Republic of Kenya

KENYA NATIONAL AIDS SPENDING ASSESSMENT FY 2016/17-2019/20

March 2023

REPUBLIC OF KENYA

KENYA NATIONAL AIDS SPENDING ASSESSMENT FY 2016/17-2019/20

National Syndemic Diseases Control Council Nairobi, Kenya

This National AIDS Spending Assessment was implemented by the National Syndemic Diseases Control Council (NSDCC) through joint funding provided by the NSDCC and United Nations Programme on HIV and AIDS (UNAIDS).

Additional information on Kenya NASA may be obtained from
NSDCC
Landmark Plaza, 9th Floor.
Argwings Kodhek Road
P.O. Box 61307 - 00200 Nairobi, Kenya
Email: communication@nacc.or.ke

Table of Contents

LIST OF TABLES ..... **vi**
LIST OF FIGURES ..... **vii**
FOREWORD ..... **viii**
ACKNOWLEDGEMENTS ..... **ix**
DEFINITION AND DESCRIPTION OF TERMS ..... **x**
ABBREVIATIONS AND ACRONYMS ..... **xii**
EXECUTIVE SUMMARY ..... **xiii**
CHAPTER 1: INTRODUCTION **1**
1.1 Context For the Assessment 1
1.2 Rationale for Conducting KNASA in 2022 2
1.1 Objectives 3
1.2 Scope of the Assessment 3
CHAPTER 2: NASA METHODOLOGY AND CLASSIFICATION **4**
2.1 Background 4
2.2 Implementation Phases 5
2.3 Sampling and Data Collection 5
2.3.1 Sampling approach 5
2.3.2 Donors 5
2.3.3 Financing agents 6
2.3.4 Government Ministries 6
2.3.5 Counties 6
2.3.6 NGOs and community-based organizations 6
2.4 Data Collection 6
2.5 Out-of-Pocket Expenditure (OOP) 7
2.6 Data Capture and Processing 7
2.7 Data Analysis 7
2.8 Quality Control 8
CHAPTER 3: RESULTS **9**
3.1 Financial Flows in HIV and AIDS Spending 9
3.2 Trends in HIV and AIDS Spending 9
3.3 HIV Spending Trends By Financing Entities, 2016/17 to 2019/20 10

3.4 HIV Expenditure by Revenue Types 14
3.5 Health-Care Financing Schemes 16
3.6 Financing Agents and Purchasers 18
3.7 Providers of HIV and AIDS Services 21
3.8 HIV Expenditure Service Delivery Modalities 21
3.9 Expenditure on Broad AIDS Spending Categories 22
3.10 Expenditure on Care and Treatment 24
3.11 HIV Expenditure on Prevention Activities 26
3.12 Expenditure on HIV Testing and Counselling 29
3.13 Programme Enablers and Health Systems Strengthening 30
3.14 Social Protection and Economic Support 33
3.15 Social Enablers 34
3.16 HIV and AIDS-Related Research 36
3.17 Beneficiaries of HIV and AIDS Spending 36
3.18 Expenditure by Broad Production Factors Categories 37
3.19 Expenditure on Personnel Cost By Financing Entity 41
3.20 Expenditure On Medical Products and Supplies by Financing Entities 42
3.21 Comparison of Spending and Estimated KNASP Costs 46
3.22 Total expenditure by National and County Level 47
3.23 Expenditure by Source 48
3.24 Conclusions 53
3.25 Recommendations 53
Appendix A 55

LIST OF TABLES

Table 1: Trend in per capita HV expenditure 10
Table 2: Trend in HIV expenditure by financing entities (%) 11
Table 3: Expenditure by financing entities (KES million) 12
Table 4: Expenditure by revenue type 15
Table 5: HIV expenditure by financing schemes 17
Table 6: HIV expenditure by FAP 19
Table 7: HIV expenditure by SDM (KES million) 22
Table 8: HIV expenditure by SDM (%) 22
Table 9: Trend in HIV expenditure by broad AIDS spending categories 23
Table 10: HIV expenditure on care and treatment by year 25
Table 11: Trend expenditure on prevention interventions 27
Table 12: Spending on HIV testing and counselling (KES million) 29
Table 13: Spending on HIV testing and counselling (%) 29
Table 14: Expenditure on programme enablers and system strengthening by FE 31
Table 15: Detailed expenditure on programme enablers and system strengthening 31
Table 16: Expenditure on social protection and economic support 33
Table 17: Expenditure on social enablers by FE (KES million) 34
Table 18: Expenditure by social enablers by intervention 35
Table 19: Spending on HIV and AIDS-related research (KES million) 36
Table 20: Beneficiaries of HIV and AIDS spending in Kenya, 2016/17 to 2019/20 37
Table 21: Expenditure by factors of production by major categories (KES million) 39
Table 22: Expenditure on personnel in total HIV funding within entity 41
Table 23: Expenditure on antiretrovirals by financing entity 42
Table 24: Expenditure on medical supplies by financing entity 43
Table 25: Expenditure on laboratory reagents by financing entity 44
Table 26: HIV expenditure by national and county levels (KES million) 47
Table 27: County and National level HIV expenditure by financing entity (KES million) 49
Table A1: Expenditure on HIV prevention by county (KES million) 55
Table A2: Expenditure on HTC by county (KES million) 56
Table A3: Expenditure on care and treatment by county (KES million) 57
Table A4: Expenditure on social protection and economic support by county (KES million) 59
Table A5: Expenditure on HIV social enablers by county (KES million) 60

LIST OF FIGURES

Figure 1: Financial flows HIV response in Kenya, 2016/17-2019/20 9
Figure 3: HIV expenditure by financing entities 11
Figure 4: Expenditure by broad financing agents and purchasers' categories..... 18
Figure 5: Percentage of expenditure by service providers..... 21
Figure 6: HIV expenditure by broad ASC (%) 24
Figure 7: Expenditure contribution on C&T by FE..... 26
Figure 8: Expenditure on prevention by financing entity 28
Figure 9: Expenditure on HTC by financing entity 30
Figure 10: Expenditure percentage on social protection by FE..... 33
Figure 11: Percentage of expenditure by beneficiary population 2016/17-2019/20..... 37
Figure 12: Funding contribution of FE to total personnel expenditure 41
Figure 13: Comparison of total HIV expenditure and total KASF I cost 46
Figure 14: Comparison of NASA expenditure on C&T and KASF I cost 46
Figure 15: Comparison of NASA expenditure on prevention and HTC and KASF I cost..... 47

FOREWORD

ACKNOWLEDGEMENTS

DEFINITION AND DESCRIPTION OF TERMS

AIDS spending category

This is a functional classification that includes the categories of prevention (including adolescent girls and young women, key populations, condoms, voluntary medical male circumcision, pre-exposure prophylaxis—and other prevention activities), HIV testing and counselling, HIV and AIDS care and treatment, and other health and non-health services related to HIV and coinfections such as tuberculosis and hepatitis. Except for direct services, new classifications include categories with the purpose of strengthening the system of response to HIV and AIDS in general, such as social protection and economic support; social enablers; programme enablers and health systems strengthening; development synergies; and HIV and AIDS-related research.

Beneficiary population

This classification refers to explicitly targeted or intended to benefit from specific activities. Identification of a beneficiary population aims to quantify the resources specifically allocated to the population as part of the service delivery process of programmatic intervention. Beneficiary populations are selected according to the intention or target of the spending in programmatic interventions. This represents an outcome linked to the resources spent, regardless of its effectiveness or effective coverage.

Production factors

This classification uses comparable breakdowns that can easily cross over to other reports. The resource cost classification captures expenditure according to the standard economic classification of resources used for the production of goods and services. The classification includes two major categories: current expenditure and capital expenditure. In NASA, the classification of production factors categorizes expenditure in terms of resources used for production.

Capital expenditure

The main categories in this classification are buildings, capital equipment and capital transfers. These categories may include major renovations, reconstruction or enlargement of existing fixed assets, as these can improve and extend the previously expected service life of an asset.

Current expenditure

This is the total value of resources in cash or in-kind payable to a health provider by a financing agent on behalf of the final consumer of health services in return for services performed (including the delivery of goods) during the year of the assessment (e.g. wages, salaries, commodities).

Financing agent-purchaser

This is an institutional unit involved in the management of one or more financing schemes that implements the revenue collection or purchasing of HIV and AIDS services. This includes

households as financing agents for out-of-pocket payments. It may collect revenues, purchase services under the given financing scheme(s) and be involved in the management and regulation of health and social services financing. There is not necessarily a one-to-one correspondence between financing schemes and financing agents.

Revenue of the schemes

This is the mechanism (transactions) involved in providing resources to financing schemes. The classification of revenues of financing schemes is appropriate for tracking the collection mechanisms of a financing framework. The new classification makes it possible to analyse the contribution of institutional units to health and social HIV and AIDS financing.

Financing schemes

These are structural components of health-care financing systems. They are financing arrangements through which people obtain health services. Healthcare financing schemes include direct payments by households for services and goods, and third-party financing arrangements. Third-party financing schemes are distinct bodies of rules that govern the mode of participation in the scheme, the basis for entitlement to health services, and the rules on raising and pooling the revenues of the given scheme.

Service delivery modalities

This is a new classification created by UNAIDS to add the option of analyzing programmes disaggregated by models in terms of efficiency and effectiveness. Out-of-pocket expenses This is expenditure by households and individuals on HIV and AIDS-related services, such as household income spent on care and treatment services and pooled funds of support groups to provide support.

Development synergies

These are programmes necessary to enable the efficacy, equity and rollout of basic programme activities. They encourage the sustainability of HIV and AIDS responses through integration into broader health and non-health sectors. Although development synergies can have a profound impact on HIV and AIDS outcomes, their reason for being is not typically for HIV and AIDS. Maximizing the HIV and AIDS-related benefits and minimizing the HIV and AIDS-related harms of development synergies would make them HIV and AIDS-sensitive.

Out-of-pocket expenses

This is expenditure by households and individuals on HIV and AIDS-related services, such as household income spent on care and treatment services and pooled funds of support groups to provide support.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CDC	Centers for Disease Control
GFATM	The Global Fund to Fight AIDS
HIV	Human Immunodeficiency Virus
KASF	Kenya AIDS Strategic Framework
NASCOP	National AIDS & STI Control Programme
NACC	National AIDS Control Council
NASA	National AIDS Spending Assessment
NGO	Non-Governmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief
UNAIDS	The Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

HIV and AIDS remain major challenges in Kenya, with substantial regional variations in HIV prevalence. New infections are occurring in both the general population and high-risk groups. In 1999, cognizant of the magnitude of the HIV epidemic, the Government of Kenya declared it a national disaster and established the National AIDS Control Council to coordinate the multi-sectoral response to HIV and AIDS. The National AIDS Control Council, in the changes following an executive order published on 5th August 2022 became known National Syndemic Diseases Control Council. Beyond HIV/AIDS response, the agency will deal with sexually transmitted infections, malaria, tuberculosis, leprosy and lung disease.

In line with the Declaration of Commitment on HIV and AIDS, Kenya, like most other countries, is required to submit annual reports on progress achieved in the national response to the epidemic. One of the key indicators reported on the implementation of the Declaration of Commitment at the national level is the assessment of the total resources from financing sources, including the Government, to address the HIV pandemic. In addition, information on HIV spending also informs policy decision-making by the Government. In this regard, the National AIDS Spending Assessment is necessary. The National AIDS Spending Assessment is a standard comprehensive and systematic methodology used internationally to determine the flow of resources for HIV and AIDS programming. It tracks the expenditure on HIV interventions from their origin, through different entities, including financing agents and service providers, to the beneficiaries.

Purpose and objectives

In light of the above context and building on the previous National AIDS Spending Assessment conducted in 2008, 2014 and 2016, the National Syndemic Diseases Control Council commissioned this report. The overall objective of the 2022 Kenya National AIDS Spending Assessment was to obtain information on the overall picture of the total spending on HIV and AIDS programme interventions implemented in the country by various stakeholders, covering the financial years 2016/17, 2017/18, 2018/19 and 2019/20 using the NASA methodology. Specific objectives were to:

- determine the total expenditures on HIV and AIDS interventions in these financial years from different sources, including the Government (national and county level), international partners (bilateral and multilateral), and private entities.
- identify and measure the expenditure on HIV by financing entities, revenue, financing schemes, financing agent-purchasers, service providers, service delivery modalities, functions or interventions, and beneficiary populations.
- prepare a report of the HIV expenditure by interventions, including the amounts spent on prevention activities, care and treatment, human resources, and HIV/AIDS research.
- compare the allocation of expenditure on HIV and AIDS and the priorities defined in the KASF I.

Methodology

Standard National AIDS spending methodology was adopted, which consisted of carrying out a survey to collect primary and secondary data on HIV expenditure from different sources,

consisting of financing entities, financing agents and purchasers and service providers. Data were collected from financing sources consisting of the Kenya Government, the United States Government, the Bill and Melinda Gates Foundation, the Clinton Foundation, the AIDS Healthcare Foundation., UNAIDS, UNICEF, UNFPA, and UNEP. The financing agents and purchasers were also surveyed and provided with expenditure data. Further, a survey of 10 counties across all regions in Kenya was undertaken, collecting data on NGO implementers. The government financing agents and provided surveyed included National AIDS Control Council (now called National Syndemic Diseases Control Council), National AIDS and STI Control Program, and different government ministries.

The collected expenditure data were processed using the Data Consolidation Tool and were imported into the NASA Resource Tracking Tool for the generation of results matrices. Out-of-pocket expenditure was estimated using data from the recent activity-based costing and management costing study conducted in 2021 by the National AIDS Control Council.

Results

Total HIV and AIDS spending in Kenya was KES 73,532 million (US$ 718 million) in 2016/17 but declined slightly to KES 68,491 million (US$ 669 million) in 2017/18. The HIV and AIDS spending slightly rose to KES 72,220 million (US$ 714 million) in 2018/19. The spending declined drastically in 2019/20, being KES 56,077 million (US$ 542 million). The main reason for the decline in 2019/20 was the decline in contribution to spending from the Government of the United States. This figure reflects the constant fluctuations in external support over the period. As a percentage of gross domestic product, spending on HIV and AIDS declined steadily over the period from was about 0.91 percent in 2016/17 to 0.76 percent in 2017/18, 0.73 percent in 2018/19 and 0.53 percent in 2019/20.

The results showed that HIV expenditure was funded mainly by international partners whose contribution was over 80 per cent of the total spending. The total spending from the international entities was KES 62,703 million (US$ 612 million) in 2016/17, KES 59,343 million (US$ 580 million) in 2017/18, KES 60,473 million (US$ 598 million) in 2018/19, and KES 46,298 million (US$ 447 million) in 2019/20. The National and County Governments contributed KES 7,297 million (US$ 71 million) in 2016/17, KES 6,242 million (US$ 61 million) in 2017/18, KES 8,716 million (US$ 86 million) in 2018/19 and KES 7,236 million (US$ 70 million) in 2019/20. The domestic private entities contributed about just above 4 per cent and consisted of out-of-pocket expenditure.

The government of the United States was the leading contributor of the funds spent at KES 46,185 million (US$ 451 million) (63%) in 2016/17, KES 45,346 million (US$ 443 million) (67% in 2017/8, KES 46,365 million (US$ 458 million) in 2018/19 (64%) and KES 36,419 million (US$ 345 million) (65%) in 2019/20. The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) was the second largest source of funds contributing KES 14,703 million (US$ 144) (20%), KES 11,772 million (US$ 115 million) (17%), KES 12,021 million (US$ 119 million) (17%) and KES 8,363 million (US$ 81 million) (15%) in 2016/17, 2017/18, 2018/19 and 2019/20 respectively. The Government of Kenya was third source of funds spent, accounting for 9.9 percent in 2016/17, 9.1 percent in 2017/18, 12.1 percent in 2018/19 and 12.9 percent in 2019/20. The fourth was households' expenditure mainly consisting of transport cost to utilize HIV services, with their

contribution taking 4.8 percent of the total expenditure in 2016/17, 4.2 percent in 2017/18, 4.2 percent in 2018/19 and 4.5 percent in 2019/20. These four financing entities accounted for about 97 percent of the total HIV and AIDS expenditure.

Kenya's HIV and AIDS funds were largely managed by international financing agents in 2016/17 and 2017/18, at 44.4 percent and 47.1 percent respectively. The public sector financing agents and purchasers take second and very close share to that of the international purchasing organizations at 43.9 percent in 2016/17 and 40.3 percent in 2017/18. The public sector, which included the Ministry of Health, the National AIDS Control Council, the National AIDS and STI Control Programme and other ministries acting as financial agents, took the lead, managing 51.1 percent of the funds in 2018/19 and 50 percent in 2019/20. The share of international purchasing organizations reduced to 36.5 percent in 2018/19 and 36.1 percent in 2019/20. The increase in the share of public sector agents was partly attributed to the move by USG to use more of the domestic entities. The private sector, which includes nongovernmental organizations and businesses, managed 12 percent of the total expenditure in 2016/17, 13 percent in 2017/18, 12 percent in 2018/19 and 14 percent in 2019/20.

HIV and AIDS services are provided by several providers that include the government and other public entities, international NGOs and universities, and domestic private for-profit and non-profit organizations. The public sector providers accounted for 50 percent of the expenditure in the financial years 2018/19 and 2019/20. International NGOs and foundations also play a significant role in using funds for service provision.

Bulk of the expenditure went to care and treatment, averaging about 51 percent over the period. Programme support activities referred to as programme enablers, and systems strengthening came a distant second in terms of expenditure, accounting for an average of 20 percent over the four years, followed by HTC (12%), prevention (9%), social protection and economic support (7%) and research (0.1%). The decline in expenditure in 2019/20 affected more the treatment and care intervention.

Conclusions

The following conclusion can be drawn from the results:

a) The funding for the HIV response in the country has flattened over the last years and sharply declined in the last year. Evidence from the results shows that donor funding towards the fight against HIV/Aids has dropped in the last 5 years. This call for the government to address the funding gap left by donors to sustain the gains made. The country has for many years heavily relied on donor funding for control programmes, and given the sharp decline in funding, the government need to increase funding to the national response in order to sustain the fight against HIV Aids.
b) The funding relies heavily on two external sources, the GFATM and the Government of the United States. Kenya still continues to rely heavily on external sources. More efforts should be made to ensure the financial sustainability of the key prevention and treatment, and care services which now mainly depend on international donors. The national and county governments have a good potential to mobilise more funds for the actual service delivery by increasing their contribution as an absolute amount and a share of the total HIV spending.

c) There is a high risk of sustaining the funding of the HIV response because the bulk of the funding comes from external sources. Over the last five years, the country has continued to rely heavily on international sources, particularly the Global Fund and PEPFAR (complemented by bilateral sources), for its HIV prevention and treatment programmes. Most of the programmes are almost entirely funded by international sources. Given the risk of sustaining HIV/aids funding, and especially considering the future financing landscape, domestically funded HIV programmes need to deliver effective prevention and treatment strategies that focus on key priority interventions. This may demand strong domestic leadership and better coordination of the HIV response in the longer term. However, in the medium term, the Global Fund and bilateral donors will remain crucially important to the HIV response in the country.

d) The contribution of the Government of Kenya is critical, but it is mainly indirect through funding of human resources for health.
The GOK makes a significant contribution to the national response through the provision of health personnel and other recurrent inputs. For instance, public health facilities provide health services to about 80% of the patients on ART. The 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.

Recommendations

1. Domestic financing through health insurance in the context of UHC will go a long way in improving funding sustainability.
The Kenya government has already recognised HIV response as an integral part of the UHC agenda. However, the process needs to be fast-tracked. First, there is a need to identify a clear pathway for the inclusion of HIV into the essential benefits package is critical in order to promote the universal health coverage goal of ensuring a sustainable HIV response that is currently heavily donor dependent. Secondly, it is essential to include HIV interventions in the essential benefits package for UHC as a means of reaching the UHC for all Kenyans and achieving MOH UHC targets. Third, there is a need to determine a mechanism for channelling HIV treatment-related funds towards increasing the resource pool of health insurance available to cover persons living with HIV sustainably.

2. Increasing government allocation from own domestically generated revenue will go a long way in reducing the sustainability problem.
It is essential to incorporate most HIV/AIDS-related activities into core budgets and functions in the longer term. Additionally, both the national and county governments should develop specific resource mobilisation strategies to ensure adequate funding for HIV/AIDS activities. This should consider not only short-term funding requirements but also ways to gradually increase the availability of resources over time to cope with rising HIV/AIDS-related needs. It is also essential to develop a strategy to create budgetary space to cover key HIV/AIDS-related costs over the next decade. The major source of potential space has to be assumed to be closer management of personnel-related costs in the absence of increasing government revenue. In addition to committing additional domestic resources, the government must ensure efficiency in the utilisation of available resources for the provision of efficient and effective HIV/AIDS services.

3. However, there is an extent to which the Government can allocate additional funding, given fiscal space constraints and funding needs for other sectors. Therefore, finding cost-effective, sustainable financing options is also imperative.

CHAPTER 1: INTRODUCTION

1.1 Context For the Assessment

HIV and AIDS remain major challenges in Kenya, with substantial regional variations in HIV prevalence. Since the first HIV case was recorded in the early 1980s, the government's mechanisms to monitor the epidemic and response have expanded greatly. While for over a decade, the highest rates of infection were initially concentrated in marginalized and key population groups, new infections are occurring in both the general population and vulnerable, high-risk groups. In 1999, cognizant of the magnitude of the HIV epidemic, the Government of Kenya (GoK) declared it a national disaster and established the National AIDS Control Council (NACC) to coordinate the multi-sectoral response to HIV and AIDS. NACC, among others, partners with National AIDS and STI Control Programme (NASCOP) in managing the response.

In line with the Declaration of Commitment on HIV and AIDS, Kenya, like most other countries, is required to submit annual reports on progress achieved in the national response to the epidemic. One of the key indicators reported on the implementation of the Declaration of Commitment at the national level is the assessment of the total resources from financing sources, including funds allocated by the government to address HIV and AIDS. The overall aim of conducting NASA in Kenya is to introduce an effective tool for financial monitoring of HIV and AIDS programs and activities, better understand the spending patterns for related HIV-related activities, analyse HIV spending priorities and form indicator No.1 for 2010-2012.

The National AIDS Spending Assessment (NASA) is a standard comprehensive and systematic methodology used internationally to determine the flow of resources for HIV and AIDS programming. It tracks the allocation of funds, from their origin, through different economic agents to the beneficiaries. The NASA resource tracking algorithm is designed to describe financial flows and expenditures using the same categories as in the Global Resource Needs Estimation. The NASA framework is based on globally accepted standardized methods and definitions that are compatible with, but more disaggregated than, National Health Accounts (now called the System of Health Accounts). NASA captures data beyond health expenditure to embrace other spending in the multisectoral HIV and AIDS response. Resource tracking is an important method of transparency, accountability, and monitoring to ensure future resources are spent in high-priority areas and among people with the greatest needs. NASA tracks the flow of resources from their source to the point of expenditure.

Kenya has undertaken three previous NASA surveys. In 2008 the National AIDS Control Council, with the technical and financial support of UNAIDS, conducted the first HIV resource tracking study using the NASA methodology for two fiscal years 2006/07-2007/08, 2009/10-2011/12, and 2012/13-2015/16. The first NASA explored all possible sources of financing for HIV and AIDS-related health services (public, private and external financers). The first NASA showed that Kenya spent KES.21.81 billion (US$307.69 million) on HIV and AIDS response in 2006/07. This increased to KES. 23.86 billion (US$ 361.86 million) in 2007/08, representing a growth of 18%. In the second NASA, total expenditure on HIV and AIDS interventions increased from KES 64,338 million (US$ 826 million) in 2009/10 to KES 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 KES 69,750 million (US$ 786 million) due to a slight decline in USG and

CHAI funding. The total expenditure amounted to KES 204,476 million (US$ 2,466 million). The largest share of expenditures on HIV/AIDS in Kenya came from international sources accounting for about 62% during the period. The government of Kenya accounted for the second-largest source of financing for 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 organizations and foundations, the private sector, GFATM, and UN agencies accounted for 4%, 1.9%, 1.7%, and less than 1%, respectively, of the total spending over the three years. It is, therefore, evident that the majority of financing for activities and programs related to HIV and AIDS is accounted for by external sources.

The third NASA showed that total expenditure on HIV and AIDS interventions was KES 70.49 billion (US$ 829 million1) in 2012/13, KES 73.95 billion (US$ 856 million) in 2013/14, KES 84.87 billion (US$ 857 million) in 2014/15, and KES 86.37 billion (US$ 855 million) in 2015/16. External sources contributed 63% of the total HIV and AIDS resource envelope, public sources increased from 16% in 2009/10-2011/12 to 27% in 2012/13-2015/16 period, and households through the out-pocket expenditure, which accounted for about 13% of the total expenditure 2009/2010 – 2011/12 went down to 3 per cent in this period.

The results from this NASA will generate useful information that will help in tracking Kenya AIDS Strategic Framework (KASF III) implementation in the assessment of whether priority activities were implemented according to the plan. In addition, the results will enable stakeholders to i) assess trends in the amount and mix of HIV/AIDS spending, which will help stakeholders understand the trend in total spending for AIDS and how these funds are being used ii) estimate the HIV/AIDS financing gap.

1.2 Rationale for Conducting KNASA in 2022

The 2001 United Nations General Assembly Special Session on HIV and AIDS urged countries to invest in monitoring and evaluation systems for their HIV and AIDS responses. This entails the institutionalization of a monitoring system that enables implementers to routinely collect financial and health service delivery data on the HIV and AIDS response. The NASA results provide information that will help the country to determine expenditure incurred in each programmatic area, estimate the financing gap, and improve future allocative decions and mobilization of sustainable financing mechanisms. Furthermore, continuous tracking of HIV and AIDS resources will also strengthen the capacity of all those involved in the HIV and AIDS response to use the funding for HIV and AIDS programs effectively.

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, the need for timely, reliable, and comprehensive information for the management of the national response to HIV and AIDS cannot be overemphasized. Moreover, with the transfer of health service delivery functions to county governments, accurate data on HIV and AIDS resource flows and expenditures will be required for HIV and AIDS programming both at national and county levels.

In light of the above context and building on the previous National AIDS Spending Assessment conducted in 2008, 2014 and 2016, the National Syndemic Diseases Control Council (NSDCC), , conducted NASA 2016/17-2019/20 whose findings will go a long way in evaluating KNASP III's performance as well as informing KNASP IV development.

1.1 Objectives

The overall objective of the 2022 NASA was to obtain information on the overall picture of the total spending on HIV and AIDS program interventions implemented in the country by various stakeholders (public, private, Mission and CSOs) involved in the national response to HIV and AIDS in 2016/17, 2017/18, 2018/19 and 2019/20 using the NASA methodology.

Specific objectives were to:

- determine the total expenditures on HIV and AIDS interventions in Financial Years (FYs) 2016/17-2019/20 from different sources, including government (national and county level), international partners (bilateral and multilateral), and private (profit-making and non-profit-making) entities known to contribute to HIV and AIDS activities in 2016/17, 2017/18, 2018/19 and 2019/20.
- identify and measure the flow of HIV and AIDS resources by financing entities, revenue, financing schemes, financing agent-purchasers, service providers, service delivery modalities, functions or interventions, and beneficiary populations.
- prepare a report of expenditure trends of the public, private sectors, and international donors on the national HIV/AIDS response as well as the amounts spent on prevention activities, care and treatment, human resources, and HIV/AIDS research.
- compare the allocation of expenditure on HIV and AIDS and the priorities defined in the KNASP III.

1.2 Scope of the Assessment

The following parameters defined the scope of NASA 2022

- The assessment focused on tracking national and county HIV expenditure for the FYs 2016/17, 2017/18, 2018/19 and 2019/20
- Expenditure data on HIV and AIDS collected from domestic, external, and private sources, including funds channelled through the government to track the allocation of HIV and AIDS funds, from their origin down to the endpoint of service delivery, among the different sources of financing (public, private or external) and the different providers and beneficiaries (target groups), revenue and financing schemes.
- Household survey for out-of-pocket expenditure on HIV and AIDS services estimated from the recent NHA study.
- The expenditure data was collected in local currency but converted to United States Dollars using an appropriate rate of exchange rate and reported in US Dollars.
- Spending at the national and county levels captured.
- The beneficiaries of the spending identified, as far as the data allowed.

CHAPTER 2: NASA METHODOLOGY AND CLASSIFICATION

2.1 Background

NASA is based on standardized methods, definitions, and accounting rules of the globally available and internationally accepted System of National Accounts, National Health Accounts, and National AIDS Accounts. NASA follows the basic framework and templates of National Health Accounts but is not limited to health expenditure. It embraces other expenditures to track the multisectoral response to HIV and AIDS. The NASA approach to tracking resources is a comprehensive and systematic methodology used to determine the flow of resources for the national HIV and AIDS response. This methodology seeks to provide answers to the following questions:

- Who paid for HIV and AIDS services in Kenya in 2016/17, 2017/18, 2018/19 and 2019/20?
- What mechanisms were in place to provide resources to financing schemes?
- What were the modalities through which populations access services?
- Who pooled funds and purchased HIV and AIDS services?
- Who were the providers of HIV and AIDS services in Kenya?
- What HIV and AIDS services were provided, and what was spent on them?
- Who were the beneficiaries of HIV and AIDS spending in Kenya?
- What services are being provided, and what service delivery modes are being used?

To answer these questions, the NASA methodology reconstructs all the financial transactions related to the national response to HIV and AIDS. In the NASA 2020 framework, the financial flows and expenditures related to the national response to HIV and AIDS are grouped into three dimensions: finance, provision, and use. Each of these dimensions is broken down to give a total of nine vectors. The three dimensions and nine vectors that constitute the NASA 2020 framework are:

Financing

- Financing entities (sources) are the economic units providing resources to the schemes (used by agents).
- Financing revenues are mechanisms providing resources to financing schemes (used by agents).
- Financing schemes are modalities through which a population accesses service.
- Financing agents and purchasers are economic units that operate the schemes. They collect revenue, pool financial resources, pay for service provision, and make programmatic decisions (allocation and purchase modalities).

Provision of HIV and AIDS services

- Service providers are entities that engage in the production, provision, and delivery of HIV and AIDS services.
- Production factors are inputs and resources (e.g., labour, capital, natural resources, know-how, entrepreneurial resources) used to produce AIDS spending categories.

Use:

- AIDS spending categories are HIV and AIDS-related interventions and activities. There are eight categories of spending: prevention; testing and counselling; care and treatment; social protection and economic support; social enablers; program enablers and health systems strengthening; development synergies; and HIV and AIDS-related research. NASA spending categories are also divided into a functional classification that includes health and non-health HIV and AIDS services.
- Beneficiary segments are populations intended to benefit from specific activities, such as people living with HIV, key populations, vulnerable and accessible populations, the general population, and specific targeted populations not classified elsewhere.
- The service delivery modality is a new variable in NASA 2020 that indicates the modality of the service provided.

2.2 Implementation Phases

The 2022 NASA was conducted under the leadership of the National AIDS Control Council in collaboration with UNAIDS, USAID and NASA consultants. The NASA National Task Team was involved in guiding and overseeing NASA implementation, securing the buy-in of all partners, and ensuring the process met the country's needs. Implementation involved the following phases: i) Planning and mapping of actors; ii) Training on NASA methodology; iii) Sampling and data collection; iv) Quality control and data validation; v) Data analysis and report writing. The NASA team obtained all necessary permissions from the national and county governments to access relevant data and conduct the assessment.

2.3 Sampling and Data Collection

2.3.1 Sampling approach

With guidance from the NASA core team, the assessment targeted the top major financers of HIV and AIDS in Kenya. Data from some of their implementing partners were obtained for data triangulation and completeness of NASA transactions. The sampling frame included development partners; Government ministries, departments and agencies; county departments; international and local nongovernmental organizations; civil society organizations; and private sector organizations. An out-of-pocket expenditure was estimated using NHA survey (year) to estimate private household spending on HIV and AIDS-related interventions.

2.3.2 Donors

To facilitate the sampling process, a database of all the stakeholders involved in HIV and AIDS as sources, agents, and providers was developed. The sampling frame included major financing sources supporting HIV and AIDS to be included. This includes the following: United States through President's Emergency Fund for AIDS Relief (PEPFAR); GFATM; United Nations Agencies; Bill and Melinda Gates Foundation, Clinton Foundation; Department for International. Combined, these development partners account for over 80 percent of the HIV and AIDS funding. We expect to have close to 100% response from the main sources of funds during the period under review. These development partners largely constitute financing sources of HIV and AIDS funds.

2.3.3 Financing agents

In addition to the financing sources, a representative sample of financing agents were selected purposively based on the expected volume of funds managed by the agent. The following list of financing agents will be included in the study: UNAIDS, WHO, UNHCR, UNICEF, WFP, United Nations Development Fund (UNFPA), Drugs and Crime (UNODC), International Labour Organization (ILO), United Nations Educational Scientific and Cultural Organisation (UNESCO), Amref, Red Cross, Action Aid, Medicines Sans Frontier (MSF), FHI360, Population Service International (PSI), Plan International, Clinton Foundation, CHAK, Catholic Relief Services (CRS), The Food Foundation, Welcome Trust, Rockefeller Foundation, Elizabeth Glaser Pediatric AID Foundation (EGPAF), JHPIEGO, Aga Khan Foundation, National AIDS Control.

2.3.4 Government Ministries

For the NASA estimates, government ministries were included in the assessment. Most of the Ministries have an AIDS Control Unit (ACU) which is responsible for HIV and AIDS response in the specific ministry. Some of the key ministries to be included in the sample include The National Treasury and Planning, Ministry of Foreign Affairs, Ministry of Health, Ministry of Education, Ministry of Public Service, Youth and Gender, Ministry of Lands and Physical Planning, Ministry of Water and Sanitation, Ministry of East African Community (EAC) and Regional Development, Ministry of Sports, Culture and Heritage, Ministry of Information, Communication and Technology (ICT), Ministry of Devolution and the ASALS, Ministry of Transport, Infrastructure, Housing, Urban Development and Public Works and Ministry of Agriculture, Livestock, Fisheries, and Irrigation.

2.3.5 Counties

To estimate expenditure on HIV and AIDS at the county level, ten counties were included in the sample. Tentatively the following counties will be included in the study: Kilifi, Machakos, Kisumu, Kakamega, Homabay, Nakuru, Uasin Gishu, Garissa, Nyeri, and Meru.

2.3.6 NGOs and community-based organizations

We used the directory prepared by the NGO council to generate a sampling frame of NGOs working in the field of HIV and AIDS. The directory provided addresses, locations, and the activities of the NGOs. The NGOs will be stratified by type (local versus international) and by county. In this study focused on the active NGOs, given that some of them might not be in existence.

2.4 Data Collection

The assessment used a top-down approach to data collection. Resources allocated to financing agents from financing entities were identified and tracked down. After the identification of service providers and allocated spending, the resources were tracked down to specific AIDS spending categories and beneficiary groups. This approach successfully achieved its objectives, with only a few organizations referring to their implementing partners for further data disaggregation. The National AIDS Control Council contracted the resource tracking team, which comprised 42 research assistants. The research assistants were trained in NASA principles and methodologies, the use of NASA tools, and interviewing and research skills.

The customized NASA data collection template was applied through face-to-face interviews and virtual meetings. Respondents' expenditure records were obtained as part of the primary source

for NASA. Research assistants assisted the respondents in completing the NASA tools. The Global Fund, PEPFAR, and other financing entities provided electronic expenditure reports, which the core research team converted into the NASA format. The assessment also used secondary data through a desk review of key financial reports and documents, policies, health financing documents, and annual program reports. Where expenditure data was missing, secondary data estimations were applied based on available reports (e.g., cost estimates for health systems strengthening and human resources for the Ministry of Health), but generally, estimations were used as little as possible.

2.5 Out-of-Pocket Expenditure (OOP)

An out-of-pocket expenditure was estimated using data from the recent activity-based costing and management (ABCM) costing study conducted in 2021 by the National AIDS Control Council. The study provided the OOP for HIV services, including ART, PMTCT, HTC, VMMC and PrEP. The OOP per visit for each of these number annual visits for these services. The total visits for the different HIV services for each of the years understudy were obtained from Kenya Health Information System (KHIS). The purpose was to determine the annual total household expenditure to feed into the NASA database as part of domestic private expenditure.

2.6 Data Capture and Processing

Data were captured using hard copies of the tools. The raw data were then entered into Excel spreadsheets and translated into the NASA format. The data were entered into the Data Consolidation Tool by the consultants. This tool is an Excel-based spreadsheet that follows the nine vectors of the NASA methodology. It translates raw data into the NASA format and organizes, cleans, and verifies data completeness so that any missing, incomplete or contradictory data can be identified and addressed. The NASA principle of capturing only completed transactions and processing the data in Excel spreadsheets helped the team undertake triangulation, ensured complete transactions, and reduced the possibility of double counting.

The data on expenditure from United States Government was based on expenditure reporting. In the PEPFAR expenditure reporting, the expenditure was reported on a cash basis and not an accrual basis. In addition, the data were reported in the USG fiscal year of October to September. However, this NASA reported expenditure results using the Kenya Government fiscal year of July to June. The annual PEPFAR expenditure was aligned to the Kenya Government fiscal year by dividing it by one quarter and three quarters as appropriate and using the amount respectively in the analysis. For instance, the reported expenditure in NASA for 2017/18 used PEFPAR expenditure for two years, FY 2017 and FY 2018. A quarter of the expenditure for FY 2017 was added to three-quarters of the expenditure for FY 2018 to get expenditure for the fiscal year 2017/18. The expenditure for all the financing entities was given in the Kenya Government fiscal year.

2.7 Data Analysis

The data from the Data Consolidation Tool were imported into the NASA Resource Tracking Tool. This allows the user to create the NASA set of matrixes, linking all the NASA vectors to the HIV and AIDS spending amounts entered into the system. The Resource Tracking Tool was essential in aggregating and analyzing the data and in creating financing flow diagrams. It also generated the full dataset in Excel spreadsheets that were used to create graphical displays and tables.

2.8 Quality Control

The consultants trained data collectors on the application of the customized data collection template and provide guidance and mentorship skills in data collection, processing, and data entry. Data collection and processing occurred concurrently in the field. The collected data were checked, cleaned, triangulated, and validated before entry into the Resource Tracking Tool by the consultants. For accuracy and consistency, consultants checked the capturing of all the transactions daily from all the data collectors. During data processing, the transactions were triangulated by cross-checking multiple sources of data to avoid double-counting. The consultants reviewed the data entry sheet regularly with the aim of potential troubleshooting inconsistencies, as well as guiding standardized data coding entry in the Resource Tracking Tool. The tool's control board also indicates where there are discrepancies that need to be adjusted or fixed.

CHAPTER 3: RESULTS

3.1 Financial Flows in HIV and AIDS Spending

Figure 1 shows the financing transfer mechanisms linking financing entities, revenue of financing schemes, financing schemes through which people obtain health services, and financial agents that pool funds and make decisions to allocate and make payments to service providers.

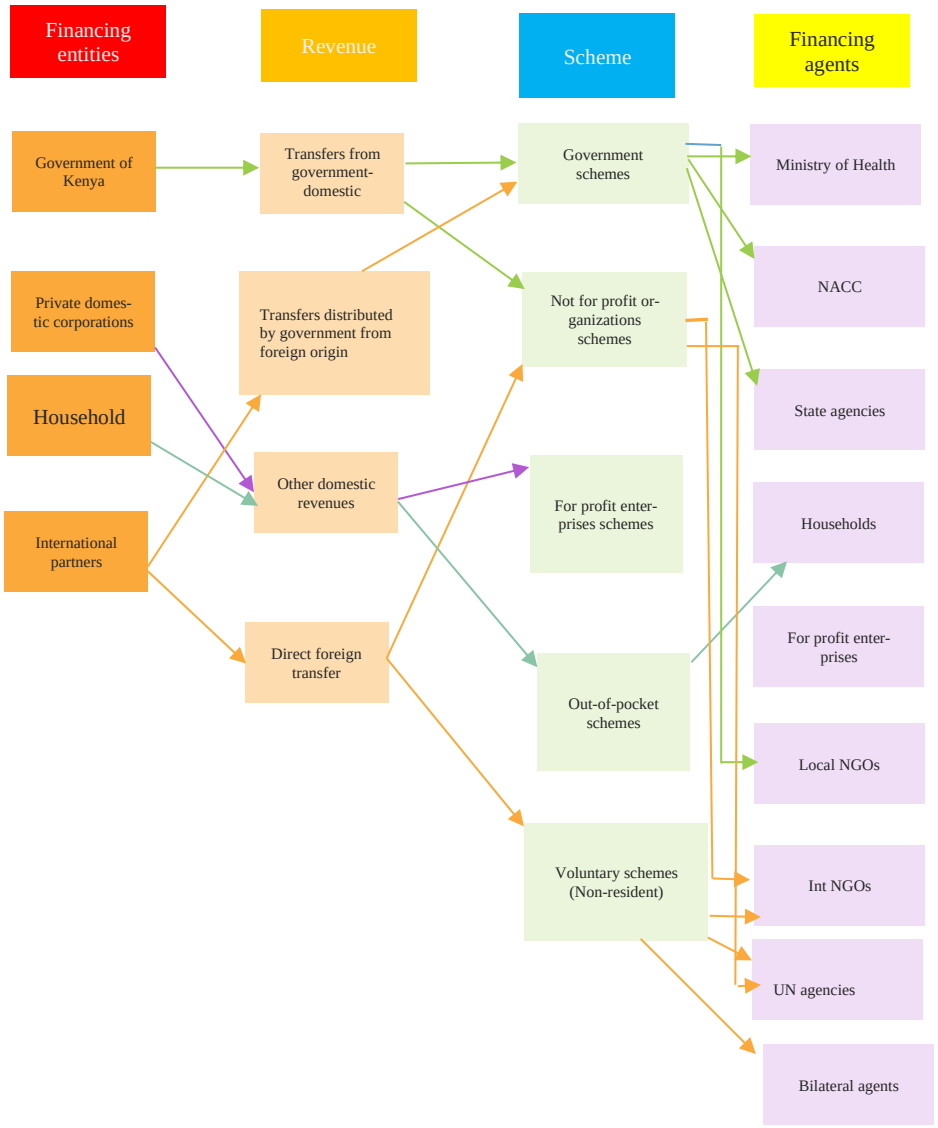

Figure 1: Financial flows HIV response in Kenya, 2016/17-2019/20

3.2 Trends in HIV and AIDS Spending

Total HIV and AIDS spending in Kenya was KES 73,532 million (US$ 718 million) in 2016/17 but declined slightly to KES 68,491 million (US$ 669 million) in 2017/18. The HIV and AIDS

spending slightly rose to KES 72,220 million (US$ 714 million) in 2018/19. The spending declined drastically in 2019/20, being KES 56,077 million (US$ 542 million) (Figure 2). The main reason for the decline in 2019/20 was the decline in contribution to spending from the Government of the United States. This figure reflects the constant fluctuations in external support over the period.

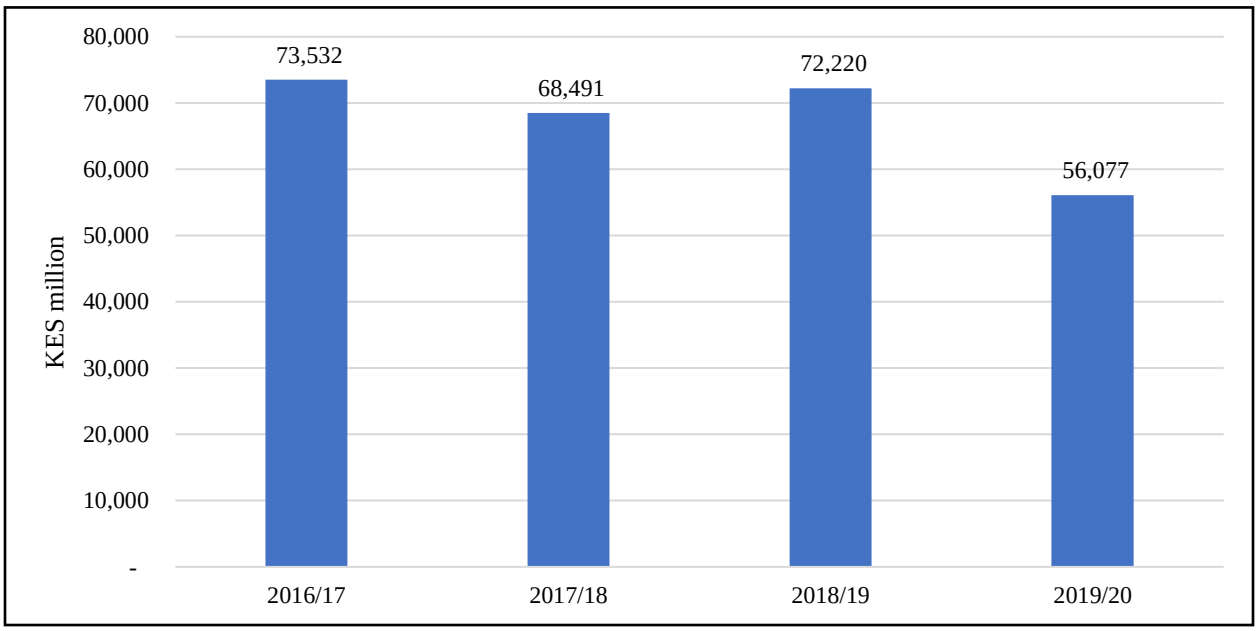

Figure 2: Trends in HIV and AIDS spending in Kenya, 2016/17 to 2019/20

As a percentage of gross domestic product, spending on HIV and AIDS declined steadily over the period from was about 0.91 percent in 2016/17 to 0.76 percent in 2017/18, 0.73 percent in 2018/19 and 0.53 percent in 2019/20. The per capita HIV expenditure is presented in Table 1.

Table 1: Trend in per capita HV expenditure

	Per capita HIV spending (KES)	**Per capita HIV spending (US$)**
2016/17	1,633	15.94
2017/18	1,487	14.53
2018/19	1,534	15.17
2019/20	1,145	11.07

3.3 HIV Spending Trends By Financing Entities, 2016/17 to 2019/20

The HIV and AIDS spending by financing entities, which are the sources of funding. is shown in Figure 3 and in percentages in Table 2.

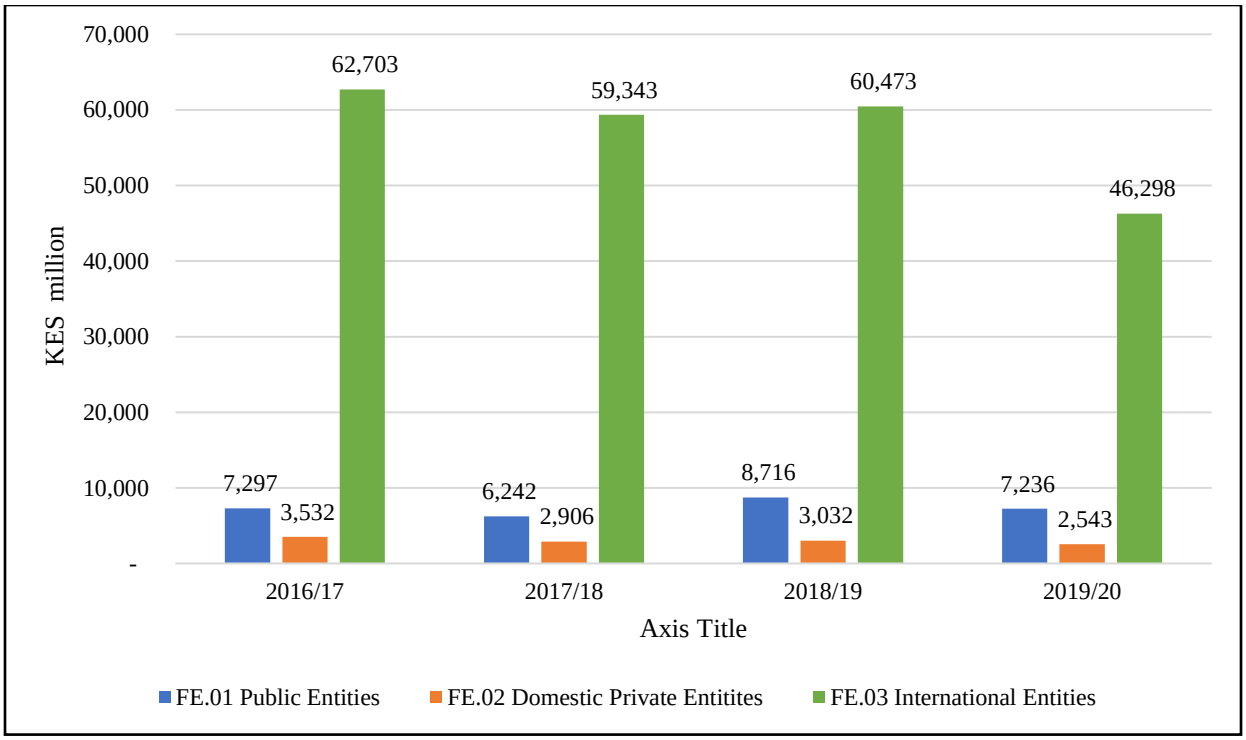

Figure 3: HIV expenditure by financing entities

Table 2: Trend in HIV expenditure by financing entities (%)

	2016/17	2017/18	2018/19	2019/20
FE.01 Public Entities	9.9%	9.1%	12.1%	12.9%
FE.02 Domestic Private Entities	4.8%	4.2%	4.2%	4.5%
FE.03 International Entities	85.3%	86.6%	83.7%	82.6%
Total	**100%**	**100%**	**100%**	**100%**

The results in Figure 3 and Table 2 show that HIV expenditure over the period was funded mainly by international partners whose contribution was over 80 percent of the total spending. The total spending from the international entities was KES 62,703 million (US$ 612 million) in 2016/17, KES 59,343 million (US$ 580 million) in 2017/18, KES 60,473 million (US$ 598 million) in 2018/19, and KES 46,298 million (US$ 447 million) in 2019/20. The National and County Governments contributed KES 7,297 million (US$ 71 million) in 2016/17, KES 6,242 million (US$ 61 million) in 2017/18, KES 8,716 million (US$ 86 million) in 2018/19 and KES 7,236 million (US$ 70 million) in 2019/20. The domestic private entities contributed about just above 4 percent and consisted of out-of-pocket expenditure. The detailed listing of expenditure by specific financing entities is shown in Table 3.

Table 3: Expenditure by financing entities (KES million)

	2016/17		2017/18		2018/19		2019/20	
	Amount (KES million)	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**
FE.01.01.01 Government of Kenya	7,296.85	9.92%	6,241.75	9.11%	8,716.04	12.07%	7,235.97	12.90%
FE.02.01 Domestic corporations	13.43	0.02%			1.41	0.00%		
FE.02.02 Households	3,518.73	4.79%	2,906.31	4.24%	3,030.22	4.20%	2,542.96	4.53%
FE.03.01.29 Government of United Kingdom	0.77	0.00%	72.31	0.11%	29.14	0.04%	24.32	0.04%
FE.03.01.30 Government of United States	46,184.80	62.81%	45,345.88	66.21%	46,364.87	64.20%	36,419.33	64.95%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	14,703.34	20.00%	11,771.89	17.19%	12,021.47	16.65%	8,362.90	14.91%
FE.03.02.08 UNAIDS Secretariat	11.64	0.02%	41.08	0.06%	31.03	0.04%	47.84	0.09%
FE.03.02.09 United Nations Children's Fund (UNICEF)	130.77	0.18%	375.40	0.55%	443.71	0.61%	262.68	0.47%
FE.03.02.11 United Nations Development Programme (UNDP)	13.16	0.02%	16.56	0.02%	2.68	0.00%	3.63	0.01%
FE.03.02.17 United Nations Population Fund (UNFPA)	193.17	0.26%	46.99	0.07%	107.66	0.15%	134.21	0.24%
FE.03.02.18 World Bank Group (WB)	24.76	0.03%	17.95	0.03%			39.41	0.07%
FE.03.02.19 World Food Programme (WFP)	0.16	0.00%						
FE.03.02.20 World Health Organization (WHO)	10.40	0.01%	1.97	0.00%	5.07	0.01%		
FE.03.03.06 Bill and Melinda Gates Foundation	950.37	1.29%	1,101.72	1.61%	876.04	1.21%	505.65	0.90%

	2016/17		2017/18		2018/19		2019/20	
	Amount (KES million)	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**
FE.03.03.12 Elizabeth Glaser Pediatric AIDS Foundation					2.31	0.00%		
FE.03.03.18 International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies	7.11	0.01%						
FE.03.03.25 The Clinton Foundation					4.79	0.01%		
FE.03.03.26 The Ford Foundation			11.09	0.02%				
FE.03.03.30 The Rockefeller Foundation	15.67	0.02%	16.69	0.02%			4.15	0.01%
FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	457.23	0.62%	523.16	0.76%	575.54	0.80%	488.97	0.87%
FE.03.04 International for profit organizations					8.41	0.01%	4.87	0.01%
Total	**73,532.38**	**100%**	**68,490.74**	**100%**	**72,220.39**	**100%**	**56,076.88**	**100%**

Table 3 shows that there were four main specific financing entities in the assessment period, consisting of the Government of Kenya (National and County), the Government of the United States and the Global Fund for AIDS, Malaria and Tuberculosis (GFATM) and households. The government of the United States was the leading contributor of the funds spent at KES 46,185 million (US$ 451 million) (63%) in 2016/17, KES 45,346 million (US$ 443 million) (66% in 2017/8, KES 46,365 million (US$ 458 million) in 2018/19 (64%) and KES 36,419 million (US$ 351 million) (65%) in 2019/20. The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) was the second largest source of funds contributing KES 14,703 million (US$ 144) (20%), KES 11,772 million (US$ 115 million) (17%), KES 12,021 million (US$ 119 million) (17%) and KES 8,363 million (US$ 81 million) (15%) in 2016/17, 2017/18, 2018/19 and 2019/20, respectively. The Government of Kenya was third source of funds spent, accounting for 9.9 percent in 2016/17, 9.1 percent in 2017/18, 12.1 percent in 2018/19 and 12.9 percent in 2019/20. The fourth was households' expenditure mainly consisting of transport cost to utilize HIV services, with their contribution taking 4.8 percent of the total expenditure in 2016/17, 4.2 percent in 2017/18, 4.2 percent in 2018/19 and 4.5 percent in 2019/20. These four financing entities accounted for about 97 percent of the total HIV and AIDS expenditure. Besides, the results underscore the problem of sustainability of funding and the urgent need for increased domestic financing of the HIV response.

3.4 HIV Expenditure by Revenue Types

Revenues describe the main flows through which financing schemes obtain their revenues—that is, the mechanisms through which resources enter the system. The classification of revenues of financing schemes tracks the collection mechanisms of a financing framework. Table 4 shows HIV and AIDS expenditure by the different types of revenues.

Direct financial transfers from foreign entities accounted for the highest proportion of HIV and AIDS spending, at 85 percent in 2016/17, 87 percent in 2017/18, 84 percent in 2018/19 and 83 percent in 2019/20. Direct foreign transfers from bilateral organizations, mainly based on funding from Government of United States, accounted for above 60 percent and being an average of 64.5 percent over the entire period of the four years. Direct multilateral financial transfers contributed an average of 18.1 percent of the total HIV and AIDS spending over the period. Other direct foreign transfers accounted for 1.9 percent, 2.4 percent, 2.0 percent, and 1.8 percent in 2016/17, 2017/18, 2018/19 and 2019/20, respectively. Transfers from government domestic revenue accounted for 9.9 percent of total HIV and AIDS financing in 2016/17, 9.1 percent in 2017/18, 12.1 percent in 2018/19 and 12.9 percent in 2019/20.

Table 4: Expenditure by revenue type

	2016/17		2017/18		2018/19		2019/20	Per Cent
	Amount (KES million)	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**
REV.01 Transfers from government domestic revenue including reimbursable loans (allocated to HIV purposes)	7,296.85	10%	6,241.75	9%	8,716.04	12%	7,235.97	13%
REV.01.01 Internal transfers and grants	7,296.85	100%	6,241.75	100%	8,716.04	100%	7,235.97	100%
REV.06 Other domestic revenues n.e.c.	3,532.16	5%	2,906.31	4%	3,031.63	4%	2,542.96	5%
REV.06.01 Other revenues from households n.e.c.	3,518.73	99.6%	2,906.31	100%	3,030.22	99.95%	2,542.96	100%
REV.06.02 Other revenues from corporations n.e.c.	13.43	0.4%			1.41	0.05%		
REV.07 Direct foreign transfers	62,703.36	85%	59,342.69	87%	60,472.71	84%	46,297.95	83%
REV.07.01 Direct foreign financial transfers	61,261.34	98%	57,648.95	97%	58,974.59	98%	45,246.47	98%
REV.07.01.01 Direct bilateral financial transfers	46,185.57	75%	45,418.20	79%	46,394.01	79%	36,443.64	81%
REV.07.01.02 Direct multilateral financial transfers	15,087.41	25%	12,271.83	21%	12,611.61	21%	8,850.66	20%
REV.07.99 Other direct foreign transfers n.e.c.	1,430.38	2%	1,652.66	3%	1,467.09	2%	1,003.64	2%
Total	**73,532.38**	**100%**	**68,490.74**	**100%**	**72,220.39**	**100%**	**56,076.88**	**100%**

Note: n.e.c. means not elsewhere classified.

3.5 Health-Care Financing Schemes

Health-care financing schemes are structural arrangements through which HIV and AIDS services and goods are paid for and obtained by households. Financing schemes help to define how HIV and AIDS funds are managed and organized, and the extent to which resources are pooled and allocated to pay for HIV and AIDS services by different health-care financing agents and purchasers. Examples include direct payments by households, third-party financing arrangements such as voluntary and social health insurance, government schemes, and voluntary payment schemes from non-profit-making institutions serving households. Voluntary payment schemes accounted for the largest share of the expenditure in the first two years at 51.3 percent, of HIV and AIDS funds in 2016/17, 56.8 percent in 2017/18 and consequently the second lead at 46.8 percent, in 2018/19 and 47.7 percent in 2019/20. Government schemes was the second largest type in the first two years and then become the largest in the last two years, averaging 44.6 percent of the total expenditure over the period. The third financing was Household out-of-pocket payment, accounting for 4.4 percent of the expenditure during the period. Table 5 provides the details.

Table 5: HIV expenditure by financing schemes

	2016/17		2017/18		2018/19		2019/20		Total	
	Amount (KES million)	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**
SCH.01 Government schemes and compulsory contributory health care schemes	32,276.82	43.89%	26,707.62	38.99%	35,376.19	48.98%	26,789.43	47.77%	121,150.06	44.82%
SCH.01.01.01 Central government schemes	32,244.26	99.9%	26,513.19	99%	35,224.49	99.6%	26,589.17	99%	120,571.11	99.5%
SCH.01.01.02 State/regional/local government schemes	32.56	0.1%	194.43	1%	151.70	0.4%	200.26	1%	578.95	0.5%
SCH.02 Voluntary payment schemes	37,736.83	51.32%	38,876.82	56.76%	33,813.98	46.82%	26,744.49	47.69%	137,172.11	50.74%
SCH.02.02 Not-for-profit organisation schemes	37,736.83	100.00%	38,876.82	100.00%	33,813.98	100.00%	26,744.49	100.00%	137,172.11	100.00%
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.2.2.2)	24,397.61	64.65%	27,315.24	70.26%	23,620.88	69.86%	20,003.07	74.79%	95,336.80	69.50%
SCH.02.02.02 Resident foreign agencies schemes	13,339.22	35.35%	11,561.58	29.74%	10,193.10	30.14%	6,741.42	25.21%	41,835.30	30.50%
SCH.03 Household out-of-pocket payment	3,518.73	4.79%	2,906.31	4.24%	3,030.22	4.20%	2,542.96	4.53%	11,998.22	4.44%
SCH.03.01 Out-of-pocket excluding cost-sharing	3,518.73	100.00%	2,906.31	100.00%	3,030.22	100%	2,542.96	100%	11,998.22	100%
Total	**73,532.38**	**100%**	**68,490.74**	**100%**	**72,220.39**	**100%**	**56,076.88**	**100%**	**270,320.39**	**100%**

3.6 Financing Agents and Purchasers

A health-care financing agent or purchaser is an institutional unit that mobilizes and pools funds and makes decisions to allocate and make payments to providers for the services rendered. Financing agents are mainly involved in the management of one or more financing schemes.

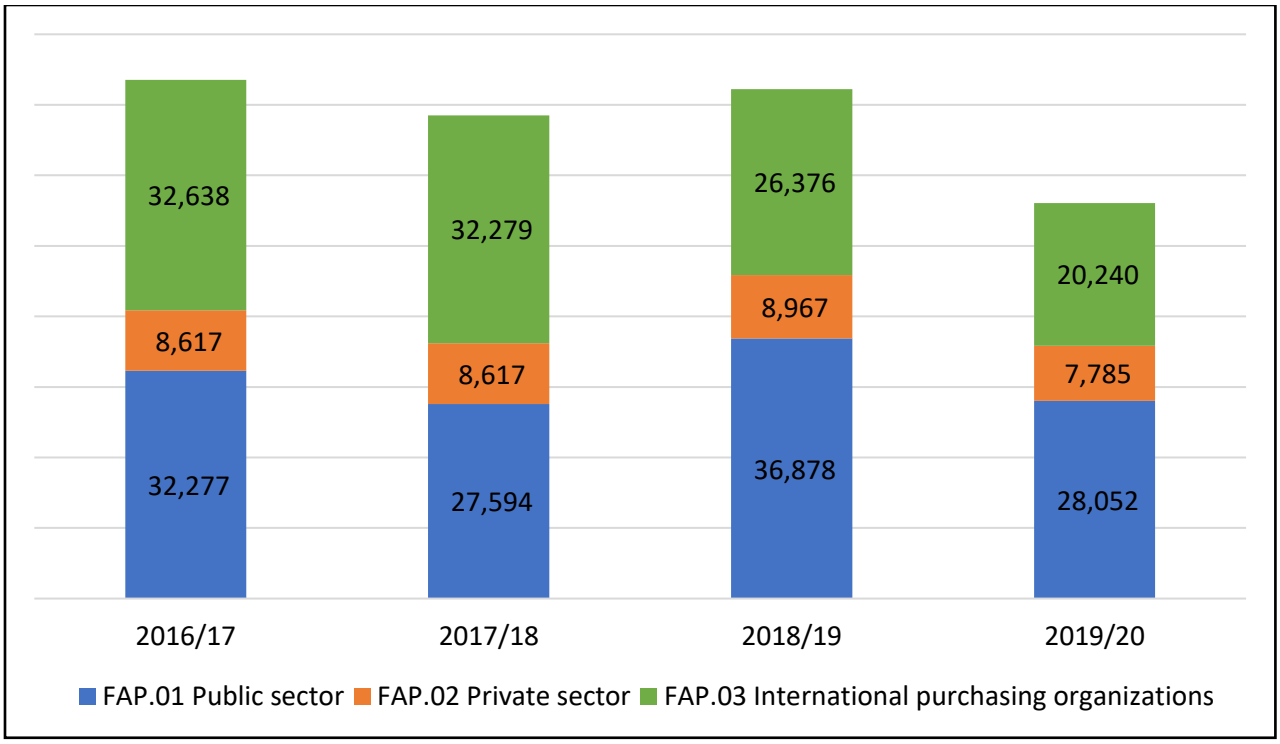

Figure 4: Expenditure by broad financing agents and purchasers' categories

Kenya's HIV and AIDS funds were largely managed by international financing agents in 2016/17 and 2017/18, at 44.4 percent and 47.1 percent respectively. The public sector financing agents and purchasers took second and very close share to that of the international purchasing organizations at 44 percent in 2016/17 and 40 percent in 2017/18. The public sector, which included the Ministry of Health, the National AIDS Control Council, National AIDS and STI Control Programme and other ministries acting as financial agents, took the lead, managing 51 percent of the funds in 2018/19 and 50 percent in 2019/20. The share of international purchasing organization reduced to 37 percent in 2018/19 and 36 percent in 2019/20. The increase in the share of public sector agents was partly attributed to the move by USG to use more of the domestic entities. The private sector, which includes nongovernmental organizations and business, managed 12 percent of the total expenditure in 2016/17, 13 percent in 2017/18, 12 percent in 2018/19 and 14 percent in 2019/20.

Table 6 provides more details on the FAP with Ministry of Health and County Departments of Health taking the highest share of the total expenditure. The Country offices of bilateral agencies managing external resources and fulfilling financing agent roles and Other International not-for-profit organizations also account for a significant share of the expenditure.

Table 6: HIV expenditure by FAP

	2016/17		2017/18		2018/19		2019/20		Grand Total	
Financing Agent and Purchaser	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	24,930.62	33.90%	19,702.36	28.77%	29,134.18	40.34%	22,087.68	39.39%	95,854.84	35.46%
FAP.01.01.01.03 Ministry of Social Development (or equivalent sector entity)	359.11	0.49%	779.34	1.14%	773.05	1.07%	905.05	1.61%	2,816.55	1.04%
FAP.01.01.01.05 Ministry of Finance (or equivalent sector entity)	6,804.51	9.25%	5,810.78	8.48%	5,027.84	6.96%	3,282.30	5.85%	20,925.42	7.74%
FAP.01.01.01.08 Other ministries (or equivalent sector entities)	149.01	0.20%	213.39	0.31%	274.67	0.38%	303.63	0.54%	940.70	0.35%
FAP.01.01.01.10 National AIDS Commission	1.02	0.00%	7.33	0.01%	14.75	0.02%	10.51	0.02%	33.61	0.01%
FAP.01.01.03.01 Department of Health (or equivalent local sector entity)	32.56	0.04%	194.43	0.28%	151.70	0.21%	200.26	0.36%	578.95	0.21%
FAP.01.04 Parastatal organizations			886.65	1.29%	1,501.51	2.08%	1,262.78	2.25%	3,650.94	1.35%
FAP.02.04 Private households' (out-of-pocket payments)	3,518.73	4.79%	2,906.31	4.24%	3,030.22	4.20%	2,542.96	4.53%	11,998.22	4.44%
FAP.02.05 Not-for-profit institutions (other than social insurance)	4,711.85	6.41%	5,173.92	7.55%	5,528.39	7.65%	4,800.70	8.56%	20,214.85	7.48%
FAP.02.99 Other private financing agents n.e.c.	386.67	0.53%	537.05	0.78%	408.18	0.57%	441.36	0.79%	1,773.26	0.66%
FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles	12,022.86	16.35%	11,561.58	16.88%	10,193.10	14.11%	6,741.42	12.02%	40,518.95	14.99%

	2016/17		2017/18		2018/19		2019/20		Grand Total	
Financing Agent and Purchaser	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**
FAP.03.02.07 UNAIDS Secretariat	10.61	0.01%	33.06	0.05%	24.44	0.03%	35.86	0.06%	103.97	0.04%
FAP.03.03.09 Caritas Internationalis/Catholic Relief Services					737.23	1.02%	251.59	0.45%	988.82	0.37%
FAP.03.03.12 Elizabeth Glaser Pediatric AIDS Foundation	1,944.68	2.64%	2,043.98	2.98%	1,334.78	1.85%	1,132.52	2.02%	6,455.95	2.39%
FAP.03.03.18 International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies	1,971.88	2.68%	1,253.60	1.83%	1,544.63	2.14%	2,277.38	4.06%	7,047.50	2.61%
FAP.03.03.22 Plan International	2,043.06	2.78%	1,615.23	2.36%	325.62	0.45%			3,983.90	1.47%
FAP.03.03.25 The Clinton Foundation	0.77	0.00%	80.82	0.12%	50.58	0.07%	44.52	0.08%	176.69	0.07%
FAP.03.03.36 PATH	346.50	0.47%	1,521.28	2.22%	866.27	1.20%	123.30	0.22%	2,857.36	1.06%
FAP.03.03.40 FHI 360	838.23	1.14%	1,141.42	1.67%	668.30	0.93%	115.41	0.21%	2,763.36	1.02%
FAP.03.03.99 Other International not-for-profit organizations n.e.c.	7,894.11	10.74%	6,628.88	9.68%	7,006.69	9.70%	6,207.34	11.07%	27,737.03	10.26%
FAP.03.04 Projects within Universities	4,245.30	5.77%	4,815.31	7.03%	2,724.44	3.77%	2,689.70	4.80%	14,474.75	5.35%
FAP.03.05 International for-profit organizations	1,320.32	1.80%	1,584.04	2.31%	899.80	1.25%	620.60	1.11%	4,424.76	1.64%
Total	**73,532.38**	**100%**	**68,490.74**	**100%**	**72,220.39**	**100.00%**	**56,076.88**	**100%**	**270,320.39**	**100%**

3.7 Providers of HIV and AIDS Services

HIV and AIDS services are provided by several providers that include the government and other public entities, international NGOs and universities, and domestic private for-profit and non-profit organizations. Figure 5 summarises the distribution of expenditure by the broad categories of providers of HIV services.

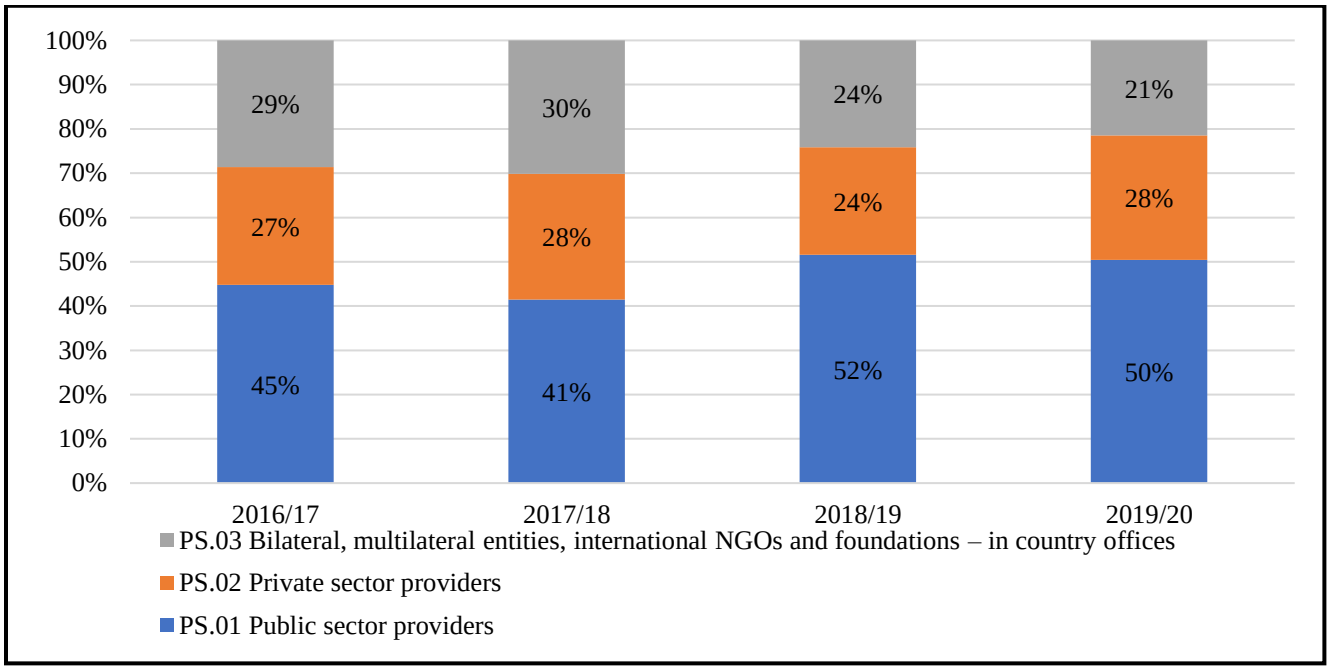

Figure 5: Percentage of expenditure by service providers

Figure 5 shows that public sector entities, such as ministries and agencies, public hospitals and clinics, were the main providers of HIV services. The public sector providers accounted for 50 percent of the expenditure in the financial years 2018/19 and 2019/20. International NGOs and foundations also play a significant role in using funds for service provision.

3.8 HIV Expenditure Service Delivery Modalities

The NASA 2020 framework has included the new service delivery modality vector to identify the different ways in which HIV and AIDS services are delivered. The data provide an opportunity to analyse the efficiency of programmes according to their modes of delivery, provided all expenditure is labelled correctly and comprehensively. Service delivery modalities include models of HIV testing, antiretroviral therapy initiation, and antiretroviral therapy delivery for stable and unstable clients and different subpopulations.

By 2016/17, facility-based service modalities accounted for 65.5% percent of total HIV and AIDS spending. It accounted for 62.0 percent in 2017/18, 66.6 percent in 2018/19 and 68.1 percent in 2019/20. The “not applicable” category for services that did not have a specific delivery model (e.g., programme enablers and health systems strengthening) accounted for about 21 percent overall.

Table 7: HIV expenditure by SDM (KES million)

	2016/17	2017/18	2018/19	2019/20
SDM.01.01 Facility-based: Out-patient	48,128	42,477	48,128	38,177
SDM.02.98 Home and commu-nity based not disaggregated	9,858	10,790	9,562	7,029
SDM.03 Non applicable (ASC which does not have a specific SDM)	15,509	15,185	14,488	10,831
SDM.98 Modalities not disaggre-gated	37	38	43	40
Total	**73,532.38**	**68,490.74**	**72,220.39**	**56,076.88**

Table 8: HIV expenditure by SDM (%)

	2016/17	2017/18	2018/19	2019/20
SDM.01.01 Facility-based: Out-patient	65.5%	62.0%	66.6%	68.1%
SDM.02.98 Home and commu-nity based not disaggregated	13.4%	15.8%	13.2%	12.5%
SDM.03 Non applicable (ASC which does not have a specific SDM)	21.1%	22.2%	20.1%	19.3%
SDM.98 Modalities not disaggre-gated	0.1%	0.1%	0.1%	0.1%
Total	**100%**	**100%**	**100%**	**100%**

3.9 Expenditure on Broad AIDS Spending Categories

NASA uses the term "AIDS spending categories" to define all HIV-related interventions and activities in the HIV and AIDS response. AIDS spending categories include prevention, care and treatment, and other health and non-health services related to HIV and AIDS. This section presents the broader programme areas and a breakdown of each category. It is important to note that in the NASA 2020 classifications, the HIV testing and counselling programme has been separated into a new programme area. Previously, voluntary testing and counselling was considered part of prevention, and provider-initiated testing and counselling was part of treatment. In the new framework, all forms of HIV testing and counselling are combined. Table 9 and Figure 6 provide expenditure disaggregated by AIDS intervention areas.

Table 9: Trend in HIV expenditure by broad AIDS spending categories

	2016/17		2017/18		2018/19		2019/20		Total	
Intervention	KES million	US $ million	KES million	US $ million	KES million	US $ million	KES million	US $ million	KES million	US $ million
ASC.01 Prevention	5,473	53	6,613	65	6,538	65	6,415	62	25,040	245
ASC.02 HIV testing and counselling (HTC)	8,701	85	8,626	84	9,362	93	5,771	56	32,459	317
ASC.03 HIV Care and Treatment Care	39,183	382	32,764	320	37,349	369	29,333	283	138,630	1355
ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	4,666	46	5,302	52	4,483	44	3,727	36	18,178	178
ASC.05 Social Enablers (excluding the efforts for KPs above)	495	5	515	5	581	6	965	9	2,556	25
ASC.06 Programme enablers and systems strengthening	14,991	146	14,604	143	13,836	137	9,841	95	53,271	521
ASC.08 HIV-related research (paid by earmarked HIV funds)	24	0.2	67	1	70	1	26	0.2	186	2
Total	**73,532**	**718**	**68,491**	**669**	**72,220**	**714**	**56,077**	**542**	**270,320**	**2,642**

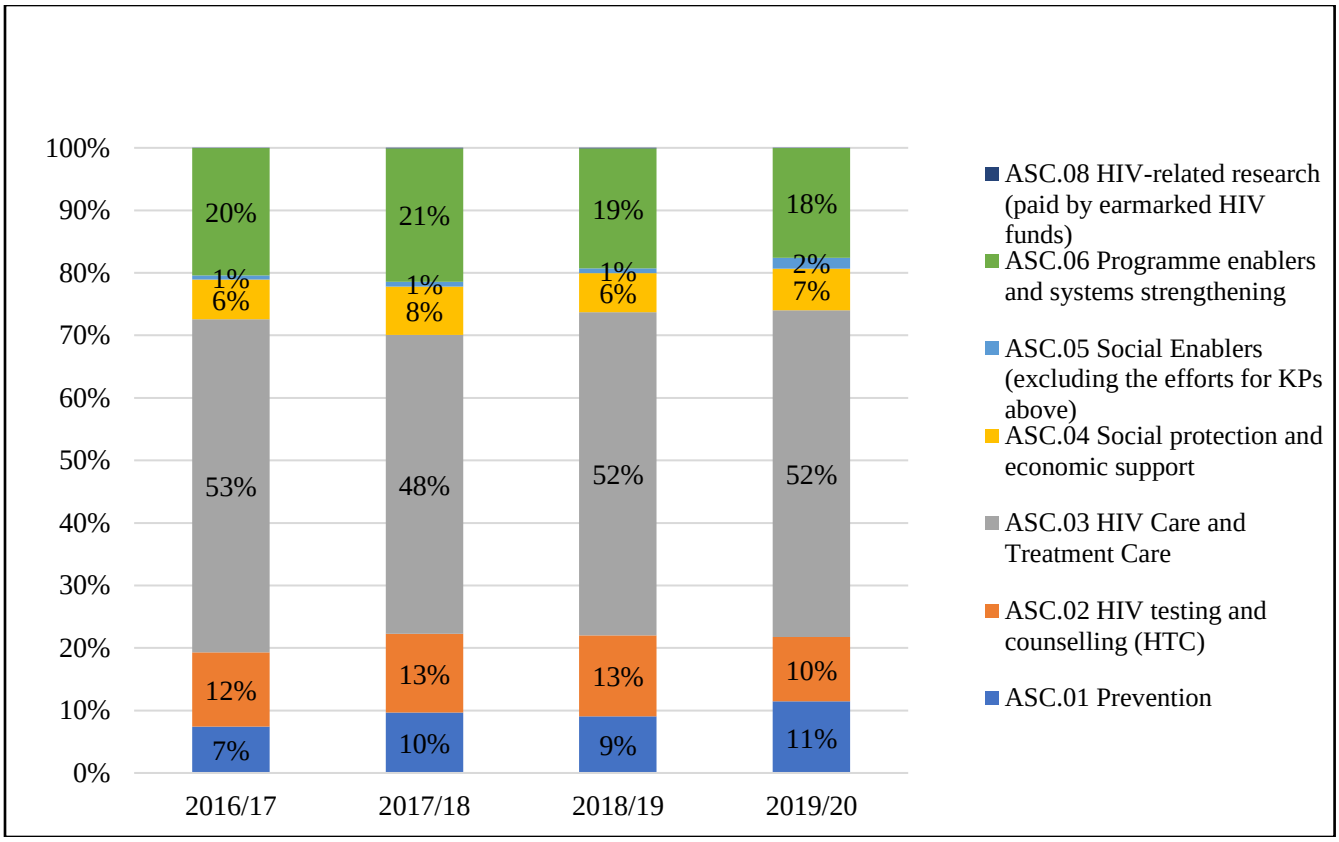

Figure 6: HIV expenditure by broad ASC (%)

Table 9 and Figure 6 show that bulk of the expenditure went to care and treatment, averaging about 51 percent over the period. Programme support activities referred to as programme enablers, and systems strengthening came a distant second in terms of expenditure, accounting for an average of 20 percent over the four years, followed by HTC (12%), prevention (9%), social protection and economic support (7%) and research (0.1%). The decline in expenditure in 2019/20 affected more the treatment and care intervention.

3.10 Expenditure on Care and Treatment

The trends in the expenditure in care and treatment interventions are shown in Table 9. Antiretroviral therapy (ART) took bulk of the funds accounting for about 82 percent of total expenditure, followed by care and treatment not disaggregated, services offered but are not specified whether it is drug-provision or care or support services (6.7%),specific ART-related laboratory monitoring (5.9%), Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs (2.7%), adherence and retention on ART - support (including nutrition and transport) and monitoring (2.3%). Figure 7 shows that the Government of the United States was the main funder of care and treatment, followed by GFATM and third was the Government, both the National and County.

Table 10: HIV expenditure on care and treatment by year

	2016/17		2017/18		2018/19		2019/20		Total	
AIDS Spending Category	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**	**Amount (KES million)**	**Per Cent**
ASC.03.01.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	7,487	19%	6,952	21%	9,459	25%	5,759	20%	29,658	21%
ASC.03.01.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	741	2%	688	2%	785	2%	549	2%	2,764	2%
ASC.03.01.03 ART for PMTCT (for pregnant women not previously on treatment)	2,468	6%	1,195	4%	760	2%	548	2%	4,972	4%
ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	23,654	60%	18,383	56%	21,253	57%	13,228	45%	76,518	55%
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	690	2%	691	2%	919	2%	840	3%	3,139	2%
ASC.03.03 Specific ART-related laboratory monitoring	864	2%	2,554	8%	2,446	7%	2,352	8%	8,216	6%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	977	2%	1,161	4%	1,214	3%	386	1%	3,739	3%
ASC.03.05 Psychological treatment and support service	250	1%	119	0.4%	14	0.04%	7	0.03%	390	0.3%
ASC.03.98 Care and treatment services not disaggregated	2,052	5%	1,020	3%	499	1%	5,663	19%	9,234	7%
Total	**39,183**	**100%**	**32,764**	**100%**	**37,349**	**100%**	**29,333**	**100%**	**138,630**	**100%**

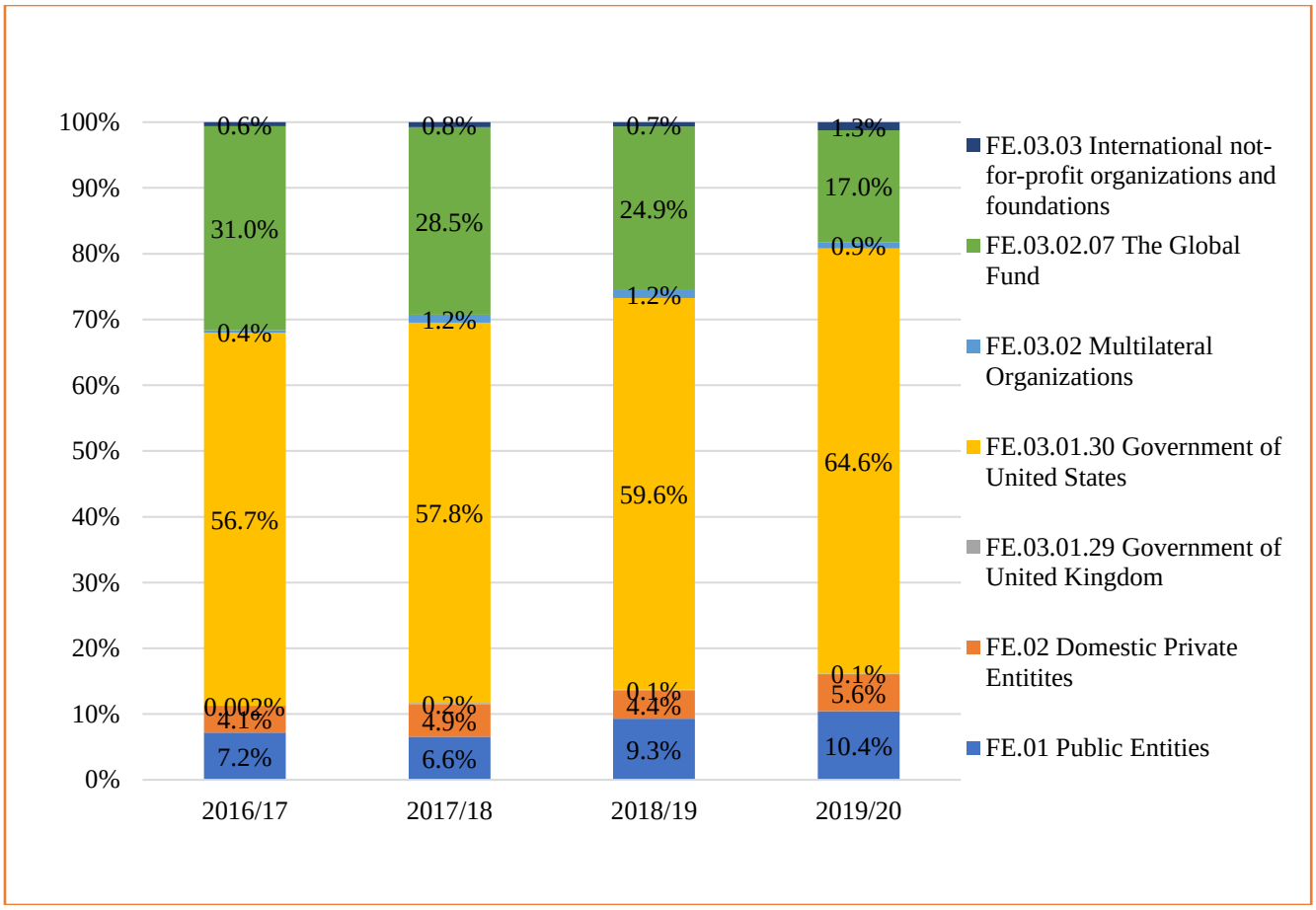

Figure 7: Expenditure contribution on C&T by FE

3.11 HIV Expenditure on Prevention Activities

Table 11 shows that prevention services for key populations accounted for the amount and percentage of the total expenditure in each year, averaging 22.7 percent in the four financial years. Voluntary medical male circumcision was the second largest funded intervention, accounting for 20.6 percent of the total HIV and AIDS spending in the period under consideration. The third was Pre-Exposure Prophylaxis which took an average of 9.4 percent during the period, followed by Prevention for adolescent girls and young women (AGYW) and their male partners at 8.2 percent.

As in the case of treatment, prevention activities relied heavily on external funding. The distribution of expenditure on prevention by financing entity is presented in Figure 8 where the United States Government provided 57 percent of the funding during the period. GFATM contributed 20 percent of the total in the four years, with international NGOs and foundations accounting for an average of about 13 percent and the Government provided 8 percent of total expenditure.

Table 11: Trend expenditure on prevention interventions

Prevention Intervention	2016/17		2017/18		2018/19		2019/20		Total	
	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent
ASC.01.01.01 Prevention for adolescent girls and young women (AGYW) and their male partners in settings with high HIV prevalence	81	1.5%	484	7.3%	744	11%	746	12%	2,055	8%
ASC.01.01.02 Services for key populations	1,543	28.2%	1,566	23.7%	1,552	24%	1,024	16%	5,685	23%
ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above)	603	11.0%	470	7.1%	356	5%	735	11%	2,165	9%
ASC.01.01.04 Voluntary medical male circumcision (VMMC) for HIV prevention	1,149	21.0%	1,696	25.6%	1,386	21%	926	14%	5,157	21%
ASC.01.01.05 Pre-Exposure Prophilaxis (PrEP)	651	11.9%	705	10.7%	591	9%	403	6%	2,351	9%
ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT)	7	0.1%	94	1.4%	154	2%	130	2%	385	2%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	39	0.7%	160	2.4%	286	4%	117	2%	602	2%
ASC.01.02.03 Community mobilization for populations other than key populations	2	0.03%	2	0.03%	-	0%	177	3%	181	1%
ASC.01.02.04 Programmatic activities for vulnerable and accessible populations	-	0.0%	195	3.0%	355	5%	122	2%	672	3%
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	-	0.0%	22	0.3%	196	3%	420	7%	638	3%
ASC.01.02.07 Prevention and wellness programmes in the workplace	171	3.1%	423	6.4%	439	7%	337	5%	1,370	5%

Prevention Intervention	2016/17		2017/18		2018/19		2019/20		Total	
	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent
ASC.01.02.10 STI prevention and treatment programmes for populations other than key populations - only if funded from earmarked HIV budgets	2	0.04%	0.04	0.001%	117	2%	108	2%	227	1%
ASC.01.02.98 Prevention activities not disaggregated	1,224	22.4%	796	12.0%	364	6%	1,169	18%	3,552	14%
Total	**5,473**	**100%**	**6,613**	**100%**	**6,538**	**100%**	**6,415**	**100%**	**25,040**	**100%**

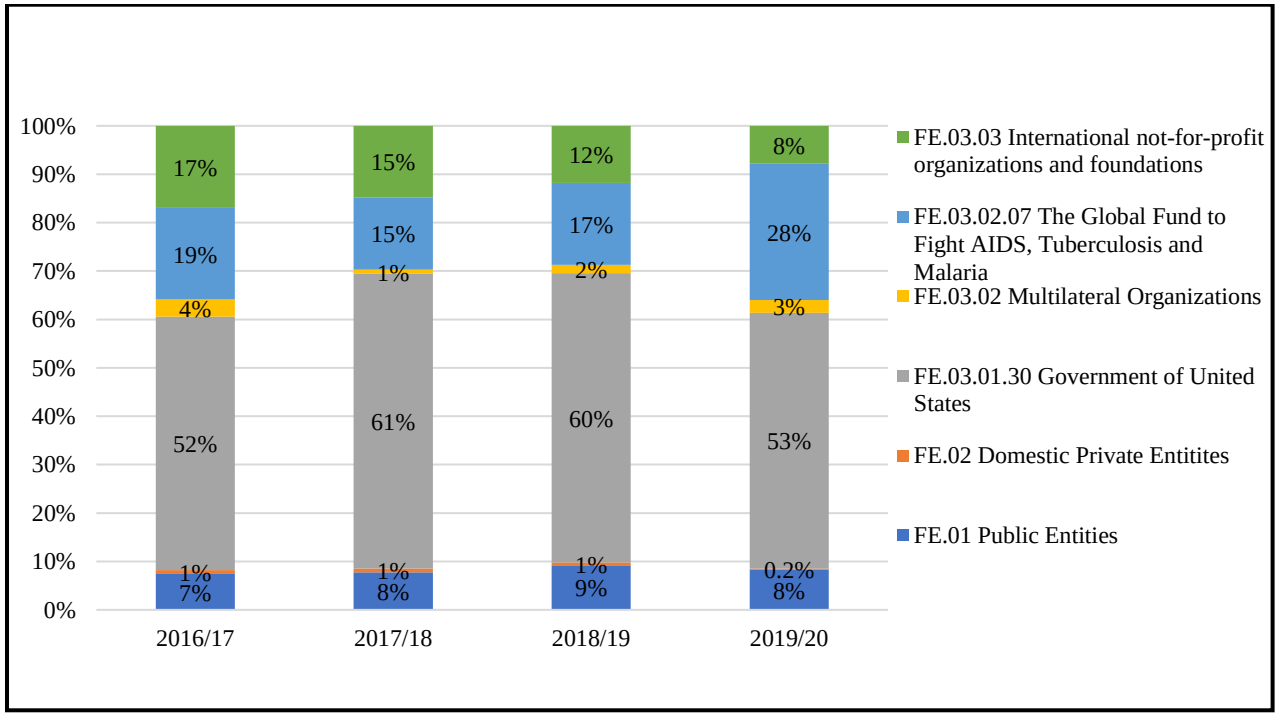

Figure 8: Expenditure on prevention by financing entity

3.12 Expenditure on HIV Testing and Counselling

Voluntary testing and counselling for the general population and provider-initiated testing and counselling (PITC) accounted bulk of the expenditure. The other notable category was HIV testing and counselling for pregnant women (part of the PMTCT programme). While the Government of the United States continued to provide the bulk of the funding, there was a sizeable funding contribution by the Government of Kenya. The GFATM continued to provide a significant financial share of funds spent on HTC interventions, as shown in Figure 9.

Table 12: Spending on HIV testing and counselling (KES million)

Intervention	2016/17	2017/18	2018/19	2019/20	Total
ASC.02.01 HIV testing and counselling for sex workers	8.1	34.4	49.4	52.3	144
ASC.02.02 HIV testing and counselling for MSM	0.7	98.2	115.2	33.1	247
ASC.02.03 HIV testing and counselling for TG	0.7	0.7	-	0.4	2
ASC.02.04 HIV testing and counselling for PWID	0.1	0.6	7.1	317.7	325
ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities	-	17.1	15.4	14.5	47
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	583.5	721.5	605.2	692.0	2,602
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	-	0.7	23.9	195.9	220
ASC.02.09 Voluntary HIV testing and counselling for general population	5,621.7	4,966.5	3,730.2	2,367.5	16,686
ASC.02.10 Provider initiated testing and counselling (PITC)	-	1,540.6	2,784.1	1,399.7	5,724
ASC.02.11 HIV screening in blood banks	80.7	151.4	28.5	-	261
ASC.02.98 HIV testing and counselling activities not disaggregated	2,405.3	1,094.2	2,003.0	697.6	6,200
Total	**8,701**	**8,626**	**9,362**	**5,771**	**32,459**

Table 13: Spending on HIV testing and counselling (%)

Intervention	2016/17	2017/18	2018/19	2019/20
ASC.02.01 HIV testing and counselling for sex workers	0.1%	0.4%	0.5%	0.9%
ASC.02.02 HIV testing and counselling for MSM	0.0%	1.1%	1.2%	0.6%
ASC.02.03 HIV testing and counselling for TG	0.0%	0.0%	0.0%	0.0%
ASC.02.04 HIV testing and counselling for PWID	0.0%	0.0%	0.1%	5.5%
ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities	0.0%	0.2%	0.2%	0.3%

Intervention	2016/17	2017/18	2018/19	2019/20
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	6.7%	8.4%	6.5%	12.0%
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	0.0%	0.0%	0.3%	3.4%
ASC.02.09 Voluntary HIV testing and counselling for general population	64.6%	57.6%	39.8%	41.0%
ASC.02.10 Provider initiated testing and counselling (PITC)	0.0%	17.9%	29.7%	24.3%
ASC.02.11 HIV screening in blood banks	0.9%	1.8%	0.3%	0.0%
ASC.02.98 HIV testing and counselling activities not disaggregated	27.6%	12.7%	21.4%	12.1%
Total	**100%**	**100%**	**100%**	**100%**

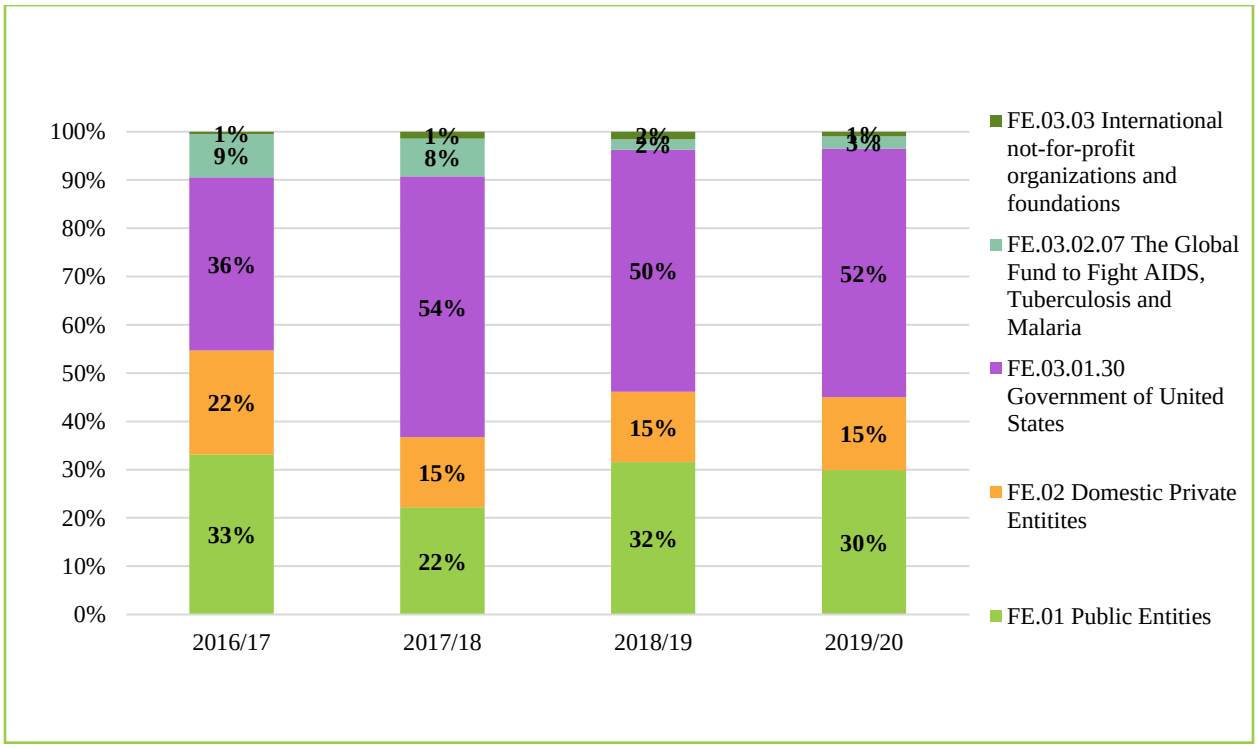

Figure 9: Expenditure on HTC by financing entity

3.13 Programme Enablers and Health Systems Strengthening

The second largest expenditure after the care and treatment was programme enablers and system strengthening. Table 14 shows the sources of funding for programme enablers and system strengthening during the four years under consideration. Furthermore, Table 14 presents the expenditure programme enablers and system strengthening by specific activities in each of the four years.

Table 14: Expenditure on programme enablers and system strengthening by FE

Year	FE.01 Public Entities	FE.02 Domestic Private Entities	FE.03.01.29 Government of United Kingdom	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations
2017/16	3.5%	0.0%	0.0%	91.3%	0.2%	3.9%	1.0%
2017/18	3.6%	0.0%	0.0%	91.3%	0.3%	3.5%	1.4%
2018/19	4.1%	0.0%	0.0%	85.1%	0.2%	9.0%	1.6%
2019/20	6.1%	0.0%	0.0%	81.6%	0.4%	11.6%	0.2%

Table 15: Detailed expenditure on programme enablers and system strengthening

Intervention	2016/17		2017/18		2018/19		2019/20		Total	
	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent
ASC.06.01 Strategic planning, coordination and policy development	49	0.3%	514	3.5%	759	5.5%	481	4.9%	1,803	3.4%
ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes	88	0.6%	90	0.6%	103	0.7%	95	1.0%	376	0.7%
ASC.06.03 Programme administration and management costs (above service-delivery level)	2,508	16.7%	7,957	54.5%	9,299	67.2%	6,884	70.0%	26,649	50.0%

Intervention	2016/17		2017/18		2018/19		2019/20		Total	
	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent	Amount (KES million)	Per Cent
ASC.06.04 Strategic information	2,587	17.3%	2,032	13.9%	1,991	14.4%	1,334	13.6%	7,943	14.9%
ASC.06.05 Public Systems Strengthening	206	1.4%	1,063	7.3%	1,283	9.3%	618	6.3%	3,170	5.9%
ASC.06.06 Community system strengthening	118	0.8%	113	0.8%	-	0.0%	-	0.0%	231	0.4%
ASC.06.07 Human resources for health (above-site programmes)	-	0.0%	0.1	0.0%	122	0.9%	180	1.8%	302	0.6%
ASC.06.98 Programme enablers and systems strengthening not disaggregated	9,435	62.9%	2,836	19.4%	279	2.0%	248	2.5%	12,798	24.0%
Total	**14,991**	**100%**	**14,604**	**100%**	**13,836**	**100%**	**9,841**	**100%**	**53,271**	**100%**

3.14 Social Protection and Economic Support

Spending on social protection and economic support in Kenya increased from KES 4,666.09 million in 2016/17 to KES 5,301.96 million in 2017/18. It however decreased to KES 4,483.05 million in 2018/19 and KES 3,727.35 million in 2019/20. The largest share of the social protection was support for OVC services not disaggregated by activity, which accounted for 40.8% of the total spending in the four years under consideration. OVC Social Services (including financial benefits) took a significant share, KES 2,259.41 million of total social protection spending in 2017/18; this increased to KES 2,433.62 million in 2018/19 but decreased to KES 2,371.48 million in 2019/20. International entities fully funded the social protection and economic support programme (Table 16). Figure 10 also shows that the United States Government almost exclusively provided the expenditure through PEPFAR. However, the Government of Kenya's contribution through cash transfers to OVC has increased steadily over time.

Table 16: Expenditure on social protection and economic support

Intervention	2016/17	2017/18	2018/19	2019/20
ASC.04.01.01 OVC Basic needs (health, education, housing)	0	341	278	208
ASC.04.01.03 OVC Social Services (including financial benefits)	359	2,259	2,434	2,371
ASC.04.01.98 OVC Services not disaggregated by activity	4,307	1,742	484	121
ASC.04.02.01 Social protection through monetary or in-kind benefits	0	145	183	46
ASC.04.02.02 Social protection through provision of social services	0	61	39	6
ASC.04.02.03 HIV-specific income generation projects	0	140	119	130
ASC.04.02.98 Social protection services and social services not disaggregated by type	0	614	946	844
Total	**4,666**	**5,302**	**4,483**	**3,727**

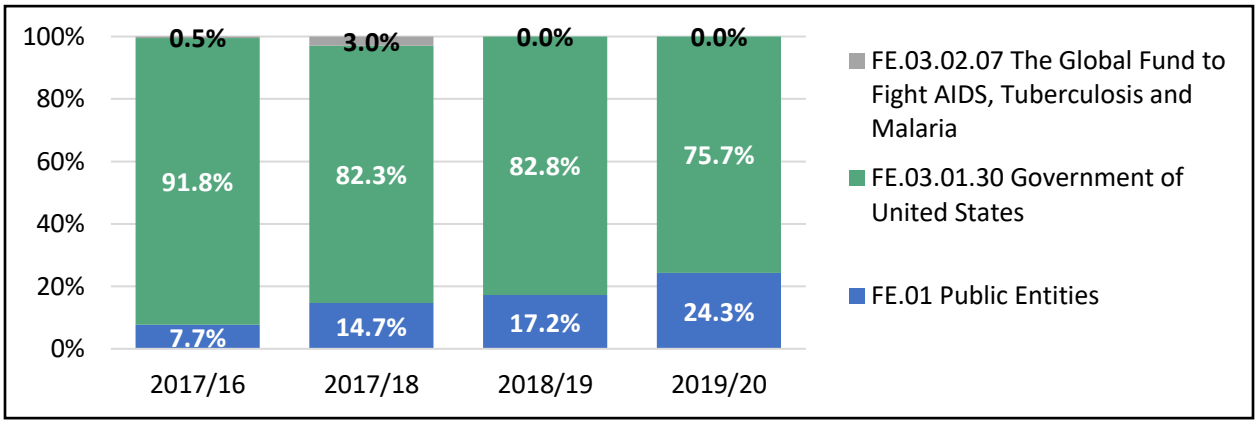

Figure 10: Expenditure percentage on social protection by FE

3.15 Social Enablers

Public sector entities heavily financed social enablers through activities carried out by the National AIDS Control Programme, at 62.5% in 2016/17, 69.5% in 2017/18, 59.9% in 2018/19 and 42.5% in 2019/20. The Global Fund, financed 24.3% in 2016/17, 18.6% in 2017/18, 31.2% in 2018/19 and 28.7% in 2019/20.

Table 17: Expenditure on social enablers by FE (KES million)

Social enabler	**2017/16**	**2017/18**	**2018/19**	**2019/20**
FE.01 Public Entities	309.63	357.86	348.05	409.91
FE.02 Domestic Private Entities	6.16	0	0.72	0
FE.03.01.29 Government of United Kingdom	0	0	0	0
FE.03.01.30 Government of United States	0	15.77	29.53	249.48
FE.03.02 Multilateral Organizations	10.81	9.43	2.44	1.85
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	120.46	95.66	181.49	277.03
FE.03.03 International not-for-profit organizations and foundations	48.10	36.24	14.54	23.89
FE.03.04 International for profit organizations	0	0	4.28	2.48
Total	**495.16**	**514.96**	**581.05**	**964.64**

Overall spending on social enablers amounted to KES 400.63 million in 2016/17, KES 423.27 million in 2017/18, KES 497.79 million in 2018/19 and KES 888.62 million in 2019/20. A significant proportion of funding is on stigma and discrimination reduction, which accounted for 78.2% in 2016/17, 75.5% in 2017/18 and 74% in 2018/19. It, however, decreased to 41% in 2019/20 (Table 18).

Table 18: Expenditure by social enablers by intervention

	2016/17		2017/18		2018/19		2019/20		Total	
Intervention	**Amount (KES million**	**Percent**	**Amount (KES million**	**Percent**	**Amount (KES million**	**Percent**	**Amount (KES million**	**Percent**	**Amount (KES million**	**Percent**
ASC.05.01 Advocacy	95	19.1%	92	17.8%	83	14.3%	76	7.9%	346	13.5%
ASC.05.02.01 Stigma and discrimination reduction	313	63.3%	320	62.1%	369	63.4%	364	37.8%	1,366	53.4%
ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV	17	3.5%	32	6.3%	44	7.5%	32	3.3%	125	4.9%
ASC.05.02.04 Sensitization of law-makers and law enforcement agents	0	0.0%	0	0.0%	12	2.1%	-	0.0%	13	0.5%
ASC.05.02.05 Reducing discrimination and violence against women in the context of HIV	11	2.1%	11	2.1%	72	12.3%	12	1.2%	105	4.1%
ASC.05.02.06 Capacity building in human rights	59	12.0%	61	11.7%	1	0.2%	182	18.9%	303	11.9%
ASC.05.02.98 Human rights programmes not disaggregated by type	-	0.0%	-	0.0%	-	0.0%	299	31.0%	299	11.7%
Total	**495**	**100%**	**515**	**100%**	**581**	**100%**	**965**	**100%**	**2,556**	**100%**

3.16 HIV and AIDS-Related Research

In 2016/17, the highest expenditure was on HIV and AIDS-related research activities not disaggregated by type (67.7%) and economic research (31.9%). Spending on HIV and AIDS-related research activities not disaggregated by type decreased in the subsequent years, 23.7% in 2017/18 and 18.7% in 2018/19, but increased to 51.6% of the total HIV and AIDS-related research in 2019/20. HIV and AIDS-related research expenditure was funded mainly by international sources (98.9%) in 2016/17, 99.8% in 2017/18, 99.9% in 2018/19 and 100% in 2019/20. Only about 1% came from the public sector.

Table 19: Spending on HIV and AIDS-related research (KES million)

Intervention	2016/17	2017/18	2018/19	2019/20	Total
ASC.08.04 Socio-behavioural research	0.09	6.39	12.71	6.38	25.56
ASC.08.05 Economic research	7.54	44.63	44.49	5.99	102.65
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	16.03	15.87	13.19	13.15	58.25
Total	**23.66**	**66.89**	**70.39**	**25.52**	**186.46**

3.17 Beneficiaries of HIV and AIDS Spending

The main beneficiaries of HIV and AIDS spending were people living with HIV, accounting for 53.3 percent (KES 39,183 million) in 2016/17, 48.1 percent (KES 32,955 million) in 2017/18, 52.0 percent (KES 37,551 million) in 2018/19 and 53.4 percent (KES 29,970 million) in 2019/20. The second-largest group of beneficiaries was non-targeted populations, accounting for 21.1 percent (KES 15,509 million) in 2016/17, 22.2 percent (KES 15,185 million) in 2017/18, 20.1 percent (KES 14,488 million) in 2018/19 and 19.3 percent (KES 10,831 million) in 2019/20. When there was no explicit intention of directing the benefits to a specific population, the expenditure was labelled “non-targeted interventions”. The general population received the third largest share of the total expenditure in each year. The fourth largest share went to vulnerable, accessible and other target populations. Key populations took the least share of the expenditure (see Table 20 and Figure 11)

Table 20: Beneficiaries of HIV and AIDS spending in Kenya, 2016/17 to 2019/20

Beneficiary Population	2016/17		2017/18		2018/19		2019/20	
	Amount (KES million)	%	Amount (KES million)	%	Amount (KES million)	%	Amount (KES million)	%
BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)	39,183	53.3 %	32,955	48.1 %	37,551	52.0 %	29,970	53.4 %
BP.02 Key populations	2,204	3.0%	2,423	3.5%	2,331	3.2%	1,876	3.3%
BP.03 Vulnerable, accessible and other target populations	5,008	6.8%	6,468	9.4%	6,173	8.5%	4,781	8.5%
BP.04 General population	11,627	15.8 %	11,459	16.7 %	11,678	16.2 %	8,619	15.4 %
BP.05 Non-targeted interventions	15,509	21.1 %	15,185	22.2 %	14,488	20.1 %	10,831	19.3 %
Total	**73,532**	**100%**	**68,491**	**100%**	**72,220**	**100%**	**56,077**	**100%**

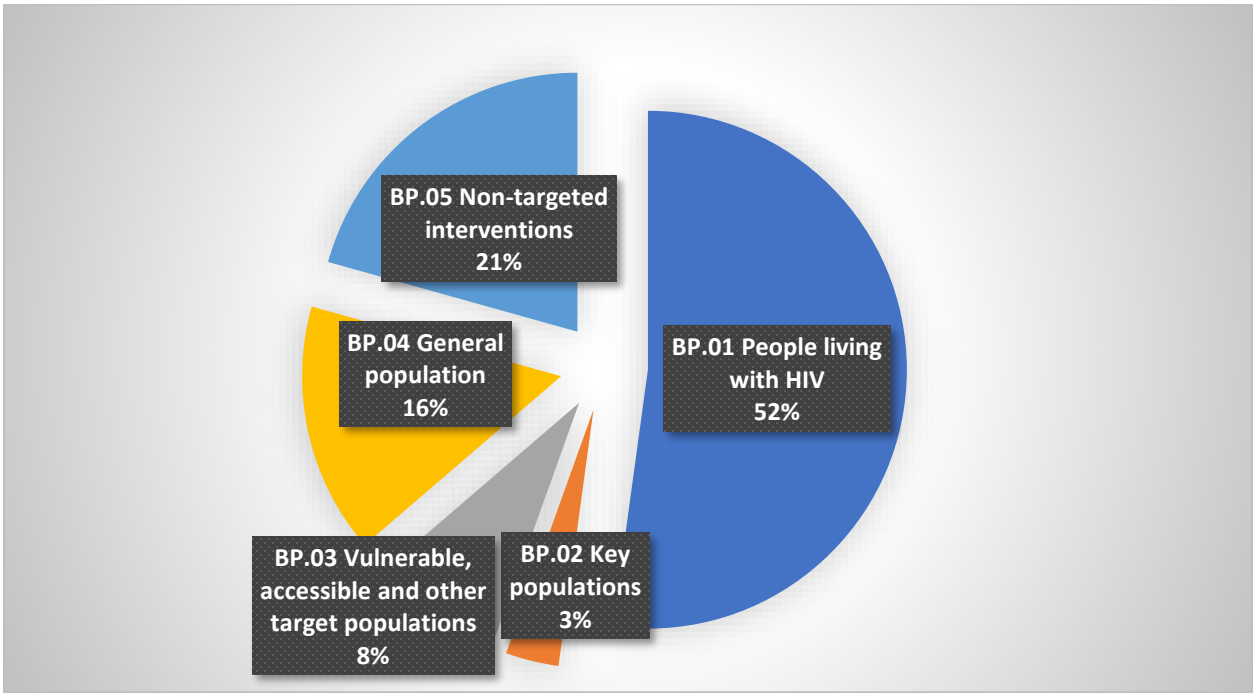

Figure 11: Percentage of expenditure by beneficiary population 2016/17-2019/20

3.18 Expenditure by Broad Production Factors Categories

Production factors are critical inputs required to deliver planned services and goods to beneficiaries. Production factors comprise capital and recurrent expenditure. Capital expenditure is the value

of the non-financial assets acquired. Capital expenditure includes building, vehicles, IT equipment, laboratory and other medical equipment. Recurrent expenditure is expenditure on goods and services consumed within the current year that needs to be made recurrently to sustain the production of services. In NASA classification, recurrent expenditure includes, among other things, salaries and wages, medicines, and administrative and consulting services.

Table 21 shows that recurrent expenditure took a significant percentage of the total expenditure, averaging 98 percent in the four years. Capital expenditure accounted for about 2 per cent. Medical products and supplies consisting mainly of ARVs, laboratory reagents and materials, HIV tests, diagnostics as well non-medical supplies accounted for 37 percent of total expenditure during the period under consideration. The second largest component was personnel cost (25%) and followed in third place by contracted services (11%).

Table 21: Expenditure by factors of production by major categories (KES million)

	2016/17		2017/18		2018/19		2019/20		Total	
Factor	**Amount (KES million**	**Per Cent**	**Amount (KES million**	**Per Cent**	**Amount (KES million**	**Per Cent**	**Amount (KES million**	**Per Cent**	**Amount (KES million**	**Per Cent**
PF.01 Current direct and indirect expenditures	**70,645**	**96.1%**	**67,108**	**98.0%**	**71,642**	**99.2%**	**55,702**	**99.3%**	**265,096**	**98.1%**
PF.01.01 Personnel costs	18,994	25.8%	16,348	23.9%	18,014	24.9%	15,212	27.1%	68,569	25.4%
PF.01.02 Other operational and programme management current expenditures	5,592	7.6%	3,590	5.2%	3,351	4.6%	3,133	5.6%	15,665	5.8%
PF.01.03 Medical products and supplies	31,349	42.6%	23,144	33.8%	26,511	36.7%	18,745	33.4%	99,749	36.9%
PF.01.03.01 Pharmaceuticals	18,684	25.4%	14,928	21.8%	19,430	26.9%	14,156	25.2%	67,198	24.9%
PF.01.03.02 Medical supplies	4,528	6.2%	968	1.4%	1,051	1.5%	1,296	2.3%	7,843	2.9%
PF.01.03.03 Laboratory reagents and materials	2,066	2.8%	3,541	5.2%	3,918	5.4%	1,577	2.8%	11,103	4.1%
PF.01.03.04 Non-medical supplies	5,938	8.1%	3,562	5.2%	1,929	2.7%	1,534	2.7%	12,963	4.8%
PF.01.03.05 Office Supplies	92	0.1%	86	0.1%	108	0.1%	95	0.2%	380	0.1%
PF.01.03.98 Medical products and supplies not disaggregated	41	0.1%	58	0.1%	75	0.1%	87	0.2%	261	0.1%
PF.01.04 Contracted external services	1,525	2.1%	7,475	10.9%	11,665	16.2%	9,471	16.9%	30,135	11.1%
PF.01.05 Transportation related to beneficiaries	3,519	4.8%	2,906	4.2%	3,030	4.2%	2,543	4.5%	11,998	4.4%
PF.01.07 Financial support for beneficiaries	379	0.5%	1,316	1.9%	1,189	1.6%	1,247	2.2%	4,131	1.5%
PF.01.08 Training- Training related per diems/transport/other costs	3,216	4.4%	2,773	4.0%	2,373	3.3%	1,338	2.4%	9,700	3.6%

	2016/17		2017/18		2018/19		2019/20		Total	
Factor	**Amount (KES million**	**Per Cent**	**Amount (KES million**	**Per Cent**	**Amount (KES million**	**Per Cent**	**Amount (KES million**	**Per Cent**	**Amount (KES million**	**Per Cent**
PF.01.09 Logistics of events, including catering services	16	0.02%	23	0.03%	160	0.2%	146	0.3%	344	0.1%
PF.01.10 Indirect costs	977	1.3%	2,781	4.1%	3,595	5.0%	2,689	4.8%	10,041	3.7%
PF.01.98 Current direct and indirect expenditures not disaggregated	5,078	6.9%	6,753	9.9%	1,755	2.4%	1,178	2.1%	14,764	5.5%
PF.02 Capital expenditures	**2,888**	**3.9%**	**1,383**	**2.0%**	**579**	**0.8%**	**375**	**0.7%**	**5,224**	**1.9%**
PF.02.01 Building	328	0.4%	222	0.3%	95	0.1%	72	0.1%	717	0.3%
PF.02.01.01 Laboratory and other infrastructure upgrading	27	0.04%	50	0.1%	11	0.01%	29	0.1%	116	0.04%
PF.02.01.02 Construction and renovation	301	0.4%	172	0.3%	85	0.1%	43	0.1%	601	0.2%
PF.02.02 Vehicles	2	0.003%	3	0.004%	7	0.01%	3	0.01%	16	0.01%
PF.02.03 Other capital investment	1,414	1.9%	777	1.1%	476	0.7%	300	0.5%	2,967	1.1%
PF.02.03.01 Information technology (hardware and software)	14	0.02%	11	0.02%	6	0.01%	5	0.01%	36	0.01%
PF.02.03.02 Laboratory and other medical equipment	775	1.1%	325	0.5%	191	0.3%	131	0.2%	1,422	0.5%
PF.02.03.03 Non medical equipment and furniture	367	0.5%	441	0.6%	279	0.4%	164	0.3%	1,251	0.5%
PF.02.03.98 Other capital investment not disaggregated	259	0.4%	-	0.0%	-	0.0%	-	0.0%	259	0.1%
PF.02.98 Capital expenditure not disaggregated	1,143	1.6%	381	0.6%	-	0.0%	-	0.0%	1,524	0.6%
Total	**73,532**	**100%**	**68,491**	**100%**	**72,220**	**100%**	**56,077**	**100%**	**270,320**	**100%**

3.19 Expenditure on Personnel Cost by Financing Entity

Table 22 shows the percentage of expenditure on personnel for each of the financing entities as a proportion of the total expenditure from that entity. Table 22 shows that the Government of Kenya (National and County) spent just above 50 percent of its financial contribution of the direct personnel involved in the delivery of HIV services in the first two years. However, the portion declined in 2018/19 and 2019/20 mainly due to an increase in government funding of other inputs. The Government of the United States (USG), through the PEPFAR programme, had personnel expenditure accounting for about 28 percent of its expenditure in the four years. The cost of personnel by international NGOs and foundations was also almost the same as that of USG. Although in 2018/19 and 2019/20, the personnel took over 40 percent of the funding from International for-profit organizations, their contribution in total HIV expenditure was negligible.

Table 22: Expenditure on personnel in total HIV funding within entity

Financing entity	2016/17	2017/18	2018/19	2019/20
FE.01 Public Entities	52.6%	52.6%	38.8%	39.7%
FE.02 Domestic Private Entities	0.12%	0.00%	0.02%	0.00%
FE.03.01.30 Government of United States	26.7%	26.7%	28.5%	29.9%
FE.03.02 Multilateral Organizations	2.0%	1.5%	0.4%	0.4%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	4.2%	4.7%	8.4%	13.2%
FE.03.03 International not-for-profit organizations and foundations	25.1%	25.3%	28.2%	34.6%
FE.03.04 International for profit organizations	0.0%	0.0%	44.2%	49.2%

Figure 12 show the percentage of contribution of the different financing entities to total expenditure on personnel from the entities (sources).

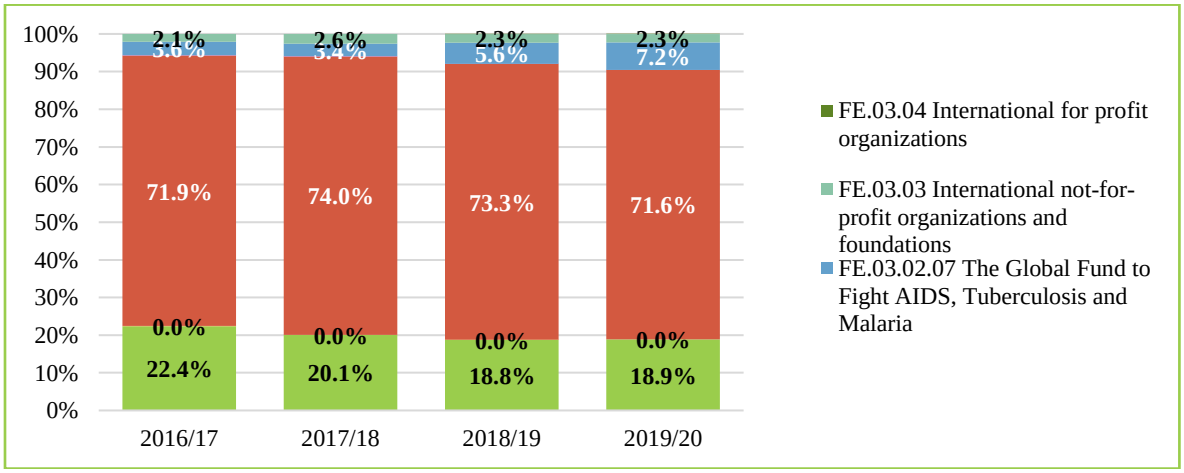

Figure 12: Funding contribution of FE to total personnel expenditure

The USG dominated funding for personnel expenditure, accounting for over 70 percent of the total expenditure on personnel across all the entities.

3.20 Expenditure On Medical Products and Supplies by Financing Entities

Table 23: Expenditure on antiretrovirals by financing entity

	2016/17		2017/18		2018/19		2019/20		Total	
Financing entity	**Amount (KES million)**	**Percent**	**Amount (KES million)**	**Percent**	**Amount (KES million)**	**Percent**	**Amount (KES million)**	**Percent**	**Amount (KES million)**	**Percent**
FE.01 Public Entities	602	3.6%	295	2.2%	1,431	7.9%	851	6.9%	3,179	5.3%
FE.03.01.29 Government of United Kingdom	0.77	0.0%	72	0.5%	17	0.1%	-	0.0%	90	0.1%
FE.03.01.30 Government of United States	7,176	43.2%	4,989	37.4%	8,387	46.4%	7,343	59.1%	27,895	46.2%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	8,838	53.2%	7,970	59.8%	8,199	45.4%	4,190	33.7%	29,197	48.3%
FE.03.03 International not-for-profit organizations and foundations	5.84	0.0%	6.40	0.0%	30	0.2%	35	0.3%	77	0.1%
Total	**16,623**	**100%**	**13,333**	**100%**	**18,063**	**100%**	**12,419**	**100%**	**60,438**	**100%**

Note: Expenditure was based on procured and distributed antiretrovirals

Table 24: Expenditure on medical supplies by financing entity

	FE.01 Public Entities		FE.03.01.30 Government of United States		FE.03.02 Multilateral Organizations		FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria		FE.03.03 International not-for-profit organizations and foundations	
PF and Year	**Amount (KES million)**	**Percent**	**Amount (KES million)**	**Percent**	**Amount (KES million)**	**Percent**	**Amount (KES million)**	**Percent**	**Amount (KES million)**	**Percent**
PF.01.03.02.02 Condoms										
2016/17	0	0%	0	0%	193.32	24.60%	587.75	74.90%	3.83	0.50%
2017/18	0	0%	24.3	5%	46.99	9.60%	414.19	84.60%	4.00	0.80%
2018/19	0	0%	8.05	3%	107.66	35.00%	187.31	60.90%	4.38	1.40%
2019/20	0	0%	0.02	0%	134.21	28.80%	331.72	71.20%	0.20	0.04%
Total condoms	**0**	0%	**32.36**	2%	**482.18**	23.50%	**1,520.96**	74.30%	**12.42**	0.60%
PF.01.03.02.03 Lubricants										
2016/17	2.68	28.70%	0	0.00%	0	0.00%	6.64	71.30%	0	0.00%
2017/18	2.63	27.30%	0	0.00%	0	0.00%	7.02	72.70%	0	0.00%
2018/19	4.42	99.40%	0.02	0.40%	0	0.00%	0.01	0.20%	0	0.00%
2019/20	11.5	85.70%	0.01	0.10%	0	0.00%	1.91	14.20%	0	0.00%
Total lubricants	**21.24**	57.70%	**0.03**	0.10%	**0**	0.00%	**15.57**	42.30%	**0**	0.00%
PF.01.03.02.98 Medical supplies not disaggregated										
2016/17	498.17	13.30%	3,235.64	86.60%	0	0.00%	0.34	0.01%	0	0.00%
2017/18	394.17	84.10%	71.23	15.20%	0	0.00%	3.52	0.80%	0	0.00%
2018/19	407.14	55.10%	195.04	26.40%	0	0.00%	137.02	18.50%	0	0.00%
2019/20	331.75	40.70%	59.61	7.30%	0	0.00%	424.82	52.10%	0	0.00%
Total medical supplies not disaggregated	**1,631.23**	28.30%	**3,561.52**	61.90%	**0**	0.00%	**565.70**	9.80%	**0**	0.00%

Table 25: Expenditure on laboratory reagents by financing entity

	FE.01 Public Entities	FE.03.01.29 Government of United Kingdom	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations
PF.01.03.03.01 HIV tests screening/diagnostics						
2016/17	0	0	425.25	0	713.24	3.83
2017/18	0	0	685.9	0	644.11	4
2018/19	892.85	0	1,051.35	0	136.46	4.38
2019/20	380.03	0	297.62	0	106.02	0
Total	**1,272.88**	**0**	**2,460.13**	**0**	**1,599.83**	**12.22**
PF.01.03.03.02 VL tests						
2016/17	0	0	374.35	0	0	0
2017/18	0	0	1,098.28	0	0	0
2018/19	0	0	718.46	0	13.93	0
2019/20	0	0	135.76	0	0	0
Total	**0**	**0**	**2,326.85**	**0**	**13.93**	**0**
PF.01.03.03.03 CD4 tests						
2016/17	0	0	374.35	0	0	0
2017/18	0	0	1,098.28	0	0	0
2018/19	123.21	12.09	718.46	33.06	18.67	7.09
2019/20	197.27	24.32	135.76	0	2.43	0
Total	**320.48**	**36.41**	**2,326.85**	**33.06**	**21.1**	**7.09**
F.01.03.03.04 Diagnostic tests for STI (including rapid testing)						
2018/19	108.68	0	0	0	6.47	0
2019/20	102.46	0	0	0	4.32	0

	FE.01 Public Entities	FE.03.01.29 Government of United Kingdom	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations
Total	**211.14**	**0**	**0**	**0**	**10.79**	**0**
PF.01.03.03.06 Diagnostic tests for hepatitis (including rapid testing)						
2016/17	0	0	0	0	0	0
2018/19	0	0	0	0	56.47	0
2019/20	0	0	0	0	10.81	0
Total	**0**	**0**	**0**	**0**	**67.28**	**0**
PF.01.03.03.98 Reagents and materials not disaggregated						
2016/17	0	0	0	24.36	84.61	0
2017/18	0	0	0	2.41	8.37	0
2018/19	0.2	0	0	0	16.17	0
2019/20	10.5	0	135.86	15.94	30.42	0
Total	**10.7**	**0**	**135.86**	**42.71**	**139.57**	**0**

3.21 Comparison of Spending and Estimated KNASP Costs

A comparison of the NASA expenditure results and the estimated cost of the Kenya AIDS Strategic Framework 2014/2015 - 2018/2019 was made. There was no costing for the extended KASF that covered 12019/20. The total expenditure is shown to have been just short of 70 percent of the estimated cost of KASF.

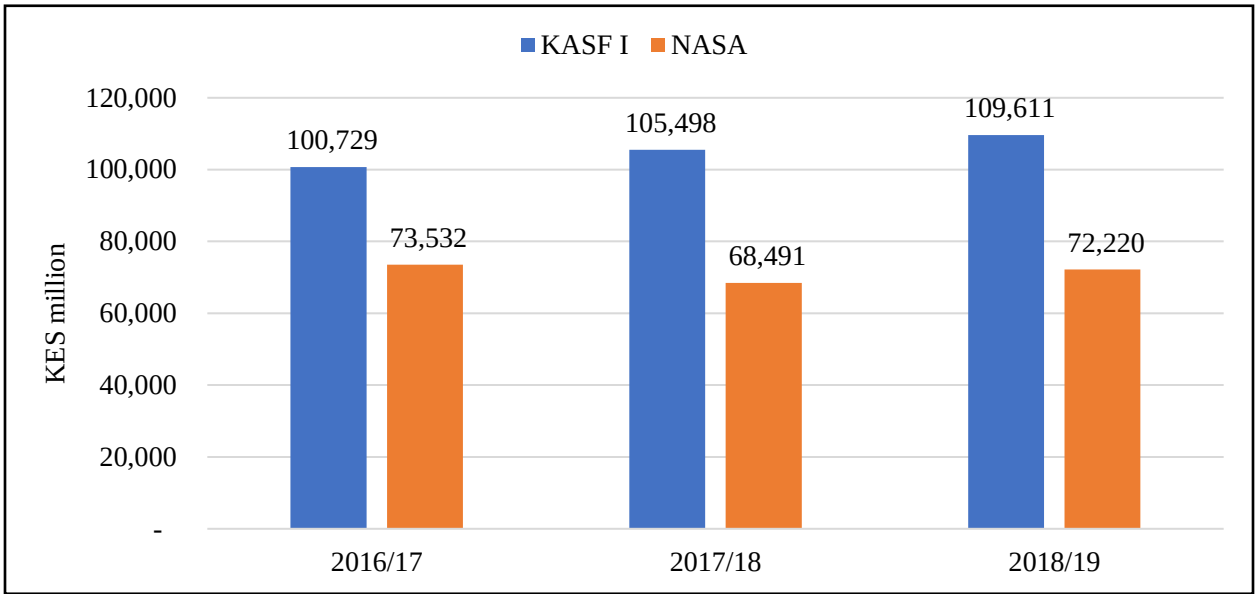

Figure 13: Comparison of total HIV expenditure and total KASF I cost

The comparison over the four years in terms of care and treatment interventions is shown in Figure 14, and prevention and HTC in Figure 15.

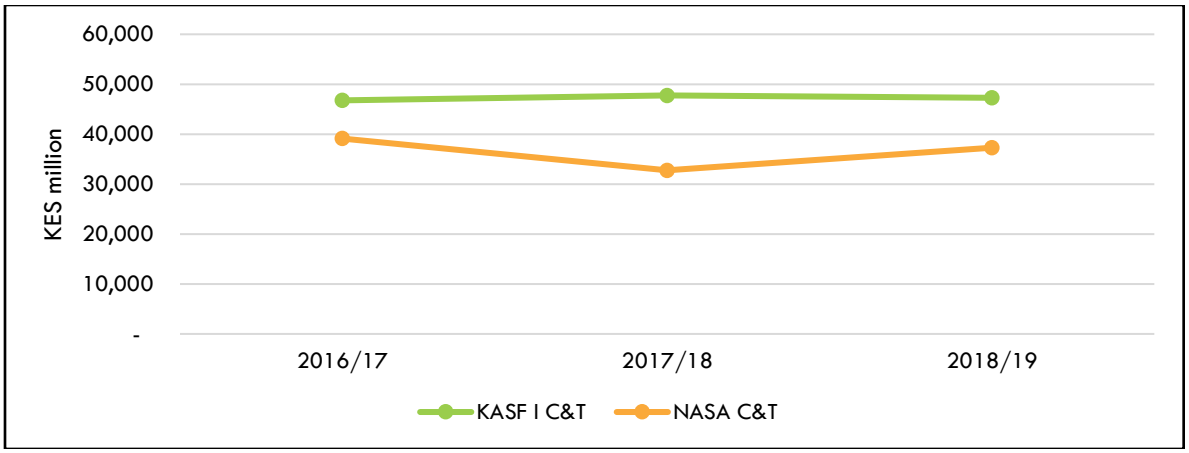

Figure 14: Comparison of NASA expenditure on C&T and KASF I cost

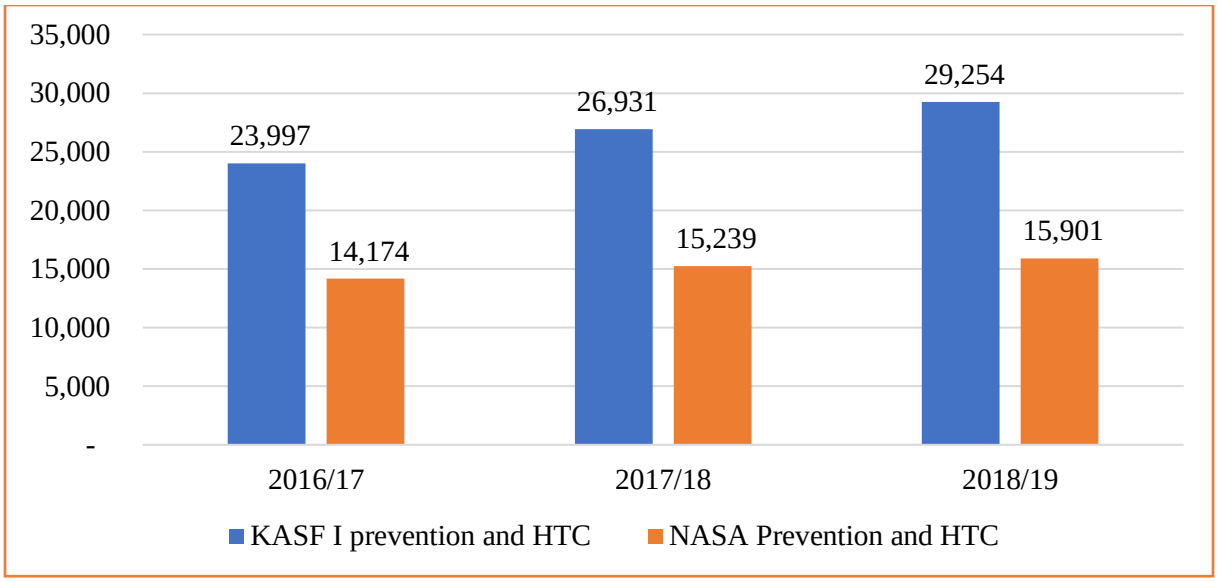

Figure 15: Comparison of NASA expenditure on prevention and HTC and KASF I cost

3.22 Total expenditure by National and County Level

Table 26 presents total expenditure disaggregated by the national and county levels.

Table 26: HIV expenditure by national and county levels (KES million)

Level	2016/17	2017/18	2018/19	2019/20
National	15,014.33	14,670.51	13,906.63	9,866.06
Baringo	217.12	175.66	227.86	196.78
Bomet	667.06	472.82	532.91	428.29
Bungoma	1,088.38	314.01	1,147.72	881.15
Busia	1,634.60	1,437.89	1,525.90	1,114.80
Elgeyo/Marakwet	161.09	158.60	225.30	189.94
Embu	419.55	470.66	560.61	496.45
Garissa	83.16	127.99	118.64	107.03
Homa Bay	5,463.99	5,378.64	5,180.52	3,873.77
Isiolo	144.18	121.19	100.90	72.15
Kajiado	666.69	522.75	664.74	566.15
Kakamega	1,970.72	1,665.92	1,849.10	1,364.80
Kericho	805.27	663.75	847.45	722.90
Kiambu	1,844.72	1,638.35	2,063.24	1,560.47
Kilifi	1,196.59	1,090.68	1,275.43	1,077.09
Kirinyaga	519.22	588.33	713.77	602.08
Kisii	1,708.95	1,649.51	1,799.50	1,268.29

Level	2016/17	2017/18	2018/19	2019/20
Kisumu	5,571.20	5,473.43	4,943.12	3,853.56
Kitui	1,048.15	1,046.61	1,356.66	1,167.35
Kwale	566.28	548.80	668.81	520.88
Laikipia	435.90	357.50	447.51	367.60
Lamu	103.04	125.59	147.71	120.81
Machakos	1,302.85	1,340.56	1,303.99	1,089.77
Makueni	1,079.70	1,100.14	1,153.80	977.88
Mandera	84.71	91.18	127.22	135.22
Marsabit	110.02	106.35	81.41	80.63
Meru	809.09	780.37	861.85	683.66
Migori	3,317.57	3,177.88	3,253.67	2,436.25
Mombasa	2,285.67	2,168.03	2,270.17	1,860.05
Murang'a	892.16	898.18	1,093.41	799.69
Nairobi City	8,144.75	6,764.49	7,144.38	5,886.89
Nakuru	1,864.70	1,518.81	2,308.37	1,880.94
Nandi	507.10	450.87	589.79	477.26
Narok	542.26	562.51	541.78	456.85
Nyamira	780.21	816.30	749.76	541.78
Nyandarua	481.77	438.49	542.70	459.65
Nyeri	913.20	841.95	954.69	713.71
Samburu	113.26	78.52	139.03	136.42
Siaya	4,353.21	4,340.84	3,827.26	2,875.53
Taita/Taveta	342.64	238.07	463.76	356.78
Tana River	76.02	193.54	151.84	132.53
Tharaka-Nithi	410.58	490.26	498.91	429.72
Trans Nzoia	624.25	557.71	700.40	548.44
Turkana	865.87	876.25	799.39	718.35
Uasin Gishu	1,380.75	1,179.80	1,263.92	1,005.80
Vihiga	627.39	597.65	728.91	592.68
Wajir	72.43	40.46	167.19	173.77
West Pokot	220.05	142.36	198.74	208.22
Total	**73,532.38**	**68,490.74**	**72,220.39**	**56,076.88**

3.23 Expenditure by Source

Table 27 below shows the total HIV expenditure for the four years 2016/17, 2017/18, 2018/19 and 2019/20 by the different financing sources both domestic and international. More results on the HIV expenditure by HIV interventions are shown in appendix A.

Table 27: County and National level HIV expenditure by financing entity (KES million)

	FE.01 Public Entities	FE.02 Domestic Private Entitites	FE.03.01.29 Government of United Kingdom	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations
National	2,224.06	7.41	-	46,820.93	132.10	3,492.32	774.74	5.97
Baringo	123.30	44.30	0.46	420.61	16.15	207.23	5.21	0.16
Bomet	305.66	142.02	1.19	1,159.63	13.49	464.19	14.75	0.16
Bungoma	448.97	188.53	1.58	1,996.05	24.84	746.97	24.16	0.16
Busia	654.50	280.64	3.70	3,482.16	39.66	1,214.69	37.68	0.16
Elgeyo/Marakwet	91.83	40.84	0.34	415.44	6.03	175.62	4.67	0.16
Embu	194.67	83.10	1.03	1,267.96	11.55	377.77	11.04	0.16
Garissa	73.17	31.40	0.14	179.79	28.55	120.24	3.38	0.16
Homa Bay	2,561.71	1,157.20	12.39	11,573.05	130.54	3,922.35	539.52	0.16
Isiolo	47.18	19.36	0.19	230.94	6.02	131.79	2.77	0.16
Kajiado	328.60	141.22	1.41	1,362.82	20.87	548.17	17.09	0.16
Kakamega	914.12	405.09	4.74	3,857.64	53.36	1,564.27	51.16	0.16
Kericho	317.94	136.17	1.71	1,926.31	20.22	619.03	17.85	0.16
Kiambu	961.54	417.18	4.46	3,906.35	47.19	1,429.30	340.61	0.16

	FE.01 Public Entities	FE.02 Domestic Private Entitites	FE.03.01.29 Government of United Kingdom	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations
Kilifi	574.20	245.79	2.60	2,726.44	38.51	912.93	139.16	0.16
Kirinyaga	281.80	126.78	1.20	1,547.10	13.43	437.79	15.14	0.16
Kisii	852.12	391.51	3.51	3,468.22	39.99	1,227.93	442.82	0.16
Kisumu	2,319.96	1,035.63	11.97	12,112.07	129.37	3,811.88	420.29	0.16
Kitui	512.09	226.77	2.24	3,050.28	37.37	762.32	27.54	0.16
Kwale	244.32	101.03	1.14	1,396.42	17.49	423.16	121.05	0.16
Laikipia	220.91	97.28	0.98	894.40	17.41	365.75	11.62	0.16
Lamu	45.27	19.42	0.17	306.15	3.14	120.32	2.51	0.16
Machakos	637.20	282.40	2.91	3,061.33	39.85	978.47	34.85	0.16
Makueni	545.05	247.86	2.24	2,569.17	30.16	779.30	137.57	0.16
Mandera	75.15	14.91	0.07	191.54	61.42	93.42	1.65	0.16
Marsabit	52.58	16.26	0.14	162.91	28.66	115.68	2.02	0.16
Meru	433.56	188.97	2.11	1,740.83	26.80	717.96	24.56	0.16
Migori	1,575.14	695.27	8.06	6,901.11	87.52	2,540.38	377.73	0.16
Mombasa	949.62	409.04	5.08	5,016.12	58.98	1,692.46	452.47	0.16

	FE.01 Public Entities	FE.02 Domestic Private Entitites	FE.03.01.29 Government of United Kingdom	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations
Murang'a	506.95	237.60	1.72	2,164.41	18.07	620.63	133.91	0.16
Nairobi City	3,349.63	1,437.80	17.21	16,832.68	265.31	5,454.38	583.35	0.16
Nakuru	994.51	443.82	4.22	4,595.30	58.11	1,424.67	52.02	0.16
Nandi	241.05	104.49	1.19	1,207.39	17.08	440.44	13.22	0.16
Narok	360.29	166.64	1.01	1,130.53	16.75	411.50	16.51	0.16
Nyamira	415.71	198.95	1.57	1,644.01	18.50	587.28	21.88	0.16
Nyandarua	227.90	99.33	0.94	1,219.18	11.27	352.14	11.71	0.16
Nyeri	444.18	196.99	1.95	2,059.60	23.17	673.86	23.64	0.16
Samburu	67.83	22.91	0.14	248.60	6.04	119.22	2.34	0.16
Siaya	2,074.45	951.69	9.78	8,663.28	102.88	3,190.20	404.40	0.16
Taita/Taveta	130.42	55.20	0.64	940.12	9.21	258.21	7.30	0.16
Tana River	33.46	14.84	0.09	400.06	4.86	98.70	1.76	0.16
Tharaka-Nithi	176.90	80.20	0.74	1,251.11	9.09	301.57	9.69	0.16
Trans Nzoia	316.48	137.57	1.55	1,378.05	23.24	556.17	17.58	0.16
Turkana	450.09	213.61	0.89	1,934.23	92.51	441.03	127.35	0.16

	FE.01 Public Entities	FE.02 Domestic Private Entitites	FE.03.01.29 Government of United Kingdom	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations
Uasin Gishu	637.82	262.59	3.19	2,743.37	41.62	1,106.92	34.59	0.16
Vihiga	332.97	145.05	1.66	1,446.60	17.75	583.79	18.67	0.16
Wajir	62.81	7.16	0.01	276.66	29.94	76.41	0.70	0.16
West Pokot	100.94	43.26	0.26	435.91	15.81	168.77	4.26	0.16
Total	**29,490.62**	**12,013.06**	**126.53**	**174,314.89**	**1,961.92**	**46,859.60**	**5,540.49**	**13.27**

3.24 Conclusions

The following conclusion can be drawn from the results:

e) The funding for the HIV response in the country has flattened over the last years and sharply declined in the last year. Evidence from the results shows that donor funding towards the fight against HIV/Aids has dropped in the last 5 years. This call for the government to address the funding gap left by donors to sustain the gains made. The country has for many years heavily relied on donor funding for control programmes, and given the sharp decline in funding, the government need to increase funding to the national response in order to sustain the fight against HIV Aids.

f) The funding relies heavily on two external sources, the GFATM and the Government of the United States. Kenya still continues to rely heavily on external sources. More efforts should be made to ensure the financial sustainability of the key prevention and treatment, and care services which now mainly depend on international donors. The national and county governments have a good potential to mobilise more funds for the actual service delivery by increasing their contribution as an absolute amount and a share of the total HIV spending.

g) There is a high risk of sustaining the funding of the HIV response because the bulk of the funding comes from external sources. Over the last five years, the country has continued to rely heavily on international sources, particularly the Global Fund and PEPFAR (complemented by bilateral sources), for its HIV prevention and treatment programmes. Most of the programmes are almost entirely funded by international sources. Given the risk of sustaining HIV/aids funding, and especially considering the future financing landscape, domestically funded HIV programmes need to deliver effective prevention and treatment strategies that focus on key priority interventions. This may demand strong domestic leadership and better coordination of the HIV response in the longer term. However, in the medium term, the Global Fund and bilateral donors will remain crucially important to the HIV response in the country.

h) The contribution of the Government of Kenya is critical, but it is mainly indirect through funding of human resources for health.

   The GOK makes a significant contribution to the national response through the provision of health personnel and other recurrent inputs. For instance, public health facilities provide health services to about 80% of the patients on ART. The 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.

3.25 Recommendations

4. Domestic financing through health insurance in the context of UHC will go a long way in improving funding sustainability.

   The Kenya government has already recognised HIV response as an integral part of the UHC agenda. However, the process needs to be fast-tracked. First, there is a need to identify a clear pathway for the inclusion of HIV into the essential benefits package is critical in order to promote the universal health coverage goal of ensuring a sustainable HIV response that is currently heavily donor dependent. Secondly, it is essential to include HIV interventions in the essential benefits package for UHC as a means of reaching the UHC for all Kenyans and achieving MOH UHC targets. Third, there is a need to determine a

mechanism for channelling HIV treatment-related funds towards increasing the resource pool of health insurance available to cover persons living with HIV sustainably.

5. Increasing government allocation from own domestically generated revenue will go a long way in reducing the sustainability problem.
   It is essential to incorporate most HIV/AIDS-related activities into core budgets and functions in the longer term. Additionally, both the national and county governments should develop specific resource mobilisation strategies to ensure adequate funding for HIV/AIDS activities. This should consider not only short-term funding requirements but also ways to gradually increase the availability of resources over time to cope with rising HIV/AIDS-related needs. It is also essential to develop a strategy to create budgetary space to cover key HIV/AIDS-related costs over the next decade. The major source of potential space has to be assumed to be closer management of personnel-related costs in the absence of increasing government revenue. In addition to committing additional domestic resources, the government must ensure efficiency in the utilisation of available resources for the provision of efficient and effective HIV/AIDS services.
6. However, there is an extent to which the Government can allocate additional funding, given fiscal space constraints and funding needs for other sectors. Therefore, finding cost-effective, sustainable financing options is also imperative.
7. If it will be possible to collect data on expenditure directly from PEPFAR implementation partners, it will assist in capturing expenditure by Kenya Government fiscal year. The PEPFAR expenditure reporting data was based on the USG fiscal year, and hence a simple division of the expenditure was used, which might not be exact but an estimate of expenditure in the Kenya Government fiscal year.

Appendix A

Table A1: Expenditure on HIV prevention by county (KES million)

County	2016/17	2017/18	2018/19	2019/20
Baringo	26.67	30.47	32.86	36.48
Bomet	31.74	38.69	57.53	59.78
Bungoma	58.50	56.04	98.91	87.31
Busia	120.39	156.35	162.07	128.68
Elgeyo/Marakwet	20.94	26.11	45.14	47.15
Embu	43.50	80.65	106.63	118.34
Garissa	15.73	16.64	27.43	40.98
Homa Bay	429.91	570.06	476.84	392.78
Isiolo	31.02	27.18	18.02	23.44
Kajiado	69.54	75.08	46.85	58.55
Kakamega	85.96	92.23	102.43	106.45
Kericho	68.11	76.02	150.17	167.20
Kiambu	178.39	203.30	200.39	153.89
Kilifi	141.20	168.50	155.14	157.39
Kirinyaga	44.78	85.83	121.25	132.63
Kisii	205.35	262.08	227.76	197.75
Kisumu	544.90	736.24	510.21	463.24
Kitui	115.93	140.19	250.21	269.70
Kwale	116.22	142.38	114.75	118.89
Laikipia	39.34	40.78	34.01	41.23
Lamu	28.17	37.99	41.33	40.44
Machakos	139.38	168.17	104.94	138.29
Makueni	132.90	155.88	128.08	171.23
Mandera	37.20	30.10	54.83	71.09
Marsabit	38.52	29.34	21.28	29.80
Meru	46.29	51.44	47.61	50.91
Migori	253.46	325.14	251.42	201.06
Mombasa	282.65	354.67	311.25	302.90
Murang'a	103.80	119.27	151.13	148.98
Nairobi City	873.26	855.03	709.26	648.82
Nakuru	87.25	95.74	334.05	284.93
Nandi	32.62	39.18	95.24	90.74
Narok	34.95	44.36	48.45	57.99
Nyamira	44.69	84.58	65.05	54.87
Nyandarua	70.06	83.53	76.44	81.60
Nyeri	90.18	109.70	83.25	88.73
Samburu	22.69	23.71	39.68	45.24

County	2016/17	2017/18	2018/19	2019/20
Siaya	296.96	394.96	267.03	247.45
Taita/Taveta	62.51	25.82	116.01	105.45
Tana River	21.41	82.24	58.66	57.38
Tharaka-Nithi	64.86	105.53	109.23	115.10
Trans Nzoia	44.11	48.69	65.92	61.75
Turkana	172.56	211.77	167.14	188.15
Uasin Gishu	91.68	93.48	95.78	99.32
Vihiga	33.91	40.23	71.54	73.86
Wajir	29.27	24.50	85.11	93.11
West Pokot	23.39	26.86	56.57	64.33
Total	**5,546.87**	**6,686.70**	**6,594.91**	**6,415.36**

Table A2: Expenditure on HTC by county (KES million)

County	2016/17	2017/18	2018/19	2019/20
Baringo	45.94	8.96	32.56	29.83
Bomet	197.00	84.94	88.96	71.95
Bungoma	138.08	14.03	175.88	99.76
Busia	159.93	134.18	148.06	69.14
Elgeyo/Marakwet	36.84	30.67	44.32	26.58
Embu	39.05	44.75	55.34	44.71
Garissa	17.72	66.39	40.69	30.72
Homa Bay	923.37	1,045.52	706.39	411.01
Isiolo	6.29	22.34	17.42	10.48
Kajiado	104.67	45.97	133.63	108.03
Kakamega	315.35	246.73	254.05	98.36
Kericho	80.52	59.52	76.67	56.97
Kiambu	278.83	152.22	423.98	287.88
Kilifi	139.96	126.67	213.12	186.73
Kirinyaga	79.30	103.94	132.18	86.40
Kisii	350.17	324.92	428.37	153.91
Kisumu	738.21	887.05	535.79	300.82
Kitui	148.30	195.54	216.10	120.10
Kwale	59.36	0.73	112.92	97.06
Laikipia	72.79	29.11	103.64	74.61
Lamu	8.46	14.28	25.73	20.65
Machakos	155.57	240.69	260.67	170.00
Makueni	153.55	239.03	267.04	157.03
Mandera	11.03	30.09	19.64	12.16
Marsabit	7.12	18.16	21.12	11.97
Meru	90.42	133.79	166.85	103.41
Migori	460.24	479.98	474.56	260.77

County	2016/17	2017/18	2018/19	2019/20
Mombasa	158.24	222.17	279.65	226.19
Murang'a	199.47	238.35	324.73	158.17
Nairobi City	869.71	531.56	1,113.35	729.46
Nakuru	348.65	260.48	381.84	322.79
Nandi	68.95	64.59	67.95	49.98
Narok	190.99	217.63	156.80	121.93
Nyamira	199.38	242.71	177.46	75.57
Nyandarua	68.38	38.29	115.37	89.60
Nyeri	138.10	113.19	222.53	112.45
Samburu	28.60	6.37	27.52	25.41
Siaya	858.53	1,071.12	496.98	182.13
Taita/Taveta	23.62	24.69	50.09	45.63
Tana River	12.67	9.38	21.90	16.83
Tharaka-Nithi	44.14	92.21	72.50	51.41
Trans Nzoia	89.48	81.78	105.25	58.07
Turkana	273.67	259.64	258.15	209.96
Uasin Gishu	140.52	158.20	173.08	94.21
Vihiga	83.17	99.15	110.23	65.88
Wajir	17.63	3.87	4.34	6.94
West Pokot	65.55	36.67	26.73	27.06
Total	**8,697.52**	**8,552.26**	**9,362.13**	**5,770.70**

Table A3: Expenditure on care and treatment by county (KES million)

County	2016/17	2017/18	2018/19	2019/20
Baringo	129.99	114.09	141.31	110.16
Bomet	416.54	317.81	341.09	253.54
Bungoma	838.37	198.15	787.66	621.36
Busia	1,210.30	983.88	1,067.43	808.16
Elgeyo/Marakwet	94.49	84.96	103.30	88.41
Embu	296.74	268.35	306.74	237.50
Garissa	46.10	38.81	43.06	25.62
Homa Bay	3,700.37	3,256.27	3,632.33	2,760.00
Isiolo	80.41	54.06	59.35	32.16
Kajiado	419.17	334.14	456.77	370.77
Kakamega	1,488.36	1,232.75	1,402.42	1,077.25
Kericho	585.06	460.13	487.12	362.14
Kiambu	1,288.97	1,165.58	1,316.86	1,007.60
Kilifi	784.09	650.33	797.36	636.03
Kirinyaga	351.99	314.59	354.26	273.63
Kisii	1,053.07	910.49	1,026.73	816.54
Kisumu	3,680.51	3,144.84	3,478.20	2,696.51

County	2016/17	2017/18	2018/19	2019/20
Kitui	645.87	568.35	662.80	543.87
Kwale	281.77	291.10	367.73	245.34
Laikipia	293.00	254.16	288.00	226.33
Lamu	44.06	43.48	51.35	40.10
Machakos	832.82	755.11	853.01	676.81
Makueni	663.36	572.40	669.46	532.42
Mandera	17.12	16.33	21.10	16.55
Marsabit	48.39	41.38	30.97	29.18
Meru	633.05	547.41	614.33	493.90
Migori	2,407.25	2,114.88	2,357.12	1,817.02
Mombasa	1,637.91	1,338.95	1,482.62	1,131.67
Murang'a	498.87	447.39	504.65	391.80
Nairobi City	5,442.37	4,569.22	4,747.71	3,991.07
Nakuru	1,356.81	1,066.83	1,276.35	1,017.06
Nandi	384.86	314.56	345.35	266.03
Narok	289.59	260.22	299.63	238.65
Nyamira	495.39	405.70	454.44	377.22
Nyandarua	262.76	237.09	287.24	223.59
Nyeri	580.40	509.49	578.52	442.03
Samburu	48.06	32.91	44.50	39.96
Siaya	2,941.44	2,536.51	2,875.86	2,268.82
Taita/Taveta	185.50	170.16	197.45	123.78
Tana River	29.16	24.15	26.61	23.96
Tharaka-Nithi	227.41	188.10	223.31	171.75
Trans Nzoia	460.52	384.11	476.89	386.92
Turkana	266.95	221.28	267.55	226.07
Uasin Gishu	1,063.89	837.87	915.01	730.12
Vihiga	484.02	423.05	490.03	401.98
Wajir	6.82	0.90	9.04	6.57
West Pokot	122.47	62.04	72.00	74.82
Total	**39,116.41**	**32,764.35**	**37,292.63**	**29,332.77**

Table A4: Expenditure on social protection and economic support by county (KES million)

County	2016/17	2017/18	2018/19	2019/20
Baringo	12.04	18.82	16.51	12.92
Bomet	16.33	26.85	39.55	32.80
Bungoma	44.57	42.55	74.62	56.20
Busia	131.70	150.97	133.98	87.52
Elgeyo/Marakwet	6.60	15.39	29.56	21.24
Embu	36.49	73.12	86.35	82.41
Garissa	2.19	4.20	4.50	4.41
Homa Bay	367.52	455.03	316.97	245.80
Isiolo	24.72	16.39	3.64	2.12
Kajiado	68.00	62.72	19.37	16.11
Kakamega	66.02	78.30	72.47	58.87
Kericho	64.74	61.74	125.41	117.46
Kiambu	80.19	99.48	102.21	84.49
Kilifi	120.50	133.54	96.91	74.57
Kirinyaga	38.99	79.17	99.83	94.21
Kisii	83.46	134.22	99.78	71.82
Kisumu	565.98	658.19	373.21	323.94
Kitui	130.39	133.62	216.63	204.21
Kwale	103.01	109.51	65.80	45.39
Laikipia	26.82	30.01	17.17	17.77
Lamu	21.23	28.82	26.87	14.08
Machakos	166.14	165.15	72.83	82.75
Makueni	121.20	122.69	79.00	96.25
Mandera	14.71	11.85	26.70	25.77
Marsabit	13.41	14.81	5.15	4.37
Meru	32.38	40.12	24.04	23.45
Migori	166.80	226.97	139.89	118.91
Mombasa	184.05	230.42	175.29	160.67
Murang'a	82.82	84.86	103.62	83.23
Nairobi City	895.68	746.44	509.19	413.08
Nakuru	57.29	81.34	296.60	219.96
Nandi	16.36	27.89	75.27	58.17
Narok	23.02	34.17	29.87	26.73
Nyamira	35.44	76.24	45.68	23.40
Nyandarua	77.27	76.24	58.25	53.60
Nyeri	97.91	102.60	61.27	56.23
Samburu	12.46	13.73	23.99	18.59
Siaya	221.32	297.26	149.15	126.51
Taita/Taveta	68.44	15.01	95.60	70.58

County	2016/17	2017/18	2018/19	2019/20
Tana River	11.81	76.79	42.39	28.01
Tharaka-Nithi	71.17	101.06	89.06	78.94
Trans Nzoia	24.55	37.97	44.72	30.09
Turkana	144.21	172.23	97.85	74.40
Uasin Gishu	73.58	78.84	64.27	59.15
Vihiga	21.10	29.50	49.24	37.78
Wajir	14.62	10.14	63.18	54.79
West Pokot	6.28	15.02	39.60	33.63
Total	**4,665.50**	**5,301.96**	**4,483.05**	**3,727.35**

Table A5: Expenditure on HIV social enablers by county (KES million)

County	2016/17	2017/18	2018/19	2019/20
Baringo	3.22	4.23	5.09	7.40
Bomet	5.82	5.03	6.09	10.22
Bungoma	8.84	4.56	10.54	16.52
Busia	11.91	13.07	13.93	21.31
Elgeyo/Marakwet	2.96	2.19	3.51	6.56
Embu	4.39	4.55	5.87	13.49
Garissa	2.20	2.28	3.53	5.31
Homa Bay	39.52	46.53	45.56	64.18
Isiolo	2.49	1.94	3.02	3.94
Kajiado	5.95	5.90	8.72	12.69
Kakamega	14.37	15.82	17.11	23.87
Kericho	7.16	7.43	8.31	19.14
Kiambu	18.10	18.39	19.28	26.60
Kilifi	11.18	12.27	13.09	22.36
Kirinyaga	4.63	5.05	6.52	15.21
Kisii	16.87	16.88	16.94	28.28
Kisumu	39.13	43.53	43.45	69.05
Kitui	7.92	8.71	10.94	29.47
Kwale	6.69	6.33	8.04	14.20
Laikipia	4.52	4.27	5.03	7.66
Lamu	1.92	1.80	2.95	5.53
Machakos	9.09	10.83	12.60	21.92
Makueni	8.90	9.51	10.23	20.95
Mandera	5.51	3.43	5.52	9.65
Marsabit	3.48	3.45	3.49	5.31
Meru	7.09	7.80	9.19	12.00

County	2016/17	2017/18	2018/19	2019/20
Migori	28.14	29.35	29.29	38.50
Mombasa	22.46	22.19	20.96	38.62
Murang'a	7.52	7.59	9.47	17.51
Nairobi City	60.19	62.79	62.24	104.46
Nakuru	14.40	14.18	18.86	36.21
Nandi	4.69	5.30	6.26	12.34
Narok	4.22	5.37	7.42	11.54
Nyamira	5.53	6.25	7.35	10.72
Nyandarua	3.90	4.15	5.74	11.26
Nyeri	6.90	7.34	9.27	14.26
Samburu	2.24	2.67	3.94	7.23
Siaya	32.61	34.95	36.48	50.62
Taita/Taveta	3.26	3.18	5.06	11.34
Tana River	1.77	1.79	2.86	6.36
Tharaka-Nithi	3.63	3.61	5.24	12.52
Trans Nzoia	6.05	5.68	7.88	11.60
Turkana	9.21	10.43	9.54	19.77
Uasin Gishu	11.21	12.01	15.98	23.00
Vihiga	5.42	6.06	8.17	13.19
Wajir	4.93	1.91	6.10	12.36
West Pokot	3.01	2.39	4.37	8.39
Total	**495.16**	**514.96**	**581.05**	**964.64**