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Country Report – Kenya

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National AIDS Control Council



Republic of Kenya

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Country report – Kenya

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Abbreviations

| | | | |
|--------|---|----------------------|--|
| AIDS | acquired immune deficiency syndrome | KNASP 2005/6–2009/10 | Kenya's National HIV and AIDS Strategic Plan |
| ANC | antenatal clinic | M&E | monitoring and evaluation |
| ART | antiretroviral treatment | MCG | Monitoring and Coordination Group |
| ARV | antiretroviral | MoH | Ministry of Health |
| BCC | behaviour change communication | MP | Member of Parliament |
| CACC | Constituency AIDS Control Committee | MSM | men who have sex with men |
| CBO | community-based organization | MTEF | medium-term expenditure framework |
| CCM | Country Coordinating Mechanism | NACC | National AIDS Control Council |
| COBPAR | Community-Based Programme HIV and AIDS Activities Reporting | NASCOP | National AIDS and STD Control Programme |
| CSO | civil society organization | NCPI | National Composite Policy Index |
| CSW | commercial sex worker | NGO | non-governmental organization |
| DASCO | District AIDS and STI Coordinator | OVC | orphans and vulnerable children |
| DfID | Department for International Development (UK) | PEP | post-exposure prophylaxis |
| DTC | district technical committee | PEPFAR | President's Emergency Plan for AIDS Relief |
| FBO | faith-based organization | PLWHA | people living with HIV and AIDS |
| FSW | female sex workers | PMTCT | prevention of mother-to-child transmission |
| GIPA | greater involvement of people living with HIV and AIDS | STI | sexually transmitted infection |
| HBC | home-based care | TSF | Technical Support Facility |
| HIV | human immunodeficiency virus | TWG | technical working group |
| ICC | Interagency Coordinating Committee | UNAIDS | United Nations Joint Programme on AIDS |
| IDU | injecting drug user | UNODC | United Nations Office on Drugs and Crime |
| IEC | information, education and communication | VCT | voluntary counselling and testing |
| JAPR | Joint HIV and AIDS Program Review | WSW | women who have sex with women |
| KAIS | Kenya AIDS Indicator Survey | | |
| KDHS | Kenya Demographic and Health Survey | | |

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The National AIDS Control Council acknowledges various development partners, stakeholders and individuals who took part in developing the Kenya UNGASS report. In particular, civil society and networks of most-at-risk populations played a crucial role in developing the report.

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- PEPFAR for supporting the consultant who drafted and edited the report.
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The following stakeholders who were involved in the development of the Kenya UNGASS report are acknowledged for having played a tremendous individual and collective role:

- NGOs, faith-based organizations, PLWHA, CSOs working with most-at-risk population members and networks, among others, are thanked for having taken part in preparing the Kenya UNGASS report; they helped identify best practices, the support needed from the development partners, major challenges and remedial actions that need to be undertaken in the country to improve HIV and AIDS response. In addition organizations are acknowledged for their continued support for various HIV and AIDS activities in the country.
- Various government ministries and departments are acknowledged for having identified the major challenges met in mainstreaming HIV and AIDS in the public sector.
- The UNAIDS M&E adviser and key staff from the Ministry of Health and the National AIDS Control Council are acknowledged for spending a significant amount of time to coordinate various aspects in preparing the report.
- The National AIDS Control Council would also like to acknowledge the part various consultants played in developing this report.

Status at a glance

Inclusiveness of stakeholders in writing the report

After the briefing meeting by the UNAIDS Global Office of the monitoring and evaluation field officers in August 2007, the National AIDS Control Council with assistance of the UNAIDS country office appointed three committees: the Oversight Committee, the Technical Committee, and the Civil Society and Most-at-Risk Engagement Committee.

The purpose was to oversee the development of inputs needed to prepare the country's progress report for UNGASS 2008 on the response towards HIV and AIDS.

The Oversight Committee

This committee was responsible for overseeing development of the UNGASS report. This included guiding the process and mobilizing the necessary resources. It is through this committee that support from Constella Futures, DfID, PEPFAR, the UNAIDS Technical Support Facility and NACC was mobilized.

The Technical Committee

The role of this committee was to address the technical aspect of the process including consideration of data sources, validating the collected data and determining if it was reliable to use in the report.

The Civil Society and Most-at-Risk Engagement Committee

This committee engaged the civil society and most-at-risk groups using the NCPI questionnaire. The three groups were the civil society group, men having sex with men (MSM), and female commercial sex workers (CSWs). The outputs of these engagement processes are included in the report.

Report development plan and support

The Oversight Committee mobilized resources to undertake writing of the report. The support received was as follows:

- Data collection and data analysis were supported by the National AIDS Control Council. The University of Nairobi Clinical Epidemiology Unit was appointed to undertake the exercise.
- Engagement of civil society organizations and most-at-risk groups was supported by DfID through Constella Futures; a consultant was appointed to undertake the exercise.
- Collection of data on AIDS spending was supported by the UNAIDS Technical Support Facility; consultants were appointed to undertake the exercise.
- Report writing, compilation and editing were supported by PEPFAR through the Health Policy Initiative; a consultant was identified to undertake the task.

The draft report was discussed in a wider stakeholder workshop, consisting of over 100 persons from government, civil society, and private organizations and networks of most-at-risk groups involved in HIV and AIDS response in Kenya.

Status of the epidemic

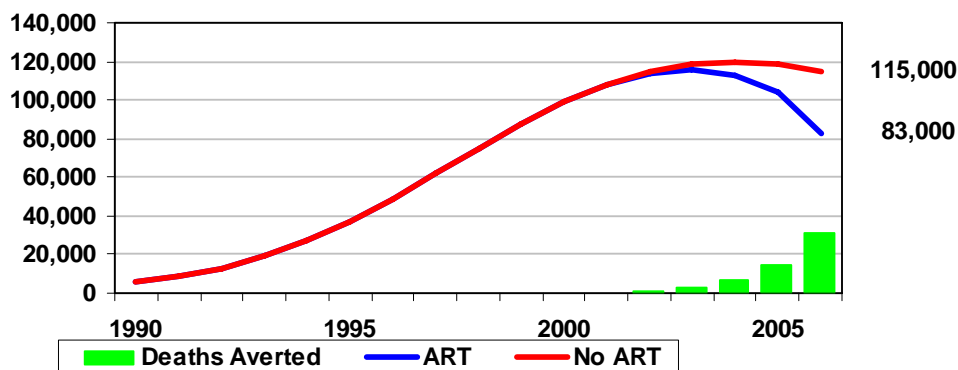
Kenya's HIV prevalence has halved in a decade—a dramatic and sustained decline that has rarely been seen in Africa. The most recent modelling of sentinel surveillance data indicates that prevalence stood at 5.1% among adults at the end of 2006 compared with 10% in 1997/98. This turnaround can be attributed to greater awareness and the resulting behaviour change as well as a lower incidence of new infections and higher death rates.

There is strong evidence to suggest that there has been a reduction in risky behaviour, such as through increased condom use, delay in sexual debut and fewer partners. VCT sites are more widely available so that a greater number of Kenyans now know their status. New adult infections peaked at 200,000 in 1993. The epidemic is now moving into the death phase, which means that the mortality rate has doubled since 1998 and exceeds the rate for new infections.

Given that there is better understanding that Kenya has a mixed epidemic, attention is being accorded to population groups that are particularly most at risk, which are perceived as drivers of the epidemic. These population groups include commercial sex workers, same-sex partners, injecting drug users, discordant couples, truckers, and cross-border mobile populations. In the past, baseline data on these groups has been insufficient or non-existent, thus posing a challenge to tailor intervention measures that are specific to these groups. Young women aged 15–24 form another group that is particularly most at risk. They are 5.5 times more likely to become infected with HIV than young men of the same age. Taking note of this glaring discrepancy, efforts are under way to undertake research to establish the reasons for this phenomenon.

The HIV and AIDS epidemic is changing with the introduction of free delivery of antiretroviral treatment (ART). Annual adult AIDS deaths peaked at 120,000 in 2003, reflecting the expanding number of new infections in the early 1990s. AIDS deaths would have remained at that level if it had not been for the rapid and expansive rollout of free antiretroviral treatment. By 2006, the annual AIDS mortality number had dropped to 85,000. This implies that ARVs have averted about 57,000 deaths since 2001 as illustrated in figure 1.

Figure 1. Number of deaths averted by expansion of the ART programme, 1990–2006.



The recent emphasis on treatment has overshadowed programmatic activity in prevention and is becoming costly. The demand for ARV is on the increase and up to this point delivery is almost entirely supported by development partners. Even then, the budget deficit for Kenya's ART rollout targets will exceed USD 75 million by 2010. This raises concerns about the long-term sustainability of ART. One of the measures that should be taken to close this gap is to increase health's share of the national budget to 15%.

There are other ongoing or emerging trends. Of the 1.1 million HIV-positive people, 18% are either children (0–15 years) or older adults (50+ years). Almost 55,000 men and women aged 50 or more have either survived earlier infection or become infected later in life. Infection is rapidly reversing the gains in child survival that had been won over past decades. The national under-5 mortality rate was 97 per 1000 in 1990 and rose to 120 per 1000 in 2007.

The policy and programmatic response

The Kenya National AIDS Strategic Plan 2005/6–2009/10 is evidence based and enjoys broad ownership. The National AIDS Control Council (NACC) has been strengthened to provide effective leadership in coordinating an ever-growing and more participatory number of stakeholders. These include people living with HIV and AIDS and the most-at-risk, the government, civil society, the faith-based community, the private sector and development partners. The programmatic focus has been to target communities and at-risk groups to ensure that HIV and AIDS interventions are effective.

Decentralization of NACC's structures and the annual Joint HIV and AIDS Programme Review process has enhanced the participation of all stakeholders at all levels. In 2008 development partners—DfID and the World Bank—have jointly committed to provide resources for prevention and mitigation activities to be carried out by community-based organizations as part of the Kenya Total War on AIDS (TOWA) project.

Strong political will and commitment at all levels to stemming the epidemic continues to be a hallmark of the fight against HIV and AIDS. Some of the factors that have undoubtedly contributed to Kenya's current status are the improved harmonization and leveraging of resources with and among development partners and Kenya's observance of the 'Three Ones' principle.

UNGASS Indicator Data

| Indicator | Sub-population | 2006 | | | | 2007 | | | | Remarks |
|--|------------------|---|-----------|-------------|-------|---|-----------|-------------|------|---|
| | | Source | Numerator | Denominator | % | Source | Numerator | Denominator | % | |
| 1. Domestic and international AIDS spending by categories and financing sources | | | | | | | | | | Data collection on-going |
| 2. National Composite Policy Index | | | | | | | | | | See appendix 2, 3 and 4 |
| 3. Percentage of donated blood units screened for HIV in a quality assured manner | | National Blood Transfusion Centres Reporting system | | | 100% | National Blood Transfusion Centres Reporting system | | | 100% | |
| 4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy. This indicator should be disaggregated by sex and age (<15, 15+) and percentages given for 2006 and 2007 to track annual trends in coverage | Male | Facility based reporting system | 38,150 | 128,000 | 30% | Facility based reporting system | 60,200 | 135,667 | 44% | |
| | Female | | 70,000 | 256,000 | 27% | | 111,800 | 271,333 | 41% | |
| | Children under 5 | | N/A | 23,000 | N/A | | N/A | 23,000 | N/A | The data collected is for children under 5 |
| | Total adults | | 109,000 | 407,000 | 27% | | 172,000 | 407,000 | 42% | |
| 5. Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission | | Facility based reporting system | 22,542 | 105,000 | 21.5% | Facility based reporting system | 26,429 | 50,824 | 52% | The denominator is based on the actual number of women tested during PMTCT. |

| Indicator | Sub-population | 2006 | | | | 2007 | | | | Remarks |
|--|----------------|---------------------------------------|-----------|-------------|-------|--------|-----------|-------------|---|---|
| | | Source | Numerator | Denominator | % | Source | Numerator | Denominator | % | |
| 6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV | | Global Tuberculosis Report - WHO 2007 | | | 16% | | | | | The reporting period for the data was 2005 |
| 7. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results (every 4–5 years) | women 15-19 | KDHS 2003 | 76 | 1,856 | 4.1% | | | | | New data expected in 2008 out of KAIS |
| | women 20-24 | | 157 | 1,691 | 9.3% | | | | | |
| | Women 25-49 | | 316 | 4,648 | 6.8% | | | | | |
| | men 15-19 | | 31 | 856 | 3.6% | | | | | |
| | men 20-24 | | 62 | 681 | 9.1% | | | | | |
| | men 25-49 | | 162 | 1,826 | 8.9% | | | | | |
| 8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results (every 2 years). Data for this indicator should be disaggregated by sex and age (<25, 25+) | Sex Workers | BSS 2002 | | | 35.0% | | | | | To check in BSS 2002 for numbers on sex workers |
| | MSMs | Onyango Auma et al. 2005 | 200 | 500 | 40.0% | | | | | |
| 9. Percentage of most-at-risk populations reached with HIV prevention programmes. Data collected for this indicator should be reported separately for each most-at-risk population and disaggregated by sex and age (<25, 25+) | < 25 | | | | | | | | | No data |
| | 25 + | | | | | | | | | |

| Indicator | Sub-population | 2006 | | | | 2007 | | | | Remarks |
|---|----------------|--------|-----------|-------------|---|--------|-----------|-------------|---|--|
| | | Source | Numerator | Denominator | % | Source | Numerator | Denominator | % | |
| 10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child (every 4–5 years)most-at-risk population and disaggregated by sex and age (<25, 25+) | | | | | | | | | | No new data - see previous UNGASS report |
| 11. Percentage of schools that provide life skills-based HIV education in the last academic year (every 2 years) | | | | | | | | | | No new data - see previous UNGASS report of 2006 |
| 12. Current school attendance among orphans and among non-orphans aged 10–14 years (every 4–5 years) | | | | | | | | | | No new data - see previous UNGASS report of 2006 |
| 13. Percentage of young women and men aged 15–24 years who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission | | | | | | | | | | No new data - see previous UNGASS report of 2006 |

| Indicator | Sub-population | 2006 | | | | 2007 | | | | Remarks |
|--|----------------|-----------|-----------|-------------|-------|--------|-----------|-------------|---|--|
| | | Source | Numerator | Denominator | % | Source | Numerator | Denominator | % | |
| 14. Percentage of most-at-risk populations who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | FSWs | BSS 2002 | | | 47% | | | | | Figures to be checked from BSS 2002 |
| 15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 (every 4–5 years) | | | | | | | | | | No new data - see previous UNGASS report of 2006 |
| 16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (every 4–5 years). Indicator should be presented as separate percentages for males and females and should be disaggregated by age groups 15–19, 20–24, 25–49 years | women 15-19 | KDHS 2003 | 28 | 1,856 | 1.5% | | | | | Based on KDHS 2003 |
| | women 20-24 | | 30 | 1,691 | 1.8% | | | | | |
| | Women 25-49 | | 86 | 4,648 | 1.8% | | | | | |
| | men 15-19 | | 62 | 856 | 7.3% | | | | | |
| | men 20-24 | | 112 | 681 | 16.4% | | | | | |
| | men 25-49 | | 220 | 1,826 | 12.0% | | | | | |

| Indicator | Sub-population | 2006 | | | | 2007 | | | | Remarks |
|---|----------------|--|-----------|-------------|-----|--------|-----------|-------------|---|--|
| | | Source | Numerator | Denominator | % | Source | Numerator | Denominator | % | |
| 17. Percentage of women and men aged 15–49 who had more than one partner in the past 12 months reporting using condom during their last sexual intercourse (every 4–5 years). Indicator should be presented as separate percentages for males and females and should be disaggregated by age groups 15–19, 20–24, 25–49 years | | KDHS 2003 | | | | | | | | To try an re-analyse data |
| 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client (every 2 years). Indicator should be disaggregated by sex and age (<25, 25+) | | University of Nairobi 2000 Female sex workers | | | | | | | | |
| 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (every 2 years). Indicator should be disaggregated by age (<25, 25+) | | Horizons report (2005) | 375 | 500 | 75% | | | | | This data was from a Nairobi study and the age groups were not categorised as per the guidelines |

| Indicator | Sub-population | 2006 | | | | 2007 | | | | Remarks |
|---|----------------|----------------------------|-----------|-------------|-------|----------------------------|-----------|-------------|------|---|
| | | Source | Numerator | Denominator | % | Source | Numerator | Denominator | % | |
| 20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse. Indicator scores are required for all respondents and should be disaggregated by sex and age (<25, 25+) | | | | | | | | | | |
| 21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected | | | | | | | | | | No data |
| 22. Percentage of young women and men aged 15–24 years who are HIV infected (annually). Indicator scores should be given for the whole age range (15–24 years) and disaggregated by 5-year age groups (i.e. 15–19 years, 20–24 years) | 15-19 | Sentinel Surveillance 2005 | | | 6.0% | Sentinel Surveillance 2006 | 122 | 2,447 | 5.0% | |
| | 20-24 | Sentinel Surveillance 2005 | | | 6.3% | Sentinel Surveillance 2006 | 284 | 4,588 | 6.2% | |
| 23. Percentage of most-at-risk populations who are HIV infected (annual) | IDUs | Ndetei, et al 2004 | 50 | 100 | 49.5% | | | | | This study was a skewed serological survey in Mombasa and Nairobi |

| Indicator | Sub-population | 2006 | | | | 2007 | | | | Remarks |
|--|----------------|---------------------|-----------|-------------|-------|------------------------------|-----------|-------------|-----|--|
| | | Source | Numerator | Denominator | % | Source | Numerator | Denominator | % | |
| | MSMs | Sanders, et al 2007 | 49 | 114 | 43.0% | | | | | |
| 24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (every 2 years) | | | | | | LSTICK Analysis Kenya (2007) | 1,268 | 1,453 | 87% | This study is based on patient records after 20 months on treatment, collected in 2007 |

Overview of the AIDS epidemic

Overall prevalence rates are falling. Mortality rates are double the rate of 1998 and exceed the rate of new infections that reduces prevalence as the epidemic moves into the death phase if adequate treatment services are not provided. VCT is more widely available and a greater proportion of Kenyans know their status. The scale-up of ART is on course, but as treatment needs continue to grow the demand for a cost-effective way of managing treatment on a larger scale becomes ever more critical. For this reason, Kenya requires predictable and sustainable HIV and AIDS financing.

There are many other challenges too. There are major differences in the risk of infection faced by different population groups. Young girls are 5.5 times as likely as young men their age to become infected. The negative partner in a discordant relationship is at particular risk. High-risk social groups such as commercial sex workers, those in same-sex relationships, injecting drug users and migrant workers have been neglected in programming, treatment and care. Affordable ARV treatment falls well below the benchmark while client adherence is all too frequently ill informed and irresponsible. The impact from the gathering cumulative AIDS deaths is gathering momentum. Orphans, vulnerable children, widows and the elderly suffer the most. The impoverished status of many of those affected exacerbates these circumstances.

Trends in prevalence

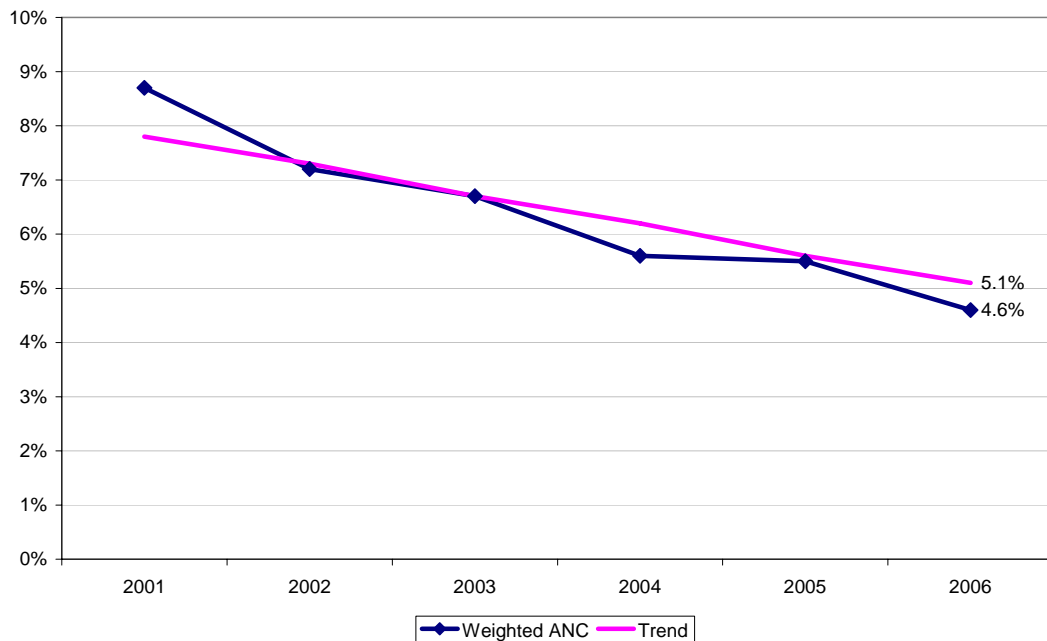
The epidemic in Kenya peaked in 1997/1998 with an overall HIV prevalence of around 10% in adults. The most recent sentinel surveillance evidence indicates that adult prevalence had declined to 5.1% by 2006. The current estimate of infection levels among urban residents is 8.3% while infection levels among rural residents is slightly less than half that at 4.0%. While rural prevalence rates are historically lower than urban prevalence rates, rural populations continue to trail behind urban ones in the pace at which infection rates drop.

The national estimate is based on sentinel surveillance data from 44 antenatal clinics and sexually transmitted infection (STI) clinic sites. The STI clinic clients reflect high-risk populations while pregnant mothers are representative of the general population even though the data only measure prevalence among younger women. The Kenya Demographic and Health Survey estimated prevalence in the general population for the first time in 2003 by comparing prevalence of recently pregnant women with that of the general population.

At some sites data span 17 years. At sites added in 2001, data have been available for only six years. Epidemic curves are fit to the data from each using the Estimation and Projection Package (EPP) developed by the UNAIDS Reference Group on Estimates, Models and Projections. Almost all the 24 sites with eight years or more of data show clear signs of declining prevalence. As a result, the starting assumption was that prevalence is declining. Two sites were chosen from each district—one to represent the urban population and one for the rural population.

The continuing decline in HIV incidence and prevalence is at least partially due to awareness and behavioural change. Significant numbers of Kenyans have adhered to safer sexual behaviour during this millennium decade (fig. 2).

Figure 2. Estimated HIV prevalence and its range in Kenya among adults (1980–2006).

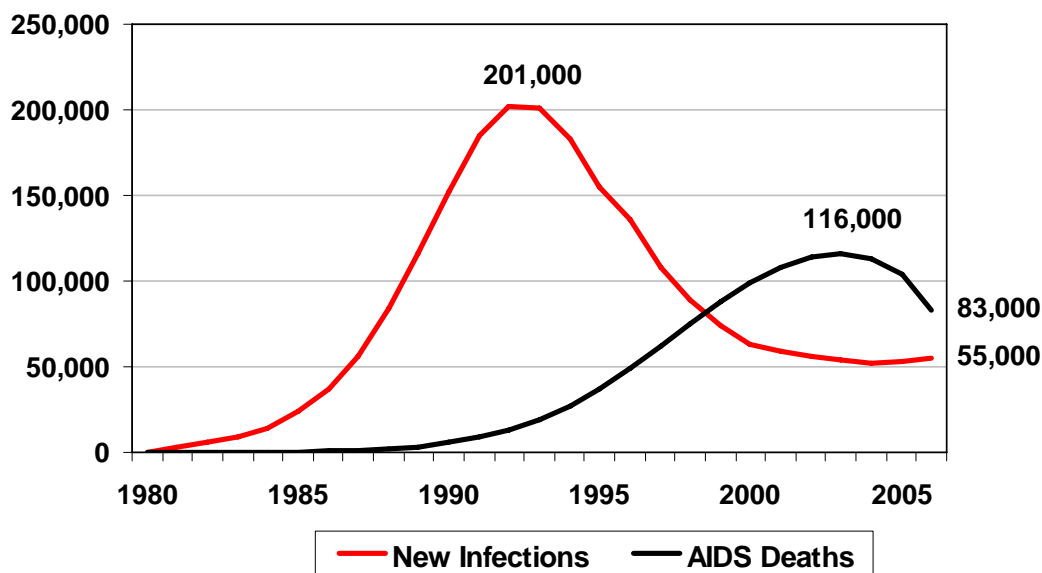


Trends in the 15–49 age group provide the international standard for measuring the burden of HIV infection. However, an increasing proportion of those who are infected with HIV fall outside the adult age span of 15–49 years. Of 1.1 million positive people, 18% are either children or older adults. An increasing number of men and women over 50 are not only surviving HIV infection but are becoming infected in later life. There are almost 55,000 people in this age bracket who are living with HIV. There are also 102,000 children who have been infected, almost invariably through mother-to-child transmission. In 2006 19,000 children between 0 and 14 years were newly infected.

Prevention-of-mother-to-child transmission (PMTCT) programmes greatly reduce infection among new-borns. These programmes provide counselling and testing for pregnant women and treatment for those who are HIV positive. Each year there are 1.5 million women who need this programme. In 2006 about 637,000 were actually counselled and tested. About 57,800 of these women were HIV positive although only 39% of them were treated with Nevirapine. During the first two quarters of 2007 the uptake of Nevirapine among HIV positive pregnant women was nearly 52%.

A model created with SPECTRUM software estimates that new adult infections peaked at 200,000 in 1993. In 2006 there were approximately 55,000 new adult infections in as compared with 90,000 in 2004. Annual adult AIDS deaths peaked at 120,000 in 2003, reflecting the rise in infection during the mid-1990s. AIDS deaths would have remained at that level if it had not been for the expanding delivery of antiretroviral drugs. In 2006, these drugs had cut the annual AIDS mortality rate to 85,000. This implies that antiretroviral programmes have averted about 57,000 deaths since 2001 (fig. 3).

Figure 3. New adult HIV infections and AIDS deaths, 1980–2006.



The epidemic in Kenya continues to rapidly reverse the significant gains in child survival that had been achieved over the decades. HIV infection has increased child mortality despite the availability of cotrimoxazole and ART. The national under-5 mortality rate was 97 per 1000 in 1990. This had risen to 121 per 1000 by 2006 (UNICEF 2007, State of the world children 2007).

HIV prevalence and most-at-risk populations

Kenya was previously categorized as a country with a generalized epidemic. This resulted in little attention being given to collecting data on HIV prevalence and behavioural indicators among the most-at-risk groups such as IDUs, MSM, truck drivers, CSWs and youth.

Limited data indicate that the high prevalence in some of these groups confirms that the epidemic pattern in Kenya indeed is concentrated in them.

Kenya is preparing to model modes of transmission that it will use in the mid-term review of the HIV and AIDS strategic plan.

Socio-economic impact

Kenya is a low-income country with a per capita gross domestic product (GDP) of USD 21,186 millions in 2006 (World development indicators database, World Bank 1 July 2007). Approximately 80% of its 37.2 million people (revised population projection for Kenya 2000–2020, Central Bureau of Statistics, August 2006) live in rural areas and subsist almost entirely on agricultural production. The epidemic threatens Kenya's long-term ability to provide the infrastructure and services essential for robust economic growth. There should be investment to expand the response to HIV and AIDS in all sectors to avert this scenario. The KNASP 2005/6–2009/10 highlights socio-economic impact as a key area for intervention.

Research across many severely affected low-income countries clearly demonstrates that HIV and AIDS constitute the most serious impediment to their economic growth and development. There is no reason to expect Kenya to be an exception. Sector reviews suggest that HIV and AIDS undermine all sectors of the economy and the quality of life for most of society. The epidemic has deepened poverty among the already impoverished and has stunted national development (Sector Impact Studies, Futures Group Europe/DFID 2004).

The majority of Kenyans rely on the agricultural sector for their livelihood, from subsistence farming through to cash crop foreign exchange earners. It has been set back by the negative impact on labour supply. Loss of labour due to illness and caring for sick family members has resulted in delays in agricultural production, land being left fallow, changing crop mix and dependence of labour sharing (*NACC 2006b*). Commercial agriculture, a major source of foreign exchange earnings and of employment, has been affected by rising health costs and the protracted morbidity of workers (*NACC 2005a*).

Areas where traditionally food production has been high have recently experienced major shortfalls, even with favourable weather conditions (Impact of HIV/AIDS on Labour Productivity in Kenya, Tropical Medicine and International Health, March 2004). Over 70% of the people work in the informal sector and are more likely to be affected than those in the employed sector where health and other benefits allay the costs of HIV and AIDS treatment. This is not the case for the self-employed, whose asset base can be quickly eroded. A 2006 report states that 79% of all affected household heads in the informal sector had an annual income of less than KES 15,000 a year (*NACC 2006b*).

The epidemic has particularly affected education. The increase in morbidity and mortality among teachers and education officials has caused a decline in educational quality. With the introduction of free primary education in 2003, schools have more orphans and other students than teachers can cope with, further compromising the quality. Gender disparities in education have also emerged. Girl children, rather than boys, are expected to stay at home to care for parents or other relatives dying from AIDS-related illnesses or to work on the farm. Children, particularly younger ones, from affected households are more likely to drop out of school (36%) because of education-related costs than children from unaffected households (25%) (*NACC 2006*).

A well-developed human resource base has been one of Kenya's economic mainstays but there has been a striking effect from the pandemic on the labour force. This is caused by absenteeism, frequent sick leave and funeral attendance. Funerals play an important role in Kenyan culture. Given the long distances that people travel to find work, attending a funeral can take a week, and funerals are occurring increasingly frequently. This marked detrimental effect from HIV and AIDS on the workforce and productivity has led to low profit margins and in some cases has caused businesses to close (*MoH 2005a*).

Orphans and vulnerable children

Currently, it is estimated that there are 2.4 million orphans in Kenya. Half are orphans caused by the AIDS pandemic (table 1).

Table 1. Estimated number of orphans by type

| | |
|-------------------------|-----------|
| Maternal orphans | 1,282,000 |
| AIDS | 692,000 |
| Non-AIDS | 590,000 |
| Paternal orphans | 1,591,000 |
| AIDS | 750,000 |
| Non-AIDS | 841,000 |
| Double orphans | 443,000 |
| AIDS | 349,000 |
| Non-AIDS | 94,000 |
| Total orphans | 2,430,000 |
| All AIDS orphans | 1,149,000 |

Source: National AIDS Control Council and the National AIDS and STI Control Programme, epidemic review report, Nairobi, Kenya, June 2007

National response to the AIDS epidemic

Leadership and coordination

In 2002 Kenya declared 'Total War on AIDS' (TOWA). This is reflected in Kenya's second National HIV and AIDS Strategic Plan (KNASP 2005/6–2009/10), which runs from 2005/6 to 2009/10. KNASP 2005/6–2009/10 is the template for the national response to HIV and AIDS. Its guidelines are an action framework within which public and private sectors, civil society organizations (CSOs) and faith-based organizations (FBOs) can work in accord to achieve the same set of goals and targets. KNASP 2005/6–2009/10 underscores the ongoing political commitment to containing the AIDS epidemic and mitigating its effects on Kenyans.

To ensure the long-term sustainability of HIV and AIDS programmes, the Kenyan government tied the implementation of KNASP 2005/6–2009/10 to the government budgetary cycle. This enabled ministries to commit and disburse a part of their budgets to HIV and AIDS programmes itemized in the KNASP 2005/6–2009/10 results framework. KNASP 2005/6–2009/10 has a financial framework developed by the main stakeholders rather than a detailed budget of its own.

The current KNASP 2005/6–2009/10 identifies the priorities in responding to the HIV and AIDS epidemic: preventing new infections, improving the quality of life for infected and affected people (care, treatment and human rights) and mitigating the socio-economic impact of HIV and AIDS with M&E and other support services. It has already surpassed its target of reducing HIV prevalence to less than 5.5% before the end of the plan period.

Kenya has enjoyed considerable progress since the last reporting period. Overall prevalence rates are falling. VCT is more widely available and a greater proportion of Kenyans know their status. The scale-up of ART has been rapid and is on course. Even so, enormous challenges lie ahead.

There are stark differences in the risk of infection faced by different population groups. Young girls are 5.5 times more likely than young men their age to become infected even though young men tend to be more sexually active. The negative partner in a discordant relationship is at particular risk. High-risk groups such as sex workers, those in same-sex relationships, injecting drug users and migrant workers have been neglected. Comprehensive ARV treatment is a financial challenge for many because of the cost of transport, supplementary foods and laboratory fees. Thus client adherence is frequently constrained by poverty and also insufficient information. Impact from the cumulative AIDS deaths is on the rise. Orphans, vulnerable children, widows and the elderly suffer the most. The impoverished status of many of those affected exacerbates the situation.

Kenya operates on the '**Three Ones**' principle agreed by African nations at the 2003 International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA):

- One national AIDS coordinating authority with a broad-based multi-sectoral mandate
- One AIDS action framework to coordinate the work of all partners
- One national monitoring and evaluation system

One national AIDS coordinating authority

Since 1999 the National AIDS Control Council (NACC) operates under of the Office of the President with Cabinet Subcommittee on AIDS being the oversight body. The NACC board consists of permanent secretaries drawn from a range of ministries as well as representatives from wide range of civil society organizations, people living with HIV and AIDS (PLWHA) groups and the private sector.

NACC coordinates all Kenyan programmes, policy and interventions in the AIDS sector. It is able to influence stakeholders in various ways, depending on their position in the complex firmament of government ranking, civil society, partnership with external agencies and the corporate world. For instance, NACC encourages civil society to assume a greater role in the delivery of services and programmes.

In 2003 NACC devolved to the grassroots with the introduction of Constituency AIDS Control Committees (CACCs). There is now a CACC in each of Kenya's 210 constituencies and nearly all (95%) are meeting their targets (NACC JAPR 2007). This organizational restructuring is a critical improvement as it enables the national response to attune to experience on the ground. CACCs invite broad-based community participation and encourage the involvement of the local Member of Parliament. This arrangement gives rise to opportunities for liaison with local government to ensure that interventions are being implemented, particularly in rural communities.

In 2008 NACC will begin disbursing World Bank and DfID funds to community-based organizations (CBOs) for prevention and mitigation interventions as part of the government's Total War on AIDS (TOWA). Previously, funds were disbursed to CACCs through the Kenya HIV and AIDS Disaster Response Project (KHADREP). TOWA has benefited from the lessons learned to improve accountability, to target the groups driving the epidemic and to institute internal reorganization.

Responsibility for policy and strategy development and oversight falls to NACC's Policy and Strategy Department and its Coordination and Support Department. Government, international partners and agencies, civil society and the private sector influence strategy and policy through the Interagency Coordinating Committee for HIV and AIDS (ICC-AIDS), the Joint Interagency Coordinating Committee (JICC) and the Country Coordinating Mechanism (CCM). ICC-AIDS is the primary forum for convening stakeholders to deliberate on the national response to AIDS. It presents decisions on Global Fund issues at the CCM.

NACC convenes the Joint HIV and AIDS Programme Review (JAPR) annually so that stakeholders can assess achievements, shortfalls, challenges and emerging issues. It is an excellent forum for monitoring HIV and AIDS activities and for reviewing the extent to which KNASP 2005/6–2009/10 has been implemented by using the results framework. JAPR then resolves a plan of action and agrees on a lead agency to implement recommendations.

JAPR has been meeting since 2002. In 2006 NACC began a decentralization process that devolved discussion on the epidemic to Kenya's 9 regions and 38 of its 71 districts. In 2007 devolution was complete. Kenyans nationwide were able to voice the challenges, gaps and priority issues in their communities. District JAPRs hosted delegates drawn from CACCs, District Technical Committees (DTCs), local government, the private sector and civil society organizations including those serving people with special needs. Representatives from government ministries, local government, development partners and civil society developed provincial KNASP 2005/6–2009/10 Results Frameworks through a participatory process. The national JAPR also produces a KNASP 2005/6–2009/10 Results Framework that covers achievements, shortfalls, emerging issues, lessons learned, programmatic challenges, and priorities for the following year and a time frame. The 2007 national meeting resolved to reinforce the decentralized system and harmonized stakeholder programmes. It was also agreed to align the JAPR process with district and national priorities and planning and with the medium-term expenditure framework (MTEF).

NACC was included in the government's annual public expenditure review for the first time in 2005. During 2006 and 2007 NACC and other stakeholders were involved in the budgetary and the MTEF processes. NACC contributed to the Budget Outlook Paper 2006/7 and sat in sector working groups. As a result, all key ministries now have funding for HIV and AIDS activities.

The civil society perspective

The inclusion of CSOs in AIDS policy, planning and programming has improved. CSOs believe overall that they are well represented in the sector dealing with AIDS and they make a meaningful contribution to political commitment and policy formulation. However, nearly half of those questioned said that they were excluded from the government's budgetary and planning processes and that their provision of services for HIV and AIDS had been excluded from KNASP 2005/6–2009/10. Nearly all felt they were under-funded and half complained of inadequate technical support. Nevertheless, this rating is an improvement on 2005 when the respondents answered the same questions.

Source: NACC 2007a, Consultative meeting with wider civil society organizations

One AIDS action framework

KNASP 2005/6–2009/10 has its genesis in the 2004 JAPR. It is the product of a highly consultative process led by NACC. As a result there is a strong sense of ownership among government, civil society, UN agencies, development organizations and the corporate sector. This serves to make it more effective than its predecessors.

The institutional arrangements for implementing KNASP 2005/6–2009/10 reflect its multi-sectoral nature. No single agency has overall responsibility for implementation. Thus it is essential to have strong coordination mechanisms so that stakeholders can achieve the KNASP 2005/6–2009/10 targets and objectives. The national coordination of KNASP 2005/6–2009/10 is one of NACC's core functions (*NACC 2005a, KNASP 2005/6–2009/10*).

KNASP 2005/6–2009/10 core principles

- multi-sectoral approach to promoting advocacy, building strategic partnerships and mainstreaming HIV and AIDS into key sectors of the economy
- interventions targeted at groups vulnerable to HIV infection and its consequences
- recognition of the special needs of women and youth
- maximum engagement of people living with HIV and AIDS in implementing the strategy
- inclusion of all stakeholders in an effective participation in the national response
- interventions that are evidence based and culturally specific
- support for international and regional initiatives

KNASP 2005/6–2009/10 organizational achievements

- Clear link between priorities, resource flows and outcomes
- Efficient allocation of resources across the spectrum of national response
- Inclusion of all partners in joint reviews to assess progress
- External support agencies committed to national coordination
- HIV and AIDS linked to poverty reduction and development
- Inclusion of civil society and the private sector in service delivery

The civil society perspective

An assessment of CBO capacity to implement HIV and AIDS programs has been conducted.

The grassroots distribution of explanatory material for Kenya's national strategy for HIV and AIDS is virtually nonexistent. The best media for doing this would be radio, newspapers, *barazas* (meetings), schools and posters in national and vernacular languages.

There is also a dearth of civil society national and regional forums where the public can share information network and build partnerships. These forums should be

officially recognized. National umbrella organizations have been created that in theory could act as information conduits between grassroots communities and government and donors. However, they are under funded and have low capacity, which means that their potential has not been realized.

Currently NACC has recruited an officer for civil society engagement as was recommended in the UNGASS report of 2006.

There is a Monitoring and Coordination Group (MCG) for each of the three priority areas—Prevention, Improvement of Quality of Life, and Mitigation of the Socio-economic Impacts and for KNASP 2005/6–2009/10 support services such as research, M&E, financing and procurement, communication, coordination and networking, and institutional capacity building. MCG membership is drawn from the key implementing agencies in that specific area and from other strategic partners. MCGs monitor progress against the yardstick of the results framework in conjunction with M&E reports and reports from MCG members. MCGs help stakeholders to overcome implementation delays and, if necessary, make recommendations for policy action to the ICC. MCGs are pivotal in preparing for the annual JAPR through reporting on and revising their respective sections of the KNASP 2005/6–2009/10 Results Framework (*NACC 2005a, KNASP 2005/6–2009/10*).

During this reporting period HIV and AIDS was integrated into the National Development Plan and the UN Development Assistance Framework (UNDAF) 2004–8 and the Economic Recovery Strategy (Kenya's poverty reduction strategy). Both documents to some extent address gender and income inequalities in the context of HIV and AIDS prevention and care. However, there should be more thoughtful links between these documents and KNASP 2005/6–2009/10 objectives.

One national monitoring and evaluation system

NACC is the coordinating authority for Kenya's national HIV and AIDS M&E framework. With 13 performance and effectiveness subsystems,¹ it is regarded as the template for reporting requirements. The M&E framework's objective is to improve the implementation of KNASP 2005/6–2009/10 and to provide evidence-based data that can inform national decision making and policy development. The 13 data sources are all functional with their respective indicators identified in the framework, but they are at different levels of performance and coverage. It is currently being strengthened to provide quality data and feedback on the national response.

The M&E framework was recommended for revision during the JAPR meeting of 2006. It has been revised to take in the JAPR recommendations, and inputs obtained during revision have been prepared to use during the mid-term review of the KNASP 2005/6–2009/10.

NACC's M&E unit comes under the Policy, Strategy and Communication Department. It is responsible for coordinating all HIV and AIDS M&E initiatives in Kenya with input from the Monitoring and Coordinating Group for Coordination and

¹ 1) monthly programme activity reports, 2) quarterly programme reports, 3) financial management reports, 4) Kenya Service Provision Survey, 5) National Blood Transfusion Centres report, 6) National Leprosy and Tuberculosis Control report, 7) health information system, Ministry of Health, 8) DIS+ survey, Central Bureau of Statistics, 9) Sentinel Surveillance, 10) Behavioural Sexual Surveillance, 11) lot quality assurance sampling, 12) incidence studies, 13) demographic surveillance surveys

Support as outlined in KNASP 2005/6–2009/10. NACC’s annual M&E report summarizes progress on indicators including trends in national HIV prevalence. It also produces national reports that mark progress in implementing KNASP 2005/6–2009/10. M&E was included in the national strategy for the first time in the current KNASP 2005/6–2009/10.

Monitoring HIV prevalence and impact is done through 44 antenatal clinics (ANCs) on women making their first visit for their current pregnancy. Population-based household studies such as KDHS 2003 and KAIS 2007 provide the actual estimate on prevalence in the general population plus demographic and socio-economic characteristics. Based on sentinel surveillance and a population-based survey in 2003, a statistical calibration model was developed to extrapolate annual sentinel surveillance data to the general population. In 2006 and 2007 NACC and national and international technical partners statistically calibrated surveillance data on the general population. The general population survey will be updated through the recently launched Kenya AIDS Indicator Survey (KAIS) and the KDHS 2008.

Only Kenya and South Africa have conducted annual surveillance at consistent sites since 1990

It is recognized that the M&E system can be improved. There should be an in-depth analysis of why the prevalence rate is dropping. Data from VCT sites are not being used even though behaviour change communication (BCC) programmes are almost entirely evidence based.

The Community-based Program Activity Reporting (COBPAP) tool was introduced following decentralization and the establishment of CACCs. However, it is facing problems because of poor M&E infrastructure in the rural areas and low awareness of the importance of M&E as a strategic weapon in the war against AIDS. M&E databanks are lacking at the decentralized levels. At lower decentralized levels, data management is manual due to inadequate information technology infrastructure. CACCs should be equipped with computers and a link to the NACC LAN for efficient communication with national headquarters. M&E staff must be trained on the internet so they can download reporting forms. CSOs and larger implementing agencies are needed to support the efforts of COBPAP rollout and efficient operationalisation for completeness of data.

Prevention

The KNASP 2005/6–2009/10 guidelines for prevention are sexual abstinence, delayed sexual debut, prevention of mother-to-child transmission, blood safety, injection safety, male circumcision, and post-exposure prophylaxis (PEP), consistent condom use, reduction in number of sex partners, and knowledge of HIV status. National consensus is that a full scale-up of prevention strategies should be a priority to offset the escalating costs for treatment.

Counselling and testing

Over the past seven years, and especially during the current reporting period, there has been a substantial increase in the number of people who go for testing. The cumulative number has grown from a thousand in 2000 to more than 2 million in 2007. This has largely been due to expansion of CT services. For example, the number

of VCT sites increased from 3 in 2000 to almost 1000 in 2007. The KNASP 2005/6–2009/10 target for 2010 is at least 2 million people tested annually, comprising 500,000 at VCT sites and 1.5 million in clinical testing to include pregnant women. CT strategies include PITC, VCT, mobile CT, moonlight CT, camelback CT, door-to-door CT, and PCR and early child diagnosis.

In 2008, 95% of TB patients will be tested and all those who are positive will be put on ART. Conversely, 50% of people living with HIV and AIDS (PLWHA) will be screened for TB.

Despite this performance, the figure for uptake is low compared with the eligible population for universal access. For instance, only 760,000 of men and women aged 15–49 were tested in 2006 (NACC M&E report 2006). This means that most Kenyans still do not know their status or that of their spouse or sexual partner.

Most VCT sites do not address the special needs for people with disability. There are also issues whether the VCTs adequately cater for the changing profile of the epidemic. The distribution of sites is skewed—60% of sites are urban or peri-urban. Mobile sites for remote rural areas are being promoted. Home-based testing, door-to-door and public event (*baraza*) testing have been introduced as well (NACC JAPR 2007).

Quality assurance, training for government counsellors and data-capturing systems all need improvement. For instance, the effect of VCT on behaviour change has not yet been established. There are no reports on the uptake of VCT by at-risk groups such as migrant workers and commercial sex workers (CSWs) due to lack of adequately disaggregated data and inconsistency in data collection. NACC intends to conduct surveys in 2008 to establish the role of VCT in prevention of new infections.

The target for the KNASP 2005/6–2009/10 is for at least 50% of CSWs and 25% of their clients to know their status. Targets for some of the other at-risk groups are a 75% testing rate for the uniformed services and for prisoners and at least 50% for migrant workers. However, determining the definition and extent of CSWs and some other most-at-risk groups is still a challenge.

Prevention of mother-to-child transmission

PMTCT services were introduced in Kenya on a pilot basis in 2000. Since then services have expanded considerably. The KNASP 2005/6–2009/10 target of introducing PMTCT to 80% of facilities offering antenatal care by 2007 has been met. Over 1,000 ANC sites now offer PMTCT. Another 2100 sites are planned. The standard regimen for PMTCT now includes introducing women to follow-on HIV care and treatment and supplementary infant feeding.

The total number of pregnant women in need of counselling and testing each year is almost 1.5 million. In 2006, 42% (up from 28% in 2005) of this number were counselled and tested; 57,800 of these women were HIV positive and only 39% were treated with Nevirapine. During the first two quarters of 2007 the uptake of Nevirapine among HIV-positive pregnant women was nearly 52% [*figures provided by NASCOP*].

PMTCT is available at all health facilities that have a laboratory. The current KNASP 2005/6–2009/10 target is to train 50% of the health workers in every public health

facility in PMTCT. To date, 10,000 out of 30,000 government health workers have been trained. Another challenge is to feed PMTCT data into M&E frameworks, including the national M&E system. Currently the reporting rate is only 50%.

Male circumcision

A randomized control trial on male circumcision and HIV transmission was conducted among 2784 men aged 18–24 years. The trial showed that the protective effect was 60% and reinforced recent findings that circumcision of young African men considerably reduces the risk of HIV infection. To this end, voluntary and affordable circumcision services must be integrated with other interventions as a matter of urgency (Bailey et al. 2007).

Circumcision among Kenyan men stands at 84% (KDHS 2003).

The civil society perspective

Cultural practices must be taken into account when policy documents are being developed. The reality is that there is a tendency to impose recommendations without considering local traditions and culture. For example, traditional birth attendants play a big role in traditional communities but are excluded from PMTCT. In this regard, CSOs are well informed and should be consulted on policy formulation. African circumstances and cultures must be acknowledged, understood and then written into donor conditionality. Application forms for grants are lengthy and complex and are not designed within an African context. This deters launching important initiatives.

Blood safety

In 2006, 80% of blood demand was met. The National Blood Transfusion Service has led the transition from a hospital-based transfusion system to a national one. Hospitals receive screened blood from a provincial health facility. Progress is being made towards national coverage through a network six regional blood banks and satellite transfusion centres using properly screened blood but to date not all regions have a blood bank.

Blood safety is recognized as a national public health priority as outlined in *Policy guidelines on blood transfusion 2001*. It stipulates that all donated blood be screened. Only units with no infections transmissible by transfusion may be used. Kenya policy is to screen out HIV, hepatitis B and C and syphilis. Because screening methods are highly sensitive, it is extremely unlikely that any infectious agent will be overlooked. All blood units that test positive are discarded. The percentage of blood units screened for HIV is equal to 100% (Nganda et al. 2001).

Condom promotion

One of Kenya's prevention messages is to use condoms in a consistent manner. However, condom shortages have been reported throughout the country (NACC 2007c). The national condom strategy is being revised to give attention to distribution to youth in tertiary education institutions; to promote the female condom; to ensure that distribution is demand driven; and to make condoms more easily accessible (NACC JAPR 2007).

Progress has been made in increasing the use of male condoms and in making them more readily available. However, several hurdles must be overcome to expand condom use. Kenya's condom procurement procedure must be streamlined to eliminate stock-outs. In 2007 the majority of provinces reported that male condoms were consistently in short supply (*NACC 2007c, Report of the provincial/regional harmonization workshop*). In addition, condom dispensers are placed in public areas such as chiefs' camps, which discourages uptake by youth and at-risk groups (*NACC 2007a, Consultative meeting with wider civil society organizations*).

Uptake of female condoms is extremely low, because they are expensive, hard to find and viewed with suspicion by both men and women—300,000 female condoms were distributed in 2005 but only 18,000 in 2006 (*NASCOP data*).

The KNASP 2005/6–2009/10 target of 160 million condoms distributed annually by 2010 is on course. Condom distribution has grown from 10 million in 2004 to 144 million in 2006 and 84 million for the first half of 2007 (*NASCOP data*). Social marketing plays an important role in increasing demand for male condoms and for their use, and the media have reduced the stigma once associated with them. A behaviour change campaign on generic condom efficacy has increased Kenyans' faith in the effectiveness of condoms in preventing disease by 80%.

Treatment of sexually transmitted infections

There has been sentinel surveillance of patients with sexually transmitted infections (STIs) since 1990. HIV prevalence among STI patients has declined almost without interruption since 2000. In 2006, 19.1% of patients were HIV positive compared with 21.5% in 2005. There was a decline in prevalence among all age groups in 2006 with the exception of the 35–44 age group, in which prevalence from 2002 to 2006 has risen from 25.6% to 29%. By comparison, prevalence in the 25–34 age group has declined from 30.4% to 21.7% over the same period. There has also been a drop in the prevalence of STIs, which is due to increased awareness of the link to HIV, free treatment and greater condom use (*NASCOP data*).

The National AIDS and STD Control Programme (NASCOP) provides all public health facilities with flow charts, guidelines and training protocols for managing STIs. The Ministry of Health also provides standard drug kits for managing common STI syndromes. A KNASP 2005/6–2009/10 target is for 40% of STI units to provide counselling and referrals to a VCT site. This service is available in all health centres and high-volume dispensaries.

Knowledge and behaviour change

Kenya established a national BCC consortium in 2005 and is now forming regional BCC consortiums, initially in at least four provinces. This will help to harmonize interventions nationwide. A BCC strategy for youth is in the final stages of development. This will be followed by strategies for other at-risk groups such as discordant couples, CSWs and their clients, young girls, injecting drug users (IDUs) and men who have sex with men (MSM) (*NACC JAPR 2007*).

Nearly all (90%) BCC programmes are evidence based, which is why there are efforts to continually improve M&E reporting, particularly among non-governmental organizations (NGOs) and CBOs.

Knowledge of HIV and AIDS and its transmission

Nationwide the level of HIV and AIDS awareness is high (98%) (KDHS 2003). Yet despite this, discrimination and stigma continue to confound planners and implementers. Stigma reduction messages are woven into strategic BCC messages. A national anti-stigma campaign is planned for 2008. In its implementation, the campaign will involve religious leaders.

In 2003, 47% of men and 34% of women aged 15–24 who were surveyed correctly described the ways HIV infection is spread and rejected popular misconceptions about transmission (*KDHS 2003*). In-school youth are more likely to know about transmission and prevention and the difference between HIV and AIDS than out-of-school youth. By 2005, 60% of schools had life-skills education in the curriculum. This broke down as just over 60% of primary schools and 50% of secondary schools (*Kenya UNGASS 2006*).

Sexual behaviour

There is a paucity of M&E data regarding BCC. This situation must be corrected urgently, given that a major driver for the drop in prevalence rates is greater awareness and more responsible behaviour. A 2003 survey among people aged 15–24 showed that nearly 14% of the women said their sexual debut was before the age of 15 while for the men it was nearly 30%. Another 30% of the women had had more than one sexual partner in the last 12 months while among the men it was 84% (*KDHS 2003*). The risk of infection when there is an early onset of sexual activity is extraordinarily high for young girls. Not only are they anatomically vulnerable, but they commonly have sex with older men, some of whom are positive. There is an overall indication of a slight decline in prevalence among young girls although it is still very high compared with their male counterparts and the general population.

There continues to be room for improvement in the use of condoms among all targeted groups. In 2006, 24% of women and 46% of men aged 15–24 who had had sex with more than one partner in the previous 12 months reported using a condom in their last sexual encounter. These figures have remained the same since 2003. Sex with casual partners or sex workers without a condom is prevalent. Out-of-school youth in particular tend to engage in early and risky sex. High-risk groups have the lowest rating for condom use. For instance, only 17% of CSWs use condoms (see www.unaids.org). However, a study conducted in Mombasa among men who have sex with men (MSM) showed that 28% consistently used a condom with regular partners and 39% with casual partners (Sanders et al. 2007) with only 2.2% for MSM and 17% for CSWs.

Two of KNASP 2005/6–2009/10's core principles are targeting the most vulnerable groups for interventions and including all Kenyans in a national response to the AIDS epidemic. In the past, meaningful engagement with all vulnerable groups has fallen short. A special survey targeting vulnerable groups has been commissioned to provide insights into what drives the epidemic.

The current reporting period has paid considerable attention to high-risk groups such as same-sex partners, injecting drug users and commercial sex workers. Due to the stigma attached to same-sex relationships, these groups were largely ignored and data on them were scarce. These groups have been further excluded because of the criminalization of their activities (homosexuality, commercial sex and drug use).

IDUs commonly inject with shared, dirty needles because their drug use is by necessity clandestine—70% of injecting drug users tested positive for hepatitis C and 34% for HIV. A United Nations Office on Drugs and Crime (*Ndetei 2004*) survey estimated Kenya has 12,000 heroin users although less than 10% are likely to become injecting users (Deveau et al. 2006). There is an urgent need for interventions and services specifically targeted at these groups, whose numbers are far higher than previously thought. It is estimated that there are 60,000 or more CSWs in Nairobi (*NACC 2007c*).

A 2007 study of MSM in Mombasa showed HIV prevalence of 43% among men who had sex with men exclusively and 12.3% among men who had sex with both men and women. Among those who had been sexually active in the previous week, 44% said they did not use condoms with casual partners. Over a three-month period, 74% said they had paid for sex. Nearly all (93%) of clients in transactional sex were local residents rather than tourists, as had previously been assumed (*Sanders et al. 2007*).

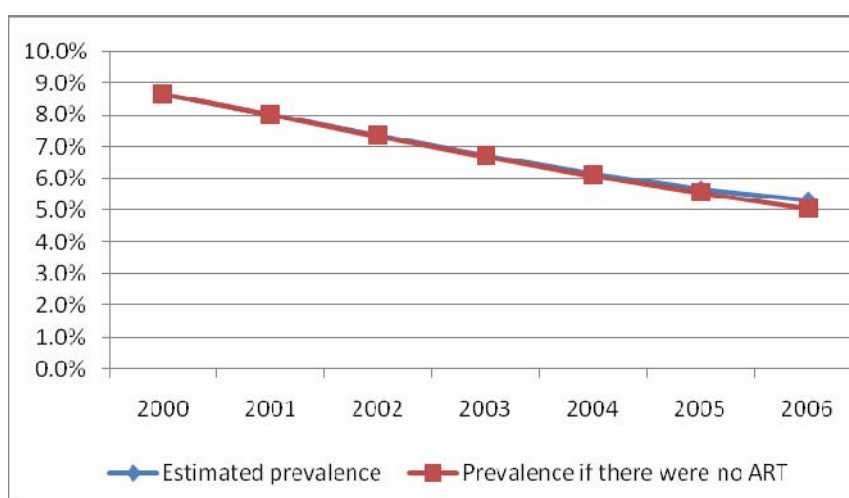
Discordant couples are another high-risk group on which a paucity of data has been collected. There are about 750,000 couples living with HIV in Kenya of whom 450,000 are discordant. In Nairobi, 10% of couples who visit VCT sites are discordant. Retention rates after disclosure are estimated to be more than 90%.

Improving quality of life of those infected and affected: care, treatment and protection of human rights

Care and treatment

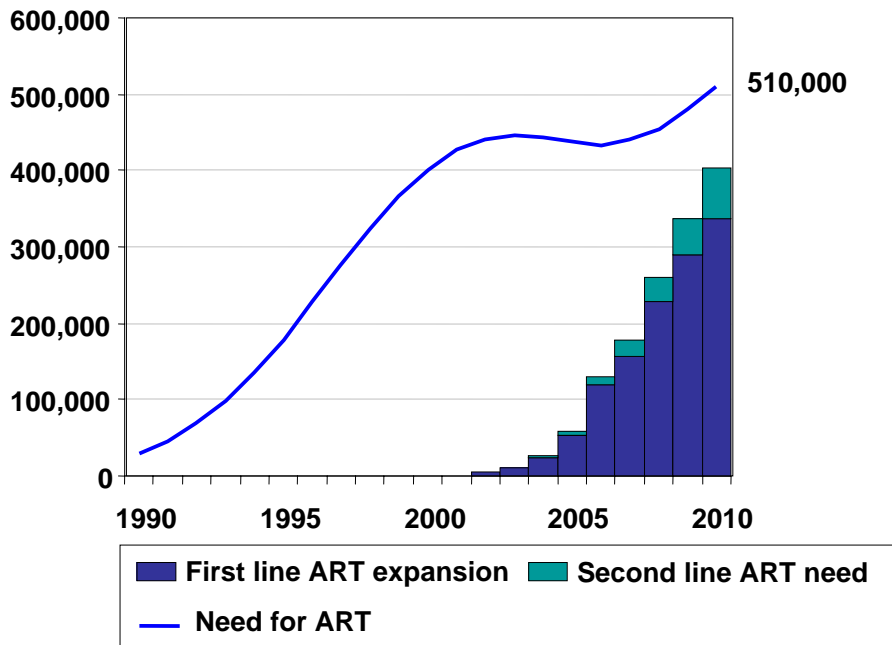
It is estimated that by 2006, as a result of care and treatment related to ART, about 57,000 deaths were averted. Donor support for care and treatment has been strong, but despite good progress in the expansion of ART services, the task ahead is enormous. At a 0.2% increase in prevalence as a result of ART delivery, the effect is negligible but it will increase in the future (fig. 4).

Figure 4. The effect of ART on prevalence is small but will grow in the future.



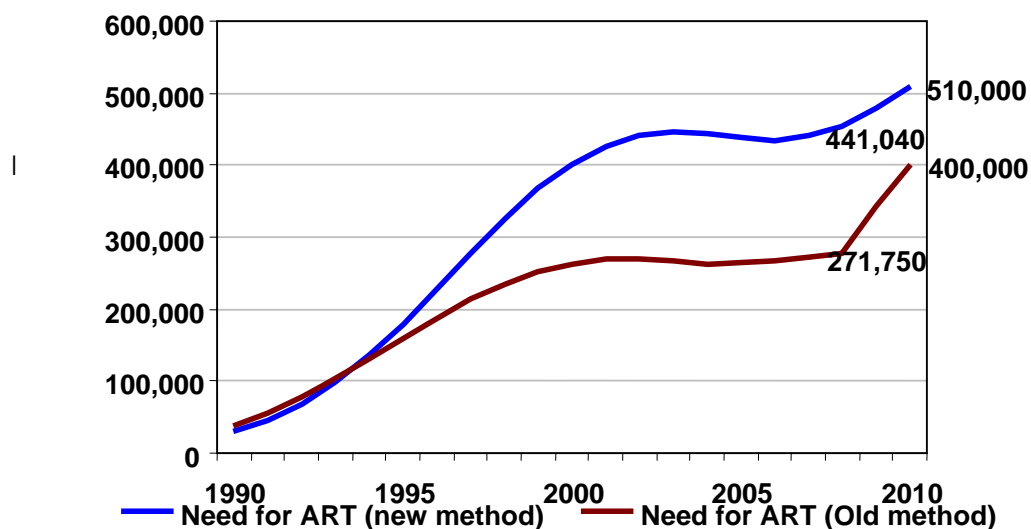
Kenya has made tremendous strides in scaling up ART. It is forecast that the need for second-line ART will increase (fig. 5).

Figure 5. Estimated needs for first- and second-line ART and its expansion in Kenya.



In 2007, 172,000 were on ART compared with 60,400 in 2005 (*NASCOP database*), equivalent to 35% of the 430,000 adults and 23,000 children requiring treatment (*JAPR 2007*). Of the 100,000 children who are HIV positive, 23,000 need ART but by 2007 only 13,000 children were receiving it. This was due more to poor awareness on the part of parents and caregivers than non-availability of drugs. In 2005 only 4000 children were on ART. From analysis of district data, the male-to-female ratio for ART is 35%-to-65% (*NASCOP data*).

Figure 6. Estimated need for ART in Kenya by UNAIDS methods (1990–2010).



It is intended to have 209,000 adults and 20,000 children on ART by 2008 with 180,000 actively adhering to treatment. Currently only 25% of TB patients who test positive receive treatment. This will be extended to cover all positive TB patients. Nearly all (97%) patients are still on first-line treatment, exceeding the target of 85%. ARVs will be provided to all private facilities that have agreed to dispense them free of charge (NACC JAPR 2007).

Cost of treatment

ARVs have been delivered free since early 2005, but the user bears the cost of medical support services and transport. These additional costs are an often insuperable financial burden, which causes patients to default on their treatment. As such, it was agreed at the JAPR 2007 that support services should also be free.

All provincial and district hospitals provide comprehensive HIV care including counselling services, prevention and treatment of opportunistic infections, and ART. ARVs are free but laboratories operate on a user-fee basis. There have been standard treatment guidelines for care since 2002. These include standard regimens that simplify ART delivery and commodity management and that minimize procurement costs.

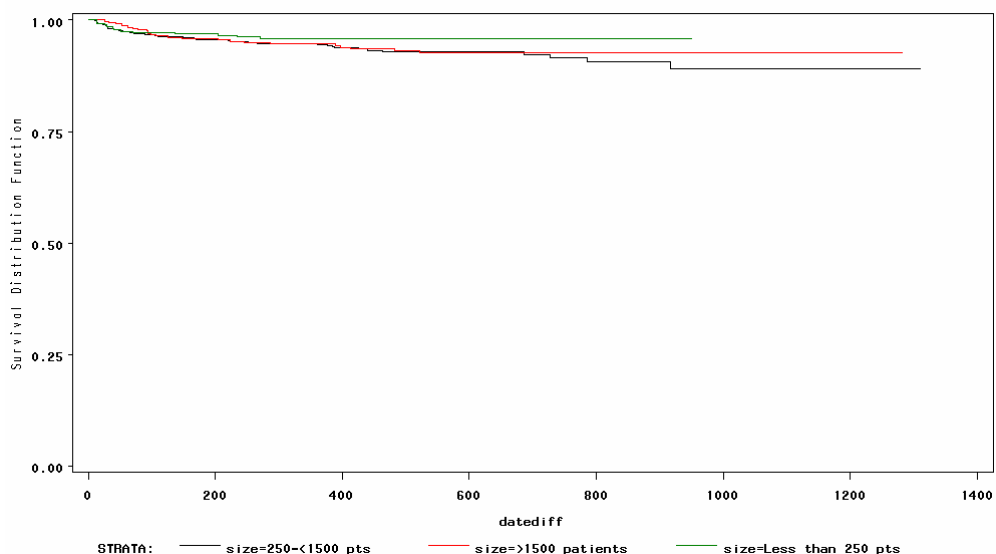
There has been a rapid increase in the delivery of ART since its inception in 2002 when 3000 patients received treatment. This is a remarkable achievement in responding to HIV and AIDS. However, anecdotal evidence is suggesting certain problems that contribute to default rates. For instance it is said that some men use their partners' ARVs irrespective of their status. A few patients may sell all or part of their ARVs for profit.

Adherence to ART is high. A review of records for a 20-month period by NASCOP suggests that 13% of the patients are either dead, transferring out or stopping ART. Only 5 (3%) patients stopped ART voluntarily. However, the default rate is particularly high among children who are cared for by the elderly (NACC JAPR 2007).

Access to ARVs is poor, especially in some rural areas. It is government intent to integrate TB and HIV and AIDS programmes. Despite a commitment in 2006 to ensure 50% of HIV-positive TB patients go on ARVs, by 2007 only 25% were receiving treatment. Similarly, only 50% of the 20,000 of the children who were to be put on ARVs in 2007 are receiving treatment.

Treatment appears to have taken precedence over prevention in the donor world. In fact, some HIV patients are put on ART prematurely to help reach donor targets. ARV delivery requires exponentially increasing sustained and reliable funding as more and more of the infected reach the point of requiring ARVs. A full scale-up of prevention strategies and interventions is the most cost-effective way of offsetting escalating treatment costs (NACC JAPR 2007).

Figure 7. Probability of survival after ART initiation by site size, $n = 1304$ (Kaplan-Meier).



The civil society perspective

Difficult access

Private NGOs and FBOs have problems finding the funding for ARVs and then accessing them.

Treatment challenges

- Options are limited after the first-line regimen fails.
- Patients with CD4 counts under 100 may be turned away because they do not have the proper nutritional diet or access to support services.
- There are no treatment centres for multi-drug-resistant TB.

Donor funding rationalization

There is a large flow of donor funding for ART, but individual donor targets may not necessarily conform to KNASP 2005/6–2009/10 or even PLWHA interests. Donors' objective should above all be to safeguard and promote PLWHA wellbeing. Civil society feels that patients are being put on ART before it is required so that donor ARV delivery targets can be met. Heavy reliance on donor support is incautious. The Kenyan government should have a fall-back arrangement for ARV delivery in case donors withdraw support. There is no budgetary allocation for ARVs even though HIV and AIDS have been declared a national disaster. Organizations who receive donor funding should be more transparent and accountable.

More effective protection of human rights

PLWHA in Kenya are frequently subject to rights abuses such as discrimination and the violation of women's and orphans' inheritance rights. They also encounter difficulties accessing health care, shelter, education and food. However, there is

insufficient information to provide the basis for advocacy or mitigation policies or to design effective interventions. Kenya has now enacted an anti-discrimination law, the HIV and AIDS Prevention and Control Act. The date for the legislation to commence has not yet been set as the set of regulations needed to operate the Act are being drafted. The Act also requires some amendments to include marginalized groups and to address other emerging issues.

Awareness of legal, treatment and reproductive rights among PLWHA and health workers is low as information on rights is not posted at health facilities and other pertinent sites.

Kenyan law criminalizes homosexuality, commercial sex work and drug use, thus presenting obstacles to effective HIV prevention and care for most-at-risk populations. Although Kenya has a policy to ensure gender equality in access to prevention and care, a similar policy does not exist for most-at-risk groups (*NCPI, NACC 2005a*).

Challenges facing people living with HIV and AIDS

- Promotion of rights of PLWHA through public education and advocacy programmes is limited, especially with regard to the rights of women and children.
- Counselling on legal, treatment and reproductive health rights is not included in the comprehensive care services packages.
- Health care workers have limited knowledge of human rights and reproductive rights.
- Links of HIV and AIDS programmes to organizations providing legal services are weak.
- Communication and advocacy programmes have not effectively mainstreamed the rights of vulnerable groups, including MSM, people living with disabilities, CSWs and IDUs.
- Violations of PLWHA rights are experienced in all sections of the society.

Source: Report on the Joint AIDS Programme Review, NACC 2005b)

Home-based care

Home-based care (HBC) is identified in the national strategic plan as a strategy to continue support to people on treatment. The country has developed guidelines for operationalisation of home-based care programmes in the country. Initiatives have been taken by civil society organizations to improve models for home-based care. A notable example is the Nyanza model, which provided the template for national HBC guidelines that were developed through a consultative process. The model is being costed and rolled out.

Several challenges hinder implementing HBC. Referral and reporting systems are weak. There is no funding for the delivery of kits, food and nutritional supplements. Care is based on volunteers, a system that cannot be sustained. And there is a great shortfall of health workers trained in HBC. As a result, enrolment in HBC is low.

It is intended to harmonize HBC approaches and integrate HBC with the Kenya Essential Package for Health (KEPH). In 2008 the national response will also

standardize HBC training and provide care and support for the caregivers, particularly the elderly.

Mitigation of social and economic impact

Impact studies

NACC has conducted a study on the socio-economic impact of HIV and AIDS with particular reference to economic development, the labour force, and women and children. The survey was released late 2006. This will inform the planning and budgetary processes for interventions in 2008. The epidemic's impact on livelihoods and social security among communities, families and individuals will also be assessed and quantified. Sectoral studies in education and agriculture were initiated towards the end of 2007. Other studies from partners must be consolidated so that they can be used as reference for developing mitigation guidelines (*NACC JAPR 2007*).

Advocacy

The advocacy strategy for policy in the public sector workplace has already been launched (*NACC JAPR 2007*). Advocacy among policy makers and the general population during the reporting period increased awareness of the impact of HIV and AIDS and of the need for comprehensive mitigation action. Advocacy strategies for other sectoral policies will be developed by mid-2008.

Mitigation policy

An effective policy framework is critical for harmonizing and focusing the national response to the impact of HIV and AIDS. A comprehensive national policy on mitigation of the impact of HIV and AIDS is being developed to provide the framework in which all partners involved in mitigation will work. Sectoral policies in place must be revised to align them with national policy (*NACC 2005a, KNASP 2005/6–2009/10*). However, the economic impact of HIV and AIDS on livelihoods and social security has yet to be quantified so that it can inform national policy (*NACC JAPR 2007*).

Community empowerment

KNASP 2005/6–2009/10 aims to empower community organizations and local governance institutions to use and strengthen existing systems for coping with the impact of HIV and AIDS, with particular reference to caring for and providing access to education for orphans (*NACC 2005a, KNASP 2005/6–2009/10*). Many CBOs were formed during the Kenya HIV and AIDS Disaster Response Project (KHADREP) and have continued to sustain themselves despite the lack of funding. They provide a good window for response to HIV and AIDS on availability of funding.

Food insecurity is a serious threat to gains made in AIDS treatment and care. The National Food Security and Nutrition Policy, which is at draft stage, must include food delivery to orphans and vulnerable children (OVC) and affected families. Local government is expected to take leadership in addressing food insecurity issues (*NACC JAPR 2007*).

Workplace initiatives

Mortality and morbidity are making considerable inroads into both public and private sector workforces. It is high time that HIV and AIDS is mainstreamed into human resources, planning and management approaches and procedures. As yet there are neither standardized workplace guidelines with reference to AIDS nor an enforcement mechanism.

To address the negative effects of HIV and AIDS on productivity, measures are currently being undertaken in the public sector through the AIDS Control Units (ACUs) in line ministries to develop workplace programmes that inform staff and treat those who are infected. Some ministries have developed a comprehensive HIV and AIDS policy and implementation plan (*MoH 2005a, AIDS in Kenya*).

The private sector has created an HIV and AIDS coalition to develop and implement comprehensive care programmes through the Federation of Kenya Employers (FKE) and the Kenya Business Council (KBC). Some businesses run awareness-raising activities and a comprehensive care package that includes treating STIs and opportunistic infections and providing ART. They promote anti-discrimination policies and do not lay off staff because of their HIV status or institute mandatory testing. Most large companies now provide comprehensive medical cover (*MoH 2005, AIDS in Kenya*).

Current workplace policies emphasize providing prevention and treatment services. This must be expanded to include strategies for mitigating the deleterious effect of HIV and AIDS on individual worker performance and the overall productivity of institutions. Small enterprises and the informal sector require enforcement legislation for workers on the minimum pay package. The adoption and implementation of HIV and AIDS guidelines in these workplaces must be monitored closely.

Mitigation programmes

KNASP 2005/6–2009/10 outlines mitigation programmes that dovetail with the developing policy framework, both nationally and in communities. They include increased support for PLWHA, OVC and other vulnerable groups, community empowerment and human resource planning. The effective engagement and coordination of civil society will be particularly important to the success of community mitigation interventions (*NACC 2005a*).

KNASP 2005/6–2009/10's mitigation guidelines are not given priority in Vision 2030, which has succeeded the Economic Recovery Strategy. However, Vision 2030 does acknowledge the threat HIV poses to achieving its goals. NACC is currently improving mitigation guidelines across the board.

The civil society perspective

Focus on vulnerable groups

Vulnerable groups such as sexually active youth and adult risk groups are not adequately addressed in programming. Only a limited number of loosely coordinated programmes target these groups. They must now become a priority in the national response.

Orphans and vulnerable children

The OVC situation is a deepening crisis as funding and programming fail to keep pace with the 2.4 million orphans who need care and support from their extended families and communities (*NACC JAPR 2007*). Only 17% of OVC households received free basic external support in caring for the child in 2006 (*PEPFAR 2007*). This is a slight improvement over the 14% rate for 2003 (*UNGASS/UNAIDS Progress Report on the Global Response to the HIV and AIDS Epidemic 2003*) There is a marked bias favouring the urban in delivery of services, which means that the percentage of support for rural children is significantly lower.

The good news is that orphans appear not to be penalized within the education system since the introduction of free primary education. In 2006 among children aged 10 to 14, 88% of orphans and 92% of children who were not orphans attended school (*www.unaids.org*). Further, the children's department in the Ministry of Home Affairs is becoming more active.

The ministry implements a cash transfer programme for OVC that provides about USD 15 a month to OVC households for health, school enrolment and retention, and food security. The programme has been scaled up from 500 families in 2004/5 to 12,500 in 37 districts by the end of 2007. (*Children's Department, Ministry of Home Affairs*)

The OVC National Steering Committee was constituted in May 2004. It is chaired by the permanent secretary in the Office of the Vice President and Ministry of Home Affairs. It has representatives from government line ministries and departments that deal with OVC as well as NACC, interagency organizations, umbrella national and international NGOs, development partners, FBOs, civil society organizations and the private sector.

The national OVC action plan

- strengthen the capacity of families to protect and care for OVC
- provide economic, psychosocial and other forms of social support
- mobilize and support community-based responses
- increase OVC access to essential services such as food and nutrition, education, health care, housing, water and sanitation

OVC programmes are still limited. Government and UNICEF projects with OVC (cash transfers) need to be scaled up. M&E must be improved as well (*NACC JAPR 2007*). Due to the varied needs of OVC and their sheer numbers, many programmes are not able to provide comprehensive support. Mechanisms for effectively coordinating and harmonizing programmes targeting OVC need to be put in place. This will ensure that OVC beneficiaries receive a combination of psychosocial support, nutrition, education and shelter.

The government recognizes its responsibility to ensure that the most vulnerable children are protected. It is therefore making ongoing efforts to improve policy and legislation and to mobilize and make resources and services available to communities through existing community structures such as CACCs (*NACC JAPR 2007*).

The civil society perspective

A comprehensive approach for children: The number of orphans and vulnerable children is growing at a rapid rate. Many are HIV positive. The burden of nutritional support and adherence to ARV prescriptions for OVC is enormous. This burden is left to the CSOs and communities.

Programmes targeting children mainly address physical needs. A comprehensive approach including education, social and psychological support as well as protection of children's rights should be advocated and implemented widely.

Women and HIV and AIDS

Women in Kenya are particularly vulnerable to HIV and AIDS. Of the 1.1 million adults infected with HIV, twice as many women as men are positive. HIV prevalence among women aged 15–49 years is 6.7%, compared with 3.5% in men of the same age group. Gender differences are most striking in the 15–24-year age group. Among young women the prevalence is 4.4% while it is only 0.8% for young men. Most new infections occur among women between the ages of 15 and 24 (*Kenya HIV/AIDS Data Booklet 2005*, NACC).

The good news is that there is an overall indication of a slight decline in prevalence among young girls, although it is still high compared with prevalence in their male counterparts and the population in general. Overall prevalence among women has declined more noticeably.

High rates of infection can be attributed to a combination of biological and social factors. Available evidence indicates that girls start sexual activity earlier than boys, have large numbers of sexual partners, a high prevalence of sexually transmitted infections, and are victim to a high incidence of violent sexual contact.

The disproportionately high rates of HIV infection among women and girls are starting to trigger a national awareness of violence against Kenyan women and its effects. Traditional, deep-rooted gender inequalities are often expressed in violence, coercion or physical or emotional intimidation. Women may also give in to male demands for unprotected sex, despite the danger, as they often have nowhere else to go—limited financial options, limited land rights and fear of losing their children (*NAAC 2006a [or UNAIDS 2006?]*). The Sexual Offences Act 2007 is not as rigorous in safeguarding women's interests as had been hoped, but it has raised public awareness of gender violence and allows limited recourse in the courts.

Paid sex

- 6% of women report receiving money, gifts or favours for sex (in the past 12 months)
- 16% of girls 15–19 report receiving money, gifts or favours for sex
- Almost 4% of 15–24-year-old men report they paid for sex in the previous 12 months

Source: *KDHS 2003*

There is adequate legislation covering succession, child custody, marriage and matrimonial causes in Kenya. But unfortunately, most women and children are not able to access legal protection. Among other factors, awareness of the existence of these laws is low, legal help may be beyond their means, and civil cases move extremely slowly through the courts. As a result, many feel they have no alternative but to stay in abusive relationships or they will suffer worse consequences.

According to one report, women living with AIDS, virtually all of whom were infected by husbands or regular male partners, were essentially condemned to an early death when their homes, land, and other property were taken when they became widows (*Human Rights Watch 2003*).

Challenges

- Links are limited between mainstream women's groups and groups working with HIV and AIDS; women are often unable to broaden their financial, human resource and time perspectives.
- Data on HIV and AIDS commonly are not disaggregated by gender, which poses a challenge in targeting effective treatment.
- Female condoms need greater promotion and distribution.
- PEP (post-exposure prophylaxis) kits are not universally available.
- Women's groups have been actively and meaningfully involved in shaping policy but these are usually organizations working directly with HIV and AIDS. Women's and development groups and organizations dealing with women's rights must become more involved.
- Evidence suggests that there are particularly critical gaps in the area of services provided for girls and young women.

Violence against women in Kenya

- In the 2003 Kenya Demographic and Health Survey, 49% of Kenyan women reported experiencing violence and one in four had experienced violence in the previous 12 months.
- Over 60% of Kenyan women and children who have been abused did not report the event to anyone. Only 12% of Kenyan women who have been physically or sexually abused reported to someone in authority such as a village elder or police (Johnston 2002).
- In Kenya, 25% of 12–24-year-olds lost their virginity by force.
- A majority of the victims of violence are girls: 60% of women who have experienced violence reported age at first abuse was between 6 and 12 years (34% at age 10; 20% at 12); 24% between 13 and 19 years (35% age 15) (Johnston 2002).

The civil society perspective

Special attention for the girl child: Girls are hapless victims of the AIDS epidemic. They are 5.5 times more likely than boys to become infected. KNASP 2005/6–2009/10 must place far more emphasis on specific interventions for girls.

Best practices

Joint Annual Review Programme reinforces the Three Ones principle

Civil society activities are the backbone of the national response to HIV and AIDS while development partners underwrite a major portion of these programmes. It is difficult to monitor and coordinate the diverse spectrum of budgetary and programmatic planning. This is why JAPR was created in 2002. Since then NACC has been convening the JAPR annually to assess achievements, shortfalls, challenges and emerging issues in the national response.

The JAPR embodies the Three Ones principle and gives it a solid foundation. It is an excellent forum for monitoring HIV and AIDS activities and for reviewing the extent to which KNASP has been implemented as measured against the yardstick of the results framework. JAPR then resolves a plan of action and agrees on lead agencies to implement recommendations for every sector. The annual summary of all activities nationwide also makes it easy to see if the national response is skewed in favour of one sector over others.

There is a Monitoring and Coordination Group (MCG) for each of the three priority areas—intervention, care and support, and mitigation—and for support services such as M&E. MCGs are meant to overcome implementation delays and if necessary make recommendations for policy action to the ICC. They are pivotal in preparing for JAPR through reporting on and revising their respective sections of the KNASP results framework.

JAPR has enjoyed seminal achievements. As of 2008, DfID and the World Bank will only commit funding to programmes that come through the JAPR system. KNASP is a product of the 2004 JAPR. Because it was formulated in a highly participatory process, it has been more effective than its predecessors.

In 2006 and 2007 NACC devolved the JAPR process to the districts so that far more Kenyans could articulate the challenges, gaps and priority issues in their communities. Restructuring the JAPR process means that programmes can be harmonized and aligned with government planning and its MTEF. District JAPRs host delegates drawn from CACCs, DTCs, local government, the private sector and CSOs. As a result, representatives from government ministries, local government, development partners and civil society are able to develop provincial KNASP Results Frameworks through a participatory process.

There are still challenges. JAPR cannot achieve its targets without efficient MCGs. Membership is drawn from the key implementing agencies in that specific area and from other strategic partners. They should meet at least quarterly to review activities and report on progress. However, the MCG structure does not lend itself to this. For instance, the MCG for the prevention of new infections was responsible for nine subcommittees. Initially all MCGs and other technical working groups (TWGs) were convened outside NACC. For the past three years NACC has chaired all MCGs to ensure that meetings are convened regularly. Even so, the public sector and civil society need to attend with greater regularity so that they can respond to the debate.

Linking JAPR recommendations to the national plan and budget is another problem. Ministries must sit in on TWGs so that they can write HIV and AIDS into their provisional budgets. Likewise, development partners should attend TWGs so that they can reflect the consensus of Kenya's needs in their programmatic planning. Another shortfall is the poor representation of high-risk groups in the JAPR. This is being addressed.

Increasing public sector budgetary allocations by mainstreaming HIV and AIDS

Stakeholders from all sectors were enlisted to help implement the first KNASP (2000/1–2005/6). The public sector and line ministries tended to rely on donor funding disbursed through NACC. As a result, they did not use resources raised through government planning and budgetary procedures.

In the financial year 2005/6 the mainstreaming of HIV and AIDS was accelerated. This is being taken a step further by linking the annual JAPR, which monitors KNASP 2005/6–2009/10, to the MTEF process. This involves capacity-building workshops for line ministry personnel and civil society representatives, meetings with line ministry management, and participation in MTEF hearings on sectoral policies and priorities. NACC and its partners have also conducted impact studies in various sectors, which can provide a baseline for decision making. This process has also devolved to the provinces. For instance, a provincial level report informed sectoral MTEF policy review papers.

This best practice was led by NACC with the support of partners such as the Ministry of Planning and Development, the Ministry of Finance and DfID. It is coordinated by the Mainstreaming, Finance and Procurement MCG subgroup.

It has resulted in a better understanding of the importance of mainstreaming HIV and AIDS in policy, planning and resource allocation. HIV and AIDS issues are now being incorporated into sectoral and line ministry policy and planning documents. This has prompted increased resource allocation to HIV and AIDS interventions for both internal and external mainstreaming. During the financial year 2006/7, for example, HIV and AIDS allocations in line ministries increased more than 100% over the previous year. At the same time the 2007/8 recurrent budget allocation increased by 32.5%.

Cash transfers help orphans and vulnerable children

The OVC situation is critical, as funding and programming fail to keep pace with the 2.4 million orphans who need care and support. Only 17% of OVC households received free basic external support in caring for the child in 2006.

In 2004 Kenya responded to the crisis with a pilot programme for cash transfers to OVC families. It provided about USD 7 a month to 500 OVC households in three locations. The beneficiaries used the money to buy school uniforms and textbooks or household necessities. By the end of 2007 the programme had been scaled up to cover 12,500 households in 37 districts. The individual grant amount was found to be insufficient to meet basic needs and has been doubled to about USD 15 a month per household.

The programme was designed by the Ministry of Home Affairs with assistance from UNICEF. Its guidelines are mindful of quality, integrity, uniformity, transparency and accountability in programme delivery. The objectives of the programme are to boost OVC school enrolment and retention; to reduce under-5 mortality and morbidity rates through immunization; to underwrite household nutrition and food security through a guaranteed monthly income; and to encourage caregivers to obtain birth certificates and identity cards for their OVC charges.

The greatest challenge lay in selecting geographic areas and the beneficiaries. The criteria for selecting a district are a high number of OVC and child-headed households, an absence of development partners, a minimum population of 5000 per location, and at least 60% of the population living below the poverty line.

Beneficiary households are impoverished and have at least one OVC. They do not benefit from other programmes that offer similar assistance. Under-5 beneficiaries are required to receive immunizations and vitamin A at a health facility. OVC aged 6 to 17 must attend school. Caregivers must attend awareness sessions. By the end of 2007, more than 5800 were in school. More than 3600 had been immunized and more than 3300 had been registered for birth certificates that year.

Challenges have already surfaced. The number of OVC is increasing rapidly, which means that the programme must be scaled up further. Yet already it has gaps. Resources are inadequate for addressing all OVC issues. Vehicles and office equipment are inadequate for the task while staff would benefit from further training. Greater attention should be paid to caregivers to ensure they understand their responsibilities and the parameters of the programme. M&E needs a larger budget allocation.

Political leadership reinvigorates HIV and AIDS campaign

Following initial reluctance to acknowledge the gravity of the epidemic during the 1980s, there is now political commitment to reversing the spread of HIV and AIDS in Kenya. President Mwai Kibaki's support of the fight against AIDS has provided an example that is being followed by politicians and bureaucrats. President Kibaki appears in advertising posters. He has also signed his commitment to KNASP 2005/6–2009/10. The first lady, Lucy Kibaki, sponsors an annual AIDS run for women.

Younger members of parliament have appeared in advertising posters as part of a campaign to encourage youth to get tested. As a result there has been an increase in the number of young people being tested. However, public testing to persuade others to follow suit works only if it is done in the right setting. On 1 December 2007 several MPs were tested at Nairobi's Kenyatta International Conference Centre to promote the message that everyone should know their status. This would have carried more weight if each MP had tested in his own constituency, where their constituents would have heard about it.

US Senator Barack Obama was tested when he visited his paternal home in rural western Kenya. However, this had an effect opposite to that intended. The VCT site was a trailer that had been imported for the occasion, and access was by stairs. The trailer sent out the signal that testing is elitist, expensive and beyond the reach of the ordinary man.

Successful leadership occurs within the context of target audiences. For instance, in June 2007 a district commissioner was publicly tested at the town of Maragua; 235 subsistence farmers, who had seen him enter the site and leave it again, then followed suit and were also tested that day. In the following three-month period some 6500 people were tested, encouraged to do so by the informality of the setting. Clients underwent communal counselling and then were tested in an assistant chief's office rather than in a hospital.

Kenyan leadership has yet to take its commitment a step further by being transparent about the status of those politicians who fall sick with AIDS. This would go a long way to dispelling the entrenched stigma attached to the disease.

Post-test clubs' supportive environment empowers PLWHA

Starting with one post-test club in Nairobi, the concept of mutual support and peer education has been so successful that it has expanded countrywide through the National Network of Post-test Clubs. The clubs are community initiatives that show people who have tested positive how to treat HIV as just another chronic illness and lead a nearly normal life.

The clubs empower PLWHA by providing information and support on a peer basis. Central to this are four-day training programmes for trainers, who are also club members. Trainers demystify HIV and AIDS by helping their peers become literate regarding the disease. They learn not only AIDS facts but its epidemiology, the effects of HIV, management of the disease as it progresses to AIDS, PLWHA rights and legal recourse for PLWHA if they are denied access to services or work.

As a result of this awareness, club members' behaviour becomes more responsible. They understand the disease and can discuss authoritatively with health personnel the various medical options that are open to them. Adherence to ART among club members is above average. They are sick less often than those who are not members. They also suffer less from the side effects of ARVs.

The clubs are cost effective because they operate on a very low budget and because good medical awareness cuts down on treatment costs. However, the national network lags behind demand because there is a funding shortfall in the training of trainers and the production of education and information material. Education material should be standardized and updated to address emerging issues. The national network would also like to see post-test clubs included in KNASP 2005/6–2009/10.

Some government health facilities offer a similar awareness course on healthy living for positive people as an extension of the VCT package. Participants learn about nutrition, ARVs and laboratory investigations. Because those who attend have other obligations, the course is held one day a week for four weeks.

Prevention through changing the face of custom

Customary law and procedure regarding succession has been a major trigger for the spread of HIV. In western Kenya many people still observe a deep-seated tradition that a woman must be inherited by her brother-in-law on her husband's death. In some areas this has become a professional business where 'wife inheritors' have

sexual intercourse with the widow to formalize her inheritance. Legal recourse to safeguard child custody and property inheritance is virtually non-existent. This leaves women with no alternative but to succumb to prevailing custom.

The Movement of Men against AIDS in Kenya has developed a programme to overcome the deleterious effects of wife inheritance. Realizing that it would be futile to attempt to overturn a time-honoured tradition, they have created a symbolic rite of passage as a substitute. Professional wife inheritors are still paid one bull and as much as USD 30 for their services. However, for this they are no longer required to be intimate with the widow. Instead they hang their coat on the door of the widow's home to show that they have temporarily taken up residence.

Low sero-conversion in PMTCT programme

The district health officer in Maragua has boosted the survival rate of babies born to HIV positive mothers considerably through a thoughtful PMTCT programme. It has proved so successful that it has already been replicated and will soon be rolled out to 16 health facilities throughout Central Province.

Pregnant mothers who tested HIV positive in this farming district were discouraged from doing the follow-up laboratory tests because of the long distances to the nearest laboratory. Under the Maragua programme, health dispensary personnel take the blood samples to the laboratory and bring the results back so that mothers can be tested without having to travel.

Mothers who have a CD4 count above 350 are put on a regimen of Nevirapine while those whose count is less are put on HAART (highly active antiretroviral treatment). Babies born to these mothers are put on a six-month supplementary feeding programme, which is about to be extended to 12 months. The mothers are sent home with an education package, a water filter and other utensils. Out of a cohort of 181 infants born to HIV-positive mothers only two, or slightly more than 1%, sero-converted. The morbidity rate among infants in the programme has also been well below average.

The apathy of the fathers continues to be a problem just as it is nationwide, which in turn inhibits adherence. Health officials running the programme are considering a number of incentives such as waiving maternity fees for couples who attend PMTCT sessions together.

Community-based reporting informs strategic planning

Community-based Program Activity Reporting (COBPAP) was rolled out in 2006 in the wake of decentralization and the establishment of CACCs. HIV and AIDS programmes take place in the community as well as health facilities. COBPAP's great advantage is that it captures both health and community information through a network of 8000 implementers. These include civil society, CBOs, NGOs and FBOs.

COBPAP design was developed in a participatory process with NACC and other stakeholders. Using the decentralized NACC system, implementers report on a quarterly basis to the M&E section in NACC headquarters. The data received cover the range of HIV and AIDS activities from behaviour change communications and

condom distribution to programme funding and economic impact. The collated data are posted on NACC's website and are accessible to the public.

COBPAN has enabled planners to have a better overview of the status of HIV and AIDS in Kenya. For instance, it identifies duplication in funding and programmes and makes it possible to rationalize resources. It is a useful tool for informing strategic planning too.

It is facing problems, however, because of poor M&E infrastructure in the rural areas and low awareness of the importance of M&E as a strategic weapon in the war against AIDS. CACCs should be equipped with computers and a link to the NACC local area network (LAN) for efficient communication with national headquarters.

Leaders inspire greater VCT uptake

In the week preceding World AIDS Day in 2007, NACC organized an 'HIV Testing and Counselling Campaign Week' to emphasize HIV prevention. The campaign aimed to reach 100,000 people from both the general population and high-risk groups—50,000 in Nairobi, 30,000 in Nyanza Province and 20,000 in the Coast Province.

In line with the World AIDS Day Kenya theme 'Take Leadership, Keep the Promise', teams provided financial and human resources, logistics and testing tents. One team did fundraising and liaised with the government, the uniformed forces, and the private sector and development partners. The Secretariat was responsible for coordination and communication.

Competitive sports and dance extravaganzas were organized to encourage young people to visit the mobile counselling and testing sites. Moonlight counselling and testing by registered counsellors was extended to female sex workers and their clients, late-night workers and people in the entertainment industry. Youth celebrities, corporate executives and officers from the uniformed services encouraged everyone to attend. Quality control using tests approved by the Ministry of Health ensured that services were consistently good. An exit poll provided baseline data for each site.

At the week's end, more than 96,300 people had been counselled. About 94% of these were also tested. 8.2% of those tested were positive.

Media coverage of corporate executives, officers from the armed forces and youth celebrities triggered a multiplier effect for VCT uptake during the week. The week-long event also helped reduce HIV stigma and emphasized positive living for those who tested positive. Currently, about 30,000 people are tested every week in Kenya.

Improvement in support of home-based care clients

Mildmay International has pioneered an integrated model of home-based care in Nyanza that involves community, the Ministry of Health, and medical training institutes enabling improved access to ART and other necessary support for people living with HIV and AIDS in the rural areas. In 2006, the model was adopted as a national blueprint. Currently, a costing study for applying the model nationally is nearing completion with a view to national rollout.

Major challenges and remedial actions

Leadership and coordination

One coordinating authority

As Kenya's one coordinating authority, NACC needed to coordinate cooperation among a wide range of national and local organizations rather than focus on financial management and implementation. There are still shortcomings in the harmonization and alignment of donor activities and resources with the priorities outlined in the national response. JAPR 2007 reiterated that NACC's role as national coordinator must be recognized and observed.

A harmonization task force was created, drawn from development partners, UNAIDS, civil society, key government ministries and NACC. Its mandate includes developing a database of CSOs and their financing, a joint technical assistance plan, and attention to harmonized reporting procedures and forms. It also supports the pooling of funds in specific areas and encourages mainstreaming HIV and AIDS into all development planning and the government budget cycle.

Civil society activities are the backbone of the national response to HIV and AIDS. In 2006 and 2007 NACC devolved the JAPR process to the districts so that Kenyans nationwide could articulate the challenges, gaps and priority issues in their communities. Restructuring the JAPR process means that in future stakeholder programmes can be harmonized and aligned with government planning and its MTEF.

NACC encourages civil society to assume a greater role in the delivery of services and programmes through its CACCs. However, there is a shortfall in their ability to train, to include vulnerable groups in its activities and to report M&E data. The COBPAP reporting system was rolled out in constituencies in July 2006 with more than 800 people trained on its use.

Strengthening CACCs and grassroots communities is an ongoing objective that is hampered by inadequate funding. In 2008 NACC will begin disbursing World Bank and DfID funds to CBOs for prevention and mitigation interventions as part of TOWA. TOWA has benefited from the lessons learned to improve accountability, to target the groups driving the epidemic and to institute internal reorganization. A much better information flow between communities and national planners and policy makers will also help strengthen HIV and AIDS interventions at the grassroots level.

The civil society perspective

Civil society is concerned about the accountability of CACCs and DTCs and their ability to guide and coordinate local implementation. Mechanisms for determining membership and for reporting back to communities should be open and transparent. In particular, there is concern that the positive contributions Member of Parliament make in communicating HIV and AIDS messages and mobilizing communities are outweighed by concern over potential breach of power in finance decisions as well as bias and favouritism.

Even though civil society in Kenya is active, its organizational skills could be improved. Umbrella organizations exist, but funding shortfalls leave their long-term

viability in doubt. As a result, member CSOs are not coordinated and speak with different voices. This can lead to donor confusion and mistrust. Clearly we need to organize ourselves, while at the same time umbrella bodies must be funded by the government and donors so that they can effectively deliver resources to grassroots CSOs.

Similarly, implementing KNASP 2005/6–2009/10 successfully will depend on strong and effective strategic partnerships, built between national and international stakeholders, government, civil society and the private sector. A partnership approach for implementing KNASP 2005/6–2009/10 has been promoted through forums and networks such as the JAPR, MCGs, ICC, civil society, the corporate sector, the UN, development partners and CCM.

At the beginning of the reporting period local government participation in implementation plans and processes was weak. At the same time, many district stakeholders did not have the technical capacity to implement KNASP 2005/6–2009/10. This must be rectified by building capacity and producing a standardized HIV and AIDS training curriculum. It is intended to use the African Regional Capacity on AIDS Network (ARCAN) healthcare practitioners to train stakeholders. In 2008 stakeholders will have access to a databank of HIV and AIDS trainers of trainers.

Financial

Kenya faces hard choices over allocating scarce resources. Donor funding underwrites by far the largest portion of HIV and AIDS expenditure. This raises concerns as to the sustainability of HIV and AIDS budgetary expenditure. Development partners have also favoured ART rollout over less costly prevention measures, which underscore the importance of writing a far greater part of HIV and AIDS funding into the recurrent rather than the development budget. The government allocation for 2007/8 is USD 7.7 million. Even allowing for potential commitments from donors when budgeting to meet Kenya's ART rollout targets, the deficit will top USD 75 million by 2010 (*Government of Kenya, Quarterly HIV/AIDS Monitoring and Evaluation Report, National AIDS Control Council, Quarter 3 and 4 2006 report, Nairobi, March 2007*).

These challenges have the best chance of being met if the Ministry of Health and donors increase ART budget allocations substantially. However, external support is through time-limited project arrangements. External assistance is crucial through the medium term, but the Kenyan government must take measures immediately to close the projected long-term funding gap. HIV and AIDS budget lines must be across the board while health expenditure must grow to a 15% share of the national budget. Meanwhile NACC and NASCOP must continue to track resource requirements closely.

PLWHA suffer serious financial burdens as a result of their status, which inhibits their ability to maintain ART adherence and to access the required supplementary foods. Individual household and PLWHA expenditure may be small measured against the national yardstick, but it is a significant contribution in the context of equity. PLWHA spend approximately three times more on health care than the general population. This has been ameliorated by waiving user fees for ART. Support services such as laboratory tests are not yet free, but it is hoped that charges will be waived during the next reporting period.

Those involved with national response to the epidemic must build stronger links to make sure that HIV and AIDS are not overlooked. The link between KNASP 2005/6–2009/10 and national planning processes has in the past posed a problem. The situation has improved, but the gap between KNASP 2005/6–2009/10 intent and Vision 2030, MTEF and the relevant national M&E systems in the Ministry of Planning still exists. This is why NACC and interested partners are making a concerted and systematic effort to integrate HIV and AIDS into national development planning processes.

Similarly, budget transparency among stakeholders is critical so that expenditures can be translated into a joint national work plan. Another shortcoming that poses an ongoing challenge is the low level of disbursement capacity in government ministries.

The civil society perspective

Increase government funding

Civil society is responsible for the majority of Kenya's programmes. For instance, FBOs deliver almost 40% of health care services. However, they receive little or no government funding. Exacerbating this problem is the fact that when the government does a survey or sets a target it includes and relies on our programmes but still does not contribute to our operations. The government should give us a formal commitment to work with civil society and to allocate funds to us.

Increase donor funding

We believe that clear expressions of partnership with civil society should be incorporated into all calls for proposals.

KNASP 2005/6–2009/10

CSO budgets should be aligned with KNASP 2005/6–2009/10. Donors should allocate funding to operational research as outlined in KNASP 2005/6–2009/10.

More transparency in funding allocation

Decisions about the allocation of funds are made without clear criteria or proper consultation. Civil society representation in decision-making forums is ensured on paper, but in reality our voices and contributions are often ignored.

More effective regulation of claimant organizations

Organizations that are eligible for grants should be better regulated. It is also important to take note of local mobilization constraints. Regulation should not inhibit genuine applicants from poor and vulnerable groups who are sincere in their intent but find it difficult to meet the demands of bureaucratic procedures.

Promote coordination of funding allocation

Funding mechanisms such as the World Bank's programme of support, constituency development funding and various multilateral and bilateral initiatives must coalesce around one coordinating body to avoid multiplicity of funding to singular components, geographic areas or implementers.

Prevention

At-risk groups, considered to be the drivers of the AIDS epidemic, have been marginalized in prevention interventions. There are no BCC programmes tailored to specific high-risk groups. This will change noticeably during the next reporting period. BCC among targeted risk groups is starting with a youth BCC campaign anticipated for 2008.

Expanding the number of VCT sites and controlling their quality were a challenge but both have now happened. However, there should be a needs survey to ascertain current quality control. Couple counselling and testing and trauma counselling should be scaled up.

PMTCT coverage was low in the previous reporting period but has improved significantly during the current period. An expanded PMTCT protocol extends the care and treatment period for infants and mothers beyond the birthing process. However, male involvement in PMTCT is still very low. Civil society advocates training traditional birth attendants in PMTCT.

Male condom distribution is on track, but the uptake of female condoms has been a failure and nothing has been done to turn the situation around.

Care and treatment

ART rollout has been rapid and relatively smooth. A rapid results initiative and the decentralization of services to peripheral facilities accelerated the pace of scale-up. Treatment delivery to women initially was not equitable. This has been addressed and now 65% of those treated are female. However, the network for scaling up paediatric ART is still poor. There are far too few facilities while awareness on the part of elderly caregivers and paediatric psychosocial support is poor. Most importantly, there is a shortfall in the supply of paediatric ARVs. Young people aged 15–24 years fare little better. There are no baseline data for care and treatment services. Teacher awareness is low and health facilities are not youth friendly, which discourages attendance. In the previous reporting period TB treatment was not integrated into ART programmes. This is now happening but must be rolled out further. During the reporting period 25% of HIV-positive TB patients were put on ARVs, falling short of the target of 50% on ARVs.

The most-at-risk groups—commercial sex workers, people with same-sex relationships and injecting drug users—have historically been placed beyond the pale of HIV and AIDS programme activity. They have been excluded from care, treatment and prevention strategies, policy and programmes. During the current reporting period high-risk groups were prioritized as they are considered to be driving the AIDS epidemic. A consultative process with most-at-risk populations in 2007 resulted in greater knowledge of their environment and the challenges they face. In 2008 most-at-risk groups will be included in programmatic activity. Meanwhile, interventions have already been launched such as MSM counsellors at VCT sites.

Rights awareness among most-at-risk groups continues to be virtually non-existent. Creating awareness requires training in the legal, judicial and health sectors as well as alerting the general public.

Kenya still struggles to meet its obligations to OVC, whose numbers increase substantially every year. OVC needs cut across the board, which complicates comprehensive service policy, planning and service delivery. The OVC National Steering Committee was constituted in 2004. Its members are drawn from government line ministries and departments, NACC, interagency organizations, NGOs, FBOs, development partners, civil society and the private sector.

Strengthening programmatic support has become a priority. The Kenyan government and UNICEF implemented programmes such as cash transfers during the reporting period. However, scaling up is constrained by a poor database and incomplete M&E. Even greater priority must be given to food security for OVC during the next reporting period.

The civil society perspective

Regulate ARV rollout

Donor goals for ART may not necessarily reflect goals set out in KNASP 2005/6–2009/10. ART is unregulated. Neither is there a safety net for ARV clients should donors withdraw funding.

A comprehensive approach for children

The number of orphans and vulnerable children is growing rapidly. Many are HIV positive. The burden of nutritional support and adherence to ARV prescriptions for OVC is enormous. This burden is left to the CSOs and communities.

Programmes targeting children mainly address physical needs. A comprehensive approach including education, social and psychological support as well as protection of children's rights should be advocated and implemented widely.

Monitoring and evaluation

M&E capacity continues to fall below the required benchmark countrywide. M&E cannot rise to the challenge unless there is greater focus on training and standardization of reporting procedures. The M&E framework must also be aligned with KNASP 2005/6–2009/10. This process is under way and must be rolled out in 2008 so that gains made will not be lost. However, there is no clear link to the health management information system of the Ministry of Health.

Nearly all (90%) BCC programmes are evidence based and rely heavily on M&E reporting. Therefore, M&E systems must continually be improved, particularly among NGOs and CBOs. Facility-based reporting needs further improvement despite the COBPAR roll out. COBPAR is under funded and staffs need further training on internet and other tools. Also, some implementing agencies fail to report as their M&E systems run parallel to the national M&E framework. In 2008 NACC training of M&E staff will cascade down to district health facilities. This will improve data flow on ART patients from health facilities. The integration of ART registers and report forms into the reporting system was piloted in 2007. Its rollout is urgently needed but is constrained by lack of funds.

Support required from Kenya's development partners

What needs to be done

In the previous reporting period development partners coordinated to different degrees with the NACC Secretariat and took part in various degree in AIDS-related forums, either within NACC technical and working groups or, for example, in the Ministry of Health coordination structure.

Overall, the level of engagement with development partners needed to be strengthened to increase harmonization with KNASP 2005/6–2009/10. Some bilateral donors tended to work with little communication with NACC, NASCOP or other coordination entities although consultation improved with the introduction of KNASP 2005/6–2009/10.

What has been done

Development partners were encouraged to work closely with NACC to develop the KNASP 2005/6–2009/10 financing arrangement, thus ensuring that available resources were well allocated, gaps were filled and duplication was avoided.

During the current reporting period development partners such as the World Bank, DfID, PEPFAR and Sida provided support. This included developing and costing the current KNASP 2005/6–2009/10 as well as providing technical and programme support for its M&E component. They spearheaded the sector-wide approach (basket funding) that led to TOWA. They helped to mainstream HIV and AIDS in all development sectors and participated in formulating the civil society code of conduct. They also contributed to institutional strengthening of NACC's board of directors and its management.

PEPFAR committed a total of USD 208 million to Kenya for 2006 and USD 368 for 2007. Support for 2008 is expected to exceed USD 500 million. During the reporting period these funds were used for activities including HIV prevention, treatment, care and support. These included promotion of behaviour change through abstinence, faithfulness, and correct and consistent condom use, PMCT, blood safety, orphan support, access to antiretroviral treatment (ART), supply of antiretroviral drugs (ARVs) and drugs for opportunistic infections, TB/HIV, home-based care, counselling and testing, lab infrastructure, policy development and health systems strengthening, and monitoring and evaluation. PEPFAR supports Kenya's leadership in expanding HIV counselling and testing, including rolling out provider-initiated CT. In 2007, PEPFAR supported 110,000 Kenyans who are on ARVs and contributed to the support of another 44,000 on ART, delivered basic care packages to 75,000 households, and provided funding and technical expertise for Kenya's first-ever National HIV Prevention Summit.

What still needs to be done

Development partners must continue to support NACC to achieve UNGASS targets. They should provide technical, financial, institutional, programmatic and research support to prevention, treatment and mitigation programmes. The mid-term review of KNASP 2005/6–2009/10 requires their technical and financial resources.

Their programmes and funding must be aligned to national response priorities. They must refrain from implementing systems parallel to the Three Ones for M&E and reporting. PEPFAR should follow the example of other development partners and observe the principle of basket funding. Commitment should be to joint programming through the Harmonization Task Force and decentralized structures as well as input into rolling out a code conduct for CSOs. Stock-outs are a perennial problem. Thus development partners should also encourage NACC to be involved in overseeing supply chain management of condoms, ARVs and other drugs and supplies.

The civil society perspective

While some development partners recognize the importance of civil society, this does not yet translate to optimal engagement with civil society as equal partners. Nor does it address the long-term, sustainable financing needs of civil society implementers.

Development partners should harmonize the way they work with civil society. The different approaches and requirements of individual donors create confusion among CSOs and increase their workload. The requirements related to calls for proposals and reporting should be simplified so that all applicants are able to meet them.

Donors tend to focus their support in the same geographic areas. They should map interventions, disaggregated by geographical area and target group, and let this guide them in spreading the benefits of their funding and activities equably.

Because civil society is often represented by big NGOs, development partners tend to overestimate CSO capacity. Development partners could help strengthen CSO capacity by allocating a percentage of each grant for that purpose.

Development partners' funding of civil society would be more effective if disbursements were direct rather than through the government.

Monitoring and evaluation environment

Kenya continues to hold JAPR annually to review progress made with KNASP 2005/6–2009/10. The 2007 JAPR was decentralized for the first time to capture regional response efforts. Many of the recommendations for M&E were based on the content of the National HIV and AIDS Monitoring and Evaluation framework as well as the progress made on its rollout. Among notable recommendations are harmonizing indicators to measure some of the deliverables of the strategic plan and reviewing the framework.

A number of new indicators have been added to the data collection tools and recommended for inclusion in the revised M&E framework. Through the framework review process recommendations have been developed for consideration during the midterm review of the strategic plan.

National HIV and AIDS M&E framework rationale

- enhance decision-making strategy, policy, programming, and implementation
- track progress made in the national response

- provide grounds for partnership, networking and collaboration among stakeholders
- provide the basis for global, regional and national reporting
- integrate national and sectoral M&E systems

The national M&E framework

The national M&E framework was finalized and made integral in overseeing implementation of KNASP 2005/6–2009/10. Since the framework was put into operation, routine systems have met its rationale by providing quality data quarterly.

COBPAP and the quarterly programme report submitted by health facility systems were strengthened to enhance monitoring of the implementation of HIV programmes.

Results from the Sentinel Surveillance, Kenya AIDS Indicator Survey (KAIS) and KDHS provide information on the effectiveness of the response. A special survey targeting vulnerable groups has been commissioned to provide insights into what continued to drive the epidemic.

Challenges of one national M&E system

Although most subsystems are in place, the Health Management Information System (HMIS) requires strengthening. HMIS has introduced an integrated reporting tool, which needs support for its rollout. Support is also needed in developing a rollout plan with relevant user manuals and in harmonizing the integrated system with all information from the districts.

Some partners still rely on their parallel M&E systems. They should share their joint annual work plans and contribute to developing M&E reports that are linked to the joint work plans. Many stakeholders consider it would be worthwhile to have one centre for developing and producing national reports on HIV and AIDS. Suffice it to say that most stakeholders are willing to buy into the national M&E framework.

M&E training should be conducted at local levels using revised COBPAP forms. This will strengthen reporting from health facilities. Information is useful if used at the source, but there is weak competence in data use at all levels. As a result, a data use manual is being developed.

The civil society perspective

CSOs have been considerably involved in policy formulation and general HIV and AIDS programming. A lot has been done by the government and the CSOs with regard to prevention. Better access to services and the enactment of the HIV and AIDS Prevention and Control Act are both milestones. These efforts have been captured in the prevalence statistics. However, it has not been fully possible to measure the effectiveness of CSO efforts because they are at variance with the donors' targets. CSO activities should serve the interests of the people they serve. Finally, it is vital that the government has a fall-back position for delivering ARVs.

Appendix 1: Kenya 2008 UNGASS report engagement process

Introduction

After the briefing meeting by the UNAIDS Global Office of the monitoring and evaluation field officers in August 2007, the National AIDS Control Council with assistance of the UNAIDS country office appointed three committees: the Oversight Committee, the Technical Committee, and the Civil Society and Most-at-Risk Engagement Committee.

The purpose was to oversee the development of inputs needed to prepare the country's progress report for UNGASS 2008 on the response towards HIV and AIDS.

The committees

Oversight Committee

This committee had the responsibility of overseeing the UNGASS report development. This included guiding the process and mobilizing the necessary resources. It is through this committee that support from Constella Futures, DfID, PEPFAR, the UNAIDS Technical Support Facility and NACC was mobilized.

Technical Committee

The role of this committee was to address the technical aspect of the process including consideration of data sources and validating the collected data and determination of reliability for use in the report.

Civil Society and Most-at-Risk Engagement Committee

This committee engaged the civil society and most-at-risk groups using the NCPI questionnaire. The three groups were the civil society group, men having sex with men (MSM), and female commercial sex workers (CSWs). The outputs of these engagement processes are included in the report.

Report development plan and support

The Oversight Committee mobilized resources to undertake writing of the report. The support received was as follows:

- Data collection and analysis process were supported by the National AIDS Control Council. The University of Nairobi Clinical Epidemiology Unit was appointed to undertake the exercise.
- Engagement of civil society organizations and most-at-risk groups was supported by DfID through Constella Futures, and an individual consultant was appointed to undertake the exercise.
- Collection of data on AIDS spending was supported by the UNAIDS Technical Support Facility and consultants were appointed to undertake the exercise.
- Report writing, compilation and editing were supported by PEPFAR through Health Policy Initiative, and an individual consultant was identified to undertake the task.

Civil society and most-at-risk groups engagement

The targets here were both the organizations that are involved in HIV and AIDS activities and the beneficiaries—the most-at-risk people.

The most-at-risk groups were engaged in discussions guided by the priority areas of KNASP 2005/6–2009/10 to capture qualitative data for the UNGASS report.

The civil society organizations had group discussions according to priority KNASP 2005/6–2009/10 areas. They further had plenary discussions to harmonize the output of the meeting. All discussions were guided by the NCPI questionnaire.

Targets (beneficiaries)

- civil society organizations involved in HIV and AIDS activities—36 organizations
- CSWs—35 participants
- IDUs—59 (in both Nairobi and Mombasa) participants
- MSM—26 participants

Networks involved

- Bar Hostess Empowerment and Support Programme (BHESP)
- Gay and Lesbian Coalition of Kenya (GALCK)
- Gay Kenya
- ISHTAR
- Malindi Shella
- Muslim Education and Welfare Association (MEWA)
- MEWA Community Outreach
- MEWA Drug Treatment Centre
- Minority Women in Action (MWIA)
- Muslim Education and Welfare Association
- Omari Project
- Rasini Girls (Lamu)
- Reach Out Centre

Organizations working with most-at-risk groups

- Constella Futures
- Kenya AIDS Vaccine Initiative (KAVI)
- Liverpool VCT, Care and Treatment

Finalization of the report

The indicator data collected were presented to the National HIV and AIDS Monitoring and Evaluation Committee for approval for use in the report. The considerations undertaken during the process were whether the data were of the

period for UNGASS 2008 reporting, that is, 2005, 2006 and 2007, the appropriateness of the groups surveyed, and the coverage of the surveys undertaken. The quantitative (indicator) data were based on desk review, the qualitative data were based on the NCPI questionnaire, and stakeholder discussions were based on primary data collected by the University of Nairobi Clinical Epidemiology Unit.

Report writing was undertaken based on the literature review, the NCPI questionnaire and data collected by the data collection consultant including the most-at-risk population groups engagement report. The key content of the report was distributed to stakeholders by email and was presented for validation and approval at a key stakeholders meeting of over 100 persons. All consultants participated in the meeting and updated the components they were dealing with accordingly.

Following are lists of organizations and networks of most-at-risk and affected groups that participated at the final consultation meeting.

- Multilaterals
 - UNAIDS – Joint United Nations Programme on HIV/AIDS
 - United Nations Office on Drugs and Crime (UNODC)
- Bilateral
 - Constella Futures
 - President's Emergency Plan for AIDS Relief (PEPFAR / US government)
 - MEASURE Evaluation
 - Department for International Development (DfID)
- Non-governmental organizations (NGOs)
 - African Medical and Research Foundation (AMREF)
 - Christian Action Research and Education (CARE Kenya)
 - Cooperative Housing Foundation (CHF International)
 - DSW – German Foundation for World Population
 - Family Health International (FHI)
 - Health Policy Initiative (HPI)
 - Help Age International
 - Kenya AIDS Network Consortium (KANCO)
 - Liverpool VCT Care and Treatment
 - Médecins sans Frontières (MSF) – Belgium
 - National Alliance of Orphans and Women in Kenya (NOWEK)
- Public sector
 - Ministry of Health
 - Ministry of Home Affairs
 - Ministry of Planning and National Development

Ministry of Roads and Public Works
Office of the President – Provincial Administration
Office of the President – Special Programmes
University of Nairobi

- Provinces represented

Central
Coast
Eastern
Nairobi
Nyanza
Rift Valley
Western

- Faith-based organizations (FBOs)

Heart of Love Foundation Kenya (HLFK)
I Choose Life
Kenya Treatment Access Movement (KETAM)
Tupendane Club

- Community-based organizations (CBOs)

AIDS Orphans Care and Support Programme (AOCASP)
Dandora Youth for Development Self-Help Group (DAYFOD)
Haki Self-Help Group Programmes (HAKISHEP)
Islamic Africa Relief Agency (IQRA)
Jitahidi Community Self-Help Programme (JICOSHEP)
Kibera Community Self-Help Programme – Kenya (KICOSHEP)
Life Link
Lyon Special Programme of Disabled and AIDS (LYSPODA)
Mother/Child with AIDS Support Organization (MOCASO)
Participatory Methodologies Forum of Kenya (PAMFORK)
Ruprani House
Young Girls Protection

- People Living with HIV and AIDS (PLWHA)

Coalition of HIV-Infected and Affected Community Service Organizations
Kenya (CHIACSOK)
Foundation of People Living with HIV/AIDS in Kenya (FOPHAK)
Kenya Network of HIV Positive Teachers (KENEPOTE)

Kibera Post-Test Club (KIPOTEC)

National Network of Post-Test Clubs (NNEPOTEC)

Network of People Living with HIV/AIDS in Kenya (NEPHAK)

The Association of People with AIDS Kenya (TAPWAK)

- Most-at-risk groups

Bar Hostess Empowerment and Support Programme (BHESP)

GAY and Lesbian Communities in Kenya (GALCK)

ISHTAR

Liverpool VCT, Care and Treatment

Minority Women in Action (MWIA)

Movement of Men against AIDS in Kenya (MMAAK)

Muslim Education and Welfare Association (MEWA) Drug Treatment

Omari Project – Intravenous Drug Users

Reach Out Centre Trust – Intravenous Drug Users

Thanks a Million for Men Having Sex with Men

Appendix 2: National composite policy index

Introduction

The survey to compile the National Composite Policy Index (NCPI) was carried out in the month of December 2007 using the NCPI Instruments given in the *Guidelines on Construction of Core Indicators: 2008 Reporting (UNGASS 2007)*. Identification of key stakeholder organizations was done by the consulting organization in collaboration with NACC. Four research assistants with prior experience in key informant interviewing underwent two days of training. Pre-testing was carried out among the research assistants, only for familiarization, as no alteration of the instrument was intended. Mid-process progress was reported in the NACC M&E Technical Working Group and no alterations to the process were suggested. Out of the 42 stakeholders identified, successful interviews were held with representatives of 20 government ministries and agencies and 19 UN, bilateral or civil society organizations (see appendix 1).

Findings

1. Strategic plan

Kenya has developed a national multi-sectoral strategy or action plan to combat AIDS; the current plan runs from 2006 to 2010. The sectors of health, education, labour, transport, military and police, and young people are covered in the framework, with earmarked budgets. The framework addresses women and girls, young women and men, specific vulnerable subpopulations and OVC as target populations; workplace, school and prison settings, and the issues of HIV and AIDS cross-cutting with poverty, human rights protection, PLWHA involvement, stigma and discrimination, and gender empowerment and equality. The framework includes an operational plan with formal programme goals and clear targets and milestones.

Target populations had been identified through a process of needs assessment or needs analysis. Target groups identified include young people, men, migrant workers, rural populations, women, commercial sex workers, children, long-distance truck drivers, orphans and vulnerable children, men who have sex with men, injecting drug users, people with disabilities, pastoralists, migrant traders and pregnant women.

The country has ensured that civil society was fully involved and fully participated in developing the framework. Active involvement was ensured through wide, decentralized consultation with various stakeholder organizations. Availability of funding for these organizations also enhanced their involvement.

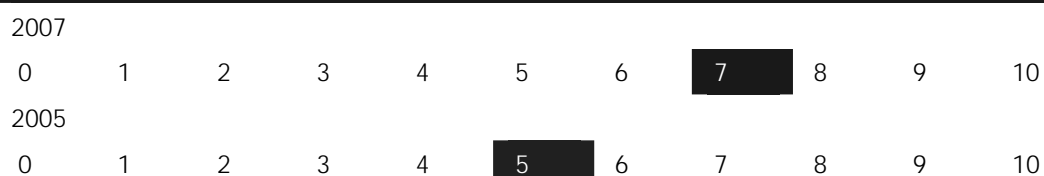
Most major external development partners have endorsed the framework and, except for one, they have aligned and harmonized their HIV and AIDS programmes with the national multi-sectoral strategy and action framework.

The country has integrated HIV and AIDS into its general development plans, which include national development plans, common country assessments and United Nations Development Assistance Framework (UNDAF), Poverty Reduction Strategy papers and Sector Wide Approach.

The country has evaluated the impact HIV and AIDS have made in its planning for socio-economic development. It has a strategy and action framework for addressing HIV and AIDS among uniformed services. Its programmes for BCC, condom provision, HIV testing and counselling, STI services, treatment, care and support have been implemented beyond the pilot stage.

The country has followed up on commitments towards universal access made during the high-level AIDS review in June 2006. National strategic plan and budgets have been revised accordingly. Estimates of the main target population subgroups are updated on an ongoing basis and programme-coverage monitoring is by sex, gender and vulnerable groups at district, constituency and provincial levels.

Overall rating in strategy planning efforts



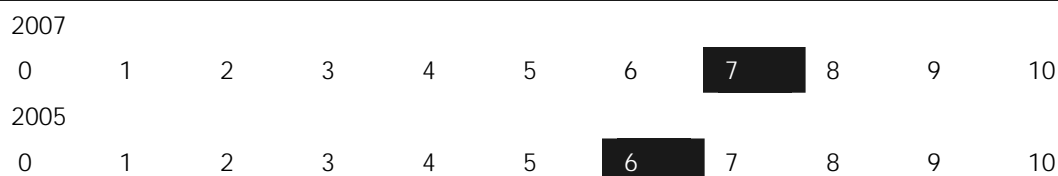
2. Political support

The president and other high officials speak publicly and favourably about AIDS efforts in major forums at least twice a year. The country has an officially recognized national multi-sectoral AIDS management and coordination body with terms of reference, an action plan and functioning secretariat. The body has active government leadership and defined membership that includes civil society participants, people with HIV and the private sector.

NACC meets at least quarterly, reviews actions on policy decisions, actively promotes policy decisions, provides opportunity for civil society to influence decision making, and strengthens donor coordination to avoid parallel funding and duplication of effort in programming and reporting.

The percentage of the budget for HIV and AIDS that is spent on activities implemented by civil society is estimated by many respondents at 60%.

Overall rating in political support



Reduced corruption has increased availability of funds. It is hoped that MPs will be sensitized to become better partners in the fight, reducing political interference.

3. Prevention

The country has a policy or strategy that promotes information, education and communication on HIV to the general population. The key messages that are explicitly promoted include being sexually abstinent, delaying sexual debut, being faithful, using condoms consistently, engaging in safer sex and involving people with HIV to a greater extent. Other policies the government promotes include knowledge of status, blood safety, personal hygiene and sanitation, improved methods of waste disposal.

The country has a policy or strategy that promotes HIV-related reproductive and sexual health education for young people and HIV education is part of the curriculum in primary schools, secondary schools and teacher training. The country also has a policy or strategy to promote IEC and other preventive health information for vulnerable subpopulations. The subpopulations mostly covered were IDUs, MSM, commercial sex workers and prison inmates.

Overall rating in policy efforts in support of HIV prevention

2007

0 1 2 3 4 5 6 7 8 9 10

2005

0 1 2 3 4 5 6 7 8 9 10

Focus has shifted from treatment to prevention—much cheaper. Implementation of HIV/AIDS Prevention and Control Act would improve situation. The target populations have been more responsive to promotion of counselling and testing as entry points for prevention, new strategies have been embodied into programmes, resources have increased. There are also fewer misconceptions about AIDS.

The country has identified districts in need of HIV prevention programmes. In most districts in need, programmes in blood safety, universal precautions in health care settings, PMTCT, IEC on risk reduction, IEC on stigma and discrimination reduction, condom promotion, HIV testing and counselling, programmes for other vulnerable subpopulations, reproductive health services and school-based education. Programmes not implemented in most districts in need include harm reduction for IDUs, risk reduction for MSM, risk reduction for commercial sex workers and HIV reduction in the workplace.

Overall rating in efforts in the implementation of HIV prevention programmes

2007

0 1 2 3 4 5 6 7 8 9 10

2005

0 1 2 3 4 5 6 7 8 9 10

4. Treatment, care and support

The country has a policy or strategy to promote comprehensive HIV treatment and three-quarters agree that it gives sufficient attention to barriers for women, children and most-at-risk populations. All the informants also said that the country has identified the districts in need of HIV and AIDS treatment, care and support services.

The country has a policy for developing and using generic drugs or parallel importing of drugs for HIV and has access to regional procurement and supply for critical commodities. Commodities include ARVs, condoms, substitution drugs, food supplements and training materials.

The country has a policy or strategy to address HIV- and AIDS-related needs of orphans and other OVC. The cash transfer to OVC in Kenya is being undertaken by the minister of Home Affairs. In the financial year 2006/7, 10,500 children in 17 districts were covered. During the financial year 207/8, the government has designated 169 million Kenya shillings for the programme. An operational definition exists of who constitutes an OVC, as does an action plan specifically for OVC. Most of the respondents interviewed could not, however, estimate the proportion of OVC being reached.

Overall rating in efforts to meet the needs of orphans and other vulnerable children

2007

0 1 2 3 4 5 6 7 8 9 10

2005

0 1 2 3 4 5 6 7 8 9 10

5. Monitoring and evaluation

The country has one national monitoring and evaluation plan, which is endorsed by key partners in M&E. The plan was developed in consultation with civil society including PLWHA. The plan includes a data collection and analysis strategy, behavioural surveillance, HIV surveillance, a well-defined standardized set of indicators, guidelines on tools for data collection, a strategy for assessing the quality and accuracy of data, and a data dissemination and use strategy. There are mechanisms to ensure major implementing partners submit their M&E data and reports working through the DASCO, PASCO and health facility reporting system.

Overall rating in the M&E efforts of the AIDS programme

2007

0 1 2 3 4 5 6 7 8 9 10

2005

0 1 2 3 4 5 6 7 8 9 10

There are now harmonized indicators through the operationalisation of the M&E framework and standardized tools have been developed. Pressure from donors and corruption reduction efforts has enhanced accountability.

6. Human rights

The country has laws and regulations that protect people living with HIV against discrimination. Civil society is in agreement that the HIV/AIDS Prevention and Control Act was passed but it has not yet been gazetted. The bill is also widely publicized, with both the government and civil society discussing it in various forums but there doesn't seem to be the political will to push for its gazettelement. The country has anti-discrimination laws and regulations that specify protection for vulnerable subpopulations, which include women and young people.

The country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support. The subpopulations most affected by these laws are women and young people. Promotion and protection of human rights is explicitly mentioned in some HIV policy or strategy.

National policy is for free HIV-prevention services, ART and HIV-related care and support interventions. VCT, ARVs and TB medication are given free of charge in government facilities. However, since providing services is sometimes donor initiated, the government may not have a contingency plan as such. The global community is committed to fighting HIV and AIDS, hence the continued financial support.

The country has a policy prohibiting HIV screening for general employment purposes, and all informants agree that the country has a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national or local ethical review committee.

Overall rating in the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS

2007

0 1 2 3 4 5 6 7 8 9 10

2005

0 1 2 3 4 5 6 7 8 9 10

There has been some improvement in the policies, laws and regulations in place to promote and protect human rights, as evidenced in the passing of the HIV/AIDS Prevention and Control Act in December 2006.

Overall rating in the efforts to enforce the existing policies, laws and regulations

2007

0 1 2 3 4 5 6 7 8 9 10

2005

0 1 2 3 4 5 6 7 8 9 10

The Act is not yet operational; therefore, enforcement is still a challenge although there has been some slight improvement in this too. There has been too much concentration on treatment, to the extent that prevention programmes have been ignored. This is an area that is being worked on now and so there is likely to be some positive result after some time.

7. Civil society participation

The country has included civil society, national and decentralized levels in a national review of the National Strategic Plan, usually annual in the JAPR. Types of organizations representing civil society include umbrella networks—PLWHA, FBOs, CBOs, IDUs, MSM, human rights organizations, children and young persons organizations. They are also members of various MCGs.

Overall rating in the efforts to increase civil society participation

2007

0 1 2 3 4 **5** 6 7 8 9 10

2005

0 1 2 3 **4** 5 6 7 8 9 10

There is a deliberate effort and commitment to involve civil society.

Key organization

Action Aid

Centre for HIV Prevention and Research,
University of Nairobi

City Council of Nairobi

Constella Futures

GTZ

IOM

IRC

Jamhuri High School

Jomo Kenyatta University of Agricultural
Technology

KENWA

Kenya Long Distance Truck Drivers
Association

MAP

Ministry of Agriculture

Ministry of Education

Ministry of Finance

Ministry of Gender and Sports

Ministry of Home Affairs

Ministry of Justice and Constitutional Affairs

Ministry of Labour

Ministry of Planning

Ministry of Tourism

Ministry of Trade

Ministry of Transport

Ministry of Youth Affairs

NACC

NASCOP

National Council of Churches of Kenya
(NCCCK)

Office of the Attorney-General

Policy Project

Public Service Commission

SUPKEM

SWAK

Teachers' Service Commission

UNAIDS

UNHCR

USAID Kenya

WOFAK

World Bank

World Vision

Appendix 3: Engagement of civil society dealing with most-at-risk groups

3 December 2007, Nairobi

Workshop objectives

- Understand the UNGASS country report process
- Identify progress made, challenges, lessons learned and recommendations on HIV and AIDS interventions since UNGASS 2005 report
- Identify good practices
- Plan the way forward

Participants of the consultation process

The participants were drawn from civil society organizations working on HIV and AIDS programmes at national and grassroots levels.

Consultation methods and approach

The methods used included having the organizations share their experiences by using tools and guidelines for their participation and involvement in national HIV and AIDS response. Groups were divided according to the KNASP 2005/6–2009/10 priority areas for discussion and were guided by a prepared tool comprising these elements: area of focus, progress, challenges, lessons learned, and recommendations or action points. Groups and other members presented and shared their results and additional input in plenary sessions.

Group discussions and feedback

Participants were divided into four groups according to the priority areas in the Kenya National HIV and AIDS strategic plan. Guidelines for discussion included the following elements: progress since 2005, challenges, lessons learned, and recommendations or action points. The group discussion results are presented here.

Priority area 1: Prevention of new infections

The organizations that participated in the discussion of priority area one included; AOCASP, IQRA, Self help group, Life link, YWCAA, KENWA, TAPWAK, Red Cross, MSF and Dandora youth for Development.

◇ Access to counselling and testing

Progress:

- More people are reached through VCT services.
- An increased number of people are coming out to be tested as a result of sensitization and outreach programmes such as mobile VCTs.
- Acceptance and use of male condoms is increasing.

- VCTs are serving as one-stop shops for HIV and AIDS services and related issues like rape.

Challenges:

- Follow-up mechanisms for clients are inadequate.
- The number of VCT sites is still inadequate, especially for at most-at-risk populations.
- VCTs are not target-group friendly; for instance, they are not youth friendly.

Recommendations:

- Improve on networking and partnership building for those working on HIV and AIDS programmes.
- Incorporate client-friendly VCT services, especially for most-at-risk populations and youth.
- Create more awareness of the need to be tested and the services available.

◇ *Condom promotion*

Progress:

- Male condom use has increased among the various groups.
- Male condoms are available in all areas.

Challenges:

- Female condoms are inaccessible and expensive.
- The attitude towards female condoms is negative in both females and males.
- Incorrect and inconsistent use of condoms has put people at risk of being infected.
- Condoms are placed in areas, such as the chief's camp, that deter people and especially the most-at-risk populations and youth.

Recommendations:

- Increase awareness of the importance of correct and consistent condom use.
- Increase availability and awareness of female condoms.
- Place condoms in areas more friendly for privacy and confidentiality.

◇ *Strengthening STI and HIV programme links*

Progress:

- A decrease in STI infections is due to increased awareness, condom use and free treatment.
- Good links have been initiated between HIV and STI programmes.

Challenges:

- Attitudes of health care providers need to improve, especially towards most-at-risk populations such as MSM, WSW, CSWs, and IDUs.

- Some STIs take long to show symptoms, especially in women.

Recommendations:

- Sensitize health care providers to treat all without being judgemental.
- Encourage and sensitize most-at-risk populations, especially women, to have regular checkups.

◇ *Expanding prevention of mother-to-child treatment*

Progress:

- More children are being protected from HIV infection as a result of an intensified campaign on the initiative.
- More mothers are able to know their status and take care of their pregnancy and beyond.
- The ARVs are available and free at health facilities.

Challenges:

- Supportive feeding programmes are inadequate or unavailable, especially for the poor and most-at-risk populations such as IDUs.
- Notifying partners of HIV status is still an issue.
- There is little understanding of discordant couples.
- Male involvement in PMTCT activities is low.
- Adherence to HIV treatment is low.
- Cultural interference—society expects a mother to breastfeed regardless of her status.

◇ *Behaviour change communication*

Progress:

- Creating awareness of the various issues around HIV and AIDS has led people to change their behaviour.
- Various information, education and communication (IEC) materials are aimed at influencing behaviour change.

Challenges:

- Communication is not oriented towards target groups—it is not, for instance, targeting most-at-risk populations such as IDUs, CSWs and MSM.

Recommendations:

- Develop and distribute more IEC materials focused on most-at-risk populations; these materials should be translated into local languages.
- Consistently and sustainably promote BCC.

◇ *Blood screening*

Progress:

- Safe blood is available in health facilities.

Challenges:

- Blood supply is inadequate.
- Awareness of blood safety is inadequate.

◇ *PEP – post-exposure prophylaxis*

Progress:

- ARVs are available in health facilities.
- Institutions and health facilities are addressing the needs of survivors.

Challenges:

- There is little awareness that these services exist.
- Limitations because of small number of health facilities providing the services are compounded by lack of awareness of the existence of the few.

Lessons learned:

- Creating awareness of PEP services would lead to their uptake, which would also help reduce the number of new infections.

Recommendations:

- Awareness should increase on what services are available in health facility centres.

Good practice

Good testing and counselling services are available for survivors of sexual violence. Drugs and support services are available, and this has encouraged uptake of the services.

Priority area 2: *Improved quality of life for those infected and affected by HIV and AIDS*

The CSOs included NEPOTEC, KIPOTEC, Cana, MOCASO and I Choose Life.

Progress:

- Use of ARVs has scaled up; they are free in government hospitals.
- Stigma and discrimination have been reduced because of intensified sensitization and advocacy programmes.
- There has been a lot of capacity building for health care workers to enable them to meet client needs. For instance, there are now a few VCTs addressing MSM needs.

- ART services are better coordinated and physical facilities such as the District AIDS and STI Coordinators (DASCOS) improved; there are more community health workers, who are organized to respond to current needs and challenges.
- There has been an increase in VCT and TB testing. TB treatment is free, which has encouraged people to seek the services.
- Referrals and links have been improved, with service providers seeing each other as partners, not competitors.
- Most centres have nutritional counsellors, thus improving counselling services on nutrition.
- Legal, policy and administrative frameworks have been developed.
- PLWHA have been mainstreamed in programmes of the national human rights agenda and organizations. Such examples cited included the GIPA principle (greater involvement of people living with HIV and AIDS).
- Rescue centres have been set up for OVC, and the children's department in the Ministry of Home Affairs has become more active.

Challenges:

- Private NGOs and FBOs still have problems obtaining ARVs and have to seek funding to purchase them.
- Some people in need of ARVs come when their CD4 count is below 100 and they are not given medication because they lack the proper nutritional food and other support services.
- Diagnostic tests (baseline HIV tests) and opportunistic infections treatments are not free in most institutions so patients cannot have access to them.
- There are no established treatment centres for multi-drug-resistant TB.
- Options are limited for those who react to the free ARVs given in government hospitals, that is, the first-line regimens.
- Support groups have, to some extent, created a dependency syndrome among PLWHA that is not sustainable.
- The HIV and AIDS Prevention and Treatment Act has not been put into operation.
- Counselling on legal, treatment and reproductive health rights has not been included in the CCC as a package offered to PLWHA.

Lessons learned:

- HIV and AIDS treatment should go hand in hand with TB treatment.
- ARV scaling up is not possible without equal investment in treatment literacy.
- For effective treatment to take place, nutritional supplements are necessary and should be part of the package.

Recommendations:

- Food supplements should be given to those down with HIV and TB, and their families should be sensitized to support them.

- Treatment literacy should be emphasized in all health centres.
- More efforts should be made in public education and advocacy, especially in rural areas.
- Men and the boy child need to be strongly targeted for public education and advocacy as most programmes exclude them despite the crucial male role as decision makers and owners of family and community resources.
- A lot more needs to be done to build capacity of PLWHA to advocate and protect their rights.

Good practice

Post-test clubs have been established that support and complement the work of health-care givers.

Structuring has been good in coordinating HIV and AIDS interventions, from the national level to the CACCs.

Priority area 3: *Mitigation of social and economic impact of HIV and AIDS*

CSOs in the group included KICOF (Kibera Counselling and Feeding—centre for OVC), Cana Family Life, Haki, KICOSHEP, LYSPODA and NOWEK.

Advocacy

Progress:

- Through free primary education more orphans have had access to education.
- Initiation of a feeding programme in some primary schools has improved the situation for OVC.
- Initiation of youth and women funds is expected to contribute to more income-generating activities being initiated.
- Implementation of cash transfer funds targeting OVC in some districts in the country has led to improved lives and community willingness to take care of the OVC.
- An OVC national action plan is in place.
- A national children's policy is in draft.

Challenges:

- Response of lawmakers to develop and implement policies is slow.
- Networking mechanisms in place are poor or inadequate.
- Local administration and church leaders are little involved in mitigation issues.
- Resources to support advocacy activities are inadequate at all levels.

Lessons learned:

- Although cash transfers have contributed to improved welfare of the OVC, the efforts are not sustainable.

Recommendations and action points:

- CSOs should be empowered to develop and implement sustainable mitigation programmes and strategies.

Mitigation programmes

Progress:

- More CSOs have been started to mitigate the social and economic impact of HIV and AIDS.
- All sectors have mainstreamed their mitigation strategies into their programming.

Challenges:

- Participatory efforts from other stakeholders are low.
- Resources to support mitigation programmes are inadequate.
- There is no baseline databank that would avoid duplication of services and efforts.

Lessons learned:

- Community members should be involved at all levels of programming so as to own and take responsibility.
- School dropouts stand to benefit more by being enrolled in vocational schools where they will learn life skills for self-reliance.

Priority area 4: KNASP Support services

The CSOs that participated in this group include KANCO, KENEPOTE, Action Aid and Dandora Youth.

Monitoring and evaluation

Progress:

- The M&E framework has been finalized, launched and disseminated through training meetings at DTCs, CACC, where feedback on challenges was raised.
- Access to ART and VCT has increased.
- The Three Ones principle provides a support mechanism for HIV and AIDS response.
- JAPR, which has involved the participation of CSOs and CBOs from the grassroots to national levels, has been produced and circulated.

Challenges:

- Although there are M&E managers, the CSOs have not felt their support.
- Communities have little understanding of how to fill in COPBAR forms for feedback.
- CACC committees are not very active in engaging CSOs; they tend to work parallel while their mandate and role should be of support.

- CSOs get no feedback on TB, malaria, ART and VCT reports.
- CSOs are unaware of baselines carried out by NACC.
- CSOs are unaware of the national HIV and AIDS M&E databank.

Recommendations:

- COPBAR needs to be reviewed and CSOs should be involved in the review.
- PASCO should be disseminated more frequently than once a year.
- CSOs should participate in cash transfers for OVC; NACC should engage the Ministry of Home Affairs to work with CSOs in addressing OVC needs.
- NACC needs to engage all departments and CSOs to get information on TB, malaria, VCT and ART.
- NACC should build CSO capacity to harmonize and fully appreciate M&E amidst the many donors and partners.
- There is need for more linking and sharing of information among stakeholders; this could be through sharing information on research and research findings.

Research

Progress:

- KARSCOM has been set up.
- Research strategy has been developed.

Challenges:

- CSOs are not represented in KARSCOM committee. CSOs are involved minimally in research activities yet they play a major role in identifying and capturing operation research in the community.
- There is a gap in feedback of research findings with respect to CSOs and target communities; this discrepancy was also cited by most-at-risk populations.
- Research strategy has not been disseminated; CSOs are not involved in the process and neither are they aware or sensitized to the strategy contents.

Recommendations:

- NACC should disseminate research findings to inform CSOs, to improve programming.
- Other groups such as most-at-risk populations should be involved in various research activities. These groups include MSM, WSW, CSWs and IDUs.

Financing and procurement

Progress:

- NACC has involved CSOs in budget (MTEF) and Swaps (sector-wide approaches).

Challenges:

- CSOs not included in this result framework yet have a crucial role to play.

- NACC is involved in procuring drugs, and CSOs feel they should be represented in the process so as to monitor and evaluate the availability of supplies. CSOs raise their voices when supplies run low.

Recommendations:

- In financing, CSOs advocate open engagement, budget tracking and capacity building for communities. NACC needs to strengthen CSO capability to effectively participate in these processes.
- The role of other stakeholders such as the private sector should be spelled out and use made of these stakeholders.

Communication, coordination and networking

Progress:

- The partnership strategy is being developed.
- CSOs are involved in developing and disseminating their terms of reference.
- ICC in HIV and AIDS is open to CSOs.
- JAPR process has involved the stakeholders at all levels and has contributed to enhanced sharing and networking.

Challenges:

- It is not easy for NACC to strengthen a multi-sectoral approach to addressing HIV and AIDS response in Kenya.
- ACUs are challenged because their level in ministries is low and the officers in charge are junior.

Recommendations:

- NACC should identify target groups and go to them directly instead of picking a few representatives from such groups to participate.
- NACC should engage in TB and malaria work, as these diseases have a relationship with HIV and AIDS.
- CSOs should be engaged in co-funding KNASP 2005/6–2009/10.
- JAPR should be open to all the stakeholders, not only people pushing to participate.
- NACC should hold frequent inter-ministerial meetings to strengthen ACUs and CSOs.
- The communication process should be strengthened by spearheading and sharing best practices.

Best practices

The JAPR process that involves the participation of key stakeholders at local, district, provincial and national levels has made it possible to share progress, challenges, lessons learned and identification of way forward at all levels. The 2007 JAPR process was conducted in all districts and provinces in the country and the perspectives gained were shared in the national forum.

The Interagency Coordination Committee process has also let the voices of the various stakeholders be heard. Coordination is improved and efforts aimed at responding to HIV and AIDS challenges are being shared.

Civil society participation

In this session the CSOs were provided with a form to respond to various elements and their full responses have been reflected in the annex two of the report. A synopsis of the CSOs response is captured as:

CSO contribution to strengthening the political commitment

Asked the extent of CSO contribution to strengthening the political commitment of top leaders and to formulating national policy, 15 out of 26 of the respondents gave a score of 3 and above, 0 being the lowest. Nine of the CSOs gave a score of 2 and below while two did not respond to the question.

Involvement of CSOs in planning and budgeting

On the involvement of CSOs in planning and budgeting, 14 gave a score of 3 and above while 12 gave a score of 2 and below.

CSO services inclusion in the National Strategic Plan and national reports

The HIV and AIDS services CSOs provided included in the National Strategic Plan and the national reports. The response was that 14 rated the inclusion at 3 or above while 12 scored it at 2 or below. On inclusion in the national budget, 10 respondents scored it 3 or above, 14 scored it 2 or below, and 1 opted not to respond.

CSO inclusion in national review

On including CSOs in national review of the national strategic plan, 10 of those who responded stated they were included, 15 said they were not included and 1 did not respond.

CSO representation in HIV and AIDS efforts

On question 5, the extent the CSO sector was represented in the HIV- and AIDS-related efforts, 20 gave a high score of 3 or above, 2 gave a score of 2, and 4 did not respond.

On the extent to which CSOs had adequate financial support to implement HIV and AIDS activities, only 2 gave a high score of 5, 9 gave a score of 3 or 4, an overwhelming 9 gave a score of 2, and 2 gave 0. On technical support to CSOs to implement HIV activities, 13 gave a score of 3 or above, 12 gave a score of 2 or below, and 1 did not respond.

Comparing 2007 with 2005

Response to the request to compare 2007 efforts to increase CSO participation with those of 2005 are summarized:

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?

| | 2007 | | | | | | | | | | Good | No answer | |
|-------|------|---|---|---|---|---|---|---|---|---|------|-----------|---|
| | Poor | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | | 9 |
| Score | | 0 | 0 | 0 | 3 | 3 | 3 | 1 | 4 | 1 | 2 | 9 | 1 |
| | 2005 | | | | | | | | | | Good | No answer | |
| | Poor | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | | 9 |
| Score | | 2 | 3 | 5 | 6 | 2 | 3 | 2 | 0 | 0 | 0 | 2 | 2 |

Efforts to involve the CSOs have improved. On a scale of 0 to 10, in 2005, 21 respondents scored efforts at 5 or below while 2 gave those efforts the highest score. In 2007 only 9 gave a score of 5 or below, 8 gave scores of 6 to 9, and 9 gave efforts the highest score of 10.

Appendix 4: Consultative meeting with most-at-risk populations

MSM Consultative Meeting, 7 December 2007, Nairobi

The MSM consultations were held on 7 December 2007. A major drawback was that the WSW were absent, as they were away on a camp.

Workshop objectives

- Share experiences
- Identify success, challenges, lessons learned and recommendations on HIV and AIDS response
- Way forward

Priority area 1: Prevention of new infections

Progress:

- Programmes with Kenya AIDS vaccine (KAVI) testing for HIV every three months led to increased and sustained testing.
- Establishment and promotion of MSM VCT centres contributed to more people seeking services as these centres were more sensitive to their needs.
- Condoms were distributed well and made accessible to many people.
- Screened blood was available for transfusion.
- Use of disposable syringes in the health facilities increased.
- The use of vernacular by the media to spread HIV messages has led to increased awareness on how to prevent HIV transmission and improve the quality of life through access to the various services available.
- Increase in the use of drama and demonstration has led to better and effective understanding of HIV messages.
- MSM and WSW have been included in the Joint HIV and AIDS Programme (JAPR), especially in the last two years.

Challenges:

- Inappropriate disposal of syringes could lead to other people using the needles and thus risking infection.
- Poor distribution of condoms, especially in bars and lodgings at night, has led to a hike in the price to KES 50.
- Lubricants are in short supply and expensive when found at KES 200 per tube. Liverpool VCT was said to be the only place MSM could access lubricant free of charge.
- Health care providers are unfriendly and uninformed on MSM and WSW. Examples were cited where the first question of health-care staff was, 'Where is your wife [or husband]?'

- Criminalization of MSM and WSW has led to this group to go into hiding and thus they do not have access to adequate information and services related to HIV and AIDS.
- Self-denial within the MSM community limits men from seeking access to sexual and reproductive health services.
- The high social stigma and discrimination against MSM and WSW in society has at times resulted in violence being meted on group members.
- Disclosure even to parents and family is still a major challenge. In fact, only one member had 'somewhat/ disclosed his orientation to his mother.

Lessons learned:

- It is difficult to work with illegal groups as members cannot openly accept assistance.
- Separation of important issues from politics would make programmes more effective.

Recommendations:

- Networking and building partnership among groups should be encouraged as it would lead to greater effectiveness.
- MSM should be legally recognized to reduce the stigma and discrimination and to make it easier for members to have access to services. Their presence in society was summarized thus:

Legislators should recognize us; they cannot kill us as we are a mass. They have no choice but to recognize us!

- The number of MSM-friendly VCT centres, such as exist in KEMRI, KAVI and Liverpool VCT, should be increased.
- Training health workers on special needs of MSM and WSW should also address worker attitudes and language.
- Distribution of condoms and lubricants in prisons should be increased, as it is obvious that the inmates engage in sexual activities.

Priority area 2: Improvement of quality of life

Progress:

- MSM programmes providing care and support to PLWHA have increased. There is a helpline to give MSM access to information on HIV and AIDS.
- Networking and interaction with NACC has improved. However, more needs to be done at programme level to address MSM and WSW needs.
- The number of MSM organizations such as ISHTAR that provide support has increased. KAVI and KEMRI are undertaking research.
- Liverpool VCT is training an increased number of counsellors to improve services targeting MSM.

Challenges:

- MSM face double stigmatization and discrimination when they test positive for HIV.
- There are no groups to protect the human rights of MSM. Organizations addressing HIV and AIDS have not adequately addressed MSM rights.
- The few organizations such as ISHTAR that work with MSM lack resources to effectively carry out their activities.
- MSM are criminalized, and the right for consensual sex between same-sex lovers is not recognized.

Lessons learned:

- An increase in the number of MSM-friendly health-care providers and services would lead to an increase in the number of MSM seeking and using services.

Recommendations and action points:

- Awareness of MSM issues should be increased among health providers and communities.
- NACC should move ahead a step and advocate including MSM in programming.
- Groups and organizations working with MSM should be registered.
- Public health facilities should be sensitized to accommodate and provide services to MSM. This should be countrywide as MSM populations also exist in rural areas.
- The capacity of organizations working with MSM and WSW should be augmented to effectively address HIV and AIDS issues.

Priority area 3: Mitigation of social and economic impact of HIV and AIDS

Progress:

- No progress was identified in this priority area.

Challenges:

- No national policy considers the social and economic impact of HIV on MSM.
- There is no research or information on the number of MSM; know this would go a long way towards helping develop effective programmes.

Lessons learned:

- Community recognition of MSM would improve support and decrease discrimination and stigmatization.

Recommendations:

- Awareness should be increased at policy, programmatic and community levels on the effect issues pertaining to HIV and AIDS have on MSM and WSW.
- A social and economic mitigation study should be conducted that would focus on the effect of HIV and AIDS on MSM and WSW.

Priority area 4: KNASP 2005/6–2009/10 support services

Progress:

- KNASP 2005/6–2009/10 recognizes MSM and WSW, which opens way for consultations and programming.
- Networking with NACC and the few organizations working with MSM and WSW has improved.

Challenges:

- There are no guidelines or strategic plans to guide partnerships and networking.
- MSM and WSW are not officially involved in NACC committees.
- Criminalization of MSM prevents groups from registering.
- Organizations working with MSM do not have adequate financial or human resource capacity.
- MSM, WSW and PLWHA are not well represented in NACC subcommittees.

Lessons learned:

- Excluding MSM from national strategies may lead to their being more marginalized in programming.

Recommendations:

- Programmes, strategies and policies that target MSM should be developed and implemented.
- Research to address the gaps on MSM and WSW should be undertaken, as it would contribute to effective and efficient programming.

Good practice

Integrating MSM in the services provided in VCT facilities has led to an increased number going for testing. In addition, MSM feel that they are a part of society as they gain access to these services.

Consultative meeting with CSWs: 10 December 2007, Nairobi

CSWs at this meeting included both women and men as compared with last year when there were no men.

Priority area 1: Prevention of new infections

Progress:

- Increased access to condoms in bars has led to an increased number of CSWs using condoms. Previously condoms were placed in public places such as chiefs' camps.
- CSWs have been educated on proper condom use and have encouraged members to go for VCT.

- CSWs have increased their knowledge about services available such as PMTCT and PEP; examples were cited where young CSWs who had been raped were taken to Nairobi Women's Hospital.

Challenges:

- Police harass CSWs and at times law enforcement officers, including the council *askaris*, rape them. These law enforcement officers do not use condoms and thus further expose CSWs to infection.
- It was reported that in some of the bars and social places, free condoms were not available. Instead people were selling them at KES 50, which CSWs felt were too expensive as their clients refused to pay.
- No female condoms are available to women CSWs. Besides, their clients do not want them using the female condoms; thus CSWs have to resort to negotiating with clients to use male condoms.
- Health-care providers are hostile to CSWs; also, VCT staff is not well informed on how to counsel CSWs, either females or males.
- VCT facilities are not sensitive to the hours CSWs have available; most health facilities operate only during the day when CSWs are asleep.
- Some clients mete out both physical and sexual violence on CSWs.

Recommendations:

- Condoms should be placed in areas accessible and sensitive to the user,
- Health care providers need to be sensitized; health facilities should be open longer hours to enable CSWs access to the services.
- Measures should be taken to prevent the risky behaviours of law enforcement officers.
- CSWs need advocacy to protect them from harassment and exploitation by law enforcement officers.

Priority area 2: Improvement on the quality of life

Progress:

- Knowledge has increased on the availability of services as a result of sensitization and outreach programmes. CSWs were aware of ARVs and the need for good nutrition when infected with HIV.
- Treatment and care of CSWs infected with STIs has improved.
- CSWs are receiving more attention than previously, when they were simply labelled as the source of the virus.

Challenges:

- Hostility from neighbours make CSWs live in fear and not disclose their trade. They are also shy to share the information they have on improving the quality of life as they would also have to explain the source of the information.
- They suffer from poverty as a result of their erratic trade, which although at times yields high returns.

- Treating STIs and paying for related services is expensive and not easily reached by CSWs.
- Competition and hostility between male and female CSWs is increasing. Male CSWs are paid KES 3000 to KES 15,000 while females earn only KES 200 to KES 1000.
- Law enforcement officers and the community do not respect CSW rights. If a CSW is beaten, the matter is likely dismissed as merely a violation on a *Malaya* (a Swahili reference to CSWs).

Recommendations:

- Food should be given with ARVs, especially for poor populations.
- Some accompanying services, such as laboratory tests, should be made free.
- Rights of CSWs should be advocated, especially as whether they have security or suffer abuse hinges on those rights.

Priority area 3: Mitigation of social and economic impact of HIV and AIDS

Progress:

- No progress report was given in this area.

Challenges:

- Most CSWs, especially the females, had little education and therefore could not easily find gainful employment.
- The stigma associated with CSWs and the discrimination against them in the community is high.
- There are no social and economic programmes aimed at improving CSW status. Many of those interviewed stated that they would leave the trade if they were able to support their children.

Lessons learned:

- If CSWs had access to credit, many would set up their own income-generating activities. This was especially stated by those who had long been in the trade; they stated they were tired and wanted to do something else.

Recommendations and action points:

- Give CSWs skills training and make credit available to them for business and income-generating activities.
- Improve CSWs' knowledge of STIs, HIV and AIDS and build their capability to train other CSWs and the community.
- Undertake research on CSWs so as to comprehend the magnitude of the issue and also identify who among them are male, to develop and implement appropriate programmes. The Bar Hostesses Organization estimates that there are at least 60,000 CSWs in Nairobi alone, but the number could be higher.

Consultative meeting with IDUs

11 December 2007, Mombasa, and 14 December, Nairobi

Consultations with injecting drug users were held in Mombasa on 11 December 2007 and in Nairobi on 14 December. This report is a synthesis of results from the two groups but differences are highlighted as appropriate.

Priority area 1: Prevention of new infections

Progress:

- Knowledge has increased on the dangers of infection as a result of such practices as sharing needles.
- There is more understanding of the IDU role in preventing new infections.

Challenges:

- Needles are not easily available and affordable for IDUs, despite the cost being only KES 10–15. For IDUs, the priority is not on the needle but to be able to purchase the heroin sachet. One costs KES 100–150, and a user may take four to six in a day.
- IDUs hide needles for use later but other IDUs may find a needle, use it and not clean it, thus putting the owner at risk. They hide needles because the police arrest people carrying syringes.
- Rehabilitation is expensive and out of reach of many IDUs. The cost was stated to be KES 20,000 per month for six months. Besides, most centres are for alcoholics not IDUs.
- IDUs are stigmatized and excluded by their families and the community. They are not viewed as sick but as deviants who are responsible for their situation.
- Few VCTs are drug-user friendly. For instance, the time a counsellor take to discuss with a client is too long for an IDU. IDUs are fidgety and too impatient to wait in a long queue or for the services.
- Female IDUs are more at risk of infection as many become CSWs and are likely to encounter sexual violence while in the streets.
- The information, education and communication (IEC) materials focused on IDUs are inadequate.
- IDUs are criminalized and ostracized. Cases were cited where an IDU was arrested and jailed. Then after 10 years of being clean, they wanted to travel internationally but were denied a visa. On appeal they were asked to get a certificate of clearance, which was denied by police. Cases were cited where the recovered clients were denied employment for having done drugs in the past.

Lessons learned:

- Treatment of IDUs living with HIV and AIDS must be accompanied by feeding programmes.
- Criminalizing and arresting IDUs only leads to the practice being hidden and issues not being addressed adequately.

Recommendations:

- There should be advocacy for engaging rehabilitated drug users in gainful employment and for law enforcement officers to set a time limit after which one could get a certificate of good conduct.
- Parents, family and the community need to understand and support IDUs, as doing so would lead to faster recovery and fewer relapse of cases.
- VCT staff should be sensitive and gauge situations with IDUs, who cannot go for services when they are low and neither can they go when they are high. Hence the need judge their condition. In many cases the questions counsellors ask are not relevant to the IDUs. For instance, they are asked when they had sex during the last month and this was irrelevant as most IDUs stay for even more than a year without sex. They say the desire for sex evaporates with the intake of the drugs.

Priority area 2: Improvement of quality of life of infected and affected

Progress:

- Knowledge has increased on the availability of treatment services including PEP.

Challenges:

- Adherence to treatment is low, because of IDUs' condition. One can test HIV positive and get the ARVs but is unable to follow through with the drugs because of being high.
- Health-care workers are insensitive to the impatience of active users and send them away.
- The team was informed that 70% of IDUs tested positive for hepatitis C and 34% for HIV. Testing for hepatitis is expensive, costing KES 800–1000—far beyond what a user could afford.
- Users lack money to buy food when taking the ARV drugs.

“An addict will default taking ARVs because it is not easy to get food and they would rather use the money they have to buy drugs. In some hospitals, they give food baskets to some people but discriminate against us.”

- Support services such as testing for CD4 count may be lacking. Organizations such as KEMRI may not provide services to IDUs as their focus may be on other groups such as MSM.
- Programmes address drug users, as before one becomes an IDU they are drug users. The programmes are therefore only short-term measures due to the numbers graduating to IDUs.
- Rehabilitation services are not women friendly and the number in such programmes is low. For instance, only the Omari Project in Malindi has female clients, and even there, the number is only 4 as compared with 20 male clients.

Recommendations:

- Train and position health care providers who understand IDUs and issues touching on them so as to improve the services provided.
- Machines for CD4 count are needed—'Organizations like KEMRI have the machines, but you go and they specify they are dealing with MSM. The small hospitals that are nearby are ill equipped.'
- Home-based care by the government should be strengthened so that counsellors can reach more people, provide information and encourage them to take ARVs.
- Communities should be sensitized to understand and support IDUs and include them in activities.

Priority area 3: Mitigation of social economic impact of HIV and AIDS

Progress:

- Institutions such as MEWA, Reach Out in Mombasa and Omari Project in Malindi work with IDUs. In Nairobi, Asumbi works with Maisha House, which focuses on IDUs.
- Awareness has increased of the role IDUS can play in addressing HIV and AIDS.

Challenges:

- Few institutions deal with rehabilitating IDUs, compared with the number working with alcoholics.
- IDUs lack the resources to start business activities. Most cannot get jobs because of their status and even those who are rehabilitated suffer from discrimination.
- IDUs do not get family support because their families cannot trust them due to their previous antisocial behaviour. In addition, family members have little understanding of IDUs and see them as criminals. This minimizes the effectiveness of rehabilitation programmes as many do not adhere to treatment and often relapse.
- If IDUs suffer sexual violence, they may be 'too high' to remember to act within the 72 hours required to minimize the risk of infection.
- The link is high between orphanhood and involvement in drugs, eventually graduating to being an IDU. It was reported that 90% of drug users and IDUs are from single-parent families.
- IDUs' plans are short term—they live for the day. Most programmes focus on the long term and thus do not address immediate needs.

Lessons learned:

- Acceptance and integration of IDUs in community activities would lead to lowered rate of relapse. Besides, the IDUs would regain their feeling of self-worth and participate in beneficial activities.

- Mobile VCTs encourage people to get tested as the services are brought to them. There is also the feeling that the service providers do not know them, which increase service uptake.
- Unaware discordant couples blame the person who encouraged them to get tested: 'The discordant couple blames *you* for messing up their life.'

Recommendations:

- Communities and especially parents should be sensitized to recognize and support their children who have become drug users, so as to assist them in their efforts to kick the habit.
- The family, community and law enforcement officers need to be educated that addiction is a disease and should be treated as such.
- Those who are on the recovery path need help in initiating business activities as most cannot get gainful employment because others are suspicious of them.
- A needle exchange programme should be established to ensure that the IDUs use clean needles.
- Increased use should be made of mobile VCTs to reach IDUs.

Good practice

Reach Out, an organization based in Mombasa, learned that 90% of their rehabilitated clients relapsed when they went back to the community. To reverse this trend, they set up a halfway house where IDUs stay, briefly visit their families and then return to the house. They share rooms for two months as they are weaned off the institution. This system has been found to work, but it faces problems such as lack of financial resources and can accommodate only 20 recovering addicts at a time.

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