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Constitutional Reforms and Access to HIV Services for Women in Low-resource Settings in Nairobi, Kenya

Empowerment of Women and Girls

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Background

After two decades of agitation for a new constitution, the violence that followed Kenya's 2007 presidential elections finally led to a reform movement to overhaul the way the country was governed. On 4 August 2010, voters approved a new Constitution (Government of Kenya 2010) by a clear majority, reflecting a widespread desire for change. The new Constitution was designed to improve government accountability and democracy by reorganising the system of government. There are now more checks and balances, parliamentary oversight of the executive is stronger, and the Bill of Rights provides greater protection for citizens, including women and minorities.

Perhaps the most profound change brought about by the new Constitution was devolution, i.e. the transfer of power from the centre to regional authorities and to the citizens. For Kenya, this has meant statutory powers being granted to the counties. The rationale behind this devolved system of government was to promote self-governance, development, and the equitable sharing of resources. The new Constitution gives prominence to the participation of citizenry in planning and budgeting, specifically through Articles 10(2), 69(d), 174(c), 184(1)(c) and the County Government Act (sections 99 to 101) (Republic of Kenya 2013). Thus, powers once held by the legislature and the executive branch have been handed over to Kenya's newly created 47 political and administrative counties. The county governments started up shortly after the March 2013 elections, when local representatives were elected. These new counties now oversee functions that were once the responsibility of the national government, such as education and health care. They receive a share of national revenues but are also expected to raise their own funds, i.e. from local taxes.

The devolution of health services began in 2013 with the election of governors and county principals. Devolution potentially has wide-ranging implications for Kenya's health sector, which is already failing on several levels. In Kenya, the prevalence of the human immunodeficiency virus (HIV) slowed from between 13 per cent and 15 per cent of the general population in 1999 to 5.6 per cent in 2012. Nevertheless, this is still one of the highest rates of HIV infection in the world. Women in Kenya have been disproportionately affected by HIV.

Four years after the approval of the new Constitution, this case study examines: the difficulties that poor women and girls living in slum areas face in getting access to HIV services, including anti-retroviral treatment (ART); their perception of how devolution has affected HIV and other health-related services; and their ability to participate in political decision-making and to bring about change at the local level. Are HIV-positive women and girls in slums able to get the attention of policymakers at the county level in order to get the services they need?

The case study seeks to answer the following questions:

- What are the perceived effects of Kenya's devolution policy on access to HIV prevention and ART services for women and girls in urban areas?
- What are the factors that shape county-level policies on HIV prevention and ART?
- Are women and girls in slums who are on ART able to get the attention of policymakers at the county levels in order to get the services they need?
- What is the role of organisations of people living with HIV (PLHIV) in the formulation of policy at county level on HIV services, including ART access?

Methods

The study was conducted in 2014 in two large slums – Kibera and Majengo – in the capital Nairobi, which is one of the 47 administrative counties under the new Constitution. It is the most populous county, with the majority of people living in one of the more than 80 slums.

Researchers conducted a literature review and collected qualitative data from key informant interviews – 53 in-depth interviews with policymakers, implementers, health staff, HIV advocates and HIV-positive women. We also used participant observations and digital storytelling, which is a qualitative narrative story method capturing voice and images on iPads through various applications, to capture the lived experiences of six women from slum areas. They can be viewed at: http://interactions.eldis.org/urbanisation-and-health/country-profiles/kenya/digital-stories.

Findings

Lack of access to and utilisation of government health services

Women and health-care workers raised concerns over a number of issues that affected their access to HIV-related services, which they would like to see changed. These issues included: (1) unavailability of HIV-related health services especially in terms of essential drug stock-outs and non-working CD4 cell-counting machines, leading to time-consuming referrals; (2) health-care workers not always respecting confidentiality; (3) lack of youth-friendly services – HIV-positive women in the study noted that a lack of youth-friendly services was a reason for young people not taking advantage of health-care services; (4) inconvenient opening hours and long waiting times in health facilities; (5) unintended negative effects of new programmes that aim to involve men but end up putting pressure on the women to produce a father and/or partner when they have none.

Factors that shape health policy

National health policy frameworks provide Kenyans with health rights including the right to the highest attainable standard of health. Despite these implicit and explicit rights, health indicators have progressively declined since 1993. Mortality rates, including child mortality rates, have risen. The HIV epidemic has contributed to this general decline in Kenyans' health status. Policies illustrate the willingness of the government to use international and national evidence to affect change but implementation has been mixed.

The institutions that shape county-level policy on HIV prevention and ART are currently being reformed in a three-year transition period, but with the national agencies National AIDS Control Council (NACC) and National AIDS and STI Control Programme (NASCOP) still in charge of the national and county HIV interventions.

Devolution and its impact on access and utilisation of government health services

For the majority of HIV-positive women in the study, not much had changed in HIV-related services since implementation of devolution. The only really noticeable change was that the essential drugs were now frequently out of stock. Frontline health workers confirmed that procurement had suffered since devolution.

Respondents felt politicians and policymakers did not pay attention to HIV-related services and they blamed this on county governments being politicised. Members of county assemblies were seen to be advancing their interests at the expense of the constituents. NACC and NASCOP key informants reported educating county governments, especially members of county assemblies, about the need to prioritise HIV services, obtain donor

funding, and make HIV a priority. Policymakers felt that it was too early to talk about the effects of devolution on access to HIV prevention services and ART. Several blamed citizens for expecting too much from services provided by the state. County policymakers did not seem to consider ensuring access to the available services to be part of their responsibility. Instead, they saw it as a duty of their constituents to find and use the services

Financing and budgeting under devolution

It is not clear how HIV services will be financed under the new system of devolved government. Article 189 requires the national and county governments to have fiscal autonomy, but financial management has to be in line with the national government framework. Over 80 per cent of HIV funding in Kenya is from external donors, which is administered through NACC and NASCOP. NACC disburses funding to both local civil society and lower-level government organisations. Before devolution, the then Nairobi City Council (now the Nairobi County government) had a budget. But this year, some policymakers at the county level say they received no funding and are confused about national HIV financing. Major international non-governmental organisations (NGOs) are withdrawing and their financial support is decreasing. It is not clear where the money for HIV/AIDS will come from.

Institutional reorganisation

There is also confusion about who is in charge and who is responsible for programmes and services, which has delayed implementing devolution. The fate of NACC staff is unclear and this has held back planning. Patients are confused as to which changes to their health care are a result of devolution and which are not. For example, when the Médecins Sans Frontières (MSF) Kibera South clinic was handed over to the Nairobi County government, HIV clients in the study attributed the change to devolution. In fact, it was because of a choice made by MSF to hand over services, which it – as a humanitarian organisation specialising in emergencies – had provided for many years in a situation which had then ceased to be an emergency.

Participation of women and girls in making decisions on HIV services

PLHIV have been participating in HIV policy development since before devolution, often in a consultative role. Even though PLHIV NGOs and networks may have a membership that is mostly female, they generally do not place HIV-infected women in decision-making managerial positions. This reflects a general exclusion of women from the political arena. Under the new Constitution, public participation has a central role, and devolution is a key factor in its promotion, with citizens supposed to have access to appropriate civic education programmes. However, one year after the introduction of devolution, low overall public participation in decision-making and governance was reported. HIV-positive women had no knowledge of civic education on public participation, and they had noticed little change since the passing of the new Constitution.

Devolution, however, could be an opportunity for marginalised populations to start participating in various decentralised structures. HIV activists in Kenya have historically been successful in getting the attention of politicians. But poor women in slums face internal and external barriers to participation in the political arena, including: a lack of confidence and knowledge regarding how to engage policymakers; not knowing how the political system works, and not belonging to any networks; a lack of both income and time; and competing priorities.

PLHIV organisations in Kenya have increasingly succeeded, over the past two decades, in getting access to the national policy arena. Yet our findings suggest that policymakers at the county level are not reaching out to these groups, and nor do they see it as their job to

respond to the difficulties that people experience in getting access to health care. Rather, they feel it is the job of the women to find out where the available health-care services are. It is not a priority for policymakers to get involved in county-level politics in order to improve access to, or the quality of, services. This attitude reflects a mindset that this study found, in which policymakers take little personal responsibility for their own actions when putting devolution into practice, and are keen to blame any delays on external factors.

Conclusion

The new Constitution and the push for a decentralised government came in response to citizens demanding government accountability, social equity, and better access to services. Devolution of governance can be an important step towards these demands being met, bringing policymakers closer to the people they serve. We found that the HIV-positive women in this study wanted policymakers to take more interest in them and to visit the slum areas to learn about their lives. But ensuring that decentralisation brings real benefits involves major restructuring of institutions, relocating and hiring staff, and reallocation of resources, as well as the development of new systems for accountability between central and county levels in both directions. It also involves a great deal of prioritising of HIV services and citizen participation.

Women have been marginalised in the political arena as a result of gender norms and barriers. Politicians and policymakers are not easy to reach, as the researchers' own experiences show. For HIV-positive women in slums – even if they are organised – these barriers to participation are considerably higher, not least because of practical constraints, such as a lack of time and money.

Engaging with policymakers and bureaucrats in order to obtain services has been very difficult in Kenya for decades. Although devolution represents a positive move towards citizens becoming engaged, women still have to take active steps to get the attention of policymakers. Poor women in slum areas are excluded and marginalised. They have also internalised these views and do not see themselves as political activists who can effect political change.

Since the introduction of the new Constitution and devolution, hospitals in Nairobi are being refurbished, and money is being spent on essential drugs. These changes cannot be attributed to devolution alone, though, as they reflect and build on other national health policies. Nevertheless, they show that the County is in a position to implement health policies. HIV is not a priority, however.

Citizens in slum areas have been under-served by the government for decades. Years of dysfunctional centralised governance has left them distrustful of the state. Instead, many rely on NGOs and community-based groups for social services, including ART. Now that international services are being downscaled or handed over to the State, it means they will be taken over by county-level departments. It is not clear what will happen to these services under devolution or how they will be viewed by clients, particularly women.

HIV is just one of the many health challenges that face women and girls living in slums. As women in slums have never been very active in the leadership of the PLHIV organisations that operate at national level, because of gender and class barriers, they are not familiar with effective policy engagement. They lack the confidence, knowledge and resources, including time, to be politically active.

Recommendations

- Establish initiatives to enhance the participation of poor women and girls in the political arena, and recognise the broader internal and external barriers that prevent participation.
- Acknowledge the various ways in which women do organise themselves in informal and practical needs-oriented groups, and focus on helping women to access more resources, as well as providing training on governance and organisation.
- Coach and train county-level policymakers on management, including personal and professional time-management, while implementing public accountability mechanisms, which monitor the time that transactions take.
- Provide rewards for good public management, such as awards for reducing waiting times and red tape.