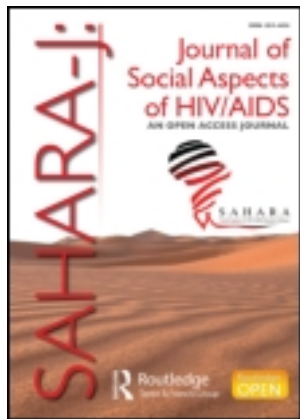


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Demand for programs for key populations in Africa from countries receiving international donor assistance

Owen Ryan*, John Macom, Michelle Moses-Eisenstein

Abstract

There has been increasing attention in recent years to the HIV prevention, treatment, and care needs of key populations in Africa, in particular men who have sex with men (MSM), injection drug users (IDU), and female sex workers (FSW). While several major donors have undertaken efforts to prioritize these groups, it remains unclear which African countries are actively seeking donor support for these programs. For this analysis, we reviewed publicly available proposal and budget documentation from the US PEPFAR for fiscal years 2007 through 2010 and Rounds 1 through 10 of the Global Fund to Fight AIDS, Tuberculosis and Malaria for 40 countries in sub-Saharan Africa. Of the 164 searchable documents retrieved, nearly two-thirds contained at least one program serving FSW (65%, 107 proposals), less than one-third contained at least one program serving MSM (29%, 47 proposals), and a minority proposed programming for IDU (13%, 21 proposals). Demand for these programs was highly concentrated in a subset of countries. Epidemiological data for at least one key population was included in a majority of these proposals (63%, 67 proposals), but in many cases these data were not linked to programs.

Keywords: PEPFAR, Global Fund, key population, MSM, IDU, SW

Résumé

Ces dernières années, une attention grandissante est donnée aux besoins en prévention, soins et traitement du VIH au profit des populations clés en Afrique, particulièrement les hommes ayant des rapports sexuels avec les hommes, les personnes faisant usage des drogues injectables, et les travailleuses de sexe. Pendant que plusieurs bailleurs principaux déploient des efforts pour rendre prioritaires ces groupes, il demeure incertain que les pays africains recherchent activement l'appui des bailleurs pour ces programmes. En rapport avec cette analyse, nous avons examiné les propositions et la documentation budgétaire disponible au public du PEPFAR pour les années fiscales allant de 2007 à 2010, ainsi que les rounds 1 à 10 du Fonds Mondial de lutte contre le Sida, la Tuberculose et la Malaria pour 40 pays d'Afrique Sub-saharienne. De ces 164 documents consultables, presque deux-tiers contenaient tout au moins un programme en faveur des HSH (29%, 47 propositions), et une minorité a proposé de programme pour les hommes faisant usage des drogues injectables (13%, 21 propositions). Les demandes pour ces programmes étaient fortement concentrées dans un sous-ensemble (a subset) des pays. Les données épidémiologiques pour au moins une population clé étaient incluses dans la majorité de ces propositions (63%, 67 propositions), mais dans la plupart des cas ces données n'étaient pas liées aux programmes.

Mots clés: Travailleuses du sexe (TS), Homme ayant des rapports sexuels avec d'autres hommes (HSH), utilisateurs de drogue (UD), populations clés, PEPFAR, Le Fonds Mondial

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Introduction

In 2008, the two largest donors to HIV/AIDS programs in Africa separately adopted new guiding documents emphasizing the importance of addressing the HIV epidemic among key populations. In the USA, Congress included new language prioritizing men who have sex with men (MSM) and injection drug users (IDU) in the legislation reauthorizing the US President's Emergency Plan for AIDS Relief (PEPFAR) (Lantos & Hyde 2008). At the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the Board of Directors approved a new strategy focused on the needs of MSM and other sexual minorities (The Global Fund 2009) shortly after other efforts to prioritize the gender dynamics of the epidemic, especially for female sex workers (FSW) (The Global Fund 2008).

These decisions came at a time of dawning consensus about the increased disease burden among MSM, IDU, and FSW throughout the world. While previously thought to experience HIV prevalence rates greater than the general public in only certain geographical contexts (e.g. MSM in Asia and IDU in Eastern Europe), recent surveillance studies have shown that these groups bear an especially heavy disease burden in settings where they were previously presumed not to exist, particularly in Africa (Baral, Beyrer, Muessig, Poteat, Wirtz, Decker, *et al.* 2012; Beyrer, Baral, Walker, Wirtz, Johns & Sifakis 2010; Dutta, Wirtz, Baral, Beyrer & Cleghorn 2012; Mathers, Degenhardt, Phillips, Wiessing, Hickman, Strathdee, *et al.* 2008; Sabin, Lazarus, Frescura, Gill & Mahy 2012).

PEPFAR and the Global Fund have provided partner countries with guidance on how they can respond to the epidemic among key populations within their borders (PEPFAR 2010, 2011a; UNAIDS 2011). The Global Fund has gone one step further to incentivize national governments' adoption of programs for key populations by earmarking specific funding (Aidspan 2010). Despite these efforts, it has been unclear which countries actively demand programs for key populations in Africa, since neither donor reports specifically on these populations. This analysis sought to address that knowledge gap in an effort to better understand country demand for programs for MSM, IDU, and FSW.

Methods

Data were gathered from all publicly available documents from the websites for PEPFAR and the Global Fund (PEPFAR 2007–2010; The Global Fund Portfolio 2012). Countries were organized into three regional categories (Eastern Africa, Southern Africa, and Western/Central Africa) based on the classification system in place at the Global Fund (The Global Fund Portfolio 2012). Proposals that were not available in English or were not searchable due to file format were excluded. Countries that do not receive international donor assistance from PEPFAR or the Global Fund were also excluded.

For PEPFAR, we obtained the Country Operational Plans (COPs) for each country receiving funding through that program for US Fiscal Years 2007 through 2010. We were unable to review COPs for any time earlier than 2007 because the link on PEPFAR's website is broken. Full COPs are not available for any year after

2010. Regional Operational Plans and Partnership Frameworks were excluded from this analysis.

For the Global Fund, we obtained all original, approved proposals focused on HIV or HIV/TB for each country. In rare cases, grant scorecards and performance reports were also obtained and used as secondary sources to verify any unclear information in the original, approved proposal. We did not consider health systems strengthening or unfunded proposals. Rolling continuation channel and single-stream funding proposals were excluded from this analysis due to lack of clarity around newly proposed and existing programming (The Global Fund 2012). Multi-country proposals to the Global Fund were examined separately as discussed below, and do not count toward overall proposal tallies.

Global Fund grants were considered in the aggregate per funding round. For example, Nigeria received three grants from the Global Fund for Round 1. For the purposes of this analysis, those grants are considered together as one proposal.

Documents were analyzed according to standard search methodology using the terms: MARP, most at risk, vulnerable, MSM, men who have sex with men, homosexual, gay, FSW, sex work, commercial sex, transactional sex, IDU, inject, needle, syringe, and drug. In most cases, only a small number of these terms were required to find the appropriate information. Relevant portions of proposals were collected and analyzed to determine if, and to what extent, each proposal was attempting to address one or more of the key populations considered in this analysis (MSM, IDU, and FSW). Any epidemiological information related to these groups was recorded.

Through a qualitative analysis, we determined whether each proposal included programs focused on these key populations. Proposed programs were considered valid if they sought to deliver HIV prevention, treatment, or care programs directly to one of these groups. Programs that indirectly addressed these groups (e.g. discouraging sex work) and programs designed to collect additional data through surveillance or other means were not included.

Countries frequently used terms such as 'most-at-risk', 'high risk', and 'vulnerable' to prioritize certain populations. MSM, IDU, and FSW were inconsistently included in these groups. Therefore, we only considered proposed programs valid if a definition for these terms was included.

Limitations

The PEPFAR and Global Fund documents reviewed for this analysis are imperfect proxies for determining the demand for programs for key populations from African governments. Though we refer to documents from both donors as 'proposals', the information in them and the way in which they are used by each donor are very different.

Global Fund proposals come directly from national country planners and may more accurately reflect country demand. However, these documents are the first stage of a lengthy negotiation process between the financing agency and countries that involves

Eastern Africa (11)	Burundi, Comoros, Democratic Republic of Congo, Eritrea, Ethiopia, Kenya, Madagascar, Mauritius, Rwanda, Tanzania, Uganda
Western and Central Africa (19)	Benin, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Congo, Cote d'Ivoire, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Nigeria, Sao Tome & Principe, Senegal, Sierra Leone, Togo
Southern Africa (10)	Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe

Fig. 1. List of countries by region. Note: The Global Fund separates Tanzania and Zanzibar; however, for this analysis, they are considered one country.

	Global Fund	PEPFAR	Total
Eastern Africa	33	23	56
Western / Central Africa	35	11	46
Southern Africa	27	35	62
Total	95	69	164

Fig. 2. Proposals per region and donor.

		MSM	IDU	FSW	Total proposals with at least one program
Eastern Africa	Global Fund	7	6	18	40
	PEPFAR	9	4	22	
West/Central Africa	Global Fund	6	4	22	33
	PEPFAR	10	1	11	
Southern Africa	Global Fund	3	1	10	34
	PEPFAR	12	5	24	
Total		47	21	107	

Fig. 3. Proposals with key population programming by region and by donor.

significant programmatic and budget changes (The Global Fund Portfolio 2012). Previous analysis has shown that the outcomes of this process often disproportionately impact key populations (amfAR & Johns Hopkins Bloomberg School of Public Health 2012) and may contribute to some over-counting of programs. On the other hand, our decision to exclude single-stream and rolling continuation channel grants has likely excluded some programs that would otherwise qualify.

PEPFAR COPs are developed by US agencies in coordination with national planners. These documents may reflect the policy priorities of the USA and are limited by policy restrictions placed on PEPFAR by Congress. However, unlike Global Fund proposals, PEPFAR COPs are a closer approximation of actual work plans and are therefore a more accurate representation of actual programming.

Finally, the breadth of this analysis impeded its depth. We do not consider if programs are adequately addressing the needs of key populations or if funding is of a level to meet those needs. We also did not consider other funders in these countries who may be supporting programs for key populations. All of these areas are suited for additional research.

Results

A total of 180 documents were obtained for 40 countries from both websites (111 from 40 Global Fund countries and 69 from

19 PEPFAR countries). The list of these countries and their geographic classification can be found in Fig. 1.

Sixteen Global Fund proposals were excluded from this analysis because they were not available in English or the file was unsearchable due to its format, leaving 164 total proposals for review (95 Global Fund; 69 PEPFAR). Of these, 56 were from Eastern Africa (34%), 46 were from Western and Central Africa (28%), and 62 were from Southern Africa (38%) (Fig. 2). The 10 countries in Southern Africa had the greatest weight in our sample with an average of six proposals per country. Western and Central Africa had the smallest number of proposals per country (approximately 2) and also had the largest number of proposals that were excluded because of language and search issues (9 of 16 proposals).

Fig. 3 summarizes the number of proposals containing at least one program for each key population included in this analysis, by region and by funder. Of the 95 Global Fund proposals, 16 proposed programs for MSM (17%), 11 proposed programs for IDU (12%), and 50 proposed programs for FSW (53%). Of the 69 PEPFAR proposals, 31 proposed programs for MSM (45%), 10 proposed programs for IDU (14%), and 57 proposed programs for FSW (83%).

Of the 164 total proposals, 107 contained at least one program related to one of the key populations (65%), 64 proposals had

		MSM epi	IDU epi	FSW epi	Proposals with matched epi
Eastern Africa	Global Fund	0	2	6	6
	PEPFAR	4	7	14	14
West/Central Africa	Global Fund	2	0	7	6
	PEPFAR	5	1	5	5
Southern Africa	Global Fund	1	1	1	1
	PEPFAR	2	3	13	11
Total		14	14	46	44

Fig. 4. Proposals with key population epidemiology by region and donor (2007–2010).

programs for at least two key populations (39%), and 19 contained programs for all three (12%). Programs intending to serve FSW were included in a large majority of proposals (107; 65%), while those serving MSM were less common (47; 29%) and programs serving IDU, least common (21; 13%). All proposals with programs for MSM or IDU also contained programs for FSW.

Of the 56 proposals in East Africa, 40 contained at least one program for one of the three key populations (71%). In West and Central Africa, 33 of 46 proposals contained at least one program (72%), and in Southern Africa, 34 of 62 proposals contained at least one program for one key population (55%).

A small number of countries comprised the majority of proposals for MSM and IDU. Six countries (Cote d'Ivoire, Ghana, Kenya, Nigeria, South Africa, and Tanzania) accounted for 60% of all proposals containing programs serving MSM (28 of 47 proposals). Four countries (Kenya, Nigeria, South Africa and Tanzania) accounted for 62% of all proposals containing programs serving IDU (13 of 21). Programs for FSW were more evenly distributed, with 23 countries having two or more proposals containing these services.

Approximately 41% of all proposals contained some epidemiological information on at least one key population (67 proposals). More than half of the proposals containing programs for at least one key population also contained epidemiological information for one of these groups (58; 54%). Only nine proposals contained epidemiological information on key populations without also proposing programs. To address these populations the majority of epidemiological information was presented in 2007 or later (52 of 67 proposals; 78%). Fig. 4 summarizes the presence of epidemiological information in proposals from 2007 to 2010 (38 Global Fund proposals for Rounds 7 through 10 and all PEPFAR COPs) and whether that information was matched to programming (i.e. proposals with epidemiological information on a key population also included programming for that same population).

Of the 86 proposals containing programs for FSW between 2007 and 2010, 51% (44 proposals) matched that data to epidemiological data (abbreviated as 'epi' above). For IDU, 9 of 21 proposals during this period (43%) contained matched data and programming; for MSM, 12 of 46 proposals were matched (26%).

FSW

The type of programs proposed for FSW were consistent across countries and donors but varied by year with earlier proposals

to both PEPFAR (2007 and 2008) and the Global Fund (Round 1 through 7) focused mainly on peer education, behavior change communication (BCC), and condom social marketing. In a majority of earlier proposals, FSW were included as part of a much larger target population focused on sexual networks, including long-distance truck drivers, police, military, miners (in Southern Africa), and fishermen.

More recent proposals (PEPFAR 2009 and 2010 and Global Fund Rounds 8, 9 and 10) included screening for sexually transmitted infections (STI), sex work 'friendly' clinical care, income-generating programs, male and female condom distribution, and HIV counseling and testing. A minority of proposals also included FSW as targets for treatment of opportunistic infections and HIV.

MSM

All programs for MSM recorded in this analysis appeared in proposals submitted in 2007 or later. In many cases, MSM were first mentioned as targets for epidemiological surveillance. These instances were not counted as part of this analysis. When MSM were mentioned as targets of programming, those programs most often included BCC, STI screening and treatment, peer education and outreach, condom and lubricant distribution, and HIV counseling and testing. A small number of programs included sensitivity training for clinicians working with MSM. The majority of programs for MSM were occurring in major urban centers.

IDU

Like MSM, all of the proposals containing programs serving IDU appeared in 2007 or later. Several proposals that indirectly addressed IDU were excluded. Those directly targeting IDU most frequently focused on programs similar to those offered to other key populations: BCC, STI screening and treatment, and HIV counseling and testing. Four proposals contained drug replacement or methadone programs. One proposal specifically mentioned syringe exchange (Mauritius).

Multi-country

There were two multi-country proposals to the Global Fund that were included in our analysis. The Western Africa Round 6 grant spanned five countries (Benin, Cote d'Ivoire, Ghana, Nigeria, and Togo) and primarily targeted truck drivers traveling between Abidjan and Lagos and the FSW along that route. Though 'homosexuals' were mentioned in the proposal, it is unclear if there were any programs that directly addressed this group. The proposal included country-by-country epidemiology for FSW.

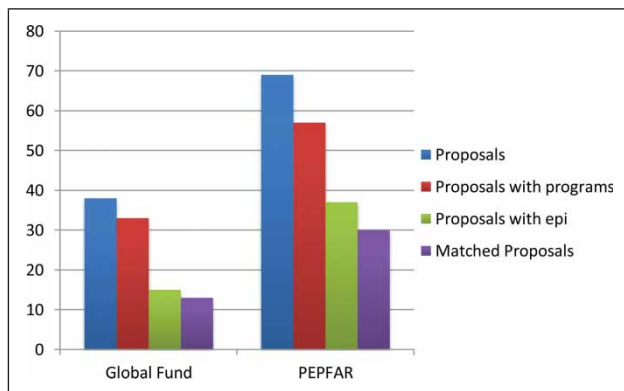


Fig. 5. Cascade of total proposals by donor (2007–2010).

The Southern Africa Round 9 grant spanned 14 countries (Angola, Botswana, Democratic Republic of Congo, Lesotho, Mauritius, Malawi, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe). FSW are targeted for condom promotion and distribution activities. MSM and IDU are mentioned, but there are no programs for them. The proposal has no epidemiology specific to key populations.

Due to the difficulties in determining which of these programs occurred in which countries, the multi-country proposals have been excluded from our overall tally.

Discussion

Awareness of the HIV epidemic among MSM, IDU and FSW in Africa has increased in recent years (Avdeeva 2011; Baral *et al.* 2012; Dutta *et al.* 2012; Global Fund 2011; Hladik, Barker, Ssenkusu, Opio, Tappero, Hakim, *et al.* 2012; Vuylsteke, Semdé, Sika, Crucitti, Ettiègne Traoré, Buvé, *et al.* 2012). These data refuted previously held beliefs that key populations either did not exist or did not contribute greatly to the epidemic on the continent (UNAIDS 2007, 2010). This analysis shows that demand for programs addressing key populations is highly concentrated. The sum total of proposals containing programs for these populations obscures the more important truth that a very small subset of countries accounts for the majority of programs. Kenya, Nigeria, South Africa, and Tanzania account for 1 in 5 proposals containing programs for FSW, 2 in 5 of the proposals for MSM, and 3 in 5 of the proposals for IDU. Tanzania alone accounts for 1 in 6 of all proposals containing programs for MSM and IDU combined.

Epidemiological data were not closely linked to programming even though they were present in a majority of proposals with key population programming. Fig. 5 demonstrates the cascade that occurs between total proposals and those with epidemiological data matched to programming for proposals submitted in 2007 or later (when the majority of these programs were proposed).

The cascade shows the dramatic drop-off in proposals that are informed by epidemiological data and an even further reduction in the number of proposals that match data and programming.

Programming for key populations in Africa is detached from data that would better inform the delivery of those services.

This is particularly troubling given recent trends. The global financial crisis of the last 5 years forced a greater focus on the efficient use of resources for responding to HIV. The discussion about how countries and donors should spend limited funds was best articulated in an article in the *Lancet* in 2011 (Schwartlander, Stover, Hallett, Atun, Avila, Gouws, *et al.* 2011). The authors proposed an 'investment framework' for HIV that is premised on the need to tie national responses to the latest epidemiological and scientific data. Responding to the epidemic among key populations plays a central role in this framework.

Implementation of the investment framework in Africa will require two simultaneous efforts. First, donors and national governments must fund the collection of strategic information on key populations, including the latest epidemiological data, and second, donors must actively incentivize programs for key populations in countries that may be reluctant to adopt them. The Global Fund's recent work on the Round 10 reserve fund is an example of the latter (Aidspan 2010).

Effective programs for key populations take years to build. Countries with the most expensive proposals in 2010 often first proposed programs for these populations many years earlier. Concerted efforts by implementers, county planners, and donors are needed to encourage programming from countries that have been reluctant to address the epidemic among these groups. This will require all of these actors to confront the appalling human rights record that exists in many settings where PEPFAR and Global Fund are investing (von Zinkernagel 2010). Incentivizing demand for and increasing the quality of services delivered to key populations in Africa are not simply matters of addressing bureaucratic inefficiencies, but, rather, of challenging the structures that enable stigma, discrimination, and violence.

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