

KENYA FINAL REPORT

September 1999–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



USAID
FROM THE AMERICAN PEOPLE





Family Health International
2101 Wilson Blvd.
Suite 700
Arlington, VA 22201 USA
Tel: 703.516.9779
Fax: 703.516.9781
www.fhi.org

This publication was funded by USAID's Implementing AIDS Prevention and Care (IMPACT) Project, which is managed by FHI under Cooperative Agreement HRN-A-00-97-00017-00.

Produced October 2007

**Kenya Final Report
September 1999–September 2007**

for

**USAID’s Implementing AIDS Prevention
and Care (IMPACT) Project**





Kenya Final Report

*Submitted to USAID
By Family Health International*

October 2007

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington, VA 22201
TEL 703-516-9779
FAX 703-516-9781

In partnership with

**Institute for Tropical Medicine
Management Sciences for Health
Population Services International
Program for Appropriate Technology in Health
University of North Carolina at Chapel Hill**



Copyright 2007 Family Health International

All rights reserved. This book may be freely quoted, reproduced or translated, in full or in part, provided the source is acknowledged. This publication was funded by USAID's Implementing AIDS Prevention and Care (IMPACT) Project, which is managed by FHI under Cooperative Agreement HRN-A-00-97-00017-00.

ACKNOWLEDGMENTS

This report on achievements of USAID's IMPACT Project in Kenya was written by Deryck Omuondo, with help from colleagues at Family Health International (FHI) in Kenya. John McWilliam, senior director, and Peter Mwarogo, country director, offered insights on overall content. Other contributors included Stefania Slabyj, consultant, FHI-Arlington; Charity Muturi, senior program officer, FHI-Kenya; Sam Wambugu, monitoring and evaluation specialist, FHI-Kenya; and technical and program staff at FHI-Kenya.

We would also like to thank the following partners for contributing to the project's success: Institute for Tropical Medicine, Management Sciences for Health, Population Services International, Program for Appropriate Technology in Health, and the University of North Carolina at Chapel Hill.

Deepest gratitude to all implementing partners who executed interventions outlined here. Their hard work ensured that IMPACT achieved results.

Finally, special gratitude to the Kenyan Ministry of Health for delivering most of the clinical-based services supported under IMPACT.

We are pleased to present highlights of all IMPACT achieved in eight years.

GLOSSARY OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
AMKENI	Reproductive health project of USAID
ANECCA	African Network for the Care of Children Affected by AIDS
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behavior change communication
BSS	Behavioral surveillance survey
CA	Cooperating agency
CACC	Constituency AIDS Coordinating Committee
CCC	Comprehensive Care Center
CME	Continuing Medical Education
CDC	U.S. Centers for Disease Control and Prevention
CHW	Community health worker
COPHIA	Community-Based HIV/AIDS Prevention, Care, and Support Project (Pathfinder)
CSW	Commercial sex worker
DACC	District AIDS Coordinating Committee
DFID	Department for International Development (United Kingdom)
DHMT	District Health Management Team
DMOH	District Medical Officer, Health
DRH	Department of Reproductive Health
ECR	Expanded and Comprehensive Response
FAHIDA	Finance and Health Integration Development Assistance
FBO	Faith-based organization
FHI	Family Health International
FHOK	Family Health Options, Kenya
FSW	Female sex worker
GGCH	Gertrude's Garden Children's Hospital
GOK	Government of Kenya
HAART	Highly active antiretroviral therapy
HAPAC	HIV/AIDS Prevention and Care Project
HBC	Home-based care
HIV	Human immunodeficiency virus
HMIS	Health Management Information Systems
HPP	Health Professionals Program
ICRH	International Centre for Reproductive Health (University of Ghent)
ICROSS	International Community for Relief of Starvation and Suffering
IDU	Injection drug user
IGA	Income-generating activities
IMPACT	Implementing AIDS Prevention and Care
IP	Implementing partner
IPD	In-patient department
IRAC	Inter-Religious AIDS Consortium
IT	Information technology
JAPR	Joint AIDS Program Review
JICA	Japan International Cooperation Agency
JKUAT	Jomo Kenyatta University for Agriculture and Technology
KANCO	Kenya AIDS NGO Consortium
KAPC	Kenya Association of Professional Counselors
KEMRI	Kenya Medical Research Institute
KEPI	Kenya Expanded Programme on Immunization
KGGA	Kenya Girl Guides Association

KNH	Kenyatta National Hospital
K-REP	Kenya Rural Enterprise Program
LSTM	Liverpool School of Tropical Medicine
MAP	Medical Assistance Program
M&E	Monitoring and evaluation
MIS	Management information systems
MOE	Ministry of Education
MOH	Ministry of Health
MOST	Micronutrient Operational Strategies and Technologies
MOU	Memorandum of understanding
MSC	Mumias Sugar Company
MSH	Management Sciences for Health
MSF	Médecins Sans Frontières
MTCT	Mother-to-child transmission
MTE	Mid-term evaluation
NACC	National AIDS Control Council
NARESA	Network of AIDS Researchers of Eastern and Southern Africa
NASCOP	National AIDS and STD Control Program
NYU	New York University
NGO	Nongovernmental organization
NLTP	National Leprosy and TB Program
OI	Opportunistic infection
OPD	Out-patient department
OPH	Office of Population and Health (USAID)
OVC	Orphans and vulnerable children
PACC	Provincial AIDS Coordinating Committee
PATH	Program for Appropriate Technology in Health
PCSWC	Pumwani Commercial Sex Workers Cohort
PI	Pathfinder International
PE	Peer education
PEP	Post Exposure Prophylaxis
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PLHA	People living with HIV/AIDS
PMCT	Prevention of mother-to-child transmission
PMO	Provincial medical officer
PSI	Population Services International
QA	Quality assurance
RRF	Rapid Response Funds
SBC	Strategic behavioral communication
SO	Strategic objective
STD/I	Sexually transmitted disease/infection
SWAK	Society for Women and AIDS in Kenya
TA	Technical assistance
TB	Tuberculosis
TWG	Technical working group
UNAIDS	Joint United Nations Program on HIV/AIDS
UoN	University of Nairobi
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	Voluntary counseling and testing
WFP	World Food Program
WHO	World Health Organization

TABLE OF CONTENTS

ACKNOWLEDGMENTS	I
GLOSSARY OF ACRONYMS	II
EXECUTIVE SUMMARY.....	1
PROGRAM STRATEGIES, OBJECTIVES, IMPLEMENTATION, AND RESULTS	2
Introduction.....	2
Country Context.....	2
Program Strategies and Activities.....	4
Strategic Information	4
Health Management Information Systems (HMIS).....	5
Improving Knowledge and Practice of Preventive Behaviors	6
Behavior Change Communication.....	6
Condom Promotion and Distribution.....	11
Community Capacity Building	12
Counseling and Testing.....	12
Service Provision	12
Quality Assurance of HIV VCT	13
Post-test Clubs	13
Diagnostic Testing and Counseling	14
Kenyatta National Hospital Centre of Excellence	16
VCT and Family Planning Integration.....	16
Prevention of Mother-to-Child Transmission.....	16
Blood Safety.....	18
Treatment, Care, and Support.....	19
Prevention and Clinical Management of Opportunistic Infections (OIs).....	19
Treatment and Control of STIs	20
TB and HIV Coinfection.....	20
Home and Community Support	20
Orphans and Vulnerable Children	21
Psychosocial Support.....	21
Antiretroviral Treatment	22
Reinforcing Human Resources	23
Using Rapid Start-up Teams to Establish New Sites.....	23
Strengthening Existing Infrastructure.....	23
Supporting the Role of Government.....	23
Developing National Guidelines and Tools.....	24
Outcomes	24
Comprehensive Care and ART Services.....	25
Provider Network Support in the Private Sector and Workplace	29
Pediatric HIV Treatment, Care, and Support.....	30
Support for a National and District Level Response	30
Expanded Comprehensive Response (ECR) to the HIV/AIDS Epidemic.....	30
The Health Professionals Program.....	31
Kenya Medical Training College.....	32
Faith-based Organizations	32
National Organization of Peer Educators	33

Rapid Response Funding to Local Organizations.....	33
IMPLEMENTATION AND MANAGEMENT	35
Implementation	35
Management.....	35
IMPACT PROJECT TIMELINE	37
PROGRAM RESULTS.....	40
Outputs per PEPFAR and Non-PEPFAR Indicators	40
Indicative Behavior Change Results.....	43
Program Outcomes and Impact.....	44
Peer Education	44
Counseling and Testing.....	44
Prevention of Mother-to-Child Transmission.....	44
Orphans and Other Vulnerable Children	44
Treatment and ART Management Information Systems	45
Blood Safety.....	45
Capacity Development.....	45
LESSONS LEARNED AND RECOMMENDATIONS.....	46
Lessons Learned: Behavior Change Communication.....	46
Lessons Learned: Antiretroviral Treatment.....	46
Lessons Learned: Comprehensive Care.....	46
Lessons Learned: Expanded Comprehensive Response.....	47
Lessons Learned: Orphans and Vulnerable Children	47
HIGHLIGHTS OF IMPLEMENTING PARTNER ACTIVITIES.....	48
PUBLICATIONS PRODUCED	55

EXECUTIVE SUMMARY

Throughout an eight-year period, the Implementing AIDS Prevention and Care (IMPACT) Project in Kenya evolved to address the changing face of the epidemic. It first set out to prevent HIV, but later began providing care and treatment to patients.

USAID provided US\$52,741,000 to enable IMPACT/Kenya to do this work. More than 100 partner organizations, including governmental, nongovernmental, faith- and community-based organizations, joined prime implementing partner Family Health International (FHI) in these efforts.

At IMPACT's outset, USAID and FHI selected five community sites in Western, Rift Valley, and Coast provinces for prevention programming, based on HIV prevalence and intervention needs. Activities included the following:

- community outreach focusing on salaried workers, female sex workers, women, and youth
- health care sector upgrading in sexually transmitted infections (STIs), maternal health, and voluntary counseling and testing (VCT) services
- behavior change communication

The project design included activities to support the HIV/AIDS program at the national level. It involved mobilizing private and parastatal businesses to initiate HIV interventions; supporting nongovernmental organizations (NGOs) and other networks to expand coverage; improving blood safety; strengthening sero-surveillance and behavioral surveillance; and supporting prevention and care initiatives.

In 2000, with USAID's Leadership and Investing in Fighting an Epidemic (LIFE) Initiative, FHI expanded IMPACT/Kenya's geographic coverage from five to ten community sites in the three provinces and broadened its focus to include activities linking prevention, care, and psychosocial support.

In 2003, IMPACT/Kenya adapted to address priorities put forth by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). As a result, IMPACT increased its focus on care and treatment and linked it to the prevention, care, and support program. Likewise, the communication response evolved from purely a prevention program to include treatment and support messages and prevention in the care setting. Nairobi was also added as a priority region.

IMPACT/Kenya was a pioneer in HIV and AIDS programming, particularly in VCT, antiretroviral therapy (ART) and clinical treatment, behavioral surveillance (BSS), and health management information systems (HMIS).

From the beginning, IMPACT collaborated with the Kenyan government in all of its programming. It supported the development of national policies, guidelines, and tools, and was viewed as a trusted technical partner. IMPACT/Kenya was able to leverage its USAID funding to obtain support and funding from other donors and the private sector, including the Japan International Cooperation Agency (JICA) and Coca Cola. This increased the reach and activities of the IMPACT Project.

PROGRAM STRATEGIES, OBJECTIVES, IMPLEMENTATION, AND RESULTS

INTRODUCTION

USAID began supporting the IMPACT Project in Kenya in 1999. The original IMPACT/Kenya design focused on prevention of HIV and supportive care among priority communities. FHI's experience with its USAID-funded AIDS Control and Prevention (AIDSCAP) program in Kenya from 1992 to 1997 showed that targeting groups whose activities expose them to a higher risk of HIV can help slow the epidemic. Using these lessons, IMPACT/Kenya designed a targeted intervention strategy. The design combined intensive prevention and supportive care activities in selected regions with activities at the national level to help create an environment supporting sustained behavior change. To have the greatest impact on HIV with the resources available, IMPACT/Kenya originally focused on five "priority communities" in three provinces — Western, Rift Valley, and Coast—which were selected based on HIV rates and high population densities in the chosen communities.

Prevention activities included community outreach to salaried workers, female sex workers, women and youth; the upgrading of STI, maternal health, and VCT services; improvement of blood safety; strengthening of surveillance; and intensive behavior change communication. The project design focused on strengthening the capacity of the Ministry of Health, other public sector partners, and local nongovernmental organizations (NGOs).

With increased funding through USAID's LIFE Initiative, IMPACT/Kenya expanded geographic coverage from the five original priority sites to ten community sites in the three provinces and broadened its strategic focus to include activities linking prevention, care, and psychosocial support.

In 2003, IMPACT/Kenya expanded its activities in care and treatment and added Nairobi as a priority site with funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). At the national level, IMPACT was a key member of the technical committees of the National AIDS Control Council (NACC) and the National AIDS and STD Control Program (NASCOP). The project spearheaded the development of national protocols and guidelines and organized national information-sharing forums within technical areas.

COUNTRY CONTEXT

The government of Kenya's response to the HIV/AIDS epidemic has evolved since the first case of HIV/AIDS was detected in 1984. The Ministry of Health (MOH) instituted an AIDS Control Committee in 1987 when it developed the first five-year strategic plan for AIDS control. The Sessional Paper No. 4 (1997) on AIDS in Kenya marked an important change on the political front and outlined a new institutional framework. With the creation of the NACC in 1999, AIDS control units were put in place in all government ministries. That same year, the HIV/AIDS epidemic was declared a national disaster. In March 2003, President Kibaki declared war against HIV and AIDS, mandating that the NACC would coordinate and manage the implementation of a multisectoral approach to the national HIV/AIDS program, provide policy direction, and mobilize resources.

Kenya has a severe, generalized HIV epidemic, but in recent years, the country has experienced a notable decline in HIV prevalence, attributed in part to significant behavior change and increased access to clinical services. National adult HIV prevalence is estimated to have fallen from 10 percent in the late 1990s to about 6.1 percent in 2005 (UNAIDS, *Report on the Global AIDS Epidemic*, 2006; Ministry of Health, *AIDS in Kenya*, 7th edition, 2005). The Kenya Demographic and Health Survey 2003 found a prevalence rate of 9 percent in adult women and 5 percent in adult men. Kenya has been able to demonstrate a clear trend of decreasing HIV prevalence over the past several years. During the past three years, critical HIV services have been scaled up. As a result, general awareness and knowledge of HIV transmission are nearly universal. In 2006, 760,000 adult Kenyans underwent HIV testing, and 110,000 (35 percent) of those in need of treatment had access to it, including about 6,000 children. Up to 40 percent of pregnant women attending antenatal care clinics in 2004 benefited from prevention of mother-to-child transmission services. However, with 1.3 million people currently living with HIV, Kenya is still contending with a serious AIDS epidemic.

PROGRAM STRATEGIES AND ACTIVITIES

The original IMPACT/Kenya design focused on prevention of HIV among priority communities within a comprehensive framework of services and support. The first two and a half years of the project built the foundation for a comprehensive approach. This approach (referred to as an Expanded and Comprehensive Response (ECR)) was fully supported by the Government of Kenya (GOK) and USAID.

IMPACT was one of the first USAID-supported projects in Kenya to have a decentralized, district-based focus. Previously, most programs had not involved districts in planning and execution, and were mainly managed from Nairobi. IMPACT established offices in the regions and involved district stakeholders in planning and designing interventions.

FHI and USAID conducted a mid-term evaluation of IMPACT/Kenya between July 2002 and August 2002. As a result, IMPACT began conducting comprehensive program planning at the field level with the full involvement of key stakeholders.

Programmatically, IMPACT/Kenya targeted four areas:

- strategic information
- improving knowledge and practice of preventive behaviors
- treatment, care, and support
- support for a national and district response

Strategic Information

The midterm evaluation of IMPACT was carried out in 2002. The 16-member midterm evaluation team credited IMPACT with remaining on the “cutting edge” of scientific, technological, and programmatic developments in the rapidly changing field of HIV/AIDS. The evaluation noted that IMPACT staff had the technical and professional expertise to manage innovation and ensure technical quality. In the review of the program’s design, including the technical approach, it was recommended that its comprehensive approach should follow the ECR methodology espoused by FHI, with more planning at the field level, including the full involvement of key stakeholders (government, faith-based organizations, and NGOs).

In order to understand trends in behavior among key social groups, IMPACT collaborated with NASCOP and CDC on a behavioral surveillance survey (BSS). The BSS is the largest survey so far ever undertaken in Kenya, with more than 15,000 respondents. The target groups interviewed included commercial sex workers, men in the workplace, van drivers, bicycle taxi drivers, and out-of-school youth. A summary of the findings of the BSS was presented at ICASA in 2003, and the full report was published and disseminated in 2005. Nearly 4,000 copies were distributed.

IMPACT/Kenya conducted several other studies as well. These include studies on abstinence and being faithful messages to youth in Naivasha; adherence to ART; effects of antiretrovirals on sexual behavior; and a study focusing on the Girl Guide program and its role in reducing HIV transmission among young girls.

These studies were done together with the Population Council's Horizons Project. Other studies include an assessment of condom distribution and use; an STI assessment; a rape management assessment conducted in collaboration with the Nairobi Women's Hospital Gender Violence Recovery program; and a Population Services International tracking study of VCT for couples that assessed whether greater treatment availability meant that more people would be willing to go for VCT.

Another study, which examined various methodologies to assess CD4 and viral load, was also conducted in collaboration with the Center for AIDS Research of New York University.

Health Management Information Systems (HMIS)

IMPACT made tremendous strides in developing effective systems and tools for quality diagnosis, treatment, and follow-up of clients on ART treatment. IMPACT has supported 22 districts in setting up facility-based management of health information systems. The IMPACT project supported the training of government and NGO officers, provided computers, and supported the MOH in carrying out supervision. More than 300 health workers have been trained through IMPACT to support their comprehensive care facilities in data recording and overall management.

Data management systems at 55 comprehensive care centers were established, with 17 of the facilities using a mix of electronic and paper-based systems. Follow-up supervision showed that reporting rates improved in those districts. In collaboration with NASCOP, FHI trained 274 health care providers to use HMIS for facility and community-based activities such as TB, counseling and testing, prevention of mother-to-child transmission, orphans and vulnerable children, and palliative care.

In June 2003, the first USAID-funded ART program in a government health facility in Kenya was launched at Coast Provincial General Hospital as part of comprehensive care services for people living with HIV/AIDS. Through this initiative, partners developed standard operating procedures for comprehensive care and ART using basic information management. The program was supported by USAID through IMPACT/FHI, Rational Pharmaceutical Management plus/Management Sciences for Health, and Horizons/Population Council.

To establish current ART uptake patterns and explore short- and long-term solutions for scaling up comprehensive care, IMPACT carried out a rapid ART assessment in seven project-supported comprehensive care and ART sites in Kenya. The assessment revealed the need to (1) maintain a cohort of clients receiving clinical care; (2) improve uptake of ART based on CD4 results and medical eligibility; and (3) strengthen MIS.

A paper-based ART-MIS was developed and pilot tested at several Nairobi ART sites. It aimed to strengthen program and clinical monitoring and management. It consisted of a data requirements inventory, including indicators of major stakeholders (MOH, the President's Emergency Plan, USAID, and FHI); definitions of those indicators; clinical forms; and registers and tracking cards. The tracking cards were particularly valuable for capturing client details and tracking staff workload.

Next, a sophisticated computer program originally developed by FHI for use in Ghana was modified and introduced in Kenya. The program collected data and generated reports on clients for program and clinical management. The software was pilot tested at Coast Provincial General Hospital.

By December 2004, both the paper-based and computer-based ART-MIS, along with pilot test data, were presented to the NASCOP. At this point, the computer-based ART-MIS was considered complete. The final package contains standard operating procedures with a series of clinical forms, registers, and a tracking card system, along with instructions for information management. The electronic comprehensive care management software was scaled up to 20 of the 50 comprehensive care centers in the Coast, Rift Valley, and Nairobi regions. Data clerks and clinicians increasingly appreciate the system's dexterity in program and patient management.

The overriding principles of HMIS presented by IMPACT emphasize decentralization of data systems to regional offices. This is because regional offices are closer to the data collection points. Collaborating with other stakeholders in designing data collation forms, data collection, analysis, and use has eased the work of FHI and demystified data collection. This has led the MOH to adopt some FHI systems. Because of IMPACT, data reporting and use in the community, in facilities, and within FHI have improved, leading to better appreciation of monitoring and evaluation.

Improving Knowledge and Practice of Preventive Behaviors

The IMPACT/Kenya prevention strategy included behavior change communication; STI and counseling and testing services; prevention of mother-to-child transmission (PMTCT); blood safety; and condom distribution. These interventions targeted groups at highest risk of HIV infection, including in-school youth, out-of-school youth, female sex workers, women in low-income communities, and men in worksites.

Behavior Change Communication

Through an integrated, site- and community-level BCC strategy, IMPACT/Kenya reached at-risk populations through multiple channels (e.g., peer education and facilitation, Magnet Theatre, radio soap opera, and activities for girls in school). The Program for Appropriate Technology in Health provided significant assistance in this area.

The IMPACT BCC strategy promoted interaction with target groups to develop tailored interventions and messages that would promote healthier behaviors and support behavior change. Multi-layered approaches and channels were used to deliver consistent messages to achieve maximum effectiveness. As the IMPACT/Kenya program incorporated more clinical services, particularly ART in 2003, its communication activities extended into the care setting as well.

In-school Youth

The Kenya Girl Guides Association and the Kenya Association of Professional Counselors were key implementers of the in-school component of the IMPACT/Kenya BCC strategy. Through Guide and *Straight Talk* Club activities, both girls and boys in primary and secondary schools were reached with sexual health messages. These messages centered on HIV and abstinence, life

skills, relationships, and self respect in accordance with abstinence and be faithful for youth (ABY) guidelines.

The Kenya Girl Guides Association integrated the Sara Communication Initiative into its program. The Sara Communication Initiative was a five-year program that produced and disseminated a regional communication package on the rights of the child emphasizing gender issues. The comic book, animated film, and supporting printed materials composing this package were designed to address disparities in the treatment of girls by providing an empowering role model for them in the face of HIV and AIDS in countries in sub-Saharan Africa.

Achievements of the Kenya Girl Guides Association life skills program included

- 788 schools reached through the Sara Communication Initiative
- 43,200 copies of Sara Communication distributed to schools
- over 900 teachers oriented
- 50 guide leader coordinators trained
- 875 guide leaders trained
- 80,000 pupils reached by the Sara program
- over 40,000 peer educators trained
- 1,818,114 pupils reached through peer education
- 1,500 girls earned Sara badges

The overall goal of the Kenya Association of Professional Counselors program was to help youths develop values and behavioral skills that would encourage them to practice abstinence to prevent HIV infection. The Kenya Association of Professional Counselors conducted outreach activities on a weekly basis, and provided a forum for *Straight Talk* club members to discuss reproductive health, HIV/AIDS, abstinence, and other issues affecting youth, mainly drawn from the students and *Straight Talk* magazine, a magazine produced by the *Straight Talk* clubs. *Straight Talk* clubs in mixed secondary schools served as forums where boys and girls could discuss sex education, boy/girl relationships, issues appearing in the magazine, and their own reproductive health concerns. Other club activities included health talks, debates, quizzes, exchange visits (visits by club members from one school to another), conferences, and community service projects. These clubs helped members develop a sense of self-respect, respect for others, and other positive values.

The Kenya Association of Professional Counselors prevention program reached some 3 million youths in school through the mass media. In addition, some 1,385,614 youth were reached through the Kenya Girl Guides Association program, and 1,800,960 copies of the *Straight Talk* magazine were printed and distributed.

The youth murals project selected in-school youth from the three priority regions to become involved in a process enabling them to discuss and role-play various behavior options centering around a particular relationship-focused dilemma. Community murals provided an informal setting for a semi-structured discussion of health issues that affect the community. A total of 20 murals were painted: ten in Western, six in Nakuru, and four in Mombasa. Over 200,000 people were reached through this project. In 2002, Sanaa Arts, a local IMPACT/Kenya partner, applied for funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria and was able to expand the mural program to the national level from 2003 to 2005.

Out-of-school Youth

Out-of-school youth are considered to be at risk for HIV. Many have dropped out of school because of poverty and therefore are exposed to HIV because they need income. A formative assessment carried out in 2004 in the Naivasha division of Nakuru district indicated that those who dropped out of school because of low educational aspiration had less parental support, lower self-esteem, or a combination of these and other psychosocial factors that put them at greater risk for HIV. The formative assessment also showed that most out-of-school youth were unemployed and idle, and as a result, exposed themselves to sexual risk.

IMPACT/Kenya used a variety of methods and channels to reach out-of-school youth with HIV and AIDS messages and make appropriate referrals. The BCC activities included peer education/facilitation, Magnet Theatre, radio soap opera, *Nuru* comics, and community and youth murals.

Magnet Theatre was employed to reach out-of-school youth through interpersonal communication. It is a BCC approach in which performers are drawn from local theater groups that perform at fixed times in fixed venues, such as under trees in open spaces. Instead of performances moving to different communities on different days, audiences were encouraged to attend weekly theater shows. It was hoped that exposing the same audience to the same messages over and over would have greater impact. This approach sought to improve HIV/AIDS knowledge among youth; strengthen confidence in condoms and awareness of VCT; and promote positive attitudes about reducing partners, abstaining before marriage, and delaying sexual debut.

IMPACT trained youth groups in popular community theater branded “Magnet Theatre.” The youth groups held 88 theater outreaches at designated sites. The approach allowed theater facilitators to engage the audience in developing the storyline by employing problem-posing techniques and encouraging audience participation in deciding the next action and consequences of that action. The approach was also used to recognize those who had taken a step toward behavior change, such as by testing for HIV.

As of June 2006, 2,960 Magnet Theatre performances had been conducted, reaching 609,872 youth. The other notable achievements of Magnet Theatre included increased confidence in VCT and confidence in condom use among youth; and a display of positive attitudes about abstinence. A total of 609,872 youth were reached through Magnet Theatre.



The *Kati Yetu* (Between Us) radio program offered a 15-minute drama segment followed by a chat show featuring interviews from the community, panel discussions, songs, and conversations with those who had changed their behavior. The soap opera portion followed the exploits of a character called *Nuru*, a maturing, intelligent girl, and her family. It explored the trials *Nuru* faced as she reached sexual maturity. The aim was to help youth and adolescents develop quality relationships and encourage sexual behavior choices that reduce the risk of STI/HIV infection and unwanted pregnancies. The series served as a vehicle to provoke lively, informal discussions among young people. A series of comics on *Nuru*'s life were also linked to the *Kati Yetu* radio program. Characters from *Kati Yetu* and *Nuru* were also incorporated into community and youth murals. Through participatory methods involving youth and the community, mural sites and

themes were selected. The group provided an outline for each illustration and pasted it onto the site. Artists later painted it, and members of the community were invited to paint as well. Some community members were used as models.

Using radio listenership data of Kenya Broadcasting Corporation, it is estimated that the *Kati Yetu* radio program reached at least ten percent of the population of about 3 million people.

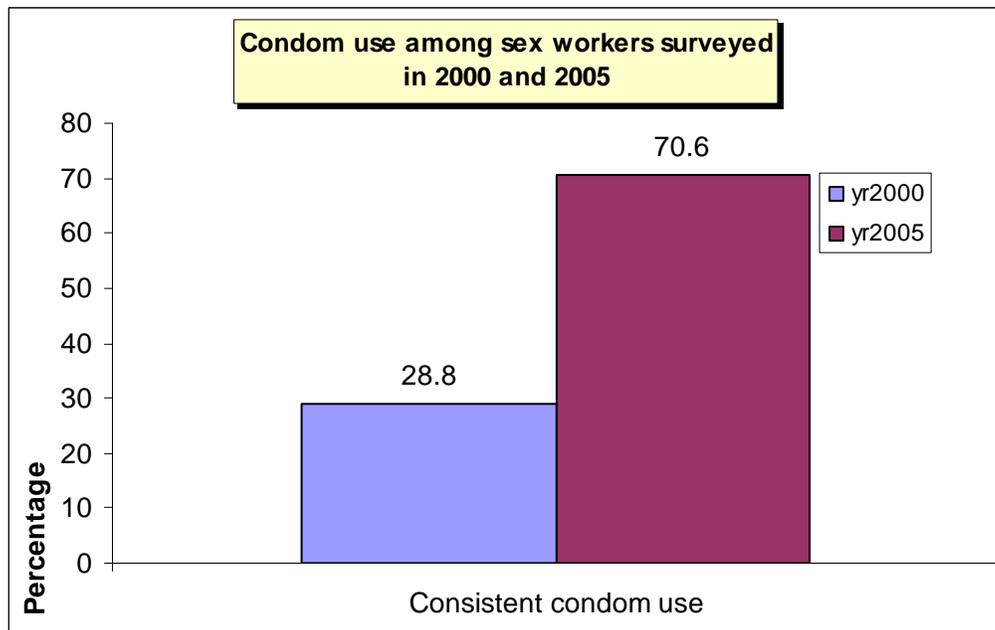
Over the life of the project, six editions of the *Nuru* comic were produced and 385,200 copies were distributed, reaching around 300,000 individuals.¹

Female Sex Workers

In its programs with female sex workers, IMPACT/Kenya adopted the model developed by the STD Project of the University of Nairobi. By mobilizing sex workers to use condoms, seek STI treatment, and forming support groups empowering them with negotiating skills, the project helped the women protect themselves from HIV. Within the support groups, 1,325 peer educators were selected and trained. In total 37,056 sex workers were reached during the implementation period.

According to the STI prevalence and behavioral follow-up study of sex workers in Kisauni Division of Mombasa District conducted by FHI with the International Centre for Reproductive Health between 2000 and 2005, consistent condom use with paying clients increased from 28.8 percent to 70.6 percent (see graph on next page). In 2005, women who participated in peer education activities in the past (peers) reported less partners per week and greater condom use. Knowledge and attitudes regarding STI/HIV and prevention remained largely the same, but the proportion of women having refused a client because he was not willing to use a condom increased from 41.4 percent to 77.7 percent (OR=4.9, $P<0.001$). This shows that the incidence of self-reported risk behaviors has lessened over time. In addition, FSW peers show improved knowledge, behavior, and HIV prevalence rates compared with non-peers. Unfortunately, this accounted for only one-third of the sex worker target population over a five-year period.

¹ Some of the readers in schools received more than one copy.



Source: STI prevalence and behavioral follow-up study in Kisauni results

Women in Low Income Communities and Men in Worksites

Women considered to be at highest risk for HIV infection are those who are divorced, widowed, or who have been abandoned by their husbands or partners, with a number of children to support and with little education or means of providing support. During the 2000 formative assessment in Western and Coast provinces, it was determined that women living in communities near large worksites sought occasional or long-term sexual relationships in exchange for money with men at these worksites. Given that men at worksites have an above-average risk for HIV because they have a relatively large amount of disposable income they can use to purchase sex, 15 worksites were initially selected as priorities.

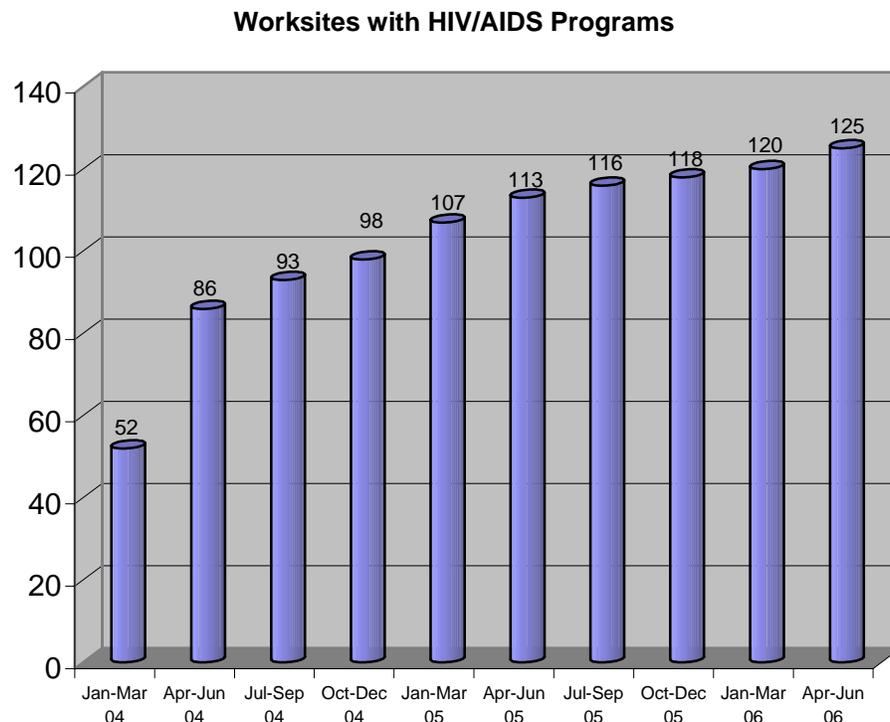
Working with PATH, FHI developed an outreach approach and curriculum for workplace peer educators to use in factories. Topics included abstinence, being faithful, the importance of HIV testing, and consistent and correct condom use. In some companies, peer educators addressed their communities and talked with spouses of workers as well. By 2002, 28 companies had ongoing peer education programs and had provided peer education to more than 76,000 workers. From 2003 to 2006, using its peer education approach, IMPACT/Kenya reached 125 employers with a combined workforce of more than 143,425. In total, 3,433 peer educators in these companies had been trained as of 2006. Companies involved in the workplace program ranged from major companies and parastatals (quasi-governmental corporations) in Kenya, such as Hotel Intercontinental, Barclay's Bank of Kenya, and the Kenya Revenue Authority in Mombasa, to agricultural industry companies including Mumias Sugar Factory, Nzoia Sugar Company, and Mumias Sugarcane Outgrowers Company. In 2004, 11 transport companies began taking part. In 2005, IMPACT expanded worksite prevention interventions to include the police force, resulting in the training of 74 peer educators.

With the introduction of antiretroviral therapy (ART) in Kenya in 2003, IMPACT implementing partners began educating employers to incorporate ART as a benefit or referral service. For

example, NOPE and Pharm Access Africa Ltd., another IMPACT partner, oriented and provided ARV drugs to 11 Kenyan companies.

Although most of the programs were IMPACT-driven, during the course of IMPACT, 72 businesses assumed the cost and responsibility of managing these programs.

The following graph shows the increase of worksites implementing HIV/AIDS programs as a result of IMPACT support.



Through IMPACT prevention interventions, the following were achieved:

- 125 worksites are implementing HIV/AIDS prevention activities with a workforce of 143,425
- 3,433 workplace peer educators have been trained
- 504 workplace peer educator trainers have been trained
- 860 management personnel have been oriented to ART
- 49 worksites are now offering ART to their employees as part of their medical coverage
- 1,265 clients are receiving ARVs at the workplace as of June 2006

Condom Promotion and Distribution

Several of IMPACT's partners distributed condoms through peer educators. The condoms were obtained free of charge from government depots. IMPACT partners distributed a total of 52,289,016 condoms (male and female) over the life of the project.

Community Capacity Building

IMPACT/Kenya established and built the capacity of three provincial and six district teams in the three regions to develop site-specific HIV communication action plans. The project ensured that there was harmony among messages going out to the community and that communication on HIV addressed local root causes of risk behavior. Provincial and district teams received help in developing messages and materials to address local risk situations. For example, the local HIV communication committee in Naivasha developed a communication strategy focusing on the HIV-associated risk around the Naivasha truck stop and flower farms.

Through the decentralized BCC planning process, a critical team composed of 150 individuals was built at the provincial and district levels. Sixty people worked closely with IMPACT/Kenya to evolve the communications strategy, thereby acquiring the skills necessary to move the process forward beyond IMPACT.

Counseling and Testing

National-level planning for voluntary counseling and testing (VCT) in Kenya began in September 2000 with a consultative technical meeting on HIV voluntary counseling and testing organized by IMPACT/Kenya. Over 50 participants from the government, technical agencies, and donor agencies attended. The September meeting highlighted the urgency of initiating VCT services in Kenya, including the development of standardized VCT guidelines, standardized training curriculum for VCT counselors, supply chain management, and a plan for service rollout. Following the meeting, IMPACT/Kenya provided significant technical and financial assistance to the VCT Taskforce of the NACC, resulting in the development and dissemination of the *National Guidelines for Voluntary Counseling and Testing* (2001), quality standards, a VCT communications strategy, testing protocols, and a training curriculum for counselors.

Service Provision

In February 2001, IMPACT began implementing VCT. By the end of the year, the project had established 25 VCT centers at a number of sites. Over the course of the project, IMPACT/Kenya supported 231 VCT clinics serving 569,485 clients.

IMPACT/Kenya placed priority on the government of Kenya taking ownership of the VCT program. In that vein, most IMPACT-supported sites were located in government health facilities, selected in collaboration with government health officials. Also, counselors providing the services were government employees. This approach enabled IMPACT and the Kenyan government to provide comprehensive care where infrastructure and personnel already existed, resulting in a less costly program that could expand rapidly using government infrastructure. Initially IMPACT/Kenya provided HIV test kits and reagents, but in 2004 the government assumed this responsibility.

To truly achieve comprehensive care, integrated VCT services require an active, sound referral system to services like tuberculosis (TB) treatment, family planning, and sexually transmitted infection management. Sensitization of other health professionals to making linkages and referrals is critical to this process. Therefore, IMPACT/Kenya supported trainings conducted in partnership with the Johns Hopkins Program for International Education in Reproductive Health

(JHPIEGO). District-level personnel acquired skills as trainers who in turn taught health facility-level providers about VCT and the importance of referrals.

To popularize VCT with the general public, a branding campaign was financed by IMPACT/Kenya, through which branded VCT signs were erected. The logo was supported by a mass media campaign on radio, television, newspapers, and billboards that continued for three years. The mass media campaign was linked to IMPACT/Kenya's interpersonal communication activities in the community and in workplaces targeting youth, women in low-income settings, sex workers, and men in workplaces.

Quality Assurance of HIV VCT

VCT quality assurance focuses on counselor training and lab-testing. Supervision for all VCT sites took place at the national level. It was conducted by officers from the NASCOP. In 2002, IMPACT commissioned the Kenya Medical Research Institute (KEMRI) to implement a quality assurance system for HIV tests to ensure that tests were accurate. To orient health professionals in Kenya, IMPACT, through JHPIEGO, organized widespread orientation of health personnel to VCT, targeting 10 districts where IMPACT was working. In 2004, a rollout strategy and a quality assurance strategy were developed by NASCOP with technical assistance from IMPACT and other partners. The quality assurance work commissioned by IMPACT/Kenya and executed by KEMRI informed the national quality assurance strategy.

Post-test Clubs

The overall goal of a post-test club is to provide support to both HIV-positive and HIV-negative clients to enhance psychosocial adjustment and promote healthy lifestyles and behavior change. Membership is voluntary. Depending on the objectives of the club, members can be a combination of those infected with HIV and those who are not, or exclusively of persons living with HIV or AIDS.

Under IMPACT, post-test clubs (PTCs) were established to provide ongoing psychological and social support to clients who had tested for HIV regardless of sero status. The concept was borrowed from Uganda, where the first post-test clubs were set up for that same purpose.

By the end of 2001, there were four post-test clubs in Mombassa under the International Centre for Reproductive Health, one in the district, of Malindi, and five in Thika established with support from the Liverpool School of Tropical Medicine. There was also one post-test club in each of the districts of Kakamega and Busia and one in Mumias. All these were attached to hospitals or health centers, depending on where the VCT center was located. They were run voluntarily by members, although in some places VCT counselors helped run services. In 2002, the Kenyatta National Hospital VCT center established its post-test club. By 2003, it had a membership of over 200 clients, with an average of 60 regular attendees.

Membership of PTCs differed from place to place. In the Coast region, most members were HIV negative young people, whereas at Kenyatta National Hospital, all members were HIV positive. In the Western province, most PTC members were HIV infected, tended to be older, and were more likely to be women. Attendance also differed from place to place.

PTCs mainly provided psychological and emotional support through ongoing counseling and educational talks on topical issues, offered by guest speakers. Kenyatta National Hospital secured nutritional supplements and conducted nutritional assessments for its members. This was supported at different times by the Kenya Expanded Programme on Immunization (KEPI), Nestle Kenya Ltd., and the UNICEF country office. Several people were involved in HIV/AIDS education, and some even went public with their status.

The PTC in KNH became part of the drop-in-clinic at the patient support center unit. Here, patients began receiving cotrimoxazole prophylaxis and ongoing counseling, medical examinations, and referral for treatment of opportunistic infections, as well as nutritional counseling. This later became the start of a comprehensive care center (CCC) for KNH.

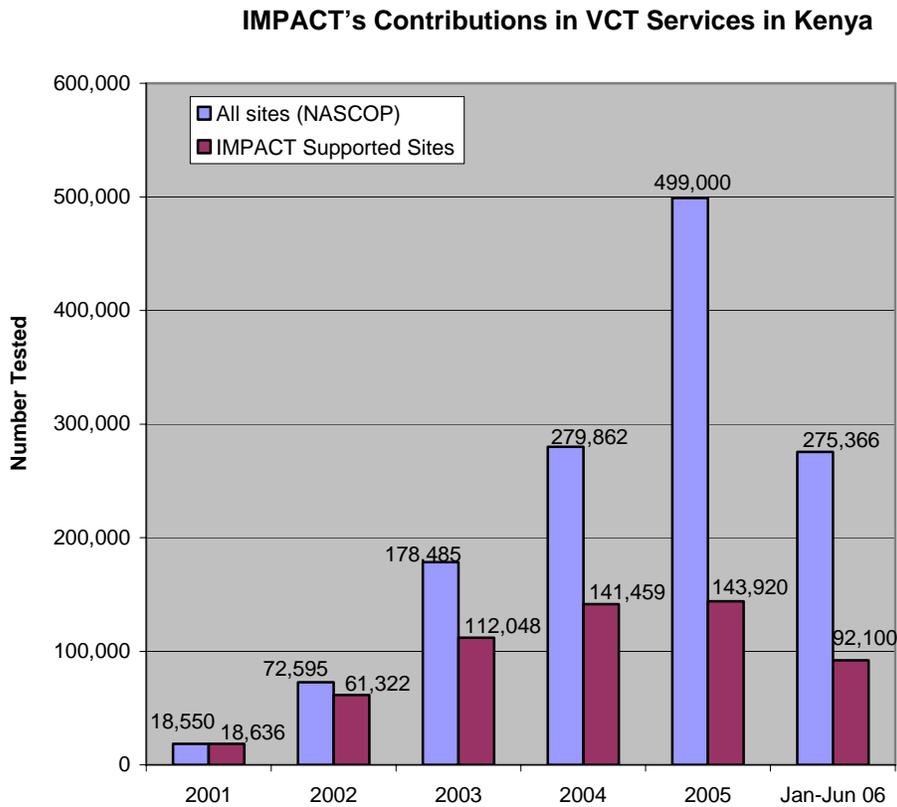
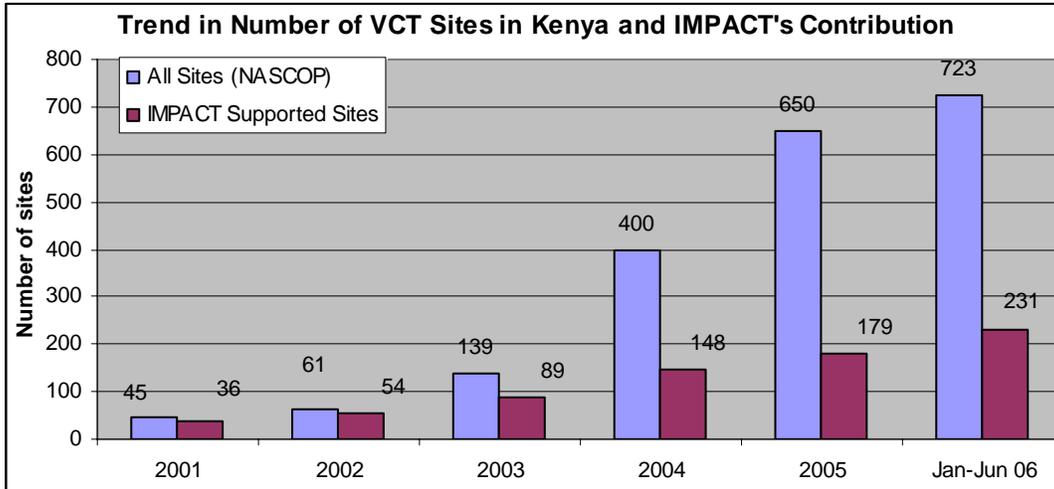
Some of the major challenges of PTCs were lack of funding support for the activity, lack of involvement by the facility management (including the counselors in helping coordinate activities of the PTC), and distances people needed to travel to attend meetings. It was difficult for members to travel long distances on a regular basis for meetings and non-medical services. Some members expected transport reimbursement. With time, attendance waned except among those who lived nearby.

Diagnostic Testing and Counseling

In 2005 IMPACT/Kenya began rolling out testing for HIV in clinical settings. A training curriculum, patient forms, and tally sheets were developed for provider use. Thirty trainers and 147 providers were trained. By 2006, all ART sites were routinely undertaking diagnostic testing and counseling (DTC).

The data profiles below indicate VCT performance and trends between 2001 and 2006 under IMPACT/Kenya:

Cumulative number of clients tested for CT at IMPACT-supported sites	569,485
Total number of sites established through IMPACT support (2001–2006)	231
Total number of sites as of June 2006 under IMPACT	199
Total number of ACTIVE sites as of June 2006 under IMPACT	168



**NASCO data includes data from IMPACT-supported sites

As of June 2006, NASCO reported that 1,323,858 Kenyans accessed CT services at 723 sites around the country. IMPACT/Kenya supported 231 of these sites, which provided CT services to 569,485 clients.

Kenyatta National Hospital Centre of Excellence

In 2002 with the support of USAID and the Embassy of Japan, Kenyatta National Hospital opened its VCT “Centre of Excellence.” IMPACT/Kenya provided significant technical assistance to Kenyatta National Hospital in this undertaking. The Centre of Excellence was the first high-volume VCT center in the country, seeing approximately 1,000 clients per month. It was the model VCT center in the country, and was the training site for many other VCT centers around Nairobi and the country.

Beginning in 2002, the Kenyatta National Hospital (KNH) VCT team sought to provide quality training packages to Kenyans in many sectors, including health institutions, NGOs, CBOs, and service provision organizations supported by USAID-funded projects including FHI/IMPACT and AMKENI, a reproductive health project of USAID. The KNH VCT center packaged refresher courses for all network partners on topics such as couples counseling, diagnostic HIV testing, and VCT and ARV management. The VCT center also provided continuous medical education in various aspects of care and support.

The post-test club at KNH grew over the life of IMPACT/Kenya and built the capacity to start satellite centers for the network forum. The Centre of Excellence also supported KNH staff who tested positive. The group started with four members and grew to 30.

VCT and Family Planning Integration

In June 2002, FHI provided funding for and facilitated an assessment of family planning/VCT integration. The assessment confirmed the need for and efficacy of such an approach. A family planning/VCT subcommittee was formed at the national level, culminating in the development of the National Family Planning/VCT Integration Strategy. To operationalize the strategy, IMPACT/Kenya helped orient provincial health management teams, and helped with training of trainers (39) and service providers (101). Integrated services are currently underway in 59 pilot sites across the country, including IMPACT-supported sites.

Prevention of Mother-to-Child Transmission

In 2000, IMPACT/Kenya, through the Network of African Researchers in Eastern and Southern Africa (NARESA), initiated PMTCT services at some of the earliest public sector facilities (Busia District Hospital, Kakamega Provincial General Hospital). Data from the pilot sites and from prior sites was used by NASCOP to scale up PMTCT nationally. Projects began with a research orientation, with help from NARESA, but soon were transformed into full-fledged health interventions. As PMTCT services increased in the country (primarily in provincial and district hospitals), IMPACT/Kenya hoped to expand services to lower level health facilities to reach women at facilities closer to their homes. As a result, five health centers were incorporated into the PMTCT service network in Western Province. With additional funds from PEPFAR, PMTCT services continued to grow. Soon, IMPACT/Kenya expanded PMTCT efforts in Coast, Rift Valley, and Western provinces. A total of 66 hospitals and health centers were providing PMTCT to mothers and their babies by the end of IMPACT. Through IMPACT support, 734 service providers were trained to support PMTCT service delivery.

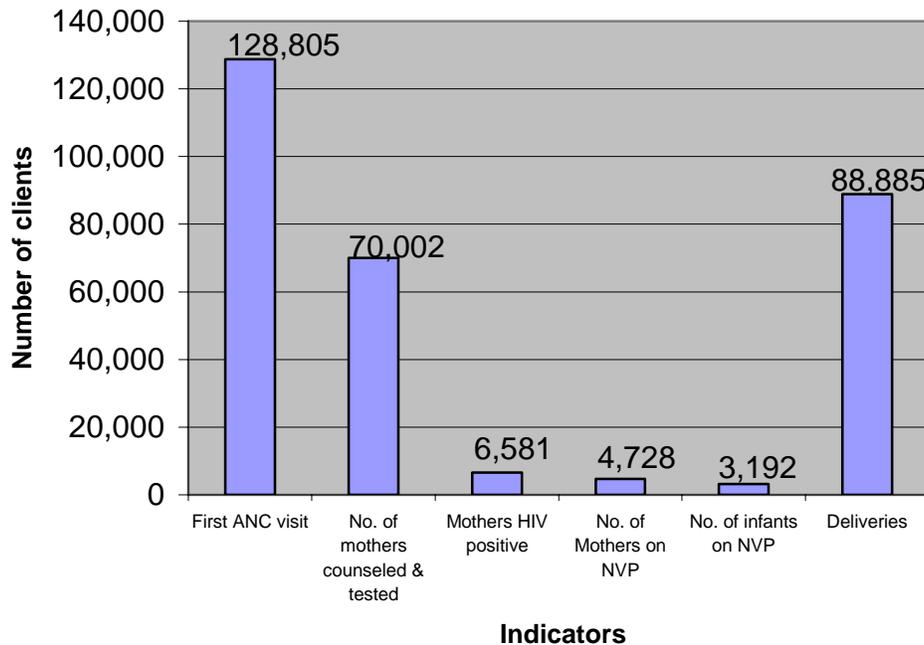
When NASCOP established a technical working group for PMTCT in 2003, IMPACT/Kenya was a key member. At the national level, in addition to participating in the PMTCT technical working group, USAID through FHI supported a PMTCT National Stakeholders Consultative Forum in March 2006, convened by NASCOP and the Division of Reproductive Health (DRH). In partnership with NASCOP, FHI supported the printing of PMTCT wall charts, an important part of the Kenyan-adapted PMTCT training curriculum package.

IMPACT/Kenya also contributed to the increasing response to PMTCT needs in Kenya by working with the MOH. Specific activities included capacity building for program planning and management; infrastructure upgrades; and technical capacity building for managers and staff. Together with the MOH, IMPACT/Kenya also supported adherence to standardized reporting processes, including ensuring availability and use of national registers and reporting systems. Physical infrastructure was upgraded to include private counseling space, with funding leveraged through JICA. In addition, FHI managed and administered PMTCT donations (HIV Determine Test Kits and Nevirapine tablets and suspension) through Axios International for sites supported by FHI and other partners. This offset national stock-outs of PMTCT commodities and supplies. At the end of 2005, the program had provided test kits and Nevirapine to 164 sites across three provinces.

Between 2000 and 2006, more than 128,805 ANC mothers received counseling at PMTCT-implementing sites supported by IMPACT/Kenya, with the potential to avert more than 4,700 pediatric HIV infections. During the same period, 70,002 ANC women were tested for HIV during pregnancy, including 28,202 who were tested during labor and delivery. More than 7,000 pregnant HIV-infected women were identified, 68 percent of whom accessed Nevirapine antenatally.

Toward the end of the project, IMPACT/Kenya began supporting the integration of more complex ARV regimens at two sites to model an integrated pediatric prevention, treatment, care and support approach centered around the MCH clinic but with strong linkages to the HIV clinical care/ART, in-patient department, out-patient department, and other departments, as well as community support services.

IMPACT PMTCT Implementation Status by End of June 2006



Blood Safety

Kenya is home to one of the most successful blood transfusion services in Africa, thanks to IMPACT/Kenya, which partly funded the project. USAID and FHI worked with the National Public Health Laboratories (NPHL) of the Kenyan MOH to establish this national system for voluntary blood collection.

In 1994, participants at a national stakeholder meeting on blood transfusion identified the challenges facing blood transfusion services in Kenya. Historically, most blood was collected from replacement donors. With the emergence of HIV in Kenya, the established pattern of blood donation was abruptly broken, since blood was often contaminated by HIV and other pathogens. The bombing of the United States Embassy in Nairobi in 1998, which resulted in numerous deaths and injuries, revealed a severe shortage of safe blood for both disasters and normal medical care. As a result, USAID made a major commitment to the Government of Kenya to develop and implement blood transfusion centers (BTCs) to serve 80 percent of the country’s blood requirements.

Between 1999 and 2000, a team composed of FHI, the MOH, and other stakeholders designed and implemented plans for blood transfusion services. FHI, with financial support from USAID, moved this agenda forward. A total of US\$383,183 from IMPACT was used to achieve the following outcomes:

- Helped the BTCs conduct outreach and mobilize blood donors, leading to the collection of 127,745 units of blood by March 2005 from the BTCs—an increase of more than 1,900 percent since the program began in 2002. FHI also helped the BTCs develop and submit a proposal to PEPFAR. As a result they received their own funds to expand programs.

- Supplied the BTCs with commodities and reagents that enabled them to collect blood and test it before distribution.
- Developed policy guidelines for blood transfusion in Kenya.
- Collaborated with the MOH to develop an institutional framework for blood transfusion services.
- Collaborated with the Kenya Medical Training College (KMTC) to create a blood transfusion certification course for providers.
- Development of a national strategy for blood donor mobilization.
- Developed guidelines for medical staff to ensure minimal wastage of blood.
- Created quality assurance guidelines to ensure the correct handling of blood and blood products.
- Decreased HIV prevalence rate in donated blood from 20 percent to 3.2 percent.

Treatment, Care, and Support

In the initial years of IMPACT/Kenya, the care and support component of the program consisted of supportive activities at the national level (e.g., development of guidelines and training curricula for home-based care, diagnosis and management of opportunistic infections, and anti-retroviral therapy) and discrete activities within priority communities, including home-based care ; TB diagnosis, treatment, and prophylaxis; management of other opportunistic infections; and STI management. In 2003, IMPACT/Kenya initiated a pilot ART site in Coast Province and expanded treatment and support interventions.

Prevention and Clinical Management of Opportunistic Infections (OIs)

Prevention and management of OIs is very important because it addresses a critical period when PLHA may need preventive therapies and/or medical care. It also can be a vital link to post-test clubs, community support activities, and ART.

In 2001, IMPACT conducted feasibility studies on TB and OI preventive therapy in Mombasa. The studies demonstrated that the number of HIV infected individuals diagnosed with TB went up by 14 percent when active screening was undertaken. The study also found that TB preventive therapy was not feasible in a routine VCT setting because of high dropout rates among those started on preventive therapy.

In 2002, IMPACT also participated in the review of national guidelines for OI management. In addition, the project supported training of health service providers in OI management within the context of ART delivery.

Treatment and Control of STIs

IMPACT/Kenya supported STI management in the three provinces by providing low-cost and client-friendly STI treatment using the syndromic approach. During the life of the project, IMPACT/Kenya upgraded 59 clinics, the majority of them at the Coast, and trained 156 health workers and supervisors of STI activities. IMPACT/Kenya intermittently provided STI drugs and reagents when clinics experienced stock-outs. IMPACT also provided regular supervision to partners in collaboration with the MOH.

TB and HIV Coinfection

IMPACT helped the National Leprosy Tuberculosis Programme upgrade its Central Reference Laboratory to enable it to perform culture and sensitivity testing. IMPACT also helped draft a TB preventive therapy policy and also helped expand diagnostic and treatment centers in Coast and Western provinces. In 2000, IMPACT supported PATH to conduct a community and patient-centered behavioral study on TB and TB/HIV. The study looked at stigma, alternative treatment-seeking, psychosocial support, structural barriers to care, perceptions about symptoms, and knowledge. In addition, 200,000 pamphlets providing general information on TB care-seeking and 2,500 TB/HIV guidelines and algorithms were printed and distributed. The TB clinics served 5,000 HIV-positive patients. More than 1,000 were referred for HIV clinical care and follow-up.

Training of 26 HIV counselors in TB diagnosis, and 14 lab technicians in TB microscopy took place in Mombasa. Seventy-seven prison wardens attended three workshops and discussed TB suspicion and DOTS. Eight schools were also covered by the TB school program in Mombasa and Nairobi.

Under the urban TB initiative, three laboratories in TB diagnostic centers in Mombasa District were rehabilitated (Mtongwe, Mikindani, Mwembe Tayari). In Nairobi Province, IMPACT supported the rehabilitation of three TB diagnostic centers (Kararani Dispensary, Pumwani Majengo, and Lunga Lunga). In addition, slum TB coordinators for Nairobi and Mombasa were hired to enhance active TB case finding in major slum dwellings in Mombasa and Nairobi. These coordinators also mobilized the community and educated people about TB-HIV coinfection, reaching over 20,000 people by June 2006. Six laboratory technologists were hired under IMPACT to help alleviate the TB workload at Coast Provincial General Hospital, Port Reitz District Hospital, Kangemi Health Centre, Rhodes Chest Clinic, Mathare North Health Centre, and Dandora II Health Centre.

Home and Community Support

At the initiation of the IMPACT/Kenya program, two local implementing partners conducted formative assessments in Western Province on the medical, psychosocial, and community needs of PLHA and the health and social infrastructure of communities. In subsequent years, the two local partners provided home-based care and referrals to local clinics in their communities. In Coast Province, IMPACT collaborated with the USAID-funded COPHIA (Swahili for “hat” and slang for condom) Project managed by Pathfinder International, as well as other donor-funded programs to ensure a continuum of care in all IMPACT-supported communities. From 2004 to 2006, IMPACT directly funded the COPHIA Project. As the availability of VCT and ART

services increased during the course of IMPACT, home-based care became a growing priority. Over the course of IMPACT, 330,901 clients (including OVC) were supported by home- and community-based care.

Orphans and Vulnerable Children

At the national level, in 2002 IMPACT/Kenya assisted the Kenyan government by hiring a consultant to develop the Kenyan National Programmatic Guidelines for OVC. IMPACT was also instrumental in facilitating the formation of the Kenyan National OVC Task Force. At the program level, IMPACT supported two OVC programs in Mumias and Bungoma, Western Province. Interventions targeting orphans and vulnerable children (OVC) were integrated within existing home-based care programs. By June 2006, 79,586 OVC had received care and support services from various IMPACT-supported partners in Western Province.

IMPACT/Kenya recruited and trained or re-trained 14,233 home caregivers in orphan care and trained 25 child counselors (12 males and 13 females). By mid-2006, community child counselors had organized educational sessions for OVC called “children fun days” and counseled 2,513 children (100 boys and 1,480 girls). The children were drawn from two project sites in Western Province. They paid particular attention to orphaned girls, who are thought to be more vulnerable. In addition, 11,953 OVC received care and support, while 2,336 OVC (918 males and 1,418 females) received psychosocial support.

Eleven community-based organizations and groups were established as a result of IMPACT/Kenya OVC activities. By the time the project ended, these organizations had begun seeking funds from several sources to ensure their sustainability.

Psychosocial Support

Under IMPACT, psychosocial services were provided to PLHA, their families, and orphans through various interventions such as the memory book (creating a book containing information on family history), paralegal support, community counseling, and systemic child counseling. Involvement of PLHA in all programs contributed significantly to the success of the programs and reduction of stigma and discrimination.

The Society for Women and AIDS in Kenya (SWAK) provided these services to 1,320 PLHA and helped them form 44 support groups that played an important role in fighting stigma and providing group therapy to members. The initial two groups were formed in Western Kenya, with memberships of 30 apiece. They were formed at a time when HIV-related stigma was high and disclosure was rare. They became a source of encouragement to community members who tested and were found positive.

The memory book initiative enabled parents living with HIV and AIDS to develop supportive strategies for their children, helped families prepare for permanent separation, and empowered parents to plan for the future of their children. By June 2006, 125 parents had successfully developed memory books. The trained PLHA then taught others, resulting in the writing of 1,710 memory books and 705 wills. Because of this training, 1,200 people disclosed their status to family and friends.

By June 2006, SWAK had helped communities establish 10 children's clubs, with a membership of over 1,000 children. Children of PLHA met every school holiday for interaction, play, counseling, and referral to other services. Ninety adults who interact with children were trained in systemic child counseling so they could support children living with HIV-positive parents.

This activity began in 2004 and aimed to empower PLHA, known as Ambassadors of Hope, to go public in their communities and challenge negative perceptions promoting stigma and discrimination. Ambassadors of Hope engaged in community outreach in their regions. By June 2006, 105,290 community members had been reached by the Ambassadors of Hope through community outreach in the Western, Rift Valley, and Coast regions. In the Naivasha area of Rift Valley, there had been very high stigma. No one went public with his or her HIV status. SWAK was the only organization that managed to get PLHA to go public after Ambassadors of Hope training.

Community counseling was aimed at empowering women with knowledge and skills to provide psychosocial support and referral for those infected and affected in their communities. Community counselors played the critical role of offering basic counseling to community members in distress and referring them for further counseling, testing, drug treatment adherence, and follow up in the community. More than 100 community members were trained as community counselors to offer counseling in drug adherence, self denial with HIV/AIDS status, gender based violence and other domestic problems, the role of parents, the importance of VCT, networking, and referrals.

Antiretroviral Treatment

In September 2001, the MOH, USAID, FHI and the CDC convened a technical and consultative meeting to discuss ART in Kenya and build consensus on the way forward. A key outcome was the creation of a national ARV task force that would set standards, revise national guidelines, involve relevant training institutions, select drug regimes, and recommend ART interventions to the MOH. FHI, secretariat of the task force, was a key technical resource. At monthly task force meetings, which began in February 2002, FHI advised members on a host of treatment-related topics, including patient eligibility and drug selection. Suggestions informed ART program planning and were incorporated into the national guidelines.

IMPACT/Kenya launched the first USAID-funded ART program in a government health facility at Coast Provincial General Hospital in Mombasa, as part of comprehensive care services for PLHA. IMPACT collaborated with Management Sciences for Health and the Population Council to provide ART using standard operating procedures, guidelines, and tools for comprehensive care and ART. These served as entry points to HIV care and treatment. After initiating the one pilot site at the Coast Provincial General Hospital in June 2003, IMPACT expanded to three additional sites in Coast Province in 2004. By June 2005 the project was supporting 20 ART sites, and 39 sites by June 2006.

As part of the roll-out of ART treatment and comprehensive care to all of its sites, IMPACT/Kenya employed the following strategy: strengthening related services, including counseling and testing; reinforcing human resources; using rapid start-up teams to establish new sites; strengthening existing infrastructure; supporting the role of government; and developing national guidelines and tools, including monitoring and reporting systems.

To prepare for the introduction of ART in health facilities, essential HIV services like VCT and PMTCT were established or strengthened. Interpersonal communication approaches supported by IMPACT began incorporating treatment messages in the hopes of mobilizing the community to seek ART.

Reinforcing Human Resources

To train service providers in clinical and management practices, FHI established four public facility sites as learning centers for providers in Mombasa. These centers piloted service guidelines, clinical management practices and procedures, multidisciplinary training, dedicated treatment service centers, commodity management tools, and ARV drug dispensing practices.

In addition to training received at the Mombasa learning centers, multidisciplinary care teams were trained at identified scale-up sites in other districts and regions. Provider mentorship programs were established to allow for on-site clinical support by clinicians who had undergone advanced HIV care training.

IMPACT/Kenya provided training in ART care for recent graduates of health professions and developed HIV care and ART modules for integration into the Kenya Medical Training College curricula. Twenty-five health professionals from Kenya Medical Training College were given this specialized training. After completing the training, the health professionals were posted to various health facilities in Coast, Rift Valley, and Western provinces for internships. Notably, the government has since absorbed this Health Professionals Program (HPP), and the training modules have been launched by Kenya Medical Training College (please see “Support for a National and District Level Response” section for more information on the Health Professionals Program).

Using Rapid Start-up Teams to Establish New Sites

IMPACT supported the training of multidisciplinary teams at scale-up sites. The teams included a medical doctor, a laboratory technologist, a nurse, a pharmaceutical technologist, and a clinical officer. Teams were mentored by experienced clinicians who had undergone advanced HIV care training at New York University or other sites. These clinicians provided on-site clinical support.

Strengthening Existing Infrastructure

Existing facilities were renovated to provide additional service space. Laboratory services, a key component of ART delivery, were also strengthened through equipment provision, reagent supply, and improved guidance on procurement.

Supporting the Role of Government

IMPACT/Kenya supported the integration of ART activities into the MOH decentralized framework by organizing provincial planning and monitoring forums in partnership with the GOK. IMPACT/Kenya also supported site supervision and the training of provincial and district focal persons. IMPACT/Kenya worked closely within set government systems to create ownership and capacity within the MOH. The HPP was developed in partnership with the NASCOP and Kenya Medical Training Program to upgrade the HIV/AIDS service delivery skills

of newly trained health professionals so they could safely and proficiently provide comprehensive care for HIV-infected persons. Initially ARV drug supplies were financed by private FHI funds. Later, USAID supported drug costs. In 2003 the Kenyan government assumed responsibility for purchasing and distributing ARV drugs in the country.

Developing National Guidelines and Tools

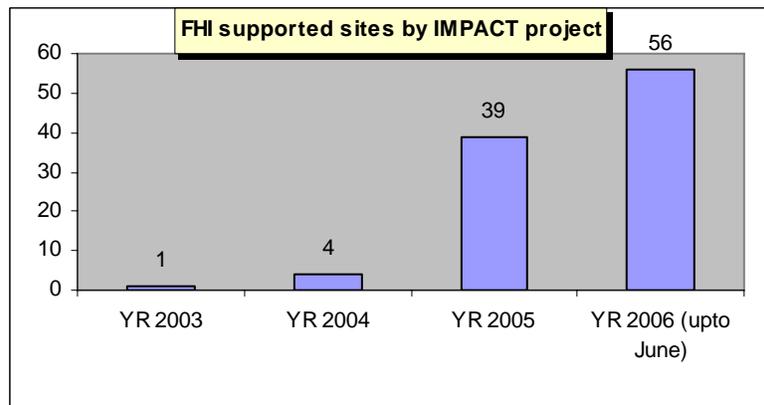
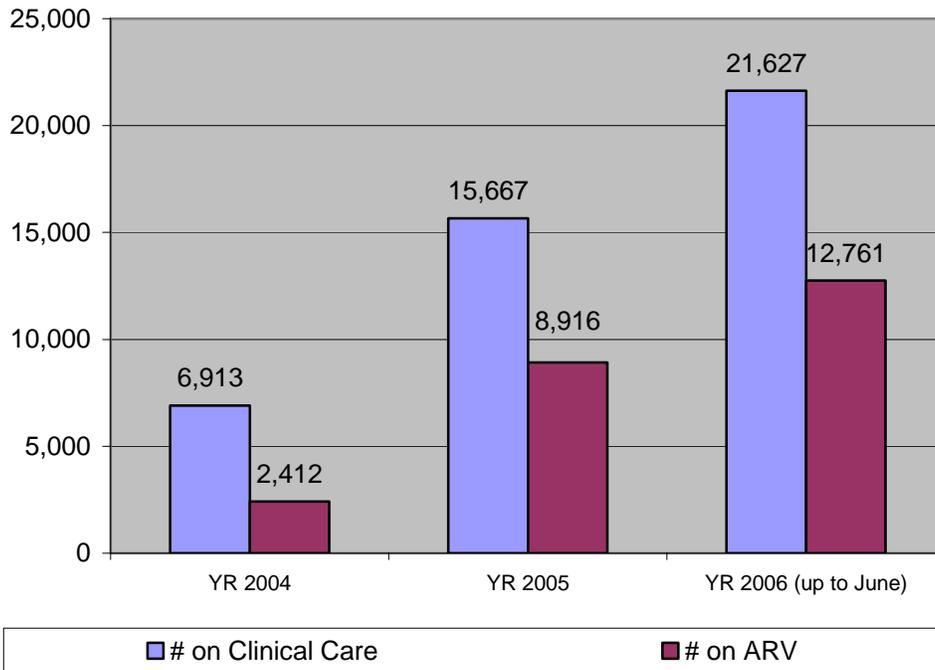
While establishing the pilot site at Coast General Hospital in 2003, IMPACT/Kenya and its partners developed standard operating procedures for comprehensive care and ART using basic information management. To establish current ART uptake patterns and explore short- and long-term solutions for scaling up comprehensive care, IMPACT carried out a rapid ART assessment in 2004 in the seven project-supported comprehensive care and ART sites. The assessment illuminated three priorities: to maintain a cohort of clients receiving clinical care; to improve uptake of ART based on CD4 results and medical eligibility; and to strengthen current management information systems.

Following this baseline ART assessment, IMPACT and its partners developed a paper-based ART-MIS and pilot tested it at several Nairobi ART sites. The purpose of the system was to strengthen program and clinical monitoring and management. It consisted of a data requirements inventory, including indicators of major stakeholders (MOH, the President's Emergency Plan, USAID, and FHI), definitions of those indicators, clinical forms, and registers and tracking cards. The tracking card was a particularly valuable tool for capturing client details and monitoring staff workload. In December 2004, a sophisticated computer program originally developed by FHI for use in Ghana was modified and introduced in Kenya through the NASCOP. This computerized ART-MIS system was introduced in 13 high volume health facilities in August 2005 and later introduced in the remaining number of high volume health facilities at district and sub-district hospitals, where the system is currently still in use.

Outcomes

- 39 ART sites established in public and FBO/CBO facilities; over 7,250 patients started on therapy
- Over 1,500 health workers trained to provide HIV care and ART services
- 36 clinical mentors received advanced HIV care and treatment training and now serve as on-site clinical preceptors and mentors
- HIV care and ART data management system in operation and adaptable for both paper-based systems and software programs
- Over 7,250 patients started on therapy: 62 percent of new ART clients are female, 6.4 percent pediatric, 44 percent access treatment through VCT and OPD diagnostic services
- 50.5 percent of clients entered into care are on ART
- At 6-month follow-up, 9 percent have died and 86 percent are continuing treatment. Among these, there is an average 6 kg. weight gain and a CD4 increase of 106, starting from an average CD4 of 69

Clients on Care Supported by IMPACT Project



Comprehensive Care and ART Services

IMPACT/Kenya, in collaboration with the MOH, developed the Comprehensive Care Centre model as a means to integrate AIDS care and support services. In the model, patients can receive care and services from multiple entry points, including hospitals, PMTCT and MCH programs, VCT centers, TB control programs, and pediatric clinics. Specifics of comprehensive care in each of the provinces can be found below.

Coast Province

Using counseling and testing and PMTCT services as entry points to care and treatment of HIV/AIDS, IMPACT initiated one pilot site at the CPGH in June 2003 and expanded it to three sites (Port Reitz, Magongo, Municipal Clinic, and Bomu Mkomani in Coast Province) in 2004. These sites aimed to put 300 patients on treatment. With the scale-up of ART provision under the

President's Emergency Plan, the growing number of sites and AIDS clients served increased dramatically from 2004–2005. This was initially based on a network model, with CPGH being the ART initiation site and three others being follow-up sites.

Start-up activities included an assessment of training needs, and the state of physical infrastructure, systems, and laboratory equipment needs. This culminated in training of staff in basic ART, physical infrastructure upgrades, and the equipping of the laboratory to support this new service. In addition, development of clinical standard operating procedures for patients in need of chronic HIV care was undertaken and adopted for each site.

Home-based or community-based palliative care and support was provided through linkages with activities of the USAID-funded COPHIA Project. Scale-up of services beyond Mombasa District was occasioned by demand for treatment services. This resulted in adoption of the training curriculum and adoption of the national ART program. By September 2006, IMPACT had trained 426 health workers in the Coast Province. A total of 19 ART sites in six districts (Mombasa-9, Malindi-1, Kwale-2, Lamu-3, Kilifi-1, and Taita Taveta-3) in the province were supported by IMPACT.

IMPACT Project support entailed the following:

- Training of staff from each site in basic adult ART
- Provision of basic furniture and rehabilitation of the clinic
 - Two of the clinics (CPGH and Malindi DH) were renovated to accommodate counseling and testing, TB services, and nutrition and STI services under one roof.
- Provision of ART HMIS data collection tools (registers, cabinets, and clinical forms)
- Computer procurement in four of the high-volume ART sites and FHI clinical software installation to upgrade medical record keeping
- Procurement by CPGH of laboratory equipment for ART monitoring, including a CD4 machine, hematology analyzer, and chemistry analyzer. Sample referral modalities were put in place to maximize availability of the equipment. Port Reitz and Bomu were eventually provided with CD4 machines.
- Procurement of reagents for CPGH (CD4, chemistry and hematology)
- Placement of ten sessional clinical staff in six of the MOH HIV comprehensive care clinics and five data clerks to manage data entry in four clinics. These staff worked under contract.
 - IMPACT supported most of the clinical and clerical staff in the clinic at Bomu for this service.
- Involvement of PLHA in the comprehensive care centers (CCCs) was introduced in one clinic, with two as treatment supporters, but this soon scaled up to six sites involving 11 of them.

By the end of September 2006, the 19 sites had registered 12,000 patients for HIV clinical care, of whom 1,000 were children. Approximately 6,100—including 440 children—were on ART. Two-hundred-twenty-five patients stopped ART because they died. Cumulatively, 696 patients had received treatment for post exposure prophylaxis of HIV.

At the end of September 2006, IMPACT supported 60 VCT sites in six of the seven districts in Coast Province. Ten of these were either standalone or mobile; the rest were integrated sites. Cumulatively, 148,950 clients received counseling and testing.

Rift Valley Province

In 2003, IMPACT partnered with the MOH to construct the first comprehensive care center in the country at Nakuru Provincial General Hospital in partnership with the Japanese government. Later, two other comprehensive care centers were constructed at Kapkures Health Centre and Naivasha Sub-district Hospital. By September 2006, IMPACT had partnered with the MOH to establish 10 CCCs. Other CCCs included Gilgil, Kajiado, Koibatek, Maralal, Molo, Nanyuki, Narok, and Njoro. The project renovated and furnished the facilities so they would be conducive to service delivery. By September 2006, 5,947 PLHA had been put on care. Of these, 2,074 were on ART. The Nakuru PGH functioned as the learning site in the region and provided services to 57 percent of the total number of clients on care and 54 percent of those on ART.

Due to inadequate health worker knowledge and skills in the care and treatment of infected persons, IMPACT invested in training staff from the province in ART. As a result, 468 health workers were trained in ART. Six doctors also benefited from advanced training in ART treatment by New York University Medical School. Mentoring of new sites as they were established was critical to the successful operation of CCCs. Mentors were identified among the trained doctors. They provided much-needed support to sites in their infancy and also mentored health professionals at those sites.

IMPACT also offered essential equipment to selected sites. A CD4 machine was provided to Nakuru PGH. Other equipment included chemical analyzers and computers to improve the quality of services and monitoring systems at the CCCs.

Under the auspices of IMPACT and with funding from the FHI Board of Directors, the MOH constructed a pediatric CCC. By September 2006, the CCC had served more than 500 children, of whom approximately 300 were on pediatric ART treatment.

In October 2005, FHI launched the *Nuru Ya Jamii* (“Light of the Family” in Kiswahili) initiative in Nakuru with private funds. The goal of *Nuru Ya Jamii* was to reduce the vulnerability of children and their surviving parents and other primary caregivers to HIV/AIDS through a child-focused and family-centered approach. The program sought to prevent orphaning by providing the full continuum of HIV/AIDS prevention, care, treatment, and support services to not only children infected or affected by HIV/AIDS but also to the entire family unit. It was hoped that this would preserve a healthy, loving environment in which children would thrive. *Nuru Ya Jamii* offered families a range of services including education, food and nutrition, home-based care, legal support and child protection, psychosocial support, and economic strengthening (vocational training for young family members). Clinical health services for these families were also provided at IMPACT-supported sites. A total of 1,800 family members accessed clinical services at IMPACT-supported sites.

Western Province

In late 2003, following the successful establishment of comprehensive care and ART services at the Coast Provincial General Hospital, IMPACT/Kenya rolled out services to Western Province in line with national scale-up plans. Initial assessments confirmed that there were existing services at the Kakamega Provincial General Hospital and St. Mary’s Hospital that would form a good basis for starting comprehensive care, including VCT and PMTCT services; STI and TB clinics, labs, and pharmacies; and clinical care for those who test positive.

There were, however, gaps in infrastructure, staffing levels, and inadequate skills for service delivery. Initial work centered on staff training and the improvement of infrastructure at St. Mary's and the Provincial General Hospital. Seventy-five staff from the two facilities were trained to provide comprehensive care. A select few doctors and one clinical officer received advanced training at the NYU School of Medicine. Renovations and other structural improvements were completed, and both facilities began operating their HIV clinics in June 2004. PGH-initiated services with drugs from NASCOP at a monthly cost of US\$6.70. St. Mary's received an initial donation of drugs worth US\$5,000 from the FHI Board of Directors. Owing to the success of the initial two sites, services were then replicated at nine other IMPACT-supported CCCs in Western Province.

By the end of the project, 4,673 PLHA from these centers were receiving continuing care. Of this number, 1,937 PLHA were on ART. All of these facilities offered basic opportunistic infection (OI) prophylaxis and treatment. By project's end, 974 clients had received OI treatment. This was made possible through staff capacity building in identification, treatment, and referral for common OIs. Home-based care programs in Mumias and Bungoma empowered community health workers in these services, forming a crucial link between the community and facilities for care across the continuum. In addition, as emphasis shifted toward diversifying entry points to care, diagnostic testing and counseling began at the CCCs. This increased access to care for symptomatic clients.

Uptake of CC/ART Services Since 2004

Year	# enrolled in CCCs (cumulative)	# on ART (cumulative)	# referred from DTC
2004	495	167	-
2005	2,374	695	25
2006	4,673	1,937	73

IMPACT/Kenya also supported two home-based care initiatives, one at St Mary's in Mumias, which was centered on a Catholic mission hospital's existing community based health care program, and one in Bungoma under the MOH. The two initiatives employed a mix of health facility and community-based approaches in what were termed *home care teams*. These teams comprised nurses and public health technicians who served as trainers of trainers. These staff trained community health workers (CHWs) in basic home care skills, which the community health workers in turn were able to impart on household caregivers. The trainers of trainers were based at health centers and dispensaries, which were the primary health care units within communities. Community health workers obtained home care kits from these centers, and by the end of the project, more than 5,000 kits had been procured and distributed by the two home-based care programs. These programs catered to more than 5,000 PLHA by providing them with palliative and psychosocial care. They were also a crucial link to comprehensive care, with close to 1,000 of their clients on ART at various centers within the province. Approximately 722 active community health workers were supervised by 117 trainers of trainers. The HBC program helped identify 13,200 OVC and linked them to support organizations for assistance.

HBC initiatives at both Mumias and Bungoma started with six sites in 2001. Due to increasing need, activities were replicated to contiguous areas; there were 20 sites at project close-out.

PLHA organized themselves into support groups that held regular update meetings, some of which accessed microfinancing for income generation. Some groups submitted proposals and received funding from the National AIDS Control Council.

Care and treatment and HBC initiatives were administered under MOH guidelines. FHI helped MOH supervisors visit the HBC sites and ensure quality of care. The growing number of clients suggested that the quality of care was perceived to be high. The involvement of the local health ministry in planning, training, and program implementation ensured ownership and sustainability of the initiatives.

Nairobi Province

Although IMPACT/Kenya had worked at the national level with government and other partners to shape policy, it was not until June 2004 that program interventions were initiated in Nairobi Province, including counseling and testing and ART.

In September 2004, in collaboration with the University of Nairobi Institute of Tropical & Infectious Diseases, IMPACT supported comprehensive care services in five clinics in Nairobi Province. IMPACT facilitated HIV/AIDS care and treatment to a cohort of sex workers from the Pumwani and Majengo slums in Nairobi. The care and treatment component focused on two cohorts established more than two decades ago: the Pumwani Commercial Sex Workers Cohort and the Pumwani Mother to Child Perinatal Transmission Cohort. Participants had been receiving a relatively high standard of general medical care without ART. The provision of ARV care and treatment significantly improved the lives of these women and indirectly their families.

Over the one-and-a-half years of IMPACT support the following were achieved:

- A total of 78 HIV positive patients were placed on reliable provision of ARV drugs (70 adult females, 5 adult males, and 3 children).
- A total of 257 HIV positive patients were on clinical care (245 adult females, 6 adult males, and 6 children).
- Staff said that the training courses they have been offered through the project, together with the regular monthly and quarterly meetings, have strongly empowered them.
- Due to the close monitoring of patients who are on ARVs, both clinically and with efficient regular laboratory back-up, significant drug toxicity and side effects are less than 1 percent.

Provider Network Support in the Private Sector and Workplace

Initially with private funding, FHI and the Kenya Medical Association signed an agreement in December 2005 to implement an ART Private Provider Network, which later became known as the Gold Star Network. The goal of the Gold Star Network was to expand access to comprehensive and quality HIV care and ART services in the private sector, based on a franchised care model that was delivered through a network of providers in Nairobi, Mombasa, and Nakuru. This was later expanded to cover other sites in Kenya. The Gold Star Network program included training, clinical support, pharmaceuticals, laboratory tests, counseling support, and network information management. With IMPACT funding, 85 private practitioners were trained and 1,500 patients were enrolled in ART.

Pediatric HIV Treatment, Care, and Support

Recognizing the fact that the number of HIV-infected babies continues to increase significantly in Africa even in the face of scaled-up PMTCT services, in 2001 the IMPACT-supported CCC at Coast Provincial General Hospital linked to a pediatric AIDS clinic established by New York University Medical School's Center for AIDS Research. Looking to replicate the model of collaboration with NYU in Coast Province, IMPACT/Kenya collaborated with NYU Medical School to provide technical assistance in pediatric HIV and ART. Eight pediatricians and clinicians with pediatric responsibilities participated in a three-week clinical training course at NYU. In 2004, under NASCOP leadership and with funding from the Kenyan government, IMPACT/Kenya and other technical agencies developed a comprehensive pediatric HIV treatment and care training package and delivery system. In February 2005, select IMPACT-supported ART sites in Kenya received pediatric ARV formulations through PEPFAR. This was a breakthrough in addressing the urgent needs of HIV-positive children.

Through IMPACT support, 30 pediatric specialists received training in pediatric HIV comprehensive care. Original participants included clinicians at provincial hospitals, high-volume district hospitals, and national ART sites, as well as private practitioners already implementing treatment for children. Each pediatric training course graduate received a certificate and an ANECCA pediatric AIDS handbook, published by FHI with USAID funding. As of June 2005, the pediatric cohort at FHI-supported sites had grown to more than 1,683 children, 553 of whom are on ARVs.

Ongoing activities to strengthen PMTCT and pediatric HIV treatment and care at existing ART sites include improving follow-up and providing HIV primary care services in maternal and child health (MCH) or out-patient department (OPD) clinics, and strengthening referrals for symptomatic women and children to CCCs.

Support for a National and District Level Response

IMPACT/Kenya had significant achievements through interventions to support the Expanded Comprehensive Response to the HIV/AIDS epidemic, Health Professionals Program, the HIV/AIDS curriculum development for Kenya Medical Training College, and disbursement of Rapid Response Fund grants.

Expanded Comprehensive Response (ECR) to the HIV/AIDS Epidemic

IMPACT/Kenya helped the NACC implement an expanded and comprehensive response. The goal was to ensure rapid delivery of a comprehensive range of interventions and programs to reduce the transmission and impact of HIV on the populations in three pilot districts: Bungoma in Western Province, Malindi in Coast Province, and Nakuru in Rift Valley Province. Implementation of this comprehensive response in Kenya covered 13 parliamentary constituencies with a total population of 2,579,590.

The Kenyan government, through the NACC, took ownership of and adopted the ECR approach as a major multisector and interagency coordination framework to advance the community level comprehensive HIV/AIDS response. Implementation of the ECR framework was aligned to the

NACC Strategic Plan. It is also being used as one of the main strategies for scaling up the HIV/AIDS epidemic response at the district and constituency levels.

Each of the three ECR pilot districts established a District ECR Technical Committee that sought to coordinate and monitor ECR-related activities in collaboration with the District Development Committees. Membership of the District ECR Technical Committee was drawn from government, NGOs, CBOs, FBOs, and the private sector.

The three pilot districts successfully implemented constituency-level ECR work plans that resulted in

- training of Constituency AIDS Control Committees (CACCs) to strengthen community level HIV/AIDS prevention and control structures. Seventy-one members of the CACC (Malindi and Magarini) were trained to coordinate and respond to HIV and AIDS in the district. The CACCs opened their bank accounts so the NACC would send funds for coordination. The CACCs then started to meet on the first Wednesday of each month to discuss the progress of activities, status of funding, and use of funds by community-based organizations.
- training and assisting DDCs, CBOs, and FBOs to implement comprehensive and rapid response strategies. To address management and technical capacity gaps, 90 CSOs from the two constituencies of Malindi and Magarini were trained in all HIV/AIDS technical areas (BCC, VCT, ART, PMTCT, HBC, M&E), resource mobilization, project management, financial management, and proposal writing.
- helping CBOs, FBOs, and CACCs scale-up HIV/AIDS activities
- helping map and mobilize resources for CBOs, FBOs, and CACCs
- helping constituencies in participatory M&E
- enabling districts to develop HIV/AIDS service directories and referral systems

Implementation of constituency ECR work plans in all three pilot districts occurred within the framework of overall district-level HIV/AIDS prevention and control programs, including the government, NGO, CBO, and FBO sectors. In areas where ECR was satisfactorily conceptualized and implemented, it was found to be a practical tool that increased the value of HIV/AIDS programming, especially at the community level, where it enables community members to take ownership of programs aimed at responding to the HIV/AIDS epidemic.

The Health Professionals Program

In 2005, IMPACT/Kenya launched an innovative initiative known as the Health Professionals Program, the first of its kind. The HPP was a strategic response to the shortage of trained HIV/AIDS medical staff and a growing need for improved treatment of PLHA in Kenya. HPP was developed in partnership with NASCOP, the Kenya Medical Training College, and IMPACT/Kenya. The primary focus of the program was to upgrade HIV/AIDS service delivery skills of selected newly trained health professionals, the *HPP fellows*, to safely and accurately provide comprehensive care for HIV-infected persons. The six key activities of the HPP were classroom training, field agency orientation, internships, the NYU Grand Round, a dissemination meeting of the lessons learned, and placement of HPP participants. Originally the HPP was funded centrally from USAID/Washington in 2003, although IMPACT/Kenya supported the

grand rounds held in Kenya and the HPP fellows benefited from the field orientation that was funded through IMPACT's partnership with the MOH.

Kenya Medical Training College

In May 2004, IMPACT/Kenya entered into an agreement with the Kenya Medical Training College (KMTC) to strengthen its capacity to train Kenyan healthcare staff working in HIV/AIDS care and treatment. The main strategy consisted of rapidly improving KMTC pre-service and in-service curricula and training modules, in order to provide the most accurate and up-to-date knowledge and skills to the Kenyan paramedical workforce (clinical and nonclinical). The curricula and training modules targeted 200 nurses, 200 clinical officers, and 200 laboratory technologists and pharmaceutical technologists, as well as 200 nutritionists. During the project, a ten-module HIV/AIDS Comprehensive Care Curriculum was developed. In addition, 92 KMTC lecturers were trained as trainers in HIV/AIDS.

Faith-based Organizations

IMPACT/Kenya reached out to the religious community. It shared information and concerns, and enlisted FBOs to further HIV/AIDS prevention, care, and support efforts. Activities included the following:

- IMPACT/Kenya supported MAP International in developing an HIV/AIDS curriculum for theological schools. Fifteen institutions incorporated this curriculum into their pastoral training programs.
- St. Mary's Hospital, a Catholic Mission Hospital in Western Province, was an early IMPACT partner. FHI supported the hospital in expanding its care and support services to a Comprehensive Care Center for HIV, providing HIV testing and counseling, PMTCT, and ART. The hospital also implements a home-based care and orphan support program targeting the surrounding community.
- IMPACT/Kenya funded and collaborated with the Mumias Muslim Community Project (MUMCOP), a Muslim-based organization, to provide HIV prevention messages to youth 15–24 and madrasa teachers within the Mumias catchment area. Using the mosque as the center for peer education and community outreach, MUMCOP was able to train 120 peer educators and reach 7,800 young Muslim youth with HIV/AIDS prevention messages. A draft curriculum incorporating relevant teachings from the Quran was developed as IMPACT came to an end.
- IMPACT/Kenya developed long-term subagreements with six key FBOs: Young Men's Christian Association (YMCA) Naivasha branch, Supreme Council of Kenyan Muslims (SUPKEM), Anglican Church of Kenya (ACK), World Relief, Malindi Education Development Association (MEDA), and Mumias Muslim Community Project (MUMCOP). These organizations continue to make significant contributions to HIV/AIDS programming in Kenya, even in the absence of IMPACT funding.

National Organization of Peer Educators

One of the most notable successes of IMPACT/Kenya is the National Organization of Peer Educators (NOPE). It is made up of trainers from several IMPACT implementing partners, and was established in 2000. Since December 2001, when it was officially registered as a nongovernmental organization, NOPE has become the leading technical assistance provider of peer education in Kenya and East and Southern Africa.

To date, NOPE has trained more than 3,000 peer educators and trainers, of which approximately 1,000 are workplace peer educators. Roughly 860 company managers have also received sensitization on workplace HIV/AIDS policies and programs. NOPE has worked with 24 companies to develop workplace HIV/AIDS policies and programs. The quality of NOPE's services has led some of the biggest business enterprises in Kenya to request its services. This includes Unilever Tea Ltd., the Kenya Ports Authority (KPA), British American Tobacco, East African Breweries Ltd., Serena Hotels, D. T. Dobie, Coca-Cola (Nairobi Bottlers Ltd.), and the Hotel Intercontinental.

Rapid Response Funding to Local Organizations

IMPACT/Kenya developed a rapid response fund to support innovative projects created by local organizations. These grants for local organizations (capped at US\$5,000) enabled groups to try innovative approaches.

Highlights of the rapid response fund initiative included the following:

- fifty faith-based organizations and 33 groups of PLHA received rapid response funding
- more than US\$500,000 in rapid response fund grants was awarded since the program began in 1999

A sampling of FBOs benefiting from the RRF includes

- *Islamic Anti-AIDS Society*: 60 Muslim leaders studied Islamic principles and culture and developed guidelines for addressing HIV/AIDS.
- *Catholic Diocese of Kakamega*: 300 church members were trained in will-writing, legal issues, and reduction of stigma and discrimination toward widows and orphans.
- *Salvation Army*: 72 officers were trained in home-based care for terminally ill patients.
- *Pentechrist Revival Ministries*: 30 church members were trained to counsel orphans, providing them information about nutrition and ways to deal with personal loss.
- *Najaah Islamic Center*: 40 Muslim women were trained to negotiate safer sex in polygamous families.

PLHA groups receiving RRF funding for innovative projects include

- *Network of People Living with HIV/AIDS*: 300 participants attended a three-day strategic planning workshop.
- *Women Fighting AIDS in Kenya*: 10,000 posters were produced to honor the memory of those lost to AIDS and to demonstrate public support for PLHA.

- *Coast People Living with AIDS*: 20 young PLHA learned about abstinence and sexuality to reduce HIV transmission.
- *Galamoro Network*: 50 community leaders in the Mukuru slums were trained in home-based care planning, promotion of positive living, and stigma reduction.

Community-based groups were also prime candidates for RRF grants. Eighty-three groups were funded between 1999 and September 2006, including

- *Talking Horn Theatre Group*: 300 youth in Lurambi were trained and prepared to educate others on the need to reduce negative cultural practices predisposing community members to HIV infection.
- *Kenya National Association of the Deaf*: 20 deaf persons were provided with HIV/AIDS information and safer sex negotiation skills.
- *United Disabled Persons of Naivasha*: 84 parents and children were trained to minimize HIV risk and reduce the burden of care brought about by HIV.
- *Kakamega Deaf Association*: 30 deaf persons were taught about HIV/AIDS, stigma reduction, and the care and support of deaf persons affected by HIV/AIDS.

IMPLEMENTATION AND MANAGEMENT

To facilitate collaboration among IMPACT partners, FHI established field offices in Mombasa, Nakuru, and Kakamega. IMPACT/Kenya held monthly meetings bringing together the implementation team of representatives of all IMPACT partners in each province to review progress, plan future activities, and discuss opportunities and constraints. These kinds of regular interactions helped the program achieve a unique degree of collaboration.

IMPLEMENTATION

The original design of IMPACT/Kenya focused on prevention of HIV among priority communities within a comprehensive framework of services and support. The first two-and-a-half years built the foundation upon which this approach was fully launched, with enough partners and local buy-in to effectively implement a comprehensive program. This comprehensive approach—referred to as the Expanded and Comprehensive Response (ECR)—was formally endorsed by USAID/Washington. ECR is also supported by the Kenyan government through the NACC, the latter of which has worked closely with FHI to adapt the global ECR to a Kenya-specific framework that focuses mainly on an HIV/AIDS response at the constituency and community levels.

IMPACT/Kenya was a community-focused project implemented by grassroots and community-level implementing partners. The project supported the capacity building of community-based organizations, NGOs, and health facilities to design, implement, and monitor HIV/AIDS/STI prevention activities. IMPACT/Kenya awarded subgrants to the MOH and its subsidiaries for development and operation of comprehensive care, VCT, PMTCT, and blood safety centers, and to 100 Kenyan institutions and organizations implementing activities that would cover the full range of IMPACT interventions.

MANAGEMENT

The IMPACT/Kenya office management responsibilities were divided among the country director, deputy country director, and three field managers. The country director was responsible for overall management and program direction, ensuring that IMPACT strategies met both the country's needs and fit within USAID/Kenya's HIV/AIDS strategy. The country director was also responsible for partner and donor liaison and coordination. The deputy country director was responsible for coordinating technical, management, and logistical support required for program implementation. Field managers were responsible for directing implementation of activities to ensure

- program monitoring and reporting at the field level
- coordination of implementing partner activities
- representation of IMPACT/Kenya at national and provincial forums, including GOK, IPs, and other organizations implementing HIV/AIDS activities in the area
- implementation of IMPACT/Kenya activities at the field level
- dissemination of IMPACT/Kenya policies and procedures to IPs
- monitoring the use of IMPACT/Kenya-funded equipment

Professional and administrative staff in Nairobi provided technical assistance to field offices and local implementing partners. Project monitors were responsible for oversight of subagreement implementation, including design and monitoring, through quarterly meetings with local partner project managers based in Nairobi, field visits, and local partner reports.

Technical monitors provided input during the development of subagreements and provided technical assistance as issues and problems arose during implementation. Technical monitors also provided overall guidance on strategy development for each of the technical areas and prepared quarterly and other reports related to their technical areas. The technical staff at FHI in Arlington, Va., supplemented the efforts of country office staff by providing input on monitoring and evaluation, and information about the latest developments in ART, VCT, BCC, and PMTCT, and ideas on how to integrate new research findings at the country level.

IMPACT PROJECT TIMELINE

Year	Milestone
1999	<ul style="list-style-type: none"> • Established IMPACT field offices in Mombasa and Kakamega sites. • Hired key staff, procured vehicles, and developed subagreements with partners. • Defined the IMPACT peer education approach. • Started implementation activities at priority community sites. • FHI and the Population Council assessed health and NGO facilities in Nairobi that provided HIV counseling and testing. This highlighted the lack of service sites in the city.
2000	<ul style="list-style-type: none"> • Completed biological and behavioral baseline surveillance in the Mombasa project area and initiated it in the Western Province project area. • Expanded the IMPACT Project from five to ten priority sites in Western, Coast, and Rift Valley provinces. • Submitted a revised strategy and implementation plan for the IMPACT Project to USAID/Kenya in April. • Held first Technical Consultative Meeting on VCT, bringing together government, donors, and technical agencies interested in promoting VCT in Kenya. • Initiated VCT program in Mombasa. • Opened Nakuru IMPACT office. • Initiated PMTCT intervention in Busia and Kakamega sites in Western Province Kenya based on research findings that showed the significant benefits of Nevirapine in stopping HIV transmission from mother to child.
2001	<ul style="list-style-type: none"> • Held Expanded and Comprehensive Response (ECR) for HIV and AIDS Programming Symposia in Nairobi and Kakamega under NACC sponsorship. • Launched interactive radio show, <i>Kati Yetu</i>, a component of the BCC strategy, on May 5, 2001. • Completed VCT guidelines and dissemination in collaboration with NASCOP. • Completed VCT communication strategy.
2002	<ul style="list-style-type: none"> • Kenyatta National Hospital in Nairobi opened the VCT “Centre of Excellence” with technical assistance from IMPACT. • Began VCT campaign. • First ARV stakeholders meeting held in Mombasa. • USAID mid-term evaluation undertaken. • Integration of family planning into VCT study completed and disseminated. • Began behavioral surveillance survey (BSS).

	<ul style="list-style-type: none"> • Introduced the refined ECR methodology to the National AIDS Control Council for piloting in Bungoma, Malindi, and Nakuru districts.
2003	<ul style="list-style-type: none"> • Completed BCC evaluation and implemented a community BCC strategy in Mombasa. • National blood donor mobilization strategy developed with technical assistance from IMPACT. • Completed rehabilitation of TB Reference Laboratory. TB culture testing ongoing, and the capacity for drug sensitivity testing restored. • Launched the first USAID-funded ART program in a Kenyan government health facility at the Coast Provincial General Hospital. • Completed FBO assessment to establish the capacity of FBOs to implement HIV/AIDS interventions. • Began VCT couples counseling mass media campaign.
2004	<ul style="list-style-type: none"> • NASCOP developed rollout and quality assurance strategies with help from IMPACT. • Through support from IMPACT, Gertrude Garden Children's Hospital (GCCH) developed a comprehensive pediatric HIV treatment and care training package and delivery system; training curriculum; and specialized pediatric patient data forms and registers. • Introduced a clinical care computer program and piloted it at CPGH. • Naivasha and Malindi became new IMPACT geographic sites, with prevention, care, and support programs. • Developed and implemented a memorandum of understanding with the AIDS Research Center at NYU Medical School to provide technical assistance to the IMPACT Project in ART training, pediatric AIDS, and ART operations research. • KGGA integrated Sara communication materials into their HIV/AIDS program targeting in-school youth.
2005	<ul style="list-style-type: none"> • Developed a handbook on ART for the workplace that is being used by employers to provide their staff with services. • The Kenya Medical Training College produced a nine module HIV/AIDS course curriculum with IMPACT support. • Supported 22 districts in the facility-based management of health information system (HIS) through training and support supervision. • Completed computer-based ART-MIS and introduced paper-based system in all IMPACT supported CCCs. • Started a public/private sector partnership to provide technical assistance and antiretroviral drugs to private pharmacies in Kenya, collaborating with Pharm Access Africa Ltd. • Provided technical assistance to the Kenya Medical Training College to establish a health professionals program responding to the shortage of trained HIV/AIDS care and treatment personnel. • An HIV/AIDS exhibition appeared at the Nairobi Museum. It featured Sara and Nuru comic characters and helped launch an interactive multimedia program.

2006	<ul style="list-style-type: none">• Initiated a prevention program among the police in partnership with the Kenya Police.• In collaboration with NASCOP, hosted the Second National PMTCT consultative forum.• Expanded the prevention program in Narok District to target Maasai cultural leaders, cattle traders, rural Maasai women, youth in Naro town, and sex workers.• Began IMPACT Project close-out processes.
2007	<ul style="list-style-type: none">• Supported NASCOP to print HMIS tools.• Transitioned IMPACT Project interventions to APHIA Project.• Intensified the IMPACT Project close-out processes.

PROGRAM RESULTS

OUTPUTS PER PEPFAR AND NON-PEPFAR INDICATORS

* Other/Non-PEPFAR Indicators

Indicator	IMPACT achievement to-date
Abstinence and Being Faithful	
1.1: Number of individuals reached through community outreach promoting HIV/AIDS prevention through abstinence and/or being faithful ²	2,417,986
Males	427,544
Females	1,990,442
1.1.A: Number of individuals reached through community outreach promoting HIV/AIDS prevention through abstinence	1,808,114
Males	79,917
Females	1,728,197
*Number of Magnet Theatre performances	2,960
*Number of individuals/youth reached through Magnet Theatre sessions	609,872
*Number of youth peer educators trained in Magnet Theatre	362
1.2: Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	24,887
Other Behavior Change Indicators	
2.1: Number of targeted condom service outlets	14,083
2.2: Number of individuals reached through community outreach promoting HIV/AIDS prevention through other behavior change mechanisms beyond abstinence and/or being faithful	4,640,157
Males	1,995,268
Females	2,644,889
2.3: Number of individuals trained to promote HIV/AIDS prevention through other behavior change mechanisms beyond abstinence and/or being faithful	14,083
*Number of condoms distributed (male and female condoms)	52,289,016
*Workplace Programs	
*Number of workplaces implementing HIV/AIDS prevention activities	125
*Number of workforce in the above workplaces	143,425
*Number of workplace peer educators trained	3,433
*Number of workplace peer educator ToTs trained	504
Blood safety	
3.1: Number of service outlets carrying out blood safety activities <i>These include Bloodlink and six blood transfusion centers supported previously.</i>	7
3.2: Number of individuals trained in blood safety	1,287
*Number of units collected at regional blood transfusion centers	142,784

² Abstinence is a subset of Abstinence and/or Being faithful

Indicator	IMPACT achievement to-date	
Number of health care facilities receiving blood from the center	356	
Number of donor mobilizers trained	485	
Number of organizations mobilized through donor drives and outreaches	23	
Prevention of Mother-to-Child Transmission		
5.1: Number of service outlets providing the minimum package of PMTCT services according to national and international standards	66	
5.2: Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	70,002	
5.3: Number of pregnant women provided with a complete course of antiretroviral prophylaxis with their test results	4,728	
5.4: Number of health workers trained to provide PMTCT services according to national and international standards	734	
*Number of first antenatal care (ANC) visits (mothers receiving minimum package of PMTCT services)	128,805	
*Number of mothers testing HIV positive at the PMTCT supported sites	6,581	
*Number of infants provided with a complete course of antiretroviral prophylaxis (NVP)	3,192	
*Number of mothers delivering in PMTCT-supported sites	88,885	
Counseling and Testing		
6.1: Number of service outlets providing counseling and testing according to national and international standards	231	
6.2: Number of individuals who received counseling and testing for HIV and received their test results	569,485	
	Males	266,519
	Females	302,966
6.3: Number of individuals trained in counseling and testing according to national and international standards	2,629	
HIV/AIDS Treatment/ARV Services		
7.1: Number of service outlets providing ART (includes PMTCT+ sites)	56	
7.2: Number of individuals initiating ART during the reporting period (new clients)	11,751	
	Male (0–14)	370
	Male (15+)	4,097
	Female (0–14)	375
	Female (15+)	6,909
	Pregnant female (all ages)	29
7.3: Number of individuals who ever received ART by the end of the reporting period (cumulative clients)	15,451	
	Male (0–14)	609
	Male (15+)	5,348
	Female (0–14)	591
	Female (15+)	8,929
	Pregnant female (all ages)	49
7.4: Number of individuals receiving ART at the end of the reporting period	11,398	
	Male (0–14)	465
	Male (15+)	3,771

Indicator	IMPACT achievement to-date
Female (0–14)	426
Female (15+)	6,736
Pregnant female (all ages)	27
7.5: Total number of health workers trained or re-trained to deliver ART services, according to national and/or international standards	2,001
Palliative Care: Basic Healthcare (HIV/TB)	
8.1: Total number of service outlets providing HIV-related palliative care (including TB/HIV)	56
8.1.A: Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) according to national or international standards	56
8.2: Total number of individuals provided with HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB) (Indicator 8.2.A)	33,467
Males	11,639
Females	21,828
8.2.A: Number of HIV-infected clients attending HIV care/treatment services who are receiving treatment for TB disease (this is a subset of 8.2)	1,555
Males	667
Females	888
8.2.B: Number of HIV-positive clients given TB preventive therapy (this is a subset of 8.2)	697
Males	312
Females	385
8.2.C: Number of HIV-infected clients attending HIV care/treatment services, excluding TB/HIV (this is a subset of 8.2)	32,770
Males	11,327
Females	21,443
8.3: Total number of individuals trained to provide HIV-related palliative care (including TB/HIV)	1,921
8.3A: Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed) (This is a subset of all trained).	461
*Number of HIV positive patients receiving TB prophylaxis	1,668
*Number of patients receiving palliative care at home	11,455
*Number of individuals reached by community and HBC programs	330,901
*Number of CHWs trained	4,768
*Number of PLHA trained to disclose their HIV status to the public	156
Orphans and Vulnerable Children	
9.1: Number of OVC served	79,586
Males	30,243
Females	49,343
9.2: Number of providers/caretakers trained to care for OVC	14,233
*Number of ToTs trained to care for OVC	292
*Number of vulnerable households receiving USAID assistance	34,918

Indicator	IMPACT achievement to-date
Strategic Information	
11.1: Number of local organizations provided with technical assistance for strategic information activities	68
11.2: Number of individuals trained in strategic information (included M&E, surveillance, and/or HMIS)	426
*Number of studies carried out	6
Other/Policy Development and System Strengthening	
12.1: Number of local organizations provided with technical assistance for HIV-related policy development	0
12.2: Number of local organizations provided with technical assistance for HIV-related institutional capacity building	68
12.5: Number of individuals trained in HIV-related stigma and discrimination reduction	26
12.6: Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	205
Special Programs	
*Rapid Response Fund (RRF) Activities	
*Number of RRFs	210
*Cost of the RRFs in US\$	516,307
*Number of people reached/trained with RRF funds	81,412
*Workplace Access ART and Pharmacy Program	
*Number of workplaces pharmacies	18
*Number of worksites offering ARVs	49
*Number of clients receiving ART at the workplace programs	1,265
Gold Star Network Private Providers Program	
*Number of clients receiving ARVs through private practitioners program	65
*Number of private practitioners trained	59

Indicative Behavior Change Results

In late 2003, FHI evaluated its BCC strategy. The evaluation survey showed evidence of behavior change in IMPACT's target provinces: Kenyans are changing their behavior, as evidenced by increases in VCT uptake, levels of condom use, numbers of persons reached in peer education programs, and number of schools with Girl Guide HIV/AIDS programs and "Straight Talk" clubs.

PROGRAM OUTCOMES AND IMPACT

Peer Education

In a 2005 behavioral surveillance survey conducted among sex workers of Kisauni division of Coast province, women who participated in peer education activities reported fewer partners per week and more consistent condom use (86 percent vs. 64 percent). HIV prevalence was lower among peers as compared with non-peers (30.3 percent (43/142) vs. 36 percent (128/356).

Counseling and Testing

Although by the end of IMPACT 213 VCT sites had been established, as of June 2005, a cumulative 184 VCT sites—more than half of those in Kenya—had been developed with support from IMPACT/Kenya. VCT sites developed through FHI have reached 440,406 Kenyans. National policy, strategies, and curricula have been informed by the work of FHI, including quality assurance, family planning/VCT integration, and standardized VCT guidelines and curricula.

The majority of sites are integrated with family planning (84 percent). FHI facilitated the orientation of provincial health management teams and the training of trainers (39) and service providers (101 to integrate family planning/VCT service delivery. Integrated services are currently underway in 59 pilot sites across the country, including IMPACT-supported sites, and will inform national rollout of family planning/VCT integration).

Another 14 percent of sites are youth-dedicated, or have youth friendly corners. Youth ages 15–24 who are highly affected by HIV constitute 39 percent of the total number of people receiving services at FHI-supported sites.

Prevention of Mother-to-Child Transmission

The project worked with the Ministry of Health to build capacity for program planning and management, upgrade infrastructure, and increase technical knowledge among managers and staff. IMPACT also supported adherence to standardized reporting processes, including ensuring availability and use of national registers and reporting systems. At the end of 2005, the program provided test kits and Nevirapine to 164 sites spread across three provinces. At these sites 58,515 new ANC visits were recorded. Of these, 38,826 (66 percent) accessed counseling and testing; 4,210 (11 percent) HIV positive women were identified; of these, 95 percent of the women and 77 percent of the infants received ARVs. In partnership with NASCOP, IMPACT also supported the printing of PMTCT wall charts, an important part of the Kenya-adapted PMTCT training curriculum package.

Orphans and Other Vulnerable Children

IMPACT's OVC intervention was integrated within the two home-based care programs in Mumias and Bungoma. The intervention sensitized local and opinion leaders, and networked with government and other organizations on the need to address the needs of orphans. By the end of the project 79,586 OVC had received psychosocial support.

Treatment and ART Management Information Systems

IMPACT/Kenya ensured the increasing response to treatment needs in Kenya by strengthening related services. IMPACT improved counseling and testing, strengthened human resources, developed monitoring and reporting systems, used rapid start-up teams to establish new sites, and strengthened existing facilities so they could take on new services. The project also made tremendous strides in developing systems and tools for diagnosis, treatment, and follow-up. IMPACT and partners developed a paper-based ART-MIS and pilot tested it at several Nairobi ART sites to strengthen program and clinical monitoring and management. This computerized ART-MIS system was introduced in 13 high volume health facilities in August 2005 and later introduced in the remaining number of high volume health facilities at district and sub-district hospitals where the system is currently in use.

Blood Safety

Kenya is home to one of the most successful blood transfusion services in Africa, thanks to IMPACT/Kenya. USAID and FHI worked with the National Public Health Laboratories (NPHL) of the Ministry of Health to establish this national system for voluntary blood collection.

Capacity Development

IMPACT/Kenya supported the Expanded Comprehensive Response (ECR) to the HIV/AIDS epidemic and the Health Professionals Program (HPP). The program also developed HIV/AIDS curriculum for Kenya Medical Training College (KMTTC), and disbursed Rapid Response Funds (RRF).

The Kenyan government, through the National AIDS Control Council (NACC), has taken ownership of the ECR, a major multisector and interagency coordination framework. They are moving forward with a community level comprehensive HIV/AIDS response.

The HPP intervention demonstrates that it is possible to develop specific cadres of health personnel to provide HIV and AIDS services at health facilities. The KMTTC assistance has enabled the college to instill HIV and AIDS service delivery skills to health workers.

LESSONS LEARNED AND RECOMMENDATIONS

LESSONS LEARNED: BEHAVIOR CHANGE COMMUNICATION

- It is critical to have a national coordinating platform enabling BCC implementers to share work plans with each other. This enables them to leverage communication interventions and campaigns.
- District-level HIV communication committees are also critical in ensuring the quality of BCC activities, especially as the number of groups implementing prevention activities at the community level increases.
- It is important to invest in maintaining quality of interventions during scale-up of HIV-related communication interventions so effects are sustained as more people are reached.
- If a communications strategy promoting a service is to succeed, those delivering the service must ensure that supplies are available to satisfy the increased demand that will result because of the communications campaign. Service providers must also ensure that the service can be sustained, and that technical personnel are on hand to support it.
- Peer educator curricula and quality assurance policies should be standardized to ensure consistent messages are relayed to target groups.

LESSONS LEARNED: ANTIRETROVIRAL TREATMENT

- Stakeholder buy-in is essential.
- During start-up, facilities will require considerable support to improve existing infrastructure and establish systems of practice and accountability for clinical services, ARV drugs, and related commodities.
- Site support to establish services after initial start-up inputs is critical and should be done by experienced mentors and clinicians.
- Systems for supervision and monitoring must be established or strengthened through capacity building for ART services to be sustained.
- Because of increasing workloads, treatment decentralization that sends stable patients to primary care sites should be planned well in advance. Nurses and other cadres should be prepared to receive and manage the cases referred downwards.
- Hubs of referral sites should be established from where capacity for laboratory monitoring and review of difficult or failing cases is established.
- Entry into care and treatment should be broadened beyond VCT. This will allow for the identification of more people eligible for treatment from SDPs in the care system.

LESSONS LEARNED: COMPREHENSIVE CARE

- Existing government structures should be used by NGOs and FBOS to ensure sustainability and avoid duplication of efforts.
- Using CHWs as ToTs and community mobilizers reduces the cost of capacity building (as opposed to using institution-based training).
- The introduction of diagnostic testing and counseling in health facilities has led to increased uptake of testing and access to care.
- There is a need for satellite/outreach comprehensive care centers (CCCs) clinics around heavy workload CCCs in each province

- In the absence of VCT supervisors, monthly counselor meeting can serve as an intergroup supervisory mechanism.

LESSONS LEARNED: EXPANDED COMPREHENSIVE RESPONSE

- Buy-in from the Kenyan government, through relevant line ministries and key HIV/AIDS stakeholders, is critical for successful ECR roll-out and mainstreaming.
- If well-conceptualized and systematically implemented, the ECR framework is a practical tool that can increase the value of HIV/AIDS program implementation and output, particularly at the community level. This is because ECR enables community members to take ownership of program interventions aimed at responding to the HIV/AIDS epidemic.
- Community capacity organizational assessment is an important step in identifying programmatic and technical gaps. Identified gaps were instrumental in initiating the agenda for ECR roll-out.
- ECR facilitates greater collective commitment among HIV/AIDS implementers for sector-wide planning, implementation, and evaluation (teamwork/partnerships, networking/collaboration, information-sharing, resource mobilization, and accountability).

LESSONS LEARNED: ORPHANS AND VULNERABLE CHILDREN

- Efforts should be made to integrate OVC interventions within broader HIV/AIDS programs. An integrated, interlinked, and comprehensive program will do a better job of addressing the needs of children and adults.
- Projects must be flexible and adaptable to local settings. To that end, targeted communities should be involved in program design and implementation. Involving the community will also promote ownership of the project, increasing its chances of success and sustainability.
- OVC programs must provide services that the community considers useful. While psychosocial health is important, interventions must also provide material goods such as shelter, food, and other forms of tangible support.
- Though the extended family is considered the preferred choice for the care of orphans and other vulnerable children, it is not always the best option. In instances of abuse or acute poverty, alternative solutions must be sought.

HIGHLIGHTS OF IMPLEMENTING PARTNER ACTIVITIES

Partner	Organizational Type	Geographic Location	Target Population	Budget	Intervention	Project Dates
African Medical Research Foundation (AMREF)	NGO	Coast, Rift Valley, and Western	Worksites and low income women	US\$886,699	Condom distribution, STI diagnosis and IEC/BCC/BCI	8/99–6/05
African Medical Research Foundation (AMREF)	NGO	Coast, Rift Valley, and Western	Transport employees	US\$338,862	Condom distribution, STI diagnosis, and IEC/BCC/BCI	4/04–6/06
Family Planning Association of Kenya (FPAK), now known as Family Health Options Kenya (FHOK)	NGO	Coast, Rift Valley, and Western	Workplaces and communities	US\$805,904	VCT, condom distribution, and STI diagnosis	8/99–6/06
International Centre for Reproductive Health (ICRH)	NGO	Coast	Sex workers, worksite employees, health workers, and people living with HIV/AIDS/TB	US\$1,196,481 US\$433,149	VCT, TB, HBC, PMTCT, and condom distribution	4/03–6/06 8/00–7/03
National Organization of Peer Educators (NOPE)	NGO	Coast, Rift Valley, and Western	Worksite employees, their families, and surrounding communities	US\$422,174	Workshops/conferences, technical assistance, advocacy, IEC, and condom distribution	4/03–6/06
Solidarity with Women in Distress (SOLWODI)	NGO	Coast	Sex workers	US\$155,147	Condom distribution, IEC/BCC/BCH and HBC	4/03–6/06
Strengthening Community Partnership and Empowerment (SCOPE)	NGO	Coast	Youth and women	US\$115,109	Condom distribution, IEC/BCC/BCH, and HBC	4/03–6/06
Kenya AIDS NGOs Consortium (KANCO)	NGO	Coast, Rift Valley, and Western	Community- and faith-based organizations	US\$4833,027	IEC/BCC/BCI, advocacy, and human capacity-building	12/99–3/06

Partner	Organizational Type	Geographic Location	Target Population	Budget	Intervention	Project Dates
Kenya Girl Guides Association (KGGA)	Other	Coast, Rift Valley and Western	Youth in school	US\$592,825	IEC/BCC/BCI	8/99–6/06
MKOMANI CLINIC	NGO	Coast	Women in low income communities	US\$842,596	VCT, condom distribution, STI diagnosis, IEC and HBC	11/99–6/06
Program for Appropriate Technology in Health (PATH)	NGO	Coast, Rift Valley, and Western	IMPACT partners	US\$3,779,867	Technical assistance	11/99–6/06
Society for Women and AIDS in Kenya (SWAK)	NGO	Coast, Rift Valley, and Western	Vulnerable women and girls	US\$794,227	Children and women affected by HIV/AIDS, HBC, and nutrition	8/99–9/06
University of Nairobi STD Project	University	Rift Valley and Western	Sex workers	US\$870,677 US\$786,508	Condom sales/distribution, STI diagnosis and treatment, IEC/BCC/BCI, VCT, PMTCT, ART, and HBC	9/99–6/02 10/02–3/06
Bungoma Organization for Empowerment of Women (BOEW)	NGO	Western	Low income women and young men	US\$217,666	Condom distribution, STI diagnosis and treatment, and VCT	5/00–6/06
St. Mary's Hospital Mumias	Other	Western	Community and PLHA	US\$450,012	ART, VCT, HBC, PMTCT, clinic-based care, and delivery of OI services	12/00–6/06
Kenyatta National Hospital (KNH)	Other	Nairobi	General population	US\$744,960	VCT, ART	9/00–6/06
Ministry of Health – Blood Safety	Government	Countrywide	Upgrade BTC staff and target general population, especially youth	US\$524,041	Blood safety	7/00–3/05

Partner	Organizational Type	Geographic Location	Target Population	Budget	Intervention	Project Dates
Population Services International (PSI)	NGO	Coast, Rift Valley, and Western	Youth and adults	TO# 7 US\$ 3,779,867 TO# 8 US\$ 77,830 TO#9 US\$ 1,374,486 TO#11 US\$ 435,147	VCT	11/99–6/06 4/01–12/01 2/02–5/05 11/05–6/06
Ministry of Health – Nakuru	Government	Rift Valley	General population and health professionals	US\$736,175	HBC, VCT, PMTCT, and ART	5/03–3/06
Ministry of Health – Western	Government	Western	General population and health professionals	US\$724,461	HBC, VCT, PMTCT, and ART	7/03–6/06
KIMA Integrated Community Based Program	FBO	Western	Low income women	US\$114,487	Condom distribution, STI diagnosis and treatment, and VCT	12/03–6/06
Ministry of Health – Coast	Government	Coast	General population and health professionals	US\$623,803	HBC, VCT, PMTCT, and ART	7/03–6/06
Kenya Association of Professional Counselors (KAPC)	NGO	Coast, Rift Valley, and Western	Youth in and out of school	US\$240,970	Development and production of IEC materials and guidelines	5/04–3/06
Kenya Medical Training College (KMTC)	Government	Coast, Nairobi, Rift Valley, and Western	Health workers and medical students	US\$310,947	Human capacity building	5/04–6/06
Saidia Aid in Africa (SAIDIA)	NGO	Kenya	Community and TB patients	US\$143,605	TB	5/04–6/06
National AIDS and STD Control Program (NAS COP)	Government	Countrywide	PLHA, health professionals, and stakeholder organizations	US\$675,270	Development and productions of materials and guidelines	5/04–6/06

Partner	Organizational Type	Geographic Location	Target Population	Budget	Intervention	Project Dates
Pharm Access Africa Ltd.	NGO	Coast, Rift Valley, and Western	Private sector workforce and their families	US\$519,927	Logistics and drug management	5/04–6/06
National Museums of Kenya (NMK)	Other	Coast, Rift Valley, and Western	NMK staff, general population, in- and out-of-school youth	US\$176,100	Advocacy, IEC/BCC/BCI	5/04–9/05
Ministry of Health – National Leprosy and Tuberculosis Program (NLTP)	Government	Coast	Vulnerable slum population and the general population with TB	US\$525,643 US\$169,392	Tuberculosis (TB)	6/03–6/06 4/01–3/03
MOH – Nairobi	Government	Kenya	General population, health professionals	US\$441,192	HBC, VCT, PMTCT, and ART	6/04–6/06
Mumias Muslim Community Program (MUMCOP)	FBO	Western	Out-of-school youth and madrasa pupils	US\$95,133	IEC/BCC/BCI	3/04–6/06
John Hopkins University (JHPIEGO)	NGO	Coast, Rift Valley, and Western	General population, healthcare workers, and PLHA	US\$250,000 US\$157,077	IEC/BCC/BCI	8/01–11/02 10/04–5/05
Kenya National Outreach, Training and Counseling Program (K-NOTE)	NGO	Coast	Youth of school age	US\$93,606	Condom distribution and IEC/BCC/BCI	9/04–3/06
Young Men's Christian Association (YMCA)	FBO	Coast	Church and mosque-going congregations	US\$104,632	IEC/BCC/BCI	9/04–6/06
Life Bloom Services	NGO	Coast	Youth and sex workers	US\$80,548	Condom distribution, IEC/BCC/BCI	10/04–6/06

Partner	Organizational Type	Geographic Location	Target Population	Budget	Intervention	Project Dates
Kenya Police	Government	Coast, Rift Valley and Western	Police force	US\$196,522	IEC/BCC/BCI	12/04–6/06
Nairobi Women's Hospital (NWH)	Other	Coast, Rift Valley and Western	Women and girls	US\$133,838	IEC/BCC/BCI and ART	10/04–6/06
Gertrude Garden Children's Hospital	Other	Nairobi	Children living with HIV care providers and health providers	US\$205,196	ART, IEC	11/04–6/06
New York University (NYU)	University	Coast, Rift Valley and Western	Health providers (doctors)	US\$171,651	ART	11/04–6/06
Blood-link Foundation	NGO	Countrywide	Corporate employees	US\$52,796	Blood safety	6/05–6/06
Mama na Dada Africa	NGO	Western	Youth out of school	US\$36,587	IEC/BCC/BCI	8/05–4/06
University of Nairobi Institute of Tropical and Infectious Diseases (UNITID)	University	Nairobi	PLHA	US\$183,386	ART	11/04–6/06
Supreme Council of Kenya Muslims (SUPKEM)	FBO	Nairobi	Muslim Community in Kenya	US\$73,220	IEC/BCC/BCI	9/05–5/06
Family Programs Promotion Services (FPPS)	NGO	Nairobi	Youth	US\$74,919	IEC/BCC/BCI and condom distribution	9/05–4/06
Kenya Wildlife Services (KWS)	Government	Nairobi	KWS rangers and staff personnel	US\$77,489	IEC/BCC/BCI	11/05–6/06
World Relief	NGO	Nairobi	Religious congregations focusing on youth	US\$101,543	IEC/BCC/BCI and technical assistance	8/05–4/06
Crystal Hill	NGO	Western	Worksite employees and their families	US\$57,289	Technical assistance	11/05–6/06

Partner	Organizational Type	Geographic Location	Target Population	Budget	Intervention	Project Dates
Muslim Education Development Association (MEDA)	NGO	Coast	Youth	US\$40,272	Condom distribution, IEC/BCC/BCH and HBC	8/05–4/06
Goal Kenya	NGO	Nairobi	Youth and street and slum children	US\$85,223	IEC/BCC/BCI	12/05–6/06
Tumaini Awareness Group	NGO	Nairobi	Youth	US\$43,913	IEC/BCC/BCI	11/05–6/06
St. Johns Ambulance	NGO	Nairobi	Youth	US\$60,131	IEC/BCC/BCI	8/05–4/06
Anglican Church of Kenya (ACK)	FBO	Coast, Rift Valley, and Western	Youth	US\$123,145	IEC/BCC/BCI	8/05–6/06
Kenya Medical Association (KMA)	Private	Coast, Rift Valley, and Western	Health providers in the private sector	US\$41,282	ART, logistics and drug management, and technical assistance	12/05–6/06
Voi Youth Forum	NGO	Coast	Matatu touts, sex workers, low income families, and petty traders	US\$12,517	IEC/BCC/BCI	11/05–6/06
World View Kenya	NGO	Nairobi	Children and families affected by HIV/AIDS	US\$35,007	IEC/BCC/BCI and children affected by HIV/AIDS	3/06-9/06
Columbia University	University	Nairobi	PLHA	US\$150,055	Operations research	10/05–6/06
Pathfinder International	NGO	Coast and Rift Valley	PLHA, their families, caregivers and OVC	US\$1,225,000	HBC	4/05–1/06
Childcare International	NGO	Nairobi	OVC and PLHA	US\$49942	IEC/BCC/BCI, children affected by HIV/AIDS	12/06–9/06
Apex Communications	NGO	Nairobi	Youth, adults, and PLHA	US\$47,599	Development and production of IEC materials and guidelines	7/05–3/06
Center for British Teachers (CfBT)	NGO	Rift Valley	Youth in school	US\$282,843	IEC/BCC/BCI	6/00–8/02

Partner	Organizational Type	Geographic Location	Target Population	Budget	Intervention	Project Dates
Map International	FBO	Nairobi	Churches and theological colleges	US\$210,953	Policy/Advocacy	8/99–3/03
Network of AIDS Researchers in East and Southern Africa (NARESA)	Private	Western	Women and mothers	US\$399,866	PMTCT	11/00–9/03
Liverpool School of Tropical Medicine	Private	Nairobi	Youth and adults	US\$ 679,197 US\$ 73,474	VCT	2/01–9/02 10/02–12/02
TOP Com Productions Ltd.	NGO	Nairobi	Youth and adults	US\$100,305	IEC/BCC/BCI	7/00–9/02
Regional AIDS Training Network (RATN)	NGO	Nairobi	Employed men, youth, and adult women	US\$117,580	IEC/BCC/BCI	7/00–6/01
ARTNET Waves Communication	NGO	Coast, Rift Valley, and Western	Youth	US\$190,275	IEC/BCC/BCI	9/99–3/01
Population Communication Africa (PCA)	NGO	Nairobi	Youth	US\$10,150	Research	2/00–1/01

PUBLICATIONS PRODUCED

Society for Women and AIDS in Kenya (SWAK)

- *Empowering Women and Girls to Fight HIV/AIDS Handbook*

Kenya AIDS NGO Consortium (KANCO)

- *Networking Guide for NGOs, CBOs and Religious Institutions: A Comprehensive Resource for Individuals and Organizations Who Wish to Build, Strengthen or Sustain a Network*
- *AIDS in Kenya: A Directory of HIV/AIDS Service Organizations Working in Kenya*

Kenya Girl Guides Association (KGGA)

- *Participatory Peer Education for HIV and AIDS Prevention: A Manual for Trainers of Peer Educators*
- *KGGA: Training of Trainers on Participatory Peer Education for HIV and AIDS Prevention (Prepared by PATH)*
- *KGGA: Handbook for Award of an HIV and AIDS Badge*
- *KGGA: Talking Points for Peer Educators*

Program for Appropriate Technology in Health (PATH)

- *Managing the Impact Peer Education Program*
- *Nuru Vol. 1, Challenges and choices*
- *Nuru Njia Panda, Toleo 1*
- *Nuru Vol. 2, Facing the Music*
- *Nuru Toleo 2, Ngoma Ikilia Sana*
- *Nuru Daring to Care, Volume 3*
- *Nuru Toleo la 3, Utu ni kuwajali wenzio*
- *Nuru Walking the Talk, Volume 4*
- *Nuru Tenda Usemavyo, Toleo 4*
- *Nuru Counting on Courage, Volume 5*
- *Nuru, Kupiga moyo konde, Toleo 5*
- *Splash Facilitators Guide, Draft*

National Organization of Peer Educators (NOPE)

- *Steps in Establishing a Workplace HIV and AIDS Program (An Advocacy Package for Managers)*

University of Nairobi

- *Behavioral Surveillance and STD Seroprevalence Survey, Western Province, Kenya, 1999, Female Sex Workers*

JHPIEGO

- VCT brochure: “Just ask me about VCT”
- An orientation package for healthcare workers in voluntary counseling and testing (VCT services in Kenya)

Population Services International (PSI)

- Voluntary counseling and testing formative research (indepth interviews with current referral-makers to VCT services and potential referral-makers to VCT services), draft report Sept. 2001
- Voluntary counseling and testing formative research (indepth interviews with current users of VCT services), draft report Sept. 2001
- Voluntary counseling and testing formative research (focus group discussions with non users of VCT services)

Kenya Medical Research Institute (KEMRI)

- Training manual for standard operating procedures (SOPs) for HIV testing at FHI VCT sites
- VCT counselor training curriculum

Kenya Association of Professional Counselors (KAPC)

- *Insyder Magazine*
- *Supa Striker Magazine*

IMPACT/Government Documents

- *VCT guidelines for orphans and other children made vulnerable by HIV and AIDS*
- Proceedings of a consultative meeting on orphans and other children made vulnerable by HIV/AIDS
- Proceedings of a consultative meeting on orphans and other children made vulnerable by HIV/AIDS, 16–19 December 2001, Matuu, Machakos, Kenya
- National condom policy and strategy, September 2001
- *National guidelines for voluntary counseling and testing*
- *Guidelines on antiretroviral drug therapy in Kenya*
- Proceedings of the consultative technical meeting on implementation of the new blood safety policy (draft) 29 and 30 April 2002
- *Guidelines for appropriate use of blood and blood products, 2nd edition*, April 2004

Government Documents/Guidelines

- *The Kenya National HIV/AIDS Strategic Plan 2000–2005* (Popular version)
- *AIDS in Kenya: Background, Projections, Impact, Interventions, Policy, Sixth edition*, 2001
- *VCT guidelines on orphans and other children made vulnerable by HIV and AIDS*

- Proceedings of a consultative meeting on orphans and other children made vulnerable by HIV/AIDS, 16–19 December 2001, Matuu, Machakos, Kenya
- Proceedings of the Consultative Technical Meeting on HIV: Voluntary Counseling and Testing (7 and 8 September, 2000, Nairobi, Kenya)
- *National Guidelines for Voluntary Counseling and Testing*
- *Guidelines on Antiretroviral Drug Therapy in Kenya*
- Brochure: “Kenya Blood Transfusion Service”
- Policy Guidelines on Blood Transfusion in Kenya
- *Kenya National Manual for Training Counselors in Voluntary Counseling and Testing for HIV – NASCOP 2003* (Trainers’ Notes and Handout)
- *National Quality Assurance Strategy for Voluntary Counseling and Testing*
- *TB/HIV Guidelines: What Health Care Workers Need to Know about Implementing TB/HIV Collaborative Activities*
- *HIV/AIDS and Sexually Transmitted Infections in Kenya: Behavioral Surveillance Survey 2002*

Booklets for Low Literacy Audiences

- “ART: Managing the side effects”
- “Maudhi yanayotokana na dawa za ART”
- “How to avoid Opportunistic Infections”
- “Maelezo Kuhusu Magonjwa Tegemezi”
- “Basic facts about ART”
- “Maelezo Kuhusu dawa za ART”

Brochures for Literate Audience

- “Antiretroviral Therapy (ART): Managing the Side Effects”
- “Maudhi yanayoweza Kutokea unapotumia dawa za ART”
- “Antiretroviral therapy (ART) ART may help you feel strong even if your immune system is weak”
- “Maelezo Kuhusu dawa za ART, Dawa za ART zinaweza kukuongezea nguvu hata kama kinga yako ya mwili imedhoofika”
- “Understanding Opportunistic Infections”
- “Maelezo Kuhusu Magonjwa Tegemezi”

Cards

- “How to use ART drugs”
- “Jinsi ya kutumia dawa za Antiretroviral (ART)”

Flip Charts

Healthy Living: A counseling guide for health workers in:

- Opportunistic infections, antiretroviral therapy (ART) and
- Management of ART side effects

Kenya Police

- Pocket diary
- Poster

Kenya Wildlife Service

- Calendar
- Pocket diary
- Posters
- Flipchart