

## 6 Corruption and HIV/AIDS



Some 5,000 demonstrators take part in a protest march to the Constitutional Court in Johannesburg on 2 May 2002 to protest the government's appeal of a court ruling forcing it to provide a key AIDS drug to HIV-positive pregnant women. (Themba Hadebe/AP)

While the corruption that affects HIV/AIDS prevention and treatment does not look very different from corruption found in other areas of the health sector, the scale of the pandemic, the stigma attached to the disease and the high costs of drugs to treat it magnify the problem. The response to HIV/AIDS must involve an increase in funds available to purchase drugs. But scaling up budgets without paying due regard to the anti-corruption mechanisms needed to ensure their proper use provides further opportunity for corruption. A case study from Kenya shows a worst-case scenario, of corruption and profligacy at the national AIDS body set up to coordinate prevention programmes. An examination of the Global Fund finds that including all stakeholders in the design of programmes, from governments and NGOs to the sufferers themselves, could help provide a safeguard against corruption.

## The link between corruption and HIV/AIDS

*Liz Tayler and Clare Dickinson<sup>1</sup>*

While it is difficult to draw a causal link between corruption and the spread of HIV, there is ample evidence that corruption impedes efforts to prevent infection and treat people living with AIDS in many parts of the world. The mechanics of corruption affecting the prevention and treatment of HIV/AIDS are not substantively different from those affecting the health sector more generally: opaque procurement processes, the misappropriation of funds earmarked for health expenditure and informal payments demanded for services that are supposed to be delivered free. What are different are the scale of the problem and the nature of the disease – a chronic, usually fatal and often-stigmatised disease that can be contained only with expensive drugs. Moreover, the individuals responsible for tackling corruption may themselves be severely affected by AIDS. These factors create particular vulnerabilities to corruption.

There are multiple opportunities for corruption in the prevention and treatment of AIDS. In prevention programmes, corruption occurs when false claims are presented for awareness-raising activities that never took place, or for materials that were never purchased. Corruption occurs in programmes aimed at alleviating the socio-economic effects of the disease on victims and their families, such as feeding programmes or support for school fees. Corruption can also contribute directly to infection when relatively low-cost measures, such as the use of sterile needles and the screening of blood donations, are ignored because a corrupt procurement or distribution process holds up supplies. Alternatively, health workers may use non-sterile equipment as an additional source of income by extorting illicit payments from patients who demand clean equipment.

But it is treatment programmes that are most vulnerable. Money for high-value drugs can be embezzled at any number of points in the procurement and distribution chain. At the grand end of the scale is theft by ministries and national AIDS councils of funds allocated for treatment, and the misappropriation or counterfeiting of medicine. At the petty end are doctors who extort 'tips' for medicines and patients who sell their own medication because it is the only valuable commodity they have.

The international response to the epidemic has increased in recent years and there is pressure to spend large sums of money in countries with limited capacity to oversee their proper usage. The IMF reports that HIV/AIDS resources flows were US \$5 billion in 2003 and US \$8 billion in 2004. With this much money in play, and with donors insisting that disbursement be the standard metric for judging programme success, recipient nations will find ways to absorb the funds, whether legally or illegally. The prime requirement for recipient nations seems to be 'spend it or lose it'.

The numbers of people infected with HIV are high and rising. In sub-Saharan Africa overall, 7 per cent of women and 2 per cent of men aged 15–24 are infected.<sup>2</sup> In Botswana, Swaziland and Zimbabwe, over 25 per cent of the adult population is now HIV infected. In Asian countries the rates are generally lower, but they are rising fast. The impact of a large proportion of a community becoming sick and dying is unclear.

Some have suggested that more widespread corruption might be a result of increased 'short-termism' as those infected seek financial security by any means possible for the families they will leave behind, and informal structures emerge to meet the vast needs that formal health systems are failing to meet.<sup>3</sup>

## Corruption in the treatment of HIV/AIDS

Relatively effective drug treatment has changed the nature of HIV/AIDS in the West. Increasingly, it is seen as a condition people can live with. Hospitalisation and death rates have fallen, and anti-retroviral drugs (ARVs), when properly administered, offer people with HIV many extra years of productive life, depending on when treatment begins.

In Africa, it is estimated that people live an average six and a half years after infection. If ARV treatment is started at the appropriate time, life expectancy is doubled or tripled. Over the past decade, ARV treatment has gone from being something that even people in developed countries could not afford to a treatment that over 700,000 people in developing countries now receive. The WHO is attempting to get 3 million people onto treatment by 2005 under its '3 by 5' initiative.

Even with this massive and rapid scaling-up, treatment is not available to all who need it. This is no different from other health services in Africa and the rest of the developing world where many are excluded through financial or cultural constraints, or because of the distance to health facilities. Access to ARV sharpens these issues, however. Demand frequently exceeds supply even when there is an official policy to determine who gets treatment, such as a cut-off point based on blood test results (the CD4 count). Those whose result is 'not quite bad enough' may try to use financial, political or other inducements to get onto treatment programmes. A 29-year-old Nigerian father of three spoke for many across the continent in the 2005 civil society organisation statement to the African Union Summit of Heads of States: 'The ARVs that come to the centre are not given to those of us who have come out to declare our status, but to those "big men" who bribe their way through, and we are left to suffer and scout round for the drug.'<sup>4</sup>

Where ARVs are provided for free or at heavily subsidised rates through donor-funded programmes, requests for 'top-up payments' are common. The Malawi Network of People Living with HIV/AIDS (PLWHA) reported instances of abuse from hospital workers demanding sexual, monetary or material favours in return for proper medication and care. Those who refuse are either neglected or receive sub-standard care. In cases where PLWHA do report receiving high-quality care, it is followed by suspicion by other care providers and patients that those who furnish it are receiving bribes.<sup>5</sup>

Those that get onto programmes offering free or highly subsidised drugs receive a valuable commodity. They and their family will have other needs as well, and many elect to share or trade their drugs to meet these needs. There is a ready market for ARVs. In Tsavo Road, Nairobi, huge quantities are traded every day.<sup>6</sup> Some come from patients, others leak out of the health system, and a large proportion is counterfeit. The drugs are often cheap and there are fewer stigmas, no hassle and no waiting. Some vendors sell their own treatment drugs; some are registered on multiple programmes

and have ARVs to spare; and others have access to the supply chain through central and hospital pharmacies.

People buy drugs from informal sources like Tsavo Road because it is convenient and anonymous. The problem with doing so is that ARVs are effective only when there is rigid adherence to the treatment protocol. Buying treatment from those who know little about the appropriate combinations, side-effects or dosage, and substituting one drug for another depending upon availability, means treatment is likely to become ineffective and result in the development of resistance to ARVs. Moreover, the product may be expired or fake.

The WHO estimates that the global market in fake and sub-standard drugs is worth US \$32 billion – or around a quarter of all drugs used in developing countries.<sup>7</sup> Well substantiated reports from Ethiopia,<sup>8</sup> DRC<sup>9</sup> and Cote d'Ivoire<sup>10</sup> indicate that the problem may be even greater and is increasing. Given the demand for, and value of the drugs, faking ARVs is potentially much more profitable than faking other drugs. Corruption contributes to the extent of the problem when regulatory authorities turn a blind eye to counterfeiting or public officials receive inducements to procure from less reputable suppliers, as Dora Akunyili describes (see 'The fight against counterfeit drugs in Nigeria', Chapter 5, page 97).

Concerted advocacy by civil society groups and governments, and competition from generic and research-based companies have been extremely effective in lowering the price of ARVs in the developing world, resulting in a system of differential pricing between OECD countries and developing countries. A month's supply of GlaxoSmithKline's Combivir, for example, costs around US \$610 in Britain and US \$20 in Uganda, Tanzania and Kenya. The potential profit from re-importation or smuggling is large for vendors in developing countries and drugs brokers in developed countries. How much of a problem this is in reality is controversial, however, and there have been allegations that the pharmaceutical countries are exaggerating the scale of the problem in order to dampen pressure for differential pricing.<sup>11</sup>

Competition in the supply of ARVs has not stopped corruption in national procurement processes. For example, the Romanian government has launched an investigation following allegations by US Ambassador Michael Guest that ARVs were being sold at prices 50 per cent higher than in the United States and that the health ministry had engaged in corrupt dealings with drug suppliers. A government watchdog agency reported in April 2003 that the ministry had ignored an agreement with GlaxoSmithKline to reduce the price of its ARVs by up to 87 per cent<sup>12</sup> and denied drug importation contracts to foreign companies, granting them instead to four local ones. These levied 'taxes and commissions' were worth up to 55 per cent of the drugs' value.

## National programmes: new approaches and roles

Where systems are weak and corruption endemic, it is difficult to disentangle corruption from mismanagement and system failure as the root cause of poor HIV/AIDS responses. Nigeria's ARV programme attracted much criticism in 2003 when treatment centres

began handing out expired drugs and rejecting patients.<sup>13</sup> But it is not yet clear whether the prime cause was corruption or a weak drug procurement, supply and distribution service that was unable to respond to the demands that the rapid scaling-up of the programme had placed upon them.

Fresh approaches have developed involving new actors and sectors not traditionally involved in health programmes, such as education, security, agriculture and social services. National AIDS commissions have been established to coordinate the response in many countries. They are often seen as a donor construct, however, and the extent to which they have been assimilated into domestic governance systems is variable. Kenya provides an example of the worst-case scenario: its agency was discredited when it was discovered that senior staff had paid themselves inflated salaries and allowances (see 'Corruption in Kenya's National AIDS Control Council', page 112).

In Zimbabwe the government has imposed an 'AIDS levy' since 2000 whereby employees contribute 3 per cent of their gross salaries towards a fund administered by the National AIDS Council (NAC). It is estimated that the government collects about US \$20 million per year through this mechanism, but no information about how the fund is used and who benefits from it has ever been made public. In March 2005, the health ministry ordered an audit of the NAC, but at the time of writing it had not yet been published.

Civil society organisations (CSOs) are increasingly seen as important providers of services and receive substantial grants to do so, but the transaction costs of processing and monitoring CSO applications are very high. An attendant risk is that CSO directors will siphon off their funding. For example, the director and senior staff at the Zimbabwe National Network for People Living with HIV/AIDS were suspended after allegations of corruption.<sup>14</sup> The network received more than US \$1.8 million from the NAC between 2003 and 2004.

### The international response: more money

The sums now being disbursed to tackle HIV/AIDS are huge compared to the existing budgets of many countries.<sup>15</sup> In Ethiopia, Liberia and Malawi, the money allocated by global health partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria represents more than a doubling of the health budget. Funds from the World Bank and the US President's Emergency Project for AIDS Relief (PEPFAR) are also massive.

While the need for money is undisputable, the systems to use these funds appropriately are poorly developed. The fact that the 'performance' of a grant or loan is assessed by how rapidly it is disbursed gives incentives to donor and recipient to allocate the money carelessly. For corrupt officials, rapidly expanding budgets offer greater scope to siphon off significant volumes without anyone noticing. This is especially true where health systems are fragile, where there is a lack of monitoring and oversight, and where the capacity to channel the money effectively is limited.

Beyond the immediate risk of money being squandered by corruption, commentators such as Stephen Knack<sup>16</sup> suggest that development assistance may actually reduce

### Box 6.1 Accountability in a time of crisis: corruption and the Global Fund

The Global Fund to Fight AIDS, Tuberculosis and Malaria was established in January 2002. At the time, international efforts were failing to dent a death toll of 6 million people each year who die of illnesses that in rich countries are controlled or cured. Its foundation coincided with growing concern that corruption was lessening the impact of development aid.

The Global Fund's mandate was simple: to provide a massive infusion of financing for efforts to combat these three diseases in developing countries. Its role would be limited to supplying funding rather than, as has classically been the case in development assistance, bundling financing with technical support to prepare and implement programmes. This model was developed out of a recognition that adequate capacity existed at local level to scale up disease control interventions, should sufficient financing be made available. No country offices would be established, and instead the Global Fund would be created with a small board supported by a small Secretariat in Geneva.<sup>1</sup>

To date, the Global Fund has approved proposals totalling almost US \$3.5 billion for combating the three diseases in nearly 130 countries. More than US \$1.41 billion was disbursed as grants in the organisation's first three years, and the figures are growing rapidly. The countries being financed are among the most corrupt in the world: 23 of the 25 lowest-ranked countries in Transparency International's 2004 Corruption Perceptions Index have received money from the Global Fund.<sup>2</sup>

Working in countries where corruption is endemic, and under pressure to work fast, the Global Fund's approach has been to include parties from government, civil society, the private sector, UN and donor agencies, and people affected by the diseases in Country Coordinating Mechanisms that have responsibility for submitting proposals and overseeing the use of funds. The idea is that the different stakeholders will exert peer pressure to promote more effective implementation and reduce the likelihood of money disappearing.

But the experience to date with this approach to ensuring accountability has been mixed.<sup>3</sup> In Armenia, Cambodia, Ghana and Rwanda, the country bodies have taken on active roles in overseeing implementation, including developing monitoring tools and operating procedures. In other countries, however, they have been appropriated by a single constituency – typically the government – particularly in Eastern Europe and central Asia; have fallen prey to competing political agendas; or simply have not met regularly enough to ensure any adequate oversight role.

A second aspect of the Global Fund's accountability system is that ongoing funding is performance-based. Global Fund resources are provided as advances and the financial reporting requirements are generally quite streamlined. But expenditure reporting is required to be linked with programme monitoring and evaluation, shifting the focus from inputs (whether or not a computer was bought or a shipment of drugs arrived at the port, for example) to outputs (such as whether the financing was used to scale up interventions against AIDS, tuberculosis or malaria). If expenditures occur without demonstrable results, it is an immediate red flag that corruption may be diverting resources away from their intended purposes. This enables the Global Fund's Local Fund Agent (LFA)<sup>4</sup> to pay increased attention to the recipient's financial records.

However, LFAs are more familiar with financial data than health outcomes and have not always adequately addressed this weakness by bringing in outside expertise. Adding to



the problem, the contracting system does not systematically ensure that an LFA working in a very corrupt country has more resources at its disposal than one working in a country with robust accountability systems. The Global Fund has terminated grant agreements because of corruption concerns in two cases, Ukraine and Uganda. In both cases, the corruption was detected as a result of a combination of the work of the LFA and that of partners in the country.

A third innovation of the Global Fund is its transparency. The Global Fund makes information about the dates and amounts of every disbursement available on its website and in its publications. The ideal is that the government and non-government partners with a stake in the programme will use this information to ensure that resources are not diverted.

There are concerns that this vision is losing some of its clarity, however, as the Global Fund Secretariat grows in size and slowly takes on more responsibility for doing the work that its partners were originally expected to be able to assume. This has arisen both because of pressure on the new organisation to prove itself and because partners have tended to view the Global Fund as yet another external body coming in to finance its own projects, rather than one that simply provides additional resources to a national response that all parties would support.

Given the Global Fund's short history, it is difficult to assess fairly how well these various accountability and transparency mechanisms are working. What speaks in the organisation's favour is that it has been willing to amend its processes as corruption concerns emerged; for example, in deciding in mid-2005 to set up an Office of the Inspector General to tackle suspected fraud and abuse. It has also begun to introduce risk management principles into its operations, both to allocate staff resources appropriately and to tailor procedures and responses to varying contexts.

*Toby Kasper<sup>5</sup>*

#### Notes

1. Of the 19 board members, 14 are from national governments or regional groups, generally represented by health ministries, HIV/AIDS committees, and development cooperation ministries. Three are from non-governmental organisations and two are from the private sector. Two of the NGO members were from developing country NGOs, while the 14 governmental representatives were evenly divided between developing and developed countries.
2. Transparency International, *Global Corruption Report 2004*, available at [www.transparency.org/cpi/2004/cpi2004.en.html#cpi2004](http://www.transparency.org/cpi/2004/cpi2004.en.html#cpi2004)
3. See [www.theglobalfund.org/en/apply/mechanisms/casestudies/default.asp](http://www.theglobalfund.org/en/apply/mechanisms/casestudies/default.asp)
4. The Global Fund Secretariat does not have any offices outside Geneva, so it contracts independent firms to assess the capacity of the principal recipients of the funds to handle the large volume of resources and to monitor implementation. The LFAs are generally accountancy firms (particularly PricewaterhouseCoopers and KPMG), selected through a competitive tendering process.
5. The author worked at the Global Fund to Fight AIDS, Tuberculosis and Malaria from August 2002 until March 2004, initially responsible for the management of a portfolio of countries and later as policy manager.

the quality of governance in recipient countries. Donors may set up parallel systems to avoid the risk of corruption, but this means taking talent and capacity away from the official government system, with the concomitant that governments and officials become more accountable to the donor than to their own constituents. PEPFAR is an example of an approach that combines a political imperative to spend money rapidly within narrow political constraints.

In an attempt to prevent this, some donors – mainly European, but also the Global Fund (see page 108) – are moving towards ‘budget support’, essentially putting their money through government channels. While recognising the fiduciary risk, they believe that the benefits – improved efficiency, legitimacy in focusing on public financial management and support to domestic accountability – outweigh the disadvantages in many countries.

### Could more be done to minimise corruption?

As with attempts to tackle corruption in the health sector generally, the terms and conditions of health workers should be improved in parallel with the introduction of mechanisms to increase their accountability to the communities they serve. However, though paying health workers and civil servants more is necessary, it is not enough to limit corruption, as the Nigerian experience in 2000 illustrated. And minimising the opportunities for corruption without providing alternative sources of income may induce health workers to give up, resulting in an escalation of the human resource crisis in the health sector.

Increasing transparency is vitally important in health services. The public needs to be more aware of the eligibility criteria for ARV programmes, which should ideally become more consistent within and across countries. They need to be aware of what they have to pay and what they will receive. The quantities and values of drugs supplied at each level of the system should be well publicised, and health workers should have to account for them. There also needs to be a mechanism whereby people can complain without fear of victimisation.

Pharmaceutical companies also need to take action. To minimise the risk of drugs for developing countries being reimported, GlaxoSmithKline is rebranding and changing the colour of ARVs sold in developing countries. An alternative approach is to develop different branding and packaging for products designed for use in developing countries.

The EU employs a system of registration whereby products are given a number and bar code, and can be identified by customs or drug brokers if reimported. Tight monitoring of pharmaceutical sales within the United States and Europe is an important disincentive to reimportation, and needs to be maintained. However, implementation of the recent WTO agreement regarding compulsory licences, and the export and import of generic varieties of drugs may restrict the availability of cheap generic varieties of drugs, providing additional scope for bureaucratic corruption.

Donors have an important role to play in minimising corruption, one that is not specific to HIV/AIDS treatment or prevention programmes. With vast resources flowing in for HIV/AIDS, however, a new paradigm has been created that distorts the donor–recipient relationship. What rich nations view as the provision of funds to purchase AIDS medicines, many in poor nations have monetised upwards as a currency of street trade.

Donors need to find a choke point to reduce corruption. One step towards making recipient governments more transparent would be for donors to be open and explicit

about what they are giving, when and to whom. This requirement is included in international recommendations, but the reality is far from ideal. Donors should ensure that aid is used in line with good procurement guidelines, and work with pharmaceutical companies to encourage and ensure responsible behaviour.

Ultimately, it is the responsibility of national governments to deal with corruption. Given the associated sensitivities about international action, regional pressure may be more appropriate; in Africa, the New Partnership for African Development (NEPAD) peer review system could become an important tool. Finance and health ministers control the foreign exchange that is used to purchase medicines and need to be aware of the long-term effects of their misuse. When medicines are sub-standard or distributed inadequately, the onset of drugs resistance is accelerated, leading to a growing burden of chronically ill people. The cost of medical care to treat them will be far greater than the price of the legitimate medicines in the first instance.

HIV/AIDS is going to be a major problem for the next two decades at least. Experience gained in other areas of development, and the need for transparency and strong domestic accountability, should not be ignored if sustainable and effective approaches to tackling the disease are developed.

## Notes

1. Liz Tayler is a UK public health physician, who worked for several years as the DFID health adviser in Nigeria before joining the HLSP institute as an adviser. Clare Dickinson is an HIV/AIDS specialist with HLSP and formerly worked in Indonesia on a health policy project based in the Ministry of Health.
2. UNAIDS, 2004 situation report, [www.unaids.org/wad2004/EPI\\_1204\\_pdf\\_en/Chapter3\\_subsaharan\\_africa\\_en.pdf](http://www.unaids.org/wad2004/EPI_1204_pdf_en/Chapter3_subsaharan_africa_en.pdf)
3. Alex de Waal, 'HIV and the Security Threat to Africa'. Evidence submitted to the high-level forum panel on security threats and challenges, Justice Africa, May 2004.
4. Statement by CSO at the fourth ordinary African Union Summit of Heads of States, January 2005 Nigeria.
5. Malawi Network of People Living with HIV/AIDS (Manet), 'Voices for Equality and Dignity: Qualitative Research on Stigma and Discrimination Issues as they Affect PLWHA in Malawi', July 2003, [www.synergyaids.com/documents/Malawi-MANET.pdf](http://www.synergyaids.com/documents/Malawi-MANET.pdf)
6. *The Nation* (Kenya), 22 January 2004.
7. 'Fake and Counterfeit Drugs', WHO Fact Sheet 275, November 2003.
8. [www.addistribune.com/Archives/2003/10/10-10-03/Black.htm](http://www.addistribune.com/Archives/2003/10/10-10-03/Black.htm)
9. [www.essentialdrugs.org/edrug/archive/200402/msg00028.php](http://www.essentialdrugs.org/edrug/archive/200402/msg00028.php)
10. [www.essentialdrugs.org/edrug/archive/200401/msg00004.php](http://www.essentialdrugs.org/edrug/archive/200401/msg00004.php)
11. *Financial Times* (Britain), 23 May 2005.
12. Agence France-Presse (France), 22 April 2003.
13. Associated Press, 4 February 2004.
14. *The Chronicle* (Zimbabwe), 3 February 2004, 23 April 2004 and 19 July 2004.
15. In 2001, US \$2.1 billion was spent on HIV and AIDS; within three years this almost tripled to US \$6.1 billion, with an expectation that needs will triple again by 2008. See 'Resource Needs for an Expanded Response to HIV/AIDS in Lower and Middle Income Countries' (UNAIDS, 2005).
16. Stephen Knack, *Aid Dependence and the Quality of Governance: A Cross-Country Analysis* (Washington DC: World Bank, 2001).

## Corruption in Kenya's National AIDS Control Council

*Kipkoech Tanui and Nixon Ng'ang'a*<sup>1</sup>

HIV/AIDS is one of the biggest challenges facing the health sector in Kenya, and was declared a national disaster in 1999. The National AIDS Control Council (NACC) was set up later that year to coordinate the prevention and control of HIV/AIDS. Its role became even more critical when the current government placed at the centre of its 2003–07 development plan the goal of achieving 90 per cent awareness of the disease and its effects across society.

The NACC was given control over funds pooled under the Kenya HIV/AIDS Disaster Response Project (KHADREP), financed by the World Bank, the UNDP, and the UK and US development agencies. In the 2004–05 financial year, the NACC was allocated just under KSh4 billion (US \$41 million). The most significant portion of its budget is channelled into community-based organisations. It claims to have channelled KSh1.8 billion (US \$24 million) to community-based organisations during 2000–03.

The NACC was set up under the Office of the President (OP). However, a more natural home for it is the health ministry, which is also a recipient of large amounts of bilateral funding and runs the National AIDS and STD Control Programme (NASCOP). The choice of the OP as home for the NACC was made ostensibly out of the government's desire to control the sizeable budget it manages. The OP's record belies the wisdom of this decision, however. It has been the focus of some of Kenya's most egregious acts of corruption, often perpetrated by well-connected officials who have proved almost impossible for prosecutors to touch.

In April 2003, the OP was enveloped in scandal when it was revealed that the head of the NACC, Margaret Gachara, had been receiving a salary seven times what she should have been entitled to as a senior civil servant. She had negotiated the salary based on a fraudulent letter from her previous employer that exaggerated her earnings there. Once in office, she raised her salary even higher than the already inflated amount she had been offered. In August 2003 she was ordered to refund US \$340,000 to the NACC.

Fears that the corruption did not end with her high salary were confirmed in April 2005 when a report by the Efficiency Monitoring Unit (EMU), also based in the OP, revealed that for years high-level public servants had used the NACC as their personal cash cow. There had been a number of early warning signals. An internal audit in June 2002 found irregularities in procurement procedures and in June 2003 the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria withheld a US \$15 million AIDS grant until the government addressed corruption in the NACC.

The 300-page EMU report revealed that Kenya could not account for KSh3.64 billion (US \$48 million) donated by the United Kingdom over five years since 2001. It put a figure of more than KSh37.3 million (US \$490,000) on the amount used by NACC employees to pay themselves inflated salaries and fraudulent allowances, such as the payment of private water, electricity, telephone and home security bills. The largest sum was the money embezzled by Gachara, but others were also involved, including eight permanent secretaries or their representatives, and NACC Chairman Mohammed Abdallah, who was charged with embezzlement but later acquitted due to 'lack of evidence'.

Even where money did find its way out of NACC to the community organisations it was intended to support, the report into its use was damning. The EMU found that on a sample examination of the community-based organisations funded by the NACC, at least half of the money allocated has been squandered.

Investigators probed three of the 10 national NGOs funded by NACC and several provincial, district and constituency-level organisations. They found wanton theft of the NACC money granted to noble-sounding projects that turned out to be sham. The worst cases involved shell organisations purposely formed to cash in on the NACC windfall. The NACC itself had cracked down on some of the so-called 'briefcase' NGOs cited in the report, including the Neema Children's Centre in Nairobi. The NACC awarded Neema US \$14,000 out of a World Bank grant to finance grassroots work on HIV/AIDS. It was closed down in mid-2003 after inspectors could not find a single Neema worker or a single orphan who had benefited from the children's centre.

Money was squandered by almost all the AIDS Control Units (ACUs) formed in each ministry to sensitise staff to the disease. Grants were spent on needless seminars, usually involving the same participants. Of the US \$205,000 given to the Ministry of Agriculture, for example, more than 75 per cent was spent on staff accommodation, allowances and participation fees at various awareness-raising shows, the EMU report noted. Almost one-third of the amount spent was not accounted for and was presumed wasted.

Investigations into the three national NGOs revealed similar misdeeds. Par Aid, a well-connected organisation based in Eldoret, received US \$100,000 for a proposal to study the efficacy of Par Aid herbal medicine in the treatment of HIV/AIDS infection. The chairman of the Institutional Research and Ethics Committee at Moi Teaching Referral Hospital, which is part of Moi University, withdrew a letter approving the project because he was concerned that Par Aid was not serious about the study, but his decision was quickly overturned with no explanation given by the hospital's director. The study went ahead, and the EMU report found that most of the money was spent on trips to collect the medicine, or on fuel. The medicine that should have been used in free trials was sold to desperate patients, leading the EMU to conclude that Par Aid was conducting a profitable business with NACC funds.

Corruption in the case of the AIDS Prevention Forum of Kenya (APFK) is even more blatant. Also given US \$100,000 in NACC funds, its directors appear to have gone on a spending binge under the guise of organising seminars and workshops.

EMU noted a claim by the organisation that it spent US \$16,000 hosting school pupils at a seminar in the Chania Tourist Hotel. The schools said to have been involved denied any knowledge of the activity and said some of the pupils alleged to have participated did not even exist. Similarly, hotels refuted several account entries, saying they were either paid considerably less, or did not host the seminars at all. For example, the Hotel Big Five in Homa Bay, which was said to have hosted 150 students at a cost of US \$6,200, consists of just 12 rooms and denied ever accommodating the group.

A number of APFK directors were simultaneously directors of the third NGO investigated, Technologies and Action for Integrated Development (Techno Aid), where similar practices were uncovered. Techno Aid claimed to have organised seminars and workshops for the same people as APFK, consulted academic experts who denied ever

working for the NGO, and paid large bills to non-existent hotels. Both Techno Aid and APFK presented receipts for stationery from the University of Nairobi bookshop, which has disowned them as frauds.

The report points the finger of blame at the lax implementation of the NACC's own funding rules and, in the worst cases, outright collusion between crooked NGOs and NACC staff. In some cases the NACC continued to finance organisations even when its own officers had expressed concerns over the accounting for previous allocations.

As isolated cases, the funds may seem petty especially when juxtaposed with the huge sums that HIV/AIDS attracts. But in their consolidated amounts, and if spent on effective prevention programmes, life-prolonging anti-retroviral drugs (ARVs) or income-generating activities for the affected and infected, the sums are significant.

The fight against HIV/AIDS in Kenya attracts massive funding. The Global Fund has promised US \$129 million over five years while the United States has pledged US \$115 million. Other donors who have responded to Kenya's appeal for more funds include UNAIDS (US \$15 million) for disease mitigation initiatives and the World Bank (around US \$658,000 on top of a 2004 grant of US \$4 million). The bulk of these funds go to NASCOP, which has also fallen under suspicion for failing to deliver results commensurate with its budget. If there were no leakage or inefficiencies in the use of NASCOP funds, they should be enough to provide ARVs to 200,000 of the 1.4 million Kenyans who are estimated to be infected with HIV. The real figures are scandalously small. By November 2004 only 24,000 people were reported to be on ARVs.

The EMU is based in the OP, and was created in response to donor pressure to contain corruption in the institutions they support. Every state institution is liable to be investigated by the unit, but given its scant resources – staffed by just 50 people – it opts to probe those with sizeable budgets, often guided to them by rumours of sleaze. The EMU is reputed to conduct thorough and impartial investigations. Its report, 'Financial Management Audit of the National AIDS Control Council (NACC) in the Office of the President' is the culmination of a two-year investigation.

The EMU has called on the Anti-Corruption Commission to investigate all the cases of fraud and abuse of office listed in the report. Gachara, the former NACC director, was sentenced in August 2004 to one year in prison on three counts of fraud and misuse of office. She was granted a presidential pardon in December 2004, along with 7,000 'petty offenders' who had stolen from various government offices. Her release was publicly decried.

In response to the report, the NACC claims to have hired auditors to probe the accounts of the NGOs it funds. It says it will release funds in tranches, conditional on proof that the previous allocation was properly utilised. It ordered 20 NGOs to refund money that was misappropriated, or face prosecution. At the time of writing none had refunded the money and none had been taken to court.

The role of constituency-based AIDS councils has also been bolstered in response to the scandals. These had already been given a larger role in resolving the Global Fund's concerns and now have responsibility to scrutinise the expenditure of NACC money. Many MPs – who are the patrons of their respective constituency councils – have welcomed moves in this direction and some have called for the NACC to be

disbanded in favour of constituency-based AIDS management committees, citing bias in NACC decisions over which NGOs to fund. Whether this will help curb corruption is questionable, however. Civil society groups and the media have levelled accusations of favouritism in appointments to the constituency councils and in their decisions over the disbursements of funds.

#### Note

1. Kipkoech Tanui is deputy managing editor and Nixon Ng'ang'a is a journalist with *The Standard*, Kenya.

