This year's COP has been particularly interesting, as theoretically, the guidance includes some good and strong languages that could really benefit the community and key population.

However, we also know that programmes for PWID have not been the strongest component of PEPFAR Funding. Yet, they are the second largest donor for harm reduction, after the Global Fund. And not just for harm reduction, funding for prevention in general has been stagnant. Despite the global efforts to remobilize and renew political commitment through the Global Prevention Coalition, particularly in meeting the 25% for prevention target (in the previous political declaration). In the last 5 years, we have only seen less than 16% allocated annually for prevention, and only 1% of that allocation was for PWID programming. Of this 1%, only about 40% was led by local organisations. And there is very little information to understand how many of these local organisations were community or key population-led.

Data on allocation for HIV prevention, PWID and implemented by local organisations by PEPFAR Funding in 2016-2020:

	HIV Prevention	HIV Prevention for PWID	HIV Prevention for PWID implemented by local organisations
2020	617.957.595	7.241.810	2.939.830
	14.61%	1,17%	40,60%
2019	562.557.077	7.594.948	2.521.604
	13.85%	1,35%	33,20%
2018	626.224.514	4.638.910	2.290.068
	16.04%	0,74%	49,37%
2017	492.166.825	13.088.499	4.536.052
	13.50%	2,66%	34,66%
2016	459.829.573	13.957.972	5.394.581
	13.00%	3,04%	38,65%

Source: http://copsdata.amfar.org

COP22

We know that harm reduction has not been PEPFAR's favourite. COP22 only specifies OAT (was previously MAT) instead of harm reduction services. And we know that harm reduction services should include a wide-range of services and that they also need to suit to the needs of PWID, including needles and syringes, condoms, overdose prevention, take away dose, community-led drop-in centers, and viral hepatitis services.

In previous COPs, section on key population had always fallen under prevention, thus limiting the range of interventions to mainly biomedical. This year, we have a separate section on key population, allowing more rooms and opportunities for important areas such as structural interventions and social protection. And despite the strong recognition on the important roles of key population, it isn't clear on how PEPFAR is going to put this commitment into practice, especially when they put more focus on building key population-

competent organisations, instead of focusing on investment for key population-led organisations (see the part about key population-competent organisations).

CLM has been a major focus in any programming, including this year's COP. This is an opportunity for the community, particularly in the absence of data availability of key population. However, CLM requires a lot of skills and capacity to implement. PEPFAR needs to also allocate technical assistance and capacity building within the CLM framework. And when data is produced by the community, it is important to ensure the data is recognised, especially by the government, and if it isn't, we need to make sure PEPFAR uses their diplomatic power to really put the community and key population in the center.

COP22 emphasises on the need to address structural barriers, including policy reform. Unlike other earmarked budget, like OVC, there is no minimum funding allocation required for structural interventions. Without us watching, structural interventions can be easily dropped from the budget, considering the biomedical focus of PEPFAR to achieve the treatment targets and to reach epidemic control.

COP22 also includes explicit languages on meaningful involvement of key population throughout the process. However, knowing how PEPFAR works all these years, we know that if we don't demand and fight for it, things will not get done.

ADVOCACY ENTRY POINTS

- Advocate for comprehensive harm reduction services, instead of only OAT. This should align with the WHO Consolidated Guidelines that COP22 keeps on referring to, and those services need to suit the community's preference – this would also involve advocating PEPFAR and health providers to shift away from "abstinence as the only indicator of progress." **<<see page 434-436**
- Advocate for transparent and inclusive processes. We know that if we don't ask for it, we will not be invited. Especially the community of people who use drugs where the lack of quality data continues to leave us further behind. We also need to make sure that PEPFAR country team provides the funding opportunity for competent key population-led organisations, not only key population-competent organisations. Or we can demand the country office to develop a clear timeline and milestones in building the capacity of KP-led organisations to become competent and to receive funding from PEPFAR. **<<see page 428-430, 460-464**
- With the completion of KPIF last year, we need to continue advocating for a dedicated funding stream for key population (globally and nationally).
- Advocate for a minimum funding allocation for structural interventions, and link them with the 10-10-10 targets, particularly on decrim of possession of drugs. **<<see page 454-460**
- We can also make use of the small grant mechanism and to ensure the country team to allocate this in their budget and dedicate this to fund key population-led organisation in addressing structural barriers. **<<see page 759**
- We need to ensure that PEPFAR, along with their implementing partners, use the tools that Global KP Networks have developed (IDUIT, MSMSIT, SWIT and TRANSIT) for planning and designing the programmes. **<<see page 454-455**

- Advocate the possibility of using the discretionary budget to cover for HCV services, and to advocate HCV as an integral part of services and programmes for PWID (instead of only certain countries to be eligible to include HCV intervention in their programme) **<< see page 87**
- Ensure that CLM is initiated, led, and implemented by community-led and/or key population-led organisations or networks. Advocate for a central coordinated structure funding for CLM – in many countries, a consortium of key population networks has worked well. **<<see page 140-146, 465-470**