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[National Advocacy Action Plan]

[Campaign to End Pediatric HIV/Aids - KENYA]

[KETAM]

KENYA TREATMENT ACCESS MOVEMENT (NATIONAL ADVOCACY ACTION PLAN Draft 1)

Introduction and Overview of Kenya Context

During the past decade, the international community has continually committed to scale up access to health services and reduce the burden of HIV among women and children. In the Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly Special Session on HIV/AIDS in 2001, countries committed to reduce the proportion of infants with HIV by 50% by 2010 by ensuring that 80% of pregnant women and their children have access to essential prevention, treatment and care services to reduce the mother-to-child transmission of HIV.

These commitments were re-affirmed by the Group of Eight (G8) countries in 2005 and 2007, the Abuja Call to Action Towards an HIV-free and AIDS-free Generation in 2005 and the Political Declaration of the United Nations General Assembly High-Level Meeting on AIDS to work towards universal access to HIV prevention, treatment, care and support in 2006. These global commitments have been accompanied by regional commitments beyond the goal of ensuring an HIV-free and AIDS-free generation, global action to prevent the mother-to-child transmission of HIV directly contributes to achieving the Millennium Development Goals 4, 5 and 6, which target reducing by two thirds the mortality rate of children younger than five years, reducing by three quarters the maternal mortality ratio and halting and beginning to reverse the spread of HIV/AIDS by 2015.

Currently the HIV prevalence rate in Kenya is at 7.4% for adults (15-49 years) ¹ and every 3 out of 5 people living with HIV/AIDS is a woman. About 10% of the total population of the country is HIV positive, though this is not a true representation as this accounts only for those who have tested.

In Kenya currently, HIV testing at Anti Natal Clinics increased from 50.4% in 2003 to 78.6% in 2007 where the HIV prevalence amongst pregnant women was 9.0% in 2007²

Kenya is one of the 20 Contributing countries with the largest numbers of women needing antiretroviral for preventing the mother-to-child transmission of HIV to the global gap to reach 80% of those in need, we are at 110 000 [53 000–160 000] 8% 49 000 [25 000–71 000] 7% Kenya is currently at 5% ³

Currently, 27,000 children are on ARTs whereas 90,000 are in need. Despite increased attention to pediatric AIDs during the last joint AIDS programme review (JAPR) by NACC (2008) only 30% of children born to HIV +ve mothers or are exposed to HIV accessed pediatric treatment, this was

¹ Kenya AIDS indicator Survey report 2008

² KIAS final report 2009

³ UNAIDS universal access report

due to poor procurement and distribution chain systems and management, unstable pediatric formulation hence causing difficulty in adherence, storage and efficacy.

At this time, moreover, insecurity and strife due to the recent post electoral violence have led to a fall of Kenya's main foreign income earners: revenues have fallen in tourism, tea and horticulture. The violence further caused the disruption of other economic activities that sustain the local economy. In addition the unchecked and rapid spread of HIV/AIDS is claiming an estimated to 700 lives daily, exerting its toll on both the economic and social welfare indicators (NACC Strategic Plan, 2000-2005). It is further estimated that the nature of violence during the post election violence (rape of women, many people suffering from brutal cuts), disruption of services at Anti-Retroviral Treatments Centres and the displacement of caregivers has escalated the impact of the AIDS virus.

During a period of humanitarian crisis, the vulnerable, HIV-infected pediatric population had disruptions in clinical care and in medication adherence, putting children at risk for viral resistance and increased morbidity. Conflicts, population displacement, and the economic consequences of disasters affect children disproportionately. Children are more vulnerable to communicable diseases and environmental exposures than adults and they have special dietary needs for growth and development, and they are generally dependent on their families. Studies have shown that children under five have the highest mortality rates in conflict-affected settings. Furthermore, while acute illnesses and injuries are important in humanitarian emergencies, exacerbation of underlying chronic illnesses can lead to significant morbidity and mortality. When these emergencies occur in the setting of pre-existing poverty, low nutritional status, and immune-compromising diseases such as HIV, children face even greater risks, little is known about the provision of care for HIV-infected children during complex emergencies. In a small study from an area with long-standing conflict in Uganda, children on ART had high adherence and low mortality. However, there are few guidelines to direct HIV care in these settings, and the optimal methods to coordinate services for conflict-affected populations have seldom been studied.

Kenya, which has long been one of the most stable and economically developed nations in East Africa, experienced political and humanitarian crises following contested presidential elections held on 27 December 2007. The election results sparked widespread, ethnically related violence and internal displacement of hundreds of thousands of families. By official estimates, over 1,200 people were killed, and over 300,000 people were displaced from their homes. The extent to which the children of Kenya were affected is unknown. HIV-infected children in Kenya may have been particularly vulnerable during this conflict period. Kenya has over 1.4 million persons (7.8% prevalence) living with HIV (including 150,000 children). As of 30 November 2007, the USAID-Academic Model Providing Access to Healthcare (AMPATH) clinical care system was caring for over 10,000 HIV-infected and exposed children in 17 clinics in western Kenya.

Because the western portion of Kenya was severely affected by the violence and displacement of persons, these pediatric patients may have been affected.⁴

Currently in the world 9.2 million children die every year on treatable diseases. An additional 400,000 will die in the next 10 years on the same factors. To curb this 40 billion dollars annually is required. One of the contributing factors is severe drought and floods in the sub-Saharan Africa. – *“Nearly all of the 9.2 million under-fives who die unnecessarily - 97 per cent - are from low- or middle-income countries, and disproportionately from the poorest and most marginalised communities within those countries, a report published by the Save The Children Alliance said.”*

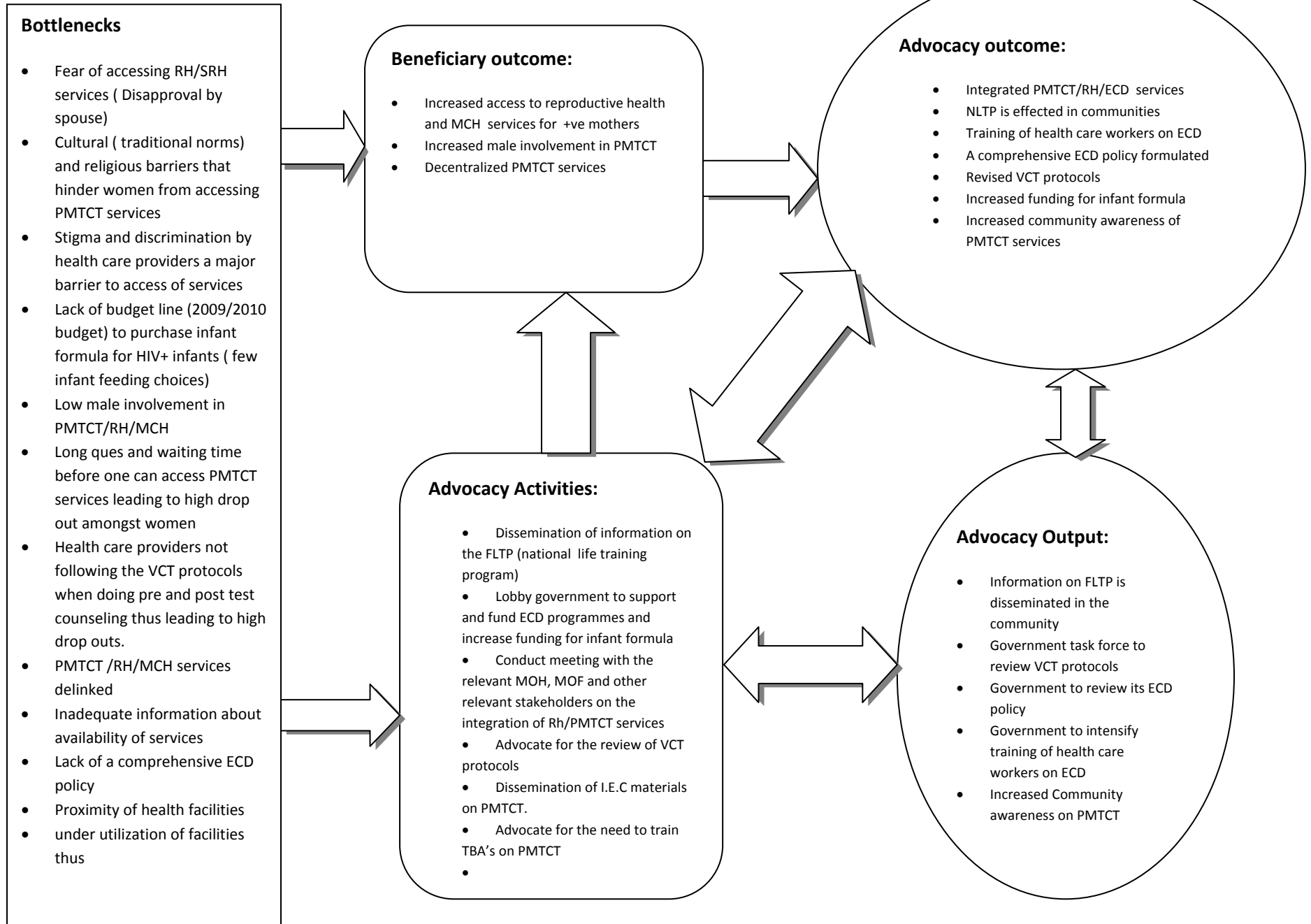
*“We know what needs to be done - we need to mobilise resources, to **invest in healthcare** in developing countries, to tackle under-nutrition, and to **pay special attention to the plight of newborns**, who continue to die in extraordinarily high numbers,”*

The Campaign to End Pediatric HIV/AIDS (CEPA) seeks to increase coverage rates for prevention of mother-to-child transmission (PMTCT) and pediatric treatment to the globally agreed-upon target of 80% and ensure high-quality services. The campaign works to expand and activate in-country advocacy networks that can help catalyze reforms at the national and global levels; hold governments and other decision-makers accountable for tangible progress toward their commitments; and overcome key policy and implementation bottlenecks around CEPA's four core strategic objectives:

1. **Family-Centered Care and Nutrition.** Expand access to PPTCT+ and pediatric treatment, care, and support, including nutrition services, and integrate child and family services with other health services in order to improve survival rates and health outcomes for children, HIV-positive mothers, and their families.
2. **Early Infant Diagnosis and Treatment.** Expand access to early infant diagnosis and earlier and improved pediatric treatment in order to improve survival rates and health outcomes for children.
3. **Access to Appropriate Medications.** Reduce distribution barriers and increase the global supply of high-quality, low-cost lifesaving medicines for children and their families, including ARVs, drugs to treat opportunistic infections, and first and second-line regimens to ease dosing and administration.
4. **Full Funding to Eliminate Pediatric AIDS.** Secure the financial resources needed to facilitate country-level scale-up of PPTCT+ and pediatric and maternal treatment programs.

⁴ <http://www.conflictandhealth.com/content/3/1/5>

CEPA objective one: Family Centered Care and Nutrition

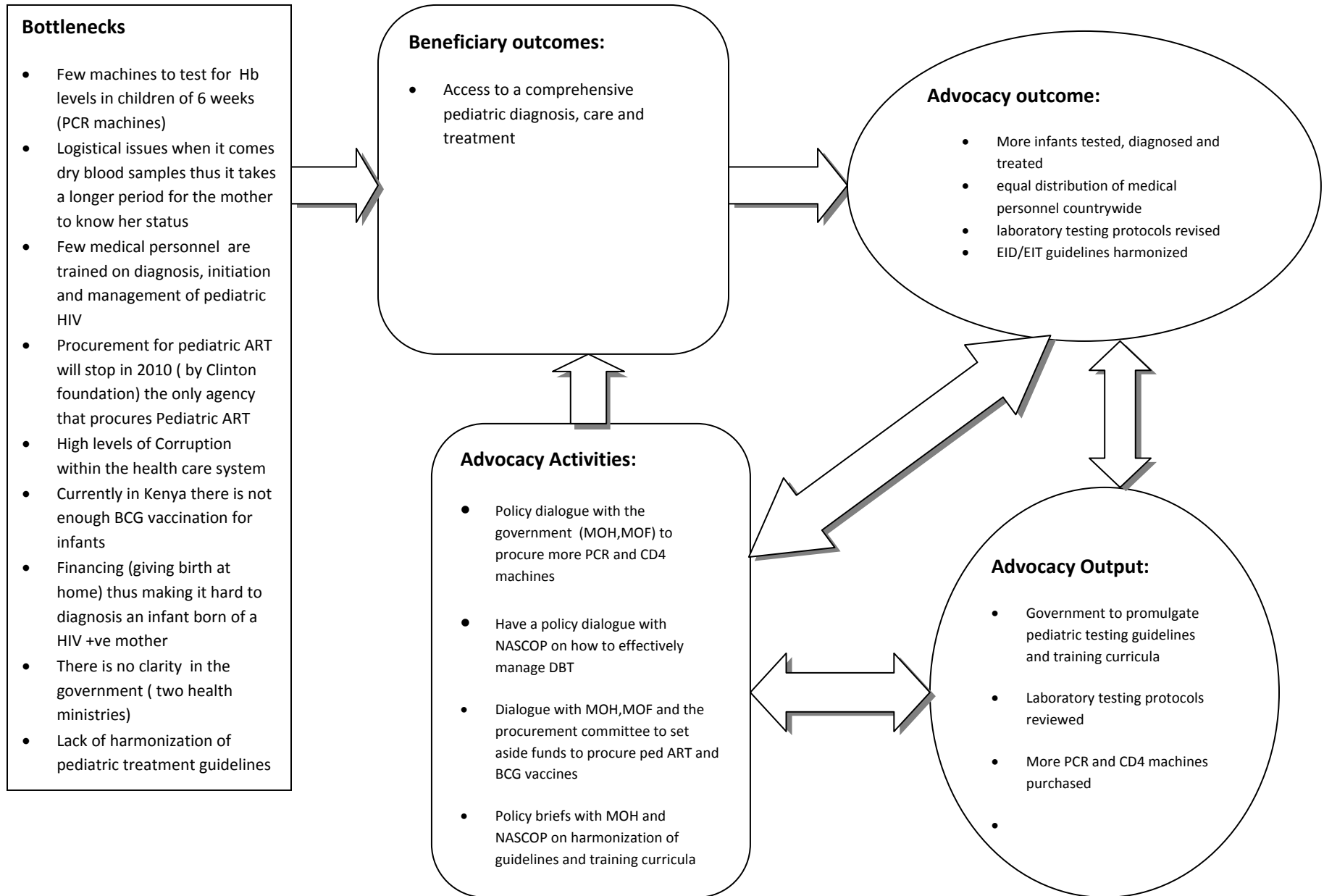


- High levels of corruption
- Medical personnel not adequately trained
- Financing (home deliveries due to harsh economic times and increased poverty

Key Performance Indicators:

- A national comprehensive ECD guidelines accredited
- Integration of PMTCT/RH services
- Current VCT protocols revised

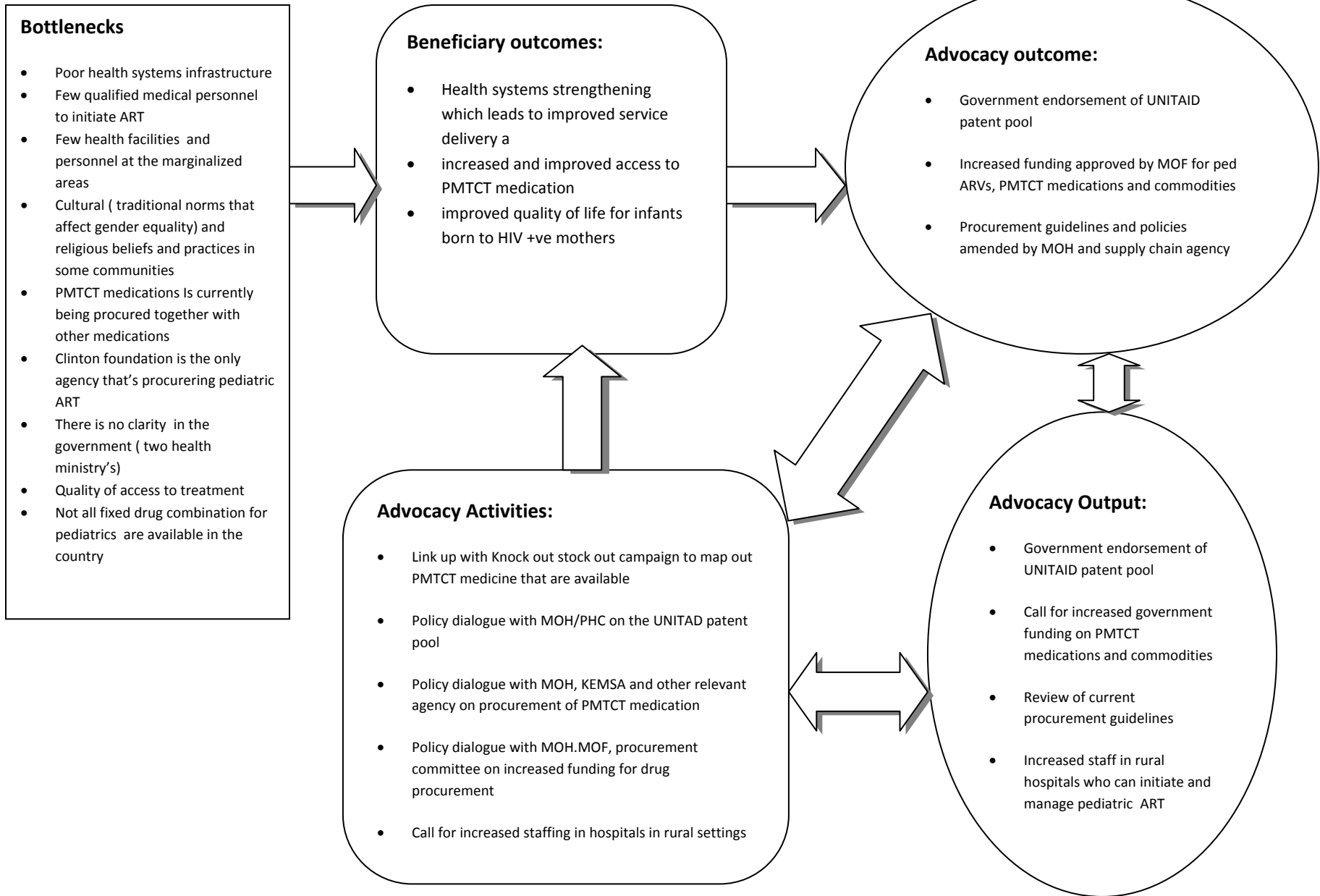
CEPA Objective 2: Early Infant Diagnosis and treatment



Key Performance Indicators:

- New pediatric testing guidelines formulated and rolled out

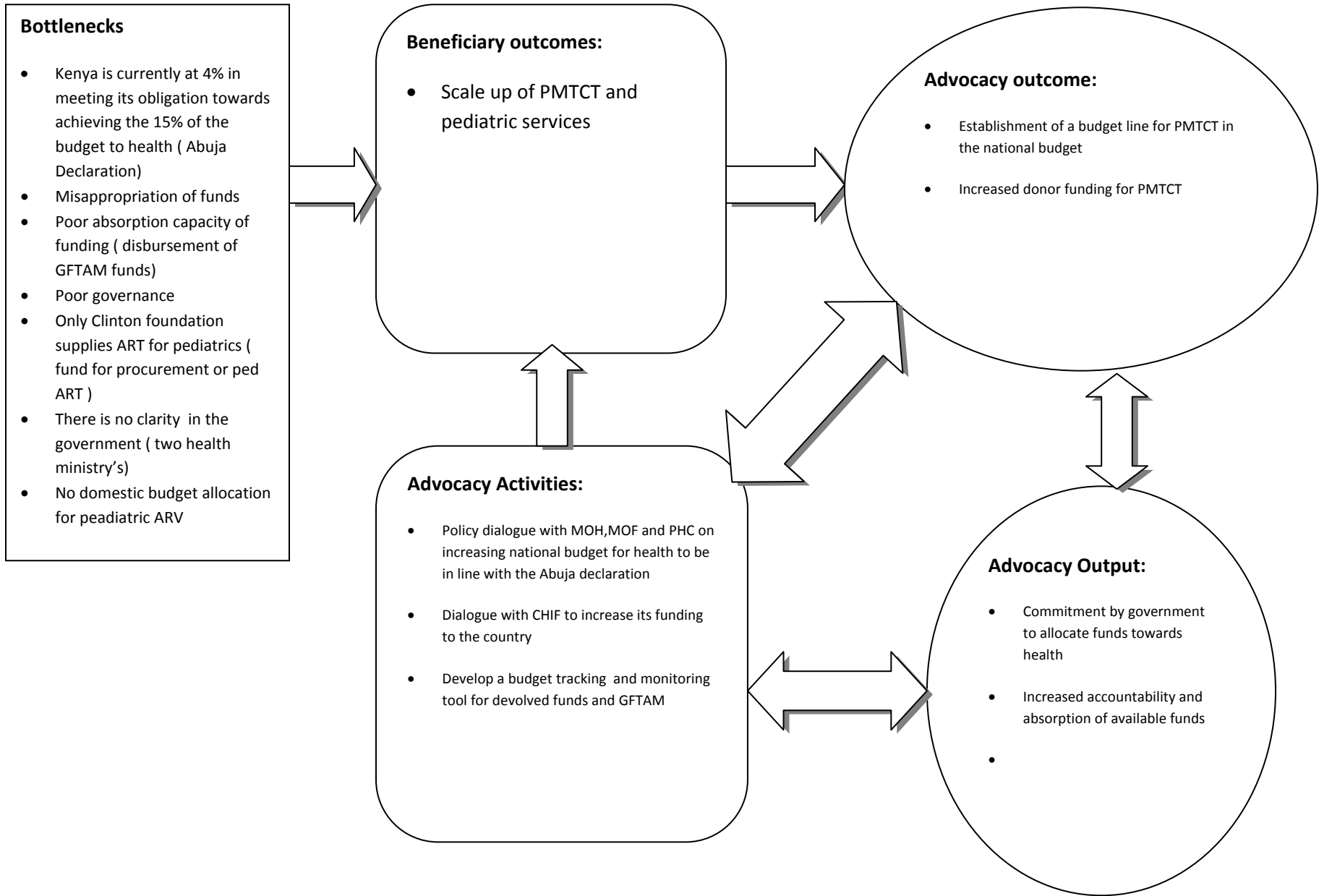
CEPA objective Three: Access to appropriate Medication



Key performance indicators

- Government call for upon pharmaceutical companies to join the UNITAD patent pool
- Improved procurement, distribution and supply chain management systems

CEPA objective four: Full funding to Eliminate paediatric Aids



Key performance indicators:

- Government commitment to the Abuja declaration of 15% budget to health