FIRMER FOUNDATIONS

RECOMMENDATIONS TO PEPFAR, USAID AND CDC FOR POLICY AND STRUCTURAL REFORM TOWARDS EQUITABLE, DIGNIFIED, SUSTAINABLE KEY POPULATIONS PROGRAMMING; LESSONS LEARNED FROM COMMUNITY MONITORING OF THE KEY POPULATIONS INVESTMENT FUND (KPIF)

POSITIVE VIBES
Hope - Respect - Voice

INTRODUCTION

Positive Vibes is a Namibian-registered regional civil society organisation working primarily in Southern and East Africa. To advance its vision – its impact ambition – of the End of Othering, Positive Vibes supports and accompanies LGBTIQ people, sex workers, people living with HIV, adolescent girls and young women and their respective communities and organisations in their work to find and express voice, to more effectively exercise civic action and public accountability, and to achieve access to health, rights and justice with equity, dignity and respect.

In 2020, Positive Vibes partnered with ViiV Positive Action to strengthen community-led monitoring and accountability through the entry-point of the Key Populations Investment Fund (KPIF). One product of that partnership was the *Talking Points* series through which LGBTIQ and sex worker organisations, and networks of people living with HIV – co-implementing sub-recipients of KPIF through USAID and CDC – reflected on and documented their experiences of KPIF-implementation and partnership with their respective Principal Recipients.

> In Lesotho, local partners developed *"Where the Shoe Pinches: More Than Numbers; a call for empathy, dignity, equity and accountability in partnership for the health and rights of sexual and gender minorities in Lesotho."*
>
> In Eswatini, local partners developed *"Treat All Like Equals: a call for egalitarian partnerships in Key Populations Programming."*
>
> In Namibia, local partners developed *"Net Nommers en 'n Klomp Moffies[1] : an appeal for care, dignity and equality in partnership for Key Populations Programming in Namibia."*
>
> In Zambia, local partners developed *"Squatters in Our Own Camp: a call to respect the leadership, agency, and dignity of Key Populations communities in Zambia."*

[1] *"Just numbers and a bunch of gays"*

Although each country context is unique, and the experiences of local partners were varied in detail, several themes were consistent across all four countries, and confirmed in the anecdotal reflections of Key Population-led community organisations in other countries such as Uganda and Kenya. Communities felt distanced from the vision, promise and operations of KPIF, and disappointed, disenfranchised, devalued, diminished, and disrespected by the architecture of the project. Specifically, in each country, Key Populations communities were dissatisfied by the way they were regarded and treated by powerful Principal Recipients, whose passively careless or actively harmful practices towards their considerably less powerful community sub-recipients were enabled and protected – or interpreted and represented to be as such – by systems, structures and policies prescribed by PEPFAR, USAID and CDC. Issues, challenges, concerns, and injury were not idiosyncratic or localised; they are systemic and structural, and have direct, demonstrable, and measurable impact on trust, confidence, reputation, quality, reach, receptiveness, uptake, continuity of care, and effectiveness of essential services and interventions amongst already hard-to-reach and vulnerable populations.

As PEPFAR embarks on a new strategic period from 2021, with greater emphasis on community-led monitoring, community participation and consultation, and a more cooperative and collaborative therapeutic alliance, sustainable quality improvement in programming cannot be achieved exclusively through situation-specific remedial action to resolve short-term operational challenges at discrete local level. Structural reform is necessary within PEPFAR, USAID and CDC to address unproductive and unconstructive disparities in equity and power that destabilise the foundations on which high-quality, ethical, sustainable service-delivery are built.

Recommendations are offered below that may have value and relevance across agencies and US Government institutions – PEPFAR, USAID and CDC – where the US government engages supportively with Key Populations communities through health and development programme assistance.

1

TRANSPARENCY

PEPFAR, USAID and CDC should make provision for **reasonable transparency** of contracts and agreements within cooperative partnerships between CDC and Principal Recipients.

Communities and indigenous organisations who are intended beneficiaries of programmes supported through cooperative partnerships with Principal Recipients – and who are co-implementers of activities and strategies through sub-grants – should have insight into, within reason and to the greatest extent possible:

a. terms and conditions of the contract.

b. obligations and deliverables of the Principal Recipient, particularly where these have implications for action towards or with communities and sub-grantees (for example, to deliver meaningful capacity-strengthening support to Key Populations-led organisations).

c. financial information that may include:

   i. the overall budget allocation
   ii. the distribution of the grant across programme, administration, and management areas
   iii. the proportional distribution of the grant between Principal Recipient and sub-grantees
   iv. expenditure data disaggregated by budget line or programme.

   Transparency may be easily facilitated through the release of readily available PEPFAR Financial Classification data on budget and expenditure, disaggregated at below-country level.

2

ACCOUNTABILITY

Abuse of power is made possible through disparities in power between Prime Recipients and community sub-grantees. These disparities, in turn, are the product of unequal access to information, an absence of transparency, and the absence of a **standard, institutionalised mechanism for bi-directional accountability**.

Sub-grantees are subject to scrutiny for their effective management of the funds they receive, but Principal Recipients who receive the substantially greater proportion of the grant are under no obligation to share similar information.

PEFPAR, USAID and CDC should require that:

a. Principal Recipients periodically **publish appropriate, specified financial information** to make expenditure against agreements and deliverables transparent to sub-grantees who are, themselves, beneficiaries of the work of the Principal Recipient and select direct interventions (eg. capacity-strengthening)

b. Principal Recipients periodically **publish their programmatic reports that include service-delivery data** and other outputs, as per the grant agreement, and performance-reporting against programme indicators. These data are presented to sub-grantees for review, analysis, and validation.

c. A standard mechanism for bi-directional accountability be institutionalised. To be effective, that mechanism cannot be ad hoc; it must be **formalised with clear guidance and procedures** that may include:

   i. Clarity to both Principal Recipients and sub-grantees around communications access to USAID or CDC, to reinforce present policy that no legal barriers exist prohibiting direct contact between agencies and communities when warranted (although discussion about specific budgetary or contractual details may not be permissible in the absence of the Principal Recipient).

   ii. A clearly communicated, transparent process for systematic oversight and management of the Principal Recipient by USAID or CDC, against deliverables that are known to community beneficiaries and sub-grantees.

   iii. A clearly defined procedure for reporting incidents that, through the action of the Principal Recipient, amongst other things, violate dignity or safety of sub-grantees, demonstrate homophobia or transphobia, compromise the organisational integrity of sub-grantees, seek to intimidate through direct or indirect threat, or are ignored when reported. That procedure must include guidance for escalating grievances when necessary, and provisions to protect sub-grantees and community stakeholders from retaliatory consequences.

   iv. A provision for direct feedback and reflection from sub-grantees on their experience with the Principal Recipient, their satisfaction with the conditions of the partnership relationship, the performance of the PR to manage and administer the project efficiently, and to deliver on agreed supportive interventions. Potentially, feedback of this type could be formalised in standard reporting forms that, periodically, go directly to USAID or CDC – not through the Principal Recipient as do other operational reports – to support its awareness and oversight function, and to inform periodic structured dialogue between USAID or CDC, Principal Recipients, and sub-grantees.

3

CAPACITY STRENGTHENING

Key Population-led organisations at community level are commonly ineligible to receive direct funding to advance their work – including reaching their constituencies effectively, responsibly, and sustainably – owing to **a frequently cited *"lack of capacity",*** a principle that both illustrates and perpetuates the disparities between country-based international NGOs who function as Principal Recipients and community sub-grantees.

In as much as Principal Recipients are charged to build capacity that will support transition of funds to indigenous organisations, there is no incentive for them to do so; it is to their detriment in an environment in which they are competing with communities for resources.

To optimise and maximise the impact of the therapeutic alliance – where effective services are designed, planned, and delivered by Key Populations themselves – PEPFAR, USAID and the CDC should:

a. **Develop and implement a systematic capacity-strengthening process** that is not simply ad hoc, at the discretion of Principal Recipients to interpret, characterise and deliver. Principal Recipients for a grant must have, to inform their own deliverables during that grant period, the clear mandate to achieve the US Government goal of developing sub-recipient community organisations to receive and administer funds directly. A systematic capacity-strengthening programme will be incremental; it will be structured; it will have achievable milestones and markers of progress. Alternatively, PEPFAR, USAID or CDC should outsource that institutional strengthening function to an independent organisation, allowing the Principal Recipient to focus on service-delivery. Or the Principal Recipient should sub-contract a partner, identified and trusted by communities, with experience in capacity-strengthening and organisational development to achieve these objectives within the active project period.

CAPACITY STRENGTHENING/cont.

b. **Reconceptualise the conventional definition and interpretation of 'capacity'**, and the theories around how this is achieved within organisations. Small, community-level organisations 'receive capacity-building' when they – often non-professional staff who initially joined organisations as volunteers and activists from the community – are trained by their larger organisational partners in professional functions, for example, financial management, administration, monitoring, reporting or data-collection. Large organisations – like Principal Recipients, for example – have a different orientation to capacity building: they buy it. They strengthen the capacity of their organisations – their systems, their proficiency, their competitiveness – by employing permanent staff or contracting short-term consulting support. They offer a living wage that is at market rate to attract talent. They provide benefits. There is a fundamental inequity in the definitions of capacity as a strategy for institutional strengthening that apply to community sub-grantees compared to the definitions that apply to Principal Recipients.

c. **Reconfigure its grant-structure** – possibly through increasing its indirect cost rate -- to give sub-grantees the ability to increase their capacity by bringing on-board personnel. Sub-grants should better reflect capacity-strengthening strategy, and not only emphasise operational, programmatic, and service-delivery priorities. This might imply, practically:

    i. Allocating resources – either through the systematic capacity-strengthening process, or through reasonable salary and benefits for personnel, or through a specific budget-line – for human resource development to allow existing staff to upgrade skills and qualifications.

    ii. Ensuring that sub-grantees attract a minimum 10% indirect cost rate.

4

LANGUAGE

Decades of a global HIV response have shown the fluidity of language to adapt to become **more appropriate, more sensitive, more inclusive**, more aware of the dignity and humanity of people. Many years ago, *"AIDS Victims"* and *"AIDS Patients"* became *"People living with HIV".* And most recently, PEPFAR's COP-21 guidance updated terminology, replacing *"retention"* with *"continuity"* to emphasise client agency.

PEFPAR should consider that **language shapes beliefs and attitudes that, in turn, shape behaviour and interactions.** Fundamentally, the language of *"Prime"* or *"Principal"* and *"sub"* support a hierarchical relationship that may be intended to simply describe a structure and function for the flow of funds but, practically, has the effect to frame and normalise disparities in power and position and authority, and to undermine the independence and agency of so-called *"subs"* to act, to reach out, to connect, to exercise accountability without requiring permission from the *"Prime".*

Changes in language will not automatically or comprehensively change the associations inherent in the relationship between Primes and subs, but it could indicate important intention by making institutional power and hierarchy less explicit. Could Principal Recipients, for instance, be the *"Grant Administrating Partner"?* Could sub-recipients, for instance, be the *"Frontline Implementation Partners"?*

5

KP-COMPETENT AS A SUBSTITUTE FOR KP-LED

Increasingly, as policies reflect an intention to transition funding to indigenous organisations, **two distinct categories of organisation** are being described by agencies such as PEPFAR, USAID and the CDC, and subsequently presented in ways that are, operationally, interchangeable, or complementary.

Certainly viewing these as similar is convenient for the allocation of funds according to a policy that prioritises Key Populations. But *Key Population-led* organisations – comprised of and representing actual communities and population groups – are not the same as *Key Population Competent* organisations. So-called *"KP Competent"* organisations may have a history of delivering services, but that does not automatically speak to their acceptability or appropriateness or proficiency in working with communities. Often, the opposite may be true: service-providing organisations can be homophobic, transphobic, marginalising, and harmful of already vulnerable communities.

PEPFAR, USAID and CDC should:

a. **Revise its working definition of *"KP Competent"*.** Competence must involve more than a historic association with Key Population's communities who are beneficiaries of services; technical knowledge of HIV-programming; and financial management ability. PEFPAR's COP-21 Guidance (Chapter 6) may offer a useful point of departure against which practice, behaviour, reputation, and attitude of prospective KP-Competent organisations must be assessed:

> *"KP-competent" organizations have specific aptitudes to service KP communities. Fundamentally, these competencies value the insight and leadership of KP community members in designing, implementing, and evaluating KP programs. Services offered are non-judgmental and non-stigmatizing, meeting the unique needs of KP clients, and 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. These competencies are based on the WHO (2016) Consolidated Guidelines on HIV Prevention Diagnosis, Treatment and Care for Key Populations."*

KP-COMPETENT VS. KP-LED/cont.

b. In keeping with the PEPFAR COP-21 Guidance,

   i. **Consult with communities and populations, and sub-grantees, at country level to develop practical working definitions of and criteria for determining *"KP Competence"*** in organisations that are specifically *KP-led,* relevant to the local setting and experience.

   ii. **Consult meaningfully and systematically with communities to identify and, ultimately, select non-KP Led organisations that meet a community-determined standard of acceptability.** PEPFAR, USAID and CDC country offices may have experience of working alongside traditional service-delivery organisations, and may hold them in high regard, but that estimation is no substitute for community endorsement. (Enabling communities to have a legitimate voice in selection of KP Competent organisations is a complementary strategy for equalising power and establishing accountability.)

   iii. As in *'3: Capacity Strengthening'* above, **prioritise development of Key Population-led organisations through accelerated, systematic, capacity-strengthening** so that non-KP led organisations no longer need to be a substitute for genuine community leadership, expressed at the highest levels of professionalism as possible.

6

COMMUNITY-LED MONITORING

Formalising and institutionalising monitoring and accountability by communities towards service-providers is **a complementary strategy for equalising power through normalising accountability**. It is a way to make community voice and experience central to quality assurance and quality improvement. It is a way to build confidence and trust amongst communities who respond favourably to receptive facilities and service providers and increase utilisation of services. It is a means to support the exercise of civic and political rights through the entry-point of health, without explicitly funding advocacy or structural intervention.

PEPFAR, USAID and CDC should:

a. Prioritise and accelerate the **roll-out of community-led monitoring** as a complementary intervention alongside biomedical service-delivery.

b. **Protect the integrity of the monitoring practice:** that communities retain the ability to monitor with some measure of independence; that methods for monitoring and specific indicators and components are not prescribed to communities but that they, instead, retain leadership and initiative to decide about the issues that matter most; that monitoring does not become reduced to decentralised data-collection and health outcome surveillance performed for others (eg. Ministry of Health; Principal Recipients; Implementing Partners; US government agencies) by communities.

c. **Review eligibility criteria for access to funding for community-led monitoring**. Many of the Key Population-led organisations that represent communities who should be monitoring service-delivery are, at the same time, co-opted into service delivery as sub-grantees (often only with a role to mobilise peers, with no responsibility to influence clinical practice by healthcare workers); consequently, they are not eligible to access funds to support monitoring, even though they, themselves are communities and populations who are beneficiaries of the services.

7

POLICIES ON HARM, SAFETY, AND SECURITY

Work is needed to, specifically and explicitly, **safeguard sub-grantees from harm** that might come through direct physical violence; coercion; intimidation; pressure to perform in unsafe conditions; victimisation by law enforcement or exposure to contagious, infectious disease.

PEPFAR, USAID and CDC should:

a. **Formalise policy and guidance that are explicitly incorporated into cooperative agreements** to protect sub-grantees and beneficiaries from certain types of harm. Policies and agreements make a *"do no harm"* principle, that includes non-coercion, explicit to Principal Recipients who may not compromise the wellness or safety of implementers or community members to, for example, meet targets, or require them to expose themselves to harm to avoid the risk of funding being withdrawn for poor performance.

b. Develop **a framework of minimum expected requirements or minimum standards for safety and security** to be observed by Principal Recipients that:

   i. Requires Principal Recipients to position themselves pro-actively and supportively of sub-grantees, communities, and Key Populations within their restrictive socio-legal environments.

   ii. Makes US Government funding to "KP-Competent" Principal Recipients responsible for Key Populations programming **conditional upon a signed undertaking by the Principal Recipient** – similar in effect to the Mexico Policy – to be available to and supportive of sub-grantees who experience harm or violation during the course of programming.

c. Require that prospective **Principal Recipients submit, with application for funds, a document that details their internal organisational policy and principles around Safety and Security.** A successful applicant organisation will have policies that demonstrate their values and outline their practical provisions to ensure that no harm will come to implementers or sub-grantees, and their position on providing recourse.

8

COMPREHENSIVE PROGRAMMING TOWARDS THE END OF HIV: SERVICE-DELIVERY + STRUCTURAL INTERVENTIONS

It is a false binary that Key Populations-led **organisations should choose between public health and service-delivery programmes or human rights, advocacy, and structural intervention programmes** when evidence is overwhelmingly clear that the vulnerability of Key Populations to HIV is a function of biomedical and sociolegal environmental factors.

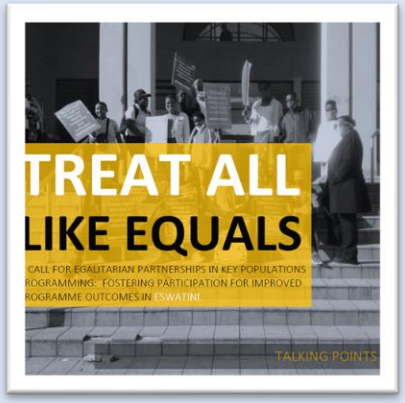
Structural issues compromise access to, uptake and continuity of testing, care, and treatment. Structural issues exacerbate behaviours and practices that increase people's risks of exposure and transmission. Violations of rights occur, routinely, to sub-grantees during the course of their service-delivery, even at the hands of law enforcement. LGBTIQ treatment supporters and community mobilisers get arrested or attacked.

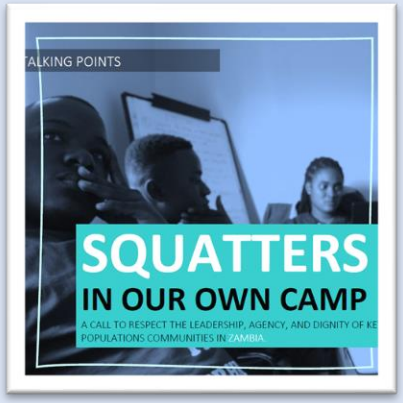
PEPFAR, USAID and CDC should:

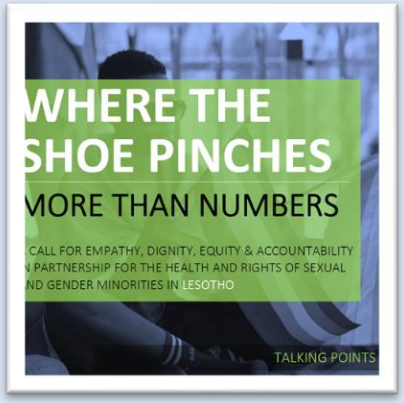
a. **Be attentive to and responsive to Key Population proposals for programme design:** that comprehensive programming that makes resources available for both service-delivery and structural reform, together with capacity-strengthening of organisations, yields higher, deeper, more sustainable HIV-related outcomes.

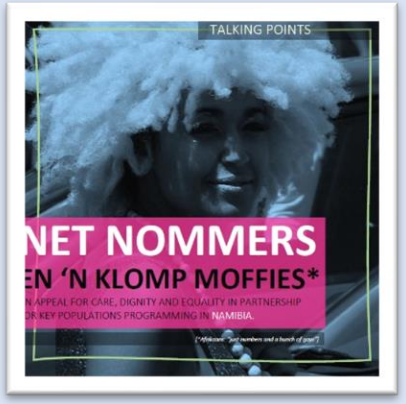
b. Consider reserving a **10%-15% proportion** of Key Population programme grants for structural interventions and human rights work that are critical enabling factors for consistently accessible and effective biomedical HIV-related service delivery.

For more information about or insight into this publication or these recommendations, or for information about the *Talking Points* series that informed these recommendations, please contact Positive Vibes Deputy Director responsible for Regional Programming, Lee Mondry, at Lee@positivevibes.org









Developed by Positive Vibes, in collaboration and consultation with LGBTIQ and sex worker-led partners: TBZ (Zambia); The People's Matrix Association (Lesotho); Rock of Hope (Eswatini); Voice of Hope Trust (Namibia); MPower Community Trust (Namibia); Wings to Transcend Namibia (Namibia); Rights Not Rescue Trust (Namibia).

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