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Country Report – Kenya

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National AIDS Control Council

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PROF Alloys S.S. ORAGO

DIRECTOR NACC

Abbreviations

ACU	AIDS Control Unit
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
AMREF	African Medical Research Foundation
ASC	AIDS Spending Categories
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CACC	Constituency AIDS Control Committee
CBO	Community-Based Organisation
CCC	Comprehensive Care Centre
COBPAR	Community-based Programme Activity Report
CSO	Civil Society Organisation
DDO	District Development Officer
DFID	Department for International Development
DHMT	District Health Management Team
DTC	District Technical Committee
FBO	Faith-Based Organisation
FSW	Female Sex Worker
GAVI	Global AIDS Vaccine Initiative
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV and AIDS
GJLOS	Governance, Justice, Law and Order Sector
GLIA	Great Lakes Initiative on AIDS
GoK	Government of Kenya
HCBC	Home and Community-Based Care
HCW	Health Care Worker
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HSS	Health Systems Strengthening
HTC	HIV Testing and Counselling

ICC	Inter-Agency Coordinating Committee
IEC	Information, Education, and Communication
IDP	Internally Displaced Person
IDU	Injecting Drug User
JAPR	Joint HIV and AIDS Programme Review
KAIS	Kenya AIDS Indicator Survey
KARSCOM	Kenya AIDS Research Coordinating Committee
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Agency
KNASA	Kenya National AIDS Spending Assessment
KNASP	Kenya National AIDS Strategic Plan
KPSAN	Kenya Private Sector Advisory Network
M&E	Monitoring and Evaluation
MARPs	Most-at-Risk Populations
MCG	Monitoring and Coordination Groups
MDG	Millennium Development Goal
MoGCASD	Ministry of Gender and Children Affairs and Social Development
MoH	Ministry of Health
MoMS	Ministry of Medical Services
MoPHS	Ministry of Public Health and Sanitation
MoSPS	Ministry of State for Public Service
MoSSP	Ministry of State for Special Programmes
MoT	Modes of Transmission
MOU	Memorandum of Understanding
MOYAS	Ministry of Youth Affairs and Sports
MSM	Men having Sex with Men
MSW	Male Sex Worker
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plan
MTR	Mid-Term Review
NACC	National AIDS Control Council
NASA	National AIDS Spending Assessment
NASCOP	National AIDS & STI Control Programme
NBTS	National Blood and Trasfusion Services
NCAPD	National Coordination Agency for Population and Development
NGO	Non-Governmental Organisation
NHSSP	National Health Sector Strategic Plan
NLTP	National Leprosy and TB Control Programme
NPO	National Plan of Operations

NSA	National Strategy Application
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHMTs	Provincial Health Management Teams
PITC	Provider-initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PWD	People With Disabilities
PwP	Prevention with Positives
STIs	Sexually Transmitted Infections
SW	Sex Worker
TA	Technical Assistance
TB	Tuberculosis
ToT	Training of Trainers
TOWA	Total War against HIV and AIDS
TSP	Technical Support Plan
UA	Universal Access
UNAIDS	Joint United Nations Programme on AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drug Control
USG	United States Government
VMMC	Voluntary Medically-Assisted, Adult Male Circumcision
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

1. Status at a glance

1.1 Inclusiveness of the stakeholders in the report writing process

The Kenya 2010 UNGASS reporting process began with a briefing of all partners by the National AIDS Control Council (NACC) and the UNGASS Technical Working Group. Three sub-committees were established to guide data collection and analysis process – the Stakeholder Engagement, AIDS Spending and Core Indicators Sub-Committees. Three consultants were contracted to support data collection, analysis and the development of the UNGASS report. Data was collected through consultative meetings and one-to-one interviews with civil society organizations (CSOs), development partners, UN Agencies and public sector representatives. The NCPI PART A was completed by key informants from line ministries, departments and relevant institutions in collaboration with NACC. Part B of the NCPI was completed through consultations with CSO networks (national and international NGOs) UN Agencies and development partners. NACC organized a consensus meeting to validate the NCPI responses. Data collection for the UNGASS Core Indicators and for the Universal Access Report was undertaken as a joint process. The UNGASS TWG, NACC and NASCOP organized a final validation meeting with all the stakeholders involved in the process in order to agree on and validate the final report.

1.2 The status of the epidemic

The Kenya AIDS Indicators Survey (2007) estimated the average HIV prevalence among the general population aged 15-49 at 7.4 percent while the Kenya Demographic and Health Survey (KDHS 2008-09) estimated prevalence for the same population at 6.3 percent. The difference between the HIV prevalence estimates of the two surveys is not statistically significant given the overlap of confidence intervals. The findings show that Kenya's epidemic has stabilized in the past few years. The surveys confirmed that women still have a higher prevalence compared to men: women 8.4 percent against 5.4 percent for men (KAIS 2007) and women 8 percent compared to 4.3 percent for men (KDHS 2008-09). Sex differential is more pronounced among young women 15-24 age group who tend to have HIV prevalence four times higher than young men - 5.6 percent against 1.4 percent respectively (KAIS 07) and 4.5 percent and 1.1 percent respectively (KDHS 2008-09).

The estimated number of people living with HIV is 1.3 million to 1.6 million. New infections are estimated[1] at 100,000 in 2009 for adults (15+). The HIV Prevention Response and Modes of Transmission Analysis (2009) found out that the largest new infections (44 percent) occur among men and women who are in a union or in regular partnerships, men who have sex with men (MSM), and prisoners contribute about 15 percent of new infections and injecting drug use accounts for 3.8 percent.

1.3 The policy and programmatic response

The NCPI Questionnaire Parts A and B provide information on policy and strategy development and implementation over the past two years.

Part A of the questionnaire covers aspects of the policy development and implementation including strategic planning, political support, prevention, treatment, care, and support, and

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National HIV Indicators for Kenya: 2009 National AIDS Control Council and the National AIDS and STD Control Programme. April 2010

monitoring and evaluation (M&E). Strategic planning was rated high at 7 out of 10 points which is the same rating as UNGASS 2008 report. There was high stakeholder involvement in the development of the KNASP III and the strategy is well prioritized. Political support for the national response was rated 8 out of 10 an improvement from a rating of 7 in 2008. There is budgetary allocation by Government to HIV and AIDS interventions and the Parliamentary Health Committee is engaged in HIV and AIDS response at policy level. HIV prevention efforts were rated at 8 and treatment and care was rated at 7 out of 10 (see annex I). There is continuing involvement of MARPs in the national response and prevention efforts are better targeted towards priority populations. With regard to treatment, care and support, Kenya has a strategy to scale up ARTs and care for adults and children.

Part B of the questionnaire covers human rights, civil society involvement, prevention, and treatment, care, and support. Civil society involvement was rated 7 out of 10 points. CSOs in Kenya are highly involved in planning, implementation and advocacy for HIV and AIDS. Prevention efforts were rated 8 out of 10 points because new strategies such as male circumcision and prevention with positives have been introduced. There is also a scale up of testing and counseling services using multiple strategies beyond the stand alone VCTs. Treatment and care was rated 8 out of a scale of 1 to 10 ((see annex I). There is an increase of the number of people on ART due to government efforts to scale up access to treatment.

1.4 UNGASS core indicators data table

National Indicators		
Indicator	Status	Comments
National Indicators		
1. Domestic and international AIDS spending by categories and financing sources	√	The detailed component is attached
2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	√	The detailed component is attached
National Commitment and Action		
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%	
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	**2008** Adult: 55.3% (230,059/416,000) Children: 26.4% (20,576/78,000)	
	2009 Adult: 70.4% (308,610/438,000) Children: 24.2% (28,370/117,000)	The denominator for the children went up due to the new criteria that all HIV+ children under 18 months are in need of ART
5. Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce risk of mother-to-child transmission	**2008** 73.6% 59,601/81,000)	
	2009 72.33% (58,591/81,000)	
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	23% (14,116/60,508)	
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Women: 29% Men: 22.8% (KDHS 2009)	
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	Sex Workers: 78% (Sex Workers Survey 2009)	The data refers to sex workers who have ever been tested
9. Percentage of most-at-risk populations reached with HIV prevention programmes	Not available	
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic	21.5% (KAIS 2007)	

National Indicators		
Indicator	Status	Comments
external support in caring for the child		
11. Percentage of schools that provided life skills-based HIV education in the last academic year	100% (Ministry of Education)	Life skills-based HIV education is integrated in school curriculum
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10-14	1.0 (MICS 2007)	
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Women: 47.5% Men: 54.9% (KDHS 2009)	
14. Percentage of most-at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	SWs: 59.4% (Sex Workers Survey 2009)	
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before age of 15	Women: 11%; Men: 22.2% (KDHS 2009)	
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Women: 1.2% Men: 9.3% (KDHS 2009)	
17. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of condom during their last sexual intercourse	Women: 31.8% Men: 37.0% (KDHS 2009)	
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	87.7% (Sex Workers Survey 2009)	
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not available	
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Not available	
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Not available	
Impact		
22. Percentage of young women and men aged 15-24 who are HIV infected	15-19 Age group: 4.3% 20-24 Age group: 6.1% ANC Sentinel Surveillance (2009)	
23. Percentage of most-at-risk populations who are HIV infected	N/A	
24. Percentage of adults and children with HIV known	80.1%	

National Indicators		
Indicator	Status	Comments
to be on treatment 12 months after initiation of antiretroviral therapy		
25. Percentage of infants born to HIV-infected mothers who are infected	27% (Spectrum)	

2. Overview of the AIDS epidemic

2.1 Trends on prevalence

HIV prevalence in Kenya has been declining in the last two decades. National estimates show that in 1997-98 the prevalence among adults (15-49 years) was 10 percent (Sentinel Surveillance) declining to 6.7 percent (KDHS 2003), 7.1 percent (KAIS 2007) and 6.3 percent (KDHS 2008-09). Recent EPP and spectrum modelling estimates for 2009 gave a HIV prevalence of 6.2%.. The recent surveys (KAIS 2007 and KDHS 2008-09) show that the prevalence has stabilized and the Mode of Transmission Study (2008) – MoT shows that Kenya has a mixed HIV epidemic.

HIV prevalence by sex and age

Women have a prevalence rate almost two times higher than men: women 8.4 percent against 5.4 percent for men (KAIS 2007) and women 8 percent compared to 4.3 percent for men (KDHS 2008-09). Young women (aged 15-24 years) have a prevalence four times higher than young men in the same age group: 5.6 percent against 1.4 percent (KAIS 07), and 4.5 percent against 1.1 percent (KDHS 2008-09). KAIS 2007 was the first study to include older adults aged 50 to 64 years. The survey estimated HIV prevalence in this age group at 5.0 percent, which did not differ significantly by sex (women 5.2 percent; men 4.7 percent). This shows the need to provide HIV services to this age group which had previously been assumed not to be at such high risk of HIV infection.

HIV prevalence by residence and region

There are significant differences in HIV prevalence across provinces as well as between urban and rural areas. The HIV prevalence among adults aged 15 to 64 years in rural areas was estimated 6.7 percent compared to 8.4 percent among adults living in urban areas. According to KDHS 2008-09, 7.2 percent of adults aged 15-49 in urban areas were infected, compared with 6 percent in rural areas. However, given that the vast majority of people (75 percent) reside in rural areas, the absolute number of HIV infections is higher in rural than urban areas. An estimated 1 million adults in rural areas are infected with HIV, compared to 0.4 million adults in urban areas.

HIV prevalence also varies by sex. Women age 15-49 in urban areas have a higher HIV prevalence than those in rural areas (10.4 and 7.2 percent respectively), while among men, the HIV prevalence rate in urban areas is marginally lower than rural areas (3.7 and 4.5 percent respectively).

HIV prevalence also varies between regions, ranging from a prevalence of 0.9 percent in North Eastern province to 13.9 percent in Nyanza province. The regional variations in prevalence are shown in the figure below.

HIV prevalence by marital status

A key characteristic of HIV epidemic in Kenya is the risk of infections among people in unions. KDHS (2008-09) found significant variation of HIV prevalence by marital status, the highest being among widowed respondents (44.4 percent) and the lowest among those who had never been married (2.4 percent). About 14.3 percent of respondents who are married or cohabitating are HIV positive.

HIV prevalence is twice as high among respondents in polygamous unions (12.9 percent) compared to respondents in non-polygamous union (6.1 percent). Among those in a polygamous union, HIV prevalence is higher among men than women (15.7 and 11.8 percent respectively). On the contrary, in non-polygamous union, HIV prevalence is marginally higher among women than men (6 and 5.3 percent respectively). This differs significantly among women who are not currently in union (9.8 percent) compared to men in the same category (2.7 percent). This shows the need to prioritize people in married unions as key vulnerable populations.

Prevalence among children

According to the Kenya National HIV and AIDS Estimates (2010), the cumulative number of children infected is estimated to be 184,052 by 2009. It is estimated that 22,259 children got newly infected in 2009. The high incidence of pediatric infection contributes directly to infant and young child mortality, complicates child malnutrition, and requires lifelong and expensive treatment.

Most at risk populations

The MARPs in Kenya include Female Sex Workers (FSWs), and their Clients, Men who have Sex with Men (MSMs) and Injecting Drug Users (IDUs). Surveillance for MARPs is weak and therefore adequate prevalence data for these groups is not available.

The Mode of Transmission study underscores the significance of MARPs in driving the HIV epidemic in Kenya. According to this study Sex Workers and their clients contribute about 14 percent of new infections, while MSM and prison populations contribute 15 percent of new infections. Finally, injecting drug users and HIV transmission in health facilities settings contributed 6.3 percent of new cases.

Table 1: Contributors to new HIV infections across adult populations (Spectrum Model, MoT, 2008)

Source of Incidence	***Percent of National Incidence***
Heterosexual sex within union/regular partnership	44.1
Casual heterosexual sex	20.3
MSM and prison	15.2
Sex work	14.1
Injecting Drug Use (IDU)	3.8
Health facility related	2.5

3. National response to the AIDS epidemic

3.1 National commitment

Methodology used for data collection

The National AIDS Control Council (NACC) has undertaken a comprehensive Kenya National AIDS Spending Assessment (KNASA) to track actual HIV and AIDS spending from public, international – bilateral and multilateral and private sources. The KNASA is a comprehensive and systematic methodology used to determine the flow of resources intended to respond to the HIV and AIDS epidemic of a nation. It describes the flow of funds from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the epidemic.

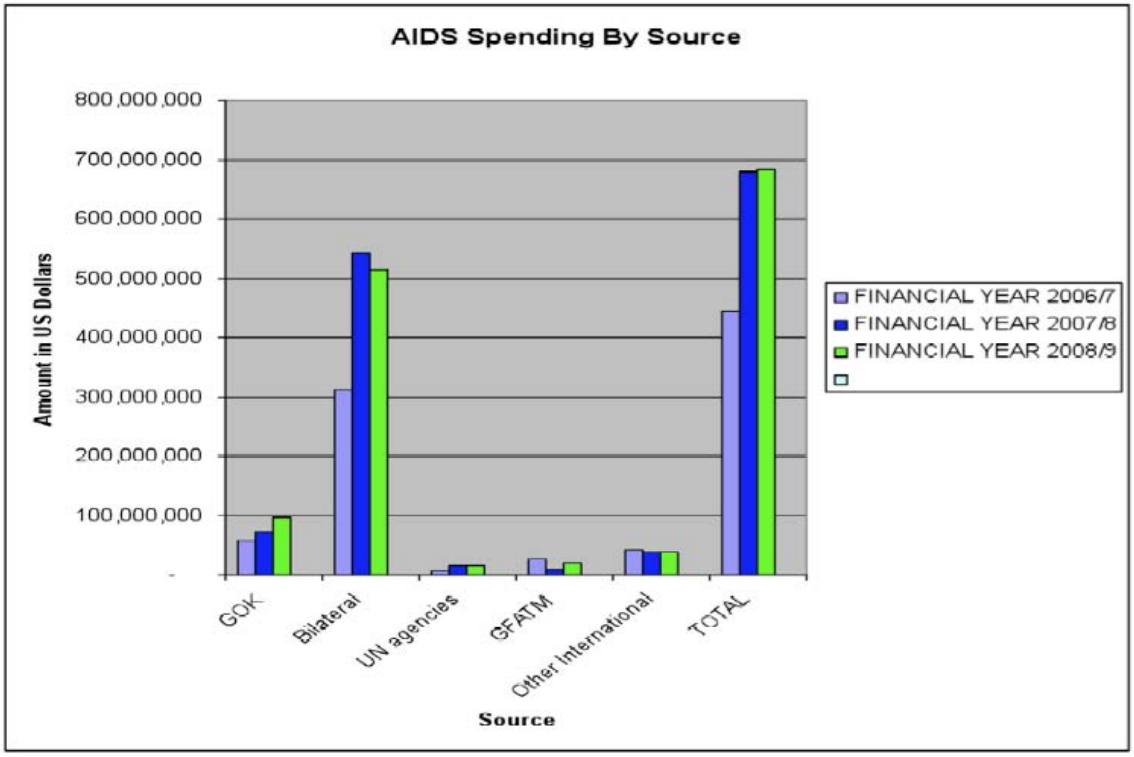
The assessment focused on tracking HIV and AIDS expenditure for fiscal year 2006-07 and 2007-8 and 2008/9. Data collection covered public, external and private spending on HIV and AIDS, including funds channelled through the government budget system. The KNASA did not cover private sources such as household out-of-pocket expenditure on HIV and AIDS and this is planned for in the second phase.

Most of the key sources of data (detailed expenditure records) were obtained through surveys that targeted development partners, NGOs, public sector, health facilities, private firms and community based organizations (CBOs) while secondary sources were used where data on HIV and AIDS expenditure were not available through primary sources. Costing was also done to estimate some of the expenditures on HIV and AIDS related activities using best available data and some agreed assumption.

a. Financing sources

The graph below shows the trend in AIDS spending by source over a three-year period.

Figure 1: AIDS Spending by financing source

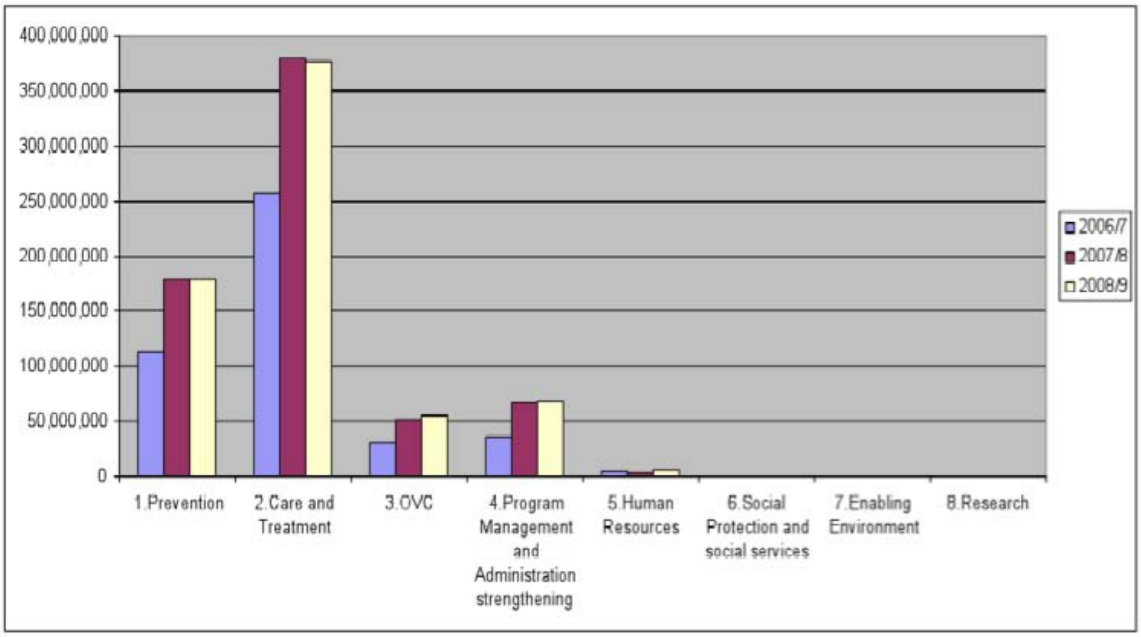


The amount of resources available for the national response has been increasing in the last three years. In 2006/7, total funding was USD 418 million, USD660 million in 2007/8 and in 2008/9 the funding increased to USD687 million. Bilateral donors contribute over 70% of the funding for HIV and AIDS.

b. Financing by HIV programme intervention

The graph below shows the trend in AIDS spending by category of interventions.

Figure 2: AIDS spending by category of intervention



The proportion of distribution of spending by intervention over the three years has not significantly changed although the amount of spending has increased in absolute terms. Care and Treatment takes the highest proportion (about 55%) followed by prevention at about 25%, programme management at about 10% and OVC about 7%.

3.2 Policy and strategy development

Kenya's development agenda is articulated in Vision 2030, which outlines the key objective of transforming the country into a globally competitive and prosperous nation with a high quality of life by 2030. Vision 2030 is anchored in three pillars -- economic, social, and political. The second document is the Medium Term Plan for 2008-2012, which outlines national indicators and targets for HIV.

Overall coordination of the National Response is the responsibility of the National AIDS Control Council assisted by its decentralised structures – District Technical Committees and Constituency AIDS Control Committees and in collaboration with sectoral coordination bodies for civil society and private sector and AIDS Coordinating Units in Government Ministries and Departments. NACC is mandated to ensure a multi-sectoral coordination and implementation of the National Response.

The Kenya National HIV and AIDS Strategic Plan for 2009/10-2012/13 (KNASP III) has been finalised to provide guidance in implementation of the national response. KNASP III is organised along four pillars: (1) Health Sector HIV Service Delivery, (2) Sectoral Mainstreaming of HIV, (3) Community-based HIV Programmes, and (4) Governance and Strategic Information.

KNASP III emphasises four primary strategies:

Strategy 1: Provision of cost-effective prevention, treatment, care and support services, informed by an engendered rights-based approach, to realise Universal Access

Strategy 2: HIV mainstreamed in key sectors through long-term programming, addressing both the root causes and effects of the epidemic

Strategy 3: Targeted, community-based programmes supporting achievement of Universal Access and social transformation into an AIDS competent society

Strategy 4: All stakeholders coordinated and operating within a nationally owned strategy and aligned results framework, grounded in mutual accountability, gender equality and human rights

3.3 Programme implementation

3.3.1 Prevention

HIV Testing and Counseling in the general population

Kenya has adopted a multi-pronged approach to provision of HIV Testing and Counseling (HTC) services. HTC is provided through voluntary counseling and testing provided in 960 sites countrywide; while Provider Initiated Testing and Counseling (PITC) is provided in 73% (4,939) of health facilities[2] and through Outreach/Mobile Counselling and Testing which target MARPS and Vulnerable Populations in community settings. For instance, in one Outreach CT activity, in Mlolongo and Nairobi, over 6,000 sex workers and their clients were tested for HIV during a 5-day "moonlight" testing campaign. The moonlight testing for MARPs, which includes involvement of their peers (commercial sex workers, barmaids), is an innovative method moving the testing services to the targeted group in their own area[3].

As a result of the multiple approaches to HTC, there has been a significantly increase in the number of people tested for HIV between 2003 and 2009. In 2009 alone, 3,471,567 individuals above 15 years of age received an HIV test. The scale up of HTC services has contributed to an increase in number of men and women tested from 14.3 and 13.1 percent respectively in 2003 to 40.4 and 56.5 respectively in 2008 as shown in figures 3 and 4 below.

Figure 3: Trends on percentage of male and female ever tested for HIV

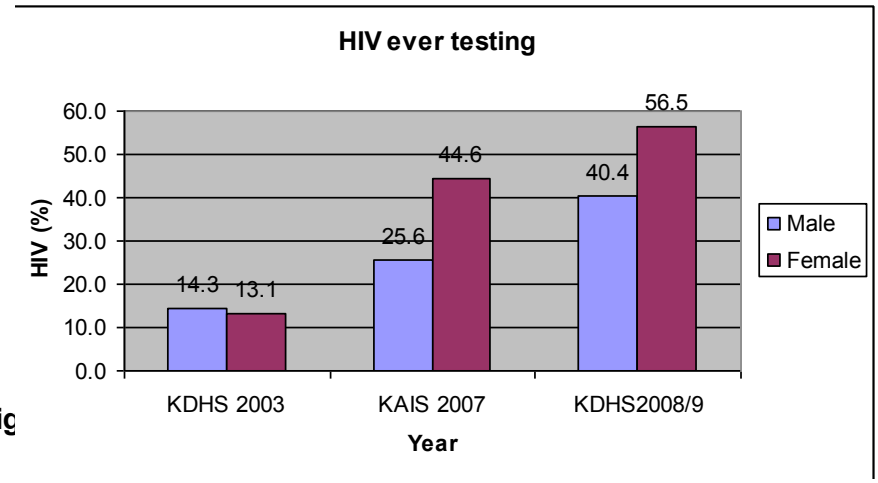
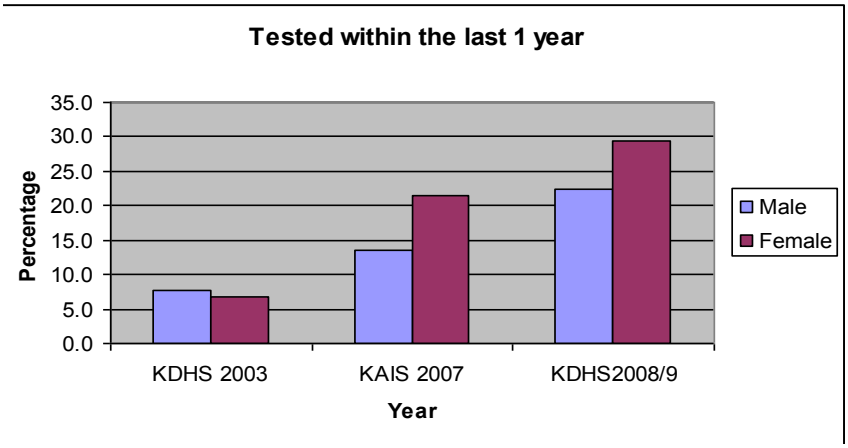


Fig past 1 year

[2] Health Information Management System Report
[3] Joint UN report 2009



The KAIS 2007 found out that 36 percent of adults know their HIV status. KAIS estimated that about 83 percent of HIV infected people do not know their status[4].

Prevention of mother to child transmission (PMTCT)

In 2009, about 58,591 HIV positive pregnant women received antiretroviral prophylaxis to reduce the risk of mother-to-child transmission of HIV. According to SPECTRUM estimation model, it is estimated that there were 81,000 HIV positive women in need of PMTCT services, giving a coverage of 72.32 percent for HIV positive pregnant women who received antiretroviral prophylaxis to reduce risk of MTCT The PMTCT services in Kenya are free and integrated into Maternal and Child Health (MCH) services. They includes various interventions, such as HIV testing and counseling, preventive treatment with antiretroviral (maternal and infant), counseling and support for appropriate infant feeding, access to safe obstetric care, family planning services. The health facilities offering PMTCT services have been increased from about 2000 in 2007 to 3000 in 2008 and 3,397 in 2009. Thus, about 50 percent of the health facilities in the country are offering PMTCT services.

KDHS 2008-09 showed that 72.7 percent of HIV positive pregnant women were offered and accepted an HIV tested and received their results during ANC. About 39,482 children are getting ARV to prevent HIV infection out of the 81,000 estimated number of children born from HIV positive mothers. This shows an increase from 47 percent in 2008 to 49 percent in 2009.

KAIS 2007 found out that of the women who gave birth between 2003 and 2007, knowledge of each mode of MTCT was much higher among women who attended ANC compared to those who had not. Knowledge of antiretroviral preventive therapy for PMTCT was also higher among women who attended an ANC (76.3 percent) compared to women who had not (58.3 percent).

During the reporting period, infant feeding counseling was scaled up at facility and community levels in 5 provinces targeting 67 percent of the 1.5 million pregnant women receiving antennal and postnatal care. Consequently, exclusive breastfeeding rates increased from 12.7 percent in 2003 to 31.9 percent in 2008.

[4] KAIS 2007

Some of the challenges in providing the PMTCT services include low utilization of ANC services with about 44 percent of pregnant women giving birth at a health facility, inefficacious regimes for PMTCT (about 33 percent of HIV positive pregnant mothers are treated with Nevirapine only), lack of integration of PMTCT services with Reproductive Health and Family Planning (RH/FP)services, loss to follow up on women who do not return to the ANC to get their HIV test results, and lack of integration of early infant diagnosis in the MCH continuum resulting in missed opportunities for pediatric treatment.

Blood safety

Kenya National Blood Transfusion Service (KNBTS) was established in 2001 with the responsibility of ensuring blood safety. In 2007, Kenya developed the national standards for blood banks and transfusion services. The blood units collected per year has increased from 41,869 in 2003 to 124,090 in 2009. 100 percent of donated and transfused blood is screened for HIV, hepatitis and syphilis.

STI and HIV

The Ministries of Health supports strategies for managing Sexually Transmittable Infections, including the provision of guidelines and training protocols for all public health facilities. The Ministries of Health also provides standard drug kits for managing common STI syndromes. Linkages between STI clinics and counseling and testing services, however, are weak.

According to KAIS, one third of people aged 15 to 64 years are infected with Herpes Simplex Virus-2 (HSV2); over half of the adult females are infected with HSV2. Among HSV2 infected adults, 16.4 percent were HIV infected while among HSV2 uninfected adults, 2.1 percent were HIV infected. In 2006, the MoHs Reproductive Health Department and NASCOP updated STI guidelines to include data on genital herpes. To undertake an effective fight against HIV, it is necessary to increase awareness of HSV2 and other STIs, as well as its role in transmitting HIV to the general population. In addition, diagnostic and treatment services for HSV2 should be expanded.

Syphilis positivity is also significantly higher among HIV-infected people than HIV-uninfected adults. The prevalence of syphilis positivity in Kenya is 1.8 percent, and it is similar between women (1.7 percent) and men (1.9 percent), except among adults aged 50-64 years, among which there is a higher prevalence for men compared to women (4.4 percent vs. 2.5 percent).

New interventions

In the last two years (2008/2009), two new interventions were introduced to address emerging priorities in addressing the epidemic: prevention with positives and voluntary medically assisted male circumcision.

(i) Voluntary Medical Male Circumcision (VMMC)

According to KAIS 2007, 85 percent of all men in Kenya have been circumcised, however in some areas like Nyanza province the rate is only 48.2 percent. For this reason, VMMC intervention has been introduced targeting those regions where men are not culturally circumcised.

The Male Circumcision Policy and strategic plan, communication and advocacy strategy and M&E tools are in place. VMMC services are provided in about 124 health centres across 11 districts most of which are in non-circumcising communities, and more than 700 health workers have been trained to offer safe VMMC services. Community members and leaders have been sensitized to support VMMC. The cumulative number

of men circumcised through this intervention in the non-circumcising Districts increased from about 10,000 before 2008 to about 90,000 by 2009. However, most of the men being circumcised are below the age of 20, indicating that the VMMC strategy has to be further strengthened to address circumcision among older sexually active men.

(ii) Prevention With Positives

This strategy aims at involving PLHIV in the reduction of new HIV infections. The importance of involving PLHIV in prevention of HIV, especially among discordant couples, became more evident after the finding of the MoT study, including a focus on scaling up HIV testing, awareness of status, disclosure of results, and use of condom between couples. The programme includes a communication campaign that targets health workers so that they know how to inform and counsel positive people. Prevention with Positives strategy and guidelines have been developed and disseminated.

HIV Knowledge and Behaviour

Knowledge and attitudes

KDHS 2008-09 shows that knowledge of HIV prevention methods is high: 75 percent of women and 81 percent of men aged 15 to 49 years know that the use of condom can reduce the risk of getting AIDS virus, and 92 percent of women and 93 percent of men know that abstinence or limiting sexual intercourse to one uninfected partner reduces the chances of getting HIV. A significant reduction in HIV stigma has also been noted. In 2003, 26.5 percent women and 39.5 percent men indicated accepting attitudes towards people with HIV and AIDS. This percentage increased to 47.5 percent for men and 32.6 percent for women.

Behavior change

Kenya has developed and implemented several behaviour change communication strategies including:

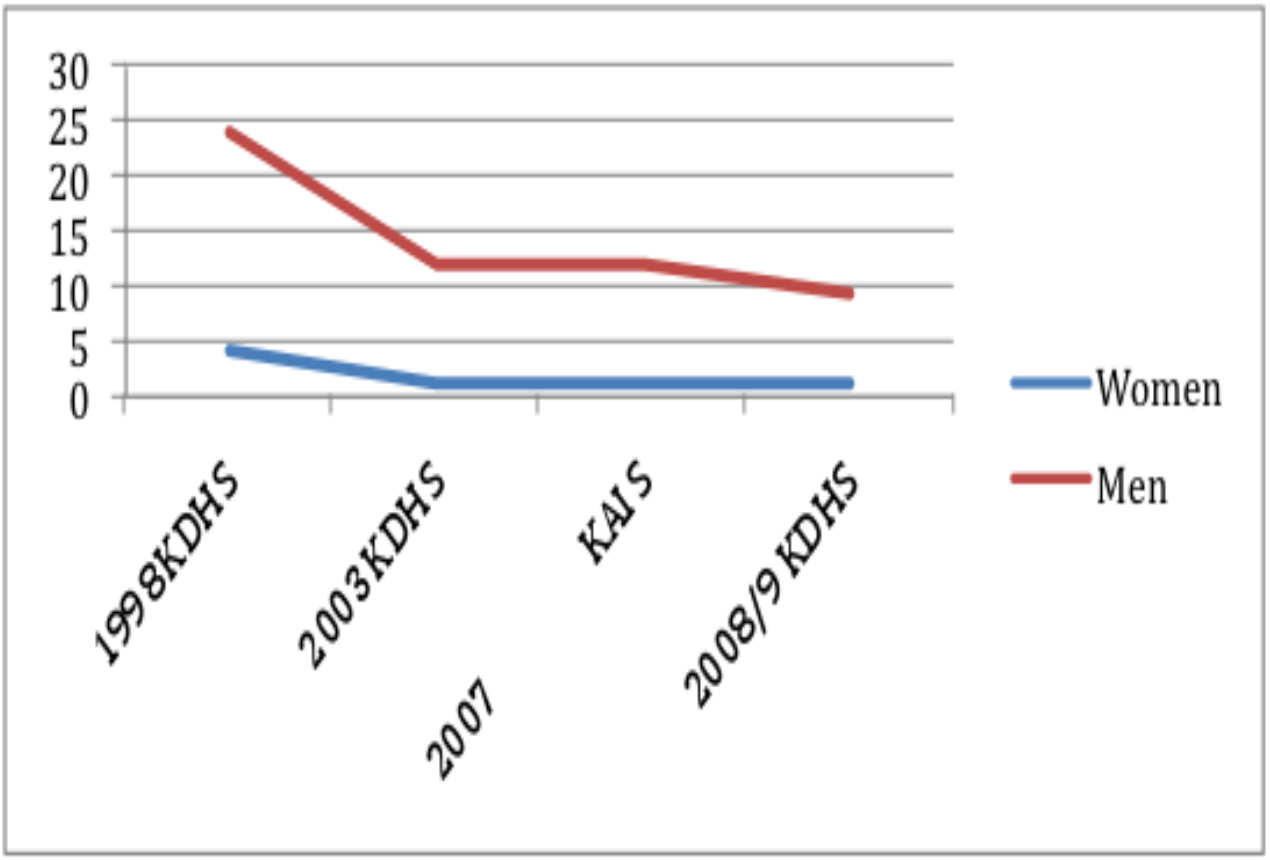
- The National HIV Communication Strategy for Youth developed in 2008 to address all aspects of prevention, care and support as well as mitigation and socio-economic impact of HIV and AIDS among young people.
- Communication strategies around condom use have been implemented in recent years, increasing the number of condoms distributed from 91,201,721 in 2007 to 124,523,984 in 2008. Currently, 15 millions condoms are being distributed each month.
- Communication strategies for Prevention of Mother to Child Transmission of HIV (PMTCT)
- Communication strategies raising awareness on male circumcision.
- Communication and education on life skills targeting the youth in school implemented through mass media and Ministry of Education

The behavior change interventions have had an effect on behaviour. Recent studies including KAIS 2007 and KDHS 2008-09, show an increase in condom use, delay in sexual debut and reduction in number of sexual partners.

The KDHS 2008-09 indicates that among those who had sex in the last 12 months, 35 percent of men and 18 percent of women are likely to engage in higher–risk sex, defined as sex with non-marital, non-cohabitating partners. Likewise, 9.4 percent of men had sex with two or more partners in the past 12 months, compared with only 1.2 percent among women. A comparison with previous population based surveys shows a general

decrease in the number of sexual partners in the past ten years: from 24.1 percent to 9.4 percent among men and from 4.2 percent to 1.2 percent among women.

Figure 5: Number of sexual partners in the past 12 months

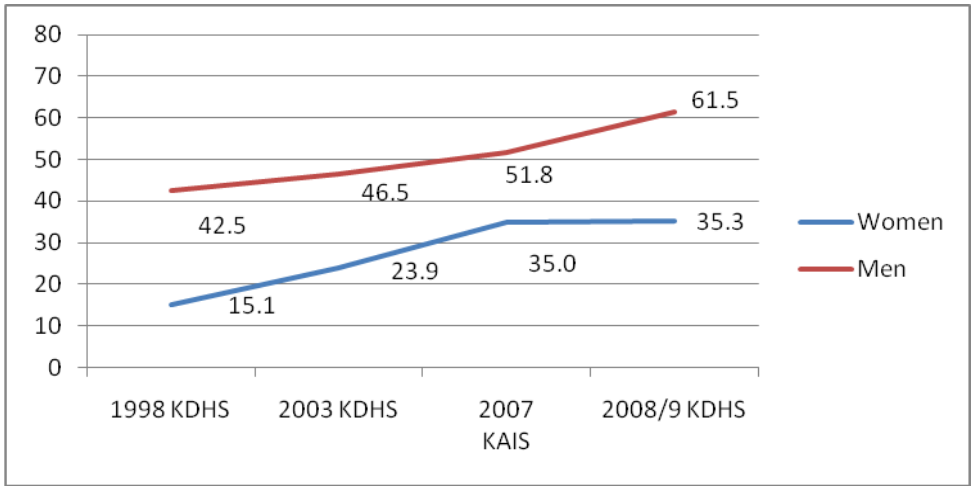


KDHS 2008-09 results indicate that more men were found to have multiple sexual partners in their lifetime than women (6.3 percent against 2.1 percent respectively). As KAIS 2007 showed, prevalence of HIV among both women and men varied significantly by the number of lifetime sexual partners.

According to KDHS 2008-09, among respondents who had sex with two or more partners in the past 12 months, only 32 percent of women and 37 percent of men reported using a condom during their last sexual intercourse. Among respondents who had sexual intercourse in the past 12 months with a person who was neither their husband or wife nor a cohabitating partner, 35.3 percent of women reported using a condom during last sexual intercourse, compared with 61.5 percent of men. This shows

progress for both women (23.9 per cent in the KDHS, 2003, and 35.0 per cent in the KAIS, 2007) and men (46.5 per cent and 51.8 per cent in the two studies, respectively).

Figure 6: Condom use at last higher risk sexual intercourse



Data also suggests a delay in the initiation of sexual activity. The percentage of women reporting sexual debut before 15 years of age decreased from 13.7 in 2003 to 11 percent in 2008, and for men from 28.8 to 22.2 respectively.

With regard to female sex workers, about 78 percent of sex workers reported having ever been tested for HIV and 87.7 percent of them reported use of condom with their most recent client. According to the sex worker survey, 59.4 percent of the sex workers both correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission.

3.3.2 Treatment, care and nutrition

Adult treatment

The number of health facilities providing antiretroviral therapy has increased from 731 in 2008 to 943 in 2009, which represents 14% of the total health facilities in the country. In 2007 a total of 172,000 HIV positive patients were on ART, and the number increased to 236,881 in 2008 (230,059 adults and 20,517 children) and to 336,980 in 2009 (308,680 adults and 28,370 children). At least 30,000 of those on ART also receive nutritional support. Overall, ART coverage has increased from 42 percent in 2007 to 70.4.Percent in 2009..

Pediatric treatment

About 1000 health facilities are providing Early Infant Diagnosis for HIV. The number of children tested for HIV has increased from 30,640 (37.8 percent) in 2008 to 49,344 (61%) in 2009. Pediatric treatment has also increased during the reporting period (from 13,000 children treated in 2007 to 20,517 in 2008 and 28,370 in 2009) covering about 24.2% of children in need of ART. Although number of children on ART has increased

from 2008 to 2009, there is a reduction in percent coverage because of the change in denominator in the view of the new guidelines that all HIV + children below 18 years need ARVs.

Opportunist infections and cotrimoxazole coverage

According to KAIS 2007, 12.1 percent of HIV-infected adults were taking cotrimoxazole daily to prevent infections. Uptake among infants born to HIV infected mothers started on cotrimoxazole within two months of birth was lower at 3 percent in 2008 and 6 percent in 2009[5]. KAIS survey of 2007 found that among those known to be infected with HIV, 76.1 percent were taking cotrimoxazole daily[6].

TB/HIV collaboration

The coverage of TB patients being tested for HIV has increased from 80 percent to 2008 and 88 percent in 2009. The proportion of HIV positive TB patients who are on ART treatment has also increased from 16 percent in 2006 and 31 percent in 2008, to 36 percent in 2009.

3.3.3 Orphans and Vulnerable Children

It is estimated that more than 2.4 million children are orphans and half of them are due to HIV and AIDS. With regard to support to OVC, KAIS 2007 reported that 21.4 percent lived in households that received at least one type of free external support to help care for the children, while the majority of OVC and their households (78.6 percent) had never received any kind of support. A few households (0.03 percent) had received all types of support.

During the period 2008/09, the Orphans and Vulnerable Children Policy and National Action Plan were developed and widely disseminated to stakeholders.

The national cash transfer programme was scaled up to cover 65 districts in 2009, up from 30 districts covered in 2007. The households being reached have also increased from 7,500 in 2006/7 to 75,000 in 2008/09. The Government funding to the programme has increased US$8 million in 2008 to more than US$10 million in 2009 while development partners are contributing over USD30 million. As a result, almost 250,000 OVCs will have improved access to nutrition, education, health and birth registration services. By 2010, the programme is expected to reach more than 100,000 households in 47 districts.

Through the PEPFAR program, 514,594 OVCs were reached in 2008 and 569,616 in 2009. This programme provides a package of basic needs including food and clothes.

[5] Universal Access report 2008 and 2009
[6] KAIS 2007

4. Best practices

4.1 Rapid Response Initiative(RRI) on 'Know your status Campaign'

Kenya is one of the few countries that have adopted the Rapid Results Approach (RRA) to improve performance in service provision on the public sector. RRA is a "Results Based Management" tool aimed at accelerating achievement of results within a 90-day period. The approach involves focusing an institution on carefully selected and designed results which are expected to be of high impact and unleashing the organisation's energy through effective leadership, team work and resource allocation to achieve the results.

Kenya adopted this approach to scale up HIV testing and Counselling (HTC) in 2008 and 2009. In 2008, over 700,000 people were counseled and tested in one week and 1.2 million over three weeks in 2009 through a carefully planned HIV testing campaign using multiple strategies. The campaign showed that demand to know ones status is high. The approach provided a forum to advocacy for free HTC services across the country; promoted private/public partnerships; brought all partners and stakeholders together from both private and public sectors for a common cause; and mobilized resources to achieve the targets set. Community mobilization and awareness was promoted using public address systems, posters, radios, barazas, and churches and mass media especially using radio. Road shows were also used to mobilise high risk groups such as MSMs. There was also advocacy within health facilities which ensured ownership by all providers within the facilities. The initiative was launched by the Minister for Public Health and Sanitation to increase its profile and demonstrate government support.

The campaign used different strategies in different locations: health facility based, community outreach, stand alone sites, door to door and workplace sites, mobile outreach, e.g. pitching tents outside health care facilities. Testing at hospitals and health facilities was promoted regardless of the original reason why the patient had been admitted. Home based HIV testing was particularly useful for populations that have limited access to regular testing and counseling services. Other strategies for implementing this initiative include testing at work places which involved the private sector and „Opt-out' testing carried out at PMTCT sites.

Lessons learnt for future implementation include: early planning, total ownership of the exercise by government, team work with partners, community mobilization especially at the grassroots level, linkage and referral to ensure positive clients are enrolled and retained on care and supplying kits directly to the facilities.

4.2 Cash Transfer programme for orphans and vulnerable children (CT-OVC)

Kenya's Cash Transfer Programme for Orphans and Vulnerable Children (OVC) provides regular cash transfers to poor families living with OVC. The aim is to foster the continued care of OVCs and to promote their human development through basic education, basic health and nutrition services and birth registration. From a 500 household pilot in 3 districts, the CT-OVC Programme now covers 75,000 households that receive cash payouts every two months at the nearest Post Office. Almost 250,000 children now have improved their access to health, education, nutrition and birth registration. The programme will reach its initial target of 100,000 households two years earlier than expected due to the increased capacity, commitment and funding allocation from the GOK, as part of its national social expenditure programme.

4.3 Annual Joint HIV and AIDS Programme Review (JAPR)

The first sessions of the Annual Joint HIV and AIDS Programme Review (JAPR) between 2002 and 2005 were convened at the national level with minimal involvement of the decentralized level. This, however, began to change in 2006, when those meetings were deliberately decentralized to improve involvement of the grassroots level. A further improvement of the process has seen a different approach to reporting which is now results based, reporting on achievements rather than on activities. In addition, partners, are aligning their plans to the national strategy ensuring full engagement and harmonization of efforts.

5. Major challenges and remedial actions

5.1 Progress made on challenges reported in 2008

Reported in 2008	Progress made by 2009
Leadership and coordination: Inadequate harmonization and alignment of activities and resources	NACC has developed a framework on the basis of which harmonization and alignment under KNASP III will be achieved. Memoranda of Understanding will be signed with sector/pillar coordinators, some development partners have signed partnership frameworks, national results have been defined on the basis of which performance of programmes will be assessed and a national accountability committee has been established.
Financial: Funding of HIV skewed towards treatment and inadequate funding by Government of Kenya compared to development partner contribution.	Progress has been made in the last two years in leveraging resource from the development partners and also from GOK to support HIV programmes. The contribution of GOK has improved. The country is currently developing an HIV financing strategy to improve sustainability of the national response.
Prevention: HIV preventions interventions did not target At-risk populations	MARPs have been prioritized under KNASP III and specific interventions are being implemented targeting these groups. Currently, HTC, Condom Distribution and Awareness and education interventions are specifically prioritising female sex workers, MSMs and IDUs.
Care and treatment: Scaling up of pediatric ART was poor	Pediatric ART has been scaled up with an increase of children on ART from 20,517 in 2008 to 29,819 in 2009. Sites providing pediatric ART have also increased and referral services with PMTCT sites are being strengthened.
Monitoring and evaluation: Weak M&E capacity	M&E capacity needs assessment has been completed and a the new National HIV and AIDS M&E and Research Framework developed based on lessons learnt. There are plans underway to establish a robust information management system to support M&E.

5.2 Challenges faced in 2010 and remedial action planned

a. Prevention: Targeting of MARPs

Although KNASP III focuses on MARPs, challenges remain in how to operationalise the plan. There is an overall lack of comprehensive data on MARPs that hinders effective targeting. For example, it is known that sex workers, with relatively high HIV prevalence, are widespread in urban centres and along major transport routes. However, attempts to quantify accurately the population size have so far been unsuccessful. KNASP III uses the latest model default estimates to arrive at 80,000 sex workers for planning purposes. MSMs are a significant population but their size is difficult to estimate. IDU is increasing in Kenya, but again real numbers and their distribution remain unknown[7].

Remedial action proposed: The remedial action proposed is to undertake a mapping and behavioural survey of the key MARPs- FSWS and clients, MSMs and IDUs in order to provide information required to effectively plan interventions targeting these groups. The survey should be comprehensive using sound methodologies to provide baseline data and a basis for setting realistic targets.

b. Monitoring and Evaluation

Compared to the status highlighted in the previous UNGASS report, the M&E systems has greatly improved especially in terms of coordination and alignment of stakeholders to the national reporting system. However, capacity remains a challenge, particularly among Civil Societ Organisations (CSOs)_ including NGOs and CBOs, that need continuous training. While one M&E system is in place, it is not fully operationalised and parallel systems, also related to donor programmes, are still in place. The HMIS needs to be strengthened.

Remedial action proposed: The capacity of CSOs in M&E will be improved through training. A standardized tool and system for reporting exists and the organisations will be trained on reporting within the existing framework. Secondly, NACC will proactively pursue the signing of MoUs with lead coordinating bodies and implementers in each sector to ensure that these partners report to the national M&E system. Increased rate of reporting will enable NACC to effectively coordinate the national response.

c. Financing of KNASP III

The global economic crisis is likely to pose a real threat to financing of HIV and AIDS Programmes globally and Kenya will equally be affected. In the wave of the economic crisis, donor funding is expected to decrease, and grants can no longer be taken for granted. Such effects could erode the gains already made in addressing HIV and AIDS. However, Kenya's improved capacity, information base, results-based programming, cost effectiveness and accountability and a new national AIDS plan, all ensure that the country has an opportunity to maximize the use of the substantial amount of HIV funding available.

Remedial action: Kenya is in the process of developing a financing strategy for HIV and AIDS which focuses on mobilizing resources from domestic sources to complement donor funding. The financing strategy aims at sustaining the national response to HIV and AIDS in a predictable manner. This strategy will be completed in 2010.

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[7] A United Nations Office of Drug Control (UNODC) study conducted in 2004 estimated HIV prevalence among injecting drug users in Nairobi, Malindi and Mombasa to be 68 to 88 per cent

d. Procurement

At least three procurement and supply management systems exist within the HIV response, with little coordination among them. There have been frequent stock-outs, and imminent stock-outs, of HIV medicines, vaccines and technologies and there is poor storage capacity.

Remedial Action: The capacity development of Kenya Medical Supplies Agency (the public procurement and supplies body) is on-going and it is envisaged that KEMSA will, with time, start taking up responsibilities currently undertaken by other procurement agencies. This will streamline procurement and supply of drugs. In the short term, an harmonized system for developing procurement plans and coordinating procurement and supply of HIV and AIDS commodities will be put in place to address the current bottlenecks.

6. Support from the country's development partners

6.1 Key support from donors

- The current donor support for the national response to HIV and AIDS includes:
- Global Fund to Fight AIDS, TB and Malaria: Kenya has received funding under Rounds 7 to scale up prevention of HIV infections and expand treatment and care for PLHIV.
- World Bank/Government of Kenya funding for Total War Against AIDS (TOWA) project focusing on prevention of HIV infections. This funding aims at mobilizing communities and priority populations to change behaviour.
- PEPFAR is supporting treatment and care, prevention of HIV infections and mitigation of socio-economic impact of HIV.
- Clinton foundation supports pediatric treatment of HIV
- DFID is supporting HIV prevention through community mobilization. DFID is also providing technical assistance through the UN system.
- UN Agencies support to the national response through the UN Joint AIDS Programmes

6.2 Actions necessary for achievement of UNGASS targets

For UNGASS targets to be met, development partners should sustain funding for the national response. Some of the specific actions the donors can take to achieve UNGASS targets include:

- Aligning support to national targets as specified in KNASP III in line with the Paris Declaration
- Supporting the one national M&E system to improve reporting rates and make information available for decision-making. This will also reduce the parallel reporting requirements for each donor programme.
- Participating actively in the planning and monitoring of the national response to enhance accountability and assess performance in achieving targets. This will

ensure that development partners are involved in making decisions to improve performance and to hold implementers accountable for effective service delivery.

7. Monitoring and Evaluation Environment

7.1 Overview of Current M&E System

In order to coordinate stakeholders towards One Agreed Country level Monitoring and Evaluation system, NACC developed a comprehensive National HIV and AIDS Monitoring and Evaluation and Research Framework. This framework has identified 55 national indicators that will be used to track the national response at the national level. Moreover the framework has been aligned to the new KNASP III.

The goal of this National HIV and AIDS M&E and Research Framework is to establish a well coordinated, harmonized, monitoring, evaluation and research system that provides timely and accurate information to guide planning of HIV programmes.

Under KNASP III, the National Multi-sectoral M&E Committee provides technical oversight in operationalising the National M&E framework. At the decentralized level, Regional M&E fora provide oversight at that level. Monitoring and evaluation at decentralized structures is coordinated by the Constituency AIDS Control Committees and District Technical Committees at the constituency and District respectively. The health sector response monitors and evaluates HIV responses through the Health Management Information System which collects data from health facilities and sends reports to the national level. The National AIDS and STI Control Programme coordinates the health sector M&E.

The Kenya HIV and AIDS Research Coordination Committee (KARSCOM) guides the planning, prioritization, resource mobilization and dissemination of HIV and AIDS research that is relevant to the information needs of the national response. The committee coordinates research institutions, development partners and medical institutions in carrying out clinical and operational research.

Overall, a monitoring plan is in place specifying the indicators to be reported on, data collection tools, reporting schedules and organisations responsible for reporting. This plan forms the basis for operationalising the M&E framework. An M&E system is in place with a detailed operational manual to guide data collection, reporting, verification and decision-making.

7.2 Challenges faced in implementation of M&E system

The HIV and AIDS M&E system was assessed during the process for developing the KNASP III. The assessment identified various weaknesses:

- Low compliance – some partners and implementers are not submitting reports to the national M&E system. This undermines harmonization and alignment and weakens coordination.
- Weaknesses in the M&E sub systems that the national M&E system relies on for data. This hinders effective reporting on the national response.
- The management information system at the national level requires to be reviewed to capture data on KNASP III given the expanded number of indicators and need for detailed analysis.

7.3 Remedial action

- NACC and NASCOP have started revising national data tools to harmonise them with the KNASP III indicators
- Harmonisation and alignment of partners and implementers to the national M&E system through signing of MoUs and demonstrating the use of data collected for decision making on the part of NACC.
- Capacity development for M&E will be undertaken with a focus on training coordinating bodies and implementers on the M&E operations, data analysis and verification/validation. Adequate funding is also required to enable the coordinating bodies to undertake data verification and validation exercises.

9. ANNEXES

NCPI RESPONSES – PUBLIC SECTOR

Sector/ line Ministry	Name/ Position					
		A.I	A.II	A.III	A.IV	A.V
The Kenya Police	**John Willis Okello** Assistant Commissioner of Police – Head of the Kenya Police AIDS Control Unit (ACU)	√	√	√	√	√
Provincial Administration and Internal Security	**Daniel Bolo** Under Secretary – Head of Provincial Administration and Internal Security ACU	√	√	√		
Ministry of Planning –	**Meshek Ndolo.** HIV/AIDS Coordinator	√	√			
National AIDS Control Council	**Prof Alloys Orago** Director, NACC	√	√	√	√	√
National AIDS Control Council	**Dr. Sophie Mulindi** Deputy Director, Stakeholder…			√		
National AIDS Control Council	**Dr. Patrick Muriithi** Acting, Head of Monitoring and Evaluation Unit NACC					√
State Law Office – Office of the Attorney General	**Irene Ogamba** Deputy Head of AIDS Control Unit (ACU), State Law Office	√		√		
Ministry of Agriculture	**Alice Kinyua** Head of ACU, Ministry of Agriculture	√	√			
Ministry of Education	**Elizabeth Kaloki** Deputy Head of ACU - Ministry of Education	√	√	√		

Teachers Service commission	**Oliver Munguti** Head of ACU – Teachers Service Commission	√	√	√		
Prisons Department	**Mary Chepkonga** Head of ACU – the Kenya Prisons	√		√		
Ministry of Public Health and Sanitation/ Ministry of Medical Services	**Anne Barsigo/Dr. Mukui** M&E Manager **Irene Njahira – Mukui** ART Manager				√	
Commission for Higher Education	**Teresia Muthui** Acting Deputy Commission Secretary PAF. Head of ACU – Commission for Higher Education	√		√		

STRATEGIC PLAN

1.0 Has the country developed a national multisectoral strategy to respond to HIV:

YES √	NO	N/A

Kenya has had the following national multisectoral strategies to respond to HIV since 2000: i) Kenya National HIV and AIDS Strategic Plan (KNASP) I; ii) KNASP II; and now currently iii) KNASP III. In addition, line ministries and their departments/institutions have developed their own HIV and AIDS Strategic Plans which are aligned to the KNASP.

1.1 How long has the country had a multisectoral strategy?

Indicate years: 9years

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

(Tick if yes or no)

Sectors	**Included in Strategy**		**Earmarked budget**	
	Yes	No	Yes	No
Health	√		√	
Education	√		√	
Labour	√		√	
Transportation	√		√	
Military/Police	√		√	
Women	√		√	
Young people	√		√	
OTHERS				
Provincial Administration & internal security	√		√	
Prisons (GJLOS)	√		√	
Physical Infrastructure	√		√	
Agriculture and Rural Development	√		√	
Public Administration	√		√	
Environment, Water and Sanitation	√		√	
Tourism and Industry	√		√	
Research Innovation &	√		√	

Technology				

Comments:

√* - YES **All sectors have earmarked budget allocation through MTEF.**

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

(Tick if yes or no)

	YES	NO
Target Populations		
a. Women and girls	√	
b. Young women/ young men	√	
c. Injecting drug users	√	
d. Men who have sex with men	√	
e. Sex workers	√	
f. Orphans and other vulnerable children	√	
g. Other specific vulnerable subpopulations *(clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).* Crossborder migrants, migrant workers, IDPs, refugees, prisoners, pastoralists, fisherfolk, discordant couples, elderly.	√	
Settings		
h. Workplace	√	
j. Schools	√	
j. Prisons	√	
Cross-cutting issues		
k. HIV and poverty	√	
i. Human rights protection: Social protection of widows/widowers, children orphaned by HIV and	√	

AIDS, inheritance issues.		
m. Involvement of people living with HIV: KENWA, NEPHAK, SWAK.	√	
n. Addressing stigma and discrimination: This is being done through FBOs and "prevention with positives where there is first dealing with self stigma before distigmatising others.	√	
o. Gender empowerment and/or gender equality: All programmes have mainstreamed including Gender Based Violence.	√	

1.4 Were target populations identified through a needs assessment?

YES	NO
√*	

*Some of the target populations were identified through needs assessment, while others through informal networks.

If yes, when was this needs assessment conducted?

Year:

2008: Prisoners vulnerability assessment

2008/9: Sex workers study – ongoing

2007/8: IDUs and MSMs

2007/8: Pastoralists – suctioned by IGAD Regional AIDS Partnership Program (IRAPP)

If no, how was the target populations identified?

Other target populations have been identified through informal networks, for example the IDPs were identified through information given by relatives.

1.5 What are the identified target populations for HIV programmes in the country?

Women, youth, MARPs, mobile and migrant populations, OVCs…….

1.6 Does the multisectoral strategy include an operational plan?

YES	NO
√	

KNASP III has NPO (National Plan of Action)

1.7 Does the multisectoral strategy or operational plan include:

	YES	NO
Formal programme goals	√	
Clear targets and milestones	√	
Detailed costs for each programmatic area	√	
An indication of funding sources to support programme implementation	√	
A monitoring and evaluation framework	√	

1.8 Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?

ACTIVE INVOLVEMENT	MODERATE INVOLVEMENT	NO INVOLVEMENT
√		

If active involvement, how was this organized?

- Involvement was organized through consultative forums and validation workshops.
- Out of the stakeholders involved in the development of the KNASP III, 58% were CSOs.
- Have been involved in KNASP III Pillars.
- Active involvement in the regional JAPR forums.

If NO or MODERATE involvement, explain why this was the case?

1.9 Has the multisectoral strategy been endorsed by most development partners (bi-laterals, multi-laterals)/

YES	NO
√	

The development of the KNASP III was supported by most Development Partners (JICA, USAID, WB, DFID, among others).

1.10 Have development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

YES, ALL PARTNERS	YES, SOME PARTNERS	NO
√		

- All partners aligned and harmonized their HIV and AIDS programmes to the current KNASP III and have committed to adhere during implementation.
- The US Government HIV and AIDS response has been aligned to KNASP III (PEPFAR, Peace Corps, CDC, etc).
- The entire UN is aligned.

If SOME or NO, briefly explain for which areas there is no alignment/harmonization and why:

2. Has the country integrated HIV into its general development plans such as in: a) National Development Plan; b) Common Country Assessment/ UN Development Assistance Framework; c) Poverty Reduction Strategy; and d) Sector-wide approach?

YES	NO	N/A
√		

2.1 **If yes,** in which specific development plan(s) is support for HIV integrated?

	YES	NO	N/A
a. National Development Plan	√		
b. Common Country Assessment/ UN	√		

Development Assistance Framework			
c. Poverty Reduction Strategy	√		
d. Sector-wide approach	√		
e. Other: - District and constituency development plans; sector plans etc. - Vision 2030 - Sector Impact studies	√		

2.2 **IF YES,** which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)	**Yes**	**No**
HIV prevention	√	
Treatment for opportunistic infections	√	
Antiretroviral treatment	√	
Care and support (including social security or other schemes)	√	
HIV impact alleviation	√	
Reduction of *gender* inequalities as they relate to HIV prevention/ treatment, care and/or support	√	
Reduction of stigma and discrimination	√	
Women's economic empowerment (e.g. access to credit, access to land, training)	√	
Other: OVC support programme	√	
Widows support programme	√	

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

YES	NO	N/A
√		

3.1 **If yes**, to what extent has it informed resource allocation decisions?

0	1	3	4	5

Rated: 4

The government has allocated KSHS 1.5 billion to HIV and AIDS and the related capacity building: infrastructure, human resource, and systems development and has been based on impact assessment.

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff etc)?

YES √	NO

Yes has strategy and programs for each of them and a budget allocation.

4.1 **If YES**, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

	YES	NO
Behavioural change communication	√	
Condom provision	√	
HIV testing and counselling	√	
Sexually transmitted infection services	√	
Antiretroviral treatment	√	
Care and support	√	
Others: OVC support		√
Impact mitigation		√

NB: It is only the OVC support and impact mitigation which have not; this has been implemented in pilot districts only.

If HIV testing and counseling is *provided* uniformed services, briefly describe the approach taken to HIV testing and counseling (e.g. indicate if HIV testing is voluntary or mandatory etc):

The approach to testing and counseling is officially voluntary; however, there are cases of mandatory testing during recruitment.

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

YES	NO √

- There are no Laws but all MARPs and vulnerable sub-populations can access services.
- Non-Discrimination Laws in Kenya are general and not specific to certain populations.
- The HIV and AIDS Prevention and Control ACT has sections on non-discrimination to HIV and AIDS and not to specific population groups.

5.1 **If YES**, for which subpopulations?

	YES	NO
Women		
Young people		
Injecting drug users		
Men who have sex with men		
Sex workers		
Prison inmates		
Migrant/ mobile populations		
Other:		

If YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Briefly comment on the degree to which these laws are currently implemented:

- There is a penalty if there is discrimination/if there is contravention of the Law.
- The UN convention on Human Rights – states that there should be no discrimination/ cannot discriminate on the basis of HIV status.
- The Kenya's Public Sector HIV and AIDS Workplace Policy has a component on non-discrimination, however, it is general.
- The Kenya Public Sector HIV and AIDS Workplace Policy has guidelines for implementation but there are no laws that would facilitate its implementation.
- The constitution of Kenya has "no discrimination" component but again it's not specific to particular populations.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

YES √	NO

6.1 **IF YES**, for which subpopulations?

	YES	NO
a. Women	√	
b. Young people	√	
c. Injecting drug users	√	
d. Men who have sex with men	√	
e. Sex workers	√	
f. Prison inmates	√	
g. Migrants/ mobile popualtions		√
Other:		

IF YES, briefly describe the content of these laws, regulations or policies:

- The MARPs activities are regarded as criminal in nature and unlawful.
- The Law of Succession states that a woman once a widow loses the right to her late husband's properties. This makes the woman more vulnerable. While for the man he does not lose right to his wife's property upon her death.
- The Kenya's Marriage Act only recognizes a union between man and woman and not same sex. Therefore the rights of MSMs and WSWs have not been articulated.
- Sex work is not regarded as work in Kenya, it has not been legalized. So their issues are not articulated by Trade Unions in Kenya (COTU), FKE etc. However, there are some organizations for example CSOs that have articulated their issues.
- Prisons inmates – their issues are not articulated by the laws. The Kenya Prisons have a workplace HIV and AIDS policy; however, it's not clear how the prisoners HIV and AIDS issues are being addressed by it.

Briefly comment on how they pose barriers:

They have caused marginalization of these sub-populations and this has given rise to inaccessibility to HIV and AIDS services, and increases their risk to HIV infection.

7. Has the country followed up on commitments towards universal access made during the High-level AIDS Review in June 2006?

YES √	NO

- The KNASP II reporting has been in areas of prevention, counseling and testing, Blood Safety, PMTCT, STI management, Injection Safety.
- Components of Universal Access fall both under NACC and Ministry of Health. This has caused confusion to stakeholders and has been impeding implementation progress.
- Over-reliance on external funding for example the Global Fund for ARVs has affected accessibility.
- The female condom has been lacking – this has disempowered the woman.

7.1 Have the national strategy and national HIV budget been revised accordingly?

YES √	NO

The new KNASP III has taken account of prevention, counseling and testing, Blood Safety, PMTCT, STI management, Injection Safety.

7.2 Have the estimates of the size of the main target populations been updated?

YES √	NO

- KNASP III has been based on evidence of epidemic dynamics. It is therefore an updated version and has been costed accordingly.
- The KAIS has provided accurate estimates.
- The networks of PLHIV have information on number of people who are HIV positive.

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	Estimates of current needs only	NO
√		

The estimates are made through modeling.

7.4 Is HIV programme coverage being monitored?

YES √	NO

All data is disaggregated by sex, age and level of vulnerability, for example MARPs and other vulnerable populations.

a) **IF YES**, is coverage monitored by sex (male, female)?

YES √	NO

b) **IF YES**, is coverage monitored by population groups?

YES √	NO

Monitoring data is disaggregated by men, women, rural, urban, MARPs, elderly, care givers, among others.

IF YES, for which population groups?

Fishing communities, CSWs, IDU, MSM, Prisoners, PLHIV, people with disabilities, and OVCs.

Briefly explain how this information is used:

- For targeted interventions.
- Planning services using information on levels of infection, progress made and what needs to be done differently.
-

c) Is coverage monitored by geographical area?

YES √	NO

IF YES, at which geographical levels (provincial, district, other)?

Coverage is monitored nationally, regionally/provincial, rural/urban, and community levels.

Briefly explain how this information is used:

- Regional planning and programming interventions
- Information is used for planning intervention services; for increasing programme coverage, and planning for emerging challenges.

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

YES √	NO

Through the Health Sector Strategic Plan and the health sector human resource strategy.

Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate - 7

Since 2007, what have been key achievements in this area:

1. Raised level of resource allocation by the treasury by over 100%
2. Meaningful partnerships have been established.
3. Intervention programmes are now „results focused'.
4. Interventions are based on cost-effectiveness and "value for money"
5. The KNASP III is evidence based.
6. There has been increased funding through call for proposals,
7. There is gender mainstreaming of HIV and AIDS in all sectoral activities/programmes.
8. There were indepth discussions and consensus during the development of KNASP III.
9. Activities have been costed and targets set in the National Plan of Operation.
10. KNASP III was PEER reviewed both nationally and internationally.
11. Rights and gender are adequately captured in all intervention strategies (engendered and rights based).

What are remaining challenges in this area:

1. Governance issues such as accountability have not been resolved.
2. Weak systems for delivery of services.
3. Legal and ethical issues are still outstanding, they have not been finalized.
4. The country has not invested in ARV drugs and therefore is still highly donor dependent (sustainability is not established).
5. Concerns on whether commitments made by all partners will be translated into actual implementation to achieve set targets.
6. Issue of sustainability of targets in the KNASP III and NPO because of high donor dependability. Funding for HIV and AIDS is 81% by donors.
7. The legal aspects of HIV and AIDS have not been adequately addressed. There should be involvement of CSOs dealing with legal issues such as KENLIN who were involved in the drafting of HIV and AIDS Prevention and Control ACT.
8. There are glaring gaps in Universal Access.

What are the best practices in this area:

- All partners have committed to and adhered to the NPO and to reporting on the national HIV and AIDS indicators. There is now a one-country M&E system.

Way forward:

- The HIV and AIDS Prevention and Control ACT and the Sexual Offences ACT need to be revised so that all the issues of HIV and AIDS that are affecting the MARPs, PLHIV and other vulnerable sub-populations are addressed.

II POLITICAL SUPPORT

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	YES √	NO
Other high officials	YES √	NO
Other officials in regions and/or districts	YES √	NO

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

YES √	NO

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 **IF YES**, when was it created? Year: 2000

2.2 **IF YES**, who is the Chair?

Name: Prof. Mary Getui

Position/title: Chairman to the Board

2.3 **IF YES,** does the national multisectoral AIDS coordination body:

	YES	NO
Have terms of reference?	√	
Have active government leadership and participation?	√	
Have a defined membership? **If YES,** how many members?	√ **17**	
Include civil society representatives? CSOs are involved in Interagency Coordinating Mechanism, Pillars and Decentralised JAPR. CSOs are represented in ICC and board, advisory committee of ICC and multi-sectoral representation. **IF YES, how many? CSOs constitute 65% of the members** **- 3 CSOs slots out of 17 members of the Board.** **- 4 CSOs slots out of 19 members in the Advisory Committee of ICC.** **-**	√	
Include people living with HIV? **IF YES**, how many? **One slot.**	√	
Include the private sector? **IF YES**, how many? 4 slots out of the total	√	
Have an action plan?	√	
Have a functional Secretariat?	√	
Meet at least quarterly?	√	
Review actions on policy decisions regularly?	√	
Actively promote policy decisions?	√	
Provide opportunity for civil society to influence decision-making?	√	
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	√	
Coordination is weak.	√	

- Donor coordination is weak; there is a lot of duplication of the services being supported by different funding agencies in some of the line ministries. Reason is low uptake of the three ones principles by CSOs, DPs and GOk.

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

YES √	NO	N/A

IF YES, briefly describe the main achievements:

- The national AIDS Control Council has a stakeholder coordination desk that brings them together.
- Stakeholder coordination requires further strengthening.

Briefly describe the main challenges:

- Full engagement of CSOs.
- Capacity building for CSOs.
- Engagement of Local Authorities
- Capacity building of Local Authorities.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year? Percentage: 70%

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

	YES	NO
Information on priority needs	√	
Technical guidance	√	
Procurement and distribution of drugs or other supplies	√	
Coordination with other implementing partners	√	
Capacity-building	√	
Other:		

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

YES	NO √

- However, KNASP III has the recommendation for review of national policies and laws to determine their consistency with the National AIDS Control policies.

- The HIV and AIDS Prevention and Control Act and the Sexual Offences Act need to be reviewed to support HIV and AIDS policies.

6.1 **IF YES**, were policies and laws amended to be consistent with the National AIDS Control policies?

YES	NO

IF YES, name and describe how the policies/laws were amended:

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

- Policies regarding MSM, IDUs, Prisoners still have to be put in place and relevant laws established.

- Sector HIV and AIDS policies need to be reviewed and aligned to HIV Prevention and Control Act and KNASP III.

Overall, how would you rate the political support for the HIV programme in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate - 8

Since 2007, what have been key achievements in this area:

- Budgetary allocation to HIV/AIDS – Public Sector and Civil Society.
- Sustaining of HIV and AIDS leadership.
- The National Integrated Monitoring and Evaluation System (NIMES) has two HIV/AIDS indicators out of 66. This is a great achievement for Kenya.

- Held workshop on HIV and AIDS for all members of Parliament in November 2008.
- Continued interaction with Parliament Health Committee to appraise them on HIV and AIDS situation in the country.
- Mainstreaming of HIV and AIDS in Private, Public and Civil Society Sectors.

What are remaining challenges in this area:

- The Cabinet Committee on HIV/AIDS appointed about two years ago has become redundant. It needs to be revived.
- The Civic government (Local Authority) is doing very little, this is mainly due to local authorities not having relevant capacity.
- NACC has not engaged the Civic Government in HIV and AIDS interventions.
- LATF has not been utilized because of lack of capacity.
- 95% of all HIV and AIDS activities are still donor funded.
- The government should commit more funding locally for HIV and AIDS budget.

What are the best practices

- The launching of the KNASP III
- National M&E (integrated) – National Integrated M&E System (NIMES) has incorporated two HIV and AIDS indicators among a total of 66 national indicators. This is a great achievement for Kenya.

What is the way forward?

- An all inclusive implementation of KNASP III should be established.
- The HIV and AIDS funding from the Government should be increased. Kenya's HIV/AIDS funding is currently highly donor reliant.
- Review national policies/laws to be consistent with HIV and AIDS policies.

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

YES √	NO	N/A

1.1 **IF YES**, what key messages are explicitly promoted?

Be sexually abstinent	√
Delay sexual debut	√
Be faithful	√
Reduce the number of sexual partners	√

Use condoms consistently	√
Engage in safe (r) sex	√
Avoid commercial sex	**NO**
Abstain from injecting drugs	√
Use clean needles and syringes	√
Fight against violence against women	√
Greater acceptance and involvement of people living with HIV	**NO more needs to be done.**
Greater involvement of men in reproductive health programmes	**NO more needs to be done**
Males to get circumcised under medical supervision	√
Know your HIV status	√
Prevent mother-to-child transmission of HIV	√
Other: Fight against men	**NO more needs to be done.**
Greater and Meaningful Involvement of PLHA	**NO more needs to be done.**

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

YES √	NO

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

YES √	NO	N/A

2.1 Is HIV education part of the curriculum in:

	YES	NO
Primary schools?	√	
Secondary schools?	√	
Teacher training?	√	

- HIV education is not examinable and hence might not be taken seriously.
- Universities that are training teachers for example Kenyatta University and Catholic University among others, have HIV education in the training programme and/or as a core subject.

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

YES √	NO

2.3 Does the country have an HIV education strategy for out-of-school young people?

YES √	NO

However, the media needs to be involved.

3. Does the country have a policy or strategy to promote information education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

YES	NO √

IF NO, briefly explain:

The country has just developed the Third strategic plan which intends to address most at risk populations and other vulnerable sub-populations.

3.1 **IF YES**, which populations and what elements of HIV prevention do the policy/strategy address?

(Which specific populations and elements are included in the policy/strategy)

	IDU	MSM	Sex	Clients of	Prison	Other

			workers	sex workers	inmates	populations
Targeted information on risk reduction and HIV education						
Stigma and discrimination reduction						
Condom promotion						
HIV testing and counselling						
Reproductive health, including sexually transmitted infections prevention and treatment						
Vulnerability reduction (e.g. income generation)	N/A	N/A		N/A	N/A	
Drug substitution therapy		N/A	N/A	N/A	N/A	
Needle & syringe exchange		N/A	N/A	N/A	N/A	

Overall, how would you rate policy efforts in support of HIV prevention in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate – 6*

*There are several gaps (see 1.1 and 3.0); secondly, the HIV prevalence has gone up, therefore raising questions on the effectiveness of Behaviour Change Communication Strategy.

Since 2007, what have been key achievements in this area:

- There is continuing mapping of MARPs and involving them in the formulation of the HIV and AIDS policy and development of the strategic plan.

What are remaining challenges in this area:

MARPs acceptance by the general public and policy makers.

What are the best practices in this area:

There is availability of resources through call for proposals to address issues affecting the MARPs. Advocacy and activism from civil society has become quite evident.

What is the way forward:

i) Develop policies targeting MARPs ; ii) Full participation and engagement of MARPs in planning, implementation, reporting, and monitoring and evaluation.

4. Has the country identified specific needs for HIV prevention programmes?

YES √	NO

IF YES, how were these specific needs determined?

Yes through Kenya AIDS Indicator Survey (KAIS) and Modes of Transmission (MOT) study, as well as Joint AIDS Programme Reviews (JAPR) of 2007, 2008, and 2009.

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV Prevention Component	**The majority of people in need have access**		
	Agree	Don't Agree	N/A
Blood safety	√		
Universal precautions in health care settings	√		
Prevention of mother-to-child transmission of HIV	√		
IEC on risk reduction	√		
IEC on stigma and discrimination reduction	√ More needs to be done		
Condom promotion	√ More needs to be done		
HIV testing and counselling	√ More needs to be done		

Harm reduction for injecting drug users	√ More needs to be done		
Risk reduction for men who have sex with men	√ More needs to be done		
Risk reduction for sex workers	√ More needs to be done		
Reproductive health services including sexually transmitted infections prevention and treatment	√ More needs to be done		
School-based HIV education for young people	√		
HIV prevention for out-of-school young people	√ More needs to be done		
HIV prevention in the workplace	√ More needs to be done		
Other: Empower youth out of school and PLHAs			

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate – 8

This is based on the gaps identified above.

Since 2007, what have been key achievements in this area:

- Increased advocacy and media coverage and involvement as well as funding through call for proposals under Total War Against AIDS (TOWA) project.

- Establishment of ACUs and sub-ACUs have increased since late 2008, and also the increased availability of financial resources has enabled development of work place policies.

What are remaining challenges in this area:

Effective policies formulation and mapping of MARPs.

What are the best practices in this area:

Formulation of the new strategic plan (KNASP III) that is addressing MARPs issues in a more comprehensive manner.

What is the way forward:

Effective implementation of the new strategic plan (KNASP III).

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive JHIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care).

YES √	NO

1.1 **IF YES,** does it address barriers for women?

YES √	NO

1.2 **IF YES**, does it address barriers for most-at-risk populations?

YES √	NO

2. Has the country identified the specific needs for HIV treatment, care and support services?

YES √	NO

IF YES, how were these determined?

Using spectrum model.

Through an extensive situation analysis conducted during the review of Kenya National AIDS strategy II and development of KNASP III.

There were extensive stakeholder consultations and numerous planning meetings ands sessions and reference to WHO guide on HIV care and treatment priorities

IF NO, how are HIV treatment, care and support services being scaled-up?

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	**The majority of people in need have access**		
	Agree	Don't Agree	N/A
Antiretroviral therapy		√	
Nutritional care		√	
Paediatric AIDS treatment		√	
Sexually transmitted infection management	√		**Integrated**
Psychosocial support for people living with HIV and their families		√	
Home-based care		√	
Palliative care and treatment of common HIV-related infections		√	
HIV testing and counseling for TB patients	√		
TB screening for HIV-infected people	√		
TB preventive therapy for HIV-infected people		√	
TB infection control in HIV treatment and care facilities			
Cotrimoxazole prophylaxis in HIV-infected people	√		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)		√	
HIV treatment services in the workplace or treatment referral systems through the workplace		√	
HIV care and support in the workplace (including alternative working arrangements)		√	
Other:			

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

YES √	NO

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, substitution drugs?

YES	NO√

IF YES, for which commodities?:

Overall, how would you rate the efforts in the implementation of HIV Treatment, care and support programmes in 2009?

0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

- Rapid scale up of antiretroviral therapy in the country reaching over 360,000 persons on ART both adult and paediatrics
- Free ARVs provided in GOK, FBO facilities
- Increase in numbers of those accessing nutritional support

What are remaining challenges in this area:

- Sustainability of financing for treatment
- Monitoring and evaluation including monitoring of quality of care

What are the best practices in this area:

- None identified.

What is the way forward:

- Decentralization of HIV treatment services to lower level health facilities

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

YES √	NO	N/A

5.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country?

YES √	NO

5.2 **IF YES,** does the country have a national action plan specifically for orphans and vulnerable children?

YES √	NO

5.3 **IF YES,** does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

YES √	NO

IF YES, what percentage of orphans and vulnerable children is being reached? …45%……%

Funds are low comparatively to the number of OVCs

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate – 6*

*there is no distinction between HIV and AIDS related orphans and those from other causes of death because of stigma and discrimination.

Since 2007, what have been key achievements in this area:

- Making available required resources.
- Media highlighting the plight of OVCs.

What are remaining challenges in this area:

- Training and capacity building.
- Mechanisms to collect data for purposes of planning.
- Disaggregation of data into different categories of OVCs.
- Inclusion in the HIV and AIDS Prevention and Control Act.

What are the best practices in this area:

i) Integration of OVC within families and communities.
ii) Cash-transfer to families supporting OVCs.

What is the way forward:

90 – 100% support to OVCs.

IV. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

YES √	IN PROGRESS	NO

IF NO, briefly describe the challenges:

1.1 **IF YES**, years covered:
2009/10 – 2012/13

1.2 **IF YES**, was the M&E endorsed by key partners in M&E?

YES √	NO

Involved in M&E technical working group and facilitated multisectoral M&E TWG.

1.3 **IF YES**, was the M&E plan developed in consultation with civil society, including people living with HIV?

YES √	NO

-They are members of TWG.

1.4 **IF YES**, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	**Yes, most partners**	**Yes, but only some partners**	**No**
	√		

IF YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

	YES	NO
a. A data collection strategy	√	
IF YES, does it address:		
Routine programme monitoring	√	
Behavioural surveys	√	
HIV surveillance	√	
Evaluation/research studies	√	
b. A well-defined standardized set of indicators	√	
c. Guidelines on tools for data collection	√	

d. A strategy for assessing data quality (i.e., validity, reliability)	√	
e. Data analysis strategy	√	
f. Data dissemination and use strategy	√	

3. Is there a budget for implementation of the M&E plan?

YES √	IN PROGRESS	NO

3.1 **IF YES**, what percentage of the total HIV programme funding is budgeted for M&E activities? 10%

3.2 **IF YES**, has full funding been secured?

YES	NO √

Budgeting for M&E is done annually. There is a challenge because partners cannot commit themselves to the future yearly funding.

IF NO, briefly describe the challenges:

3.3 **IF YES**, are M&E expenditures being monitored?

YES √	NO

4. Are M&E priorities determined through a national M&E system assessment?

YES √	NO

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

The M&E assessment is done yearly. During the reporting period, this was done prior to the new KNASP (III) and M&E Framework. The Global Fund M&E system strengthening tool was used. Also, adhoc M&E system strengthening assessments were carried out during the period for example strategic review of the previous M&E framework.

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E unit?

YES √	IN PROGRESS	NO

IF NO, what are the main obstacles to establishing a functional M&E unit?

5.1 **IF YES**, is the national M&E Unit based

	YES	NO
In the national AIDS Commission (or equivalent)? In the National AIDS Control Council	√	
In the Ministry of Health?		
Elsewhere? [write]		

5.2 **IF YES**, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff:		
Position:	Full time/ Part time?	Since when?:
Head M&E Unit	√ Full time	2005
M&E Coordination Specialist	√ Full time	2006
Two (2) Programme Officers M&E	√ Full time	2007
Eleven (11) M&E Officers. Two(2) at headquarters and nine (9) in the regions	√ Full time	2008
Number of temporary staff:		
Position:	Full time/ Part time?	Since when?:
Nine (9) data clerks	Part time	2009

5.3 **IF YES**, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

YES √	NO

IF YES, briefly describe the data-sharing mechanisms:

There is an established data flow mechanism in place. All partners are required to submit data at agreed time-periods. Data submitted is on indicators in the national HIV and AIDS M&E framework. Submissions are done as follows

- Through the COPBAR – the grassroots/community level implementers submit to the regional levels, who in turn submit to NACC.
- The Public Sector line ministries/departments/institutions submits directly to NACC through activity reporting tool.
- The Ministry of Health collects data through its HMIS and submits relevant data to NACC.
- National Blood Transfusion Center and National Leprosy and Tuberculosis Programmes both submit directly to NACC.
- Reports received by NACC from stakeholders are reviewed and relevant data is extracted for the indicator reporting.

What are the major challenges?

- Low compliance – some partners are not keen to report on the indicators to NACC; they instead report to the donors who fund them.
- There is lack of understanding among partners on their obligation to report on indicator performance to NACC.

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	**Yes, but meets irregularly**	**Yes, meets regularly √**

The Technical Working Group meets quarterly; and additionally any other time as required.

6.1 Does it include representation from civil society?

YES √	NO

IF YES, briefly describe who the representatives from civil society are and what their role is:

These are PLHIV networks, CSOs networks and International NGOs as members of Technical Working Group (TWG), their role is to ensure that Civil Society rights are respected.

7. Is there a central national database with HIV-related data?

YES √	NO

7.1 **IF YES,** briefly describe the national database and who manages it:

This is managed by National AIDS Control Council. The database has all national indicators and it's web-based. There is data management information unit that ensures update and management of data.

7.2 **IF YES**, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all the above
   Information from community levels is disaggregated as indicated.

b. Yes, but only some of the above:

c. No, none of the above:

7.3 Is there a functional Health Information System?

	YES	NO
At national level	√	
At provincial level	√	
At district level	√	

At community level	√	

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

YES √	NO

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

0 1 2 3 4 5

Rate = 5

Provide a specific example:

The development of new KNASP III was informed by data and published reports. Baseline data for KNASP performance framework; national reports; KAIS; MOT studies all informed the development of KNASP III

What are the main challenges, if any?

None

9.2 for resource allocation?:

0 1 2 3 4 5

Rate = 4

Provide a specific example:

The KNASP III costing was based on different target populations identified through M&E data.

What are the main challenges, if any?

Data and information on MARPs is not accurate.

9.3 for programme improvement?:

0 1 2 3 4 5

Rate = 3

Provide a specific example:

All Technical Working Groups and programmes receive information on regular basis to improve the programmes.

What are the main challenges, if any?

10. Is there a plan for increasing human capacity in M&E at national, sub-national and service-delivery levels?:

a. Yes, at all levels:

Yes, at all levels:

b. Yes, but only addressing some levels:

c. No:

10.1 In the last year, was training in M&E conducted

	YES	NO
At national level?	√	
IF YES, Number trained: Above 100		
At provincial level? Sub-national level	√	

IF YES, Number trained: 500		
Civil society	√	
IF YES, Number trained: 8,000		

10.2 Were other M&E capacity-building activities conducted other than training?

YES √	NO

Capacity building included: Improvement of infrastructures; procurement and supply of computers; internet connectivity; mentoring of staff; supervision of lower staff cadres and implementers; hiring of new staff; establishment of M&E units; and exchange visits.

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate = 8

Since 2007, what have been key achievements in this area:

- Building capacity of M&E in all sectors.
- Development and harmonization of M&E tools.
- Commissioning and finalization of major surveys: KAIS, MOT.
- Development of robust M&E plan that is harmonized with KNASP III.

What are remaining challenges in this area:

Still not all partners are aligned to the national HIV/AIDS M&E.

What are the best practices in this area:

- Male medical circumcision randomized control trials 2006, provided data that guided policy development and scale-up of voluntary male medical circumcision.
- Use of information from the MOT study, KNASP II implementation review, and reports to develop KNASP III.

NCPI RESPONSES – CIVIL SOCIETY ORGANIZATIONS

CSO/UN and Bilaterals	Name/ Position	Respondents to Part B			
		B.I	B.II	B.III	B.IV
UNAIDS Kenya	Girmay Haile. Senior Institutional Development Advisor UNAIDS	√	√	√	√
KANCO – CSO network	Allan Ragi – Executive Director KANCO	√	√	√	√
KECOFATUMA	Dr. Tobias Gicahri	√	√	√	√
KIRAC	Bishop (Dr) Stephen Muketha, KIRAC	√	√	√	√
Network of African People Living with HIV and AIDS – East African Region (NAP-EAR)	Joe Muriuki	√	√		
GESTOS & KAHII UNGASS Kenya Project	Dr. Kibe	√	√		
Global Child Hope	Hassan Osman. Executive Director	√	√	√	√
Life Care and Support Centre	Matiko Chacha	√	√	√	√
NEPHAK	Rahab Mwaniki. Project Coordinator	√	√	√	√
WOFAK	Hellen Otieno	√	√	√	√
NNEPOTER	Bethwel Nyangweso	√	√	√	√
NETMAT	Francis G. Apina	√	√	√	√
Provide inter	Allan M. Koigi	√	√	√	√
KAWCO	David Nderitu	√	√	√	√
LCCASU	Matiko Chacha	√	√	√	√

LICASU	John Njuki Gachuku	√	√	√	√
WCC	Susan Muigu	√	√	√	√
NNEPOTEC	Peter Odenyo	√	√	√	√
NCC	Wilfred Mutiso	√	√	√	√
WOFAK	Dorothy Onyango	√	√	√	√
Nephak	Rahab Mwaniki	√	√	√	√
NCC	Elizerbeth W. Michire	√	√	√	√
KIRAC	Bishop Stephen Mukhetha	√	√	√	√
KIRAC	Jennifer W. Maina	√	√	√	√
KIRAC/ SUPKEM	Shaban Bakari	√	√	√	√
KIRAC	Janet Makena	√	√	√	√
AMREF	Vincent Ojiambo	√	√	√	√
ISHTAR MSM	Peter Njane	√	√	√	√
GOODWILL	Molly Akinyi	√	√	√	√
SIAYA OSIEPE GROUP	Nichanor Okumu Obango	√	√	√	√
NOSET MAISHA HOUSE	Calleb Angira	√	√	√	√
Keeping Alive Society Hope (KASH)	Velvine Jobiese	√	√	√	√
I choose life Africa	Okwaroh O. K	√	√	√	√
MCC (MYIRU H/C)	Margereter Mqaku	√	√	√	√
NCC (Mathere North H/C)	Emma W. Mwangi	√	√	√	√
GAZEK	David Kuria	√	√	√	√
AOCASP	Jodiah Mueni	√	√	√	√
BHESP	Peninah Mwangi	√	√	√	√
Council of Imama and Preachers Malindi	Abdulrahman Ahmed Badawy. Secretary.	√	√	√	√
TEENS WATCH	Cosmus W. Maina. Project co-co-ordinator	√	√	√	√
SCOPE	Mwakirilo Michael. Director	√	√	√	√

	community liason.				
Joint effort CBO	Johnson Maina. Chairman	√	√	√	√
	Dini Adnan Mudhiiru. Co-ordinator	√	√	√	√
C.I.P.K. Mombasa	Mahamud Abdullahi Mahamud. Secretary	√	√	√	√
The Omari Project	Said Islam Said. Finance controller	√	√	√	√
The Omari Project	Mohamed Shosi	√	√	√	√
Kenepote	Rose Ondengo. Chairperson	√	√	√	√
Kich AIDS Out Of Kenya	Anisa Kombo. Member	√	√	√	√
Nation Media Group LTD(AKDH)	Daniel Munyao	√	√	√	√
SIYU DEUT	Athman A. Kiteri. Secretary	√	√	√	√
Pwani CCS	Lilian Odhiambo. Member	√	√	√	√
Kenya Girl Guides association.	Rosaline W. Muteru. Admin. Secretary/ accounts clerk	√	√	√	√
Sauti Ya Wanawake Lamu	Raya Famau Ahmed. Secretary/ board of directors	√	√	√	√
WOFAK	Florence Kadzo Eric. Social worker	√	√	√	√
L.V.C.T. Liverpool V.C.T. Cardy Treatment	Anne Njagi. Site incharge	√	√	√	√
ICRH-K	Godfrey Mwayuki. Project officer	√	√	√	√
ICRH-K	Phelister Wamboi. Zone leader	√	√	√	√
ICRH-K	Josphine Okumu. Zone leader	√	√	√	√
Assalam Muslim Women Foum (AMWOF)	Amina Ali Mohammed. Regional co-coordinator	√	√	√	√
MYWO Kwale	Riziki M. Alfami. Project	√	√	√	√
Alpha II Coast Mariakani Office	Zuhura Mzee. OVC- Project co-ordinator.	√	√	√	√
Reachout Center	Saida Hussew. VCT	√	√	√	√

Trust	Counsellor Reachout Center Trust.				
MEWA	Madina Sheikh. Heartboard member.	√	√	√	√
St. Luke's Support Group Kaloleni	Kasena Changawa. Member	√	√	√	√
Reach out center trust	Masudi Omar.Programs officer	√	√	√	√
Reach out center trust	Twalib Breik. Beneficiary of reach out center trust	√	√	√	√
International center for reproductive health	Sewe Malamba. Project officer.	√	√	√	√
HUSIKOLA Pwani Coast	Millicent Opar. Program officer.	√	√	√	√
NEPHAK	Irene K. Mukiira. Program officer.	√	√	√	√
Dzimanyrire Network Kwale	Mutangiki Munyasya. CPerson Dzimanyrire	√	√	√	√
L.C.C./MEWA	Cllr Hussein Abdalla Taib. Cllr Lamu governor MEWA and board.	√	√	√	√
LEA Mwana C. Center	Dzombo Christopher. Director	√	√	√	√
AMSEA-Kenya Msa Branch	Simon Kiarie. Secretary	√	√	√	√
Hope worldwide Kenya	Faith Waikiyu Kamau. SNR program co-ordinator	√	√	√	√
Kenya AIDS NGO'S Consortium (KANCO)	Patrick Mwai. Regional Officer	√	√	√	√
Kenya Red Cross Society	Mize Moh'd. HBC Focal person	√	√	√	√
Constituency AIDS Control Committee	Mwa Chuo Ali Teuzi. Co-ordinator.	√	√	√	√
C.I.P.K.	Fatuma Hussein Ramadhan. Member	√	√	√	√

VOI Youth Forum	Omar Ahmed. Project manager/ CEO.	√	√	√	√
DSW Coast	George Ouma. Field officer	√	√	√	√
Solwond	Glady's Kanja. PEER Educator.	√	√	√	√
MEDA	Anisa Menza. Field officer	√	√	√	√
Crisis center (triple c)	Rose Ochien'g. program co-ordinator.	√	√	√	√
House of courage initiative.	Omar Ahmed. Chairperson.	√	√	√	√
Helpage Kenya	Erastus Maina, HIV Coordinator	✓	✓	✓	✓

I. HUMAN RIGHTS

1.0 Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

YES	NO
√	

1.1 **IF YES,** specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision:

- HIV is specifically mentioned in the HIV and AIDS Prevention and Control Act 2006 Chapter 8: Discrimination and Policies, part III(b)
- The Act has a general non-discrimination provision and not specific to HIV and AIDS.
- Additionally, the Act has several gaps in its address of HIV and AIDS issues which require review. These include gaps in implementation, for example the HIV and AIDS tribunal needs to be operationized and funding allocated.

2.0 Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

YES	NO
√	√

Approximately, 75% of the respondents indicated “yes” and 25% “no”: Responses were “no” for MARPs and “yes” for some of other vulnerable sub-populations. The question will need to be reframed in future; respondents had difficulties giving a response because of its broadness.

2.1 IF YES, for which populations?

(Tick if yes or no)

	YES	NO
a. Women	√	
b. Young people	√	
c. Injecting drug users		√
d. Men who have sex with men		√
e. Sex workers		√
f. Prison inmates		√
g. Migrants/mobile populations		√
h. Other: IDPs, Schools, general population, older persons and people with disabilities,		√
Fishing Communities		√
Truck drivers, matatu drivers and touts		√
People living with disabilities		√
Married couples, Armed forces	√	

If yes, briefly explain what mechanisms are in place to ensure these laws are implemented:

- Both the MOH and NACC are the entities with key responsibility for implementation of these regulations and laws. While the PLHIV networks and CSOs operate as watchdogs.
- The KNASP II and KNASP III have actions incorporated as part of response implementation.

- The Sexual Offences Act has a section on issues of Gender Based Violence (GBV) and GBV guidelines have been developed, they are both guiding implementation; Gender desks have been established in some police stations to deal with GBV. And Special Courts have been established to deal with offences related to the laws. In addition, guidelines on GBV are guide implementation.
- The Children's Department and Children's Courts are dealing with issues and offences related to children.
- Two ministries have been established by the government: i) Ministry of Gender, ii) Ministry of Youth Affairs.

Briefly describe the content of these laws:

The content includes the following:

- HIV/AIDS Prevention and Control ACT 2006 Part 6 deals with "Transmission of HIV" – not gazetted.
- Sexual Offences Act (2006) provides protection of women from GBV.

Briefly comment on the degree to which they are currently implemented:

- It is difficult to determine the degree; however, there is some implementation being done.
- Implementation of both the HIV and AIDS Prevention and Control Act and the Sexual Offences Act is still a challenge. The Act is under review and some emerging dynamics are at play.
- There are policy guidelines and strategies for implementation of gender, youth, people with disabilities and PLHIV; including the GIPA guidelines.
- To some extent there has been an attempt to implement the Act by having Gender Violence desks at most police stations in Kenya.
- These two Acts have not been widely disseminated and therefore their implementation has been minimal.
- CSOs are advocating for implementation of the Children's Act and Sexual Offences Act.
- There is no visible effort for implementation of HIV and AIDS Prevention and Control Act.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

YES	NO
√	

3.1 **IF YES,** for which subpopulations?

	YES	NO
a. women	√	
b. Young people	√	
c. Injecting drug users	√	
d. Men who have sex with men	√	
e. Sex workers	√	
f. Prison inmates	√	
g. Migrant/mobile populations		√
h. Other: IDPs, Older Persons, people with disabilities		√
Truck drivers and touts		√

IF YES, briefly describe the content of these laws, regulations or policies:

- Most at risk populations are still considered to be in conflict with law, while other groups like IDPs and mobile populations lack supportive policies.
- There is an attempt to criminalize MSMs, IDUs and also generally the HIV infection.
- Sex work is illegal. The law criminalizes IDUs, sex workers, and prison inmates.
- Health insurance coverage for vulnerable populations is not explicit in the HIV and AIDS Prevention and Control Act.
- Sex workers are prosecuted for "Loitering with intent" which is criminal by law.
- There is a policy for implementation of substitution therapy for drugs users.
- The laws and policies are silent on accessibility of accurate HIV information and services to older persons and persons with disabilities.

Briefly comment on how they pose barriers:

- Affects access to prevention and promotive health care and support services provision; protection of human rights; resource allocation; and programme planning to vulnerable groups, and MARPs.
- It is not allowed to distribute condoms to women, youth and prison inmates.
- Cultural and religious values affect services provision to IDUs, MSMs, prisoners.
- Women are highly affected by cultural, social and economic placement; denying them equal access to services compared to men (.Older carers who are mainly women lack adequate home based care and social protection services. (It is estimated that 40% of the 1.2 million children orphaned by AIDS in Kenya are cared by older carers, mainly older women).
- The customary laws are contradicting the Act on inheritance (women and children). Additionally, the Act does not have a provision on property ownership by young people, OVCs, and mentally challenged.
- The confidentiality and disclosure sections of the HIV and AIDS Prevention and Control Act is hindering prevention interventions, spouses are not disclosing their status.

- Police harassment of sex workers and IDUs

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

YES	NO
√	

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

- The new KNASP III is based on evidence that has highlighted the human rights aspects of MARPs, vulnerable populations and populations of humanitarian concern.
- The KNASP III clearly identifies rights-based approach for implementation of the plan.
- There is an emphasis for building capacity of the relevant CSOs and communities living with HIV in advocacy for their rights and relevant training documents are available for use.
- HIV/AIDS prevention and control Act chapter 1 part 3b states: Extend to every person suspected or known to be infected with HIV & AIDS full protection of his/her human rights & civil liberties.
- The Act further states that no person shall be denied access to any employment or have his/her employment terminated on the ground of only his/her actual, perceived or suspected HIV status.
- GIPA principle and Gender Mainstreaming are in all KNASP III pillars.
- Additionally, the HIV and AIDS Prevention and Control Act provides provision for: i) Rights to access information and services; ii) confidentiality under the Client Charter; and rights to a) manage family/child; b) be employed without prior testing; c) non-discrimination; and d) medical care/education.

NB: medical testing including HIV testing is still being practiced by some employers.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

YES	NO
	√

IF YES, briefly describe this mechanism:

- In general terms, to some extent but not in an organized manner.
- Reporting at CACC level captures this information; however, communities do not always keep a record of such abuses.
- Mechanisms are available but are minimal and only for some groups such as MSMs. MARPs access legal services from Kituo Cha Sheria
- A mechanism is being discussed for implementation under KNASP III.

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

YES	NO
√	

IF YES, describe some examples:

- Involvement in NACC's planning and review processes.
- PLHIV and MARPs participate in ICCs and MCGs (monitoring coordination groups); and are involved in NACC council meetings.
- Through TOWA financial support the MARPs and other vulnerable populations have been involved in: i) GIPA principle, ii) Affirmative Action, and also through ACUs in line ministries/departments/institutions (external HIV and AIDS mainstreaming).
- These groups of sub-populations have been involved in the development of KNASP III; and in UNGASS country reporting and JAPR.

NB: However, there is a gap in representation of MARPs at community levels.

7. Does the country have a policy of free services for the following:

	YES	NO
a. HIV prevention services	√	
b. Antiretroviral treatment	√	
c. HIV-related care and support interventions	√	

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

- Policy on Opportunistic Infections is not being followed.

- It is difficult to separate HIV prevention services from other health related services at health facilities level. Therefore PLHIV have to pay the mandatory cost-sharing fee at the government health facilities.
- ARVs are being distributed for free but not reaching 100% coverage.
- PLHIV pay for nutrition support and other opportunistic infections (treatment).
- The government and CSOs have established partnerships that have beefed up funding for HIV and AIDS services.
- Bureaucracy is reducing accessibility to financial resources by CSOs.
- Health facilities are inaccessible and health personnel are few causing congestion at health facilities. Additionally, there are inadequate medical personnel with skills of attending to special needs of older persons and people with disabilities.
- Mechanisms have been established to ensure efficiency in the management of scarce financial resources.
- The Public Procurement and Disposal Act of 2005 – has provisions for ensuring efficient management of resources.

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

YES	NO
√*	

*However, there is scarcity of the female condoms.

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

YES	NO
√	

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, care and support?

YES	NO
	√

- Only a strategy is available, there is no policy yet.
- There is neither special recognition/treatment facility for MARPs or facilitation of the same.

- The level of stigma is high and also health workers are ill-prepared to take care for special groups such as MARPs, older persons and people with disabilities.
- The costed KNASP III has incorporated access to prevention services for MARPs; however, there are still gaps.

IF YES, briefly describe the content of this policy:

- The cash transfer policy for OVCs, caters for their schooling, food/nutrition, shelter and clothing.

9.1 **IF YES**, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

YES	NO
	√

There is a mismatch between strategy and policies in the penal code. This depends on where one is working and hence poses a risk to MSMs.

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

- Free VCT with mobile and moonlight HCT.
- PMTCT and ARVs services are in all public health facilities.
- There is door to door counseling and testing.
- Peer education is being used for preventive and promotive interventions.
- There is well established home and community based care (HCBC)
- Voluntary medical male circumcision has been rolled-out.

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

YES	NO
√	

The following are in existence:

- Public Sector HIV and AIDS policy.
- Employment Act of 2007 has a section on it.
- HIV and AIDS prevention and control Act

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

YES	NO
√	

- But it is never followed due to differentiation in the same policy
- HIV and AIDS Prevention and Control Act has a section on it.
- Country Advisory Board (CAB) has representation from KEMRI, CDC, KAVI

11.1 **IF YES**, does the ethical review committee include representatives of civil society including people living with HIV?

YES	NO
√	

However, does not always apply:

- CSO and PLHIV are part of the ethical committees – KAVI, KEMRI; and National Research Ethics Committee.
- PLHIV are only involved in clinical trials, however, the selection of those involved is not clear.
- The roles and responsibilities of the Country Advisory Board should be known to the wider society.

IF YES, describe the approach and effectiveness of this review committee:

It is effective but CSOs and PLHIV representation is questionable.

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

YES	NO
√	

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment.

YES	NO

√*	

*But more needs to be done.

- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts.

YES	NO
	√

IF YES on any of the above questions, describe some examples:

- ACUs are the government focal points in both internal and external HIV and AIDS mainstreaming.
- Kenya National Human Rights Commission (KNHCR) has the mandate for ensuring there is compliance.
- COPBAR captures information for reporting on human rights.
- Human rights NGOs are advocating and ensuring adherence.
- HENNET is carrying out capacity building for CSOs but its country coverage not known
- There is the Human Rights Committee in NACC
- FIDA assists women who have undergone GBV

13. In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

YES	NO√

- East African Regional meetings have been carrying out sensitization; however, this has been on Post Election Violence.

14. Are the following legal support services available in the country?

- Legal aid systems for HIV casework

YES	NO
	√

- There is some training but no legal aid

- A few CSOs are offering legal support services; however, the government is not.
- There is no representation in court.

- Private sector law firms or university-based centers to provide free or reduced-cost legal services to people living with HIV

YES	NO
√	

There are isolated cases, this needs to be scaled up.

- Programmes to educate, raise awareness among people living with HIV concerning their rights

YES	NO
√	

- CSOs have done a lot of work in this area unlike the government.

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

YES	NO
√	

However, they are not adequate.

IF YES, what types of programmes?

	YES	NO
Media	√	
School education	√	
Personalities regularly speaking out	√	
Other: CSOs, Ambassadors of Hope Outreach Forums Peer educators Barazas	√	

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

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

Rate – 4*

There is limited focus on Most at Risk Populations and yet they are the drivers of the epidemic in Kenya.

Since 2007, what have been key achievements in this area:

- Review of the HIV and AIDS Prevention and Control Act.
- Development of new HIV and AIDS policies.
- HIV and AIDS Prevention and Control Act became operationalized.
- Integration of human rights in HIV and AIDS programs
- There is increased government involvement and support for HIV and AIDS strategies.
- Commencement of implementation of part of the HIV and AIDS Prevention and Control Act.
- Engagement of CSOs in the dissemination of policies.

What are remaining challenges in this area:

- There has been no protection of MARPs.
- The Equity Tribunal has not been funded and hence the tribunal has not held a single meeting.
- The existing need for an improved version of HIV and AIDS Prevention and Control Act; in its current state it has gaps and related emerging issues have developed.
- Increasing numbers of sex workers, MSMs, and IDUs.
- Lack of awareness on existing laws.
- Lack of harmonization of existing laws with KNASP.
- Lack of operationization of important sections of the HIV and AIDS Prevention and Control Act.
- Documenting data and information on human rights needs of MARPs and vulnerable populations
- Confusion created by the two ministries of health affecting implementation.
- Lack of ministerial ownership of HIV. There are three ministries involved: MoPHS; MoMS; and MoSP)
- Limited funds for human rights intervention activities.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?

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

Rate – 2*

*There has been no allocation of resources for implementation of these laws and policies. Therefore, until there is funding and mechanisms in place for implementing laws and policies the efforts will not be recorgnized.

Since 2007, what have been key achievements in this area:

- Strategic review of the NSP (KNASP II) and policy influence as a result of MOT study and KAIS results.
- Mobilization of HIV and AIDS financial resources has been great.
- Development of the costed KNASP III
- Development of Code of conduct for Civil Society Organizations.
- Success of PMTCT: There is increased HIV negative babies who have been born to HIV positive mothers.
- Stigmatization has gone down.
- Partial commencement of implementation of HIV and AIDS Prevention and Control Act.
- M&E systems have been improved.

What are remaining challenges in this area:

- There is still an existing need for continued influence for policy and drive to achieve Universal Access to all.
- There is still existing need for intensified counseling and testing.
- There is poor enforcement of the policies due to lack of awareness
- Formulation of policies has applied up-bottom approach.
- Governance issues – Global Fund and implementation of programmes.
- No budget set aside for implementation of laws and regulations.
- Dissemination of laws, policies not adequately done.
- Emerging trends of high prevalence among an unusual sub-groups i.e. married couples and adults +50 years (KAIS 2007).
- GIPA guidelines in NACC structures not adequate.
- There is inadequate political will.

What are the best practices

- The Prevention Summit held annually.
- JAPR partnership.
- Development of Health Sector and community-based response
- Mainstreaming of the pillars in the public sectors, private sector and CSOs.
- Rights based programming has been adopted.
- Strategic direction on human rights provided by NACC
- Empowerment of communities on human rights.

What is the way forward?

- Development of Health Sector and community-based response.
- Mainstreaming of the pillars in the public sectors, private sector and CSOs.
- Resource mobilization for KNASP III

- Harmonization of policies.
- Creation of a databank for human rights as part of monitoring system.
- GIPA implementation.

II. CIVIL SOCIETY INVOLVEMENT

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

0 1 2 3 4 5

Rate - 4

Comments and examples:

- CSOs in Kenya are one of the most engaged and vocal forces in the continent, and are usually participatory in keeping pressure on the political will – **60%**
- Enactment of the HIV and AIDS Prevention and Control Bill **– 70%**.
- Development of KNASP III – **58%**
- Through advocacy and lobbying CSOs have managed to contribute towards i) availability of free drugs, ii) sexual offence Act, iii) HIV/AIDS prevention and Control Act **– 70%**.
- FBOs have been disseminating and advocating in Mosques, Churches and Public Barazas by sensitizing political leadership to support effective policy formulations.
- CSOs' contribution to development of KNASP III was 58%
- Dissemination of policies to the communities **– 50%**.
- CSOs engaged in forums with political leaders **– 50%.**
- Private sector actively engaged in the development of work place policy and National Code of Conduct.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

0 1 2 3 4 5

Rate – 3*

*There is an issue with the development of AOP; it was done at a higher level with minimal CS representation. Secondly, CSOs are not adequately engaged in planning

and budgeting because their capacity has not built in this area. Thirdly, CSO's suggestions were not captured during the costing.

Comments and examples:

- 58% of total participation in KNASP II was from CSOs.
- CSOs have been participating in budgeting processes.
- There is need for a two-way feedback mechanism to be established between implementers and NACC.
- Have been fully involved in planning and budgeting.
- Participation of CSOs in the development of National Plan of Operation (NPO) was 68%.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. the national AIDS strategy?

0 1 2 3 4 5

Rate – 4

b. the national AIDS budget?

0 1 2 3 4 5

Rate - 3

c. national AIDS reports?

0 1 2 3 4 5

Rate – 2*

*The COPBAR reporting is not widely known; secondly, COPBAR is not accessible.

The high reporting is by PEPFAR who finances close to 90% of CSOs.

Comments and examples:

- Most of the activities are donor driven.
- There is COPBAR reporting but not by all CSOs.
- There is quarterly community programme activity reporting
- There is no harmonized reporting by CSOs
- COPBAR does not capture data on MARPs

- COPBAR and existing VCT protocols do not disaggregate data for 50+ age cohorts (a short fall from KAIS).

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?

0 1 2 3 4 5

Rate – 3

b. participating in the national M&E committee/ working group responsible for coordination of M&E activities?

0 1 2 3 4 5

Rate – 3

There is minimal participation in MCGs.

c. M&E efforts at local level?

0 1 2 3 4 5

Rate – 2*

There is no capacity to document M&E

M&E is not known at community levels.

Comments and examples:

- The national M&E system is challenged by partners who control big resources and monitoring is not done at a uniform level and standard.
- HMIS for Aga Khan Foundation and APHIA II was developed with participation of CSOs.
- CSOs are represented in all M&E committees
- Uptake of the COPBAR reporting is good.
- Involvement of CSOs in M&E has been minimal.
- Involvement in the JAPR that reviews progress is good.
- There is lack of information on M&E
- There is need to strengthen the JAPR at district/community levels.
-
- Lack of coordination of reporting and duplication of services.
- Inadequate capacity in M&E among MARPs.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

0 1 2 3 4 5

Rate – 4

Comments and examples:

- FBOs are still reluctant to work with sex workers and MSMs.
- CSOs are collaborating with different stakeholders and reaching the grassroots.
- All CSOs are involved except the people living with disabilities.
- Very few CSOs addressing issues of HIV and vulnerable populations

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

0 1 2 3 4 5

Rate – 2*

*A lot of conditions are attached to CSOs' funding systems. Financial Management Agency (FMA)'s systems are poor.

NB: Government budget allocation for HIV and AIDS is still very low. While the donor funding is very good.

b. adequate technical support to implement its HIV activities?

0 1 2 3 4 5

Rate – 2.5

Comments and examples:

- APHIA II provides Technical Support to CSOs.
- Capacity building has been inadequate.
- TOWA has improved availability of financial resources.
- There is no technical support at CACC level

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

	<25%	25-50%	51-75%	>75%
Prevention for youth			√	
Prevention for most-at-risk-populations -Injecting drug users -Men who have sex with men -Sex workers			 √	 √ √
Testing and counselling		√		
Reduction of stigma and Discrimination				√
Clinical services (ART/OI)		√		
Home-based care				√
Programmes for OVC			√	

Overall, how would you rate the efforts to increase civil society participation in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate – 7

Since 2007, what have been key achievements in this area:

- Increased participation in the development of KNASP III
- Increased involvement for MARPs
- Participation in JAPRs
- Representation in CCM
- CSO's Code of Conduct
- Work Place Policy.

What are remaining challenges in this area:

- Sustainability of civil society participation.
- Representation of CSOs not good enough.
- Two-way feedback to the grassroots level
- Meaningful engagement of CSOs in planning and budgeting.
- Unpredictable funding for CSO's activities in HIV prevention

What are the best practices

- MARPs involvement and outreach events.
- M&E integrated plan with many players on board.
- Integrated planning; research agenda; programme monitoring

- CSOs involvement in the development of the costed NOP.
- National technical support planning

What is the way forward?

- Integrated planning; research agenda; programme monitoring; and budgeting.

- Investment in School Health Education in response to HIV prevention needs in Behaviour Formation to achieve HIV free generation.

III. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

YES	NO
√	

IF YES, how were these specific needs determined?

- Through emerging evidence
- Through research and programme reviews.
- Through baseline surveys
- Through JAPRs
- KAIS report
- Through meetings at CACC level
- Evaluation research
- Consultation meetings
- MOT study
- Sentinel Surveillance

IF NO, how are HIV prevention programmes being scaled-up?

For the needs that have not been determined, universal targets are set at 80% or more for various prevention interventions such as VMMC, HTC, PMTCT, BCC.

1.1 To what extent has HIV prevention been implemented?

HIV Prevention Component	**The majority of people in need have access**		
	Agree	**Don't Agree**	**N/A**
Blood safety	√		
Universal precautions in health care settings	√		
Prevention of mother-to-child transmission of HIV	√		
IEC on risk reduction	√		
IEC on stigma and discrimination reduction		√	
Condom promotion	√		
HIV testing and counselling	√		
Harm reduction for injecting drug users		√	
Risk reduction for men who have sex with men		√	
Risk reduction for sex workers		√	
Reproductive health services including sexually transmitted infections prevention and treatment	√		
School-based HIV education for young people	√		
HIV Prevention for out-of-school young people	√		
HIV prevention in the workplace	√		
Condom access for all		√	
Other: access of prevention and promotive services to People living with disabilities, older persons, fisherfolk, and OVCs, prisoners		√	
Prevention and promotion services to truck drivers and touts	√		
Male circumcision	√		

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate – 6.5

Since 2007, what have been key achievements in this area:

- Increased awareness on HIV and AIDS prevention.
- The advocacy and support for prevention programmes have been very good.
- CSOs have started working with MARPs.
- Development of prevention strategy and moonlight VCT.
- Introduction of VMMC.
- Availability of HIV prevalence data for older persons

What are remaining challenges in this area:

- Education level (literacy level).
- Cultural barriers.
- Ignorance and self-stigma.
- Stigma reduction.
- Access to accurate HIV information/messages that are sensitive to prevention needs of older persons and people with disabilities.
- Couples uptake of HIV and AIDS services.
- Sex workers uptake of HIV and AIDS services.
- Prohibitive laws for IDUs and MSMs make prevention efforts impossible.

What are the best practices

- Integration of prevention with treatment for example: i)Prevention with positives; ii) Voluntary medical male circumcision (VMMC).
- Scaling up of community based prevention
- Targeted prevention – for example the “Prevention with Positives”

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

YES	NO
√	

IF YES, how were these specific needs determined?

- Through baseline surveys.
- KAIS 2007.
- Research.
- JAPR.
- HIV and AIDS socio-economic impact studies.
- M&E.
- Consultations.

IF NO, how are HIV treatment, care and support services being scaled-up?

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	**The majority of people in need have access**		
	Agree	**Don't Agree**	**N/A**
Antiretroviral therapy		√	
Nutritional care		√	
Paediatric AIDS treatment		√	
Sexually transmitted infection management	√		
Psychosocial support for people living with HIV and their families	√		
Home-based care	√		
Palliative care and treatment of common HIV-related infections		√	
HIV testing and counseling for TB patients	√		
TB screening for HIV-infected people		√	
TB preventive therapy for HIV-infected people		√	
TB infection control in HIV treatment and care facilities.		√	
Cotrimoxazole prophylaxis in HIV-infected people	√		
Post-exposure prophylaxis (e.g. occupational exposure to HIV, rape)	√		
HIV treatment services in the workplace or	√		

treatment referral systems through the workplace			
HIV care and support in the workplace (including alternative working programmes)		√	
Other programmes: HIV testing and counseling for vulnerable groups, older persons and people with disabilities prisons Drugs adherence and compliance		√	

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate - 8

Since 2007, what have been key achievements in this area:

- There are more people on ARVs (scaling-up)
- TB screening has been scaled up
- There is improved uptake of counselling and testing
- Partnership of government with FBOs.
- There is availability of PEP

What are remaining challenges in this area:

- Poor infrastructure
- MDR-TB on the increase.
- Genital Herpes on the increase
- Food and Nutrition insecurity
- Sustainability of funding
- Integration of TB/HIV collaborative services.
- Expensive drugs to treat OIs
- Diagnosis of TB in PLHIV
- Stigma and discrimination.
- Non disclosure and the related treatment defaulting.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

YES	NO	N/A

√		

2.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country?

YES	NO
√	

2.2 **IF YES,** does the country have a national action plan specifically for orphans and vulnerable children?

YES	NO
√	

2.3 **IF YES**, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

YES	NO
√	

IF YES, what percentage of orphans and vulnerable children is being reached? 25%; (*write in)*

Documentation and sharing of information on OVCs intervention coverage is poor.

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

0 1 2 3 4 5 6 7 8 9 10

Rate – 3

Since 2007, what have been key achievements in this area:

- Cash transfer programme.

- Improved coordination between government and CSOs
- Increased support for OVCs
- Development of Children's Policy
- Development of OVC Policy
- Bursary scheme
- Costed KNASP III with an NPO addressing to needs of elderly and child headed households

What are remaining challenges in this area:

- Corruption
- Duplication of resources
- Lack of data
- Inadequate coverage of the programme
- Inadequate funding.
- Accessibility of bursary scheme is a challenge because of corruption.
- Data collection and reporting tools not harmonized.
- No coordination of funding and implementation mechanisms; and also duplication of data.
- Policy interpretation issues for example are street children under OVCs.

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