

Closing the Prevention Gap among Key Populations.

The Need to Accelerate Access to Services, Community Outreach and Empowerment

Key populations remain most affected by the epidemic

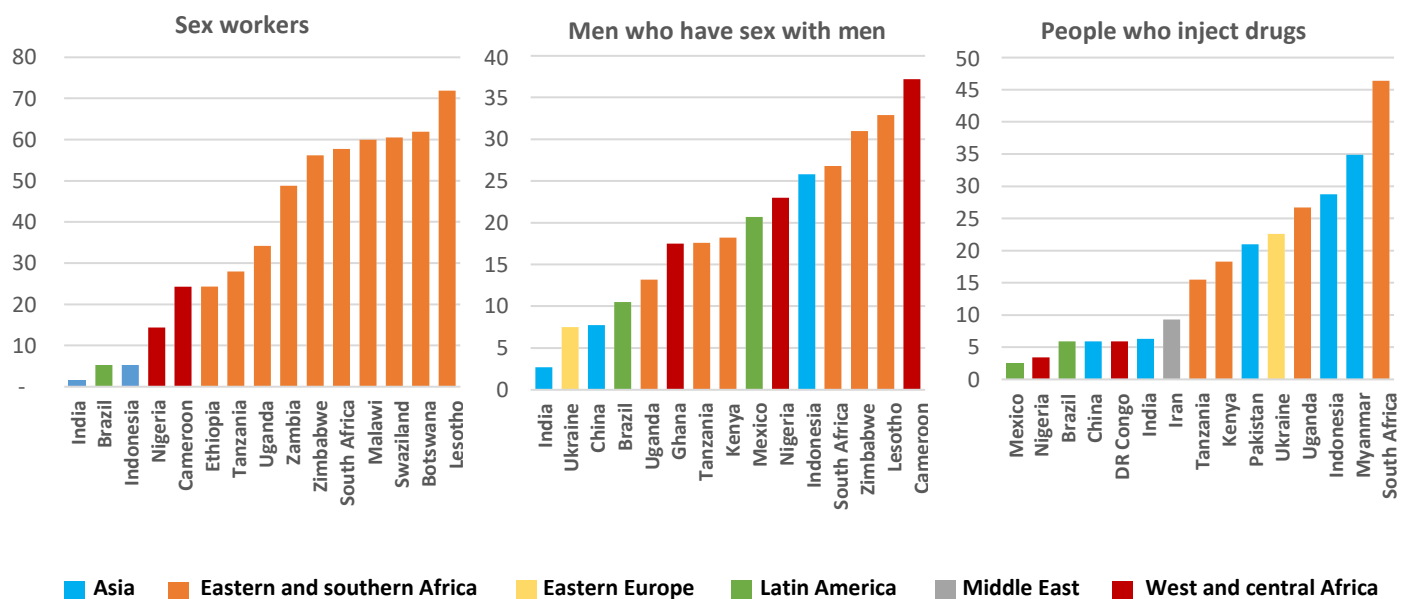
In 2017, around 47% of new infections worldwide were among key populations – defined here as **sex workers, men who have sex with men, people who inject drugs, transgender people, prisoners**¹ – and their sexual partners including clients of sex workers. Outside sub-Saharan Africa between 75% and 95% of new infections occur among key populations and their partners. People who inject drugs accounted for more than one third of new infections in Eastern Europe and Central Asia, in the Middle East and North Africa. New infections among gay men and other men who have sex with men exceeded 20% of new infections in Latin America, Asia and the Pacific, eastern Europe and Central Asia and the Middle East and North Africa.

Ensuring access to comprehensive prevention services to at least 90% of key populations by 2020* is critical to address continuously high numbers of new infections in key populations.

*Coverage target, 2016 Political Declaration on HIV and AIDS

Among female sex workers, HIV prevalence remains particularly high in sub-Saharan Africa (Figure 1). New HIV infections among people who inject drugs remain high overall despite progress in some countries, while the estimated number of new HIV infections among gay men and other men who have sex with men continues to increase.

Figure 1. HIV prevalence among sex workers, men who have sex with men and people who inject drugs in selected countries



There are limited data available on HIV prevalence in transgender populations and among people in prisons and other closed settings. However, HIV prevalence in these populations continues to be significantly higher than in the general population in most countries. Key populations are likely to be overrepresented in prison settings due to the criminalization of drug use or same-sexual relationships and sex work. The lack of comprehensive HIV prevention and treatment services can contribute to an increased risk of HIV in closed settings.

¹ These five populations are defined as key populations as they are more affected by HIV than other populations in a majority of countries and as they experience a distinct set of factors, which are the cause of elevated HIV incidence. There may be other populations at elevated risk of HIV in specific countries or regions, which might be priority populations for HIV prevention in those contexts, but these are not addressed in this brief.

What is needed for prevention programmes among key populations?

The 2016 WHO consolidated guidelines on programmes for key populations outline a comprehensive service package for all key populations (Table 1).² To support implementation of HIV programming for key populations, **global implementation tools** have been developed with the communities which entail a detailed description of prevention interventions and approaches by and with key populations.³

Combination HIV prevention programmes for key populations (including behavioural, biomedical and structural components) have been effective in reducing HIV incidence when they have been implemented well and at scale.



Table 1: Comprehensive package of interventions for key populations

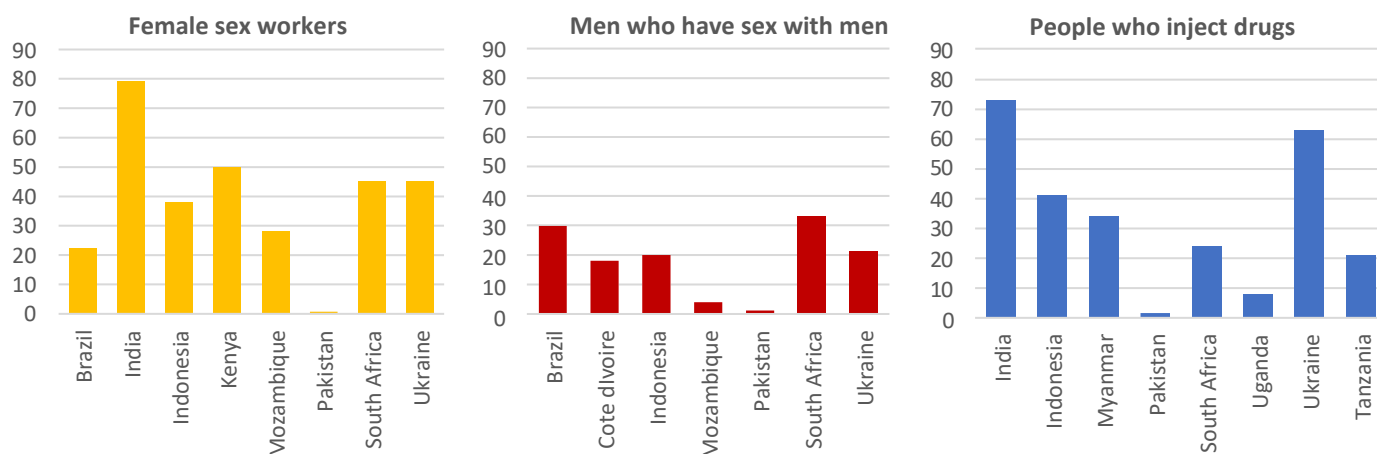
- a) Essential health sector interventions
 1. comprehensive condom and lubricant programming
 2. harm reduction interventions¹ for substance use (in particular needle and syringe programmes² and opioid substitution therapy and naloxone distribution)
 3. behavioural interventions
 4. HIV testing and counselling
 5. HIV treatment and care
 6. prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions.
 7. sexual and reproductive health interventions
- b) Essential strategies for an enabling environment
 1. supportive legislation, policy and financial commitment, including decriminalization of certain behaviours of key populations
 2. addressing stigma and discrimination, including by making health services available, accessible and acceptable
 3. community empowerment
 4. addressing violence against people from key populations.

Several countries have made visible progress in effectively rolling-out key population programmes, including large-scale HIV prevention programmes for female sex workers in Thailand, India and other countries, community-based programmes among gay men and other men who have sex with men in the United States and Western Europe, and needle-syringe programmes in Ukraine and China. **India's approach to scale up community-based programmes** under a clear national management model and implementation system has been particularly effective in improving access, service quality, uptake and community engagement.

Major gaps in Prevention Coverage among Key Populations Persist

Although examples of successful prevention programmes for key populations have existed for three decades, programmes have not been scaled up in a majority of countries.

Figure 3. Coverage of prevention programmes among key populations (estimates based on data using varying definitions)



² WHO (2016): WHO (2016) Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.

³ WHO (2013): SWIT; UNFPA (2015): MSMIT; UNODC (2017): IDUIT; UNDP (2016): TRANSIT; UNODC (2013): Policy Brief. HIV prevention, treatment and care in prisons and other closed settings. A comprehensive package of interventions.

Programme coverage among **female sex workers varies greatly across** countries participating in the Coalition ranges from less than 2% to 80%, but remains below 50% in most countries. Several highly affected countries do not have adequate coverage data available, but coverage of dedicated programmes is likely low in most of these countries.

Coverage of programmes among **gay men and other men who have sex with men** is insufficient in most countries, but data is less reliable due to often inadequate or missing population size estimates. In addition, programmes focusing on specific locations and meeting places for gay men are increasingly faced with the challenge that more men are using internet platforms and dating apps for meeting partners.

Coverage of basic outreach programmes for **people who inject drugs** (excluding opioid substitution therapy (OST)) ranges from less than 2% to more than 70% in countries participating in the Coalition. Even in many countries in eastern Europe and central Asia that made progress in providing needle syringe programmes, coverage of OST remains below 10%.

A 65-country review supported by the Global Fund assessed the design and implementation of key population service packages, indicating that programmes did not define coverage for most interventions, some key populations were not recognized, or community empowerment aspects were neglected.⁴

Over three decades sex workers in sub-Saharan Africa have been the population most affected by HIV globally among all populations. **Three decades into the response less than half of sex workers in Africa receive regular prevention services.** There is urgent need to address this gap in resource allocation.

Many countries lack key population size estimations and analyses to determine primary risk factors and geographical locations, in order to design targeted interventions and focus limited resources where they are most needed.

Communities play an important role in leading and delivering outreach programmes but require increased support in capacity and systems development to achieve and exceed the target of ‘30% community-led service delivery’. Government ownership and roll-out of prevention packages can often not be based on the existing well-funded small projects, pilots or research studies that are too costly to replicate at scale. One of the major barriers to effective prevention for key populations is related to laws and policies discriminating against or criminalizing same-sex sexual relationships, sex work or drug use. These laws and policies support harassment by police and hinder access to HIV prevention and treatment services, and community empowerment efforts.

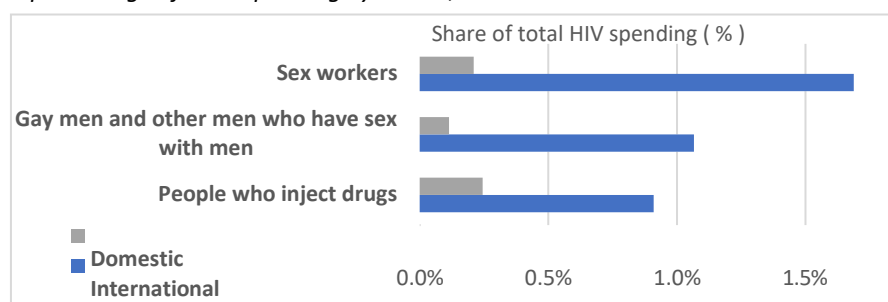
Resource needs and funding gaps - What type of investment is needed?

Key population programmes only account for an extremely low proportion of domestic HIV spending in low and middle-income countries and also a relatively small proportion of total external HIV funding (Figure 4), on which a majority of key population programmes currently rely. In 2015, HIV prevention for key populations in low- and middle-income countries accounted for less than 5% of total HIV resources, or around 9% of the resources for prevention. The gradual increase of domestic investment since 2010 remains mainly focused on treatment.⁵ The 65-country review confirmed that for most of the investigated countries, the only funding source for key population programming was the Global Fund and in some cases

the US Government⁶. Few exceptions exist such as Belarus, which has increased its domestic share for key population programming through national and municipal resources, exceeding respective Global Fund contributions.

US PEPFAR allocations to support key populations in 2018/2019 are estimated at over USD360 million including USD100 million through the Key Populations Investment Fund).⁷ In the **Global Fund’s**

Figure 4: Spending on programmes specifically for key populations as a percentage of total spending by source, 2012- 2016



⁴ APMG Health (2018): *Global Analysis. Assessment of HIV Services Packages for Key Populations in Six Regions.*

⁵ UNAIDS Global Report 2018

⁶ APMG Health (2018): *Global Analysis. Assessment of HIV Services Packages for Key Populations in Six Regions.*

⁷ PEPFAR (2018): *Presentation. Update on HIV Prevention in PEPFAR.* September 12, 2018.

HIV prevention budget, which has declined overall in recent years, the largest prevention allocation in the 2017-2019 funding cycle is directed towards key populations in 50 countries at an estimated USD250 million over the three-year period.⁸

Indicative annual resource needs for programmes for sex workers in 18 out of 19 coalition countries in sub-Saharan Africa reporting to the Global HIV Prevention Coalition Secretariat in 2018 were prepared based on indicative population size estimates and a global average unit cost (see Box 1).

For an estimated 900,000 sex workers in 18 coalition countries in Africa – the populations most affected by the epidemic globally – total annual resource needs for a basic prevention service package costing 70 USD per person/year on average would amount to 63 million USD, **more than twice the annual Global Fund allocation for sex workers** but **less than 0.5% of global HIV investment in LMICs**.

Recommendations for support to coalition countries' key population programming

Middle income countries: Support to transition processes for sustainable key population programmes

- Capacity development for government and civil society organisations;
- Systems development (implementation tools, monitoring systems, accountability mechanisms) including for community-led programmes;
- Establishment of social contracting mechanisms such that government can procure services from civil society to ensure sustainable government funding, programming and ownership;
- Transitional funding to maintain programmes in the short term.

High prevalence, low income countries: Sustained support focused on major gaps and scale-up

- Establishment of a person responsible and accountable for key populations programmes in the government with associated standard operating procedures, reporting metrics to ensure consistent programmes in country and donor coordination;
- Ongoing high-level advocacy to address discriminatory policy and laws;
- Continued and increased Global Fund and PEPFAR investment with the goal of sufficient scale-up;
- Other partners including bilaterals to cover programmatic gaps and specific country actions;
- Respond to immediate crises, e.g. where functioning programmes are at risk of discontinuation or not in place at all and coordinate among donors for shared support.

⁸ The Global Fund (2018): *Presentation. Global Fund funding patterns and trends 2008-2020*. September 12, 2018.