

FULLY FUND THE GLOBAL FUND:

STILL WAITING, STILL DYING: THE GLOBAL FUND AND KEY AND VULNERABLE POPULATIONS IN THE RESPONSE TO HIV, TB AND MALARIA



This year, the Global Fund launched its strategic plan for the years 2023 – 2028. The Global Fund is also currently engaged in its Seventh Replenishment, raising funds for the coming three years, and aiming for at least US\$18 billion in pledges.

This paper, developed by the Global Fund Advocates Network (GFAN), discusses the Global Fund's efforts and challenges to support key and marginalized populations in the response to HIV, tuberculosis, and malaria (HTM). The paper sounds an alarm and describes five key challenges that need to be widely acknowledged and addressed:

1. **Key and Vulnerable Populations:** Key and vulnerable populations, while marginalized economically, socially, and legally, are not at the margins of epidemics, but instead are at the center of infection transmissions and loss of life due to the three diseases. For this reason, global epidemic control and achievement of the SDGs depends on key and vulnerable populations being at the center of programming by country governments and international funding partnerships such as the Global Fund.
2. **Funding Gaps:** Global resource mobilization targets for the three diseases, although ambitious, fall short of the calculated total resource needs to bring the three epidemics under control. Even if resource mobilization targets are met, there will be an estimated \$28.4 billion funding gap¹. Key and vulnerable populations bear the burden of unequal resource allocations and access to services in every country, and the gap in resource mobilization will disproportionately affect those populations.
3. **Reducing morbidity and mortality:** Despite significant progress in most countries in reducing infections, global reports from UNAIDS and others show that we haven't done enough in preventing new infections and that infection levels continue to soar in many communities globally.
4. **COVID scarring:** Over the past two years, the COVID-19 pandemic has resulted in significant setbacks to the progress made to date.
5. **No seat at the table:** While KVPs are represented on the Global Fund Board and some CCMs, they are often excluded from program and policy development, implementation, and evaluation efforts. This serves to further the inequities and ineffectiveness in service delivery and health care access

EXECUTIVE SUMMARY

THE PAPER PROVIDES THE FOLLOWING RECOMMENDATIONS:

Place key and vulnerable populations at the center of efforts to reduce inequities in health care access – fund the ‘last mile’ first.

- Increase funding for prevention, treatment, care and support for key and vulnerable populations affected by HIV, TB and malaria.
- The Global Fund should be transparent about inequities within its funding allocations and develop targets and policies to address them. The Global Fund should utilize all available mechanisms to address imbalances in funding priorities for KVPs, including dual track financing, special initiatives, pooled funding efforts, and regional proposals.
- The Global Fund should work to improve the participation of KVPs throughout the grant process, including priority setting, development, allocation, implementation and evaluation. And it should place the Community, Right, Gender Department within the grantmaking and implementation process.
- Reevaluate how ‘country ownership’ principles can hinder placing key and vulnerable populations at the center of HTM response and efforts to improve human rights
- Continue efforts to improve and support sexual and reproductive health and rights and increase resources for HTM prevention for women and girls in all their diversity, including among key populations.

The Global Fund should provide comprehensive data about the level of resources that are allocated to address key population needs, how these resources are utilized, including tracking that they support rights-based programs for criminalised populations, and the outcomes from those investments.

- Without vastly improved data collection to track key population needs, allocations, and outcomes, it is impossible to hold the Global Fund, donors or implementing countries accountable.
- Rather than merely reporting a funding gap of \$28.4billion (if current targets are met), the Global Fund has an ethical and moral responsibility to report on what and who has paid the price for these funding gaps in the past, present and future.
- Data needs to be provided with information about specific key populations within each disease.

The Global Fund cannot sustain progress and legitimacy without the advocacy and community mobilization that affected communities provide. Innovative mechanisms are needed now to resource and support this essential work.

- Participate in a pooled funding mechanism to support national-level health advocacy.
- Ensure the funding for Community Systems Strengthening actually reaches and supports community-led activities
- Build upon the success of the Breaking Down Barriers initiative and scale up support for human rights. This is particularly important in TB, where little work has been done to date and which is now recommended in the Global Plan to End TB 2023 - 2023²
- Continue and increase support for community-led monitoring including costs for advocacy to utilize the data and improve health and human rights outcomes

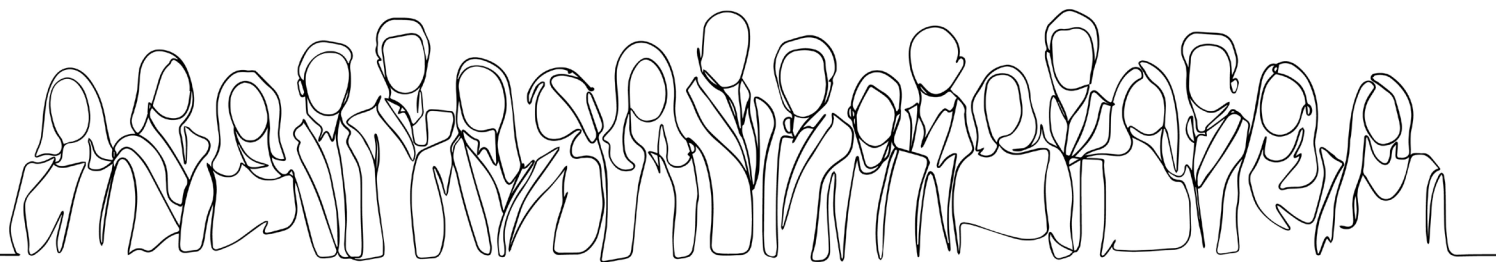
MEETING THE 2030 TARGETS IS NOT THE END OF THE HTM EPIDEMICS: PROVIDE A VISION FOR THE FUTURE.

EXECUTIVE SUMMARY

Even if the 2030 targets are met, the HTM responses will each need to continue and need resources to do so. People living with HIV will still require lifelong treatment and on-going prevention interventions for HIV, TB and malaria will still be required for decades. And, HTM control cannot be achieved or sustained if the needs of the most vulnerable remain neglected. Over time, key and vulnerable populations will likely bear an even greater disproportionate burden of HIV, TB, and malaria.

The Global Fund, its technical partners,

donors, implementing countries and civil society all need to develop a vision for the future to address these pandemics for years to come. That vision can only be developed if we start with a realistic view of where we are and what can be achieved now and in the near future. The funding gaps are enormous, but the problem is not money. The problem, as always, is the lack of political will to ensure and prioritize high quality and equitable health services for all.



INTRODUCTION

We, as key and vulnerable populations in the HIV, TB and Malaria (HTM) response, have been and remain central to innovation, leadership, and sustainability. It was key and vulnerable populations that actually started the HIV response – not governments or the public health establishment. It was key and vulnerable populations that led the way in the development of HIV prevention methods, the advocacy to bring HIV treatment to the global South, to call to address the inequities and violence that threaten women and girls, and to push for the development of the Global Fund in the first place. Key and vulnerable populations have provided the most innovative work, now considered standard within the HTM response – differentiated service delivery, harm reduction, treatment education, community-led monitoring (CLM) and adherence support services are all important examples. People living with HIV, TB and malaria have spent countless hours sitting on Global Fund Boards, Country Coordinating Mechanisms (CCMs), UNAIDS Program Coordinating Boards (PCBs), World Health Organization (WHO) guideline panels, National AIDS Strategic Planning boards, etc. etc. etc. Yet despite our efforts, despite our enormous contribution, we are still left behind and are still dying.

The Global Fund to Fight HIV, Tuberculosis (TB) and Malaria, founded in 2001, has become the largest multilateral donor supporting global public health. It has spent to date over US\$53 billion to reduce infections, illness and deaths from HIV, TB, and malaria³. The Global Fund estimates that since its founding twenty years ago, it has saved over 43 million lives⁴.

This year, the Global Fund launched its strategic plan for the years 2023 – 2028. The Global Fund is also currently engaged in its Seventh Replenishment, raising funds for the coming three years, and aiming for at least US\$18 billion in pledges.

This paper, developed by the Global Fund Advocates Network (GFAN), discusses the Global Fund's efforts and challenges to support key and marginalized populations in the response to HTM, as described within the new Strategic Plan and within the context of the replenishment process.

This paper sounds an alarm and describes five key challenges that need to be widely acknowledged and addressed:

1. Key and Vulnerable Populations: Key and vulnerable populations, although marginalized economically, socially, and legally, do not live at the margins of epidemics, but instead are at the center of infection transmissions and loss of life due to the three diseases. For this reason, global epidemic control and achievement of the SDGs depends on key and vulnerable populations being at the center of programming by country governments and international funding partnerships such as the Global Fund.

2. Funding Gaps: Global resource mobilization targets for the three diseases, although ambitious, fall short of the calculated total resource needs to bring the three epidemics under control. Even if resource mobilization targets are met, there will be an estimated \$28.4 billion funding gap⁵. Key and vulnerable populations (KVPs) bear the burden of unequal resource allocations and access to services in every country, and the gap in resource mobilization will disproportionately affect those populations.

3. Morbidity and Mortality: Despite significant progress in most countries in reducing infections, illness, and deaths due to HIV, TB and malaria, the three diseases continue to ravage many communities and cause high rates of deaths.

4. COVID scarring: Over the past two years, the COVID-19 pandemic has resulted in significant setbacks to the progress made to date.

5. No seat at the table: While KVPs are represented on the Global Fund Board and some CCMs, they are often excluded from program and policy development, implementation, and evaluation efforts. This serves to further the inequities and ineffectiveness in service delivery and health care access.



INTRODUCTION: FUNDING GAPS WILL AFFECT KEY AND VULNERABLE POPULATIONS MOST HEAVILY AND WILL THREATEN SDG GOALS

In 2015, United Nations (UN) Member State governments committed themselves to action to end epidemics of leading infectious diseases by 2030, with a focus on the leading global causes of premature deaths and disability: HIV, TB, malaria, viral hepatitis, and water-borne diseases. Further, governments committed in the SDGs to several other broad interlinked priorities including progress against poverty and hunger, and advancement of education, gender equality, and economic growth.

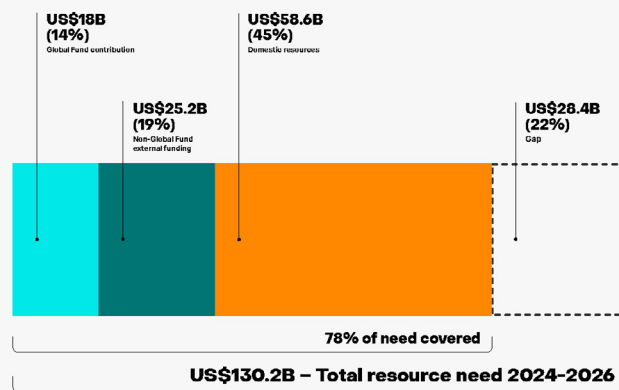
They agreed to these commitments as part of the Agenda for Sustainable Development and the Sustainable Development Goals (SDG 3.3).

The Seventh Replenishment target of US\$18 billion set in the [Investment Case](#) is based in part on the projected resource needs across the three diseases, which have been developed in conjunction with the Global Fund's technical partners, including the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS, (UNAIDS), the Stop TB Partnership and the RBM Partnership to End Malaria (RBM). The projected resource needs for HTM for 2024-2026 amount to US\$130.2 billion in countries where the Global Fund invests. This is a 29% increase on the US\$101 billion in resource needs estimated for the current three-year period (2021-2023), a period in which total resources for HTM actually declined. This sharp increase reflects the fact that across all three diseases, progress has gone backwards or stalled, the results of consistent underfunding and the COVID-19 pandemic. To meet the SDG 3 target of ending AIDS, TB and malaria as public health threats by 2030, it is essential to speed up progress to reduce deaths and new infections. This will inevitably require more money. The chart below, taken from the Global Fund's Invest-

ment Case, illustrates the Global Fund's projected contribution to the overall HTM responses along with other funding sources. Even if all these funding sources meet their targets, there is an estimated \$28.4B gap (22%) in meeting the resource needs estimates.

This is why, in GFAN's report in November 2021 we called for a 28.5 billion investment in the Global Fund and since the release of

Overall Resource Needs and Projected Available Resources for HIV, TB and Malaria in Countries Where the Global Fund Invests



the Investment Case have noted and called out this irresponsible gap. Rather than merely reporting a funding gap of \$28.4 billion (if current targets are met), the Global Fund has an ethical and moral responsibility to report on what and who has paid the price for these funding gaps in the past, present and future.

According to the Global Fund's [2020 Strategic Review](#), substantial inequalities remain between population groups for all three diseases. For HIV, adolescent girls and young women (AGYW) account for one in four new HIV infections in sub-Saharan Africa, and the target to reduce HIV incidence among this group by 58% between 2015 and 2022 is 'at risk', with only a 20% reduction as of mid-2019. Men who have sex with men (MSM), people who inject drugs (PWID), prisoners, sex workers, transgender people, and their sexual partners account for 70% of new

Source: [Global Fund Investment Case](#)

INTRODUCTION: FUNDING GAPS WILL AFFECT KEY AND VULNERABLE POPULATIONS MOST HEAVILY AND WILL THREATEN SDG GOALS

adult HIV infections globally. With regard to TB, the prevalence among some key and vulnerable populations, such as prisoners, is up to 100 times higher than for the general population. Malaria disproportionately impacts pregnant women and children under five, with up to 10% of maternal deaths caused by malaria in sub-Saharan Africa. There is little data about current resource levels aimed at meeting the needs of key and vulnerable populations, but there is little doubt that these levels are shockingly low compared to the needs. For example, only 9% of HIV prevention funding is allocated for prevention for key and vulnerable populations – a number again to contrast with their share, 70%, of new adult infections.

The Global Fund Strategy for 2023 - 2028 introduces an explicit objective to maximize the engagement and leadership of affected communities, to ensure that no one is left behind, and that services are designed to respond to the needs of those most at risk. However, neither the Strategy nor the Replenishment Investment case explicitly state a goal to increase funding for services aimed at these communities. Despite much rhetoric about the desire to address the needs of key and vulnerable populations, the 2022 - 2026 UNAIDS Strategic Plan, the Global Fund Strategy and the Seventh Replenishment Investment Case provide little to no information about how such funding can be scaled up, particularly given an estimated US\$28 billion gap in meeting resource needs. Increased funding to support key and vulnerable populations will have to come from somewhere, and it is unclear what the Global Fund will stop funding to meet this strategic objective. Without concrete funding targets, services aimed at key and vulnerable populations will continue to fall into the funding gaps.

The failure to dramatically increase support for key and vulnerable populations services, particularly prevention services, will not only lead to the continued neglect of those most vulnerable for disease, death, and discrimination; it will undermine all efforts to reach and maintain epidemic control as targeted in SDG3 and the Global Fund Strategy.

The Global Fund has and continues to provide essential and groundbreaking work that has saved tens of millions of lives, prevented millions of infections, and championed human rights. Its policies have helped to dramatically increase domestic resource levels for health. The Global Fund is also unique in its incorporation of the voices and communities of people directly affected by the three diseases into its governance, planning and implementation processes. However, despite these successes, key and vulnerable populations remain left behind.



DEFINING KEY AND VULNERABLE POPULATIONS IN HIV, TUBERCULOSIS AND MALARIA

Developing a common definition of key and vulnerable populations across the spectrum of the three diseases is difficult, as the diseases all impact different segments of society in different ways. So, broadly speaking, key and vulnerable populations in the context of AIDS, TB and malaria are those that experience a high epidemiological impact from one of the diseases combined with reduced access to services and/or being criminalized or otherwise marginalized. The Global Fund Key and vulnerable populations Action Plan 2014 – 2017 defines a group as a 'key population' if it meets all three of the criteria below:

1. Epidemiologically, the group faces increased vulnerability and/or burden with respect to at least one of the three diseases – due to a combination of biological, socioeconomic and structural factors;

2. Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
3. The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increases vulnerability and risk and reduces access to essential services.

Beyond the definition above, key and vulnerable populations are 'key' to ending epidemics because of their direct experience, expertise, commitment and potential for leadership in efforts to advance health and human rights.



28.5 billion

means
saving more
lives like mine

#GetBackonTrack

GFAN Speaker **Anton Basenko** was one of the first patients of **Global Fund**-financed opioid substitution therapy in Ukraine. He is now a **vocal advocate** for people living with HIV & people who use drugs.

gfan global fund advocates network

DEFINING KEY AND VULNERABLE POPULATIONS IN HIV, TUBERCULOSIS AND MALARIA

Key and vulnerable populations in the HIV

Response: Gay, bisexual and other men who have sex with men; people who inject drugs; people who are sex workers; and all transgender people are socially marginalized, often criminalized and face a range of human rights abuses that increase their vulnerability to HIV. In every nation that reliably collects and accurately reports surveillance data, gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender people – in particular transgender women – have higher HIV risk, mortality and/or morbidity when compared to the general population. Access to, or uptake of, relevant services is significantly lower for these sub-populations than for other groups.

Key and vulnerable populations in the Tuberculosis

Response: Prisoners and incarcerated populations, people living with HIV, migrants, refugees and indigenous populations are all groups that are highly vulnerable to TB, as well as experiencing significant marginalization, decreased access to quality services, and human rights violations.

Key and vulnerable populations in the

Malaria Response: The concept of “key and vulnerable populations” in the context of malaria is relatively new and not yet as well defined as for HIV and TB. However, there are populations that meet the criteria outlined above. Refugees, migrants, internally displaced people, and indigenous populations in malaria-endemic areas are often at greater risk of transmission, usually have decreased access to care and services, and are also often marginalized.

People living with the three diseases:

In addition to people who experience enhanced risk and vulnerability, all people living with HIV, and who currently have, or have survived, TB, fall within the Global Fund’s definition of “key and vulnerable populations”. Given that in some countries, a substantial proportion of the population has malaria, and the impact is not linked to systematic marginalization or criminalization, people who have had malaria are not included in this definition.

Additional Cross-cutting Factors:

Women and girls, including transgender women, experience an increased biological vulnerability to HIV, and are disproportionately exposed to violence and other forms of gender oppression that increase HIV risk. This is compounded for those who work as sex workers and/or inject drugs and who may be described as “key affected women”. Young people from key and vulnerable populations face increased marginalization as age-related laws and policies can hinder their ability to access HIV-related and other health services. Across the three diseases, people living with disabilities face marginalization, stigma and extreme challenges in accessing health and social services.

Vulnerable Populations: In every context there are communities and groups who fall outside of the above definition of “key and vulnerable populations” but experience a greater vulnerability to and impact of HIV, TB and malaria. These may include people whose situations or contexts make them especially vulnerable, or who experience inequality, prejudice, marginalization, and limits on their social, economic, cultural, and other rights. This might include groups such as orphans, street children, people with disabilities, people living in extreme poverty, mobile workers, and other migrants. Some occupations, such as mining, may enhance the risk of TB by limiting access to healthy environments. Children and pregnant women – in particular, women with HIV - are particularly vulnerable to malaria as their immunity is reduced.



In the review of the global 2016 – 2021 HIV ‘Fast-Track’ strategy, UNAIDS recognized that aggregate achievements in treatment, viral suppression, and prevention mask poor results in some segments of the population, which undermine overall reductions in HIV incidence. As has been the case since the start of the epidemic, ‘key population’ members are being left behind.

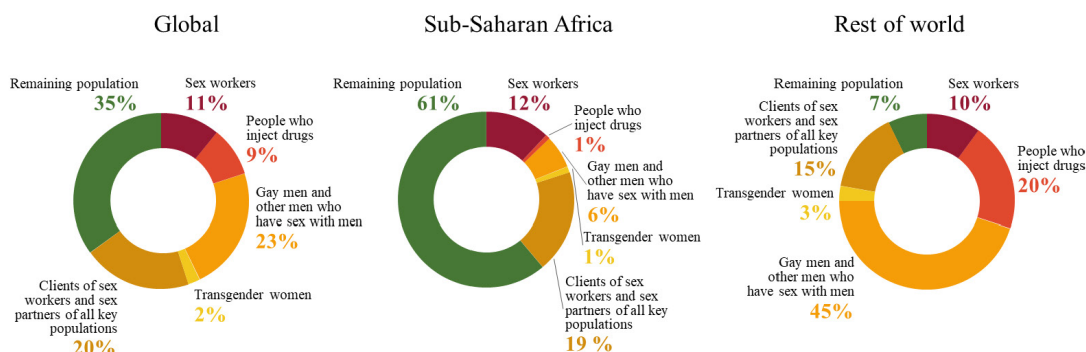
As with previous UNAIDS strategies, the newly proposed 2021 – 2026 Global AIDS Strategy emphasizes tackling inequalities, with equitable and equal access to HIV services, breaking down barriers to prevention and care, and creating a strengthened, resilient, and fully resourced response⁶. Similarly, UNAIDS released new HIV targets for 2025⁷.

However, the resources available for HIV programs in low- and middle-income countries (LMICs) fell short of the estimated needs of the previous Fast Track strategy. Annual shortfalls in resources required to fully fund the 2016-21 strategy were in excess of \$20 billion⁸. At the end of 2020, US\$21.5 billion was available for HIV responses in low- and middle-income countries—far short of the US\$30 billion that will be needed by 2025 to get on-track to end AIDS. Domestic resources accounted for 61% of available resources in 2020. However, both domestic and international investments in the response have stagnated, leaving a considerable and growing resource gap.

For the first time in the history of the Global Fund, key prevention and testing services declined compared to the previous year; between 2019 and 2020, voluntary medical male circumcision dropped by 27%; and the number of people reached with HIV prevention programs fell by 11%. The number of mothers receiving medicine to prevent transmitting HIV to their babies dropped by 4.5%. Testing dropped by 22%, holding back HIV treatment initiation in most countries. Without access to prevention services, more people will be infected with HIV. Without testing, fewer people are being diagnosed and put on treatment; this not only puts their health at risk, it also contributes to ongoing transmission of HIV⁹.

Currently, just 2% of all HIV funding, and around 9% of resources allocated specifically for prevention, are spent on prevention for key population groups¹⁰. Meanwhile, the HIV burden among key and vulnerable populations continues to grow. Sex workers and their clients, gay men and other men who have sex with men, people who inject drugs and transgender people, along with their sexual partners, accounted for an estimated 65% of new HIV infections globally in 2020, including 93% of new infections outside sub-Saharan Africa. Compared to the overall population, the risk of acquiring HIV is 35 times higher among people who inject drugs, 34 times higher for transgender women, 26 times higher among sex workers, and 25 times higher among gay men and other men who have sex with men. Available evidence indicates that HIV

Distribution of HIV infection by population, 2020



Source: Joint United Nations Programme on HIV/AIDS special analysis, 2021.

THE STATE OF HIV AND KEY AND VULNERABLE POPULATIONS: 2030 TARGETS FOR “ENDING” HIV AS A PUBLIC HEALTH THREAT

prevention, testing and treatment services are not reaching many key and vulnerable populations, including those who are young. Substantial work remains to ensure an enabling environment for a sound, inclusive and equitable HIV response. Stigma and discrimination remain rampant and are a significant barrier to engagement in health services. In 52 of 58 countries with recent population-based survey data, more than 25% of people (aged 15–49 years) reported having discriminatory attitudes towards people living with HIV, other recent data shows that in 25 of 36 countries, more than 50% of people (aged 15–49 years) displayed discriminatory attitudes towards people living with HIV. In 2020, 96 countries have laws that criminalize HIV transmission, exposure or nondisclosure; 67 countries criminalize the use, consumption and/or possession of drugs for personal use, including 35 that authorize the death penalty for such violations; 69 countries criminalize same-sex relations, including six that authorize the death penalty; 98 criminalize some aspect of sex work; and 13 countries criminalize transgender persons. More than 100 countries require parental consent before an adolescent may be tested for HIV.

The global rhetoric about ending the HIV pandemic as a public health threat by 2030 bears some examination. The goal is not HIV eradication, or local elimination, but a reduction in HIV incidence thereby reducing the burden of HIV infections. Even if these targets are met, the HIV response will need to continue and need resources to do so. People living with HIV will still require lifelong treatment and on-going prevention interventions will still be required. HIV control cannot be achieved or sustained if the needs of the most vulnerable remain neglected. Over time, key and vulnerable populations will likely bear an even greater disproportionate burden of HIV. If and as HIV is not funded explicitly and integrated into Universal Health Coverage, it is likely that funding of HIV services will be more aligned with funding of health care in general, which could lead to designated services for key and vulnerable populations becoming even less available.

Epidemic control has been defined as reaching a threshold where 73% of PLHIV¹¹ are virally suppressed (the “third 90” in the 90% diagnosed, 90% in care, 90% effectively treated paradigm) which is expected to reduce incidence, or as reaching a threshold where HIV incidence is reduced below the rate of mortality of PLHIV. These thresholds are meaningful in that the course of HIV epidemics may change, if and when they are achieved, but higher levels of community viral suppression are still needed for faster and more sustained HIV control, and that ‘more’ will require a greater concentration on the needs of vulnerable and key and vulnerable populations.

In sub-Saharan Africa, HIV epidemic control cannot be achieved until and unless significantly greater focus and resources to meet the needs of those most vulnerable to HIV infection and illness - adolescents and young adults, and particularly key and vulnerable populations. Currently, an estimated 17% of new HIV infections in East and Southern Africa (where the majority of all incident HIV infections are occurring) and 42% in West and Central Africa are occurring in key and vulnerable populations¹². However, these are likely underestimates based on limited data, and the percentages are expected to continue to increase¹³. HIV infections among key and vulnerable populations do not occur in a vacuum but affect and will continue to affect the broader population.



THE STATE OF TUBERCULOSIS AND KEY AND VULNERABLE POPULATIONS

Every year, more than 10 million people fall sick with TB worldwide. TB infection and the likelihood of progressing to TB disease is shaped by life circumstances (such as living or working conditions or malnutrition among miner workers, health care workers, prisoners, migrants or urban poor) and other health risk factors (such as living with HIV or diabetes). Out of the 10 million people who become sick with TB every year, about 3 million are being “missed” by the TB response – either not being diagnosed and treated, or not receiving a high quality of care. At least 1 million of the missing people with TB are children, and 800,000 people living with HIV develop TB every year¹⁴. Each undiagnosed and untreated person can infect as many as 15 individuals per year. The annual number of TB deaths is falling globally, but that drop has not been sharp enough to reach the 2020 milestone of a 35% reduction between 2015 and 2020. The cumulative reduction between 2015 and 2019 was 15%, less than halfway towards the target¹⁵. Many people face multiple barriers to accessing and utilizing services, barriers often linked to human rights and gender disparities¹⁶.

TB incidence, mortality and progress vary dramatically across countries. The EECA region and all countries in Africa have experienced declines in deaths that are on track to approach or meet 2030 elimination targets. In all other areas/regions, with regard to both new TB cases and TB deaths, we are not on track to meet 2030 elimination targets. In Global Fund portfolio countries, average treatment coverage is highest (at least 75%) in Latin American countries (LAC) and Middle East and North Africa (MENA), and lowest in Western and Central Africa (WCA).

As COVID-19 spread around the world in

2020, health workers, testing machines, laboratories and health centers were diverted from existing diseases like TB to fight the new pandemic. With similar symptoms such as cough, fever and breathing difficulties, TB and COVID-19 can be confused; many people with TB symptoms avoided health clinics or were turned away due to stigma and fear. The impact of these disruptions has been severe. As with HIV, for the first time in the Global Fund’s history there have been significant declines in key TB programmatic results compared to the previous year. The number of people tested and treated for TB dropped by 18% or around one million patients between 2019 and 2020; for drug-resistant and extensively drug-resistant TB, the declines were even worse, at 19% and 37%, respectively. The number of HIV-positive TB patients on ARVs during TB treatment dropped by 16%¹⁷.

The [Stop TB Partnership Global Plan to End TB](#) describes key and vulnerable populations (KVPs) as people who have increased exposure to TB bacilli, have limited access to health services, or are at increased risk of TB because of compromised immune function. The chart below, taken from the 2022 TB Strategic Plan, provides a detailed description of key and vulnerable populations for TB.

People who have INCREASED EXPOSURE to TB due to where they live or work

Prisoners, sex workers, miners, hospital visitors, health care workers and community health workers

PEOPLE WHO:

- ✦ live in urban slums
- ✦ live in poorly ventilated or dusty conditions
- ✦ are contacts of individuals with TB, including children
- ✦ work in environments that are overcrowded
- ✦ work in hospitals or are health care professionals
- ✦ are in contact with or live with livestock

People who have LIMITED ACCESS TO QUALITY TB SERVICES

Migrant workers, women in settings with gender disparity, children, refugees or internally displaced people, illegal miners, and undocumented migrants

PEOPLE WHO:

- ✦ are from tribal populations or indigenous peoples
- ✦ are homeless
- ✦ live in hard-to-reach areas
- ✦ live in homes for the elderly
- ✦ have mental or physical disabilities
- ✦ face legal barriers to access care
- ✦ are lesbian, gay, bisexual or transgender

People at INCREASED RISK of TB because of biological or behavioural factors that compromise immune function

PEOPLE WHO:

- ✦ live with HIV
- ✦ have diabetes or silicosis
- ✦ undergo immunosuppressive therapy
- ✦ are undernourished
- ✦ use tobacco
- ✦ suffer from alcohol-use disorders
- ✦ inject drugs

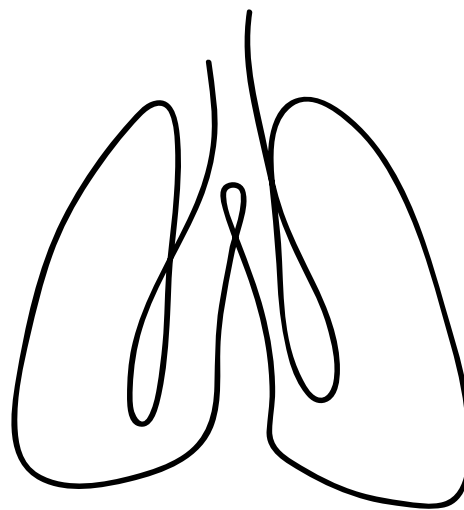
THE STATE OF TUBERCULOSIS AND KEY AND VULNERABLE POPULATIONS

The concept of key and vulnerable populations at risk for a particular illness comes out of the HIV response in which certain groups are both at greater risk of transmission, stigmatized within their society, and have limited access to prevention and health care services. They often require specialized and targeted approaches to reach them with services and information. The concept is somewhat less applicable to TB and malaria, where the primary reasons for increased infection rates, morbidity and mortality in highly affected populations are poverty, gender disparities, inadequate health care systems, and political unrest. It is beyond the scope of the Global Fund to truly address these broader inequities that have an impact on most health outcomes. However, there are populations at higher risk of TB that, like HIV, require and can benefit from specialized and/or targeted services. In one telling example, there are more than half a million refugees living in Kenya and approximately 250,000 in Ethiopia. These populations are at elevated risk for the three diseases, but they have not been a primary focus of TB or malaria program proposals or funding in either country, thus little funding from the Global Fund supports interventions targeted to these key and vulnerable populations¹⁸. The Global Fund can best address these kinds of gaps in coverage through targeted funding approaches.

Reaching KVPs in the TB response is equitable, conforms to human rights, and is essential if countries are going to end the TB epidemic. The Political Declaration of the UN High-Level Meeting on the Fight Against TB specifically includes commitments for finding and treating TB in adults and children. The Global Plan to End TB articulates these targets as 90-(90)-90 targets, with the middle 90 referring to reaching 90% of people in need of treatment and prevention among vulnerable, under-served, and at-risk populations. However, there is very limited data to determine the size of key and vulnerable populations affected by TB or to monitor service coverage and burden of disease in these populations¹⁹. Reaching these

targets requires not only understanding of the epidemiological context, but also understanding of the structural, human rights and gender barriers these populations face in accessing the TB prevention, diagnosis, treatment, care, and support for vulnerable populations.

Given that TB key and vulnerable populations are context-specific, generating an adequate response to their needs requires addressing the current limitation in data availability and quality and the determination of what factors result in increased exposure to bacilli, limited access to health services, or compromised immune function for key and vulnerable populations. A sufficiently tailored TB response requires that they be identified, quantified, and characterized. There needs to be an understanding of the data gaps, the factors at play making populations vulnerable, the barriers to care they face, and how treatment outcomes vary. Generating this knowledge – and the capacity to build effective responses – requires the meaningful participation of key and vulnerable populations. Yet, people living with and/or surviving from TB are rarely included in program and policy development, including Global Fund processes.



THE STATE OF MALARIA AND KEY AND VULNERABLE POPULATIONS

The world has made dramatic progress against malaria since 2000. Globally, malaria case incidence declined by 27% and mortality fell by 49% between 2000 and 2020²⁰. In countries where the Global Fund invests, malaria deaths have reduced by 45% since 2002. The regions of EECA, Latin America and the Caribbean, Middle East and North Africa, and Southeast Asia have all demonstrated successful malaria elimination efforts. However, in recent years, progress against incidence reduction and other targets has stalled²¹. Despite concerted efforts and successes in adapting malaria programming to COVID-19, disruptions have set back progress, and the world is off track to meet many of the 2030 WHO Global Technical Strategy and malaria-related SDG targets²².

Malaria progress has also been uneven. While 23 countries have eliminated malaria since 2000, Africa carried 95% of global malaria cases and 96% of malaria deaths in 2020²³. Children under 5 and pregnant women, as well as rural and mobile populations, remain disproportionately affected by malaria and face barriers in accessing preventative services, diagnostics, and treatment. As a disease highly linked to poverty, wealth-based inequalities affect malaria outcomes. Despite recent reductions in wealth-based inequalities in access to prevention services, there are continued disparities for those living in poverty in accessing prompt care for children under 5 years of age with fever²⁴.

Population growth, poverty, shifting vector composition and behaviors, and residual transmission all challenge progress, which is compounded by inequities and barriers associated with gender, age, and socioeconomic and legal status. Climate change and other environmental factors, migration, complex emergencies, and political instability impact malaria transmission dynamics, resulting in changes in the distribution and local burden of disease. Malaria is concentrated in low-income countries that have weaker health systems and a limited ability to increase domestic resources.

Throughout the world, malaria rates are also higher among the economically poorest populations, including mobile and migrant populations, people in humanitarian crises, and indigenous and rural communities. People in humanitarian emergencies and in fragile states are particularly vulnerable to malaria because of the breakdown of health services, displacement of health workers, movement of non-immune people to endemic areas, and concentrations of people in high-risk, high-exposure settings. Examples of malaria-related vulnerability in cases of conflict or political, social, or environmental upheaval include recent malaria outbreaks in the Rohingya refugee camps in Bangladesh, Nigeria (Borno State), South Sudan, and Yemen; and the rapid spread of malaria cases in Venezuela as people flee national economic and social crises.

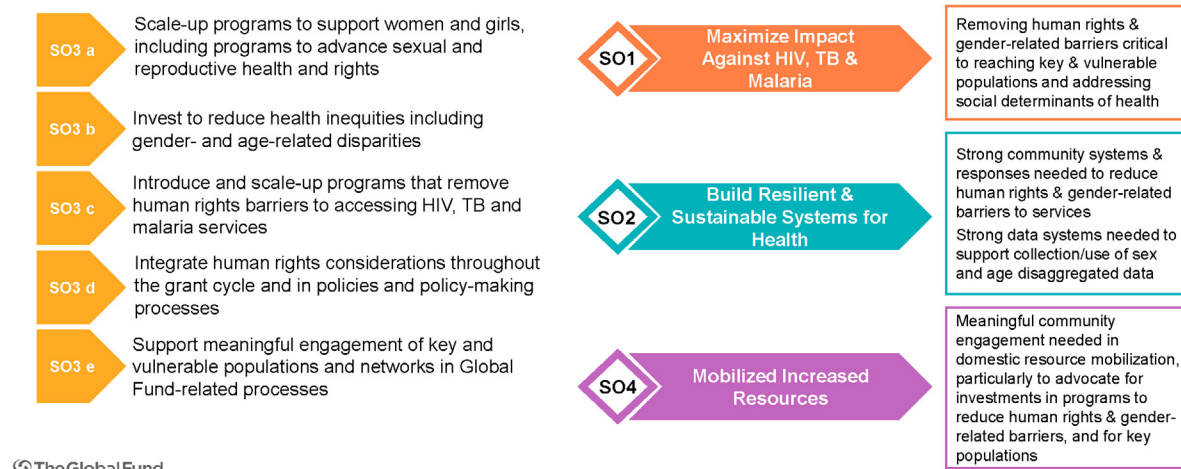


RECOMMENDATIONS TO IMPROVE THE GLOBAL FUND'S EFFORTS TO MEET THE NEEDS OF KEY AND VULNERABLE POPULATIONS AND PLACE THEM AT THE CENTER OF HTM RESPONSES

The inclusion of a strategic goal in the Global Fund's 2017 – 2022 Strategic Plan to strengthen human rights and gender equity in the response to HTM provided important opportunities to invest resources and develop policies and procedures to better address the availability of health services for key and vulnerable populations, mobilize their communities, and to reduce stigma, discrimination, criminalization, and gender-based violence. However, the 2020 Strategic Review from the Global Fund's Technical Evaluation Review Group (TERG) reports that CRG-related investments, including KVP services, suggest that such investments peaked in 2017, that they are heavily concentrated in HIV, and they represent approximately 1% of the total portfolio. Building on the efforts under the previous strategy, more can be done to place key and vulnerable populations, gender and economic equity, and human rights protection at the center of the HTM responses.

it objective “to maximize the engagement and leadership of affected communities, to ensure that no one is left behind, and that services are designed to respond to the needs of those most at risk”. Second, the “principle that communities are at the center of the Global Fund's work is core to the new Strategy”. Third, the Strategy reiterates and reinforces the imperative to maximize health equity, gender equality and human rights by “deepening the integration of these dimensions into our HTM interventions, including through expanding the use of data to identify and respond to inequities, scaling up comprehensive programs to remove human rights and gender-related barriers, and leveraging the Global Fund's voice to challenge harmful laws, policies and practices.”. Although these are laudable goals, the US\$28.4 billion funding gap (if current resource goals are met) calls into question whether and how the Global Fund can meet these goals. Again, this is why

2017 – 2022 Strategy established the “*promot(ion) and protect(ion) of human rights and gender equality*” as a corporate priority (SO3) with five operational objectives; human rights & gender also integrated throughout the Strategy's other three strategic objectives



The Global Fund Strategic Plan for 2023 – 2028 goes further than the previous strategy in highlighting the need to further support for key and vulnerable populations. First, the new Strategy introduces an explicit

GFAN's report in November 2021 called for a \$28.5 billion investment in the Global Fund, and, since the release of the Investment Case, have repeatedly noted and called out this irresponsible gap.

Source: Global Fund Annual Update on Community, Rights and Gender & Strategic Objective 3

PLACE KEY AND VULNERABLE POPULATIONS AT THE CENTER OF EFFORTS TO REDUCE INEQUITIES IN HEALTH CARE ACCESS - FUND THE 'LAST MILE' FIRST.

The 2020 TERG Strategic Review found that there has been limited progress in addressing equity, human rights and gender issues across the Global Fund portfolio, albeit with variation by geography, disease and KVP group. Significant inequities exist in access to health services and health outcomes across the Global Fund's portfolio and particularly by KVP group. These inequities act as a significant constraint to the achievement of Strategic Objective 1 (SO1²⁵) and are driven by social, economic, political, demographic and geographic factors. These issues are difficult to address and require engagement in issues over which the Global Fund often has limited influence. The TERG review reported that the factors driving observed inequities often do not receive sufficient attention in grant and program design, and wide variations in health service access and health outcomes still exist within and across countries. The 2023 – 2028 Strategy recommends that the Global Fund 'use its diplomatic voice' to further progress on these issues. Before it urges others to act on improving the health and rights of key and vulnerable populations, the Global Fund needs to examine its own policies and practices to ensure their investments in this area are, in fact, maximized. Rather than promoting pipe-dreams about ending the epidemics in eight years, the Global Fund's diplomatic voice should be used to highlight the severe and growing inequality in health access created and perpetuated through inadequate funding for global health and through the widespread use of laws that both violate human rights and worsen health outcomes.

The Global Fund should be transparent about inequities within its funding allocations and develop targets and policies to address them.

The Global Fund Community Rights and Gender department (CRG) reported poor success in achieving objectives to improve health equity. In 2020, the Global Fund supported WHO to conduct a comprehensive

analysis on the state of inequality in HIV, TB and malaria in Global Fund supported countries. The analysis found that, on average, equity – especially income equity – is not improving over time²⁶. Such inequity lies at the heart of increased vulnerability of key and vulnerable populations, especially those affected by malaria and TB. The Global Fund cannot solve the overall challenges of inequities in health care access. However, the Global Fund can address these inequities within their own funding allocations. For example, transgender women experience a disproportionately high risk of HIV acquisition, driven by substantial human rights and gender-related barriers and significant unmet HIV prevention needs. Yet, in the 2018 – 2020 implementation period, investments in HIV prevention for transgender people totaled only US\$9.3 million in 37 countries and three regions²⁷. There is also a specific need to scale up investments in overcoming human rights and gender related barriers to accessing TB services. The Challenge Facility for Civil Society is a proven mechanism to do this.

Utilize mechanisms to address funding imbalances when country ownership approaches fail to equitably and adequately address the needs of key and vulnerable populations.

'Country ownership' is not a goal of the Global Fund. It is a principle based on the idea that countries are best able to develop and implement health services approaches that best meet their needs. The goal of the Global Fund is to reduce disease and death from HTM. The Global Fund's primary constituency, therefore, must be the people it is meant to help. Sometimes, the principle of country ownership is the best way to meet these needs. However, sometimes it is not. While the Global Fund has defined 'country ownership' as including all relevant stakeholders in decision making, including civil society and affected communities; governments will, in most cases, have the power and authority to control much of

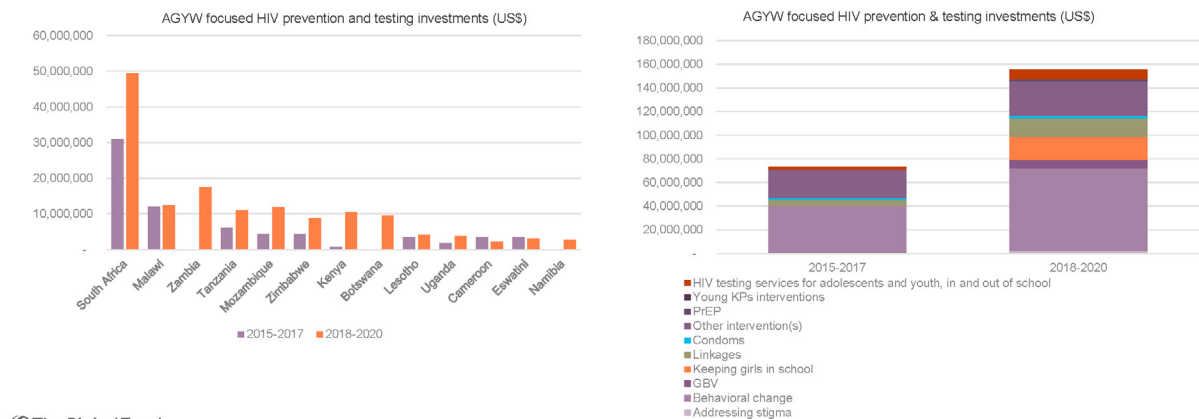
PLACE KEY AND VULNERABLE POPULATIONS AT THE CENTER OF EFFORTS TO REDUCE INEQUITIES IN HEALTH CARE ACCESS - FUND THE 'LAST MILE' FIRST.

what happens. And this is particularly true for key and vulnerable populations, who in so many of the countries affected by HTM remain criminalized, stigmatized, neglected, and abused. The Global Fund needs to reevaluate when and how the principle of country ownership does and does not align with its goals. Without doing so, it will never meet the needs of key and vulnerable populations. Most important, the Global Fund should utilize currently available mechanisms to address these funding imbalances, including dual track financing, regional proposals, special initiatives, pooled funding mechanisms, and catalytic funding. The Global Fund should also insure the participation of key and vulnerable populations throughout the entire grant cycle, not just on the CCM, including priority setting and proposal development, allocation, implementation and evaluation.

Continue efforts to improve and support sexual and reproductive health and rights and increase resources for HTM prevention for women and girls.

Scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights

In the 2018 – 2020 implementation period, AGYW focused investments in HIV prevention and testing increased by **>107%** in the 13 priority countries*



TheGlobalFund

* Data only reflect budgeted investments made in the *Prevention programs for adolescents, in and out of school* module. Methodology for calculating HIV prevention investments is aligned with *implementation* periods; totality of NFM2 investments for some countries therefore not fully represented.

As demonstrated below, the GF Community, Rights and Gender Department (CRG) reported significant progress in both its support for efforts to reach adolescent girls and young women and in positive health outcomes because of those efforts. The TERG review, however, found that progress against gender objectives are below target. Performance against the KVPI focused on gender and age equality (KVPI 8, targeting a reduction HIV incidence in women aged 15-24 years old), is currently below target, reported by the Secretariat as 'at risk'.

Source: Global Fund Annual Update on Community, Rights and Gender & Strategic Objective 3

COMPREHENSIVE DATA ABOUT THE LEVEL OF RESOURCES THAT ARE ALLOCATED TO ADDRESS KEY POPULATION NEEDS, HOW THESE RESOURCES ARE UTILIZED, AND THE OUTCOMES FROM THOSE INVESTMENTS.

In preparing the first Five Year Evaluation of the Global Fund in 2005, the TERG requested data on funding levels to serve key and vulnerable populations and the outcomes from that funding. The Global Fund Secretariat failed to produce that information and has continued that failure to this day. The new Global Fund strategy highlights the need for improved data collection. It is crucial that the Global Fund finally address these glaring gaps in their data. It is not acceptable that the public cannot know how much the Global Fund actually spends on key population services as well as what the outcomes are from these investments; especially critical with the focus in the Strategy and Investment case.

There is no question that funding for prevention, care, treatment, and human rights protection for key and vulnerable populations across the three diseases remains extremely low. And because of the gaps in data, there is no clear or accurate view of (1) the size of these populations, (2) where they are, (3) their rates of infection, (4) what service delivery approaches are most effective at meeting their needs, (5) what it costs to scale these services to sufficient levels, and (6) how much the Global Fund is currently allocating towards meeting their needs.

What is known is that services for key and vulnerable populations often cost more than those for the 'general public'. Countries faced with limited resources will continue to be reluctant to focus on populations that cost more to serve. However, the failure to fund these services will ultimately lead to the continuation of the three epidemics beyond the 2030 target and will ultimately cost more in the long run than investing now in key population needs.

The Global Fund has the potential to provide perhaps the most significant data set available about the needs of and response to the HTM epidemics. Yet, despite the endless reporting it asks of its grantees, the Global Fund has failed to compile, analyze, and make publicly available essential information about both the epidemics and the Global Fund's own efforts to meet its goals.



THE GLOBAL FUND CANNOT SUSTAIN PROGRESS WITHOUT THE ADVOCACY AND COMMUNITY MOBILIZATION THAT AFFECTED COMMUNITIES PROVIDE. INNOVATIVE MECHANISMS ARE NEEDED NOW TO RESOURCE AND SUPPORT THIS ESSENTIAL WORK.

The Global Fund has invested significant amounts of funding over the years to support the engagement of affected communities and civil society in Global Fund governance and grant making processes. Continued support for these functions is essential. But engagement in the workings of the Global Fund is not a substitute for increasing resources for advocacy and community mobilization. That work, particularly at national levels, is what will ensure that Global Fund investments are used properly, that human rights will be protected, and that key and vulnerable populations will get the services they need. The Global Fund should view funding health advocacy and community systems as essential as funding doctors and medicines.

Increase resources for human rights protection and support an independent funding stream for national level health advocacy

The Global Fund strategy reinforces its commitment to strengthening human rights protections. Over the course of the previous strategy, some progress was made toward these goals through the Breaking Down Barriers and other strategic initiatives. But the total resource amounts allocated for this work remain low. A significant increase is required if the Global Fund intends to meet its 2030 targets. But, equally important, is the need to better understand the role that advocacy plays in addressing human rights abuses and inequity. The Strategy acknowledges the value of advocacy and the role that civil society has played to address these challenges. But the Global Fund has failed to embrace innovative funding models for this advocacy work, which, by its nature cannot be funded by or through domestic governments. To be effective, advocacy funding must be independent. Currently, there is no dedicated funding stream to support health advocacy at national levels. Funding for this vital work has only decreased over the past five years.

The Global Fund could support such work through its Dual Track Financing Mechanism. It could also contribute to pooled funding mechanisms to support an independent flow of resources. In fact, the new strategy states that the Global Fund “will also engage in efforts to create pooled funding mechanisms with partners to support civil society legitimacy and advocacy; and contribute to efforts that seek to assess, analyze and reform laws and policies that impede access to services among KVP.” However, in discussions about the development of such a pooled mechanism for health advocacy funding at national levels between a global coalition of community-based health advocates, including members of the Global Fund Board, and Global Fund Director Peter Sands, Sands refused to consider the idea, stating that it would conflict with the principle of country ownership. Perhaps, given the language in the new Strategy, he will reconsider his position.

Ensure the funding for Community Systems Strengthening actually reaches and supports community-led activities

The Global Fund’s Results Report 2021 states that a preliminary analysis of signed grants in the latest cycle shows that approximately US\$827 million was invested in community responses. However, the majority of these investments (US\$740 million) were made in interventions formalized under health systems – including integrated community case management and community health workers. However, the community systems strengthening activities that would most benefit key and vulnerable populations are often based outside of the formal health care systems. The Results report states that direct Resilient and Sustainable Systems for Health (RSSH) investments in community systems strengthening (CSS) outside or partially connected to the formal health sector increased by 145% since the last funding cycle, supporting activities such as community health education, treatment

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adherence support and home care, and community-led social accountability and advocacy. However, the actual amount of those investments is not provided. The TERG report states that very little of the CSS funding has been allocated toward community-led programs.

It is also not clear if and how the Sustainability, Transition and Co-Financing policy has worked to ensure increased funding for key and vulnerable populations in middle-income countries. That policy provides incentives for governments to increase their domestic resources allocations for health. This incentive funding should be used for community systems strengthening, key and vulnerable populations services, and human rights protections. The amount of such funding and the extent to which such funding has been utilized for these areas is not readily available from the Global Fund. Without this data, it is not possible to measure progress or impact.

Build upon the success of the Breaking Down Barriers and the TB Strategic Initiative and scale up support for human rights

The Breaking Down Barriers (BDB) initiative further strengthened the Global Fund's understanding of the human rights environment. The BDB initiative provided US\$45 million in additional funds in 2017-2019 and another US\$41 million in 2020-2022, to 20 countries to scale up evidence-based programming to reduce human rights-related barriers to HIV, TB and malaria services. Countries include: Benin, Botswana, Cameroon, Democratic Republic of Congo (province level), Cote d'Ivoire, Ghana, Honduras, Indonesia (selected cities), Jamaica, Kenya, Kyrgyzstan, Nepal, Mozambique, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda and Ukraine. Baseline assessments of human rights-related barriers to services have been completed in each of these countries, and many have already adopted country-owned, budgeted strategic plans to reduce the barriers identified.

Introduce and scale-up programs that remove human rights barriers to accessing HIV, TB and malaria services

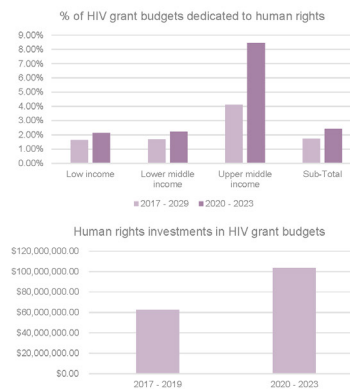
Promoting and protecting human rights has been at the core of the Global Fund's mission since its founding, and was included as strategic objective in both the 2012 – 2016 and 2017 – 2022 strategies

Under the current Strategy, a significant increase in the proportion of grant funding going to human rights interventions has been observed; for countries with signed NFM3 HIV grants, the proportion of budgeted HIV funding going to human rights has increased by **40%** over NFM2 levels (from 1.73% - 2.42%)*

The absolute increase in human rights investments in HIV grant budgets between NFM2 and NFM3 is **>US\$41 million**

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* Calculations for NFM3 grants represent 69% of the total HIV portfolio. These values will change as additional grants are approved in 2021 and 2022.



Source: Global Fund Annual Update on Community, Rights and Gender & Strategic Objective 3

Introduce and scale-up programs that remove human rights barriers to accessing HIV, TB and malaria services

Efforts in the 20 BDB countries led to a **7x increase** in human rights investments in NFM2

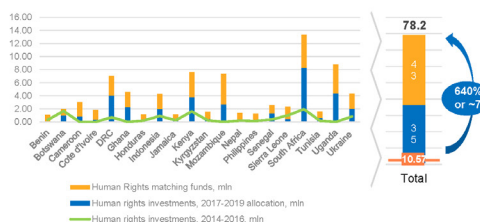
Coupled with the intensive support of the BDB model, the availability of **matching funds** has proven transformative for both increasing GF investments in human rights and fostering **greater country engagement**

This progress appears to be continuing in NFM3; in a **preliminary** analysis of the 13 BDB countries that had TRP approved grants at the end of 2020, human rights investments has increased by **40%**

Early analysis of NFM3 budgets indicates that the decision to make matching funds cross-cutting has helped catalyze a **67% increase** in TB-related human rights investments

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Global Fund investments in programs to reduce stigma & discrimination & increase access to justice, \$ Million of USD, 2017-2019 allocation



Source: Global Fund Annual Update on Community, Rights and Gender & Strategic Objective 3

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In one example from the BDB initiative, the Global Fund supported Mozambique with US\$4.7 million of a human rights matching fund. Mozambique allocated an additional US\$2.7 million from within its HIV allocation to expand programs to address human rights barriers to health²⁸. Mozambique started to invest in a wide range of human rights programs, with a strong focus on integrated community legal empowerment programs through trained peer educators and community paralegals, who monitor, identify and report human rights violations against key and vulnerable populations in TB and HIV.

An independent mid-term progress assessment showed that these activities have started to reduce human rights barriers to accessing services, while supporting people affected by the diseases to stay in care. The work helped secure the release of 45 sex workers who were detained for possession of used condoms. The Centro de Colaboração em Saúde developed a network of

community activists who are trained on human rights and ensure that people living with HIV and people with TB are supported throughout their care by addressing barriers to health and reconnecting them with care.

People who experience human rights barriers are referred to community paralegals or a lawyer for appropriate support. In the second semester of 2020, people made more than 49,000 such visits. Of these, more than 89% were referred to health facilities while more than 95% of them were reintegrated into antiretroviral therapy. To support the country to progress further, the Global Fund invested US\$4.4 million in Mozambique for the 2021-2023 period as part of another human rights matching fund. This time, the country allocated an additional US\$9 million from the HIV and TB allocations to significantly expand community-led monitoring linked to community legal empowerment as well as building human rights trainings for health care workers and law enforcement officers to prevent, identify, and address gender-based violence.

As seen above, the CRG reports that efforts to increase support to address human rights barriers have led to increased investments. However, the 2020 TERG Strategic Review states that for the countries not participating in the BDB, which include many high-impact countries and where there are substantial human rights-related issues, only 29% invested grant funds toward removing human rights-related barriers, and these were typically small. A good example is Ethiopia, a high-impact country well known for denying that MSM exist in the country, and for the absence of programming for this key population. Despite repeated efforts on the

part of the Global Fund and the global community to address this denial, signed grants for the 2017–19 funding cycle include no funding for evidence-based prevention programming for MSM (or transgender or PWID populations), and investment in the removal of human rights-related barriers remains minimal (0.3% of its HIV allocation).

Continue and increase support for community-led monitoring including costs for advocacy to utilize the data and improve health and human rights outcomes

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Community-led monitoring (CLM) refers to service users assessing the effectiveness, quality, accessibility and impact of health programs and services which they receive. CLM includes any type of monitoring led by communities, however a key principle of CLM is that communities decide what to monitor and act upon the data collected. Unlike monitoring led or undertaken by health systems, advocacy based on the evidence and observations gathered is an essential component of community-based monitoring initiatives. The Global Fund's Community-led Monitoring Strategic Initiative was approved in 2020 for implementation in 2021-2023. It provides long-term support to five countries and one regional grant to strengthen the uptake and implementation of community-led monitoring mechanisms across the three diseases while generating evidence and learning on community-led monitoring and impact on health outcomes. However, it is not clear what level of resources are available for this initiative.

CLM can provide important tools for data collection that can then be utilized to support advocacy efforts to ensure equitable and high-quality provision of services, track budget allocations and expenditures, and to strengthen human rights protections. The genesis of this work came from community organizations and networks often led by and serving key and vulnerable populations. The One Impact CLM program for TB is now conducting work in 20 countries. The outcomes of such work can be particularly useful to better understand the state of services, funding, and protection for and of key and vulnerable populations. The danger is if funding for CLM only covers the costs of data collection and analysis and not the advocacy work that allows affected communities to use their data effectively. Without a dedicated funding stream to support national-level health advocacy, CLM can easily turn community advocates into bean counters and stifle their work to make change. Below are examples of CLM projects supported by the Global Fund that have included advocacy components in the work.

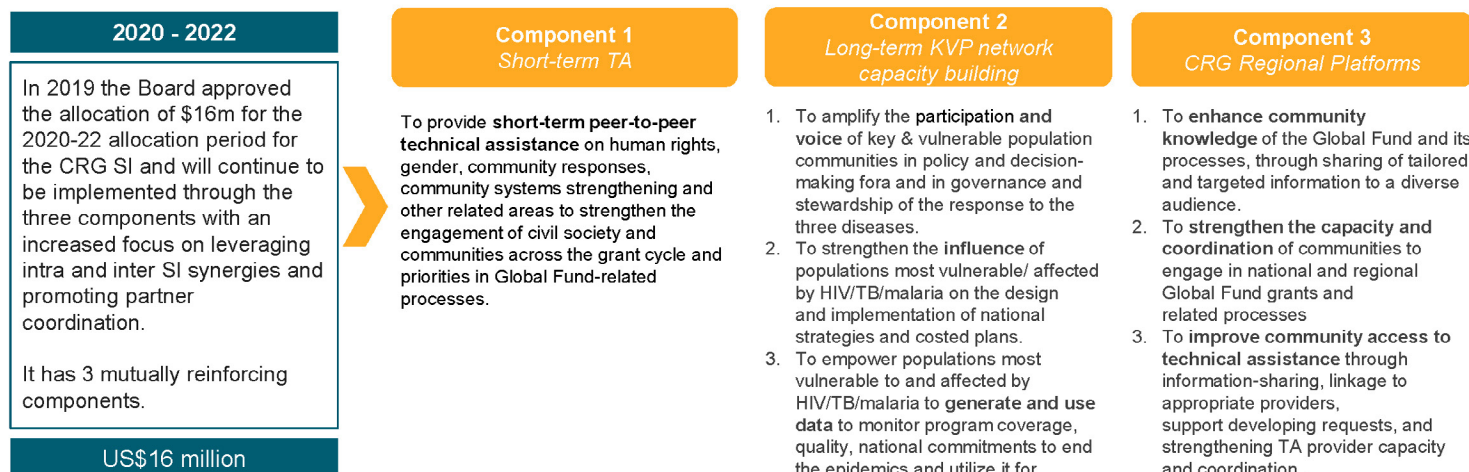
- In Malawi, the **Coalition of Women Living with HIV and AIDS (COWLHA)** monitored the availability and accessibility of TB screening and TB-related testing at a peripheral health center, a district hospital, and a central hospital. Utilizing a variety of data collection tools, COWLHA identified several gaps, including that peripheral health centers continue to use smear microscopy as the initial TB diagnostic test, which is contrary to WHO recommendations to use rapid molecular tests as the initial TB test. The data also showed lack of awareness and inadequate information given to recipients of care and challenges of transportation to clinics. COWLHA is now working with country partners and international partners to mobilize additional financial resources for TB screening and TB-related testing. COWLHA developed an advocacy agenda based on these findings and is now working to improve TB care²⁹.
- The **Uganda Network of Young People Living with HIV AIDS (UNYPA)** implemented a community monitoring initiative to involve young people living with HIV, including adolescent girls and young women, in assessing the accessibility and quality of HIV and sexual health services. Young people and service providers were involved in developing the CLM design, concept note and budget. Data was collected and reported on through meetings with health facility management teams and district health officials. Based on the reports, Jinja Referral Hospital created a youth center, and other clinics boosted their services and staff training so that youth coming in for HIV services have a positive experience and good access to health services³⁰.
- In Jamaica, community-led monitoring is being conducted by several community organizations, including **CVC, JN+, JFLAG, and Transwave**. One focus of the CLM

has been use of community score cards and mystery shopper assessments to track the quality and accessibility of services at the country's 16 largest HIV treatment clinics serving 80 percent of the country's PLHIV. A second focus has been on stigma and human rights violations experienced by key and vulnerable populations in the HIV response. Jamaican CLM implementers developed a unified framework for country coordination of HIV-related CLM activities including a proposed collective country CLM data base, a CLM advocacy roadmap, and a national CLM steering group to provide advice and support for data analysis and evidence-informed advocacy. CLM implementers then worked with the Jamaican Ministry of Health and other government officials to design and establish an agreed data feedback process through which all stakeholders would use regularly updated CLM data for evidence-informed service quality improvements to increase uptake and effectiveness of HIV prevention and treatment services³¹.

The CRG Strategic Initiative is a good start – but not enough to do the job.

To support the meaningful engagement of key and vulnerable populations in Global Fund processes, a \$16 million strategic initiative was launched in 2020 through the CRG at described below.

Through this initiative, the CRG reports an increase in requests for technical assistance. And overall, reports an increase in the engagement of affected communities in the proposal development process. However, there is less engagement of these communities in the grant implementation process and very often, resources initially proposed for community systems strengthening, human rights advocacy, and key and vulnerable populations services are re-allocated for health services³². It is at this stage of the process that the \$28 billion funding gap will most likely undermine resource allocation for key and vulnerable populations.



Source: Global Fund [Annual Update on Community, Rights and Gender & Strategic Objective 3](#)

CONCLUSION: MEETING THE 2030 TARGETS IS NOT THE END OF THE HTM EPIDEMICS: PROVIDE A VISION FOR THE FUTURE

The Global Fund and its technical partners also need to be wary of their own rhetoric about 'ending' the epidemics. Even if the infection reduction targets are met, all three diseases will require on-going investment in treatment and prevention to sustain control. And, given the existing and unchallenged gaps in resources, the likelihood of meeting these targets is low. The Global Fund, UNAIDS, WHO, Stop TB and the Partnership to End Malaria need to start speaking frankly and openly about how we address these epidemics beyond 2030. To not do so is a disservice to the people living with and at-risk from HTM. Without that, we cannot plan responsibly. The Global Fund, its technical partners, donors, implementing countries and civil society all need to participate in developing approaches to address these pandemics for years to come.

We need a vision for the future that is both honest and equitable. That vision can only be advanced unless we start with a realistic view of where we are, what can be achieved now and in the near future. The funding gaps are enormous, but the problem is not money. The problem, as always, is the lack of political will. The heart of the vision we need must be a path that ensures continued and sustained progress against the three diseases, provides universal health care for all, and which recognizes the protection of human rights as a primary health concern.



CREDITS

PROJECT LEAD:

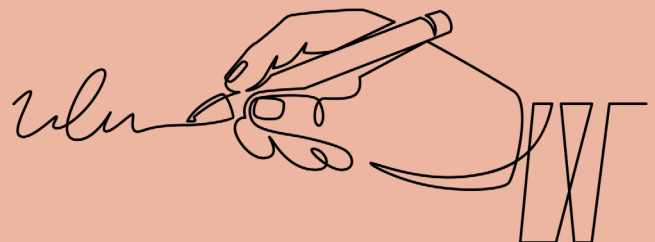
Katy Kydd Wright

EDITING & LAYOUT:

Quentin Batréau and Tara Hogeterp

CONSULTANT/WRITER:

David Barr



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