REGIONAL SUMMARY OF FINDINGS OF AN ASSESSMENT OF HIV SERVICE PACKAGES FOR KEY POPULATIONS IN SELECTED COUNTRIES IN LATIN AMERICA AND THE CARIBBEAN

April 2019
This report was produced by APMG Health, Inc. for Global Fund to Fight AIDS, Tuberculosis and Malaria, under Purchase Order 20177290. The opinions presented here belong to the author and do not represent Global Fund’s official position.

This work may be cited as follows:


**ACKNOWLEDGEMENT**

This regional report is drawn from the Key Population country reports and desk reviews for the Latin America and the Caribbean region. APMG Health would like to thank Nathalie Zorzi, Jinkou Zhao, Chinelo Ogbuanu and the other staff of the Monitoring and Evaluation and Country Assessment Team (MECA); Ed Ngoksin from the Community, Rights and Gender Department; and Susie McLean from the HIV program at the Global Fund, for their leadership and assistance in this project and in preparing this regional report. We also thank the international and local consultants who conducted the country-level assessments, the staff from global and regional organizations who provided feedback on the draft version of the report and the stakeholders/informants from the various services and key populations who participated in the process.
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### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>CARICOM</td>
<td>Caribbean Community (Organization of States)</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
</tr>
<tr>
<td>CDC</td>
<td>US Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CERITS</td>
<td>Centro Especializado de Referencia de ITS/VIH y SIDA</td>
</tr>
<tr>
<td>DR</td>
<td>Dominican Republic</td>
</tr>
<tr>
<td>ECVC</td>
<td>Encuesta Centroamericana de Vigilancia de Comportamiento Sexual</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion(s)</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex worker(s)</td>
</tr>
<tr>
<td>GAM</td>
<td>UNAIDS Global AIDS Monitoring reports</td>
</tr>
<tr>
<td>GARPR</td>
<td>Global AIDS Response Progress Reporting</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based Violence</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counseling</td>
</tr>
<tr>
<td>IBBS</td>
<td>Integrated Bio-Behavioral Surveillance</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education and communication</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>LAC</td>
<td>Latin America and the Caribbean</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
</tr>
<tr>
<td>LTFU</td>
<td>Loss to follow-up</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MARP</td>
<td>Most-at-risk-populations</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>MSW</td>
<td>Male sex worker(s)</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NSP</td>
<td>Needle and Syringe Program(s)</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
</tr>
</tbody>
</table>
# Assessment of HIV Service Packages for Key Populations

## Latin America & Caribbean

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The US President’s Emergency Fund for AIDS Relief</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission of HIV</td>
</tr>
<tr>
<td>PR</td>
<td>Principal Recipient(s)</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
</tr>
<tr>
<td>PSE</td>
<td>Population size estimate(s)</td>
</tr>
<tr>
<td>PUDR</td>
<td>Progress Update Disbursement Request</td>
</tr>
<tr>
<td>PWID</td>
<td>People who inject drugs</td>
</tr>
<tr>
<td>PWUD</td>
<td>People who use drugs</td>
</tr>
<tr>
<td>SASOD</td>
<td>Society Against Sexual Orientation Discrimination</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedure(s)</td>
</tr>
<tr>
<td>SR</td>
<td>Sub-recipient(s)</td>
</tr>
<tr>
<td>SSR</td>
<td>Sub-sub-recipient(s)</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection(s)</td>
</tr>
<tr>
<td>SW</td>
<td>Sex Worker(s)</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender people</td>
</tr>
<tr>
<td>UAMP</td>
<td>Unidad de Atención Médica Periódica</td>
</tr>
<tr>
<td>UCSF</td>
<td>University of California, San Francisco</td>
</tr>
<tr>
<td>UIC</td>
<td>Unique Identifier Code</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>VMMC</td>
<td>Voluntary medical male circumcision</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
**EXE**CUTIVE **SUMMARY**

The World Health Organization (WHO) has clearly outlined the comprehensive package of services that should be available for men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), transgender people (TG), and prisoners (WHO, 2016). Global Fund contracted APMG Health to assess the design, implementation and monitoring of national HIV service packages for key populations (KP) in 65 countries, across six regions, in which Global Fund has provided HIV grant funds.

These are the results of the assessments conducted in the region of Latin America and the Caribbean (LAC). This report is based on six country-specific desk reviews and five in-country assessment reports. Each of the latter group of assessments consisted of an initial desk review and an in-country assessment. The Global Fund Country Team for each country provided data sources used for completing all desk reviews. For those five countries with in-country assessments, fieldwork was conducted over the course of five days, with the exception of Haiti, which was selected for an extended visit of 10 days. For the five-day country visits, two KP and two sites were selected, with the exception of Haiti and Guatemala, where three sites were selected. All populations and sites were selected with guidance from Global Fund Country Teams and Country Coordinating Mechanisms (CCM) based on existing programs in the countries.

Table ES1. Latin America and the Caribbean Key Population and Site Selection

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Selected</th>
<th>Sites Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominican Republic</td>
<td>MSM &amp; TG women</td>
<td>Santo Domingo &amp; Santiago de los Caballeros</td>
</tr>
<tr>
<td>Guatemala</td>
<td>MSM &amp; TG women</td>
<td>Guatemala City, Mazatenago &amp; Escuintla</td>
</tr>
<tr>
<td>Guyana</td>
<td>MSM &amp; FSW</td>
<td>Georgetown (Region 4), Region 5 &amp; Region 6</td>
</tr>
<tr>
<td>Haiti</td>
<td>MSM &amp; FSW</td>
<td>Port-au-Prince, Cap-Haitien &amp; Saint-Marc</td>
</tr>
<tr>
<td>Peru</td>
<td>MSM &amp; TG women</td>
<td>Lima-Callao &amp; Iquitos</td>
</tr>
</tbody>
</table>

Data was collected through the following mechanisms: document review; interviews with national stakeholders responsible for design of packages; visits to at least two sites where packages are implemented, including observation of service delivery, interviews with staff and KP focus group discussions (FGD); and interviews with and examination of monitoring forms, methods and databases. It should be noted that the primary method of assessing quality of services was through FGD with KP. A desk review was also conducted on recent literature related to KP in the region.
There were several limitations in conducting this assessment process, including during the initial desk review portion of the country assessments. For the ‘desk review only’ countries, APMG Health did not conduct an in-country assessment to collect data and information that could disprove or verify information found in the initial desk review. Data for these six countries has been included throughout this review, however, it has been noted that consultants were limited to those data provided by Global Fund in quarter four of 2017.

Due to time restrictions of country visits, only two to three sites were selected for assessment during the in-country assessments (see Table ES1). It is important to note that because of this, country assessments are not national and reports only speak to data available in the regions, districts and cities that were visited or within other reports reviewed. Also due to time restrictions, only two out of the five key populations were assessed during in-country data collection in most countries. This regional analysis is based on a selection of countries within a region and therefore is not representative of the entire region.

This report is one of six regional reports produced to summarize the assessment findings. A global report has also been prepared.

DESIGN

Almost all the assessed countries have taken the opportunity to formally recognize most KP in their national plans and strategies and acknowledge the importance of providing services to KP by designing tailored packages based on WHO guidance. Designs of key population service packages from the LAC region are a blend of over- and under-specification, especially of commodities. The fact that only seven countries specify distribution of male condoms and three specify female condoms for female sex workers (FSW) is concerning. Similarly, there seems to be variable attitudes among countries regarding the need for lubricant distribution to MSM, TG women and FSW. Yet in both the Dominican Republic (DR) and Guatemala, there are stipulated numbers of condoms and lubricant sachets identified, and these are identical for KP with very different needs.

The lack of inclusion of post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) for MSM and TG women in most countries is also problematic, given the relatively higher levels of HIV prevalence in these populations in most of the assessed countries. As will be noted further in this report, packages specific to important sub-populations such as male and/or transgender SW, women who inject drugs and adolescent KP are rarely included.

The availability of testing models to reach harder-to-reach populations (e.g. rapid testing in various venues and through different outreach methods) is highly variable and warrants careful planning in the design phase, according to population size and distribution.

High levels of stigma, discrimination and violence towards all KP are reported, with very high violence and murder rates for TG women. The legal situation is mixed with sex between men and sex work illegal in some countries, but not in others. Illicit drug injecting is illegal in all countries. All countries have undertaken or are planning activities to enhance the enabling environment.
RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Defined packages of services should include interventions for all key populations that have been identified in the country. There may be minor variations depending on local epidemiology and behavior. The involvement of members of KP should be seen as integral to the package design process.

2. All countries in the region should recognize prisoners as a KP and develop a specific package of HIV services to be provided to this population.

3. Rapid situation assessments (using WHO methodology) should be conducted to understand more about the PWID population and the level of injection drug use in the region; once more information is available about this population and their needs, it will be necessary to design and develop a specific package of services for PWID in those countries where it is epidemiologically appropriate to do so.

4. All countries in the region require at least the basic services for each KP to be in the designed service packages. All KP packages should contain condom and lubricant distribution, with female condoms included (at least) in all SW programs (depending on acceptability), and needle and syringe programs (NSP) included (at least) in all PWID programs. Distribution should be based on the needs of KP rather than a figure contained in the design document. Sexually Transmitted Infection (STI) screening, diagnosis and/or treatment should be free of charge to these populations.

5. Needs-based services should also be included in service packages for all KP, including the offer of PEP, STI, TB, and hepatitis B and C services. Programs for MSM, TG women and SW should include access to PrEP.

6. Critical enabler activities should be specified in all KP packages. Assessments on human rights barriers to key populations’ access to HIV services have been carried out in some LAC countries (Honduras and Jamaica). Similar exercises should be carried out in all countries. All countries should have a strategy to address ongoing human rights issues that impact key populations’ access to HIV and broader health services. This strategy should be explicitly linked to overall national HIV strategies and plans.

7. All countries should continue to progress toward clear definitions of coverage of all elements of service packages.

8. Consideration should be given to providing flexibility for optional, enhanced services to be provided alongside core services in order to attract clients and to address some of the underlying reasons why various KP may not want to present for HIV testing, PrEP or antiretroviral treatment (ART), or may not want to remain on ART.

9. Additional services may need to be defined for specific sub-populations, such as male and/or transgender SW, women who inject drugs, and adolescent KP.

10. Where mental health interventions are included in service packages, there is a need for greater understanding of the mental health needs of different KP, and therefore, more
thoughtful, realistic and well-described interventions within service packages as well as adequate resourcing of these services.

11. The development of minimum standards for behavioral interventions, which are attuned to population needs, would ensure that the intent of the design of this intervention carries over into appropriate resource mobilization and implementation as well as impact.

IMPLEMENTATION

In general, packages appear to be implemented largely as designed, though with a variety of problems in terms of service delivery. It is evident that some interventions in some countries began prior to the introduction of defined packages of services, but the guidance from international organizations, coupled with national design processes, appears to have broadened the types of services available to KP.

Coverage for most interventions is variable across the countries assessed and there appear to be particular problems in testing sufficient numbers of the right people and, where they test positive, linking them to care. In addition, issues were raised regarding:

- Behavior change communication (BCC) through time-limited group education sessions (Haiti, DR and Guatemala).
- Numbers of condoms and amounts of lubricant issued.
- ART and condom stock-outs and the lack of specific earmarking of condoms for KP, with KP needs supposed to be met out of general population condom procurement.
- Interruptions in service availability due to issues with delays in signing of Global Fund grants.

RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS

1. After determining core interventions for each KP in national, defined service packages, ensure that these services are implemented at the scale needed to address the HIV epidemic in each country. Strategies need to be put in place to ensure that core interventions are available to the majority of KP in each country, regardless of funding source or service delivery agent.
2. Introduce and maintain regular feedback sessions with clients, whose concerns should be acted on quickly through the chain of responsibility from sub-sub-recipient (SSR) through sub-recipient (SR) to principal recipient (PR) and, if needed, CCM or CCM Oversight Committee. This procedure should be connected to a continuous quality improvement program.
3. The distribution of condoms and lubricants only or mostly through group peer education or information sessions, such as the séances in Haiti, needs to be carefully evaluated. While these sessions may provide opportunities for building awareness and empowerment among KP, strategies for broader distribution are necessary for ensuring sufficient supplies of prevention commodities to key populations.
4. The frequent mention of ART stock-outs in several countries suggests a strong need to address procurement and supply management issues in the LAC region. This is not specific to KP, but it is critical to ensuring the health of KP living with HIV.
5. The focus on information, education and communication (IEC) and BCC materials and peer discussions on HIV testing and prevention often results in less emphasis on living well with HIV, and this gap in IEC/BCC can lead to a lack of understanding among KP of the benefits of knowledge of HIV status and of clinical care and treatment for those living with HIV. There is a need to create space in prevention-focused MSM organizations for a culture that supports people living with HIV (PLHIV) on living well, and that educates staff, volunteers and community members about HIV as a manageable, long-term chronic condition. This involves treatment literacy workshops and IEC and BCC materials on living with HIV.

6. An ongoing collaborative process should be used at the local level to determine whether SW, MSM, or TG organizations – either separately or, preferably, together - will ensure that the needs of male and transgender SW are met.

7. Differentiated service delivery should be further developed to assist in expanding reach of key interventions among KP. These include self-testing, lay provider testing, community-based testing, assisted partner notification, community-based initiation and distribution of ART.

8. Outreach and support service models need to be reviewed to verify that there are sufficient resources to ensure linkage to treatment for newly-diagnosed PLHIV and that case-management models are in place to cover at least the first three months following diagnosis.

9. UN agencies in collaboration with regional KP organizations should work to develop a set of regional guidelines for e-outreach, covering safety and security for e-outreach workers, ethics, privacy and effective messaging.

10. Community HIV testing and self-testing models in the region need to be assessed and guidance for expanding access and improved quality developed.

11. Strategies to engage countries in transition planning for the outreach (demand-creation) workforce for KP need to be strengthened.

12. Key population non-government organizations (NGOs) need to be assisted to secure resources in order to pursue broad health goals for their constituents, including reduction of stigma and discrimination, responses to KP-related violence, gender-based violence (GBV) and other issues that increase service access obstacles for people from KP.

13. Critical enabler activities have low levels of coverage in the assessed countries, and the range of activities implemented is generally much smaller than needed. As Honduras and Jamaica work with Global Fund funds to reduce human rights barriers for KP, other countries in the region should study the activities implemented in these countries and their results for possible replication. Policy and legal interventions may be specifically needed to address the needs of adolescent KP and breaches of confidentiality.

14. The safety of outreach workers, particularly among MSM, needs to be addressed through the use of written security protocols that are the subject of training and supervision for outreach staff.

**MONITORING**

There continues to be some misunderstanding of the role of a unique identifier code (UIC). These codes were developed to allow for anonymous access to HIV prevention and testing services (at least)
by KP members who, due to criminalized behavior and/or identities or fears of stigma, did not want to provide full identifying information (date of birth, name, address, etc.). When a UIC comprises the national ID number as well as other details, there can be many difficulties in implementing a UIC. The plan in the Dominican Republic, to use its new UIC only for newly-enrolled KP, needs further consideration, as applying the UIC across all KP accessing services will provide better data for tracking service use and health outcomes and will assist in onward service planning.

As in all other regions, there are difficulties in linking UIC databases (where they exist) with clinical records of those who test positive for HIV, with the exception of El Salvador. The work by LINKAGES in Haiti to follow KP into the health system using peer navigators may be a useful method of linking prevention and treatment data.

Table ES2. UIC System Scores by Country in Latin America and the Caribbean

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominican Republic</td>
<td>2</td>
<td>A new integrated registration system (UIC) has been launched for new users that will be, in principle, shared by all stakeholders.</td>
</tr>
<tr>
<td>Guatemala</td>
<td>2</td>
<td>Two programs use their own registration system and do not merge data. A national UIC is planned.</td>
</tr>
<tr>
<td>Guyana</td>
<td>2</td>
<td>UIC is universally implemented to monitor the uptake of prevention and HIV testing services among community organizations, but two different codes are used.</td>
</tr>
<tr>
<td>Haiti</td>
<td>2</td>
<td>A standardized UIC is used by most agencies delivering HIV prevention and testing services. It was not determined that this UIC was applied across all countrywide prevention programming.</td>
</tr>
<tr>
<td>Peru</td>
<td>2</td>
<td>Each stakeholder uses their own registration system and registered entries, which in some cases are still done manually, are not verified for duplication.</td>
</tr>
</tbody>
</table>

*For countries that only received a desk review, there was not enough information available to adequately and reliably assess the existence and use of a UIC. Therefore, details are not included here.

The above table refers to the use of UIC to track KP through prevention services. The UIC can either be alpha-numerical, numerical or biometric. To provide treatment and care cascades by KP, it is necessary to draw data from both prevention and testing databases (via UIC) and from ART databases. The US President’s Emergency Fund for AIDS Relief (PEPFAR) is working towards this in Haiti; El Salvador is also working on this issue, but APMG was not asked to visit the country.
RECOMMENDATIONS: MONITORING OF SERVICE PACKAGES FOR KEY POPULATIONS

1. For accurate coverage calculations, countries need to follow established guidelines to develop KP population size estimates (PSE), together with national consensus processes involving substantial representation from the key populations concerned. From these processes, more accurate, agreed-upon PSE should be derived.

2. Mapping of KP, including the involvement of community networks in mapping, should be carried out nationally, where possible, to aid in verifying each PSE and in planning, implementation and monitoring of coverage of KP programs.

3. All countries should continue to progress towards a single UIC for all KP and a single database, preferably accessible online, for both uploading data and generating reports. The system of collecting client names and addresses (especially in paper registers, but also electronically) should cease.

4. Tracking of service use and health outcomes for KP needs to be integrated into national e-health and unique patient record initiatives, where this can be done without compromising safety of KP.

5. There may need to be specific monitoring arrangements established to follow the collaborative process at the local level in order to determine whether SW, MSM, or TG organizations – either separately or, preferably, together – ensure that the needs of male and/or transgender SW are met.

6. More effective methods for capturing community empowerment and psychosocial support in routine reporting tools need to be developed.

7. After determining what interventions should be considered ‘core’ in the service package design, countries should establish routine surveillance to ensure that all coverage of all core interventions can be regularly measured.

8. Feedback loops should be extended throughout the reporting system so that problems regarding quality are quickly reported to the level at which action can be taken to remedy the situation.

9. Providing SR with access to a cloud-based system for data reporting should be examined for possible use by all PR.

10. Mechanisms or systems should be developed so that data collected by donor-funded programs, including by SR and PR of Global Fund and USG-funded interventions, are fed into national-level information systems.

11. Monitoring systems should strive to link data on prevention activities to treatment and care; treatment cascade reports should be generated on a regular basis.

12. Monitoring and evaluation (M&E) related to human rights-related barriers to service access should be a priority for learning and generating best practices to improve the enabling environment for KP. As much as possible, this documentation should be specific to each KP.

13. It is important to stress that none of these data are useful unless they are used for decision-making – at both the policy and the implementation level. Capacity building may be needed to help staff see the value in not merely collecting, but also routinely analyzing service data and using this information as the basis for suggesting changes to services.
Details on funding for KP activities are mostly unknown and no evidence was found of substantial funding of KP packages from domestic sources from any of the five countries with in-country assessments. There is a grave risk of funding shortfalls for KP programming both during and after transition from external donor funding. In the context of transition from Global Fund and/or PEPFAR support in coming years, much greater effort is required to ascertain how much funding is provided for HIV prevention, testing, treatment, care and support among KP. Reducing dependence on external funding across the region will require new resource mobilization approaches, improvements in allocating and tracking HIV resources, and increases in efficiencies and cost savings.

Table ES3. Recommendations by country and priority

<table>
<thead>
<tr>
<th>Priorities</th>
<th>DR</th>
<th>Guatemala</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
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</tbody>
</table>

Defined packages of services should include interventions for all KP that have been identified in the country.

Rapid situation assessments should be conducted to understand more about the PWID population and the level of injection drug use.

All KP packages should contain condom and lubricant distribution, with female condoms included (at least) in all SW programs.

Offer of PEP, STI, TB, and hepatitis B and C services. PrEP should be included in MSM, TG and SW programs.
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Country 1</th>
<th>Country 2</th>
<th>Country 3</th>
<th>Country 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical enabler activities should be specified in all KP packages</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Additional services need to be defined for male and/or transgender SW and adolescent KP</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ensure service packages are available to the majority of KP in each country, regardless of funding source or service delivery agent</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Introduce and maintain regular feedback sessions with clients, whose concerns should be acted on quickly through the chain of responsibility</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Re-assess distribution of condoms and lubricants only or mostly through group peer education or information sessions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Address PSM issues for ART</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Create space in prevention-focused MSM organizations for a culture that supports PLHIV on living well</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Determine whether SW, MSM or TG organizations will ensure that the needs of male and transgender SW are met</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Promote differentiated service delivery through self-testing, lay provider testing, community-based testing, assisted partner notification, community-based initiation and distribution of ART for KP</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Recommendation</td>
<td>DR</td>
<td>Guatemala</td>
<td>Guyana</td>
<td>Haiti</td>
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<tr>
<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Increase coverage of critical enabler activities</td>
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<tr>
<td>Address safety of outreach workers, especially among MSM and TG</td>
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<tr>
<td>Follow established guidelines to develop PSE, together with national consensus</td>
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<tr>
<td>processes involving substantial representation from the KP concerned</td>
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<tr>
<td>Mapping of KP, including the involvement of community networks in mapping,</td>
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<tr>
<td>should be carried out nationally, where possible, to aid in verifying each</td>
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<tr>
<td>PSE and to aid in planning, implementation and measurement of coverage of KP</td>
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<tr>
<td>programs</td>
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<tr>
<td>Continue to progress towards a single UIC for all KP and a single database,</td>
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<tr>
<td>preferably accessible online, for both uploading data and generating reports</td>
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<tr>
<td>Establish a more effective way of capturing community empowerment and work on</td>
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<tr>
<td>addressing human rights barriers and psychosocial support in routine reporting</td>
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<tr>
<td>tools</td>
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<tr>
<td>Providing SR with access to a cloud-based system for data reporting should be</td>
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<tr>
<td>examined for possible use by all PR</td>
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<tr>
<td>Mechanisms or systems should be developed so that data collected by donor-</td>
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<tr>
<td>funded programs, including by SR and PR of Global Fund and USG-funded</td>
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</tr>
</tbody>
</table>
Assessment of HIV Service Packages for Key Populations  
Latin America & Caribbean

| interventions, are fed into national-level information systems |   |   |   |   |
| Monitoring systems should strive to link data on prevention activities to treatment and care; treatment cascade reports should be generated on a regular basis |   |   |   |   |
### Table ES1. Summary of Key Findings in Latin America and the Caribbean

Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O); (*) Indicates Desk Review Only

Data sources are footnoted in the tables in the body of the report

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Bolivia*</th>
<th>DR</th>
<th>Ecuador*</th>
<th>El Salvador*</th>
<th>Guatemala</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO 2015 country population</td>
<td></td>
<td>10,671,200</td>
<td>10,403,761</td>
<td>15,737,878</td>
<td>6,340,454</td>
<td>15,468,203</td>
<td>799,613</td>
<td>10,317,000</td>
<td>8,097,688</td>
<td>3,864,170</td>
<td>6,802,295</td>
<td>30,375,603</td>
</tr>
<tr>
<td>PSE (% of total population)</td>
<td>MSM</td>
<td>29,490 (0.28%)</td>
<td>130,572 (1.3%)</td>
<td>47,410 (0.30%)</td>
<td>54,140 (0.9%)</td>
<td>104,872 (0.68%)</td>
<td>3,327 (0.42%)</td>
<td>30,853 (0.30%)</td>
<td>40,949 (0.51%)</td>
<td>15,842 (0.41%)</td>
<td>24,115 (0.35%)</td>
<td>266,565 (0.82%)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>N/A</td>
<td>950 (&lt;0.01%)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2,858 (0.04%)</td>
<td>N/A</td>
<td>5,714 (0.08%)</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prisoner</td>
<td>17,946 (0.12%)</td>
<td>26,286 (0.25%)</td>
<td>37,497</td>
<td>38,714 (0.56%)</td>
<td>24,386 (0.03%)</td>
<td>2200 (0.3%)</td>
<td>10,512</td>
<td>18,950</td>
<td>16,183 (0.47%)</td>
<td>13,607</td>
<td>87,995 (0.27%)</td>
</tr>
<tr>
<td></td>
<td>SW</td>
<td>13,130 (0.12%)</td>
<td>97,758 (0.94%)</td>
<td>34,420 (0.22%)</td>
<td>12,098 (0.19%)</td>
<td>25,846 (0.17%)</td>
<td>5,256 (0.66%)</td>
<td>70,302 (0.68%)</td>
<td>22,771 (0.28%)</td>
<td>5,217 (0.06%)</td>
<td>3,369 (0.05%)</td>
<td>70,558 (0.22%)</td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>833 (&lt;0.01%)</td>
<td>3,900 (0.04%)</td>
<td>12,230 (0.08%)</td>
<td>2,011 (0.03%)</td>
<td>4,840 (0.03%)</td>
<td>401 (&lt;0.01%)</td>
<td>N/A</td>
<td>2,975 (0.04%)</td>
<td>888 (&lt;0.01%)</td>
<td>904 (&lt;0.01%)</td>
<td>35,542 (0.11%)</td>
</tr>
<tr>
<td>MSM</td>
<td>15.5% (S)</td>
<td>65.5% (P)</td>
<td>29.5% (P)</td>
<td>58.2% (P)</td>
<td>25.4% (O)</td>
<td>64.0% (P)</td>
<td>72.2% (P)</td>
<td>23.7% (P)</td>
<td>61.7% (P)</td>
<td>16.0% (P)</td>
<td>13.9% (P)</td>
<td></td>
</tr>
</tbody>
</table>

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1 All data sources are provided in footnotes to tables for each KP in Implementation
2 Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators and nationally accepted PSE as denominators
3 TG women
## Assessment of HIV Service Packages for Key Populations

### Latin America & Caribbean

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Bolivia*</th>
<th>DR</th>
<th>Ecuador*</th>
<th>El Salvador*</th>
<th>Guatemala</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV Prevention Programming</strong></td>
<td>PWID</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>SW</td>
<td>56.9% (P)</td>
<td>81.6% (P)</td>
<td>52.9% (P)</td>
<td>63.0% (O)</td>
<td>63.0% (P)</td>
<td>40.1% (P)</td>
<td>16.1% (P)</td>
<td>41.6% (P)</td>
<td>66.1% (P)</td>
<td>34.9% (P)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>35.0% (O)</td>
<td>82.6% (P)</td>
<td>21.0% (P)</td>
<td>55.0% (P)</td>
<td>100.0% (O)</td>
<td>15.9% (P)</td>
<td>70.9% (P)</td>
<td>62.1% (P)</td>
<td>14.3% (P)</td>
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</tr>
<tr>
<td><strong>HIV testing</strong></td>
<td>MSM</td>
<td>7.2% (P)</td>
<td>67.7% (P)</td>
<td>35.6% (P)</td>
<td>66.4% (G)</td>
<td>12.9% (P)</td>
<td>79.3% (P)</td>
<td>20.3% (O)</td>
<td>46.0% (P)</td>
<td>23.1% (P)</td>
<td>23.7% (P)</td>
<td>50.7% (P)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
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</tr>
<tr>
<td></td>
<td>SW</td>
<td>60.5% (P)</td>
<td>20.0% (P)</td>
<td>79.6% (G)</td>
<td>22.4% (P)</td>
<td>23.0% (P)</td>
<td>57.0% (O)</td>
<td>38.0% (P)</td>
<td>17.8% (P)</td>
<td>58.6% (P)</td>
<td>86.3% (P)</td>
<td>77.4% (P)</td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>7.7% (P)</td>
<td>65.0% (P)</td>
<td>40.0% (P)</td>
<td>11.8% (P)</td>
<td>22.8% (P)</td>
<td>71.5% (O)</td>
<td>12.5% (P)</td>
<td>14.3% (P)</td>
<td>55.0% (P)</td>
<td>6.7% (G)</td>
<td>74.1% (P)</td>
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<tr>
<td><strong>ART coverage</strong></td>
<td>MSM</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>PWID</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>27.4% (S)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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4 Coverage of HIV prevention programs among the KP  
5 Percentage of the KP that have received an HIV test in the past 12 months and know their results
<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Bolivia*</th>
<th>DR</th>
<th>Ecuador*</th>
<th>El Salvador*</th>
<th>Guatemala</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoners</td>
<td>SW</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>27.7% (S)</td>
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</tbody>
</table>
BACKGROUND

In 2017, approximately 40% of new HIV infections were among KP and their sexual partners (UNAIDS, 2018). A range of policy and legal barriers and harmful social factors increase the HIV vulnerability of KP and undermine their access to HIV and other services. The criminalization of sex between men, sex work, drug use and HIV transmission, as well as high rates of incarceration, homophobia, transphobia, violence and social marginalization, all serve to influence risk practices and undermine access to services. Women in KP face specific challenges and barriers, including GBV and poorly-tailored services; these factors further intensify their vulnerability to HIV. Male KP also face high levels of violence.

While the World Health Organization (WHO) has clearly outlined the comprehensive package of services which should be available for MSM, PWID, SW, TG and prisoners (WHO, 2016), these populations rarely have access to the full range of recommended services (UNAIDS, 2015).

Global Fund contracted APMG Health to review the design, implementation and monitoring of national HIV service packages for KP in 65 countries across six regions in which Global Fund has provided HIV grant funds. Out of the 65 countries assessed, 55 countries were selected based on the Global Fund KPI2 (2014-2016) results, where key population size estimations were classified as ‘nationally adequate’ by 2016. The additional 10 countries were selected based on discussions with the Global Fund regional teams and consultation with global partners. The specific objectives of this assessment were:

1. To determine whether HIV service packages as designed in the national guidelines or supported by Global Fund programs are in line with international standards and guidelines (e.g. WHO Consolidated Guidelines for Key Populations, Key Populations Implementation Tools, amongst others), and are appropriate to epidemiological context;
2. To examine the implementation of HIV service packages in reaching intended target groups, taking into account specific needs and vulnerabilities within sub-groups of KP (e.g. age, sex), along with the coverage and reported quality of these programs;
3. To assess whether the monitoring framework, tools and other mechanisms set up by implementation partners are appropriate to local contexts and are used effectively to regularly report on programmatic coverage;
4. To examine the enabling environment and other factors facilitating and inhibiting the availability, accessibility and utility of intervention services; and
5. To determine the degree to which financial resources are made available and used accountably for funding the implementation of service packages for KP.
These objectives were completed through a combination of desk review and in-country visits, as further described below. This report is one of six regional reports produced to summarize the assessment findings.⁶

⁶ Regional reports are available on Eastern and Southern Africa, West and Central Africa, Middle East and North Africa, Asia Pacific, Latin American and the Caribbean, and Eastern Europe and Central Asia.
METHODOLOGY

COUNTRY ASSESSMENTS

Each of the in-country assessments consisted of an initial desk review and a field assessment. The Global Fund Country Team for each country provided data sources used for completing a desk review prior to the country visit. In the case of LAC, the major sources of information are:

- Global Fund Performance Framework
- Integrated Bio-behavioral Surveillance Reports (IBBS Reports)
- National Strategic Plans
- M&E Plans
- Global Fund Funding Request Reports & Concept Notes
- Global AIDS Monitoring Reports (GAM)
- Global Fund Program Update data
- Programmatic Spot Checks
- Cross checking of findings at a debrief with PR and other stakeholders

Out of the 11 countries assessed for the LAC region for this project, data collection ended with the completion of the desk review for six countries. In five of the countries, a follow-up field assessment was carried out to verify and expand data collected during the initial desk review process.

Each field assessment was conducted over the course of five days, with the exception of Haiti, which was conducted over the course of ten days. For each country, KP and two sites were selected with guidance from The Global Fund Country Teams and CCM, with the exception of Guatemala and Haiti, where three sites were selected.

Table 1. Latin America and the Caribbean Key Population and Site Selection

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Selected</th>
<th>Sites Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominican Republic</td>
<td>MSM &amp; TG women</td>
<td>Santo Domingo &amp; Santiago de los Caballeros</td>
</tr>
<tr>
<td>Guatemala</td>
<td>MSM &amp; TG women</td>
<td>Guatemala City, Mazatenago &amp; Escuintla</td>
</tr>
<tr>
<td>Guyana</td>
<td>MSM &amp; FSW</td>
<td>Georgetown (Region 4), Region 5 &amp; Region 6</td>
</tr>
<tr>
<td>Haiti</td>
<td>MSM &amp; FSW</td>
<td>Port-au-Prince, Cap-Haitien &amp; Saint-Marc</td>
</tr>
<tr>
<td>Peru</td>
<td>MSM &amp; TG women</td>
<td>Lima-Callao &amp; Iquitos</td>
</tr>
</tbody>
</table>
One international consultant and one local consultant carried out in-country assessments, with the exception of Haiti and Guyana, where two international consultants and one local consultant carried out the assessment. The majority of the data collected during each in-country assessment were collected through:

- An initial meeting with representatives of CCM, PR and SR working with KP
- Visits to at least two sites for observation of package delivery
- Visits to SR/SSR to examine M&E forms and systems
- Interviews with 110 key informants
- Focus group discussions with a total of 229 individuals from KP
- Debrief for the PR

REPORTING PROCESSES

For each of the five countries visited, a report was produced with detailed findings and recommendations for that country. For each region, a summary report has been produced providing analysis of trends and recommendations for consideration for decision-makers and programmers working across the region. This report provides summary and analysis of the 11 countries assessed in the LAC region, as displayed in Table 2.

Table 2. Latin America and the Caribbean Countries Assessed

<table>
<thead>
<tr>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Country Assessment</td>
</tr>
<tr>
<td>Dominican Republic</td>
</tr>
<tr>
<td>Guatemala</td>
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<tr>
<td>Guyana</td>
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<tr>
<td>Haiti</td>
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<tr>
<td>Peru</td>
</tr>
<tr>
<td>Desk Review Only</td>
</tr>
<tr>
<td>Bolivia</td>
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<tr>
<td>Ecuador</td>
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<tr>
<td>El Salvador</td>
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<tr>
<td>Honduras</td>
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<td>Panama</td>
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<tr>
<td>Paraguay</td>
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</tbody>
</table>
As the countries selected for this region were not selected on the basis of being a regionally representative sample, extrapolation of these results to other countries in the region should be done with caution. The findings of this assessment may be instructive for development of policy or practice across the region, but any country-level decisions should always be grounded in the reality of the specific country context.
PART I: REGIONAL PROFILE AND KEY POPULATIONS CONTEXT

KEY POINTS
- Population size estimates of MSM and SW appear more robust than in some other regions
- Data on TG are still aggregated with MSM in some countries
- Little data are available on PWID or prisoners
- There is confusion as to who should collect data on male and transgender SW

According to estimates from UNAIDS, there were around 2.1 million PLHIV in the LAC region at the end of 2017. The annual number of new HIV infections among adults in LAC has remained stable since 2010; an estimated 113,000 new infections occurred in 2017. Deaths from AIDS-related illness declined by 23% in the Caribbean and by 12% in Latin America between 2010 and 2017 (UNAIDS, 2018).

The UNAIDS 2017 cascade data for LAC are split into separate Cascades for Latin America and for the Caribbean (Figures 1 and 2 below). Combined, they show that more than three quarters (75.3%) of the PLHIV in the region at the end of 2017 were aware of their HIV status. Of those who knew their status, 66% were accessing ART, which is equivalent to 59% of all PLHIV in the region. Among those accessing treatment, 69% were virally suppressed.

Figure 1. HIV Testing and Treatment Cascade, Latin America, 2017 (UNAIDS, 2018)
Population Size Estimates and HIV Prevalence in Latin America and Caribbean

All countries assessed provided PSE for SW, though there was no disaggregation into female, male or transgender SW except in Guyana. All countries provided MSM PSE and, unlike all other regions studied, LAC includes PSE for TG in all countries with in-country assessments, except Haiti. Reflecting the lower level of drug injecting in this region, only four countries provided estimates of their populations of PWID. As noted in other regions, the ability to provide PSE for prisoners was lacking in the Ministries of Health in several countries.

Various methods are used to develop PSE, sometimes in the same country. For example, in the Dominican Republic, various stakeholders used PLACE or community estimations (for TG). While the different approaches have not resulted in significant differences in SW estimations, they result in varying estimations of MSM, and to a lesser extent, of TG populations.
### Table 3. Population Size Estimation and HIV Prevalence by Key Populations for In-Country Assessments

<table>
<thead>
<tr>
<th></th>
<th>DR</th>
<th>Guatemala</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MSM PSE</strong></td>
<td>130,572&lt;sup&gt;7&lt;/sup&gt;</td>
<td>104,872&lt;sup&gt;8&lt;/sup&gt;</td>
<td>3,327&lt;sup&gt;9&lt;/sup&gt;</td>
<td>30,853&lt;sup&gt;10&lt;/sup&gt;</td>
<td>250,000&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>MSM HIV Prevalence</strong></td>
<td>7.10%&lt;sup&gt;12&lt;/sup&gt;</td>
<td>10.5%&lt;sup&gt;13&lt;/sup&gt;</td>
<td>Youth: 3.1% Adult: 4.6%</td>
<td>18.2%&lt;sup&gt;15&lt;/sup&gt;</td>
<td>15.2%&lt;sup&gt;16&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>PWID PSE</strong></td>
<td>900&lt;sup&gt;17&lt;/sup&gt;</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>PWID HIV Prevalence</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>SW PSE</strong></td>
<td>97,758&lt;sup&gt;18&lt;/sup&gt;</td>
<td>25,846&lt;sup&gt;19&lt;/sup&gt;</td>
<td>5,256&lt;sup&gt;20&lt;/sup&gt;</td>
<td>70,302&lt;sup&gt;21&lt;/sup&gt;</td>
<td>67,000&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>SW HIV Prevalence</strong></td>
<td>3.70%&lt;sup&gt;23&lt;/sup&gt;</td>
<td>1.0%&lt;sup&gt;24&lt;/sup&gt;</td>
<td>Female: 6.1% Male: 5.5% TG: 9.7%</td>
<td>8.4%&lt;sup&gt;26&lt;/sup&gt;</td>
<td>Female: 1.30% Male: 14.6%&lt;sup&gt;27&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Prisoner PSE</strong></td>
<td>25,890&lt;sup&gt;28&lt;/sup&gt;</td>
<td>7,082&lt;sup&gt;29&lt;/sup&gt;</td>
<td>-</td>
<td>-</td>
<td>82,000&lt;sup&gt;30&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Prisoner HIV Prevalence</strong></td>
<td>2.00%&lt;sup&gt;31&lt;/sup&gt;</td>
<td>0.7%&lt;sup&gt;32&lt;/sup&gt;</td>
<td>-</td>
<td>4.3%&lt;sup&gt;33&lt;/sup&gt;</td>
<td>0.8%&lt;sup&gt;34&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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<sup>7</sup> PUDR 2017  
<sup>8</sup> Concept Note 2018  
<sup>9</sup> IBBS 2014  
<sup>10</sup> IBBS 2014, PSE for 5 main Departments: Ouest, Sud, Artibonite, Nord and Nord-Est  
<sup>11</sup> AIDS Info/UNAIDS 2016  
<sup>12</sup> GAM 2013  
<sup>13</sup> GAM 2017  
<sup>14</sup> Both in GAM 2014  
<sup>15</sup> GAM 2014  
<sup>16</sup> GAM 2016  
<sup>17</sup> Situation assessment 2013  
<sup>18</sup> PUDR 2017  
<sup>19</sup> Concept Note 2018  
<sup>20</sup> IBBS 2014  
<sup>21</sup> IBBS 2014  
<sup>22</sup> AIDS Info/UNAIDS 2016  
<sup>23</sup> GAM 2013  
<sup>24</sup> GAM 2017  
<sup>25</sup> GAM 2014  
<sup>26</sup> GAM 2014  
<sup>27</sup> GAM 2016  
<sup>28</sup> NHS 2015-2018  
<sup>29</sup> ECVC 2013  
<sup>30</sup> GAM 2016  
<sup>31</sup> N/A  
<sup>32</sup> GAM 2013  
<sup>33</sup> GAM 2016  
<sup>34</sup> GAM 2016
Assessment of HIV Service Packages for Key Populations
Latin America & Caribbean

<table>
<thead>
<tr>
<th>Country</th>
<th>DR</th>
<th>Guatemala</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>TG PSE</td>
<td>3,900&lt;sup&gt;35&lt;/sup&gt;</td>
<td>4,840&lt;sup&gt;36&lt;/sup&gt;</td>
<td>401&lt;sup&gt;37&lt;/sup&gt;</td>
<td>-</td>
<td>33,000&lt;sup&gt;18&lt;/sup&gt;</td>
</tr>
<tr>
<td>TG HIV Prevalence</td>
<td>17.8% - 38.5%&lt;sup&gt;39&lt;/sup&gt;</td>
<td>24.0%&lt;sup&gt;40&lt;/sup&gt;</td>
<td>Youth: 9.1% Adult: 7.8%&lt;sup&gt;41&lt;/sup&gt;</td>
<td>-</td>
<td>13.8%&lt;sup&gt;42&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

The KP most affected by HIV in the in-country assessment countries are TG women and gay men and other MSM, followed by SW and prisoners. Transgender women have an HIV prevalence of up to 38.5% in cities in Dominican Republic and up to 18.2% among MSM in Haiti. The HIV prevalence among SW is generally low, with only Haiti and Guyana above 5.0%.

Table 4. Population Size Estimation and HIV Prevalence by Key Population for Desk Review Only Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Bolivia</th>
<th>Ecuador</th>
<th>El Salvador</th>
<th>Honduras</th>
<th>Panama</th>
<th>Paraguay</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM PSE</td>
<td>29,490&lt;sup&gt;43&lt;/sup&gt;</td>
<td>47,410&lt;sup&gt;44&lt;/sup&gt;</td>
<td>54,140&lt;sup&gt;45&lt;/sup&gt;</td>
<td>40,949&lt;sup&gt;46&lt;/sup&gt;</td>
<td>15,842&lt;sup&gt;47&lt;/sup&gt;</td>
<td>24,115&lt;sup&gt;48&lt;/sup&gt;</td>
</tr>
<tr>
<td>MSM HIV Prevalence</td>
<td>25.4%&lt;sup&gt;49&lt;/sup&gt;</td>
<td>13.3%&lt;sup&gt;50&lt;/sup&gt;</td>
<td>10.3%&lt;sup&gt;51&lt;/sup&gt;</td>
<td>11.7%&lt;sup&gt;52&lt;/sup&gt;</td>
<td>13.1%&lt;sup&gt;53&lt;/sup&gt;</td>
<td>15.4%&lt;sup&gt;54&lt;/sup&gt;</td>
</tr>
<tr>
<td>PWID PSE</td>
<td>-</td>
<td>12,000&lt;sup&gt;55&lt;/sup&gt;</td>
<td>-</td>
<td>2,858&lt;sup&gt;56&lt;/sup&gt;</td>
<td>-</td>
<td>5,714&lt;sup&gt;57&lt;/sup&gt;</td>
</tr>
<tr>
<td>PWID HIV Prevalence</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9.1%&lt;sup&gt;58&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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<sup>35</sup> TG women – PLACE Survey 2016  
<sup>36</sup> TG women – Concept Note 2018  
<sup>37</sup> IBBS 2014  
<sup>38</sup> TG women  
<sup>39</sup> TG women; Range between lowest and highest prevalence depending on the province, out of a total of 6 selected provinces, ECVS Report 2016  
<sup>40</sup> TG women – GAM 2013  
<sup>41</sup> GAM 2014  
<sup>42</sup> TG women  
<sup>43</sup> GARPR 2016  
<sup>44</sup> GARPR 2015  
<sup>45</sup> GAM 2016  
<sup>46</sup> GAM 2016/2016 data  
<sup>47</sup> PSE estimation exercise 2014  
<sup>48</sup> PSE estimation exercise 2014  
<sup>49</sup> IBBS 2014  
<sup>50</sup> GARPR 2015  
<sup>51</sup> Sentinel surveillance 2016  
<sup>52</sup> GAM 2016  
<sup>53</sup> 2016 APLAFA, CLAM Registro  
<sup>54</sup> GAM 2014  
<sup>55</sup> GARPR 2015  
<sup>56</sup> 2013 data/2016 GAM  
<sup>57</sup> PSE estimation exercise 2014  
<sup>58</sup> 2006 (PEN 2014-2018
## Assessment of HIV Service Packages for Key Populations
### Latin America & Caribbean

<table>
<thead>
<tr>
<th>Country</th>
<th>Bolivia</th>
<th>Ecuador</th>
<th>El Salvador</th>
<th>Honduras</th>
<th>Panama</th>
<th>Paraguay</th>
</tr>
</thead>
<tbody>
<tr>
<td>SW PSE</td>
<td>13,130(^59)</td>
<td>34,420(^60)</td>
<td>12,098(^61)</td>
<td>22,771(^62)</td>
<td>5,217(^63)</td>
<td>3,369(^64)</td>
</tr>
<tr>
<td>SW HIV Prevalence</td>
<td>0.6%(^65)</td>
<td>3.2%(^66)</td>
<td>2.8%(^67)</td>
<td>5.3%(^68)</td>
<td>2.0%(^69)</td>
<td>7.0%(^70)</td>
</tr>
<tr>
<td>Prisoner PSE</td>
<td>-</td>
<td>-</td>
<td>35,440(^71)</td>
<td>-</td>
<td>18,000(^72)</td>
<td>-</td>
</tr>
<tr>
<td>Prisoner HIV Prevalence</td>
<td>-</td>
<td>1.4%(^73)</td>
<td>-</td>
<td>-</td>
<td>6.4%(^74)</td>
<td>-</td>
</tr>
<tr>
<td>TG PSE</td>
<td>833(^75)</td>
<td>12,230(^76)</td>
<td>2,011(^77)</td>
<td>2,975(^78)</td>
<td>888(^79)</td>
<td>904(^80)</td>
</tr>
<tr>
<td>TG HIV Prevalence</td>
<td>19.7%(^81)</td>
<td>32.0%(^82)</td>
<td>16.6%(^83)</td>
<td>11.9%(^84)</td>
<td>15.0%(^85)</td>
<td>26.2%(^86)</td>
</tr>
</tbody>
</table>

### Men who have Sex with Men

The HIV situation among gay and other MSM was assessed in all five countries visited, as well as the six countries that only had desk reviews. Sex between men is legal in all assessed countries – with the exception of Guyana - but MSM still encounter important social, cultural and gender barriers. For example, surveys in the Dominican Republic found that between 16.6% and 48.5% of MSM (according to their geographical location) had been rejected by health service establishments, and between

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\(^{59}\) GARPR 2016
\(^{60}\) GARPR 2015
\(^{61}\) 2011 figure
\(^{62}\) 2015 data/GAM 2016
\(^{63}\) PSE estimation exercise 2014
\(^{64}\) PSE estimation exercise 2014
\(^{65}\) GARPR 2014
\(^{66}\) GARPR 2015
\(^{67}\) Sentinel surveillance 2016
\(^{68}\) 2016 GAM data
\(^{69}\) HSS 2015
\(^{70}\) GAM 2014
\(^{71}\) GAM 2016 figure
\(^{72}\) UNAIDS 2014/Programa de Salud Penitenciaria
\(^{73}\) 2009 figure in GAM 2017
\(^{74}\) UNSIDS 2015
\(^{75}\) GARPR 2014
\(^{76}\) GARPR 2015
\(^{77}\) GAM 2014
\(^{78}\) GAM 2016/2016 data
\(^{79}\) PSE estimation exercise 2013
\(^{80}\) PSE estimation exercise 2014
\(^{81}\) 2012 figure, Casó inversión en VIH y sida
\(^{82}\) GARPR 2015
\(^{83}\) 2014 GF Performance Framework
\(^{84}\) 2016 data/GAM 2016
\(^{85}\) VICITS 2016
\(^{86}\) 2011 GARPR
14.3% and 46.0% by educational facilities. The same study reported that, despite the age of consent for sex being 18 years old in the country regardless of sexual orientation, between 16.0% and 26.6% of MSM declared their sexual debut with another man was before the age of 15 (DR BBS, 2012). In the Guatemalan ECVC (IBBS) from 2013, half of the participants reported that they had initiated sexual activity under the age of 15, and one in 10 said that the first sexual experience was coerced. In the 2014 Haiti IBBS, two-thirds of MSM identified as bisexual.

Transaction sex in Peru is common between MSM, as well as heavy use of alcohol in the context of sexual intercourse (Tallada et al., 2018a). Having multiple partners is common among MSM in DR, and more than 65.0% of MSM surveyed said they had sex for some kind of payment (DR BBS, 2012). Poverty rates are high, as less than 6.7% of MSM earn more than US$415 monthly (average national salary) (DR AIDS National Strategic Plan, 2014).

**Sex Workers**

Sex workers were the focus of the fieldwork in the Guyana and Haiti in-country assessments, but data on this population were gathered in several other countries as well. Unlike the other regions studied for these assessments, the LAC countries examined generally had a clear understanding of sex work as an activity in which women, men and TG participate. But Guyana is the only country assessed that provided HIV prevalence figures for SW by gender (including transgender). During the Guyana assessment, there were reports about the fluctuation in the availability of work affecting risk behaviors among MSM in relation to sex work. In one region, the MSM interviewed had mostly been employed in the sugar industry, but recent closures of sugar refineries meant that they would either have to travel to another enterprise site for work or stay where they were and return to sex work as other forms of employment were not available.

According to the DR HIV-Related Behavioral Survey in Key Populations from 2012, 20% of FSW in the country experienced hostility from their families; between 85.7% and 95.4% said they had experienced hostility from the providers of health services; and one in 10 had been forced to have sex. The illegal status of sex work in Guatemala is a major obstacle that promotes exclusion and violence against SW.

Community empowerment among SW is less prevalent in the assessed countries than in others in the region. The Guyana Sex Work Coalition, the Peru national SW group and COTRAVETD (the national association of TG and SW) in the Dominican Republic were funded by the Robert Carr Network Fund several years ago. The national SW group (Mujeres en Superación) in Guatemala participates in the CCM.

**Transgender People**

Transgender women are found to be highly stigmatized in the countries visited. The Dominican Republic (DR) IBBS among TG from 2016 shows that most TG women had been physically attacked, arrested or raped to avoid arrest in the 12 months prior to the survey. Rejection by family and society in Peru leads to leaving school before completion, family abandonment, migration to larger cities and
sex work as a main economic activity. TG women in Guatemala experience high levels of social rejection and violence, which place them in a situation of extreme vulnerability to HIV.

Transgender women fear stigma and discrimination while accessing healthcare services. Participants in FGD in Peru report that health facility staff members do not respect the use of preferred names despite specific regulations requiring them to do so. This adds to TG women’s perceived exclusion from the health system, which makes it difficult to carry out activities around the management of health risks and rights.

A study from 2010 found that more than 95% of the TG women in Guatemala reported engaging in sex work and more 65% of them had more than 30 sexual partners in the last three months. Around 75% of the participants in the survey reported using alcohol and around 55% reported using drugs (Guatemala Ministry of Health, 2016). In DR, regular sex work or occasional sex work is very common: between 46.8% and 62.5% have engaged in sex work in the last week. Of those who have ever engaged in sex work, the average age they began is 12 years old (range: 7-33 years). In Haiti, in programmatic data reporting, TG are aggregated with the MSM population.

People Who Inject Drugs

The HIV situation among PWID was not examined in any of the in-country assessments. Populations of PWID have not been measured in most countries in the region due to the widespread belief that injection drug use, with cocaine and heroin, for example, is uncommon in a region where many illicit drugs are inexpensive and can be consumed economically through other modes of administration.

The 2014 IBBS in Haiti reported that 1.5% of MSM had injected cocaine. About 900 PWID were found in the Dominican Republic, and an IBBS will be carried out among drug users there in 2019. Field visits in Guyana revealed some evidence of drug injecting, but much higher rates of non-injecting drug use. Several PSE for PWID populations were found during the desk review process, but some of these seem unlikely – for example, 12,000 PWID in Ecuador.

Prisoners

As in the other regions, limited data are available on the HIV situation among prisoners in the assessed countries. In the Dominican Republic, the National Strategic Plan 2015-2018 states that 97.4% of the 25,890 prisoners are men and 2.0% are HIV-positive. The only available data on prisoners in Guatemala comes from the ECVC survey published in 2013. In that study, the median age of the 7,000 prisoners was 32 years old, 66.0% were men and the vast majority had not progressed beyond primary school. Use of drugs is very common, however injectable drugs were used only by 6% at some point in their life. Three quarters of those surveyed reported that they had received information about HIV in prison.

Of the approximately 82,000 prison inmates in Peru, 94.0% are men and an estimated 0.8% are living with HIV. The vast majority of the prison population and of the HIV prevalence in correctional facilities is situated in the Lima region. Despite the fact that inmates’ health is the responsibility of the national
government, only 60.5% of prisoners living with HIV are on ART. Studies conducted in the largest prisoner facility of the country, Lurigancho (in Lima), suggest that inmates acquire HIV before entering prison, where prevalence has been stable over the years (Peru HIV Concept Note, 2015).

**Analysis: Do we know what we need to know about key populations in Latin America and the Caribbean?**

For a region in which most HIV transmission is among KP and their partners, there are many gaps in basic data. As noted above, the lack of PSE, HIV prevalence data and information about risk behaviors for the region’s PWID is understandable, given that injection drug use may not be as common as in some other regions; however, the most significant deficit in data on KP is among prisoners.

There seems to be some confusion in some countries about whether SW, MSM or TG agencies should be collecting data about male and/or transgender SW. But data from several countries suggests that behavior, risks and HIV prevalence among male, female and transgender SW can be very different. Therefore, a decision needs to be made about which agency will work with each population, and SW PSE, prevalence and coverage statistics need to be derived for each of male, female and transgender SW.
For all countries assessed, consultants were able to review the current national strategic plans, action plans, outlines of state-provided HIV services and national programs. Package design is assessed below based on key national reference documents, as detailed in Table 5. It should be noted that this is a sign of success in itself: several countries in the region had no defined packages of services for KP five or seven years ago. However, some national strategic plans are undated (Bolivia and Ecuador) or expire this year (Dominican Republic and Paraguay).

### Table 5. Key Populations Identified in Countries Assessed

*Notes desk-review only country*

<table>
<thead>
<tr>
<th>Country</th>
<th>KP Identified in Nationally Endorsed HIV Strategies/Plans</th>
<th>Document(s) Defining Service Packages for Key Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia*</td>
<td>MSM, FSW &amp; TG</td>
<td>Multisectoral Strategic Plan for the National Response to HIV/AIDS/STIs</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>TG women, MSM, SW &amp; prisoners*87</td>
<td>National Strategic Plan 2015-2018</td>
</tr>
<tr>
<td>Ecuador*</td>
<td>MSM, FSW &amp; TG</td>
<td>National Strategic Multisectoral Plan for HIV/AIDS</td>
</tr>
<tr>
<td>El Salvador*</td>
<td>MSM, FSW, TG &amp; prisoners</td>
<td>National Strategic Plan for HIV/AIDS and STIs 2016-2020</td>
</tr>
<tr>
<td>Guatemala</td>
<td>MSM, TG women &amp; FSW*88</td>
<td>National Strategic Plan 2017-2021</td>
</tr>
</tbody>
</table>

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*87 National Strategic Plan also identifies socially vulnerable women living in bateyes and Haitian migrants.
88 National Strategic Plan identifies these populations as “prioritized groups”; other populations identified are: PLHIV, HIV-TB co-infected individuals, pregnant women and children born from HIV-positive mothers.*
## Country | KP Identified in Nationally Endorsed HIV Strategies/Plans | Document(s) Defining Service Packages for Key Populations
--- | --- | ---
Haiti | FSW, MSM & prisoners[^90] | Haiti National HIV Strategic for 2018-2023
Honduras* | Does not specify | National Strategic Plan 2015-2019 & National Response to HIV/AIDS
Paraguay* | MSM, FSW, TG & PWID[^92] | National Strategic Plan for HIV, AIDS, and other STIs 2014-2018
Peru | MSM, TG women, SW & prisoners | National Multi-sectorial Plan to Control HIV and STDs 2015-2019

Of the five in-country assessment countries, it is unclear if KP play a significant role in the design of service packages. Both the Dominican Republic National Strategic Plan 2015-2018 and the Concept Note 2015 state that individuals from KP have been engaged in the design of their content and keep participating in national M&E mechanisms. In Guatemala, the National Strategic Plan 2017-2021 and the GF 2018 Concept Note explain that KP representatives have been engaged in the design of their content and keep participating in national M&E mechanisms. However, key actors, such as the SR Coalición Amigos Contra el SIDA or Fundación Marco Antonio that carries out fieldwork and is in daily contact with the reality do not have transparent or upstream accountability mechanisms to make their voice heard and influence policies. Key populations are represented in the CCM in Peru. However, it is unclear how they participate in national HIV-related policy making. Interviews conducted in Haiti showed that KP leaders felt meaningfully included in program design.

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) organizations exist in all five countries, and SW organizations and networks exist in several countries. It is unclear what their role has been in developing service packages.

[^89]: National Strategic Plan also includes loggers and miners; TG people are acknowledged in the plan, however, the data on this population are aggregated amongst SW and MSM.
[^90]: National Strategic Plan identifies these key populations; however, the packages designed are not KP specific, but a package of HIV services for all of the KP.
[^91]: National Strategic Plan identifies these key populations; however, the packages designed are not KP specific, but a package of HIV services for all of the KP.
[^92]: National Strategic Plan identifies these key populations; however, the packages designed are not KP specific, but a package of HIV services for all of the KP.
In the Dominican Republic, a standardized approach is used. The HIV Concept Note from 2015 includes a detailed package of prevention interventions for MSM, TG women, FSW, women living in bayetes and Haitian migrants. All five packages have the following components in common:

- Diagnosis of HIV (offer of counseling prior to HIV testing and clinical referral)
- Pre- and post-test counseling
- Diagnosis of HIV (HIV testing and delivery of results)
- Condoms (minimum of 15 condoms per month)
- Lubricants (minimum of one lubricant for every three condoms)
- Behavior change activities

It should be noted that although PWID and prisoners are not targeted, it is stated that the materials produced under behavior change activities “will be designed taking into consideration the approach strategy for reaching these populations.” The Concept Note does not clarify how it was estimated that 15 condoms and five lubricant gels (one for every three condoms) is an appropriate quantity for all five key populations.

The Guatemala National Strategic Plan for 2017-2021 does not specify a defined package of services for KP. However, it gives a description of the strategic lines that are included for what the National Strategic Plan identified as “prioritized groups,” which includes MSM, TG women and FSW, as well as PLHIV, HIV-TB co-infected individuals, pregnant women and children born from HIV-positive mothers. People who inject drugs and prisoners are not included in the plan.

The new Guatemala HIV funding request for the period 2019-2020 includes a defined package of services for five KP groups: MSM, TG women, FSW, prisoners and PLHIV. The package will be delivered to each individual population including MSM, TG women, FSW and prisoners every four months, and it will contain:

- 24 condoms/four months.
- 24 lubricant sachets/four months.
- Verbal information about combined prevention: condom use, PEP, PrEP, HIV testing, ART, counseling on HIV sexual transmission risk reduction and information on STI.
- Use of peers to reach out to individuals from KP and navigators to link them to the health system.
- Strengthening of health centers to adapt services to the three KP.
- Sensitization and training of healthcare staff.
- Engagement of individuals from KP in advocacy activities.

It is not clear how the number of 24 condoms every four months was determined, and why it is the same for each KP group. According to the information gathered during the field visit, the number of sexual encounters with partners and/or clients is much higher than 24.

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93 A batey (plural is bateyes) is a settlement around a sugar mill.
The funding request also describes the implementation of risk assessments and HIV and STI prevalence studies for three additional KP: indigenous populations, prisoners and people who use drugs (PWUD). Male sex workers (MSW) are not mentioned. The definition of services for PWUD will depend on the results of a survey that is expected for 2019. Additionally, MSM and TG women will participate in a pilot PrEP project during the period of 2018-2021. The funding request also includes a component addressing comprehensive care, linkage, adherence and retention for PLHIV, using peer navigators who will be regularly trained, together with healthcare providers, on HIV-related issues, human rights and KP social contexts in order to reduce stigma and discrimination in healthcare centers.

The Peru HIV Concept Note from 2015 and the programmatic progress report refer to integrated HIV packages for MSM, TG women and indigenous populations. Prisoners and SW, both male and female, are mentioned in the National Multi-sectorial Plan 2015-2019. The documents, however, do not give details of the definition of service packages, neither in general nor for specific KP.

The Guyana National HIV Strategic Plan 2013-2020, dubbed “HIVision”, focuses on reducing the spread of HIV and improving quality of life for PLHIV, but falls short of identifying specific strategies or services for KP. A separate document, Most-at-risk-populations (MARP) Guidelines and Standards for Non-Governmental Organizations (2012), outlines a service package for KP in Guyana. The MARP Guidelines also outline thorough standard operating procedures (SOP) for service providers across each of these services, including in-depth guides for peer educators, support groups and outreach training.

Attention to critical enablers is absent in several countries’ package design and, where present, often refers to all KP. Specific critical enabler activities for each KP are set out in the tables below. The following apply to all key populations in Paraguay related to laws and policies, and stigma and discrimination:

- Elimination of restrictive laws and policies with specific reference to compulsory HIV testing of individuals obtaining country registration, applying for scholarships or participating in international exchange programs; sexual education policy exists, the current framework limits the access of adolescents and young people to sex education; and establish a system to monitor compliance with existing and new policies related to HIV that would improve the enabling environment for interventions designed for KP, especially policies related to stigma and discrimination.

Guyana does not include specific references to KP, but calls for strengthened legislative and policy mechanisms and frameworks for all PLHIV to reduce discrimination and human rights violations.

The following apply to all KP in Guyana, Haiti and Peru related to stigma and discrimination:

- Guyana: Decrease stigma and discrimination across all sectors; decrease misconceptions and discriminatory behaviors; improved support for community including faith-based/workplace-based education and advocacy regarding human rights of MSM, SW, TG, PLHIV and other targeted populations.
- Haiti: 100% of PLHIV, MSM and SW receive legal support for discrimination or stigmatization; advocacy for adoption of codes of conduct and ethics in the workplace (nursing staff, education, manufacturing enterprises in the free zones and industrial enterprises); sensitize communities and constituted bodies (parliamentarians, judges and leaders) in the promotion and protection of human rights; train health service providers on non-discrimination, confidentiality, informed consent, partner notification and HIV-related medical ethics; carry out awareness-raising actions on legal rights and knowledge of the laws, rights and duties of PLHIV and stigmatized and discriminated populations because of their sexual orientation.

- Peru: Develop differentiated care protocols to meet the needs of male, trans and female sex workers and women living with HIV in the health system services; introduce the use of visible information in health facilities at all levels that expressly indicate the rights of all people to be treated with quality, regardless of their sexual orientation and gender identity; improve competencies and raise awareness among medical, auxiliary, administrative and managerial personnel of health facilities on issues related to STI, HIV and human rights with emphasis on gender identity and sexual diversity; design and implement strategies for equal access for gays, transgender people, sex workers and for women living with HIV; mapping and disseminating the channels for claiming rights to access education and health services for PLHIV, key and vulnerable populations with the support of community organizations; incorporate in the existing working groups advocacy with authorities and decision makers to eliminate barriers to access to health and education for PLHIV, key and vulnerable populations; carry out continuous measurements to assess the situation of stigma and discrimination against PLHIV, key and vulnerable populations in health services and educational institutions.

The following apply to all KP in Bolivia related to community empowerment:

- Bolivia: Develop innovative strategies for the prevention of HIV in the highest risk group with the participation of the population itself through the promotion of Universal Access Committees for male, trans and female sex workers and other populations according to the context of the epidemic.

Guyana does not include specific references to KP but calls for support groups across treatment sites with an active membership of over 500 PLHIV.

The following apply to all KP in Peru and Dominican Republic related to violence, including GBV:

- Peru: Incorporate contents of prevention of violence against KP and respect for diversity in the curricula of the training schools of the Armed Forces, national police, prison officers and security bodies and of local governments and establish incentives for compliance with standards in training schools.

- DR: Establish systems to register and report acts of violence motivated by hatred of vulnerable groups for reasons of gender, sexual identity, sex work, drug use and migrant status; design and implement an inter-institutional agreement to encourage non-violence to vulnerable groups based on gender, sexual identity, sex work, drug use and migrant status, through the
implementation of a guide or protocol of action of the military bodies and national police and the continuous training of their personnel; educate police personnel, detection centers, judges and security personnel to sensitize them to non-violence towards vulnerable groups for reasons of gender, sexual identity, sex work, drug use and migrant status.

Guyana does not include specific references to KP, but calls for increased public/community knowledge and awareness about domestic and gender-based violence against PLHIV.

**Men who have Sex with Men**

All 11 countries identify MSM as a key population. Otherwise, the packages are highly variable in the level of detail and types of interventions specified in their national plans and strategies.

**Table 6. Comparison of Services for MSM with Defined Package in WHO Global Guidance**

<table>
<thead>
<tr>
<th>WHO Guidelines</th>
<th>Summary of findings for 11 countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Seven of the 11 countries (Dominican Republic, Bolivia, Ecuador, El Salvador, Guyana, Haiti and Panama) specifically state male condom distribution in their national service packages for MSM. Two countries (Honduras and Peru) indicate access to condoms, but do not indicate if this is free distribution. Two countries (Guatemala and Paraguay) do not include information about condom distribution in their national MSM packages. Two countries (Bolivia and Haiti) include specifics about condom use education. Six of the countries (Dominican Republic, Ecuador, El Salvador, Guyana, Haiti and Peru) include lubricant distribution/access. Only two countries (Guyana and Haiti) include female condom distribution in their service packages.</td>
</tr>
<tr>
<td>2. Behavioral interventions</td>
<td>Six of the 11 countries (Bolivia, Ecuador, Guyana, Haiti, Honduras and Peru) indicate in the service package for MSM through a peer-to-peer model, peers being identified as promoters, peer outreach teams, peer educators or club-like groups. El Salvador includes BCC, but details are not specified. Six of the 10 countries include IEC materials and outreach as part of the service package (Dominican Republic, Bolivia, Ecuador, Honduras, Panama and Paraguay), while it should be noted that Paraguay’s plan is for all KP, not MSM-specific.</td>
</tr>
<tr>
<td>3. HTC</td>
<td>Of the 11 countries, 10 have service packages for MSM that include HIV testing in some form. Guatemala does not include specific details regarding testing in its service package. Seven countries also include counseling (Dominican Republic, Ecuador, El Salvador, Guyana, Haiti, Honduras and Peru). El Salvador and Peru include utilizing mobile units, Haiti and Bolivia include community-level testing through peer educators, and both Guyana and Honduras specify that they offer rapid</td>
</tr>
<tr>
<td>4. HIV treatment and care</td>
<td>All 11 countries include treatment and care in service packages for MSM at varying levels of detail. Six of the 10 countries have specific plans for ART in their service packages for MSM (Ecuador, Guyana, Haiti, Honduras, Panama and Paraguay). El Salvador offers referrals for treatment and adherence monitoring. Guatemala mentions treatment and care in its service package but does not provide specific details. Peru has a linkage strategy but it is not specific to MSM. Bolivia has included training for providers on treating KP.</td>
</tr>
<tr>
<td>5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosi and mental health conditions</td>
<td>Seven of the 11 countries include prevention and management of co-infections and other co-morbidities in their service packages for MSM (El Salvador, Guatemala and Paraguay do not). Five of those seven countries offer testing for TB in their service packages (Bolivia, Ecuador, Guyana, Haiti and Peru), though Peru is for PLHIV and not KP specific. Only Guyana and Peru specify treatment of TB in service packages. Three of the seven countries screen for hepatitis (Bolivia, Ecuador, and Peru), and only one (Bolivia) offers vaccination for hepatitis. Haiti and Peru are the only two specifically to include mental health services. Panama is the only country to specify referrals for general physical health and colonoscopies, though this is for all KP, not MSM-specific.</td>
</tr>
<tr>
<td>6. SRH interventions</td>
<td>Six of the 11 countries (El Salvador, Guyana, Haiti, Panama, Paraguay and Peru) include a variety of SRH interventions in service packages for MSM; it should be noted that Panama’s and Paraguay’s plans are for all KP, not MSM-specific. Four countries (Guyana, Haiti, Panama and Peru) include STI testing and treatment in service packages for MSM. Two countries (El Salvador and Guyana) include family planning services for MSM. El Salvador also offers referrals for SRH, and Haiti includes risk reduction counseling and screening for GBV. Three countries (Bolivia, Panama and Paraguay) include screening and treatment of syphilis in its service package for MSM, while it should be noted that Panama and Paraguay’s plans are for all KP and not MSM-specific.</td>
</tr>
<tr>
<td>7. Supportive laws and policies</td>
<td>Not mentioned in designs in Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Honduras and Panama. Peru includes: “Identify barriers to access prevention and promotion services in the MSM, gay and trans population, according to needs that may serve as an input for advocacy to implement public policies.” No specific MSM activities mentioned in Paraguay.</td>
</tr>
<tr>
<td>8. Addressing stigma and discrimination</td>
<td>Not mentioned in designs in Bolivia, Ecuador, El Salvador, Guatemala, Honduras and Panama. No specific MSM activities mentioned in Paraguay, Guyana, Haiti or Peru.</td>
</tr>
</tbody>
</table>
### 9. Community empowerment

Not mentioned in designs in Ecuador, El Salvador, Guatemala, Haiti, Honduras, Panama and Paraguay. Peru calls for strengthening peer educators among MSM, gay men and TG, promoting the incorporation of these peer educators “in other sectors of the state with the experience of the Ministry of Health.” No specific MSM activities mentioned in Bolivia or Guyana.

### 10. Addressing violence

Not mentioned in designs in Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Panama and Paraguay. No specific MSM activities mentioned in Peru, DR or Guyana.

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**Sex Workers**

All 11 countries identify SW (no gender specified) as a KP. Nine of the 11 countries specify FSW; Honduras and Peru do not.

**Table 7. Comparison of Services for SW with Defined Package in WHO Global Guidance**

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of findings for 11 countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Of the 11 countries, eight include distribution of male condoms in their service packages for SW (Dominican Republic, Bolivia, Ecuador, El Salvador, Guyana, Haiti, Paraguay and Peru), but it should be noted that Paraguay’s plan is for all KP, not SW-specific. The Dominican Republic and Honduras indicate access to condoms, but do not specify if that is through distribution. Five of the 11 countries distribute lubricant (Ecuador, El Salvador, Guyana, Haiti and Peru), while Bolivia does not distribute lubricant, but specifies distribution of lubricated condoms. Only three countries (El Salvador, Guyana and Haiti) offer female condoms and only El Salvador offers dental dams. Only one country (Haiti) includes specifics about condom education in the service package for SW. Two countries (Guatemala and Paraguay) do not have information available about distribution.</td>
</tr>
<tr>
<td>2. Behavioral interventions</td>
<td>All 11 countries include some sort of behavioral interventions in their service packages for SW. Four countries (Dominican Republic, Ecuador, Honduras and Peru) indicate in the service package for SW a peer-to-peer model, which can utilize promoters, peer outreach teams, educators or club-like groups.</td>
</tr>
<tr>
<td>3. HTC</td>
<td>All 11 countries offer service packages for SW that include HIV testing in some form. Ten countries (all but Guatemala) specify that they offer testing services. El Salvador and Peru include mobile units; Haiti includes community-level testing through peer educators; and both Guyana and Honduras specify that they offer</td>
</tr>
</tbody>
</table>
### 4. HIV treatment and care

All 11 countries include treatment and care in service packages for SW at varying levels of detail. Six countries specify ART as part of the service package (Ecuador, Guyana, Haiti, Honduras, Panama and Paraguay), and two countries (Dominican Republic and El Salvador) include treatment but do not state details. Bolivia includes training for providers, and Haiti offers peer support. Paraguay and Haiti are the only countries to include PEP for SW. Peru has a linkage strategy, but it is not specific to SW.

### 5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions

Nine of the 11 countries include prevention and management of co-infections and other co-morbidities in their service packages for SW (El Salvador and Guatemala do not). Six countries offer screening and/or treatment for TB (Bolivia, Dominican Republic, Ecuador, Guyana, Haiti and Peru), and four countries for hepatitis (Bolivia, Dominican Republic, Ecuador and Peru). Bolivia also offers referral to health services. Three countries (Haiti, Paraguay and Peru) include details about mental health services.

### 6. SRH interventions

Eight of the 11 countries include SRH in their service packages for SW (Bolivia, Ecuador and Guatemala do not). Four countries offer general STI screening and treatment (Dominican Republic, Guyana, Panama and Peru). Both Panama and Paraguay specify that they test for syphilis. Two countries outline services for general STI (Bolivia and Honduras). Only three countries include specifics about family planning in service packages (El Salvador, Guyana and Haiti), and Guyana is the only country to detail termination of unwanted pregnancy. Haiti and Honduras include general gynecological care, and Haiti offers PMTCT, risk reduction counseling and screening for GBV.

### 7. Supportive laws and policies

Not mentioned in designs in Bolivia, Ecuador, El Salvador, Haiti, Honduras and Panama. No specific SW activities mentioned in Paraguay.

### 8. Addressing stigma and discrimination

Not mentioned in designs in Bolivia, Ecuador, El Salvador, Guatemala, Honduras and Panama. No specific SW activities mentioned in Paraguay, Guyana, Haiti or Peru.

### 9. Community empowerment

Not mentioned in designs in Ecuador, El Salvador, Guatemala, Haiti, Honduras, Panama, Paraguay and Peru. No specific MSM activities mentioned in Bolivia or Guyana.

### 10. Addressing violence

Not mentioned in designs in Bolivia, Ecuador, El Salvador, Haiti, Honduras, Panama and Paraguay. Guatemala has a specific indicator for number of SW who report suffering violence from state institutions (disaggregated by sex). No specific MSM activities mentioned in Peru, DR or Guyana.
Transgender People

Nine of the 11 countries classify TG as a KP in their national documents: Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Panama, Paraguay and Peru. The Dominican Republic and Peru further specify TG women.

Table 8. Comparison of Services for TG with Defined Package in WHO Global Guidance

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of findings for 9 of 11 countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Seven of the nine countries include condom distribution in their service packages for TG; Guatemala does not specify if there is distribution, and there is no information available for Paraguay. It should be noted that the plans for Honduras and Panama are for KP in general, not TG-specific. Five countries include condom distribution (Dominican Republic, Bolivia, Ecuador, El Salvador and Panama). Honduras and Peru indicate access to availability, but do not specify if that is through distribution. Only three countries include lubricant distribution: Dominican Republic, Ecuador and El Salvador. Bolivia and Ecuador include condom promotion activities.</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use (in particular, NSP and OST)</td>
<td>Only three of the nine countries include harm reduction interventions in service packages for TG (Bolivia, El Salvador and Paraguay). Both Bolivia and El Salvador offer referral services. Paraguay offers counseling for risk reduction for substance use.</td>
</tr>
<tr>
<td>3. Behavioral interventions</td>
<td>All nine countries include some sort of behavioral interventions in their service packages for TG. Five countries (Bolivia, Ecuador, Honduras, Panama and Paraguay) include IEC. Four countries (Dominican Republic, Ecuador, Honduras and Peru) indicate in the service package for TG individuals a peer-to-peer model, which can utilize promoters, peer outreach teams, educators or club-like groups. Three countries (Dominican Republic, El Salvador and Paraguay) offer BCC, with different levels of detail. Panama provides information about STI, PEP and human rights.</td>
</tr>
<tr>
<td>4. HTC</td>
<td>All nine countries offer service packages for TG that include HIV testing in some form. El Salvador includes mobile units, and Honduras specifies that they offer rapid testing as part of the service package. Four countries also include counseling (Dominican Republic, Ecuador, El Salvador and Honduras).</td>
</tr>
<tr>
<td>5. HIV treatment and care</td>
<td>Eight of the nine countries include treatment and care in service packages for TG (there are no data for Bolivia) at varying levels of detail. Four countries specify ART as part of the service package (Ecuador, Honduras, Panama and Paraguay), and two countries, (Dominican Republic and El Salvador) include treatment but do not state details. Peru has a linkage strategy, but it is not KP-specific.</td>
</tr>
</tbody>
</table>
### 6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions

<table>
<thead>
<tr>
<th>Country</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraguay</td>
<td>The only country to indicate that they offer PEP in the service package, though this is not specific to TG.</td>
</tr>
</tbody>
</table>

Seven of the nine countries include prevention and management of co-infections and other co-morbidities in their service packages for TG (El Salvador and Guatemala do not) with varying levels of detail. Three countries offer screening and/or treatment for TB (Dominican Republic, Ecuador and Peru) and three countries for hepatitis (Dominican Republic, Ecuador and Peru). Paraguay and Peru include details about mental health services. Panama is the only country to also include basic physical exams and colonoscopies.

### 7. SRH interventions

<table>
<thead>
<tr>
<th>Country</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraguay</td>
<td>The only country to also include basic physical exams and colonoscopies.</td>
</tr>
</tbody>
</table>

Six of the nine countries include SRH in their service packages for TG (Bolivia, Ecuador and Guatemala do not). Four countries offer general STI screening and treatment (Dominican Republic, Panama, Honduras and Peru). Bolivia, Panama, and Paraguay specify that they test for syphilis (and Bolivia included treatment). Only one country, El Salvador, includes specifics about family planning in service packages, and two countries (Dominican Republic and Honduras) offer basic health services such as gynecology services. Paraguay is the only country to include mental health counseling.

### 8. Supportive laws and policies

<table>
<thead>
<tr>
<th>Country</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraguay</td>
<td>The only country to include mental health counseling.</td>
</tr>
</tbody>
</table>

Not mentioned in designs in Bolivia, Ecuador, El Salvador, Haiti, Honduras and Panama. Peru includes: “Identify barriers to access prevention and promotion services in the MSM, gay and trans population, according to needs that may serve as an input for advocacy to implement public policies.” No specific TG activities mentioned in Paraguay.

### 9. Addressing stigma and discrimination

<table>
<thead>
<tr>
<th>Country</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraguay</td>
<td>The only country to include mental health counseling.</td>
</tr>
</tbody>
</table>

Not mentioned in designs in Bolivia, Ecuador, El Salvador, Guatemala, Honduras and Panama. No specific TG activities mentioned in Paraguay, Guyana, Haiti or Peru.

### 10. Community empowerment

<table>
<thead>
<tr>
<th>Country</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraguay</td>
<td>The only country to include mental health counseling.</td>
</tr>
</tbody>
</table>

Not mentioned in designs in Ecuador, El Salvador, Guatemala, Haiti, Honduras, Panama and Paraguay. Peru calls for strengthening peer educators among MSM, gay men and TG, promoting the incorporation of these peer educators “in other sectors of the state with the experience of the Ministry of Health.” No specific MSM activities mentioned in Bolivia or Guyana.

### 11. Addressing violence

<table>
<thead>
<tr>
<th>Country</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraguay</td>
<td>The only country to include mental health counseling.</td>
</tr>
</tbody>
</table>

Not mentioned in designs in Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Panama and Paraguay. No specific MSM activities mentioned in Peru, DR or Guyana.
Only four countries identified prisoners as a KP: the Dominican Republic, El Salvador, Haiti and Peru. There is no information available about the service package for prisoners in the Dominican Republic.

Table 9. Comparison of Services for Prisoners with Defined Package in WHO Global Guidance

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of findings for 4 of 11 countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Of the four countries that identify prisoners as a KP, the only details about condom and lubricant distribution are in Haiti, where activities include condom and lubricant distribution, peer educators, and condom use education - however, activities are not specific to prisoners, but to all KP, so it is unclear if these activities are carried out in prisons.</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use (in particular, NSP and OST)</td>
<td>None of the four countries included harm reduction in service packages for prisoners.</td>
</tr>
<tr>
<td>3. Behavioral interventions</td>
<td>None of the four countries included BCC in service packages for prisoners.</td>
</tr>
<tr>
<td>4. HTC</td>
<td>Three of the four countries include HTC in service packages for prisoners: El Salvador, Haiti and Peru. El Salvador indicates HTC without further details, and Peru states access to universal care.</td>
</tr>
<tr>
<td>5. HIV treatment and care</td>
<td>El Salvador, Haiti and Peru include treatment and care in service packages for prisoners. Both El Salvador and Haiti specify ART, and Peru states access to universal care.</td>
</tr>
<tr>
<td>6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions</td>
<td>El Salvador, Haiti and Peru include prevention and management of co-infections and other co-morbidities in service packages for prisoners. Both El Salvador and Haiti include specific activities for TB screening.</td>
</tr>
<tr>
<td>7. SRH interventions</td>
<td>El Salvador, Haiti and Peru include SRH in service packages for prisoners. Both El Salvador and Haiti offer treatment of STI. Haiti also includes family planning, PMTCT, risk reduction counseling and cervical cancer screening - but Haiti’s service package is not specific to prisoners, but to all KP, so it is unclear if these activities are carried out in prisons. Peru states access to universal care.</td>
</tr>
<tr>
<td>8. Supportive laws and policies</td>
<td>Not mentioned in designs in Bolivia, Ecuador, El Salvador, Haiti, Honduras and Panama. No specific prison activities mentioned in Paraguay.</td>
</tr>
</tbody>
</table>
9. Addressing Stigma and discrimination
Not mentioned in designs in Bolivia, Ecuador, El Salvador, Guatemala, Honduras and Panama. No specific prison activities mentioned in Paraguay, Guyana, Haiti or Peru.

10. Community empowerment
Not mentioned in designs in Ecuador, El Salvador, Guatemala, Haiti, Honduras, Panama, Paraguay and Peru. No specific MSM activities mentioned in Bolivia or Guyana.

11. Addressing Violence
Not mentioned in designs in Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Panama and Paraguay. No specific MSM activities mentioned in Peru, DR or Guyana.

**People who Inject Drugs**

Of the 11 countries, only Paraguay includes PWID as a KP in the national plan; however, while the plan specifies key populations, it does not separate out packages for each individual population.

**ANALYSIS: ARE PACKAGE DESIGNS MEETING INTERNATIONAL STANDARDS?**

Most of the assessed countries formally recognize some KP in their national plans and strategies and have acknowledged the importance of servicing KP by designing tailored packages based on WHO guidance.

Designs of KP service packages from the LAC region are a blend of over- and under-specification, especially of commodities: for example, the Guatemala and DR designs specify respectively 24 condoms and a minimum of 15 condoms per month for a wide range of KP, while others provide no guidance on numbers of condoms or amount of lubricant to be provided. The fact that only seven countries specify distribution of male condoms and three specify female condoms for FSW is concerning. Similarly, there seems to be a variable attitude among countries toward the need for lubricant distribution to MSM, TG women and FSW. Yet in both the Dominican Republic and Guatemala, there are specifications of numbers of condoms and lubricant sachets and these are identical for KP with very different needs.

The lack of inclusion of PEP and PrEP for MSM and TG women in most countries is also problematic given the relatively higher levels of HIV prevalence in these populations in most of the assessed countries. As will be noted further below, the lack of specificity in most packages to account for important subpopulations – such as male transgender SW, women who inject drugs, and adolescent KP – can lead to confusion and difficulties in implementation and monitoring.

While behavioral interventions are universally included in packages in some form, there is a notable lack of detailed standards for what these interventions include, how they are delivered and what is considered sufficient coverage. The availability of testing models designed specifically to reach harder-to-reach populations (e.g. rapid testing, in various venues and through different outreach methods) is
highly variable and warrants careful planning in the design phase, according to population size and distribution.

Other complementary services, addressing co-morbidities, and related health needs, need more careful consideration in most countries. While services for TB, HCV, STI and other reproductive health issues may be available in the country in general, and some KP may be able to access these services in the same manner as the general population, in environments of stigma, discrimination and violence, it is often necessary to tailor these services to be more accessible to KP and to state explicitly that key populations have the right to access them. The inclusion of specific human rights and other interventions to enhance the enabling environment is also very uneven across the region.

RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Defined packages of services should include interventions for all KP that have been identified in the country. There may be minor variations depending on local epidemiology and behavior. The involvement of members of KP should be seen as integral to the package design process.

2. All countries in the region should recognize prisoners as a KP and develop a specific package of HIV services to be provided to this population.

3. Rapid situation assessments (using WHO methodology) should be conducted to understand more about the PWID population and the level of injection drug use in the region; once more information is available about this population and their needs, it may be necessary to design and develop a specific package of services for PWID in those countries where it is epidemiologically appropriate to do so.

4. All countries in the region require at least the basic services for each key population to be in the designed service packages. All KP packages should contain condom and lubricant distribution, with female condoms included (at least) in all SW programs (depending on acceptability) and NSP included (at least) in all PWID programs, and distribution should be based on the needs of KP rather than a figure contained in the design document. Sexually Transmitted Infection screening, diagnosis and/or treatment should be free of charge to these same populations.

5. Needs-based services should also be included in service packages for all KP, including the offer of PEP, STI, TB, and hepatitis B and C services. Programs for MSM, TG women and SW should include PrEP.

6. Critical enabler activities should be specified in all KP packages. Assessments on human rights barriers to key populations’ access to HIV services have been carried out in some LAC countries (Honduras and Jamaica). Similar exercises should be carried out in all countries. All countries should have a strategy to address ongoing human rights issues that impact key populations’ access to HIV and broader health services. This strategy should be explicitly linked to overall national HIV strategies and plans.

7. All countries should continue to progress towards clear definitions of coverage of all elements of service packages.
8. Consideration should be given to providing flexibility for optional, enhanced services to be provided alongside core services to attract clients and to address some of the underlying reasons why various KP may not want to present for HIV testing, PrEP and ART, or may not want to remain on ART.

9. Additional services may need to be defined for specific sub-populations, such as male and/or transgender SW, women who inject drugs, and adolescent KP.

10. Where mental health interventions are included in service packages, there is a need for greater understanding of the mental health needs of different KP, and therefore more thoughtful, realistic and well-described interventions within service packages, as well as adequate resourcing of these services.

11. The development of minimum standards for behavioral interventions, which are attuned to population needs, would ensure that the intent of the design of this intervention carries over into appropriate resource mobilization and implementation as well as impact.
There is significant variability in the implementation of HIV service packages for KP in LAC. Across the region, service packages are delivered along a continuum by civil society, private and governmental providers. Prevention services are provided primarily by NGOs and community-based organizations (CBOs), often utilizing peer educators or peer navigators to conduct outreach or drop-in ‘hot spots’ where FSW, MSM and TG women are found in the greatest density. Services may be provided through mobile outreach (e.g. through mobile units) or at static locations (e.g. drop-in centers).

The point of intersection between government and non-governmental service providers tends to be either HIV testing or linkage to care. In many cases, NGOs or CBOs are able to deliver community-based rapid testing on site (either mobile or static) and conduct referrals or accompaniment to care only for those who test positive. In other environments, clients are referred or accompanied to care facilities to initiate testing for HIV. Non-governmental organization and CBO support beyond the point of HIV diagnosis may or may not continue, depending on models employed and resource availability. Treatment and care for HIV is then generally provided by governmental service providers in government facilities.

Coverage of KP with service packages varies widely across the region, as do the definitions of coverage. As noted in Table ES1 above, the key indicator should be coverage of a KP with the defined package of services (as shown in the Design section of this report). However, this is impossible in most countries because the service package often includes ART and coverage figures usually cannot be disaggregated by KP (this is dealt with in detail in the Monitoring section). In addition, some countries use different definitions of coverage in GAM and other reports. As shown in the tables below, some coverage estimates come from research reports and others from IBBS surveys rather than from programmatic data. Recommendations on this issue are contained in the recommendation section under Monitoring.
In Haiti, HIV response efforts for both the general population and KP are coordinated by the national programme (Programme National de Lutte Contre les IST/VIH/SIDA (PNLS) and executed by the Ministry of Public Health and Population. Activities to support these objectives for KP are financially supported by Global Fund, USAID/PEPFAR, the US Centers for Disease Control and Prevention (CDC) and the Government of Haiti.

**Figure 3. Map of Haiti showing the regions where Key Population programming is delivered, and the funder providing support**

Prevention outreach services for HIV, HIV testing and counseling (HTC), and linkage to ART services supported by trained peer navigators are delivered through the activities of community-based agencies financially supported by Global Fund, LINKAGES and the CDC. In some cases, combinations of these funders provide funding for particular package elements within a single CBO. There are 46 districts where HIV prevention services are delivered: CBOs from eight districts are supported by Global Fund; CBOs in 12 districts are supported by LINKAGES program; a CBO in one district is supported by both Global Fund and the CDC; and 12 district CBOs are supported by both Global Fund and LINKAGES.

Similarly, in Guyana, delivery of the package of services for KP is implemented by USAID-supported agencies in Region 4 (Georgetown and surrounding area) and by Global Fund-supported agencies in the other nine regions of the country. At the time of the assessment, SR were unfunded as the previous Global Fund allocation had ceased in late 2017 and the new allocation had not commenced.
In other countries, the division of tasks between funders is not so clear. Services for HIV in the Dominican Republic are implemented by multiple national and international actors with similar testing and outreach programs, all provided within nearby geographical locations. The risk of overlapping and oversaturation of these services was observed during the in-country assessment. In Peru, AIDS Health Foundation (AHF), funded by the AHF US, is increasingly offering services in the country to the general population (not targeting KP exclusively) in terms of HIV/STI prevention and treatment, hepatitis B and C testing, and cervical cancer screening. This is done through a parallel, non-integrated system. Their yield of HIV-positive results is low (1.33%).

Prevention efforts by CBOs in Haiti are facilitated by peer-network driven sessions, locally called “les séances.” These sessions are the primary point of contact for access to prevention commodities, HTC and outreach by peer educators. This assessment identified a number of problems with this model including low HTC rates for KP, evidenced by programmatic reporting data from 2016 which indicated only 21.3% and 17.8% of MSM and FSW had tested in the last year. Séances seem to have limited efficacy in penetrating new social networks, and prevention commodities were only given out when the séances met. This may explain low testing rates and low availability of condoms and lubricants at the hot spots visited during the assessment.

The séances method seems to be used by other countries in the region. In the Dominican Republic and Guatemala, behavioral interventions are limited to 15-minute talks regarding outreach and testing activities. There is no defined mechanism to evaluate the impact of such interventions on behavioral change. It is interesting to note that HIV testing in DR, while available sufficiently and continuously for KP, is only taken up by one out of every 10 key population members contacted, based on the experience of the main SR implementing MSM programs for both Global Fund and PEPFAR. In Guatemala, the rate of HIV-positive results among individuals from KP who are tested is lower than the prevalence indicated by survey data. For instance, Global Fund supported activities in 2017 yielded a 3.22% rate of HIV-positive results for all MSM tested and 3.96% for all TG women tested, while the HIV prevalence data estimate is 10.5% and 24%, respectively.

In the Dominican Republic and Guatemala, condom and lubricant distribution are not limited to the séances. These products are available continuously in community centers (Dominican Republic) and Integral Assistance Units (Guatemala). Other public centers in Guatemala where condoms could be made available have restricted access because condom distribution there is meant for family planning only. In Peru, most local informants and FGD members agreed that access to free condoms is problematic, particularly in the provinces outside the capital. Stock-outs are frequent due to supply chain issues. The number of condoms received depends on willingness to be tested or be identified as a SW. Access to free lubricant is very difficult, and many KP go to the black market to obtain it, or they do not use it at all.

The outreach model in the Dominican Republic and Guatemala utilizes peer-promoters, whose effectiveness is progressively reduced once their personal networks have been saturated. Since promoters are pushed to reach their targets in order to be paid or maintain their job, it is thought that they tend to duplicate registrations to include non-KP individuals and occasionally enter false data.
(Dominican Republic) or engage in non-selective or repetitive testing (Guatemala). Open-air outreach activities in both countries do not generally ensure confidentiality. Clients are often called by their name and results are provided in partially open booths. In the case of an HIV-positive test result, breaches of confidentiality are frequent. Stigma and discrimination related to HIV in both countries is very high, both at the society level and in KP communities, it being the most cited reason why KP refuse to be tested.

The use of social media to reach individuals from KP and link them to testing services is still infrequent in the Dominican Republic and Peru, despite being the preferred form to contact sexual partners by MSM and, to a lesser extent, TG women. In Guatemala, Coalición Amigos contra el SIDA and Fundación Marco Antonio are increasingly using online social media to reach out to individuals from KP. This approach seems to be yielding higher rates of HIV-positive results. One of the reasons may be that confidentiality is better kept in social media outreach than in open-air outreach and testing activities. Knowledge about the benefits of ART (including the benefits of having an undetectable viral load) is limited and only reaches a small portion of KP.

In Peru, a very different system is used. Prevention and testing for HIV are offered through a dual system that is divided between “Fixed Offer” and “Mobile Offer” through mobile brigades. Until very recently, the Fixed Offer only included public centers known as the Assistance and Referral Center for STI and HIV (Centro Especializado de Referencia de ITS/VIH y SIDA – CERITS) and the Periodical Medical Unit (Unidad de Atención Médica Periódica – UAMP). Sixteen CBOs have now also been authorized to perform HIV testing. Mobile brigades, or units, including two healthcare professionals from the public system and peer educators, are in charge of liaising with the places where the HIV testing will take place; there are 20 mobile brigade members per region. However, Peru appears to be having significant problems related to HIV testing among KP. Test coverage for HIV is limited, and its availability is uneven partly due to supply inefficiencies. Officials from the Ministry of Health think that the new health system decentralization plan will help reduce the gaps, while other stakeholders fear it will make the situation even more chaotic. Yield rates in mobile units for MSM and TG women (both <2%) are much lower than prevalence figures in epidemiological surveys.

In the Dominican Republic, PEP is offered in the context of rape only and no KP-specific data are yet available. Post-exposure prophylaxis is said to be available in Peru, but few details could be found on its use. Pre-exposure prophylaxis is available in Peru on a pilot basis.

In the five countries assessed through in-country visits, most key medical services for people with HIV are free of charge: in all countries, ART, CD4 and viral load tests (where available) are free of charge. However, in DR, clinical guidelines are not always respected by doctors, specifically in terms of recommended treatments. Absenteeism of medical doctors and other healthcare staff is reportedly high and the hours of operation of health centers are not adapted to the needs of KP. Diagnostic tests for HIV such as CD4 and viral load measurements are also freely available but with prolonged delays to delivery of results.
Availability of viral load and CD4 diagnostic tools is very irregular in Guatemala, particularly outside the capital. The hours of operation of HIV treatment and care services in hospitals (7am to 11am) are not adapted to the needs of KP and the wait times are more than five hours in most cases – users show up around 5am to line up and wait. Integral Assistance Units are based only in department capitals, which present a time and cost barrier for individuals in rural areas. The distance to the healthcare centers is also a barrier for low-income individuals. These healthcare centers are preferable for confidentiality reasons. Long wait times for diagnostic results are also reported in Peru.

Public hospitals and clinics in Guyana are the only access point for free HIV treatment services. This assessment found evidence of peer navigation by trained members of CBOs. A treat-all approach for KP guides physicians to initiate immediate ART for all consenting HIV-positive patients. However, findings from interviews and discussions with ART service providers and PLHIV found that drug stock-outs occurred frequently.

Loss to follow-up (LTFU) is a major issue for KP in the assessed countries. In DR, FGD participants and local informants highlighted that LTFU is fueled by: a) inappropriate opening hours at health centers; b) the fact that some individuals do not want to use the health center that is close to their home because of fear of confidentiality breaches, but face challenges to travel to other cities due to lack of resources or time; and c) the high mobility of KP who are SW. Pilot programs to increase linkage and retention are being implemented; however, no outcome data on their effectiveness were available during the time of the assessment. Late diagnosis is said to be high in Guatemala and, after linkage to care, LTFU is around 25%.

In Peru, recently, a new strategy of “vinculadores” (linkers) has been put in place to reinforce the linkage between those with HIV-positive results and the health system. Linkers, 11 so far, are healthcare professionals who are knowledgeable about the complexity of the system and how to navigate it. There are not yet any KP-specific data on linkage and retention in the national health system. Stock-outs of ART are common.

Small-scale substance use harm reduction programs (counseling on needle-sharing and psychological support for PWID and alcohol and substance use for TG women) have been launched in the capital of DR; however, it is not clear how and when they could be scaled-up. Service packages – as currently designed and delivered in the five countries – do not appear to be effective in reaching adolescent and young KP.

More detailed assessments of the implementation of packages are presented below, by population.
MSM Package Implementation

All countries visited during the assessment process are attempting to implement prevention programs for MSM as designed. In countries such as Guyana, the delay in the start of a new Global Fund project meant that no activities were under way during the assessment. In Peru, the current Global Fund grant began later than expected and the Mobile Units for reaching out to MSM were not launched until November 2017.

Condom and lubricant distribution are considered insufficient or problematic in several countries. In DR, the number of condoms is considered sufficient, but not lubricant. Reported use of condoms is low, particularly with a regular partner or after a negative result of an HIV test. Condom and lubricant availability is said to be high in Haiti (71.8% for MSM), however, the in-country assessment found limited evidence of condom availability at some of the CBOs and hotspots visited. In Peru, MSM report difficulties accessing condoms, particularly in meeting places, such as cinemas, saunas and clubs. When available in these places, condoms and lubricants must be purchased. Access to condoms in public health centers is very much dependent on willingness to be tested. These centers also do not have hours of operation that are convenient for many MSM and they may be located in areas which pose a security risk.

Behaviors of MSM in Guatemala vary in the capital from behaviors of MSM in the rest of the country. In the capital, MSM predominantly use social media to contact sexual partners and report a higher use of substances other than alcohol when compared to other cities. They engage in transactional, intergenerational sex less commonly than in smaller cities, where it is very common. No specific programs exist to target the wealthier and older MSM who have not disclosed their orientation, who reportedly use condoms less frequently and who are much more reluctant to be tested for HIV. Outside the capital, the reported use of alcohol is higher.

In DR, MSM use mostly social media to contact sexual partners, although the concomitant use of public spaces (e.g. parks, avenues) is still significant in the provinces outside the capital. Intergenerational, transactional sex is common. Young MSM maintain multiple relations, including with older, wealthier and/or married MSM. This subgroup of married MSM is very reluctant to be tested for HIV. Men who have sex with men who are minors are especially vulnerable, as they cannot be targeted by outreach activities due to legal constraints.

Testing rates for HIV are low among MSM in most of the assessed countries, often due to fear of how a positive result will change the individual’s life. For example, most participants in the Dominican Republic MSM FGD insist that they will never have sex or a relationship with someone they know is HIV-positive and, if they were friends, their friendship will be affected by that fact. A diagnosis of HIV will most likely have as a consequence isolation and rejection within the MSM community and in the society at large, leading to psychological adverse effects. Participants in the FGD also declare that in the event of an HIV-positive test result, they would not tell their partner and would rather end the relationship, as they would be afraid of their partner’s reaction. Reportedly, partner violence is not
uncommon in this situation. They perceive that this kind of ‘social death’ is worse than the eventual health consequences of being HIV-positive without knowing their status or receiving treatment.

For many FGD participants in Guatemala, an HIV diagnosis meant ‘death’. When asked if they would have sex with or have a partner who is HIV-positive, the vast majority said no. Blaming HIV-positive individuals for their condition was reported as a common occurrence, as well as spreading rumors of being HIV-positive as a way to criticize someone. Societal and community exclusion, stigma and discrimination fuel the idea that is better not to know your HIV status.

In Guyana, a culture of heightened discrimination and oppression experienced by ‘out’ MSM may also be contributing to an unwillingness to test, at least within MSM service providers. Some MSM may identify themselves as MSM on anonymous surveys, but fear accessing community-based services where they may be seen and potentially ‘outed’ by fellow community members. They may still access the HIV prevention and testing services offered to the general population through primary care, but they would not be counted as service users at MSM-focused CBOs. An organization currently supported by non-Global Fund funding sources called the Society Against Sexual Orientation Discrimination (SASOD) provides prevention and testing services for middle- and upper-class MSM, while also engaging in national advocacy efforts to minimize the stigma and discrimination experienced by MSM in Guyana. These efforts are important activities in national agenda setting to increase the proportion of MSM who routinely engage in HTC.

In Peru, reluctance to be tested among MSM is mostly due to fear of a positive result, which most often leads to social and family exclusion and rejection by the MSM community. When MSM test positive, linkage activities are effective in the short-term, but LTFU increases over time. An unusual aspect of service delivery in Peru is the HIV testing for MSM offered by the organization Via Libre as a market product for which the user must pay. The organization claims HIV-positive rates of 7-10%. This may be partially because Via Libre uses mostly social media and user-to-user promotion to reach their clients.

Other reasons cited for choosing not to receive an HIV test in the Dominican Republic include the frequent breaches of confidentiality of HIV-positive test results. The observation of outreach activities during the field visit confirmed that people getting a HIV test are called by their name and test results are communicated without proper confidentiality conditions. Some MSM declared that being accompanied to the testing site by peer educators who are friends is a bad idea, as they will clearly notice if any of them have received a positive result.

In Haiti, a total of 44,055 MSM were reached in 2016 by LINKAGES-funded NGO FOSREF, of whom 22,093 (50.1%) were tested. Of those tested, 3.4% were HIV-positive, and 26.4% of those testing HIV-positive were enrolled in treatment. Between October 2015 and September 2016, 843 MSM were diagnosed with HIV, 428 (50.8%) were initiated on ART and 70 (16.4%) were retained on ART.

In Guyana, a comparison between the findings of the IBBS 2014 among MSM and the programmatic reporting for 2016 indicates improvements in the proportion reached by the package of prevention services. Among adult MSM, the 2014 IBBS reported an estimated coverage of 49.0%, while 2016
programmatic data estimate that 64.0% of MSM were reached by the package of prevention services. There are also modest improvements in the proportion of those recently tested and aware of their status: 46% reported recent testing and awareness of their status in 2016, against 43% in the 2014 programmatic data. However, it should be noted that programmatic monitoring for these two indicators aggregates data from both MSM and TG populations.

In all assessed countries, MSM reported stigmatization and discrimination in health centers, where being openly MSM is being connected to being HIV-positive to such an extent that they only access healthcare when the symptoms of a late stage of HIV infection are clear. In Haiti, ART can be accessed free of charge by any individual from a KP at many primary care sites across the country under treat-all clinical guidance. However, not all clinical sites are considered ‘KP-friendly’ and there are efforts to engage and train providers to increase the number of appropriate service sites for newly diagnosed individuals from KP. In Guyana, there was evidence of strong peer support from CBOs to direct and/or accompany MSM seeking health services to an appropriate hospital/clinic setting.

In the Dominican Republic, MSM reported access to STI screening and treatment and to psychological support in some health centers and CBOs. The heavy use of alcohol and sex-enhancing substances during sexual encounters is reported to be common.

Adolescents among the MSM population may be at elevated risk. In all geographical areas visited during the Guatemala assessment, MSM FGD participants reported that their sexual debut was at a very young age: as low as eight years old for oral sex and 14 years old for anal sex. Grant SR such as Coalición Amigos contra el SIDA and Fundación Marco Antonio indicate that the newly-diagnosed PLHIV they have identified are mostly younger men and at least a third are late diagnosis (less than 500 CD4), which may indicate HIV infection at an early age. Despite this, no specific programs targeting adolescents are in place or have been included in plans for the period 2019-2021. Similar issues were raised in FGD in Peru.

Community empowerment is not listed as a service provided through Global Fund in any of the assessed countries. In Peru, University of California, San Francisco (UCSF) piloted and assessed the feasibility, acceptability and potential efficacy of Proyecto Orgullo, a community mobilization intervention to decrease sexual risk, promote health-seeking behaviors, and facilitate personal and community empowerment among gay men and TG women. The project included six interrelated core elements: 1) self-reflection small group sessions; 2) supporting peers in HIV prevention; 3) mobilization activities addressing HIV, MSM/TG women issues and community empowerment; 4) core group (staff and MSM/TG women volunteers) designing/implementing those activities; 5) a project space; and, 6) publicity. According to the article describing the introduction of the project, it was found that the project had positively influenced MSM/TG women’s HIV prevention beliefs, self-efficacy and behaviors; provided social support and created community; facilitated individual and community empowerment; helped MSM/TG women to collaborate; and established a functional Community Centre for socializing/conducting mobilization activities (Maiorana et al., 2016).

For the interventions below, no data are available:
• PrEP
• PEP
• ART-related prevention
• ART drug interactions
• Hepatitis prevention and management of co-infection
• Mental health services and management of co-morbidities
• Nutrition
• STI prevention, screening and treatment
• Anal cancer treatment
### Table 10. Summary of Service Coverage for MSM

Survey/IBBS (S); GAM (G); Programmatic Data (P)\(^94\); Other (O); (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Bolivia*</th>
<th>DR</th>
<th>Ecuador*</th>
<th>El Salvador*</th>
<th>Guatemala</th>
<th>Guyana(^95)</th>
<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming(^96)</td>
<td>60.0% (S)(^97)</td>
<td>39.5%(^98) (S)</td>
<td>56.2%(^99) (S)</td>
<td>60.6% (O)(^100)</td>
<td>N/A(^101)</td>
<td>60.9% (S)(^102)</td>
<td>71.8%(^103) (S)</td>
<td>46.1% (O)(^104)</td>
<td>75% (G)(^105)</td>
<td>66.8% (G)(^106)</td>
<td>49.8% (P)(^107)</td>
</tr>
</tbody>
</table>

\(^94\) Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators and nationally accepted PSE as denominators.

\(^95\) MSM and TG combined

\(^96\) Percentage of men reporting using a condom the last time they had anal sex with a male partner

\(^97\) IBBS 2015

\(^98\) IBBS 2013

\(^99\) IBBS 2015

\(^100\) UNAIDS 2016, *Estudio de estimacion de poblacion de hombres que tienen sexo con hombres/UNAIDS 2016, Study of population size estimation of men who have sex with men*

\(^101\) No national data. ECVC 2017 57.1% in Guatemala City and 49.6% in Coatepeque

\(^102\) IBBS 2014: 57.8% (25+) 63.9% (<25)

\(^103\) IBBS 2014

\(^104\) VICITS 2016

\(^105\) UNAIDS 2018 Data Report

\(^106\) UNAIDS 2018 Data Report

\(^107\) Concept Note 2015
### Coverage of HIV prevention programs among MSM

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Bolivia*</th>
<th>DR</th>
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<th>Guyana*</th>
<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage with prevention package as defined in national design documents</td>
<td>15.5%(^{109}) (P)</td>
<td>65.5% (^{110}) (S)</td>
<td>29.5(^{111}) (S)</td>
<td>58.2(^{112}) (P)</td>
<td>25.4(^{113}) (P)</td>
<td>64(^{114}) (P)</td>
<td>72.2(^{115}) (P)</td>
<td>23.7(^{116}) (P)</td>
<td>61.7(^{117}) (P)</td>
<td>16.0(^{118}) (P)</td>
<td>4.8(^{119}) (P)</td>
</tr>
</tbody>
</table>

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\(^{108}\) Coverage with prevention package as defined in national design documents

\(^{109}\) IBBS 2015

\(^{110}\) GF PUDR 2017

\(^{111}\) IBBS 2015

\(^{112}\) GF Concept Note 2016

\(^{113}\) GF Concept Note 2016

\(^{114}\) Program data GF and PEPFAR reviewed by APMG

\(^{115}\) Program data GF and PEPFAR reviewed by APMG

\(^{116}\) GF Funding Request 2017

\(^{117}\) GAM 2016

\(^{118}\) GF PUDR 2016

\(^{119}\) GF PUDR 2017
## Assessment of HIV Service Packages for Key Populations
### Latin America & Caribbean

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Bolivia*</th>
<th>DR</th>
<th>Ecuador*</th>
<th>El Salvador*</th>
<th>Guatemala</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of HIV status(^{120})</td>
<td>7.2% (P)(^{121})</td>
<td>67.7%(^{122}) (P)</td>
<td>35.6%(^{123}) (P)</td>
<td>66.4%(^{124}) (G)</td>
<td>20.3% (P)(^{125})</td>
<td>46.0% (P)(^{126})</td>
<td>23.1% (P)(^{127})</td>
<td>23.7% (P)(^{128})</td>
<td>8.1%(^{129}) (G)</td>
<td>7.8%(^{130}) (P)</td>
<td>6.7%(^{131}) (P)</td>
</tr>
<tr>
<td>ART coverage(^{132})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27.4%(^{133}) (S)</td>
<td></td>
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</table>

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\(^{120}\) Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

\(^{121}\) IBBS 2015

\(^{122}\) PUDR 2017

\(^{123}\) IBBS 2015

\(^{124}\) GAM 2016

\(^{125}\) GF Concept Note 2016

\(^{126}\) Program data GF and PEPFAR reviewed by APMG

\(^{127}\) Program data GF and PEPFAR reviewed by APMG

\(^{128}\) GF Funding Request 2017

\(^{129}\) GAM 2016

\(^{130}\) GF PUDR 2016

\(^{131}\) GF PUDR 2017

\(^{132}\) Percentage of the PLHIV in a KP receiving ART in the past 12 months

\(^{133}\) IBBS 2014
SW PACKAGE IMPLEMENTATION

All countries visited during the assessment process were confirmed to be attempting to implement prevention programs for SW as designed. As with MSM, delays in commencing the new grant in Guyana and Peru meant little activity was under way at the time of the assessments.

In Guyana, a comparison between the findings from the IBBS 2014 among SW to the programmatic reporting for 2016 indicates minimal improvements in the proportion reached by the package of prevention services. But there appears to have been a significant decline in the proportion of those recently tested and aware of their status between 2014 and 2016. The 2016 program data reported that 38% of FSW reported recent testing and awareness of their status, compared to 66% of SW in the 2014 IBBS.

There is substantial variation in the services offered by CBOs serving FSW in Guyana. One organization engages people from KP by offering a range of social, health and vocational training services, while another organization focused their efforts exclusively on outreach. Findings from FGD with beneficiaries of these two organizations also found substantial differences in knowledge of contraception and reproductive health and services, suggesting that agencies with models focusing exclusively on peer outreach to FSW may limit the capacity of members to share practical and evidence-informed advice on sexual and reproductive health (SRH) strategies.

In addition, findings from key informant interviews and FGD with FSW in the assessment identified a consistent pattern of transient work: the hinterlands of Guyana have poor transportation infrastructure and are natural resource-rich. The extraction industry causes substantial mobility among miners and loggers in these regions. Sex workers described travelling across the country (and to neighboring countries) to sell sex. These mining or logging camps are often far from primary health care facilities and beyond the practical reach of CBOs. One SR agency of the expired Global Fund grant for Guyana, the International Organization for Migration (IOM), focuses their outreach and testing efforts on these mining and logging populations and the SW following them. The IOM team experiences many challenges, as transportation costs are extremely high in Guyana, making access to remote populations very difficult. There was no evidence from the assessment of any private-public partnerships between the extractive industry and civil society to deliver SRH services to these transient populations.

Findings from FGD with FSW in Guyana suggest that some women are routinely purchasing morning-after pills from street vendors and have minimal knowledge of alternative contraceptive strategies. Terminations of pregnancy are available only at private, pay-for-service clinics. With improved knowledge, existing peer support networks can help better direct, accompany and/or navigate FSW to these supportive services. Finally, several FSW in the discussions indicate that while injection drug use is not very common in Guyana, non-injection drug use is prevalent among SW. Efforts to incorporate harm reduction activities and drug and alcohol counseling into service package delivery for FSW may facilitate greater engagement with health services and improve the indicators for prevention reach and testing among KP.
Programmatic data on SW in Peru are limited. Female sex workers are under the responsibility of the Ministry of Health. The requirement is that they are screened for HIV and STI periodically in order to keep their Health Card.” Information about MSW is very scarce and outdated, and there are no specific programs addressing them.

In Haiti, condom and lubricant distribution availability is reported to be high (70.9% for FSW), but the in-country assessment found limited evidence of condom availability at some of the CBOs and hotspots visited. In 2016, a total of 116,005 FSW were reached by LINKAGES, GF FOSREF and the CDC of whom 44,546 (38.4%) were tested. A total of 2.5% of those tested were HIV-positive, and 59.7% of those were enrolled on treatment.

For the following interventions below, no data are available for this assessment:

- PrEP
- PEP
- ART-related prevention
- ART drug interactions
- Hepatitis prevention and management of co-infections
- Mental health services and management of co-morbidities
- Nutrition
- STI prevention, screening and treatment
- Contraceptive services
- Safe abortion and post-abortion care
- Cervical cancer screening and treatment
### Table 11. Summary of Service Coverage for SW

Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O); (*) Indicates Desk Review Only

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<th>El Salvador*</th>
<th>Guatemala</th>
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<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming</td>
<td>85.1% (G)</td>
<td>73.2% (O)</td>
<td>80.2% (O)</td>
<td>82.0% (S)</td>
<td>70.9% (S)</td>
<td>88.4% (O)</td>
<td>90.6% (G)</td>
<td>98.3% (P)</td>
<td>90.5% (G)</td>
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<td></td>
</tr>
</tbody>
</table>

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134 Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators and nationally accepted PSE as denominators.

135 Percentage of SW reporting the use of a condom with their most recent client.

136 GARPR 2013

137 UNAIDS 2016, *Estudio de estimacion de poblacion de hombres que tienen sexo con hombres/UNAIDS 2016*, Study of population size estimation of men who have sex with men found 92.5% (Guatemala City) 70.5% (Ecuintla & Puerto San José) 77.6% (Tecún Umán & Malacatán).

138 ECVC 2017

139 IBBS 2014

140 IBBS 2014

141 VICITS, 2016

142 GAM 2016

143 GF PUDR 2016

144 UNAIDS 2018 Data Report
### Coverage of HIV prevention programs among SW

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<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of HIV prevention programs among SW</td>
<td>77%&lt;sup&gt;146&lt;/sup&gt;</td>
<td>56.9% (P)&lt;sup&gt;147&lt;/sup&gt;</td>
<td>81.6%&lt;sup&gt;148&lt;/sup&gt; (S)</td>
<td>52.9%&lt;sup&gt;149&lt;/sup&gt; (P)</td>
<td>63% (P)&lt;sup&gt;150&lt;/sup&gt;</td>
<td>63% (P)</td>
<td>72.2%&lt;sup&gt;152&lt;/sup&gt; (P)</td>
<td>17.1%&lt;sup&gt;153&lt;/sup&gt; (P)</td>
<td>41.6%&lt;sup&gt;154&lt;/sup&gt; (G)</td>
<td>66.1%&lt;sup&gt;155&lt;/sup&gt; (P)</td>
<td>34.9%&lt;sup&gt;156&lt;/sup&gt; (P)</td>
</tr>
</tbody>
</table>

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<sup>145</sup> Coverage with prevention package as defined in national design documents

<sup>146</sup> GAM 2016

<sup>147</sup> Programmatic results 2016

<sup>148</sup> IBBS 2015

<sup>149</sup> GF Concept Note 2016

<sup>150</sup> GF Concept Note 2016

<sup>151</sup> Program data GF and PEPFAR reviewed by APMG

<sup>152</sup> Program data GF and PEPFAR reviewed by APMG

<sup>153</sup> GF Funding Request 2017

<sup>154</sup> GAM 2016

<sup>155</sup> GF PUDR 2016

<sup>156</sup> GF PUDR 2017
## Assessment of HIV Service Packages for Key Populations
### Latin America & Caribbean

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Bolivia*</th>
<th>DR</th>
<th>Ecuador*</th>
<th>El Salvador*</th>
<th>Guatemala</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of HIV status(^{157})</td>
<td>60.5%(P)(^{158})</td>
<td>20.0%(P)(^{159})</td>
<td>79.6%(G)(^{160})</td>
<td>57.0%(P)(^{161})</td>
<td>38%(P)(^{162})</td>
<td>17.8%(S)(^{163})</td>
<td>58.6%(P)(^{164})</td>
<td>86.3%(G)(^{165})</td>
<td>68.1%(P)(^{166})</td>
<td>30.4%(P)(^{167})</td>
<td></td>
</tr>
<tr>
<td>ART coverage(^{168})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27.7%(S)(^{169})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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157 Percentage of SW that have received an HIV test in the past 12 months and know their results
158 PUDR 2017
159 GAM 2017
160 GAM 2016
161 GF Concept Note 2016
162 Program data GF and PEPFAR reviewed by APMG
163 IBBS 2014
164 GF Funding Request 2017
165 GAM 2016
166 GF PUDR 2016
167 GF PUDR 2017
168 ART coverage among SW living with HIV
169 IBBS 2014
TG Package Implementation

All assessed countries, with the exception of Haiti, address TG women as a separate KP for HIV prevention, testing, care and support. This is a remarkable finding, as formal recognition of TG is not nearly as frequent in any other region assessed as part of this work. In-country assessments included TG women for three countries, the largest number in any region included in this assessment. The situation for TG women in Peru, DR, Guyana, and Guatemala is characterized by high levels of verbal, physical, psychological and sexual violence (rapes, extortions, robberies, harassment, beatings, and murder) from family members, partners, clients and the police. The average life expectancy of TG women in Dominican Republic and Guatemala is about 35 years old. The cycles of poverty, under nutrition, ill health and violence are experienced more heavily by minors who are usually rejected by their families and need to leave school and home at a very young age. Use of alcohol and illegal drugs is high and is particularly associated with sex work.

In the Dominican Republic, according to FGD participants, TG women have regular access to condoms, but do not have regular access to lubricants. Lubricant sachets, when available, are reported to be inconvenient to use and keep. Other substances bought on the black market (very few pharmacies sell lubricants and it is very expensive) or saliva are commonly used as lubricant. Condom use is higher with clients than with regular partners; however, even with clients, the heavy use of alcohol and substances and requests from partners may lead to condom-less sex. Due to these issues, UNDP is financing a pilot program for substance use harm reduction in the context of sex work, in collaboration with the SR TRANSSA. Transgender women in Peru have easy access to condoms, particularly if they declare themselves to be SW. Lubricant is rarely accessible for free in health centers, but is somewhat more accessible through outreach activities. In any case, the maximum number of condoms given is 100 per month for TG women who are SW. This is not enough, considering that the number of daily services can range from 10 to 15.

Most TG women in Guatemala engage in sex work and are highly mobile. They are very hard to link and retain in the health system, even when they are diagnosed as HIV-positive. Testing for HIV among TG women seems to face similar problems to those outlined above for MSM. Focus group discussion participants in the Dominican Republic report that they think rumors and gossip are used by other TG women who are SW to steal clients. Some TG women would prefer that the testing services are offered by educators who are not peers, i.e. who are not TG women, as they are considered competitors in the sex work market. Many who test HIV-positive leave their neighborhood or city to live elsewhere.

In most countries in the region, TG women do not have access to hormone treatment or medical gender reassignment services. They cannot use their preferred names and stigma and discrimination in schools and workplaces limit their options to develop professional careers.

Several leaders of the TG women’s population in Guyana participated in interviews and FGD during the assessment, and responses indicated that TG are rapidly collectivizing and differentiating themselves from MSM-identifying communities. A USAID-supported network called Guyana Trans
United facilitates a safe-space house and supports outreach efforts to deliver HIV prevention and testing services to this KP. Evidence to guide informed policy-making for TG populations in Guyana is not systematically collected. Both the IBBS protocol and current M&E practices aggregate TG service usage indicators with MSM. However, findings from this assessment clearly indicated a need for a more data-driven response for TG communities. A major barrier to this KP-specific response is the collection of TG-specific indicators, which is limited by a UIC that is formulated by a binary gender response option.

For the following interventions, no data are available for this assessment:

- PrEP
- PEP
- ART-related prevention
- ART drug interactions
- Hepatitis prevention and management of co-infections
- Mental health services and management of co-morbidities
- Nutrition
- STI prevention, screening and treatment
- Community-based testing
- Linkage and enrollment in care
- ART coverage
- Prevention of mother-to-child transmission of HIV (PMTCT)
- TB prevention and management of co-infection
- Anal cancer treatment
### Table 12. Summary of Service Coverage for TG

Survey/IBBS (S); GAM (G); Programmatic Data (P)\(^{170}\); Other (O); (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Bolivia*</th>
<th>DR(^{171})</th>
<th>Ecuador*</th>
<th>El Salvador*</th>
<th>Guatemala(^{172})</th>
<th>Guyana</th>
<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru(^{173})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming(^{174})</td>
<td></td>
<td>82.6% (P)(^{175})</td>
<td></td>
<td>95.8% (O)(^{176})</td>
<td>N/A(^{177})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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\(^{170}\) Coverage values have been calculated using available programmatic coverage data as numerators and nationally accepted PSE as denominators

\(^{171}\) TG Women

\(^{172}\) TG Women

\(^{173}\) TG Women

\(^{174}\) Percentage of TG who used a condom in last sexual relationship

\(^{175}\) GF PUDR 2017

\(^{176}\) UNAIDS, Estudio de estimacion de talla poblacional/UNAIDS, Population size estimation study

\(^{177}\) No national figure. ECVC 2017 found 84.9% (Guatemala City)

\(^{178}\) GAM 2016

\(^{179}\) GF PUDR 2017
### Assessment of HIV Service Packages for Key Populations

#### Latin America & Caribbean

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Bolivia*</th>
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<th>Haiti</th>
<th>Honduras*</th>
<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru(^{173})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of HIV prevention programs among TG(^{180})</td>
<td>35% (P)(^{181})</td>
<td>82.6% (P)(^{182})</td>
<td>21.0%(^{183}) (S)</td>
<td>55.0%(^{184}) (P)</td>
<td>100.0% (P)(^{185})</td>
<td></td>
<td></td>
<td>15.9%(^{186}) (P)</td>
<td>70.9%(^{187}) (G)</td>
<td>62.1%(^{188}) (P)</td>
<td>14.3%(^{189}) (P)</td>
</tr>
<tr>
<td>Knowledge of HIV status(^{190})</td>
<td>7.7% (P)(^{191})</td>
<td>65.0% (P)(^{192})</td>
<td>40.0%(^{193}) (P)</td>
<td>22.8%(^{194}) (P)</td>
<td>71.5% (P)(^{195})</td>
<td></td>
<td></td>
<td>14.3%(^{196}) (P)</td>
<td>55.0% (P)</td>
<td>6.7% (G)</td>
<td>74.1%(^{197}) (G)</td>
</tr>
</tbody>
</table>

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\(^{180}\) Percentage of TG reached with HIV prevention programs

\(^{181}\) GAM 2016

\(^{182}\) GF PUDR 2017

\(^{183}\) IBBS 2015

\(^{184}\) GF Concept Note 2016

\(^{185}\) GF Concept Note 2016

\(^{186}\) GF Funding Request 2017

\(^{187}\) GAM 2016

\(^{188}\) GF PUDR 2017

\(^{189}\) GF PUDR 2017

\(^{190}\) Percentage of TG that have received an HIV test in the past 12 months and know their results

\(^{191}\) GAM 2016

\(^{192}\) GF PUDR 2017

\(^{193}\) GAM 2017

\(^{194}\) GF Concept Note 2016

\(^{195}\) GF Concept Note 2016

\(^{196}\) GF Funding Request 2017

\(^{197}\) GF PUDR 2017

\(^{198}\) GF PUDR 2017
### Assessment of HIV Service Packages for Key Populations
#### Latin America & Caribbean

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<tr>
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<th>Panama*</th>
<th>Paraguay*</th>
<th>Peru*</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART coverage&lt;sup&gt;199&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>199</sup> ART coverage among SW living with HIV
Assessment of HIV Service Packages for Key Populations
Latin America and Caribbean

**PWID Package Implementation**

Data for PWID are only available in one country from a desk review: Paraguay, and only for two interventions. The percentage of PWID covered by HIV services in Paraguay is reported at 44.7%, and the percentage of PWID who reported safe injection practices is 92.1% (both reported by GAM).

**Prisoner Package Implementation**

Data for prisoners are only available for two of the countries included in this assessment (from the desk review process): El Salvador and Honduras. The percentage of prisoners covered by HIV prevention services in El Salvador is reported at 58.4%, and 21.3% in Honduras. The percentages of prisoners tested for HIV in the past 12 months and who know their results were reported at 20.2% in El Salvador, and 47.0% in Honduras. In Haiti, services for prisoners are delivered in prison by the International Committee of the Red Cross (ICRC) and a local NGO, Health through Walls (HTW), and include testing and treatment for TB according to the 2018 Strategy as well as ART. This assessment could not determine whether HIV prevention commodities are accessible to prisoners.

**Analysis: Are packages being implemented as designed?**

In general, packages appear to be implemented largely as designed, though with a variety of problems in terms of service delivery. It is evident that some interventions in some countries began prior to the introduction of defined packages of services, but the guidance from international organizations, coupled with national design processes, appears to have broadened the types of services available to KP.

While the provision of condoms varies across the region for MSM, FSW and TG women, it is lubricant that is lacking. This aspect of prevention programming should be scaled-up for all three of the KP who are already receiving services throughout the region. Best practices and methodology for virtual outreach to particularly young MSM could be developed, built upon and disseminated throughout the region, using countries that are already succeeding in this method as an example, such as DR.

It should be seen as a success that all countries, with the exception of Haiti, have identified TG as a separate KP from MSM or SW (as they are aggregated with these populations in many countries in other regions). Countries need to continue to provide extremely targeted services to this particularly vulnerable group, which, as previously stated, is subject to increased violence and poor health outcomes throughout the region.

As previously stated in this report, there is a lack of information and data for prisoners and PWID. In terms of prisoners, this population clearly exists in all countries throughout the region, because every country has a prisoner population. If services are in fact being provided to prisoners throughout the region (which is difficult to tell because so few coverage data are available), increased M&E of the services being provided needs to take place. If no services are being provided, prisoners quickly need
to be recognized as a KP for HIV in all countries throughout the region. In terms of PWID, either there is an extremely low rate of injection drug use in the countries throughout the LAC region, or countries are not investigating whether or not this population exists within their countries.

In addition, the specific needs of adolescent KP need to be addressed in most countries. Many MSM and TG report sexual debut below the age of 18 and adolescent SW have been encountered in most countries. But services struggle to provide appropriate services for those under 18 as laws in most countries prevent testing or treatment of adolescents without parental consent.

Coverage for most interventions is variable across the region and there appear to be particular problems in testing sufficient numbers of the right people and, where they test positive, linking them to care. In addition, issues were raised regarding:

- BCC through 15-minute group education sessions (Haiti, DR and Guatemala)
- Numbers of condoms and amounts of lubricants issued
- ART and condom stock-outs
- Service availability interruptions due to late signing of Global Fund grant contracts

**Critical enablers**

Both sex work and sex between men remain illegal in Guyana. Prevention, treatment and care for HIV infection face many legal obstacles in the Dominican Republic; transmission of HIV is criminalized when the partner does not know the HIV-positive status of the individual; and drug use is also criminalized, raising a high barrier for harm reduction approaches and treatment and care for PWID. Additionally, HIV testing in DR is part of regular health checks in the workplace and an HIV test is required for migrants to apply for residence; and, some legal obstacles exist for PLHIV to access some health and social protection services and there is no specific anti-discriminatory legislation protecting vulnerable KP.

There is no legislation protecting KP in Guatemala, and specifically no anti-discriminatory legislation. The influence of conservative political, social and religious figures is high in the country. The current legal framework for FSW in Haiti is that sex work is illegal under certain circumstances relating to age and places of work; however, the framework is vague in that women can be arrested under other laws relating to public morality, the freedom and sexual integrity of others, and exploitation. Some groups, particularly Dominican women, are victims of sex trafficking.

In DR, migrants are heavily discriminated against and homophobia and transphobia are very common – the influence of the conservative social and political sectors and the churches against these populations is strong. Stigma, discrimination and the lack of public policies to address them are the main social and political drivers of HIV in Guatemala; violations of human rights are common, affecting KP and PLHIV in general: the number of formal complaints for HIV-related issues reached 1,345 in 2016. The high levels of violence, poverty, illiteracy, unemployment and social exclusion of indigenous populations also add barriers to accessing HIV prevention and care services.
There is a high prevalence of stigma and discrimination among KP groups in Guyana, particularly among gender non-conforming MSM and TG. Stigma and discrimination against PLHIV are still very present in Haiti, with only 12.0% of women and 23.0% of men reporting that they would be tolerant of PLHIV in certain situations. While homosexuality is not illegal in Haiti, discrimination and hate crimes are prevalent.

In DR, violence of all types – verbal, physical, sexual and psychological – is very frequent against MSM and TG women; in particular, TG women have normalized violence as part of their daily life, with 47 murders in 2017 (about 1.5% of the total estimated TG population). In Guatemala, verbal, physical and sexual violence from the police against TG women is common – submitting a complaint regarding a human rights violation is considered useless due to the perception of the impunity of the police. In Guyana, while sex work is generally socially tolerated, findings from the assessment revealed frequent reports of violence and discrimination experienced by FSW. Similarly, in Peru, violence comes from society, but also from public officers, including healthcare staff and the police. Legal redress is considered useless, as the levels of impunity and judiciary corruption are very high.

All assessed countries have undertaken or are planning to carry out activities to address some of the legal, stigma, violence and other issues described above.

Recently, a new Human Rights plan was adopted in Peru, but no documented information is available on what actions have been undertaken to sensitize law enforcement and healthcare providers on KP issues. In DR, substantial activities on critical enablers are contained in the National Strategic Plan and 1% of the HIV budget is devoted to human rights issues. Healthcare providers in DR are regularly sensitized and trained on KP issues; however, personnel rotation makes it difficult to generate a culture of respect.

In Guyana, leadership from the SASOD has helped build a movement for decriminalizing homosexual behavior by strengthening national connections with the Caribbean Community (CARICOM). Indeed, a shared supreme court among CARICOM nation-states, including a majority of countries with more progressive laws towards homosexuality, is an opportunity for advocates to reform these laws through judicial pathways rather than legislative ones. Activities led by CBOs, such as Fondation SEROvie in Haiti include training workshops for police and judicial officials and public events to promote sexual diversity; MSM organizations try to reach parents and family of young MSM to build safer environment as well.

For all populations, the lack of coverage data for a large number of interventions leaves significant questions about their reach as well as quality of services.
RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS

1. After determining core interventions for each KP in national, defined service packages, ensure that these services are implemented at the scale needed to address the HIV epidemic in each country. Strategies need to be put in place to ensure that core interventions are available to the majority of KP in each country, regardless of funding source or service delivery agent.

2. Introduce and maintain regular feedback sessions with clients, whose concerns should be acted on quickly through the chain of responsibility from SSR through SR to PR and, if needed, CCM or CCM Oversight Committee. This procedure should be connected to a continuous quality improvement program.

3. The distribution of condoms and lubricants only or mostly through group peer education or information sessions – such as the séances in Haiti – needs to be carefully evaluated. While these sessions may provide opportunities for building awareness and empowerment among KP, strategies for broader distribution are necessary for ensuring sufficient supplies of prevention commodities to KP.

4. The frequent mention of ART stock-outs in several countries suggests a strong need to address procurement and supply management issues in the region. This is not specific to key populations, but is critical to ensuring the health of KP living with HIV.

5. The focus of IEC and BCC materials and peer discussions on HIV testing and on prevention often results in less focus on living well with HIV, and this gap in IEC/BCC can lead to a lack of understanding among KP of the benefits of knowledge of HIV status and of clinical care and treatment if living with HIV. There is a need to create space in prevention-focused MSM organizations for a culture that supports PLHIV on living well, and that educates staff, volunteers, and community members about HIV as a manageable long-term chronic condition. This involves treatment literacy workshops and IEC and BCC materials on living with HIV.

6. An ongoing collaborative process should be used at the local level to determine whether SW, MSM or TG organizations – either separately or, preferably, together - will ensure that the needs of male and transgender SW are met.

7. Differentiated service delivery should be further developed to assist in expanding the reach of key interventions among KP. These include self-testing, lay provider testing, community-based testing, assisted partner notification, community-based initiation and distribution of ART.

8. Outreach and support service models need to be reviewed to ensure that there are sufficient resources to ensure linkage to treatment for newly diagnosed PLHIV, and case-management models in place to cover at least the first three months following diagnosis.

9. UN agencies in collaboration with regional KP organizations should work to develop a set of regional guidelines for e-outreach, covering safety and security for e-outreach workers, ethics, privacy and effective messaging.

10. Community HIV testing and self-testing models in the region need to be assessed and guidance for expanding access and improved quality developed.

11. Strategies to engage countries in transition planning for the outreach (demand-creation) workforce for KP need to be strengthened.
12. Key population NGOs need to be assisted to secure resources to pursue broad health goals for their constituents, including reduction of stigma and discrimination, responses to KP-related violence, GBV and other issues that increase service access obstacles for people from KP.

13. Critical enabler activities have low levels of coverage in the assessed countries, and the range of activities implemented is generally much smaller than needed. As Honduras and Jamaica work with Global Fund funds to reduce human rights barriers for KP, other countries in the region should study the activities implemented in these countries and their results for possible replication. Policy and legal interventions may be specifically needed to address the needs of adolescent KP and breaches of confidentiality.

14. The safety of outreach workers, particularly among MSM, needs to be addressed through the use of written security protocols that are the subject of training and supervision for outreach staff.
PART IV: MONITORING SYSTEMS

KEY POINTS

- Lack of up-to-date coverage data for many elements of the packages
- Little evidence of countries measuring coverage of defined package of services
- UIC under-utilized and problems with formulation
- Difficulties in linking UIC databases (where they exist) with clinical records of those from KP who test positive for HIV

The process of monitoring the implementation of packages of services against their design is multifaceted. There are significant problems related to PSE for some KP in some countries. As part of this assessment process, there was a requirement to rate the systems used to monitor KP service packages. The results of this process (Table 13) show that most countries have UIC systems, though none has the same coding system used for all KP across the country.

Table 13. UIC System Scores by Country in Latin America and the Caribbean

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominican Republic</td>
<td>2</td>
<td>A new integrated registration system (UIC) has been launched for new users that will be, in principle, shared by all stakeholders.</td>
</tr>
<tr>
<td>Guatemala</td>
<td>2</td>
<td>Two programs use their own registration system and do not merge data. National UIC is planned.</td>
</tr>
<tr>
<td>Guyana</td>
<td>2</td>
<td>UIC is universally implemented to monitor the uptake of prevention and HIV testing services among community organizations, but 2 different codes are used.</td>
</tr>
<tr>
<td>Haiti</td>
<td>2</td>
<td>A standardized UIC is used by most agencies delivering HIV prevention and testing services. It was not determined that this UIC was applied across all countrywide prevention programming.</td>
</tr>
<tr>
<td>Peru</td>
<td>2</td>
<td>Each stakeholder uses their own registration system, and registered entries, which in some cases are still done manually, are not verified for duplication.</td>
</tr>
</tbody>
</table>

*For countries that only received a desk review, there was not enough information available to adequately and reliably assess the existence and use of a UIC. Therefore, details are not included here.*
The above table refers to the use of UIC to track KP through prevention services. The UIC can either be alpha-numerical, numerical or biometric. To provide treatment and care cascades by KP, it is necessary to draw data from both prevention and testing databases (via UIC) and from ART databases. In Haiti, PEPFAR is working towards this; El Salvador is also working on this issue, but APMG was not asked to visit this country.

Systems for monitoring KP service usage and coverage with service packages vary widely across the assessed countries. In the Dominican Republic to date, each stakeholder has used their own user registration system for recording services. A new integrated registration system (UIC) has been launched that will be, in principle, shared by all stakeholders. This registration system is based on the national ID number as a UIC. The use of a national ID is problematic because not all residents in the Dominican Republic have or use one. This problem affects mostly Haitian migrants, who may not have a national ID, and TG women, who may refuse to share their legal identity. The new mechanism is nevertheless considered a progression from the current fragmented information system. This mechanism will however only provide KP-specific data from newly registered individuals.

The country is lacking a full analysis of the KP distribution and characteristics of the population of PLHIV linked to the health system: profiling started several months ago and has reached 40.0%, but progress is slow, and its completion is not expected before the end of 2019. A lack of understanding of the distribution of KP among PLHIV who have already been tested and those who are already linked to the national health system presents difficulties in providing targeted outreach interventions. The country also lacks data on how many individuals from each KP group are HIV-positive but do not know their status and have to be tested and linked.

Similar issues occur in Guatemala, where it is unknown how many PLHIV are from each KP and how many of those individuals are on ART. The country has two main programs using the same mechanisms to address HIV prevention, testing and linkage. There is a high risk of overlap. Each program uses their own registration system and does not merge data, despite the fact that they collect the same basic information. This information includes name, DPI (Personal Identification Document), KP association, historical HIV test record and HIV test results. Even when beneficiaries use exactly the same identifying information, the entries are not integrated in a single database.

These issues may be partially solved if the plan to integrate all monitoring systems, by using a UIC shared by all stakeholders, is successfully implemented. This action is included in the new proposal for a Global Fund Grant for 2019-2020. The proposed new monitoring system is expected to provide figures for indicators on condom and lubricant use, HIV testing, STI screening and treatment, and ART. The rest of the WHO-related indicators in the data tables above are not explicitly mentioned, although it can be assumed that some, such as linkage and retention to care or hepatitis screening, which are part of the new proposal for Global Fund, may not be difficult to obtain in the new system.

In Guyana, a UIC is universally implemented to monitor the uptake of prevention and HIV testing services among community organizations. One element of the UIC is gender – ‘M’ for male and ‘F’ for female. The current UIC thus forces TG to nominate themselves in the code as ‘M’ or ‘F’. They reported
finding this disturbing, and it would seem sensitive and sensible to allow TG to code a “T” for gender. This would allow for the tracking of service use by TG. Another UIC, similar in its design to the one used by CBOs to monitor service uptake, is used to track initiation and retention in HIV care services. However, to-date there have been no efforts to harmonize these UIC to monitor and evaluate the uptake of services along the continuum of HIV prevention and care.

There are three main systems for monitoring HIV services in Haiti:

- MESI: monthly data reporting computerized platform used by all service delivery points
- I-Santé: computerized medical records posted on an internet-accessible primary data platform
- Programmatic monitoring by USAID/PEPFAR-LINKAGES and GF-supported CBOs

Multiple methods of M&E and platforms are used by agencies engaged in the KP response in Haiti, with activities supported by multiple funding partners that have resulted in substantial challenges for country-level M&E coordination.

A standardized UIC is used by most implementing agencies delivering HIV prevention and testing services but is not used to track individuals from KP through the clinical cascade. The same UIC was observed at the sites visited in this assessment, however it was not determined that this UIC was applied across all countrywide prevention programming. A new UIC is given to patients when they present to clinic services for HIV treatment. However, by following clients through peer navigators, the LINKAGES report has been able to generate data on uptake and retention in ART services. The COP 2016 plan states that the PEPFAR team is moving forward with the implementation of a unique identifier using biometric code.

In Peru, the level of coordination among stakeholders is low. The CCM deals with Global Fund grant oversight. Important stakeholders, such as AIDS Healthcare Foundation (AHF) or Vía Libre do not participate in the CCM, and there is no other coordination space. The country lacks a nation-wide integrated information system for HIV, but that is said to be under construction. Each stakeholder uses their own registration system, and registered entries, which in some cases are still done manually, are not verified for duplication. Data collected includes usually – even in Government-owned CERITS and UAMPS systems – name, ID, declared KP, frequency of HIV test and its results. Female sex workers specifically must also have STI screening (syphilis, chlamydia and gonorrhea) as a requirement to keep a specific card that allows them to do sex work.

**ANALYSIS: DO WE REALLY HAVE ENOUGH INFORMATION TO DETERMINE HOW WELL PACKAGES ARE IMPLEMENTED?**

There continues to be some misunderstanding of the role of a UIC in most of the countries assessed. These codes were developed to allow for anonymous access to HIV prevention and testing services (at least) by KP members who, due to criminalized behavior or fears of stigma, did not want to provide full identifying information (date of birth, name, address etc.). When a UIC comprises the national ID
number as well as other details, there can be many difficulties in implementing it. The DR’s plan to use its new UIC only for newly-enrolled KP clients is difficult to understand.

As in all other regions, there are difficulties in linking UIC databases (where they exist) with clinical records of those from KP who test positive for HIV. The work by LINKAGES in Haiti to follow individuals from KP into the health system using peer navigators may be a useful method of linking prevention and treatment data.

The confusion about whether SW, MSM/TG, MSM or TG agencies should be collecting data about male and/or transgender SW is understandable. However, the data observed in other regions suggest that behavior, risks and HIV prevalence among men, women and TG who sell sex can be very different, so a decision needs to be taken about which agency will work with each population, and SW PSE, prevalence and coverage statistics need to be derived for male, female and TG SW.

There has historically been a lack of focus on PWID in the LAC region, partly driven by a belief that no or very few PWID exist there. Given that the number of PWID in all countries of the region is likely to be much smaller than MSM and SW, it is sensible to start by ensuring that data for MSM and SW are accurate. After this has been achieved or where funding is available, PWID studies should follow. An easy way to determine whether drug injecting is present in a country is to ask MSM and SW if they or their friends ever inject drugs. This can provide preparatory data for PWID rapid assessments. The biggest deficit in data on KP is among prisoners. Globally, little is known about HIV in prisons or the coverage of HIV programs in prisons. More work needs to be done to learn about the situation for prisoners in the region.

The use of hand-written client monitoring forms is problematic. All countries should move towards electronic data capture where resources permit.

**RECOMMENDATIONS: MONITORING OF SERVICE PACKAGES FOR KEY POPULATIONS**

1. For accurate coverage calculations, countries need to follow established guidelines to develop PSE together with national consensus processes involving substantial representation from the KP concerned. From these processes, more accurate, agreed upon PSE should be derived.
2. Mapping of KP, including the involvement of community networks in mapping, should be carried out nationally where possible to aid in verifying each PSE and to aid in planning, implementation and measurement of coverage of KP programs.
3. All countries should continue to progress toward a single UIC for all KP and a single database, preferably accessible online, for both uploading data and generating reports. The system of collecting client names and addresses (especially in paper registers, but also electronically) should cease.
4. Tracking of service use and health outcomes for KP need to be integrated into national e-health and unique patient record initiatives, where this can be done without compromising safety of KP.
5. There may need to be specific monitoring arrangements established to follow the collaborative process at the local level to determine whether SW, MSM or TG organizations – either separately or, preferably, together - ensure that the needs of male and/or transgender SW are met.
6. It may be necessary to establish a more effective way of capturing community empowerment and psychosocial support in routine reporting tools.

7. After determining what interventions should be considered ‘core’ in the service package design, countries should establish routine surveillance to ensure that all coverage of all core interventions can be regularly measured.

8. Feedback loops should be extended throughout the reporting system so that problems regarding quality are quickly reported to the level at which action can be taken to remedy the situation.

9. Providing SR with access to a cloud-based system for data reporting should be examined for possible use by all PR.

10. Mechanisms or systems should be developed so that data collected by donor-funded programs, including by SR and PR of Global Fund and USG-funded interventions, are fed into national-level information systems.

11. Monitoring systems should strive to link data on prevention activities to treatment and care; treatment cascade reports should be generated on a regular basis.

12. Monitoring and evaluation related to human rights barriers should be a priority for learning and generating best practices for improving the enabling environment for KP. As much as possible, this documentation should be specific to each KP.

13. It is important to stress that none of these data are useful unless they are used for decision-making at both the policy and the implementation level. Capacity building may be needed in order to help staff see the value in not merely collecting, but also routinely analyzing service data and using this information as the basis for suggesting changes to services.
As noted by UNAIDS (2017), most of the domestic HIV funding in the Latin American region is allocated for treatment and care. By contrast, many prevention programs that focus on KP in the region rely substantially on donor funding. As donor funding in the region continues to decline, increased domestic funding will be sorely needed to sustain prevention programs in donor-dependent countries. Similarly, for the Caribbean, the report states that donor dependency is high for prevention with proven impact, in particular for the prevention services focused on KP.

In Guyana, no funding is available from domestic sources for any prevention activities, including with KP; the majority of all funding for work with KP is from Global Fund and PEPFAR (Via Libre, 2017). In Guatemala, expenditure on prevention among key populations represents 10.13% of the total expenditure on HIV, of which around 98.0% is provided by international donors.

In DR, local stakeholders agree that the government is committed to politically and financially support ART but has little interest in prevention. Of note, only 5.0% of the HIV budget is invested in prevention, and that includes blood safety and PMTCT. The overall National Strategy for 2015-2018 is costed, but not delineated by the percentage of the domestic investment vis-à-vis the international aid effort. There are no budget lines specific for KP in the National Strategic Plan. The national HIV strategy for Peru is costed in its National Multisectoral Plan 2015-2019 and includes contributions from the Peruvian government and the international donors, mainly Global Fund. However, there is no information regarding costing of services specifically for KP, either collectively or individually.

Global Fund currently has two active grants in Haiti totaling US$80,235,992 in 2017. For KP-related activities, several funding models are implemented that include direct funding through Global Fund, LINKAGES and hybrid funding models with sites that include GHESKIO, a central hospital in Port-au-Prince, Partners in Health, and smaller faith-based charities. Multiple donors and complex funding structures generated challenges for this assessment in determining which funding body and funded agency, was responsible and accountable for delivering which package element.

**Analysis: Are countries prepared to adequately finance packages of services for key populations?**

In the context of transition from Global Fund and/or PEPFAR support in coming years, much greater efforts are required to ascertain how much funding is provided for HIV prevention, testing, treatment, etc.
and care among KP. Reducing dependence on external funding across the region will require new resource mobilization approaches, improvements in allocating and tracking HIV resources, and increases in efficiencies and cost savings. Social contracting – in which government funds are allocated to civil society organizations for service delivery – is being actively explored in Guyana, Panama, Honduras and Jamaica. The expertise of the Mexican social contracting system is being publicized by the GF for other Spanish- and English-speaking countries in the LAC region.
PART VI: LIMITATIONS

There were several limitations in conducting this assessment process, including during the initial desk review portion of country assessments. It is important to note that six of the 11 countries within the LAC region were limited to ‘desk review only,’ meaning that APMG Health did not conduct an in-country assessment to collect data and information that could disprove or verify information found in the initial desk review. Desk review data from these six countries have been included throughout this review.

The desk review process was limited by contractual time allowed (an average of two consultant days was allotted to each review) and by the scope of the review: sources reviewed were limited to those provided by Global Fund Country Teams in the last quarter of 2017.

The list of documents used for conducting these assessments has been considerably expanded for those countries selected for an in-country assessment. To the degree possible, data were expanded upon and verified by follow-up country visits; however, this process was also subject to time restrictions. As such, only two sites and two populations were selected for focus in each country. It is important to note that because of this, country assessments may not have been representative of the national situation and reports only speak to the data available in the regions, districts and cities that were visited or within other reports reviewed. This has therefore limited the amount of data and information about the other KP that were not selected for the in-country data collection. Within the regional report for LAC, this presents a particular limitation for the PWID population.

In-country assessments were conducted by only one international and one local consultant, which limited the amount of site visits, key informant interviews and FGD consultants were able to conduct while in country.

During the in-country data collection, FGD participants were identified by programs that were being visited. Therefore, respondents may not have been representatives of KP more broadly. Focus group discussion participants could have experienced peer pressure or pressure from program staff to give biased answers to the moderator’s questions. Focus group discussions also seemed to be made up of program participants who sought services fairly regularly or were even peer educators themselves. Therefore, the viewpoints of those from KP who do not receive services, or face more barriers in receiving services, may not be represented. Focus group discussions were often conducted in local languages, and therefore, at times were translated for the international consultant. One limitation of this is that only some of the information that participants gave was actually recorded and presented in the country report.
REFERENCES

DOCUMENTS


Assessment of HIV Service Packages for Key Populations
Latin America and Caribbean


IBBS AND KP STUDIES


Assessment of HIV Service Packages for Key Populations
Latin America and Caribbean


UNAIDS. (2015). *Developing subnational estimates of HIV prevalence and the number of people living with HIV from survey data, Haiti.*


WHO Regional Office for the Americas. (2016). *For the Health of Trans People: Elements for the development of comprehensive care for trans people and their communities in Latin America and the Caribbean.*
APPENDICES

APPENDIX 1: SUMMARY TABLE, WHO CONSOLIDATED GUIDELINES

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   HIV prevention (condoms, lubricant, PrEP, PEP, VMMC)</td>
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<tr>
<td>2   Harm reduction interventions for substance use, in particular NSP, OST and naloxone for</td>
</tr>
<tr>
<td>overdose management</td>
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<tr>
<td>3   HIV testing and counselling</td>
</tr>
<tr>
<td>4   HIV treatment and care</td>
</tr>
<tr>
<td>5   Prevention and management of co-infections and other co-morbidities, including viral</td>
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<tr>
<td>hepatitis, TB and mental health conditions</td>
</tr>
<tr>
<td>6   Sexual and reproductive health interventions</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical enablers</th>
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</thead>
<tbody>
<tr>
<td>1   Supportive legislation, policy and financial commitment, including decriminalization of</td>
</tr>
<tr>
<td>behaviors of key populations</td>
</tr>
<tr>
<td>2   Addressing stigma and discrimination</td>
</tr>
<tr>
<td>3   Accessible, available and acceptable health services</td>
</tr>
<tr>
<td>4   Community empowerment</td>
</tr>
<tr>
<td>5   Addressing violence against people from key populations</td>
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