

COSTING HIV PREVENTION IN KENYA

Towards achieving
an equitable and
efficient response to
the HIV epidemic



The Kenya AIDS Strategic Framework II [KSAF II] has established ambitious goals to decrease new HIV infections by 75%, reduce AIDS-related mortality by 50%, and bring down HIV-related stigma and discrimination to below 25% by 2025 [1]. The framework aims to fulfil the resource requirements for the response by increasing domestic financing to 50% [1]. The analysis of the AIDS Spending Categories (ASC) in the 2022 Kenya National AIDS Spending Assessment (KNASA) report records Kenya's expenditure on HIV prevention at 9%. The United States Government provided 57% of the funding during the period, followed by GFATM (20%), international NGOs and Foundations (13%) and Kenya Government (8%) of the total expenditure.

HIV IN KENYA

Source: National AIDS Control Council, 2022



1.4 million
people living
with HIV



4.2%
adult HIV
prevalence



32,000
new infections



86%
of people on
antiretroviral
treatment



19,000
AIDS-related
deaths

Young people, men who have sex with men, women, sex workers, transgender people and people who inject drugs face a disproportionately higher risk of HIV in the country.

To optimise efficiency, the HIV Prevention Revolution Roadmap 2030 recommends scaling up high-impact interventions in priority geographies and among priority populations at high risk of HIV infections.

KASF II acknowledges key populations (KP), adolescents and young people, pregnant women, vulnerable populations as priority populations for the expansion of targeted, evidence-based combination HIV prevention interventions. The framework emphasises the importance of investing in comprehensive HIV prevention and support services to tackle the increasing number of new infections among these identified priority populations. It underscores the significance of resource allocation and utilisation efficiency and effectiveness in HIV programming, based on the specific characteristics of the epidemic typology.

Comprehensively costing HIV prevention interventions can play a crucial role in estimating the costs required to scale up these interventions. Moreover, it informs policy discussions and aids in decision-making regarding the appropriate combination and scale of prevention strategies [2]. Costing exercises also support advocacy towards allocating adequate resources for HIV prevention ensuring that services are delivered and accessed by all those in need. In the context of reducing external funding for HIV, costing HIV interventions provide evidence for advocating with county governments to ringfence resources within the county health budget for HIV prevention among priority populations.

A. ABOUT THE STUDY

The National Syndemic Diseases Control Council (NSDCC), the National AIDS and STI Control Programme (NASCO) of Kenya, the University of Manitoba, Futures Health Economics and Metric, and the Bill & Melinda Gates Foundation jointly commissioned a study to assess the cost of delivering HIV prevention services in Kenya.

OBJECTIVES

- To **cost a comprehensive HIV prevention intervention using a combination prevention approach** focused on pregnant and breast-feeding women, key populations, adolescent girls and young women, and adolescent boys and young men
- To define the **comprehensive resource need** for HIV prevention over five years.



The summary report outlines the findings of the study conducted in 2021-22 across all 47 counties.

The study focused on estimating the unit costs of interventions from the perspective of service providers. It calculated the costs associated with delivering essential and comprehensive packages of services annually for priority populations, taking into account biomedical, behavioural, and structural interventions. It also computed the total resources needed to implement the interventions over the next five years in Kenya.

A.1. STUDY APPROACH

Epidemic appraisal conducted by Kenya, the national and global recommendations on the package of services for different priority populations, and the phased coverage approach for programmes in the country guided the study.



Epidemic Appraisal: Kenya has conducted HIV epidemic appraisal since 2020 to facilitate precision programming at the national and sub-national levels. The epidemic appraisal conducted in 2022 identified the HIV epidemic in four counties as generalising, 21 counties as mixed and the remaining 22 counties as concentrated. The intervention mix is different for counties with varying typologies of the epidemic. The epidemic appraisal recommends some HIV prevention programmes, such as KPs, prevention of mother-to-child transmission (PMTCT), and antiretroviral therapy (ART), to be prioritised in all typologies of the epidemic. In counties with a mixed and generalising epidemic, it suggests an additional focus on adolescents and young people (AYP). Similarly, counties with a generalising epidemic must focus on other vulnerable populations to prevent new HIV infections. Thirteen counties, traditionally non-circumcising, will prioritise Voluntary Medical Male Circumcision (VMMC).

Package of services: The national guidelines describe the package of essential and comprehensive services for priority populations. The study also consolidated the package of services for AGYW as per UNAIDS global guidance. It allocated a proportion of cost based on existing evidence for elements of the package of services where ingredient-based costing was unavailable, especially related to structural interventions. Based on programming experience, the study assumed that priority populations need a differentiated service package based on their risk and vulnerability.





Coverage: In the next five years, Kenya aims to reach 95% of the estimated priority populations with quality services. However, the scale-up will be systematic and pragmatic. Hence, the study applied the phased coverage approach, ensuring that the target coverage is reached by the 5th year while calculating the annual resource need.

A.2. METHODS

The study employed the Activity Based Costing (ABC) approach¹ and the Resource Needs Model (RNM)² to cost the HIV prevention interventions.

A.2.1. DATA COLLECTION

The study used both secondary and primary data.

• A.2.1.1. Secondary Data Collection

The team acquired data through a comprehensive literature review. To obtain the costing data for interventions where estimates were previously available, the study team analysed strategic documents, guidelines, costing studies, and reports on HIV prevention and financing. The team reviewed 20 relevant documents and publications. Additionally, they examined secondary data for various programmes, including Key Population (KP), Condom and Lubricant, Voluntary Male Medical Circumcision (VMMC), Pre-Exposure Prophylaxis (PrEP), HIV Testing Services (HTS), Treatment, and Structural Interventions.

REVIEW OF

- > KASF II
- > Kenya HIV Prevention Revolution Roadmap (2014)
- > County AIDS Strategic Plans
- > Kenya Mode of Transmission Study
- > Kenya Population-based HIV Impact Assessment (KenPHIA)
- > Guidelines of relevant HIV interventions
- > Existing costing literature
- > Published reports on HIV prevention and financing landscape



• A.2.1.2. Primary Data Collection

The study collected primary data for programmes where the costing related data was either not available or was not updated, such as for the AGYW and ABYM programmes. The primary data collection process encompassed collection of data from a total of 50 programme sites located in three clustered regions. The first region, Nairobi, included Nairobi, Kiambu, and Machakos counties. The second region, the Lake region, consisted of Kisumu, Siaya, Homabay, and Kisii counties. Lastly, the Coast region covered Mombasa, Kilifi, and Kwale counties. These programme sites included public health facilities and those supported by PEPFAR and the Global Fund. A team of 20 research assistants collected qualitative and quantitative data over 20 days across the three clustered regions.

The primary data collection in the study adopted the ingredients costing method/activity-based costing methodology. The team conducted key informant interviews (KII), reviewed health records, and collected financial and overhead costs, medical and non-medical equipment and human resource costs.

The study administered a structured interview guide to the health facility manager, health care workers, health records and information officers, laboratory personnel and finance officers, among other staff, to collect the data. The team conducted site interviews with implementing partners to understand the interventions and gather additional programme costs where needed.

¹ The activity-based costing approach indicates the cost of all inputs required to implement different activities related to the specific interventions offered to the populations reached by the programme.

² The resource needs model estimates the resources needed for interventions aimed at a target population and the implications of expanding interventions and coverage.

A collaborative team from NSDCC and NASCOP oversaw the data collection process. Their supervision ensured adherence to standards and consistency throughout the data collection efforts.

A.2.2. DATA ANALYSIS

The study adopted the seven steps of the time-driven activity-based costing (TDABC) method by Kaplan and Anderson (2007) to develop the framework for cost analysis. The study team created an Excel template specifically designed to collect cost data from different sites. By averaging the cost data obtained from these various sites, they derived national averages for different HIV prevention packages.

A unit costs template developed for each intervention captured detailed information on the unit cost per person, service cost, and ingredients. The study employed an actual costing approach, considering the real expenditures associated with different elements of the service delivery package. It included costs related to personnel, materials, equipment, management, overhead, and other relevant factors.

However, it is essential to note that due to a lack of available data on unit costs for structural interventions, the study had to estimate the cost for this particular component. In this estimation, the study calculated a percentage of the total resource needs for structural interventions. While this estimation approach may not provide exact unit costs, it allowed for an approximate understanding of the cost implications associated with these interventions.

THE STUDY ESTIMATED THE COST OF AN INTERVENTION USING THE FOLLOWING FORMULA:

$$\text{RESOURCES (US\$)} = \text{POPULATION IN NEED} \times \text{COVERAGE TARGET} \times \text{UNIT COST}$$

The team presented, reviewed and validated country-specific unit costs, coverage rates, and population size estimates with the NSDCC and NASCOP team and revised the resource estimates based on inputs received. The estimated cost of interventions aligns with the latest strategic planning period (2021 – 2025) as per KASF II.



B. STUDY FINDINGS

The study provides insights into the financial requirements of delivering essential and comprehensive HIV prevention services, considering the unit costs of reaching priority populations and the costs associated with different intervention components.

B.1. COST OF HIV PREVENTION PACKAGE USING A COMBINATION PREVENTION APPROACH

The section discusses the study results on:

a) unit cost for reaching one identified priority population annually with a package of combination prevention services

b) unit cost of intervention components (behavioural, biomedical and structural) under each package for a specific priority population

B.1.1. PROGRAMME WITH PREGNANT AND BREASTFEEDING WOMEN

In 2022, Kenya estimated 1,610,149 annual pregnancies, with 86,130 pregnant women identified as needing the PMTCT programme. However, due to gaps in HIV testing, about 25% of the pregnant women were unaware of their HIV status and did not access the PMTCT programme. It is crucial to prioritise specific counties with higher coverage gaps as the varied coverage gaps across counties make it critical to focus prevention efforts where they are most needed [3]. The PMTCT programme aims to ensure that 95% of pregnant women are tested for HIV and that 100% of those testing HIV positive are linked to highly active antiretroviral therapy (HAART).

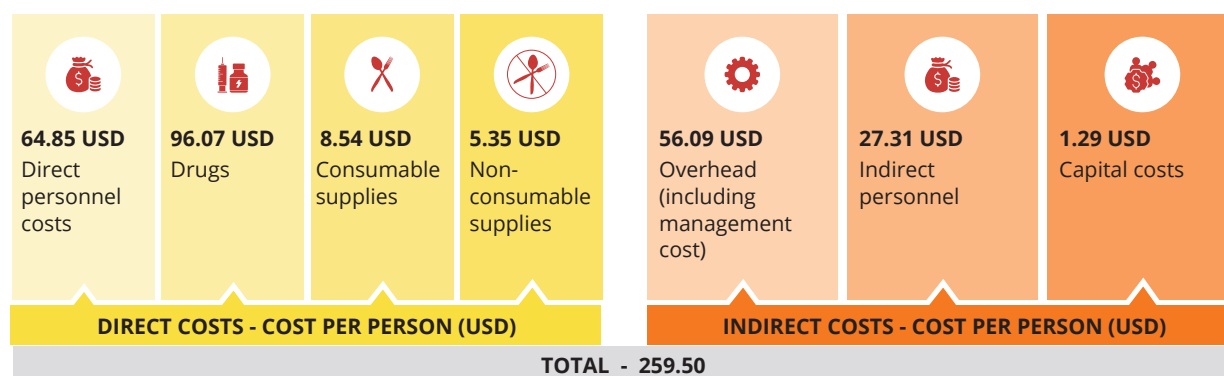
• B.1.1.1. Average unit cost of programming with pregnant and breastfeeding women

The package of interventions for pregnant and breastfeeding women (PBFW) is estimated to cost 259.50 USD per person per year in Year 1.

• B.1.1.2. Unit cost of interventions for pregnant and breast-feeding women

Among the interventions identified, the main cost drivers in the PMTCT programme are the drugs, which have a unit cost of 96.07 USD per person per year. The capital cost is the lowest cost driver, amounting to 1.29 USD per person per year.

Table 1: Cost of essential package for pregnant and breast-feeding women, Year 1



B.1.2. KEY POPULATION PROGRAMME

Kenya initiated the national KP programme in 2009. KP population size estimation exercise conducted in 2020 estimated the following number of KPs in the country [4].



197,096 female sex workers (FSWs)



26,673 people who inject drugs (PWID)



61,650 men who have sex with men (MSM)



4,370 transgender people in the country

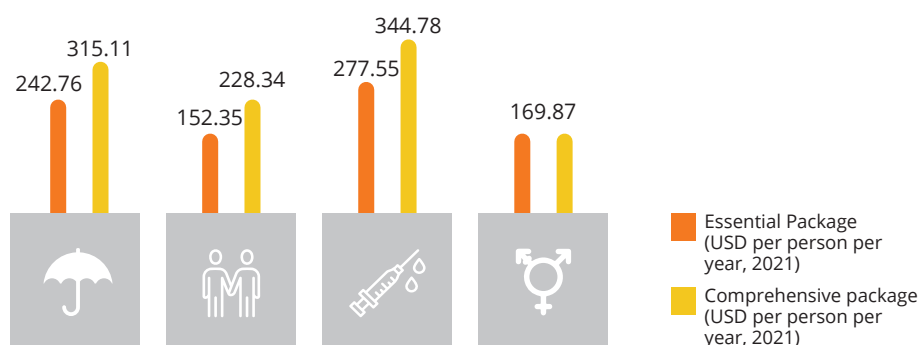
Recent epidemic appraisal data from Kenya indicates a scaled programme coverage of 84% for FSW and 100% for MSM. However, the programme for PWID requires a faster scale-up from its current coverage of 73% of the estimated population. The transgender population programme is still in its early stages, with a population coverage of 27%.

The KP programme aims to scale up and reach 95% of all estimated KPs within the next five years. Additionally, the programme plans to maintain 100% coverage for MSM. These plans reflect the efforts to expand and enhance the reach of the programmes to effectively address the needs of these populations.

B.1.2.1 Average unit cost of programming with the key population

According to the national guidelines, there are essential and comprehensive packages of interventions outlined for KPs [11]. The study determined that the average unit cost per year for reaching one person with an essential and comprehensive package was highest for PWID. Table 2 gives the estimated costs per person per year for the essential and comprehensive packages for each population.

Table 2: Cost of essential and comprehensive package of interventions for key populations, Year 1



B.1.2.2 Unit cost of each intervention for key populations

Biomedical interventions need the highest share of resources, in essential (520.9 USD) and comprehensive packages (698.33 USD), among the KP interventions, as indicated in Table 3. In biomedical interventions, the highest cost drivers are mental health (594.00 USD), Hepatitis C treatment (451.98 USD) and Medically Assisted Therapy (MAT) (445.06 USD). PrEP at 285.26 USD per person per year is also one of the highest cost drivers for all populations.

For behavioural interventions among KPs, the highest cost drivers are peer education (5.00 USD) and condom distribution (3.19 USD) per person.

Table 3: Cost of interventions in essential and comprehensive package of services for key populations, Year 1 (USD)

Interventions	Essential Package (USD)				Total	Comprehensive Package (USD)				Total
	Umbrella	Two people	Syringe	Gender symbol		Umbrella	Two people	Syringe	Gender symbol	
Behavioural Interventions	42.84	45.62	41.94	42.14	172.54	42.84	45.62	41.94	42.14	172.54
Biomedical Interventions	156.96	79.77	186.50	97.67	520.9	216.51	142.32	241.83	97.67	698.33
Structural Interventions	4.99	3.13	5.71	3.50	17.33	6.48	4.70	7.09	3.50	21.77
Management Costs	37.96	23.82	43.40	26.56	131.74	49.28	35.71	53.92	26.56	165.47
Total	242.76	152.35	277.55	169.87	842.53	315.11	228.34	344.78	169.87	1058.1

B.1.3. PROGRAMMING WITH AGYW

During the KASF I period (2014/15 - 2018/19), the National Syndemic Diseases Control Council (formerly NACC) led the formulation of a national response to reduce new HIV infections among Adolescent Girls and Young Women (AGYW) in Kenya. PEPFAR and the Global Fund allocated resources to scale up the implementation. However, currently, only 10 out of the 25 counties with generalising and mixed HIV epidemics have implemented an AGYW programme.

Kenya has planned to scale up focused programming among AGYW in the remaining 15 counties with mixed epidemics, aligning it with the national package of services.

Based on global guidance on AGYW programming, which emphasises differentiation based on risk levels, Kenya plans to prioritise interventions for high or very high-risk AGYW, including those living with HIV in high incidence locations. In the first year, Kenya aims to reach 55% of the estimated high and very high-risk AGYW, with the goal of reaching 95% coverage of estimated population by the year 2025 (Year 5).

These plans demonstrate Kenya's commitment to scaling up programming for AGYW and addressing the specific needs of high-risk AGYW and those living with HIV.

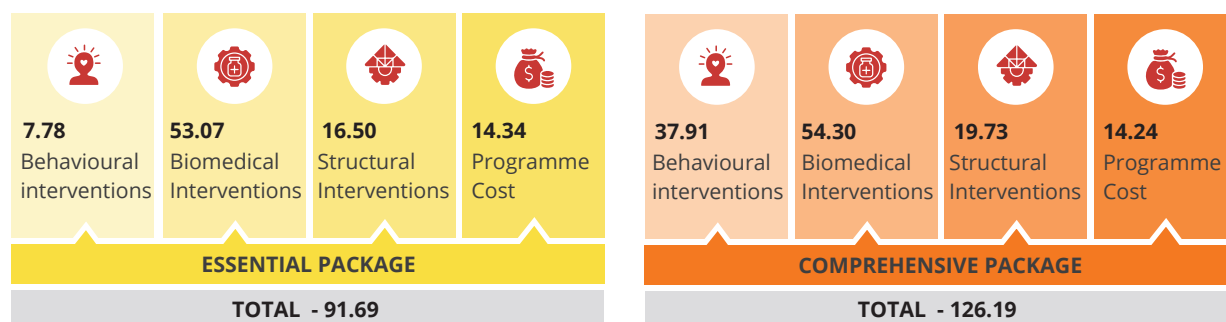
- **B.1.3.1. Average unit cost of programming for AGYW**

The study estimated that in Year 1, the average unit cost for reaching one high or very high-risk AGYW with the essential package of services is 91.69 USD. Additionally, for reaching one high or very high-risk AGYW in Year 1 with the comprehensive package of services, the estimated average unit cost is 126.19 USD.

- **B.1.3.2. Unit cost of interventions for AGYW**

Mental health diagnosis and treatment had the highest (594.00 USD), and condom promotion and distribution (3.19 USD) had the lowest unit cost to reach one AGYW in Year 1.

Table 4: Cost of reaching an AGYW with the package of services and interventions, Year 1 (USD)



B.1.4. PROGRAMMING WITH ADOLESCENT BOYS AND MEN

Currently, Kenya has limited programmes specifically targeting ABYM, except for those focusing on VMMC in specific priority counties. However, both the KASF II and global guidance recommend prioritising interventions for high-risk men, including those living with HIV. In response to this, Kenya has prioritised interventions for ABYM in counties with generalising and mixed HIV epidemics, with a particular emphasis on traditionally non-circumcising counties, which also include two counties with concentrated HIV epidemics.

The country has set ambitious goals to address the needs of ABYM. In the first year, Kenya plans to reach 55% of the estimated high-risk ABYM, including those living with HIV. The target is to reach 95% the estimated population by Year 5, ensuring that a significant proportion of high-risk ABYM receive the necessary interventions.

- **B.1.4.1 Average unit cost of programming for adolescent boys and young men**

The study estimated that for the essential package of services, the average unit cost is 72.14 USD to reach one high-risk or very high-risk adolescent boy or young man annually. Additionally, for the comprehensive package of services, the estimated average unit cost is 127.03 USD to reach one high-risk or very high-risk adolescent boy or young man annually.

- **B.1.4.2 Unit cost of interventions for adolescent boys and men**

Similar to AGYW interventions, mental health diagnosis and treatment had the highest (594 USD), and condom promotion and distribution had the lowest (3.19 USD) unit cost to reach one ABYM in Year 1.

Table 5: Cost of interventions in the essential and comprehensive package of services for ABYM, Year 1 (USD)



B.2. RESOURCE NEEDS FOR HIV PREVENTION

Estimating resource requirements is crucial as it provides valuable information to the government, partners, and other stakeholders regarding the financial needs for implementing prevention interventions. The resource requirements for each priority population are determined by considering the unit cost of interventions and the programme coverage targets set for each year (as explained earlier). This information enables better planning, budgeting, and allocation of resources to ensure the successful implementation of HIV prevention efforts.

Table 6: Resource requirement to deliver the essential package for five years

Population	Total Resources (USD million)						Proportion
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	
Pregnant Women	21.79	22.11	22.42	22.74	23.06	112.12	12%
FSW	36.93	43.13	49.60	56.36	63.42	249.45	28%
MSM	8.40	10.01	11.91	13.78	15.51	59.60	7%
PWID	3.75	4.62	6.15	7.41	8.72	30.65	3%
Transgender people	0.48	0.61	0.81	0.98	1.15	4.02	0.4%
AGYW	61.05	66.14	71.23	76.32	78.86	353.61	39%
ABYM	15.83	16.77	17.70	18.62	19.54	88.46	10%
Total	148.23	163.40	179.82	196.21	210.26	897.92	100.00%

Table 7: Resource requirement to deliver the comprehensive package for five years

Population	Total Resources (USD million)					Total	Proportion
	2021	2022	2023	2024	2025		
Pregnant Women	21.79	22.11	22.42	22.74	23.06	112.12	9%
FSW	47.94	56.82	66.11	75.80	85.92	332.60	27%
MSM	12.58	15.86	19.69	23.45	27.02	98.61	8%
PWIDs	4.65	5.90	8.10	9.92	11.80	40.39	3%
Transgender people	0.48	0.61	0.81	0.98	1.15	4.02	0.3%
AGYW	88.02	92.07	100.12	108.16	116.21	500.58	40%
ABYM	27.88	29.90	31.90	33.91	35.91	159.49	13%
Grand Total	203.34	223.27	249.15	274.96	301.07	1247.81	100.00%

B.2.1. PREVENTION OF MOTHER TO CHILD TRANSMISSION INTERVENTIONS NEED 112 MILLION USD

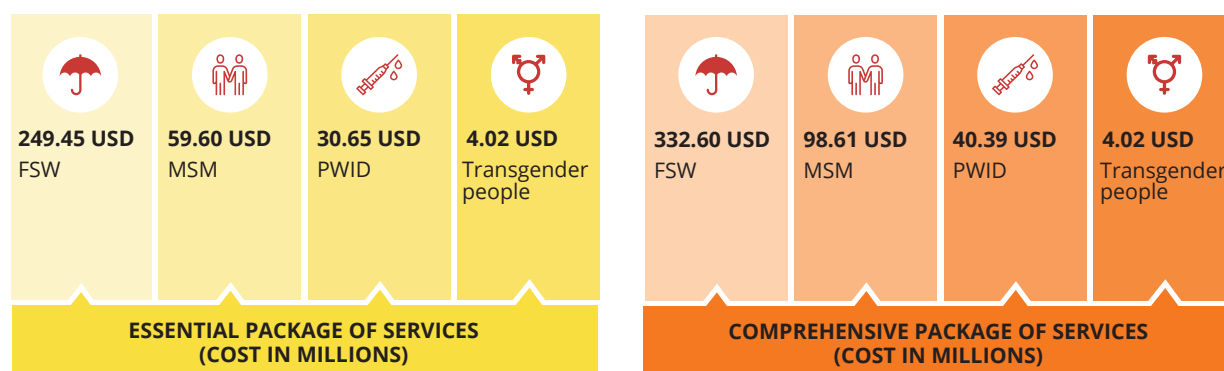
Over the course of five years, the HIV programme will require a total of 112.12 million USD to reach pregnant women with a comprehensive package of interventions as outlined in the guidelines. The annual resource requirement for this programme will increase by 6%, from 21.79 million USD in Year 1 to 23.06 million USD in Year 5. The PMTCT programme accounts for 7% of the total resource requirements for HIV prevention over the five-year period. These estimates highlight the financial investment needed to ensure effective implementation of interventions targeting pregnant women and reducing the risk of HIV transmission from mother to child.

B.2.2. HIV PREVENTION WITH KEY POPULATIONS REQUIRES 343.72 MILLION USD OVER FIVE YEARS

By 2025, Kenya will require a total of 343.72 million USD to implement essential HIV prevention interventions and 475.63 million USD to implement comprehensive prevention interventions for key populations.

The annual resource needs for these interventions will experience a 79% increase over the course of five years for the essential package and a 91% increase for the comprehensive package. This rise is primarily attributed to the higher programme coverage targets set to achieve broader coverage and make a significant impact on the HIV epidemic. The increased resource allocation reflects the commitment to scaling up prevention efforts and ensuring optimal coverage at a larger scale.

The estimated total resource requirements over five years for HIV prevention interventions are as follows.



B.2.3. AGYW INTERVENTIONS NEED 353.61 MILLION USD

HIV prevention interventions targeting AGYW require a total of 353.61 million USD over a span of five years to provide the essential package of services. This accounts for 39% of the overall resources needed for prevention efforts. AGYW programming require a total of 500.58 million USD over a span of five years to provide the comprehensive package of services, accounting for 40% of the overall resources needed for prevention efforts. During this period, the resource needs for AGYW will experience a 29% increase, rising from 61 million USD in Year 1 to 78 million USD in Year 5.

B.2.4. ADOLESCENT BOYS AND YOUNG MEN INTERVENTIONS REQUIRE 88.46 MILLION USD

HIV prevention interventions targeting ABYM require a total of 88.46 million USD over a span of five years to provide the essential package of services. This accounts for 10% of the overall resources needed for prevention efforts. ABYM programming require a total of 159.49 million USD over a span of five years to provide the comprehensive package of services, accounting for 13% of the overall resources needed for prevention efforts. During this period, the resource needs for ABYM will experience a 33% increase, rising from 15.8 million USD in Year 1 to 19.5 million USD in Year 5.

C. RECOMMENDATIONS

The study findings suggest that to achieve optimum coverage of the different priority populations with an essential package of services, Kenya needs a total investment of 897.92 million USD. Among the total investment, the interventions for Adolescents and Young People require the most resources, accounting for 49% (10% for ABYM and 39% for AGYW). Key Populations (KPs) require 21% of the resources, while 7% is for pregnant women. The proportion of resource needs for each population will change over time.

Policymakers, donors, and implementers can use the unit costing and estimated resource needs to adequately budget for an effective HIV prevention response at county and national level.

Through ingredient-based costing, unit costs for each intervention within the standard package of services for the priority population has been derived. The coverage plans for the priority populations, guided by the epidemic appraisal, can help counties estimate resource needs over the next five years and effectively allocate funds in their county budgets to prevent new HIV infections. The NSDCC has developed a tool to assist counties in using this costing information to develop county-level budgets.

National and county governments, donors, and key stakeholders should utilise this information to discuss financing options, including strategies for resource mobilisation, and improve the alignment of resource allocation based on the priority interventions for the priority populations.

There is a significant global funding gap, and there is only a short window to bend the trajectory of the HIV epidemic. National and county governments should explore domestic funding for prevention interventions through national and county government allocations. Additionally, they should consider integrating certain HIV preventive services into the Universal Health Coverage benefits package or leverage resources within other sectors like Education or Gender.

The study findings are particularly relevant for informing additional research like the relative cost-effectiveness across service delivery points, and the estimation of affordability considering the budgets of the Ministry of Health and donor budgets for scale-up.

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Priya Pillai wrote the summary report.

129 Degrees design studio designed the report.

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ANNEXURE

Package of services

Comprehensive and Essential Interventions for FSW

COMPREHENSIVE PACKAGE OF INTERVENTIONS	ESSENTIAL PACKAGE OF INTERVENTIONS	Peer Education
		Distribution of condoms
		ARV-related prevention
		HIV testing and counselling
		STI screening
		STI Treatment
		HIV care and treatment (ART)
		HIV care and treatment (EMTCT)
		TB screening
		TB treatment
		Psychosocial support
		Pre-Exposure Prophylaxis
	Post-Exposure Prophylaxis	
	Enabling environment	
	Stigma and discrimination interventions	
	Community empowerment	
	Violence prevention and response	
	Capacity building	
	Post-abortion care	
	Cervical cancer screening	
Emergency contraception		
Post-rape care		
Screening and management of Hepatitis B		
Mental health screening		
Mental health diagnosis and treatment		
Family planning		

Source: Ministry of Health/NASCOP (2014)

Comprehensive and Essential Interventions for MSM

COMPREHENSIVE PACKAGE OF INTERVENTIONS	ESSENTIAL PACKAGE OF INTERVENTIONS	Peer Education
		Distribution of lubricants
		Distribution of condoms
		ARV-related prevention
		HIV testing and counselling
		STI screening
		STI Treatment
		HIV care and treatment (ART)
		TB screening
		TB treatment
		Pre-Exposure Prophylaxis
		Post-Exposure Prophylaxis
	Psychosocial support	
	Enabling environment	
	Stigma and discrimination interventions	
	Community empowerment	
	Violence prevention and response	
	Capacity building	
	Screening for anal and other cancers	
	Post-rape care	
Screening and management of Hepatitis B		
Mental health screening		
Mental health diagnosis and treatment		

Source: Ministry of Health/NASCOP (2014)

Comprehensive and Essential Interventions for PWID

COMPREHENSIVE PACKAGE OF INTERVENTIONS	ESSENTIAL PACKAGE OF INTERVENTIONS
Peer Education	Peer Education
Distribution of condoms	Distribution of condoms
HIV testing and counselling	HIV testing and counselling
Harm reduction for people who inject drugs (Needle and syringe programme)	
Medically assisted therapy	
STI screening	STI screening
STI Treatment	STI Treatment
HIV care and treatment (ART)	HIV care and treatment (ART)
HIV care and treatment (EMTCT)	HIV care and treatment (EMTCT)
TB screening	TB screening
TB treatment	TB treatment
Pre-Exposure Prophylaxis	
Post-Exposure Prophylaxis	
Psychosocial support	
Enabling environment	
Stigma and discrimination interventions	
Community empowerment	
Violence prevention and response	
Capacity building	
Screening and management of Hepatitis B	
Hepatitis C testing	
Hepatitis C treatment	
Mental health screening	
Mental health diagnosis and treatment	
Family planning	
Post-rape care	

Source: Ministry of Health/NASCOP (2014)

Comprehensive and Essential Interventions for Transgender People

COMPREHENSIVE PACKAGE OF INTERVENTIONS	ESSENTIAL PACKAGE OF INTERVENTIONS
Peer Education	Peer Education
Distribution of condoms	Distribution of condoms
ARV-related prevention	
HIV testing and counselling	HIV testing and counselling
STI screening	STI screening
STI Treatment	STI Treatment
HIV care and treatment (ART)	HIV care and treatment (ART)
HIV care and treatment (EMTCT)	HIV care and treatment (EMTCT)
TB screening	TB screening
TB treatment	TB treatment
Post-rape care	
Screening and management of Hepatitis B	
Mental health screening	
Mental health diagnosis and treatment	
Pre-Exposure Prophylaxis	
Post-Exposure Prophylaxis	
Psychosocial support	
Enabling environment	
Stigma and discrimination interventions	
Community empowerment	
Violence prevention and response	
Capacity building	

Source: Ministry of Health/NASCOP (2020)

Comprehensive and Essential Interventions for AGYW

COMPREHENSIVE PACKAGE OF INTERVENTIONS	ESSENTIAL PACKAGE OF INTERVENTIONS
HIV testing and counselling	
HIV care and treatment (ART)	
Mental health screening	
Pre-Exposure Prophylaxis	
Post-Exposure Prophylaxis	
Distribution of male condoms	
Distribution of female condoms	
STI screening	
STI Treatment	
HIV care and treatment (EMTCT)	
Post-rape care	
HPV screening	
HPV vaccination	
Dignity Packs	
Contraception	
Emergency contraception	
Psychosocial support	
Peer Education	
Community outreach (CHWs)	
Comprehensive sexuality education	
BCC Materials	
Parenting programmes	
Psychosocial support	
Menstrual health and hygiene	
Enabling environment	
Stigma and discrimination interventions	
Community empowerment	
Violence prevention and response	
Capacity building	
Community based demand creation	
Child Birth and delivery services	
Management of pregnancy complications	
Interventions to keep girls in school	
Cash transfers/Economic assistance	
Economic Empowerment	
School Based Prevention campaigns	
Skill Based Trainings	
Linkage to social Protection	
School based clubs	

Source: KASF II

Comprehensive and Essential Interventions for ABYM

COMPREHENSIVE PACKAGE OF INTERVENTIONS	ESSENTIAL PACKAGE OF INTERVENTIONS
HIV testing and counselling	
HIV care and treatment (ART)	
Mental health screening	
Pre-Exposure Prophylaxis	
Post-Exposure Prophylaxis	
Distribution of male condoms	
Voluntary Medical Male Circumcision	
STI screening	
STI Treatment	
Psychosocial support	
Peer Education	
Community outreach (CHWs)	
Comprehensive sexuality education	
BCC Materials	
Psychosocial support	
Enabling environment	
Stigma and discrimination interventions	
Community empowerment	
Violence prevention and response	
Capacity building	
Parenting programmes	
Community based demand creation	
Child Birth and delivery services	
School Based Prevention campaigns	
Skill Based Trainings	
School based clubs	

Source: KASF II