Global Fund Sustainability, Transitioning and Co-Financing

Policy and the World Bank Transition Checklist

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In order to attain the goal of “ending AIDS” by 2030, UNAIDS estimates that US$26.2 billion will be needed in 2020 alone - an increase of US$1.5 billion per year globally. However, recent funding trends indicate that high-income countries will continue to reduce funding for the HIV response in low- and middle-income countries. In preparation for the increasing decline of donor support, Low Middle Income Countries (LMIC) and Middle Income Countries (MIC) are being encouraged to consider sustainability and transition plans that outline both domestic and international support including national costed plans and country-owned targets related to HIV and their commitments to the SDGs. Governments and agencies including the Global Fund are shifting away from traditional development assistance mechanisms, meanwhile the need for HIV services and support for key populations continues, if not grows.

In spite of this, just 2% of all HIV funding, and around 9% of resources allocated specifically for prevention, are spent on this communities - 90% of this is from foreign donors. Donor funding for the HIV response in LMIC countries declined by 7% between 2015 and 2016. In order to sustain (let alone upscale services) governments in LMIC countries will need to significantly increase domestic HIV-related funding, and at the same time development partners must commit to sustainably funding remaining resource needs. However, many questions remain - what financing mechanisms are available to stakeholders, where will the money come from, and to what extent can communities become involved and influence these funding application processes.

From 2012 to 2016, the Global Fund based the distribution of HIV funds on country need and allocation methodology was based on criteria such as epidemic prevalence and a country’s ability to finance its own response (otherwise understood as ‘eligibility’). In April 2016, the Global Fund approved a new allocation methodology for 2017 to 2019 which gives greater priority to low-income/high HIV burden countries. If a country reaches upper-middle-income status, they are no longer eligible candidates for Global Fund support (unless there is evidence that the HIV burden continues to be classified as high). These countries will go through a process known as ‘transitional funding’, as they move away from Global Fund grant dependence, towards full domestic funding. However, this will need time and preparation.

The new ‘Global Fund Sustainability, Transition and Co-Financing Policy’ (STC) addresses many of the concerns, particularly around key populations that might be left behind during a transition. The STC provides a framework for safeguarding the long-term sustainability of HIV programmes and successful transition away from donor dependence. As part of this process, the Global Fund recommends that countries and communities conduct transition readiness assessments and elaborate transition work plans, in order to facilitate well-planned and successful transitions. This process includes the assessment of health care financing and potential fiscal space, the role and sustainability of civil society (social contracting), and recommendations that this process be grounded in meaningful community engagement. Although we can recognize the importance of independence from foreign donor support, we also acknowledge the fact that communities in our region cannot simply be abandoned - it is crucial that we understand what these funding changes are and what they mean to us, and how we can become involved in these processes.
SUSTAINABILITY
WHAT IS IT?

It is difficult to apply universal definitions of locally sustainable programs to countries that vary widely in terms of governance, capacity, wealth, and disease and socio-cultural profile.

Sustainability requires a long-term commitment from a country to ensure it establishes and maintains sufficient levels of fiscal ability, technical capability, political will, and citizen engagement. For our purposes, it is important to understand what influences the issue of sustainability, and what informs the process. Global Fund suggests assessment of a number of factors: a) political will: this must be strong, demonstrable and sustained; b) financial ownership: countries cannot own their HIV response without assuming a share of the cost (however we must acknowledge that the most afflicted countries are usually the poorest); c) strong civil society engagement (this is where we can play a role); and d) effective health structures including Universal Health Care systems and National Strategic Plans.

The Global Fund defines sustainability as the "ability of a health program or country to both maintain and scale up services coverage to a level, in line with epidemiological context, that will support efforts for elimination of the three diseases, even after the removal of funding by the Global Fund and other donors."

The Global Fund sustainability approach is informed also by:

- Differentiation- the policy and associated processes are differentiated based on a country’s place within the development continuum according to income level, epidemiological context, disease burden, human rights and gender contexts, and other regional, country, and context specific factors.
- Alignment- wherever possible, Global Fund requirements related to sustainability and transition should build off already existing systems or processes in country.
- Predictability- wherever possible, countries should have sufficient notice, time and associated resources to plan for transition.
- Flexibility- country level implementers and the Global Fund should have the flexibility to adapt certain aspects of this policy to particular country and regional contexts for impact and to maintain services.

For transition to be effective, sustainability needs to be at the foundation of every programme funded by international aid. Aid is not intended to last forever, it should help countries develop their own capacity so that they can provide those services to their own populations, including to MSM and TG communities.
TRANSITIONING
WHAT IS IT?

When countries are no longer eligible for Global Fund allocations, this is commonly referred to as “transition”, or “self-reliance”.

The Global Fund considers a transition to be successful when national health programs are able to maintain or improve coverage and uptake of services through resilient and sustainable systems for health after funding stops.

According to the 2016 Global Fund Sustainability, Transition and Co-financing policy, once a country becomes ineligible for Global Fund funding, it may apply for up to three years of transition funding. The Global Fund encourages countries to actively prepare for transition, and address challenges that could prevent a successful transition away. The Global Fund recommends that countries conduct transition readiness assessments that are informed by civil society voices. These assessments include a review of a country’s epidemiological context, domestic fiscal space, policy and legal environment, and support for human rights, gender equality, and key and vulnerable populations. In order to aid in the transparency and predictability of transition processes, civil society organisations can be instrumental in helping stakeholders to develop clear set of criteria for assessment of a country’s transition preparedness and engage in national budget advocacy efforts.

As we continue to be one of the most affected communities, MSM and TG civil society must guide and participate in transition preparedness activities. The meaningful involvement of our communities can include: improved in-country capacity for advocacy based on data collection and analysis by NGOs or community-based networks representing each relevant key population; increased capacity of NGOs to demonstrate specifically the level and types of activities they will undertake in the HIV prevention and treatment cascade to justify the sustained allocation and ensured funding for police, security, and criminal justice reform programs where these structural elements have the strongest influence in our region. Addressing social inequities and legal and political barriers (especially the criminalization of our populations in some of our countries) along with mitigating stigma and discrimination will also be crucial in the transition process.

### Income Level

<table>
<thead>
<tr>
<th>Disease Burden</th>
<th>Focus of application</th>
<th>Co-financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Income Countries</td>
<td>No Restriction</td>
<td>50% focus on key and vulnerable populations/interventions</td>
</tr>
<tr>
<td>Lower-LMI Countries</td>
<td>No Restriction</td>
<td>No Restriction</td>
</tr>
<tr>
<td>Upper-LMI Countries</td>
<td>No Restriction</td>
<td>No Restriction</td>
</tr>
<tr>
<td>Upper - Middle Income Countries</td>
<td>Extreme Severe or High*</td>
<td>100% focus on interventions that maintain or scale-up evidence-based interventions for key and vulnerable populations</td>
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</tbody>
</table>

**UMICs with low/moderate DB, G-20 UMICs with less than extreme DB, and High Income Countries are ineligible**

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* Small Island Economies are eligible if they have a low or moderate disease burden.

** ‘low’ or ‘moderate’ burden country components are encouraged to show a greater share of domestic contributions that will address systemic bottlenecks for transition and sustainability.

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CO-FINANCING POLICY

WHAT IS IT?

The final and equally important policy approach in the Global Fund shift away from ongoing support is the co-financing policy. Under the co-financing approach, the Global Fund directly allocates most of its funding (85%), the missing 15% is distributed via ‘co-financing’. In order to be eligible for this type of funding, a country has to commit a minimum level of funds towards its national HIV programmes as a share of government and Global Fund investments. The co-financing threshold is currently set at 5% for low-income countries, 20% for ‘lower’ low- and middle-income countries, 40% for ‘upper’ low- and middle-income countries and 60% for upper-middle income countries. More importantly, LMIC must focus on vulnerable populations and governments provide a minimum of 50% of allocated funds to supporting these communities, including Men who have sex with men (MSM) and Transgender (TG).

MSM, TG AND STC

WHAT ARE THE KEY CHALLENGES?

When a country has not adequately prepared for and executed transition, this condition disproportionately affects key populations, including MSM and TG. Funding for key population services largely comes from donors. Where a national government is funding a large proportion of their national HIV response, all too frequently they often don’t fund the key population programmes let alone take over the work previously funded by foreign donors. Although there are clear guidelines and established recommendations for the successful implementation of S-T-C, there are a constellation of issues that impact upon the sustainability of HIV programs for MSM and TG in the Asia Pacific region. These issues include a lack of enabling environment, stigma and discrimination, lack of political will, lack of budget transparency, the criminalization of our communities, and shifting government priorities. Although the challenges may be great, civil society organisations and community-driven activism can play a crucial role in influencing stakeholder investment and ensuring that vital HIV prevention and treatment services are sustained.
Civil society organisations play a crucial role in facilitating change and in HIV prevention work. This is because civil society organisations provide valuable insight into community needs, and (when provided safe space) can advocate for legal and policy reform. However, as few LMIC governments allocate adequate funding and support to civil society HIV organisations, the Global Fund recommends that countries capacitate or strengthen “social contracting” mechanisms, in other words, supporting circumstance wherein government financing is used to directly fund and contract civil society and community organizations. Strong civil society engagement is critical to implementing this S-T-C and it is important to ensure that civil society are able to participate meaningfully in decision making platforms and accountability mechanisms. In order in ensure adequate preparedness for transition, the Global Fund and World Bank have put forward a number of strategies and opportunities for the involvement of civil society in advocating for budget allocation. To complete the analysis of transition readiness the following steps these agencies recommend:

- Developing a solid evidence base, which can help establish where service provision needs lie,
- Updating and conducting country-level population estimates and IBBS, especially facilitating a community led-research,
- Educating ourselves on Global Fund S-T-C processes, which can include collecting and analyzing all key resources/documents from the Global Fund and other major players, such as UNAIDS, WHO, PEPFAR,
- Conducting a stakeholder analysis and exploring opportunities for engagement (this analysis can include how these bodies interact with Global Fund grant planning, implementation and monitoring processes under the most recent grant),
- Drafting a calendar of important deadlines and budget advocacy moments,
- Conduct cost assessments of interventions, for example condom distribution, or outreach work,
- Conduct a context analysis that explains the condition of the MSM and TG community in your country context, highlighting legal, policy, human rights, social and religious concerns as well as service gaps in order to sensitize decision-makers at all levels,
- Identify risks, challenges and strengths of countries capacity to implement S-T-C,
- Create monitoring and evaluation frameworks that ensure active community participation,
- Establish an S-T-C Working Group consisting of stakeholders from a variety of backgrounds (key populations and key government personals, that may be also part of the CCMs with Global Fund and World Bank representatives – 10 to 12 people), and
- Establish and cultivate regional partnerships (such as those within APCOM) in order to build a collective regional budget advocacy voice and amplify advocacy efforts founded on mutual needs.
To enhance the understanding of CSOs on what transition funding is, this study will feature 2 case studies and will show how the GFATM policy and World Bank (WB) checklist helped with funding transition and sustainability of the country’s HIV and AIDS program. Domestic funding is HIV spending, by country governments in their national budgets. Historically, the HIV response has been largely funded by international donors and governments, but low- and middle-income countries are now beginning to lead on efforts to finance their HIV response. In 2015, domestic resources exceeded funds provided by donors and accounted for the majority of global HIV funding (57%), totaling US$10.9 billion. Although domestic investments increased by an average of 11% a year from 2006 to 2016, the rate of that increase slowed to 5% between 2015 and 2016.

Although challenging for low- and middle-income countries, shifting towards domestic funding has advantages. These include fostering country ownership and accountability in the implementation of the national HIV response and increasing their sustainability. The term transition was used for the move to the country-led managing and financing of donor-assisted programs, which results in a highly advanced form of country ownership. The process is a planned, gradual, multistage transfer of program ownership to the government and the program’s beneficiaries that includes the responsibility for funding programs and managing budgets. It places demands on both the donor and the government: Donor activities must be aligned with the government’s health agenda, and the government must be able to absorb the program from the donor and take over the management. Transition is essentially a “front-loaded” process: The bulk of the work occurs before the actual transfer of programming and funding. However, transition should not be viewed as a linear process. Instead, it is complex and fluid and requires monitoring, course correction, and risk mitigation.
It has built a strong partnership with 2 main funders, which is PEPFAR and the GFATM and has shifted from a donor-dependent HIV response to one that is primarily funded by its own government or domestically. These funds are decreasing as the country moves from low-income to a lower middle-income status. In response, the Vietnamese government has invested in finding more sustainable way to ensure HIV treatment and has committed to covering 70% of treatment needs by 2018.

On top of this, the government of Vietnam is taking greater responsibility for health system development, including:

- managing health workers,
- HIV sentinel surveillance,
- the harm reduction program,
- procurement of HIV commodities, and
- HIV prevention activities.

In between of 2014 and 2015, Vietnam domestically have increased its annual ARV budget, from USD 0.9 million to USD 4 million and has successfully completed its first domestic procurement, negotiating better prices comparable to those obtained from international funders. As a result, Vietnam secured enough fixed-dose combination of ARVs to treat more than 26,000 patients for one year. Equally important was the government’s decision to centralize procurement of ARVs, to be paid for by the country’s Social Health Insurance (SHI) fund beginning in 2017.

SHI is a national insurance scheme that is compulsory for those in formal employment but voluntary for the others. According to the Vietnam Authority of HIV/AIDS Control, people living with HIV are less likely to be covered under SHI. While 67% of the general Vietnamese population are covered by SHI, only 30 to 50% of PLHIV are. This is due to:

- high costs of medical expenses which is not covered by SHI and
- difficulties signing up to the scheme with missing legal documents such as an identity card (e.g. PWID make up 60% of all new HIV infections in Vietnam, yet many do not have the legal documentation to get health insurance)

Preliminary meetings leading up to the its request for 2018–2020 have considered how the GFATM can support the sustainable transition of Vietnam’s HIV program to SHI. With PEPFAR support for commodities in its final year, the Vietnam’s Ministry of Health will be responsible and manage an orderly transition to SHI, so that the care and treatment are not interrupted.

While a lot of progress has been made from donor-led to a government-run HIV response, USA government technical assistance and funding will still remain important in several areas, such as:

- uneven implementation of nondiscrimination policies (that limit PLHIV access to services);
- limited understanding of the potential market for private-sector engagement (in HIV prevention commodities); and
- weak clinical and human resource capacity at public health sites (that are taking on HIV prevention and treatment services).

CSOs activities are currently externally funded, raising questions about sustainability. Finally, while Vietnam has committed to using its own funds to fill ARV treatment gaps, close monitoring will be required beyond this year to ensure the process remains on track and the most vulnerable populations receive the services they require.
INDIA

DOMESTICALLY FUNDS MORE THAN 80% OF ITS NATIONAL HIV PROGRAMME.

First case was reported in India in 1986 and since then, the Ministry of Health and Family Welfare, Government of India, has led the HIV/AIDS response, inclusive of advocacy, policy, strategic guidance, funding, and service provision for HIV prevention, treatment and care for both, people at risk of or living with HIV.

During 2009-2012, the Bill and Melinda Gates Foundation Avahan, a large donor funded HIV/AIDS prevention program in India was transferred and transitioned from being a stand-alone program outside of government, to being fully government funded and implemented.

This transition of approximately 200 targeted interventions (TIs), occurred in three tranches, dividing the transition into phases to allow time for adjustments and corrections, which was in 2009 (transition round was problematic, subsequent rounds were implemented more smoothly), 2011 and 2012 (Avahan programs were well prepared for transition with the large majority of TI program staff trained for transition, high alignment with government clinical, financial and managerial norms, and strong government commitment to the program).

Bennet et al. (2015a) suggest that a successful transition model should have the following components: an extended and sequenced time frame for transition; co-ownership and planning of transition by both donor and government; detailed transition planning and close attention to program alignment, capacity development and communication; engagement of staff in the transition process; engagement of multiple stakeholders post transition to promote program accountability and provide financial support; and signalling by actors in charge of transition that they are committed to specified time frames.

As domestic funding fostering ownership and accountability to the country, India, a wealthier country are progressively contributing more domestic resources to the HIV response. India has embarked on an ambitious target of ending AIDS by 2030. There is considerable political will as well as policy impetus to achieve this, as is evidenced by recent developments:

- passing of the HIV Act or Bill in both houses of parliament; and
- the ‘Test and Treat’ policy which permits all individuals with HIV to be put on free and lifelong ART.
Enabling environment, HIV & AIDS Bill was introduced in the Indian Parliament and was passed in 2017, which was subsequently assented to by the President of India. This law criminalises discrimination against people living with HIV/AIDS. Some of the salient features of this Act are:

- The requirement for HIV testing as a prerequisite for obtaining employment or accessing health care is prohibited
- Every HIV-infected or affected person below the age of 18 will have the right to live in a shared household, and enjoy household facilities
- Provision for appointment of an ombudsman by State/UT Governments to address grievances related to violation of the Act and penal action in case of non-compliance
- Provides an environment for enhancing access to health care services by ensuring informed consent and confidentiality for HIV-related testing, treatment, and clinical research. It also provides ground for penal action for any health care provider, except a physician or a counsellor to disclose the HIV positive status of a person to his or her partner
- Lists the various grounds on which discrimination against people living with HIV is prohibited such as:
  1. employment;
  2. educational establishments;
  3. health care services;
  4. residing or renting a property;
  5. standing for public or private office;
  6. provision of insurance.

Considerable evolution in the nature of relationships between key actors was observed between transition rounds, moving from considerable mistrust and lack of collaboration in 2009 toward a shared vision of transition and mutually respectful relationships between Avahan and government in later transition rounds.

The evolution of the transition approach in the Gates’ Foundation’s Avahan transition in India has been noted as one of the factors in its success. One year post transition there were significant program changes, but these were largely perceived positively. Notable negative changes were: limited flexibility in program management, delays in funding, commodity stock outs, and community member perceptions of a narrowing in program focus. Service coverage outcomes were sustained at least six months post-transition.

- Bennet et al. (2015b)

Due to this also, the Indian government increased its HIV/AIDS budget by 400 percent between the second and third phases of its national program, from $500 million to $2.5 billion. The transition of programs to governments is an important sustainability strategy for efforts to scale up HIV prevention programs to reach the most-at-risk populations.
We are united in advocating for issues around HIV and those that advance the rights, health and well being of people of diverse sexual orientation, gender identity, gender expression and sex characteristics.