STOPAIDS.

UNITING UK VOICES ON THE GLOBAL RESPONSE

INCREASING DFID'S CONTRIBUTION TO ADDRESSING HIV AMONG KEY POPULATIONS

Review and recommendations

STOPAIDS.

STOPAIDS is the network of UK agencies working since 1986 to promote an effective global response to HIV and AIDS. With 80 members behind us, we raise a united voice to rally and maintain the UK's leadership in the global response to HIV. Together, and with people living with HIV at the centre of our efforts, we fight for a global response that respects, protects and fulfils human rights. We give decision-makers the proof – and sometimes the push – they need to make the right, smart choices to help improve the lives of the millions of people around the world needing treatment, prevention, care or support.

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ACRONYMS AND ABBREVIATIONS

CSOs	civil society organisations
DFID	Department for International Development
EU	European Union
FCO	Foreign & Commonwealth Office
LGBT	lesbian, gay, bisexual and transgender
MDG	Millenium Development Goals
MIC	middle-income countries
MSM	men who have sex with men
NSWP	Global Network of Sex Work Projects
PPA	Programme Partnership Agreement (DFID)
PCB	Programme Coordinating Board (UNAIDS)
TRIPS	trade-related aspects of intellectual property rights
RCNF	Robert Carr Civil Society Networks Fund
UNDP	UN Development Programme
UNFPA	UN Population Fund
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
UNODC	UN Office on Drugs and Crime
WHO	World Health Organization

1 INTRODUCTION

Female sex workers are 14 times more likely to contract HIV than other women of reproductive age, while globally men who have sex with men are 19 times more likely than other men.

Outside of Africa, **30% of new HIV infections are among people who inject drugs**, rising to 80% in some countries.

Transgender people, who are often overlooked or conflated with MSM, are also acutely vulnerable, with one study estimating that **transgender women are 49 times more likely to have HIV** than the general population.

These statistics show that Millennium Development Goal 6, which aims to halt and reverse the spread of HIV, will not be met without a stronger focus on key populations.

In developing countries, female sex workers are 14 times more likely to contract HIV than other women of reproductive age[1], while globally men who have sex with men (MSM) are 19 times more likely than other men[2]. Outside of Africa, 30% of new HIV infections are among people who inject drugs, rising to 80% in some countries.[3] Transgender people, who are often overlooked or conflated with MSM, are also acutely vulnerable, with one study estimating that transgender women are 49 times more likely to have HIV than the general population[4] and a growing body of evidence pointing to high HIV risks for transgender men too[5]. These statistics show that Millennium Development Goal 6, which aims to halt and reverse the spread of HIV, will not be met without a stronger focus on key populations.

Under its two HIV strategies, *Taking Action*[6] and *Achieving Universal Access*[7], the UK Department for International Development (DFID) made a critical contribution to scaling up HIV responses for key populations. More recently, DFID's position on HIV and AIDS has been outlined in its 2011 position paper, *Towards Zero Infections*[8], and this was recently updated in partnership with STOPAIDS. The updated version, *Towards Zero Infections – Two Years On*[9], identifies key populations as one of three DFID priorities. At the same time, DFID's 2011 bilateral aid review[10] announced plans to significantly reduce the number of UK bilateral aid programmes, and *Towards Zero Infections* outlines the resulting closure of several important programmes aimed at tackling HIV among key populations.

DFID will now support key populations primarily through the Global Fund to Fight Aids, Tuberculosis and Malaria and the Robert Carr Civil Society Networks Fund. Although STOPAIDS has been a vocal supporter of both organisations, and campaigned over several years for the UK government to increase its Global Fund contribution, we are concerned that in rapidly reorganising its key population funding, DFID has left some important gaps unfilled. These gaps exist in a context where key populations face criminalisation and myriad other crises. In Africa, state-sponsored homophobia is shutting down services for lesbian, gay, bisexual and transgender (LGBT) people, while in many parts of the world laws which conflate sex work with trafficking are resulting in forced detention and rehabilitation of sex workers, interrupting health initiatives for this community. Harm reduction programmes for people who use drugs also face financial crisis as donors pull their funding and national governments fail to step up.

This briefing has been prepared by STOPAIDS, the network of 80 UK agencies working since 1986 to secure an effective global response to HIV and AIDS, following consultation with members and global key population networks. It commends DFID on its commitments to address HIV among key populations in developing countries, and reviews areas where the Department may need to take further action.

The briefing recommends as a starting point that DFID develops a theory of change, in full consultation with key population led networks, which sets out how it plans to deliver progress for key populations in advance of the 2015 Millennium

Development Goals (MDGs) deadline. A theory of change approach would be an effective way to ensure that DFID's bilateral funding, multilateral contributions and international voice are mobilised to deliver more for key populations. The briefing also calls on DFID to support targets on HIV and key populations in the post 2015 development framework and beyond 2015, to develop a health strategy which will commit to ending AIDS as a public health threat and improving access to rights-based health services for key populations.

Defining key populations

UNAIDS uses the term 'key populations at higher risk' to describe those who are disproportionately impacted by HIV compared with the general population, highlighting these populations as key both to the epidemic's dynamics and to the HIV response.[11] While those identified as key populations can vary according to local dynamics, the UNAIDS definition encompasses men who have sex with men, transgender people, sex workers and people who inject drugs. This paper focuses on these populations.

Some STOPAIDS members also work with other groups who are subject to social pressures or circumstances that make them more vulnerable to HIV. These groups, described as vulnerable populations by UNAIDS, may include prisoners, orphaned and vulnerable children, adolescents and young people, populations affected by humanitarian crises, refugees, internally displaced people, migrants, informal workers, people experiencing food insecurity and people with disabilities. Some of these populations are the focus of other STOPAIDS work, but they will not be covered by this paper.

Plan UK is an example of a STOPAIDS member working with vulnerable populations. Its work with local partner Resources Oriented Development Initiatives in Kenya supports adolescents in prison and custodial settings so they can secure the knowledge, skills and services they need to stay healthy. © Plan UK

2 DFID'S CURRENT POSITION ON TACKLING HIV AMONG KEY POPULATIONS

Global Network of Sex Work Projects protest in Kolkata. © NSWP

The Department for International Development's position on HIV and AIDS was outlined in their 2011 position paper *Towards Zero Infections*. In 2013, STOPAIDS was a partner to DFID on the review of that paper and broadly welcomed *Towards Zero Infections – Two Years On*[12] (herein *Towards Zero Infections*). In particular, we strongly support DFID's focus on key populations as one of three policy priorities to 2015, alongside women and girls and integration. In line with that priority, one of DFID's key targets is to reduce HIV infections in most-at-risk populations, with the aim of maintaining general HIV prevalence at less than 1% in at least six countries. Towards Zero Infections lists eight countries in Asia where DFID has supported key population programmes including Cambodia, Nepal, India, Vietnam, Burma, Kyrgyzstan, Tajikistan and Uzbekistan.[13] Across these programmes DFID has targeted sex workers, men who have sex with men and people who inject drugs, distributing over 100 million condoms and 45 million needles and syringes, and providing more than 6,700 people with substitution therapy. These results testify to DFID's commitment to key populations in recent years. However, as we discuss below, all but one of these programmes will have closed by the end of 2014.

Towards Zero Infections also outlines how DFID is responding to evidence on the role of key populations in generalised epidemics in Africa. In Zimbabwe DFID is supporting the National Sex Work Programme which will reach 22,000 women with sexual and reproductive health and HIV services. In Nigeria, DFID has contributed £100 million to enhance the national HIV response, including by improving access to services for those most vulnerable to infection, supporting the introduction of anti-stigma laws and helping to generate evidence including on modes of transmission. At regional level DFID is working with civil society organisations to make prevention in prisons more politically acceptable and is supporting research to identify innovative mechanisms for scaling up prevention for prisoners, adolescents and other key affected populations.[14]

The position paper specifies that alongside funding, DFID is increasingly working with the Foreign and Commonwealth Office to challenge criminalisation, discriminatory laws and human rights abuses, particularly those against LGBT people. DFID has its own theory of change on LGBT equality in Africa, while the FCO has an LGBT toolkit aimed at enabling High Commissions and Embassies to advance LGBT equality.[15] Some DFID offices and High Commissions have actively made use of these tools, particularly in Uganda where the British High Commission provided vital support to LGBT organisations opposed to the Anti-Homosexuality Bill. However, LGBT equality is not yet a priority component of the UK's overseas development and human rights work, and efforts to advance the rights of other key populations are much more limited.

3 UK FINANCIAL COMMITMENTS TO TACKLING HIV AMONG KEY POPULATIONS

Indonesian Planned Parenthood Assocation, an IPPF Member Association, is integrating HIV and harm reduction services for people who use drugs within sexual and reproductive health services. © IPPF/Chloe Hall

DFID'S BILATERAL HIV FUNDING

DFID's HIV spending has averaged at £300 million per year over the last five years, and in 2012/13 around £180 million of this was disbursed bilaterally. DFID's bilateral funding for key populations has delivered impressive outputs, particularly in Asia. However, UK bilateral funding for HIV and AIDS has dropped by £75 million since 2010, with the number of DFID bilateral programmes decreasing from 26 to 16 and set to fall further as more programmes end. All of DFID's programmes in Asia have now closed or are set to close in the coming year, with the exception of the Three Diseases Fund, which will continue to deliver services for prisoners and other key populations in Burma until 2016. The reduction sits within a wider decision to reduce funding to middle-income countries, made as part of DFID's 2011 bilateral aid review.[16] STOPAIDS members have expressed concerns that many middle-income countries remain unwilling to support key populations and that if donors pull out, it could endanger progress made in recent years.

The recent closures amount to a 90% drop in UK bilateral support for harm reduction. DFID write in their position paper that all of the Asia harm reduction programmes have delivered or exceeded their expected results, and that "of particular note was the success of these programmes in sustained scale-up of services for key populations". However, DFID have not clarified how these results will be sustained beyond the expiry of their programmes, and a recent evaluation[17] of one, the DFID World Bank HIV programme in Vietnam, raised serious doubts about where funding would now come from (see case study below). *Towards Zero Infections* specifies that DFID will now work with key populations in Asia through the Global Fund to Fight Aids, Tuberculosis and Malaria (the Global Fund) and other multilateral agencies. However, as we discuss below, DFID needs to ensure that these institutions fully listen to and deliver for key populations and take a strong stand against criminalisation and human rights violations.

CASE STUDY

Harm reduction in Vietnam

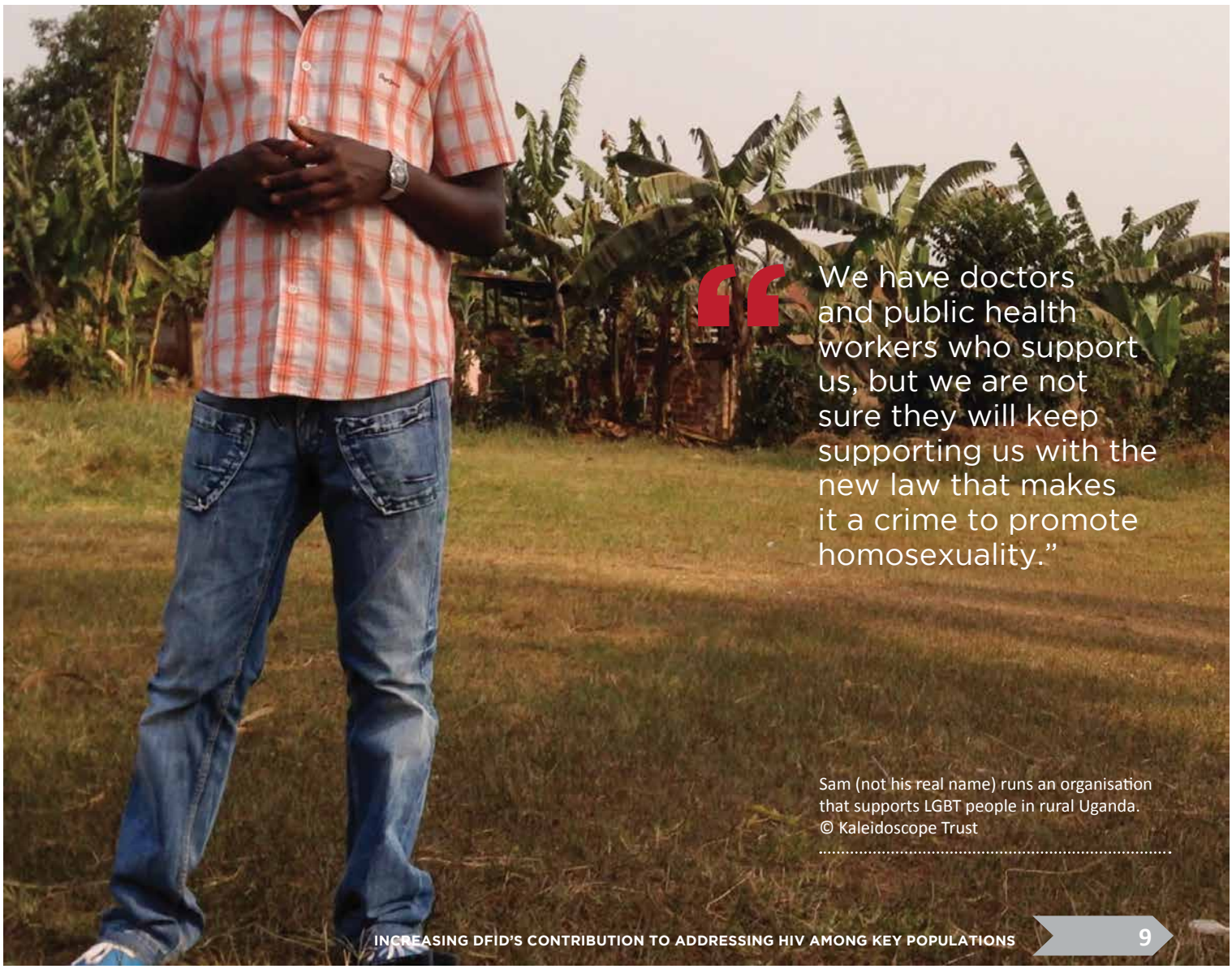
From 2003 to 2012, DFID and the World Bank supported a major HIV programme in Vietnam, focused on providing needles and syringes for people who use drugs alongside condoms for sex workers. HIV prevalence among people who use drugs in Vietnam dropped from 21.3% (2003) to 9.6% (2012) and among sex workers from 3.7% to 2.6%, with an evaluation estimating that the programme had averted more than 33,000 new infections[18].

When the programme began, Vietnam's approach to people who use drugs was a highly punitive one, involving detention and forced detoxification. Since then, Vietnam has legalised the provision of harm reduction services and support for them has increased. However, the programme evaluation notes that Vietnam continues to incarcerate people who use drugs and highlights ongoing resistance to harm reduction among law enforcers and the Vietnamese government, recommending that DFID maintain an advisory role. It also emphasises that Vietnam's HIV response is highly dependent on foreign aid and that with DFID and World Bank funding coming to an end, sustaining it at current levels is unlikely[19].

Funding for key populations and other civil society organisations and networks must remain a key strategy for DFID, including in middle-income countries where governments may be unwilling to provide key populations services or commission CSOs to provide them.

Recognising that civil society organisations (CSOs) are at the forefront of the HIV response in many countries, DFID has increased civil society funding as a proportion of its bilateral aid, from 21% in 2008/9 to 34% in 2012/13. These organisations are often leaders in delivering services, advocating for better budget allocations and policies, breaking down stigma and defending the human rights of people most affected by HIV.[20] However one of DFID's key mechanisms for civil society funding, programme partnership agreements (PPAs), is due to be reviewed and likely reduced in 2016. DFID currently has one HIV-focused PPA (with the International HIV/AIDS Alliance) and five others which include at least one HIV-focused indicator (with CAFOD, Christian Aid, Progressio, Restless Development and HelpAge). All of these have scored 'A' or 'A+' in DFID assessments, but their future is uncertain.[21] Another mechanism, DFID's Civil Society Challenge Fund, is also set to close. Towards Zero Infections highlights the Robert Carr Civil Society Networks Fund (RCNF) as a key vehicle for DFID's civil society financing going forward, but the RCNF is not yet supporting key population led networks to an adequate level. Funding for key populations and other civil society organisations and networks must remain a key strategy for DFID, including in middle-income countries where governments may be unwilling to provide key populations services or commission CSOs to provide them. In India for example, in a context of declining domestic support for civil society, the EU has already committed to continuing to fund CSOs. DFID by contrast plans to fully withdraw by 2015.

Alongside the drop in funding, STOPAIDS is concerned that the shift from funding bilateral programmes specifically focused on key populations will result in the loss of DFID's voice on the needs and rights of these groups. Although the Foreign & Commonwealth Office (FCO) is increasingly working to tackle persecution of LGBT



Sam (not his real name) runs an organisation that supports LGBT people in rural Uganda. © Kaleidoscope Trust

people, DFID also has an important role to play, especially in countries such as Uganda and Nigeria where it funds significant HIV programmes. DFID's response to the introduction of anti-gay laws in these two countries was muted, but STOPAIDS hopes that the development of a government LGBT equality strategy will help the Department to do more. As should be the case with all policy development relating to key populations, the government must consult with LGBT people who face criminalisation and other human rights abuses, including those most affected by HIV, in developing this strategy.

Harm reduction organisations, supported by the International Network of People who Use Drugs (INPUD), gathered outside the Russian embassy in London on World AIDS Day as part of a global unified Shame Russia Shame campaign.
© INPUD

Similarly, in the past, DFID's financial leadership on evidence-based health policy for people who inject drugs enabled them to advocate for harm reduction at country-level and to push for a target of halving HIV infection among people who inject drugs in the 2011 UN Political Declaration on HIV. By contrast, at the March 2014 Commission on Narcotic Drugs, the UK promoted a recovery agenda and did not explicitly support harm reduction.[22] Overall the lack of strong voices resulted in a weak and watered down joint-ministerial statement emerging from the Commission meeting. DFID were not even present in the UK delegation to the Commission and did not, as in previous years, ensure that the delegation included people who use drugs or other representatives from civil society. Again here, more meaningful engagement with key populations is required.

As a final point, STOPAIDS members have raised questions around the rationale for funding decisions in Africa and have observed the lack of a clear overarching rights-based narrative to guide interventions. For example, DFID initially identified female sex workers, people who inject drugs and MSM as priorities, yet are directly supporting services for these populations in just two countries, Burma and Zimbabwe. The burden of HIV amongst sex workers in many African countries is extremely high, and there is increasing evidence on HIV among MSM in Africa, yet both populations are frequently turned away from mainstream health services or in the case of sex workers, subjected to coercive testing and forced 'test and treat' practices. As discussed elsewhere, in most countries they also face extreme levels of criminalisation and other legal oppression, which act as deterrents for sex workers accessing health services. STOPAIDS members argue that DFID should fund rights-based HIV and sexual and reproductive health services specifically aimed at addressing the needs of these groups, provided by organisations from within these communities and implemented in line with the Sex Worker Implementation Tool (produced by collaboration between UNAIDS, WHO, UNFPA, NSWP, The World Bank) and guidelines already developed by WHO and other partners in meaningful consultation with sex workers and their networks. This more focused and community-based approach would ensure improved health outcomes and value for money, while also critically enabling a stronger emphasis on rights-based health programming and avoiding rights violations that too often take place within mainstream health contexts.

RESEARCH

DFID also funds research through its bilateral portfolio, and *Towards Zero Infections* highlights two regional projects in southern Africa, looking at HIV programming for adolescent girls and at ways to scale up prevention for prisoners.[23] The position paper does not detail what aspects of prevention the prison research will address, or discuss the links between making prison programmes more acceptable and wider efforts to champion prevention for MSM and people who inject drugs. Similarly in their research on adolescent girls, DFID could better deliver on their priorities by looking at those belonging to key population groups. There is concern among STOPAIDS members that as they are currently articulated, DFID's research programmes do not link with their stated emphasis on the primary key population groups.

STOPAIDS members welcome DFID's support of STRIVE, a research consortium which looks at ways to address four structural drivers of HIV, one of which is stigma and criminalisation.[24] The UK's funding so far largely appears to focus on gender

inequality but we hope that through DFID's engagement with STRIVE, DFID will also engage actively with STRIVE findings on stigma and criminalisation, and will use these to shape their policy and practice on key populations. More broadly, a stronger key population lens on DFID's research portfolio, shaped in consultation with key population communities, would increase the value-added of UK research funding, and ensure better alignment with DFID's stated priorities.

DFID'S MULTILATERAL HIV FUNDING

For the last two years DFID multilateral aid to HIV has amounted to approximately £120 million. Around 60% of this has been channelled through the Global Fund, 21% through the World Bank, 8% through UNAIDS and the remainder through other UN agencies (UNDP, UNFPA, UNICEF and WHO) and the European Union

For the last two years DFID multilateral aid to HIV has amounted to approximately £120 million. Around 60% of this has been channelled through the Global Fund, 21% through the World Bank, 8% through UNAIDS and the remainder through other UN agencies (UNDP, UNFPA, UNICEF and WHO) and the European Union.[25] Last July, following the roll out of a new Global Fund funding model, the UK pledged £1 billion to the Global Fund over the three years from 2014, contingent on full funding by other donors. As a result of this pledge, both DFID's multilateral spend and the proportion of it going to the Global Fund will rise significantly. Assuming that other donors will increase their Global Fund contributions up to full funding, around £500 million of the UK's contribution will go to HIV and AIDS programmes between 2014 and 2016.

The Global Fund to Fight Aids, Tuberculosis and Malaria

Towards Zero Infections identifies the Global Fund as "the UK's principle financing mechanism for HIV and TB, including support for most-at-risk populations", and notes that in the first six months of 2012, Global Fund-supported programmes delivered four million prevention activities targeted at most-at-risk populations. However, the position paper also recognises that provision for key populations in sub-Saharan Africa is limited and pledges to use its influence on the Global Fund board "to push for greater monitoring, leadership and investment in key populations".

It is critical that DFID tracks how its Global Fund investments support key populations and prioritises making the new funding model work for them.

It is critical that DFID tracks how its Global Fund investments support key populations and prioritises making the new funding model work for them. The first stage in the model is a country dialogue leading to a concept note, which the country then submits to the Global Fund's technical review panel. The panel provides feedback through an iterative dialogue and ultimately accepts or rejects the country's proposal. As a Global Fund board member, the UK was active in developing the new funding model. In countries where it has a presence, DFID can now help to ensure the meaningful involvement of key populations in country coordinating mechanisms and wider country dialogues, and that country proposals include sufficient and tailored services for them. It should also support the Technical Review Panel to ensure that no proposal is accepted that: has not meaningfully consulted with key populations; that does not acknowledge key barriers to reaching them, such as punitive legislation and aggressive police practices; or that does not include services for key populations that match the disease burden and country need.

The Global Fund also has a new strategy, which pledges to promote rights-based approaches and leverage financing to advance human rights.[26] Under its fourth strategic objective the Global Fund proposes to encourage and support countries to improve access for key populations and to create an enabling social and policy environment, through incentives or a funding mechanism. Already, objective four has enabled the Global Fund to invest in a small number of innovative projects, such as the Eurasian Harm Reduction Network's *Harm Reduction Works*, which aims to strengthen advocacy by civil society for investments in harm reduction in Eastern Europe and Central Asia.[27] A strong push will be needed to breathe further life into objective four and to fund similar programmes in the Middle East, North Africa and Southeast Asia regions, and DFID should actively champion this through its role on the board.

It is important to add that Global Fund grants to middle-income countries (MICs) are shrinking. Under the new funding model, the Global Fund assigns countries to four bands depending on their overall disease burdens and their capacity to fund their responses. Band Four, signifying low disease burden and greater ability to pay, includes 55 countries, some of which have significant epidemics among key populations. These include 20 countries in Latin America and the Caribbean, a region where HIV is concentrated among sex workers, MSM and transgender women. These groups face criminalisation alongside high levels of stigma, discrimination and violence and for the most part, governments refuse to provide services for them. Band D also includes Bulgaria and Romania which previously have seen access to harm reduction services plummet when Global Fund support dried up. Indeed overall, while the Global Fund is currently the largest funder of harm reduction programmes, the total funding it provides for harm reduction will now decline further. DFID's HIV position paper states that Global Fund support in middle-income countries "requires a robust debate and strategy which the UK will be pursuing with the Global Fund and partners". DFID needs to take a much clearer and stronger stance to ensure that the Fund will continue to support harm reduction and other vital aspects of the HIV response in middle-income countries.

The World Bank

A more appropriate role for the World Bank might be in helping governments to identify what aspects of the HIV response to invest in.

The World Bank's Multi-Country HIV/AIDS programme[28] provides financial and technical assistance to developing countries and in 2012/13, its portfolio stood at $1.5 billion. The project database on the World Bank website lists 232 projects (out of a total of 11,896) which have included work on HIV. Of the 51 of these still running, 24 refer to specific goals or outcomes on HIV and 11 explicitly include interventions aimed at 'targeted' populations. Five projects in Vietnam, Madagascar, Niger, Nepal and Barbados are explicitly focused on sex workers, people who use drugs or MSM. The other six focus on truck drivers, military personnel, young people, orphans and vulnerable children, migrants and mobile populations along with in some cases unnamed 'targeted populations'. This means that while the World Bank is willing to tackle HIV among those most at risk, overall the number of active programmes focused on the primary key populations is extremely small. DFID should therefore review whether the Bank is really the ideal recipient for its multilateral HIV funding. In doing so, it should consider previous criticisms of the Bank's health, nutrition and population projects, a third of which were deemed to have delivered unsatisfactory outcomes in 2007.[29] Performance in sub-Saharan Africa was much worse with satisfactory outcomes achieved in only a quarter of all HNP (health, nutrition and population) projects and just 18% of HIV and AIDS projects. More recently, STOPAIDS has noted with alarm Oxfam research concerning a World Bank supported hospital in Lesotho built under public private partnership.[30] The hospital's costs have spiralled to more than half of Lesotho's total health budget while delivering returns of 25% for the hospital's private sector partner.

A more appropriate role for the World Bank might be in helping governments to identify what aspects of the HIV response to invest in. STOPAIDS was a partner to the Bank in an evaluation of the community response to HIV and AIDS[31], which found that investments in communities had produced significant results in terms of improved knowledge and behaviour, increased use of health services and decreased HIV incidence, including for key populations. The Bank could more vocally support community-based programmes, and could also generate more evidence on key populations in HIV epidemiology – an approach which would tally well with its recent work on the economic cost of homophobia. Funded by DFID, the World Bank is also improving its approach to budget tracking and could use lessons learnt from this to support other multilateral agencies, donors such as DFID and country governments to better track their investments.

UNAIDS and other UN agencies

UNAIDS is a joint programme of eleven agencies – UN High Commissioner for Refugees (UNHCR), UN Development Programme (UNDP), UN Population Fund (UNFPA), UN Children's Fund (UNICEF), UN Women, World Food Programme, UN Office on Drugs and Crime (UNODC), UNESCO, International Labour Organisation, World Health Organization (WHO) and World Bank. It is run by a global secretariat tasked with the mission of leading and inspiring the global AIDS response in line with the current UNAIDS strategy[32], but each of the co-sponsoring agencies has specific areas of responsibility which are outlined in the 2010 UNAIDS Division of Labour Matrix[33]. UNAIDS also has a presence in almost 90 countries, where its Country Coordinators oversee the national activities of the co-sponsoring agencies.

In June 2011 UNAIDS and others published a new investment framework identifying six basic activities which, alongside critical social and programmatic enablers, would dramatically reduce new HIV infections and prevent AIDS-related deaths.[34] One of the six activities was programmes for key populations most affected by HIV, while the enablers also addressed many of the legal and structural barriers affecting those hardest hit by HIV.

UNAIDS has a more political remit than other multilaterals, and its strength lies in its ability to lead on issues of central importance to key populations, such as law reform, decriminalisation and human rights. Recently however, STOPAIDS members have expressed doubts about the extent to which UNAIDS is playing this role.

In 2012/13, UNAIDS received 8% of DFID's multilateral HIV budget, amounting to £10 million in core funding. However, the UK recently announced a 50% increase in its contribution, to £15 million per year. On top of this, DFID funds specific UNAIDS projects, for example a pilot roll out of the investment framework approach which has enabled a stronger focus on key populations in some countries. DFID's 2011 multilateral aid review recognised the added value of UNAIDS, stating that it "fills critical gaps in advocacy, coordination and leadership".[35] In responding, UNAIDS described its role as "political brokering, community organizing, social mobilisation, generating and sharing strategic information, offering evidence-based policy recommendations and giving voice to the voiceless – vulnerable groups and people living with HIV".[36]

UNAIDS has a more political remit than other multilaterals, and its strength lies in its ability to lead on issues of central importance to key populations, such as law reform, decriminalisation and human rights. Recently however, STOPAIDS members have expressed doubts about the extent to which UNAIDS is playing this role. UNAIDS was initially very slow to make a clear public position on HIV and key populations in discussions on the post-2015 development framework. It has since produced a position paper on post-2015, and key populations were specifically mentioned in the post-2015 decision points from the 34th Programme Coordinating Board (PCB). However, more could still be done by UNAIDS to convene civil society around HIV, key populations and human rights for the post-2015 process. Similarly, its response to crises such as the Anti-Homosexuality Act in Uganda and the suspension of opioid substitution therapy in Crimea has been frustratingly meek, while the Global Network of Sex Work Projects highlight a need for UNAIDS to draw more attention to human rights violations faced by sex workers as a result of legal frameworks that criminalise sex work or conflate it with trafficking. An example of such legislation is a recent law passed in Mexico that has resulted in the arrest of the Network's Vice President Alejandra Gil, who is awaiting trial on trafficking charges.[37] At the same time, UNAIDS is co-sponsoring a conference with the Russian government and has praised Russia for its HIV response despite its refusal to provide harm reduction and its persecution of LGBT people and CSOs.[38] It is vital that UNAIDS more actively defends the rights of key populations and resists criminalisation, and DFID should encourage it to do this.

DFID also supports UNDP, UNFPA, UNICEF and WHO, which between them received 8% of DFID multilateral aid to HIV in 2012/13.[39] UNDP is the UN's global development network and connects the HIV response to other aspects of development. Under the Division of Labour matrix, it is tasked with convening efforts to remove punitive laws, policies, practices, stigma and discrimination, as well as to empower MSM, sex workers and transgender people. It has advocated for the rights of key populations in settings such as the Commission for Narcotic Drugs.

Fabiana Pérez, a transgender peer educator with International HIV/AIDS Alliance, at her hairdressing salon in Guayaquil, Ecuador.
© The International HIV/AIDS Alliance

UNFPA focuses on family planning and sexual and reproductive health, and its remit encompasses reducing sexual transmission of HIV and convening around key populations, women and girls and young people. UNFPA has particular expertise in relation to sex work, condom programming and integration of HIV and sexual and reproductive health. Given DFID's commitments to meeting the unmet need for family planning, the UK is well placed to push for increased attention by UNFPA to new and existing dual protection methods.

UNICEF leads on preventing vertical transmission, empowering young people (including young people from key populations) to protect themselves from infection, and supporting orphaned and vulnerable children. UNICEF's work on adolescents and young people, and particularly its championing of those from key populations, should be actively supported by DFID.

WHO has already worked with sex worker communities on a Sex Worker Implementation Tool and guidelines which set out the principles that should inform all health programming for sex workers and provides good practice recommendations for community-based, sex worker-led interventions.

WHO's lead areas of responsibility include prevention of vertical transmission, access to antiretroviral treatment and prevention and treatment of TB. However, WHO plays an important technical role across all of the UNAIDS strategic priorities, facilitating policy development and producing guidelines which build capacity in country and at the level of the global health sector. WHO has already worked with sex worker communities on a Sex Worker Implementation Tool and guidelines which set out the principles that should inform all health programming for sex workers and provides good practice recommendations for community-based, sex worker-led interventions. WHO is currently working with other communities, including MSM, transgender people, people who inject drugs, people in prisons and young people and adolescents[40], to develop further guidelines and tools. DFID and the organisations that it funds should now roll out the Sex Worker Implementation Tool and guidelines across their programmes, and should follow with the other guidelines when these are finalised. WHO is also responsible for gathering data and could complement its guidelines with stronger epidemiological information on key populations which could help to make the case for better programming.

All of the co-sponsoring agencies meet on a six monthly basis at the UNAIDS PCB, along with UN member states, including the UK, and people living with HIV and those from key populations. Each PCB meeting has a specific theme, which in December 2014 will be people who inject drugs. As a PCB participant DFID must help to ensure that ambitious commitments are made at that meeting to increase access to HIV services for people who inject drugs, and must push for an agreement by UNAIDS to ensure a strong focus on the rights and health of people who use drugs at the upcoming UN General Assembly Special Session on Drugs in 2016.

The Robert Carr Civil Society Networks Fund

DFID's position paper identifies the Robert Carr Civil Society Networks Fund (RCNF) as an important vehicle for supporting key populations and CSOs. Founded in 2012 by the US government, the Bill & Melinda Gates Foundation, the Norwegian Ministry of Foreign Affairs and DFID, the RCNF supports networks that are active in the HIV response. At present, it is one of the main funding mechanisms enabling key population networks to further develop their capacity, to engage more actively in advocacy and to take ownership of health programmes that deliver HIV prevention, treatment, care and support. RCNF's special focus on community strengthening and advocacy to ensure human rights represents a distinct and vital part of the HIV response, steering it away from the purely epidemiology discourse which has led to practices such as forced detoxification, detention centres, coerced testing and 'test and treat' programmes, and towards a more human rights based approach.

… in 2012 less than half of the resources that RCNF allocated went to key population led groups. While recognising the value of other networks funded by RCNF, for example networks of people living with HIV, STOPAIDS is concerned that the current division of funding and the low overall value of DFID's contribution – just £4 million over three years – signifies a major overall reduction in the amount that the UK is allocating to key populations .

At the same time, in 2012 less than half of the resources that RCNF allocated went to key population led groups. While recognising the value of other networks funded by RCNF, for example networks of people living with HIV, STOPAIDS is concerned that the current division of funding and the low overall value of DFID's contribution – just £4 million over three years – signifies a major overall reduction in the amount that the UK is allocating to key populations.[41] DFID should increase its RCNF contribution in the near future, and in doing so it should ensure that more of RCNF's funding goes to key population led organisations. Indeed, an increase in allocations focused on building the capacity of the key populations most affected by HIV and their organisations should be a key criterion for DFID in deciding whether to increase its contribution.

STOPAIDS members have also raised issues with the RCNF application process which is very cumbersome and practically excludes community-based key population led networks. The process involves a highly confusing log frame and flow diagram as well as a rebuttal stage, even for applicants who have been recommended for funding. Community-based networks and their members are often on the frontline of the HIV response and bring a unique and insider expertise about what people from key populations need, but they do not have full-time, professional fundraising staff, or other capacity necessary to get through the process. As a founder of RCNF, DFID should address these issues without delay.

OTHER FUNDING MECHANISMS

DFID also channels 2% of its multilateral HIV funding through the **European Union** (EU). From 2007 to 2011 the EU had a global Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis, which was relatively weak on key populations.[42] It was due to be replaced with a Health Programme for Action but this has never been developed. In the meantime, the EU continues to fund HIV programmes in developing countries and has acknowledged the need for a continued response in middle-income countries. It is vital that DFID engages more proactively with the EU to speed up development of its health programme and to ensure that this supports access to services for key populations.

From 2009 to 2013 the EU also had a Commission Communication and action plan on HIV in the EU and neighbouring countries. Both had a strong focus on Eastern Europe, where HIV infection is concentrated among people who inject drugs. Funding for civil society under the communication was very limited, while the Directorate General for Justice also recently closed a fund which provided grants for public health.[43] In addition, while EU countries can use structural funds to provide harm reduction services, countries such as Romania and Bulgaria are refusing to do so, despite a dire need for these services. Harm reduction advocates have called on the EU to increase pressure on them, but so far the European Commission has declined, arguing that it is up to countries to decide their priorities.[44] The Communication's impact is currently being evaluated and the EU promises a new action plan this year. The UK should engage more proactively with all branches of the EU to ensure continued support for harm reduction and other key population programming in Eastern Europe.

The UK government made a twenty year commitment to UNITAID in 2007, and by the end of 2012, had contributed almost £230 million.

The UK is also an important funder of **UNITAID**, an international purchasing facility that has used innovative financing and donor contributions to fund market interventions which dramatically reduce the cost of HIV, TB and malaria medicines, diagnostics and other commodities. In response to demand from advocates and programmers, UNITAID's remit is expanding[45] to also cover prevention products, such as female condoms, along with treatment for co-infections such as viral hepatitis, which heavily impacts on people who use drugs and is a major cause of mortality among people living with HIV. The UK government made a twenty year commitment to UNITAID in 2007, and by the end of 2012, had contributed almost £230 million. DFID also plays an active role on UNITAID's board, and in this capacity should ensure that UNITAID helps to increase access to prevention and treatment access for key populations and that it funds programmes aimed at addressing HIV and hepatitis C co-infection. We welcome UK support for the recent decision by the board to approve funding for interventions that aim to increase access to hepatitis C treatment.

4 GAPS IN DFID'S APPROACH: STRATEGY, FINANCING AND LEADERSHIP

DFID urgently needs a theory of change on key populations, setting out what it wants to achieve and how it plans to use its funding and its voice in order to deliver progress in advance of the 2015 MDG deadline.

STRATEGY

During our 2012 *Why Stop Now?* campaign, STOPAIDS called for a DFID HIV and AIDS strategy to replace Achieving Universal Access. Guided by this last strategy, DFID had made a critical contribution to scaling up prevention for key populations alongside access to treatment. Following its expiry in 2010, DFID developed a position paper, *Towards Zero Infections*, and this was recently updated in consultation with STOPAIDS members. The updated version identifies key populations as one of three DFID priorities, but it is vague in terms of which populations DFID most wants to support, and what its goals are in relation to these groups. DFID urgently needs a **theory of change on key populations**, setting out what it wants to achieve and how it plans to use its funding and its voice in order to deliver progress in advance of the 2015 MDG deadline. In developing this, DFID should fully engage with key population networks, whose challenges, desires and needs are similar to but distinct from those of people living with HIV.

As a starting point, DFID needs to address its **lack of capacity** to more actively engage in global policy fora and interagency working groups that focus on key population issues. The AIDS and Reproductive Health Team at DFID has recently been more active in raising key population issues at broader global policy processes and fora such as the Commission on the Status of Women, Commission on Population and Development, Global Fund board and UNAIDS board. However, DFID is still absent from many important opportunities to share learning and advance the agenda of key populations such as interagency working groups, Commission on Narcotic Drugs and the International AIDS Conference. To ensure key populations are placed as a policy priority, STOPAIDS members feel strongly that one DFID staff member should work solely on key population issues, acting as a focal point within DFID and crucially linking key population issues within DFID across HIV, health, human rights and with the Global Funds and Governance Teams.

In all societies, transgender women and men experience violence and discrimination as a result of their rejection of gender norms, with attacks against them sometimes condoned or even perpetrated by state actors.

Also as an early priority, DFID should **clarify which populations** it is focused on, incorporating issues like harm reduction, an issue on which the UK has historically been strong, and recognising the links between DFID's work on HIV among MSM and the struggle for LGBT equality. With DFID increasingly looking to support LGBT work, an important population for it to consider is **transgender people**, who are not mentioned in the current position paper. In all societies, transgender women and men experience violence and discrimination as a result of their rejection of gender norms, with attacks against them sometimes condoned or even perpetrated by state actors.[46] Transgender people are often barred from registering as the gender that they identify as, meaning that there is little official data on their existence, their access to services, crimes committed against them or their HIV prevalence rates. A recent study has shown transgender women to be up to 49 times more likely to contract HIV than the general population[47] and there is also growing evidence of high HIV prevalence among transgender men[48]. In any future theory of change, it is important that DFID recognises transgender people as distinct from MSM and considers how it can improve their access to HIV services and advance their rights as part of wider efforts to promote LGBT equality. DFID should also recognise and address the intersections between key population groups, for example that transgender women may also be sex workers.

FINANCING: BILATERAL

By 2020, 70% of people living with HIV will reside in MICs and already, many MICs have large numbers of people belonging to key population groups.

STOPAIDS members have raised concerns about the recent drop in DFID bilateral funding for key populations, particularly in middle-income countries. For most countries, DFID have not made clear the rationale for withdrawing funding but certainly, it is not informed by an analysis of the HIV epidemic in the countries affected or of their governments' ability or willingness to respond, since HIV indicators were not included in DFID's 2011 *Bilateral Aid Review*.[49] By 2020, 70% of people living with HIV will reside in MICs and already, many MICs have large numbers of people belonging to key population groups. With a theory of change setting out which populations it is focused on and what it wants to achieve, DFID can take **a more strategic approach to bilateral funding**. In some cases, this may mean revisiting decisions about which countries to continue supporting or at least filling the gap with emergency funding, based on a more nuanced set of criteria that properly assess countries' epidemiology, their ability to fund their HIV responses and critically, their government's willingness to provide services for marginalised and often criminalised key populations. In countries where DFID does withdraw bilateral HIV support, it will need a more thought out strategy on how to transition away from a traditional donor-recipient relationship without damaging the gains that have been made. Again a theory of change will help to guide DFID but **key transitional strategies** could include technical support to help countries put legal and policy frameworks in place or to address unhelpful punitive approaches among police or policy makers; funding for civil society organisations who can provide sustainable services and advocate for a more supportive policy environment and more domestic resources; and support and diplomacy around human rights and discrimination, led by the FCO or by a new Human Rights Unit within DFID. This paper has also highlighted gaps in DFID's bilateral funding for **key population programmes in Africa**. With transactional sex being a clear driver of HIV transmission in many African countries, and with increasing evidence on HIV among MSM in Africa, DFID should more extensively fund services for these groups.

In countries where DFID has transitioned from HIV funding to **health systems or sexual and reproductive health investments**, DFID needs to more actively ensure continued access for key populations. DFID has recently worked on human rights indicators for Family Planning 2020 and could champion similar indicators on HIV. DFID should also explore ways to support key populations through other funding streams. Given its commitment to **gender equality**, DFID should adopt a more gendered analysis of key population issues which addresses gender-based violence against women and men from sexual minorities and where appropriate, links DFID's work with key populations more directly to its women and girls pillar, for example by addressing the specific needs of women sex workers or women who inject drugs. This paper has also highlighted gaps in DFID's bilateral funding for **key population programmes in Africa**. With sex workers clearly shown to be a key affected population in relation to HIV transmission in many African countries, and with increasing evidence on HIV among MSM in Africa, DFID should more extensively fund services for these groups, in line with the relevant WHO implementation tools and guidelines.

FINANCING: MULTILATERAL

As discussed above, the drop in DFID's bilateral HIV funding will be accompanied by an increase in multilateral funding, particularly to the Global Fund. As a Global Fund board member, DFID must prioritise **making the new funding model work better for key populations**. DFID can lobby the Technical Review Panel (TRP) to make meaningful involvement of key populations an eligibility requirement for country proposals, and can push the TRP to challenge countries which have not included sufficient and tailored services for key populations or addressed barriers to reaching them. It can also push for delivery of the Global Fund's strategic objective four, and for more innovative advocacy programmes aimed at increasing support for the rights of key populations, their access to services and enjoyment of protection

Young Women's Leadership Initiative at the International Conference on AIDS and STIs in Africa (ICASA) in 2013. The initiative builds the leadership of young women living with HIV and from key affected populations to advocate for gender equality, human rights and an end to violence against women in all of our diversity. © ATHENA Network

by the law through full decriminalisation. In addition, DFID needs to take a much clearer and stronger stance to ensure that the Fund will continue to support harm reduction and other vital aspects of the HIV response in middle-income countries.

In relation to other multilaterals, DFID should review whether the World Bank is really the ideal recipient for its multilateral HIV funding. The Bank may have more of a role to play in helping governments identify what aspects of the HIV response to invest in, and in better evidencing the value of funding responses for key populations. The World Bank is also improving its approach to budget tracking and could use lessons learnt from this to support DFID to better track their own investments.

DFID must push for ambitious commitments and for agreement by UNAIDS to demand a strong focus on the rights and health of people who use drugs, underpinned by a call for the decriminalisation of drug use and possession and the review of the global drug control conventions, at the 2016 UNGASS on Drugs.

This paper has also identified challenges relating to **UNAIDS**. Having recently increased its funding for UNAIDS, DFID must ensure that UNAIDS more actively defends the rights of key populations and promotes decriminalisation, and should engage with all co-sponsoring agencies to ensure that they do the same. In addition, at the December Programme Coordinating Board meeting's thematic segment on people who inject drugs, DFID must push for ambitious commitments and for agreement by UNAIDS to demand a strong focus on the rights and health of people who use drugs, underpinned by a call for the decriminalisation of drug use and possession and the review of the global drug control conventions[50], at the 2016 UNGASS on Drugs. In relation to **WHO**, DFID should roll out the new key population guidelines and implementation tool across its programmes, and ensure that the organisations it funds do the same.

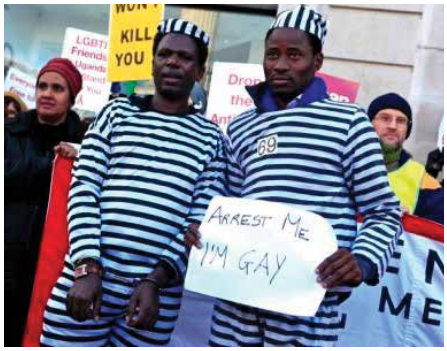
Finally, STOPAIDS members have highlighted concerns relating to the **Robert Carr Civil Society Networks Fund**, specifically that the level of funding allocated by it to key population led networks is still relatively low, and that the application process is unnecessarily cumbersome. DFID should increase its RCNF contribution in the near future, and in doing so it should ensure that more of RCNF's funding goes to key population led organisations. STOPAIDS recommends that DFID makes an increase in allocations focused on building the capacity of the key populations most affected by HIV and their organisations a key criterion for DFID in deciding whether to increase its contribution.

CONTINUING UK POLITICAL LEADERSHIP ON KEY POPULATIONS

There is also a need for stronger political leadership on decriminalisation and the protection of the human rights of key populations, as evidenced by the recent anti-gay laws in Nigeria and Uganda and possible copycat bills in other countries.

An increase in DFID **thought leadership** is important, for example through having staff attend global working groups on key populations and supporting research focused on them. DFID is currently funding regional research in southern Africa, looking at HIV prevention for adolescent girls and for prisoners. However there is concern among STOPAIDS members that DFID's research programmes do not link with their stated emphasis on the primary key population groups, and a clearer theory of change should help DFID to identify and fill **strategic research gaps** on key populations and to increase the value-added of its research funding. DFID also supports STRIVE, a research consortium which looks at ways to address four structural drivers of HIV, including gender and stigma and criminalisation. DFID should engage actively with STRIVE findings on stigma and discrimination, and should use them to shape their policy and practice on key populations.

There is also a need for **stronger political leadership** on decriminalisation and the protection of the human rights of key populations, as evidenced by the recent anti-gay laws in Nigeria and Uganda and possible copycat bills in other countries. The crises created by these laws and the global response to them highlight the close links between the HIV response and the struggle against criminalisation and for LGBT people's human rights. STOPAIDS has called for a **cross-Whitehall strategy** on LGBT equality, which identifies the special role that DFID can play as a development agency but also maximises the role of the Prime Minister, the Foreign & Commonwealth Office and other institutions, as well as the UK's important role within the Commonwealth and commitments made in the Commonwealth Charter to equality and evidence-based HIV responses. The LGBT equality strategy should be closely aligned with a DFID theory of change on HIV among key populations, both of which should be developed with the full engagement of key population communities and networks.



STOPAIDS joined a coalition of human rights groups, LGBTI organisations and HIV NGOs in urging the Ugandan Parliament to drop its Anti-Homosexual Bill and respect the universal human rights that are embodied in their nation's constitution. © STOPAIDS

The strong public and parliamentary reaction to Uganda's Anti-Homosexuality Act shows that people in the UK care about the welfare of LGBT people around the world, but the UK is understandably anxious about speaking out on LGBT equality for fear of being accused of cultural imperialism or endangering LGBT people on the ground. However, a more nuanced and creative handling of these concerns is needed. While in certain contexts and at certain moments public intervention by donors might be counter-productive, at other points it can be extremely valuable in supporting LGBT people and preventing further attacks on their rights. Financial support is also critical. Closer work with LGBT people affected by criminalisation and organisations working on LGBT issues in developing countries can help the UK government to better map these nuances.

A recent **leadership gap on harm reduction** is also apparent. At the 2011 UNGASS on HIV, the UK fought for a target in the UN Political Declaration target to halve new HIV infections among people who inject drugs. Now, ahead of the 2016 UNGASS on Drugs, we urge the UK to explicitly call for the decriminalisation of drug use. This position has recently been endorsed by UNODC, UNAIDS and the Global Commission on HIV and the Law[51], and has support from the Deputy Prime Minister who has called for a rethink of drug policy. The 2016 summit presents a major opportunity to build on the 2011 target, but also carries the threat that it could be undermined, and the UK is in a critical position to shape the debate. It should also support strong decision points ahead of the 2016 UNGASS, including on decriminalisation, at the December UNAIDS PCB meeting.

This paper also urges DFID to live up to their commitment to recognise the needs and rights of sex workers as a key population by aligning itself politically and publicly with international guidance and recommendations to decriminalise sex work, including the decriminalisation of third parties and the decriminalisation of the purchase of sex. Removing criminalisation and other forms of legal oppression

towards sex workers across the world will allow HIV prevention, treatment, care and support programmes to reach sex workers and their clients far more effectively and this has been evidenced in various internationally accepted reports, including the UNAIDS *Guidance Note on HIV and Sex Work* (2009); the *Report of the Global Commission on HIV and the Law* (2012); the UNDP, UNFPA and UNAIDS report on *Sex work and The Law in Asia and the Pacific*; and in all community-led consultations produced by the Global Network of Sex Work Projects (NSWP).

[backing proven interventions means] visible and vocal support for the utilisation of TRIPS flexibilities by MIC governments, and the rejection of approaches that have no evidence of having achieved sustainable and significant price reductions, such as tiered pricing.

Finally, as access to treatment for key populations in middle-income countries is so critical to an effective response, DFID must publicly back interventions which have been proven to overcome barriers. This means visible and vocal support for the utilisation of TRIPS flexibilities by MIC governments, and the rejection of approaches that have no evidence of having achieved sustainable and significant price reductions, such as tiered pricing. This must also extend to rejecting any TRIPS-plus terms in any free trade agreement.

BEYOND 2015

The post 2015 development framework is a vital opportunity to ensure future progress for key populations, but there is also a risk that HIV may be excluded from it. The MDG targets on HIV must be taken forward and built upon in the new framework, through the inclusion of a strong HIV target under a health goal and commitments to reach the key populations most affected by HIV. DFID recently confirmed its support for a HIV target under a health goal, and STOPAIDS members urge the UK to work with other governments and UN agencies to ensure that this target and strong commitments on key populations make it into the final framework. They should also push for a **High Level Meeting on HIV in 2016**, to review progress made under MDG 6 and to set the agenda for future action. At this point, it will be important for DFID to review its achievements and any lessons learned under *Towards Zero Infections* as well as under *Taking Action and Achieving Universal Access*, the two HIV strategies which preceded its current position paper.

In post-2015 discussions, the UK has also championed a 'leave no one behind' agenda, emphasising the importance of addressing inequality in the new framework and ensuring that progress for the most marginalised people can be monitored and accounted for. Better data on the size of key populations and their access to services is essential, but the framework must commit to **collecting data in a way that protects the human rights of marginalised and criminalised groups**. In terms of granularity, data should go no lower than city level. It should be securely stored with restrictions on who can access it and should be collected with the consent and involvement of key populations.

Finally, when the post-2015 development framework has been agreed, STOPAIDS and other health networks will call on DFID to develop a **health strategy** that commits to finishing the job on HIV and improving access to health services for key populations.

Finally, when the post-2015 development framework has been agreed, STOPAIDS and other health networks will call on DFID to develop a health strategy that commits to finishing the job on HIV and improving access to health services for key populations.

5 MATRIX OF RECOMMENDATIONS FOR DFID

Beyonce Karungi, a transgender woman from Uganda, speaking in the UK parliament during the STOPAIDS Speakers' Tour in 2013. © STOPAIDS

STRATEGY

- Develop a **theory of change on HIV among key populations**, in close consultation with key population networks and communities, which sets out what it wants to achieve and how it plans to use its funding and its voice in order to deliver progress in advance of the 2015 MDG deadline.
- Address recent the **lack of capacity** by ensuring that at least one staff member in its AIDS and Reproductive Health Team is dedicated to working solely on key population issues and can engage with the Global Funds and Governance Teams.
- **Clarify which populations** DFID is focused on, incorporating issues such as harm reduction which have historically been an area of comparative advantage for the UK, and recognising links between DFID's work on HIV among MSM and the struggle for LGBT equality.
- Clearly highlight **transgender people** as a key population group that is distinct from MSM and consider how DFID can improve their access to HIV services and advance their rights as part of wider efforts to promote LGBT equality.

FINANCING

BILATERAL

- Adopt a more strategic approach to bilateral funding in middle-income countries, based on criteria that properly assess countries' epidemiology, their ability to fund their HIV responses and critically, their government's willingness to provide services for marginalised and often criminalised key populations.
- In countries where DFID is withdrawing bilateral support, **adopt transitional strategies** which protect gains that have been made on HIV, such as technical support, civil society funding and support and diplomacy around human rights and discrimination. Also take a stronger stance to ensure that the Global Fund will continue to support the HIV response in middle-income countries.
- Responding to evidence on key populations in African countries, increase bilateral funding for **key population programming in Africa**, particularly for sex workers and MSM.
- Roll out the Sex Worker Implementation Tool and **WHO**'s other new key population guidelines and implementation tools across DFID's programmes, and ensure that the organisations it funds do the same.
- In countries where DFID has transitioned from HIV to **health systems or sexual and reproductive health investment**s, ensure continued access for key populations. Also explore ways to support key populations through other funding streams including **gender equality**, and adopt a more gendered analysis of key population issues which addresses gender-based violence against sexual minorities and links DFID's work with key populations more directly to its women and girls pillar.

MULTILATERAL

- Prioritise **making the Global Fund's new funding model work better for key populations**, by ensuring that the Technical Review Panel (TRP) makes meaningful involvement of them an eligibility requirement for country proposals, and pushing the TRP to challenge countries which have not included sufficient and tailored services for key populations or addressed criminalisation and other barriers to reaching them.
- Push for delivery of Global Fund objective four, and for more innovative advocacy programmes aimed at increasing support for the rights of key populations and their access to services.
- Review whether the **World Bank** is really the ideal recipient for its multilateral HIV funding. The Bank may have more of a role to play in helping governments identify what aspects of the HIV response to invest in, and in better evidencing the value of funding responses for key populations. The World Bank is also

improving its approach to budget tracking and could use lessons learnt from this to support DFID to better track their own investments.

- Ensure that **UNAIDS** more actively defends the rights of key populations, engage with all co-sponsoring agencies to increase their support for the rights of key populations and, at the December Programme Coordinating Board meeting on people who inject drugs, push for ambitious commitments and for agreement by UNAIDS to demand a strong focus on the rights and health of people who use drugs at the 2016 UNGASS on Drugs.
- When increasing the **UK's Robert Carr Fund** contribution, work with the RCNF to ensure that more of its funding goes to key population led organisations. STOPAIDS recommends that DFID makes an increase in allocations focused on building the capacity of the key populations most affected by HIV a key criterion for DFID in deciding whether to increase its contribution and that it urges RCNF to simplify its application process without delay.

LEADERSHIP

- Use a theory of change to identify and fill **strategic research gaps** on key populations and ensure that findings from the stigma and criminalisation strand of the STRIVE research consortium are used to shape their policy and practice on key populations.
- Increase political leadership on LGBT equality with a **cross-Whitehall strategy on LGBT equality**, in consultation with LGBT people affected by criminalisation, which identifies the special role that DFID can play but also maximises the role of the Prime Minister, the Foreign & Commonwealth Office and other institutions, as well as the UK's important role within the Commonwealth.
- **Increase political leadership on harm reduction, championing a health- and human rights-based approach to drugs which champions decriminalisation of drug use and possession** in the run up to the December UNAIDS Programme Coordinating Board meeting and the UN Summit in 2016.
- Visibly and vocally support the **use of TRIPS** flexibilities by middle-income country governments, oppose TRIPS-plus terms in free trade agreements and withdraw UK support for failed approaches such as **tiered pricing**.
- Publically support the **full decriminalisation of sex work**, including the decriminalisation of third parties and the purchase of sex as part of a wider commitment to ensuring **the health, labour and human rights of sex workers are respected, protected and fulfilled**.

BEYOND 2015

- Work with supportive governments and UN agencies to ensure **a strong HIV target under any future health goal alongside commitments** to reach key populations make it into the framework.
- Ensure that the framework commits to **collecting data in a way that protects the human rights of marginalised and criminalised groups**.
- Push for an effective High Level Meeting on HIV in 2016 to review progress made under MDG 6 and to set the agenda for future action, and **review of DFID achievements under Towards Zero Infections and previous HIV strategies**.
- When the post-2015 development framework has been agreed, develop **a health strategy** which commits to finishing the job on HIV and improving access to health services for key populations.

ENDNOTES

1. Sukthankar, A (2011). *Sex work, HIV and the Law*. http://www.hivlawcommission.org/index.php/working-papers/sex-work-hiv-and-the-law/download
2. Baral, S et al (2012). Elevated risk for HIV infection among men who have sex with men in low and middle income countries 2000-2006: A systematic review. *PLoS Med* 4: e339.
3. International Harm Reduction Association (2012). *Global state of harm reduction*. http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf
4. Baral et al (2012). *Worldwide burden of HIV in transgender women: a systematic review and meta analysis*. http://dx.doi.org/10.1016/S1473-3099(12)70315/8
5. Rowniak, S et al. *Trans men: the HIV risk of gay identity*. http://www.ncbi.nlm.nih.gov/pubmed/22201235
6. DFID (2004). *Taking Action: the UK Government's strategy for Tackling HIV and AIDS in the Developing World*. http://www.hivpolicy.org/Library/HPP000497.pdf
7. DFID (2009). *Achieving universal access – the UK's strategy for halting and reversing the spread of HIV in the developing world*. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127511.pdf
8. DFID (2011). *Towards Zero Infections – the UK's position paper on HIV in the developing world*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67523/twds-zero-infs-pos-paper-hiv-dev-wrld.pdf
9. DFID (2013). *Towards Zero Infections – Two Years On. A Review of the UK's Position Paper on HIV in the developing world*. https://www.gov.uk/government/publications/towards-zero-infections-two-years-on
10. DFID (2011). *Bilateral aid review: technical report*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214110/FINAL_BAR_20TECHNICAL_20REPORT.pdf
11. UNAIDS (2011). UNAIDS terminology guidelines: Revised version. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf
12. DFID (2013). *Towards Zero Infections -–Two Years On. A Review of the UK's Position Paper on HIV in the developing world*. https://www.gov.uk/government/publications/towards-zero-infections-two-years-on
13. *Towards Zero Infections*. Page 52.
14. *Towards Zero Infections*. Pages 49-51.
15. FCO (2013). *An FCO programme for promoting the rights of LGBT people*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35442/human-rights-lgbt.pdf
16. DFID (2011). *Bilateral aid review: technical report*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214110/FINAL_BAR_20TECHNICAL_20REPORT.pdf
17. Zhang, L et al (2014). *Evaluation of a decade of DFID and World Bank supported HIV and AIDS programmes in Vietnam from 2003 to 2012*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/303560/Decade-DFID-World-Bank-Support-HIV-Aids-Prog-Vietnam-2003-2012.pdf
18. *Evaluation of a decade of DFID and World Bank supported HIV and AIDS programmes in Vietnam from 2003 to 2012*, p24.
19. *Evaluation of a decade of DFID and World Bank supported HIV and AIDS programmes in Vietnam from 2003 to 2012*, p57.
20. ICAI (2013). *DFID's Support for Civil Society Organisations through Programme Partnership Agreements*. http://icai.independent.gov.uk/wp-content/uploads/2010/11/ICAI-REPORT-DFIDs-Support-for-CSOs-through-PPAs.pdf
21. *Towards Zero Infections*, p53.
22. http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_57/HLS/Statements/Thurs_13th_AM/21_United_Kingdom_130314_am.pdf
23. *Towards Zero Infections*, p22.
24. See http://strive.lshtm.ac.uk
25. *Towards Zero Infections*, p11.
26. Global Fund. (2012). *The Global Fund Strategy 2012–2016: Investing for Impact*. http://www.theglobalfund.org/en/about/strategy/
27. See http://www.harm-reduction.org/news/global-fund-grant-approval
28. http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20415735~menuPK1001234~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html
29. World Bank (2007). *Improving effectiveness and outcomes for the poor in health, nutrition and population*. http://web.worldbank.org/WBSITE/EXTERNAL/EXTOED/EXTWBASSHEANUTPOP/0,,contentMDK:22153992-menuPK:6080533-pagePK:64829573~piPK:64829550~thesitePK:4422776,00.html

30. Marriott, A (2014). *A dangerous diversion: will the IFC's flagship health public-private partnership bankrupt Lesotho's Ministry of Health?* http://www.oxfam.org/en/policy/dangerous-diversion-lesotho-public-private-health
31. Rodriguez-Garcia, R et al (2013). *Evaluation of the community response to HIV and AIDS: learning from a portfolio approach*. http://www.ncbi.nlm.nih.gov/m/pubmed/23745633/
32. UNAIDS. (2010). *UNAIDS 2011–2015 Strategy: Getting to Zero*. www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf
33. UNAIDS. (2010). *UNAIDS division of labour matrix*. http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/20110304_2010_UNAIDS_DivisionOfLabourMatrix_en.pdf
34. Schwartlander, B et al. (2011). Towards an improved investment approach for an effective response to HIV/AIDS. *The Lancet*. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60702-2/abstract
35. DFID. (2011). *Multilateral Aid Review: Assessment of the Joint United Nations Programme on HIV/AIDS (UNAIDS)*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/67592/UNAIDS.pdf
36. UNAIDS. (2011). *UNAIDS response to the United Kingdom's Multilateral Aid Review.* www.gov.uk/government/uploads/system/uploads/attachment_data/file/214141/unaids-response.pdf
37. Global Network of Sex Work Projects (2013). *Briefing for the office of the UN special rapporteur on the situation of human rights defenders*. http://www.nswp.org/sites/nswp.org/files/NSWP%20briefing%20Alejandra%20Gil%20final.pdf
38. http://www.unaids.org/en/resources/presscentre/featurestories/2011/july/20110701moscow/
39. UNDP received 3%; UNFPA 2%; UNICEF 2% and WHO 1% of DFID's multilateral aid to HIV. *Towards Zero Infections*, p11.
40. For more information see http://www.who.int/hiv/events/2014/kppguidelines/en/
41. *Towards Zero Infections*. Page 23.
42. Details of the Programme for Action are available at http://europa.eu/legislation_summaries/development/sectoral_development_policies/r12537_en.htm
43. See http://ec.europa.eu/justice/grants/programmes/drug/index_en.htm
44. See http://drogriporter.hu/romania
45. UNITAID. (2013). *UNITAID strategy 2013–2016*. https://www.unitaid.eu/strategy/UNITAID-Strategy_2013-2016.pdf
46. REDLACTRANS and the International HIV/AIDS Alliance (2013). *The night is another country: impunity and violence against transgender women human rights defenders in Latin America*. http://www.aidsalliance.org/includes/Publication?Violencia-e-impunidad-English.-%20Ver1.1.pdf
47. *Elevated risk for HIV infection among men who have sex with men in low and middle income countries 2000-2006: A systematic review*. Ibid.
48. Rowniak, S et al. *Trans men: the HIV risk of gay identity*. http://www.ncbi.nlm.nih.gov/pubmed/22201235
49. DFID (2011). *Bilateral aid review: technical report*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214110/FINAL_BAR_20TECHNICAL_20REPORT.pdf
50. GCHL (2012), *Global commission on HIV and the Law: Risks, rights and health*. http://www.hivlawcommission.org/index.php/report
51. GCHL (2012). *Global commission on HIV and the Law: Risks, rights and health*. http://www.hivlawcommission.org/index.php/report

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