



**KENYA NATIONAL AIDS SPENDING ASSESSMENT  
REPORT FOR THE FINANCIAL YEARS  
2009/10-2011/12**

**FINAL REPORT**

**AUGUST 2014**



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## **LIST OF ACRONYMS AND ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
ARVs	Antiretroviral Drugs
ASC	AIDS Spending Category
BAS	Basic Accounting System
BCC	Behaviour Change Communication
BP	Beneficiary Population
CBO	Community-Based Organisation
CDC	(US) Centers for Disease Control and Prevention
CSO	Civil Society Organisation
DfID	Department for International Development (UK)
ENE	Estimates of National Expenditure
ES	Equitable Share
FA	Financing Agent
FBO	Faith-Based Organisation
FS	Financing Source
GFATM	Global Fund for AIDS, Tuberculosis and Malaria

HCT	HIV Counselling and Testing
HDI	Human Development Index
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
HTA	High Transmission Area
IDU	Intravenous Drug User
IEC	Information, Education and Communication
IGA	Income Generation Activities
LSA	Local Service Area
M&E	Monitoring and Evaluation
MARP	Most-at-Risk Population
MOT	Modes of Transmission
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
MTEF	Medium-Term Expenditure Framework
MTP	Medium-Term Plan (of Vision 2030)
NACC	(Kenya) National AIDS Control Council
NASA	National AIDS Spending Assessment
NDPs	National Development Plans
n.e.c.	not elsewhere classified
NGO	Non-Governmental Organisation

NASP	National AIDS Strategic Plan
OECD	Organisation for Economic Co-operation and Development
OIs	Opportunistic Infections
OOPE	Out-of-Pocket Expenditure
OOP	Out-of-Pocket
OPEP	Occupational Post-Exposure Prophylaxis
OTC	Over-The-Counter (medications purchased without a prescription)
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PF	Production Factor
PITC	Provider-Initiated Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnerships
RTS	Resource Tracking System
SES	Socio-Economic Status
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis

UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly on HIV/AIDS
USA	United States of America
USAID	United States Agency for International Development
US\$	United States Dollars
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization

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Finally, I would like to thank the Consultant namely, Centre for Economic and Social Research (CESR) for conducting the KNASA survey. The survey report will guide the drafting of the Kenya National AIDS Strategic Plan (KNASP IV) 2014/15–2017/18. It is my hope that this report will assist in planning and budgeting for the national response to HIV and AIDS at both national and county governments.

The NACC in partnership with stakeholders will endeavour to institutionalize the NASA process so that reporting expenditures on HIV and AIDS becomes routine. This will go a long way in assessing whether the prioritized HIV and AIDS interventions are being implemented, shed light on beneficiary population(s) and document costs of interventions being implemented.

Dr. Nduku Kilonzo

**DIRECTOR**

## **PREFACE**

The Government of Kenya its development partners remain at the forefront in the efforts to move towards universal access to HIV prevention, treatment, care and support in Kenya. Annual HIV incidence is estimated at 91,000 new infections in adults and 13,000 paediatric due to vertical transmission. The high burden of HIV and AIDS in Kenya accounts for an estimated 29% of annual adult deaths, 20% of maternal mortality and 15% of deaths of children under five years old. The epidemic has also negatively affected the country's economy by lowering per capita output by an estimated 4.1%. Stable and married couples are the most affected as this group accounts for 44% of the new adult infections.

A prioritized response to the national response is informed by an evidence-based understanding of where effective services are needed most urgently. Thus, a comprehensive, scaled-up HIV prevention response is needed to avert more new infections from occurring. The Kenya National AIDS Spending Assessment (KNASA) is aimed at assisting the National AIDS Control Council in the Ministry of Health to monitor these scarce resources for HIV and AIDS, taking into account not just the health components, but also education, social protection services, and others, in order to evaluate and quantify the multisectoral approach of the national AIDS response.

NASA will help to identify funding gaps and duplication of funding in the national response to HIV epidemic. Unless new infections can be prevented, future treatment costs will continue to mount. Similarly, access to treatment is critical in order to avert productivity losses and alleviate the epidemic's impact on the economy and human development. Given the many challenges that need to be overcome in providing HIV services, high levels of funding will be needed to move towards universal access in the coming years. It is therefore imperative to have a clear knowledge of what is being spent on HIV and AIDS, in order to ascertain if the expenditures are targeted to the most cost-effective interventions. Knowledge of the total actual expenditure for the national response promotes greater transparency and accountability to the public and to donors.

In 2013, the Government of Kenya through the National AIDS Control Council (NACC) in the Ministry of Health committed itself to undertaking a comprehensive National AIDS Spending Assessment of public, international and private HIV-related expenditure.. This report provides expenditure estimates of overall HIV spending in the country for the years 2009/10–2011/12, and will be of much value to the National AIDS Control Council (NACC) in the Ministry of Health h (MOH), as well as the stakeholders who are interested in understanding the financial flows of the national AIDS response.

## **EXECUTIVE SUMMARY**

### **Purpose**

The National AIDS Control Council (NACC) commissioned National AIDS Spending Assessment (NASA) in September 2013. The purpose of the assessment was to establish the level of the resources used in the fight against HIV and AIDS epidemic in three fiscal years 2009/10, 2010/11, and 2011/12. The assessment characterized the flow of funds from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the epidemic. The outputs from this exercise informed the costing of the new Kenya National AIDS Strategic Plan IV (KNASP IV). The results also provided inputs in the investment case for the country.

### **Methodology**

The NASA focused on tracking actual HIV and AIDS expenditure from public, international (bilateral and multilateral) and private sources. Specifically, major financing sources supporting HIV and AIDS were included in the study, consisting of Clinton Foundation; United Kingdom Agency for International Development (UKAID) formerly Department for International Development (DfID); Joint United Nations Programme on AIDS, United States Government (USG- President's Emergency Plan for AIDS Relief (PEPFAR); GFATM; and Government of Kenya.

In addition to the financing sources, a representative sample of financing agents was selected purposively including United Nations Joint Programme on HIV and AIDS consisting of UNAIDS secretariat, WHO, UNHCR, UNICEF, WFP, (UNFPA), UNODC, ILO, UNESCO, AMREF, Red Cross, Care International, Population Service International (PSI), National Treasury (Ministry of Finance) . Main agents of the PEPFAR were not surveyed since the data on expenditure by USG was provided directly from the source. However, the expenditure by agents was not provided. NACC was also surveyed.

All the government ministries and NGOs providers (362) were surveyed to provide data on HIV and AIDS spending.

The initial data collection focused on the sources of funding for HIV and AIDS and financing agents. This stage was estimated to last for two weeks but lasted for one and half months. Data collection from UN Agencies took long time, lasting up to January 2014. This notwithstanding, only four UN agencies provided the data. Data on PEPFAR expenditure was sought directly. The PEPFAR expenditure analysis for 2012 was provided. However, PEPFAR country budgets figures for the years 2010 and 2011 were used to estimate the level of expenditure by USG. In the analysis, the entire budget figures for 2010 and 2011 were used.

Data collection from county level took period of 4 weeks in September 2013, focusing on service providers. Data collected included expenditure on AIDS spending categories and factors of production.

Data analysis consisted of was carried out in a number of steps consisting of estimation of indirect expenditure by government, estimation of out-of pocket expenditure, disaggregation of USG expenditure for 2010 and 2011, entry of the all into Excel processing files, and entry into resource tracking tool (RTT).

## **Results**

The results of the analysis The results show that total expenditure on HIV and AIDS interventions in Kenya increased from Kshs 64,338 million (US\$ 826 million) in 2009/10 to Kshs 70,388 million (US\$ 853 million) in 2010/11, representing an increase of 9% from the 2010/11 expenditure estimates. In 2011/12, the expenditure declined slightly to Kshs 69,750 million (US\$ 786 million) due a slight decline in USG and CHAI funding. The total expenditure over the three-year period amounted to Kshs 204,476 million (US\$ 2,466 million). The results indicated that the bulk of the expenditures on HIV/AIDS in Kenya came from international sources accounting for about 62% during the period. Government of Kenya is the second largest source of financing of the HIV response contributing about 16%. Households, through the out-pocket expenditure, accounted for about 13% of the total expenditure same period. International not-for-profit organisations and foundations, private sector, GFATM, UN agencies and accounted for 4%, 1.9%, 1.7% and less than 1% respectively of the total spending over the three year period. It is therefore evident that the majority of financing for activities and programmes related to HIV and AIDS is accounted for by external sources.

International purchasing organization as agents accounted for over 56% of funds. The public sector agents accounted for between 25% and 27% while local private organizations managed between 16% and 19% of the total funds. Specifically, international not-for-profit organizations managed the largest share (between 49% and 53%), followed and Ministry of Health (between 16% and 18%) and households (about 13%). The share of funding managed by the National AIDS Commission accounted for 3% over the three years under consideration.

The public sector remained the largest service provider, accounting for about 50% of the total expenditure. Private sector providers took the second largest share (about 28%) of the expenditure. Bilateral and multilateral agencies spent 7% of the total amount in each of the years. In terms of the priority interventions, the bulk of the expenditure went to care and treatment (54%), followed by prevention (20%) and programme management and administration (12%) and OVC (6%).

People Living with HIV/AIDS (PLWHA) accounted for about 54% of the expenditures as a beneficiary population. Non-target intervention was the second largest (15%) beneficiary population followed by general population (11%). The percentage to most at risk population was very low at 0.22%. Recurrent expenditure took about 96% with capital expenditure accounting for about 4% of the total expenditure. Overall, labour income accounted for the largest percentage (20%), followed by drugs and pharmaceuticals (15%), and ARVs (13%).

## **Conclusion**

External resources continue to dominate HIV/AIDS financing in Kenya. The fact that development partners' account for a lion share should be a major concern to the country as this raises issues of sustainability. However, government contribution has been increasing over time though most of it is indirect.

## **Recommendations**

### **(a) Allocative Decisions for Greatest Investment**

The NASA results show that generally the impact interventions consisting of behaviour change activities, ART, PMTCT, and male circumcision received significant funding in the period under consideration. However, other high impact interventions such as prevention activities on MARPs and prevention through treatment for discordant couples received less attention in terms of the expenditure. Furthermore, low impact intervention such as VCT received significant resources. It is recommended that the country should target resources towards high impact interventions that which maximize benefits.

### **(b) Sustainable, Transparent, Accountable and Aligned Funding**

As indicated in analysis, bulk of the spending on HIV response was attributed to external sources. However, contribution by government has been increasing over the years. It is recommended that government should continue to increase its contribution of improve sustainability. Although NACC has undertaken analysis possible sustainable options for financing the response, there need to actualize some of these options for sustainability purposes.

Although country comparisons were not done, there is a strong need to consider the cost-effective of funds from different sources. Additionally, the funding from all the sources should be aligned to priority areas. All these would require transparency and accountability of all those involved in the flow of funds

### **(c) Improving Financial Management Capacity and Systems**

The results of qualitative analysis revealed that financial management capacities of the organizations involved in service delivery at the local level were very low. This is constraint in service delivery which may seriously reduce the impact of the interventions. It also affects efficiency in service delivery.

### **(d) Institutionalising Routine Expenditure Tracking**

It was recommended in the previous NASA, institutionalization of NASA is critical. This is because data availability routine would assist the country to assess the performance of the response on regular basis. This is also a key component in monitoring whether funding is aligned to the priority interventions and if not aligned corrective measures can be put in place.

Institutionalization is also needed given the creation of counties in which social services have been devolved. Each county will need to carry its own NASA and there it will be cost effective to build their capacities to enable to collect data expenditure routinely for policy decisions.

(e) Additional Research

Expenditure on research was minimal and came from bilateral sources. It is recommended that more funding be provided for HIV related research.

## **CHAPTER ONE: INTRODUCTION AND BACKGROUND**

### **1.1 Background**

In accordance with the Declaration of Commitment on HIV/AIDS the UN member countries submit reports on progress achieved in the response to the epidemic. One of the key indicators included in the reports on the implementation of the Declaration of Commitment at the national level is the assessment of the amount of national funds allocated by the government to address HIV/AIDS, indicator No. 1. In Kenya, the motivation of undertaking the National AIDS Spending Assessment (NASA) is to improve financial monitoring of HIV and AIDS programmes and activities and to better understand the spending patterns for HIV related activities. In addition, analysis of the sources, financing agents, providers and overall financial flows of funding is important in informing policy makers and planners on how to improve allocation of financial resources for HIV and AIDS. Furthermore, tracking expenditures for the response to the AIDS epidemic is a prerequisite for an effective and rational allocation of domestic and international funding towards those interventions that will have an optimal impact. Thus, as the country devolves service delivery to the counties, accurate data on HIV and AIDS resource flows and expenditures will be required for to guide the national response both at national and county levels.

In light of the above context and building on the previous National AIDS Spending Assessment (NASA) conducted in 2009, the National AIDS Control Council (NACC) with support from UNAIDS and other stakeholders commissioned this NASA whose findings will go a long way in informing KNASP IV development.

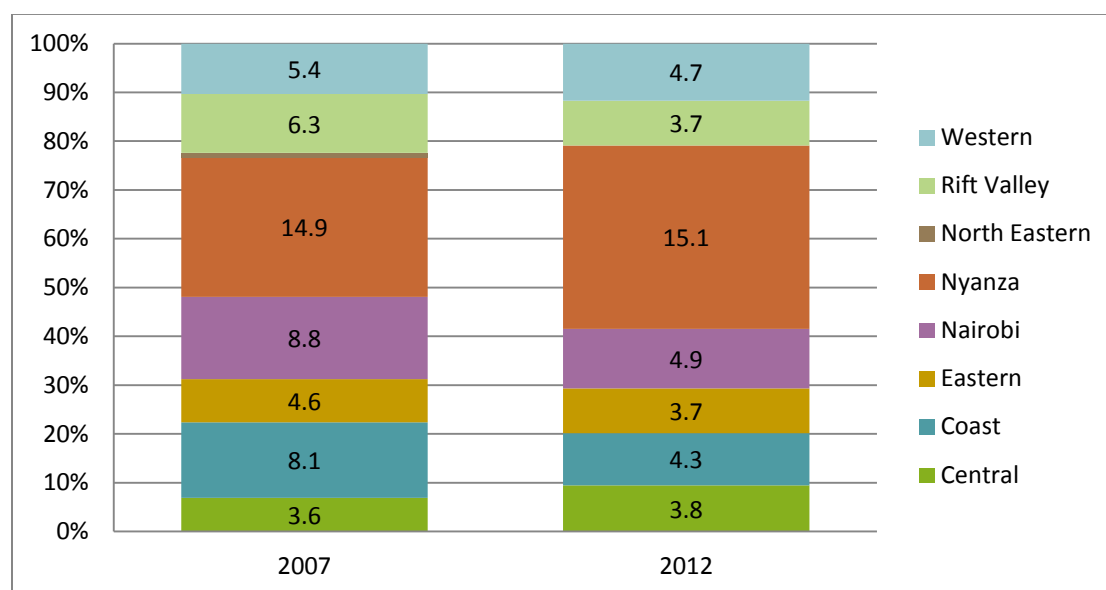
## 1.2 Country Socio-Economic Indicators

### Basic information about the country

Population size (millions) (2010)	40.5
Population density (number of people per square kilometer) (2010)	71
Proportion (%) of people living below the poverty line (2010)	46%
Proportion (%) of total population living in urban areas (2010)	23.6%
Proportion (%) of urban residents living in slum settlements (2007)	55%
Total Fertility Rate (average number of children borne per woman) (2008)	4.7
Annual population growth rate (%) (2011)	4.6
Urban population growth rate (avg. annual %) 2005-2010	4.0
Rural population growth rate (avg. annual %) 2005-2010	2.3
Urban population (%) 2007	21.3
Population aged 0-14 years (%)2009	42.8
Population aged 60+ years (women and men, % of total) 2009	4.4/3.8
Life expectancy at birth (women and men, years) 2005-2010	54.5/53.7
Education: Government expenditure (% of GDP) 2005-2008	7.0
Education: Primary-secondary gross enrolment ratio (w/m per 100) 2005-2008	85.0/88.7
<b>Economic Indicators</b>	
GDP growth (2013)	4.6
Per capita Gross National Income (2011)	\$820
<b>Distribution of poverty</b>	
Central province	30.3%
Nyanza	47.9%
Rift Valley	49.7%
Eastern	51.1%
Western	53.2%
Coast	69.7%
North Eastern Province	74.0%

### 1.3 HIV /AIDS Situation in Kenya

Kenya is experiencing a mixed and geographically heterogeneous HIV epidemic with characteristics of both a ‘generalized’ epidemic among the mainstream population, and a ‘concentrated’ epidemic among specific most-at-risk populations (MARPs). The epidemic is geographically diverse (see figure 1.1). Overall there has been a decline in HIV prevalence, from 7.2% reported in 2007 to 5.6% reported in 2012 (KAIS, 2012). The prevalence is higher among women aged 15 to 64% (6.9%) compared to men in the same age group (4.4%). However, figure 1.1 shows a general decline in HIV prevalence between 2007 and 2012.



**Figure1.1: HIV prevalence among persons aged 15-64 years by region, KAIS 2007 and 2012**

According to KAIS 2012, high-risk sexual and drug-using behaviour was low at 0.1%. The pattern emerging in Kenya is of highly variable epidemiological dynamics, geographically with respect to modes of transmission, and with substantial age and sex differentials. Kenya has a variety of localized HIV epidemics across the country, with diverse causes and outcomes. This pattern presents the following particular challenges with respect to the epidemic among the general population:

- *High levels of HIV within marriage/regular partnerships:* the high sero-status discordance rate suggests that marriage may well be a ‘high risk’ situation with variable patterns of initial introduction of HIV into the union. Social norms regarding relationships, gender roles/imbances, stigma and discrimination, fear and risk-perception, and fertility intentions present difficult prevention challenges. In addition, apart from testing, ‘discordant couples’ are virtually impossible to identify and target with services.
- *Paediatric HIV infections due to vertical transmission:* a continuing high incidence of paediatric infection, due mainly to inefficient, inaccessible, or underutilized Prevention of Mother to Child Transmission (PMTCT) services, also constitute a particular challenge. Paediatric HIV infection contributes directly to infant and young child mortality, complicates child malnutrition, and requires lifelong and expensive treatment. Children on HIV treatment that survive to adolescence and adulthood face the additional challenge of forming relationships without transmitting their vertically acquired infection horizontally.
- *Gender dimensions of the epidemic:* the ‘feminization’ of the epidemic is apparent with prevalence among women (8.8%/15-49 and 8.4%/15-64) significantly higher than among men (5.5%/15-49 and 5.4%/15-64). While prevention programmes among young people have contributed in delaying sexual debut and increasing risk perception, for young women who are already sexually active, prevention programmes have generally failed to make a difference.
- *Mismatch between service provision and geographical prevalence:* approximately 70% of PLHIV live in rural areas, but services are concentrated in urban/peri-urban areas. Where optimal prevention is service delivery-mediated, access to such services is a problem.
- *Low levels of knowledge about HIV status:* only 36% of Kenyan adults (15-64) have tested at least once for HIV and received results. However, an estimated 80% of HIV infected people do not know their correct status, and testing rates show little difference across provinces, despite large geographical variation in prevalence. HIV testing rates are higher among

women (43%) compared to men (25%).

- *Improving still low levels of condom use:* while condom use among higher-risk sex shows some positive progress for both women (23.9% in 2003 KDHS, and 35% in 2007 KAIS) and men (46.5% - 51.8%), it remains low.
- *Treatment, care and nutrition:* only 38-45% of those in need of treatment are being reached at present, with coverage for children much lower, at about 15%. Up to 300,000<sup>1</sup> Kenyans are still at the risk of dying due to lack of access to treatment.
- *TB-HIV:* Despite that fact that 80% of TB patients are being offered HIV testing and 80% of TB facilities provide HIV testing; only 27% of HIV positive TB patients receive ART.

Challenges among MARPs include:

- *Overall lack of data about a number of such populations:* it is difficult to target services effectively when so little is known about these populations. Sex workers, with relatively high HIV prevalence among them, are widespread in urban centres and along major transport routes, but attempts to accurately quantify the population size have so far been unsuccessful. KNASP III uses the latest model default estimates to arrive at 80,000 sex workers for planning purposes. Multiple concurrent partnerships are common, and MSM are not a negligible population in Nairobi, but real numbers for both are unknown. IDU is increasing in Kenya, but again, while a United Nations Office of Drug Control (UNODC) study conducted in 2004 estimated HIV prevalence among injecting drug users in Nairobi, Malindi and Mombasa to be 68%-88%; real numbers and distribution are unknown.
- *Criminalization of these groups' high risk behaviours:* sex work, homosexuality and drug use are all illegal in Kenya, and attempts to de-criminalize them have faced significant religious

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<sup>1</sup> Latest figures from WHO.

and cultural resistance among the population. However, based on new evidence<sup>2</sup>, KNASP III will work with all most at risk groups and seek innovative ways to reduce HIV transmission. Programmes have been working with all these groups for many years, but under constraints, which KNASP III systematically aims to alleviate.

- *Marginalization of such populations from standard ‘services’ – especially in the public sector:* as in many societies, many service providers find it difficult to provide non-stigmatizing services to clients perceived to be practicing illegal behaviours.
- *Denial and social intolerance of many such populations:* this leads to a reluctance to prioritize interventions and services aimed at MARPs, even among professional planners and policy-makers.

There is clearly a wide epidemiological diversity for the epidemic to be classified as both general and concentrated. It affects all sectors of the country and is more of a developmental than epidemiological challenge, encompassing identification and development of a series of appropriate sectoral responses, and their application at the local level.

#### **1.4 Key drivers of the epidemic**

Full understanding of the drivers of the epidemic in Kenya remains limited. However, the KNASP III is based on assessments of vulnerabilities at both ‘macro’ and ‘micro’ levels. At the ‘macro’ level, many of the underlying vulnerabilities that contribute to the spread of HIV remain strong. Kenya remains a deeply unequal nation in terms of disparities of income, gender norms, roles and relations, and geographic location. While the country has seen marginal declines in poverty in recent years, large income disparities remain, and are becoming exacerbated. Despite weak evidence of links between poverty and HIV risk, socio-economic disparities lead to social exclusion – the denial of population groups (e.g. women) of their full voice and agency within communities and the society – with stronger apparent correlation.

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<sup>2</sup> MoT Study 2008; KAIS 2007, 2012

In the context of the Kenyan HIV epidemic, indications of specific deprivation among the urban poor and women are clear: lack of access to social capital; lack of control of human capital, rights, assets and information; and, the denial of entitlements to inheritance and to equality of opportunity, e.g. for education and care. The HIV epidemic has also deepened elements of deprivation in the context of embattled social relations, and it has also challenged social capital networks<sup>3</sup>. Social exclusion limits, and sometimes entirely prevents, people's voice and participation within their communities in shaping, implementing, monitoring and evaluating actions that are likely to have considerable impact on their own lives.

Such social exclusion compounds vulnerability to infection. For instance, if widows or orphans are disinherited and become landless, they may be forced to undertake high risk activities, such as transactional or commercial sex work. Widows disinherited by their husband's kin may see early marriage to an older man, perhaps as a second or third wife, as the only option to escape destitution. People's capabilities and entitlements become compromised in situations of social exclusion, and they become less able to make considered decisions and choices. Equity and rights-focused approaches require that interventions promote social inclusion.

Kenya has a significant demographic problem: a large youth population, high population growth with rapid urbanization and growth of informal settlements. Young people aged 15-35 represent 38% of the population and the current 11 million young people in this age group are expected to increase to 16 million by 2012. Over 60% of new HIV infections are among this age group, yet the dynamic of this demographic challenge is in danger of being ignored as new cohorts of young people are constantly becoming sexually active. Young people will require support to prevent new HIV infections, and to have effective and equitable access to sexual and reproductive health services (NCPAD, 2006).

Nationally some 20,000 secondary school students graduate each year and these young people represent a key cohort for behaviour change communication (BCC) and character formation. Out-of-school youth (data on numbers is not available), especially young out-of-school women,

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<sup>3</sup> Cf. *Pulling Apart: Facts and Figures on Inequality in Kenya*, Society for International Development, Nairobi, 2004.

represent an even harder to reach group in terms of BCC, character formation and peer education. It is estimated that only 12% of public health facilities offer what can be defined as youth-friendly services. Provision of genuinely youth-friendly (particularly ‘girl-friendly’) and integrated sexual and reproductive health (SRH), family planning (FP) and HIV services is perceived by the MoH, NACC and other key actors such as the National Coordination Agency for Population and Development (NCPAD) as of critical importance with regard to reducing HIV prevalence rates among young people aged 12-24, and especially girls and young women in that age range.

Data from the Ministry of Trade (MoT) and KAIS studies make it clear that the HIV epidemic remains strongly associated with cultural patterns of life in Kenya: the two main determinants of HIV infection are male circumcision<sup>4</sup> and societal acceptance of concurrent multiple partnerships. The first, lack of male circumcision, is mainly limited geographically to certain areas, and would appear to present a challenge mainly in terms of massive service delivery problem. The second is still deeply rooted in a number of widely-held socio-cultural norms.

At the ‘micro’ level, it is evident that many Kenyans have changed their individual behaviour, the age at sexual debut and of marriage have risen, and condom use has increased significantly. However, while much has changed, much still remains the same. Many of these challenges remain, particularly those that relate to the position of women. Gender disparities in Kenya are high: prevalence among adolescent girls aged 15-19 is six times that of men (3% of all young women in that age group, as compared to less than 0.5% of young men); among young women aged 20-24 the prevalence rate is 9% as compared to 2% in young men. Kenyan girls’ and women’s vulnerability to HIV infection can be gauged by such statistics as 28% of men aged 15-49 believe that a woman has no right to request that a man use a condom, and only 24% of women aged 15-49 who reported having sex with a man other than a spouse or regular/cohabiting partner within the past twelve months had been able to request condom use (KDHS, 2003). Women’s vulnerability is therefore compounded by a male dominated society, whose sexual beliefs are not always scientifically correct. A particular concern is for young

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<sup>4</sup>While male circumcision is a common practice in Kenya with 84% of adult men having been circumcised, the practice is much lower among specific groups, such as the Luo, Turkana and Teso.

married women, who may have even less opportunity to negotiate safe sex than young unmarried women - many are deemed to have minimal room to manoeuvre to discuss their husbands' (in) fidelity. Indeed, infection rates are higher among young married women than among unmarried women of the same age.

### **Sources of new infections**

The prioritized response in KNASP III is informed by an evidence-based understanding of where effective services are needed most urgently. The MoT study reviewed the epidemiology of HIV in Kenya, based on the data available, including the latest KAIS data. The MoT modeling estimated that some 76,000 new infections occurred in 2006, bringing the total number of adults aged 15-49 infected with HIV to 1.2 million. A subsequent Spectrum model estimated the number of infected adults in 2009 at 1.5 million. The national epidemic is geographically diverse, however, with a particularly high prevalence in Nyanza Province<sup>5</sup> (14.9% - with 26% prevalence in Suba District and 19% in Kisumu), and higher than the national average in Nairobi (8.8%) and Coast Province (8.1%). Overall, the annual HIV incidence is estimated at 162,000 (130,000 new infections in adults and 32,000 paediatric due to vertical transmission). Sources of new adult infections are:

Nationally most new infections occur in couples who are engaged in heterosexual sex within a union/regular partnership, and those who practice casual sex, are sex workers or are clients of sex workers, are among the prison population and MSM. Those who are in a union or regular partnership contributed 44% of the new infections. Men and women who engage in casual sex contributed 20% of new infections, sex workers and their clients contributed 14% and MSM and Prison populations contributed 15% of new infections. This pattern is similar in all provinces except for Nyanza where the contribution to new infections by those who practice casual sex, and sex workers and their clients, was much higher. Heterosexual sex in a union/regular partnership, casual sex, and sex workers and their clients contribute over 70% of new infections

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<sup>5</sup> A significant contributing factor to high HIV prevalence in Nyanza Province is the low level male circumcision among Luo, who constitute around 60% of the region's population. Subsequently, distribution of HIV prevalence in Nyanza is highly unequal among different population groups and geographical locations.

nationally, except in Nyanza where they contribute over 90% of new infections. Injecting drug use and health facilities contributed 6.3% of the new cases.

Sex work in general, and particularly linked to truck drivers as clients, was the initial source of infection for the epidemic in Kenya and it still seems to be an important source of incidence. It is likely that the epidemic in the general population spread from this initial source. While it now plays a much smaller role, incidence has been maintained in these groups, so they are still contributing to the epidemic. Similarly, MSM and injecting drug users (IDUs) are populations that need to be recognized in Kenya as significantly contributing to incidence. The data around these communities still remains incomplete, and while the national model indicated that MSMs and IDUs combined account for perhaps 15% of new infections, the model for Nairobi placed this group's contribution at 26% and in Mombasa at 31%, almost one-third of new infections. Although the number of IDUs in the population is relatively low, this is a group with a high potential to transmit the disease, and this is reflected in the extremely high incidence in the MoT model.

As already noted, the level of contribution to incidence of these main modes of HIV transmission varies geographically, reflecting both the diverse causes and outcomes of the epidemic: transmission among IDUs contributes to 6% of incidence in the Coast Province, but nil in Nyanza; transmission among MSM contributes less than 6% of incidence in Nyanza, but over 16%, in Nairobi. Similarly, transmission associated with fishing communities is a particular problem around Lake Victoria, accounting for some 24% of incidence. Finally, both age and sex differentials are considerable, with HIV prevalence peaking among women (13.3%/30-34) a decade earlier than among men (10.2%/40-44), reflecting historical transmission patterns. Inter-generational sex, however, may not be as frequent as generally accepted<sup>6</sup>.

## **1.5 National Response to HIV and AIDS in Kenya**

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<sup>6</sup> A study in Kisumu found that only 4% of men's sexual partnerships were "Sugar Daddy", defined as the man being 10 years older or more and being above the sample mean in income. cf Confronting the 'Sugar Daddy' Stereotype: Age and Economic Asymmetries and Risky Sexual Behavior in Urban Kenya, Nancy Luke, *International Family Planning Perspectives*, 2005, 31(1):6-14.

In view of the evidence presented above, it is evident that prevention of new infections must be revitalized nationally through a well-coordinated response. The KNASP III identifies three major clusters of intervention priorities as follows:

- **Intensify HIV prevention in the general population**, by promoting safe affordable male circumcision, partner reduction, condom use and deferred sexual inception, particularly among young girls – to address the estimated 44.1% of HIV infections occurring in casual and low-risk heterosexual sex in the general population. And improve PMCTC for more effective prevention of vertical transmission, which remains significant.
- **Intensify couple-based HIV prevention programmes**, particularly by expanding and enhancing the quality of couple-based voluntary counseling and testing – to tackle the estimated 20.3% of HIV infections occurring among the sexual partners of those who have casual and low-risk heterosexual sex.
- **Revitalize and expand programmes among sex workers, IDUs, MSM and prison populations** – to curtail the 33.1% of infections occurring among these groups.

Based on surveillance, research, and models of new infections intervention priorities must tackle transmission clusters in the general population, within couples, and among most-at-risk-populations and their sexual partners.

## **1.6 Financing Sources and Mechanisms for Health and HIV/AIDS**

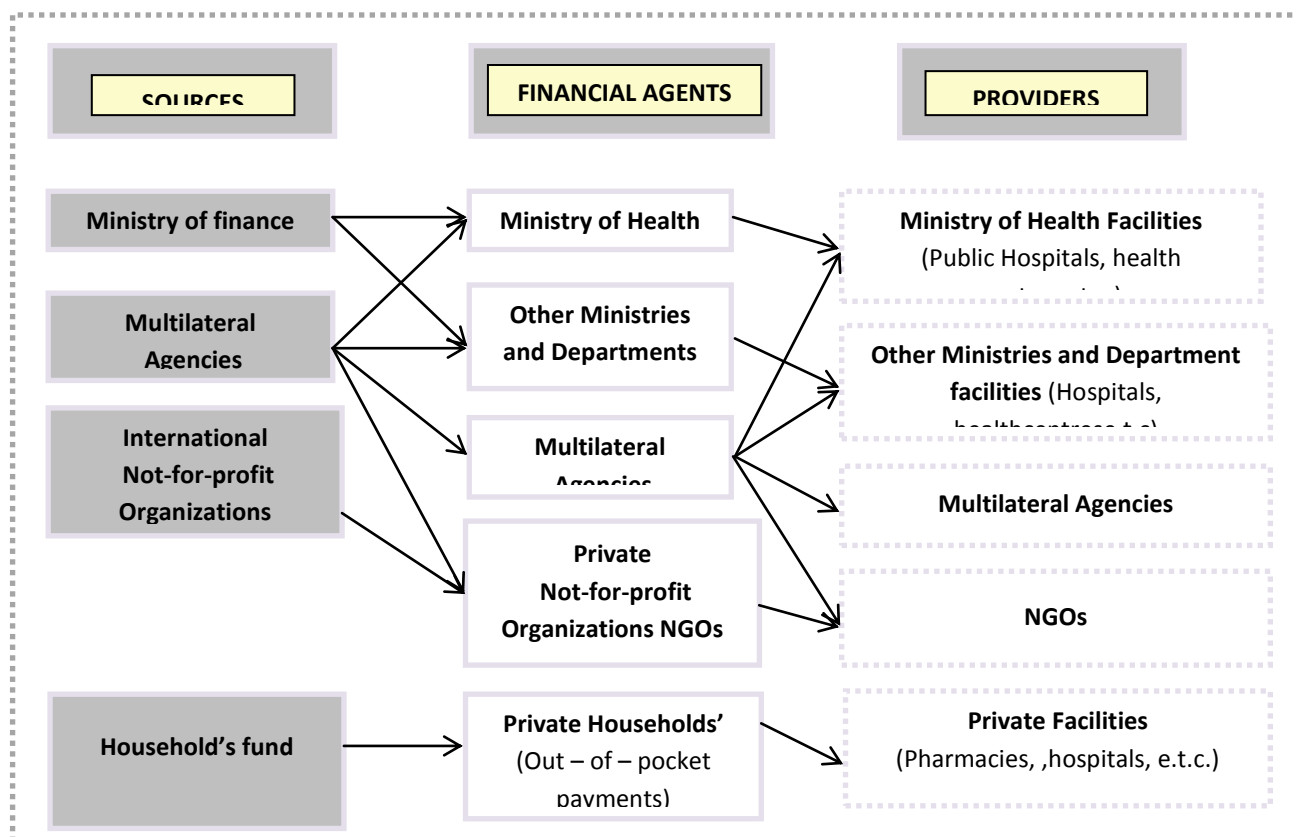
The various sources of HIV/AIDS funding include the public (Ministry of Finance (MoF), Parastatals and Local Government), development partners both bilateral and multilateral, private firms and household sources. Government sources include budget allocation to line ministries and include general tax revenue which is largely derived from direct taxes. Since 2001/02 financial year, the Government of Kenya (GOK) adopted a Medium Term Expenditure Framework (MTEF) in an attempt to align the budget and resource allocation with its poverty reduction efforts, and to address policies in key sectors, namely education, health and infrastructure. Government funding follows the government budgeting and financial procedures, with the funds for HIV/AIDS being disbursed from treasury channelled through the Ministry of

Public Health and Sanitation through National AIDS and STI Control Programme (NASCOP) and National AIDS Control Council (NACC).

The funding to Ministry of Health has been as part of its allocations for the provision of health services, including its activities for prevention and for opportunistic infections that form part of the normal workload of its health facilities. The allocations to NACC has been to support its operations to coordinate and mobilize resources for a multi-sectoral response to HIV/AIDS, including administering intergovernmental transfers under the Constituency Aids Committees (CACs), and transfers to line ministries for specific HIV/AIDS-related expenditure items and programmes.

For the implementation of the HIV/AIDS programmes, the government has heavily relied on donor support. Donor funding to health and HIV/AIDS is channelled through either the government budgetary system commonly referred to as *on-budget* or through the extra-budgetary – *off-budget*, mainly directly from donors through donor administered project/programmes or through NGOs without going through the Government budget process. The extra-budgetary allocation by donors is by far larger than the on-budget support and has been growing over the years. The donor categories comprise of both multi-lateral and bilateral agencies, and include funds made available through the World Bank Multi-Country HIV/AIDS Programme (MAP), and its project KHADREP and lately TOWA, PEPFAR, and the UN agencies core and non-core resources to support the national response to HIV/AIDS.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is another funding mechanism that is supporting HIV/AIDS programmes in Kenya, and complements the ongoing efforts by multi- and bi-lateral agencies, and by the government. Funds under the Global Fund are currently being channelled through Ministry of Public Health and Sanitation and NACC. A Country Coordinating Mechanism (CCM) has been constituted to oversee the disbursement GFTM funds.



**Figure 1: HIV and AIDS funding flows in Kenya**

## 2. The Rationale for a National HIV/AIDS Spending Assessment

The National AIDS Control Council (NACC) is in the process of strengthening the management of the national response to HIV /AIDS. One of the strategies to achieve this objective will be an annual compilation of expenditure/ spending information on the national response. Tracking of the national expenditure on HIV/AIDS interventions on annual basis would yield strategic information, and inform resource mobilization, allocation and utilization. In addition, the data collected will allow for the reporting on the UNGASS Financial indicators, inform MTEF budgetary process as well as other major national planning instruments. This process would be institutionalized through a Kenya National AIDS Spending Assessment (KNASA).

The NASA is a comprehensive and systematic methodology used to determine the flow of resources intended to respond to the HIV/AIDS epidemic of a nation. It describes the flow of funds from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the epidemic. By matching the HIV/AIDS budgeted expenditures and the actual spending on the same, financing gaps can be computed – gap analysis. The gaps would form a good basis for resources mobilization for the national response to HIV/AIDS.

The KNASA findings will inform the costing of the new Kenya National AIDS Strategic Plan IV that aims on delivering on universal Access to HIV/AIDS services at all levels of prevention of new HIV infections, reduction of HIV-related illness and deaths, and mitigation of the effects of the epidemic on households and communities. This Plan will deliver on Vision 2030, as well as realize the targets set by United Nations General Assembly for scaling up HIV prevention, treatment, care and support, and mitigation of the socio-economic impacts. KNASP IV therefore sets the stage and the framework for enabling Kenya to achieve Millennium Development Goal (MDG) 6.

The need for timely, reliable and comprehensive information for the management of the national response to HIV/AIDS is important to the Government of Kenya and key partners, through the National AIDS Control Council (NACC) to enable them: i) address the resources required to satisfy the needs of the vulnerable population directly affected by the spread of the disease, ii) identify programs that comprise the capacity to deal with the consequences of HIV and AIDS i.e. human/financial resources to strengthen prevention, care and treatment as well as social mitigation to augment society's responses to the threat and consequences of HIV and AIDS

## **2.1 Aim and Objectives of the NASA in Kenya**

The overall aim of conducting the KNASA is to contribute to the strengthening of comprehensive tracking of actual spending (from international/external, public and private sources) that comprises the National Response to HIV and AIDS in the country, to leverage both technical and financial support for the development, implementation, management, monitoring

and evaluation of the national HIV response. The assessment will provide information that will guide resource mobilisation, planning, resource allocation for and management of the National Response. It is envisaged that the ensuing NASA information would ultimately be used to guide resource mobilization at national and county levels, evaluation of KNASP III and planning for KNASP IV that will ultimately strengthen the effectiveness and efficiency of resource use.

The specific objectives of the study are:

- i. To assess the magnitude and structure of HIV/ AIDS financing and expenditure in Kenya – at national and county levels - for the financial years 2009/10-2011/12
- ii. To strengthen the institutionalization of HIV/AIDS resource tracking in the Kenya's national response.
- iii. To catalyze and facilitate actions which strengthen capacities to effectively track expenditures on HIV /AIDS, and synthesize this data into strategic information for decision-making.
- iv. To track the allocation of HIV and AIDS funds, from their origin down to the end point of service delivery, among the different sources of financing (public, private or external) and among the different providers and beneficiaries (target groups).

## **CHAPTER TWO: STUDY DESIGN AND METHODOLOGY**

### **2.1 NASA Concepts**

The National HIV/AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. The tool tracks actual expenditure (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV and AIDS. The tool was developed using the national health accounts framework and principles. It applies standard accounting methods to reconstruct all transactions in a given country, ‘following the money’ from the funding sources to agents and providers, and eventually to beneficiary populations. The NASA is expected to provide information that will contribute to a better understanding of a country’s total HIV and AIDS spending, spending by priority areas, how equitable the funding is, funding going to county levels, financial absorptive capacity, as well as on issues about the equity, the efficiency and the effectiveness of the resource allocation process. In addition to institutionalizing the resource tracking for HIV and AIDS, NASA facilitates a standardized reporting of indicators for monitoring progress towards the achievement of the target of the Declaration of Commitment adopted by the United National General Assembly Special Session on HIV/AIDS (UNGASS).

The NASA follows a system of expenditure tracking that involves the systematic capturing of the flow of resources by different financial sources to service providers, through diverse mechanisms of transaction. A transaction comprises of all the elements of the financial flow, the transfer of resources from a financial source to a financing agent or service provider, which spends the money in different budgetary items to produce functions (or interventions) in response to addressing HIV/AIDS to the benefit of specific target groups or to address unspecific populations (or the general population).

NASA applies either both top-down and bottom-up techniques for obtaining and consolidating information. The top-down approach tracks sources of funds from donor reports, commitment

reports and government budgets. The bottom-up approach, which tracks expenditures from service providers' expenditure records, facility level records and governmental department expenditure accounts was used on public sources of funding, and scaled up in the assessment to include the Ministry of Health, and other ministries and departments.

Given that the service providers, especially the health facilities lack data on actual expenditures on HIV/AIDS, costing techniques were used to estimate actual expenditure based on internationally accepted costing methods and standards used to retrogressively measure past actual expenditure. Ingredient and step-down costing is used for direct and shared expenditure for HIV/AIDS, whilst shared costs are allocated on the most appropriate utilization factor. As part of its methodology, the NASA employs double entry tables or matrices to represent the origin and destination of resources, avoiding double-accounting the expenditures by reconstructing the resources flows for every transaction from funding source to service provider and beneficiary population, rather than just adding up the expenditures of every agent that commits resources to HIV/AIDS activities.

The need to track HIV expenditure stems from the fact that decisions regarding allocations for HIV and AIDS related activities must be based on the true effect of previous expenditure patterns on the profile of the epidemic in the various regions in the country. NASA provides information that contributes to a better understanding of a country's financial absorptive capacity, as well as on issues about the equity, the efficiency and the effectiveness of the resource allocation process. In addition to establishing a continuous information system of the financing of HIV/AIDS, NASA facilitates a standardized reporting of indicators for monitoring progress towards the achievement of the targets of the Declaration of Commitment adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS).

## **2.2 The NASA Classifications**

After experimentation and an evaluation of past response to the drivers of the HIV epidemic, and the ways to address these drivers, the NASA programme and budget lines have been structured in eight spending classes or chapters of AIDS Spending Categories namely:

Prevention, Care and treatment, Orphans and vulnerable children, Programme management and administration strengthening, Incentives for human resources, Social protections and social services, Enablement of environment and community programs and Research. The beneficiary populations are classified under seven main categories with a number of sub-groups in each category to enable a further disaggregating of the data collected. Three sets of entities can be defined as financing sources, financial agents and providers.

- i. **Financing Sources:** Financing sources are defined as entities which ultimately bear the expenses of financing HIV and AIDS activities.
- ii. **Financial Agents:** Financial agents are defined as entities which pass funds from financing sources to other financial agents or providers in order to pay for the provision of HIV and AIDS services. They determine how funds are allocated to finance the different interventions.
- iii. **Providers:** Providers are defined as institutional entities that produce and provide health care goods and services, which benefit individuals or population groups.

### **2.3 Scope of the Assessment**

This assessment focused on tracking national and county HIV expenditure for FY 2009/10, 2010/11 and 2011/2012. Expenditure data on HIV/AIDS were collected from domestic, external and partially private sources. It also encompassed tracking the allocation of HIV/AIDS funds, from their origin down to the end point of service delivery.

### **2.4 Sampling**

To facilitate the sampling process, a database of all the stakeholders involved in HIV/AIDS as sources, agents and providers was developed. The sampling frame included the main sources of funds. Specifically, major financing sources supporting HIV and AIDS were included in the study, consisting of Clinton Foundation; United Kingdom Agency for International Development (UKAID) formerly Department for International Development (DfID); Joint United Nations Programme on AIDS, United States Government (USG- President's Emergency Fund for AIDS Relief (PEPFAR); GFATM; and Government of Kenya.

In addition to the financing sources, a representative sample of financing agents was selected purposively based on the volume of funds managed by the agent<sup>7</sup>. The following list of financing agents was included in the study: United Nations Joint Programme on HIV and AIDS including UNAIDS, WHO, UNHCR, UNICEF, WFP, (UNFPA), UNODC, ILO, UNESCO, AMREF, Red Cross, Population Service International (PSI) and the National Treasury (Ministry of Finance). Main agents of the PEPFAR were not surveyed since the data on expenditure by USG was provided directly from the source. However, the financing agents managing PEPFAR funds were not provided

For the purpose of the NASA estimates, all the government ministries that existed prior to the new structure of government ministries were included in the study. Each of the Ministries has an AIDS Control Unit (ACU) which is responsible for HIV and AIDS response in the specific ministry. The 42 ministries that existed before the current structure of the ministries were aligned to the current new government structure which has 18ministries.

In addition, a sample of NGOs providers (362) was surveyed to provide data on HIV and AIDS spending. The sampling frame for the NGOs was provided by NACC. The sampling was purposive and done with assistance of NACC offices at the counties. Overall, a sample of 17 counties was included for this study (see Table 2.1)

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<sup>7</sup> Note that some of the financing agents are also sources of funds as well as providers of services.

**Table 2.1: Sampled counties**

Serial number	County
1	Bungoma County
2	Garissa County
3	Kakamega County
4	Kericho County
5	Kiambu County
6	Kisii County
7	Kisumu County
8	Machakos County
9	Makueni County
10	Meru County
11	Mombasa County
12	Nairobi County
13	Nakuru County
14	Narok County
15	Nyeri County
16	Taita Taveta County
17	Uasin Ngishu County

## **2.5 Data Collection**

The initial assessment was undertaken through a desk review of key policy documents, programme documentation and institutional budgetary and expenditure reports for the period 2009/10-2011/12. This review was followed by one month period of data collection, starting in September 2013. Letters introducing NASA and requesting data from sources of HIV/AIDS financing, financing agents and service providers were sent out by NACC to the various development partners, government ministries, NGOs, bilateral and multilateral organizations in order to formally gain access to the required data.

The data collection stage comprised of the refinement of the methodology for conducting NASA study for national and county levels, drawing on the internationally approved approaches and methods used for NASA. The standard NASA Questionnaires were used to collect data from the financing sources, financing agents, and services providers.

The initial data collection focused on the sources of funding for HIV and AIDS and financing agents. This stage was estimated to last for two weeks but lasted for one and half months. Data collection from UN Agencies took long time, lasting up to January 2014. This notwithstanding, only four UN agencies provided the required data. In addition, data on PEPFAR expenditure for 2012 was obtained directly from PEPFAR headquarters. However, PEPFAR country budgets for the years 2010 and 2011 were used to estimate the level of expenditure by USG. The expenditure analysis for 2012 showed that about 95% of the 2012 budget was implemented. In the analysis, the entire budget estimates for 2010 and 2011 were used. Data collection at the county level took 4 weeks in September 2013 and focused on service providers. The data collected included expenditure on AIDS spending categories and factors of production.

## **2.6 Data Analysis**

Data analysis comprised a number of steps consisting of estimation of indirect expenditure by government, estimation of out-of pocket expenditure, disaggregation of USG expenditure for 2010 and 2011, entry of the all into Excel processing files, and entry into resource tracking tool (RTT). These steps are explained as follows:

### ***2.6.1. Estimation of Indirect Government Expenditure***

Government of Kenya makes significant contribution to the national response through provision of health personnel and other recurrent inputs. The public health facilities provide health services to about 70% of the patients on ART, while FBO and NGO facilities and private for profit facilities account for about 24% and 6% of the ART patients respectively. The FBO and NGO facilities are supported by partners in the provision of ART, PMTCT, and HTC services, and thus are reimbursed for the cost incurred including the cost of personnel. The amount they are reimbursed was already captured in the tracking of expenditure, and hence no estimation was carried on this component. However, Government pays for the health personnel and other recurrent inputs especially overhead costs. Additionally Government provides space and equipment in the provision of HIV related health services.

Indirect contribution by the Government was estimated for the period under the study. In the estimation, costing analysis was carried out to determine the actual expenditure incurred by

public health facilities during the period of expenditure tracking. Only recurrent expenditure was considered in each of the three years. The services considered included ART, PMTCT, HTC and general outpatient services. The ‘cost’ or expenditure per person in each of these services was generated using the Kenya Dynamic Costing Model. The model breaks the unit ‘cost’ or expenditure into five components consisting of drugs and medical supplies; labour, overhead, equipment and infrastructure (space). The costs of the first three components were based on actual expenditure incurred by the health facilities while the last two components were based on replacement values that were annualized. The model uses a step down method to allocate expenditure to both inpatient days and outpatient visits. The expenditure estimation and assumptions used for each of the services is presented below.

### **ART services**

Table 2.2 provides the expenditure per component per visit to a public health facility while Table 2.3 shows that estimated indirect Government expenditure on ART services in public health facilities. Unit cost of drugs and supplies was excluded as they already been included in the expenditure estimates.

**Table 2.2: Expenditure per outpatient visit for ART and general OP services**

	2009/2010	2010/2011	2011/2012
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Direct labour (Kshs)	285.51	299.78	314.77
Overhead per OP visit (Kshs)	324.65	340.88	357.92
equipment per OP visit (Kshs)	23.65	24.83	26.08
infrastructure per OP visit (Kshs)	32.93	34.57	36.30

**Table 2.3: Estimated indirect Government expenditure on ART and OP services**

	2009/2010		2010/2011		2011/2012	
	Adult	Children	Adult	Children	Adult	Children
Estimated number of patients on first line	315,558	28,751	396,525	36,096	503,271	45,317
Estimated number of patients on second line	10,271	1,462	12,906	1,835	16,381	2,304
Total number on ART (70% GOK)	228,080	21,149	286,602	26,552	363,756	33,335
Unit cost (excluding ARVs) (Kshs)	4,667.13	4,667.13	4,900.48	4,900.48	5,145.51	5,145.51
Total indirect expenditure` first line (Kshs)	1,064	99	1,404	130	1,872	172
Second line (70% GOK)	7,190	1,023	9,034	1,285	11,467	1,613

#### Assumptions used in estimating indirect government expenditure on HIV and AIDS

- 70% of individuals on ART get services from public health facilities. We used the actual number ART patients in the country.
- The numbers of adults and children on ART second line for 2009/10 are the actual numbers. However, the numbers on second line in 2010/11 and 2011/12 were estimated using the percentages in 2009/10 ( 3.1% for adults and 5.1% for children)
- The unit cost estimated includes labour, overhead, equipment and infrastructure components. The cost of ARVs and medical supplies were excluded since they do not fall under indirect support components
- Inflation rate of 5% was used to deflate the values of the unit expenditure. The unit components were based on expenditures for the year 2011/12.
- Direct labour consists of a doctor or clinical officer spending on average 25 minutes per ART patient per visit, and a nurse spending 6 minutes per patient (Dynamic Costing Model).
- Each patient makes an average of 7 visits to health facilities per year (4 ART visits annually or 1 visit quarterly, and 3 “illness visits”). Note that in Kenya, outpatient visits per capita are 2.6.

Using the above assumptions, the estimated indirect expenditure on ART was KShs1.06 billion in 2009/10, Kshs 1.40 billion in 2010/11, and Kshs 1.87 billion in 2011/12.

#### HIV care services

The patients who are not eligible for treatment are put on HIV care where they make quarterly visits to facilities for medical check-up. The assumptions used were the same as those used in the ART service provision. The results are shown in Table 2.4.

**Table 2.4: Indirect contribution by government on non-ART care**

	2009/2010	2010/2011	2011/2012
Estimated number of patients on care	470,294	580,724	590,920
Total visits annually ( 7 visits per person)	3,292,060	4,065,070	4,136,438
Direct labour (Kshs)	939,906,138	1,218,636,184	1,302,032,379
Overhead per OP visit (Kshs)	1,068,755,150	1,385,695,491	1,480,524,228
Equipment per OP visit (Kshs)	77,861,446	100,951,331	107,859,838
Infrastructure per OP visit (Kshs)	108,400,861	140,547,238	150,165,453
Total Expenditure (Kshs)	2,198,685,951	2,850,476,038	3,045,309,256

### **PMTCT services**

The estimated PMTCT expenditure covered both ARV prophylaxis and infant follow up (see Table 2.5 and Table 2.6).

**Table 2.5: Indirect contribution by government on PMTCT prophylaxis**

	2009/2010	2010/2011	2011/2012
No. HIV+ pregnant women	90,000	90,000	90,000
6 visits	6	6	6
Unit cost (Kshs)	666.73	700.07	735.07
Direct labour (Kshs)	107,921,631	113,317,713	118,983,598
Overhead per OP visit (Kshs)	122,716,295	128,852,110	135,294,715
Equipment per OP visit (Kshs)	8,940,184	9,387,194	9,856,553
Infrastructure per OP visit (Kshs)	12,446,772	13,069,111	13,722,567
Total Expenditure (Kshs)	252,024,883	264,626,127	277,857,433

In the analysis, the costs of components in Table 2.2 were multiplied by 6 visits and by 70% of the estimated HIV positive pregnant women. In addition to the indirect expenditure on ARV prophylaxis service, indirect expenditure on infant follow-up was also estimated. The results are displayed in Table 2.6.

**Table 2.6: Indirect contribution by government on PMTCT infant/ child follow-up**

	2009/2010	2010/2011	2011/2012
Direct labour (Kshs)	269,804,078	283,294,281	297,458,995
Overhead per OP visit (Kshs)	306,790,738	322,130,274	338,236,788
Equipment per OP visit (Kshs)	22,350,461	23,467,984	24,641,383
Infrastructure per OP visit (Kshs)	31,116,931	32,672,777	34,306,416
<b>Total Expenditure (Kshs)</b>	<b>630,062,207</b>	<b>661,565,318</b>	<b>694,643,584</b>

The assumptions outlined for ART services also applied to PMTCT services. However, an additional assumption was used in the estimations, that is, each infant was assumed to make an average of 12 visits to a health facilities in year 1 (1 visit every month) in the first year of the follow-up. In the second year, the infant visits a facility once a month for 6 months. The national guidelines recommend a total of 18 months of infant follow-up.

### **HIV Testing and Counselling services (HTC)**

In Kenya, HTC services are provided by both public and private sector. Stand-alone VCT sites are most popular sources of services. In the public sector, HTC services are provided in public health facilities. The results of the estimation are presented in Table 2.7.

**Table 2.7: Indirect contribution by government on HTC services**

	2009/2010	2010/2011	2011/2012
Population 15 years and over	21,402,883	22,079,047	22,771,321
Testing coverage (KAIS 2012, 2007 used for computation)	45%	50%	55%
Number people tested	9,725,862	11,049,940	12,444,896
Public sector coverage (40%)	3,890,345	4,419,976	4,977,959
<b>Unit cost (excluding reagents) )(KSHs)</b>	<b>626.85</b>	<b>658.20</b>	<b>691.11</b>
<b>Total Expenditure (Kshs)</b>	<b>2,438,673,951</b>	<b>2,909,208,671</b>	<b>3,440,293,827</b>

## Assumptions

- Annual coverage of HTC was 34% in 2007 (KAIS, 2007) and 57% in 2012 (KAIS, 2012). These were used to estimate HTC coverage in 2009/10, 2010/11 and 2011/12.
- Unit cost includes labour, overhead, and infrastructure components (from Dynamic Costing Model)
- Unit cost covers direct labour (a counsellor) spending on average 45 minutes per client.

## Summary estimated expenditure on the services

Table 2.8 summarises the estimated expenditure. Taking into consideration all the above services, the indirect government expenditure was estimated Kshs 5.75 billion, Kshs 7.10 billion, and Kshs 8.18 billion respectively for 2009/10, 2010/11, and 2011/12.

**Table 2.8: Total indirect Government contribution**

	2009/2010	2010/2011	2011/2012
HTC (Kshs)	1,506,440,797	1,795,777,973	2,122,109,480
PMTCT (Kshs)	882,087,090	926,191,445	972,501,017
HIV Care (Kshs)	2,194,923,596	2,845,830,243	3,040,581,899
ART (Kshs)	1,163,185,377	1,534,606,146	2,043,236,192
Total (Kshs)	5,746,636,860	7,102,405,807	8,178,428,587

### 2.6.2. Out-of-Pocket Spending on HIV/AIDS by Households

Out-of-pocket expenditure (OOPE) is an important source of HIV and AIDS financing in Kenya and therefore essential for creating an effective HIV policy. Despite recent improvements in the collection and use of strategic information, limited attempts have been made in the past to estimate OOPE's magnitude. In the context of increasing attention for optimization of the national AIDS response based on strategic information and cognisant of the huge cost (in terms of financial, time and human resources) in conducting household surveys to obtain this information, an estimation of OOPE was carried out.

In the estimating OOPE the per capita outpatient OOPE and per capita inpatient OOPE from the Kenya Household Health Expenditure and Utilisation Survey 2007 were used. The per capita

annual OOPE reported in the household expenditure survey was Kshs 328 and Kshs 245 respectively for outpatient and inpatient services. Further, an annual inflation rate of 5% was applied to the per capita outpatient and inpatient estimates. In addition, the number of HIV positive people was estimated using the results of KAIS 2007 and KAIS 2012. The numbers used were 1.6 million, 1.5 million and 1.4 million respectively for the years 2009/10, 2010/11, and 2011/12. The estimation results are presented in Table 2.9.

**Table 2.9: Estimated OOPE**

	2009/2010	2010/2011	2011/2012
	38,610,097	39,849,453	41,088,810
Population HIV+	1,600,000	1,500,000	1,400,000
Annual per capital outpatient OOPE (Kshs)	436.568	480.2248	528.24728
Annual per capital inpatient OOPE (Kshs)	299.4145	329.35595	362.291545
Country's total outpatient OOPE (Kshs)	16,855,932,827	19,136,695,748	21,705,051,925
Country's total inpatient OOPE (Kshs)	11,560,422,888	13,124,654,553	14,886,128,323
Country's total OOPE	28,416,355,715	32,261,350,301	36,591,180,248
HIV related total outpatient OOPE (Kshs)	4,889,561,600	5,042,360,400	5,176,823,344
HIV related total inpatient OOPE (Kshs)	3,353,442,400	3,458,237,475	3,550,457,141
HIV related total OP and IP OOPE (Kshs)	8,243,004,000	8,500,597,875	8,727,280,485

Given the paucity of literature that estimates OOPE in similar setting, a person living with HIV/AIDS spends approximately 7 times more out-of-pocket than the average Kenyan on health care. Taking this assumption into account, the per capita outpatient OOPE was scaled up by a factor of 7. The adjusted per capita outpatient OOPE was multiplied by the number of the HIV positive population to estimate OOPE. As shown in the Table 2.2, total outpatient HIV related expenditure was Kshs 4.89 billion in 2009/10, Kshs 5.04 billion in 2010/11, and Kshs 5.18 billion in 2011/12. Similarly, total inpatient HIV related OOPE was also estimated taking into consideration the assumption of scaling up per capita expenditure by a factor of 7. The estimated OOPE was Kshs 3.35 billion, Kshs 3.46 billion and Kshs 3.55 billion, respectively for 2009/10, 2010/11, and 2011/12.

It is imperative to note that the methods used to estimate OOP spending on HIV/AIDS excludes spending on nutrition, orphans, psychosocial support, burial costs, etc. Therefore the estimates

obtained for OOP spending on HIV may be an underestimation of the actual household expenditure on HIV/AIDS

### ***2.6.3. Estimating Private Corporate Sector HIV Spending***

Primary data were not collected on private corporations on HIV spending. However, estimation was done using results from Kenya National Health Accounts (NHA) for the period 2009/10. In the NHA 2009/10, private employer funds contributed Kshs 1.24 billion (US\$ 15.93 million). The estimated expenditure for the years 2010/11 and 2011/12 was obtained by inflating the expenditure for 2009/10 using annual inflation rates. The inflation rates were obtained from “KENYA FACTS AND FIGURES” published by Kenya National Bureau of Statistics (KNBS) (KNBS, 2011, 2013). According to NHA 2009/10, the expenditure from the employer funds was mainly on outpatient and inpatient health care services. Additionally, about 67% of the expenditure went to drugs and pharmaceutical supplies while 33% went to general health services fees. These percentages were used to estimate spending on factors of production.

### ***2.6.4. Disaggregation of USG Expenditure for 2010 and 2011***

As indicated earlier, USG expenditure analysis (EA) was provided. The analysis used NASA classifications, encompassing AIDS spending categories and factors of production. The analysis also provided the percentage of expenditure on each ASC over the total expenditure. Additionally, expenditure by province was given, taking a total of 84% of the total expenditure. Since expenditure analysis for 2009/10 (FY 2010) and 2010/11 (FY 2011) were missing, the percentages of ASC from 2012 EA were used to disaggregate the total expenditure in the specific categories. Applying the above assumptions, the total expenditure was US\$ 548.1 million in 2009/10 and US\$ 517.3 in 2010/11. For purposes of estimating expenditures on factors of production for 2009/10 and 2010/11, the percentages of factors of production in each ASC for 2012 EA figures were used.

#### ***2.6.5. Estimation of Expenditure by County***

The new constitutional dispensation has resulted in creation of regional level governments called county governments. In the devolution, services such as health care services and social services have been transferred from Central government to the County governments. In the spirit of devolution, attempts were made to apportion total expenditure to the County level. The total expenditure from all sources in each of the years was allocated to counties. Using the PEPFAR analysis for 2012 where 84% of the expenditure went to the provinces, we allocated 84% of the total expenditure to the counties. It is imperative to note that USG contributes over 70% of the total expenditure on HIV services in the country.

The allocation involved two steps. In the first step, the expenditure was allocated to provinces using the percentage from PEPFAR EA 2012. In the second step, the allocated amount to each province was then allocated to the counties in the province using the population in each county as the weight. The county with highest population in the province was allocated the highest amount of the province's allocation.

#### ***2.6.6. Data Entry into Excel Processing Files and into Resource Tracking Tool (RTT)***

Initially, expenditure data collected was entered into NASA Excel processing forms, verified and balance. All information obtained was verified to ensure the validity of data from the records of the source, agents and providers, and also to avoid double counting. This ensured that each transaction was tracked from the source, financing agent, service provider, uses of the funds (AIDS spending activity), beneficiaries of the funds and factors of production. Where the flow of the transaction was not complete, the Excel sheets show the missing data which enabled the data entry team to track the error. This ensured that the each transaction was complete and that only expenditures related to each source or financing agent are captured. The data from Excel files were transferred to Resource Tracking Tool (RTT) by a team of statisticians under the supervision of the team leader. It provides step-by-step guidance along the estimation process and makes it easier to monitor crosschecking among the different classification axes. The NASA RTT results data- bases were then exported to Excel to produce summary tables and graphs for analysis.

### **2.6.7. Limitations**

- a) The different sources of funds had different financial years. For instance Government of Kenya using the fiscal year starting 1st of July and ending 30th of June the following year. USG uses October-September fiscal year while other sources use calendar year. For the sources using calendar year such UN agencies, that was required for the years 2009, 2010, 2011 and 2012 and the estimated expenditure for the years 2009/10, 2010/11 and 2011/12 was obtained by summing the expenditure for the two relevant years and dividing by two. For the USG funds the actual figures were used as a proxy for expenditures in each of the years without any adjustment. The USG expenditures were almost constant during the three years.
- b) Expenditure on training on HIV by public health sector and domestic health sector was not obtained.
- c) Expenditure by private corporations was estimated based on NHA 2009/10 and inflated only for the years 2010/11 and 2011/10. This may represent an understatement of the expenditure by this sector. However, it should be noted that this aspect was not within the scope of the study but was requested when results were being presented.
- d) In some instances, expenditure data obtained were too aggregative to allow for details required in the NASA analysis. This especially so with respect to ASC, beneficiary populations and factors for production.

## **CHAPTER THREE: RESULTS AND DISCUSSION**

### **3.1 Total Expenditure on HIV/AIDS by Sources of Funding**

The main sources of funds for HIV/AIDS in Kenya are the entities that provide money to financing agents to be pooled and disbursed to service providers. In Kenya, there are four main sources of funding HIV/AIDS national response, namely: public, international (bilateral), international (Multilateral), GFATM and private. However, based on the expenditure analysis, it is evident that the country's national response to HIV/AIDS relies heavily on external sources of funding mainly from international organizations.

Table 3.1 presents the total HIV and AIDS expenditure for 2009/10-2011/12 by the major category sources.

**Table 3.1: Spending on HIV and AIDS interventions by major source categories**

	2009/10		2010/11		2011/12		Total		
	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million	Perc ent
Public	8,874	114	11,427	139	12,130	137	32,431	389	16 %
Interna tional	45,980	590	49,150	596	47,497	535	142,627	1,722	70 %
Private	9,483	122	9,811	119	10,123	114	29,417	355	14 %
Total	64,338	826	70,388	853	69,750	786	204,476	2,466	100 %

The results in Table 3.1 show that total expenditure on HIV and AIDS interventions in Kenya increased from Kshs 64,338 million (US\$ 826 million) in 2009/10 to Kshs 70,388 million (US\$ 853 million) in 2010/11, representing an increase of 9% from the 2010/11 expenditure estimates. In 2011/12, the expenditure declined slightly to Kshs 69,750 million (US\$ 786 million) due a slight decline in USG and CHAI funding. The total expenditure over the three-year period amounted to Kshs 204,476 million (US\$ 2,466 million). Table 3.1 also shows that international sources accounted for 70% of the resources followed by Government of Kenya (16%) and domestic private sources (14%).

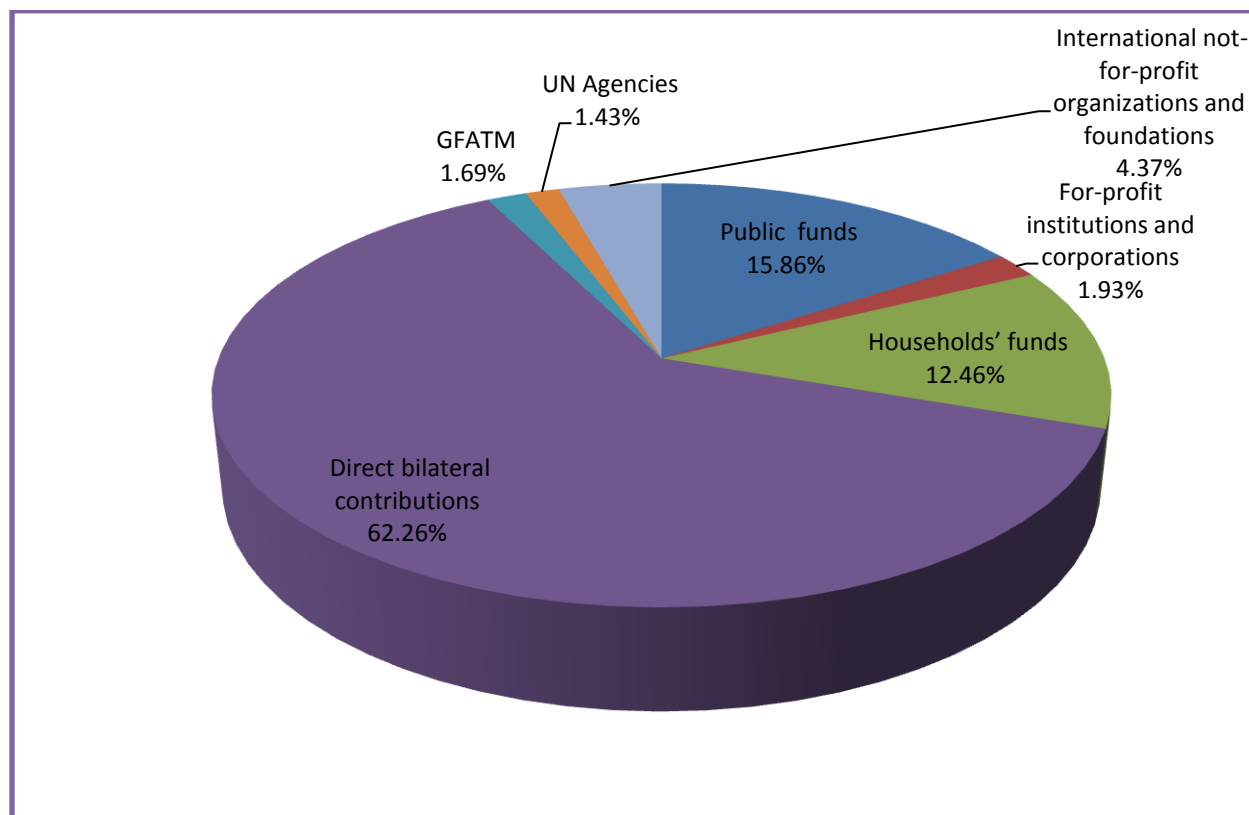
Table 3.2 provides a more disaggregated sources of national AIDS spending. The relative contributions of the different sources are presented in Figure 3.1.

**Table 3.2: Actual spending on HIV and AIDS by domestic and external Sources of Funds**

	2009/10		2010/11		2011/12		Total	
	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million
Public funds	8,874	114	11,427	139	12,130	137	32,431	389
For-profit institutions and corporations	1,240	16	1,310	16	1,396	16	3,946	48
Households' funds	8,243	106	8,501	103	8,727	98	25,471	307
Direct bilateral contributions	41,150	528	42,810	519	43,346	489	127,307	1,536
GFATM	840	11	1,644	20	966	11	3,450	42

UN Agencies	946	12	928	11	1,053	12	2,928	35
International not-for-profit organizations and foundations	3,044	39	3,767	46	2,132	24	8,943	109
<b>Total</b>	<b>64,338</b>	<b>826</b>	<b>70,388</b>	<b>853</b>	<b>69,750</b>	<b>786</b>	<b>204,476</b>	<b>2,466</b>

**Note:** Figures for the Government consists of the explicit expenditure by government ministries and estimated indirect expenditure by the Ministry of Health.



**Figure 3.1: Percentage share of total actual HIV and AIDS spending by source of finance (2009/10-2011/12)**

As shown in Table 3.2, international sources consisted of direct bilateral contributions, GFATM, UN agencies, and international NGOs and foundations. Figure 3.1 shows that direct bilateral contributions constituted 62% of the total HIV and AIDS expenditure over the three years under consideration. The percentage contributions of the other international sources were 4.37% (international NGOs and foundations), 1.69% (GFATM), and 1.43% (UN agencies). The private domestic sources of financing consisted of household out pocket spending and estimated

expenditure by private institutions and corporations. The households' sources of funding accounted for about 13% while private institutions and corporations took 1.93% of the total spending over the same period.

### 3.2 HIV/AIDS Expenditure by AIDS Spending Categories and Financing Sources

The AIDS spending categories (ASC) represent a functional classification of all possible intervention areas of AIDS expenditure incurred by service providers both within and outside the health sector, as well as out-of-pocket spending. The expenditure by ASC was disaggregated into eight categories according to the NASA classification (Prevention, Care and Treatment, Orphans and Vulnerable children (OVCs), Human Resources, Programme Management and administration, Social Protection and Social Services. Table 3.3, Table 3.4, Table 3.5, and Figure 3.2.

Table 3.3 show expenditure by ASC and by financing major sources for the three years combined. The percentage expenditure of these sources are presented in Table 3.4.

**Table 3.3: Total expenditure by major source categories and ASC, 2009/10-2011/12**

	Public		Private		International		Total	
	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million
Prevention	11,166	134	200	2	29,935	360	41,437	496
Care and treatment	15,522	186	28,592	345	67,083	811	111,728	1,342
Orphans and vulnerable children	2,685	32	-	-	8,763	105	11,480	137
Programme management and administration	3,058	37	625	8	20,324	246	24,051	290
Human resources	-	-	-	-	6,998	86	6,998	86
Social protection and social services	-	-	-	-	2,554	31	2,554	31
Enabling environment	-	-	-	-	5,757	70	5,757	70
HIV and AIDS-related research	-	-	-	-	1,212	15	1,212	15
Total	32,431	389	29,417	355	142,626	1,722	205,218	2,466

**Table 3.4: Total expenditure by major source categories and ASC, 2009/10-2011/12**

	Public	Private	International	Total
Prevention	27%	0.5%	72%	100%
Care and treatment	13%	26%	61%	100%
Orphans and vulnerable children	24%	0%	77%	100%
Programme management and administration	12%	3%	85%	100%
Human resources	0%	0%	100%	100%
Social protection and social services	0%	0%	100%	100%
Enabling environment	0%	0%	100%	100%
HIV and AIDS-related research	0%	0%	100%	100%

Table 3.3 and Table 3.4 show that international sources accounted for the largest amount and percentage in all the interventions. However, for treatment and care, the contribution of the households and private firms took the second position (26%) and government (13%). Table 3.5, Table 3.6, Table 3.7 and Figure 3.2 provide results of further disaggregation of the expenditure by sources.

**Table 3.5: Total expenditure by sources and ASC, 2009/10-2011/12 (Kshs millions)**

	Public funds	For-profit institutions and corporations	Households' funds	Bilateral	GFATM	UN Agencies	International not-for-profit organizations	Total 2009/10-2011/12
Prevention	11,166	200	-	28,965	907	30	33	41,301
Care and treatment	15,522	3,121	25,471	60,147	1,819	-	5,117	111,198
Orphans and vulnerable children	2,685	-	-	6,141	-	2,622	-	11,448
Programme management and administration	3,058	625	-	19,394	637	253	40	24,007
Human resources	-	-	-	3,342	22	2	3,632	6,998
Social protection and social services	-	-	-	2,538	-	-	16	2,554
Enabling environment	-	-	-	5,567	65	21	104	5,757

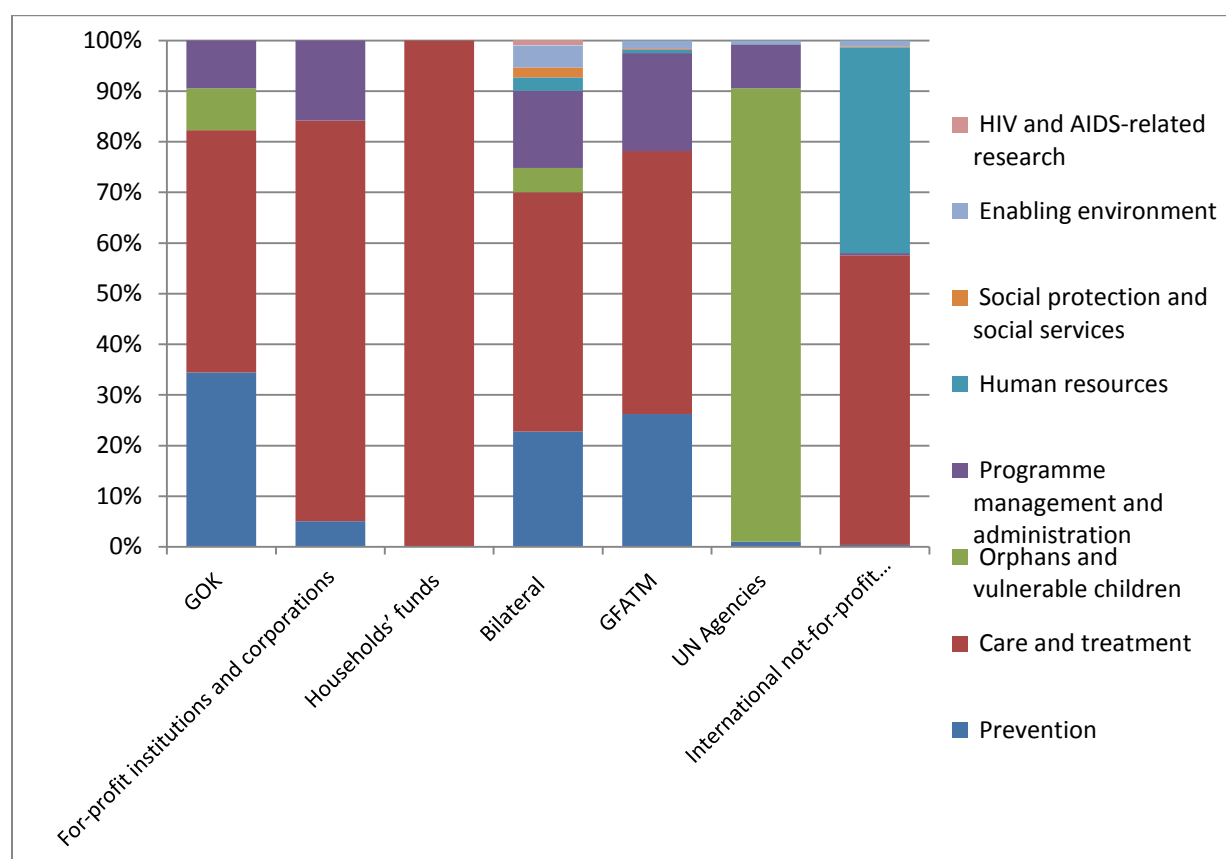
HIV and AIDS-related research	-	-	-	1,212	-	-	-	1,212
<b>Total</b>	<b>32,431</b>	<b>3,946</b>	<b>25,471</b>	<b>127,307</b>	<b>3,450</b>	<b>2,928</b>	<b>8,943</b>	<b>204,476</b>

**Table 3.6: Total expenditure by source and ASC, 2009/10-2011/12 (US\$ millions)**

	GOK	For-profit institutions and corporations	OOP	Bilateral	GFATM	UN Agencies	International not-for-profit organizations and foundations	Total 2009/10-2011/12
Prevention	133.92	2.41	-	348.38	10.67	0.36	0.40	496
Care and treatment	186.16	37.61	307.30	727.27	22.20	-	61.24	1,342
Orphans and vulnerable children	32.49	-	-	73.19	-	31.69	-	137
Programme management and administration	36.67	7.53	-	234.37	7.73	2.97	0.47	290
Human resources	-	-	-	40.32	0.25	0.02	45.29	86
Social protection and social services	-	-	-	30.66	-	-	0.18	31
Enabling environment	-	-	-	67.28	0.77	0.24	1.22	70
HIV and AIDS-related research	-	-	-	14.65	-	-	-	15
<b>Total</b>	<b>389.25</b>	<b>47.55</b>	<b>307.30</b>	<b>1,536.12</b>	<b>41.61</b>	<b>35.28</b>	<b>108.80</b>	<b>2,466</b>

**Table 3.7: Percentage expenditure on ASC by financing sources**

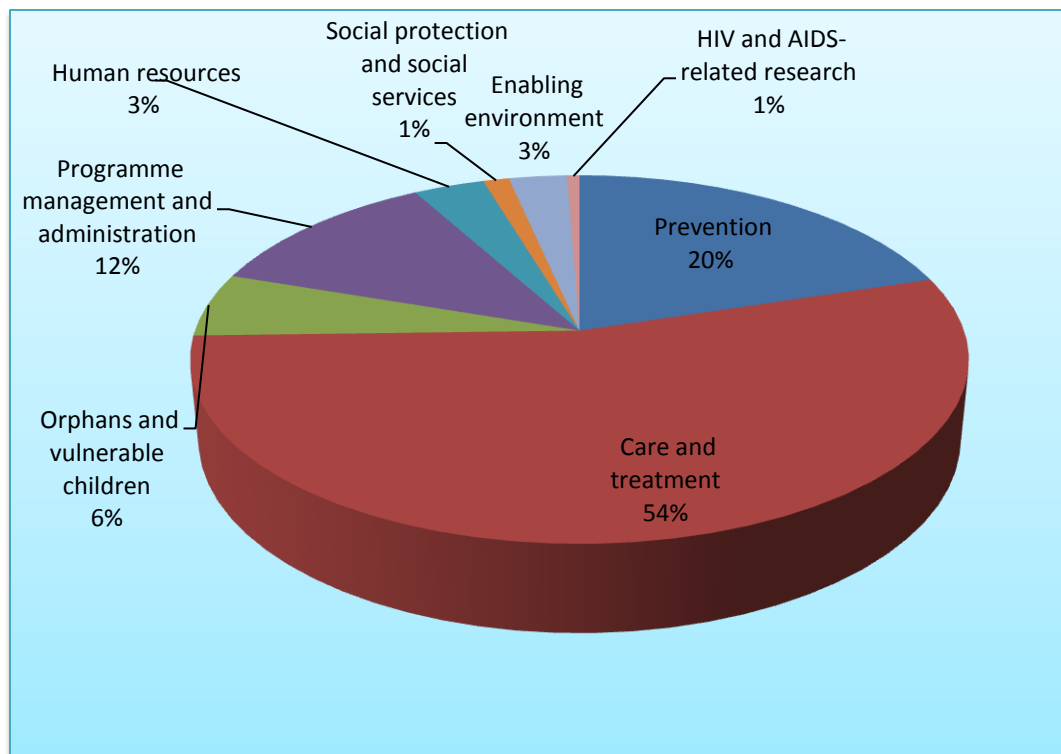
	GOK	For-profit institutions and corporations	Households' funds	Bilateral	GFA TM	UN Agencies	International not-for-profit organizations	Total 2009/10-2011/12
Prevention	27%	0.5%	0%	70%	2%	0%	0%	100%
Care and treatment	13%	3%	23%	54%	2%	0%	5%	100%
Orphans and vulnerable children	23.5%	0%	0%	54%	0%	22.9%	0%	100%
Programme management and administration	12%	3%	0%	81%	3%	1%	0%	100%
Human resources	0%	0%	0%	48%	0%	0%	52%	100%
Social protection and social services	0%	0%	0%	99%	0%	0%	1%	100%
Enabling environment	0%	0%	0%	97%	1%	0%	2%	100%
HIV and AIDS-related research	0%	0%	0%	100%	0%	0%	0%	100%



**Figure 3.2: Percentage share of spending on ASC within financing sources 2009/10-2011/12**

As shown in Tables 3.5, 3.6, 3.7 and Figure 3.2, the largest share of funding for prevention activities came from bilateral sources which accounted for 70% or Kshs 28,965 million (US\$ 348.38 million) followed by the Government of Kenya which contributed 27% or Kshs 11,166 million (US\$ 133.92 million). The bulk of funding for care and treatment over the three years under consideration also came from bilateral sources which accounted for 54% or Kshs 60,147 million (US\$ 727 million) followed by households who contributed 23% or Kshs 25,471 million (US\$ 307 million), and Government of Kenya accounting for 14% or Kshs 15,522 million (US\$ 186 million). The main financing sources for orphans and vulnerable children were from bilateral sources (54%) followed by UN Agencies (UNICEF) (22.9%) and GOK (22.5%). Expenditure on human resources came mainly from two sources namely USG (48%) and international not-for-profit organisations and foundations mainly CHAI (52%).

Overall, treatment and care accounted for the largest share (54%, see Figure 3.3) or Kshs 111.20 billion (US\$ 1,342 million) of total expenditure from all the sources. This was followed by expenditure on prevention activities taking 20% or Kshs 41.31 billion (US\$ 496 million). Programme management and administration accounted for 12% for the combined three years while orphans and vulnerable children accounted for 6% of the total expenditure.



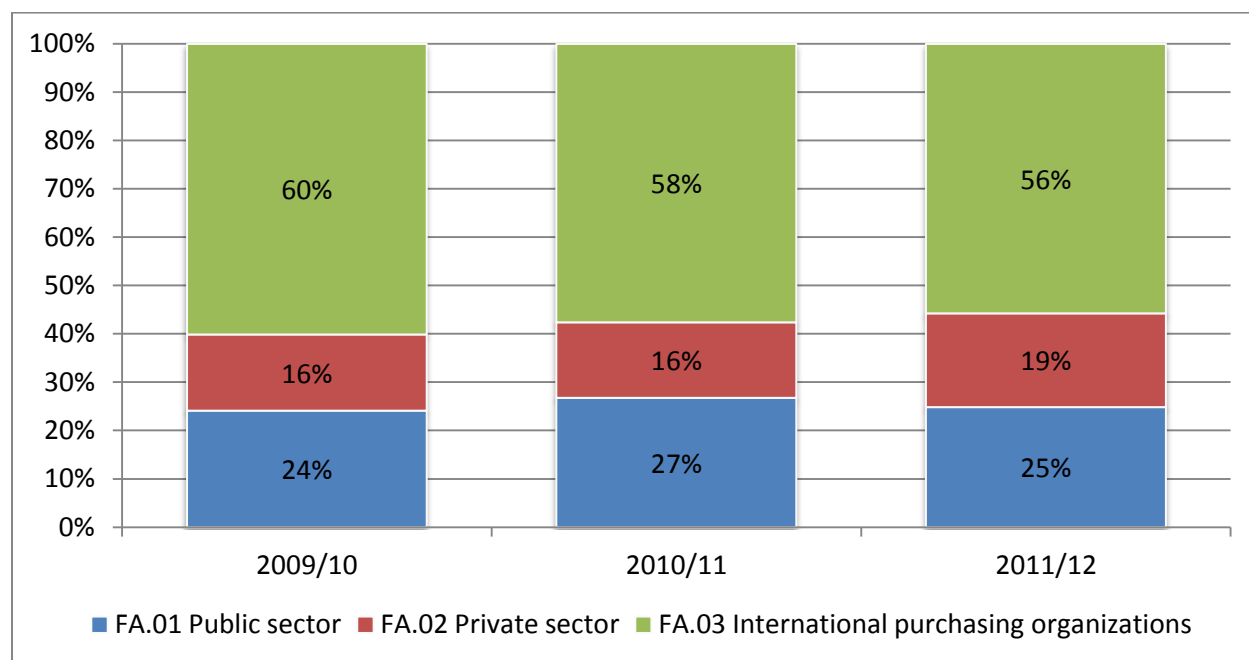
**Figure 3.3: Percentage share of HIV/AIDS spending on key intervention areas 2009/10-2011/12**

### **3.3 HIV and AIDS Expenditure Breakdown by Financing Sources and Financing Agents**

This section highlights the key priority areas by the various agents of HIV/AIDS funds in Kenya. Financing agents refer to entities that manage and use the funds for payment or purchase of health services, medical supplies and other HIV/AIDS related activities. The financing agents also decide the type of activity or product to fund or purchase. In Kenya, the main financing agents include government ministries, parastatals within government ministries, multilateral agencies managing external resources, country offices of bilateral agencies managing external resources, international NGOs, and international not-for-profit organizations.

As shown in Figure 3.4, the main financing agents are international purchasing organization, which accounted for over 56% of the total resources. Public sector agents accounted for between

25% and 27%, while local private organizations managed between 16% and 19% of the total funds.



**Figure 3.4: Percentage share of HIV/AIDS spending by main agents categories 2009/10-2011/12**

Table 3.8 and Table 3.9 provide detailed breakdown of the expenditure by financing agents.

**Table 3.8: Total HIV/AIDS expenditure breakdown by financing agent (Kshs)**

	2009/10	2010/11	2011/12
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	Kshs million	%	Kshs million	%	Kshs million	%
<b>Public sector</b>	<b>15,546</b>		<b>18,850</b>		<b>17,348</b>	
Ministry of Health (or equivalent sector entity)	10,538	16%	12,435	18%	11,875	17%
Ministry of Social Development (or equivalent sector entity)	1,647	3%	2,087	3%	1,572	2%
Ministry of Finance (or equivalent sector entity)	4	0.01%	11	0.02%	-	0%
Other ministries (or equivalent sector entities)	173	0.3%	146	0.2%	120	0.2%
National AIDS Commission	1,362	2%	2,155	3%	2,326	3%
Parastatal organizations	1,821	3%	2,015	3%	1,456	2%
<b>Private sector</b>	<b>10,117</b>		<b>11,007</b>		<b>13,516</b>	
Private insurance enterprises [other than social insurance]	1,236	2%	1,305	2%	1,390	2%
Private households' (out-of-pocket payments)	8,243	13%	8,501	12%	8,727	13%
Not-for-profit institutions (other than social insurance)	639	1%	1,187	2%	3,384	5%
Other private financing agents n.e.c.	-	0%	14	0.02%	14	0.02%
<b>International purchasing organizations</b>	<b>38,675</b>		<b>40,530</b>		<b>38,886</b>	
Country offices of bilateral agencies managing external resources and fulfilling financing agent roles	4,510	7%	4,538	6%	4,406	6%
Multilateral agencies managing external resources	369	1%	405	1%	558	1%
International not-for-profit organizations and foundations	33,796	53%	35,587	51%	33,922	49%
<b>Total</b>	<b>64,338</b>	<b>100%</b>	<b>70,388</b>	<b>100%</b>	<b>69,750</b>	<b>100%</b>

**Table 3.9: Total expenditure HIV/AIDS expenditure breakdown by financing agent (US\$)**

	2009/10	2010/11	2011/12
	US\$ million	US\$ million	US\$ million

<b>Public sector</b>	<b>200</b>	<b>229</b>	<b>196</b>
Ministry of Health (or equivalent sector entity)	135.33	150.79	133.84
Ministry of Social Development (or equivalent sector entity)	21.16	25.31	17.72
Ministry of Finance (or equivalent sector entity)	0.05	0.14	-
Other ministries (or equivalent sector entities)	2.22	1.77	1.35
National AIDS Commission	17.48	26.14	26.22
Parastatal organizations	23.39	24.43	16.41
<b>Private sector</b>	<b>130</b>	<b>133</b>	<b>152</b>
Private insurance enterprises [other than social insurance]	15.87	15.83	15.67
Private households' (out-of-pocket payments)	105.86	103.08	98.37
Not-for-profit institutions (other than social insurance)	8.20	14.40	38.15
Other private financing agents n.e.c.	-	0.17	0.15
<b>International purchasing organizations</b>	<b>497</b>	<b>491</b>	<b>438</b>
Country offices of bilateral agencies managing external resources and fulfilling financing agent roles	57.91	55.02	49.66
Multilateral agencies managing external resources	4.74	4.91	6.29
International not-for-profit organizations and foundations	434.01	431.52	382.35
<b>Total</b>	<b>826</b>	<b>853</b>	<b>786</b>

Specifically, international not-for-profit organizations managed the largest share (between 49% and 53%), followed and Ministry of Health (between 16% and 18%) and households (about 13%). The share of funding managed by the National AIDS Commission accounted for 3% over the three years under consideration. The largest share of funds managed by the public agents came from GOK budget allocations and direct bilateral contributions. However, the largest source of funds managed by international not-for-profit organizations and foundations came from direct bilateral sources.

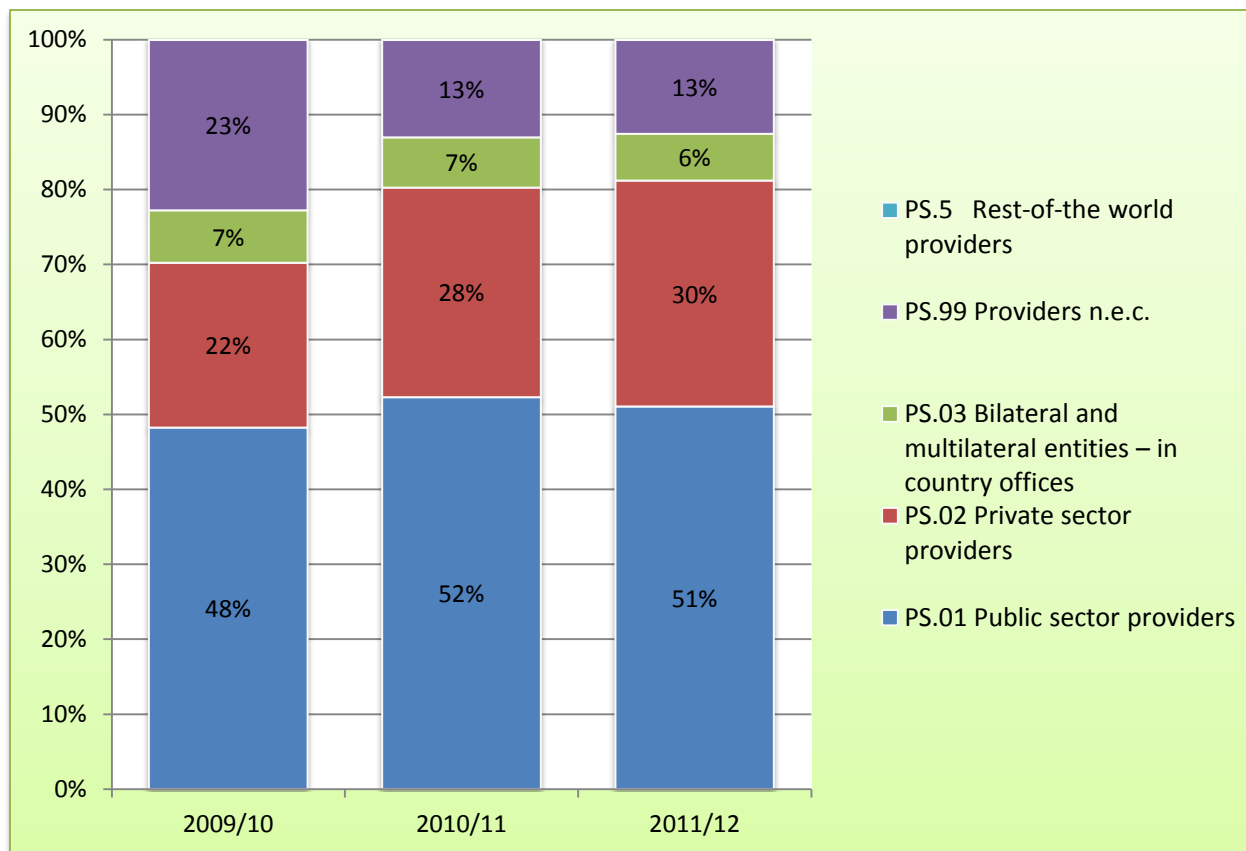
### 3.4 Providers of HIV and AIDS Services

This section presents the analysis of providers of HIV/AIDS services. According to the NASA guidelines, Service Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. HIV and AIDS

services is provided by a number of providers that include the government and other public entities, private for profit and non-profit organizations, corporate and non-corporate enterprises and, self-employed persons whose activity falls within the NASA boundaries regardless of a formal or informal legal status. Table 3.10 and Figure 3.5 provide broad picture of the main providers of HIV and AIDS related providers of services.

**Table 3.10: Summary expenditure by providers of services**

	2009/10		2010/11		2011/12		Total	
	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ milli on	Kshs million	US\$ million
PS.01 Public sector providers	31,046	399	36,820	446	35,622	402	103,489	1,247
PS.02 Private sector providers	14,126	181	19,680	239	20,999	237	54,805	657
PS.03 Bilateral and multilateral entities – in country offices	4,506	58	4,719	57	4,352	49	13,576	164
PS.99 Providers n.e.c.	14,647	188	9,156	111	8,763	99	32,566	398
PS.5 Rest-of-the world providers	12	0.16	13	0.16	14	0.16	39	0
Total	64,338	826	70,388	853	69,750	786	204,476	2,466



**Figure 3.5: Percentages of expenditure by service providers**

As shown, public sector remained the largest provider of HIV/AIDS services, accounting for about 48%, 52% and 51% of the expenditure in 2009/10, 2010/11 and 2011/12 respectively. Private sector providers took the second largest share of the expenditure accounting for 22%, 28% and 30% of the total HIV/AIDS expenditure. Bilateral and multilateral agencies spend on average 7% of the total amount in each of the years. It is shown that providers not elsewhere (n.e.c.) classified also accounted for some significant percentage of the expenditure (23%, 13% and 13% in 2009/10, 2010/11 and 2011/12 respectively). These providers were mainly international NGOs providing services directly in the country. The rest of the world providers took very small percentage (0.02%).

Table 3.11 reveals that public health facilities were the main providers of services from the public channelled through public sector agents. The public health facilities spent 87% of the resources. The children department took 5.8% of the expenditure in terms of the OVC cash transfer programme implemented by the government. Furthermore, National AIDS Control Council as a provider accounted for 3.2% of the expenditure.

**Table 3.11: Absolute and percentage expenditure within public sector 2009/10-2011/12**

	Kshs million	US\$ million	Percent
Hospitals (Governmental)	89,900	1,082.09	86.87%
Blood banks (Governmental)	1,041	12.19	1.01%
Higher education (Governmental)	92	1.19	0.09%
Research institutions (Governmental)	531	6.82	0.51%
National AIDS commission (NACs)	3,300	39.56	3.19%
Departments inside the Ministry of Health or equivalent (including NAPs/NACPs)	760	9.71	0.73%
Departments inside the Ministry of Education or equivalent	9	0.12	0.01%
Departments inside the Ministry of Social Development or equivalent	6,050	73.15	5.85%
Departments inside the Ministry of Finance or equivalent	15	0.19	0.01%
Government entities n.e.c.	426	5.19	0.41%
Parastatal organizations	1,363	16.48	1.32%
<b>Total</b>	<b>103,489</b>	<b>1,247</b>	<b>100%</b>

In the private sector (Table 3.12), faith-based providers took the lion share of the resources channelled through the private sector, with faith-based health facilities accounting 25% of the expenditure (Kshs 14,021 million or US\$ 165 million) and other non-profit faith-based private sector providers taking 22% of the total expenditure (Kshs 11,734 million or US\$ 145) million within the private sector. Other notable providers were

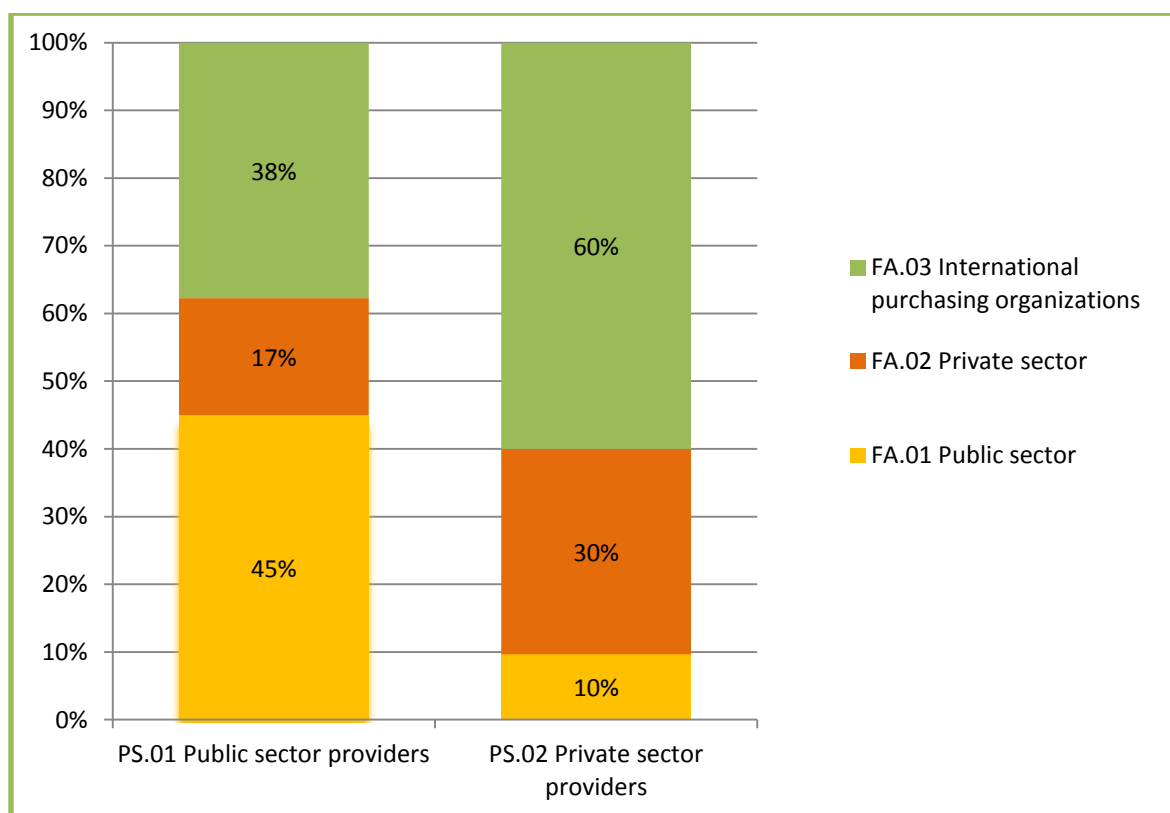
**Table 3.12: Absolute and percentage expenditure within private sector 2009/10-2011/12**

	Kshs million	US\$ million	Percent
Hospitals (Non-profit non faith-based)	2,138	24.12	3.67%
Self-help and informal community-based organizations (Non-profit non faith-based)	7,006	83.97	12.79%
Civil society organizations (Non-profit non faith-based)	634	7.64	1.16%
Other non-profit non-faith-based providers n.e.c.	1,910	23.55	3.59%
Hospitals (Non-profit faith-based)	14,021	165.02	25.13%
Self-help and informal community-based organizations (Non-profit faith-based)	3,670	41.37	6.30%
Other non-profit faith-based private sector providers n.e.c.	11,734	144.75	22.04%
Other non-profit private sector providers n.e.c.	6,255	75.40	11.48%
Hospitals (For profit)	4,264	51.80	7.89%
Ambulatory care (For profit)	607	7.31	1.11%
Pharmacies and providers of medical goods (For profit)	307	3.70	0.56%
For profit private sector providers n.e.c.	844	10.27	1.56%
Private sector providers n.e.c.	1,417	17.84	2.72%
<b>Total</b>	<b>54,805</b>	<b>657</b>	<b>100%</b>

Further analysis was carried out in terms of financing agents and providers of service. Table 3.13 and Figure 3.6 show how the agents distributed the funds to different services providers.

**Table 3.13: Expenditure by service providers and agents 2009/10 – 2011/12**

	FA.01 Public sector		FA.02 Private sector		FA.03 International purchasing organizations		Total	
	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million
PS.01 Public sector providers	46,460	560	17,959	217	39,069	470	103,489	1,247
PS.02 Private sector providers	5,284	64	16,642	199	32,879	394	54,805	657
PS.03 Bilateral and multilateral entities – in country offices	-	-	-	-	13,576	164	13,576	164
PS.99 Providers n.e.c.	-	-	-	-	32,566	398	32,566	398
PS.5 Rest-of-the world providers	-	-	39	0.47	-	-	39	0.47
<b>Total</b>	<b>51,744</b>	<b>624</b>	<b>34,641</b>	<b>416</b>	<b>118,091</b>	<b>1,426</b>	<b>204,476</b>	<b>2,466</b>



**Figure 3.6: Percent of expenditure by public sector providers according to financing agents**

Table 3.13 and Figure 3.6 indicate that the financing agents that provided resources to public sector providers consisted of public sector agents (45%), international purchasing organizations (38%), and private sector agents (17%). However, international purchasing organizations were by far the largest agents intermediating resources to private sector providers accounting for 60% of the expenditure, followed by private sector agents (30%) and public sector agents (10%).

### 3.5 Spending on Prevention Activities

The results expenditure analysis on prevention is presented in Table 3.14 for the entire period of three years.

**Table 3.14: Expenditure on prevention by service providers 2009/10 – 2011/12**

	Kshs million	US\$ million	Percent
Communication for social and behavioural change	201	2.39	0.5%
Community mobilization	2,935	34.87	7.1%
Voluntary counselling and testing (VCT)	10,304	123.83	24.9%
Risk-reduction for vulnerable and accessible populations	57	0.67	0.1%
Prevention – youth out-of-school	1	0.02	0.004%
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	65	0.80	0.2%
Prevention programmes for sex workers and their clients	347	4.06	0.8%
Harm-reduction programmes for injecting drug users (IDUs)	6	0.08	0.0%
Programmatic interventions in the workplace not disaggregated by type	424	5.17	1.0%
Condom social marketing	230	2.68	0.6%
Prevention of mother-to-child transmission (PMTCT)	8,280	99.97	20.0%
Male circumcision	4,036	48.78	9.8%
Blood safety	1,567	18.94	3.8%
Post-exposure prophylaxis (PEP)	276	3.35	0.7%
Prevention activities not disaggregated by intervention	12,572	150.54	30.4%
<b>Total</b>	<b>41,301</b>	<b>496</b>	<b>100%</b>

Total expenditure on prevention was Kshs 41.30 billion (US\$ 496 million). This total consisted of about Kshs 12.06 billion (US\$ 154.84 million) in 2009/10, Kshs 13.67 billion (US\$ 165.74 million) in 2010/11 and Kshs 15.57 billion (175.55) in 2011/12. As shown in Table 3.11, testing and counselling, PMTCT, male circumcision, and community mobilization accounted for the largest share of the total expenditure. This notwithstanding, prevention activities not disaggregated by intervention took the largest share. The component was attributed to PEPFAR EA analysis where this category took the largest share of prevention. This category includes behaviour change communication, condom distribution among other interventions but the data was not disaggregated.

### 3.6 Spending on Care and Treatment

Table 3.15 shows that the bulk (46.5%) of spending on care and treatment in the three years went to ART. Other components that took significant share of the total expenditure were outpatient health care services (27.5%), inpatient care services (10.6%), specific HIV-related laboratory monitoring (10.5%), and OI prophylaxis (7.4%).

**Table 3.15: Care and treatment expenditure by spending category, 2009/10-2011/12**

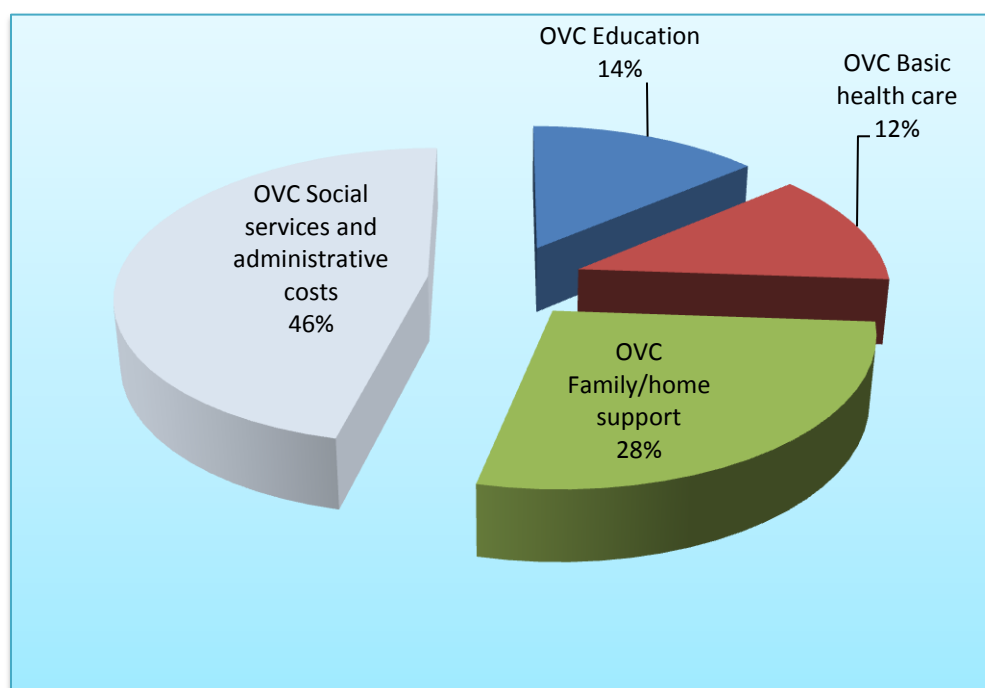
	Kshs million	US\$ million	Percent
Provider- initiated testing and counselling (PITC)	2,360	28.53	2.1%
Opportunistic infection (OI) outpatient prophylaxis and treatment	8,212	98.55	7.4%
Second-line ART – adults	1,261	14.87	1.1%
Adult antiretroviral therapy not disaggregated by line of treatment	26,035	314.44	23.4%
Paediatric antiretroviral therapy not disaggregated by line of treatment	7,630	91.97	6.9%
Antiretroviral therapy not disaggregated neither by age nor by line of treatment	9,051	108.88	8.1%
Nutritional support associated to ARV therapy	657	7.94	0.6%
Specific HIV-related laboratory monitoring	11,344	137.11	10.2%
Psychological treatment and support services	908	11.20	0.8%
Home-based care	1,346	16.57	1.2%
Outpatient care services not disaggregated by intervention	15,508	187.37	13.9%
Outpatient care services n.e.c.	15,109	182.28	13.6%
Inpatient care services not disaggregated by intervention	1,414	17.04	1.3%
Inpatient care services n.e.c.	10,362	125.02	9.3%
<b>TOTAL</b>	<b>111,198</b>	<b>1,342</b>	<b>100%</b>

### 3.7 Spending on Orphans and Vulnerable Children (OVC)

Table 3.16 and Figure 3.7 show the expenditure on different categories of OVC activities.

**Table 3.16: OVC expenditure 2009/10-2011/12**

	2009/10		2010/11		2011/12		Total	
	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million
OVC Education	266	3.42	669	8.11	650	7.33	1,585	19
OVC Basic health care	236	3.03	592	7.18	575	6.48	1,403	17
OVC Family/home support	649	8.33	1,267	15.36	1,237	13.95	3,153	38
OVC Social Services and Administrative costs	1,647	21.16	2,087	25.31	1,572	17.72	5,307	64
<b>TOTAL</b>	<b>2,798</b>	<b>35.93</b>	<b>4,615</b>	<b>55.97</b>	<b>4,034</b>	<b>45.47</b>	<b>11,448</b>	<b>137</b>



### Figure 3.7: Percent of expenditure on OVC

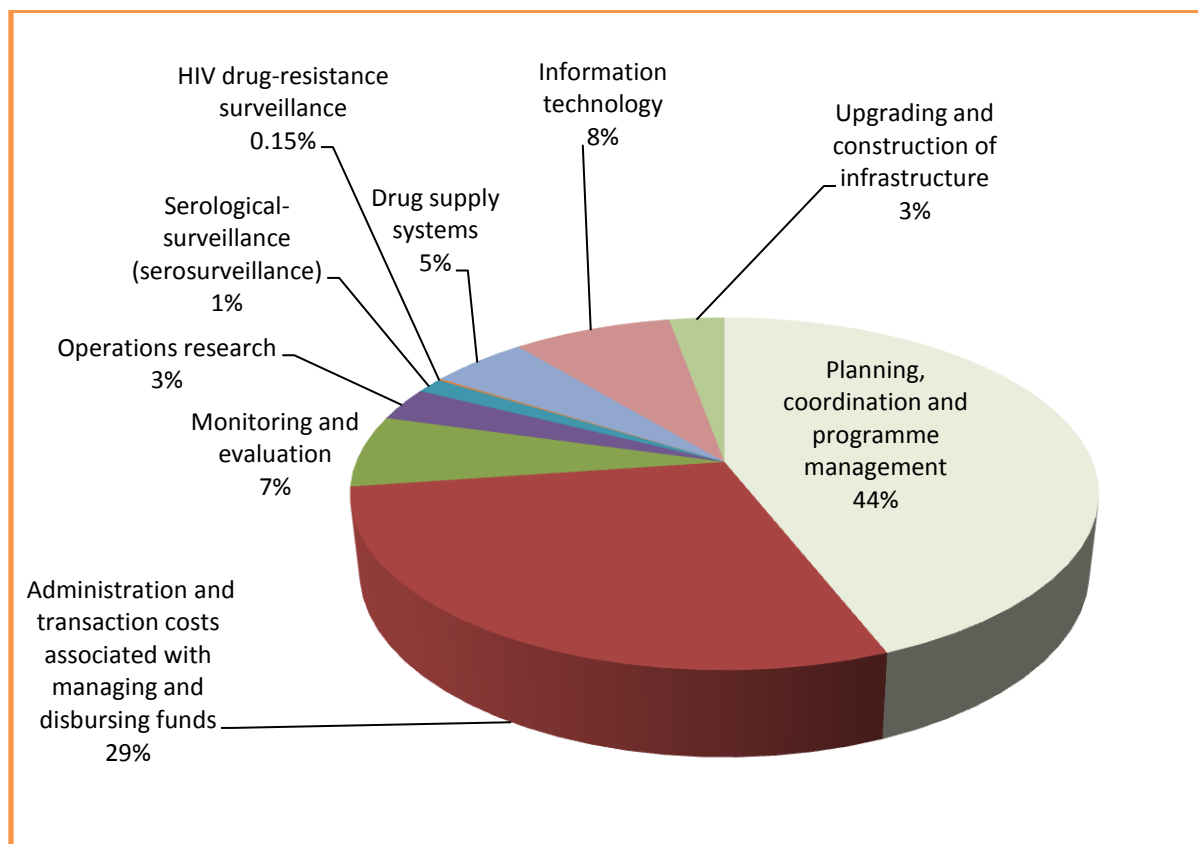
In 2010, 2011 and 2012 total spending on orphans and vulnerable children amounted to Kshs 2,798 million (US\$ 35.93 million), Kshs 4,615 million (US\$ 55.97 million) and Kshs 4,034 million (45.47 million), respectively. These show that expenditure increased between 2009/10 and 2010/11 and declined between 2010/11 and 2011/12. Overall in the three years, the expenditure was distributed into administrative costs (46%), family/ home support (28%), education (14%), and health care (12%).

### 3.8 Spending on Programme Management and Administration

Analysis of expenditure by programme management and administration function is presented in Table 3.17 and figure 3.8. Table 3.17 shows the trends in expenditure of the various categories while Figure 3.8 presents the percentage of the expenditure by the categories.

**Table 3.17: Expenditure on management and administration**

	2009/10		2010/11		2011/12		Total	
	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million	Kshs million	US\$ million
Planning, coordination and programme management	3,211	41	3,693	45	3,663	41	10,567	127
Administration and transaction costs associated with managing and disbursing funds	2,317	30	2,325	28	2,258	25	6,899	83
Monitoring and evaluation	526	7	536	6	521	6	1,582	19
Operations research	247	3	245	3	245	3	736	9
Serological-surveillance (serosurveillance)	112	1	113	1	110	1	335	4
HIV drug-resistance surveillance	12	0	13	0	12	0	37	0
Drug supply systems	403	5	405	5	394	4	1,202	15
Information technology	659	8	662	8	643	7	1,965	24
Upgrading and construction of infrastructure	229	3	230	3	224	3	683	8
<b>Total</b>	<b>7,716</b>	<b>99</b>	<b>8,221</b>	<b>100</b>	<b>8,069</b>	<b>91</b>	<b>24,006</b>	<b>290</b>



**Figure 3.8: Percent of expenditure on programme management and administration**

As shown in Table 3.17, total expenditure on management and administration increased between 2009/10 and 2010/11 but declined between 2010/11 and 2011/12. The total expenditure was Kshs 7,716 million, Kshs 8,221 million, and Kshs 8,069 million in 2009/10, 2010/11, and 2011/12, respectively. The largest share (44%) of the expenditure went planning, coordination and programme management, followed by administration and transactions costs of managing and disbursing funds (29%), information technology (8%), monitoring and evaluation (7%), and drugs supply system (5%).

### 3.9 Spending on Other ASC

The expenditure for the three year period by other ASC is shown in Table 3.18.

**Table 3.18: Expenditure on other ASC 2009/10 -2011/12**

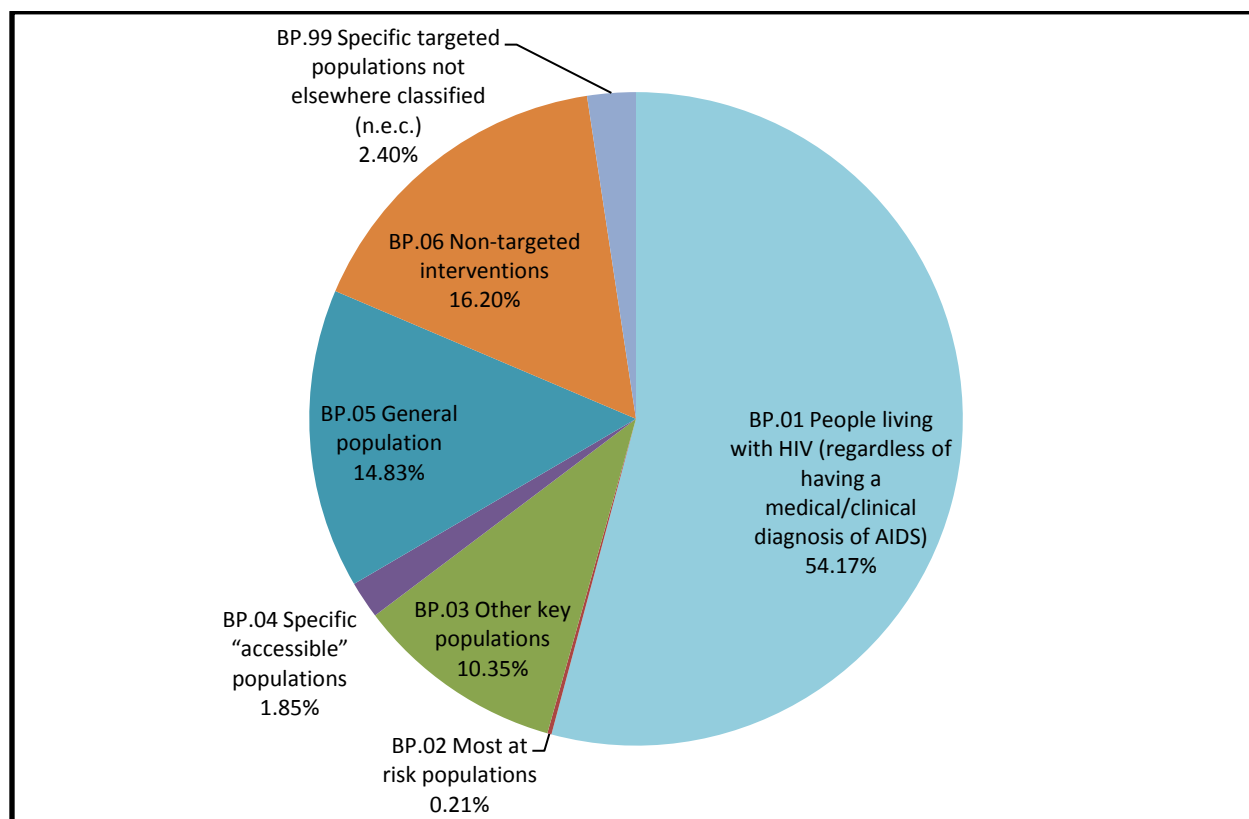
	Kshs million	US\$ million
Human resources	6,998	85.87
Formative education to build-up an HIV workforce	196	2.29
Training	5,038	62.25
Human resources not disaggregated by type	1,764	21.33
Social protection and social services (excluding OVC)	2,554	30.84
Social protection through in-kind benefits	384	4.64
HIV-specific income generation projects	2,170	26.21
Enabling environment	5,757	69.51
Advocacy	180	2.11
AIDS-specific institutional development	3,277	39.60
Programmes to reduce Gender Based Violence	11	0.13
Enabling environment not disaggregated by type	2,290	27.68
HIV and AIDS-related research (excluding operations research )	1,212	14.65
HIV and AIDS-related research activities not disaggregated by type	1,212	14.65
<b>Total</b>	<b>33,043</b>	<b>402</b>

### 3.10 HIV/AIDS Expenditures by Beneficiary Groups

The analysis of the Beneficiary Population (BP) aims at estimating resources specifically spent on a population as part of the service delivery process of a programmatic intervention (UNAIDS, 2007). Beneficiary population (BP) is a sub-sect of the population that consumes HIV/AIDS related goods and services.

Figure 3.9 presents expenditure results by the main beneficiary population of the HIV and AIDS expenditures. The results indicate that people living with HIV accounted for the largest share (54%) of the expenditure, non-targeted interventions (16%), general population (15%), and other key population (11%). The percentage share to the most at risk population was very low at 0.22%. However, this was understatement since some of the expenditure on MARPS was not

given explicitly. Details of the beneficiary populations and their percentage shares in total expenditure are given in Table 3.19.



**Figure 3.9: Expenditure results by the main beneficiary population**

**Table 3.19: AIDS spending by beneficiary population 2009/10 – 2011/12**

	Kshs million	US\$ million	Percent
<b>BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)</b>	<b>110,689</b>	<b>1,336</b>	<b>54.17%</b>
BP.01.01.02 Adult and young women (15 years and over) living with HIV	521	6	0.24%
BP.01.01.98 Adult and young people (15 years and over) living with HIV not disaggregated by gender	18,264	214	8.68%
BP.01.02.98 Children (under 15 years) living with HIV not disaggregated by gender	7,644	92	3.74%
BP.01.98 People living with HIV not disaggregated by age or gender	84,260	1,024	41.51%
<b>BP.02 Most at risk populations</b>	<b>435</b>	<b>5</b>	<b>0.21%</b>
BP.02.01 Injecting drug users (IDU) and their sexual partners	26	0	0.01%
BP.02.02 Sex workers (SW) and their clients	347	4	0.16%
BP.02.98 “Most at risk populations” not disaggregated by type	62	1	0.03%
<b>BP.03 Other key populations</b>	<b>21,205</b>	<b>255</b>	<b>10.35%</b>
BP.03.01 Orphans and vulnerable children (OVC)	11,448	137	5.57%
BP.03.02 Children born or to be born of women living with HIV	8,165	98	3.99%
BP.03.03 Refugees (externally displaced)	25	0	0.01%
BP.03.11 Children and youth out of school	1	0	0.00%
BP.03.14 Recipients of blood or blood products	1,567	19	0.77%
<b>BP.04 Specific “accessible” populations</b>	<b>3,781</b>	<b>46</b>	<b>1.85%</b>
BP.04.05 Health care workers	9	0	0.00%
BP.04.10 Factory employees (e.g. for workplace interventions)	3,745	45	1.83%
BP.04.98 Specific “accessible ” populations not disaggregated by type	26	0	0.01%
<b>BP.05 General population</b>	<b>30,487</b>	<b>366</b>	<b>14.83%</b>
BP.05.01.01 Male adult population	4,036	49	1.98%
BP.05.01.02 Female adult population	104	1	0.05%
BP.05.03.02 Young females	1	0	0.00%
BP.05.03.98 Youth (age 15 to 24 years) not disaggregated by gender	4	0	0.00%
BP.05.98 General population not disaggregated by age or gender.	26,344	315	12.79%
<b>BP.06 Non-targeted interventions</b>	<b>32,976</b>	<b>400</b>	<b>16.20%</b>
<b>BP.99 Specific targeted populations not elsewhere classified (n.e.c.)</b>	<b>4,902</b>	<b>59</b>	<b>2.40%</b>
<b>Total</b>	<b>204,476</b>	<b>2,466</b>	<b>100%</b>

### 3.11 HIV/AIDS Expenditures by Production Factors

According to UNAIDS (2009), NASA the classification of production factors categorizes expenditures in terms of resources used for the production in terms wages, salaries, materials, and capital. Expenditure categorised in terms of factors of production is presented in Table 3.20.

**Table 3.20: Expenditure by factors of production 2009/10 – 2011/12**

	Kshs million	US\$ million	Percent
<b>PF.01 Current expenditures</b>	<b>196,779</b>	<b>2,373</b>	
<i><b>PF.01.01 Labour income (compensation of employees and remuneration of owners)</b></i>	<i><b>39,337</b></i>	<i><b>474</b></i>	
PF.01.01.01 Wages	7,437	89	4%
PF.01.01.98 Labour income not disaggregated by type	31,814	384	16%
PF.01.01.99 Labour income n.e.c.	85	1	0%
<i><b>PF.01.02 Supplies and services</b></i>	<i><b>113,423</b></i>	<i><b>1,369</b></i>	
<i><b>PF.01.02.01 Material supplies</b></i>	<i><b>66,140</b></i>	<i><b>798</b></i>	
PF.01.02.01.01 Antiretrovirals	26,805	323	13%
PF.01.02.01.02 Other drugs and pharmaceuticals (excluding antiretrovirals)	30,865	373	15%
PF.01.02.01.03 Medical and surgical supplies	251	3	0.12%
PF.01.02.01.04 Condoms	85	1	0.04%
PF.01.02.01.05 Reagents and materials	271	3	0.13%
PF.01.02.01.06 Food and nutrients	960	12	0.47%
PF.01.02.01.98 Material supplies not disaggregated by type	6,157	74	3%
PF.01.02.01.99 Other material supplies n.e.c.	745	9	0.36%
<i><b>PF.01.02.02 Services</b></i>	<i><b>46,657</b></i>	<i><b>564</b></i>	
PF.01.02.02.01 Administrative services	361	4	0.18%
PF.01.02.02.02 Maintenance and repair services	5	0	0.002%
PF.01.02.02.03 Publisher-, motion picture-, broadcasting and programming services	675	8	0.33%
PF.01.02.02.04 Consulting services	1,464	18	1%
PF.01.02.02.05 Transportation and travel services	11,064	133	5%
PF.01.02.02.06 Housing services	51	1	0%
PF.01.02.02.07 Logistics of events, including catering services	5,809	70	3%
PF.01.02.02.08 Financial intermediation services	0.25	0	0.0001%
PF.01.02.02.98 Services not disaggregated by type	26,513	319	13%
PF.01.02.02.99 Services n.e.c.	1,341	17	1%
<i><b>PF.01.98 Current expenditures not disaggregated by type</b></i>	<i><b>44,019</b></i>	<i><b>530</b></i>	<i><b>22%</b></i>

<b>PF.02 Capital expenditures</b>	<b>7,697</b>	<b>93</b>	
PF.02.01.98 Buildings not disaggregated by type	2,618	<b>31</b>	1%
PF.02.02.01 Vehicles	874	<b>31</b>	0.43%
PF.02.02.02 Information technology (hardware and software)	2	<b>49</b>	0.001%
PF.02.02.98 Equipment not disaggregated by type	3,217	<b>11</b>	2%
PF.02.02.99 Equipment n.e.c.	0.45	<b>0</b>	0.0002%
PF.02.98 Capital expenditure not disaggregated by type	985	<b>39</b>	0.48%
PF.02.99 Capital expenditure n.e.c.	1.24	<b>0</b>	0.0006%
<b>Total</b>	<b>204,476</b>	<b>2,466</b>	<b>100%</b>

Table 3.20 shows that overall, recurrent expenditure took about 96% and capital expenditure accounting for about 4% of the total expenditure. Overall, labour income accounted for the largest percentage (20%), followed by drugs and pharmaceuticals (15%), and ARVs (13%). There were problems in obtaining much disaggregated data expenditure on items and this explains the reason for some expenditure given in aggregate categories consisting of current expenditures not disaggregated by type (22%) and services not disaggregated by type (13%).

### 3.12 Expenditure by County

An attempt was made to disaggregate expenditure by country. The expenditure disaggregated excluded the amount spent on the national level (see Table 3.21). The results show that HIV/AIDS expenditure was Ksh 59 billion (US\$ 717 million) in 2010/11 and Kshs 57 billion (US\$ 660 million) in 2011/12.

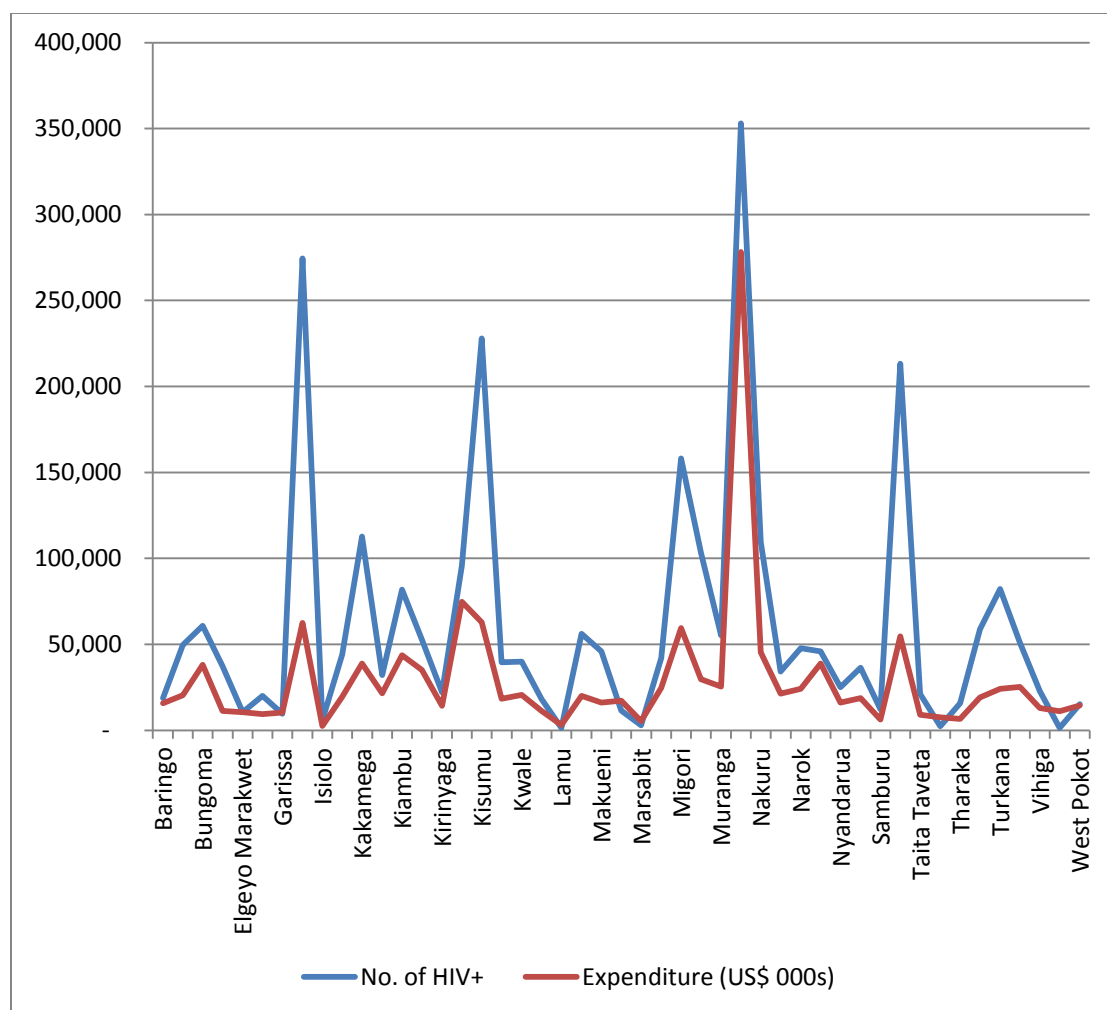
**Table 3.21: Distribution of expenditure by county (Kshs million)**

	2010/11		2011/12	
	Kshs million	US\$ million	Kshs million	US\$ million
Baringo County	676	8.20	670	7.55
Bomet County	881	10.68	873	9.84
Bungoma County	1,636	19.83	1,621	18.27
Busia County	489	5.94	485	5.47
Elgeyo - marakwet County	450	5.46	446	5.03
Embu County	403	4.89	399	4.50
Garissa County	449	5.45	445	5.02
Homa Bay County	2,682	32.52	2,658	29.96
Isiolo County	112	1.36	111	1.25
Kajiado County	836	10.14	829	9.34
Kakamega County	1,665	20.19	1,650	18.60
Kericho County	923	11.19	914	10.30
Kiambu County	1,880	22.79	1,863	21.00
Kilifi County	1,509	18.30	1,495	16.85
Kirinyaga County	612	7.41	606	6.83
Kisii County	3,207	38.88	3,178	35.82
Kisumu County	2,696	32.70	2,672	30.12
Kitui County	791	9.59	783	8.83
Kwale County	884	10.72	876	9.87
Laikipia County	486	5.89	481	5.43
Lamu County	138	1.67	137	1.54
Machakos County	858	10.40	850	9.58
Makueni County	690	8.37	684	7.71
Mandera County	739	8.96	733	8.26
Marsabit County	227	2.76	225	2.54
Meru County	1,059	12.84	1,049	11.83
Migori County	2,552	30.95	2,529	28.51
Mombasa County	1,277	15.49	1,266	14.27
Muranga County	1,092	13.24	1,082	12.19
Nairobi County	11,944	144.83	11,836	133.41
Nakuru County	1,951	23.65	1,933	21.79
Nandi County	916	11.11	908	10.23
Narok County	1,035	12.55	1,026	11.56
Nyamira County	1,665	20.19	1,650	18.60
Nyandarua County	691	8.37	684	7.71
Nyeri County	803	9.74	796	8.97
Samburu County	272	3.30	270	3.04

Siaya County	2,344	28.42	2,323	26.18
Taita Taveta County	387	4.69	384	4.32
Tana River County	326	3.96	323	3.65
Tharaka - Nithi County	285	3.46	283	3.19
Transnzoia County	821	9.96	814	9.17
Turkana County	1,041	12.62	1,031	11.62
Uasingishu County	1,088	13.19	1,078	12.15
Vihiga County	556	6.74	551	6.21
Wajir County	477	5.78	473	5.33
West Pokot County	624	7.56	618	6.97
<b>Total</b>	<b>59,126</b>	<b>716.94</b>	<b>58,590</b>	<b>660.39</b>

An attempt was made to assess if the pattern estimated expenditure by county level was had relationship with the HIV epidemic in the counties. The total number of people who were HIV positive in the financial years 2010/11 and 2011/12 was used a proxy for the need for HIV services in the counties. The numbers of HIV positive were obtained from Spectrum 2013 results for Kenya at National AIDS and STD Control Programme (NASCOP). These results were presented based on calendar years but were converted into fiscal years based on arithmetic mean of the numbers in corresponding two years.

Graphical analysis and correlation analysis were used in the assessment. Figure 3.10 depicts the relationship between the total number of HIV positive people in the two years in the counties and the total expenditure in two counties also in the two years. As shown in Figure 3.10, there was similar pattern of expenditure and the number of HIV positive persons. However, graphical analysis did not provide quantitative measure of the relationship. This necessitated the use of bivariate Pearson correlation analysis which yielded a coefficient of 0.827 which was significant at 1 percent level. The conclusion from these analyses points to strong and significant positive relationship between expenditure and the need for HIV services at the county level.



**Figure 3.10: Relationship between expenditure and number of HIV+ persons in counties**

### 3.13 Qualitative Data Analysis

The quantitative data considered the following issues: Funding process and challenges; adequacy of funds; bottlenecks in spending; conditions attached to funds; and reporting requirements.

#### Funding process and challenges

The organizations that provide HIV and AIDS services usually prepare proposals that are submitted to the financing agents. According to the responses, the main challenge they faced was the long time it takes between submission of the proposals and the time they actually receive funding from the agents. It was also noted that the capacity for proposal development is limited

in many of the organizations that responded to the qualitative questions. Majority of the respondents were of the opinion that lengthy procedures, failure or delay in submitting the requisite documents and lack of accountability were the major causes of the bottlenecks faced by the NGOs since these contribute to delayed disbursement of funds.

### **Adequacy of funds**

Although the quantitative analysis showed that huge financial resources have been mobilized, the service providers indicated that funds disbursed to them for HIV and AIDS activities were generally not adequate. As result, most of the funds end up financing staff salaries leaving limited amounts for actual service delivery. Given this scenario, it would be important to ascertain the amount the organisations budget for each of the items in the proposal so as to determine whether the spending is in line with the proposal submitted for funding.

### **Bottlenecks in spending**

The responses indicated that NGOs/CBOs faced capacity challenges in the implementation of the services. These included limited human resources, unfamiliarity with the procedures and reporting requirements and lack of and /or poor coordination of their activities leading to duplication. These contribute to poor planning, procurement procedures and slow implementation of HIV/AIDS activities. Additionally, sometimes PLWHAs demand for hand-outs that had not been budgeted for. It was also reported that when the funds are available, political interference limits the use of the funds because some committee members in some of the organisations demand allowances.

### **Conditions attached to funds and reporting requirements**

Some of the conditions relate to timely reporting, provision of work plan, spending according to budget and the strategic plan and audited financial reports. It was revealed that financial reports are required either on quarterly or annual basis. However, some NGOs and CBOs said they had capacity gaps in basic record keeping and generally in financial management.

Although reporting requirements could enhance effectiveness and efficiency use of the funds is concerned, there was a feeling that they were demanding given their capacities. Further, there are different and complicated reporting formats and budget cycles of the different sources.

### **3.14 Comparison with Kenya NASA 2006/07 and 2007/08**

The Kenya NASA report for the financial years 2006/07 and 2007/08 showed total expenditure for HIV activities was Kshs 21.8 billion (US \$ 307.68 million) and in Kshs 23.85 billion (US \$ 361.86 million) respectively. In the current NASA, total expenditure on HIV and AIDS interventions was Kshs 64.34 billion (US\$ 826 million) in 2009/10, Kshs 70.39 million (US\$ 853 million) in 2010/11, and Kshs 69,750 million (US\$ 786 million) in 2011/12. Although OOP was not included in the NASA 2006/07 – 2007/08, there is evidence of increasing expenditure over the years.

In 2006/2007, the percentages by sources were bilateral sources (50%), Government of Kenya (19%), other international organizations and foundations (13%), multilateral organizations consisting of Global Fund and UN agencies (12%), and private domestic sources (6%). In 2007/08, the share of bilateral organizations increased to 55% of the total HIV/AIDS spending in the country while the share of government sources remained constant at 19%) followed by multilateral sources (11%), other international sources (10%), and private domestic (6%).

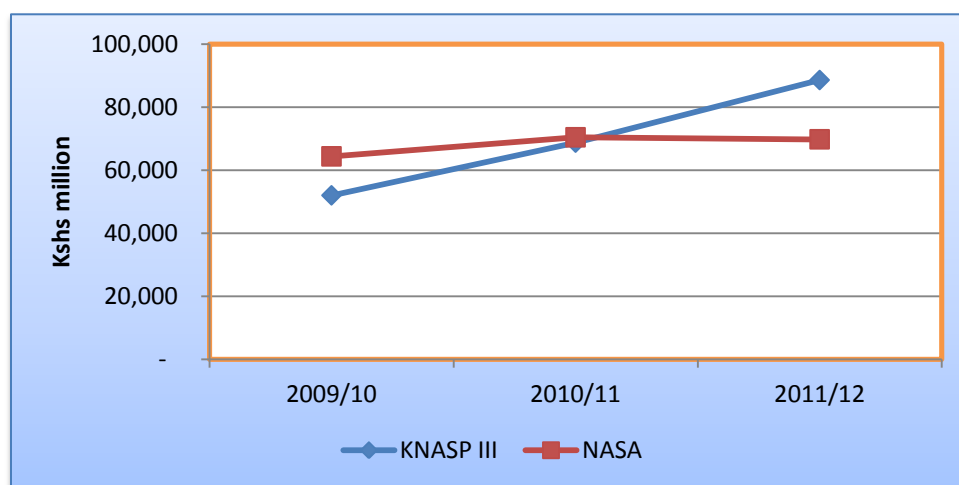
In this NASA, direct bilateral contributions constituted 62% of the total HIV and AIDS expenditure over the three years under consideration. Government source of finance took up 16% of all HIV expenditure between 2009/10 and 2011/12, while households' sources of funding accounted for 13% over the same period. International not-for-profit organisations and foundations, domestic private sector, GFATM, UN agencies and accounted for 4%, 1.9%, 1.7% and less than 1% respectively of the total spending over the three year period. It is therefore evident that over all these years, the majority of financing for activities and programmes related to HIV and AIDS is accounted for by external sources.

Expressed as a percentage of GDP (at current market prices), this level of spending accounted for 1.1% (2007/08) and 1.2% (2006/07) of the total GDP in the country. However, AIDS spending as percentage of GDP was 2.6% in 2009/10, 2.5% in 2010/11 and 2.1% in 2011/12.

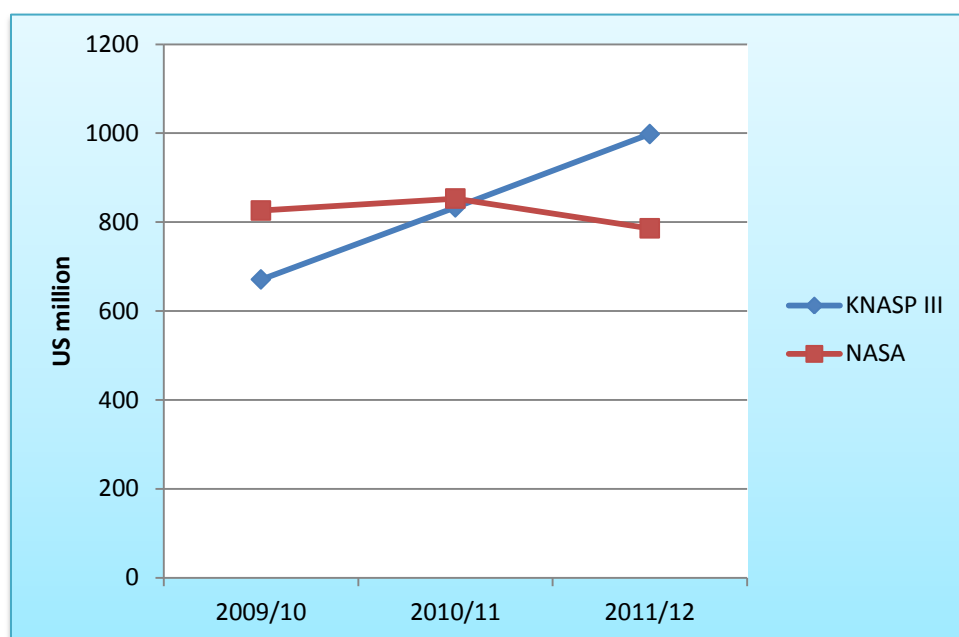
In terms of priorities, there seems that priorities have not changed significantly over the years. Spending on treatment and care has accounted for the largest share, taking 55% in 2006/07, 63% in 2007/08, and 54% in 2009/10-2011/12. Prevention accounted for 29% in 2006/07, 24% in 2006/07, and 20% in in 2009/10-2011/12. While programme management and administration took 8% in 2007/08 and 9% in 2007/08, it increased to 12% in in 2009/10-2011/12

### 3.15 Comparison of NASA Results and KNASP III Cost Estimates

The comparison of NASA results and cost KNASP III cost estimates, in terms of absolute figures may not be plausible since KNASP cost estimates were based on certain targets being achieved while NASA is actual expenditure that do not necessarily relate one on one with KNASP III target. However, their trends can be compared. Figure 3.11 and Figure 3.12 depict the trends in terms of Kenya shillings and US dollars respectively.



**Figure 3.11: Trend in KNASP III costs estimates and NASA (Kshs)<sup>8</sup>**



**Figure 3.12: Trend in KNASP III costs estimates and NASA (US\$)**

The figures above present similar trends where actual expenditure was increasing between 2009/10 and 2010/11 and decline slightly between 2011/12. However, KNASP cost estimates increased in the entire period due to the fact the targets coverage were also increasing in the period under consideration.

Comparison of the percentages of expenditure and KNASP III cost estimates by broad categories of interventions is shown in Table 3.22. The table shows actual expenditure was generally consisted with the expected allocation according to KNASP III. For instance, 20% of total expenditure was accounted for by prevention while KNASP costing also estimated prevention would take 20% of the total resource needs. While care and treatment estimated to care and treatment to take 57% of the resources, NASA revealed actual expenditure was 54% of the total

<sup>8</sup> KNASP cost estimates were converted into Kenya shilling using the exchange rates used in NASA analysis of US\$1 = Kshs 77.87 in 2009/10, US\$1 = Kshs 82.47 in 2010/11, and US\$1 = Kshs 88.72 in 2011/12.

expenditure in the three years. Overall, expenditure was generally aligned to KNASP III cost estimates in percentage form.

**Table 3.22: Shares on interventions in actual expenditure and cost estimates (2009/10-2011/12)**

	NASA expenditure	KNASP III cost estimates
Prevention	20%	20%
Care and treatment	54%	57%
Orphans and vulnerable children	6%	8%
Programme management and administration	12%	15%
Human resources	3%	0.36%
Social protection and social services	1%	0.12%
Enabling environment	3%	0.12%
HIV and AIDS-related research	1%	0.00%
Total	100%	100%

### **3.16 Institutionalization of NASA**

Kenya adopted devolved system of government in which provision of health and social services are responsibility of the county government. Since HIV and interventions are mainly provided within the context of health care and other social services, it recommended that NASA analysis be institutionalized at both national and county level. Under this process, NASA will be carried out routinely in these two levels of government. In order to achieve this process and have I implemented, there is need to undertake the following:

1. ***Governance for HIV resource tracking:*** The overall responsibility for NASA will be the Ministry of Health through National AIDS Control Council. This will entail provision, refining of customized tools and guidelines on HIV resource tracking; design of mechanism and institutional arrangement for reporting of HIV spending; conducting regular dialogue with stakeholders including implementers; and developing M&E systems that endures that HIV spending is captured and be part of the M&E core indicators.

2. ***Strengthening NACC M&E system to capture HIV resource tracking data.*** Currently there are two tools in the M&E framework that capture various data from implementers. These are Community Based Program Activity Reporting (COBPBAR) Form and sectoral HIV and AIDS mainstreaming reporting tool. The COBPBAR requires COPBAR and be replicated at the county level annually. COBPBAR requires implementers to indicate sources of funds they spent on prevention, care and treatment support, social protection, and capacity building. This tool does not require reporting of actual expenditure. It is recommended that this tool be revised to capture actual expenditure in addition to sources of funds. The NASA tools need to be simplified and incorporated to COPBAR. Additionally, mainstreaming reporting tool data on financial sources as well as amount spent on care, treatment and support for PLHIV and social protection in terms of sources of funds for OVC and IGA. This tool can also be expanded to include NASA components which are customized and simplified to make it friendly to implementers. Furthermore, the NASA tools should be required to be filled by agents and sources on a regular basis.
3. ***Reporting Frequency.*** The COPBAR and mainstreaming reporting tools are filled on a quarterly basis by the implementers. Since it was noted that different financial years or cycles presented some challenges during Kenya NASA, it is recommended that HIV tracking data under different report tools be done on a quarterly basis. This will ensure that analysis can be done easily in terms of government financial year or calendar. The current arrangement in which CACC Coordinators receive data on a quarterly basis from implementers should be used.
4. ***Capacity building for HIV/AIDS resource tracking.*** Institutionalization of NASA will entail trainings at different levels, starting from NACC M&E staff, county level staff, and implementers, including financing agents and sources. Currently, PEPFAR is harmonizing its expenditure analysis with NASA classifications and this analysis is going to be done routinely. This implies there is already existing capacity at PEPFAR, the largest financing source in the country. The country should tap into this routine analysis to leverage on routine data collected from the implementers.
5. ***Financing strategy for HIV/AIDS resources tracking.*** Since the government and county government structure will be used, both levels of government should finance the tracking

of HIV resources as this is a routine activity. Implementers should factor as part of administrative cost this component in their budget. In fact, there are already reporting in the COPBAR and mainstreaming tools.

## **CHAPTER FOUR**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

#### **4.1 Summary and Conclusions**

The Government of Kenya has initiated a comprehensive prevention, treatment and care so as to reduce future HIV transmission and meet the growing demand for HIV services. The results have revealed that substantial amounts of resources have been invested in prevention, treatment and care. Given the importance attached to “getting better value for money” and the absence of an institutionalised mechanism to track HIV and AIDS spending, it was important to undertake this assessment so as to identify what services are being purchased with AIDS-related funding, and who is benefiting from these resources.

The assessment results shows that total expenditure on HIV and AIDS interventions in Kenya increased from Kshs 64,338 million (US\$ 826 million) in 2009/10 to Kshs 70,388 million (US\$ 853 million) in 2010/11, representing an increase of 9% from the 2010/11 expenditure estimates. In 2011/12, the expenditure declined slightly to Kshs 69,750 million (US\$ 786 million) due a slight decline in USG and CHAI funding. The total expenditure over the three-year period amounted to Kshs 204,476 million (US\$ 2,466 million). The results indicated that the bulk of the expenditures on HIV/AIDS in Kenya came from international sources accounting for about 62% during the period. Government of Kenya is the second largest source of financing of the HIV response contributing about 16%. Households, through the out-pocket expenditure, accounted for about 13% of the total expenditure same period. International not-for-profit organisations and

foundations, private sector, GFATM, UN agencies and accounted for 4%, 1.9%, 1.7% and less than 1% respectively of the total spending over the three year period. It is therefore evident that the majority of financing for activities and programmes related to HIV and AIDS is accounted for by external sources.

International purchasing organization as agents accounted for over 56% of funds. The public sector agents accounted for between 25% and 27% while local private organizations managed between 16% and 19% of the total funds. Specifically, international not-for-profit organizations managed the largest share (between 49% and 53%), followed and Ministry of Health (between 16% and 18%) and households (about 13%). The share of funding managed by the National AIDS Control Council accounted for 3% over the three years under consideration.

The public sector remained the largest service provider, accounting for about 50% of the total expenditure. Private sector providers took the second largest share (about 28%) of the expenditure. Bilateral and multilateral agencies spent 7% of the total amount in each of the years. In terms of the priority interventions, the bulk of the expenditure went to care and treatment (54%), followed by prevention (20%) and programme management and administration (12%) and OVC (6%).

People Living with HIV/AIDS (PLWHA) accounted for about 54% of the expenditures as a beneficiary population. Non-target intervention was the second largest (15%) beneficiary population followed by general population (11%). The percentage to most at risk population was very low at 0.22%. Recurrent expenditure took about 96% with capital expenditure accounting for about 4% of the total expenditure. Overall, labour income accounted for the largest percentage (20%), followed by drugs and pharmaceuticals (15%), and ARVs (13%).

## **4.2 Key recommendations**

(i) Allocative Decisions for Greatest Investment

The NASA results show that generally the high impact interventions consisting of Behaviour Change Communication (BCC) activities, ART, PMTCT, and male circumcision received significant funding in the period under consideration. However, other high impact interventions such as prevention activities on MARPs and prevention through treatment for discordant couples received less attention in terms of the expenditure. Furthermore, low impact intervention such as VCT received significant resources. It is recommended that the country should target resources towards high impact interventions that which maximize benefits.

(ii) Sustainable, Transparent, Accountable and Aligned Funding

As indicated in analysis, bulk of the spending on HIV response was attributed to external sources. However, contribution by government has been increasing over the years. It is recommended that government should continue to increase its contribution in order to ensure sustainability of the national response to HIV and AIDS. Although NACC has continued to explore domestic and sustainable financing options, there need to actualize some of these options for sustainability purposes.

Although country comparisons were not done, there is a strong need to undertake a cost-effectiveness analysis of funds from different sources. Additionally, the funding from all the sources should be aligned to priority areas. All these would require transparency and accountability of all those involved in the flow of funds.

(iii) Improving Financial Management Capacity and Systems

The results of qualitative analysis revealed that financial management capacities of the organizations involved in service delivery at the local level were very low. This is constraining service delivery and has the potential to seriously reduce the impact of the interventions. It also affects efficiency in service delivery.

(iv) Institutionalising Routine Expenditure Tracking

It was recommended in the previous NASA that institutionalization of NASA is critical. This is because data availability routine would assist the country to assess the performance of the response on regular basis. This is also a key component in monitoring whether funding is aligned to the priority interventions and if not aligned corrective measures can be put in place.

Institutionalization is also needed given the creation of counties in which social services have been devolved. It is recommended that each county should carry out its own NASA, build their own capacities and make collect of HIV and AIDS data expenditure a routine.

(v) Additional Research

Expenditure on research was minimal and came from bilateral sources. It is recommended that more funding be providing for HIV related research.

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