GLOBAL BLACK GAY MEN CONNECT

THE DISAPPEARANCE OF KEY POPULATIONS

How PEPFAR's Data Rollback Is Undermining HIV Epidemic Control

KEY FINDING: PEPFAR has removed key population indicators from country-level MER reporting, making it impossible to assess whether the populations driving 55% of new global HIV infections are being reached. Prevention services in concentrated epidemic countries — the best remaining proxy for KP programming — have fallen 40–83%.

Making Rights a Reality: GBGMC's 2025 Roadmap

Global Black Gay Men Connect's mission is to secure health and human rights of Black Gay Men and other Key Populations around the world. We work across areas that are often siloed — and this report brings them into sharp focus. PEPFAR's effectiveness has always come down to a simple principle: know where the epidemic is, and go there. That has meant focusing on the populations most affected — gay men and other men who have sex with men, sex workers, transgender people, and people who use drugs — who drive a disproportionate share of new infections. Reaching them requires targeted, community-led approaches grounded in real conditions: lack of access, stigma, and criminalization. That foundation is now being dismantled. Key population indicators — KP_PREV, AGYW_PREV, KP_MAT — have been stripped from country-level MER reporting. Even the aggregate data that remains tells a troubling story. This report documents the damage, names the causes, and charts the Roadmap to Rights.

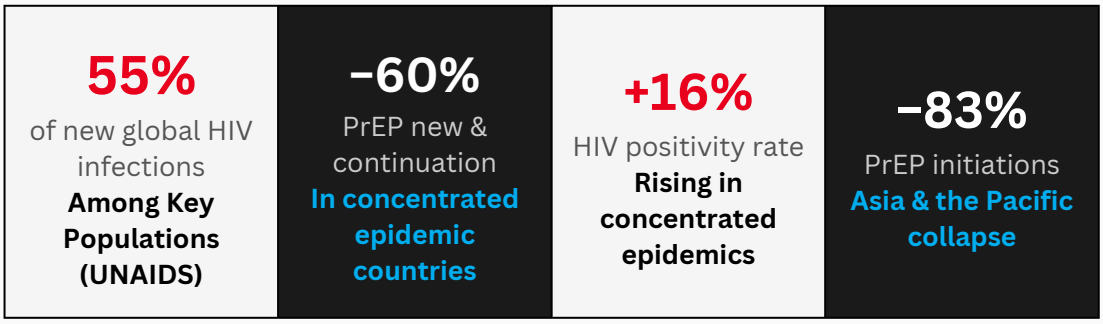

Figure 1. Selected indicator changes, FY24 Q4 → FY25 Q4 | Source: PEPFAR MER Data

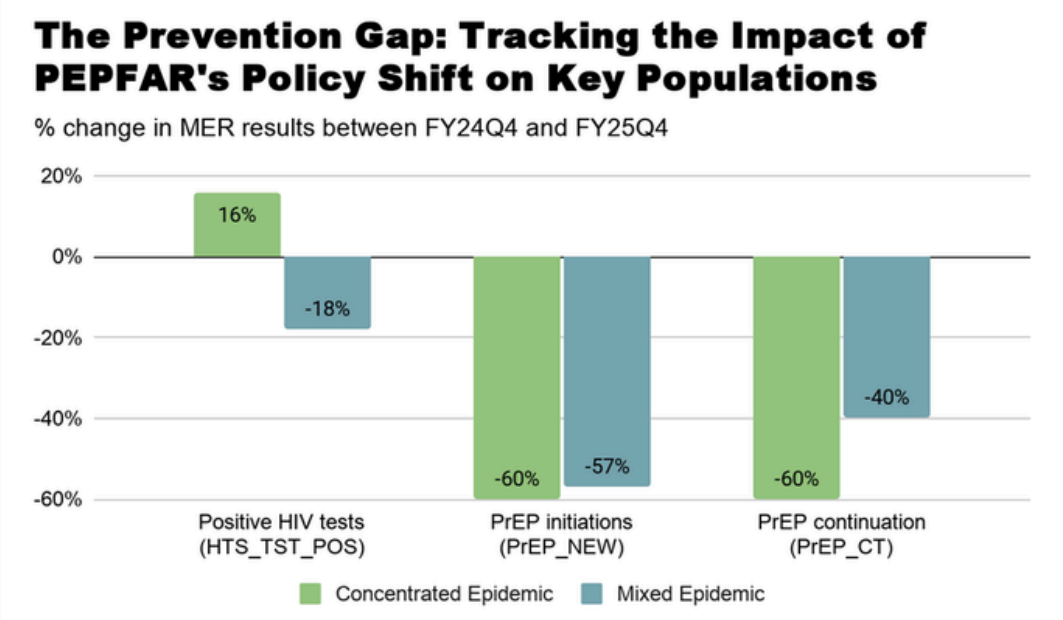

Figure 2. The Prevention Gap: % change in MER results, FY24 Q4 to FY25 Q4 by epidemic type

REALITY CHECK #1
No sustainability without survival. HIV is still an emergency for African gay men, MSM, and all other key populations.

The Removal of Key Population Data

For two decades, PEPFAR's data systems made the epidemic visible. Disaggregated indicators showed whether programs were reaching those most at risk — and forced course correction when they weren't. That visibility is now being removed. Key population indicators have been stripped from MER reporting at the country level. KP_PREV, AGYW_PREV, KP_MAT — gone. What remains — age and sex — is not enough to understand who is being reached or missed. The result is that there is no longer a way to measure whether programs are reaching the populations most affected.

Indicators Removed from Country-Level MER Reporting

- KP_PREV — Prevention coverage among key populations
- AGYW_PREV — Coverage of programs for adolescent girls and young women
- KP_MAT — Medication-assisted treatment for people who use drugs
- All population disaggregation by risk group or behavioral category

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What the Data Show — and What They Do Not

Even within the limits of the data, the direction is clear. Core HIV indicators are declining: testing is down, new diagnoses are down, treatment initiation has slowed, and PrEP uptake has dropped. These trends point to disruptions across the response. Less testing means fewer people identified. Slower treatment initiation reflects gaps in linkage to care. Declining PrEP uptake signals reduced reach in prevention.

What the data do not show is who is driving these trends. There is no disaggregation by population or risk. It is not possible to tell whether these declines are widespread or concentrated among those most at risk. The picture is incomplete. The data show change, but not where it is happening or who is being left behind

The Epidemiological Context

According to UNAIDS, key populations and their sexual partners now account for 55% of new global HIV infections — up from 44% in 2010. In regions with concentrated epidemics — Asia and the Pacific, Eastern Europe and Central Asia, Latin America and the Caribbean, and West Africa — this figure rises to 80%.

> ***"What is there to sustain? There isn't a system to sustain. We don't have data on trans people."***
> — Participant, EpiC and GBGMC-led Key Populations consultation on sustainability

Prevention: The Evidence

PrEP_NEW and PrEP_CT fell by 41% and 57%, respectively, overall. In countries with concentrated epidemics, both indicators declined by 60%, pointing to significant reductions in prevention coverage among key populations. Long-acting PrEP has not been introduced at scale in these settings, and longer-duration modalities do not account for these changes.

These declines come as global PrEP targets remain unmet by significant margins. Regions with concentrated epidemics — Asia and the Pacific, Eastern Europe and Central Asia, Latin America and the Caribbean, and West Africa — are the furthest from reaching 2025 targets.

The Testing Paradox

One of the most striking signals is the divergence in testing trends. In countries with mixed epidemics, HIV testing positivity (HTS_TST_POS) declined by 18% — consistent with a narrative of progress. In countries with concentrated epidemics, HTS_TST_POS increased by 16%.

More cases are being found in key population settings, yet the infrastructure to provide the next steps of care is being dismantled. Despite higher positivity rates, treatment initiation (TX_NEW) also decreased — pointing to a breakdown in the linkage to care. With KP-led and community organisations being shut down, clients are being pushed to public facilities where stigma is a well-documented barrier.

REALITY CHECK #2
Key populations are helping HIV prevention product developers more than they're helping us.

Regional Disparities

The following analysis compares FY24 Q4 and FY25 Q4 MER data across the HIV prevention and care cascade by region. The pattern is consistent: prevention has collapsed, testing efficiency is declining, and treatment initiation is falling even as the need grows

Region	PrEP Δ	HTS+ Δ	TX_NEW Δ	Key Concern
Asia & the Pacific	**–83%**	**–60%**	**–**	*Near-total prevention collapse; Philippines severely affected*
Eastern Europe & Central Asia	**~0%**	**–12%**	**–17%**	*Only PEPFAR region with growing HIV epidemic; gains*
Eastern & Southern Africa	**–55%**	**–18%**	**–24%**	*Zambia reversed 95-95-95 gains; TX_CURR held but precarious*
Latin America & Caribbean	**↓**	**–26%**	**↓**	*KP-concentrated; alarming TX_CURR and prevention drops*
Western & Central Africa	**>–75%**	**35%**	**↓**	*Rising positivity + collapsed prevention = critical risk*

Table 1. Regional indicator changes, FY24 Q4 → FY25 Q4 | Source: PEPFAR MER Data

Asia & the Pacific

Asia and the Pacific present the most acute prevention collapse in the available data. PrEP initiations and continuation have fallen by approximately 83%. Testing efficiency has dropped sharply — HTS_TST_POS fell from 5.5% to 2.2%. The Philippines, experiencing one of the fastest-growing HIV epidemics globally, saw declines of 69% in PrEP_NEW and 85% in PrEP_CT alongside significant testing reductions.

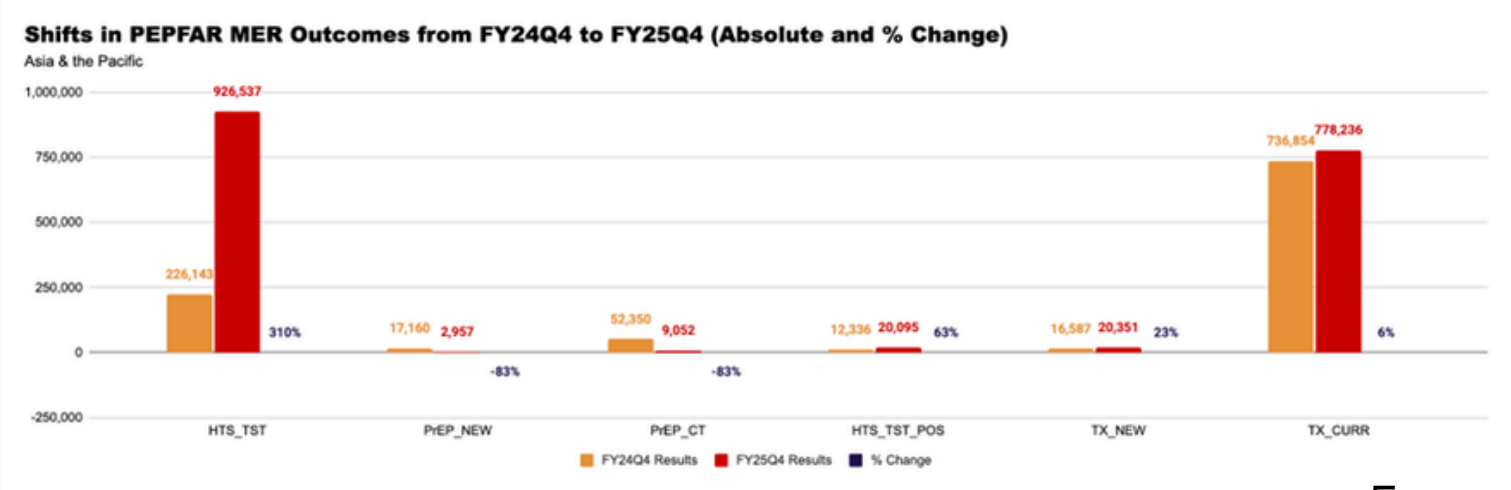

Figure 3. Asia & the Pacific — PEPFAR MER Outcomes FY24Q4 to FY25Q4

Eastern Europe & Central Asia

Eastern Europe and Central Asia are the only PEPFAR regions with a documented increase in HIV incidence — driven primarily by transmission among key populations. PrEP numbers have remained broadly stable, which is encouraging. However, declining testing efficiency and HTS_TST_POS in a region with growing transmission is a sentinel warning of under-reach.

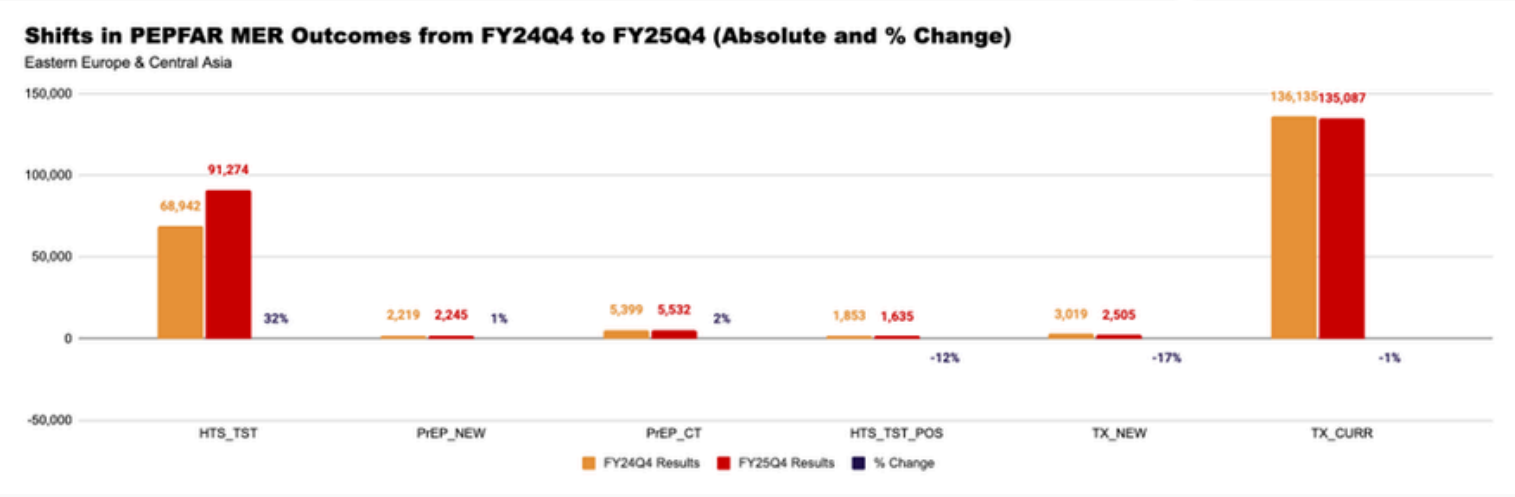

Figure 4. Eastern Europe & Central Asia — PEPFAR MER Outcomes FY24Q4 to FY25Q4

Eastern & Southern Africa

Eastern and Southern Africa carry the largest HIV burden. TX_CURR has held broadly steady, but declines across all other cascade indicators signal that stability is fragile. Zambia — which by the end of 2024 had surpassed UNAIDS 95-95-95 targets at 98-98-97 — has seen PrEP initiations fall 55%, PrEP continuation fall 67%, and treatment initiation fall 24%. Years of hard-won progress are being reversed.

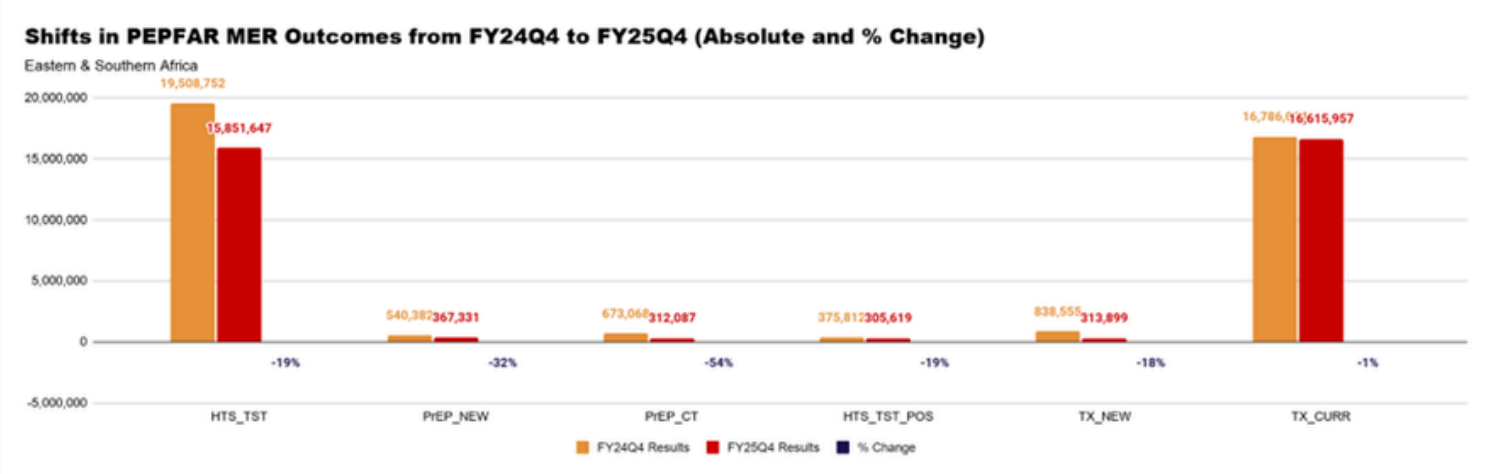

Figure 5. Eastern & Southern Africa — PEPFAR MER Outcomes FY24Q4 to FY25Q4

Latin America & the Caribbean

Latin America and the Caribbean have an epidemic concentrated among key populations. While aggregate testing increased slightly, efficiency fell. Drops in TX_CURR alongside declining PrEP coverage place epidemic control gains directly at risk.

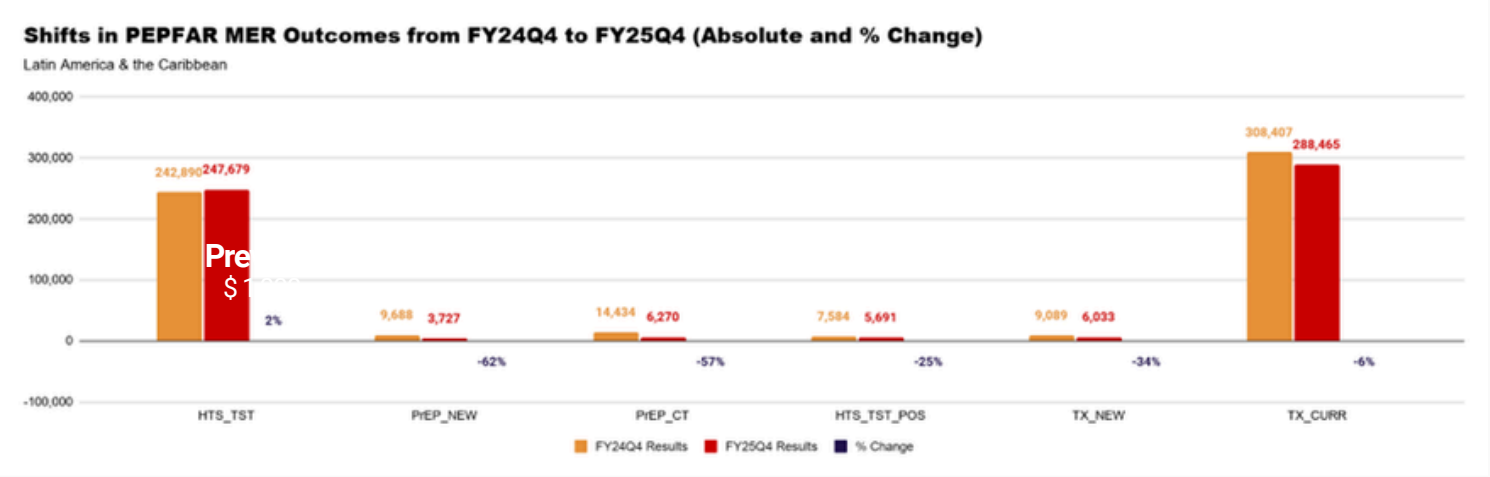

Figure 6. Latin America & the Caribbean — PEPFAR MER Outcomes FY24Q4 to FY25Q4

Western & Central Africa

Western and Central Africa shows a critical divergence: testing positivity has increased — suggesting active, undetected transmission — while prevention coverage has collapsed by more than 75%. This combination represents one of the highest-risk configurations: rising community viral load in an environment of reduced prevention infrastructure.

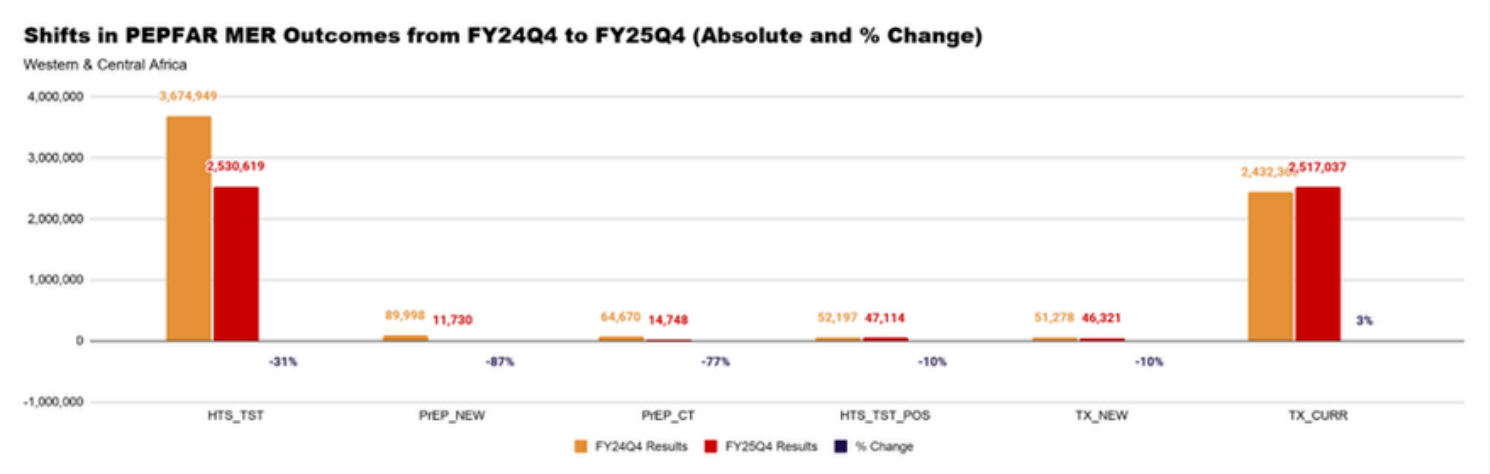

Figure 7. Western & Central Africa — PEPFAR MER Outcomes FY24Q4 to FY25Q4

REALITY CHECK #3

No Rights for Key Populations, No Health Security for Anyone.

What Is Being Counted — and What Is Not

PEPFAR's current reporting framework appears to prioritize TX_CURR. But TX_CURR has important limitations as a standalone indicator. Much of it reflects government and partner data that would be reported regardless of PEPFAR's direct contribution. It captures who is currently on treatment — not the quality of that treatment or the systems that sustain it.

What TX_CURR does not capture are the program elements most affected by recent disruptions: community-based medication dispensing, linkage-to-care navigation, differentiated service delivery, retention support, viral load monitoring, and viral suppression verification. These have been central to achieving treatment outcomes. Their loss will not be immediately visible in TX_CURR — but it will be visible in future outcomes.

What TX_CURR Does Not Measure

- Community-based medication dispensing and differentiated service delivery
- Linkage-to-care support and warm referral services
- Peer navigation and retention programs for key populations
- Viral load monitoring and viral suppression verification
- The organizational infrastructure that makes treatment continuity possible

Implications for Health Security

Epidemic control requires balance. Treatment gains cannot be sustained without prevention. Prevention is not limited to product availability — it depends on systems that ensure equitable access to a range of options for populations at highest risk. Anti-LGBTQI+ campaigns are closely tied to anti-vaccination and anti-equity misinformation. Safeguarding human rights for Key Populations is crucial for global health security.

Communities and countries that include, accept, and support the rights of Key Populations often follow and trust evidence. They find ways to be cohesive — even across differences. These are crucial strengths for responses to any crisis: health, climate, or conflict-related. When there are no rights, there is no health security for anyone.

REALITY CHECK #1 — SUSTAINABILITY

Roadmap to Rights

1. **Quantify, clarify, and resource Key Population engagement.**
   Ensure adequate, meaningful representation of individuals with a diversity of lived experiences on all relevant technical working groups and advisory bodies. A single KP representative is never enough. Fund participation in sustainability work as though the future depends on it — because it does.

2. **Define specific sustainability criteria for Key Populations.**
   Every sustainability roadmap must include: treatment and prevention cascades for different KP groups; a legal and policy analysis of structural sustainability readiness; and an audit of KP-led services addressing how each component will be sustained and strengthened.

3. **Prioritize decriminalization as a core component of pandemic preparedness.**
   UNAIDS and PEPFAR should establish an independent, cross-disciplinary working group that includes Key Populations to define decriminalization as a health security priority — not a peripheral concern.

REALITY CHECK #2 — PREVENTION ACCESS

Roadmap to Rights

1. **Fund movement-building, not committee membership.**
   Before any meeting, KP representatives should be asked whether they have funding to safely gather information from their communities. If they do not, resources should be made available. If no resources exist, this limitation must be transparently disclosed wherever the group's work appears.

2. **Resource and recognize human rights as central to biomedical HIV prevention.**
   Discuss safety and security concerns in every collaboration with a KP group. Assess how different prevention tools address peoples' safety needs. Without resources to protect communities while gathering data, we cannot implement effective solutions.

3. **Reverse key population funding cuts in all countries.**
   When core funding shrinks and existing programs disappear, new interventions become impossible. All partners must invest in preserving and expanding funding for KP treatment, prevention, care, and advocacy programs.

REALITY CHECK #3 — HEALTH SECURITY

Roadmap to Rights

1. **Develop evidence linking KP rights with health security and social resilience.**
   Counter anti-rights movements' attempts to link LGBTQI+-affirming policies with pandemic threats. Present potential allies with clear evidence. Engage with communities susceptible to misinformation to understand their concerns and counter them effectively.

2. **Include HIV and LGBTQI+ KP groups in all pandemic preparedness platforms.**
   The Pandemic Fund and country/regional working groups on health security must ensure meaningful participation of HIV and LGBTQI+ Key Population groups. We are not the only groups who should be engaged — but we cannot be left out.

3. **Consider Key Population health outcomes as a pandemic preparedness indicator.**
   Countries that don't meet the needs of those most impacted by HIV will struggle with other pandemic responses — especially early detection and community mobilization. The US supports 50+ countries through Global Health Security investments and could integrate KP health outcomes into PPR indicators.

Let's Make Rights a Reality Together

This analysis reflects the data, insights, and experiences of GBGMC's global network of fearless activists. The HIV response is entering a new phase with new prevention tools and continued commitments to ending HIV as a public health threat. At the same time, key population data are being erased.

For two decades, disaggregated data showed where transmission was happening and which populations were being reached. Programs used this information to target interventions, allocate resources, and measure impact. That visibility is no longer available. The response is operating with less precision and reduced accountability at a time when both are required to sustain progress.

The fact is, we are essential, not expendable. Our health is societal health, and our rights are human rights. If we are serious about controlling the HIV epidemic, then all people who need services must be reached — or we will never see success.

> ***"Our collective work is to channel our power to counter the dangers and change reality so that it is better for us all."***
> — Micheal Ighodaro, Executive Director, GBGMC

JOIN US IN MAKING RIGHTS A REALITY
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