

# Funding of Community-Based Interventions for HIV Prevention

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## Abstract

Since the start of the HIV epidemic, community responses have been at the forefront of the response. Following the extraordinary expansion of global resources, the funding of community responses rose to reach at least US\$690 million per year in the period 2005-2009. Since then, many civil society organizations have reported a drop in funding. Yet, the need for strong community responses is even more urgent as shown by their role in reaching the UNAIDS Fast-Track targets. In the case of antiretroviral treatment, interventions need to be adopted by a large majority of people at risk of HIV in order to have a substantial effect on the prevention of HIV at the population level. This paper carries out a review of the published literature on community responses, funding and effectiveness. Additional funding is certainly needed to increase the coverage of community-based interventions, but the current evidence on their effectiveness is extremely mixed, which does not provide clear guidance to policy-makers. This is especially an issue for adolescent girls and young women in Eastern and Southern Africa, who face extremely high infection risk, but the biomedical prevention tools that have been proven effective for the general population still remain pilot projects for this group. Research is especially needed to isolate the factors affecting the likelihood that interventions targeting this group are consistently successful. Such work could be focused on the community organizations that are currently involved in delivering gender-sensitive interventions.

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## Introduction

By historical standards the evolution of the AIDS response has been extraordinary. The global resources for HIV/AIDS in low- and middle-income countries rose from about US\$5 billion in 2000 to an estimated US\$20.2 billion in 2014 (Figure 1). This increase saw the birth of a new funding architecture, marked by the creation of the Global Fund in 2002, the Clinton Health Access Initiative (CHAI) in 2002, the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, and UNITAID in 2006. Altogether, this new financial architecture, with its marked reliance on civil society organizations (CSOs) for delivering services, has been instrumental in fuelling a rapid increase in the role of community responses in every country affected by the HIV epidemic.

At the country level, there are numerous examples of the rapid increase in the number of CSOs involved in HIV/AIDS during the period 2000-2010. However, this trend may already have come to an end, for two reasons: the strong results shown by anti-retroviral treatment have led donors to shift from funding prevention to funding treatment; and the financial crisis and economic recession experienced in several donor countries have resulted in stagnation of international assistance for HIV/AIDS (Kates & Wexler, 2015). Both impacts are felt by civil society organisations, which are reporting cutbacks in funding (UNAIDS, 2015a).

At the global level, hard clinical research and long trials in diverse population have yielded the technical tools to stop the HIV epidemic. In the words of one author, what is needed is to "follow the science" (Fauci & Marston, 2015). With the strong results shown by biomedical interventions such as voluntary male circumcision, pre-exposure prophylaxis (PrEP), antiretroviral drugs for prevention of mother to child transmission (PMTCT), and early antiretroviral therapy, it would seem that the HIV epidemic could indeed be stopped (Poku, 2016). But for this goal to be reached, interventions have to be adopted by a large majority of the people at risk of HIV infection. Doing so, however,

requires a much stronger role of community responses, including the strengthening of community-based services.

The importance of community responses was acknowledged in the Strategic Investment Framework, published by UNAIDS in 2011, which identified community responses as “critical enablers” (Schwartlander et al., 2011). Their importance for improving adherence and access to treatment and care has recently come to the fore due to a series of impact evaluation studies (Amanyaiwe, Leclerc-Madlala, & Gardi, 2014), and they are viewed as an essential component of UNAIDS’ strategy for reaching the Fast-Track Targets (UNAIDS, 2014). Achieving this goal would require community-based services for treatment and care to rise from 3% in 2013 to 30% of all services by 2030; and in the high HIV prevalence countries, the coverage of community mobilization would need to reach 80% by 2020 (UNAIDS 2014).

Yet, it is difficult to reconcile the perception that community responses can be scaled up quickly with the cuts in funding, both realised and impending (UNAIDS, 2015a). Moreover, under current conditions it is not clear how the coverage provided by community-based interventions could increase by a factor of 10. Clearly, drastic changes need to take place to unleash the envisaged rapid expansion of community responses, including a careful understanding of the different types of community responses; what they can and cannot achieve; in what sectors they can best be deployed; and the means by which they can secure funding.

### **What is the community response?**

Communities can be defined in two basic ways: the first approach is to characterize communities as a group that shares common characteristics, values or behaviours. This definition is often applied to population groups at high risk of infection such as sex workers. The other method is to define communities as a group of people linked by virtue of living in the same area such as a village or town (Rodriguez-Garcia et al., 2011).

These two definitions are not exclusive, as communities can be both geographically defined and share some common values.

Adding the term “responses” to community has resulted in much confusion. Following the increase in resources for HIV/AIDS and the large role given to interventions implemented by various organizations and actors, the meaning of community responses has become very broad. At one extreme, it is often used to describe any activities that report any level of community participation in the delivery of prevention, treatment and care. At the other extreme, the term is applied to responses that are characterized by an explicit organisational form and empowerment of its members. Faced with such a diversity of community responses, the most common approach has been to describe communities in terms of the extent of community involvement; the types of activities that are implemented; and the types of organizations and actors implementing the response.

**Extent of Community Involvement.** Campbell and Lippman highlight this dimension as being one of the most important factors for explaining the success or failure of community initiatives (Campbell et al., 2013; Lippman et al., 2013). Mobilising and empowering whole communities is viewed as being essential for creating enabling community contexts that would enable individuals to (i) participate in the design, implementation and management of HIV/AIDS programmes; (ii) build partnerships with groups outside the community; and (iii) ultimately change their behaviours (Campbell & Cornish, 2010). Empirically, it has proven difficult to translate the concept of mobilization and empowerment into effective interventions. So far, most of the successes have been found mainly among groups that have a strong collective identity, such as sex workers. Extending this approach to general communities has proven to be far more difficult and much less effective (Cornish, Priego-Hernandez, Campbell, Mburu, & McLean, 2014).

**Types of activities.** More recently, a different category has emerged, defined as community-based interventions (CBI). CBI have acquired a much greater role as a result of the on-going process of shifting some tasks from doctors to other health providers, such as nurses, community health workers (CHW) and non-health professionals. Task shifting was initially viewed as a way of remediating the shortage of skilled health professionals, especially in sub-Saharan Africa (Celletti et al., 2010), but its objective has now become one of increasing the uptake of services and enhancing health outcomes (World Health Organization, 2014).

**Institutional forms of community response.** The most common method for analysing community responses has been to use a proxy; namely organisations that represent the civil society response to HIV/AIDS. A usual approach is to differentiate: (i) small, informal community-based organisations (CBOs) that represent the response of indigenous communities; (ii) larger and more formal non-governmental organisations (NGOs) that usually operate in several communities; and (iii) large international NGOs that may implement programmes at the community level. In this classification, the term CSO is used as a generic term that covers all the different types of organization.

Unfortunately, there is little information on the conditions that lead to overall programme success. A common condition mentioned in the literature is adequate funding. The available evidence for this contention is discussed in the following paragraphs.

### **Funding of community responses**

Surprisingly, there is little data on the funding provided for community responses. Typically, the databases of the main funders do not provide a readily available source of information concerning the funding available to local HIV/AIDS organizations. The main reason is that the interventions are often delivered as part of other interventions, which

makes it difficult to isolate the sums dedicated to community responses. Another complication is that the funding channels reaching local communities have become complex. The easiest ones to trace are the funding channels that have been set up by governments or donors to provide resources to local organizations directly, but there are other channels through which community responses can be funded. For instance, national and international organizations may receive funding that they in turn redistribute to other, smaller organizations, which may also fund other community responses. Following all these channels is an extremely time consuming task as it would involve surveying a very large number of CSOs. In some countries, such as India which has over one million NGOs involved in HIV/AIDS, this task would be impossible. For this reason, the analysis of funding of community responses has broadly adopted two different methods: the first aims at estimating the funding provided by the main donors for civil society organizations; and the second focuses on surveying local organizations providing services within countries. These two methods are described below.

### **Global Resources for Civil Society Organizations**

**The World Bank MAP** (Multi-Country AIDS Program) for Africa was the first to offer substantial, long-term resources for HIV, including funding earmarked for community responses. Analysis of the projects indicates that CSOs received about 39% of MAP funding during the 2003-2006 period (Görgens-Albino, 2007). In total, MAP projects and other World Bank HIV/AIDS projects in Asia, Africa and Eastern Europe provided an estimated US\$100 million per year to national NGOs and small CBOs.

In 2002 **the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)** was established with the objective of becoming the main funder for HIV/AIDS. The Global Fund's design allows it to rapidly disburse funds to recipients. It is estimated that national CSOs received on average US\$300 million per year for HIV/AIDS during the period 2002-2010 (Table 1).

The third major source of funding for community responses is the **US President's Emergency Plan for AIDS Relief (PEPFAR)**. It was launched in 2003 as an emergency response to the HIV/AIDS epidemic with an initial pledge of US\$15 billion to 15 priority countries. Estimating the funding provided to CSOs required combining different sources of information and assumptions to separate various funding flows, but is estimated at US\$230 million per year during the 2003-2010 period (Table 1). In FY2014, PEPFAR started to monitor the funding going to local implementing agencies. Data published in its annual report to Congress indicates that PEPFAR disbursed US\$3.2 billion in 2013, out of which US\$199 million was spent on community-based treatment, care and support (PEPFAR, 2015). If anything, this latter estimate suggests that PEPFAR funding for community responses might have fallen, which could be the case in view of the relative stagnation of its funding since 2008 and the increased focus given to treatment, care and support.

Financial resources were also provided by the **UK Department for International Development (DFID)**. Funds were disbursed through a limited number of large NGOs and agencies, and country-level channels for funding smaller national CSOs. Amounts provided to CSOs for HIV/AIDS are estimated from DFID's database to have averaged US\$60 million per year during the 2004/05- 2008/09 period.

In aggregate, donor funding for CSOs is estimated to have exceeded US\$690 million per year on average between 2004 and 2009 (Table 1). This estimate measures the funding available at the national level, but the actual flows reaching local communities are likely to be much less.

## **Funding of NGOs and CBOs at country level**

As is the case at the international level, national information systems do not provide much information on the funding available to NGOs and CBOs. The existing databases have been designed to track the implementation of programmes classified by the typical categories of prevention, treatment, care and support, but they rarely provide a crosscutting classification that would identify the resources that are funding community responses. Given these shortcomings, the main alternative approach has been to carry out a survey of NGOs and CBOs.

**Worldwide surveys.** Kelly documented differences and programmatic gaps in the roles of 75 NGOs in HIV prevention in Africa, Central/Eastern Europe and Central Asia, Latin America and the Caribbean (Kelly et al., 2006). In Africa, none of the NGOs reported working with MSM and drug users. In the Caribbean, NGOs did not have programmes for MSM, IDUs, sex workers and prisoners. Limited funding was the most common barrier to HIV prevention programmes reported by NGOs in Africa (70%) and Central/Eastern Europe (72%), but stigma was reported as the greatest obstacle in Latin America (73%) well ahead of funding (40%), providing indications that funding was not necessarily the main bottleneck to more effective AIDS responses.

A more recent source of information is provided by a 2010 internet-based survey of 146 CSOs, which was organized by the HIV/AIDS International Alliance (Bonnell et al., 2012). Government funding and national grant mechanisms generated 16% of CSOs' resources, which showed that countries had developed national mechanisms to channel the increased funding coming from international aid and national governments. Compared to the earlier findings of Kelly, the survey suggested that NGOs had become more dependent on external aid, at least in Africa and Latin America (Central/Eastern Europe and Central Asia were already highly dependent on external aid). In total, foreign aid provided an estimated 68% of CSOs' resources in 2010. Especially worrying was the



finding that more than a quarter of the surveyed NGOs received funding from only one donor, which raised the issue of sustainability of these organisations, given the volatility of external aid.

**Eastern and Southern Africa.** The dynamics of civil society and AIDS funding in Southern Africa was the subject of the first large-scale survey carried out in that region (Birdsall & Kelly, 2007). Questionnaires were sent to 430 CSOs in six countries (Lesotho, Malawi, Mozambique, Namibia, Swaziland and Zambia) to obtain information on their operations and funding. Spending by the surveyed CSOs was found to have tripled between 2001 and 2005, mainly on account of international aid that provided more than 85% of the financial resources received by CSOs. The average expenditure per CSO was about US\$145,000, but the distribution of expenditures was highly skewed: the median expenditure was only US\$16,000, meaning that the bulk of the spending (89%) was concentrated among a small number of large CSOs (20%). This result provided support for the position that too little funding was trickling down to local community organizations (Foster, 2005).

Most likely, funding for CSOs continued to increase in the years from 2005 to 2009. This was at least the case of five countries (Ethiopia, Haiti, Uganda, Vietnam and Zambia) that were funded by PEPFAR. These countries (with the exception of Uganda which already had high funding levels) experienced a doubling or tripling of PEPFAR support to local organisations from 2006 to 2009 (Coutinho et al., 2012).

### **Recent trends**

There is little available information on the funding for community responses in recent years. However, indications are that CSOs have been adversely affected. On one hand, the financial crisis and economic recession experienced in several donor countries have resulted in stagnation of international assistance for HIV/AIDS (Kates & Wexler, 2015).

Given the high dependence of most CSOs on external assistance revealed by previous surveys, one would expect an adverse impact on their funding and activities. Supporting evidence comes from a recent survey of CSOs (UNAIDS, 2016b). A total of 40% of the surveyed organizations indicated that their resources had decreased since 2013, and 89% of those who reported a decline in funding also indicated that they had to scale down their services. In addition, the relative share of prevention in AIDS funding declined across the board. In low-income countries, it fell from 31% in 2005 to 22% in 2013; in lower-middle-income countries the decline was from 27% to 23% and in upper-middle-income countries the share of prevention was reduced from 27% to 23% (UNAIDS, 2015b). This is creating a difficult challenge for community responses at a time when expectations concerning their role are quite high.

### **The critical role of community responses**

The past few years have been a time of both tremendous optimism and significant disappointments in implementing the global AIDS response. Between 2001 and 2014, the number of new infections has fallen by 35% since 2000 and great progress has been made in scaling up AIDS treatment. In Eastern and Southern Africa, nearly every country with the exception of Uganda and Angola recorded a drop in new infections during the period 2001-2013 (Figure 2).

Overall, however, AIDS responses have made only a marginal gain on the future HIV burden. This is shown in Table 2 for some of the countries where the scaling up of AIDS responses have been the subject of careful detailed analysis. Despite taking into account various savings in efficiency, the financial investment needs increase between 40% and 88%. While not shown in that table, these studies also reveal that accelerating the pace at which services are being scaled up does not reduce costs below those of the baseline projection in the short- to medium-term. The reason is that the scaling up of programmes increases both the life expectancy of people living with HIV/AIDS and the

percentage of people on treatment. Both factors imply that the savings resulting from a lower number of infections materialize only over the long-term (i.e. after 20 years or more).

These results do not mean that countries should not try to scale up their AIDS responses as: (i) the available evidence shows that these interventions are cost effective; and (ii) the modelling of the HIV epidemic suggests that if the coverage of interventions remains at their current level the HIV epidemic will have rebounded by 2030 (UNAIDS, 2014). Instead, the increase in cost highlights the need for primary prevention of new infections to remain a top priority for HIV/AIDS responses. As indicated in the 2016-2021 UNAIDS strategy (UNAIDS, 2015b), this means focusing on the right locations, populations and programmes to maximize impact. In most epidemics, priority populations include a combination of groups at high risk of infection such as sex workers, men who have sex with men, and people who inject drugs and other country-specific populations (e.g. ethnic minorities). In countries with high prevalence, such as in sub-Saharan Africa, priority populations extend beyond these key groups and include women and men in specific age groups.

### **Adolescent girls and young women**

A general pattern found especially among those Eastern and Southern African countries with high HIV prevalence rates is for the HIV prevalence rates among adolescent girls and young women to increase much more quickly than for young men of the same age groups (Idele et al., 2014). In Africa, 74% of new infections among adolescents affect young girls (UNAIDS, 2013). In the case of Botswana, for example, analysis by age-cohort shows that the youngest age cohorts doubled or tripled their prevalence from 2004 to 2013 (Figure 3) whereas the national HIV prevalence rate only rose only slightly from 17% in 2004 to 18.5% in 2013.

This data indicates that young girls and young women face levels of HIV infection that are so high that they form a key population group comparable in terms of their impact on the course of the epidemic to other high risk groups that are already the focus of increased attention and financial resources. Further support for the importance for prevention programmes to focus on young women comes from studies that document a link between gender inequality and HIV transmission (Richardson et al., 2014).

### **Implications for community responses**

There is now wide recognition that community responses must play a key role in achieving the targets underlying the scaling up of AIDS responses. The UNAIDS strategy for 2016-2021 includes targets that imply reaching 90% of people in key population groups, young people and those in high HIV prevalence settings. To deliver the needed services, community-based services for treatment and care are projected to rise from a global average of 3% in 2013 to 30% of all service delivery by 2030, and in the high HIV prevalence countries, the coverage of community mobilisation would reach 80% by 2030 (UNAIDS, 2014). The financial implications are stark. According to a recent update (UNAIDS, 2016a), resources for community mobilization, community-based delivery of antiretroviral treatment, outreach to key populations and social enablers (interventions concerning advocacy, political mobilization, human rights, and stigma reduction) would reach 22% of expenditures by 2020, or the equivalent of US\$5.7 billion. In comparison, the available funding for community responses in the mid to late 2000s may have been around US\$1.0 billion.<sup>3</sup>

How likely is the funding for community responses to increase so rapidly? According to the document entitled “How AIDS changed everything” (UNAIDS, 2015a), CSOs are reporting cutbacks in the funding available. The document lists declining financial

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<sup>3</sup> This rough estimate assumes that donors provided about US\$690 million for community responses (as shown in Table 1) and that the share of international aid in CSOs’ budget was 68% as shown by the 2010 CSOs’ survey .

resources for civil society organisations as one among five gaps and challenges facing the funding of the global AIDS response.

The coverage of community mobilization (estimated at 1%) as well as the outreach for key populations are extremely low, which can only be explained by the presence of some strong constraints. At the same time, the projection that the coverage of community-based interventions can be multiplied by ten can only materialize if there are no significant obstacles preventing such a quick increase. Among these, the lack of adequate funding is only one. Other explanations found in the literature include: institutional disbursement and policy constraints (Oomman, Nandini; Bernstein & Rosenzweig, 2007); difficulties involved in scaling up community-based projects (Binswanger-mkhize, Regt, & Spector, 2010); difficulties in operationalizing the concept of community mobilization in different contexts (Cornish et al., 2014; Kongelf, Bandewar, Bharat, & Collumbien, 2015; Mburu, Iorpenda, & Muwanga, 2012); and insufficient attention given to social and structural factors (Auerbach, Parkhurst, & Caceres, 2011).

### **Effectiveness of community-based interventions for prevention**

There is compelling evidence to support the contention that community-based interventions in resource-limited countries make a positive contribution to biomedical interventions, together with a wider range of positive health outcomes. Wouters' review of the literature found that CBI helped expand access and coverage of antiretroviral therapy (ART) (9 studies), increase adherence levels (9 studies), improve virological and immunological outcomes (22 articles), and increase levels of patient retention (8 studies), and rates of survival (6 articles) (Wouters, Van Damme, van Rensburg, Masquillier, & Meulemans, 2012).

Overall, the abundance of evaluations showing positive effects of CBI for treatment, care and support suggests that such interventions should not face major issues in obtaining funding, especially as in many cases the required resources for CBI would be offset by the reduction in costs at the level of health facilities. However, the scaling up of CBI may require additional investment to strengthen human resources, health service linkages and community preparedness (Wringe, Cataldo, Stevenson, & Fakoya, 2010).

**Community responses for HIV prevention.** In contrast to treatment, care and support, the evidence concerning behavioural interventions is much more limited, and it depends on the population group being considered. Among groups at high risk of infection (especially sex workers), the evidence is consistent, showing stronger results for behavioural and social outcomes than for bio-medical outcomes (Cornish et al., 2014). Small or non-significant effects on HIV prevalence were generally found for sex workers, but these could be explained by the long time required for interventions to change the HIV prevalence rate.

For youth and the general population, the evidence is much more mixed. Salam provides a meta-analysis of CBI on HIV knowledge, behaviours and transmission based on 39 studies (including high income countries) (Salam, Haroon, Ahmed, Das, & Bhutta, 2014). Results showed that CBI to increase HIV awareness and risk reduction can be effective in improving knowledge, attitudes and practices, but they also documented a lack of impact in the case of several prevention activities (for example, e.g. communication and self-efficacy), and like other studies, no effects on morbidity and mortality were found.

**The specific case of girls and young women in sub-Saharan Africa.** The limited impact of prevention interventions is especially an issue for young women and girls in Africa given the high rates of infection that this group continues to experience. This was highlighted by a systematic review of the effectiveness of HIV prevention for youth (10-

25 years old) in sub-Saharan Africa (Michielsen et al., 2010). Overall, the evidence of effectiveness was limited and, in particular, no large change in sexual activity was found.

In recent years, the evidence on the effectiveness of behavioural interventions has become more encouraging. A number of programmes have been implemented to address some of the social and structural conditions such as gender inequalities, intimate partner violence (IPV) and gender education that had been mentioned as some of the possible reasons for the lack of success of previous behavioural interventions. Examples include SHARE (Safe Homes and Respect for Everyone), an intervention combining communication on prevention of HIV and IPV, which reduced HIV incidence by one-third in the Rakai district of Uganda (Wagman et al., 2015). Another example is SASA!, a community mobilization intervention aimed at changing community norms and behaviours that result in gender inequality, violence and increased HIV vulnerability for women. Evaluation of data collected between 2007 and 2012 in eight communities in Kampala indicated that it improved a number of HIV-protective behaviours, especially among men (Kyegombe et al., 2014). Importantly, the intervention effects were demonstrated at the community level and not limited to those with high reported levels of intervention exposure (Abramsky et al., 2014). SASA! is now being replicated in 15 countries.

A strong rationale for addressing the issues of power and gender comes from a recent review of evaluations of sexuality education (Haberland, 2015). Interventions that addressed power or gender within sexuality education programmes were found to be five times more effective at reducing sexually transmitted infections (STIs) or teenage pregnancy than programmes that did not. Fully 80% of the interventions addressing gender or power were associated with a lower rate of STIs or pregnancy. Among those that did not, only 17% had such success.

Nevertheless, the overall picture remains confusing, as the combined evidence does not provide a consistent picture. An example is provided by the role of peers. Fearon found 11 articles that provided evidence for an association between peers and sexual behaviour for at least one peer exposure/outcome association (Fearon, Wiggins, Pettifor, & Hargreaves, 2015). However, when all the findings were considered together, there were no clear patterns by outcome type, peer exposure type, gender and age, a conclusion that could be explained by the high degree of heterogeneity in the peer exposures and the means by which the concept of peers was operationalized. It appears very likely that normative and behavioural initiatives need to be precisely tailored to local circumstances.

Altogether, the available data indicates that the main issue is not the lack of impact as there are a number of behavioural interventions that deliver results. However, there is a lack of consistent evidence and implementation models. In the case of antiretroviral treatment, the intervention itself is fairly well standardized and what is being evaluated is clear. This is usually not the case for gender-sensitive interventions. So far, these interventions have taken the form of pilot programmes, each one with its specific implementation modalities as concerns the role of groups, peers and intensity of the intervention. The result is that it is not always clear what is being evaluated. Is it the intervention itself or the way the programme is being implemented? In the case, for example, of the impact of peers, the reviewer concluded that while each intervention had some results, together they generated an inconsistent body of evidence, most likely because of substantial differences in the way peers were used to influence behaviours. What is missing is an analysis of the NGO-level factors that could explain why interventions with the same stated objectives could result in such different outcomes.

## **Conclusion**



There are broad expectations that scaling up community responses would help the global community achieve the targets of the global HIV and AIDS response more quickly and effectively. This is especially the case for community-based interventions that are widely viewed as a key tool for stimulating demand for HIV/AIDS services, improving adherence to treatment and more generally enhancing various health outcomes. A key characteristic of the successful interventions is that they are delivered as part of a health package that involves health facilities or local hospitals and, although the evidence is limited, they are likely to be cost-effective. These largely bio-medical interventions are best placed to benefit from the envisaged increase in resources to fund the global AIDS response.

The situation is vastly different in the case of behavioural interventions for adolescent girls and young women. The persistence of the HIV epidemic among this group is a clear reflection of how the provision of services has not addressed the specific needs and key vulnerabilities. For the first decade of the new millennium, the HIV/AIDS response for women took three main forms: (i) reaching women as they accessed antenatal care services; (ii) providing prevention services to sex workers; and (iii) implementing behavioural campaigns largely targeting individuals. While these entry points were successful in reducing infections among young children, pregnant women and sex workers, they have not been effective in reaching adolescent girls and young women in the general population who are not yet pregnant.

Ten years ago, the main issue preventing the scaling-up of programmes for young women was the lack of evidence that behavioural interventions would work. Reviews of the impact evaluations found mixed results for reasons that are generally not investigated. Possible explanations ranged from shortcomings in evaluation methods to issues in operationalizing interventions and to insufficient attention to contexts. The importance of context was brought to light by recent research that highlighted the role of structural and social factors that influence adolescent girls and young women's sexual

behaviours and their uptake of services. Confirmation of these factors has recently been provided by several interventions, which have been shown to lower the risk of HIV infection by targeting gender inequality and gender-based violence, and providing sexual education and financial incentives. However, most programmes remain largely pilot interventions that are implemented on a small scale.

The single most effective way of reducing the financial burden of AIDS is to revitalise and scale-up prevention initiatives. Funding is needed to expand the coverage of these programmes, especially for adolescent girls and young women, but it is unlikely to materialize on the needed scale unless greater clarity is provided as concerns the type of interventions that should be scaled up and how they would be scaled up. To address these issues, further research is needed to isolate the factors that would increase the likelihood that interventions targeting girls and young women will be more consistently successful. Such work could be focused on analysing how the institutional organization of CSOs, the programme context, CSOs' linkages with the health sector and local and central governments, and networks affect the performance of the organizations that are delivering behavioural interventions. Having such information would help planners replicate and scale-up efficient models and scale-up gender responsive HIV/AIDS interventions.

The international expectation of greatly increased community-based programmes—and the achievement of the Fast Track goals—requires a considerable boost to funding, but also (and at least as important), a rapid research focus on behavioural interventions, carefully planned, targeted allocation of resources, and close tracking.

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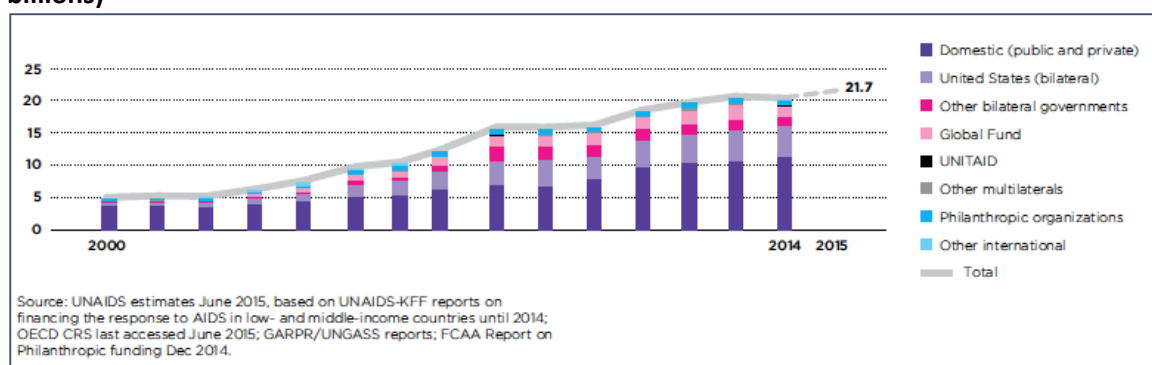
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# Funding of Community-Based Interventions for HIV Prevention

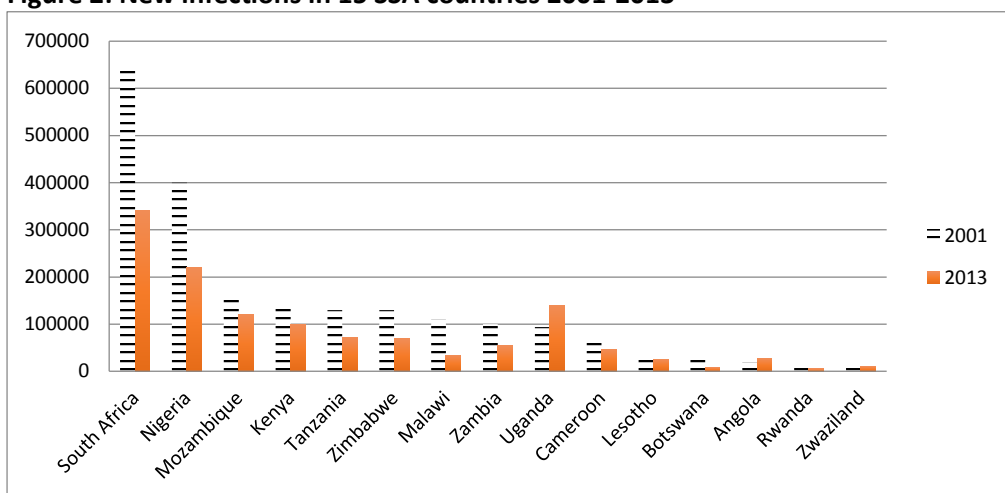
## Figures

**Figure 1: Global resources for HIV/AIDS in low- and middle-income countries, 2002-2014 (IN US\$ billions)**



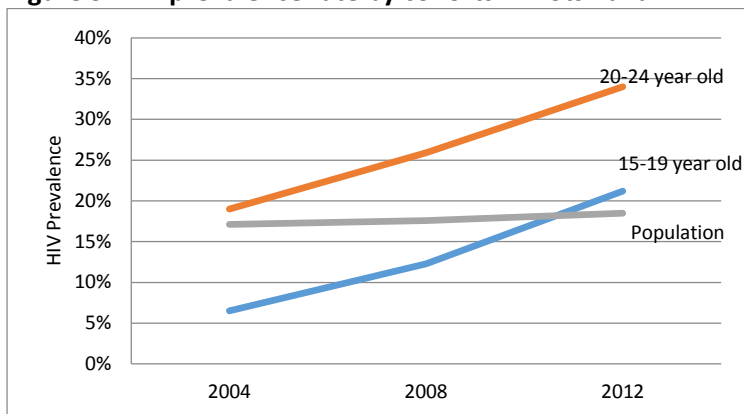
Source: (UNAIDS, 2015a)

**Figure 2: New infections in 15 SSA countries 2001-2013**



Source: (UNAIDS, 2015a)

**Figure 3: HIV prevalence rate by cohorts in Botswana**



Source: (Botswana, 2013)

# Funding of Community-Based Interventions for HIV Prevention

## Tables

**Table 1: Summary of donors' funding of civil society organizations**

Donor	Proxy for the funding of community responses to AIDS	Period	Available funding for national AIDS responses (per year in US\$)	Average per year for CSOs (US\$)
World Bank	Share of CSO funding in MAP projects applied to all Bank projects for HIV&AIDS	June 2003 to Dec 2010	\$262 million	\$100 million
Global Fund	Expenditures by CSOs	2002 to 2010	\$910 million	\$300 million
PEPFAR (USA)	Estimated funding for nonclinical activities reaching national CSOs	2004–2009: (6 years)	\$2.1 billion	\$230 million
DFID (UK)	Estimated funds to CSO first-line recipients with AIDS as a major project or significant priority	2004/05–2008/09: (5 years)	\$590 million	\$60 million
<b>Total</b>			<b>\$3.8 billion</b>	<b>At least 690 million</b>

Source: (Bonnell et al., 2012)

**Table 2: Projected cost of AIDS response: selected countries**

	2015	2020	2030
Botswana (US\$ million)	274		395
Ethiopia (US\$ million)	242	311	N.A.
Kenya (US\$ million)	1,000	1,200	1,400 1/
South Africa (Rand billion)	23	30	35
Malawi (US\$ million)	183	350	N.A.
Uganda (US\$ million)	490	600	820
Zimbabwe (US\$ million)	420	620	790

Note: 1/ data for 2025

Source: National HIV/AIDS strategies and investment cases