Extract from Bridging Research and Policy on HIV/AIDS in Developing Countries – Country Study: Kenya

Background

In contrast with Uganda, Kenya is a case of policy drift regarding HIV/AIDS. The first case of HIV was officially identified in Kenya in 1984. Table 2 below charts the trajectory of HIV infection rates, which rose to an estimated peak of 13.4% in 2000. Although the prevalence declined to 9.4% in 2003, this does not necessarily imply a reduction in infection rates, but could mean that the number of deaths has been more than the number of new infections (NASCOP, 2003). It is important to note that such figures are probably overestimated, since the most recent – and widely seen as authoritative study – put the HIV infection rates at 6.7% in 2003 (GoK, 2004).

Table 2: National infection rates, % (1990-2003)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
5.1	6.3	7.4	8.5	9.5	10.4	11.2	11.9	12.5	13.0	13.4	13.0	10.2	9.4

Source: NASCOP (2003).

The basic story of government response to HIV in Kenya was one of drift through much of the Moi regime (until late 2002). The policy response in Kenya was to set up a National AIDS Committee (1985), NASCOP (1992) and NACC (1999), which developed a range of strategic plans. However, there was little implementation on the ground. With the inauguration of the new president in early 2003, responding to HIV has been identified as the top priority for the country. The response within the NGO community has also been mixed, constrained by the problematic governance that characterised the Moi era.

Table 3 outlines the milestones for HIV in Kenya within each of the main arenas of our analysis (context, evidence, links and external influences). What explains the policy response in Kenya? What role did research have – if any?

Table 3: Kenya HIV/AIDS milestones and the RAPID framework

Date	Context	Evidence	Links	External influences
1984		First case of HIV/AIDS diagnosed in Kenya.		
1985	National AIDS Committee set up.	Project: Epidemiology and Prevention of HIV/STDs.		
1986		Publication: Impact of HIV on Mothers and Children.		
1987	Establishment of the Kenya National AIDS Control Programme.			Considerable donor support for AIDS control activities.
Early 1990s	Kenya AIDS NGOs Consortium (KANCO) established.	Indiana University collaborates with Moi University on Health Sciences.	Public awareness increase dramatically.	Donor funding rapidly declines owing to governance concern.
1992	NASCOP established.	Randomised clinical trial of breastfeeding and formula feeding starts, Nairobi.	NGOs establish localised programmes.	
		Cost-benefit analysis indicates that for every shilling spent on prevention there is 30 shillings net savings in benefits.	NGOs note President Daniel Arap Moi was 'not doing enough' to tackle HIV/AIDS.	World Bank credit of US$40 million for STI prevention.
1996	Parliament pass the Sessional Paper No. 4 on AIDS.	Clinical Trial of Nonoxynol-9 and HIV Infection Among Prostitutes in Mombasa.		
1997	Former President Daniel Arap Moi declares AIDS a national disaster; establishment of the	VCT becomes mainstream in the fight against the epidemic.		

	National AIDS Control Council (NACC).			
1999	Kenya government, biggest employer, worries about staff – begins to invest in prevention programmes.	Study on social context of perception of AIDS risk and sexual behaviour.	Most of Kenya's CSOs are members of the Kenya AIDS NGOs Consortium (KANCO).	Most donors disburse their funds through NGOs and CBOs.
2000	Moi states that Kenyans should abstain from sex for two years.	The first HIV vaccine designed specifically for Africa will begin human trials, after approval by the government.	Most religious organisations have joined the fight against AIDS, but mixed messages.	
2002	The new president, Mwai Kibaki, declares total war on HIV/AIDS.	Kenya's National AIDS Control Council calculates that the nation is losing about US$2.6 million daily to the HIV/AIDS epidemic.	NACC holds a week conference with faith-based organisations (FBOs) in a bid to solicit greater and better coordinated FBO involvement.	Internews (a media organisation that works with radio and TV stations around the world) extend their work to Kenya.
2003	President Kibaki becomes first African President to be featured in a TV commercial on HIV/AIDS; Cabinet committee set up.	Kenya conducts large-scale HIV survey for the first time. Random HIV tests of 8,000 people countrywide.	INGO Africans Unite Against AIDS Globally establishes 100 VCT centres.	US announces plans for 10-fold increase in ART for PLWHA in Kenya.
2004			Faith conference.	

Context

HIV was identified in Kenya in 1984 – just as concerns about the disease were materialising in the West. Initially, the Kenyan government accepted the presence of the disease; however, it soon moved into denial, owing to fears over the loss of inward investment and tourism, key to the economy. The context was critical to this decision: Kenya was a poor country with a major debt burden and the government did not want any more bad news. The lack of policy response reflects a failure of leadership by President Moi. The topic was slow onto the political agenda; while Moi declared AIDS a national emergency in 1999, he never engaged meaningfully in responding to it. For example, in 2001, he declared that Kenyans should abstain from sex for two years as a means of fighting the disease.

The troubled political context in Kenya through the late 1980s and 1990s also forms a key part of the story. The policymaking and implementation functions of the policy process were characterised by pervasive corruption. Internally, this meant that the policy response to HIV/AIDS was ineffective. Externally, it meant there were problematic relations with international donors and aid was withheld.

The future remains tricky. The new government must deal with a legacy of mismanagement, and concerns remain about how quickly it can improve governance in an overall sense. Given the rapidly evolving AIDS situation with ARVs, it will take time for the political system to review the policy and legal frameworks. There are likely to be major challenges at the implementation level as regards system and infrastructure. (Mundy, 2003)

Evidence

The sad point about the Kenya case is that the evidence did in fact exist. The various institutions responsible for HIV did pull together strategies based on evidence – really from the mid-1980s onwards. For example, the five-year plan launched in 1987 by the National AIDS Control Programme emphasised very much the key areas of awareness, prevention and response that might have made a difference. It included, for example, four prevention priority areas: sexual transmission; blood transmission; mother to child transmission; and disease surveillance. The second five-year plan

reinforced these and included the need to broaden the national response. The Ministry of Health produced a series of policy documents that highlighted the background to the disease, the impacts, interventions and policies. These were evidence rich – in particular, the AIDS in Kenya publications that were prepared since 1993.

However, it was only since the mid-1990s that AIDS has really been taken seriously as a development issue. This leads to the inclusion in the seventh National Development Plan (1997) of a whole chapter on AIDS. In the same year, Parliament passed Sessional Paper No. 4 on AIDS, which stresses the importance of advocacy and policy development. The paper set out an HIV/AIDS policy framework within which AIDS control activities would be undertaken for the next 15 years (1997-2012).

The future for Kenya and bridging research and policy looks favourable. Kenya has a larger research community in most disciplines compared with most other African countries, including six public and 13 private universities,[2] and several prominent regional research institutions also headquartered in Nairobi (Tostensen, 2004). The other interesting aspect is that there appears to have been a renaissance for policy analysis and research.[3] This has been reflected in the recent development of a number of autonomous public, quasi-public and private research institutions, both broad and sector-specific in their mandate. Some new bodies are consulting companies employing professionals with research backgrounds; others work as policy think-tanks for government. Tostensen (2004) highlights that these institutions are effectively situated, and act as a linking mechanism, between academic research and policymaking centres: 'While maintaining high standards of professionalism they cultivate relations with decision makers (civil servants and politicians alike), venture into policy discussion and put forward policy options underpinned by their research findings' (Page 10).

There are several reasons for this. There is a perceived disproportionate balance of foreign researchers and consultants in the policy field: since 1995, a wide range of research conducted and data generated– from randomised clinical trials to perceptions surveys – has arisen from a collaboration between the University of Manitoba and the University of Nairobi. Tostensen (2004) also suggests the renaissance stems from the 'new opening for transparent debate after years of repression and executive dominance in policy formulation', and partly from the recognition by the research community of the need to move from the academic sphere to contribute more actively to policy debate. Since the new government came into power in 2003, it has completed the most authoritative assessment of HIV incidence in the country (GoK, 2004); however, as yet there are few studies of the policy process as it unfolds in Kenya specifically.[4]

Links

CSOs in Kenya have played an important role in the health field. This was particularly the case with regard to HIV given the weak policy response by government. It is estimated that CSOs (NGOs/CBOs/religious organisations) provided over 60% of HIV/AIDS/STI services at the grassroots level (KANCO). Many donors have disbursed their funds through NGOs and CBOs, where they have sponsored a broad spectrum of prevention, treatment, care and support activities.

However, there are a number of issues in the links sector that help explain why there have been some challenges to bridging research and policy on HIV in Kenya. First, while there are numerous NGOs in Kenya, many of these are merely shell organisations and are not actually functioning. Secondly, although most religious organisations have joined the fight against AIDS, many have refused to endorse condoms. They also have divergent opinions on the issue of the sex education curriculum for primary schools. Finally, the media, although largely free, has not played as active a role on HIV issues as in other countries (e.g. South Africa).

The situation is expected to improve with the new government. The NACC held a week-long conference with faith-based organisations (FBOs) in a bid to solicit greater and better coordinated FBO involvement in the fight against the epidemic. KANCO, which deals with advocacy and capacity-building activities and acts as a resource centre, is increasingly active.

[2] Figures from Ngome (2003), quoted in Tostensen (2004).
[3] Ng'ethe (2003), quoted in Tostensen (2004).
[4] Odhiambo-Mbai (2003), quoted in Tostensen (2004).

Box 7: HAART and prevention in Kenya: evidence and policy responses

There are strong arguments both for and against the adoption of Highly Active Anti-Retroviral Therapy (HAART) in Kenya. Those arguing against HAART focus on the issue of cost effectiveness, focusing on the ratio of programme costs to health-related outcomes such as lives saved, life-years saved, or cases of HIV prevented. The evidence suggests that, overall, it would be considerably more beneficial to concentrate scarce resources on prevention strategies (Marseille et al., 2002), rather than on treating people already diagnosed with the disease. However, those arguing for HAART champion the moral compulsion to respect existing sufferers (whose lives are at stake right now) over and above future sufferers. Furthermore, the cost of ARVs has reduced massively over recent years in response to widespread pressure led by NGOs. They are predicted to become even more affordable in the future, thus reducing the strength of the cost effectiveness argument.

In 2002, the Kenyan government allocated 100 million Kenyan shillings (around US$1.24 million) for AIDS care and treatment (ARVs and PMTCT), and secured further substantial funding from the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM). However, it is clear that, even with these increases, only a small percentage of sufferers will be reached. More funding is required for HAART; at the same time, it is vital that funds are not diverted from all-important prevention policies. In this context, a key recent development has been the February 2004 decision of the US government to provide substantial funds for ART in Kenya through the newly launched 3x5 Initiative.

External influences

External influences have had some impact on policy within Kenya. International media attention ensured that policymakers were aware of it. The donor community also supported many research initiatives at various points from 1985 onwards. The role of donors was constrained through the 1990s by their reluctance to engage more generally with the government of Kenya owing to governance concerns. In the early 1990s, the paradox was that even though the epidemic was getting worse, donor funding was rapidly declining. That said, most donors did disburse significant funding through CSOs.

With the declaration in 1999 of HIV as a national disaster, donors became more able to support the fight against HIV. This engagement has increased since the new government came into play from 2003. The new emphasis on Kenyan policies towards HIV has been pushed substantially by international actors. The 3x5 Initiative has been important in setting a policy agenda. The US in particular has provided substantial funds to expand ART in Kenya.

Conclusion

The policy context has not provided an enabling environment in which research relating to HIV could be translated into policy. Even when HIV featured on the political agenda, and research was forthcoming, the research-policy gap was not bridged; even where there was evidence, the resulting policy was based more on ideological factors (only abstinence), as a result of a lack of genuine leadership. Today, the implementation of evidence-based policy remains difficult in the context of weak institutional structures, a legacy of mismanagement and weak infrastructure.

Despite the role CSO have played in the delivery of HIV services, the lack of political leadership and the uninviting political context has meant that civil society has not been strategically harnessed or motivated to act as a linking mechanism. This has been exemplified by the non-consistent and unintegrated role of FBOs. However, it is encouraging that government is now harnessing the influence of religious-based groups.

The international arena has been important in putting HIV on the Kenya national agenda. However, its influence has been restricted by the governance and corruption problems of the Moi regime and its legacy. Donors did disburse funds through CSOs, but impact appears to be limited. This may owe to a disabling environment arising from lack of political leadership. However, even with the current proliferation of international actions, important questions remain regarding the extent to which comprehensive research has fed into these new policies. For example, regarding the 3x5 Initiative, policy needs to incorporate essential evidence on the sustainability of treatment, equity in access to this treatment, the strength of the health system and transport infrastructure in order to ensure consistent access to treatment, and the overall viability of the existing governance structures in Kenya to oversee the implementation of this massive initiative. Several critics argue that such important research has not been addressed in this policy, (this is further elaborated in Chapter 4).