

KENYA AND HIV/AIDS

Key Talking Points

Kenya is one of nine African countries hardest hit by the epidemic:

- Nine to 10 percent of the adult population is infected with HIV.
- HIV prevalence ranges from 30 to 85 percent among high-risk groups.
- One-quarter of a million Kenyans died of AIDS in 1998.

AIDS Deaths The epidemic is reversing years of progress in health and child survival. AIDS will soon become the major cause of child mortality in Kenya. It has already reduced life expectancy from 63 to 48 years and orphaned half a million children.

HIV in Women In 1997, 16 percent of pregnant women in urban antenatal clinics and 13 percent in rural clinics tested positive for HIV. A study in one area found that 22 percent of 15- to 19-year-old girls were infected with HIV, compared to just 4 percent of boys in the same age group.

Socioeconomic Impact Seven out of ten HIV-positive Kenyans are 18 to 25 years old. Because the illness caused by the virus strikes people during their most productive years, HIV/AIDS threatens the stability and prosperity of Kenyan society.

HIV/AIDS is expected to overwhelm hospitals and health services, erode business profits, and reduce Kenya's gross domestic product by 14 percent by 2005.

Cost-Effective Prevention An analysis by Kenya's National AIDS and STD Control Programme (NAS COP) indicates that the benefit-cost ratio for HIV prevention programs is about 30 to 1.

USAID is the eighth largest donor to Kenya, but it is looked upon as a leader because of its 20-year history of development work in the country and its key role in donor coordination. One of USAID/Kenya's three strategic objectives is reducing the risk of HIV transmission through sustainable, integrated family planning and health services.

National Response After years of inactivity, the government approved a comprehensive, multisectoral national HIV/AIDS policy in 1997. Since then, however, inaction on many critical legal, ethical, and cultural issues has continued.

Despite alarmingly high rates of infection among teenagers, political leaders refuse to consider controversial but effective prevention methods for youth, such as comprehensive family life education and condom distribution.

Lack of political will and resources to implement proven interventions on a wider scale are the greatest barriers to slowing HIV transmission in Kenya.



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Country Profile

With the strongest economy in the Greater Horn of Africa (GHA), Kenya serves as the region's trading and commercial hub, providing sea access for several landlocked countries. It is also a major port of entry and transfer for humanitarian commodities dispersed to needy populations throughout the region.

Because of its regional influence and stature, Kenya plays a critical role in President Clinton's Greater Horn of Africa Initiative. Kenya is central to the success of the East Africa Community, and also to resolving and preventing crises in the GHA.

Four interrelated public health problems combine to constrain Kenya's political and economic development: high fertility rates and a population growth rate of 2.6 percent;

reemerging diseases such as tuberculosis, malaria, and measles; a burgeoning HIV/AIDS epidemic; and arrested progress in child survival.

The country's health system has been stretched thin by a recent explosion of malaria, cholera, and Rift Valley fever due to heavy rains, and by a 1997 nurses' strike that lasted three months. These difficulties left Kenya particularly ill-equipped to cope with rising numbers of AIDS patients and a tuberculosis epidemic fueled by HIV/AIDS. Approximately half the Kenyan population carries a latent TB infection that can be suppressed by a healthy immune system. During the past ten years, the HIV/AIDS epidemic has helped to more than triple the number of TB cases in Kenya, from 11,000 in 1988 to over 40,000 in 1997.

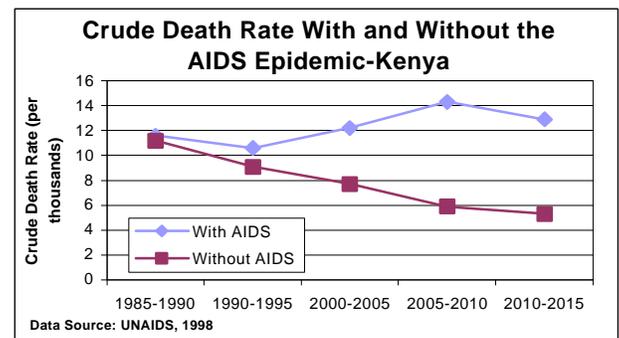
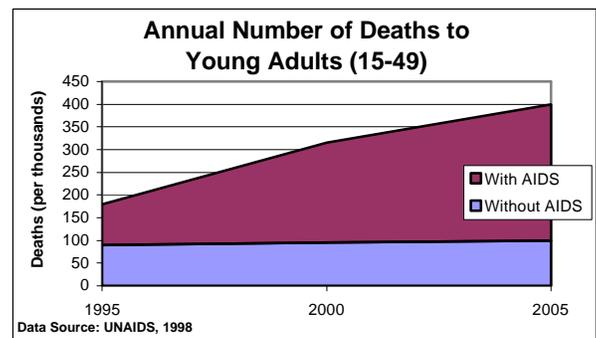
HIV/AIDS in Kenya

The Joint United Nations Programme on AIDS (UNAIDS) reports that Kenya is one of nine African countries hardest hit by the epidemic.

- UNAIDS estimates that one in ten Kenyans is HIV-positive.
- By 2005 as many as 2.1 million people will be living with HIV/AIDS.
- 77 percent of the population have access to health care, but not all facilities offer care for HIV/AIDS.

Due to AIDS, the crude death rate in Kenya will be 105 percent higher in the year 2000 than it was in 1990. By 2010 it will be 137 percent higher.

- About 250,000 people died of AIDS-related diseases in 1998, and health officials estimate that 2.1 million Kenyans will die by 2005.



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- From 1995 to the year 2000, AIDS may cause three times as many deaths among people ages 15 to 39 than all other diseases combined.

- Life expectancy has dropped from 63 to 48 years. By 2010 it will be 44 years.

Women and HIV/AIDS

Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at high risk of infection. Poverty increases the need for sex work by women, as well as the need for school girls to find sugar daddies to pay school fees. Spousal separation due to male labor migration encourages high-risk sexual behavior among men and women. The tradition of wife inheritance also contributes to HIV transmission in some parts of the country.

- In 1997, 16 percent of pregnant women in urban antenatal clinics and 13 percent in rural clinics tested positive for HIV.
- A 1996 study showed that young women of childbearing age (15 to 24) were twice as likely to be infected as males in the same age group.
- The HIV seroprevalence rate is about the same for men and women.

Children and HIV/AIDS

The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers (more than 30,000 per year) will also become infected with HIV, and most of them will develop AIDS and die within two years.

later, Kenya may have at least 1 million AIDS orphans.

AIDS will soon become the major cause of child death in Kenya, overcoming other important causes such as measles and malaria.

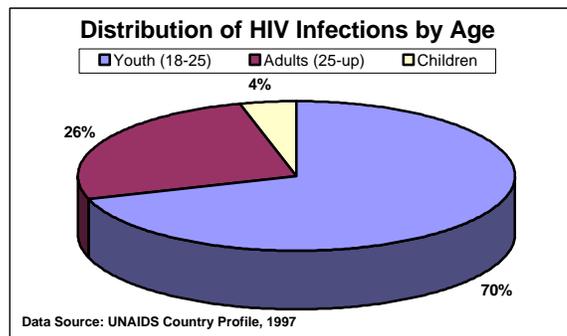
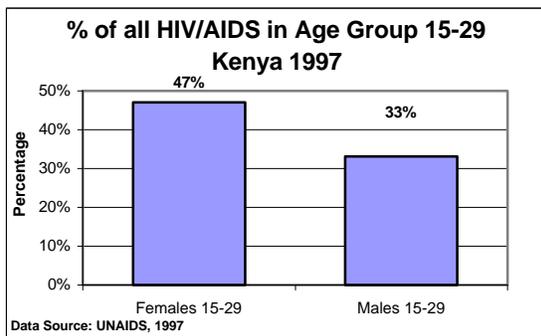
- The annual number of child deaths due to measles and malaria is expected to range from 5,000 to 10,000 through the year 2005.
- The number of children dying of AIDS every year could reach 40,000 to 50,000 over the same period.
- Reversing years of progress in child survival, AIDS will increase Kenya's infant mortality rate by 44 percent by 2015.

- By the year 2000, 600,000 children will have lost one or both parents to AIDS. Five years

Youth and HIV/AIDS

- Seventy percent of the total Kenyan population is under 20 years old.
- Seven out of ten HIV-positive Kenyans are ages 18 to 25. Girls and young women are at greatest risk of HIV infection.

- A study of nearly 10,000 schoolgirls ages 12 to 24 found that on average, girls have their first sexual experience at age 14 or 15.
- A population-based study in one area revealed that 22 percent of 15- to 19-year-old girls were



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already infected with HIV, compared to just 4 percent of boys in the same age group.

- Despite high rates of HIV risk behavior and infection among youth, few Kenyan schools

systematically provide reproductive health education to prepare young people to avoid early sex or to adopt safer sexual practices.

Socioeconomic Effects of HIV/AIDS

The HIV/AIDS pandemic threatens Kenya's food supply, trade, and travel industries, as well as the health and well-being of its people. AIDS-related death and illness among people in their most productive years affect economic prosperity, foreign investment, and sustainable development.

A number of studies indicate that high health care costs and lost income due to HIV/AIDS will be a major burden on the Kenyan economy.

- By 2005 Kenya's gross domestic product (GDP) is projected to be 14.5 percent smaller than it would have been in the absence of AIDS.
- The total direct and indirect costs of AIDS could increase from 2 to 4 percent of the GDP in 1991 to 15 percent by the year 2000.

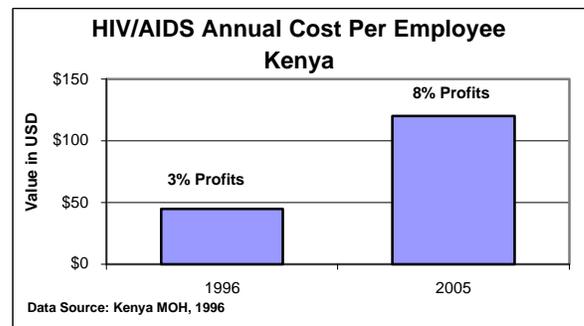
The direct costs alone of caring for millions of people living with HIV/AIDS are expected to overburden an inadequate health care system. By the year 2000, half of the country's hospital beds will be filled with AIDS patients.

HIV/AIDS will also have a significant impact on businesses. Eight percent of HIV-positive adults in Kenya are 18 to 49 years old—the same age group that constitutes the majority of the labor force. By 2005 AIDS will reduce formal sector employment to below 1985 levels, signaling a reversal in Kenya's ability to create higher-paying formal sector employment.

According to the UNDP World Report (1998), half of the Kenyan population is employed—80 percent in agriculture. HIV/AIDS will have its largest economic impact on small-scale farming. A loss of agricultural labor is likely to cause farmers to switch to less labor-intensive crops, and in several cases this may mean switching from export crops to food crops.

HIV/AIDS is expected to reduce annual profits in the coming years. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of experienced employees to illness and death, and the need to train new employees.

A 1996 National AIDS and STD Control Program (NAS COP) analysis of the costs and benefits of HIV prevention programs indicates that the benefit-cost ratio may be about 30 to 1.



Interventions

National Response

The first AIDS case was diagnosed in Kenya in 1984. The Kenyan government initially under-reported the true magnitude of the disease, partly because there was a general sense that it was a "Western" disease and not likely to become a problem in Kenya. Also, there was some concern that it would damage the tourism industry, which was the second largest foreign exchange earner for the country after agriculture. In 1987 the National

AIDS Control Programme (NACP) was established and housed in the Ministry of Health. NAS COP formerly NACP, receives and accounts for funds directly from the government, the private sector, and international donor agencies. In 1997 a comprehensive, multisectoral national AIDS policy (Sessional Paper No. 4 on HIV/AIDS) was approved for the ensuing 15 years.

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Based on this national AIDS policy, the government plans the following interventions:

- Strengthen the infrastructure for the management of sexually transmitted infections (STIs) and opportunistic infections.
- Strengthen the information, education, and communication (IEC) strategy.

Free condoms and treatment for STIs were provided to 500 sex workers in Nairobi, 80 percent of whom were already infected with HIV. After the intervention, condom use rose from 10 percent to 80 percent, averting an estimated 10,200 new infections per year.

- Enhance implementation of health delivery services.
- Provide safe blood through reorganization and effective management of blood transfusion services.
- Enhance collaboration with traditional health systems.
- Strengthen community-based health care through the involvement of individuals, families, and communities.
- Manage and coordinate HIV/AIDS programs using a multisectoral approach.

Donors

Multilateral and bilateral donors have been the major financial supporters of HIV/AIDS activities in Kenya.

USAID's HIV/AIDS funding request FY 1999 is \$3.3 million, almost equal to that of FY 1998 (\$3.2 million).

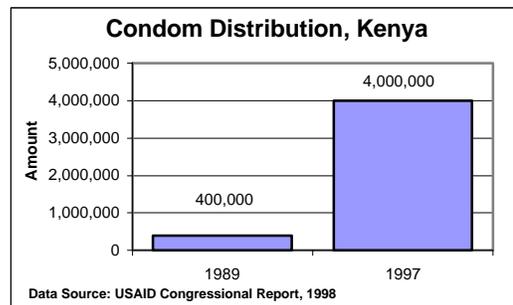
One of USAID/Kenya's three strategic objectives is reducing the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services.

USAID-supported activities will focus on the following areas:

- Supporting HIV/AIDS advocacy and policy development. USAID will work within the public and private sectors at both national and district levels to encourage selected stakeholders (parliamentarians, government workers, educators, business leaders, and others) to implement the key components of the Sessional Paper No. 4 on HIV/AIDS.
- Supporting the national sentinel surveillance system. USAID will work with the government to review the existing sentinel reporting system including data collection, analysis, training and dissemination of findings for advocacy purposes.
- Strengthening existing networks among nongovernmental organizations. USAID will work with umbrella religious organizations, persons living with HIV and AIDS (PLWHA) networks and other groups to improve their

capacity to influence policy and ameliorate the effects of AIDS upon individuals, families, and communities.

- Supporting community-based prevention, care, and support through strengthening communities and community-based organizations to care for individuals and families affected by HIV/AIDS.
- Increasing nationwide social marketing of HIV/STI information and prevention services and commodities, including condoms.
- Increasing HIV prevention, care, and support activities in public and private sector workplaces.
- Innovative operations research in areas including mother-to-child transmission; dual method protection, including female condoms; integrating HIV/STD services into ongoing family planning and maternal child health settings; and finding practical ways to improve availability and access to voluntary counseling and testing.



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Lessons learned from the more mature Kenya programs are being transferred to other countries in the GHA region. Enhancing cooperation among state, regional, and international organizations and the private sector remains a USAID priority.

UNAIDS' coordinating theme group in Kenya includes representatives of UNICEF, UNDP,

UNFPA, UNESCO, WHO, and the World Bank. They routinely meet with heads of agencies and have a system for joint programming.

UNAIDS, its cosponsors, and other UN agencies contributed the following amounts to HIV/AIDS programs from 1996 to 1999:

Organization	US\$ Amount 1996-97	US\$ Amount 1998-99
UNFPA	1,300,000	500,000
UNAIDS	921,200	402,000
UNDP	600,000	600,000
UNICEF	400,000	220,000
WHO		239,000
UNHCR		110,000
Total	3,221,200	2,071,000

UNAIDS cosponsor support 1996-1999.

- **UNAIDS** has supported activities in mother-to-child transmission (MTCT) prevention; building the capacity of community-based NGOs to undertake prevention and/or home-based care activities; workplace programs; procurement of HIV test kits, STI drugs and condoms; and surveillance. It has also taken a lead role in blood safety.
 - **The United Kingdom (DFID):** building community-based NGO capacity to undertake prevention and care activities; STI prevention and control; BCC/IEC; and procurement of HIV test kits, STI drugs, and condoms.
 - **The Government of Canada (CIDA):** STI prevention and control; BCC/IEC; blood safety; and surveillance.
 - **The Government of Belgium:** workplace programs; STI prevention and control.
 - **The European Community:** STI prevention and control; BCC/IEC.
 - **The Government of Germany (GTZ):** community-based programs; distribution of condoms.
 - **The Government of Japan (JICA):** BCC and IEC focusing on youth through TV advertising; research on MTCT; and the development of local HIV test kits.
 - **UNICEF:** MTCT; BCC and IEC focusing on programs for youth being implemented through the ministries of Home Affairs, Culture and Social Services, Information and Broadcasting, Education, and Health.
 - **UNFPA:** building community-based NGO capacity to undertake prevention and care activities; STI prevention and control; BCC/IEC; training of health workers in interpersonal communication skills; workplace programs; procurement of HIV test kits, STI drugs, and condoms.
 - **UNDP:** building community-based NGO capacity to undertake prevention and care activities; improving understanding of and alleviating the socioeconomic impact of HIV/AIDS.
 - **UNESCO:** Improving understanding of and alleviating the socioeconomic impact of HIV/AIDS.
- Donor coordination and collaboration continues to be a challenge in Kenya.

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Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

PVOs and NGOs receive support from a variety of public and private sources. Some of these major USAID-cooperating agencies include Population Services International, Family Health International, The Futures Group, and the Population Council. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas of HIV/AIDS activities. This list is evolving and changes periodically.*

With USAID support, the Kenya AIDS NGOs Consortium (KANCO) has become a strong HIV/AIDS umbrella organization for AIDS NGOs and community-based organizations in Kenya. It promotes information sharing, contributes to NGO capacity building, and supports advocacy programs for national and local leaders.

Challenges

Major constraints to HIV/AIDS control in Kenya include:

- Lack of political will and leadership at all levels. Prevention efforts have been limited by the unwillingness of many political, business, and religious leaders to confront the problem.
- Poverty and the harsh effects of structural adjustment programs, which increase vulnerability to HIV—particularly among women—and make it even more difficult for families and communities to cope with AIDS.
- The rapid increase in the number of people developing AIDS who need care and support, and the growing number of orphans.
- Continued inaction on a variety of legal, ethical, and cultural issues, despite the enactment of the 1997 Sessional Paper No. 4 on HIV/AIDS.
- The slow pace of behavior change.
- Political and religious opposition to standardized family life education, condom use, and other controversial but effective HIV prevention methods for youth. There is still resistance to institution of a nationwide Family Life Education Curriculum, but individual schools are beginning to develop curriculums addressing these issues.
- The prohibitive costs of antiretroviral drugs and treatments for opportunistic infections, which are available to only the wealthiest Kenyans.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Kenya:

- Support for greater community involvement in prevention and care.
- Effective programs for youth, including standardized family life education.
- Measures to ensure a safe and sufficient blood supply.
- Integration of HIV/AIDS and STI services into primary health care programs.
- Legislation and enforcement to protect the human rights of PLWHA.
- Replication and expansion of proven interventions.
- More involvement of PLWHA in developing prevention and care programs.
- Training, technical assistance, and resources to enable Kenya to meet the increasing demand for voluntary HIV counseling and testing.
- Lack of targeted interventions for high-risk groups, such as truck drivers.
- Support for families and communities coping with after-death issues, such as funeral costs, the emotional toll, and survivor economics.
- Recognition that HIV/AIDS is a development issue, not just a health issue.

The Future

It is not too late to mount an effective response to HIV/AIDS in Kenya. NGOs, churches, women's groups, businesses, and microenterprise and community groups have shown that they can play an important role in HIV prevention and care. With additional financial and technical assistance and a more supportive policy environment for their efforts, these groups could be mobilized to expand proven interventions on a national scale.

With the 1997 passage of the Sessional Paper No. 4 on HIV/AIDS, Kenya's government approved a comprehensive, multisectoral national policy for responding to the epidemic. What is needed now is commitment from government, religious, and business leaders at the highest levels to translate rhetoric into reality. With—and only with—such leadership will it be possible to slow the spread of HIV in Kenya.

Important Links and Contacts

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2. UNAIDS: Warren Naamara, Country Program Adviser, c/o UNDP Resident Representative, P.O. Box 30218, Nairobi Tel: (254 2) 624389; email: Naamara@arcc.or.ke.
3. Kenya AIDS NGOs Consortium: Mr. Allan Ragi, Coordinator, P.O. Box 69866, Chaka Road, Nairobi Tel: (254 2) 717664; email kenaids@inconnect.co.ke; website: www.kenaide.arcc.or.ke
4. Kenya AIDS Society:
5. Network of Persons Living with HIV/AIDS in Kenya:



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**U.S. Based
Institutional Interventions**

Kenya

Organization	Intervention																
	Advoc.	BCI	Care/S	Training	Cond.	SM	Eval.	HR	IEC	MTCT	Research	Policy	STD	VCT	Orphan	TB	Other

Cooperating Agencies

FHI/IMPACT & Pop AVSC	X	X	X	X	X		x	X	X	X	X	X	X	X				blood supply RH
Futures Group/Policy Proj. Horizons/Pop. Council	X							X			X	X						Strategic p.
Johns Hopkins University JSI/FPLM	X	X					x	X	X					X				
JHU Pathfinder International					X	X			X					X		X	X	
PRIME PSI				X					X									Drug Supply Drug dist.
Research Triange Institute	X										X	X						

PVOs/NGOs

African Enterprise ADRA	X		primary X							X								
Aga Khan Foundation																		
American Refugee Comm. Amref			X						X								X	RH/Empow. family plann.
CARE Catholic Relief Services			home- care	X					X								X	
CEDPA Child Reach/Plan Int'l.	X			X				X	X	X								
Christian Children's Fund Doctors w/out Borders	X	X	home- care							X							X	
Feed the Children FORD			X	X						X				X	X			

**U.S. Based
Institutional Interventions**

Kenya

Islamic African Relief Agency			X											
Lalmba Association			X		X			X				X	X	
Lutheran World Relief	X		primary	X			X	x	X					X
Medical Mission Sisters	X		X						X			X		X Drug dist.
Nyumbi														
Plan														
Rockefeller														

KEY:	Advoc. Advocacy	MTCT Mother to Child Transmission activities
	BCI Behavior Change Intervention	Research HIV/AIDS research activities
	Care/S Care & Support Activities	Policy Policy monitoring or development
	Training HIV/AIDS training programs	STD STD services or drug distribution
	Cond. Condom Distribution	VCT Voluntary counseling and testing
	SM Social Marketing	Orphan AIDS orphan activities
	Eval. Evaluation of several projects	TB TB control
	HR Human Rights activities	Other (I.e. blood supply, etc.).
	IEC Information, education, communication activities	