AFRICAN KEY POPULATIONS' ENGAGEMENT WITH GLOBAL HEALTH FINANCING INSTITUTIONS:

A Rapid Review

AMSHeR
African Men for Sexual Health & Rights

TRANSBANTU ASSOCIATION ZAMBIA
TRANSCENDING TOGETHER

African Sex Worker Alliance

GENDER DYNAMIX
10 YEARS
ADVANCING TRANSGENDER AND GENDER NON-CONFORMING HUMAN RIGHTS

About Partners

African Men for Sexual Health and Rights (AMSHeR)

Founded in 2009 The African Men for Sexual Health and Rights is a coalition of 18 LGBT/MSM-led organisations across sub-Saharan Africa to address the disproportionate effect of the HIV epidemic on MSM and LGBT individuals; to redress the human rights violations these populations face on the continent; and to increase the visibility of LGBT individuals and their issues. Although AMSHeR's formal membership is 18 organisations, strategically chosen to maintain geographic (Central, East, Southern and West Africa), linguistic (English, French, Kiswahili and Portuguese-speaking countries), Socio-legal (common law, civil law and Roman-Dutch legal systems) representation of sub-Saharan Africa, AMSHeR was formed in an attempt to devise 'home-grown' strategies to address local issues. AMSHeR maintains a reach across the whole of Africa through partnerships with a network of affiliate members.

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About African Sex Workers Alliance (ASWA)

Africa Sex Workers Alliance (ASWA) is the Pan African Alliance of sex worker led groups.ASWA's Vision is to see a world where sex work is recognized as work in Africa, and where the health and human rights of all sex workers living and working in Africa are protected!

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About Gender Dynamix

Gender DynamiX seeks to be a key role-player towards the realisation of all human rights of transgender and gender nonconforming people within and beyond the borders of South Africa.

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A just world, in which rights for all are upheld; where equality and equity are the norm while justice is equitably accessed, claimed and enjoyed by all.

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List of Abbreviations & Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMSHeR	African Men for Sexual Health and Rights
CCM	Country Coordinating Mechanism
CSS	Community Systems Strengthening
GAC	Grant Approvals Committee
GLOBAL FUND	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immune Deficiency Virus
HSS	Health Systems Strengthening
KP	Key Population
LGBT	Lesbian, Gay, Bisexual And Transgender
MOH	Ministry of Health
MSM	Men Having Sex With Men
NAC	National AIDS Commission
NESP	Needle and Syringe Exchange Programs
NFM	New Funding Model
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OST	Opioid Substitution Therapy
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV
PR	Principal Recipient
PWID	People Who inject Drugs
SW	Sex Worker
TB	Tuberculosis
TG	Transgendered Person
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
USAID	United States Agency for International Development

Executive Summary

In 2014-16, The Global Fund to Fight AIDS, TB and Malaria ("The Global Fund") and the U.S. President's Emergency Plan for AIDS Relief ("PEPFAR") have both taken steps to significantly increase their transparency and consultation with the key populations most affected by HIV: sex workers, men who have sex with men, people who inject drugs, and transgender people. In response, many countries have seen an unprecedented level of activity by key populations-led groups to engage with these processes. UNAIDS has been a key player in the process, as global coordinator of the HIV response.

In 2014-15, African Men for Sexual Health and Rights (AMSHeR) conducted a preliminary survey of African key populations' engagement in the Global Fund New Funding Model. Since then, many more Global Fund grants have been completed and signed, and PEPFAR has also significantly expanded its consultation with key populations representatives. This report builds on and expands the first survey to examine African key populations' engagement with both major health financing institutions and UNAIDS during 2014-16. The study is sponsored by African Men for Sexual Health and Rights, the Africa Sex Workers Alliance, Gender DynamiX, and Transbantu Association Zambia. It draws on a survey of 99 respondents from 25 African states, as well as a focus group and both in-person and telephone interviews with key populations representatives in Cameroon, Kenya, Malawi, Nigeria, Uganda, and Tanzania.

According to the survey, forty-two percent of respondents engaged with the development of National HIV Strategic Plans (NSPs), thirty-three percent were consulted about Global Fund concept notes, and only nineteen percent on PEPFAR country operational plans. Far smaller numbers reviewed and input into final draft documents in each process, fewer still saw the budgets, and unsurprisingly, most were dissatisifed with how well they felt the resulting plans and funding will meet key populations needs. UNAIDS received similarly mixed evaluations by key populations for its role as an advocate to governments, especially in the wake of the UN High-Level Meeting on HIV/AIDS in June 2016, from which 22 key populations groups were excluded.

In the best cases described in this report, the demand by international donors for increased consultation with key populations, and their more explicit commitment to a human-rights based approach, created more space for community advocacy, and led to real and measurable changes in plans and programs. However, in some countries, consultation with key populations was cursory and tokenistic. In others, key population priority interventions -- law reform, community mobilization, and clinical and prevention services sensitive to the specific needs of key populations -- were cut from funding requests without explanation. Communities questioned national data on HIV among key populations. Data was almost entirely absent for people who inject drugs and transgender people, whose erasure is widespread and systematic in the African HIV response.

The Global Fund and PEPFAR processes were complex and time-consuming. Many representatives took time off from day jobs or other funded programs to engage, in the hope that their participation would result in funding for long-neglected key populations programs. Many were disappointed when groups with a long history of providing services to key populations were not selected as implementers. The reasons provided for this were generally that key populations NGOs were not legally registered or "lacked capacity" to manage funds. However, the Global Fund and PEPFAR currently offer no path to capacity-building or

accreditation of key populations-led organizations as grant recipients.

Despite the many challenges, key populations representatives who spoke for this report acknowledged that the process of consultation by the Global Fund and PEPFAR continues to evolve. Many expressed determination to continue to engage and to advocate for their rights, in order to press for meaningful change.

Recommendations

To Global Fund Secretariat, Global Fund Board, and U.S. Office of the U.S. Global AIDS Coordinator and Health Diplomacy

- The Global Fund and PEPFAR should develop a common process through which key populations-led organizations can be trained, accredited and become eligible to be selected as sub-recipients or implementing partners. Throughout the concept note review and COP processes, both agencies should actively encourage countries to invest in community-led programs. Most direct granting for the Global Fund and PEPFAR goes to intermediary international NGOs. One potential model to examine is the U.S. Minority AIDS Initiative, which provides funding to HIV services that specifically reach into minority communities and that build capacity of community-based organizations to receive government funding and deliver services.
- Both the Global Fund and PEPFAR should set measureable targets for capacity development of community-led organizations and report on them regularly and publicly.
- The Global Fund should publish all signed grants, including budgets, and should require countries that receive their funding to publish their HIV budgets and expenditures to enable public accountability. PEPFAR's new dashboards will do this, and PEPFAR should provide training to key populations groups in the dashboards in order to enable them to play a watchdog role.
- The Global Fund and PEPFAR should publish more, and more user-friendly, information explaining their processes and tools, in all UN languages.
- Few of those surveyed for this report were aware that the Global Fund has established minimum human rights standards for its programs. The Global Fund Office of the Inspector General should work with key populations networks to conduct extensive training and communications on the minimum human rights standards for Global Fund-financed programs, to ensure that all key populations groups and PLHIV are informed and able to play a watchdog role.
- PEPFAR should incorporate minimum human rights standards for all services that are comparable to those adopted by the Global Fund.
- Key populations peer educators are subsidizing the HIV response and are unrecognized, under-appreciated and not remunerated. These community-led interventions are critical to ending AIDS. The Global Fund and PEPFAR should recognize the essential role played by peer educators in the HIV response, and develop minimum pay standards for all peer educators, in consultation with key populations representatives.
- UNAIDS, the Global Fund and PEPFAR should develop a unified curriculum on key

populations issues for all staff and funding recipients, and jointly publish the curriculum with the key populations networks. Training and sensitization of stakeholders is more effective when the communities are present and interacting with the stakeholders for the duration of the training.

- UNAIDS, UNAIDS co-sponsors, the Global Fund and PEPFAR should increase the number of their own staff they hire who are living with HIV and from key populations.
- The Global Fund should increase investment in regional and multi-country grants.
- Technical assistance offered to key populations should be advertised earlier in the process, and providers should be efficiently matched with organizations requesting TA.
- Assessment tools used to review Principal Recipients and Implementing Partners should be revised to include assessment of these organizations' past track record and expertise on key populations concerns.

UNAIDS Secretariat and UNAIDS Co-sponsors

- UNAIDS should develop an initiative to develop HIV data for people who inject drugs and transgender people in the many African countries where it does not exist. Protocols for such data collection should specify that data be collected in partnership with key populations groups and in ways that respect right to privacy and informed consent, and include robust risk assessment and management.
- As UNAIDS mandate includes advocacy, UNAIDS indicators for its new strategy should include measurable indicators linked to specific advocacy goals. UNAIDS country directors should be held responsible for progress towards specific advocacy targets in each country.
- UNAIDS co-sponsors should engage in more direct consultation and develop a close working collaboration with key populations representatives. UNAIDS should allocate a percentage of staff time and funding to support rapid response to emergency situations affecting the HIV response among key populations.
- Given the risk of censorship of and retaliation against key populations advocates in health financing consultations, UNAIDS should identify a co-sponsor with a protection mandate to engage in monitoring and support for key populations human rights defenders during health governance consultation processes.
- The UN for All training on human rights and inclusion in the workplace should be required for all UNAIDS country office staff, beginning with country directors.

To CCMs and PEPFAR country teams, and Ministries of Health

- CCMs and PEPFAR country offices must ensure that in each country, all of those affected by HIV are included in consultations regardless of legal, social or cultural resistance or other barriers.
- All CCMs should engage in training on human rights, key populations and gender, and should require participation in the training by Principal Recipients.
- Ensure an open and transparent selection of KP representatives through democratic elections, not through appointments.
- Support the development of key population reference groups to coordinate input and support key population representatives at the national level.

- CCMs should provide financial support to ensure that key populations representatives are adequately funded to consult with and report back to their constituencies.
- CCMs and PEPFAR country teams should ensure that domestic organizations that receive funding from the Global Fund and PEPFAR are trained and compliant in non-discriminatory service delivery, and communicate these standards to their staff and clients.
- Health ministries should strengthen their engagement in a public health approach to HIV by ensuring access to appropriate services for HIV prevention, care, treatment and support regardless of legal, social or cultural barriers.

To private foundations

- Recognizing that key populations have a human right to be consulted in development aid that affects them, private foundations should provide increased funding to support engagement by key populations representatives in health governance and health financing consultations.

To key populations networks and other civil society organizations

- Global Fund civil society delegations to the Board should consult regularly with regional key populations networks and CCM representatives.
- Key populations representatives should engage in consultation with and reporting back to communities they represent on CCMs and in health financing consultations, and should engage in regular communication with their communities.
- Key populations networks should coordinate and train domestic organizations to engage in systematic, ongoing monitoring of national health budgets, expenditures, key populations HIV data, and human rights standards relevant to Global Fund and PEPFAR-financed programs. Key populations networks should coordinate and train domestic organizations to engage in systematic, ongoing monitoring of national health budgets, expenditures, key populations HIV data, and human rights standards relevant to Global Fund and PEPFAR-financed programs.

1. Introduction

In 2014-16, The Global Fund to Fight AIDS, TB and Malaria ("The Global Fund") and the U.S. President's Emergency Plan for AIDS Relief ("PEPFAR") have both taken steps to significantly increase their transparency and consultation with the key populations most affected by HIV: sex workers, men who have sex with men, people who inject drugs, and transgender people. In response, many countries have seen an unprecedented level of activity by key populations-led groups to engage with these processes. UNAIDS has been a key player in the process, as an advocate for the HIV response and the agency that has often coordinated sharing of HIV epidemiological data, organized consultations, and supported the process of developing grants.

In 2014, African Men for Sexual Health and Rights conducted a preliminary survey of the Global Fund new funding model. This preliminary survey identified some early successes and challenges with rollout of the funding model, but did not address grant implementation or engagement with NSPs and PEPFAR. Since then, many more Global Fund grants have been completed and signed, and PEPFAR has completed and signed new agreements with countries. Key populations groups in Africa have shown initiative, tenacity and ingenuity in advancing the rights and health access of their communities. However, investment in their organizations by governments and other agencies has lagged.

This report builds on and expands the earlier survey to examine key populations' satisfaction with their experiences with both major health financing agencies and UNAIDS during 2014-16. The study is sponsored by African Men for Sexual Health and Rights, the Africa Sex Workers Alliance, and Gender DynamiX and Transbantu Association Zambia. It draws on a survey, a focus group, site visits, and interviews with advocates from six countries.

2. Background

In 2003, the United Nations Development Group adopted the UN Statement of Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming, which commits to upholding human rights principles in development cooperation. The Common Understanding commits to advancing the realization of human rights through development co-operation, to development of the capacity of "duty-bearers" to meet their obligations and of "rights-holders" to claim their rights. The Common Understanding also commits to treating people "as key actors in their own development, rather than passive recipients of commodities and services," and to treating "participation as both a means and a goal."(1)

In line with this commitment, as the leading global HIV financing mechanisms, both the Global Fund and PEPFAR have begun to explicitly address human rights concerns that impact on health service access, and have committed to more robust and meaningful consultation with HIV-affected key populations. This work is supported by UNAIDS, whose secretariat often has country offices.

The three agencies' approaches are briefly described below.

2. 1 The Global Fund to Fight AIDS, TB and Malaria

The Global Fund is an international funding mechanism established in 2002 to "accelerate the end of HIV, tuberculosis and malaria as epidemics." (2) The Global Fund raises about $4 billion a year. It directs funds received from its donors, mostly governments, to national programs; it does not run its own programs, and all Global Fund staff are based in Geneva, Switzerland, with frequent visits to countries where they manage grants.

The Global Fund's diverse Board is made up of constituencies which include donor and implementing governments, the private sector, civil society, and communities living with HIV, TB and malaria. Grants are managed in countries by Country Coordinating Mechanisms (CCMs), nationally-owned and managed committees that include government, implementers and civil society.

In 2013, the Global Fund significantly changed its grant-making process with the launch of the "new funding model" (now just "the funding model"). Among other changes, this included a requirement that CCMs demonstrate that they have consulted with stakeholders, including key populations and people living with the three diseases; and that key populations both participate in drafting the concept note used to apply for funding, and formally endorse the concept note.(3) However, progress has been slow: a report by the Global Fund Office of the Inspector General in February 2016 found that the majority of CCMs were not yet compliant with these and other requirements.(4)

Once submitted, an independent panel of experts review concept notes. If these are approved, the applicant then goes through a process of "grant-making", during which they develop budgets, specific plans and targets in consultation with the Secretariat. The Principal Recipient of each grant is expected to be selected through an open, competitive process, which is

supervised by the CCM. The Secretariat assesses the selected Principal Recipients on ability to implement the grant and meet Global Fund financial management requirements. The Principal Recipients then issue public tenders for sub-recipients and sub-sub-recipients to actually deliver services.

Beginning with new grants signed in 2015, the Global Fund also included minimum human rights standards in all grants, for which Principal Recipients are responsible. Programs financed by the Global Fund are expected to:

- Grant non-discriminatory access to services for all, including people in detention.
- Employ only scientifically sound and approved medicines or medical practices.
- Not employ methods that constitute torture or that are cruel, inhuman or degrading.
- Respect and protect informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered.
- Avoid medical detention and involuntary isolation, which are to be used only as a last resort.

Individuals or groups who believe their rights have been violated are encouraged to file complaints with the Office of the Inspector General, which investigates allegations of fraud, corruption and abuse.(5)

In 2016, the Global Fund is restructuring its grant management team. More staff will be allocated to larger countries with higher disease burden, such as Nigeria. In countries with smaller populations and smaller disease burden, the Global Fund will likely have fewer staff managing multiple grant portfolios. The executive director, Dr. Mark Dybul, is scheduled to complete his current term in 2017.

Earlier reviews of the rollout of the new funding model identified a number of successes and weaknesses. A 2014 study of 11 countries by the Communities Delegation to the Global Fund Board found increased community mobilization, but also challenges to their engagement, including: "Limited influence by KPs on the final selection of interventions, budget allocation and implementation modalities."(6)

2.2 The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the U.S. government initiative to combat HIV globally, launched in 2003 under then-President George W. Bush and expanded under President Obama. It is led by the U.S. Global AIDS Coordinator and Special Representative for Global Health Diplomacy, appointed by the U.S. president to coordinate national HIV programs, currently Ambassador-at-large Deborah L. Birx.

In 2016, PEPFAR enacted $5.2 billion in funding for bilateral HIV/AIDS programs, appropriated by the U.S. Congress.(7) PEPFAR is required to submit quarterly reports to Congress about the allocation, obligation, and expenditure of funds, and each year, PEPFAR publishes a

Supplement to the Fiscal Year Congressional Budget Justification for Foreign Operations to justify and report on funding. A 2012 study of 18 countries that receive PEPFAR funding found that countries where HIV is concentrated among key populations receive less funding than other countries.(8)

PEPFAR Operational Plans provide programmatic descriptions and budgetary information for PEPFAR, as well as describe the planned uses of all sources of U.S. government international HIV/AIDS funding by fiscal year. New guidelines are published annually, setting out the process through which the Country Operational Plans (COPs) are reviewed, revised and updated each year.(9) PEPFAR country teams are required to report to their headquarters in writing on their consultation with civil society, including key populations representatives, in development of the COP:

> *PEPFAR teams should ask local civil society to select up to two representatives to attend their COP Review meeting and should plan to use management funds or the ambassador's small grants program or existing implementation mechanisms to support the costs associated with supporting civil society participation at all levels of planning.(10)*

PEPFAR Dashboards online also now allows all stakeholders who can use it to view PEPFAR planned funding, program results, and expenditure analysis data.(11)

Ambassador Birx has pressed forward the expanded consultation with key populations and other stakeholders. As an appointee of the incumbent Democratic Party president, her continuation in this role depends on the outcome of the presidential election in November 2016.

2.3 The Joint United Nations Programme on HIV and AIDS (UNAIDS)

UNAIDS was established in 1994 and officially launched in 1996 to lead a strengthened global HIV response. Its five goals include:

- Leadership and advocacy for effective action on the epidemic;
- Strategic information and technical support to guide efforts against AIDS worldwide;
- Tracking, monitoring and evaluation of the epidemic and of responses to it;
- Civil society engagement and the development of strategic partnerships;
- Mobilization of resources to support an effective response.

The UNAIDS Secretariat is based in Geneva, Switzerland, on the campus of the World Health Organization (WHO), with numerous country and regional offices. The UNAIDS cosponsors include the Office of the United Nations High Commissioner for Refugees (UNHCR); United Nations Children's Fund (UNICEF); World Food Programme (WFP); United Nations Development Programme (UNDP); United Nations Population Fund (UNFPA); United Nations Office on Drugs and Crime (UNODC); International Labour Organization (ILO); United Nations Educational, Scientific and Cultural Organization (UNESCO); WHO; World Bank; and UN Women.

UNAIDS is headed by an Executive Director, currently Michel Sidibé, and governed by a

Programme Coordinating Board which consists of UN member states, UNAIDS co-sponsors, and representatives from civil society, including key populations and people living with HIV. The UNAIDS 2011-15 strategy committed to advancing human rights and gender equity for the global health response, with indicators to measure the reduction in number of countries with punitive laws affecting key populations.(12) In March 2016, UNAIDS and Global Work Force Alliance launched an "Agenda for Zero Discrimination in Health Care".(13)

In December 2014, the Global Fund and UNAIDS signed a new agreement outlining the nature of their cooperation in roll-out of the Global Fund new funding model. These included:

- Strengthening strategic investments
- Jointly leveraging political commitment
- Supporting meaningful country dialogues with all stakeholders—including civil society and communities
- Support for data collection, analysis and identification of gaps in the epidemic and the response; including on countries' enabling environments, equity in access to services, human rights, gender and key populations.(14)

Thus, in many countries, UNAIDS led the work of organizing stakeholder consultations for the Global Fund concept note, including identifying key populations representatives to participate in the process.

2.4 Who are key populations?

The term "key populations" derives from HIV research, and has been clearly defined by WHO. Based on extensive review of the scientific evidence and consultation with experts, including communities, WHO has defined key populations as

> *Defined groups who, due to specific higher-risk behaviors, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviors that increase their vulnerability to HIV. These guidelines focus on five key populations: 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people. People in prisons and other closed settings are included in these guidelines also because of the often high levels of incarceration and the increased risk behaviours and lack of HIV services in these settings.(15)*

In addition, WHO notes there are "vulnerable populations" who are "particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers."(16) Other sub-populations who are often vulnerable to HIV include long-distance truck drivers, clients of sex workers, and uniformed personnel. Women and girls also experience high rates of HIV prevalence in many countries.

In an effort to deny the existence of politically sensitive and stigmatized key populations, some political leaders have attempted to redefine the term "key populations" to include less-sensitive groups and exclude sensitive ones. As one survey respondent commented, "Key

population definitions are very subjective and it is unclear which definition the Government uses."

In a growing number of countries, key populations groups have formed national networks of civil society organizations that are led by key populations themselves, to both provide services to and advocate for their communities. At the international level, numerous groups have engaged in advocacy on the needs of people living with HIV and key populations, such as the Global Network of People Living with HIV/AIDS (GNP+), the International Network of People who Use Drugs (INPUD), the Network of Sex Work Projects (NSWP) and the MSM Global Forum (MSMGF), among others.(17)

3. Methodology

This report was researched and written over six weeks during May-July 2016. The methodology included an online survey, a focus group, and ten interviews, described below.

The online survey was developed in consultation with the four partner organizations who jointly produced the report, with some suggested questions contributed by technical staff at UNAIDS, the Global Fund, and USAID (see Annex 1). The survey included 54 questions in seven parts. It was developed in English, translated into French and Portuguese, and shared online using the websites and Facebook pages of the partner organizations, as well as through social media, email list serves, and organizational mailing lists. A total of 99 respondents replied from 25 African countries.

Statistics cited in this report are from the survey, and the note "n=" a number refers to the actual number of respondents captured in the statistic. For example, "63 percent of respondents represented lesbian, gay, bisexual people (n=59)" means that 59 survey respondents identified themselves as representing LGB people.

The consultant also spent several days each in Nairobi, Kenya and Lilongwe, Malawi conducting interviews with contacts provided by AMSHeR. The Kenyan organization contracted by the Global Fund to provide technical assistance for the concept note, KELIN Kenya, shared their report and answered questions. In Lilongwe, the Centre for the Development of People (CEDEP) organized a focus group of ten MSM, transgender and sex worker representatives.

Subsequently, follow-up interviews were requested with some respondents to the survey. Six people in Cameroon, Kenya, Nigeria, Tanzania, and Uganda were interviewed using their preferred media, which included telephone, Skype, Facebook Messenger, and WhatsApp. All interviewees were offered the chance to review and approve their statements, and the option to decide how they wanted to be named in the report. A few chose to remain anonymous for security reasons.

Based on the research, clarification questions were sent to staff of the Global Fund, USAID and UNAIDS. Both USAID and UNAIDS staff responded; the Global Fund Fund Portfolio Manager for Kenya responded; the Fund Portfolio Manager for Malawi did not.

Limitations: This report represents a rapid review aimed at forming the basis of advocacy and engagement with health governance institutions, with a view to improving the outcomes of ongoing and upcoming country processes. The time available to conduct this research was short, and more in-depth quantitative and qualitative process is planned as an outcome of this report.

The pool of respondents was relatively small, and the short timeline for the country visits

limited the scope of the research. The methodology and timeline for the report tended to favor those with regular access to internet. Few sex workers and people who inject drugs volunteered to be interviewed for the report. All those interviewed were asked to speak solely on the basis of their individual and their organizations' experience.

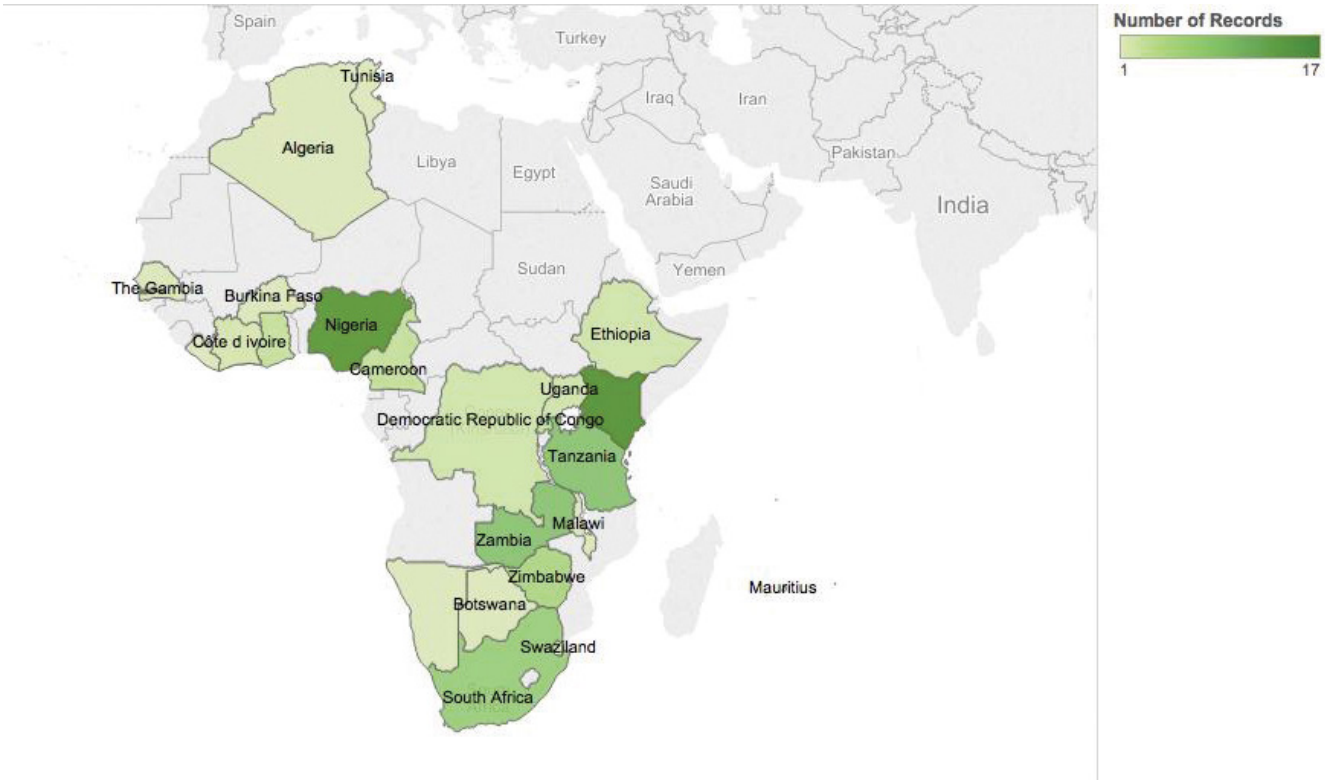
4. Findings

4.1 Characteristics of respondents

The survey respondents were diverse, representing a cross-section of key populations advocates from across Sub-Saharan Africa.

While 99 respondents completed the survey, six were disqualified either because they clearly stated that they were not themselves key populations, were not from African countries, or who did not complete more than five or six questions. The 93 qualified respondents came from 23 Sub-Saharan African countries (see Map 1).

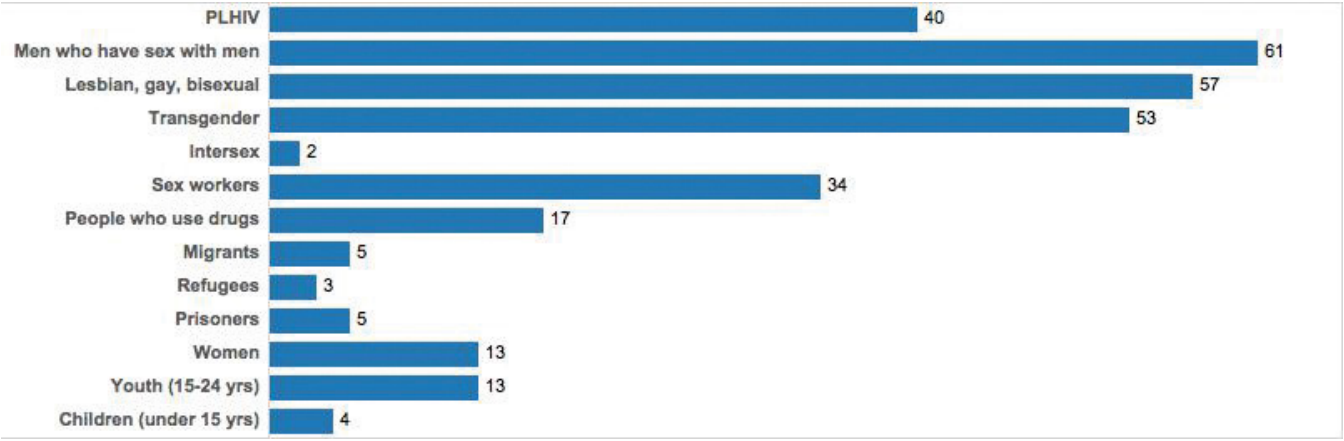
Map 1: Location of organizations in the survey



The survey asked which key populations groups respondents represented. Most respondents identified themselves as representing multiple sub-populations. A majority identified themselves as representing men who have sex with men (n=64); lesbian, gay and bisexual people (n=59) and transgender people (n=53).

Other sub-populations represented included people living with HIV, sex workers, people who use drugs, women, youth (15-24 years old), children (under 15 years old), migrants, and refugees (see Chart 1).

Chart 1: Key populations groups represented by survey respondents

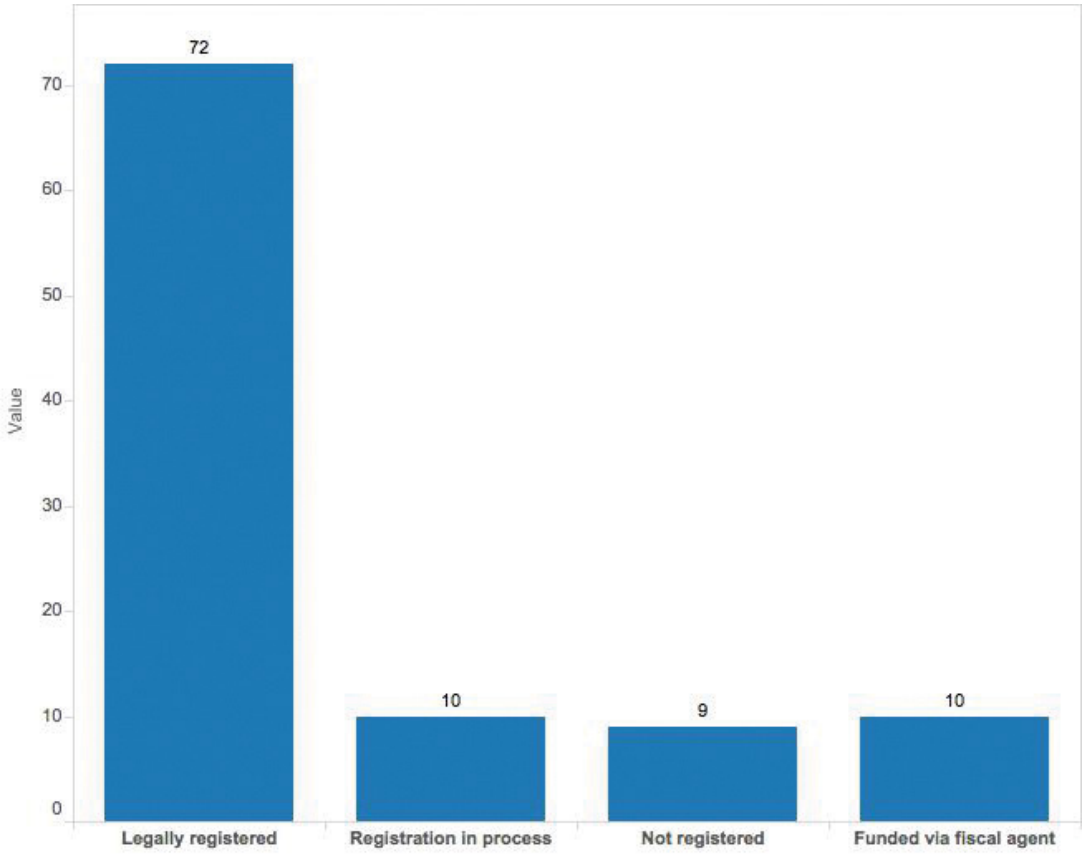


In many countries, groups representing key populations are unable to legally register. A recent report from Global Philanthropy Project finds that closing space for civil society, including new laws restricting foreign funding and "LGBT propaganda" and the scapegoating of LGBT groups by politicians, have created new challenges for LGBT groups in many countries.(18) Nonetheless, 79% of survey respondents said that they work for organizations that are legally registered (n=74, see Chart 2). Others reported that they are unregistered, funded through a fiscal agent, and/or waiting for a registration application to be processed. A respondent from Rwanda commented,

> *Many KP groups in our country are not allowed to present themselves as such. They must pass through general NGOs or register differently to access grants.*

In other countries, organizations representing criminalized and stigmatized groups are able to register by using vague terminology to describe their mandates, presenting a mission that is broader than the actual mission of the organization, or presenting the organization as working on HIV or health without mentioning the specific sub-population represented.

Chart 2: Legal registration status of survey respondents



Forty-eight percent of respondents (n=45) said their organizations had never received funding from either the Global Fund, PEPFAR, or any U.S. government funding source, responses that reflect how challenging it remains for the organizations surveyed in this report to access international health financing. One respondent commented: "Funding for grassroots organizations is zero."

Survey respondents also report that they are active in health governance at multiple levels. Twenty-eight of the respondents said their organization has a representative on the Country Coordinating Mechanism. Forty-eight of the respondents have representatives engaged in other forms of global, regional, national or local health governance mechanisms.

For some, the ability to advocate is severely constrained by lack of funding or institutional support: one issue raised by almost every interviewee, discussed further in this report, is the question of "meaningfulness" of key population representation in health governance mechanisms such as CCMs. Several interviewees reported that they face restrictions on raising human rights issues, such as legal recognition of gender identity. One transgender activist explained:

> *We as key populations have been recognized in [our country] under the umbrella of HIV and not beyond, and therefore we're limited to go beyond the borders of HIV.(19)*

For key populations whose behavior is criminalized, even getting a meeting with a government official can be challenging, said Michael Akanji in Nigeria:

> *The premise of criminalization makes the people you want to visit have excuses to not receive you. You need a letter from the Ministry of Health and a lot of bureaucratic things like that.(20)*

4.2 Challenges faced by key population groups

In order to contextualize the study, African key populations representatives interviewed for this report were asked to the challenges they face in their daily work. Key populations organizations represent the front lines of the fight against HIV, and the global HIV response rests on their ability, especially the ability of key populations peer educators, to reach hidden key populations, inform them about HIV, provide them with prevention services, and persuade those at risk to test for HIV.

Nonetheless, those interviewed for this report described difficult operating environments. They spoke of political obstacles like those mentioned above, chronic underfunding, frequent stock-outs of prevention and medical supplies, police abuse, and stigma and discrimination among others.

In Lilongwe, Malawi, the Centre for the Development of People (CEDEP) organized a small focus group of ten peer educators who had previously participated in Global Fund concept note consultations. The group traveled from various locations across the city by mini-bus to share their experiences. They included five sex workers, four MSM, and one person who identified as transgender. While most understood some English, they were more comfortable speaking Chichewa. Rodney Chalera, Program Manager for CEDEP, interpreted between Chichewa and English for the group.

The peer educators described the challenges they face. Most are only paid for their outreach work with small honoraria, and are left to subsidize the added costs of transportation and cell phone use to reach peers from their own limited incomes:

> *There may be someone the peer educators have to reach who is far away, but because it takes so long to get there and back, they end up only helping those who are close by. Sometimes a client may flash [send an alert to] their phones, and they have to call back... and they do it, but on humanitarian grounds, depleting their own air time.(21)*

Many peer outreach workers also counsel community members who are arrested:

> *Often friends flash [send alerts to] their phones and say, "I'm here with the police, arrested." This happens often at night, when the peer educators are back at their homes. They still have to go out and find a way to help, at all times of night.(22)*

The Lilongwe group said that many sex workers do not understand the point of using condoms or testing for HIV. They described police abuse as an added obstacle to persuading sex workers

to come forward for HIV testing:

> *The services are there, but if we don't improve the human rights of people, the services aren't going to be used. Anywhere we go to meet sex workers, they all say, "We get beaten up. We get raped by the very police who are supposed to protect us."...How are sex workers going to report the police officer who abused them? He's the one who's receiving the complaint.(23)*

Even when key populations in Lilongwe are persuaded to seek HIV services, often at private clinics, the peer educators said that the stigma their clients experience on a first visit by health workers may discourage key populations from ever returning. Some health workers feel key populations drive away other paying customers, said one focus group member:

> *It's not direct discrimination...[the health workers] just ignore you. You go there at 10 am. At 11am, 1pm, they are still ignoring you, and you get tired on your own and leave.(24)*

Such experiences are borne out by research in sub-Saharan Africa and globally, which has found widespread stigma and discrimination against key populations by health workers.(25)

Furthermore, the peer educators reported, they frequently run out of prevention supplies. "We have a drought in lube and a drought in condoms," they said, drawing a parallel with Malawi's ongoing water drought.

HIV prevalence is extremely high among key populations in Malawi: CEDEP believes it is as high as 24% among MSM, and similar for sex workers. When informed of the national size estimate of over 20,000 MSM, a number based on a survey of only seven districts, peer educators in the focus group were shocked at the scale of the challenge their small group faces. "It's too many," said one. "Too many for us to reach."

For all these reasons, members of the Lilongwe focus group who engaged in consultations for the NSP and the Global Fund in 2014-16 urgently hoped to see increased funding for prevention, sensitization on human rights for police and health care workers, access to justice programs, and a communications campaign to specifically target LGBT people and sex workers with HIV prevention messages.

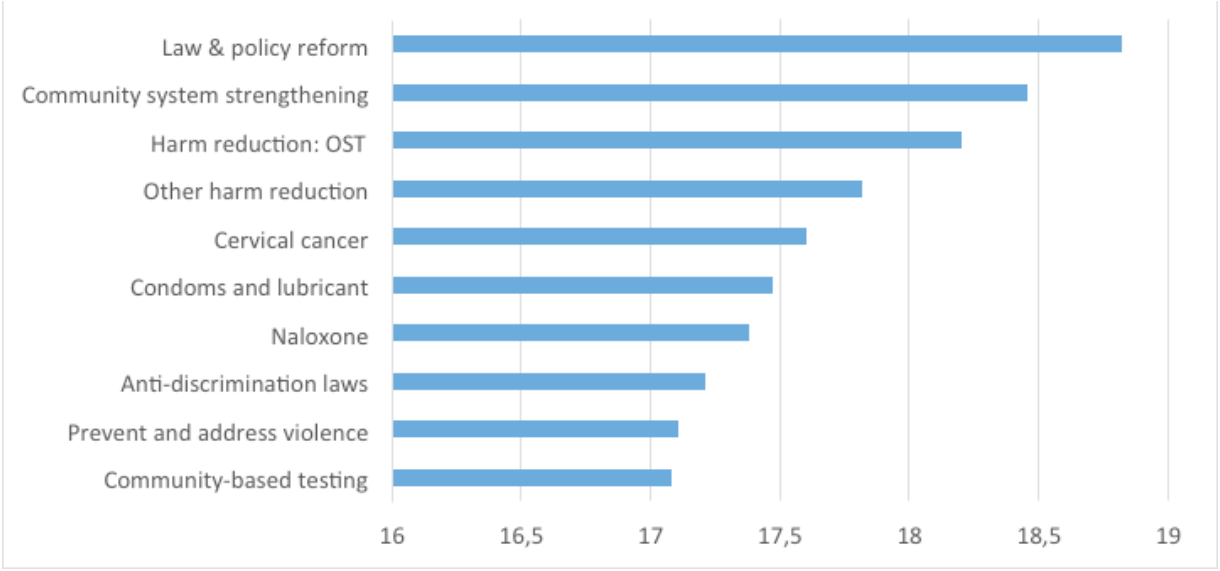
The group reported that they raised these recommendations in early consultations with a consultant for the Global Fund, but never heard back whether their recommendations were taken on board. "Being left out in that way was not good for us," said one peer educator. Subsequently Rodney Chalera and CEDEP staff engaged in ongoing advocacy over the concept note. Ultimately, they succeeded in increasing the national allocation for key populations programs, but their organization was not selected as a sub-recipient of the Global Fund grant. The "drought" in lube and condoms continues. "It's all there on paper," said Chalera. "But now we come into problems with implementation."

The pattern described by this group -- an initial consultation, lack of feedback, advocacy to press for a greater commitment, and ultimately failure to be selected as implementers -- was one repeated in varying forms across Sub-Saharan Africa, according to survey respondents.

4.3 Priority interventions

Key populations representatives interviewed for this report expressed frustration that the interventions they most prioritize, including prevention services, harm reduction and structural interventions, are the hardest to fund. Survey respondents were asked to identify their organizations' priority interventions from a list of 25 interventions recommended by WHO for key populations, all of which are also funded by both the Global Fund and PEPFAR.(26)

Chart 3: Top 10 priority interventions for survey respondents



Each of the 25 interventions received some votes, but those ranked among the top ten as priorities for most groups were largely non-medical interventions: law and policy reform, community systems strengthening, anti-discrimination and protective laws, and violence prevention, many of which overlap with and reinforce one another. Given the growing rates of injecting drug use and overall lack of access to harm reduction across the sub-Saharan African region, harm reduction interventions were also top priorities for many respondents, though relatively few respondents identified themselves as representing people who use drugs. Prevention measures, including access to condoms and lubricants and testing and treatment for cervical cancer, were also priorities for these respondents (see chart 3).

Interviewees were asked to explain their organization's priorities. Several respondents said their priority was to fund clinical services that are sensitive to the specific needs of key populations. Said Jay Mulucha, executive director of Fem Alliance Uganda, the stigmatizing attitude of many health care workers towards transgender men,

> *brings a lot of self-stigma and self-medication, which is dangerous for us. As Trans people, our health needs are different from other key populations. Hence we need much attention because we have gender-affirming problems.(27)*

For others, the most urgent need was for harm reduction services. James Eghaghe of the Nigeria Network of People who Use Drugs, which works with MSM and sex workers who use drugs, said,

> *There are no harm reduction services at all. During the Global Fund meeting in Abuja, we called for OST [opioid substitution therapy], needle and syringe exchange programs. It was not accepted; they didn't want to hear anything about it.(28)*

Wamala Twaibu describes the same lack of response to an urgent need for harm reduction in Uganda:

> *People are dying, people are injecting and overdosing and losing their lives, we lose people every day. We are referring drug users to Kenya and Tanzania to get treatment. PEPFAR keeps telling us that someday they will support us. I am so tired of someday.(29)*

Several interviewees working with men who have sex with men and sex workers said that their organizations had prioritized structural interventions to address human rights, including advocacy programs and legal aid services, but had also found this work difficult to fund. In Kenya, according to Brian Macharia of Gay and Lesbian Coalition of Kenya (GALCK):

> *The fact that we need to create a safe and enabling environment for services is not resourced. But it is critical. If you're going to walk outside with condoms and lube and you're arrested or harassed by police because you're carrying them, then the next time you will not carry condoms and lube. It rolls back the gains we have made.(30)*

Some interviewees emphasized that the environment for key populations they work in is fraught with danger, and listed security for key populations groups as a priority. In Cameroon, where LGBT advocate Eric Lembembe was tortured and assassinated in 2013, one LGBT activist said it is still a struggle to persuade donors to take the security risk seriously:

> *We feel a need [to offer legal aid] to victims of rights violations, and also for those of us who are community members, whose drop-in centers are often threatened. But there is no security plan, and when you have cases to manage you often feel a little abandoned. (Nous ressentons un besoin pour les personnes victimes de violation des droits, et même pour nous autres communautaires dont les centres d'écoute sont souvent menacés. Il n'y a pas un plan de sécurité prévu, et puis lorsqu'on a des cas à gérer on se sent souvent un peu abandonné.)(31)*

Many respondents also prioritized funding for community mobilization. In the words of Peter Njane of ISHTAR-MSM in Kenya:

> *It is something we are fighting for and will continue fighting for. As much as we come and talk about all our issues, they will not fund our organizations. They fund the mainstream organizations, but we are doing the mobilization.(32)*

Thus, while needs are wide-ranging and diverse, many African key populations representatives reported that they hoped their engagement with the Global Fund and PEPFAR during 2014-16 would lead to increased funding for key populations-sensitive clinics, prevention services, harm reduction services, human rights programs, and community mobilization. These were some of the priorities they brought to initial planning meetings at the national level.

4.4 Participation in consultations for National Strategic Plans

International health financing mechanisms have committed to investing in priorities that are identified in National HIV Strategic Plans (NSPs), which are developed in part through consultations with national-level stakeholders. Overall, more survey respondents participated in developing their NSPs than in any other governance consultations studied in the survey.

Forty-six percent of survey respondents (n=43) reported that they had participated in developing NSPs. Smaller numbers had seen the final plans and few knew their national HIV budgets. Thirty-six percent of respondents (n=34) said their national NSPs "meet a few key population needs, but there are many unmet needs."

While low, respondents who engaged in NSPs reported a higher satisfaction rate than that reported for the Global Fund and PEPFAR (see Chart 5). Nonetheless, there were numerous concerns about NSPs expressed in the comments fields of the survey:

> *[The past] NSP had some reference and data on KPs, but the new one seems to be more silent and abstract, loosely talking of the need for data, but without setting clear steps and indicators to address needs.*

> *The NSP includes the issue of key populations to satisfy donors, but there is nothing concrete on the ground [Le PSN inclu la question de la population cle pour juste satisfaire au bailleur mais sur terrain rien de concret].*

Those who were interviewed also reflected this mixed experience, which varied considerably among countries and key populations representatives. In Uganda, Wamala Twaibu said that people who inject drugs were mentioned in the NSP, but not identified as a key population: "We tried to push and engage so much, but finally in the strategic plan communities of PWID were not reflected."`(33)

In Tanzania, one activist raised issues relating to transgender people in the NSP meeting she attended, and won a commitment to do more. However,

> *Since it was late [in the process], I am not sure what they will do. We as key populations were just invited to review what was already written and make some necessary alterations.(34)*

In other countries, a struggle resulted in more tangible gains. Peter Njane of ISHTAR-MSM in Kenya said,

> *The moment you leave the room, your things go out the window. When Peter leaves, MSM go out the window, and the next time you come back, they have moved on to another chapter. But working with the NACC [National AIDS Control Council], we increased the mention of MSM in the KNASP [Kenya National Strategic Plan] from one line to pages and pages. Now the strategic framework is costed, and we can get something out of it.(35)*

In Malawi, Rodney Chalera of CEDEP also saw engagement with the NSP as resulting in a

commitment to address the legal rights of key populations:

> *Creating an enabling environment has now been taken on board. In the previous NSP, they refused anything on human rights.(36)*

Overall, advocates surveyed and interviewed for this report reported the greatest progress and optimism in relation to their work on NSPs. But once international donors entered the discussion, they said, the challenges with meaningful engagement appeared to multiply. As one anonymous survey respondent said wryly,

> *We are involved [in] the process. Once the money [comes] out we are not.*

4.5 Key populations and data

Size estimates of PLHIV and key populations are the basis for health service planning, prioritization and resource allocation at the national level. Specific budget amounts are often allocated based on numbers of sub-populations. Thus, health planning discussions begin with an estimation of the number of people who will need certain services.

However, in many countries, absent or implausible health data on key populations has created challenges in planning and resourcing for these communities. Size estimates for MSM and sex workers are often described by key populations groups as serious underestimates. In an added complication, the Global Network of Sex Work Projects has warned that the very conduct of size estimates can expose sex workers to the risk of police raids and abuse.(37) The result, according to Stefan Baral and Matthew Greenall, can be a "data paradox", in which health officials fail to do research on key populations, and the lack of data is used to justify political denial of key populations' very existence.(38) In particular, most African states have never reported size estimates at all for people who inject drugs and transgender people to UNAIDS.(39)

A majority (56%, n=52) of survey respondents reported that they knew the overall HIV prevalence in their country. However, fewer than half of respondents (47%, n=44) said they knew the HIV prevalence among their key population groups they represented, with 20% (n=19) raising questions about the data.

In many consultations, interviewees said they found themselves arguing over the size of their communities. Barbra Wangare, a gender diversity consultant in Kenya, said that there has long been a major gap in data:

> *I go to these meetings and ask "Where are the interventions for trans people?" They say, "We don't have data, there's nothing we can do." I say, "If you want data, the only way is to look for the numbers. You're not putting in the effort." There has never been a size estimate for trans in Kenya.(40)*

Allan Maleche, executive director of KELIN, which provided technical assistance on human rights to the Global Fund concept note in Kenya, agreed that the lack of data was a concern:

> *It was raised during our consultative meeting with the [Global Fund] drafting team, and they said they didn't feel it was a priority to do size estimates. Trans are not even named it the national strategic plan.(41)*

John Ochero of the Global Fund confirmed that Kenya currently has no size estimate for transgender people. He advised that health officials plan to do a new key population size estimate, but that the timeline has not yet been shared.(42)

In other countries, advocates reported that they had to fight to assert their very existence. According to Jay Mulucha of Uganda, where transgender people are also not mentioned in the NSP, the lack of data on transgender men is even more acute than for transgender women:

> *We have always asked for support to do research and come up with data, but all in vain, and yet I as a trans man know there's HIV among the trans men. People rarely believe in trans men. We have been left out of a lot of projects and activities.(43)*

Barbra Wangare in Kenya said that a challenge in counting transgender women is that

> *Femininity is frowned upon in Africa. You're not able to transition, you're not even able to self-identify....Because of the spaces I occupy...the closest identity I can work with is as a gay man, so I go to the clinic as a gay man, and my numbers go away.(44)*

Even for key populations who have size estimates, major errors may creep into the data. On the AIDSInfo website where UNAIDS aggregates HIV data reported by countries, Malawi's reported size estimate for sex workers appeared to have dropped drastically from 19,295 in 2013 to 9,338 in 2014. Inquiry to the UNAIDS Secretariat sparked a clarification that this was an error and "The leading 1, making it 19,000, was dropped."(45)

Peter Njane of Kenya reported that he and others debated with PEPFAR over the size estimate of 10,000 MSM for Kenya, which he felt was a serious underestimate:

> *We had disputes over how the data was collected. We questioned where they got their information. Donors were there, we're shown the final product, the money has been used, and the community didn't accept it.(46)*

4.6 Awareness of donor processes and tools

In addition to debating the epidemiological data, key populations representatives found that when they began to engage with the Global Fund and PEPFAR, they faced a steep learning curve, with a long list of abbreviations, tools and processes to master, sometimes in a second language. In addition, as both the Global Fund and PEPFAR have frequently modified their new systems based on feedback during the early implementation periods, tools mastered in one year often changed the following year.

The challenge in mastering this information is reflected in the survey results. Overall, respondents felt their level of information about the process and policies for both donors was low. The majority reported major information gaps.

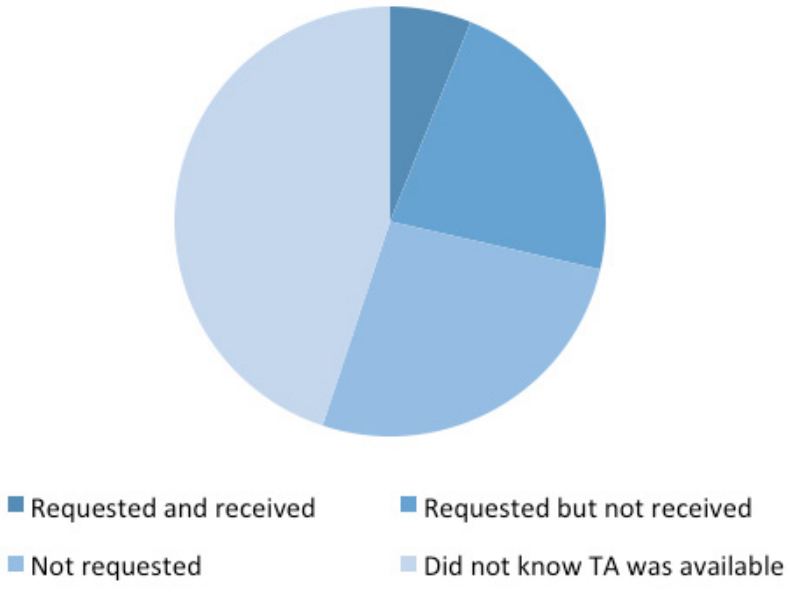
First, national HIV budget and expenditure information is largely inaccessible. Only six percent of respondents (n=6) said they knew the national budget and expenditures for HIV programs for their key population group. The majority of respondents had no information about the HIV budget or expenditures for their key population group (53%, or n=50).

Similarly, only seven percent of respondents felt they understand the Global Fund processes and tools well, and only six percent were familiar with the Global Fund's minimum human rights standards and complaints procedure. Only four percent (n=4) felt that they understood PEPFAR's processes and tools well. Interviewees shared many confusions over what the Global Fund and PEPFAR could and could not fund, and how priorities were selected. Only one interviewee was aware at all of the Global Fund's minimum human rights standards. Said the LGBT activist from Cameroon,

> *There is a huge opacity in the sharing of information. We are often hearing about some opportunity or project when the deadline for application has already passed. (Il y'a une grande opacité dans la diffusion des informations. Nous sommes souvent au courant de telles opportunité ou projet lorsque les délais de soumission sont dépassé.)(47)*

The Global Fund offered Community, Rights and Gender technical assistance to key populations to support their engagement in the consultations. However, nearly half of respondents were unaware that this was even available. Only three percent (n=3) of respondents reported that they requested and actually received Global Fund CRG technical assistance. An AMSHeR report on technical assistance provided in Angola highlighted some of these challenges, noting that "if the groups engaged earlier it would have increased the chances of having most if not all of their needs taken into account."(48)

Chart 4: Global Fund technical assistance



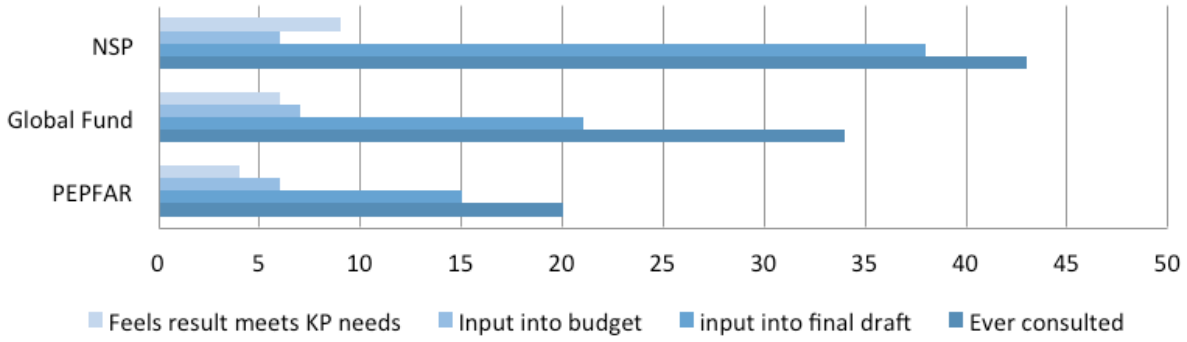
As a result, key populations representatives who engaged reported that they were sometimes unsure what was and was not already funded, what they could request funding for, how priorities would be set, and what the process would be for finalizing decisions. With this limited knowledge, key populations representatives started at a disadvantage in consultation processes.

4.7 Participation in health financing consultations

Fewer than half of the 93 respondents (n=43) had participated in any consultations relevant to HIV in their countries, the majority in development of the NSP. A smaller number had engaged in development of the Global Fund concept note (n=34), and only 20 respondents participated in consultations for PEPFAR. Respondents experienced a steep drop-off in their level of engagement over the course of the processes. Far fewer actually saw and input into final drafts of the concept note or COP than were initially involved in consultations. Fewer still reviewed the final budgets. It is unsurprising, then, that only six of those who participated in Global Fund consultations and only four who were consulted by PEPFAR felt that the resulting financing would meet "many or all needs" of key populations (see Chart 5).

The survey responses show a rapid diminution in the level of engagement of key populations, after an initial meeting, reinforcing an often-expressed perception that key populations were sometimes only brought in to endorse decisions that had already been made. This pattern was also illustrated in interviews.

Chart 5: Levels of KP engagement with NSP, Global Fund and PEPFAR



At the same time, many key populations representatives commented positively on the fact that these consultations were their first engagement with staff of the Global Fund, PEPFAR and UNAIDS Secretariat. Comments from survey respondents reflected this change, as well as the need for continued improvement; as one wrote about the engagement experience, "We are getting there, compared to two years back." Responsiveness assessments were at an average rating of 3 out of 5 (see Chart 6).

Small numbers of respondents reported that they had heard stigmatizing and discriminatory language by staff of all three organizations, with the largest number of reports relating to UNAIDS co-sponsors. Some were "unsure" if speech they had heard was stigmatizing. Respondents did not offer specific examples of this speech (see Chart 7). The UN currently offers sensitization training for staff, UN for All, which addresses human rights inclusivity in the workplace, SOGI, disability rights, and substance use. However, the training is not currently required for all UNAIDS staff.(49) In some countries, this training opened up conversations on key populations needs and issues where they were normally difficult to have. The Global Fund has provided ongoing in-house training on various key populations issues to grant management staff, and "several trainings have

been mounted for the Principal Recipient staff, sub-recipient staff, peer educators key populations clients who are project beneficiaries," according to John Ochero, Senior Fund Portfolio Manager for Kenya.(50) PEPFAR and implementing partners require staff to go through sensitization training on Gender and Sexual Diversity.(51)

Because the Global Fund and PEPFAR processes work differently and developed on different timelines, they are discussed separately in the following sections.

Chart 6: Responsiveness of staff

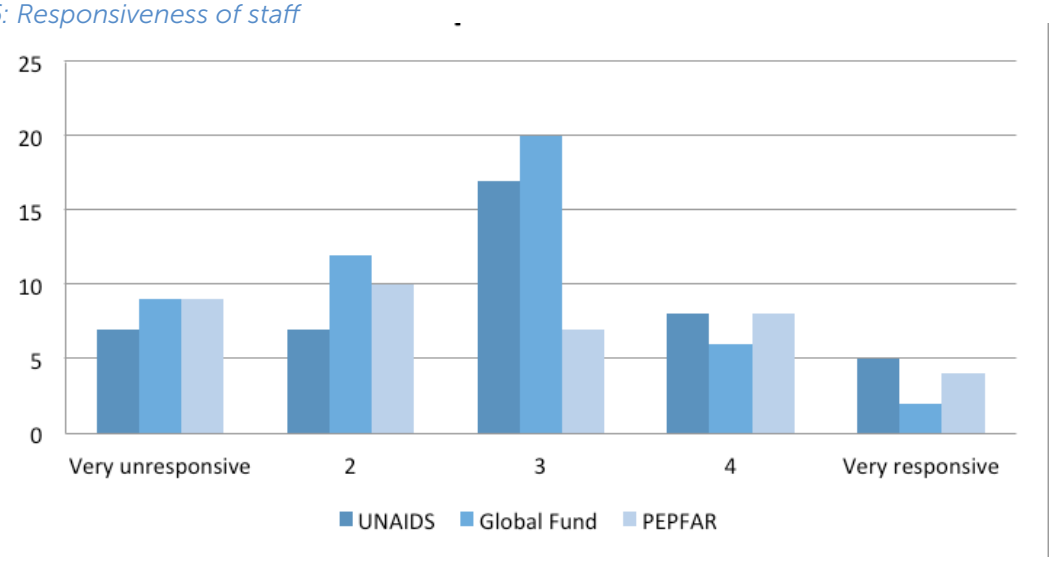
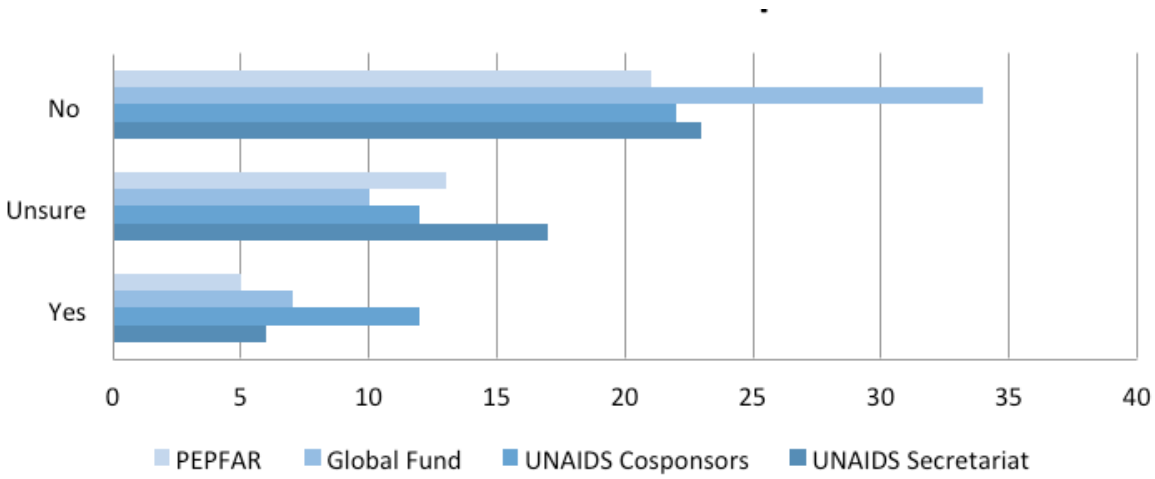


Chart 7: Number of reports of stigmatizing language used by PEPFAR, Global Fund, UNAIDS and UNAIDS cosponsors



4.8 The Global Fund to Fight AIDS, TB and Malaria

As described above, the Global Fund began its rollout of the new funding model in early 2013, and continually revised and developed the process based on feedback. Thus, the process of developing Global Fund grants during 2014-16 was often complex.

National stakeholders held initial meetings to consult on the concept note, drafts submitted to the Secretariat for feedback, and sometimes multiple iterations of review by the independent Technical Review Panel, resulting in a final concept note approved by the Grant Approvals Committee (a committee of senior managers and technical partners). After this approval, the concept note is turned into a grant agreement, a process of negotiation between the CCM and the Secretariat that often becomes less visible or transparent to community stakeholders.

This lack of access to information was reflected in comments by African key populations representatives. Often, stakeholder consultations happened in a rush, and then after an initial large meeting, the process vanished into a black box of private discussions between a few national actors and the Global Fund Secretariat. One anonymous survey respondent described engagement as "lack[ing] transparency in the budget and resource allocation. It does seem that our involvement is to rubber-stamp processes that are done without our involvement."

This was also the feeling of some key populations representatives in Kenya. Peter Njane of ISHTAR-MSM recalled that key populations formed a national network of MSM and transgender organizations to engage in health governance. After an initial series of meetings, though, communications with the network stopped. Overall, he felt

> *We were played. We really wanted to engage, we felt, "Just invite us and we will participate." They invited us to the first meeting, and we thought it would continue that way, but then, whoops! The concept note was sent out. It felt like a betrayal.(52)*

After the grant was signed and Kenyan key populations groups learned that their recommendations had not been taken on board, they collectively wrote to the CCM and the Secretariat to raise concerns. The collective advocacy by Kenyan key populations groups resulted in changes to the grant agreement, including a commitment to funding key populations groups through the Kenya Red Cross as Principal Recipient. Two key populations groups, Bar Hostess Empowerment Program and ISHTAR-MSM, were selected as sub-recipients.

Since then, Peter Njane felt things had changed for the better:

> *The Kenya Red Cross has brought a lot of positive energy, and meaningful involvement in planning processes. They are even beginning to think about human rights and structural interventions. It's commendable.(53)*

Responding to queries to the Global Fund, Senior Fund Portfolio Manager John Ochero confirmed this, sharing a list of access to justice, law reform, and community systems strengthening programs to be funded in Kenya, for a total of USD $1,449,339.(54)

Michael Akanji described a similar experience in Nigeria, with a less happy outcome. There too, he said, key populations formed a national secretariat to coordinate input. This worked well in his view until the Global Fund concept note was approved. Once the budgeting and implementation

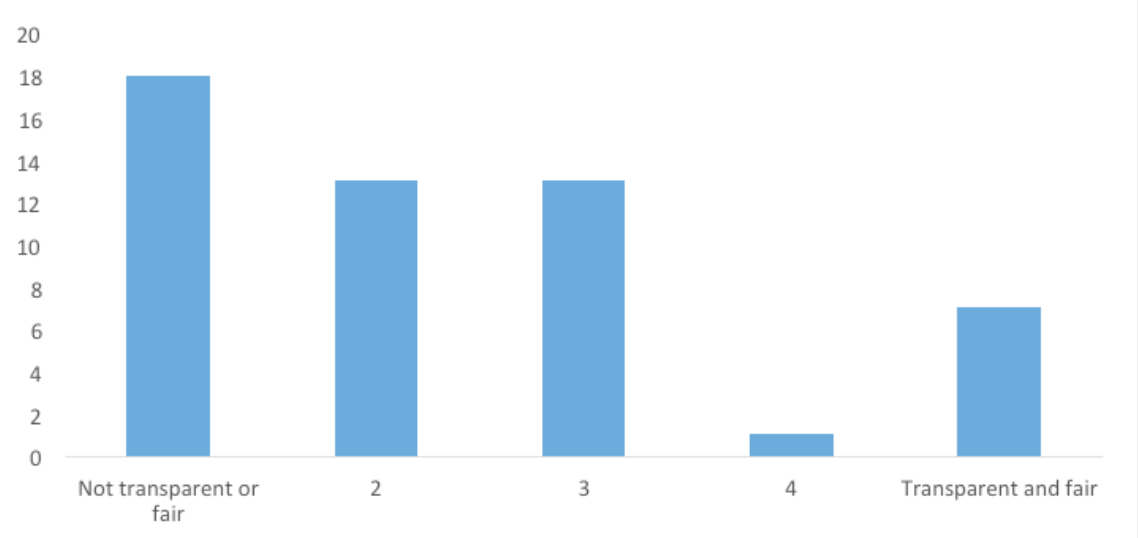
negotiations began, "Then it ends there....Up till now we don't know the budget....Along the line, we were pushed away."(55)

Similarly, James Eghaghe of the Nigeria Network of People who Use Drugs reported that he felt drug users were "puppets" in Nigeria's Global Fund concept note process. They were not afforded opportunities to present their concerns, and their proposal for harm reduction services was shot down by drug enforcement agencies:

> *The bigger agencies were not even helping, not even trying to stand for us. We were not included at all. We were shoved aside, at the end of the day.(56)*

A critical part of the grant-making process, after concept note approval, is the selection of Principal Recipients (PRs) by the CCM. The process should be an open and transparent competition. However, a majority of survey respondents described the process as not transparent or fair in their countries. Some respondents felt that the PRs were not qualified to reach key populations, and several described their national PRs as homophobic. While CCMs select the PRs, the Secretariat assesses the capacity of PRs to deliver programs; however, it is not clear if this process includes assessment of the organization's track record or policies in relation to key populations.(57)

Chart 8: Perceptions of process of selecting Principal Recipient



For some who were disappointed by their experiences in national consultations for the Global Fund, the best hope for Global Fund funding came through regional grants, a pool of funding set aside by the Board to finance regional advocacy and other initiatives that complement national health programs. A series of regional grants from the Global Fund has awarded funds to networks of key populations groups and human rights organizations across sub-Saharan Africa, including a $10.5 million grant to "address human rights barriers faced by key populations".(58) Interviewees also spoke positively about a regional harm reduction grant in sub-Saharan Africa, which is providing the first funding to some organizations that advocate for harm reduction.

4.9 PEPFAR

PEPFAR's new approach to consultation with key populations developed slightly after that of the Global Fund, in 2014-2015. As noted above, a smaller proportion of survey respondents reported that they were consulted by PEPFAR than by the Global Fund. PEPFAR staff responsiveness received the lowest ranking overall, with the smallest number of survey respondents answering PEPFAR-related questions. Similarly, relatively few interviewees had direct experience of consultation by PEPFAR. Those who did had similarly mixed experiences to respondents who engaged with the Global Fund, though several expressed optimism that the PEPFAR approach is evolving rapidly.

Reflecting the newness of this approach, Michael Akanji said that he first learned that the Country Operational Plan (COP) consultation process existed at all during his visit to Washington DC. When he asked colleagues at home in Nigeria if they had been consulted by PEPFAR, he said, "They were just involved in one final meeting for endorsement....You bring us on to say yes, yes, yes."(59)

Peninah Mwangi, executive director of the Bar Hostess Empowerment Project in Kenya, said that one challenge in PEPFAR's engagement of key populations was poor turn-out by participants in some meetings.

> *Many sex workers complained that the meeting venues were too far, and since there was no travel allowance, one had to choose between using their little resources to buy food or travel to the meeting. Luckily for the Global Fund engagement, meetings were organized by the community, which made an allowance for transport.(60)*

Peter Njane agreed that he found PEPFAR's processes bureaucratic and difficult to master. He found it particularly challenging to understand how and why PEPFAR prioritizes some interventions over others.(61) PEPFAR's COP 2016 guidance requires country teams to examine epidemiological, financial and other information to identify "core, near-core and non-core" interventions.(62) However, the criteria used to prioritize are somewhat vague, and what constitutes a core or near-core intervention may vary from one country to the next.

Despite the challenges, Njane described his experience of engaging with the COP process for Kenya as empowering; he felt that his concerns about underestimates of the size of the Kenyan MSM population were taken seriously, and that PEPFAR was willing to consider data coming from NGOs and other non-traditional sources.

As with the Global Fund, a number of interviewees and survey respondents raised concerns that the traditional partners of PEPFAR are large institutions that do not have a strong track record with key populations: "PEPFAR works with organizations that do not include the KPs in their planning process, but most times just invite KPs to endorse their implementation." Several survey respondents called for PEPFAR to engage key populations directly, rather than working through intermediary organizations. In June 2016, during the UN High-Level Meeting on HIV from which some key populations groups were excluded, PEPFAR announced the launch of a new $100 million fund to expand access to services for key populations. Specifics have not yet been announced.(63)

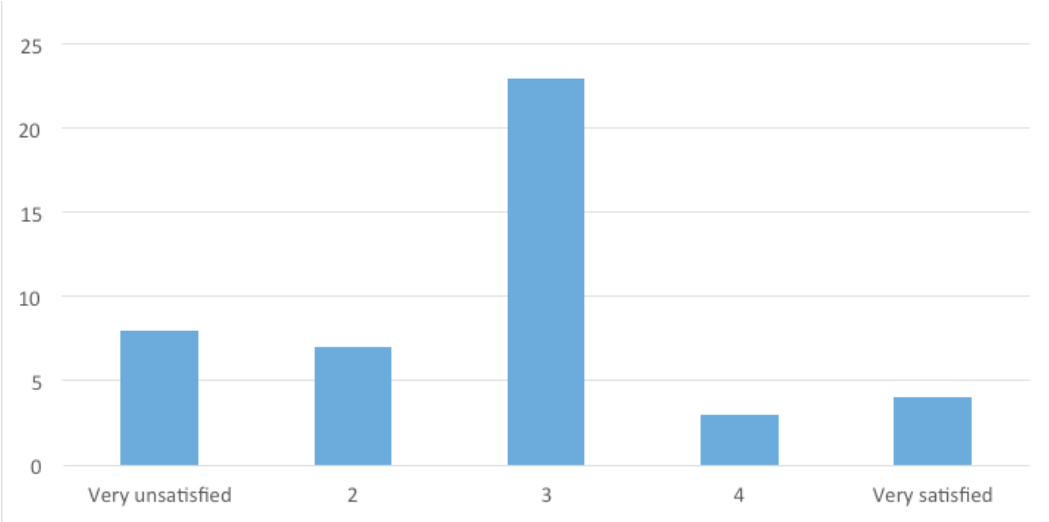
Some respondents saw encouraging good will and signs of progress in PEPFAR's new approach:

> *The staff are generally responsive and have expressed willingness to work with us. By their own admission this is a first, and they are willing to continuously engage us in the process.*

4.10 UNAIDS

As an advocate and coordinator of the global AIDS response, the UNAIDS Secretariat and UNAIDS cosponsors had a critical role to play. However, UNAIDS is also subject to pressure by UN member states. Key population views of UNAIDS were mixed, and the level of satisfaction with their work seemed to depend largely on staffing of the country office. Asked to rate their satisfaction with UNAIDS advocacy on a scale of 1 to 5, most respondents chose a median of 3. Few of those interviewed for this report said they had any experience of engagement with UNAIDS cosponsors, other than two interviewees who mentioned UNDP as positively supporting their advocacy on human rights and harm reduction.

Chart 9: Respondent satisfaction with UNAIDS advocacy to government on KP issues



In Kenya, sex worker activist Peninah Mwangi has found UNAIDS to be a good partner for sex worker organizations:

> *Sex workers have been engaging with UNAIDS over the last twenty years. They invite us for meetings and I'm in the KENYA-UN Joint Programme on HIV oversight committee. They are good advocates: they are able to communicate WHO policies on HIV programming for key populations to the government.(64)*

Similarly, a respondent from Liberia spoke positively of the role of UNAIDS in ensuring key populations are engaged, through "the formation of the first ever network of HIV key population members." Another wrote, "There is nothing that I can say except to give the UNAIDS country officials a five star [rating]."

However, a larger number of survey respondents wrote comments that were much more critical of UNAIDS' caution and close working relationship with government. As one wrote,

> *We firmly believe that UNAIDS can and should do more in supporting key populations in this country. However, the excuse that "the environment is not conducive" hinders any meaningful engagement on the matter, much to our disappointment.*

Another survey respondent reported that key populations groups in Zambia had written a letter to the UNAIDS headquarters to complain about what they saw as incompetence and homophobia at the country office.

Several interviewees noted that UNAIDS advocacy is largely done behind closed doors, making it difficult to evaluate, and urged greater transparency. Brian Macharia of GALCK in Kenya described some signs of increased engagement by UNAIDS on key populations' issues in recent years. He noted, "LGBT activists have often urged international partners to be cautious in their public statements, to ensure that MSM/LGBQ issues as not misconstrued as foreign or western issues."(65)

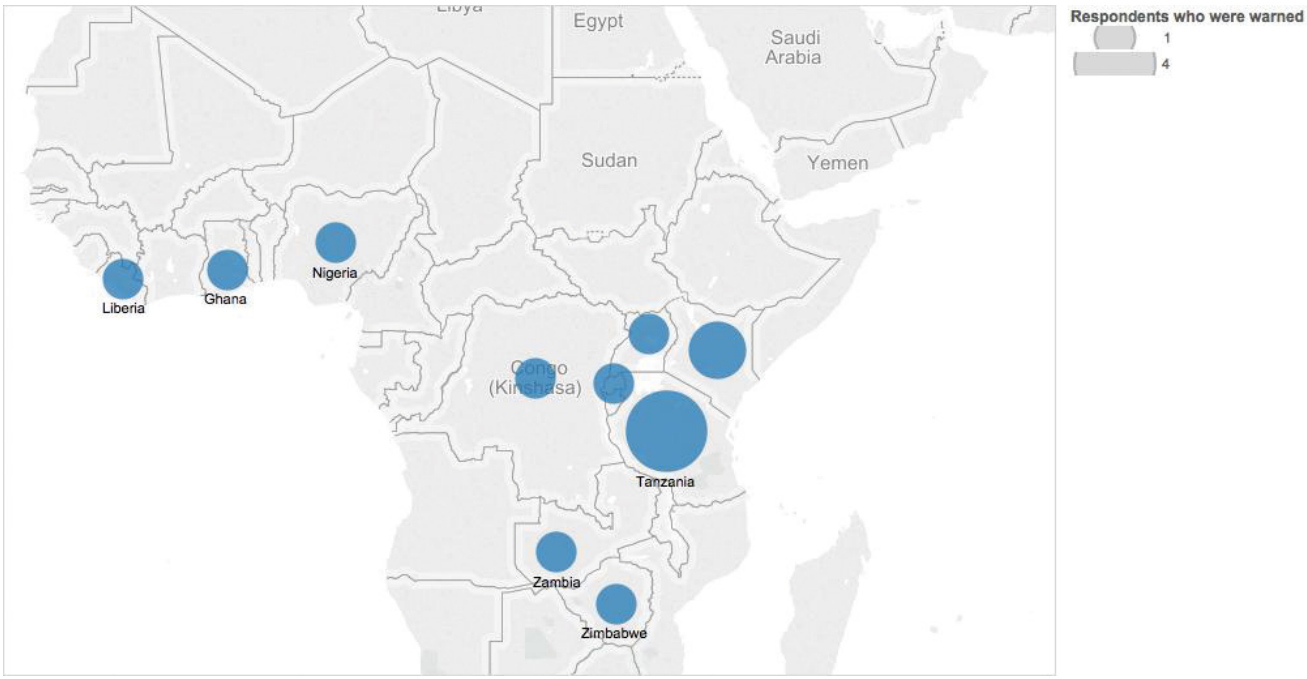
In the cooperation agreement between UNAIDS and the Global Fund, UNAIDS committed to addressing human rights issues. Survey respondents were asked whether they had been warned to avoid "sensitive issues" by anyone during national dialogues (see Map 2). Twelve percent of respondents (n=11) said that they had been warned, identifying government officials, PEPFAR staff, the National AIDS Council, the Principal Recipient, CCM members, donors, coworkers and friends as among those issuing the warnings. Five respondents said they had experienced negative repercussions because of things they had said in consultations:

> *I was threatened that I will never be invited for any further consultative meeting if I do not keep my mouth shut.*

> *To some extent, we stopped being involved or invited to a number of government and GF processes. However, due to our membership in other networks, we continued to contribute.*

Disturbingly, one transgender advocate, who requested anonymity, reported that she had been warned not to advocate for legal rights by the National Human Rights Institution. When asked why the NHRI had urged someone not to advocate for her rights, she said, "Fighting for our rights will be perceived as promotion of homosexuality. It also endangers [the NHRI] as people working very close to us."(66)

Map 2: Respondents who were warned to avoid "sensitive" topics in consultations



4.11 Access to funding for key populations

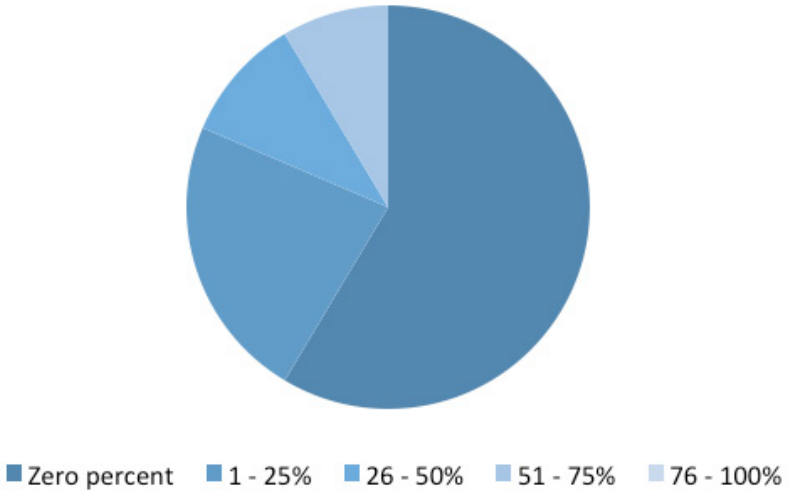
The end result of the intensive consultation and advocacy by some key populations advocates was sometimes difficult to see, as many reported that they never reviewed the final Global Fund or PEPFAR grants. Respondents were asked whether their organizations had in the past or would in the future receive funding for the Global Fund and PEPFAR, and only a handful responded positively (see Charts 12 and 13). In many cases, PEPFAR grants have not yet been signed, so this may change in the future. However, a June 2016 open letter by the AIDS and Rights Alliance of Southern Africa (ARASA) and the International Treatment Preparedness Coalition (ITPC) notes with concern that few key populations-led organizations in the region have been selected as implementers:

> *Having engaged extensively in country dialogues and invested unprecedented resources and effort to ensure the experiences of people living with HIV and key populations were captured in these processes, the institutions led by and focused on the needs of these communities have been left out when it comes to the implementation of the approved grants.(67)*

For key populations representatives, this is a serious problem, as some spent significant unfunded time in consultation processes. Most participants in health financing consultations are staff of larger organizations, including UN agencies, which are paid to provide technical expertise to health governance processes. Some were representatives of UN agencies and large international

or national NGOs with a five or ten-year history of receiving international health financing, and a strong interest in ensuring the support continued. But the key populations representatives, by contrast, were new to the discussions, faced steep learning curves, and mostly came from small NGOs with little funding to support their learning and engagement in the process. Some were employed at unrelated day jobs and used vacation days to work as community advocates. Others, like some members of the Lilongwe focus groups, support themselves through sex work with only minimal stipends for their HIV work.

Chart 10: Percentage of organization's time spent in consultations, 2014-15



Twenty-seven percent of survey respondents reported that their organizations spent more than 50% of their time on engagement with Global Fund and PEPFAR during 2014-15 (See Chart 10). In some cases, this time was partially subsidized by other donors, which provided grants or supported the cost of meeting rooms in order to facilitate key populations engagement. However, only one respondent described that funding as enough to cover the time their organization spent. Sixty-three percent (n=34) of respondents received no funding to cover the cost of engagement. Others received only some funding, or non-financial support, such as access to meeting rooms (see Chart 11).

Thus, many key populations representatives who engaged in the consultations -- not unlike some representatives of larger institutions -- hoped that their donated time would lead to institutional funding. One of the greatest causes for frustration reported by key populations representatives in the survey and in interviews was the failure to select key population-led NGOs as sub-recipients, sub-sub-recipients or implementing partners by the Global Fund and PEPFAR.

Chart 11: Number of respondents funded to engage in consultations

Did your organization receive funding to participate in NSP, Global Fund and PEPFAR consultations during 2014-15?

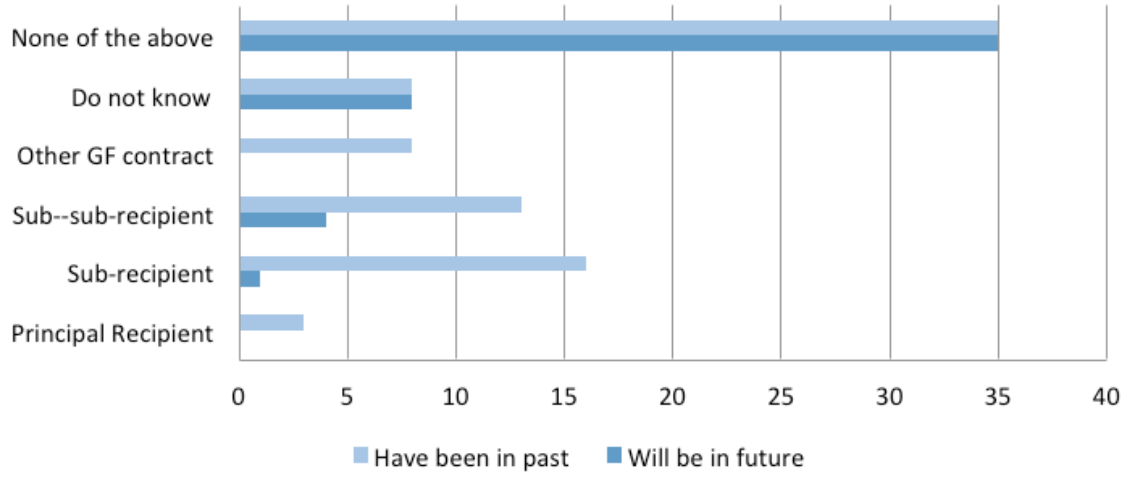
1= Yes, enough funding to cover the time spent.
2= Yes, but not enough funding to cover the time spent.
3= No, only received non-financial support (e.g. meeting rooms).
4= No, we received no support to engage.

A majority of those consulted for this report said that after the consultations, the Global Fund or PEPFAR did not fund key populations-led organizations that have worked for years in their communities. In Malawi, CEDEP estimates that the organization spent 70% of its time in both consultations for the Global Fund, and on work required by the Global Fund to conduct size estimates and strengthen the data to make the case for services to reach key populations. At the end, though, CEDEP was not selected as a sub-recipient:

> *I was frustrated with what I went through. The government always said, 'We need you here, what do you say about this,' and I had to contribute, even when it was something where I felt like 'Why do I have to do this?' Then coming to the point of not getting awarded the grant, I was frustrated.(68)*

James Eghaghe of the Nigeria Network of People who Use Drugs said the Nigerian Principal Recipient initially told the Global Fund that they would build the capacity of and fund key populations-led groups. After the grant was signed, Eghaghe said, the Principal Recipient selected other organizations instead for the reason that key populations groups could not receive funding because they were not legally registered.(69)

Chart 12: Respondents who have received Global Fund funding

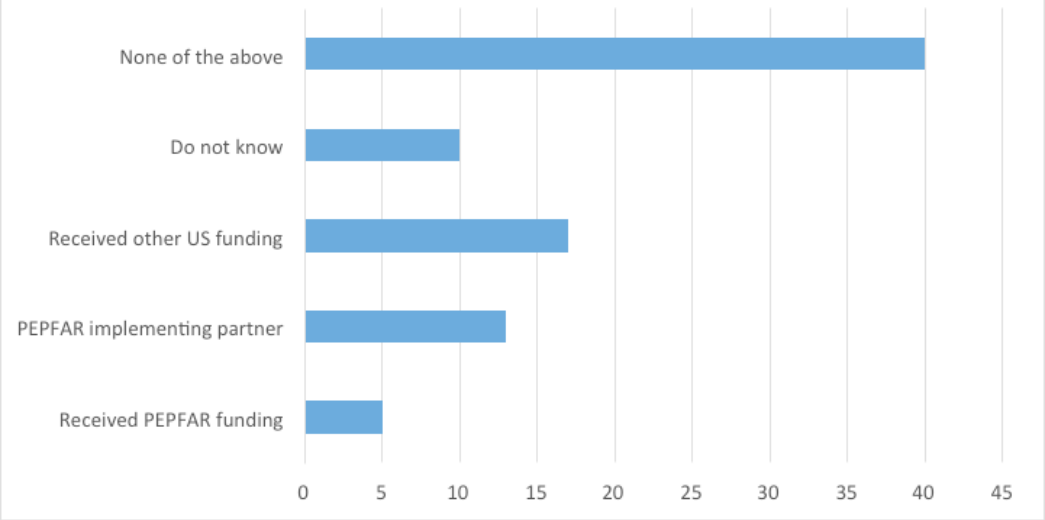


Accessing PEPFAR and other US funding can be additionally challenging for sex worker-led organizations, which are required to sign a pledge committing to not engaging in advocacy for decriminalization of sex work. Eight percent (n=8) of respondents were asked to sign the anti-prostitution pledge, and seven said they had done so. One said that their organization had refused to sign the pledge because they advocate for decriminalization. Another sex worker said,

> *You're between a rock and a hard place, so of course you sign. But...it doesn't stop me from calling for decriminalization of sex workers and for support of sex workers. I can always get support from other foundations.*

A number of respondents felt that larger organizations had advocated more effectively in their own financial interest. Said the Cameroonian LGBT activist, "Only the players know how to play the game (Sans que les acteurs ne se saisissent des enjeux)." It would seem that for these key population representatives, engagement in NSP, Global Fund and PEPFAR consultations, while a fundamental human right, was a costly one to exercise.

Chart 13: Respondents who have received PEPFAR funding



4.11 Accountability of key populations representatives

In addition to concerns about health governance mechanisms, government and INGOs, many respondents also raised concerns about key populations representatives and the degree to which some are grounded in the communities they represent. While a growing number of key populations representative have joined CCMs, respondents raised questions about the meaningfulness of the engagement.

Challenges to CCM engagement are many, and include late access to agendas for key populations representatives, large quantities of English-language material to review on short deadlines, lack of institutional support or planned time to enable representatives to consult with and report back to their constituencies in advance of critical decisions made by the CCM, and "majority

rules" voting systems at the CCM which mean that a sole key populations representative can be easily outvoted by a majority of government and other large institutional representatives.

In several cases, respondents complained that the CCMs had met the requirement to appoint a key populations representative by selecting someone who is not consulting with and reporting back to their communities. In other cases, key populations representatives lack the resources to engage in regular consultations.

A French-speaking respondent commented,

> *The key populations representative on the CCM is an opportunist who works for his own interest, and has a family relationship with the minister of health. No information or communication is done between him and the community. (Le representant de la population clé au CCM est une personne opportuniste qui travaille pour son propre compte et ayant des affinités famililale avec les ministre de la santé. Aucune information ou communication n'est faite entre la communauté et lui.)*

In Nigeria, Michael Akanji asked rhetorically,

> *They're not really bringing people on board based on their expertise; they're only bringing representation for endorsement. Is representation just sitting around the table? Or is it bringing community members who have expertise and who have been involved in implementation at the field level?(70)*

For some key populations advocates, the solution to this is to engage in wider and deeper community mobilization. Said Barbra Wangare in Kenya,

> *Things are moving now in our country. The movement by donors like Global Fund and PEPFAR are opportunities creating spaces for organizations to work with us. We need to strengthen accountability for all organizations, including those that are trans-led.(71)*

Brian Macharia of GALCK in Kenya said that a focus of his network is to build the capacity of their member organizations, strengthen leadership, and "get leaders to cascade opportunities for growth and learning to their community by sharing information."(72)

The peer educators in the Lilongwe focus group seemed open to the idea of building stronger connections. At the end of the discussion, while organizers took care of paperwork, the MSM, transgender and sex worker peer educators compared notes on skincare products, joked about their preferred sizes and flavors of condoms, mocked high-class escorts who look down on street sex workers but who may not be as smart about using condoms, and swapped cell phone numbers. They advised Rodney Chalera that they wanted CEDEP to bring MSM, transgender people and sex workers together more often, and not just for health financing consultations. "It turns out we have a lot in common," said one.

5. Conclusions

The Global Fund and PEPFAR have undertaken to significantly change their business models in the past two to three years. The shift towards consultation has opened up new space for advocacy at the national level, and has created an opportunity to develop a more targeted, effective and strategic global HIV response that truly fulfills the right to health for those most vulnerable to HIV.

However, the reality at the national level is that there are significant financial and political interests that are deeply entrenched and reluctant to give up power. Toxic national politics that scapegoat key populations, the erasure of key populations during competitions at the national level over international aid, and a trend towards closing civil society space, also create new challenges. Thus it is not surprising that a majority of key populations representatives surveyed for this report expressed overall dissatisfaction with consultations that promised so much, consumed so much of their time, but in the end, often did not result in improved access to funding.

The UN Common Understanding on a Human Rights-Based Approach to Development states clearly that the right to be consulted on development aid is a fundamental human right, and one that all UN agencies are committed to upholding. UN agencies that support health financing consultations, including UNAIDS Secretariat and UNAIDS co-sponsors should adopt a clear and public zero-tolerance policy on any stigmatizing language used by UN staff, and on any censorship or retaliation against community representatives who participate in health governance and financing consultations.

That said, most of those surveyed expressed cautious optimism. Most said they would continue to engage, while asserting that much remains to be done to deliver on the promises made by the Global Fund, PEPFAR, UNAIDS, and UNAIDS co-sponsors, and urging these mechanisms to continue to strive to improve their accessibility and their working partnership with key populations-led organizations.

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Annex 1: Survey instrument

A. About you

Question 1

Which specific key population groups does your organization represent? [Select all that apply]

X People living with HIV
X Sex workers
X Men who have sex with men
X Transgender people
X People who use drugs
X Lesbian, gay and/or bisexual people
X Migrants
X Refugees
X Prisoners
X Women
X Youth (15-24yrs)
X Children (under 15yrs)
X Other groups [Please list]

Question 2

What is the legal status of your organization? (Select all that apply)

X Registered
X Not registered
X Registration is in process
X Funded through a fiscal sponsor

Question 3

In which country is your organization based?

Question 4

What region does your organization cover through its work?

Question 5

Has your organization ever been principal recipient, sub-recipient or sub-sub-recipient of the Global Fund? (Select all that apply)

X Principal recipient
X Sub-recipient
X Sub-sub-recipient
X Will be a principal recipient in next round of funding
X Will be a sub-recipient in next round of funding

X Will be a sub-sub-recipient in next round of funding

X None of the above

Question 6

If your organization has received funding from the Global Fund, please specify the years.

Question 7

Has your organization ever received funding from PEPFAR? (Select all that apply)

X Received funding from PEPFAR

X Implementing partner of PEPFAR

X Received other U.S. funding

X Never received any U.S. funding

Question 8

If your organization has received funding from PEPFAR or other U.S. funding, please specify the years:

Question 9

If you answered yes to question 7, was your organization required to sign an anti-prostitution pledge?

X Yes

X No

Question 10

If your organization was asked to sign an anti-prostitution pledge, did you sign?

X Yes

X No

X Other

Comments on any question in this section:

_____

_____

_____

_____

B. Priorities

Question 11

Below is a list of the interventions WHO recommends for key populations. What are the TOP THREE key interventions your organization wanted to see addressed in the National Strategic Plan, Global Fund concept note, or PEPFAR COP during 2014-16? Please select only 3.

HIV Prevention

X Condoms and lubricant
X Pre-exposure Prophylaxis (PrEP)
X Voluntary medical male circumcision (VMMC)

Harm reduction for people who use drugs

X Needle and syringe programs
X Opioid substitution therapy
X Other evidence-based interventions for people with harmful alcohol or other substance abuse
X Naloxone

HIV testing and counseling

X Voluntary testing and counselling
X Community-based testing and counselling

HIV treatment and care
X Anti-retroviral therapy
X Prevention of mother-to-child transmission

Prevention and management of co-morbidities and co-infections

X TB
X Hepatitis B and C
X Mental health

Sexual and reproductive health services

X STIs
X Reproductive options
X Abortion services
X Cervical cancer
X Conception and pregnancy care

Critical enablers

X Review and reform of laws and policies
X Antidiscrimination and protective laws
X Community empowerment programs
X Prevent and address violence

Other

X Community systems strengthening
X Human rights training
X Please specify others:

C. Participation in Health Governance

Question 12

Does someone from your organization represent key populations in the CCM in your country?

X Yes
X No

Question 13

Is someone from your organization a member of the UNAIDS Programme Coordinating Board?

X Yes
X No

Question 14

Is someone from your organization involved in any other global, regional or national health governance body? (Select all that apply)

X Global
X Regional
X National
X No one from my organization is in any other health governance body

Question 15

Do you know the overall HIV prevalence in your country?

X Yes
X Some information
X No

Question 16

Do you know the HIV prevalence among the key population group(s) your organization represents?

X Yes
X Some information
X No

Question 17

Do you know your country's budget and expenditures for HIV programmes among your key populations group?

X Yes
X Some information
X No

Question 18

Did your organization participate in consultations to develop the National HIV Strategic Plan (NSP) in your country?

X Yes
X No

Question 19

Have you seen the final National HIV Strategic Plan?

X Yes

X No

Question 20

To what extent do you believe the NSP meets the needs of key populations?

1. Did not meet any needs of key populations
2. Met a very few needs
3. Met some needs
4. Met quite a lot of needs
5. Met all needs
6. I have not seen the NSP

D. Experience with UNAIDS

If you have met staff from the UNAIDS Secretariat, including the country office, please complete this section. If you have not, please skip to section E.

Question 21

Please rate how responsive you have found representatives UNAIDS Secretariat, including the country office, on a scale of 1 to 5:

UNAIDS Country office (or regional office, if there is no country office)

1	2	3	4	5
unresponsive				very responsive

Question 22

Have you heard stigmatizing or discriminatory language about key populations used by staff of the UNAIDS Secretariat (including the country office)?

X Yes

X No

X Unsure

Question 23

Have you heard stigmatizing or discriminatory language about key populations used by staff of UNAIDS Cosponsors (UNHCR, UNICEF, World Food Programme, UNDP, UNFPA, UNODC, UNWomen, ILO, UNESCO, World Health Organisation, the World Bank)?

X Yes

X No

X Unsure

X Never met staff from UNAIDS Cosponsors

Question 24

How satisfied are you with UNAIDS Secretariat (including the UNAIDS Country Office) as advocates to the government on key populations issues?

1 2 3 4 5
Very dissatisfied Very satisfied

Question 25

How satisfied are you with UNAIDS Cosponsors as advocates to the government on key populations issues? (The cosponsors are UNHCR, UNICEF, World Food Programme, UNDP, UNFPA, UNODC, UNWomen, ILO, UNESCO, World Health Organisation, the World Bank)

1 2 3 4 5
Very dissatisfied Very satisfied

Question 26

Any other comments on UNAIDS?

E. Experience with the Global Fund to Fight AIDS, TB and Malaria

Question 26

How well do you understand how Global Fund funding works, the processes and tools used? Please rate on a scale of 1-5.

1 2 3 4 5
Don't understand Well informed

Question 27

Do you know what the minimum human rights standards are for Global Fund-financed programs, and/or how the Global Fund's human rights complaints procedure works?

Please rate on a scale of 1-5.

1 2 3 4 5
No information Well informed

Question 28

Has your organization engaged in Global Fund country dialogue or other processes?

X Yes

X No

If you answered yes to Question 28, please continue. If you answered no, please skip to section F.

Question 29

Did your organization request Community Rights and Gender technical assistance for the Global Fund concept note?

X Yes, we requested technical assistance and it was delivered

X Yes, we requested technical assistance but it was not delivered
X Yes, we requested technical assistance, but I do not know if it was delivered
X No, we did not request technical assistance
X I have never heard of Community Rights and Gender technical assistance

Question 30

Did your organization review the Global Fund concept note and provide input before it was submitted?

X Yes
X No

Question 31

Was the Global Fund grant budget shared with your organization before the grant was signed?

X Yes
X No

Question 32

How would you rate the process for selection of Principal Recipient in your country? Please rate on a scale from 1 to 5:

1 2 3 4 5
Not transparent or fair Very transparent and fair

Question 33

Is your organization engaged in monitoring or oversight of the Global Fund grant?

X Yes
X No

Question 34

To what extent do you believe the Global Fund grant meets the needs of key populations?

Did not meet any needs of key populations
Met a very few needs
Met some needs
Met quite a lot of needs
Met all needs
I do not know what is included in the Global Fund grant

Question 35

Please rate how responsive you have found the Global Fund Fund Portfolio Manager and program officers, on a scale of 1 to 5:

1 2 3 4 5
Unresponsive Very responsive

Question 36

Have you heard stigmatizing or discriminatory language about key populations used by staff of the Global Fund?

X Yes

X No

X Unsure

Question 37

Any other comments about the Global Fund?

F. PEPFAR

Question 38

How well do you understand how PEPFAR funding works, the processes and tools used? Please rate on a scale of 1-5.

1 2 3 4 5

Don't understand Well informed

Question 39

Do you know what PEPFAR country offices can do to address human rights in the context of HIV?

1 2 3 4 5

No information Well informed

Question40

Has your organization engaged in PEPFAR Country Operational Plan (COP) consultations?

X Yes

X No

If you answered yes to this question, please continue. If you answered no, please skip to section G.

Question 41

Did your organization review the draft COP and provide input before it was submitted?

X Yes

X No

Question 42

Was the PEPFAR budget for your country shared with you before it was finalized?

X Yes

X No

Question 43

To what extent do you believe PEPFAR's funding meets the needs of key populations?

1. Did not meet any needs of key populations
2. Met a very few needs
3. Met some needs
4. Met quite a lot of needs
5. Met all needs
6. I do not know what is included in PEPFAR's funding

Question 44

Please rate how responsive you have found the PEPFAR Country Coordinator and PEPFAR country team

1	2	3	4	5
Unresponsive				Very responsive

Question 45

Have you heard stigmatizing or discriminatory language about key populations used by any staff of PEPFAR?

X Yes

X No

X Unsure

Question 46

Any other comments about PEPFAR?

G. Rating your Experience

Question 47

How much time did your organization spend in NSP, PEPFAR, and Global Fund consultation processes altogether in 2014-15?

1. No time
2. 0-25% of our organization's time
3. 25-50% of our organization's time
4. 50-75% of our organization's time
5. 75-100% of our organization's time

Question 48

Did your organization receive funding to participate in the NSP, Global Fund and PEPFAR consultation processes during 2014-15?

X Yes, we received enough funding to cover the time spent

X Yes, we received funding, but not enough to cover the time spent

X We only received non-financial support (e.g. meeting rooms)

X No, we received no funding to participate in any of these consultation processes

Question 49

Please rate how meaningful you feel the participation of your organization or key populations network has been in the following processes on a scale from 1 to 5. "Meaningful" means that you feel the participation has had enough impact to justify the time spent. .

National Strategic Plans

1 2 3 4 5

Completely meaningless Very meaningful

Global Fund country dialogue

1 2 3 4 5

Completely meaningless Very meaningful

PEPFAR COP

1 2 3 4 5

Completely meaningless Very meaningful

Question 50

Were you warned by anyone to avoid any "sensitive" topics during the NSP, Global Fund concept note, or PEPFAR COP processes?

X Yes

X No

Question 51

If you answered yes to Q50, who warned you to avoid "sensitive" topics? Select all that apply:

X Government official
X UNAIDS Secretariat (including country office)
X Other UN staff (not UNAIDS)
X PEPFAR staff
X Donor to my organization
X Co-worker
X Family
X Friend
X Other (specify)

Question 52

Did you experience any problems because of things you said in consultations for the NSP, Global Fund or PEPFAR?

X Yes

X No

Question 53

Do you have any other comments or experiences to share for the report?

Question 54

Are you willing to be interviewed for the report? If so, please share your name and email address. Some people may be contacted for an interview:

Name Email

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SUMMARY

In 2014-16, The Global Fund to Fight AIDS, TB and Malaria ("The Global Fund") and the U.S. President's Emergency Plan for AIDS Relief ("PEPFAR") have both taken steps to significantly increase their transparency and consultation with the key populations most affected by HIV: sex workers, men who have sex with men, people who inject drugs, and transgender people. In response, many countries have seen an unprecedented level of activity by key populations-led groups to engage with these processes. But despite intensive engagement, key populations report that their work remains underfunded. This report presents findings from a survey and interviews with representatives of key populations to analyze how well this is working in practice, and recommendations for future action.

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