

MONITORING AND EVALUATION
COUNTRY CASE STUDY
KENYA

BY:

GM

BALTAZAR

and

B

HAGEMBE

1.0. INTRODUCTION

The first case of AIDS was described in Kenya in 1984. By the end of October 1998 over 82,000 cases had been reported to the National AIDS and STDs Control Programme (NASCOP).

Like in many other developing countries the outbreak of AIDS was received with shock and panic. With technical and financial support from WHO-GPA the government through the Ministry of Health established the National AIDS Committee (NAC) to advise it on all matters pertaining to the control and prevention of the epidemic. The NAC was assisted by a small secretariat - AIDS Programme Secretariat (APS) which advised the government accordingly. However, the Government's reaction at the beginning was denial and purposeful under-reporting of the true magnitude of the disease. This was due to the misconception that the disease would damage the tourism industry which was the second foreign exchange earner for the country after agriculture.

Plan In order to address the epidemic the NAC formulated the first five-year Medium Term Plan in 1987 whose intervention strategy included:

Safe supply of blood for transfusion

Reducing the risk of transmission of the virus to health workers and

Educating the public on the deadly disease.

Although monitoring and evaluation was not a priority during the early days of the epidemic and therefore not addressed in MTP - 1 (1997 - 1991), AIDS became a visible disease in Kenya in 1990 and it was mandatory that all the cases were reported to the AIDS Programme Secretariat from all hospitals. The Bangui 1985 case definition with a positive Elisa was applied.

Monitoring of the epidemic was given more prominence in 1990 when a sentinel surveillance system was established to monitor the HIV trends as one of the strategies which was articulated in MTP - 2 (1991 - 1996). Thus, the only aspect of the control activities which has continuously been monitored is the HIV/AIDS trends through the sentinel surveillance system, reports of AIDS cases and from blood donors. The data from the sentinel surveillance system showed that, in the early 1990s, when realistic statistics were released, HIV prevalence rate was almost 5%.

At the end of 1997 the prevalence rate had reached 9.0% with high regional variation of between 5% and 35%.

2.0. MTP FORMULATION

2.1. THE FIRST MEDIUM TERM PLAN (MTP -) 1987 - 1991):

The first 5 year Medium Term Plan 1997 (MTP - 1) was formulated in 1987. The overall strategy was to implement the programme activities through the existing Ministry of Health divisions.

The main activities in the MTP - 1 were to:

Establish public awareness campaigns in order to sensitize the population on the new disease;
Strengthen laboratory services to ensure that blood was screened for HIV before transmission
Establish an HIV/AIDS surveillance system
Train health workers in the management of HIV/AIDS

As a result of the intensive public awareness campaign, more than 80% of the population knew how AIDS was transmitted in 1993. (KDHS, 1993). During the same period 98% of the facilities (Government and Non-government) were screening blood for HIV before transfusion. A sentinel surveillance system was established in 1990 to monitor the epidemic.

Although these strategies might have contributed immensely to reducing the rate of transmission compared to what it would have been without the interventions, the epidemic was still increasing at an alarming rate. AIDS was then seen as serious threat to families and society as a whole.

2.2 THE SECOND MEDIUM TERM (1992 - 1996)

The first MTP came to an end in 1991. During the review it was found that the majority of Kenyans had not translated the knowledge they had on AIDS (over 80%) to behavior change. The MTP - 11 was therefore developed in 1992 with a different strategy approach.

The goal of MTP - 2 was to prevent further spread of the epidemic by getting the individuals to make use of their knowledge on AIDS to change their behavior.

There was then an urgent need to mobilize all available human and material resources to address the social and economic impact of the AIDS epidemic.

The plan offered an outline of optimum combinations of strategies and interventions to address the main causes for and effects of HIV/AIDS. It envisaged the formation of a national inter-sectoral AIDS Board, to coordinate HIV/AIDS activities and provincial and district committees to integrate AIDS prevention into existing primary health care services countrywide. District and provincial AIDS coordinators were to be appointed from the existing Ministry of Health staff. It specified that detailed work plans to be developed each year to include specific targets and progress indicators in order to measure the implementation of MTP - 2.

The implementation of the plan was budgeted at US\$9.8 million for the first year and US\$13.2 million for the second year. Funding for the MTP - 2 activities was anticipated to come from the government, bilateral and unilateral organizations and other donors.

The funds never came and almost all the planned activities were therefore not implemented.

2.3 STRATEGIC PLANNING 1998 - 2001

The 2nd MTP was reviewed in 1997. Some of the review team's findings and recommendations were used to develop the STDs/HIV/AIDS strategic plan for 1998 - 2001 (in draft) which replaces MTP - 3.

3.0 THE NATIONAL AIDS/STDS CONTROL PROGRAMME

In 1985, with technical and financial support from WHO-GPA an AIDS Programme Secretariat was established to assist the National AIDS Committee and act as a coordinating body with the various divisions of the Ministry of Health. During this period AIDS was still being viewed as a health problem and hence the exclusion of other ministries and organizations. The secretariat was renamed National Aids Control Programme (NACP) in 1988 so as to give it a national outlook. The secretariat, small as it was, was also implementing activities at the national, provincial and district level with support from WHO technical advisors. District and Provincial co-ordinators were not well defined. Thus, the co-ordination responsibilities were under the MOH who could appoint any personnel to act on his behalf. Monitoring and evaluation was not part of the activities.

The MTP II recommended the establishment of the District Inter-sectoral AIDS Committee (DIAC) under the chairmanship of the District Commissioners. Due to financial constraints the committees were not established until 1995 when the STI Project was launched. The post of DASCO was established to co-ordinate the District AIDS activities. However, DASCOs were appointed only in the 15 STI Pilot districts until 1997 when they were expanded to cover the whole country.

The DIACs formulated work-plans which were presented to the STI Project coordinator at NASCOP for funding. Monitoring and evaluation of these projects was not addressed. Supervisory visits were not conducted as it was assumed that NASCOP would conduct the activity. NASCOP staffing at the national level was so overstretched that it was not possible to carry out the activity.

The experience gained from the pilot districts after only a year of operation showed that the Provincial Medical Officers should be strengthened to conduct monitoring, supervision and evaluation in their respective districts on behalf of NASCOP. Some of the logistics support such as computers and communication equipments, was provided through the STI project to facilitate this activity in 1996/97, but equipment alone was not enough.

Monitoring and evaluation has not been a priority in many projects and programmes. Even in government-supported projects it has not been a priority. Therefore, the capacity of the provinces and districts to conduct monitoring and evaluation required greater enhancement before they could assume this responsibility.

The importance of monitoring and evaluation of the entire programme activities was seriously addressed by the STI project in 1996. Benchmarks for monitoring and evaluation were developed for all the three supervisory levels - National, Provincial and District. Due to financial difficulties and lack of capacity at all levels, the benchmark indicators have not been fully implemented.

In order to ensure that the benchmarks are used in the field, the STI project set aside funds for the provincial medical officers to conduct M & E in fiscal year 1997/98. The role of NASCOP as regards to monitoring and evaluation is, therefore, to give technical and policy guidelines and to co-ordinate the activity nationally.

3.1 THE STI PROJECT

The termination of the WHO GPA funding to NASCOP in 1994 left a huge financial gap in the programme which adversely affected all the control and prevention activities of the AIDS epidemic.

Between 1993 and 1996, with USAID support NASCOP in collaboration with NCPD used the sentinel surveillance data to develop an AIDS impact model (AIM) which was used to sensitize policy makers on the magnitude, impact, interventions and future projections of AIDS. This catalyzed the government to address the epidemic more seriously. The Government also realized that the financial resources required to fight the epidemic were enormous. This realization made the Government to negotiate for a credit with the World Bank in 1993. A 5-year credit of US\$40 million from the International Development Association (IDA) was approved in 1995. The support of other donors like - DFID's grant of US\$ 1 million, KFW German's grant of US \$ 4 million, The Netherlands' grant of US \$ 4 million and Government of Kenya's contribution of US\$ 4 million brought the total investment in this venture to US\$ 65 million. For the first time research and monitoring was allocated US\$ 1.2 million which was partly used for surveillance.

An STI Project within NASCOP Programme was established under a project co-ordinator to manage the funds. Coupled with a clear organizational structure, vision and elaborate work plans the project soon eclipsed NASCOP. It became the most visible and most powerful project, even more powerful than NASCOP itself.

Until 1997, staff and donors were identifying themselves with STI, the project, and not NASCOP, the programme. To date, the project is still as strong since the NASCOP programme manager controls an insignificant amount of funds. This together with the low position where the programme is placed in the ministry of health hierarchy makes the programme management extremely difficult. The limited monitoring and evaluation which is conducted in the STI project areas is reported to the STI coordinator and not to NASCOP. The STI Project has shown some impacts in the areas where it has been operational by reduction in the Syphilis prevalence rate. The table below shows increase in syphilis prevalence rate in non-STI project areas. This could be due to improved syndromic management of STIs through training of health workers and regular supply of STI drugs by the project.

3.2 STDs CONTROL PROJECT:

An STDs Control Programme funded by the Belgian government has been operational in Kenya since 1988. This project has been operational in only two districts out of the 65 districts in the country.

The project operates as a vertical programme with independent funding and plan of activities without the involvement of the (NASCOP) programme manager.

With the emerging knowledge of sexually transmitted diseases as a co-factor in HIV transmission, the Ministry of Health integrated the STDs project into the National AIDS Control Programme in 1995 and the programme assumed the new name of the National AIDS and STDs Control Programme (NASCOP).

The STDs project continues to run vertical to NASCOP and monitoring and evaluation remains its major weakness (Kenya-Belgium STDs Project review report, 1998).

3.3 TUBERCULOSIS CONTROL PROGRAMME

A Tuberculosis and Leprosy control programme has been in existence in Kenya since 1988 and is funded by the government of the Netherlands. The close association between Tuberculosis and HIV necessitated the integration of Tuberculosis and Leprosy control programme into NASCOP in 1997. Like the STDs project, its activities are also vertical to NASCOP's and the integration, though on paper, is yet to be realized.

This "integration" led to the formation of the Division of National AIDS/STDs and

Tuberculosis/Leprosy, which is under a Deputy Director of Medical Services, within the Preventive and Promotional Services Department, in the Ministry of Health. The head of the division who is also the NASCOP programme manager is, therefore, not directly answerable to the Director of Medical Services.

4.0 DECENTRALIZATION IN THE HEALTH SECTOR REFORM:-

Decentralization is one of the most important objectives emphasized in the Kenya's health policy Framework paper (1994) and its subsequent implementation and Action Plans (1996).

In addition, it is the single most important strategy underlying the philosophy of district Focus for Rural Development Policy that came into effect in July, 1983.

The health reform sector envisages dispersal of power and transfer of responsibility for planning, management, resource allocation and decision making from central level to sub-national levels or the periphery. The main focus of this paper is increased resource mobilization and more efficient resource utilization by

Decentralizing the decision making and budgetary process for health services to the district level, Providing an enabling environment for NGOs, private sector and community involvement in health services provision and finance.

Reducing demand for curative services thereby permitting increased budgetary allocations for preventive/promotive services.

Restructuring the organizations, training, management and deployment of manpower to guarantee provision of effective health services.

This policy Framework Paper provides an excellent basis for strengthening monitoring and evaluation. However, substantial institutional strengthening and well directed financial &

technical assistance will be required to enable the district to be responsible for monitoring and evaluation.

4.0 GOVERNMENT POLICY

The government approved the sessional paper no. 4 on AIDS in Kenya in 1997.

The goal of this policy paper is to provide a policy framework within which AIDS prevention and control efforts will be undertaken for the next 15 years and beyond.

The specific objectives are :

- 1) give direction on how to handle controversial issues while taking into account prevailing circumstances and the social cultural environment.
- 2) Enable the government to play its leadership role in AIDS prevention and control activities.
- 3) Recommend an appropriate institutional framework for effective management and coordination of HIV/AIDS activities.

The policy paper recognizes that responding effectively to the AIDS crisis will require a strong political commitment at the highest level, implementation of a multi sectoral prevention and control strategy with priority focus on young people, mobilization of resources for financing HIV/AIDS prevention care and support and establishment of National AIDS Council to provide leadership at the highest level possible.

It is in this context that monitoring and evaluation will become a component of all the strategies adopted for control and prevention activities during the implementation of the sessional paper.

5.0 COLLABORATORS/PARTNERS

5.1 NON GOVERNMENT ORGANIZATIONS

Kenya is one of the countries which has attracted many NGOs and Community Based Organizations. These organizations have organized their own coordinating consortium - Kenya Non Government Organizations Consortium (KANCO).

The Kenyan government only registers NGOs; very little guidance or coordination comes from the government.

There are more than 300 NGOs registered and unregistered which are conducting HIV/AIDS control, prevention and care activities. Neither the Government nor NASCOP is aware of where they are or what they do.

NASCOP does not monitor or evaluate the activities of NGOs operating under its jurisdiction. The absence of guidance from NASCOP has led to disproportionate concentration of NGOs in some regions like Kisumu whereas some areas have none, e.g., North Eastern province.

In theory, NGOs are supposed to engage in Government specified priority areas, but in Kenya it is the NGOs who decide on priority activities and locations.

They carry around their own funds and by and large no one is in the know of the amount and how it is utilized.

5.2 DONORS

Donors have been the major supporters of the AIDS activities in Kenya. Unlike the NGOs, The Government coordinates well with donors. Most of them channel most of their funds through the government treasury. This provides good medium for coordination and monitoring not only for finances but also for activities.

A number of donors channel their funds directly through NGOs bypassing the government/NASCOP. In those circumstances NASCOP is kept unaware of the amount of funds allocated and for which activities. This creates confusion as activities become increasingly difficult to coordinate let alone monitor and evaluate.

5.3 UNAIDS THEME GROUP

The Theme Group was formulated in 1996. With the approval by the government of the policy paper on AIDS in 1997, UNAIDS started identifying priority areas for action that are in line with the national policy paper, and has identified strategies and interventions that aim to meet those goals.

The UNAIDS priority goals in Kenya include:

- A reduction in sexual transmission of HIV infection
- A reduction in the devastating impact of HIV on individuals, families and communities.
- Strengthened capacity to respond to the epidemic through institutional development.

UNAIDS has been the biggest advocate for establishment of monitoring and evaluation unit at NASCOP.

6.0 SOURCES OF HIV/STDs/AIDS DATA

Data for HIV/AIDS is obtained through three systems:

- Reported AIDS cases.
- Blood donors sero-status
- Sentinel surveillance (ANC and STDs patients)
- Research

6.1 AIDS CASES

WHO Bangui case definition 1985, has been applied in Kenya since 1985 - Clinical presentation confirmed with an Elisa test. Currently there are only 78 centres which have the capacity to screen for HIV using Elisa system. AIDS cases are reported monthly to NASCOP using prescribed forms which are supplied to all the 78 reporting sites with the following variables - name, hospital number, Age, Sex, Marital Status, Occupation, Education, district of birth, district of residence, Mode of diagnosis and deaths.

A cumulative total of over 82,000 cases had been reported to NASCOP by the end of October 1998.

Due to under-reporting, delayed reporting and missed diagnosis the reported AIDS cases are grossly under-estimated. NASCOP estimates that the under reporting could be up to a factor of three and therefore the actual cases are currently estimated to be over 240,000. The

number of reported cases depend on the availability of HIV screening kits to confirm the diagnosis. When the reagents are in short supply priority is given to screening blood for transfusion. This also contributes to the low number of reported cases.

The number of AIDS deaths so far reported is insignificant. This is because many patients die at home and due to the stigma associated with the disease these deaths are rarely reported as resulting from AIDS. In view of the unreliability of the reported AIDS cases for monitoring the epidemic NASCOP relies very little on this system.

6.3 HIV PREVALENCE AMONG BLOOD DONORS

One of the goals for addressing the AIDS epidemic which was identified during the formulation of MTP-1 was to ensure the safety of blood with the following policy guidelines;

- * That to prevent HIV transmission through blood, screening of all blood for transfusion is mandatory, persons with high risk behaviours are excluded from donating blood and use of haematinics to boost haemoglobin levels is advocated.
- * That the government will promote rational use of blood and blood products through the training of health care workers.

Since 1990 all persons donating blood are interviewed to determine those at high risk of HIV who are excluded from donating. Those eligible are pre and post counseled. The blood donated is screened for HIV and results reported on the prescribed forms. The forms contain similar variables as the AIDS reporting ones.

With financial and technical support from WHO-GPA all the 78 screening centers (GOK and NON-GOK) were supplied with screening equipments and reagents for this activity.

The emphasis in ensuring the safety of blood in the early days of the epidemic is responsible for the fairly stable rates being observed in blood donors as illustrated in the table below.

Table 1. SUMMARY OF DONATED BLOOD BY YEAR AND PROVINCE

PROVINCE	YEAR AND 95% C.I			
	1994	1995	1996	1997
NAIROBI	4.4% (4.1-4.9)	4.8% (4.4-5.3)	4.2% (3.8-4.7)	4.9% (4.3-5.7)
CENTRAL	1.7% (1.3-2.2)	3.3% (2.4-4.7)	4.9% (4.1-5.8)	3.3% (2.6-4.1)
COAST	9.0% (7.4-11.0)	12.5%(10.6-14.7)	11.7% (8.8-15.4)	7.8%(6.6-9.3)
EASTERN	3.6% (3.3-4.2)	4.7% (4.1-5.3)	5.0% (4.4-5.8)	3.5% (3.0-4.2)
NYANZA	10.5(10.0-11.1)	13.2%(12.5-14.0)	17.8%(16.4-19.4)	10.8% (10.1-11.6)
R/VALLEY	4.4%(3.9-5.0)	7.2% (6.3-8.3)	3.4%(2.9-4.1)	3.4%(2.8-4.2)
WESTERN	8.3%(7.5-9.20)	10.3%(9.4-11.4)	11.9%(10.6-13.5)	7.4%(6.3-8.8)
N/EASTER N	2.7% (1.8-4.0)	2.7% (1.9-4.1)	2.0% (1.3-3.20)	2.3% (1.6-3.3)

The stable HIV rates noted in the table were achieved through ensuring that only low-risk donors were recruited. Ninety-eight percent of the blood transfused in the country was screened for HIV; training and supervision for laboratory technologists was conducted; quality control for the testing kits was done and blood transfusion guidelines were developed. Most of these activities were conducted regularly when the programme had support from the WHO-GPA. The quality of blood screening declined with the termination of the WHO- GPA activities in Kenya in 1992.

The Elisa HIV screening equipments were supplied by GPA in 1986 and by the end of 1990, 78 major hospitals were screening blood for HIV. The HIV screening reagents were also supplied by the organization.

The machines are still in use but because of their age their reliability has been grossly compromised. The supply of HIV screening reagents have become erratic since 1995 and laboratory health workers have not been trained since the WHO-GPA era.

Because of the unreliable old screening machines, NASCOP through the STI Project procured 50 new machines and reagents which will be delivered in September/October 1998.

There are reports that due to the persistent shortage of HIV reagents, some patients have been transfused with unscreened blood. This is a major cause of concern particularly when it is considered that most of these transfusions occur in areas with some of the highest HIV prevalence rates (between 15% and 35%).

The withdrawal of WHO-GPA support introduced major challenge to the National Blood transfusion services in maintaining a safe blood supply.

The problems have consistently been:

- Shortage of Volunteer blood donors

- Logistics of supplying kits and maintaining a monitoring and evaluating process.

- Quality control

- Maintaining the cold chain for the reagents.

All the above are likely to increase the prevalence rates among blood donors and the general population if not urgently addressed.

Shortages of volunteer - donors often force hospitals to seek relative-donors.

Relative-donors are frequently HIV sero-positive and can be an important source of HIV infection to the patient and particularly in blood transfusion centres such as ours which have poor quality control in testing.

The sessional paper No. 4 of 1997 on AIDS in Kenya articulates the importance of ensuring the safety of blood. It states that in order to improve blood transfusion services the following interventions will be pursued:

- Donor recruitment, education, counseling and research,
- Re-organization of blood donors services.
- Provision and maintenance of blood screening facilities including protective materials.
- Training of Health workers.
- Establishment of quality control mechanisms in all laboratories.

None of these has been implemented a year after the government's approval for the policy paper.

6.3.1 CONSTRAINTS:

1. Blood donor and transfusion service is inadequate due to lack of trained personnel, funds and supplies such as blood bags, space - (even new machines supplied through the STI Project have never been installed due to lack of space in many hospitals. This was due to lack of foresight in identifying the needs of the hospital).
2. There is no clear policy guideline for the organization and management of blood donor services at district level.
3. The existing guidelines on the appropriate use of blood and blood bank services have not been adequately promoted and circulated to the relevant end users.
4. There is no established mechanism for the maintenance of the HIV screening machines.
5. The new machines supplied in 1996 (Abbot) are a closed system and therefore cannot use any other kit. This arrangement compromises the replacement of kits in case the supplier fails to deliver. In addition those machines cannot be installed in some of the hospitals because of lack of space.
6. There is no quality control assurance system for blood transfusion services.
7. Unco-ordinated supply of HIV kits in excess of demand with short shelf life lead to expiry of kits in the sites thereby creating artificial shortage in 1997/98.
8. The laboratory and blood safety sub-committee which is the technical body that advises on matters pertaining to issues of blood safety is not consulted when decisions on blood safety are made.
9. Lack of guidelines for HIV screening for blood transfusion.

6.3.2 RECOMMENDATIONS:

1. The blood donor and transfusion services should be re-organized and strengthened by supporting the National Public Health Laboratories to take the leadership role in blood safety. This is possible since NPHLS has the infrastructure up to the primary health facility level.
2. The HIV screening guidelines which were developed in 1997 should be finalised and distributed.
3. The National guidelines for the appropriate use of blood and essential blood bank services should be widely circulated and promoted.

4. The role of the laboratory and blood safety sub-committee in giving technical advice to NASCOP should be appreciated and enhanced.
5. The procurement, storage, distribution and monitoring use of reagents and other supplies should as a matter of urgency be addressed. The current distribution of the supplies through the Family Planning Logistics Management Unit has to be evaluated in view of the perishable nature of the reagents supplied. Procurement of laboratory supplies must be approved by the laboratory and blood safety sub-committee.
6. In view of erratic electric supply and total lack of it in some facilities, reagents which do not require refrigeration and machines must be considered. Rapid assays will be appropriate and cost effective in the long term.
7. After sales, servicing of laboratory equipment must be ensured at all times - beyond the warranty period.
8. Quality assurance through adequate training and supervision of health workers must be strengthened.
9. Recommendations of the blood transfusion services evaluation report by Kataha, 1998, that was supported by UNAIDS should be implemented.

6.4 SENTINEL SURVEILLANCE FOR HIV PREVALENCE

The HIV sentinel surveillance system in Kenya is implemented by the National Aids and STDs Control Programme. It became operational in 1990 and has been conducted annually. The Sentinel surveillance system complements the passive AIDS surveillance system which has its own limitations. These limitations include the fact that AIDS cases do not reflect current transmission rates of HIV infection since the median interval between HIV infection and the onset of AIDS is between 7 and 10 years. Furthermore, reported AIDS cases represent only a small proportion of Aids cases which have occurred.

Data is collected for both ante-natal clinic (ANC) clients and for STD patients. The STD data is primarily designed to represent high risk populations while the ANC data represent the general healthy and sexually active population. In estimating the general HIV prevalence rate the ANC data is applied.

The sentinel surveillance system started initially with 23 sites, which were later in 1992 reduced to 13 because of logistical problems and unreliable data from some of the sites. All the sites were located in urban areas until in 1994 when 6 rural sites were included to represent the rural population. Beginning in the third quarter of each year, blood samples from the first 200-300 ANC women who are making their first visit to the clinic for the current pregnancy, are tested for HIV.

Blood used for HIV testing is obtained through an unlinked anonymous procedure - after testing for syphilis, which is the purpose for which the blood was originally drawn, all the personal identifiers are removed. The remaining serum sample, is then later tested for HIV. The key advantage in the unlinked procedure is the reduction of self selection bias with a resultant increase in accuracy.

The objectives of the Kenya HIV sero-surveillance system are:-

I.

To estimate the prevalence and distribution of HIV infection in specific populations in specific geographic areas.

2"

3"

To monitor trends in HIV infection.

To provide information for evaluating intervention programmes against HIV/AIDS. The population groups used over the years have been ante-natal clients and STD patients. In many of the sites the number of STD patients screened was too small for any inference. Results for each of the sentinel surveillance sites are shown in the table below.

Table 2. PERCENTAGE OF PREGNANT WOMEN TESTING POSITIVE BY SENTINEL SITE AND YEAR, 1990 - 1997

SITE	1990	1991	1992	1993	1994	1995	1996	1997
NAIROBI	12.1	12.1	12.9	16.2	14.8	15.7	15.7	15.9
MOMBASA	10.2	16.7	11.1	16.5	12.2	12.3	12.0	17.4
BUSIA	17.1	10.5	29.7	22.2	19.4	22.4	22.0	28.1
GARISSA	4.9	4.6	5.3	3.7	5.8	5.8	8.1	5.9
KAKAMEGA	5.3	5.3	11.5	15.1	8.6	10.3	11.7	11.7
KISII	1.6	4.4	3.5	2.5	8.6	10.3	11.7	11.7
KISUMU	19.2	20.0	20.0	19.6	30.4	27.3	27.4	34.9
T/NZOIA	3.5	5.6	6.6	7.5	9.3	10.0	12.1	12.7
KITUI	1.0	4.8	2.0	4.2	6.3	4.1	4.4	5.9
NAKURU	9.9	13.3	12.5	22.5	30.0	27.2	11.0	24.6
NYERI	2.9	5.0	7.9	6.3	6.3	6.2	9.1	10.2
MERU	2.7	2.5	2.5	2.3	6.9	8.7	15.5	13.8
THIKA	2.5	9.6	2.6	27.6	19.6	15.6	19.6	28.1

PREVALENCE OF HIV AND OTHER STDs IN THE GENERAL POPULATION OF KISUMU, 1997.

(A) Women _____ **AGE GROUP**

	15 -19	20 - 24	25 - 29	30 - 39	40 - 49	Total
HIV Inf.	48/215 22.3%	78/200 39.0%	63/163 38.65	60/189 31.7%	20/103 19.4%	269/870 30.9%
Gonorrhoea	4/206 1.9%	1/187 0.5%	1/168 0.6%	2/192 1.0%	0/97 0%	8/850 0.9%
Chlamydia	20/206 9.7%	11/187 5.9%	6/168 3.6%	2/192 1.0%	0/97 0%	39/850 4.6%
Syphilis	7/205 3.45	8/187 4.3%	4/154 2.6%	5/181 2.8%	1/95 1.0%	25/822 3.0%
Trichomonas	30/89 33.7%	32/101 31.7%	29/86 33.7%	27/118 22.9%	15/61 24.6%	133/455 29.2%

source: PI study, Kisumu (1995)

(B) MEN _____ **Age group**

	15 - 19	20 - 24	25 - 29	30 - 39	40 - 49	total
HIV inf.	6/141 4.2%	20/149 13.4%	25/85 29.9%	51/150 34.0%	23/77 29.9	125/602 21.0%
Syphilis	1/138 0.7%	2/142 1.4%	1/81 1.2%	5/140 3.6%	1/75 1.3%	10/576 1.7%
Gonorrhea	0/147 0%	0/145 0%	0/84 0%	0/151 0%	0/77 0%	0/604 0%
Chlamydia	6/147 4.1%	7/145 4.8%	2/84 2.3%	1/151 0.6%	0/77 0%	16/604 2.6%

The above tables (a) and (b) from a WHO funded study to test priority prevention indicators in Kisumu district (1995) show that women had higher infection rates than men. HIV rates for women aged 20 -24 show rates of 39%.

Monitoring of classic STDs has been irregular and inconsistent because of the following;

- * Over 80% of the STIs are managed in private hospitals/clinics, pharmacies etc. Mechanisms for monitoring activities to capture the patients in these facilities have not been developed.
- * The Kenya /Belgian STD project which was responsible for STDs in the country is quite weak in monitoring activities and data collection remains its major weakness (K/B STD project eval. 1998)
- * The K/B project is localized in 2 districts out of the 65 districts in Kenya.
- * STD patients seen in the general outpatient clinics in the hospitals are rarely reported.
- * The small number of health workers trained on STD syndromic management compromises monitoring activities.

In the absence of better data to monitor the classical STDs, NASCOP uses the syphilis prevalence rates from ante-natal clinics in the sentinel sites as a proxy to estimate STDs prevalence rates.

6.4.1 CONSTRAINTS:

The major constraints encountered included:

- The small sample size obtained in some of the sites is not sufficient for desegregation and analysis of the various variables.
- Since 1994, the supervision of the sampling exercise has been irregular thereby compromising the quality control efforts.
- High attrition rate of staff trained in surveillance necessitates annual training before sampling is begun. This raises the annual budget for sentinel surveillance.
- The number of sites representing the rural population is few and in the absence of regular supervision the data obtained from them are incomplete.
- There are only 23 sites in Kenya and although the sites were selected to represent different geographical regions, ethnic, social, cultural and religious backgrounds the sites are not representative of the prevalence rates in Kenya. The system needs to be evaluated to determine the adequacy of the existing sites.
- Though the system generates data for HIV trends over time, causes of increase or decrease in

those trends are not known. There is therefore need to incorporate behaviour sentinel surveillance in the sites.

- Lack of periodic surveys to validate the surveillance data
- Lack of capacity to screen for HIV in health centres where most cases are attended
- Districts do not have capacity to analyse the data for their local use. Data is analysed at NASCOP and at times it takes long before the sites are given any feedback.

6.4.2 STRENGTHS

- The sentinel surveillance system has been operational for over 10 years and therefore availing HIV prevalence trends for that period. The data has been used for advocacy and creating awareness to the policy makers and the public. The strength of the data led to the successful formulation of the national policy on AIDS in 1997. In addition, the information on the magnitude of the epidemic caused the government to negotiate for the World Bank credit for STIs control.
- Though the sentinel sites have not been reviewed, data obtained from independent studies like the multi-centre study in Kisumu population (1997) showed similar HIV prevalence rates in women aged 24-29 indicating sentinel surveillance as a robust source of quality data if it could be strengthened.
- MTP - 2 review recommendations addressed monitoring and evaluation particularly on surveillance.

It is unfortunate that the reviews which have so far been conducted have not addressed monitoring and evaluation in total.

- Availability of benchmark indicators
- Existence of wide range of studies which could be used to supplement the sentinel surveillance system.

7.0 PROGRAMME EVALUATIONS:

One major achievement made by NASCOP is regular evaluation, e.g., evaluation of the programme and the projects within it. MTP.1 was evaluated in 1992. The recommendations made the basis for the formulation of MTP-2.

MTP - 2 was reviewed in 1997. The findings and recommendations of the review were applied in developing NASCOP strategic plan 1998 - 2001 (In draft). The STD Kenya- Belgium project has been evaluated regularly in July 1989, 1991, 1993 and 1998. A mid-term review for the World Bank funded STI project was conducted in August 1998. The main recommendations made in the report are strengthening of the capacity of the districts to plan, implement, monitor and evaluate AIDS control activities, implementation of the policy paper on AIDS in Kenya and the establishment of the National AIDS Council which will enable NASCOP to take the leadership role in coordinating activities to control the epidemic.

Programme evaluations submitted to NASCOP include;

Evaluation report for the first MTP (1987-1991)

Evaluation report for the second MTP (1992-1996)

Evaluation reports for the Kenya -Belgium STD project
The World Bank STI project mid-term evaluation report (August 1998)
Blood transfusion services evaluation report (1998)

Despite the regularity of the evaluations and availability of reports with numerous recommendations to improve services, these are rarely implemented due to financial constraints and sometimes inadequate capacity to implement.

8.0 RESEARCH

8.1 SURVEY ON KNOWLEDGE AND ATTITUDES

Studies on knowledge and attitude have been conducted by various individuals and institutions - University of Nairobi, KEMRI, AMREF and other organizations.

These studies are not coordinated by NASCOP and therefore most of the results are not known to the programme let alone utilized. Many researchers receive grants from donors to conduct studies which interest the donor without consulting NASCOP. Reports are published in some overseas journals or are submitted directly to the financier.

The problem is compounded by a lack of a research database at the national office documenting the studies which have been undertaken in order to identify research gaps. This would facilitate prioritization of research needs for the country and cost-effective use of limited research resources.

8.2 HIV INCIDENCE

HIV incidence is better estimated through the longitudinal studies. These have not been conducted.

8.3 HIV PREVALENCE AMONG YOUNGER WOMEN

The sentinel surveillance system conducted by NASCOP targets women of the reproductive age 15 - 49. Programmes targeting younger women to determine their HIV prevalence rates are non-existent. However, a population survey conducted in Kisumu in 1995 as part of the multi center study to pilot the WHO PIs, showed HIV prevalence in women aged 15 - 19 years to be 22.3% compared to their male counterparts (4.2%).

9.0 INTERVENTIONS

9.1 CONDOMS:

Over the years, condoms have been supplied by donors to the Kenya Government for free distribution to other outlets through the Family Planning Logistics Management Unit (FPLMU). Some of the condoms are supplied to the condom social marketing unit, Population Services International (PSI) for repackaging and later sold mainly in the urban areas.

The table below shows the number of condoms distributed between 1995 and 1997.

Table 3: Condoms Distributed by the Ministry of Health and by the Social Marketing Programme, 1995 - 1997

YEAR	GOK CONDOMS	PSI CONDOMS
1995	36,000,000	6,162,352
1996	55,000,000	4,070,766
1997	65,000,000	7,806,345
TOTAL	156,000,000	18,039,463

A total of 44,121,104 condoms were received in the country in 1997. About 33 million condoms were freely distributed by the Ministry of Health through the Family Planning logistics Management Unit (FPLMU) in 1997. These were distributed to government provincial and district hospitals from where they are distributed to all the health facilities within the province/district including several outlets like entertainment houses. At the community level, condom distribution is conducted by the community based distributors (CBD). Condom social marketing is undertaken by the Population Services International (PSI). PSI receives condoms from donors and the government. In 1997, Overseas Development Agency (ODA) donated 7,411,920 condoms to PSI. They were repackaged and sold at Kshs. 10.00 (US \$ 0.1) for a package of 3 condoms under the trade name "Trust." The Trust Condoms are sold only in urban centers. Plans are underway to begin condom social marketing in rural areas later in 1998/99

A total of 18,039,463 condoms were sold through PSI between 1995 and 1997 as shown in the table above.

Condoms are widely available in the country up to the community level. However, data shows only the number of condoms distributed and not the number of condoms used. Knowledge and perception of condoms is quite low.

The Family Planning Association of Kenya together with the Population Council in the Rift Valley province (1997) found that 62% of the adolescents (and 60% of their parents) said they believe that condoms did not protect against HIV.

The KDHS (1993) also found that among the men who had sex in the last six months prior to the survey only 20% reported having used a condom compared to 6% of the women. The 1998 KDHS did not find any significant change (21% and 6% respectively)

It is therefore not known where the millions of condoms distributed in Kenya go.

By the end of June 1998 there were 78 million condoms at the central stores. Additional 66 million condoms had been procured by the World Bank STIs project and was awaiting delivery in August/September 1998.

9.2 SEX EDUCATION IN SCHOOLS

Sex education in schools remains very controversial in Kenya. Whereas the Ministry of Education in collaboration with UNICEF have developed a Family Life education curriculum for schools, this has not been possible to implement. This has been caused by the strong opposition from the religious groups particularly the catholic church. This is despite evidence from recent studies which show that the age of first intercourse was found to be between 9 - 14 years in 20% of the respondents and 80% of them had experienced sexual intercourse by the age of 20 (multi centre study, Mombasa, 1995).

A study by UNICEF, shows that in 1997, 14 years into the AIDS pandemic;-

- one third of Kenyan school girls are sexually active
- 90% of Kenyan youth are sexually active by the age of 19

- 20% of first born babies are from mothers below the age 19
And yet a national school curriculum is not implemented and it was not even important enough to be identified as a forward looking programme for the ministry of education 1997 - 2001 Development Plan.

9.4 MASS MEDIA EVENTS

Prior to 1993, AIDS education for the media was scanty. In 1993 the first workshop for journalists and editors of the major publications was held in Nairobi. During this workshop current information was availed to the participants and information was given on where to obtain data and reference materials.

This marked the beginning of collaboration between NASCOP and the news media as shown by the regular accurate reporting of AIDS in both the print and electronic media. The monitoring and evaluation of this activity has not been implemented but the benchmarks contain indicators for this.

9.5 CARE AND SUPPORT INDICATORS

In spite of the inclusion of support and health care to people living with AIDS (PLWA) as part of NASCOP's strategy in MTP-2, little has taken place. The plan included the establishment of patient support centers at government health facilities. These were expected to have reached 90% of all the centers by 1996 but only 15% have been established so far.

In 1997 NASCOP through the insistence of the World Bank developed benchmark indicators for monitoring and evaluation of STDs/HIV/AIDS activities at national, provincial and district level. Indicators for care were developed focussing on policy formulation, drug distribution, and management and on linkages with NGOs and CBOs active in the field. A small number of indicators are currently being measured, e.g., development and distribution of national guidelines on STD syndromic management and on the management of opportunistic infections, STD management curricula, number of drugs procured, drugs distributed and number of patients provided with drugs. The delay in implementing the benchmark indicators has been caused partly by;

NASCOP does not have a specific unit mandated with the tasks of monitoring and evaluation. The epidemiology and research unit only monitors the HIV/AIDS trends. Other activities are rarely monitored.

Lack of funds.

9.6 HUMAN RIGHTS AND LEGAL ISSUES

A policy framework to address HIV/AIDS in Kenya was not available until September 1997 when parliament approved the "Sessional Paper No.4 of 1997 on AIDS in Kenya. The approval of the Sessional paper signals the clear intention of the Government to support effective programmes to control the spread of AIDS, to protect the human rights of those with HIV and AIDS and to provide care for those infected and affected by HIV/AIDS.

The goal of the sessional paper on AIDS is to "provide policy framework within which AIDS prevention and control efforts will be undertaken for the next 15 years and beyond"

Some of the key aspects of this framework are:

9.6.1 Legal and Ethical challenge:

Discrimination against individuals with HIV or AIDS violates their human rights and hampers prevention efforts by discouraging people from learning about their HIV status. A key element of the sessional paper is the guarantee that the human rights of all Kenyans will be respected.

Human rights - All forms of discrimination against people with AIDS status be outlawed.

Testing for HIV - Testing for HIV individuals shall be voluntary.

Confidentiality - ethical codes regarding confidentiality of AIDS status shall be enforced.

Employer - employee rights - the employer does not have the right to know the HIV status of an employee without the consent of the employee.

A legal body with a clearly defined mandate will be established to coordinate HIV/AIDS/STD research.

Children infected and affected by HIV/AIDS will be protected from exploitation and discrimination using existing laws.

Insurance - the government will work closely with insurance companies to establish guidelines pertaining to policies and benefits for people affected and infected with HIV. The guidelines will ensure that compensation is available to all those who were not infected prior to the issuance of their insurance policy.

Counseling - Codes for counseling will be developed that will take into account the need for voluntary testing and confidentiality.

Drugs - Clear legal provisions will regulate drug trials and provide sanctions against those peddling, cutting up for sale and advertising substances which have not proven curative value against HIV.

Criminal sanctions - Criminal sanctions will be upheld against all those who deliberately infect others.

The challenge now is to translate these guidelines into successful plans, programmes and action.

To this end, plans are underway to implement the sessional paper and put in place monitoring and evaluation indicators.

7.0 PREVENTION INDICATORS (PIs)

Prevention Indicators study was conducted in 1995. To date, the reports are yet to be finalized and made use of.

8.0 INTERACTION BETWEEN MONITORING AND EVALUATION AND POLICY MAKING/PROGRAMME PLANNING AND IMPLEMENTATION

The reporting of the first AIDS case in Kenya was received with shock, confusion and disbelief as its origin and all modes of transmission were not known. The stigma associated with the disease was almost instantaneous. AIDS cases rose from a single case in 1984 to 7,672 in 1990. The government's reaction was at first denial of the magnitude of the problem and therefore all the reports regarding AIDS in Kenya was classified information.

The formulation of MTP -1 with financial and technical support from WHO-GPA partially addressed the monitoring and evaluation in as far as monitoring the epidemic was concerned. Other aspects of the programme, specifically the monitoring of the interventions applied was not addressed throughout the life of MTP -1 (1987 - 1991). Monitoring of the trends continued to be conducted and this was later to play a major role in sensitizing the policy makers on the magnitude of AIDS in Kenya.

In 1992, NASCOP in collaboration with the FUTURES Group and Research Triangle with funds from USAID developed the AIDS Impact Model (AIM) whose purpose was to sensitize policy makers on the background, projections, impact and the interventions available to control the epidemic in Kenya. AIM achieved its objectives as policy makers started discussing AIDS openly. Similar presentations were made to the print and electronic media between 1993 and 1996 resulting in more accurate information on AIDS. This awareness by policy makers, media and other stakeholders culminated in the approval of the policy paper on AIDS, the “Sessional Paper No.4 on AIDS in Kenya” in 1997.

The publicity of the AIDS situation in the country made the government to address the epidemic more seriously and funds were sought to combat it. In 1995, the government signed the agreement with the World Bank for US \$ 40 million for the period 1996-2000 to support AIDS control activities. In 1997, AIDS was declared a disaster making it a governments priority programme. Since then, AIDS has been discussed at all levels including the head of state.

The World Bank stressed development of indicators to track the epidemic. This lead to the development of the Benchmark Indicators for monitoring and evaluation in 1996. Due to capacity and financial constraints, these indicators have not been implemented in full.

The termination of the WHO-GPA activities in Kenya found the government completely unprepared to take over the organization’s activities, and although the number of HIV screening reagents were known, the government could not afford to procure them. The blood transfusion services therefore were adversely affected. The limited reagents were strictly used to screen low risk blood donors. This lead to a drop in the number of units screened and in the number of reported AIDS cases since AIDS cases must be confirmed by an Elisa Test.

9.0. M & E INTERACTION BETWEEN NATIONAL PROGRAMME AND DONOR ASSISTANCE

Most of the donor activities in the country are not coordinated by NASCOP. Even projects within NASCOP like the Belgium STD and Netherlands funded TB Control projects have direct funding from the donors and they conduct their activities without the involvement of the Manager or other NASCOP units. These projects tend to run vertical to the NASCOP’s despite the integration.

Similarly, other organizations with their own sources of funding establish projects in the country. The extent to which monitoring and evaluation is addressed in those projects is therefore not known as the national programme does not have links with most of the organizations.

It is however common knowledge that monitoring and evaluation is not a priority in many donor supported organizations in Kenya as most of them do not even have baseline data from their area of operation.

10.0 STRENGTHS

The existence of a strong surveillance system for HIV/AIDS and to a lesser extent, STDs since 1990.

Development of the benchmarks for monitoring and evaluation of STDs/HIV/AIDS activities in 1997.

Availability of regular programme and projects evaluation reports since 1990.

The approval of the Sessional Paper No. 4 on AIDS in Kenya 1997. The approval is the clear intention of the government to support effective programmes to control the spread of AIDS, to protect the human rights of those with HIV and AIDS and to provide care for those affected and infected with HIV/AIDS.

The establishment of a decentralized system at the district level to conduct STDs/HIV/AIDS activities on behalf of NASCOP.

The existence of a consortium coordinating all NGOs involved in HIV/AIDS work.

Willing donors to support M & E.

Existence of the strategic plan addressing M & E

Regular DHS reports to supplement NASCOP data

Presence of strong research institutions

Behaviour sentinel surveillance started

Research database developed

10.1 MAJOR WEAKNESSES

Absence of a monitoring and evaluation unit at NASCOP to coordinate the activities at national level.

Lack of an NO/C.O. coordinating unit to link these organizations with NASCOP and provide them with policy guidelines.

Delay in field testing and implementation of the Benchmarks for monitoring and evaluation.

Non-implementation of the Sessional Paper No. 4 on AIDS in Kenya, 1997.

Non-implementation of recommendations provided through the numerous evaluation reports.

Lack of understanding by the policy makers on the crucial role played by M&E.

Lack of capacity for NASCOP to take up the leadership role in the STDs/HIV/AIDS control and prevention activities, e.g., NASCOP is placed quite low in the Ministry of Health hierarchy and donors channeling funds to the NGOs without the involvement of NASCOP.

Insufficient funding for monitoring and evaluation, e.g., need to strengthen the capacity at all levels for Monitoring and Evaluation.

11 CONCLUSION

Monitoring and Evaluation of the STDs/HIV/AIDS activities has not been adequately addressed by the national programme since its inception in 1985. The focus of monitoring has always been on monitoring the HIV/AIDS trends which has been fairly successful in achieving its objectives. However, much more improvement could be achieved if the programme could build on its strengths and address its areas of weaknesses in order to plan for better monitoring and evaluation.