Governments fund communities

Six country experiences of financing community responses through governmental mechanisms

Contents

Introduction

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Community-based service delivery and advocacy are essential for achieving the ambitious treatment, prevention and human rights targets set through the UNAIDS Fast-Track approach. Resources for the community response must grow markedly over the coming years. The updated UNAIDS strategy for 2016–2021 and Fast-Track needed investment estimates show that enabling efficient scale-up of services will require expanding community-based HIV service delivery from a global average of 5% in 2013 to at least 30% of all service delivery in 2030 *(1-3)*. UNAIDS Fast-Track modelling in 2016 also estimates that resources for community mobilization, including outreach and engagement, support activities and advocacy and transparency and accountability, will need to increase three fold to 3.0% in 2020 and 4.2% in 2030 *(2, 3)*.

Expanded community mobilization and community-based service delivery programmes will require an increased investment in communities. Although international and private funders have typically provided the majority of funding for community HIV responses, several low- and middle-income country governments have recognized the critical contribution of community and succeeded in allocating funding to community-based organizations through national policies that recognise and fund civil society. The trend towards greater country ownership and the priority of reaching all populations with services, including marginalized groups, means it will be increasingly important to channel domestic financing to community responses.

Learning from six country experiences

UNAIDS reviewed the experiences of six countries that have supported community-based HIV programmes through a variety of government mechanisms: Argentina, Brazil, India, Malawi, Malaysia and the Republic of Moldova. Every country is different, but lessons from these countries' experiences can inform approaches that will be appropriate in other countries' unique contexts. The examples from Argentina, Brazil, India and Malaysia demonstrate how national resources available for the AIDS response can be allocated to civil society. The examples from Malawi and the Republic of Moldova demonstrate how Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) resources allocated to the government can be directed to civil society organizations.

Each of the countries discussed in this report has found ways to finance the community component in its HIV response. They have decentralized services, formed strong partnerships with community-based organizations and focused investments to reach people who are most vulnerable.

Governments and civil society have seen significant benefits from direct support being given to communities *(4)*. For example, governments have been able to expand the reach of services by transferring some tasks to community health workers and volunteers *(5)*, and community organizations were able to maintain a continuum of care and to facilitate access to services for hard-to-reach groups.

The innovative approaches used in the countries presented in this report have helped to address challenges common to many countries. These challenges include bureaucratic barriers that impede or slow the movement of funds from central treasuries to local programmes, and fluctuating political will to support community-led programmes, especially during elections. Some national regulatory frameworks do not allow community-based organizations to deliver services traditionally provided by health professionals, such as HIV tests, and policy changes are needed to make this possible.

Some countries face difficulty in justifying government funding for community programmes, which are sometimes seen as lacking an evidence base compared with traditional public health services. The World Bank has found that community-led initiatives deliver concrete results in the HIV response, particularly among vulnerable and key affected populations *(6, 7)*.

In many countries, punitive laws, police abuse, stigma and discrimination drive key populations away from health services. Community-based organizations that have the trust of these populations can be effective service providers, but in many cases such organizations lack the capacity to receive and manage funding. When funding for community-based programming is low or unpredictable, it is difficult to build lasting institutions that can deliver effective services efficiently.

Looking forward

Integrating community responses to HIV in national AIDS plans, including budget allocations, will be key to ending the AIDS epidemic by 2030. This will require transforming financing mechanisms and service delivery and linking community systems into resilient systems for health.

Despite challenges, health officials in the countries presented in this report have found innovative ways to mobilize funding, channel resources and build partnerships to respond effectively to HIV. Some of the factors key to success have included:

- Inclusion of community representatives in the panels that review and select grant recipients—this helps to ensure that the funded organizations have the trust of and connection to key populations, and strengthens community ownership of the process.
- Creating quasi-governmental organizations to receive government funding and redirect it to nongovernmental organizations, in particular nongovernmental organizations working with stigmatized or criminalized key populations.
- Maintaining rigorous standards for grant recipients, while investing in capacity-strengthening to ensure that organizations doing good work have a chance to succeed, grow and become mentors of other peer groups.
- Standardizing procurement, costing and monitoring and evaluation processes to reduce corruption and ensure good-quality programming across a decentralized service delivery process.
- Mobilizing private funders for community HIV programmes.
- Calculating the costing of programmes realistically, including overheads and administrative costs, so the community component of the national response is fully funded.
- Facilitating collaboration among nongovernmental organizations working in the HIV response, while supporting regular dialogue between governments and nongovernmental organizations.

To reach the Fast-Track Targets, there is a need for expanded programmes and increased investments in community mobilization and community-based service delivery *(2, 3)*. As the domestic share for financing the response to HIV is increasing, and in some cases international funding is in transition, it is hoped that examples such as the ones presented in this report can support governments to overcome administrative challenges and ensure domestic funds can reach community-based organizations to deliver services, advocacy and participation in decision-making and accountability.

Argentina

"Grant recipients note that although funding is limited, receiving resources from the Ministry of Health has often opened doors to collaboration with municipal and regional governments."

Background

HIV in Argentina is concentrated among key populations, including men who have sex with men, sex workers, people who use drugs and transgender people. HIV prevalence in the general population is about 0.3%, while reported prevalence is 35% among transgender women, 12–15% among men who have sex with men, 2–5% among sex workers and 4–7% among people who inject drugs *(8)*.

Universal access to antiretroviral therapy has been a state policy since 1997 *(9)*. Argentina was one of the first countries in the world to provide free care and antiretroviral therapy to all people in need. Currently about 69 000 people are receiving treatment, out of an estimated 126 000 people living with HIV *(10)* in Argentina. In 2012, the Government of Argentina reported spending about US$ 110 million per year on HIV treatment, testing and related care. In addition to direct medical support, people living with HIV are among the population groups eligible for Argentine Government-subsidized housing and disability allowances.

Funding mechanism, background and functionality

Between 2003 and 2013 Argentina received US$ 28.5 million for HIV programming from the Global Fund. Of this, US$ 2 million was disbursed between 1 January 2012 to 31 December 2013 to support programming focusing specifically on vulnerable and key populations. The ultimate goals of the programme were to reduce HIV incidence among key populations; to reduce stigma and

discrimination based on sexual orientation, gender identity and HIV status; and to promote universal access to health care. The Global Fund grants provided capacity-building to nongovernmental organizations, including support for some organizations to obtain legal status and develop capacity to seek funding from other sources.

Before transitioning from Global Fund financing, the Argentine Ministry of Health Directorate for HIV and Sexually Transmitted Infections began funding community organizations and networks directly. In 2011 a total of 971 000 Argentine pesos (US$ 103 384) was granted to 15 organizations: six networks of people living with HIV; two organizations addressing stigma and discrimination; two networks of transgender people; two organizations focusing on children living with HIV and other vulnerable children; and three organizations of people who use drugs.

Funding to support community programming has increased each year since 2011 and in 2015 a total of 2.1 million Argentine pesos (US$ 223 591) was allocated to 14 organizations working in several high-priority areas. The community programming includes disseminating information on preventing the transmission of HIV, hepatitis and sexually transmitted infections; promoting access to timely testing and counselling for HIV, hepatitis and syphilis; supporting high-quality care for people living with HIV, hepatitis and syphilis; and reducing stigma and discrimination.

The Directorate for HIV and Sexually Transmitted Infections contacts organizations with a strong track record of working in high-priority areas and invites them to complete a simple application process. To be eligible, the organizations need to meet several criteria:

- Previous experience working in HIV or a related field.
- Legal status or affiliation with an organization that has legal status.
- A bank account and financial management system.
- Ability to submit a project proposal aligned with the high-priority interests of the Directorate.
- Presence in the project area or affiliation with appropriate community partners.
- Ability to collaborate with health authorities in the project area.

The current protocol for awarding grants requires a technical review by the Directorate of HIV and Sexually Transmitted Infections, after which the proposals are submitted to the Minister of Health for final approval.

Under this programme, the Directorate can make a maximum award of 200 000 Argentine pesos (US$ 21 294) to a nongovernmental organization. Although the amounts are small, these grants are important because they can be used for grass-roots community-level work for which it is very difficult to find other sources of funding. The funding is provided in advance as a lump sum, and recipients are required to provide a narrative and financial report at the end of the nine-month grant term.

Grant recipients note that although funding is limited, receiving resources from the Ministry of Health has often opened doors to collaboration with municipal and regional governments.

Looking forward

The Directorate for HIV and Sexually Transmitted Infections has indicated an interest in increasing the level of funding available to 5 million Argentine pesos (US$ 532 359) by 2016. In addition to the grants, the Directorate supports nongovernmental organizations and networks by covering the cost of printing brochures and other materials, and it supports costs to host or attend relevant meetings.

Funding levels are subject to change, and community groups have asked for greater transparency and predictability of Argentine Government funding for the community response. Although the Ministry of Health acknowledges the essential role of community organizations, stronger political commitment at the highest level and an ongoing dialogue with community organizations are needed.

Brazil

"Financing community-based HIV programmes started in 1994 ... at the beginning of the 2000s a formal ministerial regulation was designed to allow direct fund transfers to states and municipalities."

Background

Brazil, a country with a population of more than 200 million people, boasts significant successes in its HIV response. Despite international warnings of an impending disaster in 1990, HIV prevalence is currently just 0.4% in Brazil. Eighty-three per cent of people estimated to be living with HIV have been diagnosed, and approximately 80% of people diagnosed have been linked to health services. More than 88% of people living with HIV on antiretroviral therapy had an undetectable viral load in 2014 *(11)*. The epidemic is concentrated among key populations, including young men who have sex with men.

Brazil has used a combination prevention strategy: condoms distribution through the national health system, post-exposure prophylaxis and targeted HIV prevention programmes with key populations. Brazil has provided universal access to free HIV treatment and care since 1996. Until 2013 free HIV treatment and care were offered only to people with a CD4 count below 500 mm^3, but since December 2013 Brazil's policy has been to offer treatment to everyone diagnosed with HIV, regardless of their CD4 count.

Using the national legal frameworks to protect human rights, and more specifically the right to health, civil society organizations have advocated effectively and played an active and prominent role in Brazil's AIDS response. The Brazilian Government attributes its success to its evidence-informed policies and to ongoing dialogue with diverse stakeholders, including broad social participation in the development of HIV policies.

Access to treatment and care is a governmental responsibility, protected by specific laws, and service provision in these areas is part of the national health service. The heavily decentralized national health system regulates roles and responsibilities through federal norms, agreed by both state and municipal health authorities. Local governments are accountable for the health of their citizens.

Funding mechanism, background and functionality

The Brazilian approach to HIV was developed as part of democratization in the late 1980s, which set the legal basis for the national health system. This political process relied heavily on community mobilization and brought together health-care workers, trade unions, academics, faith-based organizations and activists who demanded health reform *(12)*. As Jane Galvão writes, "In Brazil, the early HIV/AIDS movement relied on experienced activists who had organized against the military regime; some of these individuals helped create the first nongovernmental organizations and some came to assume roles in local, state and federal government. Not surprisingly, this first generation of Brazilian activists approached the government about the new disease using strategies they had implemented against the dictatorship, strategies that included the demand for the democratization of access to information and the protection of human rights" *(13)*.

The HIV response model that eventually emerged in the 1990s and early 2000s was grounded in the establishment of municipal, state and national health councils. These health councils are bodies that make decisions on governmental policy and act as watchdogs to monitor programme implementation. They comprise 25% representatives of government and service providers, 25% representatives of health workers, and 50% national health service users (networks and nongovernmental organizations). At the national level, people living with HIV are explicitly included in the governance architecture. Two commissions on AIDS include civil society representatives: the National AIDS Commission and the Joint Committee with Social Movements.

Financing community-based HIV programmes started in 1994, when Brazil signed the first of a series of four World Bank HIV loan agreements. Because the formal health sector experienced challenges in reaching key populations, especially men who have sex with men, sex workers and people who use drugs, civil society was brought in to assist in outreach. Grants were small, at around US$ 50 000, and aimed at encouraging the growth of grass-roots organizations. Budgets were set at the national level, which then had to be approved by the health councils at the state and municipal levels.

To strengthen the HIV response at the local level, at the beginning of the 2000s a formal ministerial regulation was designed to allow direct fund transfers to states and municipalities (the "incentive policy"). The development of this incentive was driven by the need to implement alternatives to sustain the response to HIV and other sexually

transmitted infections. The funding was initially directed to finance shelters for homeless people living with HIV and to provide infant formula for affected newborns; later, the funding was used to fund a broad range of activities. Furthermore, a percentage had to be allocated for nongovernmental organization-led projects, through public calls for proposals.

After so many years, however, there are still legal barriers in some states regarding transferring governmental funds for nongovernmental organizations. Some have been successful and can transfer the funds via agreements or contracts. The Ministry of Health disseminates good practice and encourages local managers to learn from successful experiences. In 2011 these policies went through a process of profound legal changes. The criteria for direct funding changed, greatly increasing the number of eligible municipalities, while the prioritization of shelters, infant formula and nongovernmental organization support remained.

Civil society organizations also receive financial support from the Department of Sexually Transmitted Infections, AIDS and Viral Hepatitis through public calls for proposals, which, since 2007, are published on the Ministry of Health website[1] and include specific eligibility criteria. To be eligible for funding for HIV testing services among key populations, for instance, applicants must demonstrate at least three years' experience in delivering HIV prevention or community-based programmes for key populations. The calls for proposals include civil society projects to strengthen actions related to sexually transmitted infections and HIV. Recent public notices include human rights promotion and protection, and increasing access to (oral) self-testing of HIV among key populations. During the implementation of the project, the civil society organization grantee must send regular progress reports as a condition of release of remaining funding. Recognizing the important role of communities in participation in accountability, in addition to service delivery, the Department of Sexually Transmitted Infections, AIDS and Viral Hepatitis also offers travel and accommodation support to members of civil society organizations so they can participate in representative bodies at the Ministry of Health.

The technical team of the Department of Sexually Transmitted Infections, AIDS and Viral Hepatitis carries out the evaluation and selection of grant recipients. The activities of civil society organizations financed by the public administration are monitored by municipal health councils, state health councils and the National Health Council.

Looking forward

One example of successful partnership between government and civil society to deliver community-based services is the project Viva Melhor Sabendo ("Live Better Knowing") being piloted to scale up oral self-testing among key populations, including peer testing and counselling. Voluntary testing takes place in social spaces selected by community

1 http://www.aids.gov.br/pagina/editais-fechados-1

organizations based on acceptability and where key populations get together. In the first year of Viva Melhor Sabendo (2014–2015), almost 30 000 people were tested through 53 nongovernmental organizations from 20 of the 27 states in Brazil. A new round of the project has been launched, and more than 50 nongovernmental organizations have been selected to participate and are already in the programme implementation phase.

As an alternative to providing funding to nongovernmental organizations and contributing to the overall sustainability of their work, Fundo PositHiVo (National Sustainability Fund for Civil Society Organizations) was established in December 2014, supported by the Brazilian Government. This aims to raise funds from the private sector to finance civil society organization projects related to sexually transmitted infections, HIV and viral hepatitis. Fundo PositHiVo is not managed by the Brazilian Government and brings an additional source of resources for the response to HIV in Brazil.

India

"Three aspects of the programme were especially innovative: standardization of programme design and costing, an emphasis on key population-led programming, and investment in capacity-building for community-based organizations."

Background

With a population of 1.2 billion people and an HIV prevalence of 0.26%, India has the third largest population of people living with HIV and one of the largest HIV epidemics in the world *(14)*. The epidemic is largely concentrated in key populations; about 40% of new infections are among women. In India, although sex work in private is not criminalized, solicitation in a public place, living on the earnings of sex work and maintaining a brothel are illegal. Sexual relationships "against the order of nature" (interpreted by many to include homosexuality) are criminalized. India does, however, now legally recognize a third gender.

India's focused and strategic efforts at prevention have helped to reduce new infections by 66% since 2000, with national progress reports continuing to show a steady decline *(15)*. HIV prevalence among sex workers and men who have sex with men has fallen; prevalence among people who inject drugs is increasing. India has achieved these reductions in new infections in part through a unique system of decentralized direct funding to, and capacity-building of, community-based and community-led organizations that have the trust and experience to reach key populations.

Funding mechanism, background and functionality

India's National AIDS Control Organization (NACO), established in 1992, leads the process of implementing the national AIDS programme. From its outset, NACO, working closely with civil society, emphasized a strategic focus: "Resources

were directed at attaining coverage of critical programmes among key affected populations over broad-based prevention programmes for the general population" *(15)*.

Also from the outset, policy-makers at the national level recognized that an effective national AIDS response needs to use innovative strategies, reach key populations and include communities.

NACO has been conducting size estimates of key populations since the early 1990s, mapping concentrations in cities, and identifying civil society organizations and academic centres already working with key populations. Although some of these organizations, such as organizations working with the urban poor, were new to HIV prevention, they had the experience and trust of relevant key populations, and NACO worked with these organizations as the starting point for the national response. The Indian Government began to fund targeted programmes for key populations, such as peer outreach to sex workers and men who have sex with men, provision of opioid substitution therapy, prevention programmes for migrants, and community-based programmes in rural areas. Successful projects were scaled up as international funders began to invest.

An innovation in the Indian model of governmental financing of civil society organizations was the costing of packages of focused programmes among different subpopulations. States can fund organizations through the procurement of their services *(16)*. For a state to procure services from civil society organizations working on HIV, a standardized way of costing the deliverables of those services was developed. Costing exercises calculated the cost to deliver a package of services to 1000 sex workers, for example. Civil society could then be contracted to deliver a certain number of packages. Through this innovative approach, procurement of services through civil society was standardized, as was costing, including advocacy, participation in accountability and service delivery.

Early on, there were challenges in funding civil society organizations through government agencies. Funds sent from the Indian Government to the state treasuries were slow to reach state-level civil society organizations. In some cases, impoverished states that had significant funding gaps were using AIDS funding to meet payroll or other budgetary needs and were not disbursing funds to HIV programmes.

The state of Tamil Nadu was one of the first to establish an independent funding mechanism to address some of these challenges. Tamil Nadu set up an independent state AIDS control society, chaired by a senior Indian Government official, with an executive committee that included other Indian Government officials, civil society representatives, representatives of key populations and people living with HIV. The central Indian Government was able to disburse AIDS funding directly to the state AIDS control society, bypassing the bottlenecks in the state treasury. Based on mapping of prevalence and data from surveillance centres, which identified high-priority districts and high-priority populations to be targeted with programmes, funding allocations were made and implementers were

identified through a competitive bidding approach. The state had improved flexibility, was able to respond more rapidly to changing epidemiological data, had high coverage of key populations and made rapid progress.

Reviews by the World Bank and international funders found the state AIDS control society model in India to be successful in improving the flow of disbursements. Soon, similar state AIDS control societies were set up in all the other states, following a standardized process set out by NACO. Three aspects of the programme were especially innovative: standardization of programme design and costing, an emphasis on key population-led programming; and investment in capacity-building for community-based organizations.

NACO's highly standardized process for state AIDS control societies is set out in published guidance *(17)*. The process begins with the state AIDS control society issuing calls for applications by nongovernmental organizations, community-based organizations and networks through open advertisement in regional newspapers and online. A matrix developed by NACO identifies the recommended number of programmes given the population size (for instance, for a region with 1500–2000 sex workers, two or three projects are recommended for two or three agencies to manage).

A state-level technical advisory committee, including the nongovernmental organization coordinator, the state AIDS control society procurement officer, a member of the technical support unit, and a nongovernmental organization representative of the executive committee, together conduct preliminary screening of applications. Joint appraisal teams then conduct field visits to shortlisted agencies in order to assess their institutional capacity and programme effectiveness. These teams include a technical officer of the state AIDS control society, a financial officer and an external technical officer; together, they complete a checklist of questions, meet with board members and staff, and assess the level of rapport with the community. This team may also identify some capacity needs at the nongovernmental organization.

The shortlisted agencies then conduct their own needs assessment, including mapping and size estimates of communities. The technical advisory committee assigns technical mentors to each organization. The state AIDS control society then holds a proposal development workshop for shortlisted agencies to train them in how to create a logical framework, budget and documents needed for the proposal.

The programme includes intensive capacity-strengthening for all organizations selected to receive funding. This includes an induction programme for staff of the grantee organization, which covers the basics of sexually transmitted infections and HIV, sex and sexuality, programme management, peer education training, behaviour change communication, and care and support. In addition, staff are trained in documentation, reporting and programme monitoring, and visits are arranged to model programmes. Each state is

required to set out a comprehensive monitoring and evaluation programme, which includes monthly reports, participatory site visits, experience-sharing and review meetings, and cluster meetings to facilitate coordination among partners. NACO sets targets for the number of key populations to be reached by each peer outreach worker, and standardized data collection forms are used in the field. These data are used by project managers to identify gaps and to provide feedback to peer educators *(15)*.

Although the process is highly standardized, NACO has emphasized the importance of having key population programmes led by members of the community: "Community members only start to fully understand the issues once they gain control and ownership over the processes of intervention. Thereafter, the community starts defining HIV prevention as their own agenda" *(15)*.

Looking forward

The use of state AIDS control societies increased the speed of distribution of funds at the state level. According to the World Bank and Indian civil society organizations, the model "helped increase the pace of implementation" *(18)*. It was seen widely as a successful model for directing funding to areas of greatest need and effectively reducing HIV incidence rates among hard-to-reach sex workers and men who have sex with men.

Once the state AIDS control society approach was seen as successful in eluding bottlenecks and flexibly directing funding to community needs, other development and aid sectors (including environmental and other programmes) established their own state-level societies. In 2014 the method of fund transfers was changed. Where NACO once funded state AIDS control societies directly, funds were routed through state treasuries again, as they were before 1997. Disbursement from state treasuries slowed, delaying payments to nongovernmental organization health workers *(19)*. Between 2014 and 2015, the central AIDS budget was also cut significantly, with states asked to fill the gap—a move that has resulted in significant layoffs *(20)*. On 1 December 2015, however, the decision was reversed and funds are again directed through the state AIDS control societies.

Malawi

"This flexibility to fund small local community groups is one of the strengths of Malawi's community engagement approach. The approach has demonstrated the potential impact and cost-effectiveness of supporting motivated local groups."

Background

AIDS-related illnesses are the leading cause of death among adults in Malawi, and are a major factor in the country's low life expectancy of 55.4 years. It is estimated that 980 000 Malawians were living with HIV in 2015 *(21)*. The Malawian Government has mounted a robust response to the HIV epidemic in recent years. The number of new HIV infections decreased from 89 000 in 2004 to 33 000 in 2015. In 2015 HIV prevalence was estimated to be 9.1%, and more than half of all new HIV infections occurred among women aged 15 years and older *(21, 22)*. Studies suggest prevalence among certain groups in Malawi is higher than among the general population, including female sex workers (63%), female police officers (23%), male police officers (17%), men who have sex with men (from 5% to 25% across sites), female primary-school teachers (23%), and male primary-school teachers (13%) *(23)*.

The Malawian Government and international funders have made concerted efforts to increase access to antiretroviral therapy and to improve prevention initiatives. The scale of the epidemic and a shortage of human and financial resources have hindered progress. Nonetheless, funding for community engagement in the HIV response has been central to Malawi's national AIDS strategy since the national AIDS control programme was established in 1989.

Funding mechanism, background and functionality

The current National Strategic Plan 2015–2020 calls for the active participation of civil society, including cultural and religious leaders, the private sector, community-based organizations and people living with HIV, in moving towards the ambitious 90–90–90 treatment target *(24)*. The Malawian Government has shifted a number of the nonclinical tasks related to patient follow-up and adherence support to community-based lay health workers and volunteers, thus relieving the burden on the health-care system. According to the National AIDS Commission, community and civil society organizations are able to promote accountability, catalyse demand creation, deliver services (within the facility and directly in the community) and handle resources efficiently *(25)*.

Malawi has put in place a comprehensive programme to decentralize the implementation of the HIV response at the district level. Local councils are mandated to identify and support community organizations to implement activities, such as home-based care, support for orphans and other vulnerable children, prevention and promotion of voluntary medical male circumcision.

To identify community organizations to fund, the National AIDS Commission launches calls for proposals in local papers and on radio stations on a regular basis, and invites proposals for projects aligned to the national AIDS strategy. Most proposals are submitted first to local councils for review and pre-approval. The local councils establish a proposal review committee to analyse the proposals in the light of priorities set out in the district integrated HIV plan.

Within seven days of the receipt of the application, the National AIDS Commission conducts a second review and then provides comments to the applicant organization through the appropriate local council. Where the proposal is found to be technically and financially sound, its approval is endorsed by the management of the National AIDS Commission.

The local council informs the applicant organization of the results of the application. In cases where a proposal is rejected by the National AIDS Commission, the local council is required to help the organization revise its proposal for resubmission to the National AIDS Commission within four weeks. The local council is then expected to finalize the work plan, develop a grant agreement and disburse funding for the first two quarters of the project. The funded community organization is required to set up a separate bank account with two signing officers.

Organizations, including those working with vulnerable and key populations, are eligible to apply if they meet minimum criteria. These include governance and accountability systems (such as boards of directors, bank accounts and recent audits) and registration with the Ministry of Gender, Children, Disability and Social Welfare. Community-based organizations that are not registered or do not meet the minimum criteria may still be eligible for funding administered on their behalf by district government agencies.

This flexibility to fund small local community groups is one of the strengths of Malawi's community engagement approach. The approach has demonstrated the potential impact and cost-effectiveness of supporting motivated local groups. Recent examples include a community-run campaign costing around US$ 200 that resulted in recruitment of over 100 men to take part in voluntary medical male circumcision.

Monitoring, evaluation and technical support are arranged by the National AIDS Commission, either directly or through other Malawian Government departments. A United States-funded initiative and other bilateral funders provide complementary technical support to both the National AIDS Commission and implementing nongovernmental organizations.

The National AIDS Commission was able to direct funds to community programmes from 2008 to 2015 using funding from the Global Fund and from a pooled funding mechanism that consolidates resources from several funders. A 2012 audit report by the Global Fund Office of the Inspector General indicated that the National AIDS Commission programming with community organizations was generally successful *(26)*.

Looking forward

The National AIDS Commission will continue to set funding priorities based on the national AIDS strategy. The success of Malawi's support to the community response was built on a clear commitment to the role of community as articulated in the national AIDS strategy, and on effective coordination between the Government of Malawi, United Nations agencies, funders and civil society. The HIV response was, until recently, run from the office of the President of Malawi, which ensured strong collaboration among Malawian Government departments and between national and international partners.

In 2014 several community organizations came together to develop the Malawi Civil Society Priorities Charter, an advocacy road map for programmes that civil society believed were crucial to address the epidemic *(27)*. This civil society gathering and the Charter have been critical in informing the Global Fund concept note *(28)* and the United States President's Emergency Plan for AIDS Relief Country Operational Plan 15 in Malawi and consequently strategically positioned community responses in these two major funding mechanisms. In 2015, building on this work, many of these same networks collaborated with UNAIDS to launch the Malawi Community Charter on Getting to 90–90–90 *(29)*. The Charter spells out the wide range of programmes that civil society will take in addressing HIV in Malawi. Roles include advocacy, monitoring of stock-outs, support for programmes targeting vulnerable and key populations, demand creation for testing, and follow-up to increase adherence.

Malawian nongovernmental organizations raise concerns that although they have built substantial capacity and demonstrated that they play an essential role in the HIV response, the overall funding available to support their work

is decreasing. Although the Global Fund's new grant with Malawi has not yet been signed, it is anticipated that it will allocate increased funding to the community response, but to a fewer number of organizations to ease principal and secondary recipient management.

Finally, in the context of overall decline in financing for health and HIV in Malawi, and recognizing the centrality of the community response to the Fast-Track approach to the end of the AIDS epidemic as a public health threat by 2030, the idea of a civil society organization sustainability strategy is being considered (to be developed in 2016 with the participation of civil society). As an initial step, the Government of Malawi together with the HIV/AIDS Donor Group and civil society have requested UNAIDS to chair a multi-stakeholder taskforce to identify short- and long-term solutions to the funding crisis faced by the community response, particularly regarding critical community-based critical services at risk of disruption.

Malaysia

"The funding mechanism allows for appeals, and each year some applicants that are turned down for funding appeal against the decision. If the Malaysian AIDS Council believes the programmes merit support, the Council may work with the Malaysian AIDS Foundation to secure private funding for rejected applicants who appeal against the decision."

Background

Malaysia has a population of 29.72 million people, including an estimated 100 000 people living with HIV. The HIV epidemic is concentrated among key populations: people who inject drugs, sex workers, men who have sex with men and transgender people. According to Malaysian Government reports, Malaysia's success in responding to HIV since 2001 is due to the prioritizing of programming for key populations, combined with other prevention and control programmes *(30)*.

Malaysia provides free antiretroviral therapy to people on first-line regimens. Malaysia also has an ambitious harm reduction programme, including Malaysian Government-financed needle–syringe exchange programmes and opioid substitution therapy, since 2005–2006. Outreach to men who have sex with men and sex workers is challenging due to current legal and policy restrictions, but the Ministry of Health and the Malaysian AIDS Council have expressed their determination to overcome these challenges *(31)*.

It is expected that in 2017 Malaysia will be reclassified as an upper-middle-income country and thus will no longer be eligible for financing from the Global Fund. Plans and negotiations are ongoing to transition to Malaysian Government support for all aspects of the HIV response.

Funding mechanism, background and functionality

In 1992 the Ministry of Health established the Malaysian AIDS Council as an umbrella project to focus on prevention among key populations, with the goal of providing 80% service coverage to key populations. In 2013, the Malaysian Government reported that 95% of the HIV funding or US$ 55 million comes from domestic public sources, 4% or US$ 2 million from international sources and 1% or US$ 628 million from private sources. Funding has gradually increased since the Malaysian AIDS Council was established, and 49 civil society organizations have been funded to date.

The Malaysian AIDS Council maps HIV prevalence among key populations in order to identify specific programme needs. Based on this mapping, the Malaysian AIDS Council issues an annual call for proposals. Partner organizations submit proposals for programmes that can include harm reduction, HIV prevention among specific key populations, and HIV-related shelter homes for women and children.

The Malaysian AIDS Council has an internal technical review panel, made up of Malaysian AIDS Council programme and finance staff and the Executive Director, which evaluates proposals. The panel reviews each proposal's technical soundness, proposed budget and applicants' past performance and recommends which proposals should be funded. Proposals receive a second review by the Ministry of Health technical review panel, made up of officials from various Malaysian Government agencies. The Malaysian AIDS Council then negotiates with the grantee on targets, budget and activities. The funding mechanism allows for appeals, and each year some applicants that are turned down for funding appeal against the decision. If the Malaysian AIDS Council believes the programmes merit support, the Council may work with the Malaysian AIDS Foundation to secure private funding for rejected applicants who appeal against the decision.

Funding is provided as a three-month advance, and grantees are required to submit monthly financial and monitoring and evaluation reports on programme activities. Organizations must be legally registered and in good standing with the Register of Societies, which requires nongovernmental organizations to file annual returns *(32)*. Organizations that fail to submit their monthly reports to the Malaysian AIDS Council may not be eligible for future funding.

Looking forward

When it was established in 1992, the Malaysian AIDS Council aimed to achieve 80% coverage of key populations, and it has shown substantial results *(30)*. However, Malaysia's national AIDS progress reports and its reports to the Global Fund indicate that coverage of key populations with HIV services has not yet approached the 80% target.

Malaysia now confronts the challenge of addressing the rapidly increasing burden of HIV among men who have sex with men, sex workers and transgender people, communities among whom there is a significant programmatic gap. The

Malaysian AIDS Council argues there are few organizations with the capacity to reach men who have sex with men, and that few organizations are able to legally register. Funding for programmes for men who have sex with men and transgender people comes predominantly from international sources. Incorporating representatives of key populations on the technical review panel and allocating additional resources to funding and capacity strengthening for organizations serving marginalized and criminalized groups could help to address these concerns.

Republic of Moldova

"The national AIDS programme acknowledges that community organizations should implement these programmes, because they are better equipped and better trusted by key populations than state agencies."

Background

The Republic of Moldova has a low-prevalence HIV epidemic concentrated among people who use drugs, with evidence of increasing incidence in the general population *(33)*. HIV prevalence is lowest in the capital Chisinau and significantly higher in regional towns such as Balti and Tiraspol. In these towns, prevention programming for people who use drugs is available, but there is less prevention programming for men who have sex with men and sex workers; stigma makes all these populations hard to reach. Prevalence ranges from 8.5% to 41.8% among people who use drugs, from 5.4% to 8.2% among men who have sex with men and from 11.6% to 21.5% among sex workers. In 2014, 17 541 people were estimated to be living with HIV in the Republic of Moldova *(33)*.

The Republic of Moldova is recognized in the region as an example of good practices in the HIV response due to its successful implementation of harm reduction programmes in communities and prisons. In 2014 Moldova spent US$ 9.2 million on the HIV response, of which 75% was provided by international partners *(33)*.

Funding mechanism, background and functionality

Currently there are several national civil society organizations providing services to vulnerable and key populations and people living with HIV. They lead community-based activities focusing on psychosocial support, prevention programming and harm reduction services for these groups. Funding for this work has come predominately

from the Global Fund and has been administered by a nongovernmental principal recipient. These nongovernmental organizations also benefit from some modest in-kind support from the Moldovan Government, such as provision of rapid tests and local authority office space.

In anticipation of the reduction of Global Fund funding, the Moldovan Government has indicated it will assume the cost of all antiretroviral therapy, including second- and third-line therapies, treatment monitoring and patient follow-up, through the Ministry of Health budget and the national health insurance programme.

In 2014 the Ministry of Health set aside money in its budget to support one prevention project focusing on people who use drugs, to be implemented by a national nongovernmental organization. The Ministry of Health plans to increase its commitment to fund two harm reduction projects per year starting in 2016. The national AIDS programme acknowledges that community organizations should implement these programmes, because they are better equipped and better trusted by key populations than state agencies.

To be able to allocate funding to nongovernmental organizations, the Moldovan Government needs to approve a new normative framework that defines a mechanism for financing health nongovernmental organizations. A technical working group under the Ministry of Health has developed the framework, but due to changes in the Moldovan Government, as of September 2015, the framework had not yet been approved. The funding set aside in 2014 and 2015 for nongovernmental organization programming has lapsed.

In order to be eligible for funding, nongovernmental organizations must be accredited by the Ministry of Health or the Ministry of Labour, Family and Social Protection. The accreditation process is participatory and interactive and begins with self-assessment of the nongovernmental organization, followed by a dialogue with the Ministry of Health based on defined standards. Nongovernmental organizations are required to demonstrate they have the professional, managerial and technical capacity, as well as the infrastructure, to implement and monitor programmes with key populations. This very thorough accreditation process also includes interviews with beneficiaries and analysis of the nongovernmental organization's past track record.

The Republic of Moldova recently introduced a law requiring companies to donate 2% of their profits to charitable activities. In August 2015 the National Health Insurance Fund also announced a mechanism to finance nongovernmental organization prevention programmes, the details of which are still to be worked out. Subject to approval by the Ministry of Justice, a call for proposals was announced in early 2016.

Even when these new mechanisms are in place, it is unclear whether funding will be sufficient to meet the needs of the community component of the HIV response. Nongovernmental organizations anticipate that unless additional funding is made available, they will be unable to continue offering the current levels of services.

Looking forward

Moldovan health officials have demonstrated a commitment to support the community component of the HIV response. They have agreed to replace some of the funding provided by the Global Fund and other external funders through their own resources. Regulatory hurdles have turned out to be more time-consuming than was anticipated, which may delay the smooth transition to country-financed support for community responses. Nongovernmental organizations from the Republic of Moldova and elsewhere in the region have argued it is crucial to monitor levels of funding available to support the community component of the response *(34)*. If funding decreases and community services are discontinued, the gains achieved so far in addressing the epidemic could be in jeopardy.

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