Dangerously Off Track

How Funding for The HIV Response is Leaving Key Populations Behind

Love Alliance
Together for health and human rights

aidsfonds

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Acknowledgements

This report was commissioned by Aidsfonds through the Love Alliance. The Love Alliance is supported by the Dutch Ministry of Foreign Affairs under Dutch development and brings together national thought leaders, GALZ, SANPUD, and Sisonke, regional grantmakers UHAI EASHRI, ARASA, and ISDAO, with the Global Network of People Living with HIV (GNP+) and the Netherlands-based administrative lead Aidsfonds.

The report was researched and written by Shannon Kowalski, with the support of many people to ensure its quality and completeness. Julia Lukomnik (Aidsfonds) coordinated the research and provided overall guidance on methodology and approaches. We deeply appreciate the support of the members of the co-creation committee, who provided invaluable guidance on methodology and key messages, and provided insightful feedback throughout the process. They include Judy Chang (International Network of People Who Use Drugs – INPUD), Cedric Nininahazwe (Global Network of People Living with HIV – GNP+), Anwar Ogrm (Global Action for Trans Equality – GATE), and Jules Kim (International Network of Sex Work Projects – NSWP).

We would also like to thank the many people who contributed throughout the research by providing data, reviewing the report, and providing advice. These include Catherine Cook, Charlotte Davies, Colleen Daniels, and Gaj Gujurang (Harm Reduction International), Caterina Gironda (Funders Concerned About AIDS), Matteo Cassolato, Aura Frangioni, Susie McLean, Maria Phelan, and David Traynor (the Global Fund to Fight AIDS, Tuberculosis and Malaria), Erika Castellanos (GATE), Jolijn van Haaren (Dutch Ministry of Foreign Affairs), Olga Szubert and Aditia Taslim (INPUD), Aline Fantinatti (GNP+), and Rafiatu Abdul-Salam, Raghad Abuulshaikh, Simone Camps, Tushar Malik, and Rami Sharif (Aidsfonds).

Executive Summary

Context and methodology

This report examines funding for HIV programs for key populations:[1] gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers and transgender people in low- and middle- income countries for the years 2019-2023.[2] This is a follow up to an initial report in 2020 which found that only 2% of HIV funding was going to support work with key populations, drastically below what was needed at the time.

The data in the report is primarily drawn from publicly available databases on budgets or expenditures from the US President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to fight AIDS Tuberculosis and Malaria (Global Fund), UNAIDS Global AIDS Monitoring, and the International AIDS Transparency Initiative. Anonymized data on grants made by private philanthropies was provided by Funders Concerned About AIDS. Additional data was drawn from public reporting on key population expenditures from the Global Fund and Harm Reduction International. The main criteria for inclusion within the analysis was budget or expenditure line items or grants between 2019 and 2023 that were primarily or substantially targeting one or more of the key populations in low- and middle- income countries. Funders report differently on their investments in HIV key population programs: PEPFAR reports the beneficiaries of all investments, whereas the Global Fund and domestic public sources only report on funding for specific programs, such as HIV prevention programs. This makes comparability between funders difficult. Due to these and other limitations with the data, the analysis may over-estimate funding for key populations in some respects and under-estimate it in others. Detailed methodological notes for major funders are included in Annex 1.

Key populations are being left behind

In 2021 at the United Nations General Assembly High Level Meeting on HIV/AIDS, governments recommitted to end AIDS as a public health crisis by 2030. In the years since, funding to achieve this commitment has fallen dangerously short of the estimated $5.7 billion that is needed annually in low and middle- income countries for prevention programs targeting key populations, and the $3.1 billion needed to for societal enablers that create the grounds for success.[3]

Addressing the HIV needs of key populations is a global health and human rights imperative. In 2022, 80% of new HIV infections outside of sub-Saharan Africa and 25% of infections in sub-Saharan Africa were among key populations and their sexual partners.[4] Yet more than 50% of all people from key populations are still not being reached with prevention services, with the most significant gaps affecting men and women who use drugs, gay and bisexual men and other men who have sex with men, and transgender people.[5]

In most countries, progress is being hampered by high levels of stigma, discrimination, and violence, as well as punitive criminal laws and policies. These increase barriers to essential HIV services for key populations, as well as their vulnerability to HIV. At the same time, key populations and their organizations are facing increasingly hostile environments, fueled by anti-rights, anti-gender and anti-democratic movements and increasing government restrictions that undermine the ability of key population-led organizations to work freely. The combination of hostile environments and limited resources means that HIV services are out of reach for far too many.

Resources are not keeping pace with needs

By 2025, UNAIDS estimates that $29.5 billion will be needed annually for HIV programs in low- and middle- income countries, with $5.7 billion of that dedicated towards comprehensive prevention programs for key populations. Despite the need, investments in the HIV response are regressing. In 2023, only $19.8 billion was available to support HIV programs in low and middle- income countries, falling almost $10 billion short of what is needed to achieve the 2025 targets.[6] This is the lowest amount of funding invested in the HIV response since 2011.[7]

The regression in funding extends to programs for key populations: Aidsfonds' prior report estimated that in 2018 approximately $529.4 million was invested in key population programs in low- and middle- income countries, from both domestic and donor sources.[8]

In 2023, only an estimated $487.5 million in funding was available for all programs targeting key populations. Of this, an estimated $261.5 million was focused on comprehensive prevention programs, representing just 4.5% of the need.

The gap between the need and available resources is staggering. Without a drastic increase in funding, the goal of ending AIDS as a public health threat by 2030 may be out of reach.

Major funders

Of the $2.4 billion spent on HIV programs primarily benefiting key populations between 2019 and 2023, $969.7 million came from PEPFAR (40.5%), while the Global Fund contributed $962.3 million (40.1%). Domestic public sources, including funding from national and local governments, accounted for another $339.9 million (14.2%), while private philanthropies contributed at least $93.4 (3.7%) million to the overall response. Bilateral donors contributed at least $36.5 million (1.5%) in direct spending in low- and middle- income countries, with the Netherlands contributing $22 million of that amount (1% of the total response).

Funding by region

Funding for HIV programs among key populations did not keep pace with the need in any region. UNAIDS estimates that about 20% of all HIV spending in low- and middle- income countries should go towards prevention programs for key populations to meet the 2025 targets;[9] yet funding for key populations did not even reach 5% in any region. In Asia and the Pacific, where key populations account for 62.8% of all new HIV infections, resources for key population prevention programs and societal enablers comprised only 3% of all available resources. In Latin America, where 57.5% of new infections are among key populations, total spending on key population programs amounted to less than 1% of all HIV expenditures.

The average spending on key population programs across all regions was just 2.6% in 2020.

Funding by key population

Of all funding available for HIV programs that are likely to primarily benefit key populations, at least 44% is not disaggregated by population type. These are often for programs that serve more than one key population and/or that address intersections between them. Another 21% is invested in HIV programs for gay and bisexual men and other men who have sex with men, while 17% and 16% addresses the HIV program needs of people who inject drugs and sex workers, respectively. Just 2% of available key population funding is directed towards HIV programs for transgender people.

Between 2019 and 2022, the years that data is most complete, an estimated annual average of:

- $106.4 million was allocated towards programs for gay and bisexual men and other men who have sex with men;
- $86.1 million was allocated towards programs for people who inject drugs;
- $79.3 million was allocated towards programs for sex workers; and
- $9.8 million was allocated towards programs for transgender people.

Average annual funding decreased for all key populations compared to the 2020 report, except funding for people who inject drugs.

For all key populations, the share of funding was a fraction of what is needed to address their HIV needs. While men who have sex with men comprise 20% of all new HIV infections, in 2020 funding for HIV programs focused on men who have sex with men represented only 0.3% of all available HIV funding. People who inject drugs and sex workers account for 8% and 7.7% of all new HIV infections respectively, however just 0.5% and 0.4% of all HIV resources in 2020 were available to meet their needs. For transgender people, who represent 1.1% of all new infections, only 0.03% of all funding was directed towards HIV programs for them in 2020. At a time when urgent attention is needed to accelerate access to HIV services for key populations, the world is dangerously off track.

Recommendations

All major funders – national governments in low- and middle- income countries, the Global Fund, PEPFAR, other bilateral donors, and private philanthropies – must recommit and take decisive action to ensure that the needs of key populations are being centered within HIV responses, and resources allocated accordingly. National governments should take action to reduce their reliance on donors to fund key population programs by increasing funding from domestic public sources, and work in partnership with key population-led organizations to remove harmful punitive laws and other barriers to access to HIV services. Other donors should set ambitious targets for their HIV spending among key populations that are in line with what is needed to achieve UNAIDS funding targets. Ensuring that money reaches organizations that are led by key populations themselves will increase the effectiveness of key population prevention programs and help ensure longer term sustainability.

HIV funders should:

1. Provide long-term, flexible and unrestricted funding directly to key population-led organizations.
2. Reduce barriers to funding for key population-led organizations.
3. Set ambitious benchmarks for investments in comprehensive prevention programs for key populations.
4. Increase investments in programs to address human rights-related barriers to HIV services and other societal enablers for key populations.
5. Publicly push back against oppressive and criminal laws, attacks on civic space, and the influence of anti-gender, anti-rights and anti-democratic movements.
6. Strengthen mechanisms that support the leadership of key populations in defining priorities and making funding decisions, including in national HIV strategies and budgets, and in funding requests.
7. Ensure that key populations are included in funded research and data collection efforts.
8. Ensure that HIV programs and services that are implemented by non-key population-led organizations meet the needs of key populations and are consistent with the World Health Organization's consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations.
9. In countries that are facing the end of bilateral or multilateral funding ("transition countries"), work in collaboration with key populations, national governments, philanthropy, and other donors to ensure that critical key population programs are sustained.
10. Increase data transparency by ensuring that budgets for HIV prevention programs and investments in human rights and other societal enablers are disaggregated by key population, and are publicly available.
11. Ensure that staff within funding organizations have sufficient capacity and expertise to support the active engagement of key population-led organizations in the design, implementation, monitoring and evaluation of grants.

The lack of funding for comprehensive HIV programs addressing the needs of key populations is not just undermining progress towards the global goals, it's harming already marginalized communities who are bearing both the brunt of the HIV epidemic and the fallout from a world that is experiencing political and social upheaval. At a moment when democracy and fundamental human rights are at risk, support for key populations, who are often the first to be targeted, is more important than ever.

Gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers, and transgender people cannot wait any longer for comprehensive and effective programs that meet their needs. It's past time. A dramatic increase in political will and funding is needed now.

Introduction

This report examines funding for HIV programs for key populations:[10] gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers and transgender people in low- and middle- income countries for the years 2019-2023.[11] This is a follow up to an initial report in 2020 which examined funding flows for the period 2016-2018.[12] The 2020 study found that only 2% of HIV funding was going to support work with key populations, drastically below what was needed at the time.

The world is dangerously off track

In 2021 at the United Nations General Assembly High Level Meeting on HIV/AIDS, governments recommitted to end AIDS as a public health crisis by 2030. In doing so, they recognized the need to significantly increase investments to ensure that key populations have access to tailored HIV combination prevention approaches that effectively meet their needs. They made additional commitments to address stigma and discrimination against key populations, and to roll back harmful laws and policies that undermine key populations' access to HIV services and violate their human rights. Governments also committed to empower communities to lead HIV responses, including by ensuring their participation in decision-making and increasing their role in the delivery of HIV services.[13]

In the years since, funding to achieve these commitments has fallen dangerously short of the estimated $5.7 billion that is needed annually in low- and middle- income countries for prevention programs targeting key populations, and the $3.1 billion needed to for societal enablers that create the conditions for success.[14]

This analysis reveals that in 2023, at least $487.5 million in funding was available for all programs targeting key populations. Of this, an estimated $261.5 million was focused on comprehensive prevention programs, representing just 4.5% of the need.

2025 Prevention targets focused on key populations

Ensure 95% of people at risk of HIV infection, within all epidemiologically relevant groups, age groups and geographical settings, have access to and use appropriate, prioritized, person-centered and effective combination prevention options.

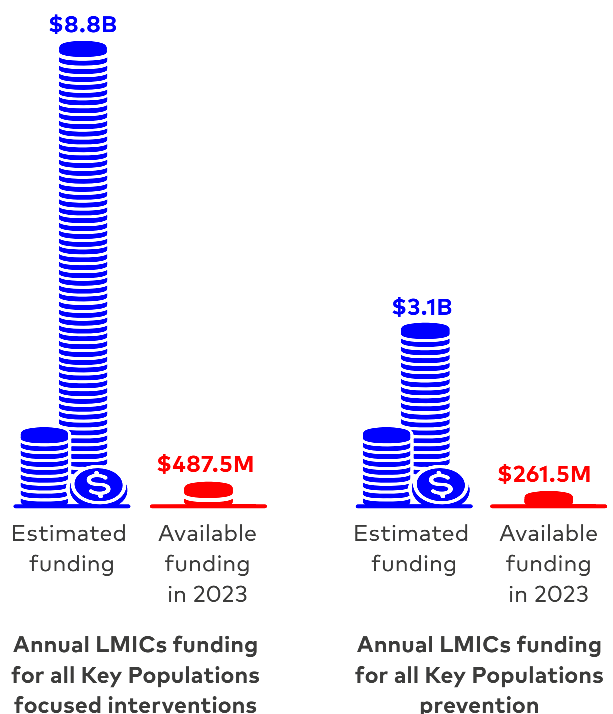
Ensure availability of PrEP for 10 million people at substantial risk of HIV and PEP for people recently exposed to HIV by 2025.

Ensure 50% coverage of opioid agonist therapy among people who are dependent on opioids.

Ensure 90% sterile injecting equipment use during last injection among people who inject drugs and people in prisons and other closed settings.

UNAIDS (2022). End Inequalities. End AIDS. Global AIDS Strategy 2021-2026. Geneva: UNAIDS.

Figure 1. Estimated funding needed vs. actual funding available 2023



2025 Community leadership and societal enabler targets focused on key populations

Community leadership 30-60-80 targets
Ensure community-led organizations deliver 30% of testing and treatment services, with a focus on HIV testing, linkages to treatment, adherence and retention support, and treatment literacy by 2025.

Ensure community-led organizations deliver 80% of HIV prevention services for people from populations at high risk of HIV infection, including for women within those populations by 2025.

Ensure community-led organizations deliver 60% of programs to support the achievement of societal enablers by 2025.

Societal enablers and human rights
Reduce to no more than 10% the number of people from key populations who experienced physical or sexual violence in the past 12 months by 2025.

Less than 10% of countries criminalize sex work, possession of small amounts of drugs, same-sex sexual behavior and HIV transmission, exposure or non-disclosure by 2025.

UNAIDS (2022). End Inequalities. End AIDS. Global AIDS Strategy 2021-2026. Geneva: UNAIDS.

An increasingly hostile world for key populations is undermining progress

In most countries, key populations are still being left behind. In 2022, 80% of new HIV infections outside of sub-Saharan Africa, and 25% of infections in sub-Saharan Africa, were among key populations and their sexual partners.[15] Key populations continue to face high levels of stigma, discrimination, and violence, as well as punitive criminal laws and policies, which increase barriers to essential HIV services and increase their vulnerability to HIV. Consequently, key populations comprise the majority of people who are newly infected with HIV and are not accessing HIV treatment and other life-saving care.[16] In many countries, these communities are facing increasingly hostile environments as anti-rights, anti-gender and anti-democratic movements partner with governments to further marginalize and criminalize them.[17]

There is a clear correlation between hostile environments and progress toward ending HIV as an epidemic: countries with closed and repressed civic space accounted for 85% of new HIV infections and almost 80% AIDS mortality in 2021.[18]

While key population-led organizations and their allies continue to do critical work to ensure access to lifesaving health services, they are facing formidable challenges. Governments in many countries are increasing restrictions on the rights of community-led and other civil society organizations to register, receive funding, and operate freely, as well as to exercise their rights to freedom of expression, association and assembly. In 2023, almost 31% of the world's population, or 2.4 billion people, lived in countries classified as closed, where "state and non-state forces routinely imprison, harm or kill dissenters with impunity."[19] Another 40% lived in countries classified as repressed, where there are severe restrictions on fundamental freedoms.[20] LGBTIQ+ organizations in Africa are facing the greatest restrictions, including being denied registration, raided, and forcibly closed.[21]

There is glaring gap between global targets and results for key populations

To makes sure the world is on track to end AIDS as a public health threat by 2030, UNAIDS set a series of global targets on prevention, treatment, community leadership and societal enablers, to be achieved by 2025.[22] At the current rate of progress, many of these targets are not likely to be met. For key populations, there are significant disparities.

Globally, people from key populations are at significantly greater risk of acquiring HIV than the general population. Yet more than 50% of all people from key populations are not being reached with prevention services, with the most significant gaps affecting people who use drugs, gay and bisexual men and other men who have sex with men, and transgender people.[23] Although extremely effective in curbing HIV risk, access to pre-exposure prophylaxis (PrEP) remains a challenge for key populations. In all but a few countries, coverage of harm reduction

services for people who inject drugs remains woefully inadequate.[24]

People from key populations who are living with HIV are less likely to be on HIV treatment and have worse treatment outcomes than other people living with HIV. The gap is particularly glaring in sub-Saharan Africa, where significant progress is otherwise being made.[25]

While some countries have removed punitive laws that undermine the HIV response, an increasingly hostile environment for key populations has resulted in the adoption of even harsher laws in some countries, and stalled reform efforts in others. Among low and middle- income countries, only Venezuela and Uruguay have no laws that criminalize sex work, possession of small amounts of drugs, same-sex sexual behavior, HIV transmission, and HIV exposure or non-disclosure. Another two countries — Colombia and Paraguay — have no criminal laws but have prosecuted people for HIV exposure in the last ten years.[26]

While the targets aim to ensure that community-led populations play a leading role in delivering 80% of HIV prevention services for key populations and 60% of programs in support of societal enablers, most donors have no way of tracking how much of their funding reaches organizations led by key populations.

Overall decline in funding for HIV threatens progress

In 2021, UNAIDS revised its estimates of how much funding is needed to reach the goal of ending AIDS as a public health threat by 2030. By 2025, it estimated that $29.5 billion would be needed annually for HIV programs, up from the $26 billion in 2020. At least $9.5 billion of that is needed for comprehensive prevention programs, almost double the $5.3 billion they estimated was needed by 2020. At least 60%, or $5.7 billion, should be dedicated towards comprehensive prevention programs for key populations. UNAIDS also estimated that an additional $3.1 billion in investments would be needed to address societal enablers — programs to remove punitive laws and policies, promote the human rights of key populations and people living with HIV, strengthen community leadership, and reduce stigma, discrimination and violence — much of which should benefit key populations.[27] Despite the increased need, investments in the HIV response are regressing. In 2023, only $19.8 billion was available to support HIV programs in low- and middle- income countries, falling almost $10 billion short of the $29.5 billion needed to achieve the 2025 targets.[28] This is the lowest amount of funding invested in the HIV response since 2011; $2.2 billion less than was available in 2018.[29]

While most funding for the HIV response in low- and middle- =income countries comes from domestic resources, donor funding is particularly important for sustaining key population programs. Yet donor funding has also declined by more than 20% since its height in 2013.[30] In 2023, the US Government contributed $4.7 billion to the AIDS response, down $600 million from their contribution in 2018. Most other bilateral donors have also pulled back. In 2023 they contributed just $1.2 billion directly to the AIDS response in low- and middle- income countries, down from $1.7 billion in 2018. Some of their investments have been redirected toward the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), which accounts for an increasing amount of donor funding in low- and middle- income countries. In 2023, the Global Fund spent $2.2 billion on HIV programs; an increase of $600 million since 2018.[31]

The 2020 report estimated that in 2018 approximately $529.4 million was invested in key population programs in low- and middle-income countries, from both domestic and donor sources.[32] In 2023, the amount of funding had declined to approximately $487.5 million. Of this, an estimated $261.5 million in funding was specifically for HIV prevention programs targeting key populations. This is less than 5% of the $5.7 billion needed annually to ensure at least 95% of people from key populations who need prevention programs can access and are using them. An estimated additional $76.2 million was invested in societal enablers, representing 2.5% of the overall $3.1 billion needed. Without a drastic increase in resources for key population prevention programs, the goal of ending AIDS as a public health threat by 2030 may be out of reach.

About this report

This report is divided into two parts. The first analyzes funding flows for HIV programs for key populations in low- and middle- income countries. Specifically, it analyzes the amount of funding available in the five years between 2019 and 2023, to the extent that data is available: which funders contributed toward key population programs; how funding was distributed between regions; and the overall resourcing gap. The global figures are aggregated, representing total funding available for programs that address the HIV needs of key populations. Given that some funding for key populations is not disaggregated by key population, global figures may also include some funding for prisoners and people in closed settings.

The second part of the report analyzes levels of funding available for focus key populations: gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers, and transgender people. To the extent possible, it shows trends in funding over time.
Finally, the report recommends actions for major funders in the global HIV response. While it is unlikely that the interim 2025 targets will be met, with political will, increased resources and concerted action, it is still possible to meet the goal of ending AIDS as a public health threat by 2030.

Methodology

This report represents the most comprehensive mapping of combined HIV funding for programs targeting key populations in low- and middle- income countries. The report analyzes available domestic public expenditure and donor investments made by the major funders of the global HIV response, including United States President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, key bilateral donors, and philanthropic donors, including: private foundations, private sector donors, and non-governmental organizations that receive funding from other donors and sub-grant it to other organizations in low- and middle- income countries (also referred to as intermediary organizations). The report compares available data with the resource needs estimated by UNAIDS for HIV prevention programs for key populations and societal enablers. All monetary amounts are in U.S. Dollars (USD) as reported in donor databases, not pegged to a consistent year.

The main criteria for inclusion within the analysis was a budget item or expenditure through grants or programs between 2019 and 2023 that was identified as primarily or substantially targeting one or more of the key populations that are the focus of this report in low- and middle- income countries. This includes funding for comprehensive prevention programs and societal enablers for all funders, to the extent that this can be distinguished, as well as funding for HIV testing, clinical care and other programs for PEPFAR, which identifies the beneficiaries of most program expenditures. A fraction of PEPFAR expenditures in this report (0.06%) are allocated towards HIV treatment. This makes it difficult to compare funders' total investments in HIV programs that benefit key populations. For example, while the Global Fund and national and local governments contribute significant funding towards HIV care and treatment for key populations, this data is not captured for various reasons, including to respect the privacy and confidentiality of those receiving services. To the extent possible, the report distinguishes funding for key population prevention programs and societal enablers from other forms of support, to enable comparison of similar programs. However, the aggregate term "key population funding" is used to include funding for prevention programs, societal enablers, and other programs where key populations are identified as direct beneficiaries.

This report focuses on investments in low- and middle- income country because that data is more readily available from key donors than funding in high-income countries. Few high-income countries report their domestic investments to UNAIDS Global AIDS Monitoring. Further, domestic public financing in high-income countries may come from various sources, including local, state and federal budgets, which increases the complexity in tracking funding flows. What is clear from the epidemiological data is that key populations in high income countries still do not have their HIV needs met. In 2022, almost three-quarters (73.9%) of new HIV infections in Western and Central Europe and North America were among key populations.[33] Gay and bisexual men and other men who have sex with men accounted for 59% alone, while people who inject drugs accounted for 8.8%, and sex workers and transgender people comprised 3.6% and 2.2% of

new injections respectively.[34] Just as in low and middle- income countries, widespread stigma, discrimination, and punitive laws undermine access to HIV services.

The analysis is based on a desk review of existing sources including published expenditure data from PEPFAR;[35] an analysis of budget data from the Global Fund and reporting on its expenditures for key population prevention programs;[36] a search of data published by bilateral donors as part of the International Aid Transparency Initiative Datastore;[37] anonymized reporting to Funders Concerned About AIDS by philanthropic donors;[38] and domestic spending as reported to UNAIDS through the Global AIDS Monitoring system, or verified in other funding analyses.[39]

The years 2019-2023 were selected because data was available for all years from most funding sources, except for private philanthropic donors.[40] Including the most recent data gives a clearer picture of progress and challenges, so that action can be taken quickly to change course and get back on track towards the global goal of ending AIDS as a public health threat by 2030. Additional methodological notes for each major funder can be found in annex 1.
The methodology of this report departs from the methodology used in the 2020 report in several ways.

First, the previous report did not attempt to disaggregate funding for various types of programs or activities for key populations. To the extent that funding for HIV prevention programs can be distinguished from other types of key population programming in this report, it is.

Second, in the 2020 report, 100% of philanthropic funding that targeted two or more key populations was counted under the total reported funding for each specific key population group. However, there was one key exception: funding that was specifically targeted for men who have sex with men and transgender people was allocated between the two groups via a 9:1 ratio. This was consistent with the methodologies used in other reports of donor expenditures on HIV programs. In this report, the 9:1 ratio is maintained for funding that targeted both gay and bisexual men and other men who have sex with men and transgender people. In other cases, if funding targeted more than one key population (e.g. sex workers and people who use drugs or all key populations), it was not counted in funding totals for any of those population groups to avoid potential over-counting. Instead, the proportion of funding that is specifically earmarked for one key population is compared to funding available for broader programs that cover two or more key populations. This acknowledges the value of funding that may allow for more intersectional approaches – recognizing that there are often broad overlaps between key populations – while also recognizing the value of specific funding streams so that it is possible to understand where there are gaps or where funding may be falling short of need.

In the 2020 report, funding to intermediary organizations from bilateral and philanthropic donors was included in funding estimates. In this report, only funding that bilateral and philanthropic donors provided directly to organizations in low- and middle- income countries is included in the estimates, to avoid potential over-counting. Since many intermediary organizations report their sub-granting to organizations in low- and middle-income countries to Funders Concerned about AIDS, this funding is accounted for as private philanthropic support.

Finally, in the 2020 report's analysis of Global Fund funding, funding for HIV testing was not disaggregated by key population and was included in overall estimates. Funding for non-disaggregated HIV testing was not included in this report due to the inability to differentiate HIV testing programs for key populations from programs targeting other groups. To increase comparability, the funding data for 2016-2018 for the Global Fund that is included in this report has been revised to exclude funding for HIV testing programs that are not part of comprehensive HIV prevention packages for key populations.

Limitations

Despite efforts to present the most comprehensive analysis of funding available for key populations, there are limitations to the data presented here.

First, the data presented in this report comes from various sources, which each have their own methodologies for collecting and reporting on funding flows. For example, PEPFAR reports on expenditures by intended beneficiaries

for many types of programs, although the extent to which the groups of beneficiaries is disaggregated varies. The Global Fund reports spending on specific types of programs — such as comprehensive prevention programs for men who have sex with men. However, for most grants for the period 2021-2023, budgets for prevention programs are not disaggregated by key population in the Global Fund's publicly reported data. For these years, data is drawn from the Global Fund's own analysis of prevention spending for key populations in a subset of grants, combined with any available data on specific interventions for key populations that was available in the Global Fund's budget data service. Global Fund support for other types of programs, such as HIV treatment, is never disaggregated by intended beneficiary in order to protect the confidentiality of clients, and is thus not included in this analysis. On the other hand, funding by philanthropic organizations is more likely to be general operating support or for programs that include a broad range of interventions, making it difficult to separate prevention funding from other forms of support.

The differences in methodologies for reporting expenditures make comparisons between donors difficult. It also makes reporting on the amount of funding by specific intervention challenging. That said, available data does allows us to draw conclusions about the overall amount of funding available for HIV prevention programs targeting specific key populations. In this report, data is provided to the extent it is available on programs focused on achieving societal enablers,[41] recognizing that while not all that funding specifically benefits key populations, a significant proportion of it should.

Second, the names of the end recipients of funding for all sources, except for funding reported through the International Aid Transparency Initiative, is not publicly available. This makes it impossible to determine how much funding is going to organizations that are led by key populations themselves, which is critical for ensuring that programs have the greatest impact. Despite the 2025 targets that community-based organizations deliver at least 30% or testing and treatment services, 80% of HIV prevention programs, and 60% of programs focused on societal enablers, there is currently no way that progress toward these targets can be measured.

Third, intersectional approaches are not well captured in the data. Many individuals that are being targeted with programs may fall into one or more key populations: men who have sex with men or transgender people may also be sex workers, sex workers may also use drugs and so on. The methodology of reporting by key population group makes it difficult to identify these overlapping identities or determine to what extent the needs of people who belong to two or more of these groups are being met.

Fourth, for the most part, funding that addresses one or more key population groups is reported as aggregated data in this report. No attempt was made to apportion it between specific key populations. There was however, one key exception. Consistent with the previous report, for programs that targeted both men who have sex with men and transgender people, 90% of the funding was assigned to men who have sex with men and 10% was assigned to transgender people.[42] This may result in some limited under- or over-reporting for each group.

Fifth, to the extent possible, only funding that was intended for the direct benefit of men who have sex with men, people who inject drugs, sex workers, and transgender communities was included in the analysis, not funding that benefited their sexual partners, children or other family members. While stigma and discrimination do impact family members and sexual partners, and they may face greater HIV risks, programs targeting them specifically were not within the scope of this study. That said, some funding categories aggregate data on key populations and their sexual partners and it was not possible to further disaggregate this.

Sixth, some funding was included that was focused on protecting the human rights of lesbian, gay, bisexual and transgender people and addressing stigma, discrimination and punitive laws, given their contribution towards creating environments that are conducive toward addressing HIV among gay and bisexual men and other men who have sex with men and transgender people. Funding targeting LGBTIQ+ communities broadly (and not men who have sex with men or transgender people specifically) is reported in aggregate key population funding. However, funding that was specifically targeted towards intersex communities and lesbian and bisexual women was excluded from the

data, given that they are not among the focus populations for this report.

Seventh, data on domestic expenditures for HIV programs targeting key populations is extremely limited. The data was drawn from UNAIDS' Global AIDS Monitoring database, which includes data for only a subset of low- and middle- income countries that report voluntarily. In 2023, for example, data was reported for only 37 low- and middle- income countries. Not all low- and middle- income countries report every year; many do not report at all. To the extent that data was available, it was included in the report. However, it is very likely an under-estimate of the amount of funding available for key populations in national programs. In addition, the estimates in this report include verified data on national-level harm reduction funding that was identified by Harm Reduction International in their 2024 report on funding for programs for people who inject drugs.

Finally, by excluding philanthropic and bilateral funding to intermediary organizations and organizations headquartered in high-income countries, it is likely that some funding was excluded that was used to support key population programs in low- and middle- income countries. Given that many intermediary organizations also report their sub-granting to Funders Concerned About AIDS, it is assume that most of the funding that ultimately reached organizations in low- and middle- income countries is captured in that data.

As a result of these limitations, the analysis may over-estimate funding for key populations in some respects and under-estimate it in others.

Section 1: Global investments in HIV programming for key populations

This section analyzes the global funding landscape of HIV programs for key populations in low- and middle- income countries (LMICs). It explores what resources were available, how major funders contributed towards key population programs, the distribution of funding across regions, and the extent of the gap between the needs and availability of resources.

Gay and bisexual men who have sex with men, people who inject drugs, sex workers and transgender people continue to bear a disproportionate burden of the HIV response, due to stigma, discrimination, and harmful laws and policies that violate their human rights and create barriers to HIV prevention, treatment, and care. According to UNAIDS, key populations and their sexual partners accounted for 55% of all new HIV infections in 2022, up from 40% in 2010.[43]

To reverse course and bring about a decline in HIV infections among key populations, UNAIDS estimates that at least 60% of the $9.5 billion needed by 2025 for comprehensive prevention programs should be focused on key populations. That amounts to $5.7 billion annually. That target is not even within sight: in 2023, an estimated $261.5 million in funding from all sources was available for programs addressing the HIV prevention needs of gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers, and transgender people.

The gap is astonishing: 95.5% of the funding that is needed for prevention programs for the people most affected by HIV is not being provided, either by donors or through domestic expenditures.

The underfunding of prevention programs means too many people among key populations are going without the critical services they need to prevent new HIV infections. Currently, only 50% of sex workers and about 40% of men who have sex with men, people who inject drugs and transgender people are being reached with comprehensive, combination prevention programs.[44] With the scale of these gaps, the 2025 target of 95% of people at risk of HIV infection using appropriate, prioritized, person-centered and effective combination prevention options, is out of reach.

Beyond prevention, funding is also needed to address the factors that drive key populations away from HIV services and to support the delivery of comprehensive, people-centered care. This includes funding for programs to reduce stigma, discrimination and violence against key populations, remove punitive laws, and support the leadership of key population-led organizations within HIV responses.

While total spending benefiting key populations, including funding for societal enablers and other programs reached at least $487.5 million in 2023, it amounted to just 2.5% of the $19.8 billion available for all HIV programs that year. Without a drastic increase in funding to bring programs for key populations to scale, the 2030 goal of ending HIV as an epidemic may well be out of reach.

Resource availability and gaps

Over the past five years, total funding for programs where key populations were specifically identified as beneficiaries in low- and middle-income countries remained relatively steady: $447.4 million was invested in 2019, compared to at least $487.5 million in 2023. However, 2019 marked a sharp decline in funding compared to the year prior: in the 2020 report it was estimated that approximately $529.4 million was available for all key population programs in 2018.[45]

Table 1. Total key population funding in LMICs, 2019-2023

Year	Key population prevention funding in LMICs[46]	Societal enablers[47]	Total key population funding in LMICs[48]	Total HIV funding in LMICs[49]	Key population funding as a percent of total funding in LMICs
2019	$298.7M	$56.6M	$447.4M	$21.6B	2.1%
2020	$234.5M	$71.8M	$399.7M	$21.5B	1.8%
2021	$307.1M	$89.8M	$518.2M	$21.4B	2.3%
2022	$317.9M	$89.6M	$544.5M	$20.8B	2.6%
2023	$261.5M	$76.2M	$487.5M	$19.8B	2.4%
Total	**$1.4B**	**$384.1M**	**$2.4B**	**$105.1B**	**2.3%**

Table 2. Three-Year totals of key population funding in LMICs, 2016-2018 and 2021-2023

Year	Key population prevention funding in LMICs[50]	Total key population funding in LMICs	Total HIV funding in LMICs[51]	Key population funding as a percent of total funding in LMICs
2016-2018	N/A[52]	$1.3 Billion[53]	$65.9 Billion[54]	2.0%
2021-2023	$886.6M	$1.6 Billion	$62 Billion	2.5%

Some of the fluctuations in funding over the past five years are attributable to variations in reporting in domestic spending, which accounts for the decline in 2023. Other year-to-year changes in funding levels can be attributed to funding cycles. For example, the procurement of prevention commodities may be frontloaded in multi-year grants. For many Global Fund grants, 2019 marked the final year of a three-year funding cycle when funding tends to be lower compared to earlier years. As such, average spending over three-year periods may give a better indication of overall trends in funding than year-to-year comparisons. When the total amount of funding available for the period 2021-2023 is compared to the three years in the prior report, 2016-2018, overall funding for key population prevention programs, societal enablers and other programs where key populations are specifically identified as beneficiaries, has increased by almost $300 million.

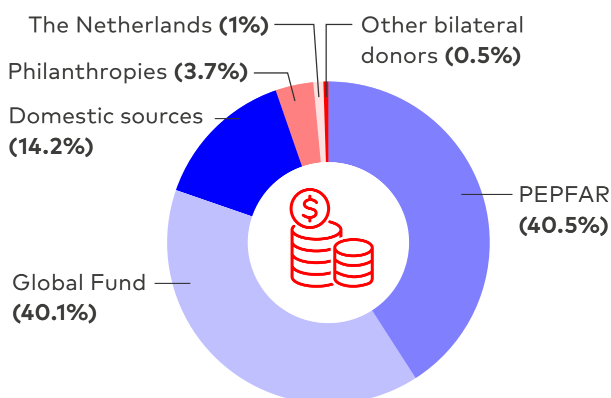
For the first time with this analysis, specific funding streams for combination prevention programs targeting key populations are identified. This includes funding for: the provision of condoms, safe needles or information; education; discrimination reduction; promotion of access to testing, treatment, and retention; opioid substitution therapy for people who inject drugs; and pre-exposure prophylaxis, among other interventions.

Between 2019 and 2023, at least $1.6 billion was spent on comprehensive, combination prevention programs for gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers, and transgender people.

This accounts for 55.4% of all funding for key populations. However, it is far from sufficient. The underfunding of prevention programs means that too many people among key populations are going without the critical services they need to prevent HIV.[55]

With only 4.5% of the need for HIV prevention funding being filled, investments in HIV prevention for key populations would need to increase 22-fold to meet the target.

Figure 2. Total key population funding in LMICs by funder type, 2019-2023



The gap in HIV prevention funding has dire consequences for the health and well-being of gay and bisexual men who have sex with men, people who inject drugs, sex workers, and transgender communities, as well as for health systems and health security. While new HIV infections have decreased by 35% since 2010, new infections among key populations have decreased only by 11%.[56] Among key populations, the progress has not been even. While sex workers and people who inject drugs have experienced a decline in relative risk to their counterparts in the general population (from 12 to 9 times greater risk and 21 to 14 times greater risk, respectively), the risk for gay and bisexual men and other men who have sex with men compared to the general population has increased slightly (from 20 to 23 times greater risk), while for transgender women it has almost doubled (from 11 to 20 times greater risk).[57] Far from leaving no-one behind, in most countries the HIV response is failing gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers, and transgender communities. Increased resources for key population programs are urgently needed to close the gap.

In addition to funding specifically for key population prevention programs, an estimated $384.1 million was invested in societal enablers between 2019 and 2023. This funding includes programs to address stigma and discrimination, remove punitive laws, protect human rights, address other barriers to care, as well as provide flexible support for key population-led organizations. At an average of $76.9 million per year, this investment falls well short of the $3.1 billion needed annually.

Major funders

The major funders of the global HIV response include the United States government through the US President's Emergency Plan for AIDS Relief (PEPFAR); the Global Fund to Fight AIDS, Tuberculosis and Malaria, a multilateral financing mechanism; philanthropic organizations, including private foundations, the private sector, and non-governmental organizations; and other governments, including donor governments through their bilateral assistance programs, and national governments in low- and middle- income countries.

Of the $2.4 billion that was spent on HIV programs primarily benefiting key populations between 2019 and 2023, $969.7 million came from PEPFAR (40.5%), while the Global Fund contributed at least $962.3 million (40.1%). Domestic public sources, including funding from national and local governments, accounted for another $339.9 million (14.2%), while private philanthropies contributed at least $93.4 (3.7%) million to the overall response. Bilateral donors contributed at least $36.5 million (1.5%) in direct spending in low- and middle- income countries, with the Netherlands contributing $22 million of that amount (1% of the total response).

PEPFAR

PEPFAR is the largest donor to the global HIV response. It increased its share of overall funding in HIV programs benefiting key populations

Table 3. Total key population funding in LMICs, PEPFAR[59]

Year	Key population prevention funding	Funding for societal enablers[60]	Total key population funding[61]	Total PEPFAR funding in LMICs	Key population funding as a percent of total PEPFAR funding	PEPFAR key population funding as a percent of total key population funding in LMICs
2019	$60.6M	$5.0M	$159.2M	$4.03B	4%	35.5%
2020	$52.4M	$3.0M	$150.1M	$3.8B	4%	37.6%
2021	$74.2M	$1.8M	$195.9M	$4.1B	5%	38.4%
2022	$76.7M	$3.9M	$216.1M	$4.1B	5%	40.2%
2023	$92.8M	$5.65M	$248.3M	$3.9B	6%	52.3%
Total	**$356.9M**	**$19.4**	**$969.7M**	**$19.9B**	**5%**	**40.9%**

from 23% in the 2020 report to 40.5% during the period 2019-2023. Over this period, key population funding as a proportion of all PEPFAR funding increased from 4% in 2019 to 6% in 2023. In the previous report, for the period 2016-2018, PEPFAR invested an average of 2.1% of all its' funding in programs that benefitted key populations.[58] While this a welcome and significant increase in funding from PEPFAR, it still falls far short of the overall need.

In the years between 2019 and 2023, PEPFAR investments in combination prevention programs[62] for key populations increased by 34.5%. Much of this increase was driven by investments in pre-exposure prophylaxis (PrEP), which have been steadily increasing from $6.4 million in 2019 to $33 million in 2023. Funding for other combination prevention programs remained relatively steady but declined as an overall share of PEPFAR funding for key populations from 34% in 2019 to 29% in 2023.

Table 4. Total key population prevention funding in LMICs, PEPFAR

Year	Combination prevention	PrEP	Total prevention	Total prevention funding as a percent of all key population funding
2019	$54.3M	$6.4M	$60.7M	38%
2020	$44.4M	$8.0M	$52.4M	35%
2021	$65.5M	$8.7M	$74.2M	38%
2022	$56.0M	$20.7M	$76.7M	39%
2023	$59.7M	$33.2M	$92.9M	37%
Total	**$279.9M**	**$77.0M**	**$356.9M**	**37%**

Over the five years, PEPFAR also spent $19.8 million in programs for key populations that could be considered societal enablers, including its investments in socioeconomic programs, as well as in interventions to strengthen laws, regulations and the policy environment. PEPFAR invested another $222.2 million in HIV testing for key populations. Combined, investments in HIV prevention, societal enablers, and testing account for 61.7% of all funding that PEPFAR identifies as benefiting key populations.

PEPFAR also identifies key population-focused investments in above-site programs, program management, and HIV care and treatment, which accounts for 38.1% of all PEPFAR programs where key populations are identified as beneficiaries. However, it is likely that these figures do not fully represent PEPFAR's investments in key populations. For example, just 0.06% of the total PEPFAR investment in this report was spent on HIV treatment for key populations. Most of PEPFAR's spending on HIV treatment for key populations cannot be known, due to the need to protect confidentiality and privacy, and to prevent stigma, discrimination, and additional barriers to care.

In 2022, PEPFAR released its five-year strategy, which aligns with the targets outlined in the UN General Assembly's 2021 Political Declaration on AIDS and articulates the U.S. Government's role in reaching them.[63] The strategy sets a goal of closing equity gaps for priority populations, including key populations. It also aims to "transform key population service delivery through key population leadership," recognizing that their engagement in program design and delivery makes services more effective. While PEPFAR's work on key populations is important, legal constraints on funding for organizations that "promote or advocate for the legalization or practice of prostitution" continue to impede its ability to fund comprehensive, evidence-informed, and human rights-based prevention programs for sex workers.[64]

In June 2024, PEPFAR announced a new action plan to address HIV-service equity gaps for key populations. Noting that addressing the unique needs of key populations was essential to end AIDS as a public health threat by 2030, PEPFAR committed to ensure that at least 7% of its overall annual budget for country and regional operational plans support activities serving key populations, along with additional matching funds to address structural barriers to access to services for key populations, and other forms of support.[65] However, this announcement must be placed in the context of an overall planned funding cut of 6% for PEPFAR's financial year 2025, over financial year 2024 levels.[66]

Ongoing support from PEPFAR will be critical for sustaining and increasing investments in key population programs in many low- and middle-income countries. However, PEPFAR's future remains uncertain. In March 2024, the United States Congress reauthorized PEPFAR for just one year, a departure from past practice of five-year reauthorizations. The re-election of U.S. President Donald Trump, along with the Republican House and Senate in November 2024, could have a significant impact on its future. While PEPFAR has historically benefited from broad non-partisan support, there is evidence that this might be eroding, buoyed by anti-gender and anti-rights movements.[67]

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund contributed approximately 40.1% of all funding that could be identified for HIV programs that primarily benefit key populations between 2019 and 2023.

The Global Fund is the largest funder of HIV key population prevention programs, contributing at least $724.4 million over the five years.[71]

Global Fund key population prevention programs include funding for a range of behavioral interventions, community empowerment interventions, interventions to address barriers to services, harm reduction interventions, and specific HIV testing programs, among other interventions. This report finds that funding for key population HIV prevention programs averaged 9.7% of all HIV funding provided by the Global Fund in low- and middle- income countries between 2019 and 2023.

The Global Fund also invested significant resources in programs to achieve societal enablers.[72] These investments include funding for interventions focused on community systems strengthening,[73] and programs to address human rights-related barriers to services. Its investments in societal enablers have grown considerably over

Table 5. Total key population prevention funding and funding for societal enablers, the Global Fund, 2019-2023

Year	Key population prevention funding[74]	Societal enablers[75]	Total funding for key population prevention programs and societal enablers	Total Global Fund HIV funding in LMICs[76]	Key population prevention funding and societal enablers as a percent of all Global Fund HIV funding	Global Fund funding as a percent of all key population funding
2019	$114.4M	$22.3M	$136.7M	$1.25B	10%	30.6%
2020	$159.1M	$37.9M	$197.0M	$1.60B	12.3%	49.3%
2021-2023	$450.9M[77]	$177.7M	$628.6M	$4.65B	13.5%	39.2%
Total	**$724.4M**	**$237.9M**	**$962.3**	**$7.49B**	**12.8%**	**40.1%**

the five-year period, increasing from $22.3 million in 2019 to $63.5 million in 2023. While not all investments in societal enablers are focused on key populations, a significant proportion of them are. Combined, the Global Fund spent an average of at least 12.8% of its total HIV funding on key population prevention programs and societal enablers annually between 2019-2023.

In addition to its investments in specific key population programs and societal enablers, other Global Fund support is likely to significantly benefit key populations, including its funding for differentiated HIV testing (beyond that which is provided through key population prevention programs) and HIV care and treatment. However, the full extent of this investment cannot be known, as doing so could create barriers to life-saving care and increase stigma and discrimination against an already criminalized and marginalized community.

For many countries with concentrated epidemics among key populations, the Global Fund has been the main source of donor support. In Eastern Europe, Central Asia, Latin America, and the Caribbean, several countries are now in some stage of transition from receiving Global Fund support: Albania, Armenia, Costa Rica, Guyana, Kosovo and St. Lucia are now implementing what are likely to be their final HIV grants, while El Salvador is likely to receive its final HIV grant in the Global Fund's next grant cycle.[78] While well-planned transitions should result in continued support for key population prevention programs from national governments and other donors, this has not always been the case. For example, the Global Fund's withdrawal from Serbia at the end of 2014 led to a collapse in civil society-led programs for key populations. A subsequent increase in HIV infections among men who have sex with men, resulted in the country once again becoming eligible for Global Fund support, although with a much smaller allocation of funding than previously.[79]

In countries that are facing transition, the Global Fund must work in collaboration with key populations and other actors – including human rights organizations, health and humanitarian organizations, national governments, and other philanthropic and bilateral donors – to ensure that critical key population programs continue. In places where hostile social and political environments or the refusal of governments to take over support make this impossible, the Global Fund should continue to provide resources directly to key population-led organizations to sustain their vital work.

The Global Fund's support for key population prevention programs and societal enablers has been the cornerstone of key population programs in many low- and middle- income countries. Any reductions in funding would be devastating for the key populations that depend on its support. The Global Fund's

ability to invest in HIV programs is determined by triennial replenishments, with the next replenishment set to take place in 2025. With increasing political and social turmoil, including reductions in development assistance in many donor countries, significant work will be needed by all stakeholders to ensure that the Global Fund is able to sustain and increase its investments in key populations over the longer term.

Global Fund methodology and data challenges

The analysis of the Global Fund's support for programs that benefit key populations is primarily drawn from their publicly available Grant Budgets Reference Rate data set,[68] which includes budget information for programs and interventions for all signed grants from 2017 to present. However, it is critical to note that the estimate in this report of the Global Fund's support for HIV prevention programs for key populations for the years 2021-2023 is based on incomplete data.

A change in the Global Fund's budgeting methodology for grants in the Global Fund's 2021-2023 funding cycle (grant cycle 6) resulted in disaggregated budget data not being collected for comprehensive prevention programs for key populations. Budget data was collected for a subset of harm reduction interventions for people who inject drugs, including needle and syringe programs, opioid agonist therapy, and overdose prevention programs. However behavioral interventions, community empowerment programs, HIV testing for key populations, and other investments that are included in the Global Fund's prevention programs for people who inject drugs are also not captured. Budget data was also collected for interventions for young key populations (not further disaggregated).

Because of the lack of disaggregated budget data for these years, the data on HIV prevention budgets for key populations in this report is drawn from the Global Fund's reporting on its 2017-2022 key Performance Indicator 5a,[69] which tracked budgeted investments in key population prevention programs in a subset of 111 out of 149 HIV grants for their 2021-2023 funding cycle. This data is disaggregated by key population, but not disaggregated by budget year. Because of the nature of Global Fund funding cycles, for some grants included in the Global Fund's analysis, implementation may extend into 2024 and 2025. To offset potential overcounts, for grants where the three-year implementation period extends beyond 2023, the budget data that was available for comprehensive prevention programs for key populations from the prior grant cycle (grant cycle 5) from the years 2021 and 2022 was excluded. To the extent that some budget data was available in the Grant Implementation Budget Data Set for key population prevention programs in the 38 grants that were not included in the Global Fund's analysis, this data was added to the prevention funding totals in this report.

The Global Fund's analysis shows that their investments in key population prevention programs within these grants increased steadily from 5.9% of all HIV investments for the 2015-2017 funding cycle (grant cycle 4) and 6.8% for the 2018-2020 funding cycle (grant cycle 5) to 8.2% for 2021-2023 (grant cycle 6).[70]

A detailed methodology is included in Annex 1.

Domestic public expenditure

Few national governments report their HIV program expenditures through UNAIDS Global AIDS. Monitoring, making it difficult to accurately assess how much national governments are investing in key population prevention programs and societal enablers. Of the 80 low- and middle- income countries that reported any expenditures for HIV programs between 2019 and 2023, only 31 countries reported investments in key population programs at least once.[80] This indicates that 60% of reporting countries are either not investing any resources in key population prevention programs, or are not disaggregating this data. Either way, it demonstrates significant shortfalls in domestic responses.

Of countries that did report key population investment:

- 27 countries reported expenditures on prevention programs for gay and bisexual men and other men who have sex with men;
- 18 reported expenditures on prevention programs for people who inject drugs;
- 24 reported expenditures on prevention programs for sex workers; and
- 13 reported expenditures on prevention programs for transgender people.

Those that did report spent approximately $323.6 million on prevention programs for key populations, including PrEP, over the five years. Another $16.7 million was spent on programs to address human rights-related barriers to services and support community systems and responses, much of which is likely to benefit key populations. This brings total funding for programs that primarily benefit key populations to $339.9 million.[81]

As with the 2020 report, most of this funding can be attributed to just one country: India. For the three years that data is available, India spent at least $156 million on prevention programs for gay and bisexual men and other men who have sex with men.[82] It spent at least another $21 million on harm reduction services for people who inject drugs. Combined, this accounts for more than half of all reported domestic expenditures from public sources.

While there are reasons to believe that the overall level of investment in key population programs in many countries is low – including increasing hostility to key populations and crackdowns on civic space in many countries – it is likely that this estimate is an undercount of total spending. In a 2024 report on funding flows, Harm Reduction International identified domestic spending in several countries that did not report them through the National AIDS Spending Assessments (NASA). According to their research, India spent $10.17 million on harm reduction programs for people who inject drugs in 2022, yet that funding was not reflected in the Global AIDS Monitoring database.[83]

Strengthening reporting on domestic public expenditure remains critical. Governments in low- and middle- income countries are currently contributing the most significant share of resources to their national HIV responses. The lack of visibility of domestic public funding for key populations makes it difficult to know whether gaps in donor funding for necessary HIV services are being filled locally, or whether the communities that need them are simply going without.

Bilateral donors

Bilateral funding is static; however the Netherlands still plays an important role. For the period 2016-2018, bilateral donors other than PEPFAR contributed $33.3 million directly to key population programs in low- and middle- income countries.[84] This time, using data published on the International AIDS Transparency Datastore, $36.5 million was identified in direct bilateral funding for HIV programs targeting key populations in low- and middle- income countries for the period 2019-2023.[85] Of this, $22 million was provided by the Netherlands, while $14 million was provided by Sweden.

For more than a decade bilateral funding for HIV programs in low- and middle- income countries has been declining, from a peak of $3 billion in 2012, to just $1.2 billion in 2023.[86] In some cases, bilateral donors have redirected their funding to multilateral organizations, such as the Global Fund. In 2023, for example, bilateral donors contributed $4.04 billion to the Global Fund, up from $3.3 billion in 2012.[87] In other cases, they have contributed to intermediary organizations like Aidsfonds, Frontline AIDS, and the Robert Carr Fund for Civil Society Networks, which play a critical role in channeling funding to key population-led organizations and networks including in low- and middle- income countries. For example, the Netherlands, Norway, and United Kingdom contributed a combined $22 million towards the Robert Carr Fund's 2022-2024 funding pool.

Table 6. Key population funding and contributions to the Global Fund, bilateral donors, 2019-2023

Key bilateral donors (excluding U.S.)	Direct bilateral funding in low- and middle- income countries, 2019-2023	Contributions to the Robert Carr Fund for Civil Society Networks, 2019-2024[88]	Contributions to the Global Fund, 2019-2023[89]
The Netherlands	$22M	$15.6M	$321.7M
United Kingdom	$0	$17.6M	$3.2B
Norway	$0	$11.5M	$505.6M
Sweden	$14M	$0	$524.8M
France	$372,000	$0	$2.5B
Total	**$36.4M**	**$44.7M**	**$6.9B**

Direct funding in low- and middle- income countries is important. However, bilateral funding to the Global Fund and through intermediary organizations is also critical in ensuring sustainable and diverse sources of funding for key populations and key population-led organizations. These complimentary funding streams serve different purposes and help strengthen the overall response. The Global Fund's support can help to strengthen the integration of key population programs within national responses, for example, while intermediary organizations are often better placed to get funding to smaller key population-led organizations that comes with fewer administrative hurdles and is accompanied by capacity strengthening and other forms of support. Sustaining and increasing the range of funding, including direct support, support for intermediaries, and funding for the Global Fund, is necessary to close funding gaps and ensure that the HIV needs of key populations are being met.

Philanthropies

Philanthropies continue to be critical donors for key populations. Using anonymized data provided by Funders Concerned about AIDS, philanthropic organizations – including private foundations, private sector donors, and intermediary organizations – contributed an estimated $93.4 million to key population HIV programs in low- and middle- income countries between 2019 and 2022. While funding data for 2023 was not yet available, over the five-year period covered in this report, philanthropic funding accounted for 3.7% of total resources available for key population programs. The amount of funding provided by philanthropies for key population programs annually increased from $19.4 million in 2019 to $29.4 million in 2022.

Despite this positive trend, overall funding from philanthropies was down significantly from the last report: between 2016-2018 philanthropies contributed $131.5 million, accounting for 10% of the total resources available for key population programs at that time. The overall decline reflects broader trends in the philanthropic landscape, with some key donors reducing or ending their funding for HIV and key population programs. As a result, a smaller number of philanthropic donors are providing most of the available resources. Indeed, Funders Concerned about AIDS observed with alarm that all HIV funding from the philanthropic sector decreased by 6% between 2021 and 2022.[90]

For key population-led organizations, philanthropic funding is particularly important because it is more likely to be longer term, support general operating costs, and be flexible, allowing them to adapt and respond to the changing needs of their communities, and shifting social and political dynamics.

It is also more likely to support advocacy, community mobilization, and movement building, which is the backbone of the HIV response and creates the grounds for strong and effective programs that meet key populations' needs. At a time when many key population-led organizations are facing increasing attacks and hostility, philanthropic funding is more important than ever.

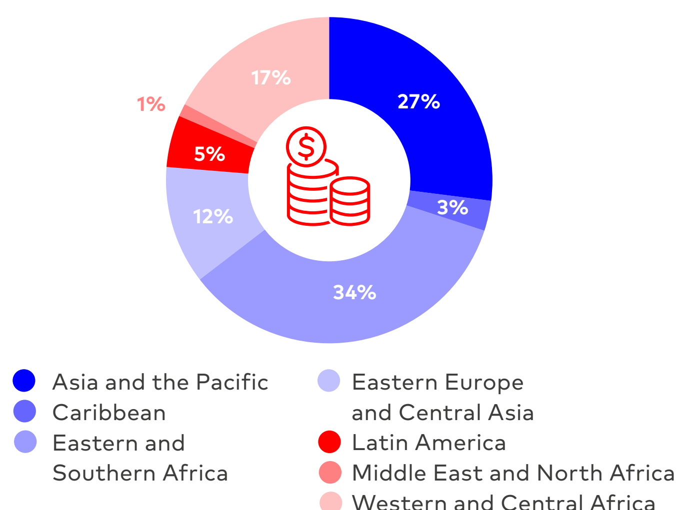
Funding by region

In 2020 — the last year for which funding could be disaggregated by region for all major donors — the greatest amount of funding for HIV key population prevention programs, societal enablers and other forms of support, was concentrated in Eastern and Southern Africa (34%), followed by Asia and the Pacific (27%), and Western and Central Africa (17%).

There are high levels of dependence on donor financing for key population programs across all regions. The Global Fund was the largest donor for key population programs in all regions outside of Eastern and Southern Africa. It provided 84% of all funding benefiting key populations in the Middle East and North Africa and more than half of all funding benefiting key populations in Asia and the Pacific, Eastern Europe and Central Asia, Latin America, and Western and Central Africa. PEPFAR provided 47% of all funding benefiting key populations in Eastern and Southern Africa and 46% of all funding in West and Central Africa, and an average of 28% in other regions, apart from the Middle East where they provide no funding.

Domestic public expenditures on HIV prevention programs for key populations and societal enablers were the highest in Eastern Europe and Central Asia, and Latin America, at 18% and 16% respectively. No domestic spending was reported in 2020 by countries in Western and Central Africa and the Middle East and North Africa.

Figure 3. Distribution of key population funding between regions, 2020



Funding for HIV programs benefiting key populations did not keep pace with the need in any region.

In all regions outside of sub-Saharan Africa and the Caribbean, key populations account for the largest overall proportion of new HIV infections, followed closely by their sexual partners. While there has been significant progress reducing new HIV infections in countries in sub-Saharan Africa, in other regions the numbers of new infections are rising. Almost a quarter of new HIV infections

Table 7. Key population funding by region and funder, 2020

	Global Fund	PEPFAR	Other bilateral donors	Domestic public sources	Philan-thropies
Asia and the Pacific	$61.0M	$36.0M	$597,094	$7.2M	$3.0M
Caribbean	$6.1M	$4.6M	$0	$76,165	$1.2M
Eastern and Southern Africa	$53.5M	$64.7M	$9.3M	$2.6M	$7.7M
Eastern Europe and Central Asia	$24.7M	$9.2M	$157,040	$8.2M	$4.5M
Latin America	$11.8M	$4.2M	$0	$3.3M	$1.2M
Middle East and North Africa	$4.2M	$0	$549,305	$0	$277,563
Western and Central Africa	$35.6M	$31.5M	$0	$40,542	$1.8M
Africa regional	$0	$0	$0	$0	$1.1M
Total	**$197M**	**$150.1M**	**$10.6M**	**$21.4M**	**$20.6M**

Table 8. Combined key population infections and percent of funding benefiting key populations, by region 2020

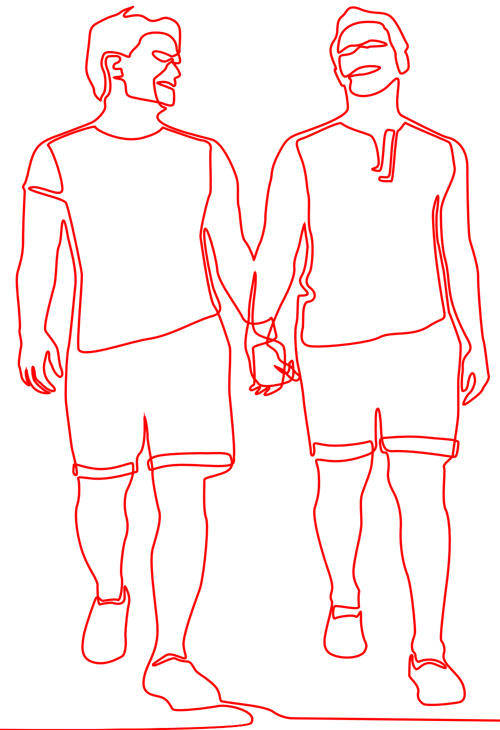
Region	Total HIV funding, 2020	Combined key population percent of new HIV infections, 2022[92]	Total funding for programs benefiting key populations, 2020	Key population funding as a percent of total HIV funding, 2020
Asia and the Pacific	$3.52B	62.8%	$107.7M	3.1%
Caribbean	$278.4M	32.4%	$11.9M	4.3%
Eastern and Southern Africa	$10.4B	9.1%	$137.8M	1.3%
Eastern Europe and Central Asia	$1.6B	45.0%	$46.7M	2.9%
Latin America	$3.6B	57.5%	$20.5M	0.6%
Middle East and North Africa	$172.6M	72.2%	$5.1M	2.9%
West and Central Africa	$2.0B	22.2%	$68.9M	3.5%

now occur in Asia and the Pacific, while new infections have increased since 2010 by 49% in Eastern Europe and Central Asia and 61% in the Middle East and North Africa.[91] These increases are driven by insufficient investments in key population prevention programs, combined with criminalization and stigma, discrimination, and violence, which prevent key populations from accessing available services.

UNAIDS estimates that about 20% of all HIV spending in low- and middle- income countries should be going towards prevention programs for key populations to meet the 2025 targets;[93] yet according to these estimates, funding for key populations did not even reach 5%. In Asia and the Pacific, where key populations account for 62.8% of all new HIV infections, resources for key population prevention programs and societal enablers comprised only 3% of all available resources. In Latin America, where 57.5% of new infections are among key populations, total spending on key population programs amounted to less than 1% of all HIV expenditures.

The average spending on key population programs across all regions was just 2.6% in 2020; far short of the need. In every region, key populations are still being left behind.

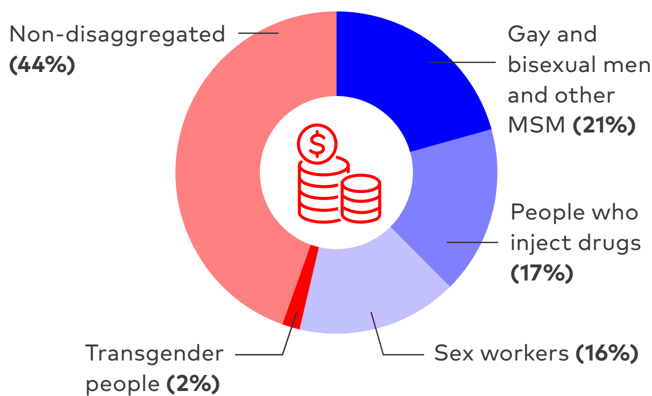
Section 2: Funding by key population



This section provides an analysis of funding that specifically targeted each of the four key populations that are the focus of this report: gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers and transgender people. Between 2019 and 2023, less than 5% of the $5.7 billion needed for key population prevention programs was provided, leaving a staggering gap of more than 95%.

Of all funding available for HIV programs that are likely to primarily benefit key populations, at least 44% is not disaggregated by population type. These are often for programs that serve more than one key population and/or that may address intersections between them.
Of the remaining key population funding, 21% is invested in HIV programs for gay and bisexual men and other men who have sex with men, while 17% and 16% addresses the HIV program needs of people who inject drugs and sex workers, respectively. Just 2% of available key population funding is directed towards HIV programs for transgender people.

Figure 4. Funding by key population, 2019-2023



Gay and bisexual men and other men who have sex with men (MSM)

While HIV infections declined rapidly for most over the last decade, globally the number of HIV infections among gay and bisexual men and other men who have sex with men (MSM) increased by 11% between 2010 and 2022. They now comprise one in five people newly acquiring HIV, up from about one in ten a decade ago.[94] HIV prevention programs are falling far short of their targets: more than 60% of gay and bisexual men and other men who have sex with men did not have access to or receive the suggested two HIV prevention services within the previous three months, and only an estimated 50% of all gay and bisexual men and other men who have sex with men are aware of PrEP.[95]

At the same time, increasing hostility toward the LGBTIQ+ community is doing unprecedented harm to HIV programs for gay and bisexual men and other men who have sex with men in many of the countries where they are needed most. In recent years, LGBTIQ+ organizations across Africa reported that they were facing an uptick in threats, intimidation and violence, as well as increasing challenges to their ability to register, receive funds, and operate freely.[96] Laws that restrict civic space have resulted in the closure or scaling back of HIV prevention programs for key populations in many countries, undermining

Table 9. Total HIV resources for MSM in LMICs, 2019-2023, by funder

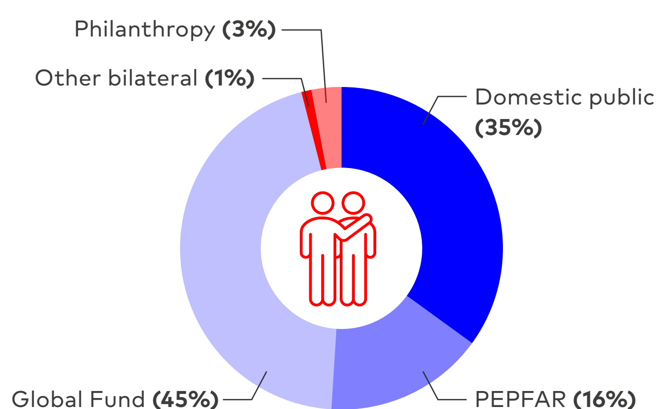
Year	Total	Global Fund[99]	PEPFAR[100]	Other bilateral donors[101]	Domestic public sources[102]	Philanthropies[103]
2019	$106.3M	$30.3M	$13.8M	$2.8M	$56.8M	$2.7M
2020	$66.6M	$45.2M	$11.5M	$1.7M	$3.8M	$4.3M
2021	$319.3M	$145.3M[104]	$14.9M	$1.6M	$57.4M	$3.8M
2022			$18.7M	$0	$54.3M	$4.0M
2023			$18.8M	$0	$0.5M	N/A
Total	**$492.2M**	**$220.8M**	**$77.8M**	**$6.1M**	**$172.9M**	**$14.8M**

HIV responses.[97] Many of the setbacks are due to the increasing influence and power of anti-rights movements who are working to roll back hard-won legal protections and further criminalize and marginalize LGBTIQ+ people, as well as attack their rights to freedom of association and expression.[98]

At a time when funding is urgently required for both core prevention programs and societal enablers to overcome human rights-related barriers to HIV services, available funding is falling well below need. Between 2019 and 2022 – the years with the most complete data – an estimated annual average of $106.4 million was allocated towards programs focused on addressing the HIV needs of gay and bisexual men and other men who have sex with men. This is a decrease from an annual average of $111.1 million between the years 2016-2018. Although community-led HIV responses are essential for the success of HIV programs among gay and bisexual men and other men who have sex with men, it is currently not possible to identify how much funding is being channeled to community-led organizations, and what role they play in implementation of the programs that are being funded.

The Global Fund continues to be the largest funder of programs focused specifically on the HIV prevention needs of men who have sex with men, contributing an average of $44 million per year and 45% of all resources over the five years. PEPFAR provided an average of $15.6 million per year and 16% of all resources. While many private philanthropic donors invest significant resources into funding for LGBTIQ+ communities, fewer target their funding specifically toward men who have sex with men. This period saw a decline in specific philanthropic funding for gay and bisexual men from an average of $19.8 million in the last report, to an average of just $3.7 million in the four years that data was available.[105] While domestic funding was significant during this period, accounting for 35% of all resources, India alone accounted for $156 million, or 90%, of all reported domestic public expenditures.

Figure 5. Funding for MSM in LMICs, 2019-2023, by funder

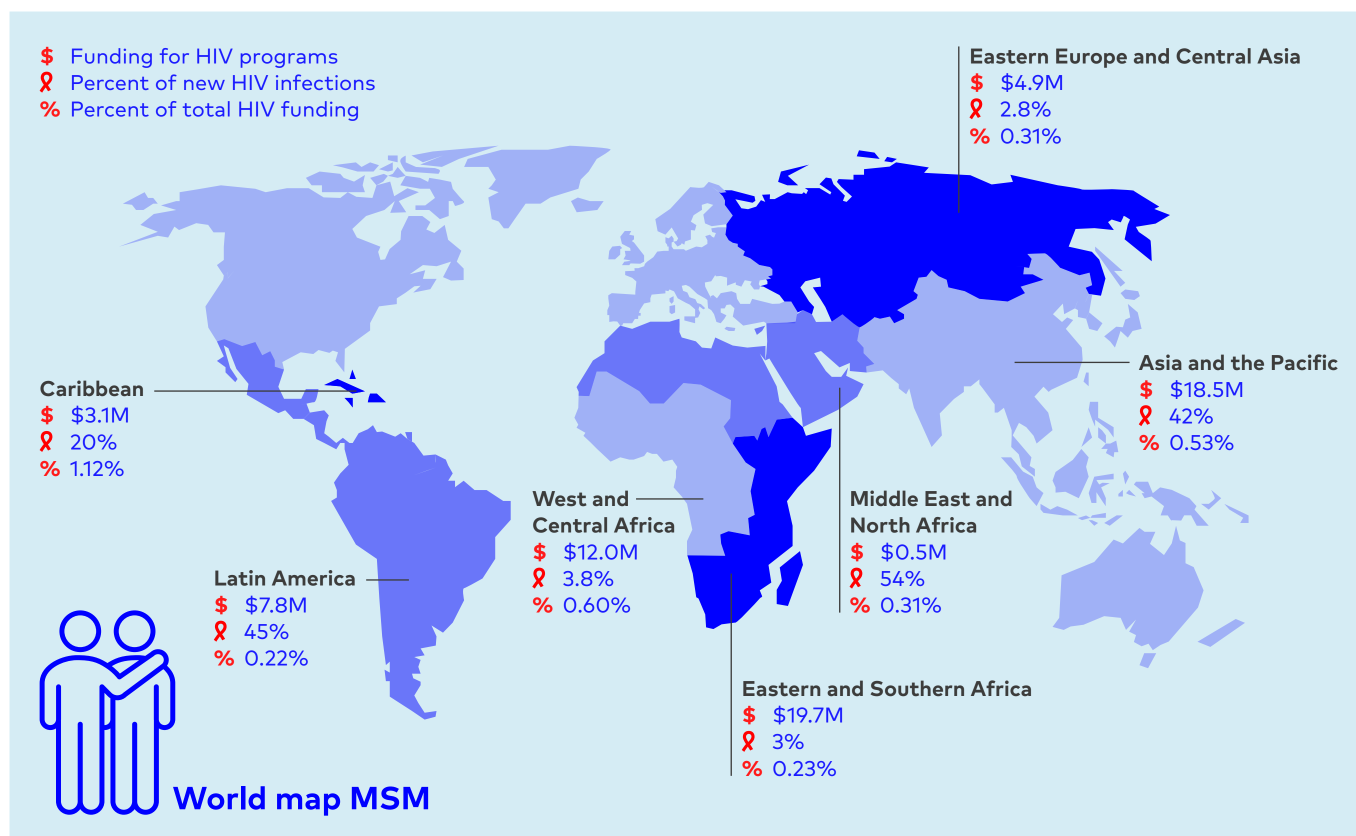


Funding by region

The funding available for HIV programs targeting gay and bisexual men and other men who have sex with the men does not even begin to meet the need. In Asia and the Pacific, Latin America and the Middle East and Africa, where gay and bisexual men account for 40% of those who newly acquired HIV in 2022, the funding available for targeted HIV prevention programs averaged just 0.35% of all expenditures in the region in 2020. Only in the Caribbean, where gay and bisexual men account for 20% of new HIV infections, did funding for prevention programs exceed 1% of total HIV expenditure.

Table 10. HIV infections among MSM and percent of funding benefiting MSM, by region, 2020

Region	Funding for HIV programs benefiting MSM, 2020	Percent of new HIV infections, 2022[106]	Percent of total HIV funding, 2020
Asia and the Pacific	$18.5M	42%	0.53%
Caribbean	$3.1M	20%	1.12%
Eastern and Southern Africa	$19.7M	3%	0.23%
Eastern Europe and Central Asia	$4.9M	2.8%	0.31%
Latin America	$7.8M	45%	0.22%
Middle East and North Africa	$0.5M	54%	0.31%
West and Central Africa	$12.0M	3.8%	0.60%
Total	**$66.6M**	**20%**	**0.3%**



HIV responses are leaving gay and bisexual men and other men who have sex with men behind. Their increasing risk of HIV infection has not been met with increasing resources. Instead, the percentage of funding invested in HIV responses specifically for gay and bisexual men and other men who have sex with me, as a percentage of overall HIV funding, declined from an average of 0.97% for the period 2016-2018,[107] to just 0.30% in 2020.

People who inject drugs

Significant gains have been made in reducing HIV risk among people who inject drugs, with the annual number of new infections among people who inject drugs declining by 24% between 2010 and 2022. Their relative risk of acquiring HIV was 14 times greater than the general population in 2022, down from 21 times greater in 2010. Despite this success, HIV prevention programs are still failing to keep pace with the need, as people who inject drugs accounted for a growing share of new HIV infections: 8% in 2022, up from 6.8% of all new HIV infections in 2010.

Few countries are on track to meet the 2025 targets on HIV prevention for people who inject drugs. Since 2019, only 39% of people who inject drugs received at least two prevention services in the preceding 3 months in the 22 countries that reported. Only 11 of 27 reporting countries have reached the 90% target on coverage of safe injecting practices. Among 26 reporting countries, just 10% of people who inject drugs are receiving opioid agonist maintenance therapy, far below the 50% target. There are significant gender disparities: in the nine countries that reported sex-disaggregated data, 9.4% of men who inject drugs received opioid agonist therapy, while only 3.4% of women did.[108] The reality is that in many low- and middle- income countries, needle and syringe programs and opioid agonist therapy are illegal or are simply not available to people who inject drugs: only 55 countries had at least one needle and syringe program, and only 52 offered any form of opioid agonist therapy.[109] The widespread prevalence of punitive laws against people who inject drugs fuels stigma and discrimination and undermines progress in meeting their HIV service needs. A total of 152 countries continue to criminalize the possession of small amounts of drugs for personal use. In nine reporting countries, a median of 40% of people who inject drugs reported experiencing stigma and discrimination within the past six months, while a median of 17% of people who inject drugs in 19 reporting countries avoided health services because of stigma and discrimination.[110] Even in countries where there are national policies supportive of harm reduction programs, people who use drugs are still subject to police harassment, arbitrary arrest, and other human rights violations.[111]

Despite the urgent need, just 0.4% of all available HIV funding was dedicated toward meeting the needs of people who use drugs between 2019-2023; the same proportion as in the 2020 report covering the period 2016-2018. Between 2019-2022, an estimated average of $86.1 million was allocated to HIV programs for people who inject drugs. This is a slight increase over the average $81.2 million available during the years 2016-2018. While the delivery of harm reduction services by community-led organizations increases service access and quality, it is not possible to identify the extent to which community-led organizations are involved in implementing funded programs.

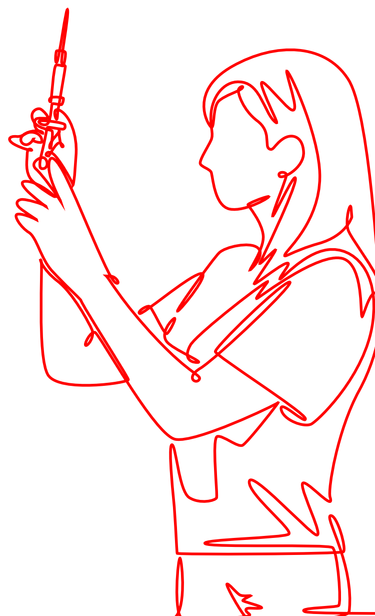


Table 11. Total HIV resources for people who inject drugs in LMICs, 2019-2023, by funder

<table>
<tr><th>Year</th><th>Total</th><th>Global Fund[112]</th><th>PEPFAR[113]</th><th>Other bilateral donors[114]</th><th>Domestic public sources[115]</th><th>Philan-thropies[116]</th></tr>
<tr><td>2019</td><td>$102.9M</td><td>$37.6M</td><td>$8.4M</td><td>$0</td><td>$55.7M</td><td>$1.3M</td></tr>
<tr><td>2020</td><td>$73.0M</td><td>$54.3M</td><td>$7.8M</td><td>$0</td><td>$9.3M</td><td>$1.6M</td></tr>
<tr><td>2021</td><td rowspan="3">$240.0M</td><td rowspan="3">$148.1M[117]</td><td>$11.7M</td><td>$0</td><td>$13.2M</td><td>$1.1M</td></tr>
<tr><td>2022</td><td>$7.9M</td><td>$0</td><td>$36.9M</td><td>$1.6M</td></tr>
<tr><td>2023</td><td>$8.9M</td><td>$0</td><td>$10.6M</td><td>Not available</td></tr>
<tr><td>Total</td><td>$416.0M</td><td>$240.0M</td><td>$44.7M</td><td>$0</td><td>$125.7M</td><td>$5.6M</td></tr>
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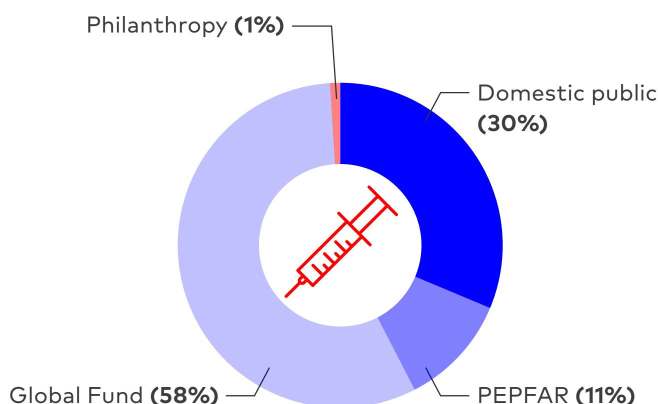
The Global Fund remains the most important funder of harm reduction programs and other prevention interventions for people who inject drugs, providing more than half of all available resources (58% or $240M). Funding from domestic public sources increased significantly over the prior report and accounted for 30% of the funding up from 7.8% during the period 2016-2018. The greatest levels of funding from domestic public sources were in India ($21.2), Vietnam ($21.1M), Georgia ($20.1M), and Iran ($18.3M). PEPFAR provided 11% of total funding, a slight decrease in share compared to the previous report (12%).

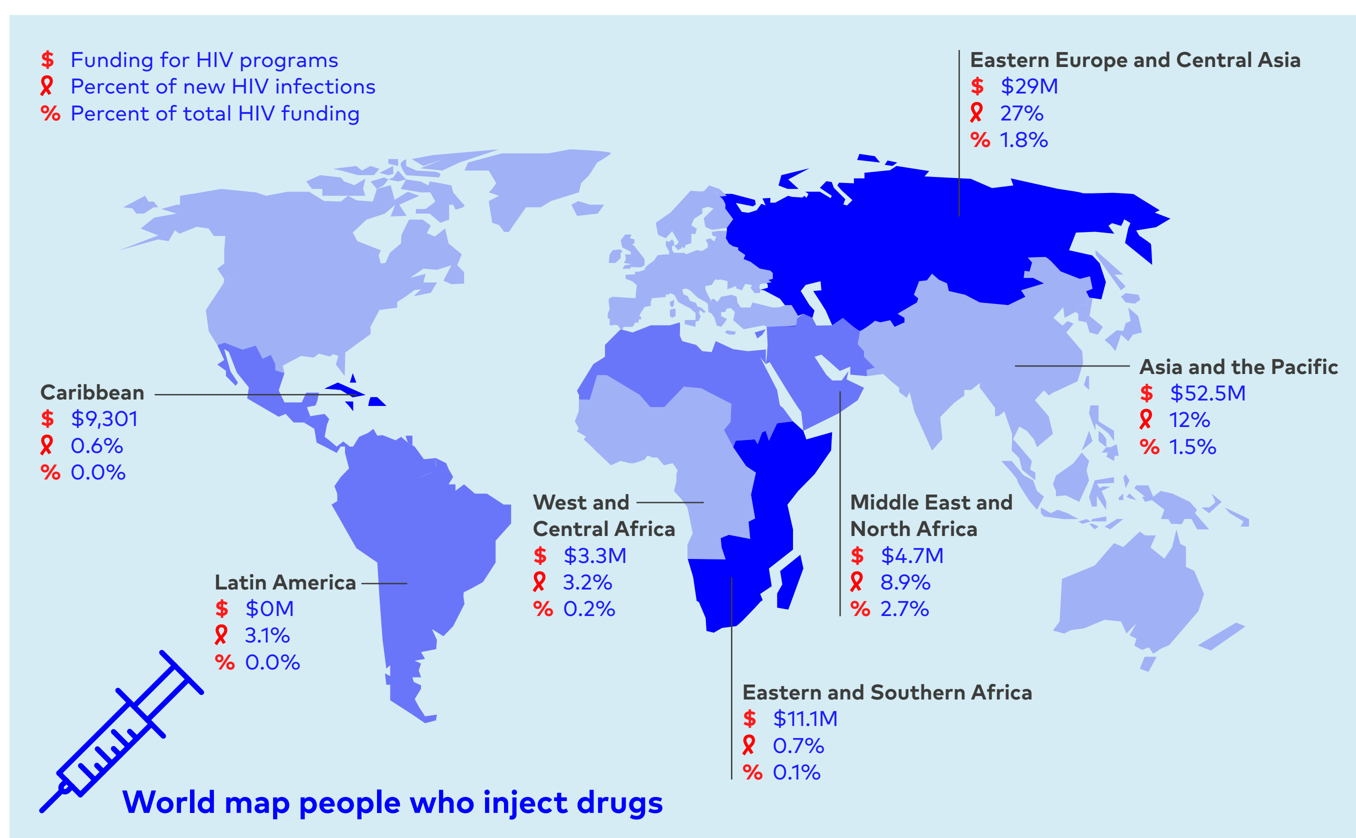
Figure 6. Funding for people who inject drugs, 2019-2023, by funder



Support from private philanthropies dropped considerably in the period 2019-2023 compared to the prior report: an annual average of approximately $1.4M was identified in direct support to organizations in low- and middle-income countries, down from an average of $8.2M. Some of this drop may be accounted for by a change in methodology, which now discounts funding provided to international or intermediary organizations and general key population funding. However, a shift in priorities from the Open Society Foundations (OSF) has also had a significant impact: according to Harm Reduction International, OSF's total funding for harm reduction — including to international non-governmental organizations and others in high income countries — declined from $6.9M in 2019 to $3.9M in 2022.[118] While other funders — such as the Robert Carr Fund for Civil Society Networks, the Elton John AIDS Foundation and ViiV Healthcare — have increased funding for harm reduction programs, this has not fully offset the gap.[119]

Table 12. HIV infections among people who inject drugs and percent of funding benefiting people who inject drugs, by region, 2020[120]

Region	Funding for HIV programs for people who inject drugs, 2020	Percent of new HIV infections among people who inject drugs, 2022[121]	Percent of total HIV funding, 2020
Asia and the Pacific	$52.5M	12%	1.5%
Caribbean	$9,301	0.6%	0.0%
Eastern and Southern Africa	$11.1M	0.7%	0.1%
Eastern Europe and Central Asia	$29M	27%	1.8%
Latin America	$0	3.1%	0.0%
Middle East and North Africa	$4.7M	8.9%	2.7%
West and Central Africa	$3.3M	3.2%	0.2%
Total	**$100.5M**	**8%**	**0.5%**



While people who inject drugs account for 27% of new HIV infections in Eastern Europe and Central Asia, just 1.8% of all spending in the region in 2020 was invested in programs specifically for people who inject drugs, representing a staggering gap. While the establishment of harm reduction programs in the region has been critical for HIV prevention, the passage of "foreign agent" and "drug propaganda" laws are threatening progress by reducing access to funding for organizations that work on harm reduction, and by criminalizing harm reduction services and advocacy.[122]

In Asia and the Pacific, where people who inject drugs account for 12% of new infections, only 1.5% of all HIV investments went towards meeting their HIV needs. In the Middle East and North Africa, 2.7% of all funding available in the region in 2020 was focused on programs for

people who inject drugs, up from an average of just 0.7% in for the period 2016-2018.
In 2020, only a small proportion of funding was available to meet the needs of people who inject drugs across sub-Saharan Africa. For that year, no funding could be identified for programs for people who inject drugs in Latin America, and less than $10,000 was allocated for programs in the Caribbean. In these regions, there are significant numbers of people whose HIV needs are simply going unmet.

Sex workers

HIV infections among sex workers in sub-Saharan Africa declined by 50% between 2010 and 2020, but in most other regions there has been no change. In some countries HIV incidence is increasing.[123] Globally, sex workers account for 7.7% of all new HIV infections; they are nine times more likely to acquire HIV than the general population.[124] There are significant disparities in HIV risk among female, male and transgender sex workers. In the few countries that report disaggregated data, HIV prevalence is higher among transgender and male sex workers than female sex workers. Sex workers continue to face barriers to HIV prevention services, with only half accessing the recommended two or more HIV prevention services within the past three months.[125]

Sex work continues to be highly criminalized, with more than 170 countries criminalizing some or all aspects of sex work. Criminalization significantly increases HIV risk by increasing stigma, discrimination, intimidation, and violence, and erecting barriers to HIV services. An analysis of the impact of criminal laws in 10 sub-Saharan African countries found that HIV prevalence was seven times higher among sex workers in countries where sex work was criminalized, compared to those in countries where it is at least partially legal or decriminalized.[126]

Over the four years between 2019 and 2022, an estimated annual average of $79.3 million was allocated towards programs specifically focused on addressing the HIV needs of sex workers. In the last report, an annual average of $118.9 million was spent on programs for the period 2016-2018. This represents a significant year on year decline in specific investments in sex worker programming.

Although sex worker-led organizations have been indispensable in providing HIV prevention services, addressing barriers to access, and advocating for the removal of punitive laws, it is not possible to track how much funding is being received by sex worker-led organizations.

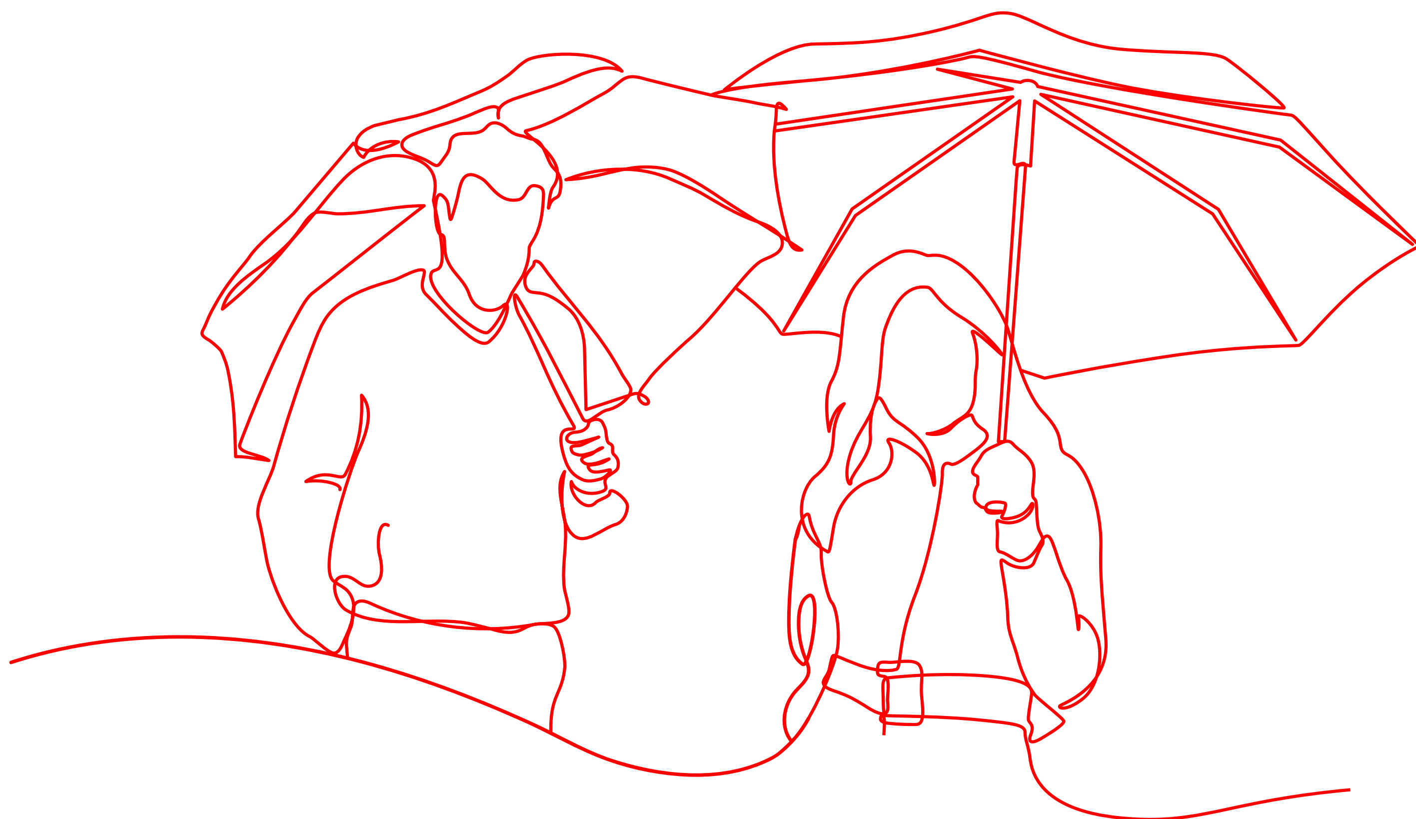
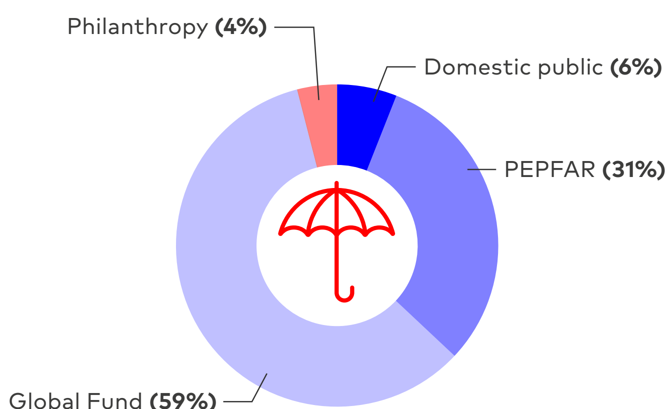


Table 13. Total HIV resources for sex workers in LMICs, 2019-2023, by funder

Year	Total	Global Fund[127]	PEPFAR[128]	Other bilateral donors[129]	Domestic public sources[130]	Philan-thropies[131]
2019	$77.9M	$43.9M	$23.3M	$0	$7.8M	$2.8M
2020	$83.0M	$54.9	$18.8M	$0	$5.4M	$3.8M
2021	$223.1M	$127.3M[132]	$24.4M	$0	$9.4M	$4.8M
2022			$27.8M	$0	$584,267	$3.9M
2023			$25.5M	$0	$127,671	Not available
Total	**$384M**	**$226.0M**	**$119.8M**	**$0**	**$23.5M**	**$14.7M**

The Global Fund remains the leading funder of HIV prevention programs specifically for sex workers, accounting for at least 59% of all funding. PEPFAR provided 31% of resources, increasing its share of funding from 26% in the prior report. Domestic public sources of funding accounted for a growing proportion of available resources, however reports of investments in sex worker-specific programs dropped considerably in 2022 and 2023. South Africa ($8.6M), Thailand ($4.6M), Bangladesh ($3M), Kazakhstan ($2.5M), and El Salvador ($2.2M) accounted for most reported domestic public spending.

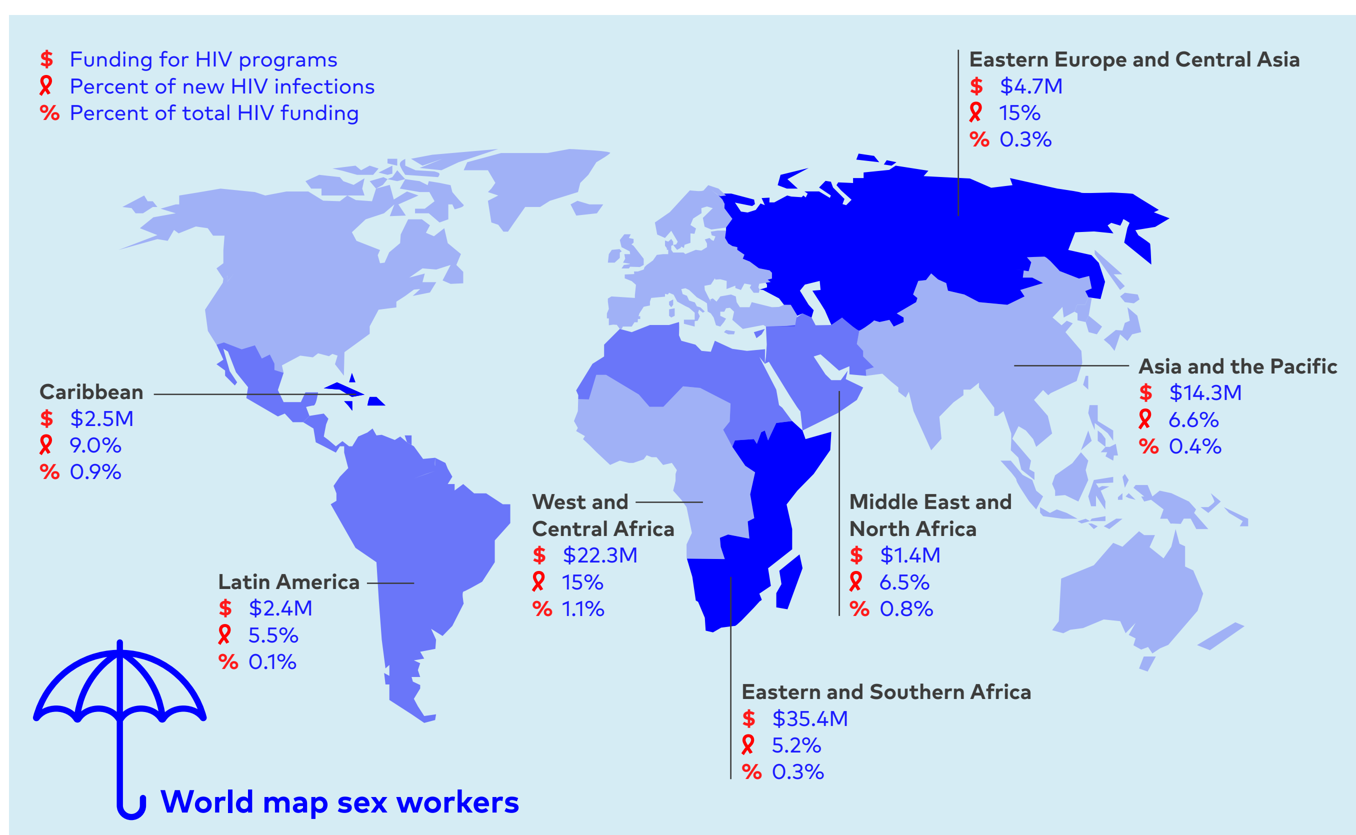
Figure 7. Funding for sex workers, 2019-2023, by funder



Philanthropies continue to play a critical role in investing in HIV programs specifically for sex workers, investing 4% of available resources, although funding has decreased significantly compared to the 2020 report.[133] As with funding for harm reduction programs, the closure of the Open Society Foundation's Sexual Health and Rights Project, is likely to have an outsized impact moving forward. For example, while OSF's funding extended beyond HIV programs, they provided $4.7 million to organizations in sub-Saharan Africa working to advance sex workers' health and rights between 2018 and 2023, mostly in flexible general operating support to sex worker-led organizations.[134] No specific direct investments from bilateral donors in sex worker programs in low- and middle- income countries could be identified between 2019 and 2023. This is in part due to States' funding being channeled through intermediary organizations, such as the Robert Carr Civil Society Networks Fund.

Table 14. HIV infections among sex workers and percent of funding, by region, 2020

Region	Funding for HIV programs for sex workers, 2020	Percent of new HIV infections, 2022[135]	Percent of total HIV funding, 2020
Asia and the Pacific	$14.3M	6.6%	0.4%
Caribbean	$2.5M	9.0%	0.9%
Eastern and Southern Africa	$35.4M	5.2%	0.3%
Eastern Europe and Central Asia	$4.7M	15%	0.3%
Latin America	$2.4M	5.5%	0.1%
Middle East and North Africa	$1.4M	6.5%	0.8%
West and Central Africa	$22.3M	15%	1.1%
Total	**$83.0M**	**7.7%**	**0.4%**



In 2020, the last year for which funding can be disaggregated by region, investments in sex worker-specific programs did not come close to meeting the need. The highest level of investment was in Eastern and Southern Africa, where $35.4 million was provided for sex worker-specific HIV programs. However, this accounts for just 0.3% of all HIV funding in Eastern and Southern Africa, a region where sex workers accounted for 5.2% of all new infections. As a proportion of overall HIV funding, the investment was greatest in West and Central Africa, where 1.1% of available resources ($22.3M) were invested in sex worker-specific HIV programs; a region where one in six new HIV infections occur among sex workers. In Eastern Europe and Central Asia, where 15% of new HIV infections are among sex workers, just 0.3% of available resources were invested in programs designed to meet their specific HIV needs. The glaring gap in investment in sex worker-specific programs has the potential to undermine fragile gains that have been made in reducing HIV incidence among sex workers.

Transgender people

Funding for transgender communities continues to be minimal. Transgender women are now 20 times more likely to acquire HIV than cisgender people who are not part of other key populations, up from 11 times higher risk in 2010.[136] The median HIV prevalence rate among transgender people is 9%, reaching as high as 58% in South Africa.[137] Data on HIV risk for transgender men and other trans people who were assigned female at birth (AFAB) is sparse due to the persistent assumption that they are at low HIV risk. Only nine countries have reported data for HIV prevalence among transgender men within the past five years.[138] However, where data is available, transgender men and other AFAB transgender people are estimated to be almost seven times more likely to be living with HIV than the general population.[139] A recent study in Zimbabwe, for example, found an HIV prevalence rate of 38.5% among trans men and other AFAB trans sex workers, almost four times higher than among the general population.[140] Data is similarly scarce on transgender communities' access to services. However, the available information suggests that access to HIV prevention services remains out of reach for most transgender people. Among 13 reporting countries, only 39% of transgender women were able to access the recommended two or more HIV prevention services in the prior three months.[141]

Transgender communities are a particular target of anti-gender and anti-rights movements, with harmful consequences. In 2023, Global Action for Trans Equality (GATE) reported that increased attacks against transgender communities have limited advocacy opportunities, cut off access to decision-makers, and reduced access to funding. At the same time, these attacks have reduced access to HIV and other critical services, increasing transgender communities' vulnerability.[142] In light of these attacks, funding to support and strengthen transgender-led organizations, including for advocacy, addressing gender and human rights-related barriers to HIV services, and HIV service delivery, is particularly urgent. Yet, there are significant gaps between the urgent need and available resources: $43.3 million was specifically designated for HIV programs for transgender people between 2019 and 2023. For the years 2019-2022, where data is most complete, this represents an average of just $9.8 million annually.

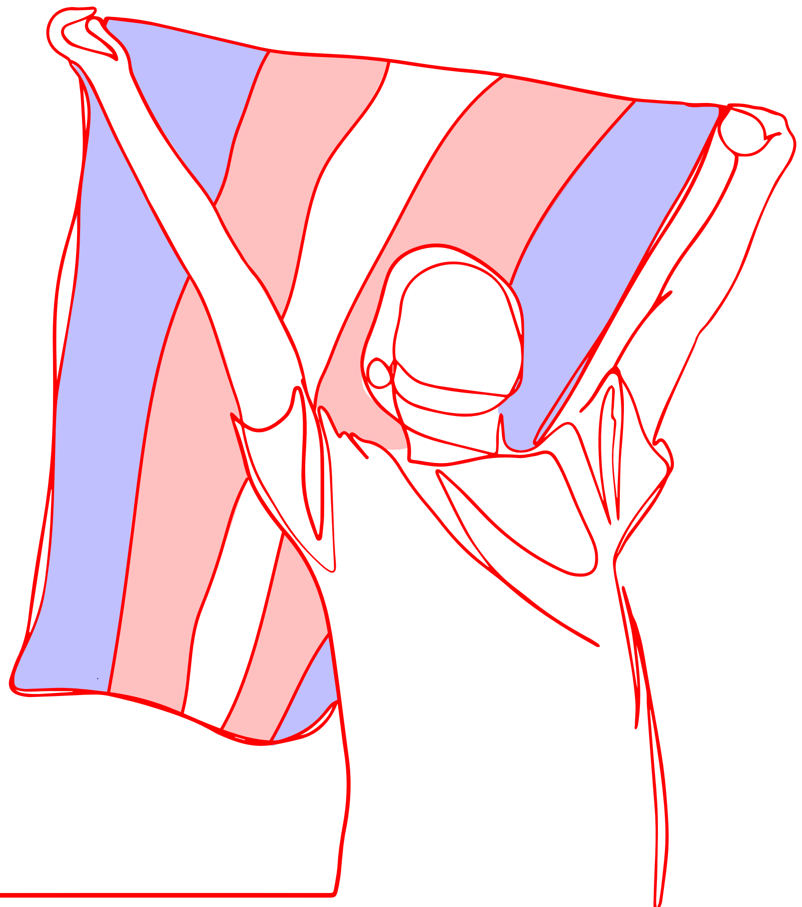


Table 15. Total HIV resources for transgender people in LMICs, 2019-2023, by funder

Year	Total	Global Fund[143]	PEPFAR[144]	Domestic public sources[145]	Other bilateral[146]	Philan-thropies[147]
2019	$4.5M	$2.7M	$468,682	$361,174	$310,793	$664,576
2020	$7.2M	$4.8M	$808,935	$370,273	$193,547	$1.1M
2021			$717,664	$552,034	$177,842	$1.8M
2022	$31.6M	$23.3M	$1.2M	$172,665	$0	$2.6M
2023			$1.0M	$23,247	$0	Not available
Total	**$43.3M**	**$30.8M**	**$4.2M**	**$1.5M**	**$682,183**	**$6.2M**

Between 2019-2023, the Global Fund was the largest funder of HIV prevention programs for transgender people. Investments increased from $2.75 million in 2019, to an average of $7.8 million in the years 2021-2023, accounting for 71% of funding between 2019 – 2023. Philanthropies provided 14% of support for HIV programs among transgender communities, increasing from $665,000 in 2019 to $2.6 million in 2022. PEPFAR support remained relatively small, representing only 10% of all funding and hitting a peak of $1.15 million in 2022.

Domestic sources accounted for $1.5 million, 3% of all funding during this period, with Thailand accounting for 47.7% of that amount ($719,000). While fewer countries overall reported funding for 2023, it is important to note that in many reporting countries – including Thailand, El Salvador and Georgia – there was a significant reduction of funding from domestic public sources compared to previous years. Other direct bilateral support accounted for only 1.5% of the total investment in transgender communities, although as with other key populations some bilateral support was likely channeled through intermediaries.

Figure 8. Funding for transgender people, 2019-2023, by funder

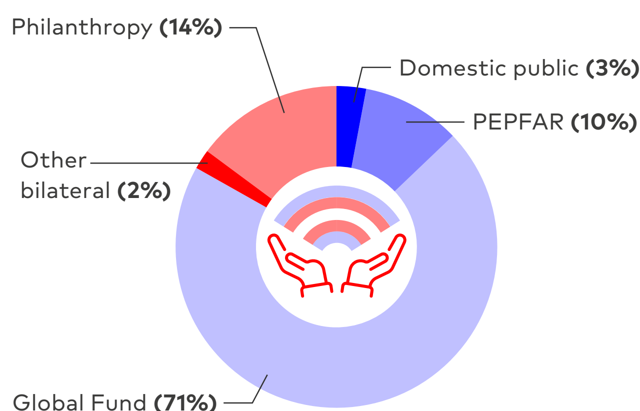
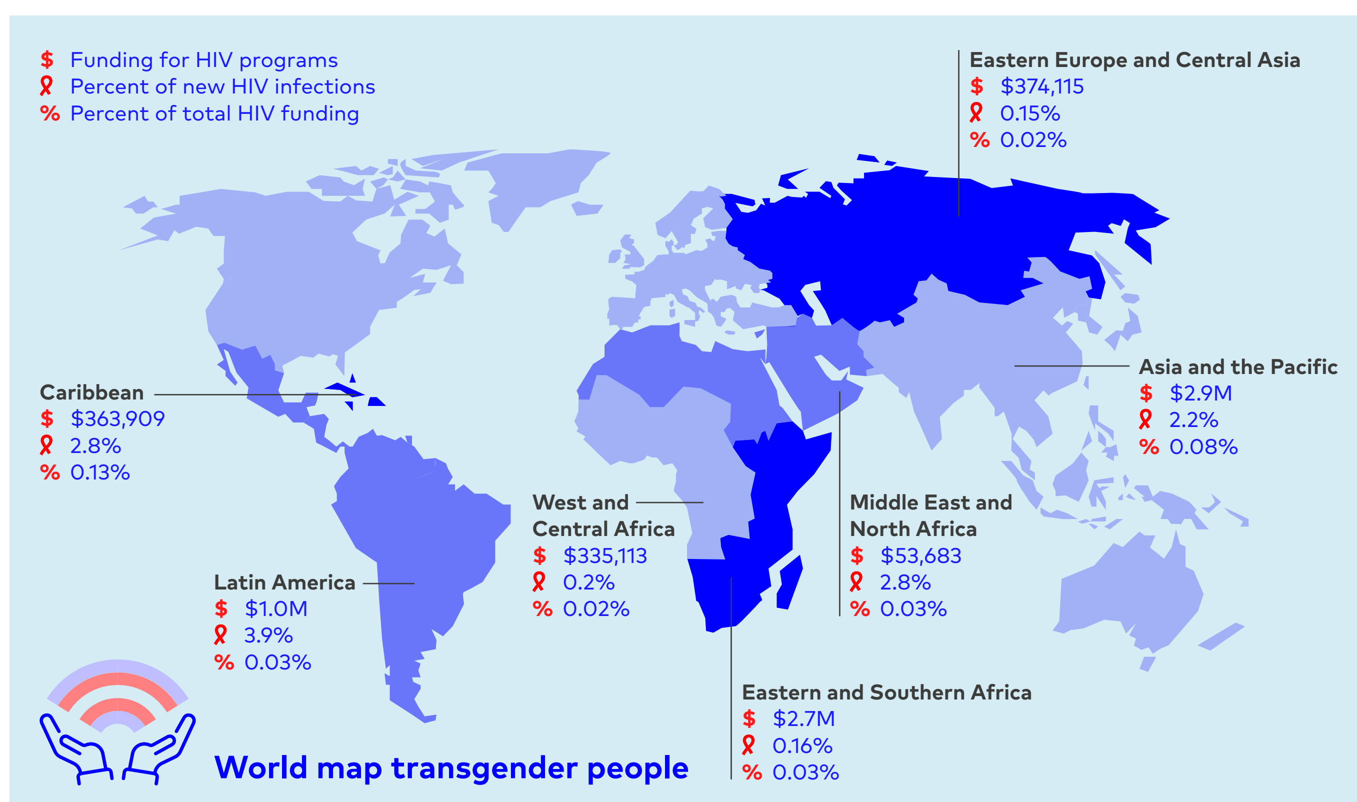


Table 16. HIV infections among transgender women and percent of funding benefiting transgender people, by region, 2020[148]

Region	Funding for HIV programs for transgender people, 2020	Percent of new HIV infections among transgender women, 2022[149]	Percent of total HIV funding, 2020
Asia and the Pacific	$2.9M	2.2%	0.08%
Caribbean	$363,909	2.8%	0.13%
Eastern and Southern Africa	$2.7M	0.16%	0.03%
Eastern Europe and Central Asia	$374,115	0.15%	0.02%
Latin America	$1.0M	3.9%	0.03%
Middle East and North Africa	$53,683	2.8%	0.03%
West and Central Africa	$335,113	0.2%	0.02%
Total	**$7.0M**	**1.1%**	**0.03%**



Across all regions, investments in transgender communities were less than 0.15% of the total HIV investment in the region, despite the fact that transgender women are 20 times more likely to acquire HIV than cisgender people who are not part of other key populations.

Transgender people account for a growing proportion of new HIV infections globally, yet investments in specific programs to address their HIV prevention needs, and reduce barriers to access, are not proportionate to need in any region of the world. The greatest levels of investment in 2020 were in Asia and the Pacific at $2.9 million, followed by $2.7 million in Eastern and Southern Africa. In Latin America, where 1 in 25 new HIV infections are among transgender persons, only $1 million was available; just 0.03% of all HIV funding in the region. As a proportion of all HIV funding, the greatest investment was in the Caribbean, where 0.13% of all available resources are invested in specific HIV programs for transgender communities.

Conclusions and recommendations

Funding for key population programs is dangerously off track, undermining progress towards the goal of ending AIDS as a public health threat by 2030. As this report demonstrates, the gap between available funding and the need is staggering. At least 20% of all available HIV resources should be dedicated to HIV programs addressing the needs of key populations, yet between 2019 and 2023 only 2.6% of HIV funding was focused on key population programs. $5.7 billion is needed specifically for HIV prevention, yet in 2023 just 4.5% of the funding needed for comprehensive prevention programs was available. $3.1 billion is needed for societal enablers, which should primarily benefit key populations. However in 2023, just 2.5% of that amount was identified. For key populations, the consequences of failing to meet these needs are devastating.

Outside of sub-Saharan Africa, key populations and their sexual partners account for more than 80% of new HIV infections. And while significant progress has been made in reducing the number of new HIV infections within sub-Saharan Africa, key populations now account for 25% of all new cases of HIV in this region.[150]

Yet across the world, more than half of all men who have sex with men, people who inject drugs, sex workers, and transgender people do not have access to the HIV prevention services that they need.[151] Not only are key populations' HIV prevention needs not being met, they are also significantly less likely to be on treatment than their peers in the general population. At the same time, widespread stigma, discrimination and other human rights violations are on the rise due to anti-gender, anti-rights, and anti-democratic movements who are working to roll back key populations' hard-won protections.

The world is failing key populations. Without a drastic turnaround in funding and action to protect their human rights, it will not be possible to end AIDS as a public health crisis by 2030.

All major funders — national governments in low- and middle- income countries, the Global Fund, PEPFAR, other bilateral donors, and private philanthropies — must take decisive action to ensure that the needs of key populations are centered within HIV responses. And they must allocate resources accordingly. National governments should reduce their reliance on donors to fund key population programs by increasing funding from domestic public sources, and work in partnership with key population-led organizations to remove harmful punitive laws, and address other barriers to HIV services. Other donors should set ambitious targets for their HIV spending among key populations, in line with the 2025 targets. Ensuring that that money reaches organizations that are led by key populations themselves will increase the effectiveness of key population prevention programs and help ensure longer term sustainability.

In addition, HIV funders should:[152]

1. **Provide long-term, flexible and unrestricted funding directly to key population-led organizations.** Flexible funding allows key population-led organizations to better meet the HIV needs of the communities they serve, as well as to engage in advocacy, adapt strategies in response to changing political and social environments, invest in strengthening their capacity, and increase their long-term sustainability and resilience.
2. **Reduce barriers to funding for key population-led organizations.** Many key population-led organizations face challenges accessing funding due to burdensome administrative requirements established by donors, lack of networks with other HIV organizations and donors, and exclusion from decision-making processes. Mechanisms to directly fund community-led organizations, strengthen their capacity, and otherwise reduce barriers are urgently needed to ensure that they can effectively access resources.

3. **Set ambitious benchmarks for investments in comprehensive prevention programs for key populations in line with the 2025 targets, and track and report on investments over time.** Take action to ensure that 80% of prevention programs are implemented by community-led organizations, and report on progress toward this goal.
4. **Increase investments in programs to address human rights-related barriers to HIV services and other societal enablers for key populations.** This should include funding for community empowerment, as well as funding that enables key population-led organizations to increase their safety and security, prepare for crises, and respond to emergencies. To achieve the 2025 community leadership target, take action to ensure that 60% of programs to achieve societal enablers are implemented by community-led organizations, and report on progress toward this goal.
5. **Publicly push back against oppressive and criminal laws, attacks on civic space, and the influence of anti-gender, anti-rights and anti-democratic movements.** Funders of HIV responses should use their diplomatic voice and political leverage to protect the human rights of key populations. In doing so, they should work closely with key population-led organizations to guide how and when to leverage their influence, to avoid additional harm.
6. **Strengthen mechanisms that support the leadership of key populations in defining priorities and making funding decisions, including in national HIV strategies, budgets, and in funding requests.** Whether through participatory grantmaking, ensuring engagement of key population in country coordinating mechanisms, country dialogues or PEPFAR COP processes, key populations must be engaged in decision-making about funding to ensure that resources are available for appropriate programs. No decisions should be made on HIV programs for key populations without their active and meaningful engagement.
7. **Ensure that key populations are included in research and data collection efforts,** including program evaluations, operational research, and integrated biological and behavioral surveillance. Including key populations closes gaps in epidemiological and other data, increases knowledge of effective key population programming, and informs the allocation of resources.
8. **Ensure that HIV programs and services implemented by non-key population-led partner organizations meet the needs of key populations** and are consistent with the World Health Organization's consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations.
9. **In countries that are facing the end of bilateral or multilateral funding ("transition countries"), work in collaboration with key populations, national governments, philanthropy, and other donors, to ensure that critical key population programs are sustained.** In places where this is not possible due to hostile social and political environments, continue to provide resources directly to key population-led organizations.
10. **Increase data transparency** by ensuring that budgets for HIV programs – including prevention, treatment, and investments in human rights and other societal enablers – are disaggregated by key population and are publicly available.
11. **Ensure that staff within funding organizations have sufficient capacity and expertise to support the active engagement of key population-led organizations** in the design, implementation, monitoring, and evaluation of grants. Engage relevant key population-led networks and their resources in internal capacity strengthening efforts.

The lack of funding for key population programs is not just undermining progress towards the global goals, it's harming already marginalized communities who are bearing both the brunt of the HIV epidemic and the fallout from a world that is experiencing political and social upheaval. At a moment when democracy and fundamental human rights are at risk, support for key populations, who are often the first to be targeted, is more important than ever.

Gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers, and transgender people cannot wait any longer for comprehensive and effective HIV programs that meet their needs. It's past time. A dramatic increase in political will and funding is needed now.

Annex 1: detailed methodology

PEPFAR

Figures shown for PEPFAR are based on reported expenditures by PEPFAR implementing partners, contained within the data set "PEPFAR Program Expenditures, February 1, 2024". This data set is available for download from PEPFAR at https://data.pepfar.gov/datasets. A search of the data set for the years 2019 to 2023 was conducted using the following filters:

Beneficiary: key Pops

Sub-beneficiary:
- Men having sex with men;
- People who inject drugs;
- Sex workers;
- Transgender; and
- Not disaggregated.

Results were then filtered by operating unit, which is the highest geographic unit (countries or regions) where PEPFAR works, and then each of the individual expenses were combined to establish total expenditure for the specific key population within in countries or regions by year. Expenditures that were not disaggregated were included in the total global and regional figures for key population funding by PEFAR, but are not counted under investments in specific key populations in section 2. It is important to note that the key populations not disaggregated category may include some investments in people in prisons and other closed settings.

Of all investments in key populations, further analysis was done to identify PEPFAR expenditures in specific program areas, specifically for prevention and societal enablers. Investments in prevention programs were identified by filtering the program field by PREV. Additional filtering was done by the sub-program PrEP to identify specific investments in Pre-Exposure Prophylaxis for key populations.

Investments in societal enablers were identified by filtering the program field by SE (Socio-Economic Programs, which includes investments in human rights protection and advocacy, among other areas) and additionally by filtering the sub-program field by Laws, Regulations and Policy Environments (under the ASP Above-site Program category). All investments in socio-economic programs, sub-program laws, regulations, and policy environments, were counted as societal enablers.

PEPFAR does not include HIV testing for key populations as part of their prevention program, but instead report on that as a separate program. PEPFAR spent $222.25 million on HIV testing over the five-year period.

It is important to note that significant amounts of PEPFAR expenditures for key populations are in other program areas including Program Management, Above-Site Programs (apart from investment in laws, regulations and policy environments included elsewhere), and HIV Care and Treatment. These programs comprise 38.3% of all expenditures where key populations were identified as beneficiaries. However, only $618,000 over the five-year period was spent on HIV drugs and 80% of that funding was spent in 2019. This accounts for just 0.06% of the total PEPFAR funding counted in this report. Most of the expenditures under this program area focused on clinical care. This indicates that, like the Global Fund and domestic public sources, most HIV treatment funding for key populations is not captured in data.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The data for 2019 and 2020, and some grants for 2021-2023, is drawn from the Global Fund's Grant Agreement Implementation Period Detailed Budget data set, which is publicly available through the Global Fund's Data Service. The detailed budget data provides budget information for each grant in each allocation period starting with Grant Cycle 5 (2017-2019). The data set is frequently updated as budgets are changed or adapted during grant implementation. The primary data used in this analysis was downloaded on April 17, 2024 and

July 19, 2024. In June 2024, the Global Fund changed the way that it reported its data to provide additional information on budgets for specific interventions, in addition to modules or broader program areas.

For grant cycle 5 (grants signed between 2017-2020), the data was filtered by the following modules to identify specific investments in HIV prevention programs for key populations:

- Comprehensive prevention programs for MSM
- Comprehensive prevention programs for people who inject drugs (PWID) and their partners
- Comprehensive prevention programs for sex workers and their clients
- Comprehensive prevention programs for TGs

This data was further filtered by budget year and geography name and then each of the individual budget line items were combined to establish total expenditure for the specific key population prevention programs within in countries or multicountry grants by year. It is important to note that for some grants and countries, such as India and Uganda, disaggregated data for comprehensive prevention programs for key populations was not available.

Due to a change in the Global Fund's budgeting methodology, similar disaggregated data for grant cycle 6 (grants signed between 2021-2023) was not collected in the Implementation Period Budget Data Set. Instead, there is one prevention module. Interventions under that module include some harm reduction interventions, including needle and syringe programs, overdose prevention programs and opioid agonist therapy, as well as interventions for young key populations (not further disaggregated). The data set was filtered for these interventions, then further filtered by budget year and geography name, to establish budgeted amounts for these specific prevention interventions within countries.

However, most of the aggregate data for grants signed between 2021 and 2023 is drawn from the Global Fund's board reporting on its Key Performance Indicator 5a, which tracks investment in key population prevention programs in a subset of countries, available at: https://archive.theglobalfund.org/media/13540/archive_bm50-16-strategic-performance-mid-2023_report_en.pdf. While this data is disaggregated by key population, it is not disaggregated by country or region or budget year. It includes budget data only for a subset of grants: 111 out of a total of 149 grants that were signed during grant cycle 6. The list of grants included in the analysis was provided to Aidsfonds separately.

All grants signed between 2021 and 2023 have three-year implementation periods, and as such implementation for some grants included in the Global Fund's analysis may extend into 2024 and 2025. For such grants, to offset overcounts, budget data for grant cycle 5 grants that was implemented in the years 2021 and 2022 was excluded from the overall total prevention numbers. The amounts excluded include $21.7 million for men who have sex with men; $13.5 million for people who inject drugs; $17 million for sex workers; and $2.6 million for transgender people, for a total of $54.8 million. Most of this funding ($44.9 million or 81.9%) was budgeted for 2021; the remainder was budgeted for 2022.

For all remaining 38 grants not included in the Global Fund's analysis, funding for comprehensive prevention programs for key populations from grant cycle 5 grants that were implemented in 2021, 2022 and 2023 were added to the totals for those years. In addition, any funding for the harm reduction interventions and interventions for young key populations that were also budgeted for implementation in 2021, 2022, or 2023, were also added to the total budget amounts for HIV prevention programs for key populations for those years. The 38 grants included one or more grants for the following countries and regions: Afghanistan, Albania, Algeria, Belarus, Cabo Verde, Cameroon, Central African Republic, Comoros, Côte d'Ivoire, Dominican Republic, Ghana, Guinea-Bissau, Indonesia, Iran, Jamaica, Lesotho, Liberia, Madagascar, Mauritius, Myanmar, Namibia, Nigeria, North Macedonia, Panama, Rwanda, Sao Tome and Principe, Sierra Leone, South Sudan, Sri Lanka, Thailand, Togo, Tunisia, Ukraine and the Multicountry Western Pacific.

To establish estimates of the Global Fund's investments in societal enablers, the budget data was filtered to include the RSSH module: Community Systems Strengthening, if it was included in grants with an HIV component and the module: Reducing human rights-related barriers to HIV/TB services. The data was then disaggregated by budget year. These modules were available for all budget years. Data on

societal enablers was only included in the aggregate funding in section 1 of the report and not in specific funding for men who have sex with men, people who inject drugs, sex workers and transgender people in section 2 of the report. While much of the Global Fund's investments in societal enablers is likely to benefit key populations, not all of it does.

Domestic public expenditure

The data on domestic public expenditure was drawn from UNAIDS' Global AIDS Monitoring Programme Expenditures Data Set, which is available for download on UNAIDS' HIV Financial Dashboard at https://hivfinancial.unaids.org/ and includes information voluntarily reported by countries.

To establish investments in specific key population prevention programs, the data was filtered by the following HIV Programmes:

- PrEP for gay men and other men who have sex with men
- PrEP for sex workers
- PrEP for persons who inject drugs
- PrEP for transgender persons
- Prevention, promotion of testing and linkage to care programmes for gay men and other men who have sex with men
- Prevention, promotion of testing and linkage to care programmes for sex workers and their clients
- Prevention, promotion of testing and linkage to care programmes for people who inject drugs
- Prevention, promotion of testing and linkage to care programmes for transgender persons

The data was further filtered by expenditure year, country, and domestic public sources to establish total expenditures for HIV prevention programs by year and by region.

To establish investments in societal enablers, the data was filtered by the following HIV programmes:

- Key human rights programmes
- Community mobilization and systems strengthening

The data was further filtered by expenditure year, country, and domestic public sources to establish total expenditures in societal enablers by year and by region.

In addition to the data reported through UNAIDS Global AIDS Monitoring, verified investments reported in Harm Reduction International's report, The Cost of Complacency: A Harm Reduction Funding Crisis, were included. The report is available for download at https://hri.global/wp-content/uploads/2024/06/HRI_Funding-Report-2024_AW_080724.pdf. This included data only for 2019 and 2022.

It is important to note that there are significant gaps in data on domestic public expenditures. Only 80 countries reported any expenditures in HIV programs to UNAIDS for the years 2019-2023 at least once, and of them only a subset reported any expenditures in key population programs.

Philanthropies

Anonymized data was provided by Funders Concerned about AIDS (FCAA), drawn from the submissions received from private philanthropy as part of their annual tracking report. The data was reviewed to remove funding that benefited key populations in high-income countries, as well as funding to intermediary organizations to the extent that it could be identified within grant descriptions, even if that funding was intended to benefit key populations in middle-and low-income countries. This decision was made to minimize duplications in funding, given that many intermediary organizations also report their sub-granting to FCAA. Funding that was primarily benefitted intersex people, lesbian and bisexual women, or other vulnerable populations such as adolescent girls and young women, was also removed from the data, given that they are not the focus of this report.

The funding was then disaggregated by year of disbursement, each of the key populations, and at the country, regional and multi-country level. If the grants covered more than one key population group, it was included in an aggregate key population category and not further disaggregated or counted as funding for specific key populations; this included funding for LGBTIQ+ organizations where there was not a specific focus on men who have sex with men or transgender people and where funding was primarily focused on achieving societal enablers. This is a departure from the previous report, where the full amount of each grant was counted for each key population, as is the methodology used by FCAA.

However, 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%, consistent with the previous report.

These methodological decisions mean that the funding totals for philanthropies in this report are significantly lower than the previous report. However, it is important to note, there has been some overall decline: FCAA noted a 6% overall decrease in philanthropic funding for HIV in 2022 compared to 2021.

Other bilateral donors

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, bisexual men
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 and were included. Where men who have sex with men and transgender people were combined, funding was split 90%/10%. For grants that specifically focused on key populations, but did not disaggregate, or that covered two or more key populations, the amount was included in the total global figure only.

Only disbursements made in 2019, 2020, 2021, 2022, and 2023 were included. Amounts reported in currencies beside US dollars were converted using https://www.ofx.com.

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End notes

1 In this report, the term key populations is used to refer collectively to gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers and transgender people. Information about specific key populations is disaggregated and discussed as needed. This analysis does not examine funding specifically for people in prison and other closed settings, however some funding for HIV key populations that is not disaggregated by population may also include funding specifically addressing their HIV needs.

2 This research looks at all reported funding by international donors — including PEPFAR, other major bilateral donors, the Global Fund to Fight AIDS, TB and Malaria, and philanthropic organizations — where key populations were either target populations or named beneficiaries. It also examines funding from domestic public sources to the extent available. Prevention programs, including specific funding earmarked for PrEP, is analyzed separately, to the extent possible.

3 UNAIDS (2022). End Inequalities. End AIDS. Global AIDS Strategy 2021-2026. Geneva: UNAIDS. P. 150.

4 UNAIDS (2024). The Urgency of Now: AIDS at a Crossroads. Global AIDS Update 2024. UNAIDS: Geneva, available at: https://crossroads.unaids.org/wp-content/uploads/2024/09/GAU-2024-Full-report_En.pdf.

5 UNAIDS (2024).

6 UNAIDS, HIV Financial Dashboard. Accessed October 10, 2024. Available at https://hivfinancial.unaids.org/.

7 UNAIDS. HIV Financial Dashboard.

8 Aidsfonds (2020).

9 UNAIDS (2024).

10 In this report, the term key populations is used to refer collectively to gay and bisexual men and other men who have sex with men, people who inject drugs, sex workers, and transgender people. Information about specific key populations is disaggregated and discussed as needed. This analysis does not examine funding specifically for people in prison and other closed settings, however some funding for HIV key populations that is not disaggregated by population may also include funding specifically addressing their HIV needs.

11 This research looks at all reported funding by international donors — including PEPFAR, other major bilateral donors, the Global Fund to Fight AIDS, TB and Malaria, and philanthropic organizations — where key populations were either target populations or named beneficiaries. To the extent possible it also includes funding from domestic public resources. Prevention programs, including specific funding earmarked for PrEP, is analyzed separately, to the extent possible.

12 Aidsfonds (2020).

13 United Nations General Assembly (8 June 2021). Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. Available at: https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf.

14 UNAIDS (2022).

15 UNAIDS (2024).

16 UNAIDS (2022).

17 CIVICUS (2023). Challenging Barriers: Investigating Civic Space Limitations on LGBTIQ++ Rights in Africa. CIVICUS.

18 The Global Fund to Fight AIDS, Tuberculosis and Malaria (2023). Advocacy Roadmap 2023-2025. Available at: https://www.theglobalfund.org/media/13367/publication_advocacy-roadmap_report_en.pdf.

19 CIVICUS (2024). People Power Under Attack 2023: Civicus Monitor. Available at: https://monitor.civicus.org.

20 CIVICUS (2024).

21 CIVICUS (2023).

22 UNAIDS (2022).

23 UNAIDS (2024).

24 UNAIDS (2024).

25 UNAIDS (2024).

26 UNAIDS. Laws and Policies Analytics Database. Accessed October 10, 2024. Available at https://lawsandpolicies.unaids.org/. UNAIDS (2024).

27 UNAIDS (2022).

28 UNAIDS HIV Financial Dashboard.

29 UNAIDS HIV Financial Dashboard.

30 UNAIDS (2024).

31 UNAIDS HIV Financial Dashboard.

32 Aidsfonds (2020).

33 Korenromp, Eline L. PhDa; Sabin, Keith PhDa; Stover, John MAb; Brown, Tim PhDc; Johnson, Leigh F. PhDd; Martin-Hughes, Rowan PhDe; ten Brink, Debra MPHe; Teng, Yu PhDb; Stevens, Oliver MPHf; Silhol, Romain PhDf,g; Arias-Garcia, Sonia MSca; Kimani, Joshua MD, MPHh,i; Glaubius, Robert PhDb; Vickerman, Peter DPhilj; Mahy, Mary ScDa. (2024). New HIV Infections Among Key Populations and Their Partners in 2010 and 2022, by World Region: A Multisources Estimation. JAIDS Journal of Acquired Immune Deficiency Syndromes 95(1S):p e34-e45 | DOI: 10.1097/QAI.0000000000003340 (Korenromp, et al. 2024)

34 Korenromp, et al (2024).

35 PEPFAR Program Expenditures, February 1, 2024. Available at https://data.pepfar.gov/datasets.

36 The data for 2019 and 2020, and a subset of grants for 2021-2023, is drawn from the Global Fund's Grant Agreement Implementation Period Detailed Budget data set, which is publicly available through the Global Fund's Data Service. Other data for the years 2021-2023 is drawn from the Global Fund to Fight AIDS, Tuberculosis and Malaria (2023). Strategic Performance Reporting mid-2023. 50th Board Meeting, 14-16 November 2023, Geneva Switzerland. GF/B50/16. Available at: https://archive.theglobalfund.org/media/13540/archive_bm50-16-strategic-performance-mid-2023_report_en.pdf.

37 International Aid Transparency Initiative Datastore, available at https://datastore.iatistandard.org.

38 Data provided by FCAA; on file with the Aidsfonds.

39 The UNAIDS Global AIDS Monitoring Database is available for download on the UNAIDS HIV Financial Dashboard, https://hivfinancial.unaids.org/. Domestic funding for harm reduction programs for people who inject drugs verified by Harm Reduction International was added to our estimates of total domestic expenditures. Davies, Charlotte; Cook, Catherine; and Gurung, Gaj (2024). The Cost of Complacency: A Harm Reduction Funding Crisis. Harm Reduction International: London. Available at: https://hri.global/wp-content/uploads/2024/06/HRI_Funding-Report-2024_AW_080724.pdf (Davies, C. et al. (2024)).

40 The data for philanthropic donors covers 2019-2022.

41 Societal enablers are the legal, cultural, social, political and economic factors that increase the effectiveness of HIV responses by removing barriers to health care and supporting individuals and communities to protect their health and well-being. The 2021 political declaration identifies several societal enablers, including protection of human rights, supportive legal environments and access to justice, gender equality and empowering women and girls to take charge of their sexual and reproductive health and reproductive rights, and freedom from stigma and discrimination. See United Nations General Assembly (2021).

42 In the previous report, a decision was made in consultation with the Global Fund to divide funding for combined programs targeting gay and bisexual men and other men who have sex with men and transgender communities by a 9:1 ratio. This breakdown was based on the ratio of funding for gay and bisexual men and other men who have sex with men and funding for transgender people from the Global Fund in 2018, when they began to track funding for the two populations separately. This ratio was then applied to other funding from bilateral and philanthropic donors that jointly targeted gay and bisexual men and other men who have sex with men and transgender communities.

43 UNAIDS (2024a). New HIV Infections among Key Populations: Proportions in 2010 and 2022. Geneva: UNAIDS.

44 UNAIDS (2024).

45 Aidsfonds (2020).

46 Data for 2021, 2022, and 2023 includes an average derived from the total estimated amount of the Global Fund's investments in that three-year period. This average may not provide an accurate assessment of how funding was distributed in each year over that period, however the aggregate number represents the best available data.

47 This includes all philanthropic funding; specific investments in community system strengthening and human rights from the Global Fund and Domestic Public Sources; some bilateral funding; and PEPFAR funding for all socio-economic programs and laws, regulations and policy environments under its above-site program area.

48 This includes all other PEPFAR investments where key populations are identified as beneficiaries; as well as all investments in prevention and societal enablers.

49 UNAIDS. HIV Financial Dashboard.

50 Data for 2021, 2022, and 2023 includes an average derived from the total amount of the Global Fund's investments in that three-year period. This average may not provide an accurate assessment of how funding was distributed in each year over that period, however the aggregate figure for 2021-2023 represents the best available data.

51 UNAIDS. HIV Financial Dashboard.

52 In the 2020 report, HIV prevention funding for key populations was not disaggregated from other types of funding for HIV key populations.

53 Aidsfonds (2020).

54 UNAIDS. HIV Financial Dashboard.

55 UNAIDS (2024).

56 UNAIDS (2024a).

57 UNAIDS (2024a).

58 Aidsfonds (2020).

59 PEPFAR Program Expenditures, February 1, 2024. Available at https://data.pepfar.gov/datasets.

60 This includes all investments in socioeconomic programs and programs to address laws, regulations, and policy environments, which could be collectively considered societal enablers.

61 This includes investments in other programs where key populations are identified as beneficiaries, including HIV testing, above-site programs, program management, and care and treatment.

62 "Combination HIV prevention seeks to achieve maximum impact in preventing HIV acquisition by combining human rights-based and evidence-based behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic." UNAIDS (2024). UNAIDS Terminology Guidelines. UNAIDS: Geneva. Available at https://www.unaids.org/sites/default/files/media_asset/2024-terminology-guidelines_en.pdf. Combination prevention programs can include, for example, community-based testing, condom and lubricant programs, needle and syringe programs, pre- and post-exposure prophylaxis, combined with peer education, programs to reduce stigma and discrimination in health care settings, community empowerment approaches, among others.

63 PEPFAR (2022). Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030. Washington: US Department of State. Available at: https://www.state.gov/wp-content/uploads/2022/11/PEPFARs-5-Year-Strategy_WAD2022_FINAL_COMPLIANT_3.0.pdf.

64 Network of Sex Work Projects. Briefing Paper #01: PEPFAR and Sex Work. Available at: https://www.nswp.org/sites/default/files/PEPFAR%20%26%20SW.pdf.

65 United States Department of State (July 19, 2024). PEPFAR Press Release: New PEPFAR Action Plan to Address HIV-Service Equity Gaps for Key Populations.

66 Funding for PEPFAR is appropriated annually by the US Congress, and for FY2025 appropriated funding was a flat $4.4 billion compared to the prior year. In previous fiscal years, PEPFAR was able to supplement the annual appropriated amount of funding by drawing down unspent funds from previous years. However, those funding reserves have now been depleted, resulting in an overall cut.

67 Moss, K. and Kates, J. (27 March 2024). PEPFAR's Short-Term Reauthorization Sets an Uncertain Course for Its Long-Term Future. Kaiser Family Foundation: Washington. Available at: https://www.kff.org/policy-watch/pepfars-short-term-reauthorization-sets-an-uncertain-course-for-its-long-term-future/.

68 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Grant Agreement Implementation Period Detailed Budget data set. Available at: https://data-service.theglobalfund.org/downloads.

69 The Global Fund to Fight AIDS, Tuberculosis and Malaria (2023a). Strategic Performance Reporting mid-2023. 50th Board Meeting, 14-16 November 2023, Geneva Switzerland. GF/B50/16. Available at: https://archive.theglobalfund.org/media/13540/archive_bm50-16-strategic-performance-mid-2023_report_en.pdf. (Global Fund 2023a).

70 The Global Fund to Fight AIDS, Tuberculosis and Malaria (2023a).

71 See Annex 1 for detailed methodological notes.

72 See annex 1 for detailed methodological notes on the calculation of the Global Fund's investments in societal enablers.

73 The Global Fund's support for community systems strengthening includes funding for community-based monitoring; community-led research and advocacy; and social mobilization, building community linkages and coordination.

74 See Annex 1 for the detailed methodology.

75 This includes all key population prevention funding, as well as funding for modules focused on human rights-related barriers to HIV/TB services and community systems strengthening, much of which benefits key populations. Funding on similar interventions were included in the 2016-2018 analysis, as provided by the Global Fund and on file with Aidsfonds

76 Global Fund to Fight AIDS, Tuberculosis and Malaria. Grant Implementation: Budgets Time Cycle Data Set, which shows aggregate HIV spending over time. Available at: https://data.theglobalfund.org/viz/budgets/time-cycle (Downloaded June 6, 2024).

77 This is likely an underestimate, due to the lack of data on funding for prevention programs for key populations in a significant number of grants during the years 2021-2023. Disaggregated data was available for more grants in 2019 and 2020.

78 The Global Fund to Fight AIDS, Tuberculosis and Malaria (3 July 2024). Projected transitions from Global Fund Country Allocations by 2028: Projections by component. Available at https://www.theglobalfund.org/media/9017/core_projectedtransitionsby2028_list_en.pdf.

79 Open Society Foundations (2017). Lost in Transition: Three Case Studies of Global Fund Withdrawal in South Eastern Europe. OSF: New York. Available at: https://www.opensocietyfoundations.org/publications/lost-transition.

80 UNAIDS Global AIDS Monitoring Program Expenditures Database (Downloaded 13 October, 2024). Available at https://hivfinancial.unaids.org/.

81 UNAIDS Global AIDS Monitoring Program Expenditures Database.

82 UNAIDS Global AIDS Monitoring Program Expenditures Database.

83 Davies, et al. (2024).

84 In the last report, bilateral donors other than PEPFAR contributed $69.2 million toward key population programs over the period 2016-2018, however this included $35.9 million in funding to intermediary organizations including Aidsfonds and the Robert Carr Fund for Civil Society Networks that sub-grant to organizations in low- and middle- income countries. In this report, contributions to global intermediary organizations were not counted, to avoid duplications in the data, given that many intermediary organizations report their sub-grants to organizations in low- and middle- income countries to Funders Concerned about AIDS.

85 Contributions to global intermediary organizations were not included in this year's report, to avoid duplications in the data given that many intermediary organizations report their sub-grants to organizations in low- and middle- income countries to Funders Concerned about AIDS.

86 UNAIDS HIV Financial Dashboards.

87 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Pledges and Contributions Data Set (Downloaded 6 Nov 2024). Available at: https://data-service.theglobalfund.org/downloads.

88 The Robert Carr Fund operates on three-year funding cycles. The data in this report covers two funding cycles: 2019-2021 and 2022-2024. Robert Carr Fund for Civil Society Networks (2022). Annual Report 2021: Stronger Networks, Stronger Communities. RCF: Amsterdam; Robert Carr Fund for Civil Society Networks (2024): With Communities in the Lead: 2023 Annual Report. RCF: Amsterdam.

89 The Global Fund to Fight AIDS, Tuberculosis and Malaria. Pledges and Contributions Data Set.

90 Funders Concerned about AIDS (2024). Philanthropy's Response to HIV and AIDS: 2022 Grantmaking. FCAA: Washington, available at https://resourcetracking.fcaaids.org/wp-content/uploads/2024/07/FCAA-SupportReport2022.pdf.

91 UNAIDS (2024).

92 Korenromp, et al (2024).

93 UNAIDS (2024).

94 UNAIDS (2024); Korenromp, et al (2024).

95 UNAIDS (2024); UNAIDS (2024c). HIV and Gay Men and Other Men Who Have Sex with Men: 209204 Global AIDS Update Thematic Briefing Note. UNAIDS: Geneva. Available at: https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update-gay-men_en.pdf.

96 CIVICUS (2023).

97 Holt, Ed (2024). NGOs seek novel funding sources amid global crackdown. The Lancet, Volume 404, Issue 10461, 1390-1391.CIVICUS, PITCH, Aidsfonds, Frontline AIDS and BZ (2020). Activism and AIDS: Protect civil society's space to end the epidemic; International Center for Not-for-Profit Law (2018). Reinforcing Marginalization: The Impact of Closing Civic Space on HIV Response in Ethiopia, Kenya and Uganda. Washington, D.C., ICNL.

98 While some countries have expanded protections for LGBTIQ+ rights, homosexuality is still criminalized in 63 countries, and some countries have recently passed laws imposing new restrictions, including Uganda, Iraq, and Georgia. An anti-homosexuality law passed in Ghana, however it is undergoing a legal challenge and has not been signed into law by the President. In the past year, bills increasing penalties for homosexuality or banning "same sex propaganda" have been introduced in Senegal, Moldova, Belarus, and Russia, while courts have upheld existing criminal laws in Ghana, Malawi, and St. Vincent and the Grenadines. ILGA World Database (Accessed 12 November, 2024). Available at: https://database.ilga.org/en.

99 The Global Fund numbers only include investments in comprehensive prevention programs for men who have sex with men.

100 PEPFAR identifies men who have sex with men as beneficiaries of multiple program areas, including HIV prevention, HIV testing, above-site programs, care and treatment, and program management.

101 Funding from bilateral donors includes all investments in societal enablers and HIV prevention programs where men who have sex with men are identified as the beneficiary.

102 Funding from domestic public sources only includes expenditures in comprehensive prevention programs for men who have sex with men.

103 Funding from philanthropies includes all investments in programs where gay and bisexual men and other men who have sex with men are identified as the primary beneficiary.

104 Data disaggregated by year for the period 2021-2023 is not available from the Global Fund. See FN67 for a detailed explanation. Given the lack of available data for 2021-2023 on funding in a number of grants, this is likely an underestimate of the Global Fund's contribution towards programs for gay and bisexual men and other men who have sex with men.

105 Some, but not all, of this decline can be attributed to a change in methodology which no longer counts funding for both men who have sex with men and sex workers or people who use drugs as funding for men who have sex with men.

106 Korenromp, et al (2024).

107 Some of the decrease in overall percentages may be due to changes in this reports' methodology, which does not include in estimates of funding designated specifically for men who have sex with men funding that is provided to intermediary organizations or funding that is not specifically disaggregated by key population.

108 UNAIDS (2024d). HIV and People Who Inject Drugs: 2024 Global AIDS Update Thematic Briefing Note. UNAIDS: Geneva. Available at https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update-people-who-inject-drugs_en.pdf.

109 Harm Reduction International (2024). The Global State of Harm Reduction 2024. HRI: London.

110 UNAIDS (2024d).

111 Harm Reduction International (2024).

112 Funding from the Global Fund only includes its investments in comprehensive prevention programs for people who inject drugs.

113 PEPFAR identifies people who inject drugs as beneficiaries of multiple program areas, including HIV prevention, HIV testing, above-site programs, care and treatment, and program management.

114 Funding from bilateral donors includes all investments in societal enablers and HIV prevention programs where people who inject drugs are identified as the beneficiary.

115 Funding from domestic public sources only includes expenditures in comprehensive prevention programs for people who inject drugs.

116 Funding from philanthropies includes all investments in programs where people who inject drugs are identified as the primary beneficiary.

117 Data disaggregated by year for the period 2021-2023 is not available from the Global Fund. Given that for some grants data is only available for a subset of harm reduction interventions for people who inject drugs, this is likely to be an underestimate.

118 Davies, et al. (2024).

119 Davies, et al. (2024).

120 A regional breakdown is provided only for 2020 because it is the last year that data disaggregated by region is available for most donors.

121 Korenromp, et al (2024).

122 Harm Reduction International (2024).

123 UNAIDS (2024); Korenromp, et al (2024).

124 UNAIDS (2024); Korenromp, et al (2024).

125 UNAIDS (2024); UNAIDS (2024e). Sex Workers: 2024 Global AIDS Update Thematic Briefing Note. UNAIDS: Geneva. Available at: https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update-sex-workers_en.pdf

126 UNAIDS (2024); UNAIDS (2024e).

127 Funding from the Global Fund only includes its investments in comprehensive prevention programs for sex workers.

128 PEPFAR identifies sex workers as beneficiaries of multiple program areas, including HIV prevention, HIV testing, above-site programs, care and treatment, and program management.

129 Funding from bilateral donors includes all investments in societal enablers and HIV prevention programs where sex workers are identified as the beneficiary.

130 Funding from domestic public sources only includes expenditures in comprehensive prevention programs for sex workers.

131 Funding from philanthropies includes all investments in programs where sex workers are identified as the beneficiary.

132 This is likely an underestimate of Global Fund support, given that disaggregated funding for prevention interventions among sex workers was not available for a significant number of grants for the period 2021-2023.

133 Some of this decrease can be accounted for by a shift in the methodology: in this report, funding to intermediary organizations or those based in high-income countries is not included in funding totals for sex worker programs. In addition, broad key population funding that is not specifically designated for sex worker programs is not counted in the overall totals for sex worker-focused programs. In the previous report any funding that included sex workers as beneficiaries alongside other key populations was counted as sex worker-specific funding.

134 Jang, Beksahn and Erin Howe (2024). The Impact of Open Society Foundation's Funding Withdrawal on the Sex Worker Rights Movement, and Recommendations for a Path Forward. Sex Worker Donor Collaborative and Strength in Numbers Consulting Group. Available at: https://strengthinnumbersconsulting.com/wp-content/uploads/2024/02/SWDC-report.pdf.

135 Korenromp, et al (2024).

136 UNAIDS (2024f). HIV and Transgender People: 2024 Global AIDS Update Thematic Briefing Note. UNAIDS: Geneva. Available at: https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update-transgender-people_en.pdf.

137 UNAIDS (2024f).

138 GATE (2023) Policy Brief on Effective Inclusion of Trans Men in the Global HIV and Broader Health and Development Responses. GATE: New York; UNAIDS (2024f).

139 GATE (2023); Stutterheim SE, van Dijk M, Wang H, Jonas KJ (2021) The worldwide burden of HIV in transgender individuals: An updated systematic review and meta-analysis. PLOS ONE 16(12): e0260063. https://doi.org/10.1371/journal.pone.0260063

140 GATE (2023) UNAIDS (2024g). Zimbabwe Fact Sheet 2023. Available at: https://www.unaids.org/en/regionscountries/countries/zimbabwe (accessed Nov. 23, 2024).

141 UNAIDS (2024f).

142 GATE (2023a). Impact of Anti-Gender Opposition on TGD and LGBTIQ+ Movements: Global Report. GATE: New York. Available at: https://gate.ngo/wp-content/uploads/2024/02/GATE_Global-report-on-the-impact-of-AG-opposition-on-TGD-and- LGBTIQ+-movements_2023.pdf.

143 Funding from the Global Fund only includes its investments in comprehensive prevention programs for transgender people.

144 PEPFAR identifies transgender people as beneficiaries of multiple program areas, including HIV prevention, HIV testing, above-site programs, care and treatment, and program management.

145 Funding from domestic public sources only includes expenditures in comprehensive prevention programs for transgender people.

146 Funding from bilateral donors includes all investments in societal enablers and HIV prevention programs where transgender people are identified as the beneficiary.

147 Funding from philanthropies includes all investments in programs where transgender people are identified as the primary beneficiary.

148 Global epidemiological estimates are currently only available for transgender women, representing a significant gap in data.

149 Korenromp, et al (2024).

150 UNAIDS (2024).

151 UNAIDS (2024).

152 Many of these recommendations are drawn from key population-led organizations. Including the following resources: TGEU, GATE, ILGA World, APTN, IGLYO, and ESWA (20 Nov. 2024). Trans Day of Remembrance Joint Statement: We honor the lives of our sibling and demand safety amidst growing hate and anti-rights movements. Available at: https://tgeu.org/trans-day-of-remembrance-2024-joint-statement/; GATE (2023); Davies, et. al. (2024).

Ministry of Foreign Affairs of the Netherlands

Made possible by support from the Dutch Ministry of Foreign Affairs