

Supporting community action on AIDS in developing countries



**DON'T STOP NOW,
FINISH THE JOB!**



**MAKING HIV PREVENTION
FUNDING WORK**

ABOUT THE CAMPAIGN

‘What’s Preventing Prevention?’ is a campaign of the International HIV/AIDS Alliance. Our mission is to support community action to prevent HIV infection, meet the challenges of AIDS, and build healthier communities.

That’s why we’re calling on donors and governments to guarantee a more effective HIV prevention response that enables groups that are at higher risk of being infected or affected by HIV to access prevention services and realise their rights. The campaign has three strands:

BETTER FUNDING

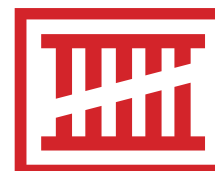
Donors need to increase the proportion of their funding for HIV prevention interventions that reach communities at higher risk of HIV.

REMOVE BARRIERS

National governments need to remove the political and social barriers that stop people from accessing prevention services.

OUR SAY

Communities at higher risk of HIV must be able to participate in decision-making around HIV prevention programmes. This is the best way to ensure services meet their needs.



ABOUT THE INTERNATIONAL HIV/AIDS ALLIANCE

Established in 1993, the International HIV/AIDS Alliance is a global partnership of nationally-based linking organisations working in over 40 countries, to support community action on AIDS in developing countries.

Alliance linking organisations support local community groups and other NGOs to take action on HIV, and are supported by technical expertise, policy work, knowledge sharing and fundraising carried out across the Alliance.

www.whatspreventingprevention.org
www.aidsalliance.org/aboutus



International HIV/AIDS Alliance
(International secretariat)
91-101 Davigdor Road
Hove, East Sussex
BN3 1RE
United Kingdom

Tel: +44 1273 718 900
Fax: +44 1273 718 901
Email: mail@aidsalliance.org

Registered charity no. 1038860



WWW.WHATSPREVENTINGPREVENTION.ORG

THE GLOBAL HIV EPIDEMIC IS STILL

OUTPACING THE RESPONSE

PROGRESS HAS BEEN MADE:

At least **33 countries** have experienced a decline in HIV incidence of at least 25%

From 2001 through 2009, the annual number of people newly infected with HIV has **decreased by 19%**

As of 2010 more than **6 million people** are accessing life-saving antiretroviral therapy

10 high prevalence countries have achieved a global goal of **reducing HIV prevalence** among young people by at least 25%

BUT MORE IS NEEDED TO BRING THE EPIDEMIC UNDER CONTROL

More than **2.5 million people** are newly infected with HIV every year, with a total of 33.4 million people living with HIV at the end of 2009

Fewer than **40% of people** living with HIV are aware of being HIV-infected, and most people find out they have HIV by getting sick - clear indicators that HIV testing and treatment programmes are not reaching people in need

Two people are **newly infected** each year for each individual who starts treatment. Although the global HIV infection rate is dropping, the overall number of people at risk of illness and early death continues to climb

MORE IS NEEDED IN ALL ASPECTS OF THE GLOBAL RESPONSE TO HIV. PARTICULAR ATTENTION SHOULD BE PAID TO CURRENT INTERNATIONAL INVESTMENTS IN HIV PREVENTION, GIVEN THE POTENTIAL FOR THESE INVESTMENTS TO CURTAIL THE NUMBER OF NEW INFECTIONS AND ULTIMATELY END THE EPIDEMIC.

(endnotes) iii iv v viii

SUMMARY

During the past decade, since the 2001 UN General Assembly Special Session on AIDS, the global response to HIV has made substantial gains. Because of unprecedented mobilisation of countries and communities, more than 6 million people are accessing life-saving antiretroviral therapy and the rate of new HIV infections is starting to slowly decrease.

However, the global HIV effort is not yet on track to long-term success (see page 2). More is needed, particularly to refocus and renew international investments in HIV prevention, to curtail the number of new infections, provide treatment to those in need, and ultimately end the epidemic.

Under our campaign, **What's Preventing Prevention?** and in advance of the 2011 UN General Assembly High Level Meeting on AIDS in New York, the International HIV/AIDS Alliance (the Alliance) has recently commissioned new funding analysis¹ that suggests that international investments in HIV prevention can be improved, especially in regard to programming by and for communities at higher risk of HIV infection (key populations).¹

The Alliance has been building the local capacity of key population groups and communities for nearly 17 years. The involvement of these groups is vital for an effective and sustainable response to HIV. However, there are many ongoing challenges that Alliance linking organisations face when working to support key population groups and organisations.

HIV prevention programmes for key populations are not prioritised by national governments and international donors; there is widespread social and institutional discrimination towards people living with HIV and other key populations and other violations of their human rights; and there is an increasing trend towards using punitive laws and law enforcement practices which makes it more difficult for HIV programmes to reach men who have sex with men (MSM), sex workers, transgender people and people who use drugs.

IN THIS PAPER, THE ALLIANCE CALLS ON INTERNATIONAL DONORS TO:

- 1.** recommit to Universal Access by 2015
- 2.** invest in rights-based, evidence-informed HIV prevention programmes for and with key populations
- 3.** fund country-owned HIV programmes with meaningful involvement of key populations

¹ Key populations vary according to the local context but include vulnerable and marginalised groups such as people living with HIV, their partners and families, people who sell or buy sex, men who have sex with men, people who use drugs, orphans and other vulnerable children, migrants and displaced people, and prisoners.

2.5
MILLION
PEOPLE ARE
NEWLY INFECTED
WITH HIV EVERY
YEAR



1: RECOMMIT TO UNIVERSAL ACCESS BY 2015

AND STRENGTHEN COUNTRY REPORTING

- The global HIV epidemic is still outpacing the response: international HIV investments should be maintained and increased. In particular, countries should fund the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) and build overall commitments to HIV prevention.
- Strengthen UNAIDS country progress reporting guidelines (a.k.a. UNGASS progress reports) to collect consistent detail about national epidemiology and expenditures, especially in regard to key populations including by age, gender, risk group and likely route of HIV exposure.
- Support data collection especially through technical support and funding for countries to implement standardised methodologies for National AIDS Spending Assessments (NASAs).

THE EVIDENCE

- Overall global HIV spending was US\$ 13.7 billion in 2008. Spending categorised as HIV prevention accounts for a median level of 21% of all HIV spending, or approximately US\$ 3 billion, which is only one-third of the amount that UNAIDS estimates is needed to scale up to achieve universal access and end new HIV infections.ⁱⁱ

- International donors support approximately half of all HIV spending, or roughly US\$ 6.5 billion, with the remaining half supported by national, local, and household resources.ⁱ
- An analysis of reported HIV spending in 51 countries in 2005-2007 showed that 40% of total HIV spending in those countries came from international funding.ⁱ
- The United States President's Emergency Fund for AIDS Relief (PEPFAR), the Global Fund, and the World Bank have been the three largest international AIDS donors. They have categorised between 26% to 35% of their HIV-related funding as dedicated to HIV prevention. (see Table 1)
- A total of 107 UN Member States submitted 2008 country progress reports to UNAIDS and 184 countries submitted country progress reports in 2010. However, in 2008 reporting, 24 countries (22%) did not report spending on total prevention, only 28 (26%) reported complete disaggregated data for prevention spending, and 56 out of 107 (52%) did not report any spending data for HIV prevention among key populations.ⁱ
- The country reporting statistics for 2010 were not much improved. Response rates about prevention programme coverage for key populations were also low: just 39% of countries responded regarding sex workers, 28% regarding men who have sex with men, and 20% regarding people who inject drugs.



PREVENTION FUNDING AMOUNTS TO JUST 1/3 OF WHAT IS NEEDED TO END NEW HIV INFECTIONS

TABLE 1. FUNDING ALLOCATION FOR HIV RESPONSE BY A SELECTION OF INTERNATIONAL DONORS

GLOBAL FUND	PEPFAR	WORLD BANK MAP
Prevention 30%	Treatment 36%	Health System Strengthening 40%
Treatment 27%	Prevention 26%	Prevention 35%
Health system strengthening 16%	Care 21%	Care and Treatment 15%
Supportive environment 16%	Other 17%	Impact and mitigation 6%
Care and Support 10%		M&E 4%
TB/HIV collaboration activities 1%		

Source: OPM analysis 2010

2: INVEST IN RIGHTS-BASED, EVIDENCE-INFORMED PROGRAMMES

FOR & WITH KEY POPULATIONS

- HIV prevention and treatment approaches need to be ‘rights-based’^{vi} People’s ability to negotiate reduced risks of HIV transmission and increased access to testing, treatment and care are heavily impacted by issues such as discrimination, violence, and a lack of protective laws. Conversely, people gain an opportunity to avoid HIV and AIDS when they are free from discrimination and threat of violence, and have access to supportive law enforcement and access to justice.
- Sustain and expand dedicated funding channels to build capacity and support programmes for key populations, including through the Global Fund (e.g. the ‘Most-at risk populations (MARPs) channel’) and similar mechanisms from PEPFAR and other international AIDS funders.
- Donors should commit to a ‘combination prevention’ approach. ‘Combination prevention’ programmes are defined as including a rights-based, evidence-informed and community-owned mix of biomedical, behavioural, social and structural interventions that have been selected, prioritised and tailored to meet the HIV prevention needs defined by particular communities, so as to have the greatest sustained impact on reducing new infections.^v



ONLY 50% OF LOW & MIDDLE INCOME COUNTRIES HAVE HIV PREVENTION TARGETS

THE EVIDENCE

- Only 21% of HIV spending is dedicated to HIV prevention and spending for HIV prevention targeted to key populations is minimal (see table 2). A bigger share of resources going to populations that are most affected and key to the HIV response would have greater impact on the HIV epidemic.
- UNAIDS reports that prevention strategies are well-matched with epidemiological trends in only 10% of low and middle income countries, only about 50% have targets for prevention, with the exception of prevention of mother to child transmission (PMTCT).
- Countries should ‘know their epidemics’ but the international HIV effort continues to operate with a lack of reliable data and limited ‘policy space’ for interventions that focus on marginalised (and in many countries criminalised) groups.

- According to the March 2011 UNAIDS Secretary-General’s report, “in 2009, only 26% of countries had established prevention targets for sex workers, 30% for people who use drugs and 18% for men who have sex with men.”^{vi} As a result, “most countries do not report data on these key populations”, indicating they have “little understanding of the size, age and geographical distribution.”
- In nearly all countries high HIV prevalence (e.g. more than 5 in 100 people found to be HIV-infected) has been documented among key populations such as people who inject drugs, people engaged in sex work, and men who have sex with men.^{viii}
- In countries with generalised epidemics, less than 1% of HIV prevention spending is targeted to sex workers, people who inject drugs, or men who have sex with men. In countries with concentrated epidemics – where infections are, by definition, heavily centred in one or several key populations – analysis by OPM of the 51 countries with strongest reporting showed that only about 7.7% of all HIV prevention spending was targeted to key populations. Analysis of a broader set of countries by UNAIDS calculated that only 4.7%, 3.3% and 1.8% of all prevention spending was allocated to programmes for injecting drug users, men who have sex with men, and sex workers, respectively. This global pattern of under-investment is seen repeatedly at regional and country levels.^{viii ix} See how key populations are missing out on page 8.

TABLE 2: DISTRIBUTION OF HIV PREVENTION EXPENDITURES ACROSS 51 SELECTED COUNTRIES

SUB-CATEGORY WITHIN PREVENTION CATEGORY	TYPE OF EPIDEMIC			
	LOW	CONCENTRATED	GENERALISED	ALL COUNTRIES
PMTCT	0.96%	8.58%	15.5%	11.49%
CONDOMS	2.23%	10.3%	5.58%	7.42%
MSM, IDUS AND SEX WORKERS	14.1%	7.66%	0.57%	4.59%
VCT	2%	7.04%	13.52%	9.9%
BEHAVIOUR CHANGE	6.98%	8.19%	13.49%	10.71%
OTHER	73.73%	58.23%	51.34%	55.89%

Source: OPM analysis based on data from 2008 UNAIDS global report

HOW KEY POPULATIONS ARE MISSING OUT

THERE IS A GLOBAL PATTERN OF UNDER-INVESTMENT IN HIV PREVENTION

HIV is routinely tracked in key populations by only a fraction of the 169 countries reporting epidemiological data to UNAIDS. In 2008 reporting to UNAIDS, 44 provided a survey-based estimate of HIV prevalence among people who inject drugs, 53 for men who have sex with men, and 65 for female sex workers.

Even fewer countries have set formal HIV prevention coverage targets for key populations. According to UNAIDS, as of early 2009, only 22 countries had targets for prevention coverage for sex workers, only 15 for people who inject drugs, and only 13 for men who have sex with men.

Country spending for HIV prevention targeted to key affected populations is minimal. Across all 2008 National AIDS Spending Assessments (NASAs) reported to UNAIDS, countries reported spending less than 5% on HIV prevention services and programmes targeted to key populations.ⁱ

WHICH IS SEEN REPEATEDLY AT REGIONAL AND COUNTRY LEVELS.^{viii ix}

In Asia, 90% of prevention resources for young people support programmes focused on low-risk youth, who account for only 5% of the people acquiring HIV infection.

In China, despite 90% of HIV transmissions being among people who inject drugs and men who have sex with men, 54% of all donor funding for HIV prevention is allocated to the 'general population'.

In Eastern Europe and Central Asia, where epidemics are primarily concentrated among people who use drugs, 89% of prevention investment fails to focus on the people at highest risk.

3: FUND COUNTRY OWNED HIV PROGRAMMES WITH

MEANINGFUL INVOLVEMENT OF KEY POPULATIONS

- Influence host-country control over international funds in order to: prioritise community-led responses that ensure the meaningful involvement of key populations in the national response; enable laws and policies that protect and promote human rights; and establish national strategies that guarantee leadership and strong systems for quality multisectoral programme planning governance, management, accountability, and quality.
- Where criminalisation, violence and stigma limit the ‘space’ for marginalised communities to respond, legal reform is essential.

THE EVIDENCE

- The desire for (host) country ownership is a driving force behind the creation of country-level governance structures - such as Global Fund-related Country Coordinating Mechanisms (CCMs) and funding driven by country-level strategies - such as the Global Fund National Strategy Applications (NSAs), PEPFAR Partnership Frameworks and Country Operational Plans (COPs), and World Bank funding of National Strategic Plans (NSPs).
- Recipient government control over international aid should be predicated on national co-investments, not only of funding but also of supportive laws and policies, leadership, and strong systems for multisectoral programme planning, governance, management, and accountability, and quality and comprehensiveness of national strategies and policy environments.
- Furthermore, the concept of ‘country-owned’ should be interpreted broadly to include an understanding of the many entities within any country that can contribute to the effort for health and rights. This includes governments and non-governmental organisations. In recognition of the role of non-governmental organisations in the response to HIV, the Global Fund, PEPFAR, and World Bank are all exploring new mechanisms to facilitate funding to civil society organisations in ways that are not necessarily mediated through national governments.
- The idea that the personal experiences of people living with HIV could and should be translated into helping to shape a response to the HIV epidemic was first voiced in 1983 at a national AIDS conference in the USA through ‘The Denver Principles’. It was formally adopted as a principle at the Paris AIDS Summit in 1994, where 42 countries declared the Greater Involvement of People Living with HIV and AIDS (GIPA) to be critical to ethical and effective national responses to the epidemic
- Key populations understand the social, cultural, economic, and behavioural drivers that increase their risk to HIV and know the barriers that prevent access to HIV and AIDS services. Involvement of key populations brings legitimacy and relevance to responses. Public involvement of marginalised groups can reduce stigma towards these communities, and shift harmful cultural perceptions by demonstrating that they are equal contributors to society with values, dreams and dignity.



**INVOLVEMENT
OF KEY
POPULATIONS
IS VITAL FOR
AN EFFECTIVE
RESPONSE**

ENDNOTES



ⁱ Oxford Policy Management (OPM), “Making HIV prevention funding work for most-at-risk and vulnerable populations: Expenditure data availability and resource allocation processes for AIDS prevention for most-at-risk and vulnerable populations.” September 2010. Research commissioned by the International HIV/AIDS Alliance. Available on www.opml.co.uk

ⁱⁱ Global Prevention Working Group – Global HIV Prevention Progress Report Card. November 2010.

ⁱⁱⁱ UNAIDS. Global AIDS Epidemic Update. November 2010

^{iv} WHO. Towards Universal Access. 2010.

^v UNAIDS. Outlook Report. 2010

^{vi} International HIV/AIDS Alliance. Campaign briefing: Protecting human rights as the core of the response to HIV. July 2010.

^{vii} International HIV/AIDS Alliance. HIV Update: Meeting the needs of populations through combination HIV prevention. March 2011.

^{viii} United Nations Secretary-General. Uniting for Universal Access. March 2011.

^{ix} Forsythe S., Stover J., and Bollinger L. The past, present and future of AIDS resource allocation. Futures Institute. 2009.

^x Includes programmes for sex workers and their clients, for men who have sex with men, and programmes for harm reduction for people who inject drugs.



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For more information, contact:
mail@aidsalliance.org

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