

**PROGRESS REPORT ON BARRIERS TO
EFFECTIVE FUNDING OF COMMUNITY-LED
RESPONSES BY INTERNATIONAL AND
PRIVATE FUNDERS AS WELL AS BETTER
UNDERSTANDING OF THE CHALLENGES
FACED BY NATIONAL GOVERNMENTS IN
ALLOCATING FUNDING TO COMMUNITIES'
RESPONSES**

Additional documents for this item:

Action required at this meeting—the Programme Coordinating Board is invited to:

40. *Take note* of the progress report on barriers to effective funding of community-led responses;

41. *Request* that the Joint Programme provide an update at a future meeting of the Programme Coordinating Board.

Cost implications for the implementation of the decisions: *none*

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Introduction

1. In approving the Sustainable Development Goals (SDGs), United Nations (UN) Member States made several interwoven commitments: to end the AIDS epidemic by 2030; reduce inequalities; empower all women and girls and advance gender equality; create just, peaceful and inclusive societies; and promote effective civil society partnerships to realise those goals.¹
2. Mobilised political commitment is needed to fulfil people's right to the highest attainable standard of physical and mental health, and to ensure that no one is left behind. But reaching those goals also requires the active engagement of community-led organisations and constituency-based networks that are rooted in communities of people living with HIV, women, young people, gay men and other men who have sex with men, people who use drugs, sex workers, prisoners and transgender people.
3. Those organisations require funding if they are to uphold the human rights of their constituencies and sustain their abilities to realise those rights.² This builds on the "UN Common Understanding on a Human Rights-Based Approach", which commits UN partners to uphold the right to participation in development cooperation.
4. Despite growing evidence of ambitious country commitments to investment in the community-led response to HIV and of the effectiveness of such investment, numerous barriers also exist. They include structural hindrances, such as laws, policies and institutional practices; economic barriers, including those created by donor conditions to avoid engaging in specific types of programming; and social barriers, including practices fostered by the current funding climate. These factors undermine long-term sustainability.
5. Data on official development assistance (ODA) for HIV programming from the Organisation for Economic Cooperation and Development's Creditor Reporting System show the share of ODA expenditures for HIV that was channelled through civil society and nongovernmental organisations (NGOs)³ from bilateral and multilateral financing mechanisms. In 2017, an estimated 23% of total international resources for HIV was channelled through civil society and NGOs, compared with 28% in 2016. This reflects a continuing downward trend in the share of funding going to NGOs and civil society organisations for HIV. That share peaked at 31% in 2012 of total ODA and has declined gradually since then.⁴ The actual amount of funding to NGOs and civil society appears to have flat-lined in the past five years.
6. At the same time, closing civil society space and restrictions on foreign funding are hampering the work of NGOs in the AIDS response in many countries.⁵ Restrictive and punitive legal regimes for people living with HIV, key populations, and women and girls exacerbate the situation. As noted in the 2016 report to the Programme Coordinating Board (PCB) by the PCB NGO Delegation, legal and political barriers include laws that create dangerous environments for organisations, service providers and service recipients.⁶ Criminalisation of same-sex relations, sex work and drug use can also impede registration of key population-led organisations. A recent study of closing civil society space for the HIV response found that criminalisation of key populations is used to justify the curtailment of civil society activity in relation to HIV by hindering organisations from opening bank accounts, holding public gathering and posting signs at their offices.⁷

7. Civil society platforms, led by communities, have been essential for empowering and mobilising women and key populations.⁸ Civil society plays a critical role in upholding fundamental human rights principles and ensuring transparency and accountability. Within the AIDS response, new sectors continue to emerge, joining a long tradition of community activism on HIV led by those most affected by the epidemic. These sectors represent, among others, the voices of young women and young key populations, migrants, indigenous peoples and persons with disabilities.
8. AIDS advocates around the world are a major force for an accelerated and more equitable scale-up of effective HIV and health programming. The meaningful engagement of communities in the design, implementation, and monitoring of programmes has proven to lead to more sustainable and fit-for-purpose outcomes, especially when communities are partners and leaders.⁹
9. The 2016 Political Declaration on ending AIDS recognised the important leadership role played by community organisations.¹⁰ It called for:
 - realisation of the Greater Involvement of People living with AIDS;
 - the protection of human rights for all;
 - recognition of the right to equal participation in civil, political, social, economic and cultural life;
 - empowerment to know one's rights and to access justice and legal services to prevent and challenge violations of human rights; and
 - the removal of prejudice, stigma, or discrimination.¹¹
10. Also crucial were specific commitments to “ensure that at least 30% of all service delivery is community-led by 2030”¹² and that “at least 6% of HIV resources are allocated for social enabling activities, including advocacy, community and political mobilisation, community monitoring, public communication, and outreach programmes for rapid HIV tests and diagnosis, as well as for human rights programmes such as law and policy reform, and stigma and discrimination reduction”.¹³
11. At the 39th PCB meeting, in response to the report of the NGO Delegation, Board Members adopted a set of decision points regarding funding for the community HIV response. Among the decision points was a directive to analyse further the barriers to funding of community-led responses, to provide guidance on good practices in funding grassroots and community-based organisations, and to report back to the PCB. The report back occurred at the 43rd PCB meeting in December 2018.
12. At the 43rd PCB meeting, additional decisions points were adopted. They included Decision Point 10.4, which requested the Joint Programme to:
 - a. support the process of reviewing laws and policies that may impede financing of both community-led AIDS responses and social enablers;
 - b. convene a task team with diverse donors, implementing countries, and civil society representatives, including representatives of people living with HIV, women and adolescent girls and young women, youth and key populations, to standardise the use of definitions, including, “community-led AIDS response” and “social enablers” and to recommend good practices and improved modalities to ensure access to funding for community-based organisations and constituency-based networks.
13. The commitment to quantify and report on investment in community-led AIDS responses and in social enablers reflected a breakthrough recognition that social mobilisation and community engagement have a critical role to play in health. As these commitments represent a paradigm shift in the way health is managed, financed and evaluated, they require careful and precise adjustments to global health financing. Those changes need to be backed with robust, collective efforts to ensure that the commitments are realised.

14. In response to that decision point, UNAIDS convened a multi-stakeholder expert meeting, where definitions of community-led responses and key population-led responses were developed and agreed upon. Experts in community responses later joined the UNAIDS technical consultation on target-setting for social enablers, where community-led responses were identified as one of the key pillars to be included in the 2025 targets for social enablers. An expert advisory group¹ was subsequently established to operationalise the definitions by incorporating them in two global monitoring mechanisms, the Global AIDS Monitoring (GAM) and the National AIDS Spending Assessment (NASA) tools. Field testing of these indicators will be piloted in 2020 to assess the feasibility, quality and utility of collecting such data, and will be reviewed by the UNAIDS Monitoring Technical Advisory Group (MTAG) after the 2020 reporting rounds.
15. The task team as outlined in decision point 10.4b of the 43rd meeting of the Programme Coordinating Board will be established further to this review. In addition, a dedicated consultation with organisations led by women living with and affected by HIV is planned for early 2020 to develop a definition of women-led responses.
16. This update summarises these recent developments and progress made.

The expert consultation on defining HIV community-led responses

17. For the definitional work on community-led responses, the UNAIDS Secretariat convened an Expert Consultation on defining HIV community-led responses on June 17–18 in Montreux, Switzerland. The Consultation brought together representatives of people living with HIV, young people, gay men and other men who have sex with men, transgender people, sex workers, people who use drugs, women’s organisations, treatment activists, and people living with TB. Participants came from all regions.
18. In preparation for the meeting, the UNAIDS Secretariat reached out to global networks of people living with HIV, women living with HIV, young people living with HIV, and key populations with an online survey. That exercise gathered inputs from community members regarding their understandings of what “community-led” means, as well as on the specific content of a definition. The inputs informed the work of representatives participating in the Expert Consultation, as well as:
 - the consolidation of definitions from existing key population implementation tools (e.g. MSMIT¹⁴, SWIT¹⁵, IDUIT¹⁶ and TRANSIT)¹⁷;
 - materials from the 43rd PCB thematic session on funding for community-led responses; and
 - related definitions used by the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund).
19. At the Montreux meeting, representatives drafted a definition of “community-led responses”. It was decided that “community-led” must be an umbrella term, can be inclusive of the leadership of people living with HIV, key populations, women, youth, and other self-organized groups, in all of their diversity. Community experts attending the consultation, including people living with HIV, key populations, women, youth and people

¹ The expert advisory group had also been named task team in the initial iteration of the paper. To clarify the difference between the task team called for by the PCB and the expert advisory group, which is part of the broader technical process for the indicators, this revised version has been issued.

living with TB, worked throughout the process to define “community-led” in ways that included their constituencies.

20. Representatives emphasized that “community-led responses” must be understood as a separate category from “community-based responses.”²¹⁸ “Community-based” refers to *where* a response happens, irrespective of whether communities, governments, or the private sector conducts the response. “Community-led” refers to *who* it is that leads and implements the response. Community-led responses are frequently community-based, but they are not necessarily so.
21. In addition to “community-led responses”, participants drafted definitions of "community-led organisations", sub-definitions for "key population-led responses" and "key population-led organisations", and called for sub-definitions for “women-led responses” and “women-led organisations”.¹⁹
22. The following definitions were drafted:
 - a. Community-led organisations, groups and networks,²⁰ irrespective of their legal status, are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers,²¹ reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies.
Community-led organisations, groups, and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas.
Not all community-based organisations are community led.
 - b. Key population-led organisations and networks are led by people living with HIV, female, male and transgender sex workers, gay men and other men who have sex with men, people who use drugs, and transgender people.²² Key populations share experiences of stigma, discrimination, criminalisation, and violence and shoulder disproportionate shares of HIV infection in all parts of the world.
Key population-led organisations and networks are entities whose governance, leadership, staff, spokespeople, members and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies.
Key population-led organisations and networks and their expertise are anchored in our lived experiences, which determine our priorities. We speak for ourselves and are an intrinsic part of the global HIV response.
 - c. Community-led responses are actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organisations, groups and networks that represent them.
Community-led responses are determined by and respond to the needs and aspirations of their constituents.
Community-led responses include advocacy, campaigning and holding decision-makers to account; monitoring of policies, practices, and service delivery; participatory research; education and information sharing; service delivery; capacity building, and funding of community-led organisations, groups and networks.

² The Global Fund describes Community-led responses as “those that are managed, governed and implemented by communities themselves and community-based responses are those that are delivered in settings or locations outside of formal health facilities.”

Community-led responses can take place at global, regional, national, subnational and grassroots levels, and can be implemented virtually or in person.

Not all responses that take place in communities are community-led.

- d. Key population-led responses: key populations are primary actors in, and intrinsic to, the global AIDS response. Our responses are transformational, based on our priorities, needs and rights. Key populations should be included, on our own terms and with consideration to varying social and structural determinants, at all levels of the global HIV response.

Key population responses aim to strengthen the capacities of our communities and are committed to action, irrespective of resource availability. Key population communities are overlapping and thus our responses strive to be intersectional. Key populations choose our own representative and how we engage in HIV-, gender-, human rights-, and development-related processes.

23. For the definition of “women-led” responses and organisations, the community expert group called for an additional consultation, exclusively by and for women living with and affected by HIV, focused specifically on their leadership, specific needs and contributions. It was decided that women living with and affected by HIV, in all their diversity, would need to lead this process, given their crucial roles in the AIDS response and the multiple impacts of gender discrimination and gender-based violence against women and girls. The women’s consultation to define women-led responses will take place in early 2020.
24. Women and adolescent girls belonging to especially marginalised groups, including those belonging to key populations, face elevated risks of violence, discrimination and stigma, which compound the risks of HIV and the difficulties in accessing and adhering to treatment and related services. Furthermore, women and adolescent girls living with HIV are subjected to sexual and reproductive rights violations, which demand women-led responses to drive ongoing monitoring, greater access to justice and stronger accountability for the protection of those rights.²³
25. Too frequently, women and adolescent girls across all groups continue to be underserved and underrepresented meaningfully in HIV-related decision-making, policies, services and investments.²⁴ Definitions that clarify women-led responses and highlight their vital roles, leadership and centrality to the AIDS response are crucial—for the reasons stated above and especially in the context of the minimal funding available to women-led groups (particularly at national and local levels).

Social Enablers

26. Following the Expert Consultation on defining HIV community-led responses, participants joined a multi-stakeholder Technical Consultation on social enablers. Also held in Montreux, Switzerland, this consultation was part of the series to develop the 2025 AIDS targets and resource gap estimations. At the meeting, the new definitions on community-led responses were discussed further. Participants recommended additional priority social enablers for inclusion in the 2025 targets. Community-led responses was also recommended as a critical social enabler.
27. The starting point was a definition of social enablers that was used in the 2011 Investment Framework. It defined social enablers as political commitment and advocacy; laws, legal policies and practices; community mobilisation; stigma reduction; gender-based violence; and local responses to change the risk environment (“structural approaches”). Participants were asked to consider which social enablers and targets

would be needed to address stigma and discrimination and support communities; with attention to different needs by gender and age; key populations; and decriminalisation.

28. Various social enablers were suggested and then grouped into "clusters". Available evidence was discussed, synergies were noted, targets were considered, along with appropriate actions, programmes and strategies. Only the "clusters" are shared in this report, below.
29. A number of cross-cutting issues were identified and proposed for consideration as social enablers, including the right to health and other human rights. Investment in social enablers was also identified as a distinct cross-cutting issue, as were political will and commitment to promote an enabling environment for all social enablers. The consensus was to include community system strengthening as a cross-cutting issue or strategy.

List proposed for consideration of social enablers and cross-cutting issues³

Cross-cutting issues

- a. Human rights, including the right to health;
- b. political will and commitment—investment;
- c. community system strengthening.

Social enablers

- a. Laws, policies, practices and enforcement
 - including decriminalisation;
- b. access to justice;
- c. community-led organisations;
- d. addressing stigma and discrimination;
- e. gender equity;
- f. sexual rights and reproductive rights;
- g. addressing violence (prevention and response);
- h. economic justice, security and livelihoods (poverty, housing stability, work, social capital);
- i. changing public views/attitudes
 - education—upstream, comprehensive sexuality education, sensitization
 - knowledge skills and training.

Expert advisory group for operationalisation of HIV community-led responses

30. In addition to the work on social enablers, an expert advisory group for the operationalisation of HIV community-led responses was established as an outcome of the Expert Consultation. It was initiated through a joint call of the heads of global networks of key populations, communities of people living with HIV, treatment activists, and people living with TB, bringing together representatives from the Expert Consultation with members of UNAIDS Strategic Information and Community Mobilisation teams. The expert advisory group is convened by the UNAIDS Community Mobilisation team and will function through December 2020.
31. The advisory group's core mandate is to inform the development of indicators for agreed-upon definitions of community-led organisations and responses, as well as their related sub-definitions. That includes developing proposed language, indicators and implementation guidance for GAM to measure support and coverage of community-led responses, and for National AIDS Spending Assessments to measure resource tracking.

³ The social enablers and cross-cutting issues are not ranked by priority, but are presented in the order of discussion.

32. The expert advisory group began its revision of the Global AIDS Monitoring guidelines in September 2019, including indicator definitions, and it submitted suggestions, including:
- a. The addition of disaggregation for indicators related to service delivery, based on the type of service provider (key population-led organisation or public sector) across the following indicators:
 - 3.7A-D Coverage of HIV prevention programmes among sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people;
 - 3.9 Number of needles and syringes distributed per person who injects drugs;
 - 3.10 Percentage of people who inject drugs receiving opioid substitution therapy.
 - b. Proposed revisions to existing language in the GAM and NCPI questionnaire, including:
 - elaboration of language referring to communities in the GAM guidelines;
 - further inclusion of community-led organisations and responses in the National Composite Policy Index (NCPI);
 - NCPI questionnaire.
33. The advisory group is currently developing guidance for how item (a) will be applied ahead of the 2020 data collection round. It will begin item (b) as part of an in-depth review of the GAM in the months ahead, which could include the addition of new indicators. This will occur alongside similar analysis of the NASA.
34. Once those steps have been completed, UNAIDS will provide support to communities and governments to report in accordance with the new disaggregation. It will monitor results to inform improvements in the monitoring of community-led responses. The expert advisory group will also contribute to and provide feedback on the definition of targets for social enablers as the 2025 target-setting process moves on.

Conclusion

35. Several follow-up steps are planned, including:
- the development of a guidance for governments, funders and other partners who support community-led activities on working with and using the definitions outlined in this report (timeline: early 2020);⁴
 - continued engagement with the Global Fund Community, Rights and Gender team, which has been supportive of aligning its documents for the next funding round with these definitions (on-going); and
 - the organisation of a meeting of women living with and affected by HIV to define women-led responses, in collaboration with UN Women (timeline: early 2020).
36. This work integrates with and supports ongoing Joint Programme initiatives to address structural barriers and empower communities.
37. In the Global HIV Prevention Coalition, work to clarify prevention-related indicators for key populations in the GAM (such as community outreach) intersects with and is reinforced by the work of the expert advisory group.

⁴ This is part of ongoing work to respond to Decision Point 10.4b in its entirety, including the request that the Joint Programme “recommend good practices and improved modalities to ensure access to funding for community-based organisations and constituency-based networks.”

38. In the Global Partnership for action to eliminate all forms of HIV-related stigma, the operationalisation of community-led responses provides a framework for supporting interventions such as:
- empowering people living with HIV and key populations to increase their health literacy;
 - engaging communities in the design, implementation and evaluation of services in the health sector; and
 - strengthening mechanisms and community capacity for reporting, monitoring and advocating to end discrimination in healthcare settings.
39. In the jointly implemented Social Protection Assessments, community engagement and leadership are essential for empowering people living with and affected by HIV to access social protection benefits, including food security services. All of this is integral to ensuring that communities understand and can demand their rights, as well as hold stakeholders accountable for commitments to make those rights a reality.

Decisions:

40. *Take note* of the progress report on barriers to effective funding of community-led responses;
41. *Request* that the Joint Programme provide an update at a future meeting of the Programme Coordinating Board.

[Annexes follow]

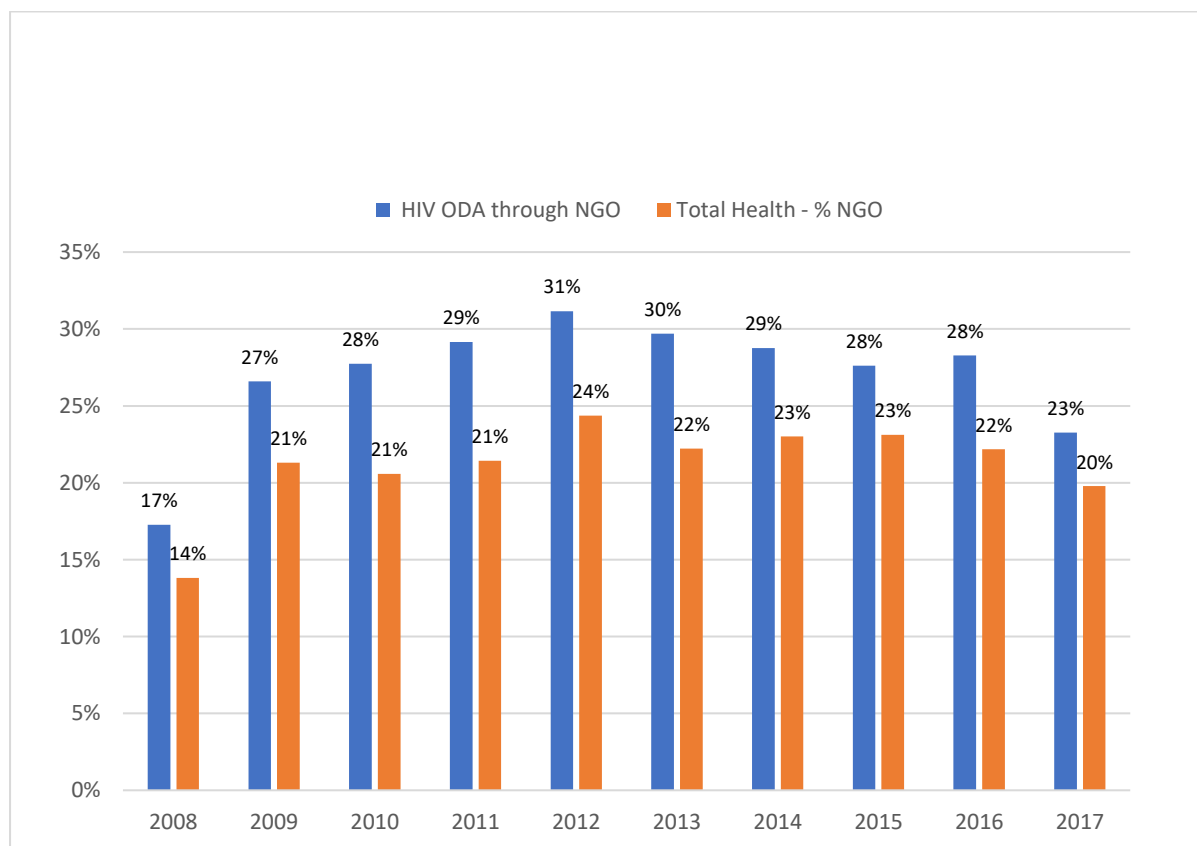
ANNEX 1: Funding for civil society responses

The definitions of community-led responses will be used for monitoring in 2020. Work is in progress to include these definitions in resource tracking through NASA. As a result, the first data on funding flows specifically for community-led responses, based on the definitions, will be available only in 2021. However, it is still possible to gain a general picture of trends in civil society financing in the meantime.

Since community-led responses are a sub-set of civil society responses, these data can be understood to include funding for communities. We anticipate that decreases in funding to the civil society sector as a whole are likely to be steeper for community-led organisations. There is already some evidence to this effect, and we will be able to test and confirm this assumption in coming years.

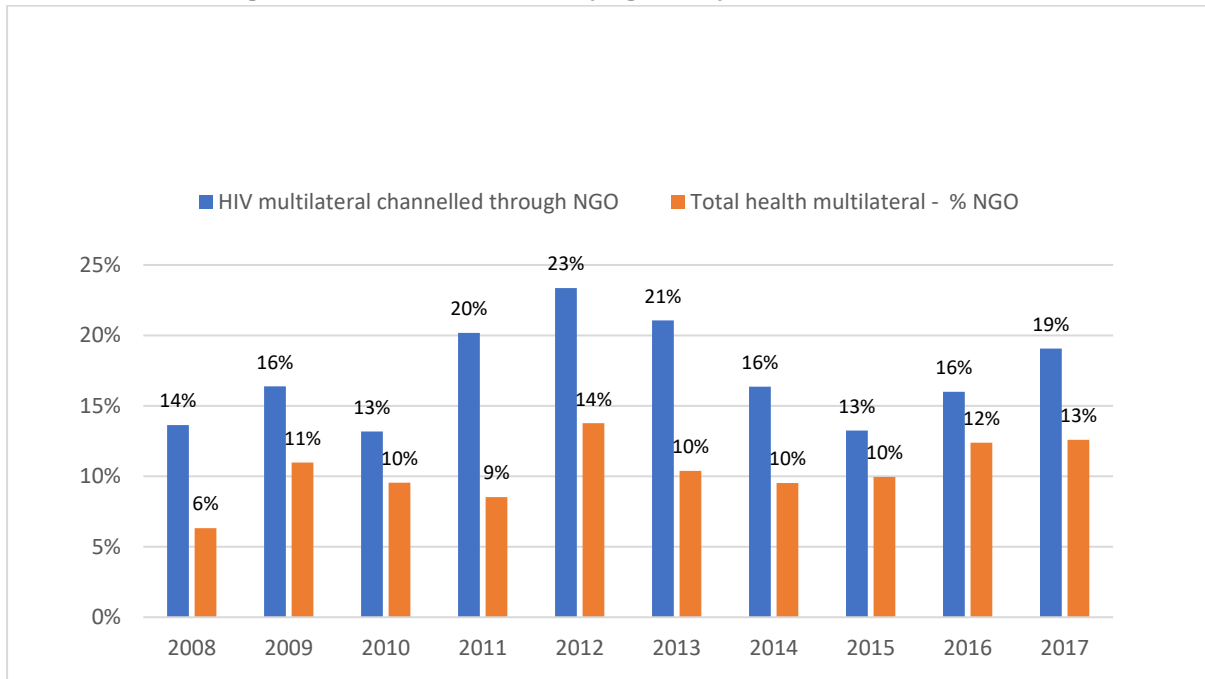
To gather updated information on financing for civil society, UNAIDS extracted data on official development assistance (ODA) for HIV programming from the Organisation for Economic Cooperation and Development’s Creditor Reporting System. The data show the share of ODA expenditures for HIV that were channelled through civil society and NGOs,²⁵ and combine funding that passes through bilateral and multilateral financing mechanisms (Figure 1). In Figures 2 and 3, the data are disaggregated into results for bilateral funding and multilateral funding. The amounts in USD are shown in figure 4.

Figure 1. Percentage of international resources for HIV and health resources channelled through NGO and civil society, globally, 2008–2017



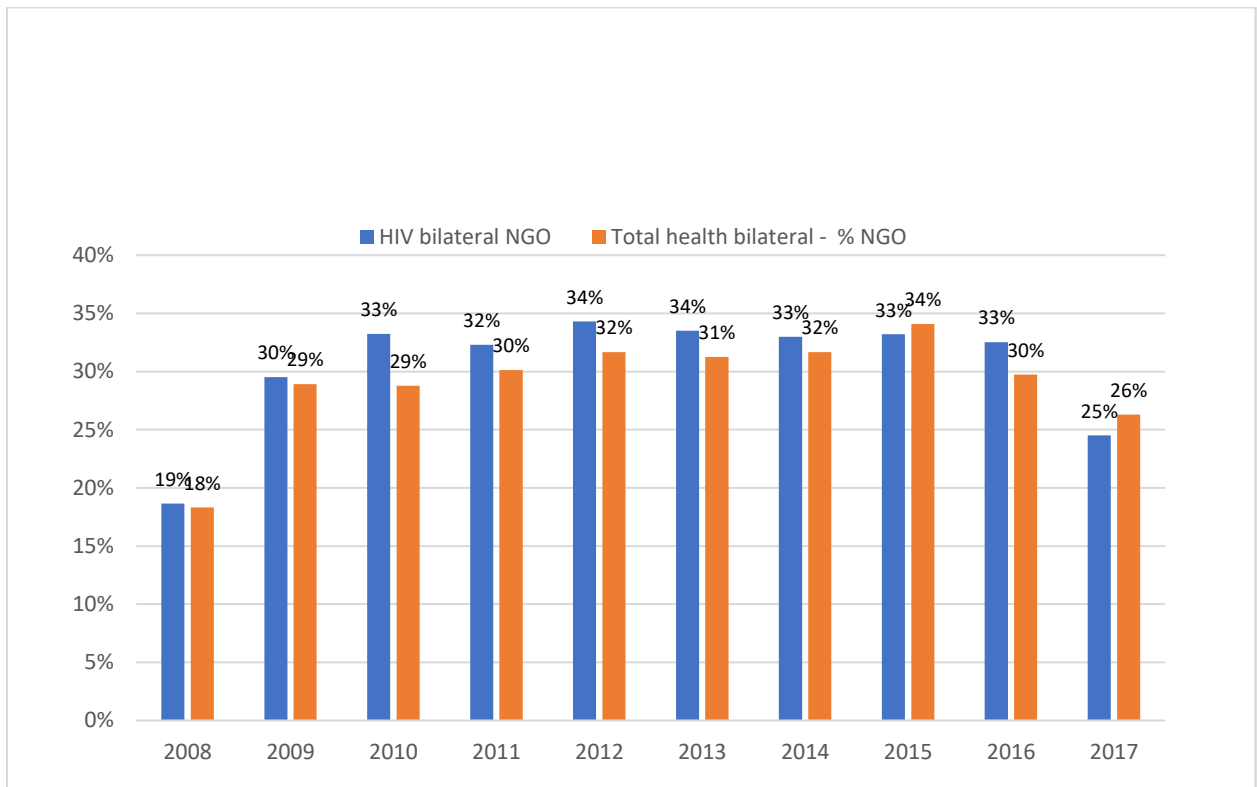
In 2017, an estimated 23% of total international resources for HIV was channelled through NGOs and civil society. This was a slightly larger percentage than the estimated 20% of international resources for health (other than HIV) that was channelled through NGOs and civil society. Nevertheless, as Figure 1 shows, the share of funds that went to NGOs and civil society organisations across all health interventions peaked in 2012, at 31% of total ODA for HIV and 24% for health broadly. That share has stabilised or declined since then.

Figure 2. Percentage of international resources (multilateral) for HIV and health channelled through NGOs and civil society, globally, 2008–2017



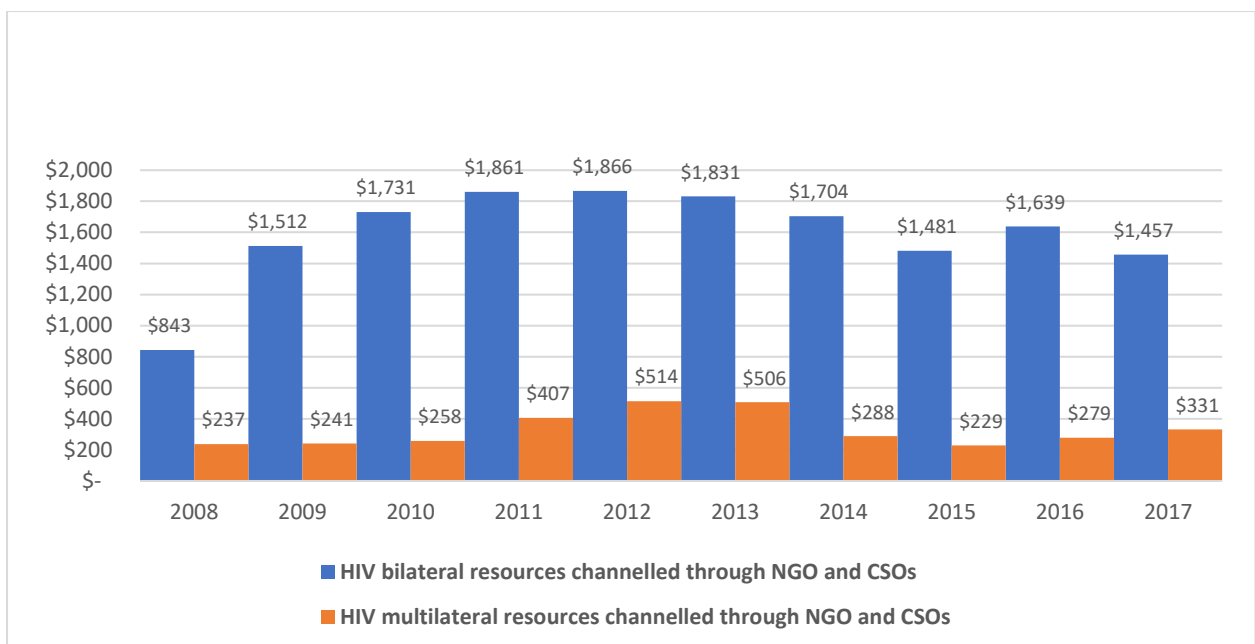
Of the total amount of international resources for HIV channelled through NGOs and civil society in 2017, 25% was from bilateral sources (Figure 3), while 19% was from multilateral sources (Figure 2).

Figure 3. Percentage of international resources (bilateral) for HIV and health channelled through NGO and civil society, globally, 2008–2017.



Even though the total amount of funding from bilateral sources increased by 13% between 2016 and 2017, the overall amount of international resources (both bilateral and multilateral) channelled through NGOs and civil society declined slightly in that period (Figure 4). In the bigger picture, total disbursements channelled through NGOs and civil society appear to have remained relatively flat. The decrease in bilateral resources between 2016 and 2017 in actual USD amounts equalled less than USD 180 million, with actual funds in 2017 being comparable to 2015 levels (Figure 4). For multilateral resources, the level is consistent for most of the period shown, except for 2011 to 2013, when resources were higher. Unlike the year-to-year changes in the percentage of ODA for HIV provided through civil society organisations (Figures 1, 2, 3), no clear trends can be reliably discerned in the absolute amounts of funds that went to civil society organisations.

Figure 4. International funding for HIV channelled through civil society organisations, globally, 2008–2017 (USD millions).



ANNEX 2: Community engagement for better health outcomes

More sustainable and fit-for-purpose outcomes can be achieved when communities are meaningfully engaged as partners and leaders in the design, implementation or monitoring of research, programming or service delivery. This is demonstrated in the following recent examples, published between the end of 2017 and the end of 2019:

Community engagement in research

- In the iPrevent study on the preferences for long-acting PrEP among youth aged 18–24 years in Cape Town, youth were convened as co-researchers, which affected iPrevent's approach and outputs in several ways. Youth input informed the use of local actors in the study's educational video, creating a “real-world” community setting that situated the dialogue and content in meaningful and accessible ways. Their participation in cognitive interviews led to the successful development of language and images to explain scientific concepts in terms that would resonate. Lastly, their insight reviewing results led to clarifications around misinterpretations of risk perception and confirmed youth's desire for future long-acting products that fit with their desires and goals.²⁶
- Recruitment and retention were considered major potential barriers for the AMP trials, which were the first efficacy trials of a broadly neutralizing antibody (bnAb) for HIV prevention among heterosexual women in sub-Saharan Africa (HVTN 703/HPTN 081) and cisgender men and transgender persons who have sex with men in North and South America and Switzerland (HVTN 704/HPTN 085). However, through the integration of communities throughout the clinical trial process and in education, recruitment, and retention, full study enrolment exceeded projected rates, recruitment was efficient and substantial, and as of January 16, 2019, retention in the AMP studies was 96% in HVTN 703/HPTN 081, 95% in HVTN 704/HPTN 085. There was also strong community enthusiasm regarding the overall bnAb concept for HIV prevention.²⁷
- ATHENA, AVAC (AIDS Vaccine Advocacy Coalition), and Salamander Trust—three civil society organisations—undertook the first peer-led global study to date that looks at HIV care and treatment access for women living with HIV. The methodology of this review was designed, led and governed by a Global Reference Group of 14 women living with HIV from 11 countries. The outcome document, *Key barriers to women's access to HIV treatment: a global review*, highlights the experiences of women living with HIV in accessing treatment and quality care. The document includes recommendations regarding laws, policies and programmes that are rights-based, gendered and embrace diversity, and which can maximize women's voluntary, informed, confidential and safe access to and adherence to medication, and optimize their long-term sexual and reproductive health.²⁸

Community-led interventions

- ePrEP was a six-week online campaign addressing PrEP barriers, and had been developed and delivered by young black and Latinx, gay, bisexual, and other men who have sex with men (aged 18–29 years). It was led by influential peers via private Facebook/Instagram groups with their existing online-social-networks (e.g. friends/followers) in New York City. They posted condition specific contents to their respective groups and facilitated discussions about the contents. Outcomes included retention, acceptability, and PrEP related-knowledge, -communication skills, -stigma, and -use collected through online surveys.²⁹

- In a comprehensive review of community empowerment approaches for addressing HIV among sex workers, researchers conducted a systematic review and meta-analysis of the effectiveness of community empowerment for sex workers in low-income and middle-income countries. Defining community empowerment as the process by which sex workers take collective ownership of programmes, they found that community empowerment-based approaches to addressing HIV were significantly associated with reductions in HIV and other sexually transmitted infections, and with increases in consistent condom use with all clients.³⁰
- In a study conducted in South Africa among black gay men and other men who have sex with men living in rural areas, the impact of community engagement was examined through interviews with this population and with health-care providers who had been involved in an HIV community engagement programme in several rural villages. The findings show that community engagement encouraged gay men and other men who have sex with men to access and utilize HIV testing, prevention, treatment, care and support more than they used to previously. Furthermore, community engagement seemed to reinforce community solidarity and social cohesion among the men in order to combat homophobia in communities where they lived. Through community engagement, the men were also able to create “safe spaces” where they could mingle with each other without experiencing prejudice and also offer each other moral and social support.³¹
- Researchers conducting a systematic review of 49 abstracts examined the outcomes of community participation in high and upper-middle income countries. Community participation included involvement of the community, service users, consumers, households, patients, public and their representatives in the development, implementation, and evaluation of health services, policy or interventions. The review found that community involvement had a positive impact on health, particularly when substantiated by strong organisational and community processes. The study results also supported the effectiveness of community participation in yielding positive outcomes at the organisational, community and individual level.³²
- In a nationwide cross-sectional online survey conducted among Chinese gay men and other men who have sex with men, the potential mediating roles of peer norms and self-efficacy in the association between community engagement and condom use were examined. The study found that HIV/sexual health community engagement, condom use peer norms, condom use self-efficacy, and frequency of condom use were mutually correlated. HIV/sexual health community engagement was associated with frequency of condom use, which was directly mediated by condom use peer norms and indirectly through self-efficacy, therefore suggesting the importance of peer-based interventions to improve condom use.³³

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REFERENCES

- ¹ Transforming our world: the 2030 agenda for sustainable development. 70/1 Resolution adopted by the General Assembly on 25 September 2015. Seventieth session agenda items 15 and 116.
- ² The human rights-based approach to development cooperation: Towards a common understanding among UN agencies (<https://hrbportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies>).
- ³ This includes civil society and nongovernmental organisations of all sizes and compositions, and as such the data should be interpreted with caution.
- ⁴ See “ANNEX 1: Financing community-led responses.”
- ⁵ Reinforcing marginalization: The impact of the closing of civic space on AIDS in Ethiopia Kenya and Uganda. Washington DC: International Center for Non-Profit Law (ICNL) 2018 (<http://www.icnl.org/news/2018/28%20Feb.html>).
- ⁶ Report by the NGO representative: An unlikely ending—ending AIDS by 2030 without sustainable funding for the community-led response. UNAIDS/PCB(39)/16.23 39th meeting 6-8 December 2016;
- ⁷ <http://www.icnl.org/programs/africa/ICNL-Reinforcing-Marginalization.pdf>
- ⁸ Key populations are groups of people who are more likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful HIV response everywhere. In all countries, key populations include people living with HIV. In most settings, gay men and other men who have sex with men, transgender people, people who inject drugs, and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, as discussed in the UNAIDS *Gap report*, each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and social context.
- ⁹ See “ANNEX 2: Community engagement for better health outcomes” for 2018–2019 data.
- ¹⁰ Political declaration on HIV and AIDS: On the fast track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030. 70/266 Resolution adopted by the General Assembly on 8 June 2016. Seventieth session agenda item 11; paragraphs 60a-64.
- ¹¹ <http://www.hivjustice.net/tag/political-declaration/>
- ¹² Global AIDS monitoring: Indicators for monitoring the 2016 United Nations Political Declaration on Ending AIDS. Geneva Switzerland: UNAIDS 2018.
- ¹³ Report on feasible ways to measure the achievement of the financial-related targets of the 2016 Political Declaration. UNAIDS PCB report (42)/18.13. Geneva: UNAIDS, 26-28 June 2018.
- ¹⁴ <https://www.who.int/hiv/pub/toolkits/msm-implementation-tool/en/>
- ¹⁵ https://www.who.int/hiv/pub/sti/sex_worker_implementation/en/
- ¹⁶ <https://www.who.int/hiv/pub/idu/hiv-hcv-idu/en/>
- ¹⁷ <https://www.who.int/hiv/pub/toolkits/transgender-implementation-tool/en/>
- ¹⁸ https://www.theglobalfund.org/media/4790/core_communitysystems_technicalbrief_en.pdf
- ¹⁹ Participants also identified the need for an additional definition for women-led responses, to be determined at a later date by a group of women leading HIV responses by and for women, with a consultation planned by UNAIDS and UN Women.
- ²⁰ Including collectives, coalitions, and other ways in which people self-organize.
- ²¹ These entities may structure themselves differently and may not include all of these actors.
- ²² This definition of key populations is not intended to preclude the ways in which people describe themselves, including in relation to sexual orientation, gender and gender identity.
- ²³ https://www.unaids.org/en/resources/presscentre/featurestories/2017/june/20170630_ending-discrimination-in-health-care-settings
- ²⁴ https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf
- ²⁵ This includes civil society and nongovernmental organisations of all sizes and compositions. The data should be interpreted with caution, since such aggregated data can hide significant differences in funding.

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- ²⁶ Hartmann M, Minnis A, Krogstad E, Ndwayana S, Sindelo S, Atujuna M et al. Engaging youth as long-acting HIV prevention product co-researchers in the iPrevent study in Cape Town, South Africa. International AIDS Society Conference, July 2019, Mexico City. Abstract TUAD0101.
- ²⁷ Andrasik M, Broder G, Lucas J, Davis J, White R, Luthuli N et al. The game-changing nature of early and ongoing community engagement in HIV prevention efficacy trials: The AMP studies' experience (HVTN 703/HPTN 081 & HVTN 704/HPTN 085). International AIDS Society Conference, July 2019, Mexico City. Abstract TUAD0104.
- ²⁸ <https://www.hhrjournal.org/2017/12/in-womens-eyes-key-barriers-to-womens-access-to-hiv-treatment-and-a-rights-based-approach-to-their-sustained-well-being/>
- ²⁹ Patel VV, Rios N, Horvath KJ, Golub SA, Zhang C, Mayer KH et al. Empowering with PrEP (ePrEP)—a peer-delivered online social network intervention for PrEP adoption among young Black and Latinx men who have sex with men: Cluster randomized controlled trial. [JMIR Res Protoc.](#) 2018;7(8):e11375.
- ³⁰ Kerrigan D et al. A community empowerment approach to the HIV response among sex workers: effectiveness, challenges, and considerations for implementation and scale-up. *The Lancet.* 2015;385(9963):172-185.
- ³¹ Mampane JN. The impact of an HIV community engagement programme among men who have sex with men in a rural community in South Africa. *Africa Journal of Nursing & Midwifery*, 2017;19(3): 1–14..
- ³² Haldane V, Chuah FLH, Srivastava A, et al. Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. *PLoS One.* 2019;14(5):e0216112.
- ³³ Haochu L. Condom use peer norms and self-efficacy as mediators between community engagement and condom use among Chinese men who have sex with men. *BMC Public Health.* 2017;17:641.