

Global Fund HIV Investments Specifically Targeting Most-at-Risk Populations: An Analysis of Round 8 (2008) Phase 1

EXECUTIVE SUMMARY

The Global Fund is committed to strengthening its processes and policies to ensure that communities most affected by HIV, tuberculosis and malaria are effectively reached through its investments. The Secretariat and partners conduct regular analyses of Global Fund proposals and supported programs to identify strengths and weaknesses that can inform future approaches. HIV prevention funding addressing most-at-risk populations represented around 6 percent of cumulative funding (or US\$ 196 million) for the period 2002-2009 according to previous research undertaken by the Global Fund.ⁱ

This analysis focuses on funding for activities that specifically seek to address most-at-risk populations and their indirect costs in Global Fund Round 8 (2008) signed Phase 1 budgets. As such, it builds upon the 2002-2009 analysis as part of on-going efforts to strengthen the impact of Global Fund HIV investments in relation to most-at-risk populations.

Of the US\$ 903'105'728 signed HIV budgets in Round 8, Phase 1, a total of US\$ 79'154'825 (8.8 percent) specifically targets men who have sex with men (MSM), sex workers and people who inject drugs as follows:

<p>MSM - US\$ 19 million (2.1 percent of the US\$ 903 million total) Sex workers - US\$ 29 million (3.2 percent) People who inject drugs - US\$ 31 million (3.5 percent)</p>

The money allocated to most-at-risk populations was predominantly focused on prevention (57 percent) and supportive environments (25 percent); with only 4 percent focused on treatment specifically for these groups (all of which is provided in compulsory detention centre settings).

It is important to stress that this analysis does not provide a comprehensive understanding of activities *reaching* most-at-risk populations in the first phase of Round 8 – rather it describes budgeted activities that *specifically seek to target* these groups. It also provides just a ‘snapshot profile’ of one funding phase of one round.

It should be noted that grant applicants rarely explain which population groups will benefit from their treatment programs, unless they are in special environments like prisons and detention centres. Therefore these results represent an underestimate of Global Fund supported interventions reaching most-at-risk populations. This will certainly be the case in the context of concentrated epidemics that received funding for treatment that will by default reach most-at-risk populations.

This analysis also only describes the contribution made by the Global Fund in Round 8 and does not capture contributions from other funding rounds or sources of funding. Therefore it is important to stress that these results cannot be used to anyway reflect a ‘national overview’ in relation to the funding of HIV programs for most-at-risk populations.

Just over half of the total Round 8 investments targeting most-at-risk populations are managed by governmental bodies, compared to a third that is managed by non-governmental organizations and 16 percent managed by multilateral organizations.

In countries with concentrated epidemics, only about 30 percent of their HIV grant budgets specifically address most-at-risk populations. In 14 countries reporting both generalized and concentrated HIV epidemics, the proportion of Round 8 grant budgets targeting most-at-risk populations is 7 percent. However, this figure falls to below 3 percent when Thailand (which allocated 75 percent of its Round 8 grant budget to most-at-risk populations) is excluded from the sample.

Clearly more work is needed at country level to ensure that HIV grants are being appropriately allocated to interventions targeting most-at-risk populations. In addition further research is needed to understand how non-targeted budgets are being spent – especially in countries with concentrated epidemics.

Since 2008, when the Round 8 budgets were signed, applicants have been encouraged to be more focused in their HIV applications through: the Board approved Sexual Orientation and Gender Identities Strategy; enhanced work of technical partners; the strengthening of civil society organizations in many regions; stronger data and evidence; and most recently through the Round 10 'MARPs Reserve'. It will be important to repeat this research for Rounds 9 and 10 in order to assess the impact of these initiatives and developments on the targeting of HIV funding in relation to most-at-risk populations.

BACKGROUND

Since the Global Fund was founded in 2002 it has been an important and innovative mechanism through which applicants can finance interventions that target communities most affected by HIV, tuberculosis and malaria. The Global Fund is committed to strengthening its processes and policies to ensure that communities most affected by these diseases are effectively reached through its investments.

This analysis forms part of a wider effort underway at the Global Fund to build greater understanding of its strengths, weaknesses, successes and challenges in relation to the targeting and effectiveness of investments. It assesses the levels of funding specifically allocated (in Phase 1 of one funding round¹) to HIV interventions that are designed to reach populations that have historically been overlooked in national responses. These include men who have sex with men, people who inject drugs and sex workers.

A previous analysis of resources allocated to HIV prevention programs targeting these groups from 2002-2009 shows that approved funding represents about 6 percent of cumulative funding on HIV prevention, or US\$ 196 million. In countries with concentrated epidemics, funding for HIV prevention interventions targeting MARPs accounted for 10 percent of all preventive activities. In countries with generalized epidemics it accounted for 4 percent. In the countries with low-level epidemics, funding for MARPS represented 9 percent of funding for prevention.ⁱⁱ

In early 2010 the Global Fund Secretariat also conducted an analysis of HIV proposals submitted in Round 8 (2008) and Round 9 (2009) to ascertain how well they responded to the needs of men who have sex with men, sex workers and transgender communities.ⁱⁱⁱ Like this analysis, the work was undertaken as part of the implementation of the Board-approved Sexual Orientation and Gender Identities Strategy.^{iv} It demonstrated that 8 out of 10 proposals contained at least one activity targeting these groups with the majority of the proposals focused on HIV prevention activity. In Round 8, 39 percent of the proposals included at least one element related to treatment; 31 percent identified at least one activity generally related to community systems strengthening; 25 percent included at least one activity related to stigma or rights promotion; and 23 percent included an item related to care and support. Although useful, this kind of proposal analysis does not offer any insight into the proportion or totals of Global Fund investments specifically targeting most-at-risk populations.

Know Your Epidemic, Know Your Response

Sex workers, men who have sex with men and people who inject drugs are widely recognized as populations with relatively high risk of HIV infection in all regions of the world. These groups also experience marginalization and criminalization in most societies.

Between 5 percent and 10 percent of HIV infections worldwide are the result of sex between men, according to UNAIDS.^v In addition, the United Nations Reference Group on HIV and Injecting Drug Use has estimated that in 2008 there were around 3 million people who inject drugs who were also living with HIV (range 0.8 to 6.6 million), or approximately 30% of the total HIV infections outside of Sub-Saharan Africa.^{vi} HIV prevalence among sex workers is also higher than the general population.^{vii}

¹ Most proposals to the Global Fund are for five-year grants. For accepted proposals, funding is agreed and disbursed for the first two years ('Phase 1'), after which a review of performance is conducted before the remaining funding is disbursed for the final three years ('Phase 2').

Despite these groups forming a significant part of HIV epidemics, numerous studies have described the failures of countries to appropriately match their HIV responses to the realities of their epidemics:

Around the world – even in countries where [most-at-risk populations] are nominal beneficiaries of Global Fund funding – there are consistent and extensive reports of funds not being allocated to appropriate interventions, a severe lack of services related to health and rights, and continued disregard for human rights.^{viii}

METHODOLOGY

This paper focuses on signed Round 8 (2008), Phase 1 HIV grants. It uses the final, signed grant budgets for Phase 1 that are available within the Secretariat, and the original proposals found on the Global Fund website^{ix}. This method allows for a more detailed assessment than is possible through using original proposals alone. The signed budgets take into account any efficiency savings or changes negotiated after the approval of proposals. However, it should be noted that this overall approach is not fully aligned to other Global Fund resource tracking reports (such as the 2002-2009 research^x) and was developed as an initial one-off study.

This research sets out to provide a snapshot profile of Global Fund HIV investments from Round 8 in 2008: the last round of funding to be initiated prior to the approval of the Sexual Orientation and Gender Identities Strategy in 2009. The analysis included the complete HIV portfolio for Round 8 of 57 grants from 34 countries.

The most-at-risk populations selected for this analysis include men who have sex with men, people who inject drugs and sex workers – the three population groups most readily recognized as experiencing heightened levels of HIV-related risk. Transgender communities were excluded early on in the analysis as there was insufficient data available for analysis in this funding round. The research was managed by a PhD research graduate, with a background in social justice and human rights research within sex worker communities, who was recruited for a three month internship by the Global Fund. An internal advisory group was also set up within the Global Fund Secretariat to guide the research process. The aim is that this analysis can be repeated for other funding rounds (and for Phase 2 of Round 8) when the necessary data (i.e. the signed budgets) are available, in order to develop an understanding of trends in funding over time.

Financial Data Collection

In the Global Fund proposal documents, sections 4.5 or 4B outline the implementation strategy for the grant. For all 57 HIV proposals approved in Round 8, these sections of the proposal documents were reviewed in order to identify activities and workplans targeting most-at-risk populations.^{xi} The final, signed grant budgets were analysed by service delivery area, and cross-checked with the original proposals and implementation strategies to identify the amounts of funding allocated to specific interventions. Assessing the signed budgets in this way allows for a more detailed understanding of the targeted funds. It should be noted that the final budgets that are signed within the grant agreement are constructed following Technical Review Panel clarifications and a period of grant negotiations; therefore, they are more closely representative of the reality on the ground than the activities and budgets described in the original proposals. They are, however, not publically available documents.

Direct and Indirect Costs

A decision was made to include both direct and indirect costs in this analysis. Direct costs are those allocated to activities that explicitly seek to address most-at-risk populations. In cases where proposals requested funding for more than one most-at-risk population collectively, it is difficult to know how much of the costs are destined for each of the different groups. In these instances, it was decided to attribute an equal amount to each of the populations mentioned. For example, where a budget included one activity for condom distribution to four groups (out-of-school youth, sex workers, people who inject drugs, and poor women) a decision was taken to attribute a quarter of the costs to each of these populations: so, for the purposes of this analysis, 25 percent of the costs were allocated to sex workers, 25 percent to people who use drugs, and (in this case) none to men who have sex with men.

Indirect costs include those for overhead activities linked to direct costs designed to benefit these groups – they include activities such as monitoring and evaluation, procurement management, administration and other overheads related to programme management. For these areas of the grant, a share of the allocated budgets was calculated, for grants which also included direct costs for most-at-risk populations. It was decided that the share of these broader activities and costs that are attributed to each most-at-risk population should reflect the share of the direct total costs in the program. For instance, if 17 percent of the direct costs (i.e. the overall budget minus the indirect, program support costs) of a certain grant was attributed to sex workers, then 17 percent of the indirect costs in the grant budget was also attributed to sex workers.

Epidemiological Data Sources

In order to obtain national estimates of most-at-risk population sizes and HIV prevalence, the following three main sources of epidemiological data were used:

1. UNGASS Country Progress Reports, 2010^{xii}
2. The Global State of Harm Reduction, 2010^{xiii}
3. The epidemiological background included in section 4.2 of the original proposals^{xiv}

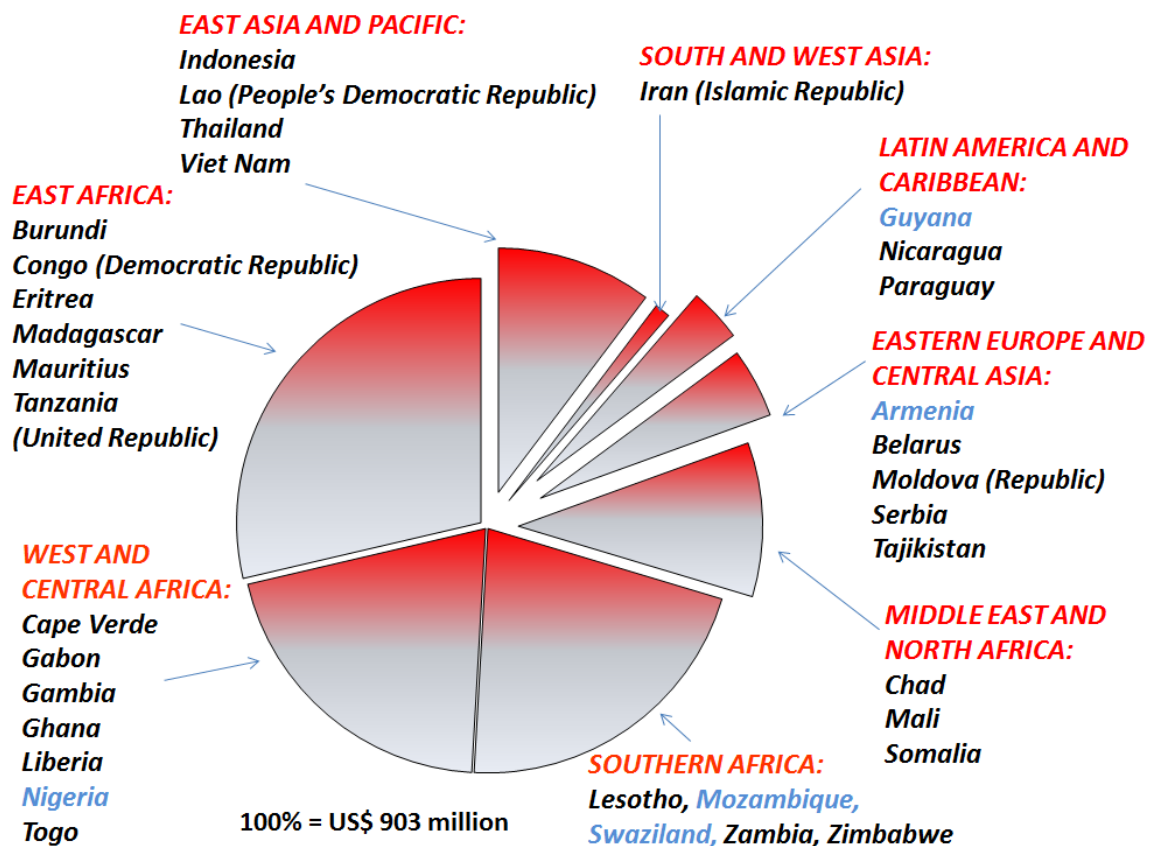
The prevalence of HIV among most-at-risk populations is chiefly available through the 2010 UNGASS Country Reports,^{xv} and reported under indicator number 23. However seven of the 34 countries in this analysis did not report specific data. Out of the other countries that did report data, 20 reported HIV prevalence of greater than 10 percent in one of the focus most-at-risk populations; six countries reported prevalence of between 5 and 10 percent; and one country reported prevalence of less than 5 percent. Out of the 34 countries, 24 give prevalence data on sex workers, 18 give prevalence data on men who have sex with men, and 10 give prevalence data on people who inject drugs. When necessary, gaps in the data (or cases where verifications were needed) were addressed by cross-referencing other data sources.^{xvi}

RESULTS AND DISCUSSION

The Round 8, Phase 1 Sample

Figure 1 shows the geographic distribution of the 34 countries with approved HIV grants in Round 8 (2008). Of these countries, 12 submitted proposals with separate health systems strengthening sections and five countries (marked in blue) only had these health systems strengthening components of their HIV proposals approved for funding (referred to in this report as “HSS-only grants”). Four of these HSS-only grants requested activities for most-at-risk populations in their original proposals, but none of their final, approved grants included these activities.

Figure 1 HIV Investments in Round 8, Phase 1

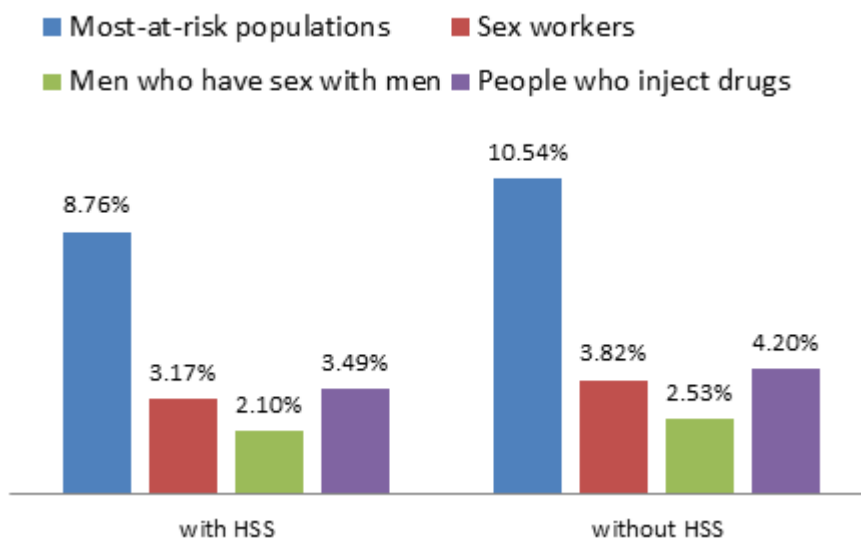


Budget Allocations to Most-At-Risk Populations

The total signed amount for HIV proposals in Round 8, Phase 1 is US\$ 903'105'728, of which US\$ 79'154'825 (8.8 percent) was identified through this analysis as specifically targeting men who have sex with men, sex workers and people who inject drugs.

As Figure 2 illustrates, investments specifically targeting men who have sex with men were recorded at US\$ 19 million (2.1 percent of the US\$ 903 million total), with slightly higher levels noted for sex workers (US\$ 29 million or 3.2 percent) and people who inject drugs (US\$ 31 million or 3.5 percent). When the US\$ 150 million allocated to HSS-only grants is removed, the percentage figures for most-at-risk populations increase slightly.

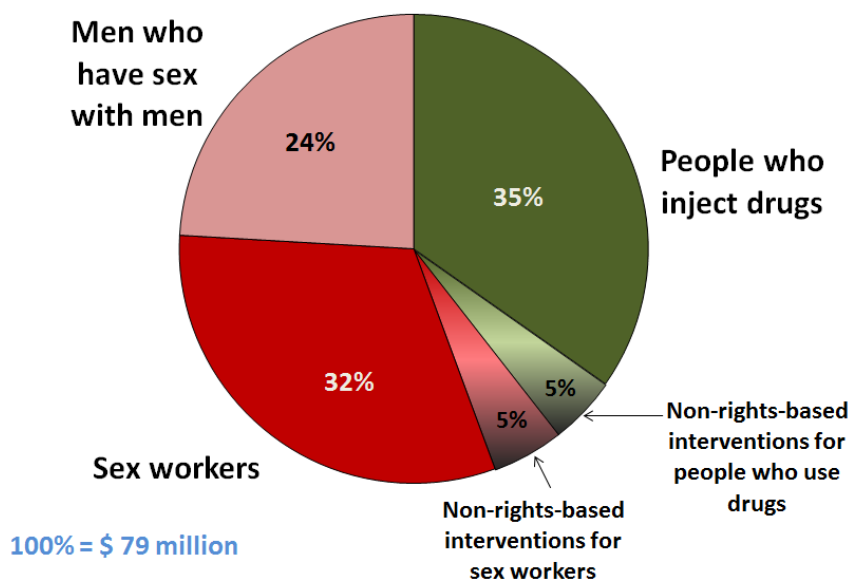
Figure 2 Specific shares of HIV investments for most-at-risk populations, with and without health system strengthening components



Abbreviations: HSS – health systems strengthening.

Figure 3 shows the allocation of resources that can be specifically linked to the different most-at-risk populations. Almost 40 percent of the US\$ 79 million targeting most-at-risk populations is allocated to interventions for people who inject drugs. Around 37 percent is allocated to interventions for sex worker interventions and 24 percent to interventions targeting men who have sex with men. See Box 2 for a discussion on interventions for these groups which potentially violate human rights.

Figure 3 Specific investments per most-at-risk population



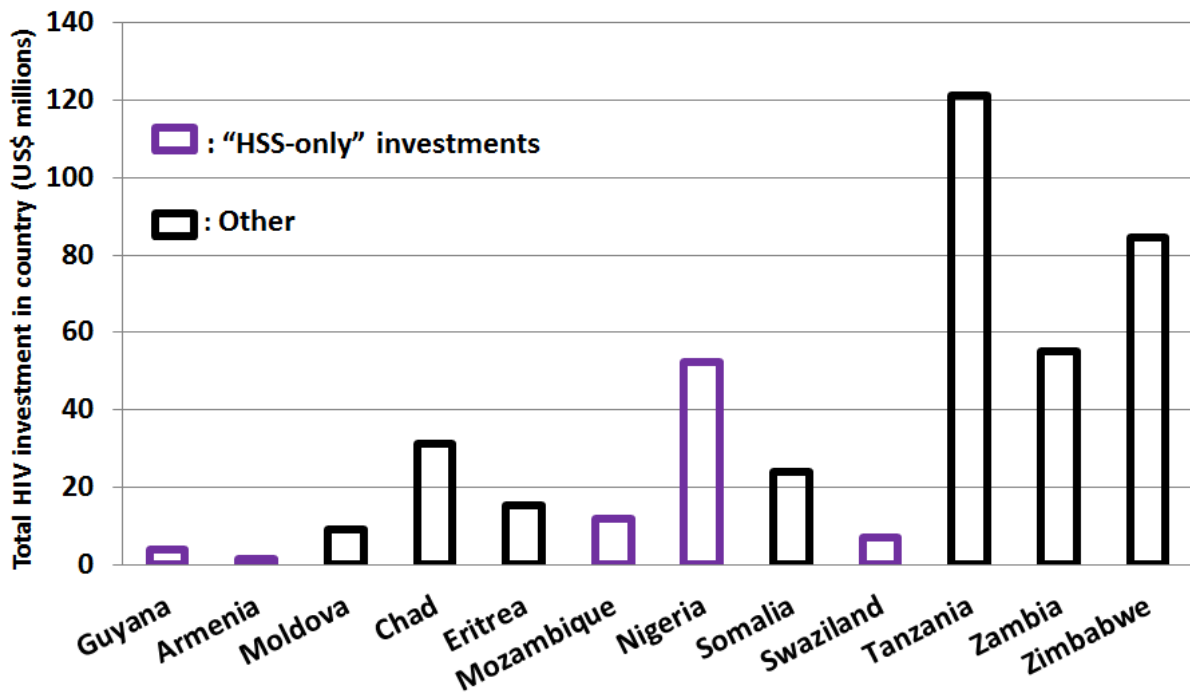
Box 2: Interventions for most-at-risk populations that violate human rights

During the analysis it became clear that some of the approved HIV proposals included interventions which specifically targeted sex workers and people who inject drugs, but did so in a way that potentially violates basic human rights principles and does not reduce risks or harms. In Round 8, Phase 1, these interventions largely take place in the context of “Treatment and Education Centres” in Viet Nam which provide antiretroviral treatment, HIV testing, training and TB/HIV services. Both drug use and sex work are illegal in Viet Nam and the dominant policy response to these behaviours is a punitive one involving compulsory rehabilitation in detention centres for between two and five years. In Viet Nam, the centres are officially known as “05/06 centres” and are located throughout the country.

Countries with No Focus on Most-At-Risk Populations

Of the 34 countries with HIV proposals approved in Round 8 (2008), 12 did not specifically target most-at-risk populations (Figure 4). These proposals accounted for a total of US\$ 417 million (46 percent) of the total HIV budgets for Round 8, Phase 1. These included countries with large investments and generalized epidemics (such as Tanzania) and some countries with smaller investments and concentrated epidemics (such as Armenia and Guyana, where health systems strengthening was the sole focus of the approved grant).

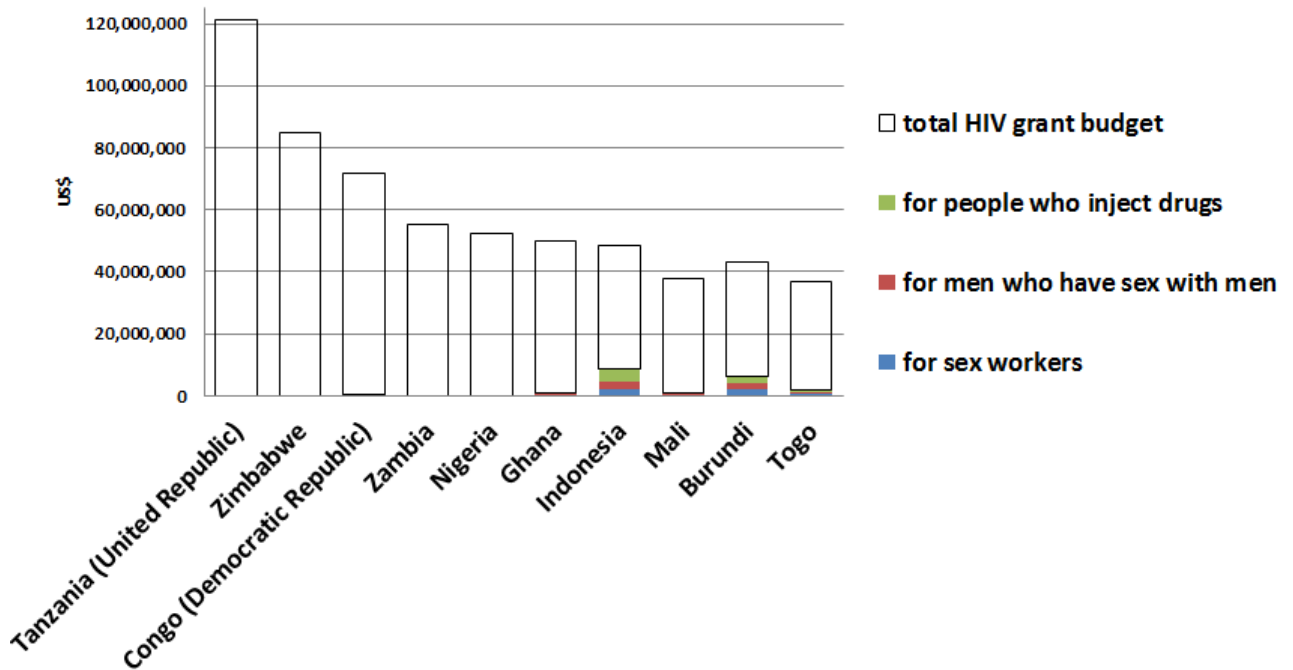
Figure 4 Countries with no specific investments for most-at-risk populations in Round 8



Original proposals for Guyana, Armenia, Mozambique, Nigeria (all the HSS-only grants with the exception of Swaziland) did include a focus on most-at-risk populations in their original proposals, but these were not approved after technical review.

As Figure 5 shows, few of the larger recipient countries in Round 8 (primarily Sub-Saharan Africa countries with high prevalence and generalized epidemics) allocated any of their funding specifically to most-at-risk populations. These countries account for around half of the US\$ 900 million budgeted in Round 8, Phase 1 HIV proposals, and this high volume of financing is one factor in the low overall allocation of budgets to most-at-risk populations.

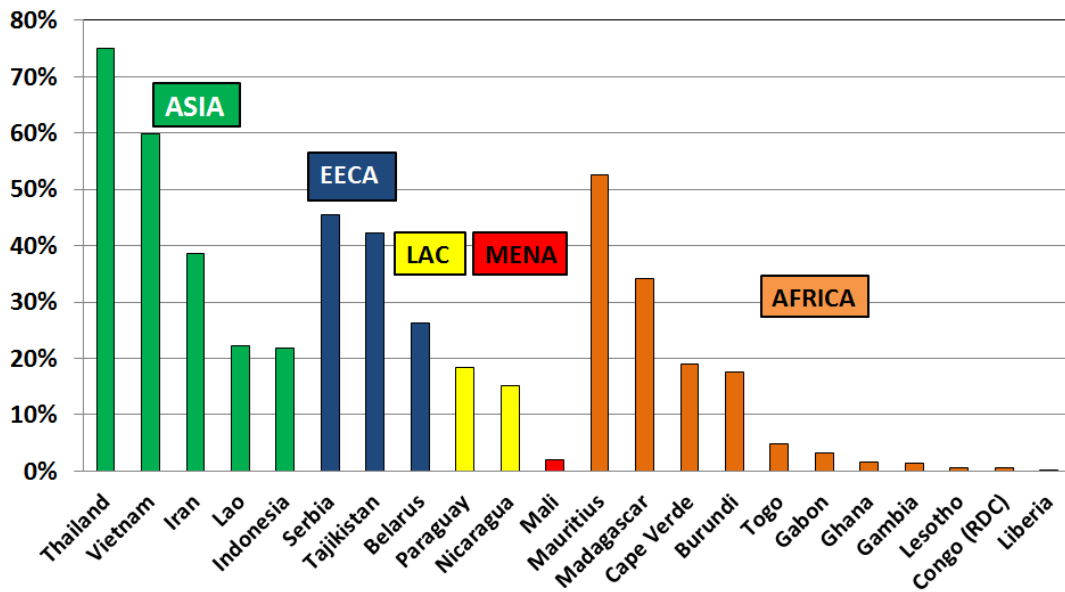
Figure 5 Specific investments for most-at-risk populations in the 10 largest HIV grant in Round 8 (2008)



Countries with a Focus on Most-At-Risk Populations

Figure 6, overleaf, shows the 22 countries that allocated part of their Round 8, Phase 1 budgets to most-at-risk populations, and divides these countries by region.

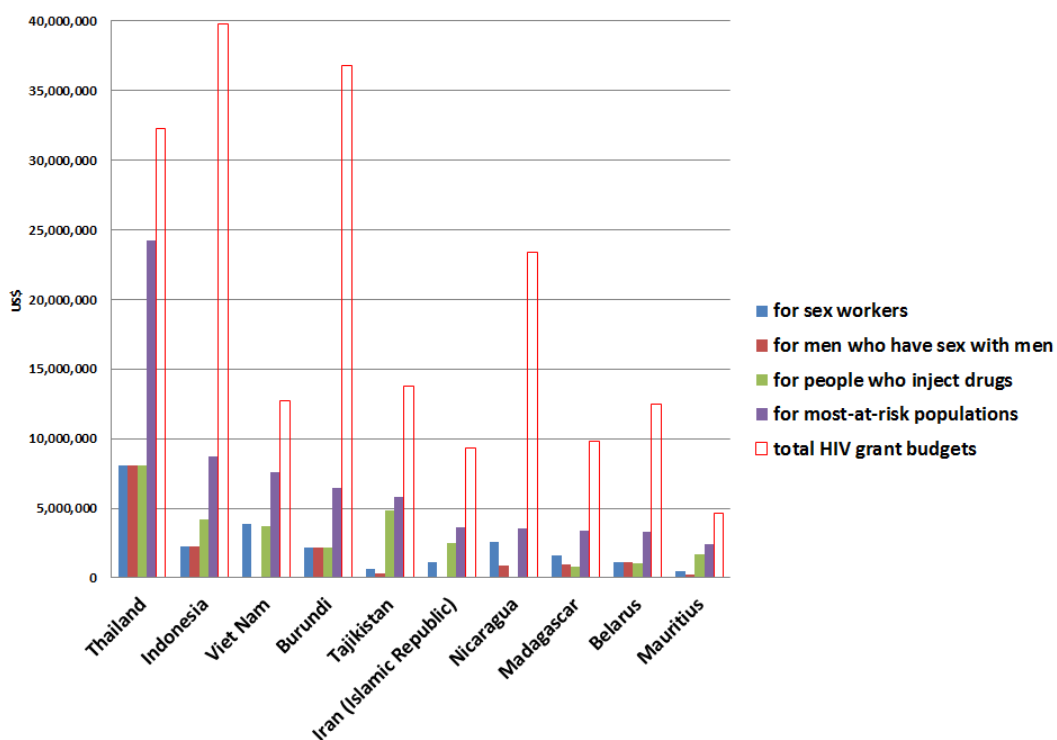
Figure 6 Countries with specific investments in most-at-risk populations, as a share of total HIV grant budgets



Abbreviations: EECA – Eastern Europe and Central Asia Region; MENA – Middle East and North Africa Region; LAC – Latin America and the Caribbean.

Figure 7 shows the 10 countries with the largest levels of investment specifically targeting most-at-risk populations. These include Thailand, with 75 percent of the total budgets for Round 8, Phase 1 are specifically allocated for most-at-risk populations, and Viet Nam, where 60 percent of the total is allocated to these groups.

Figure 7 The ten countries with the largest investments in most-at-risk populations

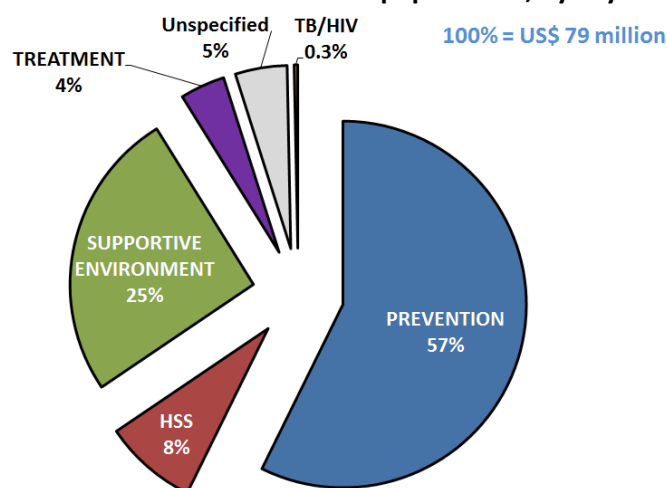


Investment by Key Area

In the signed budgets, the applicants assign each activity to one of the standardized service delivery areas used by the Global Fund without guidance from the Secretariat. This approach is core to the country-driven nature of the Global Fund model, but creates challenges in terms of monitoring the consistency and quality of service delivery areas across grants. For example, harm reduction interventions for people who inject drugs may be included as ‘behaviour change communication’ in some countries but as ‘programs for specific groups’ in others. In addition, some activities – including ‘stigma reduction’ and ‘strengthening of civil society’ are classified by some countries as prevention, but by others as enabling supportive environments. Similarly, ‘information system and operational research’ is classified in some cases as health system strengthening and in other cases as enabling supportive environments.

Nonetheless, as Figure 8 shows, the majority of the direct costs allocated to most-at-risk populations in the Round 8, Phase 1 signed budgets came under the service delivery areas for prevention (57 percent) and the creation of supportive environments (25 percent) only 4 percent was focused on treatment specifically for these groups (all of which is provided through compulsory detention centres).

Figure 8 Specific investments for most-at-risk populations, by key area



Abbreviations: HSS – health systems strengthening.

When these overall totals are examined by service delivery area it becomes clear that much activity that specifically targets most-at-risk populations falls into the service delivery area of ‘behaviour change communication and community outreach’.

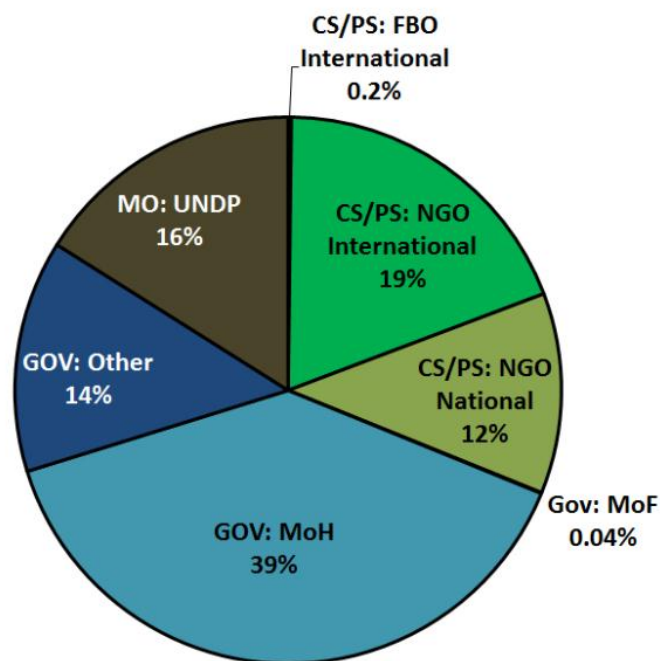
It is important to stress that treatment activities in Global Fund grants rarely target specific populations. This helps to explain the relatively low proportion of budgets assigned to treatment that are specifically allocated to most-at-risk populations.

It is also an important to recognize that treatment is often one of the largest budget components in Global Fund HIV grants, so this could contribute to the relatively low amount of money (US\$ 79 million) that is specifically found to be target to these groups in Round 8. It is clear that people from most-at-risk populations do access Global Fund-supported treatment, particularly in countries with highly concentrated epidemics, yet the limitations posed by the data available makes it difficult to attribute precise numbers or percentages for broad treatment elements. It may be possible to apply

a formula for treatment similar to that used to determine the proportion of overhead management or indirect costs allocated to most-at-risk populations for this study. However the advisory group guiding the research felt that this could be misleading and that more in-depth country case studies would be a better way to assess the percentage of treatment investment reaching most-at-risk populations in different contexts. The advisory group felt it not unreasonable to assume that applicants requesting specific HIV prevention funding for most-at-risk populations may well demonstrate success in providing access to treatment through mainstream services for most-at-risk populations. Further research is needed to assess the levels of treatment uptake from within most-at-risk populations in different epidemic contexts.

Investments by Principal Recipient

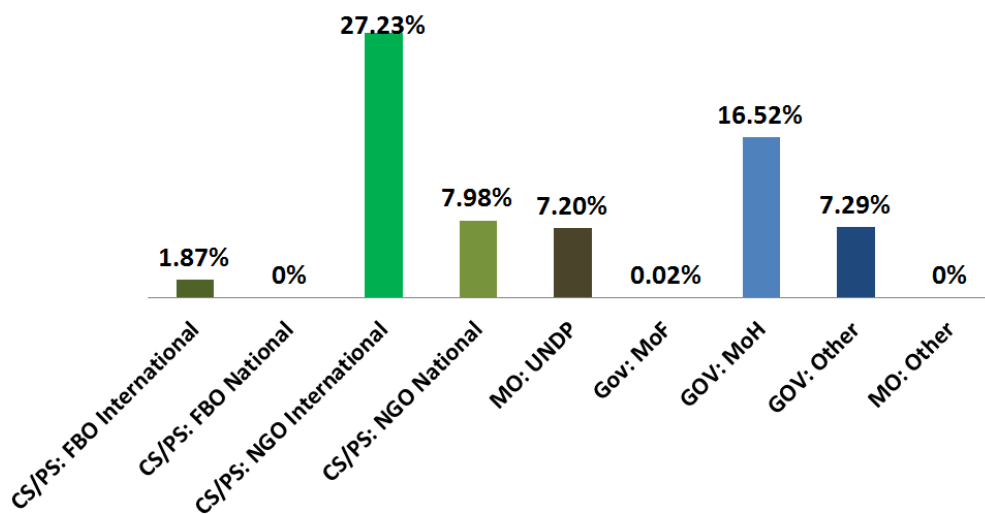
Figure 9 Specific investments in most-at-risk populations, by type of Principal Recipient



Abbreviations: NGO – nongovernmental organization; CS – civil society; PS – private sector; MoF – Ministry of Finance; MoH – Ministry of Health; GOV – government; MO – multilateral organization; UNDP – the United Nations Development Programme.

In Round 8, the largest proportion (39 percent) of the US\$ 79 million budgeted for most-at-risk populations were managed by governmental Principal Recipients (Figure 9). By contrast non-governmental or civil society Principal Recipients were responsible for 31 percent of the allocated budgets. However, closer inspection of the allocations to most-at-risk populations as a percentage of overall grant size managed shows that international non-governmental organizations are more likely than government agencies to focus on targeted programming. Among governmental bodies, ministries of health appear to handle larger investments for most-at-risk populations (16.5%) than ministries of finance (0.02%) or other governmental bodies (7.3%). It should also be noted that no analysis was performed in terms of sub-recipients of grants, nor on which organizations are actually implementing activities on the ground.

Figure 10 Specific investments in most-at-risk populations as a share of the total grant amount managed by different types of Principal Recipients

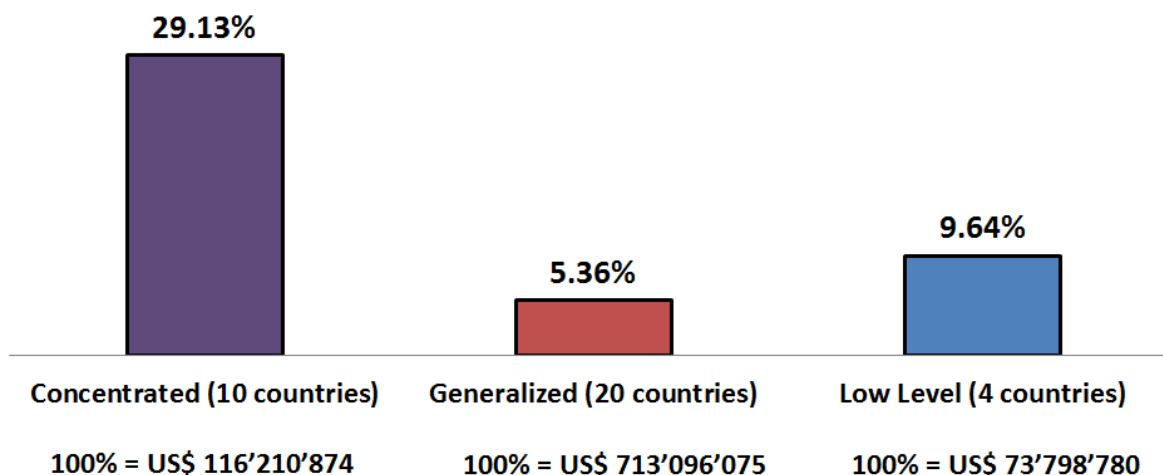


Abbreviations: NGO – nongovernmental organization; CS – civil society; PS – private sector; MoF – Ministry of Finance; MoH – Ministry of Health; GOV – government; MO – multilateral organization; UNDP – the United Nations Development Programme.

Investments Relative to the Type of Epidemic

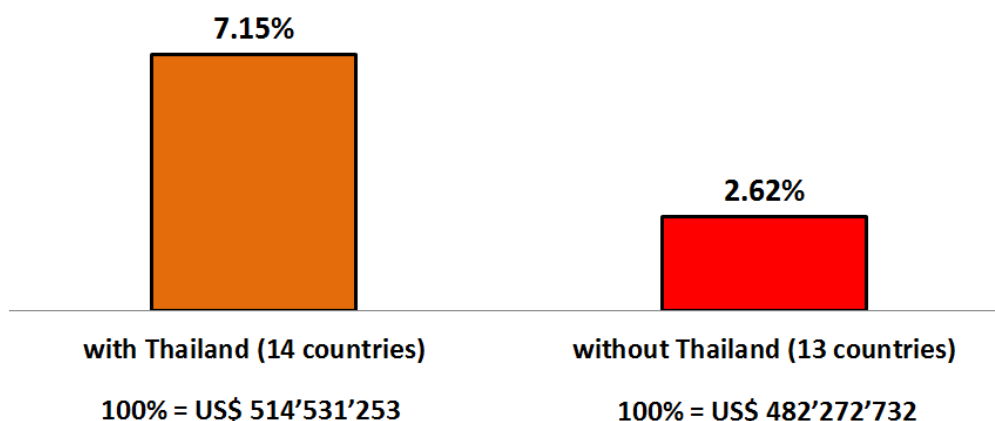
The 10 countries that report concentrated epidemics received a total of US\$ 116 million in approved HIV funding in Round 8, Phase 1. Of this, nearly US\$ 34 million (30 percent) was specifically allocated to one or more of the three specific populations in this analysis (Figure 11). Of these countries 11 are lower-middle and five are upper-middle income countries, meaning that they must focus the majority of their activities on “poor and vulnerable” communities in order to be eligible for Global Fund support.^{xvii} Unfortunately, this research was unable to explore where the remaining 70 percent of their HIV grant budgets was being allocated: this work should be conducted in the future, however, and is important to assist in efforts to strengthen the targeting and effectiveness of Global Fund resources.

Figure 11 Investments for most-at-risk populations as a share of HIV investments, by type of HIV epidemic



The 20 countries with generalized HIV epidemics^{xviii} received US\$ 713 million in Round 8, Phase 1 (79 percent of the total HIV budgets for this round), yet only allocated 5 percent (US\$ 38 million) of this money specifically to one or more of the three most-at-risk populations (Figure 11). However, 14 of these 20 countries also report concentrated epidemics within their generalized epidemics: i.e., high levels of HIV prevalence in the general population together with even higher rates of prevalence among most-at-risk populations. These 14 countries allocated just over 7 percent of their signed HIV budgets to one or more most-at-risk populations, Figure 12). This group of countries includes Thailand – the country with the highest proportion of Round 8 budgets assigned to most-at-risk populations (75 percent of its approved grant). When Thailand is removed from the sample, the remaining 13 countries in this group allocate just 2.6 percent of their overall HIV Round 8, Phase 1 budgets to most-at-risk populations: US\$ 13 million out of the total of US\$ 482 million. In low-level epidemic scenarios, where HIV has not spread to significant levels in any sub-population, the level of investment is slightly higher than in generalized epidemics at 9.6 percent (Figure 11).

Figure 12 Specific investments for most-at-risk populations as a share of total HIV investments in countries reporting both generalized and concentrated epidemics



Limitations of the Research

The timeframe for this analysis only allowed for focus to be applied to three most-at-risk populations: men who have sex with men, sex workers and people who inject drugs. It therefore, could not capture Round 8 efforts targeted to other important most-at-risk populations (such as young people, migrants and prisoners). In addition data on transgender people was limited: Thailand, Burundi and Zambia were the only countries to report coverage data for transgender sex workers, and Nicaragua and Paraguay were the only countries that included specific programmatic activities for transgender people.

It was also not possible, from this analysis, to assess the quality of interventions funded, or to fully account for treatment activities reaching most-at-risk populations. Therefore it is important to appreciate that the US\$ 79 million figure represents a level of underestimation.

There was also a degree of inconsistency across countries in relation to how activities were termed, categorized and targeted, as well as in the quality and availability of population and prevalence data. The signed budgets are complex documents that are not currently publically available, making this level of analysis difficult to conduct from outside of the Global Fund Secretariat or to align with other

resource tracking methodologies. Even within the Secretariat, the storage and presentation of these documents is not standardized: in this respect, this analysis was greatly assisted by previous efforts to collect together the signed budgets for this particular round of funding.

This analysis only covers one part of one funding round (Round 8 Phase 1) and so offers no indication of previous levels of Global Fund investments. For example, the absence of a country from this analysis does not mean that there are no Global Fund grants targeting most-at-risk populations in that country. A country may have allocated less to these groups in a Round 8 proposal because targeted activities were already approved in previous on-going grants. The data presented in this document are therefore indicative and it would be wrong to assume that the results identified in this analysis of Round 8 can be applied to all other rounds.

Finally, it should be noted that several assumptions were made during the analysis in order to attribute both direct and indirect costs – for example, where specific budget lines were assigned to more than one population group.

In order to further develop our understanding of Global Fund investments in most-at-risk populations, this research should now be followed by more detailed country case studies to better assess what is happening on the ground. This analysis could be used as a baseline upon which to compare similar analyses that should be conducted once all signed budgets are available for subsequent rounds. This would allow an assessment of the impact of the Board-approved Sexual Orientation and Gender Identities Strategy and other initiatives (such as dual-track financing and the Round 10 funding reserve for most-at-risk populations).

CONCLUSIONS AND RECOMMENDATIONS

The Global Fund is committed to strengthening its processes and policies to ensure that communities most affected by HIV, tuberculosis and malaria are effectively reached through its investments. The Secretariat and partners conduct regular analyses of proposals and supported programs to identify strengths and weaknesses that can inform future approaches. This analysis of Global Fund Round 8 (2008) signed Phase 1 budgets was completed as part of this commitment towards strengthening the impact of Global Fund HIV investments in relation to most-at-risk populations.

The analysis reveals that funding specifically targeting men who have sex with men, people who inject drugs and sex workers accounts for around US\$ 79 million (or 9 percent) of the US\$ 903 million total of HIV funding in Round 8 (2008) Phase 1. If we consider that people from these three risk groups combined are likely to contribute to at least 20 percent of people living with HIV globally^{xix} it would appear that the Global Fund mechanism requires further strengthening to ensure activities more effectively and equitably target and reach these groups.

It is important to stress that the analysis does not provide a comprehensive understanding of activities *reaching* most-at-risk populations in Round 8 – rather it describes budgeted activities that specifically *seek to target* these groups. It also does not use the same resource tracking methodology as many other Global Fund analyses – focusing on the signed grant budgets rather than approved funding and grant proposals – and so care should be taken in making comparisons with other studies.

The analysis does not offer an overall national picture of funding for interventions targeting most-at risk populations as it does not consider other Global Fund rounds or other funding sources.

Treatment is often one of the largest budget components in Global Fund HIV grants yet applicants rarely explain which population groups will benefit from treatment. Further research is needed to assess the levels of treatment uptake from within most-at-risk populations in different epidemic contexts.

More work to better understand the amounts of funding reaching the community level, in line with Global Fund commitments to community system strengthening^{xx}, is also important in moving this agenda forward.

Despite the limitations of the scope of this research it is clear, from this analysis, that more work is needed at country level to ensure that HIV grants are appropriately allocated to most-at-risk populations.

It is also clear that further research is needed to understand how non-targeted Global Fund budgets are being spent – especially in countries with concentrated epidemics.

Countries need further support to strengthen their data on most-at-risk populations and concentrated HIV epidemics. Applicants should be reassured that where prevalence data or size estimations do not exist for a population, Global Fund resources can be requested to carry out this research.

Countries with concentrated HIV epidemics that occur within the context of generalized epidemics should be supported to focus more of their attention and investments on most-at-risk populations – with a possible need for a specific strategic focus across Sub-Saharan Africa.

There is a clear need for Global Fund to assess the impact of decisions made by the independent Technical Review Panel on levels of activities and investments targeted at most-at-risk populations, as well as analysis of the impact of the grant negotiation process that takes place between the Global Fund and applicant countries after the Board has approved a grant.

Since 2008 – when the grants in this analysis were signed off - Global Fund applicants have been encouraged to be more focused in their HIV applications through: the Board approved Sexual Orientation and Gender Identities Strategy; enhanced work of technical partners; the strengthening of civil society organizations in many regions; stronger data and evidence; and most recently through the Round 10 'MARPs Reserve'. It will be important to repeat this research for Rounds 9 and 10 in order to assess the impact of these initiatives on the targeting of HIV funding in relation to most-at-risk populations.

Finally this research should be shared to support advocacy to secure more effective and targeted HIV investments.

ACKNOWLEDGEMENTS

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- ⁱⁱ See note (i)
- ⁱⁱⁱ Global Fund, Analysis of Sexual Orientation and Gender Identities related Activities in Round 8 and 9 Global Fund Proposals (report Adam Graham) (2010) http://www.theglobalfund.org/documents/rounds/9/Rnd8-9_Analysis_SOGI.pdf
- ^{iv} Global Fund, The Global Fund Strategy in Relation to Sexual Orientation and Gender Identities (2010) http://www.theglobalfund.org/documents/publications/other/SOGI/SOGI_Strategy.pdf
- ^v UNAIDS website (accessed 8 November 2010) <http://www.unaids.org/en/AboutUNAIDS/PolicyAndPractice/KeyPopulations/MenSexMen/default.asp>
- ^{vi} Reference Group to the UN on HIV and Injecting Drug Use (2007) Steffanie A Strathdee, Alex Wodak, Samiran Panda, Mark Tyndall, Abdalla Toufik, Richard P Mattick, for the 2007 Reference Group to the UN on HIV and Injecting Drug Use The Lancet 2008, Volume 372
- ^{vii} UNAIDS 2008 Report on the Global HIV/AIDS Epidemic notes that HIV prevalence as high as 35 percent in West Africa, 10 percent in Latin America and higher than 10 percent across Asia and Eastern Europe
- ^{viii} See Note (ii) page 4 section 1.9
- ^{ix} Global Fund website Grant Portfolio overview <http://portfolio.theglobalfund.org/?lang=en>
- ^x See note (i)
- ^{xi} Global Fund Round 8 Proposal Forms and Guidelines (2008) <http://www.theglobalfund.org/en/rounds/8/>
- ^{xii} UNAIDS 2010 UNGASS Progress Reports by Country <http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2010CountryProgressAllCountries.asp>
- ^{xiii} International Harm Reduction Association (2010) <http://www.ihra.net/contents/245>
- ^{xiv} See note (vii)
- ^{xv} See note (ix)
- ^{xvi} Sources included: the 2008 UNGASS Report on the Global AIDS Epidemics; Mathers et al. (for the Reference Group to the UN on HIV and Injecting Drug Use) 'Global Epidemiology of Injecting Drug Use and HIV among People Who Inject Drugs', The Lancet, 372, 2008; Beyrer et al. 'The Expanding Epidemics of HIV Type 1 Among Men Who Have Sex With Men in Low- and Middle-Income Countries', Epidemiological Reviews, 32, 2010
- ^{xvii} See note (viii) In order to be eligible, a proposal must fulfill the two minimum requirements for funding: (i) income level, and (ii) applicant eligibility. Full details on these requirements can be found in section 2 of the Round 8 Guidelines for Proposals
- ^{xviii} UNAIDS HIV Prevention Toolkit (2008) Different Epidemic Scenarios http://hivpreventiontoolkit.unaids.org/support_pages/faq_diff_epi_scenarios.aspx
- ^{xix} See notes (iii) (iv) and (v)
- ^{xx} Global Fund Round 10 Information Note on Community Systems Strengthening (2010) http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_CSS_en.pdf