



CDC and the Key Population Investment Fund (KPIF) Successes and Challenges

A Report from MPact: Global Action for Gay Health & Rights





Content

Summary

What is PEPFAR ?

What is KPIF ?

Overview

Important Takeaway

Highlights

Areas of Improvement

Conclusion

Summary

The President's Emergency Plan for AIDS relief, colloquially known as PEPFAR, is one of the United States' most effective tools in the global fight against HIV/AIDS. To date, PEPFAR remains the largest commitment by any nation to address a specific disease in history. PEPFAR houses multiple initiatives, including the Key Population Investment Fund (KPIF), which was an initiative specifically designed to increase access for various key populations (KPs). Using

insight and input from various stakeholders, this brief report highlights the importance and promise of KPIF while also identifying some key areas for improvement. Based on the interviews, respondents identified four (4) overarching "highlights" or success stories as well as two (2) barriers to success. However, it is important to note that overall, KPIF has proven to be an incredibly effective tool in assisting the most systematically disenfranchised populations

What is PEPFAR?

PEPFAR was launched by President George W. Bush in 2003. Often with bipartisan support, PEPFAR maintains a healthy budget. For example, in 2020, PEPFAR had access to \$6.3 billion compared to \$2.19 in 2004; it represents 64% of our nation's global health expenditures. Although officially housed under the U.S. Department of State, the success of PEPFAR relies on various partnerships including U.S. agencies such as the U.S. Agency for International Development (USAID), Centers For Disease Control and Prevention (CDC), as well as civil society organizations (CSOs) and the

governments of the host country. PEPFAR's work spans the globe. At its core, PEPFAR focuses on expanding access to HIV prevention and treatment, but the strategy varies based on the country and issue at hand. Harm reduction efforts for injection drug users and sexual prevention programs (including condoms & PrEP) are often utilized, but most countries must specifically outline their strategy in a Country Operational Plan (COPs). The impact of PEPFAR cannot be overstated. The list below is a mere snapshot of PEPFAR's impact at the global level.

- Supported HIV testing for nearly 80 million people
- Prevented Vertical HIV transmission of 2.5 million babies
- Trained nearly 300,000 new healthcare workers
- Provided antiretroviral treatment for over 15 million people

What is KPIF?

KPIF was a \$100 million investment specifically designed to increase access for key populations which includes: men who have with men (MSM), people who inject drugs, sex workers, and transgender individuals. It is important to note that KPIF represents a paradigm shift in funding. KPIF provides critical resources to push new

approaches for HIV prevention, treatment, care and support. ***Under the fund, key populations were not just invited to the table, instead, they were asked to help build the table. KPIF was intentionally designed to provide funding to KP-led, KP-competent, and KP-trusted organizations.***

02

Overview

As previously mentioned, PEPFAR is implemented through various organizations, including the CDC. The individuals interviewed for this report were all referred by the CDC; the titles range from CDC country director to CSO leader to member of a key population. This approach was intentional as we wanted to capture as many experiences and perspectives as possible. . In order to ensure anonymity, names of individuals, job titles, and specific places of employment were omitted.

Overall, the interviews were seeking to understand the following:

- Importance of maintaining KPIF in PEPFAR's portfolio
- Feedback to funders and key partners
- Identifying the components that were (or were not) successful for key populations.

Important Takeaway

Highlight	Area of improvement
1: More productive partnerships	1: Perception of Gatekeeping
2: Increased engagement by removing structural barriers	2: Various attitudinal barriers
3: Enhanced institutional capacity via trainings	
4: New model of empowerment	

Highlight

1: More Productive Partnerships: KPIF proved crucial in the development of constructing more effective partnerships, and this is true for both existing and proposed new organizations. KPIF provided resources and support in a way that allowed new KP organizations to flourish and function. First, it increased the pool of KP competent organizations that a government could partner with. As one respondent stated, “many organizations I just named would not exist without KPIF.” Another respondent noted, “KPIF has allowed us to expand to 36 other states and municipalities.” In many countries, especially African nations, government based facilities are often the sole provider of HIV related care. In turn, their medical system is often overburdened and/or KP members rarely feel safe in an “official” government building. KPIF played a vital role in filling the gap. In one instance, the interviewee explained that 9 out of 10 HIV tests at a government site are dedicated to pregnant women. Thus, KPIF was critical in providing KPs a safe space to receive an HIV test.

KPIF also helped the implementation of KP led partnerships. In a Latin American nation, KPIF was used to establish a robust private-public partnership with an existing KP organization that previously lacked resources.

On the other hand, KPIF highlighted the need for other types of partnerships, ones that did not exclusively focus on biomedical interventions. For example, in one African country, KPIF was directly responsible for the construction of an organization that was designed to assist in communication and advocacy. Many expressed that KPIF funding allowed organizations to focus on their “unique needs,” whereas larger, government organizations often ignore the communities or blatantly stigmatize their efforts. KPIF exponentially increased access by providing organizations the ability to do the work that government often refuses to do.

Lastly, these partnerships were incredibly important because it helped KP organizations “formalize.” In many instances, there was already mobilization and outreach, but no “official capacity.” As one respondent explained, “KPIF helped organizations see what was possible and why having an actual org matters.” From monthly report budget breakdowns, increased index testing to following up on MER indicators, KPIF partnerships allowed for “consistency, cohesion and comprehensive approaches,” for a country’s most marginalized citizens. In turn, key populations not only felt tolerated, instead, they felt supported; additionally, the investment in KPs represented a shift in resources and signified the importance of lived experience/expertise.

2: Mitigating Structural Barriers: In addition to being an effective tool for establishing partnerships, KPIF was crucial in alleviating various structural barriers that disproportionately impact key populations. During an interview, a country director stated, “organizations often fail to have bank accounts, and are surprised to learn that we can’t disperse funds. Just one example of a barrier that most people wouldn’t think about.”

KPIF was used to pilot an ART home delivery program to individuals who felt intense shame or guilt from living with HIV that prevented them from leaving their home. Additionally, KPIF was specifically used to reach KPs who were not located in major metropolitan areas; as one stakeholder stated, “without KPIF, I can’t imagine what rural outreach would look like.” There was often a constructed and purposeful outreach

plan for KP communities in locations that have yet felt the impact of PEPFAR or Global Fund. In one instance, KPIF was explicitly used to fund a new Undetectable=Untransmittable (U=U) campaign that specifically targeted Indigenous transwomen and MSM in their native language opposed to Spanish. In this same country, KPIF was used to help agricultural workers living with HIV secure more stable employment, a known risk factor for both (1) acquiring HIV and (2) being retained in care.

In other scenarios, same sex intercourse and injection drug use is not only stigmatized, but illegal and actively policed, representing a massive structural barrier to these communities. Interviewees explained that KPIF was used to directly mitigate the impact of these archaic beliefs and policies. For example, one organization created a network of “safe houses,” unmarked

locations where wraparound HIV services are provided. In other situations, KPIF money was used to train members of the key population to be employed as paralegals within the KP led CSOs.

Structural barriers are incredibly difficult to dismantle, but KPIF has been able to chip away at various systemic inequities. One of KPIF’s most important tools was access to various trainings, which were led by multiple parties including KPs and members of the CDC. As one respondent explained, “it’s hard to beat a system when you don’t know how it works.” KPIF offered a plethora of trainings, and often, these trainings were designed to eliminate structural barriers. As a direct result of the fund, recipients of KPIF were able to draft and deliver independent, tailored trainings that they felt centered their unique needs and lived experience.

3: Increased Institutional Capacity: Every single interviewee vocalized KPIF exponentially increased KP organization’s institutional capacity. For organizations who already had set infrastructure, KPIF allowed for them scale up previously successful campaigns and projects. However, for others, KPIF was essential to the success of the organization.

First, institutional capacity was increased via trainings that resulted in tangible skills. One of the most important expansions of capacity was in financial and account management. Under KPIF, KP organizations frequently requested and received trainings on US reporting requirements and other financial information. For instance, in one African nation, 3 KP organizations used KPIF to learn better accounting procedures by tracking invoices and payments. They also used funds to host various funding proposal workshops. As one KP member stated, “we want to be able to do this on our own. This feels like a start.”

Second, institutional capacity is bolstered by investing in human infrastructure. KPIF was used to increase capacity by bolstering employment opportunities, both internal and external. One country director explained that in their country, transwomen and feminine gay men often have no employment opportunities, but KPIF changed this reality. Individuals could find employment within the KP org, and in some instances, they completed interview trainings and resume workshops.

Finally, individuals expressed the importance of KPIF being used to help new KP orgs develop their vision/strategic plan. When asked to elaborate on this, one CSO leader stated, “we are normally told, here is the money. Now, here is how many people to test and this is how to do it. But KPIF was different. It asked us, what would your organization do? What do you want to do?”

4: Empowerment: One of the most promising takeaways in this report is that KPIF allowed for the empowerment of the KPs. As one proudly boasted, “it feels like KPIF ushered in a new model of HIV service delivery for the community.” For the first time, local initiatives were KP designed, KP led, and KP compensated. Instead of talking about KPs, KPIF provided the framework for talking with KPs. When asked how/why KPIF is different, there were a multitude of answers. For many, this was the first time that PEPFAR asked them about their needs; one director stated “KPIF is rooted in the needs of the community. Who knows what KPs need more than the KPs.” This sentiment was reinforced by others. In one instance, a KP CSO leader was explicitly asked by a government official “how can we provide

services better,” a question he said he was never asked before the rollout of KPIF.

The power of KPIF assisted trainings was previously highlighted, but it is important to note who conducted the training and what perspective was bolstered. In virtually every instance, trainings were developed and administered by the KPs themselves. On multiple occasions, interviewees stated that they would much rather train members of their community to do the work compared to a “health worker that’s a stranger.” This represents a massive paradigm shift on who receives training. Health workers are no longer perceived as the default medical authority, instead, KPs were assumed as subject matter experts and delivered trainings that centered their needs.

Area of improvement

KPIF has proven to be an effective tool in our global fight against HIV/AIDS. As a fund that focuses on highly stigmatized populations, it must be preserved. Generally, individuals expressed a strong sentiment that the fund is effective now, but it could be enhanced over time.

Highlights above clearly reveal the promise of KPIF, but as with all programs, there are multiple areas for improvement.

I: Perception of Gatekeeping: Due to a change in how the funding would be dispersed, many expressed concerns that the funds are still filtered and allocated based on stigmatized beliefs. Originally, money was supposed to go directly from US -> KP org; however, as a means to accelerate the process, money was distributed to host countries, and in turn, host countries decided how money was allocated. To some, because of the stigma of being a member of a KP, this prevented KPIF from reaching its full potential; some countries simply refused

to dedicate resources to certain KPs, clearly hindering the impact of KPIF. For example, in one scenario, a country director revealed that programs for injection drug users and sex workers received little funding in comparison to MSM. Additionally, in one instance, a CSO worker stated, “sometimes I feel short changed. Like they (his federal govt) have favorites. It doesn’t feel like we’re one of them.” When asked how this could be fixed, multiple solutions were proffered, but most expressed the desire to apply to the CDC directly.

2: Attitudinal Barriers: It is no surprise that one of the largest barriers to success was various attitudinal barriers. The stifling impact of HIV and/or KP stigma is still prevalent in many of the nations. For one director, he believes KPs are at best, still tolerated, not accepted. Obviously, stigma still impacts access to care, but there are other attitudinal barriers at play as well.

(1) Some key stakeholders, including governments and important CSOs, in nations do not want to follow KPIF as they believe it is pushing unnatural American ideas and values. For example, as previously stated, in multiple KPIF affiliated countries, same-sex relations can be punished by imprisonment. In turn, governments had visual and verbal disdain for “having to treat key populations.”

(2) According to the interviewees, many governments and health departments believe that involvement in KPIF is “doing enough,” and have little to no desire to augment their own spending for KPs. Essentially, when KPIF is implemented successfully, it bolsters KP led CSOs and CBOs, but this often has unintended consequences. When KPIF is “too successful,” governments often disengage with key populations as KPs become perceived as the CBO/CSO’s “problem,” not the federal government. In turn, this creates a scenario where only CBOs/CSOs are providing services to KPs. Even when there is institutional support, it may come with parameters. This report previously discussed a Latin American KPIF supported U=U campaign in an Indigenous language, but it is important to note that because of homophobia and HIV related stigma, the campaign was not allowed on any official government communication channels.

Conclusion

Utilizing interviews with multiple CDC related stakeholders, this report serves as a brief snapshot of the powers and perils of the Key Population Investment Fund (KPIF). While there are ample areas for improvement, not only has KPIF has been effective in increasing cooperation between KP led orgs and their governments, but it also ushered in a new model of HIV

delivery predicated on the power of various key populations. KPs repeatedly expressed the importance of KPIF, but were concerned about long term sustainability. For many organizations, KPIF was their only funding stream, and are often left to ask “what is the next step? How can we become self-sufficient?”



