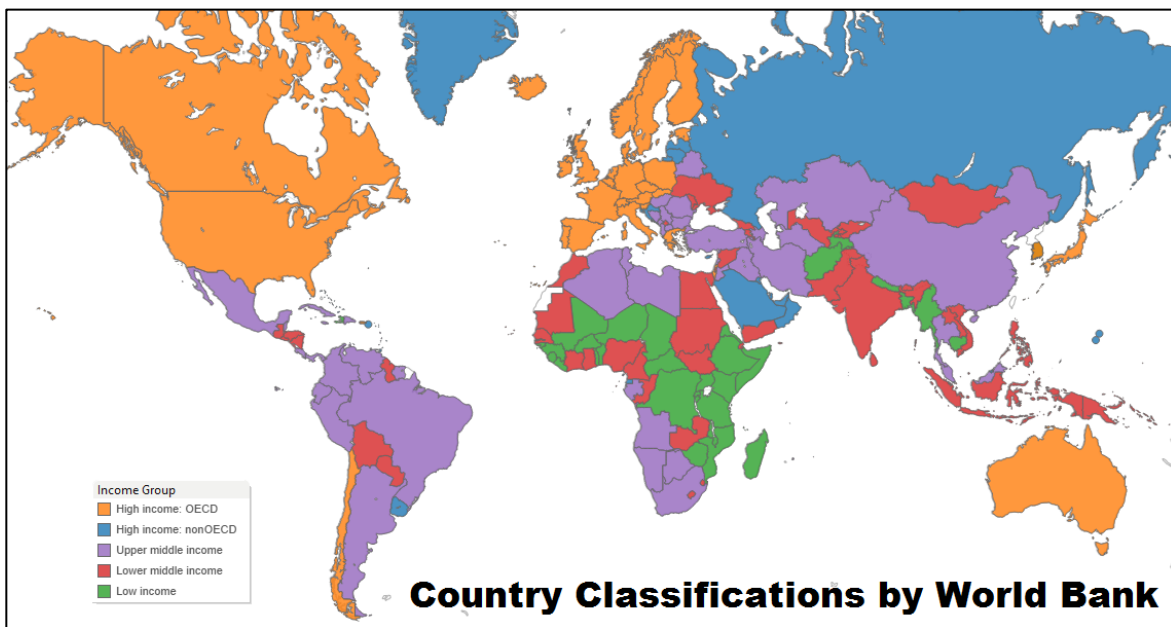


Action plan to reverse destructive HIV financing trends in middle-income countries



2015 Country Classifications by World Bank

Action plan to reverse destructive HIV financing trends in middle-income countries

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Acronyms and abbreviations

ARV =	antiretroviral drug
EECA =	Eastern Europe and Central Asia
Global Fund =	Global Fund to Fight AIDS, Tuberculosis and Malaria
LIC =	low-income country
MENA =	Middle East and North Africa
MIC =	middle-income country
MSM =	men who have sex with men
ODA =	official development assistance
OSF =	Open Society Foundations
UHC =	universal health care
UNAIDS =	Joint United Nations Programme on HIV/AIDS

Note on text: All \$ figures are U.S. dollar amounts, unless specified otherwise.

This action plan was developed following a series of discussions held in New York, Durban and Amsterdam. For the Amsterdam meeting, held at the end of October 2016, International Civil Society Support (ICSS) and the Open Society Foundations (OSF) organized a gathering of 35 advocates from around the world to discuss the need for and methods to coordinate advocacy, capacity-building and communications efforts to address the funding crisis in middle-income countries. This document is a result of those discussions and the background documents that informed them. The Amsterdam meeting agenda and the participants list are included in this document as Annex 2 and Annex 3, respectively.

The organizers wish to thank those who participated in the planning of the meetings and in providing background information: Peter van Rooijen and Raoul Frasen of ICSS, and Julia Greenberg, Ekaterina Lukicheva, Melania Trejo and Raminta Stuiyte of OSF. David Barr and Jeff Hoover of The Fremont Center prepared this document.

1. A Plan for Action: Why the MICs' Withdrawal is a Civil Society Advocacy Priority

All countries and all stakeholders, acting in collaborative partnership, will implement this plan. We are resolved to free the human race from the tyranny of poverty and want and to heal and secure our planet. We are determined to take the bold and transformative steps which are urgently needed to shift the world on to a sustainable and resilient path. As we embark on this collective journey, we pledge that no one will be left behind.

—Transforming our world: the 2030 Agenda for Sustainable Development, September 2015

Despite commitments from governments to “leave no one behind” across all health and development work, funding from donors for HIV and TB responses is decreasing and governments are not living up to their obligations to ensure the right to health of their citizens. The first and hardest hit are people living in middle-income countries (MICs), where donor governments and multilateral funding mechanisms are withdrawing financial support. HIV and TB primarily affect key populations in these countries—sex workers, men who have sex with men (MSM), people who use drugs, the incarcerated, migrants, and poor women and girls. Unless action is taken, millions will suffer and die. This document serves as both a call to action and a plan for coordinating communications and activities to stop this attack on people’s lives and human rights.

With few exceptions, most countries in the developing world are caught between two opposing pressures. On the one hand, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has prioritized achievement of the “Fast-Track” targets, which focus on rapid scale-up of access to HIV prevention and quality HIV treatment, including the gold standard viral load diagnostic tool. On the other hand, donors are cutting back on external HIV financing and national governments are failing to absorb HIV and TB programmes (which are often needed in particular by criminalized and marginalized groups) into their health systems.

To put it simply, most countries, especially MICs, are being asked to do more with less—an impossible task and unfair responsibility in countries that still host some of the poorest populations in the world. The inevitable consequences include overstretched public health systems and precarious treatment and prevention services that are stretched too thin. That is a recipe for disaster, or, more precisely, for losing

Transitions can threaten the continuity and coverage of vital health services, especially for key and vulnerable populations. Governments are often reluctant to absorb programs for criminalized and marginalized groups. Civil society and community groups MUST ensure that key and vulnerable populations are not left behind when countries transition from Global Fund support.

—A Community Guide to the Global Fund’s Sustainability, Transition and Co-Financing Policy¹

what limited control has been gained over the HIV epidemic. If public health systems fail to cope with dual pressures of Fast-Track and “do more with less”, the inevitable results will be drug resistance, drug stock-outs, lack of sufficient prevention and support, and limited ability to reach all clients in need at all stages of the HIV and TB prevention, treatment and care cascades.

Upper-middle-income countries (UMICs) and other MICs, especially those with low disease burdens but concentrated epidemics among key populations, fare the worst because most donors are shifting financing priorities to lower-income

countries severe epidemics. The reasons given typically include the need to direct funds to countries and contexts with the most limited resources and capacity. That rationale sounds reasonable from a theoretical

¹ Prepared by the Regional Platform for Communication and Coordination on HIV/AIDS, Tuberculosis and Malaria for Anglophone Africa, which is hosted by the Eastern Africa National Networks of AIDS Service Organisations (EANNASO).

or conceptual level, but makes little logical sense from an epidemiological or practical standpoint. For one, countries are categorized as middle or lower or upper income, or one of various gradations in between, solely on the basis of per capita income. That factor is notoriously imprecise in terms of identifying where the most pressing needs are. MICs remain home to the majority of poor people in the world. Data published in 2012 identified that 80% of the world’s poorest people—those who live on less than \$2 per day—are now living in MICs. The burden of the three diseases is concentrated in MICs, which currently are home to about 57% of all people living with HIV, 72% of those living with active TB, and 54% of malaria cases annually. MICs’ share of the world’s people living with HIV is projected to rise to 70% by 2020. About 60% of worldwide cases of multidrug-resistant TB (MDR-TB) are in just four countries, all of which are MICs: India, China, Russia and South Africa. In addition, focusing solely on countries that contribute the most to global disease burden means ignoring epidemiological realities—including countries with concentrated epidemics and/or countries with high national burden but smaller population size.

These figures underscore a retreat from principles that advocates and global leaders fought for years to place at the centre of HIV and broader development policies and programming. In 2001, for example, then-UN Secretary-General Kofi Annan noted that “we must all remember that while HIV/AIDS affects both rich and poor, the poor are much more vulnerable to infection, and much less able to cope with the disease once infected.” Fourteen years later, as noted in this document’s introductory quote, the 2030 Agenda for Sustainable Development, which laid the basis for the Sustainable Development Goals (SDGs), pledged that “no one will be left behind” as we seek to “free the human race from the tyranny of poverty and want and to heal and secure our planet.”

The move away from HIV and TB financing: forsaking the poor and most vulnerable

In 2015, the year that the SDGs were adopted, donor government funding to support HIV responses in low- and middle-income countries totalled \$7.5 billion. That amount represented a steep decline from the \$8.6 billion made available in 2014. There is no indication that this trend will reverse or even stabilize in the immediate future. Assuming that the downward trend continues, there is no possible way that the estimated funding gap of some \$7 billion to meet global HIV needs over the next five years can be bridged. Instead, the gap will only widen.

We are also in danger of losing momentum in the TB response just at the time when there are a number of new tools and opportunities to substantially improve outcomes for people with TB and its drug-resistant forms. Such opportunities must be seized, rather than squandered, given the urgent need to accelerate and improve diagnosis and treatment of TB globally.

Regardless of the size of the gap, one thing is clear: yet again, global leaders are saying one thing about poverty and priorities and doing something quite different. It is, in our opinion, a serious miscalculation on behalf of global leaders to underfund the response at this important juncture—when some semblance of control has been achieved, due to the concerted efforts of developing countries, donors, development partners and civil society (including community-based organizations) over the last two decades. We have to see the job through. Stepping away from MICs means stepping away from the poor, and it jeopardizes the gains made in these countries overall and their health systems in particular.

Preventing preventable illness, disability and premature death, like preventing human rights abuses and genocide, to the extent that it involves protecting the vulnerable, must be understood as a challenge to the political and societal status quo.

—Jonathan Mann, 1997²

² “Health and Human Rights: If Not Now, When?”, *Health Human Rights*. 1997. Jonathan Mann, who died in 1998, was the head of the World Health Organization’s global AIDS programme, the precursor to UNAIDS.

As seen in countries where the Global Fund has already stopped its funding, the combination of donors withdrawing from MICs and national/local governments and other stakeholders unwilling or unable to continue funding programmes, particularly those vital for key populations, constitutes a deliberate deprivation of services that are needed for such groups' physical survival.

As suggested above, donors are not the only ones complicit in and contributing to this problem. For years, countries in some regions such as Eastern Europe and Central Asia (EECA) have relied heavily on international funding for their responses to HIV and TB in particular. Due to structural challenges and government indifference or antipathy, external donor funding has often been the only source of financing for programmes targeting key populations and vulnerable groups such as MSM, people who use drugs, transgender people and sex workers. At best, countries might invest in generalised epidemics yet ignore the key population needs within their borders, thus creating chronic and concentrated epidemics among these populations.

Using only World Bank economic growth indications [is] not fair for countries, especially in the case of massive cuts to donor funding for HIV. The Global Fund knows better than anyone that in some countries in the region, the transition to domestic funding will cause the disappearance of all developed services for key affected populations.
—Anna Dovbakh, Acting Executive Director of the Eurasian Harm Reduction Network (EHRN)³

Moreover, many governments in countries classified as MICs—including those that have relied on donor funding—decide not to invest more in health funding. Instead, they often prioritize other development areas such as infrastructure and energy, not to mention the armed forces. By making such decisions, they are failing to take proper and sufficient action on HIV and public health. These decisions are made with full knowledge of the likely consequences. The

governments are deliberately ignoring the fact that they have committed to leaving no one behind, by signing up to the 2030 Agenda for Sustainable Development, and are parties to various HIV-specific declarations and agreements leading up to the 2016 High Level Meeting on Ending AIDS.

Even when their governments have the best intentions, HIV responses in several countries will struggle to maintain current coverage levels at sufficient quality. It is nearly impossible to imagine how they can be expected to meet the financial and structural responsibilities of scaling up that are embedded in the Fast-Track targets as discussed in Section 2.1.1 below

2. The Landscape Influencing Future Action

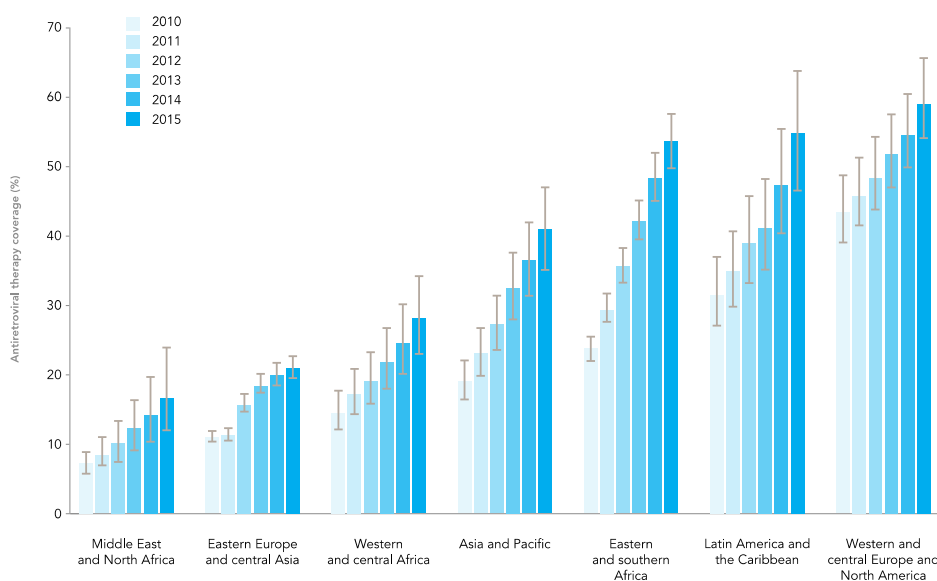
2.1 Current status of HIV and TB responses in MICs

2.1.1 Meeting HIV 90-90-90 targets: a fast track?

An estimated 18 million people have initiated HIV treatment, with increases seen in every region over the years. However, significant gaps in coverage remain, particularly in EECA and the Middle East and North Africa (MENA), regions largely comprising MICs. Coverage in West Africa is also poor, with most people living with and at risk for HIV living in Nigeria, another MIC facing potential funding withdrawals. Although coverage is relatively higher in Asia, Latin America and the Caribbean, funding withdrawals may significantly undermine the progress made to date.

³ Tinatin Zardiashvili, “Seven Countries in the EECA Region Projected to Transition by 2025”, *Global Fund Observer*, 1 November 2016, www.aidspan.org/node/3966.

Antiretroviral therapy coverage among people living with HIV, by region, 2010–2015



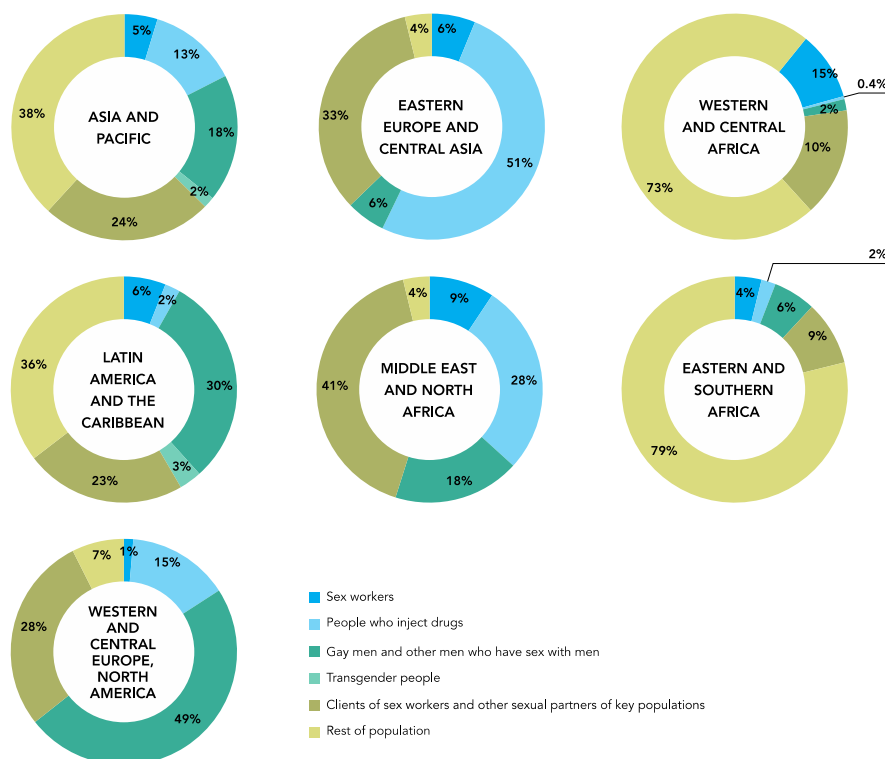
Sources: GARPR 2016; UNAIDS 2016 estimates.

The chart below shows that in regions mostly composed of MICs, the large majority of new HIV infections occur within key populations. Analysis of data from UNAIDS suggests that more than 90% of new HIV infections in EECA, Europe, North America, and MENA in 2014 were among members of key populations and their sexual partners. In two regions, Asia and the Pacific and Latin America and the Caribbean, people from key populations and their sexual partners accounted for nearly two thirds of new infections. The annual number of new HIV infections in EECA increased by 57% from 2010 to 2015 and it is the only region where HIV prevalence continues to grow⁴. At the same time, however, this region is hit hardest by funding withdrawals from MICs.

HIV prevention for key populations in low- and middle-income countries accounted for less than 2% of total HIV resources in 2015, or around 9% of the resources for prevention. With the exception of a relatively small number of countries such as Brazil, Mexico and a few in the Asia and the Pacific region, the majority of resources for services focused on key populations come from international donors.

⁴ UNAIDS GAP Report 2014. Available at www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport.

Distribution of new HIV infections among population groups, by region, 2014



Source: UNAIDS special analysis, 2016.

According to UNAIDS, to meet Fast-Track targets, low-income countries require a 35% increase in HIV resources, from \$5.5 billion available in 2014 to a peak of \$7.4 billion needed in 2020. In lower-middle-income countries, investment needs to increase by 91%, from \$4.3 billion available in 2014 to a peak of \$8.2 billion needed in 2020. In upper-middle-income countries, which generally have higher unit costs, investment needs peak in 2017 at \$11.3 billion, 20% higher than the \$9.4 billion available in 2014.

From 2014 to 2020, the share of HIV investment from domestic public sources is proposed to increase from 10% to 12% in 31 low-income countries, from 22% to 45% in 43 lower-middle-income countries and from 84% to 95% in 42 upper-middle-income countries. Given the high percentage, in most MICs, of key populations among all those living with and affected by HIV, it is not realistic to assume that gaps left by funding withdrawals will be covered by increased domestic investment.

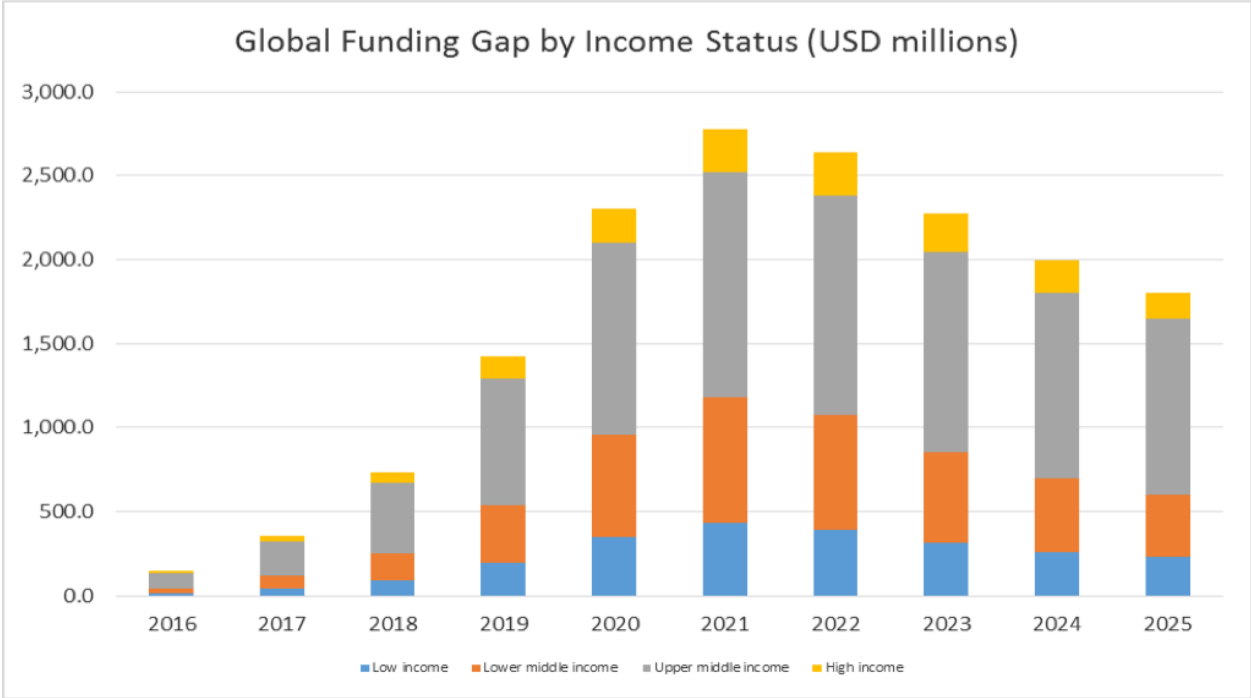
2.1.2 Stopping TB?

Tuberculosis (TB) remains one of the world's most deadly diseases, killing three people a minute. It is also a continually growing public health crisis. Recently conducted prevalence surveys in a number of high-burden countries revealed that the TB burden is much higher than estimated in the past. Each year, some 9 million people develop TB and 1.5 million die from it. Of the 9 million individuals who develop TB each year globally, 3.3 million are not enrolled in TB treatment programmes. Only 20% of people newly eligible for MDR-TB treatment in 2015 received it.

The TB funding needs and gaps are substantial. Without a significant increase in resources, it is not possible to reach the targets described in the Global Plan to End TB, 2016–2020, which represent the goals unanimously approved at the World Health Assembly in 2014. A total of more than \$56 billion is needed for effectively implementing TB programmes worldwide over that five-year period. The Global Fund currently accounts for approximately 80% of funding for the global TB response. The cost for implementation in countries where the Global Fund invests is estimated at \$17.7 billion over its next three-year funding cycle, from 2017–2019. For Global Fund-eligible countries, with even the most optimistic domestic funding forecasts and with external funding maintained at current levels, an additional \$7.4 billion must be mobilized in order for countries to reach the Global Plan’s 2020 treatment and prevention milestones.

The table below describes the global funding gap for TB services by country income status. The gaps are greatest in upper-middle-income countries, countries that are the first to lose donor support. EECA, for example, is the region with the highest prevalence of MDR-TB: it includes 8 of the world’s 16 MDR-TB high-burden countries. However, EECA experienced the deepest Global Fund cuts of all regions in the 2014–2016 allocation period, a region-wide 15% reduction in funding support compared with the previous cycle. The withdrawal is about to accelerate even faster. For the upcoming funding cycle (2017–2019), the region overall is expected to receive up to 50% less money than 2014–2016.

Global TB Funding Gap by Income Status



2.2 The where and when of funding withdrawals

One of the challenges facing advocates is the difficulty in gathering accurate and current information about when and where funding withdrawals will occur. The Global Fund has provided more information than other donors about its withdrawal process. Moreover, the formal engagement of civil society in Global Fund governance has also led to a relatively high level of attention to and awareness of Global Fund withdrawals (or “transitions”, as it refers to the process).

Bilateral funding is also being reduced, but less is known about where and when these funding withdrawals will take place.

Some examples of significant donor-initiated transitions toward increased domestic funding responsibility include those from the U.K Department for International Development (DFID), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and Australia's Department of Foreign Affairs and Trade (DFAT: formerly AusAID). From 2010 to 2014, PEPFAR began a transition process in 12 countries in the Eastern Caribbean as well as South Africa, Botswana and Namibia. DFAT has substantially reduced its HIV funding in the Asia and the Pacific region, including to Indonesia, Papua New Guinea and countries in the Mekong region, with the expectation that national governments will in turn increase their funding of HIV efforts. In 2016, the Netherlands announced that it will stop giving Kenya aid in the next four years on account of the country's "significant" economic growth. DFID, meanwhile, is cutting nearly all of its bilateral funding to MICs. Its transition process to date has been criticized for lack of transparency and poor communication and relationship management.

2.2.1 The Global Fund and transition

The flat-lining of external HIV financing and the shift away from MICs are closely linked and wide-ranging trends across the development landscape. The Global Fund is just one of several donors; it cannot stop or reverse either trend on its own. Yet it is often the nexus of complaints and criticisms about these trends because, unfairly or not, many advocates and people living with or affected by HIV, TB or malaria hold it to a higher standard. The Global Fund has earned respect for being the most transparent and progressive donor in the field of HIV over the past several years precisely because of its institutional commitment to including key populations and maintaining high human rights standards in all its programming. In addition, the Global Fund was founded to address the needs of everyone affected by the three diseases. Its withdrawal from MICs undermines the Global Fund's origins and principles and conflicts with its stated goal of making human rights central to global health programming.

Nevertheless, the Global Fund remains institutionally committed to prioritizing its support in lower-income and high-burden countries. The countries most affected by this strategy in the near term are upper-middle-income countries with lower disease burdens. But most MICs will eventually be affected. Reduced allocations in many regions are already markedly reducing the amount of funds available to countries that are still eligible for Global Fund grants.

To its credit, the Global Fund is trying to help mitigate the impacts of its withdrawal. In its 2017–2022 Strategy, the Global Fund commits to "supporting sustainable responses for epidemic control and successful transitions". With that objective in mind, its Sustainability, Transition and Co-financing Policy (STC), approved by the Board in April 2016, lays out a series of conditions and guidelines intended to signal far in advance when a country will no longer be eligible for Global Fund support in one or more of the three disease components. The assumption is that with sufficient notice, sometimes five years or more, recipient governments and other stakeholders will have time to develop and implement a transition policy that ensures the sustainability of Global Fund programmes. Up to three years of special "transition funding" is available under certain circumstances to help countries prepare for the end of Global Fund support.

The STC and transition funding may help to lessen the harm of funding withdrawals. Yet the fact remains that the first casualty from these funding cuts are most likely to be community-based organizations (CBOs). These groups tend to get very limited funding from their respective governments and even less for anything related to human rights protection or services for key populations, even though they are often

the only, or at least the most prominent, sources of prevention and treatment services for highly vulnerable individuals.

The harm is evident in many countries that have already transitioned. In Romania, a surge in new HIV infections occurred among people who inject drugs after the Global Fund withdrew in 2010. Within three years, the share of new HIV cases linked to injecting drug use had reached 30%, compared with just 3% in 2013. A similar resurgence is ongoing in Serbia, from which the Global Fund withdrew in 2014—but which ironically became eligible again for HIV funding in the 2017–2019 allocation after almost all harm reduction programmes in the country had closed. In both Romania and Serbia, where HIV is concentrated among the key population of people who inject drugs, national governments chose not to support critical community-based HIV prevention programmes such as syringe exchange. Both countries support a very low level of opioid substitution therapy (OST).

The first casualty from these funding cuts are most likely to be community-based organizations, which, as a rule, get very limited funding from their respective governments and even less for anything related to human rights protection or services for key populations.

Governments hostile to other key populations, such as MSM, also are not likely to continue or expand Global Fund programmes supporting them, thereby opening the floodgates to more infections and AIDS deaths. Gay men and other MSM in Jamaica, for instance—among whom HIV prevalence may be as high as 32%—almost certainly will be further marginalized and vulnerable after Global Fund support ceases in 2018.

The irrationality of basing financing decisions on crude income figures can further be seen in Global Fund allocations by region for 2017–2019. Two regions where overall allocations will be lower than the previous funding cycle are MENA, a decline of 2.6%, and EECA, down by 2.3%. These two regions, which comprise solely or mostly MICs, are the only regions where new HIV infections have continued to increase every year. By stepping away when the need is clearly evident, the Global Fund appears to have decided that prevention is not a priority even in places where its support makes a massive difference in terms of infections averted and lives saved.

2.3 Changing focus and approaches to development and aid

The prioritization undertaken by most external HIV donors—which is directly responsible for the unfolding human rights and health tragedy in MICs—is not happening in a vacuum. The broader aid landscape is changing into what might even be termed a “post-aid” era. The SDGs and universal health care (UHC) are at the forefront of most donors’ thinking now in the broader health sphere. At the same time, the old paradigm of donor nations and recipient countries is less relevant due to the rise and influence of alternative powers (e.g., the BRICS⁵).

For these and other reasons, donors increasingly view aid as part of a larger package that includes trade and security. In practice, this means linking aid with domestic economic and security agendas—such as fighting terrorism, dealing with migrants, and promoting trade (including to MICs as emerging markets). A prime example was the change made a few years ago to Development Assistance Committee (DAC) rules at the Organisation for Economic Co-operation and Development (OECD) that made migration financing eligible for official development assistance (ODA).

⁵ “BRICS” is an acronym for “Brazil, Russia, India and China”. It is commonly used to refer to emerging economies in the developing world that are growing in political and economic clout and influence.

It is difficult to know what this new era will mean for HIV and TB advocates. It is clear, though, that responding to the MICs funding crisis by simply saying “don’t withdraw!” is not enough. Advocates need to understand the current situation better, including how their governments plan to integrate HIV and TB into national health systems under UHC goals. They also need to understand the terms and conditions of new financial instruments through which aid is increasingly flowing, such as governmental social contracting mechanisms including social impact bonds and public private partnerships for health.

Advocates must also continue to explore innovative financing mechanisms and push for tax reforms as a means to generate more revenue for health. This may require changing the way HIV and TB advocates approach their work so that they are able to respond effectively at a time when ODA is flowing out of MICs and, to a lesser extent, also out of low-income countries. The urgency to devote attention and resources to the “new era” could be further exacerbated by recent political developments such as the election of Donald Trump as U.S. president and the United Kingdom’s impending withdrawal from the European Union. Advocates must plan for how to monitor and respond to potential shifts in aid policy as soon as possible.

2.3.1 Opportunities to explore: alternative funding mechanisms

For advocates, it is important during this uncertain period for HIV and TB financing that they investigate and understand so-called alternative funding mechanisms. Some might deserve support in certain contexts and situations. The following are very basic descriptions of some key tools and approaches currently in use or which have been proposed:

- **“Blended finance”** has been proposed as a solution to the funding crises in MICs and LICs. This refers to two or more different sources of funds, usually from more than one sector (public, private, not-for-profit, etc.), that are leveraged jointly to achieve maximum impact. As described in the Global Fund’s Sustainability, Transition and Co-financing Policy, blended finance is “the strategic combination of grants with government-sourced loans, resulting in a highly concessional financing package that covers an identified funding need and/or ensures a smooth transition from international to domestic funding of a country’s health program.”
- **UHC** is not a funding mechanism per se, but it is an increasingly high-profile development priority among donor and MIC governments alike. It will be important for advocates to consider how, from their perspective, HIV, TB, malaria and other such diseases should fit into UHC and other health schemes. And with this in mind, it will be necessary to review strategies and approaches used by countries for implementing and achieving UHC.
- **“Sin taxes”** on alcohol and tobacco (primarily) can and do raise a lot of money, including for health in some countries. The World Health Organization (WHO), among other leading groups, supports their use for UHC financing. Advocates may need to consider both the merits of such taxes and their problematic basis in focusing on what is considered “immoral” behaviour. Key population advocates quite rightly will consider this tricky.
- **AIDS levies** automatically direct tax revenue to national HIV responses. The most prominent example is in Zimbabwe, where a 3% tax on employers and employees goes into a National AIDS Trust Fund.
- **Debt to health swaps** have been used to remove crushing financial burdens on government budgets in exchange for increased domestic funding for health. This approach has a notable human rights component, as do all debt relief schemes. But it is not always clear whether the

money is diverted to on-the-ground services or instead flows through external stakeholders (and gives them some relief as well) such as the World Bank or Global Fund.

- Development and health advocates have been pushing for **financial transaction taxes (FTTs)** for years now. Some political success has been achieved, especially in a number of European countries (France, Germany, Italy and Spain), but an FTT is not expected to materialize in Europe before 2018. Also, given the wealth of other development priorities such as climate change, there is no consensus on whether or to what extent funds raised this way will be allocated to the Global Fund or other health-focused sources. An FTT of any sort to benefit health and development is almost impossible to imagine in the United States now that the Republican Party is set to control all branches of government.
- **Public-private partnerships (PPPs)** are regularly touted as innovative sources of funding for a range of government priorities. It is possible that they are a beneficial solution for health funding. But the term and concept are interpreted in many different ways, which makes it difficult to know whether the approach is a good idea or not. How they work, and whether they work well, is probably going to be context-specific and hard to replicate easily elsewhere.
- **Social impact investment** refers to the idea that using for-profit investment models, with rigorous measures of impact, can be a helpful solution to social problems. Wealthy individuals and some investors have gravitated to this approach, usually with full recognition that even if they do not get their investment money back they may have shown how improvements can be achieved. The potential pitfalls of this approach from many advocates' standpoint centre on the possibility that investors will seek to exercise extensive control over where the funds are directed and how the programmes are structured. Their preferences may not be in the best interests of people living with and affected by HIV, TB and other diseases.

2.4 Access to medicines and drug costs: critical casualties of transition in MICs

High drug costs present another serious obstacle to sustaining and scaling up HIV and TB services in MICs. Patent and other intellectual property (IP) barriers are often to blame. Antiretroviral drugs (ARVs) tend to be patented more frequently in MICs than in lower-income countries, and many MICs are excluded from pharmaceutical companies' voluntary licenses and other programmes that can lower costs. As a result, drugs such as Truvada, which are widely used for first-line antiretroviral therapy (ART), are far more expensive in many MICs (such as Argentina and Ukraine) than elsewhere. Due to high costs of ARVs across the spectrum, such countries often have fewer alternative options (including second- and third-line drugs) than much poorer and higher prevalence places.

The Global Fund has helped ease the problem by providing funds for drug purchases and, as importantly, using its procurement programmes and influence to negotiate for much lower prices. The differences can be striking: key ARVs cost four times more in Algeria, which has no Global Fund HIV programme, than in next-door Morocco (where a Global Fund HIV grant is still ongoing). However, the Global Fund has resisted taking a proactive policy role in ensuring that countries with higher gross national income (GNI) have technical support they need to overcome intellectual property barriers that put them in a double bind: declining external funding for HIV and TB, and exclusion from access to the lowest medicine prices, because of their income status.

The already-evident equity gap in access to medicines will persist and almost certainly get larger as donor withdrawals from MICs escalate. Countries may no longer be able to afford some or many of the drugs they currently make available, and they might cap the number of clients who can get ART. The most

likely places for such steps are precisely those that already lag behind: EECA and MENA. Access to treatment in those regions, at 44% and 54%, respectively, is lower than in other regions, and they are home to the fastest-growing rates of HIV.

Vital prevention services are already skimpy in these regions, largely because epidemics are concentrated among MSM, sex workers, and people who inject drugs. They already face severe legal, social and cultural barriers in most countries. Often the Global Fund and other external donors are the only source of funding for targeted prevention services for them—and many governments have long signalled that they do not intend to prioritize such services with their domestic funding. Many of these highly vulnerable individuals could benefit greatly from pre-exposure prophylaxis (PrEP), which is being introduced around the world. Availability of that prevention option, which has been shown to be highly effective, is likely to be delayed or restricted due to the double whammy of the high cost of Truvada (the PrEP drug that is patented in most MICs) and governments' reluctance to prioritize services for key populations.

Community mobilisation is a critical, urgent priority in any effort to effectively address these entrenched and complicated challenges. Local groups need to collaborate with regional and global allies to gather evidence of price and cost barriers and to highlight their devastating impact on people living with and affected by HIV and TB. While doing so, they should focus not only on the health and human rights consequences, but also on the economic ones: why are their governments being asked to pay such high prices, and why aren't they pushing back against pharmaceutical companies and demanding lower ones?

3. Identifying Gaps, Needs and Strategies for Advocacy and Capacity Building at All Levels

Much that is described above, including discussion about changing development priorities and environments, directly influences the advocacy and capacity-building needs at global, regional and national levels. The ongoing changes will not only affect MICs and are not solely related to sustainability. They instead reflect what fighting HIV, TB and malaria—and for improved health systems overall—will be like for the next several years. Advocates should keep this in mind when considering what to do, how to do it, and whom or what to target.

Summarized below are some notable advocacy and capacity-building needs and potential strategies for civil society, community and key population advocates.

- **Building global solidarity.** Events over the past few years have served to increasingly divide both HIV- and TB-affected communities, with people living with and affected by HIV and TB often left without a clear pathway of mobilization to meet their needs and stay alive and healthy. Donors are dividing us by where we live, using economic and disease burden classifications that are not based on people's needs. Yet any perceived differences are less important than the shared challenges: funding for HIV and TB responses is inadequate in both low and middle-income countries. And divisive demographic classifications also serve to downplay the fact that everyone living with or at risk for HIV or TB requires equitable access to quality care and services. When we are divided in our demands for our right to health care, we are all weaker.

Not only are people divided by donors and governments, but our own organizational infrastructures also can often serve to divide us, stressing our differences above our similarities. It remains important and useful to sometimes meet as gay men, as sex workers, as women, as youth, as transgender people to share lived experiences and set priorities. Yet it is also important for us to recognize the many things we share across these identities. Similarly, we need to re-consider the divide between people living with HIV and people at high risk of infection. Certainly, the experience of living with HIV is

unique; there will always be a value in creating space for people to talk and work together as people living with HIV. But many of the issues that people living with HIV face are also challenges for those at risk.

The donor withdrawal from MICs threatens both HIV treatment and prevention programmes, particularly for key and vulnerable populations. Underfunding of HIV programmes in low-income countries also makes inconsistent access to medicines and prevention a concern for everyone. The prevention impact of treatment and the effectiveness of PrEP means that everyone living with and at risk for HIV has a stake in access to consistently available and fairly priced medicines for HIV, TB, hepatitis C and other diseases. The stigma and discrimination that violates people living with HIV also affects women and girls and key populations as they try and seek out care, are harassed by police, and are ostracized in their communities.

If we share a goal of ending HIV and TB, if we are mutually threatened by a lack of political will, if we are equally oppressed by human rights violations, then we must strengthen alliances and infrastructures based on these similarities. Campaigns supporting our solidarity, which call out the funding withdrawals as immoral and a threat to all of us, regardless of where we live, can send a powerful message to both donor and implementing governments that we are united in our actions to ensure that their commitments are met.

- **Both “insider” and “outsider” approaches must be undertaken.** There is important work to do within and alongside governments and multilateral institutions. Much of this work will seek to mitigate harm, advocate for improved language in programme and policy development, and, of course, advocate for increased funding. Working to ensure the best possible transition is essential and time-consuming work that needs to take place at both global and country levels. Equally important are advocacy and mobilization efforts that occur outside of governmental processes. This includes sounding the alarm about these development trends and mobilizing among communities, key populations and other civil society partners and allies. It can further include denouncing the policies to withdraw funding as immoral and harmful, even as we are working from within to mitigate harm. “Outsider” actions can include campaigns, demonstrations, civil disobedience, and other efforts to raise awareness and create a sense of urgency among our constituents. Such actions can be useful to those working on the “inside”, in that they create pressure to act and make the “insiders” look “reasonable” compared to those out on the street.
- **Supporting country-level advocacy on transitions and resource mobilization:** Responsible transition from donor to sustainable domestic financing requires sufficient timelines, resources and support in transition planning and implementation. The way transitions are currently being managed threatens the sustainability of programming for key populations and requires strategic advocacy at national, regional and global level to ensure that civil society is part of transition planning and that governments take over financing for rights-based HIV prevention and treatment services.

At national level, advocacy is needed for removal of legal and policy barriers for financing and delivery of services for key populations; removal of barriers that criminalize key population groups; ensuring that quality, stigma-free comprehensive services are prioritized in national HIV/TB/malaria plans; and for access to affordable medicines. Moreover, engagement with local authorities needs to be strengthened. Often these authorities are expected to take over funding for services but are not part of Global Fund country coordinating mechanisms (CCMs), transition planning processes or development of national disease plans.

Generally there is little or no clarity at national level about who is responsible for transition planning and implementation and/or who should be responsible for financing of prevention services in the future. As a result, there can be significant delays in transition planning and no indication to advocates or others as to who is accountable for it. Such challenges are further complicated by a lack of coordination on the donor side and the fact that certain transition processes, such as transition assessments, are being introduced without prior consultation with country stakeholders and alignment with national processes. Sustainability planning efforts are also being undermined by lack of clear transition timelines and funding predictability.

Regional and global networks can play an important role in supporting these advocacy efforts and ensuring that transition policies are implemented and sufficiently funded. This includes work on exposing the impact of rapid donor withdrawal, influencing donor priorities and monitoring funding commitments, pushing donors to develop transition policies and allocate funding for their implementation, supporting dialogue between different stakeholders at regional and global level, and tracking progress at country level. Considering that Global Fund country grants often lack support for advocacy, regional networks play an important role in channelling advocacy funding, supporting capacity building for civil society groups in such areas as human rights and budget advocacy, and facilitating the dialogue between the civil society and the government.

Transitioning to dependence on domestic financing in an HIV response creates a large risk to the financing of national, regional or local advocacy actions and mobilisation of communities. Most implementing governments are not ready or are reluctant to expend funding for technical support, community systems strengthening or advocacy. In most countries, funding for community-based advocacy and monitoring functions, law reform and policy change will not be funded by the public sector. Continued and increased external and independent funding sources are needed to support such work.

In addition, there is an urgent need for support for impending transition or transition that is already underway. These are political crises that require empowered, mobilized advocacy, deploying ambitious but winnable campaigns. For example, in South Africa, campaigning by national and global partners with clear demands (e.g., a halt by PEPFAR of its precipitous withdraw from treatment, especially for key populations) was successful—in large part because an explicit political strategy was developed and deployed. This strategy included pressure on targets and effective use of the media, among other things.

- **Creating a safety net:** While advocacy for increased resources and to mitigate harm from funding withdrawals is essential and ongoing, there also is an urgent need to address the immediate impact of funding withdrawals on access to services. A “safety net” would mobilize resources to fill sudden and emergency gaps, such as closures of services, in countries that have been deemed ineligible by donors and did not have the benefit of support for transition planning. Such gaps are likely to become more frequent, and urgent, as transitions are initiated and proceed. Useful support would need to be nimble and streamlined so it can be deployed quickly. It would have to be highly flexible because contexts and needs differ, and for local acceptance purposes it would be necessary to align with a country’s transition and sustainability plans and efforts. Priority would be placed on countries that are no longer eligible for Global Fund support, especially where transitions are failing.
- **Communications:** Activities to confront funding withdrawals should take place at global, regional and country levels. They should involve multiple donors, programmes, policies and strategies. Advocates need infrastructure to coordinate their efforts; facilitate communications; share evidence, tactics and outcomes; and provide support to one another.

More coordinated efforts are needed. They might include the development of universal messages and campaigns, regular reporting from monitoring activities, and opportunities to share strategies and challenges. Messaging should be improved and be more universal so key messages can be used and shared by communities and advocates everywhere. Successful messaging would be simple, direct and straightforward about the challenges and opportunities of transition, sustainability and broader negative trends in HIV and TB financing without getting obscured by the issue's complexities.

Several advocates working on MICs' financing issue created a *listserv* following the 2016 International AIDS Conference (IAC) in Durban, South Africa, held in July 2016. The Durban listserv still exists but has not been used frequently. It was proposed that it be repurposed to serve as a central internal communications mechanism for all civil society advocates engaged or interested in the new advocacy agenda and plan. Access to the listserv can be obtained by writing to mics-transitions@dgroups.org.

Organizers of the Amsterdam meeting set up a dedicated *Dropbox folder* in which several background documents were made available to participants in advance and after the meeting. This Dropbox folder will be a central library for all relevant future information and resources, including those added by anyone with access to it. To be helpful and user-friendly, it will need to be structured efficiently into various sub-folders and categories and then maintained on a regular basis. ICSS will take responsibility for overseeing the Dropbox library. Advocates who wish to have access to the folder should contact David Barr at david@thefremontcenter.org.

A number of *teleconferences* will need to be arranged both on a regular and ad hoc basis. They might include broad-based ones involving numerous advocates and smaller ones for sub-groups that, for example, are working on concept notes or terms of reference (ToR) for various components of the action plan. ICSS has agreed to take responsibility for overseeing and coordinating this critical function.

The centrepiece of a *communications strategy* is a platform that is developed, implemented and maintained by individuals and organisations with sufficient expertise and understanding of the constantly evolving landscape. Likely initial actions and priorities might include working with global and national press—especially in MICs already undergoing or facing transitions—to highlight some of the transition-related failures. Developing opinion pieces and blogs, particularly in globally relevant English-speaking outlets, is considered another initial priority.

Some additional tools are recommended from a communications perspective. They include a *shared calendar* to which involved advocates can add events and find out about others and some sort of *simple, brief presentation that outlines the agenda and plan* and can be used and shared among community groups at grassroots level in particular. Such a tool, which should be made available in different languages, could be in the form of a leaflet or pamphlet.

4. Where We Are Now: Examples of Advocacy and Technical Activities

The global advocacy efforts at the heart of this action plan can build on important work that is already being done by many key population, civil society and community groups. Several participants at the meetings in New York, Durban and Amsterdam gave examples of their organisations' relevant advocacy and technical activities and projects.

Convening, mapping and impact research are three categories in which much of that work can be grouped, as suggested by the list below. To date, most of these activities, projects and interventions have

been uncoordinated even when the approaches and objectives are similar. Yet the fact that significant and substantial work is already being done indicates that there is energy and space to do much more, including collaboratively and in a more unified manner. (Note: The organisations associated with the activities below are mentioned by their commonly used acronym or abbreviation, not by their full name.)

- *Mapping of European donors*, including how and where they have been moving out of many countries. This is part of an effort to create a political cost to donors by naming and shaming them [MSF].
- *Building platforms to enable people living with HIV and key population networks to work together, understand each other and support each other*. An example of this coordination effort is ensuring that people living with are included on Global Fund country coordination mechanisms (CCMs) to explicitly represent key populations (especially if no key population members are directly represented) [GNP+].
- *Understanding how government budgets work at national and local levels*, to help improve ability to engage with them. This is an important step in the sustainability of harm reduction programmes [EHRN].
- *Developing tools to assess the readiness of counties to transition from Global Fund support to national funding of HIV/TB/malaria programmes or particular programme components most vulnerable in terms of sustainability* [EHRN, PEPFAR, APMG Health].
- *Documenting the consequences of poorly planned transitions on the sustainability of programmatic components for key populations* [EHRN].
- *Creating a regional advocacy programme with the main objective of increased domestic investment in HIV*, with particular emphasis on ensuring money is available for key populations and their organisations [APCASO].
- Working with other colleagues to highlight when, where and why MICs are excluded from voluntary licenses by pharmaceutical companies. This is one of many *efforts to standardize work on a wide range of intellectual property (IP) obstacles* [ITPC MENA]. Similar IP-focused work includes collaborative partnerships to help revise patent laws in some countries [APN+].
- Coordinating with eight networks and over 1,000 peer educators, among others, to *build an advocacy and high-level political agenda* as the Global Fund has withdrawn funding [Corporacion Red Somos].
- *Partnering in a project that supports three countries to advocate for funding for key populations and to mobilize around programming for them*. A central objective is to get governments to understand what the impact of transition could and would be [ITPC].

Mapping and assessing transitions in EECA: EHRN's tool and approach

The Eurasian Harm Reduction Network (EHRN) is based in and focuses on EECA, the region considered the most heavily affected by external donors' retrenchment from MICs. Nearly all of the countries are categorized as upper or lower middle-income and therefore are no longer eligible for any Global Fund support at all, or will be ineligible for one or more disease component in the next few years. Many countries, which collectively are home to the majority of the region's people, have governments that are hostile, stigmatizing and discriminating toward key populations. Domestic or other funding sources are rarely available to continue or expand Global Fund programmes.

EHRN has begun an ambitious, extensive and continuous process of mapping transitions across EECA. To enable better comparison and coordination, it has developed a Transition Readiness Assessment Tool (TRAT) that has recently been piloted in five countries (Albania, Bosnia and Herzegovina, Macedonia, Montenegro and Romania) at different stages in transition. The tool focuses on, among other things, readiness and preparation for transition in areas such as policy, governance, finance and programmes. A main focus TRAT is on harm reduction and other services for people who use drugs, a focus that makes sense given the organisation's primary mission and the fact that HIV epidemics in most EECA countries are concentrated among people who inject drugs.

Based on a set of standardized benchmarks, each country is given a "readiness for transition" score at the end of the process. Scores in pilot countries have ranged from a low of 19% in Albania to 47% in Macedonia, which is considered relatively advanced in the transition process though still lagging in progress related to some indicators. EHRN hopes to complete this regional mapping project by mid-2017.

Adapting the tool for broader advocacy purposes

The EHRN transition assessment tool elicited significant interest among Amsterdam meeting participants in October 2016. Many suggested that it could be a useful template for other groups and advocates to use elsewhere, for regional or national mapping and assessment. Utilizing one template as the basis for global work could contribute to the collection of information and recommendations that are relevant globally for advocacy purposes.

Another suggestion was to hone the existing tool into something more direct and specific, perhaps by focusing on a handful of markers that clearly show how poorly or well a country is doing, including in regards to drug pricing. A more targeted and simpler tool could be used more effectively for broader advocacy purposes in a wider range of regions.

5. Action Areas

Three main potential advocacy areas and activities are proposed here as priorities for initial, preliminary action planning. Each of the three is summarized below. This should be considered a start: these ideas will be refined and reconceptualised and additional ideas will be introduced as the overall advocacy effort to reverse and mitigate the effects of funding withdrawals from MICs moves forward.

The three focus activities have similar goals and objectives overall. Yet collectively, they are starting points from different (yet complementary) perspectives: *technical assistance/information provision* (the Civil Society Sustainability Network idea, Activity 1 below); *advocacy and awareness* (a global

solidarity campaign, Activity 2); and *basic access to core treatment and prevention services* (a “safety net” structure, Activity 3).

5.1 Activity 1: Civil Society Sustainability Network (CSSN)

Goal: To advocate for and support a medium and long-term sustainability of HIV- and TB-related programming for civil society and key and vulnerable populations.

Objectives

- To build and support a strong global network of effective advocates with meaningful involvement of those living in the most affected countries and regions.
- To halt, redefine, and reverse harmful and premature transition by PEPFAR, the Global Fund, national governments and others.
- To support the development of comprehensive sustainability frameworks for HIV and TB programmes.
- To support in-country transitioning assessments, implementation processes and sustainability plans, all of which inform advocacy.
- To hold donor and national governments to account on responsible transition.
- To facilitate information and knowledge sharing on country transition processes to support global, regional and national strategizing and mobilization.

The CSSN would be a civil society–owned group composed of experts from the sector. Its primary task would be to bring new and vital evidence to the table. On a revolving basis, it would collect and analyse information and observations from a limited number of countries to identify and highlight harmful impacts related to transition. The results from the analysis could be used to advocate for increased domestic resources and to appeal to the Global Fund and other donors to reconsider funding decisions in light of evidence-informed negative consequences for people living with and affected by the three diseases.

Operationally, the CSSN might, for example, be a flexible and perhaps even virtual group of local and external civil society actors that would look at three countries, at least initially, to gather provocative and critical data from the perspective of people living with HIV and key populations. Resulting reports and other outputs would show the investment wasted both from a financial and public health perspective. They would also point to options and solutions, such as through a costed gap analysis for transition. *This initiative would be to make the case that if transitions are going to happen, they must be done responsibly.*

To ensure that the CSSN is able to deliver on its goals and objectives, the following organizational functions will need to be put in place:

1. CSSN core team: The CSSN core team would be a virtual, coordinated team of civil society experts who work together on assessing information on sustainability and transition policies and processes, and who support, inform, and help develop and implement country and global level advocacy plans. The team will annually develop a global overview of the *state of affairs* regarding sustainability and transition processes. Based on this overview, it will then share

regular transition alerts that signal situations of risk and/or potential harm. The team would bring together experts from civil society⁶ (max 10) that reflect the following areas of expertise:

- HIV, key population and human rights programming
- Health economics (including costing and modeling)
- Health financing (including budget tracking)

When necessary, the team will engage with and mobilize additional and specific expertise from academia, technical partners, and global institutions (such as the Global Fund), etc. The team will also liaise on a regular basis with the Global Fund Secretariat with the aim to share information, review practices at country level, discuss alternative or mitigation strategies when necessary, etc.

2. CSSN communications platform: The CSSN communications platform will enable information sharing and strategizing through the use of:
 - monthly teleconferences;
 - sharing and discussing the transition alerts; and
 - sharing information on emerging trends or signals of potential harm that require action.

The communications platform will also support mobilization, rapid-response information dissemination, advocacy and campaigning at country and global level through:

- A CSSN website that provides (up-to-date) global and country level information on sustainability and transition policies and processes;
- sharing action alerts and campaign briefs and tools. and
- providing social media tool kits that support mobilization and campaigning.

3. Coordination and host organization: ICSS has offered to provide secretariat support for the CSSN core team and the communications platform functions, coordination. Secretarial support is needed to:
 - providing secretarial and technical support to the CSSN core team;
 - organizing the communications platform; and
 - coordinating the development of the mobilization, advocacy and campaigning tools (including the website and use of social media).

5.2 Activity 2: Global solidarity campaign

Goal: Mobilize communities to meet the needs of *all* people living with and at risk for HIV and TB and ensure the human right to health for all.

Objectives:

- Develop shared messaging for organizations and networks around the world urging governments to meet global health and development commitments and “leave no one behind”.
- Bridge geographic, economic and demographic divides to strengthen community responses.
- Reinvigorate activism to increase resources and implement high quality, consistent, rights-based programming to respond to HIV and TB.

A broad focus would be on the responsibility of governments to fulfil their commitments in HIV, TB and other health responses—which means they can and must ensure adequate funding, services and

⁶ Ideally, this CSSN core team would include a balance of members from civil society organisations in developed Countries, MICs (including upper-middle-income countries); lower-income countries; civil society and key population networks and academia, etc. Regional, gender and HIV status balance is a priority.

human rights protections for all people (and especially the poorest and most marginalized). Within this overall focal point, specific objectives could include (a) national governments increasing domestic funding and taking action to end discrimination and reduce inequalities; (b) donor governments acknowledging and responding robustly with sufficient development assistance to meet the treatment, prevention and core health needs of all in need; and (c) communities uniting and mobilizing to better hold their governments accountable.

Key components of this work would include the following:

- Establish a steering group to coordinate the campaign
- Identify an initial set of priority countries facing imminent threat, and work together at global and national levels to respond through advocacy
- Identify a host group or other entity to take responsibility for core things such as coordinating calls and steering committee meetings, populating a website and social media outreach, building and honing a brand, etc.
- Map out potential donors, partners and allies, including those not normally engaged in such issues, and getting them involved as part of a broader effort to build linkages
- Develop consistent and clear messages and graphics that underscore the global relevance of the problem while also ensuring that country-specific situations and issues are in the spotlight as needed
- Develop and disseminate informational materials with different target audiences that can build awareness and support in a wide range of contexts
- Develop a simple and easy-to-explain set of indicators that provide a basic overview of challenges and trends regarding all countries affected by donor withdrawals
- Research and identify entry points to influence opinions, such as by highlighting governments' lack of commitment to specific international and regional agreements regarding HIV and TB funding and services
- Identify meetings, conferences and other such entry points that offer opportunities for targeted and successful advocacy

Campaign messages can build upon successful efforts from the past that conveyed global solidarity, such as the “HIV-positive” t-shirts pioneered by South Africa’s Treatment Action Campaign (TAC) to help reduce stigma and discrimination. One idea for global solidarity, for example, would be to have advocates around the world, from African women to Thai transgender individuals, wear t-shirts with messages such as “We’re all Russians living with HIV”.

Other notable observations and recommendations about moving this plan forward:

- People living with HIV should spearhead this campaign and be front and centre in all respects, both to ensure its authenticity and to bolster its impact.
- GNP+ agreed to lead a process to determine who will host the global campaign.
- The three civil society delegations to the Global Fund Board should be directly involved, and that suggestion was acknowledged and agreed to by representatives from those delegations at the Amsterdam meeting.

5.3 Activity 3: Creating a safety net

Goal: Develop a funding mechanism to fill short- to medium-term emergency gaps in services and advocacy programming in countries (a) currently ineligible for Global Fund support, (b) which never received funds and technical assistance for transition planning, and (c) which are seeing failed transitions (e.g., spikes in HIV prevalence or closure of services).

Objectives:

- Mobilize funding to fill gaps in services and advocacy created because of funding withdrawals and failed transitions
- Develop streamlined funding mechanisms that are adaptable to support service delivery in diverse country environments that will catalyse government action to absorb them
- Support services for key and vulnerable populations left behind in transition planning and implementation
- Ensure continuity of treatment, prevention and support services in countries that have failed to do so because of funding withdrawals and inadequate or inequitable transition planning

Changes in the Global Fund allocation methodology—pushed by the decision of such powerful donors as the United States, the United Kingdom and the European Commission to withdraw from MICs—has led to a significant decrease in funding for countries in EECA, MENA and Latin America and Caribbean (LAC) in particular.

There is an urgent need for mobilizing a multilateral, bilateral and private donor support for an emergency funding safety net to sustain HIV prevention services targeting key populations. This safety net funding should ensure continuity of these prevention programmes and complement other transition planning and sustainability efforts, including technical assistance and support for civil society advocacy.

A number of civil society consultations on the safety net that took place in Durban and elsewhere suggested that the safety net funding should prioritize emergency support for countries with failing transitions, countries not eligible for Global Fund support, and countries that are not included in other multilateral and bilateral initiatives, such as PEPFAR. The safety net should be able to provide flexible and direct support to countries responding to current needs and gaps identified by the civil society groups. The donors should ensure that the disbursement mechanisms are efficient and transparent, and that they allow fast response with easy application procedures and minimal transaction costs.

There are divergent views on whether a safety net should prioritize civil society advocacy or services. Continued advocacy is needed to mobilize domestic funding and to remove legal barriers for government financing of NGOs and delivery of services for key populations. Such advocacy is not going to be funded by governments. At the same time, the need for support for community-led services and commodities is becoming more urgent—especially considering that this is where the impact of donor withdrawal is being felt the most. The safety net support for services could also be leveraged to generate political will by governments to support such services in the future.

This initiative would be used to fill emergency gaps, such as closures of services. Such gaps are likely to become more frequent, and urgent, as transitions are initiated and proceed. It would need to be nimble and streamlined so it can be deployed quickly. Priority would be placed on countries that were not or are not eligible for transition grants, are not eligible for Global Fund support, where transitions are failing, or where those plans failed to adequately address key populations.

Potential funding for the initiative should come from a range of donors active in global and national HIV responses. Any funding for this purpose from the Global Fund and PEPFAR would need to be additional, and not reprogrammed away from existing vital needs. Other existing funding mechanisms could be explored, even “outside the box” ones such as private philanthropy and the private sector.

Substantial work remains to determine how a safety net fund might work in practice, how and by whom it would be funded, how its impact would be measured and monitored, and what criteria would determine funding decisions, among other things. The following are proposed in terms of next steps and priorities:

- OSF will take responsibility for drafting a concept note for a safety net initiative, which would include a proposed timeline.
- OSF and the Robert Carr civil society Networks Fund (RCNF) will jointly lead on donor mobilization efforts.
- A process will be initiated to begin mapping countries, potential costs and immediate needs. This mapping work might be something for the CSSN to take on.

Annex 1. Call for Action from October 2016 Amsterdam Meeting

Presented below is the text of the call for action and global solidarity that was drafted at the October 2016 Amsterdam meeting. It was finalized shortly thereafter and made available for distribution across civil society, community and key population groups working on HIV and TB as well as a wide range of health, human rights, and social justice allies in the global, regional and national civil society sectors.

Meet Global HIV and TB Commitments Now: A Call for Action and Global Solidarity

Irresponsible and destructive declines in HIV and TB funding in middle-income countries

The world is failing people living with and affected by HIV and TB. Despite commitments to meet ambitious global targets for HIV and TB treatment and prevention, governments have consciously, even deliberately, refused or failed to uphold them. This is a health and human rights catastrophe that can and must be avoided.

In the same year that governments agreed to Sustainable Development Goals (SDGs) that “leave no one behind”, donor government funding to support HIV responses in low- and middle-income countries decreased from \$8.6 billion in 2014 to \$7.5 billion in 2015.⁷ Equally at fault are national governments that have failed to adequately fund their HIV, TB and health programmes and have all too often left key and vulnerable populations without services and facing increased discrimination and criminalization. Especially hard hit are middle-income countries (MICs).

This World Bank classification is used by the Global Fund and other donors and based on a simplistic and crude per capita income estimate. It is inappropriate for assessing health needs. “Middle-income” countries are home to most people living in poverty and the majority of all people living with HIV and TB. People in upper-middle-income countries (UMICs) will suffer most, and many are already doing so. They are facing the risk of immediate and steep funding cuts that will gut prevention programmes for key populations, as well as programmes addressing gender inequality. At the same time that MICs and UMICs are targeted with funding cuts, these countries are also facing higher medicines prices because of intellectual property barriers—and they are excluded from most voluntary licensing agreements.

A Call for Global Solidarity

As organizations advocating on behalf of people living with and affected by HIV, TB and vulnerable populations, we cannot allow these irresponsible funding withdrawals to exacerbate inequality and force communities and countries to compete and be pitted against each other. We refuse to be divided this way. We stand together to oppose the destructive and devastating retreat from HIV and TB responses that equally value all people in need, wherever we live and whoever we are. These funding cuts and the processes to implement them are immoral and antithetical to public health and human rights goals.

Domestic governments must meet their commitments and provide their share of needed resources for HIV and TB. In fact, no one has worked harder than civil society to advocate that our governments increase their funding for health and development. But, as funding transitions take place, the first priority must be

⁷ Kaiser Family Foundation, “Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2015”, July 2016.

to ensure that progress is sustained to address the specific and distinct needs of people living with HIV and TB and communities of key and vulnerable populations.

The deadly impacts are already evident—and are on a fast track of accelerating harm.

The consequence of this reckless behaviour is evident in countries where transitions have already taken place. In diverse contexts such as Colombia, Romania, and Vietnam, actual or planned decreases in external funding have led to steep declines in resources available for domestic HIV, TB and other key health services. National and local governments are unable or unwilling to fill the gaps. Much of the significant progress made to date is rapidly lost and investments made over the last decade are wasted. One of many examples of the impact of these funding cuts is Romania, in which HIV infection rates among people who use drugs rose significantly after the Global Fund's withdrawal in 2010. At that time, 4.2% of new HIV infections were related to intravenous drug use. That percentage rose to 49.2% by 2013 after harm reduction programmes were defunded.

Such dire consequences will be repeated and magnified as more countries are pushed aside by myopic and heartless decisions to withdraw from MICs and essentially abandon those whose survival depends on access to treatment and services. The most affected are women, girls, men who have sex with men, sex workers, transgender people, migrants, and people who use drugs. Their basic human rights are ignored because of decisions made by their own governments and those in distant donor countries.

We call on donor and implementing governments:

- To honour the global commitments of the 2015 SDGs to leave no one behind
- To fully fund HIV and TB responses around the world, and thereby forestall a fully preventable health, social, financial and moral emergency; and
- To structure HIV and TB funding transition processes on the basis of what is best for **people** infected and affected by HIV and TB, their **families** and **communities**.

This Call for Action was developed by participants at the recent meeting, *Financing HIV and TB Services and Advocacy in Middle Income Countries: Developing an Action Plan*. This statement will be followed by a detailed advocacy strategy to mobilize and unite our communities and fight the failures of our governments from both north and south to honour their commitments.

Sign on and support this statement and we will provide multiple ways to support these efforts.

Annex 2. Meeting Agenda

Financing HIV Services and Advocacy in Middle Income Countries: Developing an Action Plan

27–28 October, Lloyd Hotel, Amsterdam

This goal of this two-day meeting is to develop an advocacy agenda and action plan to address donor withdrawal from HIV and TB responses middle-income countries. We seek to develop an advocacy/activism agenda that is rooted in global solidarity between low, middle, and high-income countries. The proposed meeting will focus on global and regional-level advocacy and capacity building to:

1. Identify advocacy strategies to hold external donors to their funding commitments in MICS and encourage them to do more to address inequality and the disproportionate impact of HIV and TB on key populations in MICS
2. Develop methods to monitor, document and respond to gaps in services and programmes due to reduced funding levels in order to make the case for continued external and increased domestic funding, and
3. Develop approaches to assist country level advocates and service providers addressing the country-level impacts of donor withdrawal, including monitoring, critiquing and/or engaging in transition planning processes imposed by external donors and governments.

The meeting will seek to assign responsibility for these tasks among the participants and identify the needed components for a communications platform to continue and coordinate these efforts.

DAY ONE

- 9:00 – 9:30: Introductions and agenda review - Peter van Rooijen, ICSS
- 9:30 – 9:50 Presentation: The pending HIV funding crisis – David Barr, The Fremont Center
- Overview of the state of current and upcoming donor withdrawals and the process by which donors will withdraw over the coming five years
- 9:50 – 10:50 Panel: Working on the inside and the outside: Developing a multi-tiered response to donor withdrawal
- Community mobilization - Solidarity campaigns: We will not be divided. We reject the funding withdrawal as immoral – Olive Mumba, EANNASO
 - Strategies for alternative funding mechanisms – debt consolidation, earmarked levies, health insurance schemes, new non-ODA funding streams, creating a safety net – Julia Greenberg, OSF
 - Access to medicines and drug pricing specific to MIC funding withdrawals, Othman Mellouk, ITPC
 - Supporting country-level advocacy: Increasing domestic investment, development of transition strategies, ensuring quality and equity in National AIDS Plans. What do country-level advocates and service providers need from the global and regional level organizations? -Elizabeta Bozinoska, HERA

- Monitoring the affects of donor withdrawal: what to advocates needs to document the affects of donor withdrawal on service delivery, human rights and health outcomes? - Miguel Angel Barriga Talero

10:50 – 11:15

Break

11:15 – 12:00

Responding to the panelists: Full group discussion

12:00 – 1:00

Who is doing what now? – Full group discussion

- Informal presentations about current activities
- How to move beyond the usual players in this work – building alliances and coalitions beyond HIV

1:00 – 2:00

Lunch

2:00 – 3:45

Break-out sessions: Each small group will discuss the components of an action plan for their topic area: *Groups will define the activities that need to be organized or scaled up to address their topic area. A second session on Day Two will then address the needs and logistics of implementing these activities.*

- Global solidarity campaigns and outside agitating
- National and regional advocacy: What support is needed and how to link to global work
- Drug pricing
- Mobilizing resources for safety net funding for countries with failing transitions
- Monitoring and documenting the effect of funding withdrawals and transitions

3:45 – 4:00

Break

4:00 – 5:30

Report backs and full group discussion

DAY TWO

9:00 – 9:15

Recap from Day One and agenda review

9:15 – 10:45

Break out sessions: Implementing the Action Plan: *Building on the proposed activities presented on Day One, identify what kinds of groups/people need to be involved in implementation, how to organize these groups, funding needs, communications needs, timeline, etc.*

10:45 – 11:00

Break

11:00 – 12:30

Report backs and full group discussion

12:30 – 1:30

Lunch

1:30 – 3:30

Next steps: Full group discussion

- Who will coordinate what?
- Building a communications platform
- Funding the action plan

3:30

Close

Annex 3. List of Participants

The following people attended all or part of the 27–28 October 2016 meeting in Amsterdam. They are listed in alphabetical order by surname.

Kerstin Akderfeldt	Médecins Sans Frontières (MSF)	kerstin.akerfeldt@london.msf.org
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Annex 4. Civil Society Statement Following the 47th Union World Conference on Lung Health, Liverpool (October 2016)

The Global Fund Must Not Squander Improvements to the TB response

15 NOVEMBER 2016

The Global Fund to Fight AIDS, Tuberculosis, and Malaria has played an indispensable role in supporting countries' TB programmes through a country-driven and multi-stakeholder approach. However, given new allocation, co-financing, and transition policies, we are in danger of losing momentum just at the time when there are a number of new tools and opportunities to substantially improve outcomes for people with TB and its drug-resistant forms.

Such opportunities must be seized, rather than squandered, given the urgent need to accelerate and improve diagnosis and treatment of TB globally. According to the WHO Global TB Report (2016):

- 1.8 million people died of TB in 2015.
- Only 59% of people with TB were diagnosed and reported, leaving a gap of 4.3 million people not diagnosed or not reported in 2015.
- Only 20% of people newly eligible for MDR-TB treatment in 2015 received it. However, the Global Fund's focus on "highest impact countries," and an allocation of funds increasingly determined by two criteria (country income and disease burden), as well as lower resource mobilisation targets by the Secretariat, have resulted in decreased support to several countries, including many middle-income countries. The Eastern Europe Central Asia (EECA) region has the fastest-growing HIV epidemic and highest prevalence of MDR-TB with 8 of the 16 MDR-TB high-burden countries. However, EECA experienced the deepest Global Fund cuts with a reduction of 15% in the 2014–2016 allocation period. The region is estimated to lose a further 40%–50% in the next allocation period (2017-2019). **We urge the Global Fund to take measures to ensure countries, especially those in the Eastern Europe Central Asia (EECA) region, are able to maintain and expand TB programmes using quality assured treatment and diagnostics at affordable prices.** In addition to the allocation reductions, countries in the region also face restrictions on how to use the funds. The Global Fund's new Sustainability, Transition and Co-financing (STC) policy will lay out funding requirements applicable to countries depending on their income level. The pre-existing co-financing criteria of the 2014 Investment Guidance for EECA requested lower-middle income countries to cover the costs of 60% of ARVs and 50% of second-line TB drugs by the end of their current grant implementation period. These GNI-based targets for phasing out Global Fund support raises significant concerns regarding procurement-related risks to purchasing quality and affordable medical commodities, including new drugs and diagnostics. We also believe that the Global Fund stepping back its support for TB in the region will result in weaker TB programmes, including services for key populations, and an upswing in new TB cases and poorer patient outcomes. **We, therefore, call upon the Global Fund to freeze the implementation of these policies until steps are taken to review them in light of their potential impact and mitigate harm to TB programmes.** Specifically, the Global Fund should:
 - Freeze the implementation of the Investment Guidance for EECA, as well as the STC policy in order to conduct robust risk assessments and roadmaps on MIC countries' a) upgrade of national TB policies and practices to reflect WHO guidelines and b) procurement and rollout quality affordable drugs and diagnostics, including the new pediatric fixed-dose combination, rapid molecular testing, and new and re-purposed drugs to treat drug-resistant TB.
 - Avoid premature implementation of these policies that would damage services to vulnerable

populations, procurement of affordable optimal tools, and scale-up plans where governments are either unwilling or unable to rapidly take over costs previously covered by the Global Fund. Ultimately, international donors and national governments will need to substantially increase financial support to the fight against TB. However, merely shifting from donor to domestic funds curtails ambition by default, at a time when we urgently need all actors to accelerate and improve their TB response.