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EVIDENCE FOR HIV PREVENTION IN SOUTHERN AFRICA

EHPSA SHORTS
MARCH 2018

The Kenya model of research into policy

Making policy for key populations in eastern and southern Africa

In the world of HIV, key populations (KPs) have been defined as sex workers (SWs), men who have sex with men (MSM), and people who inject drugs (PWID). These are groups whose behaviours put them at heightened risk of HIV.

It is challenging to do research with KPs in rights-constrained environments where the safety of participants, researchers and clinical staff is a real concern. Most countries in eastern and southern Africa could be defined as rights-constrained environments where homosexuality, drug use, and sex work are both stigmatised and criminalised. As a result, sex workers, drug users, prisoners, and men who have sex with men (MSM) (and the wider group of LGBTI) are 'hidden' or 'hard-to-reach' populations.

It is even more challenging to develop policy and programming for these stigmatised and marginalised groups. National AIDS councils (NACs) and their technical working groups (TWGs) are key institutions that drive policy and programming for HIV in the region. Research results can play a catalytic role in such change processes.

> The Kenya experience shows that it is possible to move from research to a national policy within less than two years

Kenya, and the role of its NAC and TWG in driving change, is a model for other countries in the region that are taking tentative steps towards improving the environment and services for key populations. The Kenya experience is a good example of a TWG taking up scientific knowledge to push for policy change. This can be illustrated in tracing the development of the first KP policy in Sub-Saharan Africa, which was launched in Kenya in 2010.

Five steps from research to policy, the Kenyan example

The National Guidelines for HIV/STI Programs for Sex Workers was the first HIV KP policy in Africa and a major achievement, given that the laws criminalising KPs had not changed in Kenya. The document was launched in January 2010 in conjunction with the revised

Kenya National AIDS Strategic Plan 2009/10-2012/13 that prioritised comprehensive programming for key populations. Obviously, the government's decision to include KPs as part of official policy and programming was not made overnight, and an analysis of the change process demonstrates five critical junctions, milestones or turning points that unfolded over two decades, but were each instrumental in leading to the eventual declaration of a KP policy in 2010.

The change process in Kenya followed a pathway that is very much the standard paradigm for development but which is too seldom seen in practice: scientific evidence being used for advocacy aimed at government, which results in government acceptance of the results, policy change and subsequent implementation of the revised policy with the collaboration of researchers, key population organisations, the health sector and donor agencies.

A summary of the five key steps is given below

1. From denial to government action.

The first turning point in this narrative was the shift from official denial about HIV to government action. In the late 1980s, the indisputable evidence of a high HIV prevalence among sex workers and the rising prevalence in the general population meant that the Kenyan government could no longer maintain its position of denial of the epidemic, and it therefore established, within the Ministry of Health, the National AIDS and STI Control Programme (NASCOP) to take action. At this stage, it was the research institutions working in the country, most often connected to universities or research institutes, that were the most important civil society actors, as it was they who were generating, reporting and publishing the emerging knowledge about the state of the epidemic.

Scientific evidence was used for advocacy and government accepted the results, leading to policy change and implementation

2. AIDS declared a national disaster.

The second milestone came in 1999 when AIDS was declared a national disaster. This Presidential declaration opened political space for donors to initiate interventions against HIV, and the government, at the same time, established the National AIDS Control Council (NACC) as a policy-making and coordination body. It marked a critical juncture and coming together of political will, international donor interest and grassroots organisations, which had been forming over the previous decade, but which were now part of the national dialogue.

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3. New evidence on HIV and KPs

In 2008 the Kenya HIV/AIDS Modes of Transmission Report (MoT) was released. This influential study, supported by the Government, World Bank and UNAIDS, drew on a comprehensive search of the available data and concluded that sex workers, MSM and other key populations may have been contributing up to 30% of the new cases of HIV (incidence). The Kenya AIDS Indicator Survey (KAIS), which had been released in 2007, provided further evidence of the state of the epidemic, and other research carried out in Nairobi and the Coast, confirmed the high HIV prevalence of up to 25% in some KPs, who were not able to access prevention, counselling and care at ordinary clinics. Besides concerns about sex workers' and MSM's rights to health information and services, 30-40% of MSM reported stable sexual relationships with women. This raised the issue of transmission into the general population.

A principal recommendation of the MoT Study was that effective HIV prevention interventions tailored for sex workers and MSM were critical for curbing HIV transmission, not only among the key population but in the general population as well. The MoT study confirmed the critical role that three key populations (sex workers, MSM, PWID) play in new HIV infections in Kenya, and this led to a political decision to immediately revise the existing strategic framework and to prioritise KPs in the National AIDS Strategic Plan. Again, the research institutes played the most important role in civil society, through the generation of knowledge, with the main difference between 2008 and the late 1980s being that the research institutes were now working in coalition with the Kenyan government departments. This could be seen as another critical juncture: this time of knowledge, political will, and 'champions of change' in the Ministry of Health and in research institutions.

> Technical working groups played a vital role, making Kenya a leading African country in HIV policy and programming for KPs

4. Key Population programme launched.

The fourth turning point was when the government launched the Key Population Programme and established a KP Technical Working Group. This occurred later in 2008, soon after the results of the MoT study were announced and came about as the result of discussions between the government, donors, research institutes and NGOs, but with the notable addition of KP organisations to the dialogue.

5. The first HIV key population policy in Africa

Finally, in 2010, the fifth milestone was the launch of the first HIV key population policy in Africa. The KP Technical Working Group was tasked to formulate a national operational guideline and help design interventions for key populations in the next Kenya National AIDS Strategic Plan. It was a delicate task due to the absence of an enabling legal and policy environment, i.e. sex work and homosexual practice still being illegal in Kenya. However, the Guidelines were developed on a rights-based model in the context of the newly-drafted Kenya Constitution, which guaranteed all Kenyans the right to health care.

The TWG led the planning, drafting, editing and reviewing of the national sex workers guidelines, and involved stakeholders from the wider research community, KP organisations, and international donors. UNAIDS supported the policy process, CDC provided financial and technical support, and the University of Nairobi/University of Manitoba hosted the secretariat for the policy development.

This marked a final critical juncture of knowledge, political will, funding, and 'champions of change' in government, research, donors, and KP organisations.

Kenya is now a leading African country in HIV policy and programming for key populations

Conclusion

The Kenya experience demonstrates that when the six main actors - research institutes, National AIDS Commission, donors, KP organisations, multilateral agencies and implementing organisations - work together in a technical working group, it is possible to move from research findings to a national policy addressing the identified problem within less than two years. It could be viewed as a best practice example of a process of positive change for key populations in relation to HIV policy making. The TWG has played a vital role in the implementation of policy, making Kenya a leading African country in HIV policy and programming for key populations.

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