Communities Delegation

to the Board of the Global Fund to fight AIDS, Tuberculosis and Malaria

EQUITY MATTERS

Discussion Paper on the Global Fund Disease Split Eligibility Policy, and Allocation Methodology

For the Strategy Committee meeting
5-6 July

CONTENTS

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
CRG	Community, Rights and Gender
CSS	Community systems strengthening
EAI	Equitable Access Initiative
GNI	Gross National Income
HIV	Human immunodeficiency virus
HSS	Health systems strengthening
KP	Key population
NGO	Non-governmental organization
PC	Per Capita
RSSH	Resilient and sustainable systems for health
STC	Sustainability, Transition and Co-financing
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

The **Global Disease Split** determines the total amount of funding per disease, although the split of resources is different for each country. To produce country allocations, the allocation formula first divides the total funds available by the global disease split. The current disease split allocates 50% of resources for HIV, 18% for TB and 32% for malaria[1].

The **Eligibility Policy** identifies country disease components (e.g., HIV/AIDS, Tuberculosis and Malaria) that are eligible to receive an allocation from the Global Fund. The Eligibility Policy is designed to support the Global Fund Strategy and ensure that available resources are allocated to countries with the highest disease burden and the lowest economic capital, and to key populations disproportionately affected by the three diseases[2].

The **Allocation Methodology** determines how much funding eligible countries receive as an allocation. The allocation methodology formula allocates funding within each disease funding envelope based on each country's disease burden and economic capacity (measured by GNI per capita). It further defines set-aside amount and priorities for catalytic investments. The allocation methodology seeks to increase the impact of programs to prevent, treat and care for people affected by HIV, TB and malaria, and build resilient and sustainable systems for health.

Both policies have metrics to measure disease burden and economic capacity.

1 The Global Fund. Description of the 2020-2022 Allocation Methodology, December 2019
[2] The Global Fund Eligibility Policy. As approved by the Global Fund Board on 9 May 2018.

1 INTRODUCTION AND BACKGROUND

Year 2001 saw the birth of a new partnership that has rewritten the history of global health, uniting world leaders, communities, civil society, health workers and the private sector in solidarity to end AIDS, tuberculosis, and malaria. Twenty years in, the partnership is estimated to have saved 38 billion lives nearly halving the number of deaths caused by AIDS, malaria and tuberculosis. Yet, none of the Global Plan targets for the three diseases have been met and equity remains a major issue for communities living with and affected by all three diseases. Inequalities are driving all three epidemics, and the COVID-19 pandemic has worsened these three crises. The broad and inclusive consultations that informed the development of the new Global Fund Strategy highlighted the urgent need to ensure access to health services for those most marginalized in every country.

The Global Disease Split, Eligibility policy, Catalytic Investments and the Allocation Methodology, together are the tools used to invest to reduce these barriers and gaps sustainably and equitably. Decisions made will have a tremendous impact on the lives of persons living with or affected by the three diseases and on the impact of Global Fund investments and can help to ensure that no one is left behind.

The Communities Delegation, through this discussion paper, aims to provide a 'reality check', bringing the voices of those living with and affected by the three diseases to the Strategy Committee and the Board deliberations. It is based on desk review and analysis of relevant policies, previous position papers, Secretariat presentations to the Strategy Committee, and information from technical agencies. On-line consultations included semi-structured interviews with technical agencies, various constituencies, SC and Board members, community representatives and Global Fund staff.

As an organization, the Global Fund must live up to its reputation of being swift and agile and must be encouraged by the Board to innovate and adapt in line with the evidence, boldly and swiftly. We caution against allowing time pressure and convenience to lead us into maintaining the status quo, instead of continuously improving and increasing impact.

The paper discusses:

- Adapting Global Disease Split to ensure **equity** in light of emerging evidence, and some questions for consideration.
- Country economic capacity: time to move away from GNI per capita to determine income classification.
- Important considerations for the Eligibility Policy, and additional information and analysis needed to inform the Board decision.

2 REACHING TARGETS

Despite the Global Fund having grown to invest US$ 4 billion a year to defeat the three diseases, the gap to reach Global Plan targets remain significant for all three diseases:

- For HIV/AIDS: Persistent HIV incident infections and deaths with an estimated 3.5 million additional infections and 820,000 additional deaths (since 2010)[3]; a significant number of these deaths were in upper-middle income countries.
- For Tuberculosis: TB burden remains high with 10 million incident cases per year and increasing mortality, with 1.9 million deaths in 2020 alone[4].
- For Malaria: reduction in incidence has stagnated at 1.2 percent (in the last 5 years). Mortality has decreased by 15 percent only (since 2015)[5].

A key challenge from the perspective of Communities is the continuing difficulties for those most vulnerable to HIV, TB and malaria in accessing health services. Despite commitments in the Global Fund Strategy 2017-2022, including Strategic Objective 3 (SO3) on human rights and gender equality, equity and rights remain an afterthought in many countries, and often, in the daily work of the Secretariat. As demonstrated in the Community, Rights and Gender (CRG) annual presentation to the SC and the Board, significant efforts are needed within the Global Fund operations to integrate human rights considerations in policies and policy making processes.

Discrimination and criminalization in many countries continue to create gaps in data, and this affects whether countries prioritize or provide support to key populations at all. Availability of data also determines the amount allocated. Therefore, extra steps need to be taken to consider the impacts of the lack of data and the equity issues at every stage of eligibility, allocation, transition".

The preliminary strategy framework highlights the need to serve people and communities, and to make meaningful progress on global targets for HIV, TB and malaria we must put **equity** at the centre of decision-making and in all the policies we will use to implement that strategy.

3 GLOBAL DISEASE SPLIT

The main issue before this SC is the Global Disease Split. In particular, the Strategy Committee is asked to recommend options within the Global Disease Split: no change to current split, a change to address shifting epidemiological trends, a change only if an increased resource envelope is available. The Committee is further asked to consider options beyond the Global Disease split: whether catalytic investments could be used to increase share of catalytic investments for a component, or whether the Secretariat could be more prescriptive to countries on recommendations to prioritize TB/HIV funding.

The Board-approved global disease split is currently: HIV/AIDS – 50%, Tuberculosis – 18%. Malaria – 32%. Countries have the flexibility to revise the funding split between disease programs and programs

3 The Global Fund, Eligibility & Allocation Review. 16th Strategy Committee meeting. For Committee input.
4 Ibid.
5 Ibid.

that build resilient and sustainable systems for health. The program split is subject to Global Fund review.

The gap to reach Global Plan targets remain significant for all three diseases. As it comes to TB, Global Fund resourcing remain modest compared to HIV and malaria, an imbalance that needs to be addressed. Among all deaths from HTM, TB accounts for 61 per cent (52% plus 9% of those living with HIV) and in most high-burden countries, TB capacities and resources are shifted to COVID-19. HIV and Malaria responses are also heavily impacted by COVID-19.
In the interests of promoting a global response that is equitable and evidence-based, the Communities Delegation remains open to a change to the global disease split that would not significantly change the overall country distribution.

In response to the questions raised in the context of the Global Disease Split Review, the Communities Delegation finds that (A) there is compelling evidence that the share of Global Fund investments should increase for TB, (B), the degree of change in disease split should be limited, and (C), that the most appropriate option to increase the share of Global Fund investment for TB is to change the allocation.

To ensure overall impact of all programs, the Communities Delegation also calls for a significant effort to increase overall levels of funding for the Global Fund. A USD 17.8 billion resource gap was identified for overall HTM response in the lead-up the GF last replenishment (2019), and out of this USD 10 billion is for TB. The biggest needs include community mobilization, capacity building, coordination, human rights, gender sensitive and stigma reduction.[6] Funding for the Global Fund has increased with every replenishment since its 2002[7] up by 9 per cent in 2019 compared to 2016 replenishment, raising an unprecedented US$14 billion. Despite recent slowdown in the rate at which overall ODA has increased (ODA doubled in volume since 2000[8]), there is still space for increase. Foreign aid from official donors rose to an all-time high of USD 161.2 billion in 2020, up 3.5 percent in real terms from 2019[9]. This includes additional spending mobilised to help developing countries respond to the COVID-19 crisis.

4 GROSS NATIONAL INCOME (GNI) PER CAPITA (PC) TO DETERMINE INCOME CLASSIFICATION

Since the early days of the Global Fund, GNI pc has been used to determine the economic capacity of the country, or in GF language “ability to pay”. This indicator however is based on a national average and does not account for inequalities within the country, or the resources that may or may not be available for health. As a result, and to account for the realities in many countries, the Eligibility Policy has become a complex jigsaw puzzle of exceptions that are increasingly illogical and absurdly elaborate, and none of which capture the realities of national epidemics or economic capacity. It is long past time to discard GNIpc in favour of a more rational and sophisticated assessment of countries’ fiscal space for health. This is especially crucial to address equity, and the needs of those most

6 StopTB presentation
7 $6.2 billion in 2004; 9.9 in 2007; 10.3 in 2010; 12.3 in 2013; and 12.9 in 2016.
8 https://www.oecd.org/about/secretary-general/official-development-assistance-2019-data-and-trends-release-paris-april-2020.htm
9 https://www.oecd.org/newsroom/covid-19-spending-helped-to-lift-foreign-aid-to-an-all-time-high-in-2020-but-more-effort-needed.htm

marginalised, who are systematically left behind – and as we have seen, are highly unlikely to have their needs met once the Global Fund divests from the country (or "transitions").

In 2014, the Global Fund joined in convening the Equitable Access Initiative (EAI), which systematically reviewed indicators GNIpc and other indicators. The EAI panel concluded that "*the largest share of disease burden is now concentrated in middle-income rather than low-income countries, a reality that GNI per capital alone cannot capture*"[10]. They affirmed that while GNIpc "*continues to be relevant, it may be inadequate" as the principal basis for determining aid eligibilit*y."[11] Rather, the panel recommended that policymakers develop "*a more comprehensive framework for decision making that accounts for countries' position on health development continuum, based on the analysis if countries' needs, fiscal capacity ad policies*". [12]

As already highlighted by the Communities Delegation in the review of Eligibility in 2017, jointly with the two other civil society delegations (GF/B38/20) the EAI found that "*The analyses demonstrate that the metric is an imperfect measure. GNI per capita is a better measure of the level of wealth in a society, rather than the resources available to a government for investments in health.*"[13] Instead, the EAI recommended analysing budgets, tax revenue, debt burden, and annual interest payments to determine whether a country had resources for health. There was no recommendation from the EAI to use a three-year average of GNIpc, and this does not address the limitations of this indicator. The use of GNIpc as the sole economic criterion has led to an accumulation of rules and exceptions: the small island economy exception, the G-20 rule, the OECD-DAC list of ODA recipients, the 'Approach to Non eligible Countries in Crisis,' and more. The more exceptions are piled on, the more they point to the underlying weakness of GNIpc on its own to accurately guide Global Fund support where it is most needed to achieve the Global Fund strategy[14].

The Global Fund has utilized more sophisticated economic assessments for other purposes. These include:

- Assessments for sustainability and transition
- Assessments used to determine counterpart financing

We urge the members of the Strategy Committee and the Board to consider other options to replace GNIpc and ask the Secretariat to provide reporting on implementation of other economic assessments for Sustainability, Transition and Co-financing (STC) and to propose alternatives to GNIpc.

5 ELIGIBILITY POLICY AND RELATED POLICIES – KEY CONCERNS

To inform future discussions and decisions about the Eligibility Policy, the Board needs more information about the effectiveness of the current policy to address the equity concerns highlighted

[10] The World Bank, The Equitable Access Initiative, 2016. Cited by Sara L.M. Davis. "The Uncounted. Politics of Data in Global Health", 2020, p.163
11 Ibid.
12 Ibid.
13 The Global Fund. The Equitable Access Initiative. 2016; p. 31.
14 Three (3) Civil Society Denegation's Statement on the Review of Eligibility 14-15 November 2017. GF/B38/20

above. This should include an overview on the numbers of countries that have transitioned out of eligibility in the past three years, and which countries are currently either transitioning or projected to transition in the next 3-6 years of the Global Fund Strategy.

- Overall, how are countries that are projected to transition currently performing on indicators relevant to disease burden, and in particular, relevant to gender and marginalized groups affected by each epidemic?
- Are those countries that have recently transitioned or that are projected to transition on track to achieve the end of HIV, TB and malaria?
- Is the general trend positive or retrogressive? How has COVID-19 affected these trends?

In addition, given the worrying increases in deaths related to HIV and TB in UMICs, it would be helpful to understand how countries that are ineligible due to exceptions unrelated to economic or disease burden indicators (such as Argentina, Brazil, China and Mexico, which are ineligible under the G-20 rule) are performing on progress towards the end of HIV, TB and Malaria. Are they on track, and in particular, are they successfully ensuring that no one is left behind? Or rather, are we seeing that countries where the Global Fund does not invest are failing to progress and failing to address equity? Similarly, it would be helpful to have a balanced analysis on the performance of the funding allocated to Russia under the exception to the OECD DAC Requirement for HIV (former "NGO Rule"), and an explanation of why Romania and Bulgaria were deemed to be ineligible, despite policies and human rights abuses against key populations that undermine access to health in both countries. Analysis and explanation of these diverse contexts would be critical strategic information in order to enable the Board to exercise its role and provide well-grounded direction to the Secretariat.

Additionally, we wish to highlight the following key concerns in future discussions of the Eligibility and related policies:

1. Disease burden and incidence of new infections
2. Exception to the OECD DAC Requirement for HIV (former "NGO-rule")

5.1 Disease burden and incidence of new infections

Eligibility is determined based on two criteria: disease burden and economic capacity. To assess **economic capacity**, the Global Fund uses latest three-year average of Gross National Income (GNI) per capita (pc) to determine income classification according to the World Bank income group categories and thresholds. All low and lower-middle income countries are eligible to receive and allocation for the three diseases regardless of disease burden. Upper-middle income countries (UMIC) must meet additional **disease burden criteria**. The criteria to qualify as "High" disease burden is different for the three diseases:

- HIV/AIDs: **prevalence** (national or in a key population) officially requested from UNAIDS and WHO and country is on OECD-DAC list of ODA recipients.
- Tuberculosis: **incidence** rate or proportion of **drug-resistant** new TB cases requested from WHO

- Malaria: **mortality rate** or **contribution to global deaths** or **relation mortality rate/morbidity rate** or **artemisinin resistance** requested from WHO

The Global Fund currently uses *prevalence data* (national level and for key populations) to determine eligibility for HIV. Prevalence data captures the number of People living with HIV (PLHV). It is recognized that the number of PLHIV alone does not adequately reflect the disproportionate burden of HIV amongst key populations[15]. A more accurate way of measuring disease burden would be *incidence rate*, which capture estimated numbers of new HIV Infections. HIV incidence is one of the best measures to understand if the HIV response is having an impact in a setting among a particular population. While incidence rates[16] are currently published by UNAIDS, rates for individual countries are not published due to non - reliability of data.

Key populations and their partners, including men who have sex with men (MSM), transgender women, sex workers and their clients, and people who inject drugs (PWID), remain disproportionally affected and according to recent publication by The Lancet, 62 per cent of all new HIV infections globally in 2019 occurred among these vulnerable groups.[17] The need to focus the response on these high-risk groups wherever they are, cannot be neglected and this should be taken into account starting with the eligibility process.

The HIV and MDR-TB epidemic in Eastern Europe and Central Asia (EECA) has been worsening over the past decade with a spike in new infections. Other regions with significant increase in new HIV infections and where international aid agencies have been transitioning are Latin America and the Caribbean and Middle East and Noth Africa.[18] This is also the case in BRICS countries for tuberculosis. A question to be asked is whether the GF will be able to deliver results if countries with spikes in new infections are being cut out of eligibility. It furthers seems legitimate to ponder whether it would not be sensible to initially focus on where the new infections are incurring in addition to prevalence rates. Explosion of new HIV infections in EECA could have been attenuated if resources were allocation for size estimation and prevention among MSM.

This would mean, instead of using income level as an initial excluding indicator, focus on where the new infections occur and as a second step look at the estimated fiscal space for health any particular country has to prevent new infections and treat existing. The country's ability to pay would determinate the amount the country would receive, not the eligibility.

To counter the issues on reliability of data, additional investment in data gathering and systems and advocacy/pressure from donor countries need to be accelerated. Efforts should also be put into including (aggregations of) community- or citizen generated data. The GF could further explore ways of better capturing disease burden among key populations where data is not available or grossly

[15] As it comes to allocations, as recognized during board meeting (GF/B41/02) using prevalence rates particularly affects the calculation of allocations for low prevalence settings. Therefore, technical partners recommend maintaining, as part of qualitative adjustments, an adjustment for key populations in low prevalence settings

[16] The sex and age distribution in each subnational area is based on HIV incidence rate ratios from Spectrum applied to the population structure in each area. UNAIDS data 2020.

[17] The Lancet. 40 years of HIV/AIDS: a painful anniversary. Vol 397 June 5, 2021. https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2901213-7

[18] Sara L.M. Davis. "The Uncounted. Politics of Data in Global Health", 2020

underestimated (due to criminalization or discrimination discussed in the next section). The GF is further encouraged to together with UNAIDS explore the possibility of complementing the HIV prevalence indicator with potential numbers of infection (size estimates) to improve and increase prevention related intervention and reduce new infections.

5.2 Exception to the OECD DAC Requirement for HIV

The exception to the OECD DAC Requirement for HIV (former "NGO-rule") is clearly in line with the eligibility criteria in the Framework Document, which state that the Global Fund should respond to rapid risk in increase in the diseases, and that civil society should be able to apply directly, given a good rationale. The current policy however does not have sufficient flexibility to cover ineligible UMIC that meets disease burden thresholds. The 'Challenging Operating Environments (COEs) flexibility' does not apply to many of the risk situations and the 'Approach to Non eligible Countries in Crisis,' only allows to respond to "exceptional situations", i.e., crisis situations in non-eligible countries.

In Russia, a relatively small grant in a large country proved effective, despite the difficult operating environment. It has brought together networks of key populations and people living with HIV, who worked together—as well as with provincial and local officials, police, and healthcare providers—to gather information about the HIV and tuberculosis epidemics, advocate for human rights and law reform, and to provide life-saving harm-reduction services to some thousands of people who inject drugs. Some of these services were taken on and financed by local, provincial and national authorities.

The Board should consider expanding this "exception" to cover any ineligible UMIC that meets disease burden thresholds and that is excluded for political reasons (whether OECD DAC rule or G-20 rule).

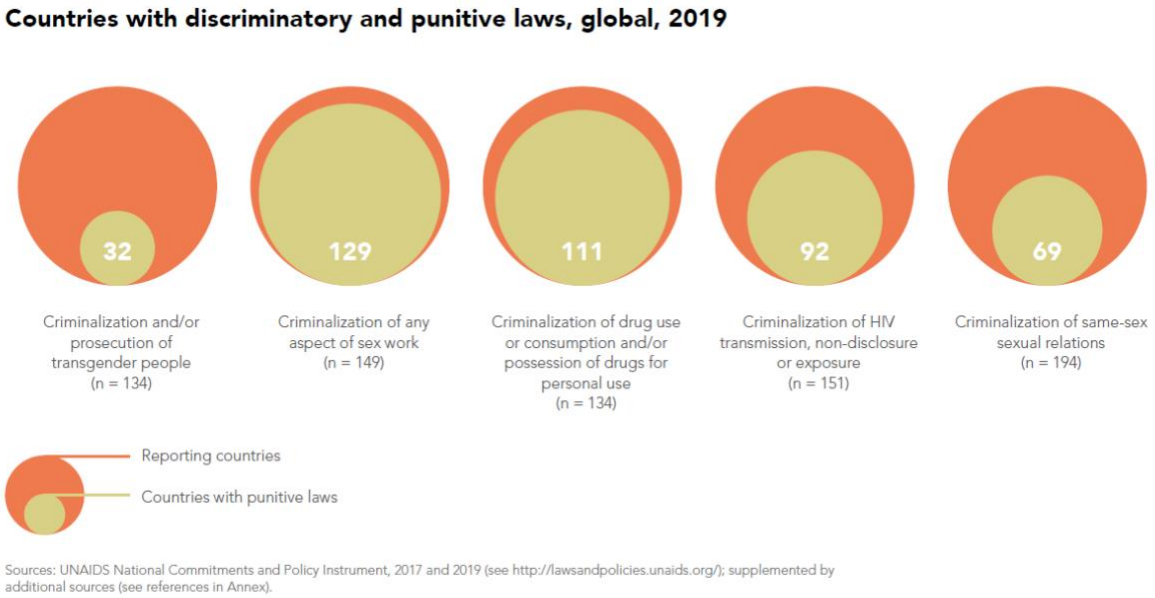
6 CRIMINALIZATION OF KEY POPULATIONS

Previous section referred to over 60 per cent of new HIV infections incurring among key populations globally. Yet many countries continue to criminalise these groups. The Lancet reports that 67 UN member states still criminalise consensual same-sex conduct and 92 continue to criminalise HIV exposure, transmission, and nondisclosure of HIV infection. 18 criminalise transgender people. UNAIDS figures on discriminatory and punitive laws presented below align. With sex work and injection drug use also illegal across much of the world, it is not surprising that effective health interventions are not reaching vulnerable and marginalised people at risk for HIV[19]. Criminalized and discriminated populations understandably tend to avoid health services, and often times health surveys as well. In addition, many governments still deny the existence of certain key populations groups within their borders.

Criminalization of key populations thus brings challenges in generating key population size estimates. Sara (a.k.a. Meg) Davis in her book "The Uncounted" *explores the data paradox in which government*

[19] The Lancet. 40 years of HIV/AIDS: a painful anniversary. Vol 397 June 5, 2021. https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2901213-7 Countries such as Russia, United Arab Emirates, Ethiopia, and Chad still do not report on the numbers of MSM in their countries.

denialism and criminalization reinforce invisibility and shows that criminal laws may make it harder to estimate the actual size of key populations, creating mistaken impressions of success[20]. She further points out that due to the denial of decision makers, little if any research is undertaken on these populations, and the lack of data feeds the denial. She refers to it as *the vicious cycle of invisibility, in which absence of evidence is taken as evidence of absence, and the bodies whose existence is denied are driven into invisibility, illness, even death*[21].



Criminalization and discrimination of key populations in many countries and subsequent lack of data or and/or underreporting on size estimates significantly reduces funding and access to essential health services. In addition, other structural barriers impede the access to services for key populations. The lack of legal gender recognition for example and the pathologizing of trans identities negatively affects trans and gender diverse people accessing health services.

Vulnerable groups exist irrespective of disease. Vulnerability is largely based on lack of access, discrimination, criminalization, stigma and human rights abuses, and vulnerable groups and key populations must be at the forefront of any intervention for them. As it comes to **tuberculosis**, prisoners and incarcerated populations, people living with HIV, migrants, miners, mobile populations and indigenous populations are all key population groups that are highly vulnerable to TB, as well as experiencing significant marginalization, decreased access to quality services, and human rights violations. Discrimination and criminalization constitute challenges for **malaria** as well and populations particularly vulnerable to malaria include refugees, migrants, internally displaced people and indigenous populations in malaria-endemic areas. Pregnant women and children under five overall are the most affected.

The current eligibility policy, to address lack of data for key populations mentions in a footnote: *In the event that there is no officially reported prevalence data for key populations or if the data is*

[20] Sara L.M. Davis, "The Uncounted. Politics of Data in Global Health", 2020, p. 46

[21] Ibid. p. 48

significantly different to the previous year's data and this results in a change in eligibility, the Secretariat will seek clarification from UNAIDS to determine the disease burden data that should be used for assessing eligibility. If UNAIDS did not publish nationally reported data for certain countries because of concerns around data reliability but is nevertheless able to share data from other sources, for example the Key Populations Atlas, with the Global Fund, this data will be used to determine eligibility.

The Global Fund should provide an update on how this has worked in practice and whether additional efforts are needed in order not only to more adequately assess data, but also to advocate for decriminalization and data gathering.

The Global Fund to undertake/fund research research/modelling to better understand the impact of criminalization among key populations, including the relationship between criminalization and availability of data and access to treatment. Where official data is missing, the GF should increasingly exploit qualitative and alternative evidence to analyse needs of 'hidden populations". Ending TB, Malaria and HIV cannot be achieved without targeted programmes that are tailored to key and vulnerable populations.

7 TRANSITION

Country disease components that become ineligible during an allocation period will remain eligible for the duration of that period and may be eligible to receive up to one allocation of Transition Funding to support priority transition needs[22] . The Secretariat will determine the appropriate period and amount of Transition Funding in line with the Sustainability, Transition and Co-financing Policy, taking into account the allocation methodology, country context and existing portfolio considerations.

The impact of COVID-19 on countries in transition and in countries that have become ineligible will need to be taken into account. Decreased domestic and international funding for HIV, TB and Malaria, in the middle of a pandemic response is highly likely to increase infections rates and the effects of the pandemic in many countries will have a negative impact on economic indicators. Ensuring solid on the long-term impact of COVD-19 in these countries on economy and disease burden will thus be important before making any further decisions on transition.

The GF needs to ensure no transition takes place before the full effect of the pandemic has unfolded and date is available. The COVID-19 pandemic will continue to impact the ability of countries to commit domestic resources to fill gaps and a premature or failed transition is mostly affecting key, marginalized and vulnerable populations. Changes in disease burden due to the knock-on effect of the COVID-19 pandemic could also result in previously or newly ineligible countries to become eligible.

The Global Fund to provide any available or forecasted information on disease components that might become re-eligible. In addition, and as mentioned above, more information is needed on the numbers

[22] Unless the reason for the change in eligibility is due to the country moving to High Income status or becoming a member of the OECD-DAC in which case a case-by-case request may be approved on an exceptional basis

of countries that have transitioned in and out of eligibility in the past three years, and which countries are currently either transitioning or projected to transition in the next 3-6 years of the Global Fund Strategy.

The pandemic situation provides an opportunity for the GF to explore additional or alternative metrics for economic capacity instead of current classification based on GNIpc alongside increased investment in community-led monitoring, watchdogs and advocacy.

8 ALLOCATION METHODOLOGY

The allocation methodology is made up of two parts: country allocations and catalytic investments. After the initial allocation formula based on disease burden and economic capacity (GNI/capita), the allocations are reviewed in a qualitative adjustment process which considers contextual factors (defined and plied under the oversight of SC and the Board) such as the needs of key and vulnerable populations in HIV, risk of malaria resurgence and coverage gaps of all three diseases.

As referred to above, the Global Fund Board in 2019 (GF/B41/02) recognized that the number of PLHIV alone does not adequately reflect the disproportionate burden of HIV amongst key populations, which particularly affects the calculation of allocations for low prevalence settings. Therefore, technical partners recommended maintaining, as part of qualitative adjustments, an adjustment for key populations in low prevalence settings. The Communities Delegations would like to receive more information on how this will be put into practice in view of the new allocation period 2023-2025.

8.1 Catalytic investments

Catalytic investments are available for key priorities not possible to address through country allocations alone. For the 2020-2022 period, US$890 million was available and programmed to fund 26 catalytic priorities in three ways:

- **Matching funds** incentivize the use of country allocations. Countries receiving matching funds must meet a defined set of programmatic and financial criteria to access the funds, described in the allocation letters.
- **Multi-country approaches** focus on areas such as sustainability of key population programs and malaria drug resistance, where regional coordination is critical.
- **Strategic initiatives** provide technical support to improve programs, strengthen systems, and catalyse innovation.

The Communities Delegations would like to receive more information and evidence on the results of the various catalytic investments as well as on the decision-making process on how the amount of the catalytic funding will be determined, within the catalytic funding, how much will be allocated to matching funds, multi-country approaches and SIs respectively, and lastly how decisions within these categories will be decided.

9 CONCLUSION - LEAVING NO ONE BEHIND

Many HIV, TB and Malaria strategies have claimed to leave no one behind. But in reality many populations and regions remain neglected and at higher risk of infection and death.
The Communities Delegation and the two civil society delegations have repeatedly urged the Global Fund to take bold and concerted action to access data and to help eliminate barriers and reach the most marginalised and vulnerable. Leaving 'no one behind' requires ambitious action to close equity gaps, and an increased strategic focus on specific sub-groups and intersections of people from key affected populations. Maximizing engagement and leadership of communities will play a critical role in removing barriers to achieving better HTM outcomes.

Leaving countries with higher income classification behind (through non-eligibility or graduation), in addition to putting people at risk, reduces the leverage for donors to put pressure on governments that discriminate against key populations. It also deprives networks of domestic and community activists from much needed funding to continue to advocate their respective countries to generate better data and to push for reform laws to decriminalize key populations.

Smaller size grants could be allocated to civil society including community led organizations in UMICS, to reduce political barriers and to sustain the gains through a range of low-cost approaches that could further contribute to building capacity and to leveraging domestic and additional external funding. The size of grant could be made in relation to the fiscal space for health in respective countries. To reduce transactional costs the Global Fund secretariat could consider efficient ways of clustering and outsourcing management of smaller grants.

UNAIDS in a recent (2021) report asserts: *The people being left behind are preponderantly those subjected to gender inequalities, ostracization and criminalization*[23]. The Lancet article concludes[24]: *The HIV/AIDS pandemic cannot be brought under control without recognising and ensuring the human rights of all, most fundamentally the right to health. If it continues to be a struggle even to acknowledge who is at risk for infection, HIV/AIDS will remain a public health concern for another 40 years and many more lives will be lost.* [25]

[23] UNAIDS, Global commitments, local action
[24] The Lancet. 40 years of HIV/AIDS: a painful anniversary. Vol 397 June 5, 2021. https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2901213-7
[25] Ibid.