

Following the Money to Key Populations, National Priorities, and Evidence-Based Budgeting



A Qualitative
Assessment of the
Use of Key Populations
Data in Domestic
Budgeting Practices in
Kenya and South Africa

The Foundation for AIDS Research

amfAR
MAKING AIDS HISTORY

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INTRODUCTION

The strategic use of national and subnational health data for budgetary resource allocation is essential for improving HIV outcomes, generating targeted HIV interventions, enhancing country ownership, developing the sustainability of programs, and improving budgetary responses. Resources do not flow to populations when the data to document their needs are absent or lack quality, nor when available data are not used to inform budgetary allocations. Since HIV risk and prevalence are unequally distributed in all countries, data must be disaggregated by the populations most at risk, including key populations (KPs) such as people who inject drugs (PWID), commercial sex workers (CSW), men who have sex with men (MSM), and transgender (TG) people.

However, the implementation of data-driven policy decision-making is complicated by several factors. First, many countries do not routinely collect high-quality data on key populations, which are often marginalized or less visible by standard data collection strategies (see box below). Second, even where this type of information is collected, data are often not used to guide resource allocation across all levels of government. Indeed, while overall HIV funding is typically allocated at the national level, individual programs and funding allocations are usually implemented at the local level. This layering of responsibility requires that data be appropriately utilized at all levels of decision making. Finally, even where resource planning does incorporate all available data, resources may not

DATA AVAILABILITY

For policy makers and health program managers to use health data to inform budgetary allocations, data must both exist and be of a sufficiently high quality. However, the availability and quality of data on key populations affected by HIV remains a significant challenge in many low- and middle-income countries (LMICs). A 2015 assessment of 140 countries found that 41 countries do not report any population size estimates for female sex workers (FSW), men who have sex with men (MSM), people who inject drugs (PWID), and transgender (TG) women.¹ Of the 99 countries reporting size estimates, the majority reported only a single estimate between 2010 and 2014 (Figure 1), only half had estimates for the entire country (53–66% by population group), and only 38% had estimates of nationally adequate quality. A similar assessment of the availability of key population size estimates in LMICs found only 12 mentions of these data in ministry of health documents.² Promisingly, the number of countries with available key population size estimates is increasing (Figure 2); however, significant progress remains to be made.

FIGURE 1: Number of estimates used in countries with known estimation methods, 2010–2014

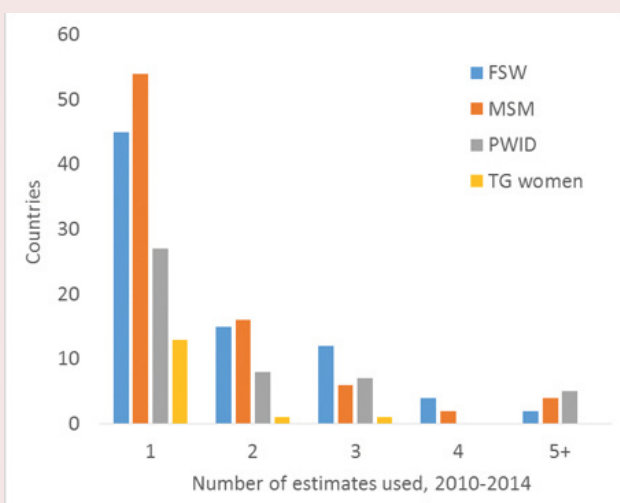
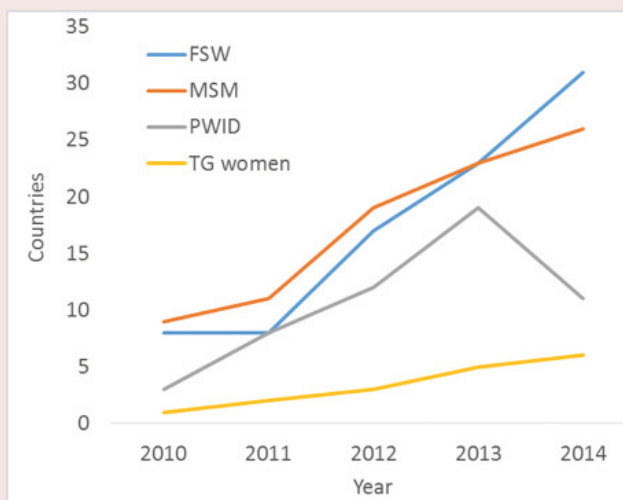


FIGURE 2: LMICs with available size estimates, 2010–2014



ultimately be spent according to designated allocations, whether due to the marginalization of targeted populations, corruption, changing political priorities, or lack of accountability.

In order to evaluate opportunities to strengthen data collection and utilization in resource allocation, the Centre for Economic Governance and AIDS in Africa (CEGAA), amfAR, The Foundation for AIDS Research, and AVAC performed a multi-country analysis of data usage at the local and national levels. The study reviewed public systems and processes for resource allocation for health and HIV interventions, identified epidemiological data currently in use, highlighted information and procedural gaps in resource allocation for key populations, and developed recommendations for future research.

The researchers collected responses to numerous questions through face-to-face interviews with state and non-state actors in South Africa and Kenya, including representatives from nongovernmental organizations (NGOs) delivering HIV services to key populations, individuals providing technical assistance to governments on the financing and programming of HIV interventions and/or on research on key populations, financing partners, and government officials in ministries of health and on national AIDS committees. The study followed a convenience sampling strategy, wherein research respondents were recruited for their involvement in key population issues and HIV/AIDS work.

The findings from South Africa and Kenya were not strikingly different, with respondents from both countries reporting a lack of data on KPs, an absence of government ownership of research and data collection, very

limited use of data to inform government allocations, and unequal prioritization of KP groups.

BUDGET PROCESS IN SOUTH AFRICA AND KENYA

Many African countries, including South Africa and Kenya, receive HIV funding from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and other bilateral and multilateral organizations, NGOs, and private entities.

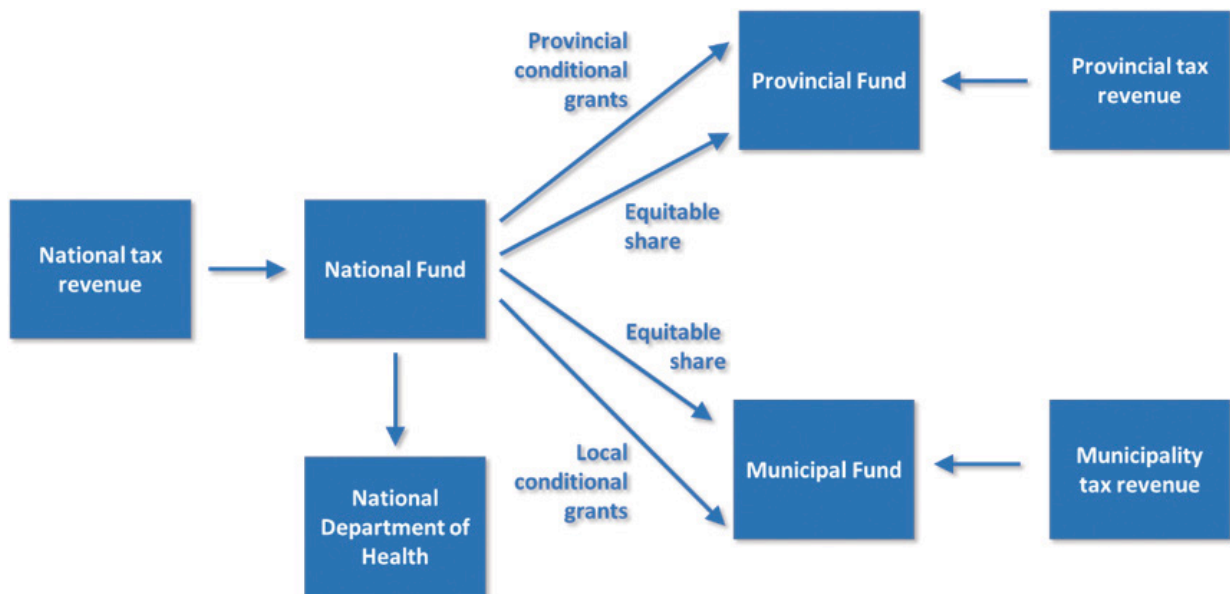
Although donor funds often finance a significant portion of the HIV response, a large proportion of these funds is typically disbursed directly to nongovernmental implementing partners, and thus is not under the control of the national government. However, it is essential to keep in mind that the environment into which HIV resources are directed—and the success of those investments—depends greatly on the status of the overall health system, which is primarily funded through domestic resources. Building and maintenance of health facilities, salaries of most health care workers, general primary health care, and overall management are primarily domestically funded health activities. As a comparison, the World Bank estimates that 27.5% of health expenditures in Kenya are from external resources, versus only 1.8% in South Africa.³ As countries continue to grow their economies, domestic resources will progressively make up higher proportions of total health funding.

TABLE 1: Investment profile for HIV/AIDS expenditures in South Africa and Kenya

Program area	Total expenditure	Funding source				
		PEPFAR	GFATM	Host Country	Other	
<i>Total funding</i>						
South Africa	\$2,138,539,803	18%	5%	78%	N/A	
Kenya	\$574,956,668	64%	8%	21%	7%	
<i>Key population prevention</i>						
South Africa	\$22,480,214	26%	46%	29%	N/A	
Kenya	\$6,772,420	70%	29%	0%	1%	

Source: Source: South Africa and Kenya Country Operational Plan 2016 (COP16) Strategic Direction Summaries (SDS).

FIGURE 1: Resource allocation in South Africa



The sustainability of KP programming is then highly dependent on how domestic budgeting processes adopt and utilize data for resource allocations. As health care is decentralized in its planning and implementation—with provinces or counties given broad discretion as to how to allocate health resources locally—different advocacy efforts at different levels of government are necessary to fully realize the implementation of KP programs. National level action may be a necessary but insufficient condition for seeing real implementation of evidence-based budgeting practices respecting the needs of KPs. It is important for KP advocates to understand these dynamics in order to be able to effectively target strategic advocacy efforts.

The focus of this assessment is therefore on the domestic budgetary process and opportunities for appropriate data use at all levels of government.

South Africa

In South Africa, the HIV/AIDS response is primarily funded through domestic sources, with 78% of funding generated by individual and business taxes (Table 1). An additional 18% of funding comes from PEPFAR contributions and 5% is projected to come from the Global Fund in its next funding cycle (2016–2019). In 2015, South Africa spent nearly 40% of its national health budget on the Programme for HIV and AIDS, Tuberculosis, and Maternal and Child Health.⁴ However,

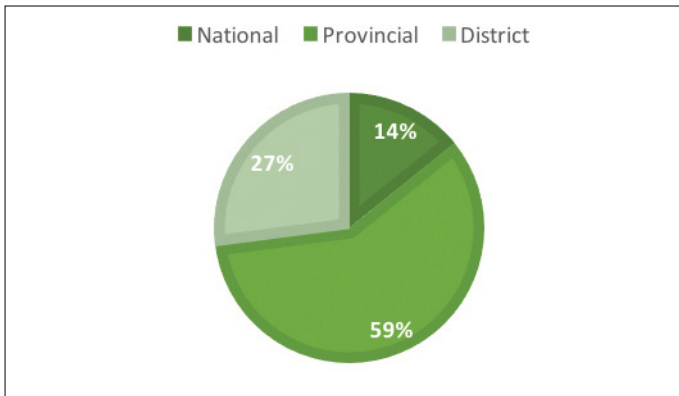
the overall HIV program represents only about 14% of the consolidated national and provincial health budget in the country.

The government of South Africa is organized into three spheres: national, provincial, and municipal. At the national level, the Department of Health is responsible for policy development, legislation, monitoring and evaluation, commodity procurement, national interventions such as communication and education, and specialist health care services at tertiary level facilities.⁵ The majority of HIV/AIDS programming and health service delivery occurs at the provincial and municipal levels.

Revenue raising occurs primarily at the national level, with resources divided among the three levels of government. Every year, a Medium-Term Expenditure Framework (MTEF) is developed based on three-year projections from the Department of Finance and the Reserve Bank. Informed by these projections, the Department of Health submits budgetary proposals to the National Treasury, with guidance and review from a technical group composed of program and financial officers, public entities, and provincial representatives.⁶ The National Assembly votes annually on the Division of Revenue Bill, which specifies the division of resources among provinces; the Appropriation Bill, which divides funds among national departments; and the Income Tax Laws Amendment Bill.

The majority of funding for health services is distributed to each of the nine provinces via the provincial equitable share (PES) formula,

FIGURE 2: Domestic health budget division of resources (South Africa)



through which relative need is calculated based on several weighted indicators: the size of the population with and without medical aid support, educational enrolment, overall population size, economic activity, poverty, and an equally-distributed institutional grant.⁷ In 2015, nearly 82% of provincial revenue was from PES funds.⁸

Provinces receive additional funding from conditional transfers designed to fund areas identified as national priorities, and they

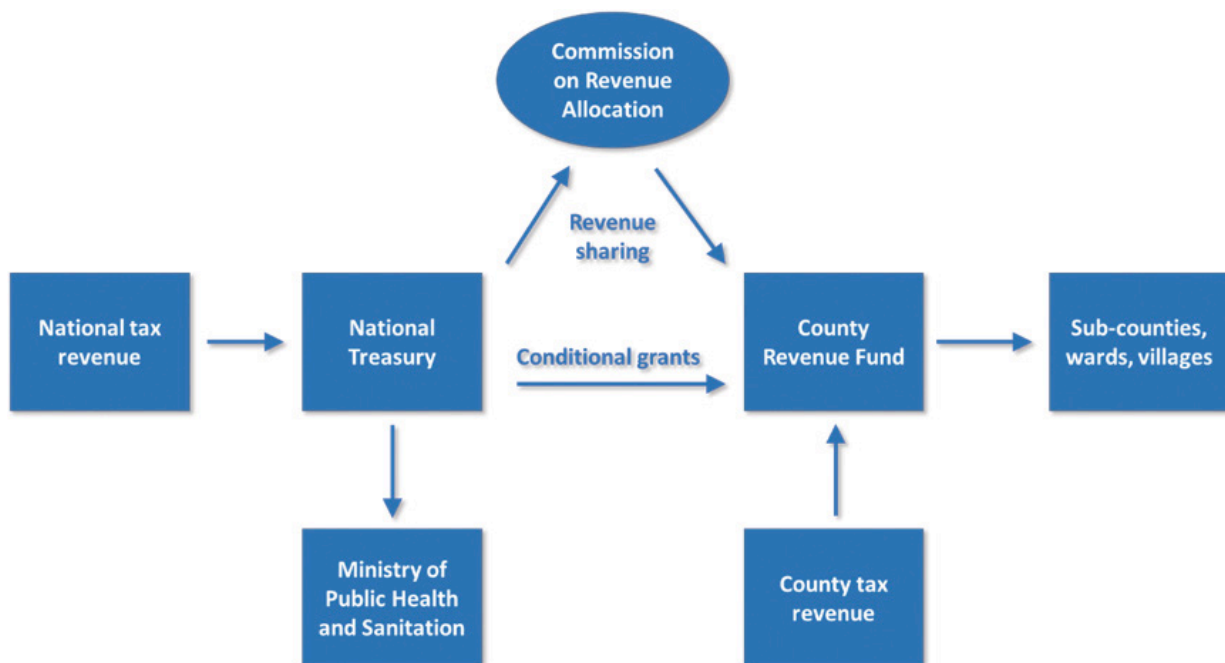
may generate their own revenue—though their capacity to do so is constitutionally limited (in 2015, approximately 3% of provincial resources were raised provincially⁹). The Comprehensive HIV and AIDS grant is the second largest conditional grant for the provinces.¹⁰ Provinces may allocate discretionary funds to HIV/AIDS programs as well. By contrast, conditional grants for HIV are legally mandated to be spent on HIV-related programs and require provinces to submit specific business plans to access the funds.

Likewise, funds are transferred to districts and municipalities via the local government equitable share, local government conditional grants, and further disbursed from provincial resources.¹¹ The local government equitable share is calculated from the costs of basic services, administrative and governance capacity, and a correction and stabilization factor.¹² Although districts and municipalities are constitutionally freer than provinces to generate revenue from charges and taxes, resource allocation and spending are heavily concentrated at the provincial level.

Kenya

In contrast to South Africa, the majority of HIV/AIDS funding in Kenya is from PEPFAR (64%), with the government of Kenya providing 21% of all funding and the Global Fund contributing 8%. While much of this funding is distributed directly to donor-supported programs

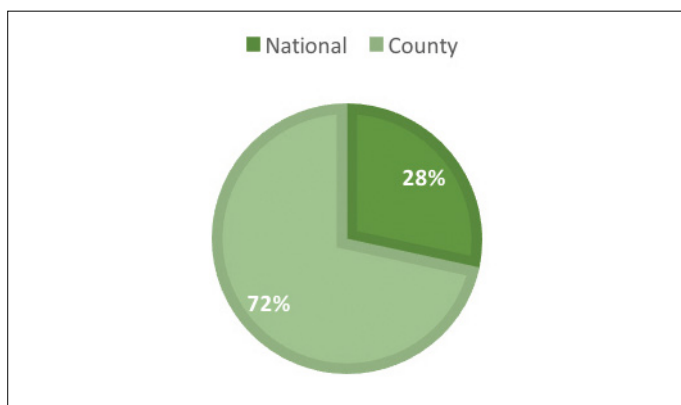
FIGURE 3: Resource distribution in Kenya



administered by NGOs, PEPFAR allocated more than \$144 million (29.5% of its resources) to Kenyan government agencies in 2015.¹³

Since the constitutional reform of 2010, Kenya has undergone a significant decentralization that has resulted in the creation of a new layer of government at the county level.¹⁴ Today, the government of Kenya divides revenue and governing functions between the national and county levels, with many health functions devolved to the 47 counties. Counties are often further subdivided into smaller administrative units including sub-counties, wards, and villages.¹⁵ The national government is primarily responsible for policy making, education, economic governance, and large-scale infrastructure, while county governments administer county health facilities, sanitation, housing development, and local infrastructure.

FIGURE 4: Domestic health budget division of resources (Kenya)



Each year, the Parliament votes to approve the National Appropriations Bill, while individual county assemblies separately approve their own budgets. Counties have constitutional authority to levy taxes without approval of the national government. National revenue for HIV programs is disbursed from the National Treasury through the Ministry of Public Health and Sanitation.¹⁶

More than 90% of county operations are funded by transfers of funds from the national government, with the remainder drawn from county-level revenue collection. Revenue is transferred to the counties through unconditional revenue sharing (block transfers) or conditional grants.¹⁷ The division of national revenues between national and county governments is determined by the Commission on Revenue Allocation (CRA) using a revenue allocation formula that incorporates

data on population, poverty, and land area.¹⁸ County governments are free to distribute these funds according to their own identified budget priorities and needs. By contrast, conditional grants are legally obligated to a predefined beneficiary, project, or program area.

Every year, each county creates a budgetary framework, termed a “County Integrated Development Plan,” that describes strategies for raising revenue, proposals for programs, and plans for implementation, monitoring, and evaluation.¹⁹ To combat corruption, the Kenyan constitution mandates that county financial secretaries must report financial data to the County Assembly every three months for monitoring.

FINDINGS: DATA AVAILABILITY ON KEY POPULATIONS

Findings from this analysis reveal that while some data exist on CSW and MSM, interviewees were generally unaware of data for other key populations such as PWID or transgender people. In general, the available information does not provide sufficient detail to inform robust resource allocation and programming decisions at all government levels. However, it does provide sufficient information to require that counties or districts develop local level responses to ensure these populations access to prevention services.

In recent years, several Kenyan and South African research studies have collected data on MSM and CSW population size, behavioral characteristics, sexual health, and HIV risk factors (see Table 2). Several of these are just from the last two years. Additionally, Kenya has developed a portal of KP data, disaggregated by population groups, which provides qualitative and quantitative details for participating health facilities—particularly around care and treatment cascades. The portal could prove a vital tool for budgeting practices in the future.

Unfortunately, the quality of KP data at present ranges from highly suspect to outright incorrect. Current KP size estimates for MSM in Kenya are particularly egregious, ranging from only 10,000 to 49,000 MSM in the entire country.²⁹ Even at the high end, this suggests that only 0.21% of men in Kenya are MSM—an inconceivably low figure.

South African CSW research projects include a rapid size estimation targeting sex worker hotspots in Cape Town, Durban and Johannesburg. The High Transmission Areas (HTA) programme of the health department, which receives funding as part of the national

TABLE 2: Size Estimate Data

Systematic reviews of size estimate studies on key populations in the published literature, as well as studies referenced by interviewees, are included below. While the availability of data is clearly limited, it is also essential to note that these data are available for programming

	FSW	MSM	PWID	TG
<i>Kenya</i>				
Populations at increased risk for HIV infection in Kenya ²⁰ (2014)	X	X	X	
Estimating the size of the female sex worker population in Kenya to inform HIV prevention programming ^{21†} (2014)	X			
Estimates of the size of key populations at risk for HIV infection ^{22†} (2013)	X	X	X	
Kenya Most-at-Risk Populations Size Estimate Consensus ²³ (2013)		0	0	
Geographic Mapping of Most at Risk Populations for HIV in Kenya ^{24†} (2012)	0			
Heroin scarcity in coastal Kenya ^{25†} (2012)			0	
HIV prevention among injection drug users in Kenya and Tanzania ²⁶ (2011)			0	
<i>South Africa</i>				
Estimating the size of the sex worker population ^{27†} (2013)	0			
Drug trafficking, use, and HIV risk ²⁸ (2012)			X	

X indicates data from a published peer-reviewed study

0 indicates data from referenced non-peer-reviewed studies.

† indicates studies with subnational estimates

conditional grant (CG) for HIV/AIDS, regularly collects hotspot-based program data and has estimated HIV prevalence of 88% among sex workers but low prevalence among truck drivers. Additionally, the Global Fund has provided funding to do size estimations on all key populations in the near future.

To date, we have been unable to identify any proper size estimation studies on transgender¹ individuals in either country.

COUNTRY OWNERSHIP OF KEY POPULATIONS RESEARCH

In interviews, almost all nongovernment respondents indicated that the Kenyan and South African governments rely heavily on academic and NGO partners to do credible research on KPs and that there are no immediate plans for either government to take ownership of this work. Respondents in both countries indicated that there is no public funding for KP research, with some indicating that the public budget process is not supportive of budgeting for KP research.

¹ One research respondent indicated that transgender people are involved in research through sex worker programs, where they are identified as sex workers instead of transgender people.

Currently available data in Kenya and South Africa are derived primarily from research studies and not from regular surveillance. In South Africa, data on MSM and CSW are collected by collaborative efforts among government bodies (the South African National AIDS Council [SANAC], the National Department of Health, and the Human Sciences Research Council), international research institutions (University of California, San Francisco), international funders (CDC/PEPFAR), local nonprofit organizations (SWEAT, NACOSA) and international nongovernmental organizations (ANOVA Health Institute, FHI 360). In Kenya, research on KPs is conducted by collaborations between the Kenya National AIDS Control Council and donor partners. Research partners identified were primarily academic institutions and included the Universities of Manitoba, Nairobi, Maryland, San Francisco, Cambridge, the Kenyan Medical Research Institute, and the Kenya AIDS Vaccine Initiative. Respondents in both countries indicated that if it were not for external funding partners, almost none of the existing research on KPs would have occurred.

This assessment differed from that of government respondents. South African state respondents involved in research indicated that all the research that has happened was because of government's initiative or interest, noting that if government were not supportive of the research done by partners, then the research would not have taken place at all. Some respondents expressed an openness to government-initiated research, including one senior government official who indicated that *"generally, donor funding can be good to stimulate research, facilitating government to start engaging on these things—but government can do this research and fund it too. Why not?"*

Some South African respondents felt that the government's failure to take the initiative in funding and performing KP research was sufficiently compensated by other government functions, such as the provision of research sites, coordination of research studies, and research ethics processes. Some felt that the government was so burdened by other competing demands that it could not conduct research, while others raised concerns about issues of research expertise within the government. As evidence of the government's involvement, some cited the National Department of Health's work with research partners to ensure that research findings inform policy and programming and benefit the public. Many indicated that although the government does not currently finance KP research, if there were plans for government led-research, the National Treasury would be willing and able to provide the necessary funding. Nonetheless, a Treasury perspective was that South Africa would continue to need PEPFAR's technical assistance in identifying which interventions to prioritize and how to budget with the greatest impact.

Notably, some South African government officials argued that HIV/AIDS is a generalized epidemic in South Africa and that targeting KPs is difficult or even irrelevant. In addition, they pointed out that key populations operate mainly underground, and thus are hard to identify and target for HIV/AIDS interventions. Civil society respondents identified stigma and criminalization of sex work as the main factors leading to failure of key populations coming forward to seek services.

DIFFERENT FUNDERS, DIFFERENT PRIORITIES

A range of researchers in Kenya and South Africa, funded both domestically and by international donors, have analyzed biomedical and behavioral risk factors for HIV, evaluated program implementation strategies, and piloted novel interventions for KPs. However, focused academic research is fundamentally distinct from routine collection and modeling of national KP size estimates, epidemiological indicators, and demographic data. While the former has considerable scientific merit, the latter are the requisite 'building blocks' of an effective surveillance system. In order for South Africa and Kenya to develop the capacity to make data-informed budgeting and programming decisions, both countries must commit to collecting high-quality surveillance data on KPs, distinct from the research performed by nongovernmental scientific groups.

In Kenya, research respondents indicated that the government is best positioned to generate data and to use it for resource mobilization and allocation, but noted that in practice this does not happen. Funding for KPs was described as *appropriation in aid*, which could be jeopardized if donors withdrew funding. However, the Kenyan National AIDS and STI Control Programme (NASCOP) indicated that the government is already taking action on size estimation gaps in KP research. A CDC-funded and University of California, San Francisco-facilitated meeting was held in 2015 to help address these gaps and improve KP resource allocation, planning, and programming. NASCOP claimed to have produced an internal report from this meeting, and to be taking the necessary steps to use the meeting

recommendations to inform KP interventions. The document reportedly informs government's new strategy and enhances what the health ministry has already started doing in partnership with other stakeholders regarding research, resource mobilization and program implementation.

In Kenya, all respondents reported political and legal challenges to performing KP research and emphasized the importance of government support for KP research and programs. Respondents described the 'political backlash' occurring around KP discussions and described the tendency of political leaders to claim a commitment to KPs in public, while displaying resistance or lack of ownership in the implementation of KP programming in practice.

“Generally, donor funding can be good to stimulate research, facilitating government to start engaging on these things – but government can do this research and fund it too. Why not?”

This situation becomes significantly harder to manage in both Kenya and South Africa due to the devolution of decision-making powers from national to county and provincial/district level governments. In the decentralized system, counties or provinces have autonomy from the national government over decisions about spending health funds, thus reducing the power of the national government to dictate where funds should be used. This has a direct implication for KP spending at county level as counties/provinces can decide if they want to participate in KP work or not. In both Kenya and South Africa, county and provincial budgets have thus far not included mentions of KPs.

However, respondents suggested that funding and implementing partners in Kenya are starting to engage with counties to influence plans. They are spearheading sensitization activities and connecting counties to data collection processes for KP research, then using that information to inform higher levels of decision making and budgeting.

At the same time, South Africa is in the process of establishing a more robust district implementation planning process. However, details of this process and what it will entail are not yet available.

USE OF EPIDEMIOLOGICAL DATA FOR BUDGETING

Information from studies on KPs has generally not been maximized for programming and budgeting, nor has it been used to ascertain the amount of effort needed to address HIV/AIDS in KPs. Both Kenya and South Africa include data on KPs in their Global Fund application process – a requirement of the Global Fund – although neither country fully uses this same data in the public budgeting process. Respondents from both countries expressed concerns that available data were insufficiently detailed or of insufficient quality to inform resource allocation decisions.

In South Africa, the National Student Survey, the MSM Data Triangulation Report, and the Marang Men project produced published manuscripts, reports, programmatic data, and recommendations that have informed the Global Fund application process but have not been used in public budgeting processes.

Only the High Transmission Areas (HTA) programs uses CSW data for resource allocation. However, because the population size estimates have not been tested for accuracy, respondents expressed their dissatisfaction with the quality of available information and concluded that the information was insufficient for informing programming or budgeting for KPs. One respondent suggested that the government's own data management systems (such as the District Health Information Service (DHIS) and tier.net) were collecting enough service information on KPs to inform budgeting, but questioned the accuracy of these data since most members of KPs would not self-identify when accessing general health facilities, and would thus not be flagged as belonging to these population groups. It is also likely that these data would primarily inform care and treatment cascades for KPs, but would not necessarily track KP specific prevention services. There was a strong feeling that if the health department built evidence and requested additional funding for KP interventions from the National Treasury, these funds would be made available, with one respondent stating that *'As long as there is evidence, money will be mobilized and made available to fund budget bids from implementers.'*

In Kenya, research data on KPs have not been proactively used to inform government budgeting. The Kenyan Ministry of Health did publish the *Kenya HIV Prevention Revolution Road Map* in 2014. The Road Map developed county level models to identify the best mix of combination prevention services based on county level epidemiological and demographic population estimates—including

discussions of the need for combination prevention services for KPs—in order to encourage counties to adopt the most cost-effective programs.

However, the implications of the Road Map are not yet clear. Respondents indicated that most decisions concerning KP programming and budgeting in Kenya are not always based upon the available data. As noted above, individual county level plans have to date not mentioned KPs. Respondents also noted that usability of government routine monitoring and evaluation data on service utilization is hampered by systemic inaccuracies. While these data have been used to develop disaggregated information on KPs, they are inherently inaccurate since members of KPs do not identify themselves as such when accessing services. This results in a persistent and mutually reinforcing data gap resulting in plans and budgets that fail to properly reflect the needs of KPs.

KNOWLEDGE OF GENERAL HEALTH RESOURCE ALLOCATION PROCESSES

Respondents in both countries were asked about their knowledge of the budget process at national and subnational levels. Such knowledge is important for advocates to know how to influence the resource allocation process and to know and engage with the budget actors. In South Africa, although none of the respondents except two worked directly with the budget process, everyone had some understanding of how the budget was formulated, or had contributed in one way or another to the resource allocation process for HIV/AIDS or general health spending. Overall, the respondents were clear about the general health resource allocation process, with two of them claiming to have influenced it through implementation plans they have contributed to, through SANAC, the Global Fund, PEPFAR, and the National Department of Health HIV/AIDS Cluster (through the HTA program). Our limited sample of respondents asserted that KP data were not used for resource allocation except for the information coming from the HTA sites, which informed the HTA budget line-item within the HIV/AIDS Conditional Grant. There is an assumption that the very large HIV/AIDS budget in South Africa covers the general population as well as KPs; however, the HIV/AIDS budget does not mention KPs in any of the HIV/AIDS programs or sub-programs other than the HTA program.

In Kenya, most respondents did not know how the budget was formulated, or the steps followed to determine budget allocations.

Respondents indicated that the National AIDS Control Council (NACC) and NASCOP were in charge of the budget process for HIV/AIDS and were knowledgeable about the actual budgets for KPs. NASCOP reported to have formed a technical working group as a coordinating mechanism for HIV/AIDS resource allocation, which included representatives from all sectors, including KPs. Interestingly, NASCOP indicated that the technical working group involved all populations affected by HIV/AIDS, but nongovernmental stakeholders interviewed in this research denied any involvement.

PRIORITIZATION AMONG KEY POPULATIONS

Respondents from South Africa differed on which KP group they considered to be the highest priority. As noted above, some government officials were skeptical of the need to prioritize KPs given the generalized epidemic in the country; others indicated that almost all South African KPs should be prioritized, while still others singled out MSM and CSWs as the groups requiring government's special attention in both research inclusion and budgeting. There was an assertion that MSM and CSWs were of high priority since they have been prioritized by many donor-initiated projects, as well as by SANAC and the National Department of Health.

There was concern about the total silence on TG women, particularly given the greater vulnerability of TG CSWs, and the suggestion of bringing TG issues to the center of both research and funding. A few respondents mentioned incarcerated populations, citing inadequate advocacy for this population. Some respondents identified PWID as needing attention, while others mentioned the spread of HIV among young women and girls and noted their inclusion as an important priority in the Global Fund concept note. Respondents also expressed a feeling that South Africa should improve its health system generally to respond to overall needs in one location, rather than running stand-alone services for KPs that may ultimately increase stigma. Some recommended that stand-alone sites like HTA should serve only as referral centers in order to avoid vertical service provision.

In Kenya, most respondents indicated that FSWs were the largest KP group and that prioritizing them could be more impactful due to the availability of better data, less stigma than other groups, and fewer implementation challenges. By contrast, Kenya is known for its silence on MSM and it continues to criminalize homosexuality. In the absence of MSM-specific programs, MSM have received some basic services through interventions targeting FSWs. Some respondents

indicated that despite the need to increase prioritization of some KPs, it is ultimately best to work with all KPs as all groups require increased resources in order to have any impact. Some respondents noted efforts by NASCOP to increase access to PWID and change attitudes and perceptions, which may eventually reduce stigma. They also pointed to the Global Fund's investments in the PWID program that included a methadone treatment package for more than 1,000 PWID clients per year. The government has reportedly increased allocations to scale up PWID interventions, but this has not been seen in government budget statements and expenditure reports.

In both countries, criminalization of KPs undermines the very programs necessary to prevent new infections. As noted above, criminalized populations are unlikely to identify themselves to the public health system, systematically invalidating data collection efforts at those points.

RECOMMENDATIONS AND OPPORTUNITIES MOVING FORWARD

Respondents in both Kenya and South Africa have made clear that greater advocacy around the domestic budgeting process is necessary to increase domestic resource allocations for KP programs and research. We therefore make the following recommendations:

1 Increase domestic resource allocations for KP programs and research.

- Increase the overall availability of KP funding.
- Increase country ownership of KP research and capacity for surveillance of quality programming.
- Ensure that KP data collection is in line with government budgeting and planning needs.

2 Decriminalize KPs.

- Laws criminalizing key populations increase stigma, discrimination, and vulnerability to HIV infection, and are out of step with both science and human rights.
- Criminal laws hamper biomedical, epidemiologic, and demographic research, undermine prevention and treatment programs, and harm individuals.

- Criminal laws increase the difficulty for policy makers to appropriately plan and program cost-effective interventions and programs.
- Criminal laws present barriers to sensitization training for health care workers, service providers, and government officials.

3 Develop realistic size estimates for all KPs.

- Planning and implementation of KP services will require better figures and actual population sizes.
- Since past size estimation efforts have returned unrealistically low estimates unsuitable for program development or targeting, new and ongoing efforts must learn from these failings and improve methodologies.

4 Target advocacy efforts at multiple levels of government.

- District, county, provincial, and national levels all play distinct and important roles in the resource allocation process.
- Advocates must target all levels of government to increase local programming for KPs that includes distinct interventions.
- Pressuring one county or province to include KP programming line items in budgets may incentivize other regions to follow.
- Targeted approaches such as one-on-one government official sensitization may help reduce political backlash for policy makers supporting KP programs and research.

5 Multi-stakeholder engagement remains critical.

- Policy makers should continue to engage and expand on existing stakeholder engagement processes as part of the budgeting process at all levels of government.

6 Sustainability of KP programs is key.

- International donors currently support the majority of KP programs in both Kenya and South Africa.
- As donor priorities and engagement evolve, countries must remain vigilant to ensure that KP programs are not undermined as they transition out of donor assistance.
- Sustainable transitions from donor funding will require that KP programming be embedded in the basic structures of the HIV response at all levels of government and that there is sufficient multi-year notice of impending transitions.
- Increase the direct visibility of KP program funding across all levels of domestic budgets.

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ENDNOTES

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amfAR Public Policy Office 1100 Vermont Avenue, NW • Suite 600
Washington, DC 20005 • T: +1 202.331.8600 F: +1 202.331.8606