

United States Mission to Kenya  
Five Year Strategy  
*for the*  
President's Emergency Plan  
*for AIDS Relief*

***Strong Networks for a  
Sustained Response***

Prepared by the Interagency Team



Final Draft (public version)

October 29, 2004

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## List of Acronyms / Abbreviations / Terms Used

ABC	: Abstinence, Being faithful, Condoms	MOH	: Ministry of Health
ACU	: AIDS Control Unit	MP	: Member of Parliament
AIDS	: Acquired Immune Deficiency Syndrome	MRU	: Medical Research Unit
ANC	: Antenatal clinic / Antenatal care	MTCT	: Mother-To-Child-Transmission
ART	: Antiretroviral Treatment	NACC	: National AIDS Control Council
ARV	: Antiretroviral medications	NASCOP	: National AIDS and STD Control Programme
BCC	: Behavior Change Communication	NBTS	: National Blood Transfusion Service
BSS	: Behavioral Surveillance Survey	NCPD	: National Council for Population and Development
CACC	: Constituency AIDS Control Committee	NLTP	: National Leprosy and Tuberculosis Control Programme
CBO	: Community-Based Organization	NGO	: Non-Governmental Organization
CDC	: (the US) Centers for Disease Control and Prevention	OI	: Opportunistic Infection
CHAK	: Christian Health Association of Kenya	OP	: Office of the President
CSW	: Commercial Sex Worker	OVC	: Orphans and Vulnerable Children
DAGA	: Development Assistance Grant Agreement	PLWHA	: Person(s) Living With HIV/AIDS
DFID	: Department for International Development (United Kingdom)	PMCT	: Prevention of Mother-to-Child Transmission
FBO	: Faith-Based Organization	SM	: Social Marketing
FY	: Fiscal Year	STD, STI	: Sexually Transmitted Disease, Sexually Transmitted Infection
GFATM	: Global Fund on HIV/AIDS TB and Malaria	TB	: Tuberculosis
GOK	: Government of Kenya	TBA	: Traditional Birth Attendant
HBC	: Home-Based Care	UNAIDS	: Joint United Nations AIDS Programme
HIV	: Human Immunodeficiency Virus	UNDP	: United Nations Development Program
IGA	: Income Generating Activity	UNFPA	: United Nations Fund for Population Activities
JAPR	: Joint HIV/AIDS Programme Review	UNICEF	: United Nations Childrens Emergency Fund
KDHS	: Kenya Demographic and Health Survey	USAID	: United States Agency for International Development
KEC	: (Roman Catholic) Kenya Episcopal Conference	USG	: United States Government
KNASP	: Kenya National AIDS Strategic Plan	VCT	: Voluntary Counseling and Testing
KSPA	: Kenya Service Provision Assessment	WHO	: World Health Organization
MEDS	: Mission for Essential Drugs and Supplies		
MOEST	: Ministry of Education Science and Technology		

## I. Introduction and Background

### *1. Vision*

The US Mission to Kenya has selected a priority *structure*, a priority *population*, and a priority *intervention* to continue the theme of transformation in our first Country Operational Plan.

We believe that *strong networks for a sustained response* will provide the structures in both public and private sectors to achieve the targets of the Emergency Plan in Kenya and will assure their continuation into the future. We believe that *putting youth first* will protect them from infection and will prolong their productive lives if they are already infected. We believe that *personal knowledge of HIV status* is a critical element in all of our programs, as Kenyans who know their status can access care if needed, and can prevent HIV transmission. Together, these flexible structures, this energetic population, and this essential service can transform the response to AIDS in Kenya.

### **Strong Networks for a Sustained Response**

We will work across sectors and program areas to build systems that promote sustainability. In the public sector, we will make strategic investments in Government of Kenya capacity to plan, secure resources for and implement the treatment, care and support, and prevention interventions that her citizens require.

At the central level, we will support results-oriented coordination by participating in work of the National AIDS Control Council (NACC) and the National AIDS and STI Control Programme (NAS COP) of the Ministry of Health. Coordination through these groups that reinforces the health care logistics and service delivery networks essential to meeting care and treatment needs will be a special priority.

From Kenya's two strong central referral hospitals in Nairobi and Eldoret to the most isolated nomadic cattle camp in Northeastern Province, we will help strengthen public health delivery networks so that all Kenyans can be reached with life-saving prevention and treatment programs. We will structure systems so that those co-infected with tuberculosis or other opportunistic illnesses and whose lives are most at risk are reached as rapidly as possible by treatment. Concurrently, we will employ innovative extensions of networks to assure that those in rural areas, in refugee camps and institutional settings, those in the various uniformed services, and those who live migratory lives are not left behind.

Because the Emergency Plan cannot and should not seek to meet all needs associated with HIV and AIDS, we will invest attention and resources in the network of donors so that our responses are non-duplicative, synergistic, and well-coordinated.

In the private sector, we will capitalize on the already robust networks of mission health care facilities, support formation of networks of employment-based health delivery and invest in the nascent networks of health maintenance organizations serving urban centers. The Christian Health Association of Kenya, Mission for Essential Drugs and Supplies and others will be important partners in these areas, providing resources and technical support for smaller organizations.

Private sector networks will also be catalyzed to organize and rationalize the growing responses to home and community support for the infected, education and care for orphans and vulnerable children, and opportunities to protect young people from infection through abstinence and behavior change interventions. The Supreme Council of Kenya Muslims, Kenya Episcopal Conference, National Council of Churches of

Kenya, Kenya Inter-religious AIDS Consortium and the National Council for Children's Services will be linked and strengthened.

### Putting Youth First

Fifty percent of the 31.5 million Kenyans are under 18. Fully 72 percent are younger than 29. Focusing on young people will be essential to long-term success of the networks referenced above because they are the best hope for transforming despair into hope in Kenya. They also deserve our priority concern because the overwhelming majority is not infected but many young people remain at great risk. HIV incidence among young people under 20 is less than two percent. We will work with proven partners as well new ones to insure that today's young people – especially Kenya's young women -- are the first in a generation free from AIDS.

But there is an equally insidious infection against which we can protect young people. If we engage them in designing and delivering a transformed response to AIDS in Kenya, we have the opportunity to inoculate them – and our efforts – against the tolerance for corruption and inefficiency acquired by too many of their elders over the last decades of authoritarian rule.

In *prevention*, we will engage young people as full partners in defining and delivering programs and messages that

- enable them and their peers to choose abstinence as a life-saving option,
- promote new behavioral norms and legal protections responsive to the special vulnerability of girls, including very young women in marriage,
- focus on the heightened risk faced by orphans and other vulnerable children, and
- produce sustained efforts to reduce the risk and preserve the future of children who are out of school and on the streets.

In *care and support*, our five year strategy will put youth first as both recipients and providers. Our programs will

- stabilize the situation of children orphaned by AIDS through access to education and livelihood training,
- respond to the practical and profound emotional needs of children who are caring for ill parents or are heads of households, and
- link the US Peace Corps with the National Youth Service, Kenya Medical Training College and others to develop an in-country AIDS Care Corps providing entry-level work and a career ladder in home care and support for thousands of young Kenyans which will also give them a strong work ethic.

In *treatment*, the networks we support will assure that young Kenyans are not an afterthought. We will

- expand both the depth and breadth of capacity for pediatric ART,
- assure community- and facility-based ART for children, especially those orphaned by AIDS,
- develop programs where older youth are treatment advocates and buddies for younger ones, and
- target infected young adults as prime ART candidates who can
  - commit their restored health to strengthening the national response, and
  - by greater openness as people receiving ART, reduce stigma and other barriers to treatment.

New and renewed networks in the public and private sectors for prevention, care and treatment will provide the structures for a transformed response to HIV and AIDS in Kenya. Kenya's young people will in turn

provide the creativity, idealism and sense of responsibility to ensure that each network actually *works* for the transformation of Kenya.

### Personal Knowledge of HIV Status

Personal knowledge of HIV status is essential for Kenyans to access care and treatment, and for them to prevent further HIV transmission. USG agencies in Kenya have been encouraging a new prevention paradigm of ABCD, with D meaning “diagnosis.” Advances in testing technologies enable HIV testing to occur outside the laboratory and counseling and testing services can be provided virtually anywhere. As we work to increase access to ARVs, one of the major barriers is that so many HIV+ Kenyans do not know their status, or only learn it when they are ill. Studies in 2003 found that only about 15% of Kenya’s adult population had been tested for HIV status, and of them, about 90% actually learned their results. Other studies have found that over 65% of un-tested Kenyans are interested in getting tested. Factoring in testing since 2003, this means that over 13 million adult Kenyans still do not know their HIV status; at least 8 million of them would utilize testing if it were available. During this strategic period, we will make every effort to reach these millions of Kenyans who want to know their status but do not have access to counseling and testing (CT). We will support traditional VCT in non-medical settings, we will support CT for pregnant women, exposed health workers, and patients in hospitals and clinics, and we will support efforts to ensure that all TB patients in Kenya have access to testing. Through mobile units, we will also make CT available to remote and nomadic populations, to refugees, and to the disabled. Based on the success of several pilot efforts begun in 03-04, we will ensure that youth, our priority population, have access to “youth-friendly” VCT services.

## 2. United States Government Targets

Emergency Plan treatment goals for Kenya are ambitious, particularly considering the fact that recently measured HIV rates are substantially lower than previously thought. Our annual targets are sensitive to anticipated implementation barriers that we believe will lead to an initial gradual scale up, followed by more rapid progress toward overall targets in the middle years of the plan, with a leveling off of numbers of new patients, as we approach the 5<sup>th</sup> year of the plan and must reach into more remote and difficult areas. Anticipated annual progress toward selected national goals is shown in the table.

Target Area	Target for April 2005	Target for April 2006	Target for April 2007	Target for April 2008	Target for end of the strategy period
Total # Infections averted	30,000	75,000 cum. 105,000	120,000 cum. 225,000	175,000 cum. 400,000	180,000 cum. 930,000 (2010)
# Infections averted: PMTCT (doses NVP x 0.20)	2,500	5,000 cum. 7,500	7,500 cum. 15,000	10,000 cum. 25,000	12,500 cum. 37,500
# OVC receiving Care and Support	112,000	250,000	350,000	450,000	550,000
# Receiving Palliative Care	60,000	175,000	210,000	250,000	300,000
ART (Drugs supported by Emergency Plan)	15,000	45,000	75,000	100,000	130,000
ART (Other Direct Support)	5,000	15,000	30,000	70,000	100,000
Art (Additional Indirect support)	7,000	7,000	10,000	15,000	20,000
ART Total USG support	27,000	67,000	115,000	185,000	250,000
ART Total in Kenya	38,000	75,000	125,000	205,000	270,000

### Comments on specific targets

*Infections averted:* We await full guidance on measurement of this goal, but have estimated the annual progress that would need to be made in order to reach the national goals by 2010.

*PMTCT:* We are currently estimating prevention based on the efficacy of an intervention based on single dose nevirapine. We anticipate changing to more potent PMTCT regimens, however we do not yet have field experience or program effectiveness data for these regimens, and have therefore maintained conservative estimates based on the effectiveness of nevirapine-based regimens.

*Care and Support:* Our targets for providing services to OVCs and PLWHAs are shown in the table. We have omitted annual targets for care because we have yet to fully incorporate the recent substantial shifts in definitions for this target. If this target remains as an additive target including all people receiving testing and counseling, we will have no trouble reaching the overall target for Kenya of 1,250,000 (in the 2005

program period alone, we anticipate counseling and testing 440,000, supporting services for an estimated 250,000 orphans, and supporting palliative care services to an estimated 175,000).

*OVCs:* The target for numbers of orphans to receive care through the Emergency Plan approached the estimated current number of number of orphans and vulnerable children in Kenya (estimated by UNAIDS to be nearly 900,000 in 2001 [12.4% of all children 0-14 years]). We anticipate that the number of orphans will rise, but hope to contribute to limiting that rise with our prevention and treatment programs. We therefore hope to be in the challenging situation that by 2008, we will need to reach a fairly high proportion of the orphans in Kenya. Our experience in the first year of the plan demonstrated that despite implementation challenges, it is possible to provide services to large numbers of OVCs and we are fortunate to have numerous capable partners in this area. Thus, we believe that these goals can be achieved

*Total number to receive ART:* The estimated number of people who currently require ART in Kenya is 190,000, well below the total target for Kenya of 250,000. However, we recognize that as some people are and maintained on ARVs, others with HIV will progress to the point where ART is required. Thus, with adequate resources (particularly for drugs), we believe it will be possible to achieve emergency plan targets for treatment in Kenya.

A breakdown of anticipated sources of drugs and other support for patients receiving ART is shown in the table. These estimates are highly sensitive to several important factors including the whether Kenya qualifies for additional support through the Global Fund and the availability of quality of low cost ARVs in Kenya. Kenya was awarded Global Funds during round two, but the round-4 application for funds for HIV treatment was not successful. As a result, targets for patients supported by sources other than the Emergency Plan have fallen, at least for the immediate future. We hope that by supporting the Kenyan Government to further develop implementation plans, that future Global Fund applications will be successful.

Regardless of the sources of drugs, we expect that Emergency Plan funds will contribute directly or indirectly to the care of the vast majority of Kenyans who access ART during the next 4 years.

As we pursue progress on all of the specified targets, we will place a high priority on assuring that services are distributed with geographic equity and that we reach underserved populations such as those with disabilities, and women and girls who are disproportionately vulnerable to infection for cultural, sociological, and biological reason, receive access to the treatment, services, and support that they need and deserve.

### 3. The AIDS Crisis in Kenya

#### A. Basic Indicators of the Epidemic

Kenya continues to have a severe generalized HIV epidemic. The first case of AIDS in Kenya was documented in 1984. Estimates of HIV prevalence are prepared by NASCOP each year to assess the ongoing impact of the epidemic on the country. The 2003 estimates were developed by an international technical working group and submitted to UNAIDS using data from a recent national household survey (the Kenya Demographic and Health Survey 2003) and the results of sentinel surveillance conducted annually at antenatal clinics throughout the country from 1990 through 2003.

The estimated HIV/AIDS prevalence in adults 15 to 49 years in Kenya in 2003 is about 7%, meaning that there are currently about 1.1 million adults infected with HIV. Nearly two-thirds of those infected are women. HIV infection among adults in urban areas is almost twice as high as in rural areas (Table 1). As a result of the new information from the KDHS and new antenatal clinic data, the national HIV prevalence estimates for recent years have been revised downward. This does not reflect a change in prevalence but is due to a better understanding of past trends due to new information. Still, there are some hopeful signs in that prevalence has declined from about 13% in the mid-1990s to around 8% today in seven urban sites where surveillance has been conducted since 1990. For the country as a whole prevalence may have peaked in the mid- to late-1990s at about 10% for adults 15-49.

Table 1. National HIV estimates for Kenya 2003

National adult HIV prevalence (15-49)	7%
Number of adults (15-49) HIV+	1,100,000
Urban adult HIV prevalence	10%
Number of urban adults HIV+	410,000
Rural adult HIV prevalence	6%
Number of rural adults HIV+	670,000
HIV+ children	100,000
Number of HIV+ adults aged 50+	62,000
Total HIV+ pop	1,250,000

HIV prevalence remains high in some areas. Rates are 10% or higher in pregnant women in 17 of the 39 sentinel surveillance sites, including sites in Nairobi, Mombasa, Kisumu and Kakamega. Other sites have low or falling HIV prevalence; the range of prevalence is 1% to 41% at the sentinel surveillance sites. Some low prevalence regions, however, have evidence of significant behavioral risk for sexual transmission of HIV. An estimated 62,000 adults over 50 years are HIV infected, and about 30,000 infants are infected with HIV each year. Nearly one-third of Kenyans infected with HIV live in Nyanza Province where the rate in men and women 15-49 combined is 15% (Table 2).

These trends suggest that the annual number of AIDS deaths is still rising steeply, doubling in the last six years to about 150,000 AIDS deaths per year. These deaths can be delayed and quality of life improved if those who are infected and symptomatic are identified and treated. Diagnostic testing for HIV is a critical element; currently only 18% of infected women and 22% of infected men in Kenya know their HIV status.

The number of new infections each year may be dropping to about 80,000. Behavioral indicators from the KDHS indicate risky sexual behavior has declined in the last five years. Still, the majority of new infections occur among youth, especially young women aged 15 to 24 years and young men under 30. Many of these young people are married, but do not know their own or their partner's HIV status. Without testing and disclosure, ideally though couple VCT, prevention programs will fail, even among married couples who adopt faithfulness since condom use is very low among married couples. It is estimated that over 450,000 married couples are currently discordant for HIV, representing the largest high risk group in Kenya.

**Table 2. Number of adults infected with HIV in 2003 by Province**

(Percent Prevalence: KDHS 2003 and Number of HIV+ Adults: Epidemic Projection Package)

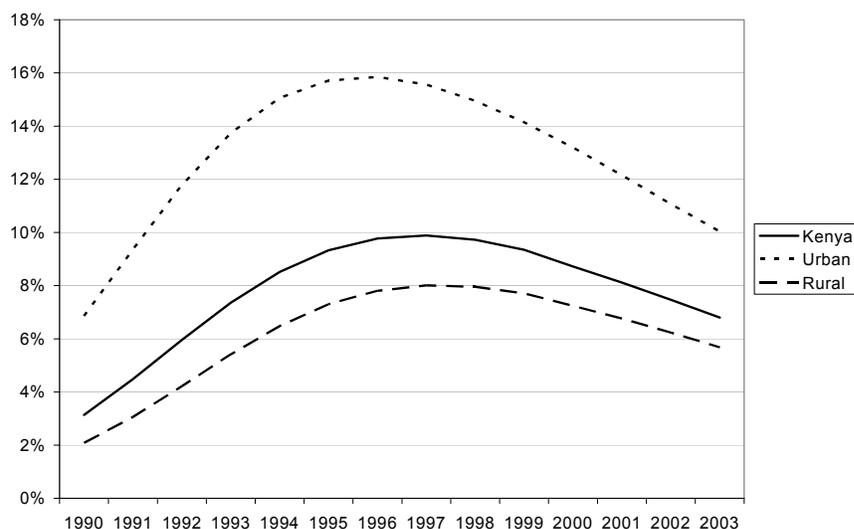
Province	HIV Prevalence	Number of HIV+ adults
Nyanza	15%	310,000
Nairobi	10%	130,000
Coast	6%	110,000
Rift Valley	5%	180,000
Central	5%	100,000
Western	5%	110,000
Eastern	4%	110,000
North Eastern	<1%	20,000
Total	7%	1,100,000

Commercial sex appears to be declining in Kenya; only 3% of men report having paid for sex in the last 12 months. Yet young women, including 16% of sexually active 15-19 year olds and 23% of those who have never married, report receiving gifts or money for sex, underlining the sexual and economic vulnerability of young women. Increasing use of injection drugs and emerging groups of men who have sex with men in urban areas and prisons are at-risk populations who have previously received little attention and require special intervention.

AIDS will continue to have severe social and economic consequences over the next five years with increasing rates of death, disability and orphanhood. HIV disease will also put an increasing burden on the health infrastructure in Kenya, with increasing rates of TB and HIV related illness. The scale up of

HIV services, while producing long-term benefits in reducing mortality, also add to the strain on the health manpower and infrastructure.

**Figure 1. Percent HIV prevalence among rural and urban adults in Kenya**



## B. Overarching Kenyan AIDS Context

A previous national HIV/AIDS strategic plan (2000-2005) was developed for a multi-sectoral national HIV/AIDS control program and is in the process of being updated for the next five years. Linked to the National Development Plan (1997-2001) and National Poverty Eradication Plan (1997-2001), the overarching theme was social change to reduce HIV/AIDS and poverty. Kenya has subscribed to the 3x5 campaign of the World Health Organization, and it is anticipated that the forthcoming five-year plan will reflect this commitment to expanding the availability of treatment.

On the 23<sup>rd</sup> of March 2003, then newly-elected President Mwai Kibaki declared *total war against HIV/AIDS*. His mandates to NACC were to coordinate and to manage the implementation of a multi-sectoral approach

to the national HIV/AIDS program, to provide policy direction, and to mobilize resources. NACC is emerging from a period of instability due to discredited leadership, and the US and other donors are seeking to assist it to achieve its full potential.

Donor harmonization is a key component of the struggle to control HIV/AIDS in Kenya. While there are over 15 donor nations working in Kenya, all have agreed to the “three ones” to better coordinate the scale-up and staying power of AIDS responses. US efforts over the life of this strategy will include unifying our voice and positions in the committees and councils – most of which operate under the auspices of NACC or NASCOP – that can make unified planning, action, and monitoring and evaluation a reality for Kenya. All donors are pursuing enhanced collaboration with colleagues in the Ministry of Health and NACC to establish stronger partnerships to achieve the objectives outlined in the Government’s policy framework

Donor and GOK funding will be used to scale up programs that provide anti-retroviral treatment; abstinence-based prevention programs, including those targeted at youth and young women; safe medical practices programs; and programs to provide care for orphans and vulnerable children. These rapidly expanding integrated prevention, care, and treatment programs are building on existing successful programs that are consistent with the government’s national plan.

All partners recognize that there are serious capacity and quality challenges in public health. The Ministry of Health follows the network model extending from the Kenyatta National and Moi Teaching and Referral hospitals (in Nairobi and Eldoret respectively), through provincial and district hospitals to rural health centers in towns and dispensaries in most rural locations. The human and material resources to make these networks function effectively, however, are often simply not available.

Human capacity development is a major concern and all partners are working on capabilities and human resource management systems to enable people to respond effectively to HIV/AIDS. Nonetheless, the Ministry can rightly point to many positive achievements in preparing the groundwork for achieving a more robust public health policy framework, including an explicit commitment to the effective decentralization of public health services to hospital and district management boards. Kenya has a large number of trained, unemployed, health care workers. The key will be developing effective mechanisms to engage these trained staff to implement the Emergency Plan. There is also substantial technical expertise among Kenyans, however the rapid pace of scale up of HIV prevention and treatment activities has outstripped this capacity. There is therefore a need to utilize technical experts from the US or other nations. We have already involved University Partners (from University of Washington, University of California at San Francisco, New York University and others), many of whom have been conducting USG funded biomedical research in Kenya, and will expand the roles of these partners to meet technical needs.

In the private sector, high quality adult and pediatric HIV services are provided by a number of faith-based health care facilities and a limited but growing number of workplace sites. In the for-profit private sector, significant work is needed to bring practice standards in line with GOK policies and guidelines.

Kenya is in a transitional period, with a relatively new government seeking to restructure many elements of the apparatus of the state. It also has a serious HIV epidemic. This context offers clear opportunities but also many constraints for controlling AIDS. We are hopeful that solid HIV/AIDS programming, linked to improved political and policy responses based on realistic options and limits will help Kenya move from intentions to results in its total war on AIDS.

## II. Critical Interventions

### *1. Introduction*

In prevention, treatment, and care the US team in Kenya will focus on engaging new partners and leveraging additional resources to enhance the sustainability of our efforts. In both the public and private sectors, we will pursue innovative approaches to ameliorating long-standing deficits in both the numbers and capabilities of personnel delivering critical interventions.

Our commitment to new partners is genuine, but is tempered by the realization that some partners will take time to achieve the level of both results and accountability that we require on behalf of American taxpayers. For this reason, we will make strategic and limited use of intermediary organizations to provide organizational capacity building for new partners at the same time they share some of the management burden for US government agencies. We will make selection of Kenyan organizations a priority in these instances, and where Kenyan groups are not fully capable of assuming these responsibilities we will insist that international agencies identify and build the capacity of Kenyan groups to take full ownership of this role by the end of the strategy period.

We will contribute creative solutions to the human capacity crisis in close consultation with the host government. Within the policy limitations of the Emergency Plan, we will support contract positions in public and private health facilities to manage the vital referral link from facility to community care and back again when needed. During the first year of the Emergency Plan, we are piloting the hiring of a small number of health care workers on contracts, and will seek to expand this program if it is successful. We expect to initiate intensive planning in this second year to launch an AIDS Care Corps in the third year. It will link the experience and ethos of the US Peace Corps with the strong capabilities of the Kenyan National Youth Service and Medical Training College branches to identify and equip thousands of young Kenyans with the practical skills and work ethic to care for their family members and neighbors. We believe this program can also be linked to a career ladder that helps fill the growing demand for competent and committed health professionals.

Kenya has a strong and growing private sector that we will increasingly engage in prevention, care and treatment efforts. Workplace prevention programs in the sugar and tea industries will be expanded within those industries and to other sectors, most notably to manufacturing and tourism. Our significant first year success with workplace treatment on tea estates in Kericho will be promoted to others in the private sector. We will build the evidence base to convince them that their investments, linked with ours, can prolong human lives and improve productivity (and thus the corporate bottom line).

Our existing very strong engagement with faith-based partners will be broadened and deepened. We will work through the Christian Health Association of Kenya to reach the networks of mission hospitals. Through our process of inviting concept papers, we have identified many additional indigenous Kenyan religious groups capable of responding to the needs of their neighbors, and we will seek to expand “twinning” opportunities to bring resources of religious groups in the north and west into partnership with Kenyan groups.

As Kenya is transformed to a nation where success is not just possible, but expected, we will assist the government in encouraging other private, bilateral and multilateral donors to participate in the change we are privileged to assist.

## *2. Prevention*

The USG has a long history of promoting HIV prevention efforts in Kenya and these programs are effective in that they adopt an integrated rights-based approach, involving youth participation at every stage. Specific USG-supported activities have included general AIDS education, peer education in workplaces, outreach for youth both in and out of school, community mobilization to change social norms regarding risky sexual behavior, and the promotion and distribution of condoms. CDC-sponsored research in 1994, and the bombing of the US Embassy in 1998, revealed severe shortcomings in the safety of the blood transfusion system, and there has been considerable investment in this area since 1999. Since 2000, USG agencies have collaborated to promote voluntary counseling and HIV testing (VCT), resulting in an increase in VCT sites from just three in 2000 to over 350 by mid-2004, and a dramatic increase in numbers of persons seeking these services, from about 1,000 annually in 2000 to over 200,000 in 2003. USAID began supporting PMCT projects in Kenya in early 2000, and since then USAID and CDC sponsored projects under the Emergency Plan have provided the impetus for the introduction of these services in many parts of Kenya.

### **A. Opportunities and challenges**

As a result of these multiple interventions, and the efforts of the GOK and other donors, knowledge of AIDS is now almost universal in Kenya. The long history of USG involvement in HIV prevention has positioned USG agencies to continue to provide national level leadership, technical assistance, and practical support for HIV prevention in Kenya. The infusion of Emergency Plan funds allows expansion of many of these interventions that have demonstrated effectiveness in Kenya.

The challenges we anticipate center around three broad areas: 1) fear of HIV testing, especially among women for PMCT services; 2) difficulties in extending services to rural and remote areas of the country and to marginalized populations; and 3) complex social, cultural, and economic factors that contribute to HIV risk, especially in girls and young women. We plan to address the fear of HIV testing through continued promotion of the importance of knowing one's sero-status, and through targeted promotion of PMCT services. Understanding health workers' fears of HIV testing will assist in making these efforts more successful, and a study to assess these barriers will be completed by mid-2005.

While most of Kenya's population lives in the southern part of the country which has a reasonable network of roads and access to communication, there are substantial populations living in the north and in some parts of southern Kenya who maintain nomadic life styles. Increasing our partnerships with organizations serving these hard to reach populations, and investing in mobile VCT and AIDS education services will help us reach these groups who are currently not well served. Pilot interventions with the deaf in Kenya have revealed that they are eager to receive services, though we have also learned that it is labor-intensive and expensive to serve them.

The MOH's revised cost share policy for health centers and dispensaries has resulted in a rapid increase in utilization of health facilities. This is both a response to genuine need and a case of moral hazard. Health workers are forced to place more emphasis on curative services that generate more income, and therefore have less time for promotive and preventive services. PMCT services in many health centers are practicing an opt-in strategy both as a result of health workers' reservations to test pregnant women and in order to cope with increased clientele. GOK and donors are challenged to ensure adequate personnel to offer quality integrated ANC services including PMCT and to address health workers' reservations about diagnostic as opposed to voluntary testing.

The complex social, cultural, and economic factors that contribute to HIV transmission are difficult for public health programs to address effectively. The lack of empowerment of women, employment patterns that separate husbands and wives for long periods of time, cultural traditions such as widow inheritance and female genital mutilation (FGM), and a lack of educational and employment opportunities for young people all contribute to HIV risk in Kenya. Polygamy and early marriages present their own unique challenges for women. Addressing these issues has proven to be difficult. For example, in spite of decades of efforts to outlaw FGM, this practice is still prevalent. Though many Kenyans recognize that widow inheritance is risky, this practice is also still prevalent in parts of Kenya. Economic factors external to Kenya, combined with inefficiency and on-going misuse of public funds, contribute to the continued stagnation of Kenya's economy. At a local level, this results in young women engaging in transactional sex, as so many are deprived of both education and productive employment. Emergency Plan funds cannot address these complex structural problems that impede HIV prevention, but we intend to continue supporting community-level groups working to change social norms and practices that put young people at risk.

## **B. Strategies to be employed under the Emergency Plan**

Because knowledge of AIDS is so high in most parts of Kenya, we now have the opportunity to move from interventions designed to increase awareness and knowledge to interventions that provide specific prevention services, especially for specific target groups. Our proposed strategy will focus on the services, interventions, and target groups below, incorporating a heavy focus on young people as they are the best resource for promoting their own healthy development and that of their country.

i. **PMCT:** Although these services have now been introduced in 49 district hospitals in Kenya, PMCT services are not yet available in 25 district hospitals. Increasing PMCT coverage to 100% of government, mission, and private hospitals is planned by the end of 2005. In addition, extension of PMCT services to government health centers, especially those in rural areas, is planned, along with training and support for private providers, such as private midwives and traditional birth attendants. PMCT is also an entry point for the HIV infected women and their families to access other HIV care and support services. In line with this, we will expand the scope of ongoing PMCT services to include continuous care and support to HIV infected women and their families, infant HIV diagnosis and care, prevention and treatment of opportunistic infections, and provision of ARVs to eligible women and infants (PMCT- Plus).

An additional preventive element of PMCT that we will seek to emphasize in its marketing and execution is the extent to which it prevents – when infected mothers and fathers are linked to quality care – some of the otherwise inevitable increase in orphanhood.

ii. **ABC and youth:** Increasing the scope of projects addressing the particular risks facing young people is a high priority in our strategy. According to the 2003 KDHS, reported abstinence is high in Kenya, with 37% of women and 33% of men aged 15 to 24 reporting they have never had sex; an additional 11% and 20% respectively report they have had sex but not in the last 12 months. However, among those aged 15-19, 15% of women and 31% of men report first sex before the age of 15. Among sexually active Kenyans aged 15 – 49, high rates of faithfulness are reported: only 2% of women and 11% of men report more than one partner in the last 12 months. The validity of these data is unknown and there may be an under-reporting of risky behavior, but these findings do suggest that previous messages about abstinence and faithfulness have been internalized by Kenyan young people. Continuing to emphasize the protective effects of abstinence and faithfulness to a partner of known HIV status will be a major focus of both mass media campaigns and inter-personal level education efforts. Providing appropriate messages and services to pre-adolescents and their families will also be a priority.

Preliminary work in a demonstration project for rural youth in a very high prevalence area near Kisumu has demonstrated that parents and families are eager to be involved in programs to promote changes in social norms that put girls and young women at risk, including parental participation in an educational program developed in the US called "Parents Matter." The Family Planning Association of Kenya has achieved good results with an approach involving influential adults through a "Friends of Youth" project. These efforts, along with faith-based abstinence programs, will be expanded and extended to other parts of Kenya, in collaboration with such groups as the Africa Inland Church, the Baptist AIDS Response Agency, the Anglican Church of Kenya, the Supreme Council of Kenya Muslims and others.

**iii. High risk groups:** The 2003 Kenya DHS has documented that 7% of married couples are HIV discordant, almost twice the percent of couples where both are infected. Knowledge and understanding of discordancy is low in Kenya, even among AIDS counselors and educators. The USG has funded a campaign to be launched this year that encourages couples to come together for VCT; depending on response to this campaign, we will support a campaign in 2005 or 2006 that focuses on the issue of discordancy. Couple-focused VCT will be expanded, and counselors will be trained in specific issues relating to couples and discordancy.

The uniformed services in Kenya are another high risk group. The USG has been working with the police and military since 1995, and these efforts were expanded to the Kenya Prisons Service and National Youth Service in early 2004 using Emergency Plan funds. Expansion to other uniformed services, including the Kenya Wildlife Service and Kenya Ports Authority, will occur in 2005 or 2006, and continued support for existing partnerships with the uniformed services is planned throughout this five year period.

High risk linked to occupational status will also be addressed. Employment patterns that separate wives and husbands are still prevalent in Kenya, and workplace programs addressing HIV risk behaviors will be expanded.

**iv. Condom promotion:**

Condom use in Kenya is low; only 1.2% of married women report current use of male condoms. Even among sexually active unmarried women, only 16% report current condom use. However, their use of condoms doubled since 1998, which suggests that messages about the risks of sex outside of marriage have influenced the behavior of these women. Among young people under 25 who have had sex, 12% of women and 14% of men reported using a condom the first time they had sex. Other findings suggest a high level of risky behavior in young people: among young women 15-19 who have had sex in the last 12 months, 47% did so with a non-marital, non-cohabiting partner, and only 23% of these used a condom. The perception of risk is perhaps one of the biggest challenges in condom promotion among youth. Although the knowledge of AIDS is high, we need more programs for youth in and out of school, and those in tertiary colleges with an emphasis on the concept of risk. Innovative approaches will be required to reach married adolescents who often lack access to conventional preventive strategies.

Promoting the use of condoms in high risk encounters, and ensuring the reliable supply of condoms will be part of the USG strategy in Kenya, in close partnership with other donors, particularly DFID. Both public sector and private sector social marketing activities are increasingly targeting high risk groups through high risk *settings* such as bars and "lodgings." Condom distribution through these channels is increasing and will continue to be supported.

v. **Blood safety:** A national survey by the MOH with CDC assistance in 1994 demonstrated a 2% risk of HIV transmission in all transfusions. As a result of this survey and in response to the US Embassy bombing in 1998, the USG has assisted in the development of improved blood collection and testing services in Kenya. This has included building of five Regional Blood Transfusion Service Centres (with a sixth in Eldoret under construction) and supporting the development of policies and guidelines to improve blood safety. Yet the supply of blood is only half of the need for blood and approximately 40% of this comes from high risk, family replacement donors. The goal of establishing a National Blood Transfusion Service that collects, tests, and distributes an adequate supply of safe blood is limited due to funding and staff limitations and by legislative authority.

A five-year cooperative agreement under Track 1 has been awarded to the National Blood Transfusion Service that will assist in bridging the funding gap for blood safety services. The GOK has committed to a regional system but parliamentary authority is required. This system will need to more than triple the volume of collection, processing and distribution of blood from low-risk donors to meet projected national needs. Hospital transfusion services will need to improve quality control and monitor the benefits and side effects of clinical transfusion services. This cooperative agreement under the Emergency Plan will provide the additional staff, facilities, equipment, supplies, and technical assistance to meet these objectives and implement existing policies to achieve a safe and adequate blood supply.

vi. **Injection safety:** A recent survey by WHO and the MOH concluded that high rates of unsafe injection practices are found in Kenya. This includes inadequate health worker precautions during medical injection, other procedures that may result in blood exposure, lack of safe injection equipment, and improper disposal of medical waste. In addition to health workers having a high risk of occupational injury, many health workers either do not have access or do not avail themselves of post-exposure prophylaxis.

A Track 1 task order currently supports development of national injection policies and pilot projects in two districts. Our strategy will utilize the lessons learned from 2004-2005 activities to develop and implement a national program to improve injection safety and reduce medical transmission of HIV through a cooperative agreement with the Ministry of Health. National supply of single use syringes with advanced safety technology will be supported in collaboration with the MOH and with other donors to reduce risk of occupational and nosocomial exposure to HIV. Improved infrastructure to handle medical waste through safe and environmentally acceptable means will also be developed.

vii. **Policies** As a result of the socio-cultural, psychological, economic, moral, ethical and legal ramifications, control of HIV/AIDS is beyond containment by the health sector. The country can best respond by strengthening the multi-sectoral AIDS control approach. The multi-sectoral policy and strategy, which calls upon the involvement of everyone individually and collectively to join the fight against HIV/AIDS, needs to be strengthened through the development of policies and implementation guidelines, integration of support, and the monitoring of all AIDS control programs and activities throughout the country.

Critical areas include PMCT, ART, gender and access to information and services for youth. Some of these have been introduced in the draft HIV/AIDS Control Bill that is about to be presented to the Kenya Parliament intended to guarantee the rights of PLWHAs. These include issues of confidentiality surrounding HIV testing; broadening the responsibility of counseling and testing to lower levels of care; access to treatment; content of peer education programs and other issues. USG will support GOK in modifying the Bill where necessary in order to ensure continuation of effective HIV programming.

To date, PMCT services have focused on women, and they may have become stigmatized as the parent responsible for transmitting the virus. Couple counseling will help to alleviate this misconception. When a woman delivers at home, either a CHW or a traditional birth attendant (TBA), neither of whom is authorized to administer Nevirapine to the mother or the baby, will most likely attend her. Should the MOH policy change, CHWs and TBAs could be trained and contribute to preventing HIV infection at birth. For HIV+ mothers alternative feeding is also an issue; a mother who does not breastfeed, or who exclusively breastfeeds, is often suspected of being infected, but clear messages are needed on the value of formula vs. breastfeeding. Poor mothers don't have access to clean water for formula feeding; this and other issues of poverty need to be addressed.

At present in Kenya there is no policy on ARV prophylaxis. Currently, PEP is available only in a few sites, mostly major hospitals. To ensure quality in hospitals it needs to become a common practice. Police personnel need training and sensitization to refer for service and thus assist in preventing infections through rape and defilement. In addition, policies are needed that ensure provision of protective wear for people in high-risk situations. This includes home-based care where a policy should require the provision of easily affordable supplies, e.g. gloves, disinfectants, antiseptics and clean needles. Teaching universal precautions in health and home care settings will reinforce this.

Youth are a central focus of this five-year plan, and it is imperative they have equal access to information and services which will enable them to both avoid and live with HIV infection. Infected teenage mothers need access to PMCT services. There is also a growing number of IDUs among youth, and this problem will be addressed for this age-group as well. More work will be done in prisons and remand homes where IDU is also a problem. New policies must allow these populations access to information and to condoms. The same applies to men who have sex with men, presently a population whose behavior is criminalized.

A national condom policy was developed in 2001, and USG will assist GOK with implementation. Guidelines have also been developed for VCT, home-based care, and PMCT; these will all be adhered to and promoted in USG programs. USG will promote policies on gender equality, work toward improving women's socioeconomic status and address violence against women.

**viii. Integrating prevention with treatment and care:** The USG program is disseminating information on ART to the general public, dispelling misconceptions and myths as well as unrealistic expectations. Behavior change interventions will continue to include messages linking VCT with treatment options or home-based care where applicable, problems highlighted in the 2003 KDHS.

A key HIV prevention activity in care and treatment programs will be positive prevention, i.e., HIV prevention efforts that are directed toward infected persons who are under care for opportunistic infections and/or receiving ART. The strategy will be to empower HIV-infected persons with information on effective HIV prevention methods for them and their sexual partners, as a strategy to reduce incidence of re-infection and also to avoid resistant viruses from spreading in the population. Individuals on ART will need special targeting since once they've regained their health, risky sexual activities may become more common. One way to reach them will be through PLWHA organizations and networks in Kenya, as well as through health care providers and counselors.

Efforts to encourage couple-testing will be strengthened to help detect discordant couples at early stages and to reinforce prevention of further exposure to HIV infection for spouses and sexual partners of infected persons.

ix. **Linking prevention with other efforts:** With USG and other donor assistance the education sector has already developed a policy on HIV and AIDS, and a similar activity will be undertaken with other sectors as needed, particularly in agriculture and tourism. Strengthened by this policy, the Ministry of Education, Science and Technology (MOEST) is working with the USG to expand skills-based HIV education in schools, through a twinning project with American and Kenyan teacher unions, and with NGOs working with teachers and schools. Out-of-school programs have also been developed, and more will be undertaken, specifically with street children and orphans. USG is supporting the establishment of a management information system for the education sector that will greatly enhance the government's ability to track the effects of the epidemic and determine where assistance is most needed. Within OVC programs, basic needs such as education, food and shelter have been identified and need to be addressed. Some Title II food assistance has been utilized; however, a greater emphasis will be placed on food supplementation. In both rural areas and urban slums, food production is being encouraged to the extent possible, whether in kitchen gardens or in drums outside slum housing.

x. **Gender:** Economic power creates more choices, and empowering women to participate in HIV prevention will be a priority. Under this strategy, the USG will help women access income generating activities, support policy reforms in property and inheritance laws, and help break the link between poverty, prostitution and AIDS. Economic empowerment will result in better family care and perhaps fewer OVCs. A higher economic status will also enable women to have access to prevention methods such as the female condom. The networks of women's association within FBOs provide a good entry point to enhance access to information and to increase women's involvement in HIV prevention and care. However in an attempt to address women's empowerment, we will need to continue with efforts aimed at ensuring male involvement to ensure adequate political and community support.

As noted in the targets section on page 4 above, we will design and implement programs in a way that responds to the increased vulnerability of women and girls and the increased need for services that results when they are infected or directly affected by HIV.

USG will expand its work with the predominantly male uniformed services personnel. Through military and police services, as well as transport services, men are often away from their partners, leaving them at high risk for HIV and other STIs. Peer education and local mass media are some of the interventions used to promote responsible sexual behavior. VCT services along truck routes linked to clinics and treatment services will be increased and strengthened.

xi. **Private sector:** Commercial as well as not-for-profit organizations are critical partners in prevention efforts, particularly behavior change interventions. These partners have the expertise to develop coordinated campaigns including mass media and also logos, slogans, signage and promotional hand-outs. For instance, over the past four years they have been essential in promoting use of VCT services in Kenya. More recently the social marketing program, in partnership with local public relations and advertising firms, has initiated campaigns promoting abstinence and highlighting the dangers of alcohol use as increasing other risky sexual behavior. NGOs are also considerably more experienced in working with especially vulnerable sub-groups than are public health officials. Therefore, prevention efforts by both not-for-profit and for-profit entities are expected to expand under this COP. In addition, private health providers including workplace health units, clinics and pharmacies have been engaged in prevention efforts under the 2004 COP and these initiatives will be more systematically integrated with national prevention efforts during this period.

### *3. Treatment*

#### **A. Specific opportunities and challenges**

Key opportunities include substantial commitment and support from the Government of Kenya (GOK), and a committed and capable staff at NASCOP. There are relatively good data regarding HIV prevalence and fairly widespread availability of HIV testing. There has been substantial progress to date in national scale up for treatment, including:

- Convening of an ARV task force including representatives of GOK, major donors, NGOs, and FBOs;
- Development of national treatment guidelines;
- Procurement and distribution of drugs for several thousand people using government of Kenya and PEPFAR funds and;
- Development of a 5-year strategy for ART scale up that utilizes the network model.

In addition, Kenya has a large pool of trained but unemployed health care personnel who can be engaged in the scale up effort. USG has capable partners in the areas of pharmaceutical procurement and distribution (MEDS); logistical and technical assistance for drug procurement, distribution and management (RPM-plus, JSI-Deliver); training (Mildmay and others); and treatment (within the Ministry of Health, universities, FBOs, international NGOs, and numerous small local NGOs with capacity to provide treatment on a small scale). Other resources include established organizations and networks of people with HIV, as well as a strong and vibrant private and FBO sector that will act as important vehicles in social mobilization for HIV care and treatment.

Key challenges include incomplete coordination of government and Global Fund activities with bilateral activities, widespread poverty (56% of Kenyan's live below the poverty line), weak infrastructure including utilities and road, and inadequate numbers of and demoralized public sector health care personnel. We also estimate that all eight provincial hospitals and 50 of 70 district hospitals require new construction in order to allow full implementation of plans for scale up. Assuring an adequate and continuous supply of both antiretrovirals and other medicines is a very serious challenge. There is little knowledge about ARVs among leaders in the community that impairs uptake of and adherence to treatment regimens, although this is improving. Stigma – including the strong gender bias encountered by women that is so often associated with HIV/AIDS stigma – continues to present a barrier to treatment.

#### **B. Strategies to be employed under the Emergency Plan**

We will follow the strategic direction of NASCOP to expand availability of ARV treatment services, but with added emphasis on certain activities prioritized by the Emergency Plan, including strengthening networks in the mission sector. Public sector medical care in Kenya is currently provided through a network that includes two national referral hospitals, 8 provincial hospitals, 70 district hospitals, and numerous health centers and dispensaries. HIV treatment is being provided through an adaptation of this system including seven referral centers that are being established at both of the national referral hospitals as well as selected provincial, district, and mission facilities.

This network for HIV treatment is already well established (see map and summary, Annex G-1). Future activities will include strengthening and expanding treatment at established sites and adding sites, particularly at district hospital and health center levels, with an emphasis on working “down” through the network model to assure that both urban and rural populations are reached.

Referral centers for HIV treatment are a top priority for capacity building in ART initiation and management of complicated HIV disease, and for strengthening of laboratory and pharmacy capacity related to ART. In addition, these centers are being strengthened to serve as training sites for HIV treatment. There are medical schools at both of the national referral hospitals and many of the other HIV treatment referral centers host training facilities for health care personnel. Training at these sites will be expanded to incorporate HIV care into the curricula for all categories of health workers and to provide ongoing and advanced training in ART for clinicians in practice.

Capacity at district level hospitals will also be strengthened further, with a focus on ARV continuation, provision of non-ART HIV care, and performance of routine basic laboratory testing. Approximately 67 district-level HIV treatment centers (including government, mission, and military facilities) have been identified by the Ministry of Health, of which 40 are already receiving at least partial support through the Emergency Plan. An additional 60 facilities (beyond the MOH priority facilities) will be supported with Emergency Plan funds in the coming year.

In areas where HIV prevalence is extremely high, or access to larger health facilities is restricted, programs to provide non-ART HIV care are being established at rural health centers and dispensaries (approximately 10 such sites currently supported by the Emergency Plan). Community-based antiretroviral treatment will be provided and expanded when appropriate for vulnerable populations, including slum dwellers and people living in very remote areas with extremely restricted access to larger health facilities.

Emergency Plan partners are working with several private corporations (for example, national corporations such as sugar production companies in Western Kenya and international corporations on tea plantations in southwest Kenya) to provide HIV treatment. Our current corporate partners are part of a network system attached to a district hospital. Expanding the numbers of corporate partners will be an expanding focus of the next five years of the Emergency Plan. We will do this by developing specific relationships with individual corporate partners and also by working with the Kenya HIV/AIDS Business Council, which has been very effective at promoting development of workplace policies and has supported the development of treatment programs at several corporations.

While Kenyan women are more affected by HIV than Kenyan men, many for-pay treatment programs served substantially more men than women. Provision of subsidized treatment (for example treatment supported through the Emergency Plan) is leading to improved gender equity as women and children are increasingly able to access treatment, but this is an area that will require constant focus. A small number of programs focus exclusively on provision of treatment to children. At several programs there are focused efforts to optimize treatment for children with HIV by developing specific approaches to diagnosis, counseling, and adherence support that are specific to infants and children. In addition, a small number of sites focus primarily or exclusively on provision of PMTCT-plus (for example, the maternity hospital in Pumwani) or emphasize existing PMTCT programs that were begun under the President's Mother and Child Treatment Initiative.

#### **i. National-level support**

Treatment scale-up will include national level support for various functions as well as support for specific sites. Examples of ongoing and planned national level support are described in the following table:

<b>Support for NASCOP for training and supervision of the overall program</b>
Financial support will be provided for key personnel and supervisory activities at national and regional levels, with intensive involvement in the national committees responsible for scale up of HIV treatment. These committees/subcommittees are responsible for determination of national choices for treatment regimens for both adults and children, development of training curricula and programs, strengthening of health system logistics related to HIV treatment, and development of communication strategies regarding HIV treatment
<b>Support for national level drug procurement and distribution systems</b>
KEMSA (government supply system) and MEDS (a faith-based organization that provides medicines to a country-wide network of mission, NGO, public and small community facilities) will both be strengthened as they are complementary rather than redundant. Because of better capacity, the initial distribution of Emergency Plan drugs has been through MEDS; we anticipate that supply of ARVs to government facilities will eventually be carried out by a strengthened KEMSA. Even if we shift toward central procurement of drugs and supplies we anticipate that KEMSA and MEDS will maintain responsibility for drug distribution.
<b>Support for improved quality control procedures in drug registration and post-market surveillance</b>
The quality control laboratories at MEDS, National Quality Control Laboratory, and the Pharmacy and Poisons Board will be strengthened (primarily through RPM-plus).
<b>Support for infrastructure improvement</b>
Coordination of design and construction of new clinic facilities is underway. We are collaborating with DFID and other donors to develop standardized, flexible plans for clinic space and architectural requirements for this space, and to identify and engage capable building contractors. We request funding for some clinic construction in the FY05 COP. Next steps will include improvement in infrastructure of hospital laboratories and pharmacies (for example expanded, secure, air-conditioned space for appropriate storage of ARVs).
<b>Support for human resources</b>
While we await further guidance from S/GAC on this issue, partner organizations are being encouraged to employ health care personnel with sensitivity to the needs of the country, e.g., not shifting health care personnel employed by the public sector to do HIV program work. This is possible because of the large numbers of unemployed, trained health care personnel in Kenya. We are piloting the hiring of health care personnel using one-year renewable contracts (as outlined in the HR guidance). We anticipate scale up of this effort if the pilot program is successful. In the meantime, the government of Kenya has engaged in efforts to expand and rationalize the health care work force.
<b>Provision of training</b>
A national training curriculum and manual for basic HIV care and treatment with antiretroviral drugs has been designed and is being used to train multidisciplinary teams for scale-up in various geographic areas. We will help develop more advanced training (e.g., more in-depth training on second line treatment regimens, treatment in special situations such as ARVs in pregnancy, children, and people with tuberculosis co-infection). Training using mobile teams with mixed training and service provision is being piloted in Nyanza Province and will be expanded if successful. Practical modules are being conducted at several of the referral centers. We are working on formalizing curricula and expanding these practical modules.
<b>Support for laboratory infrastructure and capacity at a central level</b>
The National Public Health Laboratory is supported by the USG to serve as a reference laboratory and to coordinate training in laboratory procedures, quality control and equipment maintenance.
<b>Support for sites for specific functions</b>
Development of standard operating procedures for laboratories and pharmacies is coordinated nationally through partners with specific expertise in these areas (JSI, RPM-plus). While this strengthening is specifically focused on HIV, it should result in system-wide strengthening of general pharmacy and laboratory capacity.
<b>Strengthening of monitoring and evaluation systems</b>
Monitoring tools that meet the needs of the national program, the Emergency Plan and other donors are in development. We will build capacity related to monitoring of drug resistance through the National Public Health Laboratory and the two national referral hospitals, in collaboration with WHO and the US Department of HHS.
<b>Support for policies and communication strategies that facilitate treatment scale up</b>
A key element in achieving supportive policies is advocacy and education through key government and community leaders, PLWHA organizations and networks, the press, and others to expand knowledge related to HIV and HIV treatment. The strategy will support production and distribution of patient, clinician, and community education materials; and advertising campaigns to expand knowledge of HIV treatment and encourage uptake of and adherence to HIV treatment .
<b>Support for focused operational research</b>
Targeted evaluation will be done to identify innovative and best practices for HIV treatment, and to evaluate the impact of these interventions at individual and population levels.

## ii. Site-specific support

In addition to support from central sources as outlined above, specific sites are receiving comprehensive support to develop and implement treatment programs. Technical support is provided by a wide range of partners, including USG agencies, international and Kenyan universities, international and local NGOs, and faith-based organizations with program management and technical medical expertise.

Because of in-depth involvement of USG staff in scale-up efforts, we are familiar with many of the organizations capable of providing technical support. We are also engaged in an ongoing process to identify additional groups with this capacity, including use of a nationally advertised solicitation for concept papers related to the 2005 Country Operational Plan. In the facility list in Annex 1, sites are identified by the type of facility, technical partners, numbers of patients treated to date and targets for the coming year. Many of our technical partners have been successful at garnering additional support, for example for food programs, and developing linkages to organizations providing community services. At many of these sites, the same technical partner is supporting activities both at the hospital providing referral services within the network model and at referring facilities. Several of the partnerships with universities represent “twinning relationships” in which individuals from Kenyan sites receive training from the international university staff while staff from the university regularly visit sites to train and be trained in HIV treatment. In general, technical support is initially intensive, but the technical partner gradually withdraws from daily activities, leaving the local facility to take responsibility for the ongoing treatment program, allowing the technical partner to shift attention to another facility.

Site support may or may not include provision of ARVs. At some of the larger sites, drugs have come from GOK or Global Fund sources and PEPFAR. This has allowed good coordination of efforts, for example when one or another program is missing a specific drug. At smaller sites, every effort is made to ensure a single source of drugs to reduce confusion for pharmacies, care providers, and patients.

At each site, HIV treatment programs are integrated with other related programs. In every case, HIV treatment and HIV care are well integrated, as they are provided in the same facility, by the same staff. Most sites have excellent coordination between PMCT programs, tuberculosis control programs and the treatment clinics (in many cases these services are provided by the same individual). Individual sites have succeeded to varying degrees in developing referral networks with STI clinics. Because of the extremely high rates of HIV among patients with tuberculosis, the Government of Kenya, in collaboration with USG agencies, has embarked on broad scale provision of diagnostic HIV testing for people with or suspected of having tuberculosis. We have found that it works well to incorporate HIV testing into the initial evaluation of patients with symptoms of tuberculosis, rather than to specifically target HIV testing to individuals with confirmed tuberculosis.. This effort will be expanded, as will efforts to provide diagnostic HIV testing for hospitalized patients.

Many sites already involve people with HIV in program design and in implementation (for example as counselors and care providers). We will expand the role of people with HIV in the implementation of treatment programs to ensure meaningful PLWHA involvement in such initiatives. The vast majority of treatment programs also associate with or sponsor patient support groups/post test clubs etc, and this effort will also be expanded.

Linkage to hospice services has just begun. Hospices in Kenya have recently come together and registered as an association and have taken the bold step of agreeing to accept HIV as a primary diagnosis for

eligibility for hospice services. Hospice services themselves, and the links between clinic-based services and hospice services, will be strengthened in the next five years of the plan.

Linkages between basic and referral sites will be strengthened and inpatient treatment capacity for complications of HIV and HIV-treatment (e.g. management of adverse reactions to medications) will be improved. In sum, the Emergency Plan in Kenya is supporting a wide array of elements essential to the delivery of effective antiretroviral treatment. USG staff has planned an expanded program that meets the needs of Kenyans with HIV, within the guidelines established by the Emergency Plan and the Kenyan Government.

#### 4. *Care*

##### A. Specific Opportunities and Challenges

###### i. Opportunities and challenges in counseling and testing

Kenya was slow to implement HIV testing and counseling strategies; voluntary counseling and testing (VCT) was essentially not available in Kenya until 2001, and appropriate use of HIV testing in medical settings is still very limited. Since 2000, with USG support including intensive levels of technical assistance and support for a multi-phased mass media campaign, VCT services have improved markedly. The number of people receiving VCT services increased from about 1,100 in 2000 to an anticipated total of over 350,000 by the end of 2004. According to the KDHS, nearly half of all women and 62% of men had heard of VCT. In spite of these accomplishments, the percentage of Kenyans who know their sero-status remains low: the KDHS reveals that only 15% of women and 16% of men report being tested for HIV; about 90% of these said they had received the test results. Rates of HIV testing and disclosure of results to TB patients and hospitalized patients remain very low. Many doctors currently test patients without their knowledge or consent, and few patients outside of VCT or PMCT settings learn their results with appropriate counseling or diagnostic information.

The Kenya government has now made access to HIV testing one of the key national strategies, and VCT is a major focus in the GOK Global Fund workplan. USG technical leadership in the areas of VCT and PMCT paved the way for the USG to provide intensive technical assistance in the development of national guidelines for HIV testing in clinical settings, which will be released soon.

Challenges in expanding knowledge of sero-status include: 1) continuing problems with the procurement and distribution of test kits through GOK institutions; 2) clinical health workers' reluctance to conduct testing because of the mistaken belief that intensive counseling is required in clinical settings; and 3) logistic challenges impeding the extension of testing services in remote areas.

The opportunity presented by rapidly expanding availability of treatment will also mean that more Kenyans will be motivated to learn their HIV status. We will retool counseling and testing services to efficiently refer people to the appropriate level of preventive or treatment care when they learn they are HIV-positive. Using models tested in neighboring Uganda, we will begin to intervene early with a basic care package that delays the point at which people infected with HIV will require ARV intervention, reducing both the financial and the treatment burden for health facilities.

## ii. Opportunities and challenges related to palliative care

Poverty, hunger, stigma, denial and unrealistic community expectations are fundamental challenges to effective care and support of HIV positive individuals. Stigma also can restrict access to palliative care by making HIV positive individuals unwilling to accept such care in their homes.

To date, home based care program support has not been adequately linked to health care facilities, and providers are often inadequately trained, equipped or supervised. Home-based care that is primarily psychosocial in nature will be clearly differentiated from home- or community-based health service delivery. Both types of programs are appropriate for our support, but we will undertake provider, patient and community re-education to minimize unrealistic expectations of consumers of either service, and thus help reduce stress among care providers.

Opportunities include the wide number and type of FBOs and CBOs available to provide palliative care that are eager to improve and expand their services. Coupled with an increased interest on the part of health care providers to link their services with other types of support for HIV positive individuals, these groups are vital to the success of palliative care in Kenya.

USG agencies are supporting a care model that establishes comprehensive care centers that offer a range of services from testing for HIV through medical management, including ARVs. Sixty such sites are in varying stages of development. Substantial opportunities thus exist for expansion of HBC outreach services that operate from these comprehensive care centers; these activities will close the gaps for clinical supervision and other needed HBC services.

## iii. Opportunities and challenges related to orphan support

The needs of OVCs are well known, but are inadequately quantified and addressed by the current complement of services offered. USG agencies support a number of initiatives, and many *ad hoc* community-level and community-sponsored programs exist. Standards for OVC care have been developed but are not widely disseminated or applied. Disparate groups in Kenya and abroad have undertaken aggressive and disproportionate fund-raising in support of orphanages. However, orphanages are consistently cited by US and international program experts as the least desirable or sustainable option for meeting the needs of OVCs. Our current activities focus on strengthening communities to provide orphan support in a family environment.

The existing community coping mechanisms for OVCs are over-stretched. The extended family system in Kenya can no longer bear the burden, and the situation is further aggravated by high poverty levels. The National OVC Action Plan outlines key areas of focus, concentrating primarily on engaging local leaders to respond to the issues in their communities, organization and support of activities that promotes open community discussion about HIV/AIDS, and organization of cooperative support activities such as access to micro-finance, education, food production and nutritional supplements. The GOK has prioritized service delivery to double orphans and orphans who are heads of households.

## B. Strategies to be employed under the Emergency Plan

The approaches detailed below that will be pursued over the course of this strategy emphasize the US comparative advantage in selected technical areas and existing capacity in areas of the country with high HIV prevalence. These approaches will be implemented and expanded through the network model to assure that our increased investments contribute to development of a continuum of care while seeking to

minimize the distortive effect they may have on already under-funded, under-staffed, and fragile public and private health care delivery systems.

We will seek partnerships with other donors whose procurement and other capacities complement our own. We will seek additional opportunities for twinning and less formal partnering of US-based institutions and groups with Kenyan public and private groups active in provision of care. We will also support tightly focused application of approaches that have been shown to enhance treatment success, such as nutritional support for people preparing to go on ART and those already in treatment.

### C. Counseling and Testing Strategies

The new GOK guidelines on HIV testing define different settings for HIV testing, and the USG will support all of these types except required testing, as detailed below.

<b>Voluntary counseling and testing</b>
Although there has been a significant and steady increase in the number of Kenyans accessing VCT, in 2003 only 9% of VCT clients attended with a spouse or sexual partner. The high rate of discordance (17%) in VCT couples and high proportion of infected persons with sero-negative partners (50%) highlight the need for sex partners in stable relationships to know and disclose their status. The USG VCT strategy will continue to promote VCT in general, with an emphasis on services for couples and for youth. In USG supported sites, over 63% of VCT clients were under age 30 but some of these clients request more “youth-friendly” services, which are planned. Extension of VCT services, including mobile VCT, for marginalized populations, such as the disabled, refugees, and nomads is also planned.
<b>Routine testing and counseling</b>
Testing in the context of PMCT services and STD clinics is increasingly offered on an “opt-out” basis, which has resulted in many more HIV+ mothers being treated to prevent transmission to their infants. Continued support for this approach in the PMCT and STD clinic context is planned, with a goal of reaching over 90% of antenatal clinic attenders and 80% of STD patients.
<b>Diagnostic testing and counseling</b>
To date this has been a seriously neglected area and very few TB patients or patients hospitalized with conditions suggestive of HIV infection are tested. However, new guidelines on HIV testing in clinical settings, strong support from the National Leprosy and TB Program, and development by CDC of a new curriculum to train health workers in HIV testing and communication of results are expected to dramatically increase the number of sick patients who are tested, and thus the identification of persons in need of ART. CDC is working with the National TB program to introduce wide-scale testing of TB patients, which will identify large numbers of patients in need of ART. The USG will support the training of clinical health care workers so they understand the new national guidelines and are skilled in discussing the need for HIV testing, and test results with their patients.
<b>Testing for blood and tissue donation</b>
The testing of donated blood for transfusion is discussed in the section on blood safety. Providing results to those who donate and have transfusion transmissible infections is a national goal, but there are logistic challenges. The USG will support development and implementation of policy to achieve this goal.
<b>Testing for medical research and surveillance</b>
This type of testing will follow international ethical standards for consent and communication of results. The surveillance protocol is linked to PMCT services for testing and counseling.
<b>Required testing</b>
This form of testing is now performed in Kenya for military recruits and prior to deployment of soldiers on peace-keeping missions; <i>there is no need for USG support for this purpose.</i> Pre-employment testing, insurance related testing and testing prior to travel remain controversial in Kenya and is now conducted by the private sector; <i>USG support for these forms of testing is not appropriate.</i>

#### **D. Palliative Care Strategies**

Palliative care will be provided in the context of a comprehensive continuum of care for people living with HIV/AIDS in Kenya. By 2008, palliative care services will be well integrated with other services. This will occur through expansion of an interdisciplinary approach to palliative care and support, using interventions to relieve physical, emotional, practical, and spiritual suffering.

Palliative care services will be organized and supported to address social inequalities, including the low status of women, girls and the poor; marginalized or confined communities such as prisoners and refugees; and migrant laborers. We will mobilize resources to expand services, building on existing successful programs and best practices. Public-Private Partnerships will be encouraged and supported. Faith and Community-Based Organizations will be assisted to scale up their activities to reach more people. New partners will be encouraged through an open and inclusive competitive system, with careful selection of cost effective concepts and initiatives.

Three broad systems that support an effective continuum of palliative care include: 1) health service; 2) community based care; and 3) coordination and technical support. Rollout to new districts, rather than whole provinces or smaller areas, will be prioritized to improve efficiency and simplify support. Preference will be given to new projects or sites that have a demonstrated need, propose sustainable approaches, and are supported by key partners such as the MOH and other HIV/AIDS programs.

Strategies to improve palliative care coverage and sustainability include using and disseminating existing expertise. New initiatives will be linked to existing programs. Efforts to optimize nutritional status, including medical nutrition therapy and nutrition-related education will be components of the total health care package provided to people infected with human immunodeficiency virus (HIV).

##### **i. Home and community support services**

Services offered through home and community support programs will include counseling and support for HIV testing, disclosure, and adherence to clinical care and medications. Where appropriate, programs will offer medical services including recognition and referral for evaluation of tuberculosis, treatment with multivitamins, malaria prevention, provision of food as appropriate, and cotrimoxazole preventive therapy. Management of symptoms, particularly pain, and assistance with activities of daily living (eating and bathing) will also be offered where possible. Emotional and spiritual support will also be offered as components of all programs, for example assistance with preparation of memory books to pass family information to children.

##### **ii. Non-ART Health Services**

Non-ART health services will be offered in clinical settings to help establish good practices for uninterrupted drug supply, develop networks of referral to other services (for example legal and community based services) and to help patients become accustomed to regular follow up and taking of medications. The basic package of services will include emotional counseling and support, nutrition advice and support as appropriate, prevention of opportunistic infections with cotrimoxazole, multivitamins, training regarding interventions that improve the safety of drinking water, and diagnosis and management of opportunistic infections and cancers. These services will be offered in addition to ART where possible, but will generally precede ART, both at the level of the individual patient and for newly established clinics.

All services will be linked to other HIV prevention and treatment programs, such as VCT and PMTCT programs, ART provision, and services for orphans and vulnerable children.

## E. Orphan Care Strategies

USG agencies support the national Action Plan, which builds on communities as well as involving high-level government officials. We will work with the Ministry of Home Affairs, in particular the Children's Department, the Ministry of Education, Science and Technology (MOEST) and the Ministry of Health where appropriate, and other partners. USAID has assisted the MOEST in developing their sectoral AIDS policy wherein they recognize the Ministry's responsibility to cater for OVCs and respect gender differences. USG will assist GOK, UNICEF and other stakeholders to finalize the draft policy on OVCs and monitor its implementation including the development of a supportive legislative framework.

New USG supported activities will emphasize strengthening community-level capacity to develop, implement and sustain appropriate responses to the OVC crisis and enlist new faith-based partners. We will develop the capacity of partners currently implementing OVC services to support the needs of children who are HIV+ and on ART. An umbrella grant mechanism has been put in place to provide technical assistance to CBOs. Peace Corps volunteers will be provided with resources to identify and initiate sustainable responses in some of the most isolated areas of the country.

The Ready-to-Learn/Speak for the Child (SFTC) project, implemented by the Academy for Education and Development (AED) addresses the physical, cognitive and psychosocial needs of OVCs by providing support and education to caregivers regarding the emotional development and health of children.

As noted under PMCT, we will link services that prolong the lives of infected parents, and especially infected mothers, to our plans and strategies to reduce the overall burden of orphanhood on Kenyan children, families and communities.

There is no national M&E system for OVC activities, although many organizations carry out M&E in their own programs. Some limited indicators for the M&E of OVC situation and response can be found in the M&E framework of NACC. The national OVC Steering Committee, of which USG is a member, will develop national M&E indicators that will include those of the Emergency Plan.

## III. Supportive Interventions

### 1. *Engendering Bold Leadership*

The USG team in Kenya will capitalize on the strongly expressed concern of both President Mwai Kibaki and First Lady Lucy Kibaki for a stronger and more compassionate response to HIV and AIDS across all sectors and at every level of society. Examples from other nations, most notably our neighbor Uganda, clearly demonstrate that bold and consistent leadership from the highest levels of government make profound contributions to the success of HIV/AIDS interventions.

#### A. Specific opportunities and challenges

At a recent national organizing conference for the Network for Empowerment of People Living with AIDS in Kenya (NEPHAK), it was noted that their potential "constituency" of 1.1 million adult Kenyans was larger than any single parliamentary constituency in the country. As treatment availability encourages more HIV-positive Kenyans to publicly disclose their status, more champions of this massive constituency will be able to advocate for strong national leadership and appropriate policies and programs.

Unfortunately, condemnation of AIDS as “God’s judgment” continues to be proclaimed from Kenyan pulpits. This language reinforces isolation of, or overt discrimination against, those living with AIDS and must be confronted directly if people in need are to be returned to the mainstream of community. Recent public proclamations by some in Government have also raised distracting questions about the origins of the AIDS virus and whether “Western scientists” created it in an effort to decimate the population of African nations.

#### **B. Level of host country leadership**

As noted above, the President and First Lady have publicly committed their personal prestige and political capital to strengthening the response to AIDS. While this support is evidenced by the fact that the first ARVs procured for treatment of 5,000 Kenyans in the public sector were bought with Kenyan government revenues, not donor funds, some have noted that the Government’s declared “total war on AIDS” needs more consistent attention and vision if it is to be won. Minister of Health Charity Ngilu is a passionate advocate for greater response, with a special concern for the needs of women and children affected by HIV/AIDS. Other cabinet ministers, notably Minister for Information Raphael Tuju, also speak out regularly and knowledgeably on AIDS issues.

The new government decided early in its tenure to establish offices for each Constituency AIDS Control Committee (CACC) in all 210 parliamentary constituencies. The donor community has by and large adopted a position of skepticism on whether these groups and the resources needed to staff them represent meaningful added value in raising the level of leadership.

The National AIDS Control Council, which is tasked with coordinating the work of AIDS Control Units across government ministries as well as the CACCs at local level, continues to experience difficulty in fully expressing its leadership role despite a full time headquarters staff of over 70 individuals.

#### **C. USG strategic approaches**

The host government continues to place HIV/AIDS at the top of its political agenda, and we will work through public and private diplomacy and in concert with other donors to assist the government in fulfilling its promises to the people of Kenya.

In civil society, we will work with journalists to assure more accurate and in-depth reporting of HIV/AIDS issues. We will affirm the courage of self-disclosing Kenyans living with AIDS and work with them and with their associations as well as with Kenyan elected officials and policy makers to bring about the bold leadership needed to transform decades of denial and silence into forthright and vigorous action that has been proven to save lives.

## ***2. Achieving Sustainability and Human Capacity Development***

#### **A. Prediction for sustainability**

Given the demonstrated commitment of the host government and the rich human resource base coupled with anticipated increases in support from the Global Fund and other donors, the US team in Kenya is reasonably confident that indigenous physical and human capacities will exist in 2008 to sustain the interventions initiated under United States government sponsorship during the initial five years of the Emergency Plan. The Government of Kenya is committed to decentralization of both significant decision-making and resources for the health sector, and this will reinforce the public networks necessary to sustain the care and treatment that Emergency Plan programs help expand.

We are also confident that strong local networks will have been reinforced or brought into being to manage the flow of funds to non-governmental groups providing essential prevention, care and support, and treatment services outside the public sector. The Kenya Inter-religious AIDS Consortium, networks of HIV/AIDS NGOs and other groups will have been given the capacity to support community-level enterprises in delivering effective and accountable services.

The need for significant continuing financial support from the United States is not expected to disappear. Far too many Kenyans will still live on – or beyond – the edge of poverty to contribute more than modest amounts to the costs of their care in 2008. Because treatment is for life, external support for treatment costs will continue to be needed. Even if the costs of first and second line ARVs decline, as the number of people on treatment increases, so will the number who require treatment with more expensive third and fourth line combinations of medicines.

While we are encouraged by the steps being taken by the government related to economic and political reforms, it is still far too early to predict whether or not they will have gone far enough quickly enough to improve the general financial well-being of “wananchi” – ordinary Kenyans. For this reason, we feel it is also prudent to anticipate that many of the community-level interventions we will assist related to care of orphans will continue to need US financial support.

## **B. Human capacity development**

Kenya’s public and not-for profit health organizations are overwhelmed by the strain of coping with HIV/AIDS prevention, treatment, care and support in addition to other priority health activities, while also coping with serious attrition within their own ranks from HIV/AIDS and other causes. Their human resources systems are unable to keep up with requirements for qualified staff for HIV/AIDS program management and implementation. Because of poor HR system and capacity, it is currently impossible to accurately forecast the number of qualified staff needed to deliver ARV treatment in the coming five years. Managers at all levels must be competent in planning, supervising, monitoring and reporting on these programs. Pre-service and in-service training systems must gear up to meet all these requirements. Equally importantly, HR systems of the implementing agencies must be capable of hiring, deploying, tracking, supporting, and motivating HIV/AIDS staff, while continuing to meet the HR needs of other health programs. Finally, it will be necessary for the USG to directly support the salaries of additional staff within key implementing agencies to meet the rising number of clients for all HIV/AIDS services. Any salary subsidies or other direct support for HIV/AIDS workers must be introduced in a context that reinforces and strengthens existing staff structures, incentive systems, and general HR procedures in a sustainable manner, rather than contributing to their destruction by raiding staff from other critical areas.

USAID/Kenya will strive to assist key organizations to do a comprehensive HR needs assessment, including the need for policy changes, changes in pre-service and in-service curricula and training strategies, systems strengthening in HR, reinforcement of management skills, and changes in processes to hire, deploy, track, support, and motivate not only HIV/AIDS workers but other critical and related health personnel. The need for any direct support of HIV/AIDS frontline staff by USAID will also be quantified. Based on this assessment, The Emergency Team will prepare for approval by the USG PEPFAR committee a detailed one-year workplan and an overall five-year workplan to address the most urgent needs for successful attainment of PEPFAR objectives. The plan will address the HR system needs that are agreed by both the MOH and USG and offer the greatest potential feasibility and results, encompassing not only the MOH system but strengthening its role as coordinator of all health services in the country. It will

also address HR constraints in delivering HIV/AIDS services in not-for-profit organizations, working with intermediaries such as MEDS or CHAK to reach the maximum number of NGOs, including FBOs, care and support organizations, and youth organizations. It will cover an appropriate mix of policy, systems, operational and monitoring/tracking activities. This plan will be initiated immediately upon approval by the USG PEPFAR committee.

There is a necessary tension in our Country Operational Plan between effecting long-lasting, fundamental change and effecting rapid change as we transform the ways we lead, conceive of, organize, implement, and report on our work in fighting the HIV/AIDS disaster. In developing the human capacity to deal with this pandemic we want both to work quickly to put skilled staff in place - to prevent infection and save lives today - and to build a sustainable system to ensure a steady supply of well trained people. Our strategy will therefore be two-pronged. In the early part of our program, we will focus on rapidly using Emergency Plan resources to put the necessary trained staff in place. We will shift that focus over the next five years towards making the fundamental changes in human resource planning, encouraging civil service reform, and teaching needed skills to all cadres of staff during their pre-service training.

With DFID assistance, there is an ongoing effort to assess the total human resource and training resources needed to expand access to HIV and other health care. Early results reflect previous findings of a serious lack of properly trained staff in cadres consistent with need and in appropriate geographic areas. It is also finding large-scale "absenteeism" among health care providers, perhaps indicating that government resources could be released to recruit from the pool of unemployed doctors and nurses. Working with DFID, the GOK, and other donor partners interested in human capacity development we will use the results of this study to develop an overall Kenyan human resources strategy, covering recruiting, paying, motivating, and retaining health care workers. We will then program the technical resources the USG has available (e.g., USAID/Washington's new HCD project) to implement this strategy.

Quality of care is also a problem. The 1999 Kenya Service Provision Assessment Survey (KSPA) found that although virtually all health workers had graduated from either a medical training center or a university, 2 in 5 health workers had never had an in-service training course and only 40% had had any training in the past five years. Half of the health workers involved in providing STI/HIV/AIDS services had not been trained in universal precautions and among those trained a third found the training inadequate. In addition, less than half of the health workers providing STI/HIV/AIDS services had received training in the management of TB cases.

Many Emergency Plan activities started in 2004 have a strong in-service training component, giving existing health workers new skills either via on-the-job training or short-term residential training. At the same time, efforts are being made to ensure long-term sustainability. For example, assistance is being provided to the Kenya Medical Training Colleges to develop a human resources capacity, revise pre-service training curricula, and train instructors on ARV treatment and comprehensive care. The 2004 KSPA survey, which will be completed by the end of the year, will show where progress has been made and where gaps remain.

Small twinning and volunteer programs have a long history in Kenya, often through faith-based organizations. For example, the Catholic Medical Mission Board has provided short-term health professional volunteers to work in-country to establish PMCT programs. Many mission hospitals have received similar capacity building exchange visits on broader health areas from US faith-based organizations. Numerous institutional relationships exist. For example, a consortium lead by Indiana

University provides capacity building in health to Moi Teaching and Referral Hospital (whereby teachers from a consortium of medical schools visit Kenya for short periods); the Peace Corps has posted volunteers in health facilities; and the University of Washington and Manitoba University have a long-term relationship with the University of Nairobi to conduct STI research and train researchers. When the HQ-awarded larger scale volunteer and twinning mechanisms are in place, there are a number of long-term relationships in Kenya to build on. While Emergency Plan funds will quickly build up a critical mass of trained Kenyans, faith-based, philanthropic, and academic resources can sustain the less intensive effort required in the future.

### **C. Organizational capacity development**

Consistent with our commitment to the network model, we will seek to use networks wherever possible to build the capacities of organizations critical to turning the tide against AIDS in Kenya. In the public sector, we will strengthen the health services and educational networks of the appropriate ministries so that their lower-level facilities and personnel develop strong capacities for prevention, treatment, and care.

In the NGO sector, we will use the USAID Capable Partners program to fund and strengthen smaller CBOs. Capable Partners has agreed to identify a Kenyan counterpart organization in their first year serving the Emergency Plan here and will fully vest that indigenous group with responsibility for support to smaller CBOs before the end of this strategy period. We will also seek to support networks of AIDS-specific NGOs, but will avoid favoritism in a current period of tension between competing networks.

In the mission health care sector, we will continue our strong commitment to MEDS for the commodities and supplies essential to that network of essential providers. We will also begin a partnership with the Christian Health Association of Kenya (on their own behalf and in support of the Roman Catholic facilities reportable to the Kenya Episcopal Conference) that will enable CHAK to assume ever greater responsibility for managing the flow of resources to, and achievement of results by, their constituent facilities.

USAID/Kenya has recently launched an extremely well received course in health facility management developed in partnership with the Ministry of Health and United States International University. This program was designed and implemented with non-HIV funding and while intended for public sector facility managers, high levels of interest have been expressed by managers of FBO health facilities. We will explore the possibility of using Emergency Plan funds to build from this experience to develop courses responsive to the unique management needs associated with the expanding AIDS response, including

- managing exponential growth in budgets, programs, and accountability
- managing for optimal performance in the context of stressful HIV/AIDS service provision
- managing for sustainability, including effective resource mobilization.

### **D. Systems strengthening and coordination**

Poor management is a significant problem in all sectors of Kenya's health care system. Building on past successes, the USG team will use Emergency Plan funds to strengthen health service delivery systems. For example, we have been strengthening the capacity of KEMSA, the public sector Kenya Medical Supplies Agency, to run the national logistics system. Under the 2004 COP, we are strengthening KEMSA's pharmaceutical management to support expanded access to ART and other needed commodities. It is the intention of the GOK to make KEMSA self-sustaining in the future, preserving and institutionalizing this USG investment. Other systems that will be strengthened using Emergency Plan funds or complementary

resources from other donors include training and supervision, financial management, and health information.

A number of opportunities for coordination and collaboration exist in Kenya. A Joint Inter-agency Coordinating Committee (JICC) within the Ministry of Health brings together ministry staff and donors to discuss issues brought forward by thematic Inter-agency Coordinating Committees (ICCs) in areas such as HIV/AIDS, reproductive health, and malaria. USG representatives, our implementing partners, and other stakeholders sit on these thematic ICCs. Due to its unique nature there is a separate group, the Country Coordinating Mechanism (CCM), made up of GOK officials, NGOs, professional and research organizations, and donors to coordinate Global Fund activities.

As noted at the beginning of this document, the designated national HIV/AIDS coordinating body is NACC, the National AIDS Control Council. USG representatives meet frequently with NACC staff, provide assistance at meetings of its various Technical Groups, and participate in the Joint AIDS Review Process, held every year. As the focal point for multi-sectoral AIDS activities in Kenya, NACC provides an opportunity to participate in HIV/AIDS areas outside of medical ones, such as education and social services. Despite significant donor investment of time and resources, concerns persist about the capacity of NACC to provide the level of visionary leadership and energy needed to bring about a truly multi-sectoral response to AIDS in Kenya. Some ministries – notably health, education, and home affairs – have already progressed to a stage where they are coordinating and implementing AIDS activities in their own sectors.

### *3. Strengthening Coordination and Collaboration*

#### **A. Specific opportunities and challenges**

Starting from a point of extraordinary coordination and mutual respect across the USG interagency team, Kenya has the further advantage of a well-functioning Health Donor Working Group (HDWG). The HDWG has recently gone through a process to “rationalize” donor participation in key GOK health coordination fora and the US fully supports the steps that have been outlined. In the process of considering these new directions, the interagency team had useful internal discussions resulting in a clear understanding that we would use the interagency forum to share information gathered from these committees and unify the messages we carry to them.

Due to this very high level of shared commitment to health, and the need to carefully coordinate the inputs that many donors add to those of the Government of Kenya to improve the health of her people, the first year of the Emergency Plan has presented challenges to coordination. The timelines for early planning cycles limited our opportunities to consult with host government and donor counterparts. Our evolving understanding of the scope, and perhaps more importantly the limitations, of the Emergency Plan made us less than fully effective public health “diplomats” in assuring that our greatly increased resources complemented those of others and didn’t excessively distort the public health infrastructure.

While we had initially anticipated that this strategy would be developed concurrent with the new Kenya National AIDS Strategic Plan (KNASP), our timeline has in fact preceded theirs. That lag in timing notwithstanding, the US team in Kenya is committed to both full participation in the remaining process for development of the new KNASP and to using it as the detailed guide by which we translate this broad strategy into annual operating plans in ensuing years.

## **B. Level of coordination to be achieved in five years**

We are committed to using the solid foundation of our internal USG coordination as a place from which to much more proactively coordinate our Emergency Plan efforts with those of other players in the field of health in Kenya. By 2008, we expect to have firmly established our HIV/AIDS program as one that is central to but does not overwhelm or dominate the priorities of government or the contributions of other donors. To achieve that, we will need to temper our pride in being part of this historic initiative with a level of humility that acknowledges that any of our individual (governmental or agency) contributions is only sufficient to the level of need associated with AIDS when it is part of a combined effort.

A consensus has recently emerged for inclusion of detailed updates on PEPFAR activities at each regular meeting of the AIDS Interagency Coordinating Committee (AIDS ICC) convened by NACC. US mission leadership and the US interagency team welcome this opportunity to regularly, and with consistent representation, coordinate our efforts with those of GOK, other donors, and major implementers. We believe that over time this step will significantly increase HIV/AIDS program coordination.

## **C. USG strategic approaches given USG comparative advantage**

The USG team recognizes that more time of interagency leadership will be required to achieve optimum levels of coordination with GOK and other donors. Ways must be found to free the interagency coordinator from a near-exclusive focus on internal coordination so that donor and host government representatives have adequate access.

Because the various USG agencies have specific technical, political, financial and other capacities a deliberative process to assure that those capacities are engaged in the best coordinating councils convened by NACC, NASCOP and the donor community will be undertaken within the next year. By the same token, the parameters within which the Emergency Plan is to operate made famous by Ambassador Tobias's progressively narrower hand gestures accompanying his declaration that, "This is development . . . this is health in development . . . this is HIV/AIDS in health . . . this is PEPFAR within HIV/AIDS" make it incumbent upon US representatives in Kenya to exercise diplomacy with other donors and utilize all available flexibility represented by other development funding.

## **D. Coordination with NACC and Kenya HIV/AIDS Strategic Plan**

NACC earlier this year embarked on development of a new multi-year KNASP and we had hoped and expected to be able to closely coordinate development of our Emergency Plan strategy with that of GOK. Timetables have not permitted us to fulfill that intention, but as noted above we are fundamentally committed to

- participation in the KNASP process as it moves to conclusion
- tailoring our annual country operating plans to fulfill both this USG strategy *and* appropriate elements of the KNASP, and
- consulting with other donors to assure that any investments we may subsequently make in host government HIV/AIDS coordination efforts are complementary to theirs.

We also assure both Kenyan and American readers of this document that our 2004 COP, this multi-year strategy, and our 2005 COP have all been prepared with respectful consideration of the Kenyan national plan now in place.

#### *4. Strategic Information*

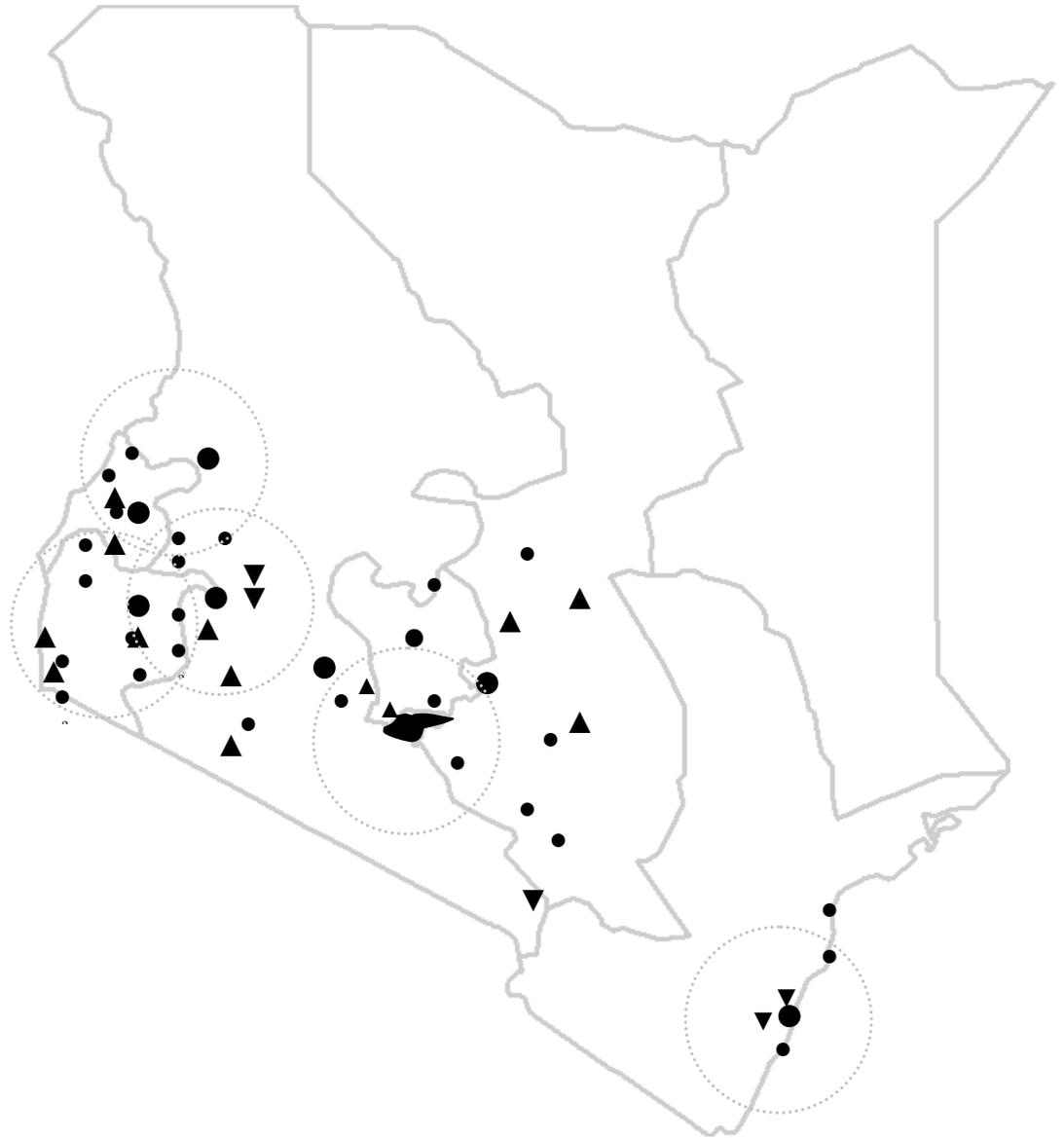
A. The USG team is strategically placed to build capacity for Kenya to meet its information needs as well as capture and report on Emergency Plan results. USAID has historically funded the Demographic and Health Surveys, with CDC providing technical and financial assistance in 2003 to add a full AIDS module and HIV testing. This survey provides critical baseline information on patterns of behavioral risk and HIV distribution for the Emergency Plan. The Kenya Services Provision Assessment scheduled for late 2004 will also provide critical information about facilities and manpower that will guide the rollout of this Five Year Plan. CDC has supported NASCOP since 2001 through a cooperative agreement that has provided both funding and technical assistance to conduct HIV surveillance in pregnant women and STI patients, behavioral surveillance and special studies, and to develop monitoring systems for PMCT, VCT, and ART. Building on this experience and the already close collaboration with the MOH will enable the USG team to strengthen strategic information systems in Kenya.

Capacity for data management and utilization of information at facility level continues to be weak. National systems for HIV and TB strategic information are strong but are not well integrated with other health management information system activities, which are currently under funded and under staffed. Other partners have strong teams either in Kenya or supporting targeted evaluations in collaboration with the USG team, MOH, NACC, National Centre for Population and Development (NCPD), and Central Bureau of Statistics (CBS) including ORC Macro, Measure Evaluation, FHI, Population Council, Pathfinder, PSI, PATH, and others. These efforts are expected to strengthen local capacity; funding, however, is likely to remain donor dependent.

Over the next five years, USG support and technical assistance will work with NACC, NASCOP, NCPD and CBS to provide and disseminate strategic information on HIV/AIDS trends in order to monitor the epidemic, report effectively on indicators to monitor progress toward national and international targets, and to utilize this information effectively for program planning and improvement. Sentinel surveillance will continue annually and integrate sentinel PMCT information for evaluation purposes. Major national surveys will be repeated, including the KDHS in 2008, KSPA in 2009, and BSS or AIS in 2005. Within the MOH, targeted evaluations will focus on improving services for HIV care, treatment and prevention, while integrating HIV information effectively in the programs of curative and preventive services at the district and facility level. This will engage the National Blood Transfusion Services (NBTS), National Public Health Laboratory Services (NPHLS), Reproductive Health Services (for PMCT and family planning activities), National Leprosy and Tuberculosis Program (NLTP), the Health Sector Reform Secretariat (for health manpower and infrastructure issues), the STD program, and Health Management Information Systems (HMIS). The USG SI team includes strong expertise in demography, epidemiology, behavioral science, and monitoring and evaluation that will link with program experts to develop appropriate systems. There will also be an SI Advisory Group for the Emergency Plan that will include our key GOK multilateral and NGO partners to guide the development of systems and enhance the use of strategic information.

There is strong desire to collaborate on a single monitoring and evaluation plan, as articulated in the “third one” of UNAIDS, between bilateral and multilateral donors, partner agencies, Global Fund, and the government for consensus indicators and consistent monitoring systems. The USG team and programs will continue to play a central role in support to Kenya.

Annex G-1 Map of US-Supported Networked Sites for Antiretroviral Treatment and Other HIV Health Services



- ▲ Mission Facilities/FBOs, Track 1
  - ▼ NGOs/Private Facilities
  - Nairobi, with 27 supported sites (3 Referral, 8 MOH, 9 FBO, 7 pvt or NGO)
  - , ▲ Referral Centers in Network Model
  - Well established Networks (Eldoret, Kericho, Kisumu, Mombasa, Nairobi)
- Some symbols may represent more than one facility in a program.

Notes to Map on Previous Page: This map shows the approximate locations of the best-developed HIV treatment networks in Kenya (in Eldoret, Kericho, Kisumu, Nairobi, and Mombasa) and additional sites planned for Emergency Plan-supported scale up of antiretroviral treatment. By April, 2006, antiretroviral treatment including drugs purchased through the emergency plan will be delivered to an estimated 45,000 people at approximately 100 sites. The sites include 50 MOH facilities (many through NGO support), more than 30 FBO facilities, more than 15 NGO facilities/programs, and several private institutions. Treatment sites and networks are located primarily in the heavily populated areas surrounding and between the urban centers of Nairobi, Mombasa, and Kisumu, and are concentrated in western Kenya, where HIV rates are the highest. ARV programs are linked to other services in all geographic areas. Emergency Plan funds will be used to support addition of sites to existing networks as well as addition of networks/sites in areas that are more remote or have lower rates of HIV.

### Plans for Antiretroviral Treatment in Kenya 2005

By April, 2006, we anticipate that 75,000 Kenyans will access antiretroviral treatment for HIV as outlined below. Nationally in Kenya, more than 170 health facilities have been targeted to begin HIV treatment programs by April 2006, of which an estimated 150 will receive some support (training, renovations, staff support, equipment or supplies), directly or through partners under the USG Emergency Plan.

Type of Site	Total Sites targeted for 2005	Sites to receive USG support
Referral	4	4
GOK—Provincial	8	6
GOK—District	53	26
GOK—Other	21	15
Mission	65	34
Other	22	15
Site type/locale not confirmed		50
<b>TOTAL</b>	<b>171</b>	<b>150</b>

By Province	Sites targeted to provide HIV treatment	Sites receiving USG support	Patients receiving ARVs in Sept 2004	Patients to receive ARVs with direct PEPFAR Support	Patients to receive ARVs with GOK support	TOTAL Patients to receive ARVs
Central	22	4	1428	1500	1632	3132
Coast	12	6	573	1450	631	2081
Eastern	19	10	637	2650	1072	3572
Nairobi	38	27	5816	8475	2277	10352
Northeastern	3	0	0	0	54	54
Nyanza	27	22	3138	5480	1568	7148
Rift Valley	36	23	3859	11400	1698	13178
Western	14	8	963	2070	404	2394
Subtotal of sites or patients from known sites	1	100	16414	33025	9336	42361
Subtotal of other sites/patients from other sites		50	~8000	11975	5664	32639
<b>Total</b>	<b>171</b>	<b>150</b>	<b>24414</b>	<b>45,000</b>	<b>15,000</b>	<b>75000</b>

The estimated total number of patients on treatment includes stable estimates (generated in 2004) for the numbers of patients receiving treatment in private practices and other self pay situations (8000) plus a substantial number of patients treated through other programs supported by other partners such as MSF or GTZ (~7000). This combined effort will avail ART to an estimated 40% of the 190,000 patients who currently require therapy or 25% of the estimated number of patients who will require therapy by April 2006.

## Annex G-2: Complementary Networks

Consistent with the overarching theme of this strategy – *Strong Networks for a Sustained Response* – the Interagency team wishes to highlight networks beyond those in the public sector health care delivery context that will be essential to the success of the strategy during its lifetime. Some will be directly funded, all will be closely consulted with as we expand our response in Kenya. Those that are either in formation or whose formation will be encouraged through the Emergency Plan appear in *italics*.

### Planning, Coordinating and Funding Networks

The National AIDS Control Council of Kenya

Constituent AIDS Control Units in key ministries including Health (NAS COP), Home Affairs, Defense, Prisons, and others

Health Donor Working Group

AIDS Interagency Coordinating Council

### Private Health Care Delivery Networks

Christian Health Association of Kenya

Health Office, Kenya Episcopal Conference of the Roman Catholic Church

Mission for Essential Drugs and Supplies

*Workplace Health Care Providers*

### Health Logistics Networks

Kenya Medical Supplies Agencies (public medical stores)

Mission for Essential Drugs and Supplies

### NGO Networks

Kenya AIDS NGO Consortium

Kenya Coalition for AIDS, Tuberculosis and Malaria (KECOFATUMA)

*Home-Based Care Providers Network*

### Special Population Networks

National Empowerment Network for People Living with HIV/AIDS in Kenya (NEPHAK)

Kenya Network of Women with AIDS

National Council for Children's Service / *OVC Network*

*Handicap International and 6-10 identified Disability Coalitions*

*Kenya Department of Defense and Other Uniformed Services Coalition*

### Faith-Based Organization Networks

National Council of Churches of Kenya (NCCK)

Supreme Council of Kenya Muslims (SUPKEM)

Kenya Inter-Religious AIDS Consortium (KIRAC)