FAST-TRACK or OFF TRACK?

How insufficient funding for key populations jeopardises ending AIDS by 2030

PITCH Partnership to Inspire, Transform and Connect the HIV response

BRIDGING THE GAPS

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Contents

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Executive summary

In 2016, global community agreed to work together to end AIDS by 2030. United Nations Member States backed UNAIDS' Fast-Track strategy to realise this vision. Key populations, such as gay and bisexual men and other men who have sex with men, transgender people, sex workers and people who inject drugs, were recognised as being central to achieving this ambitious goal. These marginalised communities continue to bear the brunt of the epidemic, prevented from seeking HIV services by stigma and criminalisation.

To end AIDS by 2030 there needs to be a rapid scale-up of funding for effective HIV programmes for key populations

To address this and ensure an effective HIV response, World Health Organization (WHO) guidance stipulated that key populations should either lead, or be meaningfully engaged in, programmes targeting their communities. Yet, three years into the strategy, funding for HIV programming for key populations is way off track. To end AIDS by 2030 there needs to be a rapid scale-up of funding for effective HIV programmes for key populations.

This report highlights the resource gaps in HIV programming for these communities and compares this to funding for the overall HIV response. The analysis is informed by documented spending on HIV programming for key populations in low and middle-income countries (LMICs) between 2016 and 2018. It was commissioned by Aidsfonds and supported by key population partnerships Bridging the Gaps and PITCH[1].

Key populations (and their partners) account for the majority of new infections

Globally, the total number of new HIV infections has hardly declined for several years, stagnant at 1.7 million in 2018. This is far above the Fast-Track target of 500,000 per year by 2020 and reflects a worsening picture for key populations. In 2018, for the first time, key populations and their partners accounted for the majority (54%) of all new infections worldwide. In Eastern Europe and Central Asia, and the Middle East and North Africa, regions where the epidemic is expanding, key populations accounted for almost all new infections (more than 95% of the total).

Key populations

The term key populations throughout this report refers to gay and bisexual men and other men who have sex with men, transgender people, sex workers and people who inject drugs.

Now even more important to target resources

The COVID-19 pandemic has exacerbated the situation; more than ever HIV resources must be targeted where they are most needed. COVID-19 undermines health for the most vulnerable and marginalised people now and, through economic, social and political pressures, in the future. The epidemiological data on HIV demonstrates that in every region of the world, the resources needed most are those that adequately fund HIV programming for key populations.

Only 2% of funding for HIV programmes targets key populations

Between 2016 and 2018, total combined resources for the HIV response in LMICs was approximately $57.3 billion. In the same period, the total funding of HIV programmes for key populations in LMICs is estimated at around US$1.3 billion. So, during the first three years of the Fast-Track approach, programmes targeting key populations received only 2% of all HIV funding, even though key populations accounted for over half of all new infections in 2018.

The figure for total HIV funding above includes HIV treatment. The available data that informs this report does not disaggregate funding for HIV treatment programmes by key populations, so it is likely that some of the funding for HIV treatment in LMICs was in fact directed to key populations.

Programmes targeting key populations received only 2% of all HIV funding, even though key populations accounted for over half of all new infections

However, disaggregated data does exist for HIV prevention programmes, and it still points to a huge disparity. Funding for all HIV prevention programmes in LMICs was estimated at $11.5 billion between 2016 and 2018; funding for all HIV programmes for key populations was $1.3 billion. The gap between those two numbers makes it clear that HIV programmes for key populations are still disproportionately under resourced.

Resource gap for HIV programmes for key populations is 80%

The resource gap for HIV programming for key populations was much bigger than the funding gap for the overall HIV response in LMICs. In 2016 UNAIDS estimated that $6.3 billion was necessary for the delivery of comprehensive service packages for key populations between 2016 and 2018. Another $551 million was required for the distribution of pre-exposure prophylaxis (PrEP) to these communities, making a total of $6.8 billion needed. So, there was a staggering gap of 80% between the budget required for HIV programmes targeting key populations ($6.8 billion) and the amount made available ($1.3 billion).

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Funding should be directed to community-led organisations and programmes

The World Health Organization's (WHO) consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations advises that funds should be channelled to community-led organisations and/or to programmatic responses that are community driven.

It was only possible to identify the ultimate recipients of funds from donor governments that reported through the International Aid Transparency Initiative. This information was not available from other funding data sources used in this study. This means it is not clear how much of the total funds were given to community-led organisations and/or for programmatic responses that were community driven.

Evidence from civil society and donors suggests that funding for community-led organisations and responses is contracting. For example, almost half (46.7%) of the civil society and community-based organisations in East and Southern Africa surveyed reported an overall decrease in their funding over the past three to five years.

It is also not possible to see to what extent funding spent on programmes for key populations was in line with the WHO guidelines, which recommend increased investment in policy and law reform to decriminalise HIV transmission / exposure / non-disclosure, sex work, drug use, same-sex sexual behaviours, gender identities expression, and institutionalising gender equality, ending gender-based violence, and securing access to comprehensive sexual and reproductive health and rights services.

Availability of accurate data obscures true picture

By analysing data on HIV funding between 2016 and 2018 this report provides the most comprehensive mapping to date. It covers funding for key population HIV programming at the global, regional and national levels, including domestic public expenditure and investments by all the major funders of the global HIV response.

The analysis is based on a desk review of existing sources. A single comprehensive data set on funding for key population HIV programming across all funder types does not yet exist, so the mapping drew on a range of data sources for each of the different types of funder.

While this report represents the most comprehensive mapping of funding for HIV programming for key populations available, it does not represent the full picture. Because of the lack of available data, lack of transparency, inconsistency in how data is recorded and historical invisibility of transgender identities within the response, it was not possible to reflect an accurate assessment of actual spending on HIV programming for key populations, or provide a breakdown by key populations.

From the information that was available spending was analysed to assess how much funding was directed to HIV programmes for gay and bisexual men, transgender people, sex workers and people who inject drugs.

Spending on HIV programming for key populations by funder

Of the $1.3 billion spent on HIV programming for key populations over 2016 to 2018, $718.6 million (55%) was disbursed by the Global Fund, while PEPFAR contributed $305.7 million (23%). Private philanthropy accounted for $131.5 million (10%), followed by public domestic expenditure by governments in LMICs of $93.2 million (or 7%). The Dutch Government provided $56.1 million (4%) with other donor governments and multilateral institutions contributing a further $13.1 million (1%).

Spending analysed by key population

Total funding for HIV programmes for gay and bisexual men is less than 3% of all prevention funding

The risk of acquiring HIV was 22 times higher for gay and bisexual men, than for all adult men in 2018. Yet HIV programmes targeting gay and bisexual men accounted for less than 1% of the amount spent on the overall HIV response in LMICs between 2016 and 2018. When compared to the estimated amount spent on prevention during that period, the total spent on programmes for gay and bisexual men was still only 3%. Only one fifth of the estimated resources needed for HIV programming for gay and bisexual men in the 28 Fast-Track LMICs was available between 2016 and 2018.

Only 0.3% of prevention funding reaches programmes for transgender people

Although globally transgender people are 12 times more likely to acquire HIV than the general adult population, the HIV response among transgender communities in LMICs is minimal. UNAIDS estimates that transgender women accounted for around 1% of all new HIV infections globally in 2018, yet funding to specifically address HIV among transgender people in LMICs was less than $40 million between 2016 and 2018. That means only 0.06% of total HIV expenditure and 0.3% of total estimated prevention spending in LMICs over the three years was specifically for HIV programming for transgender people. The $40 million funding represents just over a fifth of the estimated resources needed between 2016 and 2018.

Sex workers 21 times more likely to acquire HIV yet funding just 3% of spending on all HIV prevention

In 2018 sex workers accounted for 6% of all new HIV infections globally. According to UNAIDS, sex workers are 21 times more likely to acquire HIV than the rest of the adult population. Yet, between 2016 and 2018, funding for HIV programming for sex workers in LMICs totalled just $356.7 million, 0.6% of all HIV expenditure and just 3% of estimated total HIV prevention funding. Less than a fifth of funding needed for HIV programming for sex workers in the 28 Fast-Track LMICs was provided from 2016 to 2018.

People who inject drugs account for 12% of new infections yet funding just 2.1% of spending on all HIV prevention

People who inject drugs are 22 times more likely to acquire HIV than the general population. In 2018, 12% of all new infections globally were attributed to these marginalised people. Between 2016 and 2018 funding for programmes addressing HIV among people who inject drugs in LMICs totalled $243.5 million, just 0.4% of total HIV expenditure and 2.1% of total estimated HIV prevention funding.

Recommendations to get on track

Resources for HIV programmes for key populations, in the first three years of the Fast-Track approach, fell far short of what was needed. It is time for a significant scale-up of resources for HIV programming for, and crucially led by, the key populations most affected by HIV. Programming must be in line with the evidence and human rights-based WHO consolidated guidelines on HIV prevention, treatment and care for key populations.

To be able to assess whether the global community is achieving its ambition there needs to be an overhaul on how funding data is tracked and recorded. For transparency and accountability, the availability, quality and consistency of data on resource flows for HIV programming for key populations must be improved.

Specifically, to get on track to end the AIDS epidemic by 2030 will mean that:

- All major funders collectively invest the $36.49 billion needed for HIV programming for key populations, over the next decade.
- All major funders commit to scaling up the proportion of their funding focused on community-led and community-based interventions.
- All major funders commit to increasing the proportion of their funding for advocacy and to support key populations to create enabling environments.
- UNAIDS leads global target setting on investments for HIV programming for and led by key populations.
- All major funders make concerted and coordinated efforts to systematically disaggregate, track and make public, funding allocation and spending for key population HIV programming.
- UNAIDS systematically monitors resource flows of HIV programming for key populations, to inform and improve funding strategies and priorities across all donors and governments.

Introduction

World commits to ending AIDS by 2030

In 2016 United Nation Member States agreed to work together to end AIDS by 2030. Member States adopted the Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 (the 2016 Political Declaration). On 8 June that year Member States committed to:

"Ensuring that financial resources for prevention are adequate ...and are targeted to evidence-based prevention measures that reflect the specific nature of each country's epidemic by focusing on geographic locations, social networks and populations that are at higher risk of HIV infection, according to the extent to which they account for new infections in each setting, in order to ensure that resources for HIV prevention are spent as cost-effectively as possible and to ensure that particular attention is paid to those populations at highest risk[2]."

The 2016 Political Declaration supported UNAIDS' ambitious vision to end the AIDS epidemic by 2030. UNAIDS set out a global plan to avert millions of AIDS-related deaths and new HIV infections through the rapid scale up of collective efforts and resources. The Fast-Track strategy involves:

"Rapidly scaling up effective HIV services during the next five years. It involves using rights-based approaches to reach the people who need these services and focuses the programmes in locations and among populations where they can have the greatest impact[3]."

Three times more HIV infections than UNAIDS target

Globally the number of new HIV infections has barely declined in recent years, stagnating at 1.7 million in 2018, far higher than the Fast-Track target of 500,000 per year by 2020. It reflects a worsening picture for key populations, who account for an increasing proportion of the total number of infections. In 2018 key populations and their partners accounted for more than half of new HIV infections worldwide and they bear the brunt of expanding epidemics in several regions. Globally key populations and their partners are at considerably greater risk of acquiring HIV than the general population.

Ending AIDS by 2030 will not happen unless there is a significant increase in investment for effective HIV programmes for key populations

Report highlights disparity between goals and resources for key populations

In this document we analyse investments in HIV programming for key populations in low and middle-income countries (LMIC) between 2016 and 2018[4]. This work was commissioned by Aidsfonds and supported by key population partnerships Bridging the Gaps and PITCH[5]. We highlight the gaping disparity between the aspirations of the Fast-Track goals and the reality of resources for the HIV response among key populations in LMICs[6].

The report is divided into two main parts. The first looks at the global landscape for resourcing HIV programmes for key populations in LMICs.

This part of the report explores:

- What resources were available in the three years to 2018,
- Which major funders contributed towards key population programming,
- How funding was distributed across each region, and
- The extent of the gap between resource needs and resource availability for key populations in the 28 low and middle-income countries prioritised in the Fast-Track approach[7].

The figures presented in the global overview include both funding data that could be disaggregated by key population and general, aggregated funding for key population HIV programming.

The second part of the report explores the funding picture in LMICs for each of the four key populations – gay and bisexual men and other men who have sex with men, transgender people, sex workers and people who inject drugs – from 2016 to 2018.

Finally, the report recommends actions for major funders in the global HIV response. Only if the recommendations are adopted can we finally get on track to end the AIDS epidemic by 2030.

COVID-19 poses new threat to HIV response

The global response is already falling behind, and the COVID-19 pandemic threatens to push us further off track. While this report reviews past resource flows, its intention is to spur dialogue and action for the future. We expect the fast-evolving COVID-19 global pandemic will have significant, long-term and likely devastating impacts for those most affected by HIV. There is an immediate threat to health and wellbeing, particularly for people with underlying health conditions or advanced or poorly controlled HIV disease. In addition, the expected severe economic downturn will manifest in social, political and legal shifts across every region of the world in ways that are impossible to fully comprehend right now.

Already the widespread lockdown of public spaces across the world is denying many sex workers the ability to earn an income, while human rights violations targeted at key populations are on the rise. In Hungary, the government is seeking to ban transgender people from being able to amend their legal documents to reflect their gender. In Uganda, 24 lesbian gay bisexual and transgender people (LGBT) were arrested by police in a raid on a shelter, under the guise of seeking to enforce physical distancing rules. Twenty people were detained in horrific conditions for almost two months. Harm reduction services and programmes are being disrupted, threatening the HIV response and access to health for people who inject drugs.

While COVID-19 creates new threats it also brings some hopeful opportunities. For example, take-home methadone treatment is being scaled up in many countries, and community outreach workers are taking an increasingly active role in distributing antiretroviral drugs.

Communities will need sufficient financial resources to be able to secure these important gains and to help the most marginalised people recover from the negative effects of COVID-19. Instead, we fear there will be a shift away from addressing global health challenges. In this context, there is an even greater more urgent need for HIV resources to be targeted where they are most needed.

The epidemiological data on HIV demonstrates that in every region of the world the resources most needed are those that adequately fund HIV programming for key populations. This report illuminates the resource gaps in HIV programming for these populations.

Methodology

By analysing existing data on HIV funding between 2016 and 2018 from a range of sources, this report provides the most comprehensive mapping to date on combined funding for key population HIV programming[8] at the global, regional and national levels. The report looks at domestic public expenditure and donor investments made by the major funders of the global HIV response, including PEPFAR, the Global

Fund, the Netherlands, other donor governments and private philanthropy. Comparison is made between the data drawn from these sources and the resources needed for programmes reaching gay and bisexual men, transgender people, sex workers and people who inject drugs outlined by UNAIDS under the Fast-Track approach.

The analysis is based on a desk review of existing sources. Time and resource constraints of this project limited detailed submissions of original data from most funders (except for the Global Fund). A single comprehensive data set on funding levels for key population HIV programming across all funder types does not yet exist. So, the mapping drew on different existing data sources for each of the funder types (outlined in more detail in Appendix 1).

The main criteria for inclusion within the analysis was expenditure through grants or programmes between 2016 and 2018 that were either primarily targeting one or more of the key populations or substantially targeting one or more key populations, where the percentage of resources going to the key populations can be accurately established.

Given the historical and ongoing discrimination experienced by each of the four key populations in healthcare, legal and social settings this analysis does not assume that key populations would be reached by general HIV programmes. Therefore, apportioning a percentage of the resources for those programmes based on population estimates, was not included within the methodology.

The years 2016 to 2018 inclusive were chosen as 2018 is the most recent year where data across all funders was available, and a three-year analysis gives an opportunity to account for trends and any year-on-year fluctuations. It is important to note that some funders such as the Global Fund and PEPFAR operate on three-year budget cycles, which may explain fluctuations in expenditure from year to year.

Limitations

There are a few limitations in the analysis that should be considered.

Different data sources and types of information presented challenges

First and foremost, the data analysed is from a range of sources, with each having a distinct methodology for how the data was collected and the type of information available to analyse. Except for the donor governments analysed through the International Aid Transparency Initiative, it was not possible to determine who the recipients of the funding were. This means that the analysis does not tell us how much of the funding was directed to community-led organisations and/or for programmatic responses that were community driven. It is widely recognised that funding community-led or driven response is critical to reaching key populations.

The study focused on all interventions addressing HIV that target one or more of the four key populations. The differences in detail disaggregated by key populations of reported amounts based on interventions, meant that it was not possible to provide analysis on the level of resources by intervention type.

The data from the Global Fund and PEPFAR, the two major international donors in the global HIV response, included funding for key populations that covered a broad range of interventions, some of which was disaggregated by key populations, and was therefore included in the analysis of resources for each of the four groups. The remainder was coded as general key population expenditure and included in the total aggregated figures. Also, a limitation of the research is the lack of available data from major funders about how much care and treatment expenditure between 2016 and 2018 was specifically focused on key populations. The Global Fund was not able to provide disaggregated data by key population on its care and treatment expenditure. A review of PEPFAR's publicly available expenditure documentation showed, with some minimal exceptions, its care and treatment expenditure is also not disaggregated by key population. The limited domestic public expenditure information reviewed only included information on the total amount spent each year in the relevant country. So, it was not possible to determine whether such funding included care and treatment.

Lack of consistency about when actual funding took place

Second, there was lack of consistency across data sources in terms of what resourcing transaction was being measured. While most data sources recorded expenditures or disbursements that year, the data gathered from the Global Philanthropy Project on gay and bisexual men and philanthropic funding of transgender people is based on the year that a grant was awarded. Relatedly, some funding data may include overhead and programme management costs, whereas other data, such as from the Global Fund, is net of these costs. This presents a limitation in establishing the most accurate comparison between funders of resources flowing to HIV programmes for key populations.

Not possible to account for intersectionality among population groups

Third, in an effort to provide the most accurate and comprehensive data to date on the funding levels that each of the four key population groups receive for HIV programming, the desire to disaggregate data meant that it was not possible to account for the intersectionality among these population groups. For example, there are gay men who are sex workers and transgender people who inject drugs. Tracking funding through disaggregation by key population group makes it challenging to accurately capture what level of resources are being directed to intersectional programmes.

Although family and friends are affected, they were excluded from this study

Fourth and related to the point above, HIV among key population groups also impacts their sexual partners as well as children, other family members and dependants. The stigma and discrimination key population groups experience often extends to other people in their lives. This can place families and friends at increased risk of infection and having their human rights violated. However, the scope of this research as well as the lack of funding data available, meant that these other groups were not included within this funding analysis.

Probable underreporting of amounts spent on HIV programming for key populations

Finally, there were gaps in the data across the sources, which means that the figures in the analysis probably represent an underreporting of the actual amounts for HIV programming for key populations over the three years. In particular:

- Data was only included in the sections for each of the key population groups where it was disaggregated to the level of one of the key populations as beneficiaries. The total global figures included both this disaggregated data as well as where funding was identified as for the four key populations together. So, for example, the roll out of a general antiretroviral treatment programme in a country may be reaching key populations. However, without the means to attribute accurately and credibly a percentage of that expenditure to one or more key populations, it is not possible to include it within the analysis.

- The significant lack of reporting by LMIC governments on their domestic spending on key populations through the National AIDS Spending Assessment process means that it was hard to get a full picture of what these countries are funding.

- The historical invisibility of transgender identities within the response, and the assumption that transgender people are included in programmes for gay and bisexual men, means that there are limitations on the availability of accurate data on the amount of funding for HIV programming for transgender people.

- Similarly, in some instances data that was provided on LGBT and HIV funding was not included. Funding that was left out did not accurately disaggregate what amount of that funding was going to HIV programming for gay and bisexual men, transgender people or lesbian, bisexual or intersex people of which the latter groups were outside the scope of this report[9].

For a more detailed explanation of the methodology used for this analysis, please see appendix 1.

Part 1 - Global investments in HIV programming for key populations

This chapter looks at the global landscape for resourcing HIV programmes for key populations in LMICs. It explores what resources were available, which major funders contributed towards key population programming, how funding was distributed across each region, and the extent of the gap between resource needs and resource availability for key populations in the 28 lower and middle-income countries prioritised in the Fast-Track approach.

Key populations and their partners accounted for more than half of all new HIV infections globally in 2018[10]. However, HIV programmes targeting key populations in LMICs received only 2% of the total amount spent responding to HIV, and just 11% of all prevention funding, between 2016 and 2018.

UNAIDS estimated that $6.8 billion was needed for HIV programmes for key populations between 2016 and 2018, but only $1.3 billion was made available. The shortfall between the amount needed and the amount available was a staggering 80%.

1.1 Resource availability and gaps

During the first three years of the Fast-Track approach, total funding[11] on HIV programmes for key populations in LMICs[12] is estimated at US$1.3 billion[13]. According to UNAIDS, the total combined resources for HIV in LMICs was approximately $57.3 billion[14] over the three years. Although the funding for these four groups increased each year during this period, it fell far short of what was needed to fast-track the global response.

HIV programmes targeting key populations in LMICs received only 2% of the total amount spent responding to HIV, and just 11% of all prevention funding, between 2016 and 2018

Table 1 - Total key population funding in LMICs in 2016-18

Year	Key population funding in LMICs	Total HIV funding in LMICs[15]	Key population funding as % of total HIV funding in LMICs	Estimated total HIV prevention funding in LMICS[16]	KP funding as % of total HIV prevention funding in LMICS
2016	$337.6m[17]	$18,400m	1.8%	$3,700m	9.1%
2017	$451.4m	$19,900m	2.3%	$4,000m	11.3%
2018	$529.4m	$19,000m	2.8%	$3,800m	13.9%
2016-2018	$1,318.4m	$57,300m	2.3%	$11,500m	11.5%

The lack of disaggregated data by key population on funding for HIV treatment programmes means it is not possible to know how much of that funding was directed to key populations. So, we compared the total funding of all HIV prevention programming of approximately $11.5 billion[18] between 2016 and 2018 in LMICs, with funding for HIV programmes for key populations of $1.3 billion. From this, it is still clear there is significant under-resourcing of key populations within the global HIV response.

Gap between resources available and programming needs much greater for key populations

The UNAIDS' Fast-Track: Update on Investments Needed in the AIDS Response[19] showed that $6.28 billion was needed to deliver comprehensive packages of services for key populations in LMICs from 2016 to 2018. These packages included the provision of condoms, safe needles or information, education, discrimination reduction, promotion of access to testing, treatment, and retention, and opioid substitution therapy for people who inject drugs. A further $551 million was estimated to be needed for the distribution of PrEP to key populations[20]. This means that funding of HIV programming for key populations at $1.3 billion was a mere fifth of the $6.8 billion needed[21], representing an 80% shortfall.

By comparison, it was estimated that almost $74 billion in total resources would be needed for addressing HIV and AIDS in LMICs between 2016 and 2018, so the shortfall of 22% was much smaller, though still significant.

> Funding of HIV programming for key populations at $1.3 billion was a mere fifth of the $6.8 billion needed, representing an 80% shortfall

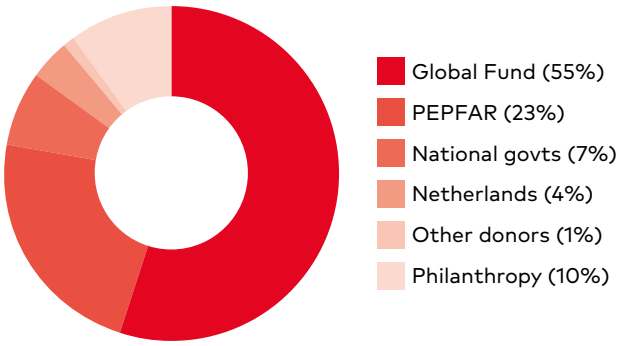
Within the context of a general shortfall of HIV funding, HIV programming for key populations is critically underfunded, dramatically undermining the global response. Getting on track to end the AIDS epidemic by 2030 requires major increases in funding for prevention and treatment programmes for key populations. To ensure effectiveness, and in line with World Health Organization (WHO) consolidated guidelines, such programmes should be led and delivered by key population organisations and communities themselves.

1.2 Major funders

The Global Fund: largest donor of HIV programming for key populations

Of the $1.3 billion spent in HIV programming for key populations from 2016 to 2018, $718.6 million (55%) was disbursed by the Global Fund, while PEPFAR contributed $305.7 million (23%). Private philanthropy accounted for $131.5 million (10%), followed by domestic public expenditure by LMIC governments of $93.2 million (7%). The Dutch government provided $56.1 million (4%) with other donor governments and multilateral institutions contributing $13.1 million (1%)[23].

Figure 1 - Total key population funding in LMICs, by funder type



As well as being the largest donor of HIV programmes for key populations, the Global Fund also contributed a larger percentage of its total funding disbursements between 2016 and 2018 to key populations. This amounted to 13.3% of the Global Fund's HIV spending in LMICs over those three years.

Table 2 - Total key population funding in LMICs, Global Fund

Year	Global Fund key population funding in LMICs	Total Global Fund HIV funding in LMICs[24]	Key population funding as % of total Global Fund HIV funding in LMICs
2016	$186.9m	$1,830m	10.2%
2017	$298.9m	$1,980m	15.1%
2018	$232.6m	$1,600m	14.5%
2016-2018	$718.6m	$5,410m	13.3%

In contrast to the Global Fund, PEPFAR contributes less than half of its funds to key population programming, though this increased significantly in 2018.

Although PEPFAR is the largest donor of the overall response to HIV in LMICs, it contributed a smaller amount than the Global Fund to specific programming for key populations between 2016 and 2018. This is both in actual dollars spent and as a percentage of its total HIV funding for LMICs (2.1%)[25]. Encouragingly, PEPFAR's overall expenditure on key population programming more than doubled in 2018. A considerable amount of that was not disaggregated by specific key populations, so may indicate funding across more than one of the population groups. At the same time, PEPFAR's funding for sex workers and gay and bisexual men declined between 2017 and 2018[26]. The United States government announced the establishment of a $100 million Key Population Investment Fund during the High-Level Meeting in 2016. However, the bulk of the implementation and expenditure of the fund took place from the financial year 2019 onwards, so it is not captured in this analysis.

Table 3 - Total key population funding in LMICs, PEPFAR

Year	PEPFAR key population funding in LMICs	Total PEPFAR HIV funding in LMICs[27]	Key population funding as % of total PEPFAR HIV funding in LMICs
2016	$66.9m	$4,380m	1.5%
2017	$67.3m	$5,230m	1.3%
2018	$171.4m	$5,140m	3.3%
2016-2018	$305.8m	$14,750m	2.1%

Few national governments report domestic public expenditure on key populations

Of the 70 LMICs that reported on domestic public expenditure for HIV programming between 2016 and 2018 only:

- 19 reported any funding for gay and bisexual men,
- 5 reported any funding for transgender people,
- 16 reported any funding for sex workers, and
- 19 reported any funding for people who inject drugs.

This lack of data makes it challenging to estimate how much governments in LMICs are spending on key population programming, as part of their national responses. Of those that did report, more than half ($50.1 million) of the total domestic public expenditure on key population HIV programming ($93.2 million) in LMICs came from India's public spending on gay and bisexual men in 2018. If this were removed, domestic public expenditure would amount to just $42.1 million. This is less than the total funding for key population HIV programming than philanthropy or the Dutch government, based on available data.

The low level of reporting of domestic public expenditure on key populations may indicate a general lack of investment and commitment for such programmes by national governments in LMICs. However, it is likely that some governments did fund programmes for key populations but did not report these through their National AIDS Spending Assessments. For example, according to Harm Reduction International's The Lost Decade[28] report, there was ten times as much domestic public expenditure on harm reduction ($48 million) in 2016, compared to what was reported by national governments that year ($5.1 million). Such discrepancies can in part be explained by the considerable work done by civil society organisations to fill the knowledge gap on domestic public expenditure. The thorough examination of national public budgets, programme tracking and other methods that informed The Lost Decade report is outside the scope of this report. This underlines the importance of disaggregating and reporting on domestic public expenditure by key populations, so that all actors in national, regional, and global responses have an accurate picture of resource availability for such critical programmes.

The Netherlands provided significant resources

The Dutch government's funding of the Bridging the Gaps Alliance and the PITCH partnership, as well as other initiatives meant it accounted for one in every twenty dollars spent of HIV programming for key populations. A few other donor governments funded key population programming during these three years, including through the Robert Carr Fund.

It is important to note that the shift toward funding the HIV response through multilateral mechanisms, particularly the Global Fund, in recent years means donor governments' contribution to key population programming in LMICs may be less explicit (as highlighted above).

Philanthropy prioritise funding for key populations programming

Private philanthropy contributed around 2% of the total resources for HIV in LMICs according to data from Funders Concerned About AIDS (FCAA)'s annual tracking report, Philanthropic Support to Address HIV/AIDS[29] for the years 2016 to 2018. In comparison, we found that philanthropy contributed 10% of total key population HIV programming in LMICs during this time, and more for transgender people (42%) and gay and bisexual men (17%). This highlights the important role that philanthropy plays in addressing the resource gap for key populations, particularly given that philanthropic funders often resource community mobilisation, advocacy, and capacity-building of key population-led organisations.

1.3 Funding by region

Investments do not reflect the disproportionate impact that HIV is having on key populations within regional epidemics.

Key populations experience a significant, and disproportionate HIV burden in every region of the world. HIV prevalence has increased in Eastern Europe and Central Asia in recent years, primarily because of new infections among key populations. Key populations and their sexual partners accounted for almost all recorded new infections (95%) in the Middle East and North Africa region in 2018, and more than half in Asia and the Pacific, Latin America, and Western and Central Africa. Just under half of new infections in the Caribbean were among key populations and their sexual partners in 2018. Key populations and their sexual partners accounted for a smaller percentage (25%) of new infections in Eastern and Southern Africa in 2018. However, available data suggests that key populations are still generally more at risk of acquiring HIV than the general population in the region.

In every region, the percentage of total HIV funding dedicated to programmes targeting key populations does not reflect the disproportionate burden they face. While the level of funding for key populations in each region is insufficient, the situation is particularly stark in Latin America. This region saw a 7% increase in new infections between 2010 and 2018. Key populations accounted for half of all new HIV infections in 2018 but received less than 1% (0.8%) spent between 2016 and 2018.

Similarly, in the Middle East and North Africa total HIV infections rose by 10% between 2010 and 2018, with key populations accounting for more than two-thirds of new infections in 2018. Yet, only 1.8% of HIV funding specifically targeted key populations between 2016 and 2018.

Table 4 - Combined key population infections and percentage of funding, by region

Region	Combined key population funding, 2016-2018	Combined key population % of region's new HIV infections[30], 2018	% of region's total HIV funding, 2016-18
Asia and the Pacific	$291.0m	53%	2.8%
Eastern Europe and Central Asia	$133.3m	70%	7.0%
Middle East and North Africa	$9.7m	67%	1.8%
Eastern and Southern Africa	$251.3m	15%	0.8%
Western and Central Africa	$148.4m	39%	2.4%
Caribbean	$37.9m	35%	4.4%
Latin America	$60.7m	50%	0.8%

1.4 Fast-Track priority countries

The key population funding gap is even greater in the low and middle-income Fast-Track priority countries than across all LMICs.

In 2016 UNAIDS identified 30 focus countries within the Fast-Track approach. These countries accounted for 89% of all new HIV infections at the time[31]. They were prioritised for scaled up testing, treatment and retention, strong reductions in new HIV infections and measures to combat discrimination.

Among the Fast-Track countries, 28 were classified as low and middle-income at the time (see table 1 in appendix 2 for the list of countries). Russia[32] and USA were the other two countries. A review of available country level HIV prevalence data found that with a few exceptions, HIV prevalence among key populations was significantly higher than the general population in the 28 low and middle-income Fast-Track priority countries[33]. Therefore, effectively addressing HIV among key populations in these countries was crucial to the overall aspirations of the Fast-Track approach.

Yet, the total recorded funding for key populations amounted to only 18% of what was estimated as being needed to deliver service packages for the four key population groups[34] in these 28 countries between 2016 and 2018. In half of the 28 countries, less than 50% of estimated resource needs were met[35].

Important that investments follow WHO guidelines

Ending the AIDS epidemic by 2030, and averting millions of new infections and AIDS-related deaths around the world, will only be achieved if HIV programmes led by and for key populations are adequately resourced. This was recognised by governments in the 2016 Political Declaration which stated "the meaningful involvement of people living with, at risk of and affected by HIV and populations at higher risk of HIV facilitates the achievement of more effective AIDS responses"[36]. Consequently, commitment was made by all Member States to:

- Ensure that at least 30% of all service delivery is community-led by 2030[37].

- Ensure that at least 6% of HIV resources are allocated for social enabling activities, including advocacy, community and political mobilisation, community-led 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[38].

Despite commitments to funding key population-led HIV responses[39] the lack of publicly available HIV resource data disaggregated by recipient makes it difficult to understand how far these targets are being achieved. It is difficult to assess how much of the limited resources for HIV programming for key populations analysed in this report flowed to key population-led interventions or to programmatic responses that were community driven. In addition, current data is not sufficient to analyse to what extent the funding spent on key populations is directed to human rights-based approaches in line with the WHO guidelines.

Contrary to WHO guidelines, evidence from civil society and donors suggests that funding for community-led organisations and responses contracted during the period. For example, almost half (46.7%) of civil society and community-based organisations from East and Southern Africa reported an overall decrease in their funding over the past three to five years[40]. In the same survey, conducted by the AIDS Rights Alliance of Southern Africa, only a third (33.3%) of organisations had seen an increase in funding.

According to UNAIDS: "communities are not being funded adequately, with international resources for community-led organisations shrinking and domestic funding mechanisms often inadequate".[41] Within the context of the urgent need for all domestic and international funders to scale up resourcing of HIV programming for key populations, it is crucial that priority is given to programming that is led by, and meaningfully involves, these groups.

Part 2 – Funding by key population

This chapter explores the funding picture in LMICs for each of the four key populations – gay and bisexual men, transgender people, sex workers and people who inject drugs – from 2016 to 2018.

Funding of HIV programmes for each of the key populations fell far short of what was required in the LMICs between 2016 and 2018. Only around a fifth of the funding needed was made available for HIV programming for gay and bisexual men, sex workers and transgender people. HIV programming for people who inject drugs only received 7% of what was needed.

2.1 Gay and bisexual men

The risk of acquiring HIV for gay and bisexual men was 22 times higher than for all adult men in 2018[42]. Nevertheless, programmes targeting this group received less than 1% of the amount spent on the overall HIV response, and less than 3% of all HIV prevention funding, in LMICs between 2016 and 2018.

As shown in table 5 below, $333.4 million was spent globally on HIV programming targeting gay and bisexual men between 2016 and 2018. Funding increased annually over the three years, though the rise between 2017 and 2018 is largely due to significant public expenditure on programmes for gay and bisexual men in India in 2018. Both the Global Fund and PEPFAR spent less on HIV programming for gay and bisexual men in 2018, than they did in 2017.

In 2018 gay and bisexual men accounted for an estimated 40% of new HIV infections in Latin America, 30% in Asia and the Pacific, 22% in the Caribbean, 22% in Eastern Europe and Central Asia, 18% in the Middle East and North Africa, and 17% in Western and Central Africa[43]. Yet, the amount spent on HIV programmes specifically targeting these men was 0.58% of total expenditure for the HIV response in LMICs between 2016 and 18.

0.58% of total expenditure for the HIV response in LMICs between 2016 and 18

Table 5 - Total HIV resources for gay and bisexual men in LMICs in 2016-2018, by funder

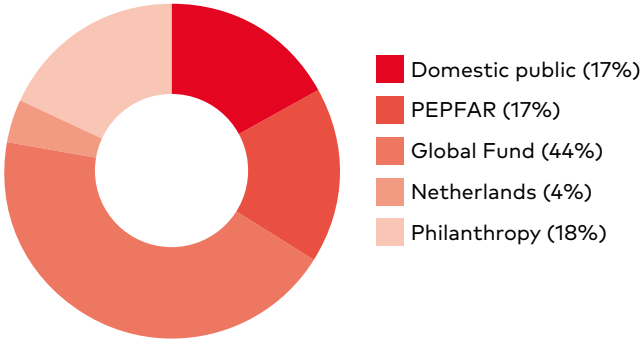
Year	Total	Domestic public	PEPFAR	Global Fund	Netherlands	Sweden	Philanthropy
2016	$76.4m	$3.8m	$19.1m	$30.4m	$3.6m	$0.3m	$19.1m
2017	$114.9m	$1.1m	$20.0m	$69.6m	$4.6m	0	$19.5m
2018	$143.1m	$52.4m	$16.5m	$48.5m	$5.0m	0	$20.8m
2016-2018	$333.4m	$57.2m	$55.6m	$148.6m	$13.2m	$0.3m	$59.4m

Major funders

Over the three years, the Global Fund was the largest funder of HIV programming for gay and bisexual men, although its funding dropped considerably in 2018.

The Global Fund accounted for just under half (44.6%) of all funding for gay and bisexual men between 2016 and 2018. Domestic public expenditure in LMICs, PEPFAR and philanthropy each accounted for just under one in every five dollars spent on HIV programming for gay and bisexual men, while the Dutch government contributed 4%.

Figure 2 - Funding for gay and bisexual men in LMICs in 2016-2018, by funder



CASE STUDY:
Addressing stigma and discrimination in the Middle East and North Africa through digital visibility

The Middle East and North Africa (MENA) has the highest level of criminalisation of same sex relations and behaviour than any other region in the world. With punishments ranging from one-year imprisonment to brutal capital punishment the community lives in fear. State supported persecution acts as a significant barrier to gay and bisexual men accessing HIV prevention, testing and treatment services. M-Coalition is one of the few regional advocacy networks specifically devoted to the needs of the LGBT community in the MENA region. It receives core funding from the Robert Carr Fund which helps address the criminalisation and stigma that fuels HIV among gay and bisexual men in the region. In 2017 M-Coalition participated in the Gay Star News Digital Pride campaign which provided an opportunity for individuals from around the world to celebrate Pride, particularly in areas where it is not possible to go out onto the streets.

Individuals from across the region submitted short videos discussing what they take pride in. Lesbians, gay and transgender people and allies from Lebanon, Syria, Morocco, Tunisia, Algeria, Egypt and Sudan featured in the video, which was viewed all over the world. M-Coalition received positive messages from LGBT community members from across the region stating that the video helped address their social isolation. The campaign highlighted the importance of funding digital visibility campaigns as a way of removing barriers that stop key populations from accessing the support they need. The video is an important advocacy tool which M-Coalition uses to demonstrate the existence and pride of the LGBT community in the Middle East and North Africa.

Funding by region

Investments fall short in every region

Funding for HIV programmes for gay and bisexual men was largest in Asia and the Pacific ($124.3 million). This was in large part due to the 2018 domestic public expenditure in India mentioned above (see table 6). If this funding is excluded, Eastern and Southern Africa had the most funding ($73.9 million) for HIV programmes for gay and bisexual men between 2016 and 2018. If we compare the percentage of overall funding of HIV programmes targeting gay and bisexual men between 2016 and 2018 with the percentage of new HIV infections in this group in 2018, it becomes clear that resources are not being

targeted effectively. For example, in Latin America, where overall infection rates are increasing, gay and bisexual men are by far the largest population group affected by the epidemic. Yet only one in every two hundred dollars spent responding to HIV in the region, is focused on them. Similarly, in Eastern Europe and Central Asia, which has the fastest growing regional epidemic, gay and bisexual men account for one in every five new infections, but receive only 1% of HIV funding.

Table 6 - Gay and bisexual men infections and percentage of funding, by region

Region	Gay and bisexual men funding, 2016-2018	% of region's new HIV infections, 2018	% of region's total HIV funding, 2016-18
Asia and the Pacific	$124.3m	30%	1.3%
Eastern Europe and Central Asia	$19.3m	22%	1.1%
Middle East and North Africa	$2.6m	18%	0.5%
Eastern and Southern Africa	$73.9m	4%	0.2%
Western and Central Africa	$40.4m	17%	0.7%
Caribbean	$20.3m	22%	2.4%
Latin America	$36.4m	40%	0.5%

Fast-Track priority countries

HIV programming for gay and bisexual men received only 20% of the resources needed in Fast-Track countries.

Between 2016 and 2018, the total reported resources for gay and bisexual men in the 28 Fast-Track priority LMICs amounted to $184.4 million, while UNAIDS estimated that a total of $944.6 million was needed to reach gay and bisexual men over those three years.

Limited data highlights the impact that the resource gap had on the provision of HIV prevention services and the Fast-Track response at country level. In Pakistan, gay and bisexual men accounted for almost 40% of all infections in 2018, yet resources allocated to them were less than 1% of the resources needed between 2016 and 2018. Only 1.3% of the population group reported receiving at least two prevention services in the past three months[44].

In Côte d'Ivoire, 12.2% of gay and bisexual men are living with HIV. More than one in five (22.6%) of these men reported that they avoided accessing healthcare because of stigma and discrimination. In this country only a third (34%) of the resource needs were met between 2016 and 2018 and less than two in five people received at least two prevention services in the past three months[45].

Although they accounted for around one in five of all infections in 2018, gay and bisexual men in Vietnam received only 18% of the funding needed for HIV programming. Less than one quarter of this population (24.7%) received at least two prevention services in the past three months[46].

See appendix 2, table 2 for a complete overview.

2.2 Transgender people

Transgender people are 12 times more likely to acquire HIV than the general adult population globally[47], yet the HIV response for this population in LMICs is particularly under-resourced.

UNAIDS estimates that transgender women accounted for around 1% of all new HIV infections globally in 2018[48]. Yet specific funding to address HIV among transgender people in LMICs totalled less than $40 million between 2016 and 2018 (see table 7). This means only 0.06% of total HIV expenditure in LMICs over the three years was specifically for HIV programming for transgender people.[49]

0.06% of total HIV expenditure in LMICs over the three years was specifically for HIV programming for transgender people.

Increasing policy and research is highlighting the urgent need to scale up targeted and specific resources for HIV prevention, treatment and care for transgender people across the world. At the same time, understanding the size of scale-up needed is hindered by lack of data, with very few governments providing any data on domestic spending on HIV programmes for transgender people. Additionally, PEPFAR and the Global Fund only started recording HIV expenditure on transgender communities, as a separate category from gay and bisexual men, in 2018[50].

Table 7 - Total HIV resources for transgender people in LMICs in 2016-18, by funder

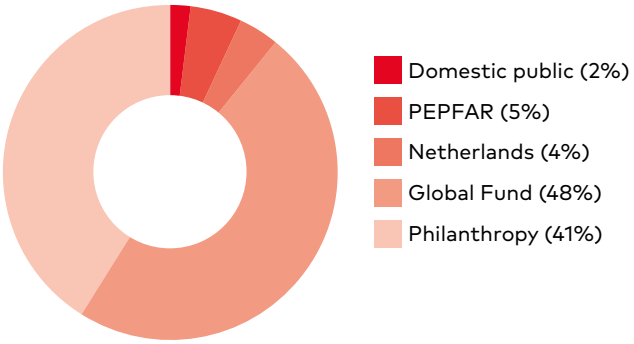
Year	Totals	Domestic public	PEPFAR	Global Fund	Netherlands	Philanthropy
2016	$8.9m	$0.6m	N/A	$3.3m	$0.4m	$4.6m
2017	$13.8m	$0.02m	N/A	$8.0m	$0.5m	$5.2m
2018	$13.5m	$0.07m	$1.7m	$5.9m	$0.6m	$5.2m
2016-2018	$36.3m	$0.6m	$1.7m	$17.2m	$1.5m	$15.2m

Major funders

Philanthropy has played a key role in resourcing HIV programming for transgender people.

Unlike the other key population groups, funding from philanthropy was almost equivalent to the Global Fund expenditure for transgender people HIV programming from 2016 and 2018. This highlights the leading role that philanthropy has played in supporting the emergence of a distinct HIV response for transgender communities. PEPFAR's apparent smaller contribution was due in part to the fact that it only commenced tracking transgender people as a distinct beneficiary of its programme expenditures in 2018.

Figure 3 - Funding for transgender people in LMICs in 2016-2018, by funder



CASE STUDY:
Global Fund transgender community monitoring in Guyana

Transgender people-led organisations, networks and their allies have worked creatively to increase the inclusion of transgender people within global HIV funding mechanisms, such as the Global Fund.

GATE, an international organisation working on gender identity, gender expression and bodily diversity issues, undertook an initiative to implement its "Global Fund Monitoring and Evaluation for Transgender Communities Tool". During a two-day capacity building and planning session with Guyana Trans United (GTU) the GATE project aimed to:

- improve understanding and ensure meaningful engagement of transgender people in Global Fund activities at the national level,
- strengthen capacity of national transgender people organisations and build peer-to-peer knowledge sharing,
- encourage evidence-based programmatic interventions and polices based on the needs of transgender people, and
- inform funding transition processes to preserve investments made in strengthening transgender communities.

Through the project, members of Guyana's transgender community identified priority areas for interventions to improve their health and wellbeing. These included repealing discriminatory legislation, challenging stigma and discrimination, addressing the lack of skills within the community, and improving access to comprehensive health and treatment.

To advocate for future Global Fund resourcing to address these priorities, GTU worked with GATE to apply for support from the Global Fund for technical assistance. This would enable the transgender community to act as a 'watch-dog' monitoring the community readiness model process. The application was successful, and the International Council of AIDS Service Organizations was appointed as technical advisor to support GTU in this monitoring role in 2019.

Funding by region

The data available at the regional level demonstrates how little resources are flowing to HIV programmes for transgender people in LMICs. This contrasts with the disproportionate impact that HIV is having on transgender communities.

Resources for HIV programming for transgender people were largest in Asia and the Pacific ($9 million), followed by Latin America and Eastern and Southern Africa (both $6.8 million) (see table 8). The historic invisibility and marginalisation of transgender communities within the global HIV response has resulted in a lack of data in some regions. This makes it impossible to accurately understand the level of HIV infections among transgender people. In regions where sufficient and accurate data is available, it is possible to see the significant disconnect between the HIV burden experienced by transgender people and the amount of resources dedicated to addressing HIV among this population.

It is estimated that more resources flow to HIV programmes for transgender people in Asia and the Pacific than any other region. However, while transgender women accounted for 1 in every 50 new HIV infections in 2018, just 0.09% of all HIV funding was for programming targeting transgender people. Likewise, 1 in every 20 people newly infected with HIV in the Caribbean in 2018 were transgender women, but fewer than one in every three hundred dollars were allocated to transgender people programming out of the total spent on the HIV response in the region.

Table 8 - Infections amongst transgender people and percentage of funding, by region

Funding for transgender people	Funding for transgender people, 2016-2018	% of region's new HIV infections, 2018[51]	% of region's total HIV funding, 2016-18
Asia and the Pacific	$9.0m	2%	0.09%
Eastern Europe and Central Asia	$2.0m	N/A	0.11%
Middle East and North Africa	$0.3m	N/A	0.05%
Eastern and Southern Africa	$6.8m	N/A	0.02%
Western and Central Africa	$2.0m	N/A	0.03%
Caribbean	$2.6m	5%	0.30%
Latin America	$6.8m	4%	0.09%

Fast-Track priority countries

As with funding across all LMICs, HIV programming for transgender people in the Fast-Track priority countries was significantly under-resourced. In total, just over 22% of the estimated resources needed for HIV programming for transgender people in the 28 Fast-Track LMICs was available over 2016 to 2018. In more than half of the countries, less than 50% of resource needs were met (see appendix 2, table 3).

Although data about the HIV response at the country level for transgender people is minimal, the data available does highlight the impact of the lack of funding. For example, although 5.5% of transgender people in Pakistan are living with HIV, only 6% of the estimated resource needs for HIV programming for transgender people from 2016 to 2018 was met. At the same time, data from a 2016 study showed that only 1 in 100 transgender people in Pakistan had received at least two prevention services in the past three months[52].

In Brazil, 30% of transgender people are living with HIV. However, reported resources for HIV programming for transgender people amounted to only 10% of the estimated resources needed. This contributed to less than 60% of the transgender community accessing any prevention services[53].

2.3 Sex workers[54]

In 2018 sex workers accounted for 6% of all new HIV infections globally. Their clients as well as sexual partners of other key populations account for another 18% of new infections. Yet programmes for sex workers received only 0.6% of all HIV expenditure and only 3% of estimated prevention funding in LMICs, between 2016 and 2018.

According to UNAIDS, sex workers are 21 times more likely to acquire HIV than the general adult population[55]. Yet, between 2016 and 2018, funding for HIV programming for sex workers in LMICs totalled only $356.7 million. While this was the highest of any key population group, it still represents a small fraction (0.6%) of total HIV expenditure ($57.3 billion) (see table 9).

Table 9 - Total HIV resources for sex workers in LMICs[56], by funder

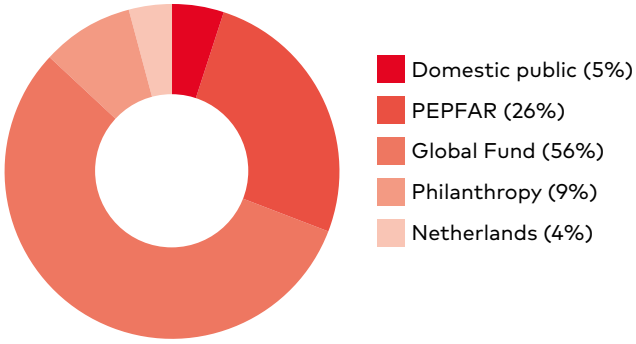
Year	Total	Domestic public	PEPFAR	Global Fund	Other donors	Netherlands	Philanthropy
2016	$123.6m	$8.4m	$30.8m	$67.8m	$0.4m	$3.0m	$13.2m
2017	$137.3m	$7.5m	$35.1m	$80.4m	0	$4.3m	$10.0m
2018	$95.8m	$0.4m	$27.9m	$52.9m	0	$5.5m	$9.1m
2016-2018	$356.7m	$16.2m	$93.9m	$201.0m	$0.4m	$12.8m	$32.3m

Major funders

The Global Fund was the leading funder of HIV programming for sex workers in 2016 and 2018.

The Global Fund was the largest source of funding for HIV programming specifically for sex workers (56% of all resources), providing more than double the amount of the next largest funder, PEPFAR (26%). Philanthropy was the third largest (9%), providing around twice as much as domestic public expenditure in LMICs and funding from the Dutch government.

Figure 4 - Funding for sex workers in LMICs in 2016-2018, by funder



CASE STUDY:
Nepal's sex worker-led clinic protecting health of its community

The sex worker-led organisation Society for Women Awareness Nepal (SWAN), in Kathmandu, has successfully advocated for and implemented the Sex Worker Implementation Tool (SWIT), including:

- building community empowerment,
- addressing violence against sex workers,
- promoting and providing community-led services,
- condom and lubricant programming, and
- clinical and support services.

SWAN provides sexual health clinical services to sex workers based on the SWIT principles. The clinic provides services such as sexually transmitted infections (STI) screening and treatment, HIV testing and pre and post diagnosis counselling. SWAN's clinic has their own lab for confirming HIV and STI tests. For HIV treatment, the clinic's service users are referred to a government hospital to collect their medication. Thanks to SWAN's counselling, and the safe space it offers for testing, the clinic enjoys 70% HIV treatment adherence. SWAN's clinic became an example of good practice for other community-led projects in Kathmandu, including Parichaya Samaj, one of LINKAGES' implementing partners in Nepal.

SWAN implemented the SWIT with support from the Asia Pacific Network of Sex Workers (APNSW). The roll out training was conducted in 2017 and follow up training and focus group discussions occurred through 2018 and 2019. These activities, alongside the technical support provided by APNSW to build SWAN's organisational capacity, were funded by the Robert Carr Fund through the Sex Worker Networks Consortium. The operation of SWAN's clinic is supported by FHI-360.

Funding by region

Addressing HIV within sex work is crucial to an effective HIV response in all regions. Yet, across each region, there is a dearth of specific funding for HIV programming for sex workers.

Eastern and Southern Africa received the largest proportion of funding for HIV programming for sex workers over 2016 to 2018, with Western and Central Africa, receiving the second most (see table 10). The gap between the rate of new infections among sex workers and the percentage of funding for HIV across each of the regions is telling. Sex workers accounted for 14% of all new HIV infections in 2018 in Western and Central Africa, but only 1.5% of all HIV expenditure in the region. One in every eight new HIV infections

in 2018 in Middle East and Northern Africa were among sex workers, yet only 1 in every 166 dollars was allocated between 2016 and 2018 specifically for HIV programmes targeting sex workers.

Table 10 - Sex worker infections and percentage of funding, by region

Region	Sex worker funding, 2016-2018	% of region's new HIV infections, 2018	% of region's total HIV funding, 2016-18
Asia and the Pacific	$62.0m	8%	0.6%
Eastern Europe and Central Asia	$22.5m	7%	1.3%
Middle East and North Africa	$3.2m	12%	0.6%
Eastern and Southern Africa	$141.0m	3%	0.5%
Western and Central Africa	$90.5m	14%	1.5%
Caribbean	$14.3m	6%	1.7%
Latin America	$16.4m	3%	0.2%

Fast-Track priority countries

Less than a fifth of funding needed for HIV programming for sex workers in the 28 Fast-Track LMICs was provided from 2016 to 2018.

The limited data available on prevention coverage for sex workers at country level indicates that the lack of resources hindered vital services for sex workers.

In South Sudan, where only 17% of estimated resource needs were met between 2016 and 2018, HIV prevalence among sex workers is 29.8% and only 16.3% reported receiving at least two prevention services in the past three months[57].

In Tanzania, 15.4% of sex workers are living with HIV but only one in five reported receiving at least two prevention services in the past three months[58]. Over 2016 to 2018, only 41% of resource needs for HIV programming for sex workers in the country were met.

In Brazil, the recorded expenditure on HIV programming for sex workers between 2016 and 2018 amounted to less than 1% of what was needed[59], even though 5.3% of all sex workers are living with HIV. At the same time, less than one-quarter (22.4%) reported receiving at least two prevention services in the past three months[60]. See appendix 2, table 4.

2.4 People who inject drugs

The risk of acquiring HIV for people who inject drugs is 22 times higher than for the general population, yet only 0.4% spent on HIV programming in LMICs in 2016 to 18 was focused on them.

Funding for programmes addressing HIV among people who inject drugs in LMICs totalled $243.5 million between 2016 and 2018. While 12% of all new infections in 2018 were attributed to people who inject drugs globally, only 0.4% of total HIV expenditure, and 2.1% of estimated prevention funding, over the three years to 2018 was specifically for HIV programming for people who inject drugs. Following a significant increase in funding from 2016 to 2017 for HIV programming for people who inject drugs, there was an equally significant drop between 2017 and 2018. This can largely be attributed to the considerable growth and then decline in Global Fund support (see table 11).

Table 11 - Total HIV resources for people who inject drugs in LMICs, by funder

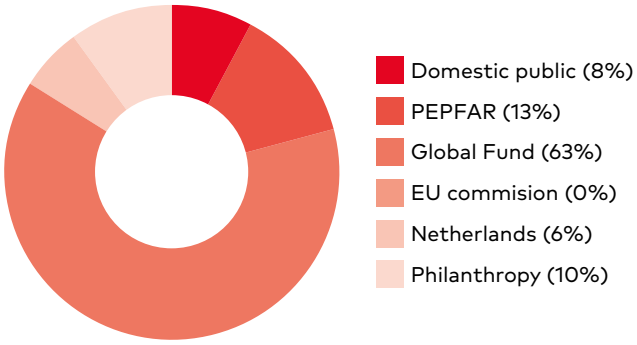
Year	Total	Domestic public	PEPFAR	Global Fund	Netherlands	EU Commission	Philanthropy
2016	$67.6m[61]	$5.1m	$12.3m	$36.9m	$3.4m	$1.1m	$8.8m
2017	$106.7m	$11.2m	$9.1m	$74.1m	$4.8m	$0.01m	$7.4m
2018	$69.3m	$2.8m	$10.0m	$42.8m	$5.2m	0	$8.4m
2016-2018	$243.5m	$19.1m	$31.4m	$153.8m	$13.5m	$1.1m	$24.6m

Major funders

The Global Fund was by far the largest funder of HIV programmes for people who inject drugs over 2016 to 2018.

Support from the Global Fund for programmes to address HIV among people who inject drugs represented almost two-thirds of all expenditure (63%) and was five times larger than the next biggest funder, PEPFAR (13%). Philanthropy and domestic public expenditure contributed similar levels (10% and 8% respectively), with the Netherlands providing slightly less (6%).

Figure 5 - Funding for people who inject drugs in LMICs in 2016-2018, by funder



CASE STUDY:
Drug user activists demand a more effective, rights-based drug policy

In recent years a growing number of authoritarian regimes and a rise in populism and right-wing extremism in some Eastern European and Central Asian countries has exacerbated the vulnerability of people who inject drugs and other marginalised groups. Tougher drug laws have been introduced and access to HIV prevention and harm reduction services has been further restricted. Networks of people who inject drugs in Belarus and Kyrgyzstan, with support from their regional and international partners, have succeeded in challenging the move towards more regressive drug policy in their respective countries. In February 2018, the International Network of People who Use Drugs, the Eurasian Network of People who Use Drugs, the Eurasian Harm Reduction Association and AFEW International trained community representatives from 11 EECA countries on the use of the Injecting Drug User Implementation Tool (IDUIT) in national contexts, as well as Global Fund processes.

Following the training, representatives of people who inject drugs on the Belarus Global Fund Country Coordinating Mechanism advocated for the diversification of substitution treatment in the funding application. As a result, buprenorphine is expected to be purchased under the Global Fund in Belarus in 2019. Further community-led advocacy has resulted in the Belarus Ministry of Health reintroducing provisions allowing for take-home self-administration of methadone in the national opioid substitution therapy treatment protocols.

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In Kyrgyzstan, the drug user community is increasingly mobilised to monitor the impact – and to challenge and participate in the formation – of new drug legislation, specifically in the context of inflated punitive interventions. Using the IDUIT, new proposals including community-led interventions have now been submitted for Global Fund funding, and a monitoring mechanism that documents the impacts of emergent drug legislation and policy has been implemented.

Funding by region

People who inject drugs accounted for the largest proportion of infections in Eastern Europe and Central Asia, and the Middle East and North Africa in 2018. Nevertheless, resources for the HIV programming for these people did not match the impact on their community.

Two in every five new HIV infections were among people who inject drugs in Eastern Europe and Central Asia in 2018. While considerable resources were allocated to address HIV among people who inject drugs, funding was still limited to only one in every twenty dollars of total HIV expenditure in the region.

A comparable level of disease burden is experienced by people who inject drugs in the Middle East and North Africa. Though the significant funding needed has yet to be allocated to specific programmes to address HIV among this key population group in this region. Less than 1% of all HIV expenditure in the MENA region between 2016 and 2018 was focused on people who inject drugs (see table 12).

Other regions face similar issues, particularly Eastern and Southern Africa where people who inject drugs represented 1 in 12 new HIV infections in 2018. However, an incredibly small proportion (0.1%) of all HIV expenditure in the region focused on this population. Many countries in Eastern Europe and Central Asia are transitioning from donor funding. Some governments are starting to use their own national budgets to increase funding for people who inject drugs and other key populations. However, this transition is fragile and needs to be carefully managed and monitored so that funding for people who inject drugs does not fall further behind. Punitive drug policies in these and other regions are major barriers to positive gains from allocated funding.

Table 12 - People who inject drugs infections and percentage of funding, by region

Region	People who inject drugs funding, 2016-2018	% of region's new HIV infections, 2018	% of region's total HIV funding, 2016-18
Asia and the Pacific	$95.6m	13%	1%
Eastern Europe and Central Asia	$89.5m	41%	5.1%
Middle East and North Africa	$3.6m	37%	0.7%
Eastern and Southern Africa	$29.7m	8%	0.1%
Western and Central Africa	$15.6m	8%	0.3%
Caribbean	$0.8m	2%	0.1%
Latin America	$1.1m	3%	0.01%

Fast-Track priority countries

The gap between estimated resources needed for HIV programming and what was provided in Fast-Track LMICs was largest for people who inject drugs

Funding for HIV programming for people who inject drugs in the 28 Fast-Track LMICs amounted to only 7% of what was needed. In other words, there was a staggering 93% shortfall of resources needed for HIV programming for people who inject drugs, according to available data. Examples at country level highlight how this undermines efforts to address the epidemic among people who inject drugs.

In Uganda, more than one in four (26.7%) people who inject drugs are living with HIV, yet only 8% of people who inject drugs reported receiving at least two prevention services in the past three months[62]. Between 2016 and 2018 only 7% of resources needed to address HIV among Ugandans who inject drugs was provided.

In Pakistan, where 21% of people who inject drugs are living with HIV, only 2% of resources needed were provided. Less than 2% of all people who inject drugs reported receiving at least two prevention services in the past three months[63].

Likewise, Viet Nam has an HIV prevalence of 11% among people who inject drugs. Only 28.2% of people who inject drugs reported receiving at least two prevention services in the past three months[64].

In the first three years of the Fast-Track strategy only a third of the resources needed, to address HIV among people who inject drugs, were available[65]. See appendix 2, table 5.

Recommendations for getting on track

This report shows that resources for HIV programmes for key populations, in the first three years of the Fast-Track approach, fell far short of what was needed. The unfolding impact of the COVID-19 pandemic threatens public health infrastructure in the short-term, and development assistance over the longer-term. We cannot allow this global crisis to further undermine funding of HIV programming for key populations. UNAIDS Executive Director, Winnie Byanyima said that "the COVID-19 pandemic must not be an excuse to divert investment from HIV."[66] This is particularly true for HIV programming for key populations.

Over the next decade, all major funders (LMIC governments, the Global Fund, PEPFAR, other donor governments and private philanthropy) can get the global AIDS response on track by adequately funding HIV programming for key populations. A significant increase in resources is needed now for HIV programmes for and led by key populations.

The targets set out by UNAIDS in the 2016 Political Declaration stipulate that at least 30% of all service delivery is community-led by 2030, and at least 6% of HIV resources are allocated for social enabling activities, including advocacy.

All major funders can get the global AIDS response on track by adequately funding HIV programming for key populations

Getting on track to end the AIDS epidemic by 2030 will mean:

1. **Increased investments: All major funders collectively invest the $36.49 billion needed for HIV programming for key populations, over the next decade.**
   In its Fast-Track investment case UNAIDS estimated that $36.49 billion is needed for HIV programming for key populations in LMICs over the next decade. The significant resource gap uncovered by this report can be addressed if all the major funders commit to collectively investing the $36.49 billion needed.

2. **Community driven interventions: All major funders commit to scaling up the proportion of their funding focused on community-led and community-based interventions.**
   Within the urgent need for all domestic and international funders to scale up resourcing of HIV programming for key populations, it is crucial that funders give priority to programming led by key population groups. Given their expertise and lived experience, and in line with the WHO consolidated guidelines, key population-led organisations should be funded to lead the implementation of HIV interventions. These include the delivery of prevention packages, HIV testing, policy, research, community mobilisation and capacity development.

3. **Enabling environments: All major funders commit to increasing the proportion of funding for advocacy and to support key populations to create enabling environments.**
   The WHO guidelines advise increased investment of at least 6% of overall funding for key populations for policy and law reform activities. Organisations and networks led by key populations must be adequately funded so they can lead advocacy aimed at creating safe and enabling environments. This is needed

urgently to decriminalise HIV transmission / exposure / non-disclosure, sex work, drug use, same-sex sexual behaviours, gender identities expression and to institutionalise gender equality, ending gender-based violence, and securing access to comprehensive sexual and reproductive health services. To ensure increased investments are effective, funding is needed to support advocacy and monitoring by key population communities and civil society.

4. **Target setting: UNAIDS leads global target setting on investments for HIV programming for and led by key populations.**
The dearth of funding available for key population HIV programming outlined in this report demonstrates that each of the major funders has an important role to play. To increase the total HIV expenditure on HIV programming for and led by key populations, it will be necessary to secure agreement from all the major funders (PEPFAR, the Global Fund, the Dutch Government and private foundations such as the Bill and Melinda Gates Foundation). UNAIDS should lead a process to agree targets for, or percentages of, funds directed to programming for and led by key populations.

5. **Transparency: All major funders make concerted and coordinated efforts to systematically disaggregate, track and make public, funding allocation and spending for key population HIV programming.**
This report was a first attempt to comprehensively track combined resource flows for HIV programming for and led by key populations in LMICs. Future tracking initiatives would benefit greatly from an increase in the availability and quality of data from donors on their funding activities. In particular:

   I. LMIC governments must report their domestic public expenditure for key population-led community responses and, if possible, for each of the four key population groups. As noted in the report, a main gap in data is LMIC government spending on key population programming, within their national responses. While the lack of data in some countries may indicate that key populations are not receiving any resources, in others it may simply be that spending is not being recorded or presented separately.

   II. Funding institutions should improve their capacity to disaggregate the resources reaching key population-led community responses and, if possible, for each of the key populations, by intervention. Although this may be difficult, particularly for the latter, funders should continue to work towards improving their expenditure monitoring processes to demonstrate how much of their funding for specific interventions is being directed towards key populations in LMICs. With key populations now accounting for more than half of all new infections globally, and HIV among these groups having a major influence on the characteristics of regional and national epidemics, the need for more detailed disaggregated data has never been greater. Related to this, in many countries population-size estimates for specific key populations are not available. This must be addressed to get greater clarity on the extent of resources needed to address HIV among key population groups.

   III. Donors and governments are encouraged to engage in discussions about intersectionality between different key population communities and how they might best reflect the complexity of intersectionality in resource tracking.

6. **Monitoring: UNAIDS systematically monitors resource flows of HIV programming for key populations, to inform and improve funding strategies and priorities across all donors and governments.**
Aidsfonds, supported by the key population partnerships Bridging the Gaps and PITCH, commissioned this mapping exercise. It was a first step to creating a better understanding about the funding landscape for HIV programming for key populations in LMICs. The findings highlight the current significant gap between resource needs and resource availability. Key to addressing this gap is having coordinated and credible ongoing monitoring of resource flows. This process should be led by UNAIDS or another credible actor within the global

AIDS response. Achieving this will require input, engagement and resources from the major funders of the global AIDS response. This work will need to be informed by the expertise and experience of key population networks, partnerships and organisations.

About us...

PITCH Partnership to Inspire, Transform and Connect the HIV response | aidsfonds | FRONTLINE AIDS | Ministry of Foreign Affairs

About the Partnership to Inspire, Transform and Connect the HIV response

The Partnership to Inspire, Transform and Connect the HIV response (PITCH) enables people most affected by HIV to gain full and equal access to HIV and sexual and reproductive health services.

The partnership works to uphold the sexual and reproductive health and rights of lesbian, gay, bisexual, and transgender people, sex workers, people who use drugs and adolescent girls and young women. It does this by strengthening the capacity of community-based organisations to engage in effective advocacy, generate robust evidence and develop meaningful policy solutions.

PITCH focuses on the HIV response in Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Vietnam and Zimbabwe. Partners in these countries also share evidence from communities to influence regional and global policies that affect vulnerable populations.

PITCH is a strategic partnership between Aidsfonds, Frontline AIDS and the Dutch Ministry of Foreign Affairs.

BRIDGING THE GAPS
Health and rights for key populations

About Bridging the Gaps

Bridging the Gaps is an alliance of nine international organisations and networks and more than 80 local and regional organisations in 15 countries, working towards the end of the AIDS epidemic among key populations. To get there we envision a society where sex workers, lesbian, gay, bisexual and transgender (LGBT) people and people who use drugs (PWUD), including those living with HIV, are empowered and have their human rights respected.

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INPUD International Network of People who Use Drugs | ITPC International Treatment Preparedness Coalition | MAINline | GNP+ Global Network of People Living with HIV | nswp

Appendix 1. Methodology

This analysis uses data from multiple sources. The methodology used for each source is outlined below.

Domestic Public Expenditure

A search was conducted of the UNAIDS' HIV Financial Dashboard[67] indicator on country level spending on key populations in LMICs. Total annual prevention programme expenditures[68] for each of these populations is disaggregated by funding source (domestic public expenditure, domestic private, and international expenditure). As information on the exact source of domestic private and international expenditure was not available, analysis from this data source was limited to mapping domestic public amounts. To avoid double counting international expenditure this data was taken from other sources listed below. If a country reported zero expenditure for a specific key population, this was included in the analysis as evidence that no domestic public money was spent on programmes for that key population in that year(s).

PEPFAR

Figures shown for PEPFAR are based on reported expenditures by PEPFAR funding recipients, contained within the excel sheet "PEPFAR Program Expenditures FY15-FY19". This document was downloaded from the PEPFAR data dashboards. A search of the excel sheet for the years 2016 to 2018 was conducted using the following filters:

- Sub-beneficiary:
  - Gay and bisexual men
  - Transgender people
  - People who inject drugs
  - Sex workers and clients of sex workers.

Within each of these filters, results were filtered by country/operating unit, and then each of the individual expenses were combined to establish total expenditure for the specific key population in that country/operating unit. Where individual expenses were marked as "Key Pops" being the beneficiary, but not then disaggregated by sub-beneficiary, these expenses were included in the total global figures for key population funding by PEFAR.

Global Fund

Analysis of Global Fund resourcing was based on data submitted by the Community, Rights and Gender team at the Global Fund. The data was based on expenditures for the 2016 to 2018 period, disaggregated by country and multi-country grant. The expenditures included were those that the Global Fund had identified as key population-related for that country/multi-country grant. Only those that could be specifically disaggregated by each of the four key populations were included in the final analysis by key population group. Expenditures that were identified by the Global Fund as key population-related but not disaggregated by key population groups were included in the total global figures for key population funding by the Global Fund.

As the Global Fund only began marking funding for transgender communities as distinct from gay and bisexual men in 2018, figures for 2016 and 2017 were included as "comprehensive prevention for MSM and TG". To provide a more accurate breakdown of these amounts between gay and bisexual men and transgender people, it was decided in consultation with the Global Fund, that the 2016 and 2017 totals for comprehensive prevention would be divided 90% for gay and bisexual men, and 10% for transgender people. This breakdown was based on the ratio of funding for gay and bisexual men and funding for transgender people from the Global Fund in 2018, when the two populations were counted separately. While this means for some grants

the actual expenditure levels for the two populations was either over or under-estimated, it was agreed that taking this ratio as an average across the full Global Fund portfolio was the best way to achieve a reasonable estimate of total funding levels for both population groups.

Other donor governments

A search was conducted of data reported by major donor governments and the EU (aside from the US and the Global Fund) to the International Aid Transparency Initiative (IATI). The search focused on the sector – "STD Control Including HIV/AIDS (13040)" and used a key word search of the following terms that donors may have used to describe the four key populations when submitting to the IATI.

Population	Search Term
Key populations	Key populations, Most at risk populations, MARPS Vulnerable population
Men who have sex with men	MSM, men who have sex with men, gay, homosexually active
Transgender people	Transgender, trans, TG, FTM, MTF
Sex workers	Sex worker, FSW, MSW, commercial sex worker, CSW
People who inject drugs	People who inject drugs, people who use drugs, PWID, PWUD, IDU, harm reduction

Where any of these terms were found, a review of the grant information including title and description helped determine whether it could be included in the analysis. Only grants that explicitly mentioned one or more of the key populations were included, and in the few instances where two key populations were the focus of a grant, the total grant amount was split 50/50. For grants that specifically focused on key populations, but did not disaggregate, the amount was included in the total global figure only.

Only disbursements made in 2016, 2017 or 2018 were included and amounts reported in currencies beside US dollars were converted based on year end exchange rates using https://www.ofx.com/en-au/forex-news/historical-exchange-rates/.

Data submitted by Aidsfonds for the Bridging the Gaps and PITCH expenditures for 2016 to 2018 was used to estimate key population funding by the Dutch government, as the funder of both partnerships. Data was presented at the country and general coordination levels. Where data could be disaggregated by the four key population groups, it was included in the funding analysis per each of the key population groups. Following consultation with Aidsfonds, in the case of expenditure marked "LGBTI", the same ratio was applied for allocating that funding between gay and bisexual men and transgender people as for the Global Fund above. Where expenditure for the two partnerships was not disaggregated for one of the key population groups i.e. for cross-cutting project coordination or research, it was included in the totals for the global figures.

In addition, data submitted by the Robert Carr Fund (RCF) on donor sources for 2016 to 2018 was also included to track contributions from major donor governments. The Bill and Melinda Gates Foundation, which funds the RCNF, was excluded as its funding is included in the Funders Concerned About AIDS (FCAA) philanthropic tracking data discussed below. As this data could not be disaggregated by the four key population groups, the contribution by donor governments was included in their totals for the global figures, but not for the funding analysis per each of the key population groups.

Philanthropy

Data was provided by FCAA, drawn from the submissions received from private philanthropy as part of their annual tracking report. The data was disaggregated by each of the key populations, and at the country, regional and multi-country

level. It is important to note for the grant submissions that FCAA receives, where more than one key population group is included within an individual grant, FCAA includes the full amount of that grant for each key population group. As there has historically been and continues to be, a conflation of gay and bisexual men and transgender people within HIV programming, specific attention was paid to separating out these two population groups. Where both gay and bisexual men and transgender people were included as priority populations, the total grant amount was divided 90%/10% following the ratio used for the Global Fund described above.

There were likely also some instances within the grants data that FCAA received and shared for this research, where other key population groups overlapped (i.e. sex workers and transgender people or people who inject drugs and sex workers). It was outside the scope of this report to develop an appropriate methodology for attributing a portion of the grant total between the relevant population groups. Therefore, the full amount of such grants was attributed to each of the population groups covered. This means that the total philanthropic support for key populations in LMICs may be overestimated.

Additional data was received from the Global Philanthropy Project and Funders for LGBTQ Issues, drawn from their 2015-16 Global Resources Report: Government and Philanthropic Support for Lesbian, Gay, Bisexual, Transgender and Intersex Communities and 2017-2018 Global Resources Report, which set out HIV funding for gay and bisexual men and transgender people at the country and regional level in 2015 to 2018, excluding funding focused on the US. As the Global Resources Report includes inputs from FCAA's tracking, these were excluded from the data received from the Global Philanthropy Project to avoid double counting. Further, the Global Resources Report includes funding from donor governments and multilateral funders, which was excluded in this analysis to avoid double-counting. Where both gay and bisexual men and transgender people were included as priority populations, the total grant amount was divided 90%/10% following the ratio used for the Global Fund (above).

Appendix 2. UNAIDS resource needs estimates

In reviewing the tables below, it is important to consider a few things. First, the UNAIDS Fast-Track resource needs estimates were calculated by multiplying the size of the target population by the coverage (the percentage reached with the intervention) and the unit cost (the cost to provide the service to one person for one year). The unit cost of delivering the specific key population service package or PrEP was based on a calculation of the most efficient and cost-effective means of doing so and does not include overhead or programme management costs. However, some of the funders that were analysed within the report may include such costs within their reported expenditures.

Second, while a higher level of expenditure for key populations in a country, in comparison to the estimated resource needs, suggests a higher level of investment and donor attention, it does not necessarily translate to the most effective and efficient availability of resources to respond to the HIV epidemic for that population in that context. In such instances, there is a need for further investigation of whether quality services are being delivered and adequate service coverage is being achieved. Finally, the lack of consistency and availability of key population size estimates in various contexts may mean that some of the resource needs estimates may be lower than what is needed to reach the target population group effectively and efficiently.

Table 1 - Key population HIV funding in Fast-Track priority LMICs

Fast-Track LMICs	Total HIV funding for key populations, 2016-2018	UNAIDS Fast-Track resource needs estimates 2016-18	% of resource need met
Angola	$5.4m	$29.9m	18%
Brazil	$2.2m	$129.4m	2%
Cameroon	$13.2m	$9.9m	133%
Chad	$0.7m	$6.3m	11%
China	$1.7m	$702.6m	0.2%
Cote d'Ivoire	$8.0m	$5.3m	151%
DRC	$13.3m	$74.8m	18%
Eswatini	$2.8m	$2.2m	132%
Ethiopia	$16.4m	$97.2m	17%
Haiti	$9.3m	$75.6m	12%
India	$85.3m	$119.9m	71%
Indonesia	$34.6m	$846.2m	4%
Iran	$1.9m	$87.2m	2%
Jamaica	$7.5m	$8.7m	86%
Kenya	$56.6m	$36.1m	157%
Lesotho	$6.1m	$3.1m	196%
Malawi	$18.6m	$11.1m	167%
Mozambique	$13.6m	$60.5m	23%
Nigeria	$52.6m	$14.2m	369%
Pakistan	$9.6m	$671.8m	1%
South Africa	$62.5m	$68.2m	92%
South Sudan	$6.3m	$22.8m	28%
Tanzania	$24.8m	$39.9m	62%
Uganda	$23.8m	$10.2m	233%
Ukraine	$42.1m	$128.6m	33%
Viet Nam	$59.1m	$134.5m	44%
Zambia	$20.5m	$16.9m	121%
Zimbabwe	$16.4m	$29.9m	55%
Total	**$615.2m**	**$3,443m**	**18%**

Table 2 - Gay and bisexual men funding in Fast-Track priority LMICs

Fast-Track LMICs	Total HIV funding, gay and bisexual men 2016-2018	UNAIDS Fast-Track resource needs estimates 2016-18	% of resource need met
Angola	$0.5m	$4.9m	10%
Brazil	$2.0m	$26.9m	7%
Cameroon	$3.2m	$0.8m	400%
Chad	0	$1.5m	0%
China	$1.1m	$73.7m	1%
Cote d'Ivoire	$1.5m	$4.4m	34%
DRC	$4.2m	$18.9m	22%
Eswatini	$0.2m	$0.5m	43%
Ethiopia	$0.02m	$14.1m	Less than 1%
Haiti	$2.5m	$5.7m	44%
India	$66.5m	$19.2m	346%
Indonesia	$8.0m	$501.2m	2%
Iran	0	$78.5m	0%
Jamaica	$4.5m	$4.3m	105%
Kenya	$19.6m	$1.3m	1,500%
Lesotho	$0.7m	$1.2m	58%
Malawi	$2.3m	$5.4m	43%
Mozambique	$2.9m	$12.3m	24%
Nigeria	$17.3m	$1.7m	1,017%
Pakistan	$0.4m	$71.7m	Less than 1%
South Africa	$24.5m	$22.3m	110%
South Sudan	$0.7m	$1.5m	47%
Tanzania	$3.7m	$4.6m	80%
Uganda	$26m	$0.5m	5,200%
Ukraine	$4.7m	$22.0m	21%
Viet Nam	$6.0m	$33.8m	18%
Zambia	$3.3m	$11.4m	29%
Zimbabwe	$1.3m	$0.1m	1,300%
Total	**$184.4m**	**$944.6m**	**20%**

Table 3 - Funding for transgender people in Fast-Track priority LMICs

Fast-Track LMICs	Total HIV funding, transgender people 2016-2018	UNAIDS Fast-Track resource needs estimates 2016-18	% of resource need met
Angola	$0.03m	$0.2m	15%
Brazil	$0.2m	$2.2m	10%
Cameroon	$0.2m	$0.04m	500%
Chad	0	$0.07m	0%
China	$0.08m	$4.5m	2%
Cote d'Ivoire	$0.02m	$0.2m	10%
DRC	$0.5m	$0.9m	56%
Eswatini	$0.004m	$0.03m	13%
Ethiopia	0	$10.9m	0%
Haiti	$0.1m	$1.1m	9%
India	$0.9m	$3.0m	30%
Indonesia	$2.0m	$17.4m	11%
Iran	0	$3.9m	0%
Jamaica	$0.8m	$0.2m	400%
Kenya	$1.2m	$2.3m	52%
Lesotho	$0.05m	$0.06m	83%
Malawi	$0.7m	$0.4m	175%
Mozambique	$0.03m	$0.6m	5%
Nigeria	$0.2m	$0.08m	250%
Pakistan	$0.2m	$3.6m	6%
South Africa	$2.4m	$0.2m	1,200%
South Sudan	$0.07m	$0.08m	88%
Tanzania	$0.1m	$0.2m	50%
Uganda	$0.4m	$0.03m	1,333%
Ukraine	$0.4m	$1.1m	36%
Viet Nam	$5.0m	$1.2m	42%
Zambia	$0.7m	$0.6m	117%
Zimbabwe	$0.3m	$0.006m	5,000%
Total	**$11.9m**	**$55.2m**	**22%**

Table 4 - HIV resources for sex workers in Fast-Track priority LMICs

Fast-Track LMICs	Total HIV funding, sex workers 2016-2018	UNAIDS Fast-Track resource needs estimates 2016-18	% of resource need met
Angola	$1.6m	$14.4m	11%
Brazil	$0.08m	$9.3m	Less than 1%
Cameroon	$4.7m	$0.9m	522%
Chad	$0.7m	$0.2m	350%
China	$0.4m	$231.1m	Less than 1%
Cote d'Ivoire	$1.8m	$0.6m	300%
DRC	$5.0m	$47.2m	11%
Eswatini	$0.8m	$1.4m	57%
Ethiopia	$16.4m	$3.4m	482%
Haiti	$2.6m	$20.8m	13%
India	$3.1m	$66.9m	5%
Indonesia	$10.1m	$178.6m	6%
Iran	$0.3m	$5.7m	5%
Jamaica	$0.9m	$1.9m	47%
Kenya	$14.1m	$28.2m	50%
Lesotho	$1.2m	$09m	133%
Malawi	$2.0m	$1.5m	133%
Mozambique	$5.2m	$22.6m	23%
Nigeria	$15.0m	$5.9m	254%
Pakistan	$0.005m	$28.8m	Less than 1%
South Africa	$22.3m	$43.6m	51%
South Sudan	$2.3m	$13.2m	17%
Tanzania	$8.7m	$21.0m	41%
Uganda	$5.0m	$0.9m	555%
Ukraine	$2.8m	$30.1m	9%
Viet Nam	$3.9m	$11.3m	35%
Zambia	$3.7m	$1.6m	231%
Zimbabwe	$3.1m	$0.2m	1,550%
Total	**$137.7m**	**$792.3m**	**17%**

Table 5 - HIV resources for people who inject drugs in Fast-Track priority LMICs

Fast-Track LMICs	Total HIV funding, people who inject drugs 2016-2018	UNAIDS Fast-Track resource needs estimates 2016-18	% of resource need met
Angola	0	$10.4m	0%
Brazil	0	$91.0m	0%
Cameroon	$0.2m	$8.2m	2%
Chad	0	$4.5m	0%
China	$0.1m	$393.3m	Less than 1%
Cote d'Ivoire	$0.4m	$0.04m	1,000%
DRC	$0.1m	$7.7m	1%
Eswatini	0	$0.3m	0%
Ethiopia	0	$68.7m	0%
Haiti	0	$48.0m	0%
India	$8.9m	$30.7m	29%
Indonesia	$6.5m	$149.0m	4%
Iran	$1.6m	$77.6m	2%
Jamaica	$0.2m	$2.2m	9%
Kenya	$14.7m	$4.3m	342%
Lesotho	0	$1.0m	0%
Malawi	$0.002m	$3.8m	Less than 1%
Mozambique	$0.4m	$25.0m	2%
Nigeria	$12.7m	$6.5m	195%
Pakistan	$8.9m	$567.6m	2%
South Africa	$4.1m	$2.1m	195%
South Sudan	0	$8.0m	0%
Tanzania	$5.5m	$14.1m	38%
Uganda	$0.6m	$8.7m	7%
Ukraine	$30.6m	$75.5m	41%
Viet Nam	$27.9m	$88.2m	32%
Zambia	$0.3m	$3.3m	9%
Zimbabwe	$0.2m	$0.5m	40%
Total	**$124.0m**	**$1,700.3m**	**7%**

Appendix 3. Endnotes

1 Both partnerships are funded by the Dutch Ministry of Foreign Affairs. Bridging the Gaps is a joint initiative of AFEW International, COC Netherlands, GNP+, INPUD, ITPC, Mainline, MPact, NSWP and Aidsfonds. PITCH, the Partnership to Inspire, Transform and Connect the HIV response, is an initiative of Frontline Aids and Aidsfonds.
2 United Nations, General Assembly, Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, A/RES/70/266 (22 June 2016), annex.
3 UNAIDS (2015), Understanding Fast-Track: Accelerating Action to End the AIDS epidemic by 2030: https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf.
4 UNAIDS prioritises gay and bisexual men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people as the 5 main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services. As the work of the Bridging the Gaps and PITCH partnerships centres on the first 4 of these groups, they are the focus of this report. Further, this report focuses on people who inject drugs as a population group rather than the broader group of people who use drugs, as it follows the classification used by UNAIDS.
5 Both partnerships are funded by the Dutch Ministry of Foreign Affairs. Bridging the Gaps is a joint initiative of AFEW International, COC Netherlands, GNP+, INPUD, ITPC, Mainline, MPact, NSWP and Aidsfonds. PITCH, the Partnership to Inspire, Transform and Connect the HIV response, is an initiative of Frontline Aids and Aidsfonds.
6 As defined in the World Bank's FY2019 country income classifications: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.
7 In interpreting the Fast-Track resource needs estimates referenced in this report, it is important to consider a couple of issues. See Annex 2 for these considerations. Population size estimates in various contexts may mean that some of the resource needs estimates may be lower than what is needed to reach the target population group effectively and efficiently.
8 There are several previous and ongoing research projects focused on tracking funding for HIV programming for various key populations that this project seeks to build on. These include: Harm Reduction International, (2018), The Lost Decade: Neglect for harm reduction funding and the health crisis among people who use drugs, https://www.hri.global/files/2018/09/25/lost-decadeharm-reduction-funding-2018.PDF ; Mama Cash, Red Umbrella Fund & the Open Society Foundations, (2014), Funding for Sex Worker Rights: Opportunities for Foundations to fund more and better, https://www.redumbrellafund.org/wp-content/uploads/2017/10/Report_funding-sex-worker-rights_FINAL_WEB.pdf ; Global Philanthropy Project and Funders for LGBTQ Issues, Global Resources Report: Government and Philanthropic Support for Lesbian, Gay, Bisexual, Transgender and Intersex Communities (bi-annual tracking report), https://globalresourcesreport.org; Funders Concerned About AIDS, Philanthropic Support to Address HIV/AIDS in 2018 (annual tracking report), https://www.fcaaids.org/what-we-do/research/resource-tracking-report/.
9 This report focuses on gay and bisexual men and transgender people as two of the key population groups as defined by UNAIDS, based on existing HIV epidemiology. It is important to recognise that these key population groups are often part of a broader group that encompasses lesbian, bisexual and intersex communities as well as other diverse sexualities and genders. Greater attention to understanding the HIV epidemic among these other groups within LGBT communities in LMICs may facilitate an increase in resources being directed to addressing HIV among these groups, as well as other diverse sexualities and genders.
10 UNAIDS, (2019), UNAIDS Data 2019, page 5: https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data.
11 From all major funders.
12 Major funding sources includes domestic public expenditure, PEFAR, Global Fund, other bilateral sources and private philanthropy.
13 This figure is based on available data.
14 See UNAIDS Financial Dashboard, indicator "Trends in resource availability for HIV": http://hivfinancial.unaids.org/hivfinancialdashboards.html#.
15 See note 14, above.
16 This figure is based the UNAIDS 2016 estimate that approximately 20% of total HIV expenditure in LMICs is for HIV prevention. Source: UNAIDS (2016), Prevention Gap Report, page 12. https://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf
17 As all figures in the report have been rounded to one decimal place, there may be small discrepancies between the total funding amounts found in the analysis as presented and the total that would be gathered from adding each of the individual rows or columns in a particular table.
18 See note 16, above.
19 UNAIDS, (2016), Fast-Track: Update on Investments Needed in the AIDS Response: https://www.unaids.org/en/resources/documents/2016/unaids_fast-track_update_investments_needed. For a detailed description of the analysis informing the UNAIDS document, see Stover J, Bollinger L, Izazola JA ,Loures L, DeLay P ,Ghys P D , et al. (2016) What Is Required to End the AIDS Epidemic as a Public Health Threat by 2030? The Cost and Impact of the Fast-Track Approach. PLoSONE11(5):e0154893. doi:10.1371/ journal.pone.0154893.
20 See note 19 above, Stover J et al (2016), page 9.
21 The gap between resource availability and need may be an underestimation, given that some information was available from a number of the funder data sources for expenditure of other interventions besides those included in the UNAIDS calculation of resource needs for key population service packages i.e some figures on HIV testing, provision of HIV drugs and social enablers. Such interventions were counted in the total figure on expenditure for the 4 key population groups in LMICS between 2016-2018.
22 See note 19, above.
23 Contributions made by government and multilateral donors to the Global Fund were excluded from their total, in order to avoid double counting. Further, it would not be possible to disaggregate the overall contribution by each of the Global Fund donors by key populations.
24 UNAIDS Financial Dashboard, indicator "Trends in resource availability for HIV by funding source": http://hivfinancial.unaids.org/hivfinancialdashboards.html#.
25 It is important to note that the United States Government is the largest funder of the Global Fund, with the Department of State, Foreign Operations, and Related Programs Appropriations Act, 2020, appropriating $1.560 billion for a U.S. government contribution to the Global Fund. Since 2004, the United States has contributed $15.4 billion to the Global Fund, comprising 32.5% of all donor contributions. As mentioned in note 23 above, this contribution to the Global Fund is not included within the analysis of key population spending by PEPFAR/the United States.
26 As noted in the methodology section above, it is important to recognise that some funders such as the Global Fund and PEPFAR operate on 3-year budget cycles, which may explain fluctuations in expenditure from year to year.
27 See note 24, above.
28 See note 8, above.
29 Funders Concerned About AIDS, (2017), Philanthropic Support to Address HIV/AIDS in 2016, page 9; Funders Concerned About AIDS, (2018), Philanthropic Support to Address HIV/AIDS in 2017, page 10; Funders Concerned About AIDS, (2019), Philanthropic Support to Address HIV/AIDS in 2018, page 10. All available: https://www.fcaaids.org/what-we-do/research/resource-tracking-report/.
30 Does not include percentage of new infections attributed to the sexual partners of key populations. Source: UNAIDS, see note 10 above.
31 See note 3 above, page 7.
32 Russia has since been re-classified as an upper middle-income country.
33 HIV prevalence rates for gay and bisexual men were around the same as the general population in Malawi (7% vs 9.2%) and South Africa (18.1% vs 20.4%), and about half the rate in Eswatini (12.6% vs 27.3%).
34 See note 19, above.
35 See note 19, above.
36 See note 1, above.
37 See note 1, above.
38 See note 1, above.
39 WHO, (2014). Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations. https://apps.who.int/iris/bitstream/handle/10665/128048/9789241507431_eng.pdf;jsessionid=7E221D614A0D01B-6206BCC6939C5763D?sequence=1
40 ARASA, Expanding Needs, Diminishing Means, page 5 (forthcoming publication).
41 UNAIDS, (2019), World AIDS Day 2019 Brief: Communities Make the Difference, page 2: https://www.unaids.org/en/resources/documents/2019/world-aids-day-2019-communities-make-the-difference.
42 See note 10, above, page 9.
43 Although a smaller percentage (4%), gay and bisexual men in eastern and southern Africa were still disproportionately affected. See note 10, above, page 9.
44 See note 10, above, page 191.
45 See note 10, above, page 105.
46 See note 10, above, page 207.
47 See note 10, above, page 9.
48 See note 10, above, page 10.
49 It is important to note that epidemiological data on HIV among transgender communities is primarily focused on transgender women, with transgender men, non-binary people and other genders largely excluded from such research. While there was not consistency in disaggregation by gender of the HIV transgender funding data reviewed as part of this research, it is fair to assume that such funding was largely directed towards HIV programming for transgender women.
50 See Appendix 2 – Methodology for an explanation of how estimates of funding for transgender people, distinct from gay and bisexual with men, have been made.
51 All figures are for transgender women only.
52 See note 10, above, page 191.
53 See note 10, above, page 227.
54 The data on funding for HIV programmes for sex workers as well as the HIV epidemiology data referred to in this report is inclusive of sex workers of all genders. None of the funding data sources disaggregated sex worker funding data by gender. Likewise, the epidemiological data drawn from UNAIDS was not separated out by gender.
55 See note 10, above, page 9.
56 Some of the funder totals include programmes targeting clients of sex workers.
57 See note 10, above, page 65.
58 See note 10above, page 69.
59 It is important to note that there was no available data on domestic public expenditure on HIV programmes for key populations between 2016-2018 in Brazil, which means that this figure is likely an underreporting of the actual expenditure on HIV programming for sex workers in the country over those 3 years.
60 See note 10 above, page 227.
61 The total amount found in this analysis for HIV programming for people who

inject drugs in LMICs in 2016 differs considerably from the amount reported in the Lost Decade report by Harm Reduction International on total funding for harm reduction in LMICs in 2016 ($188m). There is likely a few reasons for this: a) the scope of the Lost Decade project meant that original data submissions and follow up interviews and correspondence with a broader number of funders was possible, which may have facilitated more detailed and comprehensive data on funding levels; b) researchers for the Lost Decade project were able to look at a broader range of sources to analyse national government expenditure on harm reduction, then was possible in this project; c) there have been improvements in data collection and transparency by the Global Fund and PEPFAR on key population funding in the last few years. The Global Fund was able to provide expenditure figures by key population, rather than allocations and PEPFAR has introduced a new expenditure reporting and financial classification system, which enabled greater detail on the disaggregation by key population of expenditure figures. These changes since the Lost Decade research have resulted a significantly reduced estimate in this report for both major funders; and, d) the data analysed in this report is limited to HIV programming for people who inject drugs, whereas the Lost Decade has a broader focus on harm reduction, which includes HIV programming but may also include other funded projects that are not specifically tagged by funders as related to HIV.

62 See note 10, above, page 67.

63 See note 10 above, page 191.

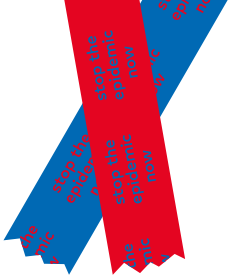
64 See note 10, above, page 207.

65 According to the Lost Decade report, more than $10m was spent by the Vietnamese Government on harm reduction in 2016, based on analysis conducted by Harm Reduction International and Vietnamese consultants. Therefore, it is likely that the actual expenditure in Viet Nam for people who inject drugs over 2016-2018 as a percentage of resources needed was higher than was discovered through this research.

66 UNAIDS, (2019), The cost of inaction: COVID-19-related service disruptions could cause hundreds of thousands of extra deaths from HIV (press release): https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/may/20200511_PR_HIV_modelling.

67 The UNAIDS' HIV Financial Dashboard brings together more than 85 different indicators on HIV funding based on data reported by governments through the Global AIDS Monitoring framework as part of their commitments under the 2016 Political Declaration to End AIDS.

68 While the indicator in the dashboard does not explicitly state that the expenditure is for prevention, the information submitted by governments is for sub-indicator 8. 1E (expenditure on the 5 pillars of combination prevention) of the Global AIDS Monitoring framework, which includes the pillar of "prevention among key populations".



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