

## Case Study on Local Government Responses to HIV/AIDS in Kenya

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*September 28, 2004*

### *Abstract*

In recent years, donor support for HIV/AIDS in Africa has shifted from centralized health responses to more decentralized multisectoral responses. As more types and levels of institutions (community, local government, private, etc.) participate in the national HIV/AIDS response, there is a need to better understand and coordinate these new players as they manage their evolving responsibilities in addressing HIV/AIDS.

This paper draws upon the analytical framework of the *World Development Report 2004: Making Services Work for the Poor* in examining the challenges and opportunities of decentralized service provision. Presenting a short case study based on field research in two towns and one city in Kenya, the author draws lessons from local government experiences in managing the challenges of the epidemic in an environment of decentralization. How does a small municipality know where to start in building a response to HIV/AIDS? Where does a Public Health Officer find the budget to support HIV/AIDS activities? How does a city council ensure that its staff have access to information and services? These are some of the questions raised in this qualitative note.

The paper illustrates how the challenges of supporting decentralized HIV/AIDS responses relate to broader decentralization themes (e.g. unclear and unfunded mandates, poor coordination between service providers) and provides some recommendations on how to approach these challenges.

This paper—a product of the Urban Development Unit (TUDUR)—is part of a larger effort in the World Bank to support local governments in the increasingly challenging environment of HIV/AIDS.

*\*The author would like to thank the Association of Local Government Authorities of Kenya (ALGAK) for their valuable help in facilitating the field research and providing much of the background material.*

## **Abbreviations and Acronyms**

ALGAF	African Local Government Action Forum
ALGAK	Association of Local Government Authorities Kenya
AMICAALL	The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ASO	AIDS Service Organizations
CACC	Constituency AIDS Control Committees
CHW	Community Health Worker
COPHIA	Community-based HIV/AIDS Prevention, Care and Support
DACC	District AIDS Control Committees
DTC	District Technical Committees
ICASA	International Conference on AIDS and Sexually Transmitted Infections in Africa
IEC	Information and Education Communication
KANCO	Kenya AIDS NGO's Consortium
KIREC	Karen Information and Resource Information Center
LA	Local Authority
LASDAP	Local Authority Service Delivery Plan
LATF	Local Authority Transfer Fund
LGRHA	Local Government Responses to HIV/AIDS (Handbook)
MAP	Multi-country AIDS Program
MoH	Ministry of Health
MoLG	Ministry of Local Government
NACC	National HIV/AIDS Control Council
NAP	National AIDS Program
PACC	Provincial AIDS Control Committees
VCT	Voluntary Counselling and Testing
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
WEHMIS	WEM Integrated Health services

## Introduction

The following report is part of the follow-up to the *World Development Report 2004: Making Services Work for the Poor*. In presenting a case study of local government responses to HIV/AIDS in Kenya, the author wishes to illustrate the challenges and opportunities implicit in the decentralization of key services.

The paper is presented in the following four parts.

1. Analytical framework
2. National HIV/AIDS response and local governance in Kenya
3. Case studies of 3 cities and towns in Kenya
4. Lessons and recommendations

### Section 1: Analytical Framework

In recent years, nearly all countries in Africa have undergone reforms to promote decentralization. “A 1994 survey of developing and transitional nations showed that out of 75 economies with populations greater than 5 million, all but 12 had embarked on some type of decentralization” (Kelly 2003: 13). These reforms have aimed to increase the roles and responsibilities of local government institutions in order to support more responsive and accountable forms of governance. Increasingly at the local level, the stakeholders involved in governance are changing as well- with larger roles being played by the private sector and civil society, and a shrinking role being played by central government (figure 1 below). “In summary, it may be said that public goals (delivery of basic services) may be achieved, and increasingly are by non-public means” (Kelly 2003: 14). While this framework allows for greater choice for service-users, it also presents increasing coordination and management challenges for local governments.

**Figure 1:** The Emerging Shape of Governance. (Kevin Kelly, 2003)



*“Decentralization can be a powerful tool for moving decision making closer to those affected by it. Doing so can increase the links and accountability between policymakers and citizens—local governments are potentially more accountable to local demands—as well as between policy makers and providers—local governments are potentially more able to monitor providers.” WDR (2004) 1.23*

To say that HIV/AIDS presents enormous governance challenges, is to severely understate the impact that the epidemic is having on every aspect of development and well-being, particularly in sub-Saharan Africa, home to 70% of the world's 42 million people living with HIV/AIDS. As a public health and development challenge, the response to HIV/AIDS has become increasingly multisectoral –meaning that all levels and departments of government, and all sectors of civil society and the private sector are finding it necessary to proactively address the epidemic or defensively react to the compounding development challenges it creates. Donor support for HIV/AIDS, especially the World Bank Multi-Country AIDS Program (MAP)<sup>1</sup> funding, has been emphasizing a pro-active multi-sectoral approach to the epidemic.

In recent years there has been an increased interest in understanding how HIV/IDS is being dealt with at the local level. A body of literature has emerged to examine 'local responses' to HIV/AIDS, but few of these studies have looked at the role that local governments play in participating, supporting and coordinating the local responses to HIV/AIDS. *This paper, takes the position that given the important role that local governments play in supporting accountable and responsible governance under decentralization reforms, and given the need for HIV/AIDS responses to be both locally driven and multisectoral → then it should follow that local governments have an important dual role to play in supporting and coordinating local responses to HIV/AIDS (by civil society and the private sector) and ensuring that national responses are effectively translated to meet local needs (integrating HIV/AIDS into all government institutions and planning, facilitating partnerships etc.)* See Figure 2.

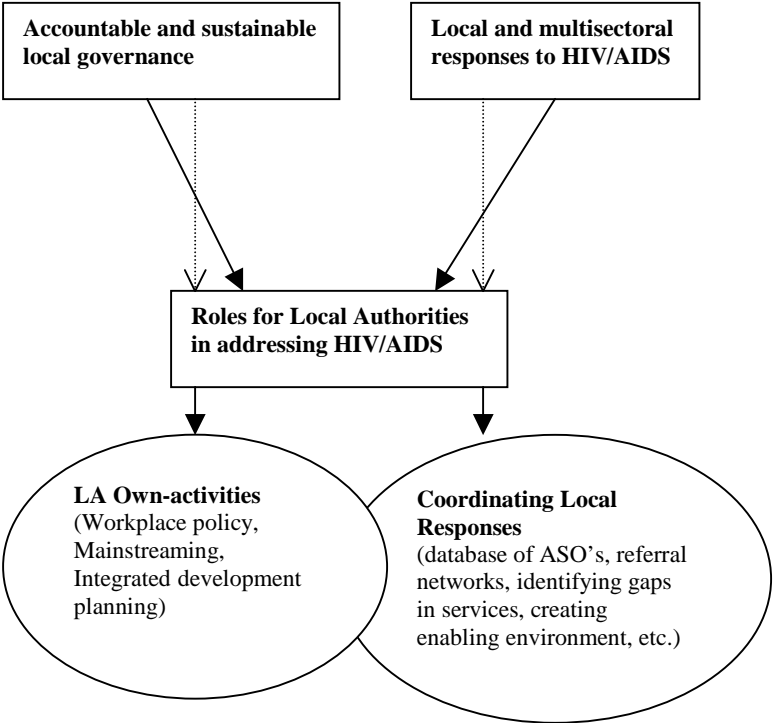
To complement the analytical work that has been done on local government responses to HIV/AIDS<sup>2</sup> this short case study of Kenya will highlight how local governments are responding to HIV/AIDS and identify the obstacles and challenges facing them.

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<sup>1</sup> [http://www1.worldbank.org/hiv\\_aids/](http://www1.worldbank.org/hiv_aids/)

<sup>2</sup> Kelly, 2003.

**Figure 2:** Roles for Local Authorities in Addressing HIV/AIDS



## *Section 2: National HIV/AIDS response and local governance in Kenya*

The local government response to HIV/AIDS is shaped by both design and implementation of the national HIV/AIDS program as well as the way in which decentralization reforms have defined the scope of activities for local governments.

### **2.1 HIV/AIDS**

While there has been recent debate over the prevalence rate in Kenya, the most recent figures by UNAIDS estimate the adult HIV prevalence rate to be 9.4% (2003), with higher prevalence in urban areas (from 16-17% with some evidence of areas with prevalence above 20%). The Kenya National HIV/AIDS Strategic Plan was launched in 2000 (2000-2005), but has gained momentum since the democratic election of President Mwai Kibaki. In addition to declaring HIV/AIDS a national disaster, the President has ensured that the National HIV/AIDS Control Council is located within the office of the President and receives high political visibility.

The National HIV/AIDS Control Council (NACC) is responsible for the oversight of the national response to HIV/AIDS and serves as the conduit for all donor funding (including MAP \$50 million, Global Fund \$132 million.) The World Bank funding for HIV/AIDS in Kenya has been through 2 projects –one focusing on the Health Sector (Decentralized Reproductive Health and HIV/AIDS Project: \$50 million, 2000) and an additional MAP<sup>3</sup> project that emphasizes the multi-sectoral elements of an HIV/AIDS Response (HIV/AIDS Disaster Response Project: \$50 million, 2000). The MAP funds are coordinated by the NACC to carry out the National Strategic Plan, however the project design focuses primarily on Public Sector Line Ministries (\$10.3 million) and Civil Society Responses (\$30 million). In addition the MAP supports the NACC and its decentralized management units in coordinating the National AIDS Program (NAP) (\$12.1 million).

*Kenya, a country with an external debt of US\$ 8.94 billion, has recently declared HIV/AIDS a national disaster. This was in recognition of the fact that over 2 million out of a total population of 29.5 million (2000) were HIV infected and a cumulative number of 1.5 million people had died due to AIDS. Because of HIV/AIDS, life expectancy has dropped by approximately 13 yrs to 51 yrs (1998); while GDP reduced by -0.3 in 2000 and is expected to worsen in coming years. (UNAIDS, 2004)*

The National AIDS Program has developed a decentralized management system to coordinate its activities nationally. There are two components to this decentralization process.

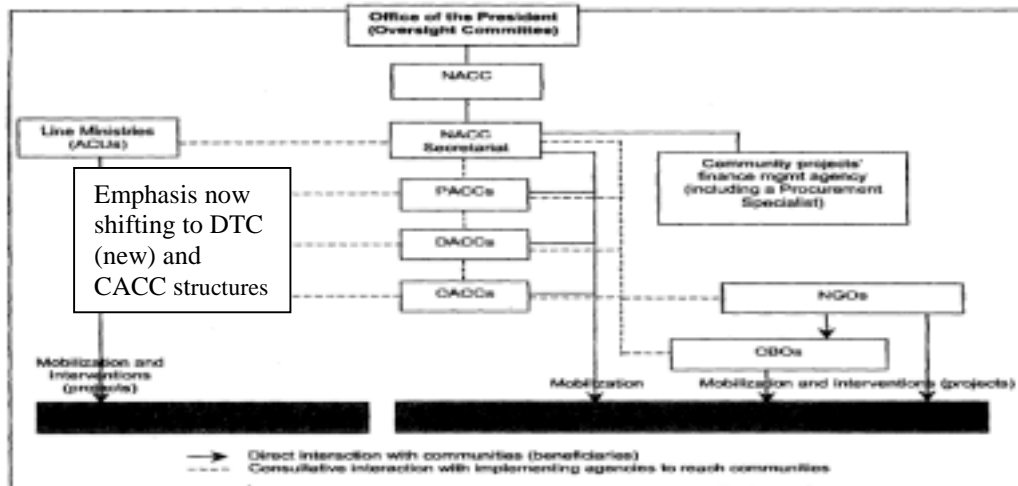
(i) On the one hand there are the **deconcentrated public sector responses** Each line ministry that receives funds from the NACC is expected to develop a workplan that includes integration of HIV/AIDS into all levels of government. The Ministry of Local Government, as of September 2003, had an early draft workplan that proposed activities to (i) establish baseline HIV/AIDS impact analysis for local authorities, (ii) develop awareness activities for Ministry and local authority staff (in total more than 60,000 employees) and (iii) prioritize HIV/AIDS related policies and establish a central AIDS database with Resource center.

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<sup>3</sup> The Kenya MAP Project (2000) was part of the first round of MAP funding for HIV/AIDS to be disbursed by the World Bank. Since 2000, the MAP projects have become better organized, having learned from experiences. In addition, as of 2002 under IDA13, funding for HIV/AIDS for IDA countries has become grant funding rather than lending. However, projects implemented prior to this decision are still loans.

(ii) The other component of decentralized management is the **local coordination of civil society responses**. Originally, the decentralized structure was intended to consist of Provincial HIV/AIDS Control Committees (PACC), District AIDS Control Committees (DACC), and Community AIDS Control Committees (CACC) (see Figure 3).

**Figure 3:** Decentralized arrangements for HIV/AIDS in Kenya (World Bank, 2000a)



These decentralized units were designed to coordinate the activities of civil society by centering the planning at various levels to ensure community involvement (Constituency AIDS Control Committees: CACCs) and to coordinate with deconcentrated activities (line ministries). However, this structure proved to be difficult to implement effectively in practice because of (i) unclear mandates and clear functions at the various levels, (ii) concern over political capture of the CACCs, and (iii) perceptions of community proposals being processed through multiple levels of administration before reaching the NACC. Instead, it was decided to eliminate the Provincial structures, and instead focus on District Technical Committees (DTC) and Constituency AIDS Control Committees (CACCs) both taking on mobilization and coordination function at their respective levels, while the DTCs were also tasked with technical support to CACCs. This new structure is still in its early stage and training of both DTCs and CACCs had not started as of August 2004.

However, the core function of the new DTC/CACC structure remains centered on coordination with civil society groups, and there is little support or reference to functions to be carried out by the local authorities themselves- such as developing a workplace policy for municipal staff and mainstreaming HIV/AIDS into municipal functions.

In May 2003, the Association of Local Government Authorities of Kenya (ALGAK) with the NACC, Kenya NGO Consortium (KANCO), and UNDP hosted a workshop of local authorities to

adopt a resolution affirming the commitment of local authorities to addressing HIV/AIDS and in initiating the process of launching the Alliance of Mayors Initiative for Community Action at the Local Level (AMICAALL<sup>4</sup>). In this resolution, and through activities supported by the NACC and coordinated by ALGAK, local authorities have been increasingly motivated to take initiative in addressing HIV/AIDS.

## **2.2 Decentralization in Kenya**

The process of decentralization in Kenya has been well documented in recent years. Most notably, two recent studies commissioned by the World Bank, '*Kenya: An Assessment of Local Service Delivery and Local Government in Kenya*' (2002) and '*Kenya: Community Driven Development: Challenges and Opportunities*' (2002) offer detailed and insightful reviews of decentralization, local governance, and community participation in Kenya<sup>5</sup>.

While there are multiple challenges apparent in the decentralized governance system in Kenya, there are two elements that are of particular relevance to the role that local authorities can play in addressing HIV/AIDS. These are the (i) unclear mandates for local government authorities, and (ii) parallel systems of administration and planning & lack of effective coordination between local authorities and civil society (both through CSO, NGO participation as well as community level planning).

A third challenge often cited by local authorities is lack of funds. While this is a common concern, relating to all areas of service delivery, in the context of HIV/AIDS the issue is not so much lack of funds but lack of information on how to access available funds. In this respect, this paper will look at how local governments can (i) access available funds for HIV/AIDS (through NACC) and (ii) how local government activities on HIV/AIDS can be more effectively integrated into existing development planning and budgeting.

### **Challenges: Unclear Mandate**

Local authorities fall under the guidance of the Ministry of Local Government and are bound to the legal framework of the Local Government Act (1977). However, the functions and responsibilities of the local authorities are defined only in terms of 'permission' rather than being mandated. The activities that local authorities are permitted to carry out cover a range of services including, provision of health and education, road maintenance, markets, slaughterhouses, water and sanitation, recreation and street lighting. While all activities undertaken by local authorities require the approval of the relevant ministries, the provision of education and health services have generally been most clearly articulated, generally falling into the activities of only the larger municipalities (with regards to health, these are referred to as the 'Big 7'.) (Services:19:2002)

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<sup>4</sup> The actual launch of the AMICAALL chapter was delayed until June 12, 2004.

<sup>5</sup> These papers were written in advance of the 2003 constitutional review of the Local Government Act and does not include changes that have emerged from that process. However during the case study period (October 2003) the reforms of the constitutional review were not yet in place, and therefore the conditions described in the research papers are relevant.

In addressing HIV/AIDS at the local level there is often a tension between the prescribed mandates of the District Health Boards (overseen by Ministry of Health) to coordinate and manage activities relating to communicable diseases and the activities involved in coordinating a multi-sectoral response to HIV/AIDS that involves non-health, and non-government partners.

**In practice...**

- Do local authorities feel that they have a mandate to address HIV/AIDS? Where would this message come from, and what would be needed to support it?

**Challenges: Parallel Systems and Coordination of local planning**

The chart below (figure 4) illustrates the parallel systems for delivery of local services in Kenya, with a 'district system' that serves as a coordinating and planning function under the Office of the President, a 'sector system' that functions as the deconcentrated arm of the line ministries, and the 'local government system' that is supported by the Ministry of Local Government and consists of elected councils.

The emphasis of this research is on local authorities, decentralization and HIV/AIDS and so within this context, the emphasis is placed on local authorities that have locally elected representatives rather than on deconcentrated sector ministries. The District Government structure, which will not be discussed here, consists of deconcentrated sector ministries while local authorities are responsible for municipal management. Kenya currently has 174 local authorities; 3 city councils, 45 municipal councils, 62 town councils and 66 county councils. Under the Local Government Act, local authorities are legal bodies that operate under the direct supervision of the Ministry of Local Government (MoLG). The MoLG, and other sector ministries, have considerable authority over local authorities; and with respect to HIV/AIDS their policy direction and technical guidance is important in providing local authorities a framework in which to define their activities.

Local authorities consist of representatives elected at the ward level. The local authorities operate through systems of committees, composed of elected councilors, and chief officers which are appointed by the Public Service Commission. The committees allow for some participation of other interest groups in their areas of jurisdiction, but few authorities have so far allowed outsiders in their meetings. (CDD 30) This is a particular challenge when it comes to coordinating HIV/AIDS responses, as civil society organizations, who most often receive external funding and support to carry out their activities- often have little incentive or interest in 'being coordinated' by local authorities. This tension aside, the need for coordination of local HIV/AIDS responses is critical in ensuring that all populations (particularly vulnerable groups) are adequately served and that there are common standards for service. Functional integration, or ensuring that there is a

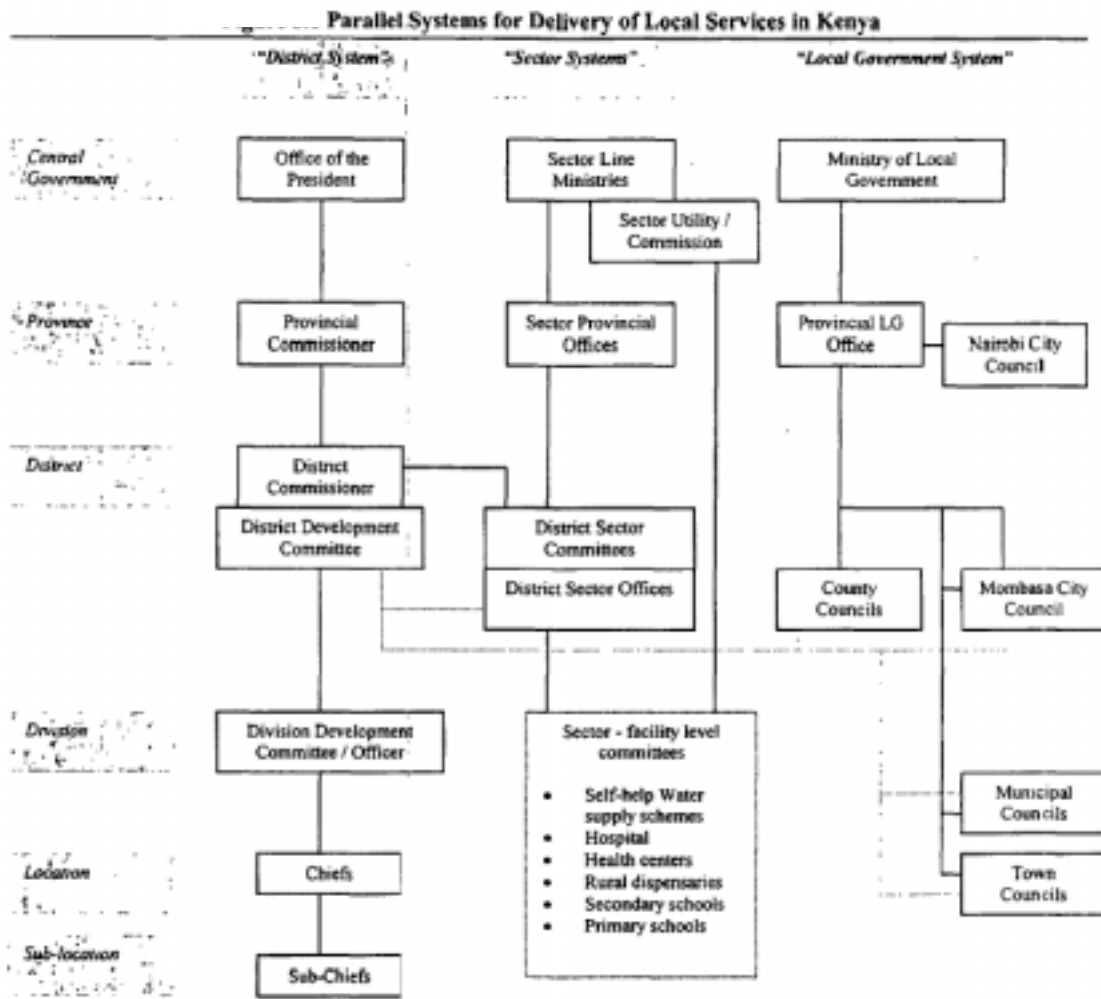
continuum of care and support for those seeking AIDS related services, remains one of the areas where local authorities have a clear and important comparative advantage.

In a 1998 reform, parliament established the Local Authority Transfer Fund (LATF) which allocates 5% of the national income tax to be directed to local authorities, based on a formula (for size, population, need) and the submission of a Local Authority Service Delivery Plan (LASDAP). The LASDAP is intended to be a 'participatory planning process to identify and prioritize local expenditures that can be included in the annual budget process.' (Local Services 10) While HIV/AIDS is changing the landscape of service delivery and demands in communities, this has, to date, not been reflected in the development planning process. One might venture three reasons for this omission. First, there has been little direct guidance/incentive from the MoLG on the importance and process of making development planning respond to HIV/AIDS related needs. Secondly, given the large amounts of external funding that is being coordinated through the NACC, there has often been a feeling that HIV/AIDS is 'already being taken care of' and should therefore not compete for the scarce resources which are allocated through LATF. Thirdly, and closely related to the above points, the relevance of HIV/AIDS as a development issue that extends beyond the mandate of the health sector is still not universally accepted and agreed upon. At the time of this research, the MoLG was considering working on the guidelines for the LASDAP process to better integrate HIV/AIDS related activities.

#### **In Practice...**

- Do local authorities know 'who is doing what' on HIV/AIDS? Do they have an interest in playing a coordinating role? Do they have the necessary authority and capacity to do so? How do local authorities interact with the DACC and CACC?
- Is HIV/AIDS integrated into the LASDAP (Local Development Planning)?

**Figure 4:** Parallel Systems for Delivery of Local Services in Kenya (World Bank, 2002a)



### *Section 3: Case Studies of two towns and one city in Kenya*

The national HIV/AIDS response and the decentralization framework provides a larger context from which to examine how local authorities are responding to HIV/AIDS in the three sites selected for this study.

#### **Local Government Responses to HIV/AIDS: A Handbook**

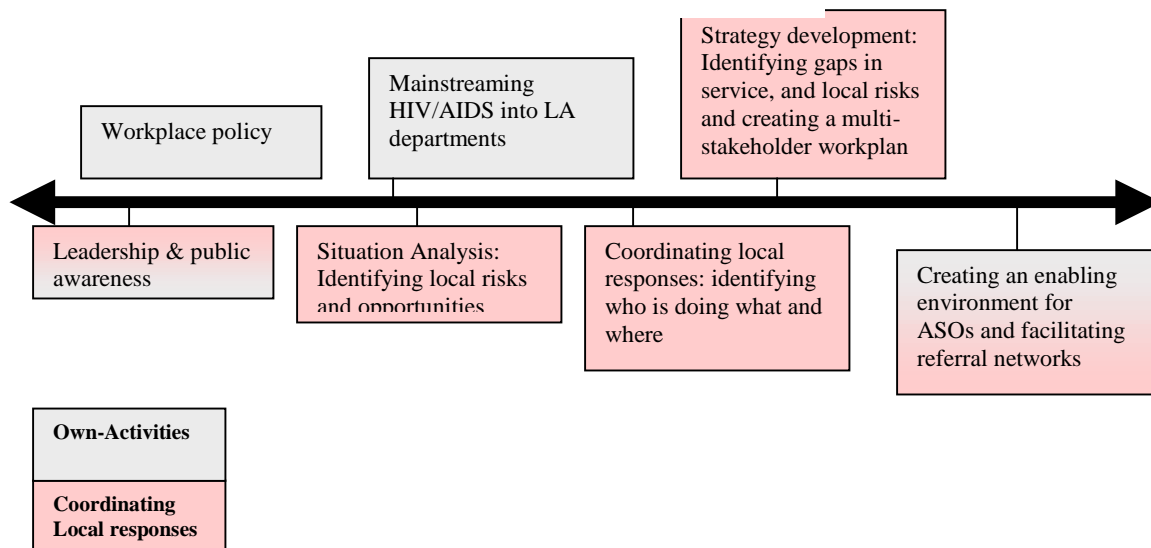
The case study research for this paper was conducted in September 2003, directly following the launch of a new World Bank publication, **Local Government Responses to HIV/AIDS: A Handbook**<sup>6</sup> (LGRHA Handbook) at the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) which was hosted by Kenya and held in the city of Nairobi.

The LGRHA Handbook was developed with a number of international partners, and presents an analysis of issues and opportunities for local governments in addressing HIV/AIDS. The main purpose of the Handbook is to provide mayors, councilors and elected officials with practical tools and recommendations for how they might address HIV/AIDS in their locality. The Handbook recognizes that local government responses will range significantly, and are dependent on a number of factors (including population and size, nature of the epidemic, issues of decentralization, strength and commitment of local leadership, funds available to local governments, strength of civil society, history of relations between local government and civil society, etc.). However, across the many different contexts in which local governments operate, there are certain functions which local governments have a comparative advantage. These areas of comparative advantage include: coordination and oversight of service providers and provision of services and information to municipal staff, as well as mainstreaming. The figure below (figure 5) illustrates some of the activities that may be carried out by local authorities—both internally through their own-activities (internal to the local authority functioning) and externally by coordinating local responses.

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<sup>6</sup> Available online at <http://www.worldbank.org/urban/hivaids/localgovernments.htm>

**Figure 5: A Continuum of Local Authority Responses to HIV/AIDS**



### Methodology

The research for this study was conducted in a brief field study (5 days) in 3 towns – Nairobi, Kajiado and Thika. In each city, the researcher visited with representatives from the municipal office (meeting with town clerks, mayors and elected officials), local AIDS Service Organizations, and representatives of the private sector. The interviews (see Annex 1) provided sufficient information to draw a general picture of the involvement of local authorities in addressing HIV/AIDS, and to draw some lessons and provide some tentative recommendations (see section 4).

### 3.1 The Case Studies: Kajiado

Kajiado is a community of approximately 5000 persons, and is situated x kilometers from Nairobi. This region is home to the bulk of the remaining Kenyan Masai community, a distinct ethnic group in Eastern Africa known for their nomadic lifestyle. With respects to HIV/AIDS, the Masai practices of nomadic lifestyle and polygamy present unique challenges. In addition, Kajiado is situated on the Nairobi-Mombasa transport corridor, which raises additional concerns . The Municipal Council, while aware and sensitized to the importance of HIV/AIDS, felt that with the challenges of providing basic services HIV/AIDS was not clearly in their mandate, and also that they did not have the resources (or capacity) to take action to address HIV/AIDS. Also, given the many facets of the epidemic and the many responses needed, there was a clear lack of knowledge on ‘where to begin.’

The Kajiado Municipal Council comprises 56 elected councilors, who serve as the representatives of rural constituencies. *Several councilors and the Mayor were present for a group discussion on HIV/AIDS.*

### **Awareness vs. behavior change**

In a country with high prevalence, there are often high levels of awareness. In Kajiado, the representatives were eager to point out that there was 98-100% awareness of the risks and safe behavior to address HIV/AIDS. Yet at the same time, all of the activities<sup>7</sup> and recommendations for activities (e.g. videos for youth) were centered around more awareness raising.

The challenge is the transition from awareness raising to creating an enabling environment for behavior change. For example, the issue of purchasing and disposal of condoms in a small town was highlighted as a significant impediment to condom usage<sup>8</sup>. The issue of stigma remains a central issue that impedes the enabling environment for effective behavior change. When asked if they have been tested for HIV or would be willing to be tested publicly (a popular advocacy activity in some countries), there was an overwhelmingly negative response by the group of local leaders interviewed, demonstrating that even opinion leaders are reluctant to lead by example when faced with the stigma surrounding HIV/AIDS.

### **Identifying local priorities and taking the first step**

For a small municipality with minimal resources and limited capacity, it is essential that any activities are (i) targeted specifically at local priorities and (ii) integrated into ongoing activities. It is unrealistic – and inefficient— to suppose that every small town and city will have the means or interest to carry out comprehensive HIV/AIDS activities. Instead **targeted interventions that are integrated into ongoing activities are most essential.**

In Kajiado, there were three areas identified as priority issues. These were (i) the polygamous lifestyle of the population (both within and outside of marriage), (ii) the road networks and their impact on the epidemic and (iii) the youth whose behaviors might be influenced so as to prevent infection. After some discussion, the local leaders decided that the priority with the greatest opportunity for targeted action was likely interventions with youth. This is not to say that the other priorities are less important, but simply that given the resources available there is a **need to prioritize**, and the selection of the youth intervention was linked directly to the Council's participation in providing education services and the possibility of targeting interventions through this channel (mainstreaming).

### **Accessing resources and partners**

The municipal council of Kajiado is unclear as to **what resources are available and how to access them.** This is a common issue that arises from a lack of coordination of HIV/AIDS resources and activities at the national and local levels. For example, while the participants expressed concern over the need for awareness-raising for the Masai community, there was little

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<sup>7</sup> For example, the town leaders explained the successful impact of a recent youth project, where students held a 'mock funeral' for an imaginary person who had died of AIDS, and as each person was asked to pass by the casket, they were asked to look into a mirror so that they might internalize the real risk that they face.

<sup>8</sup> In a small town, there is little confidentiality in buying condoms. Men or women that would like to use condoms when having sexual relations with multiple partners are faced with the difficulty of buying condoms in a non-confidential manner and therefore making it public that they are having multiple partners.

knowledge of where and how they might access information and education (IEC) materials, what NGOs are working on this issue, etc. National groups like ALGAK (Association of Local Government Authorities of Kenya) and KANCO (Kenya AIDS NGOs Consortium) face a similar challenge, on the flip side, having access to resources and networks (knowing who is doing what), but uncertain of where the demand is and how to meet that demand.

### 3.2 The Case Studies: Thika

Thika is one of the largest cities in Kenya, with a population of approximately 200,000 people. Located just 45 kilometers to the north of Nairobi, Thika is home to much of the country's industry, with particular emphasis on agricultural production, in pineapples (DelMonte) and ornamental plant cuttings (Kenya Cuttings). As an industrial center, with over 100 small and 26 major factories, Thika is home to a fluctuating population, with a day population (including daily/seasonal labors) that is considerably higher than night-resident populations. Many of the workers travel from the surrounding rural areas and reside in dormitory style accommodation while employed in the city. The shifting working population coupled with the centrality of transport hubs is likely responsible for the high HIV prevalence in Thika. Anecdotal evidence suggests that the percentage may be as high as 34%, which is more than twice the national prevalence.

As a large city, Thika Municipal Council is at the district-level of administration (see figure 4), which means that Thika has both district and local functions. The council comprises of 12 elected and 4 nominated councilors, with a town clerk appointed from the central government and a mayor elected from among the councilors. There are seven council departments - Education, Housing and Social Services, public health and Environment, Administration, Finance, Water and Sewerage, Works and Town Planning. While the Municipal Council is not responsible for health services (the District Hospital is run by the Ministry of Health) the Public Health Office is one of the largest departments in the council, and in addition to monitoring food hygiene, water quality, solid waste management, environment sanitation, it also has authority for "carrying out emergency operations to counter looming epidemic diseases." Thika is perhaps the most active of all of the local government authorities in Kenya in the area of HIV/AIDS, and has been actively involved in networks to share their experiences and to build their capacity in this area<sup>9</sup>.

While not clearly within the mandate of the municipal council, Thika has demonstrated leadership in undertaking HIV/AIDS activities. In 1998, Thika Municipal Council, in collaboration with Pathfinder International and Holy Rosary Sisters (a faith based organisation) began an initiative to conduct Training of Trainers within the municipal staff (with an emphasis on behavior change communication). These activities were expanded to include training of all municipal staff, as well as training in home-based care for community health workers. In 2000, Thika Municipal Council developed a proposal with the goal to, 'carry out preventative and control activities, establish and sustain home based care to the infected and affected families and give care, support and provide shelter to orphans resulting from infected families.' (Thika Municipality: HIV/AIDS Control

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<sup>9</sup> Thika has been active in the ongoing launch of AMICAALL, and they have recently (February 2004) completed a training in the African Local Government Action Forum (ALGAF) supported by WBI and MDP on HIV/AIDS and local government responses.

Programme, 2000). While the proposal presents a range of activities, the follow-up has been minimal, largely due to lack of funding.

*Discussions in Thika were held with the Town Clerk, councilors, former mayor, public health officer, representative from a local AIDS-related NGO (WEHMIS), as well as a team from the Del Monte pineapple plantation.*

### **Institutionalizing the response of leadership**

The activities to address HIV/AIDS in Thika Municipality have been centered, and largely limited to the Office of Public Health, where one staff person has been allowed to focus exclusively on HIV/AIDS. The budget for all activities to date has come from a line item on 'communicable diseases' (supported by funds from the MoH) as there is **no direct reference to HIV/AIDS in the budget** for the municipality.

One of the questions that often surfaces when designing and implementing multi-sectoral responses to HIV/AIDS is 'what office is most effective in coordinating important issues across sectors'? While traditionally HIV/AIDS responses have been located in departments of health, or in Thika—the Department of Public Health—there are good reasons why it may be more effective to place the HIV/AIDS tasks within a more **multi-sectoral level of administration**, meaning the office of the Chief Executive or mayor. For example, in the case of Thika, an initiative to conduct awareness-raising training for all municipal staff faced opposition by some department heads who felt that HIV/AIDS training was not a priority, and time should not be carved out of the workday for such activities. Because the individual coordinating the training was an employee of the Public Health Department, there was a challenge of authority and priority. With intervention from the Town Clerk, the trainings were carried out, but the challenge of authority remains.

While **good leadership** is an essential ingredient for local government responses to HIV/AIDS, it is critical that such leadership aims to institutionalize a response rather than to carry out independent one-off activities. The history of Thika municipality's involvement dates back to the late 1990's, but unfortunately early activities were not sustained as they were not integrated into an overall municipal strategy and commitment to HIV/AIDS.

Many of the activities conducted by the municipality on HIV/AIDS have centered on raising awareness and advocacy within the municipality itself. In addition to the staff trainings mentioned above, trainings were also conducted for lower level staff responsible for janitorial and maintenance work. As one staff person explained, the municipality was feeling the impact of HIV/AIDS- losing '5 staff persons a month' when it recognized that there might be a link between the cleaning staff working late at night, the 'free environment' in which they work and the impact of HIV/AIDS on the municipal staff. When the ensuing training for all staff (686 persons have been trained) was completed, there was a sense that the problem was 'solved' and that there was little need for ongoing activities. While this anecdote reflects the view of only one staff person, it serves well to hint that the **stigma associated with HIV/AIDS runs deep**, and that there remains a perception that the impact is not felt at all levels of society but is instead limited to cleaners and sweepers etc. This also demonstrates a need for more substantive data on the impact of HIV/AIDS on all levels of municipal staff.

### **Carving out a role for local authorities and expanding networks and partnerships**

While a common concern raised was the lack of resources to carry out more activities, there was little discussion of or familiarity with ongoing **activities by other local stakeholders- from civil society and the private sector**. For a large municipality such as Thika, one of the major challenges in all sectors- not just HIV/AIDS- is to identify and fill gaps in available services (such as VCT, home-based care, care for orphans and destitute, etc.), identify groups whose needs are not being met (poor neighborhoods, vulnerable populations (sex workers, migrant workers, truckers, youth, women, orphans, elderly etc.) and to provide a referral system or information that can link individuals to relevant services. Thika Municipal Council has a close relationship with Pathfinder International, an NGO (see figure 6) which has provided considerable technical assistance and capacity building to the council. However, there appears to be little formal interaction between Thika Municipal Council and other AIDS Service Organizations<sup>10</sup> (aside from the district hospital). In part this appears to be related to a perceived lack of mandate by the municipality to 'coordinate HIV/AIDS responses.' Interviews with WEM Integrated Health Services (WEMIHS), a large NGO that provides VCT services, orphan care and community outreach, indicated that while they were familiar with the HIV/AIDS Focal person in the Thika Municipal Council, they did not have contact on a regular basis, and were unfamiliar with the scope of activities being undertaken by Thika Municipal Council. In addition, while both WEMIHS and Thika Municipal Council have developed systems of training and mobilizing community health workers to support home-based care there was no coordination of these efforts to ensure maximum coverage.

**Figure 6: Partnerships- Pathfinder and Thika Municipal Council**

#### **Pathfinder and Thika Municipal Council: COPHIA**

Pathfinder focuses the bulk of its efforts in Kenya on its "Community-based HIV/AIDS Prevention, Care, and Support (COPHIA)" Program. Named for the Swahili word for "hat", which is slang for "condom", COPHIA aims to improve the ability of local communities to manage and implement HIV/AIDS prevention, care, and support activities for people living with HIV/AIDS (PLWHAs), their families, orphans and vulnerable children. COPHIA depends on the development and maintenance of two-way referral linkages between community-based support services such as home based care and facilities for medical treatment and clinical services such as treatment of opportunistic infections and community based services for support services. Community support services provide emotional, spiritual, and material support to both the infected and affected through a network of local groups. The other critical link is between voluntary counseling and testing (VCT) sites and community network of services to promote knowing ones status and ensuring services for those who need them.

The key to COPHIA's success is the mobilization of existing community resources to provide care and referral, and the involvement of local leaders in promoting community interventions. The resulting political commitment of community leaders provides the necessary foundation for a successful community-based HIV/AIDS prevention and care program; it is from this base that community involvement, ownership and sustainability develop. Besides this intensive community mobilization process, the program works to reduce stigma and discrimination of PLWAs by helping to ensure they remain active, contributing members of their families and communities to the extent possible. Through COPHIA, Pathfinder works to "normalize" HIV by increasing involvement between the infected and non-infected community members, such as adolescents helping their positive neighbors to plant vegetable gardens. By reducing AIDS's exception status, individuals become more receptive to prevention messages, are more likely to go for testing, and are more likely protect themselves and others from infection. COPHIA has specific activities geared towards orphans and vulnerable children such as vocational training for older orphans, support for school fees, legal services, and training to help protect them from exploitation and violence. However, there is much more that needs to be done to meet the increasing health, emotional, and material needs of this growing group.

<http://www.pathfind.org/>

There is another dimension to the gap in cooperation between the municipal council and civil society, and this relates to the enabling environment. If coordination of local HIV/AIDS responses and joint-proposal development to address key issue in partnership between local authorities and civil society is on the ‘strong coordination’ end of the spectrum of cooperation, then creating an enabling environment is at the other end. This means that even where the local authority may not be actively engaged with civil society partners in addressing issues together, there should be a recognition of the value-added of these groups and an effort to facilitate them in carrying out their work. For example, WEMIHS is required to pay for its license to operate a business, although it would appear that in an enabling environment such organizations might have such fees waived.

As an industrial town, Thika has the dual challenge and opportunity of the private sector. The challenge rests in the HIV risk factors generated by fluctuating populations and dormitory communities and the opportunities lie in the resources and capacity available to the private sector in addressing HIV/AIDS. Del Monte, for example, employs 6000 persons and manages an area of some 23sqkm. In this respect, Del Monte functions as something of a sub-municipality providing key services to its staff. Del Monte has not been very active in addressing the HIV/AIDS crisis, and has explained this in terms of a lack of guidance from national partners (i.e. NAC or Business Coalition) and lack of coordination with municipal partners. However, recently with support from a major trade union (COTU), they sponsored a staff wide awareness raising campaign. Given the relative autonomy of these large firms, and their strong independent resource base- the relationship between private sector and municipal authority with respect to HIV/AIDS is challenging but potentially rewarding.

### **3.3 The Case Studies: Nairobi City**

Nairobi is both the largest city and the administrative capital of the country, with an estimated population of 4 million. While there are enormous pockets of poverty in the city, Nairobi is also the center of economic activity for the country and a major international hub for the region. In this context, the HIV/AIDS challenge is of particular concern because (i) the Nairobi City Council has 17,000<sup>11</sup> employees that are at risk of infection, (ii) HIV/AIDS prevalence in the city is generally higher (estimated at 16%<sup>12</sup>) than the national average (9.4%), and (iii) an estimated 60% of the urban population lives in informal settlements (slums) which exposes them to a range of vulnerabilities, many of which relate directly to HIV/AIDS.

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<sup>11</sup> If we assume that each staff member is connected to a family/social network of dependents of at least 3 persons per staff member, then the Nairobi City Council functioning is impacted by the well-being of over 50,000 people. Meaning that if a family member falls sick, the Council will be impacted by the time taken to care for sick relatives etc.

<sup>12</sup> This figure was offered by the Nairobi City Council, but cannot be confirmed. Evidence from across the continent however indicates that urban prevalence is in nearly all cases higher than the national average.

The Nairobi City Council is already aware of these issues and while there has been no study of the impact of HIV/AIDS on the city or on the capacity of the council, there is a considerable amount of anecdotal evidence of staff loss, increased medical costs for staff, as well as increased numbers of vulnerable orphans and street children in the city.

*Discussions in Nairobi were held with the Deputy Town Clerk, representatives from KIREC (Karen Information and Resource Information Center), ALGAK (Association of Local Government Authorities of Kenya), and representatives from a number of departments who participated in a half day workshop on this topic.*

### **Institutional Commitment**

There is recent and clear leadership and commitment to the issue of HIV/AIDS in the Nairobi City Council. Most notable, of their efforts is the decision to allocate 1,000,000 shillings (approx. \$12,000) for each of 12 departments for HIV/AIDS related issues. This decision to actually allocate own-resources for HIV/AIDS both demonstrates commitment of leadership but also provides incentives to departments to tackle the issue proactively. It provides departments with a funded mandate to address HIV/AIDS. This is a positive departure from the case in many local authorities where HIV/AIDS, as a multisectoral issue, becomes an unfunded mandate or 'add-on' for local authorities.

Currently, the Medical Officer of Health is head of 'committee' to promote advocacy, prevention and awareness on HIV/AIDS. However the Council is interested in expanding its efforts and its manpower within the council and has recently submitted funding proposals<sup>13</sup> for leadership training for council staff to the National AIDS Commission and Ministry of Health for review.

In addition, the Nairobi City Council has been a lead driver in supporting the launch of the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa. While the official launch of the National AMICAALL (The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level) Chapter was delayed until June 2004, the Nairobi City Council was one of the first councils to pass a motion within the council to join the Mayor's Alliance.

### **Strategic Planning: Ensuring that activities are coordinated within clear objectives**

During September 2003, the Nairobi City Council hired a consulting firm to conduct a full day workshop for 300 women staff members. The workshop presented a comprehensive overview of HIV/AIDS prevention and management, a clear analysis and discussion of the gender dynamics and vulnerabilities of the epidemic and also provided an opportunity to access on-site confidential voluntary counseling and testing (VCT) services. A similar workshop for male staff was being organized for later in 2003.

While these workshops are commendable in their own right, there appeared to be a lack of clarity on where these activities fit into a larger strategy. Instead they appeared to be 'one-off' activities that were not linked in with a larger vision or program of activities. At a workshop that was hosted by the research team, representatives from a number of departments discussed this issue

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<sup>13</sup> The funding proposals were developed by an independent consulting firm. While this can be a costly approach, it can also expedite access to funding particularly where technical skills in proposal development may not be strong in the council.

and decided that the current activities would fit best as part of an initiative to support the development and implementation of a Workplace Policy for council staff. In September 2003, the participants established an internal working team to develop a strategy and action plan to move forward with the development of a Workplace Policy.

#### ***Section 4: Lessons and Recommendations***

Through the overview and case studies in the previous sections, we have presented a rather complex and fragmented picture of what it means to look at local government responses to HIV/AIDS. This is an intentionally fragmented picture, because the issues at hand do not fall easily with a traditional service delivery model with clear roles and responsibilities for all players. In fact, one might argue that an unclear allocation of functions and responsibilities between different levels of government is in fact more the norm than the exception. But, HIV/AIDS is different and an urgent challenge, because it is changing the playing field- for local and central governments, local service providers, and citizens.

For example, HIV/AIDS at the local level is:

- Impacting of the capacity of local authorities to provide services through staff absenteeism, death, reduced productivity etc. and the changing burden of service demands.
- Impacting household ability to pay for services.
- Changing the short term and long term priorities for development and resource allocation in local communities.
- Creating webs of vulnerability that were perhaps less visible before. (i.e. an infected working adult/parent infects their spouse, and leaves behind an orphan unable to support herself.)
- Increasing and strengthening the number of non-governmental service providers who have access to external resources and are not directly accountable to local governments.
- Demanding new institutional structures within local and central government to address the impact of the epidemic, and to manage external resources and support responses by civil society.

While HIV/AIDS is changing the playing field externally, many governments are simultaneously changing the playing field internally through decentralisation reforms. The table below highlights some of the intersections between these two forces, and presents some possible recommendations for addressing them.

**Figure 7: A matrix of decentralization challenges relating to HIV/AIDS and local governments**

Challenges of Decentralization	Impact on Local Authority (LA) capacity to address HIV/AIDS	Possible interventions
Unclear Mandate <i>(esp. with regards to Health)</i>	<ul style="list-style-type: none"> <li>* Although impacted by AIDS, LGAs are not given the directive (and the funds) to address HIV/AIDS in any capacity.</li> <li>* Impedes support for LGA own-activities such as workplace policy and mainstreaming.</li> <li>* Delineation of district boundary for health services is not the same as political boundary for district</li> </ul>	<ul style="list-style-type: none"> <li>* MoLG can provide policy directive (Draft is in progress: 2003) and capacity building for LGA.</li> <li>* Mayors and local leaders do not need to wait for policy directives and can act independently and can work with the NACC to access funding.</li> <li>* NACC can include LGA as clear partner in National Strategic Plan, and/or in separate policy outline expectations and opportunities for LGAs.</li> <li>* Local agreements on referral networks for different parts of district</li> </ul>
Parallel Systems and poor Coordination <i>(esp. with regard to coordination between decentralized AIDS activities and decentralized governance systems)</i>	<ul style="list-style-type: none"> <li>* LGAs are unclear of the activities of other public sector agencies, and civil society responses to HIV/AIDS and can therefore not target activities and support effectively. Also creates an environment where there is an assumption that HIV/AIDS are being coordinated by other agencies where they may in reality not be.</li> </ul>	<ul style="list-style-type: none"> <li>* Mayors and local leaders can take the lead in coordinating local actors within their jurisdiction by working with decentralized NAP structure. .</li> <li>* NACC can clarify the role of decentralized agencies and ensure collaboration and involvement of LGA.</li> <li>* Coordination between MoH and MoLG to identify overlaps and gaps in provision of services relating to HIV/AIDS.</li> </ul>
Resource Challenges <i>(esp. with regards to accessing HIV/AIDS funding)</i>	<ul style="list-style-type: none"> <li>* LGAs know that there is money available from the NACC for HIV/AIDS, and although they are not accessing this money they are also not integrating HIV/AIDS into development plans (LASDAP etc.)</li> </ul>	<ul style="list-style-type: none"> <li>* LATF and LASDAP guidelines may recommend the inclusion of HIV/AIDS.</li> <li>* NACC and DACC may clarify the procedures that would allow LA to develop and submit proposals for HIV/AIDS.</li> </ul>

Through this short case study on Kenya, we have identified some of the challenges and opportunities facing local governments in addressing HIV/AIDS. However these challenges and lessons are not unique to Kenya, and may be quite relevant to other countries facing similarly high HIV prevalence.

The conditions for meeting the challenges faced by local governments in addressing HIV/AIDS can often be supported (or made more challenging) by the national context. Ministries of Local Government, international donors and the National AIDS Commissions can support local governments through ensuring that (i) mandates to address HIV/AIDS are recognized, articulated and funded, that (ii) capacity building programs for local governments also include HIV/AIDS, and that (iii) local governments are recognized as valuable partners in the national HIV/AIDS strategy.

In Kenya, and in most countries in Africa, there is a considerable pool of resources available for responding to the current AIDS crisis, but there is a challenge of absorption capacity, which at its very simplest refers to a (i) lack of clear vision for action (a strategic, results based vision), that (ii) is presented effectively (in clear well organized proposals) (iii) to the appropriate channels (relevant donor funding sources). At the local government level, a central lesson that emerges is that political commitment to meet the needs of the municipal staff and the community in the context of AIDS can often make up for a potentially lacking enabling environment (with unclear mandates etc.).

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## **Annex 1: Interviews<sup>14</sup>:**

Albertus Voetberg, Senior Health Specialist, World Bank

### **National**

Dr. Julius M. Malombe, Deputy Director, Urban Development Department, Ministry of Local Government, Nairobi

Waruingi Muhindi, Senior Program Officer, Street Families Rehabilitation Trust Fund, Nairobi

Grace Masese, Principal social Development Officer, Ministry of Local Government, Nairobi

Eng. Florian J. Mulli, Ministry of Local Government, Nairobi

Augustine Odipo, Secretary General, ALGAK, Nairobi

Joyce Nyambura, Programme Officer, ALGAK, Nairobi

Josia Magut, Chairman, ALGAK, Nairobi

Joshua Ng'elu, Public Sector Manager, National AIDS Control Project, Nairobi

Esther Gatua, POLICY Program Manager, KANCO, Nairobi

Donna Sherard, Regional HIV/AIDS Advocacy Project, Family Care International, Nairobi

Jamine Madera, Pearl Stone Associates, Kisumu

Dr. Oburu, Majiwa Aro Health Center, Kisumu

Joe Odundoh, Clerk to Council, Kakamega County Council, Kakamega

### **Thika**

Waririmu Mungai, WEHMIS, Thika

J. K. Munyiri, Human Resources Manager, Cirio Del Monte Kenya limited, Thika

Dr. N.A. Olembo, Chief medical Officer, C/R/Del Monte (K) Ltd, Thika

Tubmun Otieno, Municipal Clerk, Municipal Council of Thika, Thika

R.N. Mathenge, Public Health Officer, Municipal Council of Thika, Thika

Anne Kariuki, Public Health Officer, Municipal Council of Thika, Thika

Rosemary Kahuki, Councillor, Thika Municipal Council, Thika

### **Kajiado**

David Muti, Chairman, Kajiado Town Council, Kajiado

Peter Msiko, Councilor, Kajiado Town Council, Kajiado

Juliet Yirre, Councilor, Kajiado Town Council, Kajiado

### **Nairobi**

M.N. Ngethe, Asst. Town Clerk, City Council of Nairobi, Nairobi

Hamisi Mboga, Deputy Town Clerk, City Council of Nairobi, Nairobi

David Okech, Director City Education, Nairobi City Council, Nairobi

Dr. Njagi, Medical Officer of Health, Nairobi City Council, Nairobi

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<sup>14</sup> Unfortunately, this is an incomplete list and does not include names of interviewees from civil society organizations in Nairobi and Kajiado.

G. Wambua, City Treasurer, Nairobi City Council, Nairobi  
Mr. Maneno, Director City Inspectorate, Nairobi City Council, Nairobi  
Mrs. Nyaga, Asst. Town Clerk, Nairobi City Council, Nairobi  
Mrs. Woyengo, Chief Establishment Officer, Nairobi City Council, Nairobi  
Mrs. Kariuki, Ag. Senior Committee Clerk, Nairobi City Council, Nairobi  
Mrs. Wanjara, Chief Administration Officer, Nairobi City Council, Nairobi  
Muthoni Orlale, Chief Administrative Officer, Nairobi City Council, Nairobi

Dr. Betty Gikonyo, Karen Information Resource and Education Centre (KAREN), Nairobi  
Mrs. Pauline Muriuki, KAREN, Nairobi  
Dominic Kiarie, Managing Director, NBC Kenya Limited, Nairobi



Map No. 4187 Rev. 1 UNITED NATIONS  
January 2004

Department of Peacekeeping Operations  
Cartographic Section

