

KENYA NATIONAL AIDS SPENDING ASSESSMENT
REPORT FOR THE FINANCIAL YEARS
2006/07 AND 2007/08

JULY 2009

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ASC	AIDS Spending Category
BCC	Behaviour Change Communication
CACs	Constituency AIDS Committees
CBO	Community-based Organizations
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control
DASCO	District AIDS/STD Coordinator
DFID	Department for International Development
DPHK	Development partners in Health, Kenya
EU	European Union
GDP	Gross Domestic Product
GFATM	The Global Fund to fight AIDS, tuberculosis and malaria
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
IDU	Intravenous/ Injecting Drug Users
JICA	Japan International Cooperation Agency
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
KNASA	Kenya National AIDS Spending Assessment
KNASP	Kenya National HIV and AIDS Strategic Plan

MAP	Multi-Country HIV/AIDS Programme
MTEF	Medium Term Expenditure Framework
MDG	Millennium Development Goals
MSM	Men having sex with other men
MoH	Ministry of Health
MoT	Modes of Transmission
MARPS	Most- at- Risk Populations
NACC	National AIDS Control Council
NASA	National AIDS Spending Assessment
NASCOP	National AIDS/STI Control Programme
NCAPD	National Coordinating Agency for population and Development
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PLWHA	People living with HIV /AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
RTS	Resource Tracking Software
SIDA	Swedish International Development Agency
TB	Tuberculosis
TOWA	Total War Against AIDS
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Childrens Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

UNFPA	United Nations Population Fund
UNODC	United Nations Office of Drugs Control
USAID	United States Agency for International Development
USG	United States Government
WFP	World Food Programme

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The Kenya National AIDS Spending Assessment (KNASA) for 2006/2007 and 2007/2008 is the first full-pledged NASA to be undertaken in Kenya. This exercise informed the costing of the new Kenya National AIDS Strategic Plan III (KNASP III), especially in the gap analysis. Concerted efforts of many organizations, institutions, ministries, and individuals resulted in the accomplishment of the exercise.

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EXECUTIVE SUMMARY

Financing of HIV and AIDS in Kenya is undertaken through three main sources namely: public, external (international) and private sources. Like many developing countries, Kenya's national response to HIV and AIDS is to a large extent sustained by international sources mainly from bilateral and multilateral organizations. These sources channel HIV/AIDS funds using two main funding mechanisms: government budgetary system and the "Off-budget" system. The National AIDS Control Council (NACC) is currently in the process of strengthening the management of the national response to HIV and AIDS through annual compilation of expenditure/ spending information on the national response. This process will be institutionalized through a Kenya National AIDS Spending Assessment (KNASA). Tracking of the national expenditure on HIV and AIDS interventions on annual basis would yield strategic information, and inform resource mobilization, allocation and utilization and more importantly inform MTEF budgetary process as well as other major national planning instruments.

The National AIDS Control Council (NACC) undertook a full Kenya National AIDS Spending Assessment (KNASA) to exhaustively track actual HIV and AIDS spending from public, international – bilateral and multilateral and private sources. The KNASA is a comprehensive and systematic methodology used to determine the flow of resources intended to respond to the HIV and AIDS epidemic of a nation. It describes the flow of funds from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the epidemic. The assessment focused on tracking HIV/AIDS expenditure for fiscal year 2006/07 and 2007/8. Data collection covered public, external and private spending on HIV and AIDS, including funds channeled through the government budget system. The KNASA did not however cover private sources such as household out-of-pocket expenditure on HIV and AIDS. Household out-of-pocket expenditure on HIV/AIDS will be included in the second phase of KNASA.

Most of the key sources of data (detailed expenditure records) were obtained through surveys that targeted development partners, NGOs, public sector, health facilities, private firms and community based organizations (CBOs) while secondary sources were used where data on HIV/AIDS expenditure were not available through primary sources. Costing was also done to estimate some of the expenditures on HIV and AIDS related activities using best available data and some agreed assumption.

A number of limitations were experienced by the assessment, key among them was the problem related to missing HIV expenditure information especially in the sectoral ministries. It was therefore difficult to draw firm conclusions about HIV and AIDS financial flows to certain sectors. On the basis of information provided by funding sources and service providers, the study attempted to reconstruct some sectoral spending on HIV and AIDS programmes. It was also

difficult to carry out a detailed comparison of expenditure by priority HIV and AIDS intervention areas due to differences in KNASP priority areas and the NASA categories.

Main Findings

The KNASA assessment shows that overall; Kenya spend Kshs.21.81 billion (US\$307.69 million) on HIV and AIDS response in 2006/07. This increased to Kshs. 23.86 billion (US\$ 361.86 million) in 2007/08, representing a growth of 18%. The total spending on HIV and AIDS from all sources over the two years accounted for approximately 79% (2006/07) and 74% (2007/08) of the total Government expenditures on health. Over the two period, HIV/AIDS spending as a percentage of GDP (at current market prices) remained constant at approximately 1.2 percent (annually).

The analysis of the total expenditure disaggregated by source of funding indicate that in 2006/2007, the largest source (50%) of actual expenditure was bilateral organizations (US \$ 154.17 million) followed by the Government at 19% (or US\$ 57.49 million), other international organizations (13% or US\$ 38.68 million) and multilateral organizations consisting of Global Fund and UN agencies (12% or US\$ 37.57 million). In 2007/08, the share of bilateral organizations increased to 55% (US\$ 197.51million) of the total HIV/AIDS spending in the country while the share of government sources remained constant at 19% (or US\$ 69.01 million).

A large portion of external resources for HIV and AIDS constituted “Off-budget” and was disbursed through vertical projects and NGOs and was therefore not captured in government accounts. In 2006/07, Donors and international NGOs controlled 57% (US\$ 146.10 million) of HIV/AIDS spending. This increased to 59% (to US\$ 189.84 million) in 2007/08. Over the same period, the share of HIV/AIDS expenditures within the control of public sector declined from 43% (or US\$ 131.19 million) in 2006/07 to 41% (US\$ 144.16 million) in 2007/08.

KNASA reported an increase in spending on treatment and care and a drop in spending on prevention. The increase in spending on treatment and care may be attributed to the increase in donor funding particular spending emanating from PEPFAR and Global Fund that have helped to scale up access to ARVs. In 2006/07, treatment and care account for 55.8% of the total HIV/AIDS expenditures. This was followed by prevention at 29.4%, programme management at 9.6%, OVC at 3.1% and Human resources at 1.6%. In 2007/08, the scenario changed as the amount that went to treatment and care increased to 63.7%. The HIV/AIDS resources that were spent on prevention decreased to 24.2%, programme management to 7.3%. At the same period, OVC decreased to 2.9% and human resources to 1.4%.

The public sector providers provided bulk of the HIV/AIDS services accounting for 50% (or US\$ 158.8 million) and 45% (US\$ 164.3 million) in 2006/07 and 2007/08 respectively followed

by the FBO providers at 22% (US\$ 67.17 million) and 24% (US\$85.7 million) in 2006/07 and 2007/08 respectively.

The absorption capacity for HIV and AIDS funds among the NGOs and Providers of HIV and AIDS services was high. Out of the total financial resources mobilized from all sources 98% and 96% was spend in 2006/07 and 2007/08 respectively, an indication that the country has enormous capacity to absolve the increase in resources required to implement the KNASP III. However, the absorptive capacity by the providers of HIV/AIDS related services could further be enhanced through building capacity in the areas of financial management, harmonize and simplify the reporting systems, flexibility in spending and recruiting more qualified personnel

The main beneficiary groups during the assessment period were People Living with HIV/AIDS (PLWHA) accounting for 60 % (or US\$ 217.1 million) in 2007/07 and 53% (US\$ 163.68 million) in 2006/07 of the HIV/AIDS resources spend. This pattern of expenditures by beneficiary groups is consistent with the reported spending by core functions in which care and treatment accounted for 63% in 2007/08 and 55% in 2006/07.

Conclusion and policy Implication

External resources continue to dominate HIV/AIDS financing in Kenya. This seems to have increased with increased resources coming from PEPFAR. The fact that development partners' account for a lion share of HIV/AIDS spending in Kenya should be a major concern to the country as this raises issues of sustainability.

Donors and NGOs continue to control bulk of the HIV/AIDS spending in the country. Aligning the HIV/ AIDS spending to the KNASP and the MTEF will therefore pose a major challenge. KNASA tracked all HIV/AIDS expenditure in the country and it was found that some of the expenditures were not aligned to the KNASP II. KNASA assessment showed that while some achievements were made in terms of spending by priority areas, other spending on priority areas were not attained. It will therefore be critical to ensure that HIV/AIDS spending is aligned and harmonized to priority areas as stipulated by KNASP III.

Expenditure by prevention programmes decreased from 29.4% as reported in 2006/07 to 24.2% in 2007/08. The overall decline in expenditure on prevention programmes as a share of total expenditure over the study period should be monitored given the importance of intensifying prevention interventions so as to reduce the HIV/AIDS prevalence rate.

Human resource is a major challenge affecting the HIV/AIDS sector. However, despite being a major challenge, not much in terms of resources has been devoted to human resources for HIV/AIDS. The assessment showed that as little as 2% and 1% was spent on human resources in 2006/07 and 2007/08 respectively. If the country was to achieve the desired targets as stipulated

by the KNASP, 2005-2010 and therefore sustain the fight against HIV/AIDS, more resources will have to be devoted to Human resources for HIV/AIDS programmes.

CHAPTER ONE: INTRODUCTION

1.1 HIV and AIDS Situation in Kenya¹

Kenya is experiencing a mixed and geographically heterogeneous HIV epidemic with characteristics of both a ‘generalized’ epidemic among the mainstream population, and a ‘concentrated’ epidemic among specific most-at-risk populations (MARPs). The epidemic is geographically diverse, with a particularly high prevalence in Nyanza Province (14.9%), and a higher than national average prevalence in Nairobi City (8.8%) and Coast Province (8.1%). Apart from some major cities, and the major transport corridors, HIV prevalence is lower than the national average across the rest of the country. Prevalence rate among the urban population is 8.4% as opposed to 6.7% in the rural population. However, because of Kenya’s large rural proportion an estimated 70% of people living with HIV (PLHIV) live in rural areas.

The contribution of the main modes of HIV transmission to incidence also varies geographically, reflecting the diverse nature of the epidemic: transmission among IDUs contributes to 17% of incidence in Coast Province, but less than 4% in Nyanza Province; transmission among men having sex with other men (MSM) contributes to less than 6% of incidence in Nyanza, but over 11%, in Nairobi. Similarly, transmission in fishing communities is a particular problem around Lake Victoria, accounting for 26% of incidence. Age and sex differentials are considerable with HIV prevalence peaking among women aged 30-34 (13.3%) a decade earlier than among men aged 40-44(10.2%); reflecting both historical transmission patterns and significant levels of inter-generational sex.

The pattern emerging in Kenya is of highly variable epidemiological dynamics, geographically with respect to modes of transmission, and with substantial age and sex differentials. In essence, Kenya has a variety of localized HIV epidemics across the country, with diverse causes and outcomes. This pattern presents the following particular challenges with respect to the epidemic among the general population:

- ***High levels of HIV within marriage/regular partnerships:*** the high sero-status discordance rate suggests that marriage may well be a ‘high risk’ situation with variable patterns of initial introduction of HIV into the union. Social norms regarding relationships, gender roles/imbances, stigma and discrimination, fear and risk-perception, and fertility intentions present difficult prevention challenges. In addition, apart from testing, ‘discordant couples’ are virtually impossible to identify and target with services.
- ***Paediatric HIV infections due to vertical transmission:*** a continuing high incidence of paediatric infection, due mainly to inefficient, inaccessible, or underutilized Prevention of Mother to Child Transmission (PMTCT) services, also constitute a particular challenge. Paediatric HIV infection contributes directly to infant and young child mortality, complicates child malnutrition, and requires lifelong and expensive treatment. Children on HIV treatment

¹Section 1.1, 1.2 and 1.3 were adopted from KNASP III

that survive to adolescence and adulthood face the additional challenge of forming relationships without transmitting their vertically acquired infection horizontally.

- **Gender dimensions of the epidemic:** the ‘feminization’ of the epidemic is apparent with prevalence among women (8.8%/15-49 and 8.4%/15-64) significantly higher than among men (5.5%/15-49 and 5.4%/15-64). While prevention programmes among young people have contributed in delaying sexual debut and increasing risk perception, for young women who are already sexually active, prevention programmes have generally failed to make a difference.
- **Mismatch between service provision and geographical prevalence:** approximately 70% of PLHIV live in rural areas, but services are concentrated in urban/peri-urban areas. Where optimal prevention is service delivery-mediated, access to such services is a problem.
- **Low levels of knowledge about HIV status:** only 36% of Kenyan adults (15-64) have tested at least once for HIV and received results. However, an estimated 80% of HIV infected people do not know their correct status, and testing rates show little difference across provinces, despite large geographical variation in prevalence. HIV testing rates are higher among women (43%) compared to men (25%).
- **Improving still low levels of condom use:** while condom use among higher-risk sex shows some positive progress for both women (23.9% in 2003 KDHS, and 35% in 2007 KAIS) and men (46.5% - 51.8%), it remains low.
- **Treatment, care and nutrition:** only 38-45% of those in need of treatment are being reached at present, with coverage for children much lower, at about 15%. Up to 300,000² Kenyans are still at the risk of dying due to lack of access to treatment.
- **TB-HIV:** Despite that fact that 80% of TB patients are being offered HIV testing and 80% of TB facilities provide HIV testing, only 27% of HIV positive TB patients receive ART.

Challenges among MARPs include:

- **Overall lack of data about a number of such populations:** it is difficult to target services effectively when so little is known about these populations. Sex workers, with relatively high HIV prevalence among them, are widespread in urban centres and along major transport routes, but attempts to accurately quantify the population size have so far been unsuccessful. KNASP III uses the latest model default estimates to arrive at 80,000 sex workers for planning purposes. Multiple concurrent partnerships are common, and MSM are not a negligible population in Nairobi, but real numbers for both are unknown. IDU is increasing in Kenya, but again, while a United Nations Office of Drug Control (UNODC) study conducted in 2004 estimated HIV prevalence among injecting drug users in Nairobi, Malindi and Mombasa to be 68%-88%; real numbers and distribution are unknown.
- **Criminalization of these groups’ high risk behaviours:** sex work, homosexuality and drug use are all illegal in Kenya, and attempts to de-criminalize them have faced significant religious and cultural resistance among the population. However, based on new evidence³, KNASP III will work with all most at risk groups and seek innovative

² Latest figures from WHO.

³ MoT Study 2008; KAIS.

ways to reduce HIV transmission. Programmes have been working with all these groups for many years, but under constraints, which KNASP III systematically aims to alleviate.

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

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

Key drivers of the epidemic

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

In the context of the Kenyan HIV epidemic, indications of specific deprivation among the urban poor and women are clear: lack of access to social capital; lack of control of human capital, rights, assets and information; and, the denial of entitlements to inheritance and to equality of opportunity, e.g. for education and care. The HIV epidemic has also deepened elements of deprivation in the context of embattled social relations, and it has also challenged social capital networks⁴. Social exclusion limits, and sometimes entirely prevents, people’s voice and participation within their communities in shaping, implementing, monitoring and evaluating actions that are likely to have considerable impact on their own lives.

⁴ Cf. *Pulling Apart: Facts and Figures on Inequality in Kenya*, Society for International Development, Nairobi, 2004.

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

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

Nationally some 20,000 secondary school students graduate each year and these young people represent a key cohort for behaviour change communication (BCC) and character formation. Out-of-school youth (data on numbers is not available), especially young out-of-school women, represent an even harder to reach group in terms of BCC, character formation and peer education. It is estimated that only 12% of public health facilities offer what can be defined as youth-friendly services. Provision of genuinely youth-friendly (particularly 'girl-friendly') and integrated sexual and reproductive health (SRH), family planning (FP) and HIV services is perceived by the MoH, NACC and other key actors such as the National Coordination Agency for Population and Development (NCPAD) as of critical importance with regard to reducing HIV prevalence rates among young people aged 12-24, and especially girls and young women in that age range.

Data from the MoT and KAIS studies make it clear that the HIV epidemic remains strongly associated with cultural patterns of life in Kenya: the two main determinants of HIV infection are male circumcision⁵ and societal acceptance of concurrent multiple partnerships. The first, lack of male circumcision, is mainly limited geographically to certain areas, and would appear to present a challenge mainly in terms of massive service delivery problem. The second is still deeply rooted in a number of widely-held socio-cultural norms.

At the '**micro**' level, it is evident that many Kenyans have changed their individual behavior, the age at sexual debut and of marriage have risen, and condom use has increased significantly.

⁵ While male circumcision is a common practice in Kenya with 84% of adult men having been circumcised, the practice is much lower among specific groups, such as the Luo, Turkana and Teso.

However, while much has changed, much still remains the same. Many of these challenges remain, particularly those that relate to the position of women. Gender disparities in Kenya are high: prevalence among adolescent girls aged 15-19 is six times that of men (3% of all young women in that age group, as compared to less than 0.5% of young men); among young women aged 20-24 the prevalence rate is 9% as compared to 2% in young men. Kenyan girls' and women's vulnerability to HIV infection can be gauged by such statistics as 28% of men aged 15-49 believe that a woman has no right to request that a man use a condom, and only 24% of women aged 15-49 who reported having sex with a man other than a spouse or regular/cohabiting partner within the past twelve months had been able to request condom use (KDHS 2003). Women's vulnerability is therefore compounded by a male dominated society, whose sexual beliefs are not always scientifically correct. A particular concern is for young married women, who may have even less opportunity to negotiate safe sex than young unmarried women - many are deemed to have minimal room to manoeuvre to discuss their husbands' (in) fidelity. Indeed, infection rates are higher among young married women than among unmarried women of the same age.

Sources of new infections

The prioritized response in KNASP III is informed by an evidence-based understanding of where effective services are needed most urgently. The MoT study reviewed the epidemiology of HIV in Kenya, based on the data available, including the latest KAIS data. The MoT modeling estimated that some 76,000 new infections occurred in 2006, bringing the total number of adults aged 15-49 infected with HIV to 1.2 million. A subsequent Spectrum model estimated the number of infected adults in 2009 at 1.5 million. The national epidemic is geographically diverse, however, with a particularly high prevalence in Nyanza Province⁶ (14.9% - with 26% prevalence in Suba District and 19% in Kisumu), and higher than the national average in Nairobi (8.8%) and Coast Province (8.1%). Overall, the annual HIV incidence is estimated at 162,000 (130,000 new infections in adults and 32,000 paediatric due to vertical transmission). Sources of new adult infections are:

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

⁶ A significant contributing factor to high HIV prevalence in Nyanza Province is the low level male circumcision among Luo, who constitute around 60% of the region's population. Subsequently, distribution of HIV prevalence in Nyanza is highly unequal among different population groups and geographical locations.

partnership, casual sex, and sex workers and their clients contribute over 70% of new infections nationally, except in Nyanza where they contribute over 90% of new infections. Injecting drug use and health facilities contributed 6.3% of the new cases.

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

Although the number of IDUs in the population is relatively low, this is a group with a high potential to transmit the disease, and this is reflected in the extremely high incidence in the MoT model.

As already noted, the level of contribution to incidence of these main modes of HIV transmission varies geographically, reflecting both the diverse causes and outcomes of the epidemic: transmission among IDUs contributes to 6% of incidence in the Coast Province, but nil in Nyanza; transmission among MSM contributes less than 6% of incidence in Nyanza, but over 16%, in Nairobi. Similarly, transmission associated with fishing communities is a particular problem around Lake Victoria, accounting for some 24% of incidence. Finally, both age and sex differentials are considerable, with HIV prevalence peaking among women (13.3%/30-34) a decade earlier than among men (10.2%/40-44), reflecting historical transmission patterns. Inter-generational sex, however, may not be as frequent as generally accepted⁷.

Working with the MoT and KAIS data, a cost-effectiveness exercise was conducted⁸ to inform this strategic plan and identify priority targets for prevention service interventions⁹. The bar graph below presents the cost-effectiveness of all possible interventions based on the KAIS and MoT study data. The yielded cost-effectiveness is better than \$4,000 per case averted. The most cost-effective intervention, at about \$225 per case averted, is for men in rural Nyanza aged 25-49

⁷ A study in Kisumu found that only 4% of men's sexual partnerships were "Sugar Daddy", defined as the man being 10 years older or more and being above the sample mean in income. cf *Confronting the 'Sugar Daddy' Stereotype: Age and Economic Asymmetries and Risky Sexual Behavior in Urban Kenya*, Nancy Luke, *International Family Planning Perspectives*, 2005, 31(1):6-14.

⁸ Cf. *Conceptual framework for HIV prevention in Kenya: Issues, challenges and implications for programming*, 'Prevention Advisory Team', NACC, March 2009.

⁹ Due to the focus of MoT on incidence among adult population, the analysis does not include interventions directly addressing vertical transmission of HIV. However, PMTCT is considered a specific, highly effective intervention, both for purposes of preventing vertical transmission and by providing a critical entry point for extending required prevention, treatment, care and support services to the parents and other family members.

who are given VAMC. This highly favourable result is due to the extraordinarily high incidence in this group (0.025), combined with the substantial risk reduction (60%) and the long duration of VAMC benefits (15 years). By contrast, if this same group receives a standard intervention, the cost per case averted is about 10 times this level as shown in the first yellow bar (moving in from the left side of the graph). The other highly cost-effective interventions are in high-risk groups defined by specific behaviours or situations, i.e., prisoners, MSM, IDUs, sex workers, and fishing communities.

1.2 National Response to HIV and AIDS in Kenya

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

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

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

1.3 Financing Sources and Mechanisms for Health and HIV/AIDS

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

with the funds for HIV/AIDS being disbursed from treasury channelled through the Ministry of Public Health and Sanitation through National AIDS and STI Control Programme (NAS COP) and National AIDS Control Council (NACC).

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

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

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

1.4 Rationale for a HIV/AIDS Resource Tracking Exercise

The National AIDS Control Council (NACC) is in the process of strengthening the management of the national response to HIV and AIDS. One of the strategies to achieve this objective will be an annual compilation of expenditure/ spending information on the national response. Tracking of the national expenditure on HIV and AIDS interventions on annual basis would yield strategic information, and inform resource mobilization, allocation and utilization. In addition, the data collected will allow for the reporting on the UNGASS Financial indicators, inform MTEF

budgetary process as well as other major national planning instruments. This process would be institutionalized through a Kenya National AIDS Spending Assessment (KNASA).

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

The KNASA I findings will inform the costing of the new Kenya National Aids Strategic Plan III (KNASP III 2009/10 – 2012/13), that aims on delivering on universal Access to HIV and AIDS services at all levels of prevention of new HIV infections, reduction of HIV-related illness and deaths, and mitigation of the effects of the epidemic on households and communities. This Plan will deliver on Vision 2030, as well as realize the targets set by United Nations General Assembly for scaling up HIV prevention, treatment, care and support, and mitigation of the socio-economic impacts. KNASP III therefore sets the stage and the framework for enabling Kenya to achieve Millennium Development Goal (MDG) 6.

The need for timely, reliable and comprehensive information for the management of the national response to HIV and AIDS is important to the Government of Kenya and key partners, through the National AIDS Control Council (NACC) to enable them:-

- Address the resources required to satisfy the needs of the vulnerable population directly affected by the spread of the disease,
- Identify programs that comprise the capacity to deal with the consequences of HIV and AIDS i.e. human/financial resources to strengthen prevention, care and treatment as well as social mitigation to augment society's responses to the threat and consequences of HIV and AIDS.

1.5 Goal and Objectives of Undertaking KNASA

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

Specific objectives of the assessment are:

- a) To build the national capacity, including that of NACC and the national research team to undertake KNASA and institutionalize the KNASA through existing financial information systems,
- b) To develop tools and systems for tracking of resources for all implementers on an on-going basis within the national system,
- c) To track all financial and other resource in-flow into the national response on HIV and AIDS in Kenya during the period of assessment,
- d) To identify and measure all domestic/public, external and private expenditure on HIV and AIDS in Kenya for the assessment period and to present these according to the thematic NASA AIDS spending categories,
- e) To prepare a comprehensive report and synthesize this data into strategic information to inform decision-making during the KNASP Strategic Review process and the national budget/MTEF processes,
- f) To catalyze and facilitate actions which will strengthen and institutionalize country level tracking of expenditure and coordination by NACC.

CHAPTER TWO: STUDY DESIGN AND METHODOLOGY

2.1 The Overall NASA Methodology and Scope

The National AIDS Spending Assessment (NASA) approach is a comprehensive and systematic methodology used to determine the flow of resources intended to tackle this disease in a country or region (UNAIDS 2007). It describes the flow of funds, from their sources to the end point and beneficiary groups among the different institutions dedicated in the fight against the disease. The NASA establishes the level and determinants of expenditure on HIV/AIDS, thus measuring the national response to HIV/AIDS. NASA also facilitates creative efforts in diversifying financial sources as well as identifying areas for improved allocation in a more efficient and equitable way.

Information about the existing HIV/AIDS resource sources, allocation and utilization offers a rationale for reforms in the funding, distribution and use of resources in response to HIV/AIDS. Moreover, NASA generates useful information for the decision-making and policy design process intended to reduce the burden of disease caused by HIV/AIDS. Though not an all-in-one tool, NASA supports the UNAIDS “Three Ones” principle¹⁰ and facilitates a standardized reporting method of indicators that monitor progress towards achieving the targets of the Declaration of Commitment adopted by the United Nations General Assembly Special Sessions on HIV and AIDS (UNGASS I & II)(UNAIDS, 2007).

This tracking of actual expenditures for HIV/AIDS in Kenya used the recently agreed NASA methodology, and captured the public and external sources of funds as well as the private sector contributions (from business, private and faith based health system). Spending by the households will be included in the next phase.

2.2 Classifications

In line with the NASA framework, expenditures for HIV/AIDS activities were measured and organized on the basis of the entities making the expenditures, and those entities passing or using the expenditures. The classification of entities within Kenya’s health care system was critical for

¹⁰ The “Three Ones” principle for the coordination of national HIV and AIDS responses relates to One agreed AIDS action framework, that provides the basis for coordinating the work of all partners; One national AIDS coordinating authority with a broad-based multi-sectoral mandate: One agreed AIDS country-level monitoring and evaluation system.

estimating and structuring the NASA. Three sets of entities can be defined as financing sources, financial agents and providers.

(a) Financing Sources: Financing sources are defined as entities which ultimately bear the expenses of financing HIV/AIDS activities.

(b) Financial Agents: Financial agents are defined as entities which pass funds from financing sources to other financial agents or providers in order to pay for the provision of HIV/AIDS services. They determine how funds are allocated to finance the different interventions.

(c) Providers: Providers are defined as institutional entities that produce and provide health care goods and services, which benefit individuals or population groups.

2.3 Preparatory Phase

During the planning phase, a team of research assistants drawn from our local universities and partner institutions in health development were trained on the NASA methodology. The training was undertaken from January 19-23, 2009 by the consultants supported by the Centre for Economic Governance and AIDS in Africa (CEGAA). During the same period data collection tools were fine tuned to reflect the Kenyan context.

2.4 Sampling Procedures and Data Sources

To facilitate the sampling process, a database of all the stakeholders involved in HIV/AIDS as sources, agents and providers was developed. The sampling frame included all the donors, governmental and non-governmental organizations, faith based organizations and community based organizations. Overall, the final sample included all main sources of funds (external and public), representative number of agents of funds in Kenya, and key providers.

Donors

With the help of the Development Partners in Health, Kenya (DPHK), a list of development partners was generated. From the list, all development partners supporting HIV/AIDS were included in the assessment (census). The following development partners were therefore surveyed: Clinton Foundation; DFID; EU; Italian Cooperation; JICA; UNFPA; UNICEF; USG- This includes CDC and PEPFAR; World Bank; WFP; SIDA; GFATM; UNDP; MSF. Although the response was not 100 percent, the main sources of HIV and AIDS funds, during the period under review, provided information. The donor agencies that provided information included

USAID, DFID, GTZ and other German agencies, SIDA, EU, Italian Cooperation, GFATM, JICA, and UNICEF. One of the main sources of HIV funds for paediatric ART, the Clinton Foundation, did not provide the information although several attempts were made in that respect. The necessitated an estimation of expenditure from this source using the information it provided for the NHA 2005/2006.

NGOS and community based organizations

The latest directory produced by the NGO council was used to compile a sampling frame of NGOs working in the field of HIV/AIDS. The Directory provided addresses, location and the activities of the NGOs. The list generated from the directory, a list provided by HENNET and one that was provided by the TA to the DPHK was used to generate a sampling frame. In total, 385 NGOs formed the sampling frame (230 local and 155 International NGOs).

The NGOs were then stratified by type (local versus international) and region. A total of 115 NGOs were randomly sampled from both category (46 Local and 69 international NGOs). The supervisors liaised with the District AIDS Coordinators (DASCOS) in the sampled districts to assist in locating the sampled local NGOs and also replaced the ones that did not exist/operational. It is apparent that many of the local NGOs were not operational while some NGOs sampled had ceased operations since the publication of the NGO Directory. A total sample of 80 NGOs provided information.

Government ministries

For the purpose of the NASA estimates, all the ministries including Ministry of medical services and public health were included for the assessment. Although a census method was adopted, targeting all the 27 ministries that existed during the period under review, data was obtained from 16 ministries. These provided a sample from which an estimation of expenditure for the entire population of ministries was done.

State corporations (Parastatals)

State Corporations (Parastatals) incur expenditures related to HIV/AIDS. A listing of 120 state Parastatals was obtained from the State Statutory Board. These were stratified by sector and region. Out of the 120 Parastatals, 54 Parastatals distributed throughout the country were sampled for the survey. A sample of 8 provided information and this number was too small for making estimation and generalization.

Private firms

The sampling frame for the private firms consisted of a list of firms provided by the Kenya Private Sector Alliance (KEPSA) and Federation of Kenya Employers (FKE), which yielded a total sample of 211 firms. The firms were then stratified by sector namely agriculture, finance and investment, commercial and services and industrial and allied. From each category, a representative sample of firms determined by simple random sampling method was obtained. Although a total sample of 80 private firms were surveyed, only 7 firms provided data. The limited sample led to exclusion of the private corporate firms from the analysis.

Health facilities

A list of health facilities was obtained from the Ministry of Medical Services, Division of Health Management Information Systems. Another list comprising of facilities that provide ART services was obtained from NASCOP. The list from NASCOP also comprised VCTs, both stand alone and integrated. Altogether, there were about 5,259 health facilities distributed across the provinces, with 644 providing ART services. The population of the facilities providing ART services was used for selecting the sample of facilities for expenditure tracking and estimation.

The selection of the sample of health facilities was done in three stages. First, the country was divided into 10 regions, consisting of the Central Province, Coast Province, Eastern Province, Nairobi Province, North Eastern Province, Nyanza Province (2 regions – north and south), Rift Valley Province (2 regions – north and south), and Western Province. Second, a certain number of districts were sampled from each region based on the HIV prevalence (see Table 2.1). Third, the ART facilities in each of the districts were stratified by level of care and type of ownership. A stratified proportional random sampling method was used to select a representative sample of 86 facilities. All the public district hospitals in each of the selected districts were included in the sample. In addition, Kenyatta National Referral Hospital, Moi Referral Hospital, all the provincial general hospitals, and the Aga Khan Teaching Hospital were selected. In order to guard against non-response, the sample was increased to 120 facilities. However, the response rate was very high, with 118 facilities provided data.

Table 2.1: Sampled districts

Province	Districts
Central	Nyeri, Thika
Coast	Mombasa, Taita-Taveta
Eastern	Machakos, Kitui, Embu
Nairobi	Nairobi
North Eastern	Garissa
Nyanza	Gucha, Kisii, Kisumu, Siaya, Homa Bay
Rift Valley	Bomet, Bureti, Kericho, Nakuru, Uasin Gishu
Western	Bungoma, Kakamega

Obtaining permissions

The NACC facilitated the process of obtaining permission to collect data from different organizations, by sending introduction letters to all the sampled organizations prior to the actual fieldwork. In some cases, NACC facilitated the process by calling some organizations, to emphasize the importance of the assignment and request for the information.

2.5 Data Collection

Both primary and secondary data, quantitative and qualitative data, were collected from the sources, agents and providers in the selected districts. Primary data included HIV/AIDS expenditure data at sources, Agents and Providers as well as qualitative information on various thematic areas around funding and reporting mechanisms for HIV/AIDS spending.

Secondary data included audited reports, annual reports and work plans and action plans for the sampled institutions for financial year 2006/07 and 2007/08. “Top down” and “bottom up” approaches were used to gather expenditure information from the sampled institutions. Top down approach involved gathering information from the sources, and agents, while bottom up approach involved collecting detailed data from the provider on their expenditure activities and the beneficiary groups and linking this back to the agent to source. Triangulation was also used to create each complete transaction, so as to avoid double counting.

The data collections tools used were the standard NASA collection forms developed by the UNAIDS. They consisted of NASA source form, NASA agent form, NASA form 2 providers, and annex 1 for FORM2 PFs. In addition to these tools, another tool was designed by the research team, to capture the costs and expenditure of health facilities in provision of health services in general.

Nine teams of enumerators were used to collect data in the 10 regions. However, for logistical and operational reasons, the 10 regions were reclassified into 9 regions. One team collected data in each region, each taking a total period of four weeks. One supervisor was assigned to each of the 9 teams.

2.6 Data Processing and Analysis

The data collected was first captured in Excel sheets for cleaning, calculations and estimation purposes. In the excel sheets, the data was verified, checked and balanced before being transferred to the NASA Resource Tracking Software (RTS). NASA RTS has been developed to facilitate the data processing for NASA into matrices of different classification axes. The NASA RTS outputs were then exported to Excel software to produce summary tables, and graphs for analysis

2.7 Assumptions and Estimations

The NASA methodology allows for further disaggregation of the HIV/AIDS data to show provider expenditures by HIV and AIDS functions show HIV/AIDS spending by the categories of beneficiaries and factors of production. Due to the nature of the data collected, some assumptions were necessary to allow for the above breakdown of HIV/AIDS data.

- HIV expenditures information was missing for the selected NGOs, Ministries etc. It was therefore difficult to draw firm conclusions about HIV and AIDS spending by the ASC. However, on the basis of information provided by funding sources and service providers, the study attempted to reconstruct some NGOs and other sampled agents spending by ASC.
- USG expenditure data is based on a number of sources and assumptions. PEPFAR and CDC provided information on HIV and AIDS financial commitments and a list of organizations that received CDC funding during the reporting period. Expenditure data was then obtained from some of these recipient organizations. The assessment obtained a list of partners who received USAID funding and also managed to provide aggregate expenditure data for 2006/2007 and 2007/08. In order to minimise the potential for double counting, the assessment utilised the aggregate expenditure data reported by USAID for its own activities.
- Where the data on beneficiaries were not disaggregated and detailed enough the bulk of it was assumed to be targeted to the general population.
- Donors had different financial reporting periods from that used by the government (July-June) e.g. USAID (October-September). Effort was made to capture the actual expenditure within each fiscal year, according to the government's fiscal year.
- Costing estimations were used to determine the actual expenditure incurred by health facilities during the period of expenditure tracking. Only recurrent expenditure for 2006/2007 and 2007/2008 were considered. A simple step down method was used to allocate overhead costs and personnel costs to both inpatient and outpatient services. The allocated costs of

inpatients and outpatients services were further allocated to HIV positive patients and other patients. The following assumptions in used in the allocations. 1 inpatient to 4.6 outpatients, based on the costing study of health services in Kenya during the year 2006/2007 that was undertaken by Oxford Project Management (OPM) for the then Ministry of Health.; 30% bed occupancy by HIV positive patients based on the NASA survey results; and the proportion of ART patients in the total outpatients in a facility.

CHAPTER THREE: KEY FINDINGS

3.1 Total Expenditure on HIV/AIDS and Sources of Funding

Sources of funding for HIV/AIDS are entities that provide money to finance HIV and AIDS activities through financing agents. In Kenya, there are three main sources of HIV and AIDS, namely: Public sources, International sources (bilateral and Multilateral) and private sources that include private firms and households. However, in this assessment, the contribution of households towards the national response to the pandemic was not included. The assessment for the two years show that Kenya spent an estimated Kshs. 21.8 billion (US \$ 307.68 million) in 2006/07 (see Table 3.1). In 2007/08, the HIV/AIDS spending increased to a total of Kshs 23.85 billion (US \$ 361.86 million). Expressed as a percentage of GDP (at current market prices), this level of spending accounted for 1.1% (2007/08) and 1.2% (2006/07) of the total GDP in the country.

The sources of these funds consisted of public (Government of Kenya)¹¹, bilateral agencies, multilateral agencies and private firms. The preliminary results presented in Table 3.1 indicate that, the bulk of expenditures on HIV/AIDS in Kenya came from international sources (81.4% - 2006/07) and (80.6 % - 2007/08). The relatively high level of external funding may not reflect well with future sustainability of the national response to the HIV/AIDS pandemic in the country.

Table 3.1: Public and external sources of funds for actual expenditure

Funding Sources	2006/2007			2007/2008		
	KES	US \$	%	KES	US \$	%
GoK (public)*	4,074,868,214	57,497,788	18.7%	4,550,146,538	69,014,812	19.1%
Private Domestic	1,400,399,230	19,760,113	6.4%	1,347,577,101	20,439,513	5.6%
International Sources	16,330,593,741	230,430,277	75%	17,959,917,566	272,408,882	75%
TOTAL	21,805,861,185	307,688,178	100%	23,857,641,206	361,863,207	100%

*Government of Kenya (GoK)

Table 3.2 show a further analysis of the expenditure disaggregated by source of funding. In 2006/2007, the largest source (50%) of actual expenditure was bilateral organizations (US \$ 154.17 million) followed by the Government at 19% (or US\$ 57.49 million), other international

¹¹ Public include Ministry of Finance and expenditures by Parastatals.

organizations (13% or US\$ 38.68 million) and multilateral organizations consisting of Global Fund and UN agencies (12% or US\$ 37.57 million). In 2007/08, the share of bilateral organizations increased to 55% (US\$ 197.51million) of the total HIV/AIDS spending in the country while the share of government sources remained constant at 19% (or US\$ 69.01 million).

Table 3.2: Actual Expenditure on HIV/AIDS by major source category

Funding sources	2006/07	2006/07	2007/08	2007/08
	KES	US \$	KES	US \$
Government of Kenya	4,074,868,214	57,497,788	4,550,146,538	69,014,812
Private domestic	1,400,399,230	19,760,113	1,347,577,101	20,439,513
Bilateral	10,926,175,717	154,172,086	13,022,158,598	197,514,919
Multilateral	2,663,162,215	37,578,132	2,642,428,498	40,079,304
Others International	2,741,255,809	38,680,059	2,295,330,471	34,814,659
TOTAL	21,805,861,185	307,688,178	23,857,641,206	361,863,207

Note: Figures for the Government consists of the explicit expenditure by government ministries and, estimated expenditure by the Ministries of Health.

Figures 3.1 and 3.2 (derived from table 3.1) display the distribution of percentage shares by broader source classification in the two years under review.

Figure 3.1: Percent shares by broader source classification: Kenya 2006/07

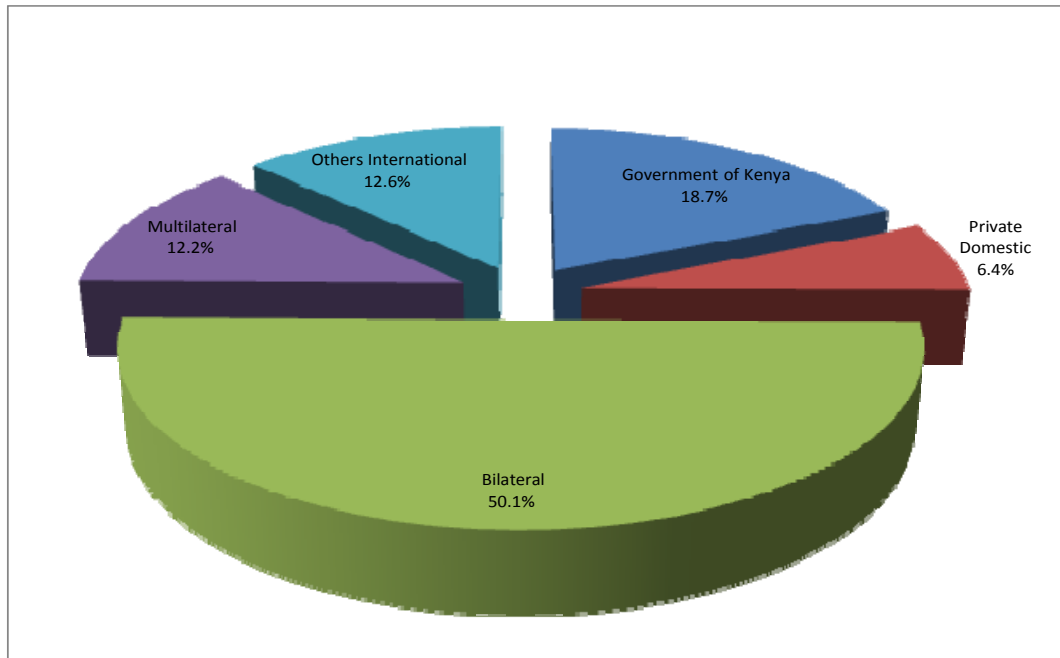


Figure 3.2: Percent shares by broader source classification: Kenya 2007/08

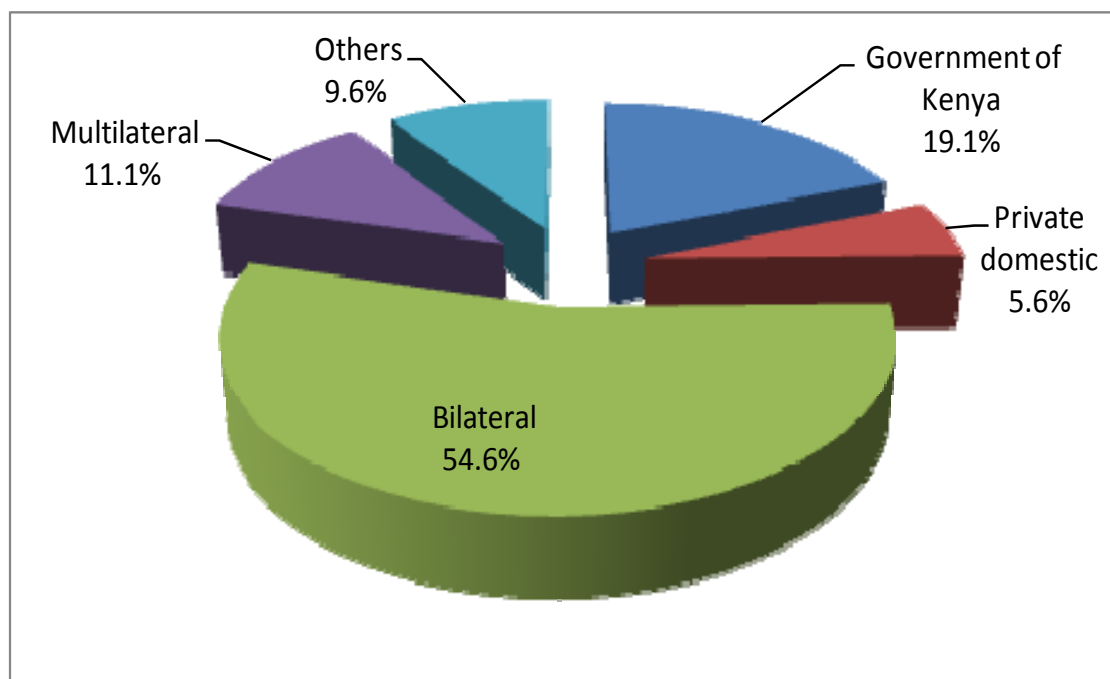
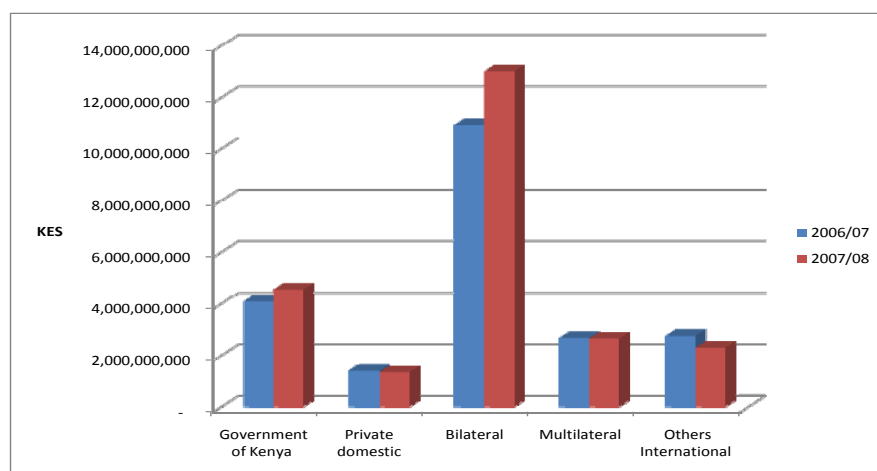


Figure 3.3 shows the trends in HIV/AIDS spending in Kenya over the two year period. Overall, the combined expenditures by source on HIV and AIDS increased from US\$ 307.68 million in 2006/07 to US\$ 361.86 million (2007/08), representing a growth of 18% over the period under review. A close examination of the figure further reveals that spending by bilateral organizations increased from US\$ 154.17 million (2006/07) to US\$ 197.51 million in 2007/08 representing a 28% increment. Similarly, spending from public sources (GoK) increased from US \$ 57.49 million (2006/07) to US \$ 69.01 million in 2007/08 (or 20% increase). We however, note that spending by other international organizations declined from US \$38.68 million (2006/07) to about US\$ 34.81 million in 2007/08 (10% decrease). The increased growth in spending by bilateral organizations reflects the influx of external funds (mainly from PEPFAR) to step up HIV and AIDS response in the country.

Figure 3.3: Trends in HIV/AIDS spending in Kenya: 2007-2008



3.2 HIV and AIDS Spending on Broad Categories by Sources of Actual Expenditure

According to the NASA framework, the HIV and AIDS Spending Categories (ASC) measure the amount of commodities consumed or invested in the delivery of services (NASA, 2009) for the purpose of alleviating the suffering induced by the HIV virus or some of its consequences or to prevent its diffusion. The Kenya NASA adopted and measured expenditures on the following eight priority areas:

- Prevention (ASC.01);
- Care and treatment (ASC.02);
- Orphans and vulnerable children (ASC.03);
- Program management and administration (ASC.04);

- Incentives for human resources (ASC.05);
- Social protections and social services (SCA.06);
- Enabling of environment and community programmes (ASC.07) and;
- HIV and AIDS related research (ASC.08).

Tables 3.3 and 3.4 present a broad overview of expenditures by the different HIV and AIDS priority interventions in 2007/08 and 2006/07 respectively. The tables reveal that over the two years, the bulk of the expenditures were expended on treatment and care accounting for 63% (US\$ 225.9 million) in 2007/08 and about 55% (US\$ 169.17 million) in 2006/07 representing a growth of 34 percent from the previous year. The second largest share of HIV and AIDS spending over the two years went into prevention 24% - US\$ 85.9 million (2007/08) and 29% - 88.9 million (2006/07) representing a slight decline of about 3% over the two years(see also figures 3.4 and 3.5 derived from tables 3.3 and 3.4 respectively) . The decline in the share of prevention works against the national priorities as spelt out in the previous and current strategic plans for HIV and AIDS response in the country (KNASP I, KNASP II and KNASP III)

Table 3.3: HIV/AIDS expenditures by overall core functions and sources: 2007/2008

CORE FUNCTION	Government of Kenya		Private Domestic		B i l a t e r a l		M u l t i l a t e r a l		Others International	
	KES (million)	U S \$	KES (million)	U S \$	KES (million)	U S \$	KES (million)	U S \$	KES (million)	U S \$
PREVENTION	265.68	4.03	.	.	4,590.67	69.63	674.46	10.23	128.97	1.96
TREATMENT & CARE	3,742.02	56.76	1,347.58	20.44	6,356.91	96.42	1,663.86	25.24	1,782.71	27.04
O V C	242.66	3.68	.	.	406.11	6.16	18.05	0.27	13.85	0.21
PROGRAMME MANAGEMENT	299.79	4.55	.	.	1,491.11	22.62	164.27	2.49	45.07	0.68
HUMAN RESOURCES	.	.	.	.	.	.	216.50	3.28	116.14	1.76
SOCIAL PROTECTION	.	.	.	.	.	.	74.64	1.13	14.49	0.22
ENABLING ENVIRONMENT	.	.	.	.	19.78	0.30	.	.	3.61	0.05
HIV RESEARCH	.	.	.	.	157.57	2.39	.	.	21.12	0.32
T O T A L	4,550.15	69.01	1,347.58	20.44	13,022.16	197.51	2,811.79	42.65	2,125.97	32.25

Table 3.4: HIV/AIDS Expenditure by overall core functions and sources 2006/2007

CORE FUNCTIONS	Government of Kenya		Private Domestic		B i l a t e r a l		M u l t i l a t e r a l		Others International	
	K E S	U S \$	K E S	U S \$	K E S	U S \$	K E S	U S \$	K E S	U S \$
PREVENTION	156.28	2.21	.	.	4,857.79	68.55	656.36	9.26	632.20	8.92
TREATMENT & CARE	3,363.00	47.45	1,000.00	19.76	3,830.98	54.06	1,720.94	24.28	1,674.20	23.62
O V C	264.97	3.74	.	.	408.15	5.76	.	.	74.35	1.05
PROGRAMME MANAGEMENT	290.63	4.10	.	.	1,573.70	22.21	119.91	1.69	74.67	1.05
HUMAN RESOURCES	.	.	.	.	.	.	235.99	3.33	112.78	1.59
SOCIAL PROTECTION	.	.	.	.	.	.	.	.	32.30	0.46
ENABLING ENVIRONMENT	.	.	.	.	92.56	1.31	.	.	29.17	0.41
RESEARCH	.	.	.	.	163.00	2.30	.	.	41.55	0.59
T O T A L	4,074.87	57.50	1,000.00	19.76	10,926.18	154.17	2,733.20	38.57	2,671.22	37.69

Figure 3.4: Percent distribution of total expenditures by core functions in 2007/08

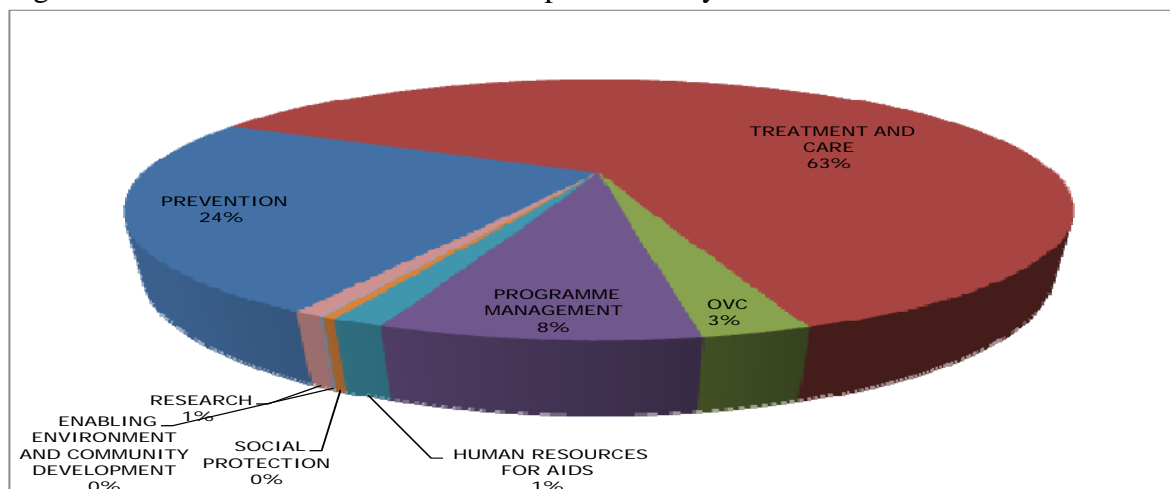
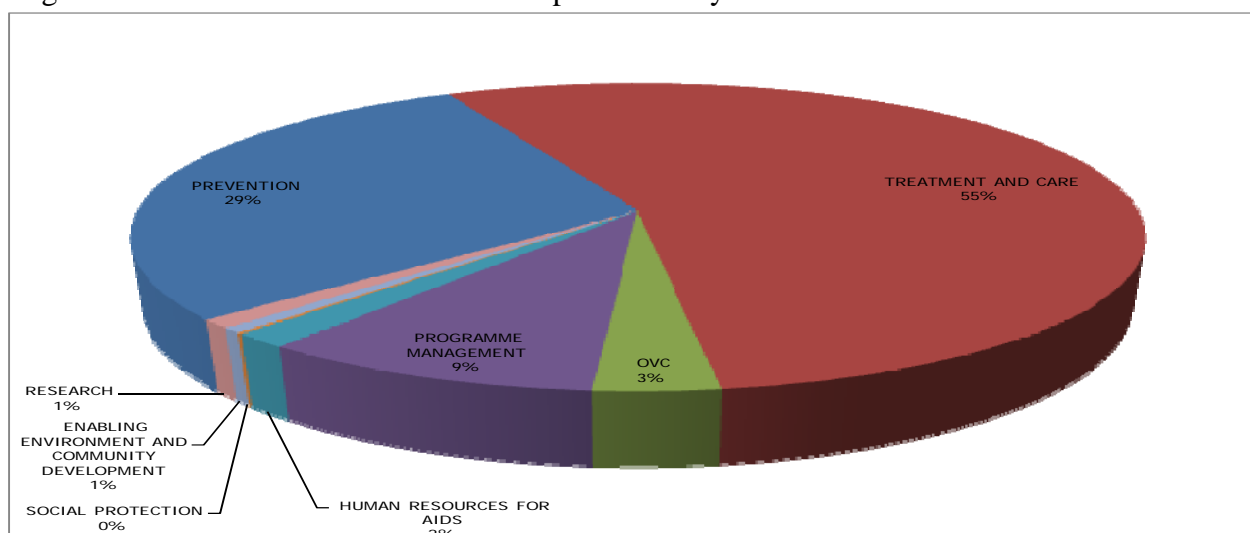


Figure 3.5: Percent distribution of total expenditures by core functions in 2006/07



Figures 3.6 and 3.7 display the percentage share of spending by sources on core functions. The figures show that majority of total expenditures on prevention were funded by bilateral organizations accounting for about 81% (2007/08) and 77% (2006/07) of the total resources mobilized for prevention. Similarly, of the total resources mobilized for treatment and care, the bulk of expenditures were expended by bilateral organizations (43% in 2007/08 and 32% in 2006/07) followed by government sources (25% in 2007/08 and 28% in 2006/07). It is interesting to note that between 80-88% of the total resources mobilized for HIV –related research came from bilateral organizations while about 75% of the total resources mobilized for program management also came from bilateral organizations over the two years.

Figure 3.6: Percent distribution of HIV/AIDS expenditures by sources and core functions 2007/08

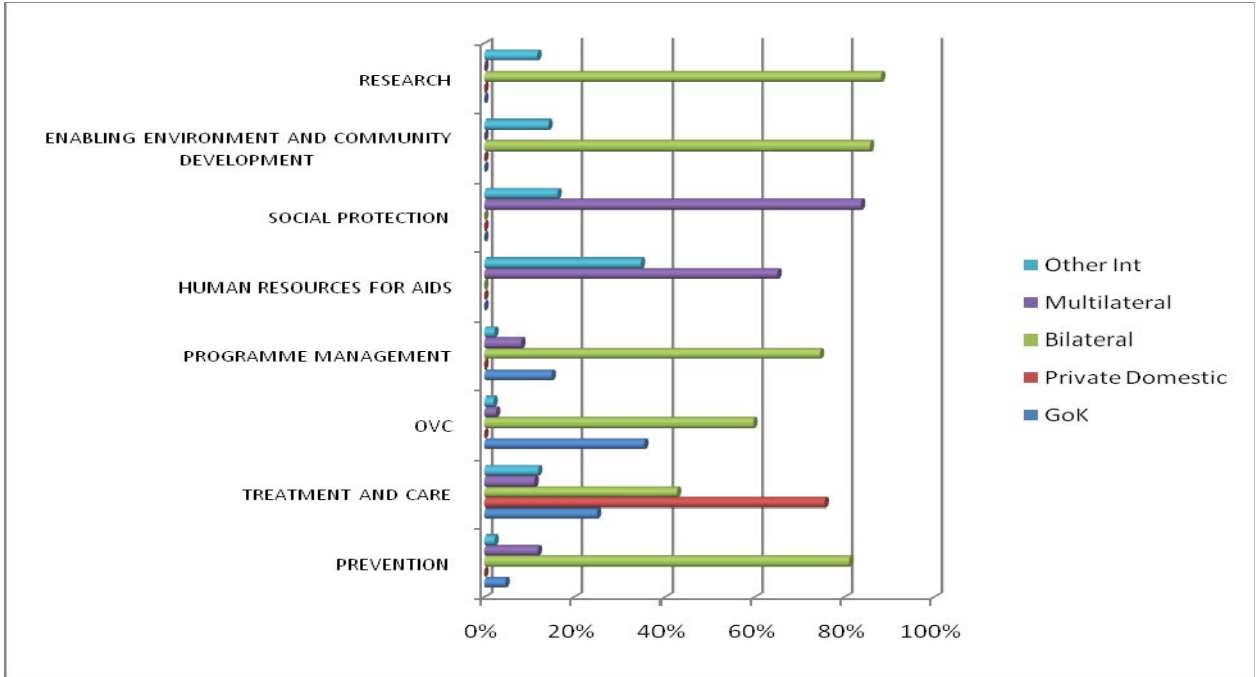
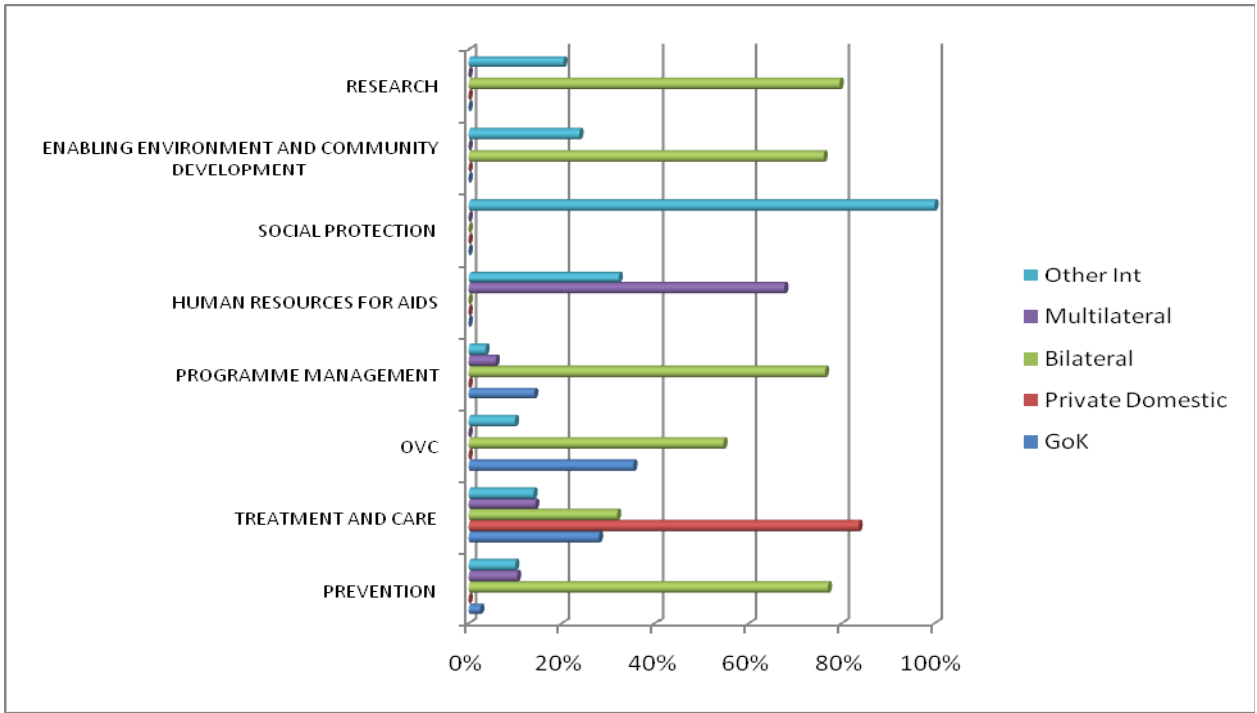
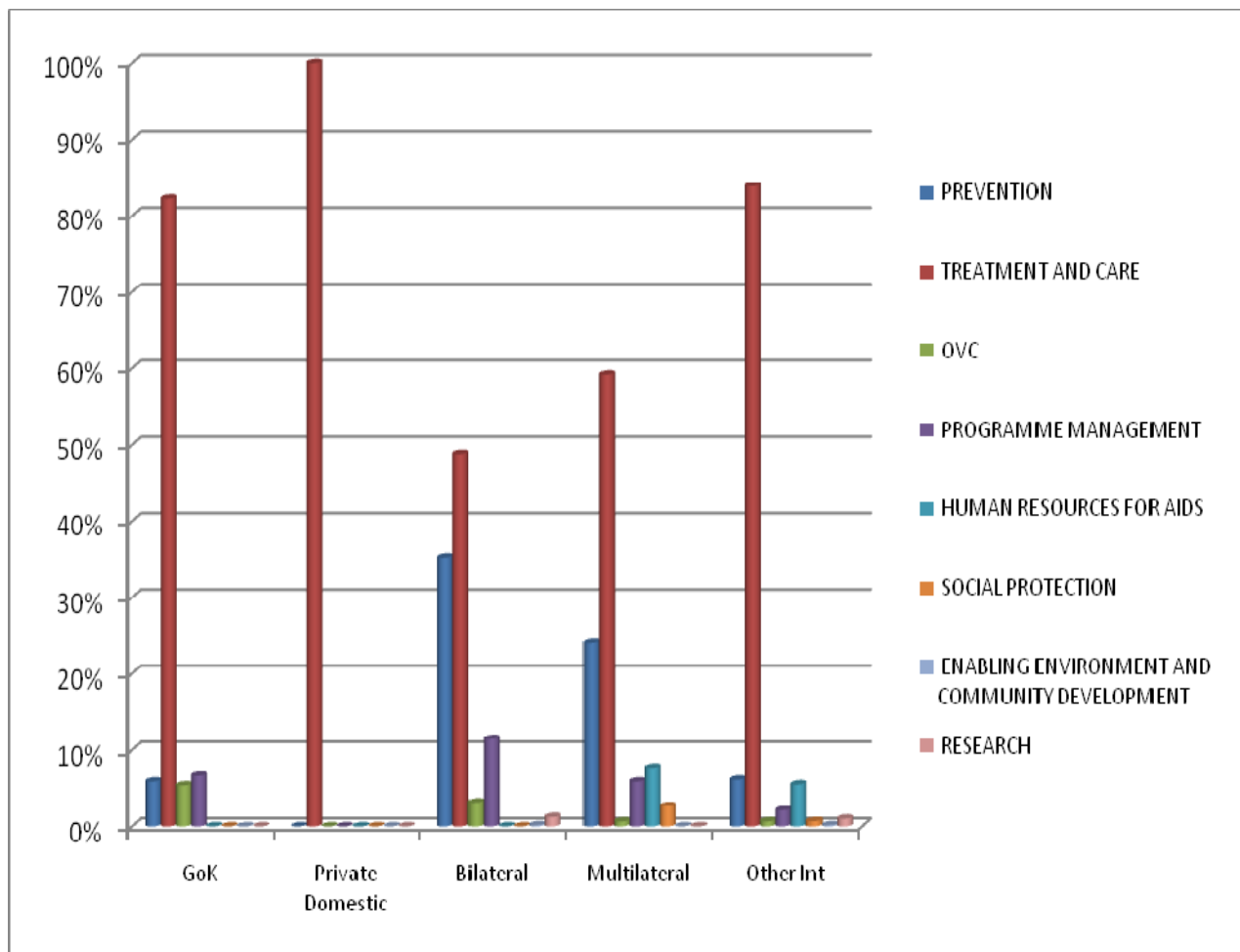


Figure 3.7: Percent distribution of HIV/AIDS expenditures by sources and core functions 2006/07

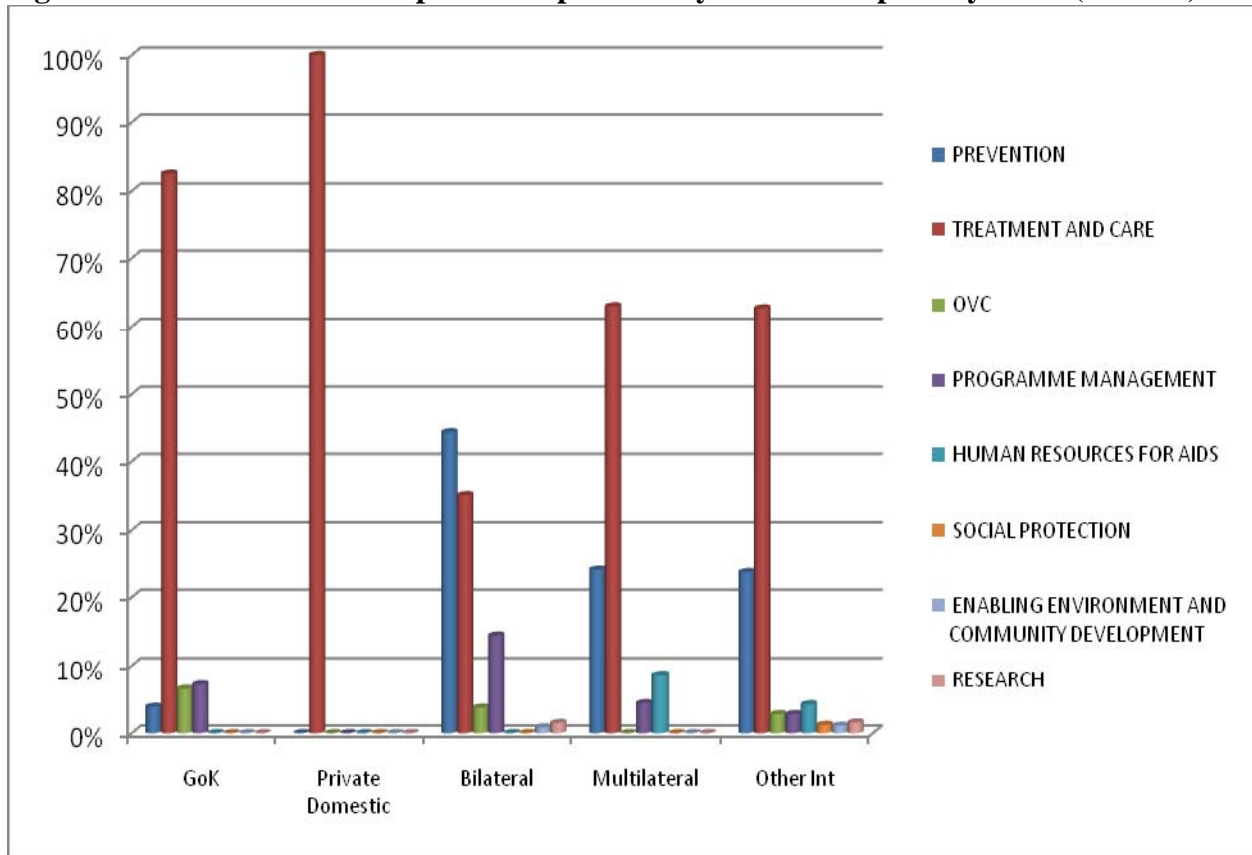


Figures 3.8 and 3.9 shows the distribution of expenditures by sources on the eight priority areas. Overall, the figures suggests that over 80% (2007/08) and over 50% (2006/070) of expenditures from the government, International and multilateral organizations and, private domestic sources went into treatment and care. Expenditures by international and multilateral organizations on prevention accounted for 35% and 25% respectively in 2007/06 and the pattern of spending in shares remained the same in 2006/07. The share of spending on program management from bilateral organizations stood at 11-14% (in 2007/08 and 2006/07 respectively).

Figures 3.8: Distribution of expenditure patterns by source and priority areas (2007/08)



Figures 3.9: Distribution of expenditure patterns by source and priority areas (2006/07)



3.3 Spending by Financing Agents: Managers of resources for HIV/AIDS in Kenya

Financing agents are organizations/institutions that receive and manage funds from financing sources to pay for or purchase goods and services for HIV/AIDS. Financing agents maintain programmatic control over how resources for HIV/AIDS are allocated to various priority interventions (core functions) and how these resources are spent. There are a number of financing agents in the country that manage HIV/AIDS funds namely, public entities such as ministry of health, ministry of education and government departments and parastatals; international for profit and not for profit organizations; international foundations; bilateral and multilateral bodies and local non governmental organizations.

Table 3.7 show the distribution of total HIV and AIDS expenditures by financing agent. The table reveals in 2007/08 international organizations including bilateral and multilateral organizations controlled the largest share (59%) of HIV/AIDS spending in the country amounting to US\$ 189.84 million. Similarly, in 2006/07, the share of HIV/AIDS spending controlled by the international community was approximately US\$ 146.10 million (or 57%).

Over the same period, public financing agents (mainly ministries of health, education and defense) and government departments managed about 41% in 2007/08 (or US\$ 144.16 million) and 43% in 2006/07 (or US\$ 131.19 million) - See also figures 3.10 and 3.11.

Table 3.5: HIV/AIDS expenditures by financing agents 2006/07-2007/08

FINANCING AGENT	2007/08		Percent	2006/07		Percent
	KES (million)	US \$ (million)		KES (million)	US \$ (million)	
FA.1.1.1.1 - Ministry of Health (MoH)	5,861.4	88.9	25%	5,673.9	80.1	26%
FA.1.1.1.1.10 - National AIDS Commission (NACC)	449.8	6.8	2%	292.2	4.1	1%
FA.1.1.1.2 - Ministry of Education	1,566.0	23.8	7%	2,082.1	29.4	10%
FA.1.1.1.4 - Ministry of Defense	183.0	2.8	1%	85.0	1.2	0%
FA.1.1.1.8 - Other Ministries	509.8	7.7	2%	423.5	6.0	2%
FA.1.4 - Parastatal organisations	759.0	11.5	3%	629.7	8.9	3%
FA.1.99 - Other Public Financing Agents. n.e.c	175.5	2.7	1%	111.1	1.6	1%
FA.2.5 - Not-for-profit institutions	1,820.1	27.6	8%	2,038.3	28.8	9%
FA.2.6 - Private non-parastatal organizations	17.1	0.3	0%	109.3	1.5	1%
FA.3.1.22 - Government of United States	773.4	11.7	3%	764.3	10.8	4%
FA.3.2.01 - Commission of the European Communities	169.4	2.6	1%	70.0	1.0	0%
FA.3.2.07 - United Nations Children's Fund (UNICEF)	247.7	3.8	1%	212.1	3.0	1%
FA.3.2.12 - United Nations Office on Drugs and Crime	34.9	0.5	0%	26.9	0.4	0%
FA.3.2.15 - World Food Programme (WFP)	700.0	10.6	3%	700.0	9.9	3%
FA.3.3.08 - Care International	54.4	0.8	0%	-	-	0%
FA.3.3.12 - Elizabeth Glaser Pediatric AIDS Foundation	145.0	2.2	1%	95.7	1.4	0%
FA.3.3.23 - PSI (Population Services International)	250.3	3.8	1%	297.2	4.2	1%
FA.3.3.14 - Family Health International	-	-	0%	631.2	8.9	3%
FA.3.3.25 - The Clinton Foundation	620.4	9.4	3%	410.1	5.8	2%
FA.3.3.99 - Other International not-for-profit org.n.e.	8,014.8	121.6	34%	4,788.9	67.6	22%
FA.3.99 - Other International Financing Agents.n.e.c	1,505.6	22.8	6%	2,364.2	33.4	11%
GRAND TOTAL	23,857.6	361.9	100%	21,805.9	307.7	100%

Figure 3.10: Percent distribution of HIV/AIDS spending by type of financing agent 2007/08

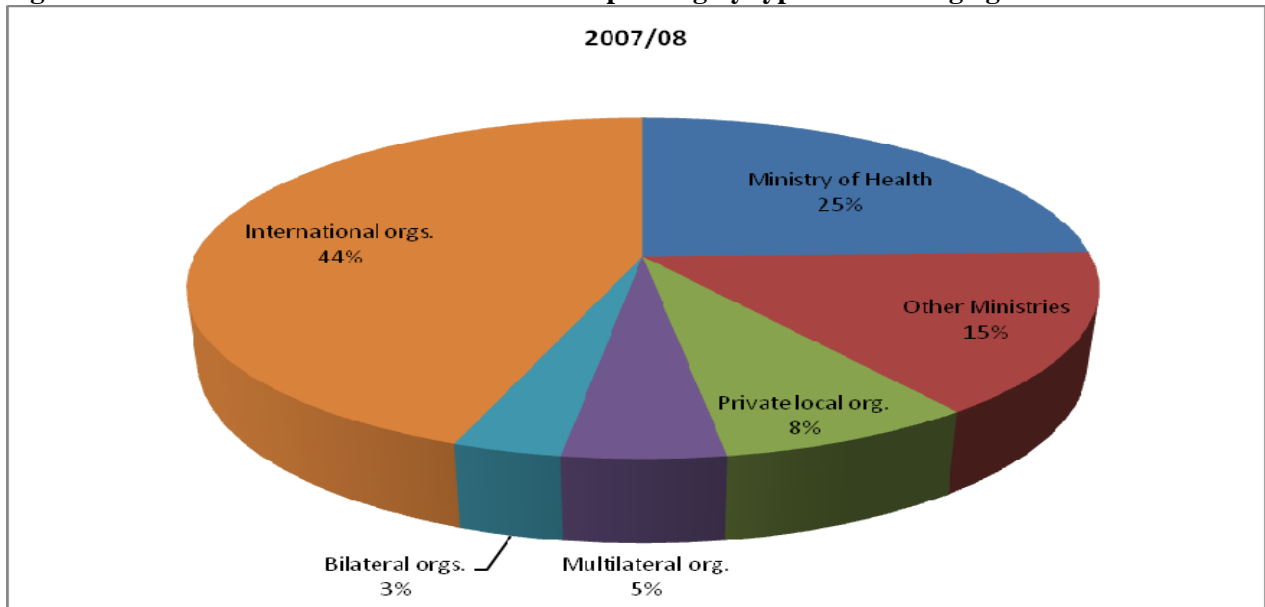
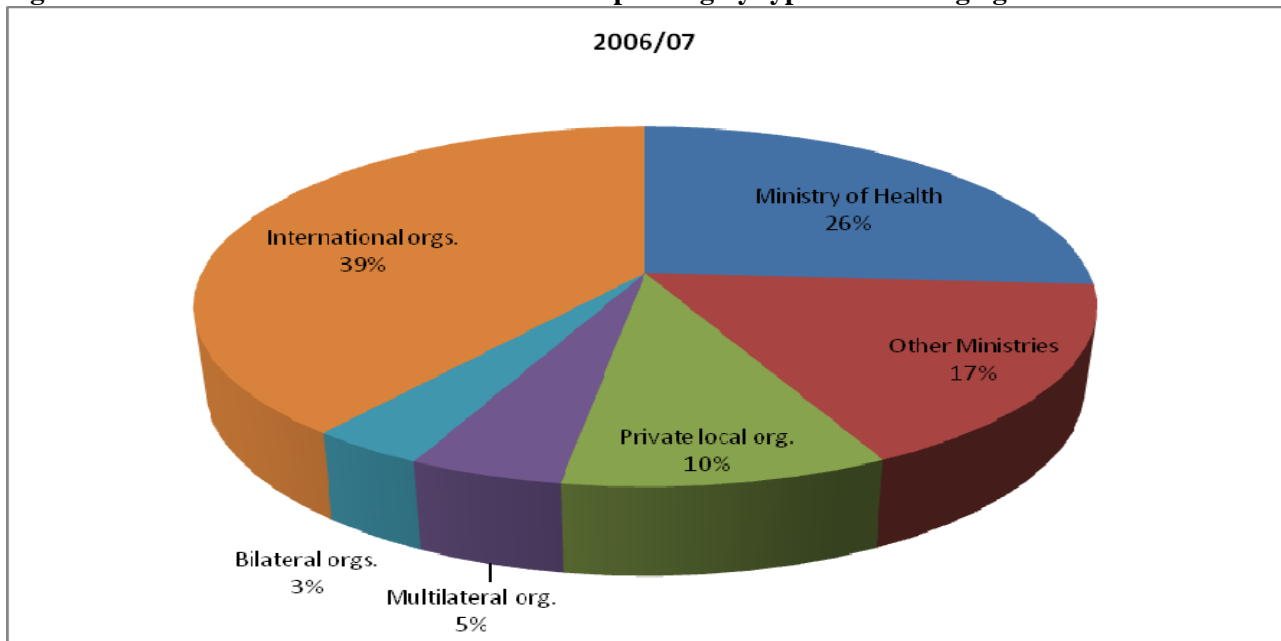


Figure 3.11: Percent distribution of HIV/AIDS spending by type of financing agent 2006/07



3.4 HIV/AIDS Expenditures by Beneficiary Groups

The analysis of the Beneficiary Population (BP) aims at estimating resources specifically allocated to a population as part of the service delivery process of a programmatic intervention (UNAIDS, 2007). Beneficiary population (BP) is a sub-sect of the population that consumes HIV/AIDS related goods and services. KNASA attempted to generate HIV/AIDS spending by beneficiary groups for fiscal year 2006/07 and 2007/08.

Table 3.6 shows the main beneficiaries of the HIV/AIDS expenditures for the two years. The main beneficiary groups during the assessment period were People Living with HIV/AIDS (PLWHA) accounting for 60 % (or US\$ 217.1 million) in 2007/07 and 53% (US\$ 163.68 million) in 2006/07 of the HIV/AIDS resources spend. This pattern of expenditures by beneficiary groups is consistent with the reported spending by core functions in which care and treatment accounted for 63% in 2007/08 and 55% in 2006/07. In the area of treatment, most of the funds were spent on high cost Antiretroviral Therapy (ART) program during the period under review.

Table 3.6: HIV and AIDS-related Spending by Beneficiary Population

BENEFICIARY POPULATION	2007/08		Percent	2006/07		Percent
	KES million	US\$ million		KES million	US \$ milli	
BP.01.01.98 Adult and young people (15 years and over) living with	16.5	0.3	0%	600.64	8.48	3%
BP.01.02.98 Children (under 15 years) living with HIV not disaggrega	5,908.9	89.6	25%	389.33	5.49	2%
BP.01.98 People living with HIV not disaggregated by age or gender	8,387.3	127.2	35%	10,609.99	149.71	49%
BP.02.01 Injecting drug users (IDU) and their sexual partners	34.9	0.5	0%	26.93	0.38	0%
BP.02.02.01 Female sex workers and their clients	9.3	0.1	0%	10.82	0.15	0%
BP.02.03 Men who have sex with men (MSM)	-	-	0%	14.17	0.20	0%
BP.02.98 "Most at risk populations" not disaggregated by type	-	-	0%	12.00	0.17	0%
BP.03.01 Orphans and vulnerable children (OVC)	686.2	10.4	3%	1,183.32	16.70	5%
BP.03.02 Children born or to be born of women living with HIV	860.5	13.1	4%	375.41	5.30	2%
BP.03.03 Refugees (externally displaced)	0.4	0.0	0%	57.13	0.81	0%
BP.03.07 Prisoners and other institutionalized persons	0.1	0.0	0%	0.10	0.00	0%
BP.03.08 Truck drivers/transport workers and commercial drivers	8.1	0.1	0%	0.04	0.00	0%
BP.03.11 Children and youth out of school	157.6	2.4	1%	-	-	0%
BP.03.14 Recipients of blood or blood products	88.3	1.3	0%	21.15	0.30	0%
BP.03.99 Other key populations n.e.c.	1.4	0.0	0%	4.83	0.07	0%
BP.03.98 Other key populations not disaggregated by type	-	-	0%	0.05	0.00	0%
BP.04.02 Elementary school students	38.0	0.6	0%	54.66	0.77	0%
BP.04.03 Junior high/high school students	1,009.8	15.3	4%	2,085.11	29.42	10%
BP.04.04 University students	0.0	0.0	0%	-	-	0%
BP.04.05 Health care workers	0.2	0.0	0%	0.84	0.01	0%
BP.04.08 Police and other uniformed services (other than the military	1.4	0.0	0%	9.33	0.13	0%
BP.04.10 Factory employees (e.g. for workplace interventions)	279.3	4.2	1%	281.08	3.97	1%
BP.04.98 Specific "accessible " populations not disaggregated by typ	0.7	0.0	0%	0.47	0.01	0%
BP.04.99 Specific "accessible " populations n.e.c.	3.2	0.0	0%	27.72	0.39	0%
BP.05.01.01 Male adult population	3.7	0.1	0%	87.35	1.23	0%
BP.05.01.02 Female adult population	3.1	0.0	0%	106.85	1.51	0%
BP.05.01.98 General adult population (older than 24 years) not disac	1.7	0.0	0%	768.04	10.84	4%
BP.05.02.01 Boys	2.9	0.0	0%	74.79	1.06	0%
BP.05.02.02 Girls	2.4	0.0	0%	62.33	0.88	0%
BP.05.02.98 Children (under 15 years) not disaggregated by gender	0.6	0.0	0%	0.77	0.01	0%
BP.05.03.01 Young men	0.0	0.0	0%	0.96	0.01	0%
BP.05.03.02 Young females	0.6	0.0	0%	14.68	0.21	0%
BP.05.03.98 Youth (age 15 to 24 years) not disaggregated by gende	1,383.7	21.0	6%	556.85	7.86	3%
BP.05.98 General population not disaggregated by age or gender.	2,454.9	37.2	10%	1,731.09	24.43	8%
BP.06 Non-targeted interventions	2,511.6	38.1	11%	2,637.02	37.21	12%
Grand Total	23,857.6	361.9	100%	21,805.86	307.69	100%

3.5 Providers of HIV/AIDS services

This section presents the analysis of providers of HIV/AIDS services. Providers of HIV/AIDS services are entities that receive resources from Financing Agents or directly from sources and use these resources to produce and deliver HIV/AIDS related services. According to the NASA guidelines, Providers of HIV/AIDS services are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. HIV/AIDS services is provided by a number of providers that include the government and other public entities, private for profit and non-profit organizations, corporate and non-corporate enterprises and, self-employed persons whose activity falls within the NASA boundaries regardless of a formal or informal legal status.

The KNASA assessed four broad categories of providers of HIV/AIDS services in Kenya namely: Public sector providers; Faith Based Organizations (FBOs) – not for profit: NGOS not for profit organizations: and Bilateral and Multilateral organizations.

Table 3.7 shows the distribution of HIV and AIDS expenditures by provider category. The Table reveals that public sector providers provided bulk of the HIV/AIDS services accounting for 50% (or US\$ 158.8 million) and 45% (US\$ 164.3 million) in 2006/07 and 2007/08 respectively. The main public HIV service providers in 2006/07 were public hospitals including other public health facilities accounting for 29% of the total HIV services. The FBOs provision of HIV and AIDS services accounted for 22% (US\$ 67.17 million) and 24% (US\$85.7 million) in 2006/07 and 2007/08 respectively. Among the FBOs, hospitals were the main providers of HIV and AIDS services at US \$ 43.8 million in 2006/07 and US\$ 67.3 million in 2007/08

Table 3.7 : HIV and AIDS Expenditures by Provider Category (2006/07-2007/08)

	PROVIDER CATEGORY	2006/2007			2007/08		
		KES	US\$	Percent	KES	US\$	Percent
1	PUBLIC:						
	. Hospitals & other health facilities	6,313,757,022	89,089,276	29%	6,620,114,383	100,426,492	28%
	. Ministry of health	667,164,087	9,413,914	3%	534,504,724	8,108,385	2%
	. Ministry of Education	2,087,427,607	29,454,319	10%	1,567,250,032	23,775,031	7%
	. Other Ministries	935,785,937	13,204,260	4%	943,557,016	14,313,668	4%
	. Research Institutions	608,040,204	8,579,656	3%	718,122,147	10,893,843	3%
	. NACC	292,222,447	4,123,359	1%	449,772,538	6,823,006	2%
	Sub-total	10,904,397,304	153,864,785	50%	10,833,320,840	164,340,425	45%
2	NGOs/CBOs(not for profit)						
	. Hospitals	117,379,983	1,656,272	1%	120,921,629	1,834,369	1%
	. Orphanages/foster homes	16,122,360	227,492	0%	78,226	1,187	0%
	. Research Institutions	401,124,200	5,660,000	2%	811,136,790	12,304,866	3%
	.CBOs (self help and Civil society)	389,966,820	5,502,566	2%	269,741,436	4,091,951	1%
	. Others (n.e.c)	3583009652	50,557,495	16%	4,499,932,293	68,263,536	19%
	Sub-total	4,507,603,015	63,603,824	21%	5,701,810,374	86,495,910	24%
3	Faith Based Organizations						
	. Hospitals	3,106,910,613	43,839,574	14%	4,432,967,366	67,247,685	19%
	. Training centres	8,150,050	115,000	0%	174,916,459	2,653,466	1%
	. Foster homes/shelters	428,932,763	6,052,388	2%	145,046,000	2,200,334	1%
	.CBOs (sekf help & civil society)	18,690,906	263,735	0%	125,346,668	1,901,497	1%
	. Others (n.e.c)	1,198,125,678	16,905,964	5%	772,561,362	11,719,681	3%
	Sub-total	4,760,810,010	67,176,662	22%	5,650,837,855	85,722,662	24%
4	Bilateral and Multilateral organizations						
	. Bilateral	865,724,356	12,215,668	4%	908,379,337	13,780,026	4%
	. Multilateral	767,326,500	10,827,240	4%	763,292,800	11,579,078	3%
	Sub-total	1,633,050,856	23,042,908	7%	1,671,672,137	25,359,104	7%
	GRANT TOTAL	21,805,861,185	307,688,178	100%	23,857,641,206	361,918,101	100%

3.6 Absorption Capacity

Absorption capacity is the extent to which the institutions like NGOs and the governments receiving financial resources from donors are able to effectively and efficiently spend the financial resources received from the donor institution or country. From the data collected, the KNASA was able to measure absorption capacity in terms financial resources spend against resources mobilized from sources.

The analysis indicated that, out of the total financial resources mobilized from all sources 98% and 96% was spend in 2006/07 and 2007/08 respectively. The spending rate appears to be high indicating good absorptive capacity by the providers of HIV/AIDS related services. This implies the country has capacity to absolve the increase in resources required to implement the KNASP III. However, based on the qualitative information gathered, a number of factors could affect the absorption capacity of NGOs. Key among them include: capacity gaps in the areas of basic book keeping and financial management; different reporting systems for different donors; rigid budget and spending frameworks, length procurement processes and bureaucracy.

3.7 Qualitative Information

This section presents the results from qualitative key informants' interviews that targeted respondents from sources, agents and providers of HIV/AIDS services in Kenya. The key informants included representatives of donors, local and international NGOs, government ministries and health facilities. Issues discussed with the key informants were organized around the following themes:

- i) Funding process and challenges (securing, spending and reporting)
- ii) Adequacy of funds;
- iii) Bottlenecks in spending;
- iv) Conditions attached to donor funds;
- v) Donor reporting

Below is a summary of the responses by type of respondent:

Donors

Donors of HIV/AIDS programmes in Kenya were asked to respond to questions with respect to the process of funding and conditionalities they impose upon transferring funds to organizations. Majority of the donors indicated that NGOs respond to calls for proposals or for funding on specific HIV/AIDS areas. The proposals are then evaluated and any successful applicant receives funding on annual installments basis. Evaluations are conducted to ensure proposals are in line with the specific donor objectives.

On reporting, donors insist on timely submission of technical and financial reports either on quarterly or annual basis. In most cases, donors expect clear governance structure, good financial management, transparency and accountability. Technical and financial reports are therefore

required after every quarter or 12 months of project implementation. And depending on the size of the grant, annual audit reports are also required. However, irrespective of the size of grant, a final audit report is a must. In addition, a midterm and end of term external evaluation is needed. Quarterly programme updates from NGOs and in line with government reporting requirement for Sector support, midterm progress reports (narrative and financial), annual and final project reports for multi-laterals are issues that were sited delaying disbursement of funds by donors to NGOs.

Key informants interviewed from the development partner fraternity indicated that NGOs face a number of challenges in meeting the stated funding requirements. The challenges mentioned include inadequate staff, capacity gaps in basic record keeping, financial management and inadequate skills for proposal writing, poor planning, slow implementation of projects and procurement procedures. Majority of the respondents were of the opinion that lengthy procedures, failure/delay in submitting requisite documents and lack of accountability were the major causes of the bottlenecks faced by the NGOs.

Non-Governmental organizations

The NGOs operating in Kenya receive funding from bilateral and multilateral agencies, international NGOs and foundations as well as the private sector. A number of local NGOs have also been receiving funding from the Government through NACC. Respondents from the NGO fraternity indicated that availability of funding for most of NGOs is limited and were very competitive “Only a few out of the many proposals submitted finally end up being funded”. In addition, most of the NGOs implementing HIV/AIDS related activities complained that the funds disbursed by donors are not adequate to fund their activities and staff salaries. The problem has been exasperated by the Global melt down which makes it difficult for international NGOs to source for funding beyond 2010.

On conditionalities imposed by donors, responses varied from one NGO to another. Most NGOs were aware that the conditions are imposed to ensure that the funds provided for are spent according to the stated objectives and are therefore not abused. Some of the conditions relate to timely reporting, provision of work plan, spending according to budget and the strategic plan and audited financial reports. However, some NGOs felt that that the conditions were reducing the effectiveness and efficiency of the HIV/AIDS programme, such as having to procure drugs and equipment, at greater cost, from the donor country. In addition some NGOs expressed concerns that the spending rules were very strict and not flexible to respondent or emerging local needs. It was also learnt that NGO spending must be in the area of interest for donors.

On reporting requirements, majority of NGOs were of the opinion that the reporting requirements by donor are critical as far as effectiveness and efficiency use of donor funds is concerned. This is because they allow for accountability and transparency of spending of donor funds. However, some donor reporting requirements were reported to be demanding because NGOs have to report on monthly, quarterly, biannual and annual basis. It was observed that different donors have different and complicated reporting formats and their budget circles are also different from government and that of local NGOs. The different calendar years among different donors contribute to delays in donor funding. Capacity gaps in financial management

among CBOs staff were the cause of delays in submitting reports causing delays in funding. The capacity gaps were the major cause of low absorption capacity among the NGOs

Public funding for NGOs and CBOs

There were mixed views regarding the accessibility of Government funding through NACC. While some NGOs and CBOs acknowledge that Government funds are more accessible, other NGOs felt that the funds channeled to NGOs and CBOs are inadequate. However, there was general agreement that NACC is slow in disbursing funds which affects implementation of the activities and that the funding from the government is not in line with the priorities of health care providers. The NGOs and health providers also raised concerns that the demand for ARTS outstrips supply and that health providers lack regular updates/training on HIV management. Issues of sustainability of HIV response in the absence of international organizations dominated most of the discussions. There was consensus that there is need to explore alternative financing options in the long run. Overall, funding for HIV and AIDS activities in the country are inadequate and there is need for the government to increase funding for HIV and AIDS activities.

CHAPTER FOUR: SUMMARY, CONCLUSIONS AND POLICY IMPLICATIONS

4.1 Summary and Conclusions

Total expenditure on HIV and AIDS response increased from Kshs.21.81 billion (US\$307.69 million) in 2006/07 to Kshs. 23.86 billion (US\$ 361.86 million) in 2007/08. The KNASA results indicate that the bulk of the expenditures on HIV/AIDS in Kenya came from international sources accounting for 79% and 81 % in the fiscal years 2006/07 and 2007/08 respectively. The total spending on HIV and AIDS from all sources in the country over the two years accounted for approximately 79% (2006/07) and 74% (2007/08) of the total Ministry of Health expenditures and about 1.1% (2007/08) and 1.2% (2006/07) of the GDP (at current market prices).

The analysis of total expenditures on HIV and AIDS disaggregated by source of funding suggest that in 2006/2007, the largest source of actual expenditure was bilateral organizations (50%) followed by the Government (18.7%), other international organizations (12.6%) and multilateral organizations (12.1%) consisting of Global Fund and UN agencies. The same pattern of spending by source was observed in 2008 in which, the contribution share of bilateral organizations increased to 54.6% of the total HIV/AIDS spending followed by the Government sources at 19% and multilateral organizations (11%).

A large portion of external resources for HIV and AIDS constituted “Off-budget” and was disbursed through vertical projects and NGOs and was therefore not captured in government accounts. In 2006/07, Donors and international NGOs controlled 47% (US\$ 146.10 million) of HIV/AIDS spending. This increased to 52% (to US\$ 189.84 million) in 2007/08. Over the same period, the share of HIV/AIDS expenditures within the control of public sector declined from 43% (or US\$ 131.19 million) in 2006/07 to 40% (US\$ 144.16 million) in 2007/08.

In 2006/07, treatment and care accounted for 55.8% of the total HIV/AIDS expenditures. This was followed by prevention at 29.4%, programme management at 9.6%, OVC at 3.1% and Human resources at 1.6%. In 2007/08, the scenario changed as the amount that went to treatment and care increased to 63.7%. However, the HIV/AIDS resources that were spent on prevention decreased to 24.2%, program management to 7.3%. At the same period, OVC decreased to 2.9% and human resources to 1.4%.

The public sector providers provided bulk of the HIV/AIDS services accounting for 50% (or US\$ 158.8 million) and 45% (US\$ 164.3 million) in 2006/07 and 2007/08 respectively followed by the FBO providers at 22% (US\$ 67.17 million) and 24% (US\$85.7 million) in 2006/07 and 2007/08 respectively.

The main beneficiary groups during the assessment period were People Living with HIV/AIDS (PLWHA) accounting for 60 % (or US\$ 217.1 million) in 2007/07 and 53% (US\$ 163.68 million) in 2006/07 of the HIV/AIDS resources spend. This pattern of expenditures by beneficiary groups is consistent with the reported spending by core functions in which care and treatment accounted for 63% in 2007/08 and 55% in 2006/07.

The absorption capacity for HIV and AIDS funds among the NGOs and Providers of HIV and AIDS services was high. Out of the total financial resources mobilized from all sources 98% and 96% was spend in 2006/07 and 2007/08 respectively, an indication that the country has enormous capacity to absolve the increase in resources required to implement the KNASP III. However, the absorptive capacity by the providers of HIV/AIDS related services could further be enhanced through building capacity in the areas of financial management, harmonize and simplify the reporting systems, allow flexibility in spending and recruit more qualified personnel.

4.2 Policy Implications

External resources continue to dominate HIV/AIDS financing in Kenya. This seems to have increased with increased resources coming from PEPFAR. The fact that development partners' account for a lion share should be a major concern to the country as this raises issues of sustainability.

Donors and NGOs continue to control the bulk of the HIV/AIDS spending in the country. Efforts to align the HIV/ AIDS spending to the KNASP III may therefore be undermined. KNASA tracked all HIV/AIDS expenditure in the country and it was found that some of the expenditures were not aligned to the KNASP II. KNASA assessment showed that while some achievements were made in terms of spending by priority areas, other priority areas spending were not met. It will therefore be critical to ensure that HIV/AIDS spending is aligned to priority areas as stipulated by KNASP III.

Human resource is major challenge affecting the HIV/AIDS sector. However, despite being a major challenge, not much in terms of resources has been devoted to human resources for HIV/AIDS. The assessment showed that as little as 2% and 1% was spent on human resources in 2006/07 and 2007/08 respectively. If the country was to achieve desired results in the fight against HIV/AIDS more resources will have to be devoted to Human resources.

KNASA reported an increase in spending on treatment and care and a drop in spending on prevention. The increase in spending on treatment and care may be attributed to the increase in donor funding particular spending emanating from PEPFAR and Global Fund that have helped to scale up access to ARVs.

REFERENCES

- Republic of Kenya (2005). *Kenya National AIDS Strategic Plan 2005/06-2009/10*. Nairobi: NACC
- Republic of Kenya (2006). *Development Estimates 2006/2007*, Government Printer, Nairobi.
- Republic of Kenya (2006). *Recurrent Estimates 2006/2007*, Government Printer, Nairobi.
- Republic of Kenya (2007). *Development Estimates 2007/2008*, Government Printer, Nairobi.
- Republic of Kenya (2007). *Recurrent Estimates 2007/2008*, Government Printer, Nairobi.
- Republic of Kenya (2007). *Recurrent Estimates 2007/2008*, Government Printer, Nairobi.
- Republic of Kenya (2009). *Public Expenditure Review 2008*. Nairobi: Ministry of Health
- Republic of Kenya (2009). *National Health Accounts 2005/06*. Nairobi: Ministry of Medical Services and Ministry of Public Health and Sanitation.
- Republic of Kenya (2009). *Economic Survey 2009*. Nairobi: Kenya National Bureau of Statistics.
- Republic of Kenya (2009). *Draft Kenya National AIDS Strategic Plan 2009/10 – 2012/13*. Nairobi: NACC
- UNAIDS (2007). *NASA RTS User's Guide*. Geneva: UNAIDS
- UNAIDS (2009). *NASA: Classification Taxonomy and Definitions*. Geneva: UNAIDS