



HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	38.6 million (2009)
Estimated Population Living with HIV/AIDS**	[1.6–1.9 million] (end 2007)
Adult HIV Prevalence***	6.3% (2008)
HIV Prevalence in Most-at-Risk Populations**	IDUs: 36% (Nairobi) (2009) MSM: 43% (Mombasa) (2007)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy****	38% (end 2007)

*Kenya Census Bureau **UNAIDS ***KDHS 2008—2009
****WHO/UNAIDS/UNICEF *Towards Universal Access* report, 2008

The first case of HIV was diagnosed in Kenya in 1985; adult HIV prevalence has now stabilized around 6.3 percent, according to the most recent Kenya Demographic and Health Survey (KDHS) 2008—2009. Heterosexual sex is the primary form of transmission in the country, and the epidemic varies greatly across demographic groups. HIV prevalence is nearly two times higher among adult women compared to men, varies markedly by region, and is higher among the richest wealth quintile when compared to the poorest. Data from recent national surveys, including the 2007 Kenya AIDS Indicator Survey (KAIS) and

KDHS 2008—2009, have shown promising increases in behaviors that help slow the spread of HIV, including an increase in condom use, delay in sexual debut, and reduction in the number of sexual partners.

In Kenya, heterosexual sex within a union or regular partnership accounts for 44.1 percent of new HIV infections across adult populations, according to the 2010 United Nations General Assembly Special Session (UNGASS) *Country Progress Report*. Casual heterosexual sex accounts for an additional 20.3 percent of new infections, followed by transmission among men who have sex with men (MSM) and in prisons (15.2 percent); through sex work (14.1 percent); through injecting drug use (3.8 percent); and through transmissions in health facilities (2.5 percent). The high proportion of new infections occurring within regular unions is a key characteristic of the epidemic in Kenya and highlights the importance of prioritizing married men and women as key vulnerable populations in the country, as having multiple concurrent partnerships is common. Approximately 14.3 percent of the married or cohabitating respondents in the KDHS 2008—2009 survey were HIV positive, compared to 6.3 percent prevalence in the adult population.

Prevalence varies up to 15-fold between regions, ranging from 0.9 percent in North Eastern province to 13.9 percent in Nyanza province, according to KDHS 2008—2009, and the gap in prevalence between urban and rural populations has been narrowing in the past decade. Over time, prevalence among urban Kenyans has decreased among women from 12.3 percent in 2003 to 10.4 percent in 2008, and from 7.5 percent in 2003 to 7.2 percent among men. In contrast, there has been a notable increase in prevalence among men in rural areas, rising from 3.6 percent in 2003 to 4.5 percent in 2008, according to KDHS 2008—2009. While a decrease in AIDS-related deaths and scale-up of treatment may influence these data, the increase in risky sexual behavior is an additional contributor to these changes in prevalence, especially among rural men.

Young adults are a vulnerable population in Kenya, a country where the majority of the population becomes sexually active between 15 and 19 years of age. Approximately one-quarter of young people use a condom the first time they have sex. While this is double the percent using a condom in 2003, it remains low for a country with a generalized HIV epidemic. As noted, women are disproportionately infected when compared to men, and young women are particularly vulnerable. Prevalence among young women 15 to 19 years of age (2.7 percent) is nearly four times higher than prevalence among young men of the same age (0.7 percent); prevalence in 20- to 24-year-old women (6.4 percent) shows a similar fourfold increase compared to that of their male counterparts (1.5 percent).

There is limited data on most-at-risk populations (MARPs), which include sex workers, injecting drug users (IDUs), and MSM. Although the Joint United Nations Program on HIV/AIDS (UNAIDS) reports that these three MARPs and the clients of sex workers together accounted for nearly one-third of new infections in 2006, funding for programs targeting and collecting data about MARPs has been limited. The UNAIDS 2009 *Epidemic Update* reported 36 percent of IDUs in Nairobi tested positive for HIV in a recent survey, and a 2009 survey in the same



area found 42.9 percent of IDUs tested positive. A 2007 survey in Mombasa found 43 percent of MSM tested positive, while another survey cited by UNAIDS estimates 15 percent HIV prevalence among MSM throughout Kenya. Additional vulnerable populations in Kenya include cross-border migrants, migrant workers, internally displaced persons, prisoners, refugees, pastoralists, fishermen, discordant couples, and the elderly.

Knowledge of HIV/AIDS is relatively high in Kenya, with 75 percent of women and 81 percent of men 15 to 49 years of age aware that the use of a condom can prevent the transmission of HIV. HIV testing and counseling is provided both through voluntary sites and through provider-initiated sites, with 73 percent of health facilities currently offering provider-initiated HIV counseling and testing. Mobile outreach sites target MARPs and other vulnerable populations. The widespread availability of counseling and testing services through multiple outlets has resulted in significant increases in the number of people tested for HIV between 2003 and 2009. In 2003, 14.3 percent of adult men and 13.1

percent of adult women received an HIV test. By 2009, the proportion of adult men and women tested had risen to 40.4 percent and 56.5 percent, respectively.

Stigma toward people living with HIV/AIDS (PLWHA) has decreased markedly in recent years, though it remains a challenge. The 2003 and 2008–2009 KDHS asked if respondents would be willing to care for an HIV-positive family member in their home, would buy fresh vegetables from an HIV-positive vendor, believe an HIV-positive female teacher who is not sick should be allowed to continue teaching, and would not want to keep secret that a family member got infected with the AIDS virus. The proportion of men and women who answered yes on all four accounts increased, from 39.5 and 26.5 percent in 2003 to 47.5 and 32.6 percent, respectively. In the same period, there was a decline in the proportion of respondents willing to disclose a family member's HIV-positive status, and the number of Kenyans with an overall accepting attitude toward PLWHA remains low. The KDHS also found stigma towards PLWHA decreases as both level of education and wealth quintile increase.

Coverage for prevention of mother-to-child transmission (PMTCT) has improved, despite challenges including low utilization of antenatal care services, a low percentage of health facility births (44 percent), and lack of integration of PMTCT services with reproductive health and family planning (FP) services. EPP-Spectrum estimates 72.3 percent of HIV-positive pregnant women received antiretroviral drugs (ARVs) for PMTCT in 2009.

The World Health Organization (WHO) estimated 38 percent of HIV-positive adults were receiving antiretroviral therapy (ART) at the end of 2007, according to the 2008 *Towards Universal Access* report. Since then, there have been substantial increases in ART coverage; the 2010 UNGASS report estimates coverage among adults has increased to 70.4 percent in 2009. As a result of treatment, people are living longer; according to UNAIDS, AIDS-related deaths in the country have fallen by 29 percent since 2002.

PLWHA are particularly vulnerable to developing tuberculosis (TB) because of the increased susceptibility to infection and progression to active TB, which is one of the leading causes of death of PLWHA. The 2008 incidence rate of TB in Kenya was 330 cases per 100,000 population. HIV-TB co-infection is high; 45 percent of new adult TB patients are HIV positive.

National Response

The response to HIV/AIDS in Kenya is currently guided by two documents: Vision 2030 and the Medium Term Plan 2008–2012. Vision 2030 outlines the country's goal to become a globally competitive and prosperous nation with a high quality of life by 2030. The Medium Term Plan 2008–2012 outlines national indicators and targets for HIV. In addition, the Kenya National HIV and AIDS National Strategic Plan for 2009/10–2012/13 (KNSP III) provides guidance on how to implement the national response and reach agreed-upon targets. KNSP III is organized around four primary strategies: health sector HIV service delivery; sectoral mainstreaming of HIV; community-based HIV programs; and governance and strategic information. Programs under KNSP III emphasize community-based approaches, achievement of universal access, coordination among stakeholders to maximize the impact of HIV/AIDS programs, cost-effective approaches, and a rights-based approach.

Coordination of the response to the epidemic is the responsibility of the National AIDS Control Council and its decentralized structures, including District Technical Committees and Constituency AIDS Control Committees. The Council also collaborates with civil society and private sector organizations. The Government is actively seeking ways to increase domestic, sustainable financing of the response to HIV/AIDS, in light of the global economic crisis and the potential for reductions in donor support.

There are 2.4 million orphans in Kenya, and the National AIDS Control Council and National Plan of Action for OVC estimates approximately half of them have been orphaned due to HIV/AIDS. During 2008—2009, the Government's Orphans and Vulnerable Children Policy and National Action Plan was developed and widely disseminated to stakeholders. The country sponsors a cash transfer program for orphans and vulnerable children (OVC) and provides regular cash transfers to poor families caring for OVC. The program aims to foster continued care for OVC and promote their human development through basic education, nutrition, health services, and birth registration, and was named a best practice in the 2010 UNGASS report. Government funding for the program has increased from \$8 million in 2008 to more than \$10 million in 2009, while development partners contributed an additional \$30 million each year. Approximately 250,000 OVC in 75,000 households across 65 districts were received services through the program in 2009, and the program is expected to reach its target of 100,000 households two years ahead of schedule due to increased funding and capacity building.

The number of health facilities providing ART increased from 731 in 2008 to 943 in 2009; 14 percent of all health facilities in Kenya currently provide ART. PMTCT services are free and integrated into maternal and child health (MCH) services and include HIV testing and counseling; preventive treatment with ARVs for both HIV-positive mothers and their infants; counseling and support for infant feeding; access to safe obstetric care; and FP services. The number of health facilities offering PMTCT services has steadily increased from 2,000 facilities in 2007 to 4,000 in 2010. According to the National AIDS and STD Control Program, approximately 60 percent of all health facilities currently offer PMTCT services.

In the past two years (2008–2009), two new interventions were introduced to address emerging priorities in combating the epidemic. Voluntary medical male circumcision has been introduced through the Male Circumcision Policy and Strategic Plan. Data from KAIS 2007 found uncircumcised men were three times more likely to be HIV positive (13.2 percent prevalence) compared to their circumcised counterparts (3.9 percent prevalence), underscoring the potential of this intervention. Services are now provided in approximately 124 health centers across 11 districts, most of which are in communities that do not traditionally circumcise men. The number of men circumcised in these districts increased from 10,000 before 2008 to 90,000 by 2009, the majority under 20 years of age. The second new intervention was prevention with positives, which aims to involve PLWHA in the reduction of new HIV infections. This strategy targets serodiscordant couples in particular and focuses on increasing HIV testing, awareness of status, disclosure of results, and communication between couples. A communication campaign targets health workers, teaching them how to inform and counsel HIV-positive people.

Public-private partnerships (PPPs) have become important tools in the fight against HIV/AIDS in Kenya and throughout sub-Saharan Africa, creating collaborative projects among donors, the private sector, and the Government. One example is Health at Home/Kenya, a PPP that provides home-based HIV counseling and testing, targeting 2 million people in western Kenya from 2009 through 2011. The PPP was launched in 2009 by the Government; the Global Business Coalition on HIV/AIDS, TB, and Malaria; and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in order to bring HIV counseling and testing, TB screening, and insecticide-treated nets to remote households, which often have difficulty accessing care.

PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, Clinton Foundation, the United Kingdom's Department for International Development, and select United Nations agencies are the key donors and partners in the Government of Kenya's fight against HIV/AIDS. The Global Fund has made a significant investment in HIV programs in Kenya, having disbursed a total of \$105.8 million since the first grant in 2003. The country's most recent seventh-round grant focuses on improvement of the quality of life for PLWHA and reduction in the number of new infections. The grant was approved for \$30.7 million to be administered by the Minister of Health and \$16 million by CARE International; in total, the project will receive \$46.7 million. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's total contributions worldwide.

USAID Support

Through the U.S. Agency for International Development (USAID), Kenya received \$328.6 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in Kenya are implemented as part PEPFAR. Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

In December 2009, the Government of Kenya signed a Partnership Framework (PF) fully aligned with the new KNSPIII. This commitment ensures all partners are working as one to support Kenya's most urgent, priority needs

in responding to HIV. The PF will provide a five-year, joint strategic agenda for cooperation between the Government of Kenya and the USG to support progress toward national goals in controlling the HIV epidemic, as well as contributing to the global PEPFAR goals for HIV prevention, care, treatment, and health systems strengthening. The PF is organized around the four core pillars of the KNSPIII.

PEPFAR prevention activities in Kenya include interventions to improve blood safety, reduce exposure through medical injections, expand voluntary male circumcision, and continued scale-up of PMTCT programs. An exciting new prevention program is the Nairobi pilot of the Partnership for an HIV-Free Generation, a unique and promising network of PPPs linking the core competencies of the private sector with the experience and reach of PEPFAR youth programs. Behavioral programs include abstain and be faithful messaging, promotion of condom use, and work with IDUs and other high-risk populations. Programs for PLWHA have expanded, and the PEPFAR *Mwangalizi* Project recruits and trains HIV-positive adults who are successfully managing their own treatment to be *accompagneurs* (mentors) for children without consistent care managers in their homes.

USG activities in Kenya aim to integrate MCH, FP, reproductive health, and HIV/AIDS services in both clinical and community settings across eight provinces. Pregnant and postpartum women who attended FP, antenatal, and PMTCT clinics received counseling on both FP and HIV prevention, as did attendees at voluntary counseling and testing centers, enabling programs to reach a large cross section of the population. PEPFAR support has assisted with the scale-up of the national PMTCT program, which has almost reached national scale.

The USAID East Africa Regional office also supports USG activities in Kenya. In 2009, USAID East Africa worked with communities and local businesses to develop solutions to issues that impede service uptake and behavior change among high-risk populations. An increasing number of programs in Kenya have incorporated substance abuse into their programs, and an alcohol abuse support group developed by a Kenyan community has served as a model for other programs targeting drug adherence and behavior change. The program has expanded to 106 groups with 1,592 members in two years. Initial data suggest this program increases ART adherence and reduces risky behavior.

Innovative programs have improved economic security and access to financial resources for Kenyans. The LifeWorks program increased the economic security of vulnerable women, allowing them to make healthy life decisions. Employees in the Kenya LifeWorks program reported a significant decrease in the incidence of sexually transmitted infections in a 12-month period (from 17 to 0 percent) and doubled regular HIV testing (from 50 to 100 percent). A development program partner worked with one of the country's largest credit unions to extend HIV/AIDS education to 4,000 teacher members, with an estimated total reach of close to 280,000 individuals.

Progress achieved in Kenya through direct PEPFAR support during FY 2009 included:

- 297,800 individuals receiving ART
- 890,400 HIV-positive individuals who received care and support (including TB-HIV)
- 1,057,200 pregnant women receiving HIV counseling and testing services for PMTCT
- 58,600 HIV-positive pregnant women receiving antiretroviral prophylaxis for PMTCT
- 3,412,000 individuals receiving counseling and testing (in settings other than PMTCT)
- 10,833,300 individuals reached with community outreach HIV/AIDS prevention activities that promote abstinence and/or being faithful
- 9,768,700 individuals reached with community outreach HIV/AIDS prevention activities that promote correct and consistent use of condoms and related interventions

Important Links and Contacts

USAID/Kenya

P.O. Box 629, Village Market 00621

Nairobi, Kenya

Tel.: (254) 20 862 2000

Fax: (254) 20 862 2680

Web site: <http://kenya.usaid.gov>

USAID's HIV/AIDS Web site for Kenya: <http://kenya.usaid.gov/programs/health/77>.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids/.