Sustainable Financing of HIV and AIDS Care in Kenya

**Figure 1: Projected HIV positve population by year**

**NACC team led by Deputy Director Finance and Administration,**

**Dennis Kamuren(left),Head of Strategy Regina Ombam(Centre)**

**Deputy Director, Coordination and support Dr Sobbie Mulindi**

**(2nd left) after receiving the award for the NACC’s effort in**

**attaining MDG-6**

**Head of Strategy Regina Ombam(left) and Deputy Director**

**Finance and Administration Dennis Kamuren(Centre)presents**

**the award to the NACC Director Prof Alloys S.S Orago(left)**

Total expenditure on HIV and AIDS

alone has been rising from about Ksh

7.7 billion in 2000/01 to Ksh 53 billion

in 2008/09. The AIDS spending rose

seven-fold between 2000-2001 and 2008-

2009, including 18% in 2008-2009 alone.

The bulk of this funding estimated at 87%

however, comes from development partners

with the government contribution estimated

at about 13%. This rapid and unprecedented

expansion has led to many important gains.

The PMTCT programme which started as a

pilot in 2000 has expanded rapidly to cover

over 4000 health facilities with interventions

in both public and private health institutions.

HIV testing and counselling is routinely

offered to pregnant mothers attending

antenatal clinics resulting in high uptake

of testing. The NACC projections indicate

that 81,000 mothers were likely to be HIV

infected annually in 2009 and 2010 out of a

total of 1.5 million annual pregnancies (NACC

Projections 2010).

Antiretroviral therapy forms a core

component of HIV care and treatment

for those infected with HIV among other

supportive interventions. Since the

introduction of ARVs in the public sector in

the late 2003, the numbers of those benefiting

from active antiretroviral therapy has risen

from less than 10,000 in 2003 to more than

400,000 in 2010.This provision of free ARVs

in public, NGO and faith based sectors has

seen the cost of treatment to persons living

with HIV reduce dramatically as access to

ART has increased tremendously.

Despite these gains, additional large

increases in spending for HIV prevention

and treatment will be needed to control

the epidemic in the future. Without a

revolutionary prevention technology such

as an effective vaccine or a curative drug,

effective prevention methods such as male

circumcision, condom use, needle exchange,

prevention of mother to child transmission

would need to be expanded further leading

to increased financial outlays.

At the same time, demand for ART for

adults and children with HIV infections will

continue to grow rapidly. With the 2009

WHO Treatment guidelines recommending

an earlier initiation of ART having been

adopted by the Kenyan Government in 2010,

the number of people in need of treatment

has significantly increased. Over 800,000

persons are estimated to be in need of ART

as of 2010 (117,000 children aged less than

15 years and 694,000 adults); with over

440,000 persons on ART as of November

2010 (54% coverage). But, the country is

still not providing ART to over approximately

46% of those in need of treatment.

The intensifying situation raises a series

of difficult questions for domestic and

international financing of HIV and AIDS

interventions. HIV and AIDS has now become

a long–term problem and not a short-term

crisis hence some key long-term financing

issues to be addressed by the Kenyan

Government include: How large will the

resource requirements be to combat HIV and

AIDS effectively over the next 20 years? What

benefits will the country get from increased

spending, as measured by infections averted

and lives saved?

**COUNTRY RESULTS**

In the Kenya National AIDS Strategic Plan

(KNASP III) for the period 2009 -2013,

the country modelled the long-term

financial requirements for strengthening

of prevention, treatment, care and support

and related health systems. The total four

year programme cost (2009-2013) was

estimated at US$3.5567 billion, with annual

requirements rising from US $671 million

in 2009/10, US$ 833million in 2010/11, US

$998million in 2011/12 and US $1,054 million

in 2012/13. The annual increases are mostly

due to proposed scale –up in interventions

targeting communities, MARPs, HCT,

PMTCT, ART, Nutritional Support, Treatment

of Opportunistic Infections, OVC, HIV

Programme Management and M&E.

The results of the costing model showed that

policy choices made in the next few years

would have a large effect on the course of

the epidemic. The rapid scale –up scenario,

including widespread efforts to achieve

universal access to prevention and treatment

services demonstrated that our country’s

already heavy financial requirements must

increase emphasizing the severe pressure

that HIV and AIDS places on available

resource. The KNASP III showed that Kenya’s

estimated funding gap for the HIV and AIDS

programme was roughly USD 1.67 billion. Of

the available funding, most (87%) comes from

external sources, which undermines country

ownership and sustainability and constrains

national efforts to update intervention

priorities and decentralize service delivery.

The country has to devise innovative ways

of raising revenue domestically to enhance

sustainability for HIV financing both in the

immediate and long run.

**COUNTRY PROJECTIONS**

Modelling projections can help us understand

the persisting nature of the HIV and

AIDS epidemic and the need for action, including

targeted

inter ventions.

Since the first

incidence of HIV

infection was

diagnozed in

1984, the number

of HIV positive

Kenyans

has steadily

increased. The

trend is projected

to continue

to a peak

in 2015 and

thereafter decline

gradually if necessary interventions are

implemented (see Figure 1).

The HIV epidemic in Kenya peaked in the late

1990s with an overall prevalence rate of over

14% in adults which has however, declined

to 6.3 % among those aged 15-49 years. This

notwithstanding, incidence remains high at

100,000 adults and 22,000 paediatric new

infections every year (NACC Spectrum Modelling,

2009).

**ACTION BY GOVERNMENT OF KENYA**

Over the last decade, the government

in collaboration with key stakeholders

has mounted a robust and multi-faceted

response to AIDS starting with The

Sessional Paper No. 4 of 1997 on AIDS in

Kenya. The paper marked an important

change on the political front and outlined

a new institutional framework. In 1999,

the Government declared AIDS a national

disaster and consequently established the

National AIDS Control Council (NACC) within

the Office of the President to coordinate

the multisectoral National response to the

epidemic. To reinforce its commitment, the

Government in 2003 established a rightsbased

framework for effective action on AIDS

by approving legislation that made it illegal

to engage in discrimination in employment

on the basis of a person’s HIV status. The law

also prohibited insurers from withholding

services to people living with HIV or from

imposing discriminatory premiums on HIVinfected

individuals. In 2006, the Government

enacted the HIV and AIDS Prevention and

Control Act (although the legislation is yet

to be fully implemented) to formally protect

the rights of people living with HIV, prohibits

mandatory HIV testing, and authorizes

various measures to mitigate the epidemic’s

impact. A declaration of ‘Total War on AIDS’

was one of the first acts of H. E. former

President Kibaki and bringing together an

ecumenical group of religious leaders has

been an important step in this fight. Since the

declaration, formal policies and guidelines

have been developed to support programme

planning and implementation with respect

to specific aspects of the AIDS response.

Various areas are covered by different

guidelines including antiretroviral therapy,

voluntary counseling and testing, sexual

and reproductive health services for young

people, sectoral and gender mainstreaming

of HIV and AIDS education in primary school

settings.

**IMPACT OF THE EPIDEMIC**

The epidemic has however, caused farreaching

social, economic, health and

population effects. It is the main cause of a

sharp deterioration of basic health indicators.

For instance, in 2009, an estimated 1.2

million children in Kenya had lost one or

both parents to AIDS. Kenyan children with

one or more HIV-infected parents were

significantly less likely than other children to

be in school, more likely to be underweight,

and less likely to receive basic medical care.

The National AIDS Control Council has

estimated that there are 1.5 million people

currently living with HIV and AIDS while

approximately 68,000 people die of AIDSrelated

complications annually, leaving

behind over 2.4 million orphans.

In a UNAIDS report of 2010, it was envisaged that there would be

many more Kenyans living with HIV, with the large majority in need

of the more costly second-line treatment. A portion of the household

contribution in terms of out-of-pocket expenditure went to financing

HIV and AIDS services. In 2001/02, the National Health Accounts

(NHA, 2002) study demonstrated that out-of-pocket expenditure by

households (OOP) on HIV and AIDS services was Ksh 2.61 billion (

approximately 26.30% of total HIV spending in the country), but in

2005/06 it was Ksh 4.24 billion (approximately 22.5%). Out-of-pocket

outlays account for more than one-fifth of all AIDS expenditures in

Kenya. HIV infections nevertheless results in considerable expenses

for affected households (Source NHA, 2005/06).

**TRANSMISSION OF HIV INFECTION**

The epidemiological analysis and modeling from the Kenya Modes of

Transmission study (KMOT, 2008) revealed that 80% of new infections

in Kenya occurred through heterosexual partnerships (Figure 2).

Figure 2: Sources of new infections as captured in the KMOT (2008)

The KMOT (2008) also revealed the epidemic was geographically

diverse, influenced by prevalent cultural and behavioural practices,

most notably male circumcision and multiple concurrent relationships

(Figure 3).