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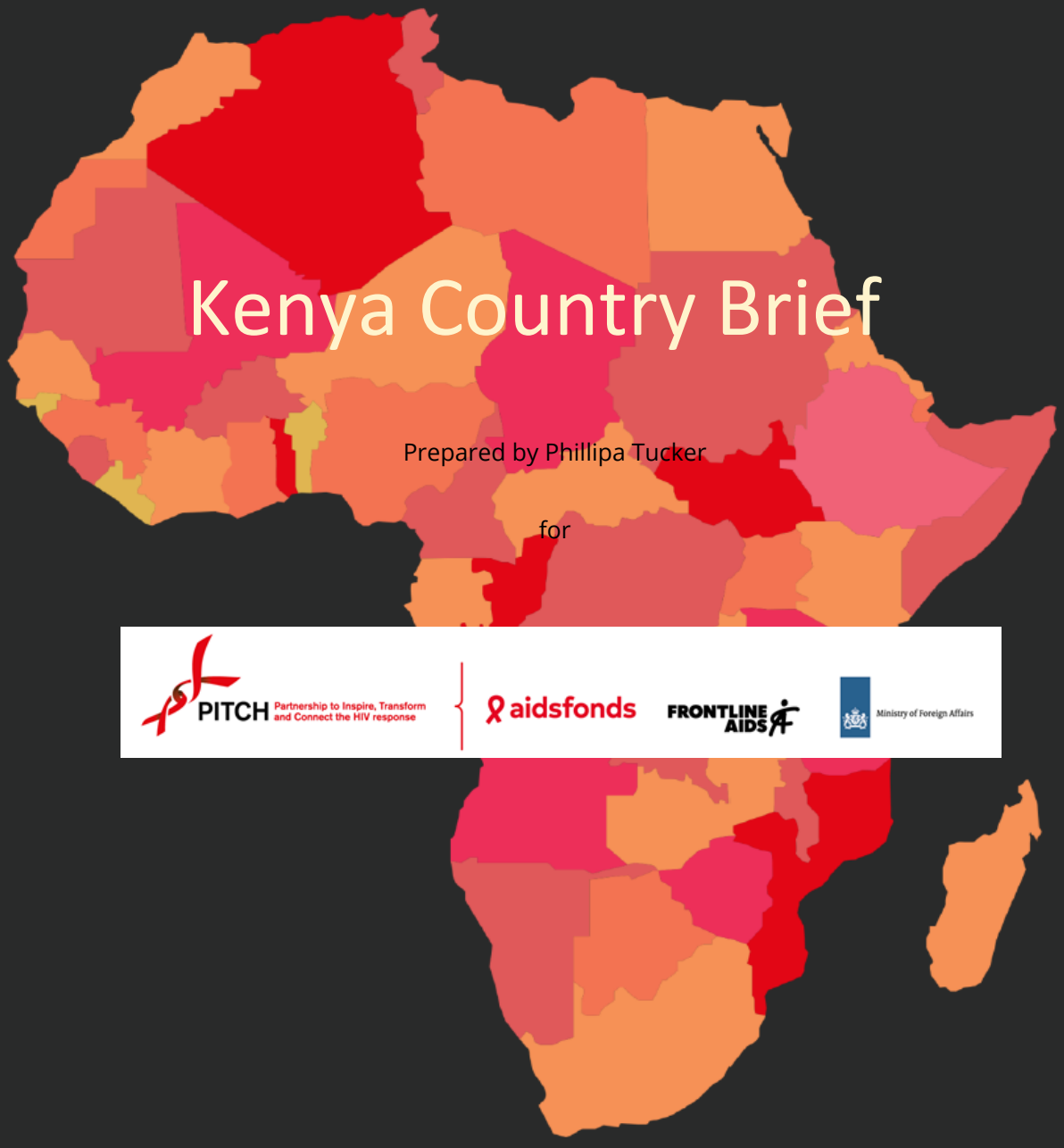


Kenya Country Brief

Prepared by Phillipa Tucker

for

PITCH Partnership to Inspire, Transform and Connect the HIV response | aidsfonds | FRONTLINE AIDS | Ministry of Foreign Affairs

MIND THE GAP:
AFRICAN HIV FINANCING SCORECARD

This country brief should be read in conjunction with the full
HIV Financing Scorecard for Africa

Background

In the past 20 years, national governments, global funders and civil society have made significant progress in expanding access to life-saving antiretroviral treatment and prevention options in the fight against HIV.

Almost sixty percent of people living with HIV are now accessing antiretroviral treatment, and new infections have been reduced by almost 50% since 1996. But at the same time that great progress has been made, so we see that contributions by international donors have flatlined even though there is a US$5 billion gap in the resources needed to achieve the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90–90–90 targets.

These targets which are to diagnose 90% of all HIV-positive persons, provide antiretroviral therapy for 90% of those diagnosed, and achieve viral suppression for 90% of those treated by 2020 need to be achieved if we are to control the HIV epidemic. Currently, low- and middle-income countries contribute approximately 56% of the global resources for HIV, but the investment by countries varies and a significant 20% global funding gap remains, which leaves the HIV response in a precarious position.

As a result of this situation, in early 2019 the Society for AIDS in Africa began an evidence-based advocacy campaign that focusses on this resource gap that exists, with the aim of meeting the UNAIDS 2020 and 2030 targets in Sub-Saharan Africa.

As part of this campaign, a group of African and global HIV advocates and activists have developed a strategy for creating and implementing such an advocacy campaign. The campaign has developed this African HIV Financing Scorecard in partnership with Accountability International (previously AIDS Accountability International) as a means to analyse the existing funding, interrogate the gaps in required funding, and provides evidence-based advocacy messaging for action by the various stakeholders involved.

The Scorecard tracks current country investments in HIV treatment and prevention in order to shed more transparency on the topic. It also examines existing frameworks and funding in general, as well as looks at the current use of innovative financing and what sources for funds might exist. The report then delves into partnerships with business and public-private

partnerships and impact investment and the potential role these tools can play in financing the HIV response. The report also examines what corporate social responsibility programmes and individual philanthropists are currently doing to finance the response to HIV. Other sources such as diaspora remittances are also interrogated so as to create understanding on how they may be a potential source of finance.

The next section then goes on to look at the current situation in each country and how the countries are faring in their current HIV response. This provides both an indication of what has been done to date, what political will currently exists and what issues still need to be addressed. Identifying priority areas for funding is vital if funding will remain limited. This then also provides a starting block for a discussion on the cost to end the epidemic in each of the African countries. The report then goes on to examine current programme spending patterns, existing sources of health financing, and expenditure on clinical trials. The report also examines the role of International Development Partners and Civil Society, looking into a variety of HIV finance issues in that arena, such as international funding for HIV, finance for HIV research, loss of African funds to illicit outflows, funding of the Global Funds Country Coordinating Mechanisms and accountability around those grants. Next, we look into the state of transparency, openness and democracy in each of the countries as a means to locate the dialogue in the broader landscape of accountability, transparency and anti-corruption. The report ends with findings from the research and a list of recommendations that were collectively developed during a workshop "Consultative >Meeting for Scorecard Validation on HIV Financing in Africa" held in Accra from 15th to 17th October 2019. These findings and recommendations inform the SAA campaign, as well as the work of others in designing policy reform and making the case for sustained and increased investment.

Increasing domestic investment on HIV treatment and prevention will require a regional coordinated, evidence-based advocacy campaign and partnership, and the Society for AIDS in Africa sees this African HIV Financing Scorecard as a first but critically important step in the broader campaign which aims to increase domestic funding for HIV programming. This program is well suited to SAA's strength in policy analysis and advocacy as SAA is an independent organization devoted to transparency and accountability and whose work is respected by a wide range of global stakeholders. We hope that this research, our findings and recommendations provide evidence to start a discussion, across many stakeholders, on what and how we can sustainably, inclusively and accountably finance the final stages of the HIV epidemic in Africa.

Kenya Country Brief

This brief was developed by Phillipa Tucker as part of a larger training on the HIV Financing Scorecard for Africa, and especially on its findings and recommendations for Kenyan activists as part of the PITCH project. Tucker is the principal author of these pieces and should be emailed at phillipa at accountability dot international if any errors or omissions need correction. This brief aims to analyse country specific data comparatively to the other countries and aims to provide a snapshot for local activists to begin their discussions on what a country driven advocacy campaign could look like. These briefs have been presented to country partners and their feedback included where provided.

1. Donor dependence

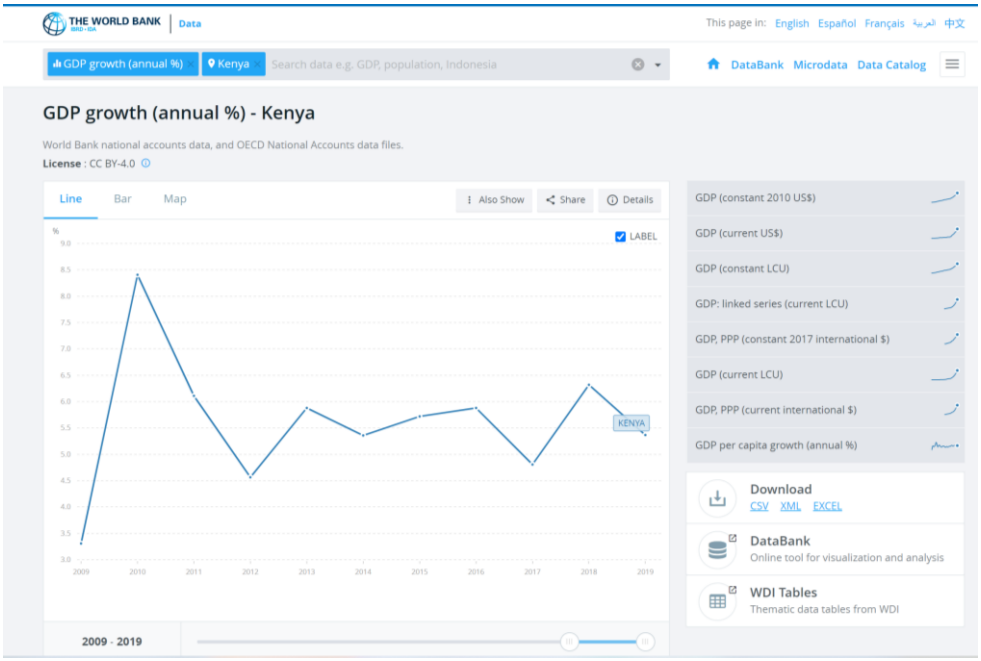
	Donor dependence by country Country	Graded highest A / Domestic public expenditure	Graded highest E / Domestic private expenditure	Graded highest E / International: PEPFAR expenditure	Graded highest E / International: Global Fund expenditure	Graded highest E / Int: all others expenditure
	Kenya	29%	8%	53%	10%	0%

Source: UNAIDS DATA 2018 https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf

Kenya has a very high PEPFAR reliance, which when added to GFATM reliance totals 63%! This is a very precarious and unsustainable position to be in, and with a healthy economy and large GDP, Kenya could be doing better than this. **Kenya can be said to be over-reliant on foreign sources of aid, and domestic financing for the response should be improved.**

2. Economic growth or decline:

GDP in Kenya is very changeable. GDP is growing but rate varies a lot.



	Economic strength of all African countries Country	GDP per capita (Constant Local Currency (LCU)) 2018	Tax revenue as % of GDP 2018	Real GDP growth -Annual % change 2018 - 2019
	Kenya	$93,297	16.30%	5.8%

Sources: Column 1: The World Bank: https://www.worldbank.org/; Column 2: AUC *Scorecard on Financing for Health, 2018,*

Kenya has a reasonably healthy economy and if managed well has good possibilities, even in the COVID pandemic era. **Kenya does well on tax revenue and should continue to strengthen this area through pro-poor tax policy and collection.**

3. Source of spending

	Source of spending, as a % of total health spending (2015) Country	Government	Households & employers	Development Partners
25	Kenya	33.10%	48.21%	18.68%

Notes: All percentages are out of 100%, except the following four countries: Ethiopia (out of 99.8%); Malawi (out of 99.7%); Nigeria (out of 101%) and Zimbabwe (out of 87.1%). * Out of Pocket is money spent by individuals and Workplace health insurance is funds paid by employers to cover staff. *Source: AU, Africa Scorecard on Domestic Financing for Health, 2018*

According to OECD statistics, the Top 10 recipients of Overseas Development Assistance (from OECD countries) in 2017 were all African:

1. Ethiopia (8% of all ODA)
2. Nigeria (6%)
3. Tanzania (5%)

4. Kenya (5%)
5. Democratic Republic of Congo (4%)
6. South Sudan (4%)
7. Uganda (4%)
8. Morocco (4%)
9. Mozambique (3%)
10. Somalia (3%)[i]

As mentioned, Kenya has an over-reliance on foreign sources for health, and as we see, also an over-reliance on user fees. There are 32 other countries that are performing better on this indicator than Kenya, so the **local activists should look to other countries for examples on how to campaign to lower user fees.**

4. Government spending on health

	Government Spending Country	Abuja Commitment: The % of the government budget dedicated to health, 2015	Current health expenditure (% of GDP), 2016	Military expenditure (% of GDP), 2018
25	Kenya	6.3%	4.5%	1.2%

Source: Columns 1 and 2: *AUC Scorecard on Domestic Finance for Health, 2018, AUC. Column 3: Stockholm International Peace Research Institute (SIPRI)* https://www.sipri.org/ *all* 2018 (except Equatorial Guinea /2016 and Guinea-Bissau /2015)

Health expenditures at national and county governments are on an increasing trend in absolute terms but are stagnant in real terms at an average of 5% of total government expenditures (20% for county expenditures), stagnant as % of GDP and lower as expenditure per person in the past 20 years![1]

Campaigning for 15% of budget to be allocated to health is overly simplistic and should be avoided and health and finance ministers know and understand this, and so activists need to get more sophisticated in our demand for health investment. Some countries need to invest in water and sanitation or other areas more urgently or can deliver great health for less than 15% for example. **Leveraging policy for public-private projects, spend through**

[1] INNOVATIVE HEALTH FINANCING MODELS FOR UNIVERSAL HEALTH COVERAGE IN KENYA. https://www.intellecap.com/wp-content/uploads/2019/02/Innovative-Financing-Models-for-achieving-Universal-Health-coverage-in-Kenya_20th-Feb-2019_Final_Print.pdf

of budgets, eliminating corruption and inadequate implementation, and cost-effectiveness and efficiency are more strategic entry points for activists.

5. ART spending

UNAIDS reports that from 2009 to 2014 public spending on anti-retroviral therapy (ART) doubled in Chad, Cote d'Ivoire, Gabon, Kenya, Namibia and Swaziland.[ii] **Kenya is doing well, comparatively on providing ART, but this is linked to its donor dependence.**

6. Remittance flows

Remittance flows over past three years and as % of GDP
Migrant remittance inflows (US$ million)

	2016	2017	2018	Remittances as a share of GDP in 2018 (%)
Kenya	1,745	1,962	2,720	3.0%

Source: https://www.knomad.org: based on World Bank staff calculation based on data from IMF Balance of Payments Statistics database and data releases from central banks, national statistical agencies, and World Bank country desks. Note: All numbers are in current (nominal) US $

a. In 2018, was number 27 in Africa for remittances as % of GDP, but **number 5 in Africa for sheer size of remittance flows**. Only Egypt, Nigeria, Morocco and Ghana were higher.

b. And growing substantially every year. Estimate diaspora remittances into Kenya in 2018 were 2.720 billion. **In 2020 estimates rank Kenya at number 3 at 2.9 billion USD.**

c. **A good possibility for a mechanism to be put in place where bank/transfer fees can be used for HIV response.** Can be public or private initiative. See point below on HNWI as a source of tech for just such an initiative.

d. Remittances fees estimates at 11% equals 110,000,000 USD (one hundred ten million USD) on 1 USD billion.

e. At 2.9 billion USD remittance flow, 11% is 319,000,000 USD (three hundred nineteen million USD).

f. In 2020 health budget was 114 000 000 000 KS (one hundred fourteen billion KS) or (1 019 860 000 USD/ one billion nineteen million USD).

g. Remittance flows are almost three times larger than health budget.

7. Philanthropists

There are a large number of High-Net-Worth **Individuals (rich individuals) which are a good possibility for funding health, HIV and for funding activists work** watchdogging health financing. These individuals are businesspeople and could also be approached to **invest in developing a money transfer mechanism which would channel profits to HIV, as a legacy project** for them, examples: Naushad Merali and Manu Chandaria

8. Innovative financing

Kenya has used IF for water, microloans, job creation, but a lack of political stability and government investment in creating these ventures means it is a non-starter. **Activists need to campaign for government to create a more stable political climate and a policy environment that makes innovative financing a better possibility.**

9. Where governments report spending money on HIV

Where governments report spendi	Governance & sustainability/HIV/AIDS research	Of which Admin (part of governance &	Treatment, care & support (1)/ Treatment	All prevention including Prevention of	Programmes for children, adolescents on	TB / HIV co-infection, diagnosis &	Community mobilisation (7)	Critical enablers	Of which Key Human Rights Programmes/HR and	Other essential programs for sele	TOTAL	Year of Expenditure Data
Kenya	$0	$37,000,000	$186,000,000	$134,000,000	$32,000,000	ND	ND	ND	ND	ND	$389,000,000	2009/10 - 2011/12

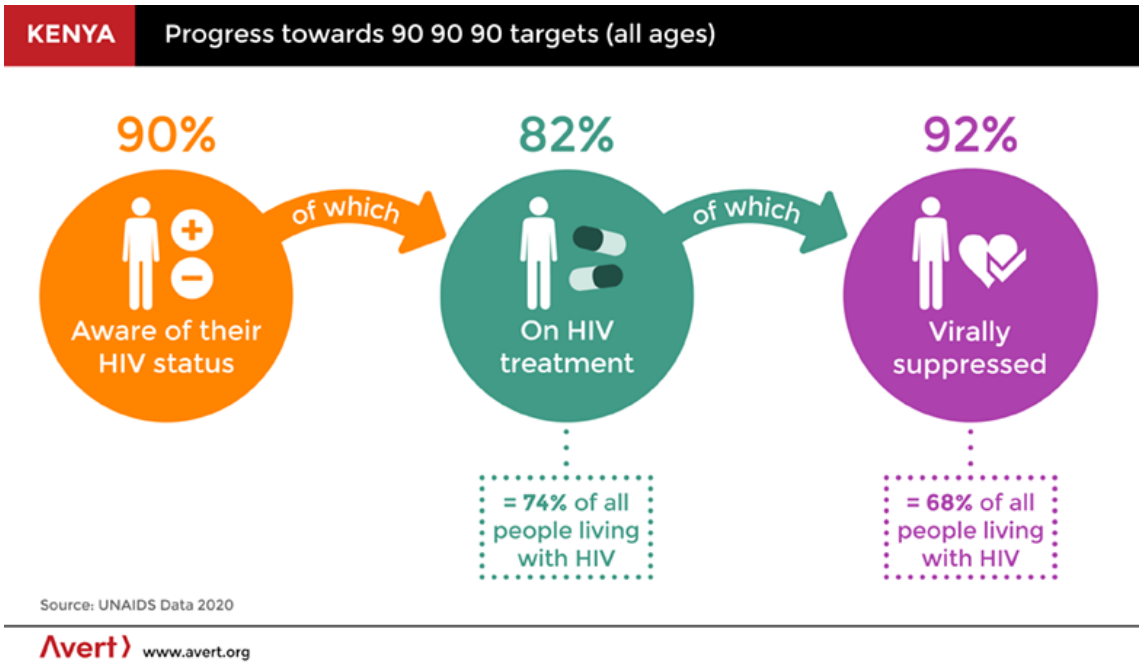
Source: UNAIDS GAPR, GAM Reports/ UNAIDS NASA Reports

Kenya reports no spending on the sustainability areas: areas where critical enablers, social norms, human rights, rule of law, etc are funded and implemented. Funding goes to supply of general service delivery and administration. This means that there is not a sustainable strategy being implemented, but rather constant "band-aids". **Activists need to campaign for the enabling environment and targeted projects (proven repeatedly to have better impact) to be prioritised.**

10. Data on KPs:

Related to sustainability and changing environment, Kenya reports little to no data on the six key population groups: sex workers, men who have sex with men (MSM), people who use drugs, transgender people, people living with HIV (PLHIV), and prisoners. **More focus needs to be placed on community mobilisation of these groups in all campaigns.**

11. 90-90-90



a. Most countries are offering ART but the share of people who are accessing treatment remains low across the continent.
b. In 2020 we should not be celebrating 82% but rather be pushing for 100% so that every person who needs has access and is retained on their medications.
c. **Kenya is moving towards the goals but needs to push harder as all expectation are now on 100%.**

12. HIV Outcome Data

HIV Outcome data Country	Condom use at last high-risk sex	Prevalence of male circumcision	Coverage of pregnant women who receive ART for PMTCT	Knowledge about hiv prevention among young people (15-24)
Kenya	44%	93%	91%	60%

Source: UNAIDS

HIV Outcome data points to a **lack of engagement with youth, probably as a result of stigmatising sex amongst young people and moral policing.**

13. Clinical trials

	Calculations of HIV clinical trial investments in various countries in Africa.	Trial Participants	Trial cost total @ $ 8,000 per participant	5% of Trial Cost	1% of Trial Cost
1	Botswana	5489	$ 43,910,933.00	$ 2,195,546.00	$439,109.00
2	Burkina	533	$ 4,264,000.00	$ 213,200.00	$42,640.00
3	Cameroon	1544	$ 12,352,000.00	$ 617,600.00	$123,520.00
4	Congo	6000	$ 48,000,000.00	$ 2,400,000.00	$480,000.00
5	Côte d'Ivoire	1158	$ 9,266,667.00	$ 463,333.00	$92,666.00
6	Egypt	400	$ 3,200,000.00	$ 160,000.00	$32,000.00
7	Ethiopia	4493	$ 35,944,000.00	$ 1,797,200.00	$359,440.00
8	Gabon	644	$ 5,152,000.00	$ 257,600.00	$51,520.00
9	Ghana	4482	$ 35,856,000.00	$ 1,792,800.00	$358,560.00
10	Guinea	300	$ 2,400,000.00	$ 120,000.00	$24,000.00
11	Kenya	234382	$ 1,875,057,333.00	$ 93,752,867.00	$18,750,573.00
12	Lesotho	10300	$ 82,400,000.00	$ 4,120,000.00	$824,000.00
13	Liberia	4000	$ 32,000,000.00	$ 1,600,000.00	$320,000.00
14	Malawi	50657	$ 405,258,667.00	$ 20,262,933.00	$4,052,586.00
15	Mozambique	30850	$ 246,797,333.00	$ 12,339,867.00	$2,467,973.00
16	Nigeria	5262	$ 42,096,000.00	$ 2,104,800.00	$420,960.00
17	Senegal	954	$ 7,632,000.00	$ 381,600.00	$76,320.00
18	South Africa	74240	$ 593,922,667.00	$ 29,696,133.00	$5,939,226.00
19	Swaziland	3318	$ 26,545,143.00	$ 1,327,257.00	$265,451.43
20	Tanzania	26794	$ 214,348,000.00	$ 10,717,400.00	$2,143,480.00
21	Uganda	222878	$ 1,783,020,000.00	$ 89,151,000.00	$17,830,200.00
22	Zambia	25838	$ 206,701,333.00	$ 10,335,067.00	$2,067,013.00
23	Zimbabwe	44251	$ 354,008,000.00	$ 17,700,400.00	$3,540,080.00
	Total	758766	$ 6,070,132,076.00	$ 303,506,604.00	$60,701,320.00

Our calculations (developed by Kevin Fisher at AVAC) estimate that Kenya is investing enormous amounts in clinical trials in the country. **Activists should engage with whether this is the priority for them locally and unpack the benefits and drawbacks of such large investment.**

14. CCM inclusion and diversity

Country Coordinating Mechanisms are the important and influential decision-making committees at country level that decide on how funds from the Global Fund for the Elimination of HIV, TB and Malaria are spent. They are often connected to the national AIDS committee and also sometimes have decision-making powers over other grants like PEPFAR (USA), UNAIDS (UN) and USAID (USA) or DFID (UK). **CCMs are important spaces and need to be engaged to be friendly, open and serve the needs and interests of key populations.**

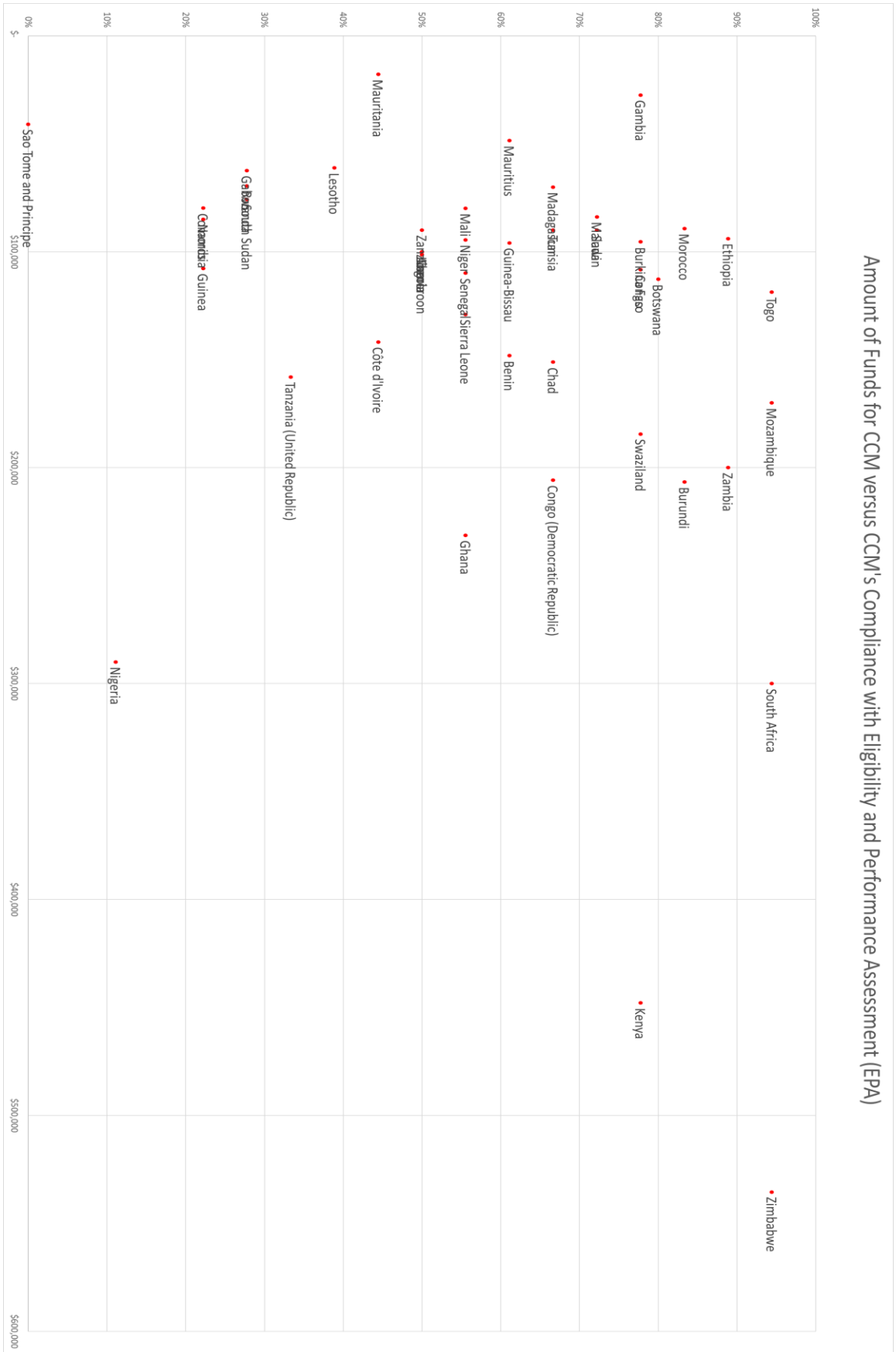
People living with diseases, KP and Civil Society representation on CCM Country	All CSOs as % of CCM members	People living with and/or affected by HIV/AIDS, TB and/or malaria as % of CCM	People representing key affected populations as % of CCM members	Religious/ faith-based organizations as % of CCM members	CSOs, PLWD, KPs and Faith based Total as % of CCM members
Kenya	44%	19%	6%	13%	81%
Notes: Includes chairs and vice chairs but excludes seconds; It is important to note that some individuals mark themselves as "general" civil society and not as PLWD, KP nor religious despite the name of their organisation pointing to the contrary. For this reason, we have separated CSOs and the various community groups and provided a total for all in the final column.					
Source: Global Fund for HIV, TB and Malaria CCM Composition 2016					

Kenya, Malawi, Swaziland, and Tunisia are all ensuring the inclusion of KPs, and People living with HIV, TB and Malaria on their CCMs on paper, and they should be applauded for doing so. But, it is important to remember that in some countries, populations like men who have sex with men (MSM) are not legally able to participate on CCMs in such a capacity because same-sex sexual conduct is criminalized. **Decriminalization is the first step to ensuring these communities can engage in the HIV response.**

In discussions with local activists, there remain significant challenges for KPs representatives to speak out in the CCM space and to influence decision-making. **Activists should collaborate on how the KCM space can be made to be more KP friendly, inclusive, and serve the needs of key populations.**

15. CCM budgets and EPA

a. Regularly, CCMs are assessed for or how they are performing. They are scored against a list of criteria. The Global Fund in Geneva historically only used consultants and quantitative bureaucratic indicators to do these assessments but has adapted their method and the list of criteria after the CCM Scorecard project.
b. We plotted this performance data against the amount of funding that each CCM received in 2017 from Global Fund HQ in Geneva.[iii]
c. The resulting chart shows that Zimbabwe and Kenya were the recipients of the highest CCM budgets in Africa in 2017 (US$535,561 and US$447,852 respectively). Zimbabwe proved that this investment works well on paper and achieved an EPA performance of 94%, whereas Kenya achieved only 78% with its big budget.
d. Interestingly, Ethiopia, Mozambique, and Togo and achieved similar results (89%, 94%, and 94%) with considerably smaller budgets (US$93,876, US$170,000, and US$118,615 respectively).
e. South Africa used US$300,000 to achieve its 94% rating.
f. The Gambia achieved 78% on US$27,452, while Kenya achieved 78% with US$447,852, a budget 16 times larger than the Gambian budget for the same results on paper.
g. Local activists should interrogate how the budget is being spent and what it is allocated to.
h. In 2017, Accountability International successfully advocated in Geneva at the Technical Expert Working Group that 15% of all CCM budget should be allocated to community engagement. **Local Kenyan activists should engage with partners like AI and their partners, who are watchdogging CCMs in Mali, Nigeria and Ghana on exactly this issue.**
i. Lead is Kids n Teens Nigeria, working with Nigeria Peer Review Forum, Arcad Sante Mali, Society for AIDS in Africa: read more here: https://voice.global/grantees/full-circle-tax-watch-for-all/


Amount of Funds for CCM versus CCM's Compliance with Eligibility and Performance Assessment (EPA)
$-
$100,000
$200,000
$300,000
$400,000
$500,000
$600,000
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Sao Tome and Principe
Nigeria
Mauritania
Lesotho
Tanzania (United Republic)
Côte d'Ivoire
Mali
Niger
Senegal
Sierra Leone
Ghana
Mauritius
Guinea-Bissau
Benin
Madagascar
Tunisia
Chad
Congo (Democratic Republic)
Gambia
Burkina Faso
Swaziland
Kenya
Morocco
Botswana
Burundi
Ethiopia
Zambia
Togo
Mozambique
South Africa
Zimbabwe

	CCM budgets versus performance as measured by Global Fund EPA	CCM Funding Disbursements from Global Fund for HIV, TB and Malaria: Amount (USD)	Degree of compliance with Eligibility and Performance Assessment (EPA)
1	Algeria	ND	ND
2	Angola	$100,000	50%
3	Benin	$148,102	61%
4	Botswana	$112,765	80%
5	Burkina Faso	$95,429	78%
6	Burundi	$206,609	83%
7	Cabo Verde	ND	ND
8	Cameroon	$101,311	50%
9	Central African Republic	ND	ND
10	Chad	$151,099	67%
11	Comoros	$79,712	22%
12	Congo	$108,346	78%
13	Côte d'Ivoire	$141,755	44%
14	Democratic Republic of Congo	$205,800	67%
15	Djibouti	ND	ND
16	Egypt	ND	ND
17	Equatorial Guinea	ND	ND
18	Eritrea	ND	ND
19	Ethiopia	$93,876	89%
20	Gabon	$62,376	28%
21	Gambia, The	$27,452	78%
22	Ghana	$231,330	56%
23	Guinea	$107,680	22%
24	Guinea-Bissau	$95,876	61%
25	Kenya	$447,852	78%
26	Lesotho	$61,087	39%
27	Liberia	$100,000	50%
28	Libya	ND	ND
29	Madagascar	$70,000	67%
30	Malawi	$83,785	72%
31	Mali	$79,803	56%
32	Mauritania	$17,772	44%
33	Mauritius	$48,523	61%
34	Morocco	$89,194	83%
35	Mozambique	$170,000	94%
36	Namibia	$85,000	22%
37	Niger	$94,477	56%
38	Nigeria	$290,000	11%
39	Rwanda	$69,527	28%
40	Sahrawi Republic (Western Sahara)	ND	ND
41	São Tomé and Príncipe	$41,000	0%
42	Senegal	$109,866	56%
43	Seychelles	ND	ND
44	Sierra Leone	$129,026	56%
45	Somalia	ND	ND
46	South Africa	$300,000	94%
47	South Sudan	$75,764	28%
48	Sudan	$90,000	72%
49	Swaziland (eSwatini)	$184,432	78%
50	Tanzania	$158,069	33%
51	Togo	$118,615	94%
52	Tunisia	$90,000	67%
53	Uganda	ND	ND
54	Zambia	$200,000	89%
55	Zimbabwe	$535,561	94%

Source: Global Fund for HIV, TB and Malaria, Funding Disbursements database, 2017: https://data.theglobalfund.org/home

16. Human Rights environment

Cato Human Freedom Index by country	Personal Freedom	Economic Freedom	Human Freedom	Freedom Rank / 162
Kenya	6.45	7.20	6.82	82

Source: https://www.cato.org/human-freedom-index-new

[i] Development Aid at A Glance Statistics By Region: Africa 2019 edition, OECD, Paris, France. https://www.oecd.org/dac/financing-sustainable-development/development-finance-data/Africa-Development-Aid-at-a-Glance-2019.pdf

[ii] UNAIDS. 2016. 90-90-90: On the right track towards global target. https://reliefweb.int/sites/reliefweb.int/files/resources/90_90_90_Progress_ReportFINAL.pdf

[iii] Global Fund for HIV, TB and Malaria, Funding Disbursements data base, 2017: https://data.theglobalfund.org/home