Agenda item 8

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BEST PRACTICES ON EFFECTIVE FUNDING OF COMMUNITY-LED HIV RESPONSES

11-13 December 2018 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
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Additional documents for this item: *none*

Action required at this meeting—the Programme Coordinating Board is invited to:
See draft decision points in the paragraphs below:

129. Recalling the 2016 United Nations Political Declaration on HIV and AIDS, paragraphs 60d and 64a:

130. *Take note* of the report;

131. *Encourage* Member States to:

a. Dedicate maximum available resources to fulfilling the right to health, including the 30% coverage by community-led HIV programmes and 6% of HIV financing towards social enablers, as agreed in the 2016 Political Declaration;

b. review and amend relevant laws, policies, institutions and mechanisms to create and maintain a safe and enabling environment in which civil society can efficiently support the AIDS response and the achievement of the targets for, and the goal of, ending AIDS by 2030;

c. report on coverage and expenditures using the Global AIDS Monitoring and National AIDS Spending Assessment tools on an annual basis;

132. *Request* the Joint Programme to:

a. Support the process of reviewing laws and policies that may impede financing of both community-led AIDS responses and social enablers;

b. convene a task team with diverse donors, implementing countries, and civil society representatives, including representatives of people living with HIV, women and adolescent girls and young women, youth and key populations, to standardize the use of definitions, including, “community-led AIDS response” and “social enablers” and to recommend good practices and improved modalities to ensure access to funding for community-based organizations and constituency-based networks.

Cost implications for the implementation of the decisions: *none*

TABLE OF CONTENTS

EXECUTIVE SUMMARY

1. In approving the Sustainable Development Goals (SDGs), United Nations (UN) Member States committed to end the AIDS epidemic by 2030; as well as reduce inequalities; promote gender equality; create just, peaceful and inclusive societies; and to promote effective civil society partnerships to realize those goals.[1]

2. Reaching the people who are left furthest behind will require the active engagement of community-led organizations and constituency-based networks that are embedded in affected communities and have their trust. Civil society also plays an important role in upholding fundamental human rights principles such as transparency, accountability and non-discrimination. The 2016 Political Declaration on Ending AIDS included two highly pertinent commitments:[2]
   - "Ensure that at least 30% of all service delivery is community-led by 2030";[3] and
   - ensure that "at least 6% of HIV resources are allocated for social enabling activities, including advocacy, community and political mobilization, community monitoring, public communication and outreach programmes for rapid HIV tests and diagnosis, as well as for human rights programmes such as law and policy reform, and stigma and discrimination reduction".[4]

3. The commitment to quantify and report on investment in community-led AIDS responses and in social enablers was a ground-breaking recognition that social mobilization and community engagement have a critical role to play in health. As the international community strengthens global partnerships to fulfill the SDGs, the global AIDS response is leading the way in addressing underlying determinants to health and in mobilizing the energy and knowledge of communities at grassroots level.

4. This report responds to the Decision Points from the 39th Programme Committee Board (PCB) meeting and follows on the *Report on feasible ways to measure the achievement of the financial-related targets of the 2016 Political Declaration*, submitted to the 42nd PCB meeting. The latter report noted the challenges to financing the AIDS response and renewed the call on all countries to improve systematic and routine reporting to the Joint UN Programme on HIV/AIDS (UNAIDS).[5]

5. The current report presents an overview of available information on progress towards the two cited commitments from the 2016 Political Declaration on Ending AIDS. It is based on published information from UNAIDS, national governments, donors and civil society organizations. The report identifies persistent barriers to financing these critical areas of work and explores opportunities for overcoming those barriers.

6. In summary, the report finds that:
   - global investment in AIDS activities managed by civil society organizations has declined slightly since peaking in 2012–2013;
   - political and administrative barriers are impeding access to funding for civil society, although good practices exist and could be taken up more widely;
   - more robust data are needed to determine where the remaining funding is being allocated;
   - UNAIDS has developed tools and indicators to enable countries to monitor coverage of and investment in community-led responses and social enablers. These could be utilized more widely in routine reporting. Good reporting practices used by some donors could also be adopted more widely;
   - in order to facilitate consistent reporting among UN Member States and donors, the term “community-led AIDS response” should be defined further to clarify its specific components;

- similarly, “social enablers” are grouped and reported on in diverse ways. Breaking this umbrella term down into its component parts would facilitate increased routine monitoring of coverage and increased investment, including in the seven key programmes UNAIDS recommends for reducing stigma and discrimination and for increasing access to justice in national AIDS responses;[6] and
- HIV funding to civil society organizations should be disaggregated further to track investment in organizations that are led by people living with HIV, women, young people and key populations.[1]

7. The two highlighted commitments in the Political Declaration on Ending AIDS set the stage for reshaping the ways health services are planned, financed and evaluated. They will yield lessons that can be assessed and adopted by other global health initiatives in the future. Living up to those commitments also requires some adjustments to global health financing and data systems in order to monitor progress, along with a strong collective effort to take the actions needed to end the AIDS epidemic.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

8. This section summarizes the most important findings of a review of publicly available literature and aid data (as well as some unpublished data) from UNAIDS and external aid agencies on funding for community-led responses and on barriers to funding these responses. It also presents as set of recommendations.

Findings	Recommendations
1. Global investment in AIDS responses through civil society organizations has declined since peaking in 2012–2013. Political and administrative barriers impede access to funding for community-led AIDS responses and for social enablers.	Countries should commit maximum available resources to fulfilling the right to health, including ensuring 30% coverage by community-led HIV programmes and 6% of HIV financing towards social enablers, as agreed in the 2016 Political Declaration on Ending AIDS. The Joint Programme should support countries to review laws and policies that may impede financing of community-led AIDS responses and social enablers. Countries should review and amend relevant laws, policies, institutions and mechanisms to create and maintain a safe and enabling environment in which civil society can operate free from hindrance, insecurity and reprisals. The right to freedom of association should be subject only to such limitations as are in accordance with applicable international obligations.

[1] UNAIDS defines key populations as including people living with HIV, sex workers, gay and other men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants.

2. To facilitate consistent reporting among UN Member States and donors, the term "community-led AIDS response"[2] should be clearly defined to clarify its specific components. Similarly, "social enablers" are grouped and reported on in diverse ways. Clearly defining the component of this concept would facilitate increased routine monitoring of coverage and investment, including in the seven key programmes UNAIDS recommends for reducing stigma and discrimination and for increasing access to justice in national AIDS responses. HIV funding to civil society organizations should be disaggregated to track investment in organizations led by women, youth and key populations.	UNAIDS should urgently convene a task team with diverse donors, implementing countries and community representatives (including representatives of people living with HIV, women and adolescent girls and young women, young people and key populations) to agree on definitions for "community-led AIDS response" and "social enablers" that reflect the realities of the AIDS response and that can be monitored effectively.
3. Multilateral and bilateral aid and private foundations use diverse terms and metrics for reporting on investments in community-led AIDS responses.	Donors are encouraged to review their financing and reporting modalities. They need to help ensure that those modalities are aligned with the commitments in the Political Declaration on Ending AIDS and that they enable monitoring of relevant activities.
5. UNAIDS has developed tools and indicators to enable countries to monitor coverage of and investment in the community-led response and social enablers. These could be utilized more widely in routine reporting.	Countries are encouraged to report on coverage and expenditures using the Global AIDS Monitoring (GAM) and National AIDS Spending Assessment (NASA) tools on an annual basis. UNAIDS should share that information online to enable collective monitoring of progress towards the two highlighted commitments in the Political Declaration on Ending AIDS.
6. Current funding architectures and modalities may limit access to funding for community-based organizations and identity-based networks.	A task team should be established to recommend good practices and improved modalities to ensure access to funding for community-led organizations and constituency-based networks.

[2] As described by Dr. Rosalía Rodriguez-García during the 38th PCB meeting, "Communities are formed by formal (CBOs) and informal organizations (mothers' groups) or a combination of formal and informal. Communities are defined by sharing a geographic sense of place or sharing common characteristics, interests, and cultural identity". See Rodriguez-García, R. The Role of Communities in Ending AIDS: Community Engagement Achieves Results. Evidence from a Portfolio of Evaluations in support of Community Engagement for Services Delivery, Advocacy and Change. Geneva, 30 June 2016 (http://www.unaids.org/sites/default/files/media_asset/20160630_UNAIDS_PCB38_Thematic_Rosalia_Rodriguez-Garcia_presentation.pdf).

INTRODUCTION

9. In approving the Sustainable Development Goals (SDGs), United Nations (UN) Member States committed to end the AIDS epidemic by 2030; as well as reduce inequalities; promote gender equality; create just, peaceful and inclusive societies; and to promote effective civil society partnerships to realize those goals.[7]

10. The mobilization of political commitment towards those two goals will help fulfil the right to the highest attainable standard of health, ensuring that no one is left behind. This builds on the "UN Common Understanding on a Human Rights-Based Approach", which commits UN partners to uphold the right to participation in development cooperation. Providing funding to organizations that are led by and for their constituents is an important way to uphold the human rights of those groups.[8]

11. Reaching the people left furthest behind also requires the active engagement of community-led organizations and constituency-based networks rooted in communities of people living with HIV, women, young people, gay and bisexual men and other men who have sex with men, people who use drugs, sex workers, prisoners and transgender people.

12. Civil society platforms have been essential for the empowerment and mobilization of women and key populations in many countries. Civil society also plays a critical role in upholding fundamental human rights principles and ensuring transparency and accountability. New sectors have emerged in the AIDS response to represent the voices and serve the needs of marginalized populations, such as young key populations, migrants, indigenous peoples and persons with disabilities. In this way, the global AIDS response is developing inclusive approaches to community mobilization that will offer useful lessons as the world moves towards fulfilling Universal Health Coverage.

13. Advocacy has sparked action, mobilized unprecedented financial resources and enabled communities to participate in designing health services that meet their needs. When traditional policy-making processes stall, advocacy often highlights the problems and leverages community power and political will to drive action and innovation.

14. For these reasons, AIDS advocates around the world are a major force for an accelerated, more equitable scale-up of effective HIV and health programming. Increased funding support for advocacy from private funders, multilateral organizations and governments is therefore essential if the world is to meet ambitious Fast-Track targets on treatment, prevention and human rights, and advance towards ending the AIDS epidemic as a public health threat by 2030.[9]

15. The 2016 Political Declaration on Ending AIDS reaffirmed the commitments made to the SDGs by Heads of State. It further recognized the important leadership role played by community organizations, with several specific commitments.[10] The first was a commitment to "*Ensure that at least 30% of all service delivery is community-led by 2030*".[11] The second was a commitment to ensure that "*at least 6% of HIV resources are allocated for social enabling activities, including advocacy, community and political mobilization, community monitoring, public communication, and outreach programmes for rapid HIV tests and diagnosis, as well as for human rights programmes such as law and policy reform, and stigma and discrimination reduction*".[12]

16. Both those commitments represent important steps forward in the strategic planning and financing of the global AIDS response. While the AIDS response started as a social movement spearheaded by small, grassroots groups of people living with HIV and their families and friends, it eventually evolved into a global transnational sector made up of

diverse actors and funding streams. The commitment to quantify and report on two catalytic aspects not routinely addressed in health governance is unique to the AIDS response. As the international community strengthens global partnerships that can work together to fulfill the SDGs, these commitments establish inclusive and human rights-based approaches that should be integrated into broader systems of financing and evaluating health.

17. Since these two commitments in the Political Declaration on Ending AIDS represent a paradigm shift in the way health is managed, financed and evaluated, they also require careful and precise finetuning of global health financing. This needs to be backed by a robust collective effort to ensure that the commitments are realized.

18. This is especially pertinent in light of the changing landscape of global health financing. Increasingly, donors and countries are developing new approaches to health financing that emphasize progress towards Universal Health Coverage.[13] A 2018 report from Kaiser Family Foundation and UNAIDS found that global HIV financing to low- and middle-income countries has flatlined; a slight, apparent increase in disbursements in 2017 reflected the timing of US funding and is unlikely to continue.[14]

19. Civil society organizations working on HIV have reported a reduction in available funding. A survey by UNAIDS of more than 480 community-based organizations in 2015 found that 40% reported that their funding had decreased since 2013 and 89% of those who reported a decrease said they had scaled back services as a result.[15] Fifty-three percent of respondents (mostly small community-based organizations) to a web-based survey done by the PCB NGO Delegation in 2016 reported that they had experienced a downturn in available funding from the Global Fund.[16]

20. Building on the *Report on feasible ways to measure the achievement of the financial-related targets of the 2016 Political Declaration*, submitted to the 42nd PCB meeting in June 2018, the current report provides an overview of barriers to funding the community-led AIDS response and social enablers. It also provides an overview of the available data, available tools and the current state of reporting on the two highlighted commitments.

BACKGROUND AND CONTEXT

21. Social science research has generated to a body of literature that demonstrates the effectiveness of community-based programmes and of social enablers in reaching the 90–90–90 Fast-Track targets. Several studies published since the 2016 Political Declaration on Ending AIDS highlight specific areas of impact:

    - A major challenge is to **maintain adherence to antiretroviral therapy (ART)**. Several studies now show that community-based programming, including peer groups, can lead to measurable improvements. The evidence includes a systematic review of studies of task-shifting, which found evidence that these methods can decrease the number of patients lost to follow-up.[17] A randomized controlled trial evaluation of community delivery of antiretroviral (ARV) drugs found that the approach performed at least as well as standard facility-based care in averting virological failure, and reported high levels of satisfaction.[18] Two studies of ART adherence clubs found that they enhanced adherence for people living with HIV by improving patients' self-efficacy and motivation, and by reducing stigma.[19]

- Community-based programmes are effective for **tuberculosis (TB) case-finding and for linkage to care for TB**, as shown in two studies in South Africa and Uganda, for example.[20]

- A 2018 randomized controlled trial of the impact of nurse-led behavioural and nutritional intervention among women living with HIV in rural India found that interventions run by community workers were **efficacious in improving health outcomes and may be beneficial for meeting critical health-care needs**.[21]

- A 24-month study of community-based ART programmes in rural Sierra Leone has provided new evidence that community-based ART has the potential to **improve retention and adherence among people living with HIV**.[22]

- A 2018 clinical trial in Malawi found that community-based care offered many advantages over hospital-based care for patients receiving long-term injectable treatment for TB and their families.[23]

- A 2018 RCT of LifeSkills, an empowerment-based group intervention to reduce sexual risk for HIV among young transgender women at highest risk in the United States of America (USA), found that the intervention resulted in a **40% greater mean reduction in condomless sex acts** during the 12-month follow-up in comparison to the standard of care group.[24]

- A 2013 study of legal empowerment programmes that integrate legal literacy and legal services into health-care in Kenya found that clients showed a notable **increase in practical knowledge and ability to claim their rights, as well as an enhanced ability to communicate with health-care providers**. In turn, health-care providers became more adept at identifying human rights violations and other legal difficulties, enabling them to provide better advice and referrals.[25]

- Several studies also show that community mobilization programmes can be powerful in HIV prevention when they **reduce harmful gender norms, sexual risk behaviours and HIV stigma**.[26]

- A study of strategic litigation in South Africa found that this enabled courts to mandate systemic improvements in prison conditions, increasing **access to HIV and TB services for people in detention**.[27]

- Two new studies advance the value for money agenda, as well, including a 2017 South African costing study of community-based HIV testing services which found that **mobile services improved HIV service uptake at a lower overall cost**.[28]

22. Together, these and other studies demonstrate the quantitative impact of investing in community-led programmes and in social enablers. They add urgency to the global commitments to measuring investment in these two areas.

OBJECTIVE AND SCOPE

23. At the 39th PCB meeting, Members adopted a set of Decision Points regarding funding for the community AIDS response. These included a directive to report on barriers to funding the community-led AIDS response and to report on progress on the commitments made to the 41st PCB meeting.

24. In response, this paper provides an overview of these barriers. Using available information, it reviews global progress in meeting two financial commitments made in the 2016 Political Declaration on Ending AIDS for the community-led response. After analysing both barriers and specific emerging trends in financing, the report recommends a series next steps.

APPROACH AND METHODS USED

25. The current paper draws on analysis of publicly available literature and aid data, as well as some unpublished data, from external aid agencies and UNAIDS.

26. Reviews of normative guidance included published guidance by UNAIDS on the GAM indicators, the NASA tool and the National Commitments and Policies Index (NCPI). Also consulted were reports published or shared by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), UNAIDS, the UN Development Programme (UNDP), the UN Office of the High Commissioner for Human Rights (OHCHR), Funders Concerned About AIDS, the Robert Carr Fund for Civil Society Networks, Kaiser Family Foundation and various civil society organizations.

27. To obtain publicly available data, searches using the key words “civil society”, “HIV”, and “community-based organizations” were conducted for grants dated after 2016 (the date of the Political Declaration on Ending AIDS) in the public online databases of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the United Kingdom's Department for International Development (DFID), Agence France de Developpement, Initiative 5%, the Global Fund, Unitaid and the Japan International Cooperation Agency.

28. Data on service provision reported by countries using the GAM system were aggregated and reviewed. The NASA reports listed on the UNAIDS web page were consulted. Previously unpublished NASA reports from Niger, Senegal and South Africa were also reviewed, as well as data from a pilot initiative to track a civil society marker for UNAIDS deliverables.

29. Data on donor-reported disbursements were extracted from the Organization for Economic Co-operation and Development (OECD)’s Creditor Reporting System. The Global Fund shared data on proportions of funding routed through civil society Principal Recipients. PEPFAR and Initiative 5% were contacted, but were unable to share data on the type of grantees in advance of publication of this report; those data may be available at a later date.

30. A search was conducted using the key words “HIV” and “community-based” in the titles of articles in PubMed published after 2016. The search identified 205. Time limitations prevented a comprehensive review of each article and some relevant articles were not readily accessible due to paywalls.

31. UNAIDS gathered input from civil society experts at an initial stage of the research through a teleconference and through input on a draft of this report. It also hosted a focus group discussion with six former UNAIDS Country Directors in Geneva in October 2018 (see Annex 1).

32. These data were gathered primarily from publicly available sources and may not be representative. The report was researched and written in a short time period, which imposed limitations on the quantity and quality of data consulted. In future, routine and systematic reporting by countries and donors of both coverage and investment would enable a more finetuned analysis and would enrich assessment of progress.

RESULTS

33. This section begins with an overview of available data on global progress on investment in the community-led AIDS response and on social enablers. It then explores some of the persistent barriers to funding community-led AIDS responses. Finally, it explores current definitions and questions that may be considered in aligning around a shared definition of “community-led AIDS response” and “social enablers” to facilitate better investments and monitoring.

Global progress on investment in community-led response and social enablers

34. The commitments made in the 2016 Political Declaration on Ending AIDS include a coverage indicator (“community-led services”) and a financing indicator (“social enablers”).[29] Different tools would normally be used to report on each of those indicators. UNAIDS has developed several practical and useful tools that facilitate national reporting on the two highlighted commitments. As discussed below, data are sparse thus far, those some data are available and more routine and systematic reporting is clearly feasible.

35. In addition to reporting by countries, multilateral and bilateral donors also report on their investments in HIV programmes via civil society organizations. Private philanthropy and thematic reporting provide further valuable insights and some potential good practices. However, agencies' diverse views of what should be measured has led to some diversity in the way reporting occurs and in the available data.

36. Initial data reviewed for this report, in particular data shared by the Global Fund and data on bilateral aid extracted from OECD databases, suggest that there has been a decline in available funding for civil society organizations in the AIDS response. However, this finding is preliminary. It also does not capture differences in the extent of the decline experienced by large international organizations, national nongovernmental organizations (NGOs), small community-based organizations or constituency-led networks, respectively. It also does not differentiate between funding that is directed to community organizations for their own use and funding is routed via them to other entities. As such, there are opportunities to better identify and collect data that are needed for a more complete picture of where the world stands in relation to the commitments in the Political Declaration on Ending AIDS.

UNAIDS tools and reporting to date

37. UNAIDS has developed several tools since 2016 that can be used to assess coverage of prevention services by community providers, government expenditures through civil society providers, the existence of laws and policies that facilitate community service provision, and monitoring of UNAIDS’ own financing through civil society partners. However, not all countries report on all indicators. As recommended in the June 2018 report to the PCB, countries are encouraged to use these tools for routine reporting.

Coverage of prevention sites by community providers

38. The GAM system requests countries to report against a set of indicators to monitor progress toward the commitments in the 2016 Political Declaration on Ending AIDS. Country rapporteurs are requested to provide information on prevention programmes designed for each of the key populations. Sub-elements of this information include the number of prevention service provision sites and whether those sites are operated by the national programme/government or the community (civil society or NGO).[30]

39. In 2016 and 2017, several countries used the GAM to report on coverage of key population prevention sites by community providers, with data disaggregated by key population (sex workers, people who use drugs, transgender, and gay and other men who have sex with men). The data shared show that this type of reporting is feasible for countries (see Annex 2). However, since it does not capture all services, it provides only a partial glimpse of HIV service coverage that is attributable to communities.

National investments reported to UNAIDS

40. The commitment to 30% coverage of community-led AIDS response is a coverage indicator. However, since not all coverage information is available, financial investment can be used as a partial proxy.

41. UNAIDS has developed a NASA tool to capture “the flow of resources spent in the AIDS response from their origin to the beneficiary populations ”, which makes this information comparable across national monitoring and evaluation frameworks.[31] NASA reports are compiled primarily for national level use and would require translation from local languages to be accessible to global audiences. Therefore only a few NASA reports have been made publicly available in the past two years. However, some previously unpublished data are shared in this report. They show that it is feasible for countries to report on this commitment, and illustrate the richness of data NASAs could provide if reporting were done routinely and made available in the public domain.

42. The NASA was specifically developed to track HIV financing flows and expenditures. When properly completed, NASAs estimate expenditures for each of the five pillars of prevention (including investments for key populations), as well as for social enablers and for support to civil society organizations that provide services.

43. The results are used as inputs for allocative and technical efficiency analyses. NASA analyses can also estimate service-by-service funding gaps, identify opportunities to improve efficiencies in service or geographic areas and describe current financing schemes to clarify the sustainability of financing arrangements for each core service delivery area.[32]

44. Providers are disaggregated in NASAs and grouped into various categories of organizational types. [33] The spending categories can include prevention, care and treatment, and a variety of other interventions.[34] Some “social enabler” activities, such as community mobilization, are grouped under other types of activity, such as prevention. When considered together, however, the three dimensions of measurement used in the NASAs—sources, providers and uses—could provide the data needed to measure investment in diverse types of civil society organizations and in some social enablers. NASAs do not reflect whether organizations are led by key populations or by women.

45. The NASA classifications and definitions developed by UNAIDS have been applied in more than 70 countries to date. [35] While countries are requested to report on their

expenditures annually, not all countries do so. UNAIDS maintains a web page with 156 published country NASA reports dating from the year 2000[36].

46. At the 42nd PCB in June 2018, UNAIDS shared the NASA report from Mozambique as an example of a best practice in reporting. In this report, UNAIDS has included some additional, previously unpublished, data on national expenditures for community-led services from Niger, Senegal and South Africa. Those data show that countries can and do successfully track data on funding for HIV programming through civil society organizations. Equally importantly, those countries are demonstrating the high value they place on honouring their commitments to the community led response (Annex 3).

47. In order to track progress towards the two Political Declaration on Ending AIDS commitments on funding the community-led response and on funding for social enablers, countries are encouraged to regularly complete and share their NASA reports and to approve their publication online. If all countries do so regularly, there would reduce the need for more precise data from other funding mechanisms. Regular country reporting would include the investment by the other donors considered below: multilateral, bilateral and private philanthropy.

48. In addition to the NASA, UNAIDS asks countries to complete the NCPI, which includes several questions related to policies that promote or facilitate community services.[37] Other sources of data available for assessing the legal environment for provision of services include Legal Environment Assessments, which are available on the website of the Global Commission on HIV and the Law.[38]

UNAIDS financing

49. In order to facilitate the tracking of progress on the commitments in the Political Declaration on Ending AIDS, UNAIDS has piloted approaches to track its own financing for civil society.

50. In 2018, UNAIDS piloted a "civil society engagement marker", a financial tracking tool for monitoring investments in civil society engagement and which could be applied consistently across all Joint UN workplans on AIDS being implemented by Joint UN Team on AIDS. While the tool does not allow for tracking direct expenditures on civil society engagement, it provides a clearer sense of the investments made in the Joint Programme’s engagements with civil society. In 2018 the Marker was only applied to core UBRAF allocation to Cosponsors at country level (a total amount of US$ 22 million). To pilot the marker, the UNAIDS Secretariat reviewed deliverables from the Joint UN Plans, marking deliverables with codes that measure the level of contribution to civil society engagement. The results for 2018 are summarized in Table 1. For 2018, this marker was applied only to core UBRAF allocations at country level and did not cover the full resources available to Joint UN Teams on AIDS (i.e. core and non-core UBRAF). Therefore, it presents a new and interesting approach but the results need to be understood in a special context and as a minimum contribution to civil society engagement by the Joint Programme.

Table 1. Civil society marker results for 2018[3]

Rating	Amount (US$)	Distribution (%)
No contribution to civil society engagement	10 million	46%
Partial contribution to civil society engagement	8.5 million	38%
Principal objective is to advance civil society engagement	3.5 million	16%
Total Core UBRAF allocation to Joint UN Teams on HIV	**22 million**	**100%**

Source: UNAIDS

51. For 2019 allocations, the civil society engagement marker was refined and applied against all resources allocated to Joint UN Teams on AIDS. Results will be made available in Q2 2019.

52. The UNAIDS Joint Programme partnership with civil society focuses on the following[39]:
- engaging people living with HIV, other key populations and broader civil society in strengthening community voices to improve policy development, strategic planning, monitoring and evaluation, resource allocation, service delivery, human rights protection and capacity building at local, regional and global levels;
- supporting civil society to be 'watchdogs" of national AIDS responses and to hold governments to account;
- providing services to PLHIV, other key populations, communities and affected groups and constituencies on HIV prevention, treatment, care and support;
- leveraging the HIV movement's passion and experience to generate a new, integrated movement that situates the AIDS response within the broader context of health, development, human rights and gender equality;
- engaging civil society, especially groups of key populations, in advocacy to promote and protect human rights
- engaging women's organizations (e.g. networks of women living with HIV, to support their institutional strengthening and priorities as well as on the Agenda for Accelerated Country Action and building synergies);
- engaging civil society outside of HIV (e.g. in human rights, education, nutrition, humanitarian situations, rule of law, sexual, reproductive, maternal, newborn and child health, and trade unions) to strengthen links between HIV and other SDGs to realize a robust, sustainable movement for HIV and the goals;
- brokering partnerships between civil society and other sectors, including government and the private sector, to ensure a sustainable civil society response and engagement;
- engaging youth and related organizations.

[3] Data refer to the allocation of resources in the 2018–2019 Joint Plans on AIDS, in particular to the 2018 envelope allocation.

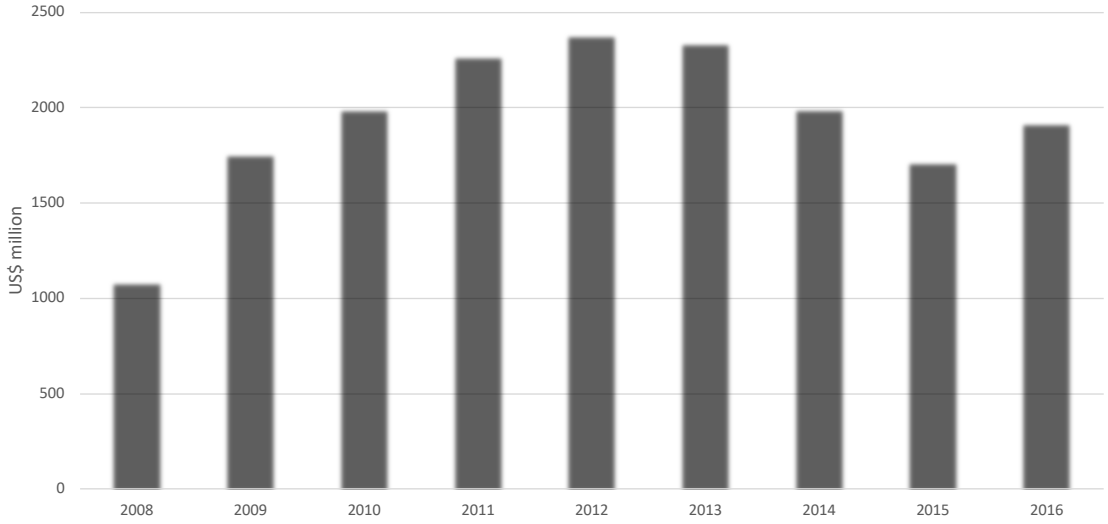
53. In addition, the UNAIDS Secretariat reported to the 42nd PCB meeting that Secretariat funding to civil society included:[4]
    - 2016–2017 core spending (Secretariat only) to the value of US$ 4.4 million, which represented 18% of total core Programme funds or 2% of total core spending;
    - 2016–2017 non-core funds (Secretariat only) to the value of US$ 28 million, which represented 32% of total non-core funds.[40]

OECD data on HIV financing

54. UNAIDS extracted data on official development assistance (ODA) for HIV programming from the OECD's Creditor Reporting System. The data show the share of ODA expenditures for HIV that were channeled through civil society and nongovernmental organizations, combining data passing through bilateral and multiateral financing mechanisms (see chart 1).

[4] UNAIDS funds provided to individual civil society representatives for travel costs were excluded, as were funds allocated to organizations such as the International AIDS Society to organize international (regional or global) conferences.

Chart 1: Multilateral and bilateral official development aid for HIV channeled through civil society 2008 – 2016



Source: OECD CRS last accessed October 2018

55. As the chart shows, the disbursement of funds to NGOS and civil society organizations peaked in 2012 at 31% of total ODA. In 2016, it dropped off slightly, before increasing again to 28% of the total.

56. In addition, OECD data extracted from the Creditor Reporting System show that in 2016, 33% of the total HIV ODA reported to the OECD Development Assistance Committee (DAC) went through civil society organizations and NGOs. However, only 28% of ODA for HIV provided by DAC members went through civil society and nongovernmental organizations. In 2016, only 16% of HIV ODA given through multilateral mechanisms went through civil society and nongovernmental organizations.

57. These data are consistent with those reported by the Global Fund, which showed a decrease in civil society Principal Recipients. However, caution is advised interpreting these data, since the the funding data reported to the OECD are not disaggregate by type of NGO or civil society organization; the data include both large national and international organizations, as well as smaller community-led organizations. Aggregated funding amounts therefore could mask considerable disparities between larger and community-led organizations. The reports also do not disaggregate funding that may have been subcontracted by civil society organizations to government providers.

58. In addition to their reporting to the OECD, multilateral and bilateral donors also publish reports on their financing through civil society, as summarized briefly below.

<u>Multilateral financing</u>

59. While UNAIDS tools are designed for national reporting, multilateral health financing mechanisms, such as the Global Fund and Unitaid, use their own definitions and modalities to track and report on financing. These produce some valuable data that suggest a small decline in funding for civil society in recent years. However, to understand the impact of this decline, more information is needed to determine which kinds of organizations and activities, and in which locations the largest declines are occurring. As noted earlier, community organizations and networks themselves are reporting devastating cuts, particularly in budgets for advocacy.

The Global Fund

60. The Global Fund shared unpublished data for this report on expenditures through civil society organization Principal Recipients (PRs) for HIV and joint HIV/TB grants, from 2003 through 2016. The Global Fund's data showed a steady increase in the percentage of expenditures passing through civil society PRs between 2003 and 2013, from 0% of US$ 63.5 million to US$ 334.1 million (22% of the amount to all PRs). However, from 2013 to 2016 this declined by about 5% to US$ 319.7 million in 2016 (24% of all PRs; see Annex 4).[5][41]

61. Important as these data are, they also raise questions. Global Fund PRs tend to be large national or international organizations that may have diverse Sub-Recipients (SRs), including government or private sector SRs that are contracted to implement specific interventions. Some civil society PRs may sub-contract to government SRs, and some government PRs may also contract with multiple civil society SRs. In addition, some PRs may have policies that prevent them from implementing sexual and reproductive health services for adolescent girls and young women or services for key populations. Thus more information is needed to assess and understand the actual impact of the funding trend.

62. In addition to channeling funding through civil society PRs, the Global Fund supports cross-cutting interventions through various PRs that are important for a community-led response, such as "community systems strengthening".[6] The Global Fund does not publicly report the amounts invested in community systems strengthening for HIV programmes. It also finances a diverse array of social enabler programmes through an US$ 800 million set of catalytic initiatives (see Annex 4).

Unitaid

63. Unitaid funding for civil society is reported online as part of broader funding for work on HIV coinfections. Unitaid funds some work on social enablers, such as advocacy and litigation to remove patent barriers for key medicines. This includes, for example, a grant of US$ 677 100 to the Lawyers Collective for 2013–16 to prevent or remove low-quality patents by filing patent oppositions for HIV, TB and hepatitis C medicines in India.[42] Unitaid does not report an annual amount invested in social enablers or in community-led responses to HIV.

64. In sum, the two multilateral HIV financing mechanisms examined here, the Global Fund and Unitaid, are contributing significantly towards increasing the coverage of community-led HIV programming and financing social enablers. However, their current reporting does not facilitate tracking of progress towards the two commitments highlighted in this report.

65. While preliminary data from the Global Fund suggest a decrease in the total amount routed through civil society organizations, analysing this trend and its impact would require more specific data on SRs (including those contracting with government PRs) and on activities, across both country allocations and catalytic investments.

[5] These data will be updated with more recent data as soon as they are available.

[6] CSS providers include "government or public health systems (made up of health facilities, regulatory and governance bodies, and state-employed health-care professionals), as well as community members and groups, community-based organizations and networks, nongovernmental organizations, faith-based organizations and private sector organizations—both formal and informal". See Maximizing impact by strengthening community systems and responses. Geneva: The Global Fund to Fight AIDS, TB and Malaria; 2016, p 3).

Bilateral financing

66. Bilateral donors to HIV programming report their expenditures on HIV through civil society organizations to the OECD, as summarized below. However, this is not disaggregated by type of CSO or by social enabler activities. PEPFAR reports its funding by activity but does not disaggregate it by civil society organization. Other individual bilateral donors tend to report through a simple online listing of projects.

PEPFAR

67. PEPFAR provides more than US$ 6.5 billion per year to the global AIDS response, including the U.S contribution to HIV/AIDS, TB and Malaria interventions to the Global Fund. Much of PEPFAR's funding is through Country Operational Plans and Regional Operational Plans. PEPFAR's publicly reported funding is not currently disaggregated by the various providers of services, though such detail may be available in the future.[43] Funding by interventions may be viewed for each country on PEPFAR's online dashboard platform. At the moment, however, those data cannot be searched by type of provider.[44] Data may be available for investments in an intervention titled, for example, "Injecting and Non-Injecting Drug Use", but it would not necessarily be clear whether community-led organizations and/or government agencies were implementing the intervention.

68. As with the multilateral mechanisms discussed earlier, PEPFAR has also launched several initiatives that fund social enablers. They group together a variety of interventions and providers (such as the DREAMS Partnership) and initiatives to finance key populations and social enablers (see Annex 5). While these initiatives are important, expenditures are not disaggregated or reported in ways that facilitate easy tracking of progress towards meeting the highlighted commitments in the Political Declaration on Ending AIDS.

Other bilateral donors

69. Online reports from three other bilateral donors were consulted for this report: France, Japan and the United Kingdom (UK). They report their funding commitments on a project-by-project basis which does not currently facilitate measuring progress towards the two pertinent commitments in the Political Declaration on Ending AIDS. A fourth donor, the Robert Carr Fund for Civil Society Networks, does provide reports that enable progress towards the two commitments to be measured.

70. The UK's DFID has an online "Development Tracker" listing of all of its health-related development funding, but the site is not searchable by sub-sector (e.g. funding for HIV) and the site does not disaggregate reports by implementing organizations.[45] A 2017 stock-taking review by STOPAIDS of DFID's funding for HIV found that direct support to civil society decreased from GBP 30 million in 2011 to GBP 8 million in 2015, and warned of the potential for continuing reductions.[46] In 2018, DFID committed to increasing its support to "grassroots organizations" with a GBP 6 million commitment to the Robert Carr Fund over three years.[47]

71. Similarly, the two main French mechanisms for development aid list activities and programmes in online databases. Initiative 5% provides a listing of its grants that is searchable by disease (in French, *VIH/SIDA*), but not by civil society implementers.[48]

72. The Japan International Cooperation Agency finances a variety of NGO and other organizations, including through partnership programmes, technical support and other citizenship cooperation activities.[49] The Agency reports on a list of technical cooperation

projects that are searchable by country or sector (e.g. “health”) but that do not identify amounts invested in the community-led response.[50]

73. The Robert Carr Fund for Civil Society Networks is a mechanism financed predominantly by bilateral aid (including the Netherlands, Norway, UK and USA, as well as the Gates Foundation). Because its focus is on HIV and on civil society networks, and because it emphasizes both core support and social enabler activities, its reporting does align with the two highlighted commitments in the Political Declaration on Ending AIDS.

74. Partly due to its focus, the Robert Carr Fund is the only donor considered in this paper which reports in ways that facilitate easy monitoring of progress on the two Political Declaration commitments. In doing so, the Fund provides a valuable example of approaches and modalities which could be useful to other donors as well.

Private philanthropy and thematic reporting

75. An analysis by Funders Concerned About AIDS examined US$ 680 million in HIV-related philanthropy given by 392 private foundations in 15 countries in 2016.[51] The foundations included the Bill & Melinda Gates Foundation, the M.A.C. AIDS Fund, the Elton John AIDS Foundation, Open Society Foundations, the philanthropic arms of pharmaceutical companies and others.

76. The analysis found that less than half of the charitable giving in 2016 (US$ 306 million) was invested in civil society organizations, with US$ 85 million of that amount going to local civil society organizations (i.e., those working at sub-national level). Another US$ 50 million was given to national civil society organizations (i.e. organizations based in a country and that provide services country-wide, often including advocacy).[52]

77. On social enablers, Funders Concerned About AIDS reports that philanthropic donors gave US$ 123.5 million to human rights programming in 2015, including HIV-related advocacy and other human rights programming. An unspecified portion of that amount may have gone to civil society organizations.[53]

78. Some civil society and foundation partnerships with specific areas of interest have issued periodic assessments of the amount of funding dedicated to specific constituencies or interventions. Global Philanthropy Project has issued reports on the amount of bilateral and private funding to organizations that are primarily focused on serving or advocating for lesbian, gay, bisexual, transgender and intersex (LGBTI) communities, or that have projects specifically for those communities.

79. Similarly, Harm Reduction International periodically reports on funding for harm reduction programming, including funding for harm reduction-related advocacy and human rights programming.[54]

Barriers to community responses

80. Despite the growing evidence of effectiveness and ambitious country commitments to investment in the community-led response to HIV, numerous barriers to funding exist. They include structural barriers, such as laws, policies, and institutional practices; economic barriers, including those created by donor withdrawal; and social barriers that include practices created by the current funding climate. These barriers were identified in consultation with civil society experts and UNAIDS former country directors.

Political and legal barriers

Restrictions on civil society organizing and fundraising

81. In many countries, in part in response to counterterrorism and national security measures, closing civil society space and restrictions on foreign funding are hampering the work of NGOs on the AIDS response.[55] A 2016 Human Rights Council resolution noted this trend, including the use of more restrictive regulations on funding for civil society organizations and on registration. The Council called on countries to review and amend "relevant laws, policies, institutions and mechanisms to create and maintain a safe and enabling environment in which civil society can operate free from hindrance, insecurity and reprisals."[56]

82. An earlier UN General Assembly resolution had emphasized the important work of NGOs and asserted that the right to freedom of association should be "subject only to such limitations as are in accordance with applicable international obligations and are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society."[57]

Criminal laws and policy practices that penalize people living with HIV, key populations, and women and girls

83. Many countries face legal and policy barriers to financing civil society organizations. These include restrictive and punitive legal regimes for people living with HIV, key populations, and women and girls.

84. As noted in the 2016 report to the PCB by the NGO Representative, legal and political barriers include laws that create dangerous environments for organizations, service providers and service recipients.[58] Criminalization of same-sex relations, sex work and drug use can also impede registration of key population-led organizations. Laws restricting access to non-coercive and evidence-informed drug dependence treatment also hamper the work of civil society in meeting the needs of key populations.[59] Gender inequality and restrictions on women's ability to engage in public life also limit the number of HIV organizations led by women.

Restrictive intellectual property regimes

85. Additional policy barriers include restrictive intellectual property regimes that can increase the cost of procurement of ART and limit available funding for community-led interventions.

Barriers created by donors

Donor-created institutional barriers

86. Donor-created barriers include burdensome application, procurement and reporting procedures that favour larger organizations and a lack of investment in mechanisms to decentralize funding or identify community-based programmes. Funding approaches towards civil society programmes that are overly centralized can reinforce the marginalization of community-based organizations in more remote rural regions. Since many international donors require funding to be routed through large, established and legally-registered organizations, funding for small community-based organizations is often too limited to deliver the required impact.[60]

87. Institutional reluctance to fund advocacy, legal aid and litigation can reduce financing available for social enablers that are vital for the community-led AIDS response. A tradition of providing separate funding streams for HIV from other health and social justice initiatives has meant that funds from non-HIV sector donors for community programming and mobilization may not be available to organizations that have traditionally focused on HIV.

Transition policies and abrupt donor departures

88. Donor transitions from countries or regions within countries, based on rigid externally-determined criteria may negatively impact on the ability of community-based organizations to sustain services for key populations. For example, countries that are classified as middle-income, based on World Bank income classifications, may face a variety of internal and external realities that limit their ability or willingness to use domestic resources to fund community responses.

89. More than half of people living with HIV are projected to be in middle-income countries by 2020. The metrics used to classify countries by income level, such as gross national income per capita, capture neither the fiscal space and resources available for health nor laws and policies that may impede government financing of key populations. This is especially true in the case of abrupt and unplanned donor withdrawal, which can result in the closure of community-based organizations and loss of key staff, capacity, institutional memory and data. These sudden transitions undermine efforts to maintain community networks and make it difficult to rebuild and regain the trust of affected communities. In countries where key populations' behaviours are criminalized, domestic funding via mainstream health services may not be accessible to community-based programmes that reach those populations.

Competition between donors and weak donor coordination

90. Donor-imposed pledges to avoid engaging in one or another type of programming can also harm long-term sustainability. Weak donor coordination, for instance among bilateral donors with diverse and frequently-changing mandates, may create gaps and unpredictability.

Limited funding for core costs and sustainability

91. Many donors that provide funding for civil society and community activities allocate funding based on the cost of delivering interventions, often without consideration for the need to finance core expenses, such as staff salaries, governance costs, human resources support costs, or financial and other administration costs such as annual audits. An over-emphasis on project or activity funding impedes the ability of smaller organizations to stabilize and grow.[61]

92. At times, sufficient funding for core costs is available only for large grants or to large organizations with the capacity to manage complex accounting systems. This can lead to situations where only the most sophisticated and well-funded organizations are able to meet donors' complicated requirements to demonstrate the need to fund core costs.

93. For example, in a 2018 study of PEPFAR grants, small and local organizations were highlighted as groups that seldom take advantage of the mechanism established by the US government for negotiating indirect costs that match their costs (the Negotiated Indirect Cost Rate Agreements, or NICRAs).[62] International organizations and universities were found to have negotiated from 8.3% to 19.5% of their total grant amounts for their indirect costs, while smaller organizations asked a flat ten percent or

billed items such as rent or communications separately. The authors noted: “The under-availability or under-utilization of NICRAs by local implementing partners could contribute to a slower process of developing this local capacity— with the subsequent effect of delaying local partners’ from taking over the bulk of service delivery responsibilities”. [63]

94. Civil society representatives consulted by UNAIDS for this report also noted their concern about a trend which has donors requiring organizations to pay for services upfront and receive reimbursements afterwards, based on results. The practice is said to create substantial risks for smaller organizations that lack the resources to pay for programing in advance, such as reserve funds.

Civil society practices that create barriers

95. Civil society practices can also impede funding reaching community-led AIDS responses. These include the absorption of administrative funds by larger civil society organizations that act as fiscal agents for smaller groups. This may enable access to funding but it contributes little to measurable deliverables. Competition among civil society groups over legitimacy and funding can sometimes alienate potential donors. Some civil society organizations may suffer from founders’ syndrome, in which pioneering founders find it difficult to separate themselves from day-to-day operations and hand over to new leaders, thereby jeopardizing potential funding.[64]

Good practices

96. While the barriers cited above exist in many contexts, there have also been many instances where diverse stakeholders came together with a common goal, formed practical partnerships and devised solutions. At the same time, risks associated with some new practices have to be thought through and addressed.

97. As part of efforts to scale up rapidly and meet the Fast-Track targets, some countries have established social contracting mechanisms between government and civil society that regulate civil society organizations’ roles in the AIDS response. Social contracting is a potentially valuable approach for financing community-led service provision.[65] Regularizing the relationship enables rapid expansion of reach and coverage for critical services. In Namibia, for example, the Government, civil society and donors are working together to assess and plan ways to systematize social contracting.[66]

98. Innovative financing approaches that utilize new technologies are opening up new possibilities to direct funding to programmes more efficiently and at lower cost. For example, UNICEF and World Food Programme have begun to experiment with use of blockchain technology to transparently distribute funding across diverse smaller recipients, including direct cash transfers to individuals.[67] The Danish Foreign Ministry has reported that it is considering using the technology to distribute humanitarian aid.[68] At the same time, use of cryptocurrencies and blockchain involve new risks for privacy, safety and identity theft that should be considered carefully as pilot projects continue.

99. Other innovative financing mechanisms may appeal to new donors, but many create risks and burdens for civil society implementers. As noted, some donors are requiring upfront expenditures by civil society organizations which are then reimbursed later. This can impose unrealistic burdens on small organizations that lack ready access to the capital or reserves they need to apply this approach. For example, the International Commission for the Red Cross has launched a Humanitarian Impact Bond to finance physical rehabilitation centers in Democratic Republic of the Congo, Mali and Nigeria. This requires the programmes to spend investors’ funds on the programmes, with donor

governments paying ICRC and social investors only if results are achieved. Failure to achieve the results could mean a loss of funds for the investors.[69]

100. Donors could also find ways to reduce the administrative burden on civil society partners by aligning the requirements and the reporting modalities they use. They could consider jointly certifying networks and organizations as providers of services to under-served and hard-to-reach populations.

101. A model to consider is the US Minority AIDS Initiative. Among many other activities, it specifically focuses on capacity-building services to community-based organizations, establishing them as credentialed providers and enabling them to address HIV among the racial and ethnic minority populations they serve.[70] Another example was developed by the Global Fund Community, Rights, and Gender Strategic Initiative. It selects, across multiyear cycles, networks of people living with HIV, young people, women and girls and key populations that are capable of providing technical assistance to national organizations to support the development, budgeting and monitoring of Global Fund grants. A 2018 study by Funders Concerned About AIDS has found that community-based organizations report that high levels of engagement, an ability to provide feedback to funders, and participation in the development of funder processes can drive increased effectiveness of funding.[71]

102. While barriers and risks remain, as one former UNAIDS Country Director observed, focusing on the people served can sometimes help unite government, donor and civil society stakeholders to find practical solutions to these challenges: “Every time people start thinking about the people, instead of who is taking the money and who is doing what, then the unity of purpose makes it possible to do what is needed.”[72]

103. In order to enable unity of purpose and efficient, effective investments, it is important to clarify terminology. The next section of this report explores this issue further.

Community-led response and social enablers: unpacking definitions

104. The Political Declaration on Ending AIDS included two important commitments to ensuring that specified percentage of the AIDS response is community-led and to ensure that work on social enablers is financed. However, the terms "community-led" and "social enablers" are frequently used in inexact and fluid ways, making it challenging to assess progress. This section explores some of the existing understandings of these terms and related questions that could benefit from further discussion.

105. The first of those commitments requires that countries “Ensure that at least 30% of all service delivery is community-led by 2030”.[73] It refers to both health services and social enablers. Note that the term “community-led” is distinct from the term widely used in social science and public health research, “community-based.” Services that are “community-based” can include services led by any agency, including community health workers who employed by the national government. However, “community-led” is not explicitly defined in the Political Declaration on Ending AIDS.

106. The second commitment is to ensuring that “at least 6% of HIV resources are allocated for social enabling activities, including advocacy, community and political mobilization, community monitoring, public communication, and outreach programmes for rapid HIV tests and diagnosis, as well as for human rights programmes such as law and policy reform, and stigma and discrimination reduction.”[74] This commitment could refer to activities led by civil society organizations as well as to activities led by government

agencies or other actors, such as the Ministry of Health, Ministry of Justice or a national human rights body, for example.

What does "community-led" mean?

107. The global, transnational nature of the AIDS response has led to a complex system of actors. The response has fostered important fluidity and space for diverse and innovative social formations which calls for creative and systematic ways of capturing comparable data for financing and evaluation purposes. Multiple and rich definitions already put in place by people living with HIV and key population networks and the UN system provide a solid starting point. It would be useful to clarify the term **"**community-led**"** so as to determine more clearly which kinds of organizations and programmes it refers to.

108. A joint 2015 UNAIDS and STOPAIDS report provides a framework for the types of programmes supported by the "community AIDS response".[7] The Robert Carr Fund for Civil Society Networks, which funds HIV-related networks, has also created a useful definition of a network, which could be useful for defining the critical elements of a community-led AIDS response[8]

109. At the 38th meeting of the PCB, Dr. Rosalía Rodriguez-García, former Director of the Center for International Health at George Washington University, identified two types of communities, both of which are essential for the AIDS response. She described communities as entities "formed by formal (CBOs) and informal organizations (mothers' groups) or a combination of formal and informal. Communities are defined by sharing a geographic sense of place or sharing common characteristics, interests, and cultural identity".[75] These characteristics can include being a person living with HIV or belonging to a key population.

110. Building on that description, the following questions could be considered when developing a more precise and measurable definition of "community-led":

    a. To what extent should community-led responses be delivered by organizations whose staff, leadership and governance (directors, managers and/or trustees) share characteristics with beneficiaries or are accountable primarily to beneficiaries?
    b. What is the appropriate mix of local and national community organizations for effective service delivery? What, if any, is the desired role of regional or global community-led responses?
    c. Can a government agency initiate or support a community-led programme? Can a larger civil society organization do so?
    d. Does the critical work of human rights organizations in the AIDS response potentially fit within the definition of "community-led work"?

[7] This report defines the term as "the collective of community-led activities in response to HIV, including four components: advocacy, campaigning, and participating in accountability, community-based service delivery, participatory community-based research, and community financing." See Communities deliver: The critical role of communities in reaching global targets to end the AIDS epidemic. Geneva: UNAIDS and Stop AIDS Alliance, 2015 (http://www.unaids.org/sites/default/files/media_asset/UNAIDS_JC2725_CommunitiesDeliver_en.pdf, p 8).

[8] Robert Carr Fund defines a network eligible for its HIV funding as "a membership of organizations and/or individuals that pool skills, experience, and resources, working towards common goals. A network creates venues for social action and is sustained through jointly developed governance structures, resources and regular communication. Eligible networks demonstrate democratic governance structures, which are representative of their constituencies in terms of both geography and population" (2018 Request for Proposals (RFP). Amsterdam, the Netherlands: Robert Carr Fund for Civil Society Networks, 2018, p 7).

e. How should funding received by larger civil society organizations be categorized when it is that is routed to smaller organizations?

111. Some funders have advanced the work of developing definitions in ways that may be useful for unpacking the term “community-led”. For example, Funders Concerned About AIDS has created a taxonomy to classify grantees:
- Individuals,
- Civil Society Organizations,
- Local (sub-national),
- National (single country),
- Regional (multiple countries)
- International (multiple regions),
- UN Technical Partners,
- Professional & Medical Associations,
- Government entities,
- Academic or Research Institutions,
- Funds & Foundations,
- Hospitals,
- Private Sector, and
- Other.

112. The organization also uses secondary tags to identify faith-based organizations and organizations that are local affiliates of "National" or "International" organizations.[76] In addition to the current classifications, it is refining the taxonomy to ensure it captures broader networks based on affiliation and constituency, such as networks of key populations or of people living with HIV.

What is a social enabler?

113. The second highlighted commitment in the Political Declaration on Ending AIDS calls for ensuring that “*at least 6% of HIV resources are allocated for social enabling activities, including advocacy, community and political mobilization, community monitoring, public communication, and outreach programmes for rapid HIV tests and diagnosis, as well as for human rights programmes such as law and policy reform, and stigma and discrimination reduction*.”[77] In the Investment Framework, UNAIDS defines “critical enablers” as “activities that are necessary to support the effectiveness and efficiency of basic programme activities.” [78] These include social enablers and programme enablers.[79]

114. Assessing investments and monitoring progress towards this commitment should emphasize that social enablers include the activities referred to in UNAIDS’ recommended "Seven key programmes to reduce stigma and discrimination and increase access to justice in national AIDS responses":
- stigma and discrimination reduction;
- training of health-care workers on human rights and medical ethics related to HIV;
- sensitization of lawmakers and law enforcement agents;
- legal literacy (“know your rights”);
- HIV-related legal services;
- monitoring and reforming laws, regulations and policies relating to HIV; and
- reducing discrimination against women in the context of HIV.[80]

115. A 2015 UNAIDS study of donor commitments to fund HIV-related human rights programming contributed crucial analysis of the available funding for these

interventions. However, countries currently do not routinely report on investment or coverage of the seven areas of intervention as part of social enablers.[81]

116. The Global Fund currently offers matching funds to enable rapid scale-up of these seven programmes as part of HIV financing in 20 focus countries. Alongside that work, as part of the Global Partnership to End HIV-related Stigma and Discrimination in All Its Forms, UNAIDS, UN Women and UNDP will provide support to 10 of those countries. This support is designed to demonstrate how focused commitments, leveraging the financial and technical support of key partners, can meaningfully address the seemingly intractable problems in addressing HIV-related stigma and discrimination. More routine reporting by countries on investments to address human rights barriers would help to contextualize the Global Fund's and UN system's financing for this area of work.[82]

117. Overall, much work has been done to define these terms, while a certain fluidity has remained. Because the HIV sector is dynamic and evolving, the terms used to describe its activities and actors are also diverse. This dynamism is a sign of the strength of the response and the global movement that created it, and fluid definitions allow space for innovation and diversity. At the same time, parameters and shared understandings are needed to allow the critical work of monitoring and evaluating progress toward funding commitments to proceed.

LESSONS LEARNED AND CONCLUSIONS

118. UNAIDS, its partners and various financing agencies have done significant work to put in place mechanisms that can increase and support development of the community-led AIDS response and to finance social enablers. This includes developing new tools to monitor coverage and investment, and highlighting existing tools, such as the NASA reports, which allow governments to track their commitments. However, greater efforts are needed to remove political and administrative barriers to financing, reach alignment around terminologies and definitions, and begin routinely and regularly report on the progress made.

119. Improved tracking of the AIDS response would also facilitate building the evidence base of best practices. This could include unpacking the components covered by "community-led AIDS response" and "social enablers", and disaggregating funding recipients based on the types of organizations and on whether they are led by women, youth and/or key populations.

120. The availability of some national-level data on expenditures, based on information from NASAs and the GAM, and the success of some donors (e.g. the Robert Carr Fund) in classifying and reporting data for specific types of grantees and for social enablers, suggests that there is a way forward. A coordinated effort from stakeholders can improve data and reporting and enhance results at a global level.

121. Community-led AIDS responses will play a key role in meeting the SDG goal of ending the AIDS epidemic. Funding communities and social enablers and monitoring the funding they receive are critically important to provide services to the people who need them most and to ensure that no one is left behind in the AIDS response.

RECOMMENDATIONS

122. Countries need to commit maximum available resources to fulfil the right to health, including ensuring that 30% of service delivery is community-led HIV and that 6% of HIV financing towards social enablers, as stated in the 2016 Political Declaration on Ending AIDS.

123. The Joint Programme should support countries to review laws and policies that may impede financing of both community-led AIDS responses and social enablers.

124. Countries should review and amend relevant laws, policies, institutions and mechanisms to create and maintain a safe and enabling environment in which civil society organizations can operate free from hindrance, insecurity and reprisals. The right to freedom of association should be subject only to such limitations as are in accordance with applicable international obligation.

125. UNAIDS should urgently convene a task team with diverse donors, implementing countries and community representatives (including representatives of people living with HIV, women and adolescent girls and young women, young people and key populations) to agree on definitions for “community-led AIDS response” and “social enablers” that meet the needs of the AIDS response and that can be effectively monitored.

126. Donors are encouraged to review their financing and reporting modalities and should ensure that these are aligned with the commitments in the Political Declaration on Ending AIDS and that they enable monitoring of progress towards the relevant targets.

127. Countries are encouraged to report annually on coverage and expenditures using the GAM and NASA tools. UNAIDS should share those data online to enable collective monitoring of progress towards the highlighted commitments in the Political Declaration on Ending AIDS.

128. A task team should be established to recommend good practices and improved modalities to ensure access to funding for community-led organizations and constituency-based networks.

PROPOSED DECISION POINTS

The Programme Coordinating Board is requested to:

129. Recalling the 2016 United Nations Political Declaration on Ending the AIDS epidemic, paragraphs 60d and 64a:

130. *Take note* of the report;

131. *Encourage* Member States to:

    a. dedicate maximum available resources to fulfilling the right to health, including the 30% coverage by community-led HIV programmes and 6% of HIV financing towards social enablers, as agreed in the 2016 Political Declaration on Ending AIDS;

    b. review and amend relevant laws, policies, institutions and mechanisms to create and maintain a safe and enabling environment in which civil society can efficiently

support the AIDS response and the achievement of the targets for, and the goal of, ending AIDS by 2030;

c. report on coverage and expenditures using the Global AIDS Monitoring and National AIDS Spending Assessment tools on an annual basis;

132. *Request* the Joint Programme to:

a. support the process of reviewing laws and policies that may impede financing of both community-led AIDS responses and social enablers;

b. convene a task team with diverse donors, implementing countries and civil society representatives, including representatives of people living with HIV, women and adolescent girls and young women, youth and key populations, to standardize the use of definitions, including “community-led AIDS response” and “social enablers”, and to recommend good practices and improved modalities to ensure access to funding for community-based organizations and constituency-based networks.

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ANNEX 1

Informal brainstorming call with civil society and community-led HIV organizations
15 September 2018

Moderator: Laurel Sprague, UNAIDS

Participants

George Ayala, MPact Global Action for Gay Men's Health and Rights
Jonas Bagas, Asia Pacific Council of AIDS Service Organizations
John Barnes, Funders Concerned About AIDS
Ganna Dovbakh, Eurasian Harm Reduction Association
Jonathan Gunthorp, SRHR Africa Trust
Felicita Hikuam, AIDS Rights Alliance of Southern Africa
Jay Levy, International Network of People who Use Drugs
Sonal Mehta, PCB NGO Delegation (Alliance India)
Millie Milton, PCB NGO Delegation (Guyana Trans United)
Olive Mumbo, East African National Networks of AIDS Service Organizations
Alessandra Nilo, PCB NGO Delegation (Gestos, Brazil)
Ikka Noviyanti, YouthLEAD
Omar Syarif, Global Network of People Living with HIV
Ruth Morgan, Thomas International Network of Sex Work Projects
Ivan Varentsov, Eurasian Harm Reduction Association
Lee Waldorf, Stephen Lewis Foundation
Chris Mallouris, UNAIDS
Meg Davis, consultant
Matt Greenall, consultant

Focus group discussion with former UNAIDS Country Directors: National barriers to funding a community-led AIDS response
Geneva 2 October 2018

Moderator: Laurel Sprague, UNAIDS; Meg Davis, consultant

Participants

David Chipanta, former UNAIDS Country Director, Liberia
Sun Gang, former UNAIDS Country Director, Myanmar, Botswana and Zimbabwe
Ani Shakarishvili, former UNAIDS Country Director Ukraine
Tatiana Shoumilina, former UNAIDS Country Director, Thailand, Zimbabwe, Uzbekistan and Ethiopia
Jacek Tyszko, former UNAIDS Country Director, Ukraine
Henk Van Renerghem, former UNAIDS Country Director, Namibia

ANNEX 2

Key population prevention sites: coverage by community providers

The following tables show data on sites offering prevention services to sex workers, people who use drugs, transgender persons and gay and other men who have sex with men reported by countries to UNAIDS using the Global AIDS Monitoring system in 2016–2017.

Sex workers					
Region	Country	Year	Total sites	Number of government sites	Number of community sites
Asia and Pacific	Cambodia	2016	33	0	33
Asia and Pacific	Lao People's Democratic Republic	2016	12	6	6
Asia and Pacific	Lao People's Democratic Republic	2017	13	5	8
Asia and Pacific	Malaysia	2017	16	0	16
Asia and Pacific	Marshall Islands	2016	1	0	1
Asia and Pacific	Mongolia	2016	15	5	10
Asia and Pacific	Mongolia	2017	15	5	10
Asia and Pacific	Myanmar	2017	160	82	78
Asia and Pacific	Nepal	2016	19	0	19
Asia and Pacific	Nepal	2017	55	0	55
Asia and Pacific	Pakistan	2016	6	0	6
Asia and Pacific	Thailand	2016	230	225	5
Asia and Pacific	Vanuatu	2016	17	13	4
Caribbean	Cuba	2017	451	451	
Caribbean	Dominican Republic (the)	2017	7		7
Caribbean	Guyana	2016	17	0	17
Caribbean	Guyana	2017	12	0	12
Eastern and southern Africa	Ethiopia	2016	80		80
Eastern and southern Africa	Kenya	2016	93	10	83
Eastern and southern Africa	Kenya	2017	85	13	72
Eastern and southern Africa	Madagascar	2016	1714	1670	44
Eastern and southern Africa	South Sudan	2016	3	0	3
Eastern and southern Africa	Zambia	2017	14	2	12
Eastern and southern Africa	Zimbabwe	2016	36		36
Eastern and southern Africa	Zimbabwe	2017	35	0	35
Eastern Europe and central Asia	Armenia	2017	3	0	3
Eastern Europe and central Asia	Azerbaijan	2017	38	38	0
Eastern Europe and central Asia	Belarus	2016	13		13

Sex workers					
Region	**Country**	**Year**	**Total sites**	**Number of government sites**	**Number of community sites**
Eastern Europe and central Asia	Belarus	2017	10		10
Eastern Europe and central Asia	Georgia	2017	10	0	10
Eastern Europe and central Asia	Kazakhstan	2016	32	32	0
Eastern Europe and central Asia	Kazakhstan	2017	30	30	0
Eastern Europe and central Asia	Kyrgyzstan	2016	9	0	9
Eastern Europe and central Asia	Kyrgyzstan	2017	9	0	9
Eastern Europe and central Asia	Republic of Moldova	2017	12	0	12
Eastern Europe and central Asia	Tajikistan	2016	26	10	16
Eastern Europe and central Asia	Tajikistan	2017	27	11	16
Eastern Europe and central Asia	The former Yugoslav Republic of Macedonia	2017	7	0	7
Eastern Europe and central Asia	Ukraine	2016	1 119	0	1 119
Eastern Europe and central Asia	Ukraine	2017	474	0	474
Latin America	Chile	2016	125	106	19
Latin America	Chile	2017	120	106	14
Latin America	Guatemala	2017	136	136	0
Latin America	Nicaragua	2016	155	153	2
Latin America	Panama	2017	6	6	0
Middle East and North Africa	Iran (Islamic Republic of)	2017	39	0	39
Middle East and North Africa	Morocco	2016	1 034	1 000	34
Middle East and North Africa	Morocco	2017	1 234	1 200	34
Middle East and North Africa	Tunisia	2016		2	6
West and Central Africa	Benin	2017	54	47	7
West and Central Africa	Burkina Faso	2017	1 022		
West and Central Africa	Côte d'Ivoire	2017	21	21	
West and Central Africa	Ghana	2016	35	0	35
West and Central Africa	Niger	2017	108	88	20
West and Central Africa	Sierra Leone	2017	9	0	9
West and Central Africa	Togo	2016	30	25	5

People who inject drugs					
Region	**Country**	**Year**	**Total sites**	**Number of government sites**	**Number of community sites**
Asia and Pacific	Bangladesh	2016	53	22	31
Asia and Pacific	Cambodia	2016	8	1	7
Asia and Pacific	Cambodia	2017	1	0	1
Asia and Pacific	Myanmar	2017	106	51	55
Asia and Pacific	Nepal	2016	37	17	20
Asia and Pacific	Nepal	2017	36	8	28
Asia and Pacific	Pakistan	2016	29	0	29
Asia and Pacific	Thailand	2016	164	150	14
Asia and Pacific	Viet Nam	2017	51		
Caribbean	Dominican Republic	2017	5	1	4
Eastern and southern Africa	Kenya	2016	20	16	4
Eastern and southern Africa	Kenya	2017	24	16	8
Eastern and southern Africa	Madagascar	2016	1 714	1 670	44
Eastern and southern Africa	Mauritius	2016	84	77	7
Eastern and southern Africa	Seychelles	2017	32	11	21
Eastern and southern Africa	Uganda	2017	4	2	2
Eastern Europe and central Asia	Armenia	2016	0	0	0
Eastern Europe and central Asia	Armenia	2017	6	3	3
Eastern Europe and central Asia	Azerbaijan	2017	45	45	0
Eastern Europe and central Asia	Belarus	2016	50	19	31
Eastern Europe and central Asia	Estonia	2016	47		
Eastern Europe and central Asia	Kazakhstan	2016	157	152	5
Eastern Europe and central Asia	Kyrgyzstan	2016	69	57	12
Eastern Europe and central Asia	Kyrgyzstan	2017	68	56	12
Eastern Europe and central Asia	Republic of Moldova	2017	32	11	31
Eastern Europe and central Asia	Tajikistan	2016	67	36	31
Eastern Europe and central Asia	Tajikistan	2017	65	40	25
Eastern Europe and central Asia	The former Yugoslav Republic of Macedonia	2017	25	12	13
Eastern Europe and central Asia	Ukraine	2016	2 174	174	2 000
Eastern Europe and central Asia	Ukraine	2017	1 421	180	1 241
Middle East and North Africa	Iran (Islamic Republic of)	2017	7 737	186	7 551

People who inject drugs					
Region	**Country**	**Year**	**Total sites**	**Number of government sites**	**Number of community sites**
Middle East and North Africa	Morocco	2016	15	6	9
West and Central Africa	Senegal	2017	6	1	5
West and Central Africa	Sierra Leone	2017	5	0	5

Transgender people					
Region	**Country**	**Year**	**Total sites**	**Number of government sites**	**Number of community sites**
Asia and Pacific	Cambodia	2016	33	0	33
Asia and Pacific	Malaysia	2017	5	0	5
Asia and Pacific	Nepal	2016	27	10	17
Asia and Pacific	Nepal	2017	32	0	32
Asia and Pacific	Pakistan	2016	2	0	2
Asia and Pacific	Samoa	2016	4	2	2
Asia and Pacific	Thailand	2016	239	224	15
Asia and Pacific	Tonga	2016	1		1
Caribbean	Cuba	2016	451	451	0
Caribbean	Cuba	2017	451	451	
Caribbean	Dominican Republic	2017			5
Caribbean	Guyana	2016	2	0	2
Caribbean	Guyana	2017	2	0	2
Eastern Europe and central Asia	Ukraine	2016	13	0	13
Eastern Europe and central Asia	Ukraine	2017	20	0	20
Latin America	Chile	2016	29	15	14
Latin America	Chile	2017	67	51	16
Latin America	Guatemala	2017	23	23	0
Latin America	Honduras	2017	4	4	
Latin America	Nicaragua	2016	156	153	3
Latin America	Panama	2016	6	6	0
Latin America	Panama	2017	6	6	0

Men who have sex with men					
Region	**Country**	**Year**	**Total sites**	**Number government sites**	**Number community sites**
Asia and Pacific	Cambodia	2016	33	0	33
Asia and Pacific	Lao People's Democratic Republic	2016	16	16	0
Asia and Pacific	Lao People's Democratic Republic	2017	7	0	7
Asia and Pacific	Malaysia	2017	10	0	10
Asia and Pacific	Mongolia	2016	4	1	3
Asia and Pacific	Mongolia	2017	4	1	3
Asia and Pacific	Myanmar	2017	142	62	80
Asia and Pacific	Nepal	2016	27	10	17
Asia and Pacific	Nepal	2017	36	0	36
Asia and Pacific	Pakistan	2016	4	0	4
Asia and Pacific	Samoa	2016	4	2	2
Asia and Pacific	Thailand	2016	239	224	15
Asia and Pacific	Tonga	2016	1		1
Asia and Pacific	Vanuatu	2016	17	13	4
Caribbean	Bahamas (the)	2016	4	1	3
Caribbean	Cuba	2016	451	451	0
Caribbean	Cuba	2017	451	451	
Caribbean	Dominican Republic (the)	2017	12		12
Caribbean	Grenada	2017	1	0	1
Caribbean	Guyana	2016	12	0	12
Caribbean	Guyana	2017	14	4	10
Caribbean	Haiti	2016	5	5	0
Eastern and southern Africa	Kenya	2016	42	6	36
Eastern and southern Africa	Kenya	2017	62	7	55
Eastern and southern Africa	Madagascar	2016	1714	1670	44
Eastern and southern Africa	Zambia	2017	14	2	12
Eastern and southern Africa	Zimbabwe	2016	14		14
Eastern Europe and central Asia	Armenia	2016	3	0	3
Eastern Europe and central Asia	Armenia	2017	3	0	3
Eastern Europe and central Asia	Azerbaijan	2017	3	3	0
Eastern Europe and central Asia	Belarus	2016	13		13
Eastern Europe and central Asia	Belarus	2017	12		12
Eastern Europe and central Asia	Georgia	2017	11	0	8
Eastern Europe	Kazakhstan	2016	14	14	0

Men who have sex with men					
Region	**Country**	**Year**	**Total sites**	**Number government sites**	**Number community sites**
and central Asia					
Eastern Europe and central Asia	Kyrgyzstan	2016	3	0	3
Eastern Europe and central Asia	Kyrgyzstan	2017	4	0	4
Eastern Europe and central Asia	Republic of Moldova	2017	4	0	4
Eastern Europe and central Asia	Tajikistan	2016	16	0	16
Eastern Europe and central Asia	Tajikistan	2017	14	0	14
Eastern Europe and central Asia	The former Yugoslav Republic of Macedonia	2017	6	0	6
Eastern Europe and central Asia	Ukraine	2016	205	0	205
Eastern Europe and central Asia	Ukraine	2017	107	0	107
Latin America	Chile	2016	47	15	32
Latin America	Chile	2017	91	51	40
Latin America	Guatemala	2017	28	28	0
Latin America	Honduras	2017	4	4	
Latin America	Nicaragua	2016	156	153	3
Latin America	Panama	2016	6	6	0
Latin America	Panama	2017	6	6	
Middle East and North Africa	Morocco	2016	1034	1000	34
Middle East and North Africa	Morocco	2017	1234	1200	34
West and Central Africa	Benin	2017	8	8	
West and Central Africa	Burkina Faso	2017	189		
West and Central Africa	Côte d'Ivoire	2017	21	21	
West and Central Africa	Ghana	2016	10	0	10
West and Central Africa	Guinea	2017	17	16	1
West and Central Africa	Niger	2016	108	88	20
West and Central Africa	Niger	2017	108	88	20
West and Central Africa	Sierra Leone	2017	5	0	5
West and Central Africa	Togo	2016	8	2	6

ANNEX 3

Investment in civil society for the HIV and TB response: Data from Niger, Senegal and South Africa

1. South Africa

Contribution to NGOs for HIV and TB services for the period 2011/12 – 2013/14

In 2013/14, the total Department of Health (DOH), US President's Emergency Plan for AIDS Relief (PEPFAR), and Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) funding for NGOs for HIV and TB (2011–2013) was ZAR 6 billion (approximately 10%) of the total spend over the period) as shown in Table 2., Between 2011/2012 and 2012/2013, total funding increased by 117%, from ZAR1.3 billion to ZAR 2.8 billion, before declining by 30% to ZAR 1.96 billion in 2013/14.

Table 1. Total South African Department of Health, PEPFAR and Global Fund funding for NGOs for HIV and TB, 2011–2013 (ZAR millions)

Source Of Funds	2011/2012	2012/2013	2013/2014	Grand Total
GLOBAL FUND	137 100 049	130 293 167	209 166 232	476 559 447
DOH	16 812 466	18 275 501	13 750 592	48 838 560
PEPFAR	1 129 334 112	2 638 246 305	1 741 522 310	5 509 102 727
Total	1 283 246 627	2 786 814 973	1 964 439 135	6 034 500 734

Source: BAS DOH records; GF PR EPRs; PEPFAR (Amfar database); Guthrie et al (2015): South African Consolidated HIV and TB Expenditure (for the Investment Case)

PEPFAR made the largest contribution of ZAR 5.5 billion (91.3%) over the three-year period for NGOs for HIV and TB services followed by GFATM (ZAR 476 million or 7.9%) and the DOH (ZAR 48.8 million or 0.8%).

2. Niger NASA data, 2013–2015 (CFA)

REDES Niger NASA data, 2013–2015						
Agents de financement	**2013**	**%**	**2014**	**%**	**2015**	**%**
Ministère de la Santé	996 839 047	14.86%	1 143 419 940	21.22%	1 364 634 454	16.03%
Ministère de la Défense	40 343 006	0.60%	63 485 106	1.18%	37 947 183	0.45%
Autres ministères		0.00%	2 736 000	0.05%		0.00%
Organisme national de coordination de la lutte contre le sida	3 631 406 784	54.14%	2 446 437 025	45.40%	5 570 662 898	65.45%
Autres ministères	27 000 000	0.40%		0.00%		0.00%
Total secteur public	**4 695 588 837**	**70.01%**	**3 656 078 071**	**67.85%**	**6 973 244 535**	**81.93%**
Institutions à but non lucratif	1 179 306 054	17.58%	1 016 614 104	18.87%	35 259 124	0.41%
Organismes et entreprises non parapublics privés	31 148 222	0.46%	1 255 000	0.02%		0.00%
Autres agents de financement du secteur privé non classifiés ailleurs (n.c.a.)		0.00%		0.00%	1 400 000	0.02%
Total secteur privé	**1 210 454 276**	**18.05%**	**1 017 869 104**	**18.89%**	**36 659 124**	**0.43%**
Gouvernement français		0.00%		0.00%	132 524 910	1.56%
Gouvernement allemand		0.00%		0.00%	1 127 230 444	13.24%
Gouvernement de la République populaire de Chine		0.00%		0.00%	3 450 985	0.04%
Secrétariat de l'ONUSIDA	104 298 500	1.56%	44 603 500	0.83%	61 141 566	0.72%
Fonds des Nations Unies pour l'enfance (UNICEF)	1 215 000	0.02%	389 000	0.01%		0.00%
Haut Commissariat des Nations Unies pour les Réfugiés (HCR)		0.00%		0.00%	12 464 060	0.15%
Fonds des Nations unies pour la population (UNPFA)	243 075 840	3.62%	248 233 705	4.61%	104 736 967	1.23%
Caritas Internationalis/Catholic Relief Services	10 621 000	0.16%	8 357 906	0.16%		0.00%
Fédération internationale des sociétés de la Croix-Rouge et du Croissant-Rouge	3 871 750	0.06%		0.00%		0.00%
Plan International	28 766 078	0.43%	4839 468	0.09%		0.00%
Autres organisations et fondations internationales à but non lucratif n.c.a.	408 992 831	6.10%	408 404 832	7.58%	60 221 722	0.71%
Total organismes internationaux	**800 840 999**	**11.94%**	**714 828 411**	**13.27%**	**1 501 770 654**	**17.64%**
Total général	**6 706 884 112**	**100%**	**5 388 775 586**	**100%**	**8 511 674 313**	**100%**

3. Senegal, NASA data 2015 (CFA)

REDES Senegal NASA data, 2015									
PS.02, Prestataires du secteur privé	PS.02.01.01 .08, Pharmacies et prestataires de produits médicaux	PS.02.01.01.1 5, Organisations de la société civile	PS.02.02.14 , Cabinets de consultants	PS.02.0 2.15, "Sur le lieu de travail"	PS.03, Entités bilatérales et multilatérales – dans les bureaux de pays	PS.03.02, Organismes multilatéraux	PS.04, Prestataires pour le reste du monde	Total général	%
571 813 284	0	563 843 406	7 969 878	0	0	0	0	**4 087 007 700**	**36.39%**
0					0			42 242 402	0.38%
571 813 284		563 843 406	7 969 878		0			4 044 765 298	36.02%
464 433 816	0	464 433 816	0	0	0	0	0	**624 204 457**	**5.56%**
31 344 014		31 344 014			0			103 107 386	0.92%
167 161 460		167 161 460			0			174 938 521	1.56%
194 459 963		194 459 963			0			199 106 493	1.77%
71 468 379		71 468 379			0			147 052 057	1.31%
928 415 309	0	928 415 309	0	0	0	0	0	1 169 456 708	10.41%
38 295 790		38 295 790			0			38 295 790	0.34%
1 402 500		1 402 500			0			162 603 194	1.45%
176 156 273		176 156 273			0			176 156 273	1.57%
0					0			3 987 000	0.04%
0					0			36 331 730	0.32%
691 929 490		691 929 490			0			720 989 931	6.42%
20 631 256		20 631 256			0			31 092 790	0.28%
75 364 472	0	70 498 932	0	4 865 540	0	0	291 096 463	474 841 523	4.23%
0					0			45 207 641	0.40%
0					0			1 577 600	0.01%
0					0			1 710 000	0.02%
0					0			8 691 920	0.08%
3 637 500		3 637 500			0			34 587 681	0.31%
0					0			525 000	0.00%
0					0			3 135 497	0.03%
20 954 508		16 088 968		4 865 540	0			25 484 257	0.23%
0					0		15 897 968	27 950 968	0.25%
50 772 464		50 772 464			0		275 198 495	325 970 959	2.90%
837 370 752	51 753 075	785 617 677	0	0	50 981 906	50 981 906	0	2 148 793 210	19.13%
100 000		100 000			0			100 000	0.00%
260 256 943		260 256 943			0			345 013 586	3.07%
103 596 269		103 596 269			50 981 906	50 981 906		267 240 914	2.38%
473 417 540	51 753 075	421 664 465			0			1 536 438 710	13.68%
518 186 097		518 186 097			0			2 725 544 561	24.27%
3 395 583 730	51 753 075	3 330 995 237	7 969 878	4 865 540	**50 981 906**	50 981 906	**291 096 463**	**11 229 848 159**	**100%**
30.24%	0.46%	29.66%	0.07%	0.04%	**0.45%**	0.45%	**2.59%**	**100%**	

ANNEX 4

Global Fund expenditure through civil society organization Principal Recipients for HIV and joint HIV/TB grants

The Global Fund's data showed a steady increase in the percentage of expenditures through civil society principal recipients in its first decade of operation, from 0% of US$ 63 568 851 in 2003 to an absolute amount of US$ 334 185 777 in 2013 (22% of the amount to all principal recipients).

However, from 2013 to 2016 the amount decreases by about 5% to US$ 319 694 837 in 2016 (24% of all principal recipients).[83]

While these trends are significant, they also raise questions. Global Fund principal recipients tend to be large national or international organizations that may have diverse sub-recipients, including government or private sector sub-recipients contracted to implement specific interventions. Some civil society principal recipients may sub-contract to government sub-recipients and some government principal recipients may also contract with multiple civil society sub-recipients.

In addition, some principal recipients may have policies that prevent them from implementing sexual and reproductive health services for adolescent girls and young women or services for key populations. Thus more information is needed in order to assess and fully understand the impact of this trend.

In addition to its funding through civil society principal recipients, the Global Fund funds a number of cross-cutting interventions through diverse principal recipients that are important for a community-led response, such as "community systems strengthening".[9] The Global Fund does not publicly report the amount invested in community systems strengthening for HIV. As of 2018 and including grants that ended in 2017, the Fund's *Results report* noted that it had invested 10.8% of the previous funding allocation in health systems strengthening which includes "community responses and systems."[84] However this was for all three diseases.

The Global Fund also finances a diverse array of social enabler programmes through an US$ 800 million set of catalytic initiatives. These include:

- matching funds "to incentivize the programming of allocations towards strategic priorities, including for key and vulnerable populations and gender-related programmes" and other priorities;
- multicountry approaches "to target a limited number of key strategic multicountry priorities"; and
- strategic initiatives to fund centrally-managed cross-cutting and other programmes.[85]

Several of the catalytic initiatives address social enablers and are funded by civil society organizations. These include multicountry funding for "Key Populations Sustainability and Continuity" (US$ 50 million); as well as matching funds for "Key Populations Impact" (US$ 50 million), "Human rights" (US$ 45 million), and "Adolescent Girls and Young Women" (US$ 55 million). It also includes a US$ 15 million Strategic Initiative for Community Rights and Gender.

[9] CSS providers include "government or public health systems (made up of health facilities, regulatory and governance bodies and state-employed health-care professionals) as well as community members and groups, community-based organizations and networks, nongovernmental organizations, faith-based organizations and private sector organizations—both formal and informal". See Maximizing impact by strengthening community systems and responses. Geneva: The Global Fund to Fight AIDS, TB and Malaria; 2016, p 3.

The Community Rights and Gender Special Initiative includes among other funding, technical assistance to support such activities as country dialogue, funding request development, grant making and grant implementation. Technical assistance is provided by a roster of pre-qualified organizations some of which may be considered community-led.[86] However, this not a community-led response to HIV so much as technical assistance to facilitate participation in planning and implementation of national funding for all three diseases. A future definition of "community-led AIDS response" should clarify whether technical assistance is included; as well as whether the goals and parameters for the technical assistance are set by community representatives.

The Human Rights matching funds encourage implementing countries to scale up investment in the UNAIDS key programmes to reduce stigma and discrimination and increase access to justice. The initiative focuses on 20 countries that are eligible for matching funds. These programmes may be led by government or nongovernmental agencies. By mid-2018, 16 of these countries had applied for and received matching funds and in 12 of those countries funding for human rights programmes increased from US$ 6 million to US$ 50 million for 2017–2019.[87]

These are just two examples of the Global Fund's cross-cutting funding of catalytic initiatives. Taken together the Global Fund's commitment to financing a community-led AIDS response and to social enablers make an important contribution but they do not easily produce data to monitor progress towards the two commitments in the 2016 Political Declaration and further alignment of definitions and reporting modalities among partners would be helpful.

	2003	2004	2005	2006	2007	2008
Civil society principal recipients		5 875 001	16 596 451	18 174 854	23 065 278	34 685 423
All principal recipients	63 568 851	260 319 461	485 553 618	591 652 759	767 287 832	1 060 017 148
Share of civil society principal recipients	0%	2%	3%	3%	3%	3%

	2009	2010	2011	2012	2013
Civil society principal recipients	41 528 529	80 134 279	159 580 704	225 234 023	334 185 777
All principal recipients	1 020 313 900	1 191 021 035	1 266 116 526	1 387 094 181	1 323 471 978
Share of civil society principal recipients	4%	7%	13%	16%	25%

	2014	2015	2016
Civil society principal recipients	322 160 154	253 344 593	319 694 837
All principal recipients	1 465 655 834	1 430 206 809	1 304 992 626
Share of civil society principal recipients	22%	18%	24%

ANNEX 5

Additional information on sources of financing

PEPFAR

PEPFAR finances several cross-cutting initiatives to serve girls and women and key populations and to promote an enabling environment.

The DREAMS Partnership, a US$ 385 million programme launched with Johnson and Johnson the Gates Foundation and other partners, supports a package of interventions to serve young women and girls. In July 2016, 60% of the organizations selected to implement new DREAMS programmes were described by PEPFAR as community-based.[10] In June 2016, PEPFAR committed to establishing a US$ 100 million Key Populations Investment Fund to provide "direct funding to key populations-led community-based organizations."[88]

In its budget submission to US Congress in 2018, PEPFAR outlined related initiatives:

- Support for a partnership with Elton John AIDS Foundation to address HIV-related needs of lesbian, gay, bisexual and transgender (LGBT) people;
- A local capacity initiative to strengthen the capacity of national, district and local-level civil society organizations to reduce legal and policy structural barriers, end stigma and discrimination, and ensure key populations' involvement in programme planning and implementation;
- Support over three years to the Robert Carr Fund;
- LINKAGES, a multiyear capacity-strengthening initiative focused on key populations; and
- The Key Populations Investment Fund.[89]

Specific allocations are not outlined in the budget submission, although a PEPFAR statement at the 2018 International AIDS Conference noted that US$ 260 million was allocated for key populations through Country Operational Plans (COPs) and the US$100 million Key Populations Investment Fund.[90]

France

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[10] "Community-based organization" is not defined. However, according to Cameron Wolf, USAID Senior HIV/AIDS Advisor for Key Populations, "Under PEPFAR, a 'local partner' may be an individual or sole proprietorship, an entity, or a joint venture or other arrangement. However, to be considered a local partner in a given country served by PEPFAR, the partner must meet the criteria under paragraph (1), (2), or (3) below:

(1) an individual must be a citizen or lawfully admitted permanent resident of and have his/her principal place of business in the country served by the PEPFAR program with which the individual is or may become involved, and a sole proprietorship must be owned by such an individual; or

(2) an entity (e.g., a corporation or partnership):

a) **must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the PEPFAR program with which the entity is or may become involved;**

b) must be at **75% for FY 2018 beneficially owned by individuals who are citizens** or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), or by other corporations, partnerships or other arrangements that are local partners under this paragraph or paragraph (3);

c) at least **75% for FY 2018 of the entity's staff** (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), and at **least 75% for FY 2018 of the entity's senior staff** (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country; and

d) where an entity has a Board of Directors, at least **51% of the members of the Board must also be citizens or lawfully admitted permanent residents of such country**; or

(3) Partner government ministries (e.g., Ministry of Health), sub-units of government ministries, and parastatal organizations in the country served by the PEPFAR program are considered local partners. A parastatal organization is defined as a fully or partially government-owned or government-funded organization. Such enterprises may function through a board of directors, similar to private corporations. However, ultimate control over the organization rests with the government." Personal communication, 16 October 2018.

In addition to Initiative 5%, other French aid modalities include Plateforme ELSA (*Ensemble luttons contre le SIDA en Afrique*), which brings together a network of community associations in francophone Africa; Partnership Framework Papers, which coordinates aid partnerships in implementing countries, including with civil society partners; and financing in countries via the French Ministry of Foreign and European Affairs (MAEE) through the Mission for Relations with Civil Society.[91] However, these initiatives do not appear to publicly report their funding for the community-led AIDS response.

Robert Carr Fund for Civil Society Networks

In 2016–2018, the Robert Carr Fund awarded grants totaling US$ 20 003 800 to HIV networks and consortia for core costs and programmatic activities.[92] Most of this funding is dedicated to social enablers. Fifty-nine percent of Robert Carr funding for programmatic activities went to advocacy, 31% to “increased influence of Inadequately Served Populations [ISPs] and civil society”, and 6% to “more enabling rights-affirming environment for ISPs”, all interventions that could be grouped under social enablers, depending on how this is defined.[93]

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