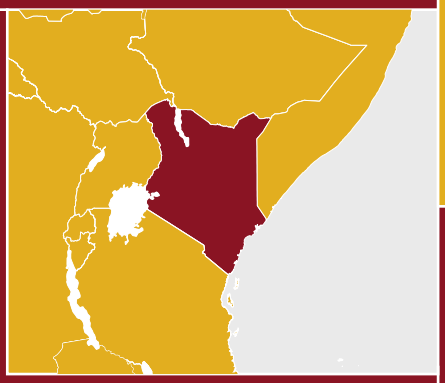
policy

October 2014

ANALYSIS OF THE SOCIAL FEASIBILITY OF HIV AND AIDS PROGRAMS IN KENYA



Sociocultural Barriers and Facilitators and the Impact of Devolution

This publication was prepared by Allan Korongo, Daniel Mwai, Annie Chen, Nicole Judice, and Tom Oneko for the Health Policy Project.

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Suggested citation: Korongo, A., D. Mwai, A. Chen, N. Judice, and T. Oneko. 2014. *Analysis of the Social Feasibility of HIV and AIDS Programs in Kenya: Sociocultural Barriers and Facilitators and the Impact of Devolution*. Washington, DC: Health Policy Project, Futures Group.

ISBN: 978-1-59560-084-4

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The project is implemented by Futures Group, in collaboration with Plan International USA, Avenir Health (formerly Futures Institute), Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

Analysis of the Social Feasibility of HIV and AIDS Programs in Kenya

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ACKNOWLEDGMENTS

We are grateful for the technical support provided by Stephen Muchiri, Thomas Maina, and David Mbote in the Kenya office of the USAID- and PEPFAR-funded Health Policy Project (HPP). We thank the consultant social scientists—Bibi Mbete, Tom Nyangau, Rahma Hassan, and Claudette Jollebo—who served on our fieldwork team. We also thank the research assistants—Diana Wendo, Margaret Mundia, Carol Gakii, Maryanne Mwangi, and Bernard Musyoka—who collected and analyzed the data; and Alice Wanjuu of HPP's Kenya office for making logistical arrangements to facilitate this assessment.

We appreciate the support of the National AIDS Control Council (NACC) for this assignment. Special thanks go to Regina Ombam and Bryan Okiya for organizing interviews through NACC's regional offices. We also thank all of the NACC regional officers in the study sites for supporting our fieldwork in their counties: Busia, Garissa, Homa Bay, Kiambu, Kwale, Makueni, Mombasa, Nairobi, Nandi, Narok, Tharaka-Nthi, and Turkana.

Finally, we thank all of our respondents—national and county policymakers, community leaders, religious leaders, representatives of civil society organizations, and service providers—for their contributions to this report.

EXECUTIVE SUMMARY

Overview

The Government of Kenya, through the National AIDS Control Council, is developing the *Kenya AIDS Strategic Framework 2014/2015 to 2018/2019* to provide guidance on the country's priorities in HIV programming and increase the effectiveness of the national response. The framework will build on and succeed the *Kenya National AIDS Strategic Plan 2010–2013* (KNASP III).

To inform work on the new framework, from April to October 2014, the council collaborated on a study with the Health Policy Project (funded by the U.S. Agency for International Development and the U.S. President's Emergency Plan for AIDS Relief). The study team examined the social, cultural, and political barriers to and facilitators of policies intended to support the four pillars in HIV programming: HIV prevention, treatment, and care and multisectoral mainstreaming. The team also considered how these barriers and facilitators, in turn, affect clients' experience of HIV programs under previous HIV strategic plans. This information made it possible to assess the social feasibility of Kenya's HIV programs.

This analysis was conducted using two approaches:

- **A desk review of the social and political acceptance of existing HIV policies.** The desk review surveyed findings from KNASP III's end-of-term review, *Kenya HIV Prevention Revolution Roadmap: Countdown to 2030*, and *Policy Analysis and Advocacy Decision Model for Services for Key Populations in Kenya.*
- **A field study comprising 150 key informant interviews and 23 focus group discussions.** Representatives of civil society organizations and national and county policymakers provided insight on barriers and facilitators in the development and implementation of HIV programs during the establishment of the new, devolved county government system mandated by Kenya's 2010 Constitution.

The field study covered 12 counties: Busia, Garissa, Homa Bay, Kiambu, Kwale, Makueni, Mombasa, Nairobi, Nandi, Narok, Tharaka-Nithi, and Turkana. These counties were chosen because they have high HIV prevalence and large key populations (men who have sex with men, female sex workers, and people who inject drugs). The heterogeneity of the populations living in these counties is important in studying the broad spectrum of socioeconomic development and ethnic diversity affecting HIV programming.

Findings

The analysis revealed HIV-related needs in the following areas:

- **Prevention commodities:** Problems with access to condoms emerged in pastoral and fishing communities and, most acutely, among men who have sex with men.
- **Antiretrovirals and other drugs for treatment of opportunistic infections:** Respondents in all counties reported that antiretroviral therapy and treatment of other sexually transmitted infections are inadequate and unfriendly to youth (ages 12–24), people living with HIV, and key populations.
- **Integrated services for key populations:** Respondents in counties with big key populations reported dire need for structural, biomedical, and behavioral services for these groups; interventions to address advocacy, stigma, and discrimination; HIV care and treatment; postexposure prophylaxis; management and diagnosis of sexually transmitted infections; prevention of mother-to-child transmission of HIV; peer education; and harm reduction.

- **HIV testing and counseling services:** These are needed in all 12 counties, especially among the hard-to-reach populations. The quality of services also needs improvement. It was reported that youth find most of the available services unfriendly.
- **Nutritional and economic support:** Respondents reported that lack of adequate nutrition undermines treatment and care. Uptake and adherence to antiretroviral therapy is negatively affected by food insecurity and poverty in some counties.
- **Harm reduction services for people who inject drugs:** Respondents said these services in Busia, Kwale, and Mombasa are inadequate and complicated by Kenya's laws that criminalize drug use.
- **Motivation for peer educators/volunteers:** In all the counties covered, most peer educators provide services without adequate motivation and remuneration.
- **Training of county officials on HIV issues:** Respondents said that county officials—especially the members of county assemblies who are involved in policy making, budgeting, and management of resources—are not well-informed about HIV and need training.
- **Psychosocial support for people living with HIV:** The need is especially great in counties with the highest HIV prevalence.

Other issues that emerged are the need to strengthen HIV referral systems, link community-based organizations to the healthcare system, and improve HIV testing and counseling in the voluntary medical male circumcision program. The counties' ability to mobilize resources is challenged by confusion about the requirements of devolution, international agreements, lack of cash, donor fatigue, a shift in donors' interests, policy alignment, and lack of capacity within organizations to write proposals.

KNASP III's achievements

Kenya has made progress toward achieving KNASP III's goals to reduce new infections by half and AIDS-related mortality by a quarter. Noticeable reductions have been realized in overall HIV-related morbidity and the socioeconomic impact of HIV on households and communities. The following shifts were cited as significant factors in the decline in HIV mortality and prevalence and in new infections among children:

- Increased uptake of male circumcision
- Increased awareness and testing
- Expansion of the health system's HIV services
- Increased domestic and international financing
- Enhanced programming for key populations

The study linked these shifts to the following programmatic successes:

- Stakeholders participate consistently in HIV policy making, and their perspectives are reflected clearly in many policy goals and strategies.
- Community awareness of HIV increased, and communication efforts in hard-to-reach areas are increasing the uptake of HIV testing and counseling and early treatment.
- Under KNASP III, the central and county governments have implemented massive interventions to address the health needs of women, couples, and youth.
- More people are using services for the prevention of mother-to-child transmission of HIV; HIV testing and counseling; and treatment, care, and support. In most counties, the number of people living with HIV who are enrolled in antiretroviral therapy has increased, too.

- "Prevention with Positives"—a KNASP III program to reduce high-risk behavior among people living with HIV—performs well in some counties, and postexposure prophylaxis services were reported to be available in many facilities.
- HIV programs are focusing more closely on key populations.
- Coordinating agencies such as the Ministry of Health, the National AIDS Control Council, and the National AIDS and STI Control Programme are reaching out to grassroots communities with programs at local levels to complement the efforts of other government agencies.

According to respondents, if devolution is well-managed, the delivery of HIV services should improve. They said that devolution is an opportunity to understand the local contexts of HIV and tailor the response. Moreover, devolution can instill a sense of local ownership of policies and interventions and increase community participation.

Challenges Going Forward

The following challenges were observed in KNASP III's implementation, and need to be addressed for the next national HIV and AIDS framework to succeed:

- Grassroots stakeholders are poorly informed and unable to articulate HIV policy issues.
- Many interventions focus more on the general population than on key populations, where they would have greater impact.
- Uptake of condom use is problematic in all counties; promotion campaigns pay scant attention to female condoms.
- Mechanisms for coordination and follow-up at the grassroots level are underfunded and not well organized.
- Technical expertise is concentrated at the national level, and national and field offices are not closely linked.
- The country's monitoring and evaluation system and feedback and communication mechanisms are ineffective in informing decision processes.
- Resources to support the logistics of implementing national HIV policy are inadequate.
- Youth are wary of stand-alone HIV testing and counseling centers and public health facilities, for fear of stigma and discrimination.
- The uptake of services for the prevention of mother-to-child transmission of HIV is very low in some counties.
- Services for key populations are erratic, inadequate, and heavily reliant on donor funding.
- The national strategy has not done well in providing nutritional support for people living with HIV and for orphans and vulnerable children under the age of five. The problem is most acute in the poorest counties. Stigma and lack of family and social support have suppressed the uptake of this service.

Conclusion

In recent years, researchers have come to understand that the development, uptake, and effectiveness of biomedical and behavioral strategies for HIV prevention are strongly influenced by social and cultural contexts. As a result, interest in applying social research to HIV prevention has intensified. Sociocultural barriers promote HIV transmission by encouraging practices that can lead to infection. For example, stigma and discrimination deter key populations from using HIV services. Such barriers are opportunities for interventions to alter practices that can lead to infection or the context in which

these practices occur. By the same token, sociocultural facilitators—for example, the ability to read and understand information about HIV—discourage practices that can lead to infection. These, too, are programmatic opportunities.

This report assesses the barriers and facilitators of HIV interventions—their social feasibility— under Kenya's current policies, recommends changes, and offers foundational principles to guide new policy for the successful implementation of HIV programs.

ABBREVIATIONS

ART	antiretroviral therapy
ARV	antiretroviral
CACC	constituency AIDS control coordinator
CASCO	constituency AIDS and STIs coordinator
CBO	community-based organization
CSO	civil society organization
FSW	female sex worker
HPP	Health Policy Project
HTC	HIV testing and counseling
KNASP	Kenya National Aids Strategic Plan
MOH	Ministry of Health
MP	Member of Parliament
MSM	men who have sex with men
NACC	National AIDS Control Council
NASCOP	National AIDS and STDs Control Programme
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
PWP	Prevention with Positives
STI	sexually transmitted infection
SW	sex worker
TOWA	Total War against HIV and AIDS
USAID	U.S. Agency for International Development
VCT	voluntary testing and counseling
VMMC	voluntary medical male circumcision

1. INTRODUCTION

Since September 2013, the National AIDS Control Council (NACC) has been developing the *Kenya AIDS Strategic Framework 2014/2015 to 2018/2019*. The framework will guide the country's priorities in HIV programming, building on and succeeding the current *Kenya National AIDS Strategic Plan 2010–2013* (KNASP III).

To increase the effectiveness of the national response to HIV, the government sought to examine the social, cultural, and political dimensions of Kenya's HIV policies that influence how clients experience HIV programs. NACC and the Health Policy Project (HPP)—funded by the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)—conducted a study to assess factors that support the HIV programs' effectiveness ("facilitators") and those that interfere ("barriers"). The result is this assessment of the programs' social feasibility under Kenya's current HIV policies.

1.1 Methodology

This assessment, conducted from April to October 2014, comprised a desk review, key informant interviews, and focus group discussions.

The desk review sought to identify social, cultural, behavioral, and political barriers and facilitators encountered in the development and implementation of policies for HIV prevention and treatment under KNASP III. The review surveyed findings from KNASP III end-of-term review reports, *Kenya HIV Prevention Revolution Roadmap: Countdown to 2030*, and *Policy Analysis and Advocacy Decision Model for Services for Key Populations in Kenya*, among other documents.

The desk review's results informed the study questions and the data collection instruments used in the interviews and focus groups. This part of the study consulted county and national government officials, community leaders, and representatives of nongovernmental organizations (NGOs), civil society organizations (CSOs), and community-based organizations (CBOs) to obtain insight into the impact of devolution on the implementation of HIV programs.

1.1.1 Sample size and sampling procedures

The assessment collected information from 12 counties in Kenya, selected on the basis of high HIV prevalence, ethnic diversity, geographic location, level of socioeconomic development, and size of key populations: men who have sex with men (MSM), female sex workers (FSWs), and people who inject drugs (PWID). Interviews with 150 key informants and 23 focus group discussions were conducted (see Table 1).

Table 1: Sites of Key Informant Interviews and Focus Group Discussions, by Type of Participant

County	NGO/CSO/CBO representatives	County government officials	National policymakers	Focus group discussions
Busia	10	4		2
Garissa	9	2		2
Homa Bay	9	2		2
Kiambu	10	1		2
Kwale	9	3		2
Makueni	9	3		2
Mombasa	10	3		2
Nairobi	9	4	3	2
Nandi	9	4		2
Narok	9	4		1
Tharaka-Nithi	8	3		2
Turkana	10	3		2
Total	**111**	**36**	**3**	**23**

1.1.2 The assessment process

Four social scientists and four research assistants conducted the interviews and focus groups. All focus group discussions were recorded, and the researchers took detailed notes. The audio recordings were transcribed after the study. After review and cleaning, the transcriptions were coded for verification of facts and quotes and for further analysis.

1.1.3 Ethical considerations

All interviews and focus group discussions were conducted in English. No personal identifiers were collected. Prior to each activity, subjects were asked to read a consent form and provide verbal consent to participate in the study and to be recorded. If a subject refused to give consent, the activity did not proceed. Likewise, if a subject agreed to participate but not to be recorded, the activity proceeded and only detailed notes were taken.

1.1.4 The study's limitations

This study was not a program or implementation evaluation. The findings cannot be used to evaluate specific projects or full implementation of KNASP III. The results of the interviews and focus group discussions may be influenced by personal biases and memory lapses.

1.2 Background

HIV prevalence in Kenya declined from 8.5 percent among those between the ages of 15 and 49 in 2000 to 6 percent for this age group in 2013 (National AIDS Control Council (NACC) and National AIDS and STD Control Programme (NASCOP), Ministry of Health (MOH). 2014.). The drop corresponds to reductions in high-risk sexual practices in the general population, increased access to antiretroviral therapy (ART), and increased access to surveillance data. The HIV epidemic in Kenya has "considerable geographic heterogeneity," with large variations in HIV prevalence depending on geographic location (Dutta et al., 2013). The prevalence of HIV is highest among key populations: 29.3 percent among FSWs, 18.2 percent among MSM, and 18.3 percent among PWID (NACC and NASCOP, MOH, 2014). These rates are extremely high (Kerrigan et al., 2013).

KNASP III called for strengthening prevention initiatives among these and other key populations to achieve the following four results:

- Reduce the number of new infections by at least 50 percent
- Reduce AIDS-related mortality by 25 percent
- Reduce HIV-related morbidity
- Reduce the socioeconomic impact of HIV at the household and community levels

KNASP III's end-of-term reviews and epidemiological trends suggest that key populations encountered barriers that hindered their participation in the strategic plan's interventions and projects for HIV prevention, services, and care.

Kenya's 2010 Constitution gives every citizen the right to the "highest attainable standard of health" and devolves significant authority to counties. It offers an opportunity to establish new mechanisms for financial transfers, decision making, and service delivery to improve the health system (Republic of Kenya, 2010). However, in this changing sociopolitical environment, county and national policymakers wonder what devolution's impact on national HIV programs will be.

Kenya HIV Prevention Revolution Road Map: Countdown to 2030 (NACC and National AIDS and STI Control Programme [NASCOP], Ministry of Health [MOH], 2014) takes a cluster-based approach to the heterogeneity of the country's HIV prevalence and incidence and emphasizes combination prevention. (In this approach, a local team designs and delivers the right mix of biomedical, behavioral, and community interventions to reduce the spread of HIV, targeting the predominant mode of transmission—through sexual activity or sharing needles.) The map identifies a cluster of nine counties that contribute 54 percent of new HIV infections: Busia, Homa Bay, Kisii, Kisumu, Migori, Mombasa, Nairobi, Siaya, and Turkana. It gives priority within this cluster to seven populations: people living with HIV (PLHIV); sero-discordant couples; youth, especially young women between the ages of 15 and 24; sex workers (SWs); MSM; PWID; and fishing communities.

For these seven populations, the roadmap calls for specific, high-impact interventions (see Table 2).

Table 2. Interventions to Prevent HIV among Kenya's Highest Priority Groups

Type of Intervention	Intervention
Biomedical	Antiretroviral therapy regardless of CD4 count; elimination of mother-to-child transmission; treatment as prevention; pre-exposure prophylaxis; post-exposure prophylaxis; voluntary medical male circumcision; family planning; human papillomavirus (HPV) vaccination; treatment of 100% of sexually transmitted infection (STI) cases; linkage of 100% of HIV and STI cases to care and adherence; 3-month regular HIV counseling and testing and screening for STI and HPV; needle/syringe exchange program; medication-assisted treatment of people who inject drugs
Behavioral	Living positively; Prevention with Positives; condom use; couples HIV testing and counseling; support for disclosure to partners; alcohol and substance abuse programs; healthy choices
Structural	Local government bylaws against stigma and discrimination; universal access to HIV and reproductive health services; programs to keep girls in school such as preferential cash transfers for students to stay in school and stay negative; gender-based violence programs; 100% condom use policy; laws that promote social rights and dignity of key populations; improved sensitivity training for healthcare providers and police; empowerment of men who have sex with men; reduction of stigma and discrimination; psychosocial support for key populations

2. FIELD STUDY FINDINGS

2.1. Perspectives on HIV and AIDS Policy Development and Implementation

2.1.1 Perspectives on policy goals, objectives, and targets

This study sought to establish the respondents' general understanding of the policy, goals, and objectives of KNASP III.

The three national policymakers interviewed were well-informed about the objectives and goals of KNASP III and could refer to its supporting documents. At the county level, knowledge of the strategic plan's objectives and goals varied. Most county government officials and most staff members of CSOs that were implementing programs in counties also had a good grasp of the plan's components. Although local implementers of programs, especially those with CBOs, could refer to interventions in the plan, they were unable to articulate HIV policy issues.

Among the CSO staff, the study also found that those who were involved in HIV advocacy could articulate aspects of KNASP III better than those involved in service provision. Among the county health officials, those who had worked with MOH for some time were more knowledgeable about HIV policy issues than those who were recently hired. Knowledge was lowest in the general population; most people could not name any aspect of the strategy or the supporting documents.

Most respondents who had a good grasp of KNASP III felt that its vision, objectives, and targets were well-framed and realistic. They felt that the plan was geared to the provision of comprehensive, high-quality, accessible, and affordable interventions both for the general public and key populations. The interventions were seen as having been designed to influence positive behavior change among Kenyans generally and in key populations particularly. These respondents considered HIV testing and counseling (HTC) and prevention of mother-to-child transmission (PMTCT) offered at community and health facilities to be especially important. Other interventions they considered important were the timely linking of all PLHIV to care and treatment, the provision of a social environment supporting access to and uptake of HIV interventions, and the improvement in adherence to ART.

Busia, Homa Bay, Kwale, and Mombasa have large key populations and also large fishing communities—one of the *Roadmap*'s high-priority populations. They are also home to many truck drivers—another group among whom HIV is more prevalent. In these counties, respondents from NGOs focusing on key populations felt that KNASP III's interventions were spread among the general population rather than focused on the groups with greatest need. In counties with hard-to-reach communities—Kwale, Makueni, Turkana, and some parts of Narok—respondents felt that HIV services had poor geographical coverage, limiting access.

NACC's responsibility to disseminate and explain the policies and strategies to everyone charged with implementing them was at the core of these findings. Most respondents felt that the understanding of KNASP III, or lack of it, depended on NACC's ability to reach out to organizations implementing the national strategy. There was consensus that KNASP III's communication strategy was either inadequate or did not exist. Although respondents felt that KNASP III was conceptualized well, some saw challenges in county-level dissemination. A policymaker at the county level had this to say about KNASP III's communication strategy:

> *I believe this is a well-thought-out document. However, most of the stakeholders down here don't know much about the content. I think there should have been a better strategy to ensure that those implementing interventions at the community level have a better understanding of the document.*
>
> —County policymaker, Narok

These findings suggest that a clear plan for dissemination of the national AIDS strategic framework and its supporting documents is required.

2.2 Perceived Achievement of KNASP III Goals and Objectives

Generally, respondents who were aware of KNASP III rated it highly. They attributed most of the challenges that arise to poor implementation rather than to inadequacies of the strategy itself, which they described as "progressive." They felt that most of the interventions have been helpful in addressing community health needs.

> *As someone who has worked on HIV and AIDS issues for a long time, I can say that KNASP III was very comprehensive. At least it addresses most issues not only in regard to prevention, care, and treatment but also it includes other vulnerable populations. In my view the implementation may be the challenge.*
>
> —CSO worker, Busia

Respondents saw the strategy as successful, because it addresses important concerns: raising awareness, preventing new infections, improving access to services, reducing stigma, and easing the burdens that HIV imposes on families. Respondents also commended KNASP III's emphasis on evidence-based interventions and efforts to draw lessons from experience.

Respondents interviewed in most counties also noted that KNASP III has addressed the health needs of women, couples, and youth (those ages 12 to 24), with massive interventions by the national and county governments to meet women's needs through antenatal care, PMTCT, family planning, and cervical cancer screening and treatment services. In contrast, they said, the strategy has failed to address the needs of men comprehensively. Respondents in Busia, Homa Bay, Kwale, Makueni, and Narok felt strongly that there are more women-related services and that HIV services reach more women than men. They also felt that minimal attention has been paid to men, especially HIV-negative heterosexual men and men not in steady relationships:

> *Here you see services for women all over. Men have been forgotten. I think donors are more inclined towards supporting interventions that target women.*
>
> —CSO worker, Kwale

> *I think when we consider gender, there is a bias towards women-related services here. Women are vulnerable, but men are being left out. Here, men are not well-targeted for services such as HIV testing.*
>
> —Religious leader, Homa Bay

2.2.1 HIV prevention

One major projected outcome of KNASP III is to strengthen HIV prevention by (1) increasing uptake of prevention measures by men and women, (2) enhancing PMTCT and voluntary medical male circumcision (VMCC), and (3) increasing access to post-exposure prophylaxis. This study sought respondents' opinions on whether this outcome has been realized.

Community awareness of HIV

Generally, respondents felt that continuous education about HIV is central to the strategy's implementation and key to its success. Because of KNASP III, they said, awareness of HIV has grown, increasing uptake of HTC and early treatment, especially in rural and hard-to-reach areas in Garissa, Kwale, Makueni, Narok, and Turkana. Even so, they said, awareness is greater in urban areas than in rural and marginalized ones, because interventions to promote awareness in rural areas and among some key populations depend highly on donor support and are sporadic as a result. They called for more consistent focus of HIV education on young people, key populations, and rural areas.

Condom promotion, demonstration, and distribution

The Kenya government has actively promoted condom use since 2001. KNASP III recognizes the importance of condom marketing and distribution in preventing new infections. Our findings show that uptake is still problematic in some counties, despite a campaign to make condoms widely available. Especially in the largely rural counties, people consider condoms taboo for cultural and religious reasons and do not openly use them.

> *Condoms here are considered haram (prohibited) and people use them discreetly for fear of being labeled prostitutes. No shop here sells condoms, as their use is considered un-Islamic. People depend on NGOs and hospital dispensers for access to condoms.*
>
> —Focus group participant, Garissa

The use of condoms is also hindered by misconceptions about that, as well as by social, economic, and structural barriers. For example, in Kwale, Makueni, and Mombasa, stockouts both of male and female condoms were reported. Moreover, many county respondents mentioned that the condom promotion campaigns pay scant attention to female condoms. CSOs working with key populations, especially MSM and SWs, reported that more rigorous and targeted campaigns to promote, demonstrate, and distribute condoms and lubricants are needed.

Prevention of mother-to-child transmission of HIV

KNASP III was seen to have done fairly well in reducing cases of mother-to-child transmission of HIV. Half of the counties visited in this study reported increased uptake of PMTCT services. However, in Busia, Garissa, Homa Bay, Kwale, Narok, and Turkana, uptake remains low, because of ignorance and lack of information, poor use of antenatal care services, and social pressure to breastfeed, stigma, and home deliveries by traditional birth attendants. Here are some excerpts of discussions about this:

> *Many women here are uneducated. They are completely ignorant of PMTCT services. This is especially the case in rural, remote areas.*
>
> —Focus group participant, Turkana

> *Very few women here attend antenatal services and most deliveries are at home. Apart from services being far from them, traditional birth attendants also discourage them. In this way, they may not enroll for PMTCT services.*
>
> —Policymaker, Narok

> *The culture here is that a mother should breastfeed a baby. When you don't breastfeed, questions are raised in the community.*
>
> —Focus group participant, Busia

These barriers must be addressed for the uptake of PMTCT services to increase.

HIV testing and counseling

Respondents were aware of the value of HTC as the entry to care. They reported that KNASP III's implementation has increased uptake of the services in most counties, but uptake is very low in hard-to-reach areas. Uptake is also low among youth, married couples, and some key populations. For example, in the fishing communities around Port Victoria, in Busia, and the beaches around Mbita, in Homa Bay, HTC was reported to be low.

> *These fishermen have no time for HIV testing, because they hardly go anywhere far away from the beaches. Things would be better if the services were provided near the beaches.*
>
> —Focus group participant, Mbita, Homa Bay

In most counties, married men were said to be unaware of their HIV status, but their wives are tested during antenatal care visits. The comments below are typical of responses on this subject:

> *Most men here do not even know their HIV status. The married ones depend on results for their wives when they visit clinics for testing. The youth dislike public facilities for testing.*
>
> —Focus group participant, Homa Bay

> *Men here don't go for health services like women do. Even when a woman tests positive, the man may not be told, for fear of being blamed for the disease and chased away from their matrimonial homes.*
>
> —Focus group participant, Narok

Respondents reported challenges in scaling up HTC among in- and out-of-school youth, who shy away from stand-alone HTC centers and public health facilities. They said new community-based approaches would better serve all populations who lack access to HTC services and create better linkages to care.

In most counties, there were complaints about erratic supply of test kits. For example, respondents in Busia, Kwale, Mombasa, and Narok expressed concern that lack of test kits in some of the testing centers undermines the uptake of HTC.

> *Can you imagine a situation where there are no test kits in a facility for a month? This sometimes happens here.*
>
> —County policymaker, Narok

> *Shortage of test kits is very common in our facilities here. The supply is very erratic and one may not even be sure of the next supply.*
>
> —Focus group participant, Kwale

Voluntary medical male circumcision

KNASP III and the Kenya National Strategy for Medical Male Circumcision, developed by NASCOP, recognize male circumcision as an additional HIV prevention strategy and provide the framework for implementing it. Respondents in this study reported increased uptake of VMMC and attributed it to facility-based and mobile outreach services. However, cultural traditions limit uptake in Busia, Homa Bay, and Turkana. For example, in Homa Bay, it was reported that some community elders discourage VMMC as contrary to Luo traditions.

> *There are some old people here who do not want to hear about it, to the extent of threatening youth with curses.*
>
> —County policymaker, Homa Bay

Also in Homa Bay, the HTC component of VMMC was said to be quite weak. This, coupled with misconceptions about the role of VMMC in HIV prevention, was said to have engendered negative consequences in some areas among the youth in Nyanza, such as multiple sexual partners and unprotected sexual intercourse:

> *There was need for youth to understand clearly that circumcision does not completely remove the risk of infection. Some go for it without proper counseling and thereafter feel empowered to engage in illicit sex….it's counterproductive for some.*
>
> —Religious leader, Homa Bay

Despite these difficulties, most respondents said that as a result of consistent and continuous sensitization, many people are now embracing male circumcision in areas where traditionally the practice has not existed, such as in Luo Nyanza and Turkana. In Nyanza, the involvement of local politicians in sensitizing youth was said to have worked well.

> *The Luo traditionally did not circumcise men. For some time now, there have been efforts by health practitioners, community leaders, and even politicians to encourage people to go for the cut. Key politicians in the region have made a contribution. I think the efforts of political leaders have borne fruit.*
>
> —Community leader, Homa Bay

> *I never thought in my lifetime that people here will begin to circumcise men as they are doing now. Things have changed.*
>
> *—Community leader, Turkana*

Prevention with Positives (PWP)

KNASP III promotes "Prevention with Positives" (PWP) interventions to reduce high-risk sexual behavior among PLHIV. In counties such as Homa Bay, Makueni, and Turkana, activities to encourage prevention among PLHIV were reported to have picked up. Respondents reported that some PLHIV are attending events to support one another and to share information on how to protect relatives and partners from HIV. However, stigma was reported to be a significant impediment to scaling up this initiative.

> *For PWP to work well, PLHIV have to come out. However, there is still a lot of stigma, which makes it difficult for those infected to come out openly.*
>
> —Focus group participant, Makueni

Access to post-exposure prophylaxis

KNASP III recognizes that post-exposure prophylaxis services are an important preventive intervention, and numerous facilities offer them. Many respondents did not know that the services were part of the national strategy, even though counties such as Busia, Kwale, and Mombasa have had a high number of cases of sexual abuse and rape, including of children.

> *There is something happening here in Busia. Men are becoming beasts. Cases of men raping small children are becoming too common. I really don't know what is happening, because we are raping our own children.*
>
> —Female community leader, Busia

> *Female sex workers and men who have sex with other men here experience a lot of abuse, sexual violence, and discrimination. The problem is that those meant to offer protection—…the police—are the worst abusers…it's that bad.*
>
> —Focus group participant, Kwale

Access to post-exposure prophylaxis is limited by lack of knowledge and awareness, stigma, and cultural values and beliefs that make it difficult for children and adults who experience rape and other forms of sexual exploitation to receive help. For example, respondents reported that most rapes happen in family settings, perpetrated by family members, and the families of the victims choose not to report the crimes because of stigma.

> *When a child is sexually molested by an uncle, what do you expect? Rape among the Luhya is taboo. It is worse if the victim and the perpetrator are related by blood. When it happens, families keep it secret to avoid ridicule and stigma.*
>
> —County policymaker, Busia

Participants from NGOs working with MSM and SWs in the counties we visited reported sexual partners as the main perpetrators of sexual and gender-based violence.

Focusing on key populations

KNASP III highlights the importance of focusing HIV interventions on key populations, who contribute significantly to new cases of HIV in Kenya. NGO representatives interviewed in most counties reported an improvement in programs for these groups. However, they felt that more interventions, especially those disseminating prevention messages, are needed. They also expressed concerns about the legal and policy environment for MSM and injecting drug users.

> *The problem of providing services to men who have sex with other men or those who use drugs begins with their legal acceptance. These groups of clients are almost criminalized here. This increases stigma and lack of access to services.*
>
> —CSO worker, Mombasa

> *You get the strong feeling that people around here do not think we deserve services….we are criminals….we deserve jail. I think it should be made clear that we are human and have rights like any other people.*
>
> —Male sex worker, Busia

Counties such as Busia, Homa Bay, Kwale, Mombasa, and Nairobi had some services for SWs, MSM, truck drivers, and fishermen, but these were described as erratic, inadequate, and heavily reliant on the availability of donor funding. Respondents felt that groups who engage in high-risk behavior—such as frequent engagement with sex workers, alcohol use, and unprotected sex with multiple concurrent partners—should be included in the definition of key populations. For example, in Busia, respondents said that cane cutters and loaders and *boda boda* (bicycle or motorcycle taxi) operators should be considered key populations. Respondents in Kiambu cited coffee farmworkers and, in Narok, livestock traders. In some counties, respondents said that interventions for key populations such as SWs need to be buttressed by livelihood programs. In Garissa, special clinics that are friendly to key populations were seen as playing a great role in ensuring access to services. For instance, bar owners said that Sisters Maternal Home satellite clinics bring HIV services closer to the people who need them.

Respondents worried that even though reports have clearly articulated the health needs of key populations, county governments and CSOs working with general populations do not give those needs much priority.

> *I think the needs of key populations are coming out more clearly every other day. This can be seen in various reports by government and other agencies. However, prioritization by county governments and NGOs is the problem.*
>
> —Focus group participant, Mombasa

We have come a long way. There is a lot out there being written about key populations and their needs. There are also some strategies on how to address the issues affecting these populations. Most of the time they just remain on paper. They are never given priority.

—Focus group participant, Busia

2.2.2 HIV treatment, care, and support

Respondents reported that the national strategy helped to improve access to antiretroviral (ARV) drugs. Enrollments in ART were said to have increased in all counties. However, stigma and lack of family and social support negatively affect the uptake of this service. Respondents expressed concern that the national HIV strategy does not adequately address nutritional support for PLHIV and orphans and vulnerable children (OVC) under age five. The lack of nutritional support is reportedly acute in impoverished areas of Busia, Homa Bay, Kwale, Makueni, and Turkana.

Some respondents observed that KNASP III and other HIV policies ignore livelihood interventions to address socioeconomic needs as causal factors in high-risk behaviors, poor nutrition, and low ART adherence. In the counties studied, uptake of ART and adherence to it were said to be hampered by poverty and lack of adequate nutrition.

As much as KNASP III and other policy documents recognize the importance of improving livelihoods in order to reduce vulnerability to the epidemic, there are no clear measures being put in place to address poverty and socioeconomic needs in general.

—County policymaker, Kwale

Some people here on ART complain of lack of food. They claim some of the drugs make them need food all the time. The poor are hard hit. They end up either not using the drugs correctly or not going for them at all.

—Service provider, Makueni

Respondents in Mombasa and Makueni also felt that the HIV strategy fails to guide the counties on the appropriate social support systems for drug adherence by HIV-positive school children and adolescents.

In all the counties, it was reported that most OVC programs rely on donor funding and end when the funding does, and thus are not comprehensive or sustainable. In Homa Bay, for example, many OVC programs were reported to have collapsed, despite the high prevalence of the epidemic.

Homa Bay County is badly hit by the epidemic. We have many orphans here. The community members are trying their best to help, with the support of government, donors, and well-wishers. The problem is that there is a lot of reliance on donors. When there is no donor support, nothing happens. Well-wishers here are also fatigued.

—Community leader, Homa Bay

2.2.3 Community response to HIV within the local context

KNASP III recognizes community support in response to HIV within local contexts. In most counties, constituency AIDS control coordinators (CACCs), representatives of CSOs, and county officials reported that NACC—through its decentralized structures in the counties—has tried to establish inclusion criteria for the community response to HIV. This is done by increasing support for CSOs to deliver HIV services at the community level and by linking community-owned and community-managed structures with the healthcare system.

In all counties visited in this study, many CBOs are providing services. Respondents singled out NACC's Total War against HIV and AIDS (TOWA) project as a positive move in empowering communities to respond to HIV. Although many local CSOs provide HIV services in most of the counties, an urgent need exists for large-scale capacity building of CBOs, buttressed by strong national coordination. Most CBOs are underfunded and lack systems to coordinate and monitor their activities. Further, most are not linked to the healthcare system.

> *There are many AIDS activities now in the community than ever before. Many groups are receiving some little money from TOWA. The problem is that the money is little and activities are not well-organized…there is a lot of wastage, too.*
>
> —Service provider, Tharaka-Nithi

Most CBO staff in the counties called for more money and a system to ensure that funded activities reflect the needs on the ground. In Homa Bay, Makueni, and Narok, respondents reported that the conditions NACC imposes on its funding of CBOs can hamper the agencies' ability to respond effectively to community health needs. The conditions cited were rigid accounting procedures and funding cycles and lack of flexibility for CBOs to prioritize their interventions. Respondents recommended coordination and networking mechanisms for CBOs to improve their effectiveness.

2.2.4 Stakeholder participation in policy development and implementation

The study sought to find out the extent of stakeholder and community participation and feedback mechanisms in the development of the national strategy. There was a general view among those interviewed that stakeholders' involvement has been minimal and that feedback mechanisms are weak. One respondent said:

> *For a good HIV and AIDS policy framework to be in place, all stakeholders must be brought on board. There has been an attempt to do this. However, I feel all relevant sectors are not meaningfully involved, especially at the grassroots level.*
>
> —Focus group participant, Kiambu

However, it was also reported in all the counties that CACCs are providing sensitization and updates on HIV information and interventions to CBO staff and community health workers. And NACC was said to be engaging communities in policy and coordinating their feedback. For example, in Nairobi and Coast, respondents knew of CSOs that have participated in the development and dissemination of HIV policies, especially those for SWs and PWID. Government officials in Garissa, Homa Bay, Nandi, and Turkana reported that they had contributed to the development of county health strategic and operation guidelines. In some counties, these documents are awaiting public input on their content before completion. County officials from Busia, Kwale, Makueni, Nairobi, and Narok reported that CSOs are well-represented as key stakeholders on technical working teams. However, CSOs representing key populations in most of the counties reported being sidelined in this process. Service providers and staff working with key populations felt the same way:

> *Most of us who work with MSM and SWs here are not meaningfully involved as stakeholders…we are often left out. Still, our views don't count much…there is still a lot to be done.*
>
> —Service provider, Mombasa

Some CSOs working with key populations reported being deliberately excluded from the policy process by county administrators. Consequently, CSOs serving key populations have minimal representation and participation at the subcounty and county levels.

For us who work with key populations, there are times when we are nowhere…we are forgotten. As much as we try to put issues related to the welfare of key populations forward, other priorities by county officials are put to the fore. Our participation at the local level is therefore hampered.

—CSO representative, Busia

2.2.5 Effectiveness of coordination agencies in the local HIV response

Respondents generally agreed that coordination of HIV activities should be multisectoral. They cited these coordinating mechanisms: primarily NACC, through the local offices of its CACCs, but also NASCOP, through the subcounty and constituency AIDS and STI coordinators; the MOH, through health facilities; the Ministry of Education; and related NGOs.

NACC was seen as having a good network and representation at the grassroots. However, its ability to coordinate HIV activities in the counties was said to be hindered by the lack of autonomy, adequate funding for the CACCs, and adequate staff. The efficiency both of NACC and NASCOP was seen as highly dependent on partner support. For instance, respondents pointed out that CACCs and constituency AIDS and STI coordinators (CASCOs) have no clear funding to coordinate partner interventions effectively:

NACC is doing a good job, as it has good representation at the grassroots. Unfortunately, the offices tasked with coordinating its activities at the grassroots lack that capacity. They are completely understaffed and work with very little resources.

—Service provider, Kiambu

My budget is very small. In fact, we work mostly with volunteers, who sometimes get completely demotivated due to lack of support. Most of the time, donors help to enhance our ability to be felt on the ground here.

—CACC, Busia

NASCOP and NACC have a lot of visibility on the ground. Unfortunately, they are felt more when their activities are supported by donors. Without donor funding, you see very little activity at the grassroots.

—Focus group participant, Turkana

The Ministry of Health and hospitals have roles in ensuring that services are offered. Respondents associated with CBOs said that NGOs reach out to grassroots communities with local programs to complement the efforts of government agencies.

Overall, respondents supported the coordination framework. They said the deliberate efforts to bring all stakeholders together have worked well, especially because all the agencies involved share their plans for HIV activities. In addition, community and religious leaders, particularly in rural areas, help draw more agencies to share information directly with community members.

The respondents said the lack of central organization and clear stakeholder engagement frameworks affects operations. Many actors implement the HIV strategy at the national and local levels, and fragmentation of the agencies' work makes coordination difficult. In some cases, the sheer number of actors limits or even rules out effective coordination and desired outcomes. Even with the best effort, some actors are often left out of local programs, and along with them, useful contacts and linkages that could lead to better programmatic results.

2.2.6 Unintended consequences of KNASP III

When asked if KNASP III has had any unexpected adverse effects, most respondents could not identify any. Nevertheless, some emerged as interviews and discussions progressed.

HIV's lack of priority at the county level: In all counties, CSOs were said to have played prominent roles in implementing KNASP III. Respondents in Busia, Mombasa, Nandi, and Narok said that county governments believe that CSOs have received a lot of funding for their HIV activities, and as a result, give HIV lower priority in their own budgets than curative care:

> *County officials here believe that it is the work of NGOs to fight AIDS….there is too much money being given to NGOs. They are very reluctant to allocate money for HIV and AIDS activities.*
>
> —Service provider, Nandi

> *All that members of county assemblies would like to hear about is whether there are drugs in hospitals or not. HIV activities are not their concern. They have a feeling that that is the role of CSOs…It is unfortunate."*
>
> —Service provider, Narok

Lack of standards for interventions: Respondents in some counties commented that because CSOs work with little or no oversight, the behavioral interventions they implement lack standardization:

> *I have observed that some CBOs do as they wish. There is no proper monitoring of standards of interventions. At the end of the day, there are many activities which cannot easily be monitored and accounted for.*
>
> —County policymaker, Kwale

Inadequate information about VMMC and high-risk sexual behavior: In Homa Bay, HIV counseling in VMMC services was said to be weak. As a result, many young men who are circumcised lack adequate information on HIV protection and engage in high-risk sexual behavior thereafter. This, it was argued, undermines the overall impact of this intervention.

> *Male circumcision is increasing here. But I know that some youth are becoming more promiscuous, thinking that circumcision protects them from infection…I have heard this is being reported in other parts of Nyanza. It is probably because enough counseling is not being done.*
>
> —Service provider, Homa Bay

Poor uptake of ART: In Garissa, Homa Bay, Kwale, Makueni, and Turkana, poverty and its associated challenges, such as access to good nutrition or money to pay for travel to a clinic, significantly impinge on the uptake of HIV treatment as well as adherence to ART. The side effects of some antiretrovirals also discourage adherence to treatment regimens.

> *In a poor county like ours, some people are so poor that they cannot meet transport cost to the nearest health facility. Uptake and adherence are complicated by this state of poverty.*
>
> —Focus group participant, Makueni

> *I have noticed that one of the major obstacles to adherence in ARV treatment here is the effects of some of the drugs on the patients. Some complain of side-effects of treatment and are reluctant to follow through the treatment.*
>
> *—Health worker, Kwale*

Clients' preference for distant clinics*:* Some PLHIV avoid going to clinics or health centers near their homes for ART, because they fear stigma and doubt that providers will protect their anonymity. This issue, reported in almost all the counties visited in this study, may cause confusion in follow-up and monitoring. Moreover, clients who cannot get money to travel to the more distant clinics drop out of treatment.

> *We receive many people from far-off places who come here for treatment. When you interrogate some, you realize they could as well used services near their homes…Stigma is a challenge.*
>
> Health worker, Kiambu

> *I would rather die with the disease than go to the clinic here. When I have money, I go far for ART. I can't go here, because they treat you so bad and talk to other people about you.*
>
> Man with HIV, Mombasa

Client overdependence: Part of the national strategy's implementation is to educate people about HTC and promote the services. Respondents reported that some people who test positive and begin receiving care and treatment demand more support than service providers can give. Providers at an NGO in Nandi, for example, reported that some clients feel that it is the program's responsibility to take care of all of their needs. These demands, especially for nutritional and economic support, overwhelm the program.

> *You encourage people to go for HTC. When they test positive and need care, they feel that you should be responsible, because you made them go for the test in the first place. They will demand for food and economic support.*
>
> —Service provider, Nandi

> *The level of dependency here is too high. People believe that if you tell them they go for testing, and then you also need to satisfy their demand for related services. CSOs end up being overburdened with demand.*
>
> —Service provider, Homa Bay

Unsustainable interventions: In Busia, Kiambu, Kwale, Homa Bay, and Nandi, respondents decried the lack of long-term commitment to interventions. For example, they said, NACC's TOWA project will end when the funding ends. As a result, the impact is not felt and clients have to look for other ways to support themselves, which is especially difficult for those undergoing treatment:

> *The problem with NACC funding is that the money is very little and most interventions require more time and resources to be felt. Because of this, interventions are not sustainable.*
>
> —CBO worker, Homa Bay

Stigmatization of key populations: Although this issue did not come up often in the interviews, some respondents did say that the implementation of KNASP III has increased the experience of stigma by key populations, especially MSM. In Busia, for example, truck drivers felt that implementing the prevention services tailored to their needs has shifted stigma to them.

> *Before they started focusing on us, nobody in this area knew that we existed. Now people know our existence and some are developing open hostility towards us.*
>
> —Man who has sex with men, Busia

I think people have begun to view us negatively, especially as far as the spread of HIV and AIDS is considered. Since NACC and other donors began providing special attention to truck drivers, community members here think we are all infected with the disease….It is not very good.

—Truck driver, Busia

2.3 The Political Context of HIV Policy Implementation

2.3.1 Devolution and HIV policy implementation

Kenya's new constitution provides for a devolved structure of governance and transfer of power to 47 county governments. Health is one of the devolved services.

This study sought to assess perceptions of the role devolution plays in the development and implementation of Kenya's HIV policy. Respondents described the first year of devolution as "very bumpy" and said no significant changes could be attributed to the new system yet. They said that most of the other sectors are settling in well, but that the health sector has been characterized by confusion, which has affected ongoing work on HIV.

Positive impact: Respondents said that devolution, if well managed, will improve the delivery of HIV services in the counties. They felt that devolution presents an opportunity for counties to understand their HIV epidemic and tailor their response, including policies and interventions, to their unique social, cultural, economic, and political contexts.

They also felt that devolution processes will give the county governments and nonstate actors, including the beneficiaries, a sense of ownership of the policies and interventions. Several respondents also said that some networks that NACC put in place continue to function effectively in the new systems and structures, making devolution of HIV activities easier. Respondents also said that devolution will encourage more community participation than was the case when all decisions were made in Nairobi.

It is too early to evaluate devolution. But devolution has the potential to increase community ownership and participation in HIV and AIDS interventions. Counties now have an opportunity to organize and implement HIV and AIDS interventions to suit their own needs. I think this is very positive.

—County policymaker, Kiambu

Devolution is a good thing. HIV and AIDS activities are becoming more localized. I think, with adequate capacity-building in the counties, counties have the capacity to boost public ownership and participation in the fight against HIV and AIDS in the country.

—Community leader, Tharaka-Nithi

Negative impact: In all counties, respondents said that the creation of county government health services means that new people are taking on roles formerly fulfilled by others. The study found that these changes have led to confusion, which affects the implementation of the national strategy. In addition, the competence of some new office holders to manage HIV activities in the counties was reported to be wanting.

Respondents felt that devolution of healthcare services was done in a hurry. As a result, they said, there is lack of clarity on who reports to whom and what should be done by the national government and by the county governments.

Devolution of health services, though a good thing, was hurriedly implemented without proper thought. Here, there is a lot of confusion….This definitely affects HIV and AIDS activities.

—Service provider, Turkana

This confusion has sometimes led to delays in processing the salaries of healthcare service providers, which has a bearing on their motivation.

Respondents also felt that counties might not be channeling their resources to HIV activities or even to health in general. Especially in poor counties—Busia, Kwale, Homa Bay, Narok, and Turkana—respondents said HIV has been given lower priority than other development areas. In Busia, poverty alleviation was said to be prioritized over HIV. In Narok, it was reported that the county assembly pays more attention to curative care than prevention, and therefore, invests little in HIV-related activities.

If not well-managed, devolution may easily take HIV to the back seat. I have keenly observed that county officials here have the feeling that there are more pressing issues to direct resources to other than HIV and AIDS. This may reverse gains made in the fight against the epidemic.

—CSO service provider, Narok

It was argued in some counties that with devolution, NACC's independence has been compromised, because at the county level, the agency has been integrated in the MOH, even though HIV is a cross-cutting issue. This move has blocked adequate participation by the different sectors in HIV-related issues.

Some respondents in several counties argued that, with devolution, donor funding has declined or vanished. One respondent said that many CBOs lack funds but are operational—waiting for new systems to be put in place and hoping that things will get back to normal. There was a strong feeling that devolution has influenced withdrawal of international funding. For example, representatives of many CSOs across the counties mentioned that funds from some donor agencies that had been supporting ongoing and new projects have been reduced drastically since the new devolved structure of government came into being.

My experience working with HIV and AIDS for many years is enough for me to tell that something is wrong. With devolution there is no money for HIV activities here in the county. I don't know whether money is the problem or whether the county government is not prioritizing HIV and AIDS.

—CSO representative, Busia

I think donors don't like the current national government. Since they came to power, donors are withdrawing support for HIV and AIDS…. Donors seem to be pulling out.

—Focus group participant, Mombasa

2.3.2 Status of county-specific HIV strategies

This study shows that while most of the counties are developing health sector strategic plans, only two—Busia and Kwale—have HIV strategies that are county-specific. The others are using KNASP III to guide their HIV programming. Respondents reported that counties receive support only for capacity building from the national government. For other activities, they use guidelines provided by NGOs working in their regions. Continuous lobbying and education are necessary to ensure that counties make HIV a priority in their plans.

> *I am aware that the county government will soon embark on developing health plans and strategies. As much as they may receive some support and guidance from the national government, they should be encouraged … to prioritize HIV and AIDS issues in the process. Otherwise, the county has many issues to deal with, and HIV may not be prioritized at all.*
>
> —Focus group participant, Kiambu

2.3.3 Capacity of county governments to implement the national HIV strategy

Questions about county governments' capacity to implement the national HIV strategy elicited divergent opinions among the respondents. Overall, though, there was a feeling that, as currently constituted, most county governments cannot implement the strategy.

> *Here in Kiambu, I think we are up to the task in terms of technical capacity. We have the personnel we need and the support of a good network of partners. However, we may need more resources as well as capacity building for some of our staff.*
>
> —County policymaker, Kiambu

> *Many healthcare providers here lack skills ... to address the needs of some key populations, such as MSM and SWs. They need training specifically on how to deliver services to key populations, such as MSM.*
>
> —County policymaker, Mombasa

> *I think we here only need the resources. With resources, we should be able to implement the strategy very well. For now, we lack adequate resources.*
>
> —County policymaker, Busia

> *We are putting structures in place. For now, I should admit we have challenges as we still organize the health sector … The current structures cannot implement the strategy well.*
>
> —County policymaker, Narok

The majority of CSO respondents argued that counties have not communicated the devolved structure and their responsibilities to stakeholders and that this hinders the ability of CSOs to align themselves to county governments. For example, in all the counties visited, respondents mentioned that they often miss county forums such as those related to planning and budgeting, where beneficiaries of HIV services are supposed to be represented. As a result, the services are not well-funded.

Respondents said that county government staff need to improve their technical capacity. Some public service providers in Kiambu, Kwale, and Mombasa reported that many of the health departments do not have enough copies of the current HIV services documents. Most of them said that they rely a lot on sensitization workshops or on their colleagues' advice to implement any new activities or guidelines.

In many of the counties, the respondents said that healthcare providers lack knowledge and skills to provide services friendly to youth and key populations, especially MSM and PWID. In Makueni and Mombasa, service providers from public facilities and those run by CSOs said that they lack knowledge and skills to perform some procedures—for example, anal examination of MSM for STI screening. The findings show that Busia, Garissa, and Turkana have low technical capacity and inadequate staff to meet the demands of implementing the HIV strategy. In Kiambu and Nairobi, in contrast, technical capacity was not said to be a problem. Regarding finances, respondents felt that if well-managed, resources channeled to county governments plus the resources of CSOs could go far toward implementing the strategy.

2.3.4 Political factors that facilitate or hinder implementation of the national HIV strategy

This study sought to examine the political factors that may have hindered or facilitated the implementation of the HIV strategy. The findings are summarized in the following sections.

Facilitating political factors

Devolution and new governance structures: Devolution, which has brought about changes in the health sector, was identified as a potentially facilitating factor in future, when all the governance systems start to operate smoothly and optimally.

> *The new structure of government should enhance the planning and implementation of HIV and AIDS interventions when it is fully rolled out in future. I think it has more gains, especially if it empowers local political actors to play an important role in HIV and AIDS issues and mobilize communities in the process.*
>
> —County health official, Homa Bay

Devolution's challenges were said to derive mainly from the "confusion" that the new administrative structure has brought and the effects that has on service delivery in the counties. There was optimism that effective county operations will facilitate more participation by all stakeholders, and over time, generate good case studies for county-specific strategies.

Respondents felt that the new political structures at the national and county levels could have a positive influence on HIV programming. For example, it was observed that having a county women's representative can be instrumental in the articulation of gender and children's issues in HIV interventions if the incumbents are mobilized and involved in advocacy.

> *Women representatives in the new structure of governance can help in talking about women and HIV and AIDS. They are well positioned to play a role in mobilizing communities in addressing gender issues that affect women. They can also help address issues of children, too, if well mobilized.*
>
> —Focus group participant, Narok

> *County members of Parliament are deep in the villages. We pay them a lot of money. I think they don't do a lot. They can be motivated and mobilized to help fight AIDS at the grassroots.*
>
> —Community leader, Kiambu

Respondents believed that the number of political actors has increased at the county level. They said that members of county assemblies, for example, can be mobilized to strengthen community responses to the HIV epidemic.

International agreements and protocols: Many respondents said that international agreements such as the Abuja Declaration and the Millennium Development Goals have been important advocacy tools for CSOs. Many of them reported that they refer to Kenya's international commitments to push the government to fulfill its obligations. Respondents saw this advocacy approach as having been significant in ensuring the implementation of KNASP III.

Engagement of political actors: Respondents thought that the engagement of politicians in various HIV events and in the dissemination of information in most counties is useful in community mobilization and securing financial support for HIV interventions.

> *The support of politicians is very important in implanting HIV and AIDS strategies here. Some help to mobilize community members …. People listen to them.*
>
> —Focus group participant, Makueni

> *You see, people listen to their leaders. If they support an idea, people are more likely to go with them. They have been useful in spreading the message of HIV and AIDS.*
>
> —CSO worker, Narok

In Nyanza, it was reported that certain politicians have mobilized the community to embrace VMMC, by openly supporting the procedure.

> *When key political readers in the Nyanza region came out openly in support of VMMC, we saw young people go for it in larger numbers. Other politicians in the region also began spreading the message.*
>
> —County official, Homa Bay

2.3.5 Political barriers

The following were identified as key political barriers to the implementation of the national HIV strategy:

Poor transition to devolved government structures: Respondents pointed out that the counties may have rushed to deploy new officers without first creating processes to manage the transition. For instance, the national government needs continuous engagement with established psychosocial support groups and community leaders. It was feared that this may have been lost in the transition to new county officials.

Legal provisions contradicting policy: The study found that the HIV policy has not yet incorporated elements needed for successful HIV programming in Kenya. For example, service providers argued that criminalization limits the reach of interventions for MSM and PWID. They said it is important to work closely with policymakers and lobby for an enabling legal and policy environment for interventions among these groups.

> *I think it is high time that the legality of SWs, MSM, and PWID be addressed once and for all. It poses a lot of challenges in not only the social acceptance of these populations, but also service provision.*
>
> —Service provider, Kiambu

Lack of understanding of HIV issues by county political actors: Political actors at the national and county levels were seen as key drivers of the health agenda. For example, at the county level, the county assemblies approve plans and budgets for HIV activities. In most counties, many political actors who are central in planning and budgeting cannot articulate HIV issues. Thus, HIV is relegated to the periphery and implementation of the national strategy is undermined.

> *County members of Parliament have a lot of power under the new county system. Most of them are not well-educated and cannot articulate health issues, yet they are meant to approve health budgets. They may not appreciate the need to prioritize HIV and AIDS in resource allocation.*
>
> —Community leader, Busia

Politicization of development initiatives at the county level: Respondents said that counties treat health issues—particularly HIV—as secondary to other competing interests. Some respondents also said that county priorities are closely linked to power, where leaders tasked to budget for all areas focus only on those that are most popular.

> *Politicians do what they feel benefits them politically. Like any other development issue, HIV interventions are obviously affected by politics. Here MCAs [members of county assemblies] will only pass budgets depending on their interests.*
>
> —Focus group participant, Makueni

In Busia and Homa Bay, it was reported that CACC jobs are filled by the political patronage of members of Parliament (MPs), who recommend incompetent cronies. In reference to this, a county policymaker observed:

> *How do you expect the CACC to work well when a local MP influences who sits there? They recommend their supporters, who may have no idea ... how to deal with HIV and AIDS issues.*
>
> —County official, Busia

Respondents also noted that the devolution of some services has created conflict between those who were in office previously and the new appointees:

> *We have a problem here. You know, with devolution, some offices are now occupied by people appointed by politicians. Some are experienced; others are not. Some conflicts arise between political appointees and those who have been in the health sector for long… and feel they deserve the positions.*
>
> —Health worker, Homa Bay

Donor priorities and interests: Donor interest in specific problems and geographic areas was identified as a challenge in implementing the national strategy. Respondents observed that some target groups and geographic areas have been left out in the strategy's implementation, because they are not an international donor's priorities. In some counties, examples were cited of disconnect between the groups KNASP III focuses on and those that the communities feel should be given priority.

> *Here, we consider cattle traders a high-risk group. If you tell a donor that you need money to target them, they won't give it to you. They have their own preferences.*
>
> —County official, Narok

> *There is a growing risky population here which donors do not focus on. These are the cane cutters and loaders.*
>
> —FGD participant, Busia

2.3.6 Support for KNASP III's implementation

This study found that support for the HIV strategy's implementation exists in most of the counties and is strongest in those with higher HIV prevalence—Busia, Homa Bay, Kwale, and Mombasa.

In most counties, CSOs were cited as key government partners in the implementation and support of HIV prevention, care, and treatment at the community and health facility levels. With funding from international and local governments, these organizations continue to roll out interventions in partnership with national and county governments. The CSOs were seen as most supportive in providing social mobilization, capacity building, and the funding of care and treatment and other services and activities.

> *We would not have achieved much here without the support of NGOs. They are all over the place and doing a good job in service delivery.*
>
> —County policymaker, Homa Bay

In some counties, corporate entities (e.g., banks and private companies) and institutions (e.g., schools, colleges, and universities) also support implementation of the HIV strategy. They sponsor formulation of the county strategic plans, provide commodities to facilities, and provide money for venues for HIV activities and to support OVC and HIV services. In some counties, interventions rely heavily on the goodwill and support of politicians and religious leaders. Religious institutions support service delivery and community mobilization. Their role has been crucial to communities in Garissa, for example, where their opinions on health and HIV-related issues are taken very seriously.

2.3.7 Opposition to KNASP III's implementation

In most counties the study covered, the national HIV strategy's implementation is not opposed openly. However, opposition exists, from the following groups:

Religious leaders and institutions: In some cases, Christian (Catholic) and Islamic religious organizations and leaders oppose the implementation of some behavioral, biomedical, and structural HIV interventions both for general and key populations—for example, the promotion, demonstration, and distribution of condoms; needle and syringe programs; and provision of hormonal family planning methods. In some areas, some religious beliefs and practices were reported to undermine the use of ART by PLHIV, leading to poor uptake and adherence to the therapy. In none of the counties covered did religious groups and institutions openly endorse most interventions benefiting SWs and MSM.

Traditional health practitioners: Respondents in all the counties covered said that spiritual leaders and medicine men hinder the implementation of the HIV strategy, because they give PLHIV false hope of a cure and lead believers to default on ART.

> *There are many emerging religious people claiming to offer prayers to cure AIDs. Here in Homa Bay, we have witnessed a problem where many women go for such healers, leading to default.*
>
> —Service provider, Homa Bay

> *People are easily convinced that prayer cures HIV. Some don't come for medicine as a result.*
>
> —Service provider, Kwale

Community elders: In some areas, there were reports that community leaders were against some interventions. For example, in Busia, some community leaders were said to disapprove of interventions among MSM.

> *Some community leaders do not approve of the work we do with MSM. They may not openly speak against it, but we know they silently oppose what we do.*
>
> —Health service provider, Busia

In Nyanza, the study found opposition from some community leaders to VMMC.

> *In some areas here, local community leaders still discourage young people from going for male circumcision. They argue it is against Luo culture.*
>
> —Focus group participant, Homa Bay

2.4 The Sociocultural Environment of HIV Strategy Implementation

2.4.1 HIV needs in the counties in relation to services

This study established that in most counties, HIV services are inadequate to meet the needs of key populations. The needs identified across the counties are as follows:

HIV prevention commodities: In all the counties covered, there was a fairly good supply of male condoms. However, respondents reported problems with condom supplies among some groups—for example, pastoral communities in Narok and Turkana and fishing communities around Lake Victoria. More acute, however, was the lack of prevention commodities, such as lubricants among MSM in Busia, Kwale, and Mombasa:

> *It is very difficult to get lubricants here. Some of us have to rely on getting supplies from our contacts in Nairobi. Programs do not support us the way they support female sex workers.*
>
> —Focus group participant, Busia

This study also established that some segments of the population find it difficult to access condoms, even though condom-marketing strategies have borne a lot of fruit. Respondents in all the counties felt that adherence counseling is required, too.

Antiretrovirals and drugs for the treatment of opportunistic infections: This study established that the uptake of antiretrovirals has been scaled up in all the counties visited. However, respondents in most counties noted that the erratic supply of drugs in most facilities challenges the treatment of opportunistic infections. In most counties, population groups such as fishing communities, MSM, SWs, PWID, and pastoralists lack direct outreach for treatment services. Also in most counties, ART and STI treatment services were reported to be inadequate. Further, the available services were described as unfriendly to youth, PLHIV, and key populations.

Services for key populations: In counties with higher visible numbers of PWID, MSM, and SWs, such as Busia, Kiambu, Kwale, Mombasa, and Nairobi, respondents reported a dire need for nondiscriminatory and nonstigmatizing services for key populations. They said service providers are not well-sensitized and trained to deal with the unique needs of these groups, including maintaining confidentiality. In Busia, Kwale, Mombasa, and Nairobi, it was reported that MSM and SWs find available services unfriendly.

HTC services: Respondents in hard-to-reach populations in the counties were especially likely to report that HTC is compromised by a scarcity of facilities, erratic supply of test kits, and poor quality of service. Respondents also felt that the skills of service providers should be addressed. One respondent observed:

> *Counselors in testing centers are mainly volunteers who are not well-trained, hence affecting their quality of service. Although they can administer the test, few have adequate counseling skills.*
>
> —County policymaker, Narok

Youth find most of the available services unfriendly. In Busia and Homa Bay, it was reported that HTC services are not well-sited for the fishing communities and should be provided at the beaches.

Psychosocial support for PLHIV: Psychosocial support emerged as a major theme in discussions with service providers, especially in counties with high prevalence, such as Homa Bay. Although it was reported that psychosocial services exist, they are inadequate to cope with the demand.

> *The burden of the epidemic here is very heavy. We can say drugs are needed. However, that alone will not deal with the sociopsychological challenges the disease imposes. Many individuals and families are suffering, but the services to deal with psychosocial support are not enough.*
>
> —Community leader, Busia

Nutritional and economic support: In most counties, respondents reported that lack of adequate nutrition undermines HIV treatment and care. In poor communities, such as Homa Bay, Kwale, Narok, and Turkana, uptake and adherence to ART are negatively affected by food insecurity and poverty.

> *People [with HIV] definitely would want to go for medicine. Many fail to go, arguing that some of the drugs require them to eat well, yet they have no food. Most are too poor to afford food.*
>
> —Religious leader, Turkana

Harm reduction services for PWID: In Busia, Kwale, and Mombasa, it was reported that harm reduction services for PWID are inadequate, because there are few delivery points and the supply of commodities is erratic. This, it was argued, undermines efforts to reduce HIV transmission among this group. Using narcotic drugs is a criminal offense in Kenya, complicating the delivery of services to PWID.

> *The number of PWID in the coast region is very large. Many of them have nowhere to go for harm reduction services. The supply of commodities is also very erratic where these services can be found. Since they are seen as criminals, this worsens the situation for them.*
>
> —CSO worker, Kwale

Incentives for volunteers: In counties with a high prevalence of HIV, respondents reported heavy reliance on people who volunteer to provide HTC services and peer education. They receive little compensation and, as a result, are not sufficiently motivated to provide high-quality services.

> *We work with many volunteers here. Usually we don't compensate them adequately, because we have no money. Definitely, they can't provide their best in terms of services, because they are not motivated.*
>
> —County health official, Kiambu

2.5 Social and Cultural Factors

2.5.1. Sociocultural factors that facilitate HIV interventions

Respondents said that the presence of NACC structures at the county and subcounty levels through CACCs and CASCOs is central in facilitating prevention, care, and treatment services. Respondents from public health facilities and CSOs working with key populations, for example, reported that through these structures, the national and county services obtain information on HIV epidemiology and are therefore able to identify the main drivers of the infection among key populations and put in place cost-effective interventions:

> *The ministry of health, including the CACC and CASCO, are visible on the ground here. They do a lot of work of passing across prevention messages and treatment of [PLHIV]. We also rely on them for information on the epidemiology of the disease among both general and key populations.*
>
> —CSO worker, Tharaka-Nithi

The presence of CSOs was also seen to facilitate access to HIV prevention, treatment, and care for both the general and key populations. Many respondents—particularly key populations such as MSM and SWs—felt that most CSOs offer friendlier health services than many of the health facilities do.

> *We prefer private services provided by NGOs than public facilities. At least some of the private facilities are friendlier.*
>
> —Female sex worker, Mombasa

Community support for PLHIV and their families is central to treatment and care. In most counties, community members ensure that OVC stay in school and are able to meet their basic needs. The values of charity and supporting orphans that are products of both cultural and religious teachings are supporting KNASP III's implementation.

> *I think, for now, our cultural communal values as well as religious teachings play a very important role in making people share the little they have with the unfortunate in society, such as [PLHIV] and orphans However, with time this may go away.*
>
> —Religious leader, Busia

> *Our traditional way of life, although changing drastically, continues to play an important role in some villages in helping the sick. Those orphaned by AIDS continue to benefit from the goodwill of community members because of this.*
>
> —Religious leader, Homa Bay

Respondents also regarded education as a facilitating factor. Increasing school enrollment means that more people can read about HIV and understand the issues from different sources. This reduces the burden of lack of awareness and understanding that the response to HIV has had to bear for a long time.

> *I can partly attribute the gains we are having in the fight against HIV to the increasing literacy levels in our area. Education is helping in HIV awareness campaigns. [More] people are beginning to read and comprehend HIV and AIDS messages than before.*
>
> —Community leader, Turkana

2.5.2 Sociocultural factors that create barriers to HIV interventions

The barriers that respondents said hamper access to HIV services are social stereotypes; deep-rooted negative cultural beliefs; religious affiliations and beliefs; stigma related to ignorance; apathy toward PLHIV; and sociopolitical and socioeconomic factors that worsen these dynamics.

Gender norms and expectations: Socially-constructed norms and expectations for women and men affect HIV intervention programs. According to respondents in all counties, more women than men turn up for testing and counseling as well as other health services, and their number is increasing.

> *By nature, women are sensitive to their health and that of their children. Their perceived weakness sometimes works for them…. They seek services and share problems.*
>
> —Religious leader, Kwale

It was observed that in most of the communities, men who go to a hospital are considered cowards, reflecting deep-rooted patriarchy and flawed notions of masculinity.

> *For men, being seen in hospitals all the time is not a good thing…. It's a way of saying you are weak and a coward. Men sometimes suffer in silence…. It is culture…. That is the way they are.*
>
> —Policymaker, Busia

Respondents said that some men who do not want to take an HIV test hide behind their wives. For example, during antenatal care visits, pregnant women are tested for HIV, and men use their spouses' results to guess their own status.

It was also reported that in some places, women have to obtain their husbands' permission in key decisions, including seeking healthcare and being tested for HIV. For instance, in Garissa's Somali community, most women have no say in decisions. Moreover, if they seem to know much about sex, they are labeled prostitutes. This has implications for their ability to negotiate safe sex.

> *Here, religion suppresses women completely…Those who express knowledge of sexual matters are branded prostitutes….This undermines going for services. They have to ask permission from men.*
>
> —Female focus group participant, Garissa

Cultural values and practices: This study established that access to HIV services is restricted by such cultural values and practices as polygamy, breastfeeding, early and forced marriage, wife inheritance, and traditional cleansing rites. Others are adolescent rites of passage, belief in curses and witchcraft, misconceptions about male circumcision, female genital mutilation, and misconceptions about HIV transmission, use of herbal therapies, and cultural meanings and significance of sex.

Besides promoting high-risk sexual behavior, polygamy was singled out in almost all the communities visited as a major barrier to the use of HTC:

> *In a community such as ours, men are allowed to marry more than one wife. This at times makes men engage in risky sexual behavior…including concurrent multiple sexual partnerships.*
>
> —Community leader, Homa Bay

Breastfeeding: In most communities visited, social expectations about a mother's duty to breastfeed were seen as undermining the uptake of PMTCT services; mothers with HIV breastfeed their children for fear of being shunned by their communities.

It is very unusual culturally for a woman not to breastfeed a baby in this community. Questions are raised if you don't breastfeed your child. This affects PMTCT services

—CSO worker, Busia

In Busia, Garissa, Homa Bay, and Kwale, wife inheritance and the traditional practice of "cleansing" a widow by having sexual intercourse with her are seen as social customs that facilitate the spread of HIV.

Culture demands that a woman be inherited upon the death of a husband. If a man dies of AIDS, the widow spreads the disease through inheritance. A man can inherit as many women as he feels.

—Community leader, Homa Bay

Also in Garissa, Homa Bay, and Kwale, HIV is linked to witchcraft and curses, undermining the uptake of modern preventive and treatment services.

In Homa Bay, misconceptions about male circumcision were reportedly undermining the use of preventive measures, such as condoms, by the youth.

Some young men here believe that circumcision prevents them from contracting HIV. It's a terrible misconception.

—CSO worker, Homa Bay

Other respondents cited the cultural and social significance attached to sex as a major barrier to the adoption of preventive measures. For example, in Homa Bay, it was reported that practices such as having sex at the onset of the planting season *(golokodhi*), having sex to cleanse a widow *(tiekochola*), and exchanging sex for fish (*jaboya)* are rampant.

Among the Maasai in Narok, sex was described as taboo during pregnancy, and therefore, it is socially acceptable for men to look for other sexual partners during that time. The following views were expressed in a focus group discussion:

It is not unusual here for married men to look for other sexual partners when their wives are pregnant. This is completely acceptable in Maasai culture. The wives have no problem with that, because it is culture.

—Focus group participant, Narok

The nomadic culture of pastoral communities in Marsabit and Narok complicate delivery of HIV services such as HTC and ART.

Pastoralists here are highly mobile, making organization and delivery of services such as HTC and ART very difficult.

—CSO worker, Marsabit

Religious beliefs and practices: Respondents said that some Christian and Islamic leaders strongly prohibit the use of condoms to prevent HIV and other STIs or as a family planning method. Because condoms are perceived as un-Islamic (*haram*), shops are encouraged not to sell them. Religious leaders were also said to use their influence to advocate against interventions for MSM, SWs, and PWID—people they regard as sinful. In Garissa, it was reported that PLHIV suffer discrimination in churches and mosques, exacerbating stigma.

Here, the use of condoms is castigated by religious leaders. The sale and use of this commodity is considered haram in Islam.

—County official, Garissa

Respondents said that in Tharaka-Nithi, a Christian group referred to as "Kavanokia" prohibits members from going to the hospital for any health problem, thus barring them from HIV testing and treatment.

Poverty and unemployment: Respondents in all the counties said that poverty and unemployment undermine HIV prevention efforts as well as access to and uptake of HIV services. Poverty makes people vulnerable to engaging in high-risk sexual practices in exchange for money. Furthermore, poverty makes good nutrition and transportation to health facilities unaffordable. Support for OVC and the distribution of information about HIV are also hampered by poverty. In Kiambu, it was reported that many PLHIV register in more than one ART facility and collect antiretroviral drugs concurrently for sale to the local alcohol brewers, who use them to increase the potency of the brew. They also sell the surplus drugs to other PLHIV who stay away from health facilities because of stigma.

> *Poverty is an issue here. Due to lack of money, some PLHIV are selling antiretroviral drugs. Others are registering themselves for ART in different centers to get the drugs that they sell or exchange for food. It's tragic.*
>
> —Health worker, Kiambu

Stigma and discrimination: In all the counties, respondents strongly felt that stigma and discrimination on the part of family members, religious leaders, and service providers keep PLHIV and key populations from seeking health services. Despite many gains in reducing stigma, the study noted deep-rooted, systematic discrimination in communities and at health facilities. Social rejection and isolation still exist, and those who fall sick due to HIV are sometimes thrown out of their homes. In Garissa, for instance, respondents said that families care more about their social status than they do a family member living with HIV who needs their care and support. In Homa Bay, cases were reported of wives being ejected from their homes when they tested positive for HIV.

In all the counties visited, the respondents interviewed reported that stigma and discrimination make it difficult for key populations to seek health services. In Tharaka-Nithi, respondents spoke of a clinic that works with key populations, which has created a rift within the community due to the unfounded rumor that sex workers and MSM are paid to use the clinic's services.

> *There is a negative perception of MSM here. There is a notion that those who provide services to this group are wasting resources on a sinful group instead of assisting the general population. This creates a lot of hostility against the MSM here.*
>
> —Health worker, Tharaka-Nithi

In Garissa, those who chew *miraa* (an herbal stimulant) and inject drugs are considered mad and no one wants to talk about their existence and plight. They are referred to as "people who abuse drugs," and for them, access to services becomes harder, because of stigma and community exclusion. In Busia, Kwale, and Mombasa, it was reported that MSM and PWID find it difficult to access services due to stigma. In most counties, SWs and MSM said they fear physical harm, sexual harassment, and exploitation, because communities regard them as social misfits who need to be banished.

> *We are perceived negatively here. Some health workers treat us as if we do not deserve services.*
>
> —Focus group participant, Busia

Lack of youth-friendly services: Lack of youth-friendly services was mentioned as a barrier in all counties. The majority of the respondents said that stigma discourages many youth from seeking voluntary counseling and testing (VCT). Stigma by teachers and fellow students, especially those in boarding schools, was reported to lead young people to drop out of ART.

Young men and women shy away from VCT centers due to stigma. Those in boarding schools face stigma from teachers and fellow students. We have observed that this undermines not only uptake of HTC but also ART among them.

—Health worker, Homa Bay

Lack of education: High illiteracy was blamed for the lack of knowledge in some areas about where to access HIV services. Respondents reported that some communities might not benefit from KNASP III's information campaigns about HIV, which use written materials that locals cannot understand. The study found that in some places, HIV is still taken casually. Many people continue to believe it is a myth or conspiracy that has been propagated by western countries.

We are doing a lot in terms of creating awareness here. We have seen a lot of gains. However, illiteracy in the population, particularly among women, undermines our efforts.

—County policymaker, Marsabit

In parts of Busia, Homa Bay, Kwale, Marsabit, Nandi, Narok, and Turkana, it was noted that the majority of women lack education and this hinders their access to services. Respondents also said that those who are less educated are more likely to acquire HIV, because low literacy keeps them from accessing information and other services.

Lifestyle factors: In Busia and Homa Bay, respondents said that fishing communities have trouble accessing services because of their movement from beach to beach. The same was reported of truck drivers in Busia, cattle traders in Narok, and nomadic pastoralists in Turkana. In Mombasa, respondents reported that SWs, MSM, and PWID move frequently, and their adherence to ART is interrupted because most forget to take their clinic cards. People cannot receive ART without these cards.

2.5.3 Institutional capacity for policy development and implementation at national and county levels

Most respondents in all counties said that the technical and leadership roles, financial infrastructure, and other resources of the MOH, through NACC and NASCOP, position the ministry to coordinate and manage the HIV response regionally and nationally. However, many respondents also thought that the roles and responsibilities of NACC and NASCOP are unclear.

The two agencies were said to have the following strengths:

- Legal mandate and national coverage
- Competent technical staff
- Experience in handling HIV issues at national and county levels
- Capacity to source funding for HIV activities (NACC)
- Good network of partners in counties
- Structured calendar that is communicated well to stakeholders
- Skill in policy making and in developing and sharing guidelines (NASCOP)
- Good local-level representation and support (NACC)

The following weaknesses were identified:

- Unclear and underfunded grassroots coordination structure
- Ineffective follow-up mechanisms
- Gap between national offices and field offices, with technical know-how concentrated at the national rather than county level
- Inadequate number of technical staff

- Challenged in community entry
- Low resource base to support the implementation of the national policy
- Constrained logistical support
- Jurisdiction that is too broad, compromising effectiveness
- Feedback and communication mechanisms that do not effectively inform program decision processes
- Slow to roll out tools and guidelines, notwithstanding capacity to develop them (NASCOP)

2.5.4 Resource mobilization and use by policy-implementing institutions

Respondents interviewed in all counties reported that the national and local governments are the main sources of funding for public health facilities. They said that international donors such as the Global Fund, PEPFAR, and USAID are the main funders of CSOs. Some CSO representatives said their organizations have received money from the Global Fund through NACC's TOWA initiative.

Responses varied on whether organizations experience problems in accessing and spending funds. Representatives of international organizations said they have not. Others said they have, and attributed the challenges to devolution, international agreements, cash crunch, and donor fatigue. They also cited shifting donor interests, a lack of political will in government offices, and a lack of capacity within the organization to write successful proposals.

NACC's funding for CBOs was reported to be minimal, and the mode of disbursement was seen to work against the sustainability of interventions. CBOs in the counties had the following complaints about accessing funds from donors:

- **Lack of proposal-writing capacity.** Donors' complex requirements for proposals and a lack of capacity to satisfy them were cited as a challenge. Respondents felt that proposals by local organizations for funding do not fit donors' expectations and thus fail to win grants.
- **Donor priorities that are not responsive to local needs.** Respondents felt that fundable priorities do not reflect people's real needs.
- **Inconsistent funding.** A one-off allocation of funds for a project without follow-up dooms an intervention from the start.
- **Unsustainability.** Most projects initiated with external funding have failed, because they did not incorporate sustainability in their design, strategic decision making, or implementation.

Respondents made the following suggestions to improve resource mobilization and use for HIV interventions:

- Increase budgetary allocation by the government
- Have a specific pool of resources for counties, matching NGO support to specific local priorities
- Provide training on resource mobilization strategies and proposal writing
- Provide funding by merit
- Diversify a project's sources of funding
- Educate county leaders on health issues
- Favor local solutions
- Encourage public-private partnerships as part of social investment

3. CONCLUSION

This study examined sociopolitical factors that serve as barriers and facilitators in the development and implementation of HIV programs in Kenya during the establishment of the new, devolved, national and county government system mandated by the 2010 Constitution. The accounts of key informants and focus group participants show that Kenya has made considerable progress in fostering an enabling policy environment for HIV over the past four years, with the development and implementation of KNASP III. However, the HIV policy environment could be strengthened by addressing some shortcomings in planning and policy formulation and other structural, political, and sociocultural impediments.

The findings reveal that the new governance structure of national and county governments can contribute significantly to an enabling environment for the response to HIV in Kenya. Worth noting is that the devolved system of government, if managed well, can lead to enhanced grassroots ownership of HIV initiatives. County governments can better understand their epidemic and mobilize national and local resources to tailor their response appropriately.

However, as currently constituted, most county governments lack the capacity to implement the national HIV strategy. Most counties are still putting governmental structures in place and have only begun to develop county-specific HIV strategies. The administrative reform process brought about by devolution has intensified challenges relating to multisectoral coordination, as roles and responsibilities have shifted. There are also concerns that, unless well-sensitized, county policymakers—especially the local political actors—will not prioritize HIV in county development planning. This situation calls for initiatives to help counties put adequate governance structures in place, enhance technical capacity, develop county-specific HIV plans, and prioritize the epidemic in county planning and budgeting.

Informant accounts show that neither the national nor the counties' HIV response has comprehensively addressed the needs of men. KNASP III is interpreted mainly to address the health needs of women, couples, and youth, with massive interventions by the central and county governments reportedly focusing on women's needs. More women receive services as a result, but future HIV programming will need to include measures supporting men, especially in hard-to-reach communities.

This study also shows that KNASP III has enhanced community response to HIV by increasing support for CSOs to deliver HIV services at the community level and by linking community-owned and -managed structures with the healthcare system. Although numerous CSOs provide HIV services in many counties, most are underfunded and lack proper coordination and an adequate system to monitor their activities. Large-scale capacity building of CSOs and strong national coordination are urgently needed.

Respondents' reports also reveal that, with the development of KNASP III, programs in most of the counties visited have tightened their focus on higher-risk populations. However, although the needs of key populations are articulated in various official reports, county governments and CSOs working with general populations do not give them much priority. Services for key populations are still erratic, inadequate, and heavily reliant on the availability of donor funding. The legal and policy environment was reported to exclude some higher-risk population groups. Most key populations also still experience discrimination, violence, and stigma, which interfere with their access to and use of services.

Despite ongoing efforts to stop the spread of HIV, the study reveals the persistence of socially rooted stereotypes; deep-rooted negative cultural beliefs; punitive religious beliefs; stigma related to ignorance; apathy among PLHIV; and sociopolitical and socioeconomic factors that escalate the epidemic. These undermine prevention, care, and treatment, as well as psychosocial support for PLHIV and others affected by HIV.

Addressing the barriers and challenges outlined in this report could have significant positive impacts on Kenya's' HIV policy environment. National and county policymakers and other stakeholders must decide which issues are most pressing. This assessment's findings should help them find the way forward.

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