Summary

What the cancellation of Round 11 and the funding crisis mean for Bolivia:

- Cancellation of Round 11 will disrupt the continuity of prevention activities for key populations such as MSM and lesbian, gay, bisexual, transgender and intersex (LGBTI) populations that are at the centre of the HIV epidemic in Bolivia.
- The recent classification of Bolivia as a middle-income country will further reduce the funds available from the Global Fund, while an increased contribution from the national government to cover this gap and match counterpart financing is unlikely, based on the current situation.
- It is presently unclear what consequences reprogramming of Round 9 Phase 2 funding to cover essential services will have on HIV prevention and support for MSM/LGBTI and sex workers.
- There is now no opportunity to expand the key MSM/LGBTI outreach work to other populations that do not currently access formal health establishments, such as prisoners, people living on the streets, young adolescents and indigenous people.
- There seems little possibility of achieving universal access to prevention, diagnosis, and treatment in key populations and the general population, with under-resourced activities including prevention of vertical transmission of HIV. Increases in HIV transmission rates are expected amongst MSM, LGBTI, and sex worker populations.
- Important investigations planned to provide insight into the HIV epidemic will be cancelled.

National epidemiology and current coverage

The first case of HIV was detected in Bolivia in 1984. By September 2011, 7,213 people had been diagnosed with HIV in Bolivia, and 744 are known to have died of AIDS-related illnesses. Bolivia is considered to have a concentrated HIV epidemic, with an estimated prevalence of 21% among MSM. The prevalence among the general population aged 15–49 is 0.16%.

According to the National HIV AIDS and STI Programme, by September 2011, 1,624 people living with HIV were receiving ART, mainly as a result of Global Fund support. However, it is estimated that at least 5,700 more people require treatment and do not receive it. This low coverage of ART may be contributing significantly to the spread of HIV infection. Of the total number of cases diagnosed in Bolivia since 1984, almost 50% were reported between 2009 and 2011. Apart from actual growth in the HIV epidemic, this could also be attributed to better disease surveillance.

Only 7% of Bolivia’s government-run health centres provide HIV counselling and testing. At the end of 2010, there were 305 testing and counselling facilities, the equivalent of six facilities for every 100,000 people. Consequently, access to HIV testing is extremely poor, and is generally limited to pregnant women and commercial sex workers. In addition, there is a great need to revise and update the HIV testing protocol, and to oversee service quality when HIV tests are offered. While good progress has been made in increasing ART coverage among HIV-positive pregnant women.

References:

39. Presentation made by the Director of the National Programme for HIV and STIs to civil society partners in December 2011.
41. Ibid.
42. Ibid.
43. UNGASS (2010), Civil Society Shadow UNGASS Report for Bolivia.
diagnosed with HIV to between 89% and 100%, research shows that due to the poor access to HIV testing, only 27% of the total number of women estimated to be HIV-positive receive ART.44

The level of stigma and discrimination for PLHIV and MSM/LGBTI populations is high in Bolivia. Human rights violations of PLHIV and members of key populations are common, although perhaps under-reported. Violations occur in schools and universities, places of work, health facilities, and families, as well as within the legal system, armed forces, police, and media. In a study from the Defensor del Pueblo, persons interviewed identified people living with HIV as most discriminated-against population group.45

Currently, there are no government health services specifically aimed at MSM/LGBTI populations. However, an estimated 51% of MSM/LGBTI people do access tailored HIV prevention programmes that are provided by civil society groups. As a result, 35% of MSM/LGBTI people received results of an HIV test during the past 12 months, a figure higher than amongst pregnant women.46

These prevention efforts are beginning to bear significant results. For instance, the proportion of men who report using a condom during last anal sex with a male partner is 69%47 and rising. The latest figures obtained in surveys of MSM and LGBTI populations, as part of the Global Fund Round 9 proposal, showed that the proportion of men using condoms with a male partner had increased to 81%. Similarly, the proportion of transgender people working as sex workers who reported condom use at last sex is almost 95%.48 By September 2011, 1,583,391 condoms49 had been distributed by civil society sub-recipients of Global Fund Round 9 funding, and by the National HIV and STD Programme through the Departmental Centres for Surveillance and Reference.

By September 2011, 1,267 members of MSM/LGBTI populations had been reached with HIV/AIDS behaviour change communication and awareness-raising training through the peer educator strategy. Subsequently, 94% of them could correctly identify methods for preventing sexual transmission of HIV, and rejected incorrect modes of transmission.50 However, much more education work needs to be done with other groups. For example, only 23.6% of young men and women (aged 15–24)51 and 48% of female sex workers52 can identify correct methods for preventing sexual transmission of HIV.

The role of the Global Fund and proposed scale-up

Bolivia has one current Global Fund grant from Round 9 for $7,688,768. In 2009, the Global Fund covered 58.6% of the national AIDS response. The grant is currently in Phase 1, which started in September 2010. It will need to be renewed for Phase 2 on 1st September 2012, and is intended to run through August 2015. Association Ibis Hivos is responsible for the administration and activities related to the Round 9 HIV grant. The current grant supports important supplementary services, such as a mobile HIV testing and counselling unit that has provided services to 303 MSM/LGBTI. The Round 9 grant has also supported the training of peer educators across the country, the establishment of mutual support groups for people living with HIV, and condom access outside of the public Departmental Centres for Surveillance and Reference. During the first year of Round 9 implementation, 752 PLHIV received support for treatment adherence from peer educators. It is presently unclear what the consequences will be for Phase 2 of Round 9, but there is no doubt that prioritisation and grant reductions will be required, focusing on the Global Fund’s definition of ‘essential services’. It appears likely that interventions focusing on creating an enabling environment or developing synergies with other sectors may suffer.

What the crisis means for Bolivia

Bolivia was planning to apply for Round 11 and the National HIV AIDS and STI Programme had taken initial steps through the Country Coordinating Mechanism to map out key strategic and high-impact interventions. In addition, Bolivian organisations such as Instituto para el Desarrollo were planning to apply for a regional grant with the Latin American and the Caribbean Council of AIDS Services Organization. Overall, complementary Round 9 activities were planned, including a focus on HIV prevention and diagnosis in key populations such as LGBTI and other MSM.

The cancellation of Round 11 thus means that there will be a lack of continuity of important activities related to HIV prevention among the most affected populations, including LGBTI and other MSM. This is likely to have a negative impact, considering the epidemiological importance of these populations in driving the HIV epidemic in Bolivia. Prevention and outreach work with MSM/LGBTI is a key way

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45. Así se ve en Bolivia la discriminación, Defensor del Pueblo, La Paz (2007).
46. SEMVBO, 2008.
47. Estudio Sexualidad Masculina y VIH en Bolivia, SEMVBO (coordinated by the National Programme for HIV and STIs, and supported by Alliance LO, IDH, UNAIDS amongst others) (2008).
49. Of these, 374,876 condoms were distributed to female sex workers, and 140,821 condoms to MSM/LGBTI populations, by means of prevention activities carried out by civil society sub-recipients.
of reaching these populations, which often do not have good access to formal health establishments. It was hoped that this type of work could be expanded with Round 11 funding to work with other populations at risk including prisoners, people living on the streets, young adolescents, and indigenous people. This will not now be possible. Furthermore, there is a significant gap in universal access to treatment as well as prevention of mother-to-child transmission of HIV (PMTCT). An increase in the rate of HIV transmission may occur amongst MSM/LGBTI, which could also pose an increased risk in the general population. In addition, important studies programmed within Round 9 would give insight into the epidemic in different key populations; these could be jeopardised as well.

Government counterpart funding has increased steadily from $125,000 in 2005 (7.27% of HIV funding for the HIV response) to $936,587 in 2009 (21.53% of HIV funding), which is encouraging. However, government funds do not cover medications or condoms and as mentioned previously they do not provide tailored services for key populations through the public health system. The government mainly focuses on support through human resources and the operation of services. The crisis here, as with so many other countries now unable to access further Global Fund grants, is that no other donor is currently seen to fill this gap. For example, United Nations Population Fund will reduce funding for HIV considerably in 2012, with HIV becoming only a cross-cutting issue rather than a programme in its own right. In addition, USAID, which has been contributing close to $1 million annually in recent years, will no longer provide funding specifically for HIV.

Bolivia was recently classified as a middle-income country and as such the Bolivian government will be expected to significantly increase its financial commitment to tackle HIV. However, it is uncertain that the government will be able to increase its counterpart financing in keeping with this economic tier. There is also a risk that some bilateral organisations may reduce their presence and contributions to Bolivia because of this change in income classification, which will have incrementally dire consequences for HIV and other health issues.