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The First to Go: How communities are being affected by the Global Fund Crisis

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1.

INTRODUCTION

In November 2011, facing a deficit of about half a billion dollars due to unfulfilled donor pledges, the Global Fund to Fight AIDS, TB and Malaria was forced to cancel Round 11 of its funding.

In March 2012, the Open Society Initiative for Southern Africa (OSISA) and the Open Society Foundations (OSF) undertook research to ascertain the impacts of the funding shortfall on civil society organisations (CSOs), particularly community-based non-governmental organisations (NGOs). Swaziland, Malawi and Zimbabwe were selected because all three countries had advanced draft proposals for HIV and/or TB programmes at the time of the cancellation.

BETWEEN MARCH AND APRIL 2012, OSISA and OSF contacted 35 CSOs in the three countries. Of these, 32 agreed to be interviewed regarding the impacts of the Global Fund crisis through a mix of telephonic, email and online questionnaires. An additional 12 interviews were conducted with high-level contacts – representatives from the Country Coordinating Mechanisms (CCMs), national HIV and TB coordinating bodies, and United Nations agencies – to provide a broad overview of civil society dynamics and the cancellation's impact.

Round 11 would have been a watershed moment in southern Africa. Under their HIV applications, some countries - including Swaziland - would have moved to include interventions for sex workers and men-who-have-sex-with-men (MSM) in Global Fund proposals for the first time. In Swaziland,

Round 11 would have been a ***watershed moment*** *in southern Africa.*

there were also plans to include activities addressing the HIV prevention needs of a small community of injecting drug users.

Round 11 funding would have also supported community-based NGOs to provide treatment literacy and adherence support; lead community education, mobilisation and prevention efforts; and address barriers to treatment, care, and support. A new funding window would have allowed countries to fill critical gaps in HIV and TB treatment, diagnostics, and other commodities; scale-up prevention interventions such as prevention of mother-to-child HIV transmission (PMTCT) services and medical male circumcision (MMC); and strengthen health systems.

After a history of failed proposals, Round 11 provided the opportunity for these countries to begin to close funding gaps and scale up essential services.

Now, countries are forced to choose between funding the biomedical interventions highlighted in the UNAIDS Strategic Investment Framework and funding the supporting activities, or 'critical enablers', that the global HIV body has said are crucial to these interventions' success. When countries are forced to choose between providing essential services or the initiatives that support them, CSO-led supporting activities such as human rights programmes, community systems strengthening and, to a lesser extent, interventions among most-at-risk populations (MARPs) - are the first to go.

Civil society organisations in all three countries were already facing a funding crisis when Round 11 was cancelled; in Round 11, there was hope that CSOs might be able to access funding to sustain their work. OSF research reveals that the organisations most vulnerable to current cuts are community-based organisations (CBOs) working at the local or district levels. Years after UNAIDS and the Global Fund drove the involvement of people living with HIV (PLWH), pushing for their involvement in international decision-making bodies, CCMs and civil society, PLWH organisations are among those most affected.

This preliminary report begins by highlighting the importance of Round 11 as a new funding window among the three focus countries, all of which had been denied funding through previous rounds. It then describes what countries would have applied for under Round 11 before moving to discuss broadly some of the initial national and civil society impacts of both the cancellation and decreasing Global Fund money. The document then argues that, due to funding constraints internationally and within the Global Fund, CSOs are unlikely to see much relief in the future due to an inability to source alternate donors, the structure of the Global Fund's Transitional Funding Mechanism (TFM) and impacts of the Global Fund crisis on Phase II renewals of existing grants.

In light of the report's findings OSF puts forth the following recommendations:

RECOMMENDATIONS

1. The **Board** should agree to issue a new call for applications as soon as possible. The new call for applications should emphasise the importance of investing in "critical enablers" to increase the effectiveness of core programme activities, including community-based programme design and delivery, and programmes to address human rights and barriers to access to services.

2. The **Board** should reaffirm the importance of CSOs in health responses by calling upon the **Secretariat** to develop a strategy that outlines how CSOs will be supported through the implementation of the new Global Fund strategic plan (2012-2016) and restructured Global Fund secretariat. The strategy should reinforce the value of the Fund's investments in community systems strengthening, including core support for community-based organisations, to enable them to facilitate community links to health services and retain skilled staff.

3. **Fund Portfolio Managers** and **Country Teams** at the Global Fund Secretariat should ensure that funding for community-based service delivery and community systems strengthening is protected through the negotiation of Phase II renewals, recognising the essential role they play in increasing the efficiency and effectiveness of core HIV and TB programmes. Any reprogramming should be done transparently, in full consultation with sub-recipients in addition to principal recipients and CCMs.

4. **Technical partners**, including UNAIDS, the Stop TB Partnership, the World Health Organisation (WHO), and others, should provide guidance and technical support to country coordinating mechanisms to ensure that support is retained for critical enablers, including community-based service design and delivery, and programmes to address human rights and barriers to access, in initial proposal development and Phase II requests. They should also provide concise guidance that draws on existing evidence demonstrating how these interventions represent good 'value for money'.

5. **Donor countries**, including new and emerging donors, must meet their commitments to funding sustainable HIV, TB and malaria programmes through increased pledges to the Global Fund at its next replenishment conference in 2013. They should adhere to their commitments to aid effectiveness by making long-term pledges that enable the Global Fund to offer predictable and sustainable funding.

2.

ROUND 11:
A "DO-OR-DIE MOMENT" FOR NATIONAL HIV AND TB RESPONSES

In the weeks following Round 11's second postponement in September 2011, the Swaziland CCM released a statement in response to the delay, stating it would continue drafting its HIV proposal for the round that CCM Chairperson Senzo Hlatshwayo termed a "do-or-die for Swaziland".

Round 11 was a "do-or-die" moment because, with Global Fund funding set to end in December 2013, Swaziland - like Zimbabwe and Malawi - had already been denied funding through previous rounds. All three countries had made unsuccessful Round 10 HIV applications; Zimbabwe had additionally also failed to secure TB funding under the same round. Malawi meanwhile had failed to secure Global Fund money for HIV and TB not only in Round 10, but also in Round 9. Round 9 came at roughly the same time that Swaziland's HIV application was also rejected through the first pilot of national strategy applications in 2009.

The three countries were at varying stages of drafting proposals when Round 11 was cancelled, but reported that these proposals had been based on previous Round 10 applications and related feedback from the Fund's Technical Review Panel. In response to concerns about the funding crisis at the Global Fund, some countries were already planning to scale back their asks in Round 11 in the hope that this would increase their chances of success.

"There was a communication that there was going to be a ceiling in Round 11, and that in Round 10 we had been overly ambitious in applying for almost half a billion (in US dollars)," said Robert Ngaiyaye, executive director of the Malawi Interfaith AIDS Association and a CCM member.

According to Ngaiyaye, the country had already scaled back its asks to meet a CCM-determined ceiling under Round 11.

National Round 11 proposals would have focused on HIV/TB treatment and prevention, as well as community health systems strengthening

In interviews with drafting teams, CCMs and UN agencies, respondents said Round 11 draft proposals from the three focus countries would have included plans to scale up prevention of PMTCT and MMC, support for health worker salaries, and HIV treatment, to varying degrees.

Malawi is almost wholly dependent on the Global Fund for its national HIV treatment programme. In Zimbabwe, the Global Fund supports about 35 percent of all HIV treatment, according to members of the Round 11 drafting team.

Swaziland's government has committed to domestically funding HIV treatment, largely from Southern African Customs Union revenues, but its proposal would have asked for buffer stocks of antiretrovirals (ARVs) and the lab reagents for CD4 count and toxicity testing.

Swaziland committed to funding HIV treatment in 2010, but financial difficulties in 2011 led to widespread stock-outs of ARVs and reagents in 2011. Emergency provision of these items by international donors and humanitarian organisations was set to finish in April 2012.

Malawi and Zimbabwe applied for HIV and TB, and would have asked for TB treatment and support to increase TB diagnostic capabilities. Both countries reported that they would have asked for salary support to hire additional microscopists to diagnose TB in culture, and Zimbabwe's drafting team also hoped to expand what has been a limited GeneXpert rollout, as well as bolster lab capacity for TB cultures.

Malawi would also have asked for salary support for nurses and other health workers, including its task-shifting cadre of Health Surveillance Assistants, who are responsible for a broad range of activities that includes HIV counselling and testing, infant HIV testing and condom distribution.

Ngaiyaye said the Fund had theoretically approved this support in Round 10 but had raised some concerns, which he felt had been substantially addressed in the follow-up proposal.

A missed opportunity:
Round 11 would have been the first to include programming for most-at-risk populations (MARPs)

Responding to Round 10 Global Fund feedback, Round 11 applications in Swaziland and Namibia would have been the countries' first to include MSM and sex workers.

In Swaziland, the proposal would also have been the first to include the country's small population of injecting drug users.

Malawi's application would have been the second to include MSM and sex workers but possibly the first to be funded.

Same-sex relationships, sex work and drug use are criminal offences in Malawi Namibia and Swaziland.

A 2008 study among MSM in Botswana, Malawi and Namibia found that 17 percent were HIV positive; HIV prevalence rates among MSM were almost twice the national average in their respective countries.

Malawi first included MARPs in its failed Round 10 application, just months after the country's high-profile court case in which two men were charged with sodomy and indecency after their public engagement.

Malawi sees an estimated 52,000 new HIV infections annually; [1] in Swaziland, new HIV infections are expected to rise to about 14,000 per year in 2015. All three countries would have included a focus on HIV prevention. In Swaziland, this would have included behaviour change communication.[2]

To strengthen links between clinics and communities, and create demand for and uptake of biomedical interventions, the three countries included components for strengthening community health systems – like those encouraged by the Global Fund through its own community systems strengthening strategy and framework, which have been broadly identified as a critical enabler in the UNAIDS Strategic Investment Framework.

Community systems strengthening was expected to not only increase uptake of services but also these services' cost-effectiveness.

"Malawi's response to HIV is still far too centralised, and more control needs to be decentralised to the district level," said UNAIDS Country Coordinator Patrick Brenny. "At the local level, you have more cost-effectiveness if you successfully mobilise local partners, and if HIV is integrated into district planning."

Both Swaziland and Malawi would have asked for resources to support PLWH, women, and/or orphaned and vulnerable children (OVC).

Zimbabwe's TB application would have included an advocacy component that, according to local NGOs, would have sensitised community health workers about paediatric TB to facilitate early diagnosis. Malawi would have asked for funding to train existing HIV personnel in TB integration and to support community sputum collection volunteers. These volunteers have been effectively assisting in not only sputum collection and transportation, but also sensitising communities about TB. However, they have not been adequately supported in the past, according to Dr James Mpunga, programme manager of Malawi's National TB Control Programme.

Without new funding soon, Mpunga said initiatives like these, which have been shown to benefit patients, would not be scaled up.

It's likely that Malawi's move was influenced by the focus on MARPs ushered in under the Global Fund's Round 10 following the May 2009 release of the Global Fund Strategy in Relation to Sexual Orientation and Gender Identities.

The strategy was premised on the idea that as a major donor, it was able to exercise significant influence on governments, which could "be used to ensure that those most vulnerable to infection and most in need of services were reached." Following from this, the strategy stated that the Fund bore a responsibility "to reinforce local advocacy voices" - a responsibility that was largely an extension of the Fund's long-time policy of advocating for the inclusion of those affected by the diseases under its mandate, such as PLWH.

Among the document's many action points was a commitment by the Fund to support Principal Recipients (PRs) in improving plans and budgets for strengthening community systems relevant to reaching MARPs.

The inclusion of MARPs in Round 11 by countries in southern Africa may have been a result of the Fund's influence and attitude gains due to its advocacy.

3.

IMMEDIATE IMPACTS OF ROUND 11'S CANCELLATION ON NATIONAL PROGRAMMES

Chimwemwe Mablekisi of Malawi's National AIDS Commission says the country has already begun deprioritising programmes such as community mobilisation, advocacy and print and electronic behaviour change communication, and has shifted these savings into HIV treatment and PMTCT services - a move echoed across the three focus countries.

Swaziland

The UN Children's Fund (UNICEF) estimates that 45 percent of children in Swaziland can be classified as OVC. The government has already scaled down school feeding programmes. The feeding schemes at neighbourhood care points are in danger of running out of funding in the next two years, according to interviews with UNAIDS and UNICEF country representatives.

Khanya Mabuzo, deputy director of the Swaziland's national AIDS council, the National Emergency Response Council on HIV and AIDS (NERCHA), says all HIV prevention programmes, with the exception of PMTCT and MMC, have been halted until 2013.

Swaziland is now hoping to shift condom procurement to development partners such as Population Services International or the UN Population Fund (UNFPA), according to UNAIDS Country Coordinator Sophia Mukasa-Monico.

"The key for the Round 11 proposal was to look at prevention," Mabuzo said. "We've had to do away with mass media communications, ICT (information communication technology) production, and community dialogues."

In April 2012, the World Bank released a study entitled, "The Fiscal Dimension of HIV/AIDS in Botswana, South Africa, Swaziland, and Uganda", re-affirming what UNAIDS has long advocated: that unless countries begin to curb new HIV infections, the cost of treatment could become unmanageable. Without a reduction in new HIV infections, Swaziland will spend about 7 percent of GDP on its HIV

Swaziland had a total of 184 doctors ***- less than one doctor per 1,000 people.***

response by 2020, with care, treatment and impact mitigation as major cost drivers.[3] The Bank predicted that to sustain programming, external aid would have to increase substantially over the next decade or so.

In the meantime, it remains unclear whether the government will be able to employ the doctors previously supported by the Fund. In 2009, the World Health Organisation (WHO) estimated that Swaziland had a total of 184 doctors - less than one doctor per 1,000 people.[4]

Swaziland's Red Cross Society notes that the clinics it supports are operating without data clerks, which it was hoping the Ministry of Health would support with new Global Fund money. The Society's Jabu Mthethwa says that without them, monitoring, evaluation and reporting are difficult. Clinics supported by the Red Cross are struggling to implement proper TB infection control measures, and have had no HIV treatment literacy supporters since 2008.

Malawi

In July 2010, Malawi started a phased implementation of the latest WHO HIV treatment guidelines, moving to earlier treatment initiation, better drugs and placing all pregnant HIV-positive women on ARVs for life under the WHO PMTCT B+ option. This at least doubled treatment costs in the national programme, which by April 2012 had about 350,000 people on ARVs.

In light of the cancellation and decreased Global Fund resources, the country will continue enrolling new patients but will not be able to switch existing patients to newer, better tolerated drugs, said Patrick Brenny, UNAIDS Country Coordinator for Malawi.

As a result of limited resources, Malawi has only been able to roll out the new, better treatment regimen to pregnant women, TB/HIV co-infected individuals and antiretroviral patients suffering side effects from the standard, stavudine-containing regimen. In light of Round 11's cancellation and alternative funding sources, Malawi will continue enrolling new patients on the stavudine regimen, and will not be able to switch everyone in need of treatment to the new regimen until additional resources become available, said Brenny.

A symptom of the funding constraints Malawi was already facing in the wake of the Round 11 cancellation, the country has seen periodic shortages of HIV testing kits this year, said Ngaiyaye. So far Malawi has not seen ARV stock-outs, but there have been reports of HIV treatment rationing, in which patients are issued with, for instance, two weeks of treatment instead of the standard one-month supply, he added.

Research by the Reproductive Health and HIV Institute at the University of the Witwatersrand in South Africa found that most HIV patients who defaulted on treatment did so because they were unable to get time off work for repeated clinic visits, or could not afford the associated transport costs.[5] Increasing the frequency of collecting ARV

drugs has been shown to impact negatively on adherence not only in South Africa but also in neighbouring countries like Mozambique.

Global Fund salary support for health workers on the frontline of the HIV/TB response also ended in June 2012, according to Aye Aye Mon, Chief of HIV/AIDS for UNICEF Malawi. As of early June, the NAC has proposed including salary support for affected health workers under the country's Rolling Continuation Channel but no decision had been taken. These top-ups, important to retaining the country's scarce health workers, may therefore come to an end.

Figures presented by MSF have forecasted a gap of about US$ 12 million in health worker salary support between June 2012 and June 2014.[6]

Zimbabwe

In the absence of Round 11, HIV and TB policy dialogues have been cut, although organisations continue to try to get government support for these, said Paidamoyo Magaya of the Zimbabwe Network of People Living with HIV and a member of the Round 11 HIV proposal drafting team. HIV prevention is also likely to suffer in favour of sustaining treatment, said Magaya, who predicted that the national TB programme would also be negatively impacted as it was established under the Fund and is wholly funded by it.

Community-based care workers, who have been supported with kits and incentives such as stipends or foodstuffs, may also be hard hit by the loss of Global Fund money, she said. While UNAIDS Partnerships Adviser Gloria Billie said there was less need for home-based care workers in light of

Projected HIV treatment gaps in Zimbabwe
(Source: Ministry of Health and Child Welfare, National AIDS Council)

Year	***Number of people in need of treatment who will not receive it***
2012	66,500
2013	About 71,000
2014	87,000
2015	361,000

initiating HIV patients on treatment at CD4 counts of 350 to 550 ***reduced their risk of transmitting HIV to sexual partners by about 96 percent.***

increased treatment uptake, some HIV-related illnesses continue to occur at fairly high CD4 counts, including the HIV-related cancer, Kaposi's sarcoma.[7] Meanwhile, research at South Africa's Chris Hani-Baragwaneth Hospital Palliative Care Service, presented at a 2011 UNAIDS regional consultation in Johannesburg, found that even many stable and cancer-free HIV patients reported high levels of chronic pain. This may point to the continued need for home-based care workers, especially when health systems remain centralised.

Tatiana Shoumilina, UNAIDS Zimbabwe Country Coordinator, says the country has predicted gaps in HIV treatment (see table) - a blow to a country looking to take advantage of recent research showing the effectiveness of treatment as prevention.

In 2011, the HPTN 052 study showed that initiating HIV patients on treatment at CD4 counts of 350 to 550 reduced their risk of transmitting HIV to sexual partners by about 96 percent.[8]

While she admitted Round 11 was important for Zimbabwe, Shoumilina emphasised that what the round's cancellation represented, i.e. the lack of access to sustainable, predictable HIV funding, was equally as important for countries generally:

"We (Zimbabwe) placed a lot of hope in it and committed to submitting the best proposal we could, but it's not the whole story. What's the issue is the sustainability and predictability of funding. The existence of the Global Fund as a recurrent funding mechanism, with annual funding rounds, is more important. In the Global Fund there has been a largely nonpartisan, impartial objective mechanism that offered access to funding for some justified proposals. So, every year, you could look into your critical gaps and apply."

Jack Bbabbie Mukulu, executive director of the Family-In-Need-Trust of Zimbabwe said that, as of March 2012, he had already seen shortages of treatment in Manicaland province where the organisation works.

"There are a few people struggling to get medication... a number of people are on waiting lists but aren't getting anything," he said. "Supply has been the challenge. Medication is no longer at the clinics, you have to go to the hospital now."

The Global Fund's lack of predictability poses a major challenge

Several respondents, including Malawi CCM's Robert Ngaiyaye and Swaziland's national AIDS council's Khanya Mabuzo, reported that the lack of a new funding window had negatively affected national planning.

4.

CIVIL SOCIETY IMPACTS OF GLOBAL FUND SHORTFALLS

In his November 2011 report to the Global Fund board at its meeting in Accra, former Global Fund Executive Director Michel Kazatchkine noted that the percentage of countries fulfilling their stated commitments had fallen steadily since 2009.

In the Fund's first seven years, donors fulfilled all their commitments, with some giving more than originally pledged. Almost 15 percent of donor pledges went unpaid in 2009. A year later, almost a quarter of donor pledges failed to materialise.

In 2009 the Global Fund mandated a 10 percent "efficiency gain" in Round 8. Unpublished research by OSF's Public Health Programme examined how this "efficiency gain" was achieved in nine countries. OSF found that during grant negotiations, most stakeholders felt resources for medicines, lab equipment and infrastructure could not be reduced. Instead, they achieved the requisite "efficiency gains" by decreasing allocations for programmatic components primarily implemented by CSOs - information, education, and communication materials and campaigns; prevention activities; and outreach services targeting marginalized and vulnerable groups.[9]

This research found that, as in 2009, countries are again choosing to cut support to CSOs in light of unavailable funding.

While about 70 percent of CSOs contacted for this research reported said they had hoped to receive funding under Round 11, the effects of the round's cancellation on civil society remain difficult to ascertain. At the time of the cancellation, none of the countries surveyed had selected sub-recipients.

However, about half of the 32 organisations that completed study questionnaires were likely to be dependent on some level of Global Fund support through stated support from national AIDS councils, councils or committees (NACs).

In Malawi and Swaziland, the NACs acts as the Principal Recipients of rounds active in the country as of May 2012. In Zimbabwe, the NAC has been receiving support through the United Nations Development Programme (UNDP) since the NAC was removed as PR in 2009 after the Reserve Bank's mishandling of Global Fund money.

Donald Makwakwa of the Malawi Network of AIDS Service Organisations said the NAC has already introduced ceilings on the amount of money CSOs can apply for through the national body.

CSOs in the region were already struggling when the round was cancelled - 80 percent of CSO respondents said their budget had decreased in the last two years and several longstanding CSOs such as the Malawi Network of Religious Leaders Living or Personally Affected by HIV and AIDS (MANERELA+) and the regional organisation Soul City indicated that their budgets had been cut by at least a third.

To cope, MANERELA+ has retrenched staff and scaled back on the frequency of programme activities, as has the Swaziland Action Group Against Abuse (SWAGAA).

UNAIDS Strategic Investment Framework

Released in 2011, the framework is intended to improve management of the HIV response through six basic programmatic activities, and interventions - or "critical enablers" - maximising these activities' effectiveness. According to its authors, implementation could advert more than 12 million new HIV infections and almost 7.5 million AIDS-related deaths between 2011 and 2020.

The framework centres on the following programmatic areas: PMTCT; condom promotion; addressing key populations e.g. MSM & sex workers; treatment, care and support; MMC; and behaviour change.

Critical enablers are divided into two categories:

1) Social enablers, including:

- outreach for HIV testing and treatment literacy;
- stigma reduction;
- human rights advocacy;
- monitoring of the equity and quality of programme access and results; and,
- mass communication designed to raise awareness and change social norms.

2) Programme enablers, which include:

- incentives for programme participation
- methods to improve ARV patient retention;
- capacity building for community-based organisations, strategic planning, communications infrastructure, information dissemination; and,
- improved service integration and linkages between HIV testing and care and efforts to improve service integration and linkages from testing to care.

In a policy brief published in the 3 June online edition of The Lancet, the framework's authors stress that both community mobilisation and human rights-based approaches are essential for the strategy's effectiveness.

The organisation was able to access about US$20,000 in 2012 ***to procure condoms*** *and, more importantly, the scarcely available lubricant that reduces the risk of condom breakage during anal sex.*

In a country like Swaziland, where 40 percent of children are stunted and families are already struggling with rising food prices, SWAGAA has scaled back impact mitigation programming aimed at OVC.[10]

"We've definitely had to scale down on service provision for OVC, reaching 24 communities," said SWAGGA director, Cebile Manzini-Heywood. "SWAGAA is in an unprecedented situation of having to rationalise its operations under the current financial circumstances, even though the demand for the organisation's services is increasing."

The survey for this research asked CSOs to identify which of five programmatic areas related to critical enablers – MARPs, community programme design and delivery, community systems strengthening, human rights programming, and community mobilisation – had been affected by lack of access to new funding.

About 75 percent of respondents reported that their programming on community systems strengthening, human rights and community mobilisation had been adversely affected; two-thirds reported that their work in community programme design and delivery had been impacted.

"It affects our networks greatly both in terms of community mobilisation... (and) support with monitoring and evaluation and technical support at the community level," said Itai Rusike, executive director of Zimbabwe's Community Working Group on Health.

He added that organisations are already trying to do more with less, sharing vehicles and fuel costs on field visits.

"CBOs play a key role, especially in the Zimbabwean situation because with less resources in past years, the government has shifted the responsibility of caring for the sick to the community," he said. "The Ministry of Health, in the past ten years or so, has not really been supporting community outreach programmes and it's the NGOs that have taken up that role."

Finally, about half reported that their work with MARPs had been affected.

HIV prevention gaps among vulnerable populations are widening

Malawi's Centre for the Development of People (CEDEP) is one of the few CSOs interviewed that is heavily focused on MARPs, and one of only four organisations reporting that budgets increased in the last two years, largely due to the organisation's involvement in a large-scale MSM study. But even CEDEP is struggling to meet the needs on the ground.

The organisation was able to access about US$20,000 in 2012 to procure condoms and, more importantly, the scarcely available lubricant that reduces the risk of condom breakage during anal sex. However, CEDEP's director Gift Trapence said there is a need for greater provision of these items to MSM.

With most of its funding earmarked for the on-going study, or for lesbian, gay, bisexual, transgender or intersex (LGBTI) advocacy rather than HIV prevention, CEDEP has had to scale back its work. The organisation used to operate in eight of Malawi's 28 districts, now it operates in just five.

Malawi's Centre for Human Rights and Rehabilitation (CHRR), a CEDEP partner, was also one of the few organisations to report increased funding tied to new projects, but is also constrained by the earmarking of funding for LGBTI advocacy, not HIV prevention, among MARPs, specifically sex workers, prisoners and MSM.

CHRR had hoped to access Round 11 funding to scale up delivery of a minimum service package to these key populations.

"In Malawi, access to HIV and health services for MSM and transgender people is almost zero, owing to the prohibitive legal environment and lack of political will to implement policy action points in the National HIV Strategy," said the organisation's Michael Kaiyatsa. "We had also intended to use part of the money to lobby and advocate for a repeal of anti-sodomy laws, and amendment of the draft HIV legislation to include the criminalisation of discrimination based on sexual orientation and gender identity."

Most CSOs had an average of four primary donors, and many indicated that they had sought additional donors, but those working with MARPs reported constraints in sourcing funding alternatives to the Global Fund to finance work with sex workers. "The cancellation of Round 11 has crippled our capacity to implement this advocacy," Kaiyatsa added.

Less funding diminishes CSOs' access to Global Fund processes

The recent declines in CSO funding generally have also hampered the participation of PLWH in Global Fund processes. In Round 7, Swaziland for Positive Living (SWAPOL) received OSISA funding to form a women's coalition comprised of 14 organisations. The coalition used this money to take part in the country's application, hiring their own consultant as part of the drafting team to mainstream gender issues in the application.

"That's when we were able to first be empowered in the Global Fund process," said SWAPOL programmes coordinator, Cebile Bhembe. "We

were able to call for a fair process and, because we had our own consultant on the team, we were able to monitor that our activities were there, right up until the final product."

Although SWAPOL was able to build on this momentum with involvement in Round 8, Bhembe said it was short-lived, and by the time of Round 11's cancellation, the organisation had been unlikely to benefit from the round.

SWAPOL has closed its legal aid unit, which focused on defending women's rights to property, for example, in a country where women are legally still minors.[11] The Swaziland Young Women's Network, which under its human rights programming has advocated for the repeal of laws reinforcing harmful social norms and discriminating against women, also reported being told that they would not benefit from the country's Round 11 application.

Similarly, Itai Rusike, executive director of Zimbabwe's Community Working Group on Health noted difficulties in accessing Global Fund money when local organisations had to compete with international NGOs for funding.

"The big challenge we have is that international organisations are also competing with us for some national resources," Rusike said. "International organisations tend to get most of the money because they are better equipped in resource mobilisation. We don't even have a resource mobilisation desk. The same programme managers that are responsible for directing programmes are the same ones that are responsible for resource mobilisation. We tend to lose out as national NGOs."

"It's very disheartening that there is a lack of democracy in global health governance to the extent that you find little participation of local NGOs and CSOs in some of the decisions made by the Global Fund," he added. "We have been making progress reducing the HIV prevalence in Zimbabwe and all that can disappear overnight because of decisions made in some headquarters in the West."

Without access to additional funding, or a new funding window, almost 90 percent of responding CSOs said they would have to scale back programming; about a quarter said that they would also have to retrench staff.

Changing civil society

As CSOs continue to retrench staff, scale back programming and even close, the landscape of civil society is changing.

All of the CSOs interviewed reported that organisations within their networks had been affected, either cutting programmes, retrenching staff or closing down. MacBain Mkandawire, executive director of Malawi's YouthNet and Counselling, said shrinking networks mean existing CSOs lose the ability to complement the activities of others and harness comparative advantages.

Respondents in all three countries said that smaller, more localised CSOs that have relied mainly on NACs for support have been hardest hit by the decrease in Global Fund money.

Godfrey Mkandawire of Malawi's Council of Churches highlighted that this may disproportionately affect CSOs at the district level, precisely where Malawi UNAIDS Country Coordinator Patrick Brenny said the HIV response should be located for maximum cost-effectiveness.

Two-thirds of the CBOs that originally comprised the Tsabango HIV/AIDS network of 30 organisations in Malawi have closed, said Michael Kaiyatsa.

Mkandawire noted that as civil society lost more local organisations, its work became even more centralised in urban areas. He added that shrinking international health funding had also prompted

some CSOs to shift their focus from HIV and TB to areas they perceive as better funded, such as climate change.

A similar but less pronounced shift was noted in Zimbabwe, where Paidamoyo Magaya of the Zimbabwe Network of People Living with HIV reported that health CSOs were not refocusing, but were attempting to link their programmes to new international funding focuses.

Effects on PLWH

Organisations headed by and comprised of PLWH - originally encouraged by international bodies such as UNAIDS and the Global Fund to become involved in the HIV response - have also been affected.

The Lilongwe People Living with HIV/AIDS Support Group, an umbrella body for support in Malawi's capital and National Association of People Living with HIV/AIDS (NAPHAM) affiliate, has lost all but seven of its original 26 groups.

The Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA) is facing closure, as are some of its local affiliates that provide adherence support and defaulter tracing to local clinics, said the organisation's Sipho Dlamini. According to SWANNEPHA Vice Chairperson and CCM member, Vusi Nxumalo, the organisation now faces tough choices as to whether to support itself, or the smaller organisations under it.

Ultimately, the impact of decreased funding on civil society may reach a tipping point that will undo almost a decade of progress in PLWH involvement.

"Community structures that were there are not there anymore. Most of the prevention programmes, those to sustain livelihoods attached to PLWH have been halted," said Rev MacDonald Sembereka, national coordinator of the Malawi Network of Religious Leaders Living or Personally Affected by HIV and AIDS (MANERELA+).

Ultimately, the impact of decreased funding on civil society may ***reach a tipping point that will undo almost a decade of progress in PLWH involvement.***

Nothing for us, without us?

Albertina Nyatsi was diagnosed HIV-positive when she was 25 years old. Shortly after she disclosed her HIV status to the principal of the primary school where she taught she was dismissed.

Nyatsi is now the director of Positive Women Together, a small support organisation founded in 2004 by four women living with HIV.

Positive Women Together, which struggles to receive core funding like many, hoped to receive new funding in Round 11 via its mother body, SWANNEPHA.

Nyatsi cares for the children of two younger sisters who died of TB, feeding about seven people on her stipend from Positive Women. After taxes, which were recently increased to try to alleviate Swaziland's financial crisis, she takes home about US$720 per month.

With decreased organisational funding, and increasing membership, Nyatsi also uses part of her stipend to assist the 10 support groups now run by Positive Women, and do community training on adherence support

"Without money we are not going to be able to reach people in the communities. It means that women in the communities are not going to get the programming they were being given. It means that we will have to close offices, and that woman who we've been supporting in the community will no longer get that support, it means we'll be killing that woman."

SWANNEPHA has retrenched staff, closed two regional offices, and suspended income generation activities for the support groups of PLWH it assists.

Nxumalo echoed Sembereka: "Funding has become quite critical - unfortunately, it ends up to be the biomedical areas that get funded."

"A lot of organisations under PLWH have been affected, and these are not organisations that are going to be supported under the Transitional Funding Mechanism," Nxumalo said. "We are losing the community structures that we've built up. If there comes a time when there is money for HIV, we're going to have to go back into communities and build these structures all over again."

When asked about their budget forecasts, about 40 percent of respondents said their budgets would decrease between now and 2014; an equal proportion responded that their budget forecast for the next two years was uncertain. No CSO said they expected their budget to increase.

"We are losing the community structures that we've built up. If there comes a time when there is money for HIV, we're going to have to go back into communities and build these structures all over again."

5.

INTERIM RELIEF THROUGH DOMESTIC FUNDING, TFM AND PHASE II RENEWALS UNLIKELY

While the inability to access new Global Fund money has led to renewed calls from CSOs for increased domestic funding for HIV and TB, focus countries are unlikely to be able to fill the gap.

In Swaziland, where the World Bank has predicted a need for increased external aid, the country continues to rely heavily on revenues from the Southern Africa Customs Union (SACU) to finance healthcare. SACU applies a common set of tariffs among member states Botswana, Lesotho, Namibia, South Africa and Swaziland. Profits are shared annually among member states according to a pre-determined formula.

Partly due to the global economic downturn, SACU revenues have fallen in recent years, and the five member states have seen cuts in disbursements. SACU also began reviewing its revenue-sharing formula in 2010, with the possibility of allocating smaller shares of revenue to Swaziland, Lesotho and Botswana. By mid-2010, declines in SACU revenue prompted academics at South Africa's University of KwaZulu-Natal to advise Swaziland to move away from over-reliance on SACU disbursements to fund its HIV programme.

Although the country has received adequate SACU revenues in 2012, local NGOs report that the staff of at least one government hospital did not receive their April salaries from the Ministry of Finance.

Financial forecasts also predict a possible downturn in available funding in Swaziland between 2014 and 2016. By this time, the Global Fund should have released Round 11 monies, but if Swaziland does not receive additional funding then, Mukasa-Monico predicts this is when impacts will be felt nationally:

"We've had a SACU windfall but we don't envision that after 2014, when it might go back to how it was in 2011. 2014 to 2016 is when the fiscal situation is not so clear in Swaziland. Most of the response is going to rely on the Global Fund because existing development partners won't increase funding more than a certain proportion. We won't have any funding mechanism for interventions, other than treatment, PMTCT and OVC care and support. That's where we will get the negative impact, [because] then it's government's responsibility."

In Zimbabwe, UNAIDS is assisting in the development of sustainable financing mechanisms to compliment its national AIDS levy. This would include approaching the private sector, such as mining companies, to contribute in line with social responsibility policies, but UNAIDS Country Coordinator Tatiana Shoumilina expects it will take several years for private sector contributions to begin flowing regularly.

The national AIDS levy contributes about US$30 million to the HIV programme annually. According to Shoumilina, attaining universal access in Zimbabwe would cost at least US $150 million. The AIDS levy would contribute about 20 percent to this total. An HIV investment case study has been undertaken to evaluate response and reprioritise programming in light of constrained resources.

Zimbabwe and Malawi have been selected by UNAIDS as test cases for implementation of the agency's Strategic Investment Framework.

Transitional Funding Mechanism to focus on treatment and medical prevention with limited scope for traditional CSO activities

Malawi and Swaziland have applied to access the Global Fund's Transitional Funding Mechanism (TFM). Malawi requested money to ensure the continuation of TB programming. Swaziland has asked for about US$13.2 million in its TFM HIV application to fund PMTCT, lab reagents and health worker salaries.[12] Adherence supporters through the Swaziland National Network of People Living with HIV and AIDS account for three percent of the total proposed TFM budget, and is the only activity that explicitly involves a CSO.

The TFM does not allow for the scale up of treatment.[13]

Designed to ensure the continuation of "life saving services", the TFM money will likely be channelled mainly through Ministries of Health and national TB or HIV programmes to fund treatment, commodities, and a limited set of prevention activities, such as PMTCT. As respondents highlighted previously, CSOs are unlikely to see any additional money before the Global Fund's next call for proposals, under which agreements may not even be signed until the fourth quarter of 2013.[14]

Paidamoyo Magaya of the Zimbabwe Network of People Living with HIV (ZNNP+) and Shoumilina

noted that Zimbabwe cannot apply to the TFM because HIV funding under its reprogrammed Round 8 grant will only terminate in 2014.

Reprogramming Phase II grant renewals to fill gaps

Respondents in all three countries also reported that their Phase II grant renewals have been negatively affected by the crisis. In mid-March, Swaziland's CCM was discussing reprogramming its Phase II activities to channel savings into ARVs, said Vusi Nxumalo, Vice chairperson of the Swaziland National Network of People Living with HIV and AIDS and CCM member.

Meanwhile, Malawi has scaled back some activities under its Round 7, Phase II renewal due to delays in Global Fund disbursements. Round 7 was predominately focused on HIV prevention and therefore had large CSO components, according to Chimwemwe Mablekisi of Malawi's National AIDS Commission. The country has also scaled back or cut HIV prevention activities under its Round 1 RCC Phase II grant in order to free up resources for the procurement of medical commodities such as medicines and HIV testing kits. This phase cycle was also cut by a year, Mablekisi added.

Aye Aye Mon, Chief of HIV/AIDS for UNICEF Malawi, said Phase II has been revised away from CSO activities in order to shift cost savings to medicine procurement.

The Fund has also not disbursed all of the money it committed to under Phase I of the countries Round 1 rolling continuation channel grant. This outstanding money will be deducted from the country's Phase II renewal meaning that the country will lose out on a proportion of new money, Mablekisi added.

In Zimbabwe, newly negotiated budgets for the Round 8, Phase II show deep cuts in CSO-led activities. These savings have been shifted to support interventions like PMTCT. A number of sub-recipients indicate that they were not consulted about the proposed programme changes.

The recently approved Round 8, Phase II renewal has slashed funding for behaviour change communication in communities and schools (-54%); institutional capacity building and strengthening PLWHIV networks (-27%); and OVC support (-17%).

"The removal of behaviour change communication is not justified. Whilst they are saying, 'Focus on low-cost, high-impact interventions,' for a programme to be effective you really need it to be well integrated," said Joyce Siveregi, Deputy Director for Programmes at the Zimbabwe Aids Network. "I thought this was what the Investment Framework was all about."

According to Magaya the country may have had to consequently scale-down peer education training, which would have continued training on TB diagnosis, treatment adherence, and stigma reduction for PLWH support groups.

Among the CSOs likely to be most affected by these cuts is the Southern Africa HIV and AIDS Information Dissemination Service (SAf-AIDS) a regional non-profit based in Harare, Zimbabwe. SAf-AIDS was to implement BCC in conjunction with Population Services International. In responding to OSISA questions, the organisation indicated it was scaling back programming, with possible staff cuts.

6.

CONCLUSION

In the aftermath of the Global Fund's Round 11 cancellation, and amid decreasing resources at one of the world's largest HIV and TB donors, countries have often had to choose between biomedical interventions and the activities that support them.

To safeguard supplies of medical commodities, countries like Swaziland, Malawi and Zimbabwe have begun to shift budgets - through TFM applications and reprogramming existing grants - away from human rights programming, community mobilisation, community programme design and delivery, politically sensitive MARPs programmes, and community systems strengthening, with adverse effects on CSOs.

Round 11 and the reprioritisation of existing Global Fund grants away from such programmes is the latest blow to CSOs, which have been struggling since donors began backtracking on their promises

Now, with decreased funding and what appears to be less and less access to Global Fund money, ***civil society networks are in danger of collapse.***

to the Global Fund and, by extension, to those affected by HIV and TB, particularly PLWH.

CSO funding has fallen steeply in the last two years and there is little sign of relief for the organisations that play a fundamental role in linking communities and health systems in a region hard hit by HIV and TB, but still characterised by heavily centralised health service delivery. CSOs have worked to create demand for services such as ARVs, PMTCT and MMC, while informing patients of their rights and educating them about their treatment.

Now, with decreased funding and what appears to be less and less access to Global Fund money, civil society networks are in danger of collapse. In CSO responses collected by OSISA and OSF, 100 percent of the survey sample reported that their networks have been adversely affected by shrinking budgets in recent years.

With the closure of CSOs, their networks and governments lose the advantages they have grown to rely on, especially in countries facing huge challenges in domestically financing HIV and TB responses.

Ironically, the closures and scaled back programming come at a time when, true to its philosophy of including those affected, the Global Fund has prompted attitude gains in addressing criminalised and at-risk populations, such as sex workers, MSM and injecting drug users in southern Africa. Almost a decade ago, the Global Fund and UNAIDS called for the inclusion of PLWH in the HIV response. Now, PLWH are activists, treatment supporters and expert patients. They created CSOs that responded to their needs and amplified their voices. These local CSOs are among those most at risk of closure.

ENDNOTES

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10. *Gulaid, Jama. Telephonic Interview. April 11 2012*

11. *Submission for the Universal Periodic Review of Swaziland. Amnesty International. March 2011: pg. 2*

12. *Swaziland's initial TFM application asked for US$25 million to support neighbourhood care points that provide nutritional support to OVCs but this activity was removed.*

13. *Continuity of Services: Operational Policy Note, Global Fund to Fight AIDS, TB and Malaria. July 2011*

14. *Global Fund Observer, Issue 159: 28 September 2011*

OSISA

Open Society Initiative for Southern Africa

The open society initiative for southern africa (osisa) is a growing african institution committed to deepening democracy, protecting human rights and enhancing good governance in southern africa. Osisa's vision is to promote and sustain the ideals, values, institutions and practice of open society, with the aim of establishing a vibrant southern african society in which people, free from material and other deprivation, understand their rights and responsibilities and participate democratically in all spheres of life.

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OPEN SOCIETY FOUNDATIONS

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She has spent the last six years covering HIV in southern Africa for the United Nations humanitarian news service, the Integrated Regional Information Networks (IRIN). Based in Johannesburg, South Africa, she has partnered with organizations such as the Johns Hopkins Center for Global Health and South Africa's Aurum Institute to train fellow journalists in the reporting of HIV, tuberculosis and clinical trials.

In 2010, she was awarded a Gender and Media in Southern Africa Award for best sustained reporting for her work on forced sterilisations among HIV-positive women in Namibia and pregnancy-related HIV stigma. In 2011, she became an investigative HIV reporting fellow with the International Women's Media Foundation for which she produced a series of articles on local and international HIV funding.