



A History of HIV and AIDS Responses in Kenya, 1983-2003

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To cite this article:

Samwel Ongwen Okuro. A History of HIV and AIDS Responses in Kenya, 1983-2003. *International Journal of HIV/AIDS Prevention, Education and Behavioural Science*. Vol. 8, No. 2, 2022, pp. 42-54. doi: 10.11648/j.ijhpebs.20220802.11

Received: January 4, 2022; **Accepted:** February 17, 2022; **Published:** September 29, 2022

Abstract: HIV was first detected in Kenya in 1984. Since then, Kenya's government has launched a number of response measures in collaboration with other development partners. The Kenyan government's initial responses to HIV/AIDS were characterized by denial and inactivity. External donors and significant global financial institutions were invited to assist the government in creating HIV/AIDS prevention, treatment, and care structures and strategies as a result of the government's inaction and lack of political commitment. While external donor financing and support are critical in the battle against HIV/AIDS, relying solely on donor funds and policy guidance puts the intervention methods' identity, autonomy, and mission at risk. External funders have monopolized and dictated the HIV/AIDS conversation in Kenya, particularly in terms of establishing programs and policies, to the point where government initiatives are stymied if not dictated. Kenya's government spends more time negotiating competing donor demands than identifying their own priorities and implementing their own programs as a result of this approach.

Keywords: HIV/AIDS, Policies, Legislations, Responses, Strategies, Kenya

1. Introduction

In 1984, the East African Medical Journal published the first case of AIDS sickness in Kenya. The patient was a 34-year-old Ugandan journalist who had spent four years in Nairobi but had traveled extensively. He was hospitalized to Kenyatta Hospital and died on May 8, 1984, from the sickness. [30]. Following the first recorded cases of AIDS sickness in Kenya, Kenya's political, religious, and communal leaders went into denial and skepticism. This pattern is not unique to Kenya: several countries in Sub-Saharan Africa have gone through comparable denial stages. [34]. In Kenya, HIV infection rates were low in the 1980s. However, by the end of 1998, about 14% of Kenya's adult population, or 2.1 million people, were infected with HIV. According to the Kenya Demographic Health Survey, HIV prevalence rates decreased from around 13% in 2000 to 10.2% in 2002 and then to 6.7 percent in 2003. This is a significant decrease, which can be attributed to the government's and other organizations' aggressive anti-disease initiatives. [27].

Since the first case was detected, Kenya's HIV epidemic has grown to become one of the leading causes of death,

putting enormous strain on the health system and the economy. Children, teens, adults, women, and men have all been afflicted by the epidemic. Over time, the country's response to the epidemic has developed from a health-focused approach to a multi-sectoral response coordinated by a single national authority, a single strategic framework, and a single monitoring and evaluation framework. The country's response to the pandemic has improved in line with the increased availability of reliable and comprehensive data, allowing it to focus on the important HIV transmission locations and populations in order to reduce new infections.

While the success of response initiatives was measured, among other things, by the presence of strong political leadership from the president and others in government; political stability; and a coordinated and agreed-upon nationally "owned" strategy involving non-State actors over time, the Kenya case demonstrated the extent to which external donors and global financial institutions pressured the government to build strong institutional capacity and an enabling policy environment. In this work, we used primary data obtained in Kenya in 2003 with purposively recruited respondents using interview schedules and focus group discussion guides. Secondary data from Kenyan libraries and the German Institute of Global and Area Studies was used to

back up these claims. Between 1983 and 2003, the majority of secondary data came from books, newspapers, journal articles, periodicals, legislations, policies, health survey reports, comments, research reports, strategic plans, project reports, and Kenyan Ministry of Health Reports.

2. HIV/AIDS Policies and Legislations, 1983-2003

The Kenyan government was not interested in reducing the prevalence and effect of HIV/AIDS in any way. According to the administration, HIV/AIDS was not a serious enough problem to merit government attention, and that it was small in comparison to other diseases prevalent in Kenya, such as malaria and tuberculosis. During this time, however, many Kenyans were mystified by the new lethal disease and yearned for important information, notably regarding the disease's origins, how it spreads, and how to avoid contracting it. [31].

In fact, pressure was building on the government to release information on the disease as early as mid-1985, partly because the public needed to be informed about the potential risks and precautionary measures, and partly to counter the widespread misinformation at the time, particularly in rural areas. Kenya's critical health sector partners, particularly the World Health Organization (WHO), exerted pressure on the government to take HIV/AIDS seriously. Dr. Fakry Assad, the WHO's director of communicable diseases, was candid about the situation. He urged African leaders to confront the reality of HIV/AIDS. Better understanding of the disease and ways to combat it, he believed, was required. [30].

The administration began to give in slowly and haphazardly as a result of local and international pressure, particularly the necessity to secure external donor financing. In 1986, the government established a number of HIV/AIDS committees, held a number of seminars and workshops for healthcare personnel, and published a number of policy documents. By early 1986, for example, the government had established an HIV/AIDS Central Coordinating Committee tasked with diagnosing and managing HIV at Kenyatta National Hospital for both public and private facilities. Similarly, the government established the National Advisory Committee on AIDS to aid in research and disease control. The Ministry of Health also released a policy paper in the same year aiming at informing, guiding, and directing health personnel on diagnostic management and AIDS control. Most notably, the National AIDS Committee was established to coordinate AIDS research and to provide recommendations in numerous areas so that research findings are as clear as possible. [30].

To improve on its coordination, AIDS Programme Secretariat which was formed in 1985, was elevated to the status of National HIV/AIDS Control Programme (NACP) under Ministry of Health in 1987. NACP became strategic in implementing activities at the national, provincial, and district level with support from WHO technical advisors. To motivate

its demoralised health workers, some of which, were terrified treating HIV patients, the government via the Ministry of Health organised a series of workshops for them on themes such as origin of HIV/AIDS, how it affects human body cells and clinical management of AIDS patients [30].

The AIDS Programme Secretariat (APS) created the First Medium Term Plan (MTP) for the years 1987 to 1991 in 1987. This was carried out on the advice of the World Health Organization and other strategic development partners. Furthermore, because the government saw AIDS as solely a health issue, it saw no need for a comprehensive program. [38]. Under the direction of the National AIDS Committee, the AIDS Programme Secretariat (APS) was established to combat HIV/AIDS (NAC). Preventing HIV transmission through blood screening, promoting safer sexual behaviors, public awareness and HIV/AIDS surveillance, and early diagnosis of STIs were all priorities in the Medium Term Plan. It also described the responsibilities of the health sector and the Ministry of Health, as well as the support and assistance of other sectors, and gave policy and strategic direction for action. By July 1987, the government had issued a Legal Notice declaring AIDS to be a Notifiable Disease, which required all medical personnel to report all HIV cases to the director of medical services for statistical purposes. Blood screening, the use of disposable syringes, and large public awareness efforts in the press, radio, television, pamphlets, films, community-based organizations, churches, and schools were all supported in the Legal Notice. [30].

However, some have pointed out that simply declaring HIV/AIDS as a Notifiable Disease is insufficient. To make the Legal Notice effective, the Public Health Act was amended, and this notice had to be followed by an enforcement mechanism. This is because the act was created to address STDs and other treatable infections; as a result, steps to prevent infection spread have been shown to reduce prevalence. Because HIV is incurable, it was necessary to draft explicit regulations with caution in order to ensure that the processes for HIV counselling for prevention were sensitive. The anticipated enforcement mechanisms in the Legal Notice were not applicable to HIV/AIDS, posing a dilemma in interpreting the law. [13].

The government produced the Second MTP (1992-1996) in 1992, which, among other things, emphasized the importance of involving all sectors in HIV prevention in order to mobilize broader national responses to the epidemic. In 1992, the NACP merged with the National STD Control Programme (NSTDCP) to form the National AIDS and STI Control Programme (NASCOP), which assumed a stronger coordinating role, especially among NGOs and religious groups (KNASP/NACC 2000-2005). This was in response to the World Health Organization's (WHO) advocacy for early treatment of STIs as a cost-effective strategy to prevent HIV transmission and to improve coordination. Under the Ministry of Health's supervision, NASCOP became the technical branch of the AIDS programs. Furthermore, the Kenya Health Policy Framework (1994) identified five goals in the fight against AIDS, including prevention of HIV

infection through information campaigns, prevention of transmission through effective blood screening, prevention of prenatal transmission, healthcare counseling and social support for AIDS patients, and national coordination and mobilization of funds to combat the disease. The administration even went so far as to label AIDS as a developmental concern. As a result, the AIDS issue was included in the Seventh National Development Plan, the Fifth District Development Plans, and other policy documents that followed. [27].

The acceptance of Session Paper Number 4 on AIDS in Kenya in 1997 was perhaps the most important document in the history of HIV/AIDS interventions in Kenya. The preparation of this document began in 1996, in response to donor discontent with the progress made in Kenya's HIV/AIDS fight. Previous programs were impeded by a lack of defined policy on contentious matters, which resulted in uncertainty and avoidable disputes between special interest groups and individuals who were to be helped. To organize expert knowledge and create sections of the policy, nine technical subcommittees were formed. These committees' proposals were presented at meetings held across the country to gather input from all sectors of society and reach an agreement on the best policies. This effort resulted in a draft national policy that was presented to parliament and approved as Sessional Paper No. 4 of 1997 on September 24, 1997. The government's ratification of this paper signaled a clear intention to support effective programs to restrict the spread of AIDS, safeguard HIV/AIDS patients' human rights, and provide care for individuals afflicted and affected by the disease. [38].

The purpose of the Sessional Paper was to establish a policy framework for AIDS prevention and control throughout the next 15 years and beyond. Its specific objectives were as follows: 1. provide guidance on how to deal with contentious issues while taking into account the current situation and socio-cultural environment, 2. allow the government to play a leadership role in AIDS prevention and control activities, and 3. recommend an appropriate institutional framework for effective management and coordination of HIV/AIDS program activities. A comprehensive examination of the Sessional Paper reveals various points.

This paper recognized that effectively responding to the AIDS crisis required a strong political commitment at the highest level, the implementation of a multisectoral prevention and control strategy with a priority focus on young people, mobilizing resources for HIV prevention, care, and support, and the establishment of a National AIDS Council to provide leadership at the highest level; and to complement NASCOP activities at the national level, particularly in coordinating activities. Second, the Sessional Paper discussed the problems faced by the AIDS epidemic, as well as the measures and initiatives that the government had used or planned to implement. It also bemoaned the difficulty of turning the guidelines into effective strategies, programs, and actions. [16].

While the adoption of Sessional Paper No. 4 Aids in Kenya was important in demonstrating the government's commitment to the battle against HIV/AIDS, the document was actually the work of the NASCOP secretariat, which was overseen by the World Bank-funded STI Project Director. It wasn't what the government thought would drive the battle against AIDS in Kenya, but rather what the World Bank thought was missing in terms of strengthening the national HIV/STI policy framework and improving the political environment for STI/HIV activities, in partnership with other donors. [45].

According to NASCOP figures from 1999, between 0.8 and 1.7 million Kenyans were living with AIDS. Since 1984, an estimated 1.5 million people have died of AIDS, and more than 1.2 million children under the age of 15 have been orphaned as a result of their parents' deaths (3.7 percent of the total population). AIDS kills at least 800,000 people each year. With this knowledge, the government moved quickly to proclaim AIDS a national disaster during an AIDS awareness seminar held in Mombassa from November 25 to 30, 1999, for 224 members of parliament. [4].

"AIDS is not just a major threat to our social and economic progress; it is a true menace to our own existence, and every effort must be made to bring the problem under control," the president said at the time [4]. Major financial announcements from strategic donors were expected at this seminar, and the president authorized the formation of the National AIDS Control Council (NACC) and the teaching of special courses to children in primary schools. Similarly, the provincial government was required to organize an elders' group to come up with answers to cultural practices and beliefs that facilitate AIDS transmission [30]. This announcement allowed the government to devote more resources to the battle against AIDS while also allowing for more AIDS-related donor financing.

External factors also influenced the declaration of HIV/AIDS as a national calamity. The monitoring unit of a World Bank-funded HIV/STI project, along with "counterpart money," hosted a two-day seminar for members of parliament in a posh beachside hotel in 1999, in which politicians and the president were enticed to declare HIV/AIDS a national calamity. This proclamation was not issued in accordance with the National Disaster Act, but rather as a sort of roadside declaration, a presidential edict [30].

In response to the presidential order, the National AIDS Control Council (NACC) was established as a body corporate under the State Corporations Act in Legal Notice No. 170 November 1999, and placed in the office of the president. The council's functions were incorporated in NACC mission statement. Its broader aim was to provide institutional framework for the coordination and management of the multisectoral national AIDS control programme and to ensure that HIV/AIDS Strategic Plan and Policies are integrated into the agenda and the core process of the entire government of Kenya. It also became the structure through which donor funds to fight AIDS were to be channelled. NACC developed the Kenya National HIV/AIDS Strategic

Plan (2000-2005), which identified five priorities for prevention and control of HIV/AIDS: 1. prevention and advocacy for positive behaviour change, 2. treatment, continuation of care and support, 3. mitigation of socio-economic impacts, 4. monitoring, evaluation and research, 5. management and coordination [37].

The strategic plan's main goal was to stop the epidemic and lessen its impact on Kenyan society and economy by lowering HIV prevalence in Kenya by 20-30% among people aged 15-24 years by 2005, increasing access to care and support for people infected with HIV/AIDS, and strengthening response capacity and coordination at all levels (NACC 2000). NACC established decentralized committees at the province, district, and constituency levels to fulfill its goal. They also distribute NACC grants to NGOs and community-based organizations. The NACC's multisectoral approach necessitates the creation of AIDS Control Units (ACU) in each line ministry. Through workplace programs and HIV/AIDS services, the ACUs are responsible for addressing HIV/AIDS issues within ministries from the central to the district levels. [28].

Many national policies and program standards have been developed since the foundation of NACC. National Voluntary Counseling and Testing Guideline 2001, Condom Policy Strategy 2001-2005, Blood Safety Policy Guidelines 2001, Anti-Retroviral Drug Therapy Guidelines 2001, National Home-Based Care Programme and Service Guideline 2002, and Gender Mainstreaming in Kenya were among them. National HIV/AIDS Strategic Plan 2002, National Guidelines for Preventing HIV Transmission from Mother to Child 2002, National HIV/AIDS Communication Strategy 2002-2005, and National Program Guidelines for Orphans and Other Children Vulnerable to HIV/AIDS 2003 [17-24].

The founding of NACC revealed a number of flaws, particularly in terms of its organization and mandate. The objective was to create a structure to manage all HIV/AIDS-related activities and organizations. With that mandate, it had to create a structure that could oversee AIDS efforts at all levels, from national to grassroots, in both the commercial and public sectors. Furthermore, there was a general need to recruit the help of legislators at all levels. Constituency AIDS Control Committees (CACC) were founded specifically for this purpose, and local members of parliament were invited to serve as chairpersons and patrons of these committees. CACC was to be made up of representatives from the provincial government, the public health officer, a respected elder, a church member, a youth leader, a women's leader, a PLWA representative, and other people the committee thought were acceptable. However, no criteria for appointment were established, allowing for committee politicization, corruption, nepotism, favoritism, and tribalism [1, 10-12, 14, 17, 35, 42, 43].

The government released a National Condom Policy and Strategy in 2001 with the goal of increasing access to affordable, high-quality condoms. This includes a thorough study of condom demand, condom social marketing, and fund raising for condom supply and distribution. Youth,

antenatal and other mothers, commercial sex workers, individuals living with HIV/AIDS, and those who visit bars and drinking establishments are among the categories targeted [15]. The campaign against HIV/AIDS in general, and specifically condom use, was riddled with difficulties. Despite widespread awareness, condom use to prevent HIV transmission has not been entirely accepted by different major religious groups, particularly Catholics, whose membership is particularly strong in rural regions. [31].

Despite all of this, there was a ray of hope. The Anglican Church, through the Council of the Anglican Province in Africa (CAPA), has called for an end to discrimination against AIDS patients and their families since 2002. "This morality of condoms is about preserving life," said a piece of the statement read by CAPA chairman. It is not the way to save lives to sentence someone to death because of a misunderstanding about sexual behavior" [30]. While Catholics have long opposed and opposed condom usage, one year after Pope Benedict XVI's election, the Vatican was forced to embrace condom use to combat AIDS. [6].

The government promulgated the HIV/AIDS Prevention and Control Bill in 2003 to provide an explicit legal framework for the national response to the HIV pandemic. The bill sought to regulate education and information about AIDS, as well as safe clinical practices and procedures, screening, testing, and access to healthcare; confidentiality, including disclosure of information and penalties for breach of confidentiality; and discrimination in the workplace and schools. [27].

President Mwai Kibaki, who took office in March 2003, did not hesitate to keep up the pace in the fight against HIV/AIDS. President Obama vowed "Total War" on HIV/AIDS. He charged the NACC with coordinating and managing the implementation of a multi-sectoral HIV/AIDS response, as well as providing policy direction and mobilizing resources. In the same year, the government reinforced its anti-HIV/AIDS efforts by forming a cabinet committee, which was chaired by the president himself. In some ways, this was a sign of the government's seriousness in combating the epidemic. Workplace programs and practices are an important part of the AIDS intervention effort. The most prevalent form of prevention is education, which includes the dissemination of reading materials, AIDS conversations, presentations, and peer education programs. [29].

The fight against HIV/AIDS was not solely the responsibility of the government and strategic donors; community-based organizations and faith-based organizations were also heavily involved. The subject of HIV/AIDS was taken seriously by many non-governmental organizations. In order to accomplish this, these NGOs formed the Kenya AIDS NGOs Consortium in 1995. (KANCO). More than 300 NGOs, both recognized and unregistered, were doing HIV/AIDS control, preventive, and care activities in 2006. Despite the controversy over condom usage and the introduction of Family Life Education in Schools, religious institutions were also actively involved in HIV/AIDS prevention and treatment. [9].

3. HIV/AIDS Interventions Strategies 1983-2003

Despite the government's refusal to fight HIV/AIDS, various international donors launched and sponsored the Kenyan government's initial AIDS prevention efforts. Support came from the World Health Organization's Global AIDS Program, the World Bank, USAID, and UNAIDS, among others, and was channeled to a number of projects, some of which had nationwide coverage. For example, starting in 1989, the children's magazine *Pied Crow*, which was supported by CARE, WHO, UNICEF, SIDA, and the Ministry of Education, was used to spread AIDS messages to children in elementary schools. The magazine was provided free of charge to all Kenyan elementary schools, totaling over 800,000 copies. The *Pied Crow* newsletters utilized cartoon images to show how HIV damages the immune system of the body. Two pages were also devoted to debunking misunderstandings about how AIDS is not spread. It made excellent use of color and illustrations, making it an enjoyable read. During various reviews in Kenya, children cited the *Pied Crow* as a significant source of AIDS education. There were immediate responses: up to 80 letters a day, some from countries other than Kenya, were submitted to editorial offices. Adult readers were drawn to the magazine, which sparked a thirst for knowledge. [39]. Apart from HIV/AIDS messages, *Pied Crow* Magazines also questioned established gender roles by depicting boys and men in stereotypically female activities and expressing traditionally 'feminine' feelings and vice versa.

The challenges that public education programs faced were highlighted in an analysis of letters received in response to a series of radio programs called "AIDS the Facts" that began in 1988. By November 1999, a total of 9,897 letters had been received, and a random sampling of one-third of them revealed the types of worries expressed by Kenyans who are literate: they were divided into nine categories. 1. those who believed the disease was only propaganda, that it only affected evil people, or that catching it was simply an accident like any other ailment 2. people who want to know if the disease can be contracted through casual social contact, such as sharing a bed, plate, or cutlery with an AIDS patient. 3. people who want to know if the disease can be caught through needles, barber's instruments, an infected butcher, infected woman's menstrual blood, or infected person's urine 4. those interested in learning more about the symptoms, how to recognize them, the virus's incubation period, and the prospect of a cure, 5. inquiries into whether AIDS can be transmitted by insects, 6. people who want to know how to find out if their intended spouse is clean, how to protect themselves, and how to safeguard those who are just starting out sexually, 7. those calling for more radio time to be allocated to the disease and more hard data on the prevalence of the disease in the public, 8. those requesting educational supplies 9. those discussing their own and/or their friends' and relatives' problems and seeking particular advice [39].

Based on a preliminary examination of these letters, it

appears that there was a high demand for information. The most letters fell into two categories: category 4 (inquiries for information) and category 8 (requests for information to be sent). The minimal amount of letters falling into category one [2] was especially reassuring. However, such a conclusion cannot be applied to the entire community, because the replies were from those who had access to radio, listened to it, and were prepared and ready to write a letter—clearly the more sophisticated elements of the population. [39, 40].

Since the mid-1980s, USAID was very instrumental in providing global leadership to the international efforts to prevent further transmission of HIV and, to mitigate the impact of AIDS on individuals and communities. In 1986, USAID support to the World Health Organization (WHO) helped launch its Global Programme on AIDS (GPA). A few months later, USAID developed its agency wide policy for addressing HIV/AIDS through a concerted prevention strategy. In May 1987, the USAID Strategy culminated into the authorization of the AIDS Technical Support Project (AIDSTECH). The AIDSTECH incorporated USAID's initial public health communication project for HIV/AIDS prevention (AIDSCOM) which had started in 1986.

Under the AIDSTECH program, USAID began a series of HIV/AIDS intervention activities in Kenya in 1989. The project's goal was to prevent HIV infection and control the spread of AIDS by providing technical assistance to developing countries, with a focus on surveillance, blood transfusion systems, the reduction of high-risk sexual transmission behaviors, and interventions to prevent AIDS transmission through skin-piercing practices.

Between September 1987 and September 1992, AIDSTECH aided in the development of ability to plan, administer, evaluate, and sustain HIV prevention programs for sexual and blood transfusions. The AIDSTECH project's broad objectives were preventing HIV transmission through sexual contact by focusing on identifying high-risk populations, implementing teaching programs for high-risk populations, and promoting condom usage and STI prevention. Its second objective was to limit HIV transmission through transfused blood by bolstering blood screening systems, improving blood transfusion techniques, and encouraging people at low risk of HIV to donate blood freely and voluntarily. The project's focus on high-risk groups limited its efforts to Nairobi, Mombasa, and Eldoret, with little influence on rural areas.

Despite the fact that AIDS activities were extended under AIDSTECH, the project's own evaluation revealed that it failed to accomplish the majority of its goals. USAID built a new 5 project to replace AIDSTECH based on the findings and suggestions of the review. The new project would be implemented in fewer countries and would focus on a smaller area of impact. This is what drew the lavishly funded AIDS Control and Prevention Project from USAID (AIDSCAP). Kenya was also recognized as a priority nation under the AIDSCAP initiative in September 1992. The activities of the transitional project began in 1994 with the purpose of lowering the prevalence of sexually transmitted HIV. The

goal of the initiative was to reduce high-risk behavior in a particular group in a few locations. An integrated strategy including interventions in behavior change, enhanced STI case management, and condom advertising was to be used to address this. The interventions were aimed at people in three cities: Nairobi, Mombasa, and Eldoret. Through policy discourse, assistance for the media, behavioural and operations research, and capacity building and sustainability efforts, national interventions offered a supportive network for these intense preventative measures.

The AIDSCAP program had a number of successes in its core objectives, particularly in its media projects, which included the Miujiza Players, a theatre company that combined HIV/AIDS plays with interactive communication with audiences; Maajabu, a weekly soap opera produced in five local languages; and AIDS Watch, a weekly newspaper column in the national press. All media interventions included mechanisms for learning about and responding to the viewers. This resulted in Maajabu receiving an incredible 2,000 letters every month on average from listeners.

Similarly, Population Communication International (PCI) began HIV/AIDS prevention efforts in Kenya in 1985. PCI was founded in 1985 with the goal of implementing entertainment, education, and radio and television initiatives with in-country partners. PCI's entertainment-education soap operas, based in New York City, promote sexual and reproductive health, as well as HIV prevention, gender equality, education and literacy, and environmental protection. Since 1998, PCI has made a concerted effort to include HIV/AIDS education in its entertainment programming. PCI's 15-minute radio soap opera Ushikwapo Shikamana is still remembered by many Kenyan households (if assisted, assist yourself) [32].

The program, which first aired on Voice of Kenya in 1987, was designed to improve family planning services in rural communities (VOK). Since 1998, the program has included an HIV/AIDS component, which airs twice a week on Mondays and Wednesdays, with a 30-minute omnibus on Saturdays. Kiswahili, Kenya's national language, was used in the soap opera. Ushikwapo Shikamana, in its ideal form, dramatizes life in three typical Kenyan settings: a city center, a city's outskirts, and a rural area with limited educational and economic prospects. The program focused on HIV/AIDS prevention, compassion for persons living with the disease, and the burden of AIDS orphans. The story included details on risk factors, transmission methods, and prevention testing, informing partners, compassion for the sick, and death [32].

PCI collaborated with Twaweza Communications to create a comic strip called Ushikwapo Shikamana to help spread the word about the educational challenges discussed on the popular radio show. The comic strip was first published in 1999 and is still published three times a week in the national Kiswahili daily Taifa Leo, which was Kenya's largest Kiswahili national newspaper at the time. [37]. Despite the fact that the comic strip did not follow the radio show episode, the characters and plot of the serial drama were similar. Readers were urged to comment on the plot and offer

questions about the themes discussed. PCI researchers observed this data and used it to clarify the messages transmitted on the radio program.

In 1999, the impact of the PCI program was assessed. According to the survey, 99 percent of all Kenyans who were exposed to the radio listened to Kenya Broadcasting Corporation (KBC) (formerly VOK) on a regular basis, with 90 percent of these listening to the KBC Kiswahili program. In the preceding month, 56 percent of Kiswahili listeners tuned in to Ushikwapo Shikamana, and 61 percent of these listened on a regular basis. Epilogues were utilized to increase the drama's effect by urging listeners to take concrete steps to solve the issues presented in the drama. After each episode, the phone numbers and addresses of organizations that provide related services were mentioned. Hundreds of mails are received each week in reaction to the epilogue and newspaper comic strip. Listeners wrote in to express their feelings about the radio show and how enjoyable and enlightening it was. [36].

Faced with rising criticism and no indication of increased funding for her Second Medium-Term Plan (1992-1996), the government acquired a US\$40 million World Bank credit for the Sexually Transmitted Infection (STI) Project in 1995. With this credit, a slew of additional donors joined in, and money began to pour into the government's HIV/AIDS fund. With rare exceptions, the main focus was on controlling HIV through donor-approved information, education, and communication (IEC) to the general public and, in particular, those considered at risk [35].

The government's priorities for the Second Medium Term Plan (1992-1996) were to: 1. prevent HIV transmission through sexual contact, 2. prevent HIV transmission through blood, 3. reduce the social and economic impact of AIDS, 4. improve surveillance, and 5. coordinate research and AIDS control activities across sectors. The plan's implementation cost was estimated to be \$9.8 million in the first year and \$13.2 million in the second. The government, bilateral and unilateral organizations, and other donors were expected to provide funding. Because the finances never arrived, practically all of the scheduled activities were never carried out.

The government reverted to the US\$40 million STI project loan to support this approach through three major updated objectives to overcome the budgetary gap: 1. enhance both health sector and community provision of physical and psychological care, and develop strategies to mitigate the social and economic consequences of AIDS at the national and district levels; 2. promote preventive measures to reduce risks of HIV/STI transmission; and 3. enhance both health sector and community provision of physical and psychological care and develop strategies to mitigate the social and economic consequences of AIDS.

There were three primary components to the STI project: component (1) (US\$13.9 million) supported and strengthened national and district institutional capacity to design, implement, and evaluate interventions by supporting and strengthening (a) national capacity to provide adequate

policy, planning, coordination, supervision, and technical support related to STIs; (b) district capacity to plan, coordinate, implement, and evaluate integrated multi-sectoral HIV/AIDS activities; and (c) national and district STD surveillance. Component 2 (USD\$26.7 million) aimed to promote preventive measures to reduce the risk of STI transmission through the following sub-components: (a) providing accessible, acceptable, and effective clinical management of STDs; (b) developing and implementing information, education, and communication (IEC) activities for STIs and HIV; and (c) providing condoms to districts, municipalities, NGOs, and those providing health services. Component (3) aimed to improve both the health sector and community provision of physical and psychological care, as well as develop strategies to mitigate the socio-economic consequences (US\$19.4 million) by: (a) supporting tuberculosis (TB) control measures; (b) treating opportunistic infections; (c) supporting district-based NGO/CBOs, home-based care, and counseling for people living with HIV/AIDS; and (d) promoting occupational safety activities and minimising occupational hazards [45].

In less than nine months, the STI project was designed and approved. The project was an essential aspect of the government's larger STI/HIV program, although it was supplemented by a variety of other government and non-government operations.

At the time of the STI project approval, three Bank-financed projects in the health and population sectors were also in the works. The United Kingdom (formerly ODA, now DFID) agreed to provide \$12.5 million in parallel financing for the HIV/AIDS Prevention and Care (HPAC) project, which provided technical assistance and training to NASCOP and districts to support STI project implementation—as well as support for NGO activities in Nyanza province—shortly after the STI project was approved. Parallel funding for the national initiative was given by the German KfW (\$4 million). Other donors, such as USAID, the European Union, and DANIDA, as well as the Belgian government, funded HIV/AIDS initiatives, with much of the money going through international NGOs.

Other UN agencies (UNICEF, UNDP, and UNAIDS) had contributed a total of US\$7 million by 2000, in addition to parallel money. Their contributions were diverse, but they were mostly focused on advocacy, technical support, and monitoring. The Japanese International Cooperation Agency (JICA) has also continued to promote biomedical research development in Kenya, particularly through the Kenya Medical Research Institute (KEMRI). The Canadian International Development Agency (CIDA) funded STD research and interventions for commercial sex workers through the University of Nairobi and the University of Manitoba. Furthermore, GTZ-Kenya created a successful model for incorporating AIDS as an inter-sectoral issue within its organization. Other funders contributed significantly to the success of the STI project during its implementation.

According to the World Bank, the STI initiative was a success at both the national and local levels. For example, in

1998, the initiative and numerous donor partners sponsored a meeting in Nyanza Province with professional and political leaders, at which President Moi made his first public remark on HIV/AIDS, including a call for increased condom use [5]. The PMU also assisted in the sponsorship (with counterpart funding) of a special two-day Parliamentary session in Mombasa in 1999, during which the President declared AIDS a National Disaster, a watershed event.

Other regional events for political and civil society leaders, as well as a series of district-level constituency meetings, were funded by the STI project, in collaboration with UNICEF and other partners. The Bank and its donor partners also made it clear to GOK that expanded HIV/AIDS activities as well as improved governance were prerequisites for future assistance. According to interviews and press clippings, political officials at both the national and district levels began to speak out more frequently about HIV/AIDS as a result of these occurrences. When compared to the silence that prevailed when the project began, those interviewed by OED unanimously stated that the climate for HIV/AIDS activities had improved as a result.

A chart summarizing STI treatment techniques was also printed and widely distributed as part of the STI initiative. These standards were apparently adopted by both public and private clinics to assist standardize STI treatment. The programme funded substantial syndromic management training, which began in the 15 pilot regions and then expanded across the country. The training covered STI treatment guidelines, patient counseling, condom distribution, and partner tracing, and it was designed to complement other partners' training (including CIDA, Belgian cooperation, and DFID). The project increased the number of medications available to treat sexually transmitted illnesses. The project raised HIV/STI awareness and encouraged behavior change by giving US\$7 million in funding for national and district-sponsored information, education, and communication (IEC) activities. These initiatives lead to a greater understanding of HIV/AIDS and sexually transmitted infections (STIs), as well as changes in sexual behavior. Blood screening has improved in a number of government and non-government health institutions. However, religious opposition and a lack of champions inside government hampered the establishment of a sexual health curriculum.

Additionally, the IEC materials, as well as the STI project's radio and television ads, had a clear message highlighting the "ABC's" of HIV/STI prevention (Abstain, Be faithful, use a Condom). "The Silent Epidemic," one of the most extensively circulated and viewed videos produced under the multi-media contract, featured graphic images of sexually transmitted illnesses. The movie (which was broadcast at the 1999 Parliamentary session in Mombasa) had a high "shock value," according to focus group data, but the key message was that "free medications are now available" in government clinics, and persons with STIs should seek treatment. The one-hour documentary drama produced by ACE Communication, which aired on Kenyan television and on mobile videos, effectively highlighted the personal toll of

AIDS and dramatized themes surrounding sexual behavior, such as unfaithful spouses. Around US\$500,000 was spent on research and message design, US\$650,000 on production, and US\$700,000 on distribution as part of the entire multimedia contract. District AIDS and STI Coordinators (DASCOS) and District Intersectoral AIDS Coordinating Committees were also established as part of the STI initiative (DIACs). The DASCOS have been crucial in organizing the district-level response to STIs and HIV. The project funded program planning and management training for DASCOS, District Medical Officers, and later district accountants. Additionally, the project delivered laptops, office equipment, and trucks to over 40 districts, bolstering HIV/STI and general health efforts, according to reports. The initiative also funded the writing of a Session Paper on AIDS, as well as the institutional development of NASCOP and NACC (KNASP/NACC, 2000-2005). According to a study conducted at the end of the initiative, more than 90% of respondents could name two or more measures to prevent HIV transmission. By June 30, 2001, the project was formally closed, with the remaining credit of US\$0.9 being cancelled [45].

In September 2000, the World Bank, in collaboration with the Kenya government, designed, funded, and implemented two new projects to strengthen the national response to HIV/AIDS and the health system overall, based on lessons and experiences learned during the STI Project implementation period, several internal reviews, and independent evaluation by the Operations Evaluation Department (OED). The Kenya AIDS Disaster Response Emergency (KADRE) Project received US\$50 million, while the Decentralised AIDS and Reproductive Health (DARE) Project received US\$50 million. The DARE project's development goals were to improve maternal and child health, reduce the spread of HIV, and establish a conducive environment for decentralized delivery of child survival, reproductive health, and HIV/AIDS services. However, due to audit requests, the DARE project had to be redesigned, and the implementations were not very successful. [45].

The World Bank launched various HIV/AIDS projects, notably the Multi-Country HIV/AIDS Program for Africa (MAP) and the Global HIV/AIDS Program, as part of its mission to alleviate poverty and improve quality of life. The World Bank developed the MAP initiative in 2000 to assist African countries in developing the institutional, organizational, and human resources needed to implement a large-scale prevention, care, treatment, and research program in response to HIV and AIDS. The MAP's overall goal was to greatly enhance access to HIV/AIDS prevention, care, and treatment services, with a focus on vulnerable populations (such as youth, women of childbearing age, and other groups at high risk).

MAP funding are distributed in the form of IDA grants, soft loans, and concessionary loans. For the delivery of local HIV/AIDS services, MAP provides funding to community organizations, non-governmental organizations, and the private sector. The MAP covered the entire spectrum of care,

from basic prevention through antiretroviral medication and all in between, as well as all parts of a multi-sector response. Through its MAP initiative for Africa –The HIV/AIDS Policy Fact Sheet 2005, the program's first four years saw the approval of US\$100 million in financing to address HIV/AIDS in Kenya. Through research, monitoring, and evaluation, the Kenya program aimed to increase the fight against AIDS by supporting five priority areas: prevention, advocacy, treatment, and support for AIDS-affected people's continuum of care, management, and coordination, and social impact mitigation.

Kenya HIV/AIDS Disaster Response Emergency (KADRE) received the majority of MAP funds, which were implemented by Kenya HIV/AIDS Disaster Response Project (KHADREP). The goals of KADRE/KHADREP were to strengthen the multi-sectoral response to HIV/AIDS and speed the process of reaching the targets outlined in the National Strategic Plan with broad community engagement. This initiative supported HIV/AIDS prevention and treatment in non-health ministries, as well as the creation of new multi-sectoral coordination mechanisms. The National AIDS Control Council, Provincial AIDS Coordinating Committees, District AIDS Coordinating Committees, and local Constituency AIDS Coordinating Committees were among these organizations [45]. According to the World Bank's 2005 Status of Project Execution (SOPE) Report, the KADRE/KHADREP project's community initiative component sponsored nearly 5,000 community initiative initiatives.

The Global HIV/AIDS Program was established in 2002 to assist the World Bank in its efforts to combat the HIV/AIDS epidemic from a multi-sectoral viewpoint. The initiative provides global learning and knowledge sharing on HIV/AIDS methods and best practices. Leading the monitoring and evaluation efforts of UNAIDS (the Joint United Nations Programme on HIV/AIDS) partners at the country level is a crucial duty of the Global HIV/AIDS Program. The World Bank's efforts to mainstream HIV/AIDS into all sectors are supported through the Global HIV/AIDS Program. The program's initial goals were to: 1. strengthen the Bank's capacity to respond to the needs of national governments, civil society, and other stakeholders; 2. share and expand available knowledge about effective HIV/AIDS approaches, and develop new approaches; and 3. strengthen the Bank's capacity to respond to the needs of national governments, civil society, and other stakeholders. 3. Improve the quality of monitoring and evaluation and increase capacity in this area among partners working on AIDS-related projects and programs at the national level. The Bank, as one of UNAIDS' co-sponsors, is helping to shape the worldwide response to the HIV/AIDS epidemic.

The end of the first World Bank-funded STI programs resulted in a better climate for HIV/AIDS interventions not only in Kenya but around the world. This is because: 1. parliament approved Session Paper No. 4, 1997 on AIDS in Kenya, removing legal barriers to intervention strategies; 2. the National AIDS Control Council (NACC) was established,

providing an institutional framework for the coordination and management of multisectoral national AIDS control programs at all levels; and 3. the NACC discussed and approved the first Kenya National HIV/AIDS Strategic Plan, 2000-2005. 4. Appropriate political leadership was provided, and NACC was strategically located in the president's office, where it got high political prominence. 5. Under the Kenya Non-Governmental Organization, civil society, NGOs, PLWHA, and CBOs interested in the fight against HIV/AIDS arose and grew stronger and more vociferous (KANCO). These organizations did actually confront, pressurize, and engage the government and international community on HIV/AIDS issues, both regionally and globally. 6. The number of international non-governmental organizations (NGOs) working on various aspects of HIV/AIDS prevention, care, and mitigation has exploded. For example, USAID and DFID supported programs on behavior change communication (BCC) and home-based care (HBC); JICA and the CDC supported blood safety programs; CDC and the Liverpool Project promoted scaling up of VCT; PSI became the leading agency in social marketing of contraceptives, particularly condoms; UNICEF promoted programs for orphans and other vulnerable children (OVC); UNDP, as part of its crisis prevention program, is involved in NACC advocacy and workplace violence prevention; and UNDP.

It's also worth noting that high-level international meetings and statements were taking place in support of the need to tackle HIV/AIDS, particularly in Africa. Millennium Declaration of September 2000; Abuja Declaration of April 2001; United Nations General Assembly Special Session on HIV/AIDS Declaration of June 2001; and Commonwealth Heads of Governments Cologno Declaration of March 2002 were among the gatherings and statements. In all of these meetings and declarations, HIV/AIDS was portrayed as an unprecedented problem that demanded extraordinary action. The scale of HIV/AIDS was considered as having far-reaching consequences not only for Africa, but also for international development and security [33, 41]. Finally, in terms of the number of stakeholders and partners eager to join the fight against AIDS, HIV/AIDS has received significant global attention. People realized that they needed to back up their willingness to combat the HIV/AIDS pandemic with money, and that money had to be spent if there was to be any change, as the global environment and willingness to fight the pandemic improved. Governments, organizations, and individuals pledged significant sums of money and more funding than ever before to fight AIDS. There was also more cooperation in the allocation of donor assistance, especially among significant donors who had previously funded minimal HIV/AIDS interventions in high-risk groups with low national coverage.

4. Kenya and US President's Emergency Plan for AIDS Relief

Kenya has received HIV/AIDS donor funding multiple

times since the closure of the STI/HIV Project. Some of these monies are channeled through government budgetary allocations, whereas the majority of them are channeled directly to implementing organizations such as NGOs, civil society organizations, government ministries, and/or intermediary organizations [26]. Despite being a key contributor to the Global Fund, the United States of America has invested significant resources in Kenya's HIV/AIDS fight.

The United States Government (USG) contributed to NACC's efforts and funds the Ministry of Health's National AIDS and Sexually Transmitted Infection Control Program directly. In Kenya, the USG responded by investing strategically in Kenya's capacity to plan, secure resources, and implement prevention, treatment, and care interventions; strengthening the public health delivery network; ensuring that Kenya's youths have access to HIV/AIDS services; and expanding access to antiretroviral therapy (ART) with a focus on those co-infected with tuberculosis or other opportunistic illnesses and whose lives are most at risk.

President George W. Bush, in collaboration with USAID and the Global Fund, unveiled the US President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR) in 2003, recognizing the global HIV/AIDS pandemic as one of the major health concerns of our time. This investment has been described as the single largest international health program ever undertaken by a single country to combat a single illness. The USG implemented the Emergency Plan under the guidance of the US Ambassador, working jointly as strong interagency country teams under the leadership of the US Global AIDS Coordinator. These teams leveraged partnerships with host governments, international institutions, non-governmental organizations, and the private sector to deliver effective HIV/AIDS programs and ensure efficient use of USG resources by leveraging the expertise of each USG agency. Kenya was one of the Emergency Plan's 15 countries. Kenya got almost \$ 92.5 million in 2004 and over \$ 142.9 million in 2005 under the Emergency Plan to finance a comprehensive HIV/AIDS prevention, treatment, and care program. The US expects to donate roughly \$ 208.3 million to Kenya in 2006 to aid in the battle against HIV/AIDS (HIV/AIDS Policy Fact Sheet 2005).

The PEPFAR monies were used to promote abstinence and faithfulness until marriage. Several Kenyan organizations got PEPFAR grants between 2004 and 2005. The total amount of money allocated to prevention includes money for programs aimed at preventing mother-to-child transmission, blood and injection safety measures, and high-risk community efforts.

Adventist Development and Relief Agency, Anglican Church of Kenya, Christian Health Association of Kenya, Family Health International, Hope Worldwide, Kenya Medical Research Institute, Kenya Students Christian Fellowship, Population Services International, and World Relief were among the organizations that benefited. These groups participate in a variety of grassroots activities. For example, the Adventist Development and Relief Agency is working to expand abstinence and behavior change for youth

programs, which used local educators, parent-child communication initiatives, and broadcast media to communicate messages about abstinence, fidelity, and partner reduction. Orphans and children impacted by AIDS received HIV/AIDS prevention at school through Hope World. People were educated about the hazards of promiscuity and the spread of the virus through World Relief work, which emphasized God's purpose for a loyal monogamous relationship inside marriage. The Anglican Church of Kenya's western diocese encouraged young people to defer sexual activity and boost secondary abstinence. Family Health International (FHI) assisted in the design, management, and assessment of comprehensive HIV prevention, care, and support programs, while Population Services International (PSI) continued with the three (ABC) aspects for maximal protection. PEPFAR hoped to reach nearly 6.5 million young people and their parents with abstinence and faithfulness messages through community-based programs and youth centers, as well as countrywide communication initiatives, through all of these activities.

PEPFAR is also supporting the publication and distribution of the Kenya Life Skills Manual Series in schools, in collaboration with the government. PEPFAR collaborated with community-based in-and out-of-school activities directed at teenagers, young adults, and married couples

through mass media in 2005 to enhance and extend programs encouraging and sustaining abstinence, faithfulness, and delaying sexual debut.

Kenya has continued to draw important donors and partners in the fight against HIV/AIDS as a result of its high HIV/AIDS prevalence. "Kenya is a country with a substantial concentration of multilateral and bilateral donors and NGOs," WHO said while tabulating the frequency of HIV/AIDS donor money to Africa. For example, USAID, JICA, CIDA, SIDA, AMREF, UNDP, UNICEF, DFID, UNDCP, UNHCR, ILO, UNIFEM, and countless NGOs give assistance in HIV/AIDS prevention and control, blood safety and transfusion, supply of equipment, HIV test kits, IEC/advocacy, ARV guidelines, and monitoring" [44].

The flow of donor cash in Kenya as shown in Table 1 is channeled through conventional government budgetary allocations. For the fiscal years 2000/01 to 2004/05, total donor financing for HIV/AIDS was 144.83 million Euro (12.745 billion KES). The International Development Agency is the largest donor, accounting for 79 percent of total donor assistance allocated through conventional budgetary channels, followed by the United Kingdom (12.9 percent). Overall donor HIV/AIDS budgetary allocations represent for around 97 percent of the total Kenyan budget excluding matching payments from the government [26],

Table 1. Total HIV/AIDS Budgetary Allocations from Donors (FY 2000/01-2004/05 Euro x Million).

FY	UNDP	IDA	UK	Belgium	USAID	UNICEF	WFP	EDF/EC	Total
2000/01	1.2	1.1	0.5	0.3	0.4	0	0	0	3.5
2001/02	0.7	6.4	6.1	0	0	0.1	0	0	13.3
2002/03	0	15.9	2.7	0	0	0.7	1.1	0	20.4
2003/04	0.8	28.1	1.1	0	0	0.3	0	0.2	30.5
2004/05	0.2	66.6	8.8	0	0.6	1	0	0	77.2
Total	2.9	118.1	19.2	0.3	1	2.1	1.1	0.2	144.9

Source: Public Expenditure Review, 2005

As previously stated, a large percentage of donor financing for HIV/AIDS is channeled directly to specific HIV/AIDS programs, which are mostly administered by NGOs, civil society, government ministries/or intermediary organizations, and thus off budget. These figures, however, are difficult to

calculate [7, 8]. Table 2 shows total off-budget spending by donor for each fiscal year from 2000-01 to 2004-05. Over a five-year period, expected donor financing for HIV/AIDS was 346.772 Euro. CDC and PEPFAR, among other programs, received major funding from USAID.

Table 2. Off-Budget Donor Funding (2000/01-2004/05, Euro x Million).

Source	2000/10	2001/02	2002/03	2003/04	2004/05	2001/02 2004/05	% share of total
USAID	9.142	8.400	17.760	21.910	40.390	97.602	26.75%
PEPFAR	0.000	0.000	0.000	0.000	60.483	60.483	16.58%
CDC	0.000	14.520	9.474	23.698	31.997	79.690	21.84%
UK	9.074	10.613	4.857	12.693	6.315	43.550	11.94%
UNICEF	21.973	0.000	0.000	15.074	1.659	38.706	10.61%
WHO	0.000	0.000	0.000	0.000	1.372	1.372	0.38%
UNDP	0.000	0.000	0.000	0.000	0.506	0.506	0.14%
UNHCR	0.000	0.000	0.000	2.318	0.795	3.115	0.85%
UNESCO	0.023	0.000	0.186	0.000	0.086	0.294	0.08%
UNFPA	0.705	1.030	1.030	0.736	0.598	4.098	1.12%
IOM	0.000	0.000	0.620	0.438	0.018	0.076	0.29%
FAO	0.001	0.001	0.013	0.038	0.025	0.076	0.02%
WFP	0.000	0.000	0.000	0.000	0.002	0.002	0.00%
UNODC	0.060	0.060	0.060	0.060	0.078	0.320	0.09%
WB	0.000	0.000	0.000	0.000	8.864	8.864	2.43%

Source	2000/10	2001/02	2002/03	2003/04	2004/05	2001/02 2004/05	% share of total
SIDA	0.000	0.000	0.380	0.380	1.456	2.216	0.61%
GFATM	0.000	0.000	1.466	0.000	0.000	1.466	0.40%
Italy	0.000	0.002	0.003	0.006	21.214	21.226	5.82%
Canada	0.007	0.000	0.063	0.069	0.000	0.140	0.04%
Spain	0.000	0.003	0.006	0.011	0.000	0.020	0.01%
Japan	0.002	0.008	0.010	0.000	0.000	0.020	0.01%
Belgium	0.003	0.002	0.005	0.009	0.000	0.018	0.00%
Germany	0.000	0.007	0.000	0.000	0.000	0.007	0.00%
Total	40.990	34.647	35.932	77.440	175.440	364.867	100.00%

Source: Fight against HIV/AIDS Kenya Ministry of Health, UNAIDS; OECD/DAC

Since 2003, the government and its partners have built the essential mechanisms for HIV/AIDS management. The focus switched to three important priority areas: preventing new infections, enhancing the quality of life of persons living with HIV/AIDS, and last, mitigating HIV/AIDS' socioeconomic burden. The intervention tactics were implemented in two ways. On one hand, there are those reaction actions that are directly initiated and supported by the government, utilizing the NACC and other associated agencies' mobilized resources. Several community-led initiatives have been proposed and driven by local NGOs, religious groups, traditional healers, HIV/AIDS patients, women, youth, disabled persons, widows, and others [25]. The success of these initiatives was to be measured using indicators such as HIV positive people's acceptance, young people's connections and interaction, orphan support, school assistance, the presence of NGOs, church groups, or community-based groups, and the degree of income-generating activities. To mitigate the socio-economic consequences of HIV/AIDS for affected communities, a two-pronged approach has been proposed, namely: 1. building economic resources, primarily through improved and expanded access to micro-credit programs, particularly for women and young people; and 2. supporting the creation of community safety nets.

NACC has been coordinating the disbursement of funding to various implementing organizations in this respect. This was done with the understanding that unless the community is financially and educationally empowered, it would not be able to fully face the negative social and economic effects of HIV/AIDS. As a result, NACC channeled cash to the communities, allowing them to alleviate the social and economic effects of HIV/AIDS while also preventing new infections. These funding have been channeled throughout the country through the NACC implementing organizations, including Constituency AIDS Control Committees (CACC), District AIDS Control Committees (DACC), and Provincial Aids Control Committees (PACC). International NGOs, on the other hand, work directly with local community projects and local NGOs using off-budget donor financing. The intervention techniques pursued by these international NGOs and their local collaborators are similar to those pursued by governments, with the exception that financing is provided directly to implementing bodies such as CBOs, local NGOs, Faith Based Organizations, the business sector, and PLWHA.

As a result, various HIV/AIDS programs have been launched, and lively debates about HIV/AIDS concerns have erupted in rural regions.

The recipients of NACC funds have prioritized basic HIV education and information dissemination, community mobilization to change harmful cultural practices, participatory education, including drama and puppetry, youth and adolescent training in life skills and behavior change, peer education, voluntary counselling and testing, and condom education, promotion, and distribution. The basic ABC approach is one of the specific behaviors fostered by these activities. In comparison to what it would have been without these efforts, awareness creation in rural regions has increased dramatically. The government and its partners in the fight against HIV/AIDS have moved away from general prevention and care and toward more established result-oriented initiatives in acknowledgment of Scaling Up. Behaviour Change Communication (BCC), Voluntary Counselling and Testing (VCT), Prevention Mother to Child Transmission (PMTCT), and Antiretroviral Therapy (ART) have all been linked in recent campaigns (ART).

5. Conclusion

Kenya's government caved in to donor pressure a decade after the first HIV case was revealed, prioritizing the fight against HIV/AIDS. Specifically, the government adopted various initiatives, laws, and legislations based on the finest worldwide public health policies and practices, in partnership with strategic external donors and international organizations. Legal Notice declaring HIV/AIDS a notifiable disease; Medium Term Plans (1987-1991, 1992-1996); National HIV/AIDS Control Program; National STI Control Program; National AIDS and STI Control Program, Sessional Paper Number 4, 1997; Declaration of HIV/AIDS as a National Disaster; establishment of National AIDS Control Council; National Condom Policy; and HIV/AIDS Prevention and Control Bill These efforts culminated in a multi-sectoral approach that included all of the necessary partners. However, the results are not impressive; rather, we have seen that managing HIV/AIDS responses necessitates informed and committed leadership that understands what must be done, why it must be done, and how it must be done. As of 2003, there had been little progress in empowering communities and alleviating the suffering of infected and

impacted individuals and families at the village level. Lack of openness, a leadership crisis, and heavy politicization have stymied crucial institutions that could have had a major impact at all levels..

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