

Is PEPFAR Funding for Key Populations Aligned with the Epidemiologic Burden?



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MAKING AIDS HISTORY

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Is PEPFAR Funding for Key Populations Aligned with the Epidemiologic Burden?

Introduction

Key populations (KPs)*—gay, bisexual, and other men who have sex with men (MSM); people who inject drugs (PWID), female sex workers (FSW); and transgender people (TG)—are at significantly higher risk for HIV, face a higher burden of disease, have less access to services, are frequently the target of stigma and discrimination, and are criminalized in many countries. Sustaining progress in fighting the epidemic will require focused attention and resources targeting KPs. A research team at amfAR recently evaluated the extent to which funds from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) were allocated to programs targeting KPs in proportion to their epidemic burden.

The epidemiological case for targeting key populations

Worldwide, 40–50% of all HIV infections among adults aged 15–49 occur among key populations or their partners, with the proportion even higher (53–62%) in Eastern Europe and Central Asia. Even in generalized epidemics—as in most sub-Saharan African countries—the rate of new HIV infections among KPs is disproportionately high, from an estimated 10% in Uganda to 30% in Burkina Faso, 34% in Kenya, 37% in Nigeria, 43% in Ghana, and 45% in Benin.¹

Worldwide, 40–50% of all HIV infections among adults aged 15–49 occur among key populations or their partners.

Worldwide, compared to the general adult population, MSM are 19 times more likely to be living with HIV. Among the 96 countries that reported MSM data to UNAIDS in 2013, median HIV prevalence among MSM was 3.7%. Prevalence among MSM varies significantly, both among

individual countries (from <1% to 57%) and regionally, from 6% in the Caribbean, Asia, and the Pacific to 15% in Central and Western Africa. Among countries with significant MSM epidemics, HIV prevalence among young MSM (<25 years) was 4.2%, suggesting that many MSM acquire HIV at a young age.² In several parts of the world, including Asia, HIV incidence among MSM is increasing.³

* Although all major international funders designate “key populations,” their definition varies. For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) defines KPs in a way that specifically addresses overlaps among categories, including male sex workers: gay, bisexual and other men who have sex with men (MSM); women, men and transgender people who inject drugs (PWID) and/or who are sex workers (SW); and all transgender people (TG)” (see http://www.theglobalfund.org/en/publications/2014-07-25_Key_Populations_Action_Plan_2014-2017/, p.6). The World Health Organization (WHO) includes “people in prisons and other closed settings” among key populations, arguing that prisoners are particularly vulnerable to HIV and frequently lack access to services.

In 110 countries with available data, HIV prevalence among FSW is 12 times higher than among the general adult population; in four countries, it is more than 50 times higher.⁴ While HIV prevalence among FSW averaged 12% in low- and middle-income countries, in 16 countries in sub-Saharan Africa, it approached 37%.⁵

PWID represent 5–10% of all people living with HIV, and injecting drug use continues to be a significant driver of the HIV epidemic, accounting for 30% of new HIV infections outside of sub-Saharan Africa (up to 40% in some countries). Globally, HIV prevalence is 28 times higher among PWID than the rest of the adult population, an estimated average of 13.5%.⁶ Moreover, shifting drug use patterns have the potential to greatly accelerate HIV transmission, particularly when injecting drug use increases or emerges in countries where it was not previously established.^{7, 8} For example, HIV outbreaks among PWID have recently emerged in Tanzania, Kenya and Nigeria.⁹

Two KP subpopulations merit special mention. There is a dearth of reliable data on HIV among TG, though recent estimates suggest that HIV prevalence among transgender women is extremely high. UNAIDS estimates that transgender women are 49 times more likely to acquire HIV than adults aged 15–49 in the general population.¹⁰ In a meta-analysis pooling data from 39 studies involving 11,000 transgender women in 15 countries, HIV prevalence was 19.1%, with little difference among low-, middle- and high-income countries.¹¹ Moreover, for epidemiological or other tracking purposes, transgender women are frequently grouped with MSM. Male sex workers are frequently included only as subsets of larger studies among MSM, or even FSW.¹²

Transgender women are 49 times more likely to acquire HIV than other adults.

Key populations face substantial service barriers

MSM, SW, and PWID are criminalized to some extent almost everywhere (see figure 1). According to UNAIDS, as of 2014, 75 countries criminalize same-sex sexual relations, with seven jurisdictions imposing the death penalty for convictions under such laws. Most countries (100) criminalize aspects of sex work, and sex workers are often vulnerable to police harassment. Drug use is almost universally criminalized (in some countries even drug *dependence* is criminalized) and 31 countries impose the death penalty for drug offenses. Harsh penalties are often imposed for possession of small amounts of drugs for personal use.^{13,14} Transgender women often suffer profound discrimination and stigmatization, for which legal systems rarely offer protection or remediation.¹⁵

Figure 1. Number of countries with criminalization laws affecting KPs, by region

Region	SEX WORK (any aspect) ^a	MSM (same sex sexual activity) ^a	PWID (death penalty) ^{a,b}	Total number of countries in region
Asia and the Pacific	17 ⁽²⁾	19 ⁽⁰⁾	15 ⁽⁰⁾	38
East and Southern Africa	13 ⁽²⁾	15 ⁽¹⁾	1 ⁽⁰⁾	21
Eastern Europe and Central Asia	19 ⁽⁰⁾	2 ⁽⁰⁾	0 ⁽⁰⁾	30
Latin America and the Caribbean	13 ⁽⁰⁾	11 ⁽⁰⁾	1 ⁽⁰⁾	33
North Africa and Middle East	19 ⁽⁰⁾	15 ⁽²⁾	13 ⁽⁰⁾	21
West and Central Africa	14 ⁽²⁾	13 ⁽⁰⁾	0 ⁽⁰⁾	24
Western and Central Europe, North America	5 ⁽⁰⁾	0 ⁽⁰⁾	1 ⁽⁰⁾	23
Total	100	75	31	

**Value in superscript indicates number of countries with missing data.

Source: UNAIDS AIDSinfo, 2014.

Global HIV prevention service coverage among KPs is low

In most countries, HIV services coverage is lower among KPs than among the general population. For example, according to the World Bank: worldwide in 2010, fewer than one in ten MSM had access to basic HIV/AIDS prevention, care, and treatment services;¹⁶ fewer than 50% of FSW had access to basic HIV prevention services;¹⁷ and access to needle and syringe programs (NSP), HIV counseling and testing (HCT), opioid substitution therapy (OST), and antiretroviral therapy (ART) among PWID was generally low.¹⁸

- Among 20 countries reporting to UNAIDS in 2013, average access to HIV prevention programs among MSM was 40%, compared to 59% in 2009.¹⁹ In a 2012 survey among 5,779 MSM in 165 countries, 35% of participants reported having access to condoms, 21% to lubricants, 36% to HIV testing, and (among those living with HIV) 42% to ART, with access correlating in each instance with country income level.²⁰

- Only one-third of countries report targeted risk-reduction programs for SW, and very few countries have implemented national-level SW-specific programming, primarily in Asia and sub-Saharan Africa. Many programs that do exist are limited in scope, providing only condoms and limited HIV testing.²¹
- Availability of HIV prevention services among PWID in most countries falls below even “low” thresholds established by UNAIDS, though there is very substantial regional variation. In 2010, worldwide NSP coverage was estimated to be 12 needles per person per month; only 8% of PWID had access to OST; and only 4% of PWID living with HIV had access to ART.²² By 2014, in reports to UNAIDS, only 79 of 192 countries offered OST, while only 55 provided NSPs. Countries that have implemented NSPs distribute an average of only 74 needles per person per year and only 18% of countries meet the target of 200 needles. In Southwest Asia, where HIV prevalence among PWID is higher than elsewhere in the world, no country reports high levels of coverage for any PWID prevention service. The 16 countries where 45% of the world’s PWID are estimated to live (accounting for 66% of PWID who are living with HIV) all have low NSP and OST coverage.²³ The majority of HIV-positive PWID do not have access to ART; one estimate suggests that only 10% are receiving ART.²⁴

PEPFAR support for KP programs

While in some ways, PEPFAR’s original authorizing legislation actually discouraged programs targeting KP (see text box), since its launch in 2003, PEPFAR has steadily increased its programmatic focus on KPs. In 2008, the PEPFAR reauthorization officially recognized the need for programs targeting “most-at-risk-populations,” including MSM, SW and PWID. Nonetheless, PEPFAR faced considerable resistance from many host countries to undertaking data collection efforts or implementing programs targeting KPs.²⁵ An amfAR/Johns Hopkins analysis of PEPFAR funding in 2009–2010 showed that countries with epidemics concentrated among MSM and PWID received proportionally less money than countries with generalized epidemics, after controlling for number of people living with HIV, total population, and per capita income.²⁶ A more recent analysis applying the same algorithm to 2010–2014 planned COP funding suggests that this disparity continues.²⁷

U.S. government policy barriers to PEPFAR KP programming

Since its launch, PEPFAR programming targeting KPs has been impeded by various Congressional restrictions:

- Organizations receiving PEPFAR funds have been required to explicitly oppose prostitution and sex trafficking (i.e., the “anti-prostitution pledge”). In 2013, the U.S. Supreme Court ruled that requiring U.S.-based organizations to sign the anti-prostitution pledge was unconstitutional,²⁸ though as of its FY16 guidance, PEPFAR continues to require non-U.S. organizations to adhere to the pledge.²⁹
- Organizations are permitted to limit the services they deliver based on their religious or moral philosophy (i.e., the “conscience clause”).
- The decades-long Congressional ban on the use of federal funds for syringe exchange programs complicated U.S. funding for such programs internationally. Consequently, PEPFAR administrators did not allocate funds for this purpose in the program’s early years,³⁰ even after the domestic ban was lifted by the Obama Administration in 2009. Following an HIV outbreak associated with injection drug use in Indiana, the Congressional ban was finally lifted in 2015.³¹

More recently, PEPFAR has committed to increasing access to and uptake of HIV services among KPs,³² provided technical assistance to countries for scaling up evidence-based interventions, issued guidance pertaining to HIV prevention interventions among MSM³³ and PWID,³⁴ and directed country teams to prioritize ART among KPs.³⁵

In 2012, PEPFAR announced a \$15 million implementation research initiative to identify specific interventions effective among KPs, a \$20 million challenge fund to support country-led KP plans, and a \$2 million contribution to the Robert Carr Civil Society Networks Fund, which supports capacity building among KP networks. In 2014, USAID awarded funding for LINKAGES, a five-year initiative being implemented by FHI 360 to reduce HIV transmission among KPs and to improve their enrollment and retention in care. In 2015 PEPFAR partnered with the Elton John AIDS Foundation direct an additional \$10 million to support programs focusing on Lesbian, Gay, Bisexual and Transgender people affected by HIV/AIDS. And in 2016, PEPFAR announced a \$100 million Key Populations Investment Fund, designed to expand access to proven HIV prevention and treatment services for key populations.³⁶

In many settings, key populations are at higher risk for acquiring HIV but are often the least likely to obtain HIV services. Now more than ever, people who inject drugs, sex workers, and men who have sex with men face stigma and discrimination. Human rights among lesbian, gay, bisexual and transgender (LGBT) people in certain parts of the world are increasingly under threat, creating additional barriers to key populations accessing services. If any one of our populations is left behind, we are all left behind and we will not control the epidemic.

— PEPFAR 3.0

A primer: How does PEPFAR track its support for KP programs?

All PEPFAR-funded countries and regions report spending in two ways: **planned funding** and **actual expenditures**.

Since its inception in 2004, PEPFAR-funded countries or regions have been required to develop **Country Operational Plans (COPs)** or **Regional Operational Plans (ROPs)** that describe planned activities and targets for the following fiscal year and allocate country or regional level budgets. In 2012, PEPFAR began conducting annual **expenditure analyses (EA)** that track actual expenditures.

In both COPs and EAs, PEPFAR tracks spending in a variety of ways. With COPs, all planned PEPFAR activities are allocated to specific **budget codes** and in 2009, a specific budget code (IDUP)[†] was designated to capture activities targeting people who use drugs. Also in COPs, since 2013, PEPFAR has also tracked the proportion of all planned funding by 16 **cross-cutting attributes**, including two key population attributes (MSM/TG and FSW),[‡] designed to capture **focus activities** including:

- 1) core HIV prevention interventions consistent with PEPFAR guidance;
- 2) training of health workers and community outreach workers;
- 3) collection and use of strategic information;
- 4) epidemiologic, social science, and operational research;
- 5) monitoring and evaluation; and
- 6) procurement of condoms, lubricants, and other commodities.

Conversely, EAs report actual expenditures across 17 **program areas**, four of which pertain to sexual and other risk prevention among MSM, FSW,[§] PWID, and “key populations other”.

Comparing planned funding with actual expenditures is complicated, as PEPFAR funding is both continuous and dynamic. For example, funding plans outlined in COPs may or may not be reflected as actual expenditures in the *following* fiscal year, as approved funding plans change, or unspent funds are re-allocated to subsequent years. Comparisons are made even more difficult because the two tracking systems are not well-aligned, e.g., COP cross-cutting attributes do not align with EA program areas, while EAs are not reported by budget code.

amfAR has compiled data from both COP and EA data sets in a publicly accessible online database (<http://copsdata.amfar.org/s>)

[†] The “IDUP Biomedical Prevention: Injecting and non-Injecting Drug Use” code is intended to capture activities including needle and syringe access programs, policy reform, training, message development, community mobilization and PWID networks, and medical-assisted therapies (MAT) for HIV-negative PWID or comprehensive drug treatment of other drug addictions, such as methamphetamine. Because budget codes are mutually exclusive, certain activities targeting PWID may be captured in other budget codes, including sexual or non-injection drug (e.g., alcohol) prevention programs among PWID (HVOP – other sexual prevention), MAT or continuum of care services for HIV-positive PWIDs (HBHC – adult care and support).

[‡] The MSM/TG attribute is meant to capture activities that focus on gay men, other men who have sex with men *including male sex workers*, and those who do not conform to male gender norms and may identify as a third gender or transgender (TG).

[§] Sexual and other risk prevention, commercial sex worker.

Most program spending is initially coded by the *implementing mechanism* (IM), i.e., the grant, contract, or cooperative agreement through which funds are disbursed and reported up to the PEPFAR country team. Until 2013, COPs included narrative descriptions of program activities funded under each budget code, although they rarely changed from year to year. But in 2014, the narrative requirement was dropped, and countries that attributed spending to either KP cross-cutting attribute were required only to indicate (via check box) which of the six focus activities were funded.

Is PEPFAR funding tracking epidemics among key populations?

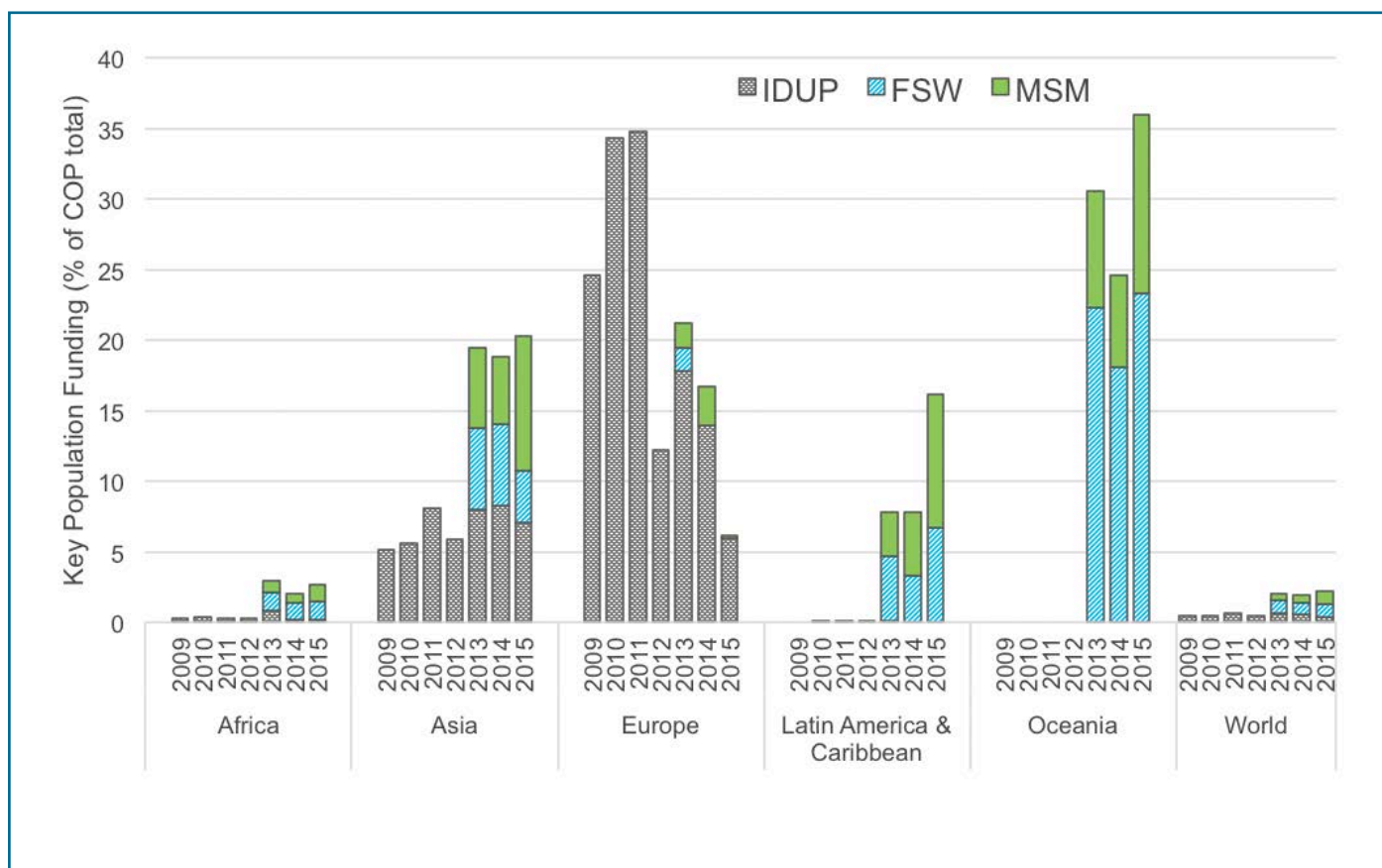
In light of PEPFAR's stated commitment to prioritize KP programming, a research team from amfAR, The Foundation for AIDS Research, undertook a study to understand the extent to which PEPFAR supports KP programs, how well such support aligns with KP epidemiology, and whether KP programming is consistent with best practices. In the study, the team compiled and analyzed both planned KP funding and actual KP expenditures data, as well as KP HIV surveillance data for PEPFAR-funded countries where available for 2009–2015.

Overall planned funding for KPs is stable, with a possible upward trend

To assess the ongoing evolution of PEPFAR's commitment to supporting KP programming, the team first compared planned funding levels for each KP from year to year (2009–2015, as available) in terms of absolute total dollars, percentage of all planned HIV prevention funding, and percentage of total funding for each country. In figure 3, below, KP prevention funding is shown as a percentage of total funding from 2013 to 2015 (2009–2015 for PWID).

- For MSM/TG, planned funding increased significantly (79%) between 2014 and 2015, with 60% of countries increasing both absolute totals and the percentage of overall planned funding.
- For FSW, planned funding was up slightly from 2013/2014 to 2015, both in absolute dollars and as a percentage of planned prevention funding. But again, some countries (59%) spent more and some spent less (41%); dramatic increases in the Caribbean (2,161%) and Nigeria (1,190%) were offset by 100% decreases in Vietnam, Zambia, Namibia, South Sudan, Swaziland, and Ukraine
- For PWID, total planned funding increased from 2009 to 2011, decreased in 2012, and increased in 2013; among countries with planned funding, however, the median increased in 2010, decreased in 2011–12, and increased in 2013–15.

Figure 3. KP prevention funding as a percentage of total funding, 2009–2015



(NOTE: MSM and FSW data are reported only for 2013–2015.)

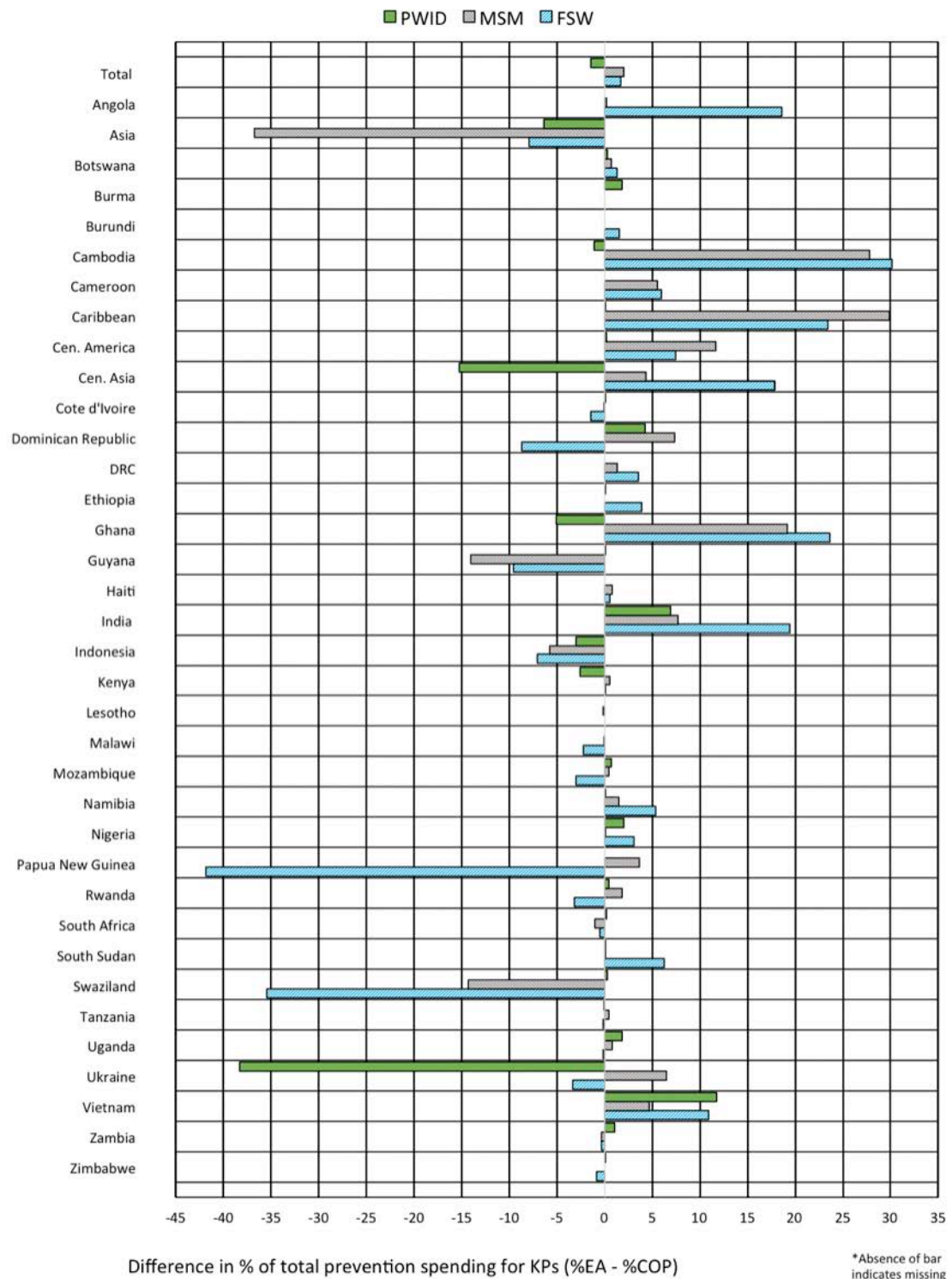
Actual expenditures for KPs don't always match planned funding

The team then compared actual 2014 expenditures with 2013 planned funding to assess the extent to which plans were carried out. In figure 4, the difference between planned funding and actual expenditures (comparing KP prevention funding expressed as a percentage of total COP prevention funding) is shown for each KP. While there is no consistent trend, in many instances actual expenditures exceeded planned funding, while in others they fell far short.

- For MSM/TG, almost a quarter of countries spent less in 2014 than planned in 2013.
- For FSW, some countries (a slight majority) spent more in 2014 than planned in 2013, while others spent less.
- For PWID, not all countries planned IDUP funding in 2013, but all countries reported actual expenditures on at least some WHO comprehensive PWID interventions in 2014; nonetheless, expressed as a percentage of total HIV prevention outlays, 2014 actual expenditures were lower (7.18%) than 2013 planned funding (8.61%).

Figure 4.

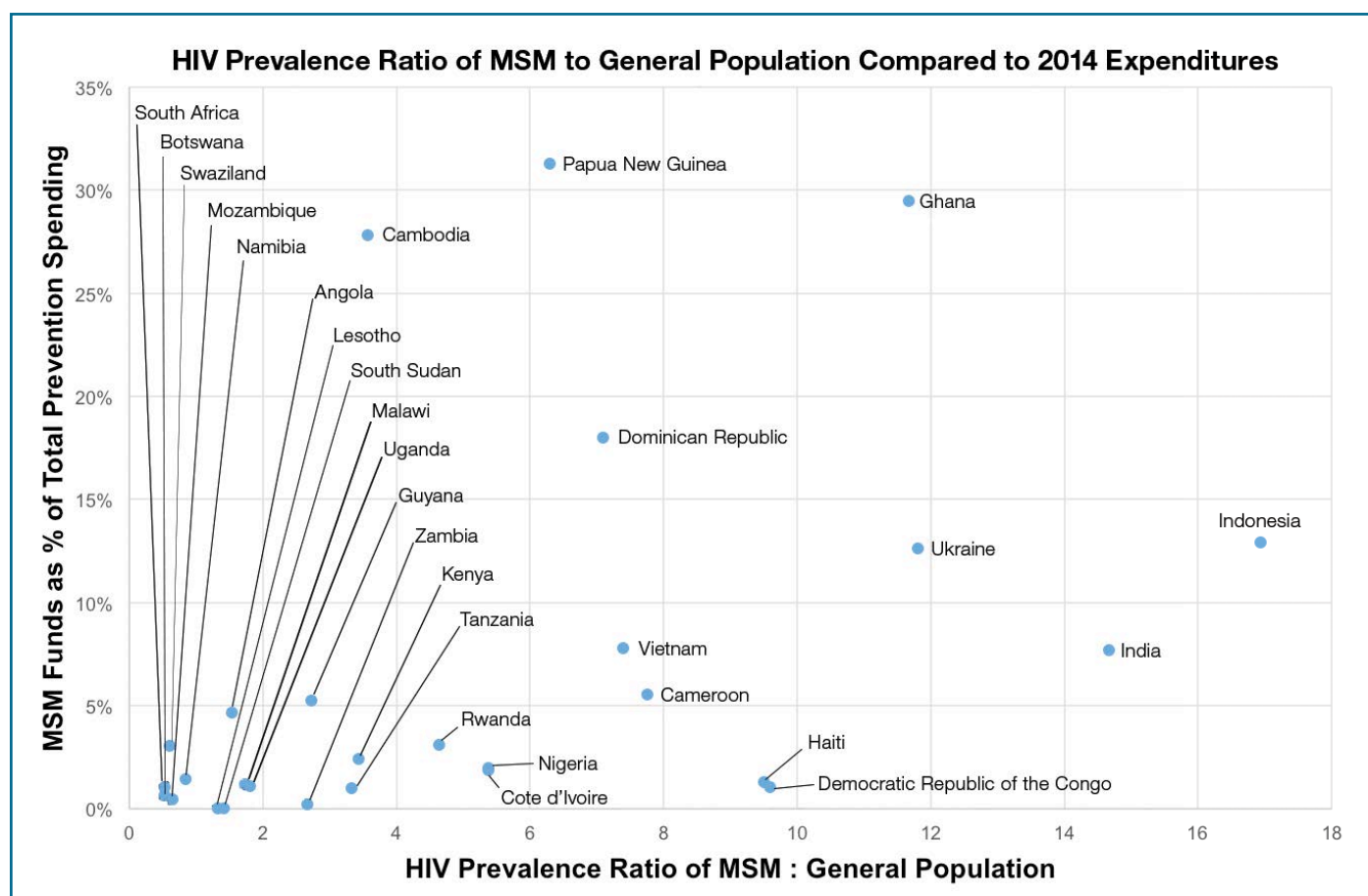
2014 actual expenditures (EAs) compared to 2013 planned funding (COPs) -- KP
 PREVENTION funding as a percentage of total PREVENTION funding



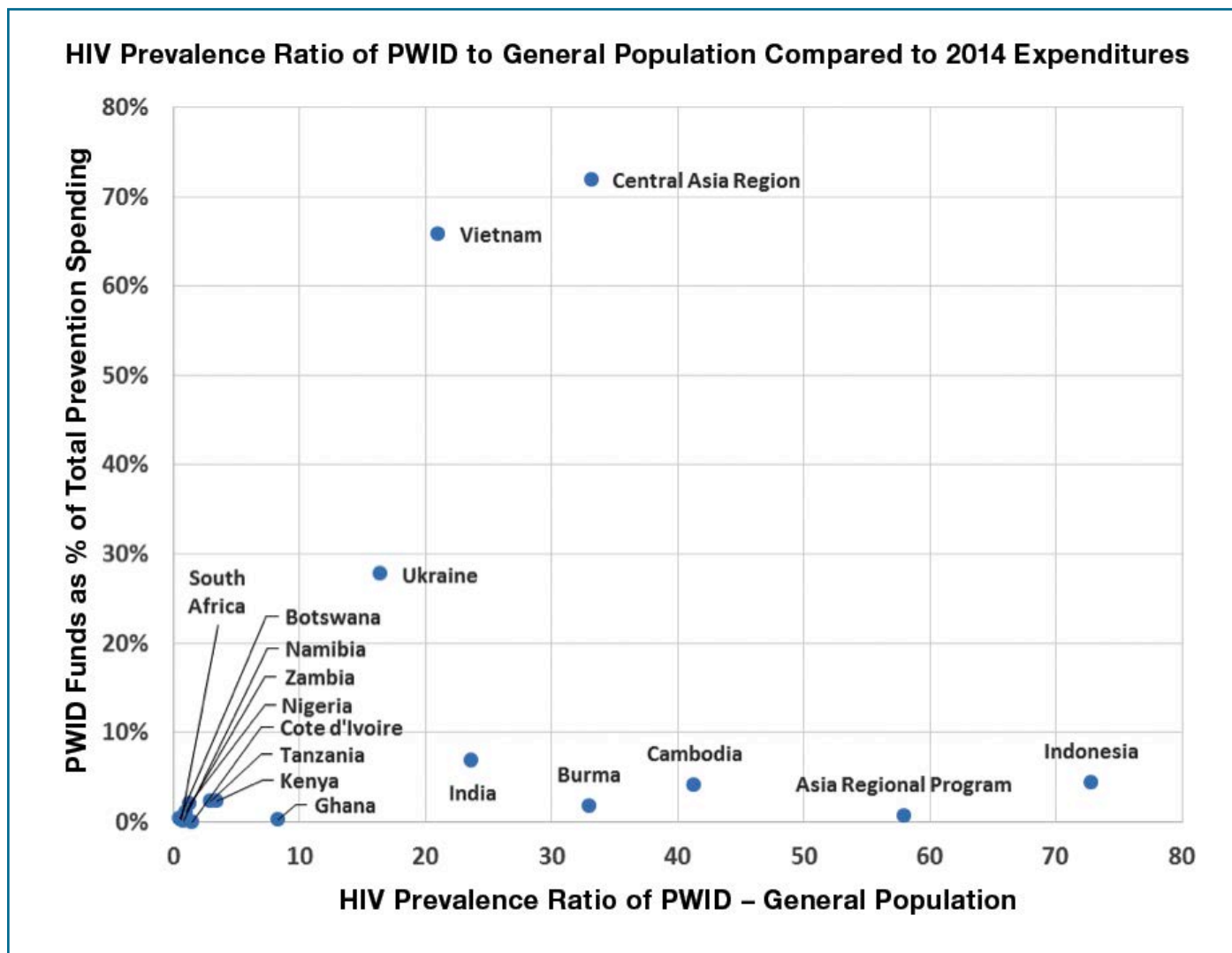
Actual expenditures for KP programming are not well aligned with KP epidemiology

To illustrate whether PEPFAR KP funding aligned with HIV epidemiology, the team plotted 2014 actual expenditures against HIV prevalence ratios for each KP, i.e., relative risk for HIV infection compared to the general population. While HIV prevalence among key populations was significantly higher than among the general population in all countries, prevalence ratios varied considerably and actual expenditures for KP programming were not well correlated with higher prevalence ratios.

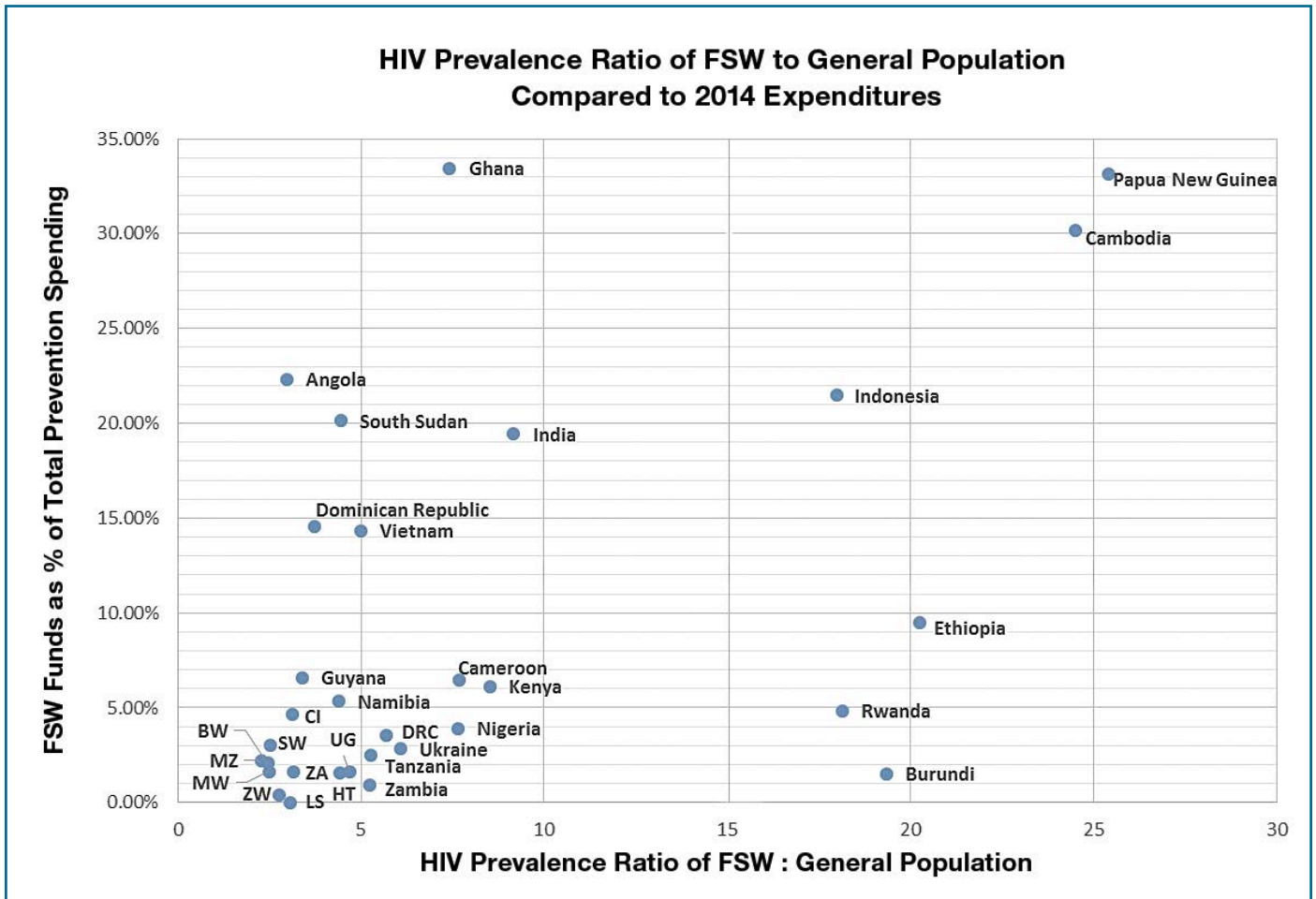
- **Figure 5.** Of the seven countries with MSM/TG HIV prevalence ratios within the top quartile, four (Cameroon, Democratic Republic of the Congo, Haiti, and India—shown in red), had below average spending for MSM/TG as a percentage of total HIV prevention expenditure.



- **Figure 6.** Among the two regions (Asia, Central Asia) and three countries (Cambodia, Myanmar, Indonesia) with PWID prevalence ratios in the top quartile, all but Central Asia reported lower than average prevention spending for PWID as a percentage of total prevention spending in 2014. [Indicated in red]



- **Figure 7.** Of the countries with the highest comparative HIV risk among FSW (PRs in the top quartile), three countries (Ethiopia, Rwanda, and Burundi—shown in red), reported below average expenditures for FSW.



It is not always clear what types of KP programs are funded, or whether funded programs are evidence-based

Finally, beyond budget coding, PEPFAR reporting is often insufficient to determine which types of KP programs are funded, and the extent to which these programs constitute evidence-based practices. To better understand whether planned activities were KP-specific, the team reviewed COP 2013 mechanism narratives for relevant budget codes for which countries designated a portion of funding with FSW or MSM cross-cutting attributes, in each case assessing the extent to which narratives referred specifically to KPs.

- **Figure 8.** The majority of mechanism narratives for MSM and FSW described programs serving the general population, including KPs. But KPs may be better served by targeted interventions, activities and outreach.

FSW Mechanism Analysis 2013 (n=96)			
Budget Code	n (%)	Mechanism Type	n (%)
HVOP - Sexual Prevention: Other Sexual Prevention	62 (43)	Non-specific (serving the general population, including FSW)	45 (47)
HVCT - Prevention: HIV Testing and Counseling	36 (25)		
HBHC - Care: Adult Care and Support	12 (8)	KP-specific (targeting KPs, including FSW)	33 (34)
HVSI - Strategic Information	9 (6)		
IDUP - Prevention: Injecting and Non-Injecting Drug Use	6 (4)	Non-inclusive (no mention of FSW or KPs)	17 (18)
OHSS - Health Systems Strengthening	4 (3)		
MTCT - Biomedical Prevention: PMTCT	3 (2)	FSW-specific programs	1 (1)
HTXS - Treatment: Adult Treatment	3 (2)		
HVAB - Sexual Prevention: Abstinence/Be Faithful	3 (2)		
HVTB - Care: TB/HIV	2 (2)		
HKID - Care: Orphans and Vulnerable Children	2 (2)		
HLAB - Laboratory Infrastructure	2 (1)		
MSM Mechanism Analysis 2013 (n=73)			
Budget Code	n (%)	Mechanism Type	n (%)
HVOP - Sexual Prevention: Other Sexual Prevention	20 (40)	KP-specific (targeting KPs, including MSM)	32 (44)
HVCT - Prevention: HIV Testing and Counseling	13 (26)		
HBHC - Care: Adult Care and Support	3 (6)	Non-specific (targeting the general population, including MSM)	22 (30)
OHSS - Health Systems Strengthening	3 (6)		
HVSI - Strategic Information	3 (6)	Non-inclusive (no mention of MSM or KPs)	16 (22)
HVTB - Care: TB/HIV	2 (4)		
HTXS - Treatment: Adult Treatment	2 (4)	MSM-specific programs	3 (4)
HVAB - Sexual Prevention: Abstinence/Be Faithful	2 (4)		
MTCT - Biomedical Prevention: PMTCT	1 (2)		
IDUP - Prevention: Injecting and Non-Injecting Drug Use	1 (2)		

The team also reviewed mechanism narratives for all program activities designated with the IDUP budget code, to determine their nature and alignment with COP guidance by assessing whether relevant programs were mentioned.

- While overall IDUP funding for PWID activities fell short of need, NSPs were mentioned in only 13% of mechanism narratives, suggesting that one of the most effective interventions specified in WHO guidance is insufficiently prioritized, possibly the result of persistent U.S. government policy.

IDUP Budget Code Analysis 2013	
# of mechanisms in which key program activities are mentioned, among all mechanism narratives (n=71)	
Most frequently mentioned activities:	n (%)
Technical assistance, training, and capacity building	43 (60)
Medication-assisted treatment (MAT)/Opioid substitution therapy (OST)	30 (42)
Linkages and referrals	29 (41)
Least frequently mentioned activities:	
Psychosocial health & behavioral interventions for addiction	11 (15)
Policy reform around PWIDs	9 (13)
Needle and syringe exchange programs (NSP)	9 (13)

PEPFAR KP investments are substantial and increasing, though often inconsistent and not always well documented

An analysis of planned funding and actual expenditures for KP programs suggests that while both are increasing slightly overall, there are dramatic variations from country to country. There were examples of large increases (>1,000%) in KP planned funding from year to year, but also some dramatic decreases—in several instances to zero KP funding. Although it is difficult to interpret KP funding increases or decreases in a single year, it will be important to follow KP funding trends over time, as significant decreases run counter to the epidemiological evidence and do not represent adequate investments in the HIV response.

Actual KP expenditures don't always match planned KP funding, though examples were not consistent. In some instances, countries spent less than planned, but in other instances they spent more. In some cases, countries reported \$0 in planned KP funding, but then reported actual KP expenditures the following year. Because of the complexity in tracking planned funding (i.e., budget codes are not well aligned with expenditure analyses), additional mechanisms are needed to ensure that planned funding occurs and to understand discrepancies between planned funding and actual expenditures.

Planned KP funding and actual KP expenditures were not always well correlated with HIV prevalence ratios. For example, some countries with very high prevalence ratios among KPs reported disproportionately low planned KP funding or actual KP expenditures. The relationship between reported KP expenditures and HIV prevalence ratios is insufficient to assess the adequacy of KP programming in any given setting. For example, it is possible that in hostile political environments, KP programs are undertaken discreetly and not appropriately coded, though it is more likely that in making funding decisions, factors other than epidemiology came into play. In the majority of countries, the percentage of total actual HIV prevention expenditures comprising KP programming is small, regardless of HIV prevalence ratios—and countries with low expenditures and high HIV prevalence ratios signal a mismatch in allocations.

Additional mechanisms are needed to ensure that planned funding occurs and to understand discrepancies between planned funding and actual expenditures.

Much PEPFAR data reporting was ambiguous or difficult to interpret, making it challenging to understand how funds were used. Moving forward, it will be important that PEPFAR tracking and reporting of KP programs provides a clearer understanding of how resources are allocated, and incentivizes the implementation and scale-up of evidence-based programs.

In particular, while it is important that interventions serving the general population do not exclude KPs, interventions are also needed that recognize and respond to the specific social and structural barriers KPs face. Among programs designated with an MSM or FSW cross-cutting attribute, a significant proportion of mechanism narratives neither specified how the funds would be used, nor even mentioned KPs (18% for FSW and 22% for MSM). Large proportions of programs designated with either attribute (47% for FSW and 30% for MSM) appeared to be designed for the general population *including* KPs, who might be better served by targeted programs.

Among programs designated with the IDUP budget code (i.e., targeting PWID), NSPs were among the least frequently funded (mentioned in only 13% of mechanism narratives), though such programs are among the most effective HIV prevention interventions. Similarly, though adverse policies often constitute a significant barrier to services for PWID, policy reform efforts were rarely funded (13% of mechanism narratives).

Finally, it is difficult to know the extent to which internal PEPFAR coding has been validated, raising questions about comparability of funding data between countries, or from year to year. Perhaps most critically, planned funding and expenditure analyses are themselves inconsistently reported (i.e., with different coding systems that do not align), making it extremely challenging to evaluate the extent to which funding plans are executed.

To fulfill its stated mandate to increase access to and uptake of services among KP, PEPFAR should continue to strive to direct resources to targeted programming commensurate with epidemic burden, but also ensure that such resources support evidence-based interventions. Additionally, though PEPFAR has made measurable strides in the implementation of KP programs, significant policy barriers remain, including

NSPs were among the least frequently funded ... though such programs are among the most effective HIV prevention interventions.

the anti-prostitution pledge still required of non-U.S. organizations, failure to promote lifesaving syringe access programs, and a lack of clear guidance to country teams regarding which harm reduction interventions can/cannot be funded.

Conclusion

PEPFAR funding remains of critical importance to KP programming in many countries. However, disproportionate HIV risk and suboptimal service coverage among KPs underscores the continuing importance of prioritizing both KP resources and targeted interventions. Though overall PEPFAR planned KP funding has increased in recent years, extreme variability among countries suggests the need for a greater system-wide emphasis and closer alignment with HIV epidemiology. This is not a challenge for PEPFAR to meet alone. It is imperative that all donors supporting the global AIDS response make stronger commitments to those populations that have been historically marginalized and continue to face the greatest risk

All PEPFAR tracking and reporting mechanisms should provide sufficient information to understand how resources are being allocated.

KPs also require specifically targeted interventions that address the social and structural barriers they face, including, in most cases, significant discrimination, violence and criminalization. Reducing barriers faced by KPs in accessing programs targeting the general population, while important, is insufficient. All PEPFAR tracking

and reporting mechanisms should provide sufficient information to understand how resources are being allocated. In this regard, PEPFAR should collaborate with civil society advocates to understand how best to encourage the appropriate implementation and scale-up of evidence-based programs for KPs. In crafting reporting requirements for KP funds, PEPFAR should solicit input from and collaborate with civil society, taking into consideration how reporting data will be of most use in supporting community advocacy.

Endnotes

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