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Donor transitions from HIV programs: What is the impact on vulnerable populations?

AUTHORS

Kelly Flanagan, Hannah Rees, Hanna Huffstetler, Kaci Kennedy McDade, Gavin Yamey,
Diana Gonzalez, and Robert Hecht

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ACRONYM LIST

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
CENSIDA	Centro Nacional para la Prevención y el Control del VIH y el sida
CSO	Civil Society Organizations
EU	European Union
FUNSAUD	Fundación Mexicana para la Salud
GDP	Gross Domestic Product
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
KP	Key Populations
LGBT	Lesbian, Gay, Bisexual, Transgender
LIC	Low-income country
MAC	Malaysian AIDS Council
MIC	Middle-income country
MOH	Ministry of Health
MSM	Men who have Sex with Men
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
SSO	Social Service Outsourcing
SW	Sex Workers
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UMI	Upper Middle-Income
US	United States
USAID	United States Agency for International Development

GLOSSARY

Transition: The process by which a country moves towards fully funding and implementing its health programs independent of donor support while continuing to sustain the gains and scaling up programs as appropriate.

Social contracting: The Global Fund to Fight AIDS, Tuberculosis and Malaria defines “social contracting” as a mechanism whereby governments can provide funds directly to civil society organizations to implement specific activities.

These definitions have been adapted from The Global Fund's Sustainability, Transition and Co-financing Policy.¹

 EXECUTIVE SUMMARY

Introduction

As low-income countries (LICs) move into middle-income status, donors reduce their financial support for HIV programs, and countries are expected to eventually transition to entirely domestically-funded responses. One of the most serious challenges in transitioning countries is the impact of transition on key populations (KP). KP—including sex workers (SW), men who have sex with men (MSM), people who inject drugs (PWID), transgender people, and prisoners—are widely subjected to stigma and discrimination. Country governments are often unwilling to recognize that these groups are especially vulnerable to HIV infection and therefore are unwilling to fund and support programs for KP. Due to this unwillingness, outside donor agencies are often the major funders of HIV program activities for KP. Donors often contract with local and international non-governmental organizations to deliver services and provide legal support and support for human rights protections for KP. As donors scale back their funding and exit countries, it is unclear if national governments will continue to support programs for KP (in some cases their support seems doubtful). If they do continue such support, it is also unclear whether they will contract with civil society organizations (CSOs), who are often among the most effective organizations in reaching KP. Without prevention and treatment programs for KP, there is a significant risk that the HIV epidemic could resurge, both within KP and the general population.

Objective of this policy analysis

While this challenge is recognized by the HIV community, in many LICs and middle-income countries (MICs), the risks to KP during transition are often unforeseen, ignored, or not fully addressed in transition planning. To better inform future transition planning efforts for KP, we reviewed and assessed past and ongoing country transition experiences to answer the following questions:

1. What has been the effect of past HIV donor transitions on KP?
2. What were the enabling factors for successful past transitions and what were the challenges that contributed to unsuccessful transitions for KP?
3. What are the risks for KP and what are the opportunities to mitigate these threats in transition planning?

Methods

Our analysis focused on KP in MICs that have recently transitioned or are likely to transition in the near future. We identified twenty MICs that had at one point been eligible for funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and had a high prevalence of HIV among KP. When examining this list of countries, some consistent patterns began to emerge, including that most countries had concentrated epidemics with an overall general population HIV prevalence of less than 1%. However, even in those countries with a generalized epidemic (such as Nigeria or South Africa), the prevalence of HIV among certain KP was almost always greater than 5%. For example, among MSM, HIV prevalence was greater than 5% in fifteen of the twenty countries. It also became clear that although anecdotally it is well known that transgender people and prisoners have a greater burden of HIV than the general population, there is very limited data on the HIV prevalence among these KP in MICs.

We narrowed these initial twenty countries down to six: three countries that had already undergone transition (**post-transition countries**) and three countries that are likely to transition in the coming years (**pre-transition countries**). These six countries were chosen based on regional diversity, high prevalence of HIV among KP, the availability of data, feasibility of conducting key informant interviews remotely, and the anticipated success of the transition. Our **post-transition countries** were China, Mexico, and Romania. For these countries, our aim was to (a) draw out lessons learned, (b) understand the enabling factors for a successful transition for KP, and (c) identify challenges that other countries may face as they approach transition. Our **pre-transition countries** were Cambodia, Malaysia, and Nigeria. For these countries, our aim was to determine any potential challenges these countries may face relevant to KP in their upcoming transition. These six countries are not meant to be statistically representative of transition experiences globally; instead, we believe that they help to illustrate the successes and failures of countries in transition.

We used an in-depth case study approach that included review of the published and grey literature related to transitions in these six countries and key informant interviews.

Findings

From our assessment of the selected **post-transition country experiences**, several key takeaways emerged (Table 1). Our assessment of the three selected **pre-transition countries** highlights several threats to a successful transition as well as some opportunities that the governments and donors can pursue (Table 2).

Table 1. Key Messages from Analysis of Post-Transition Countries

COUNTRY	COUNTRY EXPERIENCE	KEY MESSAGES
Romania	<ul style="list-style-type: none"> A lack of planning and preparation for transition, in part caused by the rapid and precipitous departure of the Global Fund, resulted in a significant financing gap for HIV prevention and services for KP that was not covered by domestic funds. Just 1% of domestic HIV expenditure is dedicated to prevention services and even less to KP prevention services. The lack of a mechanism to fund civil society organizations (CSOs) in Romania, combined with persistent stigma, led to the underfunding of CSOs and forced them to cut back on service provision. 	<ul style="list-style-type: none"> In countries preparing for transition, early and extensive planning may be needed to mobilize domestic financing to cover costs previously funded by donors, including HIV treatment and prevention services targeted towards KP. In situations where donors focus their efforts on HIV prevention and KP, transitioning countries need to increase their prevention spending to avoid a collapse in the delivery of these services following transition. Global Fund and local advocacy organizations need to engage the government earlier and more convincingly to ensure such scaled up prevention spending. Pre-transition countries should begin to identify and develop pathways for domestic funding to be used to support the work of CSOs in effectively providing HIV services to KP.

Table 1. Key Messages from Analysis of Post-Transition Countries (continued)

COUNTRY	COUNTRY EXPERIENCE	KEY MESSAGES
Mexico	<ul style="list-style-type: none"> • Some CSOs in Mexico that received institutional support and training from the Global Fund were not fully prepared to take over service delivery, financed through domestic sources, immediately following transition. • Mexico benefited from its strong history of social contracting, but this mechanism does not hold CSOs fully accountable for results. • Mexico’s transition was successful in part because national HIV program leadership was seamlessly transitioned from a CSO, Fundación Mexicana para la Salud (FUNSALUD), to the Ministry of Health (MOH). 	<ul style="list-style-type: none"> • CSO capacity should be strengthened while donors are still present to ensure that CSOs are prepared for both service delivery and advocacy activities. • Social contracting mechanisms should be established prior to donor exit and should ensure accountability for results. • Donors and governments should work together to ensure that leadership of the HIV response is effectively transitioned.
China	<ul style="list-style-type: none"> • China had a successful transition due to strong political will, high profile support for the HIV response, and the deep involvement of the government in the transition from Global Fund support. • China’s social contracting mechanism is predicated on targets being met by implementing CSOs. • After China’s transition from donor aid for HIV, the continued technical support provided by the US government and UNAIDS has helped to give national institutions the necessary technical capacity to continue a robust and effective HIV response. 	<ul style="list-style-type: none"> • Governments should be fully engaged and well-informed in the transition process. • Social contracting should be results-driven. • Even after financial support has ended, donors should consider continuing technical support to transitioned countries.

Table 2. Key Messages from Analysis of Pre-Transition Countries

COUNTRY	THREATS	OPPORTUNITIES
Nigeria	<ul style="list-style-type: none"> • Legal barriers that are based on deeply-entrenched stigma greatly hinder KP from accessing treatment and services. • Domestic funding of activities targeting KP is very low, and there is no social contracting mechanism through which the government can provide funding to CSOs working with KP. 	<ul style="list-style-type: none"> • Donors and advocates for KP in Nigeria must work together to address and work around the legal impediments to reaching KP. • Donor co-financing requirements should consider the burden of HIV among KP and encourage the government to expand its allocations to these groups.
Cambodia	<ul style="list-style-type: none"> • Social contracting is not currently used by the Cambodian government. • Cambodia has a Sustainability Technical Working Group, a group made up of donor, government, and civil society stakeholders in charge of ensuring the sustainability of the HIV response. This working group is a good example of a country-led transition process, but the government now needs to implement its recommendations. 	<ul style="list-style-type: none"> • Cambodia should take advantage of legal measures allowing the establishment of social contracting mechanisms. These mechanisms should be used to support CSOs targeting KP prior to donor exit. In partnership with donors, the government could also begin to co-fund part of the work that CSOs are doing with KP during the transition period. • The government should create an action plan to implement recommendations of the Sustainability Technical Working Group.
Malaysia	<ul style="list-style-type: none"> • Although Malaysia finances 95% of its HIV response from domestic resources, it is essential to plan for transition, since donor financing comprises a significant portion of the financing for HIV programs that target KP. • The effectiveness of Malaysia’s social contracting mechanism, the Malaysian AIDS Council, is built upon strong leadership and political support. • Malaysia has a large national debt and constrained fiscal environment. Thus, the HIV unit within the MOH, and CSOs working with KP, need to have strong capacity to advocate for HIV funding, especially following transition. 	<ul style="list-style-type: none"> • Donors should require countries to align their co-financing with current epidemiological trends. In the case of Malaysia, such alignment would mean increasing funding for MSM and SW prior to transition.

Recommendations

Based on the lessons learned from those countries that have already undergone transition and the emerging themes from pre-transition countries, we propose five concrete recommendations for donors and countries for the transition planning process.

- 1 Strong political will for the HIV response, as seen in Mexico and China, and an understanding of the importance of HIV programs for KP, should be established prior to transition.** Political leaders need to be sensitized to the challenges surrounding HIV and KP and local champions cultivated.
- 2 Transition planning should start early and be a country-driven process** supported by donors and transition planning tools, as seen in Cambodia, and tied to a monitoring and reporting mechanism.
- 3 Budget lines should be created for the inclusion of HIV program activities for KP in MOH budgets prior to transition,** as seen in Malaysia. Donor co-financing requirements should similarly ensure that countries are substantially supporting HIV program activities for KP prior to transition.
- 4 Social contracting should be introduced in pre-transition countries.** Such contracting should include (1) strong technical and managerial leadership, (2) monitoring and evaluation to ensure that CSOs meet service delivery targets and have the established capacity to deliver services, and (3) the flexibility to cover innovative and potentially controversial activities, such as advocacy and defense of human rights.
- 5 In countries where stigma and discrimination make it hard to implement nationwide policies and programs for KP (such as in Nigeria), sub-national units of government (provinces, municipalities, etc.) can sometimes still take action to support services for KP under the rules of decentralization.**

Conclusion

The record of donor transitions from HIV programs and their impact on KP is a mixed one. Positive outcomes in places like Mexico and China show that success is possible, but serious setbacks have also occurred in other countries like Romania. The next wave of countries facing transition, including Nigeria, Malaysia and Cambodia, will face major obstacles to ensure that KP do not suffer at the expense of transition to full national ownership and financing of the HIV/AIDS response.

1 INTRODUCTION

As low-income countries (LICs) grow economically and become middle-income countries (MICs), donor support for their HIV response begins to decline and countries transition towards entirely domestically-funded and domestically-implemented responses. Both the transition process and its implications for the sustainability of a country's HIV response differ depending on the country context. One of the most serious challenges observed in transitioning or post-transition countries is sustaining high quality services for key populations (KP). Such populations are at a higher risk of HIV infection and often do not receive adequate services because of high levels of stigma and discrimination. This challenge poses serious dangers for individuals in these communities, who may continue to experience high rates of infection and more HIV-related illness and mortality because of the stigma and discrimination they face.

In addition, if KP are not adequately assisted during the donor transition period, there is a chance that HIV infection will “bridge” or spread to the general population. Such spread would set back efforts to achieve national HIV targets, such as the 90-90-90 goals (by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression). It would also undermine the millions of dollars previously invested in controlling and ending the epidemic.

While this challenge is recognized by the HIV/AIDS community, the importance of providing HIV services to KP to the global HIV response, as well as the risk that such services may be neglected during donor transition, is not fully recognized in many countries that face transition in the coming years. These countries currently receive funding from two major external sources – the Global Fund and the US President’s Emergency Plan for AIDS Relief (PEPFAR) – and both donors have made commitments to sustainability and coordinated transitions.^{1,2} Strong transition plans are not yet in place in these countries, though this situation is starting to change thanks to new processes such as the Global Fund’s “transition risk assessments” (TRA)³ and PEPFAR’s Sustainability Index Dashboard (SID).²

Several recent studies have focused on HIV donor transitions that have already occurred and the sometimes negative impact of these transitions on KP.^{4,5,6} However, few have applied the lessons learned to the next wave of countries likely to undergo transition in the coming years.

This new policy analysis attempted to draw out such key lessons. Specifically, the analysis seeks to answer three questions:

1. What have been the effects of past HIV donor transitions on KP? What has gone well and where have failures occurred?
2. What were the enabling factors for successful past transitions and what were the challenges that contributed to the failures?
3. What challenges are KP in the current cohort of pre-transition countries likely to face and what could be done to mitigate these problems through improved country and donor policies?

Why this analysis focuses on KP

KP, including MSM, transgender people, SW, prisoners, and PWID, are ten to twenty times more likely to become infected with HIV than the general population.^{7,8} In sub-Saharan Africa, 25% of new HIV infections in 2016 were in KP, while in all other regions of the world KP and their partners accounted for 80% of new infections.⁹ There are both biological and structural factors responsible for this disproportionate burden. MSM face greater transmission risks through a complex set of behavioral and biological risk factors (including infection with other sexually transmitted infections).¹⁰ PWID are at greater risk for HIV due to risk factors such as sharing needles or having high risk sex when using drugs. Further, KP often lack adequate access to care and services because of stigma and discrimination.¹¹ Only 8% of KP have regular access to HIV services.¹²

The human rights of KP are often jeopardized. Same-sex relations are criminalized to some extent in seventy-four countries, and only nine countries globally protect the rights of lesbian, gay, bisexual, and transgender individuals in their constitution.¹³ PWID are almost universally criminalized, and between 56% and 90% of PWID will be incarcerated at some point in their life.¹⁴ Sex work is also criminalized in most countries, and for this reason, many SW do not seek help from law enforcement when they are discriminated against or abused for fear of prosecution.¹⁵

Because of the disproportionate burden of HIV infection that KP face, and the discrimination that they experience, KP are particularly vulnerable when countries transition away from donor support to a domestically-funded HIV response. Over 90% of HIV programming for KP is funded by donors in LICs and MICs.¹⁶ Country governments are often reluctant to fund programs for these marginalized, stigmatized, and at times criminalized populations, and when donors stop providing funds, these programs may end. Maintaining funding for HIV programs for KP is critical, not only from a human rights perspective, but also because neglecting these populations could risk HIV resurgence and jeopardize the achievement of the 90-90-90 targets. In Romania's capital, for example, HIV prevalence among PWID was 1.1% in 2009; however, it rose to 6.9% in 2012 following the Global Fund's exit and peaked at 53% in 2013.¹⁷

The role of CSOs in the HIV response

CSOs have a critical role to play in the HIV response when it comes to KP. CSOs often are the main providers of prevention, care, and treatment services for KP, and they act as advocates for the KP they serve. As independent organizations, they can hold the government accountable for its actions.

The Global Fund and PEPFAR are often the primary source of funding for HIV-focused CSOs in a given country.¹⁸ When Global Fund and PEPFAR funding ends, governments often either do not fund KP activities at all, decide to only fund services for KP through government facilities, or do not provide all of the funds necessary for CSOs' activities. CSOs thus struggle to find funding for their programming, reducing their ability to provide services to KP and significantly weakening a country's HIV response.

CSOs are essential to the HIV response following transition, particularly if the government does not prioritize KP as donors do. CSOs can advocate for more funding to be allocated to HIV programs for KP, and the HIV response in general, when donors no longer have a say. CSOs can also reach KP to provide services in ways that the government cannot through community-based programming, peer-to-peer approaches, and less traditional outreach such as condom distribution in nightclubs. When KP are criminalized, CSOs have the autonomy to work with these populations even when governments cannot. “Social contracting” is a mechanism used in some countries where governments can directly fund CSOs to implement these activities that the government cannot implement as effectively. This mechanism has been proven successful in several countries pre- and post-transition.

Given that CSOs are a major provider of services to KP and because of the unique risk transitions pose to CSOs, our analysis considers the impact that transitions have had on CSOs. The analysis includes examples where CSOs’ activities have been seriously curtailed after donor exit, as well as examples where governments have replaced donors and maintained support for CSOs.

2 METHODS

In this analysis, we began by examining a large number of MICs in all regions where donor transition has already happened as well as countries where donors are likely to exit in the next few years. Countries were considered if they had at one point been eligible for Global Fund funding and had a high prevalence of HIV among KP. We identified twenty countries (Annex A). We noted that in these countries, especially where there is a concentrated epidemic (overall prevalence is less than 1%), KP account for a large share of people living with HIV (PLHIV). Even in countries with larger generalized epidemics, KP still experience much higher rates of infection.

From there, we selected three countries that have already undergone transition (**post-transition countries**) to (a) identify lessons learned, (b) understand the factors that can help ensure that KP are not harmed by transition, and (c) consider the challenges that other countries may face as they approach transition. We then selected three countries that are likely to transition in the coming years (**pre-transition countries**) to determine the challenges that KP may face from these upcoming transitions. These six countries were chosen based on regional diversity, high prevalence of HIV among KP, the availability of data, feasibility of conducting key informant interviews remotely, and the anticipated success of the transition.

In the following sub-sections, we begin by explaining our selection of countries. We then describe our overarching methodological approach, in which we triangulated the results of a literature review with those emerging from key informant interviews.

Selection of countries for inclusion in the analysis

Of the twenty initial countries (Annex A), six were selected based on several criteria including:

- **Region.** We selected countries from multiple world regions.
- **High HIV prevalence in KP.** Since our analysis focused on the experiences of KP in transitioning countries, we chose countries that have a high HIV prevalence in KP.
- **Availability of data.** We included countries that have publicly available HIV-related data.
- **Feasibility of conducting key informant interviews.** We included countries where it was feasible to conduct key informant interviews by telephone (we did not have funding to conduct in-country visits and in-person interviews).
- **Anticipated success of the transition.** To generate lessons learned, we chose a range of post-transition countries that had transitioned with varying success in terms of HIV program sustainability and disease burden. Similarly, for the pre-transition countries, we tried to include countries that face varying vulnerability to HIV resurgence in the wake of transition.

Based on these criteria the **post-transition countries** included in our analysis were **China, Mexico, and Romania**. The **pre-transition countries** were **Cambodia, Malaysia, and Nigeria**. We recognize that the findings from six countries cannot be generalized to all settings. However, we believe that studying a range of post- and pre-transition countries has allowed us to draw out a number of broadly applicable lessons.

Country case studies

We used an in-depth case study approach. We conducted a literature review and structured key informant interviews to supplement the literature review and help close any knowledge gaps (Annex B gives a sample interview guide). We included both peer-reviewed and grey literature, along with program data from the Global Fund and PEPFAR. We interviewed fourteen key informants familiar with one or more of the six selected countries. These informants were chosen based on their professional experience with the selected countries. We interviewed five representative of HIV donor organizations, two academic researchers, three representatives from CSOs, three government officials, and one employee from UNAIDS.

As the Global Fund was or is the main funder of HIV programming in most countries examined, our report mostly focuses on transition from Global Fund support. PEPFAR also contributes a substantial amount, particularly in Nigeria and Cambodia, and therefore is also included in our analysis.

In the country case studies of post-transition countries, we first describe the epidemiological context for the burden of HIV among KP and the history of donor support. We then describe the country's transition experience, highlighting the impact this has had on KP and the current status of service provision and social contracting (financing of CSOs). These analyses helped identify the key enabling factors to a successful transition for HIV services for KP and any challenges threatening the future of the country's response. We end each section summarizing the lessons learned from the country's experience and offering recommendations for future country transitions.

In the country case studies of pre-transition countries, we provide an overview of the prevalence of HIV among KP. We then outline access to services among KP, how KP programming is financed, and what legal barriers KP may face. We also describe the role of social contracting in these settings. Finally, we end each section summarizing the threats to and opportunities for a successful transition from a donor-financed HIV response.

3 FINDINGS

Table 3 (on the following page) provides an overview of the six selected countries. Although prisoners are considered a KP by some organizations and in some contexts, most donors have little programming for this population and therefore the transition is unlikely to have a major impact on outcomes for prisoners. However, prisoners are an often-neglected population and implementation of interventions for prisoners should be considered both prior to and following transition. We found limited information on prisoners and the HIV response in the countries included in our study.

Table 3. Overview of Selected Countries

	TRANSITION STATUS	GNI PER CAPITA ¹⁹	KP HIV PREVALENCE ²⁰	PERCENT OF HIV PROGRAM THAT IS DOMESTICALLY FINANCED*	TOTAL GLOBAL FUND HIV FUNDING TO DATE (MILLIONS) ²¹	TOTAL PEPFAR HIV FUNDING TO DATE (MILLIONS)
Post- transition						
Mexico	Post-transition	US\$8610	MSM: 20.7% SW: 7% PWID: 2.5% Transgender people: 19.5% ²² Prisoners: 0.7%		US\$34.68	US\$25.00 (from 2003-2012)
Romania	Post-transition	US\$9970	MSM: 18.2% SW: No data PWID: 21.4% Transgender people: No data Prisoners: No data		US\$37.67	No support
China	Post-transition	US\$8690	MSM: 7.75% SW: 0.19% PWID: 5.9% Transgender people: No data Prisoners: No data	99%	US\$323.23	US\$28.30 (from 2009-2011) ²³
Pre-transition						
Malaysia	Pre-transition (Global Fund: late 2018)	US\$9650	MSM: 21.6% SW: 6.3% PWID: 13.5% Transgender people: 10.9% Prisoners: 0.11%	95% ²⁴	US\$11.12	No support
Cambodia	Pre-transition (Global Fund: after 2025)	US\$1230	MSM: 2.3% SW: 14.8% PWID: 15.2% Transgender people: 5.9% Prisoners: No data	17.5% ²⁵	US\$244.84	US\$204.20 ²⁶
Nigeria	Pre-transition (Global Fund: after 2025)	US\$2080	MSM: 23% SW: 14.4% PWID: 3.4% Transgender people: No data Prisoners: No data	23% ²⁷	US\$753.65	US\$5,000+ ²⁸

* At the time of transition for post-transition countries

Post-transition countries

Several key themes emerged from our assessment of post-transition country experiences. These themes were related to (a) lessons learned, (b) factors that can help ensure that KP are not harmed by transition, and (c) challenges that other countries may face as they approach transition. These themes are summarized in Table 4 and detailed in the country case studies that follow.

Table 4. Key Messages from Analysis of Post-Transition Countries

COUNTRY	COUNTRY EXPERIENCE	KEY MESSAGES
Romania	<ul style="list-style-type: none"> • A lack of planning and preparation for transition, in part caused by the rapid and precipitous departure of the Global Fund, resulted in a significant financing gap for HIV prevention and services for KP that was not covered by domestic funds. • Just 1% of domestic HIV expenditure is dedicated to prevention services and even less to KP prevention services. • The lack of a mechanism to fund civil society organizations (CSOs) in Romania, combined with persistent stigma, led to the underfunding of CSOs and forced them to cut back on service provision. 	<ul style="list-style-type: none"> • In countries preparing for transition, early and extensive planning may be needed to mobilize domestic financing to cover costs previously funded by donors, including HIV treatment and prevention services targeted towards KP. • In situations where donors focus their efforts on HIV prevention and KP, transitioning countries need to increase their prevention spending to avoid a collapse in the delivery of these services following transition. Global Fund and local advocacy organizations need to engage the government earlier and more convincingly to ensure such scaled up prevention spending. • Pre-transition countries should begin to identify and develop pathways for domestic funding to be used to support the work of CSOs in effectively providing HIV services to KP.
Mexico	<ul style="list-style-type: none"> • Some CSOs in Mexico that received institutional support and training from the Global Fund were not fully prepared to take over service delivery, financed through domestic sources, immediately following transition. • Mexico benefited from its strong history of social contracting, but this mechanism does not hold CSOs fully accountable for results. • Mexico's transition was successful in part because national HIV program leadership was seamlessly transitioned from a CSO, Fundación Mexicana para la Salud (FUNSALUD), to the Ministry of Health (MOH). 	<ul style="list-style-type: none"> • CSO capacity should be strengthened while donors are still present to ensure that CSOs are prepared for both service delivery and advocacy activities. • Social contracting mechanisms should be established prior to donor exit and should ensure accountability for results. • Donors and governments should work together to ensure that leadership of the HIV response is effectively transitioned.

Table 4. Key Messages from Analysis of Post-Transition Countries (continued)

COUNTRY	COUNTRY EXPERIENCE	KEY MESSAGES
<p>China</p>	<ul style="list-style-type: none"> • China had a successful transition due to strong political will, high profile support for the HIV response, and the deep involvement of the government in the transition from Global Fund support. • China’s social contracting mechanism is predicated on targets being met by implementing CSOs. • After China’s transition from donor aid for HIV, the continued technical support provided by the US government and UNAIDS has helped to give national institutions the necessary technical capacity to continue a robust and effective HIV response. 	<ul style="list-style-type: none"> • Governments should be fully engaged and well-informed in the transition process. • Social contracting should be results-driven. • Even after financial support has ended, donors should consider continuing technical support to transitioned countries.

In sub-sections 3.1-3.3 below, we present the findings from in-depth case studies of these three post-transition countries.

3.1 Romania: A failed transition for KP

As a first-wave transition country, limited planning went into Romania's transition from Global Fund support. This lack of planning was reflected in the deterioration of outcomes for KP – specifically by the spike in HIV prevalence among Romania's PWID population – in the years following transition. Furthermore, Romania's Global Fund transition was compounded by the simultaneous withdrawal of funding from the United Nations Office on Drugs and Crime (UNODC), which had previously supported harm reduction efforts including needle and syringe exchange programs.

Planning and preparation for transition were particularly needed in this context because of insufficient political will to support HIV prevention efforts and a limited history of social contracting.

Romania's concentrated HIV epidemic

The HIV epidemic in Romania is concentrated in KP, with the highest prevalence among PWID at 28.9%,²⁹ followed by MSM at 18.2%.³⁰ The prevalence of HIV among prisoners is unknown. Among prisoners living with HIV, it is estimated that two thirds are receiving antiretroviral medicines (ARVs).³¹ In 2015 there were 13,766 PLHIV in the country and an overall adult prevalence of 0.1%.³¹

Donor support to the HIV response

Romania received limited but critical donor support for its HIV response, including two grants from the Global Fund. These grants are described in Table 5.

The second grant (2007-2015) was the last Global Fund HIV grant to the country. Romania joined the European Union (EU) in 2007, which led to a rapid rise in its GDP and classification of its economy to upper middle-income status. Despite this economic progress, in 2015 Romania allocated the smallest percent of its GDP to healthcare out of all EU countries (5%, compared with an EU average of 8.4%).³²

Table 5. Overview of Global Fund Support to Romania

AREA	DESCRIPTION	TOTAL GRANT AMOUNT	PRINCIPAL RECIPIENT	YEAR
Grant 1: Rising to the challenges of HIV/AIDS: A comprehensive, coordinated multi-sector response in Romania ³³				
Objective 1: Prevention interventions	Ensuring sustainable prevention programs to reduce the transmission of HIV/AIDS, including testing and counselling, condom distribution, training health care personnel on post-exposure prophylaxis	US\$26.4 million	Ministry of Health and Family	2003-2010
Objective 2: Clinical care and support for PLHIV	Strengthening the national system of health care and psychosocial support to reduce the impact of HIV/AIDS on infected, affected, and vulnerable people			
Objective 3: Monitoring and surveillance systems	Developing and strengthening the monitoring and surveillance systems for HIV/AIDS and associated risk behaviors			

Table 5. Overview of Global Fund Support to Romania (continued)

AREA	DESCRIPTION	TOTAL GRANT AMOUNT	PRINCIPAL RECIPIENT	YEAR
Grant 2: Towards universal access to HIV/AIDS prevention, treatment, care and social support for vulnerable and underserved populations ³⁴				
Objective 1: Prevention interventions for vulnerable groups	Implementing prevention programming for KP at the local level in the most affected area, including distribution of condoms, clean injection equipment, and education materials	8.2 million Euros	Romanian Angel Appeal Foundation	2007-2015
Objective 2: Improve services available for young PLHIV	Improving prevention services, life skill education, access to jobs, education and vocational training, housing, and family planning to young PLHIV			
Objective 3: Program management	Efficient and effective implementation of the program, including coordination of monitoring and evaluation, communication and visibility of program activities, and coordination with national advocacy work			

Romania did receive other international funding for their HIV response after 2015, including 1.3 million Euros from the Norwegian Funding Mechanism, 960,000 Euros from the Global Fund for TB prevention and control (this included prevention and control of HIV co-infection), and 2.3 million Euros from the European Economic Area (EEA) for HIV and drug use prevention campaigns.^{17,35} External funding from the EEA and Norway is set to continue until 2021 through grants focused on improving outcomes for vulnerable populations and strengthening civil society (275.2 million Euros from the EEA and 227.3 million Euros from Norway).¹⁷

Romania's transition experience

Due to a low burden of disease and an improvement in the economy, the Global Fund's support for HIV in Romania ended in 2010 with no national transition plan in place. Withdrawal of the Global Fund left a significant gap in financing for HIV prevention activities that was not covered by the government. Even after its transition from Global Fund grants for HIV, Romania's prevention activities were still heavily dependent on other external donors. Following the withdrawal of Global Fund and UNODC funding in 2010, there was a collapse of harm reduction services in Romania and a subsequent spike in HIV prevalence among PWID from 1.1% in 2009 to 6.9% three years later, peaking at 53% in 2013.¹⁷

Status of KP programs

This rise in prevalence was mainly a result of the cessation of harm reduction programs for PWID, including needle and syringe exchange and opioid substitution therapy.¹⁷ In 2016, Romania spent 70 million Euros on HIV treatment, but allocated just half a million Euros to prevention efforts – comprising just 0.7% of domestic funding of its HIV response.²⁹ In recent years, other sources of external funding, including the Norwegian Funding Mechanism, Global Fund TB grants, and EEA grants, have allowed for the reinstatement of some harm reduction programming, lowering the HIV prevalence among PWID to 21% in 2014.^{29,31}

The status of programs for KP in Romania is so dire that CSOs have been advocating for the return of Global Fund support to Romania. Given its accession to the European Union, Romania no longer qualifies for the Organization for Economic Co-operation and Development's Development Assistance Committee's list of recipients for official development assistance. Consequently, Romania is ineligible for continued Global Fund support unless sufficient "barriers" exist, including policies and laws that restrict the provision of services to KP.³⁶ Because there are no explicit policies preventing the delivery of services to KP, merely a lack of political will to deliver HIV care to KP, it is unlikely that Romania would requalify for Global Fund support under this new eligibility rule.³⁷

Nevertheless, civil society in Romania has continued to push back against the Global Fund's decision regarding its ineligibility for funding, citing three barriers to adequate care for Romania's most heavily burdened populations.³⁸ These barriers are (1) the lack of a national HIV strategy since 2007, (2) limited targeting of national prevention measures toward PWID and MSM, and (3) a shortage of government funding for harm reduction efforts. In fact, in 2011 domestic funding comprised merely 7% of harm reduction expenditure while the bulk of support came from external donors.³⁶ Additionally, CSOs note that there is limited coverage of opioid substitution therapy, with merely five sites existing nationally, four of which are operated by CSOs.³⁶

Social contracting

There is a limited history of the government working with and funding HIV-specific and other CSOs in Romania. HIV-specific CSOs that survived the transition were sustained by other donor funding, including a Global Fund TB grant and EEA funds. The government works with CSOs on an ad hoc basis and there is no budget line for these activities, leading to under budgeting and discontinuity of services. In 2010, all CSOs in Romania spent between 800 million and one billion Euros, but an estimated 95% of this funding came from external sources, with the remaining 5% covered by central and local governments.³⁹ Funding sources drawn upon by HIV-specific CSOs include the European Social Fund, which is administered by the EU Ministry of Work and Labor, as well as the French CSO, SIDACTION, which has supported the Romanian CSO, Romanian Association Against AIDS, in its harm reduction activities.³⁶

A lack of political will to support CSOs working with KP in Romania prevented these organizations from receiving consistent funding, and consequently jeopardized their relationships with KP and their ability to effectively serve these communities. For example, resource shortages led CSOs who work with PWIDs to conduct fewer visits where they provide needle and syringe exchange programming for PWIDs; their reduced interactions caused many organizations to lose touch with PWIDs, who were consequently driven further underground.³⁶ PWIDs in Romania expressed frustration that although they continued to be informed by these organizations of the risks posed by sharing needles, they had reduced access to needle and syringe exchange programming since mobile clinics were forced to visit these communities less frequently.³⁶ This example shows that adequate funding for CSOs prior to transition is necessary for the sustainability of their interventions, regardless of prevailing political will.

In summary, our analysis suggests there were no enabling factors for a successful transition in Romania and there were several challenges that persist today. Table 6 outlines the key challenges with Romania's transition.

Table 6. Enabling Factors and Challenges to Romania's Transition

ENABLING FACTORS	CHALLENGES
Our analysis did not identify any enabling factors for a successful transition in Romania.	A lack of planning and preparation for transition, in part caused by the rapid and precipitous departure of the Global Fund.
	Limited political will to support HIV prevention and treatment services for KP.
	The lack of a mechanism to fund CSOs, which led to the underfunding of CSOs and forced them to cut back on service provision.

Lessons learned from Romania's experience and recommendations for future transitions

- **Transition planning cannot be overlooked.** Planning is critical to ensure a successful transition. No transition planning tools had been developed by the Global Fund at the time of Romania's transition from Global Fund support. Because no steps were taken to cover the financing of prevention and KP services previously funded by the Global Fund HIV grants, the transition had significant consequences for the country's overall HIV response and particularly impacted PWIDs. Although more transition planning tools are being developed and piloted by development partners, funding for the implementation of these tools is important to ensure that they are used by the transitioning country and that the results are applied to transition planning.
- **Prevention spending must be established before transition.** Because of continued stigma and limited political will to support HIV prevention for KP, less than 1% of domestic HIV expenditure is dedicated to targeted prevention services for KP. Donors need to advocate for this funding to be established in the government budget prior to transition.
- **There needs to be a mechanism to fund CSOs.** The lack of a government mechanism to fund CSOs in Romania has led to the underfunding of CSOs and forced them to cut back on service provision. Because of the unique role CSOs play in service delivery for KP, it is essential that CSOs are adequately supported after transition.

RECOMMENDATIONS:

- In countries preparing for transition, early and extensive planning may be needed to mobilize domestic financing to cover costs previously funded by donors, including HIV prevention and KP services.
- In situations where donors focus their efforts on HIV prevention and KPs, transitioning countries need to increase their prevention spending to avoid a collapse in the delivery of these services following transition. The Global Fund and local advocacy organizations need to engage the government earlier and more convincingly to ensure this happens.
- Pre-transition countries should begin to identify and develop pathways for domestic funding to be used to support the work of CSOs effectively providing HIV services to KPs.



3.2 Mexico: A transition with mixed success and room for improvement

Mexico is a leader in HIV treatment and care in the Latin America region and has already achieved the second 90-90-90 target. The country has largely self-financed its HIV response, receiving only one grant from the Global Fund in 2010 and limited PEPFAR funding. Nonetheless, the transition from Global Fund financing was only somewhat successful, with room to improve both the effectiveness of its social contracting mechanism and prevention efforts for KP.

HIV is concentrated among KP in Mexico

In 2017, Mexico reported an HIV prevalence of 0.3% and the fourth lowest HIV incidence in the Latin American region with an annual rate of 0.20 per 1,000 of the population. However, given its population size, the 2017 prevalence meant that there were 230,000 PLHIV, the second highest number in the region after Brazil.⁴⁰ The epidemic is concentrated among KP, including male SW (prevalence of 22.1%), transgender women (19.5%) and MSM (15.9%).²² PWID, male prisoners, and female prisoners report lower prevalence rates, of 2.4%-5.7%, 0.7%, and 0.8%, respectively.²²

Mexico has committed to the 90-90-90 HIV treatment targets and has already achieved the second target with more than 95% of PLHIV receiving treatment, owing to Mexico's commitment to provide universal access to ARVs beginning in 2003. However, Mexico is further from achieving the first and third of the 90-90-90 targets, with only 64% of PLHIV knowing their HIV status and 75% achieving viral suppression.⁴⁰

Donor support to the HIV response

The Global Fund and PEPFAR have both provided limited support to Mexico's HIV response. Mexico received financing for HIV from the US Agency for International Development (USAID) beginning in 1987 and was supported by PEPFAR until 2012.

In 2010, Mexico received its first and only Global Fund grant, called "Strengthening the National Response for HIV and MSM and male and female IDU in Mexico." At that time, Mexico already had universal access to treatment, but HIV prevention was weak, with existing screening and diagnostic interventions only targeting the general population. Investing in prevention strategies at a population level is considered a marker of weak prevention and epidemic control when epidemics are concentrated in KP, as it was in Mexico. This strategy led to low coverage for KP who had the highest incidence and transmission rates in the country. Monitoring and evaluation, information systems, and strengthening of provider capacity were also areas in need of improvement within the national response.

The CSO Fundación Mexicana para la Salud (FUNSALUD) was selected as the Principal Recipient of this grant, not the MOH or the National HIV Program. The government was only involved in the grant through the National Institute of Public Health, a major public health research center. The main three focus areas of the Global Fund grant are summarized in Table 7.

Table 7. Overview of Global Fund Support to Mexico

AREA	DESCRIPTION	AMOUNT	SUB-RECIPIENTS AND IMPLEMENTERS
Health worker training	Training of public providers and CSOs on the epidemic, preventive activities, stigma and discrimination reduction, and administrative management.	US\$2.4 million	National Institute of Public Health – Sub-recipient Mexican Foundation for Family Planning (MEXFAM) – Sub-recipient
Prevention interventions	Strategies to raise awareness, improve detection, and increase access to services through peer promoters; the distribution of condoms and other prevention tools; and the implementation of rapid HIV tests	US\$32.3 million	MEXFAM Population Services International – Sub-recipient Red Democracia y Sexualidad (DEMYSEX) – Sub-recipient
Research	Research on the epidemiological impact, incidence and prevalence among KP, community dialogues and a catalog of evidence-based prevention interventions	US\$1.3 million	National Institute of Public Health Colectivo Sol Consortio de Investigación sobre VIH SIDA TB
Total	Phase 1 + “transition” grant	US\$36 million	

Source: Authors based on the Final Report, FUNSALUD.

The grant totaled US\$67 million and was divided into two phases. Phase 1 lasted from January 2011 to December 2012 with a budget of US\$26 million, and Phase 2 was anticipated to begin in 2013 and go through 2015 with the remaining US\$41 million. However, the project was forced to finish early, when the Global Fund announced its decision to stop funding G-20 countries in 2012. This unexpected change in the eligibility criteria left Phase 2 practically unfunded and many of the interventions unfinished. Nevertheless, due to its high performance on project execution, Mexico received an additional year of funding (for 2013), or a “transition” grant, for US\$12 million to finalize some activities and to continue the prevention interventions in 24 of the 44 cities included in Phase 1.

Mexico’s transition experience

Epidemiologically, it is difficult to say if the transition has had a significant impact on outcomes among KP. It is unknown whether the prevalence of HIV among KP has changed after transition since the last national survey occurred at the end of the Global Fund project. However, MOH data show that the Mexican government has continued to support the HIV response overall with an increase of 124% in HIV screening and a budget that has more than doubled for rapid tests in the last five years.⁴¹

Transition planning in Mexico was domestically-led and domestically-funded. Transition planning activities were not funded through the Global Fund grant. The extra year of funding termed the “transition” grant was actually used to finalize projects and continue the prevention activities targeted at KP in a smaller sample of cities. Nevertheless, the prevention activities that were being led by FUNSALUD were eventually transitioned to El Centro Nacional para la Prevencion y Control del VIH y el SIDA (CENSIDA) leadership. These prevention activities were seamlessly transferred to CENSIDA because the Administrative Coordinator at FUNSALUD,

who was leading the implementation of these activities under the Global Fund grant, was appointed to the national HIV Program at the MOH at the time of transition and continued to implement the same activities. This leadership transition led to the institutionalization of some grant interventions and a natural absorption of many of the activities by CENSIDA.

Status of KP programs

Following transition, Mexico not only sustained the level of spending on HIV in the immediate year after transition (2014) but continued to increase federal funds to HIV. From 2013 to 2018, the MOH's public spending increased by 89% while the budget for focused HIV and STI prevention, implemented by CSOs, increased by 75% (Table 8). Part of this financing success is because the political will to sustain and increase HIV spending, specifically for prevention for KP, existed even before the Global Fund grant. In addition, prior to the Global Fund grant, CSOs were involved in the implementation of focused interventions for KP. This engagement of CSOs is exemplified by the existence of a social contracting mechanism prior to Global Fund involvement in the country (discussed in more detail below).

Table 8. Evolution of CSO Contracting Mechanism

	2013	2014	2015	2016	2017	2018	Change 2013-2018	
							No.	%
CSOs	72	184	118	142	123	121	49	68%
Number of HIV-specific CSOs	n.a.	n.a.	92	108	91	94	n.a.	n.a.
Budget (Million Mexican pesos)	60.7	100.9	96.8	97.6	102.3	106.4	46	75%
Budget (Million US\$)	4.6	7.6	6.1	5.2	5.4	5.6	0.9	20%

Source: CENSIDA, <https://www.gob.mx/censida/articulos/censida?idiom=es>

Annual average exchange rate, Banxico 2013-Oct 2018.

Social contracting in Mexico

Mexico is one of the few countries in the Latin America and the Caribbean region that has a social contracting mechanism in place for HIV related activities. This mechanism was initiated in 2006, several years before the Global Fund grant started.^{41,42} Social contracting is still in place and consists of financing CSOs through grants for specific projects.

Through the CSO financing mechanism, CSOs compete to implement interventions in the regions and populations where CENSIDA determines that there is the highest need or incidence. The Global Fund strengthened the social contracting process by using epidemiological data to inform whom the CSO activities should target and by introducing results-based payments. However, CENSIDA later changed the allocation process so the grants no longer exclusively target the most affected populations.

The current HIV projects funded through social contracting focus on:

- Condom and lubricant promotion and distribution
- HIV detection
- Risk mitigation
- Adherence to treatment
- Vertical transmission
- KP screening, including the use of community centers as screening sites.

While selected projects mainly target MSM, transgender women, SW and PWID, proposals targeted to prisoners, PLHIV, and women and girls are also eligible to receive funding.

The application and selection processes for CSO contracting are transparent. They involve the registration of the project on an electronic platform and the evaluation of criteria such as the experience of the CSO in providing these services, along with different fiscal and regulatory requirements. The evaluation committee includes federal and state public officers, academics, members of development agencies, and independent consultants. Each project is monitored by a supervisor who performs supervision visits throughout the duration of the project.

Mexico has a favorable environment for social contracting mainly due to the federal law promoting activities carried out by CSOs. As of 2018, 40,463 CSOs were formally registered and legally allowed to receive public funds.⁴³ In 2017, 2,275 CSOs received a total of 4,885 million pesos (US\$258 million), of which the health sector CSOs received 7.1% (348 million pesos, US\$18 million) and CENSIDA received 2.1% (105 million pesos, US\$5 million).⁴⁴ Table 9 summarizes key enabling factors and challenges to Mexico’s transition.

Table 9. Enabling Factors and Challenges to Mexico’s Transition

ENABLING FACTORS	CHALLENGES
Mexico benefited from its strong history of social contracting.	Mexico’s social contracting mechanism does not hold CSOs fully accountable for results.
National HIV program leadership was seamlessly transitioned from a CSO, Fundación Mexicana para la Salud (FUNSALUD), to the MOH.	Some CSOs in Mexico that received institutional support and training from the Global Fund were not fully prepared to take over service delivery, financed through domestic sources, immediately following transition.

Lessons learned from Mexico's transition and recommendations for future transitions

- **Data should be used to advocate for funding.** For example, by facilitating the collection of HIV prevalence data among the transgender population, the Global Fund grant improved HIV programming for this group. Before the grant it was difficult to target interventions to the transgender population because there was limited evidence to suggest that the epidemic was concentrated among this population. This lack of information was compounded by the stigma that still prevails in the public sector. In countries where there is stigma and discrimination surrounding KP, it is essential to use evidence to advocate for targeted programming and to illustrate how ignoring these populations could lead to a resurfacing of the epidemic in the general population.
- **Even without a long history of Global Fund grants, a transition planning process is necessary.** Mexico faced several challenges and missed opportunities in the transition process. The Global Fund grant established an electronic system to improve HIV detection and track prevention activities, but it has not yet been transferred to the national surveillance system. This system is key to maintaining up-to-date knowledge of the HIV treatment cascade for each KP group, which can be used by policy makers and KP advocates leading the response. The missed opportunity in transferring the electronic system for KP could have been avoided if a concrete transition plan had been in place. Such a plan would have indicated how the system would be transferred to the national surveillance system and who would have ownership of this system after the transition.

A transition plan could have also ensured that procurement processes for supplies like clean needles and condoms were maintained following transition. Following the end of the Global Fund grant, the Mexican government was never able to reach the same levels of needle procurement because the national procurement regulations made it difficult to buy the volume and type of syringes needed for the PWID population. Further, procuring condoms for the response was also challenging following transition.

- **Social contracting is not a panacea.** Finally, from the Mexico experience, it is clear that social contracting is not a panacea. Mexico has more than ten years of experience implementing social contracting and a transparent process that continues to be updated. Nonetheless, more efforts are needed to guarantee accountability for results and ensure interventions achieve the highest value for money. Further, the continuous innovation in HIV treatment and care makes it crucial to have a flexible and adaptable response, and decentralization of health systems also demands a strengthening of local responses and financing prior to transition.

RECOMMENDATIONS:

- CSO capacity should be strengthened while donors are still present to ensure that CSOs are prepared for both service delivery and advocacy activities.
- Social contracting mechanisms should be established prior to donor exit and should ensure accountability for results.
- Donors and governments should work together to ensure that leadership of the HIV response is transitioned.

3.3 China: A transition success story

Strong political will and a strong economy drove the successful transition in China from external HIV financing. At the point of transition, China was funding 99% of its HIV response.⁴⁵ High-level and public political commitments were made in support of HIV/AIDS programs, most notably by the first lady Peng Liyuan. There was a strong political drive to eliminate dependence on the Global Fund and it was made clear by the Global Fund that support was going to end. Further supported by a strong financial situation after years of economic growth in the country, China was well positioned to transition from donor support.

HIV is Concentrated among KP in China

In the early 1990s the Chinese government's neglect of the emerging threat of HIV largely contributed to the spread of HIV in the country. Such government neglect included its support of unhygienic commercial blood collection and its understatement of the true HIV prevalence in the country.⁴⁶ Today there are half a million PLHIV in China. However, within the last decade, the domestically-led response has curbed the spread of HIV and the national prevalence remains low at just 0.037%.⁴⁷ KP are more severely burdened by HIV in China: prevalence is 7.7% among MSM,⁴⁵ 6% among PWID,⁴⁵ and 0.2% among SW.⁴⁸

Donor support to the HIV response

The Global Fund was the main external donor to the HIV response in China, contributing over US\$265 million. The Global Fund contributed to the reduction in new HIV infections in the country, focused the response on KP, introduced the formal participation of CSOs in the HIV response, and built CSO capacity.⁴⁹ The Global Fund grants are described in greater detail in Table 10. UNAIDS and USAID also provide technical assistance to the HIV response in China.

Table 10. Overview of the Global Fund's Support to China

AREA	DESCRIPTION	TOTAL GRANT AMOUNT	PRINCIPAL RECIPIENT
Grant 1: Mobilizing Civil Society to Scale Up HIV/AIDS Control Efforts in China			
Objective 1	Help create a supportive environment and build capacity of CSOs working on HIV/AIDS projects, including capacity to fight stigma and discrimination	US\$5.8 million	The Chinese Centre for Disease Control and Prevention of the Government of the People's Republic of China
Objective 2	Scale up and increase impact of prevention services to hard-to-reach populations, including the most vulnerable SW and their clients, PWID, MSM, and out-of-school youth		
Objective 3	Scale up and fill gaps in treatment and support services for PLHIV, including care and support to children/orphans affected by HIV/AIDS		

Table 10. Overview of the Global Fund’s Support to China (continued)

AREA	DESCRIPTION	TOTAL GRANT AMOUNT	PRINCIPAL RECIPIENT
Grant 2: Reducing HIV Transmission Among and From Vulnerable Groups and Alleviating its Impact in Seven Provinces in China			
Objective 1	Create an enabling social environment and strengthen policy implementation	US\$21.45 million	The Chinese Centre for Disease Control and Prevention of the Government of the People’s Republic of China
Objective 2	Use comprehensive approaches to reduce high-risk behavior/HIV transmission among SW, MSM, migrants, and their partners		
Objective 3	Strengthen sexually transmitted infection services and management, and link to HIV prevention activities		
Objective 4	Strengthen the capacity of civil society groups to plan and implement HIV/AIDS prevention activities		
Objective 5	Strengthen the local capacity to conduct HIV situation analysis, including improved surveillance, monitoring, and evaluation		
Grant 3: China CARES (China Comprehensive AIDS Response) A Community-Based HIV			
Objective 1	Strengthen supporting environment to ensure universal access to prevention, treatment, care and support services for target populations through the strengthening of policy implementation, strategic planning, leadership, and community systems	US\$238 million	The Chinese Centre for Disease Control and Prevention of the Government of the People’s Republic of China
Objective 2	Increase coverage of comprehensive HIV prevention programs for high risk populations (SW, MSM, and PWID), migrants and prevention of vertical transmission		
Objective 3	Increase access and quality of treatment, care, support, and secondary prevention services to PLHIV		
Objective 4	Strengthen surveillance, laboratory quality control, monitoring and evaluation and program management		

China’s transition experience

The success of the transition can be seen in outcomes for KP. In the year following transition, prevalence of HIV declined slightly for PWID from 6.33% to 6%.⁴⁵ The already low prevalence among SW has remained steady following transition.⁵⁰

These outcomes were achieved due to the planning and ownership of the response by the Chinese government. The national drive to an entirely domestically-funded response led to a more successful transition process as it was not donor-driven. A 2016–2020 China AIDS Action Plan was developed, which includes mention of high-risk groups (including KP) and achieving the three 90s.⁵¹

Status of KP services

Despite the stigmatization and criminalization of drug use in China, both methadone and needle exchange programs have been implemented in multiple provinces following transition.⁵¹ The needle exchange program is extensive enough to be designated as “high coverage” by UNAIDS.⁵² An increase in the number of health service facilities and HIV/AIDS laboratories following transition has been critical in the response and more PLHIV are being diagnosed now than ever before.^{45,53} The government had very little difficulty funding the response, and since China’s transition, the total HIV expenditure has grown from US\$987 million in 2014 to over US\$1 billion in 2016.⁵⁴ Although this growth is relatively small, the total expenditure has not decreased since transition. Further, most government spending on prevention is targeted toward KP and delivered by both CSOs and the government themselves.⁵⁵

Social contracting in China

The government also provides funding for some CSOs working with KP. Through a process introduced by the Government of China in 2015 termed Social Service Outsourcing (SSO) (referred to elsewhere as social contracting), CSOs have been able to apply for funding for their HIV programming.⁵⁰ Currently, about US\$7.2 million in government funding is available for these organizations. Although this is a small fraction of the US\$1 billion being spent on the response overall, it is significantly more than the average US\$1.85 million that the Global Fund contributed to CSOs per year (US\$16,650,634 total over nine years).⁵⁶ In the 2016-2020 action plan for HIV/AIDS, the government notes the unique and important role that CSOs can play in the response. CSOs must meet certain service delivery quotas to continue to receive funds.⁵⁰

However, there are several problems with China’s social contracting mechanism, including that the government does not allow funds to be used for politically controversial activities such as advocacy, legal activities, or programming to reduce stigma and discrimination.⁵⁰ CSOs have used alternative resource mobilization strategies, such as fundraising events, to supplement their more politically controversial activities. However, over 1,000 CSOs have been unsuccessful in raising these additional funds since the Global Fund exit and no longer exist.⁵⁷ Further, some CSOs working with criminalized populations, such as PWID or SW, are not true CSOs, but are organizations with strong ties to the government.⁵⁸ Key informants have also indicated that the registration process for CSOs in China is cumbersome and has led to some CSOs remaining unregistered and therefore ineligible to receive funding from the SSO despite the CSOs’ significant contributions. Table 11 summarizes key enabling factors and challenges to China’s transition.

Table 11. Enabling Factors and Challenges to China’s Transition

ENABLING FACTORS	CHALLENGES
China had a successful transition due to strong political will, high profile support for the HIV response, and the deep involvement of the government in the Global Fund transition.	Some CSOs have not received adequate funding from the government to survive.
China’s social contracting mechanism is predicated on targets being met by implementing CSOs.	
The continued technical support provided by the US government and UNAIDS following the end of most external financial support has helped to give national institutions the necessary technical capacity to continue a robust and effective HIV response.	

Lessons learned from China's transition and recommendations for future transitions

Despite the overall success of the transition experience of China, MSM, transgender people, and PWID remain marginalized and there is still a tension between civil society and the government. There have also been some reports of increases in the number of PLHIV in the past year, particularly due to stigma surrounding the MSM population. These problems may impact the success of the response in coming years.

- **CSO activities must be sufficiently funded to reach high service coverage for KP.** Although there is tension between CSOs and the Chinese government, the SSO should still be looked to as a successful example of a social contracting mechanism that holds CSOs accountable to outcomes. However, even with the SSO contracting mechanism, the number of formally registered CSOs has been significantly reduced – from around 1,500 to 476 – following the reduction in donor funding.⁵⁰ The government denies that transition has impacted service coverage.⁵⁰
- **Transition planning should address criminalization, stigma, and discrimination against KP.** MSM continue to face stigma and discrimination and hide their sexual identity, contributing to a growing HIV prevalence in female partners of MSM.⁴⁷ Higher rates of HIV testing among MSM and the use of self-testing kits may help to curb the increasing prevalence. However, targeted prevention strategies and government support are needed to truly reach this population in the absence of external support.⁵⁰ Although the prevalence of HIV has been declining among PWID, the criminalization of drug use and discrimination against this population may reverse this trend in the future.⁵⁰ No data currently exists on prevalence among transgender people,⁵⁰ which may present a potential setback in achieving the three 90s.

Human rights must also be protected in this domestically-led and funded response. Several provincial laws, including mandatory premarital HIV testing in high prevalence regions and mandatory screening of SW,⁵⁹ have been introduced in hopes of curbing the epidemic. In reality, these laws jeopardize the autonomy and human rights of these individuals. Further, patient confidentiality is often jeopardized by physicians and other healthcare workers.⁶⁰

- **Technical support should continue as necessary in transitioned countries.** The only remaining bilateral donor for HIV/AIDS currently in China is the US Centers for Disease Control and Prevention, which still operates a small office in Beijing.⁵⁰ The Centers provide technical support on an annual budget of just US\$1.5 million.⁵⁰ UNAIDS also provides technical support to the country.⁴⁸ These key partners have critical roles to play to ensure that the government and CSOs have the technical capacity to effectively reach those that are most vulnerable and that health outcomes for KP improve.

RECOMMENDATIONS:

- Governments should be fully engaged and well-informed in the transition process.
- Social contracting should be results-driven.
- Even after financial support has ended, donors should consider continuing technical support to transitioned countries.

Pre-Transition Countries

In our assessment of the three pre-transition countries, we looked for threats and opportunities as indicators of what the path to transition could look like for these countries. These threats and opportunities are summarized in Table 12.

Table 12. Threats and Opportunities from Analysis of Pre-Transition Countries

COUNTRY	THREATS	OPPORTUNITIES
Nigeria	<ul style="list-style-type: none"> • Legal barriers that are based on deeply-entrenched stigma greatly hinder KP from accessing treatment and services. • Domestic funding of activities targeting KP is very low, and there is no social contracting mechanism through which the government can provide funding to CSOs working with KP. 	<ul style="list-style-type: none"> • Donors and advocates for KP in Nigeria must work together to address and work around the legal impediments to reaching KP. • Donor co-financing requirements should consider the burden of HIV among KP and encourage the government to expand its allocations to these groups.
Cambodia	<ul style="list-style-type: none"> • Social contracting is not currently used by the Cambodian government. • Cambodia has a Sustainability Technical Working Group, a group made up of donor, government, and civil society stakeholders in charge of ensuring the sustainability of the HIV response. This working group is a good example of a country-led transition process, but the government now needs to implement its recommendations. 	<ul style="list-style-type: none"> • Cambodia should take advantage of legal measures allowing the establishment of social contracting mechanisms. These mechanisms should be used to support CSOs targeting KP prior to donor exit. In partnership with donors, the government could also begin to co-fund part of the work that CSOs are doing with KP during the transition period. • The government should create an action plan to implement recommendations of the Sustainability Technical Working Group.
Malaysia	<ul style="list-style-type: none"> • Although Malaysia finances 95% of its HIV response from domestic resources, it is essential to plan for transition, since donor financing comprises a significant portion of the financing for HIV programs that target KP. • The effectiveness of Malaysia's social contracting mechanism, the Malaysian AIDS Council, is built upon strong leadership and political support. • Malaysia has a large national debt and constrained fiscal environment. Thus, the HIV unit within the MOH, and CSOs working with KP, need to have strong capacity to advocate for HIV funding, especially following transition. 	<ul style="list-style-type: none"> • Donors should require countries to align their co-financing with current epidemiological trends. In the case of Malaysia, such alignment would mean increasing funding for MSM and SW prior to transition.

3.4 Nigeria: not well placed for a successful transition

Reminiscent of some of the transition experiences described above, several KP in Nigeria face criminalization and systematic discrimination.⁶¹ In addition to other legal, structural,⁶² and financial barriers,⁶³ Nigeria does not seem well poised for a successful transition. Although Nigeria is still receiving significant funds from PEPFAR and the Global Fund, since the country has moved into middle-income status, the government should consider beginning preparations for potential reductions in donor funding.

Prevalence and access to services among KP

Nigeria has a generalized HIV epidemic, but the HIV burden among KP is still much higher than in the general population. The KP most affected by HIV in Nigeria include SW (14.4% prevalence), MSM (23%), and PWID (3.4%).⁶⁴ This disproportionate burden among marginalized groups is in part due to the legal barriers that lead to difficulties in accessing prevention, health care, and treatment services, and that also make it challenging for CSOs to reach these populations.⁶²

Despite continued support from donors, Nigeria faces challenges with expanding HIV testing and treatment. Although there are 8,000 HIV testing and counseling sites in Nigeria, this number is much lower than the 23,640 sites needed to provide adequate coverage.⁶² Nigeria adopted a “test and treat” policy in 2015, through which anyone with a positive HIV diagnosis is eligible for treatment.⁶⁵ However, treatment rates remain low. In 2016, of the 28% who knew their status, only 30% were receiving treatment, and of those on treatment, only 24% had achieved viral suppression.⁶⁶ These figures are far from the 90-90-90 targets. Further, while ARVs are provided free of cost, patients often struggle to pay for transportation and other costs associated with travelling to the clinic, which creates a barrier for many people trying to access care.⁶³ Even when patients can afford these extra non-medical costs, drug stock-outs are common.⁶⁷

Nevertheless, some national programs are reaching KP successfully. The national Behavior Change Communication strategy, coordinated at the national level by the National Prevention Technical Working Group, targets female SW, MSM, PWID, and young people, among others. Strategic interventions for HIV prevention include media communication on stigma and discrimination reduction and programs to strengthen provider-patient relationships.⁶² Nigeria’s National Agency for the Control of AIDS, in collaboration with its partners, has designed HIV education programs that could impact the behavior of communities that engage in high risk behaviors.⁶⁷

SW and MSM benefit from the Minimum Prevention Package Intervention, which uses social networking approaches to reach hidden and stigmatized groups. The Minimum Prevention Package Intervention includes targeted peer education/interpersonal communication, condom programming, management of sexually transmitted infections, HIV testing and counseling, community level system strengthening, and structural level interventions. The end-of-term report on the 2010-2015 National Strategy noted that in 2014, 374,705 female SW and 37,072 MSM were reached by KP-friendly clinics.⁶⁷ In addition, some CSOs, such as the Initiative for Equal Rights, provide sexual health education, advocacy, psychosocial services and management of HIV and sexually transmitted infections for sexual minorities, including MSM and transgender people. However, the harsh criminalizing laws have made it harder for CSOs to work with LGBT communities and have pushed MSM underground, making them more vulnerable to HIV infection.

There is no active national HIV program targeting PWID.⁶⁷ Harm reduction services such as opioid substitution therapy and clean needle exchanges are currently not available in Nigeria.^{69,70} While it is reported that needles are “widely available at pharmacies and medicine stores,”⁷⁰ it is unclear how accessible pharmacy provisions are to PWID.

Funding of KP programming

Nigeria relies heavily on donors for the funding of its HIV response and the programs described above. Public sources cover less than 5% of KP programming, while the remainder is covered by external donors (68% from direct bilateral contributions and 27% from multilaterals). The major international donor for the HIV response in Nigeria is the United States, contributing nearly 64% of HIV/AIDS expenditures in 2014.⁷¹ Since 2004, PEPFAR has invested over US\$5 billion towards achieving HIV/AIDS epidemic control in Nigeria.²⁸ Around 6% of the expenditure in 2016 went to most-at-risk populations and PEPFAR’s support is a main contributor to the engagement of KP in Nigeria. The Global Fund also contributes to KP programming with over US\$4 million allocated for KP prevention activities in 2015.⁷²

Legal barriers for KP in Nigeria

Because legal barriers for KP are so extensive in Nigeria, this case study covers these laws in more detail than other case studies included in our analysis. According to Nigeria’s 2018 country progress report, published by Global AIDS Monitoring Report, there are no laws that specifically seek to protect KP.⁶⁷ However, Nigeria does have a national HIV/AIDS Anti-Discrimination Law, which was signed into law in March 2016. This law is meant to prevent HIV-related discrimination and ensure access to healthcare and other services. Yet this law has faced several challenges: only ten states (out of thirty-six) have passed the law, and even in states that passed the bill into law, some law enforcement agencies are not aware of the law or how to enforce it.⁶⁷ Further, Nigeria maintains other discriminatory laws directly relating to the activities of KP that contradict the aims of the Anti-Discrimination Law. For example, in 2015, the Nigeria Senate passed the Sexual Offence Act, which criminalizes intentional transmission of HIV infection. This law could further contribute to the negative stigma surrounding PLHIV and KP.⁶²

Impact of criminalization of PWID

Nigeria maintains laws that mandate compulsory detention for drug offences.⁶⁷ Due to this criminalization, PWID prefer to remain underground and often refuse to access health services to avoid incarceration. Despite the criminalization of this population and lack of programming for PWID, HIV prevalence remains low among this group.

The legal status of sex work

The legality of female sex work is broadly addressed by the Criminal Code in Southern Nigeria and Penal Code in Northern Nigeria. Sex work is illegal in all states that use the Penal Code. In states that use the criminal code, sex work is not a crime if practiced by someone above the age of sixteen, however “soliciting and promotion” is considered a crime.⁷³ In the northern states where the Penal Code is applicable, the criminalization of sex work drives the activities of SW underground, thus preventing this population from being publicly recognized and engaged for effective HIV prevention, treatment, care, and support. In the southern states where the criminal code is applicable, the 2015 National Agency for the Control of AIDS assessment found that policemen capitalize on the “soliciting and promotion” provision of the law to extort money from female SW, rather than enforce the law. This practice and the negative attitude towards SW fuel stigma and discrimination thereby driving sex work underground, denying SW access to quality health care, and increasing the spread of HIV.⁶¹ Further, while there

is no law that prevents healthcare workers from providing SW with health services, the laws discourage SW from seeking health services. A Global Network of Sex Work Projects regional report notes that in Nigeria, SW prefer to buy medicine in anonymous settings rather than hospitals. The report also notes that most healthcare services for SW are provided by CSOs that have relationships with the SW community.⁷⁴

The legality of same sex relations

The criminalization of MSM significantly impacts this population's ability to access care and seek medical services. The Same-Sex Marriage (Prohibition) Bill, signed into law January 2014, imposes a ten-year prison sentence on those who "directly or indirectly" make a "public show" of a same-sex amorous relationship and on anyone who "registers, operates, or participates in gay clubs, societies, and organizations," including supporters of those groups. In the states where Sharia law is operational, the punishment for same sex relationships differs from state to state and ranges from caning to imprisonment and, in extreme cases, death by stoning.⁶¹ Due to this criminalization, MSM prefer to remain underground and often refuse to access health services to avoid incarceration. Further, stigma and discrimination have led to denying MSM quality health care and increasing the spread of HIV.

The neglected transgender population

According to Nigeria's 2018 country progress report, Nigeria does not maintain laws that criminalize or prosecute transgender people.⁷⁵ However, Nigeria does not have any programs in place to specifically help transgender individuals access HIV services or improve prevention. Some of the same legal challenges faced by the other KP – PWID, female SW, MSM – apply to the transgender population. In general, due to social exclusion, economic vulnerability, and a lack of employment opportunities, sex work is often the most viable form of income available to the transgender population. A high proportion of transgender individuals engage in high-risk sex work.⁷⁶ It is also common for transgender individuals to obtain injectable hormones and carry out the injecting themselves. Those going through this process may be vulnerable to HIV transmission due to the risk of sharing needles with others.⁷⁷

Social contracting in Nigeria

Many CSOs who work with KP in Nigeria are funded through the Global Fund.⁷⁸ There is currently no established mechanism through which the government can provide funds to these organizations, and the creation of such a social contracting mechanism is unlikely given the criminalization and stigma associated with KP.⁷⁹ Many CSOs face difficulties finding funding for their advocacy work and CSOs working with MSM struggle to register with the national government. There is also no civil society forum in the country.

Threats to and opportunities for a successful transition

There are significant barriers to accessing prevention and treatment services facing KP and barriers to reaching KP for those implementing KP programming in Nigeria (Table 13). The criminalization of MSM, sex work, and drug use drives these populations underground, hinders their access to services, and makes it more difficult for prevention and service providers to reach them. These legal barriers also lead to minimal domestic funding for KP programming. Although Nigeria has a generalized HIV epidemic, the HIV burden among KP is still much higher than in the general population. Without targeted prevention efforts, this high prevalence among KP could spread to the general population and jeopardize the gains that have been seen in Nigeria's declining overall prevalence.

Fortunately, Nigeria is not projected to transition from Global Fund or PEPFAR support in the near future. Donors should capitalize on the continuation of donor support and ensure that KP programming is established in the government’s response and budget. Where the criminalization of KP hinders access to services, donors should further aim to improve capacity within CSOs working with KP and seek to advance KP programming in municipalities where the criminalization of KP is not as severe. Donors should also use evidence and KP surveys to show to the government the importance of focusing interventions on KP in the overall HIV response.

Table 13. Threats and Opportunities to Nigeria’s Transition

THREATS	OPPORTUNITIES
<ul style="list-style-type: none"> • Legal barriers that are based on deeply-entrenched stigma hinder the access of KP to treatment and services. 	<ul style="list-style-type: none"> • Donors and advocates for KP in Nigeria must work together to address and work around these legal impediments.
<ul style="list-style-type: none"> • Domestic funding of activities targeting KP is very low, and there is no social contracting mechanism through which the government can provide funding to CSOs working with KP. 	<ul style="list-style-type: none"> • Donor co-financing requirements should consider the burden of HIV among KP and encourage the government to expand its allocations for these groups.

3.5 Cambodia: proactively planning for its transition

Cambodia has a smaller HIV burden than Nigeria; however, KP are still disproportionately affected by HIV and require targeted attention. Given Cambodia's proactive transition planning led by the Sustainability Technical Working Group, its eventual transition from donor aid is likely to occur without any major foreseeable challenges. However, if certain steps are not taken in the coming years to prepare for transition, a transition from donor support could significantly impact KP in the country. Given that Cambodia is on the brink of achieving the three 90s, ensuring a smooth transition is paramount to maintaining epidemic control in the country.

Prevalence of HIV and access to services among KP

HIV is concentrated in KP in Cambodia. Among KP in Cambodia, PWID have the highest prevalence, at just over 15%.⁸⁰ SW are the second most affected group, with an HIV prevalence that ranges from prevalence at 6% (for those with fewer than seven clients per week) up to 14.8% (for those with more than seven clients per week).⁸¹ The third highest prevalence is in transgender people (the prevalence is 5.9% in this group).⁸¹ The prevalence of HIV among MSM is 2.3%.⁸²

Funding of KP programming

Despite the higher prevalence of HIV among KP, the government does not prioritize funding for activities targeting KP. As of 2018, PEPFAR funding for Cambodia has been reduced to technical assistance only and all PEPFAR funding for CSO activities has been cut. The Global Fund grant is funding almost all current activities aimed at improving the access of KP to HIV services.

A recent reduction in Global Fund funding to CSOs has led to a reduction in the number of CSOs providing support to KP from twenty to six. This reduction is a harbinger of what could happen after an eventual Global Fund transition. In the absence of Global Fund financing for KP activities and CSOs, the government would need to provide this funding of over US\$4 million annually.⁸³ Although social contracting has not been used in Cambodia, there are no legal barriers that would prevent it from being implemented to fund CSO activities. Key informants have stated that by creating a line in the MOH budget dedicated to funding CSOs now, when the Global Fund ends its support, it will be easier for the government to provide funding to CSOs. The Global Fund and other partners can assist in advocating for this budget line creation. Further, the National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases – the unit within the MOH responsible for the HIV response – has already used a mechanism for the selection and funding of CSOs, which includes a financial and monitoring reporting system.

Legal barriers for KP in Cambodia

The legal environment is generally supportive of PLHIV and KP. The Law on the Prevention and Control of HIV/AIDS was established to eliminate discrimination against PLHIV, improve awareness of facts on HIV, and to mainstream HIV prevention and control programs in the national development plan.⁸⁴ However, the Village and Commune Safety Policy, which was enacted with the intent of reducing crime, including prostitution, has been misinterpreted by law enforcement. At times, the Village and Commune Safety Policy directly contradicts the Law on the Prevention and Control of HIV/AIDS and the Law on the Suppression of Human Trafficking and Sexual Exploitation, which intends to curb human trafficking. Both of these laws promote condom use by SW and allow consensual sex to take place. However, the Village and Commune Safety Policy has been used to justify the arrest of SW carrying condoms.⁸⁵ Further, police are still arresting PWID for drug use, although the

law only states that the circulation and sale of drugs is illegal.⁸⁶ The Police Community Partnership Initiative has been implemented in order to deal with the discrepancies between these laws and to engage law enforcement, KP, civil society, and health care workers in creating an enabling environment for KP for both health and non-health services. Workshops to sensitize police to the needs of KP and build their capacity to work with KP are delivered jointly by CSOs and the government,⁸⁶ showing the government's commitment to improving the legal environment for KP. Although there are no legal barriers to funding CSOs in Cambodia, there is currently no mechanism in place to fund HIV CSOs for service delivery. However, through Cambodia's decentralized health system there may be an opportunity to do so. Cambodia's health system is divided into three levels: the Central Ministry, the Provincial Level, and the Operational District Level. The Operational District Level is the most decentralized and each district covers between 100,000 and 200,000 people through about twenty health centers and a number of health posts or rural points of care.⁸⁷ Beginning in 2013, the Government of Cambodia began converting Operational Districts into Special Operating Agencies.⁸⁸ These agencies have a greater degree of autonomy than operational districts, and this special designation ensures flexibility in human resource and financial decision making, including the ability to receive technical assistance from CSOs to improve service quality.⁸⁸ This flexibility has the potential to lead to domestic funding of CSOs across Cambodia.

Threats to and opportunities for a successful transition

The Sustainability Technical Working Group in Cambodia has engaged in several transition planning activities over the past year to ensure a sustainable HIV response, including supporting a Transition Readiness Assessment and the development of a Sustainability Roadmap. While these processes are important, the sustainability of the response will only be guaranteed if the government acts on these recommendations and adheres to an action plan. Without a detailed action plan to implement the pre-transition recommendations and a monitoring system to track fidelity to those plans, these tools will not directly lead to better outcomes.

On its current path, Cambodia is likely to achieve the 90-90-90 targets in the coming years, but transition from Global Fund support could threaten this achievement. KP bear a significant portion of the HIV burden in Cambodia, yet the Royal Government of Cambodia currently does not provide funding specifically for KP activities. Cambodia must use a social contracting mechanism to fund CSOs as Global Fund co-financing requirements increase in preparation for eventual transition. Further, initiatives similar to the Police Community Partnership Initiative should continue to be implemented in partnership with CSOs to improve the legal environment and eliminate stigma and discrimination by law enforcement and healthcare workers. If the government can overcome these financial and legal challenges, the upcoming transition is likely to have fewer adverse consequences for KP in Cambodia. Table 14 summarizes the threats and opportunities facing Cambodia in its HIV transition.

Table 14. Threats and Opportunities to Cambodia's Transition

THREATS

OPPORTUNITIES

<ul style="list-style-type: none">• Cambodia does not currently use a social contracting mechanism to fund CSOs providing HIV services.	<ul style="list-style-type: none">• Cambodia should take advantage of legal measures allowing the establishment of social contracting mechanisms to set up such mechanisms for KP prior to donor exit. The government could also start to co-fund CSO activities with donors during the transition period.
<ul style="list-style-type: none">• The government has yet to develop a concrete action plan to implement the recommendations of the Sustainability Technical Working Group	<ul style="list-style-type: none">• Cambodia's Sustainability Technical Working Group (a group made up of donor, government, and civil society stakeholders in charge of ensuring the sustainability of the HIV response) is a good example of a country-led transition process and has the necessary political backing to ensure its recommendations are implemented.



3.6 Malaysia: well placed to capitalize on its strong HIV programming

Malaysia's national ownership of its HIV response, through high domestic contribution to the HIV expenditure and the establishment of a social contracting mechanism, suggests its impending transition from Global Fund support in December of 2018 may pose fewer challenges than in other settings. However, Malaysia's current debt of over US\$250 billion may limit the government's ability to account for the funding gap remaining after Global Fund withdrawal, consequently threatening the sustainability of KP-targeted HIV services in the country.

The HIV epidemic is concentrated among KP in Malaysia

Malaysia has an HIV prevalence of 0.4% with an epidemic primarily concentrated among KP.⁸⁹ Although most PLHIV in Malaysia know their HIV status (83%), only 54% of these individuals are on ARVs. Of those accessing treatment, 95% achieve viral load suppression.⁸⁹ The KP in Malaysia bearing the greatest burden of the epidemic include MSM (prevalence of 21.6%), PWID (13.5%), transgender people (10.9%), and SW (6.3%).⁸⁹ Prisoners in Malaysia have a lower prevalence of HIV (0.11%) than that of the country's overall population. Investment in harm reduction programs, including needle and syringe exchange programs and methadone maintenance therapy, has contributed to a decrease in the incidence of HIV among PWID from 16.6% in 2014 to 13.5% in 2017, and a decline in HIV transmission among this population.⁹⁰ Despite this progress in PWIDs, HIV infection among MSM has been on the rise and is the second leading cause of HIV transmission in Malaysia, behind heterosexual transmission.⁹⁰

Funding of KP programming

In 2011, Malaysia received a Global Fund grant dedicated to scaling up HIV prevention among high risk populations.⁹¹ This funding, totaling US\$11,632,022, will be completely disbursed by December 2018 as Malaysia transitions from Global Fund support. Similar to China in the period before Global Fund transition, Global Fund support comprises only 5% of total HIV expenditure in Malaysia, with the remaining 95% being financed by domestic sources.^{90,92} Although the Global Fund grant is a small fraction of total HIV expenditure in the country, it constitutes a significant portion of resources targeted toward KP. This funding has been allocated to prevention programs (specifically needle and syringe exchange programs and methadone maintenance therapy for PWID), recruitment of KP for HIV testing and treatment, and efforts to increase adherence to ARVs among these groups.⁹² One key informant noted that the Global Fund grant has been less successful at reaching MSM compared to other KP, potentially due to the limited number of CSOs dedicated to working with MSM in Malaysia.⁹³

Malaysia has been the primary funder of its HIV response since the start of the epidemic and increased its HIV spending by 86% between 2010 to 2014, reaching an annual expenditure of US\$59.3 million in 2014.⁹² Despite Malaysia's rising spending on HIV, a relatively small portion of funding is allocated to prevention efforts among KP; spending on prevention services for these populations comprises just 17% of total HIV expenditure.⁹² Furthermore, Malaysia co-finances only a small portion of KP services relative to other HIV services.

There are also differences in the amount of domestic funding for HIV services targeting different KP. In 2014, the government financed 84% of HIV services targeting PWID, 54% of those for MSM, and 29% for SW, with donors providing the remaining funding for these programs.⁹² These low levels of domestic contribution do not align with epidemiological trends indicating rising HIV transmission among MSM. Consequently, as Global Fund support is withdrawn from Malaysia, HIV programs that target KP – specifically those for MSM and SW – are at greatest risk of suffering from funding cuts and resource shortages.

Legal barriers for KP in Malaysia

KP in Malaysia are subject to stigma, discrimination, and criminalization, which is heightened by the enforcement of Sharia Law among Muslims in the country.⁹⁴ KP are often driven underground to avoid criminalization, subsequently limiting their access to HIV education, prevention, and treatment.⁹⁵ Furthermore, KP in Malaysia experience discrimination from health care personnel, making them less likely to seek health services.⁹⁵ Malaysia has maintained the strict criminalization of illegal drug use since its enactment in the 1970s. These punitive laws include compulsory detention and rehabilitation for drug offenders.⁹⁵ Proponents of these laws have argued that such laws could curb the epidemic in PWID, but in fact the laws have been shown to increase the vulnerability of PWID to HIV. Due to these laws, PWID are less likely to carry syringes through fear of harassment by law enforcement, leading to increased rates of needle sharing.⁹⁵

Sex work is also criminalized in Malaysia making it difficult to provide prevention programming and services to SW. Harassment by law enforcement and threat of detention for carrying more than three condoms have contributed to the spread of HIV among this population.⁹⁵

Homosexuality is criminalized in Malaysia and the stigma and discrimination faced by MSM has contributed to the limited number of CSOs working with MSM. Due to a law criminalizing the circulation of “obscene” materials, the provision of sex education and prevention tools, including condoms, can be used to criminalize venues that attempt to provide these services to MSM.⁹⁵ Further, a limited number of studies have focused on MSM in Malaysia, and those that have been conducted have found limited HIV knowledge and a high incidence of risky behaviors among this population.⁹⁵

Social contracting in Malaysia

Among other countries in the region, including Thailand, Indonesia, and the Philippines, Malaysia is the only country with an effective mechanism of transferring domestic funding to civil society.⁹⁵ To provide HIV services to its most vulnerable and marginalized populations, the Malaysian MOH established the Malaysian AIDS Council (MAC) in 1992 as the umbrella organization to coordinate and support the work of CSOs dedicated to HIV-related issues in Malaysia.⁹⁵ Today, the council consists of a secretariat and forty-eight partner organizations that it supports in coordinating HIV programs, capacity building, and advocacy work. The council serves as a channel through which the government and the Global Fund can contract CSOs working in harm reduction for PWID, HIV prevention for KP, advocacy, policy, and stakeholder relations. In 2006, the MAC was instrumental in establishing Malaysia’s harm reduction work for PWID, including its needle and syringe exchange programming and methadone maintenance therapy programs. The MAC also enabled the provision of first line ARVs free of charge at all government health centers and hospitals.⁹⁶

The council is further supported by the Malaysian AIDS Foundation, which was founded in 1993 to serve as a fundraising contributor to the council and directly provide HIV services to underserved PLHIV.⁹⁶ The foundation partners with corporate organizations and institutional donors to fundraise for the council. Although the council is primarily dependent upon government funding to contract CSOs, these organizations still engage

in advocacy efforts and negotiate for funding during the technical review of their budgets by the MOH.⁹⁶ Government funding of the council has remained steady over the years. One key informant indicated that when more experienced advocates have led the council, they have been able to guarantee and even temporarily increase government funding for the council through the provision of a block grant.⁹⁷ Thus, resources for social contracting and KP services can be bolstered when established leaders advocate for increased resources for the council.⁹⁸

While the council provides a formal mechanism for social contracting in Malaysia, it is limited by the diversity and capacity of the CSOs it supports. Of its forty-eight partner organizations, only two provide HIV services to the LGBT population, although HIV transmission in Malaysia is highest among MSM. Most organizations supported by the MAC are dedicated to providing PWID-specific services.⁹⁹ A key informant suggested that few LGBT organizations may be organically forming in Malaysia due to prevailing discrimination against this population, consequently limiting the number of LGBT-focused CSOs applying for support from the MAC. Furthermore, the MOH may be more hesitant to openly support the LGBT population due to potential political backlash and the criminalization of homosexuality by civil and Sharia law.^{100, 90}

The MAC is also constrained in the amount of funding it can provide to CSOs for the compensation of CSO employees. One key informant indicated that concerns regarding low academic qualifications of CSO leadership limits the amount of funding the council can allocate for CSO employee compensation.¹⁰¹ This restriction of funding allocated for the salaries of CSO workers contributes to high turnover of CSO leadership, undermining the capacity of these organizations. Furthermore, restricted employee compensation limits the caliber of individuals attracted to CSO leadership positions, as those with higher levels of education and experience tend to seek jobs with better compensation. A key informant supported the need to professionalize CSOs in Malaysia by providing them with increased financial support to improve their organizational capacity and the impact of their essential work with KP.⁹⁰

Threats to and opportunities for a successful transition

The identified vulnerabilities of the Malaysian HIV response – including low domestic co-financing of KP services and the limited compensation of CSO personnel by the MAC – are likely to be exacerbated by the upcoming Global Fund transition. The ability of Malaysia to account for funding gaps in KP services is limited by the government's debt, which currently exceeds 1 trillion ringgit, or the equivalent of US\$251 billion.^{90, 102} Malaysia's finance minister recently announced that the government will "bite the bullet now" to begin addressing the national debt through tax increases as well as cutbacks in government contracts.¹⁰³ Though a key informant suggested that the MAC would be protected from government cutbacks, in this current economic climate, it is unlikely that the government will increase its HIV expenditure to account for the funding gap remaining after Global Fund transition or increase CSO employee compensation.¹⁰³

Thus, Malaysia must capitalize on the strengths of its HIV response, including its established channel of CSO funding through the council (Table 15). If immediately covering the funding gap after transition is not feasible for the government, the MOH and the MAC should work with organizations that may experience funding cuts in preparation for transition. Furthermore, the government should develop and implement an intermediate to long-term strategy to increase HIV funding allocated to KP as it aligns with its national debt alleviation plan. It is essential that Malaysia, as well as other countries transitioning from Global Fund support, prioritize increasing expenditure for HIV programming for KP to address concentrated HIV epidemics and reach the 90-90-90 targets.

Table 15. Threats and Opportunities to Malaysia's Transition

THREATS

OPPORTUNITIES

<ul style="list-style-type: none">• Although Malaysia finances 95% of its HIV response from domestic resources, it is essential to plan for transition, since donor financing comprises a significant portion of the financing for HIV programs that target KP.	<ul style="list-style-type: none">• Donors should require countries to align their co-financing with current epidemiological trends. In the case of Malaysia, such alignment would mean increasing funding for MSM and SW prior to transition.
<ul style="list-style-type: none">• Given Malaysia's large national debt and constrained fiscal environment, the HIV unit within the MOH and CSOs working with KP need to have strong capacity to advocate for HIV funding, especially following transition.	<ul style="list-style-type: none">• The effectiveness of Malaysia's social contracting mechanism, the MAC, is built upon strong leadership and political support.

4 LESSONS LEARNED AND RECOMMENDATIONS FOR FUTURE TRANSITIONS

Just as the post-transition countries had varying degrees of success in their transition from donor funding for HIV, KP in the pre-transition countries are likely to face challenges of varying severity. However, if the pre-transition countries work now to implement programs and policies to ease their upcoming transitions, governments can ensure KP experience a smoother transition and that the 90-90-90 targets are not jeopardized in the process. These practices can include social contracting, budget line creation, decentralization, and transition planning tools.

Social contracting

Social contracting is an effective mechanism to ensure the sustainability of CSO funding streams and work with KP.¹⁰⁴ Evidence from global assessments has shown that social contracting brings together government and CSOs in a strong partnership, which can lead to the enhancement of a country's overall HIV response.¹⁰⁵ When countries are hesitant to provide services directly to KP, due to a culture of stigma, discrimination, or criminalization, or if the government does not have the capacity to do so, social contracting can allow CSOs to continue working with KP after transition. Social contracting also has the added benefit of maintaining the already established capacity of these organizations. However, as detailed above, there are certain enabling factors that make social contracting more effective in some settings than in others.

Malaysia has one of the oldest social contracting mechanisms for CSOs working in the HIV response. From the experience of the MAC, it is clear that the head of the social contracting mechanism must be an experienced individual with the ability to stand up to the ministry to advocate for more CSO funds when necessary.¹⁰⁶ This experience and leadership is particularly important given competing disease priorities in many countries as multiple donor exits occur simultaneously.

The government must also hold CSOs accountable for outcomes. Mexico's social contracting mechanism sometimes works more like a grant-making mechanism where CSOs do not need to reach certain targets in order to receive funding. This lack of accountability can be detrimental to the response, as funding is limited and so it should ideally be targeted at those CSOs that are the most effective at providing services for KP. One example of a social contracting mechanism that holds CSOs accountable to outcomes is China's SSO. In the SSO, CSOs must meet service delivery targets to access funds. This model should be considered in other countries' social contracting mechanisms.

However, although CSOs must meet certain targets in China's SSO, they are also restricted in the activities for which they can use SSO funds. Activities such as advocacy work and legal activities—considered controversial in China—must be funded through alternative sources. Pre-transition countries looking to develop a social contracting mechanism should allow CSOs the flexibility to engage in innovative and potentially controversial activities, such as advocacy work, to truly make use of the established capacity that CSOs bring to the response. The use of an intermediate government-funded entity, such as the MAC, that can effectively respond to government and CSO needs could be one way to protect the right of government-funded CSOs to conduct advocacy.

It is also critical that CSOs have developed the capacity to deliver services to KP and manage operations prior to donor exit. In Mexico, some key informants reported that CSOs did not have the capacity to provide the

necessary services to KP. Donors should work with CSOs prior to transition and provide the necessary technical support to ensure CSOs can effectively deliver services to KP, advocate for the rights and needs of KP, and at the same time, manage their organizational finances and operations to sustain their activities.

Social contracting mechanisms should have strong leadership, be outcome-oriented, and act as a flexible financing mechanism to allow CSOs to use funds for multiple activities.

Budget line creation

One way to ensure governments set aside funds for CSO activities and other aspects of the HIV response critical for KP is to create a budget line in the MOH budget. Given the leverage that donors have while they are still funding HIV programs, it will be easier for donors or development partners to advocate for a new budget line prior to transition. In Cambodia, government officials noted that it is standard to increase each budget line item by 5% each year. However, it is much more difficult to ask for a large amount of money for an activity that is not in the budget from the previous year.¹⁰⁷ Therefore, by inserting an activity into the MOH budget for CSO activities several years before transition and establishing co-financing of the activity, it will be easier to fund the activity entirely through domestic resources upon transition. Although budgetary procedures will vary by country, Malaysia¹⁰⁸ and other countries have similar systems where budget lines need to be created and set aside for new activities. Countries should work within their own system to achieve the same end result.

Decentralization

Depending on the country context, shifting the responsibility of the HIV response to the sub-national level could also help to address the problem of central governments not wanting to provide services to marginalized and criminalized populations directly. This decentralization was seen successfully in St. Petersburg, Russia¹⁰⁹ and Bucharest, Romania¹¹⁰ and is currently being implemented in Cambodia.¹¹¹ In Russia, the St. Petersburg municipality is implementing programming for PWID that would not have been politically viable for the national government, such as needle exchange programs.¹¹² This approach would work well in Nigeria where criminal codes affecting KP differ throughout the country and some states may be more willing than others to implement programs targeting MSM or SW. To ensure that decentralization is successful in meeting the needs of KP, building capacity at the local level should begin before transition and continue after donors have left.

Transition planning

Another critical process that should be implemented by pre-transition countries is transition planning, which must include a specific focus on KP. All post-transition countries in this assessment transitioned prior to the development of rigorous transition planning mechanisms by the Global Fund and other donors. For this reason, little transition planning was documented in the three case studies. However, as seen in Cambodia, pre-transition countries are already beginning this transition planning process and transition planning is much more robust now than it was even five years ago. For the most part, transition planning is still largely shaped by donors. Transition planning tools currently include Transition Readiness Assessments,³ Transition Readiness Tool,¹¹³ Sustainability Strategies,¹¹⁴ and Sustainability Roadmaps, among others (see Annex C).

These tools are still being tested in different country contexts and iterated upon. Further, they have been mainly used to assess transitions from Global Fund support and do not always take into account other HIV donors or donors supporting other health and development programs in the country. Mechanisms to track fidelity to these plans and keep governments accountable have also not been established at the global level. As seen

in Romania, the government can say that certain systems are in place for KP even when they are not. With a monitoring mechanism, donors and countries would both be aware of which recommendations have been implemented and what still needs to be done to guarantee the sustainability of their efforts after transition.

Although there are a number of tools to assess readiness for transition, there are limited tools to actually help a country going through transition to implement the recommendations. More tools should be developed as necessary to fill these gaps. The optimal time to use these various tools in preparation for transition is also debated. The question of when to develop sustainability strategies, versus conduct a transition readiness assessment, should be determined to move countries through the transition process in a logical manner. A cross-learning platform could be developed to encourage South-South learning and ensure that the same transition mistakes are not repeated. Such a platform could be modeled on the Joint Learning Network, which facilitates cross-country sharing of experiences in working towards universal health coverage, or on the Learning Network for Countries in Transition (<https://lnct.global/>), which supports countries that are transitioning out of support from Gavi, the Vaccine Alliance.

Indicators of a challenging transition

In addition to best practices that emerged from this study, some warning indicators of a poor transition also emerged. In Romania, prior to and following transition, the necessary political will to support essential HIV programming for KP, particularly harm reduction programming targeted at PWID, was lacking. In contrast, China had a relatively successful transition, which was due in part to the strong political support for the HIV response. From China's experience, it is clear that political support is necessary not only for the HIV response, but also for transition. Transition should not be donor-driven but instead led by country stakeholders, as is seen in Cambodia. In pre-transition countries where it is clear that a domestically-funded response would not prioritize the needs of KP, donors should support activities to create an enabling political environment. Programming could include engagement of law enforcement in a manner similar to Cambodia's Police Community Partnership Initiative or the development of transition working groups that include members of civil society and representatives from government ministries.

Another warning sign in Romania was that the government was not financially supporting KP prior to transition; merely 7% of funding for harm reduction programs came from domestic sources in 2011.³⁶ This lack of co-financing for services for KP can be seen in several of the pre-transition countries, including Cambodia and Nigeria. This lack of domestic financing made it challenging for Romania to absorb the costs of harm reduction programs after the Global Fund exited both because of the limited existing political will and due to the large increase in domestic financing required to maintain the programs.

Donors should consider the share of domestic contributions to HIV programming for KP in determining country co-financing requirements and should also implement activities to ensure these requirements are met. For example, in Mexico, the Global Fund showed through surveys of KP that focusing interventions on transgender people would be beneficial to the overall epidemic. In countries such as Nigeria, where KP continue to be highly stigmatized, this evidence-based advocacy could encourage governments to allocate more funds to these populations and allow governments to justify this decision to their citizens. By pairing budget line creation, as described above, with donor co-financing requirements targeted to HIV program activities for KP, failure to fund KP services could be avoided for future pre-transition countries.

5 CONCLUSION

While planning for donor transitions is improving, donor transitions from HIV programs are still risky, particularly for the sustainability of services that target KP. Where KP still face stigma and discrimination, poorly managed donor exits risk jeopardizing the health and well-being of these populations. The prevalence of HIV is high among KP in most MICs, including those countries with concentrated epidemics but also in countries with a generalized epidemic, such as Nigeria. Moreover, there are few data on transgender and prisoner populations; future research should seek to better understand the experiences and needs of these populations as related to HIV.

In contrast with other health transition challenges that affect the general population, such as securing bed nets for malaria prevention and funding vaccination programs, the HIV donor transition is more likely to affect KP than the general population. If steps are not taken by donors and governments to maintain HIV programming for KP in the face of transition, HIV could spread to the general population in higher rates, jeopardizing the progress that has been made over the past decade and risking the country's achievement of the 90-90-90 targets. Given past examples showing how detrimental poor transitions can be to KP, such as the impact of transition on PWID in Romania, it is imperative that donors intensify their focus on protecting KP and ensuring that the needs of KP are addressed early and often in the years leading up to transition. While there are no easy answers for these issues given the presence of punitive laws and discrimination against KP, we believe that the recommendations provided here take into consideration the needs of KP in the transition process. These recommendations are aimed at ensuring that the financial, structural, and political processes are in place to maintain, or even improve, access to essential treatment and prevention services. The positive examples cited in this paper give hope, showing that it is possible to protect services and rights for KP in an environment where external support winds down and ends over several years.

ANNEX A

The larger picture on KP in middle-income countries

The six countries were chosen from a larger list of middle-income countries (MICs). In nearly all MICs, HIV prevalence is higher for most KP when compared to the general population. In many, prevalence in MSM, transgender people, SW, and PWID can be as much as five to twenty times higher than that of the general population. It is useful to note that while official data on HIV status in some KP including MSM, SW, and PWIDs are widely available, they are missing in most countries for transgender and prisoner populations. While some academic studies on these groups have been published, more work needs to be done in this area.¹¹⁵

Middle-Income Countries Considered for Inclusion¹¹⁶

REGION	COUNTRY	INCOME STATUS	GLOBAL FUND TRANSITION STATUS FOR HIV ¹¹⁷	HIV PREVALENCE					
				OVER-ALL	MSM	TRANS-GENDER PEOPLE	SW	PWID	PRISONERS ¹¹⁶
Europe and Central Asia	Albania	UMIC	Not eligible	<.1%	.5%	No data	0%	.5%	No data
	Armenia	UMIC	Transitioning	.2%	0.8%	No data	0.1%	.5%	2.4%
	Bosnia and Herzegovina	UMIC	Not eligible	No data	1.1%	No data	0%	No data	0%
	Macedonia	UMIC	Not eligible	<.1%	5.35%	No data	0%	No data	0%
	Moldova	LMIC	Eligible	.6%	5.7%	No data	3.9%	13.9%	No data
	Montenegro	UMIC	Eligible	<.1%	12.5%	No data	0.5%	0.5%	No data
	Romania	UMIC	Not eligible	.1%	18.2%	No data	No data	21.4%	No data
	Serbia	UMIC	Eligible	<.1%	8.3%	No data	1.6%	1.8%	3.5%
	Ukraine	LMIC	Eligible	0.9%	7.5%	No data	5.2%	22.6%	14%
	Uzbekistan	LMIC	Eligible	0.3%	3.3%	No data	2.9%	5.6%	No data
East Asia and Pacific	Cambodia	LMIC	Eligible	0.5%	2.3%	5.9% ⁸¹	14.8% ⁸¹	15.2%	No data
	China	UMIC	Not eligible	No data	7.75%	No data	0.19%	5.9%	No data
	Malaysia	UMIC	Eligible	0.4%	21.6%	10.9%	6.3%	13.5%	No data
	Thailand	UMIC	Eligible	1.1%	9.15%	4.9%	1%	19.02%	No data
	Vietnam	LMIC	Eligible	.3%	12.2%	No data	3.7%	14%	No data
Latin America and Caribbean	Dominican Republic	UMIC	Eligible	.9%	7.1%	No data	3.7%	No data	No data
	Jamaica	UMIC	Eligible	1.8%	32.8%	No data	2%	No data	3.3%
	Mexico	UMIC	Not eligible	0.3%	20.7%	19.5%	7%	2.5%	0.7%
Sub-Saharan Africa	Nigeria	LMIC	Eligible	2.8%	23%	No data	14.4%	3.4%	18%
	South Africa	UMIC	Eligible	18.8%	26.8%	No data	57.7%	46.4%	14%

UMIC: upper-middle-income country, LMIC: lower-middle-income country. The World Bank classifies countries as UMIC if they have a gross national income (GNI) per capita between US\$ 3,896 and US\$ 12,055. LMICs are those with a GNI per capita between US\$996 and US\$3,895.

ANNEX B

Malaysia: Key Informant Semi-Structured Interview Guide

Stakeholder(s): NAME, TITLE

Interviewers:

Date:

Objectives

- Clarify our scope of work
- Understand your perspective on the barriers and the enabling factors in access to services (HIV-specific and general health services) for KP in Malaysia
- Understand how much of domestic funding and donor funding for HIV is targeted to KP compared to general spending for HIV in Malaysia
- Solicit recommendations on opportunities to improve access to HIV-specific and general health services for KP
- Solicit recommendations on opportunities to strengthen the provision of HIV-specific and general health services with a focus on government contracting of CSOs

QUESTIONS

Background

1. Tell me a little bit about your role at [X] organization and your experience working with [govt./KP/CSOs].

KP access to HIV and general health services & financing HIV services for KP

PWIDs

2. Can you tell me about the current government's stance towards methadone maintenance treatment and needle and syringe exchange programs (introduced in the mid-2000s)?
 - a. Are there barriers to the effective implementation of these programs, and/or other programs directed towards PWIDs (i.e. criminalization, stigma)?
 - b. Who implements and manages these programs?
 - c. How, if at all, does the government engage with CSOs that work with this population?
 - d. What organizations work most effectively with this KP?
 - e. How much domestic funding is allocated to these programs (i.e. % domestic vs. % international)?
 - i. How has the share of domestic vs. international funding of these programs changed over time, if at all?
 - ii. How much donor funding is targeted to this KP compared to general funding in Malaysia?
 - iii. What percent of international funding is Global Fund support?

Sex workers

3. Can you tell me about the current government's stance toward the provision of health services to SW?
 - a. What are there barriers to SW accessing HIV and general health services (i.e. criminalization, stigma), if any?
 - b. Who implements and manages these programs?
 - c. How, if at all, does the government engage with CSOs that work with this population?
 - i. What organizations work most effectively with this KP?
 - d. How much domestic funding is allocated to these programs (i.e. % domestic vs. % international)?
 - i. How has the share of domestic vs. international funding of these programs changed over time, if at all?
 - ii. How much donor funding is targeted to this KP compared to general funding in Malaysia?
 - iii. What percent of international funding is Global Fund support?

MSM

4. Can you tell me about the current government's stance toward the provision of health services to MSM?
 - a. Are there barriers to MSM accessing HIV and general health services (i.e. criminalization, stigma)?
 - i. Can you tell me about the distribution of criminalization of MSM and the LGBT community in Malaysia? (i.e. is criminalization concentrated in regions where Sharia law more strictly enforced?)
 - ii. How does this distribution, if at all, effect the provision of health services to this KP?
 - b. Who implements and manages these programs that target MSM?
 - c. How, if at all, does the government engage with CBOs/CSOs that work with this population?
 - i. What organizations work most effectively with this KP (i.e. the PT Foundation)?
 - d. How much domestic funding is allocated to these programs (i.e. % domestic vs. % international)?
 - i. How has the share of domestic vs. international funding of these programs changed over time, if at all?
 - ii. How much donor funding is targeted to this KP compared to general funding in Malaysia?
 - iii. What percent of international funding is Global Fund support?

Female transgender people (mak nyahs)

5. Can you tell me about the current government's stance toward the provision of health services to transgender people?
 - a. Are there barriers to transgender people accessing HIV and general health services (i.e. criminalization, stigma)?
 - b. Who implements and manages these programs?
 - c. How, if at all, does the government engage with CSOs that work with this population?
 - i. What organizations work most effectively with this KP (i.e. PTF)?

-
- d. How much domestic funding is allocated to these programs (i.e. % domestic vs. % international)?
 - i. How has the share of domestic vs. international funding of these programs changed over time, if at all?
 - ii. How much donor funding is targeted to this KP compared to general funding in Malaysia?
 - iii. What percent of international funding is Global Fund support?

KP CSOs and government contracting

6. Can you tell me about the relationship between CSOs and the affected KP they serve? How do they engage with these KP? What advantages and/or limitations do they have compared to other HIV service providers in Malaysia?
7. How, if at all, does the government work with international CSOs and local CSOs that provide HIV-services to KP (i.e. social contracting, domestic funding)?
 - a. Can you tell me about the current legislative basis for social contracting or other mechanisms through which the government can support CSOs?
 - b. Can you describe the mechanisms, if any, that support CSOs in engaging in decision-making processes relevant to programming and financing of HIV-services for KP? How institutionalized is the participation of KP CSOs in national HIV strategy?
 - c. With what organizations, if any, has the government most effectively worked/funded?
 - d. What other donors, if any, play a significant role in supporting CSOs? What is the breakdown of international vs. domestic funding of CSOs?
 - e. Is there a difference in governmental support for CSOs based on the KP they target or the region in which they work? If so, where does this stem from and how does this manifest?
 - f. Can you tell me about ways in which CSOs generate income (i.e. social enterprise, business planning), which may support their work in the absence of donor funding?
8. How, if at all, does the Societies Act affect the registration of CSOs in the country (i.e. those that are politically unfavorable)?
 - a. How did CSOs that are more difficult to register because of this Act maneuver through that process?
9. Can you tell me about the Government-Non-Government Organization (GONGO) partnership? How does it aim to strengthen relationships between the government and CSOs/community organizations (i.e. contracting, programming)?

General Areas for Collaboration

- Is there any other work of which we should be aware?
- Who else should we speak with?

ANNEX C

Transition Planning Tools

DEVELOPED BY	TITLE	DESCRIPTION OF TOOL
PEPFAR	Sustainability Index Dashboard ²	Consists of 90 questions completed by PEPFAR country teams and key stakeholders to assess the current state of the sustainability of the HIV response. Results are displayed in a color-coded dashboard.
USAID and PEPFAR Health Policy Project	Readiness Assessment: Moving Toward a Country-Led and -Financed HIV Response for KP	Guide to assess the capacity of governments and other country stakeholders to lead and sustain the HIV response and donor financing decreases.
Vogus and Graff (2015)	Guidance to PEPFAR on Impending Transitions in the Caribbean Region ¹¹⁸	Recommendations for key steps that PEPFAR can take to ensure effective transitions. Recommendations are generalizable to other regions.
The Eurasian Harm Reduction Network	Transition and Sustainability of HIV and Tuberculosis Responses in Eastern Europe and Central Asia ¹¹⁹	A framework for sustainability and transition to examine lessons learned from transition, define key elements and timelines for transition processes, identify areas that require technical support and detail opportunities to support responsible future transitions in the region.
Curatio International Foundation	Transition Preparedness Framework ¹²⁰	Developed for the Global Fund to assess preparedness for transitions. Has been piloted in four countries.
The World Bank	Checklist for Transition Planning of National HIV Responses ¹²¹	Framework to support transition planning processes by diagnosing gaps in preparedness.
Oberth and Whiteside (2016)	Conceptualization of Sustainability ¹²²	A theoretical framework for sustainability consisting of six main principles and the argument that donors should focus on sustainability of programs above all else.
Aceso Global/ APMG Health	Guidance for Analysis of Country Readiness for Global Fund Transition ³	A Global Fund-specific tool to determine a country's readiness to transition from Global Fund support. Consists of three core modules (summary of support, epi situation, human rights) and three optional modules (financing, service delivery, and CSOs) to include in the assessment.
APMG Health	Social Contracting Diagnostic Tool ¹²³	A tool that can be used to assess whether CSOs are able to use government resources to fund their activities with key and vulnerable populations.

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