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

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All opinions expressed in this report, and any omissions and errors, remain the responsibility of the authors and should not be attributed to other parties.
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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>CCM</td>
<td>Country Co-ordinating Mechanisms</td>
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<td>COP</td>
<td>Country Operational Plan</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<td>CSP</td>
<td>Country Strategy Paper</td>
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<td>CRS</td>
<td>Creditor Reporting System</td>
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<td>CSW</td>
<td>Commercial Sex Workers</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<td>DCI</td>
<td>Development Co-operation Instrument</td>
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<td>DGIS</td>
<td>Directoraat Generaal Internationale Samenwerking</td>
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<tr>
<td>EDF</td>
<td>European Development Fund</td>
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<tr>
<td>GAO</td>
<td>United States Government Accountability Office</td>
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<td>GBS</td>
<td>General Budget Support</td>
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<td>LFA</td>
<td>Local Fund Agent</td>
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<td>MARP</td>
<td>Most At Risk Population</td>
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<td>MAP</td>
<td>Multi-Country AIDS Programme</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>NASA</td>
<td>National AIDS Spending Accounts</td>
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<td>NORAD</td>
<td>Norwegian Agency for Development Co-operation</td>
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<td>OGAC</td>
<td>United States Global AIDS Co-ordinator</td>
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<td>OPM</td>
<td>Oxford Policy Management</td>
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<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
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<td>PEPFAR</td>
<td>Presidents Emergency Plan for AIDS Relief</td>
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<tr>
<td>SOGI</td>
<td>Sexual Orientation and Gender Identity</td>
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<tr>
<td>TRP</td>
<td>Technical Review Panel</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Twenty Sixth Special Session</td>
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</tbody>
</table>
1 Introduction

HIV/AIDS impacts heavily on most at risk and vulnerable populations, which, depending on the context include men who have sex with men (MSM), intravenous drug users (IDU), sex workers, displaced people, street children, and so on.\(^1\) Prevalence levels among MSM are as high as 25 percent in Africa, 11 percent in the Caribbean, 28 percent in Southeast Asia and 51 percent in parts of Latin America. HIV prevalence and incidence levels among sex workers tend to be higher than in the general population (Global fund 2010). However, at the same time prevention services reach only 9% of MSM, 8% of injection drug users, and under 20% of sex workers globally (Global HIV prevention working group, 2007).

To be effective HIV prevention programmes must target an appropriate share of resources to populations most at risk of infection and where most new infections are occurring. Effectiveness further depends on whether these groups are able to access the services. However, stigmatisation, discrimination and prosecution often prevent vulnerable and most at risk population to access available HIV prevention services and programmes. They are often excluded from decisions that affect them and HIV activists are harassed and intimidated by local communities for carrying out prevention activities. Sometimes this violence is endorsed or condoned by governments who fail to respect, protect, and promote the human rights of vulnerable and most-at-risk populations.

Oxford Policy Management (OPM) has been contracted by the International HIV/AIDS Alliance (the Alliance) to undertake a desk based study into the allocation of HIV/AIDS resources to HIV prevention. The output of this study will contribute to the formulation of messages in the Alliance’s What's preventing HIV prevention? Campaign to provide evidence based prevention programmes that target vulnerable and most at risk populations efficiently and cost-effectively.

This is a desk-based study which relied on the analysis of secondary data, mostly documents and reports. For section 3 – Resource allocation processes by major AIDS donors – the documentary review was complemented with information from 14 key informants who were interviewed using a semi-structured questionnaire developed in collaboration with the Alliance.

In the last decade there has been a surge in global funding for HIV/AIDS, a telling indicator of response and commitment to curbing the spread and impact of the disease. In 2008, officials estimated that over $13 billion was spent on AIDS prevention, treatment, and related social mitigation activities in developing countries up from several hundred million dollars annually a decade earlier. However, not only the amount invested in HIV/AIDS is important. Effective AIDS programmes most also reach those most in need. Because Overseas Development Assistance (ODA) increased by less than anticipated, a trend exacerbated by the 2008 global financial crisis, governments and donors re-consider allocations for HIV and AIDS. This provides an important opportunity to ensure that resources effectively reach vulnerable and most at risk populations.

This study examines global funding for HIV/AIDS prevention programmes targeted at most at risk and vulnerable populations. Section 2 looks into data availability about HIV prevention for MARP. Section 3 reviews resource allocation and decision making processes in relation to HIV prevention and MARP focusing on a selection of donors. The last section summarises the findings.

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\(^1\) The International HIV/AIDs Alliance considers most at risk and most vulnerable populations as part of “key populations”, defined as the groups that are at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. Key populations vary according to the local context but include vulnerable and marginalized 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. For most “key populations”, high risk and vulnerability converge.
2 Data on prevention expenditure for MARP

In this section we examine publicly available data to answer the question ‘How much is spent on prevention for MARP?’ First, we examine which data are collected using a standardised methodology across countries and time, as those allow making inferences about the evolution of spending per AIDS spending category over time within a country, and between countries. Studies which use a case study approach, for example, examine spending in one particular country, or spending at one particular time, or on one particular geographical area, are not considered here. However valuable their insights, they do not generate a routinely produced and consistent set of data that allow tracking of resources over time and between countries. Second, we look into expenditure data made available by the major AIDS donors. Lastly, we provide some details on expenditure for prevention for MARP using the best available data, i.e. NASA, and comment on some of its shortcomings.

2.1 Routine AIDS expenditure datasets

2.1.1 UNAIDS- NASA

The National AIDS Spending Assessments (NASA), were introduced to produce accurate and detailed in-country estimates of the actual expenditures on HIV programmes by tracking and describing spending from funding sources over financing agents to service providers and ultimately to (intended) beneficiary populations.

All NASA assessments follow a standardised methodological framework across all countries. The expenditure related to HIV national responses are organised in to 3 areas (finance, provision and consumption) and 6 vectors as follows: (1) financing sources (entities that provide money to the agents); (2) agents (entities that pool financial resources and pay for service provision and make programmatic decisions); (3) providers (entities that engage in the production, provision and delivery of HIV services); (4) production factors (resources used for the production of services); (5) HIV spending categories\(^2\); and (6) beneficiary populations (targeted groups intended to receive the benefits from specific programmes and activities). However, some countries apply different categories to capture data according to the programmes in the national plans. NASA applies the accrual\(^3\) method to reconstruct all transactions from sources to agents, providers and users of services to estimate total spending. To increase reliability and reduce measurement error, all transactions in the system are reconstructed using both top-down and bottom-up approaches (Izazola–Licea et al 2009).

UNAIDS NASA data are not always publicly available although it is by far the most comprehensive in terms of its scope, particularly in systematically reporting expenditure by financing sources; financing agents; providers; intervention categories and intended beneficiaries. The most at risk category of intended beneficiary include groups like CSW, IDU, MSM. However, not all NASA’s contain further disaggregation of most at risk populations.

\(^2\) HIV spending is structured into the following 8 categories of spending: (1) prevention, (2) treatment and care, (3) orphans and vulnerable children, (4) program management and administration, (5) human resources, (6) social protection, (7) enabling environment and (8) research

\(^3\) Accrual is an accounting method that records revenues and expenses when they are incurred, regardless of when cash is exchanged
2.1.2 OECD- DAC CRS Database

The Creditor Reporting System (CRS) database\(^4\) administered by the Organization for Economic Co-operation and Development’s Development Assistance Committee (OECD DAC) compiles data on commitment and disbursement to HIV/AIDS by DAC members and multilateral agencies (the Global Fund to Fight AIDS, Tuberculosis and Malaria, the UN agencies and selected development banks), based on self reporting. The data output allows for analysis of commitments and disbursements by year, donor, recipient country, type of flows (i.e. grant or loan), and purpose of aid. Although updated annually, as of the time this research the latest reported data referred to 2008. Additionally DAC datasets does not capture the private sector resources (international nongovernmental organizations and foundations, and corporate) despite its increasing importance of this sector to HIV/AIDS funding.

Indeed, the OECD-DAC CRS database suffers a major limitation in terms of its scope for use in identifying specific interventions where HIV/AIDS funding is allocated; it is only disaggregated into two main categories - HIV/AIDS ‘control’ (comprising information, education, communication, testing, prevention, treatment and care) and ‘social mitigation’ (special programmes to address the consequences of HIV/AIDS, e.g. social, legal and economic assistance to people living with HIV/AIDS). Given its mandate to record ODA flows of DAC members and multilateral organisations, this level of aggregate reporting is probably the only feasible way to accommodate the different systems of definitional complexity arising from donors having different expenditure classifications.

2.1.3 UNAIDS – UNGASS

At the 2001 Declaration of Commitment on HIV/AIDS, member states committed to reporting regularly on their progress towards achieving AIDS response targets to the United Nations General Assembly by submitting Country Progress reports\(^5\) to the UNAIDS Secretariat every two years. Country reports submitted in recent years are a useful source of information on expenditure. Countries report against a set of core **indicators which includes** domestic and international AIDS spending by categories and financing sources. Four rounds of UNGASS reporting have since taken place in 2004, 2006, 2008 and 2010. These report are publicly available via the UNAIDS website.

The UNGASS country response rate has been high from the outset, and has increased significantly subsequently. In 2004, 54% of UN Member States submitted progress reports; that percentage rose to 77% in 2008\(^6\). Although the increasing response rate reflects a commitment to accountability and responsiveness on the part of recipient countries, it must be noted that the level of detail in the way countries report expenditure varies, and not all countries submit detailed expenditure by intervention category.

2.1.4 UNAIDS – 2008 Global Report

The 2008 UNAIDS Global Report\(^7\) provides a comprehensive albeit imperfect disaggregated dataset of international and domestic spending by intervention areas by country. The original source of this dataset are NASA and if not available UNGASS reports.

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The dataset reports 157 entries with some countries entered against multiple years. Expenditure years span between 2005 and 2007, and 107 countries across nine geographic areas – Caribbean, East Asia, Europe and Central Asia, Latin America, Middle East and North Africa, Oceania, South and South East Asia, Sub-Saharan Africa and Western and Central Europe.

All 107 countries report aggregate international and domestic spending. However, spending data, disaggregated by intervention area were less complete; the reported detail is constrained by what countries report. Out of 107 countries, 24 (22%) do not report spending on total prevention. Only 28 (26%) countries reported complete disaggregated data for prevention spending. 56 out of 107 (52%) do not report spending data for MARP prevention.

Of those countries reporting total expenditure for prevention, Gambia spent the highest proportion its total expenditure on HIV prevention (94%) whilst panama spent the least (3.1%). The average amount spent on prevention among all countries was $8,289,190.

Total spending is disaggregated into four main intervention areas with further disaggregation into service types – Prevention (Communication for social and behavioural change, Voluntary Counselling and Testing, Programmes for sex workers and their clients, MSM and programmes for harm reduction for IDUs, Condom social marketing, public and commercial sector condom provision and female condom, Prevention of Mother to Child Transmission); Treatment and Care (Antiretroviral therapy); Orphans and Vulnerable Children; Programme and Management support and other expenditure. Specifically for prevention, the dataset reports against only five prevention categories (out of a possible 24) representing the most likely reported prevention categories and the common denominator which fits most countries.

This data set is routinely updated every two years following UNGASS reporting. The next update is scheduled to be released at the end of 2010.

### 2.1.5 UNAIDS/WHO and World Bank Databases

Neither the World Health Organization nor the World Bank collects financial data on HIV/AIDS. For example, the UNAIDS/WHO Global HIV/AIDS Online Database only contains up to date country specific data on the spread (prevalence and incidence) of the virus, together with information on risk behaviours (e.g. casual sex and condom use) and health sector response information (e.g. data on people receiving treatment and coverage of HIV counselling and testing).

### 2.1.6 UNFPA/NIDI Resource Flows Project

The resources flows projects (established in 1997) is a joint initiative by the United Nations Populations Fund and Netherlands Interdisciplinary Demographic Institute (NIDI), which aims to monitor global financial flows for population and AIDS activities. As part of their activities the project has set up a database on financial data on population and AIDS activities from donors to developing countries. However, this database is currently not available online and remains the property of UNFPA. It is also unclear whether it contains information on flows up to beneficiary level.

### 2.2 AIDS expenditure data from major donors

This section looks at publicly available AIDS expenditure data from PEPFAR, the Global Fund, and the World Bank’s Multi-Country AIDS Programme, which together accounted for 56% of total spending.

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8 The datasets simply adapts prevention category to what is available. If a country reports against one of the five categories, the expenditure will be reported in that category and all other expenditure classified as ‘other’. This leads to high proportions of ‘other prevention’ spending.
disbursements for AIDS by major donors globally in 2006. This section looks into the total volume of resources being committed and disbursed by each funder, and to prevention and/or MARP where data are available.

**Figure 2.1 AIDS disbursement by major donors in 2006**

Source: Oomman et al 2007

### 2.2.2 President's Emergency Plan for AIDS Relief (PEPFAR)

Data regarding commitment and approved funding of PEPFAR allocations to US government agencies, and to intervention areas, is regularly reported and is easily accessible online via operational plans and annual reports. However, information regarding actual spending at country level is not easily accessible. Nor does PEPFAR regularly release information about spending by recipient category.

Table 23.1 shows the breakdown of funding allocated by activity across all country spending plans for 2009. Treatment comprised 37 percent of planned expenditures for 2009 ($1.4 billion), including purchases of anti-retroviral drugs, laboratory infrastructure, and adult and paediatric treatment delivery. Roughly a quarter of funds were planned to be spent on prevention ($1 billion), and a fifth on care ($800 million). This more or less follows the set allocation targets (PEPFAR Operational Plan, 2010).

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9 Under PEPFAR I allocation targets (earmarks) directed PEPFAR to spend 55 percent of funds on treatment, 20 percent on prevention (a third of which was earmarked for abstinence and faithfulness promotion), 15 percent to care, and 10 percent to programming that supports orphans and vulnerable children (Oomman et al 2008).
Table 2.1  Approved activity funding for 2009 Country Operational Plans

<table>
<thead>
<tr>
<th></th>
<th>$ millions</th>
<th>% of category</th>
<th>% of planned expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory infrastructure</td>
<td>213.4</td>
<td>15.0</td>
<td>0.1</td>
</tr>
<tr>
<td>ARV drugs</td>
<td>398.1</td>
<td>28.0</td>
<td>10.2</td>
</tr>
<tr>
<td>Adult treatment</td>
<td>705.0</td>
<td>49.6</td>
<td>18.0</td>
</tr>
<tr>
<td>Paediatric Treatment</td>
<td>106.3</td>
<td>7.5</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>1422.8</strong></td>
<td></td>
<td><strong>36.3</strong></td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male Circumcision</td>
<td>37.6</td>
<td>3.7</td>
<td>1.0</td>
</tr>
<tr>
<td>Blood safety</td>
<td>56.2</td>
<td>5.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Injection safety</td>
<td>22.5</td>
<td>2.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Abstinence, be faithful</td>
<td>209.2</td>
<td>20.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Counselling and testing</td>
<td>208.7</td>
<td>20.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Other sexual prevention</td>
<td>240.3</td>
<td>23.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Injecting and non-injecting drug use</td>
<td>17.9</td>
<td>1.8</td>
<td>0.5</td>
</tr>
<tr>
<td>PMTCT</td>
<td>227.8</td>
<td>22.3</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>1020.2</strong></td>
<td></td>
<td><strong>26.0</strong></td>
</tr>
<tr>
<td><strong>Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult care and support</td>
<td>310.1</td>
<td>37.7</td>
<td>7.9</td>
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<td>OVC</td>
<td>324.0</td>
<td>39.4</td>
<td>8.3</td>
</tr>
<tr>
<td>TB/HIV</td>
<td>144.5</td>
<td>17.6</td>
<td>3.7</td>
</tr>
<tr>
<td>Paediatric Care and Support</td>
<td>44.5</td>
<td>5.4</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>823.1</strong></td>
<td></td>
<td><strong>21.0</strong></td>
</tr>
<tr>
<td><strong>Other</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Management and Staffing</td>
<td>225.8</td>
<td>34.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Strategic information</td>
<td>184.9</td>
<td>28.3</td>
<td>4.7</td>
</tr>
<tr>
<td>health system strengthening</td>
<td>242.8</td>
<td>37.2</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>653.5</strong></td>
<td></td>
<td><strong>16.7</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>3919.6</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Fiscal Year 2009: PEPFAR Operational Plan

Some detail of planned spending per intervention area (prevention, treatment, and so on) is released. Figure 3.2 shows approved funding for prevention services by region (PEPFAR Operational Plan, 2010).
Figure 2.2  Approved funding by prevention programme area and region, 2009

Source: Fiscal Year 2009: PEPFAR Operational Plan

However, PEPFAR does not publicly release actual spending data related to beneficiaries, either for its overall funding or by specific programme areas. As such this data source does not allow to establish the actual spending for prevention for MARP per country.

2.2.3  World Bank Multi Country AIDS Programme (MAP) to Africa

Contributions to MAP fall outside the World Bank reporting system. As such data on MAP expenditure has to be derived from MAP’s annual survey of country and regional projects and by making extrapolations from project planning documents.

The World Bank MAP has undergone two phases since its inception in 2001. The first phase was between 2001 and 2006, in which total MAP commitment was $1.286 billion for HIV/AIDS in Africa or 47 percent of the Bank’s global investment in HIV. The survey data was reported in the 2007 phase one completion report (Gorgens-Albino et al, 2007). Although the Bank’s 2007 report gives a sense of the breakdown of spending between different interventions in the period 2001-2006 (see Error! Reference source not found.), further disaggregation into service types and beneficiaries within each intervention area is not reported. Further analysis of the annual World Bank questionnaires itself and MAP project planning documents is necessary to obtain this kind of information. The largest intervention was health system strengthening with 40% of MAP funding. Prevention received 34% of funding whilst care and treatment received 15% of funding.

Like PEPFAR, although MAP reports disaggregate data by intervention area, data on beneficiary groups (including MARP are not reported and only disbursement data is reported not actual expenditure.

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10 For project document see http://web.worldbank.org/WEBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTRAFRHEANUTPOP/EXTRAFRIEGTOPHIVAIDS/0,,contentMDK:20450733~menuPK:717179~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html Then click on the project ID for a country project, then the "Financial" tab.
Figure 2.3 MAP disbursement by intervention area, 2001-2006

Source: Gorgens-Albino et al, 2007

2.2.4 Global Fund to fight AIDS, Tuberculosis and Malaria

Following the approval of Round 9 proposals in November 2009, the Global Fund was supporting programmes in 144 countries and had approved proposals totalling US$ 19.2 billion of which US$ 10.8 billion for HIV programs\(^\text{11}\). As of the end of 2009, the Global Fund had disbursed US$ 10 billion of which US$ 5.7 billion for HIV programmes. By intervention area, roughly 30 percent of the expenditure in 2008 was for prevention, 27 percent for treatment, and 10% for care. (Global Fund 2010).

There have been a few analytical reports by the Global Fund which report on resource allocations for MARP. For example in 2010, the Global Fund undertook an analysis of HIV budgets in Round 8. Of the US$ 903’105’728 signed HIV budgets in Round 8, Phase 1, a total of US$ 79’154’825 (8.8 percent) specifically targeted MSM, sex workers and IDUs\(^\text{12}\). Almost 40 percent of the US$ 79 million targeting most-at-risk populations is allocated to interventions for people who inject drugs. Around 37 percent is allocated to sex worker interventions and 24 percent to interventions targeting men who have sex with men.

\(^{11}\) US$ 3.2 billion for TB programs and US$ 5.3 billion for malaria programs.

\(^{12}\) Investments specifically targeting men who have sex with men were recorded at US$ 19 million (2.1 percent of the US$ 903 million total), with slightly higher levels noted for sex workers (US$ 29 million or 3.2 percent) and people who inject drugs (US$ 31 million or 3.5 percent)
2.3 How much for prevention for MARP?

The Alliance’s is particularly interested in prevention spending on ‘Most at Risk Populations’ (MARP). MARP refer to populations that are most likely to be exposed to HIV and most likely to become affected. Risk is defined as the probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase, and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex, and injecting drug use with contaminated needles and syringes. Most-at-risk populations are most often also vulnerable due to social and institutional rejection and discrimination. Depending on the context, they could include drug users, sex workers, men who have sex with men, transgender people, prisoners, and other groups (International HIV/AIDS Alliance, 2010).

The preceding sections show that the three major external AIDS donors do no routinely publish disaggregated data on HIV/AIDS expenditure. Moreover, most data concerns planned or budgeted expenditure, as opposed to actual expenditure. The best data source regarding actual prevention expenditure for MARP remains therefore the 2008 UNAIDS Global report (described in section one).

From the total of 107 countries reported in the UNAIDS dataset, we selected 51 countries with complete reports of HIV expenditure to conduct descriptive analysis on spending by intervention area. Annex A.1 provides data for expenditure from source to spending categories for the 51 selected countries. All together countries spent a total of US$ 3.2 billion on HIV programmes and services between 2005 and 2007. Brazil (US$565 million), Tanzania (US$ 266 million), Botswana (US$ 229 million) and Uganda (US$ 202 million) are the top four spenders. The proportion of total

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13 Countries were selected on the basis on having the most complete expenditure data. 8, 23 and 17 countries had low, concentrated and generalised epidemics respectively. For 3 countries St.Lucia, Moldova, Palau, the research team could not classify their epidemic because of inadequate data availability.
expenditure from domestic and external sources varies between countries. In all 51 countries 40% of total HIV spending came from international funding\(^\text{14}\).

Table 2.2 shows data on actual HIV spending. For analytical purposes countries have been grouped into 3 categories according to type of epidemic – low, concentrated and generalised\(^\text{15}\). According to the latest resource needs estimate by UNAIDS for 2010, about 46%, 27.9%, 9.96% and 13.42% of total HIV spending should be made available globally for prevention, treatment and care, OVC and programme cost respectively (UNAIDS, 2009b). Yet, in the 51 countries analysed it is treatment which receives the bulk of the resources in HIV/AIDS spending (53.7%). Prevention receives 22.3%. Orphans and Vulnerable Children, programme support and all 'other expenditures' receive 4.0%, 11.7% and 8.4% respectively. This suggests that not enough resources are devoted to prevention.

<table>
<thead>
<tr>
<th>Epidemic type</th>
<th>prevention</th>
<th>treatment and care</th>
<th>OVC</th>
<th>programme management and other expenditure</th>
<th>other expenditure</th>
</tr>
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<tbody>
<tr>
<td>Low</td>
<td>53.1</td>
<td>33.7</td>
<td>0.15</td>
<td>6.9</td>
<td>6.1</td>
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<td>Concentrated</td>
<td>19.6</td>
<td>67.5</td>
<td>0.6</td>
<td>7.1</td>
<td>5.2</td>
</tr>
<tr>
<td>Generalised</td>
<td>23.4</td>
<td>39.9</td>
<td>8.0</td>
<td>16.9</td>
<td>11.9</td>
</tr>
<tr>
<td>All countries</td>
<td>22.3</td>
<td>53.7</td>
<td>4.1</td>
<td>11.7</td>
<td>8.4</td>
</tr>
</tbody>
</table>

The analysis becomes more revealing when specifically analysing the expenditure within prevention programmes. In Table 2.3 countries are again grouped into epidemic states. The bulk of prevention activities, 56%, are spent on 'other prevention activities'. This category groups 24 prevention categories not specifically reported in the dataset. This large aggregated category presents a major limitation in drawing any meaningful conclusions as to where the bulk of prevention money is spent on.

Zooming in on the prevention expenditure data that are reported, see table 3.2, spending on programmes for sex workers and their clients, IDU and MSM are allocated the smallest amount, with less than 5% of total spending for prevention across all countries. Countries with concentrated epidemics are likely to spend more on broad prevention programmes than on interventions focusing on groups such as SW, IDU and MSM. In our analysis expenditure addressing most at risk population receives only 7.66% of resources in concentrated epidemics. Indeed, our findings support numerous other studies that have cited examples of this pattern of expenditure of HIV resources. For example in Latin America, the epidemic pattern for many countries in the region suggests that the top priority population group should be men who have sex with men (MSM). However, in much of Latin America there is little support for spending resources on MSM, and thus

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\(^{14}\) The dependence on international sources of funding varied according to GNI levels. Typically, 15 countries low income countries included in our analysis spent 79% of their total HIV spending came from international sources. This compares to only 5% for upper middle income countries in our sample.

\(^{15}\) In a low epidemic state, although HIV infection may have existed for many years, it has never spread to exceeded 5% in any sub-population. In a concentrated epidemic HIV has spread rapidly in a defined sub-population, but is not well-established in the general population. In a generalised epidemic, HIV is firmly established in the general population; and HIV prevalence is consistently over 1% in pregnant women (UNAIDS and WHO, 2003).
policymakers often decide to focus their prevention resources on services for the general population (Forsythe et al, 2009).

Low epidemic countries spend the highest proportion of their prevention expenditure on IDU, CSW, MSM – around 14%. Expenditure addressing this same group represents less than 1% of spending on HIV prevention in countries with generalised epidemics. Even in generalised epidemics HIV/AIDS prevalence in MARP is often still higher than the rest of the population.

Table 2.3  Expenditure for prevention breakdown, 51 selected countries, %, 2008
UNAIDS Global Report

<table>
<thead>
<tr>
<th>%</th>
<th>Low</th>
<th>Concentrated</th>
<th>Generalised</th>
<th>All countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMTCT</td>
<td>0.96</td>
<td>8.58</td>
<td>15.50</td>
<td>11.49</td>
</tr>
<tr>
<td>Condom</td>
<td>2.23</td>
<td>10.30</td>
<td>5.58</td>
<td>7.42</td>
</tr>
<tr>
<td>SW, MSM, IDU</td>
<td>14.10</td>
<td>7.66</td>
<td>0.57</td>
<td>4.59</td>
</tr>
<tr>
<td>VCT</td>
<td>2.00</td>
<td>7.04</td>
<td>13.52</td>
<td>9.90</td>
</tr>
<tr>
<td>Behaviour change</td>
<td>6.98</td>
<td>8.19</td>
<td>13.49</td>
<td>10.71</td>
</tr>
<tr>
<td>Other</td>
<td>73.73</td>
<td>58.23</td>
<td>51.34</td>
<td>55.89</td>
</tr>
</tbody>
</table>

The data cited above are generated by the UNAIDS NASA - National AIDS Spending Assessments. They describe funds for HIV/AIDS by identifying (i) who pays for and who purchases HIV/AIDS services (funding source and funding agent); (ii) who provides the services (provider); (iii) what services are provided (HIV spending categories or services); and (iv) who is the intended beneficiary of the services (Dmytraczenko et al, 2006).

Funding sources can be international (donors) or national, and public or private. Financing agents receive resources from funding sources and channel them to selected service providers. These providers offer HIV and AIDS services such as VCT and treatment to beneficiary populations. Beneficiaries are often typified as the general population, vulnerable and epidemiologically at risk population such Men who have Sex with Men (MSM), Commercial Sex Workers (CSW), and Intravenous Drug Users (IDU) but may also include accessible population such as prisoners, People Living With AIDS (PLWA), etc. (UNAIDS, 2009).

Several points can be made with regards to NASA data on MARP prevention spending:

- As shown in table 3.2 data are currently not reported per MARP category separately, but spending on SW, MSM and IDU is lumped together. Data on other categories of MARP is currently not available.

- Funding sources often overlook financing agents by passing resources directly onto service providers. This may be for a variety of reasons, including supposed effectiveness when funders can direct resources more precisely, efficiently or rapidly. Perceived levels of fiduciary risk when funders lack guarantees that the resources will be used for the intended purposes are also often cited as reasons to target providers directly (Lievens et al, 2009). For example, the US President’s Emergency Plan For AIDS Relief (PEPFAR) has US state agencies as first line recipients and financing agents of resources for HIV/AIDS. Other major international donors such as UN agencies, the EU and some international foundations often have independent systems for funding and management of HIV and AIDS activities that largely fall outside the national structures. These national structures may include the Ministry of Health or the National AIDS Commission whose prime responsibility is often the coordination and allocation of resources for HIV/AIDS and for the health sector as a whole. This common practice may increase the resources for prevention for MARP if
this funding area is of a higher priority to donors than to national level financing agents, especially if the latter have high level of decision making power. But it often sits in the way of building sustainable national-level policy and resource allocation bodies, in which MARP themselves could play a long-term role.

- An accounts framework for HIV spending often only indicates how much resources are targeted at precise beneficiary populations such as MARP. Unless a household survey complements the expenditure tracking exercise these are estimates only. In other sectors such as health and education studies have repeatedly found that sometimes considerable portions of resources do not reach the intended beneficiaries. In the education sector in Zambia in 2001, for example only 10% of fixed school grants were spent on intended beneficiaries (Lievens et al 2009). ‘Leakage in the range of 30 to 50%, i.e. discrepancies between expenditure levels in the accounts and spending reaching beneficiary groups in reality, are not uncommon in social sectors in low and middle income levels. Leakage helps explain why outcomes (e.g. reduced incidence levels) expected on the basis of expenditure levels in the accounts do not materialise. As the analysis in the remainder of this work uses accounting data, this limitation must be kept in mind when interpreting the figures.
3 Resource allocation processes for prevention by major AIDS donors

The HIV/AIDS response has received vast financial resources in the last decade. However, a number of studies in recent years have pointed out that particularly most at-risk populations may be underfunded as a beneficiary group. For example in Ghana, it has been estimated that 76% of all new HIV infections occur between sex workers and their partners. However, the World Bank Multi Country AIDS Programme spent only 0.8% of its resources on sex worker interventions and the remaining 99.2% of resources on the general population. Similarly in China and with specific reference to prevention interventions, despite 90% of HIV transmissions being attributable to Men who have sex with Men (MSM)\(^{16}\) and Intravenous Drug Users (IDUs), 54% of all donor prevention money is allocated to the "general population" (Forsythe et al 2009). Globally less than 5% of HIV prevention funding is reported to be allocated to MARP, see above. Although this is likely an under limit, the data available do not allow to produce a better estimate.

As illustrated above donors and decision makers not always use evidence as the basis for resource allocation. This section examines the resource allocation processes to HIV prevention for MARP, with special attention to the role MARP play in the process. We specifically look the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Presidents Emergency Plan for AIDS Relief, the World Bank Multi Country AIDS Programme, the European Commission, the Norwegian Agency for Development Co-operation, the Directoraat Generaal Internationale Samenwerking (DGIS/The Netherlands), and the Department for International Development (DFID/UK). Together these donors contribute over 50% of HIV/AIDS resources globally.

This section relies heavily on 14 key informant interviews with donor officials and funding recipients within the international HIV/AIDS architecture as well as a desk review of donor documents. Each donor’s decision making and resource allocation processes is analysed by answering the following key questions:

- What are the donor’s strategy or policy for HIV prevention with particular emphasis on MARP?
- How are resources allocated and what role do MARP have to play in this process? What are the barriers to MARP participating in decision making for funding HIV prevention?
- What factors influence donor decision making and allocation of resources to HIV prevention for MARP?
- What systems or mechanisms do donors have in place (if any) to know how their funding for prevention is allocated in the field and to ensure that this is in line with strategic objectives related to prevention within MARP?
- What are the main external barriers and facilitating factors to ensure that resources are allocated effectively?

3.1 The Global Fund to Fight AIDS, Tuberculosis and Malaria

Strategy for HIV prevention for MARP

The Global Fund to Fight AIDS Malaria and Tuberculosis has always emphasised its role as a financial instrument and not an implementing entity. It creates the necessary policy and strategic environment which guides implementing agents in executing appropriate and effective HIV/AIDS programmes. For example, the Global Fund Framework Document establishes that priority will be

\(^{16}\) In two southern Chinese provinces prevention spending for MSM was less than three percent and actually zero in one area (Sarker et al, undated)
given to “the most affected countries and communities, and to those countries most at risk” and will include efforts to “eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS, especially for women, children and vulnerable groups”.

The Global Fund does not have an explicit HIV/AIDS prevention strategy for MARP. However, it has developed the Sexual Orientation and Gender Identities Strategy (SOGI) with the aim of helping its investments more effectively reach men who have sex with men; transgender populations; male, female, and transgender sex workers; and women who have sex with women17. The strategy was developed in response to the evidence showing ongoing failure by the international donor community and national governments to allocate adequate financial resources to MARP and the challenges that MARP face in accessing the Global Funds resources (Personal Communication, 04/08/10). The Global Fund also recognized that addressing the needs of marginalized and previously overlooked groups brings public health and societal benefits to a wider population (Seale, 2010).

The strategy articulates that the limited impact of existing resources allocated to men who have sex with men; transgender populations; male, female, and transgender sex workers; and women who have sex with women is a result of ongoing human rights abuses, poorly designed interventions, and the absence of a broader supportive environment. Accordingly, the strategy (among other things) encourages the strengthening of the Country Co-ordinating Mechanisms (CCMs) in order to deliver more effective programmes addressing HIV for these groups. Box 3.1 summarises the strategic action points of the SOGI strategy (Global Fund, 2009).

The SOGI strategy with its objective of ensuring that its investment is maximised for men who have sex with men, male, female, and transgender sex workers etc represents in theory, a positive step forward in the Global Fund financing strategy. However, it would seem that in practice, the Global Fund must grapple with the classic development challenge of ensuring that its funding continue to adhere to Global Fund’s all important characteristic of country ownership as well as ensure the incorporation of internationally established rights–based approaches and principles (Seale, 2010). The extent to which the current decision making and resource allocation lives up to the expectation of the strategy and the recent efforts by the Global Fund to align its funding practices to the SOGI strategy is discussed below.

17 The strategy does not consider Intravenous Drug Users (IDUs). This is because the strategy had initially been a gender strategy. Additionally, an internal working group for IDU already existed in the fund adopting elements of an IDU strategy, although not yet formalised at the time the SOGI strategy was being developed.(Personal communication 27/08/10).
Box 3.1 Summary of SOGI strategy action points

The Global Fund’s SOGI strategy challenges country and regional implementing partners to better demonstrate how they will address gender diversity and sexual orientation in their processes and programs.

The strategy describes how to

- strengthen CCMs in order to deliver more effective programming addressing HIV, sexual orientation, and gender diversity;
- improve guidelines for proposals submitted to the Global Fund;
- strengthen the expertise of the Technical Review Panel, which now includes those with expertise on gender and sexual diversity issues;
- ensure monitoring, evaluation, and reporting is improved and strengthens programming for sexual minorities;
- mobilize and harness supportive and strategic partnerships;
- use advocacy, communication and leadership to promote the values, principles and expectations of the Global Fund in this area and finally,
- strengthen the capacity of the Secretariat to encourage and support more effective programming

Source: Global Fund, 2009

Resource allocation process for prevention for MARP

Since its inception, the Global Fund relies on a resources allocation process that begins with calls for proposals by the Board, whereby Country Coordinating Mechanisms (CCMs) prepare proposals based on needs and within-country financing gap. The proposal development process also requires the CCM to nominate a Principal Recipient (PR) to be responsible for administering the funds. The proposals are submitted to the Secretariat of the Global Fund for review by the independent Technical Review Panel (TRP).

The panel's recommendations are submitted to the Global Fund Board, which approves the final grants based on the double principle of technical merit and availability of funds. The Secretariat and the Principal Recipient then negotiate the formal grant agreement, which identifies specific, measurable results to be tracked using identified indicators. Once the approved grant agreement is signed, the first disbursement is made and the Principal Recipients may then make further disbursements to sub-recipients. The Global Fund has no staff in country. A Local Fund Agent (LFA) is contracted to certify the financial management and administrative capacity of the nominated Principal Recipients of funding.

18 The panel assigns four categories: 1) recommended for approval without changes; 2) recommended for approval with minor changes; 3) not recommended in current form, but strongly encouraged to re-submit following major revision; and 4) rejected.
Role of MARP in resource allocation process

Within this allocation process, the Global Fund associates with MARP through two main avenues. Firstly, at the Board level\(^{19}\), through NGOs. NGOs provide the necessary checks and balances and acts as a watch dog in ensuring that the interest of MARP are represented and adequately addressed in the Global Fund’s processes. For example, NGOs representing the interest of sexual minorities were some of the most important constituencies in the development of the SOGI Strategy (Personal communication, 04/08/10).

Secondly the Global Fund associates with MARP through CCMs at country level (Personal communication, 04/08/10). Basic eligibility for funding requires that representatives from all communities infected or affected be present at CCMs (Global Fund, undated). In recent years, the Global Fund has recognized the importance of emphasising a rights-based approach to ensure that MARP have access to decision-making processes in CCM through additional support to strengthen participation and outreach.

However, there are several challenges coming forth from the limited capacity of organizations who represent the interest of MARP, access to information, lack of adequate epidemiological data at country level, which hinder the participation of MARP in the decision making processes and therefore limits access to Global Fund resources once grant life cycle starts (International HIV/AIDS alliance 2009).

The limited capacity with respect to organizations working exclusively with MARP touches upon several dimensions. First, although these communities know best what their needs are, and the strategies most effective in addressing these needs, they do not have the technical ability to describe this in a proposal. This is important because proposal development is the entry point for decision making in Global Fund processes. Secondly, organizations who work with MARP often lack experience in areas of programme management such as monitoring and evaluation, developing yearly fiscal reports etc. These are necessary prerequisites in decision making and allocation of resources for the Global Fund. Thirdly, the general absence of funding for MARP in many countries creates a culture of reactive response to funding opportunities that arise. For this reason, MARP organizations often lack a long term strategic vision which means that when they are invited to participate in decision making, their own inputs and suggestions may be weak and lack in strategic vision. The likelihood of being excluded in future decision making processes and therefore the omission of MARP focused activity in the final proposal submitted to the Global Fund are high (International HIV/AIDS alliance 2009).

The Global Fund’s work with MARP in decision making and allocation of resources is also challenged by MARP’s lack of access to information on general Global Fund processes when trying to include them in decision making processes (International HIV/AIDS alliance 2009). As MARP work “below the radar” they are unlikely to be members of national AIDS networks etc who are responsible for disseminating information about Global Fund processes. Additionally, the low technical capacity easily translates to an inability to understand information even where it is provided. This limits negotiation ability to be represented on CCMs which is the platform into Global Fund decision making process. The difficulty in accessing information suggests a lack of transparency among those making the decisions. Although CCMs are required to have a documented and transparent process for ensuring the input of a broad range of stakeholders,

\(^{19}\) The Global board is made up of four main constituencies: (i) Public sectors, (representing government that correspond to regional blocks); (ii) Civil Society Organizations (this comprising of North and South NGOs as well as affected communities) (iii) Private Sector (consisting of companies) (iv) Technical partners (includes WHO, UNDP etc)
including non-CCM members, in proposal development procedures, a recent survey by the Global Fund found that only 31% of CCMs do so (Seale, 2010).

Lastly, the absence of up to date credible epidemiological data about HIV prevalence and incidence rates in MARP results in their need for financing being underestimated, which in turn leads of often low shares in resource allocation for MARP.

It is interesting to note that the barriers to MARP participating in Global Fund processes are mainly at national level given the country-driven development of the Proposal (Personal communication 04/08/10). The SOGI strategy provides some counter-balance to this procedural set-up which generally plays against recognising an adequate place of MARP in the Proposals.

Other factors influencing resource allocation for prevention for MARP

Key informant interviews and review of Global Fund documentation reveals the important role of ‘performance’ in deciding the allocation of Global Fund resources, although evidence and contextual factors such as local political situation are also important in the decision making process. It is important to note that these factors are not only relevant to prevention for MARP.

In the Global Fund, the decision over which intervention area or activities to fund begins at proposal development stage. CCMs in theory decide on what the appropriate areas to fund based on their local knowledge and evidence relating to the nature of the epidemic. CCMs have also been known to consider internationally available evidence about what works and what does not and what are the most cost effective interventions for given epidemic types (Personal Communication, 04/08/10). But most often the use of evidence in decision making by CCMs is limited. In many countries, CCM decisions about what to include in their Global Fund proposals often reflect political imperatives rather than objective, reality informed assessments of what is really needed. NGOs that are on the CCMs receive funding through the Global Fund and may feel constrained to speak critically about politically difficult issues, such as the needs of sex workers, MSM, and LGBT individuals. As a result, issues that are controversial and communities that are marginalized or criminalized may be left out (Fried and Kowalski-Morton, 2008). A study commissioned by the Global Fund on the proposal development and review process in seven countries in Africa, Asia, Latin America, and the Caribbean, released in early 2006, found that “marginalized groups were seldom discussed as an issue per se of particular relevance” by CCMs (ibid)

‘Performance’ also influences the Global Fund decision making when allocating resources in general, i.e. not specifically with regards to prevention for MARP. The important role that ‘performance’ plays is an inevitable consequence of the large amount of money the Global Fund handles and consequently the need for accountability (Personal communication, 04/08/10). The Global Fund’s assessment of program performance is based on programmatic results, outcomes/impact, program management, financial performance and external factors (whether, in exceptional cases, severe and unexpected changes in the external environment (e.g. natural disaster, civil unrest, etc.) have had a material negative impact on program implementation) (Global Fund, 2010).

The important role that ‘performance’ plays in decision making process in the GF is evidenced by the fact that it features at every stage of grant allocation.

At proposal development stage, when CCMs selects proposed Principal Recipients, the TRP and the Secretariat considers the proposed recipients’ past performance as part of the review and approval process. This indirectly influences the types of intervention areas that would be funded. For example the activities of mainstream organizations tend to be strong performers and stand a
good chance of receiving funding. Although they may have activities that addresses the needs of MARP, they may not sufficiently address them.

The SOGI strategy recognises the need to phase in new indicators related to sexual minorities (Global Fund, 2009) so that the ‘performance’ framework works in favour of improving funding for MARP.

**Monitoring**

Progress reports such as the grant score cards and the Global Funds own internal reports which assesses performance, are the main monitoring mechanisms in ensuring effectiveness of resource allocation to prevention for MARP (Personal Communication 04/08/10). This monitoring process is mainly undertaken by implementing partners and MARP direct participation is limited.

However, some issues emerge with respect to using ‘performance’ as a mechanism to monitor resource allocated to prevention for MARP. First, MARP (and indeed all beneficiaries of prevention intervention) are often simultaneously exposed to other HIV interventions which makes it difficult for any individual organization to claim success or failure of the expenditure (Personal Communication, 04/08/10). Second, linking funding to ‘performance’ can also induce single-minded attention to specific often easy-to-measure targets, crowding out harder-to-measure targets (Ooman et al, 2010) It is often harder to assess targets related to MARP due to lack of data at country level.

**Recent or planned changes to improve effectiveness of resource allocation**

The extent to which the allocation of resources by the Global Fund effectively translates to meet Global Fund strategic objectives towards MARP relies mostly on the quality of the national processes. However, the Global Fund has introduced and changed a range of well articulated mechanisms to ensure resources meet policy objectives with respect to MARP.

**New CCM funding policy**

The Global Fund requires that CCM composition involve the participation of affected and infected communities and adequately reflects the characteristics of an epidemic for the given context. CCMs must have the technical strength to guarantee that all parts of the society are represented in the preparation of the proposal and negotiate the content of the proposal in a way that reflect the epidemiological reality. However, the participation of MARP in CCMs is constrained by factors relating to weak capacity, lack of access to information, lack of epidemiological data, as discussed above. A new Country Coordinating Mechanism funding policy has introduced flexibilities to ensure that CCMs can receive funding for additional efforts to secure greater representation, participation and strengthened capacity in relation to marginalized groups.

**Technical Review Panel Strengthening**

Similarly, TRP who review submitted proposals based on technical merit provide recommendation to the Global Fund Board as to which programs to fund. Therefore the effectiveness of resource allocation in part depends on technical strength of the panel to recognise or query proposals which do not reflect the reality of a particular context. The GF is making continued efforts to strengthen the independent Technical Review Panel by recruiting members with expertise on gender and sexual minorities and other vulnerable groups, which aim to ensure adequate funding for MARP (Personal Communication 04/08/10).
HIV/AIDS application guidelines
HIV-related proposal forms and guidance for applications to the Global Fund have been strengthened in order to ensure that the needs of MARP are adequately taken into account (Personal Communication 04/08/10).

Community System Strengthening (CSS)
Community organizations and networks have a unique ability to interact with affected communities, react to community needs and issues and connect with affected and vulnerable groups. They provide direct services to communities and advocate for improved programming and policy environments. This enables them to build community contributions to health, and to influence the development, reach, implementation and oversight of public systems and policies. CSS initiatives encouraged by the Global Fund aim to improve outcomes through mobilization of key populations and community networks and an emphasis on strengthening community based and community led systems for prevention, treatment, care etc (Global Fund, 2009b).

MARP reserve
A new “MARP Reserve” of USD 200 million over five years was agreed upon by the Global Fund Board in May 2010 for Round 10 only. This reserve aims to ensure that key affected populations from all regions of the world have a chance to be funded, even if the demand for Global Fund resources in Round 10 exceeds available finances. The creation of this reserve was exceptionally agreed within the context of discussions around the prioritization of funding for Round 10 in the event that there are insufficient resources available to approve all TRP-recommended proposals (Global Fund 2010).

Flexibility in proposal development
The Global Fund Board recognizes that the criminalization or stigmatization of certain vulnerable groups may make it difficult to work within the structures of CCMs. In such cases, these groups may apply directly to the Global Fund by submitting non-CCM proposals or regional organization proposals. In reality, the eligibility criteria for non-CCM and regional organization grants are difficult to meet, and few groups that work with marginalized populations have been able to use this mechanism effectively to receive Global Fund grants.

Improving the evidence base
The Global Fund recognises the need to strengthen the epidemiological surveillance systems as a means to understanding the role of MARP in the national HIV epidemics. It also recognises that the lack of data is a huge barrier for many countries and therefore the limited use of evidence in decision making by CCM. Global Fund grants can also be used to help strengthen the evidence base around marginalized and most-at-risk populations, for example through including through operational research in proposal (Personal Communication, 04/08/10).

3.2 U.S President Emergency Plan for Aids Relief (PEPFAR)

Strategy for HIV prevention for MARP
Unlike the Global Fund, PEPFAR has an explicit prevention strategy (2010-2014) in which it identifies prevention as a priority intervention area. PEPFAR also has specific IDU guidelines. An MSM guideline is currently in development (Personal communication, 02/08/10). PEPFARs strategy documents are based on evidence (although not necessary internal) and information of best practice. (Personal communication 02/08/10) However it is worth highlighting that PEPFARs anti- prostitution pledge, ban on using federal funds for needle and syringe programmes impacts on the type of services PEPFAR funds can be used to provide for MARPs.
With respect to MARP, the prevention strategy refers to having services responsive to needs of marginalized populations (PEPFAR, 2009). The strategy emphasises on working with countries to track and reassess the characteristics of their epidemic in order to ensure a prevention response based on best available and most recent data and by so doing ensuring that interventions are aligned to existing and emerging situations. The strategy also stresses the need to target resources to prevention strategies that have been proven effective and targeting interventions to most at-risk populations with high incidence rates (PEPFAR, 2009).

In terms of specific prevention interventions, PEPFARs prevention strategy maintains that there is no single population level intervention that can prevent HIV infection. A successful prevention program requires a combination of mutually reinforcing, continually evaluated interventions that are tailored to the needs and risks of different target populations. However, the strategy supports expanding investments into high-impact prevention interventions, such as prevention of mother-to-child transmission (PMTCT), male circumcision (MC), and services for injecting drug users (PEPFAR, 2009).

In addition to this overall prevention strategy and following broad stakeholder consultation PEPFAR recently released a revised IDU harm reduction guidelines. The guidelines outline PEPFARs support for comprehensive HIV prevention package for IDUs which includes community-based outreach programs, sterile needle and syringe programs, and drug dependence treatment. Aside from programmatic interventions and activities, the IDU strategy also shows PEPFARs special interest in supporting the facilitation of appropriate programs particularly where governments have existing punitive policies that affect IDUs.

**Resource allocation process for prevention for MARP**

The current process for allocating PEPFAR funding starts by the United States Global AIDS Coordinator (OGAC) providing an initial planning budget and technical guidance to country teams. This initial budget is prepared taking account of the country’s progress toward achieving the previous years annual country-level targets; national coverage rates for individuals eligible for PEPFAR prevention, treatment, and care services; and financial obligation rates. Countries are then requested to submit Country Operational Plan (COP) which represents the country’s annual HIV/AIDS strategy (GAO, 2009).

The development of the COP firstly involves setting targets using standardised indicators to outline future achievements. To start with, the OGAC sets a 5 year country level for all interventions areas which across all countries sum up to total the total of PEPFARs global targets20. Country teams then have to set individual annual targets to assist PEPFAR to meet these targets over a five year period. However, although there are targets and associated indicators for prevention, there are none specific for MARP. This alone is an initial indication of the extent to which MARP feature in COP development process. Secondly, country teams select interventions to meet its annual targets based on the context of the country’s epidemic although the OGAC also provides guidance to country teams on selecting interventions. In reality most countries lack formal data that fully elaborates the nature and dynamics of their epidemics and this is more so for MARP whose activities are marginalized and criminalized in many of the countries PEPFAR operates in. A lack of understanding of the nature of the epidemics within this group limits the extent to which prevention strategies directed at MARP is a serious consideration when selecting interventions. Finally, country teams consider cost considerations, in which they are given the necessary technical assistance in conducting cost analysis and ensuring proposed interventions that are selected for funding are cost effective.

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20 the legislated goals were set to support at least 3 million people on antiretroviral treatment, prevent 12 million new infections, provide care for 12 million (including 5 million orphans and vulnerable children), and train and retain 140,000 new professional health workers.
Once COPs are finalised, they are submitted to the OGAC for review and a recommendation is made to headquarters who then release funds to implementing agencies to be allocated according to COP. The decision to allocate is based on challenges, opportunities and progress in the previous year as detailed in the COP (GAO, 2009).

**Role of MARP in resource allocation process**

Key informant interviews revealed that the extent to which MARP are involved in PEPFAR decision making and resource allocation process is through CSOs who by their nature have greater outreach and access to these communities. Individual country programmes demonstrate PEPFAR’s work with CSOs. For example in Senegal, the plan states that PEPFAR funds would strengthen local NGO capacity to deliver quality prevention and treatment services for sex workers, men who have sex with men, military personnel and mine workers (International HIV/AIDS Alliance 2010).

However, there are several barriers which stand in the way of PEPFAR working with CSOs and this therefore weakens the extent to which CSOs are a likely proxy of participation of MARP in PEPFAR decision making and allocation processes.

Firstly funding from the US Government to civil society as well as other sectors comes with numerous compliance requirements such as the well-known “anti-prostitution pledge” requirement that was enacted with the original PEPFAR authorisation (Personal communication, 28/08/10 and International HIV/AIDS Alliance 2010). Since 2003, US government funding to address HIV/AIDS has been subject to an anti-prostitution clause forbidding the ‘promotion of prostitution’ by grant recipients. This has compromised the efficacy of US-funded HIV prevention efforts, particularly with regard to sex workers and transgender people. For example some NGO staff have been noted to use these restrictions to promote their prejudices by limiting some of the services that they provide and the discussions of their programmes to ensure that they remain within PEPFAR guidelines (Ditmore and Allman, 2010). In addition, key informants noted that the ‘cherry-picking’ approach PEPFAR uses in selecting the CSOs they fund as a bottle neck to MARP participation in PEPFAR processes Most PEPFAR resources are transferred to organisations that have few capacity constraints and can be relied upon to make sure that funds flow quickly. (Oomman et al. 2007) This means that CSOs who work with exclusively with MARP will be excluded because as they are characteristically have insufficient capacity.

**Other factors influencing resource allocation for prevention for MARP**

Key informant acknowledged the role evidence (internally generated and that internationally available and relating to best practice) in decision making and allocation of resources. As already discussed, the selection of specific intervention types is typically based on evidence that illustrates local disease dynamics, although there is generally a lack of data on MARP. Therefore the PEPFAR prevention strategy articulates the priority to work with countries to track and reassess the characteristics of the epidemic and in particular to support countries in mapping and documenting prevention needs and reassess their prevention portfolios.

Synergy and collaboration with other key donors play a role in decision making (Personal communication 04/08/10). Particular reference was made to PEPFARs collaborations with the

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\(^{21}\) Spending plans for FY2004-06 included obligations of almost 70 percent to be allocated to civil society organisations. These included international CSOs (mostly US-based) as well as domestic NGOs, universities and faith-based organisations (FBOs) based in developing countries (International HIV/AIDS Alliance 2003).
Global Fund. The Global Fund appears to have an advantage over PEPFAR because it favours a more country-driven approach which brings the key stakeholders (united in the CCMs) to decide on what they believe the country should ask for in its grant. PEPFAR on the other hand has the advantage in its ability to bypass government coordinating bodies and national red-tape to directly fund local groups and organisations, that can be rapidly mobilised. For PEPFAR harnessing such synergies is an important consideration in the decision making process because it minimises duplication and improves the efficiency of resource use.

Finally, PEPFAR funding decisions are also influenced by performance with respect to targets, ability to manage and spend funds and the capacity to expand work into underserved areas. However, the association between decision to fund and performance is not as well defined as in the case of the Global Fund because PEPFAR has no formula or policy that clearly links decisions on funding to progress in meeting performance targets (Ooman et al 2010).

**Monitoring**

PEPFAR determines performance and therefore effectiveness differently at the global, country, and recipient levels. At the global level the effectiveness of PEPFAR resource allocation is assessed by looking at how all countries together perform against PEPFAR’s global 3-12-12 targets. Effectiveness at country level is assessed by looking at performance against country-level output targets, which PEPFAR derives by apportioning its global level targets among individual countries. At recipient level PEPFAR requests that proposals outline a specific set of activities to be conducted under a grant, including monitoring indicators.

The discussions with key-informants revealed that the main mechanism for monitoring the effectiveness of PEPFAR resource allocation is performance which is documented in field and progress reports. It is unclear to which extent MARP, and any other beneficiary group, are associated in the development of the field and progress reports.

**Recent or planned changes to improve effectiveness of resource allocation**

Apart from promoting service provision to underserved areas, PEPFAR does not have mechanisms to systematically ensure adequate resource allocation for prevention for MARP. The programme has tried a number of approaches to boost funding for MARP, see below, but little hard evidence is available on their effectiveness.

Since PEPFAR works with MARP through CSO, one could assume that the initiatives that have been introduced to strengthen the role of CSO in PEPFAR funding would go some way in ensuring participation of MARP in PEPFAR decision making processes and in ensuring that funds are allocated effectively. At the other hand, CSO may themselves fail to adequately represent MARP, in which case this mechanism doesn’t guarantee adequate funding for MARP.

Attempts to improve CSOs participation include firstly the allocation of a maximum of 8 percent of a given country programme’s funding to a CSO. Centralised reviews of COPs undertaken by the Office of the Global AIDS Coordinator have, among other things, evaluated efforts to increase the participation of indigenous organisations. The New Partners Initiative intends to help locally based organisations to move from being a sub-contractor to a manager of first-line PEPFAR funding,

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22 When PEPFAR was reauthorized for another five years (2010–14), the legislated goals were set to support at least 3 million people on antiretroviral treatment, prevent 12 million new infections, provide care for 12 million

23 Three exceptions to this rule are: funding to the government, to an organisation procuring commodities including treatment, and to organisations managing umbrella funds to smaller organisations.
although the effects of this on funding to civil society are not yet clear (International HIV/AIDS Alliance 2010).

3.3 The World Bank Multi-County AIDS Programme for Africa

Strategy for HIV prevention for MARP

The overall development objective of the World Bank’s Multi-Country HIV/AIDS Program (MAP) for the Africa Region is to increase access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable groups (World Bank, 2005). The MAP programme does not have an overall strategy in which it attempts to centrally prioritize activities or objectives in implementation as is the case for other donors (Personal Communication 11/09/10). Rather, MAP programmes and priority areas are determined by the World Bank country project team in conjunction with the recipient-country governments. Country teams typically align with the country’s existing strategic documents, including the National AIDS Strategy, the Poverty Reduction Strategy Paper and the World Bank Country Assistance Strategy. The specific details of each country’s MAP programme are drawn from the National Strategic Plans (NSP). The extent to which prevention interventions and MARP are addressed in the final MAP projects depends on whether National AIDS Councils, who are mandated to develop NSP, prioritize such interventions in the first place. From the point of view of the World Bank, however, “satisfactory evidence of a strategic approach to HIV/AIDS” is one of four eligibility criteria for eligibility for MAP funding (World Bank, 2005). There is no explicit definition of what is considered satisfactory or not.

Resource allocation process for prevention for MARP

Resource allocation under MAP follows a similar project cycle to all World Bank programmes - project initiation, identification, preparation, negotiation and approval. Once funds are approved and disbursed, the National AIDS Councils (NAC) oversees the allocation and eventual implementation of MAP funding and ensures that resources are allocated in line with National Strategic Plan. MAP allocates funds to the National AIDS Councils or in some cases it is first sent to the Ministry of Finance. The NAC is then responsible for disbursing the funds to government ministries, community organizations and or service providers according to an agreed-upon plan. At times resources may be directly allocated to implementing agencies. In either case, the NAC acts as the coordination and oversight body for the project. Funding for MARP is part of this process, and the extent to which they receive funding is conditioned by the place MARP have in the national policy documents.

Role of MARP in resource allocation process

The role of MARP in MAP allocation process is proxied by Civil Society Organizations (CSOs) and their representation and participation on National AIDS Councils (NACs) and the extent to which they are actively involved in the development of NSPs. Eligibility criteria for MAP include NACs to directly engage with CSOs by using CSOs as one of its implementing agents for the MAP funds.

In the first phase of MAP, the programme demonstrated evidence of funding reaching MARP through civil society organizations dealing with sex workers (International HIV/AIDS Alliance, 2010). Oomman et al (2007) note that within many individual country projects more than half the funds have been spent at district and community level, where the main recipients are often district governments, NGOs and CBOs.

Key informants pointed to the variability of CSOs participation in NACs, although they also acknowledged recent examples of strengthened relationships between NACs and CSOs, as in the
case Senegal. In reality, CSOs participation in NACs, in the development of NSPs and therefore in the decision making process is limited by several factors.

First, countries may not always clearly define the role of CSOs and the extent of their participation in NAC processes (Personal communication 03/08/10). For example, Zambia’s National AIDS Strategic Framework (2006-10) does not explicitly state the role of civil society, or the nature and conditions of engagement between the NAC and CSOs. This has led to some ambiguity about the appropriate role of CSOs in the national response, potential areas of comparative advantage and opportunities for strategic partnership between sectors. Similarly, structures for reporting, accountability, data exchange and participation are not well defined (Mundy et al, 2008).

Second, successful engagement with CSOs requires a clear stated understanding of “representation” and “participation”. With specific reference to Zambia, although equally applicable to other countries, CSO engagement with NAC is compounded by different understandings of “representation” and “participation.” For some CSOs, coordination is about regulation and control, whilst for others the emphasis is on facilitation or information exchange. Some are genuinely interested in representing their constituents, whilst others see representation as a means to access resources (or information about resource availability). Multiple understanding and agendas limits the effectiveness of CSO and how well they are then able to represent the interest of MARP (Mundy et al, 2008).

Finally, the numerous challenges faced by CSOs who work directly with MARP are also applicable here. Those working exclusively with MARP tend to have very limited capacity to effectively engage in policy dialogue within the NAC. Such CSOs may not have the capacity to form network organisations with strong systems for consultation, feedback and democratic election of representatives for NAC boards.

Other factors influencing resource allocation for prevention for MARP

From the key informant interviews and a review of literature it seems that given the demand driven approach of the MAP, evidence is an important consideration in decision making and allocation process. Initial MAP resources are allocated to countries whose NSP reflect the realities and dynamics of their national epidemics, although key informants revealed that countries are hardly denied funding on the basis of the quality of its NSP (Personal communication, 11/09/10).

A NSP that is evidence based should target planned interventions to those groups that are most likely to be infected and whose behaviours are most likely to contribute to further transmission (World Bank, 1999a). A review of NSPs by the World Bank noted that the degree of emphasis on high risk groups varies. Only 7 out of 20 NSP refer to high-risk groups in their statements of overall goals and objectives. For example, Madagascar’s plan does not mention high-risk groups in its overall goals, and only considers STI patients as a particular target group. Mauritania lists high-risk groups in its situation analysis, and targeting is implied, but not explicitly planned in the strategy. On the other hand, Mozambique provides an example of a clearly stated overall objective emphasizing high-risk groups, with a goal to, within three years, reach with preventive interventions 2.31 million Mozambicans who have non-regular sexual partners (World Bank 2005).

Aside from evidence, disbursements are made in response to performance, defined as the achievement of output targets set for a given quarter. In addition to assessing performance on the basis of progress against set targets, other important determinants of continued or follow on funding to MAP recipients include disbursement rates and timeliness in meeting expenditure goals. A Country Assistance Strategy lays out additional criteria for deciding whether to award funds to a country or primary recipient organization (Oomman et al 2010).
Monitoring

The MAP programme has an array of tools and mechanisms that monitor the overall effectiveness of its programmes such as Implementation Completion Reports and Project Performance Assessment reports. The monitoring and evaluation plans for individual grants are described in the Project Appraisal Documents (PADs). PADs include specific indicators for monitoring and evaluation of output, outcome and process indicators. Additionally Task Team Leaders undertake regular country visits and are in contact in projects to ensure effectiveness of projects. MARP direct involvement in this process is based on the extent to which CSOs representing their interest actively engage in the monitoring of their own activities, where they have been nominated as an implementing agency. It also depends on whether target indicators directly capture activities of MARP.

Recent or planned changes to improve effectiveness of resource allocation

This study was unable to uncover recent or planned changes that directly ensure the effectiveness of MAP resource allocation to HIV prevention for MARP. However, the overall changes in MAP processes and activities relating to strengthening monitoring and evaluation systems and the initiative of helping countries understand their epidemics through Mode of Transmission studies may improve the effectiveness of resource allocation for MARP. Strengthening monitoring and evaluation systems will enable an understanding of whether funds are actually reaching intended MARP beneficiaries, whiles Mode of Transmission studies will help facilitate a greater understanding of the dynamics of transmission among MARP.

3.4 The European Commission (EC)

The European Commission does not have a specific policy on HIV/AIDS prevention for MARP. Its overall strategy on HIV/AIDS however, is outlined in the ‘Coherent European Policy Framework for External Action to Confront HIV/AIDS, Malaria and Tuberculosis’. To implement the above policy, the European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011) was adopted in 2005. The Programme for Action proposes a collective European (EC and EU Member States) action with the aim of making up the financing shortfall to meet the MDG 6.

The EC uses two instruments in allocating resources to HIV/AIDS resources at country and global levels. First countries are allocated resources through the European Development Fund (EDF) whereby Country Strategy Papers (CSP) serve as the basis for the allocation of the bulk of EDF funds granted to a country. However, support to HIV and health generally has a very low priority in the Country Strategy Papers of the 10th EDF (current EDF Funding round) (StopAids Alliance, 2010).

Resources are also allocated through the Development Corporation Instrument (DCI) which covers geographic cooperation with Asia, Latin America, the Gulf region and South Africa through geographic and thematic programmes. The DCI includes a 20% benchmark for geographic programmes to be spent on basic health and education. Under DCI the thematic programme Investing in People covers four broad priority areas including health where HIV and other main communicable diseases are targeted directly both through specific programmes and half of the annual EC contribution to the Global Fund to which the EC is a board member. The EC pledged €522 million for the period 2002-2006 and has made available €300 million for 2008-2010 (approximately €100 million per year) – this contribution is divided equally between the EDF and Investing in People.

Over the past years, the modality used for allocating EC resources has moved from disease specific earmarked (apart from contributions to the Global Fund) responses towards broader budget support as a result of the aid effectiveness agenda. In addition, the EU is increasingly
 focussing its interventions on health systems strengthening as confirmed by the recently adopted EU Communication on the EU Role in Global Health. Support to health sector through budget support means there are no specific financing projects for HIV or MARP (Personal Communication, 27/08/10). General budget support as a financing modality for HIV/AIDS is seen as involving less transactional cost (Personal Communication, 27/08/10) and is more effective because funds are able to be aligned to partner countries priorities.

However, in order for the HIV sector to benefit from resource allocation through budget support, the health sector as a whole needs to be selected as one of the focal areas of CSPs (usually two per CSP). However, health is chosen as a focal sector in only few countries. The European Court of Auditors’ Special Report on EC Development Assistance to Health Services in Sub-Saharan Africa found for example that only two sub-Saharan African countries (Mozambique and Zambia), had health as a focal sector in their CSPs under the 9th EDF. The Court of Auditors found moreover that in sub-Saharan Africa, the allocation to health continuously decreased from 5.1% under the 8th EDF, to 3.6% under the 9th and 3.5% under the 10th EDF. In the 10th EDF CSPs, it is foreseen that AIDS is ‘mainstreamed across other thematic areas’. According to the EC, this includes awareness raising, educational activities, AIDS prevention activities in education and vocational training, transport and infrastructure and rural development. However, effective mainstreaming has only happened in very few countries. In addition to mainstreaming, AIDS is explicitly addressed as a focal sector of four countries and as an identified priority for GBS in four others. Specifically related to MARP, given that budget support is channelled through the national treasury, there is a serious risk that the health needs of marginalised and stigmatised groups are not considered by governments in budgeting. This often results in these most vulnerable populations not being able to access health care, unless NGOs are able to provide them with services, which is also questioned with the increased use of budget support: evidence shows that, in some cases, the focus on budget support can lead to NGOs being effectively excluded from receiving funds.

In order for MARP to benefit from budget support, effort is required from national governments to develop national plans which will address the needs of these populations (Personal Communication 27/07/10). It is also up to governments to strengthen the role of CSOs who represent the interest of MARP as well as put in place good accountability mechanisms so that the dynamics of the diseases within this group can be measured. (Personal Communication 27/07/10). However, the EC should have an important role to play in ensuring that programmes target MARP in case a government is unwilling or unable to do so. This could be done under the DCI or the European Instrument for Democratisation and Human Rights, for instance.

Participation of MARP is limited in monitoring the effectiveness of resource allocation to prevention. The mechanism for monitoring the effectiveness of resource allocation within the EC is done through a series of results based indicators based on progress towards the Millennium Development Goals. However, the difficulty in assessing the effectiveness of General Budget Support in delivering health outcomes particularly in the context of unavailability of health performance indicators is widely recognised (Stop AIDS Alliance, undated). The EC has now introduced a new type of budget support known as the MDG contract which will help better monitor the effectiveness of resource allocation that is often compromised under general budget support.

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26 ODI, Engaging non state actors in new aids modalities, December 2009.
MDG Contracts extends the typical financing cycle from three to six years to make financing more sustainable (Personal Communication 27/07/10). MDG contracts consist of a fixed base component of at least 70% of the total financial commitment and a variable performance component of up to 30%, to reward performance against MDG-related outcome indicators, notably in health. To be eligible, countries need to be qualified for budget support and should have used it in an accountable manner for the past three years. Not all countries have specific indicators on HIV and when they do, these are fairly broad.

The use of indicators to monitor the effectiveness of HIV/AIDS resource allocation is supposed to inspire a policy dialogue between the ECs and national governments and for considerations to be made as to whether governments are on the right track. However, the EC is typically not equipped to enter such dialogues because of the limited expertise in health and HIV (Personal Communication 27/07/10). That said, the delegation is interested from a human rights perspective to deal with the issue of MARP etc (Personal Communication 27/07/10).

The EC acknowledges the important role that NGOs play in ensuring that services are delivered in a manner that meets the needs of affected communities, as determined by the communities themselves and supports the meaningful involvement of vulnerable and marginalised populations in the HIV response. The EC is thus of the view that, it is essential to ensure that in addition to budget support, mechanisms are established to ensure the ongoing participation and involvement of civil society in the development, implementation and monitoring of funding allocations. At least 15% of budget support should be allocated to civil society capacity building in each partner country to empower them to become equal partners in the political dialogue in budget support processes and to play a meaningful role in assessing and monitoring national budget allocations (Stop Aids Alliance briefing paper, undated). However, the European Court of Auditors has noted that the NGOs role in budget support remains limited to broadly consultative and some monitoring activities, especially in general budget support. And, whereas sector budget support offers more opportunities to engage NGOs than general budget support, it is used in very few cases in health.

Finally, the EC also recognises that, what is needed is targeted financing for MARP given that it will take a long time to move the MARP agenda forward. As part of the implementation of the European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011), the European Commission has been leading on effort to establish collective EU Action Teams to implement the priority topics of the Programme for Action, notably a Human Rights Action Team and a Prevention Action Team to deal inter alia with MARP. However, so far, the operationalisation of the Action Teams has been very slow, with limited interest from EU Member States to take this forward.

3.5 Bilateral Donors: NORAD, DGIS, DFID

Strategy for HIV prevention for MARP

Three bilateral donors were also reviewed- NORAD (Norway), DGIS (the Netherlands) and DFID (United Kingdom). Although these donors do not have a stand alone strategy for HIV prevention for MARP, all three donors reported having an overall strategy on HIV/AIDS in which either support for prevention or MARP is addressed.

NORAD’s strategy identifies support for vulnerable groups (men who have sex with men, injecting drug users etc.) as 1 out of 7 priority areas for support in its strategy. Specifically NORAD identifies the following avenues of support for these groups (i) support organisations representing MARP and

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their efforts to achieve better access to prevention, treatment, support and care (ii) support to combating stigma and discrimination amongst MARP with a view to reducing their vulnerability HIV and ensuring better access to basic services; (iii) support to ensuring that the particular needs of vulnerable groups are expressed and that their voice are heard at local, national and international level; (iv) support to ensuring international agreements cover these groups and that international rules safeguard their rights, including the right to prevention, treatment, support and care.

DFID’s current HIV/AIDS strategy is under review following the recent change in government. Increasing coverage of HIV/AIDS services for MARP (specifically IDU) is outlined in the strategy. DFID’s policies for IDU and MSM within the strategy are deemed progressive and DFID sees itself as a leader in advocating and addressing the needs of MARP (Personal communication, 27/07/10).

DGIS HIV/AIDS strategy acknowledges MARP limited access to HIV services as a result of criminalisation and discrimination. The strategy goes on to identify working with UN, human rights organisations and NGOs in order to decriminalise activities of MARP and guarantee access to prevention and healthcare services for these groups (Ministry of Foreign Affairs, 2009).

All three donors emphasised the role of internally and externally generated evidence in their strategy. For example, DFID’s HIV/AIDS strategy was accompanied by an evidence volume put together by its research department. NORAD on the other hand relies heavily on UNGASS reporting and research by organisations like the international HIV/AIDS Alliance in determining the nature of support in its HIV/AIDS strategy.

Resource allocation process for prevention for MARP

Altogether, donors were reported to have three main mechanisms through which they channel their resources— Multilateral agencies, Bilateral programmes and Civil Society Organizations. The channelling of resources through multilateral agencies can be seen as relying on agencies comparative advantage in terms of technical capacity, financial and human resource etc.

Resources channelled through bilateral programme uses general budget support as the main modality. The extent to which prevention for MARP are supported therefore depends on whether it makes it on National Development Plans, Poverty Reduction Strategy Papers etc.

Donors referred to allocating resources support through CSO as the main mechanism of reaching MARP as CSOs tend to have more outreach.

For NORAD, the responsibility for policy development and therefore the decision as to what to fund sits within the Global Health and AIDS department, although the department is not directly involved in the transfer of funding (Personal Communication, 27/07/10). Funds for multilateral organizations which NORAD work with such as the Global Fund, UNITAID, Clinton Foundation, goes through the Ministry of Foreign Affairs.

Norway has very few bilateral programmes for HIV/AIDS which are managed through embassies through general budget support. However as previously discussed in section 3.4, the participation of MARP in decision making in the context of general budget support is depends on whether MARP participate in overall country processes.

Financial support for CSOs are limited (Personal Communication 27/07/10). Through its CSO Department, NORAD funds international and Norwegian CSOs but does not support local NGOs directly.
DFID's work with international partners is managed at the central DFIDs International headquarters in the UK, as well as decentralised decision making in the country offices. DFID is a significant donor for the Global Fund, UNAIDS and UNFPA in which it gives core funding and consistently plays an advocacy role to ensure that the activities of these agencies fall within their strategy.

At the country level, there are three regional divisions which oversee and support country offices, each of which in turn has responsibility for funding decisions. For each country where DFID spends at least £20 million, a country plan defines how DFID intends to contribute to poverty reduction and to achieving Millennium Development Goals (DFID, 2009). DFID's bilateral programmes use general budget support and therefore the extent to which issues of prevention for MARP are emphasised in the allocation process depends on whether governments are committed enough to addressing them their response. The participation of MARP in DFID's decision making process is mainly through CSOs that it funds.

DGIS's resource allocation to HIV is combined with sexual reproductive health and rights priorities and follows a similar allocation mechanism of allocating through multilateral agencies, bilateral agencies and CSOs as described above for NORAD and DFID.

**Role of MARP in resource allocation process**

All three donors reported associating with MARP through CSO who they fund. These CSO inputs feed into the development of appropriate programmes to reflect donors HIV/AIDS strategy. CSOs are also consulted prior to board meetings etc.

For example, NORAD engages with MARP through Aidsnett an informal network of over 170 Norwegians organisations working with AIDS internationally and in Norway. The purpose of the network is to strengthen participants' knowledge and understanding of the current issues that arise in connection with the changing nature of the AIDS epidemic. Aidsnett also plays an advocacy role with regards to NORADs own HIV/AIDS programmes and its relationship with other development organizations in the field of HIV/AIDS. Norad cooperates with Aidsnett on a regular basis, sharing information about current work and plans. The network is consulted on policy issues, and members from Aidsnett are included in Norwegian delegations to conferences or High level meetings.

(Personal Communication, 27/07/09)

NORAD also uses the National AIDS Council (NAC) as a platform for dialogue with organizations working with MARP. The NAC brings up issues of relevance in its national and international response and acts as an advisory board to NORAD. Representatives of NAC come from government, civil society, research, private sector, PLH-groups working in Norway and abroad.

(Personal Communication 27/07/09)

Similarly, DFID, both in the UK and through country offices, has multiple channels that can be used to provide funding to civil society (International HIV/AIDS Alliance 2010). At central level there is a global Civil Society Challenge Fund, the Partnership Programme Arrangements, Governance and transparency Fund, etc which CSOs who have MARP programmes are eligible for. For example the Global Network for People Living with HIV/AIDS is a prime beneficiary of the

28 Participants in the network come from non-governmental organisations working in development cooperation, non-governmental organisations working for PLHA in Norway, Norwegian government development cooperation administration, Norwegian government institutions, Norwegian research institutions

29 Eligible CSOs must be a UK-based NGO (but can have partners in developing countries)

30 Which provides funding that is largely unrestricted in its use to 30 civil society organisations
Governance and Transparency Fund. Similarly the International HIV/AIDS Alliance is a beneficiary of Partnership Programme Agreements. DFID also funds the international harm reduction network and the Global Forum on MSM and HIV (MSMGF). At country level, country offices have their own Challenge Funds that can be open to UK as well as non-UK civil society organisations.

Other factors influencing resource allocation for prevention for MARP

From discussions with the donors it has been possible to extrapolate four main factors influencing decisions. Firstly, donor's referred to their decision to prioritise prevention and work with MARP being informed by evidence. Typically donors relied on internationally available data by UNAIDS and Global Fund.

For example donors were consistent in stating that the number of new infections more than doubles the amounts of people on Antiretroviral treatment, therefore making it less sustainable to prioritise treatment.

Secondly, particularly with respect to MARP, there was a common consensus of donors wanting to complement each others work. (Personal communication 27/07/10). There was also a common consensus that historically, donors have been silent in addressing the need of MARP.

Finally there was a financial consideration with regards to funding prevention areas. One key informant argued that, treatment required bigger and longer term commitment in which donors were unwilling to make.

Finally, it seemed that donors own foreign policy was influential in decision making for prevention for MARP. For example DGIS noted that its foreign policy has always been based on human rights which is in turn reflected across programmatic areas HIV/AIDS (Personal Communication 27/07/10)

Monitoring

All three donors reported having mechanisms in place which monitored and ensured the effectiveness of their programme, although characterised by limited direct participation of MARP.

Resources channelled through multilateral agencies are given as core support with no earmarking to ensure that, multilateral agencies have the flexibility to implement their strategy. However, donors ensure their money is being used in a way that is broadly reflective of donors own objectives in HIV/AIDS strategy or policy through their role on the agency’s Boards and Committees, whereby donors engage in policy dialogue to raise concerns and push specific agendas of interest forward.

For example, NORAD sits on the policy and strategy committee of the Global Fund and has used this role in supporting the development of the new CCM guidelines. Similarly, NORAD plays an active role in UNAIDS prevention commission. Likewise, DGIS is making a plea for HIV prevention, and its agenda for its 2010 UNAIDS board chairmanship, a push for prevention for MARP and the link between HIV and sexual reproductive.

In addition to having an oversight role at board and committee level, donors also monitor the effectiveness of resources allocated through performance indicators. DFID reported that, it consistently uses a number of performance framework agreement in which they track an agreed series of key indicators and targets. DFIDs performance framework with UNAIDS consist explicitly of indicators which measure scaling up of prevention intervention for MARP (Personal

Reference was also made to the recent GF round 9 analysis of proposal.
communication 27/07/10). At national level, DFIDs monitoring of the effectiveness of its programmes fall under the remit of country offices, although headquarters plays an advocacy role in ensuring that programmes align with national AIDS strategies and that the national strategies themselves are comprehensive and allocate resources effectively. DFID is currently reviewing the HIV/AIDS national strategy of several countries to ensure that, there is a balance allocation of resources. (Personal Communication 27/07/10).

Finally, donors also reported that, they undertake missions which give more depth in terms of understanding the barriers and bottlenecks in instances where resources have not been effectively deployed. Individuals NGOs that donors fund also send field reports.

Donors were generally of the view that, with more capacity on their part, more could be done to ensure the effectiveness of their programmes (Personal communication 27/08/10). They also acknowledge the barriers at national and international levels which hinder the effectiveness of their programmes to include punitive legislative laws, stigma and discrimination etc. At the international level the lack of harmonization in the response with respect to donors pushing different agendas is a limiting factor. Secondly, the advent of the financial crisis means CSOs are likely to experience cuts in their allocation and this will invariably limit their engagement with key groups (Personal communication, 27/07/10). Thirdly, the different schools which exist within prevention – biomedical, behavioural and social context schools, have clouded the human rights agenda which is the context within which prevention of MARP are addressed. It is only recently that, UNAIDS as a family, has realised human rights and legislation as highly important.

**Recent or planned changes to improve effectiveness of resource allocation**

All donors were in agreement that resources allocated for prevention for MARP globally was inadequate. Most donors seemed content of their decision making process and how their resources were being allocated to prevention for MARP particularly with respect to multilateral organizations and consequently did not have any planned changes in their way of working with them.

### 3.6 Reflections from a donor observer- UNAIDS

Although not a donor, discussions with UNAIDS in its capacity as a global observer yielded the following findings with respect to resource allocation to prevention for MARP

- **First**, UNAIDS role in prevention expenditure to MARP is mainly through advocacy on the importance of the use of available evidence such as ‘knowing your epidemic and knowing your response’. Understanding the mode of transmission and the main drivers of the epidemic should inform resource mobilization and allocation. However typically, the current misallocation of resources is caused by a lack of insight and understanding about the most effective allocation of resources. Donors such as the Global Fund are increasingly making use of available evidence and insights to inform resource allocation to countries.

- **Currently**, the extent to which allocation of prevention resources to MARP is evidence based varies from country to country depending on the type of epidemic as well as the quality of data available. At the national level several barriers may prevent rational and evidence based resource allocation to prevention, and to MARP. First, there is often a lack of insight in what constitutes most effective allocation. Often little information is available about the size of MARP, the effectiveness of individual programmes, and the effectiveness of the combination of several programmes. Second, allocation process is influenced by societal values. Policy makers are periodically accountable to an electorate may find it difficult to justify, for example, spending tax payers’ money on brothels or MSM, and in some societies, politicians may in fact be seen as condoning “bad behaviour”.

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• With respect to resource allocation of the Global Fund, its demand driven approach limits its capacity in determining what should be supported, although the recently developed SOGI strategy aimed at filling this gap with respect to MARP.

• PEPFAR despite its many compliance constraints such as congressional earmarks and anti-prostitution pledge has made considerable effort in terms of resources allocated to MARP, although its contracting practices are weakening country ownership.

• The Mode of Transmission Initiative by the World Bank has proved useful. However with respect to resource allocation process it is harder to see participation MARP.
4 Summary findings

To be effective HIV prevention programmes must target an appropriate share of resources to populations most at risk of infection and where most new infections are occurring. These are often most at risk and vulnerable populations (MARP) such as sex workers, MSM, IDU and so on. Effectiveness of prevention programmes further depends on whether these groups are able to access the services made available. Against this background it is disturbing to observe that, globally, prevention services reach only 9% of MSM, 8% of injection drug users, and under 20% of sex workers (Global HIV Prevention Working Group, 2007).

Oxford Policy Management (OPM) has been contracted by the International HIV/AIDS Alliance to undertake a desk based study into the allocation of HIV/AIDS resources to HIV prevention. The output of this study will contribute to the formulation of messages in the Alliance’s “What’s preventing HIV prevention?” campaign to provide evidence based prevention programmes that target vulnerable and most at risk populations efficiently and cost-effectively. This study more specifically looks into the available data to systematically assess resources for prevention for MARP globally, as well as into the resource allocation processes of major AIDS donors for prevention for MARP.

Overall there is a cruel a lack of systematic data on HIV/AIDS prevention expenditure for MARP. With systematic data we mean data that is comparable between countries and over time and made publicly available on a periodic basis. An overall picture about how much of total AIDS expenditure is allocated to, and disbursed on, prevention for MARP can therefore not be computed using publicly available systematic data. Systematic data are at best available at country level. Data on prevention for disaggregated categories of MARP is only available on a case by case basis, and can generally not be compared between countries, at best over time for the same country. Some studies using a case study approach, such as ‘Three cents a day is not enough’32, which examines spending on prevention for IDU, provide valuable information but are most often one-off studies, and as such not systematic in nature.

We examined several sources of publicly available data on AIDS expenditure and found that the UNAIDS dataset that compiles NASA data is by far the most comprehensive with regular reference to intended service beneficiaries, including MARP. Carrying out an analysis for illustrative purposes on 51 countries that reported sufficiently disaggregated data, we find that 56% of prevention expenditure is spent on a catch-all ‘other’ category, and only 5% on MARP. The latter figure is likely an under limit, but the dataset doesn’t provide data to come up with a better estimate. Some trends emerge as to prevention spending per type of epidemic. Still only looking at 51 countries, in low epidemics the average prevention expenditure on MARP is 14%; this is 7.5% and less than 1% in concentrated respectively generalised epidemics.

Although the best publicly available source, this data suffer from a number of shortcomings:

- it is currently not truly global as it reports on 107 countries only;
- out of the 107 countries only 51 countries report information on MARP;
- when data of spending for prevention on MARP is reported, then it is not made available for individual MARP categories, but spending on sex workers, MSM and IDU are lumped together; other MARP categories are currently not considered;

while the data covers actual spending (which is an improvement compared to budgeted expenditure) it mostly reports spending targeted at MARP – given that some of the expenditure slip out of the service delivery channel due to leakage and capture, it is not clear how much resources actually make it to MARP.

The quality of data on expenditure for prevention, and specifically targeted at MARP, varies between the main AIDS donors examined but neither PEPFAR, Global Fund or World Bank MAP consistently provide actual expenditure data on prevention by beneficiary category including MARP and other vulnerable groups.

The Global Fund has commissioned a few analytical reports specifically examining allocations to MARP. Although very informative they are not systematic in nature. PEPFAR produces yearly reports on allocation by intervention area. World Bank MAP recipient countries report annually, but programme-wide data has only been reported in the 2007 phase one report spanning the period 2001-2006. An analysis of MAP expenditure by intervention area and beneficiaries including MARP is however not possible.

Any comparison of data between donors is further complicated by differences in the reporting categories, see table below. The numbers in parentheses refer to the percent of total spending allocated to this category.

<table>
<thead>
<tr>
<th>Global Fund</th>
<th>PEPFAR</th>
<th>World Bank MAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and Support (10%)</td>
<td>Treatment (36%)</td>
<td>Prevention (35%)</td>
</tr>
<tr>
<td>Supportive environment (16%)</td>
<td>Prevention (26%)</td>
<td>Care and Treatment (15%)</td>
</tr>
<tr>
<td>TB/HIV collaboration activities (1%)</td>
<td>Care (21%)</td>
<td>Impact and mitigation (6%)</td>
</tr>
<tr>
<td>Treatment (27%)</td>
<td>Other (17%)</td>
<td>Health System Strengthening (40%)</td>
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<td>Prevention (30%)</td>
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</table>

In the third section we examined some donor resource allocation processes for prevention spending for MARP. We report the summary findings for a number of key donors, Global Fund, PEPFAR, the European Commission, the Netherlands, the United Kingdom and Norway.

The Global Fund to Fight AIDS, Tuberculosis and Malaria. Central to the Global Fund resource allocation process are the country proposals introduced by the Country Coordinating Mechanisms to the Secretariat of the Global Fund for review by the Technical Review Panel. The extent to which resources are allocated to prevention for MARP thus firstly depends on the extent to which the proposal addresses prevention for MARP. While this may depend on a number of factors, the main approach to ensuring that the needs of MARP are addressed in the country proposal is to ensure that MARP are represented at CCM level and partake in the decision making process. While this strategy has paid off to some extent it is also associated with a number of weaknesses in MARP representation including the lack of technical ability to translate needs into actions that can be incorporated in Global Fund proposals; the lack of monitoring, evaluation and management expertise to contribute to Global Fund funding cycles; and the lack of strategic vision. These weaknesses are seen to be limiting a full participation of MARP in proposal development and thus indirectly contribute to inadequate funding of prevention activities targeted at MARP.

Submitted proposals are then subjected to technical review by the Global Fund. Central to the review is the Global Fund’s assessment of a country’s programme performance, including outcome / impact of the programme. A breakthrough in this area has been the development of the Sexual
Orientation and Gender Identities Strategy (SOGI) which aims to help Global Fund expenditure reach MARP, and is part of the criteria used in the review of submitted proposals.

The two main sources of constraints for adequate prevention funding for MARP through the Global Fund are thus on the one hand the content of the CCM country proposal and on the other hand the criteria set by the Global Fund for proposal invitation and evaluation. The Global Fund itself has recently taken a series of measures to ensure that MARP needs are adequately addressed through the Global Fund resource allocation process, which include the new CCM funding policy, the strengthening of the Technical Review Panel, HIV/AIDS application guidelines, the MARP reserve, enhanced flexibility in proposal development that allows MARP organisation to field proposals outside the CCM framework and the recognition for the need of a broader evidence base that indicates the role of MARP in the epidemic.

PEPFAR. PEPFAR is, quite unlike the Global Fund, in essence an implementing agency and it has developed an explicit prevention strategy. The resource allocation process is driven by the Office of the United States Global AIDS Coordinator (OGAC) which sets funding targets by programme. The PEPFAR country teams then elaborate Country Operational Plans that must, taken together, work towards achieving the OGAC objectives. While there are specific prevention targets both at OGAC and COP level, there are no targets associated to funding for MARP.

Both the OGAC as the COP resource allocation targets are said to be based on analytical insights regarding programme impact as well as on epidemiological country level data. However, it is difficult to assess to which extent this ‘evidence’ really underpins the PEPFAR strategy and PEPFAR acknowledges that epidemiological data for the development of evidence based COP is very often missing.

Since in reality the evidence base is often missing to drive COP, a more pragmatic approach which seeks synergy with activities by other partners often drives the resource allocation process. This is particularly the case in relation to Global Fund resources which are mainly addressing areas in the country proposals, and may leave some areas for PEPFAR funding.

The lack of specific funding targets associated with MARP is partly mitigated by the fact that PEPFAR directly funds CSO which are believed to represent the needs of MARP. While this approach may support funding for prevention for MARP, the heavy compliance requirements imposed on CSO and the bias to work with highly capacitated CSO suggests that MARP needs are only partly addressed through this approach.

The World Bank MAP programme for Africa. Increasing access to prevention services for MARP was an initial objective of the MAP programme. The resource allocation process for MAP, however, is guided by the National Strategic Plans, in most African countries developed by the NAC. World Bank country teams will design MAP programmes in compliance with the NSP and therefore the extent to which MARP needs are addressed by a country MAP programme depends on whether MARP needs are included in the NSP.

However, the World Bank assesses whether NSP displays a ‘satisfactory evidence of a strategic approach’, which implies some degree of evidence based policy formulation, and the World Bank can refuse funding if this is not sufficiently the case, although this has not happened in practice yet. The World Bank also emphasises the need for CSO (some of which (are assumed to) represent MARP) to be included in the NAC Board, which provides strategic guidance to the Secretariat in developing the NSP, and will be keen to see CSO involved in implementing MAP programmes.

Despite these measures there seems to be little guarantee that MARP needs will be addressed by MAP funding as the link between at the one hand CSO participation in NAC Boards and at the
other hand MARP needs being duly addressed in NSP but also feeding into MAP country proposals for funding, is plagued with assumptions.

The European Commission. The European Commission funds AIDS activities in developing countries through two funding instruments, the European Development Fund (EDF) and the Development Cooperation Instrument (DCI), providing together the annual EC Contribution to the Global Fund. At the onset of each multiyear EDF countries are allocated budget envelopes following which they develop Country Strategy Papers (CSP) with more detailed strategies. A CSP will typically have up to two thematic areas, which can be health or AIDS. The main funding mechanism used within the EDF is general and sector budget support and the EC uses an indicator based monitoring system to assess satisfactory use of the grants. A periodic high level dialogue between EC and government officials will then assess the extent to which country objectives, which include the servicing of the needs of the population, are met. Lack of progress in some areas, for example health, may give rise to specific concerns being raised, which may include the needs of MARP.

Resource allocation to AIDS through EDF is, apart from the contribution to Global Fund i.e. roughly € 50 million per year, dependent on the content of the CSP and only if AIDS, or health, is a thematic focus will the sector be guaranteed to attract some European resources through this mechanism. However, this was only the case in a very limited number of countries in the current EDF. The current 10th EDF assumes that AIDS is mainstreamed over all public sectors that receive public resources. But clearly, the widely described challenges to effective internal and external mainstreaming also apply to EDF and it is unclear, perhaps unlikely, to which extent this approach is effective in channelling resources for prevention to MARP.

The European Commission recognises the challenges associated to addressing the needs of often marginalised groups such as MARP through its funding strategies. Apart from the need to mainstream AIDS across all public sectors, the EU has developed are three policy responses to this challenge. First, taking note of the shortcomings identified by the European Court of Auditors, the EC emphasises the need for CSOs to be associated in the design, implementation and monitoring of EDF funding. Second, in recognition of the limited power of the current monitoring framework the EC has switched to a new, reportedly more powerful, framework called the MDG contract. It provides a longer term financing window to the recipient countries in return for better compliance to mutually agreed benchmarks captured by finer indicators. These may include MARP needs. Third, the European Commission has negotiated with the African, Caribbean and Pacific (ACP) countries, the inclusion of a new article 31bis highlighting AIDS as a development priority in the revised Cotonou Agreement, signed in June 2010 and applicable from November 2010. The Cotonou Agreement is a comprehensive partnership agreement between the 79 ACP countries and the EU, governing the programming and spending of the EDF. The Cotonou Agreement establishes that cooperation between the EU and ACP countries should among others contribute to scaling up access to HIV prevention which addresses the specific needs of MARP.

Bilateral donors – NORAD, DGIS, DFID. Norway, the Netherlands and the United Kingdom are amongst the core supporters of providing aid in a way compliant with the most recent insights on aid effectiveness and the Paris Declaration. As such they represent an interesting sample of the impact of current and future aid modalities on funding for AIDS.

The three countries have explicit policies on HIV and AIDS, prevention and / or MARP. They seek to achieve their stated policy objectives through providing resources for AIDS through three channels: multilateral and bilateral agencies, and directly to CSO. The multi- and bilateral programmes account for the lion share of funding and direct support to CSO is, comparatively spoken, marginal in budgetary terms.
Multilateral aid is mainly channelled to the Global Fund, UNAIDS and specialised United Nations agencies. The aid is given as core support, and thus not earmarked to specific spending. The countries are represented on the Board of the institutions and on selected specific committees on which they take positions to further their policy objectives. Apart from trying to influence the policies and resource allocation decisions they also make use of monitoring frameworks and will follow up if certain indicators achieve set performance levels. For example, DFID’s performance framework with UNAIDS contains an indicator regarding the scaling up of prevention expenditure for MARP. Bilateral aid is mainly given under the form of budget support, either sector or general. The countries engage into strategic dialogue with the governments of the aid recipients and apply monitoring frameworks similar to EC approach. While this approach reflects current thinking on aid effectiveness, it does not allow in any precise way, to ensure a certain level of funding for prevention for MARP. Even if comparatively small in budgetary terms contributions to CSO, either international or national, remain the only way of guaranteeing that MARP get access to prevention services. Some countries like the UK have quite some different venues through which CSO are financed.

At the more general level the three countries point at evidence being the most important driver of their policy and resource allocation decisions. Other factors are important, for example complementarity with other donors, but are of a pragmatic nature and seem less structurally anchored in the policy making process.

**National level resource allocation processes.** The analysis of the resource allocation processes of the most important international donors, apart from PEPFAR, all increasingly rely on national policy and national resource allocation processes in channelling resources to frontline AIDS service providers and ultimately, the population. This is the case for the Global Fund (relying on CCM proposals), the World Bank MAP (working with NAC), the EC (working through direct budget support) and the three bilateral donors examined (working through budget support and multilateral institutions). Today, therefore, it is ultimately the national policy process which orients, directly for domestic resources and indirectly for aid resources, the resource allocation for HIV and AIDS, and thus the allocation for prevention for MARP. In consequence any actor, which includes the Alliance, that is interested in ensuring adequate funding for prevention for MARP should engage in actions that influence national policy processes.

The way in which this can be achieved is object of much debate in the literature. Dickinson and Buse (2008) for example use a framework of institutions, ideas and interests to analyse the influence of politics on national HIV/AIDS policy. Institutions are the structures and rules which shape how decisions are made; ideas refer to arguments and evidence, and the manner in which they are developed and emerge; and interests reflect the groups and individuals who stand to gain or lose from change. Dickinson and Buse found evidence – though limited – in peer reviewed literature that each element of the framework is critical in making HIV/AIDS policy.

MacAuslan (2009) builds onto the work of Dickinson and shows that where domestic political leadership has often not been forthcoming, civil society pressure through various channels has achieved favourable policy change. In countries with pluralist institutions, civil society actors can improve policy through political mobilisation, lobbying or the legal system. The international community has supported domestic improvements in policy by providing finance to HIV activities, bringing pressure to bear on governments that do not respond, and supporting the mobilisation of local activists.

This then leads to the observation that those actors interested in supporting prevention for MARP have a host of strategies available to change the national policy and resource allocation process which has become central to the resource allocation process.
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## Annexes

### A.1 Financing flows from source to spending categories for the 51 selected countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of epidemic in 2009</th>
<th>Year of the expenditure</th>
<th>Total reported Domestic Public and International Expenditure Million USD</th>
<th>Total HIV Expenditures in selected services</th>
<th>Preven顒ion of mother to child transmission</th>
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</thead>
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<td></td>
<td></td>
<td></td>
<td>Total for Prevention Communication for social and behavioral change Voluntary counseling and testing Programs for sex workers and their clients for MSM and programme for harm reduction for IDUs Condom social marketing, public and commercial sector condom provision and female condom</td>
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## Making HIV prevention work for vulnerable and most at-risk populations

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<td>$0.506</td>
<td>$0.008</td>
<td>$0.045</td>
<td>$0.166</td>
<td>..</td>
</tr>
<tr>
<td>Mozambique</td>
<td>3</td>
<td>$95.505</td>
<td>$31.555</td>
<td>$4.811</td>
<td>$2.413</td>
<td>$0.140</td>
<td>$2.627</td>
</tr>
<tr>
<td>Rwanda</td>
<td>3</td>
<td>$84.742</td>
<td>$20.651</td>
<td>$4.002</td>
<td>$4.656</td>
<td>..</td>
<td>$0.657</td>
</tr>
<tr>
<td>Swaziland</td>
<td>3</td>
<td>$49.113</td>
<td>$8.301</td>
<td>$2.900</td>
<td>$2.243</td>
<td>..</td>
<td>$0.713</td>
</tr>
<tr>
<td>Tanzania</td>
<td>3</td>
<td>$266.371</td>
<td>$82.399</td>
<td>$1.295</td>
<td>$4.961</td>
<td>$0.044</td>
<td>$1.735</td>
</tr>
<tr>
<td>Togo</td>
<td>3</td>
<td>$11.793</td>
<td>$8.632</td>
<td>$1.790</td>
<td>$1.688</td>
<td>$0.113</td>
<td>$0.681</td>
</tr>
<tr>
<td>Uganda</td>
<td>3</td>
<td>$202.419</td>
<td>$37.841</td>
<td>$12.707</td>
<td>$12.006</td>
<td>$0.079</td>
<td>$0.154</td>
</tr>
<tr>
<td>Zambia</td>
<td>3</td>
<td>$189.930</td>
<td>$47.062</td>
<td>$5.118</td>
<td>$8.254</td>
<td>$0.117</td>
<td>$1.385</td>
</tr>
<tr>
<td>Country</td>
<td>Year</td>
<td>USD</td>
<td>EUR</td>
<td>GBP</td>
<td>CAD</td>
<td>AUD</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Poland</td>
<td>2</td>
<td>$42.786</td>
<td>$4.400</td>
<td>$0.271</td>
<td>$0.154</td>
<td>$2.881</td>
<td>$0.709</td>
</tr>
<tr>
<td>Republic of Macedonia</td>
<td>1</td>
<td>$3.627</td>
<td>$2.939</td>
<td>$0.173</td>
<td>$0.281</td>
<td>$2.071</td>
<td>$0.016</td>
</tr>
</tbody>
</table>

Notes:
..“ means that data was either “Not Applicable”, “Not Reported”; occasionally that the expenditure was $0 but not sufficiently clarified in the country reports.
1= Low epidemic 2= Generalised 3= Concentrated
A.2 An introduction to analysing funding for HIV prevention at national level. The cases of Swaziland, Zambia and Lesotho

This section refers to the extent to which resource allocation to prevention at national level is consistent with the key drivers of the epidemic for a given country - i.e evidence based. It starts with a discussion about the elements of an evidence based allocation strategy. In doing, it shows how an absence of quality epidemiological and expenditure data limits any attempt to demonstrate a mismatch between epidemiological needs and resource allocation at country level.

A.2.1 Evidence based allocation strategy

The definition of an “evidence-based allocation strategy” is one in which resources are spent in a way that takes into account the best currently available evidence and likely to achieve the greatest possible result (Forsythe et al 2009).

The simplest approach to demonstrating whether countries are allocating their resources based on evidence or need would be to assess a country’s epidemic and comparing this to an actual spending pattern. An ideal approach on the other hand would involve assessing a country’s epidemic and comparing its actual spending patterns on HIV and AIDS to some known optimal allocation pattern (Forsythe et al 2009). Unfortunately at this time, neither approaches are entirely feasible, in part because there is no known optimal allocation of HIV and AIDS resources and the data which enables an assessment of epidemiology and actual spending pattern is currently limited.

There is a plethora of grey literature to illustrate the dynamics of the HIV epidemic for many countries. However, these studies do not always make the assumptions of the models used to estimate their prevalence and incidence data immediately available thus reducing their reliability. Since 2007, the UNAIDS and the World Bank have pioneered a series of epidemiological synthesis studies known as Mode of Transmission (MoT) in a number of countries in Africa, Asia and Latin American counties. The institutional clout behind these studies means they have been conceived as the most comprehensive source of epidemiological data on HIV/AIDS currently available. However, MoT studies have only been published and made publicly available for Uganda, Kenya, Lesotho, Swaziland, and Zambia. UNAIDS is still in the process of finalizing these studies for countries in Asia, Middle East, Latin America and some additional countries in Africa. (Personal Communication 18/08/10)

NASA studies as already discussed in section 0 have also been considered the most comprehensive source of expenditure data in its systematic collection of data on financing sources; financing agents; providers; intervention categories and intended beneficiaries. However, currently only 28 countries globally have carried out NASA studies (UNAIDS, 2010).

Using the simple approach to establishing a disparity between epidemiological needs and resource allocation would thus involve matching countries that have undertaken NASA with those that have carried out a MoT study. This means there are only three countries for which such analysis is possible:- Swaziland, Zambia and Lesotho which is illustrated below.

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33 With the availability of better prospective information on spending patterns and HIV prevalence, it may become possible in the near future to design optimal allocation strategies, based on what has worked to reduce prevalence/incidence, increase treatment, and minimize the impact of HIV and AIDS (Forsythe et al, undated).
A.2.2 Swaziland

A.2.2.1 Epidemiological characteristics of HIV in Swaziland

Swaziland’s national HIV/AIDS prevalence rate of 26% (of population aged 15-49) is amongst the highest in the world (DHS 2006-2007). HIV incidence rate was estimated at 13,060 new infections for 2008, which translates into an annual adult incidence of 3% in 2008 (Swaziland MoT, 2008). Transmission through heterosexual contact between steady and long term partners aged between 25 and over is the main source of new infections.

The incidence estimates for different groups of the population illustrated in figure 5.1 below. A lack of data limits incidence estimates for groups like MSM, IDU, and CSW. However, using default regional values it is estimated that 4-6% of all new infections in 2008 occurred in MSM and 0.5% of all new infections occur in female partners of MSM. Similarly, 1-2% of all new infections in 2008 were said to have come from IDUs.

Figure: Summary incidence modelling results

<table>
<thead>
<tr>
<th>Heterosexual transmission of HIV – 94% of predicted new infections (2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with one sex partner (last 12 months): 49.8% – 65.1%</td>
</tr>
<tr>
<td>Individuals with more than one sex partner (last 12 months): 6.8% – 13.4%</td>
</tr>
<tr>
<td>Partners of individuals with more than one sex partner: 12.2% – 20.8%</td>
</tr>
<tr>
<td>Partners of clients of sex workers: ~2.6%</td>
</tr>
<tr>
<td>Clients of sex workers: ~4.7%</td>
</tr>
<tr>
<td>Sex workers: ~3.0%</td>
</tr>
</tbody>
</table>

Source: Swaziland MoT 2008

A.2.2.2 Resource Allocation to HIV/AIDS in Swaziland

Systematically following through the relevant dimensions Swaziland’s NASA facilitates the discussion of where does the money for prevention go’?

Total expenditure on HIV/AIDS in Swaziland was SZL 257,218,500 (USD 38,390,819) and SZL 346,128,488 (USD 49,446,927) in 2005/2006 and 2006/2007 respectively. In 2006/2007, public funds contributed 40% while international funds contributed 60%. In 2005/2006, public funds contributed 30% of the total expenditure while international funds contributed 70%.

In 2006/2007 from all sources. OVC was allocated the highest proportion of resources -30% of all resources, with prevention receiving only 17%.

Figure: Proportional overall spending priorities 2006/2007

34 In the absence of available data through surveillance, actual incidence data are proxied and modelled.
Within the preventive activities spending in 2006/2007, the largest amount of funds was spent on communication for social and behavioral change programme (SZL 22,168,279 or USD 3,166,897), followed by voluntary counselling and testing which amounted to SZL 15,702,609 (USD 2,243,230).

In 2006/2007, the results show that the total spending benefited people living with HIV/AIDS the most (almost 41% of funds were targeted to them), which reflects the generalized epidemic in the country, especially as they directly benefited from the spending on treatment and care (including ARVs). The vulnerable population benefited by 34%, mostly the OVCs the educational support. The general population benefited by 23% of spending (for example, from awareness raising and educational campaigns). Accessible population spending (2%) was primarily on youth in school through school educational programmes, and defence forces through condom provision. 0 show beneficiaries of HIV/AIDS spending 2006/2007.

In 2005/2006, the results show almost the same patterns as 2006/2007 with small variations. PLWHA was the largest beneficiary group (almost 36%). The vulnerable population benefited by 32%, through educational support. The general population benefited by 28% of spending and there was small reported spending on the most at risk population (almost 3%) such as for commercial sex workers (CSWs), men who have sex with men (MSM), intravenous drug users (IDUs) and so on. less benefited accessible populations (1%).

Source: Swaziland National AIDS Spending Accounts, 2008
Figure: Overall proportional beneficiaries of HIV spending in 2006/2007

Source: Swaziland National AIDS Spending Accounts, 2008

Figure: Overall proportional beneficiaries of HIV spending in 2005/2006

Source: Swaziland National AIDS Spending Accounts, 2008

In 2006/2007, the results showed that the actual spending on prevention activities was more directed to the general population, and little preventive activities were done for vulnerable or accessible groups, nor for PLWA. Spending on vulnerable populations was mostly done through the OVC programmes. 0 shows the beneficiaries of the HIV/AIDS functional spending in 2006/2007.
**Figure**: HIV/AIDS functions to beneficiaries spending 2006/2007

Similar trends in programme target groups were revealed in 2005/2006. MARP benefited directly from prevention and enabling environment Figure 0 shows HIV/AIDS spending categories to beneficiaries in 2005/2006.

Source: Swaziland National AIDS Spending Accounts, 2008
A.2.2.3 **Summary: Are resources being allocated where it is most needed?**

In summary, expenditure on prevention (17% of total in 2007), was not a priority expenditure area in the two years analysed. It was the third highest, after OVC (31%) and treatment, 19% in 2007. The bulk of prevention expenditure has been spent on communication for social behaviour programme and VCT. Within prevention, expenditure is targeted mostly at the general population.

The HIV prevention funding as seen from the above is focused at the general population and in individual communication and behaviour change programme. Given the dynamics of the HIV in Swaziland, more HIV prevention funding has to be targeted, to for example programmes to change social norms (NASA, 2008). Similarly, very small proportion of the funding was spent on positive prevention (NASA category “prevention of transmission aimed at people living with HIV”) in comparison to the total number of PLWHIV in Swaziland. In a generalised epidemic and high incidence and prevalence context one might expect that more prevention resources are dedicated to this group. However, PLWHIV tend to benefit from treatment and not prevention.
A.2.3 Zambia

A.2.3.1 Epidemiological characteristics of HIV Zambia

The HIV prevalence among the adult population (15-49) is currently estimated at about 14.3%, decreased by about 2% between 2001/2002 and 2007 (ZDHS 2007). The 2008 HIV incidence model estimated 74,263 HIV new infections. The group contributing most to this HIV incidence was individuals whose partners have casual heterosexual sex (37%). The second highest share of HIV incidence was among individuals reporting casual heterosexual sex (34% of total annual incidence). So 71% of all new infections in 2008 were in those who had casual sex, or whose partners had casual sex. The share of HIV incidence among people reporting low risk heterosexual sex was 21%. Clients of female sex workers contributed an estimated 4% of new infections. Other behaviour risk groups contributed less than 1% (0).

Figure: Estimated share of HIV incidence in adult risk behaviour groups in Zambia (2008)

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>% Share of Total Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Workers</td>
<td>0.75</td>
</tr>
<tr>
<td>Clients</td>
<td>4.04</td>
</tr>
<tr>
<td>Partners of Client</td>
<td>1.61</td>
</tr>
<tr>
<td>MSM</td>
<td>0.99</td>
</tr>
<tr>
<td>Female partners of MSM</td>
<td>0.05</td>
</tr>
<tr>
<td>Casual heterosexual sex</td>
<td>33.96</td>
</tr>
<tr>
<td>Partners with CHS</td>
<td>37.03</td>
</tr>
<tr>
<td>Low-risk heterosexual</td>
<td>21.19</td>
</tr>
<tr>
<td>No Risk</td>
<td>0</td>
</tr>
<tr>
<td>Medical Injections</td>
<td>0.17</td>
</tr>
<tr>
<td>Blood Transfusions</td>
<td>0.22</td>
</tr>
</tbody>
</table>

Source: Zambia Mode of Transmission study, 2009

Zambia has not systematically monitored HIV prevalence in populations such as sex workers, MSM, prisoners, transport workers etc and as such few HIV prevalence data is available. (See 0). In the absence of prevalence data for certain high risk groups it is not possible to determine HIV prevalence trends over time.

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35 The estimated adult HIV prevalence peaked in the mid-1990s at about 16% and has stayed above 14% ever since – see A1 in Annex A

36 The members of this group reported one sexual partner only during the past 12 months
Table: HIV prevalence in sub-populations

<table>
<thead>
<tr>
<th>Population</th>
<th>HIV prevalence</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sex workers</td>
<td>69% (Ndola, 1987-88, N=319)</td>
<td>Buve et al. 1991</td>
</tr>
<tr>
<td>Men having sex with men</td>
<td>65% (Ndola, 2005, N=283)</td>
<td>Kamanga et al. 2005</td>
</tr>
<tr>
<td>Police recruits</td>
<td>33% (2006, N=641)</td>
<td>Zulu et al., 2006</td>
</tr>
<tr>
<td>Refugees</td>
<td>15.4% (Lusaka, 1991, N=312)</td>
<td>Msiska, R., 1992</td>
</tr>
<tr>
<td></td>
<td>11.5% (Lusaka, 1992, N=87)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kala Camp: 3.3% (2006, N=300),</td>
<td>ANC Sentinel Survey Report</td>
</tr>
<tr>
<td></td>
<td>Maheba Camp: 3.9% (2006, N=304)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Zambia Modes of Transmission Study, 2009

A.2.3.2 Resource Allocation to HIV/AIDS in Zambia

Actual expenditure for HIV/AIDS amounted to $141 million in 2005 and $208 million in 2006, representing a 48% increase between 2005 and 2006. Spending on HIV is donor driven with 96% and 86% of expenditure coming from external sources in 2005 and 2006 respectively.

Between 2005 and 2006, prevention spending increased in absolute terms, but decreasing proportionally: $39,344,478 (28% of total HIV/AIDS expenditure) to $54,161,434 in 2006 (26%). For the two years combined, prevention was the second largest share of expenditure at 27% (US$93,505,912).

Figure: Proportion of spending according to spending category- 2006

In prevention, PMTCT activities received the biggest share of prevention spending (28%). VCT received 15%, BCC 12% and community mobilisation 12%. Some activities received very small amounts, for instance blood safety (0.6%), injection safety (0.4%) and sex worker programmes (0.005%). This means MARP received less than 1% of total expenditure (See 0).

**Table:** Breakdown of prevention expenditure in Zambia (2006)

<table>
<thead>
<tr>
<th>Activity and Activity Type</th>
<th>Total (US$)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of mother-to-child transmission</td>
<td>14,924,465</td>
<td>27.6</td>
</tr>
<tr>
<td>Voluntary counselling and testing</td>
<td>8,298,787</td>
<td>15.3</td>
</tr>
<tr>
<td>Prevention activities not elsewhere classified</td>
<td>7,388,669</td>
<td>13.6</td>
</tr>
<tr>
<td>Communication for social and behavioural change programmes</td>
<td>6,353,408</td>
<td>11.7</td>
</tr>
<tr>
<td>Community mobilisation</td>
<td>6,075,197</td>
<td>11.2</td>
</tr>
<tr>
<td>Antiretroviral prophylaxis for HIV-positive pregnant women and newborns</td>
<td>2,719,429</td>
<td>5.0</td>
</tr>
<tr>
<td>Prevention of HIV transmission aimed at persons living with HIV</td>
<td>2,348,287</td>
<td>4.3</td>
</tr>
<tr>
<td>Prevention - Youth in school</td>
<td>1,674,833</td>
<td>3.1</td>
</tr>
<tr>
<td>Public and commercial sector condom provision</td>
<td>1,384,666</td>
<td>2.6</td>
</tr>
<tr>
<td>Prevention programmes in the workplace</td>
<td>1,372,943</td>
<td>2.5</td>
</tr>
<tr>
<td>Prevention - Youth out-of-school</td>
<td>502,889</td>
<td>0.9</td>
</tr>
<tr>
<td>Blood safety</td>
<td>319,630</td>
<td>0.6</td>
</tr>
<tr>
<td>Prevention, diagnosis and treatment of sexually transmitted infections</td>
<td>233,429</td>
<td>0.4</td>
</tr>
<tr>
<td>Pregnant women counselling and testing</td>
<td>220,000</td>
<td>0.4</td>
</tr>
<tr>
<td>Safe medical injections</td>
<td>210,000</td>
<td>0.4</td>
</tr>
<tr>
<td>Programmatic interventions for injecting drug users (IDUs)</td>
<td>117,144</td>
<td>0.2</td>
</tr>
<tr>
<td>Programmatic interventions for vulnerable and special populations</td>
<td>16,972</td>
<td>0.03</td>
</tr>
<tr>
<td>Programmatic interventions for sex workers and their clients</td>
<td>2,686</td>
<td>0.005</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54,161,434</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Zambia Modes of Transmission Study, 2009

The NASA report does not provide prevention fully disaggregated data on beneficiary populations. Across all intervention categories and for the two years combined, the majority of spending was for PLHIV (59.8%) followed by 27.2% for the general population and 10.3% for vulnerable populations. Another 2.4% was spent on accessible populations and only 0.3% on MARP (0%). Amongst this MARP group, the bulk of spending was skewed towards sellers of sexual services and their clients (See 0).

**Table:** Expenditure according to beneficiary group 2005&2006 (USD)

<table>
<thead>
<tr>
<th>Year</th>
<th>PLHIV</th>
<th>MARP</th>
<th>Vulnerable Populations</th>
<th>Accessible Populations</th>
<th>General Population</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>78,692,841</td>
<td>920,133</td>
<td>13,526,997</td>
<td>2,869,715</td>
<td>44,511,313</td>
<td>140,520,999</td>
</tr>
<tr>
<td>2006</td>
<td>129,621,376</td>
<td>94,940</td>
<td>22,402,220</td>
<td>5,466,005</td>
<td>50,324,703</td>
<td>207,909,244</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208,314,217</strong></td>
<td><strong>1,015,073</strong></td>
<td><strong>35,929,217</strong></td>
<td><strong>8,335,720</strong></td>
<td><strong>94,836,016</strong></td>
<td><strong>348,430,243</strong></td>
</tr>
</tbody>
</table>

Source: Zambia Modes of Transmission Study, 2009
Making HIV prevention work for vulnerable and most at-risk populations

Table: Spending on MARP population in 2005-2006

<table>
<thead>
<tr>
<th>Category of MARP population</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDU and other drug users and their sexual partners</td>
<td>0.00</td>
<td>2,858.00</td>
</tr>
<tr>
<td>CSW and their clients</td>
<td>872,200.00</td>
<td>5,372.00</td>
</tr>
<tr>
<td>MSM</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>MARP not classified elsewhere</td>
<td>47,933.00</td>
<td>86,710.00</td>
</tr>
<tr>
<td>Total</td>
<td>920,133.00</td>
<td>94,940.00</td>
</tr>
</tbody>
</table>

Source: Zambia Modes of Transmission Study, 2009

A.2.3.3 Summary: Are resources being allocated where it is most needed?
The findings from NASA reports that, 27% of funding resources was spent on prevention between 2005 and 2006. In 2006, expenditure for social and behaviour change programmes received 12% of prevention spending, whereas PMTCT activities received 28%, VCT 15%, and community mobilisation 12%. Some activities received very small amounts, like the sex worker programmes (0.005% of prevention spending). In view of the epidemiological evidence (71% of all new infections in 2008 were in those who had casual sex, or whose partners had casual sex), investment in behavioural and social change communication (BCC and SCC) programmes (such as partner reduction) should be among priority areas in prevention.

In the absence of data in NASA report on prevention spending per type of beneficiary it is not possible to draw conclusions about HIV prevention spending on programmes for specific target audiences. But the analysis of total AIDS expenditure in 2005 and 2006 did show that —most at risk populations (sex workers and clients, men who have sex with men, drug users and sexual partners) received a very small share of all expenditure -- 0.3%.

A.2.4 Lesotho

A.2.4.1 Epidemiological characteristics of HIV Lesotho
Lesotho is ranked third with adult HIV prevalence rate of 23.2% in the world (NAC & UNAIDS, 2008a). Annual HIV incidence in adults was approximately 1.7% in 2007. Heterosexual sex is the predominant HIV transmission pathway in Lesotho. The bulk of new infections in 2008 occurred in those reporting a single-partner (35-62%) and people in multiple partnerships (32-59%). Commercial sex was a comparatively less important cause of new infections (~3% of total incidence). An estimated 3-4% of all new infections may arise among men having sex with men (MSM) and their female partners, while a very small number of new infections may be attributable to unsafe medical injections. There was a lack of data regarding injecting drug use (IDU), but circumstantial evidence suggests that hardly any IDU takes place in Lesotho.
A.2.4.2 Resource Allocation to HIV/AIDS in Lesotho

Total expenditure in financial year 2005/06 was M 257.43 million and M 210.28 million in 2006/07. According to the NASA 2006/07, prevention was only fifth place in expenditure priorities: only 10% of funding was spent on HIV prevention (15% in 2005/06). In 2006/07, 33% of funding was spent on care and treatment, and 24% on programme management. In a hyper endemic situation with a large HIV reservoir and considerable high-risk behaviour, the amount spent on prevention seems too little (UNAIDS, 2009).

In 2006/2007, within prevention, the priorities were PMTCT (30%) followed by VCT (13%) and STI management (12%) and condom social marketing (12%). Even in 2006/07, there is no reported prevention expenditure on MARP. This shows little specifically targeted prevention interventions for these populations (0).
Figure: Spending on prevention interventions

The figure below shows the expenditure on six set of populations. The general population was the prime beneficiaries of prevention expenditure, followed by other key population. Other key populations primarily comprise of OVCs, children born to HIV mothers and children out of school. The prevention expenditure was directed mainly at children out of school and at children born to HIV mothers through PMTCT. Specific accessible population primarily consists of people attending STI clinics, children and youth at school, women attending reproductive health clinics and any other accessible populations. In this category, people attending STI clinics and children and youth at school are the major beneficiaries of prevention expenditure.
A.2.4.3 **Summary: Are resources being allocated where it is most needed?**

The MoT study concluded that Lesotho may not be investing sufficiently in prevention with only 15%-10% of funding used for preventive interventions in the past two years. Additionally, it states that the 10% prevention expenditure may be too little within a context of a hyper-endemic and considerable high-risk behaviour.

The MoT also concludes that Lesotho’s epidemiological context is great need for care, treatment and OVC support but with constrained resources, another option is to integrate (‘mainstream’) prevention activities into other intervention categories. For instance, it has been shown elsewhere that there is a great need to integrate OVC care and support programmes with effective prevention.

A.2.5 **Conclusions**

First, there are only three countries with both MoT and NASA data available. Therefore, there is currently only a very limited basis to assess the extent to which adequate expenditure is targeted at prevention for MARP. The coverage of both MoT and NASA will have to be expanded dramatically before analysis on adequacy can be carried out.

Second, the three MoT studies examined for this work lack reliable and precise information on the size of, prevalence and incidence levels in MARP. As such, there is a very clear need to collect better data in order to carry out analysis on adequacy. It will be important to monitor the details and quality of data on MARP in future MoT studies.

Third, where MoT studies indicate the need for spending, it is NASA that record the actual spending. In line with the findings from the previous section we found that the level of detail needed to assess spending on prevention for MARP was missing in all three countries. Assessment of adequacy obviously requires inevitably such data to be available.