

Kenya Nutrition and HIV/AIDS Strategy



2007 to 2010



REPUBLIC OF KENYA
MINISTRY OF MEDICAL SERVICES



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Kenya Nutrition and HIV/AIDS Strategy 2007 to 2010

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Kenya Nutrition and HIV/AIDS Strategy

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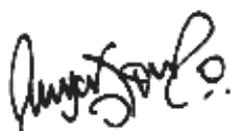
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Foreword

The national HIV/AIDS programmes are guided by the Kenya's National AIDS Strategic Plan (KNASP) and the National Health Sector Strategic Plan II (NHSSPII) for 2005-2010. These plans provide an action framework for the national response to priority areas of the epidemic as well as goals and targets for respective interventions. From these corporate plans, the National AIDS/STI Control Programme (NAS COP) along with stakeholders in nutrition care and support have developed a business plan with a nested functional strategy to guide nutrition interventions during the remaining plan period.

Globally, the ravages of the pandemic on productivity and purchasing power have heightened the risk of malnutrition among infected and affected persons. Furthermore, reduced access to adequate quality food, poor appetite due to disease or medications, increased energy demands, and malabsorption associated with HIV disease progression cause malnutrition. High rates of malnutrition among eligible antiretroviral therapy (ART) patients and emerging evidence on the significance of moderate and severe malnutrition as an independent predictor of mortality of people living with HIV/AIDS (PLWHA) underline the need to scale up nutrition interventions. With improved understanding of the relations between HIV disease and nutrition, prevention and correction of malnutrition are now universally integrated into the response to the HIV/AIDS pandemic to reduce the rates of malnutrition and associated morbidity and mortality as well as improve responsiveness, effectiveness and treatment outcomes.

The 2006 national HIV/AIDS statistical estimates indicate significant scale up of ART and prophylactic therapy. With first line interventions scaled up to national level, compelling knowledge and experience in nutrition care and support require consolidation and scale up to ensure realisation of the goals and targets agreed upon in KNASP and NHSSPII. This strategy operationalises the scale up of nutrition interventions in HIV/AIDS by Kenya's government, development partners and stakeholders. In this regard, the strategy has been developed through a participatory process and multi sectoral approach to facilitate mainstreaming for sustainability and equitability. The government fully appreciates contributions and participation by development partners and other stakeholders in preparing the strategy and for supporting ongoing nutrition interventions. We appeal to other partners and stakeholders to join this partnership to ensure that the targets agreed upon in both national and sectoral strategic plans are realised.



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Summary

The Kenya National HIV/AIDS Strategic Plan (KNASP) and the National Health Sector Strategic Plan II (NHSSP II) for 2005-2010 provide the framework for the country's response to the HIV/AIDS epidemic. The nutrition and HIV/AIDS agenda is driven by the three priority areas in the KNASP, but the main priority is improvement of the quality of life of people infected and affected by HIV/AIDS (Priority Area 2). The goal of nutritional interventions is to improve nutrition, health, quality of life and duration of survival of people infected with HIV. The targets for the period include strengthening the capacity of service providers to ensure that over 75 percent of PLWHA receive nutrition education and counselling and raising the proportion of hospitals that offer therapeutic nutritional care to 80 percent. This is intended to ensure provision of appropriate nutritional care, including supplements to all PLWHA who are eligible to receive them. Under mitigation of the impact of the epidemic, the health and nutrition needs of orphans and vulnerable children (OVC) are a key component of the livelihood target.

The Technical Working Group for Nutrition and HIV/AIDS and stakeholders held a series of consultation workshops under the aegis of NASCOP to identify strategies and targets that will drive the nutrition plan of action for the period 2007-2010. The purpose of this strategy is to accelerate mainstreaming of nutritional interventions in HIV/AIDS policies and programmes and to address key nutritional concerns of OVC with a view to realise full scale implementation at the national level. The strategy is intended to guide a two prong mainstreaming approach, namely:

- (a) Sensitising policymakers about the critical role that food and nutrition security plays and advancing nutrition and HIV/AIDS as a priority on the health agenda
- (b) Identifying nutrition interventions for integration into HIV/AIDS policies and programmes, and incorporating HIV/AIDS in food and nutrition policies and programmes

The strategy seeks to consolidate gains made, expand areas of operation in the scale up to the national level and ensure synergy. In this regard, the plan and budget estimates for implementing this strategy were determined under these areas of operation: development and production of training and educational materials, human resources capacity strengthening, quality assurance and standards, communications and advocacy, coordination and collaboration, dietary commodity support, research and dissemination, and monitoring and evaluation (M&E). Of note is the alignment of these areas to existing structures and programmes to ensure efficiency and effectiveness. Critically important is the need to ensure detailed operations plans, adequate resources, commitment by all stakeholders and an efficient M&E system. The identified operations will require a total of Ksh 6.4 billion during the three year period, an annual estimate of Ksh 2.1 billion. Eighty four percent of this budget will go toward therapeutic and supplemental foods and micronutrient supplements for treatment of malnutrition and prophylactic support. It also is critically important to integrate the strategy in the annual operations plans and the medium term expenditure framework of the health sector and other relevant sectors for sustainability, and to keep the strategy alive so that resource gaps can be addressed through emerging opportunities and innovations.

Acronyms

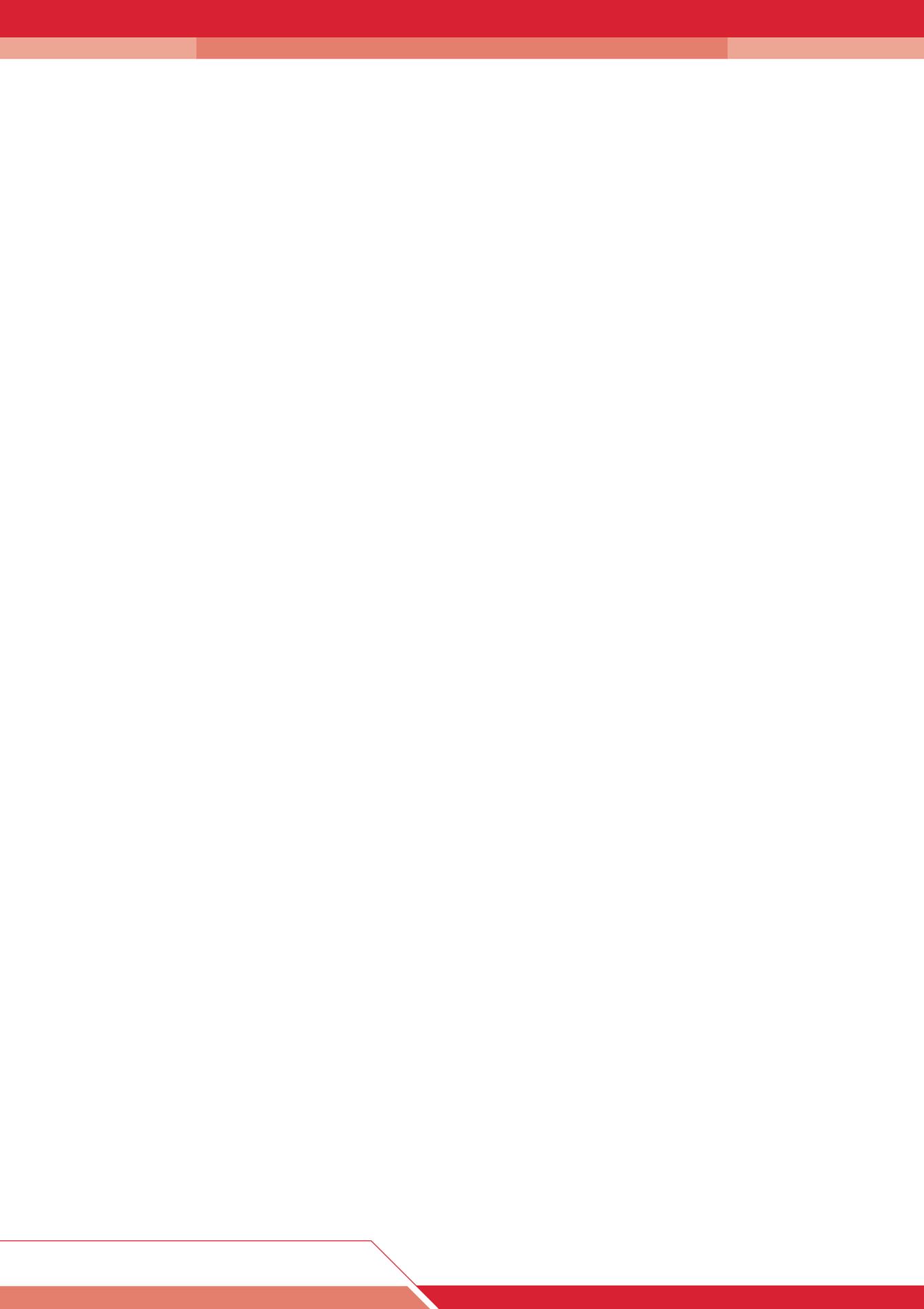
| | |
|----------|--|
| AAS | atomic absorption spectrophotometer |
| ACU | AIDS control unit |
| AED | Academy of Education Development |
| AMPATH | Academic Model for the Prevention and Treatment of HIV |
| APHIA II | AIDS, Population and Health Integrated Assistance |
| AR | applied research |
| ART | antiretroviral therapy |
| ASAL | arid and semi arid land |
| BFF | blended fortified flour |
| BMI | body mass index |
| CACC | Constituency AIDS Control Committee |
| CCC | Comprehensive Care Centre |
| CDC | Centres for Disease Control and Prevention |
| CHEW | community health extension workers |
| COBPAR | Community Based Programme Activity Reporting |
| CORPS | community owned resource persons |
| CSO | civil society organisations |
| D/CH | Division of Child Health |
| DFID | Department for International Development |
| D/Nut | Division of Nutrition |
| D/RH | Division of Reproductive Health |
| D/SRS | Division of Sector Reform Secretariat |
| DDC | District Development Committee |
| DSC | District Sectoral Committee |
| DSG | District Steering Group |
| EPZ | export processing zone |
| ERS | Economic Recovery Strategy |
| ESARO | East and Southern Africa Regional Office |
| FANTA | Food and Nutrition Technical Assistance |
| FAO | Food and Agricultural Organisation |
| FBO | faith based organisations |
| FBP | food by prescription |
| GIPA | greater involvement of people with HIV/AIDS |
| GLIA | Great Lakes Initiative on HIV/AIDS |
| GoK | Government of Kenya |
| HBC | home based care |
| HMIS | health management information system |
| HPLC | high performance liquid chromatograph |

Acronyms (Continued)

| | |
|------------|--|
| ICC | Interagency Coordinating Committee |
| ICT | information and communication technology |
| IEC | information, education and communication |
| IMCI | integrated management of childhood illness |
| IYCF | infant and young child feeding |
| JAPR | Joint Annual Programme Review |
| JICC | Joint Interagency Coordinating Committee |
| KANCO | Kenya NGOs Consortium |
| KARI | Kenya Agricultural Research Institute |
| KARSCOM | Kenya HIV/AIDS Research Coordinating Mechanism |
| KEBS | Kenya Bureau of Standards |
| KECOFATUMA | Kenya Consortium to Fight AIDS, TB and Malaria |
| KEFAN | Kenya Food and Nutrition Network |
| KEMRI | Kenya Medical Research Institute |
| KEPH | Kenya Essential Package for Health |
| KFSM | Kenya Food Security Meeting |
| KFSSG | Kenya Food Security Steering Group |
| KIE | Kenya Institute of Education |
| KIRAC | Kenya Inter Religious AIDS Consortium |
| KMTC | Kenya Medical Training College |
| KNASP | Kenya's National AIDS Strategic Plan |
| KNH | Kenyatta National Hospital |
| M&E | monitoring and evaluation |
| MEDS | Mission for Essential Drugs and Supplies |
| MGCSSS | Ministry of Gender, Culture, Sports and Social Services |
| MMN | multiple micronutrients |
| MoA | Ministry of Agriculture |
| MoE | Ministry of Education |
| MoH | Ministry of Health |
| MoLFD | Ministry of Livestock and Fisheries Development |
| MoHA | Ministry of Home Affairs |
| MoYA | Ministry of Youth Affairs |
| MSF | Médecins Sans Frontières (MSF) |
| MTEF | Medium Term Expenditure Framework |
| MUAC | middle upper arm circumference |
| NALEP | National Agriculture and Livestock Extension Programme |
| NASCOP | National AIDS/STI Control Programme |
| NEPHAK | National Empowerment Network of People Living with HIV/AIDS in Kenya |

Acronyms (Continued)

| | |
|---------|--|
| NGO | non governmental organisation |
| NHSSPII | National Health Sector Strategic Plan II |
| NPHLS | National Public Health Laboratory Services |
| OP | Office of the President |
| OR | operations research |
| OVC | orphans and vulnerable children |
| PATH | Program for Appropriate Technology in Health |
| PEPFAR | The President's Emergency Plan for AIDS Relief |
| PLHWA | people living with HIV/AIDS |
| PMTCT | prevention of mother to child transmission |
| PNO | principal nursing officer |
| PPP | public private partnerships |
| PSI | Population Services International |
| RUTF | ready to use therapeutic food |
| STI | sexually transmitted infection |
| TB | tuberculosis |
| TOT | training of trainers |
| TOWA | Total War Against HIV/AIDS |
| TWG | technical working group |
| UNICEF | United Nations Children's Fund |
| UoN | University of Nairobi |
| USAID | United States Agency for International Development |
| VCT | voluntary counselling and testing |
| WFP | World Food Programme |
| WHO | World Health Organisation |





Chapter 1:

INTRODUCTION

1.1 Conceptual Perspective

An effective response to the HIV/AIDS epidemic in Kenya requires an enhanced ability to ensure the food and nutrition security of individuals and communities to complement other established interventions. According to the Kenya National HIV/AIDS Strategic Plan (KNASP) for 2005-2010, 75 percent of PLWHA will receive nutrition education and counselling, and appropriate food nutritional supplements will be provided to all who need them. These targets were set to facilitate realisation of the national goals of improving the quality of life of people infected and affected by HIV/AIDS. In this regard, the Kenya Essential Package for Health (KEPH), under the National Health Sector Strategic Plan II (2005-2010) identified improvement of nutrition support services as a key area of intervention. The targets are to provide nutrition support services in ART centres and to raise the proportion of hospitals offering therapeutic nutritional care to 80 percent.

In the past two years, significant progress has been made toward realisation of these objectives. Midway in the plan period, achievements are below the targets set by both KNASP and NHSSP II. To roll out required interventions, the MoH, through NASCOP, development partners and stakeholders, developed a business plan for nutrition interventions in HIV/AIDS. The Kenya Nutrition and HIV/AIDS Strategy provides a framework for accelerating progress toward improving the nutritional status of PLWHA in Kenya by preventing malnutrition, improving nutrition and reducing the impact of the pandemic on individuals and communities.

1.2 Contextual Perspective

In the Economic Recovery Strategy (ERS), the HIV/AIDS agenda underlines the government's decision to set up special health care programmes for PLWHA, train communities on HIV/AIDS home based care, implement the HIV/AIDS curriculum in all schools and strengthen the health sector's response to HIV/AIDS by forming Constituency AIDS Control Committees (CACC). Under the nutrition agenda, the ERS spells out the decision to carry out awareness campaigns on the benefits of improved nutrition and promote production and consumption of nutritious food. In this respect, the draft sessional paper on Food Security and Nutrition Policy (2007) underlines the negative impact of high prevalence of HIV/AIDS on the country's socioeconomic development and calls for specific actions to mitigate the impact of the scourge.

These policy decisions are based on the fact that HIV infection affects nutrition through reduction in dietary intake, nutrient malabsorption/wastage and complex metabolic alterations that culminate in weight loss, wasting, disruption of fat and bone metabolism and changes in micronutrients levels due to loss or sequestration in response to inflammation. Breaking the cycle of poor nutrition and infection among PLWHA will prevent new infections, improve quality of life and mitigate the socioeconomic impact of HIV/AIDS. Furthermore, nutrition is increasingly being advocated as an adjunct in ART. These recommendations are based on the need to improve immune reconstitution and adherence to treatment, and on the potential role of nutrition interventions in prolonging the pre ART stage. Outside the rationale related to quality of life, poor food and nutrition security spurs risky behaviour that accelerates the spread of HIV infection. Thus, nutrition and food security play across all three areas of KNASP, namely prevention of transmission, enhancement of quality of life and mitigation, especially for OVC and affected families.

Among children, HIV infection causes growth faltering even before the onset of the infection's symptomatic phase. This hinders child development and is associated with increased risk of mortality. Interventions aimed at improving dietary intake are essential to enable infants and young children to cope with infections and regain lost weight, so these interventions are a priority. In this regard, policy guidelines on prevention of mother to child transmission (PMTCT) for infant and young children feeding (IYCF) have been developed (MoH, 2004). With improved child survival, focusing on the nutritional needs of older infected children is also important. In addition, while WHO standards for children age 0-14 years can be adapted, indicators and cutoff points that are specific to 5- to 13-year olds will be required in further development of the OVC component.

Universal access of PLWHA and those affected to nutritional support programs is a key indicator of success in the fight against the epidemic. Kenya's main gap in the realisation of universal access to nutritional care and support is the weak integration of nutrition interventions in HIV/AIDS policies and programmes and in the national health care services in general. The slow scaling up of nutritional support programmes is partly attributed to inadequate evidence of the impact of nutritional interventions on adherence to ART and compliance to care plans and the impact of the nutrient formulation of food supplements and nutraceuticals that are commonly recommended for PLWHA, as well as the feasibility of incorporating nutrition supplements into treatment and care programs. Moreover, inadequacies in health care systems with respect to personnel, equipment and supplies along with insufficient information and training at all levels on topics related to nutrition care of PLWHA and those affected by HIV/AIDS remain major drawbacks.

1.3 Purpose and Scope

The nutrition and HIV/AIDS strategy aims at developing model strategies to be implemented by institutions and organisations who provide services involved in the national response to the epidemic and by policymakers who support such institutions. The strategy describes activities and functions for the organisations and institutions to ensure efficient and effective delivery of food and nutritional services and to ensure that they influence the quality of life and survival of infected and affected persons.

Purpose

The purpose of the nutrition and HIV/AIDS programme strategy is to accelerate mainstreaming of nutritional interventions in HIV/AIDS policies and programmes with a view to making them an integral part of the national response at all levels of programming based on the following:

- (a) Articulating strategic priorities in food and nutrition for the Kenyan response to HIV/AIDS to ensure that nutrition support services are directed at those areas that are likely to realise highest benefits for PLWHA
- (b) Consolidating achievements and improving the quality and coverage of services and institutionalising key activities within the national HIV/AIDS management framework
- (c) Identifying the roles of the various key players in the national response in the development and implementation of nutrition and HIV/AIDS interventions
- (d) Defining processes and inputs necessary for the timely realisation of the national targets

The nutrition and HIV/AIDS programme strategy will be aligned with the sectoral programmes that are directly involved in mainstreaming the fight against the epidemic and with considerations for the national food security and nutrition policy session paper, along with other relevant policies and regulations.

Scope

The strategy defines the actions required in mainstreaming and the roles and functions of various key players. It excludes details of functions of intermediaries and groups such as community based organisations (CBOs). Although the strategy is aimed to influence all stakeholders in the HIV/AIDS response, some of the functions it prescribes might not be feasible for small civil society organisations (CSOs) and faith based organisations (FBOs). It is recommended that all actors strive to implement elements of the strategy where feasible to reach all PLWHA and affected people, especially OVC.

1.4 Strategy Development Process

The strategy was developed from a review of the current constraints and opportunities and identifies objectives, goals and the activities to be implemented to achieve national goals stated in KNASP. The development of the strategy was commissioned through a series of stakeholder workshops organised by NASCOP in 2007. The National Technical Working Group (TWG) on Nutrition and HIV/AIDS comprising sub sector representatives from line ministries, public institutions, private sector and associations, and development partners was requested to drive the strategy formulation process. A participatory approach and consultative process with the key stakeholders, along with expanded representation of views were used to gain high level buy in and ownership of the strategy. Service providers from different sections of the agriculture, health, academic and private sectors and CSOs; development partners; and users were involved or consulted during the process. Key partners such as USAID, FANTA/AED, CDC, UNICEF and WHO were also engaged. The workshops were also aimed at raising awareness to drive consensus on mainstreaming nutrition and HIV/AIDS in policy and programmes designed to fight the epidemic.

The output of the workshops was used as the basis for developing this strategy. The TWG provided additional inputs to the strategy design and formulation through consultations, gathering of data on critical issues and validation of the strategy proposals.

Completing the strategy involved these steps:

- Distribution of the draft document to all workshop participants for comment
- Review of all comments received by the steering committee
- Distribution of the edited version to a wider scope of key role players and interested parties for comment
- Consolidation and final review based on all comments from the TWG



Chapter 2:

SITUATION ANALYSIS

2.1 Overview of HIV/AIDS Health Service Providers

2.1.1 National Response

The core principles of the national response strategy include adoption of a multi sectoral response, the targeting of evidence based interventions to the most vulnerable and/or special groups, meaningful involvement of PLWHA and the empowering of stakeholders to participate effectively. The institutional framework to support the national response strategy is shown in Annex 1.

2.1.2 Health Services Delivery System

Health Facilities

The types of facilities in Kenya include clinics, dispensaries, health centres, nursing homes, hospitals and stand alone voluntary counselling centres. Currently, there are 5,165 facilities in total. Dispensaries and clinics account for 77 percent of these facilities. Hospitals (301), health centres (660) and nursing homes (189) account for 17 percent of the health facilities. Among hospitals, 158 are run by the Government of Kenya (GoK) government and the remainder are either mission (70), private (70) or NGO (three) hospitals. Overall, government runs 46 percent of these health facilities. Government hospitals provide inpatient care to more patients than all other providers combined. For example, in 2006, admissions to government hospitals accounted for 63 percent of all admissions in the country.

Services central to HIV/AIDS – counselling and testing services, PMTCT, ART and home based care – are available in 471 public facilities and 342 non government facilities. In all, however, there are 350 established Comprehensive Care Centre (CCC) facilities. In line with KEPH levels, the rest are treatment centres. The distribution of government and non government facilities providing intervention services for HIV/AIDS and TB treatment are shown in Annex 2. Of significance are the policy decisions to decentralise treatment, care and support services for PLWHA to treatment centres and the establishment of stronger linkages with community and home based care programmes.

Human Resources

Available estimates indicate that there are 5,700 registered doctors, 9,000 clinical officers and 28,000 nurses in active service. The public sector is currently served by an estimated 1,960 doctors, 4,000 clinical officers, 16,227 nurses and 700 nutritionists, meaning that the majority of these front line cadres are serving in the non government health sector.

Multi-sectoral Considerations

The Ministries of Agriculture (MoA), Livestock and Fisheries Development (MoLFD), Education (MoE) and Gender, Culture, Sports and Social Services (MGCSSS), Home Affairs (MoHA) and Youth Affairs (MoYA) have elaborate community/extension services that are highly mobile and readily available to the community. Within the context of external mainstreaming of HIV/AIDS, these service providers have unique opportunities to enhance their services through integration of specific interventions in their respective community programmes. For example, the National Agriculture and Livestock Extension Programme (NALEP), which has high mobility and day to day contact with rural

community, should play a major role in alleviating food insecurity. The culture and sports sectors have responsibilities and means to tackle unfavourable cultural norms and influence traditional healers and youth through sports. The MoE is the lead agency in informing and educating youth in schools and adults through the adult education programme. Other key public sector actors include the MoHA's Children's Department, which is the lead agency in coordinating OVC support programs. The MoYA provides a tremendous opportunity for advancing youth targeted HIV/AIDS interventions in the country. Under MGCSSS, the government's push for greater empowerment of women provides another opportunity to enhance their coping capacity.

NGO Sector

Provisional analysis of reports from 11,506 NGO implementers of HIV/AIDS interventions in the country indicates that 73 percent provide nutrition support to PLWHA and affected persons. These services were provided in homes and drop in centres that serve meals to clients. Only 11 implementers reported that they were carrying out growth monitoring of children under five years old. However, details of the package, quality and effectiveness of services that they provide have not been established. Nevertheless they provide a useful link between facilities and the community in treatment, care and support – especially under the home based care programme – as well as mitigation.

2.2 Overview of National Nutritional Targets

The main malnutrition concern among PLWHA is undernutrition. (Details of predisposing factors and possible interventions are provided in the NASCOP nutrition and HIV/AIDS counselling cards, among other references.) Undernutrition among PLWHA is a priority concern even with the scale up of care and treatment programs in Kenya. Data from the ongoing Food by Prescription (FBP) programme and UNICEF's nutrition interventions for PLWHA suggest that prevalence of undernutrition (BMI <18.5) among adults reporting for care and treatment in CCCs for the first time varies between 15 percent and 65 percent. Among children, the rate of undernutrition is estimated at 30 percent. Unpublished data from ongoing interventions suggest higher rates in communities with poor food security. The rates of undernutrition among PLWHA in Kenya generally seem to follow food insecurity patterns.

In KNASP, the following targets of the nutrition and HIV/AIDS interventions were set for the first year of its implementation:

- (a) Integrating the nutritional needs of PLWHA into the training curriculum for health and community workers in the national strategies for ART, home based care (HBC), infant and young child feeding (IYCF), paediatric HIV/AIDS and reproductive health
- (b) Providing nutritional supplements to 60 percent of those who need them and are receiving ART in the public, mission and NGO sites
- (c) Strengthening the draft of the national food security and nutrition strategy to address the impact of HIV/AIDS with specific focus on vulnerable groups, including OVC and affected families

During subsequent years, efforts would be directed toward scaling up coverage and quality of services to prevent malnutrition as per targets for the plan period. The Kenya Essential Package for Health (KEPH) includes provision of nutrition support services in ART centres, nutrition supplementation for malnourished children and micronutrient supplementation to correct micronutrient deficiencies among inpatient children and pregnant women.

2.3 Progress in Implementation of Nutrition and HIV/AIDS Interventions

The process of developing the strategy included an analysis of the national response and results achieved during the first two years of the 2005-2010 plan period.

Achievements

1. Under the NHSSP II KEPH, the government has defined targets to provide nutritional support services to all ART centres and 80 percent of hospitals offering therapeutic nutritional care before the end of the plan period.
2. In the area of mitigation of the socioeconomic impact of HIV/AIDS, the national food security and nutrition policy has been developed and a draft sessional paper prepared for consideration by parliament.
3. The Kenyan National Guidelines on Nutrition and HIV/AIDS, which define the recommendations for the care and support of PLWHA and how these actions can be implemented, has been developed and is in use.
4. The Kenyan National Training Curriculum on Nutrition and HIV/AIDS has been developed and is being used to develop training materials for both in-service and pre-service providers.
5. A Trainer's Manual and Trainee Tool Package for training service providers who deliver nutritional care to PLWHA going through the CCCs have been developed and is in use.
6. Key universal access targets on nutrition have been incorporated as core country priorities within the KNASP.
7. A set of counselling cards on nutrition and HIV/AIDS and reference posters on medication, nutrition and nutritional management of common symptoms has been developed. Service providers have been oriented in their use, and the materials are used in CCCs and some community settings.
8. An integrated IYCF training curriculum has been adapted, and a national training of trainers base has been established. Counselling cards, job aids and information, education and communication (IEC) materials for infant feeding and HIV/AIDS are in the final stages of development.
9. WHO clinical guidelines for nutritional clinical care for children with HIV/AIDS (age 6 months to 14 years) have been piloted and adapted for Kenya.
10. Rapid assessment and a situational analysis of infant feeding and HIV and of paediatric HIV/AIDS and malnutrition were undertaken in March to May 2007 by UNICEF ESARO (East and Southern Africa Regional Office) as part of a three-country analysis.
11. The MoH, with support from the Global Fund, deployed a nutritionist to coordinate programmatic nutrition activities in NASCOP.
12. The MoH, in collaboration with the Global Fund, appointed about 90 nutritionists/ dietitians to take responsibility for nutrition activities at service delivery points in government facilities.
13. The Kenya Medical Training College, Karen School of Nutrition, Kenyatta University and the Applied Human Nutrition Programme in the University of Nairobi have integrated nutrition and HIV/AIDS into a pre-service training curriculum.
14. Missions of Essential Drugs (MEDS) are using the training curriculum for in-service training of health service providers working in FBOs.
15. More than 1,000 service providers have been trained on nutrition and HIV/AIDS nutritional care and support, including PMTCT, IYCF and paediatric support.
16. Supplementary food support through various models of nutrition: FBP for about 25,000 malnourished PLWHA in 58 CCC facilities through a collaboration between MoH and USAID/Kenya. In addition, 28 facilities/district areas are providing about 100,000 clients with supplementary fortified nutritional support through collaborative programs between MoH, Moi University (AMPATH), UNICEF, WFP and Médecins Sans Frontières (MSF) Belgium.

17. The number of partners who have shown interest in collaborating to provide food and nutrition interventions targeting communities hardest hit by the HIV/AIDS pandemic is gradually increasing.

These achievements result from increasing partnerships among the government, key service providers, development partners and those who are infected and affected.

2.4 Gaps in Implementing Nutrition Interventions

An analysis of the strengths, opportunities and challenges of the sub sector focus on nutrition and HIV/AIDS revealed multiple strengths and opportunities. A set of gaps and attributable factors as well as existing opportunities were also identified (Table 1). Addressing these gaps is crucial to the realisation of national goals and targets.

Table 1: Gap Analysis Matrix for Nutrition and HIV/AIDS in Kenya

| Gaps to Be Addressed by the Strategy | Attributable Factors | Strengths/Opportunities |
|--|--|---|
| <p>Inadequate funding for \ nutritional activities by the government and development partners, especially for implementation of the strategy in 2007--2009 WHO</p> | <p>Lack of an advocacy strategy/agenda at all levels (national, district and community)</p> <p>Poor representation of the nutrition agenda in important forums that discuss resource mobilisation and allocation for HIV/AIDS</p> <p>Inadequate scientific evidence to support nutrition's role in survival and, in effect, management of HIV/AIDS</p> | <p>There is broad acknowledgement of the importance of nutritional care at service-provision level.</p> <p>Key partners, among them USAID, CDC, UNICEF, Global Fund and, support nutrition interventions as an important component in the care and treatment of PLWHA.</p> <p>Collaboration between WFP and UNICEF and CSOs and FBOs will broaden the programme's coverage and scope.</p> <p>Guidelines and policies that support nutrition in the care of PLWHA and management of HIV/AIDS have been developed. A study has been commissioned to assess the impact of nutrition-based interventions among PLWHA.</p> |
| <p>Inadequate coordination and consultation with wider HIV/AIDS networks</p> | <p>Limited link of nutrition with HIV issues that are being addressed in agriculture, gender and general nutrition</p> <p>Little harmonisation of nutrition messages being communicated by government and private/NGO agents</p> | <p>A multi-sectoral working group on nutrition and HIV/AIDS has been established.</p> |

Table 1: Gap Analysis Matrix for Nutrition and HIV/AIDS in Kenya (Continued)

| Gaps to Be Addressed by the Strategy | Attributable Factors | Strengths/Opportunities |
|---|---|---|
| <p>Variability in the quality of nutritional and HIV/AIDS support services</p> <p>Low coverage of nutrition and HIV/AIDS services including counselling, assessment and distribution of foods and nutritional supplements</p> | <p>CSOs and the private sector do not adequately participate in national HIV/AIDS nutritional forums.</p> <p>Low technical competence of most health workers to provide quality nutrition support services (e.g., nutrition counselling and behavioural change communication)</p> <p>No strategy for in-service and pre-service training to improve skills, competence and update knowledge</p> <p>Inadequate supervision/support of district staff on issues related to nutrition and HIV</p> <p>Service providers working with community-based programs lack nutrition and HIV knowledge/skills.</p> <p>The specifications for food supplements and food packages being distributed to PLWHA across the country have not been defined.</p> <p>The lack of a quality assurance and quality improvement system with established standards and criteria for nutrition assessment, counselling and food supplementation</p> <p>There is no established system to ensure the adequacy and safety of food supplements and packages promoted for use by PLWHA.</p> <p>Lack of basic equipment for assessment of nutrition status (height and weight changes) of PLWHA in some facilities</p> <p>Fortified food supplements have not reached most people who meet the criteria.</p> <p>Poor link between health facilities services with community-based structures Inadequate district-level planning and coordination on nutritional and HIV/AIDS services and lack of district-level financing for these services.</p> | <p>The guidelines that define the kind of services to provide, counselling tools and a service provider toolkit already exist.</p> <p>There are a variety of nutritional and food supplements and groups to distribute them, which provides a wide experience to tap.</p> <p>PEPFAR is scaling up distribution of nutritional supplements to more facilities.</p> <p>There is an emphasis of community-level initiatives by WFP, UNICEF, AMPATH and NGOs.</p> <p>APHIA II programmes are addressing regional/district HIV/AIDS issues and are keen to integrate nutrition into their intervention programmes.</p> |

| Gaps to Be Addressed by the Strategy | Attributable Factors | Strengths/Opportunities |
|--|---|---|
| <p>Inadequate human resources capacity for nutrition and HIV/AIDS services</p> | <p>Few nutritionists (or focal persons) have been trained in nutrition and HIV/AIDS.</p> <p>Coverage of facilities providing care and treatment for PLWHA with a trained person still low (<30%)</p> <p>Issues of paediatric HIV and nutrition have not been addressed adequately. The situation in the non-governmental sector is not clear. Similarly, the number and distribution of trained extension workers and community resource persons are not clear.</p> <p>Nutrition and HIV/AIDS have not been part of pre-service training at most medical and nursing schools.</p> <p>Training in HIV/AIDS and nutrition has been developed and implemented only for CCC service providers, and there is still a need for other sites in the NASCOP curriculum.</p> | <p>Training curriculum and materials, as well as counselling materials have been developed.</p> <p>WHO guidelines on paediatric HIV/AIDS are available and may be adopted with support from UNICEF.</p> <p>Other partners-among them UNICEF, the Clinton Foundation and PEPFAR-are willing to support this initiative.</p> <p>Training of CCC service providers in nutrition and HIV/AIDS has taken place, and expansion of the training is underway.</p> <p>National TOT for integration counselling in YCF has taken place, with scale-up of training to target PMTCT staff.</p> |
| <p>Inadequate coordination of research and monitoring of the effectiveness of nutrition and HIV/AIDS interventions</p> | <p>Lack of national funding for nutrition and HIV/AIDS research (dependence on external funding, which is difficult to come by)</p> <p>Poor coverage of operational research to solve targeted nutrition and HIV/AIDS problems within the health and agricultural systems</p> <p>No national research database for the various data being collected on nutrition and HIV in the country</p> <p>Weak monitoring systems at both facility and community level</p> <p>Delays in integration of indicators of nutrition in HIV/AIDS in surveillance and national surveys</p> | <p>A number of small studies on nutrition and HIV are being conducted in various universities in and outside the country.</p> <p>Review of MOH HMIS data capturing tool, including MOH form 711 which summarizes data from health facilities in the country. M&E indicators have been identified and are awaiting incorporation into CCC data registers and cards. Community- based programme activity reporting (COBPAP) for community-level activities is operational.</p> <p>Review of indicators is required.</p> <p>Under NACC, Kenya HIV and AIDS research coordinating mechanism (KARSCOM) is operational.</p> <p>A country programme to assist in knowledge translation and management for informing health policy and practice has been established in Kenya Medical Research Institute (KEMRI).</p> |





Chapter 3:

GUIDING PRINCIPLES AND
STRATEGIC OBJECTIVES

3.1 Guiding Principles

The principles adopted in the development of this programme strategy are in line with the KNASP framework, the NHSSP II, National Food Security and Nutrition Policy and the Guidelines for Nutrition and HIV/AIDS. It is important to keep in mind the principles promulgated in the KNASP and the social services sector pillar defined in the ERS. In this regard, the strategy will be guided by these principles:

- (1) Preventing and reducing the incidence of malnutrition among PLWHA, with special focus on addressing food and nutrition insecurity associated with HIV/AIDS
- (2) Protecting the rights of all individuals vulnerable groups in particular to nutrition information, education and counselling on a continual basis to enable them to prevent and control malnutrition irrespective of their HIV status
- (3) Addressing broader social and economic determinants of malnutrition, especially where there is a link with vulnerability to HIV infection
- (4) Being responsive to broader social and economic development policies and programmes that target food and nutrition security and facilitate linkage with vulnerability to malnutrition associated with HIV/AIDS
- (5) Redressing food and nutrition inequalities, especially as defined by gender, age and socioeconomic status
- (6) Collaborating and enhancing meaningful participation of affected communities and service providers in the development of implementation materials and tools for nutrition and HIV/AIDS programmes to ensure optimal effectiveness
- (7) Collaborating with different partners, stakeholders and service providers in provision, documentation, training and design of programs to ensure maximum impact as well as accountability and transparency
- (8) Developing service programs in line with internationally accepted knowledge and science but also observing the specific needs and experience of service providers and PLWHA for realising desired health and nutrition outcomes

3.2 Goals and Strategic Objectives

The overall goal of the strategy is to facilitate mainstreaming nutrition in HIV/AIDS policies and programmes and to assist alignment of structures and action designed to control and prevent malnutrition among PLWHA. Kenya's response to nutrition challenges among PLWHA and affected people is based on consensus to ensure close multi sectoral collaboration and coordination between health, education, agricultural, livestock and fisheries, gender, culture, sports and social service sectors. In the health sector, identified principles should guide the mainstreaming of nutrition care and support in ART, PMTCT, voluntary counselling and testing (VCT), tuberculosis (TB), HBC and OVC/livelihood programmes as well as programming nutrition support services. Under other sectors, the focus includes curriculum review and integration in the outreach and workplace programs.

For effective mainstreaming of nutrition care and support to be realised, the strategic objectives and strategies below will be addressed.

1. Strengthen human resource capacity in nutrition care and support.
 - 1.1. Increase the number of nutritionists, front line health personnel and community service providers with the knowledge and skills to provide quality nutritional interventions to PLWHA, OVC and other vulnerable groups.

- 1.2. Recruit and deploy additional nutritionists to reduce existing deficits.
- 1.3. Carry out a needs assessment for human resources to provide nutrition and HIV/AIDS in the non governmental sectors.
2. Strengthen key areas of policy and guideline development.
 - 2.1 Update current national policy guidelines: Review IYCF policy and Kenya's Infant and Young Child Feeding Guidelines in the Context of HIV (2004).
 - 2.2 Identify gaps in policies and programmes related to nutrition and HIV/AIDS, as well as opportunities for mainstreaming nutrition interventions in the HIV/AIDS agenda and vice versa.
3. Develop and produce educational materials and job aids on nutrition and HIV/AIDS.
 - 3.1. Develop improved training manuals suitable for ongoing programme interventions such as CCCs, infant feeding and maternal nutrition, paediatric care, HBC and inpatient care.
 - 3.2. Develop national advocacy strategy and materials for PLWHA and OVC.
4. Strengthen communications and advocacy.
 - 4.1. Improve awareness of the added value of integrating nutrition in the management of HIV/AIDS, targeting PLWHA and vulnerable groups such as OVC and TB patients.
 - 4.2. Increase awareness of the importance of integrating the needs of PLWHA, OVC and other vulnerable groups, and affected families in food security and nutrition intervention programmes.
 - 4.3. Support the widespread dissemination and application of the 2006 WHO consensus statement on HIV and infant feeding.
5. Strengthen coordination and collaboration.
 - 5.1. Improve coordination and networking among public and private stakeholders providing services and/or financing nutrition in HIV/AIDS interventions in line with ongoing coordination by NASCOP and NACC on food support used in HIV and other programmes implemented in the country
 - 5.2. Foster close multi sectoral collaboration and coordination among key sectors including health, agricultural, livestock and fisheries, education, culture and social services, national planning and development, trade and finance
6. Provide therapeutic and supplemental food and dietary commodities.
 - 6.1. Increase the coverage of therapeutic and supplemental foods and dietary formulations for malnourished PLWHA, pregnant and lactating women in PMTCT programmes and OVC through facility and community delivery systems.
 - 6.2. Increase the percentage of PLWHA, TB patients, OVC and vulnerable groups accessing supplemental quality foods and dietary supplements.
7. Develop and maintain quality assurance and standards for services and products.
 - 7.1. Standardise and harmonise specifications for appropriate therapeutic and supplementary foods for malnourished PLWHA in care and treatment programs, pregnant/lactating women in PMTCT programs and infants of HIV positive women from 6 months to 2 years old, as well as indicators and end points for 5 to 13 year olds.
 - 7.2. Conduct the Baby Friendly Hospital Assessment and external review of sites offering replacement formula.
8. Strengthen the system to ensure continuous monitoring and regular evaluation.
 - 8.1. Ensure sustainable system of collecting and collating nutrition data/information needed to inform programs and HIV/AIDS campaigns

- 8.2. Establish systems for the regular use of M&E information within HIV facilities, by programme managers, for national advocacy purposes and for tracking progress toward universal access targets for care and treatment.
9. Promote research and dissemination.
 - 9.1. Identify knowledge gaps related to nutrition and HIV/AIDS policies and programming Support implementation and dissemination of strategic operations and applied research.

Targeted Outputs

The strategies outlined above are expected to yield a number of outputs at the system development level. These outputs are requisite to programme service outputs, outcomes and impacts detailed in the M&E section below.

1. Eighty percent of nutritionists in the districts are trained on nutritional care and support for HIV/AIDS, integrated IYCF counselling and/or clinical nutritional care for children with HIV/AIDS.
2. Fifty percent of front line clinical staff (nurses, clinical officers and doctors) in public facilities are trained on nutritional care and support for HIV/AIDS, integrated IYCF counselling and/or clinical nutritional care for children with HIV/AIDS
3. All ART centres and PMTCT services offer nutritional support (in terms of nutritional counselling, multiple micronutrients (MMN), education and nutritional assessment) to HIV positive clients
4. Eighty percent of public facilities have adequate stocks of recommended therapeutic and supplementary foods for eligible clients.
5. Eighty percent of HIV positive mothers receive counselling on infant feeding before and after giving birth.
6. Eighty percent of PMTCT sites offer replacement feeding externally reviewed through the Baby Friendly Hospital Assessment.
7. Nutritional indicators are integrated in the national and district HIV/AIDS M&E framework.
8. Nutrition and HIV/AIDS resource packages for service providers and communities are regularly updated.
9. A functional TWG on nutrition and HIV/AIDS is operational and meets at least quarterly.

Actions

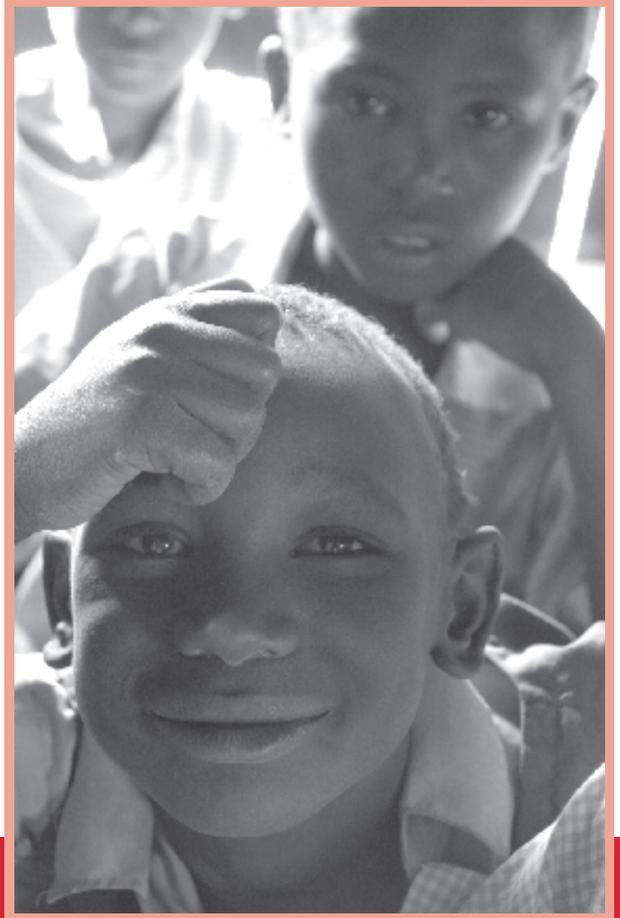
1. Develop and produce educational materials and job aids on nutrition and HIV/AIDS.
 - 1.1. Develop training manuals for CCCs, infant feeding and maternal nutrition, paediatric care, HBC and inpatient care.
 - 1.2. Facilitate adaptation and translation of nationally recommended materials for local application to ensure uniformity.
 - 1.3. Facilitate harmonisation of nutrition messages produced and communicated by government and private/NGO actors.
2. Review key policies and guidelines.
 - 2.1. Current national policy guidelines on IYCF and Kenya's Infant and Young Child Feeding Guidelines in the Context of HIV (2004) will be updated with the WHO consensus statement on HIV and infant feeding (2006) and will be disseminated nationally by 2008.
 - 2.2. Review the guidelines for nutrition and HIV/AIDS to update information.
3. Strengthen human resource capacity in nutrition care and support.
 - 3.1. Develop and implement national TOT in nutrition and HIV/AIDS and IYCF and subsequently roll out to in service training of nutritionists and other health staff serving CCCs and district facilities and to pre service training in training institutions.

- 3.2. Carry out a needs assessment for human resources to provide nutrition and HIV/AIDS in the non governmental health sector.
- 3.3. Integrate nutrition and HIV/AIDS into the training curricula of agriculture, education, livestock and fisheries, culture and social services sectors.
- 3.4. Train trainers of extension workers in agriculture, livestock and fisheries, education, and culture and social services sectors.
4. Develop and maintain quality assurance and standards for services and products.
 - 4.1. Develop and disseminate standards/specifications for food and nutrition supplements for PLWHA.
 - 4.2. Develop and disseminate standards/specifications for nutrition assessment and counselling for PLWHA.
 - 4.3. Review existing national guidelines and integrate standards of food/nutrition interventions for PLWHA and OVC. Guidelines include the National Guidelines for Nutrition and HIV/AIDS as well as guidelines for HBC, ART, TB, PMTCT, IMCI and management of severe malnutrition in children.
 - 4.4. Develop and implement quality monitoring of food and nutritional supplements being distributed to PLWHA for conformity with standards/specifications.
 - 4.5. Establish standards for best practices for nutritional interventions for PLWHA and OVC.
 - 4.6. Support acquisition of basic equipment for assessing the nutrition status of PLWHA in unequipped facilities.
5. Strengthen communications and advocacy.
 - 5.1. Increase awareness of materials and information on the nutrition and HIV/AIDS guidelines, counselling materials, curricula and training materials, and information and policy recommendations in the food security and nutrition policy sessional paper
 - 5.2. Launch the nutrition guidelines, curriculum and IEC materials and disseminate them and the national advocacy strategy nationally.
 - 5.3. Establish a clinical pathway of care and a continuum of national service delivery framework for HIV positive mothers and their infants.
 - 5.4. Facilitate and lobby for representation in key stakeholder forums to promote national standards on nutrition and HIV/AIDS.
 - 5.5. Develop messages to support a media campaign for nutrition and HIV/AIDS.
 - 5.6. Mobilise political support for nutrition care and support activities to strengthen commitments to improve availability and access to good quality services and products.
 - 5.7. Develop and upload a web page on nutrition and HIV/AIDS on the MoH website.
6. Strengthen coordination and collaboration.
 - 6.1. Support consultative meetings for stakeholders and partners supporting nutrition and HIV/AIDS programmes.
 - 6.2. Coordinate systems for providing nutritional support to PLHWA and OVC at the national and district levels.
 - 6.3. Incorporate nutrition into the District Health Stakeholders Forum in all districts and support representation on existing health and nutrition networks.

- 6.4. Facilitate integration of nutrition and HIV/AIDS services plans and budgets in the Medium Term Expenditure Framework (MTEF) process of government and development partners.
- 6.5. Coordinate consultations with the wider HIV/AIDS network to ensure realisation of GIPA (greater involvement of people with HIV/AIDS) objectives, especially in the fight against stigma.
- 6.6. Facilitate consultative and joint planning meetings at national, regional, district and constituency levels with extension workers in agricultural, livestock and fisheries, education, and culture and social services sectors to create gender sensitive demand for nutritional services.
- 6.7. Establish a resource mobilisation mechanism for government and development partners and identify and recruit other partners to participate in the programme.
7. Provide therapeutic and supplemental food and dietary commodities.
 - 7.1. Ensure all service points are stocked with nutritional commodities, namely, MMN, supplementary foods and therapeutic foods.
 - 7.2. Improve eligible clients' access to dietary supplements.
 - 7.3. Improve all clients' access to safe drinking and cooking water.
 - 7.4. Scale up an improved dry ration for eligible clients.
8. Strengthen continuous monitoring and regular evaluation.
 - 8.1. Institute monitoring and reporting of nutrition and HIV/AIDS service delivery in public and non governmental sectors and the community to ensure that standards of care are achieved for HIV positive mothers and ART beneficiaries and to monitor progress toward universal access targets for care and treatment.
 - 8.2. Review facility data collection forms 711 and the COBPART for community activities.
 - 8.3. Train district and service providers on using the data collection system proposed by NASCOP and NACC.
 - 8.4. Assess the level of nutrition risk among vulnerable communities at the district and constituency levels.
 - 8.5. Conduct an operational analysis for innovations in nutritional care.
9. Promote research and dissemination.
 - 9.1. Identify gaps in policies and programmes related to food and nutrition security and HIV/AIDS and further opportunities for integrating nutrition interventions and incorporating HIV/AIDS issues in national food and nutrition policies and programmes.
 - 9.2. Establish national research and policy priorities on nutrition and HIV/AIDS.
 - 9.3. Conduct operational research to strengthen infant feeding practices for HIV positive mothers.
 - 9.4. Establish a national database for research in nutrition and HIV/AIDS.
 - 9.5. Support implementation and dissemination of strategic operations and applied research.

The strategies underscore the need for coordination to ensure synergy and effective implementation of actions to scale up and mainstream nutrition and HIV/AIDS in policies and programmes. Financial and technical support from the GoK along with local and international development partners are critical.

In this regard, TWG and stakeholders' consultative meetings identified a lead agency for each area of intervention and key partners who would provide technical, material and financial inputs during the time frame. Details of the actors and the time frame are in the results framework (Annex 4).



Chapter 4:

FINANCING THE STRATEGY

4.1 Costing Implementation of Interventions

The estimated costs of implementing the strategy were based on the framework adopted in the KNASP and consisted of four components. . These components and relevant attributes are described below.

Services Necessary to Achieve the Results and Targets Specified in The Strategy

The services required to realise the strategy objectives fall under these areas of operation; development and production of training and educational materials, human resources capacity building, quality assurance and standards, communications and advocacy, coordination and collaboration, dietary commodity support, applied and operations research, and M&E.

Estimating Unit Costs for Each Service based on Local and International Experiences

The main service items include training sessions, materials development and production, meeting planning and coordination, field operations, communications and advocacy activities, commodities, information and communications technology (ICT) hardware and software, and operations research. For these items, experiences gained from recent training workshops by NASCOP, quotations from local suppliers and intermediate costs of technical assistance were used to estimate activity costs for year one of implementation. Follow up activities in years two and three were adjusted to account for inflation and growth in the number of clients due to improved survival that has been associated with ART scale up. In addition, the demand levels were discounted for expected reduction in the rates of malnutrition among clients.

Size of the Population in Need of Service

Training service needs were based on targeted personnel whose routine duties and responsibilities include community education and technical support services that can easily integrate with nutrition care and support. Material production was based on both the number of registered facilities in the country and HIV/AIDS statistics. Client service needs were derived from the annual national HIV/AIDS estimates for 2006. Estimates for malnutrition rates were derived from ongoing food and nutrition interventions in HIV/AIDS in Kenya and from literature. The number of clients requiring various food/dietary interventions was computed using estimated rates of moderate and severe adult malnutrition (Annex 5).

Estimation of Coverage of Services during the Period of the Strategy

Coverage was based on published national targets in the KNASP and NHSSPII. Other coverage levels were based on proportions that were considered reasonable.

The cost for each service during each year of implementation was estimated from the product of unit cost, population of beneficiaries and targeted coverage ($\text{Cost} = \text{unit cost} \times \text{population in need} \times \text{target}$). It is noteworthy that in costing therapeutic and supplemental dietary commodities, it is necessary to separate the adult, pregnant and lactating women and children client groups because they have different requirements. Since the scale up will include an increase in the number of facilities and number of clients, demand is expected to explode into a periodic pattern with every increase in the number of facilities covered. This means that the supply of commodities ideally should be based on a pull approach. Assuming that nutrition education and counselling are concurrently reinforced, once the majority of malnourished are “treated” and discharged from the programme, the demand will decrease to a steady state. Therefore, the requirement of dietary commodities is expected to rise and then decrease to a value (asymptote) that is dependent on the incidence of malnutrition.

Estimation of the dietary commodities requires field data on the number of eligible clients (prevalence), rate of relapse, number of new malnourishment cases (incidence), maximum mean number of clients that facilities can support, realistic average treatment time (in months), percentage of clients graduating based on average treatment time and variance in percentage of clients graduating based on average treatment time. Naturally, the number of clients and facilities in the programme, rate of enrolment and rate of discharge experienced before the scale up phase will be required. Information on a number of these factors was obtained from the ongoing FBP initiative under NASCOP and USAID/Kenya as well as the KEMRI/FANTA project. Whilst the average rate of enrolment varies from facility to facility, the average appears to be 20 to 39 clients. It takes a client about four months on food before regaining normal BMI. The distribution of funding requirements of priority interventions is shown in Table 2.

Table 2. Summary Financing Requirements for the Nutrition and HIV/AIDS Strategy (in Kshs '000's)

| Strategy | Year 1 2007-08 | Year 2 2008-09 | Year 3 2009-10 |
|--|-------------------|-------------------|-------------------|
| 1 Development and production of training and educational materials | 30,060 | 18,890 | 22,356 |
| 2 Policy review processes | 2,200 | 300 | 300 |
| 3 Human resource capacity strengthening (training and salaries) | 150,420 | 198,450 | 257,745 |
| 4 Quality assurance and standards | 59,270 | 51,400 | 65,350 |
| 5 Communications and advocacy | 7,630 | 5,780 | 5,530 |
| 6 Coordination and collaboration | 13,510 | 13,080 | 17,120 |
| 7 Nutritional commodity support | 1,773,090 | 1,825,847 | 1,780,080 |
| 8 M&E | 28,100 | 9,100 | 6,100 |
| 9 Research and dissemination | 20,800 | 15,800 | 15,800 |
| Total | 2,085,080 | 2,138,647 | 2,170,381 |

Dietary commodity supplies constitute the bulk (84 percent) of the estimated funding requirements. In the remaining funding for operations requirements (about Ksh 1bn) human resources capacity building will require 59 percent. Quality assurance and standards and training and educational materials development will require 17 percent and 7 percent, respectively. Other operations items will require 2 percent to 5 percent of the operations budget. Details of the funding requirements are shown in Annex 6. The non commodity financial requirements account for just over 50 percent of KNASP 2005 2010 estimates. The difference is attributed to availability of more data for more comprehensive programme plans than was the case during development of KNASP about three years ago.

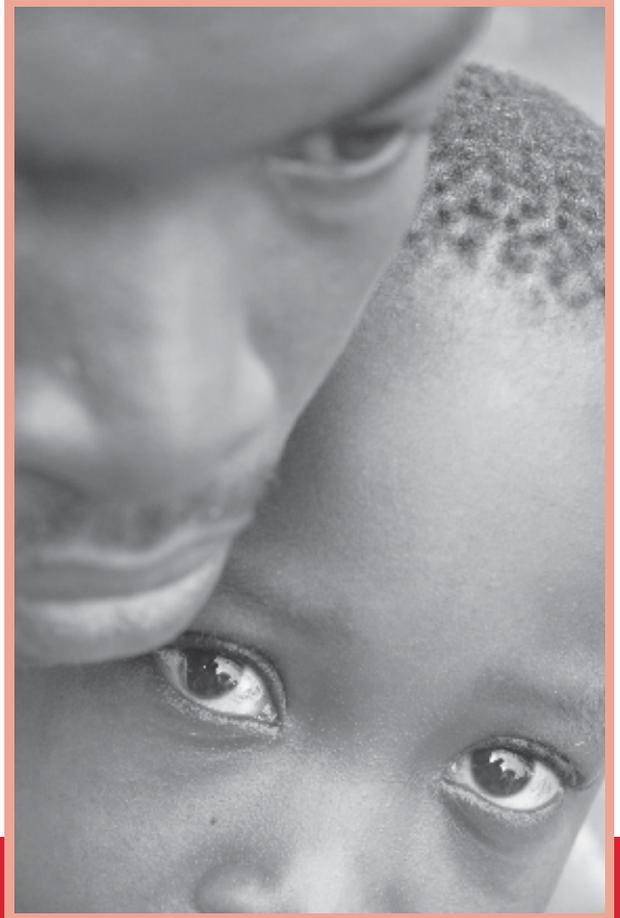
4.2 Strategy Financing Estimates

The estimated total resources committed for the strategy's first year were based on information from the government and partners providing services listed in Table 3 below. Details of field operations involving interventions using food and dietary supplements are shown in Annex 7. The government commitment includes contributions from the Global Fund. Inputs from development partners, including a recent request for applications (RFA) under USAID's nutrition and HIV programme, were considered. Inputs from the NGO sector, private sector and households were not

included. The estimated financial resources committed during FY 2007/08 are approximately Ksh 1.0 billion. The amount constitutes costs of the estimated scale up of operations and commodities. The financing gap of Ksh 1.1 billion during FY 2007/08 does not discount for the GoK/World Bank/Department for International Development (DFID) funding of the Total War Against HIV/AIDS (TOWA), which is in the final stages of review, and ongoing efforts under the Great Lakes Initiative (GLIA) and Lake Victoria Basin Development Commission. Discounting for inputs from TOWA, civil society, FBOs, private sector, line ministries and OVC partnerships will significantly reduce the resource gap. Nevertheless, the gap will require periodic review, and it is evident that mobilisation of additional financial resources during all three years of the strategy will still be required.

Table 3: Activities Planned for 2007-08

| Source | Activities | Implementer |
|-------------|---|--|
| Global Fund | Meeting emoluments for dedicated nutritionists and other personnel deployed to HIV/AIDS treatment points | NASCOP and Division of Nutrition |
| | Food and nutritional supplements, training for service providers and support supervision in the 14 CCCs in Suba district | NASCOP |
| USAID/Kenya | Operations research for infant feeding practices in Western and Nyanza Technology in Health (PATH) | Program for Appropriate |
| | Strengthening human resources recruitment of dedicated nutritionists | Capacity project and NASCOP Population Services |
| | Health communication and marketing | International (PSI) |
| | FBP programme | INSTA Ltd. and NASCOP |
| | Food and nutritional supplements | NASCOP and a partner |
| | Training of nutrition care providers implementing the FBP programme | NASCOP and FANTA/AED |
| | Strengthen national M&E structure for nutrition and HIV/AIDS interventions and expansion to include paediatric supplementary and therapeutic food support | NASCOP and FANTA/AED NASCOP, FANTA/AED and UNICEF (KCO) |
| | Development of the Kenya Nutrition and HIV/AIDS Strategy | NASCOP and FANTA/AED |
| | Recruitment of nutrition technical advisor | APHIA II partners and |
| | Provide support to regional partners in the six regions | NASCOP |
| CDC | Human resources development and training | NASCOP and CDC |
| | Coordination and implementation of nutrition and HIV/AIDS activities | |
| | Improvement of nutrition care and support services at HIV/AIDS service delivery points in health facilities | |
| UNICEF | Development of communication and advocacy strategy for nutrition and HIV/AIDS | UNICEF (Kenya) and NASCOP |
| | Capacity development and training of service providers | |
| | Technical assistance for policy, guideline and strategy development | |
| | Production and dissemination of national training curriculum and job aid tool set for PMTCT/integrated IYCF and paediatric guidelines for the clinical nutritional care of children with HIV/AIDS | UNICEF (Kenya) and NASCOP |
| | Support for clinical nutritional care and therapeutic care | UNICEF (Kenya) and NASCOP |
| WHO | Technical assistance for policy, guideline and strategy development | WHO/NASCOP |
| WFP | Expansion of food and nutritional supplements for PLWHA and OVC to Kilifi and Mariakani district hospitals (Coast) | Division of Nutrition, NASCOP and WFP |



Chapter 5:

MONITORING, EVALUATION AND RESEARCH

5.1 Monitoring, Evaluation and Research

M&E of the strategy is required to determine progress in achieving desired outputs and outcomes and to give an account to the government and stakeholders on nutrition efforts' effectiveness in achieving overall health and social outcomes for PLWHA. The current service utilisation data capture system provides very limited data on the nutritional situation and services rendered. Therefore, it is necessary to design a more comprehensive facility register and reporting tools for use in all service points. This strategy will enable detailed analysis of nutritional interventions and facilitate identification of the most sensitive indicators for inclusion in the next generation of facility/CCC registers.

Overall responsibility of monitoring the implementation of this strategy rests with NASCOP in collaboration with NACC as required in the Three Ones principle. The Nutrition and HIV/AIDS TWG will be responsible for interpretation and reviews. Evaluation of the strategy and progress toward the targets will be undertaken and reported by the proposed lead agencies. The indicators for monitoring each proposed outcome are presented in the results framework matrix in Annex 4. The framework contains a set of indicators for M&E of interventions outlined in this strategy. All institutions involved in the planning, coordination and implementation of HIV/AIDS activities in Kenya should be made familiar with these indicators so that planning, M&E and reporting can be harmonised (Annex 8).

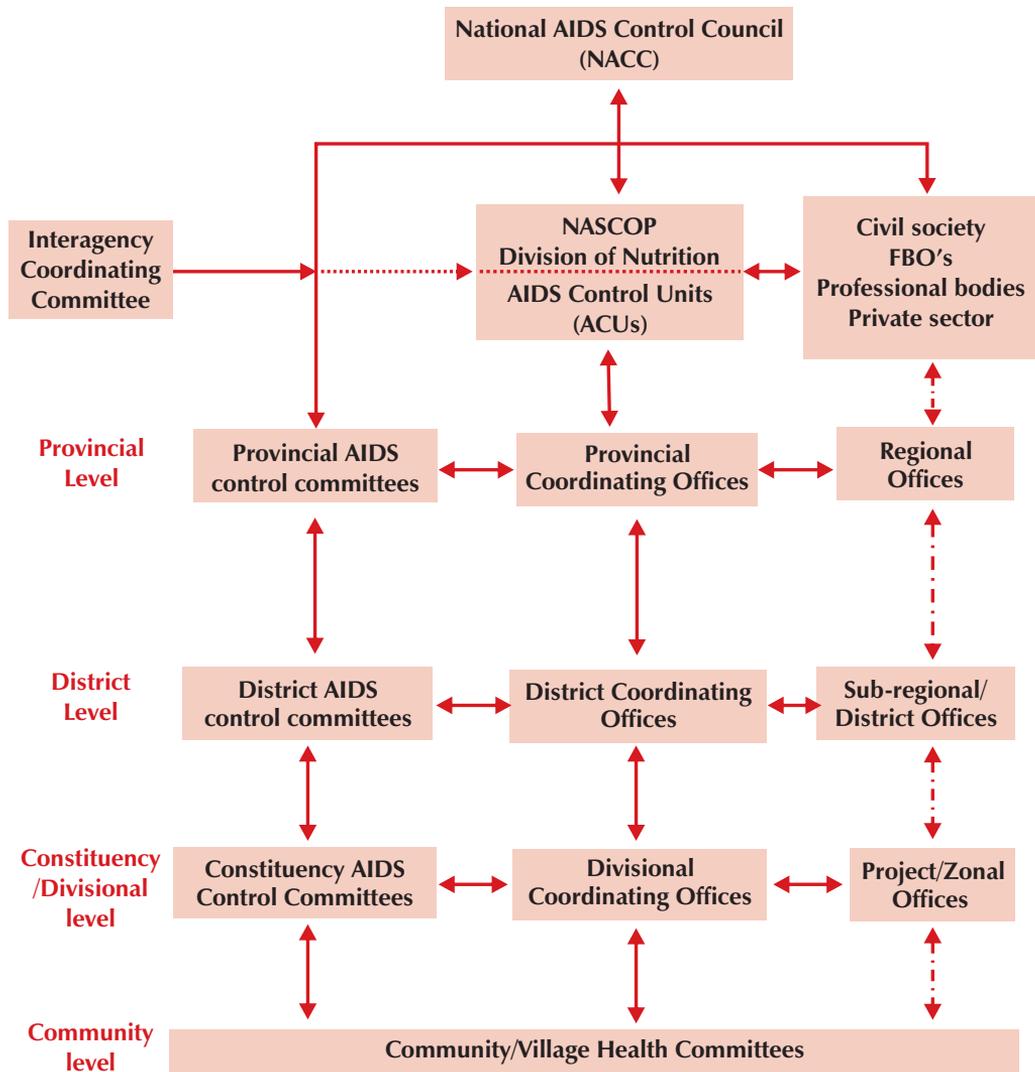
The scale up of nutrition interventions will require clear benchmarking of process and performance. Of significance is the need for all partnering organizations to generate clear service delivery action plans, implementation strategies and criteria for appraisal and schedules. However, while each lead agency and key partner are responsible for translating sector wide priorities into their operational plans, the lead agencies will make quarterly progress reports to NASCOP and the TWG. Periodic review of the strategy will be undertaken by the TWG to refine the strategy's priorities. The TWG also will support the development of an overall M&E plan and the identification of programme areas for targeted evaluations. The TWG will annually review progress in mainstreaming nutrition support in HIV/AIDS interventions and good practices that reflect the highest standards for delivering nutrition and HIV/AIDS services.

5.2 Research and Dissemination

The role of this component is to inform and advise the TWG and stakeholders in general on strategic decisions and policy development matters relevant to nutrition and HIV/AIDS. Its focus will be on applied research to support development of appropriate and affordable solutions in nutrition care and support, operational research to review the performance of service delivery systems in pilot and full scale implementation, knowledge management and review of relevant policies. The strategy will facilitate strengthening nutrition research and will support formative, applied and operational research activities in relevant institutions to realise these objectives.

Annexes

ANNEX 1: Framework for the National Nutrition Intervention in HIV/AIDS



ANNEX 2: Health Facilities and Services

Distribution of Health Facilities by KEPH Levels and Ownership

| KEPH levels of care | Ownership | | | | Total |
|---|--------------|------------|-----------|--------------|--------------|
| | GoK | Mission | NGO | Private | |
| Dispensary | 1,633 | 451 | 52 | 142 | 2,278 |
| Clinic | 30 | 51 | 27 | 1588 | 1696 |
| VCT centre | 5 | 7 | 1 | 28 | 41 |
| Health centre | 521 | 114 | 5 | 20 | 660 |
| Nursing homes | 4 | 5 | 5 | 175 | 189 |
| Primary, secondary and tertiary hospitals | 158 | 70 | 3 | 70 | 301 |
| Total | 2,351 | 698 | 93 | 2,023 | 5,165 |

Health Service Delivery and Facility and Ownership

| Service type | GoK (n=2,351) | Mission (n=698) | NGO (n=93) | Private (n=2,023) | Total number of facilities |
|---------------------------------------|------------------|--------------------|---------------|----------------------|----------------------------------|
| PMTCT | 471 | 114 | 22 | 206 | 813 |
| HIV counselling & VCT | 441 | 106 | 19 | 220 | 786 |
| ART available | 203 | 76 | 8 | 174 | 461 |
| TB diagnosis routinely performed | 596 | 145 | 21 | 208 | 970 |
| TB diagnostic laboratory available | 625 | 141 | 19 | 199 | 984 |
| TB treatment available | 1,033 | 178 | 18 | 208 | 1,437 |
| Caesarean section routinely performed | 137 | 68 | 7 | 185 | 397 |
| Emergency blood transfusion | 156 | 73 | 9 | 171 | 409 |
| HBC services available | 213 | 78 | 11 | 176 | 478 |

ANNEX 3: Health Facilities by Province

Distribution of Health Facilities by Province and Facility Type

| FACILITY TYPE | CENTRAL | COAST | EASTERN | NAIROBI | NORTH EASTERN | NYANZA VALLEY | RIFT | WESTERN | TOTAL |
|---|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|-------------------|
| Dispensaries | 205 | 144 | 325 | 18 | 43 | 180 | 540 | 81 | 1,527 |
| Health Centres | 57 | 33 | 58 | 8 | 6 | 80 | 136 | 62 | 440 |
| District Hospitals | 12 | 11 | 26 | 1 | 10 | 24 | 21 | 13 | 118 |
| Provincial Hospitals | 1 | 1 | 2 | | 1 | 1 | 1 | 1 | 8 |
| National and Specialized Hospitals | 1 | | | 2 | | | | | 3 |
| Rural Health Training and Demonstration Centres | 1 | 15 | 7 | | 5 | 6 | 12 | 7 | 53 |
| Total Facilities | 277 | 204 | 418 | 29 | 65 | 291 | 710 | 164 | 2,158 |
| Facilities % | 12.8 | 9.5 | 19.4 | 1.3 | 3.0 | 13.5 | 32.9 | 7.6 | 100.0 |
| Population | 3,918,538 | 2,860,649 | 5,180,139 | 2,656,997 | 1,235,592 | 4,868,010 | 8,077,517 | 3,954,081 | 32,751,523 |
| Population per Facility | 14,095 | 14,022 | 12,393 | 91,620 | 19,009 | 16,728 | 11,376 | 23,964 | 15,176 |
| Facilities per 100,000 population | 7.0 | 7.0 | 8.0 | 1.0 | 5.0 | 6.0 | 9.0 | 4.0 | 7.0 |

ANNEX 4: Results Framework for 2007- 2010

| Planned Results | Time Frame | Lead Agencies | Key Partners |
|--|---------------------|-------------------------------------|---|
| 1 Training and educational material development and production | | | |
| 1.1 Improved training manuals for CCCs, infant feeding and maternal nutrition, paediatric care, HBC and inpatient care | Jan. 08 - Dec. 08 | NASCOP | MoH (D/Nut, D/CH, D/RH) UNICEF, USAID, FANTA/AED, APHIA II partners, JHPIEGO, NACC |
| 1.2 IEC materials produced and disseminated | Jan. 08 - Dec. 08 | NASCOP | MoH - D/Nut, UNICEF, USAID, FANTA/AED, NACC, APHIA II partners, JHPIEGO, INSTA |
| 1.3 Harmonised national communication and advocacy strategy, materials and messages for PLWHA and OVC | March 08 - Dec. 08 | NASCOP | MoH - D/Nut, UNICEF, USAID, MoH - D/Nut, FANTA/AED, APHIA II partners, JHPIEGO, INSTA |
| 1.4 Nationally recommended materials adapted and translated into Kiswahili | May 08 - Dec. 08 | NASCOP, D/Nut | NACC, UNICEF, USAID, FANTA/AED, APHIA II partners, MoE/ Kenya Institute of Education (KIE), media |
| 2 Review key policies and guidelines | | | |
| 2.1 Update the national policy on IYCF and national guidelines on Infant and Young Child Feeding in the context of HIV (2004) and be disseminated nationally | Jan. 08 - Dec 08 | NASCOP | MoH - D/Nut, UNICEF, USAID, FANTA/AED, NACC, APHIA II partners, JHPIEGO |
| 2.2 Update guidelines for nutrition and HIV/AIDS | Sept. 08 | NASCOP | NACC, UNICEF, USAID, FANTA/AED |
| 3 Human resources capacity strengthening | | | |
| 3.1 National TOT to train in-service providers at regional level | Sept 07 - Dec. 08 | NASCOP | MoH (D/Nut, D/SRS), UNICEF, USAID, FANTA/AED, NACC, MoHA, MGCSSS, referral hospitals, AMPATH, KMTC, WHO, WFP, Plan International, Mild May, Polytechnics, JHPIEGO, APHIA II partners, INNSTA |
| 3.2 National TOT to train pre-service trainers | April 08 - Dec. 08 | | NASCOP, KMTC, tertiary institutions |
| 3.3 Review integration of pre-service training curricula in nutrition and HIV/AIDS | Jan. 08 - June 08 | NASCOP, KMTC, tertiary institutions | |
| 3.4 District training of providers in MoH, mission, CSO and private facilities | March 08 - Dec. 08 | NASCOP | |
| 3.5 Integrate nutrition and HIV/AIDS component in community strategy and train CACC coordinators, community health extension workers (CHEW) and community-owned resource persons (CORPS) | May 08 - Dec. 08 | NACC, NASCOP | |
| 3.6 National TOT on integration of nutrition and HIV/AIDS into agriculture, livestock and fisheries, education, and culture and social services sectors. | Feb. 08 - Dec. 08 | MoA, MoE, NASCOP | |
| 3.7 Develop a database on nutritionists in service in Kenya | July 08 - Dec. 08 | D/Nut, NASCOP | |
| 3.8 Dedicated nutrition professionals employed and deployed to HIV/AIDS service points | July 07 - Dec. 2010 | NASCOP | UNICEF, USAID, FANTA/AED, Global Fund, APHIA II partners |
| 4 Quality assurance and standards | | | |
| 4.1 Establish quality assurance for nutritional assessment and nutrition care practices for PLWHA and OVC | Feb. 08 - Dec. 2010 | NASCOP, KEBS, KEMRI, D/Nut | MoH/ National Public Health Laboratory Services (NPHLS), PLWHA umbrella bodies/networks, CSOs, professional associations, referral and training hospitals, international organisations, University of Nairobi (UoN), Kenyatta University (KU), AMPATH |

ANNEX 4: Results Framework for 2007- 2010 (Continued)

| Planned Results | Time Frame | Lead Agencies | Key Partners |
|--|---------------------|--|---|
| 4.2 Publish and disseminate standards for dietary and food commodity support and nutrition supplements recommended for PLWHA in Kenya and assess consistency | Dec. 07 - Dec. 08 | KEBS, NASCOP, MoH- D/Nut and Public Health | MoH/NPHLS, KEMRI, PLWHA umbrella bodies/networks, CSOs, professional associations, referral and training hospitals, international organisations, food industries, AMPATH |
| 4.3 Review and publish an inventory of food and nutrition products for PLWHA in the Kenyan market | Jan. 08 - March 08 | NASCOP/D/Nut | UNICEF, USAID, FANTA/AED, NACC, APHIA II partners, industry, AMPATH |
| 4.4 Support acquisition of basic equipment for assessment of nutrition status of PLWHA in public health facilities. | Jan. 08 - Dec. 2010 | NASCOP/D/NuT | UNICEF, USAID, NACC, APHIA II partners |
| 4.5 Review compliance of food and nutrition supplements for PLWHA with national standards | Dec. 08 - Dec. 2010 | KEBS, NASCOP | MoH, D/Nut, NPHLS, Public Health, Dept. of Standards and Regulatory Services, KEMRI, UNICEF, USAID |
| 4.6 Guidelines reviewed to integrate standards of food/nutrition interventions for PLWHA and OVC | Sept. 08 - Dec. 08 | NASCOP, D/Nut | AMPATH, UoN, training institutions, UNICEF, USAID, FANTA/AED, NACC, APHIA II partners |
| 5 Communications and advocacy | | | |
| 5.1 Nutrition guidelines, curriculum and IEC materials launched and disseminated; sessional paper on National Food Security and Nutrition Policy disseminated | Jan. 08 - Dec. 08 | NACC, NASCOP, D/Nut | UNICEF, USAID, FANTA/AED, NACC, APHIA II partners |
| 5.2 National standards for nutrition and HIV/AIDS are promoted during various forums including JICC, ICC, JAPR, among others | Nov. 07 - Dec. 2010 | NASCOP, NACC, D/Nut | UNICEF, USAID, FANTA/AED, APHIA II partners |
| 5.3 Participation and contribution toward improved nutrition and destigmatisation of PLWHA | Oct. 07 - Dec. 2010 | NASCOP, NACC, MoA, D/NuT | UNICEF, USAID, FANTA/AED, APHIA II partners |
| 5.4 Development and dissemination of nutrition and HIV/AIDS community strategy | Dec. 2008 | MoA, NASCOP, D/NuT | UNICEF, MoH, USAID, FANTA/AED |
| 6 Coordination and collaboration | | | |
| 6.1 Develop and update database of organisations providing nutritional support to PLWHA and OVC with existing networks (DSG, DDC, KFSM, KFSSG, Health and Nutrition Committee) | Jan. 08 - Dec. 2010 | NASCOP, D/Nut | UNICEF, USAID, FANTA/AED, NACC, APHIA II partners |
| 6.2 Incorporate nutrition into the existing health networks such as District Health Stakeholders Forums | Sep. 07 - Dec. 2010 | NASCOP, D/Nut | UNICEF, USAID, FANTA/AED, NACC, APHIA II partners, AMPATH |
| 6.3 Reports of consultative meetings for stakeholders and partners supporting nutrition and HIV/AIDS programmes. | Oct. 07- June 08 | NASCOP, D/Nut, NACC | UNICEF, USAID, FANTA/AED, NACC, APHIA II partners |
| 6.4 Reports of joint biannual planning meetings, financing and coordination of implementation of nutritional and HIV/AIDS services | Oct. 07 - Dec. 2010 | NASCOP, NACC, D/Nut | UNICEF, USAID, FANTA/AED, APHIA II partners, AMPATH |
| 6.5 Reports of mentoring and supervision of province and district teams. | Nov. 07 - Dec. 2010 | NASCOP, NACC, D/Nut | UNICEF, USAID, FANTA/AED, APHIA II partners |
| 6.6 Establish and strengthen facility-community linkages and train members of community. | Oct. 07 - Dec. 2010 | NASCOP, NACC, D/Nut | UNICEF, USAID, FANTA/AED, NACC, MoE, MoHA, MGCSSS, referral hospitals, AMPATH, KMTC, WHO, WFP, Plan International, Mild May, JHPIEGO, APHIA II partners, NGOs, FBOs, CBOs |

ANNEX 4: Results Framework for 2007- 2010 (Continued)

| Planned Results | Time Frame | Lead Agencies | Key Partners |
|---|---------------------|--|--|
| 6.7 TWG quarterly meetings | Jan. 08 - Dec. 2010 | NASCOP, D/Nut | UNICEF, USAID, FANTA/AED, NACC, MoE, MoHA, MGCSSS, referral hospitals, AMPATH, KMTC WHO, WFP, Plan International, Mild May, JHPIEGO, APHIA II partners, NGOs, FBOs, CBOs |
| 7 Food and dietary supplements | | | |
| 7.1 Provide therapeutic foods for severely malnourished adult PLWHA | Jan. 08 - Dec. 2010 | NASCOP, D/Nut | MoH-D/Nut, Office of the President (OP), UNICEF, USAID, MoH (NASCOP), NACC, |
| 7.2 Provide supplemental pre-cooked blended fortified flour (BFF) to moderately and mildly malnourished adult PLWHA | Jan. 08 - Dec. 2010 | NASCOP | MoE, MoHA, MGCSSS, Office of the President, referral hospitals, AMPATH, FANTA/AED, KMTCT, WHO, WFP, Plan International, Mild May, JHPIEGO, APHIA II partners, NGOs, FBOs, CBOs, private sector |
| 7.3 Provide therapeutic foods for severely and moderately malnourished pregnant and lactating HIV-positive women | Jan. 08 - Dec. 2010 | NASCOP | |
| 7.4 Provide supplemental BFF to mildly malnourished and high-risk pregnant and lactating HIV-positive women | Jan. 08 - Dec. 2010 | NASCOP, Division of Reproductive Health, D/Nut, Division of Child Health | |
| 7.5 Provide therapeutic foods for severely malnourished HIV-positive children | Jan. 08 - Dec. 2010 | NASCOP, D/Nut, Division of Child Health | |
| 7.5 Provide blended fortified functional food supplements to moderately and mildly malnourished HIV-positive children | Jan. 08 - Dec. 2010 | NASCOP | |
| 7.6 Provide supplemental nutrition interventions for OVC (ready-to-use therapeutic food [RUTF], BFF and MMN) | Jan. 08 - Dec. 2010 | NASCOP | |
| 7.7 Secure bulk commodity transport and storage space in 80 percent of facilities. | April 08 - April 09 | NASCOP | |
| 8 Monitoring and Evaluation | | | |
| 8.1 Strengthen the M&E systems at district and central levels; equip with hardware, software and trained staff | June 08 - Dec. 2010 | NASCOP | MoH-D/Nut, USAID, FANTA/AED, UNICEF, NACC, MoHA, WFP, APHIA II partners |
| 8.2 Establish a TWG M&E sub-committee, identify common monitoring indicators and develop a joint evaluation framework; produce registers and tools. | Dec. 07 - March 08 | NASCOP, NACC | MoH-D/Nut, USAID, FANTA/AED, UNICEF, MoHA, WFP, APHIA II partners, PLWHA umbrella bodies |
| 8.3 Monitor reports on scaling up integration of guidelines and their updates. | Oct. 07- Dec. 2010 | NASCOP, NACC | |
| 9 Research and dissemination | | | |
| 9.1 Establish national research priorities for nutrition and HIV/AIDS | July 08 - Sept. 08 | NACC/KEMRI/ NASCOP | Tertiary institutions, USAID, FANTA/AED, UNICEF, Kenya Agricultural Research Institute (KARI), MoA, NACC, WFP, APHIA II partners, PLWHA umbrella bodies |
| 9.2 Conduct formative, applied and operations research studies; review status reports and disseminate findings. | Jan. 07 - Dec. 2010 | KEMRI/NACC/OP | Tertiary institutions, USAID, FANTA/AED, UNICEF, MoHA, WFP, APHIA II partners |

ANNEX 5: Estimated Financing Requirements

| Strategy | Activities and Targets | Cost per Unit, Ksh | Year 1 FY 07/08 | Year 2 FY 08/09 | Year 3 FY 09/10 | |
|-----------------|--|---|--|-------------------|-------------------|-----------|
| 1 | Development and production of training and educational materials | | | | | |
| 1.1 | Development of improved training manuals suitable for ongoing programme interventions including CCCs, infant feeding and maternal nutrition, paediatric care, HBC and inpatient care | Prepare chapters or sections on nutritional care and support for PLWHA; review and print 4 manuals; print 1,000 copies of each manual | 1,340 per copy | 5,360,000 | 0 | 5,896,000 |
| 1.2 | Production and national dissemination of IEC materials to accompany training manuals and tool kits | Posters, leaflets, brochures, handbills and billboards | Brochures and bills @ 25 each; posters @100 each | 10,000,000 | 5,000,000 | 5,000,000 |
| | | Materials to be used by clients: 300,000 brochures, 300,000 handbills, 5,000 posters and 50 billboards (distributed over 3 years) | Billboards @ 60,000 each | 1,500,000 | 1,500,000 | |
| 1.3 | Develop and launch national communication and advocacy strategy for PLWHA and OVC at national, district and constituency levels | Promote use of mass media and well-targeted strategies to advocate and promote nutrition education and counselling by stakeholders | Technical assistance | 600,000 | 600,000 | 600,000 |
| | | Develop advocacy materials to reinforce and improve awareness of importance of nutritional interventions in HIV/AIDS | Workshops with media @ 250,000 each | 4,000,000 | 1,000,000 | 1,000,000 |
| | | Develop messages to support media campaign for nutrition and HIV/AIDS | TV spots | 3,200,000 | 3,200,000 | 3,200,000 |
| | | Harmonise and standardise nutrition messages being communicated by all providers | Radio spots @ 20,000 each | | | |
| | | Conduct 8 workshops with media and media house representatives | | 1,600,000 | 1,600,000 | 1,600,000 |
| 1.4 | Facilitate adaptation of nationally recommended materials for local application. Educators should be encouraged to harmonise existing materials with recommended materials for uniformity. | Identify materials to be adapted for use at community level | Translation @ 30,000 per brochure | 150,000 | 90,000 | 60,000 |
| | | Translation of 10 brochures into Kiswahili and basic assistance for CSO to translate into local dialects (5 brochures in year 1, 3 brochures in year 2 and 2 brochures in year 3) | Brochures @ 25 each | 5,000,000 | 5,000,000 | 5,000,000 |
| | | Print and distribute materials | | 900,000 | 900,000 | 0 |
| | | Hold 3 meetings with CSO producing educational materials | Translation meetings @ 300,000 each | | | |
| Subtotal | | | 30,060,000 | 18,890,000 | 22,356,000 | |

ANNEX 5: Estimated Financing Requirements (Continued)

| Strategy | Activities and Targets | Cost per Unit, Ksh | Year 1 FY 07/08 | Year 2 FY 08/09 | Year 3 FY 09/10 |
|--|---|--|----------------------|-----------------|-----------------|
| 2 Review key policies and guidelines | | | | | |
| 2.1 Update the national IYCF policy and Kenya's Guidelines in the Context of HIV and disseminate nationally | 1 TWG meeting and 1 stakeholders meeting Technical assistance Dissemination of posters and flyers to all health facilities | TWG and stakeholders meetings @ 160,000 Launch meeting @500,000 Material production @ 540,000 | 1,200,000 | 0 | 0 |
| 2.2 Review existing guidelines and integrate standards of food/nutrition interventions for PLWHA and OVC | Conduct one rapid assessment to facilitate scale-up of the integration of guidelines and updating Facilitate guidelines review meetings | Rapid assessment @ 700,000 2 guideline review meetings @ 100,000 Production of reviewed materials @ 700,000 | 1,000,000 | 300,000 | 300,000 |
| Subtotal | | 2,200,000 | 300,000 | 300,000 | |
| 3 Human resources capacity strengthening | | | | | |
| 3.1 Conduct national TOT to train in-service providers at regional level | National training workshop and 11 regional workshops; 30-40 persons per workshop Technical assistance and logistics (retrain in year 3) | 600,000 per workshop | 7,200,000 | 0 | 7,200,000 |
| 3.2 Conduct national TOT training to train pre-service learners | 7 public and 7 private universities, 10 medical training colleges, 66 nursing schools: 2 national workshops for institutional trainers Technical assistance and logistics | 600,000 per workshop | 1,200,000 | 0 | 1,200,000 |
| 3.3 Review integration of pre-service training curricula in nutrition and HIV/AIDS | 2 national workshops for trainers in health professional training institutions | 600,000 per workshop | 1,200,000 | 0 | 0 |
| 3.4 District training of in-service providers in MoH, mission, CSO and private facilities | Providers in CSO, mission and private facilities and outreach programmes: district workshops for 60 district areas Technical assistance and logistics: 35% of districts per year | 600,000 per workshop | 12,600,000 | 12,600,000 | 12,600,000 |
| 3.5 Constituency training of CACC coordinators, CORPS and relevant CBOs | 3-5 persons per constituency in 2-day workshops: 180 constituency workshops for the 210 constituencies at 35% per year | 250,000 per workshop | 15,000,000 | 15,000,000 | 15,000,000 |
| 3.6 Integration of nutrition and HIV/AIDS into training curricula of service providers in agriculture, livestock and fisheries, education, and culture and social services sectors | Conduct national TOT for pre-service and in-service providers in respective sectors | Training needs assessment and gaps in the curriculum and one national workshop for curriculum developers in target sectors Technical assistance @ 600,000 One workshop @ 300,000 | 900,000 | 0 | 0 |
| | | Conduct 2 national TOTs for pre-service and in-service providers in respective sector institutions and | 600,000 per workshop | 1,200,000 | 1,200,000 |

ANNEX 5: Estimated Financing Requirements (Continued)

| Strategy | Activities and Targets | Cost per Unit, Ksh | Year 1 FY 07/08 | Year 2 FY 08/09 | Year 3 FY 09/10 |
|--|---|---|----------------------------|--------------------|----------------------------|
| 3.7 Increase the proportion of HIV/AIDS service points that are served by dedicated nutrition professionals | Recruit and deploy dedicated professionals to cover 80% of public facilities that provide care and support and PMTCT services. Maintain current staff of 90 and recruit 100 nutritionists/dietitians per year to meet coverage target of 80% of centres. | Contract service package at 450,000 per person per year+ gratuity at 30% per year | 111,120,000 | 169,650,000 | 220,545,000 |
| Subtotal | | | 150,420,000 | 198,450,000 | 257,745,000 |
| 4 Quality assurance and standards | | | | | |
| 4.1 Establish quality assurance for nutritional assessment and nutrition care practices for PLWHA and OVC | Develop standard operating procedures for nutrition care and support, and guidelines for identifying best practices Conduct operational analysis for innovations in nutritional care Establish National Steering Committee standards subcommittee of 15 members consisting of KEBS, referral hospitals, MoH, research institutions, PLWHA umbrella bodies and international organisations | National standards subcommittee meetings@ 100,000; cost of travel by road/air, subsistence and materials | 1,000,000 | 100,000 | 100,000 |
| | Support 10 standards subcommittee meetings to develop standards meetings and annual review meetings | | | | |
| 4.2 Publish and disseminate standards for food and nutrition supplements recommended for PLWHA in Kenya and assess consistency | Support KEBS publish, disseminate and distribute standards to all public and non-GoK facilities, and training institutions Produce 30,000 copies of standards and guidelines | Production of standards and guidelines @ 120 per each distribution and courier Distribution of copies @ 200 per facility | 3,600,000 1,100,000 | 0 0 | 3,600,000 1,100,000 |
| | Distribute copies of standards and guidelines to 5,500 health facilities; reprint in year 3. | | | | |
| 4.3 Review and publish an inventory of affordable food and nutrition products for PLWHA in the Kenyan market | Update inventory of the full range of food supplements in the Kenyan market Publish a pocket book on daily inventory of supplements and therapeutic foods in the Kenyan market; print 12,000 copies | Technical assistance and printing of pocket book @ 120 each | 2,000,000 | 800,000 | 0 |
| | Technical assistance | | | | |
| 4.4 Support acquisition of basic equipment for assessment of nutrition status of PLWHA in unequipped facilities. | Systematic acquisition and repair of anthropometric equipment in all public hospitals, health centres and dispensaries: 1 adult scale, 1 paediatric scale and 1 height meter per set; 4 sets per hospital, | Set of scales and height meter @ 40,000 | | | |

ANNEX 5: Estimated Financing Requirements (Continued)

| Strategy | Activities and Targets | Cost per Unit, Ksh | Year 1 FY 07/08 | Year 2 FY 08/09 | Year 3 FY 09/10 |
|---|--|---|--|---|---|
| | scale, 1 paediatric scale and 1 height meter per set; 4 sets per hospital, 2 sets per health centre and 1 set per dispensary (158 hospitals, 521 health centres and 1,633 dispensaries) | | 39,000,000 | 50,000,000 | 60,000,000 |
| 4.5 Support monitoring food and nutrition supplements for PLWHA in the Kenya market for compliance with national standards. | Support for equipment, supplies, data collection tools and reagents NASCOP will work with NPHLS, KEBS, Division of Public Health, Dept. of Standards and Regulatory Services; KEMRI and universities Strengthen existing laboratories to analyze samples, build laboratory staff capacity, monitor and enforce the standards Provide one high performance liquid chromatograph (HPLC) and atomic absorption spectrophotometer (AAS) and annual maintenance Validation analysis during year 1; random analysis in years 2 and 3 | Equipment - HPLC, AAS and maintenance @ 200,000 Ancillary equipment and glassware Supplies for sample analysis @ 400,000 in year 1 and 200,000 per year in years 2 and 3 | 11,970,000 200,000 400,000 | 200,000 100,000 200,000 | 300,000 50,000 200,000 |
| Subtotal | | | 59,270,000 | 51,400,000 | 65,350,000 |
| 5 Communications and advocacy | | | | | |
| 5.1 Launch nutrition guidelines, curriculum and IEC materials and disseminate them nationally and sensitise stakeholders on sessional paper on Food Security and Nutrition Policy | All stakeholders will be invited from district, province and national levels Organise national launch meeting - technical support, materials, logistics | Pre-launch media activities @ 300,000 1-day national meeting @ 1,000,000 Need for more funds to meet operational costs | 1,300,000 | 0 | 0 |
| 5.2 Facilitate and lobby for representation in key stakeholders forums to promote national standards of nutrition and HIV/AIDS Integrate the nutrition care and support indicators in national HIV/AIDS surveys | Advocacy for the nutrition and HIV/AIDS strategy Broaden the scope of advocacy and intensify communications Establish groups to intensify lobbying nutrition brokerage for integration of interventions in the annual sector, agency and programme work plans | One annual stakeholders forum for policymakers, programmers, researchers and trainers Inform and lobby for support in and outside Kenya through Internet Participate in 10 conferences and workshops per year Offer continuous professional development sessions in national and regional meetings | 600,000 700,000 700,000 | 600,000 100,000 750,000 | 600,000 100,000 800,000 |
| 5.3 Promote participation in fairs and music and drama development and presentation at all levels to promote nutrition care and support and destigmatisation of PLWHA; target public occasions including World AIDS Day | Support participation by stakeholders in traditional food fairs, music and drama are targeted to promote nutrition care and support for PLWHA Participation in 17 provincial and district agricultural shows annually, and telecast and radio drama and talk shows | Facilitate one food fair per year Provincial & district agricultural shows @90,000 each Telecast drama activities | 500,000 1,530,000 700,000 | 500,000 1,530,000 700,000 | 500,000 1,530,000 700,000 |

ANNEX 5: Estimated Financing Requirements (Continued)

| Strategy | Activities and Targets | Cost per Unit, Ksh | Year 1 FY 07/08 | Year 2 FY 08/09 | Year 3 FY 09/10 |
|---|--|---|------------------|------------------|------------------|
| | Radio drama on 10 local FM stations | 1,000,000 | 1,000,000 | 700,000 | |
| | Hire drama group @ 150,000 per occasion | 600,000 | 600,000 | 600,000 | |
| Subtotal | | | 7,630,000 | 5,780,000 | 5,530,000 |
| 6 Coordination and collaboration | | | | | |
| 6.1 Coordinate systems for providing nutritional support to PLWHA and OVC with existing networks (DSC, DDC, Kenya Food Security Meeting [KFSM], KFSSG, Health and Nutrition Committee) | Support the existing coordination and supervision and regulatory support systems Establish a national database for activities in nutrition care and support Establish a database of agencies providing nutritional support, recipients by facility/ constituency/ district and the scope of support | Hardware, software and technical support to set up a national database; upload systems and update | 1,700,000 | 200,000 | 200,000 |
| 6.2 Support participation and representation in existing health and nutrition networks | Annual regional consultative meeting for stakeholders in nutrition and HIV/AIDS and professional associations; support 11 regional 3-day meetings for stakeholders | 400,000 per meetings | 4,400,000 | 4,400,000 | 4,400,000 |
| 6.3 Support consultative meetings for stakeholders and partners supporting nutrition and HIV/AIDS programme | Quarterly meetings convened by NASCOP: 3 on-site 1-day meetings and 1 2-day review with planning sessions per year. | 40,000 per on-site meeting and 340,000 per off-site meeting | 460,000 | 480,000 | 520,000 |
| 6.4 Promote consultative and joint biannual planning meetings and financing and coordination of implementation of nutritional and HIV/AIDS services at province, district and constituency levels | Support districts and provinces to effectively plan and develop work plans that can be financed; link quarterly reports to plans Support and participate in planning meetings at all levels, including contribution to the sectoral Annual Operation Plan; meetings to be held biannually Increase budget | Support reviews @ 60,000 per province | 1,020,000 | 1,020,000 | 1,020,000 |
| 6.5 Support mentoring and supervision of implementation of nutritional and HIV/AIDS services at province, district and constituency levels | Support supervision and mentoring for provinces and districts three times annually for all district areas | Support reviews @ 45,000 per district area | 3,240,000 | 3,240,000 | 3,240,000 |
| 6.6 Promote public-private partnerships (PPP) in production, prescription and dispensing of therapeutic and supplemental foods (outreach/drop-in centres) | Support PPP meetings to design alternative delivery models to improve access and sustainability. Link FBP programme to TB DOTS-PPM (public private mix) project. Support 3 design and 4 review meetings in year 1 and biannual meetings in years 2 and 3. Provide scales and technical support to 147 non-GoK facilities providing services (about 50 per year) - 1 set of scales and height meters for each facility | Support technical meetings @ 60,000 per meeting | 240,000 | 240,000 | 240,000 |
| | | | 2,000,000 | 2,000,000 | 2,000,000 |
| | | 1 set of scales and height meter @ 40,000 per set per facility | | | |

ANNEX 5: Estimated Financing Requirements (Continued)

| Strategy | Activities and Targets | Cost per Unit, Ksh | Year 1 FY 07/08 | Year 2 FY 08/09 | Year 3 FY 09/10 |
|---|---|---|-------------------|-------------------|-------------------|
| 6.7 Support strengthening of facility-community interface activities. | Develop clear food and nutrition linkages among community-based systems - CSOs (micro-enterprise activities and optimisation of resource use and coping capacity) | Technical assistance for situation analysis @ 450,000 | 450,000 | 0 | 0 |
| | Orientation of PLWHA umbrella bodies, welfare associations and families Training infected individuals and affected families Training community resource persons and brokerage for credit scheme in liaison with MoYA, MGCSSS and other sectors. Design 5 to 10 pilot projects across the country. | Pilot project design meetings to establish pilot projects | | 0 | 1,500,000 |
| Subtotal | | | 13,510,000 | 13,080,000 | 17,120,000 |
| 7 Food and dietary commodity support | | | | | |
| 7.1 Interventions for malnourished adult PLWHA | Severely malnourished clients (BMI < 16 kg/m ²) requiring therapeutic foods (RUTF): Number of clients is estimated at 15% of the malnourished pre- and ART clients (estimated at 150,050). | RUTF course @ 5,500 per client per year | | | |
| | RUTF intervention to target 22,500 clients and make provisions for relapses [adjust for scale-up based on % facility coverage; 40% in year 1 (184), 60% in year 2 (227) and 80% in year 3 (369)] | | 49,500,000 | 53,900,000 | 40,480,000 |
| | Moderately and mildly malnourished clients (body mass index [BMI] 16-18.5 kg/m ²) requiring supplemental pre-cooked BFF: Number of clients requiring BBF rations for 4 months is estimated at 85%, or 127,550. Include a 2-month course of BFF for the group on RUTF to complete weight gain and address relapses (adjust for scale-up based on % facility coverage; 40% in year 1, 60% in year 2 and 80% in year 3) | Supplemental BFF course @ 3,960 per client | | 219,859,200 | 201,239,280 |
| MMN supplements for clients at stage 3 and 4 of disease: Number of clients not receiving RUTF or BBF estimated at 50% (215,000 clients); supplementation for 3-4 months/client/year | Course of MMN @ 2,400 per client | | 516,000,000 | 516,000,000 | 516,000,000 |
| 7.2 Interventions for malnourished pregnant and lactating women (PMTCT clients) | Severely malnourished PMTCT clients (middle upper arm circumference [MUAC] < 22 cm) requiring RUTF; number estimated at 50%, or 9,302 clients (adjust for scale-up based on facility coverage of 40% in year 1, 60% in year 2 and 80% in year 3) | RUTF course @ 5,500 per client per year | | | |
| | | | 20,464,400 | 18,417,960 | 12,281,500 |
| | Moderately and mildly malnourished clients (MUAC 22-23 cm) requiring BBF rations; number of clients requiring BFF for 4-6 months is estimated at 50%, or 9,302; include a 3-month course of BFF for the group on RUTF to complete weight gain (adjust for scale-up based on facility | Supplemental BFF course @ 5,940 per client | | | |
| | | | 36,755,920 | 33,155,100 | 22,106,700 |

ANNEX 5: Estimated Financing Requirements (Continued)

| Strategy | Activities and Targets | Cost per Unit, Ksh | Year 1 FY 07/08 | Year 2 FY 08/09 | Year 3 FY 09/10 |
|---|---|---|---|---|---|
| | coverage of 40% in year 1, 60% in year 2 and 80% in year 3) MMN supplements for 39,400 clients who are not receiving RUTF or BBF supplementation for prevention or replacement from third trimester to 6 months after delivery | Course of MMN @ 800 per client per month | 189,120,000 | 189,120,000 | 189,120,000 |
| 7.3 Interventions for malnourished HIV-positive children | Severely malnourished children: Number of children requiring RUTF for at least 2 months is estimated at 15,400, or 30% of malnourished children (adjust for scale-up based on facility coverage of 40% in year 1, 60% in year 2 and 80% in year 3) Moderately and mildly malnourished children: Supplementation for least 3 months for 34,000 children (adjust for scale-up based on facility coverage of 40% in year 1, 60% in year 2 and 80% in year 3) MMN supplements for children not on food-based interventions: Supplementation for 51,000 children for at least 6 months/year, including children who have graduated from food-based interventions | RUTF course @ 5,940 per client Supplemental BFF @ 2,660 per course MMN supplementation @ 600 per client per month | 36,590,400 36,176,000 183,600,000 | 32,931,360 32,558,400 183,600,000 | 21,954,240 17,344,480 183,600,000 |
| 7.4 Point-of-use water treatment | Point-of-use water treatment using efficacious chemical formulations necessary to reduce incidence of diarrhoea among PLWHA; based on per client recommended water intake for half of HIV-positive population (471,500, increasing at 5% per year) throughout the year | Liquid and tablet water disinfection chemicals @ 30 household per month | 169,740,000 | 178,227,000 | 187,138,350 |
| 7.5 Supplemental nutrition interventions for OVC | Supplemental feeding for double orphans, estimated at 443,000: A package of RUTF and BFF for orphans 6 months to 5 years (25%, or 110,750); supplemental BFF for older children Link nutritional interventions to ongoing cash transfer strategy (adjust for scale-up of facilities giving supplemental food support to 40% in year 1, 50% in year 2 and 60% in year 3) | Early childhood supplemental package @ 6,000 per child per year | 265,800,000 | 332,250,000 | 398,700,000 |
| 7.6 Bulk commodity transport and storage to ensure maintenance of quality | Supply chain management/transport from Nairobi to facilities Renovate food storage in facilities and provide furniture to underserved facilities Provide containers to facilities without adequate food storage space (it is estimated that 50% of facilities providing ART face major food storage issues) | 3 % of commodity cost Long containers @ 80,000 each | 51,708,178 2,800,000 | 53,141,973 2,800,000 | 51,619,224 2,800,000 |
| Subtotal | | | 1,773,090,220 | 1,825,846,580 | 1,780,079,956 |
| | | | | | |

ANNEX 5: Estimated Financing Requirements (Continued)

| Strategy | Activities and Targets | | Cost per Unit, Ksh | Year 1 FY 07/08 | Year 2 FY 08/09 | Year 3 FY 09/10 |
|---|--|---|---|----------------------|----------------------|----------------------|
| 8 M&E | | | | | | |
| 8.1 Strengthen the M&E system at district and central levels | Equip all KEPH levels of service delivery with registers and tools for M&E activities | Provide hardware and software to 237 facilities, plus accessories, technical support package | ICT package @ 95,000 per facility installation and maintenance service | 21,000,000 | 8,000,000 | 1,500,000 |
| | Design data management system for strengthened nutrition services | Train nutritionists and other key cadres - records officers, nurses, pharmacists - in 6 regional areas on data collection registers, data reporting and preliminary analysis and transmission | Training workshop @ 500,000 per regional area | 3,000,000 | 0 | 3,000,000 |
| | Provide computers, accessories, software for CCCs and treatment centres in KEPH levels 4 to 6 facilities | | | | | |
| | Train staff | | | | | |
| 8.2 Identify common indicators and develop joint M&E framework. | Identify key indicators and include them in health facility MOH facility summary form 711 and community (COBPAR) data capture tools | | Review meetings and support for production of revised data capture tools | | | |
| | Integrate nutrition and HIV/AIDS data collection in the CCCs and produce nutrition registers, data transfer tools for NASCOP and NACC databases | | | 300,000 | 300,000 | 300,000 |
| | Print nutrition service utilisation registers for CCCs, treatment centres and PMTCT service points; design and produce data reporting forms (about 2,000 public and private service delivery points and about 22,000 data transfer forms for these facilities) | | Register and data transfer forms for all reporting facilities @ 1,300 per package of registers and forms; courier service at 300 per facility | 3,000,000 | 3,000,000 | 500,000 |
| 8.3 Support continuous monitoring reports to facilitate scaling up integration of guidelines and their updates. | Facilitate guidelines review meetings and assess the impact of media campaign during the different phases of programme scale-up | | Conduct one rapid assessment and support for meetings | 800,000 | 800,000 | 800,000 |
| Subtotal | | | | 28,100,000 | 9,100,000 | 6,100,000 |
| 9 Research and dissemination | | | | | | |
| 9.1 Support implementation of operational and applied research to strengthen national scale-up | Commission nutrition, systems and policy analysis studies - 2 to 3 priority operational research (OR) projects and 1 to 2 applied research (AR) projects per year | | OR projects @ 2,000,000 to 3,000,000 each and AR projects @ 7,000,000 -10,000,000 per year | 20,000,000 | 15,000,000 | 15,000,000 |
| 9.2 Establish national research priorities for nutrition and HIV/AIDS | National Steering Committee and research -institutions convene an annual research priority- setting workshop | | A national priority -setting workshop | 800,000 | 800,000 | 800,000 |
| Subtotal | | | | 20,800,000 | 15,800,000 | 15,800,000 |
| Gross total | | | | 2,085,080,220 | 2,138,646,580 | 2,170,380,956 |

ANNEX 6: Rationalisation of Therapeutic and Supplemental Food Interventions

| Client category/intervention required | Adults | Pregnant and lactating women | Children (< 14 years) ^a |
|--|---------------------------------------|---|--|
| 1 ^b Population of HIV positive clients and vulnerable children | 943,000 | 68,000 | 103,000 |
| 2 ^c Estimated total population with advanced disease status | 430,000 (46%) | 40,800 (46%) | 51,400 (50%) |
| 3 Number at high risk of malnutrition | 150,050 (35%) | 18,604 (45%) | 51,400 (100%) |
| 4 Number with severe malnutrition (requiring RUTF) | 22,500 (15%) | 9,302 (50%) | 15,400 (30%) |
| 5 ^d Number with moderate malnutrition/risk (requiring BFF) | 127,550 (70%) | 9,302 (50%) | 36,000 (70%) |
| 6 Period of RUTF course | 3 weeks | 3 weeks | 8 weeks |
| 7 Period of BFF course | 4 months (+ allowance for relapse) | 6 months (+ allowance for relapse) | 4 months [6 to 24 month olds: throughout 100%. > 24 month olds: throughout 50% |
| 8 Number requiring MMN supplementation | Vulnerable clients not on RUTF or BFF | Vulnerable clients not on RUTF or BFF | Vulnerable clients not on RUTF or BFF |
| 9 Period of MMN support | 3-4 months/client/year | 6 months then revert to regular ART care protocol | 6 months/client/year |
| 10 ^e Number requiring point of use water treatment to prevent diarrhoea and stabilise gut ecology | 471,500 (50%) | 68,000 (100%) | 103,000 (100%) |
| 11 ^f Double orphans | | | 349,000 |

a Based on provisional estimates; to be stratified by age group when data become available.

b and c Estimated from national statistics for 2006 (NACC and NASCOP, August 2007). No data are available for children. It is estimated that 50 percent will have at least one form of malnutrition.

d Data on malnutrition rates among pregnant and lactating women were not available.

e Rates of diarrhoea and severe gut ecology disturbances are estimated at 15 percent of the clients, not 50 percent as reported in literature. Water treatment at the point of use and counselling should contribute very significantly to reduction of diarrhoea episodes. Stabilisation of gut ecology using probiotics and synbiotics is on hold until a clear policy decision is made.

f The strategy augments programmes targeting OVC in the country and limits intervention to children linked to ART programmes.

ANNEX 7: Commitments for Nutritional Commodities during FY 2007-08

UNICEF Support

Train 1,200 health and nutrition care providers on the management of malnutrition including HIV/AIDS and 1,200 health care providers of MCH/PMTCT services on integrated counselling on IYCF including HIV/AIDS.

Through joint support with WFP, provide supplementary and therapeutic nutritional support to HIV infected adults and children in 10 ASAL districts and Nairobi (Kibera). Support national scale up of utilisation of MMN for PMTCT and paediatric CCC beneficiaries

Establish a baseline for nutritional interventions of PMTCT services as part of a five country UNITAID effort. Publish and disseminate national job aids, counselling cards and IEC materials for infant feeding and HIV and nutritional care for children with HIV/AIDS.

WFP Support

Provide corn soy blend and dry rations to:

- a) Nairobi Seven health facilities under Lea Toto programme sites and three community sites
- b) Busia District Four divisions
- c) AMPATH 18 sites in North Rift region
- d) Coast Province (proposed for 2008; US \$600,000) Kilifi and Mariakani district hospitals
- e) Nyanza (proposed for 2009-2013) Suba, Rachounyo, Bondo

USAID/INSTA (FBP) Programme

Provide therapeutic and supplemental foods to 58 MoH, Mission and private facilities: 16 in Nyanza province, nine in Eastern province, seven in Central province, six in Rift Valley province, five in Coast province, five in Western province, one in Eastern province and three extension sites.

MoH/Global Fund

Support 14 (target number) CCC sites in Suba district with food and nutritional supplements, training for service providers and support supervision.

ANNEX 8: Programme Monitoring and Evaluation Draft Framework and Indicators for Nutrition and HIV/AIDS Strategy

| | |
|---|--|
| <p>Input HR capacity strengthening, information systems, production and education materials, guidelines, assessment tools and other supplies, and processes</p> | <ul style="list-style-type: none"> • Key indicators related to nutrition are integrated into health national HIV/AIDS M&E reporting and plans of lead distribution of sectors and implementers • % of health facilities with necessary tools for proper nutritional • Number of health workers trained in nutrition and HIV/AIDS • % of community resource people trained in nutrition and ART use • % of facilities that have the standard package of nutritional supplies for HIV care/treatment • % of university, medical, nutrition, agriculture and veterinary faculties, and related institutions and colleges that have a curriculum and teach nutrition and HIV/AIDS • Number of community resource persons trained in nutrition and HIV/AIDS • % of health care workers sensitised on stigma issues • Number of new HIV/AIDS and nutrition print materials produced and distributed • Number of hours radio and TV spots are aired • % of CACCs and District Development Committees trained on food and nutrition |
| <p>Output services delivered and coverage</p> | <ul style="list-style-type: none"> • Number of clients assessed for nutritional risk • Number of clients given nutrition education and counselling • Number of clients provided with prescribed therapeutic or supplemental food and/or MMN and/or gut support formulations • % of eligible clients who receive therapeutic/supplemental food support • % of eligible clients who treat drinking water at the point of use • % of treatment centres, CCCs and other service points with integrated nutrition programmes • % of district HIV care programmes with nutrition integrated • Number of infected and affected people reached through outreach programmes • Number of OVC given nutritional assistance |
| <p>Outcome changes resulting from delivered services practices after counselling</p> | <ul style="list-style-type: none"> • Number of clients who adopt and maintain recommended dietary practices after counselling • Number of clients who adopt and maintain appropriate food hygiene, water safety and lifestyle • % of clients receiving therapeutic/supplemental food who fully adhere to treatment regimens • % of clients with reduced frequency of gut related and/or other opportunistic illnesses |
| <p>Impact effect of the interventions on health and nutrition of clients</p> | <ul style="list-style-type: none"> • % of clients able to work • % of malnourished adults who recovered after nutritional therapy • % of malnourished children who recovered after nutritional therapy • % of inpatients with reduced average length of stay • % of OVC in good nutrition status |

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