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KPIF and Community Engagement Grants

A Community Update Report

April 2021

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Executive Summary

In 2016, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) launched a $100 million initiative - the Key Population Investment Fund (KPIF) - to target the unaddressed HIV-related needs of key populations (KPs) who are disproportionately affected by HIV. The four KPs targeted were gay and bisexual men, transgender people, sex workers, and people who use drugs. KPIF is being implemented in selected low and middle-income countries in Sub-Saharan Africa, Southeast Asia, Central America, and Eastern Europe.

Numerous civil society entities including global, regional, and country-level KP-led networks submitted competitive proposals to PEPFAR to lead innovative, community-led initiatives as part of KPIF. However, KPIF grantee selection and subsequent roll out was stymied by bureaucratic processes and delayed for several years by PEPFAR. In response to intensive advocacy efforts by MPact and a number of collaborating partners, KPIF was finally rolled out in 2019. To the disappointment of many advocates who expected KPIF awards to reach key population-led organizations directly, PEPFAR announced that $49 million of the total funding would be disbursed by the U.S. Agency for International Development (USAID) and $51 million would be disbursed by the U.S. Centers for Disease Control and Prevention (CDC).

This community update report examines the USAID-portion of KPIF, 87% of which is being implemented by FHI 360, either through the Meeting Targets and Maintaining Epidemic Control (EpiC) project or FHI 360-led bilateral projects.[1] Information for this report was collected through a combination of desk research and stakeholder interviews.

KPIF investments are intended to support key population programs distinct from, but complementary to, funding for key populations through the Country Operational Plans (COP), which is PEPFAR's main funding mechanism. When KPIF was initially announced it was a welcome change from other HIV funding modalities, including COP, because of the explicit recognition of the need to directly fund HIV structural interventions for KP communities. A community engagement grants (CEG) component was added through global KPIF to complement country KPIF funding, once it was realized that some Missions were heavily prioritizing service delivery activities with limited structural interventions. Though CEG reflect a very small proportion of the overall KPIF funding portfolio, it has helped some local KP-led CBOs strengthen their capacity, expand HIV services, coordinate with other KP and allied organizations, and strengthen advocacy efforts. KPIF has additionally promoted Global South peer-to-peer learning opportunities. PEPFAR, USAID, and FHI360's commitment to identifying and meeting the needs of KP communities has been commendable and KPIF is a good first step for dedicated KP programs through PEPFAR.

Despite the innovations and progress represented by KPIF, the multi-year delay by PEPFAR headquarters in roll out resulted in a serious delay in the impact that KPIF set out to achieve. The selection of the CDC and USAID to administer the grants, pursuant to a call that seemed to target KP-led entities and global networks, was a clear missed opportunity for PEPFAR to place communities in the driver's seat in the implementation of KPIF.

Out of the $39 million USD available to FHI360, $9.3 million reached KP-led organizations directly. USAID has stated that at least 70% of KPIF funding has reached KP-led and KP-competent local organizations,[2] but this claim has been questioned by some KP activists. Due to the lack of easily available disaggregated data, KP communities do not know what percentage of funding was ultimately disbursed specifically to KP-led entities. Furthermore, terms such as KP-led and KP-competent were

not clearly or consistently defined by PEPFAR until approximately halfway through the KPIF program cycle. This caused confusion for some KP-led organizations and KP activists and made them question the program's transparency.

Specific to the USAID-implemented portion of the KPIF, many KP activists have noted the following issues:

- *The designation of large multinational implementing organizations as KP-competent and their selection as primary KPIF implementing partners. Several of our interviewees felt these choices by PEPFAR sidelined grassroots KP-led organizations and undermined KP leadership and ownership of KPIF.*
- *The selection of KP-competent local organizations for a significant portion of the grants - through opaque processes - as the main in country grantees, instead of local KP-led organizations.*
- *Lack of opportunity for deep involvement of KP-led global or regional networks equitably in implementation at TA provision.*
- *Inadequate focus on structural interventions and the use of KPIF funds to support basic HIV services along the treatment cascade (i.e. HIV testing, prevention and treatment), including services that are not unique to KPs and should have been funded through the COP and national budgets rather than through KPIF. This reduced KPIF funds that were intended to support wrap-around programs and structural interventions.*

Despite the relatively small grant sizes and small number of grants disbursed, the community engagement grants, which are intended to fund local HIV structural interventions, are a valuable component of KPIF. Many of the grants awarded have had concrete and immediate benefits because FHI360 has strived to explicitly engage with KP-led organizations and target the barriers they face. By addressing structural barriers and not just focusing on achieving HIV program targets, CEG are improving the social environments that KP communities live in and are building the capacity of a few KP-led organizations.

While the CEG have generally been useful, they have had limited and localized impact in removing structural barriers due to the small number of grants awarded to date and the relatively small dollar amount of each grant. Additionally, the call for applications have sometimes not been accessible for smaller organizations.

This community report concludes, based on interviews with KP activists, that KPIF and CEG supported some KP-led and KP-competent organizations to improve access to HIV services for key populations in some locations. MPact was named a TA provider for CEG recipients across eight countries and despite many gains, bureaucratic delays reduced the length of TA engagement in some instances. Further, many KP-led national and regional organizations reported feeling that KPIF did not fully engage with them and that it did not directly empower their communities to participate directly in planning, implementing, and evaluating the KPIF. They also felt that the two year performance period was too short for removing structural barriers or achieving any significant or measurable change.

New KP-dedicated funding streams as successors to KPIF continue to be critical to address the needs of KPs and to reach epidemic control. However, the next iteration must avoid relegating KP communities to a minor role and instead seek to center them in all decision-making and programming. It should also leverage larger investments commensurate with demonstrated needs on the ground.

This community update report ends with two sets of recommendations to improve the USAID-administered portion of KPIF that is ongoing through 2021 and on a potential successor program to KPIF. The recommendations are summarized below.

Recommendations for KPIF for the remainder of 2021:

- Preserve KPIF's unique role
- Make community engagement grants transparent and accessible
- Engage with KP-led global and regional networks
- Increase funding and the performance period

Recommendations for a potential successor program to KPIF:

- Maintain an unwavering focus on key populations
- Fund structural interventions meaningfully beyond just lip service
- Develop a new KP strategic initiative with robust funding and with a five-year timeline
- Collaborate with KP-led networks and organizations every step of the way
- Select KP-led global and regional networks as primary implementers
- Streamline regulatory and reporting burden on CBOs
- Remove unnecessary and harmful requirements
- Prioritize advance planning and a timely rollout
- Clearly define KP-led, KP-trusted, KP-competent, and KP-friendly
- Re-examine grantmaking policies and procedures

02

Background

The Key Populations Investment Fund (KPIF) is a $100 million initiative to expand key populations' (KP) access to and retention in HIV prevention and treatment services. KPIF was formally launched in 2016 and became operational in 2019. It was created by PEPFAR - the U.S. government entity that is the world's largest funder of the HIV response - with the intention of filling a gap, namely the lack of adequate funding for key population communities to overcome structural and legal barriers to access HIV services.

The disproportionate HIV burden borne by key populations poses a threat to their physical and mental health, social relations, and their ability to be economically productive. KPIF seeks to directly fund KP-led and KP-competent organizations and to directly reach key populations.

KPIF primarily focuses on four key populations - men who have sex with men, sex workers, transgender people, and people who use drugs. Focusing on key populations is crucial as they bear a disproportionate HIV burden. Recent data from the Joint United Nations Programme on HIV/AIDS (UNAIDS), indicates that almost one quarter (23%) of new HIV infections each year occur in gay men and other men who have sex with men, 19% occur in people who inject drugs, 8% occur in sex workers, and at least 2% occur in transgender people (where data was available).

Advocacy efforts with PEPFAR to create KPIF were led by global coalitions such as MPact, Health GAP, AIDS Vaccine Advocacy Coalition (AVAC), and the American Foundation for AIDS Research (amfAR), along with regional and in-country partners. After the initial announcement in 2016, it took until 2019 for KPIF to be fully operational. The United States Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC) are the two main entities charged with dispersing KPIF funds.

Purpose of this community report

This community report focuses on examining the USAID-implemented portion of KPIF (the CDC-implemented portion will be covered in a future report) which is being implemented in 21 countries. This report does not review MPact's own TA to CEG grants. It examines how KPIF and its community engagement grants (CEG, see table below) are perceived by a variety of stakeholders, both in terms of operational efficiency and impact. The grants are a crucial mechanism to fund KP-led organizations. By examining KPIF and CEG, this update identifies lessons learned that can help KP communities advocate for more effective future HIV programming.

Table 1: Community Engagement Grants & KPIF in numbers

KPIF's goal is to improve HIV treatment and care for key populations. This goal is pursued through a variety of means such as structural interventions, capacity strengthening of community-based organizations (CBO), and direct grantmaking.

For the USAID-implemented portion of KPIF, direct financial support is being provided to KP-led local organizations through several mechanisms, including community engagement grants. These grants support structural interventions that strengthen the capacity of CBOs working on HIV. To date, a total of 16 grants have been given out in seven countries to address structural barriers to HIV access

for key populations. The grantees have generally been selected following local advertising and a call for expressions of interest. CBOs with limited or no past PEPFAR funding were prioritized. Each grant was awarded for a period of nine months to a year.[4]

KPIF in numbers

- Total approved funding from PEPFAR: $100,000,000
- USAID-implemented portion of KPIF: $49,000,500
- Total amount disbursed by FHI360 to KP-led orgs: $9,700,000
- Largest FHI360 service delivery grant to KP-led organization: $991,000
- Total amount disbursed through 16 CEGs (as of January 2021): $492,000
- Largest CEG to a KP-led organization: $39,000
- Smallest CEG to a KP-led organization: $15,000

Methodology

The information contained in this update was obtained from a desk review of documents from MPact, PEPFAR, USAID, FHI360; interviews and email exchanges with 18 individuals involved with various aspects of KPIF; and from a call with regional and global networks representing key populations. The individuals interviewed included community partners in five countries (Côte d'Ivoire, Eswatini, Kenya, Nigeria, and Zimbabwe), headquarters and in country staff at FHI360, USAID staff, and MPact staff. Staff from FHI360 were interviewed as it is the primary implementing partner for USAID.

Adequacy and effectiveness of KPIF investments

Some KP-led organizations in countries where KPIF programming is being implemented are benefiting from direct funding and from activities supported by the fund. KPIF investments are distinct from, but complementary to, funding for key populations through the Country Operational Plans (COP), which is PEPFAR's main funding mechanism. However, community partners in some countries have reported that COP reduced funding for KP interventions once they were aware that KPIF funding was available for key population communities. This occurred even though KPIF is not a substitute for COP.

The table on the next page shows the amount of KPIF funding in the five countries from which we interviewed partners for this update. It also shows the percentage of funds that went to KP-led or KP-competent organizations. However, the lack of disaggregated data (for KP-led organizations versus KP-competent organizations) is problematic as communities do not know what percentage or amount of funding was disbursed to KP-led entities or what types of activities were funded.

Table 2: KPIF funding for KP-led or KP-competent local organizations		
Country	**KPIF funding (USAID-implemented portion)[5]**	**Percentage of funding to KP-led or KP-competent organizations[6]**
Côte D'Ivoire	$4 million	67%
Eswatini	$2 million	71%
Kenya	$3 million	29% (Year 1)/70% (Year 2)
Nigeria	$4 million	63%
Zimbabwe	$2 million	55%

Some of the notable progress made by KPIF to date are:

Recognition of the importance of funding for KP communities: USAID committed to granting seventy percent of the KPIF funds it received directly to KP-led and KP-competent local organizations. This marks a change from previous PEPFAR or other HIV programs in which KP communities have historically received much less funding and dedicated attention.

Funding: KP-led and KP-competent local organizations in 19 countries have received funding through primary implementing partners such as FHI360. This funding, including through CEG, is explicitly meant to benefit KP communities. It is helping some CBOs expand services and better serve their communities. Organizations that have received funding are generally able to pursue their own priorities within the KPIF framework. In places where KP-led organizations are not present or have been deemed (by FHI360) as not having absorptive capacity to manage grants, KP-competent organizations have been selected to receive the grants. These organizations are often larger implementers.

Primary implementing partner capacity: According to FHI360, choosing them as USAID's primary implementing partner has been beneficial in countries where they are well established, know the landscape, are acquainted with KP organizations, and are able to get programs up and running effectively using existing infrastructure.

CBO capacity building: KPIF is augmenting the organizational capacity of some KP-led organizations in countries such as Kenya and Eswatini. KPIF funding is helping efforts to expand KP access to healthcare, including HIV services. It is also helping organizations build stronger financial and administrative systems. These systems can prepare CBOs to manage U.S. government grants in the future. The primary implementing partner is helping local organizations develop work plans and access other PEPFAR funds.

Collaboration: In some countries, KPIF funding is increasing efficiency by helping KP-led organizations coordinate activities with each other and improve joint advocacy. For example, in Zimbabwe, an existing Key Populations Forum is being augmented with KPIF funding. This body provides a venue for KP communities to exchange ideas, develop strategies to mitigate problems, and provide feedback to policymakers. KPIF funding is also enabling Global South peer-to-peer learning and sharing opportunities for KP organizations and advocates. For instance, a regional gay-led organization and a regional transgender-led organization – both based in Bangkok, Thailand – are providing technical assistance to KP organizations in several Asian countries.

Table 3: Definitions of KP-led and KP-competent

PEPFAR states that KPIF includes funding for "KP-led, KP-trusted, and KP-competent" community-based organizations (CBOs). USAID has stated that 70 percent of their portion of KPIF funds (that is, 70% of USAID's $49 million portion of the total $100 million) have been given to KP-led or KP-competent CBOs to date.

Official PEPFAR guidance documents encourage meaningful engagement of operating units with KP-led and KP-competent CSOs as this is deemed to be "vital to the success of any PEPFAR KP programs." PEPFAR defines KP-competent organizations as those that "have specific aptitudes to service KP communities...these competencies value the insight and leadership of KP community members in designing, implementing and evaluating KP programs. Services offered are...implemented by trained and capable service providers, many of whom may come from KP communities themselves. KP competency entails ensuring cultural, geographical, linguistic, financial and procedural accessibility to those services and should be determined in consultation with local KP communities." PEPFAR defines KP-led organizations as having "similar aspirational goals, yet the majority of staff and board leadership are members of the KP communities they serve."

PEPFAR did not define KP-led and KP-competent until late 2020, about halfway into the KPIF program period. This caused confusion among KPled organizations and KP activists as the KP-competent designation has often been applied arbitrarily. Many of them also argued that much of KPIF funding is not necessarily given to local organizations led and staffed by KPs and serving their communities. For instance, a government health agency in one country received KPIF funds and the entity was classified as a "KP-led or KP-competent local partner." This was problematic as, historically, many KP communities have experienced stigma and discrimination at government health agencies.

In another country, while communities were consulted to come up with definitions for KP-led and KP-competent, this only happened after implementing partners had already been selected. Many KP groups and activists, unsurprisingly, have misgivings about whether the bulk of KPIF funding is reaching KP-led local organizations.

Finally, PEPFAR's definition of KP-competent is overly broad and can allow for the selection of local partners that may have expertise on KP issues while not necessarily empowering or engaging with local organizations that are KP-led.

While KPIF has been beneficial in many ways for key population communities and organizations, many stakeholders noted things that could have been done differently or can be improved as KPIF evolves. Some of these are:

Lack of timely and clear definitions: Being KP-led or KP-competent was not clearly defined and understood during the launch and the first half of KPIF. This has made it difficult to measure progress and impact (as discussed in the Table 3 above).

Selection of grantees and partners: Several stakeholders said they would have preferred the selection of KP-led organizations as the primary implementing partner or the primary in-country grantees (instead of being sub-grantees and technical assistance providers). Others noted that the main implementers are not KP-led. The bureaucratic expenses of large non-KP-led organizations has taken away potential funding that could have directly reached KP-led organizations. For example, in Zimbabwe,

where FHI360 is not the primary implementer, the bulk of KPIF resources have gone to a large international implementing partner, whereas a major lesbian, gay, bisexual, transgender, and intersex (LGBTI) organization with local expertise in HIV and human rights was not selected to implement KPIF programs (though they received a CEG). The generally opaque process by which the primary implementing partner in countries selected local partners was another problem. The calls for partners were not fully transparent in some countries and some partners selected, for instance in Nigeria, lacked adequate KP experience.

Capacity of KP-led organizations and KP communities: In some countries, the lack of adequate capacity or lack of experience managing large grants was cited as the reason why KP-led CBOs were not selected as the primary recipient or even as sub-grantees. In Côte d'Ivoire, non-KP staff were selected to lead KPIF programming with the rationale that qualified KP experts were not available. These problems could have been resolved by selecting a KP-led global or regional network – which have extensive expertise and connections with local KP-led CBOs – to be the primary implementing partner.

Global and regional KP-led networks: The significant expertise and connections of global and regional KP-led networks has been underutilized by KPIF. For example, a global KP network that had originally been envisaged in a significant sub-granting role was eventually tasked with providing limited technical assistance. There have also been missed opportunities with regard to mutual learning spaces among KP-led organizations operating in different countries and regions, who could have shared updates, frustrations, and successes in real-time via processes convened by these networks.

Funding delays: The multi-year wait for KPIF funds to be disbursed created tremendous frustration among KP advocates. As a result of the delay, only two of eight countries had finalized KPIF contractual processes and could start implementing programming and receiving technical assistance in the first year of programming. The funding delay was attributed to political and bureaucratic issues at PEPFAR headquarters and it adversely impacted the ability of the primary implementing partner, grantees, and KP communities to commence work.

Complementarity versus substitution: KPIF funding has caused some unintended and unanticipated problems. Some governments and COP ignored or did not adequately fund the needs of key populations. KPIF funds were used to support programs that should have been funded through the COP. For instance, in Côte d'Ivoire, the government declined to fund pre-exposure prophylaxis (PrEP) in the COP as some PrEP funding was already available through KPIF.

Limited focus on structural interventions: KPIF has been criticized by some KP activists for not adequately focusing on structural interventions and skills building initiatives. As a result, KP organizations in places such as Côte d'Ivoire have been competing with each other to tout results to be able to maintain their funding levels.

Table 4: HIV Structural Interventions

Structural interventions are public health measures that promote health by altering the structural context within which health is produced and reproduced. They have been recognized as a valuable strategy for HIV prevention and treatment.

Structural interventions differ from other public health interventions as they often locate the cause of public health problems in contextual or environmental factors that influence risk behavior, or other determinants of infection or morbidity, rather than in characteristics of individuals who engage in risky behaviors.[10 11]

Some examples of structural interventions that could be undertaken to control the HIV epidemic are: [12]

- Integrating violence prevention and response into HIV programming
- Comprehensive sex education that acknowledges sexual and gender diversity, provides health promotion and disease promotion information, and makes safer sex supplies easily accessible
- Syringe exchange programs as a harm reduction intervention in the context of continuing drug use
- Increasing access to high quality and affordable healthcare for all, with a focus on reaching marginalized populations
- Investments in education and social services for disadvantaged populations
- Providing stable housing, which has been shown to be efficacious in decreasing morbidity from HIV and other chronic diseases
- Reforming laws and policies that marginalizes minorities

03

COMMUNITY ENGAGEMENT GRANTS:

Alignment with KP needs and priorities

The community engagement grants have been reported by several stakeholders to be one of the most valuable components of KPIF. These grants, though few in number and of relatively small dollar amounts (see Table 1 above), have helped build the capacity of a few KP-led organizations.

The grants are perceived by most partners - such as those in Kenya, Zimbabwe, and Cote d'Ivoire - as generally being aligned with the needs and priorities of KP communities.

CEG for the most part are intended to fund HIV structural interventions and not service delivery programs. KP organizations in some countries have had considerable leeway determining their own program priorities with how to use the grants within the broader KPIF framework. However, community partners in some other countries have reported that program implementation using the grants has been limited by the priorities of the funder. The degree of control exercised by the grantmakers has meant that the priorities of the KP communities have not always been prioritized.

In some countries, such as Kenya, CEG (and KPIF more broadly as discussed in the previous section) have been occasionally wrongly perceived as an alternative to funding basic HIV services for KPs through COP. This most likely occurred as KPIF is a new mechanism and it has not always been clearly defined or differentiated from COP. Community partners have noted that it will be useful to harmonize the grants to complement COP targets and to emphasize to governments and other stakeholders that CEG and KPIF are not alternatives to COP funding and programming, which are crucial to meeting the HIV service needs of key populations.

Impact on HIV structural barriers

In some instances, CEG are making a positive impact on overcoming structural barriers that impede HIV service access for key populations. However, given their relatively small size and the limited number of grants awarded, impact is localized. Unless the interventions funded by CEG are taken to scale, it will be hard to achieve a wider and sustainable impact in the 21 countries where the USAID portion of KPIF is being implemented. For instance, in Kenya, the grants are benefiting KP communities in some localities but there is inadequate funding to scale up the benefits nationally. The small grant amounts means that the impact of CEG on removing structural barriers is limited. As a result, governments may use the limited impact as an excuse to claim that structural interventions are ineffective and they may thus cut existing funding, or avoid future funding, for structural interventions.

Community partners in several countries including Eswatini, Côte d'Ivoire, Kenya, Malawi, and Zimbabwe report that the grants are helping address structural barriers in a limited manner. One of the key structural barriers that the CEG are addressing is sensitizing healthcare providers on the needs of KP communities (Malawi, Eswatini, Zimbabwe). This is enabling easier and stigma-free access to HIV and clinical services for some KP community members. Additionally, the outreach and sensitization efforts are beginning to help some KP communities in Zimbabwe deepen their engagement with the Ministry of Health and the National AIDS Council. In other places such as Côte d'Ivoire, CEG are supporting economic and social empowerment activities. The grants are also supporting the creation of new outreach networks.

04

COMMUNITY ENGAGEMENT GRANTS AND KPIF:

What is working well

One of the main achievements of the grants is that they are funding structural interventions that build the capacity of some KP-led or KP-competent CBOs. By building capacity, CEG are increasing the ability of some small local CBOs to eventually handle larger grants and programs in the future. In many cases, the grants also recognize the importance of peer-to-peer collaboration between KP organizations and promote this. The grants have also enabled collaboration between some KP-led organizations in the Global South. Simply recognizing the importance of direct funding to KP-led organizations has been a step in the right direction. Peer outreach and collaboration has had many benefits. For example, in Côte d'Ivoire, peer outreach has made it possible to increase adherence to HIV care and it has strengthened the link between healthcare centers and KP communities.

Many of the grants have had concrete and immediate benefits. In Eswatini, two community centers funded by CEG serve as safe spaces for KP. Community outreach efforts are bringing services closer to the community, which is especially helpful during the ongoing COVID-19 pandemic which has caused loneliness and depression rates to spike.

By addressing structural barriers and not just focusing on achieving HIV program targets in Kenya, CEG are improving the environments that KP communities live in. The grants are increasing KP communities' ability to access healthcare and law enforcement services while creating a friendlier social environment. A violence prevention network is also being funded.

Kenyan KP-led organizations now have improved capacity to absorb larger U.S. government grants and implement future programming on a bigger scale.

Mpact, a global KP-led network has been engaged as a technical assistance provider, thus leveraging significant knowledge, resources, and expertise to improve the overall impact of KPIF and the grants. USAID's willingness to engage with in-country CBOs and to be evaluated by regional and global KP-led networks and by the Johns Hopkins University demonstrate a commitment to transparency and a willingness to learn.

KPIF is also having some success in sensitizing stakeholders who interact with and affect the lives of key populations. For instance, in Kenya, KPIF is supporting initiatives to sensitize paralegals and healthcare workers who provide services to KPs.

What can or could have been done differently

A problem with the CEG in many countries is the call for applicants. These calls have not always been widely disseminated and have sometimes not been accessible for small community groups. The selection metrics, process, and the performance evaluations for organizations that were selected has also been opaque in some cases. For instance, in Zimbabwe, a call for submissions was made and a single webinar was held to explain the call. Many small KP-led organizations struggled to understand the requirements and to make timely and full submissions. Larger and better resourced organizations, on the other hand, had better infrastructure and were able to make timely and complete submissions (this was also the case in Nigeria).

A logistical challenge that is causing delays with disbursing KPIF funds is the Leahy vetting process which consists of U.S. laws that prohibit federal

government funds from being given to law enforcement entities or personnel who have committed violations of human rights. As law enforcement sensitization is a big part of KP programming in many of the KPIF countries, this legal provision has often temporarily halted or delayed grantmaking.

KP-led community organizations and KP activists in countries like Kenya have expressed the need to empower KP-led CBOs by giving them more grants on a regular basis. This can improve their capacity to eventually manage larger grants and is preferable to not funding local CBOs using their low capacity as an excuse. Community partners in Eswatini felt that KP-led organizations, instead of ill-defined KP-competent organizations, should receive the bulk of the grants given KPIF's stated goal to empower key population communities.

Community partners in Nigeria are critical of a "tokenistic exercise" to define KP-friendly organizations. Some entities have been deemed to be KP-friendly regardless of whether they have anti-discrimination policies, KP staff, or actual KP-friendly policies in place. In the absence of a clear and transparent set of criteria, local partners and subgrantees have been chosen hastily without regard for past experience or competency, thus allowing opportunistic groups to benefit.

In Côte d'Ivoire, the significant overlap and close links between KPIF and COP activities being implemented by FHI360 is making it difficult to differentiate their unique roles or purposes. The slow speed of grants disbursement, which often took as long as three months after the signing of a grant agreement, also made effective and timely programming difficult.

Conclusion

The Key Populations Investment Fund and its community engagement grants mechanism have directed resources to key population-led and key population-competent organizations in several countries since 2019. KPIF has a relatively short period of performance and is expected to wrap up in late 2021. According to USAID and FHI360, the majority of the USAID portion of KPIF funding was directed to KP-led and KP-competent local organizations, although this claim is questioned by some KP activists. In the five countries we examined, KP-led and KP-competent organizations received between 39% and 76% of overall KPIF funding in any given year (see Table 2), and the overall direct grants to KP-led local organizations from FHI360 have amounted to over $9 million.

KPIF is different – and a welcome change – from other HIV funding modalities, including PEPFAR Country Operational Plans, because of its explicit focus on the urgent HIV needs of key populations and on structural interventions. It is an innovative and encouraging first step on the part of PEPFAR that is worth applauding. Gay men and other men who have sex with men, sex workers, transgender people, and people who use drugs are at significantly higher risk of HIV and have been disproportionately devastated over the course of this 40-year epidemic. It makes sense to dedicate funding through KPIF to address their needs, including structural interventions to overcome HIV service barriers.

In many countries, based on anecdotal evidence from interviews with KP activists (a detailed evaluation is yet to be carried out), KPIF and CEG appear to have strengthened the capacity of some KP-led and KP-competent organizations and have contributed towards improving access to HIV services in some locations. USAID and FHI360 staff who manage KPIF have demonstrated a

deep knowledge of KP issues and a commitment to protecting KP human rights.

Until January 2021, USAID and FHI360 staff operated under the auspices of the Trump administration, which was often hostile towards several key populations. The staff of these organizations should be commended for successfully navigating political minefields and for protecting KPIF funding. There is cause for optimism with the new Biden administration which has rescinded the harmful global gag rule, supports reproductive health and equal rights for women, and has issued a memorandum reaffirming U.S. support for the rights and safety of LGBTI people around the world.

However, PEPFAR and its primary implementers could have done even more, and can yet do more, to empower key populations. Many KP-led national and regional organizations have felt tokenized, disillusioned, and disenfranchised by KPIF. They are often sub-contracted as implementation partners by large INGOs who rely on grassroots KP partners to meet KP testing and treatment targets. Relegating KP communities to these minor roles disrespects grassroots KP leadership and fails to get to the root of the problem – the disenfranchisement, exclusion, and violence enacted against these communities.

KP activists are also concerned that vaguely defined KP-competent organizations, which are often not local nor working on KP issues, have been chosen as subgrantees. Furthermore, KPIF's limited resources and short performance period have made it hard to undertake interventions at scale, thus making any gains localized, temporary, and hard to sustain. It is impossible to overcome structural barriers in two years.

05

Recommendation

The two sets of recommendations below are directed to the U.S. government (PEPFAR and USAID in particular) and KPIF implementing partners such as FHI360. The first set of recommendations addresses issues with the USAID administered portion of KPIF that is ongoing through late 2021. The second set relates to a potential successor program to KPIF.

Recommendations for KPIF for the remainder of 2021

- **Preserve KPIF's unique role:** HIV services along the treatment cascade are not needs that are unique to KPs and must be funded and scaled up through COP and national budgets. KPIF funding should not be used to fund basic HIV services (i.e. prevention, testing, treatment, and care) for KP communities, but to support the wrap-around programs and structural interventions that make accessing basic HIV services possible for KPs, and to strengthen KP-led local organizations.

- **Make community engagement grants transparent and accessible:** In grantmaking through the CEG mechanism, the calls for submission should be widely and transparently disseminated. Small KP-led organizations should be given the opportunity to learn more about the calls for submission and receive assistance with applying for the grants.

- **Engage with all KP-led global and regional networks:** Where KP-led local organizations have been deemed to be insufficiently qualified to receive and manage grants, KPIF should tap global and regional KP-led networks to act as primary implementers. These networks are small and agile and can avoid the labyrinthine bureaucracies of larger implementing partners. They also have deep connections with local KP-led organizations and advocates and extensive experience conducting KP programming.

- **Increase funding and performance period:** PEPFAR should increase the funding allocated to KPIF and extend the performance period beyond the current two years. This will allow more time and resources to address the structural barriers that prevent key populations from accessing the HIV services they need.

Recommendations for a potential successor program to KPIF

- **Maintain an unwavering focus on key populations:** The science is clear - gay men and other men who have sex with men, sex workers, transgender people, and people who use drugs are at significantly higher risk of HIV and have been disproportionately impacted over the course of the 40-year epidemic. These numbers are a reflection of the underlying social, economic, and political factors driving HIV risk among KP. As funding cuts lead PEPFAR country teams to reduce budgets, we urge PEPFAR to align the HIV response to the epidemiology and maintain investment levels and programmatic focus on KP.

- **Develop a new KP strategic initiative with robust funding support:** We urge PEPFAR to build on lessons learned from KPIF and to adopt a more nuanced approach that prioritizes investments in KP-led organizational leadership, addresses human rights violations, and centers the response on KP communities as people and not just as 'epidemiological targets'. This recognition should be accompanied by a robust budget. Additionally, KP-led networks and organizations that provide technical assistance (TA) should also be provided with funding. This can ensure that TA is an integral part of work plans, budgets, and M&E and that it is not optional or an afterthought.

- **Develop a new KP strategic initiative with a longer timeline:** A twoyear program like KPIF has limited impact and can be set back significantly even by minor delays. The short program period makes it hard to conduct monitoring, conduct an impact evaluation, ensure sustainability, and take programming to scale. It is also inadequate to finalize a statement of work as consultations between stakeholders – which is crucial – can take significant time. As such, a new initiative should have a performance period of five years.

- **Collaborate with KP-led networks and organizations every step of the way:** PEPFAR should work directly alongside KP-led national, regional, and global civil society networks and organizations to jointly develop a new KP strategic initiative and investment portfolio that builds on KPIF's work to date, commits itself to principles of mutual respect and equality, re-establishes trust among KP partners, and sets forward a five-year plan for this work, separate from COP objectives and funding.

- **Select KP-led global and regional networks as primary implementers:** These networks have extensive expertise and in-country connections with local KP-led CBOs and have the capacity to function as primary implementing partners. Selecting these networks as primary implementers can strengthen the capacity of small KP-led CBOs and put them in a position to receive PEPFAR funding in the future. Global and regional KP-led networks were unable to be more involved with KPIF until January 2021 because of harmful policies enacted by the previous U.S. administration, such as the Global Gag Rule and the socalled anti-prostitution pledge (more on these further down).

- **Streamline regulatory and reporting burden on CBOs:** U.S. government reporting and regulatory requirements can be complex and pose an undue burden on local KP-led organizations with limited capacity and/or operating in resource scarce contexts. To maximize participation of local CBOs, regulatory and reporting requirements should be simplified and streamlined.

- **Remove unnecessary and harmful requirements:** KP-led national, regional, and global civil society networks and organizations should be exempted from having to conform to, or having to compel their partners to conform to, U.S. government policies such as the recently suspended so-called global gag rule and the requirement that grantees certify that they have an anti-prostitution pledge. These policies prevent key populations from accessing life-saving HIV treatment and care. They are harmful, not based on evidence, and unnecessary.

- **Prioritize advance planning and a timely rollout:** The delayed rollout of KPIF was a major problem. The lessons from the delay should be learned by PEPFAR and avoided by conducting more advance planning to ensure a fast and efficient rollout.

- **Clearly define KP-led, KP-trusted, KP-competent, and KP-friendly:** These terms have caused much confusion and were not formally defined until halfway into the KPIF implementation period. Definitions for these terms should be finalized in consultation with KP communities and widely disseminated to promote transparency. A specific percentage of funding must be allocated for KP-led organizations. This will help avoid tokenization of community-based KP-led organizations by larger implementers, which often relegate these groups to a "forever sub-contractor" role.

- **Re-examine grantmaking policies and procedures:** Doing so will remove bureaucratic red tape and facilitate timely and accessible funding flows to smaller, KP-led organizations. Logistical challenges such as the onerous Leahy vetting process; delays in funding disbursements; lack of transparency about application processes and selection criteria; complex grant management experience requirements; and absence of technical support for first-time applicants must all be addressed to give KP-led organizations the best chance at success.

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[1]EpiC implemented country level KPIF in: Cote d'Ivoire, Eswatini, Haiti, Kenya, Lesotho, Malawi, Namibia, Nigeria, South Africa, Tanzania, Asia Regional and West Africa Regional. FHI 360 bilateral programs implemented KPIF in Dominican Republic and Mozambique.

[2]KPIF Footprint of Partners and Activities, USAID, July 2020

[3]Key Populations Investment Fund: Global Overview, PowerPoint presentation slide 2, USAID, January 21, 2021.

[4]Ibid, PowerPoint presentation slides 12-15

[5]PEPFAR COP2021 Planning Key Populations Factsheets, amfAR, Available at http://dev.amfar.org; KPIF Footprint of Partners and Activities, USAID, July 2020

[6]KPIF Footprint of Partners and Activities, USAID, July 2020

[7]KPIF Footprint of Partners and Activities, USAID, July 2020

[8]FY2021 COP/ROP Guidance for All PEPFAR Countries, SGAC, 2020, pp.414-5

[9]Ibid

[10]Blankenship KM, Friedman SR, Dworkin S, Mantell JE. Structural Interventions: Concepts, Challenges and Opportunities for Research. Journal of Urban Health. 2006; 83(1): 59-72.

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