



**UNIVERSITY OF NAIROBI**

**Institute of Diplomacy and International Studies**

**THE ROLE OF DONOR FUNDING IN COMBATING HIV/AIDS: A  
CASE STUDY OF KENYA.**

By

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*A Research Dissertation submitted in partial fulfillment for the award of the  
degree of Masters in International Studies, University of Nairobi.*

**2001**

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## DECLARATION

This research dissertation is my original work and has not been presented for a degree in any other university.

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## **DEDICATION**

This work is dedicated to my husband, A. G. Kimani and our sons Abel Githiri and Arsenio Githinj.

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## **LIST OF ABBREVIATIONS.**

AIDS	Acquired Immunodeficiency Syndrome
APS	AIDS Programme Secretariat
AZT	Zidovudine
GATT	General Agreement on Trade and Tariffs
GDP	Gross Domestic Product
GPA	Global Programme on AIDS
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
IPR	Intellectual Property Rights
IPU	Inter-parliamentary Union
MAP	Multi-Country HIV/AIDS Programme
MSF	Medecins Sans Frontieres
MTP	Medium Term Plan
NAC	National AIDS Council
NACC	National AIDS Control Council
NASCOP	National AIDS and STD's Control Programme
NGO's	Non-governmental Organizations
SSA	Sub Saharan Africa
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TRIPS	Trade related Aspects of Intellectual Rights
UN	United Nations
US	United States of America
UNAIDS	Joint United Nations program on HIV AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
UNESCO	United Nations Education, Scientific, and Cultural Organization

UNFPA	United Nations Population Fund
USAID	US Agency for International Development
WHO	World Health Organization
WTO	World Trade Organization
VCT	Voluntary Counseling and Testing

## **ABSTRACT**

This study investigates the role of donor funding in the fight against HIV/AIDS in Kenya. These was done with a view to prescribing policies that would effectively control and curb the spread of HIV/AIDS, by stopping new infections.

The study comprises of the introduction, the HIV/AIDS situation in Kenya, Policy and Institutional framework, an assessment of international aid agencies and NGOs, treatment and drug access, empirical findings, summary, conclusion and recommendations. Data for the study was obtained through primary and secondary sources. The study largely depended on available literature for secondary data. The primary source of data was a survey carried out in Nairobi

The study reveals that one of the causes of the rise of new infections is poverty. Another contentious issue hindering efforts to fight HIV/AIDS is culture, which is deeply entrenched, in most African communities. This has made it very difficult for people to change their behaviour, which is necessary in putting the pandemic under control.

One recommendation made in the study is for the stakeholders, led by government of Kenya to demystify HIV/AIDS for the people and thus help

break the people's belief systems. This requires the collaborative efforts of the government, NGOs, who have grass root networks and international aid agencies to provide the required funds.

On policy issues, it is recommended that the government re-visit and re-evaluate its policies on HIV/AIDS in order to tally them to the changing realities. The study also recommends further academic research on donor intervention in the HIV/AIDS problem in Kenya.

## CHAPTER ONE

### THE HIV/AIDS PANDEMIC

#### 1.0 INTRODUCTION

UNAIDS and WHO estimated that by the end of 1999, about 33.6 million people were living with HIV infection, including 14.8 million women and 1.2 million children. Most do not know that they are infected. Majority of people living with HIV/AIDS are in developing countries – 23.3 million people in Sub Saharan Africa, (SSA), (50% of whom are women), 6 million in South and South East Asia and 1.3 million people in Latin America <sup>1</sup>. Nowhere has the impact of HIV/AIDS been more severe than SSA. All but unknown a generation ago, today it poses the greatest threat to development in the region.<sup>2</sup>

At the regional level, more than 11 million Africans have already died. The 21 countries with the highest HIV prevalence are in Africa. In Botswana and Zimbabwe, one in four adults is infected. In at least 10 other African countries, prevalence among adults exceeds 10 percent. <sup>3</sup>

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<sup>1</sup> See *AIDS Epidemic Update: December 1999*, UNAIDS/WHO 1999, pg 4

<sup>2</sup> See Forward by C. Madavo & J. L. Sarbib, World Bank's Vice Presidents, Africa Region, in *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*, World Bank 2000, pg v

<sup>3</sup> A Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its devastating Human, Economic and Social Impact, UNAIDS/IPU, Geneva, Switzerland, 1999 pg3

Africa is the continent least well placed to respond to the crisis of HIV/AIDS, partly because it is the poorest continent with the worst health and educational infrastructure in the world. It has the weakest civil society, and the political leadership is marked by patrimonialism, corruption, authoritarianism and even militarization and criminalization.<sup>4</sup> Africa is also subject to a high degree of disruption, with mass displacement due to war and natural disasters, and mass migration in search of employment and opportunity.

While the virus has not spared any section of society, the most affected are the productive people in society who range between the ages of 15 to 49 years. This has adversely affected the workforce and hence the development process of the countries in SSA.

Governments are faced with the responsibility to arrest the situation. To effectively succeed in this venture resources are required. In SSA resources are scarce. In this respect donors have intervened to assist SSA governments in their programmes to contain the scourge.

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<sup>4</sup> See J. Collins & B. Rau, *AIDS in the context of Development*, (no place or date given), and C. Baylies, "International Partnership in the Fight Against AIDS: Addressing Need and Redressing Injustice?," *Review of African Economy*, Vol. 32, No. 81. 1999. pg 389

Existing treatments, which enable many people with HIV/AIDS in the developed countries to live relatively healthy lives, are available to only a few people in Africa. Even though international drug companies agreed to reduce the prices of their anti-HIV drugs in 1999, they are still out of the reach of most people in Africa. Life saving HIV/AIDS drugs cocktails cost about \$12,000 a year, a figure beyond the reach of the majority of people in Africa.

Although AIDS was first diagnosed in 1981 in Africa, a systematic international and national response to the epidemic was not evident until the late 1980's. This delay in response has proved to be very costly.

### **1.1 Statement of the problem**

HIV/AIDS is now the fourth leading cause of death worldwide and the leading cause of death in SSA.<sup>5</sup> The epidemic is not only an unparalleled public health problem affecting large parts of SSA, but is an unprecedented threat to the regions' development. In many countries, the disease is reversing decades of hard won development progress.

Successful public health measures have stabilized the epidemic in most developed countries. However, many developing countries are experiencing exponential growth of HIV/AIDS cases. Global spending on

HIV/AIDS care, research and prevention reflects this disparity - developing countries only receive 12% of such resources despite having 95% of the cases.<sup>6</sup>

National governments shoulder the responsibility for protecting their citizens from the spread of the HIV epidemic and of mitigating its worst effects once it has spread. However, in SSA, governments alone cannot cope with the problem because their resources are already overstretched.

The HIV/AIDS pandemic carries serious financial implications for SSA in terms of treatment. At a yearly cost of \$12,000 per person for the cocktail of anti-retroviral drugs used in western countries to ward off the effects of the HIV virus, SSA is not in a position to widely adopt and sustain such treatments in its health programs.

Where people are exposed to poverty, food insecurity, gender inequality, migration, war and civil conflict, their vulnerability to HIV/AIDS increases. In rural areas of most countries in SSA, migration, trade, the

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<sup>6</sup> Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV AIDS in View of its devastating Human Economic and social Impact, UNAIDS/IPU, Geneva, Switzerland, 1999, pg 17

movement of refugees and strengthened rural-urban linkages accelerate the spread of HIV/AIDS.<sup>7</sup>

Due to the catastrophic situation of HIV/AIDS in SSA, the region faces a triple challenge; providing care for the growing population of people infected with HIV/AIDS, bringing down new infections through more effective prevention, and coping with the 17 million deaths on the continent.<sup>8</sup>

Public health financial allocations in SSA do not seem adequate to deal with the HIV/AIDS problem. The international communities, especially the better-endowed industrialized countries and the Bretton Woods institutions, have responded by giving some assistance to the ailing continent, in the endeavour to control and contain the spread of the scourge. However despite the positive response from the West the HIV/AIDS pandemic continues to escalate.

The current situation indicates that the HIV/AIDS crisis in Africa needs to be addressed not only fast but also adequately, yet average

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<sup>7</sup> See UNAIDS/FAO, article "HIV/AIDS is shifting from cities to rural areas" (23/06/2000) pg 2

<sup>8</sup> See P. Piot, "A million Africans Newly Infected with HIV this Year (2000)", in *AIDS in Africa: Heartbreak and Hope*, United Methodist Committee on Relief General Board of Global Ministry, at <http://gbgm-umc.org/programs/aidsafrica/africastats2000.stm> pg 1

government in SSA suffers from serious financial inadequacy, technical incapacity and lack of resources to address the crisis.

### **1.2 Objectives of the study**

This study seeks to examine what the donors are doing to combat the HIV/AIDS scourge, how they are doing it and with what results. It also hopes to establish the areas that have attracted more funding than others do, and whether there is any collaboration between the government and the donors in the administration of the funding.

This study will therefore endeavour to:

1. Find out what the donors are doing, Identify areas and programmes being funded and the impact this funding has had on the HIV/AIDS problem,
2. Find out how donor funds are being administered, whether in cooperation with the government, through NGO's or direct to specific projects.
3. Investigate the commitment and capacity of international aid agencies to tackle the HIV/AIDS problem in SSA.

### 1.3 Literature review

The literature reviewed here is derived from works done on the HIV/AIDS situation in SSA. The sources are mainly conference papers, sessional papers, Development Plans, annual reports by UNAIDS, World Bank Reports, Internet sources, newspapers and magazines.

SSA with 25.3 million HIV/AIDS sufferers is currently the epicenter of the epidemic. AIDS related diseases killed 2.4 million people in Africa in 2000, more than those killed by war, famine and floods combined.<sup>9</sup>

Today the world has awakened to the frightening magnitude of the HIV/AIDS epidemic in SSA<sup>10</sup>. Donor countries and organizations have finally began to give the unfolding HIV/AIDS crisis in Africa special attention<sup>11</sup>, and are united in the global fight against AIDS.<sup>12</sup> While Africans have welcomed increased donor attention, many have also raised concerns about the effectiveness of donor-sponsored initiatives on HIV/AIDS.

In many ways Kenya is ahead of other countries in being able to understand the epidemic, with a number of studies having already been

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<sup>9</sup> See "Mandela's AIDS Day Plea Echoes Around the World", at <http://www.ozfactors.com/AIDS%203.html> pg2

<sup>10</sup> See "Background and Objectives", in African Perspectives on HIV/AIDS: A Sampling of African Views on US & Western Policy Responses to HIV/AIDS in Africa, at <http://www.aaionline.org/bp/aidsday/report.html>

<sup>11</sup> Ibid

performed on the socioeconomic impact of HIV/AIDS.<sup>13</sup> In 1985, the government created a national AIDS council (NAC), which however lacked the authority and resources to develop awareness or prevention efforts.<sup>14</sup> While Forsythe and Rau<sup>15</sup> paint a clear picture of the social and economic aspects of HIV/AIDS in Kenya, the issue of donor funding, and its role in combating the pandemic have not been given adequate attention.

Some countries such as Australia, Brazil, Thailand, Senegal and Uganda have demonstrated that the epidemic can be slowed through commitment from the highest levels of government, direct involvement of people with AIDS and private sector involvement. Effective interventions include making condoms available and affordable, providing early diagnosis and access to treatment for sexually transmitted infections, ensuring safe blood supplies and supporting interventions to reduce mother-to-child transmission.<sup>16</sup>

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<sup>12</sup> See *HIV/AIDS in Africa: The Gains of the Durban Conference*, Africa Economic Analysis, at <http://www.afbis.com/analysis/hiv.htm> pg2

<sup>13</sup> See "Forward" by Dr. Martin Kayo, Programme Manager, National AIDS/STD Control Programme, May 1996, in S. Forsythe & B. Rau eds. *AIDS in Kenya: Socioeconomic Impact and Policy Implications*, Family Health International/AIDSCAP, 1996.

<sup>14</sup> Ibid pg 3

<sup>15</sup> S. Forsythe & B. Rau op cit

<sup>16</sup> See "Fighting a Scourge of Humankind", In *Development and Cooperation*, No. 1999 (Sept/Oct) pg 11

Despite some of the recorded successes, available evidence generally indicates that the epidemic is deepening in most of the African region. The head of the Ugandan AIDS program is worried that Ugandans may let down their guard with respect to the disease.<sup>17</sup>

Decosas argues that the prevalence of HIV is an indicator of uneven or dysfunctional social development and that the national responses to AIDS in countries of the south (developing countries) "have to shed their stifling uniformity and become more original and more country specific."<sup>18</sup>

Experts in the field note several barriers to a more effective HIV/AIDS response in Africa. These are cultural norms that render it difficult for governments, religious and community leaders to discuss sexual matters, including sexual practices, prostitution and the use of condoms,<sup>19</sup> lack of effective coordination between government departments/ministries and between governments and donor institutions as well as poor prioritization.

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<sup>17</sup> See Africa News Service, December 10, 1999, as quoted "AIDS in Africa", at <http://www.cnie.org/nle/inter-34.html> pg6

<sup>18</sup> J. Decosas, *HIV and Development. AIDS 1996*; 10(Suppl 3): 69-S75

<sup>19</sup> Ibid

A World Bank Policy research Report<sup>20</sup> offers an analytical framework for deciding which government interventions should receive high priority for addressing the HIV/AIDS epidemic. Based on this framework the authors of the report advocate a broad strategy that can be adapted by countries according to their resources and the stage of the epidemic in a particular country.<sup>21</sup>

Many studies done in SSA show that dirty needles or shortage of them may be contributing to the upsurge of HIV/AIDS infection in rural areas across SSA. Subsequently, UNAIDS published guidelines on disinfection and sterilization in the early days of the HIV/AIDS epidemic. In SSA where disposable needles and syringes may not be available, UNICEF provides units with simple pressure cookers to sterilize the needles and syringes.<sup>22</sup>

A US \$ 1 billion Export Import Bank Initiative has been among numerous facilities being dangled in front of African nations with regard to the HIV/AIDS crisis.<sup>23</sup> Under the programme announced in July 2000, major US drug companies were offering their products at a discount to 24 African countries and the export-import Bank would

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<sup>20</sup> *Confronting AIDS*, op cit

<sup>21</sup> Ibid

finance their exports through five-year loans, at commercial lending rates. However HIV/AIDS activists have pointed out that "AIDS is not an income-generating project and Africa should adopt a common position to say no to interest bearing loans."<sup>24</sup> Yet Africa, and particularly SSA is may not be in a position to make choices, in light of the HIV/AIDS crisis.

While various donor agencies are funding different HIV/AIDS projects, it has been argued by various NGOs and people working in the area of HIV/AIDS, that these donor agencies fund according to their own priorities, interests and objectives, which sometimes may not correspond with national interests.

An executive summary and key findings from discussions among a diverse cross section of Africans, made to address US and Western policy responses to HIV/AIDS in Africa, points out that there has been growing concern among many Africans working on HIV/AIDS that donor funded programmes are not as effective as they could be.<sup>25</sup>

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<sup>22</sup> See "*Dirty Needles cited in Upsurge in HIV cases*", AIDS Information Service, in *The East African Standard*, 24<sup>th</sup> January, 2001 pg 6

<sup>23</sup> Ibid

<sup>24</sup> Gumisai Mutume, "*Blessed are the Young for they shall inherit the Debt*", Published in *African Development Forum*, 2000 (ADF News)

<sup>25</sup> See "*Executive Summary and Key Findings*", in *African Perspectives on HIV/AIDS: A Sampling of African Views on US and Western Responses to HIV/AIDS in Africa*, The Africa American Institute, at <http://www.aaionline.org/bp/aidsday/report.html>. pg 1

Recent experiences in Africa and Southeast Asia show that the most effective responses to the HIV/AIDS crisis are those in which national governments commit their own political prestige and financial resources, involve civil society fully, and pursue a comprehensive agenda, that includes prevention, care and support.<sup>26</sup> International support is most effective when it is closely coordinated with such local efforts.

Lessons learnt from countries like Uganda, Senegal and Thailand indicate that the most effective national AIDS plans draw upon the strengths and support of local culture and local institutions and organizations, but also incorporate best practices developed elsewhere.<sup>27</sup>

Hemrich and Schneider<sup>28</sup> reiterate that a strong political commitment to the fight against HIV/AIDS is crucial. They state further, that those countries, which have shown the most success such as Uganda, Thailand and Senegal all have support from, top political leaders. They give several reasons why this support is critical. First it sets the stage for an open approach to HIV/AIDS that helps to reduce the stigma and discrimination, that often hamper prevention efforts. This facilitates a

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<sup>26</sup> See "UNDP's Role in the Fight Against HIV/AIDS", in HIV and Development Programme at [http://www.undp.org/hiv/policies/nudp\\_role.html](http://www.undp.org/hiv/policies/nudp_role.html) pg 1

<sup>27</sup> Ibid pg 2

<sup>28</sup> G., G., & B. Schneider, "HIV/AIDS as a cross-sectoral Issue for technical Cooperation", *GTZ working paper NO. 1* (Germany: May 1997).

multi-sectoral approach by making it clear that the fight against HIV/AIDS is a national priority.

It also signals to individuals and community organizations involved in the HIV/AIDS programs that their efforts are appreciated and valued. Finally it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Available literature seems to link HIV/AIDS with poverty. High levels of poverty are given as one of the reasons why the worst hit, are developing countries. There is evidence to suggest that the consequences of underdevelopment, such as poverty, under funded health systems and rural urban migration, may exert a profound influence on the distribution and spread of HIV/AIDS. Shortages of money and doctors in hospitals and ignorance have led in many countries to high rates of untreated sexually transmitted diseases (STDs), which are now known to facilitate transmission of HIV/AIDS.<sup>29</sup> This explains the reason why Africa has the largest share of HIV/AIDS cases in the world.

Further literature reveals that many African and other developing countries have avoided confronting HIV/AIDS head-on and have instead

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<sup>29</sup> See P. Piot & M. Laga, *British Medical Journal*, 11<sup>th</sup> march 1989, vol. 298, pg 623-4.

remained silent. Political commitment to address the crisis has until recently remained low, despite the fact that 95% of AIDS deaths occur here. Denial has been the order of the day, reinforced by poor or non-existent surveillance and diagnostic capacity and broader socio-economic constraints.<sup>30</sup>

Most governments have refrained from making HIV/AIDS a high priority issue. The few that have, Uganda, Thailand, Senegal and Brazil, have significantly reduced HIV/AIDS infections and death rates through educational programmes, provision of condoms, and in the case of Brazil, much expanded access to anti-retroviral drugs.<sup>31</sup>

#### **1.4 Justification**

This study is expected to generate data that will add to the existing knowledge in donor funding to HIV/AIDS related programmes in SSA. The study will also be useful for literature and further research. Particular areas will be identified where donor funding is playing a role in fighting the HIV/AIDS scourge.

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<sup>30</sup> "Text: AIDS May be Most Serious Health Threat in Recorded History", at <http://usinfo.state.gov/topical/global/hiv/01011201.htm> pg 5

<sup>31</sup> Ibid

This will be important not only to the governments and policymakers, but also to the donors. Both governments and donors will benefit by being able to identify the areas that require more emphasis and those that require cooperation among various actors and stakeholders.

The study is also expected to help governments identify HIV/AIDS programmes where they could play a leading role, for effective outcomes, as well as areas where donors have comparative advantage.

The study should also be useful to donors in the formulation of suitable policy for HIV/AIDS related aid in SSA. The study will also add more knowledge in the area of financing HIV/AIDS, for effective control of the pandemic in SSA where the rate of infection is the highest.

### **1.5 Conceptual framework**

HIV/AIDS needs a multi-dimensional/holistic approach in order to fill in gaps in studies related to HIV/AIDS. The HIV/AIDS condition has to do with structural problems in society that may be economic, social, cultural and political.

This study is guided by the, dependency theory. Third world nations have been and on balance remain greatly dependent on dominant rich

countries and their political policies.<sup>32</sup> One subtle but highly significant factor contributing to the persistence of underdevelopment has been the transfer of rich country values, attitudes, institutions and standards of behaviour as well as technology to third world nations.<sup>33</sup>

Donor assistance to underdeveloped countries takes different forms and it is not always clear what the rationale, if any, behind the donor assistance may be. In fact the terms and types of aid seem in a large measure determined by administrative doctrines, rules, ad hoc political pressures, traditional banking principles and the influence of practice in other donor countries.<sup>34</sup>

One major criticism of the literature on foreign aid is that it has concentrated almost exclusively on the motives and objectives of donor countries,<sup>35</sup> with meager attention to why Least Developed countries (LDC's) accept aid and with inadequate discussion of what foreign aid is expected to accomplish.

International lending to underdeveloped countries has in many cases already created staggering national debt burdens. If the existing foreign

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<sup>32</sup> M. P. Todaro, *Economics for a Developing World: An Introduction to Principles, Problems and Policies for Development*, 3<sup>rd</sup> edition, 1992, Longman, London & New York pg 29

<sup>33</sup> Ibid pg 92

exchange gap is to be removed in these countries increased lending even on fairly soft terms could create difficulties. It would be misleading to overlook the elements of uniformity in the international aid system and the forces that serve to strengthen them. There are, first, the historical aspects of the situation. Whatever the reasons, which, individual countries deem most compelling for the launching of a policy of development assistance, this fundamental economic dependency is a consequence of the pervasive change in the relationship between industrial countries and the rest of the world that the end of the colonial era helped to create.

Industrialized countries being deeply concerned about the stability of the world, have ensured economic cooperation with the less developed countries with a view to prevent anarchy, and inflammatory crisis.

On the other hand, third world countries accept aid because it is expected to facilitate and accelerate the process of development by supplementing domestic savings. Many proponents of foreign aid believe that rich nations have an obligation to support the economic and social development of the Third world.<sup>36</sup> Even though international financial

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<sup>34</sup> Ohlin G., *Foreign Aid Policies Reconsidered*, OECD, 1966, pg 96.

<sup>35</sup> Op cit pg 402

<sup>36</sup> Ibid 406

assistance is not always necessary, this assistance is usually welcomed in many poor countries with limited public budgets.

The world's poorest countries together owe around US\$ 2 trillion in external debt, yet most of the 95% of HIV infected people live in these countries. Lack of funds for an expanded response to HIV/AIDS in Africa, has been aggravated by prevailing high levels of indebtedness. Across Africa national governments pay out four times more in debt service than they spend on health and education.<sup>37</sup>

High debt and debt service have therefore compounded the problem of HIV/AIDS in SSA. They have deterred private investment, absorbed core budget resources, making governments more "cash poor" but "project rich" with a development agenda increasingly perceived as being shaped by donors.<sup>38</sup>

The HIV/AIDS crisis has come at a time when SSA is least able to cope. The vicious cycle of aid is therefore bound to continue. The crisis will inevitably create a situation where borrowing from the west will continue,

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<sup>37</sup> See "Report on the Global HIV/AIDS epidemic", at <http://www.unaids.org> pg 7

<sup>38</sup> See "Can Africa Claim the 21<sup>st</sup> Century, Summary", at <http://wbln0018.worldabnk.org/AFR/afr.n...DCE826CCD0852568F1006DBF2E?OpenDocument> pg3

while the debt burden will continue to escalate. Dependency will therefore become even more entrenched in SSA.

### **1.6 Hypotheses**

The following hypotheses guide this study,

1. Donors have not played a substantive role in fighting the HIV/AIDS epidemic in SSA
2. Governments in SSA do not have adequate capacity to cope with the HIV/ AIDS epidemic.
3. Success of donor funded HIV/AIDS projects depend heavily on the political good will of the recipient country.

### **1.7 Methodology of research**

The study utilized both primary and secondary data. In the primary data collection, information was gathered through direct interviews of representatives of donor agencies, NGOs national HIV/AIDS programmes and the general public. This was done using a structured interview schedule.

Secondary data was also collected from published and unpublished literature in form of conference papers, Sessional Papers, annual reports

and other works done on the HIV/AIDS problem in the world. The study also used survey data obtained through the questionnaires.

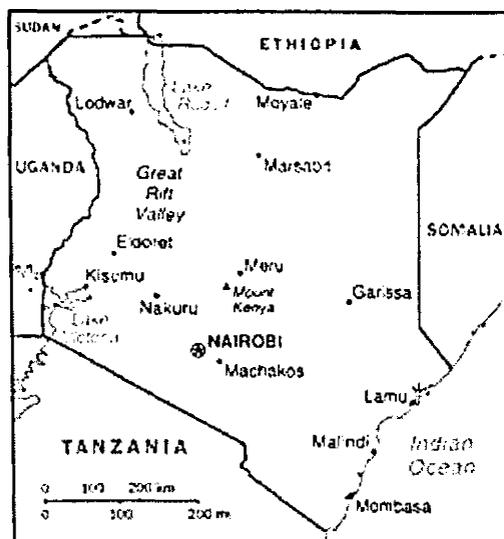
The data used in the study was drawn from Nairobi. Four different types of questionnaires were used in the study. One for the members of the public who included several categories of people including teachers, students, the self-employed, civil servants, university lecturers, and private sector employees. The second questionnaire was used to collect data from International aid agencies. A third structured questionnaire was administered to NGOs including officials of NASCOP and NACC.

## CHAPTER TWO

### THE HIV/AIDS SITUATION IN KENYA

#### 2.0 Introduction

#### 2.1 The Map of Kenya



Source: Internet

The HIV/AIDS problem in Kenya can be traced back to the late 70's or early 80's. Some sources cite that the first evidence of HIV/AIDS infection in Kenya was diagnosed in 1984<sup>39</sup>. In the neighboring countries of Uganda and Tanzania, the epidemic was reported earlier, with the first AIDS cases reported in 1983, in Tanzania and Uganda.<sup>40</sup>

<sup>39</sup> Source: NASCOP, AIDSCAP & Family Health International.

<sup>40</sup> See "HIV/AIDS" at <http://www.rki.de.GESUND/ARCHIV/IES/KENYA.HTM> pg 16, and "HIV/AIDS" at <http://www.easurf.org/kenya/hiv.htm> pg 1

**Table 2.1.0**

Reported AIDS cases in Kenya, 1986-1997

1986	1887	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
1	1299	2429	4749	7672	9554	11569	12204	8588	9133	6520	1036

*Source: WHO report on Kenya, 1998*

Table 2.1.0 shows a summary of the AIDS cases reported to WHO. Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a small portion of all cases in the country. Completeness of reporting varies substantially from one country to another, from less than 10% in some countries, with limited resources to more than 80% in most industrialized countries.

In Kenya not all AIDS cases have been reported for various reasons. For instance, many HIV/AIDS patients may not seek medical care in hospitals. In other cases, some doctors do not record a diagnosis of AIDS because of the stigma attached to HIV/AIDS because of the stigma attached it, while sometimes, people with HIV infection may die of other diseases, before they are diagnosed as having AIDS. The other most important reason is that most rural health facilities do not have the capacity to test for HIV/AIDS infection.<sup>41</sup>

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<sup>41</sup> See "AIDS in Kenya ..." op cit pg 3

However AIDS cases are only the tip of the pyramid. Many more people are infected with the HIV virus. In 1995 it was estimated that there were about 1,100,000 people infected with HIV in Kenya. This included about 1,030,000 adults and 70,000 children.<sup>42</sup> Most of these people did not even know that they had the virus.

As a result many AIDS cases have gone unreported and those that have been reported can only account for a small proportion of the total AIDS cases in Kenya. Due to lack of facilities as well as medical expertise, there is little information of the HIV prevalence in rural areas. There is evidence however that the total number of people infected is larger in rural areas than in urban areas, partly because 80% of the Kenyan population lives in the rural areas.<sup>43</sup>

In 1997 women accounted for an estimated 47% of the total number of adults living with HIV/AIDS in Kenya. Biological and social factors make women and girls more vulnerable to HIV/AIDS than men and boys. Studies have shown that HIV infection rates in young women can be 3-5 times higher than among young men.<sup>44</sup> There are several reasons for this. In the Kenyan society for instance, sexual exploitation of young women by older men sometimes occurs. This happens mainly due to lack

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<sup>42</sup> Ibid pg 3

<sup>43</sup> Ibid pg 8

of economic opportunities for women partly due to deep-rooted social-cultural practices and some aspects of the existing legal system. This has led to the dependence of women on men whose interests do not always coincide with women's need to protect themselves.<sup>45</sup>

Kenya's growth rate currently stands at 2.1%. The population is young with 46% under the age of 15. A growing body of research suggests that, a high proportion of Kenya's teenagers are sexually active, and this behaviour puts them at the risk of HIV/AIDS infection<sup>46</sup>. Consequently, the numbers of young people requiring reproductive health education and services have been increasing rapidly. The government's ability to provide these services has been inadequate. According to one study about 21% of pregnant women between the ages of 15-19 were HIV positive.<sup>47</sup>

A World Bank funded project carried out in 2000 revealed that, more than 14% of all adults in Kenya were infected with HIV/AIDS, with the prevalence rate exceeding 20% in some districts. Of the approximately 2.2 million infected Kenyans, 106,000 were children under the age of five years. Prevalence rate among young women was higher with 24% of

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<sup>44</sup> See "HIV/AIDS: A Rural Issue", at [http://www.fao.org/Focus/E/aids/aids\\_1-e.htm](http://www.fao.org/Focus/E/aids/aids_1-e.htm) pg 2

<sup>45</sup> See NASCOP, *AIDS in Kenya: Background, Projections, Impacts, Interventions*, 1996.

<sup>46</sup> See NASCOP, *AIDS in Kenya: Background, Projections, Impact Intervention*, 1999, pg 11

women aged between 15-24 being infected versus 4% of men in the same age group. Out of the estimated 500 people that died daily due to HIV/AIDS, 80% were aged between 15-49 years, the most economically productive.<sup>48</sup>

The same project put the economic loss incurred by the country at US\$3 million daily. Life expectancy also reduced from a projected figure of 65.4 years without AIDS for the periods 1995-2000 to an actual 54.7 years due to HIV/AIDS. The crisis was still far from being overcome.

**Table 2.1.1**

HIV prevalence among 15-19 year old young women and men in urban areas.

<b>Country</b>	<b>Women (in percentage)</b>	<b>Men (in percentage)</b>
Kenya (1997)	22	4
Zambia (1996)	24	6
Ethiopia (1994)	9	5

Source: WHO/UNAIDS 1998

Kenyan women have relatively limited access to good sexual and reproductive health. Out of every 100,000 pregnancies, 600 lead to deaths related to abortion or miscarriage. Although the ministry of health

<sup>47</sup> op cit pg2

<sup>48</sup> See "The Kenya-Kenya AIDS Disaster Response Project" at <http://www.worldbank.org/pics/pid/ke70920.txt> pg 2

has initiated several programs in response, services are unevenly distributed, especially in rural areas where most women live.

## **2.1 Main causes of HIV/AIDS**

### **2.1.0 Culture**

Some mechanisms to ensure women's access to land when widowed have contributed the spread of HIV/AIDS. For example the Luo custom that a widow be married by her late husband's brother. Other studies have shown that a widow who loses access to her husband's property can be forced into commercial sex as her only means of subsistence.

In some parts of Kenya, especially Nyanza province, unshakable beliefs and customs, worsened by ignorance have made communities assume that HIV/AIDS is not a new disease but "chira".<sup>49</sup> The issue of wife inheritance is also deep rooted among the Luo and has remained an obstacle to the campaign against HIV/AIDS.<sup>50</sup> This has contributed to the region being rated second after Mombasa for the number of HIV/AIDS cases.<sup>51</sup>

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<sup>49</sup> The Luo believe this to be a wasting ailment afflicting those who seriously violate societal norms or taboos.

<sup>50</sup> See Daily Nation 9/3/93, pg 6

<sup>51</sup> See Kenya Times 25/8/93, pg 14

The Maasai of the Rift Valley region on the other hand, look at HIV/AIDS as a consequence of bad omen caused by evil spirits. Many Maasai with AIDS also attribute their condition to a curse and seek purification from a laibon or witchdoctor. Along the Coastal belt the Digo and Giriama believe in jini (jinie). They blame serious illnesses on jinni sent by their enemies. This has greatly hindered efforts geared towards reducing the spread of HIV/AIDS.

The Kenyan, society, like most others in Africa does not discuss sexual matters whether in public or in private. This has been a major factor behind the rapid spread of the epidemic. Yet there is widespread evidence, as seen in the experience of Uganda's youth targeted publication *straight talk*, to show that open and honest discussion of sexual matters in the media helps reduce transmission of the HIV virus.<sup>52</sup>

Discipline and morality have been cited as the central issues that should be addressed in churches, mosques, schools and families in order to stop new infections.<sup>53</sup> Despite this fact, child marriages, initiation and surgical practices such as circumcision, teeth removal, ear piercing,

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<sup>52</sup> See M. Foreman, "An Ethical Guide to Reporting HIV/AIDS", in *Media & HIV/AIDS in East and Southern Africa: A Resource Book*, UNESCO, Panoply, 2000, pg 25

<sup>53</sup> Dr. Martin Kayo, Director of the National AIDS Control Programme, addressing a workshop

facial decorations through skin piercing that greatly endanger children when tools are contaminated are still being done.<sup>54</sup>

### **2.1.1 Vulnerability**

The other obstacles in the fight against HIV/AIDS, have been resource limitations, poverty, and harsh effects of structural adjustment programs on vulnerable groups such as widows and orphans. There has also been a rapid increase in the number of people developing HIV/AIDS and needing medical and social support, an overburdened NASCOP and lack of a clear policy framework to guide implementing agencies,<sup>55</sup> (the latter was a factor before 1997).

Another problem area is the incubation period. A person does not develop AIDS as soon as he or she becomes infected with HIV. The interval between infection with HIV to the onset of the disease AIDS is between 3 and 10 years. During this incubation period the person may not have any symptoms. Consequently there is evidence in Kenya of deliberate and intentional promiscuity by persons who are HIV positive. This has dealt a big blow on the prevention efforts in the country.

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<sup>54</sup> Dr. D. M. Owili, chairman of the national AIDS and STD Committee addressing a workshop as quoted in Daily nation February 10<sup>th</sup> 1995, pg 3.

<sup>55</sup> See "What Government's do" at <http://www.hivnet.ch:8000/africa/af-aids/viewR?284>

Additionally HIV/AIDS in Kenya is fueled by other factors such as, poor knowledge of HIV/AIDS. For example although 90% of Kenyans are aware of HIV/AIDS, there are misconceptions about how the virus is transmitted. In a study carried out in 1994 by the National Council for Population and Development (NCPD), most people interviewed believed that they could protect themselves from the virus. When asked how, 70-75% mentioned limiting the number of sexual partners. Only 35% of men and 20% of women mentioned the use of condoms and only 9% of men and 19% of women mentioned abstaining from sex.<sup>56</sup>

Another impediment in the fight against the scourge has been the high HIV/AIDS prevalence among sex workers. Various studies have shown that up to 75% of sex workers are HIV-positive. There is also high sexual mobility particularly along the Trans-Africa Highway. HIV prevalence is high among the truck drivers who use this highway. Studies also indicate that adolescent youth at the truck stops along the highway are at significant risk of HIV infection resulting from unprotected sex with the truck drivers.<sup>57</sup>

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<sup>56</sup> See AIDS in Kenya: Socioeconomic Impact and Policy Implications,, 1996, Family Health International AIDSCAP, pg 38.

<sup>57</sup> See "Kenya: Context of the epidemic", at <http://hivinsite.ucsf.edu/international/africa/2098.455c.html> pg 1

The HIV/AIDS epidemic began in Kenya at a time when the medical system was tattered by negligence, mismanagement and poor resource utilization.<sup>58</sup> Infact Kenya like many other African countries had several factors to account for the explosive HIV/AIDS situation. These are economic misery, patriarchy, culture, religion and inadequate health care resources.<sup>59</sup>

Kenya also lost an estimated 200 million pounds in desperately needed foreign currency in 1991, when the industrialized world decided to try and force political and economic reforms in the country by cutting aid. The country was therefore ill equipped to cope with the enormity of the HIV/AIDS crisis.

Another compounding problem is stigmatization and discrimination against people with HIV/AIDS and their children. This has been a serious issue in Kenya, and has caused personal pain and hampered efforts intended to respond to the needs of those infected and affected. The stigma and fear regarding HIV/AIDS hinders openness about

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<sup>58</sup> See Daily Nation 1/12/96, pg 13

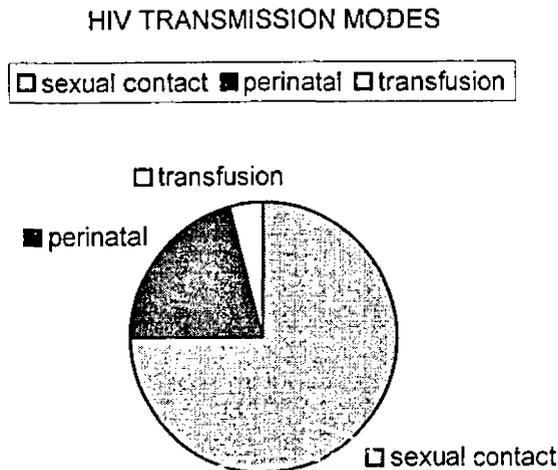
<sup>59</sup> See Barnet and Blaikie, 1992; Latham, 1993; Turshen, 1991, as quoted in D. C. Umeh ed. "Confronting the AIDS Epidemic: Cross-Cultural Perspectives on HIV/AIDS Education, Africa World Press, 1997.

HIV/AIDS, which tends to facilitate rapid and underground spread of HIV/AIDS.<sup>60</sup>

### 2.1.2 transmission

In Kenya there are mostly three transmission mechanisms (figure 2.0). These are heterosexual contact, perinatal transmission and blood transfusion. 10 - 15 % of infections are acquired through blood transfusions.

**Figure 2.0**



Source NASCOP, 1996

According to one study done on the blood supply in Kenyan blood banks in 1994, the results showed that the blood supply in Kenya at the time

<sup>60</sup> See Feature on The AIDS NGO Consortium in the Daily Nation 17/4/97, pg 18

was contaminated. The study evaluated all the blood donated in 5 government hospitals and Kenyatta National Hospital, between April and September 1994. When blood samples were retested for HIV at the US Center Disease Control and prevention (CDC) laboratories, using similar tests done in Kenya and confirmed by a more advanced test, it was found out that the Kenyan laboratory technicians missed a quarter of the infected blood, which had been all transfused as HIV negative.<sup>61</sup>

### **2.1.3 Poverty**

Poverty is a factor not just in the impact of AIDS but also in the spread of HIV. It deprives people of access to health facilities, schools and media. It limits the people's access to information and education about HIV. Poverty pushes families, often unaware of the risks, to send children into the workforce or hand them over to recruiters promising them jobs. More often than not these children are forced into harsh labour or sexual abuse, thus exposing them to HIV/AIDS.<sup>62</sup>

47% of Kenyans in urban areas and 29% of Kenyans in rural areas live in absolute Poverty. The Kenyan economy has nearly ground to a halt, employment opportunities have diminished, and the government and

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<sup>61</sup> See Study done by Dr. Guillermo Herera of the Federal Centre for Disease Control and Prevention (CDC) in the US, 1994 in Daily Nation 8/5/95, pg 6

<sup>62</sup> "HIV/AIDS: More than a Health Crisis", in HIV/AIDS Brochure, United Nations, New York, 1999, pg3

most companies have down sized in order to stay afloat. In addition, the quality of public health care has deteriorated sharply, and since the introduction of cost sharing in hospitals some poor people have been cut out of health care. These factors have been aggravated by HIV/AIDS. Consequently family structures and income security have been severely affected.

The fast spread of the HIV virus has also been blamed on ignorance, migration, civil wars, untreated STD's and socio-cultural practices.<sup>63</sup> At the end of 1999, Kenya's adult HIV prevalence rate was 13.95%, with 2.1 million adults and children living with HIV/AIDS.<sup>64</sup>

Even with this grim situation HIV/AIDS was still difficult to discuss and few people were willing to take tests. Those with HIV/AIDS were often treated like outcasts. "People die fast here, with less dignity than if they died from other diseases", said Dr. Christopher Ouma of Medecins sans frontiers (MSF) at Mbagathi Hospital in Nairobi, which receives many patients from the slum areas where MSF has projects. "People know what HIV/AIDS is and what it means. Most patients have just been abandoned."<sup>65</sup> It is therefore not surprising that most people do not

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<sup>63</sup> See EAS 2/12 96

<sup>64</sup> See "Kenya" at <http://hivinsite.ucsf.edu/international/africa/2098.455c.html>,pg 1

<sup>65</sup> See "Kenya Grappling With AIDS", in MSF International Activity Report, 2000.

consent to the HIV/AIDS test because they do not wish to find out their status, because of the stigma associated with it.

Despite these factors the campaign for condoms, as a device for protection against contraction of the virus was given the nod, in Kenya only in 1995 <sup>66</sup> after strong opposition both from the clergy and the head of state himself. The fact that this was done 11 years after the epidemic began contributed to the rapid rise in new infections.

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<sup>66</sup> See EAS 3/5/95

## CHAPTER THREE

### POLICY AND INSTITUTIONAL FRAMEWORK IN KENYA

#### 3.0 Introduction

The previous chapter discussed in detail the HIV/AIDS situation in Kenya highlighting the history of the pandemic, as well as the main causes of the problem in the Kenya. This chapter looks into the Kenya government's response to the pandemic, including the formulation of a policy framework.

Government response in the early years of the epidemic (80's) was inadequate partly because of the perceived threat to the tourist industry, the country's most important single foreign currency earner. At the time HIV/AIDS was not perceived as a serious problem for the country. Policy makers described it in the press as "a disease of westerners".<sup>67</sup>

Despite the awareness that HIV/AIDS (initially perceived to affect only the homosexuals) had moved into the heterosexual population, little efforts through a national AIDS committee attempted to address prevention and control issues. This was, however, too little too late and a mistake that proved fatal and similar to that made by Uganda prior to 1986. The efforts did not match the rate of infection.

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<sup>67</sup>See op cit pg 3

An AIDS Programme secretariat was established in 1985, with technical and financial support from WHO and Global Programme on AIDS (GPA), and renamed the National AIDS and STD Control Programme (NAS COP) in 1988. All major hospitals, both government and private, were required to report the number of HIV/AIDS cases diagnosed in their hospitals to the NAS COP on a monthly basis<sup>68</sup>.

Responsibility for managing the HIV/AIDS response however remained with the ministry of health. It raised the warnings about the consequences of the disease in Kenya, but since HIV/AIDS was still not seen as a priority then, inadequate resources were allocated to address the issue.

The ministry of health embarked on an extensive HIV/AIDS-education from 1990, centered on educating basic health providers and community leaders. Sex and HIV/AIDS education was given in mother tongues, alongside condom distribution. However this approach was not aggressive enough as evidenced by continued rise of HIV/AIDS infections

The public did not respond by changing sexual behavior. At the same time, influential religious leaders spoke out against the use of condoms

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<sup>68</sup>

as a mechanism for disease prevention. In 1995 Cardinal Otunga, then head of the Catholic Church in Kenya and Imam Ali Shee then of Jamia Mosque burnt condoms and sex education books before youth in Nairobi's Uhuru Park. They argued that condoms were a "western solution" that did not fit Kenya's situation, and was likely to encourage young people to engage in immoral sexual behaviour.

To date there are still mixed reactions from the clergy and members of the public, with regard to the campaign for condoms as a preventive measure against HIV/AIDS. This is the same reception that has met the proposal to have HIV/AIDS education in the syllabus in all schools in Kenya. These factors have hindered the fight against the pandemic.

A Short Term Plan (STP) was formulated in 1986 that mainly focused on the prevention of HIV by screening blood and promoting safer sex practices and early diagnosis of STDs.<sup>69</sup> Shortly afterwards, a few Non-Governmental Organizations (NGOs), and NASCOP with support from selected international donors began creating the required institutional infrastructure to confront HIV/AIDS.<sup>70</sup>

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See "Epidemiological Aspects of HIV/AIDS in Kenya", at <http://www.arcc.or.ke/nascop/epide.htm> pg 2

<sup>69</sup> See Joint United Nations Programme on HIV/AIDS in Kenya, July 1999

<sup>70</sup> Ibid, pg 4

The Kenya AIDS NGOs Consortium, the umbrella HIV/AIDS NGO organization, began using its networks to raise, debate and analyze policy issues. The business community also took a more active role in policy discussions about HIV/AIDS in the work place. Religious organizations also joined in the debate of issues that affected their followers.

The first medium term plan (MTP1) was developed in 1987 and lasted until 1991, in which AIDS became notifiable and all hospital cases were reported. So far two medium terms and a strategic plan have been formulated focusing on public awareness campaigns, strengthening laboratory services and establishing a HIV/AIDS surveillance system.<sup>71</sup> A multi-sectoral approach was now adopted in the fight against HIV/AIDS.

Kenya is said to have one of the best-established HIV/AIDS surveillance systems in SSA.<sup>72</sup> This system provides the basis for estimating the extent of HIV/AIDS infection. It operates in 13 urban sites and six peri-urban/rural sites around the country. These sites are all antenatal clinics, where pregnant women go for care during pregnancy, (Table

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<sup>71</sup> See G. Balthazar & B. Hagembe, "Kenya: Monitoring and Evaluating of HIV/AIDS programs", 1999, Carolina Population Centre, University of Northern Carolina Pg 3

<sup>72</sup> See "Africa, Major Countries: Kenya", in Family Health International AIDS Control and Prevention Project, Aug.21, 1991 to Dec.31 1997, Final Report Volume 2 Dec. 31, 1997, at <http://www.fhi.org/en/aids/aidschap/aidspubs/special/final/capfn21.html> pg 10

3.1.0). Each year, 200-400 pregnant women are tested for HIV in each site and the results reported to the NASCOP.

**Table 3.1.0**

Pregnant women testing positive for HIV in urban Kenya (in percentage).

Urban sentinel Sites	1990	1993	1995	1997	1999
Busia	17.0	22.0	22.0	30	34
Garissa	4.9	3.8	5.8	8.1	6
Kakamega	5.3	8.6	11.7	10.0	12
Kisii	1.6	2.5	4.3	16.0	12
Kisumu	19.0	20.0	27.3	34.9	27.0
Kitale	3.5	7.5	10.0	9.1	18.0
Kitui	1.0	2.0*	4.1	26.6	9.0
Meru	2.7	2.3	8.7	-	23.0
Mombasa	10.0	16.0	12.5	17.4	-
Nairobi	5.8	17.1	24.6	-	17.0
Nakuru	9.9	22.0	27.2	24.6	27.0
Nyeri	2.9	6.9	6.2	10.1	-
Thika	2.5	9.6**	19.6***	32.1	33

Source NASCOP 1996 and NACC, 2000

1992 data for Kitui \*\* 1991 data for Thika \*\*\* 1994 data for Thika

- data missing

Peri-urban (p/u) and Rural ®

**Table 3.1.1**

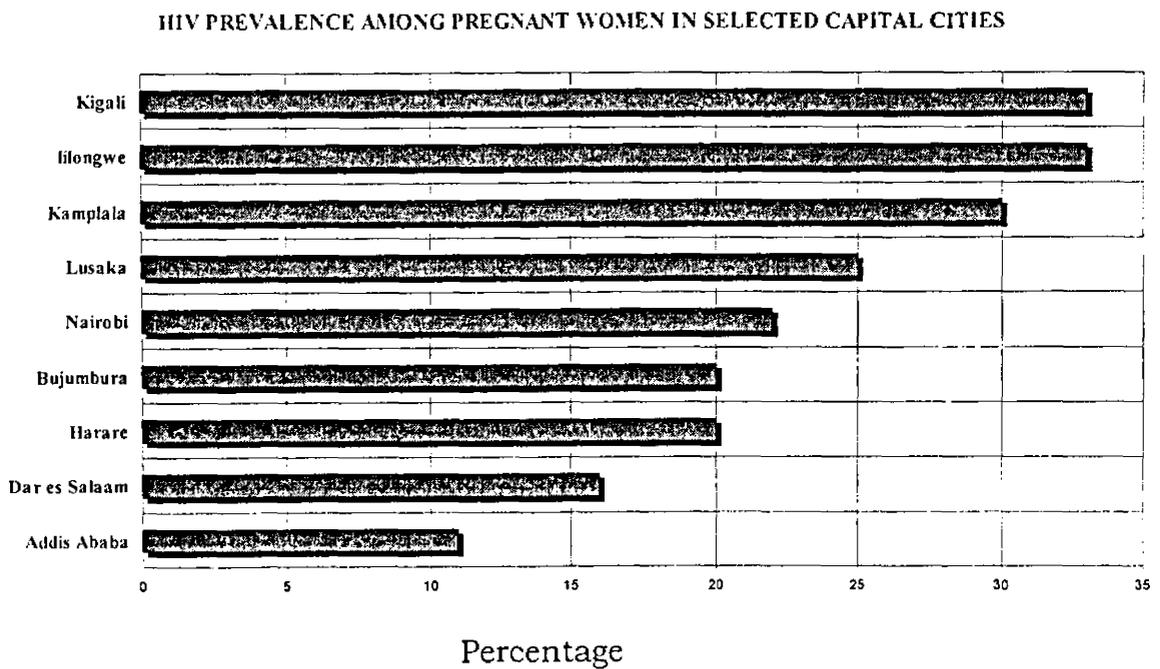
Pregnant women testing positive for HIV in rural Kenya (in percentage).

Sentinel sites	District	1994	1995
Karurumo ®	Embu	2.0	10.3
Maragua (p/u)	Muranga	7.0	12.7
Tiwi (p/u)	Kwale	12.2	24.1
Mbale (p/u)	Vihiga	11.9	10.7
Chulaimbo ®	Kisumu	49.4	21.8
Mosoriot ®	Uasin Gishu	2.0	12.5

Source: NASCOP, 1996

The number of women tested varies by year and by site. When the number tested is small, the uncertainty associated with the estimate is high. However, taken as a whole these results describe the extent of HIV/AIDS in some parts of urban and rural Kenya.<sup>73</sup> There were areas in urban Kenya where prevalence was almost 20 –30%. In other countries in the region urban HIV prevalence was even higher than in Kenya. (figure2.1). This may be due to one or a combination of two factors. These are, an earlier start of the epidemic in those countries and different behaviour patterns.

**Figure 3.0**



Source: NASCOP 1996

<sup>73</sup> See "AIDS in Kenya: Background...." op cit pg 7

District committees established in 1995 launched a program of targeting sexually transmitted infections (STI). AIDS care, was however limited, with patient support centers established at around 15% of government health facilities.<sup>74</sup> This was highly inadequate for the vast cases of HIV/AIDS patients across the country.

Like many parts of the world, Kenyan NGO's have led the way in providing care and prevention services for individuals and communities affected by the epidemic.<sup>75</sup> This has served to supplement government efforts. The Kenya AIDS NGO's Consortium was formed in 1990 by a group of NGO's and religious organizations that felt a need to network and unite to fight AIDS.<sup>76</sup>

The Consortium's main function has been to play a coordinating and facilitating role and to ensure smooth implementation of programmes by member NGO's. In 1995 the Consortium embarked on a policy project sponsored by Family Health International and AIDSCAP, in response to

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<sup>74</sup> See "Kenya....op cit

<sup>75</sup> See J. Mann & D. Tarantola, eds. "AIDS in the World II": Global Dimensions, Social Roots and Responses. Global AIDS Policy Coalition. New York: Oxford University Press, 1996 and W. Sittitrai, "Nongovernmental Organization and Community Responses to HIV/AIDS in Asia and the Pacific", AIDS 8 (suppl.2): S199-206.

<sup>76</sup> See "Country Overview", in Family Health International: Final Report, Volume 2, December 31, 1997, at <http://www.fhi.org/en/aids/aidschap/aidspub/special/final/capfn21.html> pg 11 and East African Standard of 16/4/1997 pg 20.

the need for the development of a supportive policy environment within HIV/AIDS prevention and care activities.<sup>77</sup>

### **3.1 Sessional paper**

Work began in 1994 on a parliamentary sessional paper on HIV/AIDS. The government was engaged in a two-year process of soliciting expert opinion, drafting and redrafting, and consensus building to produce a national policy. This was developed into the Sessional Paper on AIDS in 1997.<sup>78</sup>

The sessional paper was aimed at providing a policy framework within which AIDS prevention and control efforts were to be undertaken in the next 15 years and beyond. It represents a wealth of experience from individuals, technical experts, opinion leaders and experts in the area of HIV/AIDS. It was the government's response to the deepening impact of the epidemic on the Kenyan society.

It also outlines the strategies, interventions and appropriate organizational structure required for full implementation of programme activities, and identifies policy issues that need to be tackled to facilitate effective operations of the strategic plan.

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<sup>77</sup> Ibid EAS

With this the government was better placed to fulfill its obligations and show other actors the way forward. The policy on HIV/AIDS describes its stand on critical issues such as the HIV/AIDS situation, economic impact, socio-cultural issues, legal and ethical issues and the vulnerability of women, children, refugees and the youth.<sup>79</sup>

In addition, the 1994-1996 national development plan, and individual district plans included a chapter on the economic impact of HIV/AIDS and set out general statements to guide future actions. National leaders became more willing to discuss the HIV/AIDS than in the past.

To back up its policy development, the government signed an agreement with the World Bank for a loan for STD and HIV prevention and control programmes. The Ministry of Health launched a US\$ 44.5 million (Ksh 2.6 billion) project for the control and prevention of HIV/AIDS and other sexually transmitted infections (STI).

The STI project was a result of collaboration between the ministry and the World Bank through its lending arm. The International Development Association, (IDA) had given the ministry 40 million dollars credit. The

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<sup>78</sup> See Sessional Paper No. 4 of 1997 on AIDS in Kenya, Min. of Health

<sup>79</sup> See Sessional Paper No. 4 of AIDS in Kenya, 1997 as quoted in "What governments do" at <http://www.hivnet.ch:8000/africa/af-aids/viewR?284> pg 2

Overseas Development Association, ODA also gave the STI project \$12.5 million.

Other partners in fighting the scourge emerged such as the Kenya Churches AIDS network and Women Fighting AIDS in Kenya. Other non-health organizations began to take HIV/AIDS as an advocacy issue.<sup>80</sup> This was important because to achieve success in fighting HIV/AIDS as witnessed in Uganda and Thailand, a multi-sectoral approach was taken.

In November 1999, the Kenyan government declared HIV/AIDS a national disaster, and the president spoke openly and publicly for the first time about the necessity of condoms in the fight against HIV/AIDS.<sup>81</sup> This was a complete turn around from his previous stand, that condoms would promote promiscuity. However the HIV/AIDS situation was getting out of hand and fighting it had to be seen as a priority. Other countries like Uganda made HIV/AIDS a priority way back in 1986 and have since seen gains in their fight against the epidemic.

In April 2000, Kenyan health officials began distributing condoms in small market centers and towns, shifting the focus from large urban

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<sup>80</sup> See "The Policy Climate", at <http://www.fhi.org/aids/aidscap/aidspubs/serial/captions/v3-2/cp3214.html> pg2

centers. Changing people's behaviour was however difficult and even with such efforts some people in the high-risk bracket still did not use condoms. The female condom was introduced in Kenya, in May 2000 but studies done show only a 12% usage.

In the annual budget for the year 2001, the minister for finance announced a zero tariff on the importation of condoms. As the minister read his speech in parliament, there was laughter by the parliamentarians. This was an indicator that the individual members of parliament (the representatives of the Kenyan populace) have not taken the issue of HIV/AIDS seriously, yet 700 people are dying of HIV/AIDS daily. The zero tariff rate on condoms, however showed the government's commitment in helping its people to fight HIV/AIDS.

The government also announced in August 2001, that it would spend Ksh 300 million to import condoms. This did not augur well with the other sectors of the Kenyan economy that would have to suffer, for the government to realize such funds. However it is worth noting that this announcement was a clear indication that the government was now beginning to give priority to HIV/AIDS prevention efforts.

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<sup>81</sup> sessional paper op cit, pg 4

HIV/AIDS education, which had until then been banned from the curriculum, began in all schools and colleges in January 2000. The government also established the National AIDS Control Council (NACC) in accordance with the National AIDS policy. Its mandate was to coordinate a multi-sectoral response to the crisis. Nevertheless this was done late in the HIV/AIDS crisis, and the price paid was the big number of HIV/AIDS deaths that stood at 700 per day.

At the district and provincial levels, AIDS control committees were set up. In July 2000, the Vice-President announced the establishment of national AIDS control units throughout the country to assist the National AIDS Control Council develop policies to prevent the spread of HIV/AIDS and promote awareness with a view to advocating behavioral change.<sup>82</sup> These control units were however bogged down in controversy, particularly in regard to the control of funds allocated to the units. Such problems only delay the implementation of such units and the effectiveness of their advocacy.

### **3.2 Constraints**

The Kenyan government's health care budget for 1993 was US\$ 60 million, with 20% earmarked for HIV/AIDS prevention. Of this Kenya

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<sup>82</sup> See Daily Nation 8/1/00, as quoted in, "Kenya" *ibid*

could only contribute US\$ 77,000, while the rest came from foreign donors.<sup>83</sup> However the western pressure to reduce foreign assistance made this source unreliable in the future. In a bid to overcome this problem and curb the dangerous spread of the epidemic, the national leadership made a shift in attitude. President Moi and the vice president began to regularly address HIV/AIDS prevention.

HIV/AIDS, as noted earlier, is a very expensive disease that has overstretched the healthcare resources as well as the family budget. Although not all patients seek hospital care, the average length of stay in hospital is more than for most other diseases. In 1992, HIV/AIDS patients occupied 15% of all hospital beds and by 2000 about half of all hospital beds were occupied by HIV/AIDS patients.<sup>84</sup> This has been at the expense of provision of health services for all.

One of the worst impacts of HIV/AIDS deaths to young adults is an increase in the number of orphans. This has caused an increased burden on the extended family, which has the traditional mandate to care for the orphans. Many grandparents are left to care for young children, while some families are headed by children as young as 10-12 years old making them vulnerable to the HIV/AIDS virus.<sup>85</sup>

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<sup>83</sup> See HIV/AIDS op cit

<sup>84</sup> See "Aids in Kenya: Background..." op cit pg 29

<sup>85</sup> See Ibid pg 27.

At the community and national level there is an increased burden on the society to provide for these children in terms of orphanages, school fees and health care. This has led to an increase in street children, with a high prevalence of HIV/AIDS especially in the urban centers.

The HIV/AIDS epidemic has severely hit the Kenyan workforce at its prime. Many of the victims are in their 20's and 30's, their most productive years, when they develop AIDS symptoms and begin to fall ill. This has resulted in rising costs to Kenyan companies. They also suffer sharp profit losses as a result of loss of workers, and decreased working hours due to ill health, over work and stress, funeral attendance and home care of ill dependants.<sup>86</sup>

It is estimated that HIV/AIDS will cause the highest total production loss in agriculture, a sector that employs 80% of the Kenya's labour force. Medical and funeral costs today greatly exceed budget provisions. Terminal benefits, retraining and replacement measures also have expenses incurred by the epidemic.

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<sup>86</sup> See "HIV/AIDS and the Commercial Agricultural of Kenya: Impact, Vulnerability, Susceptibility and Coping Strategies", at <http://www.fao.org/sd/Exdirect/Exre0026.htm> pg2

## CHAPTER FOUR

### AN ASSESSMENT OF INTERNATIONAL AID AGENCIES AND NGOs.

#### 4.0. Introduction

The last two chapters have discussed the situation of the HIV/AIDS problem in Kenya and the government's response. This chapter will focus on the international intervention and its impact. The chapter begins by discussing the global strategy, before narrowing down to international intervention in Kenya.

The global strategy for the prevention and control of AIDS was initially drawn by WHO in 1986-1987 and unanimously approved by the World Health Assembly (1987), the Venice Summit of the Heads of States and government (June 1987) and the United Nations General Assembly (October 1987). It has since served as the main policy framework for the response to the pandemic.

The three main objectives of the strategy are; to prevent HIV infection, to reduce personal and social impact of HIV/AIDS and to mobilize and unify national and international efforts against AIDS.

Later the joint United Nations Programme on HIV/AIDS (UNAIDS), an international organization, was created specifically to address the HIV/AIDS pandemic. It was established as an independent UN agency on

January 1, 1996. It brings together the efforts of five UN organizations: UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank. The primary focus of UNAIDS has been to strengthen the capacities of national governments for an expanded response to HIV/AIDS.<sup>87</sup>

So far the US Government is the largest bilateral donor to HIV/AIDS development Assistance, providing over one billion dollars in more than seventy-five developing countries during the past eleven years. In July 1999, the US administration proposed a one hundred million dollars Leadership and Investment in Fighting an Epidemic (LIFE) initiative to fight AIDS around the world.

LIFE focuses on fifteen target countries, which are most severely affected by the problem and with the greatest number of new infections. An additional one hundred million dollars was appropriated in the fiscal year 2000 for a total of two hundred and twenty five million dollars for global HIV/AIDS assistance. This accounted for nearly half of the multilateral and bilateral overseas development funding for HIV/AIDS.<sup>88</sup>

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<sup>87</sup> See "Role of International Organizations", in 1999 U. S. International Response to HIV/AIDS, at [http://www.state.gov/www/global/oes/health/1999\\_hiv\\_aids\\_rpt/ios\\_role.html](http://www.state.gov/www/global/oes/health/1999_hiv_aids_rpt/ios_role.html) pg 1

<sup>88</sup> See "The US Government and Global HIV/AIDS" at [http://www.usembassy.it/file2000\\_1/italia/a0113014.htm](http://www.usembassy.it/file2000_1/italia/a0113014.htm) pg 1

**TABLE 4.1.0**

Global and SSA HIV/AIDS estimates, December 1998.

	<b>SSA</b>	<b>Global</b>
New AIDS deaths	2 million	2.5 million
Child HIV Infections	0.53 million	0.59 million
Child AIDS deaths	4 million	4.4 million
Child AIDS infections	3million	3.4 million
New HIV infections	4 million	5.8 million
People living with HIV	22.5 million	33.4 million
AIDS deaths	11.5 million	13.9 million
HIV infections	34 million	47.3 million

*Source: UNAIDS, December 1998*

A total of 5.8 million people were newly infected with HIV/AIDS by December 1998. This figure is alarming considering that these people are likely to infect others before they finally succumb to HIV/AIDS. SSA carries the burden of the majority HIV/AIDS deaths and infections. A total number of 33.4 million people were living with HIV/AIDS by the end of 1998. Most of these people are in the productive age group. Their eventual death will affect not only labour, but also the family unit. AIDS had caused the deaths of 4.4 million children by 1998, while the total number of infections since the beginning of the epidemic stand at a staggering 47.3 million.

**Table 4.1.1**

Regional HIV/AIDS Statistics and features, December 1999

Region	Epidemic started	Adults & Children living with HIV/AIDS	Adults & Children Newly infected with HIV/AIDS	Adult prevalence rate (*)	Percentage of HIV positive adults who are women	Main model(s) of transmission (#) for adults living with HIV/AIDS
Sub-Saharan Africa	Late 1970's-early 1980's	23.3 million	3.8 million	8.0%	55%	hetero
North Africa & Middle East	Late 1980's	220,000	19,000	0.13%	20%	IDU, Hetero
South & South-East Asia	Late 1980's	6 million	1.3 million	0.69%	30%	Hetero
East Asia & Pacific	Late 1980's	530,000	120,000	0.068%	15%	IDU, Hetero, MSM
Latin America	late 1970's-early 1980's	1.3 million	150,000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late 1970's-early 1980's	360,000	57,000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early 1990's	360,000	95,000	0.14%	20%	IDU, MSM
Western Europe	late 1970's-early 1980's	520,000	30,000	0.25%	20%	MSM, IDU
North America	late 1970's-early 1980's	920,000	44,000	0.56%	20%	MSM, IDU
Australia & New Zealand	late 1970's-early 1980's	12,000	500	0.1%	10%	
Total		33.6million	5.6million	1.1 %	46 %	

\* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers.

# MSM (sexually transmission among men who have sex with men), IDU (transmission through injecting drug use, Hetero (heterosexual transmission)

Source: UNAIDS/WHO, AIDS Epidemic Update, December 1998

Table 4.1.2 shows the HIV/AIDS statistics in the different regions of the globe. The epidemic began in the late 70's in SSA, Latin America, the Caribbean, Western Europe, North America, Australia and New Zealand. Out of these regions SSA has the highest adult prevalence rate, of 8%.

The main mode of transmission in adults is heterosexual transmission. Australia and New Zealand had the lowest number of adults and children living with HIV/AIDS, by December 1999.

In Africa the AIDS crisis has reached staggering proportions. Six thousand Africans are dying daily, making it the worst infectious disease calamity since the plague of the Middle Ages. More people will die in Africa over the next decade than those who have died from all the world's wars of the 20<sup>th</sup> century.<sup>89</sup>

#### **4.2 International Intervention**

Numerous donors including United Nations Agencies, governments, international private voluntary organizations and NGOs have been supporting HIV/AIDS prevention and care activities, as well as other measures. This intervention was however late and always short of what was required to tame the epidemic. Although funding has been increasing with time, it has not moved with the pace of the epidemic.

UNAIDS estimates that it will take \$3 billion to establish effective AIDS prevention programs in Africa. This is about the amount spent on

healthcare in the US daily<sup>90</sup>, an indication that the amount can be realized, if it was made a priority. Yet the devastation caused by the epidemic poses a clear and direct challenge to long term US economic and security interests.

There is evidence to show that HIV/AIDS is devastating whole societies and economies, depriving countries of the educated and skilled individuals required to build democratic governments, professional militaries, and free market economies.<sup>91</sup> The Current contributions from donor nations however, equal to about only one tenth of this amount.<sup>92</sup>

USAID is the US government agency that provides development and humanitarian assistance worldwide. It has HIV/AIDS programs in 21 countries in Africa, as follows;

**Table 4.1.3**

<b>Country</b>	<b>2000</b>	<b>2001</b>
Angola	\$1.0	\$1.5
Benin	\$1.0	\$2.0
DRC	\$1.5	\$3.5
Eritrea	\$0.5	\$1.5
Ethiopia	\$6.7	\$8.2
Ghana	\$4.0	\$4.5
Guinea	\$1.7	\$2.2
Kenya	\$5.7	\$10.5

<sup>89</sup> See "Intensifying Action Against HIV/AIDS In Africa...." Pg 5

<sup>90</sup> See "AIDS in Africa: A generation at risk", Church World Service, 2000

<sup>91</sup> See E. Barks-Ruggles, "Meeting the global challenge of HIV/AIDS", Policy Brief, Brooking Institution, April 2001

<sup>92</sup> See "AIDS in Africa ..." pg4

Madagascar	\$0.8	\$1.5
Malawi	\$5.0	\$7.3
Mali	\$2.5	\$3.2
Mozambique	\$5.1	\$6.7
Namibia	\$1.0	\$1.5
Nigeria	\$6.8	\$11.9
Rwanda	\$3.5	\$5.2
Senegal	\$3.7	\$4.7
South Africa	\$5.7	\$9.5
Tanzania	\$6.0	\$7.5
Uganda	\$6.9	\$13.5
Zambia	\$7.0	\$13.0
Zimbabwe	\$5.0	\$6.5
Other USAID funds	\$32.8	\$48.4
Total	\$113.9	\$174.4

Source: USAID fact sheet, 2001

In 2001, USAID's HIV/AIDS budget nearly doubled in four countries, Kenya, Nigeria, Uganda and Zambia. However it is not clear what criteria was used for the increment in funding, because countries like South Africa and Zimbabwe had higher HIV/AIDS prevalence rates, than those countries whose funding was doubled.

#### Table 4.1.4

The International Planned Parenthood Federation (IPPF) had the following donors during the months April – June, 2000

Core source		Restricted source	
Denmark	\$5,138,086	DFID	\$11,070
Sweden	\$4,498,192	Schering	\$18,055
Australia	\$908,205	Kleinwort Trust	\$ 45,600
Barbados	\$4,000	National Lottery	\$135,306
Switzerland	\$575,374	ASPFES	\$12,085
		UNFPA	\$30619

Source: Newsletter for Donors, vol. 2, Issue 3 July 2000

It is evident that the amount of money coming from the core sources is not substantial, even when combined with the amounts from the restricted sources (table 4.1.4), it still falls short of the required amount.

It is important to note that the \$3 billion would only establish effective HIV/AIDS prevention programs in Africa and not set up an infrastructure to check, control, and stop the spread of the epidemic or get a cure for the sick. All these would hence require much more money.

Yet the total amount spent on HIV prevention in SSA (excluding South Africa) in 1999 was \$165 million from all sources. Estimates now suggest that sums in the order of \$2.5 billion are needed for prevention alone. This excludes the cost of care.<sup>93</sup> On its part the epidemic is developing differently from country to country and from region to region, depending on local morals and customs. Studies done have shown that the main cause of its rapid spread in developing countries is underdevelopment.<sup>94</sup> UNAIDS has noted almost with resignation that in many parts of SSA, the epidemic is out of control<sup>95</sup>

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<sup>93</sup> See "HIV, TB and Malaria: Three Major Infectious Disease Threats", at <http://www.who.int/inf-fs/en/back001.html> pg2

<sup>94</sup> See "AIDS as a development obstacle: A Trans-Sectoral Subject of Development Cooperation" in pg 15

<sup>95</sup> op cit pg 14

**Table 4.1.5**

Donor funding, 1996.

<b>Source</b>	<b>Amount</b>
United States	\$117 million
European Union	\$55 million
Japan	\$40 million
World Bank	\$45 million

*Source: World Bank 1997*

The total amount of donor funding for AIDS was estimated at approximately \$300 million in 1996. The largest contributors of new funds in form of grants in that year was US (\$117 million); the European Union (\$ 55 million) and Japan (\$ 40 million) provided the next largest amounts of grant funding, and the World Bank provided approximately \$ 45 million in new loan commitments that year, most of which was at concessional rates.<sup>96</sup>

### **4.3 Foreign Funding**

The World Bank and UNAIDS estimate that for a basic level of prevention, care and treatment in seventeen SSA, \$1.4 billion is required over the next 5 years. This is exactly the amount that these same countries still have to pay in debt service after the Heavily Indebted Poor Countries Initiative (HIPC).

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<sup>96</sup> Ibid pg 242

According to African Development Indicators 2001, two important sources of finance, foreign direct investment (FDI) and official aid had declined in size and tended to favour those countries with lucrative mining and oil industries in the case of FDI, or countries with sound social and economic policies in the case of aid.<sup>97</sup> Most countries in SSA do not fall into any of these categories.

Of the US\$ 2.52 billion in FDI that flowed into SSA during the 1990's, three countries received a large proportion of the total. These are Angola, (US\$ 626) million, Lesotho (US\$ 170 million), and Nigeria, (US\$ 876 million). Five other countries received another US\$576 million, i.e Republic of Congo, Cote D'Ivoire, Equatorial Guinea, Namibia and Sudan. The remaining 40 countries had to compete for a paltry US\$ 275 million in annual FDI flows.

Official aid followed a similarly selective trend over the same period, and declined in terms of total volumes. Total aid in 1999 amounted to US\$10.8 billion compared to US\$17.9 billion in 1992 when development assistance to SSA reached its highest levels.<sup>98</sup>

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<sup>97</sup> See "Africa: Growth Slowing", at <http://www.africapolicy.org/docs01/wbo102.htm> pg 3

<sup>98</sup> Ibid

As a result of this decline, the latest data shows that some 300 million Africans live on barely 65 cents a day. The average GNP per capita in the region is US\$ 492, but in 24 countries GNP per capita is under US\$ 350, with the lowest incomes found in Ethiopia (US\$ 100), the Democratic Republic of Congo (US\$ 110), Burundi (US\$ 120) and Sierra Leone (US\$ 130).<sup>99</sup>

African countries also carry an exceedingly heavy debt burden in addition to HIV/AIDS. A staggering 227 million pounds debt burden remains a pervasive obstacle to Africa's capacity to address HIV/AIDS. This is because payment of debt has diverted scarce foreign exchange from the fight against poverty and HIV/AIDS.<sup>100</sup>

The United Nations estimate that if debts in SSA were cancelled, the lives of seven million children a year could be saved.<sup>101</sup> However studies done have shown that despite this scenario, funding for HIV/AIDS in SSA has been declining even as the epidemic continues to worsen.

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<sup>99</sup> Ibid

<sup>100</sup> See "Press Conference by UNAIDS", at <http://www.un.org/news/briefings/docs/2001/unaidspc.doc.htm> pg3

<sup>101</sup> See "Drop the Debt Briefing", at <http://www.dropthedebt.org/background/africatour1602.shtml> pg1,2 &3

#### 4.4 Global strategy

The Abuja Declaration on HIV/AIDS and other infectious diseases signed by African leaders, at the end of a two-day summit in April 2001 represented the strongest, concerted gesture made so far to confront the continent's biggest health emergency.<sup>102</sup>

International commitment was demonstrated at the summit, towards forming a partnership with Africa to halt the march of HIV/AIDS, tuberculosis and other infectious diseases on the continent. As the UN secretary general summed it up;

“The war on AIDS will not be won without a war chest of a size far beyond what is available so far. Money is needed for education and awareness campaigns, for HIV tests, for condoms for drugs, for scientific research, to provide care for orphans, and of course improve our healthcare systems”.<sup>103</sup>

Other commitments which had been made at the Okinawa summit of G8 countries in July 2000 and a subsequent health experts meeting in December 2000 in Okinawa, led to improved prospects for confronting HIV/AIDS and infectious diseases in SSA countries.

New financial mechanisms were sought for increasing the flow of resources to developing countries. Consensus gradually emerged that a

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<sup>102</sup> See “A global AIDS and Health Fund”, at [http://www.un.org/ga/aids/ungasfactsheets/html/fsfund\\_en.htm](http://www.un.org/ga/aids/ungasfactsheets/html/fsfund_en.htm)  
pg 8

single fund with an initial focus on HIV/AIDS, tuberculosis and malaria would be the best starting point.<sup>104</sup>

The efforts to create the fund received a huge boost when UN secretary General Koffi Annan called for the establishment of a global AIDS and Health Trust Fund, of between US\$ 7-10 billion at the organization of African Unity (OAU) summit in Abuja in April 2001.

In June 2001 representatives from more than 50 countries, multilateral bodies and NGOs, private foundations and other stakeholders met for the first consultation on the fund. The fund would however, not be limited to HIV/AIDS or the purchase of drugs.<sup>105</sup>

There were fears that the sum might be considered too much by the wealthier countries. However, they were quickly dispelled by former US President Bill Clinton, who gave his backing to the UN secretary general's proposals.

“Today it is Africa that is the epicenter of the AIDS problem. But if we don't turn the tide, in the next decade it may be India or China or the former Soviet Union where it is spreading at the highest rates.” Clinton said in his address to the summit.<sup>106</sup>

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<sup>105</sup> Ibid

<sup>104</sup> Ibid pg6

Calling on governments and donors to contribute to the fund the secretary General said,

“We must give hope to those infected with HIV, enabling them to plan for life instead of preparing for death and we must give hope to humanity – hope that the spread of the disease can indeed be halted and reversed, and that future generations will not have to live under its shadow.”<sup>107</sup>

In accordance with the Secretary General Annan’s recommendation, first year funding should be US\$ 10 billion. New US contributions were expected to total US\$ 2 billion. Other G8, OECD governments and multilateral agencies were to provide an additional \$6 billion, with the balance supplied from foundations such as the Bill Gates Foundation and other private sources.<sup>108</sup>

Initial contributions totaling over US\$ 400 million, were pledged by France, the United Kingdom and the United States, as well as by Credit Suisse, the International Olympic Committee and individuals including the Secretary General himself, who donated the proceeds of the Philadelphia Liberty Medal he was awarded in July, 2001.

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<sup>105</sup> See Ibid & “Critical Issues Surrounding an International Fund for HIV/AIDS and Other Infectious Diseases”, at <http://www.cptech.org/ip/health/fund/criticalissues.html> pg 1

<sup>106</sup> See ‘A global Aids ...’op cit pg8

<sup>107</sup> See “HIV/AIDS Africa Related Articles: May 2001”, at <http://www.medguide.org.zm/aids/aidsafr9.htm>

pg6

<sup>108</sup> See “Critical Issues Surrounding an International Fund...”, op cit pg 1

The fund would have an independent governing body and would serve as an innovative partnership between developing countries, donors and the multilateral system.<sup>109</sup>

Mr. Wolfensohn, World Bank president noted that, since the global gross domestic product stands at \$30 trillion, there was plenty of money for the global fund if it was made a priority.

“Worldwide, perhaps \$2 billion is being spent to fight AIDS now. To make up the difference, people have to be convinced that fighting AIDS is not a matter of charity but of self-interest. They need to see that AIDS is not a problem for Africa alone, but a global problem. They need to understand the new reality that if AIDS is not dealt with, it could affect every person in terms of earnings and health.”<sup>110</sup>

In the same conference, Peter Piot, the UNAIDS director, added that additional monies would come from developed countries, debt relief, regular bilateral and multilateral channels.

#### **4.5 Role of NGOS**

International NGOS work to educate the media, private sector, development organizations, and multilateral and bilateral organizations and others about the importance of international HIV/AIDS prevention

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<sup>109</sup> Ibid pg 2

<sup>110</sup> See Press Conference by UNAIDS op cit pg 1

efforts. They also create linkages with other health programs, domestic HIV/AIDS organizations and advocacy institutions.<sup>111</sup>

NGOS prevention programs target the population as a whole, as well as groups most vulnerable to HIV/AIDS. They engage in HIV/AIDS behavioural prevention strategies that traverse several levels of impact, highlighting best practices and exemplary behaviour change programs.<sup>112</sup>

At the country level NGOs develop programs that complement those of other donors. For instance, NGOs collaborate with the world Bank on specific technical areas such as STI research, and work jointly with UNAIDS and WHO on the development of guidelines for behavioural data collection needs of national HIV/AIDS/STI programs.<sup>113</sup>

In Kenya, NGOS, both local and international have been actively involved in the fight against HIV/AIDS. The local NGOS operate under the umbrella of KANCO, which serves to coordinate their efforts.

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<sup>111</sup> See "Role of International NGOS", Bureau of Oceans and International Environmental and Scientific Affairs, 1999

<sup>112</sup> Ibid

#### 4.5 Intervention in Kenya

HIV/AIDS has for the past twenty years plagued the globe unabated. At first its impact was hardly felt because it occurred in isolated cases. The scenario in Kenya was no different. However towards the end of the twentieth century there was cause for alarm. The developed world was however able to check and control the spread of HIV/AIDS. Not so for less developed countries, particularly those in SSA. In Kenya, the scourge has spread uncontrollably reducing not only the lifespan of the people but years of hard earned development.

Although HIV/AIDS is now a prominent feature of the international community's agenda, HIV/AIDS related assistance was late in coming. Most SSA countries welcomed the prospect of greater assistance while others like Kenya were still reluctant to admit the scope of the problem.<sup>114</sup>

The World Bank began funding HIV/AIDS related projects in 1986 and currently has three freestanding HIV/AIDS projects in SSA (Kenya, Uganda and Zimbabwe).<sup>115</sup> The British government in 1999 agreed to

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<sup>113</sup> Ibid

<sup>114</sup> See "AIDS may be Most Serious Health Threat in recorded history", US department of State, 2001.

<sup>115</sup> See *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*, Africa Region, The World Bank.

spend \$10m on AIDS prevention and Control in Kenya.<sup>116</sup> Through its development aid budget, Britain provides millions of condoms to dispensaries and family groups.

The Danish embassy in Kenya donated 7.5 million shillings to the Ministry of Health and several NGOs to be used in the AIDS control campaign in 1994. The Ministry spent 4.5 million shillings on brochures, booklets, t-shirts, newspaper supplements and advertisements about the dangers of HIV and AIDS. 1.1 million was given to UNICEF for the booklets to be distributed to the NACP's in specific areas in Kenya. UNDP received Ksh 400,000 shillings for consultancies and meetings. The money was disbursed under a special package administered by DANIDA health team.<sup>117</sup>

The World Bank in 2000 disbursed US\$ 50million for fighting the scourge in Kenya. 60% was to be directly injected into some 200 community based structures.<sup>118</sup> The remaining amount was to be disbursed to the health ministry to create awareness and invest in contraceptive use to reduce the high prevalence rate, especially among the reproductive segment of the population.

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<sup>116</sup> Please refer to BBC news/Africa/Moi: AIDS a 'national disaster', at [http://news.bbc.co.uk/1/hi/english/world/africa/newsid\\_538000/538071.stml](http://news.bbc.co.uk/1/hi/english/world/africa/newsid_538000/538071.stml).

<sup>117</sup> See Kenya Times 2/12/94, pg 28

The United Nations Development Programme (UNDP) in 2001 launched a Ksh 3.9 billion initiative to combat AIDS at the work place.<sup>119</sup> The programme was to be spearheaded by the Federation of Kenya Employers and other private sector implementing agencies. It was aimed at creating awareness among employees and employers, and creating effective workplace based HIV/AIDS prevention and care policies in companies.

Kenya's first conference of people living with HIV/AIDS, sponsored by UNAIDS and the Kenya's National AIDS Control Council, was held in August 2000.<sup>120</sup> The conference was useful in bringing together HIV/AIDS experts, policy makers and people living with HIV/AIDS as well as those affected by HIV/AIDS. For the first time since the epidemic began, in Kenya, people with HIV/AIDS spoke and revealed their status to the public. This broke the silence that had for a decade entrenched itself in people in relation to HIV/AIDS, and gave HIV/AIDS a human face

The European Union through International Planned Parenthood Federation (IPPF) made funds available this year to the three East African countries, to support youth initiatives targeted at the rapid spreading

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<sup>118</sup> See T. Okoko, "AIDS digs deeper into Kenya's Corporate Profits", August 22, 2000, MISAnet/Pan African News Agency. pg1

<sup>119</sup> See "*AIDS Initiative Launched: Sh3.9b Project Targets Workers*", by Mike Mwaniki, in the Daily Nation, 20<sup>th</sup> January 2001 pg 3

pandemic of HIV/AIDS. Kenya, Ethiopia and Tanzania will share US \$ 1.4 Million over the next two years to involve young people in discussing the epidemic with their parliamentarians and community leaders, and to develop their own communication initiatives to inform other young people about HIV/AIDS and its prevention.<sup>121</sup>

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<sup>120</sup> See "Kenya: Context of the Epidemic", at <http://hivinsite.ucsf.edu/international/africa/2098.455.html>.

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<sup>121</sup> See, Newsletter for Donors Volume 2 Issue 3, pg1

## CHAPTER FIVE

### TREATMENT AND DRUG ACCESSIBILITY

#### 5.0. Introduction

After discussing international intervention in the previous chapter, this chapter delves into the issue of HIV/AIDS available treatment as well as the people's accessibility to life prolonging HIV/AIDS drugs. It begins by looking at the disease and how it manifests itself in the human body.

HIV is a fatal disease, that has no visible effects on the infected person during an asymptomatic period which can be as short as two years, or as long as 20. Although the average time without symptoms is ten years in industrial countries, limited data suggests that it might be as short as five years among the poorest people in SSA.<sup>122</sup>

In all but a small proportion of the cases, the disease destroys the immune system, leaving the infected person vulnerable to other infectious diseases.<sup>123</sup> Although tests are available to indicate whether an individual has contracted HIV, they are not widespread in many parts of Africa. Many people here only discover that they have contracted the virus, when they fall ill with an opportunistic infection, which may not

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<sup>122</sup> D. Moulder, "Disease Progression and Mortality Following HIV-1 Infection", in J. Mann & D. Tarantola, eds., *AIDS in the World 11: Global Dimensions, Social Roots and Responses*. The Global AIDS coalition, New York: Oxford University Press, 1999.

respond to regular treatment. Others learn of their status when a recently born child falls ill.<sup>124</sup>

Because the virus can be transmitted from mother to child, diagnosis of HIV/AIDS in the infant confirms that the mother, and probably the father are HIV-positive – living with the virus. Without treatment, and with their immune system weakened, they will fall ill and eventually die.<sup>125</sup>

In industrialized countries, a few countries in Latin America, and Thailand, many people who test positive for HIV/AIDS have access to a combination of anti-retroviral therapy, which reduces the amount of HIV in the body and delays the onset of HIV/AIDS. In other countries combination anti-retroviral therapy is also used, but by a very small proportion of HIV infected people. Such therapies are expensive, hard to administer and require regular medical monitoring. Most African countries do not have the medical infrastructure for this sophisticated monitoring.

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<sup>123</sup> "Confronting AIDS : Public priorities in a Global Epidemic", A World Bank Policy Research, 1997, pg 17

<sup>124</sup> See "Introduction", in *Media and HIV/AIDS in East and Southern Africa: A resource Book*, UNESCO, 2000, pg4

<sup>125</sup> Ibid

Combination therapy with at least three anti-retroviral drugs was introduced in 1995 and became widespread in 1996. While it is not known how long these therapies will prolong life, and while it is clear that they do not work for everyone, their use is already having a visible impact on HIV/AIDS incidences and mortality. Apart from these drug cocktails that enable a person to have a prolonged life with the disease, HIV/AIDS has no cure so far.

### **5.1 Treatment**

HIV/AIDS requires two types of treatment – antiviral (also known as retroviral) therapy, which combats the HIV itself, and treatment for opportunistic infections. Antiviral drugs are not a cure for HIV, but when administered in conjunction with regular monitoring of the individual's health, they reduce AIDS to a long-term manageable disease for many people.<sup>126</sup>

By mid 1999, 15 antiviral drugs had been approved by the US Food and Drug Administration (FDA) and a similar number were on trial. HIV antiviral is generally divided into three types, nucleoside analogues, non-nucleoside reverse transcriptase inhibitors and protease inhibitors. Treatment with only one type of antiviral such as zidovudine (commonly

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<sup>126</sup> Ibid pg 8

known as AZT) is generally not effective. It is combination therapy, a combination of drugs sometimes known as a cocktail, which prevents the virus from replicating. This combination may include up to 20 pills a day, which must be taken at specific times, before, during or after meals, depending on the drug.<sup>127</sup>

The drugs can have powerful side effects, such as anemia, and not everyone responds well to them. People who take the numerous drugs have to stick to a rigid regime, but they have been known to reduce the virus and rebuild the immune system. In some cases the virus has been reduced to undetectable levels. However, doctors say it is too early to say yet how long they will last.

Ensuring that patients receive the right antiviral treatment depends not only on the ability to pay for the drugs, but also on access to doctors with equipment to measure the extent of viral activity and the body's immune response. This information confirms whether the current combination is working or whether another combination should be tried.<sup>128</sup>

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<sup>127</sup> Ibid

<sup>128</sup> Ibid

With half of Kenya's population earning \$1 a day, the cost of the big company anti-retroviral drug cocktails, sometimes \$ 4000 a year, is beyond the scope of all but the very wealthy not just in Kenya but across Africa. Subsequently although 2.2 million Kenyans are HIV positive, less than 2000 receive anti-retroviral treatment, which has helped reduce HIV/AIDS deaths by 75 percent in the developed world.<sup>129</sup> Qualified doctors and the required equipment can only be found in a few hospitals in the country. In Kenya most HIV/AIDS patients only receive treatment for opportunistic diseases. Some, especially in the rural areas cannot even afford the medications and often succumb to the opportunistic diseases.

The Durban international AIDS Conference (2000) put into the spotlight the issue of affordability of essential medicines. Studies and statistics presented at the conference show that a key factor in determining the cost of a particular drug is the patent on it. Of the 50% patients in developing countries who lack access to essential drugs, many die because the drugs are patented and are therefore too expensive. These patented drugs include treatment for tuberculosis, HIV/AIDS as well as the Hepatitis-B vaccine.<sup>130</sup>

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<sup>129</sup> "Battle for cheap drugs moves to Kenya", Reuters, 2001, pg2

<sup>130</sup> C. Oh., TRIPS and Pharmaceuticals: A Case of Corporate Profits over Public Health., Global Policy Forum, 2000, pg 1

The rich countries of the west have been accused of hindering the fight against HIV/AIDS in the developing countries. Medecins Sans Frontieres (MSF)<sup>131</sup> say, that they have done this by forcing poor countries to buy expensive patented medicines instead of using cheaper generic drugs to fight AIDS and other diseases. They accuse the US of using her economic sanctions on countries to stop them from manufacturing generic drugs, which SSA could purchase at a cheaper cost.

In March 2001, Kenya's Minister for Public Health said that the Kenyan government had no choice but to defy the pharmaceutical companies and look for cheaper drug alternatives. "We cannot operate in a situation where we have an epidemic, a national disaster.... And being asked to keep on observing international patent law," he said.<sup>132</sup>

The drug industry responded at the end of April by reducing some of its prices, a move critics said did not go far enough. At the 12<sup>th</sup> World Conference, J. Beloqui claimed that marginal costs of producing most retroviral drugs were so low that drug companies could sell them in third world countries for less than 10% of the present US price, and still make a profit.<sup>133</sup>

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<sup>131</sup> See BBC News/ HEALTH/ Rich Countries "Hinder Fight Against AIDS", at [http://news.bbc.co.uk/1/hi/english/health/nesid\\_537000/537514.stm](http://news.bbc.co.uk/1/hi/english/health/nesid_537000/537514.stm)

<sup>132</sup> Ibid

<sup>133</sup> See "Treatment Access – Message 960", at <http://www.hivnet.ch:8000/topics/treatment-access/viewR?960>

However despite this fact, the United States, which is home to most of the international drug companies, was the only permanent representative to the UN to abstain from a vote on a resolution to improve access to drugs for treatment of HIV/AIDS in Geneva, in April 2001. They cited that the measure was “flawed” and amounted to “bad public health policy”. They said that if the recommendations were implemented, they could “prove to be extremely harmful to collaborative international efforts to combat HIV/AIDS”. This amounts to double standards on the part of the US in the global fight of HIV/AIDS.

Public Health activists and consumer groups have warned that the WHO’s estimates - that one third of the world’s population lack access to essential drugs - will further increase. Their concern is that World Trade Organization (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS), will give rise to factors that will put access to essential drugs and healthcare out of the reach of millions of people in developing countries.<sup>134</sup>

## **5.2 Industrial Property Rights**

During the 1980’s the gradual erosion of the developed countries’ supremacy in manufacturing and technology, due to the rise of the Asian

countries as competitors was a cause for concern. The industrial lobbies convinced the developed countries on the need to link trade with Industrial Property Rights (IPRs), in order to prevent imitation and to increase returns on research and development.

IPR's granted monopoly rights which were regarded as crucial in preventing developing countries to undergo the catching up process towards industrialization based on imitating and copying technologies, as the developed countries themselves had done. In other words, IPR protection was a tool to guarantee the comparative advantage that had so far ensured the developed countries' technological supremacy.<sup>135</sup>

The minimum term of 20-year patent protection period required by the TRIPS agreement effectively allows a pharmaceutical company a monopoly over its patented drug. Free from competition, the company is able to keep the price of the drug high during the protection period.<sup>136</sup> This is done to allow pharmaceutical companies recoup their investment and enable them invest in new medications, innovation and drug development. By virtue of the TRIPS protection, no generic equivalent can

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<sup>134</sup> See "TRIPS and Pharmaceuticals: A Case of Corporate Profits Over Public Health", at <http://www.globalpolicy.org/socecon/bwi-wto/wto/trips.htm> pg1

<sup>135</sup> See C. Correa (2000) Intellectual Property Rights, The WTO and Developing Countries: The TRIPS Agreement and Policy Options, Third World Network, Malaysia, as quoted, in *ibid*

<sup>136</sup> C. Oh, TRIPS and Pharmaceuticals ...op cit, pg2

come into the market until the expiry of the 20 years, denying patients cheaper alternatives.

Developing-country pharmaceutical producers have found themselves pushed out of the market by stiff competition from the large transnational corporations (TNCs). The smaller producers in the developing world, which specialize in and depend on manufacturing cheaper generic alternatives, have to wait until the expiry of the 20-year protection period.<sup>137</sup>

The TRIPS Agreement further allows a TNC to supply global markets under the patent right monopoly, exporting the finished product without transferring technology or making foreign direct investment. This is to the disadvantage of developing countries that are in dire need of technology and foreign direct investment.<sup>138</sup> However in agreement, there are certain exceptions to patent protection of pharmaceuticals. These are parallel imports and compulsory licensing.

**Parallel importing** is a means by which developing countries could lower drug prices. Where there are price differences for the same product in different markets, it is possible to import the product from the cheaper

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<sup>137</sup> Ibid

<sup>138</sup> Ibid

market for resale. The principle of IPR allows an interested party from country A to purchase a product legally sold in country B for resale in country A, without the consent of the patent holder.

**Compulsory licensing** refers to cases where a government or court of law may grant a license to a third party to use a patent without patent holder's consent, under specified conditions such as cases of national emergency or extreme emergency.<sup>139</sup> Compulsory licensing lowers prices to consumers by creating competition in the market for the patented good. Its impact, is similar to the introduction of generic competition at the end of a drug's patent term, prices come tumbling down. Compulsory licensing can therefore lower the prices of medicines by 75% or more.<sup>140</sup>

### **5.3 WTO, Intellectual Property Rights and HIV/AIDS drugs**

Weissman <sup>141</sup> gives parallel imports and compulsory licensing as the only two ways to promote access to essential medicines, to developing countries. He says that the more important of these policy tools, compulsory licensing enables any government to instruct a patent holder to license the right to use it's patent to a company, government agency or other party.

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<sup>139</sup> op cit

<sup>140</sup> ibid

Both compulsory licensing and parallel imports are permitted under the international trade rules established by the General Agreement on Tariffs and Trade (GATT) and administered by the World Trade Organization (WTO). They are regularly used in industrialized countries, including the United States, Japan and the European Union.

Brazil, a developing nation has been producing generic drugs and distributing them free of charge to all Brazilians who require anti-HIV therapy since 1998. This has enabled the Brazilian government reduce by half the death rate from HIV/AIDS. It has also reduced the rate of transmission, stabilized the epidemic and improved the overall state of public health in Brazil.<sup>142</sup>

India on the other hand does not recognize patents on medicine. It currently leads the world in the manufacture of generic HIV/AIDS drugs, and exporting them at prices up to 90% less of the cost of the brand name drugs. The two countries have demonstrated that developing countries can supply cheaper generic alternatives and that compulsory

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<sup>141</sup> R. Weissman, "In Focus: AIDS and Developing Countries: Democratizing Access to Essential Medicines", Volume 4, Number 23, 1999, in Eds. T. Barry & M. Honey, Foreign Policy in Focus.

<sup>142</sup> "Expanding Global Access to HIV/AIDS Treatments: An Overview of the Issues", American Foundation for AIDS Research, 2001, pg2

licensing is a viable option for poor countries with large numbers of HIV-infected people.<sup>143</sup>

One of the GATT agreements on TRIPS contain the international rules the WTO enforces on intellectual property (patents, copyrights and trademarks). Industry, especially the pharmaceutical sector, exercised heavy influence over the TRIPS agreement negotiations, and many public interest advocates generally believe the TRIPS agreement inappropriately favours corporations.<sup>144</sup> But whatever the TRIPS agreement biases, and despite the requirements it imposes on signatory countries it permits compulsory licensing and parallel imports. Yet despite the WTO legality of these policy tools, multinational pharmaceutical companies object to the practices, which they perceive as curtailing corporate profits.

The US government has adopted a similar view strongly opposing developing countries' efforts to undertake compulsory licensing, parallel imports or other similar measures to make HIV/AIDS drugs and other essential medicines, more available and affordable to their people. In 1998, it lodged a complaint with WTO challenging a specific provision of Brazilian patent law that allowed authorities to license local production of pharmaceuticals unless foreign firms began manufacturing drugs in

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<sup>143</sup> Ibid pg3

Brazil within three years of receiving a patent. However they later dropped the case in favour of direct negotiations with Brazil.<sup>145</sup>

#### **5.4 Controversy**

The issue of expanding access to HIV/AIDS treatments to the more than 34 million people living with HIV/AIDS in the developing world has received increased attention from treatment advocates, policy makers, heads of states and the media.

The United nations, governments and HIV/AIDS and health related organizations in both developed and developing countries are now calling for a variety of measures to expand access to life saving medications, including price reductions and the right to manufacture or import generic versions of HIV/AIDS drugs.

Pharmaceutical firms have said that offering drugs at steep discounts in developing countries would prompt demand for lower prices in developed markets as well, and that cheaper generic versions of HIV/AIDS drugs may end up being re-exported from developing to developed countries.<sup>146</sup>

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<sup>144</sup> Ibid

<sup>145</sup> Ibid

<sup>146</sup> Ibid, pg 2

However these fact notwithstanding, developing countries desperately need affordable HIV/AIDS drugs at whatever cost.

It is now evident that developing countries have been unwilling to use the parallel imports and compulsory licensing, for fear of trade sanctions by the developed countries. A report from MSF detailed the US government's pressure on Thailand to restrict its use of parallel imports and compulsory licenses. The Thai government passed a law banning parallel imports in 1992, under the threat from the US to limit textile imports. Parallel imports were allowed again after amendments to the patent law, which came into force in 1999.<sup>147</sup>

When the South African government sought to enact the Medicines and related Substances control Bill, the US government accused it of failing to adequately protect American drug patents. The US objection was directed at provisions in the law, which would allow for compulsory licenses and parallel importing. Despite the considerable pressure exerted on the government and parliament of South Africa, the bill was passed in 1997.

The pharmaceutical industry in South Africa, backed by the TNCs and the pharmaceutical lobby in the US, filed a legal challenge to the new

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<sup>147</sup> See "TRIPS and Pharmaceuticals", op cit

law. The US government taking its cue from its pharmaceutical lobby began a process of negotiations and threats to get the South African government to change its stance.<sup>148</sup>

In Kenya a lobby group, the Kenya Coalition on Access to Essential Medicines has been championing the case for drug access to HIV/AIDS patients. It played an important role in putting pressure on the government to pass the industrial property bill 2000. It comprises of a network of associations, people living with AIDS, pharmacists, doctors lawyers, journalists, and other individuals advocating for the improvement of access to essential medicines for all in Kenya. It includes among others, the following organizations: Action Aid, The Association of People living with AIDS in Kenya (TAPWAK), Health Action International (HAI), Network of people living with HIV/AIDS (NEPHAK), Women Fighting AIDS in Kenya (WOFAK), Society for Woman and AIDS in Kenya (SWAK), Nyumbani, International Federation of Women Lawyers (FIDA), Care International, Medecins Sans Frontieres (MSF), DACASA, Pharmaciens Sans Frontieres (PSF), Kenya Medical Association (KMA), Consumer Information Network, Campaigners for AIDS free Society.<sup>149</sup>

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<sup>148</sup> Ibid

<sup>149</sup> "Land mark Victory for Patent Rights over Patent protection Kenya Coalition Welcomes New patient friendly IP bill, Press release. 2001, pg 1

The year 2000 marked the start of negotiations between the Kenyan government and five international pharmaceutical companies, to reduce the price of anti-retroviral (ARV) medicines by up to 85%, and to offer some HIV/AIDS drugs free of charge. An Industrial Property Bill was recently passed in parliament. It created opportunities to improve access to cheaper drugs.<sup>150</sup>

GlaxoSmithKline, a pharmaceutical giant in Kenya, in 2001, announced a programme to deliver cheap AIDS drugs that will include aid organizations and large employee health programmes. The company promised that it would offer drugs at a no-profit price, 90% cheaper than the retail price charged in most developed countries. Consequently the price of treatment would reduce to \$2 a day. However more funding and infrastructure build up were cited if a significant increase in access to anti-retroviral drugs is to be achieved.<sup>151</sup>

However the war to achieve access to essential drugs seems far from over. This is because in September 2001, the government admitted that it did not have funds to purchase anti-retroviral drugs for its hospitals, whose services are relied upon by majority of Kenyans. This is despite the passing by parliament of the Industrial Property Rights Act in June

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<sup>150</sup> See "Kenya Coalition Urges Government not to Trade Long-term Rights in Deal with Drug Companies", press release, 2000pg 1.

2001 and the fact that the prices for these drugs were now much lower than before.<sup>152</sup>

Another factor that now needs consideration is the administration of the anti-retroviral drugs. Very few hospitals in Kenya have both the personnel and the technology required in the administration of these drugs. Some people living with HIV/AIDS have also cited lack of food, which is a necessity before one can take the drugs. HIV/AIDS anti-retroviral drugs are still out of the reach of most Kenyans.

### **5.5 Modes of treatment and related costs**

One debate among health experts and activists, concerns whether to concentrate new resources on sophisticated treatment even at newly reduced prices to improve and prolong the lives of those in advanced stages of the disease, or an AIDS prevention, less expensive treatment of AIDS-related diseases and basic health programs aimed at stopping the disease's spread.

Resolving this and other differences has taken on new urgency as donors have indicated willingness to provide substantial new funds for the global HIV/AIDS campaign. Uneasy about lack of coordination, some donors led

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<sup>151</sup> See "CPDC - Current HIV/AIDS", at <http://www.cdpc.com/current.htm> pg 2

by Britain's Department for International Development in April 2001, issued what some described as an ultimatum to UNAIDS.<sup>153</sup>

Others have also proposed uses for new funding. Harvard economist Jeffery Sachs proposed the establishment of a massive global AIDS fund to purchase anti-retroviral drugs for Africa. AIDS activists criticized the proposal, which would involve patent-holding pharmaceutical companies, for not favouring generic producers who have offered even cheaper prices.

Microsoft founder Bill Gates also warned that the emphasis on treatment risked undermining prevention efforts. Gates family foundation has given hundreds of millions of dollars to the international fight against HIV/AIDS, the most of any single donor.<sup>154</sup>

Due to international pressure the major pharmaceutical companies are now offering the three-drug anti-retroviral AIDS "cocktail" to some poor countries for less than a tenth of the developed world's \$10,000 per

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<sup>152</sup> See EAS, 11/9/2001 pg 6

<sup>153</sup> See "Global AIDS Strategy May Prove Elusive", at

wysiwyg://111/http://washingtonpost.com...dsinafrica/latest/A42238-2001Apri20.html pg 1

<sup>154</sup> Ibid pg 2

patient per year starting price. Patent busting generic producers have offered even lower prices.<sup>155</sup>

## **5.6 HIV/AIDS vaccine**

Todate only two vaccines have been tested in the entire African continent, and only one of these, an International AIDS Vaccine Initiative (IAVI)-Kenyan-Oxford partnership was specifically designed for Africa. IAVI is a scientifically based non profit initiative formed by the Rockefeller Foundation with a mission to ensure development of safe, effective and accessible preventive HIV vaccines for use throughout.<sup>156</sup>

Dr. Seth Berkerley, managing Director of IAVI, pointed out that it was possible to make a HIV/AIDS vaccine for a country while using the local circulating strain of the HIV virus. This way if the vaccine fails to work, they are able to detect what went wrong. In his view, the first problem is finding the right vaccine that would work against the local circulating strain.

“If we used the wrong strain and it doesn’t work, then we wouldn’t know whether we used the wrong vaccine, or because it was the wrong strain. That is why there is need for research,” he argued.<sup>157</sup>

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<sup>155</sup> Ibid

<sup>156</sup> See HIV/AIDS Africa Related Articles (May 2001), at <http://www.medguide.org.zm/aids/aidsafr9.htm>

pg 13

<sup>157</sup> Ibid

In December 2000 Kenyan scientists, based at the University of Nairobi were allowed to jointly own patent rights for the HIV/AIDS vaccine currently undergoing trials, with their counterparts at the Oxford University in Britain. Initially the Kenyan scientists had been locked out of the patent rights ownership, prompting the government, through the Kenya Industrial Property office (KIPO), to intervene.

However the scientists both from Oxford and University of Nairobi were able to sort out the ownership controversy amicably, through a legal document signed in 2001, by the two universities and IAVI. Phase one of the vaccine trials began in Britain in August 2000, while another trial began in Kenya in February 2001. The HIV-DNA vaccine trial was based on subtype A, the predominant strain in East Africa.<sup>158</sup>

The Oxford and Nairobi trials mark the first steps in testing a combination (prime boost) vaccine with two components: the HIV-DNA and the same construct in a viral vector (the Modified Vaccinia Virus Ankara strain, or MVA). Full clinical testing involves three separate studies. The HIV-DNA vaccine alone, HIV-MVA alone and then given to volunteers a few weeks apart. Each step began with a trial in the UK,

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<sup>158</sup> See *Ibid* and IAVI Report, vol. 5 No. 5 Dec. 2000 – Jan 2001 pg 3

followed by a Kenyan trial several months later. The lag made it possible for preliminary safety data to inform the Kenyan approval process.<sup>159</sup>

The DNA vaccine is based on research carried out almost ten years ago on 50 Nairobi prostitutes, who appeared to have developed immunity to HIV through daily exposure to the virus. However as soon as they stopped trading their immunity waned and they became HIV positive.<sup>160</sup>

The Nairobi study involves collaboration among the groups of Andrew McMichael, Sarah Rowland-Jones Rupert Kaul from Oxford and J. J. Bwayo, Omu Anzala and Frank Plummer in Nairobi.<sup>161</sup>

So far despite the concerted efforts of doctors and scientists, a cure for HIV/AIDS has still not been realized. The vaccine is still years away. Other measures therefore have to be used especially in SSA to curb the spread and control the epidemic

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<sup>159</sup> See IAVI Report ...

<sup>160</sup> See "Kenyan Doctors own AIDS Vaccine Patent Rights, 15 Dec 2000", at [wysiwyg://211/http://www.reliefweb.int/.../countrystories/kenya20001215a.phtml](http://www.reliefweb.int/.../countrystories/kenya20001215a.phtml) pg 1

<sup>161</sup> Ibid

## **CHAPTER SIX**

### **THE HIV/AIDS SITUATION IN KENYA: DATA ANALYSIS AND EMPIRICAL FINDINGS**

#### **6.0 Introduction**

This chapter presents the empirical findings of the field research carried out to examine what different categories of people and institutions are doing to check and control the spread of HIV/AIDS as well as the level of HIV/AIDS awareness in Kenya. The institutions studied include; the government of Kenya, international aid agencies and NGOs. The categories of people covered include students, public and private sector employees, the unemployed and other groups of the Kenyan general public. The chapter examines the efforts of these categories of people and the impact of their efforts in combating the HIV/AIDS pandemic in Kenya.

#### **6.1 Key characteristics of the sample**

Data analysis shows that out of the total respondents, 43.9% were female while 54.9% were male. A large proportion of the respondents in the sample, i.e. 47.6%, had university level of education. The results also show that 61.4% of the respondents were private sector employees, while 24.3% were civil servants. The respondents were asked when they first

heard about HIV/AIDS. Their response was as follows; 56.8% first heard of it in the '80s, while 43.2% heard of it in the '90s. (Table 6.8).

## **6.2 Empirical findings**

Data collection and analysis focused on three hypotheses. The study investigated whether donors had played a substantial role in fighting HIV/AIDS. An assessment of what donors are doing to combat HIV/AIDS was carried out. This was done through a questionnaire, administered to international aid agencies. Other categories of people including NGOs and the general public were also asked to comment on donor efforts in the war against HIV/AIDS in order to evaluate how they perceived the efforts of the donors vis-à-vis other actors.

The government's capacity to cope with the HIV/AIDS epidemic was analyzed by carrying out an assessment of what the government is doing to fight HIV/AIDS. This was done by means of a questionnaire administered both to NASCOT and NACC, which are mandated by the government to strategize and fight the HIV/AIDS pandemic in Kenya. Other categories of people, including NGOs, donors and the general public were asked to comment on the government efforts in the war against HIV/AIDS.

The political goodwill of the Kenyan government was analyzed through an evaluation carried out on the environment in which donors are operating. They were asked to specify the hardships they were facing in implementing their various projects and programmes. They were also asked to comment on whether the government had either facilitated, or hindered their work in the area of HIV/AIDS. This was done with a view to ascertaining whether political good will was a factor in the success of donor-funded projects in the country.

### **6.3 General HIV/AIDS awareness and knowledge**

The questionnaires sent out to members of the public were done with a view to finding out their level of HIV/AIDS awareness as well as evaluate the efforts of the government, NGOs, private sector and international aid agencies in the fight against the pandemic.

With regard to how the respondents heard about HIV/AIDS, the results show that 34.2% of the respondents first heard of the HIV/AIDS problem in school or in college, while 32.9% heard of it in radio programmes.

The survey results show that 97.5% of the respondents had basic information on how the disease is transmitted, with the majority saying that one of the main ways of transmission of the disease was sex. Some

of the respondents, 34.2%, said that HIV/AIDS is transmitted through sex and blood transfusion. Another 41.8% gave a combination of sex, blood and unsterilized tools, 10.1% gave sex, blood and an infected mother to child as modes of HIV/AIDS transmission, while 2.5% said that the disease was only transmitted through contaminated blood.

The respondents were also questioned on whether they had taken any protective measures to guard against infection. 95% of the respondents indicated that they had done something to protect themselves from HIV/AIDS. On the specific steps taken by the respondents, 35% of the respondents said that they used abstinence, as a measure while 44.6% said faithfulness to one partner was an important protective measure. 2.7% said that they had taken a combination of faithfulness to one partner and condoms as protective measures, while 8.1% said that they used condoms to protect themselves. Another 8.1% of the respondents said that they had had to change their behaviour as a measure to protect themselves from getting infected with HIV/AIDS, while 1.4% said that they relied on prayer.

From the literature gathered for this study, it was clear that many people in most African countries including Kenya did not know their HIV/AIDS status. There are two reasons for this. HIV/AIDS testing tools and

equipment are not widely available. The other reason why many people are not willing to test for HIV/AIDS is because of the stigma that is associated with it. The study confirmed these issues in its findings.

Respondents were asked whether they had ever been tested for HIV/AIDS. 51.9% of them said that they had been tested for HIV/AIDS, while 48.1% said that they had not been tested. Various reasons were given as to why respondents were tested. 24.4% of the respondents said that they had been tested for purposes of insurance policies. 24.4% had been tested for employment purposes, while 4.9% of the respondents had been tested for study purposes. 19.5% had required testing as a result of pregnancy, 4.9% had wanted to know their blood groups, while 2.4% had been tested as a requirement for foreign travel. Only a paltry 14.6% of the respondents had been tested because they needed to know their HIV/AIDS status.

The respondents who said that they had not been tested also gave various reasons as to why they had not been tested. 16.1% said that they had not been tested for fear of the results. Another 16.1% said that they had not been tested because it was an expensive exercise while 6.5% said that they were ignorant about the procedure. 3.2% said that they lacked enough awareness about the testing procedure and had

therefore not been tested. 6.5% of the respondents said that they had not been tested because they trusted their partners, while 29% said that they had not thought seriously about the issue of testing. 22.6% said that they had no reason for not having been tested.

Nearly all the respondents (95.1%) knew of someone who had died or was living with HIV/AIDS. This is an indicator that although many of the respondents may not have been infected with HIV/AIDS, all are affected. This confirms the fact that the general HIV/AIDS awareness is quite high in Kenya.

A number of the respondents knew of an organization working in the area of HIV/AIDS. 75% of them knew of an organization, compared to 25% who did not know of any. The organizations named were; church organizations, Kenya AIDS Society, educational institutions, ministry of health, KEMRI, ESR-A, WOFAK, FKE, UNDP, UNAIDS, NACC, FPAK, TAPWAK, NASCOP and MSF-Belgium. Most of the organizations fall into the category of NGOs. This is probably because NGOs work closer to the people and majority of them have grass root networks.

**Table 6.1.0**

Respondents tested for HIV/AIDS by Gender

Gender	Yes Actual no.	Yes %	No actual no.	No %	Total Actual No.	Total %
Female	23	65.7%	12	34.2%	35	43.2%
Male	19	42.2%	26	57.7%	45	54.9%

*Source: Survey data*

A higher percentage of female respondents (65.7%) than male ones (42.2%) had been tested for HIV/AIDS (Table 6.1.0). This is probably because many of them were tested during pregnancy, as an antenatal requirement. The survey also showed that many of the respondents who had been tested, both male and female had not been tested voluntarily but due to factors beyond their control. Most of them had been tested as a requirement for study purposes, job applications, pregnancy, blood group test, routine testing at their place of work and foreign travel.

**Table 6.1.2**

Respondents tested for HIV/AIDS by Location

Ever been tested	Yes Actual no.	Yes %	No actual no.	No %	Total actual no.	Total %
Nairobi	6	35%	11	64%	17	21%
Muranga	5	71.4%	2	28.5%	7	8.6%
Meru	3	100%	-	-	3	3.7%
Coast	1	100%	-	-	1	1.2%

Nyeri	5	62.5%	3	37.5%	8	9%
Nandi	-	-	2	100%	2	2.5%
Rachuonyo	-	-	2	100%	2	2.5%
Uasin Gishu	1	33.3%	2	66.6%	3	3.7%
Siaya	1	50%	1	50%	2	2.5%
Bungoma	2	100%	-	-	2	2.5%
Kiambu	3	75%	1	25%	3	4.9%
Karachuonyo	-	-	1	100%	1	1.2%
Kakamega	-	-	4	100%	4	4.9%
Taita taveta	1	100%	-	-	1	1.2%
Molo	-	-	1	100%	1	1.2%
Mt. Elgon	-	-	1	100%	1	1.2%
Samburu	-	-	1	100%	1	1.2%
Nakuru	2	100%	-	-	2	2.5%
Embu	1	100%	-	-	1	1.2%
Busia	1	100%	-	-	1	1.2%
Kitui	-	-	1	100%	1	1.2%
Nyando	1	50%	1	50%	2	2.5%
Kirinyaga	-	-	3	100%	3	3.7%
Makueni	1	100%	-	-	1	1.2%
Nyamira	-	-	1	100%	1	1.2%
Machakos	3	75%	1	25%	4	4.9%
Thika	1	100%	-	-	1	1.2%
Kisii	1	100%	-	-	1	1.2%
Kisumu	2	100%	-	-	1	2.5%

Source: Survey Data

Table 6.1.2 indicates that all the respondents from Nandi, Rachuonyo, Karachuonyo, Kakamega, Molo, Mt Elgon, Samburu, Kitui, Kirinyaga and Nyamira had not been tested for HIV/AIDS. Some of these districts like Mt Elgon, Samburu and Kitui are in remote parts of Kenya, where awareness for HIV/AIDS testing may not be widespread.

In contrast all the respondents from Meru, Bungoma, Taita Taveta, Nakuru, Embu, Busia, Makueni, Thika, Kisii and Kisumu had been tested. In Nairobi, many of the respondents (64%) had not been tested for HIV/AIDS. This is despite the fact that Nairobi is a place with many hospitals both public and private where testing services are carried out. It is also a place where one would expect awareness about HIV/AIDS testing to be widespread, especially due to extensive media coverage.

**Table 6.1.3**

Respondents tested for HIV/AIDS by Designation

Designation	Yes actual no.	Yes %	No actual no.	No %	Total actual no.	Total %
Civil Servant	7	41%	10	58.8%	17	24.6%
Private employment	28	65%	15	34.8%	43	62.3%
Self employment	1	100%	-	-	1	1.4%
Student	2	33.3%	4	66.6%	6	8.7%

University lecturer	2	100%	-	-	2	2.9%
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Source: Survey data

41% of those respondents in the category of civil servants had been tested despite the fact that civil servants work for the government, which is at the forefront in the fight against HIV/AIDS in Kenya (Table 6.1.3.). This means that the government should begin its strategy to combat HIV/AIDS by first targeting its employees, and involve them in anti-HIV/AIDS campaigns. The table also shows that respondents in self-employment and university lecturers had all been tested, probably due to the nature of their jobs. For example they may be involved in frequent foreign travel, which necessitates HIV/AIDS testing.

**Table 6.1.4**

Respondents tested for HIV/AIDS by level of education

Level of education	Yes Actual No.	Yes %	No Actual No.	No %	Total actual no.	Total
Primary level	-	-	3	100%	3	3.7%
Secondary level	5	33%	10	66%	15	18.5%
Post secondary level	13	54%	11	45%	24	29.6%
University level	24	61.5%	15	38%	39	48.1%

Source: Survey data

As the level of education increases, the percentage of the respondents who have been tested for HIV/AIDS increases (Table 6.1.4). This is because highly educated people are the ones who are more likely get formal employment, where they may require to be tested. These are also the people who are more likely to travel abroad.

**Table 6.1.5**

Respondents with Knowledge of organizations fighting HIV/AIDS, by Designation

Designation	Yes actual no.	Yes %	No actual no.	No %	Total actual no.	Total %
Civil servant	14	82.3%	3	16%	17	24.6%
Private sector	33	76.7%	10	23%	43	62.3%
Self employed	-	-	1	100%	1	1.4%
Students	4	66.6%	2	33.3%	6	8.7%
University lecturers	2	100%	-	-	2	2.9%

Source: Survey data

All the respondent lecturers knew of an organization working in the area of HIV/AIDS. 82.3% of the respondent civil servants also had knowledge of such organizations and most of them named their employer, the government, (Table 6.1.5)

**Table 6.1.6**

Respondents' knowledge of modes of transmission by designation

Designation	Yes actual no.	Yes %	No actual no.	No %	Total actual no.	Total %
Civil servant	16	100%	-	-	16	23.2%
Private sector	42	97.6%	1	2.7%	43	62.3%
Self employment	1	100%	-	-	1	1.4%
Students	7	100%	-	-	7	10.1%
University lecturers	2	100%	-	-	2	2.9%

*Source: Survey data*

Table 6.1.6 indicates that nearly all respondents except those in the private sector knew of the modes of transmission for HIV/AIDS. However even for the private sector category, the percentage of those who did not know how HIV/AIDS is transmitted was very low (2.7%).

**Table 6.1.7**

Respondents using protection against HIV/AIDS by designation

Designation	Yes actual No.	Yes %	No actual no.	No %	Total actual no.	Total %
Civil servant	15	93.7%	1	6.3%	16	23.5%
Private sector	40	93%	2	7%	42	61.8%
Self employment	1	100%	-	-	1	1.5%

Students	7	100%	-	-	7	10.3%
University lecturers	2	100%	-	-	2	2.9

Source: Survey data

Majority of the respondents had done taken various measures to protect themselves from HIV/AIDS (Table 6.1.7). Very few respondents in the categories of civil servants and the self-employed (6.3% and 7% respectively), gave a negative answer when asked whether they had taken any measures to protect themselves from HIV/AIDS.

**Table 6.1.8**

When respondents first heard of HIV/AIDS by Designation

Designation	First heard in the '80s		First heard in the '90s		Total actual no.	Total %
	Actual No.	%	Actual no.	%		
Civil servants	14	82%	3	17.6%	17	24.6%
Privately employed	21	50%	21	50%	42	60.9%
Self employed	-	-	1	100%	1	1.4%
Students	1	14%	6	85.7%	7	10.1%
University don	1	50%	1	50%	2	2.9

Source: Survey data

Table 6.1.8 gives the percentage distribution of the different designations of respondents and when they first heard of HIV/AIDS problem. Students who are quite young compared to the respondents in employment, first heard of it in the '90s. In the category of those who are in the private sector, those who heard of it in the '90s are those who left college recently and hence are young and newly employed.

**Table 6.1.9**

Respondents using protection against HIV/AIDS by level of education

Level of education	Yes actual no.	Yes %	No actual no.	No %	Total actual no.	Total %
Primary level	2	66%	1	33%	3	3.8%
Secondary level	15	100%	-	-	15	18.8%
Post secondary level	20	86.9%	3	13%	23	28.8%
University level	39	100%	-	-	39	48.8%

Source: Survey data

Table 6.1.9 gives a summary of the different levels of the education and the response of the respondents to the questions of whether they had protected themselves against HIV/AIDS. According to the table most of the respondents despite their different levels of education, had done something to protect themselves against HIV/AIDS. Those respondents with only primary level education had the lowest percentage, while those

with secondary education, and university graduates had the highest percentage, i.e 100%

**Table 6.2.0**  
Respondents' ratings of institutions

The government	50%
Int'l aid agencies	80%
NGOs	60%
Private sector	40%

*Source: survey data*

The respondents were also asked to rate international aid agencies, NGO's, Private Sector and the government in their fight against HIV/AIDS. Table 6.0 shows the results of this exercise. Many respondents rated international Aid Agencies highly, giving them 80%. NGO's scored 60% while the government scored average, 50%. The private sector scored the poorest of the four with 40%.

#### **6.4. Findings from international aid agencies**

Ten international aid agencies were interviewed. A total of 20 questionnaires were sent out to international aid agencies as well as international NGOs working in the area of HIV/AIDS. Only seven of them

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Bank, Japan International Cooperation  
Delegation of European Commission, the  
Embassy and WHO.

was to investigate what the agencies  
in Kenya. Many of the agencies that  
funding of HIV/AIDS projects. Half of them  
activities. These are:

sick,

and orphan care.

and most of the other international aid  
the provision of drugs and institutional  
health sector.

involved in the funding of some specific  
as research, capacity development and  
counseling and testing, sentinel surveillance,  
prevention, blood safety, home based  
promotion, prevention care and support  
ment. This to large extent demonstrates

the agencies commitment to helping Kenya combat the HIV/AIDS pandemic.

All the Agencies interviewed had worked in collaboration with the government of Kenya. 71% of them said that the government had facilitated their work. Some agencies gave reasons for this, saying that they work in partnership or fund their projects through the government, whose institutions provide the infrastructure for implementation of the projects. As a result of this partnership and direct interaction with the government, these agencies felt that the government had facilitated their work in the area of HIV/AIDS. This may be interpreted, as evidence of political will on the part of the Kenyan government to facilitate and coordinate the efforts of all stakeholders in the fight of HIV/AIDS.

The same agencies said that the government had achieved a lot in areas such as political advocacy, putting up a policy framework through a policy paper on HIV/AIDS, declaring HIV/AIDS a national disaster and setting up of NACC. One agency said that political will was now evident since the government was addressing the scourge through several government ministries and also since the government had provided substantial funding to combat HIV/AIDS.

Other agencies felt that the government has taken important steps such as setting up of the national HIV/AIDS control strategic plan through NACC. They however added that a lot still remained to be done especially in the area of influencing behaviour change and the issue of addressing the problem of adolescents.

The agencies were also asked to comment on whether the government was doing enough to combat the HIV/AIDS pandemic. 57.1% of the agencies interviewed, answered positively. They gave their reasons to support this answer, saying that government had now prioritized funding for HIV/AIDS projects. They also said that the government had come up with a sessional paper to guide and coordinate efforts to combat the epidemic. They felt that this were conscious efforts on the part of the government in the fight against HIV/AIDS.

42.9% of the agencies however, felt that the government had hindered their efforts through slow and numerous governmental procedures, especially when they needed clearance for upcoming projects. This took too long and some agencies were forced to give up and abandon these projects. They added that most of the programmes that the government had come up with were too donor dependent and hence could not be

sustainable in the long run. They advised that new health financing and insurance schemes be developed in order to alleviate this problem.

These agencies responded in the negative, when asked whether they thought that the government was doing enough to combat HIV/AIDS. They gave their reasons saying that most government projects in response to the HIV/AIDS pandemic, were donor dependent, and that government effort began too late and was too weak, in response to such an intense epidemic.

The agencies were also asked give their opinion on the efforts of the government, other agencies, local NGO's and other actors in combating HIV/AIDS. Majority of the agencies rated the government highly at 70%. This was probably because most of them worked in collaboration with or funded their projects through the government. Consequently rating the government poorly would have been regarded as rating own projects poorly.

They however rated the efforts of their counterparts at 60%. This was probably because each agency was seeking superiority from the rest. Local NGO's also scored average.

## **6.5 Findings from NACC and NASCOP**

NACC has been in operation since November 1999. Its role is to provide a leadership and coordination role in the fight against HIV/AIDS. It is currently undertaking the Kenya HIV/AIDS Response Project (KHADREP).

The major sources of funding for NACC are IDA (World Bank), UNDP, DFID, USAID, UNAIDS and UNICEF. Their funding has conditionalities because it is donor dependent. Programmes and tendering procedures have to be approved and authorized by the donors. The donors also supervise or oversee every step of the various projects.

NACC also receives funds for its operations domestically. 20% of the total funds are from the government's budget allocation through the treasury. 10% of the funds are however sourced from the Kenyan private sector (companies, banks and other organizations). A small portion of funds comes from local communities such as self-help groups.

Since its inception, NACC has been collaborating with stakeholders both from the private and public sector to fight the HIV/AIDS scourge in Kenya. Other stakeholders who have not been left out are the civil society, NGO's, CBO's and religious organizations.

During the interview NACC was positive that the programmes they have been carrying out have been effective because the public appreciation and the will to join the campaign against HIV/AIDS is noticeably picking up, according to their surveillance results.

Asked about the constraints that the organizations had faced in their efforts to combat HIV/AIDS, both NACC and NASCOP said that cultural problems, whereby people were not willing to change their behaviour because it was deeply entrenched in their culture, was top on the list.

Another major problem that they gave was lack of adequate funds. The two organizations rely heavily on donors for funding. This aspect affects their projects greatly because they cannot come up with independent projects. They do not own the projects. It is the donors who decide what projects will be carried out. Sometimes these projects do not coincide with the needs of the people they are intended for. This brings to question the commitment of these agencies to assist Kenya fight the pandemic, despite their provision of funds and willingness to collaborate with the government, as discussed earlier in this chapter.

However according to NACC, international aid agencies are doing a good job to fight the HIV/AIDS pandemic in Kenya. The reason they gave for

this was that the agencies are showing a lot of cooperation and are willing to work with other stakeholders in the fight against HIV/AIDS. NACC suggested the future role of these agencies to be technical and financial assistance, according to the respective strong points of each individual donor.

NACC named the government of Kenya and local NGO's as the organizations that had done most in the fight against HIV/AIDS in terms of funding and raising awareness.

They also said that as far as NGOs are concerned, they had observed an advantage in their cooperation with them. They said that this was because NGOs are community based and therefore better placed to implement some of the programmes initiated by NACC, because of their close vicinity to the people at the grassroots.

However, they added that there was a disadvantage. This is because the NGOs are too many. There are 650 NGOs working in the area of HIV/AIDS in Kenya. As a result of this number there have been cases of duplication of projects. Again despite the large number, some places especially in the remote parts of Kenya are not covered by the NGOs. They tend to concentrate in urban centers, particularly in Nairobi and

luo Nyanza. They therefore have not helped some of the people at the grass root levels that are in dire need of their services.

Both NACC and NASCOP agreed that there is a link in the work of international aid agencies, local NGOs, the government and other actors in their efforts to fight HIV/AIDS in Kenya. They said that this was because HIV/AIDS is a global problem that affects everybody. It therefore requires the joint effort of all the stakeholders. Each stakeholder should play their role in accordance to their strong points. For example the government is better able to coordinate the efforts of all other stakeholders, because it has a network as well as the political will to play this role effectively. The government would also be able to formulate policy to support widows as well as orphans in order to shield them from being vulnerable to HIV/AIDS.

On the other hand the international aid agencies are better able to provide funds and technical assistance, because of their economic superiority as well as technological capability.

NASCOP has been in operation for the last fourteen years. It is involved in the planning, coordination and supervision of the following programmes:

- Care and counseling of the sick,
- Provision of drugs for STD's and opportunistic infections
- Provision of condoms and other preventive measures
- Raising of HIV/AIDS awareness
- Sentinel surveillance
- Blood safety programmes,
- Home care and voluntary counseling and testing (VCT) activities.

NASCOP receives funding from the government, Futures group, Policy project, UNICEF, WHO, UNAIDS, CDC, FHI and PSI. During the interview it was revealed that the programmes NASCOP has been carrying out have been effective because community awareness is now at 98%, according to their surveillance.

### **6.6 Findings from Kenya AIDS Watch Institute (KAWI)**

KAWI has been in operation for one year and has been involved in policy analysis and development. The NGO is currently running a 24-hour HIV/AIDS hotline to assist people infected or affected by HIV/AIDS. The NGO relies heavily on volunteers and receives funding mainly from domestic sources. It also collaborates with other NGOs, in the fight against HIV/AIDS, such as NACC, KANCO and TAPWAK

KAWI, like other NGOs, has received limited funds, when asked about the challenges it faces and lack of adequate funds, when asked about the challenges it faces in the fight against HIV/AIDS. They said that the government and agencies needed to do more of the war against HIV/AIDS. They said that the agencies should be given more administrative and financial support to Kenya.

It is KAWI's view that NGOs, NACC and NASCOP, have performed better than other agencies in the fight against HIV/AIDS in Kenya. They said that the four organizations had been flexible and had kept in touch with the people that were using their programmes more effectively.

**Table 6.2.1**  
Kawi's rating of Institutions

Organization	Score
International agencies	40
Local NGOs	40
The government	20
Private sector	100
KAWI	

Source: Survey data

## CHAPTER SEVEN

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 7.0 Summary

This study looks at the HIV/AIDS problem globally and assesses the international response to the pandemic. It observes that SSA governments' coping mechanisms are inadequate. This is due to Africa's historical dependency on the developing countries for development assistance. One of the objectives of the study is to assess the collaborative role of donors with government in combating HIV/AIDS, which includes the assessment of international aid agencies.

Chapter 2 looks at HIV/AIDS in Kenya and observes that cultural problems, ignorance and poverty are the major impediments to solving the HIV/AIDS problem. It also established the existence of a conflict between moral values and the promotion of condoms as a preventive measure against HIV/AIDS.

Chapter three looks at the policy and institutional framework of HIV/AIDS in Kenya. The study establishes that the governments' slow response to the HIV/AIDS problem was due to its fear of loss in tourism, one of its most important foreign exchange earner. Going public about the HIV/AIDS status would have reduced the number of tourists coming

to Kenya. One short medium plan, two medium term plans, a sessional paper and a strategic plan all geared towards providing a multi-sectoral approach in fighting the pandemic were later formulated.

Chapter four looks at the global strategy for the prevention and control of AIDS. It found that some of the active organizations were UNAIDS, UNDP, World Bank and WHO among other international agencies. They were mainly involved in funding and research work as a measure towards fighting and controlling the spread of HIV/AIDS. The NGOs were found to be the implementers of programmes as they were closest to the community and have been networking with them even through other developing projects.

Chapter five on the other hand discusses treatment and drug accessibility especially to the rural poor who are the most affected by the pandemic. Some developing countries are active in trying to get the industrial property rights and as a way of making medication more affordable to the poor. This move is thoroughly opposed by the developing countries (especially the US), as it would mean less income for them if generics were allowed. The concentration on drug accessibility however threatens to overshadow preventive measures as well as HIV/AIDS research.

Chapter six analyses the data collected from the field. It finds that HIV/AIDS awareness was high among Nairobi residents. However, the respondents were unwilling to undergo a HIV test even though they had been affected by the pandemic through the loss of a relative or friend. The international agencies on the other hand had various HIV/AIDS programmes, coordinated and implemented by the government. One finding from the study is that NGOs have been faced by problem of entrenched cultural practices during the implementation of HIV/AIDS.

Chapter seven gives a summary of the study, conclusion and recommendations to the government, NGOs, international aid agencies and other stakeholders involved in the fight against HIV/AIDS.

### **7.1 Conclusion**

The government of Kenya has the political goodwill to fight the HIV/AIDS pandemic. However the bureaucratic bottlenecks within it have not augured well with donors who may be willing to carry out projects to help the people of Kenya check and control the spread of HIV/AIDS in Kenya. The intensity and magnitude of the pandemic also requires the government to intensify its efforts through all avenues available in order to effectively to combat it.

A major obstacle in Kenya in the fight against HIV/AIDS is culture. Some cultural practices have helped spread HIV/AIDS. Some of these practices such as wife inheritance are deeply rooted and although traditionally it was meant to take care of widows and their children, today it has aggravated the spread of HIV/AIDS. The government should come up with policies to help widows and orphans in order to avoid these practices.

Another obstacle is behavioural change. Despite the fact that 98% of people are aware of how HIV/AIDS is spread, people have not changed their behaviour to avoid spreading or being infected with HIV/AIDS. Some people have deliberately spread HIV/AIDS. Currently in Kenya the clergy and some members of the church are proposing and insisting that couples be tested before they can be joined in marriage. However this is not enough because some people do not have church weddings while others are known to indulge in extramarital affairs.

Behaviour change can only occur if the people themselves are willing to change their ways. It is the mandate of the government to protect its people, hence it should come up with a policy that requires all people to be tested on a regular basis to avert this problem. The government

should also institute harsh measures to people known to have knowingly infected others.

The government could also play a role by empowering the youth. This could be done by ensuring that the educational institutions equip the youth with the knowledge they require to protect themselves against HIV/AIDS. Some youth however do not pass through the educational institutions due to poverty or deviance, these youth also need to be empowered with HIV/AIDS education. The government should formulate a policy that caters for street children and families.

The rate of crime in Kenya especially rape has gone high. The government should come up with stringent laws to ensure that the culprits of such crimes are punished accordingly. It is well known that majority of rape victims do not report the crime because of the fear of stigmatization. The government should utilize its think tanks to come up with ways not only to empower women but also protect young girls who bear the brunt of this crime. They should find ways to reduce rape cases in Kenya.

Most people not just in Kenya but also in SSA, are not aware of their HIV/AIDS status. This has served as an impediment in the fight against

HIV/AIDS, because some people spread it without knowing. It is therefore important for people to test for HIV/AIDS and those in the high-risk groups should keep testing in order to update their status. The government should introduce voluntary counseling and testing (VCT) in all hospitals and health centers, and also sensitize the people on the need to be tested. There are people who have died after knowing their status, because they were in shock and denial. Yet with proper counseling people can live quality lives.

The International Aid Agencies can help the government in refurbishing and equipping its hospitals and health centers with practicable equipment and qualified staff to carry out the VCT. Additionally these hospitals and health centers should also be equipped with HIV/AIDS drugs at affordable prices.

The only conclusive solution to this pandemic seems to be in a vaccine and a cure. This will only be possible if International aid agencies intensify funding, technology and expertise to research in a vaccine and a cure for HIV/AIDS. Scholars carrying out research in this area should given support. They in turn should share their findings with each other as they advance in their search for a cure and a vaccine. If all stakeholders work together without duplicating and overstepping each

other than a solution to this magnanimous problem may come sooner than later.

## **7.2 Recommendations**

The government of Kenya, in order to manage the epidemic better, should intensify the HIV/AIDS awareness campaigns. This should be done by providing more funds to specialized institutions, with grass root networks currently combating the HIV/AIDS in Kenya. The government should also urgently source funds and import cheaper drugs, to ensure their access by the rural poor, who are most affected by the pandemic.

The government should also concentrate on policymaking, ensuring clarity in terms of defining the different roles to be played by the various stakeholders. The government should also play a collaborative role with all stakeholders in order to avoid duplication and enhance efficiency.

The government has the capacity to reach all its people especially through the media. It should therefore utilize this facility and provide publicity, for the efforts being made by the stakeholders. This should be done in the various mother tongues so that the target groups understand what is being done, and how they can participate.

The government should also lead the way to ensure that a multi-sectoral approach is taken in the fight against the pandemic, by involving the cabinet ministers, parliamentarians, government ministries, the local administration, schools and local hospitals and dispensaries and all other public institutions. These groups of people as well as institutions should be used to demystify HIV/AIDS for the local people.

Heavy reliance on donor assistance has caused the failure of many government HIV/AIDS related programmes. This is because donor funding does not offer a long-term solution to HIV/AIDS. In addition donor funds do not always meet the demand of funding required by HIV/AIDS. Instead the government should work on good structures and health programmes that facilitate the fight against HIV/AIDS. The government should also be firm in ensuring that the projects being funded by donors benefit the people. Those that are not geared towards this end should not be allowed to take off.

The government should now re-visit the sessional paper on AIDS of 1997, with a view to updating it and moulding it to coincide with the changing realities of the 21<sup>st</sup> century. With regard to the strategic plan of 2000-2001, by NACC, there have been complaints from some quarters that only a few people can understand it because of the language used. NACC

should ensure that the plan is translated and discussed perhaps over the radio in mother tongues, so that a majority of the people, especially the rural poor may be able to relate to it.

Many donors have raised concern over the issue of bureaucratic bottlenecks, within the governments. It is impertinent for the government to deal with this problem once and for all. The government must streamline its departments, enhance efficiency and accountability in order to gain maximum benefits from donor funding.

On the other hand international aid agencies should provide more funds for HIV/AIDS activities in the country and come up with programmes that sensitize people on the threat of HIV/AIDS, through NGOs. They should also provide technical expertise and equipment, according to their area of specialization.

Most hospitals particularly in rural Kenya do not have the equipment required to test people for HIV/AIDS. These agencies can collaborate with each other and with the government to provide these equipments. With regard to research, they should prioritize funding towards a cure and a vaccine.

Local NGO's should embark on health education at the community level. Counseling has always been a strong point of many NGOs. However this should now be intensified, with a view to encouraging as many people as possible to be willingly tested for HIV/AIDS.

NGOs could also play a more focal role in assisting the local communities to understand the pandemic, particularly with regard to behavioural change and ways of avoiding further spread. NGOs could also play a lead role in the care of the infected and affected, by educating care givers on how to care for those infected without getting themselves infected.

Owing to the big number of NGOs working in the area of HIV/AIDS in Kenya it is important for the to collaborate with each other in order to avoid duplication of efforts. NGOs should also formulate a way of ensuring that they are evenly distributed around the country. This would ensure the peoples accessibility to their services. However there is evidence to show that currently NGOs are concentrated only in some areas, while other areas, some of them badly affected by the pandemic have no NGO operations.

Other actors such as the civil society must also be actively involved in spearheading the fight and participate in personal, household and

community by sharing of information, caring of the infected and affected and using preventive measures to control HIV/AIDS transmission among communities.

### **7.3 Further Research**

This study has been based on specific objectives and has had a limited scope. It was therefore not exhaustive. An exhaustive study of international intervention in controlling a problem of a magnitude of HIV/AIDS would require a lot more in terms of money and time than what was available. HIV/AIDS is a current problem and there are many issues coming up and being tackled in various ways. There is need for further studies to look into the issues arising from the problem. For instance; the HIV/AIDS vaccine. Trials are currently going on in Kenya and Britain. Studies could follow up on the trials and their impact on HIV/AIDS problem in Kenya.

Developing countries are still pressing on the issue of compulsory licensing and parallel imports. A study into the new developments in WTO regulations and provisions would be interesting and would also show how developing nations could change course in as far as strengthening their capacities to cope with the pandemic is concerned.

This could also be contrasted with the successes witnessed in Brazil and Malaysia, Thailand, India and Uganda.

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**APPENDIX I**  
**QUESTIONNAIRE**

**THE GENERAL PUBLIC**

1. Age of interviewee -----
2. District of Birth -----
3. Gender
  - a) Female
  - b) Male
4. Level of education
  - a) Primary level
  - b) Secondary level
  - c) Post secondary/Diploma level
  - d) University level
5. Designation
  - a) Civil Servant
  - b) Privately Employed
  - c) Self employed
  - d) Student
  - e) University Don
  - f) Farmer
  - g) Unemployed
  - h) Other (please specify) -----
6. When did you first hear of the HIV/AIDS
  - a) In the 80s
  - b) In the 90s
  - c) Very recently
  - d) Other (please specify) -----
7. Where did you hear about it?
  - a) 1, radio (local or international), 2, TV (local or international)

3, Newspapers

- b) In school/college
- c) In church
- d) From family/friends
- e) Other (Please specify) -----

8. Do you know how it is transmitted?

- a) Yes
- b) NO

If your answer is yes, please state how it is transmitted. -----

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9. Have you done anything to protect yourself against the epidemic?

- a) Yes
- b) NO

Please specify what steps you have taken. -----

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10. Have you ever been tested for HIV/AIDS?

- a) Yes
- b) No

Why? -----

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11. Do you know of anyone who has died or who is living with HIV/AIDS?

- a) Yes
- b) No

13. Do you know of any organization(s) near you working towards the eradication of HIV/AIDS?

- a) Yes
- b) No

If so which ones are they and what are they doing? -----

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14 On a scale of 1-10 how would you rate the following in their efforts in the fight against the HIV/AIDS epidemic?

- A, The government -----
- B, International Aid Agencies (World Bank, UNAIDS etc) -----
- C, Local NGOs -----
- D, Private sector and other stakeholders -----

15 What do you think they should do in future to effectively eradicate the HIV/AIDS epidemic in Kenya?

The government -----

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-----

International AID Agencies -----

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Local NGOs -----

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-----

Private Sector and other stakeholders -----  
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**APPENDIX II**  
**QUESTIONNAIRE**

**International aid agencies**

1. Name of organization -----
2. Position of interviewee -----
3. How long has your organization been in operation?-----
4. How long has your organization been involved in the fight against HIV/AIDS? -----
5. What is your organization doing to combat HIV/AIDS in Kenya?
  - a) Care and counseling of the sick
  - b) Provision of condoms and other preventive measures
  - c) Funding
  - d) Provision of drugs
  - e) Orphan care
  - f) Other (Please specify)-----  
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6. Are there some specific HIV/AIDS programmes that your organization is funding?
  - a) Yes
  - b) No

If your answer is yes please state which ones? -----

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7. What are the objectives and conditionalities, if any for your aid support in Kenya? -----  
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8. What is the end target for your projects? -----  
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9. Have you dealt with the government of Kenya in your programmes?  
a) Yes  
b) No

10. Has the government facilitated or hindered your work?  
a) Facilitated  
b) Hindered

Please explain in what way? -----  
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11. What problems if any have you encountered in your work in Kenya?  
a) Cultural problems  
b) Government bureaucracy or hostility  
c) Lack of cooperation by other actors  
d) Lack of adequate funds  
e) Administrative problems  
f) Others (please specify) -----  
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12. What type of organizations do you usually cooperate with in your programmes and projects?

- a) Governments
- b) Other international aid agencies
- c) NGOs
- d) Community based organizations
- e) Others (please specify) -----

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13. What criteria do you use to assess whether to cooperate with an organization or not?

- a) Past record
- b) Type of programmes and projects
- c) Transparency
- d) Others (please specify) -----

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14. In your view is the government of Kenya doing enough to curb the spread of HIV/AIDS?

- a) Yes
- b) No

Please give reasons for your answer-----  
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15. On a scale of 1-10, where would you rate the government of Kenya in its efforts to eradicate HIV/AIDS?

- a) 1-3
- b) 4-6
- c) 7-10

16. Using the same scale as in NO. 15, how would you rate the work of;

- A, other international aid agencies -----
- B, local NGOs -----
- D, Other actors in the fight against HIV/AIDS in Kenya -----

E, Would you say that their collaboration is,

- a) Complementary
- b) Haphazard
- c) Others (please specify) -----  
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17. What would you recommend to be their future role in fighting HIV/AIDS in Kenya?

Government -----  
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International Aid Agencies -----  
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Local NGOs -----

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Other Actors -----

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**APPENDIX III**  
**QUESTIONNAIRE**

**NGOs**

1. Name of organization -----
2. Position of Interviewee -----
3. How long has your organization been in operation? -----
4. What is your organization doing to combat the HIV/AIDS pandemic in Kenya? -----

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- a. Care and counseling of the sick
- b. Provision of drugs
- c. Provision of condoms and other preventive measures
- d. Raising HIV/AIDS awareness
- e. Funding

Others (please specify)

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5. Which are the major programmes that you are involved in to fight the HIV/AIDS pandemic? -----

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6. Who are the major sources of international funding for your activities? (Please indicate an approximate percentage) -----

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B, Which are the other minor sources of international funding? -----

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C, Do the funds have any conditionalities?

- a) Yes
- b) No

If your answer is yes, please state the conditionalities. -----

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7. What about domestic funding sourced locally? (Please indicate approximate percentage)

- a) Budget allocation
- b) Private sector
- c) Others (please specify)-----

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8. Which other Organizations and NGO's are you collaborating with in the fight against the epidemic? -----

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9. In your view do you think that the programmes that you have been carrying out, have been effective?

- a) Yes
- b) No

Please give your reasons. -----  
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10. What constraints has your organization faced in its fight against the pandemic? (Please rank them)

- a) Cultural problems
- b) Administrative problems
- c) Lack of cooperation by international aid agencies
- d) Conditionalities in international lending
- e) Lack of adequate funds
- f) Others (please specify) -----  
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11 Do you think the international aid agencies like World Bank, WHO, UNAIDS are doing enough to fight the HIV/AIDS pandemic in Kenya?

- a) Yes
- b) NO

Please explain -----  
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11. In your view, what do you think should be their future role in the fight against the HIV/AIDS epidemic? -----  
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12. In your view, who do you think has done most in the fight against HIV/AIDS, the government, international Aid Agencies, local NGOs or other actors? -----  
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13. What advantages and disadvantages if any have you had in cooperating with;  
A, Local NGOs-----  
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B, International Aid Agencies -----  
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-----

c, Other actors -----  
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Do you think that there is a link in the work of the International Aid

Agencies, local NGOs, the government and other actors in the efforts to eradicate HIV/AIDS from Kenya?

a) Yes

b) No

If your answer is yes, please state the link -----

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14. On a scale of 1-10 how would you rate the following in their efforts to fight HIV/AIDS in Kenya?

A, International Aid Agencies -----

B, Local NGOs -----

C, The government -----

D, Private sector -----

E, Other actors -----