Aidspan
Independent observer of the Global Fund

TURNING OFF THE TAP: THE PERILOUS STATE OF HIV PREVENTION FUNDING IN SOUTHERN AFRICA

A new report by Gemma Oberth*, a name familiar to many Global Fund Observer readers as a former GFO editor, calls on donors and governments to look at whether their HIV prevention budgets are really covering interventions aimed at the most appropriate population groups.

Are we targeting the right people with adequate funding to address their HIV prevention needs?

Over forty years into the HIV pandemic, East and Southern Africa (ESA) remains disproportionately affected by the disease. Although new HIV infections in the region have declined by 28% since 2010, in 2018 there were still 800,000 new cases – just under half of the global total. South Africa accounts for over a quarter of new infections in the region, and countries that continue to have high case numbers include Malawi, Mozambique, Zambia and Zimbabwe. Three countries have made significant leaps towards covering 90% of the HIV care cascade: Botswana, Eswatini and Namibia. Nonetheless, other countries in the region lag behind.

As Southern Africa works towards reducing new infections, it is important that donors and governments examine whether their prevention budgets are considering specific populations that are vulnerable to HIV. In the region, young women (aged 15–24 years) make up only 10% of the population, yet account for 26% of new HIV infections. Nearly half of the 254,000 new HIV infections among adolescents globally in 2016 also occurred in the region, according to 2018 data from the United Nations Children's Fund (UNICEF). And in specific countries, key populations—defined as men who have sex with men, sex workers, people who inject drugs, transgender people and prisoners—also experience unequal infection rates. For example, in Malawi, where 9.2% of the adult population is living with HIV, one in two sex workers is HIV positive. Generalised prevention programmes are unlikely to reach or cater to the needs of younger

people and key populations. Targeted and increased prevention funding is necessary to accelerate change.

Table 1. Key epidemiological and programme metrics for HIV prevention in Southern Africa

COUNTRY	NUMBER OF NEW HIV INFECTIONS (ALL AGES) (2019)	PEOPLE RECEIVING PREP (2017- 2019)	CONDOM USE AT LAST SEX (2019)	NUMBER OF MALE CIRCUMCISIONS PERFORMED (2019)	KNOWLEDGE ABOUT HIV PREVENTION AMONG YOUNG PEOPLE (15-24) (2019)	% OF HIGH-INCIDENCE LOCATIONS WITH A PROGRAMME FOR ADOLESCENT GIRLS & YOUNG WOMEN (2020)	HIV PREVENTION FINANCIAL GAP ANALYSIS (2020)
Angola	26,000	No data	44%	No data	32.3%	No data	Not done
Botswana	9500	1954	No data	19,756	47.2%	33%	Not done
Eswatini	4500	No data	60.4%	18,138	49.5%	76%	Done
Lesotho	11,000	35,478	76.3%	25,150	35.5%	100%	Done
Malawi	33,000	459	61.9%	166,350	41.9%	28%	Done
Mozambique	130,000	1934	37%	315,380	30.6%	42%	Not done
Namibia	6900	190	70.3%	30,134	58.3%	29%	Done
South Africa	200,000	8184	No data	591,941	45.8%	29%	Done
Zambia	51,000	3823	45.6%	483,816	41.7%	16%	Done
Zimbabwe	40,000	8351	79%	301,366	46.4%	17%	Done

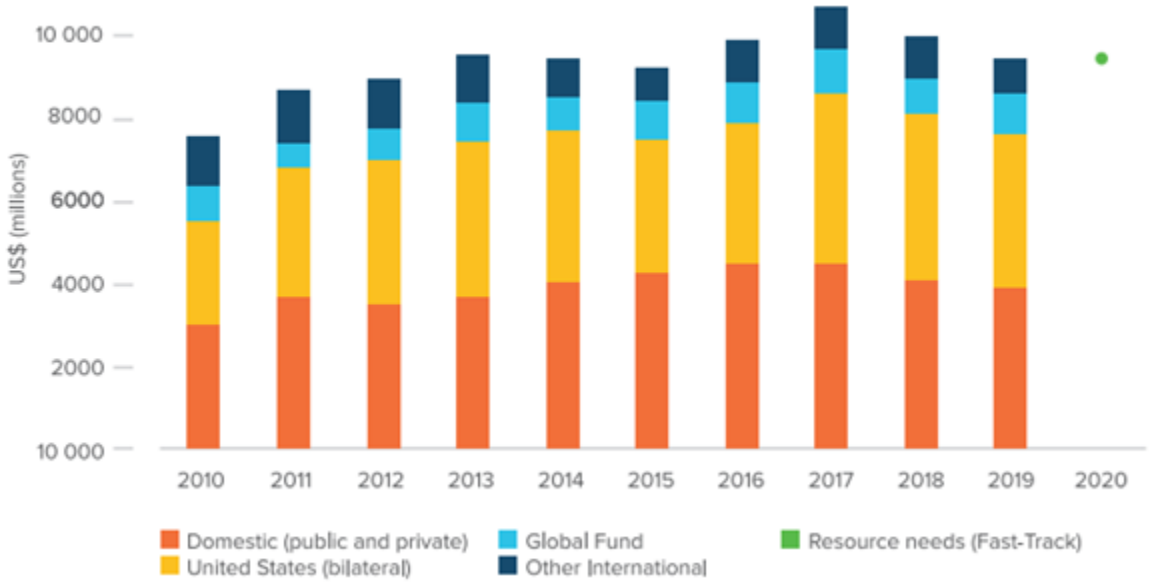
Source: UNAIDS (2019) AIDSinfo. Online at http://aidsinfo.unaids.org/

Funding landscape

Domestic sources accounted for 41% of HIV funding in ESA in 2019, United States Government bilateral funding for 40%, and the Global Fund for 10% (Figure 1). Regional domestic contributions are heavily skewed by South Africa, with the other countries in the region depending on external sources for about 80% of their HIV response financing. The most significant bilateral donor is the US government: 82% of funding from the US President's Emergency Plan for AIDS Relief (PEPFAR) goes to ESA. Other donor-supported HIV programmes for youth in the region include the United Kingdom and Sweden. The top three private funders in the region are Bill & Melinda Gates Foundation, the Wellcome Trust and Conrad N. Hilton Foundation.

Although the region remains disproportionately affected, overall HIV resources have declined for the last two years in a row.

Figure 1. HIV resource availability by source (2010-2019) in Eastern and Southern Africa



HIV prevention resource needs estimates in Southern Africa

According to UNAIDS' Fast-Track resources needs estimates, just over one billion dollars ($1,047,516,785) is needed for HIV prevention interventions in Southern Africa in 2021. This figure is projected to increase to $1,494,486,432 by 2025. In 2021, South Africa ($297,610,443) and Mozambique ($269,720,033) have the largest HIV prevention funding needs, and Lesotho ($13,996,978) and Eswatini ($9,443,387) have the smallest. With a new Global AIDS Strategy 2021-2026, a revised costing exercise is currently underway.

The report goes on to review: current funding levels for HIV prevention in Southern Africa; the need for national HIV primary prevention responses to strengthen the five central pillars outlined in the HIV Prevention Roadmap (see Figure 2 below); HIV prevention funding for adolescents and young people, as well as key populations; the HIV prevention funding gaps in the region; information about implementers and their funding; and ways to improve the financial situation (allocative efficiency and innovative finance).

Figure 2. Combination HIV prevention: five pillars

Summary of key points

The report's main messages are:

- Just over $1 billion dollars is needed for HIV prevention interventions in Southern Africa in 2021, rising to nearly $1.5 billion by 2025.
- Due to implausibly low or absent population size estimates, the resources needed for HIV prevention

among key populations in Southern Africa are probably vastly underestimated.
- Available HIV resources in the region have declined for the past two years in a row.
- Southern African countries invest less than half (42%) of what is needed for HIV prevention.
- An average of 10% of HIV spending is dedicated to prevention – below a “quarter for prevention”.
- In Southern Africa, 92% of the five HIV prevention pillars are externally funded, which is disproportionately unsustainable compared to overall HIV programming (59% externally funded).
- Lesotho is the only country in the region with adequate spending on the five prevention pillars.
- In Southern African countries where a greater proportion of prevention needs are funded, condom use is higher.
- In Southern Africa, 67% of PEPFAR’s Key Population Investment Fund support went to key population-led or key population-competent local organisations, and 40% of Global Fund grants 2018-2020 went to local civil society organisations

Recommended advocacy actions

The author finishes by outlining ten key advocacy actions to help move HIV prevention funding forwards.

1. Urge governments to invest more in HIV prevention. Southern African governments are investing resources in HIV, but prevention is not prioritised (and especially not prevention among young people and key populations). Emphasize the need for domestic funding on the five pillars of prevention in particular, as these are disproportionally donor-funded. Suggest allocative efficiencies or innovative finance models.
2. Prioritise intensive advocacy to increase HIV prevention spending in Angola, Malawi and Mozambique. In these countries, just 3%, 10% and 20% (respectively) of the HIV prevention response is currently funded. The prevention funding situation in these countries is an emergency.
3. Call for domestic HIV prevention budgets to have specific funding allocations for young people, and within that category, specific sub-allocations for adolescents by age and sex. The prevention needs of younger adolescents (10-14) versus older adolescents (15-19) are different and require tailored programming. Without specific funding allocations for younger adolescents, they often fall through the cracks.
4. Engage in Global Fund processes at country level, including funding request development in South Africa (ongoing) and grant-making negotiations in Botswana and Eswatini, to push for increased investment in HIV prevention. In the remaining countries, where grants are already signed for 2021-2023, demand that the Country Coordinating Mechanisms share information and consult consistencies on any HIV prevention re-programming decisions.
5. Engage in Global Fund processes at the global level, by pushing the Global Fund Secretariat or the Developing Country NGO Delegation to the Global Fund Board to advocate for maintaining or increasing available matching funds for HIV prevention in the 2023-2025 funding cycle. This could include creating a new matching funds category for community systems strengthening.
6. Engage in PEPFAR Country Operational Planning processes. Planning for COP21 will conclude in May 2021. Ordinarily, PEPFAR’s investment decisions are made on an annual basis with key negotiations taking place in February in Johannesburg.
7. Advocate for PEPFAR’s Key Population Investment Fund to be renewed. The KPIF ended in 2020, after two years of investment in key population-led and key population-competent organisations. Push PEPFAR to renew and expand this funding stream.
8. Push governments and funding partners to meet the new Global AIDS Strategy 2021-2026 target of “80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organisations.” Emphasize that both PEPFAR and Global Fund do not meet this threshold in Southern Africa. Demand transparent accounting of funding flows to these three implementer types so communities can track progress.

9. Ensure countries have accurate population size estimates for key populations. These are critical inputs for resource needs estimates and they impact resource mobilisation at national and global levels. If population size estimates are too low or absent, the resources needs estimate will be too. One important message to push is that population size estimates for men who have sex with men must be at least 1% of the adult male population.
10. The National Strategic Plan for HIV must have clear targets for reaching young people and adolescents with comprehensive prevention in order to attract donor financing. For example, Namibia's National Strategic Framework 2017–2019 included adolescents, while Botswana developed a National Programming Framework for Adolescents and Young Adults 2016-2020. These documents help leverage Global Fund and other external financing.

Commentary

Ever since the World Health Organization's 3 by 5 Initiative to provide antiretroviral treatment (ART) to people living with HIV in low- and middle-income countries, it can be argued that spending on prevention took a hit in favour of expanding ART. The program lasted from December 2003 to December 2005, .and the name "3 by 5" refers to the goal of treating three million people by 2005. The 3 by 5 Initiative is seen as the beginning of the scaling up of ART.

Unfortunately, however, in practical terms, it has also meant that the push for increased ART has resulted in less focus on prevention. Indeed, many countries did not need much of a reason; for those with more conservative societies and/or punitive legal environments, providing treatment is less controversial and arguably easier to do than provide prevention. Prevention programming necessitates working with key populations, frequently stigmatised and discriminated against and often with behaviours that are illegal, thus making it difficult for civil society/KP-led organisations to work openly and freely. Prevention requires targeted programming tailored to diverse populations and including behaviour change communication packages. And anyone who has ever tried dieting, or to stop smoking or drinking, knows how hard behaviour change is.

Moreover, as treatment thresholds become lower ? now ART initiation is recommended as soon as one tests positive ? more people require treatment: accordingly, treatment is always going to be funded above prevention; and we are now seeing the results of this.

SAT Executive Director, Jonathan Gunthorp, said they had commissioned the report because Southern Africa appears to have forgotten the early work on prevention and turning off the tap. "We're not going to medicate our way out of the HIV epidemics in the region; we need to invest in a programme for and monitor primary prevention, especially for young people, and that's just not happening sufficiently at the moment. We're hoping the report is useful as a start to conversations in civil society as to how to increase focus on and funding for, prevention."

To fully finance the HIV response and universal access to SRHR, we're going to have to pull off some new tricks like better co-financing, 100% integration of HIV & SRHR, and truly putting people at the centre of service delivery. It's ridiculous we're still pretending that site-based, discipline-segregated, health can address people's wellness".

It is impossible to do justice to this report in the limited space of an article; so please do read it. The case for more HIV prevention funding is compelling and this report not only provides evidence for why we should do so but gives us some very good pointers for how to do it. And it is not just relevant to starting a discussion among civil society – governments have to be engaged, as well.

Further reading:

- Oberth, G. (2021). TURNING OFF THE TAP: THE STATE OF HIV PREVENTION FUNDING IN SOUTHERN AFRICA: A briefing for civil society and community groups engaged in HIV budget advocacy. SAT (SRHR Africa Trust).

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