



Combating HIV/AIDS in Kenya: Priority Setting and Resource Allocation

1.0 Background

1.1 Introduction

HIV/AIDS pandemic has emerged as one of the leading challenges to global public health and development. The report on the global AIDS epidemic shows that about 40 million people are currently living with the virus worldwide. Each year, five million people succumb to the disease.

In Kenya, the first AIDS case was reported 1984. Latest reports indicate that at the end of 2003, 6.7 per cent of adults within 15-47 age bracket, or 1.2 million people are HIV positive. HIV prevalence is still increasing in many parts of Kenya. The national prevalence was estimated at 10.5 per cent during the year 2002, with major variations between different parts of the country. In some vulnerable population groups, HIV prevalence is as high as 35 per cent. Prevalence is consistently higher in urban (16.5 per cent) than in rural areas (12.5 per cent), but in terms of absolute total number of people infected, the effect is greatest on rural areas where over 80 per cent of the population live.

1.2 Policy and Regulatory Framework

In response to the spread of the virus, the Kenya Government prepared the **Sessional Paper No. 4 of 1997 on AIDS** as part of the contemporary long-term framework. Besides, after declaring AIDS a national disaster in 1999, the government established the National AIDS Control Council (NACC) to guide implementation of the **National HIV/AIDS Strategic Plan 2000-2005**. The Strategic Plan aims at ensuring that multi-sectoral policies and strategies are integrated into core government-wide process, including the poverty reduction strategies. The priorities of the Strategic Plan include: Prevention and advocacy; Treatment, continuum care and support; Mitigation of the social and economic impacts of HIV/AIDS; Monitoring, evaluation and research; and Management & Coordination.

The co-ordination of the HIV/AIDS programme is spearheaded by the National Aids Control Council (NACC), which is currently housed in the Office of the President and draws membership from all sectors to ensure wide representation in the multi-sectoral approach to HIV/AIDS prevention, treatment and care activities.

The organizational structure of NACC for delivery of services includes: Ministerial AIDS Control Units (ACUs); Provincial AIDS Control Committees (PACCs); District AIDS Control Committees (DACCs) and the Constituency AIDS Control Committees (CACCs).

1.3 HIV/AIDS Related Interventions

A wide range of interventions geared towards preventing the transmission of HIV and mitigating the consequences of AIDS through care, support and treatments has been adopted within a multi-sectoral approach. The interventions include: prevention of heterosexual transmissions; Promotion of abstinence and faithfulness to one partner; voluntary testing and counseling; promotion of condoms; control of other sexually transmitted diseases; prevention of mother to child transmission; safe blood transfusions; palliative care; treatment of opportunistic infections; administration of antiretroviral therapy and home-based care programmes.

This study addressed a set of key questions considered essential to resource allocation decisions for multi-sectoral HIV/AIDS-related activities in Kenya. These include: 1) The considerations that influence the process of prioritising national HIV/AIDS interventions, given that overseas development and donor funds follow different channels and procedures for budgeting and financial control; 2) Are the HIV/AIDS related budget figures rationalized with national priorities or merely based on resource ceilings? 3) How effective is the MTEF

in providing budgetary allocations to specific HIV/AIDS programmes? 4) What percentage of expenditures is allocated by the central government, as opposed to funding from donors and NGOs? 5) What are the effects of alternative patterns of resource allocation on alternative HIV/AIDS interventions?

2.0 Methodology

2.1 Conceptual Framework

The link between policy and programme implementation is defined by the relationship between program inputs and desired outcomes. In the case of HIV/AIDS, the inputs are the various cultural, social, epidemiological and economic factors that define the context of the national response. Programme outputs include training services, awareness campaigns, safe units of blood, VCT services, orphans support through school fees, condom sales, etc. The programme outcomes are often described as better knowledge, changed attitudes, adoption of safer sexual behaviour, better care of AIDS patients, etc., and ultimately such outcomes may have impacts on HIV transmission, quality of life and aversion of future expenditures.

The processes within which the programme operates influence the input and output of programmes and the extent to which outputs lead to such outcomes as behavioural changes. This process includes political commitment, socio-economic factors, donor support, national policy, planning and budgeting. Political commitment determines the way the response will be organized and integrated into appropriate government action plans, agenda and policy. This involves the establishment of legal and regulatory framework, policy formulation, the structure of the programme, and the budgeting and expenditure processes. These factors determine the programme components, which lead directly to service outputs, i.e. information, knowledge and communication, support, treatment, etc. To the extent that these services are manifestly incorporated in the budgetary provision and the extent to which they are funded and utilized by the population, the programme will have an effect on reducing HIV incidence & prevalence and improving the quality and amount of care and support services provided to people living with HIV/AIDS and their families.

2.2 Types and Sources of Data

Both primary and secondary data were used in this study. Primary data was collected through a survey in Nairobi, based on non-probability (purposive)

sampling, and interviews with 30 key informants from public, NGO, donor and the relevant stakeholder organizations including NASCOP, MoH, MoF&Planning, MoEST Trade & Industry, USAID, DfID, Policy Project, US Centre for Disease Control, Provincial AIDS Control Unit in Nairobi. Secondary data was obtained from the above stakeholder organizations.

3.0 Research Findings

3.1 Policy Environment and Priority Setting

The study revealed existence of a strong institutional capacity and enabling policy environment for effective response to HIV/AIDS pandemic in Kenya. HIV/AIDS is also given prominence in the country's poverty reduction strategy. However, the HIV/AIDS strategic plan has not been sufficiently mainstreamed and integrated into the PRSP/MTEF process. It is not possible to track HIV/AIDS-related expenditures to show national commitment to multi-sectoral and multi-level responses. As it is, the MTEF does not account for HIV/AIDS-related expenditures across the different sectors involved. HIV/AIDS related budget figures are largely based on ceilings rather than being rationalized alongside priority issues/areas. This inevitably implies that national response to HIV/AIDS will continue to be under-funded, fragmented and inadequate.

At ministerial levels, most ACUs do not have the capacity to influence budget allocation decisions. This was particularly attributed to the fact that most ACUs were headed by officials at the levels of Under-Secretaries and below who apparently have limited influence on budgetary matters within ministries. It was also established that HIV/AIDS-related expenditure items were used mainly to justify larger amounts of ministerial budgets. Funds allocated to these items were prone to reallocation to different expenditure items as deemed fit by the accounting and finance officers. The study established that ACUs headed by senior officials in the ministries, i.e. Deputy Secretaries and above were fairly much more focused and influenced budgetary allocation decisions within the respective ministries. For instance, the Ministry of Health's ACU, headed by the Director of NASCOP, was identified as one of those most active units involved in implementation of the HIV/AIDS strategic plan.

3.2 HIV/AIDS and Macro-Economic Framework

The survey, revealed that despite the existence of a strong institutional capacity and policy aspects of

HIV/AIDS, the costing of the multi-sectoral HIV/AIDS strategic plan lies outside the center of the national budget allocation decisions and the MTEF. It was also established that donor agencies, NGOs, CBOs, FBOs and private sector actors separately plan and budget for HIV/AIDS-related funds.

3.3 Co-ordination and Management of HIV/AIDS

It was established that coordination and management of HIV/AIDS activities in the country was bedeviled with several setbacks. For instance, conflicting roles of key actors involved in the implementation of national programmes, particularly the main co-ordinating body (NACC) and the Ministry of Health watered down the dialogue and effectiveness of various programmes and activities.

There were also concerns that the establishment of many organs below NACC tended to delay decision-making, breed duplication of activities as well as conflict of interests. Of particular concern were the roles of the PACCs, and DACCs CACCs regarding coordination and implementation of HIV/AIDS activities was concerned at the district and constituency levels. The roles of the PACCs and CACCs, particularly, are not clearly spelt out and distinguished from those of the other committees.

The survey also revealed that stakeholders were not keen on developing strategic partnerships amongst themselves, based on comparative advantage and cost-effectiveness. Reluctance by various actors to share information relating to expenditures makes it difficult to develop partnerships and collaborations based on comparative advantages and cost-effectiveness.

3.4 Resource Allocation and Expenditures

The consolidated budget for implementing the five-year strategic plan was estimated at Ksh 54.87 billion. The budget was developed by NACC using the description of the resource envelope obtained from the situational analysis and alternative allocations of the envelope to the priority activities.

According to the KNASP, HIV/AIDS resource allocations during the period 2000-2005 are projected as follows in order of priority: Treatment & care (56.322 per cent); Policy development (17.19 per cent); Behavior change (15.268 per cent); Impact mitigation (5.034 per cent); PMTC (2.636 per cent); STI Treatment (1.492 per cent); Research, M&E (1.482 per cent) and Blood safety (0.576 per cent).

On the other hand, the public sector has been and is projected to provide the largest share of HIV/AIDS resources. Overall, the share of resources to finance the five year HIV/AIDS strategic plan is as follows: public sector (50.69 per cent), Development partners (27.25 per cent), NGOs (15.85 per cent), CBOs (3.69 per cent), private sector (2.23 per cent) and FBOs (0.3 per cent).

It is also important to note that different organizations channel resources to different priority activities. The Development Partners mainly funded behavior change, blood safety and STI treatment, while PMTCT is largely funded by NGOs. The public sector bears the biggest burden of treatment and care. NGOs as well as development partners and CBOs mainly fund impact mitigation; research, monitoring & evaluation by NGOs and the public sector, while resources on policy development and management are largely borne by development partners. Finally, the study revealed that the share of resources from the private sector, CBOs and FBOs was minimal and evenly spread across all the priority areas.

3.5 Alternative Resource Allocation Patterns and Outcomes

The alternative resource allocation patterns as percentage of total expenditures for the KNASP 2000-2005 that would give optimal outcomes (per priority area) were found to be as follows: Behavior change: 26.72; 26.72: 0.30; STI treatment: 1.56; PMTCT: 4.02; Treatment/care affected and infected: 55.32; Mitigation of socio-economic impact: 3.57; Research and M & E: 2.01; Policy development and management: 6.50.

Specifically, the reallocation of resources in the above proportions would result in reduction of prevalence rates by 31 per cent and 45.9 per cent for the 15-49 and 15-24 year-olds, respectively, during the period 2004-2005, everything else being equal.

3.5 Constraints and Challenges

Generally, the control and management of HIV transmissions have been hindered by the following challenges and constraints: (i) Ineffective integration of the HIV/AIDS strategic plan into the PRSP/MTEF process; (ii) Weaknesses in management and coordination of HIV/AIDS programmes and activities; (iii) Lack of clear definition and delineation of the roles of the various units of the National Aids Control Council; (iv) Duplication of efforts by actors involved in HIV/AIDS activities; (v) Lack of

transparency and accountability in the control and management of HIV/AIDS resources; (vi) Inadequate or even lack of information about HIV/AIDS incidences to facilitate planning and budgeting as well M&E; (vii) lack of adequate resources and (viii) Inadequate coverage of target populations.

4.0 Summary, Conclusions and Recommendations

4.1 Summary and Conclusions

The overall objective of this study was to investigate the prioritization and resource allocation options for HIV/AIDS activities in Kenya. Identified priority areas in the 2000-2005 national AIDS strategic plan included behavior change, blood safety, STI treatment, PMTCT, treatment & care, impact mitigation, research, monitoring & evaluation and policy development & management. The broad objectives of HIV/AIDS programme interventions are to reduce HIV prevalence among targeted age groups; increase the coverage of preventive and essential treatment & care services and avert future treatment and care expenditures through preventive measures.

The study revealed that whilst there is a strong institutional capacity and enabling policy environment to address HIV/AIDS issues, these are not effectively incorporated in the PRSP/MTEF process. Institutional weaknesses and creation of numerous committees have also adversely affected the management and coordination of HIV-related matters.

The study shows that the public sector has been and is expected to provide the largest share of resources towards controlling and managing HIV/AIDS in the country. The public sector also contributes the largest share of HIV/AIDS treatment & care resources as well as for research, monitoring and evaluation. On the other hand, development partners, the private sector, CBOs and FBOs contribute the largest amount of resources towards preventive measures, impact mitigation and policy development and management.

While considerable progress has been made in harmonizing the HIV/AIDS activities by various actors, little has been done to develop stakeholder partnerships to facilitate implementation of components of the activities for which different stakeholders/actors have comparative advantage. The study also showed that with increased

partnerships and collaboration, there is room for scaling-up the participation of private sector in financing HIV/AIDS activities beyond workplace programmes.

Finally, the analysis showed that there is great potential for improving the national response by reallocating more resources towards preventive measures, particularly focusing on behavior change among the youth and adults as opposed to policy development and management as envisaged in the five-year HIV/AIDS strategic plan. Depending on the stage of the pandemic, it is important to target interventions to those whose behavior places them at highest risk, while increasing prevention efforts to reach all who are vulnerable. Besides, scaling up the response for care, treatment, and support for those infected and affected by HIV will be necessary in places with high or rising HIV prevalence.

4.2 Recommendations and Policy Implications

The following recommendations are suggested for consideration by policy-makers, planners and implementers of HIV/AIDS programme:

- 1) Integration of the HIV/AIDS strategic plan in the PRSP/MTEF;
- 2) Enhancing participatory planning and budgeting;
- 3) Developing appropriate institutional linkages, partnerships and collaborations;
- 4) Strengthening and streamlining institutional mandates and capacities;
- 5) Enhancement of accountability and best practices in HIV/AIDS programme management and administration;
- 6) Encouragement of increased private sector participation in HIV/AIDS-related activities;
- 7) Enhanced preventive and behavior change interventions;
- 8) Improved provision and availability of cheap drugs;
- 9) Encouragement of home-based activities.

For detailed discussion of the issues contained in this Brief, refer to IPAR Discussion Paper No. 059/2004: **Combating HIV/AIDS in Kenya: Priority Setting & Resource Allocation** by Christopher H. Onyango & Ernos H.N. Njeru. ISBN 9966-948-06-6.

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