



Global HIV Prevention  
Progress Report Card 2010

Global HIV Prevention Working Group

# Global HIV Prevention Progress Report Card 2010

Since 2002, the Global HIV Prevention Working Group has issued regular reports on key topics relating to HIV prevention. These reports have included a range of high-priority recommendations to key stakeholders. To promote transparency and accountability in the HIV response, the Working Group analyzed publicly available data and surveyed Working Group members to assess the degree to which the Working Group's recommendations have been implemented.

Based on the results of data analyses and key informant interviews, the Working Group has assigned a grade for each key recommendation, using the following system for grading the degree of adherence to the recommendation:

A	=	Excellent
B	=	Acceptable
C	=	Average, Needs Improvement
D	=	Poor, Unacceptable
F	=	Extremely Poor, Failure

Bringing existing HIV prevention strategies to scale – focusing the right interventions at the right scale on the right populations – would avert half or more of all HIV infections projected to occur by 2015 (Futures Institute, 2007). Unfortunately, the Working Group's analysis of available data indicates that the world is currently doing a poor job of implementing sound, evidence-based, well-planned HIV prevention programs. None of the sectors studied – national governments, international donors, multilateral agencies, prevention researchers, the private sector, and civil society – receives strong grades on its respective HIV prevention efforts. On average, grades assigned by the Global HIV Prevention Working Group range between C and D, with failing grades reported on a number of priority indicators. While the analysis undertaken by the Global HIV Prevention Working Group represents the most comprehensive canvassing of available information on the quality of HIV prevention efforts undertaken to date, the often-poor quality of available data is striking.

These findings, while disappointing, should be cause for renewed determination rather than despair. The systematic, milestone-driven, well-monitored scaling-up of antiretroviral treatment in recent years demonstrates what can be accomplished with sufficient resources, global resolve, and broad cooperation among key stakeholders. As this report card emerges, leading global actors – including the US government's PEPFAR initiative; the Global Fund to Fight AIDS, Tuberculosis, and Malaria, UNAIDS, and the Bill & Melinda Gates Foundation – are engaged in extensive strategic planning efforts to strengthen the effectiveness, impact, and sustainability of their respective prevention efforts. At country level, many national governments are taking steps to realign and sharpen their prevention programs, often in response to recent modes-of-transmission studies and HIV prevention syntheses that have highlighted key areas where improvement is needed. For the first time, promising signs emerged in 2009 from large-scale vaccine studies. And affected communities throughout the world have continued to generate their own innovative strategies to forge social norms that promote risk reduction.

Moving forward, the world should build on this momentum to address the weaknesses identified in this report. Following a description of the results of the Working Group's analysis, recommendations are set forth to overcome the obstacles that to date have prevented HIV prevention efforts from achieving optimal effectiveness.

## Global HIV Prevention Progress Report Card: Description of Methodology

Recent years have seen a major increase in HIV-related monitoring and evaluation instruments. To date, however, no comprehensive monitoring effort has specifically and exclusively focused on efforts to prevent new HIV infections.

To assess progress in HIV prevention, the Global HIV Prevention Working Group embarked on a multi-faceted effort to evaluate the degree to which key stakeholders have implemented the recommendations the Working Group has issued in its numerous reports since 2002. Consistent with the approach it has taken in prior reports, the Working Group grouped its recommendations according to various target audiences – national governments, international donors, multilateral and technical agencies, prevention researchers, the private sector, and civil society. For each target audience, the Working Group identified the most important recommendations made.

For each key recommendation, the Working Group canvassed available evidence to identify the most reliable data available regarding the degree to which each audience has implemented the recommendation. In assessing available evidence, the Working Group used several criteria in order to focus on the most reliable, timely and relevant data to draw conclusions regarding the degree of implementation for each recommendation.

Quality criteria included the following:

**Quantitative Data.** Although qualitative data were taken into account, the Working Group used prioritized quantitative measures to assess the degree to which each recommendation has been implemented. Accordingly, quantified programmatic coverage data took precedence over opinions (such as those expressed by national governments in the UNAIDS National Composite Policy Index regarding programmatic reach). Likewise, data regarding the number of country planning processes that include the input of civil society were prioritized over opinions regarding the quality of civil society inclusion.

**Population-Based Data.** Data that were collected on a population basis were prioritized over information derived from individual cohorts. Thus, for example, the Working Group included in its calculation data regarding national coverage for services to prevent mother-to-child transmission, as these are collected on a population basis by country. By contrast, the Working Group opted not to consider prevention coverage data for key populations (e.g., injection drug users, men who have sex with men, sex workers), as many such coverage estimates are based on unclear methodology or on setting-specific surveys and may not therefore be generalizable to national populations.

**Validated Data.** The Working Group prioritized data that benefited from a meaningful process of data review, analysis, and validation. For example, national HIV prevention spending data are submitted by countries but reviewed by UNAIDS and its research partners for reliability. Similarly, service coverage data benefit from a data reconciliation process involving key stakeholders, including the World Health Organization, UNICEF, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the US Government's PEPFAR program.

**Independent Qualitative Evaluations.** As many of the Working Group's recommendations were qualitative in nature – in whole or in part – it was necessary to take qualitative assessments into account. In so doing, the Working Group prioritized independent assessments over qualitative determinations that might arguably be self-interested. Accordingly, the Working Group took into account an independent evaluation by McKinsey & Company of the quality of technical assistance related to Global Fund programs, the Second Independent Evaluation of UNAIDS, the formal evaluation of the Global Fund, and an independent comparison of HIV-related funding provided by the Global Fund, the US Government's PEPFAR initiative, and the World Bank. These and other similar independent qualitative evaluations relied on a rigorous, transparently described methodology for collecting information and making qualitative determinations. By contrast, the Working Group excluded the opinions of national governments expressed in the UNAIDS National Composite Policy Index regarding the quality of national legal and policy frameworks.

**Surveys and Key Informant Interviews.** To test conclusions drawn from the above-noted data sources, Working Group members were surveyed regarding their own assessments of the degree to which each of the priority recommendations has been implemented. For difficult-to-measure indicators – such as the composition of HIV prevention research portfolios of public sector agencies – the Working Group undertook interviews with key informants who possessed information that was not easily accessible in the public domain.

## National Governments

### HIV Prevention Targets

Have comprehensive national HIV prevention coverage/outcome targets been established?

Data Quality for Indicator	<b>B</b>	Key Findings: <ul style="list-style-type: none"> <li>UNAIDS has facilitated, and issued periodic reports on, country-level processes to establish targets for universal access to HIV prevention, treatment, care, and support. Information on the precise range and diversity of national targets (e.g., interventions, outcomes, population targets) is not easily accessible.</li> </ul>
Indicator Outcome	<b>D</b>	Key Findings: <ul style="list-style-type: none"> <li>As of March 2009, 111 countries had established targets for universal access (UN-SG, 2009).</li> <li>Although roughly 90% of countries have targets for ART, only about 50% have targets for non-PMTCT HIV prevention (Piot, 2009; UNAIDS, 2008a).</li> <li>As of early 2009, only 22 countries had targets for prevention coverage for sex workers (SW), only 15 for injecting drug users (IDU), and only 13 for men who have sex with men (MSM) (UNAIDS, 2009a).</li> </ul>

### Independent Review of National HIV Prevention Strategies

Has a meaningful review of the national HIV prevention plan been undertaken in the last 3 years?

Data Quality for Indicator	<b>B</b>	Key Findings: <ul style="list-style-type: none"> <li>Available data on the independent assessment of national strategies has significantly improved as a result of the creation of the UNAIDS AIDS Strategy and Action Plan (ASAP) service, housed at the World Bank. The ASAP website identifies all countries that have received ASAP assistance, categorized according to the type of assistance received (e.g., peer review, capacity building, etc.). (<a href="http://siteresources.worldbank.org/INT/HIVAIDS/Resources/375798-1151090631807/2693180-1151090665111/ASAPProgressReportDec1208v2.pdf">http://siteresources.worldbank.org/INT/HIVAIDS/Resources/375798-1151090631807/2693180-1151090665111/ASAPProgressReportDec1208v2.pdf</a>).</li> </ul>
Indicator Outcome	<b>C</b>	Key Findings: <ul style="list-style-type: none"> <li>53 countries received assistance with the development and/or assessment of national strategies through ASAP between June 2006 and December 2008, including at least 12 that received peer reviews of national strategies (World Bank, 2008).</li> <li>Several countries are reassessing their national strategies as a result of information and recommendations gleaned from modes-of-transmission studies and ASAP reviews (UNAIDS, 2008b).</li> <li>The percentage of countries that have a national task force in place to oversee HIV prevention programs increased from 29% in 2006 to 54% in 2008 (UNAIDS/UCC, 2009).</li> </ul>

National Governments (cont'd)

HIV Information System (1) Has a gender-disaggregated household HIV prevalence survey or "modes of transmission" analysis been conducted?		
Data Quality for Indicator	*	
Indicator Outcome	D	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>31 countries have conducted national, gender-disaggregated, population-based surveys with HIV prevalence measures since 2001 (UNAIDS, 2009b). These surveys, which found that population-based HIV prevalence was almost invariably lower than prevalence in antenatal clinic settings, permitted UNAIDS/WHO to revise its general methodology for estimating HIV prevalence.</li> <li>Rational HIV prevention planning requires reliable evidence not only regarding HIV prevalence but also regarding the magnitude, dynamics, and distribution of new HIV infections. Few countries have conducted evidence-based estimates of <b>new</b> HIV infections.</li> <li>11 countries in sub-Saharan Africa took steps in 2008 to conduct modes of transmission analyses, and numerous other countries in Africa, South East Asia, and Latin America are in process of finalizing their own estimates or making plans to undertake such an exercise (UNAIDS, 2008b).</li> <li>For the first time, the Centers for Disease Control and Prevention in 2008 published evidence-based estimates of new HIV infections in the US (Hall, 2008).</li> <li>52 of 74 countries with UNAIDS Country Coordinators estimated HIV prevalence estimate in 2007-2008 (UNAIDS/UCC, 2009).</li> </ul>

\* As this indicator concerns the existence of meaningful data, the availability and quality of data are discussed under the indicator outcome.

HIV Information System (2)

Are prevalence/incidence data/estimates available for key vulnerable populations?

Data Quality for Indicator	*	
Indicator Outcome	F	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Among 169 countries reporting epidemiological data to UNAIDS in 2008, 44 (26%) have survey-based estimate of HIV prevalence among injection drug users, 53 (31%) for men who have sex with men, and 65 (38%) for female sex workers (UNAIDS, 2008a).</li> <li>For many of the countries reporting data on key populations, data are based on setting-specific surveys that may not be nationally representative.</li> </ul>

\* As this indicator concerns the existence of meaningful data, the availability and quality of data are discussed under the indicator outcome.

National Governments (cont'd)

Financial Support for HIV Prevention Do data document country-level spending on evidence-based HIV prevention that approaches or meets recommended targets?		
Data Quality for Indicator	*	
Indicator Outcome	D	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>109 countries reported HIV-related expenditure data of some kind to UNAIDS in 2008. Of these countries, 82 reported amounts spent on HIV prevention in 2006 or 2007 (UNAIDS, 2008a).</li> <li>UNAIDS technical experts report that the quality and reliability of spending data submitted by countries are highly variable (Izazola, personal communication, 2009).</li> <li>It is not possible to ascertain from spending data whether programmatic components adhere to international quality standards or are evidence-based. <ul style="list-style-type: none"> <li>60 countries reported expenditures for voluntary HIV counseling and testing.</li> <li>50 countries reported expenditures for the prevention of mother to child transmission of HIV (PMTCT).</li> <li>54 countries reported expenditures for condom social marketing.</li> <li>64 countries reported expenditures for behavior change programs.</li> <li>As noted above, most countries have not reported expenditures for focused prevention programs for populations most at risk (UNAIDS, 2008a).</li> </ul> </li> <li>The Technical Review Panel for the Global Fund in 2009 expressed particular concern regarding the poor quality of HIV prevention components of national proposals submitted in Round 9 (Global Fund, 2009).</li> </ul>

\* As this indicator concerns the existence of meaningful data, the availability and quality of data are discussed under the indicator outcome.

National Governments (cont'd)

Fit Between Prevention Strategies and Epidemiological Data

Is there a reasonable fit between new HIV infections and HIV prevention spending patterns?

Data Quality for Indicator	<b>F</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>The primary shortcoming of existing data systems is that, at best, they typically offer some understanding of HIV prevalence, whereas sound HIV prevention planning demands reliable information on the nature and distribution of new HIV infections.</li> <li>There are signs of progress in undertaking evidence-based comparisons of national prevention strategies and new HIV infections, although such efforts remain far short of what is required to ensure evidence-based planning for HIV prevention. More than 50 countries have received technical assessments from the AIDS Strategy Action Plan service housed at the World Bank. ASAP assesses national strategic plans in comparison to epidemiological profiles, including modes-of-transmission studies that characterize incident HIV infections.</li> <li>Efforts to compare national HIV prevention programs with HIV incidence estimates remain fragmented and episodic and need to be systematized to promote a more strategic approach to prevention planning and programming.</li> </ul>
Indicator Outcome	<b>D</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Prevention strategies are well-matched with epidemiological trends in only 10% of low and middle income countries (LMIC) (UNAIDS/UCC, 2009).</li> <li>Early modes-of-transmission studies have identified major gaps in national HIV prevention efforts. <ul style="list-style-type: none"> <li>While people over 25 account for two-thirds of new HIV infections in Swaziland, few prevention programs focus on older adults (Mngadi et al., 2009).</li> <li>Although people in stable relationships make up as much as 62% of new HIV infections in Lesotho, few prevention programs focus on couples (Khobotlo et al., 2009).</li> <li>Uganda's HIV prevention efforts are heavily weighted toward youth-focused services that promote abstinence, even though 43% of new HIV infections are occurring among older heterosexual adults in monogamous relationships (UNAIDS, 2008b).</li> <li>Even though SWs and their clients, MSM, and IDUs together account for roughly 1 in 3 new HIV infections in Kenya, spending on prevention programs focused on these populations is virtually nil (Gelmon et al., 2009).</li> <li>In Ghana – where SWs, MSM and IDUs account for 38% of new HIV infections – programs focused on these populations represent only 9% of national prevention spending (Bosu et al., 2009).</li> </ul> </li> <li>Even though MSM are the primary source of new HIV infections in Latin America, less than 10% of HIV prevention spending in the region is allocated toward MSM-focused programs (UNAIDS, 2008a).</li> </ul>

National Governments (cont'd)

Scale of HIV Prevention Efforts

HIV prevention coverage:

- PMTCT
- Prevention for key populations (e.g., IDUs, MSM, SWs)
- Testing and counseling
- Structural interventions to reduce risk and vulnerability

Data Quality for Indicator	<b>D</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Validated coverage estimates exist for PMTCT, although data do not clearly indicate whether all services are comprehensive and in compliance with international PMTCT recommendations.</li> <li>Reliable estimates do not exist for prevention coverage for SWs, MSM, and IDUs. Many countries do not collect such data, coverage estimates in some countries are based on surveys that are not representative, and questions exist regarding the size of these populations in many settings.</li> <li>No agreed metric exists for assessing the adequacy of testing coverage.</li> <li>No mechanism currently exists to monitor coverage for structural interventions, as reviews of such interventions remain episodic and fragmented.</li> </ul>
Indicator Outcome	<b>D</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>PMTCT coverage has significantly expanded – from 15% in 2005 to 45% in 2008 (WHO/UNICEF/UNAIDS, 2009). In 25 African countries, median PMTCT coverage rose from 31% in 2007 to 40% in June 2008 (UNAIDS, 2009b). In Eastern and Southern Africa – where regional HIV prevalence is the highest in the world – PMTCT coverage averaged 58% in 2008 (WHO/UNICEF/UNAIDS, 2009).</li> <li>Although reliable coverage estimates do not exist for services for populations most at risk, spending data clearly suggest that service coverage is extremely low. In countries with generalized epidemics, no funds were spent in 2006 on HIV prevention programs for IDUs, and only 0.1% and 0.5% of all HIV prevention spending focused on programs for MSM and SWs, respectively (UNAIDS, 2008a).</li> <li>In concentrated epidemics – where infections are, by definition, heavily centered in one or many of these populations – only 4.7%, 3.3% and 1.8% of all prevention spending was allocated to programs for IDUs, MSM, and SWs, respectively (UNAIDS, 2008a).</li> <li>The global economic and financial downturn may further reduce funding for prevention programs for key populations. Prevention programs for SWs and MSM appear to be especially vulnerable to cutbacks as a result of the economic crisis, according to surveys of UNAIDS Country Coordinators (UNAIDS, 2009c).</li> <li>Fewer than 40% of people living with HIV (PLHIV) in LMIC know they are HIV-positive. (WHO/UNICEF/UNAIDS, 2009). In 39 LMIC countries reporting comparable data in 2007-2008, the number of HIV tests performed doubled during this two-year period (WHO/UNICEF/UNAIDS, 2009).</li> </ul>

## National Governments (cont'd)

### Policy Environment

Are well-enforced legal frameworks to empower women and promote gender equality, and the protection of rights and well-being of marginalized populations in place?

Data Quality for Indicator	<b>C</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li><b>Discrimination:</b> Countries report every two years to UNAIDS whether an anti-discrimination law is in place, and non-governmental informants are asked to confirm this assessment. No agreed metric exists to monitor whether anti-discrimination laws are routinely and effectively enforced, although the UK government has supported IPPF, ICASO, GNP+ and ICW to develop an HIV stigma index that can be used to measure stigma at country level.</li> <li><b>Gender:</b> No agreed mechanism exists for ongoing international monitoring of laws relating to gender inequality and women's empowerment. Various international organizations track gender-related aspects of national legal frameworks, and IPPF, UNFPA, Global Coalition on Women and AIDS, and Young Positives assessed the HIV-related legal, policy and programmatic frameworks for women and girls in 22 countries in 2008.</li> <li><b>Marginalized Populations:</b> Various civil society organizations monitor the prevalence of harmful laws and policies concerning SWs, MSM, and IDUs.</li> </ul>
Indicator Outcome	<b>D</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li><b>Discrimination:</b> <ul style="list-style-type: none"> <li>One-third of countries lack a law prohibiting HIV-related discrimination (UNAIDS, 2008a).</li> <li>Non-governmental informants in nearly one-half (47%) of countries report that PLHIV lack access to legal services to protect their rights (UNAIDS/NCPI, 2008).</li> </ul> </li> <li><b>Gender:</b> 13 of 33 countries in sub-Saharan Africa for which information is available either prohibit or limit the right of women to own and/or inherit property (ICRW, 2008).</li> <li><b>Marginalized Populations:</b> <ul style="list-style-type: none"> <li>Offering or soliciting sex in exchange for money is illegal in at least 110 countries (IPPF, 2008; see Gable/World Bank, 2007).</li> <li>More than 80 countries (most of the LMIC) impose criminal penalties for consensual sexual relations between members of the same sex, including seven that provide for the death penalty (Ottoson/ILGA, 2009).</li> <li>Substitution therapy with methadone and buprenorphine is allowed in only 52 and 32 countries, respectively (Travel Resource Center, 2008). In recent years, however, a number of countries have taken steps to remove restrictions on access to drug substitution therapy (UNAIDS, 2008a).</li> <li>More than 50 countries impose coercive or compulsory treatment or the death penalty for people convicted of drug offenses (IPPF, 2008).</li> </ul> </li> <li>More than 30 countries have enacted HIV-specific laws that criminalize HIV transmission or exposure, 27 other countries have used non-HIV-specific laws to prosecute alleged HIV transmission or exposure, and as of December 2008, 35 other countries were considering enactment of laws criminalizing HIV transmission or exposure (IPPF, 2008).</li> <li>The Technical Review Panel for Round 9 of the Global Fund reported that country proposals that included programs for vulnerable populations failed to adequately address the legal environment (Global Fund, 2009).</li> </ul>

## International Donors

### Donor Transparency

Can donor funding be tracked by type of strategy/intervention?

Data Quality for Indicator	<b>*</b>	
Indicator Outcome	<b>F</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Of the major HIV donors, only PEPFAR (US) issues annual reports classifying its HIV assistance by type of intervention. 22.1% of PEPFAR funding in 2008 supported HIV prevention interventions (28.8% if counseling and testing are included) (OGAC, 2009).</li> <li>The Global Fund disaggregates overall support for its three focus diseases by type of intervention, but it does not specifically report its HIV grants by type of intervention supported.</li> <li>A dated roster of HIV-related projects supported by the World Bank is available online, but information is not readily available on the types of services supported by the Bank or on the distribution of Bank assistance among various services.</li> <li>Most bilateral donors report spending by sector rather than by intervention type.</li> </ul>

\* As this indicator concerns the existence of meaningful data, the availability and quality of data are discussed under the indicator outcome.

### HIV Prevention Funding

Is overall level of donor funding adequate for HIV prevention?

Data Quality for Indicator	<b>F</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>As the vast majority of donors do not report funding by type of service, it is not possible to evaluate the magnitude or adequacy of donor support for HIV prevention (Izazola, personal communication, 2009).</li> </ul>
Indicator Outcome	<b>D</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Overall HIV spending rose to US\$ 13.7 billion in 2008 – a 21% increase over 2007. International donors (including bilateral donors, multilateral institutions and philanthropic foundations) accounted for 47% of such financing, or roughly US\$ 6.5 billion (UN-SG, 2009).</li> <li>UNAIDS and its research partners estimate that HIV prevention represents approximately 45% of all HIV-related resource needs (UNAIDS, 2009a). According to reports from countries on total expenditure patterns from both domestic and external sources, HIV prevention accounted for a median share of 21% of all HIV-related spending in 2007 (UNAIDS, 2008a).</li> <li>It is not possible to precisely quantify total spending by international donors on HIV prevention specifically due to deficiencies in the way donor assistance is currently reported. However, based on information currently available, the Working Group estimates that no more than US\$3 billion was available for HIV prevention activities in 2009 – representing one-third of amounts needed to scale up toward universal access (UNAIDS, 2009a).</li> <li>Prevention programs are being disproportionately affected by the ongoing global financial and economic downturn. According to surveys of UNAIDS Country Coordinators, negative consequences for HIV prevention funding are anticipated in 59% of countries (compared to 21% for HIV treatment programs) (UNAIDS, 2009c).</li> </ul>

International Donors (cont'd)

Implementation Success Is there a satisfactory rate of disbursement for donor financial commitments?		
Data Quality for Indicator	<b>B</b>	Key Findings: <ul style="list-style-type: none"> <li>Major donors report spending by commitment and by disbursement, although such data may be difficult to access in the public domain and are primarily accessible only to researchers.</li> </ul>
Indicator Outcome	<b>D</b>	Key Findings: <ul style="list-style-type: none"> <li>PEPFAR's target-driven approach results in more rapid program implementation than for funding provided through the Global Fund or World Bank, which take a more process-oriented approach that emphasizes national ownership and involvement in decision-making. An independent evaluation of leading AIDS funders found that the World Bank and Global Fund "monies that flowed through the public system encountered major bottlenecks that delayed subsequent disbursement" (Oomman, CGD, 2007).</li> <li>For Global Fund grants, a country's high disease burden and weak health infrastructure were associated with disbursement delays and poor grant performance (Macro International, 2009).</li> </ul>

Comprehensive, Evidence-Based Approaches (1) Do donor policies promote evidence-based approaches?		
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Data Quality for Indicator	<b>F</b>	Key Findings: <ul style="list-style-type: none"> <li>As little transparency exists regarding HIV prevention spending by major donors, it is not possible to reliably assess the degree to which donor assistance supports evidence-based approaches.</li> <li>Transparency is variable regarding the policies governing the selection of services supported by donor funding.</li> <li>The five-year evaluation of the Global Fund found that "baseline data quality at country level remains an issue with serious implications for the validity and credibility of grant performance assessments" (Macro International, 2009).</li> </ul>
Indicator Outcome	<b>D</b>	Key Findings: <ul style="list-style-type: none"> <li>The Global Fund is primarily a demand-driven mechanism, responding to proposals submitted by countries, although a technical review panel assesses the evidence base of country proposals.</li> <li>The US government, the world's largest provider of HIV-related assistance, is hampered by policy restrictions from supporting evidence-based HIV prevention:                             <ul style="list-style-type: none"> <li>Prevention for Young People: During its first five years, the US PEPFAR initiative was governed by a statutory requirement that 33% of its HIV prevention funds were to support abstinence-until-marriage programs. This statutory mandate was removed in 2008 legislation that reauthorized PEPFAR for an additional five years. Studies in the US indicate that programs for young people that exclusively promote abstinence do not reduce the risk of HIV infection (Underhill, 2007).</li> <li>Prevention for Sex Workers: US law requires that recipients of US HIV and anti-trafficking assistance to pledge to oppose prostitution. The policy potentially inhibits US-supported providers of HIV prevention from implementing best practices for risk reduction programs focused on sex workers (CHANGE, 2008).</li> <li>Harm Reduction: US law prohibits US government funding from being used to support needle and syringe exchange, a critical component of evidence-based harm reduction programs for IDUs. Through the PEPFAR initiative, the US government has taken initial steps to support drug substitution therapy in some countries (OGAC, 2009).</li> </ul> </li> </ul>

International Donors (cont'd)

Comprehensive, Evidence-Based Approaches (2) Do donor policies provide adequate support for evidence-based programs for populations most at risk?		
Data Quality for Indicator	<b>F</b>	Key Findings: <ul style="list-style-type: none"> <li>Most donors do not clearly define the criteria used to select the prevention strategies they will support or the mechanisms for targeting prevention services.</li> <li>As noted, few donors specify the prevention strategies they support, making it difficult to determine whether donor-supported programs are evidence-based and effectively target groups most at risk.</li> </ul>
Indicator Outcome	<b>D</b>	Key Findings: <ul style="list-style-type: none"> <li>Spending data (summarized above) indicate that only a small minority of prevention expenditures support programs focused on populations most at risk, even in settings where HIV infections are heavily concentrated in these groups (UNAIDS, 2008a).</li> <li>National law bars the US government, the world's leading provider of HIV-related financial assistance, from providing financial support for needle and syringe programs. The US government has begun to support drug substitution therapy in some countries, although these programs tend to be small in scale (see OGAC, 2009)</li> <li>US law requires all recipients of US global HIV assistance to have in place an organizational policy opposing prostitution.</li> <li>No comparable policies restricting access to evidence-based HIV prevention services for populations most at risk are in place for the Global Fund or other leading public sector AIDS donors, although the degree to which these donors support HIV prevention programs for these populations is not well-documented.</li> </ul>

Coordination, Harmonization and Alignment Do donors coordinate and align their efforts with national strategies?		
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Data Quality for Indicator	<b>C</b>	Key Findings: <ul style="list-style-type: none"> <li>Assessing the degree of alignment and harmonization is inevitably subjective. The UNAIDS National Composite Policy Index solicits feedback from governmental and non-governmental informants on the extent of donor harmonization with national strategies.</li> </ul>
Indicator Outcome	<b>C</b>	Key Findings: <ul style="list-style-type: none"> <li>Forty-five percent of national governments report that external partners do not align their efforts with national strategies (UNAIDS, 2008a).</li> <li>Government representatives play a more central role in planning, designing, and overseeing funding provided through the Global Fund and the World Bank than they do with respect to PEPFAR funding (Oomman, CGD, 2007).</li> </ul>



### International Donors (cont'd)

#### Support for Civil Society

Do donors support capacity-building for civil society and PLHIV?

Data Quality for Indicator	<b>D</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Data on total funding available for capacity support for local organizations are not readily available.</li> <li>The UNAIDS National Composite Policy Index asks non-governmental informants whether civil society groups have meaningful access to financial and technical support. National informants are also asked to estimate the percentage of various prevention services provided by civil society.</li> </ul>
Indicator Outcome	<b>D</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>According to non-governmental informants, civil society organizations have meaningful access to capacity-building support from any source in only 20% of countries (UNAIDS, 2008a).</li> <li>A 2007 assessment of capacity-building support provided by leading AIDS donors found that "donors have not assessed whether capacity-building activities are improving the ability of recipients to manage and use AIDS funds" (Oomman, CGD, 2007).</li> <li>This comparative assessment of leading AIDS donors found that "PEPFAR funds are channeled primarily to international – mainly US – recipients" (Oomman, CGD, 2007). PEPFAR reported that in 2008 it supported 2,667 organizations – up from 1,588 in 2004 – with local organizations making up 86% of PEPFAR partners (OGAC, 2009).</li> </ul>

### Multilateral and Technical Agencies

#### Assessment of National HIV Prevention Strategies

Have agencies undertaken an external evaluation of national HIV prevention strategies?

Data Quality for Indicator	<b>C</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>UNAIDS reports aggregate data for the numbers of countries that receive an external evaluation of national prevention strategies. It is not always possible to determine which countries have received such an external review, although the UNAIDS AIDS Strategic and Action Plan service provides information regarding the countries it assists.</li> </ul>
Indicator Outcome	<b>C</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>UN agencies undertook 42 joint reviews of national strategies in 2008 and assisted an additional 22 in developing or revising strategies (UNAIDS, 2009b). Between 2006 and 2008, more than 50 countries received assistance in the review of national AIDS strategies through the UNAIDS AIDS Strategy and Action Plan service (J. Leno, World Bank, personal communication, 2009).</li> <li>Available data do not exist on the impact of such external reviews on national strategies and action plans.</li> </ul>

#### Aid to Countries to Improve National HIV Information Systems (1)

Has a gender-aggregated national household survey or epidemiological mapping been undertaken?

Data Quality for Indicator	<b>C</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>UNAIDS and WHO annually issue epidemiological updates that incorporate the latest data on HIV prevalence, incidence, and mortality. Country-specific estimates for prevalence and mortality are provided, but incident infections are estimated by region and globally. Presentation of the data does not clearly differentiate between countries where household HIV surveys have been undertaken and those where no such surveys have been made. For countries that lack a household HIV prevalence survey, UNAIDS and WHO develop epidemiological estimates, using the best available data (e.g., antenatal surveys).</li> </ul>
Indicator Outcome	<b>C</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>36 countries have conducted national, gender-disaggregated, population-based surveys with HIV prevalence measures since 2001 (UNAIDS, 2009d).</li> <li>UN and other technical agencies assisted 11 countries in sub-Saharan Africa in conducting modes of transmission analyses, and numerous other countries in Africa, South East Asia, and Latin America are in process of finalizing their own estimates or making plans to undertake such an exercise (UNAIDS, 2008b).</li> <li>A regional epidemiological mapping exercise in West Africa provided data on epidemiological trends to 15 countries in 2008.</li> </ul>

Multilateral and Technical Agencies (cont'd)

Aid to Countries to Improve National HIV Information Systems (2)

Has a National AIDS Spending Assessment been undertaken?

Data Quality for Indicator	C	Key Findings: <ul style="list-style-type: none"> <li>UNAIDS provides reports to its governing board on the number of countries it aids in conducting National AIDS Spending Assessments.</li> <li>Country-level domestic and international AIDS expenditures constitute a core monitoring and evaluation indicator on which countries periodically report information to UNAIDS.</li> <li>UNAIDS technical experts report that the quality and reliability of spending data submitted by countries are highly variable (Izazola, personal communication, 2009).</li> </ul>
Indicator Outcome	C	Key Findings: <ul style="list-style-type: none"> <li>More than 80 of the 109 countries that submitted HIV expenditure data to UNAIDS for 2007 used the National AIDS Spending Assessment methodology to report spending trends. Twenty-five countries undertook a National AIDS Spending Assessment in 2008, and 48 additional countries planned to undertake an assessment of 2008 spending in 2009 (UNAIDS, 2009b).</li> </ul>

Coordinated Technical Support

Does the UN system effectively coordinate its technical support at country level

Data Quality for Indicator	D	Key Findings: <ul style="list-style-type: none"> <li>The UNAIDS National Composite Policy Index asks countries whether they are aware of sources of technical support for program planning and implementation. The survey does not ask respondents about the quality or suitability of available technical assistance.</li> <li>The Second Independent Evaluation indicates that UNAIDS-provided or –brokered technical support is highly valued by recipient countries and “there are examples of excellent work,” but that improvement in the coordination of technical support is needed (Poate et al., 2009).</li> <li>UNAIDS reports on the total days of technical support it provides to country-level partners. Such reports do not indicate the quality of such technical support, the degree to which technical support is effectively coordinated, outcome of technical support, or the fit between recipients’ needs and the technical assistance provided.</li> <li>In the absence of clear data on the availability of needed technical support, the Working Group undertook interviews with key informants to assess the quality and coordination of technical support.</li> </ul>
Indicator Outcome	D	Key Findings: <ul style="list-style-type: none"> <li>Stakeholders in 62 countries received more than 7,000 days of technical support from UNAIDS in 2008 (UNAIDS, 2009b).</li> <li>UNAIDS has established five regional Technical Support Facilities that together cover 60 countries.</li> <li>According to an independent evaluation of the World Bank’s global health portfolio, the majority of HIV-related projects supported by the Bank performed unsatisfactorily. The evaluation found that common shortcomings for unsuccessful projects included “inadequate risk analysis or technical design, insufficient political or institutional analysis, lack of baseline data on which to set realistic targets, overly complex designs in relation to local capacity, and negligible monitoring and evaluation” (World Bank, 2009).</li> <li>At least \$66 million was spent on technical support for Global Fund grants in 2008. Nearly all countries use technical assistance for proposal preparation. However, relatively few technical support efforts focus on the pre-implementation phase, when targeted technical assistance could help accelerate disbursement and implementation. No consensus currently exists on effective approaches for the provision of long-term implement support for Global Fund grants (McKinsey &amp; Company, 2009).</li> <li>Key informants reported that prevention program planners and implementers in countries often lack access to the range of high-quality technical support required.</li> <li>The five-year evaluation of the Global Fund concluded that “functional systems to provide effective [technical assistance] are not yet in place” (Macro International, 2009).</li> </ul>

Multilateral and Technical Agencies (cont'd)

Leadership and Advocacy

Are agencies providing visible leadership at the global and national levels for strategic, evidence-based prevention programming?

Data Quality for Indicator	D	Key Findings: <ul style="list-style-type: none"> <li>No metric exists to evaluate the quality of HIV prevention leadership provided by multilateral and technical agencies. In the absence of data, the Working Group has relied on key informant interviews to assess this indicator.</li> </ul>
Indicator Outcome	C	Key Findings: <ul style="list-style-type: none"> <li>Key informants said UNAIDS was a consistent voice for HIV prevention at the global level. Informants suggested that UNAIDS could improve its articulation of the components of effective HIV prevention, provide clearer guidance to countries on prevention planning, and help demystify the role of social change and structural interventions in HIV prevention efforts. Beginning in 2009 with a meeting of its Prevention Reference Group, UNAIDS launched a process to sharpen its articulation of, and advocacy for, strategic implementation of ‘combination prevention’ programs in countries.</li> <li>Key informants applauded UNAIDS and WHO for the quality of their technical guidance on HIV prevention developments.</li> <li>The Second Independent Evaluation of UNAIDS concluded that “UNAIDS leadership and support for effective HIV prevention policies and programmes has been inadequate” (Poate et al., 2009). The formal response by UNAIDS to the Second Independent Evaluation indicates that the organization plans to intensify its work in the HIV prevention arena.</li> </ul>

## Prevention Researchers

### Support for HIV Prevention Research (1)

Are adequate resources dedicated to new HIV prevention technologies?

Data Quality for Indicator	<b>B</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>For several years, the HIV Vaccines and Microbicides Resource Tracking Group – consisting of the AIDS Vaccine Advocacy Coalition, Alliance for Microbicide Development, International AIDS Vaccine Initiative, and UNAIDS – have documented expenditures by public sector agencies, philanthropic entities, and commercial entities for HIV vaccine and microbicide research and development. In recent years, the group expanded its efforts to track resources for R&amp;D on other new prevention technologies, such as pre-exposure antiretroviral prophylaxis, cervical barriers, and enhanced treatment for herpes simplex virus type 2.</li> </ul>
Indicator Outcome	<b>C</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Public sector and philanthropic funding for R&amp;D on vaccines and microbicides roughly tripled between 2000 and 2008 (HIV Vaccines &amp; Microbicides Resource Tracking Group, 2009).</li> <li>Total funding for vaccine R&amp;D reached US\$ 961 million in 2007 (HIV Vaccines &amp; Microbicides Resource Tracking Group, 2008) – nearing the US\$ 1 billion benchmark established earlier this decade by IAVI. However, spending on HIV vaccine research fell by 10% in 2008 (HIV Vaccines &amp; Microbicides Resource Tracking Group, 2009).</li> <li>Total funding for microbicide R&amp;D reached US\$ 244 million in 2008 (HIV Vaccines &amp; Microbicides Resource Tracking Group, 2009) – an 8% increase over amounts spent in 2007 but still somewhat shy of the US\$ 300 million benchmark established by microbicide advocates. With the recent shift in the microbicide field towards antiretroviral-based candidates, it is projected that the cost of clinical trials will grow in future years as administration of these technologies requires more intensive monitoring of trial participants.</li> <li>Seven public sector funders and two foundations provided US\$ 80 million in support for operations research and R&amp;D on other experimental HIV prevention technologies in 2008 (HIV Vaccines &amp; Microbicides Resource Tracking Group, 2009).</li> <li>Although the overall magnitude of resources directed toward research on new HIV prevention technologies is impressive, some experts have questioned the distribution of resources within the respective product development pipelines (IAVI, 2008), suggesting that promising research avenues may still be insufficiently explored due to inadequate funding.</li> </ul>

## Prevention Researchers (cont'd)

### Support for HIV Prevention Research (2)

Are adequate resources dedicated toward strategies to improve behavior change, harm reduction, community-level or structural interventions, and other non-technological prevention strategies?

Data Quality for Indicator	<b>F</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>It is impossible to quantify total expenditures worldwide for HIV prevention research, as figures are not readily available from the diverse public sector and multilateral agencies that play some role in prevention research. In the absence of reliable data, the Working Group relied on key informant interviews to assess this indicator.</li> </ul>
Indicator Outcome	<b>C</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>The US government remains the leading funder for HIV prevention research. The National Institutes of Health allocated US \$440 million toward HIV-related behavioral and social science research during the most recent fiscal year (Office of AIDS Research, 2010), with the Centers for Disease Control and Prevention contributing more than \$20 million in additional resources. (J. Auerbach, personal communication, 2009).</li> <li>The US government's HIV prevention research portfolio is heavily oriented towards Phase II and Phase III studies of theory-based behavioral intervention. The US government has not historically prioritized research in community-led or structural interventions.</li> </ul>

## Social Research

Is adequate HIV-related social research being conducted?

Data Quality for Indicator	<b>F</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>No reliable database is currently available for social science research relevant to HIV prevention. In the absence of reliable data, the Working Group relied on key informant interviews to assess this indicator.</li> </ul>
Indicator Outcome	<b>F</b>	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Prevention research funding is heavily weighted toward theory-based behavioral interventions and new prevention technologies. Nearly 30 years into the epidemic, the evidence base is poorly developed regarding strategies to influence social norms, affect the structure and function of social networks, or promote social change in ways that contribute to HIV prevention.</li> <li>Social science research techniques are accorded low priority in most HIV prevention research. Even in clinical trials for new HIV prevention technologies, where most trials have not permitted definitive conclusions on the efficacy of the experimental technologies studied, failure to integrate social science research methods has contributed to confusion over the interpretation of study findings.</li> </ul>

Prevention Researchers (cont'd)

Operational and Implementation Research

Is an adequate level of operational and implementation research being conducted? Are the results of operational research readily available to and applied by policy makers and programmers?

Data Quality for Indicator	F	Key Findings: <ul style="list-style-type: none"> <li>No reliable database is currently available for expenditures for operational research or regarding the degree to which operational research is being applied by policy makers and program implementers. In the absence of reliable data, the Working Group relied on key informant interviews to assess this indicator.</li> </ul>
Indicator Outcome	F	Key Findings: <ul style="list-style-type: none"> <li>Although considerable funds have been spent to investigate the efficacy of various prevention methods, few research efforts have been undertaken to inform or guide program implementation.</li> <li>Where clinical studies have validated the efficacy of prevention methods, few such studies have been followed by field-based research to document the effectiveness of such approaches.</li> <li>There is an urgent need for simple, efficient implementation research strategies to provide timely feedback on the impact of prevention programs.</li> </ul>

Methodology

Are prevention trials for behavioral or structural interventions focusing on effectiveness as well as efficacy? Incorporating biological endpoints? Following participants for sufficient length of time?

Data Quality for Indicator	F	Key Findings: <ul style="list-style-type: none"> <li>As no easily accessible database exists for planned, ongoing or completed HIV prevention research, it is not possible to reliably categorize methodological approaches taken by prevention researchers. In the absence of reliable, comprehensive data, the Working Group has consulted meta-analyses of HIV prevention research findings, on-line listings of HIV prevention studies currently supported by public sector agencies (e.g., NIMH), and key informants who follow HIV prevention research findings.</li> </ul>
Indicator Outcome	D	Key Findings: <ul style="list-style-type: none"> <li>Few Phase IV effectiveness trials have been undertaken to determine whether prevention strategies validated in efficacy trials are effective in the real world.</li> <li>Although a growing number of HIV prevention trial designs in recent years have aimed to assess the intervention's impact on incidence of sexually transmitted infections (STI), extremely few reported studies have monitored the intervention's effect on HIV incidence. Exceptions are the EXPLORE trial (behavioral intervention for US men who have sex with men, Koblin et al., 2004) and the IMAGE trial (combination microfinance and community-based learning intervention in South Africa. Pronyk, 2006).</li> <li>Among behavioral interventions validated as efficacious by the Centers for Disease Control and HIV prevention, 20 relied solely on behavioral endpoints, 5 monitored STI incidence, and none monitored HIV incidence (CDC, 2008; Lyles, 2007).</li> <li>Published efficacy trials for behavioral HIV prevention interventions have typically followed participants for no longer than 12 months, with many only reporting the intervention's effect immediately upon completion (CDC, 2008; Lyles, 2007; Herbst, 2007).</li> <li>Most HIV prevention trials that were supported by the US National Institute of Mental Health and that were currently enrolling as of 19 April 2009 followed participants for 6-12 months, with the two trials with the longest follow-up monitoring participants 18 months after enrollment. The majority of currently enrolling NIMH trials incorporated behavioral endpoints, although two planned to assess the intervention's effects on HIV incidence. (<a href="http://www.nimh.nih.gov/health/trials/hiv-aids.shtml">http://www.nimh.nih.gov/health/trials/hiv-aids.shtml</a>, accessed 19 April 2009.)</li> </ul>

Private Sector

Workplace HIV Prevention

Are workplace prevention programs broadly available among the largest employers in high-prevalence settings?

Data Quality for Indicator	D	Key Findings: <ul style="list-style-type: none"> <li>No rigorous survey has been conducted to quantify coverage of workplace HIV prevention programs in high-prevalence settings.</li> <li>Through the UNAIDS National Composite Policy Index (NCPI), governmental and non-governmental (e.g., civil society, donor, UN system) informants are surveyed regarding whether workplace prevention programs are available in none, some, most, or all of the districts in need. Although a principal value of the NCPI is that it permits non-governmental informants to serve as a check on governmental informants, the NCPI is not a coverage survey but instead obtains informants' general impressions of program availability. Uncertainty as to the definition of a district "in need" of workplace programs further diminishes the NCPI as a reliable indicator of service availability.</li> <li>Various entities (e.g., Global Business Coalition on AIDS, Tuberculosis and Malaria; World Economic Forum; International Labor Organization) have undertaken periodic surveys of businesses regarding their HIV-related policies and practices. Statements made by business respondents are not independently validated. In addition, while businesses primarily invest in HIV programs in the countries where they are located, it is not always clear from such surveys whether the respondent businesses are located in high-prevalence settings, where workplace programs are recommended.</li> </ul>
Indicator Outcome	D	Key Findings: <ul style="list-style-type: none"> <li>Among 15 countries with adult HIV prevalence greater than 5% in 2007, governmental and non-governmental informants in one-third of countries agreed that HIV workplace programs were available in most or all of districts in need (UNAIDS/NCPI, 2008).</li> <li>Among 83 Global Business Coalition members investigated in 2008, 51% distributed condoms in the workplace, 53% trained male and female peer educators, 60% extended HIV prevention services to the surrounding community, 67% partnered with local organizations to design and implement prevention programs, and 71% provided HIV education in the workplace (Global Business Coalition, 2008).</li> </ul>

HIV Policies

Have larger companies in high-prevalence settings adopted HIV policies?

Data Quality for Indicator	C	Key Findings: <ul style="list-style-type: none"> <li>The most comprehensive survey of business policies and actions on HIV was undertaken in 2005/2006 by the World Economic Forum. The WEF surveyed more than 10,000 business executives in 117 countries to ascertain their workplace policies.</li> <li>The International Labor Organization monitors the number of workplaces that have adopted the ILO Code of Practice on HIV and the World of Work. Because ILO monitoring does not quantify the denominator for workplaces in high-prevalence settings, it does not permit an estimate of workplace policy coverage</li> <li>As a general rule, business surveys do not shed light on why individual businesses have or have not adopted recommended HIV policies."</li> </ul>
Indicator Outcome	D	Key Findings: <ul style="list-style-type: none"> <li>In 2006, 6% of businesses worldwide had HIV policies in place. In countries with adult HIV prevalence greater than 20%, 58% of businesses had formal HIV policies in place (Bloom/World Economic Forum, 2006). However, many of these policies are not implemented. In East Asia, 26% of companies with HIV policies have not followed through on their commitments, and 21% of companies in countries with HIV prevalence between 5% and 9% have failed to implement formal policies to make condoms available to workers.</li> </ul>

Private Sector (cont'd)

HIV Testing Do larger companies in high-prevalence settings provide HIV testing?		
Data Quality for Indicator	D	Key Findings: <ul style="list-style-type: none"> <li>No rigorous survey has been conducted to quantify coverage of workplace HIV testing and counseling programs in high-prevalence settings.</li> <li>The Global Business Coalition has surveyed its members regarding their testing practices, although it is unclear whether GBC members are representative of employers generally. It is also not clear what share of workplace settings these members represent. 73% of respondents have operations in Africa. Survey results have not been independently validated.</li> </ul>
Indicator Outcome	C	Key Findings: <ul style="list-style-type: none"> <li>76% of 83 GBC members surveyed in 2008 said they provided information and education in the workplace on HIV counseling and testing, and 64% said they provided workers with in-house or outsourced confidential testing services (Global Business Coalition, 2008).</li> </ul>

Civil Society

Inclusion in Development of National HIV Prevention Strategies Does civil society participate in national AIDS coordinating bodies? Do non-governmental representatives comprise 40% of membership of the country coordinating mechanisms for the Global Fund?		
Data Quality for Indicator	C	Key Findings: <ul style="list-style-type: none"> <li>Survey data exist on the participation of PLHIV and civil society in national strategy formulation, CCMs and other coordinating and planning mechanisms, but it is frequently difficult to discern the degree to which civil society has the capacity and standing to actually influence national policies and programmes through such mechanisms.</li> <li>Certain qualitative data exist regarding the opinions of civil society on the meaningfulness of their engagement in national strategy formulation.</li> </ul>
Indicator Outcome	C	Key Findings: <ul style="list-style-type: none"> <li>According to reports from UNAIDS Country Coordinators in 74 countries, PLHIV were fully engaged in national AIDS strategy reviews in 50 countries in 2008 (UNAIDS/UCC, 2009).</li> <li>In 4 of 8 countries studied by the Global Fund, NGO participation in CCMs fell short of the recommended 40% target (GFATM, 2008).</li> <li>A seven-country study undertaken by civil society research teams concluded that civil society had limited influence in preparing Global Fund proposals, shaping program implementation, or providing programmatic oversight (ITPC, 2008).</li> <li>The five-year evaluation of the Global Fund concluded that the CCM mechanism has enabled civil society organizations and affected communities to have meaningful engagement in national AIDS responses. However, the evaluation found considerable skepticism – on the part of both national governments and civil society organizations – regarding the meaningfulness of existing partnerships between government and civil society on HIV/AIDS (Macro International, 2009).</li> </ul>

Access to Capacity-Building Support Do civil society organizations have meaningful access to financial support for capacity building?		
Data Quality for Indicator	F	Key Findings: <ul style="list-style-type: none"> <li>Although some donors (e.g., PEPFAR, World Bank) report on the number of non-governmental organizations that receive assistance, it is often difficult to discern whether such support flows to indigenous community-based groups (as opposed to large international NGOs). Available data also make it impossible to determine the number or percentage of civil society organizations that receive financial support.</li> </ul>
Indicator Outcome	F	Key Findings: <ul style="list-style-type: none"> <li>According to non-governmental informants, civil society organizations have meaningful access to capacity-building support from any source in only 20% of countries (UNAIDS, 2008a).</li> <li>Surveys of UNAIDS Country Coordinators and civil society organizations undertaken in 2009 by the World Bank and UNAIDS indicate that many civil society groups are experiencing reduced access to financial support as a result of the global economic crisis (UNAIDS, 2009c).</li> </ul>

Civil Society (cont'd)

Advocacy for HIV Prevention Are civil society advocates adequately prioritizing HIV prevention advocacy?		
Data Quality for Indicator	F	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>No agreed metric exists for evaluating civil society advocacy for HIV prevention.</li> <li>The UNAIDS National Composite Policy Index asks national respondents to estimate the percentage of various prevention services that are provided by civil society. Informants' estimates are not based on formal service mapping exercises but instead represent their understanding of civil society engagement in prevention service delivery. These surveys also do not assess the quality, reach, or distribution of the prevention services provided by civil society.</li> <li>In the absence of reliable data on civil society support for prevention advocacy, the Working Group relied on key informant interviews to assess this indicator.</li> </ul>
Indicator Outcome	C	<p>Key Findings:</p> <ul style="list-style-type: none"> <li>Various civil society advocacy groups that have traditionally prioritized treatment access issues (e.g., Treatment Action Group, GNP+) have recently begun to emphasize HIV prevention as well.</li> <li>Key informants said advocates often tend to focus more on opposing objectionable policies (such as abstinence-only programming, criminalization of HIV transmission, and sodomy laws) than on holding governments accountable for providing strong, affirmative support for evidence-based HIV prevention.</li> <li>Responses by non-governmental informants vary from country to country with respect to the share of HIV prevention services provided in high-prevalence settings by civil society organizations. On the whole, non-governmental informants in high-prevalence countries in sub-Saharan Africa indicate that civil society provides the majority of HIV prevention services for young people and between 25-50% of services for SWs, MSM, and IDUs (UNAIDS/NCPI, 2008).</li> </ul>

The Way Forward

The Working Group urges that respective stakeholders take steps to implement the full array of recommendations issued in Working Group reports over the last several years. Based on the most recent findings summarized above, the Working Group recommends the following priority actions to address the weaknesses and gaps identified in its latest analysis:

**Know Your Epidemic.** National governments should take immediate steps to strengthen national HIV surveillance and information systems, and international donors and technical agencies should intensify financial and technical support for such efforts. All stakeholders must pay particular attention to rigorous documentation of HIV-related epidemiological and social trends pertinent to the populations most likely to become infected in particular settings. In hyper-endemic settings, particular focus is needed for older adults in stable, long-term relationship. In all settings, epidemiological and social science data should be analyzed for key populations

**Match Prevention Strategies to National Needs.** All countries should have in place clear national HIV prevention plans with specific, time-bound targets. Leveraging increased access to modes-of-transmission estimates, countries and technical agencies should ensure that national prevention programs (not merely strategic plans) receive a thorough, independent review at least once every three years. National governments should commit to “follow the epidemic” by supporting programs that respond to documented needs, with particular attention to focusing national strategies on the primary drivers of the epidemic and on populations most likely to become infected. International donors must formally commit – and follow through – to ensure that no sound national prevention strategy goes unfunded. Donors should be accountable for ensuring that their prevention initiatives are in line with documented national needs and support sound national prevention strategies.

**Scale-up Proven Strategies Now.** National governments, donors, technical agencies, civil society and other stakeholders should prioritize achievable, cost-effective approaches that can be immediately implemented even while working to develop new tools and close the information gap on structural and behavioral approaches. Ensuring that individuals know their HIV serostatus is critical, especially in hyper-endemic settings. It is entirely feasible to virtually eliminate mother-to-child transmission by 2015. Similarly, no one should become infected through injecting drug use since harm reduction services have shown to result in radical declines in drug-related HIV incidence.

**Reform National Laws.** The one-third of countries that have no HIV discrimination law must immediately adopt one. Countries should immediately take steps to decriminalize same-sex sexual relations and the purchase or sale of sex (with complementary national and donor support for initiatives that provide women with economic alternatives to sex work). Legal impediments to gender equality – such as restrictions on property ownership or inheritance – should be removed. Donors and international agencies should intensify efforts to oppose the criminalization of HIV transmission or HIV risk behaviors, including repeal of statutes that are already in place. International donors should explore the implementation of meaningful financial incentives to discourage enactment of punitive or counterproductive legal frameworks.

**Fund HIV Prevention.** All funders – including national governments and international donors – should commit to a dramatic increase in HIV prevention resources. To ensure universal access to HIV prevention services, prevention funding must increase nearly four-fold in 2010, reaching \$11.6 billion. Leading donors – including the Global Fund and PEPFAR – should take steps to increase the magnitude and impact of financial support for HIV prevention. While redoubling efforts to mobilize resources for HIV prevention, increased efforts should focus on maximizing efficiencies in the planning and delivery of HIV prevention programs. In particular, intensified operational and implementation research is needed to identify unit cost benchmarks for standardized prevention services, and national programs and international donors should implement protocols to incentivize efficiency in the delivery of prevention programs. Attention should be paid to rigorous programmatic management for results.

**Monitoring Results.** Donors and national governments should commit to allocating at least 10% of all HIV prevention spending for operational research and rigorous monitoring and evaluation. Both national governments and international donors should report annually on results achieved with HIV prevention spending. Reporting should include clear evidence of public health impact, as well as reporting on the unit costs for specific services and strategies. Findings from monitoring and evaluation should be taken into account in the review, revision and adaptation of country and donor strategies. Development of more reliable, affordable assays to measure HIV incidence is an urgent global health priority.

## Moving Forward: Heeding Lessons Learned

The Working Group urges that respective stakeholders take steps to implement the full array of recommendations issued in Working Group reports over the last several years. Based on the most recent findings summarized above, the Working Group recommends the following priority actions to address the weaknesses and gaps identified in its latest analysis:

**Knowing Your Epidemic.** National governments should take immediate steps to strengthen national HIV surveillance and information systems, and international donors and technical agencies should intensify financial and technical support for such efforts. All stakeholders must pay particular attention to rigorous documentation of HIV-related epidemiological and social trends pertinent to key populations, including sex workers, men who have sex with men, injection drug users, and women and girls. The World Bank and other members of the UNAIDS family should lead efforts to ensure that all countries benefit from modes-of-transmission studies and HIV prevention syntheses. Research agencies should prioritize the development of affordable, user-friendly tools to identify, characterize, and measure key social drivers that contribute to HIV risk and vulnerability.

**Matching Prevention Strategies to National Needs.** All countries should have in place clear national HIV prevention plans with specific, time-bound targets. Leveraging increased access to modes-of-transmission estimates, countries and technical agencies should ensure that national prevention programs (not merely strategic plans) receive a thorough, independent review at least once every three years. National governments should commit to “follow the epidemic” by supporting programs that respond to documented needs, with particular attention to focusing national strategies on the primary drivers of the epidemic and on populations most at risk. International donors must formally commit – and follow through – to ensure that no sound national prevention strategy goes unfunded. Donors should be accountable for ensuring that their prevention initiatives are in line with documented national needs and support sound national prevention strategies.

**Reforming National Laws.** The one-third of countries that have no HIV discrimination law must immediately adopt one. Countries should immediately take steps to decriminalize same-sex sexual relations and the purchase or sale of sex (with complementary national and donor support for initiatives that provide women with economic alternatives to sex work). Legal impediments to gender equality – such as restrictions on property ownership or inheritance – should be removed. Donors and international agencies should intensify efforts to oppose the criminalization of HIV transmission or HIV risk behaviors, including repeal of statutes that are already in place. International donors should explore the implementation of meaningful financial incentives to discourage enactment of punitive or counterproductive legal frameworks.

**Funding HIV Prevention.** All funders – including national governments and international donors – should commit to a dramatic increase in HIV prevention resources. To ensure universal access to HIV prevention services, prevention funding must increase nearly four-fold in 2010, reaching \$11.6 billion. While redoubling efforts to mobilize resources for HIV prevention, increased efforts should focus on maximizing efficiencies in the planning and delivery of HIV prevention programs. In particular, intensified operational and implementation research is needed to identify unit cost benchmarks for standardized prevention services, and national programs and international donors should implement protocols to incentivize efficiency in the delivery of prevention programs.

**Monitoring Results.** Donors and national governments should commit to allocating at least 10% of all HIV prevention spending for operational research and rigorous monitoring and evaluation. Both national governments and international donors should report annually on results achieved with HIV prevention spending. Reporting should include clear evidence of public health impact, as well as reporting on the unit costs for specific services and strategies. Findings from monitoring and evaluation should be taken into account in the review, revision and adaptation of country and donor strategies. Public sector research agencies, multilateral agencies, and philanthropic groups, should prioritize research and development of reliable, affordable, user-friendly assays to measure HIV incidence in resource-limited settings.

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