EVIDENCE OF THE IMPACT OF IMF FISCAL AND MONETARY POLICIES ON THE CAPACITY TO ADDRESS HIV/AIDS AND TB CRISES IN KENYA

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The report draws heavily on the work of a collection of background papers undertaken to improve the evidence of the effects of IMF policies on the public health sector in Kenya.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ART	Anti Retroviral Therapy
ARV	Anti-retroviral
BOPA	Budget Outlook Paper
BSP	Budget Strategy Paper
CBK	Central Bank of Kenya
CBS	Central Bureau of Statistics
CEGAA	Centre for Economic Governance and AIDS in Africa
CSO	Civil Society Organization
ERS	Economic Recovery Strategy
FY	Financial Year
GDP	Gross Domestic Product
IMF	International Monetary Fund
IEA	Institute of Economic Affairs
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic and Health Survey
KNASP	Kenya National AIDS Strategic Plan
MWG	Macroeconomic Working Group
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoPND	Ministry of Planning and National Development
MTEF	Medium Term Expenditure Framework
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NHA	National Health Accounts
NHSSP	Kenya National Health Sector Strategic Plan
NLTP	National Leprosy and TB Programme
PEPFAR	Presidential Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PRSP	Poverty Reduction Strategy Paper
PS	Permanent Secretary
QBR	Quarterly Budget Review
REF	RESULTS Educational Fund
SDR	Special Drawing Rights
SWG	Sector Working Group
TB	Tuberculosis
WHO	World Health Organisation

EXECUTIVE SUMMARY

Introduction

This report is part of a multi-country assessment of the impact of International Monetary Fund (IMF) fiscal and monetary policies on the capacity of governments to address the HIV/AIDS and tuberculosis (TB) crises. It has been argued that the macroeconomic policies endorsed by the IMF limit the options of developing countries to scale up public spending in order to meet critical development challenges because they set restrictive ceilings on the national budget. While the IMF counters these claims by arguing that the formulation and implementation of macroeconomic policies are the responsibility of the government, health policy makers point out that the budget ceiling set jointly by the IMF and the government is a key constraint preventing the Government from investing more in health.

Recent studies have expressed concern that restrictive fiscal and monetary policies imposed on developing countries by the International Monetary Fund (IMF) can impede the response to TB, HIV/AIDS and other major health emergencies in Africa. With an eye toward reducing fiscal deficits, inflation and other macroeconomic indicators below specified limits, the IMF promotes conditionalities with countries receiving IMF financing. These conditionalities, which translate into budget and wage bill ceilings, ultimately restrict health spending and public investment in health, and thus undermine the country's response to HIV/AIDS and TB. This study therefore explores the impact of IMF policies on the Government of Kenya's ability to respond with increased budgetary allocations for health in general, with consequences for responding to HIV/AIDS and TB.

This report explores previous and current IMF macroeconomic policies in Kenya's IMF programs, with a specific examination of the fiscal and monetary policy targets as they impact national budgets. The report concludes that a significant scaling-up of public spending and investment on public health is not possible under the current framework, which is designed and formulated to constrain spending toward maintaining stabilization. The current macroeconomic framework is therefore at odds with the internationally agreed goals of scaling up spending to meet the MDGs and fight HIV/AIDS and TB.

The report also identifies and critically reviews several underlying assumptions of the policies in the current neoliberal macroeconomic framework, finding many to be misguided and/or not supported by the empirical literature. It is suggested that each of these assumptions and policies informing the macroeconomic framework in Kenya be revisited and reconsidered by a larger group of public stakeholders.

The report finds that the current macroeconomic targets and conditions are set in a nontransparent, non-participatory and unaccountable manner that sidelines key ministry of health staff, key legislative committees and other key public stakeholders. Crucial decisions affecting future growth and employment and future budgets are made behind closed doors between the finance ministry and IMF without an informed public discussion of possible alternative scenarios and their potential trade-offs.

The specific objectives of this study were to: 1) review the content, process and transparency of the IMF policies under ESAF and PRGF loan programs; 2) identify the key stakeholders in the process of accepting policies and conditionalities, their influence and power; 3) identify recent trends in the total public (domestic) health expenditure; 4) more specifically identify trends in the public (domestic) expenditure for TB and HIV/AIDS; 5) identify trends in the public (domestic) expenditure for personnel for health, TB and HIV/AIDS, 6) identify trends in the number of health professionals working in the health sector, in TB and HIV/AIDS; and 7) to consider trends in accessing TB and HIV/AIDS treatment services.

This study combined both qualitative and quantitative data collection research methods to examine how IMF polices determine the limits of national budget sizes, and consequently, their impact on health funding and the Government's response to the HIV/AIDS and TB crises in Kenya. Information on IMF policies was obtained from relevant documents through a review of existing documents and interviews with key officials. In addition, the study comprised budget analysis through examination of recent national budget documents, the medium-term expenditure frameworks (MTEFs), the public expenditure reviews (PERs), expenditure records and face-to-face interviews with key informants. The results of analysis of the quantitative data were used to make general observations on the impact of IMF policies in Kenya, with the qualitative information providing a backup.

Overall, the report calls for a broad public review and reconsideration of the macroeconomic framework in Kenya, its policies and their underlying assumptions. The costs and benefits of a range of other possible more expansionary policy options for increasing public spending must be considered, and must be done in an open, inclusive and transparent process that involves a much broader group of public stakeholders.

Findings

- A major problem is that the overall policy priority of the current macroeconomic framework is stabilization, not scaling-up. The framework is designed for constraining public spending. It is not designed to enable the large scaling-up of public expenditure envisaged by the MDGs.
- Specifically, the restrictive fiscal and monetary policy targets and the neoliberal reform towards adoption of market-based interest rates, have greatly constrained the ability of

the Government to engage in the more expansionary fiscal and monetary policy options that will be required for any major scaling-up scenario.

- Such targets and policies in the current macroeconomic framework unduly limit the Government's potential fiscal space, by constraining the overall national resource envelope. This in turn affects adversely allocations to the different ministries, including the health ministry.
- The retrenchment in the public service in the 1990s, coupled with a freeze on employment that has persisted to date, have also affected adversely the health sector. Despite recent increases in health spending, the overall budget constraint stemming from the policy targets of the macroeconomic framework continues to prevent the Government from being able to fill personnel shortages due to lack financial resources and the wage bill ceiling policy, which constrains wages at 6.5 percent of GDP. The continuing scarcity of critical public human resources for health has largely contributed to the ministry's inability to fully implement effective HIV/AIDS and TB interventions.
- Civil society consultations for inputs into the PRSP documents do not include or permit discussions about the macroeconomic framework.
- The policy decisions about the macroeconomic framework continue to be decided elsewhere, confidentially and without broad public participation, scrutiny or accountability.

Recommendations

- The process of deciding the policy priorities for Kenya's macroeconomic framework should be subject to a broader national public debate and discussion involving parliament, academia, civil society, labor and the domestic media.
- Additionally, setting of specific fiscal and monetary targets should be made more transparent and involve broader public discussions of the costs and benefits of alternative policy options.
- The Finance Ministry and others should work with the IMF and other donors to open the discussion to consider more alternative policy options, with the view to allow flexibility in deficit financing geared specifically to mobilize more resources for the health sector.
- Kenya's parliamentarians need to play a more active role in urging the Government to demand the removal of all policy conditionalities in any future IMF lending arrangements.
- Civil society in Kenya should work with economists and civil society networks in other donor countries to collectively call on governments to take steps at the IMF Executive Board level to change the current IMF policies on fiscal and monetary targets.
- CSOs must work to invest in macroeconomic literacy training efforts that are inclusive of alternative ideas and involve multiple stakeholders such as parliamentarians, labor, domestic businesses and the media.

CHAPTER ONE: INTRODUCTION

1.1 Background

Over two decades of evidence demonstrates that the restrictive fiscal and monetary policies the International Monetary Fund has promoted in developing countries can limit government spending. With an eye toward reducing fiscal deficits, inflation and other macroeconomic indicators below specified limits, the IMF promotes conditionalities with countries participating in an IMF program. These conditionalities, translated into budget and wage bill ceilings, can ultimately restrict health spending and thus undermine the country's response to HIV/AIDS and TB, the achievement of the Millennium Development Goals (MDGs), and the number of, and remuneration for, public sector health workers.

The IMF's influence on health policy, in regards to developing countries in Africa, has been well linked to Structural Adjustment Programs (SAPs). SAPs are a combination of structural reforms that require that governments in developing countries implement a number of fiscal and monetary policies as conditions for receiving loans or bilateral aid. Kenya's involvement with the Fund dates back to the early 1980s when the government faced a serious financial crisis created by terms of trade shocks and lack of fiscal discipline. This made it impossible for the government to finance many of its development policies. To meet its financial obligations, the government sought financial assistance from the IMF. The disbursement of the funds was tied, however, to the government's adoption of aid conditionalities embodied in the SAPs. Through the aid conditionalities by the IMF, the World Bank also required the government to implement reforms focusing on reducing budget deficits, reducing domestic borrowing by the government, increasing foreign reserves, and reducing inflation to a single digit (World Bank, 1994).

It has been argued that the macroeconomic policies endorsed by the IMF limit the ability of developing countries to implement planned programs because a large proportion of their budget is drained by debt repayments. Many more countries operate under macroeconomic policies that set rigid spending ceilings for the social sectors and cannot accommodate minor inflation. While the IMF counters these claims by arguing that the formulation and implementation of macroeconomic policies are the responsibility of the government, health policy makers point out that budget ceilings set jointly by the IMF and the government is a key limiting factor for adequately investing in health. They further argue that macroeconomic targets and conditions are set in a non-transparent and undemocratic manner and that the process sidelines Ministry of Health staff while decisions are made without an informed discussion of alternative scenarios and their trade-offs.

Thus the restrictive nature of the fiscal and monetary policies and the stringent conditionalities that come with them negatively impact the capacity of governments in developing countries to invest adequately in health. In Kenya, for example, the IMF blocked the implementation of a

social health insurance scheme intended to mobilize resources for health sector development (CGD 2007). Furthermore, restrictions on the hiring of health workers have created a situation where thousands of trained nurses and other health workers remain unemployed, despite a health worker shortage across all health programs. In a 2006 meeting with REF and US Congressional staff, the Minister of Health of Kenya at the time cited IMF-led wage bill restrictions as a major impediment to the hiring of nurses.

This study therefore provides evidence of the impact of IMF policies on the government of Kenya's ability to scale up investment in health and thereby impact the HIV/AIDS and TB crises.

3.1 Study Objectives

This study set out to:

- Review the content, process and transparency of the IMF PRGF policies,
- Identify the key stakeholders in the process of accepting policies and conditionalities, their influence and power,
- Identify trends in the total public (domestic) health expenditure,
- Identify trends in the public (domestic) expenditure for TB and HIV/AIDS,
- Identify trends in the public (domestic) expenditure for personnel for health, TB and HIV/AIDS,
- Identify trends the number of health professionals working in the health sector, in TB and HIV/AIDS,
- Consider trends in accessing TB and HIV/AIDS treatment services, and
- Identify other effects of IMF policies on country ability to respond to TB and HIV/AIDS

1.1 Research Methodology

1.3.1 Scope of the Study

The study focuses on IMF policies under the Enhanced Structural Adjustment Facility (ESAF) and the Poverty Reduction and Growth Facility (PRGF) in Kenya. It provides a general description of how policies relevant to health, HIV/AIDS and TB are formulated, the content and context in which they were formulated, a description of the different stakeholders involved in the policy process and the extent of their influence in the policy formulation process. The study focuses only on public health, HIV/AIDS and TB allocations as indicated in budget documents and other relevant documents; expenditure trends of public personnel for health, TB and HIV/AIDS as indicated in budget documents or other relevant documents; and trends in the number of personnel working in the health sector.

1.3.2 Population and sampling

A non-probability sampling method was used to select organizations to provide information on the different aspects of IMF policies in Kenya. The choice of the organizations was based on the knowledge of the IMF policies and/or the role in designing and implementing the policies. The organizations from which interviews and discussions were conducted are presented in Table 1.1.

Table 1.1: Sampled organizations

Name of organization	**Sector**
Ministry of Finance	Public (Government)
Ministry of Health	Public (Government)
Ministry of Planning	Public (Government)
Institute of Economic Affairs	NGO
ActionAID, Kenya	NGO
Consumer Information Network	NGO
The World Bank	Multilateral

1.3.3 Desk Review

The review was accomplished by reviewing relevant policy documents including strategic plans, planning guidelines and national budget documents, international agreements and reports, other relevant policies and relevant studies. The sources of these documents included the Ministry of Finance, which provided budget outlook papers (BOPAs), budget strategy papers (BSPs), poverty reduction strategy papers (PRSPs), quarterly budget reviews (QBRs); the Ministry of Health, which provided its public expenditure review (PER); and the IMF's website, which was the source of letters of intent, PRSPs, and press releases among other resources. Two studies, one by ALMACO and AMREF (2005) and another by ActionAid (Sihanya, 2008) provided valuable information. Furthermore, data on expenditure on HIV/AIDS interventions were drawn from a strategy paper prepared by National AIDS Control Council (Republic of Kenya, 2005) and a report by Institute for Democracy in South Africa (Kioko *et al*, 2006)

1.3.4 Development of Instrument and Data Collection Process

Data gathering involved use of a variety of methods, mainly official record reviews, documentary analysis, and personal interviews. The first two methods were used to compile expenditure data on health and HIV/AIDS. A key informant interview guide[1] was developed by CEGAA for collecting primary data. The instrument included questions on the policies by IMF, the actors in the development of the policies, the budgeting process, including setting of

[1] See appendix

budget and wage ceilings, and perceived impact of the policies on the health sector, with specific reference to health, HIV/AIDS and TB.

1.3.5 Interviews

The interviews were aimed at obtaining information on the content of IMF policies, the role of various stakeholders in policy formulation and in the decision-making process on budget ceilings. The questionnaires/interview guides were sent to the selected interviewees in advance. After this, the consultants visited the interviewees and held discussions with the key informant in the selected organizations.

1.3.6 Data Analysis

The qualitative data generated from the interview guide were summarized according to the focal areas of the study: the roles of various actors, e.g. IMF, World Bank, WHO, civil society and development partners in the policy formulation process, wage ceilings, the impact of IMF policies on government spending on health, HIV/AIDS and TB.

1.2 Study Limitations

The main limitation of the study is the non-response from some key informants for varying reasons, such as being out of the country or office, delayed responses, and deferring to senior staff. Another limitation relates to the lack of information about IMF policies and processes, especially from many CSO informants and the health personnel working in the TB and HIV/AIDS programs. The data on health personnel are also not reported by specific programmatic areas.

CHAPTER TWO: THE SOCIO-ECONOMIC ENVIRONMENT

2.1 Key Economic Performance Indicators

2.1.1 Real GDP growth rate

A January 2009 review by Fitch Ratings gave Kenya a stable long-term outlook. The impact of the post-election violence has been compounded by a global economic recession, which will slow Kenya's recovery by reducing non-regional exports, tourism, remittances and capital flows for much needed investment. After a contraction by 1% year-on-year in the first quarter of 2008, growth recovered to 3.4% in the second quarter before easing to 2.1% in the third quarter. Fitch estimates that Kenya's growth slowed to around just 2% for 2008 as a whole, down from 7% in 2007. Fitch Ratings, nonetheless, believes that Kenyan growth will improve in 2009, supported by strong regional and domestic demand and a recovery of agriculture to around 4 to 5% (Fitch, 2009).

Historically, Kenya's economy recorded good performance in terms of economic growth in the 1960s and early 1970s, averaging 6.6% annual growth in GDP during 1964-73. The rapid economic growth was attributed to implementation of public investment, encouragement of smallholder agricultural production, and incentives for private, often foreign, industrial investment. However, the impressive GDP growth was short-lived. The growth rate recorded a downward trend from 1974 to 1995 due to inappropriate agricultural policies, inadequate credit to agriculture, poor international terms of trade, import substitution policy, rising oil prices, lack of export incentives, tight import controls, and foreign exchange controls. Thereafter, the economy entered a period of slow or stagnant growth. However, in 2000 GDP growth was negative. Under the guidance of the Economic Recovery Strategy for Wealth and Employment Creation, the Kenyan economy recovered and resumed the path to rapid growth (Republic of Kenya, 2007). The economy registered a growth rate of 2.8% in 2003, 4.3% in 2004, 5.0% in 2005 and 6.7% in 2006. The 2008 economic survey indicates that the estimated growth rate in 2007 was 7%.

Table 2.1: Selected key economic indicators-Kenya

Indicator	2001	2002	2003	2004	2005
GDP growth rates	4.5	0.6	3	4.9	5.8
GDP at market prices (Kshs billion)	1,020	1,022.20	1,136.30	1,282.50	1,415.20
Wage employment ('000)	1,677.10	1,699.70	1,727.30	1,763.70	1,807.70
GDP per capita (current) Kshs)	33,767	32,434	35,327	39,091	42,313
GDP per capita (constant) Kshs, 2001=100)	33,767	32,549	32,845	33,764	35,045
GDP per capita (constant) US$, 2001=100)	450	433	437	450	467
GNP (Kshs Billion)	1,010.50	1,010.90	1,129.60	1,272.50	1,406.90
Inflation rate (% change in CPI)	5.80	2.00	9.80	11.30	10.30

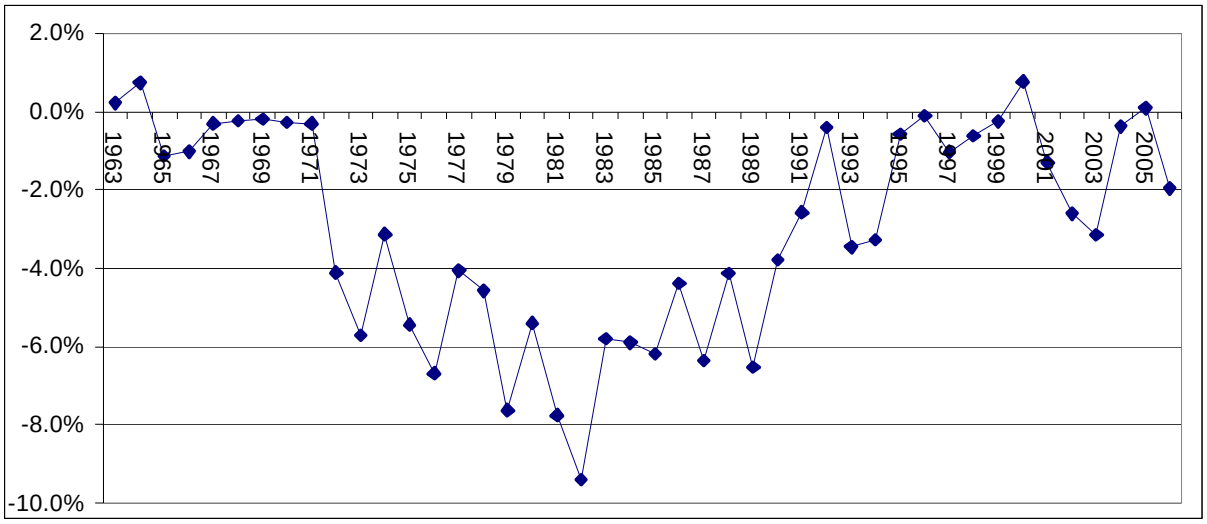
Source: Economic Surveys, 2006 & 2007

2.1.2 Budget Deficits as a percentage of GDP

According to the January 2008 report by Fitch Ratings, public finances in Kenya have proven resilient to the country's political crisis. The fiscal deficit in FY08 (July 2007-June 2008) came in at 3.5% of GDP, below the projected 5.3% of GDP, reflecting strong revenue growth in the lead-up to the crisis, while reduced capital spending offset increased spending on security. The public debt ratio continued to decline to 43% of GDP from as high as 63% in FY04, although this is higher than the 29% of GDP median for the 'B' category, where many countries, unlike Kenya, have been beneficiaries of debt relief. Deficits are projected to widen due to increased infrastructure investment, which is positive for longer-term creditworthiness but means that debt ratios will decline more gradually going forward. In FY09 the planned Eurobond issue is unlikely to go ahead due to tight global credit markets. This will delay some planned infrastructure spending, and lower the deficit to around 4% of GDP compared with a budgeted 5.5% (Fitch, 2009).

Historically, the government of Kenya has run budget deficits since independence (see Figure 2.1). Budget deficits result from expenditures falling short of government revenues. This shortfall is attributed to limited budgetary resources brought about by low economic performance, among other causes. A significant proportion of budgetary resources are internally generated through a myriad of taxes, with a huge proportion of financing devoted to recurrent expenditures. Development or capital expenditures have over the years been funded mainly by donors. The budget deficit is one of the variables influenced by IMF program policies.

Figure 2.1: Budget deficit as a percentage of GDP 1963-2006



Source: International Financial Statistics, and Economic surveys.

The instability in the budget deficit shown in Figure 2.1 can be attributed to several factors, including internal and external shocks, which sometimes require government intervention through fiscal policy. Budget deficits have contributed to the weak economic performance, by accumulating the high public debt and the associated high interest rates (Republic of Kenya, 2003b).

2.1.3 Public Debt

Table 2.2 shows that the stock of public debt has been increasing over the years in absolute terms. The total stock of public debt increased from Kshs 466 billion in June 1996 to Kshs 801 billion in June 2007. As a percentage of GDP it increased from about 68% in June 1996 to about 79% in June 1999. Republic of Kenya (2007) indicates that the external debt fell from US$ 6,025 million in 1996 to US$ 5,701 million in 2005. Table 2.2 also shows the percentage of domestic debt in the total public debt has been generally increasing over the years. For instance, it increased from 26% in June 1996 to 51% in June 2007. As a percentage of GDP, total debt declined from 68% in 1996 to 44% in 2007. The accumulation of debts was one of the causes of economic crises that necessitated the involvement of the IMF.

Table 2.2: Trend in stock of public debt (Kshs billion)

	Jun-96	Jun-97	Jun-98	Jun-99	Jun-00	07-Jun
EXTERNAL DEBT	346	308	323	408	396	397
Bilateral	128	114	108	148	139	138
Multilateral	188	164	179	220	231	240
Commercial Banks	29	26.3	34.9	35.8	24.9	0.3
Export Credit	1.4	3.5	0.9	3.9	1.5	18
(As a % of GDP)	50%	42%	40%	55%	51%	22%
(As a % of total debt)	74%	66%	65%	70%	66%	49%
DOMESTIC DEBT	120	159	172	174	206	405
(As a % of GDP)	18%	22%	21%	24%	27%	22%
(As a % of total debt)	26%	34%	35%	30%	34%	51%
TOTAL DEBT	466	467	495	582	602	801
(As a % of GDP)	68%	64%	61%	79%	77%	44%

Source: Annual Debt Management Reports for financial years 2005/06 and 2006/07.

Table 2.2: continued

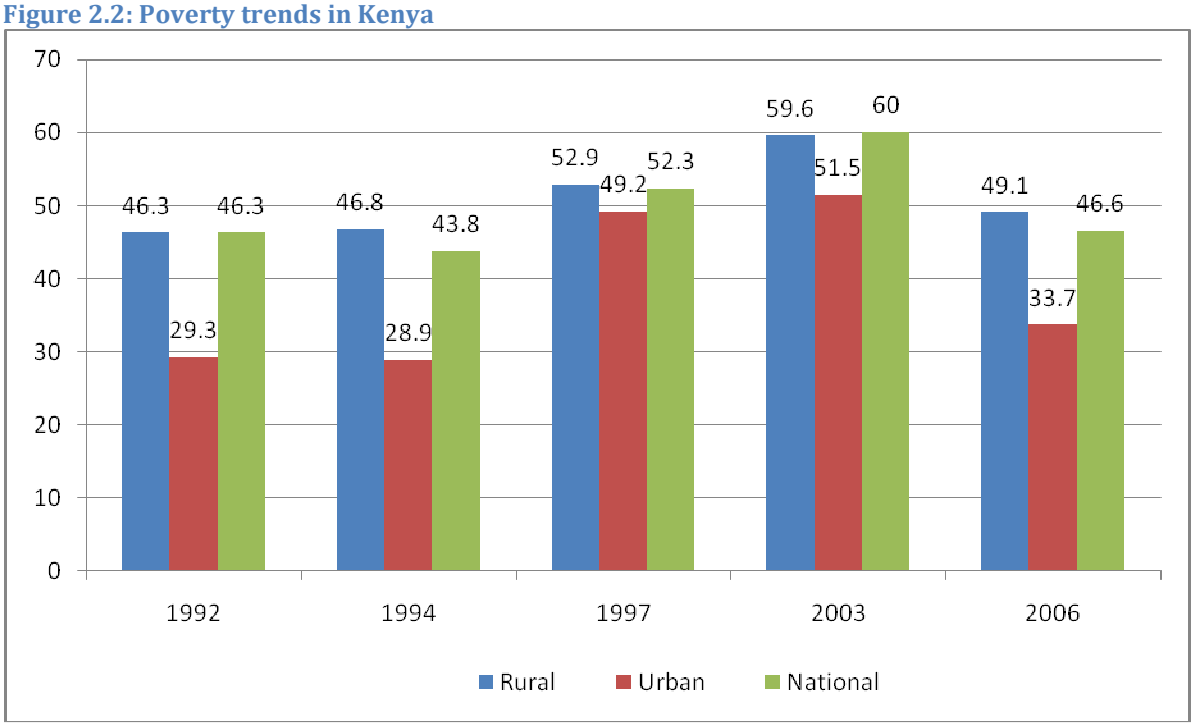
01-Jun	02-Jun	03-Jun	04-Jun	05-Jun	06-Jun
394	378	407	443	434	431
132	130	143	163	158	155
228	222	234	261	256	256
29.4	24	3.6	2.9	1.8	1.3
3.8	1.3	27	16.7	19.2	19.5
41%	37%	39%	37%	32%	28%
65%	62%	58%	59%	58%	55%
212	236	289	306	316	358
22%	23%	28%	25%	23%	23%
35%	38%	42%	41%	42%	45%
606	614	696	749	750	789
63%	60%	67%	62%	56%	51%

Source: Annual Debt Management Reports for financial years 2005/06 and 2006/07.

2.2 Poverty in Kenya

Poverty increased sharply during the early 1990s, declined during the mid-1990s, and rose steadily from 1997. By 2003, there were over 17 million Kenyans or 56% living below the poverty line, an additional 2.7 million people since 2001. National poverty incidence was estimated at 46.6% in 2005/06, implying that the number of poor individuals was 16.6 million. Regionally, there are pockets of very high poverty that exceed the national average. For instance, rural absolute poverty situation was about 47% in 1994, and had risen to 59.6% by 2003. Figure 2.4 below shows the trends in poverty in Kenya.

Figure 2.2: Poverty trends in Kenya



Source: adapted from Kioko *et al.*, 2007.

2.3 Kenyan Health Sector

2.3.1 Overview of the public health sector

After independence in 1963, the Government of Kenya pledged to fight diseases, ignorance and poverty in the country. The commitment to combat diseases led the country to design policies aimed at promoting coverage of and access to modern health care services. This commitment stemmed from recognition by the Government that good health is a prerequisite to socioeconomic development. The policies that the Government has pursued over the years have had a direct impact in improving the health status of Kenyans. The crude death rate dropped from 20 per 1000 at independence to 12 per 1000 in 1993 and the crude birth rate from 50 per 1000 to 46 per 1000 over the same periods. The total fertility rate recorded an increasing trend reaching 8.1 in the 1980s. However, between 1977 and 1992, the rate declined to 5.4 and is currently estimated at 4.6. Infant mortality fell from 98 deaths per 1000 live births during the mid-1970s to 63 deaths per 1000 live births between 1988 and 1993. Child mortality was 93.2 deaths per 1000 live births in 1988-1993. These gains have been reversed, however, due largely to the HIV/AIDS epidemic. For instance, infant mortality is currently estimated at 74, child mortality at 112 and life expectancy at 48 years (Republic of Kenya, 1994; Owino, 1997; Kazibwe et al., 1998; World Bank, 2000, 2002; Republic of Kenya, 2006d).

Despite the massive expansion of health infrastructure in the public health sector, the inability of the Government to effectively provide health services became acute in the 1980s due to steadily increasing demand for health services as a result of population growth, the AIDS

epidemic, increasing episodes of malaria, yellow fever, and cholera, and traffic accidents among others (Republic of Kenya, 1994; Collins *et al.*, 1996). Poor economic performance in the 1980s exacerbated the problem of financing of health services in the public sector. As a result, the MoH's budget, although increasing in absolute terms over the years, declined as a proportion of total Government spending. For instance, Collins *et al*., (1996) indicate that the MoH's recurrent budget as a proportion of total Government budget declined from 9.3% to 8.5% between 1979/80 and 1991/92, with a low of 7.4% reached in 1988/89. This trend has not changed significantly over the last five years, although the absolute allocation to MoH has increased considerably.

The poor economic performance and unsustainable levels of public debt in the 1980s forced Kenya to undertake IMF- and World Bank-led structural adjustment programs. Since the adjustment programs called for reduction in government expenditure, especially in social sectors including health, their implementation exacerbated the resource constraint that was already being experienced in the public health sector. The structural programs also called for health financing reform, resulting in the introduction of cost sharing (i.e., user fees) in the public health sector in 1989 (Collins *et al.*, 1996).

The problems which faced the public health sector led to recognition, by the Government, of the need to undertake a bold programme of health sector reforms. This culminated in the launching of Kenya's Health Policy Framework (KHPF) in 1994. The KHPF is currently the blue print for the development and management of the health sector. The overall goal of the health sector reforms is the provision of affordable and accessible health services to all Kenyans (Republic of Kenya, 1994).

The Kenya National Health Sector Strategic Plan I (NHSSP 1999-2004) and the current Kenya Health Sector Strategic Plan II (2005-2010) was and is, respectively, anchored on KHPF. The NHSSPI proposed a variety of actions to continue and strengthen the reform process, including governance related issues; improved resource allocation; decentralization of district health planning and implementation; shift of resources from curative to preventive and promotive health care services; autonomy for the provincial and national hospitals; enhanced collaboration with stakeholders under a Sector Wide Approach (SWAp) modality; and the reconstitution of the Health Sector Reform Secretariat (HSRS) to spearhead and coordinate the reform agenda. An evaluation of the NHSSP I concluded that the plan did not manage to make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators of health and socioeconomic development which were expected. This was attributed to a set of factors, among them inadequate funding (Republic of Kenya, 2006d). The NHSSP II is an integral part of the Economic Recovery Strategy for Wealth and Employment Creation.

2.3.2 HIV/AIDS in Kenya

Kenya's HIV prevalence has been declining over the last decade with the most recent modeling of sentinel surveillance data indicating a prevalence of 5.1% among adults at the end of 2006 compared with 10% in 1997/98. The 2007 Kenya AIDS Indicator Survey (Republic of Kenya, 2008b) has shown that the national prevalence has started to level off with 7.8% of the adult population 15-49 living with the virus. In 2003, KDHS estimated a prevalence of 6.7% among the same age group. Three out of 5 HIV-infected Kenyans are female (Republic of Kenya, 2008b). While HIV is occurring in all age groups, there are some differences in prevalence across the life span. Among youth age 15-24, women are 4 times more likely to be infected than men (6.1% compared to 1.5 %). A higher proportion of Kenyans ages 30-34 are currently infected with HIV than in any other age category. The decline in prevalence among women after age 34, and among men after age 44 could represent a decline in new infections in older age groups or an increase in HIV-related deaths in these age groups. The burden of infections is statistically higher among females than males until age 35, after which the ratio of male to female infections starts to approach 1 to 1.

The Government of Kenya declared HIV/AIDS a national disaster in 1999 and established the National AIDS Control Council. The NACC facilitated the development of the Kenya National HIV/AIDS Strategic Plan 2000-2005 and the current Kenya National HIV/AIDS Strategic Plan 2005/06-2009/10, which set out a multi-sectoral response to the epidemic, jointly agreed by stakeholders within Government, civil society, the private sector and development partners.

The combined effort by the Government and development partners, over the last decade, has resulted in substantial progress in prevention and advocacy; treatment, continuum of care and support; institutional arrangements, management and coordination; monitoring and evaluation and research; and mitigation of the disease's socio-economic impact. For instance, the ART program has registered impressive scale-up in the last two years. KIAS indicates that currently 213,000 patients are on treatment with a monthly increase of 5,000 new patients. This notwithstanding, KNASP outlines that the implementation of the multi-sectoral response in the period 2000-2005 was hampered by, among many other factors, vulnerable groups not having access to condoms, especially in rural areas, inadequate youth-friendly support services, inadequate appropriate drugs for opportunistic infections, ARVs not available and accessible, lack of food and nutritional supplements for people living with HIV/AIDS, lack of test kits for HIV/AIDS in health facilities; inadequate financial resources, infrastructure and institutional capacity of implementing agencies, poor geographical coverage of interventions due to vastness of some regions, mitigation of socio-economic impact limited by high poverty levels and unemployment, and shortage of trained personnel.

A 2006 survey on socioeconomic impact of HIV/AIDS in Kenya revealed that the impact of HIV/AIDS was more severe among low income groups; the incidence of morbidity was higher in female-headed households than male-headed households; and children from affected households were more likely to drop out of school (36%) due to education related costs than children from un-affected households (25%). Younger children, however, were more likely to drop out of school due to HIV/AIDS related morbidity and mortality than older children. A very

common coping strategy, necessitated by reduced family incomes was withdrawal of children from school for child labour either in their households or to work for wealthier relatives. Other effects on the households were increased spending on medical care than unaffected households; evidence suggested that household members with sick individuals spent less time on agricultural activities than the non-affected members. This has led to the neglect of farm areas and consequently a decrease in overall planted area (Republic of Kenya, 2006a).

CHAPTER THREE: STUDY FINDINGS

3.1 Overview of IMF policies in Kenya

3.1.1 Introduction

The country's engagement with IMF dates back to1970s. The engagement has entailed lending by the IMF to the country, based on the agreement that the country would implement structural adjustments. Structural adjustment program (SAP) is a term used to describe the policy changes implemented by developing countries under the support of the International Monetary Fund and the World Bank. Structural adjustment programs (SAPs) emphasize neo-liberal values which advocate for limited internal regulations to facilitate foreign investment, emphasize export production as opposed to production for local consumption, abolish agricultural subsidies in order to reduce government spending and finally call for reduced spending on social sectors including health and education. SAPs require that a number of fiscal and monetary policies be undertaken by the borrowing country before it is eligible for IMF loans or bilateral aid. SAPs are also intended to help countries to make debt repayments on the older debts owed to commercial banks, governments and the World Bank. From the late 1980s, the World Bank began to attach conditions to structural adjustment or policy-based loans. Generally, IMF policies centre on low one-digit inflation rates, high currency reserve levels, reduction in government expenditure on the social sectors, reduction in government budget deficits, ceilings on the overall national resource envelope and privatization of parastatals.

A serious financial crisis that the country faced in 1980s made it difficult for the government to finance most of its development policies. In pursuance of this financing, the Kenya government initiated a number of structural reforms aligned with the IMF's policy conditionalities: reduction in government spending, privatization of parastatals, financial sector reforms and civil service reforms. The structural adjustment programs that have been implemented by the Government of Kenya with the support of the IMF have been under the lending frameworks, consisting of the Trust Fund, enhanced structural adjustment facility (ESAF), and poverty reduction and growth facility (PRGF). The policies which have been implemented under these frameworks are discussed in the sub-sections below.

3.1.2 The Trust Fund

The first structural adjustment loan borrowed by Kenya Government from the IMF, under the Trust Fund, was in 1975. This was triggered by the financial imbalances created mainly the terms of trade shocks. Worsening economic conditions forced the government to return to the IMF in 1982 for the second structural adjustment loan under the fund. Although the economy stabilized between 1982 and 1984, little or no progress was made toward structural adjustment. While there were design and timing problems, the lack of compliance was

ultimately due to insufficient commitment. The unsatisfactory implementation led to a pause in adjustment lending and nearly four years passed before another attempt (Swamy, 1994).

3.1.3 Enhanced Structural Adjustment Facility (ESAF[2])

The government adopted SAPs in the context of a wide range of reforms through the publication of Sessional Paper No. 1 of 1986 on Economic Management for Renewed Growth under the support of the IMF and the World Bank (Swamy, 1994). The period 1992 to 1996 represented a time when the government showed a serious commitment to the implementation of SAPs. The According to Policy Framework Paper of 1996 (Republic of Kenya, 1996), the government of Kenya began implementing an ambitious program of macroeconomic and structural reform since 1993. The key features of this program included a reduction in the fiscal deficit and enhanced monetary discipline; liberalization of external and internal markets; initiation of parastatal reform based upon restructuring of strategic parastatals and divestiture of non-strategic enterprises; and improved government management through reduction of the size of the civil service and reorganizing key ministries. Most of the fiscal policy measures have centered on reduction of budget deficits through reduced domestic borrowing, maintaining low inflation and increasing foreign reserves.

Kenya experienced a major economic transformation during the period 1993-95. Direct controls on domestic prices, internal marketing, external trade, and the exchange system were eliminated, and the exchange rate and interest rates were left to be determined by market forces. The government budget deficit (excluding grants) was reduced from 11.4 percent of GDP in 1992/93 to 2.5 percent in 1994/95; money supply growth was brought under control and confidence in the banking system was restored. However, economic reforms slowed in 1995, and some setbacks occurred. The budgetary targets for the first half of 1995/96 were not met, mainly because of large off-budget outlays, and the restructuring of key parastatals was delayed (IMF, 2008b).

The Government of Kenya and the IMF prepared the Policy Framework Paper in 1996 for the IMF reforms that were planned for implementation in the period 1996-98 (Republic of Kenya, 1996). The economic program for 1996-98, supported by the ESAF loans, was focused on the following key areas: (a) consolidation of the fiscal adjustment; (b) privatization and restructuring of the parastatal sector; (c) avoidance of the recurrence of misuse of public funds; and (d) further development of outward-looking competitive markets. The basic medium-term macroeconomic goal was to raise the economic growth rate to about 6 percent by 1998; to maintain inflation at 5 percent throughout the period; and to lower the external current account deficit, excluding official transfers, to about 0.8 percent of GDP.

[2] ESAF was established in 1987 has a facility through which the IMF provided low-interest loans to poor countries to undertake structural adjustment programs

To achieve these objectives, the Policy Framework Paper outlined how the authorities would reduce the overall fiscal deficit (on a commitment basis and excluding grants) from 2.5 percent of GDP in 1994/95 to 1.9 percent in 1995/96, and further to 1.6 percent in 1996/97. In addition, total revenue was planned to be reduced in relation to GDP, while the tax base was to be broadened. Price stability was the overriding objective of the planned monetary policy. The main policy objectives in 1996 were: (a) further progress in privatization and restructuring of a number of key enterprises; (b) divesture of roughly one-half of the remaining non-strategic enterprises; (c) restructuring of the civil service; and (d) further strengthening of the financial system, inter alia, by making the Central Bank of Kenya more independent and by converting the National Social Security Fund into an autonomous pension fund (ibid.).

The Government of Kenya planned, in the period 1996-98, to target poverty measures and to increase access to social services by the poor. The quality and availability of health services was expected to improve as a result of the reallocation of budgetary resources from hospital care to preventive and primary health care. It was also proposed that public resources would be reallocated from university education toward primary and secondary education, particularly for underprivileged students. However, it is noteworthy that for health services, it was only reallocation but not additional budgetary allocation that was considered in the effort to fight poverty. With this framework in place, the IMF approved a three-year loan for Kenya under the enhanced structural adjustment facility (ESAF) equivalent to SDR 149.55 million (about $216 million), to support the Government's economic reform program for 1996-98.

3.1.4 Poverty Reduction and Growth Facility (PRGF)

The ESAF was renamed the PRGF in 1999. The Government of Kenya subscribed to the PRGF in 2000, and embarked on the preparation of the PRSP at the same time. According to ERS (Republic of Kenya, 2004) the preparation was undertaken through wide-ranging consultations and dialogue in order to build consensus on priority actions and activities necessary for economic growth and poverty reduction. While wide consultations took place, the effectiveness of players other than government in shaping the strategy has not been assessed. Since the process was being undertaken for the first time, the consultation may have only a “buy in” of the strategy already prepared by the government and the IMF.

The PRSP was preceded by the Interim Poverty Reduction Strategy Paper (IPRSP) released in 2001. A new government was elected in December 2002. The government prepared ERS in 2003 to provide the framework for economic recovery for the period 2003-2007. The ERS became the new PRSP. The PRSP 2004 indicates that the ERS took into account existing government policy documents, particularly the PRSP and NARC’s Manifesto and Post-Election Action Plan. The development of ERS was also a result of wide-ranging consultations with stakeholders. The stakeholders included parliamentarians, trade unions, professionals, financial institutions, industrialists, ASALs, development partners, civil society, and government (Republic of Kenya, 2004).

With the PRSP in place, the Executive Board of the IMF approved a three-year PRGF arrangement in an amount equivalent to SDR[3] 175 million (about US$252.75 million) in November 2003. As contained in IMF (2008), the Kenya government's economic strategies under this PRGF loan included fiscal consolidation in order to reduce the domestic debt to a sustainable level, and the restructuring of spending in favor of priority poverty reduction outlays and investment. The measures proposed included strengthening revenue performance through a speedy rebuilding of the integrity and capacity of the Kenya Revenue Authority and rationalization of the tax system; reducing the wage bill as a share of total expenditure by reforming the wage setting mechanism for public servants and continuing civil service reforms; and restructuring the parastatal and financial sectors to increase efficiency and reduce the government's contingent liabilities.

The Executive Board of the International Monetary Fund (IMF) completed the second review of Kenya's economic performance under a three-year Poverty Reduction and Growth Facility (PRGF) arrangement in April 2007. The completion of the review enabled the release of an amount equivalent to SDR 37.5 million (about US$56.8 million), bringing total disbursements under the arrangement to SDR 112.5 million (about US$170.4 million).

The PRGF loans were approved conditional upon reforms agreed upon by the government and the IMF, as contained in the letter of intent and the PRSP 2004. Kenya's fiscal strategy was reformed to include three objectives: fiscal sustainability, in which the fiscal policy's aim was to maintain a level of expenditures that could be funded without either an increase in the present value (NPV) of overall debt to GDP or an increase of external debt growth; expenditure restructuring for growth and poverty reduction that proposed increasing the shares of development expenditures, especially those targeting Government investments, core social expenditures (education and health) and core poverty expenditures; and improving public sector service delivery by enhancing both the efficiency and effectiveness of public expenditure through a process of internalizing the Public Expenditure Review (PER) and carrying out Public Expenditure Management (PEM) reform (Republic of Kenya, 2004). The fiscal strategy forms the basis for defining a realistic medium-term Government finance framework covering revenues, expenditures and financing, which would allow for an aggregate expenditure ceiling consistent with the stated objectives.

The fiscal strategy was anchored on a revenue policy framework that sought to maintain revenues at above 21 percent of GDP to enable the bulk of government expenditures to be met from domestic resources excluding borrowing; an expenditure strategy that was proposed to gradually reduce the level of recurrent expenditure to GDP to allow for a rapid increase in development expenditures within a sustainable macro economic framework. Public Expenditure management reforms and the ministries public expenditure reviews (MPERS) were considered as means of redirecting expenditures to national priorities and away from low

[3] Special Drawing Rights, an international reserve currency issued by the IMF.

priority areas and of reducing the budget deficit from 4 percent of GDP in 2003/04 to below 3 percent. PRSP 2004 also specified the measures to achieve the fiscal strategy: reducing the wage bill from 8.7 percent of GDP in 2003/04 to 8.5 percent by 2005/06, with any awards being matched by a proportionate downsizing of the civil service; raising of health expenditures at a growth rate least 7.5 percent faster than overall expenditures; and attaining at least 12 percent of total expenditures by 2010, among others. The fiscal strategy assumed that these health expenditures would be focused on non-wage, non-transfer expenditures to enable the rapid increase in basic health services.

In terms of monetary policy, the Kenya Government proposed to continue focusing on maintaining stability in the general price level and fostering the functioning of a stable market-based financial system. The Central Bank of Kenya would continue with its policy of keeping overall inflation below 5 percent annually, while targeting underlying inflation of 3.5 percent. In addition, the Kenya Government would continue the policy of a flexible market-determined exchange rate regime, with exchange rate interventions limited to smoothing short-term volatility (Republic of Kenya, 2004). The policies pursued under the current PRGF program are similar, including a fiscal deficit target of 3% of GDP and an inflation rate target of 5 percent.

3.1.5 Recent Developments with the PRGF in Kenya

Current Fiscal Policy

According to the IMF documents from October and July 2008, the Government's 2008/09 budget is targeting a budget deficit of 5.3 percent of GDP, which includes an increase in public investment. Although the IMF staff supported the emphasis on public investment, the IMF prefers targeting a lower fiscal deficit of 4.5 percent of GDP.

Table 3.1 Fiscal deficits in Kenya

	2007/08 **IMF Estimate**	**2008/09** **Govt. Budget Projection**	**IMF**	**2009/10** **IMF Projection**	**2010/11** **IMF Projection**
Fiscal Deficit As a % of GDP	**4.8**	**5.3**	**4.6**	**3.8**	**3.8**

Part of the Government's projected fiscal deficit of 5.3 percent of GDP is to be financed by the floating of an international bond for increased infrastructure investment. The IMF is proposing that the measures for domestic debt and external debt be combined for a total debt-to-GDP ratio to serve as the new medium-term fiscal anchor. The 2008 Budget Strategy Paper envisaged a gradual reduction of the public debt-to-GDP ratio to 35 percent over the medium-term—an objective that IMF staff supported. The authorities underscored that while overall

spending (relative to GDP) would decline over the medium-term, the composition would shift toward development spending, in particular to address urgent infrastructure needs.

In 2009, the IMF continues to revise downward its growth projections for developing countries as exports and commodity prices fall. Yet even as early as August 2008, a joint IMF/World Bank debt sustainability analysis warned:

> *Taking all public debt into account, however, the DSA shows greater risk of unfavorable debt developments, especially under a shock to GDP growth. Even temporarily lower GDP growth would set the [net present value] of public debt-to-GDP, the NPV of debt to-revenue, and the ratio of debt service-to-revenue on a sharply increasing trend. … Considering that the nominal value of public debt would be near, and in some years above the 40 percent of GDP that staff has recommended as an anchor for fiscal policy, unchanged policies would indeed imply some risk of debt distress. Potentially large but unreported contingent liabilities also pose additional risks to the sustainability of public debt* (International Development Association/IMF, 2009).

The dangerous buildup of potentially significant public liabilities refers to other plans to get financial support for infrastructure from the private sector, particularly under framework for public-private partnerships (PPPs). The Kenyan authorities have recognized that PPPs could play a useful role in infrastructure development, but are also reasonably concerned these could entail fiscal and implementation risks—particularly the buildup of potential public liabilities. In the context of many PPPs, while profits are being privatized, the risks are being socialized through this process of public guarantees deemed necessary to attract private partners.

In order to help achieve its main goals of keeping inflation under 5 percent per year and keeping deficit spending contained, the IMF uses two important monetary targets to constrain the amount of deficit financing that the government can engage in. The first target is a ceiling or limit in the amount of credit that will be available in the economy in the year, called Net Domestic Assets (NDA) or net domestic credit. This limited amount of available credit must be shared between the government sector and the rest of the economy, including private sector companies. The second target is a floor or basic required level of international hard currency reserves at the central bank or within the domestic banking system, called Net International Reserves (NIR).

Often the IMF will either lower the ceiling on available credit (NDA) or raise the floor requirement on reserves (NIR), or both, as a way limiting the available credit that the government can access for engaging in deficit spending. In Kenya's case, they will tighten both targets over the next few years. These two monetary targets restrict the government's ability to make the large, upfront increases in public spending and investment in the public health system needed to build the foundation for a more successful fight against HIV/AIDS and TB

over the long-term. This idea must be critically revisited and reconsidered among a broader group of public stakeholders.

Table 3.2 Net Domestic Assets (NDA) and Net International Reserves (NIR) in Kenya

	June 2005	June 2006	June 2007	June 2008	Sep 2008	Dec 2008	Mar 2009	June 2009
Net Domestic Assets (NDA)								
In Billions of Kenyan Shillings								
Domestic Credit	466.3	521.7	607.1	712.8	693.6	767.6	820.6	864.4
Avail for Govt	112.3	117.9	157.2	132.7	158.2	185.7	172.6	171.9
Avail for Rest of Economy	354	403.8	450	580.1	535.4	581.9	647.9	692.5
Ratio of Credit Available to Govt vs Total	0.24	0.23	0.26	0.19	0.23	0.24	0.21	0.20
Net International Reserves (NIR)								
BOK Net Foreign Assets in Millions of US $	1,212	2,159	2,357	2,896	3,067	3,078	3,089	3,192
NDA/NIR Ratio	0.09	0.05	0.07	0.05	0.05	0.06	0.06	0.05

The latest data from IMF documents project that over the next few years, the IMF will have Kenya lower the ceiling on available credit (NDA) while raising slightly the required floor for international currency reserves (NIR), thereby squeezing away possibilities for greater "fiscal space" which could enable a greater investment in health systems in order to address HIV/AIDS and TB. The data indicate that the levels for NIR are intended to increase still further to $4.1 billion in 2009/10; 4.6 billion in 2010/11; 5.1 billion in 2011/12; and $5.78 billion in 2012/13.

Current Monetary Policy:

Inflation below 5 percent per year continues to be the overall monetary policy goal. Recent measures to tighten monetary policy were in the right direction in the face of high money growth and inflationary pressures—and more steps are urgently needed to prevent second-round effects of higher food and fuel prices. Political instability took a toll on economic activity and exacerbated inflationary pressures in early 2008. First quarter GDP contracted by 1.3 percent (year-on-year), with tourist arrivals down by over 50 percent and most sectors hampered by disruptions to supply chains and displacement of productive resources. The resulting shortages compounded inflationary pressures arising from an earlier accommodative monetary policy as well as from rising international fuel and food prices. Inflation for the official headline consumer price index (CPI) was 26.5 percent in July (year-on-year).

Table 3.3 Monetary Policy Indicators in Kenya

	2005/06 Estimate	2006/07 Estimate	2007/08 Estimate	2008/09 Projection	2008/09 Projection	2008/09 Projection	2008/09 Projection	2008/09 Projection
Inflation Annual average %	**11.1**	**10.4**	**18.5**	**14.5**	**5.0**	**5.0**	**5.0**	**5.0**
Reserve Money Growth End of period %	**14.0**	**17.5**	**19.6**	**15.0**	**14.6**	**14.1**	**14.1**	**14.1**

The IMF supports the centering of monetary policy around a reduction in the growth of reserve money. According to the IMF (2008), "Monetary policy was tightened in June 2008 to address rising inflationary pressures. For much of 2007/08, reserve money growth had exceeded the authorities' target and private sector credit growth had also remained robust."
In early June, the Central Bank Rate (CBR) was raised by 0.25 percent to 9 percent in response to continued inflationary pressures. The authorities explained that the June increase in the CBR signaled their intention to let market rates rise. Staff stressed the need to employ decisively all available instruments, including appropriate term-deposit auctions and foreign exchange (FX) reserve sales, to slow reserve money growth to prevent "second round" effects of higher food and fuel prices; in this regard, the planned introduction of the CBK's own bills could provide a further useful instrument. However, reserve money growth (19 percent, year-on-years, in July) has remained above the level that the CBK and staff had considered consistent with the envisaged decline in inflation during 2008/09.

According to the Bank of Kenya's "Monthly Economic Review" on economic developments through August 2008, reserve money increased by 18.9 percent in the year to July 2008 compared with 17.6 percent growth in a similar period in 2007 as shown in Table 2.5. The increased expansion in reserve money was held as bank reserves and currency outside banks increased by 30.4 percent and 12.0 percent respectively, compared with 16.5 percent and 18.3 percent in 2007. The amount of reserve money in July 2008 was Ksh 152.6 billion or Ksh 5.7 billion above target. The excess was held in bank reserves (Ksh 3.7 billion) and currency outside banks (Ksh 2.0 billion).

According to the Review, although the economy grew by 7.0 percent in 2007 compared with 6.4 percent in 2006, overall 12-month inflation increased from 26.5 percent in July 2008 to 27.6 percent in August 2008 following higher prices of food items, as well as high imported fuel and electricity costs. Similarly, average annual inflation increased from 19.6 percent in July 2008 to 20.8 percent in August 2008. Money supply, M3, grew by 19.2 percent in the year to

July 2008 compared with 15.2 percent in the year to July 2007 and was above the projected growth of 17.3 percent for the quarter ending September 2008.

The Central Bank Rate (CBR) remained at 9 percent in August 2008. The average 91-day Treasury bill rate fell slightly from 8.03 percent in July 2008 to 8.02 percent in August 2008, while the 182-day Treasury bill rate also declined from 9.09 percent in July 2008 to 8.75 percent in August 2008. The average interbank rate declined from 8.06 percent in July 2008 to 6.92 percent in August 2008 as the liquidity situation in the market normalized. The repurchase agreement rate also fell from 7.41 percent in July 2008 to 6.35 percent in August 2008. Commercial banks' average lending rate fell from 13.91 percent in July 2008 to 13.66 percent in August 2008 while the overall deposit rate increased from 4.54 percent in July 2008 to 4.65 percent in August 2008. Consequently, the interest rate spread declined to 9.05 percent in August 2008.

Moving Towards an IT Regime:

The IMF discussions with Kenyan authorities also included alternatives to the money-based monetary framework, including moving to a formal Inflation Targeting (IT) regime over the medium term. While it is believed that monetary policy would benefit from a strong and credible focus on a low inflation target, it was agreed that more work was needed before initiating steps toward alternative frameworks, including possibly inflation targeting. In particular, this would require the resolution of IMF concerns about the methodology currently used for calculating Kenya's CPI, but also a better understanding of the monetary transmission mechanism and alternative institutional arrangements for monetary policy—areas where the CBK planned further analytical work.

An August 2008 IMF Ex-Post Assessment (EPA) overview report of Kenya's macroeconomic policies between the years 1993-2007 examined four successive IMF arrangements (IMF 2008d). According to the report, "Kenya's performance and relations with the IMF were viewed as disappointing until a recent pick-up of growth and improved implementation of structural reforms. Macroeconomic policy design was broadly appropriate and implementation was generally sound. Growth slowed in the 1990s, but picked up after the 2002 elections, reflecting buoyant global conditions, structural reforms, and a surge of private capital inflows. Monetary policies were complicated by a reluctance to allow for full interest and exchange rate flexibility. Fiscal policy advice and implementation were sound, although an earlier focus on domestic debt consolidation would have been desirable. Progress was made in structural reform, albeit often slower than programmed and with setbacks that raised doubts about ownership. Reforms have focused on governance, civil service employment, parastatal operations, revenue administration, public financial management (PFM), and financial sector supervision and development. Extensive Fund technical assistance (TA) was moderately effective." (IMF 2008d).

The IMF Executive Board "broadly concurred" with the findings and recommendations of the Ex-Post Assessment of Kenya's long-term program engagement with the Fund, and they "welcomed the consideration being given by the authorities to modalities for future engagement with the Fund, possibly in the context of a Policy Support Instrument."

3.1.6 Summary of the IMF Policies in Kenya

Table 3.4 Content of IMF Policies in Kenya

Name of policy and year of enactment	**Focus of Policy**	**Specific key conditions of the policy**	**Rationale for the enactment of policy**	**Negative consequences/outcomes**
Structural Adjustment Programs (SAPs): 1993 to date	Reduction in government expenditure in social sectors Reduction in government wage bill Reduce external and domestic debt Reduce government budget deficits Budget ceilings in the national resource envelope Privatisation of state owned enterprises Civil service reforms	Tight monetary and fiscal policies Wage containment Spend only when you have the money Tight management of the recurrent budget Direct fiscal conditionalities included i) deficit limits, ii) a cap on the share of public-sector wages in GDP, and Increase international currency reserves, Reform civil service, privatization of state enterprises	Control of huge fiscal deficits Bloated civil service Economy was too heavily driven by the public sector in social economic and administrative activities To ensure that government expenditure is in line with budget Reduce high levels of inflation	Retrenchment of civil servants Shortage of critical health personnel Poor health service delivery Reduction in real per capita health expenditure Limited budget allocation to govt ministries which has negatively affected policy implementation. Shortage of human resources i.e. inadequate number of personnel in key areas of the health sector an inequitable distribution of health personnel who are available High attrition of trained personnel from the health sector and from the country
Budget Ceilings	Financing of investment and direct support of economic growth and poverty reduction	Ministries to spend within the established ceilings Focus on medium		National ceilings constrains sectoral ceilings Inadequate resources to implement sector priorities

	Focus on ministerial strategic priorities from the ERS and interventions required to achieve the MDGs	term strategic objectives		
Poverty Reduction Growth Facility	Poverty reduction and growth			Interruption in the construction of infrastructure has often resulted in abandoning projects in process. Use of government resources for capital expenditures decreased from 11.9% of GDP in 2001 to 8.0% of GDP in 2006, and 4.3% of GDP in 2007.
Public Service Reform Programme (PSRP) – 1993	"Rightsizing," capacity building, decentralization, and development of appropriate performance management systems	Lay off public workers in order to make the civil service more efficient	Increasing efficiency and effectiveness of the public service. Central ministries (head quarters) to focus on policy formulation, resource mobilization and monitoring of sector performance	Massive loss of employment in the public service Restructuring of the MOH HQs in 2002. The partial restructuring established a new organization structure for MOH-HQ which was not accompanied with new performance management systems.
Wage Policies 1993 to present	Employment freeze Wage freeze Down sizing	Quantitative targets government wage bill to 5.2% of GDP in 2000 to 8% between 2003 and 2006 Implement a policy of restraining growth in wage payments to free resources for development purposes	Growth rate of the civil service surpassed the high annual average growth in population Unsustainable wage bill which stood at over 70% in the 1990s The Personnel Emoluments (PE) and Operational Maintenance (OM) ratio was accounting for 70% of recurrent expenditure, leaving only 30% for, equipment and facilities required for efficient delivery of	Loss of critical health personnel through voluntary early retirement programme supported by the IMF through SAPs Loss of skilled staff to other countries in search of better working conditions MoH prevented from hiring the required personnel commensurate with the human resources demand to scale up HIV and AIDS, TB interventions. Inadequate number of staff to provide health

			services Bloated Kenyan public sector	services

3.2 Process of Formulation of the IMF Policies in Kenya

The formulation process of the IMF policies can be analyzed in the context of ESAF and PRGF programs. According to respondents from the Ministry of Finance, the consultations usually involved the IMF giving "suggestions" to the Government on policies to be implemented. The suggestions are usually taken into account without much alteration, implying that the IMF plays a significant role in the policy formulation under the structural adjustment program. Under the ESAF loans, the process of formulation of the policies implemented by Kenya over the period 1992-2002 did not involve a broad consultation. They were drawn based on discussions between the government (mainly the treasury and the central bank) the IMF and the World Bank. According to IMF (2008a), the ESAF programme, unlike the PRSP process under the PRGF programme, involved limited consultation. It explains:

> "It was intended that the PRSP approach would bring about substantive changes in the way countries' economic plans were formulated. These changes would include policies that are more clearly focused on growth and poverty reduction, a full integration between the poverty reduction and macroeconomic elements of the program, and greater degrees of participation by civil society and national ownership, which in turn would lead to more consistent policy implementation."

As earlier indicated, there was improved and wider consultation in developing the PRSP under the PRGF program. In the development of the PRSP during the period 2001-2004, the consultations followed a three-tiered approach: national, provincial and district levels. The stakeholders in the consultations included the private sector, civil society, development partners, and local communities. A national steering committee that included all the stakeholders was formed to spearhead the process and ensure inclusion at all levels. Participatory Poverty Assessments (PPAs) were carried out in ten sampled districts. The District PRSP reports and PPA reports, together with inputs from the Sector Working Groups, were incorporated in the PRSP (Republic of Kenya, 2004). It can be argued that the broad consultation in drawing up the PRSP resulted in some health sector improvements. In the PRSP, the health sector was identified as one of the core areas targeted in the poverty reduction strategy. Government expenditure for the health sector was proposed to increase faster than the growth in total government spending.

The PRSP for 2001-2004 largely informed the development of ERS, which formed the basis for the Investment Programme for the period 2003-2007. The development of ERS was also a result

of wide-ranging consultations with stakeholders. The stakeholders included parliamentarians, trade unions, professionals, financial institutions, industrialists, development partners, civil society, and government. The Interim Investment Programme was discussed at a National Investment Conference in November 2003, which was organized jointly by the government and the private sector. The Investment Programme formed the basis of discussions at the Donor Consultative Group meeting held in November 2003. A prioritization workshop was also held in January 2004 where all the activities in the logical framework of the Programme were prioritized in line with the sector objectives. Comments by the development partners, other stakeholders and inputs from the National Investment Conference, the Donor Consultative Group meeting and the prioritization workshops were used to generate the final version of the Investment Programme (Republic of Kenya, 2004). The broader consultation did not change the key fiscal and monetary policies followed under the IMF loans; they remained the same as those the Government previously pursued. The macroeconomic framework, fiscal and monetary policy targets have remained largely the same in both the ESAF and the PRGF process.

3.3 Implementation of the IMF- Policies through Budgeting Process

3.3.1 Introduction

The process of formulation of IMF policies in section 3.1 mainly involves developing a macroeconomic framework, desired fiscal and monetary policies, and evaluation criteria and benchmarks. However, an analysis of IMF policies is not complete without considering the processes that result in the implementation of the policies. The budget is a critical tool that is used to translate the formulated fiscal and monetary policies in actions. The following subsections provide an overview of the major players involved in the budgeting procedure and the budget process itself.

3.3.2 Major Players Involved In the Budget Process

Since 2000, aspects of the budget process in Kenya have been undertaken in a consultative manner. The key players and actors include Government ministries, the Kenya Revenue Authority, the Central Bank of Kenya (CBK), the Parliament, interest groups, professional bodies such the Kenya Private Sector Association (KEPSA) and Institute of Certified Public Accountants of Kenya (ICPAK), and the citizens in general.

The Executive

In the budgeting process, the Executive's role is to propose fiscal policy in terms of revenue collection and expenditure. This is done in line with the broad national socio-political and economic objectives, as contained in government policy documents such as ERS and PRSPs. Once the budget has been approved by parliament, the executive arm of the government

implements it. The organizations under the executive involved in the process are the Kenya Revenue Authority, charged with collection of revenue; the CBK which is the government's banker and advisor on monetary matters; and the Ministry of Finance. The Treasury, in the Ministry of Finance, is identified by the Constitution as having delegated powers to propose measures to raise and allocate resources. Besides being the lead player in the budget process, Treasury is responsible for overseeing budget formulation, execution, collection and custody of revenues and expenditure management. The Ministry of Finance provides support to Treasury function and is responsible for implementing policies, programs and projects which support all ministries and other government agencies (Institute of Economic Affairs, 2008).

Parliament

The Parliament is the sole authority on taxation, borrowing, and spending of public funds. The constitution empowers the parliament to approve the measures proposed by the Minister for Finance to raise government revenue and also the expenditure of the revenue collections. Parliament is also expected to provide assurance to Kenyans that the systems employed by the executive to mobilize, allocate and utilize resources are effective and that the executive is not compromised either internally or externally. The parliament, therefore, occupies a central place in the budgeting process. Parliament also acts as the citizens' representatives, therefore ensuring the Executive operates according to the principle of "no taxation without representation" as well as the principle of separation of powers (ibid.).

To deal with the budget, Parliament has three key standing committees; the Fiscal Analysis and Appropriations Committee (FACC), the Public Accounts Committee (PAC) and the Public Investment Committee (PIC). The FACC was established in 2006 with the responsibility of scrutinizing policies that drive the budget, tax proposals, resource allocations and budget execution. Both PAC and PIC are long established institutions which deal with overall budget outcomes. That is, whether budgeted expenditures are utilized according to parliamentary authority and approval and whether they are compliant with the law and procedures. In addition, there are currently eight Departmental Committees of Parliament, which play complementary roles by scrutinizing the budgets of specific ministries and sectors that fall within their mandates. All these Committees are required to report to Parliament and make specific recommendations on their mandates (ibid.).

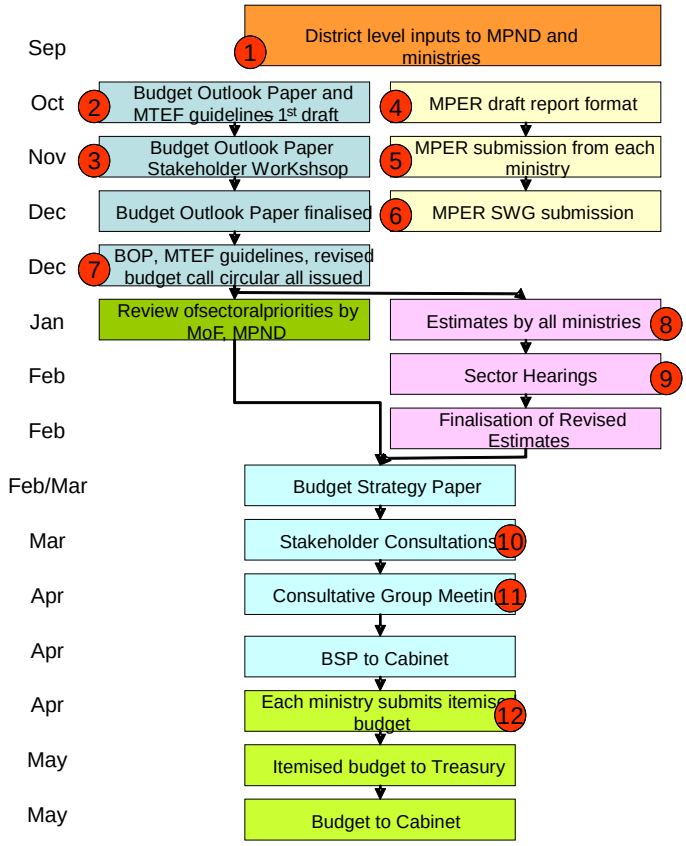
Non-state players

Among the key players in the budgeting process are the well-organized and informed major economic actors, including associations like the Kenya Associations of Manufacturers (KAM), Kenya Private Sector Alliance (KEPSA), Institute of Certified Public Accountants of Kenya (ICPAK), Farmers Association and a host of NGOs, among others. They make submissions to the Finance Minister on various fiscal issues, i.e., on expenditure and taxation, mainly on matters that concern them ((Ibid. p.) Many health-focused CSOs are also involved in budget tracking and advocacy, but they are not engaged at the macroeconomic policy level.

3.4 The budgeting process

The budgeting process is depicted in the Figure 3.1, with the discussions on the process provided below.

Figure 3.1: MTEF process



Budget outlook paper (BOPA)

The MTEF budget process starts in October every year with the preparation of the BOPA, to provide an overall medium–term fiscal framework for the MTEF budget. The MTEF is intended to be based on a consistent and sustainable macroeconomic framework, which is used to determine the overall resource envelope, comprising revenue, external resources and domestic borrowing. This framework is developed with advice of the IMF. On the basis of this resource envelope, the BOPA provides medium term sectoral ceilings, in line with the strategic objectives from the ERS. These ceilings are then used by Sector Working Groups (SWGs) in allocating resources within the sector in the medium term. The BOPA is prepared by the Macroeconomic Working Group (MWG), comprising the Central Bank (CBK), the Ministry of Finance (MoF), the Ministry of Planning and National Development (MoPND), The Kenya Revenue Authority (KRA) and the Kenya Institute for Public Policy Research and Analysis (KIPPRA). The BOPA is approved by the Cabinet (ALMACO & AMREF, 2005).

Ministerial public expenditure report (MPER)

Each ministry is required to start the MTEF process by preparing the MPER by December of each year. The MPER is basically an evaluation of the performance of the previous year's budget and provides a regular analysis of ministerial expenditures, commenting on the composition, efficiency and effectiveness of spending in meeting service delivery targets and other performance indicators. The MPER also shows the costing and resource requirements of the ministry, based on the programs and priority activities during the medium term. Expenditure analysis provides the ministries' input to the preparation of the medium term Budget Strategy Paper (BSP). The MPER is also expected to promote broader participation in the policy-making process as it opens up the budget system to public scrutiny by publishing information on budget, budget execution and public accounts (ibid.).

District inputs

District departments in each ministry provide input to the budget process through their parent ministries in December. The involvement of the district departments is to be achieved through use of District Budget Committees; a thorough review of district level activities and their performance in terms of allocations, status of project and disbursement of funds; prioritisation of activities and linkages to the district plans and other policy documents; and costing of district level activities for the medium term.

Budget strategy paper (BSP)

BOPA provides the basis from which the Sector Working Groups refine sector ceilings, as contained in BSP. The BSP provides an update of the available resources and sets firm ministerial ceilings. The BSP therefore provides specific and detailed guidance for ministries on aligning public spending patterns within the stated national priorities, which should improve

the efficiency of public spending in the forthcoming budget and over the following two years (ibid.).

Public/sector hearings

One major improvement in the MTEF process is the introduction of public/sector hearings, which are held soon after the preparation of the BSP. The purpose of the public/sector hearings is to provide a forum where various stakeholders engage in a debate about the BSP and propose amendments they deem necessary before the BSP is presented to the cabinet for approval. The BSP is disseminated to stakeholders and civil society in February through public sector hearings organised by the Ministry of Finance. During the public hearings, the SWGs present their budgets and comments are invited from the participants. The suggestions may be used to improve the budget. Theoretically, this can result in an adjustment of sector ceilings or allocations (if deemed warranted). After the public hearings, views are consolidated, and the BSP is printed and submitted to the Cabinet for discussion and approval. Based on the approved BSP, The Permanent Secretary, Ministry of Finance issues the Treasury Circular to ministries/Departments to prepare detailed and itemised budgets, based on the ceilings set in the BSP (ibid.).

Ministerial budgets

Between December and February, Ministries/Departments are involved in consultations with the SWGs. The Treasury and other stakeholders are involved in negotiations that lead to a level of resource requirements that satisfy the BSP ceilings. In March, the Treasury Circular, together with the BSP and ceilings, are issued to all ministries, which are in turn expected to prepare detailed annual and medium term estimates consistent with the BSP and submit the itemised budgets to the Treasury by mid-April. The responsibility for preparing the ministerial budget lies with the Ministerial MTEF Budget Committee. The ministry receives the budget circular from the Treasury, which sets the budget ceiling for each sector and ministry, and the calendar for preparing the budget. Based on the ceilings, the ministerial budgets are prepared by departments and consolidated by the Ministerial Budget Committee, approved by the PS and submitted to the Treasury (ibid.).

Final estimates

The Treasury receives detailed ministerial budgets, consolidates them in April and submits the national budget to the Cabinet for approval in May. The annual estimates are then presented to Parliament for debate in mid-June. Once the Minister of Finance has presented the budget to Parliament, it becomes Parliament business. If Parliament passes the budget, the ministry can proceed and implement it.

3.5 Transparency of IMF Program Policies

Before the government subscribed to the PRGF in 2000, IMF policies lacked transparency as the formulation of the policies was not consultative. The policies used to be drawn by the Government, IMF and the World Bank. However, with the development of the PRSP (2001-2003) and the ERS, there was an improvement in transparency in terms of the way IMF policies were formulated. In terms of availability of policy documents, it is imperative to note that a number of policy documents such as PRSPs, which make reference to the IMF policies that were decided elsewhere (outside of the PRSP process), are available in their final form on Treasury's website and the IMF website. Civil society consultations for inputs into the PRSP document do not discuss the macroeconomic framework or propose possible alternative macroeconomic policies. Furthermore, other documents related to Kenya's PRGF loan program with the IMF, such as the Letters of Intent (LOIs), are also available at the IMF website, but only after the finance ministry has already signed.

Although there has been some improved transparency in the formulation of the IMF's policies, it is important to note that the process of determining inflation-reduction targets, deficit-reduction targets and wage bill ceilings is still not transparent. They are based on a macroeconomic framework that is only known to IMF and Kenya's Macroeconomic Working Group (MWG) at the Ministry of Finance.

Another contentious issue in terms of transparency relates to the failure by the IMF and the MWG to avail macroeconomic policy documents to key stakeholders including officials at the Ministry of Health. As noted earlier, discussions about macroeconomic policy take place within a narrow circle of officials. This practice aggravates the lack of integration between MoH sector-level policies, and those of other line ministries, and the overall macroeconomic framework. Evidence from interviews conducted with key informants suggested that the key objectives and overall macroeconomic policies, targets, and ceilings decisions involve a very limited number of key government officials and visiting IMF Mission officials. Other key players such as the ministry of health, as well as stakeholders outside official circles, often had limited input in the macroeconomic decisions made. Those interviewed pointed out that decisions on the macroeconomic policy framework are closed and the role of other stakeholders including parliamentarians is very limited.

The IMF historically had no official policy on the release and disclosure of key documents throughout the first 50 years of its history, and was traditionally one of the most secretive international institutions. Its Articles of Agreement only mandated the publication of an annual report. Advocacy by civil society organizations and some of the IMF's member governments finally started to create change in the late 1990s. The first instance of substantively increased transparency came in April 1997. Given a country's agreement, the IMF decided to issue Public Information Notices (PINs) that summarize the Executive Board's discussion of oversight reports on a member's economy. The IMF's first wide-ranging information disclosure policy was put into place in January 2001, and has seen some minor changes since then. Today the IMF's policy

on document disclosure covers the publication of 24 types of documents by the organization. A range of information is available that can be useful to civil society organizations, parliaments, media and the general public, including on domestic economic policy, social spending, and international relations (IMF 2005). Despite progress in recent years, there remain serious limitations and restrictions on the publication of key documents and decision-making procedures that fall short of compliance with modern standards of governance and transparency that are expected of public institutions. There is also increasingly a divide between developed and developing countries over transparency, as industrialized economies publish more of their documents than developing countries. Industrial country governments have accused developing countries of being obstacles to greater transparency.

Concern about the lack of transparency at the IMF and its sister institution, the World Bank, led to the formation of the Global Transparency Initiative (GTI), which seeks to overcome the secrecy surrounding the operations of the international financial institutions. The GTI drafted a Transparency Charter that outlines nine principles that should govern access to information at the IFIs in order to address this lack of transparency (see Annex 2).

The documents which detail IMF loan programs for low-income and middle-income countries can contain controversial economic policy changes, which are often binding conditions for accessing loans, including trade liberalizations, privatizations, liberalization of capital accounts and banking sectors, as well as fiscal and monetary policy targets that can greatly constrain growth rates, budget sizes and the levels of wages available for public sector employees. Despite their importance, these documents and the information they contain are often not understood by civil society globally. Recently, the GTI produced an extremely useful “Guide for Civil Society on Getting Access to Information from the IMF” (GTI, 2007) as an attempt to help civil society learn about which key documents held which kinds of vital information about IMF loan programs and how to use the information held by the IMF, but also to provide recommended improvements that could be advocated for which would significantly improve the IMF's transparency policy.

Despite its recent progress on transparency, the IMF has moved backward in one of the most important principles contained within the IFI Transparency Charter—that of automatic disclosure. The first IMF publication policy, created in 2001, contained a protocol for disclosure of four types of documents, including Letters of Intent and Memorandum of Economic and Financial Policies. This policy meant that documents would automatically be published unless countries took a step to block the disclosure. It provided that "if a member does not wish to consent to Fund publication of a document, the member will need to notify its decision and provide an explanation." However, the IMF’s 2003 revision of the policy redefined “voluntary but presumed” to require an explicit written permission from country authorities before a document can be published. In practice this results in a non-disclosure policy. The new definition remains in place in the current policy.

The transparency policy does not cover crucial information about the structure, finances and decision-making processes of the IMF. The IMF does publish information on its structure – including Articles of Agreement, voting rights, and by-laws – but this is not mandated by its transparency policy. In addition, the release of information must be separately authorized for publication, violating the Transparency Charter's second principle of automatic access. Publication of information on the IMF's finances is mandated by the IMF's Articles of Agreement.

The IMF transparency policy also clearly states: "Documents may be published under this decision only after their consideration by the Executive Board" except for a few document types such as Poverty Reduction Strategy Papers (PRSPs), which are considered country-owned documents. This is a clear violation of the third principle of the Transparency Charter that requires that draft documents, at least on some classes of documents, be published in advance of decisions being taken by the board. This is to allow proper public stakeholder input into the decision making process before final decisions are made.

The IMF transparency policy also contains further means by which information can be kept away from the public. The policy makes provisions for the use of "side letters", which are strictly confidential, binding agreements between a borrowing country and the IMF containing conditions and economic policy plans. While member countries may consent to the publishing of official country documents in relation to a loan from the IMF, they can keep controversial decisions with regards to government economic policy out of the published version by putting them in a side letter.

Furthermore, in relation to surveillance and oversight of a country's economy, the transparency policy allows for selective "deletions" to take place. Member countries may seek deletions of two types: "highly market-sensitive material" and "material not in the public domain, on a policy the country authorities intend to implement, where premature disclosure of the operational details of the policy would seriously undermine the ability of the member to implement those policy intentions." While deletions must be "requested" by the member country, the IMF does not keep information on the number of deletion requests that are rejected.

The current IMF transparency policy must be reviewed at least every 36 months, and the IMF had scheduled its next review to take place before June 2008. However, just as civil society was taking steps to weigh in on consultations on the scheduled review, the IMF announced it would be delayed until sometime in 2009 to lighten the workload for the executive board. That leaves in place unsatisfactory arrangements guaranteeing board secrecy for potentially another two years (BWP 2007).

3.6 Trends in Government Health Budget Expenditure

Table 4.1 presents a summary of MoH expenditure during the financial years 2000/01 through 2006/07. The Table shows that total government (MoH) spending on health increased steadily from 2000/01 through 2005/06. The total expenditure rose from about Kshs 12.1 billion in 2000/01 to about Kshs 23 billion in 2005/06 but declined to Kshs 21.1 billion in 2006/07. In the financial years 2003/04, 2004/05 and 2005/06, the total MoH expenditure grew by increasing rates of 7.1%, 16.5% and a 20.1% respectively, with a decline in the rate in 2006/07 of 8%. The total MoH expenditure as a percentage of GDP was 1.44%, 1.65% and 1.49% in the FY 2000/01, 2001/02 and 2002/03 respectively. It declined to 1.37% in 2003/04 but slightly increased to 1.42% and 1.51% respectively in the FY 2004/05 and 2005/06. It decreased, however, to a low of 1.23% in 2006/07 financial year. It is evident that the MOH expenditure as a percentage of total GDP has been erratic and unpredictable.

It also shows that in the five years of the ERS, the per capita MoH expenditure generally increased. It grew from Kshs 487.86 in 2002/03, to Kshs 646.26 in 2005/06, but declined to Kshs 576.45 in the 2006/07. The WHO Commission on Macroeconomics and Health and the UN Millennium Project suggest that a basic effective public health system would require a minimum level of spending of around US$40 per head (at current prices).

Table 3.5: Ministry of health actual expenditure

		2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Recurrent	Kshs (million)	11,041	12,715	14,405	15,438	17,417	19,765	18,652
	US (million)	147	170	192	206	232	264	249
Development	Kshs (million)	1,032	2,519	945	1,003	1,741	3,242	2,475
	US (million)	14	34	13	13	23	43	33
Total MoH expenditure	Kshs (million)	12,072	15,234	15,351	16,441	19,158	23,007	21,127
	US (million)	161	203	205	219	255	307	282
Per Capita MoH expenditure		395.49	488.44	481.97	487.86	552.90	646.26	576.45
Recurrent expenditure growth			15%	13%	7%	13%	13%	-6%
Total MoH expenditure growth			26%	1%	7%	17%	20%	-8%
MoH recurrent as % of total ministries' recurrent		7.7%	8.2%	8.7%	7.8%	7.7%	7.9%	7.1%
MoH development as % of total ministries' development		4.5%	17.2%	5.1%	2.8%	2.0%	5.3%	2.4%
Total MoH expenditure as %		7.2%	9.0%	8.3%	7.0%	6.1%	7.4%	5.8%

of total government expenditure							
Total MoH expenditure (gross) as % of GDP	1.44%	1.65%	1.49%	1.37%	1.42%	1.51%	1.23%

Source: Ministry of Health's PER 2007, QBR 4th quarter 2005/06 and 4th quarter 2006/07, and own calculation. The GDP values and population figures used were for the years 2003, 2004, 2005, 2006 and 2007, and were obtained from the Economic Survey of 2008.
Note: An average exchange rate of Kshs 75 per US $1 used for each of the financial years.

3.7 Trend in HIV/AIDS Expenditure

The financing of HIV/AIDS interventions has relied heavily on the donor community. The analysis of total expenditure on HIV/AIDS response in Kenya by major sources of finance during 2004/05, 2005/06 and 2006/07 financial years[4], is presented in Tables 4.2 and 4.3. Table 4.2 shows a total amount of Kshs 12.5 billion was spent on HIV/AIDS interventions. In 2005/06, a total of Kshs 11.5 billion was spent on interventions, an amount equivalent to about 0.8% of GDP at current market prices and equivalent to approximately 80% of total expenditures for the Ministry of Health (recurrent and development). In 2006/07 financial year, expenditures on HIV/AIDS interventions from major sources more than doubled, totaling Kshs 23.4 billion, which was equivalent to 1.3% of GDP and about 85% of total MOH actual expenditures. Although expenditure data on some sources were not collected for the years 2005/06 and 2006/07, these sources together contribute only about 3 % of the expenditure in 2004/05.

As shown in Table 4.4 and Figure 4.1, the bulk of HIV/AIDS funding came from international sources. In 2006/07, funding from bilateral sources amounted to about 93.7% of total HIV/AIDS resources, mainly because of the rapid increase in financial resources from PEPFAR, which are mostly off-budget. Government contribution is minimal, accounting for about 2% of total HIV/AIDS funding.

Table 3.6: HIV/ AIDS expenditures by specific sources

SOURCES	2005/06		2005/06		2006/07	
	Kshs (million)	US $ (million)	Kshs (million)	US $ (million)	Kshs (million)	US $ (million)
GOK	219	3	581	8	270	4
PEPFAR	6,977	93	7,421	99	16,692	223
JICA	1,030	14	1,234	16	4,172	56
DFID	692	9	609	8	1,062	14
SIDA	81	1	No record	No record	No record	No record
EU	24	0	No record	No record	No record	No record
UNDP	1	0	9	0	4	0

[4] Accounts reported in financial years running from July 2005 to June 2006 and July 2006 to June 2007

UNODC	5	0	15	0	15	0
UNICEF	85	1	3	0	3	0
UNFPA	149	2	No record	No record	No record	No record
UNHCR	26	0	No record	No record	No record	No record
UNIFEM	4	0	No record	No record	No record	No record
WFP	100	1	No record	No record	No record	No record
WHO	48	1	No record	No record	No record	No record
FAO	3	0	No record	No record	No record	No record
World Bank	1,907	25	-	-	4	0
GLOBAL Fund	1,111	15	1,207	16	1,160	15
CLINTON FOUNDATION	-	-	415	-	No record	No record
OTHERS	13	0	18	0	14	0
Total	12,475	166	11,511	153	23,396	312

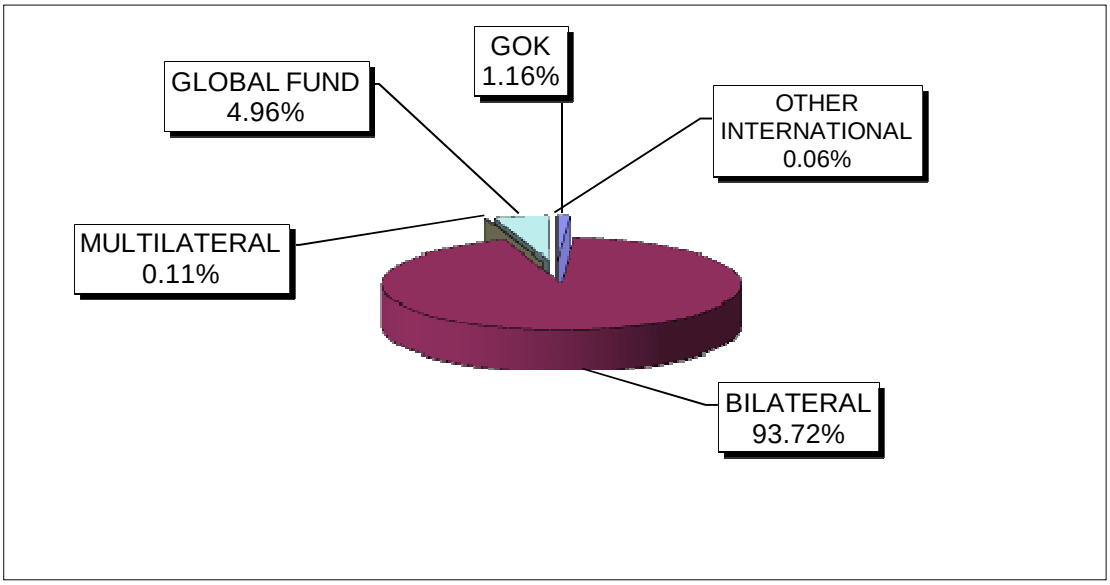
Source: Kioko et al. (2007); Korir and Nzoya, 2008.
Note: An average exchange rate of Kshs 75 per US $1 used for each of the financial years.

Table 3.7: Expenditure by major sources of funding

	2004/05		2005/06		2006/07	
Source of Funding	Kshs (million)	US $ (million)	Kshs (million)	US $ (million)	Kshs (million)	US $ (million)
GOK	219	2.92	581.17199	7.74896	270.26799	3.603573
Bilateral	8804	117.3867	9263.4469	123.5126	21925.897	292.3453
Multilateral	2327.97	31.0396	26.384144	0.351789	25.724056	0.342987
Global Fund	1111	14.81333	1207.4221	16.09896	1160.2337	15.46978
Others (international)	13	0.173333	432.49	5.766533	14.02	0.186933
Total	12474.97	166.3329	11510.915	153.4789	23396.142	311.9486

Source: Kioko et al. (2007); Korir and Nzoya, 2008.
Note: An average exchange rate of Kshs 75 per US $1 used for each of the financial years.

Figure 4.1: Contribution of HIV/AIDS funds by source (2004/2005 –006/07)



3.8 Estimated Resource Requirements for HIV/AIDS Response

According to the Republic of Kenya (2005, KNASP) the cost of implementing the KNASP was estimated to increase from Kshs 25 billion in 2005/06 to Kshs 45 billion in 2009/2010. Of this total, 30% was allocated to prevention; 27% to improving the quality of life of those infected and affected; 27% to mitigation of socio-economic impact; and 16% to support services (see Table 4.4). The KNASP 2005/6-2009/10 estimated that approximately Kshs 25 billion would be required in the year 2005/06 to finance various HIV and AIDS interventions. The financing requirement was projected to increase to Kshs 30.74 billion in the year 2006/07. The expenditures for the years 2005/06 and 2006/07 indicate that the requirements in the KNASP were not achieved, even though expenditures by private sector and households were not included. These two sources do not contribute a significant amount of financial resources to the interventions contained in the strategy (see Figure 4.3). Figure 4.2 shows that there was a significant closing of the gap in the year 2006/07, due to funds from PEPFAR (NACC, 2008, UNGASS), although the expenditure lagged behind the requirement. Out of the over 40 billion KSHS required to adequately fight HIV/AIDS in 2006/07, only 23 billion was spent, leaving a funding shortfall of 17 billion or over 42.5%. This was mainly due to a lack of funds.

Table 3.8: Estimated financing requirements5 (Kshs. millions)

	2005/06	2006/07	2007/08	2008/09	2009/10
PREVENTION					
Youth focused interventions	1017	1416	1853	2341	2883

[5] Constant 2005/06 prices

Sex workers and clients	35	37	38	39	41
Workplace	210	278	349	425	503
Harm reduction programs	14	20	24	27	31
Uniform Services	59	83	109	135	164
Other vulnerable populations	118	166	217	271	327
Condom provision	2181	2426	2747	3095	3472
STI management	422	466	513	561	612
VCT	740	789	777	830	886
PMTCT	953	1363	1357	1351	1450
Behaviour change communication	240	240	120	80	40
Blood safety	365	426	487	548	656
Post-exposure prophylaxis	40	55	70	85	108

Table 3.8: Estimated financing requirements6 (Kshs. millions) continued

IMPROVING OF QUALITY OF LIFE					
Home-based care	265	323	345	380	423
Palliative care	163	217	116	158	176
Diagnostic testing	78	95	113	130	147
Treatment of opportunistic infections	1668	1712	1364	1384	1249
OI prophylaxis	117	163	212	261	314
Lab HAART	55	93	139	173	216
ARV therapy	4000	5231	7458	8352	9357
Training	27	39	57	69	81
Nutritional support	133	164	259	299	357
Protection of Human Rights	723	795	835	835	835
MITIGATION OF SOCIO-ECONOMIC IMPACT					
Mitigation policy	883	1076	724	808	1352
Mitigation advocacy	1261	1537	1087	808	451
Livelihood and social security	1261	1537	1087	1213	1352
Mitigation programs	3153	3842	6881	8287	9236
Community empowerment	757	922	724	808	901
Human resource planning	252	307	362	202	225
Provision of support services	5311	6303	6203	6025	6627
Overall total (Kshs. million)	**25226**	**30737**	**36218**	**40424**	**45054**
Overall total (US$ million)	**315**	**384**	**453**	**505**	**563**

Source: Republic of Kenya, 2005.

3.8.1 Budget Ceilings

Budget and wage ceiling were introduced in Kenya as part of the MTEF process in 2000 (ALMACO & AMREF, 2005). Budget ceilings are set at the sector and ministerial level. The sectoral ceilings are set by the MWG, to inform ministerial ceilings which are set by the SWG. The ministerial budget ceilings in any sector cannot exceed the sectoral budget ceilings.

In the fiscal period 2003/04, 2004/05 and 2005/06, ceilings were set on eight sectors: agriculture and rural development, physical infrastructure, general economic service, public safety, law and order, public administration, health, education, and national security. During the fiscal years 2006/07, 2007/08 and 2008/09 these sectors were reclassified as nine separate sectors. Table 4.5 shows the sectors' ceilings during the years 2006/07, 2007/08 and 2008/09. The tables shows that the ceiling for the health sector increased from Kshs 35.048 billion in 2006/07 to Kshs 38.929 billion in 2007/08 but decline slightly to Kshs 37.400 billion in 2008/09.

[6] Constant 2005/06 prices

Table 3.9: Sectoral budget ceilings

	2006/07		2007/08		2008/09	
	Kshs (million)	US $ (million)	Kshs (million)	US $ (million)	Kshs (million)	US $ (million)
Agriculture and rural development	24	0.32	30	0.39	38	0.50
Education	108	1.44	119	1.59	131	1.75
General economic service	11	0.15	12	0.16	-	-
Health	35	0.47	39	0.52	37	0.50
National security	33	0.44	38	0.51	43	0.58
Physical infrastructure	81	1.08	119	1.59	111	1.48
Public administration	45	0.60	50	0.66	43	0.57
Public safety law and order	54	0.72	57	0.76	58	0.77
Information communication and technology	2	0.03	2	0.03	6	0.08
Manpower and special programs	-	-	-	-	17	-
TOTAL	**394**	5.25	**466**	6.21	**485**	6.46

Source: Budget strategy paper 2006, Budget outlook paper 2007, and Budget outlook paper 2008.

The SWGs convene and determine the ministerial ceilings using information from the BOPA ceilings and MPER; these ceilings take into account available resources and viable strategies to achieve the government's medium-term strategic objectives (ALMACO & AMREF, 2005). Because the Ministry of Health is a separate sector, the ministerial ceiling is done within the ministry, with the Department of Planning and Policy taking the lead. Though the Ministry of Health determines its own ministerial ceiling, it is constrained by the sector's ceiling. However, it does not influence the sector's ceiling as it is not directly represented in the MWG. Nevertheless, ALMACO and AMREF (2005) point out that the ministry can still influence its ceilings in the preparation of its strategic plans that clearly show their priorities, on the basis of which budgetary allocations will be made; the MPER process provides ministries with the opportunity of influencing the level of ceilings they are allocated; ministries are given an opportunity to negotiate with the Treasury on the sector and ministerial ceilings in the course of the MTEF process. Both the BOPA and the BSP ceilings can be reviewed on the basis of ministerial presentations; and the Treasury has given explicit instructions to ministries to include district's programs and activities and forward them for incorporation in the BSP.

IMF polices have continued to restrict budgetary allocations to the health sector. The Funds policies affect the resource envelope that is available to the government for apportionment to all of the sectors, including the health sector. According to interviews at the Treasury, the resource envelope is made up of projected revenue, proceeds from privatization of state enterprises, and concessional loans. The restrained resource envelope causes restricted allocations to the individual sectors, accomplished through the setting of sectoral ceilings. The IMF is not directly involved in the setting of the sectoral ceilings.

The need to maintain low rates of interest is the reason behind the need to reduce the deficit. When the government borrows heavily in the domestic economy, interest rates increase as the price of treasury bills grow, driving up the price of credit in the economy. In this case the government would crowd out private investment, which is very critical in expanding productive capacity in the economy. A casual observation lends support to this assertion in the case of Kenya. In the last five years, the restricted government borrowing in the domestic economy saw interest rates on loans fall. Furthermore, by reducing avenues available to commercial banks to make huge profits, it forced the commercial banks to undertake aggressive campaigns to "sell" loans to private individuals and firms. In spite of the positive benefits of reducing the deficit, it is not clear whether different deficit scenarios have been considered in setting the deficit targets that Kenya has been pursuing.

Though budget allocations to the Ministry of Health in the last five years have increased, the ministry is still under funded. Although total government spending on health rose substantially during the five-year period from 2001/02 through 2005/06, increasing from Kshs 15.2 billion in 2001/02 to Kshs 23 billion in 2005/06, the total amount of resource allocation as a percentage of either gross domestic product or government spending has not increased. As a percent of total government recurrent expenditure, public heath spending in fact declined slightly over the period, being 8.23% in 2001/02 and 6.29% in 2005/06, though it rose briefly to 8.69 % in 2002/03. As a percent of GDP, total government health spending declined slightly over the same period, being 1.65 % of GDP in 2001/02 and 1.55 % in 2004/05 of GDP and 1.50% in 2005/06. Actual expenditure falls short of the health sector budget ceiling. For instance, the ceiling for the year Kshs 35.048 billion while the actual expenditure was Kshs 21.127 billion.

The total health expenditure per capita in Kenya is lower than the required minimum. According to NHA 2001/02, the per capita health expenditure was US $ 19 in Kenya compared to a required minimum of US $ 34. The per capita health expenditure has not increased significantly in recent years (PER, 2006, 2007). The head of the health sector at the World Bank country office said in an interview that he felt strongly that the government's budget allocation to the health sector was too low. He said that this reflected the Bank's position.

As a result of inadequate resources, services in public health facilities have continued to deteriorate. Some of the most common challenges include: i) unavailability of essential medicine in public health facilities; ii) unavailability of doctors in public health facilities because

they are engaged in private practice; iii) patients being referred to private health facilities for some specialized diagnostic tests; iv) general poor state of the services in public health facilities.

The MoH is the main provider of health services to a majority of Kenyans, especially the poor and its ability to serve those in poverty is constrained by inadequate funding. Despite the fact that the public sector serves most of poor, the government introduced user fees in MoH facilities as a way of raising additional financial resources. It has been found that these fees have had a negative effect on utilization of health services in government facilities, with the poor being disproportionately affected. PER 2007 indicates that the need for cash payments in order to receive health care compounded the population's already inadequate access to health facilities.

3.8.2 *Wage Bill Ceilings*

The policy of wage bill restrictions may be traced back to the implementation of the IMF structural readjustment program and is the government's current policy. Although the wage bill ceiling is no longer a benchmark considered by the IMF, the Kenyan government continues its implementation in order to maintain restrictive fiscal and monetary policies.

Table 4.6 shows that, during the financial year 2007/07, the educational sector had the highest wage bill ceiling (67.02%) followed by public safety, law and order (60.47%) and the health sector (51.22%), among others.

Table 3.10: Absolute and percent wage bill ceilings 2006/07

Sectors	Wages		Net recurrent expenditure ceiling		% of sectoral recurrent expenditure ceiling
	Kshs (million)	US $ (million)	Kshs (million)	US $ (million)	
Agriculture and rural development	6,206	83	14,112	188	43.98%
Education	64,580	861	96,360	1,285	67.02%
General economic service	2,150	29	7,116	95	30.21%
Health	10,784	144	21,054	281	51.22%
National security	-	-	-	-	-
Physical infrastructure	3,790	51	7,587	101	49.95%
Public administration	7,640	102	28,475	380	26.83%
Public safety law and order	22,320	298	36,912	492	60.47%
Information communication and	493	7	1,471	20	33.51%

technology					

Source: BSP 2006

Table 4.6 notes that the 51.22% wage ceiling is not significantly different from the actual wage spending in the sector. For instance, heath sector PER 2007 documents that, for the period 2001/02 through 2005/06, 52.7% of the MoH's recurrent expenditure was on personnel emoluments, 7.5% spent on operations and maintenance, about 3% on purchases of plants and equipment, about 10.5% on drugs and medical supplies, and about 26.4% on "transfers" to MOH parastatals.

Government policy, through its use of wage ceilings, has adversely affected the health sector. Though a 52% wage bill over recurrent expenditure seems relatively high, the public health sector has been experiencing a shortage of human resources due to the restricted total recurrent expenditure, as informed by the IMF's restrictive macroeconomic framework. This suggests that the overall allocation to the public health sector is not adequate. In addition Kenya faces a variety of health personnel problems, including an inadequate number of personnel in key areas of the health sector, an inequitable distribution of those health personnel who are available, and an attrition of trained personnel from the health sector and from the country. These problems are even more daunting when seen in the light of the additional health facilities that are being put up under constituency development fund (CDF), with the expectation that the MoH will staff and equip them (Republic, 2007b).

3.8.3 Civil Service Reform Programme

The civil service reform program, which entails a reduction in civil service expenditures and a freeze on public sector employment, started in 1993. The government implemented this policy under both the ESAF and the PRGF programs. Civil service reform attempted to reduce the overall size of the civil service, to contain costs, and to improve the civil service's efficiency by bettering working conditions. The reform involved departures from the civil service via regular attrition or a voluntary retirement program. Additionally, a substantial reduction in the total number of civil servants would be achieved through limits on new hiring (Republic of Kenya, 1996). The civil service reform has adversely affected delivery of services. Due to a lack of new nurses, clinical officers and paramedical staff, available health personnel cannot provide adequate health services at public facilities. An interview with a key respondent at Division of TB and Leprosy (DTLP) revealed that one of the factors limiting the testing and diagnosis of TB in Kenya is the shortage of laboratory technologists and technicians.

Human resource mapping for the year 2005 revealed that despite a necessary staff establishment of 44,813, only 35,627, or 80 percent, of the posts were filled. The personnel shortage could not be filled given the embargo on new staff under IMF policies. The Minister for Medical Services, however, recently said that the ministry will employ about 6,000 additional health workers in 2008.

Brain drain in Kenya has been linked to wage ceilings, an employment freeze, and low pay.. Kenya, like most African countries, does not meet the WHO's standard of 1 doctor per 5,000 population. Health personnel are leaving the medical profession for other professions, while others are joining the private sector or are leaving the country to work in developed countries. In 2001, it was estimated that 167 medical doctors from Kenya were working in developed countries, but the number has increased over the years. According to the Ministry of Health, out of a total of 6000 doctors trained, only 600 are employed in public health hospitals. This is far below the number required for effective delivery of services. By 2003, over 4000 nurses had left the country for the United Kingdom or the US. Other effects of brain drain include: i) a decline in the quality of public health care services; ii) increased workload for the few health personnel available in the public health facilities; iii) inefficiency in resource utilization including health infrastructure and; iv) the inability to effectively fight the HIV/AIDS epidemic due to shortage of trained medical personnel.

CHAPTER FOUR: CONNECTING THE DOTS: HOW IMF POLICIES IMPACT GOVERNEMENT SPENDING ON HEALTH, HIV/AIDS AND TB

It is important to examine the series of critical connections to see how IMF macroeconomic policies constrain spending for any particular sector such as health. First, the IMF macroeconomic policies limit the ability of the economy to grow at higher economic growth rates and raise more revenues, so overall national budgets are smaller than they otherwise could be. Second, the IMF policies limit how much deficit spending governments can engage in, again keeping the overall national budgets smaller than they otherwise could be. Third, the IMF policies can make it difficult for countries to fully use all of the ODA inflows.

All of these outcomes then lead to smaller national budgets, which in turn translate into smaller sector budgets and less money for public sector wages. By the time the macroeconomic policies have been decided, the size and limits of the national budget have largely been determined. The national budget process and PER do not provide scope for major changes after the framework has been set. To realize their goals of significantly increased health sector funding in the future, advocates must seek to change the IMF's macroeconomic framework.

Critical Review of Main Problems with the Underlying Assumptions of the IMF Macroeconomic Framework in Kenya

For health advocates, the most important problem to understand is that the policy priorities that inform the design of Kenya's macroeconomic framework are to maintain a restrictive degree of macroeconomic stability as the IMF defines it: inflation at 5 percent per year and deficits below 3 percent of GDP. Health advocates must be aware that this particular policy priority subordinates other social goals and, consequently, the IMF's framework does not allow for any substantial "scaling up" of ODA inflows or increases in domestic spending of the kind projected to be needed to achieve the MDGs or fight HIV/AIDS and TB effectively. The current framework does make room for an adequate scaling up of public investment in the health sector. If health advocates want to see substantially increased public spending and investment on health budgets, they will need to get different macroeconomic policies that are informed by different policy priorities. We must move beyond 30 years of frameworks based on "stabilization" and adopt new frameworks that will enable a scaling-up in spending and investment, but this cannot happen until current IMF policy priorities are changed**.**

This report critically reviewed several fundamental assumptions that underpin the IMF approach to monetary policy in Kenya that deserve greater public scrutiny by a broader group of public stakeholders.

1. The IMF makes an assumption that IMF-defined macroeconomic stabilization must take priority and be constantly maintained thereafter and that this will create the conditions necessary for higher growth and poverty reduction over the long term. It is assumed that in the

short-term and medium term, the goals of maintaining low deficits and low inflation must take precedence over achieving the MDGs and fighting AIDS effectively. It is assumed that these social and health goals will be achieved eventually after a sustained long-term commitment to maintaining low deficits and low inflation.

According to the assumptions of this orthodox approach, the main monetary policy goal should be an inflation-focused monetary policy; other important goals, such as rapid economic growth and employment creation, are seen as inappropriate direct targets of central bank policy. Therefore, this orthodox approach to monetary policy focuses on stabilization rather than growth or development, with an implicit assumption that once stabilization is achieved higher rates of economic growth, employment creation, and poverty reduction will follow. This view not only specifies the appropriate target of monetary policy, but also the appropriate tools or instruments. The orthodox approach emphasizes the use of “indirect”, market-based instruments of policy, such as short-term interest rates, as the primary and often exclusive tool of monetary policy. This is in contrast to the “direct” quantitative tools often used by central banks which have involved credit allocation methods, interest rate ceilings, and other ways to direct credit to priority economic sectors and goals. In short, the IMF-sponsored orthodox approach has narrowed the goals, options and tools of monetary policy in Kenya.

The IMF approach of targeting very low inflation (often 5 percent or lower) informs the type of conditionality that the IMF imposes. The IMF states that "conditionality in Fund-supported programs is intended primarily to ensure that Fund resources are used to support adjustment toward sustained external viability, and thereby to safeguard the capacity to repay the Fund. Traditionally, monetary conditionality consists of limits on monetary aggregates - specifically, a floor is set for the level of net international reserves (NIR) and a ceiling is established on the net domestic assets (NDA) or on base money” (IMF 2006). Under the standard IMF financial programming methods, target ceilings are set for central bank monetary and credit expansion and floors are established on net foreign reserves. The original motivation for these restrictions was to ensure the ability of countries to reduce their foreign debt and remain solvent, including the protection of the IMF’s ability to be repaid. Recently the IMF has emphasized other goals such as reducing inflation, increasing foreign exchange reserves, and "creating room for private investment."

The IMF is concerned, however, that this NDA-NIR approach could allow for higher inflation if, for example, larger than necessary increases in net international reserves result from inflows of capital (including foreign aid) (Epstein 2006). As a result, some IMF programs require a further tightening of monetary conditions in order to maintain inflation rates in the low single digits. Financial programming has been used since the 1970s as part of the IMF's lending program to least developed countries. This programming has now been folded into the PRSP and HIPC processes without much alteration. The programming uses a set of "identities" and extremely simple models (or set of assumptions about the structure of the economy) to establish a set of targets that the IMF will monitor and the government will have to meet in order to receive the

next installment of IMF loans, or qualify for HIPC relief and other donor support (Easterly, 2002).

The typical program connects balance of payments constraints, the government fiscal deficit, and central bank policy in order to attempt to reduce indebtedness to a sustainable level, primarily by keeping economic growth in line with likely available foreign resources from export receipts, aid and capital inflows. Increasingly, reducing inflation into the low single-digits has become a central focus. Therefore, a central assumptions of these program are (1) that inflation rates between 10 and 20 per cent are bad for economic growth and reducing inflation below that level will not reduce economic growth; and (2) that reducing government spending is good for the economy, because more government spending crowds out private investment.

Regarding the first assumption on inflation, it is important for readers to know that the IMF has very little empirical evidence in the economics literature to justify pushing inflation down to the 5-7 percent level, with lower growth, lower taxes and lower spending as results. This is often considered surprising, given the widespread belief that the IMF is the expert on such matters. While everyone agrees that high inflation is bad and must be brought down, a more relevant question is how low must inflation be brought and at what level it should be maintained. On this point, the IMF's position that inflation must be maintained at the 5-7 percent range is not backed up by the empirical literature or historical record.

At least 9 major studies have examined this question and have tried to find the "kink" in the inflation-growth relationship, or at what level inflation begins to hurt a country's long-term GDP growth rates: 1) Fischer (1993) found the point to be between 15-30 percent; 2) Bruno (1995) cites a major unpublished World Bank study of the link between inflation and economic growth in 127 countries from 1960 to 1992 that found that inflation rates below 20 percent had no obvious negative impacts for long-term economic growth rates; 3) Barro (1996) found that an increase by 10 percentage points in the annual inflation rate is associated on impact with a decline by only 0.24 percent in the annual growth rate of GDP but says nothing about the disinflation policy targets; 4) Sarel (1996) found the danger point at 8 percent; 5) Bruno and Easterly (1998) found the danger point to be as high as 40 percent; 6) Ghosh and Phillips (1998), found inflation-growth relationship is convex, so that the decline in growth associated with an increase from 10 percent to 20 percent inflation is much larger than that associated with moving from 40 percent to 50 percent inflation, but this says nothing about disinflation policy targets; 7) Khan and Senhadji (2001) found the danger point for inflation at between 11 percent-12 percent for developing countries and 1-3 percent for industrialized countries); 8) Gylfason and Herbertsson (2001) found the danger point for inflation at between 10-20 percent; and 9) Pollin and Zhu (2005) found the danger point to be between 14-16 percent (for middle and low-income countries).

What these 9 major studies show is that not only do the estimates widely diverge and show that further research is still needed, but as Pollin and Zhu note, "There is no justification for inflation-targeting policies as they are currently being practiced throughout the middle- and

low-income countries" (Pollin and Zhu, 2005). The same literature was reviewed by a 2007 study from the Washington-based Center for Global Development which found, "Empirical evidence does not justify pushing inflation to these levels in low-income countries" (CGD, 2007) and by the House Financial Services Committee of the US Congress, which wrote to the IMF in 2007, "We are concerned by the IMF's adherence to overly-rigid macroeconomic targets" and, "It is particularly troubling to us that the IMF's policy positions do not reflect any consensus view among economists on appropriate inflation targets" (Financial Services Committee 2007).

This approach has been the policy for 25 years; it has been effective at stabilization but has done very poorly at generating higher economic growth that translates into poverty reduction, job creation and increased public investment as a percent of GDP. While it might seem obvious that stabilization-focused central bank policy represents the only proper role for central banks, looking at history casts serious doubt on this claim. Far from being the historical norm, Epstein (2007) notes this focus by central banks on stabilization to the exclusion of development represents a sharp break from historical practice, not just in the developing world but also in the now developed countries as well. In many of the successful currently developed countries, as well as in many developing countries in the post-Second World War period, development was seen as a crucial part of the central bank's tasks. Now, by contrast, development has dropped off the "to-do list" of central banks in most developing countries (Epstein 2006).

This approach underscores why the IMF should not be in the "development business," is not a "development organization," and should not be involved in an ongoing way with LICs. As the 2007 IEO report explained, there were differences of views among the members of the IMF Executive Board about the IMF's role and policies in poor countries, and that after more than 7 years after adopting PRSPs and renaming their ESAFs into PRGFs and ostensibly claiming to back the MDGs, the leadership never gave any indication on how to change any of the macroeconomic policies to create an scaling-up environment. "Lacking clarity on what they should do" the IMF staff "tended to focus on macroeconomic stability, in line with the institution's core mandate and their deeply ingrained professional culture" (IEO, 2007). If this approach remains intact, countries will not reduce poverty or achieve the MDGs or get the health personnel in place needed to fight HIV/AIDS and other diseases.

2. The second assumption, that reducing government spending is beneficial to the economy, is based on the IMF assumption that increased deficit spending by the government "crowds out" the limited available credit in the country and limits the ability for further private sector investment, thereby leading to inflation.

There is little empirical evidence that deficits lead to higher inflation while there is mounting evidence for the reverse of "crowding out" effect, as noted even by IMF's Sanjeev Gupta, et al., (2006). Depending on the nature of the public investments, public spending can actually have a "crowding-in" effect that creates new opportunities for private investment (IMF 2006; Roy, et al, 2006). However, the IMF's belief in crowding out has led to overly restrictive regulations on

the government's ability to draw from the limited supply of credit in the economy and restrains the government's capacity to finance increased public spending and investment.

3. The IMF's third major macroeconomic assumption is that inflation can be effectively controlled by the central bank's careful restriction and modulation of the growth rate of the economy's money supply. However, the empirical evidence shows that in most developing countries:

- Central banks have influence over a small portion of the money supply—only the currency and reserves of the banking system;
- Monetary policy is not always effective. Central banks may have limited influence over all of the multiple factors that contribute to the growth of the money supply (broadly defined);
- The link between the money supply and inflation is often weak;
- Uncontrollable growth of the money supply will lead to hyper-inflation, but such targets often cannot "fine tune" low rates of inflation;
- Richer countries (like the US & Europe, Brazil, South Africa) target interest rates, not the money supply;
- Inflationary pressures in most low-income countries tend to come from price shocks (food, energy price increases, etc) and therefore monetary policy is not effective in managing this type of inflation (non-monetary shocks).

- Adopting a tight monetary policy in response to a negative price shock can make the situation worse, but this is what Kenya is doing in the face of a global economic downturn;
- Many African countries have a history of fairly stable inflation, so the obsession with the need to constantly monitor and restrict inflation is misplaced;
- Other IMF reforms (like devaluing the currency) can actually contribute to inflation

4. The IMF's fourth presumption of the macroeconomic framework is that monetary policy should be dominant and fiscal policy goals should be limited accordingly in order to allow the monetary goal to be achieved. This policy approach does not allow developmental fiscal policy frameworks to be prioritized or realized; fiscal policy must follow the constraints of the adopted monetary policy. As long as monetary policies are geared for tight stabilization goals, any "scaling up" of public spending or investment to meet the MDGs or fight HIV/AIDS will be limited and significant spending increases will not be possible.

5. The IMF's macroeconomic framework's fifth major assumption is that inflation-reduction, or "price stability," should be the only monetary policy target. This ideological preference of the monetarist school within neoclassical economics neglects alternate possibilities. According to the Political Economy Research Institute (PERI) at the University of Massachusetts, different

targets can also be included in the central bank's mandate. For example, the US Federal Reserve has targets for inflation as well as employment, and balances the two objectives.

6. A sixth assumption of the macroeconomic framework is that the private-sector will lead in job creation. The IMF does not address the crisis of unemployment and underemployment in Kenya, despite the fact that almost all economists agree that the best way to decrease poverty is to create jobs. The neoclassical assumption, however, is that jobs should be created by the dynamism of the private sector instead of been provided by the government.

7. A seventh assumption of the macroeconomic framework is that the bond investors in the open market should set interest rates. According to the IMF, the state should not interfere in the free market by setting interest rates. This assumption was the basis for the first- generation IMF reforms in Kenya which called for the gradual liberalization of interest rates. Health advocates should consider that it is high, market-determined interest rates that prevent governments from being able to affordably engage in higher deficit finance or health spending. While Kenya is forced by IMF structural adjustments to accept high, market-determined interest rates, industrialized countries use various mechanisms to create lower interest rates for public investments.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

IMF policies implemented by Kenya have restricted the fiscal space available to the government, which has led to the government's inability to effectively implement and scale-up health interventions, including the scaling up of HIV/AIDS and TB interventions.

This study combined both qualitative and quantitative data collection research methods to examine how IMF polices determine the size of the national budget, and consequently, their impact on health funding and the government's response to the HIV/AIDS and TB crisis in Kenya.

As described in this report, a major problem with the current macroeconomic framework is that it is designed for public-spending stabilization, not scaling-up. The restrictive fiscal and monetary policy targets and the adoption of market-determined interest rates have greatly constrained the ability of the government to engage in the more expansionary fiscal and monetary policy options that will be required for any major scaling-up scenarios as are needed to meet the MDGs.

Such targets and policies in the current macroeconomic framework limit the government's potential fiscal space by constraining the overall national resource envelope. These restrictions adversely affect allocations to the different ministries, including health ministry. Public service retrenchment in the 1990s, coupled with a freeze on employment that has persisted until now, has also negatively impacted the health sector. Despite recent increases in health spending, overall budget constraints continue to prevent the government from being able to fill the shortage due to lack financial resources and the wage bill ceiling policy (wages are constrained at 6.5 percent of GDP). The continuing shortage of critical public human resources for health has largely contributed to the ministry's inability to fully implement effective HIV/AIDS and TB interventions.

Civil society consultations for inputs into the PRSP documents do not include or permit discussions about the macroeconomic framework. The policy decisions about the macroeconomic framework continue to be decided elsewhere, behind closed doors and without broad public participation, scrutiny or accountability.

Efforts must be made to begin a broad public review and reconsideration of the macroeconomic framework in Kenya, its policies and their underlying assumptions. The costs and benefits of a range of other possible more expansionary policy options for increasing public

spending must be considered, and must be done in an open, inclusive and transparent process that involves a much broader group of public stakeholders.

4.2 Recommendations

1). Open Macroeconomic Policy Decision Making to a Broader Group of Public Stakeholders

The process of deciding the policy priorities for Kenya's macroeconomic framework – stabilization or scaling-up – should be subject to a broader national public debate and discussion involving parliament, academia, civil society, labor and the domestic media. Additionally, setting of specific fiscal and monetary targets should be made more transparent and involve broader public discussions of the costs and benefits of alternative policy options. The implementation and evaluation of policy reforms should be participatory and inclusive with all the stakeholders.

2) Alternative Policies for Increased Public Spending & Investment Must Be Considered

The underlying assumptions and policies informing the current macroeconomic framework in Kenya should be revisited, explored and reconsidered by a larger group of public stakeholders.

The tight fiscal policy and monetary policy targets should be reviewed along with alternative policy options that could allow more flexibility in deficit financing, geared specifically to mobilize more resources for the health sector. For instance, within the IMF policies, there should be provisions that allow the country to increase deficit financing to generate resources for scaling up health interventions. The IMF must allow the government to explore and adopt more expansionary fiscal and monetary policy options, especially in the context of exogenous shocks such as last year's commodity price increases and the current continuing global economic and financial crisis.

Excellent examples of how Kenya could adopt alternative, more expansionary policies to scale-up spending in public health have been proposed by major joint studies by the Political Economy Research Institute (PERI) of the University of Massachusetts and the UNDP, including "Expanding Decent Employment in Kenya: The Role of Monetary Policy, Inflation Control and the Exchange Rate" (IPC, 2007a) and "An Employment-Targeted Economic Program for Kenya," by the UNDP's International Poverty Center (IPC, 2007b).

3.) Conduct IMF Macroeconomic Literacy Trainings:

The CSOs, parliamentarians, labor unions, line ministry staff, academics and the domestic media all need to play a more active role in urging the government to negotiate demand for removal of all conditionalities that prevent the government from increasing investment in health and particularly on HIV/AIDS and TB. For this policy to work however, IMF should show flexibility in involving key stakeholders in developing alternative policy scenarios and in

formulating policy decisions. They should be represented, especially in the MWG, since this group determines allocations to the different sectors.

It is imperative for the CSOs in the country to be familiar with IMF program policies, the content of the policies, the context in which they are introduced and the effects of the policies in relation to health care delivery. The lead CSOs should therefore create awareness among the CSOs so as to increase knowledge of the IMF policies and their effects in order to collectively advocate for macroeconomic policies that more effectively reduce poverty and advance the health of Kenyans. There is a large need for education of CSOs, and senior officials within the government who are responsible for mobilizing and spending resources for health about not only IMF issues, but even about basic economics.

4). Eliminate the Wage Bill Ceiling:

In addition to a broader review o the whole policy framework, one immediate short-term step that could be taken is to remove the current wage bill restriction. The cap on the wage bill was shown to be one of the critical factors limiting the Ministry of Health efforts to recruit adequate personnel for the scale up of HIV/AIDS and TB services. In view of this, CSOs in collaboration with MPs, other national stakeholders and international advocacy partners need to advocate for the removal of wage bill ceilings by the Government. This will enable the Government the flexibility to employ additional personnel for the scaling up of health, HIV/AIDS and TB interventions.

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