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EVIDENCE FOR HIV PREVENTION IN SOUTHERN AFRICA

EHPSA CRITICAL REVIEW
APRIL 2018

RESOURCES FOR KEY POPULATIONS

Allocations for key populations in six countries in eastern and southern Africa

FINAL REPORT

Nordic Consulting Group

Contents

EXECUTIVE SUMMARY

The aim of this review was to provide a comprehensive picture of allocations to HIV prevention for key populations[1] in six study countries (Kenya, Malawi, South Africa, Swaziland, Tanzania and Zambia) using information in the public domain.

The baseline report - carried out in 2016 - concluded that whilst it was not feasible to get a comprehensive picture of spending on HIV prevention on key populations from publicly available information (or any source for that matter) in the study countries a number of interesting developments were worth following up on. The baseline also concluded many other factors beyond current allocations influence decisions on how resources are allocated.

This report follows up on the 2016 Baseline. The work was carried out from December 2017 to February 2018 and consisted of analysis of publicly available data, a review of recent literature and telephone interviews and email follow up with a number of key informants at regional and global level.

The general picture that emerges is one of a highly resource-constrained environment for spending on HIV prevention, but one in which the study countries seem to have had some protection from its worst effects. Over 95% of donor funding for HIV in the study countries is accounted for by PEPFAR - by far the largest donor - and the Global Fund. Although PEPFAR is facing cuts in future years - budgets for 2018 should be available shortly - it is prioritising a subset of countries, which includes all of the study countries. Similarly, the reduction in overall allocations between the first and second New Funding Model periods (2014-16 and 2017-19) at the Global Fund have been offset, in part, by greater emphasis on disease burden in the allocation methodology which has benefited the study countries.

2017 saw a doubling (from 3.1% in 2016 to 6.6%) in the share of PEPFAR allocations to key populations in the study countries as a whole (though the share has declined and remains low in Malawi and Zambia). The Global Fund portfolio review of spending between 2014 and 2016 is suggesting wide variation in the share of HIV allocations for key populations - over 9% in Kenya and South Africa, below 2% in the other study countries - although this analysis has yet to be finalised.

National HIV/AIDS Spending Assessments (NASAs) remain the most comprehensive tool for assessing spending on selected key populations. However, few have been carried out in the last few years. A significant development since the baseline includes UNAIDS' intention to re-establish the NASA process and carry out NASAs in at least five of the study countries. The Global Fund is also nearing completion of a portfolio review, which attempts to estimate spending on key populations. Key populations also feature strongly as key performance indicators in the new Global Fund strategy. The emphasis here is middle income countries, reflecting Fund concerns about sustainability of services in countries which are graduating from Fund support. Efforts are also being made by PEPFAR, the Global Fund and UNAIDS to begin aligning budget classifications which would make it easier to track allocations though they remain at an early stage. This report recommends close tracking of these processes but also suggests the need to identify key policy questions at the country level and consider whether existing approaches are likely to be sufficient or whether additional, more in depth work is required.

The report suggests that better information on spending is a *necessary* but not a *sufficient* condition for more informed policy-making in relation to the allocation of resources. In capacity-constrained countries there are questions as to whether a "state of the art" NASA is the best way forward or whether more "quick and dirty" approaches would be more appropriate especially when one considers some of the other major information gaps that exist - for example the size of the target populations. The report also highlights other important inputs to the decision-making process such as data on cost effectiveness and on unit costs.

1 Key populations are defined by UNAIDS as sex workers (SWs), men who have sex with men (MSM) and transgenders, and people who inject drugs (PWID). Other populations at higher risk such as adolescent women, migrants, fisherfolk, etc. are considered to be "vulnerable" populations but are not included under the label of "key population".

1. Introduction

The overall purpose of this theme of work is to summarise publicly available information on planned allocation of resources to interventions aimed at reducing HIV/AIDS incidence in key populations (KP) in six countries – Kenya, Malawi, South Africa, Swaziland, Tanzania and Zambia

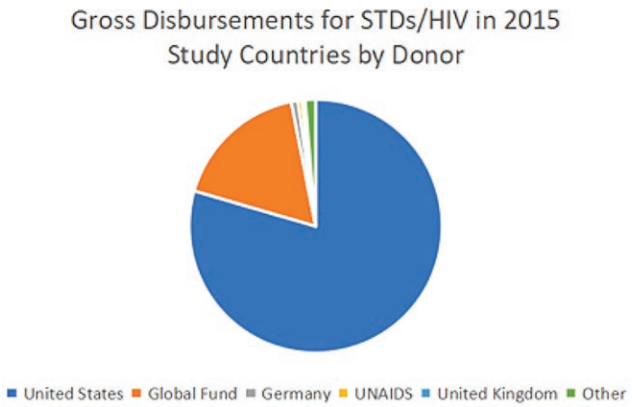
This report follows up the initial baseline report submitted in July 2016. The key messages from the baseline report are set out below:

- It is not possible to accurately and comprehensively track either planned or actual spending on HIV prevention services for KPs using publicly available sources.
- Tools to do this – such as National AIDS Spending Assessments (NASAs) – exist, but they are not being used routinely. These tools are time consuming, and because countries have limited resources they prioritise other things.
- A lot of useful information is available, but it is not possible to present a simple single figure, as data is not classified in a consistent way by key funders and between countries.
- Sensitivities, in terms of how much is actually allocated and to what purpose, seems to prevent transparency by both governments and donors.
- Simply knowing how much is being spent on its own will do little to equip decision makers to make informed decisions on how to allocate resources.
- In view of the data challenges we proposed a limited follow-up to track progress and update figures for the Global Fund and PEPFAR, approach UNAIDS to try and access data from NASAs and assess progress with the WHO CHOICE (Choosing Interventions that are Cost-Effective tool).

Following subsequent discussions - and taking these findings into account - it was agreed to carry out a more focused analysis as a follow-up. This was done through phone interviews and email interaction with a number of key informants, literature review and accessing publicly available data. The Terms of Reference are given in annex 1.

2. Updated Analysis of Funding Trends

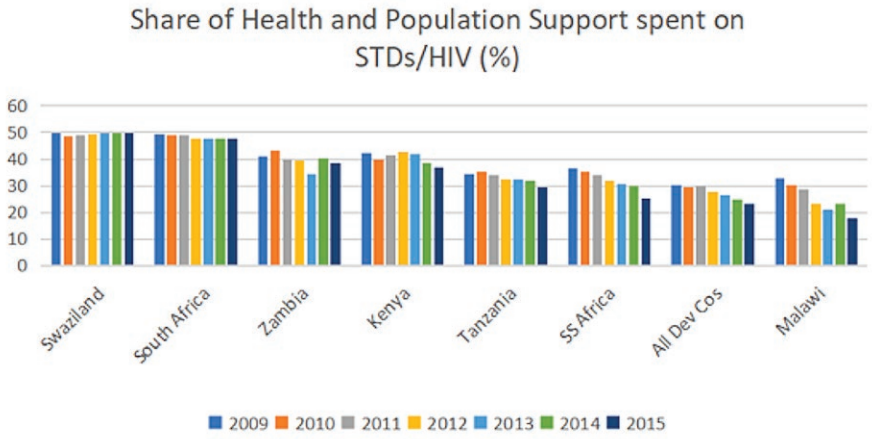
2.1 Broad Funding Landscape



Updated analysis of the overall donor funding environment using OECD DAC Creditor Reporting System (CRS) data suggests that:

- Donor *commitments* for HIV/AIDS are increasing: overall spending by donors on HIV increased by just over 20% from $4.60bn in 2014 to $5.54bn in 2015 (constant 2015 prices) and from 20.9% to 25.5% of total health and population aid.
- *Disbursements*, by contrast, declined some 13.5% from $5.15bn to $4.46bn (and from 24.8% of total health and population spend to 23.2%)
- Donor spending on HIV/AIDS continues to be dominated by PEPFAR and the Global Fund (see pie chart)

The share of donor spending going to HIV/AIDS generally remains much higher in the study countries than the average for sub-Saharan Africa as a whole. Tanzania and especially, Malawi are exceptions to this.



The study countries were much more reliant on PEFPAR to fund HIV activities than other sub-Saharan African countries. In the study countries disbursements for HIV rose by 29% from $1.42bn to $1.85bn. Most countries saw a substantial increase, though spending fell by 20% in Malawi largely due to reductions in Global Fund expenditure. Together PEPFAR and the Global Fund continued to account for more than 95% of HIV spend in the study countries.

Table 1: Disbursements for HIV ($m - 2015 constant)

	2010	2014	2015	2016	% incl 2016 over 2015
Kenya	422	504	463	533	15.1
Malawi	123	148	155	123	-20.4
South Africa	603	582	336	464	38.0
Swaziland	57	45	41	74	78.6
Tanzania	373	431	270	435	61.2
Zambia	229	302	162	218	34.4
Total	1,807	2,012	1,427	1,847	29.4

Further charts/tables are at annex 2.

A Kaiser Foundation study[2] looked at donor funding for HIV for 2016. It primarily used DAC CRS data backed up with interviews with key donors. The focus was on aggregate support rather than looking into allocations, uses or focusing on specific target groups.

The Clinton Health Access Initiative (CHAI) – with support from DFID, Sida, Norad, Bill and Melinda Gates Foundation and Irish Aid – has also been carrying out resource mapping exercises in 10 African countries including all the study countries bar Kenya. Very little appears to be publicly available other than a published case study from Malawi[3].

2.2 Country Level Developments

2.2.1 GARPR Reporting

A total of 48 countries had submitted their Global AIDS Response Progress Report (GARPR)[4] reports for 2016. Of these only 6 were from sub-Saharan Africa - none of them were from the study countries.

2.2.2 New Country Strategies

In terms of publicly available information[5] a number of countries have published new health sector strategies6. A quick analysis of their content suggests little emphasis on high-risk groups (although overall health strategies are not necessarily where one might expect great detail on specific interventions). No new approved HIV strategies have been published since the baselines. UNAIDS were able to provide a number of country investment cases (Tanzania, South Africa, Swaziland, and Malawi). Zambia does not have one, having chosen instead to incorporate aspects of the investment approach into it strategic Framework extension. Kenya plans an update of its investment case this year.

Although some of the plans provide projections of needs going forward they do not provide specific details

2 https://www.kff.org/global-health-policy/report/donor-government-funding-for-hiv-in-low-and-middle-income-countries-in-2016/

3 https://clintonhealthaccess.org/case-study-hf-malawi/

4 http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2016countries

5 http://www.nationalplanningcycles.org/

6 Kenya: Health Sector Strategic and Investment Plan (KHSSP) 2013-2017 Draft; Department of Health South Africa Strategic Plan 2015/16 - 2019/20; United Republic of Tanzania Ministry of Health and Social Welfare: Health Sector Strategic Plan July 2015 – June 2020 (HSSP IV) Reaching all Households with Quality Health Care; Zambia National Health Strategic Plan 2017 – 2021; Ministry of Health, Swaziland: The Second National Health Sector Strategic Plan 2014 - 2018 Towards attainment of Universal Health Coverage; Government of Malawi: Health Sector Strategic Plan II (2017-2022)

of spending on KPs, nor do they include any detail of breakdown on past and current spending. Although these documents are not a source of data they do appear to represent a key process in which resource allocation priorities are influenced better data on KP spending would be a useful input to this process.

2.3 Update on Global Fund and PEPFAR Plans

Global Fund Developments

Key populations are receiving increased attention within the Fund. The baseline report described the Key Population Action Plan[7] and plans for internal analyses of Fund spending on key populations.

Since the baseline report there have been a number of important developments including agreement of the 2017-22 Strategy which contains a number of indicators related to KPs, changes in policies e.g. co-financing policy which has strengthened incentives for countries to fund KP programmes from their own sources as well as major progress on the internal data collection exercise. Finally, a process is beginning to align different donors spending classifications. These are described below:

2.3.1 Global Fund Strategy: KP-relevant KPIs

The Global Fund strategy[8] (covering the period 2017 to 2022) retains the promotion and protection of human rights and gender equality as one of its four core objectives. Within this, operational objectives focus on:

- The scaling up of services that remove human rights barriers to access of key services;
- Reduction of health inequalities; and
- Ensuring meaningful participation by key populations and vulnerable forums in all Fund- supported processes.

A number of the key performance indicators (KPIs) for the strategy are directly or indirectly linked to KPs.

KPI 5 (which falls under a separate core objective focusing on service delivery) relates to the coverage of evidence-informed packages of treatment and prevention services to key populations. The Fund recognises the lack of a clear current consensus on what constitutes a comprehensive package of services - what should be covered and how can we describe it as comprehensive - and work is ongoing to look at this.

KPIs 9b and 9c relate to the share of allocations targeting key populations and human rights in middle income countries. This KP distinguishes between countries with local and generalised epidemics and the proportion of funding addressing key populations and human rights barriers in transition countries from domestic (public and private) sources.

Work is ongoing to develop hard targets for all of the KPIs for 2019 - the mid-point of the current strategy.

It is important to note following features of the indicators, which:

- Focus more on middle income countries;
- Do not focus specifically on prevention services;
- Combine service delivery efforts with measures to address human rights barriers; and
- Are focused heavily on the Fund Board's concerns about sustainability in transition countries - notably the risk that civil society programmes can potentially suffer when Fund support ends and go beyond purely financing issues.

In order to report against these indicators, the Fund will have to develop its systems so that it will be able to report more systematically on spending across the Board. As the Fund is generally willing to make data available on request to key stakeholders, it is possible that there is more comprehensive information on spending on KPs, though not publicly available.

7 https://www.theglobalfund.org/media/1270/publication_keypopulations_actionplan_en.pdf

8 https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy_en.pdf

2.3.2 Co-financing policy

The Fund has also amended its counterpart financing policy and now requires that middle income countries spend $6m on KPs from domestic sources for every $10m received from the Fund. Though this is not of specific relevance to the study countries as it is focused on the issue of transition from Global Fund support, it may become important if/when countries in the region move into higher income strategies, or if counterpart funding requirements are strengthened for lower income countries. There is no suggestion that this is likely to take place at present.

2.3.3 Internal Analyses of Planned Spending

The Fund is in the process of analysing planned expenditure for the 2014 to 2016 period - a process which has proved to be exceptionally time consuming - especially given the overhang of old grants into the period review (which is aligned with the introduction of the New Funding Model) - and has not yet been completed. As described in the baseline report, this exercise has involved analysis of both the concept note as well as line by line budget which are not publicly available. This data remains confidential.

2.3.4 New Funding Model (NFM) Allocation 2017-19

Another key driver of potential allocations for HIV prevention for KPs is the overall allocation of resources, which is driven by an allocation formula that underpins the New Funding Model. For the 2017-2019 allocation period, the Global Fund has adopted a refined allocation methodology to support the delivery of its 2017-2022 strategy goals. It ensures an increased proportion of funds go to higher burden, lower income countries and takes account of HIV epidemics among key populations, the threat of multidrug-resistant tuberculosis, and malaria elimination efforts. At the same time, it aims to provide sustainable support to countries where funding is decreasing.

A comparison between allocations through the New Funding Model over the 2014-16 period and that of 2017-19 shows considerable reductions in allocations for HIV/AIDS in absolute terms (with the exception of Tanzania). However, the *share* of country allocations going to HIV is actually increasing in all countries except Zambia (and a small decline in Malawi) (Table 2). Similarly, all countries see their share of the overall global allocation increase between the two periods (Table 3). Thus, one main conclusion is that HIV/AIDS within the study countries has been protected from the large overall falls in allocations.[9]

Table 2: Disease Allocations under the New Funding Model: 2014-16 and 2017-19

Country	Kenya		Malawi		South Africa		Swaziland		Tanzania		Zambia		Overall	
$m	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19
HIV/AIDS	337.3	246.9	474.6	370.8	386.7	317.7	48.5	35.3	407.7	412.5	228.9	184.4	1883.6	1567.6
Malaria	113.1	63.2	86.8	70.7	-	-	5.2	2.6	207.4	150.4	53.3	69.0	465.8	355.9
TB	45	45.5	13.0	9.0	78.1	35.6	26.7	11.9	32.9	27.7	14.5	10.0	210.1	139.7
Grand Total	495.4	355.6	574.3	450.5	464.8	353.3	80.4	49.8	648	590.6	296.7	263.4	2559.6	2063.2
HIV share of allocation	68.1	69.4	82.6	82.3	83.2	89.9	60.3	70.9	62.9	69.8	77.1	70.0	73.6	76

9 It should be noted that part of the reduction reflects the fact that a large amount of funding has been top-sliced from the 2017-19 pot for the Catalytic Fund so we are not exactly comparing like with like.

Table 3: Country Shares of Overall Global Allocations under the New Funding

Country	Kenya		Malawi		South Africa		Swaziland		Tanzania		Zambia		Overall	
	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19	2014-16	2017-19
HIV/AIDS	4.3	4.8	6.1	7.3	5.0	6.2	0.6	0.7	5.2	8.1	2.9	3.6	24.2	30.7
Malaria	2.6	2.0	2.0	2.2	-	-	0.1	0.1	4.8	4.7	1.2	2.1	10.7	11.0
TB	1.8	2.5	0.5	0.5	3.0	1.9	1.0	0.6	1.3	1.5	0.6	0.5	8.2	7.6
Grand Total	3.4	3.5	3.9	4.4	3.2	3.5	0.5	0.5	4.4	5.8	2.0	2.6	17.4	20.3

2.3.5 PEPFAR Planned Spending for 2017 and Actual Spending for 2016

Information presented on the PEPFAR Dashboard and other literature was used for this section.

Planned figures for 2017 suggest that spending on key populations in the study countries would more than double from around $50m in 2016 to almost $110m: thus, more than doubling in the share of support from 3.1% to 6.6%. This implies a significant shift, given that planned country spending was expected to only increase overall by 3.5% from $3.42bn to $3.53bn between 2016 and 2017.

Table 4: Planned Allocation of Resources to HVOP 2015 to 2017

	$m			% of total		
	2015	2016	2017	2015	2016	2017
Kenya	17.3	14.6	42.3	3.8	3.0	8.9
Malawi	3.0	2.1	1.4	3.6	2.4	2.3
South Africa	10.0	4.1	28.0	3.5	1.4	6.6
Swaziland	2.2	2.7	5.8	5.2	5.5	10.9
Tanzania	12.8	13.0	23.0	3.4	3.4	6.4
Zambia	7.0	13.7	9.0	2.4	4.0	3.2
Total	52.3	50.2	109.5	3.4	3.1	6.6

HVOP: Sexual Prevention - Other Sexual Prevention. All sexual prevention programs for key populations fall within this budget code.

In practice, much of this money is spent on the general population (up to 70% of spending on prevention is aimed at the general population in Malawi). Only the *actual expenditure* figures distinguish by individual target group and even here there are problems in assessing trends as categories have changed over time. However, the table below shows total spend on a range of key populations. A detailed breakdown is shown in annex 2.

Table 5: Estimated PEPFAR Expenditure on Prevention Services - Key Populations

$m	2012	2013	2014	2015	2016	Grand Total
Kenya	18.4	18.3	14.7	15.5	18.6	**85.4**
Malawi	N/a	1.3	1.2	0.4	4.9	**7.9**
South Africa	12.8	10.1	6.9	17.7	26.2	**73.7**
Swaziland	N/a	0.9	1.2	3.0	3.5	**8.6**
Tanzania	5.0	14.5	12.0	16.9	21.8	**70.1**
Zambia	2.4	3.2	2.9	8.5	11.2	**28.2**
Total	38.6	48.3	38.9	62.0	86.2	**274.0**

According to its recently published strategy PEPFAR will focus its efforts on 13 high burden countries - Botswana, Côte d'Ivoire, Haiti, Kenya, Lesotho, Malawi, Namibia, Rwanda, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. It will retain its "ongoing commitment to HIV/AIDS investments and efforts in over

50 countries" and ensure that it "will maintain life-saving antiretroviral treatment (ART) for all of the people we support, provide even more services for orphans and vulnerable children, and ensure that the most vulnerable and key populations have access to essential services for preventing and treating HIV".

Budget allocations have been severely curtailed. According to the ONE report[10] the budget allocations entail "a proposed cut of nearly $800 million for bilateral HIV/AIDS support and a $225 million cut for the Global Fund – unprecedented reductions for the two programs" and it argues "(s)igns point to the administration proposing another deadly cut to PEPFAR and the Global Fund for FY 2019". It is not clear how this will translate into country-specific allocations, or key population allocations within those, though the suggestion is that the study countries (with the exception of South Africa) will be afforded some protection in the light of their priority country status. The impact should become clearer in the coming months as Country Operational Plans (COP) are finalised. CoP approval meetings take place in Washington DC in mid April 2018.

2.3.6 Efforts to Align Classifications

PEPFAR and the Global Fund and, to a limited degree, UNAIDS have begun a dialogue at the global level which, amongst other things, aims to align the classifications to allow comparability. The process has not progressed much recently and was described as "doable …. but the world is messy".

2.4 UNAIDS and National AIDS Spending Assessments (NASA) Data

UNAIDS is making renewed efforts to re-energise the NASA process. No new NASAs have been completed in the study countries for some period of time. The most recent NASAs in the region are:

- Kenya 2009/10-2011/12 (published August 2014),
- Malawi 2007/08 and 2008/09 (published April 2010),
- Swaziland 2007-10 (published?),
- South Africa 2007/8-2009/10),
- Tanzania 2005/6 – published November 2008
- Zambia 2010-12 (published July 2014 (draft 3)).

Of the 154 reported NASAs (on UNAIDS website[11]) 75 have been in Africa, with 13 in the study countries.

UNAIDS has recently investigated the potential use of National Health Accounts/ System of Health Accounts as an alternative to NASA's as a way of collecting data on key populations. Whilst this makes some sense from a sector wide perspective - better to get the bigger picture first and then drill down into areas of greater interest - UNAIDS has concluded that such approaches do not present sufficient data granularity for their purposes. For example, a recent Health Accounts exercise in Namibia[12] focused on sources and uses of funds and not on the beneficiaries of the spending.

Thus, renewed efforts are being made to encourage countries to complete NASAs. A workshop was held at the end of 2017 to train consultants. New guidelines and tools will be made available shortly. It is understood that 10 countries in Africa plan to carry out NASAs in 2018 with the aim of establishing a good 2017 baseline. All of the study countries (with the possible exception of Kenya) are included in this list. UNAIDS confirmed that Zambia and Tanzania have included a NASA in the country plans submitted to the NASA country offices.

A number of concerns have been raised related to the burden of the exercise and its focus. Some have questioned the undue focus on sources of funds rather than use of funds (which many in country see as

10 https://www.one.org/us/aids-report/

11 http://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports

12 Namibia 2014/5 Health Accounts, Ministry of Health and Social Services, September 2017

being more important and would be consistent with a greater focus on KPs) and the potential roles for more "quick and dirty" approaches (also described as "NASA-lite" exercises). This view is based on the argument that a lot of useful information can be gleaned with relatively little effort but that the additional costs in following the methodology rigorously yields limited additional benefit. NASAs are seen as an important building block for, and input to, investment cases, which each country is expected to complete.

2.5 WHO-CHOICE: Data on Cost Effectiveness

In the first report on resource allocation to key populations, it was noted that data on allocations had limited usefulness in the absence of information on the cost-effectiveness of the interventions, and suggested that this would be an area for further enquiry.

WHO-CHOICE is in the process of undertaking a full update of tools, databases and cost-effectiveness results. Its website suggests that "new cost-effectiveness estimates and example health benefit packages based on economic efficiency will be published in Q1 2018"[13] and that "the updated country level analysis tool will make developing cost-effectiveness estimates relevant to your research question and geographical area of interest more efficient".

Follow up discussion suggests that the WHO-CHOICE work will cover a range of prevention and treatment services, and that it will not focus on interventions targeting specific populations. Results are imminent - WHO is currently going through a set of validity tests and should be able to consider requests for data sharing very shortly.

The cost-effectiveness data is likely to be of limited use as the figures are based on regional costing. Also, whilst the costing approach does make allowance for marginal costs associated with increased remoteness it does not focus specifically on any (higher) costs, or differences in effectiveness, associated with key populations. Nonetheless, any evidence on the likely cost effectiveness of different types of intervention could still play a useful role in making the case for investment in this area.

UNAIDS staff also pointed out the relevance of work by the Global Health Costing Consortium[14] that maintains a repository of unit cost studies[15] across a range of interventions, many of which focus on key populations.

2.6 Efforts by Other Disease Programmes

Brief discussions with informants suggest little emphasis is placed on tracking expenditure for key populations for other diseases. It is seen as "an HIV thing".

13 http://www.who.int/choice/cost-effectiveness/results/en/

14 https://ghcosting.org/

15 https://ghcosting.org/pages/data/ucsr/app/index

3. DISCUSSION AND Conclusions

3.1 Advantages of the NASA approach

Looking forward, the best chance of getting a comprehensive picture of spending on HIV prevention on KPs continues to be the NASA approach. If completed successfully these should present a good overview of spending levels for a number of identified key populations within the broader perspective of overall spending on HIV. They will not provide an answer to every question policy makers are asking - they have never claimed to do that - and in practice they may generate more refined questions, as often as final answers.

If NASAs are implemented as planned, much better data is likely to be available over the next year. A 2017 baseline will be available for most, if not all, study countries. However, although the methodology should collect the detailed information on KPs the published documents, which may only be available after some time lag, may not disaggregate results to the necessary level of detail. It may therefore be necessary to go back to UNAIDS for specific information unless the raw data is made available (this has not been the case before).

NASAs have the advantage of aiming to capture spending from all sources including domestic funding, and cover a range of KPs, although not the full list set out in this scope of work (see baseline report for more detailed discussion of what NASAs cover).

3.2 Stand-alone KP expenditure assessments

If NASAs do not deliver adequate data there is the option of carrying out stand-alone KP expenditure assessments. These might enable a deeper dive to address some of the additional questions being posed by policy makers e.g. related to the efficiency in allocation and use of resources not covered in NASAs. There is no reason, in principle, why these could not take place. However, they are serious technical undertakings and it is highly questionable whether it makes sense to focus so much limited technical expertise into KPs when they account for so little of overall expenditure, which might be at the expense of broader efforts to assess the effectiveness of HIV expenditure.

3.3 Donor data

PEPFAR data provides a reasonably up-to-date analysis of US spending on country programmes for a subset of KPs. It provides a detailed breakdown of planned and actual expenditure, yet the analysis and comparison over time is difficult as classifications have varied over time and may sometimes have differed between countries. Furthermore, there are ongoing challenges of comparisons between countries and over time in the absence of knowing how much of the PEPFAR funding is spent in country and on service delivery.

It would be possible to interrogate the data further - full Country Operational Plans are available online but are not provided in a very user-friendly way and do not support further analysis. It will be particularly important to do a high-level analysis of the 2018 CoPs to assess the implications of the severe budget turbulence being experienced by PEPFAR just now. This should be possible after the 18 CoPs have been finalised.

It should also be possible to access reasonably good data from the Global Fund going forward. Though the data is not likely to be made publicly available, the Fund is willing to share information with key stakeholders. Detailed portfolio analysis is entering its final stages and should be made public this year. The Fund's increasing focus on KPs - as highlighted in the KPIs supporting its strategy - increases the potential for getting relevant data.

3.4 Issues with national data

One particular advantage of focusing on the key donors relates to the challenges of collecting reliable information on government spending. There are particular problems in assessing spending where services are integrated and where they are decentralised (though these may be entirely appropriate approaches).

Allocating shared costs to particular interventions is challenging (other diseases wishing to track and cost services - especially immunisation - have faced similar challenges).

Fungibility remains an ongoing issue - the fact that governments do not spend on identifiable measures to address the needs of KPs may not signify a lack of interest or support in the area (though it could, of course). Instead, it may reflect governments' reluctance to specifically report spending on KPs in conservative societies, or reflect a perception that this area is covered by donors and that the government budget is spent largely on salaries as donors won't cover such costs. These observations may call into question the usefulness of available expenditure data as a signal of national commitment.

A number of further developments suggest a rather encouraging picture in terms of future access to data. The fact that PEPFAR, the Global Fund and, to a degree, UNAIDS, are attempting to align budget classifications can only help in making it easier to get a more comprehensive picture of spending. However, there will be ongoing challenges with such an exercise. The problems in reconciling spending by Government, PEPFAR and Global Fund in South Africa - a country where budget systems are relatively strong - was highlighted in the baseline report.

3.5 KP data and KP programming

Whilst better information on current expenditure is probably a necessary condition for more informed policy making, especially in relation to allocating resources, it is certainly not a sufficient condition. As noted throughout the process, resource allocation is an intensely political process in which technical inputs play a limited role.

This then begs the question as to where - if financial resources and human capacity is limited - should efforts be focused if one wants to get a good handle on what progress is being made for key populations. Information on spending may actually raise as many questions as it answers. Is it worth investing huge resources in getting state of the art figures on spending when the figures have relatively little meaning given the huge gaps in knowledge we face elsewhere? For example, do we know if spending $10m on an intervention aimed at MSM makes sense if we have little or no idea of the size of the target population? What do we compare it against in the absence of a defined package of essential services, which might be defined according to the size of countries' health budgets and according to the nature of the epidemic (whether generalised or focused on high risk groups)?

Indeed, as the Global Fund data suggests, we cannot assume that more spending is automatically better (with the finding that higher income countries are spending a higher a share of HIV budgets on KPs than lower income ones).

One informant reflected on the need to know which interventions become worthwhile in which circumstances. Equally, knowing how much is being spent gives us little idea of the constraints to future progress - whether it is specific financial constraints or whether there are more systemic human rights barriers. Another informant reflected on their lack of knowledge about the contributions KPs in Africa make to the epidemic, contrasting this with their very different experience in Asia. Thus, future resource tracking must also look into cost effectiveness and unit costs, the progress in terms of improving services coverage and outcomes as well as eliminating non-financial barriers and glaring data gaps such as population size.

3.6 Conclusions

The above discussion leads to two main conclusions about resource tracking on HIV prevention in relation to key populations. First, future resource tracking might look at some of the other outstanding data gaps, which can help make sense of any improved data on spending, before moving to a "state of the art" type approach to resource tracking or more "quick and dirty approaches" to resources tracking might make sense at least in the short term.

Secondly, the question does remain as to whether it makes sense to approach the problem from an HIV/KP perspective through NASAs/ 'NASA-lite", whether it is best to do it through a sector perspective using NHAs as the basis but build on these to do deep dives into areas of greatest policy relevance (which may or may not include KPs) or whether stand-alone KP specific approaches are the best way forward.

To sum up, this review began with a focus on using publicly available information to get a comprehensive picture of expenditure on KPs as an important input to the decision-making process. The analysis and discussions that have taken place as part of this work suggests that:

- Publicly available data provides no basis for getting a clear picture on resource flows particularly for KPs;
- Lack of information on spending levels is just one of many important information gaps and not necessarily the most important one;
- It will be important to track progress with ongoing efforts to better track spending e.g. NASAs, PEPFAR dashboard, Global Fund reports; and
- There is need for greater clarity on the key information gaps that prevent more rational resource allocation and, having acquired this, a need to consider the best ways of accessing this information.

ANNEXES

Annex 1: Scope of Work

The scope of work for this topic will examine the following issues:

- Tracking Global Fund and PEPFAR spending plans and specific efforts to better capture data on KPs;
- Renewed efforts to try and access NASA data from UNAIDS/understanding why it is not available, and obtaining assessment of the quality and usefulness of the NASA KP data at global, regional and country level;
- Accessing updated figures on the cost effectiveness of interventions through the WHO CHOICE model;
- A rapid assessment of how other disease programmes have tried to identify spending on key populations (e.g. malaria/immunisation);
- To acquire a better understanding of whether the key stakeholders really perceive a need to strengthen information on spending on KPs (as a basis for possible follow on work in 2018); and
- Make recommendations of the best methodology for use in 2018 to assess trends and adequacy of KP program resourcing and resource tracking, in light of new PEPFAR, GF and UNAIDS system and other developments. This could be in the form of some commentary on trends and perceptions related to Dutch, SIDA and other smaller donor allocations to KP funding (and maybe some more telephonic interviews with people in the ESA region).

All Donors - Disbursements - 2015 Constant $m

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	% inc 2016 over 2015
Kenya	241.7	345.9	407.2	422.0	472.8	581.4	629.5	504.4	463.2	533.0	15.1
Malawi	148.1	144.8	151.6	123.4	134.6	156.7	143.8	148.2	154.7	123.1	-20.4
South Africa	302.0	458.3	611.0	603.1	610.0	603.0	554.7	581.7	336.2	464.0	38.0
Swaziland	19.5	21.2	27.7	57.1	59.9	47.2	55.8	44.9	41.3	73.8	78.6
Tanzania	217.5	303.5	268.6	373.0	365.1	381.1	463.1	431.0	269.9	435.1	61.2
Zambia	157.3	268.6	235.6	228.6	294.4	286.3	271.0	302.0	162.0	217.6	34.4
Total	1,086.1	1,542.3	1,701.7	1,807.2	1,936.9	2,055.8	2,117.9	2,012.2	1,427.3	1,846.7	29.4

Annex 2: DAC CRS Data

US - Disbursements - 2015 Constant $m

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	% inc 2016 over 2015
Kenya	191.8	292.4	357.3	347.8	414.4	492.2	537.2	440.2	359.9	448.3	24.5
Malawi	28.5	24.8	28.9	40.9	59.6	71.6	70.2	77.6	55.4	83.4	50.5
South Africa	219.8	380.3	538.9	532.4	550.2	476.7	440.7	479.1	294.6	432.5	46.8
Swaziland	2.9	7.9	14.7	22.6	44.4	42.2	36.5	41.3	32.3	50.8	57.0
Tanzania	118.4	172.2	194.2	264.0	273.0	272.2	292.9	298.8	239.9	281.7	17.5
Zambia	108.3	168.4	171.4	179.8	203.4	212.9	193.0	232.7	155.2	194.0	25.0
Total	669.7	1,046.0	1,305.5	1,387.6	1,545.0	1,567.7	1,570.4	1,569.7	1,137.4	1,490.8	31.1

Global Fund - Disbursements - 2015 Constant $m

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	% inc 2016 over 2015
Kenya	21.4	17.5	15.7	23.4	5.2	53.4	65.3	55.1	97.7	80.3	-17.8
Malawi	62.0	54.8	55.9	41.6	48.8	61.8	54.5	66.0	94.9	36.3	-61.7
South Africa	33.5	43.5	24.7	41.0	18.1	92.4	78.4	82.2	26.4	8.2	-68.9
Swaziland	13.6	10.0	10.4	32.2	12.8	2.8	16.7	2.1	7.4	21.6	193.6
Tanzania	41.9	95.7	45.4	85.4	72.4	91.3	156.4	122.5	22.6	148.1	554.7
Zambia	18.4	78.1	43.3	35.1	78.2	65.7	68.4	62.0	-	18.8	#DIV/0!
Total	190.8	299.6	195.3	258.6	235.5	367.6	439.8	389.8	249.0	313.4	25.9

% US

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Kenya	61.7	67.8	76.7	76.8	79.8	76.3	74.1	78.0	79.7	80.7
Malawi	79.3	84.5	87.7	82.4	87.6	84.6	85.3	87.3	77.7	84.1
South Africa	19.2	17.1	19.1	33.1	44.3	45.7	48.9	52.3	35.8	67.7
Swaziland	72.8	83.0	88.2	88.3	90.2	79.0	79.5	82.4	87.6	93.2
Tanzania	14.7	37.2	53.2	39.6	74.2	89.5	65.3	92.0	78.3	68.9
Zambia	54.4	56.7	72.3	70.8	74.8	71.4	63.2	69.3	88.9	64.7

% Global Fund

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Kenya	17.6	19.4	11.5	14.3	12.2	17.9	20.8	19.4	17.4	17.0
Malawi	8.9	5.0	3.8	5.5	1.1	9.2	10.4	10.9	21.1	15.1
South Africa	41.8	37.9	36.9	33.7	36.2	39.4	37.9	44.5	61.3	29.5
Swaziland	11.1	9.5	4.0	6.8	3.0	15.3	14.1	14.1	7.8	1.8
Tanzania	69.7	47.3	37.4	56.4	21.4	6.0	29.9	4.7	17.8	29.3
Zambia	19.3	31.5	16.9	22.9	19.8	24.0	33.8	28.4	8.4	34.0

% US or Global Fund

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Kenya	79.2	87.2	88.2	91.1	91.9	94.1	94.9	97.4	97.1	97.7
Malawi	88.2	89.6	91.6	88.0	88.8	93.8	95.7	98.2	98.8	99.2
South Africa	61.1	55.0	55.9	66.8	80.5	85.1	86.8	96.9	97.1	97.2
Swaziland	83.9	92.5	92.2	95.1	93.2	94.4	93.6	96.5	95.5	95.0

Tanzania	84.4	84.6	90.5	96.0	95.5	95.5	95.2	96.7	96.2	98.2
Zambia	73.7	88.3	89.2	93.7	94.6	95.4	97.0	97.8	97.2	98.8

Annex 3: PEPFAR Planned and Actual Expenditure

	Kenya	Malawi	South Africa	Swaziland	Tanzania	Zambia
Care	55.6	10.5	125.3	21.1	43.3	53.8
Governance and Systems	41.1	3.9	37.5	2.5	16.9	18.8
Prevention	128.0	8.7	106.1	16.2	109.1	38.2
Treatment	252.1	38.8	155.7	13.2	190.6	171.8
Total	476.8	61.9	424.7	53.0	359.9	282.6

	Kenya	Malawi	South Africa	Swaziland	Tanzania	Zambia
Prevention	128.0	8.7	106.1	16.2	109.1	38.2

	Kenya	Malawi	South Africa	Swaziland	Tanzania	Zambia
CIRC	10.92		25.62	3.96	19.69	5.61
HMBL	2.50	0.95		0.30	0.76	
HMIN	1.50					
HVAB	3.84	2.14	4.97	0.61	2.59	0.05
HVCT	41.75	3.21	31.80	4.79	45.62	13.86
HVOP	42.27	1.45	28.04	5.79	22.98	8.98
IDUP	2.21		0.07		2.16	
MTCT	23.03	0.96	15.65	0.73	15.26	9.71
	128.01	8.71	106.14	16.18	109.06	38.21

	Kenya	Malawi	South Africa	Swaziland	Tanzania	Zambia
Prevention as % of Total	26.8	14.1	25.0	30.5	30.3	13.5
HVOP as % of Prevention	33.0	16.6	26.4	35.8	21.1	23.5
HVOP as % of Total	8.9	2.3	6.6	10.9	6.4	3.2

Budget Code	
CIRC	Voluntary Medical Male Circumcision
HMBL	Blood Safety .
HMIN	Injection Safety .
HVAB	Sexual Prevention - Abstinence/Be Faithful
HVCT	HIV Testing and Counselling .
HVOP	Sexual Prevention - Other Sexual Prevention All sexual prevention programs for key populations fall within this budget code.
IDUP	Injecting and Non-Injecting Drug Use
MTCT	Prevention of Mother to Child Transmission

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