



UNAIDS/PCB(30)/12.4

30th Meeting of the UNAIDS Programme Coordinating Board
Geneva, Switzerland
5-7 June 2012

Report by the PCB NGO representative

Document prepared by the PCB NGO Representatives

Additional documents for this item: *none*

Action required at this meeting - the Programme Coordinating Board is invited to:

Paragraph 43.

1. *urge* UNAIDS to advocate for a fully funded civil society with donor governments and the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria, using its convening authority to do so. UNAIDS should specifically advocate for the creation of direct funding mechanisms for civil society organizations within the new Global Fund architecture.
2. *request* UNAIDS, in partnership with Member States, to support civil society, notably in African, Asian and Latin American regions, to advocate for access to treatment by mobilizing existing funding mechanisms as well as by advocating to raise new ones, to dedicate direct funding to civil society to build capacity in this area.
3. *request* UNAIDS to examine how decreased funding for HIV in the current environment impact UNAIDS' strategies, including the *Strategic Investment Framework* assumptions, and the ability to meet the goals laid out in the *2011 Political Declaration on HIV/AIDS*, as a step toward developing an overarching strategy that emphasizes resource mobilization and the centrality of civil society. UNAIDS should report back at the 31st meeting of the Board.

Cost implications for decisions: *none*

I INTRODUCTION

1. The 2012 NGO Report to the Programme Coordinating Board addresses the devastating - and worsening - impact of reductions in funding for HIV on civil society, including people living with HIV (PLHIV) and key populations, such as men who have sex with men (MSM), transgender people, people who use drugs and sex workers and their partners. It is based on a review of evidence and case studies by constituents of the NGO Delegation. It starts by summarising:

Crisis 1: Reductions in bilateral funding for HIV

Crisis 2: Reductions in multi-lateral funding for HIV

Crisis 3: Inadequate progress on national investment in HIV

The Report then explores the acute and far-reaching impact of each crisis on civil society and its critical programmatic and advocacy contributions to evidence-based and cost-efficient responses to HIV. It ends by reviewing the role that UNAIDS has committed to take to address the funding crisis and making suggestions about how that role could be strengthened.

II THE FACTS: What is the scale of reductions in funding for HIV? Why does it matter?

2. Evidence demonstrates that funding for HIV is decreasing due to a number of factors. These include the global economic downturn, changes in donor priorities and limited progress by national governments to invest in their country's response to HIV. In April 2009, the World Bank stated the need to avert a human crisis during the global downturn, with people on Antiretroviral treatment (ART) *"in danger of losing their place in the lifeboat."*¹ Later in 2009, a World Bank and UNAIDS survey of 457 CSOs found 53% experiencing negative effects of reduced funding on treatment work, 59% on prevention and 65% on outreach to key populations.² At the 25th Programme Coordinating Board Meeting in December 2009, UNAIDS stated: *"The global economic crisis is having a real and tangible negative effect on HIV programmes in nearly all low- and middle-income countries."*³
3. By August 2011, UNAIDS and the Kaiser Family Foundation documented that the decade of increases in international funding for HIV was over⁴. After flattening in 2009, there was, for the first time, a 10% decrease in 2010 (from US\$ 7.6 billion to US\$ 6.9 billion). In their currency of origin, the allocation to HIV of 7 out of the 15 governments studied reduced.
4. This comes at a time when international funding remains crucial to the response to the epidemic. In Africa, two thirds of expenditure on HIV comes from external sources⁵.
5. As Michel Sidibé, Executive Director of UNAIDS, states: *"The global response has hinged on the largesse of a relatively small handful of traditional donor countries. Their commitments are unpredictable and undependable in the current economic climate, yet millions of lives depend on them."*⁶ In 2010, 54.2% of international funding for HIV was

¹ Press Release: *Averting a Human Crisis during the Global Downturn*, World Bank, April 2009.

² *Update On the Impact of the Economic Crisis HIV Prevention and Treatment Programmes*, UNAIDS and the World Bank, December 2009.

³ *Impact Of The Global Financial And Economic Crisis On The AIDS Response*, 25th Meeting of the UNAIDS Programme Coordinating Board 8-10 December 2009, UNAIDS, October 2009.

⁴ *Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2010*, the Henry J Kaiser Family Foundation and UNAIDS, August 2011.

⁵ *AIDS Dependency Crisis: Sourcing African Solutions*, UNAIDS, 2012.

⁶ *Letter to Partners: Michel Sidibé*, UNAIDS, April 2012.

provided by the United States (US), 13% the United Kingdom (UK), 5.8% France, 5.1% the Netherlands, 4.5% Germany and 2.5% Denmark⁷.

Crisis 1: Reductions in bilateral funding for HIV

6. Significant reductions are seen in bilateral funding – the means by which the majority of international resources for HIV (74% in 2010) are allocated⁸. Such reductions were the primary cause of the overall 10% decrease cited for 2009-2010⁹. Of particular significance, the 2013 federal budget for the Government of the US includes an over US\$ 500 million reduction in the President's Emergency Plan for AIDS Relief (PEPFAR)¹⁰.
7. This situation reflects not only the impact of the global downturn on donor's own economies, but conscious changes in priorities and policies. These vary by donor, but can be broadly characterised as a shift away from investing in HIV-specific interventions and towards wider health or development. The UNAIDS Reference Group on Human Rights concludes that: *"The current shortfall in funding for HIV is not the result of an economic crisis but a crisis of priorities."*¹¹

Crisis 2: Reductions in multi-lateral funding for HIV

8. Multi-lateral allocations to HIV have also been the subject of reductions and instabilities – most notably in relation to the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). In November 2011, the mechanism's Board – informed of a shortfall of approx. US\$2 billion by the end of the third quarter¹² - cancelled Round 11. This was the end result of the third replenishment in 2010 (which raised just US\$ 11.7 billion in pledges for 2011-2013, well below the lowest target) and a pattern of donors renegeing, delaying and/or reducing their pledges.
9. According to a 2011 survey of UNAIDS offices (77 country and 1 multi-country), at least 55 countries were planning to submit a proposal to Round 11 of the Global Fund¹³. Now, no new grants will be available until at least 2014. Countries can apply to a Transitional Funding Mechanism (TFM) to maintain 'essential' services for up to 2 years¹⁴. However, the TFM will not fund the scale-up of programmes or many of the key interventions by civil society - such as care and support - that save and improve the lives of people living with and affected by HIV.

⁷ *Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2010*, the Henry J Kaiser Family Foundation and UNAIDS, August 2011.

⁸ *Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2010*, the Henry J Kaiser Family Foundation and UNAIDS, August 2011.

⁹ *Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2010*, the Henry J Kaiser Family Foundation and UNAIDS, August 2011.

¹⁰ Policy Tracker, the Henry J Kaiser Family Foundation.

<http://globalhealth.kff.org/Policy%20Tracker/Content/2012/February/13/FY13%20Budget%20Request.aspx>

¹¹ *The Global Fund and the Crisis of HIV Funding – A Severe Setback for HIV and Human Rights: Statement and Recommendations*, UNAIDS Reference Group on HIV and Human Rights, January 2012.

¹² *Board Information: Forecast of Uncommitted Assets Available for Grant Approvals, 25th Board Meeting, Accra, Ghana 21-22 November 2011*, the Global Fund to Fight AIDS, Tuberculosis and Malaria, November 2011.

¹³ The unpublished survey was carried out immediately after the decision by the Global Fund Board on Round 11. As such, it focused on countries' intentions at that time – with predictions of choices and actions that may have, since, been influenced or changed by other events. *Implications of The Global Fund's Cancellation of Round 11: Initial Findings of The UNAIDS Survey*, (unpublished), UNAIDS, December 2011.

¹⁴ *Transitional Funding Mechanism (TFM): Information Note*, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Fund Advocates Network, December 2011; and *Supplementary Guidance on the Transitional Funding Mechanism (TFM)*, the Global Fund to Fight AIDS, Tuberculosis and Malaria, February 2012.

10. 2011 also saw the Global Fund introduce significant changes to several key policies – affecting which countries can apply, for what type of interventions and their likelihood of success¹⁵. For example: eligibility criteria now exclude most upper middle income countries; and counterpart financing requires all governments to contribute a minimal threshold of resources to their national disease programmes. The new policies apply to the TFM as well as the Phase 2 renewal of existing grants.

Crisis 3: Inadequate progress on national investment in HIV

11. The decline in international funding for HIV is exacerbated by the slow progress of governments in developing countries to invest domestic resources in health in general and HIV specifically. In Africa, for example, many countries have made little or no progress towards the Abuja Declaration target of allocating 15% of national expenditure to health¹⁶. With HIV, some countries, such as South Africa¹⁷, have achieved increases in domestic investment, but many more fall far short. According to UNAIDS, in Africa, an ‘AIDS dependency crisis’ highlights the urgent need for greater ‘shared ownership-shared responsibility’ and diversified funding sources.¹⁸ This slow progress comes despite national investment being central to the key strategies and investments required to accelerate action on HIV.

12. Meanwhile, there is a “*shifting paradigm*” in the role of the BRICS countries, with Brazil, Russia, India, China and South Africa gaining economic influence, transitioning (to different degrees) from a recipient to donor role and engaging in global health.¹⁹

Why do the crises matter?

13. The crises in funding matter because the response to HIV is far from done. In 2010, there were 34 million people living with HIV and 2.7 million new infections²⁰, while stigma and discrimination and human rights abuses remained a reality. However, we are also in an era of unprecedented opportunity. Since 1997, new HIV infections have been reduced by 21% and, since 2005, 2.5 million deaths averted through ART²¹. There is the promise of even greater achievements, such as with the HIV Prevention Trials Network (HPTN) demonstrating that providing ART can reduce new HIV infections by 96% in sero-discordant couples.

14. Funding is critical to maintaining past gains and grasping future opportunities to bring an end to AIDS. As reported to the 29th Programme Coordinating Board Meeting, December 2011, funding is central to fulfilling the promises made at the 2011 UN High Level Meeting²². The Political Declaration on HIV/AIDS re-committed Member States to achieving universal access to HIV prevention, treatment care and support²³. It set targets for 2015 (such as reaching 15 million PLHIV with ART and reducing HIV transmission among people who use

¹⁵ *Eligibility, Counterpart Financing and Prioritisation: Information Note*, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Fund Advocates Network, January 2012.

¹⁶ *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria, 24-27 April 2001.

¹⁷ *AIDS Dependency Crisis: Sourcing African Solutions*, UNAIDS, 2012.

¹⁸ *AIDS Dependency Crisis: Sourcing African Solutions*, UNAIDS, 2012.

¹⁹ *Shifting Paradigm: How the BRICS are Re-shaping Global Health and Development*, GHSi, 2012.

²⁰ *How to Get To Zero: Smarter, Faster, Better: UNAIDS World AIDS Day Report*, UNAIDS, November 2011.

²¹ *How to Get To Zero: Smarter, Faster, Better: UNAIDS World AIDS Day Report*, UNAIDS, November 2011.

²² *Follow-up to the 2011 UN General Assembly High Level Meeting on AIDS, 29th Meeting of the UNAIDS Programme Coordinating Board*, Geneva, Switzerland, 13-15 December 2011, UNAIDS, November 2011.

²³ *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, United Nations General Assembly, June 2011.

drugs by 50%) and urged “*decisive, inclusive and accountable leadership*” and working towards “*closing the global HIV and AIDS resource gap by 2015.*”

15. Funding is essential to achieving the vision of Getting to Zero, the UNAIDS Strategy 2011-2015²⁴. It is also the ‘raw material’ for the smart investments set out in the UNAIDS Strategic Investment Framework - that promises to avert 12.2 million new HIV infections and 7.4 million AIDS-related deaths in 2011-2020²⁵. Using the Framework will require an initial scale-up of funding from US\$16.6 billion in 2011 to US\$22 billion in 2015. However, if full funding is provided and full implementation achieved, the resulting cost efficiencies will require *decreased* funding (US\$ 19.8 billion) in 2020.
16. The cost of doing nothing is far greater than the cost of doing something. Even conservative estimates show that - by fully funding a robust response to HIV up front - nearly 90% of expenditures can be recovered by 2020 through the savings in treatment costs avoided.”²⁶

How is this relevant to civil society?

17. None of the key frameworks for the next era of the global response to HIV – including the Political Declaration on HIV/AIDS, UNAIDS Strategy 2011-2015 and Strategic Investment Framework – can be achieved without civil society. The sector encompasses a vast range of stakeholders, from informal community groups to national, regional and global nongovernmental organisations (NGOs) and networks, including those by and for PLHIV and key populations. As evaluated by the World Bank and UK’s Department for International Development (DfID), the value-added of civil society – such as increasing access to services, affecting social change and impacting on health outcomes, including for key populations – is central to effective action on HIV²⁷.
18. UNAIDS has cited the value-added of civil society to include being a watchdog of national responses to HIV, advocating on human rights and engaging PLHIV and key populations to improve policy development and resource allocation.²⁸ The sector is critical to the simplified, cost-efficient and ‘know your epidemic’ interventions – such as Treatment 2.0, combination prevention and targeted support to key populations – that are vital for the UNAIDS Strategy 2011-2015.²⁹ Meanwhile, within the incorporated Technical Support Strategy, UNAIDS commits to supporting civil society to, among other measures: “*Create the political incentives necessary to increase domestic funding and reduce reliance on external donors (particularly in emerging and middle-income economies).*” Within the incorporated Partnership Strategy, UNAIDS new approach includes that: “*Civil society, with particular emphasis on networks of people living with and affected by HIV, will join governments, donors and other stakeholders as partners in the leadership, advocacy, resource mobilization, implementation, monitoring and evaluation of national HIV responses*”.
19. Civil society is key to addressing the gaps in current responses to HIV, including – as highlighted in Political Declaration on HIV/AIDS – programmes for populations at higher risk

²⁴ *Getting to Zero: 2011–2015 Strategy*, UNAIDS, December 2010.

²⁵ *A New Investment Framework for the Global HIV Response*, UNAIDS, 2011.

²⁶ Proposed Cuts to U.S. Bilateral AIDS Funding Threaten Populations Most At Risk for HIV: *Cuts to PEPFAR Contrast Important Increases in Support to Global Fund*, Global Forum on MSM and HIV, 14 February 2012.

²⁷ *Investing in Communities to Achieve Results: A Summary of the Findings from the Evaluation of the Community Response to HIV and AIDS*, UK Consortium on AIDS and International Development, World Bank and DfID, February 2012.

²⁸ *UNAIDS Guidance For Partnerships With Civil Society, Including People Living With HIV And Key Populations*, UNAIDS, December 2011.

²⁹ *Getting to Zero: 2011–2015 Strategy*, UNAIDS, December 2010.

of HIV infection.³⁰ It is critical to addressing the barriers to effective responses which – as articulated in the NGO Report to the 29th Programme Coordinating Board Meeting in December 2011 - include ones related to human rights and legal environments³¹ (such as with 79 countries criminalizing same-sex sexual relations between consenting adults and over 100 criminalising aspects of sex work³²). The barriers also include political and trade constraints that, for example, maintain high costs for ARVs and require large proportions of budgets for HIV to be allocated to treatment.

20. UNAIDS emphasises that: “*The Investment Framework is community driven not commodity driven.*”³³ Civil society is pivotal to *all* of the Framework’s six programme activities (such as focused programmes for key populations), as well as its ‘critical enablers’ (such as community mobilisation, advocacy, stigma reduction and attention to legal policies). It is also pivotal to the fundamental shifts in programme delivery – such as to community-based treatment and testing – that are needed to achieve the ‘inflection point’ between investments and the epidemic³⁴. In February 2012 in Tanzania, a meeting of 75 representatives of African civil society, governments and UNAIDS concluded that further development and implementation of the Framework is dependent on a dramatically scaled-up role for civil society in both service delivery and advocacy.³⁵
21. It is also clear that the Investment Framework can only succeed if there is specific and scaled-up investment in targeted and evidence-based programmes for key populations. Modelling by the World Bank demonstrates a correlation between increasing investment in specific interventions for MSM and driving down HIV incidence, not only among MSM, but the wider population³⁶.

III THE IMPACTS: How are the reductions in funding for HIV affecting civil society?

Based on the context described, this section focuses on the impact of the reductions in funding for HIV on civil society, including groups by and for PLHIV and key populations, such as MSM, transgender people, people who use drugs and sex workers. The section is divided into the three areas of crisis:

Impact on civil society of crisis 1: Reductions in bilateral funding for HIV

22. As summarised, bilateral contributions to HIV by most donors are falling and/or exhibiting instability and unpredictability. As illustrated below - through case studies from countries as different as Brazil, the Pacific Islands and Denmark - the consequences for national responses to HIV and the role of civil society are devastating. And they are predicted to get much worse. Reductions in bilateral funding connect to and exacerbate the crisis with the Global Fund and the slow progress on national investment in HIV. As shown in countries such as the Democratic Republic of Congo (DRC) [see Case study 2], when major bilateral donors such as PEPFAR or the World Bank limit their resources or exit from countries, many

³⁰ *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, United Nations General Assembly, June 2011.

³¹ *Report by the PCB NGO Representative 29th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, 13-15 December 2011*, UNAIDS, November 2011.

³² *Letter to Partners: Michele Sidibé*, UNAIDS, April 2012.

³³ Quote from Michel Sidibé. *Press Release: Nearly 50% Of People Who Are Eligible For Antiretroviral Therapy Now Have Access To Lifesaving Treatment*, UNAIDS, November 2011.

³⁴ *A New Investment Framework for the Global HIV Response*, UNAIDS, 2011.

³⁵ *Investment Framework Community Mobilization Meeting: Outcomes Document*, Dar-Es-Salaam, Tanzania: February 21-23 2012, February 2012.

³⁶ *The Global HIV Epidemics among Men Who Have Sex with Men*, the World Bank, 2011.

CSOs now find themselves with few other alternatives for funding and have little choice but to down-size or even close their programmes and advocacy work.

23. This crisis has been particularly hard-hitting for CSO networks and advocacy platforms, including those focused on PLHIV and key populations. A survey of 20 donors and 20 networks by the Asia Pacific chapter of the International Community of Women Living with HIV/AIDS (ICW) documents that the number of donors supporting networks of HIV positive women fell during 2009-2010 and that current opportunities focus almost exclusively on short-term projects rather than longer-term capacity building³⁷. Also, 'grassroots' organisations (that provide a unique PLHIV voice) are losing out to larger NGOs which have stronger systems, such as for monitoring and resource mobilisation. A such: *"Not only are networks unable to meet their objectives, but they also feel that, with less money and fewer projects, they are less likely to attract new donors."*
24. Similarly, a report by the American Foundation for AIDS Research (AMFAR) and Johns Hopkins School of Public Health highlights how – as well as continuing to be de-prioritised within national responses to HIV – programmes for MSM are being particularly affected by changes in both the priorities and procedures of bilateral donors³⁸. It concludes that: *"Efforts to streamline donor bureaucracy are being undertaken without careful consideration of their impact on vulnerable populations. Consolidated funding streams, broad health systems investments and reduced reporting requirements may ultimately undercut efforts to direct money to those most at risk or in need."*³⁹

Case study 1: Closure of services for children living with or affected by HIV, Brazil

Gestos (HIV+, Gender and Communication) is an NGO based in Recife. It was set up in 1993 to defend the rights of PLHIV and marginalised communities. Its work combines programmes (especially psycho-social and legal support for PLHIV and prevention education for marginalised and poor communities) with advocacy to ensure that the voices of PLHIV and marginalised groups are heard in local, national, regional and international policy-making. In 2000, Gestos started a programme for children living with or affected by HIV – an under-served group. The project regularly supported 60 children. The tailor-made services – including therapy with specialist psychologists, educational support (including visits to schools), home-based support and family sessions – were the only ones of their type in Recife. The results included increasing the children's self-esteem and performance in school and reducing the levels of violence against children. For 10 years, the programme mainly received funds from Terres des Hommes (TDH) Holland and was often showcased in Brazil and internationally as an example of good practice.

In 2009, TDH gave Gestos notice that, due to changes in its priorities for Brazil, it would not continue to fund the children's programme. Gestos pursued all other options to cover the approx. US\$ 100,000 annual budget, but found that international bilateral donors showed dramatically decreased interest in both HIV work and Brazil (due to the country's economic classification). Also, municipal government funding channels were either inappropriate or inaccessible, while the national government (through the National AIDS Department) did not issue any new calls for proposals to support children living with HIV. Gestos was forced to close its children's programme, laying off its four highly experienced staff. It tried to establish an emergency 'safety net' to support the children, but has been unable to provide a substitute programme. Meanwhile, the demand for the services is *increasing*. Despite HIV prevalence

³⁷ *The Funding Needs of Networks of Women Living with HIV in South Asia: An Advocacy Brief*, ICW Asia Pacific, 2012.

³⁸ *Achieving an AIDS-Free Generation for Gay Men and Other MSM: Financing and Implementation of HIV Programs Targeting MSM*, AMFAR and Johns Hopkins School of Public Health, January 2012.

³⁹ *Achieving an AIDS-Free Generation for Gay Men and Other MSM: Financing and Implementation of HIV Programs Targeting MSM*, AMFAR and Johns Hopkins School of Public Health, January 2012.

stabilising among the general population in Brazil (at around 0.6%), there are continued high levels among marginalised communities⁴⁰. In 2008 and 2009, studies in 10 municipalities (including Recife) indicated rates of 5.9% among people who use drugs, 12.6% among MSM and 4.9% among female sex workers.

Case study 2: Catastrophic impact of reduced bi and multi-lateral funding for ART, Democratic Republic of Congo

As documented by MSF⁴¹, HIV prevalence in DRC is 1.5%, but coverage of ART and prevention of vertical transmission just 14% and 1%. Approx. 15,000 people are already on the waiting list for ART, while some 300,000 are in need. Lack of access to timely ART leads to higher morbidity and mortality. By the time patients arrive at MSF-supported clinics, they are often terminally ill. Yet, poor management and inappropriate government policy has led to scaling-down of the country's existing Global Fund grants. In 2011, only 2,000 additional patients were started on ART (a fifth of the number for the previous year). Due to the uncertainty around funding, treatment providers are reluctant to initiate people on ART. The country's treatment targets for existing Global Fund grants have now been revised downwards, with the aim of reaching 82,000 people by the end of 2014 potentially reduced by as many as 28,000.

Round 11 was a critical opportunity for DRC to scale-up its overall provision of ART and, specially, prevention of vertical transmission and paediatric treatment. To date, some 95% of funding for HIV has come from international donors. However, the cancellation of the Round came at a time when: the World Bank's Multi-Country AIDS Programme has ended; PEPFAR support excludes ART, except for some pregnant women enrolled in prevention of vertical transmission programmes and only for a limited period of time; and UNITAID funding of paediatric ARVs and tests is due to end by December 2012. As MSF concludes: *"HIV treatment and care in the DRC is in the grip of a downward spiral caused by funding shortfalls and disbursement delays. This leads to poor patient outcomes and poor programme performance, which in turn leads to further cuts in available funding based on performance."*⁴²

The impacts are also seen among national NGOs, such as AMO Congo – which has been receiving about 80% of its funds from the Global Fund⁴³. AMO Congo was one of the country's largest NGOs, with, at the end of 2009, its ART adherence programme reaching 11,000 patients – about a third of all PLHIV receiving treatment in the country. AMO Congo is now not able to start any new patients on ART and has had to shut down 13 of its clinics – with only 2 currently functioning, with many patients transferred to the public sector where the provision, quality and

⁴⁰ *Targets and Commitments Made by Member-States at the United Nations General Assembly Special Session on HIV/AIDS*

UNGASS – HIV/AIDS Brazilian Response 2008-2009: Country Progress Report Brazil, Brazilian Ministry of Health Surveillance

Secretariat STD, AIDS and Viral Hepatitis Department, March 2010.

⁴¹ *Losing Ground: How Funding Shortfalls and the Cancellation of the Global Fund's Round 11 are Jeopardising the Fight Against HIV and TB*, Médecins Sans Frontières, March 2012.; and *Reversing HIV/AIDS? How Advances Are Being Held Back By Funding Shortages*, Médecins Sans Frontières, December 2011.

⁴² *Reversing HIV/AIDS? How Advances Are Being Held Back By Funding Shortages*, Médecins Sans Frontières, December 2011.

⁴³ Interview with Henry Mukumba, AMO Congo: http://www.dailymotion.com/video/xpowkm_interview-d-henri-mukumbi-masangu-association-amo-congo_news?start=0#from=embedifram

follow-up of treatment cannot be assured. Between 2010 and 2011, more than 230 of the organisation's 280 salaried staff had to leave. AMO Congo is now also struggling to maintain its advocacy work – in a context where stigma and discrimination of PLHIV remain strong.

Case study 3: Crisis for regional civil society leader, Pacific Islands

While the HIV epidemic in the Pacific remains small, the number of PLHIV nearly doubled during 2001-2009⁴⁴. The Pacific Islands AIDS Foundation (PIAF) is the only regional CSO focused exclusively on HIV and representing PLHIV. In 2003-2009, under a multi-year agreement, it received core funding from the New Zealand Aid Programme (NZAID)/Ministry of Foreign Affairs and Trade (MFAT). This enabled the Foundation to fulfill its leadership role, in particular addressing stigma and promoting the rights of PLHIV. Its many advocacy successes included the inclusion of ART in a regional proposal to Round 2 of the Global Fund and the formation of a Pacific AIDS Commission. In 2009, to replace its bilateral support, NZAID pooled its funding for HIV with the Australian Agency for International Development (AusAID) in a Pacific Response Fund (PRF). This partly reflected a political change in the focus of NZAID away from health and humanitarian work and towards economic development. In 2010 and 2011, PIAF continued to receive contributions from NZAID/MFAT, but at a decreasing level. It has not received funding for 2012. Meanwhile, only 2 of its 4 proposals to the PRF have been accepted – with the Foundation struggling to meet the Fund's focus on projects and lack of provision for core funding.

PIAF is currently a recipient of a regional (11 small islands) grant from Round 7 of the Global Fund. Under this, its activities have included programmes on legal reform (supporting countries to develop rights-based and anti-stigma legislation) and 'AIDS ambassadors' (training and supporting PLHIV to become public advocates). The grant will end in June 2013. While an application will be made to the TFM, PIAF expects a significantly reduced level of funding (especially for its own type of interventions that might not be classified as 'essential') and low prioritisation (due to the region's disease burden). Furthermore, the PRF is due to finish in December 2013 and other bilateral donors involved in HIV are withdrawing from the region. Meanwhile, national governments show little sign of increasing their allocation of domestic funding to HIV. Without core funds, PIAF has taken drastic measures to survive, including closing offices, letting go staff and decreasing its unique PLHIV-focused engagement in regional policy-making forums. If future funding is not secured, the organisation faces closure in 2013.

Case study 4: Funding ends for HIV advocacy network, Denmark

Established in 2000 and based in Copenhagen, Aidsnet is a national network of NGOs and research institutions working to improve the quality of HIV programmes and policies supported by Denmark in developing countries. Its work includes building members' technical capacity and exchanging evidence-based good practice. It has also served as a joint advocacy platform to engage with and inform the strategies of the Danish International Development Agency (DANIDA). During 2003-2009, Aidsnet benefitted from grants directly from DANIDA, enabling it to employ a full-time coordinator and part-time assistant. However, in 2010-11, its grants were channelled through a network administration body (the NGO Forum) and reduced, covering just a part-time coordinator. Comparing 2003 and 2011, funding decreased by 40%. In 2012, it ceased altogether – with resources allocated to other civil society networks with wider health

⁴⁴ Fact Sheet: Oceania, UNAIDS Report on the Global AIDS Epidemic, UNAIDS, 2010.

and development remits. As a result, Aidsnet is now functioning on an ad hoc basis, dependent on individual members to initiate meetings or take on thematic projects.

The decision to stop funding Aidsnet comes at a time of sustained or slightly increased financial investment in HIV (both domestically and internationally) by the Government of Denmark. However, it reflects a shift in political priorities – with HIV receiving less prominence (including in key national strategies) and being integrated (or ‘mainstreamed’) into wider health and development. It is feared that, although HIV might be included in the work of other civil society networks, the complex issues related to the epidemic (such as stigma and key populations) will be diluted, even neglected. There is now no single, formal mechanism for civil society to work together on HIV and hold the government to account to deliver on its promises, including those from the High Level Meeting 2011.

Impact on civil society of crisis 2: Reductions in multi-lateral funding for HIV

25. The consequences of the reduced/changed funding from the Global Fund are severe for civil society. In contexts as diverse as the Philippines [see Case study 5] and Eastern Caribbean [see Case study 6], negative impacts are seen at all levels, from life-saving community programmes to organisational development and national advocacy. In some cases, projects, offices and organisations have already closed. In many others, the likelihood of such action gets closer by the day.
26. Changes in eligibility for the Global Fund are especially impacting on countries with upper and lower middle incomes and concentrated HIV epidemics, such as Algeria [see Case study 7]. Within such countries, the sector often leads – and is, sometimes, the *sole* implementer of - interventions for key populations. In many cases, such responses have become almost entirely dependent on the Global Fund – with few, if any, other opportunities for funding (due to the withdrawal of bilateral donors and/or the reluctance of national governments to support ‘controversial’ populations)⁴⁵.
27. In Eastern Europe and Central Asia (EECA), eligibility could affect harm reduction programmes related to injection drug use – which is associated with the majority of HIV cases in a region where HIV prevalence and AIDS-related deaths continue to rise⁴⁶. According to the Eurasian Harm Reduction Network, some countries may not be able to apply for the TFM⁴⁷. This will not only impact on civil society’s life-saving services, but also on the sector’s vital role in ensuring a supportive environment and cost-efficient approaches, such as through community systems strengthening (CSS) and advocacy on human rights. While it has received an exception to apply to the TFM, the Russian Federation [see Case study 8] exemplifies what is at stake if resources are not secured.
28. The Global Forum on MSM and HIV cites how changes to Global Fund eligibility mean that countries such as Argentina, Brazil, China and Mexico – where interventions for MSM are critical – will not be able to apply to the Global Fund for Round 2 renewals and/or future funding opportunities⁴⁸.

⁴⁵ *How to Get To Zero: Smarter, Faster, Better: UNAIDS World AIDS Day Report*, UNAIDS, November 2011.

⁴⁶ *How to Get To Zero: Smarter, Faster, Better: UNAIDS World AIDS Day Report*, UNAIDS, November 2011.

⁴⁷ *Action Plan 2012-2013: Responding to the Financial Crisis of the Global Fund in Central and Eastern Europe and Central Asia*, Eurasian Harm Reduction Network.

⁴⁸ *Changes at the Global Fund and What to Look Out For in Early 2012: Information Note for MSM Advocates*, MSM Global Forum.

29. In some contexts, civil society is particularly hard-hit by the cost-efficiencies being made within the Phase 2 renewal of previous Global Fund grants. In others, the sector is affected by efficiency measures within the negotiation of successful Round 10 grants. For example, in Ukraine, the Round 10 proposal underwent significant reductions for Phase 1, including in CSS initiatives.⁴⁹ However, the cancellation of the Global Fund's Round 11 is bringing the starkest impact on civil society. According to the 2011 survey of UNAIDS country and multi-country offices, many countries would have used Round 11 to expand core interventions for their national response to HIV (such as ART), within which civil society would have played a key role (for example providing adherence follow-up in communities)⁵⁰. Without this critical source of support, countries will not be able to achieve the scale up necessary to fulfill their national strategies for HIV and achieve universal access.
30. The UNAIDS survey highlighted how Round 11 would have seen a focus on interventions of specific relevance to civil society, for example with 43% of countries likely to include programmes for MSM, 40% for sex workers and 23% for people who use drugs. In Pakistan, the Round 11 proposal would have included programmes to reach 60% of the country's transgender community. Many respondents indicated that: *"The Global Fund was the sole source of financing for MARPS [most at risk populations] interventions and that, in the absence of Global Fund financing, key populations would have very limited access to resources."* Almost all respondents (91% and 89% respectively) perceived a moderate to high risk that services for MSM and sex workers will now not be scaled up. Round 11 was also seen as an opportunity for further regional/multi-country proposals to the Global Fund – a process that has proven invaluable for supporting interventions for key populations that would not be included in proposals by individual Country Coordinating Mechanisms (CCMs).
31. At the national level, the International HIV/AIDS Alliance has documented how the cancellation of Round 11, plus the limitations of the TFM, is having two particularly strong impacts on its partners⁵¹. Firstly, it is affecting the sustainability of interventions to which civil society brings 'added value'. For example, in the Republic of South Sudan – where Round 11 was critical to addressing the 80% funding shortfall for the nascent National AIDS Plan – the TFM is unlikely to cover CSOs' care and support services and advocacy for an enabling environment. Secondly, it is affecting civil society's unique role in interventions for key populations. For example, in Bolivia, CSOs will have no means to scale up HIV prevention services for communities such as prisoners and indigenous people.
32. The International HIV/AIDS Alliance – alongside RESULTS UK and the Stop AIDS Campaign – has also highlighted how the cancellation of Round 11 will impact on the integrated strategies central to smarter investments in HIV⁵². In a report to mark World TB Day, it cites Zambia – where CSOs have played a critical role in HIV/TB integration, including strengthening the links between community-based interventions and health facilities and advocating on the legal and economic barriers to services for vulnerable populations. Here, the cancellation of Round 11 means that scale-up will not be possible,

⁴⁹ *Preliminary Analysis of Potential Impact on the HIV/AIDS Situation in Some EECA Countries Resulting from Changes in the Global Fund's Grant Policies*, EurAsian Harm Reduction Network, (Draft) March 2012.

⁵⁰ *Implications of The Global Fund's Cancellation of Round 11: Initial Findings of The UNAIDS Survey*, (unpublished), UNAIDS, December 2011.

⁵¹ *Don't Stop Now: How Under-funding the Global Fund to Fight AIDS, Tuberculosis and Malaria Impacts on the HIV Response*, International HIV/AIDS Alliance, 2012; and *Don't Stop Now: How Underfunding The Global Fund to Fight AIDS, Tuberculosis and Malaria Impacts on the HIV Response in Africa: Evidence Collated in Five Countries*, (presentation at Africa Activist Strategic Planning Meeting on Health Financing, Cape Town, South Africa, 20 – 22 March 2012), International HIV/AIDS Alliance, March 2012.

⁵² *Funding for AIDS, TB and Malaria: A Looming Crisis*, Results UK, International HIV/AIDS Alliance and Stop AIDS Campaign, March 2012.

while, with the country's current TB grant ending in June 2013, disruption to services is likely. The impact is already felt – with a number of hospices that provide palliative care and ARVs closing in the next few months. As Michael Gwaba, a HIV/TB Patient Advocate says: *“I have seen the Global Fund work – I’m alive thanks to its investments in Zambia. But right now we now risk reversing the gains we have made in the fight against HIV/AIDS and TB. Without new investment fast, those still waiting for treatment and care won’t be as lucky as I have been”*.⁵³

33. According to Médecins Sans Frontières (MSF), reduced Global Fund resources reduce the ability of national governments and CSOs to scale-up: existing ART programmes; earlier initiation of treatment (in line with World Health Organisation guidelines); better first-line HIV drugs; and TB and DR-TB diagnosis and treatment⁵⁴. For example, in Lesotho – with HIV prevalence of 23% and a huge shortage of health care workers – lay HIV/TB counsellors have taken on HIV counselling and testing and support for treatment adherence, contributing to ART coverage of 66%. However, with funding for the existing programme ending in 2012 and the cancellation of Round 11, the country will not be able to support these community workers and the scale-up of treatment will come to a halt.
34. Finally, in some countries, the Round 11 crisis comes on top of financial challenges with previous Global Fund grants. In South Africa - home to the largest number of PLHIV in the world (an estimated 5.6 million)⁵⁵ - the pioneering work of the Treatment Action Campaign (TAC) has been threatened by delays in disbursements for previous Global Fund grants, due to administrative issues with the Principal Recipient and the consolidation of the country's Round 6, 9 and 10 grants into a single stream⁵⁶. This left TAC with an acute cash flow crisis, risking the retrenchment of staff, closure of offices and loss of past gains (such as a programme of treatment literacy practitioners, network of 130 branches and ground-breaking legal precedents).

Case study 5: Reduced funding for unique PLHIV services and advocacy, the Philippines

Pinoy Plus was set up 17 years ago as a national network of PLHIV. It received project funding (as a Sub or Sub-Sub Recipient) through HIV grants from Rounds 3, 5 and 6 of the Global Fund. With these resources, Pinoy Plus undertook service delivery responsibilities, in particular providing unique psycho-social and treatment adherence support to PLHIV, including those newly diagnosed. The funding also enabled it to function as a network – employing coordination staff, consulting with constituents and engaging in national advocacy. However, Pinoy Plus has experienced decreased funding since the closure of the Round 3 and 5 grants. It fears even greater implications when the Round 6 grant ends in November 2012. To date, the impacts of reduced resources have been two-fold. Firstly, the network has had to cut-back key services, such as its drop-in centre and home-based support for PLHIV and their families. Secondly, the sustainability of Pinoy Plus as a national stakeholder has been threatened - at a time when its role (as a voice for PLHIV) is more crucial than ever. As it struggles to pay salaries and office rent, it has less capacity to be a 'watchdog' and hold the government to account.

⁵³ Press Release: *Will Gains Made on TB and HIV be Lost?*, Results UK, International HIV/AIDS Alliance and Stop AIDS Campaign, 29 March 2012.

⁵⁴ *Losing Ground: How Funding Shortfalls and the Cancellation of the Global Fund's Round 11 are Jeopardising the Fight Against HIV and TB*, Médecins Sans Frontières, March 2012.

⁵⁵ *How to Get To Zero: Smarter, Faster, Better: UNAIDS World AIDS Day Report*, UNAIDS, November 2011.

⁵⁶ The Treatment Action Campaign (TAC) Will Have to Close In January 2012 - Unless the Global Fund Meets Its Contractual Agreement, TAC, January 2012.

These challenges are taking place within a wider context that has seen reduced political commitment – from both national and international stakeholders – to HIV in the Philippines and increased challenges for NGOs accessing resources from the government. Despite the country being part of the Pacific Peninsula and having funding from USAID and AUSAID, the Global Fund remains its major donor for HIV (accounting for 80% of external funds). In 2012, while a successful application to the TFM could cover ‘essential’ costs (such as maintaining the current levels of ART), there are few alternatives for funding the type of services provided by Pinoy Plus. Donors no longer fund NGOs directly, but channel their money through government departments, with money then released for health plans by Local Government Units. However, such plans largely fail to recognise or support the costs of civil society initiatives. Meanwhile, at the national level, contracts commonly go to large NGOs, rather than smaller networks such as Pinoy Plus. Overall, this situation has led to increased tension and competition within the civil society sector, for example with some CSOs – as a means of survival – applying for grants that are beyond their area of expertise. If Pinoy Plus is unable to secure resources, the impact will include lower adherence to ART by PLHIV and loss of patients in the care system (due to reduced follow-up). Meanwhile, the Philippines has one of the fastest growing epidemics in the Asia and the Pacific region, with a sharp increase (58%) in new cases during 2008-2009⁵⁷.

Case study 6: Impact of cancellation of Round 11 on regional HIV work, Eastern Caribbean

Adult HIV prevalence in the Caribbean is about 1% (the second highest in any region of the world). Research indicates much higher levels among sex workers, MSM and non-injecting stimulant users.⁵⁸ In 2005, the Secretariat of the Organization of Eastern Caribbean States (OECS) became the Principal Recipient of a Round 3 grant from the Global Fund. The 5-year, US\$ 8,008,679 programme supported 6 countries (Antigua and Barbuda, Dominica, Grenada, St Kitts and Nevis, Saint Lucia and Saint Vincent and Grenadines) and was governed by a Regional Coordinating Mechanism, including representatives of PLHIV and key populations. The programme emphasised the scale-up of comprehensive and accessible prevention, care and treatment services – with many interventions implemented by civil society, within the context of a concentrated HIV epidemic and intense stigma. Its results included providing ART to 707 PLHIV, and HIV counselling and testing to 19,840 people. They also included the development of national systems, such as mechanisms to receive and respond to incidents of discrimination against PLHIV. Meanwhile, during the same period, four of the countries - St Lucia, Saint Vincent and Grenadines, Granada and St Kitts and Nevis - also received loans from the World Bank to implement further HIV programmes.

The World Bank loans ended in 2010 and the Global Fund grant in 2011. In response, the OECS started to develop a proposal for Round 11 of the Global Fund – focused on piloting an extended care package targeting key populations and young people. With the Round’s cancellation, the proposal was stopped and – as their previous grant had already finished – the OECS was not eligible to apply to the TFM. The remaining major donor for HIV in the region is from PEPFAR – which is scheduled to end in 2013. The effects of this situation are already evident. Among civil society, programmes are being scaled-back, salaries cannot be paid and highly trained staff are leaving the sector. In communities, as explained by Joan Didier, Executive Director, St Lucia AIDS Action Foundation: *“The most significant impact is that we’re*

⁵⁷ Country Report: Follow-Up to the Declaration of Commitment on HIV and AIDS, United Nations General Assembly Special Session on AIDS, January 2008 to December 2009, Philippine National AIDS Council.

⁵⁸ How to Get to Zero: Faster, Smarter, Better: UNAIDS World AIDS Day Report 2011, UNAIDS, 2011.

seeing more people dying. During the Global Fund grant, we achieved reductions in mortality. But now people are not adhering to their treatment because the social and nutritional support they need to do so is not there." The OECS is actively seeking funding from other sources, including advocating to Ministries of Health to increase domestic contributions and incorporate HIV-related costs in wider health programmes. However, the scale and urgency of the funding gap is challenging. Meanwhile, civil society faces a double challenge. Having benefitted from the more supportive environment created by the Global Fund – where the sector, including key populations, had a 'seat at the table' - it now faces a more challenging political as well as financial environment in which to make its voice heard.

Impact on civil society of crisis 3: Inadequate progress on domestic investment in HIV

35. As summarised, increased domestic investment in HIV is mandated by the frameworks and processes that are central to the future response to HIV by the world's governments. However, despite some exceptions, governments' scale-up of domestic investment in HIV remains painfully slow. Meanwhile, those same governments now also face unrealistic expectations to 'fill the gap' left by the Global Fund and bilateral donors. The 2011 UNAIDS survey of country and multi-country offices highlighted how: *"Many countries are scrambling to keep their programmes going while identifying alternate sources of funding for scaling up – however, it is unlikely that domestic financing will be able to cover these gaps in the short term. Programmes for key populations and those managed by community groups will likely be worst affected."*⁵⁹
36. As already described in some of the case studies, even where national or local governments have established mechanisms to provide funding for HIV, these are often inappropriate or inaccessible to CSOs. For example – as in Algeria [see Case study 7] - such mechanisms may not be open to funding interventions for key populations, such as MSM, who are politically marginalised or even criminalised. In contexts such as the Pacific Islands [see Case study 3] or the Philippines [see Case study 5], such mechanisms may not respond to the specific needs of CSOs, for example in terms of recognising the full costs of their interventions or providing for capacity building needs (as opposed to short-term projects).
37. Within some of the BRICS countries – with bilateral donors exiting - mechanisms to fund the domestic responses to HIV are also not always adequate or accessible for civil society. For example, in the Russian Federation [see Case study 8] government funding will not support harm reduction programmes, while, in Brazil [see Case study 1], government funding has not yet replaced the role of international donors in supporting civil society's advocacy on the socio-political factors (such as gender inequality and marginalisation of key populations) that increase people's vulnerability to HIV.

Case study 7: Global Fund ineligibility and challenges of domestic funding threaten critical work with key populations, Algeria

With a Round 3 HIV grant of US\$ 6,945,289, Algeria was one of the first countries in the Middle East and North Africa (MENA) to benefit from the Global Fund and the first in the region to have an association of PLHIV with a woman who spoke openly about her status. The Global Fund supported CSOs to implement ground-breaking work with key populations, especially female sex workers and MSM – in a context where, despite low HIV prevalence among the general

⁵⁹ *Implications of The Global Fund's Cancellation of Round 11: Initial Findings of The UNAIDS Survey*, UNAIDS, December 2011.

public, levels among key populations are much higher (such as 3.95% for sex workers⁶⁰). Over time, however, Algeria experienced major challenges with the governance and transparency of its grant – limiting the effectiveness of decision-making and causing delays in disbursements. Meanwhile, proposals for further funds were rejected by the Technical Review Panel (TRP). The Round 3 grant is now in closure, while – due to changes in eligibility criteria – Algeria, as an upper middle income country, can no longer apply to the Global Fund.

The consequences of the financial and political challenges have been severe for civil society and its role. Some CSOs have had to close or reduce their programmes for key populations. Some larger NGOs have continued their work through support from other sources, notably international NGOs. For example, as reported to the 29th Programme Coordinating Board Meeting, Association de Protection Contre le SIDA (APCS) builds the advocacy capacity of PLHIV and takes on legal cases to fight stigma and discrimination against PLHIV and key populations.⁶¹ It also runs the first and only free and accessible HIV testing centre in the Oran region and is one of the few CSOs that address prevention of vertical transmission and support women living with HIV. However, APCS is concerned about the longer-term sustainability of its funding base – as international NGOs, themselves, face increasing constraints on their resources.

There is significant concern that, while civil society in Algeria has become dependent on the Global Fund, other donors for HIV have left the country. Meanwhile, although the government allocates domestic resources to HIV, it is reluctant to invest in programmes for groups such as sex workers, MSM and people who use drugs. As Aziz Tadjedine, President of APCS, states, financial support to such CSOs extends beyond activities and service delivery. It is also about: keeping these organizations engaged in global dialogue and advocacy; supporting high quality and equitable care for all people; fighting the stigma and discrimination that is often inherent in the system; and upholding the human rights of individuals. Making such CSOs solely dependent on domestic funding threatens their ability to do this work. At the launch of a UNAIDS report in December 2011, Hind Khatib-Othman, Director of the UNAIDS Regional Support Team for MENA, said: *“Work with key populations is difficult in settings where the levels of stigma and discrimination are high and the overall support from governments is limited.”*⁶² With the number of new cases almost doubling in the past decade, MENA is one of the two regions in the world with the fastest growing HIV epidemic. Meanwhile, as of 2010, access to ART in the region averaged at just 8%.

Case study 8: Restricted domestic funding contributes to exceptional permission to apply for TFM, Russian Federation

The Russian Federation has a growing HIV epidemic⁶³. The majority of incidents remain associated with injection drug use – in 2011, accounting for 58.2% of newly registered cases

⁶⁰ Data for 2007. *Rapport UNGASS Algérie 2010: Rapport De Situation National A L'intention De L'UNGASS Sur Le Suivi De La Déclaration D'engagement De La Session Extraordinaire De L'assemblée Générale Des Nations Unies (UNGASS) Sur Le VIH/SIDA: (Période Considérée : 2008 – 2009)*, République Algérienne Démocratique Et Populaire Ministère De La Sante, De La Population Et De La Reforme Hospitalière.

⁶¹ *Thematic Segment: HIV and Enabling Legal Environments: Format and Background Note: 29th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, 13-15 December 2011*, UNAIDS, November 2011.

⁶² *Feature Story: Middle East and North Africa Records The Highest Number of HIV Infections Ever In The Region In 2010 But Recent Progress Is Promising*, UNAIDS, 4 December 2011.

<http://www.unaids.org/en/resources/presscentre/featurestories/2011/december/20111204menareport/>

⁶³ *UNAIDS Report on the Global HIV Epidemic 2010*, UNAIDS, 2010.

with a known route of transmission⁶⁴. According to UNAIDS, in St Petersburg, HIV prevalence among people who use drugs doubled over a recent five year period (to an estimated 60%⁶⁵). The Russian Federation has received 4 grants from the Global Fund, through Rounds 3 (HIV), 4 (HIV and TB) and 5 (HIV). While the earlier HIV grants focused on ART, the latter addressed comprehensive harm reduction, including needle and syringe exchange, psycho-social support and referrals. The 5-year, US\$ 14,308,388 grant had a civil society Principal Recipient (the Russian Harm Reduction Network 'ESVERO') and started on 1 September 2006. It had the largest coverage of the HIV grants and reached or surpassed its targets - supporting 149,628 people who use drugs through 48 community groups in 33 cities⁶⁶.

ESVERO's work took place within a changing and highly challenging economic and political environment. With the Russian Federation classified as upper middle income, major bilateral donors left the country and the government showed increasing determination to be financially self-sufficient. However, under the 'zero tolerance' approach of its 2010 National Anti-Drug Strategy, the government does not recognise, or resource, harm reduction work. The situation is exacerbated by challenges in coordination among national stakeholders that, for example, contributed to the Global Fund's decision in March 2012 to cancel the country's approved Round 10 grant for TB.

As ESVERO's grant came to an end on 31 August 2011, it explored options to sustain its critical work. Despite Russia's economic status, it maintained eligibility for future Global Fund support under the 'NGO rule'⁶⁷. However, it was *ineligible* to apply to the TFM - as it did not meet the requirement of essential services being disrupted during 1 January 2012 - 31 March 2014. ESVERO and other CSOs advocated to the Global Fund – articulating the evidence base for harm reduction, effectiveness of the Round 5 grant, lives that would be lost through discontinued services and lack of alternative funding⁶⁸. On 8 March 2012, in the Board of Global Fund granted ESVERO exceptional permission to apply to the TFM⁶⁹. The decision is welcomed as a life-line for harm reduction services in the Russian Federation. However, the funding is not yet secured. Also, in accordance with TFM criteria, funds will not cover all aspects of ESVERO's work, such as CSS and the type of advocacy that secured the exception.

IV THE RESPONSE: What actions have been taken on the reductions in funding for HIV?

38. The UNAIDS Programme Coordinating Board has already addressed a number of agenda items and taken decisions relating to the reductions in funding for HIV – predominantly focusing on support to national governments. Key examples include that, at the 20th

⁶⁴ *HIV Infection in the Russian Federation in 2011*, Federal Scientific and Methodology Centre on AIDS, Russia, 2011. (<http://www.hivruussia.org/files/stat/2011/spravka.doc>)

⁶⁵ *UNAIDS Report on the Global HIV Epidemic 2010*, UNAIDS, 2010.

⁶⁶ *The Programme of The GFATM Round 5 in Russia and The Eligibility Requirements for The Global Fund's Transitional Funding Mechanism (TFM): Memo*, ESVERO, February 2012.

⁶⁷ Section 11: UMICs not listed on the OECD's DAC list of ODA recipients⁹ are ineligible to apply for funding for HIV and AIDS proposals except if the application is submitted by a non-governmental organization (NGO) within the country in which activities would be implemented, and for which the government of such country shall not receive any funding. This could be in the form of a non-CCM application or other valid application. Such funding requests¹⁰ shall demonstrate that they target key services, as supported by evidence and the country's epidemiology. Confirmation shall also be provided by applicants that the targeted services are not being provided due to political barriers. *Policy on Eligibility Criteria, Counterpart Financing Requirements and Prioritisation of Proposals for Funding from the Global Fund*, the Global Fund to Fight AIDS, Tuberculosis and Malaria, May 2011.

⁶⁸ *The Programme of The GFATM Round 5 in Russia and The Eligibility Requirements for The Global Fund's Transitional Funding Mechanism (TFM): Memo*, ESVERO, February 2012.

⁶⁹ *B25/EDP/12 – Transitional Funding Mechanism Arrangements for RUS-506—G05*, the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, 8 March 2012.

Programme Coordinating Board Meeting in June 2007, the Programme Coordinating Board requested: *“An independent assessment, building on existing studies, in consultation with UNAIDS, national stakeholders, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other partners, to review and assess the sustainability of HIV/AIDS financing”*. This item was to be included at the 22nd Programme Coordinating Board Meeting, but was deferred to the 23rd and then 24th Meetings. It has not been specifically presented to the Programme Coordinating Board (although related issues have been included in subsequent Meetings).

39. The 25th Programme Coordinating Board Meeting in December 2009 included an item on the impact of the global economic crisis. The recommendations of the UNAIDS paper included that: Member States should conduct more rigorous prioritization to demonstrate a greater impact from HIV investments; major funders should consult more with each other to ensure an orderly response to the crisis and that shifts towards funding broader health initiatives continue to cover HIV programmes; and UNAIDS should convene meetings with donors, engage in international dialogue on innovative financing and focus its technical support on areas such as priority-setting and resource mobilization⁷⁰. The Programme Coordinating Board called on UNAIDS and its partners to: *“Provide a comprehensive package of technical support to countries, paying particular attention to high burden countries, to contain and mitigate the negative impact of the current crisis on the HIV/AIDS response and to use its convening power to bring HIV/AIDS funders together, where possible coordinating with similar work underway at the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other innovative financing mechanisms including UNITAID.”*⁷¹
40. UNAIDS has also made strategic responses to the funding crisis. Alongside the Strategic Investment Framework, these include attention to sourcing African solutions.⁷² The latter sets out an agenda focused on: strengthening African ownership of development investments through utilising more diversified funding sources; creating an African Medicines Regulatory Agency for faster roll-out of drugs and strong quality assurance; and catalysing local production of medicines in partnership with BRICS countries and other emerging economies. However, the feasibility of this strategy has yet to be evaluated by all stakeholders, including Member States and civil society.
41. Within its revised Memorandum of Understanding (MoU) with the Global Fund, approved by the 22nd Programme Coordinating Board Meeting, UNAIDS commits to core functions in the partnership, such as providing strategic analysis, policy advice and technical support⁷³. The MoU states that: *“Both partners will advocate jointly to make sure that sufficient resources are mobilised for a comprehensive and sustainable response to the pandemic.”* Commitment was further detailed in Maximising Returns on Investment: UNAIDS Support to Countries to Make Global Fund Money Work, published in June 2011.⁷⁴ This outlines that the Secretariat’s role (at global, regional and country levels) focuses on: engaging partners; setting strategic priorities; mobilising resources; and supporting grant implementation.
42. Within its 2011 Guidance for Partnerships with Civil Society, Including People Living with HIV and Key Populations, UNAIDS states that: *“Securing adequate resources, specifically funding, for a robust and effective response to HIV—which includes the active involvement*

⁷⁰ *Impact Of The Global Financial And Economic Crisis On The AIDS Response*, 25th Meeting of the UNAIDS Programme Coordinating Board 8-10 December 2009, UNAIDS, October 2009.

⁷¹ *Decisions, Recommendations and Conclusions, 25th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, 8-10 December 2009*, UNAIDS, December 2009.

⁷² *AIDS Dependency Crisis: Sourcing African Solutions*, UNAIDS, 2012.

⁷³ *Memorandum of Understanding*, UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, 2008.

⁷⁴ *Maximising Returns on Investments: UNAIDS Support to Countries to Make Global Fund Money Work*, UNAIDS, June 2011.

of civil society, in particular key populations and people living with HIV—is and will continue to be a core priority and function of Joint UN teams on AIDS as well as for colleagues at regional and global levels.”⁷⁵ It further states that: “This resource mobilization work needs to be integrated into UNAIDS country budgets, regional team budgets and the UBRAF, all of which must identify how they will build capacity for partnerships among UNAIDS and civil society, as well as identifying how UNAIDS can intensify and scale up support for resource mobilization for civil society.”

V THE URGENT ACTIONS: What leadership role must UNAIDS play?

43. The 2012 NGO Report has summarised the scale and nature of the reductions/changes in funding for HIV and their worsening impact on civil society, especially on PLHIV and key populations such as MSM, transgender people, people who use drugs and sex workers. It has also noted steps that UNAIDS has taken to respond. However, the NGO Delegation expresses strong concern that - in this time of unprecedented crisis - the Programme Coordinating Board is failing to fulfil its leadership role, especially as it relates to leveraging UNAIDS' unique position as a convener capable of driving a more systematic and coordinated response, one that fully realizes the important role civil society can play. As such, the NGO Delegation calls on the Programme Coordinating Board to:

1. Take all steps within its means this year to ensure a fully funded and functional Global Fund - as a critical mechanism to support the unique work of civil society, especially with PLHIV and key populations. This includes:

i. Meeting the commitments made in its MOU with the Global Fund (including to provide strategic analysis and policy advice and implement joint advocacy for resource mobilization);

ii. Supporting an emergency donor conference and the opening of a new early funding window in 2012 (decision point 5 as noted in paragraph 39 of the third agenda item of the 25th Programme Coordinating Board);

iii. Advocating to donor governments to:

a. Make, fulfil or enhance pledges to the Global Fund, in particular in recognition of its unique role in supporting the work of civil society;

b. Cover critical, urgent gaps in HIV funding (such as those caused by the cancellation of Round 11 and limited remit of the TFM), including for civil society.

To fulfil this recommendation, the Programme Coordinating Board should *urge* UNAIDS to advocate for a fully funded civil society with donor governments and the Global Fund, using its convening authority to do so. UNAIDS should specifically advocate for the creation of direct funding mechanisms for civil society organizations within the new Global Fund architecture.

2. With urgency, reinvigorate and expand country-level approaches for addressing the impact of the funding crisis on HIV, in particular in relation to civil society. This should maximize the ‘value added’ of both the UNAIDS Programme as a whole and the Secretariat, Co-Sponsors and Member States individually. The approach should:

⁷⁵ UNAIDS Guidance For Partnerships With Civil Society, Including People Living With HIV And Key Populations, UNAIDS, December 2011.

- i. Advocate for a maintenance or increase in bilateral support to HIV.** As appropriate, revisit and revise policies and processes that have led to decreased resources for HIV, including for civil society.
- ii. Maintain adequate funding to middle income countries** and low prevalence countries with concentrated epidemic, recognizing that in many countries, civil society is the only responder for key affected populations.
- iii. Support national governments to set targets and develop plans to increase their domestic funding for health and HIV.** Within this, ensure that national resources are appropriate and accessible to civil society, including those working with key affected, marginalised and criminalised groups.
- iv. Encourage governments to develop innovative, long-term funding mechanisms,** including a Financial Transaction Tax, designed to raise additional and regular funding for HIV and other global health priorities.
- v. Advocate for the removal of political and trade barriers to cost-efficient responses to HIV.** This includes involving national stakeholders, key government sectors, bi- and multi-lateral agencies **to ensure that their strategy does not compromise the manner in which countries are able to utilize TRIPS flexibilities;** and that middle and upper-middle income countries, despite the restrictive conditions of the negotiated voluntary licenses, have access to essential drugs
- vi. Recognize the need for strategic information and in-country capacity development for generic drug production** as fundamental for guaranteeing treatment for all in need.

To fulfil this recommendation the Programme Coordinating Board is invited to *request* UNAIDS, in partnership with Member States, to support civil society, notably in African, Asian and Latin American regions, to advocate for access to treatment by mobilizing existing funding mechanisms as well as by advocating to raise new ones, to dedicate direct funding to civil society to build capacity in this area.

3. With urgency, develop an overarching UNAIDS strategy in response to the HIV funding crisis that ties together relevant UNAIDS, donor and global policies. These include: financial global commitments related to gender and human rights; *Getting to Zero*; the *UNAIDS Technical Support Strategy* and work of the Technical Support Facilities; *UNAIDS Guidance for Partnership with Civil Society*; the *Strategic Investment Framework*; and other strategies used by key donors (such as the *Global Fund's SOGI Strategy* and guidance documents issued to the Country Coordinating Mechanisms and *PEPFAR's Country Operational Plans*). The Strategy should articulate how UNAIDS will:

- i. Gather and provide strategic information,** including mapping funding gaps for civil society, documenting disruptions to civil society services and monitoring the roll-out of both Phase 2 renewals and the TFM, to ensure inclusion of and support to key populations and communities during this process;
- ii. Give specific support to countries and civil society** and provide tools and competence building to do national financial gaps analyses, national costed health plans for targeted interventions and budget tracking and monitoring.

iii. Adapt the Technical Support Strategy to ensure that it is 'fit for purpose' to address the changing needs of governments and civil society to, for example, re-programme Global Fund grants, implement TFM requirements and adapt to mobilise resources.

iv. Actively promote and fulfil the civil society focus of the UNAIDS Strategic Investment Framework. This should include:

v. Ensuring that both Member States and civil society are fully involved in the future development and roll-out of the Investment Framework.

vi. Emphasising the centrality of civil society to evidence-based and cost-efficient responses to HIV that target those most vulnerable (including key populations) with proven interventions and provide value for money.

To fulfil this recommendation, the Programme Coordinating Board is invited to *request* UNAIDS to examine how decreased funding for HIV in the current environment impact UNAIDS' strategies, including the *Strategic Investment Framework* assumptions, and the ability to meet the goals laid out in the *2011 Political Declaration on HIV/AIDS*, as a step toward developing an overarching strategy that emphasizes resource mobilization and the centrality of civil society. UNAIDS should report back at the 31st meeting.