International HIV/AIDS Alliance

Supporting community action on AIDS in developing countries

DON'T STOP NOW:

HOW UNDERFUNDING **THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA** IMPACTS ON THE HIV RESPONSE

HASAB

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International HIV/AIDS Alliance in South Sudan

Alliance ZAMBIA
Supporting Community Action for Health

Zimbabwe AIDS Network

The International HIV/AIDS Alliance

The International HIV/AIDS Alliance supports communities in developing countries play a full and effective role in the global response to HIV/AIDS. It is a partnership of 37 Linking Organisations (national, independent, locally governed and managed NGOs) around the world that support approximately 2,000 community organisations delivering HIV prevention, treatment and care services to just under 3 million people.

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ABBREVIATIONS AND ACRONYMS

ART	antiretroviral treatment
CBOs	community-based organisations
CHBC	community- and home-based care
CIDA	Canadian International Development Agency
DFID	Department for International Development
G20	Group of 20
HASAB	Health and Social Action Bangladesh
IDH	Instituto para el Desarrollo Humano
IEC	information, education and communication
LGBTI	lesbian, gay, bisexual, transgender and intersex
MARPs	most-at-risk populations
MSF	Medicins Sans Frontieres
MSM	men who have sex with men
NGO	nongovernmental organisation
OIs	opportunistic infections
PLHIV	persons living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
RCC	Rolling Continuation Channel
SIDA	Swedish International Development Agency
TB	tuberculosis
TFM	Transitional Funding Mechanism
UN	United Nations
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization
ZAN	Zimbabwe AIDS Network

EXECUTIVE SUMMARY

A crisis for the Global Fund or a crisis for everyone?

In November 2011, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) announced that its' next scheduled funding round was cancelled and that no new grants could be funded until 2014. This news hit just as major scientific breakthroughs and signs of real progress in hard-hit countries were starting to generate the most widespread optimism in the history of the AIDS epidemic. Now, all hopes of entering a new phase of the HIV response are effectively put on hold until at least 2014, and progress on many fronts may actually be reversed. The effects on individuals and communities will be devastating.

This report draws on recently collected field data from numerous countries where the International HIV/AIDS Alliance operates to explain why the funding crisis requires urgent action on the part of Global Fund donors and all other stakeholders. The Alliance's recommendations for responding to the crisis are based on our analysis of the implications of funding shortfalls in the following specific areas: HIV treatment; HIV prevention; care and support; services for key populations at higher risk of HIV infection; and efforts to create an enabling environment.

Particularly compelling evidence of the need for urgent action comes from in-depth country impact studies in five countries: Bangladesh, Bolivia, South Sudan, Zambia and Zimbabwe. Each of these countries was, until the funding crisis, making strong progress towards reducing HIV infections and AIDS-related deaths. The country impact studies document the many ways in which these countries' HIV responses are now endangered. For example:

- In **Bangladesh**, cancellation of Global Fund Round 11 means that the 20% planned increase in coverage of HIV services for most-at-risk populations will now not be possible; the national response to HIV will effectively stall.
- The cancellation of Round 11 leaves **Bolivia** with no means of scaling up HIV prevention services for key populations affected by HIV, including at-risk groups not currently being reached such as prisoners and indigenous people. Therefore an increase in HIV transmission amongst vulnerable populations is expected.
- In the new **Republic of South Sudan**, 80% of the national AIDS plan remains unfunded. South Sudan was counting on Round 11 to cover antiretroviral treatment costs and to fund a nascent HIV prevention strategy facing extra stress from returnees from neighbouring countries with high HIV prevalence.
- In **Zimbabwe**, an earlier Global Fund grant has funded care and support services in every district, including mobilising clients for HIV testing, positively contributing to treatment adherence, and providing incentives, equipment, and training for caregivers. The funding crisis puts all of these services in jeopardy.

- In **Zambia**, where 80% of tuberculosis (TB) patients are HIV-positive, Round 11 funding was seen as critical for strengthening TB/HIV services. Priorities include strengthening intensified TB case finding and TB diagnostic capacity, as well as scaling up isoniazid preventive therapy. Failure to fund these services will threaten hard-won recent progress in reducing HIV-related deaths.

In short, the scale-up of the worldwide HIV response will be seriously affected and important existing services will be reduced or eliminated in the absence of urgent measures. If the global community is to prevent this enormous setback threatening the health and lives of millions of people – and realise the numerous commitments made by United Nations member states through the Millennium Development Goals and at the 2011 High Level Meeting on AIDS – then swift and decisive action is imperative.

For donors and other stakeholders to reduce funding for the HIV response in difficult economic times is short-sighted and counterproductive. While trillions of dollars have been found by governments to bail out the reckless financial sector, donors have left the Global Fund short of the funds it needs to save millions of lives. The Global Fund is the best mechanism the world has for realising the possibility of a world without AIDS but can only do so with sufficient investment.

AS WE APPROACH THE 10TH ANNIVERSARY OF THE GLOBAL FUND, THE INTERNATIONAL HIV/AIDS ALLIANCE URGENTLY CALLS FOR DONORS AND NATIONAL GOVERNMENTS TO RESPOND TO THE FUNDING CRISIS:

1. **Donors must honour existing pledges and increase investment to provide the Global Fund with financing (approximately $2 billion) for a new funding opportunity in 2012.**
2. **National governments must increase investment in their own HIV responses and in the implementation of national AIDS strategies that reflect the epidemiology in their countries.**
3. **Bilateral donors must take immediate steps to fill critical HIV service gaps that will not be covered by existing funding mechanisms.**

DON'T STOP NOW: HOW UNDERFUNDING THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA IMPACTS ON THE HIV RESPONSE

Why the Global Fund funding crisis is a crisis for everyone

For most of 2011 there was a strong sense that we had made real global progress in the HIV response. The latest UNAIDS data showed considerable progress in curbing the global pandemic. In 2010 new HIV infections had dropped to their lowest levels since 1997, a further 1.35 million people were receiving antiretroviral treatment (ART), and there was a strong possibility of eliminating new HIV infections in children by 2015.[1] In addition, there was a buzz of excitement about the incredible possibilities that lay ahead. The new Investment Framework[2] presented by UNAIDS and the landmark research on the effectiveness of treatment as prevention[3] together demonstrated that for the first time in the history of the HIV epidemic, it is conceivable to realistically plan for a world without AIDS. In June 2011, United Nations (UN) member states made strong commitments at the UN General Assembly High Level Meeting on AIDS, which established ambitious targets such as reaching 15 million people with treatment by 2015 and reducing new infections by 50% within the same time period.[4]

The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), which has made direct investments in 150 countries, has been central to achieving many gains to date. The Global Fund provides about two-thirds of total international funding for tuberculosis (TB) and malaria services, and one-fifth for HIV services.[5] It plays a crucial role in strengthening and linking health systems and community systems in order to ensure that programmes can be sustainable, mutually supportive, and effectively scaled up. The Global Fund also has been a powerful force in advancing human rights and placing people infected with and affected by HIV on decision-making bodies such as Country Coordinating Mechanisms, with particular attention to the inclusion of those most vulnerable to human rights violations such as people living with HIV, sex workers, men who have sex with men (MSM), and people who inject drugs. These principles and approaches are embodied in the widely welcomed new Global Fund Strategy 2012–2016[6], which aims to save 10 million lives by 2016.

As the main multilateral funding mechanism for global health, the Global Fund has had staggering success over the last decade, saving more than 7.7 million lives to date (see box). Therefore, the global health community looked forward to celebrating the 10th anniversary of the Global Fund on January 28, 2012.

SNAPSHOT OF THE GLOBAL FUND'S ACHIEVEMENTS

As of December 2011 the Global Fund estimates that programmes it supports are:

- saving an estimated 100,000 lives every month
- preventing thousands of new HIV, malaria and TB infections
- funding ART for 3.3 million people (half of all those in need of treatment in poor countries)
- enabling 1.3 million mothers to receive treatment to prevent transmission of HIV infection to their infants.

1. *World AIDS Day Report 2011, How to get to zero: Faster, Smarter, Better*, UNAIDS (2011).

2. 'Towards an improved investment approach for an effective response to HIV/AIDS', Schwartländer et al, *The Lancet* Vol. 377 Issue 9782 pp. 2031_2041, (11 June 2011); see also 'What is the Investment Framework for HIV/AIDS and what does it mean for the Alliance: Discussion paper', available at: www.aidsalliance.org/includes/Publication/Discussion%20paper%20investment%20framework.pdf, International HIV AIDS Alliance (12 Aug 2011).

3. HTPN 052 – 'A Randomized Trial to Evaluate the Effectiveness of Antiretroviral Therapy Plus HIV Primary Care versus HIV Primary Care Alone to Prevent the Sexual Transmission of HIV-1 in Serodiscordant Couples'. Available at: www.hptn.org/Web%20Documents/HPTN_Protocols/HPTN052/HPTN052v1.pdf, HIV Prevention Trials Network (July 2011).

4. *Political Declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS*, 10 June 2011.

5. The Global Fund website, www.theglobalfund.org/en/ (Jan 2012).

6. The Global Fund Strategy (2011) Available at: www.theglobalfund.org/en/about/strategy/

However, the 25th Global Fund Board meeting in November 2011 concluded with the shocking announcement that the Global Fund cannot fund new grants. Many countries were finalising Round 11 grant applications for consideration in 2012; now no new grants are expected to be disbursed until 2014. Although existing grants will continue to be financed through a Transitional Funding Mechanism (TFM),[7] the Global Fund will not be able to support any new HIV, TB or malaria services. The circumstances that brought about the funding shortfall will not be relayed here, but a short overview of key factors is presented in Appendix 1.

This news pulled the rug from beneath the feet of the global HIV response just when there was the most widespread optimism in the history of the epidemic. Now, all hopes of entering a new phase of the HIV response are effectively put on hold until at least 2014, and progress on many fronts may actually be reversed. The effects on individuals and communities will be devastating. Furthermore, the funding crisis significantly undermines the global effort to meet the Millennium Development Goals by 2015.

To reduce funding for the HIV response in difficult economic times is short-sighted and counterproductive. Sustained, predictable and well-targeted investment is critical for continued progress in reducing HIV infections and AIDS-related deaths. This principle guided how the Global Fund was conceptualised at the outset, and it continues to be implicit in the 2012–2016 strategy. The 2011 UNAIDS Investment Framework combines this approach with the recognition that we finally have enough evidence-based tools for an effective HIV response. It uses mathematical modelling to show that by increasing targeted investments over the next five years we can reach a tipping point where HIV infection rates and AIDS-related mortality rates have both dropped enough to bring about a decline in the investment needed to respond to the epidemic.

The Global Fund is the best mechanism the world has for actualising this exciting vision, and the global economic crisis only underscores the need to pursue the most cost-effective strategies for bringing the HIV pandemic under control as quickly as possible. Yet while trillions of dollars have been found by governments to bail out the reckless financial sector, comparatively little effort is being made to increase the relatively small amount of needed investment in the Global Fund. As we approach the 10th anniversary of the Global Fund, we urge donors to recognise the short-sightedness of not responding adequately to this situation, and to change course before the achievable goal of a world without AIDS slips away.

How the Global Fund is managing its financial situation

A late accounting before the 25th Global Fund Board meeting revealed that not enough money was available to fund new grants until 2014, or even to fund the upcoming renewal of all existing grants. Consequently the Board implemented a number of redistributive measures aimed to ensure availability of some contingency funding between 2011 and 2013.

New criteria[8] have cut funding to higher-income countries and to non-priority or lower-impact interventions. Group of 20 (G20) member countries are ineligible for funding, with an exception being made for South Africa because of its severe disease burden. Funding available to other upper-middle-income countries with high disease burden is limited to a targeted funding pool. Unspent funds and funds for non-priority and low-impact interventions will be reclaimed rather than reprogrammed in countries. All of this – plus no new grant funding – has resulted from a $2 billion funding gap.

The redistributive measures have freed up money that will now be disbursed through the Global Fund's newly established TFM.[9] Countries facing service disruptions between January 2012 and March 2014 as a result of previous Global Fund grants ending within this period can apply for TFM funding to preserve the most critical HIV, TB, and malaria services. Seventy-five countries are eligible to seek this support.

According to the December 2011 *Transitional Funding Mechanism information note*[10],the TFM's limited pool of money can only be used for "the continuation of essential prevention, treatment, and/or care services" for which "no alternative sources of funding [are] available to fund the activities proposed, including through reprogramming." Crucially, the TFM guidelines do not allow for any scale-up; funding is only available for existing services. This means that in countries with grants coming to an end, many people already waiting for life-saving HIV treatment, as well as those newly identified as needing treatment, will not benefit from Global Fund resources for at least two years. Unless the situation changes, millions of people will die waiting for access to treatment.

The TFM applies the same eligibility and prioritisation criteria as have been applied for Phase 2 grant renewals. The definition of 'essential services' is based on the core programme activities identified in the UNAIDS Investment Framework.[11] However, it is widely recognised that in reality the priorities will be maintaining access to ART for those already on treatment and maintaining access to other key

7. Differing opinions have been expressed since the announcement of the cancellation of Round 11 as to whether the Global Fund and the broader HIV response is actually in a funding crisis. Some have misrepresented the situation by saying that the Global Fund has no money even for existing programmes. The Global Fund secretariat and some Board members rightly point out that the Global Fund still has a large amount of funding in its Trust Fund and will still disburse between $9.5 and $10 billion to existing grants in 2011–2013. This is an important clarification but this does not mean there is not still a crisis – as we shall make clear.

8. Eligibility, prioritization and counterpart financing policy, http://www.theglobalfund.org/en/application/process/eligibility/, The Global Fund (2011).

9. This is essentially an extension of the already existing 'Continuation of Services' mechanism.

10. TFM information Note, http://www.theglobalfund.org/en/application/infonotes/, The Global Fund (Dec 2011).

11. The six core programmatic areas identified in the UNAIDS Investment Framework are: 1) Treatment, care and support; 2) PMTCT; 3) condom promotion; 4) Male circumcision; 5) Behaviour Change and Communication 6) Services for Key populations.

medicines, commodities, and medical services.[12] Many urgently needed services are unlikely to find funding within the TFM – for example, basic programmatic activities such as HIV care and support appear not to have been deemed 'essential' by the Global Fund. Important advocacy and legal work to combat stigma and discrimination and to enable people to access services will probably also go unfunded. Work on building synergies with other sectors to provide a holistic and integrated approach to improving people's health and well-being and addressing many of the drivers of the pandemic – such as interventions focusing on social protection, education, and gender equality – will fall by the wayside.

What reduced support means for the poorest people affected by HIV, TB, and malaria

For many organisations delivering HIV services on the ground, the scale and scope of their work are often made possible by Global Fund grants. This is certainly true of the International HIV/AIDS Alliance (the Alliance), a global partnership of 37 national, independent, locally governed and managed Linking Organisations[13] operating in more than 40 countries in Africa, Asia, Eastern Europe, Latin America, and the Caribbean. The Alliance acts on many fronts, delivering integrated HIV testing, prevention, and treatment services to millions of people every year (2.9 million in 2010). The Alliance mobilises communities – those closest to the epidemic – to respond to and halt AIDS.

The Alliance conducted a survey of its Linking Organisations to determine how the cancellation of Round 11 and the ongoing Global Fund cuts are affecting their ability to provide HIV services. Initial survey findings indicate that for 40% of Linking Organisations (15 of 37), the funding crisis has serious implications, either because the Linking Organisations will experience cuts in Phase 2 funding of current Global Fund grants or because they were counting on Round 11 funding.

The survey was accompanied by more in-depth country impact studies in Bangladesh, Bolivia, South Sudan, Zambia and Zimbabwe. Findings from the survey and country impact studies, summarised below, informed the recommendations presented in this report. The country impact studies are presented in greater detail later in the report.

Phase 2 renewals

Cuts have already started and more will be made in Phase 2 renewals of current grants, with as many as 70 (of the total 150 funded) countries potentially being affected between now and 2014. In the absence of additional resources, the Global Fund has needed to budget on the basis of 'savings' generated by these cuts. It is seeking a 25% efficiency saving from the overall budget allocated for the whole set of Phase 2 renewals; this would come from the cancellation of grants that are not performing and from cuts to underperforming elements[14] of otherwise well-performing grants. In addition, a further 10% to 20% of grant budgets is expected to be saved by excluding lower-impact interventions from well-performing grants, rather than reprogramming the money.[15]

Nine Alliance Linking Organisations[16] that are Global Fund Principal Recipients or Sub-Recipients will face Phase 2 renewal negotiations, including Linking Organisations in four of the countries where the Alliance conducted impact studies. While the final effects of the cuts will not be clear until countries have completed the funding renewal process, there are already very problematic developments. For example, Zimbabwe has been told to cut $25 million from its Round 8 renewal request in order to sustain ART services; this will inevitably mean deprioritising other key programmes such as behaviour change communication and health workforce strengthening.

Round 11 cancellation

The biggest impact on organisations, services, and individuals will be felt as a result of the cancellation of Round 11 as there will be no new funding in 2012 or 2013. A recent UNAIDS survey of the impact of the Global Fund crisis showed that at least 55 countries had started developing or were planning to submit Round 11 HIV applications.[17] All five of the countries where the Alliance conducted impact studies were developing Round 11 HIV proposals, and it is clear that the loss of this opportunity will dramatically limit key HIV services in those countries. Outlined below are some of the consequences for treatment, prevention, and care and support services, as well as consequences for key populations and for interventions that create an enabling environment ('critical enablers'[18]).

12. The TFM guidelines state that "In the case that there is not enough money to meet demand, interventions that fall within the Continuation of Services policy will be prioritized." The Continuation of Services policy states the following is funded: (i) Medicines; PMTCT activities and Opioid Substitution Therapy; (ii) Diagnostic tests for patients currently under ARV and TB therapy; (iii) Human resources directly linked to the delivery of services for existing patients; (iv) Other ongoing direct costs (e.g., delivery and storage of drugs,); (v) Limited and critical operational costs to deliver and store drugs and comply with Global Fund reporting requirements during the COS period.

13. Linking Organisations receive technical and financial assistance from the Alliance Secretariat. In turn, the Linking Organisations provide support to more than 2,000 community-based organisations.

14. For example, a particular Principal Recipient or Sub-Recipient that had a consistently low rating with no remedial action taken.

15. For example, this might refer to an intervention that does not respond effectively to the nature of the epidemic (e.g. mass media behaviour change communication in a concentrated epidemic), or to interventions that are not meeting the planned targets.

16. All nine Alliance Linking Organisations that are Principal Recipients and sub-recipients have had consistent A and B+ ratings.

17. Unpublished UNAIDS survey (Dec 2011).

18. Specific priorities around HIV programming outlined in the UNAIDS Investment Framework.

Treatment

While HIV treatment will remain a top priority with the limited funds available, the cancellation of Round 11 means that the Global Fund will not finance the scale-up of treatment to provide ART to larger numbers of people. Nor will it support countries in the implementation of World Health Organization (WHO) treatment acceleration or regimen improvement recommendations.[19] The tragedy of not providing ART to those in need takes on even greater proportions in the context of the groundbreaking research findings that emerged in 2011: the HTPN 052 study persuasively demonstrated that HIV-positive people who adhere to treatment are 96% less likely to infect HIV-negative sexual partners.

The impact of Global Fund cuts on treatment has been well articulated in the Medicins Sans Frontieres (MSF) paper *Reversing HIV/AIDS? How advances are being held back by funding shortages*.[20] Our country impact reports illustrate two striking examples that complement the case presented by MSF. In Zimbabwe, one donor funding stream, the Expanded Support Programme,[21] covered 80,000 people on ART until it closed in 2011. Without Round 11 funding, it is anticipated that Zimbabwe will not only be unable to further scale up ART but also will fail to sustain current ART coverage. In the new Republic of South Sudan, 80% of the national AIDS plan remains unfunded; health leaders were counting heavily on Round 11 to cover ART costs.

The immediate impact of the cancellation of Round 11 can be assessed most straightforwardly with medically-based indicators of ART need and coverage. It is important to recognise that other less directly quantifiable consequences may be equally devastating. Constraints on access to treatment will reduce the incentive to undergo HIV testing, and cutting funding for treatment literacy and adherence support will also contribute to undoing much of the progress made on reducing HIV-related deaths.

Prevention

Our country impact studies have shown how the cancellation of Round 11 will bring about huge HIV prevention setbacks. In Bolivia, it was hoped that Round 11 funding would support epidemiological research that would have provided important insight into how to target prevention interventions for most-at-risk populations (MARPs).[22] Now this research will most likely not happen. The cancellation of Round 11 also means that Bolivia will not be able to scale up crucial prevention services for key populations affected by HIV, including MSM. Therefore an increase in HIV transmission amongst those populations is expected. The Republic of South Sudan has a nascent prevention strategy desperate for funding, and was relying on Round 11. The prevention strategy is part of a largely unfunded but fully costed and credible National AIDS Strategic Plan. This situation would not exist if countries honoured the pledge made in UN Member States' 2006 Political Declaration on HIV/AIDS to "provide the highest level of commitment" to ensure that "costed, inclusive, sustainable, credible, and evidence-based national HIV/AIDS plans are funded and implemented with transparency, accountability, and effectiveness, in line with national priorities"[23] – a commitment reaffirmed in the 2011 Political Declaration on HIV/AIDS.

Care and support

While it has been more difficult to determine the effects of the cancellation of Round 11 on care and support so far, one point is very clear. The Global Fund's *Transitional Funding Mechanism information note*[24] does not include care and support within essential services. This is incredibly short-sighted because psychosocial, physical, nutritional, and socio-economic support are all indispensible for ensuring the effectiveness of lifelong antiretroviral treatment. Furthermore, in settings where the scale-up of ART is stalling, care and support will be critical for keeping many HIV-positive people alive until they are able to access treatment.

In Zimbabwe, a Global Fund Round 8 grant has funded care and support services in every district, including mobilising clients for HIV testing, positively contributing to treatment adherence, and providing incentives, equipment, and training for caregivers. If none of these services are eligible for TFM support, it is unclear where funding to maintain them will come from. The same is true for the Republic of South Sudan, which had planned to include the provision of home-based care in its Round 11 proposal. TB/HIV services also look to be in danger. In Zimbabwe, where 80% of TB patients are HIV-positive, a failure to fund these services will threaten all gains made to date in reducing HIV-related deaths. In Zambia, Round 11 was seen as critical for strengthening intensified TB case finding; improving both remote and facility-based TB diagnostic capacity; and continuing to scale up isoniazid preventive therapy.

Key populations

As all of those involved in the HIV response now recognise, ensuring the provision of HIV services to key populations at higher risk of infection – particularly sex workers, people who

19. *Antiretroviral therapy for HIV infection in adults and adolescents: Recommendations for a public health approach*. WHO, (2010). Treatment acceleration refers to timely provision of ART at CD4<350 rather than only CD4<200. Treatment regimen improvement refers to the preferred use of the first-line drug Tenofovir, which has less side-effects and better outcomes for patients.

20. MSF (2011). *Reversing HIV/AIDS? How Advances are being held back by funding shortages*. Available at: www.msfaccess.org/sites/default/files/MSF_assets/HIV_AIDS/Docs/AIDS_Briefing_ReversingAIDSupdate_ENG_2011.pdf

21. The Expanded Support Programme is funded by the Canadian International Development Agency (CIDA), the Department for International Development (DFID), Norwegian Aid, Irish Aid and the Swedish International Development Agency (Sida).

22. The International HIV/AIDS Alliance (2011). Available at: www.whatspreventingprevention.org/wp-content/uploads/2011/05/WPPTransgenderBriefing.pdf

23. UNAIDS (2006), *Political Declaration on HIV*. Available at: http://data.unaids.org/pub/Report/2006/20060615_hlm_politicaldeclaration_ares60262_en.pdf. 38. Pledge to provide the highest level of commitment to ensuring that costed, inclusive, sustainable, credible and evidence-based national HIV/AIDS plans are funded and implemented with transparency, accountability and effectiveness, in line with national priorities.

24. www.theglobalfund.org/en/application/infonotes/

inject drugs, and MSM – is an imperative. The new Global Fund Strategy has a strong component on key populations. Until now, the Global Fund, often working closely with civil society, has played an essential role in the provision of services to key populations because governments in many countries are unwilling to spend funds on groups whose practices are often politically unpopular or illegal. In light of bans on needle exchange programmes from major global health donors like the US government, the Global Fund's financing of this work has taken on even more importance.

In countries with concentrated epidemics like Bolivia, where key populations make up a large percentage of those infected with HIV, the cancellation of Round 11 will hit key population groups hardest. Services for MSM and other sexual minorities are likely to be curtailed, particularly in the areas of HIV prevention, social marketing, and peer education. There will now be no opportunity to expand valuable outreach work to other populations that do not currently have access to formal health establishments – prisoners, people living on the streets, young adolescents, and indigenous people. In Bangladesh, the cancellation of Round 11 means that the 20% planned increase in coverage of HIV services for most-at-risk populations will not be possible and that the national response will effectively stall.

Critical enablers and development synergies

Lastly, the Round 11 cancellation will likely hamper efforts to create an enabling environment for basic programme activities and services to be effective and maximise value for money. In the UNAIDS Investment Framework, these interventions are called 'critical enablers'. They include community mobilisation, stigma reduction, advocacy and legal support, efforts to prevent gender-based violence, and community centred design and delivery. In addition, important interventions that cross over with other sectors and foster integration of HIV services within broader health and development services also look likely to be sidelined. These are known as 'development synergies' in the UNAIDS Investment Framework and refer to interventions such as social protection, sex equality, education, justice, health and community systems strengthening. With barely enough money for basic programme activities, it appears that both critical enablers and development synergies will suffer from underfunding or non-funding.

It is usually community service organisations, networks of people living with and affected by HIV, and key population groups and networks that deliver many of these interventions. In an already highly constrained funding environment, the Global Fund cuts will place extreme financial strains on many of these organisations, including Alliance Linking Organisations. If providers of critical services close their doors, it will be the poorest people living with and affected by HIV who will feel the full force of the impact.

Country impact studies

To try to gain a better understanding of the impact of the financing crisis we conducted in-depth country impact studies in five countries: Bangladesh, Bolivia, South Sudan, Zambia, and Zimbabwe (see Appendices 2–6). The studies focus on the impact in relation to HIV. We hope that further country studies will emerge in the coming months to emphasise the impact on TB and malaria services.[25]

The country impact studies were conducted in a very short time frame in order to release this report in time for a proposed meeting of African Leaders to discuss the HIV funding crisis at the end of January. Inevitably this means that many of the consequences of the Phase 2 budget cuts and the cancellation of Round 11 are only just starting to be felt or can only be estimated. Even so, we feel that the following findings demonstrate conclusively the extent of the impact that will be felt by millions of people infected with and affected by HIV.

25. The Stop TB Partnership is currently conducting an in-depth study

Responding to the funding crisis: Alliance recommendations

This report has discussed the extent and nature of the crisis resulting from the Global Fund financial shortfall. In the absence of urgent measures, the scale-up of the worldwide HIV response will be halted and important existing services will be reduced or eliminated. If the global community is to prevent this enormous setback threatening the health and lives of millions of people – and realise the numerous commitments made by United Nations member states through the Millennium Development Goals and at the 2011 High Level Meeting on AIDS – then swift and decisive action is imperative.

Recognising that important improvements are needed in how the Global Fund operates, and that these improvements are currently being implemented,[26] the International HIV/AIDS Alliance urgently calls for donors and national governments to respond to the funding crisis as follows:

1. Donors must honour existing pledges and increase investment to provide the Global Fund with financing (approximately $2 billion) for a new funding opportunity in 2012.
2. National governments must increase investment in their own HIV responses and in the implementation of national AIDS strategies that reflect the epidemiology in their countries.
3. Bilateral donors must take immediate steps to fill critical HIV service gaps that will not be covered by existing funding mechanisms.

1

Donors must honour existing pledges and increase investment to provide the Global Fund with financing (approximately $2 billion) for a new funding opportunity in 2012.

Global Fund donors:

- must turn existing pledges[27] into actual contributions and speed up their delivery.
- who have not yet made pledges, particularly G20 members, need to do so.
- need to host an emergency replenishment before the International AIDS Conference in Washington DC in July 2012. At a minimum, this can be a meeting of willing donors to fill the identified gaps left by Global Fund cuts.
- should increase possible funding sources for the global HIV response, including innovative funding mechanisms at the international level (particularly the Financial Transaction Tax that is being considered by the European Union, France, Germany, South Africa, Brazil, Argentina, Italy and Spain).

26. The Global Fund must have more effective financial early warning systems in place to ensure they can raise the alarm bell when donor commitments are not being met. Never again must we be in a position where life-saving programmes are cancelled or delayed, without contingency planning and support for affected countries. The Global Fund also needs to continue to increase its efficiency by further improving its governance and management systems and to restore confidence among implementing countries and partner organisations, as well as donors. The Alliance welcomes the measures that the Board has taken to respond to the findings of the High Level Panel, which highlighted deficiencies within the Global Fund structures on risk management and fiduciary controls.

27. On previous pledges the main focus of attention is on Italy, Spain and Ireland. The UK brought forward its remaining pledge in December 2011; Germany has stepped up to release EUR100 million and disburse EUR200 million in 2012, Canada honoured its $180 million disbursement and the European Commission provided EUR115 million in December 2011. Japan and the US have both recommitted to deliver their pledges but confirmation is needed from their parliaments.

2

National governments must increase investment in their own HIV responses and in the implementation of national AIDS strategies that reflect the epidemiology in their countries.

As many activists rightly declared at the December 2011 International Conference on AIDS and STIs in Africa, national governments need to step up and increase their funding of their own HIV responses. The Abuja Declaration calls for 15% of annual budgets to be allocated to health, of which HIV will be a significant percentage depending on disease burden.[28] Many countries have already considerably increased domestic funding for national HIV responses, and some almost completely finance their national HIV responses.[29] Others have made solid commitments to do so; Zimbabwe, for example, has committed to increasing its government contribution to the national HIV response from 20% in 2011 to 75% by 2015, and already utilises an innovative domestic AIDS levy to raise money for HIV treatment and prevention services.

Most governments of lower-income and middle-income countries with generalised epidemics such as the new Republic of South Sudan and Zambia are simply not in a position to increase their contributions to levels that would allow them to fully fund their national responses. In other cases, governments in middle-income countries have increased their contributions as bilateral donors have transferred more of their support to lower-income countries and fragile states. Bolivia has been gradually increasing its contribution over the last few years but limits funding to health systems strengthening rather than allocating resources to serve groups most affected by HIV. Bolivia's funding for HIV appears to be unlikely to increase any further. Other countries like Bangladesh must do much more – the Bangladesh government's contribution is extremely inadequate.[30]

National governments:

- must assume responsibility for a greater percentage of national funding for their HIV responses to reflect the epidemiology of the disease in that country.
- should explore alternative domestic funding sources for their national HIV responses, including innovative funding mechanisms (e.g. Zimbabwe's AIDS levy).
- should work closely with civil society, particularly key populations, to help civil society take on a stronger and more integrated role in national HIV responses.

National AIDS Committees:

- need to work closely with all key stakeholders – including civil society, key populations, and donors – to re-evaluate their national AIDS responses using the UNAIDS Investment Framework. This means finding funds for essential areas that are currently underfunded or unfunded, and reprogramming money from areas where interventions are unsupported by evidence or are irrelevant to their epidemiological context.

3

Bilateral donors must take immediate steps to fill critical HIV service gaps that will not be covered by existing funding mechanisms.

Although bilateral donors are understandably calling for greater domestic ownership and funding for future sustainability of the HIV response, ongoing bilateral support is still absolutely critical. The current situation does not relieve them of their responsibility to both deliver on commitments such as the pledge to ensure funding for credible national AIDS plans and to fill gaps left by the Global Fund shortfall.

There is a trend of bilateral donors consolidating their responses in-country, both in terms of directing investments to funding pools or baskets (which aids coordination) and moving away from HIV funding to broader health funding. Although this represents positive steps towards overall health systems strengthening, it is important to not ignore mechanisms for supporting community action on AIDS and leveraging the experience of the AIDS response for broader health gains.

Bilateral donors:

- must honour their commitment to ensure that no credible, costed, inclusive, and transparent national AIDS plan goes unfunded. In particular they should identify and fill the immediate HIV service gaps as a result of Global Fund cuts.
- must ensure greater predictability and sustainability for their funding.

28. OAU (2001), *2001 Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases*, p. 5. Available at: www.un.org/ga/aids/pdf/abuja_declaration.pdf

29. Brazil covers 99%, China has now taken on complete responsibility for its national AIDS response, Botswana funds close to 70% of its response, and the South African Government now funds up to nearly 80% of its response.

30. *Global Report*, UNAIDS, (2010).

CONCLUSION

Donors and others must act very quickly to maintain and scale up critical HIV services so that lives are not put at risk.

We cannot wait until 2014 for the Global Fund to support the further scale-up of HIV treatment and other life-saving interventions.

We urgently call on donors and affected countries to ensure that interventions with the highest impact on the epidemic are supported.

The clock is ticking. Millions of lives are at stake.

APPENDIX 1
WHY DID THE FUNDING CRISIS OCCUR?

The Global Fund Replenishment meeting (October 2010) held in New York for the period 2011–2013 produced only $11.7 billion in pledges, well below the stated high target of $20 billion and even below the agreed low (minimum 'maintenance' level) of $13 billion. At the time, the amount raised was still viewed favourably because it had increased the amount pledged from the previous replenishment meeting in 2007 in Berlin.

The Global Fund therefore planned the process for its next grant round (Round 11) on the basis of these projected funds. However, changing circumstances throughout much of 2011 led the Global Fund to recalculate its funding projections dramatically downward between September and November 2011, and it ultimately became apparent that there would not be enough money to fund Round 11 grants. By the time the Global Fund announced this news at its November 2011 Board meeting, applicants had already started developing Round 11 proposals for submission in March 2012. This was the first time a grant round had been cancelled in the history of the Global Fund.

While some mistakes were made in projections,[31] and the alarm surely could have and should have been raised on the funding crisis earlier, it would not have altered the reality of why the crisis occurred – namely donors decreasing, delaying, or back-loading contributions, or donors not making contributions at all, with decreases in investment income due to the economic recession making the problem even worse.

A range of reasons was reported for why donors behaved in this way. One of the main reported reasons (for the European Commission and countries such as Canada, Denmark, Germany, Norway and Sweden) was the discovery of corruption and mismanagement of grants in four recipient countries (Djibouti, Mali, Mauritania and Zambia), leading to concerns about whether the Global Fund could effectively oversee donor investments. These cases led the Global Fund to further strengthen its risk management, fiduciary controls, and governance. The Global Fund Board commissioned a High Level Panel that produced a report with wide-ranging recommendations in September 2011. The Global Fund produced a Consolidated Transformation Plan mapping how all of the identified changes would be made, and this plan is currently being implemented. Some donors withheld contributions but many of these have now contributed after seeing preliminary results of the implementation.

For other countries (e.g. Italy, Ireland, Japan, the Netherlands, and Spain) the main reasons were financial, with many citing budget constrictions due to the global recession.

EXAMPLES OF HARMFUL DONOR DECISIONS AND ACTIONS

- **Donors decreasing contributions:**
  - Denmark's contribution decreased by $10 million over three years to $86.5 million.
  - The Netherlands reduced its contribution (compared to Berlin Replenishment) to $218.2 million. Intense lobbying led to funds being partially restored.
- **Donors delaying contributions:**
  - Even while meeting their yearly pledges, many donors time their contributions to the last quarter of the year, which creates a shortfall in the earlier quarters and leads to delays in disbursements.
  - The European Commission 2011 contribution to the Global Fund was delayed due to concerns over Global Fund governance and was finally paid in December 2011, with an overall amount of EUR 115 million (EUR 65 million from the European Union general budget plus EUR 50 million from the European Development Fund).
- **Donors back-loading contributions:**
  - The US pledged $4 billion over three years but only paid $1 billion in the first year followed by $1.3 billion in 2012, then $1.65 billion in 2013 pending Congressional approval. Now the concern is that the actual contribution will be flat-lined by Congress to just $1 billion in 2012 and $1 billion in 2013.
- **Donors not making contributions:**
  - Italy, Spain, and Ireland all have outstanding payments for 2008–2010.
  - Italy and Spain failed to pledge at (or since) the last replenishment conference.

Whatever the reasons cited, the reality is that the funds required by each country to meet maintenance-level funding for the Global Fund are relatively so small that in most cases their decision not to prioritise saving lives in the poorest countries comes down to politics rather than finances. Donors must not be permitted to make such decisions with impunity. They have a responsibility to honour their existing funding commitments and provide sufficient additional funding to make it realistically possible to achieve the development targets they themselves have set. As laid out in the UNAIDS Investment Framework, it makes long-term financial sense to fully fund the response now because it will save money in the future. "Pay now or pay forever"[32].

31. For example, the whole of the US pledge was counted in calculations for this replenishment cycle even though the US fiscal year means that $0.6 billion of the US pledge will not be contributed until the next replenishment cycle.

32. Quote from Michel Sidibe, Executive Director, UNAIDS.

APPENDIX 2
COUNTRY IMPACT STUDY: BANGLADESH

SUMMARY

What the cancellation of Round 11 and the funding crisis mean for Bangladesh:

- Bangladesh's ART services are almost entirely funded by the Global Fund. The cancellation of Round 11 and cuts to Rolling Continuing Channel (RCC) grants will have devastating HIV prevention and treatment consequences for key populations as well as limiting harm reduction for people who inject drugs.
- The cancellation of Round 11 means that the approximately 20% planned increase in coverage of HIV services for MARPs will now not be possible.
- The poor performance of one RCC grant means that Phase 2 renewal is currently uncertain.
- Cuts in RCC Phase 2 would likely eliminate funding for civil society advocacy for people who inject drugs to access HIV and harm reduction services.
- Cuts in or the cancellation of RCC Phase 2 grants would likely mean that synergies with other sectors will no longer be supported, e.g. ensuring that HIV information is available in educational settings.

National epidemiology and current coverage

Bangladesh has a long history of strong political will that has guided the HIV response. Efforts to address the epidemic began four years before the first case of HIV had been detected in the country with the creation of the National AIDS Committee in 1985. Bangladesh has had three national strategic plans for HIV/AIDS. The first covered the period 1997–2002, the second covered 2005–2010, and the third covers 2011–2015.

There are an estimated 6,300 persons living with HIV (PLHIV) in Bangladesh.[33] While the prevalence of HIV in the general population is less than 0.1%,[34] HIV is concentrated among a few key populations. In addition, poverty, overpopulation, gender inequality, high in-country population mobility and high level of transactional sex are potential drivers of HIV infection that need to be addressed. Immigration to other countries for employment is also very common, particularly amongst younger people.[35]

Bangladesh is categorised as a low-prevalence country, with evidence of increasing HIV vulnerability amongst MARPs including people who inject drugs; MSM; female and male sex workers and their clients; and transgender/*hijra* groups. The prevalence of HIV amongst MARPs in Bangladesh is seven times higher than amongst the general population, at 0.7%. Although this figure is below 1%, survey data reveal that the prevalence of HIV is rising amongst these groups. The prevalence rate amongst people who inject drugs was approximately 7%, but up to 11% in certain areas of Bangladesh.[36] The overall prevalence rate amongst female sex workers, male sex workers and *hijras* was 0.3%; however rates amongst casual sex workers was as high as 2.7% in certain areas.

There are limited treatment facilities for PLHIV in Bangladesh. Less than 500 PLHIV are documented as currently enrolled on ART,[37] and ART roll-out is not available through the government health system as yet. In addition, the provision of diagnostic services for opportunistic infections (OIs) and

33. UNICEF, (2009).Available at: www.unicef.org/infobycountry/bangladesh_bangladesh_statistics.html
34. Ibid.
35. National AIDS/STI Programme, (2011), *Third NSP for HIV and AIDS Response 2011–2015 in Bangladesh*.
36. UNGASS (2010), *Country Progress Report: Bangladesh January 2008–December 2009*.
37. National AIDS/STI Programme, (2011), *Third NSP for HIV and AIDS Response 2011–2015 in Bangladesh*.

monitoring disease progression is very limited. Among public facilities, only Dhaka Infectious Diseases Hospital provides limited in-patient services for PLHIV.[38]

Currently, there is very limited HIV prevention coverage, especially prevention interventions for clients of sex workers, transport workers, factory workers, young people, and HIV-positive pregnant women.

The role of the Global Fund and proposed scale-up

The Third National Strategic Plan for HIV/AIDS provides a comprehensive framework to support the HIV response, but Bangladesh will require a significant scale-up in funding from both domestic and international sources if the goals in this plan are to be achieved. There have been three major HIV programmes implemented in Bangladesh with support from the World Bank, the US government and the Global Fund.

The HIV/AIDS Prevention Project, 2004-2007 and HIV/AIDS Targeted Intervention, 2008-2009 was supported by the World Bank-financed Health, Nutrition and Population Sector Program. It focused on intervention packages for six high-risk groups: people who inject drugs; brothel-based sex workers; street-based sex workers; hotel- and residence-based sex workers; clients of sex workers; and MSM, male sex workers, and *hijra* groups.

The Bangladesh AIDS Programme, 2005–2009 was funded by the U.S. Agency for International Development (USAID) and implemented by a range of agencies. The programme focused on supporting an effective HIV prevention strategy through improved prevention, care, and treatment services for MARPs. The programme ended in 2009, but then a new cooperative agreement with USAID led to its extension to 2013.

The Global Fund is a key donor in Bangladesh and the only funder of ART services. It has supported three programmes so far:

- A Round 2 grant (March 2004–November 2009) was focused on the prevention of HIV among youth and adolescents, amounting to $19.7 million.
- A Round 6 grant (Phase 1, May 2007–April 2009 and Phase 2, May 2009–April 2012) is focused on limiting the spread and impact of HIV by providing prevention services for MARPs; increasing coverage and quality of essential HIV services for MARPs; and improving the capacity of government and nongovernmental organisation (NGO) partners to deliver high-quality interventions.
- The Round 6 grant has subsequently been merged with three RCC grants for $3,354,432 (the Ministry of Health and Family Welfare is the Principal Recipient), $26,759,601 (Bangladesh Save The Children USA is the Principal Recipient) and $12,227,401 (International Centre for Diarrhoeal Disease Research Bangladesh is the Principal Recipient). The grants continue to allow for significant scale-up in prevention, treatment, care, and support services for MARPs. The targeted interventions under the RCC grants should reach approximately 50% coverage of total estimated people who inject drugs; 40% coverage of total estimated sex workers (hotel-based and floating); and 30% coverage of total estimated MSM and male sex workers. Phase 1 of the RCC grants runs from December

THE ROLE OF HEALTH AND SOCIAL ACTION BANGLADESH

- Health and Social Action Bangladesh (HASAB) has been operating for the past 12 years and is one of the leading national NGOs in Bangladesh devoted to HIV and broader health issues.
- HASAB was started as an Alliance Linking Organisation in 1994 and has emerged as a specialized agency in the HIV and sexually transmitted infection field with experience in grant management and capacity-building (technical, managerial, and administrative) of smaller NGOs, community-based organisations (CBOs), and faith-based organisations involved in HIV prevention, care, and support.
- HASAB has developed human resources for health including 15,869 government and NGO/CBO staff and master trainers and peer educators from the target community during the course of implementation of HIV programmes.
- HASAB has been implementing one of the 13 technical packages under the Global Fund grants covering 41 districts of seven divisions in Bangladesh. So far HASAB has provided approximately 800,000 young people with life skills education through 220 youth clubs/organisations and developed 224 health service delivery points for youth-friendly health services.
- HASAB had hoped to expand its work on children and youth with Round 11 funding.

38. Ibid.

2009 to November 2012. Thereafter the grants will need to be assessed for Phase 2, which, if approved, would run until November 2015. There are now growing concerns in Bangladesh as to whether all grants will be renewed for Phase 2 or whether there will be significant cuts (up to 40% could be expected). While both of the larger grants have been assessed as performing well, the most recent assessment of the RCC grant handled by the Ministry of Health and Family Welfare concluded that it is performing poorly. The RCC grant has received a C rating. The assessment also revealed that the grant expenditure has been only 15% of disbursements.

Bangladesh had made significant progress in preparing for Round 11. The aim of the Round 11 proposal was to fill existing gaps in HIV prevention, especially for MARPs. While final decisions had not been reached, it was envisioned that the Round 11 proposal could potentially focus on gaps in care and support for PLHIV (the care and support services under the RCC grants are likely to come to an end in 2012 following cuts), targeted services for returning external migrants and their wives (2011 data show that 65% of new HIV cases are from this group), and oral substitution therapy for people who inject drugs.

What the crisis means for Bangladesh

There is a strong chance that there will be significant cuts or even cancellation of the RCC Phase 2 grant, and this will severely impact on service coverage for MARPs.

In addition, the cancellation of Global Fund Round 11 will limit the availability of additional resources to fill this potential funding gap as well as the expansion of interventions already in place. For example a Round 11 grant potentially would have resulted in a scale-up in reach of approximately 20% for MARPs. Although Bangladesh is categorised as a low-prevalence country, HIV infection rates are rising amongst MARPs, and social and behavioural patterns threaten to exacerbate the spread of the epidemic and undermine the gains that have been made so far.

Bangladesh has a fully developed national strategic plan for HIV/AIDS but has been mostly reliant on the Global Fund since the completion of the World Bank programmes. Therefore there will be a major funding gap and potential service disruption as the Global Fund grants are winding down. For example, Bangladesh's ART services are fully supported and delivered through the Global Fund grant. The cancellation of Round 11 and the possible discontinuation of some RCC funding, therefore, will have devastating consequences on those newly requiring treatment beyond that provided by the existing grant. While Bangladesh's government has allocated some funds covering brothel-based sex workers and migrant workers under the Ministry of Health prevention program, implementation has been severely delayed.

APPENDIX 3
COUNTRY IMPACT STUDY: BOLIVIA

SUMMARY

What the cancellation of Round 11 and the funding crisis mean for Bolivia:

- Cancellation of Round 11 will disrupt the continuity of prevention activities for key populations such as MSM and lesbian, gay, bisexual, transgender and intersex (LGBTI) populations that are at the centre of the HIV epidemic in Bolivia.
- The recent classification of Bolivia as a middle-income country will further reduce the funds available from the Global Fund, while an increased contribution from the national government to cover this gap and match counterpart financing is unlikely, based on the current situation.
- It is presently unclear what consequences reprogramming of Round 9 Phase 2 funding to cover essential services will have on HIV prevention and support for MSM/LGBTI and sex workers.
- There is now no opportunity to expand the key MSM/LGBTI outreach work to other populations that do not currently access formal health establishments, such as prisoners, people living on the streets, young adolescents and indigenous people.
- There seems little possibility of achieving universal access to prevention, diagnosis, and treatment in key populations and the general population, with under-resourced activities including prevention of vertical transmission of HIV. Increases in HIV transmission rates are expected amongst MSM, LGBTI, and sex worker populations.
- Important investigations planned to provide insight into the HIV epidemic will be cancelled.

National epidemiology and current coverage

The first case of HIV was detected in Bolivia in 1984. By September 2011, 7,213 people had been diagnosed with HIV in Bolivia, and 744 are known to have died of AIDS-related illnesses.[39] Bolivia is considered to have a concentrated HIV epidemic, with an estimated prevalence of 21% among MSM.[40] The prevalence among the general population aged 15–49 is 0.16%.

According to the National HIV AIDS and STI Programme, by September 2011, 1,624 people living with HIV were receiving ART, mainly as a result of Global Fund support.[41] However, it is estimated that at least 5,700 more people require treatment and do not receive it. This low coverage of ART may be contributing significantly to the spread of HIV infection. Of the total number of cases diagnosed in Bolivia since 1984, almost 50% were reported between 2009 and 2011. Apart from actual growth in the HIV epidemic, this could also be attributed to better disease surveillance.

Only 7% of Bolivia's government-run health centres provide HIV counselling and testing. At the end of 2010, there were 305 testing and counselling facilities, the equivalent of six facilities for every 100,000 people.[42] Consequently, access to HIV testing is extremely poor, and is generally limited to pregnant women and commercial sex workers. In addition, there is a great need to revise and update the HIV testing protocol, and to oversee service quality when HIV tests are offered.[43] While good progress has been made in increasing ART coverage among HIV-positive pregnant women

39. Presentation made by the Director of the National Programme for HIV and STIs to civil society partners in December 2011.
40. WHO (2011), *Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access: Progress Report*. WHO: Geneva, 2011.
41. Ibid.
42. Ibid.
43. UNGASS (2010), *Civil Society Shadow UNGASS Report for Bolivia*.

diagnosed with HIV to between 89% and 100%, research shows that due to the poor access to HIV testing, only 27% of the total number of women estimated to be HIV-positive receive ART.[44]

The level of stigma and discrimination for PLHIV and MSM/LGBTI populations is high in Bolivia. Human rights violations of PLHIV and members of key populations are common, although perhaps under-reported. Violations occur in schools and universities, places of work, health facilities, and families, as well as within the legal system, armed forces, police, and media. In a study from the Defensor del Pueblo, persons interviewed identified people living with HIV as most discriminated-against population group.[45]

Currently, there are no government health services specifically aimed at MSM/LGBTI populations. However, an estimated 51% of MSM/LGBTI people do access tailored HIV prevention programmes that are provided by civil society groups. As a result, 35% of MSM/LGBTI people received results of an HIV test during the past 12 months, a figure higher than amongst pregnant women.[46]

These prevention efforts are beginning to bear significant results. For instance, the proportion of men who report using a condom during last anal sex with a male partner is 69%[47] and rising. The latest figures obtained in surveys of MSM and LGBTI populations, as part of the Global Fund Round 9 proposal, showed that the proportion of men using condoms with a male partner had increased to 81%. Similarly, the proportion of transgender people working as sex workers who reported condom use at last sex is almost 95%.[48] By September 2011, 1,583,391 condoms[49] had been distributed by civil society sub-recipients of Global Fund Round 9 funding, and by the National HIV and STD Programme through the Departmental Centres for Surveillance and Reference.

By September 2011, 1,267 members of MSM/LGBTI populations had been reached with HIV/AIDS behaviour change communication and awareness-raising training through the peer educator strategy. Subsequently, 94% of them could correctly identify methods for preventing sexual transmission of HIV, and rejected incorrect modes of transmission.[50] However, much more education work needs to be done with other groups. For example, only 23.6% of young men and women (aged 15–24)[51] and 48% of female sex workers[52] can identify correct methods for preventing sexual transmission of HIV.

The role of the Global Fund and proposed scale-up

Bolivia has one current Global Fund grant from Round 9 for $7,688,768. In 2009, the Global Fund covered 58.6% of the national AIDS response. The grant is currently in Phase 1, which started in September 2010. It will need to be renewed for Phase 2 on 1st September 2012, and is intended to run through August 2015. Association Ibis Hivos is responsible for the administration and activities related to the Round 9 HIV grant. The current grant supports important supplementary services, such as a mobile HIV testing and counselling unit that has provided services to 303 MSM/LGBTI. The Round 9 grant has also supported the training of peer educators across the country, the establishment of mutual support groups for people living with HIV, and condom access outside of the public Departmental Centres for Surveillance and Reference. During the first year of Round 9 implementation, 752 PLHIV received support for treatment adherence from peer educators. It is presently unclear what the consequences will be for Phase 2 of Round 9, but there is no doubt that prioritisation and grant reductions will be required, focusing on the Global Fund's definition of 'essential services'. It appears likely that interventions focusing on creating an enabling environment or developing synergies with other sectors may suffer.

What the crisis means for Bolivia

Bolivia was planning to apply for Round 11 and the National HIV AIDS and STI Programme had taken initial steps through the Country Coordinating Mechanism to map out key strategic and high-impact interventions. In addition, Bolivian organisations such as Instituto para el Desarrollo were planning to apply for a regional grant with the Latin American and the Caribbean Council of AIDS Services Organization. Overall, complementary Round 9 activities were planned, including a focus on HIV prevention and diagnosis in key populations such as LGBTI and other MSM.

The cancellation of Round 11 thus means that there will be a lack of continuity of important activities related to HIV prevention among the most affected populations, including LGBTI and other MSM. This is likely to have a negative impact, considering the epidemiological importance of these populations in driving the HIV epidemic in Bolivia. Prevention and outreach work with MSM/LGBTI is a key way

44. *Programa Nacional ITS/VIH/SIDA – MSD. Estimaciones y proyescciones*, EPP – Spectrum (2009).

45. *Así se ve en Bolivia la discriminación*, Defensor del Pueblo, La Paz (2007).

46. SEMVBO, 2008.

47. *Estudio Sexualidad Masculina y VIH en Bolivia*, SEMVBO (coordinated by the National Programme for HIV and STIs, and supported by Alliance LO, IDH, UNAIDS amongst others) (2008).

48. 'Diagnosis of transgender women working as commercial sex workers', UNFPA and MTN, 2009, cited in *Shadow UNGASS Report*, (2010).

49. Of these, 374,876 condoms were distributed to female sex workers, and 140,821 condoms to MSM/LGBT populations, by means of prevention activities carried out by civil society sub-recipients.

50. *Global Fund Principal Recipient KAP Survey,* (2011).

51. *Demographic Health Survey*, ENDSA (2008).

52. *Global Fund Principal Recipient KAP Survey*, (2011).

THE ROLE OF INSTITUTO PARA EL DESARROLLO HUMANO IN BOLIVIA

- Instituto para el Desarrollo Humano (IDH) is the Alliance Linking Organisation in Bolivia. It is an NGO that plays a significant role in dialogue and advocacy on HIV, addressing young people's HIV prevention needs, and defending the human rights of groups most affected by HIV.
- IDH has played a key role in the capacity development of organisations of PLHIV and of key populations. Important networks representing these populations, such as RedBol+ and the Mesa de Trabajo Nacional, were initially formed in Cochabamba, rather than the capital city La Paz. In part this is due to IDH's own location in this particular city and its involvement in the capacity development processes by which these organisations were established.
- IDH is an active participant in the Country Coordinating Mechanism (chair) but has not been a direct recipient of funds from previous Global Fund Rounds nor was it intending to apply as a recipient for the Bolivia Round 11 proposal. However, the organisation is concerned about the ramifications of the cancellation of Round 11 on key populations that it supports in Bolivia.

of reaching these populations, which often do not have good access to formal health establishments. It was hoped that this type of work could be expanded with Round 11 funding to work with other populations at risk including prisoners, people living on the streets, young adolescents, and indigenous people. This will not now be possible. Furthermore, there is a significant gap in universal access to treatment as well as prevention of mother-to-child transmission of HIV (PMTCT). An increase in the rate of HIV transmission may occur amongst MSM/LGBTI, which could also pose an increased risk in the general population. In addition, important studies programmed within Round 9 would give insight into the epidemic in different key populations; these could be jeopardised as well.

Government counterpart funding has increased steadily from $125,000 in 2005 (7.27% of HIV funding for the HIV response) to $936,587 in 2009 (21.53% of HIV funding), which is encouraging. However, government funds do not cover medications or condoms and as mentioned previously they do not provide tailored services for key populations through the public health system. The government mainly focuses on support through human resources and the operation of services. The crisis here, as with so many other countries now unable to access further Global Fund grants, is that no other donor is currently seen to fill this gap. For example, United Nations Population Fund will reduce funding for HIV considerably in 2012, with HIV becoming only a cross-cutting issue rather than a programme in its own right. In addition, USAID, which has been contributing close to $1 million annually in recent years, will no longer provide funding specifically for HIV.

Bolivia was recently classified as a middle-income country and as such the Bolivian government will be expected to significantly increase its financial commitment to tackle HIV. However, it is uncertain that the government will be able to increase its counterpart financing in keeping with this economic tier. There is also a risk that some bilateral organisations may reduce their presence and contributions to Bolivia because of this change in income classification, which will have incrementally dire consequences for HIV and other health issues.

APPENDIX 4
COUNTRY IMPACT STUDY: SOUTH SUDAN

SUMMARY

What the cancellation of Round 11 and the funding crisis mean for South Sudan:

- Although South Sudan has put in place a fully costed national strategic plan for HIV, it is significantly under-resourced with a funding gap of 80%. The Government of South Sudan, its national AIDS committee, and key donors were counting on Round 11 to secure funding for the implementation of this nascent national strategic plan.
- There is currently no additional funding from donors for ART procurement to scale up treatment access for thousands of South Sudanese.
- There is a nascent HIV prevention strategy which is desperate for implementing funds.
- While South Sudan is a strong candidate for the Global Fund's Transitional Funding Mechanism, it is likely that key aspects of South Sudan's national strategic plan will remain unfunded, notably care and support services; interventions that create an enabling environment for HIV programme activities to be effective; and efforts to support the key role of civil society.
- Cancellation of Round 11 and health systems funding platform will significantly delay the establishment and strengthening of national surveillance systems for HIV, TB, and other diseases.

National epidemiology and current coverage

The Republic of South Sudan became the 194th nation-state on July 9, 2011. Having recently emerged from 45 years of civil war in 2005, conditions for HIV to spread among the general population have increased with the return of refugees and internally displaced persons, and with greater cross-border travel to and from countries with high HIV prevalence rates. The country also understandably has weak health systems and limited human, organisational, and technical capacity to respond to HIV. As a result, the epidemic in South Sudan has become generalised in the population. Currently it is estimated that there are 116,000 PLHIV, which constitutes a 1.4% prevalence rate.[53]

South Sudan has taken significant steps towards providing HIV services including ART, care and support, voluntary HIV counselling and testing, PMTCT, and broader prevention services. For example:

- The number of ART centres has grown from one site in 2006 to 16 sites in 2011, leading to an expansion of access to ART, OI treatment, and management of TB/HIV co-infection.
- In 2009, 13,141 pregnant women were tested for HIV, representing only 3% coverage in Southern Sudan.[54] In 2010, however, the number tested increased to 31,391. Five hundred and fifty-two of these pregnant women tested HIV-positive, and 462 received treatment to prevent vertical transmission of HIV.

The new Government of South Sudan's prevention strategy has begun to engage the community with HIV awareness campaigns through FM radio; large-scale community information, education, and communication events; the distribution of materials; and the targeting of gatekeepers such as chiefs, women, young people, and religious leaders. In addition, it has facilitated the formation of school-based youth clubs for promotion of sexuality education to tackle

53. UNAIDS, (2010), *Report on the Global AIDS Epidemic*, www.unaids.org/documents/20101123_GlobalReport_em.pdf

54. Ibid.

gender inequalities and the mainstreaming of HIV into life-skills education and training.

However, gains are fragile and there is still a very long way to go. Currently 46,500 people need ART, and it is estimated that less than 10% (only 3,700) of those in need will be on ART at the end of 2011.[55] In the 2010 household Health Survey, 75% of the 815 men surveyed reported having two or more wives or sexual partners.[56] In a separate survey, only 41% of South Sudanese women knew that HIV could be prevented through using a condom.[57] Condom use in South Sudan remains extremely low due to barriers stemming from culture, religion, misconceptions, and poor access.[58] There is also significant stigma, discrimination, and criminal prosecution facing PLHIV and some key populations such as sex workers. As a result, there has been a failure to recognise the potential public health intervention opportunities (such as condom promotion and treatment of sexually transmitted infections). All of these factors pose barriers to scaling up necessary HIV services in South Sudan.

The government's 2007–2012 health policy provides a good framework for partnership with civil society in the HIV response, but the government can only maintain and build on recent gains with adequate funding both from within the national budget and from donors.

The role of the Global Fund and proposed scale-up

Sudan received a Global Fund Round 4 grant that started in 2006 and ended on November 30, 2011. The focus of the programme was to develop and expand treatment, care and support services for PLHIV through ART provision and OI prophylaxis and treatment in five hospitals benefiting a total of 6,800 people. The Government of South Sudan hoped that its proposal for Global Fund Round 11 would allow it to significantly scale up HIV services. The Country Coordinating Mechanism was in the process of developing a proposal that sought funding for three priority areas. The first, HIV prevention, encompassed behaviour change communication, condoms, HIV testing and counseling, sexually transmitted infection services, male circumcision, and PMTCT. The second, treatment, care and support, encompassed ART access, OI treatment, home-based care, TB/HIV integration, and food and nutrition. The third, strategic areas to strengthen the health system, included establishing and strengthening national surveillance surveys and systems.

THE ROLE OF ALLIANCE SOUTH SUDAN

- Alliance South Sudan currently supports 92 CBOs across 23 counties in eight of South Sudan's ten states, building their capacity for an integrated HIV response guided by the principles of the community systems strengthening framework. Through this, the organisation has enhanced the capacity of emerging local organisations' response to HIV/AIDS through intensive technical and financial support. This has enabled the local CBOs to provide services such as condom distribution, referral for voluntary HIV counselling and testing, and care and support.
- Alliance South Sudan has a Memorandum of Understanding with the Government of South Sudan to strengthen the civil society response to HIV. In recent years Alliance South Sudan has successfully piloted and institutionalised the development of County AIDS Committees (multisectoral bodies that coordinate country-level HIV responses) and has played a key role in the development of the Government of South Sudan HIV/AIDS strategy.
- In 2011, Alliance South Sudan scaled up the integration of HIV services with maternal, newborn, and child health services and through community mobilisation referred 3,510 women and men to antenatal/PMTCT and voluntary counseling and testing services; set up five voluntary counseling and testing centres and seven PMTCT sites in Eastern and Central Equatorial States; trained 56 home-based care providers; distributed 379,183 male and female condoms; reached 338,915 people with HIV prevention messages; and trained 53 sex workers as peer educators who implement behaviour change communication activities.
- Alliance South Sudan was counting on the Global Fund Round 11 grant to fund and expand community-led services, in close collaboration with government.

55. This is a modest increase on 5% [3-7%] coverage of ART reported in *Global HIV/AIDS Response: Epidemic update and health sector progress towards universal access*. Progress Report, WHO. Available at: www.who.int/hiv/pub/progress_report2011/hiv_full_report_2011.pdf. (2011) WHO reports that the number of people receiving ART in South Sudan in December 2010 was 2,223 (of 4,345 in Sudan as a whole).

56. *Household Health Survey*, Draft Document, Government of Southern Sudan (2010).

57. Ibid, cited in *Southern Sudan HIV Epidemic and Response Review Report*, Government of South Sudan and World Bank, (April 2011).

58. *The South Sudan HIV/AIDS Strategic Framework*, Government of South Sudan, (2008–2012).

What the crisis means for South Sudan

With its Round 4 grant now finished, the government has approval for continuation-of-services funding from the Global Fund. This provides up to two years of further funding for ART provision, OI drugs, and PMTCT for those who had already been accessing services at the end of the last grant. However, while this funding is critical for the small percentage of people who are already receiving ART, it will not provide for any scale-up or fund other critical HIV services. Continuation-of-services funding will not finance the vitally important services of HIV testing and counselling, treatment adherence, behaviour change, and stigma reduction.

The cancellation of Round 11 leaves a huge gap in funding for South Sudan's current and future HIV response. While the US government has agreed to provide some of the paediatric treatment needed in the country, there is currently no additional funding from any other source for ART scale-up.

South Sudan will be eligible to apply for Global Fund support under the Transitional Funding Mechanism. However it is currently unclear which 'essential services' could be funded through this mechanism, how much money will be available globally for the mechanism and, as a result, what prioritisation criteria will be applied to decide which funding requests get approved and when. While South Sudan is a strong candidate for this funding, the likely minimum six-month delay in funding becoming available means that key aspects of South Sudan's national strategic plan will remain unfunded – most notably, prevention, care and support services; mapping of and services for key populations; interventions that create an enabling environment for HIV programme activities to be effective; and supporting the key role of civil society.

"There are still thousands needing life-saving HIV treatment who currently cannot be initiated onto treatment because of the lack of resources and there is a nascent prevention strategy which is desperate for funding to implement."

Dr Esterina Navello Nyilok, Chair, South Sudan AIDS Commission.

APPENDIX 5
COUNTRY IMPACT STUDY: ZAMBIA

SUMMARY

What the cancellation of Round 11 and the funding crisis mean for Zambia

- TB diagnosis and control will suffer.
- Drug supply management systems will not be strengthened adequately.
- The contribution of civil society, private sector and community-based organisations to HIV prevention and care will be threatened.
- The existing funding gap of $591,452,556 already highlighted in the National AIDS Strategic Framework for the period 2012–2015 will dramatically increase.
- An estimated 131,971 people in need of life-saving treatment will not have access to it.

National epidemiology and current coverage

Zambia has adopted a multisectoral response to HIV/AIDS guided by the National AIDS Strategic Framework for 2011–2015. The country has an HIV prevalence rate of 14.2% and a population of nearly 13 million, of whom nearly 64% live below the poverty line of US$1 a day. Securing funding for the provision of HIV treatment is considered as important as ensuring that HIV prevention efforts are scaled up in Zambia, so that a 'treatment as prevention' approach may be adopted in order to reduce HIV transmission and AIDS deaths.

Zambia has made tremendous progress in its HIV response: a reduction in mother-to-child transmission to 12.4%; an increase in ART coverage to almost 60%; almost 100% coverage by blood safety programmes; effective promotion of delayed sexual debut amongst young people through peer programmes; an increase in HIV screening from 29.7% in 2006 to 50% in 2009; 39% of TB/HIV co-infected persons receiving treatment; and 15% of women and men aged 15–49 receiving an HIV test and results in the last 12 months.[59]

Despite these accomplishments, huge gaps remain. Many PLHIV still have limited or no treatment, care, and support, especially people living in high-density areas; young pregnant women; infants and children; and MSM. There is a 15% unmet need for PMTCT and a 14% treatment gap, with at least 53,634 adults and 5,516 children who need treatment still not having access to it. In addition, thousands of PLHIV do not have access to the good-quality home-based care and palliative care and support that they need.

59. Policy Overview and Status of the AIDS Epidemic in Zambia, National HIV/AIDS/STI/TB Council, Lecture by National AIDS Committee Director General (2010).

The role of the Global Fund and proposed scale-up

Currently, Zambia is a recipient of four Global Fund Round 8 grants and one Round 10 grant. The areas of focus in these grants include sexual and reproductive health, HIV prevention and community systems strengthening.

The Round 8 grants are for $31,289,518 (started January 2010, with Phase 2 running from December 2011 to December 2014; Principal Recipient, Churches Health Association of Zambia); $9,993,493 (started December 2009, with Phase 2 running from November 2011 to September 2014; Principal Recipient, Zambia National AIDS Network); $13,777,956 (started January 2010, with Phase 2 running from December 2011 to December 2014; Principal Recipient, Ministry of Finance and National Planning); $66,442,544 (started September 2011, with Phase 2 running from August 2013 to August 2016; Principal Recipient undetermined). The Round 8 funding totals $121,503,511.

The Round 10 Phase 1 grant runs from September 2011 to August 2013, with Phase 2 scheduled to continue until August 2016. The grant is for $75,410,807, and its primary areas of focus are HIV treatment and community strengthening and mitigation. Following the identification of fraud by the Office of the Inspector General of the Global Fund in October 2010, the Ministry of Health, Ministry of Finance and National Planning, and Zambia National AIDS Network were barred from being Principal Recipients and the money was frozen. The United Nations Development Programme and Churches Health Association of Zambia have taken over as Principal Recipients for both Round 8 and Round 10 grants. These grants are the cornerstone of the current HIV treatment, care, and support activities within Zambia's national response. Thus, the fact that the money has been frozen for at least a year has had a big impact on services.

What the crisis means for Zambia

With Round 11 cancelled, many services that would have been provided with Global Fund resources will remain unavailable. In particular, Zambia's Country Coordinating Mechanism was counting on Round 11 to strengthen drug and supply management and to ensure that there was uninterrupted supply of drugs to public facilities. The Country Coordinating Mechanism had also envisioned Round 11 as critical in strengthening intensified TB case finding; TB diagnostic capacity in facilities; quality assurance of TB microscopy training; the scale-up of remote diagnosis of TB using mobile technology; and the increased scale-up of isoniazid preventive therapy. Zambia has a huge TB burden, with high TB/HIV co-infection rates, threatening the gains made via the provision of antiretroviral therapy.

The cancellation of Round 11 will heavily impact HIV prevention, care and support. For instance, behaviour change programs as well as condom availability and distribution will be impacted negatively. In addition, Round 11 was expected to be critical for achieving increased community involvement, better coordination of civil society, and the engagement of private sector stakeholders in the national HIV response. Leveraging of resources through community and private partnerships is now threatened since the mechanisms for operationalising community and private participation will not be funded. The lack of resources will amplify the already existing funding gap faced by civil society organisations.

THE ROLE OF ALLIANCE ZAMBIA

- Alliance Zambia supports over 60 community-based organisations, many of which were sub-sub-recipients under the previous civil society Principal Recipient before its collapse. Alliance Zambia has presence and partnerships in six out of ten provinces in Zambia, and supports HIV prevention through awareness creation; publication and distribution of information communication and education materials; condom provision and distribution; care and support of PLHIV through capacity-building of home-based care providers; and encouraging community referrals. This includes working with traditional healers and community gatekeepers to sensitise people on treatment provision, as well as providing adherence support via community support workers.
- Alliance Zambia galvanizes community mobilisation and civil society cohesion in Zambia and is well placed to serve as a future civil society Principal Recipient for the HIV response. It advocates for the creation of a national AIDS Trust Fund and the implementation of the UNAIDS Investment Framework at the country level.

"Newly infected people and those on the waiting list [for treatment] will not have access to treatment, and that spells doom for them and increases the risk of further transmission and re-infection. Efforts to scale up interventions that have been seen to be working and the implementer's efforts to invest with focus will be derailed."

Jillian Johannsen, Executive Director, Alliance Zambia

The National AIDS Strategic Framework estimates the 2012–2015 resource gap, for civil society only, to be $98,288,429. The cancellation of Round 11 will bring many community organisations and civil society organisations to their knees and obliterate their valuable contribution to the response. Other donors already struggling to address the funding gap even before the cancellation of Round 11 now face an even greater challenge. The Zambian government provides only 2% of the resources put towards the National AIDS Strategic Framework between 2011 and 2015. It is now under pressure to increase its budget allocation to health (still below the desired 15%). The government and the National AIDS Council do have plans to establish a National AIDS Trust Fund[60] in order to create a local sustainable HIV finance mechanism. It will be used to supplement the government's resource allocation towards the National AIDS Strategic Framework. Yet even with this innovation, Zambia's fight against HIV will still be seriously underfunded.

"Most-in-need communities will suffer most as community mobilisation decreases. Many expectant mothers depend on community structures and peer support to assist them with delivery, to provide support counselling, even transport to health centres."

Jillian Johannsen, Executive Director, Alliance Zambia

60. Market segmentation, like UNITAID, x% tax on a luxury product such as an air ticket, talk time, vehicle importation duty etc

APPENDIX 6
COUNTRY IMPACT STUDY: ZIMBABWE

SUMMARY

What the cancellation of Round 11 and the funding crisis mean for Zimbabwe:

- With the closure of Expanded Support Programme funding in 2011 (covering 80,000 PLHIV on ART) and without new funding, ART shortages could affect 112,800 patients by 2014.[61] There is a high risk that the country will need to halt its ART scale-up and will not be able to sustain current ART coverage. There could be a 60% funding gap for the five-year programme.[62]
- TB/HIV co-infection is a severe problem, with 80% of TB patients estimated to be HIV-positive. Consequently, lack of funding will likely strongly affect the scale-up of TB/HIV activities as currently there is no separate TB/HIV programme funding.
- Expanded Support Programme funding for PMTCT runs out at the end of 2012 and the Global Fund Round 8 grant, which funds about 25% of ART drugs for the PMTCT programme, ends in late 2014. This could mean as much as a 50% funding gap for PMTCT from 2015,[63] affecting half of the estimated 50,000 HIV-positive women who need ART for PMTCT annually.
- Without the additional resources from Round 11, Zimbabwe will only achieve 15% of its male circumcision target by 2015.[64]
- The lack of Round 11 funding will negatively impact care and support services and community mobilisation for HIV testing and adherence support.

National epidemiology and current coverage

The estimated total number of adults and children living with HIV in Zimbabwe by 2010 was 1,168,263 (about 414,300 men and 608,700 women).[65] National adult prevalence is still very high at 14.3%, but there is reason for cautious optimism because prevalence has in fact been steadily declining since 1998, when it was as high as 27.2%.[66] While part of the decline in prevalence is due to high mortality, it is also as a result of many positive changes including reductions in sexual risk behaviour; increases in PMTCT with ART available for 84% of pregnant women in need in 2010, as opposed to only 58% in 2008; significant numbers of men being medically circumcised; and increases in both male and female condom distribution (Zimbabwe has the highest distribution figures for female condoms in the world). There has also been progress in regard to HIV testing coverage, which increased from 36% to nearly 50% between 2006 and 2011.[67]

However, more resources are essential to sustain patients already receiving ART and to initiate treatment for patients if Zimbabwe is to meet universal access targets. In 2010, Zimbabwe adopted the updated WHO global HIV treatment guidelines with higher CD4 cell count criteria for initiation of treatment. On the basis of this standard, ART coverage was 54% by December 2010: 326,241 of the 593,168 people in need were receiving treatment. Of these, 32,000 were children.[68] TB/HIV co-infection is high in Zimbabwe, with 80%

61. MSF (2011). *Reversing HIV/AIDS? How advances are being held back by funding shortages*.
62. *UNAIDS survey* (2011).
63. *Global Fund Round 11: Programmatic Gap Analysis* (unpublished study).
64. Ibid, p.39.
65. *Zimbabwe National HIV and AIDS Strategic Plan,* ZNASP II (2011–2015) p.5. Available at: www.nac.org.zw
66. *Zimbabwe National HIV and AIDS Strategic Plan,* ZNASP II (2011–2015) p.xii. Available at: www.nac.org.zw
67. 221,055 people were tested in 2011.
68. *Zimbabwe National HIV and AIDS Strategic Plan,* ZNASP II (2011–2015) p.14. Available at: www.nac.org.zw

of TB patients estimated to be co-infected with HIV.[69] TB is a leading cause of mortality among PLHIV. While there has been substantial progress in testing and counseling for co-infection, TB/HIV control overall still needs significant improvement.

The National HIV/AIDS Strategy identifies PMTCT as a priority tool for reducing maternal morbidity and mortality and for reducing new HIV infections in children. Currently coverage and drop-out rates for PMTCT are high because low numbers of mothers are accessing delivery services, and those who do so often access services late. There is also extremely low coverage of infant HIV testing at only 15%. Funding is very limited for the distribution of PMTCT information, education and communication materials; training for community health workers in behaviour change communication; community engagement activities with community and religious leaders; and improving traditional birthing practice.

Over the last few years, community- and home-based care (CHBC) has expanded from a narrow palliative care focus to include psychosocial, spiritual, and broader support for people living with and affected by HIV. The number of people receiving CHBC increased from 450,000 in 2007 to 697,000 at the end of 2009.[70] Thanks to significant multi-donor financial support there has also been a successful 2006–2010 National Action Plan, which delivered support to 25% of the country's 1.6 million vulnerable children (for 62% of them, HIV is the primary cause of vulnerability).[71] However, lack of funding (which affects supply and replenishment of home-based care kits) along with inadequate government coordination and weak referral and monitoring systems continue to limit the effectiveness and efficiency of care and support interventions.

Three key prevention strategies adopted by the government are behaviour change communication programmes, male circumcision, and condom distribution. Behaviour change communication had reached 2,277,140 people by the end of 2011. Male circumcision has been prioritised based on evidence that rapid scale-up averts more infections.[72] The national male circumcision strategy has so far led to the medical circumcision of 12% of men 15–29 years of age by 2011. While the ambitious target of circumcising 1.16 million men (80%) by 2015 is made almost impossible by the relatively low awareness of the intervention's benefits among the community and a lack of doctors and sites to perform the procedure, significant scale-up can be achieved in the short term if resources are made available.

As mentioned above, distribution and promotion of male condoms have been successful, increasing between 2006 and 2008 before decreasing again slightly as a result of the economic crisis. Female condom distribution has expanded beyond all targets. However, negative myths and misperceptions around both male and female condom use persist.

Populations particularly at risk in Zimbabwe include women (antenatal care prevalence rate at 16.1%), children (due to limited access to services)[73], youth,[74] people with disabilities, prisoners, mobile populations, sex workers,[75] and MSM. Programmes are clearly not reaching all of those most at risk, particularly sex workers, prisoners and MSM, who face a restrictive policy environment, judgemental attitudes, and negative perceptions. While limited sex worker and prisoner programmes do exist and have reached 9,862 and 3,394 people respectively, there are no programmes or even epidemiological data for MSM as no size estimation or bio-behavioural surveillance has been done under the National AIDS Strategic Plan to date.

In response to many of the ongoing challenges in the Zimbabwe AIDS response and the ambitious targets set at the High Level Meeting, the new Zimbabwe National AIDS Strategic Plan II was approved in October 2011 and runs to 2015. It has ambitious targets across all HIV interventions,[76] none of which are possible to achieve without a substantial increase in funding from both the government and external donors.

The role of the Global Fund and proposed scale-up

The Global Fund is a significant contributor and source of funding for health in Zimbabwe. The Global Fund Round 5 grant provided $60 million from 2005 to 2010. It supported HIV interventions to strengthen health service delivery and mitigated the impact of HIV in 22 priority districts.[77] Zimbabwe is now implementing a Round 8 grant, which started in January 2010. The Round 8 grant is one of the largest grants ever approved by the Global Fund, with a total budget of almost $500 million over five years. The Round 8 grant supports the provision of ART, strengthening of the health workforce, and behaviour change communication activities. Phase 1 came to an end on December 31, 2011, and Zimbabwe is now in renewal discussions with the Global Fund for Phase 2, which will run until December 2014.

69. National TB Control Programme Database, MOHCW, (2009).

70. *Zimbabwe National HIV and AIDS Strategic Plan,* ZNASP II (2011–2015) p.16. Available at: www.nac.org.zw

71. Ibid, p.17.

72. WHO and USAID 2009 projections state that male circumcision introduced over 10 years will avert 33% of infections as opposed to only 10% over 20 years.

73. Only 15% of HIV exposed infants received an HIV test within two months of birth and only 36% of children in need of ART were receiving it (2010 statistics).

74. New HIV infections among youth (15–24 years of age) are high at 6.2% among women and 3.1% among young men (ZDHS 2005/5) and Towards Universal Access 2010 WHO/UNAIDS/UNICEF).

75. Sex workers and their clients are responsible for 14% of national incidence. (ZNASP II, p.6).

76. *Zimbabwe National HIV and AIDS Strategic Plan,* ZNASP II (2011–2015) p.xiv. Available at: www.nac.org.zw

Given that national resources for HIV are limited and that Zimbabwe's Round 10 Global Fund application was not successful, Zimbabwe was counting on a Round 11 grant. The Zimbabwe Country Coordinating Mechanism had recommended that the Round 11 proposal prioritise much-needed resources for ART, PMTCT, and male circumcision. As it became clear that Round 11 resources would be limited, the Country Coordinating Mechanism made the difficult decision to only include essential 'must have' interventions, limiting the Round 11 proposal to only $40 million for HIV and $20 million for TB.

What the crisis means for Zimbabwe

The impact of not having a Round 11 grant will be mainly felt from 2014 onwards, when the current Round 8 grant comes to an end and other funding streams run out. The estimated impact in the core areas that the Round 11 grant was to cover is discussed below.

- **ART:** Without follow-on funding after Round 8, the 193,000 adults who are receiving ART with Global Fund support risk failing to access life saving treatment, leading to drug resistance, morbidity and mortality. In addition, roughly 80% of TB patients are HIV-positive. Consequently, lack of funding will likely strongly affect the scale-up of TB/HIV diagnosis, prevention, treatment, and care services. There is no separate TB/HIV programme funding.[78]
- **PMTCT:** Expanded Support Programme funding for PMTCT runs out at the end of 2012 and the Round 8 funding which secures about 25% of ART drugs for the PMTCT programme runs out at the end of 2014.
- **Male circumcision:** Zimbabwe has made male circumcision scale-up central to its HIV program success, with a goal of circumcising 1.16 million men aged 15–29 by 2015. Without the additional resources a Round 11 grant would have provided, only 13% to 15% of the male circumcision target will be achieved in 2014 and 2015. As a result, male circumcision is unlikely to have a significant epidemiological impact on HIV incidence.[79]

Other key affected areas include the following.

- **Care and support services:** As a result of Round 8 funding, care and support services are now available in every district. They are mobilising clients for HIV testing; contributing to treatment adherence; and facilitating implementation of and adoption of better nutritional practices amongst PLHIV. The care component is bolstered by the provision of caregiver incentives and provision of equipment and training. In 2011, more than 34,401 PLHIV were reached with CHBC and an additional 14,000 were reached with behaviour change communication messages via television. Without Round 11 funding it is unclear where funding to continue this work will come from beyond 2014, which will create a significant service gap.
- **Key populations:** Zimbabwe had not specifically prioritised MARPs in the current Round 8 grant or in the Round 11 proposal. However, HIVOS and other partners were actively preparing a Round 11 regional proposal to specifically address the needs of MSM and transgender populations within the region (including Zimbabwe). The government will have to urgently both better understand the nature of their epidemic (e.g. conduct robust studies of MSM prevalence) as well as secure funding to provide appropriate services for key populations groups.

THE ROLE OF ZIMBABWE AIDS NETWORK

- Zimbabwe AIDS Network (ZAN) implements community-based interventions to support social mobilisation, information and education, and community support activities for ART, PMTCT, and male circumcision. In 2011, ZAN supported more than 23,953 PLHIV through community- and home-based care.
- Currently, ZAN is a sub-recipient under the Global Fund Round 8 grant responsible for $7,847,386 under Phase 1 (9% of the grant budget), and $12,645,163 under Phase 2 (6% of the grant budget). The other sub-recipients are the Ministry of Health and Child Welfare and the National AIDS Council.
- ZAN has three sub-sub-recipients under its portfolio. Population Services International is implementing the behavior change communication programme using mass media; Hospice Association of Zimbabwe is responsible for community and home-based care; and Zimbabwe National Network for People Living with HIV/AIDS is responsible for strengthening networks of PLHIV. Before the Country Coordinating Mechanism was forced to make draconian priority decisions, ZAN was hoping to strengthen these services through the now-cancelled Round 11 grant.

77. *Zimbabwe National HIV and AIDS Strategic Plan,* ZNASP II (2011–2015) p.21. Available at: www.nac.org.zw

78. *UNAIDS Survey*, (Dec. 2011).

79. Ibid, p.39.

All of the Zimbabwe National HIV and AIDS Strategic Plan II targets will be impossible to reach without increased funding from both domestic and external sources. Overall HIV funding has been decreasing over the past couple of years and funding for HIV prevention declined significantly between 2006 and 2009.[80] There is now also anxiety and uncertainty regarding funding for HIV and AIDS beyond December 2014, when Phase 2 of the Round 8 grant is set to end.

Zimbabwe's national response to HIV has mainly been funded externally through bilateral, multilateral, and international donors including the Global Fund (Round 5 and Round 8), the Expanded Support Programme,[81] the US government, and the Programme of Support[82]. It is not yet clear if bilateral donors will step up to fund service gaps not covered by the Global Fund. As Zimbabwe's economy now finds more stability the national government has committed to increase its contribution to the AIDS response from 20% in 2011 to 75% by 2015. Domestically, the government contributes through the national budget ($7.5 million in 2009) and through the AIDS levy. Since 1999 the AIDS levy has raised money for HIV by placing a tax on businesses and on the country's 1.3 million formal sector workers at a rate of 3% of gross monthly earnings, which feeds into the National AIDS Trust Fund.[83] This is an interesting model unique to Zimbabwe that was designed to both demonstrate the government's commitment to addressing the epidemic and reduce the level of dependency on donors. Revenue from the levy has increased significantly over the past two years, and was up to $19 million in 2010.[84] The funds have primarily been used for ART commodities procurement as well as HIV prevention, impact-mitigation and advocacy.

80. *Zimbabwe National HIV and AIDS Strategic Plan,* ZNASP II (2011–2015) p.22. Available at: www.nac.org.zw

81. Consisting of CIDA, DFID, Norwegian Aid, Irish Aid and Sida and contributing $42 million during 2007–9.

82. A mitigation programme for orphans and vulnerable children, education, healthcare, registration and HIV services – $84 million over three years.

83. *The Political Economy of the Zimbabwe's National AIDS Trust Fund*, Susie Baird, p.9.

84. *Zimbabwe National HIV and AIDS Strategic Plan,* ZNASP II (2011–2015) p.21–22. Available at: www.nac.org.zw

“We urgently need donors to replenish the Global Fund and for national governments to step up and deliver funding for their HIV/AIDS response or we face a collective responsibility of failing the weakest in our society and betraying the promises that were made to the families and people affected by HIV around the world.”

Alvaro Bermejo
Executive Director, International HIV/AIDS Alliance
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