

# Triple threat:

Resurging epidemics,  
a broken health system,  
and global indifference  
to Venezuela's crisis

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From the International Council of AIDS Service Organizations (ICASO)

October 2018



**icaso**  
until **we** end aids

# The crisis at a glance...

There is an unprecedented humanitarian emergency in Venezuela. In 2017, gross domestic product plummeted by 12% and inflation rates soared to 1,600%. Economic collapse has made accessing food and life-saving medicines difficult or impossible for most. The global response has been stunning indifference. The political nature of the crisis means that information is also limited, hindering efforts for effective relief. Greater transparency is needed to compel urgent global action.

To document the health emergency in Venezuela, ICASO and Acción Ciudadana contra el SIDA (ACCSI) performed a rapid assessment during September 2017. A desk review was performed along with a series of targeted key informant interviews with people living with HIV, doctors, advocates, academics and United Nations representatives. The approach also included synthesis of information from the recent emergency consultation, convened by affected communities (with support from ICASO) in Caracas, Venezuela, from September 30 to October 2, 2017.



Venezuela is undoubtedly experiencing an acute public health emergency: There has been a 205% increase in new malaria cases after the country declared elimination; there is almost a complete lack of access to tuberculosis screening for vulnerable populations such as prisoners and indigenous communities; the number of AIDS-related deaths in the country has risen by nearly three quarters since 2011. Food is scarce and malnutrition and starvation are spreading. People on the ground describe frequent stock-outs of medicines, including antiretrovirals, and fear of imminent death.

The suffering in Venezuela is palpable; meanwhile the global community has yet to take decisive action. This is both morally reprehensible as well as dangerous from a public health perspective. Rebounding epidemics means that the world will not achieve the sustainable development goals for health if it continues to turn a blind eye to the catastrophe in Venezuela. But a solution is possible. Bilateral and multilateral donors – including the Global Fund to Fight AIDS, Tuberculosis and Malaria – should urgently address the health crisis in the country before it is too late.

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# Executive Summary

Venezuela is in the middle of an unprecedented, state-made, complex humanitarian emergency with severe and widespread social consequences. Its AIDS program, once lauded as a model, has collapsed, with chronic drug shortages and the lack of condoms or diagnostic tests putting thousands at risk of preventable diseases and death.

People living with HIV, tuberculosis and malaria are dying at a growing pace, as hospitals and pharmacies are empty of most health commodities. Measles and diphtheria, once eradicated from Latin America, are also back in force. Food is scarce and malnutrition and starvation are spreading. In the past year, Venezuelan advocates took to the global stage, demanding urgent aid from the international community. The response has been stunning indifference, but action is urgently needed: it is a matter of life and death. Continuing to ignore this humanitarian disaster means that even more people will die, and the foundations of global solidarity in the AIDS, TB and malaria response will be further eroded.

In September 2017, ICASO and ACCSI conducted a rapid assessment to collect data on the scope and extent of this crisis. We conducted interviews with more than 30 Venezuelan human rights, AIDS and health activists, service providers, academics and doctors, including some who risked their jobs in order to share censored health information. Data from key informants characterize a public health emergency: There has been a 205% increase in new malaria cases after the country declared elimination; there is almost a complete lack of access to TB screening for vulnerable populations such as prisoners and indigenous communities; and there are dangerously low (7%) levels of viral suppression among people living with HIV. Their personal accounts of anguish and frustration further underscore the urgency of intervention.

From the information provided by key informants, the case is indisputable: The Global Fund will not achieve the objectives in its new strategy (2017-2022), nor will the world achieve the sustainable development goals for health, if the global community continues to turn a blind eye to the public health catastrophe in Venezuela.

***‘People are dying because they do not have treatment. People are dying of preventable and curable diseases. People are dying for lack of political will. I have been living with HIV for 30 years. I think I am going to die soon.’***

PERSON LIVING WITH HIV

***‘We are at the edge of an abyss ... there is no vaccination for any disease.’***

PRESENTATION BY JORGE DÍAZ  
POLANCO AT MEETING SOCIEDAD CIVIL  
ANTE LA CRISIS DE SALUD (CARACAS,  
SEPTEMBER 30, 2017)

Nearly six months have gone by since the Global Fund Board decided on Venezuela (Figure 1) and no comprehensive, sustainable, or aligned regional response has been developed. While we recognize the efforts of some regional UN agencies (in particular PAHO, UNICEF and UNAIDS) these efforts are in no way commensurate with the urgency and the needs; nor are they sustainable. As recommended in May by the Global Fund, a regional comprehensive response must be developed and implemented immediately and, in the absence of action, the Global Fund Board must provide stronger and more effective leadership. The current health crisis in Venezuela is a symptom and a consequence of the failures of the global health system which should be able to mount a response to any humanitarian crisis regardless of country or region when that crisis is witnessed and evidenced. The devastation faced by Venezuelans is being perpetuated in part by the arbitrary rules and regulations that shape global health aid eligibility. It is proof that the global health architecture is not prepared to deal appropriately with country emergencies and has exposed a gaping crack in the framework of a what should be a robust and effective global health response.

Moreover, despite extensive documentation, Venezuela's government denies there is an emergency – providing the political and policy blinders for many other governments and some UN agencies to look the other way. This report describes an unfolding disaster: a health system in shambles, with no availability of basic pain relievers, antibiotics, or first aid supplies. And while the world waits for the country to ask for help for a crisis they deny even exists, the rest of the international community does not need to wait years for the country to sink further into chaos, with the inevitable loss of life that would entail. This report provides an overview of the crisis in Venezuela and describes the resultant public health disaster while delivering an urgent demand for the Global Fund to intervene. It contains a series of quotes from key informants that were collected during the interview process and offers a series of recommendations, which are summarized below.

***‘How do we expect the government to declare a humanitarian emergency that it, itself, has created?’***

VENEZUELAN HUMAN RIGHTS ACTIVIST

## GF/B37/DP11

Approved by the Board on:

04 May 2017

Health Situation in Venezuela

1

The Board expresses:

- a. Continued concern about the resurgence of malaria, shortages of critical commodities for HIV and TB, and broader health crisis in Venezuela and its impact on the region; and
- b. Appreciation for the engagement of communities, civil society groups, PAHO, UNAIDS, WHO and others and their efforts to raise awareness and explore solutions for this situation.

2

The Board discussed the situation at length, noting Venezuela is currently not eligible for Global Fund financing, and calls for a coordinated regional response to the health crisis in Venezuela and that addresses the impact on the region incorporating relevant partners, donors and financiers.

3

Under such circumstances, in the context of a regional response, the Global Fund will continue to engage and, if possible, support the regional response

4

The Board directs the Strategy Committee and the Secretariat to discuss exceptional circumstances in non-eligible countries as part of the ongoing review of the Eligibility Policy.

Figure 1: Global Fund Board decision – 4 May 2017

# OUR CALL TO ACTION – THE 4 POINT PLAN

1

**The Global Fund to Fight AIDS, TB and Malaria was established as a ‘war chest’ to fight the three diseases. The leadership of the Board is urged to use that fighting spirit to do more to combat the growing HIV, TB and malaria crisis in Venezuela.**

**Within 3 -6 months: The Global Fund Board should immediately instruct the Secretariat to take the following actions:**

- Convene a meeting of all relevant regional UN and NGO partners to develop a comprehensive regional response that directs humanitarian aid to organizations that are working in the country, including through PAHO, UNAIDS, NGOs and faith-based organizations that have a proven track record and access to those most in need.
- Reprogram unspent funds in regional civil society grants to support Venezuelan NGOs to provide aid and to continue to monitor and report on the situation.
- Direct Fund Portfolio Managers working in neighboring countries to assess the current impact of Venezuela’s health system collapse on neighboring countries, and reprogram funds to meet urgent needs on the borders, particularly with regard to malaria.
- Convene and support Venezuelan NGOs to develop a funding request that can provide immediate relief, and monitor and report on stock-outs through use of the multicounty grant mechanism or the NGO rule.

2

**Within 18-24 months: The Global Fund Board should:**

- Draw on the Venezuela case to review and simplify eligibility criteria to better align with the Global Fund Strategy, which focuses on combating the three diseases among ‘key and vulnerable populations disproportionately affected by the three diseases.’
- Review the criteria used to determine which countries can access the emergency fund to ensure that countries with similar circumstances to Venezuela fit its eligibility criteria.
- Establish an appeals process for non-eligible countries and disease components.

### 3

#### **Action required by other organizations:**

- UNICEF and other organizations working with pregnant women and children should immediately provide baby formula to pregnant women living with HIV.
- UNAIDS must convene all relevant entities including international and regional civil society organizations, Venezuelan civil society, NGOs, FBOs and private sector partners to develop a practical and fundable plan of action to address the crisis.
- The World Bank, bilateral donors, and private foundations should fund PAHO and UNAIDS to deliver needed medicines and commodities to the country and fund Venezuelan academics and civil society to document the crisis and conduct epidemiological research, especially among key and vulnerable populations, such as indigenous peoples.
- The private sector and other supporters can help by donating food, baby formula, medicines, medical tests, syringes and other essential commodities.

### 4

#### **The Venezuelan government must respect, promote and fulfill the right to health by:**

- opening a humanitarian corridor to allow aid into the country;
- publishing all its epidemiological bulletins and research; and
- providing an estimate of the cost and plans for health for 2018.



# Introduction

**Venezuela, a nation of 31 million people on the northern coast of South America, is widely recognized as an oil-exporting country dependent on imported goods to cover the basic needs of its population.**

In the early 2000s, historically high oil prices sparked an economic boom, which saw the Venezuelan government establish populist policies that initially boosted the Venezuelan economy and increased social spending, temporarily reducing economic inequality and poverty.

However, such policies later became inadequate, as their excesses – especially a uniquely extreme fossil fuel subsidy – are widely blamed for destabilizing the nation's economy. The destabilized economy has led to a crisis, resulting in hyperinflation (of up to 1,600% in 2017)<sup>1</sup>, an economic depression,<sup>2</sup> shortages of basic goods, and drastic increases in poverty, disease, child mortality, malnutrition, and crime.<sup>3,4</sup>

News media, often through videos and documentation smuggled out of the country, have vividly shown the deteriorating conditions in Venezuelan hospitals.<sup>5</sup> Activists working with people living with HIV, tuberculosis and malaria have reached out to international allies to demand urgent humanitarian assistance. This report is based on rapid research done during September 2017, including a desk review of peer-reviewed and grey literature as well as a series of targeted key informant interviews, including with people living with HIV, doctors, advocates, academics, and representatives of the UN system. Their words are weaved into the document. In many cases, key informants requested anonymity out of fears of repercussion if they shared controversial health information that has been restricted by authorities. In all cases, interviewees were informed of the purpose of the research and provided informed consent. Some interviewees shared reports, documentation, photographs and videos for use in this report. All the notes and recordings from the interviews are kept by ICASO.

***‘Sometimes I can find drugs on the black market but they cost half my salary. But it doesn’t matter anymore – I have been on and off my ARVs so much that I think the drugs are failing me.’***

PERSON LIVING WITH HIV

To give critical depth to the desk review and key informant interviews, this paper also draws content from the recent emergency consultation, convened by affected communities in Caracas, Venezuela. The consultation was held between September 30 and October 2, 2017 and organized by Acción Ciudadana contra el SIDA (ACCSI) and the Red Venezolana de Gente Positiva (RVG+) – the national network of people living with HIV, with support from ICASO. Participants and presenters included people living with HIV, AIDS and human rights experts as well as representatives of the United Nations. This report incorporates information from the consultation, including presentation data as well as interventions and discussions from participants, in order to provide vital, first-hand perspectives from the center of the crisis. A report of the meeting, as well as the presentation, will be available in English at [www.icaso.org](http://www.icaso.org).



# Crisis and chaos, a health system catastrophe

The sharp reduction in the importing of basic goods has contributed to food insecurity and a health crisis that affects the entire population. It disproportionately affects vulnerable groups: newborns and children under five (Box 1), women, prisoners, indigenous peoples, and people living with HIV and other chronic diseases. Severe shortages of medicine, medical supplies and food have been reported since 2014.<sup>6</sup> These shortages intensified during 2016 and 2017.<sup>7</sup>

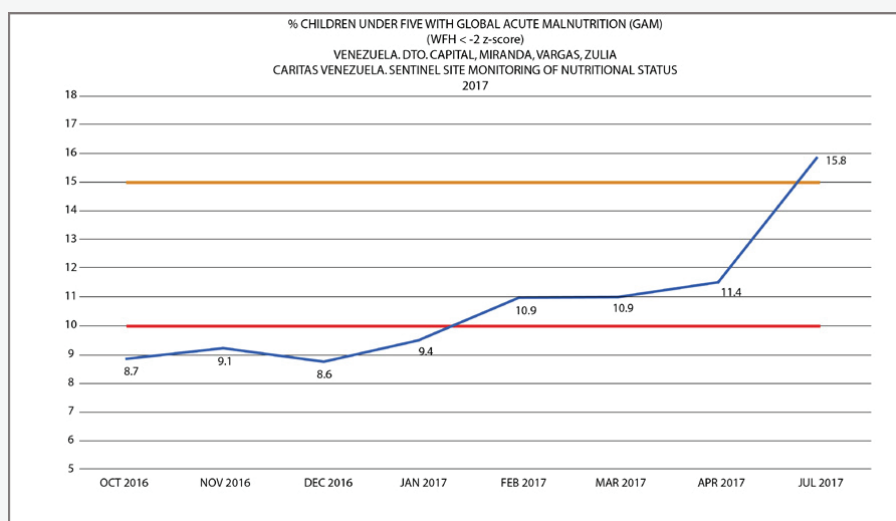
Key informants who spoke to ICASO gave examples that highlighted the impact of these numbers on their lives: for instance, that basic food supplies for a family of four cost about the average monthly wage of 90 people. One news account reported that the cost of a carton of eggs, approximately US\$5, is equivalent to 80% of a monthly salary.<sup>8</sup> Five to six children are dying weekly of starvation.

The economic crisis described above has sparked a rapid deterioration of a once-thriving health system. Hospitals have been vandalized, equipment has been stolen or is in deplorable shape, and syringes and other surgical material are being re-used.<sup>9</sup> In August 2017, a spokesperson at the Venezuela College

***The crisis in Venezuela is not the result of a natural disaster. This crisis is caused by failed policies, acute political instability, an economy in shambles and a government that refuses to acknowledge it. How do we expect the government to declare a humanitarian emergency that it, itself, has created?'***

VENEZUELAN HUMAN RIGHTS ACTIVIST

## Box 1: Global Acute Malnutrition

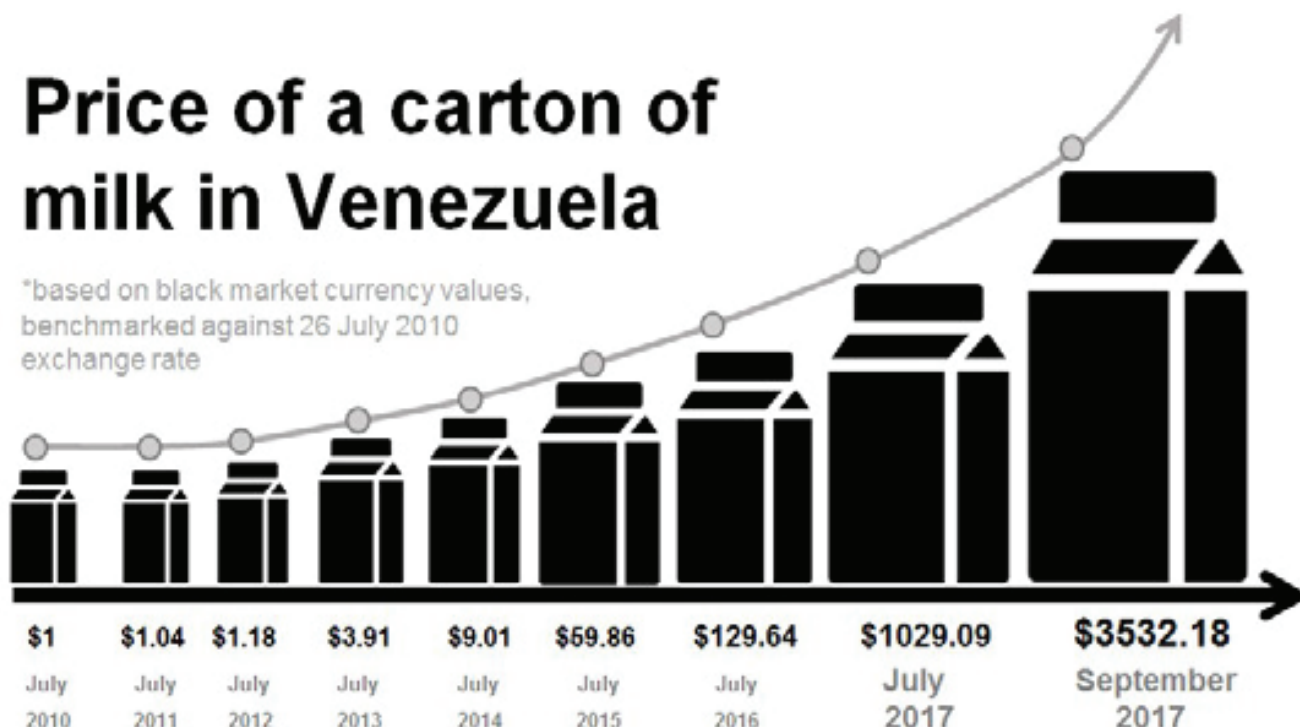


Caritas Venezuela keeps a continued record among children under five in the most vulnerable parishes, based on a network of sentinel sites that allow the screening and protection of children with global acute malnutrition (GAM). The prevalence of GAM is increasing and currently goes beyond the humanitarian emergency threshold (15% of GAM), according to the international classification endorsed by WHO.

Caritas Venezuela. Cuarto Boletín del Sistema de Monitoreo y Alerta Temprana Nutricional, agosto 2017

# Price of a carton of milk in Venezuela

\*based on black market currency values, benchmarked against 26 July 2010 exchange rate



**Figure 2: Price of a carton of milk in Venezuela<sup>10</sup>**

of Bioanalysts stated in a media interview that 10% percent of the country's network of public and private laboratories were operational.<sup>11</sup> The Venezuelan Health Observatory, a research center at the Central University of Venezuela in Caracas, estimated in 2016 that 76% of hospitals suffered from scarcity of medicines, 81% had a lack of surgical materials, 64% reported a shortage of infant formulas – which are key for women living with HIV, and 70% complained of intermittent water supply; these numbers have likely only increased in the ensuing year.<sup>12</sup> A government memo (Figure 3), shared with ICASO, instructs hospital staff to not discard and to reuse 'spinal needles, epidural needles, intubation tubes, and endotracheal tubes'. Recently, media outlets reported that the Ministry of Health would not provide more reagents to blood banks for the remainder of the year.<sup>13</sup>

Shortages of medicines are widespread. In March 2017, the Venezuelan Health Observatory (OVS), together with Médicos por la Salud (a network of medical residents in public hospitals), published a 2016 National Hospital Survey that found severe shortages of basic medicines in 76% of the hospitals surveyed, with shortages growing rapidly year on year.<sup>14</sup> According to



**Figure 3: Government memo captured via Twitter Sept. 16 2017**

one AIDS activist who spoke to ICASO, in June 2017, a coalition of Venezuelan NGOs that document medicine stock-outs (CO-DE-VI-DA) reported that approximately 70% of the drugs on the World Health Organization's (WHO) list of essential medicines had been absent from pharmacy shelves for several months. That epidemiological data from Venezuela is available at all is due in part to a former Minister of Health. Previously, publication of Venezuelan epidemiological bulletins was interrupted periodically. In early 2017, the former Minister retroactively published the bulletins corresponding to 2015 and 2016,<sup>15</sup> which documented the alarming deterioration in the overall health status of the population (e.g. a 30% increase in mortality among children under one year of age). After this information was published, the Minister was fired.

## Malaria

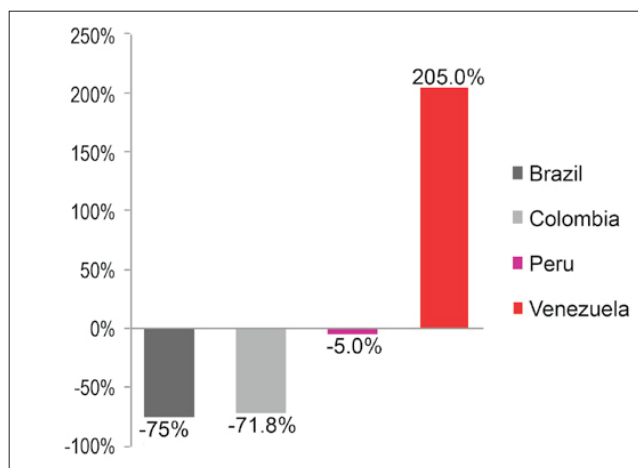
Most countries in the Americas have shown an impressive decreasing trend in malaria incidence over 2000- 2014, except for Venezuela.<sup>16</sup> Venezuela was the first country certified by WHO as having eliminated malaria in 1961.<sup>17</sup> Today the epidemic is sky-rocketing (Figures 4 and 5), raising the looming threat of drug resistance, and jeopardizing hard-won gains in neighboring countries. The government is aware of this, as this has been well-documented by experts, and most recently, evidenced through leaked government bulletins. One of the last epidemiological bulletins published by the Ministry of Health, for the week of 25-31 December 2016, showed an increase of 76.4% in new malaria cases compared to the same week in 2015.<sup>18</sup> In that week alone, 3,081 new cases were registered. This was confirmed by Dr. José Félix Oletta, renowned infectious disease specialist and former Minister of Health: Malaria has now reappeared in 10 out of 24 states in Venezuela (including the Capital District, Caracas), with new cases registered in both endemic and non-endemic regions.<sup>20</sup> A July 2017 government epidemiological bulletin leaked to ICASO shows a rapid increase in a difficult-to-eradicate form of malaria, *plasmodium vivax* (p. vivax).<sup>21</sup> This health bulletin shows that p. vivax had increased to 65.79% of all malaria infections.

***'In 2017, we already have 67% more cases than in the whole of 2016. At this pace, we will have more than 1 million cases in 1 year. These were numbers Venezuela had at the beginning of the 20th century. Malaria is out of control in Venezuela.'***

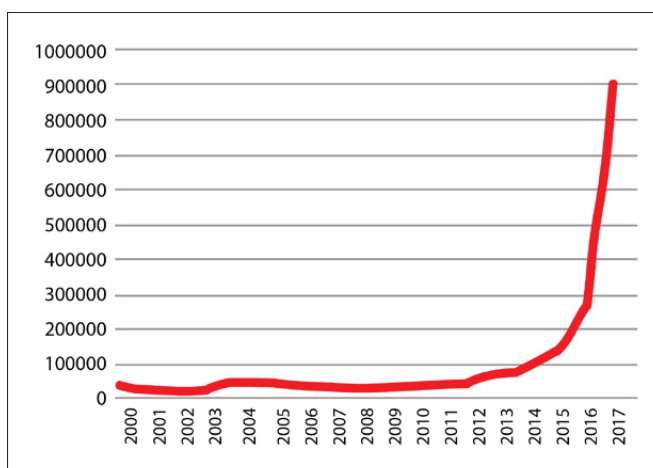
DR. JOSÉ FÉLIX OLETTA, INFECTIOUS DISEASE SPECIALIST AND FORMER MINISTER OF HEALTH

Venezuela, in common with neighboring countries, suffers from two forms of malaria: *plasmodium falciparum* and p. vivax. P. vivax can cause repeated relapses from a single mosquito bite, and requires a longer, sustained course of treatment.<sup>22</sup> The July 2017 government health bulletin shows that while vivax accounted for 38.46% of all malaria infections in December 2016, it increased to 65.79% of all malaria infections in July 2017.<sup>23</sup>

However, there are not enough medicines to successfully treat p. vivax, which raises the threat of drug resistance as a result of sub-optimal doses<sup>24</sup> including splitting pills among family and community members. This is shown in recent research published in the Malaria Journal.<sup>25</sup> The Venezuelan Health Observatory has also reported widespread stock-outs of antimalarial drugs.<sup>26</sup>



**Figure 4: Variation (%) in malaria cases in 2014 compared to 2000 baseline.**<sup>19</sup> Variation (%) in malaria cases



**Figure 5: New, notified cases of malaria in Venezuela 2000-2017.** Graphic developed by Dr. José Félix Oletta presenting the situation of malaria epidemic as of April 2017. These are estimations of notified cases, relapse, imported cases, and those without diagnosis.

It is also concerning that drug resistance could develop on the borders of other countries that are combating malaria. Bolivar state has historically registered the highest incidence of malaria, at 74.3% in 2016.<sup>27</sup> The epidemiological bulletin corresponding to the 26th week of 2017 indicated that the number of malaria cases for 2017 until that date was 184,225, an increase of 63% compared to the same period in 2016, with Bolivar state contributing 84.1% of cases. Between 60,000 and 70,000 people who work in the gold mines in Bolivar are from out of state. They work in the mines and then return to their homes. Most bring malaria with them, which has resulted in malaria being present in most states.

Bolivar's crisis is therefore a potential crisis for the region. In October 2016, twelve Venezuelan academics and health institutions jointly warned about the burgeoning malaria epidemic, calling it a 'public health emergency of national and international magnitude' that required help from the international community. Their press release included figures that indicated that, from the total number of imported cases of malaria

***'In the second quarter of 2017, four indigenous Joti walked out (of their community in Caño Iguana) with a malarial child to seek help. After 12 days of walking, they arrived in Puerto Ayacucho. The child died before receiving any medicine.'***

VENEZUELAN DOCTOR



Brazil had received from neighboring countries in 2016 (2,100 cases), 78% appeared to have come from Venezuela, while in Colombia and Guyana, Venezuela contributed to an estimated 81% of imported infections.<sup>28</sup> In February 2017, PAHO issued an epidemiologic alert signaling a recent increase in malaria cases in several countries in the Americas, including Colombia, Ecuador and Venezuela.<sup>29</sup> As disturbing as these figures are for the current year, the rapid deterioration, combined with widespread stock-outs and a failing health system, suggest worse will be in store in 2018 for Venezuela and its neighbors.

***‘Many of us were sick with this terrible disease [malaria] two, three and up to four times [last year]. Due to lack of treatment many of us died. Many times, we had to divide the treatment in two because we had no more pills.’***

LETTER TO THE INTERNATIONAL COMMUNITY  
FROM 25 AUTHORITIES REPRESENTING JOTI INDIAN  
VILLAGES

### The Jotis

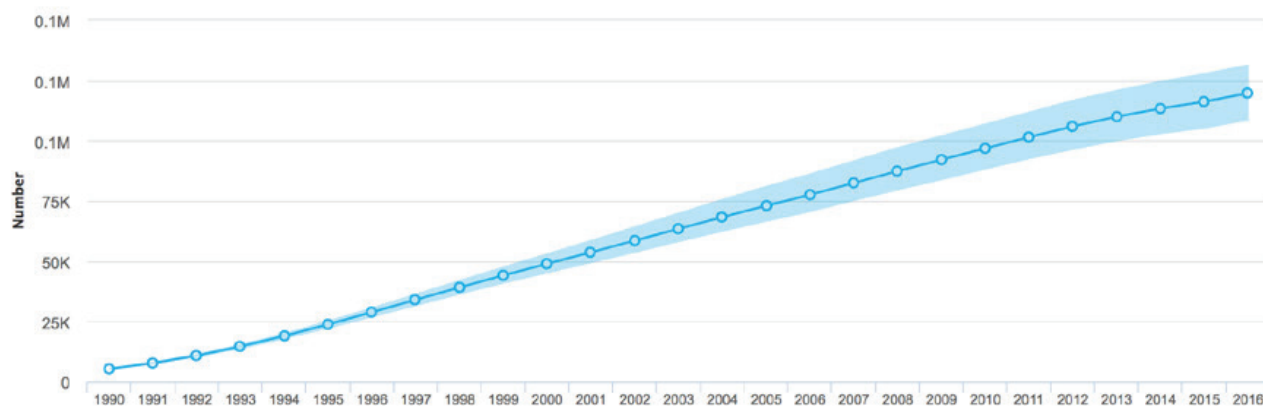


The Joti, an indigenous group of approximately 1,500 in the states of Bolívar and Amazonas, report being hard hit by both vivax and falciparum, and state that they are splitting pills due to insufficient supplies. In May 2017, authorities from the 25 Joti villages collectively published a letter to the international community describing their health emergency. The letter states that in 2016 alone, 3,792 cases of malaria (*P. vivax* and *P. falciparum*) were registered in the dispensaries in one village of 900 inhabitants. Thus, most of the village's population – adults and children – contracted malaria two, three or even four times in one year. The letter describes splitting limited medications to distribute them among patients, and appeals for urgent help.

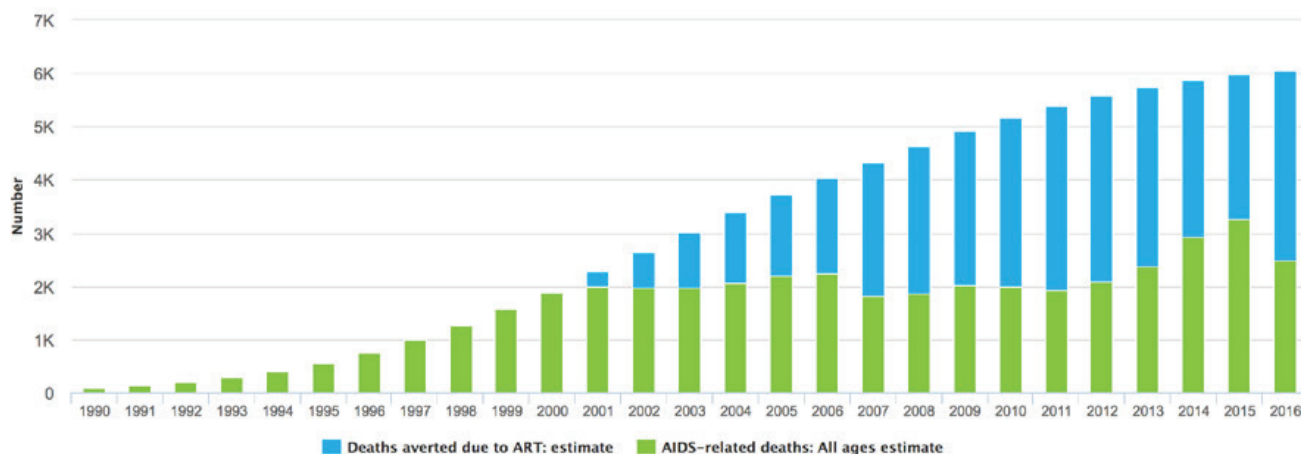
# HIV and AIDS

As with the malaria response, Venezuela's HIV program was once cited as an international model. Today the program has collapsed, leaving thousands without access to life-saving medicines. In the absence of reliable health data, communities of people living with HIV have organized themselves across the country to monitor and report on stock-outs of medicines. This section shares some of the data gathered, analyzed and published by domestic civil society groups of people living with HIV and their health providers.

Today, Venezuela is home to an estimated 120,000 people living with HIV (Figure 6)<sup>30</sup>. The country's national adult (15-49) prevalence is higher than Latin America's regional average (0.6% compared to 0.5%). Linked with frequent stock-outs of anti-retroviral therapy (ART), the number of AIDS-related deaths in Venezuela has risen by nearly three quarters, up from 1900 in 2011 to 3300 in 2015 (Figure 7). By the same token, the number of deaths averted due to ART has fallen by nearly a quarter, from 3500 in 2011 to 2700 in 2015. With 6,500 new infections in 2016, the epidemic continues to expand. The country does not have data on HIV testing coverage, condom use, or HIV knowledge among young people.



**Figure 6: People living with HIV (all ages) in Venezuela. Source: UNAIDS<sup>31</sup>**



**Figure 7: Number of AIDS-related Deaths vs. Number of Deaths Averted Due to ART in Venezuela. Source: UNAIDS<sup>32</sup>**

There is no data for key populations, such as sex workers, men who have sex with men, prisoners, transgender people or people who inject drugs. The impact of social and structural drivers of the epidemic, including intimate partner violence and stigma and discrimination, are also not known.

## Access to ARVs and other medications

Until the current crisis, a constitutional commitment to free treatment made it possible for thousands of people to access anti-retroviral treatment after being diagnosed with HIV.<sup>33</sup> In theory, the Venezuelan National AIDS Program provides for free ARVs in all 23 states through a network of public pharmacies. Until the crisis, people living with HIV picked up their ARV supply for the month in a local pharmacy. At its height, the treatment program included up to 12 different combinations of treatment for individualized regimens.

According to UNAIDS, there are currently 73,000 people registered to receive treatment<sup>34</sup> (or on treatment, although not receiving it). Approximately, 57,000 are men and 16,000 are women. There are 1,298 children (includes adolescents). There is no information regarding their gender. There is no information either about key populations registered to receive treatment.

***'If the AIDS Program doesn't have Atazanavir I get Kaletra, and then I get Viraday or whatever they have, if they have anything. They can't do that ... I can't be changing my regime based on the availability (or lack thereof) of ARVs. I don't want to die .... But I will.'***

PERSON LIVING WITH HIV (FROM NORTHWEST OF VENEZUELA)

## Monitoring the stock outs

The Venezuelan Network of Positive People (RVG+) has monitored ARV stock-outs across the country since 2013, and more intensely since 2015. RVG+ stations a focal point at each of the public pharmacies in all 23 states. Previously, focal points provided monthly reports on the availability of ARVs. Recently, given stock-outs of up to six months and conflicting information about expected medicine arrival dates, RVG+ has started reporting in real time.

Since the beginning of 2016, ARVs stock outs have been amply documented. Table 1 summarizes the stock outs, as reported by the RVG+ over the last 18 months. See Annex 1 for a list of all ARVs needed in Venezuela.

Based on direct observations from community-led services and reports from these focal points, RVG+ estimates that in approximately 10% of people living with HIV, the infection has advanced to AIDS. They note that this is difficult to confirm, as viral load tests have not been conducted for over 18 months. There is currently no official monitoring of deaths related to AIDS.



Table 1. List of ARV stock-outs as of September 8, 2017, documented by RVG+	
Drug	# of users
Lopinavir/Ritonavir 200/50 mg x 120 tablets	20,940 (including children)
Rilpivirine/Tenofovir/Emtricitabine 25/300/200 mg x 30 tablets	550
Emtricitabine 200 mg+ Efavirenz 600 mg+ Tenofovir 300 mg	180 (adolescents)
Atazanavir/Ritonavir 300 x 100 mg combined	14,606
Abacavir/Lamivudine 600/300 mg x 30 tablets	15,836
Efavirenz/Emtricitabine/Tenofovir 600/300/200 mg x 30 tablets	18,200
Efavirenz 600 mg x 30 tablets	13,067
Emtricitabine/Tenofovir 300/200 mg x 30 tablets	13,116
Lamivudine/Zidovudine 150/300 mg x 60 tablets	10,454
Ritonavir 100 mg x 30 tablets	16,389
Raltegravir 400 mg x 60 tablets	1,915

Other sources confirm the widespread stock-outs reported by RVG+. Since 2003, Acción Solidaria (ACSOL), an AIDS NGO, has documented medicine availability and shortages. According to ACSOL, supply problems have recurred for years, especially in the states far from Caracas. These stock-outs were exacerbated during 2016, with frequent and prolonged absences of other medicines for HIV and opportunistic infections.<sup>35</sup> Interruptions and unscheduled changes cause lasting harm, including drug resistance. UNAIDS recently included data about Venezuela<sup>36</sup> that shows a meagre 7% of people living with HIV are virally suppressed.<sup>37</sup> Virally suppressed (or 10 undetectable) means that the virus is no longer detectable in their blood stream making it virtually impossible for them to transmit HIV to a sexual partner.<sup>38</sup> Drug resistance is currently not monitored in Venezuela; AIDS activists report there have been no tests for this in 18 months, and that genotype and phenotype exams have also not been conducted. In 2016, the Venezuelan Society of Infectious Diseases, people living with HIV, and HIV physicians across the country jointly published information on stock-outs and the impact they have.<sup>39</sup>

# Pregnant women living with HIV

A special concern is the impact of lack of access to treatment for pregnant women, new mothers and their babies. With knowledge of their HIV status and appropriate treatment, mothers can prevent transmission of HIV to their babies and breastfeeding infants. Without appropriate tests and treatment, and without access to baby formula, mothers living with HIV have no other option but to breastfeed, knowing that this will likely transmit HIV to their infants in a context where pediatric treatment is difficult to obtain at best. UNICEF is operating in Venezuela, where it provides some medications for HIV, measles and other illnesses affecting women and children, and has a policy stating that in some emergencies it can provide 'breast milk substitutes.'<sup>40</sup> Despite their own policy regarding 'nutrition in emergencies', UNICEF is not providing baby formula in Venezuela.

***'New mothers have to breastfeed because there is no formula. In Lara (a state in the center of Venezuela) they are using fresh goat milk to feed their newborns.'***

RAIZA FARNATARO AT MEETING  
SOCIEDAD CIVIL ENTRE LA CRISIS, DE  
LA RESPUESTA AL VIH, TUBERCULOSIS  
Y MALARIA EN VENEZUELA (CARACAS,  
SEPTEMBER 30, 2017)

## Children and adolescents

Within the population living in poverty (87% of the total population)<sup>41</sup> at least 15% of children suffer from acute malnutrition, with high risk of getting sick and dying. Sixty-seven percent are malnourished.<sup>42</sup>

Currently, there are 1,298 children under treatment, based on information provided by the National AIDS Program. Around 70% have a confirmed diagnosis and the rest have been exposed and are waiting for test results. Ninety-two percent of cases in children are due to vertical transmission. The inexistence of baby formula plays a key negative role on this. Venezuela had implemented international recommendations about breastfeeding by women living with HIV. Now mothers face the dilemma: they either breastfeed or risk malnutrition and even starvation for their children. Pneumococcal infection and other childhood illnesses are killing children. This is telling of the structural decay. These infections are easily preventable through vaccination — a pillar of preventative public health, and one in Venezuela that used to be strong. Reappearance indicates that children are not receiving basic care, which could keep them healthy and alive. Children under five living with HIV are 100 times more likely to develop pneumococcal infection, and there have not been any vaccines available for the last 18 months.

***'In the case of children living with HIV (which includes adolescents) the worrisome number is the number we do not know: how many children are living with HIV without knowing?'***

PAEDIATRICIAN AT CHILDREN'S  
HOSPITAL

# HIV and key populations

Key informants, including HIV experts and advocates, told ICASO that the country has lacked a national prevalence study, or research to survey key populations. Thus, the latest National Strategic Plan (NSP 2012-2016) makes only vague reference to key populations.<sup>43</sup> The prevalence rate the report cites among men who have sex with men references only a self-reported group in one state from 1997.<sup>44</sup> A 2016 study by Perez-Brumer and colleagues surveyed 2,851 sexually active men who have sex with men from an online networking site. Self-reported HIV prevalence was 6.6%.<sup>45</sup>

***‘New mothers have to breastfeed because there is no formula. In Lara (a state in the center of Venezuela) they are using fresh goat milk to feed their newborns.’***

RAIZA FARNATARO AT MEETING  
SOCIEDAD CIVIL ENTRE LA CRISIS, DE  
LA RESPUESTA AL VIH, TUBERCULOSIS  
Y MALARIA EN VENEZUELA (CARACAS,  
SEPTEMBER 30, 2017)

## Indigenous groups

Academic studies have reported an extremely high HIV prevalence among indigenous peoples such as the Warao. In 2013, Villalba and colleagues found a ‘dramatically high’ HIV prevalence among 576 Warao survey participants of 9.55%.<sup>46</sup> The population of the Waraos is approximately 25,000. Men had a prevalence of 15.6% and women 2.6%. The study suggested that more than half of the infections had occurred within one year.

### The Waraos



In November 2015, a group of medical doctors, led by Dr. Martín Carballo, went to the Delta to deliver ARVs to those who had tested positive years earlier. What they found after several days of travelling through the jungle with respect to complete lack of health infrastructure astonished them. They provided basic medical services, together with introducing the Waraos to the ‘foreign’ concept of ARVs. They had taken a 3-month supply for those who had been identified. Upon his return, Dr. Carballo reflected that if the prevalence was indeed 10%, they would need treatment for at least for 2,500 people. They had taken ARVs for about 60.

Tucupita, Delta Amacuro. Photo: Erik Cleves Kristensen

# Tuberculosis (TB)

Venezuela's Integrated Program for Tuberculosis Control, founded in 1936, was, according to national health authorities, 'an example in the field of public health'.<sup>47</sup> WHO and PAHO epidemiological information on TB published online dates to 2015.<sup>48</sup> Information from 2016 was shared by interviewees with privileged access to official information and documents from the Ministry of Health. The lack of official health data made documenting issues relating to tuberculosis challenging for this report. Some experts who spoke to ICASO shared unpublished information that suggest a rapid increase in incidence.

During a meeting to evaluate the national tuberculosis program, organized by PAHO and WHO,<sup>49</sup> the following data were presented:

- Fifty-two percent of all new cases were found in five states, which show rates above 30.0 x 100.000 inhabitants: Distrito Capital (79.89), Delta Amacuro (50.53), Portuguesa (38.82), Amazonas (38.79) and Cojedes (31.09).
- The most affected groups are identified as: Indigenous people (631 cases); diabetics (618 cases); prisoners (588 cases); PLHIV (585 cases); health personnel (150 cases); and contacts of patients with multi drug resistance (MDR-TB) (7 cases).

International and domestic tuberculosis activists and experts who spoke to ICASO described a pattern of serious deficiencies: lack of PPD (tuberculin sensitivity) tests in most hospitals, and of PCR (polymerase chain reaction) outside of Caracas; lack of access to many critical exams except at private laboratories at high cost (including serology, bacterial culture, pathological anatomy, Ziehl Neelsen exams, ADA and DNA amplification exams); lack of medication for side effects; frequent transfers among clinics to complete thorax and blood exams; treatment interruptions; and lack of trained staff in some areas of the country. In addition, they described underestimation of TB and TB/HIV co-infection among indigenous groups, and lack of screening for HIV among TB patients.

***'The main barrier to obtaining information on tuberculosis epidemiology is the domineering role of the military who control access to the data pertaining to this disease and their unwillingness to publish it.'***

MEDICAL DOCTOR, INFECTIOUS DISEASE SPECIALIST AND MEMBER OF THE SOCIEDAD VENEZOLANA DE INFECTOLOGÍA TUCUPITA, DELTA AMACURO.

# The role of the international community: The Global Fund to Fight AIDS, TB and Malaria

The Global Fund is an international health financing mechanism, founded in 2002, which gathers resources from governments and from private foundations and redistributes these funds to eligible national and regional health programs.

Eligibility for Global Fund financing<sup>50</sup> is currently strictly governed based primarily on two criteria: a) country income classification (based on a three-year average of Gross National Income per capita [GNIpc], as reported annually by the World Bank)<sup>51</sup>; and b) disease burden (based on data reported by UN health agencies), which is used to evaluate a subset of upper-middle-income countries that might not otherwise qualify.<sup>52</sup> Countries must be eligible for two consecutive 'eligibility determinations' (i.e. years) in order to be eligible for the Global Fund, and even then, may not always receive an allocation. A number of exclusions and exceptions apply for upper-middle-income countries that are either on the Group of 20 (G-20), or on the OECD DAC list of Overseas Development Assistance (ODA), or that are small island countries, for example.<sup>53</sup> Because of its high income as measured through GNIpc, Venezuela has never been eligible for Global Fund financing.

However, most countries in the region have a higher than 5% prevalence in men who have sex with men. As the health crisis worsened in 2016, Venezuelan AIDS activists were among the most visible groups to reach out to international allies to sound the alarm. In June 2016, Venezuelan AIDS activists wrote to the Global Fund Board chair, vice-chair and executive director describing the conditions in Venezuela (Figure 8) and asked the leadership of the Global Fund 'to approve an exception to provide urgent humanitarian aid for HIV and AIDS and Tuberculosis, literally we are not only suffering hunger, but we are also dying because our health system is totally collapsed.'

For reasons that have never been publicly explained, the Global Fund waited seven months to respond. In the letter (Figure 9), the Global Fund declined to provide assistance: 'As you have rightly mentioned, and in accordance with the GNI per capita thresholds for income classification published by the World

## Understanding eligibility

An Upper Middle-Income Country (UMIC) is eligible if the average income classification in 2 consecutive years is below 'High Income'. In 2015, Venezuela was considered 'high income' but that classification was revised in 2016 to Upper Middle Income and in 2017 remained as UMIC (like Peru and Colombia, which are recipients of Global Fund money). Therefore, in terms of income, Venezuela is eligible for Global Fund support now. However, UMICs still need certain criteria in terms of burden of disease. In the case of HIV, it needs to have either a 1% or above HIV prevalence rate in the general population or at least 5% in a key population (as defined by the Global Fund: men who have sex with men, sex workers, people who use drugs, or transgender persons). Venezuela does not have 1% HIV prevalence rate in the general population and does not have information or validated studies of HIV prevalence rates in any of the key populations.





Mr. Norbert Hauser, Chair of the Board of the Global Fund  
Ms. Aida Kurtovic, Vice-Chair of the Board of the Global Fund  
Dr. Mark Dybul, Global Fund Executive Director  
Members, Alternates and Focal Points of the Board of the Global Fund

June 6, 2016

### VENEZUELA NEEDS YOUR URGENT HELP

Venezuela a country that according to the World Bank classification is high income, that is to say classified as rich, therefore completely ineligible for international aid and to get support from the Global Fund to Fight AIDS, Tuberculosis and Malaria that you represent. With this WB classification, you may imagine that we have living standards and access to healthcare services similar to the European Union, the United States, Canada, Australia or Japan. However, for us who live in dire straits, we clearly know that way of thinking is far from true, this classification does not mean anything, in fact, global travelers who have visited us recently have told us that the current situation in Venezuela on access to food and basic health services is much more like sub-Saharan Africa and especially to what happened in Zimbabwe a few years ago

Our currency has depreciated by about 900% in three years; Inflation is estimated to be at around 700%; government offices only work two days a week for lack of electricity; in terms of insecurity at this time maybe we are just below the war zone in Syria. Currently we have queues and long waiting times of several hours in supermarkets for basic products such as chicken, sugar, rice, coffee, milk, etc. And sometimes after several hours of waiting, when our turn comes the product is already sold out

Health services conditions in Venezuela are deplorable, no lab reagents, some TB referral centers cannot take simple chest X-rays because no plates or because the equipment is broken, medicines are scarce, some have been in complete zero stock for a few months, hospitalization areas without running water, fully-contaminated surgery rooms, not enough anesthesia to treat the wounded, several thousand people with HIV are now without antiretroviral treatment

We know that currently the world does not care about Venezuela or they think the problem will be solved by Venezuelans or that in any case we will receive help from Latin America, and of course perhaps in many cases many countries do not like the government that Venezuela has. In this letter we do not intend to speak bad or good about the current government of Venezuela, but make a strong call for international solidarity and support for the people of Venezuela who are not just facing the most severe economic crisis in our history, but in an emergency of food and unprecedented health services crisis

Perhaps you consider that this situation is only juncture, well then we ask for at least short term international aid, we would like to ask you to approve an exception to provide urgent humanitarian aid for HIV-AIDS and Tuberculosis, literally we are not only suffering hungry, but we are also dying because our health system is totally collapsed.

If urgent help won't pass, please at least come to Venezuela immediately come visit us to assess with your own eyes and confirm that we are not exaggerating and that our suffering is real

Our mobile phone and e-mail: (+58) 414-037.7988, [amavidazulia@gmail.com](mailto:amavidazulia@gmail.com) ; [secretario.rvg@gmail.com](mailto:secretario.rvg@gmail.com) ; [anieves@accsi.org.ve](mailto:anieves@accsi.org.ve)

SINCERELY,

By the Board of the RVG+ Network of Positive People Venezuelan:

Estevan Colina RVG+ General Secretary	Carlos Henríquez RVG+ Focal Point Amazonas	Mildred Bolívar & Ricardo Rojas RVG+ Focal Point Anzoátegui
Pablo Montilva RVG+ Focal Point Apure	Norah Blanco & Luis Figueroa RVG+ Focal Point Aragua	Annyhec Pantoja RVG+ Focal Point Barinas
Yannys Navarro & Mauro Olivares RVG+ Focal Point Bolívar	Eduardo Franco RVG+ Focal Point Carabobo	Ana Carvajal RVG+ Focal Point Delta Amacuro
Ygor Gómez RVG+ Focal Point Distrito Capital	Arcadio Bracho RVG+ Focal Point Falcón	Daniel Jerez RVG+ Focal Point Guárico
Raiza Farnataro RVG+ Focal Point Lara	Carlos Contreras RVG+ Focal Point Mérida	Ángela Delgado & José Toro RVG+ Focal Point Miranda
Juan Marciano RVG+ Focal Point Nueva Esparta	Yanneris Coll & José Antonio Becerra RVG+ Focal Point Portuguesa	Domingo Vivas, Marisol Martínez & Jhonny Parra RVG+ Focal Point Táchira

1

2

Figure 8: Letter from RVG+ to the Global Fund, June 16 2016

Bank, Venezuela remains among high-income non-OECD countries and as such is not eligible. As an agency relying itself on donations from multiple stakeholders, the Global Fund is not in the position to grant any exceptions from its rules'.

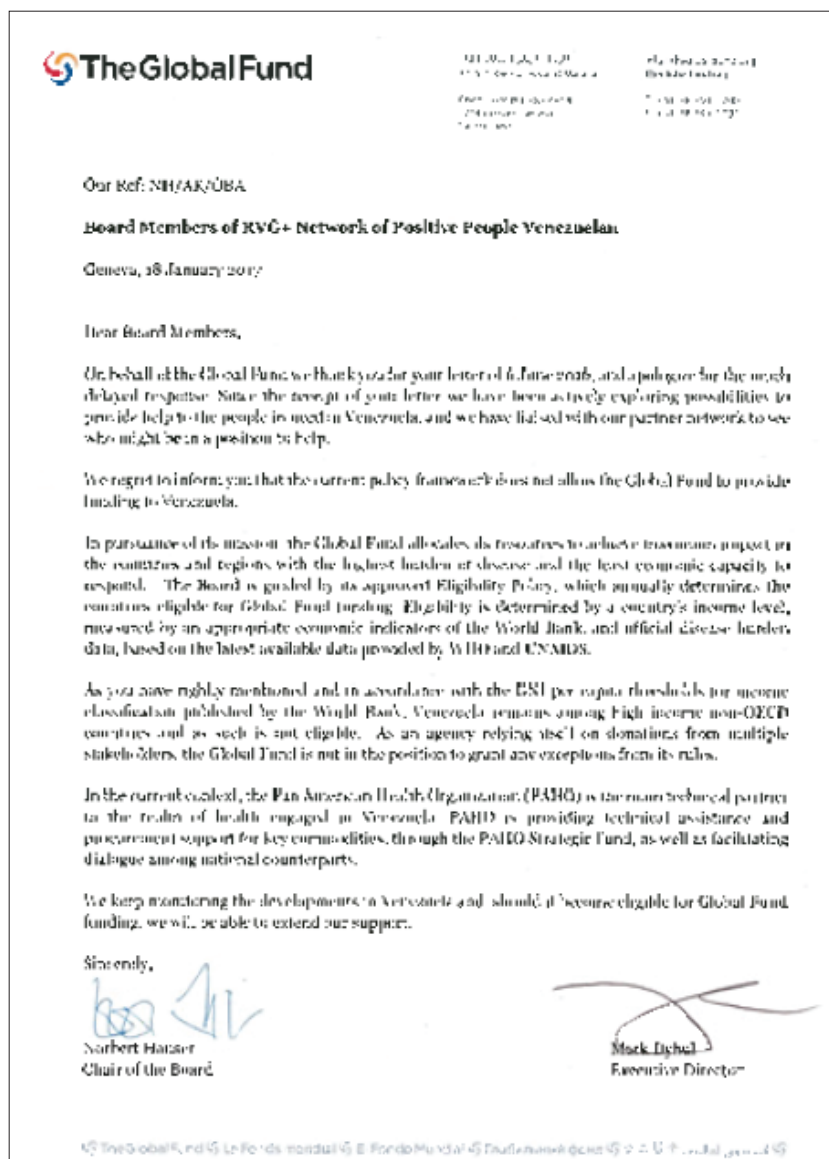
The response to this categorical refusal of aid was immediate and outraged. ICASO, the Global Network of People Living with HIV (GNP+) and AIDS Healthcare Foundation (AHF), among others, denounced the response.<sup>54</sup> An online petition calling on the Global Fund to provide exceptional funding for Venezuela received more than a thousand signatures.<sup>55</sup> Venezuelan AIDS activists also responded to the letter with another letter of their own, calling for the Global Fund to revisit its response (Annex 1). The three civil society delegations (developed countries, developing countries and communities living

Maria Almeida  
RVG+ Focal Point Yaracuy

José Bravo & María Ortega  
RVG+ Focal Point Zulia

Civil Society Organization and the citizens in Venezuela:

1. Allyoner Rodríguez de Martínez, C.I. No. 12.369.659, Lara state
2. A.C. Impulso Vital Aragua, Luis Figueroa, Presidente, Aragua state
3. A.C. MERESERE Mérida Rescatando una Salud Sexual Reproductiva Responsable, Ysrael Colmenares, Presidente, Mérida state
4. ACCSI Acción Ciudadana Contra el SIDA, Alberto Nieves & Argenis Mondragón, Caracas
5. ADHAM Asociación de Derechos Humanos Amigos de Margarita, Juan Marciano, General Coordinator, Nueva Esparta state
6. AMAVIDA Asociación Civil Manantial de Vida Pro Defensa de los Derechos Humanos, José Bravo, Zulia state
7. Anibal Anunciata, C.I. No. 7.139.348, Caracas
8. Anzoátegui Sin SIDA, Mildred Bolívar, Anzoátegui state
9. Asociación Civil VIH/DAS, Daniel Jerez, Guárico state
10. ASOMIVIV, Yanneris Coll, Portuguesa state
11. Carlos Eduardo Contreras Guerrero, C.I. No. 18.208.265, Mérida state
12. Coalición de Organizaciones con Servicio en VIH/SIDA del Interior del país COVIP, Ysrael Colmenares, General Secretary
13. FAVID Fundación Arcoiris por la Vida, José Toro & Tony Espinosa, Miranda state
14. Fundación Acción de Guayana por la Vida AQUIV, Bolívar state
15. Fundación Conciencia por la Vida, Edgar Arias, Lara state
16. Fundación Gran Familia de la Salud, Mauro Olivares, Bolívar state
17. FUNDAPEMA Fundación Pablo Emidio Montilva Aragua, Apure state
18. FUNDASIDARTIA Fundación SIDA Región Táchira, Raiza Parra de Mora, Presidente, Táchira state
19. ICW+ Consejo Internacional de Mujeres con VIH Capítulo Venezuela, María Ortega
20. ISAMAR, (Sucre)
21. MAVID Manos Amigas por la Vida, Eduardo Franco, Carabobo state
22. MERESERE Mérida Rescatando una Salud Sexual Reproductiva Responsable, Ysrael Colmenares, Presidente, Mérida state
23. Proyecto de Vida, José Antonio Becerra, Portuguesa state



**Figure 9: First letter from the Global Fund in response to RVG+, January 18 2017**

the three diseases. PAHO conducted some studies to calculate these needs, which were presented to the Global Fund.

The Global Fund's founding principles, as set out in its Framework Document, clearly state that a range of eligibility criteria are 'essential', including 'potential for rapid increase in the disease' and 'political commitment, as measured by a variety of indicators'.<sup>57</sup> It states that 'Exceptions may be made for countries in special circumstances (such as countries in conflict).' But the criteria used to evaluate eligibility today have narrowed significantly from the founding approach of the Fund, which viewed the funds mobilized as a 'war chest' to fight the three diseases. Fifteen years later, the Global Fund has positioned itself more as a development actor, supporting countries as they move along a 'development continuum' towards a permanent state of 'sustainability.' However, the case of Venezuela challenges these linear concepts of

with the three diseases) as well as the Latin American and Caribbean delegation formally complained to the Global Fund for how they were handling the case.

Because of the above actions, in February 2017, the Global Fund leadership responded again, this time with a more conciliatory letter (Figure 10). They offered to assist Venezuela to access competitive pricing for commodities, to consider a multi-country malaria grant, and to work with PAHO on procurement of medicines. Online commentary by AIDSPAN cautiously praised this second response, but asked why the Fund could not find more flexibility, as it had in some previous cases.<sup>56</sup>

In the ensuing months, in preparation for a May 2017 Board meeting, debate continued behind the scenes, including by the Latin American and the Caribbean delegations. The internal and external advocacy had several aims, among them that the Global Fund would recognize the Venezuelan situation as a crisis and that the Board would instruct its technical partners and the Secretariat to calculate the need for resources for





**Figure 10: Second letter from the Global Fund to RVG+, February 2 2017**

development, as a country that once achieved everything that might be hoped in economic development – including the elusive goal of malaria eradication – and now has rapidly lost ground.

The case also points to the ways in which infectious diseases do not respect national borders: GNI per capita in one country says nothing about its ability or willingness to respond to the health needs of those most marginalized communities on national borders – indigenous peoples, rural communities, migrants, refugees, and others – who frequently cross to neighboring countries. While the Global Fund's current strategy calls for it to focus on the populations most affected, a country-driven and GNIpc-driven approach to eligibility limits the degree to which the Fund can direct funding to communities that need it most.

As debates progressed at the Board, a variety of rules and exceptions seemed to exclude Venezuela from eligibility. As an upper-middle-income country, Venezuela could potentially be eligible with evidence of a high, severe, or extreme disease burden in either HIV, TB or malaria. For HIV, this includes national prevalence of over 1% or prevalence among a key population of over 5% (see Table 2). The absence

of official epidemiological information made this difficult. A UN representative who spoke to ICASO said UNAIDS had argued to the Global Fund that a published academic study showing high HIV prevalence among Warao indigenous peoples should be used to deem Venezuela eligible. However, the Global Fund Secretariat responded that indigenous people are not a recognized key population.

A final option proposed by advocates was to finance aid to Venezuela from an emergency fund set up at the Global Fund for crisis situations, such as health programs for refugees from Syria. However, as Venezuela was not eligible for Global Fund financing, it also was not eligible for the emergency fund – which had also been cut by the Board from a \$30 million starting fund to \$20 million. As one Secretariat official pointed out, ‘We have four famines in eligible countries this year, and \$20 million is not enough to meet the needs in Venezuela.’ The actual amount needed is itself difficult to calculate, due to the lack of data. By the end of July 2017, an exercise by experts using data from the National AIDS Program (NAP) and WHO price list of essential medicines created monthly estimates: to provide all the ARVs needed for six months would require approximately US\$12 million, with closer to \$35 million needed to also procure breast milk substitutes and HIV rapid tests. The calculations for the other two diseases were not available.

The only way for the Fund to finance programs in Venezuela, then, was for the Board to pass a decision specifically on that country. Advocates pursued this through sympathetic champions on several Board delegations. At the Board meeting in May 2017, a closed session considered available options. The resulting decision point approved by the Board expressed ‘continued concern about the resurgence of malaria, shortages of critical commodities for HIV and TB, and broader health crisis in Venezuela and its impact on the region,’ and committed to participating in a regional response (see Figure 1).

As of the time of publication of this report, that regional response has yet to materialize. Country advocates interviewed for this report indicated that UNAIDS has been actively engaged in the country, in particular working with and directly supporting civil society. PAHO provided some of their own resources to purchase ARVs, antimalaria medication and post-exposure preventive kits. UNICEF also provided ARVs for children from within their own resources. However, a more comprehensive and coordinated regional response to provide humanitarian aid to Venezuela is urgently needed. In short, the regional response, urgently needed, seems stalled. There is an urgent need for a concerted effort. The Board of the Global Fund could direct emergency funding to be allocated to PAHO, and could direct the Secretariat to work with NGOs and faith-based organizations to support the development of a regional funding request.

The World Bank also has an opportunity to lead this work. Perhaps surprisingly (given that its income data has been used to deem Venezuela ineligible for Global Fund aid), the World Bank publicly offered aid to Venezuela in April 2017.<sup>59</sup> Venezuela withdrew from the World Bank in 2007, and all World Bank projects in the country are now closed.<sup>60</sup> However, if the World Bank were to lead or participate in a regional response, this might increase the possibility of the Global Fund contributing, assuming other Global Fund criteria for grantmaking and accounting could also be met.

**Table 2: Global Fund Eligibility: Disease Burden Indicators**<sup>58</sup>

	<b>HIV*</b>	<b>TB*</b>	<b>MALARIA* ‡</b>
<b>Category</b>	<i>HIV prevalence in population and/or key populations</i>	<i>Combination of TB notification rate per 100,000 population (all forms including relapses); and add WHO list of high burden countries (TB, TB/HIV or MDR-TB burden)</i>	<i>Combination of mortality per 1000 at risk of malaria; morbidity rate per 1000 at risk; and contribution to global deaths attributable to malaria.</i>
<b>Extreme</b>	HIV national prevalence ≥ 10%	TB notification rate per 100,000 ≥ 300 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥ 2 <b>OR</b> Contribution to global deaths ≥ 2.5%
<b>Severe</b>	HIV national prevalence ≥ 2% and < 10%	TB notification rate per 100,000 of ≥ 100§ <b>OR</b> TB notification rate ≥ 50 and < 100 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥ 0.75§ and morbidity rate ≥ 10 <b>OR</b> Contribution to global deaths ≥ 1%§ <b>OR</b> country with documented artemisinin resistance
<b>High</b>	HIV national prevalence ≥ 1% and < 2% <b>OR</b> prevalence in a key population ≥ 5%	TB notification rate per 100,000 of ≥ 50 and < 100 <b>OR</b> TB notification rate per 100,000 ≥ 20 and < 50 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥ 0.75 and morbidity rate < 10 <b>OR</b> mortality rate ≥ 0.1 and < 0.75 regardless of morbidity rate <b>OR</b> contribution to global deaths ≥ 0.25% and < 1%
<b>Moderate</b>	HIV national prevalence ≥ 0.5% and < 1% <b>OR</b> prevalence in a key population ≥ 2.5% and < 5%	TB notification rate per 100,000 of ≥ 20 and < 50 <b>OR</b> TB notification rate per 100,000 < 20 and high TB, TB/HIV or MDR-TB burden country	Mortality rate < 0.1 and morbidity rate ≥ 1 <b>OR</b> contribution to global deaths ≥ 0.01% and < 0.25%
<b>Low</b>	HIV national prevalence < 0.5% and prevalence in a key population < 2.5% <b>OR</b> no data	TB notification rate per 100,000 of < 20 <b>OR</b> no data	Mortality rate < 0.1 and morbidity rate < 1 <b>OR</b> contribution < 0.01% <b>OR</b> no data

\* Data sources: HIV and AIDS: UNAIDS and WHO. If data are available for specific key populations, the highest prevalence will be taken into account. Tuberculosis: WHO. Malaria: WHO

‡ The Secretariat will use malaria data for earlier years (2000) as recommended by WHO. In the case that an application is submitted from a sub-national applicant the Global Fund will use incidence and mortality rates for those specific areas (and the contribution of those areas to the global burden).

§ And not covered by the criteria for the Extreme category

# Conclusions

Venezuela is a case study of the many ways in which international policies, based on numerical indicators and data, have failed to address a burgeoning crisis for the country and the region. Venezuela's crisis is the result of a long process of political unrest and bad economic decisions. While it is in many ways unique, the case also is an indication of things to come. Many current high-income countries are more vulnerable than they appear, and could experience shocks – whether due to conflict or natural disasters – that rapidly move them from one spot on the development spectrum to another.

In the meantime, while the international community observes and some debate the Venezuelan crisis, civil society in the country continue to respond, with minimal resources. CODEVIDA, a coalition of organizations fighting for the right to health and life in Venezuela, held hearings at the Inter-American Commission on Human Rights, and met with several missions in Geneva in January and August 2017. Other activists have raised the issue at global meetings and fora and continue providing support to organizations and activists at the forefront of the response.<sup>61</sup>

Venezuelan community-based organizations continue to take extraordinary measures to find, procure, and bring life-saving medicines and commodities into the country, to document the scale of the crisis, and to advocate for their communities. They, and the people they serve, deserve better from the international community than they have received to date.

***‘The director (of an NGO) and her team are going to Colombia by bus periodically. They arrive in Cúcuta and buy ARVs and bring them to Venezuela. Always at the risk of the national police seizing medicines at customs.’***

VENEZUELAN AIDS ACTIVIST

# An Opportunity to Act

The Global Fund to Fight AIDS, TB and Malaria was established as a ‘war chest’ to fight the three diseases. The leadership of the Board is urged to use that fighting spirit to do more to combat the growing HIV, TB and malaria crisis in Venezuela. Civil society, faith-based organizations and academia in Venezuela are ready to receive and distribute aid and goods in the country.

The Board should instruct the Secretariat to urgently convene regional UN and NGO partners to develop a comprehensive response that directs humanitarian aid, including through PAHO, UNAIDS, Roll Back Malaria, Stop TB Partnership and NGOs and faith-based organizations that have a proven track record and access to those most in need.

Through its currently active regional civil society grants, the Global Fund should reprogram unspent funds to civil society partners in Venezuela to provide aid and to play their watchdog role. Global Fund Portfolio Managers responsible for financing in neighboring countries should assess the current impact of Venezuela’s health system collapse on neighboring countries, and reprogram funds to meet urgent needs on the borders, particularly regarding malaria. Longer-term, the Global Fund and UNAIDS should work with Venezuelan NGOs to develop a regional civil society grant that can provide immediate relief, and to continue the important work of documenting stock-outs.

Additionally in the long term, the Board should draw on the Venezuela case to improve and simplify eligibility criteria to better align with the Global Fund Strategy, which focuses on combating the three diseases among ‘key and vulnerable populations disproportionately affected by the three diseases.’ The Board should create a fund to respond to emergencies, including in countries that may not fit its eligibility criteria. It should establish an appeals process for non-eligible countries and disease components.

Other donors – the World Bank, bilateral donors, and private foundations – should urgently fund PAHO and UNAIDS to deliver needed medicines and commodities to the country. They should provide financial support to Venezuelan academics and civil society to document the crisis and to conduct epidemiological research, especially among key and vulnerable populations, such as indigenous peoples. The private sector and other supporters can help by donating food, baby formula, medicines, medical tests, syringes and other essential commodities. UNICEF and other organizations working with pregnant women and children should immediately provide baby formula to pregnant women living with HIV. UNAIDS and international and regional civil society organizations must mobilize to identify practical ways to support Venezuelan civil society and networks, both through aid and through advocacy.

Last, but certainly not least, all of the above would be more feasible and more impactful if the Venezuelan government were to respect, promote and fulfill the right to health: open a humanitarian corridor to allow aid into the country, as well as publish all its epidemiological bulletins and research, and provide an estimate of the cost and plans for health for 2018.

# Acknowledgements

ICASO and Acción Ciudadana Contra el sida (ACCSI) would like to thank people living with and affected by HIV, tuberculosis and malaria in Venezuela that shared their stories, their anguish and their hope. We are also grateful to all those – community activists, doctors, academics, researchers and representatives of the Global Fund and the UN system – who shared information for this report, in some cases despite personal risk. Additionally, we are grateful for support from Tamara Tarcuk Broner, Peter Bouckaert, and others at Human Rights Watch. This report was researched, written, reviewed and edited by ICASO and ACCSI staff supported by Gemma Oberth, Javier Hourcade B., Jorge Saavedra and Rebecca Schleifer. ICASO is a Canadian organization that acts as a global policy voice on HIV issues that impact diverse communities around the world. Our advocacy work champions the leadership of civil society and key populations in the effort to end AIDS. We do this through collaborative partnerships with people and organizations in all regions and various sectors, always with a view to serving and empowering communities. [www.icaso.org](http://www.icaso.org) Acción Ciudadana contra el sida (ACCSI) (Citizens Action against AIDS) is a Venezuelan organization working to ensure effective and coordinated strategies to protect, promote and defend human rights of people living with HIV and other key and vulnerable populations. [www.accsi.org.ve](http://www.accsi.org.ve)



# End notes

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