

An advocacy brief for
community-led organisations

ADVANCING COMBINATION HIV PREVENTION

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INTRODUCTION

This brief has been produced by the International HIV/AIDS Alliance in partnership with UNAIDS and follows on from the 2015 UNAIDS reference paper, *Fast Tracking Combination Prevention*.

It is intended for advocates from community-led organisations including:

- networks of people living with HIV
- civil society organisations active in the delivery of HIV/AIDS programmes
- groups and people working with and representing populations most affected by HIV (particularly those working with women, youth, key populations, etc).

These organisations play varied roles in the HIV response from programme implementers to peer educators and advocates. This guide aims to support them as they engage with policy makers at national, district and local levels to advocate for combination HIV prevention and shape their country's HIV programmes.

Acknowledgements

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Particular thanks go to our colleagues at the Alliance Centre of Practice for HIV, health and rights of key populations (South Africa), and Centre for HIV, hepatitis C and drug use (Ukraine), and the Regional Technical Support Hub in South Asia (India).

Contents

Why act now?	1
Why combination HIV prevention?	2
What is combination HIV prevention?	2
What do you need to do in your country?	4
Case studies 1–4	13–16
Resources	17

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WHY ACT NOW?

This is a critical time for all those driving the HIV response, including communities affected by HIV, activists and governments. Decisions taken over the next five years could make the difference between ending the AIDS epidemic and allowing its resurgence.

Yet, in the heart of our communities, among those people for whom life with HIV is their daily reality, the end of AIDS is still a distant hope. Despite an increasing array of prevention tools in recent years, there has only been a slow decline in new adult HIV infections. Progress in combating HIV has been very uneven. Young women in eastern and southern Africa continue to be highly vulnerable to HIV and across the world key populations have been inadequately reached by programmes to prevent and treat HIV.

We will not end the AIDS epidemic if we do not reach these populations. The time to address their needs is now. A bold international target has been set – to end the AIDS epidemic by 2030. Meeting this target requires a rapid acceleration in treatment and prevention programmes, rooted in human rights and gender equality and centred on people living with or affected by HIV. The UNAIDS 2020 targets will serve as a benchmark by which the world can be judged to see if we are on the fast track to ending AIDS.

Some of the UNAIDS prevention targets for 2020

90%

90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services.

90%

90% of young women and girls have access to HIV combination prevention and sexual and reproductive health services, and live free from violence.

20 billion

Twenty billion condoms available annually in low- and middle-income countries for people of all ages.

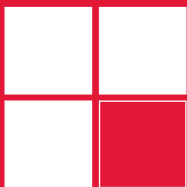
27 million

Twenty-seven million additional men in high-prevalence settings are voluntarily medically circumcised as part of integrated sexual and reproductive health services for men.

3 million

Three million people on PrEP annually, focused particularly on key populations and people at higher risk in high-prevalence settings.

Source: UNAIDS 2016-2021 Strategy, *On the Fast-Track to end AIDS*.



Quarter for HIV Prevention

Quarter for HIV Prevention (#quarter4HIVprevention) is a UNAIDS campaign to recapture imagination and hope for HIV prevention. It calls for countries to examine how much they invest in HIV prevention.

WHY COMBINATION HIV PREVENTION?

Between now and 2030, some 28 million new HIV infections can be averted through a greater focus on effective HIV prevention and treatment.

It has been clear for some time that HIV treatment and prevention mutually reinforce each other but today treatment is also seen as a means of prevention. Just as combination treatment has helped save millions of lives, combination prevention can help stem new HIV infections. Everyone at increased risk of HIV infection has the right to access appropriate prevention services.

If we are to stop the AIDS epidemic, our global HIV response needs to be based on a true understanding of the different realities of our countries and communities. We need to focus on the people, places and programmes where we can have maximum impact with the available resources.

In many cultural and political contexts people are unable to make informed choices to protect themselves, their families and their communities from HIV. We cannot rely on bio-medical tools alone, prevention programmes must be based on human rights, reflect the latest science and innovative strategies and engage people already living with HIV. A greater commitment to and effective use of combination prevention strategies, tailored to each of our communities is the only way to stop new HIV infections.

The reality of shrinking health budgets and falling donor support is an additional challenge. We must all demand the money is found and national HIV programmes are fully funded. This must include funding for proven community-led interventions.

People living with HIV, their communities and the organisations that support them have led the HIV response, mobilising funding and support and campaigning for rights-based policies. In many contexts they also play a pivotal role in delivering prevention programmes that respond to the needs of their communities. Most importantly, they have reached the most marginalised. Without empowering and meaningfully engaging these community-led organisations, the goal of zero HIV infections will remain an aspiration.

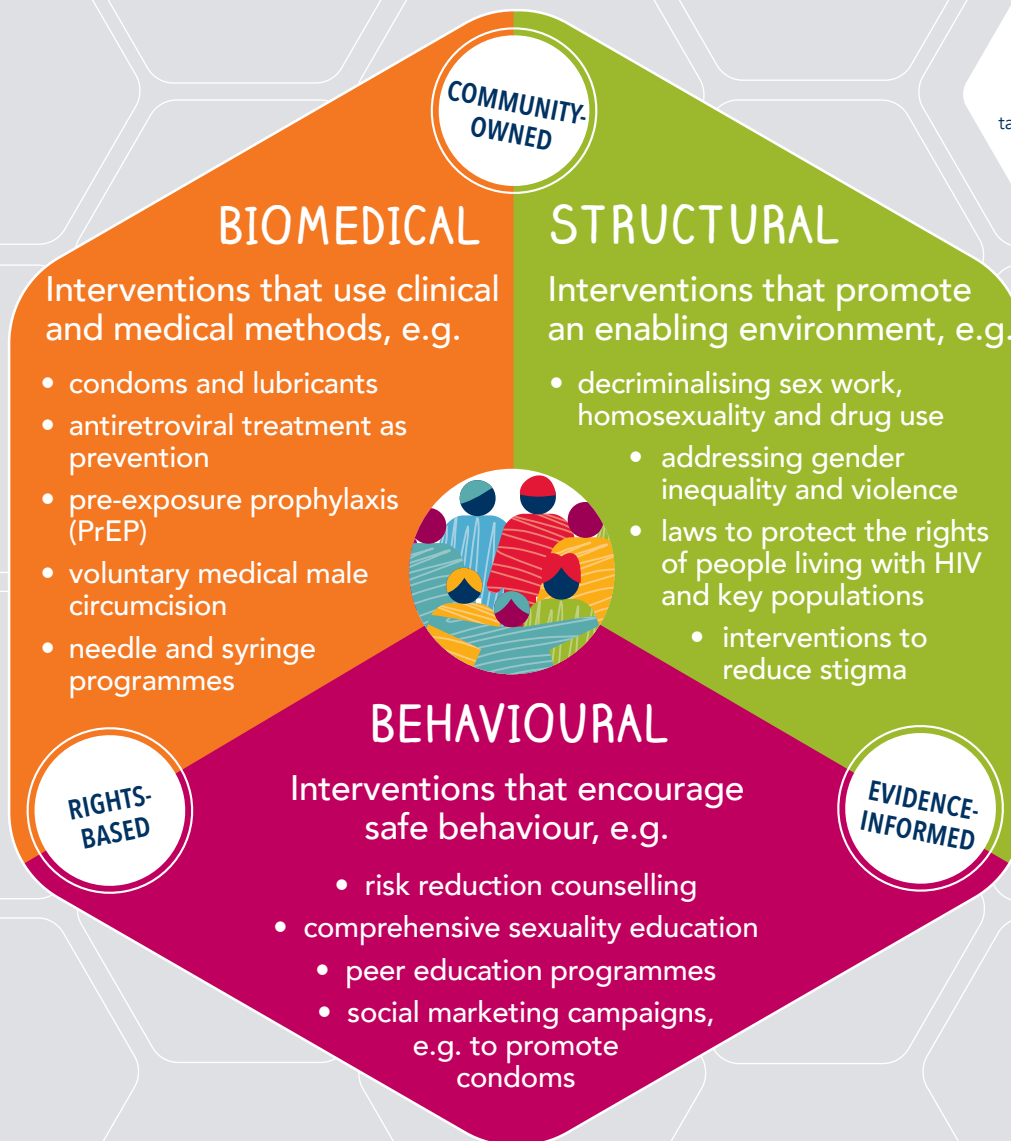
WHAT IS COMBINATION HIV PREVENTION?

Combination HIV prevention combines three types of intervention into a single, integrated approach. It needs to be tailored to the local context and works beyond the individual at the level of family, community and society.

Combination prevention programmes are “**rights-based, evidence-informed, and community-owned** programmes that use a mix of biomedical, behavioural, and structural interventions, prioritised to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections.”

Source: UNAIDS (2010). *Combination HIV prevention: tailoring and coordinating biomedical, behavioural and structural strategies to reduce new HIV infections.*

ELEMENTS OF COMBINATION HIV PREVENTION

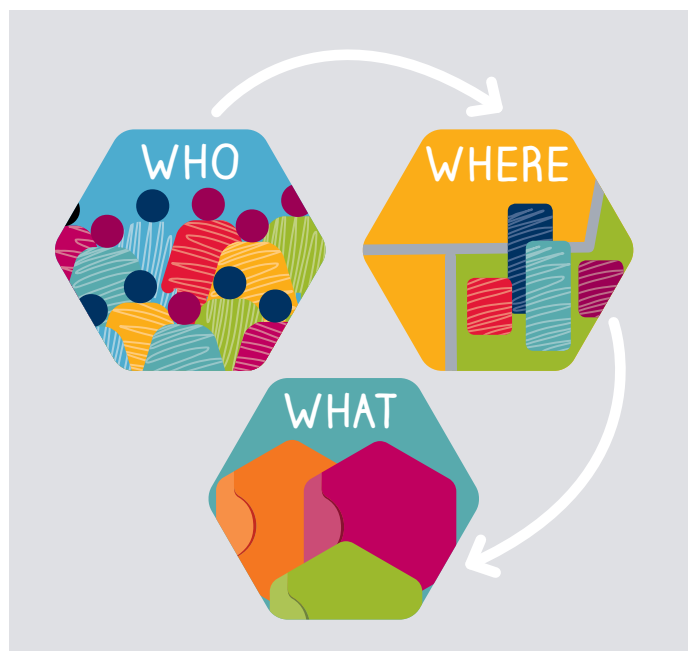


See pages 7, 13, 14 and 15 for examples and case studies of targeted combination prevention strategies.

WHAT DO YOU NEED TO DO IN YOUR COUNTRY?

1. Call for prevention programmes to be grounded on evidence

Combination prevention will only work if it is based on a genuine understanding of the nature of the epidemic in our communities. In order to know what combination of prevention strategies will be most effective in a setting, detailed evidence and data are needed to show who are the priority populations, where are they based and what interventions have worked for them. Communities themselves and community-led organisations are often well placed to contribute their knowledge and expertise to highlight who and where to focus and what works.



ENGAGE

- Help identify who and where the priority populations are in your country
- Ensure a focus on those communities currently being left behind
- Research what combination prevention strategies have been successful, including community-led interventions
- Monitor processes for choosing national priorities to ensure they do not undermine the universal right to health
- Advocate for programmes that promote human rights and community engagement and use the best evidence available

A. Help identify priority populations

In most settings, HIV incidence and prevalence is highest amongst a few key populations. However, the priority populations vary from country to country and include other groups, especially young women and their sexual partners in southern Africa. Protecting these priority populations from HIV is crucial to fast tracking combination prevention.

In each setting the priority populations need to be identified. Does data exist for your country, showing the size and location of priority populations? This should not be left to researchers or government officials alone. Evidence and data gathered by community-led organisations should help identify the priority populations. Community-led research is particularly vital in environments where key populations face repression or are criminalised and are hard to identify.

WHAT ARE KEY POPULATIONS?

Key populations are groups that are vulnerable to or affected by HIV. Their involvement is vital to an effective response. Key populations vary according to the local context and each country should identify the specific populations that are key to its epidemic based on the social and epidemiological context. Key populations are usually marginalised or stigmatised because of their HIV status or social identities and include people living with HIV, people who sell or buy sex, men who have sex with men, transgender people and people who use drugs.

Despite political and legal barriers that limit effective harm reduction programmes for people who inject drugs in many countries, it is possible to advocate for increased commitment and coverage. For example, while there remain serious challenges, China, Malaysia, Ukraine and Viet Nam have shifted their policies towards increased HIV service coverage for people who inject drugs. China and Viet Nam have expanded HIV treatment and opioid substitution therapy, and Malaysia is moving from a punitive to an evidence-informed HIV response.

B. Help identify key locations

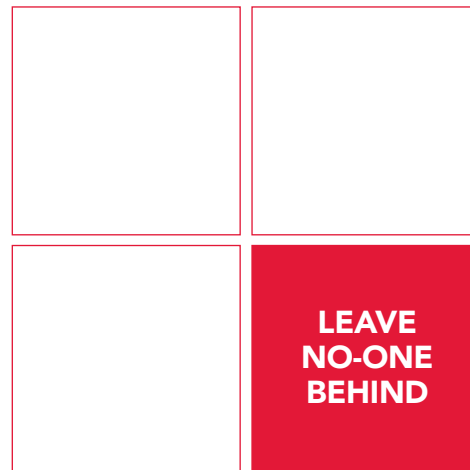
Your country will need to identify where the majority of people living with HIV are living and where most new infections are occurring. HIV infection rates vary dramatically by location, often highest in urban areas and along major trade routes.

For example, over two thirds of people living with HIV are in sub-Saharan Africa, but within the region HIV prevalence is particularly concentrated in certain locations. In Burkina Faso, HIV prevalence is

highest in the three largest cities and significantly higher among specific key population groups. Outside these major urban areas, HIV prevalence is generally low except along two major trade routes to neighbouring countries. By focusing on the priority populations within key locations, resources can be targeted to the precise spots in your country where they can be used most effectively.

Recent modelling in Kenya showed that a package of combination prevention rolled out uniformly across the country could reduce new HIV infections by 40% over 15 years. However, if the same funds were spent on a strategy focused on specific locations and populations, new infections could be reduced by a further 14%. While evidence shows that targeted programmes are likely to have the most impact, this needs to be balanced alongside universal rights to treatment and prevention and a determination not to fuel the stigma associated with certain communities and locations.

Community-led organisations must monitor policy makers to ensure that the focus on priority



QUARTER FOR HIV PREVENTION

populations and locations does not undermine the right to universal access to HIV services.

C. Advocate for the most effective programmes

There is no single prevention method that can stop new HIV infections. What is needed is a combination of effective biomedical, behavioural and structural interventions tailored to each location and population. The populations themselves must lead and be involved in shaping, implementing and monitoring prevention programmes to ensure their needs are met. The package of combination prevention tools that are chosen in your country will depend on the target population and location, as well as the cultural and epidemiological context.

For instance, while the World Health Organization (WHO) recommends that PrEP be offered to gay men and other men who have sex with men, not all these men in all locations may be at high risk and need PrEP. Equally, economic empowerment strategies have been shown to be an important tool when

preventing HIV infections among young women in Africa. However, the specific empowerment tool to use would depend on political and cultural contexts.

COMMUNITY INVOLVEMENT WORKS

SASA! is a community-led programme in Uganda that aims to involve all community members and leaders in discussions around gender inequality, violence and HIV to reduce the social acceptability of violence and change the attitudes and behaviour of men and women.

SASA! has succeeded in changing behaviour and social norms. In Kampala, men who took part in the programme were 50% more likely to have an HIV test than those who hadn't taken part and had double the rate of condom use. Women who took part were more likely to report being able to refuse sex and to make decisions jointly with their partners.

SASA! is now being used by more than 35 organisations in 15 different countries.

PREVENTION LED BY AND FOR PEOPLE LIVING WITH HIV

The Positive Health Dignity and Prevention (PHDP) framework was developed for and by people living with HIV based on consultations held by GNP+ and UNAIDS. By linking together the social, health and prevention needs of the individual living with HIV within a human-rights framework, PHDP offers a model of combination prevention for people living with HIV. PHDP promotes a shared responsibility for HIV prevention and advocates that policies and programmes for people living with HIV should be designed and implemented with the meaningful involvement of people living with HIV.

Following a regional PHDP training in 2011, Mauritius-based HIV organisation PILS have integrated PHDP principles in to all their work including their strategic plan. PILS have been advocating for a "one-stop shop" approach to programmes and services, calling, among other things, for opioid substitution therapy, antiretrovirals, psychosocial support and sexual health services to be offered together under one roof. They are now turning to address gaps in the treatment and care cascade, using PHDP as a guide.

EXAMPLE OF A COMBINATION PREVENTION STRATEGY

The graphic below illustrates how a combination prevention strategy can be designed to focus on the specific needs of certain populations in specific locations. The example is for young women aged 15–24 and their (often older) male partners in high prevalence sites in southern Africa.



2. Advocate for national plans that achieve scale and coverage

NATIONAL STRATEGIC PLANS NEED TO:

- clearly define priority populations and focus on what works for them
- set ambitious targets for prevention and treatment
- build cross-sectoral support and high level commitment
- focus on what works and ensure adequate scale and coverage
- adapt programme delivery – make the most of innovations
- evaluate impact and ensure accountability
- engage communities throughout
- be thoroughly costed and fully funded.

Once the data has been collected and it is clear which populations are most at risk of HIV, where they are situated and what programmes are likely to work best for them, it is time to revise national plans. Strategic decisions will need to be taken on where to invest money to achieve maximum scale and coverage and the best results.

Your country needs to set its own ambitious targets and mobilise commitment from different sectors including communities. A cross-sectoral approach is needed for programming to be effective. National AIDS programmes and the ministry of health will need to work alongside other government departments (such as education, trade, transport and social welfare) as well as with non-governmental organisations, civil society and communities

ENGAGE

- Take part in decision-making processes to scale up HIV prevention plans and programmes nationally and locally
- Demand the engagement of networks of key populations and people living with HIV in the development, implementation and monitoring of these plans and programmes
- Advocate for legal and policy reform to improve uptake of HIV prevention services, in particular for key populations
- Adapt community-led programmes to include combination prevention and make linkages to other prevention programmes
- Engage in monitoring processes to hold policy makers accountable to targets
- Shape public opinion and campaign to combat stigma and discrimination

themselves. Drawing together all sectors in society will not only help to make prevention programmes more effective it also helps to ensure programmes draw on the best practice, knowledge and expertise.

You should work with programme and policy makers to ensure that prevention programmes are scaled up to achieve wide, sustained coverage. Across many countries, programmes designed for men who have sex with men only reach between 12% and 70% of these men with any type of service. This is even the case in many parts of Latin America and Asia, where men who have sex with men account for the majority of HIV infections.

Prevention programmes also need intensity if they are to be effective. For example, condoms are at the core of HIV prevention strategies as a cheap and effective tool and yet their use is still very inconsistent. Widespread availability of condoms and intensive promotion addressing priority populations combined with strong community support has led to a decline in HIV incidence in several countries including Thailand and India. Communities can play a role in pushing for changes in the poor attitudes of healthcare workers, and restrictive laws and social norms to ensure condoms are accessible to young people and key populations.

Programmes also need to make the most of scientific innovations that provide new tools (e.g. PrEP) as well as innovative ways of working and reaching priority populations (e.g. use of social media). As community-led organisations, you have a particularly valuable role to play identifying which innovations best suit your setting. Service delivery models for HIV testing services have seen major innovations, including rapid diagnostic tests, community-based testing and counselling, and self-testing.

In order to keep prevention programming focussed on the right people, places, and programmes, ongoing monitoring and evaluation is essential. Targets need to be set and regular checks made to see if they are being achieved. You will need to hold your government accountable to national targets. Outcomes must be evaluated and the results used to adapt and refine future HIV prevention programmes. Wherever possible, flexibility should be built into plans so that programmes that are achieving the best results can be scaled up and those with less success can be adapted or stopped.



TARGETED INTERVENTIONS


In Zimbabwe, the *Sister with a Voice* programme supports sex workers and offers them, among other things, community-based testing services. Those women who test positive for HIV are offered immediate antiretroviral therapy (ART) and those who test negative are offered PrEP. This is accompanied by a system of regular peer support and legal advice.


COMMUNITY ENGAGEMENT LEADS TO GREATER ACCESS TO PREVENTION AND TREATMENT

Increase for each community-based organisation per 100,000 people, Nigeria and Kenya



  4 x increase in consistent condom use in the previous 12 months (Kenya)

 2 x increase in the likelihood of using prevention services (Nigeria)

 64% increase in the likelihood of treatment access (Nigeria)

Source: The World Bank (2013). Rodriguez-Garcia R, Bonnel R, Wilson D, N'Jio N. Investing in communities achieves results: finding from an evaluation of community responses to HIV and AIDS.

COMMUNITIES ENGAGING WITH AND MONITORING KENYA'S PREVENTION REVOLUTION

The *Kenya HIV Prevention Revolution Roadmap* was developed through extensive stakeholder consultation, including civil society organisations. The Roadmap aims to drastically reduce new HIV infections with a new approach:

- From intervention-driven to population-driven
- From heavily biomedical dependent to combination prevention
- From health sector-driven to a cross-sectoral approach
- From a national to geographically specific (counties, cities) approach

Civil society representatives successfully advocated for adolescent girls and young women to be given priority in the Roadmap and for the inclusion of structural and behavioural interventions to address their specific needs.

The National Empowerment Network of People Living with HIV/AIDS (NEPHAK) is using the Roadmap to advocate for the roll-out of combination prevention and to articulate the importance of community-based interventions in HIV prevention, including those delivered by community-led organisations.

While they welcome the Roadmap, civil society groups in Kenya also have some concerns. In particular, they are concerned that Kenya's reliance on external funders might mean a greater investment in bio-medical and "easy-to-measure" approaches rather than in a comprehensive combination prevention package. They are also concerned that the shift to focus on high-prevalence locations may undermine the need to address HIV nationally, and also further fuel stigma against certain communities in certain locations.



This truly revolutionary Roadmap makes the HIV response everyone's business. It extends shared responsibility beyond health authorities and defines clear roles and accountabilities for communities and key sectors at the national and county levels."

NELSON OTWOMA, EXECUTIVE DIRECTOR, NEPHAK AND MEMBER,
NATIONAL HIV PREVENTION TASK FORCE, KENYA

3. Demand funds for HIV prevention, including for community-led responses

In many settings, prevention programmes are failing because they are not adequately or intensively funded by governments or donors. There is a worrying trend of declining resources for prevention including community-led interventions.¹

You should highlight the cost effectiveness of combination HIV prevention and advocate for urgent investment in it. If programmes with sufficient coverage and scale are fully funded now, they will save money in the future. Front loading investments in the next five years, could reduce new HIV infections and AIDS-related deaths by 80 to 90%.²

UNAIDS estimates that global funding for the HIV response needs to increase from US\$ 20 billion in 2014 to around 30 billion in 2020. The UNAIDS *Quarter for HIV Prevention* campaign calls for a quarter of all global resources for the HIV response to be invested in effective and proven HIV prevention services. The campaign asks countries to examine their HIV prevention investment portfolio and aims to reinvigorate a dialogue on rights, choices and responsibilities for HIV prevention.

A *Quarter for HIV Prevention* is not a fixed formula that can be applied blindly in all settings. Investment needs in your country will depend upon the disease burden, the progress already made in providing HIV prevention and treatment services and their cost. How money should be spent will also depend on many contextual factors including: gender and social norms; criminalisation of HIV transmission; sexual behaviour; and drug use.

ENGAGE

- Advocate for funding to fast-track the HIV response in your country
- What proportion of your HIV budget is allocated to prevention? Push for a quarter.
- Monitor resource allocations at national and local level to ensure accountability
- Advocate to reduce the costs of medicines, tests and other services
- Demand greater investment in community-led prevention programmes to improve effectiveness and reach
- Call for investment in programmes that promote human rights



QUARTER FOR HIV PREVENTION

1. UNAIDS (2015). *Invest in HIV Prevention*.
2. Ibid.

Funding needs must be assessed at local, district and national levels. Budgets must be based on realistic costing of prevention services. Advocacy may be needed to ensure that your government invests in its own HIV response. Where necessary national budgetary allocations to health may need to be increased. If shortfalls are identified governments can take measures to raise funds through taxation, reducing illicit financial flows, ensuring equity in health, integrating services etc. Community-led organisations that implement prevention programmes themselves can also ensure they put available resources to the best use by reviewing their programmes, applying combination prevention approaches to them and improving linkages with other programmes.

International donor support also remains critical. HIV advocates must call on governments, the private sector and foundations to meet their commitments to increase and improve their investments. This must include adequately funding multilateral bodies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. Donors must also play their part in reducing illicit financial flows. As countries move toward universal health coverage (UHC), advocates will need to ensure that HIV prevention services are included in national UHC schemes.

Many donors are focusing their limited resources on the poorest countries. However, forecasts now predict that by 2020, 70% of people living with HIV will be in middle-income countries. If you live in a middle-income country, you may need to lobby donors and your government to adjust their strategies to ensure sufficient priority is given to key populations in your country. This may be best achieved by working in partnership or through networks of community-led organisations.

LOBBYING FOR FUNDS

In 2014, Namibian civil society organisations were concerned by national plans to remove social and behavioural change programming from the core set of HIV interventions. Civil society organisations joined together for the first time to engage with key local, regional and international stakeholders to address this and other issues of policy and funding. They achieved a reaffirmation of a combination prevention approach in the national response and the insertion of civil society organisations' budget lines in the national strategy.

Both national governments and international donors need to be reminded to allocate funding to human rights programmes. The 2015 UNAIDS report, *Sustaining the human rights response to HIV*, states that: "Despite the strongest ever policy base and increasing need for human rights work, there are indications that funding for that work is insufficient and may be decreasing. Sources indicate that little of the present annual funding for the global HIV response supports human rights programming." In fact less than 1% of the money spent annually on the HIV response went towards human rights, which are critical to scaling up prevention.

Finally, it is not enough to acknowledge the range of critical roles played by communities and community-led organisations in the HIV response. In 2014, UNAIDS estimated that to achieve the bold HIV targets, investments in community mobilisation and services must increase more than threefold between 2015 and 2020.

CASE STUDY 1: EMPOWERING GIRLS AND YOUNG WOMEN LIVING WITH HIV IN UGANDA

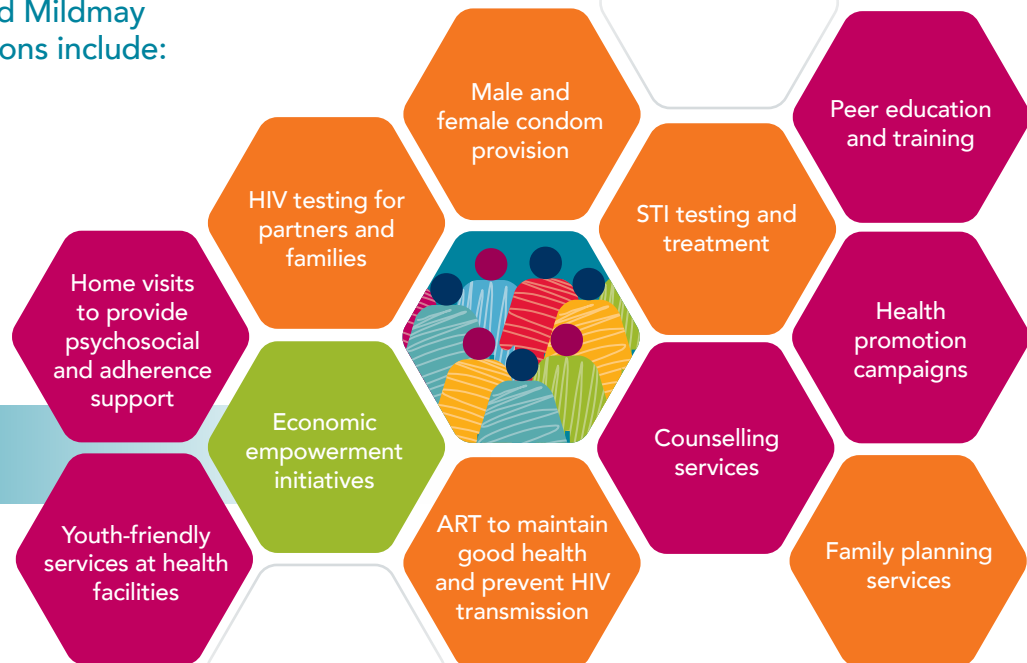
Girls and young women in Uganda are not only disproportionately affected by HIV they also face sexual and gender-related violence and a lack of access to sexual education, health services, social protection and information. The **Link Up** project works with young people, including girls and young women living with and affected by HIV (aged 10–24) to help reduce the number of unplanned pregnancies, new cases of HIV transmission and HIV-related maternal mortality. The **Community Health Alliance in Uganda (CHAU)** has partnered with **Mildmay** to empower girls and young women living with HIV to access quality integrated sexual and reproductive health and rights (SRHR) and HIV services. Their work includes peer education, counselling services, training for services providers (in particular to use softer communication skills so that

women and girls feel comfortable accessing their services) and the provision of an integrated package of services.

For example, at Mildmay, between October 2013 and December 2015, more than 3,500 young women and girls living with HIV accessed services to prevent onward transmission, including treatment adherence support, peer education and counselling. Young mothers living with HIV were also supported in preventing vertical transmission in an environment in which they could freely discuss concerns about their own health and the health of their babies. Similarly, in the same period, more than 30,000 young women and girls who tested negative were provided with an integrated package of SRHR/HIV prevention services such as family planning, HIV testing, peer education and male and female condoms.



CHAU and Mildmay interventions include:



For more information:
www.link-up.org

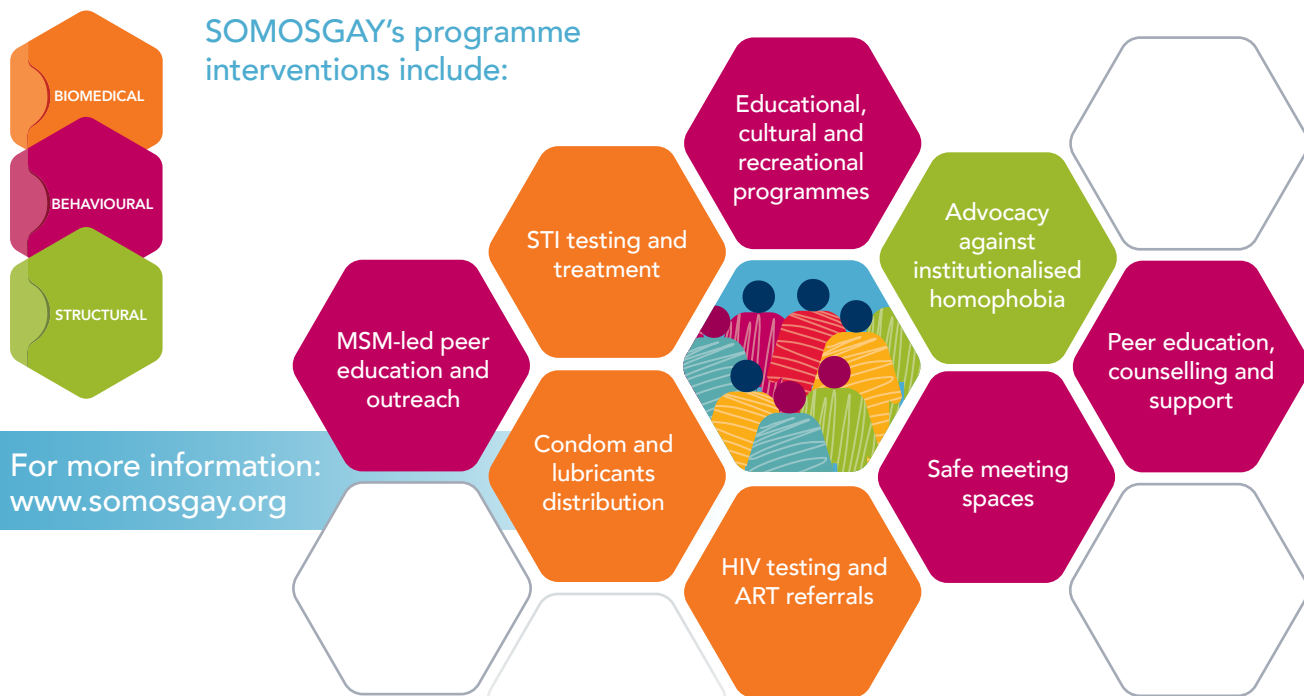
CASE STUDY 2: HOLISTIC HEALTH SERVICES FOR AND BY MSM IN ASUNCION, PARAGUAY

Men who have sex with men (MSM) account for almost one in two HIV diagnoses among men in Paraguay, yet policies and programmes to prevent HIV transmission among MSM are not fully developed. **SOMOSGAY**, a community-based organisation located in Asuncion put in place its own programme to address this.

In 2013, it set up the first men's wellness centre in South America for and by gay men and other MSM. Among other services, it provides a package of essential HIV combination prevention services to one of the key populations most affected by HIV in Paraguay. It includes the implementation of biomedical, behavioural and structural interventions to empower MSM communities while reducing

homophobia, and protecting the rights of people affected by HIV. It has since become one of the few community-based groups in Latin America that promote holistic health services for gay men and other MSM.

Since opening in October 2013, the centre has provided prevention services to more than 5,000 users and has implemented several educational campaigns combined with outreach services. One example, is the *Love Condom – Love Paraguay* campaign, which used novel strategies to respond to HIV. On the most famous beaches in Paraguay, peer-led outreach teams shared informative materials, condoms and lubricants, and offered rapid HIV testing and counselling.



CASE STUDY 3: SEX WORKERS DRIVE PREVENTION PROGRAMME IN SONAGACHI, INDIA

A ground-breaking initiative in India provides a good case study of combination prevention. In the early 1990s, research into sex workers in Kolkata's red light district, Sonagachi, identified a low incidence of HIV (1%) but a high incidence of sexually transmitted infections (STIs). The forward thinking **Sonagachi HIV/AIDS Intervention Project** was set up to try to make interventions before HIV infection levels began to rise. The holistic package of interventions were concentrated on areas of most immediate concern to sex workers – violence, the health and welfare of their children and the denial of their basic rights.

The impact of the project has been remarkable. Condom use was shown to increase from 1% at the beginning of the project to above 70%. HIV prevalence has remained considerably below that

among sex workers in other Indian cities, as have STI levels. A wide range of changes (including, increased power for sex workers, and greater economic security) have all led to an environment where sex workers are empowered to make decisions to protect their health.

The sex worker community was the driving force behind the Sonagachi Project from its inception. By 1995 they had created their own organisation the **Durbar Mahila Samanwya Committee** (Durbar) and their own financial cooperative offering savings schemes and micro credit to sex workers. Durbar has grown to take over the management of the Sonagachi Project altogether and now includes more than 40 red-light districts across West Bengal.



Sonagachi Project's first five years of interventions included:



For more information:
www.durbar.org

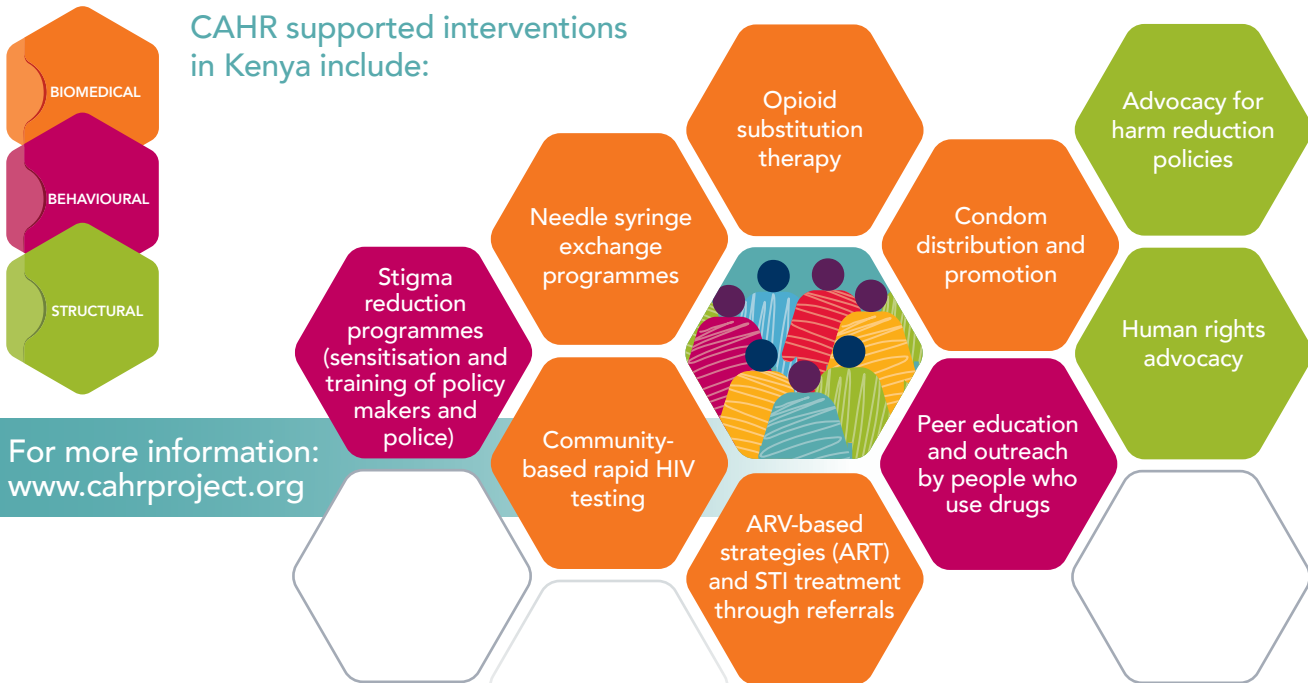
CASE STUDY 4: COMBINATION PREVENTION EMPOWERS PEOPLE WHO USE DRUGS IN KENYA

Community Action on Harm Reduction (CAHR) is an innovative project using combination prevention with communities of people who use drugs. The four-year project was started in 2011 by the International HIV/AIDS Alliance in six countries. Technical support was provided from Ukraine by the Alliance for Public Health. The project aimed to improve access to HIV prevention treatment and care for people who use drugs, their partners and children; advance their rights; and increase the capacity of civil society and government stakeholders to deliver harm reduction and health services to communities of people who use drugs.

CAHR in Kenya was implemented by the Kenyan AIDS NGOs Consortium (KANCO) and played a pivotal role in delivering the first HIV combination prevention programme for people who use

drugs in Kenya. It also resulted in impressive health outcomes, reaching almost half the estimated population using drugs in Kenya.

Over 8,800 people who use drugs have accessed CAHR-supported services, over 6,500 beneficiaries accessed voluntary counselling and testing services, and more than 350 people who use drugs initiated ART. The number of people who reported using a clean syringe in last injection rose to 88% from 52% at the beginning of the project. CAHR also supported the establishment of the Kenya Network of People who Use Drugs (KeNPUD) that now actively raises the voice of people who use drugs in national policy forums. The project has also successfully secured a Global Fund grant to support the larger Eastern Africa community to deliver harm reduction programmes.



For more information:
www.cahrproject.org

RESOURCES

For more information about combination prevention:

UNAIDS (2015). Fast-tracking combination prevention: towards reducing new HIV infections to fewer than 500,000 by 2020.

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International HIV/AIDS Alliance (2010). HIV and drug use: community response to HIV and drug use: A Good Practice Guide.

www.aidsalliance.org/resources/312-good-practice-guide-hiv-and-drug-use

USAID/PEPFAR/AIDSfree HIV Prevention Knowledge Base.

<https://aidsfree.usaid.gov/resources/pkb>

AVAC (Global Advocacy for HIV Prevention) Resource Database.

www.avac.org/resources-search

AVERT

Global information and advice on HIV and AIDS.

www.avert.org/professionals/hiv-prevention-programming



“With collective commitment in word and deed, we stand to gain a world by 2030 where AIDS is no longer a public health threat. To this end, we have sought to unite under a set of global targets. However, it is evident that many of the building blocks to achieve these targets are not yet in place. These gaps need to be acknowledged and urgently addressed.”

INTERNATIONAL HIV/AIDS ALLIANCE

“Communities will need to use their power to push this new prevention agenda and hold governments, donors and themselves accountable. Without community ownership, the target of reducing new HIV infections by 75% by 2020, and virtually eliminating them by 2030, will not be achieved.”

UNAIDS