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Fast-tracking the end of HIV in the Asia Pacific region: domestic funding of key population-led and civil society organisations

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For **WHO Global health expenditure Database** go to http://apps.who.int/nha/database/ViewData/Indicators/en/

For the **HIV and AIDS data hub for Asia Pacific** go to https://www.aidsdatahub.org/populations

Ending AIDS in Asia Pacific by 2030 requires countries to give higher priority to financing community-based and key population-led service delivery. Mechanisms must be developed for civil society organisations to deliver health and HIV/AIDS services for key populations, especially men who have sex with men, and transgender people, within national health policy frameworks. Current investments in the HIV response in the Asia Pacific region reflect inadequate HIV financing for key populations, particularly for civil society and key population-led organisations that are optimally positioned to advance HIV epidemic control. These organisations are typically supported by international agencies whose investments are starting to decline. Domestic investments in key population-led organisations are often hampered by punitive laws against their communities, pervasive stigma and discrimination by policy makers, an insufficient understanding of the most effective HIV epidemic control strategies, and financing systems that limit access to funding for these organisations from the national budget. Countries in the Asia Pacific region are evolving their community-based and key population policies and programmes. We need accessible, disaggregated financial data and in-depth case studies that showcase effective key population-led programmes, to enable countries to learn from each other.

Introduction

The HIV epidemic in the Asia Pacific region is concentrated among key populations, which include men who have sex with men, transgender people, people who inject drugs, and sex workers. Although the region is hugely diverse, an estimated 78% of new infections are among key populations and their sexual partners.[1] The highest share of new infections is among men who have sex with men (30%), followed by clients of sex workers and sexual partners of key populations (25%), people who inject drugs (13%), sex workers (8%), and transgender people (2%) (based on UNAIDS 2019 HIV estimates and AIDS epidemic modelling submitted for Global AIDS Monitoring reporting). These regional data (eg, HIV and AIDS data hub for Asia Pacific) mask a diversity of epidemics at the national level, with varying proportions of new infections among different key populations.[2–4]

High rates of HIV transmission among key populations, combined with rapidly evolving epidemics, have presented substantial challenges for controlling epidemics. Many countries have increasingly shifted their interventions to target people in key populations and their partners, using a range of methods. To increase HIV service coverage and maximise effect among hard-to-reach key populations, national programmes have involved civil society, community-based, and key population-led organisations, because they are close to, or within, communities and networks. This initiative also reflects a need to make key population programmes more evidence-based, and for countries to rethink financing options for sustaining the HIV response.

In this context, we are signalling a need for all stakeholders to give enhanced attention to HIV financing, to effectively respond to epidemics in key populations. The stagnation or decline in HIV expenditure in most countries in the Asia Pacific region since 2006 is a concern, although total health expenditures have increased,[5] as shown in the HIV and AIDS Data Hub for Asia Pacific and the WHO Global Health Expenditure Database. Evidence suggests that additional resources are needed, that existing resources are being inefficiently targeted or used, or both. Too often, domestically funded prevention programmes are targeted at general, lower-risk populations, or not targeted at all.[6] Where HIV resources exist, some countries are failing to focus spending, particularly towards where the epidemics are concentrated, and specifically among key populations in the geographical locations where the epidemic is concentrated.[7] In Indonesia, for example, despite a high prevalence of HIV among key populations, only 1% of total domestic HIV spending is on HIV prevention among these communities.[8] In the Philippines, four out of five new infections are in men who have sex with men, but only 8% of HIV spending is allocated to targeted prevention programmes.[9] Evidence suggests that failing to target funds at core transmitting groups (ie, key populations) will fail to control HIV epidemics in the region.[10]

Many countries are still highly dependent on international development assistance to finance their national HIV responses.[11] Historically, the response to HIV in low-income and some middle-income countries has been supported largely by investments from international donors, such as The Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR). According to the HIV and AIDS Data Hub for Asia Pacific and WHO Global Health Expenditure Database,

dependence on external donors for the national HIV response is estimated to be 96% in Bangladesh (2017), 85% in Myanmar (2015), 82% in Cambodia and Nepal (2015), 69% in Laos (2015), and 58% in Vietnam (2017), and at the other end of the donor-dependency continuum are Philippines (19% in 2017), India (18% in 2016), Thailand (11% in 2018), Malaysia (3% in 2017), and China (0·3% in 2019). Reliance on international funding sources is particularly high for key population HIV prevention programmes in the Asia Pacific region: 82% for men who have sex with men, 80% for sex workers, and 73% for people who inject drugs.[1] Such reliance renders the HIV response susceptible to fluctuations in the availability of external resources, putting national HIV programmes at risk of funding gaps. In addition, donor-driven resourcing can shield national governments from their responsibility to support HIV programmes for key populations.

Placing fast-track solutions in the hands of key populations and the organisations they lead through domestic financing

The fast-track approach to ending HIV by 2030, developed by UNAIDS, is based on a rapid scale-up of comprehensive HIV prevention and treatment interventions, with community-based HIV testing and treatment being essential components of this approach.[12,13] Evidence from across the globe suggests that differentiated approaches that include community-based mobilisation, task sharing, and non-facility-based service delivery accelerate the capacity of key populations to access HIV testing and antiretroviral therapy (ART), and improve overall HIV cascade performance.[14–18] Furthermore, peer-driven interventions that use peer mobilisers, navigators, and other people in community networks can engage members of key populations who were previously unreached, thus ensuring that members enter care and move more efficiently through the HIV cascade of services.[19–22] The benefits of community engagement and ownership have also been shown in more recently emphasised initiatives, such as pre-exposure prophylaxis (PrEP) promotion, in which clinics operated by community members have been essential in introducing and scaling up PrEP.[23–26]

The value of safe and confidential community engagement is perhaps most pronounced in online spaces where interventions targeting key populations, notably men who have sex with men, have been shown to be effective in increasing access to HIV testing, PrEP, and other services, by engaging with them on websites, apps, and chat spaces.[27–29] These online spaces also help to reach people who might not be willing to disclose their key population status in person, an important barrier that necessitates differentiated approaches even within distinct groups.[30] However, even partnerships between organisations and online platforms run by key populations, have tended to be financially supported by international agencies, not domestic budgets.

If fast-track solutions in HIV testing, ART initiation and adherence, and PrEP are desired, then evidence clearly points to the vital role of organisations led by key populations, through which the needed speed and scale can be achieved.[31–33]

The UN Political Declaration on HIV and AIDS Article 60(d) sets a target for community-led service delivery to represent at least 30% of all service delivery by 2030.[34] Article 60(d) includes an emphasis on building the capacity of civil society organisations to deliver HIV prevention and treatment services. The UN Political Declaration on HIV and AIDS Article 59(e) underscores the principle of national ownership and the mobilisation of domestic resources, covering both the strengthening of resource mobilisation and the effective use of domestic resources. Countries will need to align their strategies for enhancing service delivery led by civil society organisations and key populations, and for transitioning from international to domestic financing.

What is hindering adequate financing for effective and sustainable HIV responses for key populations?

A core barrier to domestic funding for key population programmes is the persistence and pervasiveness of stigma and discrimination towards these communities in both government and society in general. Broader societal acceptance of men who have sex with men, transgender people, sex workers, and people who inject drugs, including recognition of their rights, is fundamental for ensuring more inclusive and equitable health services and outcomes.[35,36] Yet in numerous countries in the region, key populations are still routine targets for harassment, arrest, and imprisonment, because the behaviours that place them at risk of HIV infection are often illegal and highly stigmatised (see, for example, Sustainable HIV Financing in Transition). This context severely constrains the political will needed to allocate scarce resources to target the health of these vulnerable and marginalised groups. This context also presents a major challenge for civil society organisations, particularly organisations led by key populations (if they are even permitted to exist), to advocate for financial investment. The combination of stigma and discrimination from political and social leaders, criminalisation, and little or no advocacy for funding allocations, leaves these communities virtually invisible to domestic financing opportunities. As a result, key populations are often left open to continuing health- care insecurity and susceptibility to HIV infection.

The often limited capacity of civil society and key population-led organisations hinders the financing of the response, in terms of human resources and financial management practices that meet the requirements of government funding regulations and procedures. Systematic training programmes, and strategies to both recruit and retain staff, will be important in meeting

For **Sustainable HIV Financing in Transition** see http://shifthivfinancing.org/reports/

these challenges. It is essential to safeguard and build confidence about domestic investments in services led by key populations, to increase the value for money of these investments over time.

Many countries do not have an enabling environment for channelling resources to civil society and key population-led organisations to support HIV programmes for key populations. Furthermore, government concerns exist around civil society organisations' legitimacy, governance, and technical capacity to undertake health and HIV service delivery. It follows that political will is needed to acknowledge and address the epidemic among key populations, which can involve addressing sensitive cultural issues and ensuring that appropriate sustainable financing is provided. Political will involves the willingness of key political players to allocate funds to where the main epidemics are concentrated and needs are highest.[7] Without continued political leadership, key population programmes and the most effective public health interventions will not be sustainable.[35] Competing

	HIV prevalence in key populations				Data on financing key population programmes (AIDS spending by service category)	Channel of funding for key population programmes	Domestically and internationally funded services targeting key populations	Approach to financing local community-based organisations	Capacity and technical support for civil society and key population-led organisations
	MSM	PWID	Female sex workers	Transgender people					
Cambodia	2·3%	15·2%	5·9%	NA	Key population prevention 7%; care and treatment 46%; NASA other prevention 8%	The National Centre for HIV/AIDS Dermatology and STDs	Outreach; linkages to HIV testing and ART; ART adherence and retention support	No specific mechanism	No information
China	6·9%	5·9%	0·2%	NA	National data are not available; CAFNGO receives approximately US$7·1 million per annum	Multiple channels: CAFNGO (national) and provincial AIDS bureaus subgrant to civil society organisations	Outreach; HIV testing; linkage to pre-exposure prophylaxis; ART adherence and retention support	Social contracting; reimbursement for costs is based on a standardised rate per client served with a predetermined service package	Provincial training centres and public health bureaus build capacity of civil society organisations to prepare proposals for funding
India	2·7%	6·3%	1·6%	3·1%	Spending breakdown for prevention in key populations is not available	Targeted interventions contracted out to local civil society organisations through state AIDS programmes; targets are set on the basis of key population size estimations and data for HIV services coverage	Outreach and behaviour change communication; access to STI services; provision of commodities (eg, condoms and lubricant); enabling environment (eg, reduction of stigma and discrimination)	Social contracting; each state publishes an expression of interest that civil society organisations can respond to with a proposed approach and budget; selection process includes assessment of organisational capacity, human resources, and the financial management system	No information
Indonesia	25·8%	28·8%	5·3%	24·8%	National data not available	International non-governmental organisations fund and implement programming for MSM health system funding for HIV is through central government funding (80%), district level funding (15%), and national health insurance (5%)	HIV prevention activities	Decentralisation to district level; no specific mechanism	No information; very little capacity at the district level to implement HIV programmes
Malaysia	21·6%	13·5%	6·3%	10·9%	Key population prevention 15%; care and treatment 77%; general population prevention 1%	Single channel: Malaysia AIDS Council	Outreach; linkages to HIV testing and ART; ART retention and adherence support; community-based testing was recently introduced; outreach workers from civil society organisations are trained and accredited	Social contracting	Malaysian AIDS Council is a hub where civil society organisations access information on funding and exchange expertise

(Table continues on next page)

	HIV prevalence in key populations				Data on financing key population programmes (AIDS spending by service category)	Channel of funding for key population programmes	Domestically and internationally funded services targeting key populations	Approach to financing local community-based organisations	Capacity and technical support for civil society and key population-led organisations
	MSM	PWID	Female sex workers	Transgender people					
(Continued from previous page)									
Philippines	4·9%	29%	0·4%	1·7%	Key population prevention 25%; care and treatment 62%; other expenditures 13%*	National health insurance system (not all clients are eligible)	Art services	Social contracting; organisations led by key populations are reimbursed for ART services	No information; accreditation for civil society organisations is a lengthy process; regulations are focused on financial control and accountability
Thailand	11·9%	20·5%	2·3%	11%	Key population prevention 5%; care and treatment 70%; NASA other prevention 10%; other expenditures 15%	National Health Security Office	Outreach activities; recruitment for STI and HIV testing; STI screening; HIV testing; pre-exposure prophylaxis; ART dispensing; civil society organisations and key population service providers are trained, certified, and accredited	Social contracting; organisations led by key populations are reimbursed for prevention services; reimbursements of HIV testing and treatment through hospitals by National Health Security Office under universal health coverage; pre-exposure prophylaxis recently included in universal health coverage	Technical support and capacity building are being institutionalised for sustainable financing; certification and an accreditation system have been put in place

ART=antiretroviral therapy. CAFNGO=China AIDS Funds for Non-Governmental Organizations. MSM=men who have sex with men. NA=not available. NASA=National AIDS Spending Assessment. PWID=people who inject drugs. STDs=sexually transmitted diseases. STI=sexually transmitted infection.*Including programme management and administration, human resources, social protection and social services, enabling environment, and research.

Table: **Sustainable financing landscape for HIV programmes targeting key populations and provided by civil society and key population-led organisations in selected countries in Asia Pacific**

political and domestic budgetary priorities across the health sector are a complicating factor.

There is an absence of international consensus on what constitutes a reasonable domestic contribution to the HIV response.[6] There are varying perspectives on financial sustainability among the donor community. For example, PEPFAR and The Global Fund have different conceptual frameworks for sustainability and country ownership. This discord calls for a more harmonised approach.

Domestic financing of civil society and key population-led organisations in Asia Pacific

Countries across Asia Pacific have found ways to include civil society and key population-led organisations within the framework of the national AIDS programmes, with international financing, domestic financing, or both. Some of these approaches are longstanding. For example, India's National AIDS Control Organisation has been contracting out targeted interventions to local organisations since 1996.[37,38] In Malaysia, the Ministry of Health established in 1992 an umbrella organisation to support and coordinate the efforts of civil society organisations working on HIV and AIDS (see Sustainable HIV Financing in Transition reports).

There exist various approaches for governments to partnership with civil society and key population-led organisations, including both centralised and decentralised models. In the absence of systematic guidance for working in partnership, countries have evolved their own initiatives. Data on specific national and subnational mechanisms for allocating funds from national and international sources are fragmented. We have tabulated available data from UNAIDS sources[39] (see table). Evidence of the efficiency and effectiveness of these mechanisms is generally absent. Disaggregated financial data on the financing of key population programmes is also often unavailable.

There appears to be a dichotomy between top-down and bottom-up civil society organisation or key population programmes. In top-down programmes, civil society organisations are invited to submit proposals for selection by national and subnational AIDS programmes. This approach is largely about contracting out predetermined programmes. The civil society organisations need to submit an appropriate budget and show their institutional capacity to manage the programme. Examples of this approach are to be found in China, India, and Indonesia. In contrast, a bottom-up approach involves programmes that are led and designed by civil

***Panel*: Key population-led programmes in Thailand**

Thailand has made substantial progress in increasing domestic financing for key population-led organisations that have historically received most of their funding from international agencies. Since 2016, the Thai National Health Security Office has made an annual budget of approximately US$6 million available to civil society organisations—most of which are key population-led organisations—for HIV prevention among key populations, including outreach activities and recruitment of key populations for HIV testing. Thailand has recently included pre-exposure prophylaxis (PrEP) in one of its national universal health care schemes funded by National Health Security Office and, at the time of writing, was planning to reimburse key population-led organisations for HIV testing and PrEP distribution.

The lessons learned from these government–civil society organisation partnerships have helped the country to develop and improve its social contracting system, which involves two major mechanisms: (1) pay-for-performance schemes, which reimburse organisations on a cost per head basis, and (2) provision of grants that cover the operational costs of an organisation reaching particular targets or goals.

Efforts to support and sustain this transition from international to domestic financing initially focused on ensuring that key population-led organisations were politically and legally supported. This support was essential to enable these organisations to provide vital HIV services. A ministerial regulation was signed by the Thailand Minister of Public Health, providing regulations for non-clinical providers to provide HIV and sexually-transmitted infections services under the supervision of a physician, pharmacist, or medical technologist. Certification and accreditation schemes for key population-led organisations enable them to receive government financing that helps them to improve the technical quality of service provision. Because domestic financing requires both civil society and key population-led organisations to learn and follow different financial management and reporting procedures, it is important to note that financial sustainability does not simply entail replacing international donor funding with government funding.

society organisations in response to local circumstances. Activities are reimbursed by governments according to an approved menu of services. Examples of this approach are found in Malaysia, Philippines, and Thailand. This social contracting is vital to the fostering of key population leadership, ownership, and capacity building, which assists in enhancing their ability to tailor programmes to local realities.

All approaches depend on the capacity of civil society and key population-led organisations to manage programme implementation, including governance, strategic information, financial management, and reporting. With the shift towards civil society and key population-led organisations delivering HIV/AIDS services (such as testing, screening for sexually transmitted infections, and PrEP and ART dispensing), new and additional capacity-building requirements exist. Our review of country approaches found little systematic information about how such capacity is being built, funded, and sustained. There is some evidence to suggest that much of this work is funded by international donor organisations. Governments also need to build capacity and trust to work with civil society and key population-led organisations, at both national and decentralised levels, under the umbrella of universal health coverage.

Since 2010, Thailand has reported a 59% decline in new HIV infections.[40] This contrasts with Malaysia and Philippines, where HIV infections are increasing.[41,42] Trend data are not available for China[43] and India.[44] Thailand observed a downward trend in the last 7 years in infections among men who have sex with men.[45] An important and distinctive feature of the national response in Thailand has been the programme space that has been given to organisations led by key populations. Innovative approaches have been externally funded through PEPFAR and the Thai National Health Security Office has subsequently taken on funding of these innovative programmes led by key populations. These programmes have enabled a rapid scaling up of HIV testing, and same-day ART and PrEP access among both men who have sex with men and transgender people.[46] Such results could not have been achieved without key population leadership. Technical support and capacity-building systems have been locally sourced and institutionalised through the Thai Red Cross AIDS Research Centre.[47] In short, Thailand has made substantial gains towards developing a model for sustainable financing of services led by key populations. This experience is currently being documented by UNAIDS for wider dissemination (see panel).

The Philippines provides a different model, involving PhilHealth, the country's national health insurance system. In 2018 it accredited a clinic run by Love Yourself (an organisation led by a men who have sex with men and transgender people key population), to provide ART services and be reimbursed for doing so. This accreditation put the clinic in the same category as many other government-supported clinics and hospitals that regularly obtain reimbursement for services from PhilHealth.[48] The Love Yourself clinic is reimbursed approximately US$600 per year for each client who initiated and adhered to ART. However, Love Yourself estimates that of its 4000 current clients, only 20% are eligible for PhilHealth insurance, thus requiring the organisation to use international funding (from The Global Fund) and patient copayments to support services for many of its patients (Pagtakhan RG, Love Yourself, personal communication). Nevertheless, this example of a nation's health insurance system reimbursing an organisation led by a key population for providing ART services and adherence interventions is a unique and impressive model.

Conclusion

In the face of declining external investments, countries that want to sustain these gains, reach universal health coverage, and minimise future costs for HIV epidemic control should make bold investments in organisations led by key populations and support their involvement in service delivery. Governments that fail to do so will most likely find that their HIV epidemic efforts stall, costing

them increased amounts of scarce resources as their HIV epidemics continue to increase. Governments that invest in scaling up HIV services with organisations trusted and used by the population groups that serve them stand a fighting chance to fast-track the HIV epidemic to a close by 2030.

Contributors

RV and NP conceptualised the manuscript. RV, VA, SM, and MMC reviewed the literature, acquired the data, and co-wrote the first draft of the manuscript with inputs from MAB, MAJ, EM, NI, and NP. RV, MAB, MMC, and NP provided important revisions and essential references. All authors read and approved the final version of the manuscript that was submitted.

Declaration of interests

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