place, if only to establish what activities should be prioritized under the concept note using focus groups comprised of those who responded to the IBBS survey. This has been approved not only by the CCM but by the Fund's own country team, which has emphasized the need for these proposals to come from the local context. If in Mauritania that means individuals,

not formal or even public groups, that will work, as long as it is a participatory approach, the Global Fund Secretariat emphasized.

While being back in the good graces of the Global Fund will be critical to Mauritania's HIV response, it is far from a magic bullet that will see an opening of Mauritanian society to homosexuality. "With or without funding, there is never going to be a legal recognition of the rights of men who have sex with men or sex workers," says Fatimata Ball. "That's non-negotiable in an Islamic country and no amount of money is going to change how Mauritanians feel about this."

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5. NEWS: More than $200 million in play during DRC negotiations with the Global Fund

Aurélie Fontaine 11 December 2014

A joint HIV/TB concept note for the central African nation has been approved by the Technical Review Panel

There were huge obstacles confronting Democratic Republic of Congo as it navigated the new requirements of the Global Fund's new funding model (NFM): a lack of credible, national-level data; logistical hurdles to reach key populations in a nationwide consultation around a country with just 2,250 km of paved roads; and a leadership vacuum and entrenched disorganization. Add to this the lack of clarity in both Geneva and Kinshasa in the first stages of the NFM -- as DRC was an early applicant -- and it spelled almost certain defeat for the country's prospects of touching its desperately needed allocation.

A first concept note, delivered in January by a fractious, untrained and leery country coordination mechanism, was rejected two months later as having poorly articulated its priorities. Its implementation roadmap was 'imprecise' and failed to deliver even the promise of high-impact interventions.

"We should have provided harmonized data [for TB and HIV]; what we did was provide multiple sources [of conflicting data]," acknowledged Sylvain Yuma, who shepherded the first note towards

submission. "Nor did we really address the problem of co-infection of HIV and TB, whereas we have a really high rate here of co-morbidity."

So back to the drawing board they went, this time charged with the task of developing a joint note due to that high co-morbidity, as recommended by the Technical Review Panel. Seizing on the lessons learned from the first failed attempt, and bolstered by considerable external support from technical partners, a second submission was made in August. This time, success; the TRP endorsed the proposal and recommended to the Grants Approval Committee that DRC proceed to the next phase. By the end of November, DRC was among the countries approved to go through to the negotiations phase of the NFM, for a grant worth nearly $230 million, including some $14.5 million in incentive funding for TB and HIV activities. Once this is approved by the Board, funds should be disbursed from mid-2015.

Steep learning curve for the NFM

The Secretariat of the Global Fund considers that this investment of time and effort will only benefit DRC, and address some of the particular difficulties it had in integrating into the new way of working under the NFM. One early problem related to confusion among principal recipients about how much they should contribute to the development of the concept note. Some considered that it would be a conflict of interest to be both involved in the design of the HIV/TB note and then be a designated recipient of funding for the proposed activities. As a consequence, their absence from the discussions meant that the first submission lacked nuance and clarity around objectives and budgeting.

"Principal recipients could have brought more expertise to the budget discussions because they have the experience there," said Patrick Kanku, in charge of the HIV program for the rural health program Sanru, a state-operated structure. Sanru is likely to be chosen among principal recipients for HIV under the new grant.

In response, many PRs insisted that while they were not 100% engaged in the concept note development, they were at least there in the design stage.

"Seeing that the development of the concept note lacked technical and organizational leadership, some of the technical partners raised the alarm; so it was France Expertise Internationale that asked me to step in," explained Eric-Marie Dupuy, an independent consultant who was part of the concept note steering committee. "For example there were discussions that went on forever about whether a community-based PR could be included -- ultimately the CCM said yes."

Another challenge: the lack of experience in collaboration between government and civil society. Marie Nyombo Zaina, coordinator of the national network of NGOs addressing gender issues, and a member of the steering committee for both concept notes criticized what she saw was a lack of consideration of the particular needs of the fledgling Congolese civil society.

"As representatives of civil society, we found it difficult to be considered equal contributors to discussions that involved experts from various government ministries. For example, doctors from the national programs didn't see the importance of including a psycho-social component -- and a rights-based approach -- to treatment," she said. "They were reluctant to let us have a taste of the cake that they were used to eating alone. But with the NFM, they gradually realized that we all had to go in the same direction, towards reform."

The second time around, in developing the joint concept note, things were easier, said Joseph Bulakali, the secretary general of the CCM. "There were misunderstandings the first time that were resolved by the second effort. Technical assistance the first time was already a done deal, with the technical partners -- UNAIDS, WHO, Pepfar, USAID, UNICEF -- making the choices," he explained. "For the second concept note, we were able to have more open discussions about who should be providing that assistance. And crucially, we had a roadmap that we were able to follow almost to the letter."

A joint note, approved with some recommendations

While the joint concept note was approved, there was still room for recommendation. The TRP said that the CCM had failed to elaborate how it was going to implement the new WHO guidelines for who is eligible for ARVs. The TRP also urged that DRC develop more programming to target patients with TB who are also HIV-positive, as well as HIV-positive pregnant women. The number of condoms and packages of lubricant for men who have sex with men and sex workers was judged insufficient, and HIV prevention activities for miners, truck drivers and security personnel needed more clarity and nuance.

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6. NEWS: Early impact of NFM discouraging, says EECA civil society

Tinatin Zardiashvili 11 December 2014

Lower funding for critical programming and restricted space for communities in decision-making cited as major detriments

Civil society groups in Eastern Europe and Central Asia continue to issue dire prognostications about the impact that the reduced contribution by the Global Fund to their harm reduction and other activities is having under the new funding model.

In an open letter signed by 24 civil society groups sent in mid-November to the Global Fund's Board chair, Dr Nafsiah Mboi, the Eurasian Harm Reduction Network urged that the NFM allocation methodology be revisited in order to maintain the level of funding to middle income countries confronting a rising HIV disease burden.

In applying the NFM allocation methodology for the period 2014-2017, the Fund sought to redistribute funds towards those countries with the highest disease burdens and least ability to pay -- a re-apportioning that, in the main, shifted the bulk of the funds away from countries in EECA towards countries in sub-Saharan Africa.

But for those groups working in EECA, the countries' classification as middle-income clouds the reality that harm reduction and activities targeting key populations -- including commercial sex workers, men who have sex with men and people who inject drugs -- are not likely to figure prominently in already tight national budgets. They warn that this could lead to an even-greater expansion of the epidemic in the region that is alone in marking a significant increase in HIV prevalence.

By calculating allocations "only on the combination of disease burden and ability to pay fails to recognize the specific challenges of concentrated epidemics in [middle income countries]. As a result, the upper middle-income countries that account for 18% of the global disease burden are only receiving $1.2 billion, or 8%, of the funding available within the NFM," the letter said. "Countries should not be punished for the declared income statements and for the achievements that they have made in HIV prevention and treatment in the past with support of the GF."

Also of concern to the civil society groups under the EHRN umbrella is the narrowing of civil society space in the ongoing country dialogues even for the reduced amount of Global Fund support. They warn that this is squeezing those community-level groups out of discussions and, ultimately, contributing to a government takeover of discussion and policymaking at a critical time when civil

society voices need to contribute to debate about how to transition away from the Global Fund's support.

For most of the countries in the region, the letter warns, the NFM is having the exact opposite effect of what was intended: participatory dialogue emphasizing human rights and key populations are being contravened by the reduced funding.

Four countries are cited as already having experienced considerable problems in maintaining the level of harm reduction services available: Kyrgyzstan, Ukraine, Russia and Romania.

For example, in Kyrgyzstan according to the letter, “the application of the NFM methodology could result in almost a 50% cut of total annual HIV funding for both prevention and treatment (from $9.5 million in 2014 to $6.8 million in 2015 and an expected $4 million to $5 million in 2016. "This reduction can only undermine the HIV and TB responses and result in the escalation of HIV, TB and HCV epidemics among both PWIDs and the general population,” the letter said.

“We realize that we live in a resource-constrained and politically challenging environment and that there are many demands on countries and funders to address the needs of the world in the public health arena," the letter said. "The challenge calls for closer coordination and collaboration between the Global Fund, donor governments, recipient governments, civil societies, and communities to prepare for and implement the transitions to sustainable HIV and TB responses in a responsible way. Let us not undo the good that has already been done."

In response, Nicolas Cantau, the Global Fund's EECA regional manager said: “Our global strategy for increasing impact in the current allocation period means more emphasis on high burden countries with the lowest ability to pay. However, the overall allocations from the Global Fund to the EECA region for the coming three years is at par with the previous three years' disbursement amount. We will work with implementers and partners for prevention, harm reduction, treatment and care among key populations to be included and funded in national AIDS programs at the appropriate level for sustainable impact against the disease.”

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7. NEWS: Harm reduction programs need more flexibility to work properly in Eastern Europe

Tinatin Zardiashvili 11 December 2014

Civil society expressing fears that rigidity of many opioid substitution therapy programs could drive away those who need them most

Restrictive policies that can sometimes prevent people from keeping their jobs could be compromising the effectiveness of Global Fund-supported opioid substitution therapy programs across Eastern Europe and Central Asia, civil society representatives from around the region told Aidspan.

Without improvements to the quality and effectiveness of these programs, they risk driving away the very people who are most in need of the services -- and could undermine the sustainability of these programs once ownership transitions to national governments.

"We want to start talking about OST program challenges, which are not only coverage and finances that are mainly discussed by the donors and NGOs, but also the effectiveness and quality of these programs," said Andrey Yarovoi, board member for Association of Substitution Treatment Advocates of Ukraine (ASTAU). They consider the fact that OST programs are still pilot, vertical programs that have yet to be integrated into the national health service one of the biggest impediments to their success.

Most doctors who work with people who inject drugs consider OST to be the same drug with different packaging, whereas drug users see it as medical treatment. This disconnect means that program participants are not often treated as patients, and are discriminated against by medical professionals.

Regionally, similar problems with OST therapy have been identified: those enrolled are restricted in their movements due to the need to check in daily to receive their dosage. This means they have a hard time getting or staying in jobs, due to the rigors of being part of the program.

"The overarching problem is that methadone (and buprenorphine where it is available), despite being medicines, are delivered in a framework that prioritizes patient control. While Western European countries (as well as Australia and the US) all provide stable patients with take home doses, these are unavailable for methadone patients," said Daniel Wolfe, the director of the international harm reduction development program for Open Society Foundations. "Rigid requirements keep patients "locked" to clinics, and unable to enjoy the social participation that we say we want to return to them

(travelling for family functions, taking a few days off, etc), and understandably mistrustful of systems that seem more concerned with control than with care."

Stigma against so-called narcomen is also pervasive; stereotypes about the untrustworthiness of drug users means that even those who are trying to kick their habits by enrolling in OST are viewed suspiciously, and the OST centers are a visible manifestation of that suspicion.

Around the region, there are other country-specific challenges being confronted. In Ukraine, although legislation has been approved by parliament to allow individuals to go home with a 10-day dosage, most centers do not follow this rule. Furthermore, there is no enforcement mechanism in place.

For people who inject drugs in Moldova, the barriers to access are so large that they prove insurmountable to many. "The program does not give a choice as the only medication available in the country is methadone," said Vitali Rabinciuc, who leads the PWID advocacy group Puls. "Plus, measures taken against drug users are often quite humiliating and discriminatory."

Oksana Ibragimova, an advocacy specialist with the Kazakh Union of People Living with HIV, said that bonding participants to particular sites has replaced collaboration, coordination and cooperation within the network of people who inject drugs. So by restricting participants from moving around, they are losing the social component of recovery that is so important to keep people in the program. And if they fail, she adds, they will wind up in prison -- where there are no OST programs in place.

OST programs were first launched in EECA in 1989, in an effort to respond to the burgeoning crisis of injected drug use that is now the primary driver of HIV infections across the region. According to statistics compiled by the UN reference group on HIV and injected drug use, there are around 3.7 million PWID in EECA region: the highest prevalence globally. One in four of these drug users are thought to be living with HIV.

Now 25 of the 28 countries in the region -- barring Uzbekistan, Russia and Turkmenistan -- have some degree of OST enshrined as part of the national HIV response. OST programs in most of these countries are paid for in whole or in part by the Global Fund, and run by local medical institutions. The threat of the Fund's departure from many of these countries due to its new allocations methodology that is prioritizing low income countries with high disease burdens means that many of these programs are vulnerable.

To ensure they remain in place, and funded by national governments, a Global Fund-supported regional campaign run by Eurasian Harm Reduction Network, 'Harm Reduction WorksFund It!' is providing community activists with communications, outreach and campaigning tools they hope will help with advocacy on behalf of OST and other harm reduction activities. Another major component

of the initiative is program assessment to develop evidence-based recommendations for improving existing programs and helping to prioritize interventions. Strengthening of community systems for people who use drugs, including those living with HIV, is a critical area of focus within this program, said Olga Belyaeva, information and technical support program officer of EHRN.

[This article was first posted on GFO Live on 11 December 2014.]

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8. NEWS: Is there true accountability in global health cooperation? A case study of the Global Fund

Angela Kageni 11 December 2014

Aidspan's analysis of what accountability means in the context of global health cooperation was published in December by Globalization and Health.

This work culminated a year-long collaboration between Aidspan and external researchers to examine how accountability translates in global health cooperation, using the Global Fund as a case study.

The paper draws out different elements of how accountability may be measured across finance, program and governance levels. It also details how participation and transparency have become vital elements of a new accountability agenda alongside the more traditional mechanisms for reporting, monitoring, evaluation, redress and enforcement.

The authors examine the prioritization of different types of accountability and what happens when they come in conflict with one another.

The emergence of new health public-private partnerships and the formal inclusion of non-state actors in policy-making processes provide the backdrop to this discussion. The authors highlight how this more complex landscape has an impact on accountability-related relationships between different actors and argue that these shifts have made the practice of ensuring accountability more complex.

The authors conclude that although accountability is about holding actors responsible for their actions, the mechanisms to do this vary substantially and are far from being politically neutral. The tensions observed in multi-stakeholder participatory models and the more traditional vertical models that

prioritize accountability upwards to donors, both of which are embodied in initiatives like the Global Fund, pose challenges not only for future financing but also for future legitimacy in such systems.

Download the paper: http://www.globalizationandhealth.com/content/10/1/73

[This article was first posted on GFO Live on 11 December 2014.]

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9. PRESS RELEASE: Aidspan releases first-ever documentary, "I didn't want to bring shame on my family": growing up gay in Ghana

Lauren Gelfand 01 December 2014

Aidspan, the independent watchdog of The Global Fund to Fight AIDS, TB and Malaria, is pleased to announce the release of its first-ever documentary film, *"I didn't want to bring shame on my family": growing up gay in Ghana.*

The film was released on December 1, 2014, to coincide with the global celebration of World AIDS Day.

The film is available on Vimeo at https://vimeo.com/114014571

The eight-minute documentary explores a young man's journey through the Ghanaian public health system: a network of facilities both large and small that is largely supported by international donors led by the Global Fund to Fight AIDS, TB and malaria. It reflects the challenges inherent in reaching those who are most vulnerable to infection by HIV, and underscores the impact of stigma, discrimination and ignorance on the health system's ability to effectively manage HIV.

The story is told from the perspective of Joe "Hillary" Afful, a dynamic and engaged leader in Ghana's gay community. A peer educator and counselor trained in programs that have received Global Fund support, Hillary shares his experiences in the public health system and provides a window into the hurdles that young men face in trying to access services in a supportive and non-judgmental way. Hillary wants his story to help encourage other men who have sex with men to not be afraid, to know their status and to take the appropriate measures to seek the right kind of medical attention.

The film was shot with the consent of all the participants, including representatives of Ghana's National AIDS Control Program and the country coordinating mechanism responsible for oversight of Global Fund activities in Ghana.

Aidspan is the leading independent analyst and explainer of the Global Fund to Fight AIDS, TB and malaria, at global and national levels. In expanding its role as critical friend of the Global Fund, Aidspan aims to deepen and widen its own visibility and reach, to improve understanding of our own impact on the Global Fund and the implementation of Global Fund-supported programming.

A better-run, better understood Global Fund means that every dollar spent will help save lives from AIDS, TB and malaria. A more visible Aidspan means that stakeholders involved in the Global Fund's system and processes can be assured that they have the most complete, detailed and unbiased information about that system and those processes.

Read this article in French. Lire l'article en français.

[This article was first posted on GFO Live on 01 December 2014.]

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This is issue 257 of the GLOBAL FUND OBSERVER (GFO) Newsletter.

We welcome suggestions for topics we could cover in GFO. If you have a suggestion, please send it to the Editor of GFO (see contact information below).

GFO Newsletter is an independent source of news, analysis and commentary about the Global Fund to Fight AIDS, TB and Malaria (www.theglobalfund.org). GFO is emailed to nearly 10,000 subscribers in 170 countries at least twelve times per year.

GFO Newsletter is a free service of Aidspan (www.aidspan.org), a Kenya-based international NGO that serves as an independent watchdog of the Global Fund, and that provides services that can benefit all countries wishing to obtain and make effective use of Global Fund financing. Aidspan finances its work through grants from foundations and bilateral donors.

Aidspan does not accept Global Fund money, perform paid consulting work, or charge for any of its products. The Board and staff of the Fund have no influence on, and bear no responsibility for, the content of GFO or of any other Aidspan publication.

GFO Newsletter is now available in English and French. Articles are also available in Russian and Spanish.

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Are you a newcomer to Global Fund issues? See Aidspan's "A Beginner's Guide to the Global Fund - 3rd Edition" www.aidspan.org/guides.

To subscribe to GFO, go to www.aidspan.org/user/register.

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For GFO Newsletter background information and previous issues, see www.aidspan.org/gfo. For information on all grants awarded by the Global Fund, see www.aidspan.org/grants

People interested in writing articles for GFO are invited to email the editor, above.

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