

Delivering HIV Prevention: Kenya's Perspective

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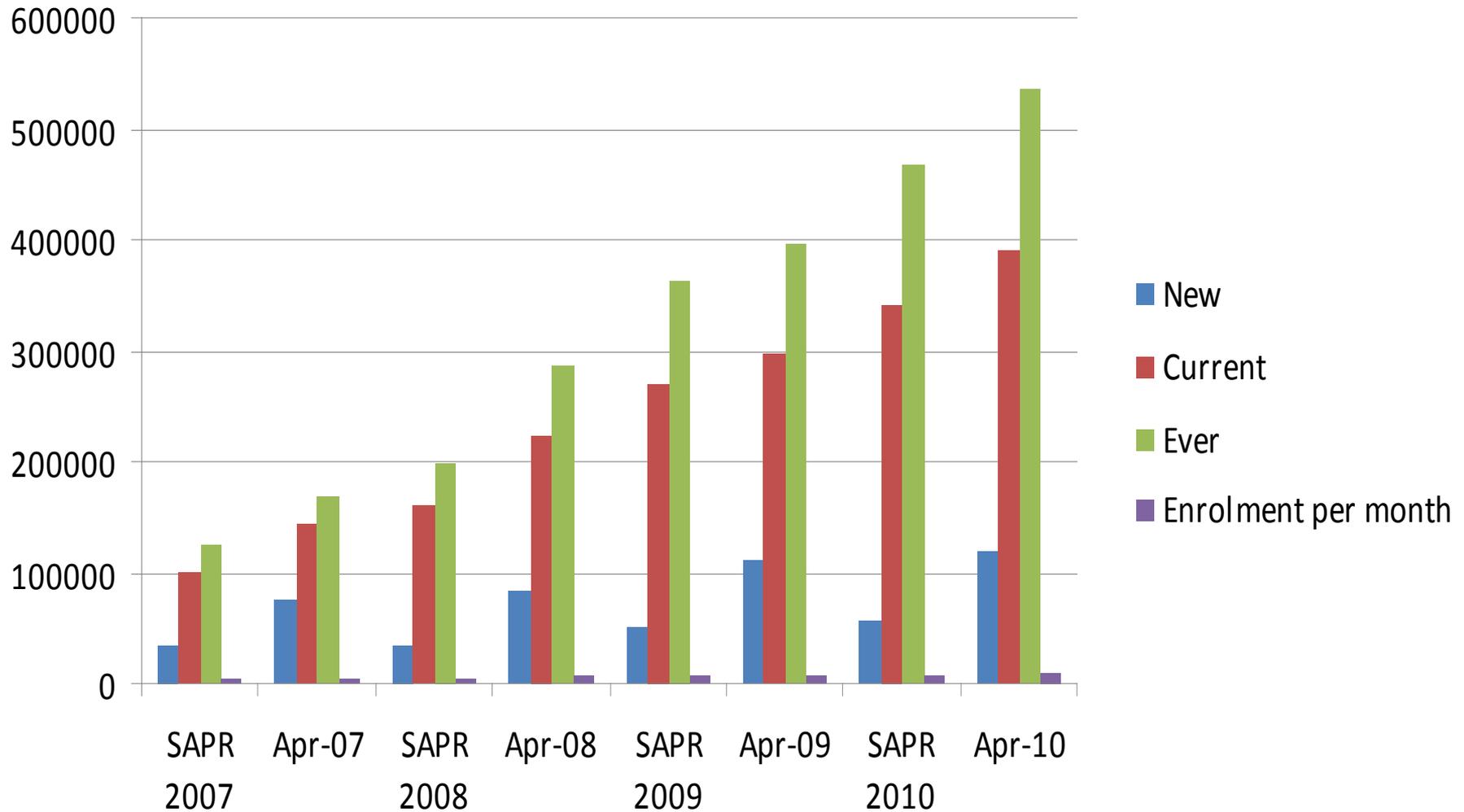
Outline

- Background of the Kenya epidemic
 - Important to understand and monitor the epidemic
- Delivering HIV Prevention
 - It is possible to scale up...
 - ...but it matters how it is delivered
- Other considerations
 - Keep the evidence flowing
 - Paradigm shift-more active..opt-out approach

HIV epidemic update

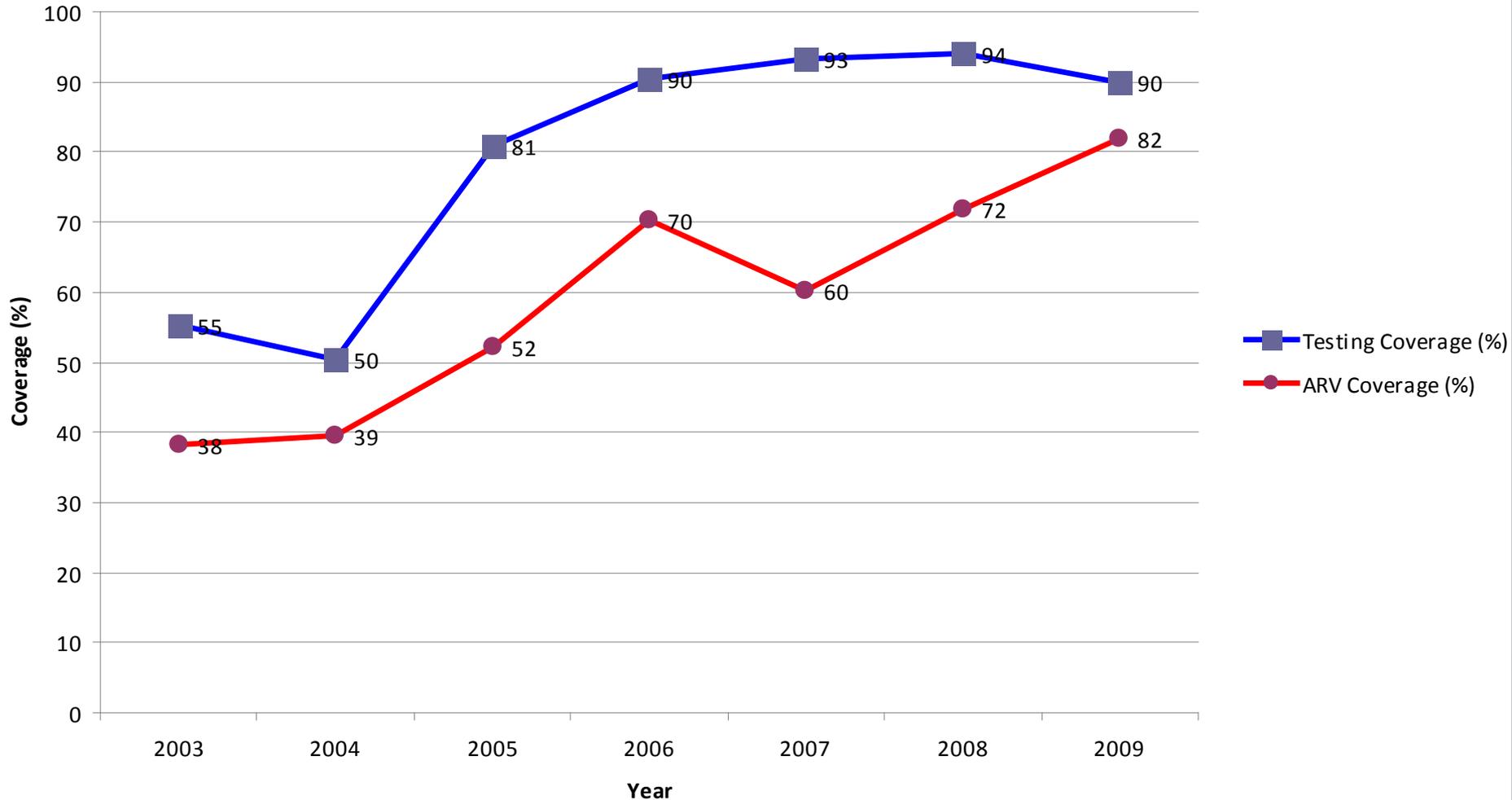
- Approx 1.45 million (1.3-1.6) people living with HIV
- Prevalence in people aged years 15-49 (6.2%), and young women 15-19(3.5%), 20-24 (7.4%), 15-24 (5.6%)
 - Men (4.3%), women (8%)
 - Key populations
 - Prevalence: uncircumcised men (13%), young women (~5%), MSM (10-38%), IDU (33-50%), sex workers (~30%)
 - Percent Incidence: Stable partnerships (44%), MSM (9.3%), fisherfolk (15.4%), IDU (6.4%), Sex workers (2.3%) etc
- Planning for AID Indicator Survey 2012 underway
 - In 47 relatively homogenous geopolitical units (counties)

Scaling up treatment...



Scaling up PMCT

PMTCT Testing and ARV Coverage, 2003-2009



MC Achievements versus Targets in VMMC strategy

	Targets 2009-10	Achievement*
Nyanza	76,500	90,000 (118%)
Rift Valley	28,500	400
Nairobi	19,500	900
Western	12,000	Nil
Others	13,500	Nil
Total	150,000	91,300 (60.8%)

Cumulatively 210,000 MCs have been done

Innovation is key....

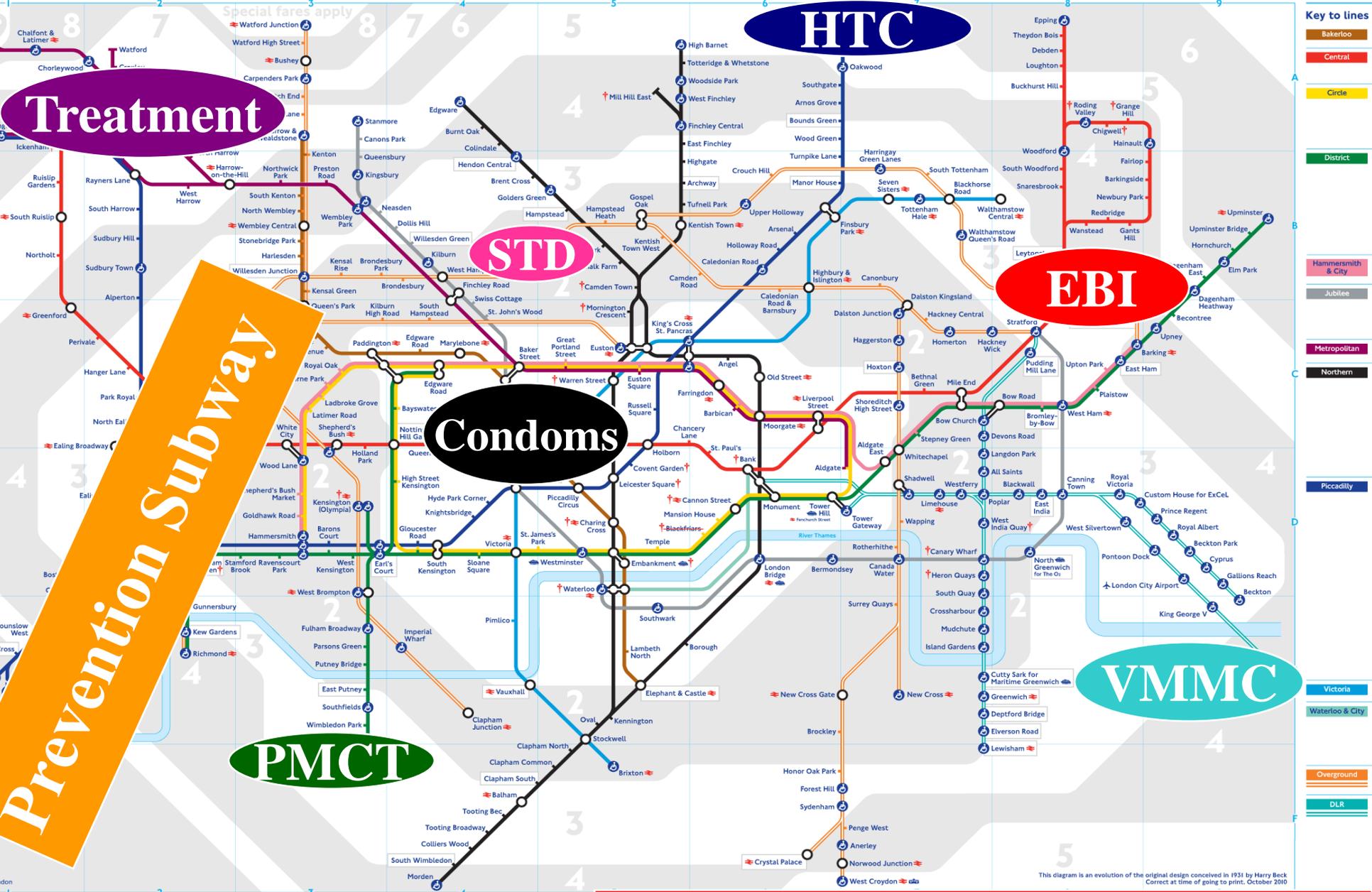
- Rapid Results Initiative
 - 36,077 MCs performed in 30 working days.
 - 28,672 done by two partners in seven districts:
 - An average of 10MCs done per team daily.
 - 39% of men tested at MC venues; 17% tested as part of but prior to RRI (56% total).
 - AE rate was 1.9% (1.83% moderate, 0.05% severe); however, of the 6,595 who returned for f/u visits, 8.4% had AEs.

Other facilitators

- Government-led coordination
 - Technical leadership from Ministries of Health
- Task-shifting-lay providers, nurses, peer counselors
 - Utilization of community resources
- Efficient partnerships
 - Mutual accountability
 - Local
- Integration
 - PMCT into maternal and child health services

But it is not easy.....

- HIV prevention delivery model sub-optimal
 - Scattered, strait-jacket approach
 - Multiple partners, available in some localities, doing different things
 - Most services happen by referral
- Referral for prevention may not be working
 - Coverage of HIV testing for VMMC~62%
 - No routine data on referral networks



This diagram is an evolution of the original design conceived in 1931 by Harry Beck Correct at time of going to print, October 2010

VMMC as HIV Prevention

- Current package
 - Social mobilization
 - HIV testing
 - Risk-reduction counselling
 - Screening for STDs
 - Male circumcision
 - Condom promotion
- Potential additions
 - PreP, Prevention with positives, group-based etc

NB: We should fund HIV prevention and not individual interventions/strategies

Other Considerations

- Integrate public health evaluations into programmes
 - Funded by default
 - Develop indicators tracking combination prevention or referral for prevention
- Change mind-set of providers
 - Prevention as a service
 - Behavioural versus bio-medical
- Biomedical/Behavioural intervention as structural
- Human rights from the right to prevention
 - Waiting for people to come for HIV prevention will not work!

Acknowledgements

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NASCOP