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RESOURCES FOR THE COMMUNITY RESPONSE MUST INCREASE IF WE ARE TO MEET OUR TARGETS: UNAIDS

Resources for the community response will have to grow markedly over the coming years if ambitious treatment, prevention and human rights targets for HIV are to be achieved, according to a report published by UNAIDS. The report said that community-based HIV service delivery will have to go from representing 5% of all service delivery in 2013 to representing at least 30% in 2030.

“Although international and private funders have typically provided the majority of funding for community HIV responses,” the report said, “several low- and middle-income country governments have recognized the critical contribution of community and succeeded in allocating funding to community-based organizations through national policies that recognize and fund civil society.”

UNAIDS reviewed the experiences of six countries that have supported community-based HIV programs through government mechanisms. In four of the countries – Argentina, Brazil, India, and Malaysia – national resources available for the AIDS response have been allocated to civil society organizations. In the other two countries – Malawi and Moldova – Global Fund resources allocated to the government flowed through to CSOs.

Both governments and CSOs have benefited. For example, governments have been able to expand the reach of services by transferring some tasks to community health workers and volunteers; and community organizations have been able to maintain a continuum of care and to facilitate access to services for hard-to-reach groups.

Although there have been challenges – such as bureaucratic barriers that impeded or slowed the movement of funds from central treasuries to local programs – UNAIDS said that in the six countries it

documented, health officials found innovative ways to ensure that funds reached the CSOs. The report identified factors that were key to success, including the following:

- including community representatives in the selection of grant recipients;
- creating quasi-governmental organizations to receive government funding and redirect it to CSOs;
- maintaining rigorous standards for grant recipients while investing in capacity building; and
- facilitating collaboration among CSOs working in the HIV response.

Reaction

GFO asked James Robertson, Chief Executive of Alliance India, to comment on the UNAIDS study. Robertson said that while the model of government funding for communities is appropriate and appealing, UNAIDS' new report highlights an approach that is overly optimistic for key populations. "Unfortunately," Robertson said, "experience has shown again and again that these groups face substantial difficulties in securing domestic government funding as it would, of course, come from the same governments that criminalize them."

Robertson said that nearly 15 years since the advent of The Global Fund and PEPFAR, "we've all seen how hard it's been for donor governments themselves to support programming for key populations." In most places, he said, donor-funded interventions for key populations do not even approximate the scale needed, "and now donors appear to be looking for an exit. If donor countries have been so reluctant to fund programming that is politically and socially unpopular even while strongly indicated epidemiologically, why should we expect others to behave any differently?"

James Robertson, Chief Executive, Alliance India

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Robertson believes that more than attractive models are needed to fund the HIV response for key populations. "We need practical strategies that acknowledge the vital role of communities and key populations have in responding to the epidemic but that also recognize limitations and gaps and provide targeted support to build capacity, sustain programming, and protect rights," he said.

Just paying lip service to communities is not enough, Robertson said, and it is altogether too early to believe that somehow domestic funding will flow without further priming the pump. "Truth be told, too many national governments have failed to leverage communities and key populations as strengths in their epidemic responses, and donor investments have also been inadequate towards supporting this goal. At this point, rather than edging toward the door, donors and national governments should be working together to identify long-term co-investment strategies to support communities and key populations."

While the case for domestic support for treatment and other clinical services is considerably more clear, Robertson said, other parts of the HIV response – such as prevention – that often rely on the engagement of communities and key populations for success will undoubtedly suffer without external donor investment. "Many governments simply don't trust civil society organizations as they are regarded as government critics not collaborators, and key populations are more often treated as criminals than as deserving beneficiaries or implementation partners," he said. "Attitudes and laws change much slower than election or budget cycles, and if we are seriously committed to leveraging communities and key populations as partners in ending AIDS, the investment horizon that guides donors needs to be informed more by the cool clarity of experience than the warm optimism of aspiration."

Findings by country

Below, we summarize what the report said about five of the six countries included in the study: Argentina, Brazil, India, Malawi, and Malaysia. (See separate GFO article in this issue for a summary of what the report said about Moldova, and reaction from civil society representatives.)

Argentina

Before Argentina transitioned from Global Fund financing, the Ministry of Health began funding community organizations and networks directly. In 2011, $103,384 was granted to 15 organizations: six networks of people living with HIV; two organizations addressing stigma and discrimination; two networks of transgender people; two organizations focusing on children living with HIV and other vulnerable children; and three organizations of people who use drugs. Since 2011, the funding has grown each year, reaching $223,591 in 2015. The MOH has indicated “an interest” in increasing the finding to $532,359 in 2016.

Although the grants are small (the maximum award is about $21,000), UNAIDS said that they are nevertheless important because the money can be used to for grass-roots community work for which other sources of funding are limited.

UNAIDS said that community groups have asked for greater transparency and predictability of the government funding for the community response. “Although the Ministry of Health acknowledges the essential role of community organizations, stronger political commitment at the highest level and an ongoing dialogue with community organizations are needed.”

Brazil

Funding community-based HIV programs began in Brazil in 1994 when the country signed the first of a series of four World Bank loan agreements. Grants were small, at around $50,000, and were aimed at encouraging the growth of grass-roots organizations. About 15 years ago, Brazil began direct fund transfers to states and municipalities. A portion of this money was to be allocated to NGO-led projects. This continues to this day, although there were some challenges along the way.

One example of successful partnership between government and civil society to deliver community-based services is the project Viva Melhor Sabendo (“Live Better Knowing”), being piloted to scale up self-testing among key populations. In the first year of the program, almost 30,000 people were tested through 53 NGOs in 20 of the 27 states in Brazil. A new round of the project has been just launched.

In addition, the Fundo PositHiVo (the National Sustainability Fund for Civil Society Organizations) was established in December 2014, supported by the Brazilian Government. This program aims to raise funds from the private sector to finance civil society organization projects related to sexually transmitted infections, HIV, and viral hepatitis.

India

UNAIDS said that India’s prevention programs have helped to reduce new infections by 66% since 2000. (The reductions are not across the board. While HIV prevalence among sex workers and men who have sex with men has fallen, prevalence among people who inject drugs is increasing.) According to UNAIDS, India has achieved these reductions in new infections in part “through a unique system of decentralized direct funding to, and capacity-building of, community-based and community-led organizations that have the trust and experience to reach key populations.”

Early on, funds sent from the Indian Government to the state treasuries were slow to reach state-level civil society organizations. Tamil Nadu was one of the first states to establish an independent funding mechanism to address this problem. Tamil Nadu set up an independent state AIDS control society, chaired by a senior Indian Government official, with an executive committee that included other Indian Government officials, civil society representatives, representatives of key populations, and people living with HIV. The central Indian Government was able to disburse AIDS funding directly to the state AIDS control society, bypassing the bottlenecks in the state treasury. Other states soon established similar state

AIDS control societies.

An innovation in the Indian model of governmental financing of civil society organizations was the costing of packages of focused programs among different subpopulations. For example, the cost to deliver a package of services to 1,000 sex workers would be calculated, and civil society could then be contracted to deliver a certain number of packages.

The National AIDS Control Organization (NACO) has released standardized guidelines for issuing calls for applications from NGOs, for screening applications, for selecting which applications to fund, for assessing the capacities of the selected NGOs, and for conducting training.

Malawi

UNAIDS said that funding for community engagement in the HIV response has been central to Malawi's national AIDS strategy since the national AIDS control program was established in 1989.

The government has shifted a number of the non-clinical tasks related to patient follow-up and adherence support to community-based lay health workers and volunteers, thus relieving the burden on the health-care system.

Local councils are mandated to identify and support community organizations to implement activities, such as home-based care, and support for orphans and other vulnerable children.

According to the report, this flexibility to fund small local community groups is one of the strengths of Malawi's community engagement approach. "The approach has demonstrated the potential impact and cost-effectiveness of supporting motivated local groups. Recent examples include a community-run campaign costing around $200 that resulted in recruitment of over 100 men to take part in voluntary medical male circumcision."

The National AIDS Commission was able to direct funds to community programs from 2008 to 2015 using funding from the Global Fund and from a pooled funding mechanism that consolidates resources from several funders.

In 2014 several community organizations came together to develop the Malawi Civil Society Priorities Charter, an advocacy road map for programs that civil society believed were crucial to address the epidemic (see GFO article). This civil society gathering and the Charter have been critical in informing the Global Fund concept note that Malawi subsequently submitted (as well as a proposal to PEPFAR).

According to the UNAIDS report, Malawian NGOs have raised concerns that although they have built substantial capacity and demonstrated that they play an essential role in the HIV response, overall funding available to support their work is decreasing. "Although the Global Fund's new grant with Malawi has not yet been signed, it is anticipated that it will allocate increased funding to the community response, but to a fewer number of organizations to ease principal and secondary recipient management."

The idea of a civil society organization sustainability strategy is being considered (to be developed in 2016 with the participation of civil society). As an initial step, the Government of Malawi, together with the HIV/AIDS Donor Group and civil society, have requested UNAIDS to chair a multi-stakeholder taskforce to identify short- and long-term solutions to the funding crisis faced by the community response, particularly regarding critical community-based critical services at risk of disruption.

Malaysia

In 1992, the Ministry of Health established the Malaysian AIDS Council (MAC) as an umbrella project

focusing on preventing among key populations. Since then, 49 CSOs have been funded.

UNAIDS said that the MAC maps HIV prevalence among key populations in order to identify specific program needs. Based on this mapping, the MAC issues an annual call for proposals. Partner organizations submit proposals for programs that can include harm reduction, HIV prevention among specific key populations, and HIV-related shelter homes for women and children. The MAC has an internal technical review panel which evaluates proposals.

Malaysia now confronts the challenge of addressing the rapidly increasing burden of HIV among MSM, sex workers, and transgender people. According to UNAIDS, the Malaysian AIDS Council argues that there are few organizations with the capacity to reach MSM, and that few organizations are able to legally register. Funding for programs for MSM and transgender people comes predominantly from international sources. “Incorporating representatives of key populations on the technical review panel and allocating additional resources to funding and capacity strengthening for organizations serving marginalized and criminalized groups could help to address these concerns,” UNAIDS said.

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