A QUARTER FOR PREVENTION?

GLOBAL FUND INVESTMENTS IN HIV PREVENTION INTERVENTIONS IN GENERALIZED AFRICAN EPIDEMICS

DISCUSSION PAPER
JUNE 2017

icaso | until **we** end aids | eannaso

TABLE OF CONTENTS

SUGGESTED CITATION

Oberth, G., Torres, M.A, Mumba, O., O'Connor, M. (2017). A Quarter for Prevention? Global Fund Investments in HIV Prevention Interventions in Generalized African Epidemics. Discussion Paper. ICASO & EANNASO. Toronto: Canada; Arusha: Tanzania.

In July 2016, the Joint United Nations Programme on HIV/AIDS (UNAIDS) announced that global efforts to reach fewer than 500,000 new HIV infections by 2020 are off track. Indeed, since 2010, the number of new adult HIV infections has remained unchanged, with an estimated 1.9 million occurring globally each year.

The freeze on prevention progress is occurring at the same time as the world is preparing to achieve ambitious global targets to dramatically reduce new infections and end the epidemic as a public health threat by 2030. In November 2014, UNAIDS set global Fast-Track targets, to accelerate progress against ending AIDS, including goals to reach fewer than 500,000 new adult infections by 2020 and fewer than 200,000 new adult infections by 2030. Based on UNAIDS modeling, ending AIDS will cost an estimated $25 billion each year until 2030. Slightly more than a quarter of this amount (26%) represents resources required for prevention.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a major financier of African HIV responses and a vital source of prevention investments. By 2015, the Global Fund supported 3.6 million pregnant women to receive ARV prophylaxis in order to prevent transmission to their unborn children and distributed 5.3 billion condoms.[1] The Global Fund's new strategy (2017-2022) is aligned to global targets, including the Fast-Track.

Is the Global Fund investing "a quarter for prevention" in Africa?

To answer this question, funding requests and signed grants from a sample of 25 African countries over the 2014-2016 Global Fund funding cycle were examined for their HIV prevention budgets. Of the 25 country sample, funding requests were accessed for 23 countries and signed grant agreements were accessed for 15 countries. Some documents were not publicly available.

Of the 23 funding requests examined, an average of 16% of the total funding requested was dedicated to HIV prevention. 10 countries requested at least "a quarter for prevention", dedicating 26% or more of their total funding requests to HIV prevention interventions. The remaining 13 had prevention requests below 26%. Mauritius' request for prevention was the largest (proportionally), at 67%, and Mozambique's prevention request was the smallest, at 3%.

Of the 15 signed grant agreements examined, an average of 15% of the total funding invested was dedicated to HIV prevention – slightly less than the 16% requested. Just two countries – Botswana and Liberia – had at least 26% of their Global Fund grant budgets dedicated to HIV prevention interventions. Liberia's grant had the largest proportion of HIV prevention funding, at 38%, while Mozambique's had the smallest, at 4%. Among the sample, 71% of HIV prevention funding is implemented by a government Principal Recipient (PR), 24% by a civil society PR, and 5% by a UN agency PR.

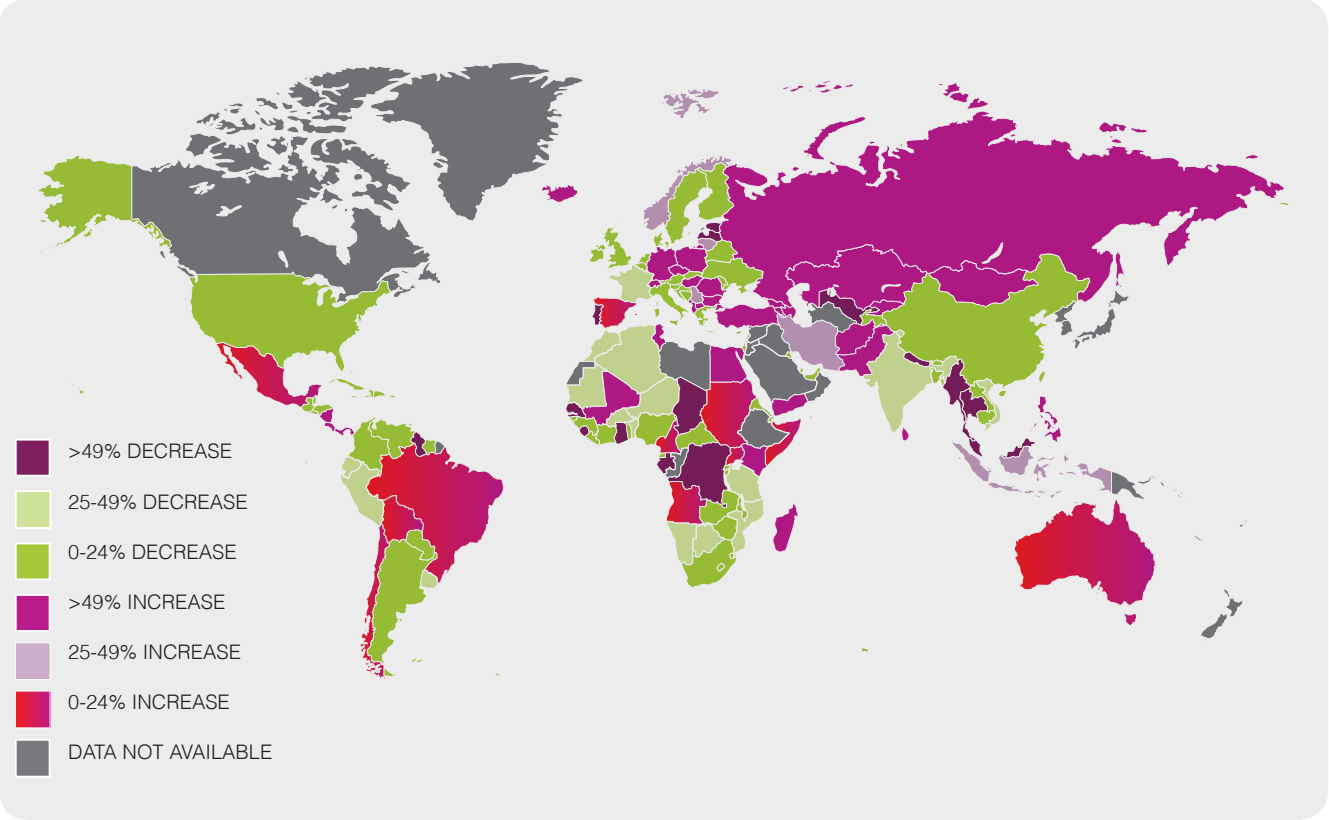
There is a significant correlation between the annual number of new HIV infections in a country and the amount of prevention funding requested from the Global Fund ($r=.782^{**}$, $p=.000$). This suggests that funding requests are largely in line with disease burden. There is also a significant correlation between the wealth of a country, expressed as GDP per capita, and the proportion of funding requested for prevention ($r=.696^{**}$, $p=.000$). This is likely because wealthier countries are able to cover treatment costs with domestic funding, freeing up more of their Global Fund allocation for prevention activities.

In order for the Global Fund to achieve its HIV prevention targets enshrined in its new strategy, there is a need to increase Global Fund investments in HIV prevention in Africa from current levels (approximately 15%) towards the UNAIDS benchmark of 26%. Part of the solution must be to stimulate greater HIV prevention requests from countries. Advocacy from civil society and communities is absolutely vital, particularly on urging countries to request greater HIV prevention funding for key populations and adolescent girls and young women.

INTRODUCTION

In July 2016, the Joint United Nations Programme on HIV/AIDS (UNAIDS) announced that global efforts to reach fewer than 500,000 new HIV infections by 2020 are off track. Indeed, since 2010, the number of new adult HIV infections has remained unchanged, with an estimated 1.9 million occurring globally each year. However, not all countries have experienced static progress on prevention. In sub-Saharan Africa – where 65% of all new infections globally occur - there are stark disparities in prevention progress. For instance, the percent change in new HIV infections from 2005 to 2015 among adults has decreased by more than 49% in the Democratic Republic of Congo and Senegal, yet new infections have increased by the same proportion in Kenya and Madagascar (Figure 1).

FIGURE 1: PERCENT CHANGE IN NEW HIV INFECTIONS AMONG ADULTS (AGED 15 YEARS AND OLDER), FROM 2005 TO 2015[2]



Further disparities exist by population and location. Adolescent girls in South Africa are eight times more likely to contract HIV than their male peers.[3] Sex workers in Ethiopia have an HIV prevalence of 24.3 % - more than 16 times the national adult average of 1.5%.[4,5] In Zimbabwe, HIV incidence is 2.5% in Bulawayo, compared to below 1% in much of the rest of the country.[6]

The freeze on prevention progress is occurring at the same time as the world is preparing to achieve ambitious global targets to dramatically reduce new infections and end the epidemic as a major health threat by 2030. In November 2014, UNAIDS set global Fast-Track targets, to accelerate progress against ending AIDS. The Fast-Track includes ambitious yet attainable treatment, prevention, and discrimination targets (Table 1).

TABLE 1: FAST-TRACK TARGETS FOR ENDING THE AIDS EPIDEMIC

BY 2020	BY 2030
90-90-90 Treatment[7]	95-95-95 Treatment
Fewer than 500,000 new adult infections	Fewer than 200,000 new adult infections
zero discrimination	zero discrimination

Achieving the Fast-Track targets is estimated to avert 28 million HIV infections between 2015 by 2030. This is modelled to deliver a 15–fold return on HIV investments, including saving $24 billion in additional HIV treatment costs based on infections averted.[8]

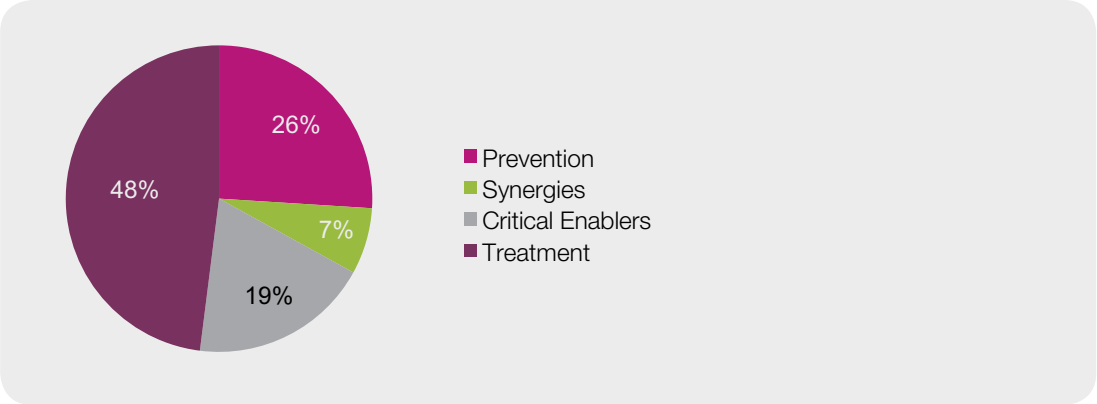
Much of the focus on the Fast-Track agenda has centred on the first set of targets (90-90-90). While treatment scale-up is critical, it is not the whole picture. In fact, fully achieving the 90-90-90 treatment targets is expected to avert about 60% of all new HIV infections by 2020. The remaining 40% of new HIV infections have to be averted through other prevention methods.[9]

Many African countries have embraced the second set of Fast-Track targets, focusing on HIV prevention. Kenya's HIV Prevention Revolution Road Map is a detailed sub-national location-based plan for targeted prevention interventions.[10] Zimbabwe's Roadmap to Revitalize HIV Prevention has seven strategies for revitalizing prevention[11] towards zero new infections by 2030, including ensuring adequate resources are set aside for prevention. South Africa's National Sex Worker HIV Plan aims to reach 70,000 sex workers and ensure that at least 95% of them use condoms with their clients and partners and that gender-based violence falls by 50%.[12]

The 2016 UN Political Declaration on HIV and AIDS enshrines the Fast-Track targets as binding national commitments.[13] In the declaration, countries commit to: redouble non-discriminatory HIV-prevention efforts; accelerate efforts to scale up scientifically accurate age-appropriate comprehensive education; saturate areas with high HIV incidence with combination prevention interventions; ensure that the needs and human rights of persons with disabilities are taken into account; and eliminate barriers, including stigma and discrimination in health-care settings. Importantly, the Declaration also encourages countries to ensure that financial resources for prevention are adequate, constituting no less than a quarter of AIDS spending globally on average, and are targeted to evidence-based prevention measures.

Based on UNAIDS modeling, the costs of achieving the Fast-Track agenda is estimated to require an average of $25 billion each year until 2030. 26% of these resource needs are for prevention (Figure 2).

FIGURE 2: GLOBAL RESOURCE NEEDS FOR THE AIDS RESPONSE BY 2020[14]



The majority of new HIV infections occur in sub-Saharan Africa, yet domestic funding for HIV prevention from African governments is not commensurate. The region is largely dependent on external donors to pay for HIV information campaigns, condom distribution, voluntary medical male circumcision (VMMC) and outreach to young people and key populations.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a major financier of African HIV responses and a vital source of prevention investments. By 2015, the Global Fund supported 3.6 million HIV-positive pregnant women to receive ARV prophylaxis in order to prevent transmission to their unborn children and distributed 5.3 billion condoms.[15] In that same year, 65% of all Global Fund resources went to sub-Saharan African countries.

The Global Fund's Strategy (2017-2022) is aligned to global targets, including the Fast-Track targets presented in Table 1. In addition, there are several corporate key performance indicators (KPIs) that the Global Fund has set in relation to HIV prevention (Table 2).

TABLE 2: GLOBAL FUND KEY PERFORMANCE INDICATORS FOR PREVENTION IN 2017-2022 STRATEGY[16]

HIV PREVENTION INDICATOR	GLOBAL FUND TARGET
Percentage reduction in new infections/cases (average rates across the three diseases)	38% (28-47%) over the 2015-2022 period
Number of males circumcised	22 (19-26) million over the 2017-2022 period
Coverage of key populations reached with evidence-informed package of treatment and prevention services appropriate to national epidemiological contexts	75% of selected countries by 2019
Percentage reduction in HIV incidence in women aged 15-24	58% (47-64%) over the 2015-2022 period
Percentage of investment in signed HIV and HIV/TB grants dedicated to programs targeting key populations	39% over the 2017- 2019 period

While the Global Fund does not have a target on HIV prevention spending, there are two key performance indicators related to specific budget allocations in signed grants:

- Investment in signed HIV and HIV/TB grants dedicated to programs to reduce human rights barriers to access to reach 2.85% over the 2017- 2019 period.
- Investment in signed HIV and HIV/TB grants dedicated to programs targeting key populations to reach 39% over the 2017- 2019 period.

In light of the global Fast-Track targets, the suggested prevention spending (26%) and the importance of Global Fund investments in prevention in Africa, it is relevant to ask: is the Global Fund investing “a quarter for prevention”? Given the Fund’s new Strategy and its ambitious HIV prevention KPIs, it is necessary to examine this question in an ongoing manner, to ensure the Fund achieves its objectives and the Fast-Track agenda becomes a reality.

BACKGROUND AND CONTEXT

In HIV, burden of disease is typically expressed in terms of prevalence. Yet, it is equally important to look at prevention indicators (numbers and rates of new infections, rates of condom use) in order to assess the state of prevention and gaps in a given country (Table 3).

TABLE 3: COUNTRY EPIDEMIOLOGICAL PROFILES – HIV PREVENTION INDICATORS (2015)[17]

COUNTRY	NUMBER OF NEW INFECTIONS	INCIDENCE RATE %	NUMBER OF MALE CIRCUMCISIONS PERFORMED	CONDOM USE AT LAST SEX AMONG PEOPLE (15-49) WITH MULTIPLE SEXUAL PARTNERSHIPS %	KNOWLEDGE ABOUT HIV PREVENTION AMONG YOUNG PEOPLE (15-24) %
ANGOLA	26,000	0.19	No data	No data	No data
BOTSWANA	9700	0.94	15,722	No data	No data
CAPE VERDE	<200	0.06	No data	No data	No data
ETHIOPIA	No data	No data	No data	0	28.35
GHANA	13,000	0.08	No data	17.5	22.2
GUINEA-BISSAU	No data	No data	No data	No data	22.3
KENYA	78,000	0.35	207,014	0	No data
LESOTHO	18,000	1.88	25,966	46.4	35.5
LIBERIA	1600	0.06	No data	20.7	33.5
MADAGASCAR	6300	0.05	No data	2.0	33.9
MALAWI	33,000	0.38	108,672	35.4	41.9
MAURITIUS	<500	0.04	No data	50.7	31.8
MOZAMBIQUE	81,000	0.71	198,340	26.9	34.9
NAMIBIA	7800	0.68	18,549	No data	58.3
NIGERIA	No data	No data	No data	64.5	24.4
SIERRA LEONE	2500	0.07	No data	9.6	29.1
SOMALIA	3000	0.05	No data	No data	No data
SOUTH AFRICA	380,000	1.44	485,552	No data	No data
SOUTH SUDAN	15,000	0.22	No data	No data	No data
SWAZILAND	11,000	2.36	12,952	71.53	55.96
TANZANIA	54,000	0.21	435,302	No data	43.4
UGANDA	83,000	0.51	556,546	30.1	38.4
ZAMBIA	60,000	0.85	222,481	27.1	43.9
ZANZIBAR	No data	No data	No data	No data	No data
ZIMBABWE	64,000	0.88	188,732	44.3	54.7

The effect of looking at absolute numbers is revealing for the prevention agenda. There are more than twice as many new HIV infections in Angola - a relatively muted country in terms of discussions around HIV - as compared to Botswana, one of the most oft cited, oft studied, examples. Even South Sudan has 50% more new infections each year than Botswana does.

Swaziland's incidence rate should also give pause, given it is five times higher than the average among this sample of African countries. Even among countries with similar population sizes and HIV prevalence rates, like Lesotho and Botswana, Swaziland is set starkly apart in terms of rates of new infections.

But perhaps most gravely, the number of new infections in South Africa ought to astound – 380,000 each year.

At the recent expert meeting to Fast-Track HIV prevention implementation in 15 Fast-Track countries, held on 23-24 March 2017 in Victoria Falls, Zimbabwe, the acting Executive Director of the Global Fund, Marijke Wijnroks, presented a call to action on HIV prevention. Indeed, one of the key objectives of the meeting was to explore opportunities for increasing investments for HIV prevention in the East and Southern African region including through the upcoming Global Fund applications for the 2017-2019 funding cycle.

Despite African countries' acknowledgement of prevention as a priority, and the commitment of partners like the Global Fund towards supporting such initiatives, challenges persist with translating rhetoric into reality. Competing demands on stretched HIV budgets and restrictive legal and policy environments potentially limit the ability of the Global Fund to invest in the fast-tracking of prevention in Africa. Some barriers to increasing Global Fund HIV prevention investments are listed here:

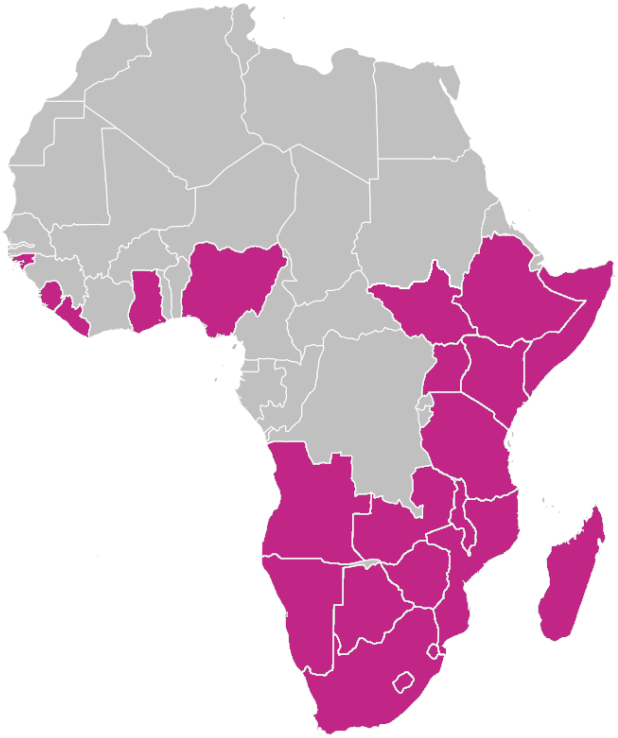
- **In many African countries, Global Fund grants are often highly commoditized, limiting the opportunities for prevention scale-up within country allocations.** For instance, in Mozambique's current grants, 87% of the $222.5 million total is dedicated solely to the treatment, care and support budget module. In Zimbabwe's most recent funding request (for the 2017-2019 funding cycle), about 70% of the $630 million request had to be dedicated to the procurement of essential medicines and health products, and a further 20% had to go towards retaining critical human resources for health and program management. These squeezes on a country's allocation leave very little room for HIV prevention to be prioritized.

- **Key populations are often criminalized, limiting (or even at times prohibiting) Global Fund prevention investments among these high-risk groups.** Research has also shown that criminalization of same-sex behaviour is linked to implausibly low size estimates and inaccurate service coverage data.[18] This negatively effects fast-tracking of prevention. In Tanzania, the government has suspended certain specific Global Fund prevention programs for men who have sex with men citing "the countries' laws, customs and traditions" in an official statement.[19]

- **There is not always a clear picture of whether "a quarter for prevention" is being invested.** There is scant analysis and budget tracking which focuses solely on prevention funding for HIV, which limits the impact of advocacy for increased funding.

METHODOLOGY

A search was performed for HIV and TB/HIV Global Fund signed grant agreements from a sample of 25 African countries over the 2014-2016 funding cycle.



25 AFRICAN COUNTRIES INCLUDED IN THE STUDY SAMPLE

- Angola
- Botswana
- Cape Verde
- Ethiopia
- Ghana
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mauritius
- Mozambique
- Namibia
- Nigeria
- Sierra Leone
- Somalia
- South Africa,
- South Sudan
- Swaziland
- Tanzania
- Uganda
- Zambia
- Zanzibar
- Zimbabwe.

These 25 African countries were selected based on several factors:

1. Disease burden, with a balance of higher prevalence and lower prevalence countries.
2. Countries which are predominantly English-speaking and Portuguese-speaking (the focus of ICASO and EANNASO's work in Africa).
3. Availability of data, with countries that did not follow the Global Fund's modular approach excluded (i.e. Rwanda).
4. A regional balance, including countries from East, West and Southern African countries.

Of the 25 country sample, funding requests were accessed for 23 countries. Seventeen[20] funding requests were accessed from the Global Fund's website and 6[21] were accessed directly from country partners (as they were not publicly available online). Signed grant agreements were accessed for 15 countries.[22] Some of the grant agreements were not publicly available from the Global Fund's website, while others were scanned to a very poor resolution and had illegible budgets.

The 23 funding requests and 15 signed grant agreements were then examined for their HIV prevention budgets. For the funding requests, the analysis includes both allocation and above allocation requests. HIV prevention budgets are defined as prevention service delivery modules.

Global Fund Budget Modules included in Study Definition of "HIV Prevention"[23]

- Prevention programs for general population
- Prevention programs for men who have sex with men and transgender populations
- Prevention programs for sex workers and their clients
- Prevention programs for people who inject drugs and their partners
- Prevention programs for other vulnerable populations
- Prevention programs for adolescents and youth, in and out of school

It is acknowledged that funding in other Global Fund budget modules may contribute directly or indirectly to HIV prevention. For instance, funding for ART under the treatment, care and support module has a preventive effect, as many studies have shown that treatment scale-up for people living with HIV can help prevent new infections to their sexual partners. Further, funding under the community systems strengthening or removing legal barriers budget modules may impact HIV prevention efforts. Despite this acknowledgement, only direct prevention service delivery modules were included in this analysis in order to be as systematic as possible.

To give depth to the results, several epidemiological and structural variables were explored along with discussion themes around specific prevention priorities and the role of civil society and communities. Epidemiological and structural variables on HIV incidence rate, number of new infections, condom use, number of male circumcisions and youth knowledge on HIV (recall Table 3), number of people on ART and the wealth of a country were tested using statistics analysis software SPSS, to see if they are associated with levels of HIV prevention funding in funding requests and signed grant agreements. Other discussion themes were explored using qualitative methodologies.

RESEARCH QUESTIONS

1. Are African countries requesting "a quarter for prevention" in their Global Fund funding requests?
2. Is the Global Fund investing "a quarter for prevention" in African HIV and TB/HIV grants?
3. What proportion of prevention funding that is requested gets included in signed grants?
4. Is the Global Fund's current HIV prevention spending higher or lower than in the past?
5. Is the amount of prevention funding requested/granted explained by any epidemiological or economic factors (HIV incidence, country income status, etc.)
6. What is the role of civil society and community groups in the Global Fund's prevention agenda?

RESULTS

Analysis of Funding Requests

Of the 25 country sample, 23 HIV and TB/HIV funding requests were accessed, either through the Global Fund's website or directly from country partners. The 23 countries requested a total of $4,259,233,917 in their HIV or HIV/TB funding requests. Of this amount, $668,662,399 was requested for prevention modules, representing 16% of total funds requested. The largest proportion was for prevention among the general population, with $361,541,418 requested for this module. This is followed by prevention programs for adolescents and youth, in and out of school, at $132,345,794. Amounts requested for key populations, including sex workers, men who have sex with men, transgender people, and people who inject drugs, were far lower. Annex 1 presents the full data from this analysis.

Among the 23 countries examined, 10 countries requested "a quarter for prevention", dedicating at least 26% of their total funding requests to HIV prevention interventions (as per the UNAIDS recommended target). The remaining 13 had prevention requests below 26%. See Table 4 for each country's prevention request, expressed as a proportion of their total HIV or HIV/TB funding request to the Global Fund during the 2014-2016 funding cycle.

TABLE 4: PROPORTION OF 2014-2016 GLOBAL FUND FUNDING REQUESTS DEDICATED TO HIV PREVENTION INTERVENTIONS

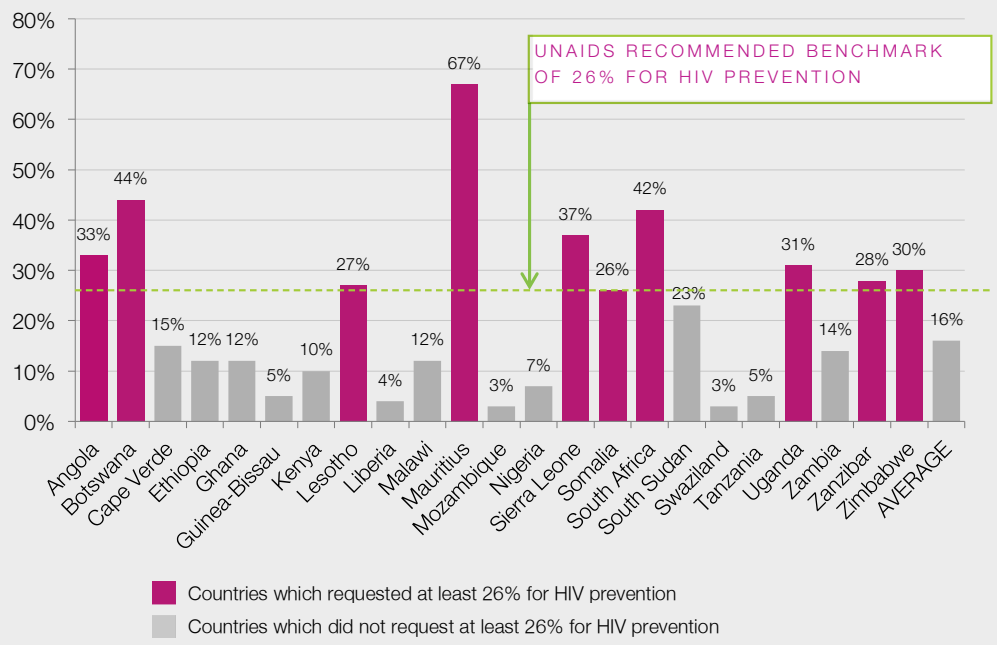
COUNTRIES THAT DID REQUEST "A QUARTER FOR PREVENTION"		COUNTRIES THAT DID NOT REQUEST "A QUARTER FOR PREVENTION"	
Angola (33%)	South Africa (42%)	Cape Verde (15%)	Malawi (12%)
Botswana (44%)	Uganda (31%)	Ethiopia (12%)	Mozambique (3%)
Lesotho (27%)	Zanzibar (31%)	Ghana (12%)	Nigeria (7%)
Mauritius (67%)	Zimbabwe (30%)**	Guinea-Bissau (5%)	South Sudan (23%)
Sierra Leone (37%)*		Kenya (10%)	Swaziland (3%)
Somalia (26%)		Liberia (4%)*	Tanzania (5%)
			Zambia (17%)
Madagascar (No data)			
Namibia (No data)			

** Abbreviated funding request submitted due to Ebola outbreak*

*** Refers to the country's 2015 incentive funding request, not the early application in 2013*

While a relatively even number of countries did request a quarter for prevention (10) versus did not request it (13), Figure 3 makes it is clear that there are extreme variations among countries in terms of how much was requested.

FIGURE 3: PROPORTION OF 2014-2016 HIV AND TB/HIV GLOBAL FUND FUNDING REQUESTS DEDICATED TO HIV PREVENTION INTERVENTIONS



The largest absolute prevention request came from Uganda, which requested $154,936,410 for prevention. This was largely driven by an above allocation request for prevention programs for the general population ($127,795,597).

The largest proportional request for prevention came from Mauritius, which directed 67% of its total funding request to prevention programs. The next highest proportional request for HIV prevention came from Botswana, at 44%. South Africa is third, at 42%. As countries with an upper-middle income status, the Global Fund requires Mauritius, Botswana and South Africa to demonstrate that their funding requests focus 100% of the budget on underserved and most-at-risk populations and/or highest-impact interventions. Lower-middle income countries must demonstrate that at least 50% of the budget goes to these areas.

The smallest absolute prevention request came from Cape Verde, which requested $355,922 for prevention. As the smallest country in the sample in terms of population size, and the country with the smallest Global Fund allocation amount, this is not surprising. The smallest proportional requests for HIV prevention programs came from Mozambique (3.1%) and Swaziland (3.5%). PEPFAR is a large investor in HIV prevention in Mozambique and Swaziland, which may have an impact on the prevention gaps that remain to be funded by Global Fund.

Analysis of Signed Grant Agreements

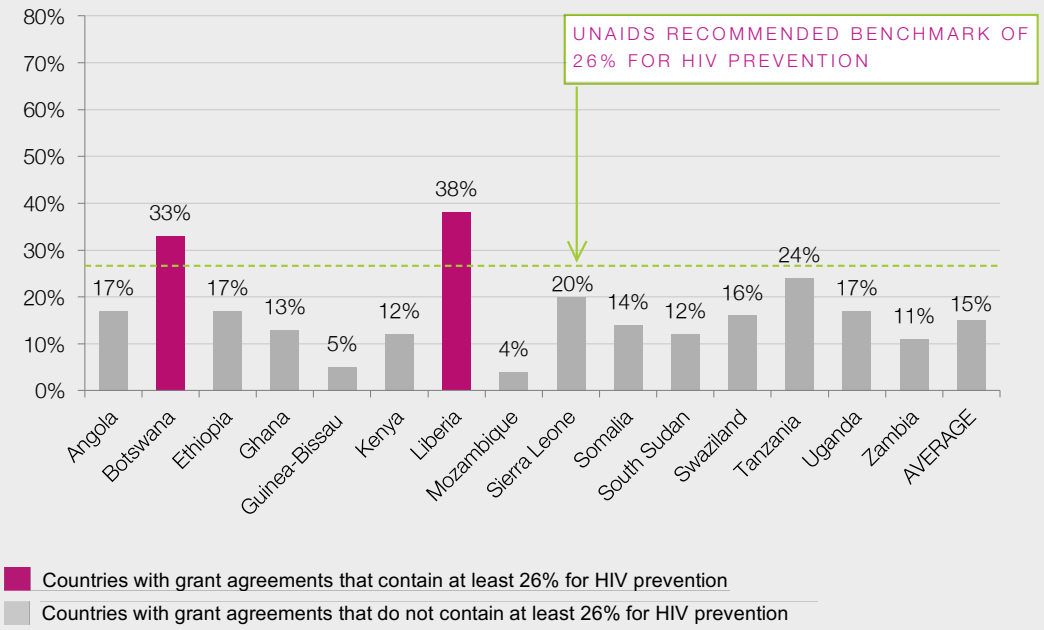
Of the 25 countries included in this study, 15 have publicly available signed grant agreements that are accessible from the Global Fund's website. The proportion of funding in these signed grant agreements that is dedicated to HIV prevention activities is presented in Table 5.

TABLE 5: PROPORTION OF COUNTRIES 2014-2016 GLOBAL FUND SIGNED GRANT AGREEMENTS WHICH ARE DEDICATED TO HIV PREVENTION INTERVENTIONS

COUNTRIES WHERE THE GLOBAL FUND IS INVESTING "A QUARTER FOR PREVENTION"	COUNTRIES WHERE THE GLOBAL FUND IS NOT INVESTING "A QUARTER FOR PREVENTION"	
Botswana (33%)	Angola (17%)	Somalia (14%)
Liberia (38%)	Ethiopia (17%)	South Sudan (12%)
	Ghana (13%)	Swaziland (16%)
	Guinea-Bissau (5%)	Tanzania (24%)
	Kenya (12%)	Uganda (17%)
	Mozambique (4%)	Zambia (11%)
	Sierra Leone (20%)	
Cape Verde (No data)		
Lesotho (No data)		
Madagascar (No data)		
Malawi (No data)		
Mauritius (No data)		
Namibia (No data)		
Nigeria(No data)		
South Africa (No data)		
Zanzibar (No data)		
Zimbabwe (No data)		

In just two of these countries – Botswana and Liberia – at least a quarter of the HIV or HIV/ TB signed Global Fund grant(s) for the 2014-2016 cycle is dedicated to HIV prevention interventions (Figure 4).

FIGURE 4: PROPORTION OF COUNTRY'S 2014-2016 HIV AND TB/HIV GLOBAL FUND SIGNED GRANT AGREEMENTS THAT IS DEDICATED TO HIV PREVENTION INTERVENTIONS



Overall, across the 15 countries assessed, 69% of the prevention funding that was requested got included in signed grants. In actual figures, $381,267,152 was requested for prevention, and $262,657,839 was included in signed grants. This means that 31% of potential prevention funding is "lost" between the submission of the funding request and the signing of the grants. In dollars, this represents an $118,609,313 "leak" of potential prevention funding during the grant-making stage. Of course, many countries requested significant portions of above allocation prevention funding, which is unlikely to be funded given limited Global Fund resources. Further, some of the requested funding might have been for interventions that the Technical Review Panel did not deem technically sound. Annex 2 and 3 present the full data from this analysis.

Among the sample, four countries – Angola, Sierra Leone, Somalia and Uganda – requested "a quarter for prevention" In their funding requests, yet their signed grants ended up being below the 26% threshold recommended by UNAIDS. The sharpest decline in prevention funding between the request and the grant occurred in Angola: 33% of the funding request was dedicated to HIV prevention interventions, yet just 17% of the signed grant is.

On the flipside, one country – Liberia – did not request "a quarter for prevention", yet its final grant includes prevention interventions worth more than 26% of the total. In fact, Liberia requested just 4% for HIV prevention, yet its signed grant contains 38% HIV prevention funding. Figures 5 and 6 present the variations between the amounts of HIV prevention funding that was requested by countries versus what was included in signed grants.

FIGURE 5: TOTAL AMOUNT OF HIV PREVENTION FUNDING IN GLOBAL FUND FUNDING REQUESTS AND SIGNED GRANT AGREEMENTS IN 15 AFRICAN COUNTRIES (2014-2016 FUNDING CYCLE), BY COUNTRY

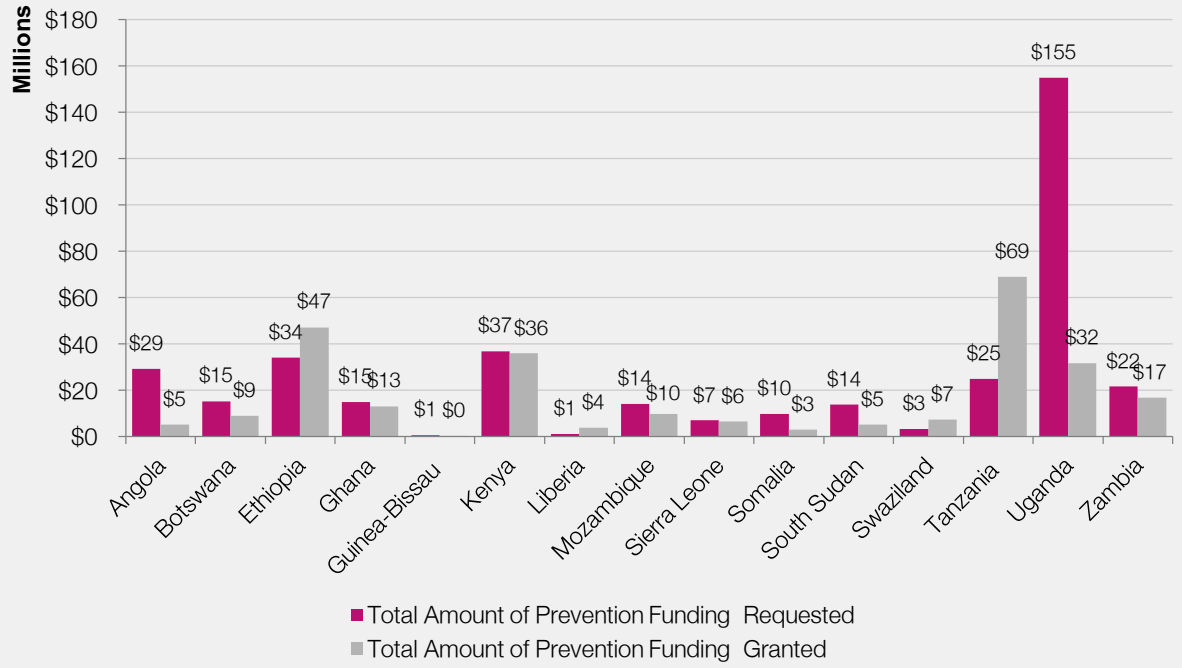
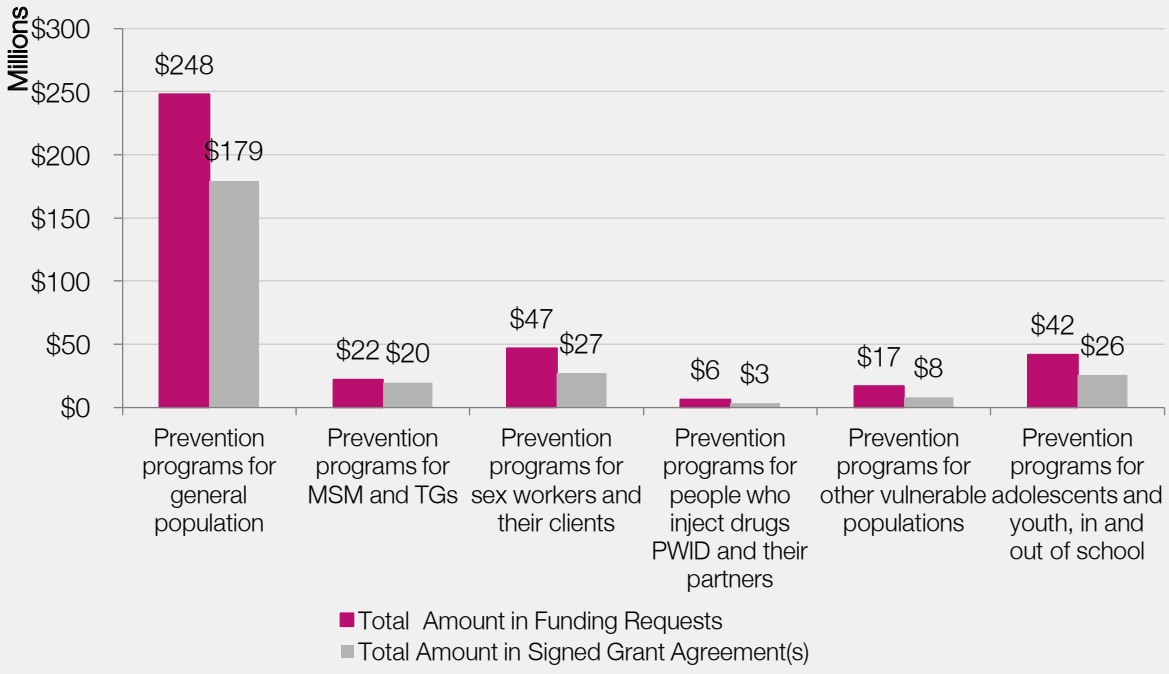


FIGURE 6: TOTAL AMOUNT OF HIV PREVENTION FUNDING IN GLOBAL FUND FUNDING REQUESTS AND SIGNED GRANT AGREEMENTS IN 15 AFRICAN COUNTRIES (2014-2016 FUNDING CYCLE), BY MODULE



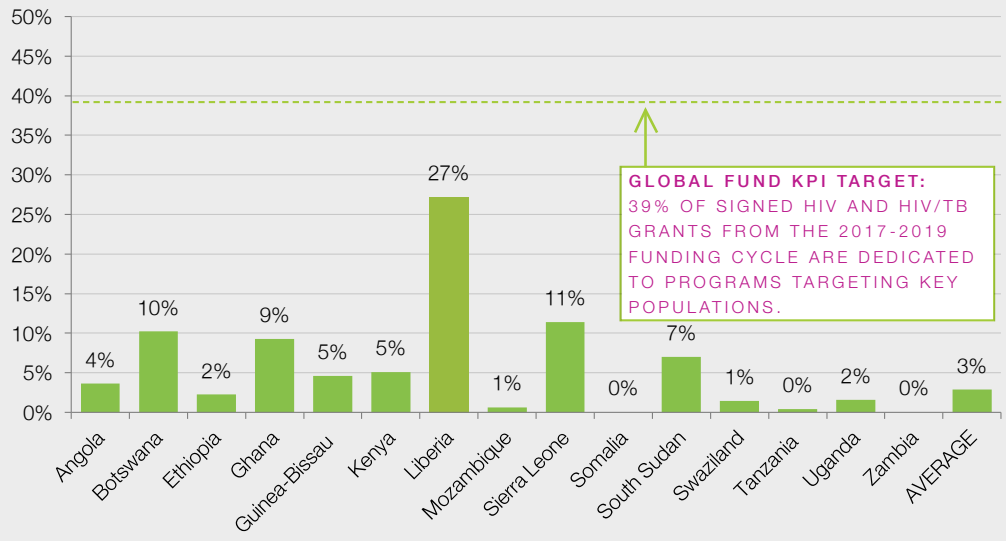
Proportionally, prevention funding for key populations – defined here as men who have sex with men, tansgender people, sex workers and people who inject drugs – was slightly less likely to get included in signed grants than prevention funding overall. Key populations are defined by UNAIDS as sex workers, men who have sex with men, transgender people, people who inject drugs and prisoners. This analysis is not able to disaggregate funding for prisoners, so it only includes the first four groups in its use of this term. Looking at the 15 countries where both funding requests and grants were available, $75,033,149 was requested for key populations and $50,112,666 was included in signed grants. This translates to 67% of key population prevention funding that was requested being included in signed grants – slightly less than the 69% across all prevention interventions.

TABLE 6: FUNDING REQUESTED AND FUNDING INCLUDED IN GRANTS FOR HIV PREVENTION AMONG KEY POPULATIONS FOR THE 2014-2016 GLOBAL FUND FUNDING CYCLE IN 15 AFRICAN COUNTRIES

	PREVENTION PROGRAMS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE	PREVENTION PROGRAMS FOR SEX WORKERS AND THEIR CLIENTS	PREVENTION PROGRAMS FOR PEOPLE WHO INJECT DRUGS AND THEIR PARTNERS	TOTAL
FUNDING REQUESTED	$22,071,005	$46,895,293	$6,066,851	$75,033,149
FUNDING INCLUDED IN SIGNED GRANT(S)	$19,805,824	$27,039,964	$3,266,878	$50,112,666

The fact that this analysis shows that 33% of potential key populations prevention funding is "lost" during grant-making, is not promising for the Global Fund's target and key performance indicator for key populations funding. The Global Fund aims to have investments in signed HIV and HIV/TB grants dedicated to programs targeting key populations reach 39% over the 2017- 2019 period (recall Table 2). This analysis shows that less than 3% - $50,846,315 out of $1,747,483,074 – is currently being invested in HIV prevention among men who have sex with men, transgender people, sex workers and people who inject drugs in 15 African countries. Of course, the Global Fund's target speaks to treatment for key populations, as well as interventions to address social and structural barriers these groups face, but the difference between current prevention investments and the 2017-2019 investment target of 39% is striking nonetheless (Figure 7).

FIGURE 7: PROPORTION OF FUNDING IN HIV AND HIV/TB GLOBAL FUND GRANTS DEDICATED TO HIV PREVENTION AMONG MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE, SEX WORKERS AND PWID (2014-2016 FUNDING CYCLE)

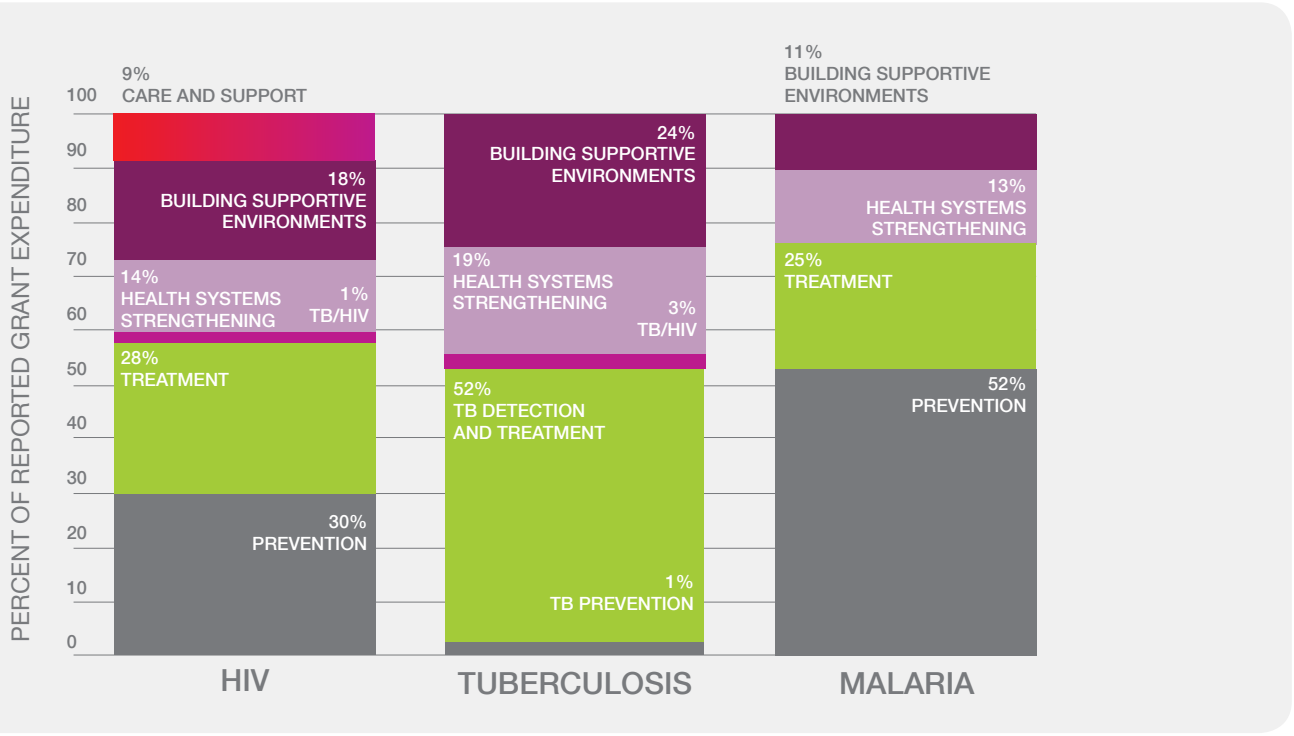


DISCUSSION

Trend Analysis

Among 23 African HIV and TB/HIV funding requests to the Global Fund in the 2014-2016 funding cycle, countries dedicated an average of 16% of their budgets to HIV prevention interventions. Among the signed grant agreements in 15 African countries (a subset of the 23), the Global Fund invests slightly less in HIV prevention than what was requested – 15%. While this is below the UNAIDS recommended level of 26%, it is relevant to understand if this is an increase or a decrease from previous years. A trend analysis shows that historical Global Fund investments in HIV prevention were higher than they are now. Cumulative Global Fund grant expenditure on HIV prevention from 2002-2011 was 30% of all HIV spending (Figure 8).[25] This is higher than the funding requests and grant agreements examined in this sample (16% and 15%, respectively) and higher than the UNAIDS recommended level (26%).

FIGURE 8: CUMULATIVE GLOBAL FUND GRANT EXPENDITURES BY AREA AND DISEASE (2002-2011)[26]



One reason why current prevention spending is lower (among this sample) than historical spending (2002-2011) is that millions more people now require sustained antiretroviral therapy, much of which is procured through Global Fund grants. This leaves less money for prevention.

Another important consideration is that many of the grants in this sample are integrated TB/HIV grants, and UNAIDS' 26% for HIV prevention recommendation uses a denominator of HIV funding only. To (crudely) control for this, one can adjust the total grant budget (the denominator) by the average disease split across Global Fund grants (51% HIV, 18%

TB and 31% malaria). This means that on average, TB/HIV grants are 74% HIV funding and 26% TB funding. With the adjusted denominator, the average HIV prevention funding in the signed grant agreements among the 15 countries examined is 20% - still well below the 26% benchmark.

Explanatory Variables

Epidemiological data from these countries helps to explain the amount of prevention funding that is requested and granted. There is a significant correlation between the number of new HIV infections which occur in a country per year, and the amount of HIV prevention funding that the country requested from the Global Fund in the 2014-2016 funding cycle (Figure 9); countries with more new infections requested more prevention funding. This is a very strong correlation (r=.782**, p=.000). See Box 1 for a basic explanation. However, this relationship is heavily skewed by South Africa, as an extreme outlier in terms of number of new infections. Removing South Africa as an outlier, the relationship between new infections and prevention funding requested still remains significant (r=.570*, p=.013). This means that the greater the number of annual new infections in a country, the more money that country requested for HIV prevention interventions from the Global Fund. In this sample, it appears that countries' funding requests for prevention are in line with their disease burden.

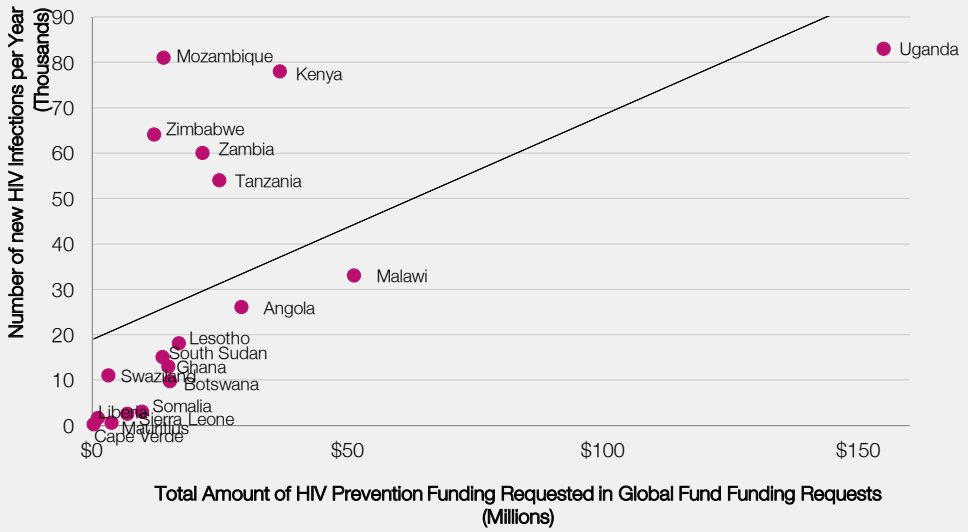
BOX 1

In statistics, the correlation coefficient "r" measures the strength and direction of a linear relationship between two variables. The value of r is always somewhere between +1 and –1. For instance, an "r" coefficient of:

- Exactly –1 = A perfect negative linear relationship
- Exactly 0 = No linear relationship at all
- Exactly +1 = A perfect positive linear relationship

The "p" value measures the statistical significance of the "r" coefficient. Numbers which have asterisks beside them are of statistical significance, meaning they pass certain confidence tests that conclude the relationship is not a random one. Those with two asterisks have the strongest relationships.

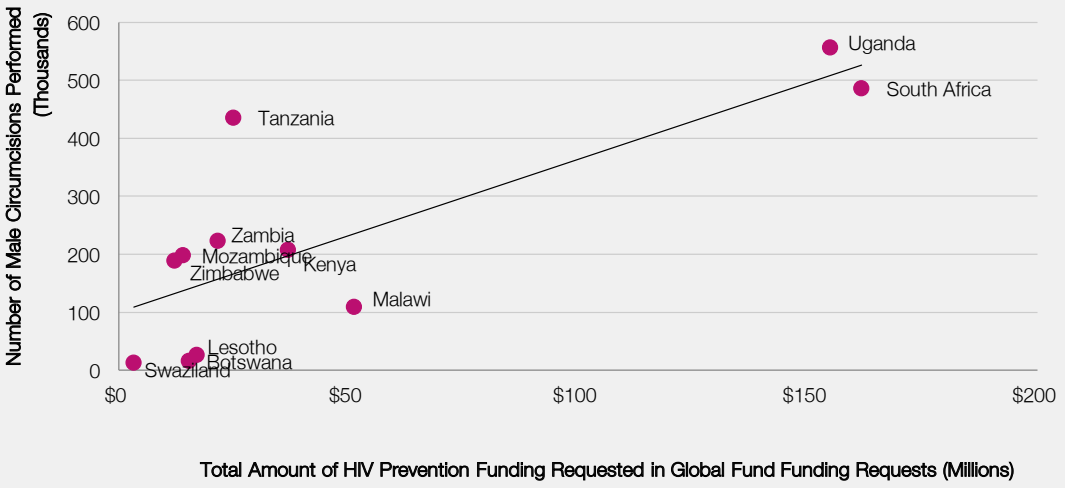
FIGURE 9: CORRELATION BETWEEN NUMBER OF NEW HIV INFECTIONS AND AMOUNT OF HIV PREVENTION FUNDING REQUESTED IN GLOBAL FUND FUNDING REQUESTS (2014-2016 FUNDING CYCLE) (r=.570*, p=.013)



The correlation between the number of new infections and the amount of prevention funding included in signed grants is also significantly correlated, and even more strongly (r=.582*, p=.037). This means that the greater the number of annual new infections in a country, the more money in signed grant agreements for HIV prevention interventions.

There is also a strong correlation between the number of male circumcisions performed in a country and the total amount of HIV prevention funding it requested from the Global Fund in the 2014-2016 funding cycle. Among the 11 countries in this sample for which there is data on both indicators, countries that have performed a greater number of male circumcisions also requested more HIV prevention funding (Figure 10). This suggests that the number of male circumcisions performed could be an indication of how strongly a country prioritizes investments in HIV prevention.

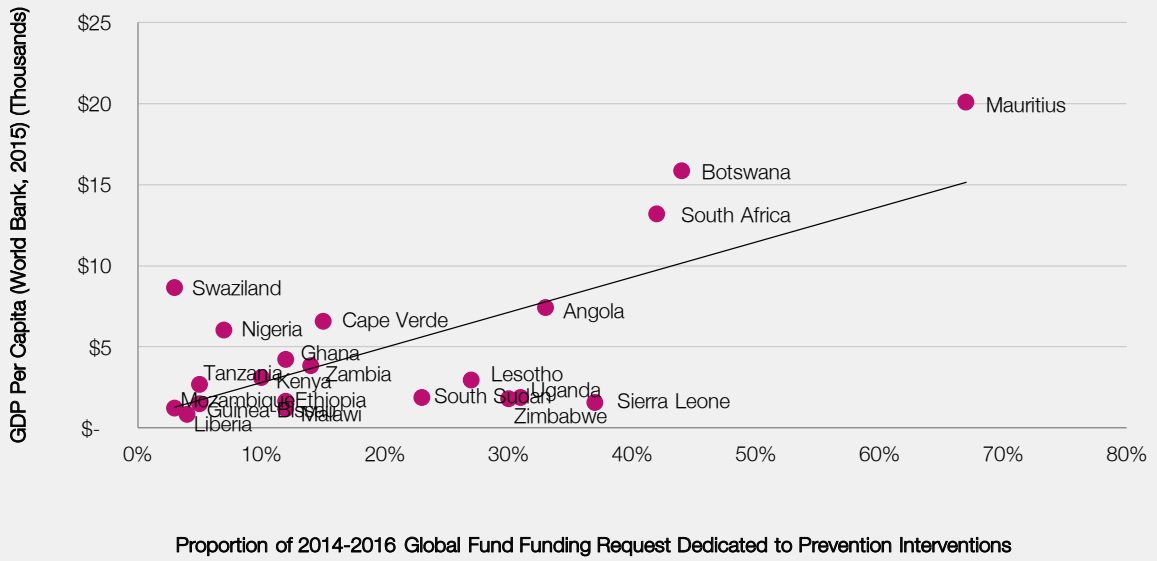
FIGURE 10: CORRELATION BETWEEN NUMBER OF MALE CIRCUMCISIONS PERFORMED AND AMOUNT OF HIV PREVENTION FUNDING REQUESTED IN GLOBAL FUND FUNDING REQUESTS (2014-2016 FUNDING CYCLE) (r=.781**, p=.005)



However, the correlation between the number of male circumcisions and the amount of prevention funding included in signed grants is not significantly correlated (r=.699, p=.081).

There is also a correlation between the wealth of a country, expressed as GDP per capita, and the proportion of funding requested for prevention (r=.696**, p=.000) (Figure 11).

FIGURE 11: CORRELATION BETWEEN GDP PER CAPITA AND THE PROPORTION OF 2014-2016 GLOBAL FUND FUNDING REQUESTS DEDICATED TO PREVENTION INTERVENTIONS (r=.696**, p=.000)



This is likely because wealthier countries are able to support more of their treatment liability with domestic funding, freeing up their Global Fund allocation to be spent on other priorities, including prevention. For example, GDP per capita in Mozambique and Liberia is among the lowest in this sample ($1,192 and $835, respectively), as is the proportion of funding requested for prevention (3% and 4%, respectively). In Liberia there is "severe dependence on donors for the HIV program" according to the country's funding request. Similarly, in Mozambique, all HIV treatment is funded by external donors, with approximately 48% from the Global Fund and the remaining 52% from the U.S. Government.[27] By comparison, Mauritius and Botswana are the two richest countries in the sample, with a GDP per capita of $20,085 and $15,839, respectively. In Mauritius and Botswana, all ART is supported by domestic funding which enables these countries to dedicate large portions of their Global Fund funding requests to HIV prevention interventions (67% and 44%, respectively).

Fast-Track Cities

In an effort to translate global goals, objectives, and targets into local implementation plans, The Fast-Track Cities initiative was launched on World AIDS Day (1 December) 2014. Fast-Track Cities is a global partnership between the City of Paris, International Association of Providers of AIDS Care (IAPAC), UNAIDS, and the United Nations Human Settlements Programme (UN-Habitat), in collaboration with local, national, regional, and international partners and stakeholders.[28] The initiative was originally launched by mayors from 27 cities, but the number has since grown. To date, more than 65 HIV high-burden cities around the world have joined the Fast-Track cities network.

Among the sample countries in this study, there are nine Fast-track cities: Accra (Ghana), Blantyre (Malawi), Dar es Salaam (Tanzania), Durban (South Africa), Lilongwe (Malawi), Lusaka (Zambia), Maputo (Mozambique), Nairobi (Kenya) and Windhoek (Namibia). Some Global Fund funding requests from the 2014-2016 funding cycle prioritize these cities for targeted HIV prevention interventions, while others do not explicitly do so (Table 7).

TABLE 7: HIV PREVENTION INTERVENTIONS PRIORITIZED FOR SELECT FAST-TRACK CITIES IN 2014-2016 GLOBAL FUND FUNDING REQUESTS

FAST-TRACK CITY	DOES THE FUNDING REQUEST EXPLICITLY TARGET THE FAST-TRACK FOR HIV PREVENTION INTERVENTIONS?	PREVENTION INTERVENTIONS THAT ARE PRIORITIZED FOR THE FAST-TRACK CITY
ACCRA (GHANA)	NO	n/a
BLANTYRE (MALAWI)	NO	n/a
DAR ES SALAAM (TANZANIA)	YES	Combination prevention; HIV testing services for pregnant women
DURBAN (SOUTH AFRICA)	YES	HIV prevention among sex workers,men who have sex with men, transgender people and people who inject drugs
LILONGWE (MALAWI)	NO	n/a
LUSAKA (ZAMBIA)	YES	HIV testing services for adolescents and young people; VMMC
MAPUTO (MOZAMBIQUE)	YES	HIV workplace programs; VMMC
NAIROBI (KENYA)	YES	VMMC; health worker sensitization and support for key populations and adolescents and youth
WINDHOEK (NAMIBIA)	No data	n/a

In Tanzania, the funding request explicitly prioritizes Dar es Salaam, among 9 other high burden regions, for the first phase of scale-up for combination HIV prevention.

South Africa's funding request explicitly prioritizes Durban (eThekwini) for HIV prevention among sex workers, men who have sex with men, transgender people and people who inject drugs.

"The proposed combination prevention will be scaled up in a phased manner: first phase will target 10 regions Njombe (14.6%), Iringa (9.1%), Mbeya (9.0%), Shinyanga (7.4%), Ruvuma (7.0%), **Dar es Salaam** *(6.9%), Rukwa (6.2%), Coast region (5.9%), Katavi (5.9%) and Tabora (5.1%)."*

~ Tanzania's TB/HIV Funding Request to the Global Fund (October 2014)

"There are more people living with HIV in the City of **Durban** *that in the whole of Brazil. [...] [It] is within the epicenter of South Africa's HIV epidemic."*

~ South Africa's TB/HIV Funding Request to the Global Fund (July 2015)

Zambia's TB/HIV funding request expressly focuses on Lusaka as a priority city for HIV prevention among adolescents and young people. Lusaka is also explicitly mentioned in the funding request as a priority city for scale up of male

circumcision. The funding request states that "the program has prioritized Lusaka, Copperbelt, Southern and Central provinces due to their high HIV incidence and prevalence and potential efficiency and effectiveness toward reaching the number of VMMCs needed to avert one HIV infection.

> ***"This intervention [HIV Testing Services] also will target in- and out-of-school youth in Livingstone, Lusaka, Kabwe, Ndola, Kitwe, and Solwezi (high social-economic activities), where there is high risk of HIV infection in youth. These populations will be reached with a full package of prevention services."***
>
> **~ Zambia's TB/HIV Funding Request to the Global Fund (June 2014)**

Mozambique requested $776,045 for HIV prevention programs in the workplace, targeting what they term "new economic zones", including Maputo, Gaza, Inhambane, Tete, Manica, Sofala Cabo Delgado and Nampula Provinces. Maputo is also prioritized for linkages between HIV testing services and male circumcision services. The funding request states that "HIV negative males [will be] refer[ed] to VMMC services in areas with high HIV prevalence and low male circumcision (Zambezia, Manica, Sofala, Gaza, Maputo, and Maputo City)."

In Kenya, the $2.1 million that is requested for male circumcision is strategically targeted at the Fast-Track city of Nairobi. The funding request states that "VMMC activities will be implemented in Turkana, Nairobi, Marsabit, and Mombasa counties." Nairobi is also a target city for ART scale up, health worker sensitization and treatment adherence for key populations and adolescents.

The Role of Civil Society and Communities

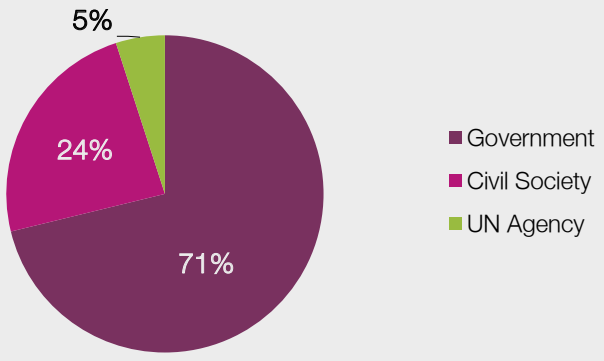
The 2016 Political Declaration includes recognition of the role that community organizations play in delivering prevention interventions, including a target to expand community-led service delivery to cover at least 30% of all service delivery by 2030.[29] Community-led services are often funded and implemented by civil society organizations, community-based organizations, faith-based organizations, and other community structures. Conversely, facility-based services are usually funded and implemented by governments.

Among the 15 countries in this sample for which signed Global Fund grants for the 2014-2016 funding cycle are publicly available, a total of $185,195,041 in HIV prevention funding is managed by government PRs (Table 8). This represents 71% of all Global Fund HIV prevention funding in these 15 countries. By comparison, $61,948,901 of HIV prevention funding in these 15 countries (Figure 12). is managed by civil society PRs,[30] which is 24% of the total. In three countries – Angola, Somalia and South Sudan – UN Agencies are PRs, managing a total of $13,009,065 in HIV prevention funding. This is 5% of total HIV prevention funding in the Global Fund grants of these 15 countries.

TABLE 8: HIV PREVENTION FUNDING IN SIGNED GLOBAL FUND GRANTS FOR THE 2014-2016 FUNDING CYCLE IN 15 AFRICAN COUNTRIES, BY TYPE OF PRINCIPAL RECIPIENT

COUNTRY	HIV PREVENTION FUNDING MANAGED BY GOVERNMENT PRS	HIV PREVENTION FUNDING MANAGED BY CIVIL SOCIETY PRS	HIV PREVENTION FUNDING MANAGED BY UN AGENCY PRS
ANGOLA	$0	$0	$5,013,116
BOTSWANA	$505,189	$8,374,333	$0
ETHIOPIA	$47,141,780	$0	$0
GHANA	$6,604,955	$3,920,701	$0
GUINEA-BISSAU	$330,864	$0	$0
KENYA	$24,095,539	$11,709,992	$0
LIBERIA	$0	$3,674,524	$0
MOZAMBIQUE	$2,285,073	$7,550,109	$0
SIERRA LEONE	$0	$6,329,952	$0
SOMALIA	$0	$0	$2,850,611
SOUTH SUDAN	$0	$0	$5,145,338
SWAZILAND	$2,733,513	$4,591,476	$0
TANZANIA	$66,889,991	$2,070,724	$0
UGANDA	$26,059,464	$5,598,030	$0
ZAMBIA	$8,548,673	$8,129,060	$0
TOTAL	$185,195,041	$61,948,901	$13,009,065

FIGURE 12: PROPORTION OF HIV PREVENTION FUNDING IN SIGNED GLOBAL FUND GRANTS FOR THE 2014-2016 FUNDING CYCLE FROM 15 AFRICAN COUNTRIES, BY TYPE OF PRINCIPAL RECIPIENTS



In addition to being important implementers of HIV prevention services, civil society and communities also have vital roles to play in advocacy and accountability work. In a 2015 EANNASO publication, civil society's HIV priorities for

Global Fund funding requests were analyzed based on civil society priorities charters that were produced in eight African countries: Kenya, Malawi, Swaziland, Tanzania, Uganda, Zambia, Zanzibar and Zimbabwe.[31] The charters are titled as "advocacy roadmaps" for civil society for the inclusion of their priorities in Global Fund funding requests.

In this analysis, behaviour change interventions and programs for key populations were most commonly ranked as the top priorities for civil society in terms of what they wanted to see included in their Global Fund funding requests. VMMC was most commonly ranked near the bottom of civil society's priorities. Civil society was found to be more successful at lobbying for the inclusion of priorities related to key populations, behaviour change and condom promotion and less successful at lobbying for PMTCT, treatment and VMMC priorities (Table 9).

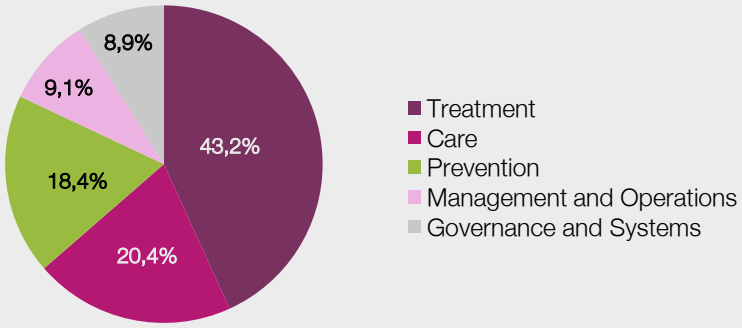
TABLE 9: PERCENTAGE OF PRIORITIES SET BY CIVIL SOCIETY THAT WERE INCLUDED IN THE 2014-2016 GLOBAL FUND FUNDING REQUESTS IN MALAWI, SWAZILAND, TANZANIA, UGANDA AND ZAMBIA[32]

TYPE OF PRIORITIES SET BY CIVIL SOCIETY	% OF PRIORITIES INCLUDED IN CONCEPT NOTES
Key Populations	68%
Behaviour Change	65%
Condom Promotion	63%
Prevention of Mother-to-Child Transmission	50%
Treatment Care and Support	40%
Voluntary Medical Male Circumcision	15%

Funding from Other Sources

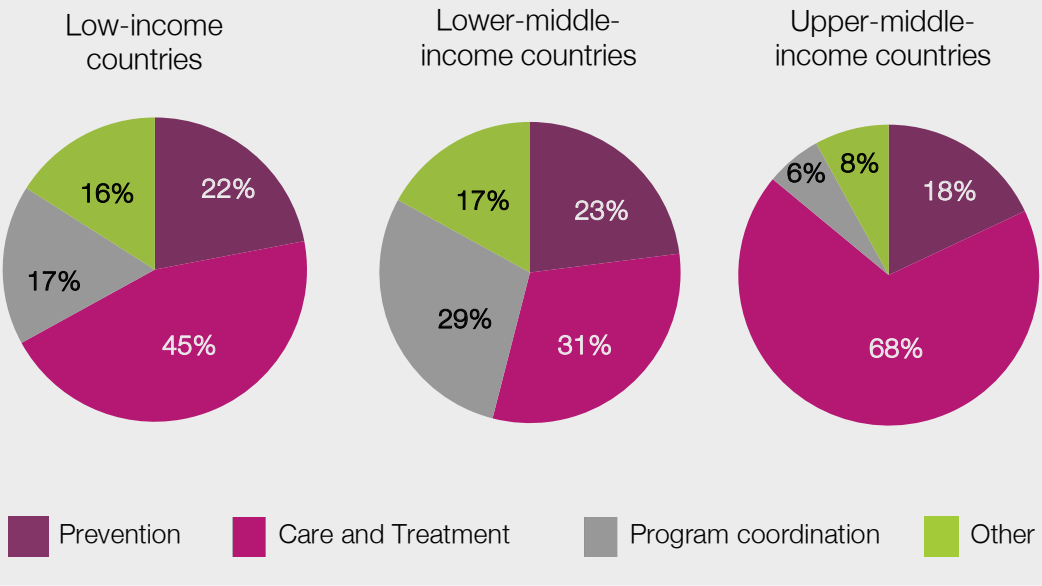
While – on average – the majority of the countries in this sample are neither requesting nor being granted "a quarter for prevention" it is important to acknowledge that this is not a shortcoming unique to the Global Fund. Indeed, Global Fund investments are certainly not a complete picture of overall AIDS spending, nor are they the only development partner that could be spending more on HIV prevention. At the very least, domestic funding and PEPFAR investments need to be considered as part of the overall HIV prevention funding landscape. PEPFAR is the largest international funding partner in the AIDS response, making up approximately 66.4% of international HIV assistance in 2015.[33] PEPFAR's planned spending on HIV prevention was 18.4% for 2016 (Figure 13).

FIGURE 13: PLANNED SPENDING IN PEPFAR'S 2016 COUNTRY OPERATIONAL PLANS (COPS)[34]



Domestic funding is also an important aspect of the AIDS financing response. In 2014, 57% of total investments for AIDS were domestic.[35] Cumulative investments from 2005-2013 in counties of all income brackets fall short of the 26% benchmark (Figure 14).

FIGURE 14: AIDS SPENDING BY PROGRAM AREA AND BY COUNTRY INCOME STATUS, 2005-2013[36]



CONCLUSION AND WAY FORWARD

In sum, of the countries sampled, an average of 16% of the total funding requested in HIV or TB/HIV funding requests to the Global Fund over the 2014-2016 funding cycle was dedicated to HIV prevention. Slightly less than this - 15% - was included in the subsequent signed grant agreements. This is far below the UNAIDS' recommended benchmark of 26%. Put simply, the world will not end AIDS if HIV prevention continues to be under-prioritized.

So - how can investments in HIV prevention be increased?

Certainly exploring opportunities for increasing investments for HIV prevention in the East and Southern Africa region through Global Fund applications for the 2017-2019 funding cycle is one avenue.

Another opportunity lies in leveraging "Matching Funds", a new part of Global Fund grant architecture that incentivizes countries to direct more of their allocation amounts to certain strategic priorities, including key populations, human rights and adolescent girls and young women.

Advocacy from civil society and communities is absolutely vital, particularly on urging countries to request greater HIV prevention funding for key populations and adolescent girls and young women.

RECOMMENDATIONS AND ADVOCACY OPPORTUNITIES

1. **Encourage countries to increasingly absorb critical aspects of their HIV response – especially ART – into domestically-funded programs**. This will enable the Global Fund to invest more in HIV prevention interventions, towards achieving the targets in its HIV prevention key performance indicators (Table 2).[37]
2. **Perform community-led monitoring on HIV prevention budgets, for Global Fund, PEPFAR, government, and other funding streams.** Having accurate, up-to-date and community-owned data on HIV prevention spending gaps is vital for effective advocacy.
3. **Advocate for the health and rights of key populations, including sex workers, men who have sex with men, transgender people, people who inject drugs and prisoners.** Criminalization and marginalization of these groups acts as a barrier to service delivery and access. This hampers the effective scale-up HIV prevention where it is needed the most.
4. **Capitalize on opportunities with Catalytic Funding ("Matching Funds") as a new way to increase Global Fund investments in HIV prevention.** Advocacy will be needed to ensure that countries dedicate the required amount in their allocation to the catalytic funding priorities, and that activities are prevention-focused wherever possible.
5. **Support incentives to encourage countries to meet the 26% HIV prevention target,** modelling successful initiatives such as the Asia Pacific Leaders Malaria Alliance (APLMA), which has markedly, increased commitment to malaria programming in the Asia Pacific region.[38]

ANNEX 1: FUNDING REQUESTED FOR SELECT HIV PREVENTION INTERVENTIONS IN 2014-2016 GLOBAL FUND FUNDING REQUESTS[39]

COUNTRY	TOTAL FUNDING REQUESTED IN HIV OR HIV/TB FUNDING REQUESTS	FUNDING REQUESTED FOR PREVENTION PROGRAMS FOR GENERAL POPULATION	FUNDING REQUESTED FOR PREVENTION PROGRAMS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE	FUNDING REQUESTED FOR PREVENTION PROGRAMS FOR SEX WORKERS AND THEIR CLIENTS	FUNDING REQUESTED FOR PREVENTION PROGRAMS FOR PEOPLE WHO INJECT DRUGS AND THEIR PARTNERS	FUNDING REQUESTED FOR PREVENTION PROGRAMS FOR OTHER VULNERABLE POPULATIONS	FUNDING REQUESTED FOR PREVENTION PROGRAMS FOR ADOLESCENTS AND YOUTH, IN AND OUT OF SCHOOL
ANGOLA	$87,293,671	$7,376,290	$2,507,770	$1,057,500	$0	$3,997,340	$14,288,300
BOTSWANA	$34,448,841	$0	$1,448,537	$1,681,917	$0	$0	$12,089,131
CAPE VERDE	$2,376,271	$0	$128,319	$227,603	$0	$0	$0
ETHIOPIA	$281,610,144	$28,031,650	$0	$4,901,573	$0	$1,149,444	$0
GHANA	$123,768,196	$0	$5,501,538	$8,152,758	$0	$1,314,732	$0
GUINEA-BISSAU	$11,257,091	$353,583	$260,355	$0	$0	$0	$0
KENYA	$352,938,136	$20,146,679	$5,534,585	$ 5,558,740	$5,540,045	$0	$0
LESOTHO	$62,149,359	$12,293,811	$1,004,957	$921,621	$0	$809,868	$1,942,975
LIBERIA	$30,459,052	$0	$599,371	$547,083	$0	$0	$0
MADAGASCAR	No data	No data	No data	No data	No data	No data	No data
MALAWI	$444,100,138	$50,012,925	$623,404	$607,929	$0	$0	$0
MAURITIUS	$5,681,383	$0	$1,235,428	$967,881	$1,626,467	$0	$0
MOZAMBIQUE	$455,044,195	$0	$847,454	$2,780,474	$0	$4,386,491	$5,998,666
NAMIBIA	No data	No data	No data	No data	No data	No data	No data
NIGERIA	$550,726,444	$12,000,000	$4,721,435	$6,686,487	$3,592,078	$0	$11,154,914
SIERRA LEONE	$18,726,509	$0	$1,287,809	$5,640,453	$0	$0	$0
SOMALIA	$38,062,219	$7,001,043	$0	$830,577	$0	$349,548	$1,651,871
SOUTH AFRICA	$380,500,261	$31,654,183	$15,661,124	$21,858,791	$4,606,141	$13,656,433	$74,260,904
SOUTH SUDAN	$60,072,070	$0	$718,451	$7,803,759	$0	$5,304,457	$0
SWAZILAND	$93,071,638	$1,483,651	$135,357	$120,008	$0	$123,276	$1,354,714
TANZANIA	$516,841,569	$17,214,804	$1,940,000	$5,200,000	$526,806[40]	$0	$0
UGANDA	$506,640,665	$145,754,882	$1,289,778	$2,620,451	$0	$0	$5,271,299
ZAMBIA	$152,453,652	$20,592,152	$0	$0	$0	$0	$1,000,000
ZANZIBAR	$10,844,161	$1,706,397	$328,663	$431,550	$569,536	$0	$0
ZIMBABWE	$40,168,252	$5,919,368	$60,375	$1,391,440	$0	$1,399,220	$3,333,020
TOTAL	$4,259,233,917	$361,541,418	$45,834,710	$79,988,595	$16,461,073	$32,490,809	$132,345,794

ANNEX 2: FUNDING INCLUDED IN SIGNED GRANTS FOR SELECT HIV PREVENTION INTERVENTIONS IN THE 2014-2016 GLOBAL FUND FUNDING CYCLE

COUNTRY	TOTAL AMOUNT OF FUNDING IN SIGNED HIV OR HIV/TB GRANT(S)	PREVENTION PROGRAMS FOR GENERAL POPULATION	PREVENTION PROGRAMS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE	PREVENTION PROGRAMS FOR SEX WORKERS AND THEIR CLIENTS	PREVENTION PROGRAMS FOR PEOPLE WHO INJECT DRUGS AND THEIR PARTNERS	PREVENTION PROGRAMS FOR OTHER VULNERABLE POPULATIONS	PREVENTION PROGRAMS FOR ADOLESCENTS AND YOUTH, IN AND OUT OF SCHOOL
ANGOLA	$30,002,727	$2,079,690	$540,500	$555,585	$0	$939,397	$897,944
BOTSWANA	$27,043,808	$0	$1,143,253	$1,618,263	$0	$0	$6,118,006
CAPE VERDE[41]	No data	No data	No data	No data	No data	No data	No data
ETHIOPIA	$276,713,816	$39,873,865	$0	$6,223,307	$0	$1,044,608	$0
GHANA	$97,772,036	$2,376,132	$2,774,520	$6,258,003	$0	$1,621,833	$0
GUINEA-BISSAU	$7,175,592	$0	$90,005	$240,859	$0	$0	$0
KENYA	$297,986,617	$20,624,597	$9,924,881	$2,023,607	$3,232,446	$0	$0
LESOTHO[42]	No data	No data	No data	No data	No data	No data	No data
LIBERIA	$9,584,090	$1,066,056	$1,339,946	$1,268,522	$0	$0	$0
MADAGASCAR[43]	No data	No data	No data	No data	No data	No data	No data
MALAWI[44]	No data	No data	No data	No data	No data	No data	No data
MAURITIUS[45]	No data	No data	No data	No data	No data	No data	No data
MOZAMBIQUE	$225,505,000	$3,184,014	$532,385	$895,719	$0	$881,771	$4,341,293
NAMIBIA	No data	No data	No data	No data	No data	No data	No data
NIGERIA[46]	No data	No data	No data	No data	No data	No data	No data
SIERRA LEONE	$32,367,617	$2,528,583	$1,399,416	$2,247,521	$34,432	$120,000	$0
SOMALIA	$20,614,311	$1,854,780	$0	$0	$0	$995,831	$0
SOUTH AFRICA[47]	No data	No data	No data	No data	No data	No data	No data
SOUTH SUDAN	$42,464,597	$0	$633,491	$2,343,552	$0	$2,168,295	$0
SWAZILAND	$45,085,465	$1,942,650	$55,863	$599,928	$0	$0	$4,726,548
TANZANIA	$290,252,753	$67,814,271	$428,681	$717,763	$0	$0	$0
UGANDA	$186,623,452	$24,338,892	$942,883	$2,047,335	$0	$0	$4,328,384
ZAMBIA	$158,291,193	$11,579,842	$0	$0	$0	$0	$5,097,891
ZANZIBAR	No data	No data	No data	No data	No data	No data	No data
ZIMBABWE	No data	No data	No data	No data	No data	No data	No data
TOTAL	$1,747,483,074	$179,263,372	$19,805,824	$27,039,964	$3,266,878	$7,771,735	$25,510,066

ANNEX 3: DIFFERENCE BETWEEN AMOUNT REQUESTED AND AMOUNT GRANTED FOR SELECT HIV PREVENTION INTERVENTIONS IN THE 2014-2016 GLOBAL FUND FUNDING CYCLE (RED TEXT REPRESENTS A DECREASE, BLACK TEXT REPRESENTS AN INCREASE)

COUNTRY	TOTAL AMOUNT OF FUNDING FOR HIV OR HIV/TB PROGRAM	PREVENTION PROGRAMS FOR GENERAL POPULATION	PREVENTION PROGRAMS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE	PREVENTION PROGRAMS FOR SEX WORKERS AND THEIR CLIENTS	PREVENTION PROGRAMS FOR PEOPLE WHO INJECT DRUGS AND THEIR PARTNERS	PREVENTION PROGRAMS FOR OTHER VULNERABLE POPULATIONS	PREVENTION PROGRAMS FOR ADOLESCENTS AND YOUTH, IN AND OUT OF SCHOOL
ANGOLA	($57,290,944)	($5,296,600)	($1,967,270)	($501,915)	$0	($3,057,943)	($13,390,356)
BOTSWANA	($7,405,033)	$0	($305,284)	($63,654)	$0	$0	($5,971,125)
CAPE VERDE	No data	No data	No data	No data	No data	No data	No data
ETHIOPIA	($4,896,328)	$11,842,215	$0	$1,321,734	$0	($104,836)	$0
GHANA	($25,996,160)	$2,376,132	($2,727,018)	($1,894,755)	$0	$307,101	$0
GUINEA-BISSAU	($4,081,499)	($353,583)	($170,350)	$240,859	$0	$0	$0
KENYA	($54,951,519)	$477,918	$4,390,296	($3,535,133)	($2,307,599)	$0	$0
LESOTHO	No data	No data	No data	No data	No data	No data	No data
LIBERIA	($20,874,962)	$1,066,056	$740,575	$721,439	$0	$0	$0
MADAGASCAR	No data	No data	No data	No data	No data	No data	No data
MALAWI	No data	No data	No data	No data	No data	No data	No data
MAURITIUS	No data	No data	No data	No data	No data	No data	No data
MOZAMBIQUE	($229,539,195)	$3,184,014	($315,069)	($1,884,755)	$0	($3,504,720)	($1,657,373)
NAMIBIA	No data	No data	No data	No data	No data	No data	No data
NIGERIA	No data	No data	No data	No data	No data	No data	No data
SIERRA LEONE	$13,641,108	$2,528,583	$111,607	($3,392,932)	$34,432	$120,000	$0
SOMALIA	($17,447,908)	($5,146,263)	$0	($830,577)	$0	$646,283	($1,651,871)
SOUTH AFRICA	No data	No data	No data	No data	No data	No data	No data
SOUTH SUDAN	($17,607,473)	$0	($84,960)	($5,460,207)	$0	($3,136,162)	$0
SWAZILAND	($47,986,173)	$458,999	($79,494)	$479,920	$0	($123,276)	$3,371,834
TANZANIA	($226,588,816)	$50,599,467	($1,511,319)	($4,482,237)	($526,806)	$0	$0
UGANDA	($320,017,213)	($121,415,990)	($346,895)	($573,116)	$0	$0	($942,915)
ZAMBIA	$5,837,541	($9,012,310)	$0	$0	$0	$0	$4,097,891
ZANZIBAR	No data	No data	No data	No data	No data	No data	No data
ZIMBABWE	No data	No data	No data	No data	No data	No data	No data
TOTAL	($1,015,204,574)	($68,691,362)	($2,265,181)	($19,855,329)	($2,799,973)	($8,853,553)	($16,143,915)

ANNEX 4: FUNDING REQUESTED AND FUNDING INCLUDED IN SIGNED GLOBAL FUND GRANTS - WAS THERE "A QUARTER FOR PREVENTION"?

COUNTRY	TOTAL FUNDING REQUESTED IN HIV OR HIV/TB FUNDING REQUESTS	TOTAL AMOUNT OF PREVENTION FUNDING REQUESTED	PREVENTION FUNDING REQUESTED AS A % OF TOTAL FUNDING REQUESTED	WAS "A QUARTER FOR PREVENTION" REQUESTED?	TOTAL AMOUNT OF FUNDING IN SIGNED HIV OR HIV/TB GRANT(S)	TOTAL AMOUNT OF PREVENTION FUNDING GRANTED	PREVENTION FUNDING REQUESTED AS A % OF TOTAL FUNDING GRANTED	WAS "A QUARTER FOR PREVENTION" GRANTED?
ANGOLA	$87,293,671	$29,227,200	33%	YES	$30,002,727	$5,013,116	17%	NO
BOTSWANA	$34,448,841	$15,219,585	44%	YES	$27,043,808	$8,879,522	33%	YES
CAPE VERDE	$2,376,271	$355,922	15%	NO	No data	No data	No data	No data
ETHIOPIA	$281,610,144	$34,082,667	12%	NO	$276,713,816	$47,141,780	17%	NO
GHANA	$123,768,196	$14,969,028	12%	NO	$97,772,036	$13,030,488	13%	NO
GUINEA-BISSAU	$11,257,091	$613,938	5%	NO	$7,175,592	$330,864	5%	NO
KENYA	$352,938,136	$36,780,049	10%	NO	$297,986,617	$35,805,531	12%	NO
LESOTHO	$62,149,359	$16,973,232	27%	YES	No data	No data	No data	No data
LIBERIA	$30,459,052	$1,146,454	4%	NO	$9,584,090	$3,674,524	38%	YES
MADAGASCAR	No data	No data	No data	No data	No data	No data	No data	No data
MALAWI	$444,100,138	$51,244,258	12%	NO	No data	No data	No data	No data
MAURITIUS	$5,681,383	$3,829,776	67%	YES	No data	No data	No data	No data
MOZAMBIQUE	$455,044,195	$14,013,085	3%	NO	$225,505,000	$9,835,182	4%	NO
NAMIBIA	No data	No data	No data	No data	No data	No data	No data	No data
NIGERIA	$550,726,444	$38,154,914	7%	NO	No data	No data	No data	No data
SIERRA LEONE	$18,726,509	$6,928,262	37%	YES	$32,367,617	$6,329,952	20%	NO
SOMALIA	$38,062,219	$9,833,039	26%	YES	$20,614,311	$2,850,611	14%	NO
SOUTH AFRICA	$380,500,261	$161,697,576	42%	YES	No data	No data	No data	No data
SOUTH SUDAN	$60,072,070	$13,826,667	23%	NO	$42,464,597	$5,145,338	12%	NO
SWAZILAND	$93,071,638	$3,217,006	3%	NO	$45,085,465	$7,324,989	16%	NO
TANZANIA	$516,841,569	$24,881,610	5%	NO	$290,252,753	$68,960,715	24%	NO
UGANDA	$506,640,665	$154,936,410	31%	YES	$186,623,452	$31,657,494	17%	NO
ZAMBIA	$152,453,652	$21,592,152	14%	NO	$158,291,193	$16,677,733	11%	NO
ZANZIBAR	$10,844,161	$3,036,146	28%	YES	No data	No data	No data	No data
ZIMBABWE	$40,168,252	$12,103,423	30%	YES	No data	No data	No data	No data
TOTAL	$4,259,233,917	$668,662,399	16%	NO	$1,747,483,074	$262,657,839	15%	NO

END NOTES

1. Global Fund (2016) Results Report 2016. Page 10. Online at https://www.theglobalfund.org/media/1122/corporate_2016resultsreport_report_en.pdf

2. UNAIDS (2016) Prevention Gap Report. Page 5. Online at http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf

3. HSRC (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Page xxiv.

4. IBBS survey, 2013-2014, as cited on http://aidsinfo.unaids.org/

5. Central Statistical Agency (Ethiopia) and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Calverton, Maryland, USA: Central Statistical Agency and ICF International.

6. Zimbabwe HIV Hot Spot Analysis 2015

7. 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression.

8. UNAIDS Fast-Track 2014 Word AIDS Day Report. Page 6. Online at http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

9. UNAIDS (2015) Invest in HIV Prevention. Page 4. Online at http://www.unaids.org/sites/default/files/media_asset/JC2791_invest-in-HIV-prevention_en.pdf

10. Kenya HIV Prevention Revolution road map: count down to 2030. Nairobi: Kenya Ministry of Health; 2014. Online at http://www.lvcthealth.org/online-library?format=raw&task=download&fid=17

11. (1) Ensuring that set targets are understood by funders, implementers and beneficiaries; (2) Addressing policy and other legal bottlenecks; (3) Prioritising hotspots and key populations to maximize impact; (4) Strengthening Research, Monitoring and Evaluation; (5) Strengthening coordination at the local level; (6) Increasing Efficiency in service delivery; and (7) Ensuring that adequate resources for set aside for prevention.

12. South African National Sex Worker HIV Plan 2016-2019. Online at http://sanac.org.za/2016/03/29/south-african-national-sex-worker-hiv-plan-2016-2019/

13. Resolution adopted by the General Assembly on 8 June 2016 [without reference to a Main Committee (A/70/L.52)] 70/266. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. Online at http://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS

14. UNAIDS (2015) Invest in HIV Prevention. Page 6. Online at http://www.unaids.org/sites/default/files/media_asset/JC2791_invest-in-HIV-prevention_en.pdf

15. Global Fund (2016) Results Report. Page 24. Online at https://www.theglobalfund.org/media/1122/corporate_2016resultsreport_report_en.pdf

16. Lloyed, M. (2017). Board approves new targets for the 2017-2022 Strategic KPI Framework. Global Fund Observer, Issue 308. Aidspan. Online at http://aidspan.org/gfo_article/board-approves-new-targets-2017-2022-strategic-kpi-framework

17. www.aidsinfo.unaids.org

18. Davis, S. L., Goedel, W. C., Emerson, J., & Guven, B. S. (2017). Punitive laws, key population size estimates, and Global AIDS Response Progress Reports: an ecological study of 154 countries. Journal of the International AIDS Society, 20(1). Online at http://www.jiasociety.org/index.php/jias/article/view/21386

19. Green, A. (2017). Global Fund-supported programs suspended amid Tanzanian government crackdown on LGBT community. Global Fund Observer, Issue 307. Aidspan. Online at http://www.aidspan.org/gfo_article/global-fund-supported-programs-suspended-amid-tanzanian-government-crackdown-lgbt-0

20. Botswana, Cape Verde, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mauritius, Mozambique, Nigeria, Somalia, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

21. Angola, Guinea-Bissau, Lesotho, South Africa, Sierra Leone and Zanzibar.

22. Angola, Botswana, Ethiopia, Ghana, Guinea-Bissau, Kenya, Liberia, Mozambique, Sierra Leone, Somalia, South Sudan, Swaziland, Tanzania, Uganda and Zambia.

23. HIV testing services and prevention of mother-to-child transmission are excluded from UNAIDS' "quarter for prevention" definition. For consistency and comparison purposes, these modules have also been excluded from measurement here.

24. While the new modular framework for the 2017-2019 funding cycle disaggregates these two populations, the 2014-2016 version – and therefore all the budget lines in the request and signed grants from that period - does not.

25. Global Fund (2012). Strategic Investments for Impact: Global Fund Results Report 2012. Page 68. Online at http://www.globalfundadvocatesnetwork.org/wp-content/uploads/2014/10/Publication_2012Results_Report_en.pdf

26. Global Fund (2012). Strategic Investments for Impact: Global Fund Results Report 2012. Page 68. Online at http://www.globalfundadvocatesnetwork.org/wp-content/uploads/2014/10/Publication_2012Results_Report_en.pdf

27. Oberth, G. (2016). Board approves costed grant extension to ensure continuity of HIV services in Mozambique. Global Fund Observer, Issue 293. Online at http://www.aidspan.org/gfo_article/board-approves-costed-grant-extension-ensure-continuity-hiv-services-mozambique

28. See http://www.fast-trackcities.org

29. Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030. Page 15

30. It is important to note that funding contained in government-managed grants is often sub-granted to civil society organizations as sub-recipients and sub-sub-recipients. The same is true for grants managed by UN agencies.

31. Oberth, G., Mumba, O., Bhayani, L., Daku, M. & Oberth, C. (2015). Assessing the Inclusion of Civil Society Priorities in Global Fund Concept Notes. Eastern Africa National Networks of AIDS Service Organizations (EANNASO). Online at http://www.eannaso.org/resources/reports/32-eannaso-2015-assessing-the-inclusion-of-civil-society-priorities-in-global-fund-concept-notes/file

32. Oberth, G., Mumba, O., Bhayani, L., Daku, M. & Oberth, C. (2015). Assessing the Inclusion of Civil Society Priorities in Global Fund Concept Notes. Eastern Africa National Networks of AIDS Service Organizations (EANNASO). Online at http://www.eannaso.org/resources/reports/32-eannaso-2015-assessing-the-inclusion-of-civil-society-priorities-in-global-fund-concept-notes/file

33. The Henry J. Kaiser Foundation & UNAIDS (2016). Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2015. Page 9. Online http://www.unaids.org/sites/default/files/media_asset/financing-the-response-to-HIV-in-low-and-middle-income-countries_en.pdf

34. See: http://copsdata.amfar.org/s/2016

35. UNAIDS (2015). How AIDS Changed Everything. MDG6: 15 Year, 15 Lessons of Hope from the Response. Online at http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf

36. UNAIDS (2015). How AIDS Changed Everything. MDG6: 15 Year, 15 Lessons of Hope from the Response. Page 194. Online at http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf

37. UNAIDS (2015) Invest in HIV Prevention. Page 6. Online at http://www.unaids.org/sites/default/files/media_asset/JC2791_invest-in-HIV-prevention_en.pdf

38. See www.aplma.org

39. Amounts include both within allocation and above allocation requests.

40. Contained in the TB/HIV module

41. Grant is publicly available, but figures in the scanned version are too fuzzy to accurately interpret.

42. Grant performance reports are available, but not the grant performance agreements (which contain the final grant budget).

43. Grant performance reports are available, but not the grant performance agreements (which contain the final grant budget).

44. Grant performance reports are available, but not the grant performance agreements (which contain the final grant budget).

45. PILS grant is available, but not the National AIDS Secretary Grant.

46. Society for family health grant is online, but there is no budget. The grant for the NACA has $17,985,828 for PMTCT. This is all that is publicly available.

47. While the funding request is not available on the Global Fund's website, signed grant agreements are (for all PRs except for the National Department of Health). Keth'Impilo's grant is extremely difficult to read.

ICASO

120 Carlton St., Suite 311
Toronto, ON
Canada M5A 4K2
Tel: +1 416 921 0018
Email: icaso@icaso.org | Web: www.icaso.org

EANNASO

Kundayo Street - Kwa Shabani
Arusha - Moshi Rd, Kimandolu
P.O Box 6187, Arusha, Tanzania
Tel: +255 737 210598
Email: eannaso@eannaso.org | Web: www.eannaso.org