WHERE IS PEPFAR'S STRATEGY FOR KEY POPULATIONS?

COMMUNITY ANALYSIS OF THE SUCCESSES AND CHALLENGES OF PEPFAR'S KEY POPULATION PROGRAM

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RECOMMENDATIONS FOR THE NEXT PEPFAR AMBASSADOR

HEALTH GAP
GLOBAL ACCESS PROJECT

PEPFAR WATCH

SUMMARY

The 2021-2025 strategy for The President's Emergency Plan for AIDS Relief (PEPFAR) must prioritise ambitious expansion of service delivery, structural interventions and human rights for key populations (KPs). Without increased funding and a bold vision supporting KP-led advocacy for policy change and decriminalisation, the U.S. contribution to global 2030 and 2025 HIV prevention, treatment and human rights goals will not be met.

Currently, PEPFAR has been without a Senate-confirmed leader for more than 7 months and has been run without a presidentially appointed health diplomat since Ambassador Deborah L Birx was detailed to the White House Coronavirus Task Force in February 2020, 1.5 years ago. This has resulted in a major leadership gap at an unprecedented time of duelling HIV and COVID-19 pandemics. As a result, the program is adrift. Major policy shifts such as the closure of the $100 million, two-year Key Populations Investment Fund (KPIF) occurred in 2021 without any attempt by U.S. government leadership to build on that initiative, threatening its sustained impact.

Our recommendations must be implemented in order to deliver on the Biden-Harris Administration's commitments to defeat global AIDS by 2030 as a public health threat and to stand up for the equality and freedom of LGBTQI and other marginalised and criminalised populations as a matter of U.S. foreign policy.

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1. The Biden-Harris Administration must immediately nominate—and the Senate must confirm—the next Ambassador to lead PEPFAR;

2. Create a dedicated stream of funding in country operational plans (COPs) for KPs to ensure that all PEPFAR-funded countries have a minimum funding level for KP programming;

3. Fund this KP funding stream with at minimum an additional $200 million each year for the 2021-2025 PEPFAR strategy period, in order to expand HIV KP-led service delivery, structural interventions, advocacy, and human rights;

4. Fully invest in KP-led service delivery;

5. Invest in the decriminalisation of KPs;

6. Meaningfully expand engagement of KPs in PEPFAR oversight and accountability;

7. Fully invest in independent, KP-led community-led monitoring;

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8. Fully invest in quality data collection, revise the PEPFAR monitoring and evaluation framework and assess KP program impact;

9. Create and enforce a mandatory ethical code of conduct for all KP service delivery partners; and,

10. Prioritise a research agenda and data collection focused on transgender people.

BACKGROUND

By 2021, key populations (gay men and other men who have sex with men, transgender persons, sex workers, people who inject drugs, and people in prisons and other closed settings) have been able to access expanded and better quality HIV prevention, treatment, and retention services than they did when the President's Emergency Plan for AIDS Relief (PEPFAR) began in 2003. This shift has come about as a result of advocacy and increased investment in key population (KP) priorities despite resistance from national governments. Communities of KPs are increasingly at the forefront of HIV and health policy-related decision-making and service delivery for their communities and have been pushing for expanded and more ambitious understanding of quality services. Although KP-led advocacy has resulted in policies that challenge national governments to support service delivery for key populations (KPs) despite criminalisation, KPs still have unmet HIV treatment and prevention needs and face many structural barriers, such as human rights violations that further undermine their access to quality services. Other barriers include but are not limited to homophobia, transphobia, taboos concerning sex, antiquated notions of gender, stigma, discrimination, and criminalisation.

Beyond access to services for individual KP consumers, countries with criminalising laws and policies targeting KPs undermine the HIV response overall. In countries where same-sex sexual acts are criminalised, the proportion of people living with HIV (PLHIV) who knew their HIV status and who had suppressed viral load was 11% and 8% lower, respectively, than in countries without those laws and policies. Despite these troubling facts, criminalisation, a lack of routine data collection regarding KPs, and a lack of political will to change country-level responses so that KP priorities are reflected in government plans and programs persist. Meanwhile, positive factors such as KP safety and security, enabling legal and policy environments, legally recognised and well-resourced KP-led community organisations, community engagement and connectedness, and supportive healthcare providers enable service access and utilisation, have been shown to promote health-seeking behaviours and lead to the overall better health outcomes for KP communities.

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As of 2020, KPs and their sex partners represent 65% of new HIV infections worldwide and 93% of new infections outside of sub-Saharan Africa. Even in the context of generalised epidemics—as in most sub-Saharan African countries—the rate of new HIV infections among KPs and their sex partners is disproportionately high, from an estimated 32% in Eastern and Southern Africa to 72% in Western and Central Africa.

TThe COVID-19 pandemic has exposed and exacerbated harm for KPs seeking health services. COVID-19 related restrictions resulted in disruptions in service delivery for KPs at the community and clinic level. KPs across many PEPFAR priority countries have been unable to access outreach services provided by community-led organisations and either abandoned care, or had to revert back to service at general health facilities, or had to pay out of pocket for prevention services at private facilities—while poverty and economic hardship increased due to economic shutdowns. HIV service access became more costly as some countries reduced the frequency of HIV medication dispensing due to fears of stock-outs, increasing the frequency of visits by PLHIV and KPs to the health facilities. Efforts to find those disengaged from care and provide support to those on treatment ground to a halt as countries restricted movements and health workers struggled to access PPE and exceptions to travel bans.

Crackdowns on non-compliance to lockdowns increased vulnerability among KPs. Communities members lost their livelihoods; Closures of hot spots affected sex workers. More people who use drugs were arrested. PEPFAR programs did not respond to the emerging needs of such key populations, and the program largely denied recommendations to increase funding for nutritional support, citing “funding limitations.”

As KP organisations and their allies, we recognise the success and gaps in the past, opportunities in the present and future of PEPFAR programming. This briefing note describes ten priority recommendations to PEPFAR regarding a vision and strategy for KPs.

THE KEY POPULATIONS PROGRAM WE WANT

We call on....

1 The Biden-Harris Administration to immediately nominate, and Senate to confirm, the next PEPFAR leader

President Biden and Vice President Kamala Harris promised during their presidential campaign to prioritise the fight against global AIDS, but they have broken that promise. President Biden has not nominated a PEPFAR leader since ascending to office 7 months ago, leaving PEPFAR without a presidential appointee for more than nineteen months. Delays in selecting leadership have led to incapacities within PEPFAR to make vital decisions. The interim head of PEPFAR has taken great strides to maintain the program but has not had the authority of Congressional selection, a high rank and oversight over USAID, CDC and other agencies needed to push the program forward.

This leadership vacuum has harmed both the COVID-19 and HIV responses. A PEPFAR leader is needed to govern as a co-equal with the U.S. Department of State's Coordinator for Global COVID Response and Health Security (Gayle Smith). Gaps in PEPFAR leadership only delay critical decision-making at the country level and pull us further from epidemic control.

2 PEPFAR to create a dedicated stream of funding in country operational plans (COPs) for KP funding to ensure that all PEPFAR-funded countries have a minimum funding level for KP programming

PEPFAR's 2021 country operational plan (COP21) development process ended with significant cuts to key populations funding, including the end of the 2-year Key Population investment fund (KPIF) funding. KPIF had been designed to increase PEPFAR's innovation in key population programming at a time where more investment was needed to reach communities with less access to services due to stigma and criminalising laws.

Worldwide, compared to the general adult population, gay men and other men who have sex with men are 19 times more likely to be living with HIV. HIV prevalence among female sex workers is 12 times higher than among the general adult population. People who inject drugs represent 5−10% of all people living with HIV. The lack of access to harm reduction and other biomedical and social services for people who use drugs continue to be significant drivers of the HIV epidemic, accounting for 30% of new HIV infections outside of sub-Saharan Africa (up to 40% in some countries). UNAIDS estimates that transgender women are 49 times more likely to acquire HIV than adults aged 15−49 in the general population.

Funding levels are inadequate and disproportionately low for the HIV burden among KPs; a $200 million per year funding increase and a dedicated funding stream for KPs is urgently needed. Like the DREAMS Partnership that created a surge in investment in adolescent girls and young women, PEPFAR needs a stand-alone investment in KPs to respond to programming gaps. While activists applaud the injection of a much-needed investment into KP programming, the $100 million for the KPIF was woefully inadequate to close service delivery gaps, fix harmful legal and policy environments, and deliver the community empowerment KPs need. When compared to PEPFAR's investments in the DREAMS Partnership there is a clear mismatch between the need and PEPFAR's response. During the COP21 process, KPIF funding was not absorbed into the yearly PEPFAR COP. KPIF successes could not be absorbed into core PEPFAR programs and most countries either flatlined or reduced key population COP budgets.

	DREAMS	KPIF
	In sub-Saharan Africa, adolescent girls and young women (aged 15 to 24 years) **accounted for 24% of HIV infections** in 2019.[10]	Key populations and their sexual partners **accounted for more than 65% of new adult HIV infections** globally in 2020.[11]
	PEPFAR invested **$200 million per year** over four years through DREAMS.[12]	PEPFAR invested **$50 million per year** over two years through KPIF.

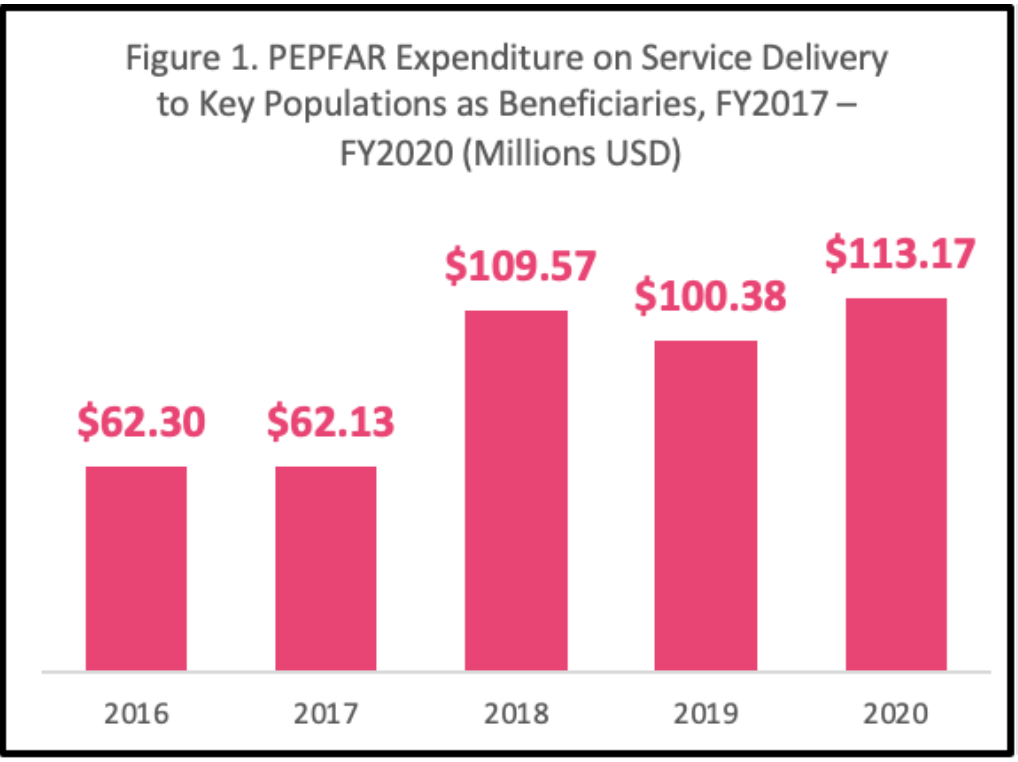
Create a dedicated stream of key population funds. To increase accountability for the funding and ensure that minimum levels of investment are maintained, PEPFAR should create an earmark for the key population program, as it has for DREAMS. The earmark will ensure that crucial successes continue to have funding and are not affected by fluctuation in COP funding.

3 Fund the dedicated KP funding stream with at minimum an additional $200 million per year for the 2021-2025 PEPFAR strategy period, in order to expand HIV KP-led service delivery, structural interventions, advocacy, and human rights

Advocacy for KPIF started with communities calling for funding that would increase participation, innovation, and engagement of key populations in the design and implementation of key population programming. KP communities, advocates, and

activists also advocated for the setting up of a fund outside the stringent PEPFAR country operational plan process to increase access to funding by smaller, KP-led and community-based organisations. In June 2016, the US State Department, through the Office of the Global AIDS Coordinator, announced the creation of the KPIF. The KPIF was intended to be a $100 million funding stream to scale up quality, key population (KP)-led community approaches to HIV/AIDS prevention, care, and treatment and structural programs. While the KPIF did not achieve its full objective and was only a two-year grant, it highlighted the importance of investing in a key population targeted effort. The KPIF highlighted critical gaps in KP funding and the need to invest in communities of key populations by supporting community-led initiatives.

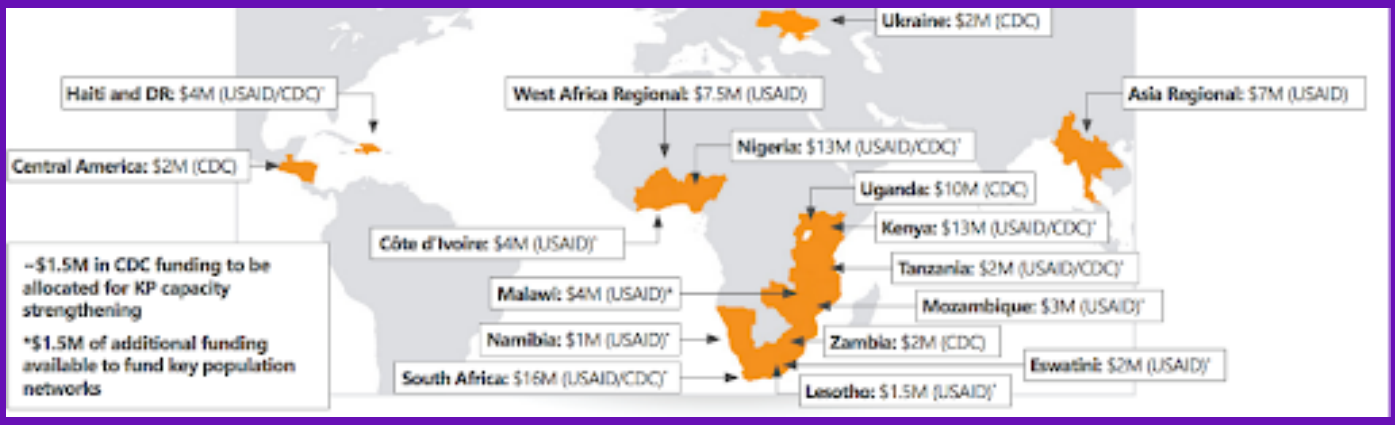
An analysis by amfAR found that, as a result of the KPIF, PEPFAR spending on service delivery for KPs increased from $62 million in 2016 and 2017 to more than $100 million in 2018, 2019 and 2020 (Figure 1). In addition, the proportion of the expenditure on key populations that was for service delivery increased from 60.47% in 2019 to 72.96% in 2020. This is welcome progress. However, given that 80% of the resources needed for key populations HIV programming remain unfunded, a much greater and faster scale-up in PEPFAR investments is needed. And now that the KPIF has been abruptly cut off with no strategy for continuing to scale up investment, even the limited gains made are in jeopardy.



2x

PEPFAR'S expenditure on service delivery to key populations as beneficiaries nearly doubled (182%) from FY2017 to FY2020.

KEY POPULATION INVESTMENT FUND (KPIF) SNAPSHOT



An additional $200 million for the key population program would contribute to programming for areas that have in the past not received PEPFAR support, such as a robust HIV response for transgender people, funding to reduce structural barriers to services such as criminalisation, homophobia and transphobia and increase in innovation to reach KPs.

Of the $200 million each year, half ($100 million each year) should be directed towards funding at the intersection between HIV and human rights. PEPFAR should ensure that the agencies are more flexible with the fund to ensure that key populations-led organisations have access to the resources for the advocacy needed. PEPFAR should coordinate the fund in partnership with an established community-led advisory committee to reduce the confusion experienced in KPIF planning and implementation.

Increase key population program funding levels by $200 million each year.

Under the new strategy, there is a significant opportunity for PEPFAR to renew and reinvigorate key population funding. Activists call on PEPFAR to inject an additional $200 million into the key population program each year and prioritise $100 million each year for structural interventions.

KPIF versus a fully-fledged investment in the key population program

KEY POPULATION INVESTMENT FUND

A one-off, two-year fund

Funds channelled through government agencies USAID ($51 million) and CDC ($49 million)

Funds disbursed to regions: the majority in Africa, followed by Asia

70% of funding received by a country from a PEPFAR implementing agency was required to be provided to local prime partners; this was not upheld. The concepts of "KP-led" and "KP-competent" in the KPIF were not defined by PEPFAR in a timely manner or universally enforced, making it difficult for communities to hold country teams accountable for selecting groups that fit the criteria.

Structural and human rights barriers were deprioritised, although the KPIF explicitly mentioned "Promoting the human rights of and social justice for all persons, without distinction" as a key focus area, few funded activities explicitly focused on this.

VS

A ROBUST PEPFAR KEY POPULATION STRATEGIC INITIATIVE

A dedicated stream of funding for KPs that allows fully integrated planning and programming with the overall COP

PEPFAR must allocate funds for innovation with eligibility criteria that ensures smaller, key-population led organizations that typically cannot qualify for funding to be eligible"

Applies to all PEPFAR-funded countries

Transition 80% of PEPFAR key population program funds to local "key population led" organisations by 2025

Prioritisation of structural interventions and human rights will be a core part of service delivery

4 Fully invest in key populations-led service-delivery

PEPFAR will not achieve its service delivery targets without the increase of $200 million described in recommendation 3. This expansion should prioritise funding for small, community-based organisations led by KPs. Large international NGOs and government agencies have dominated the implementation of KP programs up to now. But smaller, KP-led community-based organisations are more successful in finding, linking, treating and retaining key populations in quality services that are provided without discrimination and with respect and dignity. These organisations know best what communities need, and this expertise has resulted in improved outcomes where countries have expanded this model.

In the KPIF, KP-led organisations showed their capacity to provide an increased range of services for KPs, including testing coverage and HIV case finding, with more KPs enrolled on ART. Country examples include:

- **In Togo**, KPIF partners have implemented community screening, peer navigation, KP site mapping, and index texting since January 2020. As a result, they have doubled the number of HIV cases identified each month from 51 in February 2020 to 114 in June 2020 and maintained a steady case-finding rate over time. Notably, the linkage-to-treatment rate has been 100% for all four partners since January.

- **In Mali**, KPIF partners tested 2,458 individuals for HIV from January to June 2020. Of those, 220 were newly diagnosed with HIV, producing a case-finding rate of 9% and achieving 42% of their FY20 target for case finding in the first six months. By June, the partners had managed to initiate 75% of those newly diagnosed on treatment, demonstrating a monthly upward trend toward the 95% goal.

- I**n Zimbabwe**, KPIF partners strengthened access to comprehensive HIV services among mobile female sex workers across national borders, working with 15 peer navigators in Zimbabwe, Botswana, Zambia and Mozambique to link sex workers with KP-friendly facilities.

- **In Eswatini**, two community centres funded by KPIF now serve as safe spaces for KPs, and community outreach efforts are bringing services closer to the community.

In many settings, however, KP-led organisations were sub-grantees of large implementing partners of KPIF grants. KP-led organisations delivered services to their communities despite challenging conditions for implementation, overcoming micromanagement, under-delivery of capacity-strengthening commitments, and limited funding provided exclusively for operational activities.

The KPIF also committed to funding KP-led organisations. PEPFAR stated that "at a minimum, 70% of USAID KPIF funds will go to KP-led and KP-competent local organisations. "This pledge was part of broader PEPFAR efforts to achieve sustainability by accelerating country ownership of the HIV response. It was also an acknowledgement that non-KP-led implementing partners too often lack accountability to the communities they serve. The 2020 Country Operational Plan Guidance for all PEPFAR Countries stated that by the end of the fiscal year 2020, 70% of funding received by a country from a PEPFAR implementing agency must be provided to local prime partners. PEPFAR did not reach this target in all countries and also defined 'local organisations to include international NGOs who have either achieved a local registration or who are locally staffed up to a certain percentage eligible, not necessarily prioritising indigenous organisations. However, there was an increase in the number of KP-led organisations that received funds through KPIF. This organisation ordinarily would not have qualified for PEPFAR funding.

USAID self-reports that its commitment for 70% of KPIF funds to go to KP-led and KP-competent local organizations was honored in less than half of countries. Activists question these data, believing it to be much lower.

According to activists, a relatively successful aspect of the KPIF was the $25.5 million "Local Capacity Initiative," which provided funding to civil society organisations in 14 PEPFAR countries to support and build their capacity to address HIV through legal and policy advocacy, stigma and discrimination reduction, and planning and implementation of country programs. The Community Engagement Grants were a notable success in investing in improving the capacity of some small local CBOs to handle larger grants and programs in the future.

In Togo, the KPIF supported four local key population-led organisations — Espoir Vie Togo (EVT), Forces en Action pour le Mieux Être de la Mèr,by KPs ande et de l'Enfant (FAMME), Cupidon, and Association des Femmes AmaZones Zen (AFAZ). EVT and FAMME are already established organisations, while Cupidon and AFAZ have not previously worked with PEPFAR or USAID funded programs. Now, through KPIF, EVT and FAMME are coaching and supporting Cupidon and AFAZ to manage grant funds and bolster programs, including contributing to efficient case finding, enhancing linkages between testing and treatment, and expanding the availability of differentiated and key population-friendly clinical services.

In Kenya, The Kenya Key Population Consortium worked with the US Centers for Disease Control and Prevention (CDC) and American International Health Alliance (AIHA) to build the administrative capacity of eleven key population-led organisations.

The training included financial management, grant management, and navigating COP funding requirements. As a result, more key population-led organisations received knowledge on PEPFAR grant applications requirements and start-up funding for service delivery. Some KP-led organisations were then able to open up new service delivery points, including a harm reduction program.

80% Ensure 80% of funding is channelled to KP-led organisations.

Too few of the resources from the COP and KPIF fund flowed to organisations that were KP-led, despite PEPFAR's KPIF promises. PEPFAR's next KP program should grant more dollars to KP-led organisations to ensure sustainability and fulfil PEPFAR's recommendation to increase implementation by competent local organisations. PEPFAR should increase its commitment to fund KP-led organisations to 80%, in line with the new Global AIDS Strategy 2021-2026.

5 Invest in the decriminalisation of key populations

Most PEPFAR funded countries still grapple with criminalisation laws targeting key populations. The harmful effects of these laws are felt by KPs and non-KPs in their families, among their sex partners, and in their communities. KP-led organisations report that funding is needed urgently for human rights interventions: including removing harmful laws and policies and addressing stigma, discrimination and violence and supporting advocacy to overturn these laws and policies. Criminalisation, stigma, and discrimination against LGBTI people, sex workers, and drug use contributes to higher HIV prevalence and poorer health outcomes, making HIV a priority for key populations. Whilst the progress made by PEPFAR despite criminalisation is commendable, criminalisation of key populations has impacted the successes of PEPFAR's service delivery. PEPFAR has too often failed to address the failure of its IPs to respect, promote and defend the human rights and freedoms of KPs.

A recent study by Georgetown on law, criminalisation and HIV in the world showed lower knowledge of HIV status and viral suppression in countries that criminalised key populations. PEPFAR funded countries with laws on criminalisation were not spared.

A recent investigation revealing PEPFAR-funded IPs supporting the so-called 'conversion' of LGBTQ people in Kenya, Tanzania and Uganda is also a symptom of a larger problem: funding non-KP-led IPs with no accountability to or credibility in KP communities can at best undermine PEPFAR impact, and at worst contributes to exploitative, unscientific, and harmful programming.

A PEPFAR that is fully responsive to the needs of key populations will need to invest in addressing social and structural factors (such as stigma, discrimination, violence, and human rights violations) that negatively impact KP's access to and retention in HIV treatment and prevention programs. PEPFAR must show the political will to push for changes of bad laws and invest in communities of key populations to advocate for changes that promote the health and rights of LGBTI and other criminalised communities.

Under the KPIF in Zimbabwe, MPact described how local organisations with expertise in HIV and human rights were not selected to implement KPIF programs (though they did receive a capacity building grant). In Zambia, Positive Vibes found that: The approach to key population services was not human rights-oriented: There's not much information dissemination to empower communities to make informed decisions...And even then, there was no training of healthcare providers to ensure how they interacted with the community was affirming. There was none of that.

The Biden-Harris Administration should commit to advocating for the decriminalisation of KPs and of HIV as part of its overall human rights, global AIDS and global health agenda and PPEPFAR should embrace the UNAIDS top-line targets for 2025, aiming for "less than 10% of countries [with] punitive legal and policy environments that deny or limit access to services."

Create a tranche of funding for addressing structural and human rights issues under the $200 million additional financing.

This should be done in a manner similar to PEPFAR's community empowerment grants and should include funding for advocacy to remove discriminatory laws and policies, training healthcare workers, legal literacy, legal support, and gender-based violence activities, among others.

6 Meaningfully expand engagement of key populations in PEPFAR oversight and accountability

Over the years, PEPFAR has moved from a closed process to an increasingly open engagement process. Country operational plans and POART meetings now require civil society and key population inclusion. These efforts have led to a greater understanding of PEPFAR's Key population program and a more significant debate of investment areas.

The COP 21 process, however, showed signs of a reversal of the established principles of engagement. The previous process, advocated for by civil society, was replaced with a shorter country operational plan process. The meeting had fewer spaces for civil society engagement and a dismal number of civil society recommendations due to funding limitations.

A 2-day, 8-hour total meeting cannot replace the richness of a week-long physical engagement per country after in-country deliberations. Key populations partners struggled to highlight critical issues as time was always a barrier to effective engagement.

PEPFAR needs to bring back the components of engagement advocated for by civil society, including ensuring ample time and space for country deliberations and spaces to negotiate further and review recommendations from civil society. Key populations must be involved in decision-making to ensure a quality program.

During implementation, PEPFAR needs to go beyond the POART meetings to engage key population stakeholders. That mechanism will increase understanding and discussion of challenges faced by service recipients and the KP led organisation sub-grantees by PEPFAR teams.

7 Fully invest in independent, key population-led community monitoring

Over the last three years, PEPFAR has invested in community-led monitoring, starting in South Africa and rolling out to all PEPFAR funded countries with varying degrees of investment. This direction of review and assessment of the quality of service delivery to recipients of services is commendable. With such key innovation, we seek to ensure that PEPFAR commits to a fully resourced, community-led process that ensures quality outcomes.

Currently, PEPFAR CLM funds mostly pass through the Ambassador's small grant initiative at the country level. This mechanism can only release $25,000 per organisation per year for CLM unless there is a specific exception to the funding cap, which has been virtually impossible to secure. This has resulted in small, fragmented efforts, unlike the centralised effort initially supported during the pilots in countries like South Africa and possible in several countries using other, larger funding streams, such as Malawi and Uganda.

Most key population led organisations are yet to access the funds as more "KP competent organisations" are favoured instead of KP-led ones. Country teams are not taking the time to listen to communities and tailor CLM efforts based on their recommendations. Key population-led organisations are often excluded from applying due to stringent requirements at the country level, e.g. lack of registration, which is impossible for most key population groups to get due to criminalisation laws.

PEPFAR needs to holistically disperse CLM funds to enrich the quality of data collected and impact advocacy. PEPFAR should exercise flexibility in applications criteria to ensure that smaller organisations serving communities with less knowledge on PEPFAR funding but good implementation skills have access to resources

8 Fully invest in quality data collection, revise the program monitoring and evaluation framework and assess the key population program impact

Since the inception of KPIF, KP activists have demanded an impact-driven evaluation of the PEPFAR key population program. PEPFAR should conduct an assessment to evaluate the impact of the interventions supported under the KPIF and COP and their link to reducing new HIV infections.

Data at the country level on key populations are often not reflective of the accurate numbers of key populations. Fears of participating in size estimation and politicisation of size estimation data collection processes by countries have also led to smaller key population numbers and poor programming. Data on some key population groups, e.g. transgender people, are lacking. Data collected by Amfar on key populations show significantly higher estimates than what is in country health data.

During implementation, impact evaluation of the program is also a challenge due to unhelpful indicators such as KP_PREV that do not evaluate the entire cascade of key population service delivery. Data beyond prevention interventions are often not reported, making it difficult to assess successes in HIV treatment, retention, TB, broader sexual health, and human rights indicators. Services such as the number of individuals who receive emergency housing, mental health counselling, or any of the same programs provided by DREAMS are often not counted or considered core areas of service delivery, making it difficult for communities of KPs to advocate for much-needed services. PEPFAR needs to expand indicators to cover more service delivery areas and quality of services, e.g. literacy on the safe use of commodities offered and tracking actual use of commodities. PEPFAR needs to invest in a universal KP prevention cascade that assesses both service delivery and structural interventions in their entirety.

Revise the monitoring & evaluation framework.

Conduct an assessment to evaluate the impact of PEPFAR interventions and their link to reducing new HIV infections and create and invest in a universal KP prevention cascade that assesses both service delivery and structural interventions.

9 Create and enforce a mandatory ethical code of conduct for all KP service delivery partners

The code should include how to work with key populations in a safe, non-discriminatory, non-exploitative, ethical and supportive way. It should be developed by local KP, partners and recipients of service—including key population-led groups—working together to ensure ownership in its implementation.

The funding processes of PEPFAR implementing agencies disadvantage small, community-based organisations and give a massive advantage to large development and non-governmental health organisations as primary recipients. In some cases, small

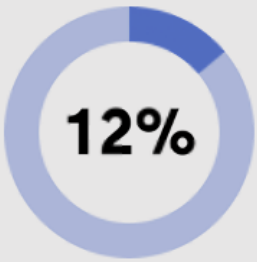
sub-grants are then made to key population-led organisations. These structures mean that the actual KP-led organisations supposed to reach their peers and implement programs receive the least funding. In many cases, they are cut out of the implementation strategy, coordination, communication loops and decision-making with the US government administrators.

This reinforces unequal power dynamics in countries where large NGOs often wield a lot of influence. In contrast, key population-led networks and groups struggle to access decision-making and advocacy spaces.

Under the KPIF, which was supposed to be more responsive, key population groups in some countries reported that principal recipients did not respectfully and inclusively work with different groups. This significantly damaged the project's ability to achieve its goals in key population communities. In some cases, key population-led groups reported no ability to negotiate the terms of their funding or provide feedback to the principal recipients, who threatened to cut off funding if they raised concerns.

> **"They gave us – the community – a raw deal. We had a plan. We agreed on what should be focused on. Then, when the resources came, we had no say. It was all up to the Implementing Partners. Agencies need to be held accountable"**
>
> **– Ugandan KP Activist, March 2021**

PEPFAR must immediately end funding agreements with implementing partners that are unaccountable to KP and have a track record of; exploiting KP organizations as underpaid sub-recipients, refusing to address homophobic and transphobic attitudes of staff, and refusing to meaningfully consult with the populations that they are supposed to serve when they are designing and implementing programs



For PEPFAR's key populations funding FY2019 - FY2020, just 12% of sub-recipients were organizations based in-country that had sub-grant titles clearly identifying a scope of work involving services to key populations.

10 Prioritise a research agenda and data collection focused on transgender people

There are an estimated 25 million transgender adults worldwide, with a global HIV prevalence of 19% among transgender women – this is 49 times higher than that of the general population. Estimated HIV prevalence among trans women in certain regions and countries is even higher, with figures for Latin America around 22% and the Caribbean at 24%. Between 2010 and 2019, global HIV incidence rates in trans women increased by 5%, widely missing UNAIDS' target to decrease new HIV infections by 75% in this key population by 2020. US estimates place HIV prevalence around 3% in trans men, while data from Zimbabwe suggest a 38% prevalence in trans male sex workers – which is as high as their female sex worker counterparts. HIV in trans men remains understudied, leading to the assumption that they bear little to no virus burden.

PEPFAR should track epidemiological data on HIV incidence and prevalence that accurately reflects the large and growing HIV acquisition rates of TGD populations, including in regions where little to no data has been collected, such as sub-Saharan Africa and Eastern Europe/Central Asia. Furthermore, PEPFAR should include transgender populations in their IBBS surveys and work with trans-identified data collectors to ensure more accurate data capture. Programme adjustments should be made to ensure that data, reporting etc. disaggregates between transgender men and transgender women as these are different populations.

In all its forms, gender-affirming hormone therapy (GAHT) is a building block of TGD health and well-being, including HIV prevention. Improved uptake and retention are a direct result of GAHT as it enhances an individual's self-worth and self-esteem. PEPFAR should prioritise GAHT across the continuum of HIV care and prevention research, from development and demonstration to delivery.

CONCLUSION

A successful, quality key population program will only be possible when PEPFAR fully invests resources and leadership in a comprehensive program response.

SIGNED

1. Health Global Access Project
2. Africa Sex Workers Alliance
3. amfAR, the foundation for AIDS research
4. Global Network of People Living with HIV
5. Kenya Key population Consortium
6. Uganda Key Population Consortium
7. Global Black Gay Men Connect
8. Treatment Action Campaign
9. Stefan Baral, Center for Public Health and Human Rights. Johns Hopkins School of Public Health.
10. Pan Africa ILGA
11. Sexual Minorities Uganda
12. MPACT Global Action
13. Positive Vibes
14. AVAC
15. Coalition Plus
16. Picture Youth Group
17. Nyarwek Network
18. Coast Sex Workers Alliance
19. Global Women's Health, Rights and Empowerment Initiative (GWHREI)
20. Hope for Change Initiative
21. Committed soul women health advocacy Africa initiative
22. Life Building Awareness Initiative(LIBAI)
23. Charity Heart For Good Health Initiative
24. Alliance for equality
25. Sustainable Impact for Youth Awareness Foundation
26. Trans & Intersex People- TIP for Human Rights In Nigeria (THRIN) now Dynamic Initiative for Healthcare & Human Rights (DIHHR).
27. Wavemakers Initiative for Health and Youth Empowerment
28. Decisive Minds
29. Ebo Innocent Chibuike
30. Green Community Health Enlightenment Initiative
31. Achievers Improved Health Initiative
32. Stay Awake Network Activities
33. Happiest Ones Initiative
34. Zambia Sex Workers Alliance
35. Men's Health Support Initiative
36. Empower Women Pride Health and Right Initiative
37. Mobile foundation for health security and rehabilitation
38. Royal House of Allure Initiative
39. Excellent Community Health and Socioeconomic Empowerment Africa Initiative (EXCOHSEAI)
40. Initiative For Access to Health and Youth Development
41. Nwafor Daniel Chukwuebuka
42. Initiative for the Advancement of Improved Health and Development
43. Amira Muhammad
44. Decisive mind
45. Key Affected Population Secretariat
46. True Vine Mentors
47. Western Kenya Sex Workers Alliance
48. Trans Alliance
49. Achievers Plight CBO
50. Health Options for Young Men on HIV/AIDS/STI
51. Kisumu Shinners
52. SAVE THE DREAM INITIATIVE
53. SWOP AMBASSADORS
54. Faraja women initiative
55. Women's Alliance for Equality Limited
56. Reachout Centre Trust
57. Kisumu Sex Workers Alliance
58. Trans*Sisters Network
59. Twange

60. Living free initiative for Equal Rights and Community Health Development
61. Arms To lean On
62. Empowering Marginalized Communities
63. NAGARTA Youth Development and Health initiatives
64. Men For Positive Living Support Community-Based Organisation
65. ZASWA
66. Kwale Network of People Who Use Drugs [KwaNPUD]
67. The Lotus Identity
68. Zambia key populations consortium
69. International Centre for Sexual Health Empowerment and Development (ICSHED)
70. OUT STAR Initiative
71. Kiambu Sex Workers Association (KIASWA)
72. Jinsiangu
73. MPEG
74. Public Health Innovations
75. Ritshidze
76. Initiative for Community Empowerment and Vulnerable Support
77. Key Affected Populations Health and Legal Rights Alliance (KESWA)
78. Amkeni Malindi
79. ISHTAR
80. World Post Changers Network-WPCN
81. Maaygo
82. Gender Action Empowering Communities(GAEC))
83. Marilyne Laini
84. Initiative for Health and Equality
85. My Space Alliance
86. The Rainbow Alive Hub Initiative
87. Zambia Center for communication programs kwatu
88. Coast Sex Workers Alliance
89. Siaya LBQ feminist community
90. Bar Hostess Empowerment and Support Programme
91. HAPA Kenya
92. Community Positive Health and Dignity Prevention Prevention(CBO)
93. PEMA Kenya
94. Survivors Kenya
95. Abeniogebeautyempire
96. Consolation East Africa
97. Kenya Youth Development And Education Support Association (KYdesa)
98. Access to Good Health Initiative
99. Girls with potential for excellence GPE
100. Decisive minds
101. Community health initiative for youth in Nigeria
102. Highlighting Equitable Access to Rights (HEAR)
103. Kiaswa
104. Youth for Equality Forum
105. IHSD
106. Tula Self Help Group
107. MIASM
108. Youths for Equality
109. Ohotu Diamond Women Initiative (ODWI)
110. Tabora House of Empowerment
111. Titandizeni Umooyo Network
112. Shinyanga Tuinuane Vijana
113. Kenya Network Of People Who Use Drugs (KeNPUD)
114. Tanzania Women for Equality and Services (TAWOES)
115. Youth Wings
116. TAYOBECO

117. Support For Health And Right Development Initiative
118. Center for Public Health Laws Social Economic Rights and Advocacy (CENTA)
119. Tanzania Healthy Education and Services for Youth (TAHESY)
121. Open hands health and Right Initiative OHHRI
121. Tanzania community empowerment foundation
122. Better Transformation Ahead Towards Power (BETAyouth)
123. Tanzania Community Health Information and Support
124. Levites Initiative for Freedom and Enlightenment
125.Ladies Power (SHY LP)
126.YOWOCE Group
127. Life and Hope Rehabilitation Organisation
128. Women In Response to HIV/AIDS and Drug Addiction
129. Pwani Transgender Initiative
130. Rural Youth peace and care foundation
131. Fishers Union Organisation -(FUO)
132. Bethel Right and Health Initiative
133. Sisters Against HIV and Cancer initiative (SACHI)
134. Tandika Youth Rehabilitation Handcraft Group (TAYOHAG)
135. Tugutuke Jamii CBO
136. Action vision empowerment and advocacy Tanzania (AVEAT)
137. House of empowerment and awareness in Tanzania (HEAT)
138. Hope For The Addicts Initiative
139. Zamzama Women Davelopment (ZAWODE)
140. Foundation for Adolescent Girls and Young Women Tanzania (FAGYWT)
141. Tawido
142. Woplah
143. Light Youth Group
144. Wake up And Support Others Organisation (WASO)
145. The Alliance for Health and Rights Advancement(TAHRA-INITIATIVE)
146. Initiative for Marginalized Women and Girls
147. Unique Women and Children Health and Rights Initiative (Unique Women)
148. Pillars kakamegs
149. McClifford Initiative “for equal access to health care and human rights “
150. Light Youth Group CBO
151. International Centre for Total Health and Rights Advocacy Empowerment (ICTHARAE).
152. Nairobi Outreach Services Trust
153. Gift Of Hope foundation
154. Youths and Adolescents Health and Rights
155. Empowerment Initiative(YAHREI).
156. LENASO
157. Matrix
158. Collectif Urgence Toxida
159. Center for Reproduction and Health Guide Initiative
160. Maintaining healthy behaviour initiative (MHBI)
161. Tanga Women Development Initiative (TAWODE)
162. Odo Ummy Foundation (UMFO)
163. Women Learning Initiative and Health Empowerment(WOLIHE)
164.Tanzania 4H Organization (4H Tanzania)
165. Busia Pillars of Hope and Empowerment among men.
166. Siaya County Vulnerable Group Alliance
167. GIYVO
168. Anti.human,trafficking,advocacy
169. KELIN
170. My Right Alliance-CBO
171. New Chapter for Protection and Environment Conservation (NCPCE)

172. KILIFI SEX WORKERS ALLIANCE

173. Good Health Community Programmes

174. Isukha Community Project

175. Greater Women Initiative For Health And Right

176. Healthy Mother And Child

END NOTES

1. Key populations (KPs) are defined by UNAIDS as: gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people. Criminalisation, stigma and discrimination make them particularly vulnerable to HIV.
2. "Stepping Up and Saving Lives in the First 100 Days," p 2
3. Memorandum on Advancing the Human Rights of Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Persons Around the World
4. 2021 UNAIDS Global AIDS Update — Confronting inequalities — Lessons for pandemic responses from 40 years of AIDS p 120
5. Law, criminalisation and HIV in the world: have countries that criminalise achieved more or less successful pandemic response?
6. 2021 UNAIDS Global AIDS Update — Confronting inequalities — Lessons for pandemic responses from 40 years of AIDS
7. amfAR. Is PEPFAR Funding for Key Populations Aligned with the Epidemiologic Burden?
8. CLM data collection efforts in multiple countries
9. Is PEPFAR Funding for Key Populations Aligned with the Epidemiologic Burden?
10. The DREAMS Partnership, launched in 2014 with $800 million invested over 4 years, is designed as an HIV prevention program for adolescent girls and young women. See PEPFAR's DREAMS Partnership Fact Sheet 2019
11. UNAIDS (2020). Seizing the Moment: Global AIDS Update Executive Summary. Tackling entrenched inequalities to end epidemics. Page 13. Online at https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_executive-summary_en.pdf
12. *Supra* note 4 https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_executive-summary_en.pdf
13. PEPFAR. DREAMS Partnership Fact Sheet, 2019. 2019
14. See https://copsdata.amfar.org/
15. Aidsfonds (2020) Fast-Track Or Off Track? How Insufficient Funding For Key Populations Jeopardises Ending AIDS By 2030. Page 5. Online at https://aidsfonds.org/resource/fast-track-or-off-track-how-insufficient-funding-for-key-populations-jeopardises-ending-aids-by-2030

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