Annual Report 2016

Eastern Mediterranean Region Constituency
at the
Board of The Global Fund
To Fight AIDS, TB & Malaria

Annual Report

2016

Eastern Mediterranean Region Constituency

at The Board of the Global Fund

to Fight AIDS, TB & Malaria

Prepared by Omid Zamani

Constituency Focal Point

Tehran, Iran

Contents:

Foreword

2016 was a pivotal year for the Global Fund, a turning point to build on past successes and reshape the organization for the challenges ahead. Throughout 2016 we set about putting in place the changes we needed to implement our new ambitious strategy. We have built a firm foundation to implement in challenging operating environments and raise the money we need to defeat the three diseases.

At the Eastern Mediterranean Region we achieved a lot through better engagement within our constituency and beyond; we were able to improve our communication and information sharing, we organized some training session for CCMs in the region, our delegates to board meetings in Abidjan and Montreux provided invaluable inputs and leveraged our advocacy at the board level. The technical meeting in Tehran was a breakthrough for bringing new ideas to our constituency. Our collaboration with other implementer constituencies reached at a peak and resulted in development of a roadmap for the Implementers Group and a joint statement at the 36th Board Meeting in Montreux.

We are in the process of revising EMRC's Governance framework and finalizing our 2017-2019 workplan which will be followed by election of new EMR representatives and new era of collective work and hopefully better achievements.

It is my honour to share with you this annual report of activities and humbly ask for improving our engagement and collaboration because have the best possible opportunity of making a lasting and sustained impact for millions of people.

With Best Regards,

Mohsen Asadi-Lari, MD, PhD
Board Member and EMRC representative, The Global Fund
Acting Minister for International Affairs
Ministry of Health and Medical Education, I.R. Iran
Professor of Epidemiology

Introduction

Eastern Mediterranean Region Constituency has established a secretariat in Tehran since May 2015 after election of Dr Mohsen Asadi-Lari, Acting Iranian Minister of Health in International Affairs, as the board member of The Global Fund in Feb 2015. There was a change in alternate board member in Dec 2015 when H.E. Dr. Adeela Hammoud Hussain Al-Aboudi could promote to this position. Also in Aug 2016 Dr. Omid Zamani was appointed as the new Constituency Focal Point.

This report provides an overview of EMRC activities and achievements in 2016 which is the first time such a report is being published. EMR Secretariat is willing to open up the doors for discussion and negotiation to improve transparency and responsibility.

The activities included some governance and communication initiatives, knowledge sharing, developing some advocacy tools and provisions for increased engagement at The Global Fund board meetings and other governance meetings.

From 2017 there will be a change in constituency funding procedures that requires implementing constituencies provide a three-year costed work plan detailing the activities and deliverables covered by this request for funding as well as their anticipated impact and success indicators for enhancing the constituency's engagement with Global Fund governance process.

Accordingly EMR Constituency secretariat has engaged the members to reach a consensus on the plan and will provide more regular reports during implementation.

Key Issues and Messages

- Protracted humanitarian and health emergencies which is present in most countries that might be considered as Challenging Operating Environments as well and how secretariat is going to facilitate progress in those countries which have different situation with regard to eligibility, transition and CCM functioning (Libya, Jordan, Yemen, Syria, Lebanon, Iraq as some examples)
- Flexibilities around transition and sustainability assessments and provisions for maintaining country mechanisms and regional connections to immediately response when transition fails or the context evolves in a harmful direction.
- Support for Sub-regional and inter-regional partnerships and collaborations and possibility of establishing a regional CCM or technical advisory group
- Improving efficiency and effectiveness of projects and portfolios by strengthening CCMs rather than relying only on PRs (usually UN or external entities)
- Human Rights of the key populations especially among IDPs and migrants, involving communities should be respected.
- Strengthening surveillance systems for tracking progress and evaluation of projects
- Advocacy and partnerships for domestic or regional investments for health such as involving Persian Gulf countries, local charities and rich religious institutions, maybe municipalities through Fast-Track Cities Initiative or similar innovations.
- Possible involvement of private-sector such as pharmaceuticals (global or local) to improve supply chain management and access to medicines

Member Countries

Afghanistan 

Djibouti 

Egypt 

Iran 

Iraq 

Morocco 

Pakistan 

Palestine 

Somalia 

Sudan 

Syria 

Tunisia 

Yemen 

Observing countries and entities:

Lebanon 

Jordan 

Libya 

MENAHRA 

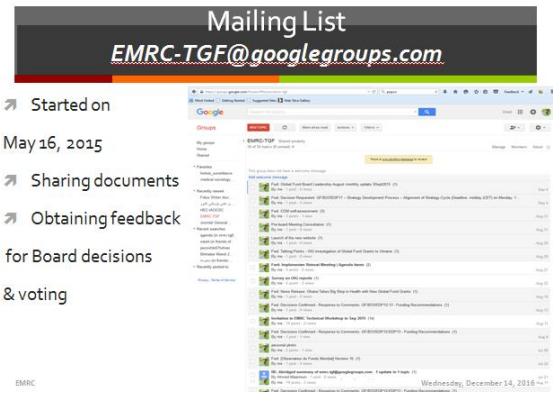
Activities

Governance & Communication

The EMRC secretariat has been engaging the EMR constituency members through various communication channels including but not limited to:

EMRC mailing list

This email list is a closed Google group for EMRC member representatives and focal points. With more than 210 emails sent during 2016, the EMR member authorities were informed about a variety of activities and were engaged in decision-making process for GF issues.

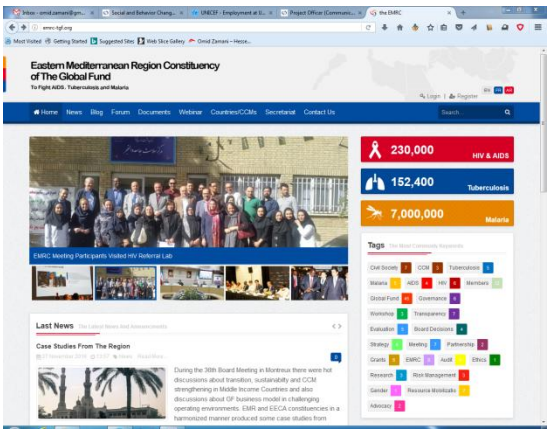


Social Media

Specific closed groups were established on Telegram and Whatsapp for sharing materials and multimedia which may need immediate attention by EMRC members. These groups were mainly used to cover progress of EMRC related events.

Website

EMRC website is the main platform for EMR Constituency which reflects important news, decisions and events related to Global Fund and the Constituency.



In 2016 it has reflected about 50 news pieces, 12 blog posts, 10 events and many resources and reference documents. Also EMRC webinars were broadcasted on this website.

Electronic Board Decisions

In between Board Meetings, decisions may be submitted to the Board for electronic decision. For decisions on funding recommendations, the Board must vote on a “no objection” basis. The vote will stand (i.e. the motion will be passed) unless at least four Board members from one voting group object to the requested decision by the deadline of the vote. For some decisions, the Board must vote on an “affirmative basis”. Therefore, in order for this motion to pass, two-thirds of the members from each of the donor and the implementer groups must cast an affirmative (yes) vote.

Moreover some Electronic Reports (ERs) might be distributed for board review or feedback.

For all EDPs and ERs distributed among board members, EMRC has sought input and comments from its members. Here are some statistics:

- 34th Board Meeting : 21 EDPs and 10 ERs
- 35th Board Meeting: 21 EDPs and 9 ERs
- 36th Board Meeting: 5 EDPs so far

Some of the decisions relate to appointment of members of board committees and working groups, including:

- Establishment of KPI targets review working group in Dec 2016
    - Dr Babak Eshrati out of Two EMRC nominees was successful in final selection
- Establishment of ED nomination committee in Nov 2016
    - EMRC nominee was not successful.
- Appointment of new independent and donor members to serve on the EGC and SC in Oct 2016
    - EMRC had no nominee.
- Nomination of Governance Focal Points in July 2016
    - Dr. Najibullah Safi was introduced as EMRC's GFP.
- Appointment of Independent Committee Members to serve on the AFC in May 2016
    - Dr Thamer Al-Hilfi was selected as a member of AFC from our constituency.
    - Other EMRC nominees for SC and EGC were not successful.
- Appointment of new Committee Chairs and Vice-Chairs in Feb 2016
    - Dr Mohamed Saleh Ben Ammar from EMR nominees was selected as EGC chair
    - Other EMRC nominees for SC and AFC were not successful.

Revising Governance Framework

Revision of EMRC governance framework started in Aug 2016 through a review at EMRC secretariat and sharing proposed edition with EMR members and Office of Board Affairs for feedback and comments. The Revision is now being finalized and ready to be used for election of new board member and alternate for the period of 2017-2018.

Knowledge Sharing

Webinars

The following webinars were conducted by EMRC secretariat in 2016 (some of them with budget set aside from 2015):

1- Communication for Fundraising and Advocacy by *Dr Everold Hosein*
2- Method to estimate the population size of key populations at risk for HIV; case studies from MENA and beyond by *Dr Ali Mirzazadeh*

3- Hepatitis C situation in the Eastern Mediterranean Region and evidence for interventions by *Dr Behzad Hajarizadeh*
4- Social & Behavioural Change Communication in EMRO, challenges and achievements for the 3 diseases by *Mr Zahid Husein*

Moreover some webinars were provided by the GF secretariat

Online Course

The Regional Knowledge Hub, and WHO collaborating centre for HIV Surveillance (HIVHub) has conducted a distance course in "Community-Based HIV Surveillance" for EMRC nominated participants from 5 member countries during March-Apr 2016 with some budget remained from the previous year.

By the end of the course participants could be able to:

- Describe HIV epidemic levels and Key Populations in Eastern Mediterranean Region/Middle East and North Africa Region (EM/MENA Region)
- Describe the main components of the second generation HIV surveillance
- Define ethical considerations in HIV surveillance
- Define gender related issues in HIV topics

The course consisted of four different units (one every week). At the beginning of each week, participants received teaching materials via the distance course website and email. They had to read the materials and do the module assignments. They were evaluated based on the completed assignments at the end of the course to be able to receive the certificate.

Developing Some Advocacy Tools

EMRC Situation Report

A review of the situation of IADS, TB & Malaria in the region, eligibility of countries and current GF grants was developed together with some recommendations and expectations considering the challenging situation in many EMR countries and the issue of transition and sustainability of programs in Middle Income Countries. This report was shared with GF secretariat, other constituencies and partners during 36th board meeting. A copy could be found in annexes.

EMR Case Studies

As a joint initiative with Eastern Europe and Central Asia (EECA) Constituency, EMRC secretariat tried to develop some brief case studies about EMR countries in transition and their challenging operating environment. Some 5 case studies from Iraq, Sudan, Egypt, Iran and Lebanon were shared with board members, GF secretariat and constituencies during 36th Board Meeting in Nov 2016. A copy of those fact sheets can be found in the annexes.

Meetings

35th Board Meeting

On 26-27 April 2016, the Global Fund Board held its 35th meeting in Abidjan, Côte d'Ivoire. GFO was present, with observer status. The main decisions made at the meeting, in chronological order, were as follows. (For precise wording of what the Board agreed, see the decision points document which should be available shortly at www.theglobalfund.org/en/board/meetings/35. Background documentation will also, in time, be posted by the Global Fund at the same location.)

New Strategy. The Board approved "The Global Fund Strategy 2017-2022: Investing to End Epidemics." Further details are provided in a separate article in this issue. [See Decision Point 4.]

2015 Annual Financial Report. The Board approved the 2015 Annual Financial Report, which includes the 2015 Consolidated Financial Statements audited by Ernst & Young, SA. The Board also approved the 2015 Statutory Financial Statements, also audited by Ernst & Young, SA. [See Decision Points 5 and 6.]

Eligibility Policy. The Board approved a revised Eligibility Policy. Further details are provided in a separate article in this issue. [See Decision Point 7.]

Sustainability, transition and co-financing. The Board approved a Sustainability, Transition and Co-Financing Policy. Further details are provided in a separate article in this issue. [See Decision Point 8.]

Challenging Operating Environments. The Board approved a Challenging Operating Environments Policy. Further details are provided in a separate article in this issue. [See Decision Point 9.]

Allocation methodology. The Board approved a methodology for the 2017-2019 allocations. The Board tasked its Strategy Committee with approving at its June 2016 meeting the method by which the Secretariat will apply and report on the qualitative adjustments that are part of the methodology. The Board also tasked the Secretariat with presenting the initiatives that could be funded as catalytic investments to the Strategy Committee for the committee's meeting in June 2016. Further details are provided in a separate article in this issue. [See Decision Point 10.]

Response to the OIG 2015 annual opinion. The Board requested that the Secretariat present a detailed action plan to advance risk management and internal controls, with measureable and time-bound targets; and report on progress to the Board in June 2016. There is a separate article in this issue on the OIG 2015 annual opinion. [See Decision Point 3.]

Partner's Constituency. The Board approved the addition of the Partnership for Maternal, Newborn & Child Health (PMNCH) to the membership of the Partner's Constituency on the Board. The PMNCH is a partnership of 730 organizations working on sexual, reproductive, maternal, newborn, adolescent, and child health. Current members of the Partner's Constituency are the STOP TB Partnership, Roll Back Malaria, and UNITAID. The Partner's Constituency is a non-voting seat. [See Decision Point 11.]

EMRC's Contribution

The call for expression of interest was sent to EMRC members on Apr 2 and the nominees were finalized on Apr 20. Because of security reasons each constituency could only take 6 persons to the event thus EMRC delegation members to the 35th Board Meeting included;

1. Dr. Asadi-Lari, the Board Member
2. Dr. Mohammad Mehdi Gouya (Iran)
3. Dr. Gamal Edlin Bashir Niam Ali (Sudan)
4. Dr. Najibullah Safi (Afghanistan)
5. Dr. Omid Zamani (designated CFP)

Dr. Omid Zamani also attended Implementers Group coordination meeting on Apr 23 to express some EMRC concerns about the new strategy, allocation model and challenging operating environment policy. The pre-board orientation sessions took place on Apr 25 and 24 which were attended by the whole team except the board member.

Some questions were put by EMRC delegates for further discussion about fundraising within the region for Middle East Response plan and tackling with the challenging operating environments.

An internal EMRC meeting was held on Apr 25th in the afternoon for discussion and finalizing EMRC position statements about various board meeting topics. This meeting was also attended by Dr. Ben Ammar the new chair of the Ethics and Governance Committee and Dr Shah Karam from WHO EMRO. On the next page you can see these statements which were reflected in the 35th Board Meeting Report as well.

Along the margins of the Board Meeting in Abidjan there was an appointment for EMRC team to meet with Mark Dybul (GF Executive Director) and the Board Leadership on Wed 27 as a luncheon. In this meeting the EMRC delegation raised their concerns about eligibility policy, sustainability and transition, allocation and emergency fund especially with consideration of the humanitarian situation in the region. There were also side meetings by the board member with WHO, EECA and SEA constituencies.

EMRC Positions and Statements regarding BM35 discussions

Positions:

Strategy (GFB35-02)

While the alignment of GF strategy with global health targets is appreciated, EMRC expresses its concern about evaluation of Impact of the programs and GF contribution to those targets. Close collaboration with partners on defining overall impact targets and indicators in line with SDGs are highly commended.

EMRC appreciates the differentiated approaches and long term support embedded into the strategy objectives. (p6 , p25)

In many middle income countries the Global Fund is the main investor and in some the only investor in addressing the needs of key populations. We appreciate the approach for ensuring proper sustainability and transition planning before stopping contribution to countries. (p35) In particular EMR is facing with highest trend of risk of HIV infection, highest number of migrants and refugees, highest gap of access to HIV services including ART, although many of the countries there are not eligible or in transition right now. Jordan, Lebanon, Yemen, Syria, Libya and Iraq are some examples. Strengthening health system would be a challenging issue before any transition as well.

Considering the shortcomings in supply chain management which have been pointed out in many OIG investigations recently, EMRC welcomes the GF approach for capacity building and expanding partnership for improvement.

As mentioned before, our constituency appreciates the strategy and again asks the Executive Director and board members to reconsider EMR security, social and health situation and conduct a rapid assessment together with technical agencies of 3 diseases to find the existing gaps and opportunities to support the countries experiencing complex emergencies.

As discussed there are excellent experiences regarding integration of the 3 diseases into Public Health Care System in different parts of the world. Now there is a good opportunity for GF to support this integration and put it into the new strategy to sustain GF activities and efficiently spend limited financial resources.

Challenging Operating Environments Policy (GFB35-03)

In addition to current GF recipient countries assessment of COE eligibility should include other middle income countries and pay more attention to especially countries experiencing complex emergencies such as Libya, Iraq, Syria, Yemen or affected by external challenges such as Jordan, Lebanon and Tunisia.

The Eastern Mediterranean region continues to face multiple and complex emergency situations on an unprecedented scale, and also is one of origin, destination and transit of refugees and migrants. The EMR in the midst of one of the largest human displacements in modern history, with 14-15 million refugees and internally displaced people (IDPs). This number includes over 10 million Syrians that are now refugees abroad or IDPs, nearly 2 million Iraqi IDPs, and hundreds of thousands of Iraqi refugees. There are 2 two million Libyans abroad, mostly in Tunisia, and 400,000 IDPs within the country.

Since CCMs and even the government may no longer remain functional to control these three diseases in some of the COEs alternative approaches for sustaining service delivery to key populations should be sought, for example strengthening the role of a single PR, or a cluster of partner agencies and putting extra measures for oversight and grant management. In this regard we have to seek a special mechanism to foster the accountability of the recipient bodies and to make sure that these grants are completely traceable. Proposals which indicate delivering the funds to the refugees rather than established entities within the countries where people are as refugees could be subject to any fraud and often illegal actions which are completely beyond our intention and good-wills in the GF.

Allocation of additional fund to COE is crucial and highly recommended. Specially supporting what proposed by Germany to have a program for Jordan and Lebanon and I am asking the board for Libya.

Sustainability, Transition and Co-financing Policy (GFB35-04)

EMRC welcomes the approach for providing transition funding for up to one allocation period upon becoming ineligible and also the emphasis on transition planning.

GF is strongly advised to support strengthening of surveillance systems through WHO, UNAIDS,… for targeted diseases, invest in systematic monitoring and evaluation mechanisms and invest in evidence-informed decision-making in transitioning countries.

EMRC also asks for putting appropriate investment in these countries during transition period and mentioning a minimum and maximum level of funding for this initiative rather than just putting a maximum amount.

Allocation Methodology (GFB35-05)

Based on the ongoing crises across the Eastern Mediterranean region, limited progress made on controlling the 3 diseases, uncertainty of the final fate of migrants and mobile populations from and within the region, EMR urges for reconsideration of eligibility and transition in this region for a considerable duration.

I think all of you agree with me that chronic emergency leads to severely increase in TB/HIV and STIs incidence. Our constituency takes this opportunity to request you seriously for;

1- Increased share of upper middle income countries especially countries experiencing complex emergencies in EMR of overall GF grant allocation,
2- Encouraging sub-regional projects and concept notes,
3- And Advocating for increased availability of and dissemination of data on various health problems especially on emergency situation including information for board decisions.

GF Eligibility Policy (GFB35-06)

GF allocations should be based on ground realities rather than other considerations. Differentiated approach based on risk assessment might have implications on risk management; however it should not defer eligibility.

Global Fund's current model on prioritizing high burden is associated with the risk of neglecting concentrated epidemic countries such as some Eastern Mediterranean countries, EMRC calls for more emphasis on the "burden of risk factors" and epidemiologic trend instead of "burden of diseases" during global investment decisions.

We propose GF to consider shift of its focus from countries and their income level towards *location and population distribution* of the 3 diseases through development of sub-regional plans. Regions experiencing complex emergencies such as the EMR may benefit from adopting more realistic criteria for eligibility.

Risk Management Report and Annual Assurance Statement on Risk Management

EMRC welcomes the efforts done for enhancing risk management at the secretariat and calls board and GF partners to assist in managing key enterprise risks mentioned in the report.

Office of the Inspector General Matters:

- **Annual Report;**

EMRC appreciates the various initiatives conducted by OIG for delivering reports that have impact, leveraging improved relationships, putting in place internal improvements and being proactive. We also commend OIG for decreasing the average time taken to close investigation cases to less than 8 months.

We recommend OIG to expand its relationship with constituencies and the civil society for further enhancing the investigations and audits.

EMRC also recommends the secretariat to be more proactive in capacity assessment of recipients and due diligence to ensure proper grant management.

- **Annual Opinion on Governance, Risk Management and Internal Controls;**

EMRC appreciates the comprehensive opinion provided by OIG and urges the secretariat and the board to improve the maturity of the organization considering the external context and the new strategic plan Global Fund has to implement.

- **Progress Update on Status of Implementation of Agreed Management Actions**

EMRC commends OIG and the secretariat for the follow ups on AMAs, however considering the high number of open and overdue AMAs in certain units we would like to ask for increasing efforts and maybe seeking additional support for improving the situation.

Corporate KPIs: Performance against 2015 KPIs

While EMRC appreciates the improvements and achievements on various KPIs, there are concerns about not achieving HSS targets which need putting more efforts on implementation and data collection.

Also EMRC expresses its concerns about not achieving targets for value for money and resource mobilizations.

Replenishment Conference

At the launch of the Global Fund's Fifth Replenishment, donors pledged over US$12.9 billion for the next three years, demonstrating extraordinary global commitment toward ending the epidemics of AIDS, tuberculosis and malaria for good.

Dr Asadi-Lari the Board Member attended this highly important advocacy meeting in Montreal, Canada.

The Replenishment Conference raised nearly $1 billion more than the previous replenishment conference in 2013, and benefitted from participation by leaders from countries all over the world, United Nations Secretary General Ban Ki-moon, and Bill Gates, Co-Chair of the Bill & Melinda Gates Foundation.

Implementer Group Retreat

From September 21-23, 2016, representatives of each of the ten implementing constituencies ("the Implementers Group") met in Nairobi, Kenya to review challenges and opportunities, and identify common objectives and areas of future cooperation.

The retreat advanced work to develop a three-year costed road-map for the period 2017-19 that defined the vision, strategic direction, priority areas and activities through which the Implementers Group can support and guide the GF Secretariat in operationalizing its ambitious new strategy for 2017-22.

Dr. Thamer Al-Hilfi and Dr. Omid Zamani attended this meeting on behalf of EMR Constituency and actively participated in working groups established during and after the retreat for follow-up activities.

Namely Dr Omid Zamani followed up activities in both "Sustainability and transition" and "Absorptive Capacity" task teams and Dr. Thamer Al-Hilfi was part of "Human rights, gender, key populations" and "roadmap finalizing" task teams.

EMRC Technical Meeting

The second Eastern Mediterranean Region Constituency's technical meeting was conducted in Tehran from 15 to 17 Oct 2016. The meeting intended to provide stakeholders involved in the governance, oversight and implementation of Global Fund financed programs including Country Coordinating Mechanisms (CCMs) and National Program Managers across the Eastern Mediterranean Region Constituency (EMRC) a summary of practical experiences Grant Management, Risk Management, Governance and Technical Assistance, as well as effective and tailored strategies for fund raising and resource mobilization. Constituency members and technical experts presented and shared their experiences. On the third day of the event, the participants visited some projects supported by the Global Fund in Iran.

The meeting had been proposed during the regional meeting in Khartoum in Sep 2015 and it was included in EMRC workplan. Planning and preparations for this meeting started in April 2016 in EMRC secretariat in Tehran with technical support of the Global Fund secretariat and the Office of Board Affairs, along with consultation and support from CCM Iran.

The opening session of the 2nd EMRC technical meeting started in Tehran on Sat, Oct 15 2016 with the speech by Mr. Norbert Hauser the chair of the board of the Global Fund whom was welcomed by Dr. Mohsen Asadi-Lari the Board Member from Eastern Mediterranean Region who expressed his gratitude to all the participants, especially His Excellency Dr. Hashemi, the Minister of Health, for his support of this meeting and other collaborations in the region.

Then H.E. Dr. Hassan Hashemi, Iranian Minister of Health & Medical Education congratulated the Eastern Mediterranean Region for collaboration on making this event happen and expressed his ministry's interest to support such international cooperation. This session in which heads of UN missions in Iran were attending, was also addressed by Dr. Sayyari the Chair of CCM Iran, and Dr. Mohammad Mehdi Gouya the vice-chair of CCM and head of Communicable Diseases Control Center.

The Board Member also stressed that EMR constituency should be structurally more robust and participatory in decision-making to have a better position in the GF Board and effectively tackle regional challenges including protracted conflicts and mass migrations unprecedented in history.

Dr. AsadiLari expressed the intention to strengthen the collaborations and develop the networks within the region and beyond to mobilize resources and harness innovative mechanisms for achieving sustainable development and stronger health systems in the region.

During two days some experts from different Global Fund structures and delegates from countries in the region presented and discussed many topics including but not limited to; the Global Fund structure, strategies, allocation model, governance, risk management, resource mobilization, transition and inter-constituency collaborations.

A reception dinner was organized by EMRC secretariat as a social event on the 1st day

Private meetings between the chair of the board were organized with the Minister of Health and also with the vice-minister for Social Affairs.

A special meeting among Iran CCM members and the chair of the Board was also organized alongside the main sessions on the 2nd day.

On the third day the participants visited one of the referral HIV laboratories in the country located at Tehran West Health Center which also offers a behavioral diseases counseling center for HIV, drug use and STIs. They also visited a community-based health house in Baharestan neighborhood of Tehran which was run by local volunteers to provide health promoting services to their community. This system is supported by Health Department of Tehran Municipality which has 354 similar centers all around Tehran.

These visits were followed by a lunch reception arranged by Tehran Municipality at the Museum of National Arts. The team also enjoyed a visit to Masoudieh Garden and Golestan Palace.

EECA Constituency Meeting

The EECA constituency invited Dr. Mohsen Asadi-lari to join their internal meeting on 5 Nov 1016, in which he talked about inter-constituency cooperation and the importance of making joint positions. His speech included the following points:

1- Our constituencies share some common challenges and interests;
   a. sustainability and transition of some countries out of GF support,
   b. Challenging operational environments (Iraq, Syria vs Ukraine for example)
   c. common pattern of HIV transmission (IDU vs Sexual)
   d. part of the route for drug smuggling/distribution
   e. problem of MDR/XDR TB
   f. Access to ARV and other medicines,
   g. political/cultural similarities and interconnections
      i. sanctions against Iran and Russia for example
      ii. weakness of Civil Society
      iii. Knowledge, Attitudes, Believes and Practices of the people
   h. need for raising Implementers' voice at the Board of GF
2- The need for epidemiologic/geographical approach to control of 3 diseases rather than the current single country grant approach, necessity of multi-country / multi-regional projects
   a. Cross-border distribution of diseases,
   b. Migration/displacement of key populations
   c. Shared risk pooling and mitigation

3- Advocacy, Knowledge sharing and transfer
   a. Surveillance
   b. Sharing Best practices and lessons learned
   c. Mutual capacity building
   d. Using Common platforms/tools for advocacy and negotiation

4- There has been a history of collaboration between the two constituencies;

a. Coordination before & during recent Board Meetings (34th & 35th)
b. Collaboration in Implementers group teams on different topics and board decisions
c. Attendance of EECA BM/ABM in EMRC technical meetings in the past two years
d. Supporting each other in elections of board committees and other GF governance structures (for example voting for election of Natalia Nizova as the vice-chair of Implementers group)

5- The willingness for further strengthening and expanding the partnership among our constituencies
   a. Establishment of joint working groups
   b. Sharing advocacy/KT tools, practices and joint statements/positions
   c. Joint research, studies and policy analyses
   d. Expanding networks among the civil society and academic institutions
   e. Establishment of knowledge hubs
   f. Pharmaceutical cooperation/joint ventures
   g. Joint investment and advocacy for inter-regional/ multi-country projects

Dr. Mohammad Mehdi Gouya the vice-chair of CCM Iran and Dr. Omid Zamani participated in this meeting as well.

36th Board Meeting

On 16-17 November 2016, the Global Fund Board held its 36th meeting in Montreux, Switzerland. GFO was present, with observer status. The main decisions made at the meeting, in chronological order, were as follows. (For precise wording of what the Board agreed, see the decision points document that is available at www.theglobalfund.org/en/board/meetings/36. Background documentation will also, in time, be posted by the Global Fund at the same location.)

Resource Mobilization. The Board requested that the Secretariat, under the oversight of the Audit and Finance Committee, develop an ambitious plan for attracting additional resources. The Board said that the plan, which may include providing additional pledging opportunities for donors, should maintain visibility of both unfunded quality demand and progress in achieving impact. The Board asked that the plan be shared with the Board at its 37th meeting, and be subsequently reported on by the AFC to the Board on a regular basis. [See Decision Point 03.]

Comprehensive Funding Policy. The Board approved an amended and restated Comprehensive Funding Policy. Further details are provided in a separate article in this issue. [See Decision Point 04.]

2017-2019 Allocations. The Board decided that the amount of sources of funds for allocation for the 2017-2019 allocation period is $11.1 billion, of which $10.0 billion is derived from the 5th Replenishment and $1.1 billion represents forecasted unutilized funds from the 2014-2016 allocations period. Of the $11.1 billion, $800 million is reserved for catalytic investments, leaving $10.3 billion available for country allocations. Finally, the Board said that of the $10.3 billion, $800 million will be used to ensure scale up, impact and paced reductions. Further details are provided in a separate article in this issue. [See Decision Point 05.]

Catalytic investments. The Board approved $800 million for catalytic investments. Further details are provided in a separate article in this issue. [See Decision Point 06.]

Selection of next Executive Director. The Board approved revised terms of reference for the E.D. position as well as the voting procedure for the selection of the next E.D. Further details are provided in a separate article in this issue. [See Decision Point 07.]

Work plan and budget. The Board approved a corporate work plan and budget narrative. The Board also approved a 2017 operating expenses budget in the amount of $300.0 million, which included $17.1 million for the expenses of the Office of the Inspector General. Further details are provided in a separate article in this issue. [See Decision Point 08.]

Key Performance Indicators. Board member discussed proposed performance targets recommended by the Audit and Finance Committee and the Strategy Committee for 2017-2022 but did not adopt them. Instead, the Board requested that: (a) Board constituencies submit statements, questions, concerns, or suggested revisions regarding the performance targets, including how country-level information or estimates will be considered, to the Secretariat by 30 November 2016; (b) that the Secretariat provide a response by 9 December 2016; (c) that the chairs and vice-chairs of the Audit and Finance Committee (AFC) and the Strategy Committee (SC) determine the performance targets to be addressed by each committee; and (d) and the chairs and vice-chairs of the AFC and the SC establish a joint-committee advisory group to work with the Secretariat to present by 9 December 2016 revised performance targets for the Strategic KPI Framework – based on country-level estimates where relevant and available – to the AFC and SC for recommendation to the Board by the first week of March 2017.

Further, the Board decided that the Advisory Group will: (a) be comprised of four individuals identified by the implementer constituency and four individuals identified by the donor constituency and two representatives of the technical partners, in consultation with the Chairs and Vice-Chairs of the AFC and SC, to work with the Secretariat to present revised performance targets for the Strategic KPI Framework; (b) consult with the Technical Review Panel and the Technical Evaluation Reference Group; (c) consider statements, questions, concerns, or suggested revisions by Board constituencies, as well as responses

provided by the Secretariat, to advise the Secretariat on presenting the AFC and SC with revised performance targets for the Strategic KPI Framework; and (d) be dissolved upon the Board's approval of performance targets for the Strategic KPI Framework. [See Decision Point 09.]

EMRC's Contribution

The call for expression of interest was sent to EMRC members on Oct 14 and the nominees were finalized on Nov 1. Because of security reasons the nominee from Yemen could not attend thus EMRC delegation members to the 35th Board Meeting included;

1. Dr. Asadi-Lari, the Board Member
2. Dr. Thamer Al-Hilfi (Iraq – designated Alternate Board Member)
3. Ms. Sara Osman (Sudan)
4. Mr. Mostapha Lamqaddam (Morocco)
5. Dr. Mohamed Awad Tageldin (Egypt)
6. Dr. Omid Zamani (CFP)

Dr. Thamer Al-Hilfi and Dr. Omid Zamani also attended Implementers Group coordination meeting on Nov 14 to express some EMRC concerns about transition, allocation, and implementer group roadmap.
The pre-board orientation sessions took place on Nov 15 which was attended by the whole team.
A series of joint meetings by EMR, EECA, SEA and LAC delegations were set with some donor constituencies including US, UK, Switzerland,… and with the GF Executive Director and the Board Leadership. EMRC delegation expressed its concerns about sustainability and transition of member countries considering the ongoing humanitarian situation and challenging operating environment in the region.
EMRC published a joint statement together with EECA, LAC and SEA constituencies with regard to implementation of transition and sustainability policy within next GF strategy cycle which can be found

in the annexes. Moreover EMRC expressed some positions related to any of the above mentioned topics at the 36th board meeting.

Meeting with Executive Director and Head of Grant Management Department

In this meeting EMRC Board Memebr and participants discussed about 3 main topics:

1- GF's update on Middle East Response initiative you might have, because this as emergency project which has underwent a long period of preparation and we would like to know what mechanisms are foreseen to implement it as quick as possible when Board approves it to catch up with the needs on the ground in affected countries.

2- EMRC's concerns about some challenging or common issues that are affecting our region:
   a. Protracted humanitarian and health emergencies which is present in most countries that might be considered as Challenging Operating Environments as well and how secretariat is going to facilitate progress in those countries which have different situation with regard to eligibility, transition and CCM functioning (Libya, Jordan, Yemen, Syria, Lebanon, Iraq as some examples)
   b. Flexibilities around transition and sustainability assessments and provisions for maintaining country mechanisms and regional connections to immediately response when transition fails or the context evolves in a harmful direction.
   c. Support for Sub-regional and inter-regional partnerships and collaborations and possibility of establishing a regional CCM or technical advisory group
   d. Improving efficiency and effectiveness of projects and portfolios by strengthening CCMs rather than relying only on PRs (usually UN or external entities)
   e. Human Rights of the key populations especially among IDPs and migrants, involving communities
   f. Surveillance systems for tracking progress and evaluation efforts
   g. Advocacy and partnerships for domestic or regional investments for health such as involving Persian Gulf countries, local charities and rich religious institutions, maybe municipalities through Fast-Track Cities Initiative or similar innovations.
   h. Possible involvement of private-sector such as pharmaceuticals (global or local) to improve supply chain management and access to medicines

3- The inter-constituency concept note which is initially drafted by CCM Iran and UNDP that has been shared and has support from EECA Constituency and the possibility of preparing other sub-regional or inter-regional concept notes to tackle some common or already-unnoticed problems.

Financial Report

The table below includes figures of planned budget for 2016 and actual expenses as recorded in the system.

(Reviewed by the fund holder [UNDP] as of 31 Jan 2017)

	CONSTITUENCY FUNDING COSTED WORKPLAN				ANNUAL EXPENDITURE REPORTING		
	To be completed at time of application				*To be completed at end of the year reporting*		
Current challenges	Minimal participation by constituency members in decision making, weakness in advocacy				**Description of achieved impact**		
Anticipated impact	On the next worksheet, briefly describe the impact that the activities covered by this funding request are anticipated to have on your constituency's engagement with Global Fund governance processes				Describe how activities funded by GF CF have contributed to your constituency's increased engagement with GF governance processes		
	Activity (Outcome)	**Deliverables (Output)**	**Cost category**	**Estimated cost**	**Total actual expenditure**	**Variance**	**Explanation of variance**
1	Holding webinars about relevant topics (Improved communication within constituency)	12 Webinars are held	Communication, Information Dissemination	4,200	1,433.37	-66	Some topics were included in our regional meeting below. No other topic was requested by EMR members for holding webinars.
2	Advocacy and Increased engagement at governance meetings	1 regional meeting held	Organization, facilitation pre-Board Meetings	15,000	33,590.92	124	The meeting was held in Tehran and included visit to CCM sites as well (see below), so these two lines could be assessed together. Also some admins support was included in this category.
3	Visiting CCMS in the region	3 visits arranged	Communication, Information Dissemination	15,000	5,018.56	-67	CCM site visits were arranged for participants of Tehran Meeting. we could not arrange more of these visits, CFP attended two inter-regional meetings
4	Production of information and communication materials	brochures, pamphlets , videos, etc. produced and disseminated	Communication, Information Dissemination	6,000	5,326.03	-11	
5	Provision of scholarship for EMR nominees training	15 delegates trained on different topics	Communication, Information Dissemination	7,500	3,389.76	-55	We used some 2015 booked money for a training course in 2016, no more request for training were received during 2016, we are in process of negotiating
6	strengthening capacity of the EMRC secretariat	a technical officer hired and administrative support provided	Constituency Focal Point salary support, fees or administrative	36,800	32,419.93	-12	some admin support for the regional meeting is included abobe (in line 2)
7	Improved representation at board meetings	delegates attend board meetings and preboard consultations	Cost of participation at Board meetings of delegation members	27,000	17,074.62	-37	All members who expressed their willingness to attend board meetings were supported, however there were few requests.
8	external evaluation of the constituency	an evaluation of EMRC secretatiat work available	Other Costs	3000	-	-100	Due to revision of EMRC governance Framework It was decided to postpone this activity to 2017 if we can keep funds
9	7% UNDP General Management Fee		Other Costs	8,015	6,879.21	-14	lower expenditure justifies lower GMS costs.
Risk assessment	*Not finding any donor to raise funds to cover the expenses beyond GF allocated budget of 100,000 USD.*		*Total: estimate:*	*122,515*	105,132.40	-14	estimated budget (122000) was above allocated budget of 100,000 USD and we did not had other sources. So we had to cut some expenses, although we had some money booked from 2015 for some activities (research and training).

Annexes

Middle income countries (MICs) are home to most people living in poverty and the majority of all people living with HIV and TB. Additionally, MICs face higher medicine prices due to intellectual property barriers and exclusion from agreements allowing low income countries cheap prices.

At the same time, MICs are targeted with funding cuts from international donors like the Global Fund. Donor government funding to support HIV responses in low and middle income countries decreased from $8.6 billion in 2014 to $7.5 billion in 2015. Currently, many MICs are at risk of no longer being eligible for Global Fund funding and transitioning in the coming years.

World Bank classification and EMRO countries:

The Global Fund uses to determine allocation funding a World Bank classification based on GDP. This classification does not grasp the reality of countries in question, leaving aside the amount of national budget dedicated to health, the respect of people living with HIV and key population's rights, or the political context. It is therefore inappropriate for assessing health needs.

Under this classification, most countries in the EMRO delegation are MICs and therefore at risk of losing funding, especially of their levels of epidemic are lower. Upper middle income countries (UMIs) are at most risk of losing funding in the coming cycles; in the EMRO delegation, this concerns Algeria, Iran, Jordan, Lebanon and Tunisia. Other countries in the EMRO delegations that are MICs and therefore at risk are: Egypt, Morocco, Palestine, Djibouti, Mauritania, Pakistan, Syrian Arab Republic and Yemen. It has already been announced Algeria was transitioning for 2017-2019 and would no longer be eligible for HIV after that date. Egypt has also been projected to no longer be eligible for TB within a few years.

Risk incurred for EMRO countries:

Cutting funding for EMRO MICs entails the risk of undermining all efforts made in the fight against the three diseases this past decade which have been extremely important. For instance, the Global Fund has enabled our countries to structure our governance on the three diseases while including all major actors of the fight through CCMs or to implement activities dedicated to HIV prevention for key populations. Several EMRO countries face complicated geopolitical contexts, low State funding allocated to the three diseases and lack of key populations recognition. In fragile contexts, many advances permitted and legitimated by the Global Fund could collapse in case of departure.

It is now recognized the HIV epidemic can be ended in 2030. This could be more easily achievable in EMRO countries where there is low prevalence (0,2%) but instead we're observing a rising number of infections and AIDS-related deaths in the region which puts it among the top two regions with the fastest HIV epidemics[1]. This shows the risk of decreasing funding: efforts

[1] WHO, EMRO regional profile page (HIV in the WHO Eastern Mediterranean Region)

in the EMRO region should rather be strengthened and funding scaled up to envision eradication of the diseases.

Official recommendations to increase funding in Middle-Income Countries:

The UNAIDS fast track means a doubling of the number of people living with HIV/AIDS on treatment compared to the current 15 million figure. Lower-middle-income countries will require US$8.7 billion by 2020 and upper-middle-income countries will require funding of US$ 17.2 billion, after which their needs will decline to US$ 14.2 billion[2]. This will require a lot more money, including from donors.

Failures of past Global Fund transitions:

Past Global Fund's transitions have shown to be failures. In Romania for instance, infection rates among people who use drugs rose significantly after the Global Fund's withdrawal in 2010. At that time, 4.2% of new HIV infections were related to intravenous drug use. That percentage rose to 49.2% by 2013 after harm reduction programs were defunded. In Jordan HIV grant transitioned in 2014, but met eligibility criteria only in 2016 after becoming a high burden considered country by the GF. According to current policy it will be eligible again if it can meet the criteria for two consecutive years, this may delay effective interventions however. The Global Fund leaving middle income EMRO countries could have similarly disastrous effects on our successes and annihilate our achievements. Instead of putting an end to the epidemics in EMRO countries where the epidemic is smallest and where it is most feasible, the Global Fund would send the signal that it is penalizing those rather of enabling them to drive change upwards for their neighbours.

Challenging Operating Environments:

As the conflict in the Syrian Arab Republic entered its sixth year, it continued to trigger massive levels of displacement, with 6.5 million internally displaced persons (IDPs), and over 4.8 million refugees in the neighbouring countries (Egypt, Iraq, Jordan, Lebanon and Turkey).

The conflict in Libya continued to have severe consequences for civilians, with approximately 350,000 IDPs, over 300,000 returnees and an estimated 100,000 refugees and asylum-seekers in need of protection and humanitarian assistance. (HCT) and launching community outreach projects. [3] In the post-conflict situation, several factors have emerged with the potential to fuel the epidemics. A nationwide stock-out of ARV drugs has led to long treatment interruptions among people living with HIV (PLHIV), which could increase transmission, drug resistance and

[2] Gemma Oberth, « A la recherche du juste équilibre entre le financement national et celui du Fonds Mondial », Aidspan numéro 12, 6 mars 2015

[3] UN High Commissioner for Refugees (UNHCR), Overview on UNHCR's operations in the Middle East and North Africa (MENA) , 23 September 2016, available at: http://www.refworld.org/docid/57f25a284.html [accessed 8 November 2016]

mortality. Disruption of infection control and blood safety systems could lead to increased risk of nosocomial transmission, and a rise in sexual and gender-based violence could increase sexual transmission and create barriers to access services.[4]

As some National AIDS Programme (NAP) services and other local institutions adapt to the security situation the new major challenge becomes the lack of funding. In addition, recent years have also seen the country suffer a severe deterioration in basic services, particularly for people who inject drugs (PWID) and in the Prevention-of-mother-to-child-transmission (PMTCT) project. The recent turmoil of 2014, giving rise to two rival governments, has caused further outbreaks of violence across the country, which eventually severely impacted disease control programmes in all its aspects.

The complex humanitarian situation in Yemen continues to be alarming, some 180,000 people have fled the country mostly to Djibouti, Ethiopia, Somalia and Sudan, and further afield. An estimated 82 per cent of the 27 million people residing in Yemen is in need of humanitarian assistance, including 2.2 million IDPs and almost 950,000 IDP returnees.

As a country in transition, the sectarian violence that dramatically increased in much of Iraq since 2014 has displaced more than 2.5 million people. This, combined with the quarter of a million refugees fleeing to northern Iraq from the conflict in Syria, have put a great strain on a health system that had been making modest progress in its recovery from the prolonged crisis of the past decade. The frequent mobility and the cramped living conditions of those displaced are a particular challenge for the country's tuberculosis (TB) programme. [5]

Iraq is home to one of the highest TB rates in the region, with about 15,000 new cases annually. The Iraqi health system has been badly affected due to the long years of war and sanctions. The current TB crisis threatens to wipe out the progress made since 2008. Patients who fled their homes have stopped their treatment, case detection is disrupted, and the deteriorating conditions in which displaced communities survive have fueled the rapid spread of the disease. Interruption of TB treatments, which normally require over six months of close monitoring, is now likely to lead to an increase in multi-drug resistant (MDR) strains of TB. It is much more difficult and longer to treat MDR patients and it implies a higher burden for the government. The cost of treating MDR-TB is about ten times the cost of regular TB. It is a regional issue as countries receiving refugees from Iraq are now exposed to the spread of TB. Domestic spending on the health sector has decreased dramatically as funds are re-directed to deal with the conflict in large parts of the country. According to the Ministry of Health, currently 75-85 percent of the health budget pays for salaries and recurring costs.

Tunisia has also been struggling with refugee crisis from Libya and other North African countries while it is in process of transition out of Global Fund.

[4] Libya (Tripoli) MoH request sent to EMRC, 2015

[5] UNDP website

Conclusive remarks:

The Global Fund must remain global and keep accompanying countries where it has brought so much. No past transition has been successful, therefore a change of approach is needed to ensure even MICs with moderate epidemics keep being funded and supported, to ensure continuity of successes. Leaving those countries behind would represent a failure from the Global Fund. One of the priorities in our region must be to ensure that progress is sustained to address the specific and distinct needs of people living with HIV and TB and communities of key and vulnerable populations.

Involvement of NGOs and private sector in addressing the needs and assisting the civil society in countries where the government is not eligible anymore to ensure sustainability of results are highly recommended.

Advocating for involving new donors from within the region to invest in health and wellbeing of the people through regional initiatives as part or parallel to GF grants could also be followed up.

Expectations

1. There is a need for realistic time for country policy change and development of domestically-funded disease responses that are evidence-based, focused on key populations and are gender and age responsive.
2. The Global Fund and partners should provide technical support for countries to develop realistic national programs and mechanisms for sustainable transition over the next 15 years to ensure achievement of Sustainable Development Goals by 2030.
3. A support mechanism should be available to countries which have become ineligible for Global Fund support but fail to transition successfully.
4. Advocacy and investment is needed to provide enabling environment for NGOs and communities to be more engaged in sustainability.
5. Global Fund should examine countries' levels of transition readiness and sustainability provisions.
6. Together with the catalytic funding, the Global Fund should increase its support through regional initiatives. Establishing regional networks of technical groups and enhancing multicountry or inter-regional cooperation are highly recommended.
7. Emergency fund should be increased as there are emerging countries in Middle East and North Africa suffering from conflict and refugee crisis's where TB and HIV prevalence is increasing: Syria, Iraq, Jordan, Lebanon, Libya etc.
8. Enhancing KPI's to reflect successful transition and ensuring achievement of SDGs by 2030 are recommended.
9. We need to slow-down the current rapid transition in middle income countries and instead of non-zero allocation we opt for some very focused/targeted grants (like up to 100K) and NGOs rule.

EMR Eligibility / Transition list*:					
Country	Income level	HIV	TB	Malaria	Comments
Afghanistan	LIC	YES	YES	YES	
Disease Burden**		Moderate	Severe	Moderate	
Algeria	UMIC	YES →	YES	Not Eligible	→Newly ineligible since 2014-16 allocation and may receive transition funding in 2017-2019
		Moderate	High	Low	
Djibouti	LMIC	YES	YES	YES	
		High	Severe	High	
Egypt	LMIC	YES	YES →	Not Eligible	→Projected to become ineligible based on country move to UMI status in 2020-2022 and may receive transition funding in 2023-2025
		High	Low	Low	
Iran	UMIC	Yes, current till end 2017	Not Eligible	Not Eligible	TB transitioned in 2015, Malaria 2016
		High	Low	Moderate	
Iraq	UMIC	Not Eligible	Current Until end 2018	Not Eligible	COE
		Low	Moderate	Moderate	
Jordan	UMIC	Not Eligible	Not Eligible	Not Eligible	HIV transitioned in 2014, but met eligibility criteria only in 2016
		High	Low	Low	
Lebanon	UMIC	Yes	Not Eligible	Not Eligible	No allocation so far
		High	Low	Low	
Libya	UMIC	Not Eligible	Not Eligible	Not Eligible	HIV & TB transitioned in 2014
Morocco	LMIC	YES	YES	Not Eligible	
		High	High	Low	
Pakistan	LMIC	YES	YES	YES	
		High	Severe	High	
Palestine	LMIC	YES	YES	Not Eligible	
		Low	Low	low	
Sudan	LMIC	YES	YES	YES	
		Low	Moderate	High	
Syrian Arab Republic	LMIC	Yes (Transition)	Yes (transition)	Yes (transition)	COE??
		Low	Low	Low	
Tunisia	LMIC	YES	Not Eligible	Not Eligible	
		High	Moderate	Low	
Yemen	LMIC	YES	YES	YES	COE??
		High	Moderate	High	

*Sources: -Eligibility List 2017
- Projected Transitions from Global Fund support by 2025 – projections by component
** According to Global Fund criteria

Agenda of EMRC's 2nd Technical Eeeting in Tehran 15-17 Oct 2016

DAY 1: 15 Oct 2016 Technical Sessions	
Time	**Topic**
09:00 – 10:00 VENUE: Minister's Office	Opening Remarks *Dr. Mohsen Asadi-Lari*, The EMR Constituency Board Member *Mr. Norbert Hauser*, The Global Fund Board Chair (Global Fund Strategy; Links to SDGs, how to implement) *Dr. A.A. Sayyari*, Deputy Minister of Health, IRAN *H.E. Dr. Hassan Hashemi*, Minister of Health and Medical Education, IRAN
10:00 – 10:30	Refreshment Break
10:30 – 12:30 VENUE: Espinas Hotel	Panel Discussion: Challenging Operating Environments Moderators: *Dr. Mohsen Asad-Lari*, The EMR Constituency Board Member *Dr. Gary Lewis*, UN Resident Representative & UNDP Representative in Iran *Dr. Sameen Siddiqi*, WHO Representative in Iran Guest Speaker: *Dr. Rana Hajjeh*, Director, Department of Communicable Diseases, WHO EMRO. Case Study from Iraq: Presenter: Dr Mohamed Jaber Hwoal, MoPH Iraq
12:30 – 14:00	Lunch Break
14:00 – 15:00	Panel Discussion: Risk Management Model & OIG issues Moderators: *Dr. Thamer Al-Hilfi*, Member of Finance and Audit Committee *Mr. Joseph Serutoke*, Regional Manager, MENA Results of EMRC Study *Presenter: Dr Ramin Radfar*, EMRC Consultant Case Study from Pakistan *Presenter: Dr Sajid Ahmad*, CCM Coordinator
15:00 – 16:00	Panel Discussion: Sustainability, Transition and Co-Financing Moderators: *Mr. Joseph Serutoke*, Regional Manager, MENA *Mr. Allan Maleche*, The Chair of Implementing Group Case Study from Iran: National Strategic Plan toward 90-90-90 Presenter: *Dr MM Goya*, Iran CCM vice-chair / director of CCDC
16:00 – 16:30	Refreshment Break
16:30-17:30	Panel Discussion: Inter-Constituency and Sub-regional cooperation, *Moderators:* Allan Maleche, Chair of Implementers Group Ana Filipovska, The Board Member, EECA Constituency
19:00-22:00	Social Event and Dinner Reception (by EMRC)

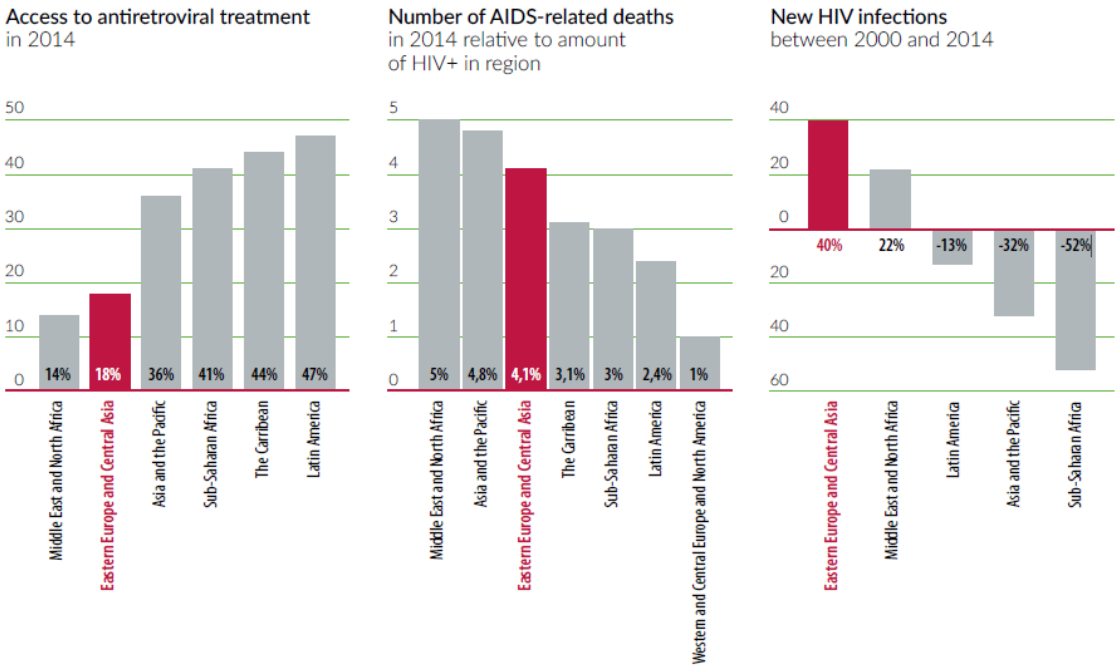
Day 2 – 16 October 2016 EMRC Consultative Meeting Venue: Espinas Hotel	
Time	**Topic**
08:30 – 10:00	Panel Discussion: The role of the civil society Moderators: *Mr. Allan Maleche*, Alternate Board Member, Developing Country NGOs Constituency *Ms. Beatrice Makar*, Senior Partnerships Liaison, TGF Case Study: Social Health Investment; Iran's Experience *Presenter: Dr. M.H Ayazi*, Social Deputy of MoHME Video Call: Private Sector Involvement in Health Initiatives • Results of EMRC study *Presenter: Zahid Hussain*, International Consultant
10:00-10:30	Case Study: Regional Knowledge Hub for HIV/AIDS Surveilance Presenter: *Dr Ali Akbar Haghdoost*, Director of HIVHUB
10:30 – 11:00	Refreshment Break
11:00 – 12:30	Governance Reform at The Global Fund, Constituencies & CCMs *Moderators:* *Ms. Sandra Irbe*, Senior Advisor, Office of Board Affairs *Dr. Thamer Al-Hilfi*, Member of Finance and Audit Committee Case Study from Afghanistan *Presenter: Dr N. Safi*, Member of CCM Afghanistan VideoCall with *Raegan Boeler*, Office of Board Affairs
12:30 – 14:00	Lunch Break
14:00 – 15:30	Plenary Discussion: Consolidating the EMRC position paper for next board meeting Co-Chairs: *Dr AsadiLari & Dr Hamood*
15:30-16:00	Plenary Discussion: Preparations for Next Constituency Elections in the Region Co-Chairs: *Dr AsadiLari & Dr Hamood*
16:00 – 16:30	Refreshment Break
16:30 – 17:30	Plenary Discussion: Revision of EMRC Governance Framework Co-Chairs: *Dr AsadiLari & Dr Hamood*

Day 3 – 17 October 2016 Field Visits	
Time	**EMR Members**
08:00 – 10:00	Visiting a Global Fund supported Project Site *HIV Reference Laboratory*
11:00-13:00	Visiting a Community –based Health Center established by Tehran Municipality

Joint Statement for 36th Board Meeting by 4 Constituencies

(EECA, EMRC, SEA, LAC)

HIV Epidemics Data from UNAIDS fact sheet "How AIDS changed everything" (2014):



As we move from Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs), accelerating progress towards ending HIV, tuberculosis and malaria is critical. Although there was due cause for celebration after the HIV targets for MDG 6 were exceeded[6], there was and is also necessary concern over the fragile nature of gains made to date. While the world celebrates declining rates of new HIV infections and deaths from AIDS, in Eastern Europe and Central Asia (EECA), the only region in the world that did not achieve the 6th Millennium Development Goal and new infections and AIDS-related deaths continue to grow. While in Middle East and North Africa and EECA region have lowest access to antiretroviral treatment. Middle East and North Africa have highest number of AIDS related deaths relative to amount of HIV in the regions. Faced with rapid transition to domestic funding, these two regions are not adequately financing programming for the HIV care continuum (including prevention, testing, linkage to care and retention) in particular for stigmatized and criminalized key populations.

Globally, between 2000 and 2014, the rate of new infections decreased by 35%[7] while in EECA it grew by 30%[8] over the same period. Between 2010 and 2015 new infections grew by 53% in EECA[9]. AIDS related deaths declined globally by 41% between 2004 and 2014[10] but increased by 27% in EECA between 2005

[6] UNAIDS (2015)
[7] UNAIDS (2015) How AIDS Changed Everything p32
[8] UNAIDS (2015) How AIDS Changed Everything p143
[9] UNAIDS (2016) Global AIDS Update 2016
[10] UNAIDS (2015) How AIDS Changed Everything p103

and 2014[11]. High rates of co-infection plague the region, with tuberculosis cases increasingly linked to HIV infection and opiate use[12] and hepatitis C virus approaching 80% prevalence amongst PWUD in many countries. The EECA region has the highest rates of multi-drug resistant tuberculosis (MDR-TB) in the world[13].

While still far from reaching targets for access to prevention, testing, treatment, care and support, the countries of EECA , EMR, LAC and SEA regions (most of which are in middle income categories according to the World Bank classification) are faced with rapid transition to domestic funding as they lose eligibility for financial support from the Global Fund. The Global Fund's eligibility criteria still do not take into account of governments' limited willingness to pay for programming targeting stigmatized and criminalized populations.

There is a need to continue increasing Global Fund investments in middle income countries as HIV prevalence is growing and highest burden on MDR-TB. For example, Iraq, Iran, Chile, Venezuela, Algeria, Malaysia, Russian, Bulgaria, Serbia, Bosnia and Herzegovina, Macedonia, Montenegro, Romania and the Central African Republic all receive less than one fifth of expected development assistance for health. Many countries would benefit significantly from additional Global Fund investment in order to sustain low HIV and TB prevalence. External funding for some regions – such as Eastern Europe and Central Asia and Latin America and the Caribbean – has fallen, whilst it has increase in a smaller sub-set of countries in other parts of the world.

How transitions are currently being managed:

1. Transitions are implemented ad hoc. There is no consensus on the best model for guiding countries through a responsible transition. A variety of frameworks and criteria has been put forward by several different sources.
2. Transitions may threaten key populations. There is uncertainty about how to ensure key populations are not cut off from services through a transition. Key populations programming is often heavily donor-funded and not eagerly absorbed by governments.

Transitions need to be based on the following sets of principles: (1) transparency and predictability, (2) good practice and (3) human rights:

1. Transparency and predictability – discusses how we might better anticipate which countries will move to self-reliance and when.
2. Good practice – looks at the available literature on good practice for transitions, sharing models and frameworks which others have developed to guide countries and donors in this process.
3. Human rights – asks important questions about how transition impacts vital key populations and human rights interventions.

[11] UNAIDS (2015) How AIDS Changed Everything p145
[12] World Health Organization Europe (2016) Tuberculosis action
[13] TB Europe Coalition (2016) Transitioning From Donor Support HIV& TB Programmes In Eastern Europe & Central Asia: Challenges & Effective Solutions

Recommendations:

10. As Government Constituencies we need realistic time for country policy change and development of domestically-funded AIDS responses that are evidence-based, focused on key populations and are gender and age responsive.
11. The Global Fund should provide technical support for countries to develop realistic plans and mechanisms for sustainable transition over the next 5 to 10 years.
12. An emergency support mechanism should be available to countries which have become ineligible for Global Fund support and finished their last grants, but have not been able to undertake any sort of structured transition planning process.
13. Global Fund should have mechanism to safeguard key populations in countries which fail to transition successfully.
14. Advocacy investment is needed for efforts to reduce stigma and sensitize law-makers, law enforcement and health care providers to legal protections of rights of key populations should be supported. Legal frameworks should be adjusted to enable social contracting of NGOs for low threshold prevention, testing and linkage to treatment and other services.
15. Global Fund should change eligibility that correspondence with the Strategy 2017-2022 for ending epidemics and leaving no one behind and allocation funding should be allocated according available information in national AIDS spending assessments[14]; HIV sub-accounts of national health accounts; public expenditure reviews, United Nations General Assembly Special Session (UNGASS) country progress reports; and other reports – to examine countries' levels of domestic effort, taking into consideration epidemic size, resource needs, fiscal capacity, and amount of external assistance for HIV.
16. Catalytic Investments for the 2017-2019 Allocation Period should be increased in particular the amount dedicated for priority area for HIV 1.1 Key Populations Sustainability and Continuity the amount of 50 million US$ is not enough to address the challenges in countries that made exit out of the Global Fund without proper transition.
17. Emergency fund under Catalytic Investments for the 2017-2019 Allocation with total amount of 30 million US$ also need to be increased as there are emerging countries in Middle East and North Africa suffering from conflict and refugee crisis's where TB and HIV prevalence is increasing : Syria, Iraq, Jordan, Lebanon, Libya etc.
18. Countries transitioning may not only fall behind in supporting key population, rules in several countries do not permit community organizations to be funded (note for ourselves: INO is example for this)
19. With transition , CCM , the dialogue making body between stakeholders, only of such kind may wither away, transition needs to take this into account., Countries can be

Incentivisation is a way for addressing to these two issues may be considered and countries agreeing to address these two issues may be eligible for additional funding or increased duration of funding

[14] Resch, Ryckman and Hecht (2015)

EMRC Case Studies

Egypt

Iran

Iraq

Lebanon

Sudan

Eastern Mediterranean Region Constituency
Case Study Series No: 01

Egypt

Country Background[i]

Upper Middle Income Country (World Bank Classification)

Population:	90.51 M (2015)
GDP per capita	2,707 USD (2015)
Health Expenditure % of GDP	**8.4 (2014)**
Health Expenditure public	38.2% (2014)
HIV Disease Burden	Concentrated epidemic
ARV coverage	24%
Estimated number of PLHIV	11000
HIV prevalence	0.01%
TB Disease Burden	
Incidence	15/ 100000
Mortality	0.24/100000
MDR	14%
Success rate ss+ (2014)	84 %
TB/HIV	1 %

GF status: Eligible and receiving grant for TB & HIV, transition after 2020

UN R/P		World Bank Gini [3]	
10%	**20%**	**%**	**Year**
8	5.1	30.8	2008

R/P 10%: The ratio of the average income of the richest 10% to the poorest 10%
R/P 20%: The ratio of the average income of the richest 20% to the poorest 20%
Gini: Gini index, a quantified representation of a nation's Lorenz curve

Malaria Disease Burden:
Very low risk
Reported cases: 313
Death Cases : 2

National Programs

HIV:

HIV prevalence among men who have sex with men was similar in the two rounds of surveillance in 2006 and 2010. It has most recently been estimated at 5.7% in Cairo and 5.9% in Alexandria . A recent urban population estimate of MSM has been undertaken and a best national estimate of about 43,000 has been determined. The best estimate of men who have sex with men in Greater Cairo and Alexandria is about 18,000.

HIV prevalence among IV Drug Users (IDUs) increased between the two rounds of surveillance in 2006 and 2010. It has most recently been estimated at 6.8% in Cairo and 6.5% in Alexandria. A recent urban population estimate of people who inject drugs has been undertaken. There were estimated to be about 30,000 people who inject drugs in Greater Cairo (Cairo & Giza) and Alexandria with a further 1,000 in Menia.[ii]

TB:

NSP (2015-2020) was developed to be aligned with the new targets of sustainable development goals:

1. To detect 90% of estimated TB cases and successfully treat 90% of them by 2020.
2. To detect 85% of estimated MDR-TB patients and successfully treat 80%by 2020.
3. To strengthen TB HIV collaboration.
4. To strengthen TB surveillance and program management including implementing comprehensive systems for data management, finances and human resources to meet the NSP targets for 2020. [iii]

Policy Environment

The MoHP's recently finalised social medical insurance law is a major step forward in improving the country's health financing situation. According to the government's State Information Service, around half of the country's

population is covered by basic government medical insurance, while 30% have private health coverage and an additional 20% have no coverage at all. The state will cover their treatment expenses through this law. The Continuous turn-over in the government officials (Ministers of health) which reached 7 different ministers over the period 2011-2013 creates difficulties in timely follow up with the scheduled activities.[i]

The current security situation in the country interferes with many outreach activities related to the HIV programming. This is particularly relevant to the area of HIV activities where HIV program beneficiaries are threatened by the current situation. Despite the great political instability experienced by Egypt through 2011 and 2013, continued political support was demonstrated to the HIV program where a new NSP was designed to cover the period 2012-2016. Foreigners staying in Egypt to work, study, or for training for more than 3 months are stated in the law as and could thus be subjected to HIV tests without their consent.[iv]

Finance

An investigation published in 2015 by OIG showed some non-compliant expenditures in HIV grant with recommendation for recovery. The Global Fund Executive Director has invoked the Additional Safeguard Measures on the Egypt portfolio.[v]

Governance

The Country Coordination Mechanism (CCM) is maintained by the Ministry of Health & Population. Global Fund (GF) started working in Egypt during 2003 for the National Tuberculosis Programme (NTP) and during 2008 for the National AIDS Programme (NAP). This partnership led to augment the current implemented activities for both programs. Subsequently, this led to improve the quality of services for the patients with implementation of many preventive activities all over Egypt.[iii]

Expectations & Recommendation

- MOHP hope that GF agrees upon extension of current grants.
- The Egyptian financial and managerial bylaw is the only acceptable one within the governmental system. In Geneva WHA meeting with HE Minister of Health ,it was agreed to execute training program for financial and managerial office in MOHP .
- MOHP agree to link with Global Fund Office of the Inspector General
- It was mutually agreed that the CCM is the National Coordination and supervising body for TB and HIV National Programs, maintaining role of CCM is nonnegotiable.
- Working with GF to support MOHP has always been a mutual cooperation and was planned to serve the TB and HIV patients demanding sincerely dedicated service [iii]

[i] WordBank, WHO, UNAIDS, GF
[ii] Country Progress Report 2015 UNAIDS
[iii] CCM Chair's Powerpoint Presentation, Nov 2016
[iv] Contry NCPI report 2014
[v] Investigation of Global Fund Grants to Egypt, GF-OIG-15-015

Eastern Mediterranean Region Constituency
Case Study Series No: 02

Iran

Country Background

Upper Middle Income Country (World Bank Classification)

Population:	79.11 Million people (2015)	GF status: receiving grant for HIVcurrently, Malaria in Transition, TB finished
GDP per capital	4763.30 USD (2013)	
Health Expenditure % of GDP	**6.9**	
Health Expenditure public	41.2 Concentrated	
HIV Disease Burden		
Number of registered PLHIV	32670 HIV/AIDS – 8311 (death)	
Estimated number of people living with HIV	75618	
HIV prevalence	0.09%	
HIV incidence	0.13%	
TB Disease Burden		
Incidence	13 / 100000	WHO estimate =16/100000
Mortality	0.52 /100000	
Non Iranian patients ratio	13%	
MDR	-primary MDR= 1.3% -secondary MDR=12%	
Success rate ss+ (2014)	84.87 %	
TB/HIV	3%	309 HIV+ among 10430 TB cases
Malaria Disease Burden (2015)		
incidence	0.001	
Mortality	0	
Total cases	797	
Autochthonous (local)	187	
Autochthonous of falciparum	24	Total = 98

UN R/P		World Bank Gini [3]	
10%[6]	20%[7]	%	Year
17.2	9.7	37.4	2013

R/P 10%: The ratio of the average income of the richest 10% to the poorest 10%
R/P 20%: The ratio of the average income of the richest 20% to the poorest 20%
Gini: Gini index, a quantified representation of a nation's Lorenz curve

National Programs

Currently the National Strategic Plan (NSP) for TB control (2014-2018) , NSP for HIV/AIDS Control (2015-2019) and NSP for Malaria Elimination are being implemented. The objectives are:

Malaria:

Elimination of local transmission of Malaria Falciparum before 2018
Reduction of local transmission of Malaria Vivax by 10% each year till 2020
Elimination of local transmission of Malaria Falciparum before 2020
Achieving Zero death due to Malaria by 2015

TB:

Increasing case finding to at least 80%
Increasing treatment success rate to at least 90%
Increasing public awareness about TB by at least 40%
Active case finding among smear positive pulmonary patient's contacts at least 95% and among at risk populations at least 30%

Case finding and treatment of asymptomatic TB among at least 95% of children under 6 who had contact with smear positive pulmonary patients and among at least 50% among others highly at risk (80% among HIV+)
Vaccination of newborns at 100%
Drug resistance testing among all previously treated TB patients and 20% of new cases
HIV testing among all TB patients and all patients concomitantly infected by HIV and TB receive ARV and CTX
At least 40% TB patient's family members receive standard nutritional support when eligible
Public-Private Partnership implemented in at least 30%
Applied research and innovations for speeding up diagnosis of active and hidden TB and drug resistance
Direct smear testing and culture available at 100% of laboratories and establishing 6 new referral labs Equipping 50% of Prison health with isolated rooms & establish at least 2 residential centers for homeless MDR-TB patients

HIV:

90% of HIV patients tested and diagnosed, 90% of PLHIV receive ARV, 90% ARV cases achieve viral load <50
HIV prevalence remain <0.15% among general public till 2018
HIV prevalence decrease to <13% among IV drug users till 2018
HIV prevalence remain <5% among sex workers till 2018
HIV incidence decrease by 90% among newborns of women living with HIV till 2018
AIDS-related death rate decrease by 20% among PLHIV

Policy Environment

There has been some fluctuation of state policies with regard to HIV/AIDS during the past 15 years.
International NGOs are not generally allowed to work in country, local NGOs are restricted in getting funds from abroad. In selected areas (i.e. Needle-Syringe Programs) government provides limited funds to NGOs for service delivery. Deputy of Social Affairs at MoHME is going to involve charity donors for drug use prevention and treatment and HIV prevention.

Finance

The Global Fund to Fight AIDS, Tuberculosis and Malaria	From 2005 till 2016	$ 100 million
	HIV/AID	$ 53842688
	TB	$ 18957412
	Malaria	$ 27436395
Domestic Financing (current)	HIV	>95%
	TB	100%
	Malaria	>95%

Governance

The Country Coordination Mechanism (CCM) for the Global Fund projects is a multisector partnership led by the Ministry of Health and Medical Education established in 2005. The members are from Government, NGOs, Private sector, UN agenesis, academia and people affected or living with diseases.
There is also a National AIDS committee under the High Council for Health & Nutrition which plans and coordinates the national program.

Expectations & Recommendation

1. Knowledge sharing and exchanging best practices and lessons learned among targeted countries through strengthening partnership, advocacy, communication and capacity building;
2. Enhancing bilateral/multilateral case detection and strengthening integrated Health Information System;
3. Strengthening care and treatment coverage and surveillance systems in borders through provision of HIV, TB and Malaria integrated services building into/up-scaling existing infrastructure.

Eastern Mediterranean Region Constituency
Case Study Series No: 03

Iraq

Country Background

Upper Middle Income Country (World Bank Classification)

GF status: in Transition, COE

Population:	**36,933,714** (2015)
GDP per capital	6288 USD (2012)
Health Expenditure % of GDP	**4.3**
Health Expenditure public	41.2
HIV Disease Burden	low (2012)
TB Disease Burden	(2014)
Incidence	43 / 100000 (WHO prevalence: 20000 cases)
Mortality	2.4 /100000
Case detection ratio	54%
MDR	-primary MDR= 6.1% -secondary MDR=24%
Success rate ss+	92 %
TB/HIV	1.6 %

UN R/P		World Bank Gini	
10%	**20%**	**%**	**Year**
		29.5	2012

R/P 10%: The ratio of the average income of the richest 10% to the poorest 10%
R/P 20%: The ratio of the average income of the richest 20% to the poorest 20%
Gini: Gini index, a quantified representation of a nation's Lorenz curve

Iraq is the ninth-highest ranking TB burden nation in the Eastern Mediterranean Region, contributing to three percent of the total cases (With estimated 15000 new cases Annually).
Over the last 2 years there has been an upsurge in violence which resulted in almost 3.2 million internally displaced persons (IDPs) across Iraq.
With more burden added due to failure of transition stage (2014-2016) due to the fact that some regions became under ISIS control which led to increased risk of silence and or under-reporting , increase the risk of loss to follow up and proper provision of drug supply for TB patients and increase the risk of MDR patients.

National Programs

The Goal is to project the objective strategies of the NTP within the policies that respond to Millennium & Sustainable development goals (MDGs & SDG).
The General objectives are to ;

- Increase case detection to at least 70% of new and relapse cases and treatment success of drug-susceptible case to 85% or more by 2019.
- Increase case detection of MDR-TB cases among notified (pulmonary) TB cases to 100% and treat successfully at least 70% by 2019.
- provide TB control services to at least 75% of the populations belonging to vulnerable groups by 2019 which include children, IDPs, refugees, marshland populations, prisons, people with TB/HIV
- Strengthen and enhance monitoring and evaluation and operational research by 2017 and beyond.
- Strengthen and maintain efficient and effective programme management by 2017 and beyond.

Policy Environment

Iraq is dealing with internal war with a terrorist group who has captured almost 40% of the country over the past 2 years. The disputes within the federal system of government and presence of some paramilitia have also complicated the situation of internally displaced populations.

Finance

The optimal use of financial resources through developing ways to cooperate with international organizations for the best use of grant and to consolidate the TB electronic statistical HIS

- The country received USD 32 million from the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM).
- The support, as part of Round 9 of the Global Fund's grant allocation, is implemented over five years starting October 2010 as a UNDP (United Nations Development programme) project in partnership with WHO (World Health Organization) and the Government of Iraq.

Overall costs by objective and activity are calculated at $152 million.

This involves the treatment of 54000 cases of all forms of TB, including MDR-TB, at an average cost of $2.810 per case. this total cost is subdivided into $29.394.051, $9.493.997,00, $2.203.104,00, $3.052.387,50, $107.644.839,00, $151.788.378,60 to respond to Objective 1: To increase case detection to at least 70% of new and relapse cases and treatment success of drug-susceptible case to 85% or more by 2019, Objective 2: To increase case detection of MDR-TB cases among notified (pulmonary) TB cases to 100% and treat successfully at least 70% by 2019, Objective 3: To provide TB control services to at least 75% of the populations belonging to vulnerable groups by 2019 which include children, IDPs, refugees, marshland populations, prisons, people with TB/HIV,

Objective 4: To strengthen and enhance monitoring and evaluation and operational research by 2017 and beyond, Objective 5: To strengthen and maintain efficient and effective programme management by 2017 and beyond in a consecutive manner.

Considering the fact of Oil revenue shortage and Security instability in some areas, sustainability of the achievements is under question mark.

Governance

The mandate of the members of the CCM, as well as the Chair and Vice-Chair, is for four years. During the whole Global Fund financed grants which is still on, this body has governing and oversight functions over the Grants.

Expectations & Recommendation

As mentioned earlier, the facts related to Oil Revenue shortage and the security situation due to ISIL occupation to some areas with the result of Risk of silent reporting, under reporting and loss to follow up. The sustainability of the already achieved targets is questioned.

For this we highly recommend

1. GF to extend its grant to cover the next coming 2 years 2017-2019
2. CCM to continue the role of supervision & oversight on the Grant
3. Build the Capacity of CCM
4. Strengthen the capacity and mandate of the EMR constituency
5. Strengthen the Role of Civil society and Patient Rights,

Eastern Mediterranean Region Constituency

Case Study Series No: 04

Lebanon

Country Background

Upper Middle Income Country (World Bank Classification)

Population:	5.85 M (+1 M registered refugees)	GF status: HIV Eligible, not granted yet. For TB among migrants it is part of a regional grant operated by IOM
GDP per capita	9928 USD (2013)	
Health Expenditure % of GDP	**6.4 (2014)**	
Health Expenditure public	47.6	
HIV Disease Burden	Concentrated	
Number of registered PLHIV	1000	
Estimated number of PLHIV	1800-2400	
HIV prevalence	0.00003%	
TB Disease Burden		WHO 2015
Incidence	16 / 100000	
Mortality	1/100000	
Non Citizen patients ratio	50%	National TB Program info
MDR	0.48 /100000	
Success rate ss+ (2014)	76 %	
TB/HIV	1%	

National Programs

HIV:

National AIDS Program, which is operating through a joint agreement between the MOPH and WHO, is in charge of every aspect of the HIV response in Lebanon. The activities of the NAP also include awareness about the disease and its management, fighting stigma and discrimination. Another major activity of the NAP is collaboration and coordination with the private sector, with non-governmental organizations (NGO's), ministries, media, religious leaders, United Nations (UN), agencies and other key stockholders to improve the situation of people living with HIV (PLHIV) and to halt the spread of the epidemic. In Lebanon, the mobilization of non-governmental organizations around preventive programs has had a significant impact on the fight against HIV. Partnerships and collaborative project with the NAP have become very frequent and have led to successful results and establishment of different projects on prevention, testing and stigma reduction.

TB:

- a five years National strategic plan was elaborated for TB elimination in Lebanon, where one of the objectives is" Improvement of TB case detection and treatment outcomes in refugees and migrants".
- updated version of TB guidelines are under finalization , where a part is "TB management in refugees and displaced population"
- SOP for referral of TB patients between countries and TB programmes.
- a steering committee was assigned for M&E of the project implementation named" enhancing TB prevention, diagnosis and treatment for Syrian refugees and other vulnerable populations affected by the Syrian crisis in Lebanon" in the years 2014-2015.

Policy Environment

1. Lack of supporting policies or laws that protect the rights of MSM, drug users and sex workers to access services

without discrimination.

2. Financial protection for HIV is still a challenges as insurance companies do not cover HIV patients, with some of the patients acquiring high costs related to laboratory tests before and after initiation of their treatment.
3. The current funding is poorly allocated for HIV programs, with a majority going towards medication. There was an identified need of financial support for trainings and awareness sessions.
4. With the growing refugee population in Lebanon, funds are being directed towards humanitarian aid. As a result, HIV has become less of a priority.
5. NAP, as key player in health system, is understaffed and could not effectively and efficiently function with only three people.
6. There is no funding for long-term recruitment of HIV healthcare providers, with clear challenge regarding the sustainability of human resource is a major issue that is negatively impacting the quality of service
7. Shortage in adequate human resources involved in HIV care, especially in the peripheral areas of Lebanon, is a key aspect to be addressed for better outcomes among PLHIV.
8. The capacity of people working with PLHIV is inadequate. Some healthcare providers and volunteers were not well trained on HIV, especially outside of Beirut.
9. Low level of provider-initiated HIV testing.
10. There is a weak information system for tracking the testing and treatment of HIV patients.
11. The existing information system is not unified, meaning that there is no sharing of information between the NAP, hospitals, labs and NGOs.

Finance

Lebanon as a high middle income country is not eligible for grant from Global Fund to fight TB, AIDS and Malaria, however Lebanon has received an emergency grant as a support for the national tuberculosis program to cope with the additional number of cases in Syrian refugees (with IOM as principal recipient)

TB financing, 2016

National TB budget (US$ millions) 1.8

Funding source: 34% domestic, 66% international, 0% unfunded

Governance

The Country Coordination Mechanism (CCM) for the Global Fund projects is a multi-sector partnership led by the Ministry of Health and Medical Education established in 2005. The members are from Government, NGOs, Private sector, UN agenesis, academia and people affected or living with diseases.

There is also a National AIDS committee under the High Council for Health & Nutrition which plans and coordinates the national program.

Expectations & Recommendation

There are still 31% of HIV-infected individuals in Lebanon are not aware of their status. Provider initiated HIV testing is still need to be strengthened part of the current culture.

1- Free HIV Voluntary Testing and Counseling should be made available and integrated to health services with the strictest confidentiality and linked to healthcare services.
2- Treatment for PLHIV based on quality care and support services provided in points of care. With financial support for follow-up tests and other medical services for PLHIV among refugees.
3- Ensuring availability of diagnosis and treatment for STIs in health facilities, and expand that to PHC level.
4- Strong prevention package targeting MSM and sex workers among the targeted communities.

Another level of prioritization of interventions was also considered very critical in the current environment, this includes the following:

5- Ensuring availability of condoms at all points of healthcare service provision in prioritized locations.
6- Ensuring availability of IEC posters on HIV and STIs as part of education programs/ campaigns in suitable venues including health facilities (PHC and hospitals) and other targeted venues.
7- Ensuring availability of Post-Exposure Prophylaxis (PEP) to all eligible people from key populations on a voluntary basis
8- Integration of youth friendly reproductive health services in prioritized health facilities make available and accessible RH services including STIs drugs at Primary health care centers.

Eastern Mediterranean Region Constituency
Case Study Series No: 05

Sudan

Country Background[i]

Upper Middle Income Country (World Bank Classification)

Population:	40.23 M (+2.7 M refugees)
GDP per capita	2081 USD (2014)
Health Expenditure % of GDP	**8.4 (2014)**
Health Expenditure public	21.4%
HIV Disease Burden	Concentrated
ARV coverage	9.5%
Estimated number of PLHIV	56000
HIV prevalence	0.3%
TB Disease Burden	
Incidence	88/ 100000
Mortality	18/100000
MDR	4 /100000
Success rate ss+ (2014)	82 %
TB/HIV	2 %

GF status: Eligible and receiving grants for all 3 diseases.

Malaria Disease Burden:

87% of population residing in high risk areas, 13% in low risk areas

15,400,000 Insecticide-treated nets distributed

Reported cases: 586,827

Estimated Cases 1,400,000

National Programs

HIV:

The goals for the Sudan HIV National Strategic Plan (HIV NSP, 2013 -2016) are focused on the three zero's – zero new infections, zero HIV related deaths and zero discrimination. The two goals of the HIV NSP are to:

1. Halt the further spread of HIV among the Sudanese population and maintain HIV prevalence blow 2.5% among all most-at-risk populations and below 0.3% among the general population by 2016.
2. To improve the quality of life, health and wellbeing of people living with HIV by providing universal access to comprehensive high quality HIV treatment, care and support services.

To maintain the steady decrease in TB prevalence and death rates beyond the level identified in 2012; all through the NSP period.

TB:

The objectives of the TB NSP are:

1. Increase number of notified TB cases by 10% annually, reaching 26,600 cases by 2016, and improve treatment outcome to reach 90% success rate in new smear positive cases and 75% in retreatment cases
2. Health system in all states is reoriented to provide integrated TB/HIV services, increase detection of MDR-TB cases so that 750 cases are detected and 70% success rate achieved, and implemented adequate infection control measures by 2016
3. TB monitoring and evaluation system is strengthened according to gap analysis, within integrated C&NC Disease Control at national and state levels, and 100% implementation of functions is achieved at national level and at least 75% at each state level.
4. Quality TB control programme performance sustained at national and state levels in an enabling environment, and guided by national and international expertise
5. Achieve high political commitment to support the implementation of Tb Activities at all levels, with social support to all TB patients and reduced stigma by 50% from baseline in 2013.

Malaria:

The overall goal of the National Malaria Strategic Plan for 2013 2016 (Malaria NSP) is to reduce malaria morbidity and mortality from the 2013 base line by 25% by 2016, and prepare the low malaria intensity areas of Red Sea, Northern, River Nile and Khartoum states to move to the malaria pre-elimination phase.

The strategic priorities to support these objectives are:

- Strengthening leadership, coordination and partnership roles of the NMCP including strengthening ties with CSOs and the private sector.
- Universal coverage with high impact control interventions (LLINs, IRS, RDTs and ACTs).
- Ensuring that quality parasitological diagnosis (microscopy or RDTs) is used to guide appropriate case management
- Strengthening malaria surveillance, including entomological surveillance, and M&E systems
- Ensuring adherence of health workers to treatment guidelines.
- Consolidate and expand larval source management (LSM)
- Increasing community participation and malaria service utilization.

Policy Environment

The health system in Sudan is three-tiered with Federal, State and locality based health structures. The Federal Ministry of Health (FMoH) has a leading role in policy and stewardship, while responsibility for delivery of public services is largely led by States and their localities. Some responsibilities remain shared between the different levels namely, early preparedness and response to disasters and epidemics, monitoring and supervision and tertiary level care.

Costs for implementing the NHSSP were SDG5.9billion in 2012 rising to SDG9.1 billion in 2016. Sudan is affected by major fluctuations in exchange rates and inflation.

Funding for government run health services are made directly by the Federal Ministry or State Ministry of Finance via the Federal and State Ministries of Health, then through localities to health facilities

Finance

The Global Fund remains one of the major contributors to health service delivery in Sudan. has recently obtaining a new GAVI grant, which incorporates broader health initiatives. The Ministry of Finance contributed a further US$100 million for broad health sector reform with the aim of consolidating and mainstreaming health service delivery through Primary Health Care facilities. This initiative is the foundation for much of the HSS component of this concept note, with the integration of services, including Malaria, TB and HIV, in PHC facilities.

Sudan may be able to received incentive funding from the Global Fund for gaps in Malaria funding. Sudan is also one of the eligible countries to receive funding under the Quality demand scheme through this concept note.

Multilateral partners such as the WHO, UNDP, UNICEF, UNFPA will continue providing support with funding and technical assistance. To support the full costs of the three diseases' strategies and priority HSS components identified about $377 million is required. With limited government and other donor support, there is a financial gap of about $165 million.

TB financing, 2016

National TB budget (US$ millions) 17

Funding source: 19% domestic, 40% international, 41% unfunded

Governance

The Country Coordination Mechanism (CCM) is maintained by the Federal Ministry of Public Health.

Expectations & Recommendation

1. Build the Capacity of CCM and FMoH and to have exist strategy for UNDP as PR
2. Strengthen the Role of Civil society
3. The Global Fund needs to establish a mechanism to allow more time for adequate domestic resource mobilization and more flexibility in reprogramming.
4. Strengthen the capacity and mandate of the EMR constituency

[i] WorldBank, WHO, UNAIDS, GF

Inter-Regional Concept Note

Project title:

South-South cooperation network toward cross-border management of HIV/AIDS, Tuberculosis and Malaria in the Southwest and Central Asia region

Project Goal
To establish a regional network for south-south cooperation as an enabling platform for joint knowledge sharing, capacity building and coordinated activities to address the cross border transmission of HIV, TB and Malaria in Southwest and Central Asia (e.g. Afghanistan, Armenia, Azerbaijan, the I. R. of Iran, Iraq, Kirgizstan, Pakistan, Tajikistan, Turkmenistan and Uzbekistan);

Brief Description

As a result of Global Fund financed interventions since 2002 as well as government initiatives, the high burden of the three targeted communicable diseases, HIV, TB and Malaria, has been reduced in many countries in the Southwest and Central Asia region. However, these achievements are at risk of cross border population movement.

While some countries in the region have made progress, the risks posed by cross-border relations indicate that there is a high potential of cross border re-introduction of these diseases from high burden states including Afghanistan, Armenia, Azerbaijan, the I. R. of Iran, Iraq, Kirgizstan, Pakistan, Tajikistan, Turkmenistan, Uzbekistan into neighboring countries. I. R. of Iran hosts more than 3 million refugees and migrants, many of whom originate from high disease burden neighboring countries. This is even overstated by intentional movements of infected people crossing borders to receive health care services in neighbouing countries. These are regional facts and realities which would lead to further increase in the risk of the re-introduction in many of the countries in the region. This regional threat could gradually have the potential to reverse the gains achieved with support of the Global Fund resources in many of the countries which could not be addressed by the governments themselves. In other words, the sustainability of countries' achievements is highly associated with the regional successes and there is a need for a regional initiative enabling and ensuring countries to join their efforts to grow together in addressing the common issue of these three communicable diseases.

In addition to the technical and geographical complexities, some of these diseases are surrounded by social and cultural barriers in many countries in the region. This has created stigma around them, making it difficult to tackle the issue, as stigma and other related barriers keep people from health-seeking behavior. Using cultural communalities and lessons learned in some of the countries such as I.R. of Iran in overcoming these barriers will also be another added value to the proposed project helping other countries to overcome these types of barriers.

The proposed project is aiming to shape a regional initiative to set up an enabling network among the countries in the region which are willing to join and share their knowledge and experiences to improve

the situation in the region including by aligning their activities toward addressing the cross-border dimensions of the management of the targeted diseases. As some of the countries in the region are already graduating from the GF due to the achievements in addressing the diseases and the burden reduction, the proposed project will ensure and the capacity and lessons learned in these countries are efficiently shared and used in the neighboring countries shaping a south-south cooperation platform reducing Assisting countries to combat the diseases at home through South-South Cooperation.

The epidemiological situation of the three diseases

By adopting the SDGs, the world has agreed to end epidemics of certain key communicable diseases including HIV, tuberculosis and Malaria by 2030. This is an ambitious goal but yet achievable if countries work together and maximize their efforts. Currently there is an imbalance in response capacity in some countries and regional initiatives and cooperation could contribute to address the challenge (for more information see table 1 in the annex).

The I.R. of Iran is one of the high impact countries in this sub-region in terms HIV infection. Although, I.R. of Iran could successfully control Malaria and reach pre-elimination stage in its country of origin and the TB programme has been successfully implemented during the last 3 decades and curbed the disease, still there is the high risk of re-introduction of Malaria and TB through influx of refugees and immigrants, both legal and illegal, mostly across the eastern borders with Afghanistan and Pakistan, while there is still high risk of re-introduction of MDR-TB cases from northern and western borders of I.R. of Iran, i.e. Turkmenistan, Azerbaijan, Armenia, and Iraq.

The status of TB in Afghanistan and Pakistan is severe while it is modest in Turkmenistan, Azerbaijan, Armenia and Iraq and low in I.R. of Iran. The high burden of MDR-TB in three countries of Armenia, Azerbaijan and Turkmenistan is another challenge, while the unavailability of sufficient data on TB statistics in Afghanistan, Pakistan and Tajikistan is a matter of more concern. The total estimated size of TB -HIV co-infection is 1,873,274 cases in the whole region which is quite a big number of infected people and a big challenge for the regional health status.

As for HIV, in most countries of this region similar cultural sensitivities, social barriers, stigma associated with most at risk populations as well as the lack of capacity to conduct a multi-sectoral approach in response has made HIV to face serious challenges in detection of infected people and retain them on sustainable care and treatment. In addition, the geopolitical situation of some countries in this region such as war, political instability and tense security situation will add to the complexity hence difficulty in service delivery and effective response.

Linkage of TB and HIV is one of the most important challenges in controlling of these two diseases due to TB-HIV co-infection, according to WHO and UNAIDS estimation that about 14% of HIV positive people have a co-infection with TB. In addition, TB is prevalent in prisons inmates and People Who Inject Drugs (PWIDS) that are also two of the most at risk groups of HIV.

As mentioned above, another big challenge affecting the health system is the risk of MDR-TB in the region for which regional collaboration and engagement with neighboring countries can be the most effective way to overcome this problem. Apart from health-related concerns, reinforced cycle of poverty along with the progress of diseases is also another barrier in combating HIV, TB and Malaria.

The efforts devoted in I.R. of Iran resulted in effective control of Malaria in almost all parts of the country and rare outbreaks. However, the risk of re-introduction due to the impact of cross-border population movement on transmission of the disease is always a big issue. For instance, 76% of total Malaria cases in I.R. of Iran are found along the border areas shared with Pakistan and Afghanistan. I.R. of Iran is hosting a very high number of refugees and migrants estimated to be more than 3 million. Cross border population movement and entrance of unauthorized immigrants, especially from the eastern border districts who illegally work and reside in rural areas, suburbs and marginalized areas of cities, is the main driver of the risk. As reported by Center for Disease Control in 2015, 14% of the target foci and 26% of the target population, about 8.7 million people, are affected by population movement. And in the case of TB, the affected population amounts to be 16.6 million people which comprise 23% of the total population in the country.

Regional Grant Objective

It is obvious that no country can protect the health of its citizens in isolation. The targeted countries encounter diverse and rapidly changing patterns of HIV transmission. This region includes Afghanistan as the world's largest producer of opium and heroin. I.R. of Iran, Afghanistan, Pakistan as well as CIS countries have high burden of opioid use and dependence. Afghanistan has high levels of domestic consumption of opium, heroin and pharmaceuticals. Injecting drug use is driving HIV epidemics in all targeted countries. IDU has been gaining increasing importance as a main attribute to HIV transmission in most of the countries. Given these facts, implementing a Harm Reduction Programme can help the target countries to effectively control HIV epidemics.

The similarity of main challenges, risks and vulnerabilities of the most at risk populations and related response as well as geographical and cultural linkage of these countries put them in the position of potentially benefiting from creation of a network to share best practices and reinforce achievements. Countries in this sub-region have different levels of capacity in terms of health system, community and civil societies including NGOs engagement, information management, infrastructure and technical expertise. The proposed project will establish a network supporting these countries to share their knowledge and experiences as well as health system infrastructures and capacities in response to the three diseases and to include broader themes like sustainable and resilient health systems overall – beyond the three diseases.

This network can maximize focus, quality and coverage of integrated national investments in HIV, TB and Malaria related services and avoid duplication through synergy resulted from this collaboration.

Moreover, the network is an opportunity to build an effective south-south cooperation platform shaping regional pool of technical expertise, training materials, documented experiences to be shared among countries as part of regional capacity building.

The above-mentioned network will be established to achieve the following five objectives:

Knowledge sharing and exchange of best practices and lessons learned among targeted countries through strengthening partnership, advocacy, communication and capacity building;

Enhancing bilateral/multilateral case management, HIV Harm Reduction Programme, strengthening integrated Health Information System with an aim to have better access to high risk population as well as timely reporting of the cases and outbreaks;

Strengthening prevention, care and treatment coverage and surveillance systems in borders through provision of TB and Malaria integrated services building into/upscaling existing infrastructure;

Facilitating civil society advocacy and support to to the government efforts for a sustainable response, which includes: NSP that reflects the epidemiology and the needs of the populations to be served; and advocates for sufficient domestic resources for health, strategy to raise other sources beyond GF.

Promoting and increasing access through fostering an enabling environment – reducing stigma and discrimination and reviewing legal and regulatory frameworks which keeps people away from seeking services.

Table 1. overview of HIV, TB and Malaria is selected countries in the Southwest and Central Asia region

Country	Income level	Population (Million)	Diseases burden			HIV prevalence status		TB status		Malaria status	
			HIV	TB	Malaria	Registered	Estimation	Notified (incidence)	Estimated (incidence)	Notified	Estimated
Armenia	Upper-LMI	3.017	H	M	L	1,953	4,000	1,104	1,200	Malaria Free	NA
Afghanistan	LI	27.5	H	S	M	<.05%	6,900	37,001	61,000	61,362	180,000-300,000
Azerbaijan	UMI	9.5	H	S	M	4,444	10,402	7,501	6,800	0	NA
Iran	UMI	79	H	L	M	31,950	73,000	10,399	13,000	365	As notified
Iraq	UMI	36.423	L	M	M	269	NA	8,255	16,000	0	NA
Kyrgyzstan	Lower -LMI	5.8	H	S	M	5,505	25,000	7,833	8,500	NA	NA
Pakistan	Lower -LMI	188	H	S	H	<1%	91,340	331,809	510,000	275,149	1,000,000-2,100,000
Tajikistan	Lower - LMI	8.20	H	S	M	5,550	14,000	6,232	7,400	NA	NA
Turkmenistan	UMI	5.3	L	L	L	------	-----	NA	3,800	NA	NA
Uzbekistan	Lower - LMI	30.24	H	S	M	30,315	37,295	19,055	24,000	NA	NA
Total		**392.9800**					**261,937**	**429,189**	**651,700**	**336,876**	

Dr. Mohsen Asadi-Lari

Acting Minister for International Affairs, Ministry of Health & Medical Education, I.R. Iran

Professor of Epidemiology

Board Member

Her Excellency Dr. Adeela Hammoud Hussein

Minister of Public Health & Environment, Iraq

Alternate Board Member

Dr. Omid Zamani

Affiliated Researcher, HIV/STI Surveillance Research Center

Constituency Focal Point