



NATIONAL SYNDemic DISEASES  
CONTROL COUNCIL

# National Multisectoral HIV Prevention Acceleration Plan 2023–2030





# NATIONAL MULTISECTORAL **HIV PREVENTION** ACCELERATION PLAN 2023-2030



NATIONAL SYNDEMIC DISEASES  
CONTROL COUNCIL



National Syndemic Diseases Control Council (NSDCC)  
National Multisectoral HIV Prevention Acceleration Plan 2023-2030. August 2023

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# FOREWORD

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**Mr. Geoffrey Gitu**  
**Chairperson**

*National Syndemic  
Diseases Control Council*

A handwritten signature in black ink, appearing to read 'Geoffrey Gitu', written over a horizontal line.

**“It features a precision and differentiated approach, which prioritises geographies and populations that are at greatest need of HIV prevention, based on epidemic appraisals conducted in the country.”**

Kenya has committed to end AIDS as a public health threat by 2030. This is in line with the Kenya HIV Prevention Revolution Road Map, which in 2014 set the country on an ambitious path to reducing new HIV infections to zero by 2030. In addition, the Global HIV Prevention Coalition’s HIV Prevention 2025 Road Map and the United Nations’ Sustainable Development Goals provide guidance to countries to end AIDS as a public health threat.

The HIV epidemic in Kenya is heterogeneous, with significant variation in the burden of HIV across geographic areas and population groups. The country has made significant progress in reducing new HIV infections. Key success factors include swift translation of scientific evidence in programmes; scale up of impactful interventions with key and priority populations in priority geographies; partnerships with donors, implementing partners, and community groups; strong leadership and coordination at national and county level; use of data to monitor and guide the response; and a multisectoral approach that engages all levels of governance, various sectors of the government, diverse stakeholders, and partners.

Despite notable progress, new HIV infections remain unacceptably high, imposing unsustainable treatment costs on the nation’s health system. Renewed efforts are urgently needed to reinvigorate and accelerate primary HIV prevention, building on lessons from previous prevention initiatives and other successful experiences that contributed to the reduction of new HIV infections.

The National Multisectoral HIV Prevention Acceleration Plan 2023-2030 has been developed to provide guidance for accelerating the reduction of new HIV infections. As recommended by KASF II 2020/21-2024/25 and the Kenya HIV Prevention Revolution Road Map, this plan puts communities at the centre of the response to increase programme sustainability, and integrates services with Kenya’s health system to enhance efficiency. The plan also emphasises embedding research in programme implementation to accelerate learning and innovation. In the context of dwindling donor resources and competing global priorities, the plan recommends various financing mechanisms to increase domestic investment in HIV prevention.

The plan also presents monitoring and evaluation indicators for tracking the progress of its implementation and impact. To enhance coordination and management of HIV prevention efforts, the plan recommends strengthening national and county coordination structures and mechanisms.

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# ACKNOWLEDGEMENTS

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**Dr. Ruth Laibon-Masha**  
**Chief Executive Officer**  
*National Syndemic  
Diseases Control Council*

A handwritten signature in black ink, appearing to read 'Ruth Laibon-Masha', written in a cursive style.

**“ The NSDCC remains committed to strengthening coordination, promoting multisectoral collaboration, and facilitating the successful implementation of an evidence-informed and multisectoral HIV prevention response in the country. ”**

The National Syndemic Diseases Control Council (NSDCC) expresses its sincere appreciation for the valuable contributions, hard work, and dedication of all individuals and organisations involved in the development of this acceleration plan. The NSDCC would like to acknowledge the following contributors: Representatives of National and County Governments, National AIDS and STI Control Programme (NASCO), various Ministries and Agencies. The input and collaboration of government representatives at the national and county levels have been instrumental in shaping this plan. Appreciation goes to the UN Joint Team, PEPFAR, USAID, CDC, IAVI and GFATM, as the support and expertise provided by these organisations have greatly enriched the development of the plan, ensuring its alignment with global best practices. NSDCC would like to thank Partners for Health and Development in Africa (PHDA); Georgetown University; AIDS Healthcare Foundation (AHF); LVCT Health; Key Population Consortium; Value Impact; Bell Consultants; Maisha Youth; and NEPHAK for their valuable contributions, which have been vital in addressing the complex challenges of HIV prevention and shaping effective strategies. We would extend our thanks to national and county stakeholders, implementing partners, and community groups who have actively participated in all consultations and dialogues and have shared their valuable insights, informing the development of this acceleration plan.

Special recognition is extended to the HIV Prevention Technical Support Unit under PHDA for their support in drafting the plan, Brooks Anderson for his editing contributions, and the South-to-South Learning Network (SSLN) for their assistance in editing and designing the document.

It is through the collective efforts of all stakeholders involved that the goals of this plan can be achieved, making a significant impact in combatting syndemic diseases.



# ABBREVIATIONS

|                |   |               |  |
|----------------|---|---------------|--|
| <b>ABM</b>     | Adolescent Boys and Men                             | <b>NACC</b>   | National AIDS Control Council  |
| <b>AGYW</b>    | Adolescent Girls and Young Women                    | <b>NASCOP</b> | National AIDS and STI Control Programme                                  |
| <b>AHF</b>     | AIDS Healthcare Foundation                          | <b>NEPHAK</b> | National Empowerment Network of People Living with HIV and AIDS in Kenya |
| <b>AIDS</b>    | Acquired Immuno-Deficiency Syndrome                 | <b>NGO</b>    | Non-Governmental Organisation  |
| <b>ANC</b>     | Antenatal Care                                      | <b>NHIF</b>   | National Hospital Insurance Fund   |
| <b>ART</b>     | Antiretroviral Treatment/Therapy                    | <b>NSDCC</b>  | National Syndemic Diseases Control Council                               |
| <b>ARV</b>     | Antiretroviral                                      | <b>PEP</b>    | Post-Exposure Prophylaxis  |
| <b>ASC</b>     | AIDS Spending Categories                            | <b>PEPFAR</b> | President's Emergency Plan for AIDS Relief                               |
| <b>AYP</b>     | Adolescents and Young People                        | <b>PLHIV</b>  | People Living with HIV   |
| <b>CDC</b>     | Centers for Disease Control and Prevention          | <b>PMTCT</b>  | Prevention of Mother to Child Transmission                               |
| <b>CIDP</b>    | County Integrated Development Plan                  | <b>PNC</b>    | Postnatal Care   |
| <b>CLM</b>     | Community-Led Monitoring                            | <b>PrEP</b>   | Pre-Exposure Prophylaxis   |
| <b>CoP</b>     | Community of Practice                               | <b>PSAT</b>   | Prevention Self-Assessment Tools   |
| <b>CSO</b>     | Civil Society Organisation                          | <b>PWID</b>   | People Who Inject Drugs  |
| <b>DoD</b>     | Department of Defense                               | <b>SRH</b>    | Sexual and Reproductive Health   |
| <b>FGM</b>     | Female Genital Mutilation                           | <b>TB</b>     | Tuberculosis   |
| <b>FSW</b>     | Female Sex Workers                                  | <b>TWG</b>    | Technical Working Group  |
| <b>GFATM</b>   | Global Fund to Fight AIDS, Tuberculosis and Malaria | <b>UHC</b>    | Universal Health Coverage  |
| <b>GPC</b>     | Global HIV Prevention Coalition                     | <b>UNAIDS</b> | Joint United Nations Programme on HIV and AIDS                           |
| <b>HAART</b>   | Highly Active Antiretroviral Therapy                | <b>UNDP</b>   | United Nations Development Programme                                     |
| <b>HIV</b>     | Human Immunodeficiency Virus                        | <b>UNFPA</b>  | United Nations Population Fund   |
| <b>HPV</b>     | Human Papilloma Virus                               | <b>UNICEF</b> | United Nations Children's Fund   |
| <b>HTC</b>     | HIV Testing and Counselling                         | <b>USAID</b>  | United States Agency for International Development                       |
| <b>IAVI</b>    | International AIDS Vaccine Initiative               | <b>VMMC</b>   | Voluntary Medical Male Circumcision                                      |
| <b>IPR</b>     | Incidence:Prevalence Ratio                          | <b>WHO</b>    | World Health Organization  |
| <b>KASF</b>    | Kenya AIDS Strategic Framework                      |               |  |
| <b>KENPHIA</b> | Kenya Population-Based HIV Impact Assessment        |               |  |
| <b>KHIS</b>    | Kenya Health Information System                     |               |  |
| <b>KP</b>      | Key Population                                      |               |  |
| <b>MCH</b>     | Maternal and Child Health                           |               |  |
| <b>MoH</b>     | Ministry of Health                                  |               |  |



# EXECUTIVE SUMMARY

The HIV Prevention Acceleration Plan 2023-2030 provides guidance for designing the nation's HIV prevention response. The plan is aligned to the Kenya HIV Prevention Revolution Road Map: Count Down to 2030 and the Kenya AIDS Strategic Framework II (KASF II) 2020/21-2024/25. At the global level, the plan is guided by the Global HIV Prevention Coalition's HIV Prevention Road Map 2025 and by UNAIDS' Global AIDS Strategy 2021-2026.

The HIV epidemic in Kenya is heterogeneous, with some geographies and subpopulations disproportionately affected. HIV prevalence in 2021 ranged from 16.2% in Homa Bay to 0.2% in Wajir. HIV prevalence is higher among females than among males, and is higher among some subpopulations, such as adolescents and young people, female sex workers, men who have sex with men, people who inject drugs, and transgender people, than among the general population.

The HIV Prevention Acceleration Plan 2023-2030 builds on the gains made during KASF I, 2014/15-2018/19, when the country achieved a 68.5% reduction in new HIV infections. Kenya partially met the global HIV prevention targets for 2020. Kenya's successful HIV response can be attributed to scaling up antiretroviral therapy for people living with HIV, voluntary medical male circumcision in traditionally non-circumcising communities and counties, preventing mother to child transmission of HIV, and prevention programmes with adolescent girls and young women in 100% of the high incidence counties. Kenya has also fielded one of the most successful pre-exposure prophylaxis (PrEP) programmes in Africa. Service packages for sex workers and people who inject drugs include all recommended elements.<sup>1</sup>

Yet, Kenya did not meet the global target of reducing HIV incidence by 75% between 2010 and 2020. And for the first time in more than a decade, in 2021 the number of new HIV infections increased, from 32,027 in 2020 to 34,540 in 2021, an increase of 7.8%.

This plan emphasises scaling up combination prevention, with focus on structural and behavioural interventions, and expediting the rollout of new HIV prevention

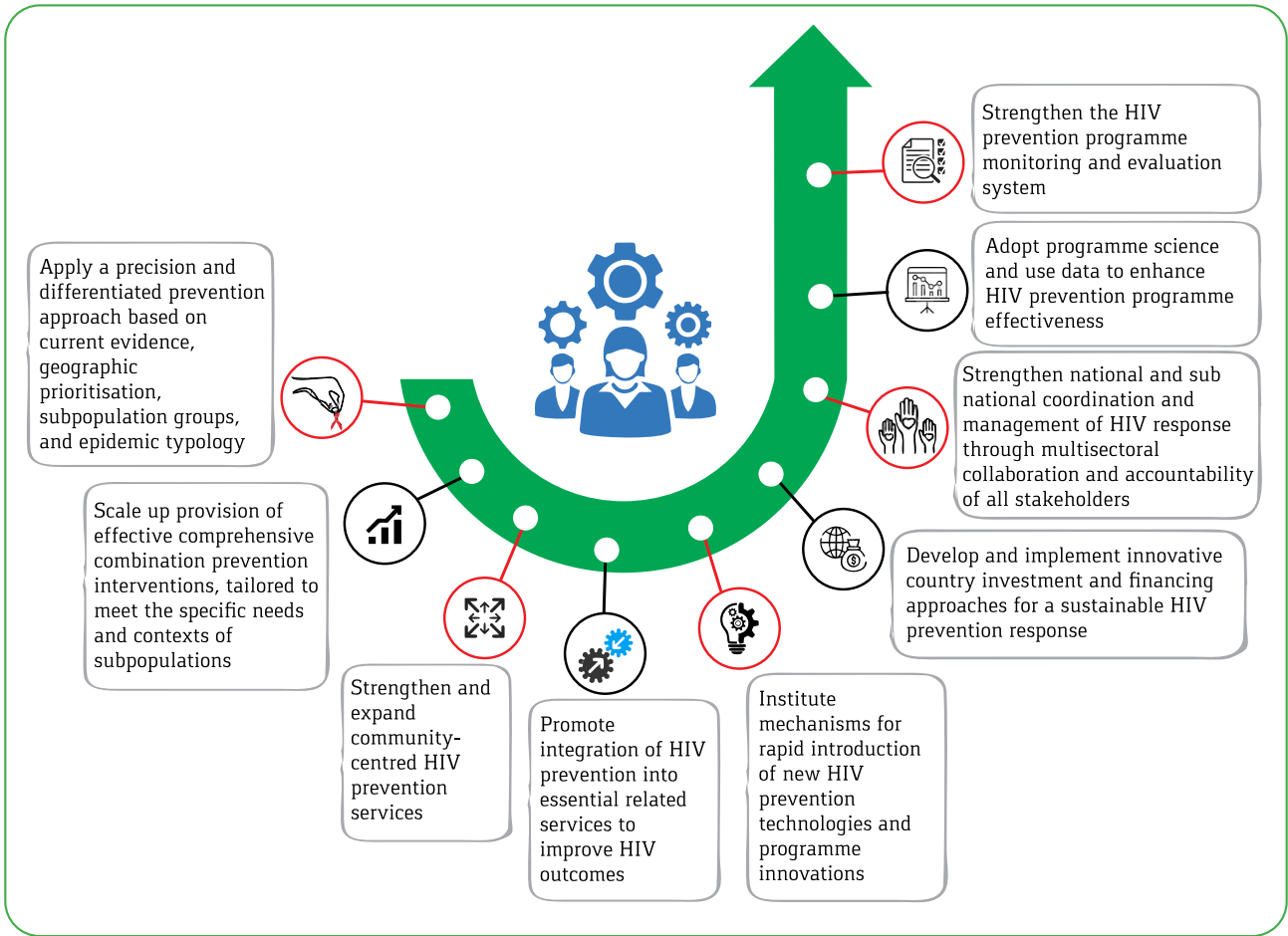
technologies and innovations. The collection and use of data to define priorities and monitor the response is enhanced. The importance of involving infected and affected communities at all stages of prevention programming is highlighted. The plan features a Programme Science approach, which embeds research in programme implementation to facilitate improved programme development and delivery. This plan proposes several ways to mobilise domestic funding to offset dwindling external financing and prioritises integration of HIV prevention services at several levels. Lessons from pandemics such as COVID 19 and the need to protect gains made in the HIV response and ensure service continuity have been addressed.

## Objectives

1. To implement a precision HIV prevention plan focusing on key and priority populations and geographical locations to optimise reduction of new HIV infections
2. To accelerate implementation of well-coordinated, community-centric combination HIV prevention interventions
3. To conduct data-driven assessments and rigorous progress tracking of the country HIV prevention programme
4. To invest in sustaining a multi-sectoral approach to HIV prevention at the national and sub-national level
5. To reinforce and strengthen leadership and accountability at all levels for HIV prevention

<sup>1</sup><https://hivpreventioncoalition.unaids.org/wp-content/uploads/2022/02/Kenya-1.pdf>

# Strategic directions



# Expected results

|   |   |   |
|---|---|---|
|   | <p>HIV incidence among adults reduced to <b>below 1000</b></p>  | <p>HIV incidence among children reduced to <b>below 200</b></p>                               |
| <p>Key populations' contribution to new HIV infections reduced to <b>below 5%</b></p> | <p>Percentage of people living with HIV who report experiencing HIV related and other stigma and discrimination reduced to <b>below 10%</b></p> | <p>Proportion of the HIV budget allocated to HIV prevention increased to <b>above 25%</b></p> |

# 01

## Situation Analysis



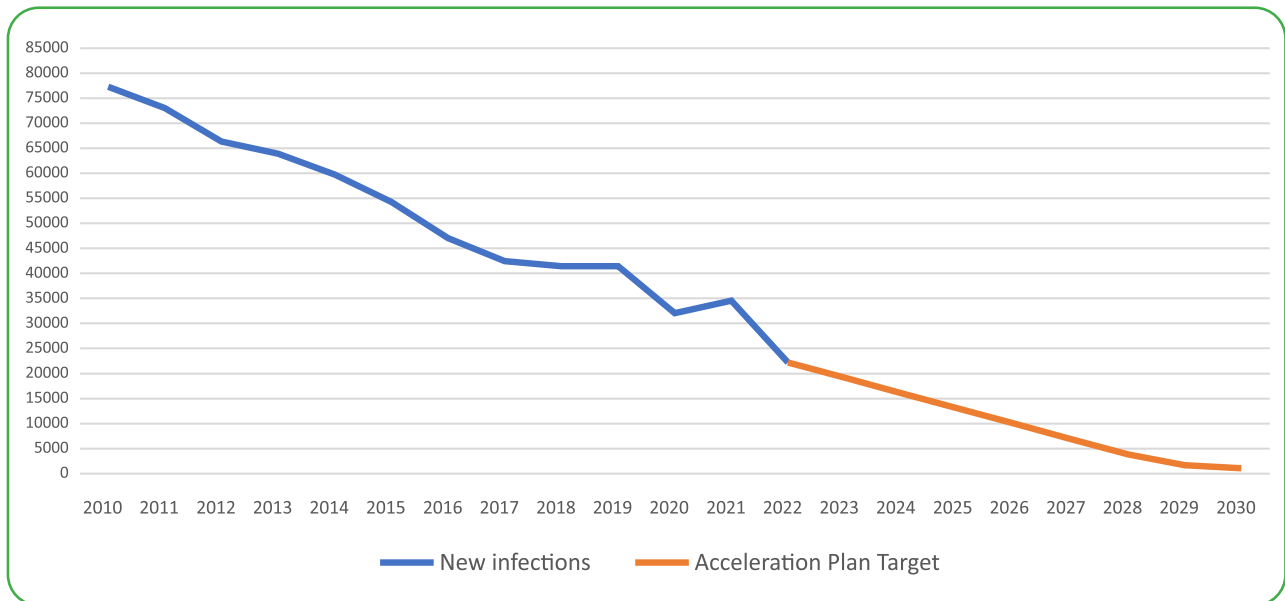
## 1.1 HIV in Kenya

Kenya has made progress in the HIV response, as evidenced by the decline in HIV prevalence among adults (15-49 years) in the general population, from a peak of about 8.7% in 2000 to 3.7% in 2022.<sup>1</sup>

New HIV infections in Kenya declined from 101,448 in 2013 to 22,154 in 2022, a 78% reduction in cases. Mother to child HIV transmission declined from 13.9% in 2013 to 8.6% in 2022.

This rapid decline in HIV new infection has encouraged Kenya to set bold targets to reduce new HIV infections. The KASF II commits to reducing new HIV infections in Kenya to 8,000 annual new infections by 2025, and this plan has set targets of fewer than 1,000 adult annual new infections and fewer than 200 child annual new infections by 2030 (figure 1).

**FIGURE 1: Actual/projected new HIV infections against 2025 and 2030 targets from KASF II and the HIV Prevention Acceleration Plan, respectively**

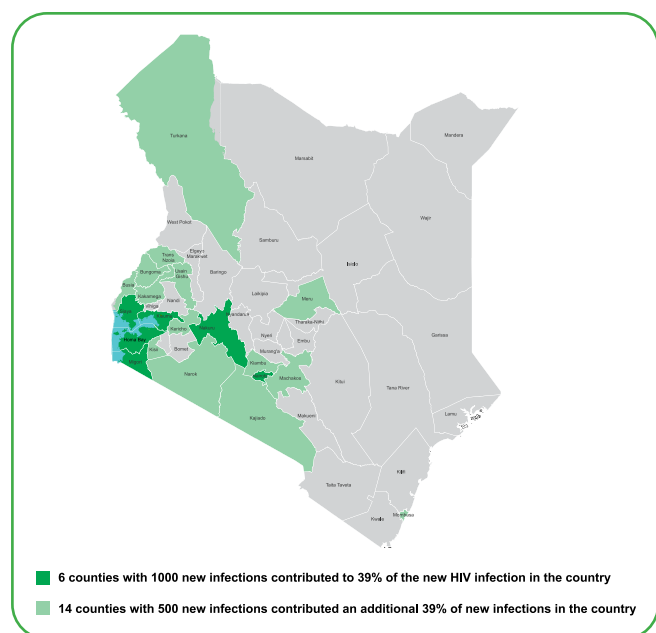


## 1.2 Diversity in the epidemic across counties and subpopulations

### 1.2.1 A large proportion of new infections are contributed by few counties.

Twenty counties with more than 500 new infections accounted for 78% of new infections in Kenya in 2022 (figure 2). Six counties-Nairobi, Kisumu, Homa Bay, Siaya, Migori, and Nakuru, each with more than 1000 new infections-contributed 39% of all new infections. The remaining fourteen counties-Usain Gishu, Kisii, Mombasa, Kakamega, Kajiado, Busia, Machakos, Bungoma, Meru, Kiambu, Narok, Trans-Nzoia, Kericho, Turkana each with more than 500 new infections-contributed an additional 39% of all new infections in the country.

**FIGURE 2: Counties with high new HIV infections**



<sup>1</sup>National Syndemic Diseases Control Council (NDSCC). Kenya HIV estimates report, 2023. Nairobi, Kenya

**1.2.2 Sizeable variability in HIV prevalence, incidence, and incidence:prevalence ratio (IPR) across counties and sub counties**

At the sub county level there are clusters of sub counties with high prevalence, incidence, and IPR, and these need to be prioritised for HIV prevention interventions (figure 3).

The IPR is the number of new infections occurring per year in a population divided by the number of persons living with HIV in that same population.<sup>2</sup> A global benchmark value of approximately 0.03 is considered the threshold indicator of HIV prevention and treatment programme performance, with values below 0.03 indicating optimal trajectories.<sup>3</sup>

**FIGURE 3: Sub counties with high HIV prevalence, incidence, and IPR**



<sup>2</sup> Ghys PD, Williams BG, Over M, et al. 2018. Epidemiological metrics, and benchmarks for a transition in the HIV epidemic. *PLoS Med.* 15: e1002678. doi.org/10.1371/journal.pmed.1002678

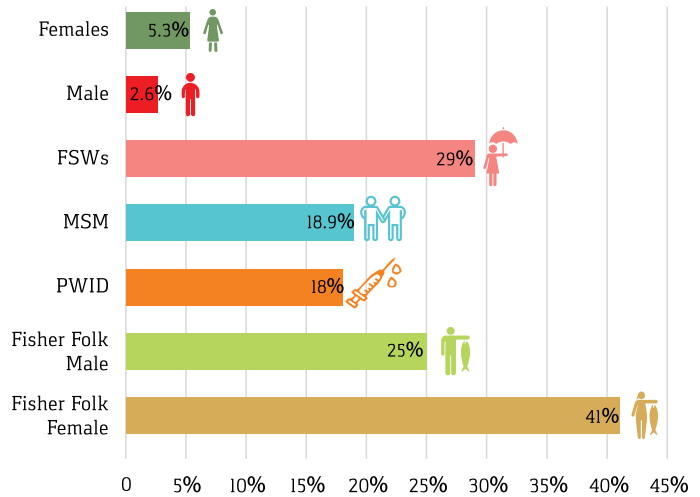
<sup>3</sup> An epidemic transition benchmark of 0.03—three HIV infections per 100 people living with HIV per year—corresponds to an average life expectancy after infection of 30 years. At this average life expectancy, the total population of people living with HIV will gradually fall if the country is below the 0.03 benchmark. The 3.0% benchmark thus combines two desirable conditions: long, healthy lives among people living with HIV and reductions in new infections. Joint United Nations Programme on HIV/AIDS (UNAIDS). 2020. *UNAIDS Data 2020*. Geneva: UNAIDS. [https://www.unaids.org/sites/default/files/media\\_asset/2020\\_aids-data-book\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf)

### 1.2.3 Heterogeneity in HIV prevalence among subpopulations

HIV prevalence in Kenya is higher among females, at 5.3%, compared to men, at 2.6%.<sup>4</sup> HIV prevalence is 29% among female sex workers (FSWs), 18.9% among men who have sex with men (MSM), and 18% among people who inject drugs (PWID).<sup>5</sup> HIV prevalence among these key populations is 5-6 times higher than among the general population. In an HIV prevalence study conducted among fisher folk in the Nyanza region, HIV prevalence was 31%; higher among females (41%) than among males (25%).<sup>6</sup>

HIV prevalence also varies by age. For both sexes combined, HIV prevalence peaks among adults aged 40-54 years. Prevalence among women peaks at 11.9% at ages 40-44 years and 11.7% in the 50-54 years age group.<sup>7</sup> Prevalence for men peaks

at 8.3% at ages 45-49 years. While the gender difference is not very stark from age 0-14 years, girls' and women's HIV prevalence increases multiple fold after age 19. HIV prevalence among women aged 20-34 years is more than two times higher than among men of the same age group.



<sup>4</sup> National Syndemic Diseases Control Council (NSDCC). Kenya HIV estimates report, 2022. Nairobi: NSDCC.

<sup>5</sup> National AIDS and STI Control Programme (NASCO). 2014. 2010-2011 Integrated biological and behavioural surveillance survey among key populations in Nairobi and Kisumu, Kenya. Nairobi: NASCO, Ministry of Health, Kenya.

<sup>6</sup> CDC, UMB, KEMRI, NASCO. 2019. Integrated bio-behavioural survey of fisher folk communities along the Lakeshore of Lake Victoria, Kenya, draft report.

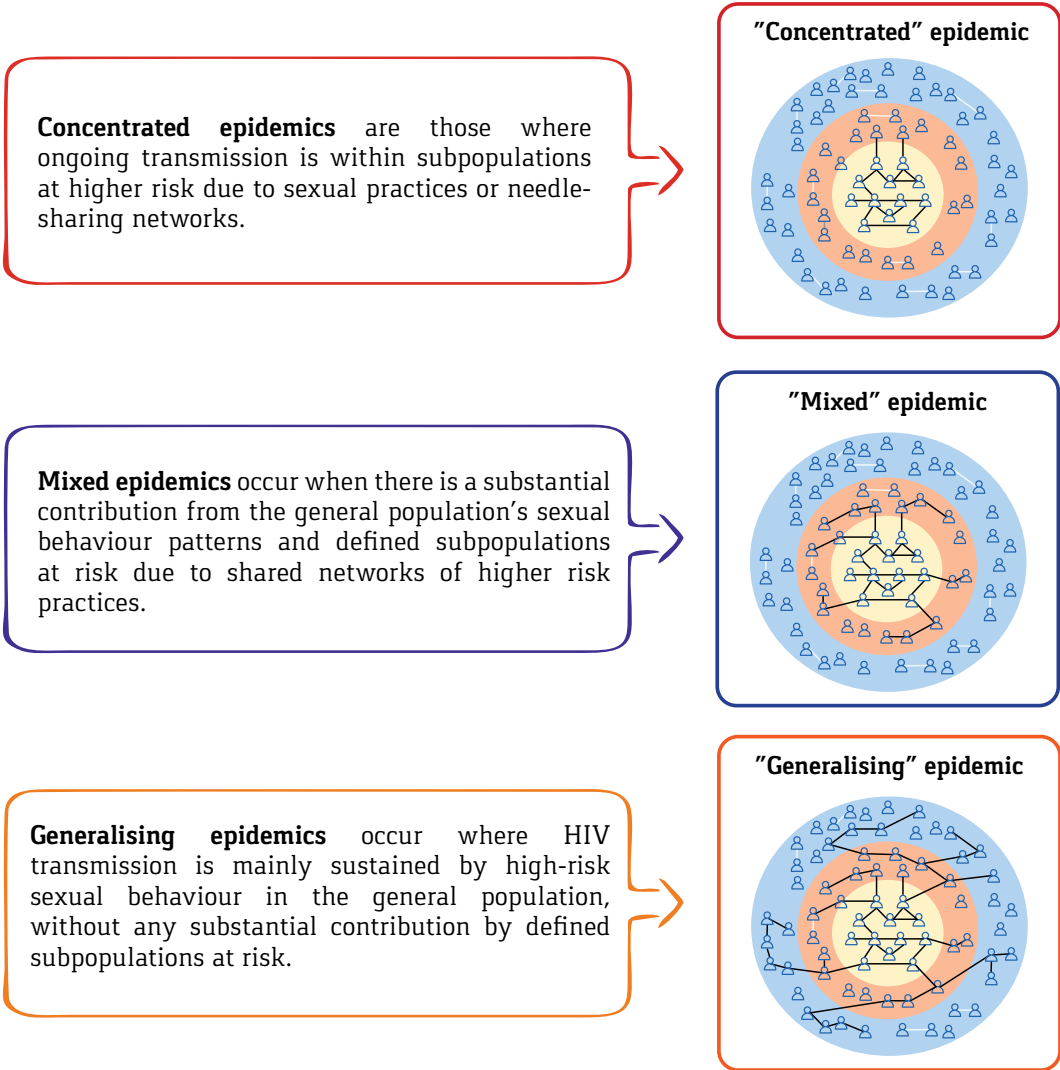
<sup>7</sup> National AIDS and STI Control Programme (NASCO). 2022. Kenya Population-based HIV Impact Assessment (KENPHIA) 2018: Final Report. Nairobi: NASCO. [https://phia.icap.columbia.edu/wp-content/uploads/2022/08/KENPHIA\\_Ago25-DIGITAL.pdf](https://phia.icap.columbia.edu/wp-content/uploads/2022/08/KENPHIA_Ago25-DIGITAL.pdf)



### 1.3 Epidemic typology in Kenya

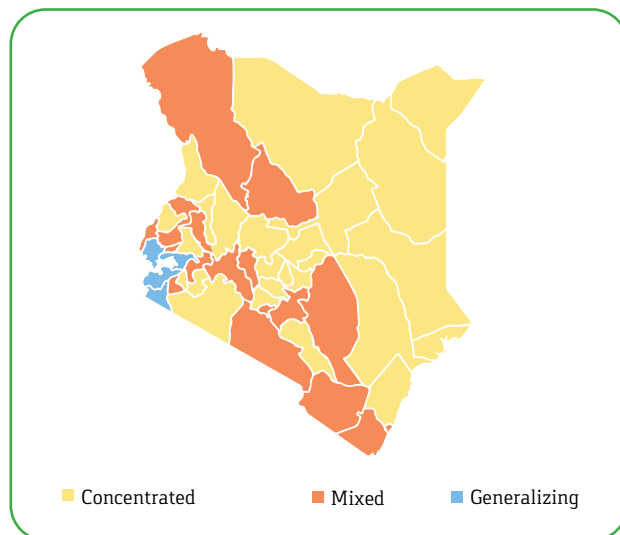
As per KASF II, the epidemic typologies in Kenya are defined as **Concentrated, Generalising, and Mixed**. The

classification reflects the specific behaviours that are required for HIV to become established in a population (i.e., behaviours that must be present for each infection to lead, on average, to more than one new infection).



**FIGURE 4: Epidemic typology in the counties**

The epidemic appraisal categorised the counties into these three epidemic types to support effective HIV prevention programming (figure 4).



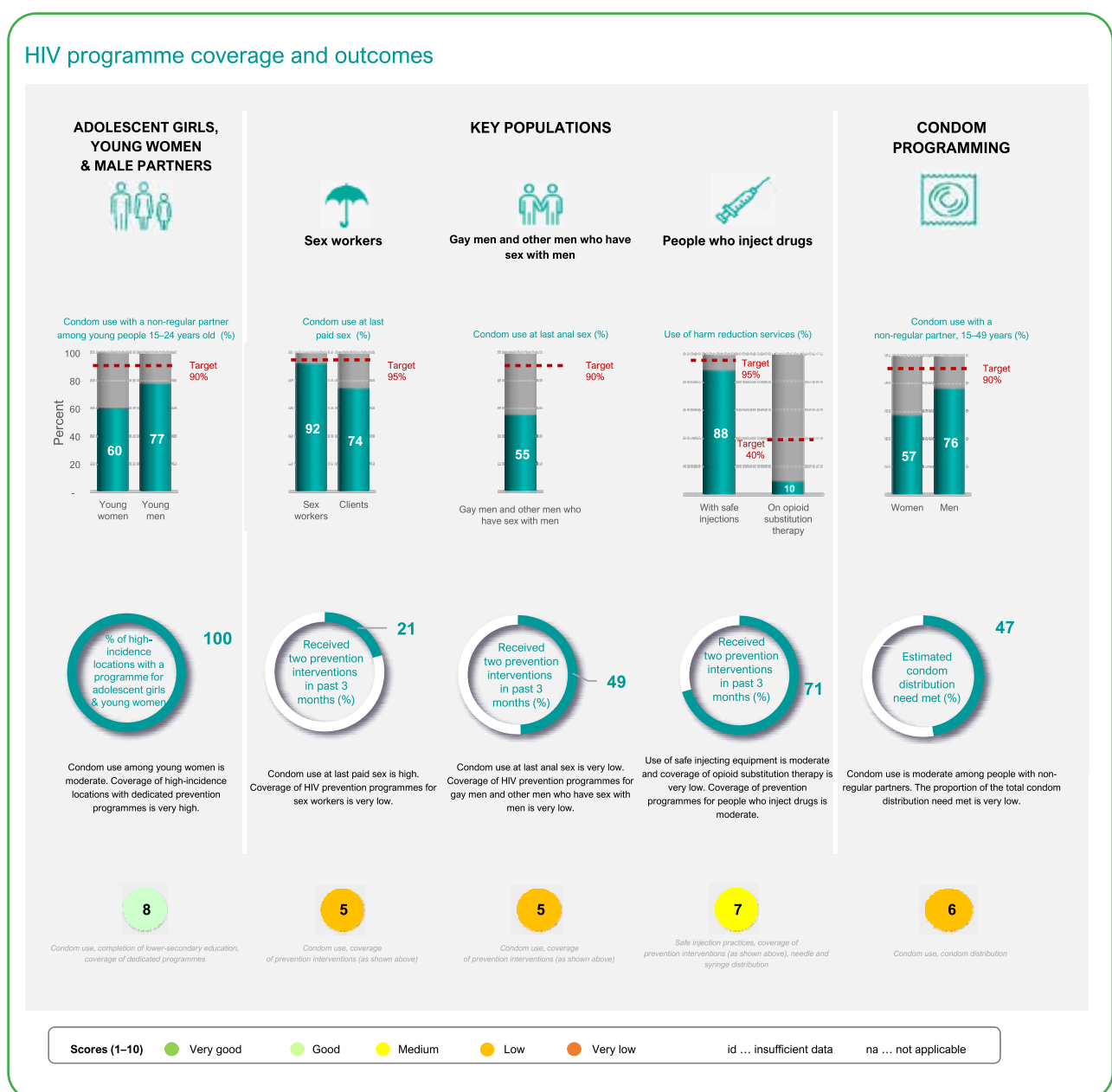
## 1.4 Progress toward global targets for programme coverage and outcomes

Kenya partially met the global HIV prevention targets for 2020. The Global HIV Prevention Coalition score cards (figure 5), which illustrate Kenya's progress toward global targets, indicate that Kenya's national programme did very well at providing antiretroviral therapy, promoting voluntary medical male circumcision, and eliminating mother to child transmission of HIV, and almost as well with prevention programme coverage

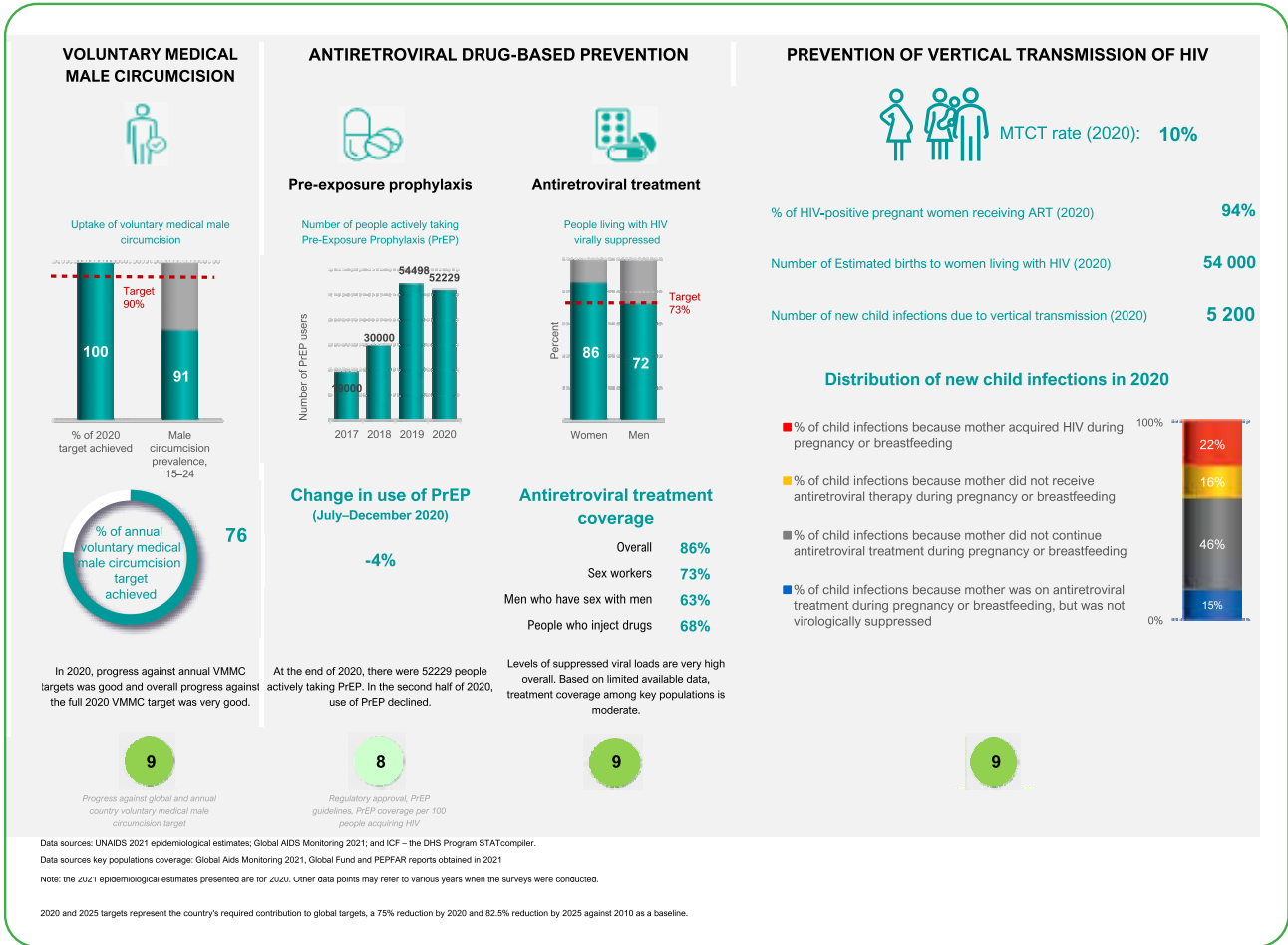
for adolescent girls and young women and their male partners, with 100% of counties with high HIV incidence having dedicated prevention programmes for adolescent girls and young women.<sup>8</sup> Kenya has also fielded one of the most successful pre-exposure prophylaxis (PrEP) programmes in Africa.

Service packages for sex workers and people who inject drugs include all recommended elements. However, the Key Populations Programme and the condom programming need strengthening. Policies and laws still criminalise sex work, homosexuality, and drug use.

**FIGURE 5: HIV prevention programme coverage and outcomes, Kenya, 2021**

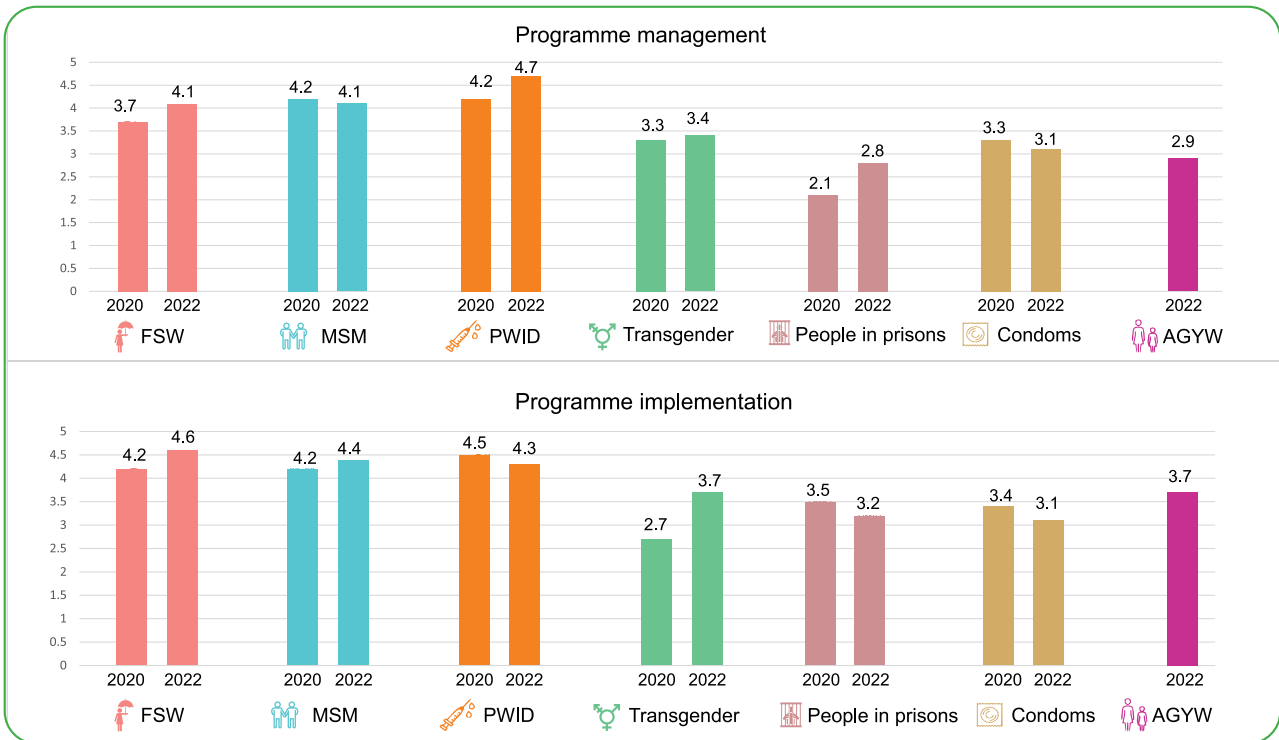


<sup>8</sup> <https://hivpreventioncoalition.unaids.org/wp-content/uploads/2022/02/Kenya-1.pdf>



The programme self-assessment conducted by Kenya using UNAIDS' HIV Prevention Self-Assessment Tools (PSAT) indicated areas that need attention (Figure 6).<sup>9</sup>

**FIGURE 6: Kenya HIV Prevention Self-Assessment Tools scores<sup>10</sup> (on a 5-point scale)**



<sup>9</sup> South to South Learning Network (SSLN), PSAT summary report, Kenya, 2022/23

<sup>10</sup> NSDCC (2022). Kenya National AIDS Spending Assessment FY 2016/17 -2019/20. Nairobi, Kenya: National Syndemic Diseases Control Council.

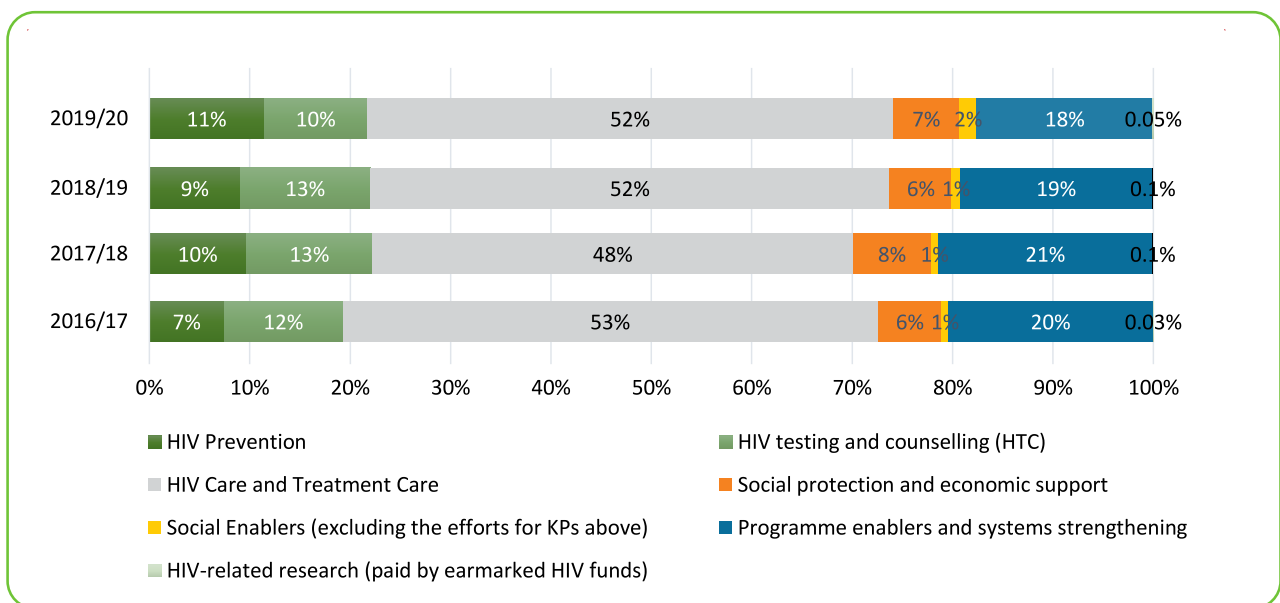
## 1.5 Expenditure on prevention

Kenya's expenditure on HIV prevention has increased minimally over the years. An analysis of the AIDS Spending Categories (ASC), according to the Kenya National AIDS Spending Assessment (KNASA) report 2022, showed that the bulk of the expenditure went to care and treatment, averaging about 51% over the period. Programme support activities, referred to as programme enablers and systems strengthening, came a distant second in terms of expenditure, accounting for an average of 20% over the four years, followed by HIV testing and counselling (HTC) (12%), **prevention**

(9%), social protection and economic support (7%) and research (0.1%) (figure 7).

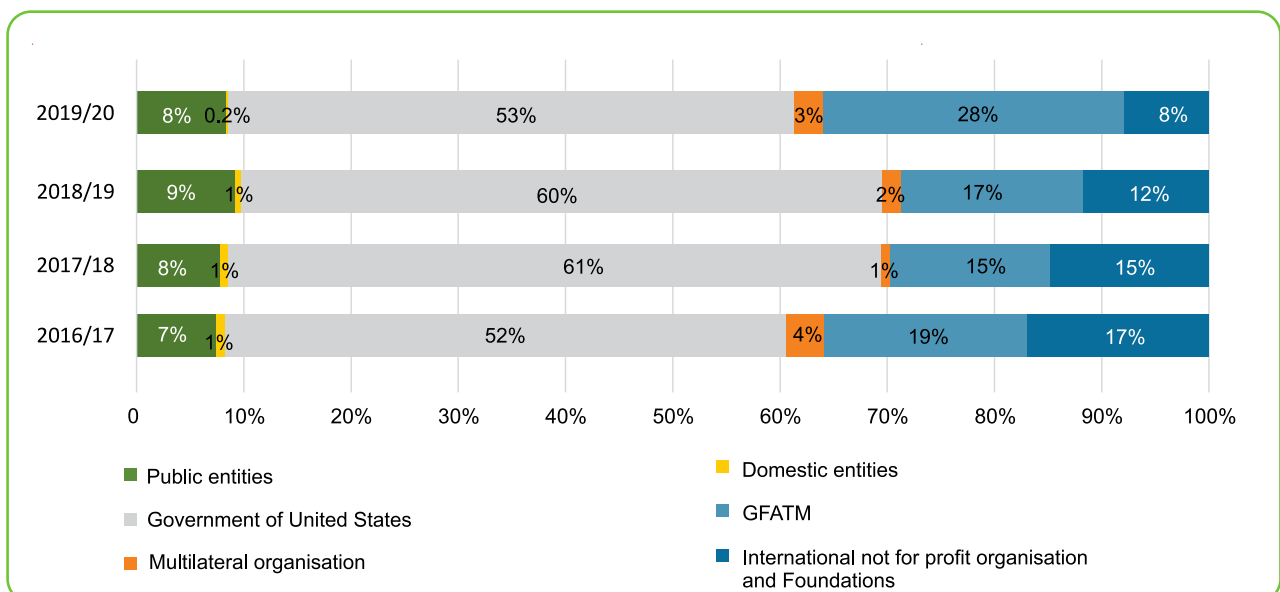
As in the case of treatment, prevention activities relied heavily on external funding. The distribution of expenditure on prevention by financing entity is presented in Figure 8. The United States Government provided 57% of the funding during the period. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) contributed 20% of the total in the four years, with international NGOs and foundations accounting for an average of about 13%, and the Kenyan Government provided 8% of total expenditure.

**FIGURE 7: HIV expenditure by broad spending category (%)**



(Source: KNASA 2022)

**FIGURE 8: HIV expenditure on prevention by financing entity**



(Source: KNASA 2022)

# 02

## The HIV Prevention Acceleration Plan

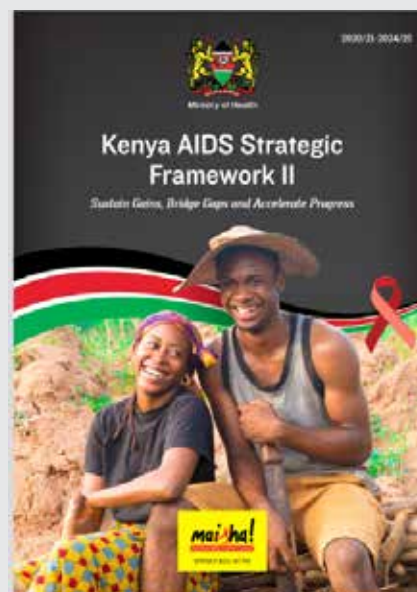
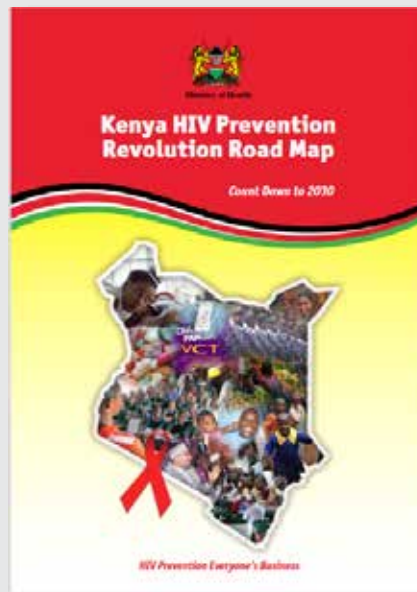


The HIV prevention acceleration plan is anchored in the Kenya HIV Prevention Revolution Road Map: Count Down to 2030, an avant-garde document that proposed high-impact, evidence-based interventions targeted towards counties and populations, based on their needs. It also emphasised the need for efficient delivery of combination prevention packages; synergistic integration of biomedical, behavioural, and structural interventions; and sustainable investment in HIV prevention research to sharply reduce the annual number of new HIV infections.

The road map guided the development of Kenya AIDS Strategic Framework 2014/15-2018/19 (KASF), which prioritised HIV prevention as one of its key strategic directions. The Kenya AIDS Strategic Framework II 2020/21-2024/25 (KASF II) further emphasised HIV prevention to sustain gains, bridge gaps, and accelerate progress towards reducing new HIV infections in the country. These three policy documents are important tools for aligning country- and county-level planning, investment, and implementation of high-impact HIV prevention interventions.

This HIV Prevention Acceleration Plan 2023-2030 builds on the gains made during implementation of Kenya HIV Prevention Revolution Road Map, the KASF, and the KASF II. Evidence gathered during this period and assessments with priority communities have guided the proposed strategies in this plan.

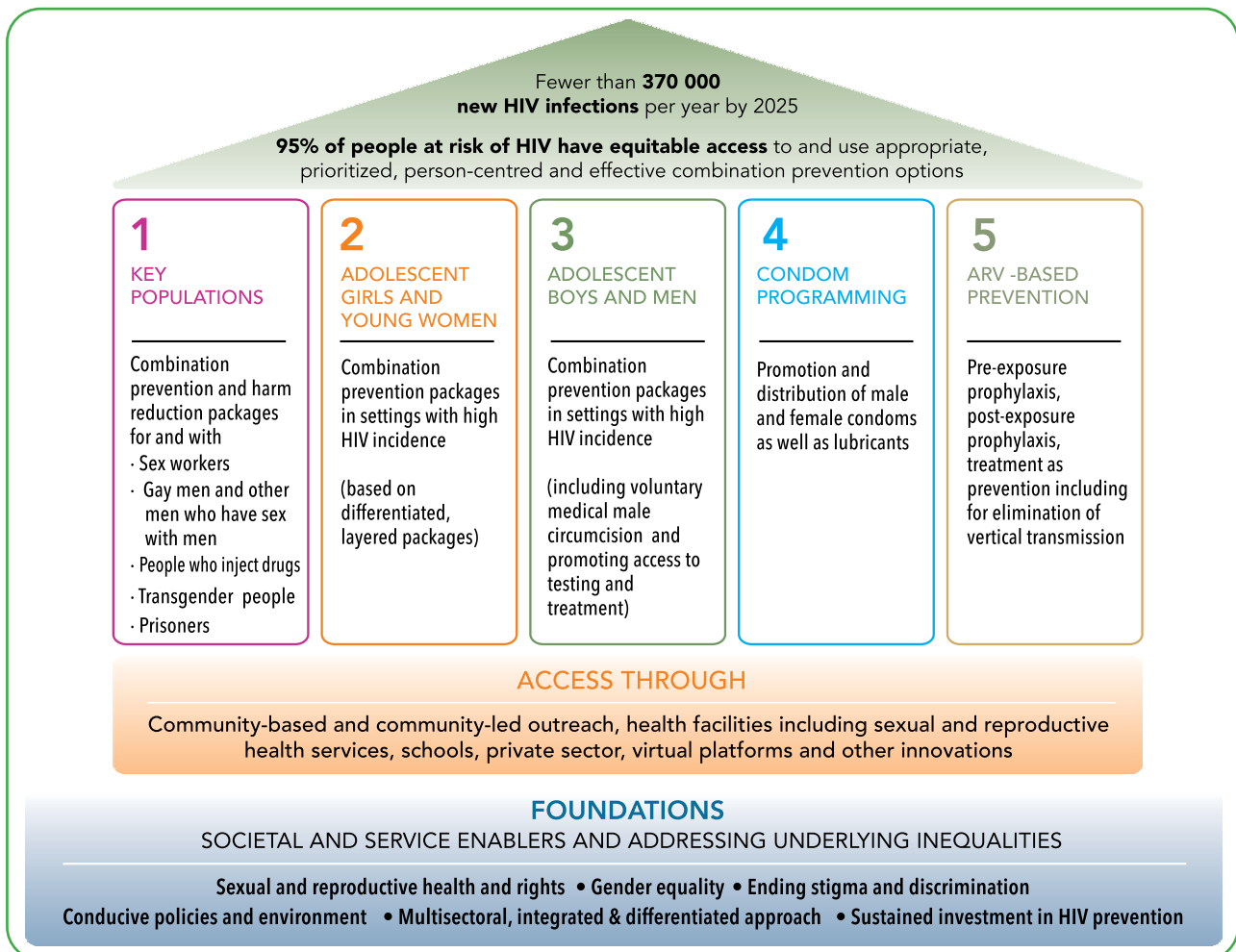
In addition, the HIV Prevention 2025 Road Map developed by the Global HIV Prevention Coalition (GPC) aims to accelerate progress on HIV prevention in 28 focus countries. Kenya is a member of the GPC and is committed to intensifying HIV prevention efforts to end the AIDS epidemic by 2030. The GPC's road map charts a way forward for country-level actions to achieve an ambitious set of targets.



The GPC recommends focussing on five prevention pillars (figure 9). Pillars 1-3 describe people-centred combination prevention packages for key populations everywhere and for adolescent and young adults in

geographical areas with high HIV incidence, Pillar 4 focuses on condoms, and Pillar 5 on antiretroviral-based prevention, emphasising complementarity between HIV prevention and treatment.

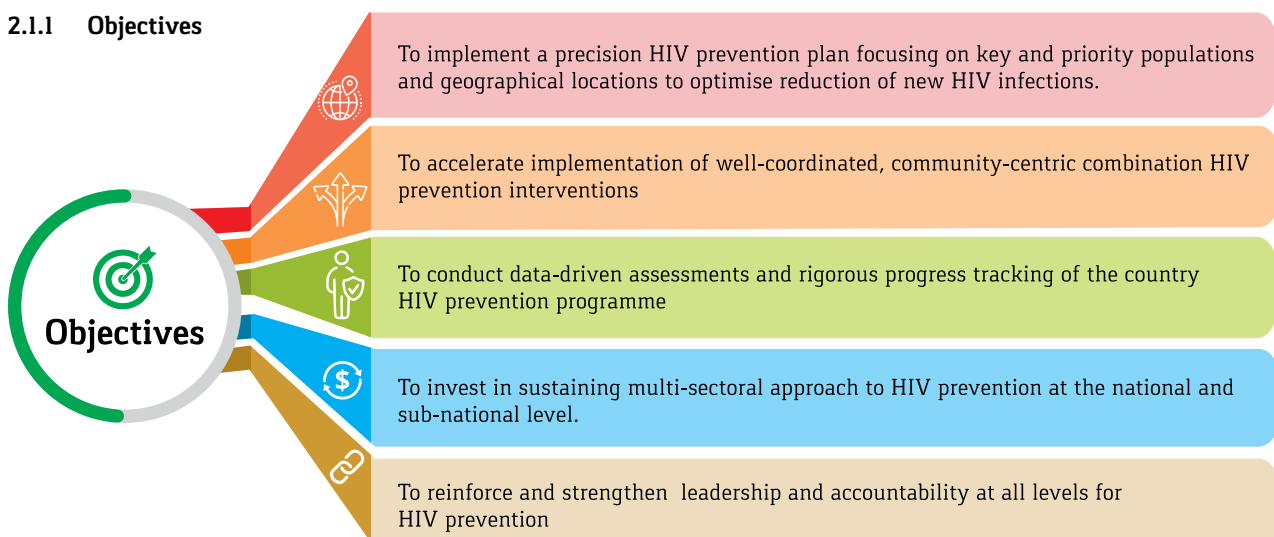
**FIGURE 9: The five HIV prevention pillars (Source: The GPC’s HIV Prevention 2025 Road Map)**



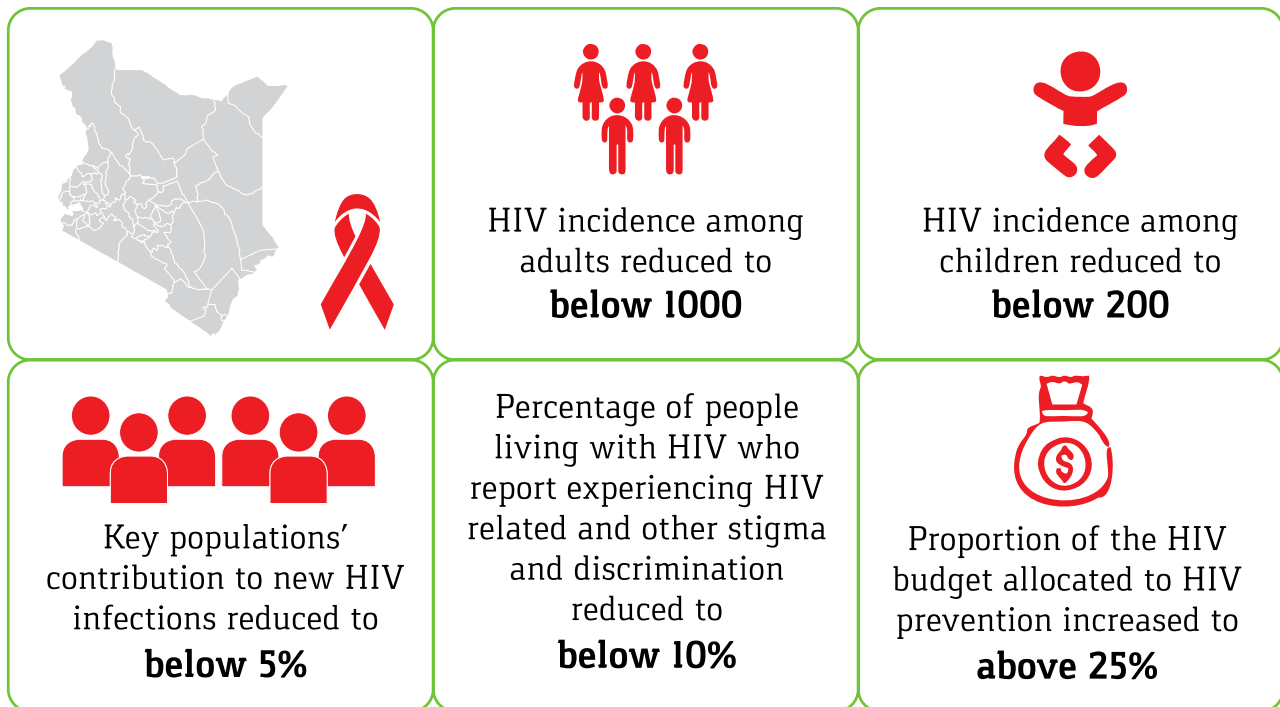
This HIV Prevention Acceleration Plan 2023-2030 is built around these five HIV prevention pillars, adapted to the local context and reality.

## 2.1 Objectives and expected results

### 2.1.1 Objectives



## 2.1.2 Expected results



## 2.2 Principles

This acceleration plan is guided by the following key principles:

- **Respect for and promotion of human rights**, as well as principles of social justice, equality, and equity in access to HIV and AIDS services in line with the provisions embedded in the Constitution of Kenya (2010)
- **Universal Health Coverage** and access to quality and integrated HIV prevention, treatment, care, and support services, embracing the principle of 'leave no-one behind'
- **Inclusion and participation** of all stakeholders at national and county levels, including community representatives of networks of people living with HIV; adolescent girls and young women; key populations, including sex workers, men who have sex with men, people who inject and use drugs, and transgender people; vulnerable populations; representation from the public and private sectors; faiths sector; implementing partners, bilateral and multilateral partners
- **People-centred** service delivery, placing people at the centre of the decision-making, planning, and implementation processes to achieve desired outcomes

- **Evidence-informed** planning, prioritisation, and investments through use of evidence and strategic information for decision making
- **Multisectoral** partnership and accountability, for collective responsibility, coordination, and shared accountability for results





## 2.3 Lessons and recommendations from implementation of the HIV Prevention Revolution Road Map from 2014 to 2023

The development of this plan was informed by lessons learnt and recommendations gathered from implementation of the Kenya HIV Prevention Revolution Road Map from 2014 to 2023 (table 1) implementing partners, bilateral and multilateral partners. This includes assessment conducted by the national programme in 2020 involving national and county stakeholders and the mid-term review of Kenya AIDS Strategic Framework II conducted in 2023.

**TABLE 1: Lessons and recommendations from implementation of the Kenya HIV Prevention Revolution Road Map from 2014 to 2023**

|  <b>LESSONS</b>  |  <b>PROPOSED RECOMMENDATIONS</b>   |
|---|---|
| <p>The counties' role in designing and implementing HIV prevention programmes is critical, but county-level capacity to design, implement, and monitor effective prevention programmes at scale is suboptimal.</p>  | <p>Capacities related to evidence-based programme scale up, data system management, programme monitoring, social contracting, service integration, designing and implementing structural interventions, resource mobilisation, and programme oversight need to be strengthened at the sub-national level.</p>   |
| <p>The interventions are "blanket and standard", not reflecting the diversity in epidemic typology. Programme impact is curtailed where HIV prevention interventions are not customised, calibrated, and combined according to local HIV epidemic typologies, modes of transmission, populations most in need of services, and programme coverage gaps.</p> | <p>HIV prevention interventions should be configured to match the type of epidemic in each county. The development and implementation of the county implementation plans should be guided by the county's epidemic typology and programme coverage data. This will also ensure precision programming for greater impact on HIV. There is also a need to define and target the populations which have the highest risk and vulnerability and hence the greatest need for HIV prevention. Expand and fast track scale up of HIV prevention programmes to all priority subpopulations in identified geographies.</p>   |
| <p>Conceptualising and implementing the prevention continuum for specific populations at risk involves analysing the size and location of such populations, mitigating impediments to their engagement in prevention, generating demand for such services, tailoring the HIV prevention packages, and training the appropriate workforce.</p>               | <p>Data gaps, especially those related to priority populations, need to be addressed. There is a need to collect more updated behavioural and risk data among specific subpopulations, and to disaggregate data by age and sex. Data need to be better used for decision making, and for improving programme accountability.</p>  |
| <p>Individuals should be monitored across the HIV prevention continuum. However, the current frameworks and systems monitor prevention in a piecemeal manner.</p>   | <p>Existing monitoring frameworks and tools should be revised to measure each step of the prevention continuum and, most importantly, the quality and effectiveness of the overall continuum. Use of the cascade analysis framework and the effective programme coverage framework need to be encouraged.</p>   |
| <p>A complex array of determinants of health at the individual and broader structural levels complicates HIV prevention. Social determinants of health, such as poverty, social exclusion, inadequate housing, food insecurity, and gender inequality, affect a person's likelihood of acquiring HIV or accessing HIV prevention services.</p>              | <p>HIV prevention programmes should adopt a multi-level and multisectoral, collaborative approach to people-centred care to address social determinants of health. A combination prevention intervention approach, with equal focus on structural, behavioural, and biomedical interventions, is needed. Community centric programming with focus on the choice agenda needs to be promoted so that people have an array of options to choose from based on their needs and preferences. There is also a need to standardise the prevention package for each priority population to ensure that these populations get a minimum package, irrespective of the donor or implementing partner.</p> |



## LESSONS



## PROPOSED RECOMMENDATIONS

Intra- and inter-sectoral action for HIV prevention is needed for effective response. Intra- and inter-sectoral collaborations require dynamic interactive processes, involving information exchange, policy development, and programme planning. These collaborations allow service providers to share their expertise and resources to identify and address health issues, keeping the person in the centre and addressing needs holistically.

Collaboration is needed: a) between the programmes within the HIV prevention rubric, b) with other programmes in the health sector, c) with sectors other than health, and d) between facility and community. The HIV prevention response must be integrated into Universal Health Coverage programming.

Lack of coordination and collaboration can lead to duplication of effort, increasing health care costs. Coordinated efforts make HIV prevention programming more effective, efficient, and sustainable.

Creating coordination and management structures at national and county levels and ensuring that these structures are supported to function optimally is critical.

Essential HIV prevention interventions using a combination prevention approach are costed at 897.92 million (USD) for five years. The resources allocated to HIV prevention in Kenya generally have been less than the global recommendation of 25% of the total HIV budget.

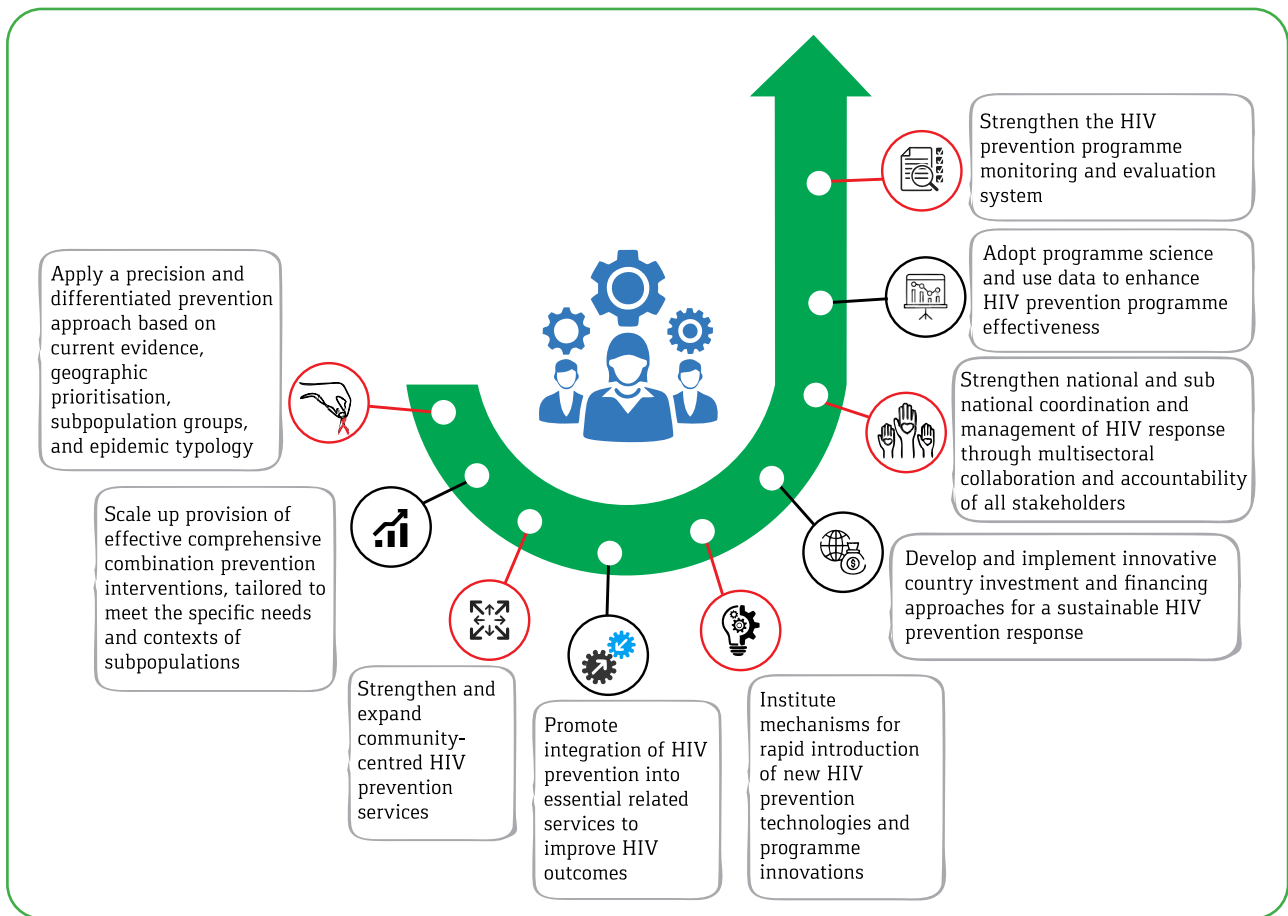
Funding for HIV prevention should match the global recommendation. Kenya needs to develop new approaches to close the funding gap, including generating domestic resources. The development of evidence-based county implementation plans and corresponding budget allocations from county budgets is critical. Development of frameworks and systems for real time data capture on investments and expenditure should be prioritised. Strengthen county capacity to enhance CIDPs to ring fence resources for HIV in county budgets.

Involving priority populations in designing, implementing, and monitoring populations-based HIV prevention programmes is critical.

Organisations and networks led by priority populations, affected, and infected populations must be involved in designing the HIV prevention response at national, county, and implementation level. Investment in community-led responses for HIV prevention should be increased. Partnerships between communities and health systems should be strengthened to enhance coverage and effectiveness of HIV prevention service delivery. Representation of priority population and priority population led organisation should be promoted in implementation of HIV prevention programmes.

## 2.4 Strategic directions

Based on the lessons learnt and the objectives of this HIV Prevention Acceleration Plan, the following strategies will be adopted:

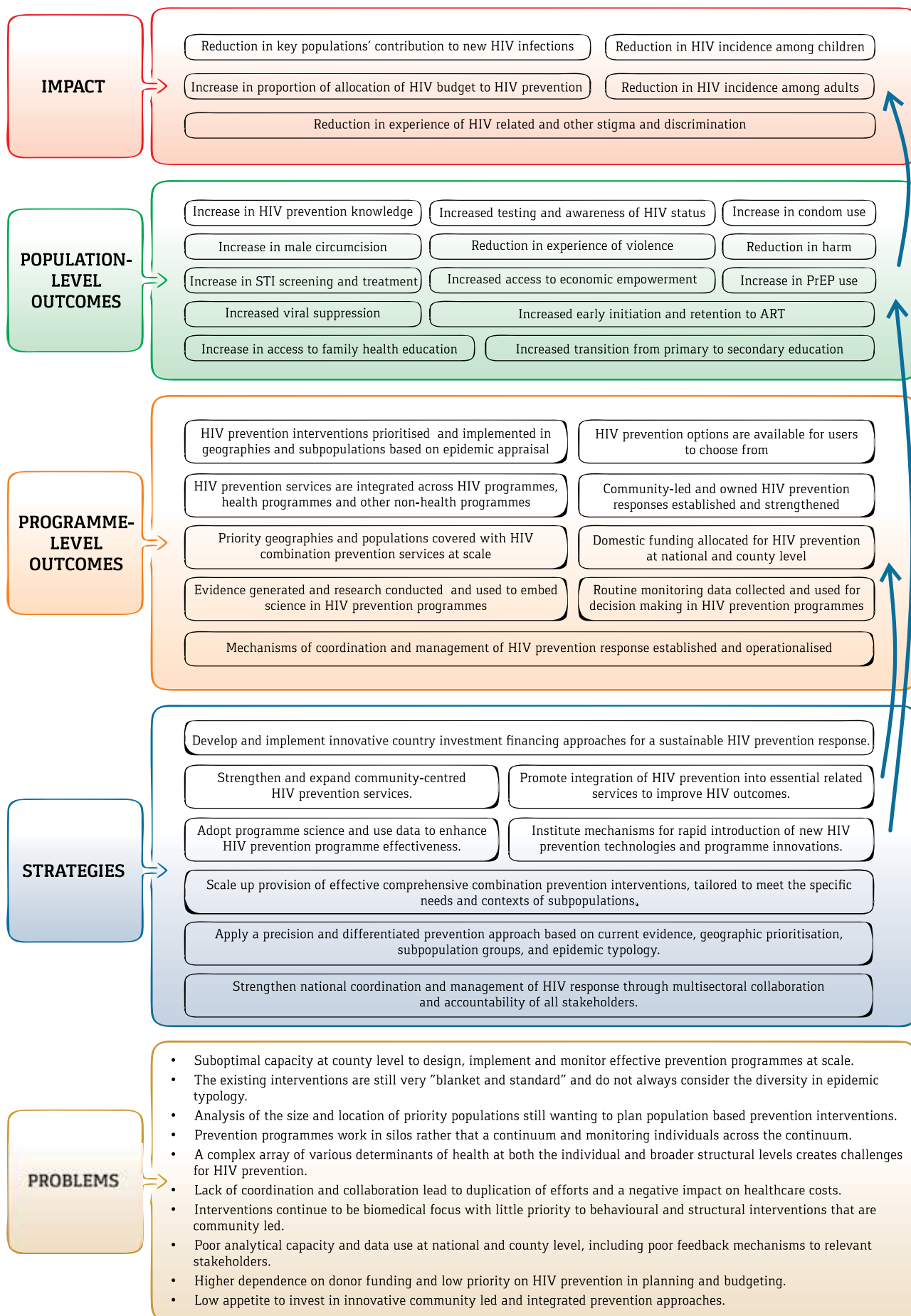


## 2.5 Theory of change

The Plan's Theory of Change (figure 10) responds to the problem that, despite prioritising HIV prevention, Kenya has not achieved the global target of a 75% reduction in new HIV infections.

We believe that accelerating Kenya's HIV response by the aforementioned strategies will lead to programme-level outcomes and population-level outcomes that will result in a reduction in new HIV infections, a reduction in HIV-related stigma and discrimination, a reduction in the proportion of HIV infections that occur among key populations, and a larger allocation of the HIV budget to prevention.

**FIGURE 10: Theory of change**

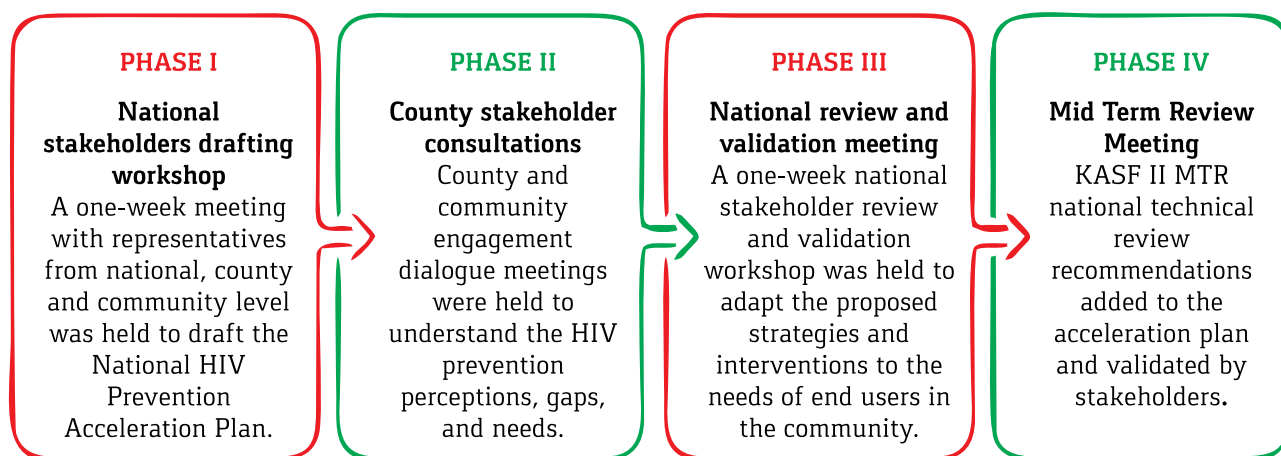


## 2.6 The process of developing the plan

The country adopted a participatory approach for developing the national HIV prevention acceleration plan. The three-phase process of drafting the plan started with an HIV prevention summit in 2021, which was a review meeting with national- and county-level stakeholders (figure 11). A drafting team was constituted to consolidate all recommendations from this summit during a four-day workshop in June 2022. This was followed by county and community dialogues and

consultative meetings to understand the perceptions and needs on HIV prevention during October to December 2022. The findings informed a further review meeting with national-level stakeholders in April 2023 to refine the proposed strategies and interventions to the needs of the end users and develop a monitoring framework to monitor implementation of the plan. In addition, the KASF II mid term review conducted in July 2023 provided several recommendations to be prioritised by the plan. This was validated by the stakeholders and included in the acceleration plan.

**FIGURE 11: Phases of the HIV Prevention Acceleration Plan's development**





# 03

## STRATEGY 1:

Apply a Precision and Differentiated Prevention Approach Based on Current Evidence, Geographic Prioritisation, Subpopulation Groups, and Epidemic Typology

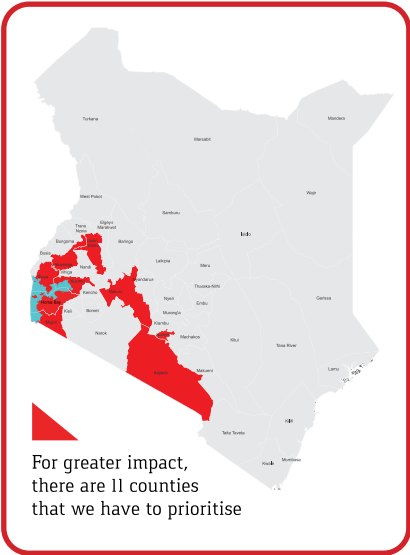


This plan recommends a progressive coverage approach, which prioritises interventions first in counties and sub-counties where the HIV prevention impact will be greatest. Granular analysis of the epidemic will be done at the sub-national and sub county levels to understand

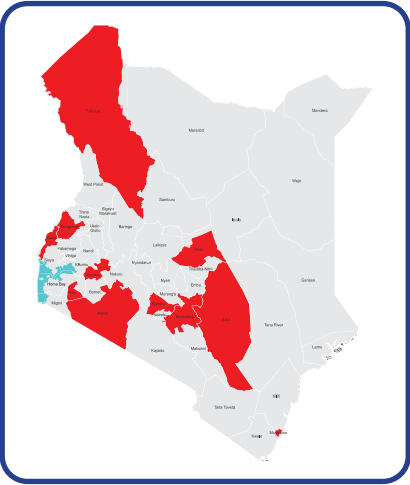
the epidemic typology, and targeting and decision making on prioritisation of the populations will be based on the typology. Among those populations, prioritisation of the interventions will be done based on their risks and vulnerabilities.

### 3.1 Prioritisation of the counties by potential for impact on HIV incidence

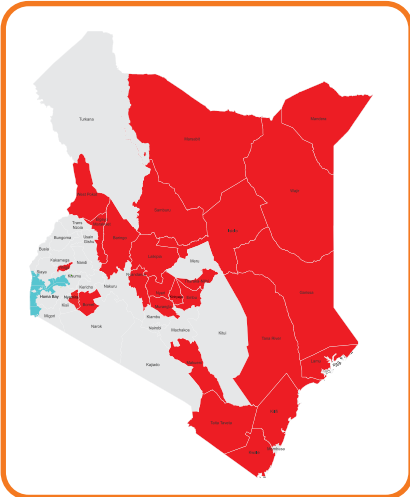
Counties where reduction in IPR will have high impact on the national HIV incidence need to be prioritised for scaling up and intensifying HIV prevention interventions. These 9 counties are Nairobi, Kisumu, Homa Bay, Siaya, Migori, Nakuru, Kakamega, Usain Gishu and Kajiado. These are the counties where reduction in IPR by 20% will have highest impact with reduction of more than 800 new HIV infections.



Counties where reduction in IPR will have moderate impact on the national HIV incidence need to be prioritised for maintaining the HIV prevention interventions and cautiously observing the trends. These 13 counties are Busia, Mombasa, Kisii, Machakos, Bungoma, Meru, Kiambu, Narok, Trans-Nzoia, Kericho, Turkana, Kitui, and Nandi. These are the counties where reduction in IPR by 20% will have moderate impact with reduction of 400-700 new HIV infections.



Counties where reduction in IPR will have lower impact on the national HIV incidence need to be prioritised for initiating HIV prevention interventions based on their epidemic typology and cautiously observing the trends. In the remaining 25 counties reduction in 20% IPR will result in reduction in lower than 400 new HIV infections.





### 3.2 Prioritisation of populations based on vulnerability and risk

The following populations should be given priority by HIV prevention interventions.



**Pregnant and breastfeeding women and children:** Though mother to child transmission has reduced to 8.6% in 2022, pregnant and breastfeeding women and their children continue to be a priority for HIV prevention.



**Adolescent girls and young women:** Adolescent girls and young women (15-24 years) contributed 26% of the new HIV infections in the country in 2022.



**Key populations:** Key populations, including female sex workers, men who have sex with men, people who inject drugs, and transgender people, have higher HIV prevalence compared to the general population and share experiences of stigma and discrimination, criminalisation, and violence, which increase their risk and vulnerability to HIV transmission.



**Vulnerable populations:** Vulnerable populations include a) people in HIV sero discordant sexual partnerships; b) fisher folk; c) truckers and d) people in prison settings. Vulnerable populations have higher HIV prevalence and experience structural barriers to services.




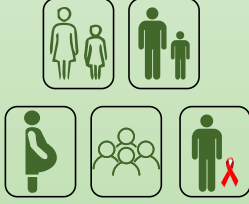

**Adolescent boys and men:** Adolescent boys and young men (15-24 years) contributed 7% of the new HIV infections in the country in 2022. Men (15 years and above) contributed 23% of the new HIV infections in the country in 2022.

### 3.3 Prioritisation of populations based on epidemic typology

Based on epidemic typology of a county and sub county, the HIV prevention programmatic focus will adjust to ensure that interventions are designed with populations based on the characteristic of the epidemic. Table 2 presents prevention programming focus for each epidemic typology.



**TABLE 2: Programmatic focus by epidemic typology**

| <p><b>Epidemic typology</b></p> <p><b>Concentrated epidemics</b></p>   | <p><b>Epidemic typology</b></p> <p><b>Mixed epidemics</b></p>   | <p><b>Epidemic typology</b></p> <p><b>Generalising epidemics</b></p>  |
|--|---|---|
| <p><b>Programmatic focus</b></p> <ul style="list-style-type: none"> <li>Scale up effective and focused HIV prevention programmes to reduce transmission in the high-risk networks.</li> <li>Focus on high coverage of pregnant women for HIV testing and HAART for those who are living with HIV.</li> <li>Scale up and saturate coverage of key populations.</li> <li>Ensure that people living with HIV are virally suppressed.</li> </ul>  | <p><b>Programmatic focus</b></p> <ul style="list-style-type: none"> <li>Focus on high risk networks and other populations at risk in the general population.</li> <li>Scale up and maintain high coverage of pregnant women for HIV testing and HAART for those who are living with HIV.</li> <li>Scale up and saturate coverage of key populations.</li> <li>Ensure that people living with HIV are virally suppressed.</li> <li>Scale up coverage of adolescent girls and young women and young boys and men (specially in traditionally non circumcising counties).</li> </ul>  | <p><b>Programmatic focus</b></p> <ul style="list-style-type: none"> <li>Focus on changing sexual behaviour patterns in the general population. The focus should be on reducing multiple and concurrent partnerships.</li> <li>Scale up and maintain high coverage of pregnant women for HIV testing and HAART for those who are living with HIV.</li> <li>Scale up and saturate coverage of key populations.</li> <li>Ensure that people living with HIV are virally suppressed.</li> <li>Scale up coverage of adolescent girls and young women.</li> <li>Increase the proportion of boys and men who are circumcised.</li> <li>Identify the vulnerable populations and saturate coverage of these subpopulations.</li> </ul>  |

**Priority actions**

- Train county and sub county teams on epidemic appraisal.
  - Develop a toolkit for epidemic appraisal.
  - Conduct training for county and sub county teams.
- Conduct epidemic appraisal at county and sub county level.
  - Update HIV incidence data on an annual basis.
  - Conduct and update size estimation for key population.
  - Conduct and update size estimation for AYP.
  - Review routine programme data for all prevention interventions.
- Use data from epidemic appraisal to align and prioritise geographies, populations, and interventions.
  - Develop a plan for coverage of geographies and priority populations in counties.
  - Map and rationalise ongoing intervention effort by different players.
  - Set national- and county-level denominators and targets for reach and coverage of all priority populations with comprehensive programmes.

# 04

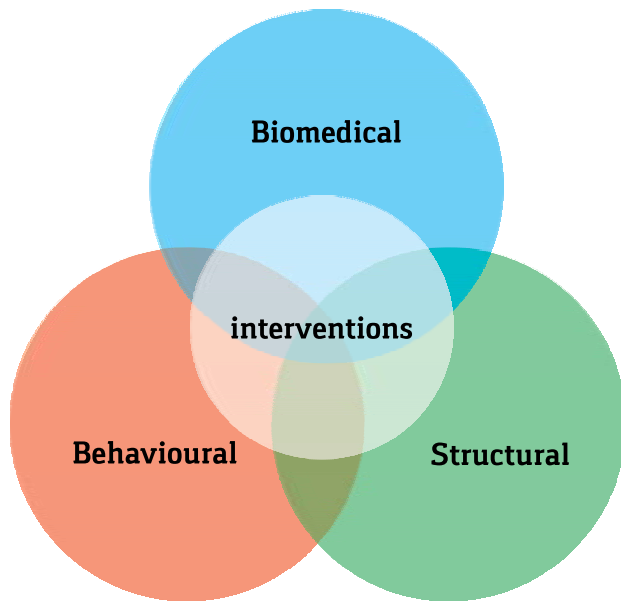
## STRATEGY 2:

**Scale Up Provision of Effective Comprehensive Combination Prevention Interventions, Tailored To Meet the Specific Needs and Contexts of Subpopulations**



An effective combination prevention package creates an enabling environment for biomedical interventions by addressing structural barriers and emphasising individual- and community-level behavioural changes. Therefore, the HIV prevention programme puts equal emphasis on behavioural, biomedical, and structural interventions. The packages must also address age-specific, population-specific, and overlapping risks.

## 4.1 Combination prevention package



### 4.1.1 Behavioural interventions

Behavioural interventions seek to prevent transmission by helping people change their sexual and injecting drug-use behaviours that place them at risk for HIV. Behavioural interventions provide knowledge and skills to influence people's motivation and capacity to enact behaviour change. Examples of behavioural interventions include peer-to-peer sexual health education, peer group interventions, and community-level demand generation activities. Behavioural interventions can be implemented at individual level, group level, and community level. Individual-level interventions encourage people who are at risk for HIV to reduce their risks by changing their personal behaviour. Group-level interventions

identify specific groups at risk and attempt to modify their behaviour. Community-level interventions are designed to change behaviours at the community level by modifying the norms and environment that support the individual.

### 4.1.2 Biomedical interventions

Biomedical interventions are those that directly influence the biological systems through which the virus infects a new host, to block virus transmission (e.g., male, and female condoms), decrease infectiousness (e.g., antiretroviral therapy for prevention), or reduce risk of acquiring infection (e.g., voluntary medical male circumcision, STI management). Specifically, these interventions involve clinical testing, diagnosis of infections and their treatment, and other clinical services that improve the health of priority populations.

### 4.1.3 Structural interventions

Structural interventions work by altering the context and environment in which people act, to influence their behaviours and reduce their HIV risk. Structural interventions locate the source of HIV vulnerability in the social, economic, and political environments that shape and constrain individual, community, and social health outcomes.

Kenya has developed guidance on packages of interventions for most of the priority subpopulations, such as the National Guidelines for HIV/STI Programming with Key Populations, 2014; National Guidance for HIV/ STI Programming with Vulnerable Populations, 2022; Kenya Framework for Elimination of Mother to Child Transmission of HIV and Syphilis 2016-2020; and Kenya's Fast Track Plan to End HIV and AIDS among Adolescents and Young People, 2015. The national HIV prevention programme recommends that implementation of these packages adopt a combination prevention and community-centred approach, with equal emphasis on behavioural, biomedical, and structural interventions.

The minimum package of services for all priority populations is presented in Annexure 2.

   Priority actions

1. Scale up combination prevention intervention packages to cover all priority populations.
2. Develop and disseminate service delivery guidelines for combination prevention interventions, where needed.
3. Build the capacity of counties, service providers, community gatekeepers and other duty bearers on combination prevention interventions.
4. Review composition and roles of the National HIV Prevention Steering Committee and county HIV Prevention Committees to ensure appropriate balance between biomedical, behavioural, and structural programming expertise.
5. Collaborate with the division of Health Information System to incorporate indicators for structural and behavioural interventions across HIV prevention interventions.
6. Include data on behavioural and structural indicators during programme review and presentations at national and sub-national level.
7. Build evidence around the impact of behavioural and structural interventions on HIV prevention.
8. Advocate for supportive legal and policy environments, access to justice, gender equality, and freedom from violence, stigma and discrimination.
9. Advocate for more resources to scale up structural and behavioural interventions.
10. Conduct assessment of HIV prevention investment to determine allocation across the three combination prevention strategies.





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# 05

## STRATEGY 3:

### Strengthen and Expand Community-Centred HIV Prevention Services



Community leadership and ownership are critical in designing and implementing HIV prevention programmes. The role of the community in enhancing ownership through demand creation, service delivery, and advocacy is paramount for sustainability of interventions. Peer-to-peer approach and other community outreaches remain the backbone of reaching all populations, especially the priority populations. Empowering the communities is essential so that they can own, define, and design the services as per their needs.

## 5.1 Community of practice

The HIV prevention programme seeks to leverage the social influence and capital of communities that have shared experiences, behaviour, or perspectives to identify, prioritise, and solve a common set of problems related to their lives. These groups of people are identified as a community of practice (CoP): a group of people who share a common concern, set of problems, or an interest in a topic, and who come together to fulfil both individual and group goals.

Through human-centred design, communities of practice will be supported to identify their priorities and potential solutions to address them. They will also be provided with relevant data to increase their awareness of health indicators. They will then be linked with each other to share best practices and lessons learnt. The communities of practice will also be linked to county departments, relevant government agencies, partners, and stakeholders to ensure that their health and other priorities are acknowledged and addressed through programme implementation.

## 5.2 Leadership and ownership of affected communities

The HIV prevention programme acknowledges that communities are the first responders to HIV, essential for delivering services and tackling HIV-related stigma and discrimination. The national HIV prevention programme is committed to supporting the development of community-led organisations. During the implementation of this plan, the HIV prevention programme will continue to advocate for the community-led organisations to receive grants and implement programmes for their communities.

## 5.3 Community-led monitoring

An aspect of community empowerment includes providing opportunities for the community to monitor programmes and hold the health system accountable. Community-led monitoring (CLM) will increase accountability for HIV responses at different levels and will be led and implemented by local community-led organisations. CLM will use a structured platform and trained community members to routinely collect and analyse qualitative and quantitative data on HIV prevention service delivery to provide feedback to the communities, programme managers, health decision-makers, and other stakeholders. The community groups and representatives through the CLM process will build evidence on what is working well, what is not working, and what needs to be improved, with suggestions for targeted action to improve outcomes.



### Priority actions

1. Build technical and managerial capacity of community-led organisations.
2. Identify and empower the CoPs to identify key HIV-related problems within the community and develop collective solutions.
3. Advocate with policy makers to create an enabling environment to implement community-driven solutions for HIV prevention.
4. Develop social contracting system and framework to enable public financing of community organisations and non-governmental organisations.
5. Fund civil society organisations and community-led organisations that are involved in HIV prevention interventions.
6. Invest in capacity strengthening of community networks, community care workers, and community leaders.
7. Scale up community referral and follow-up systems.
8. Proactively engage affected communities in designing and implementing programmes.
9. Scale up community-led monitoring in HIV prevention programmes.



# 06

## **STRATEGY 4:**

**Promote Integration of HIV Prevention into Essential Related Services to Improve HIV Outcomes**



The Kenya HIV Prevention Revolution Road Map and KASF II advocate for intra- and inter-sectoral action for health, because populations who need HIV prevention also have other health and non-health needs. Intra- and inter-sectoral coordination and collaborations will be critical for acceleration of effective HIV prevention. To achieve this, a dynamic interactive process, involving strategic information exchange, policy development, and programme-planning activities, is required.

Another level of coordination and collaboration that is needed is between facility and community. While many social-cultural events and activities (e.g., disco Matanga, FGM, wife inheritance) predispose the community to acquiring HIV, prevention services are largely provided by the health system. It is essential for community-facility linkages to create a continuum of service provision which will improve HIV response and other health outcomes. Coordinated efforts will make HIV prevention programming more effective, efficient, and sustainable.

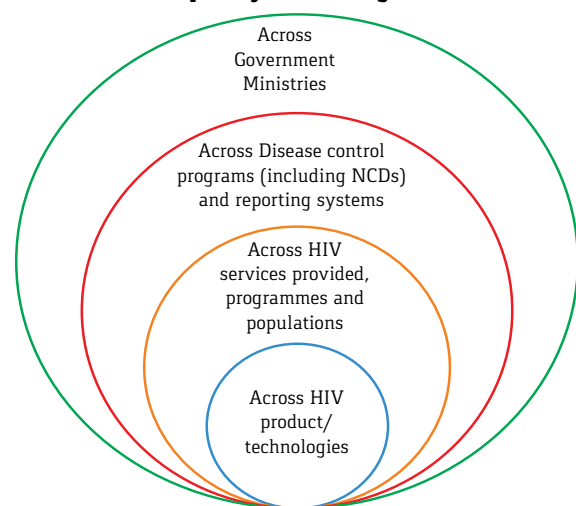
The HIV prevention response will leverage the strengths of the health system to scale up the prevention response at national and sub-national levels. The scale up agenda will also create opportunities to further strengthen the health system by focussing on leadership, governance, service delivery, commodity availability, use of data and evidence, and financial sustainability.

Integration of the HIV prevention response into universal health coverage programming is crucial to securing HIV epidemic control and health outcomes. Successful

integration will require expanding the principle of 'shared responsibility', in line with the global HIV response. For HIV programming, it is critical to advocate the elimination of all forms of barriers, including stigma and discrimination, systems, and health workforce barriers, and to incorporate HIV service provision into other health services provided at community and facility levels.

In the context of pandemics like COVID 19, it is also critical to align HIV responses with broader efforts towards universal health coverage and access to social protection. This alignment will improve cost-effectiveness and efficiency. Closer integration of HIV prevention services with the wider health system, and integrating health system platforms, such as strategic information, human resources, and procurement and supply management, are critical areas for improvement.

### Multiple layers of integration



### Priority actions

1. Conduct county-level mapping of opportunities to integrate the components of combination prevention interventions (biomedical, behavioural, and structural) within existing systems and structures.
2. Integrate HIV prevention services with SRH, mental health, care of sexual and gender-based violence, drug dependence treatment and hepatitis C prevention and treatment, tuberculosis control, prison health, non-communicable diseases, legal and social support services, etc.
3. Scale up integration of risk assessment and oral PrEP services into the MCH services for HIV prevention among pregnant women and their babies.
4. Mobilise actors across sectors to identify opportunities to increase priority populations' access to comprehensive HIV prevention service
5. Sensitise health service providers to provide priority population-centred comprehensive services in facilities and community settings.
6. Advocate county-level planning, resource allocation, and ring-fencing of programme budgets for priority populations.
7. Ensure inclusion of HIV prevention services within the UHC package.

# 07

## STRATEGY 5:

Institute Mechanisms for Rapid Introduction of New HIV Prevention Technologies and Programme Innovations

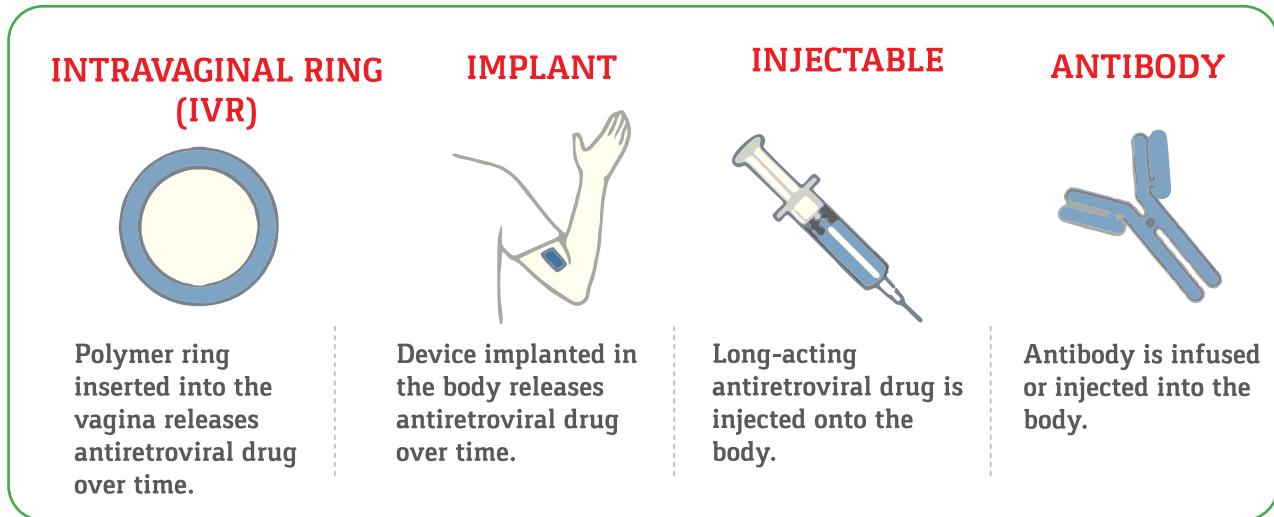


KASF II prioritises expanding HIV prevention options. Innovative and successful strategies will be adopted and scaled up to expand HIV prevention choices. KASF II also recommends the use of mixed models of service delivery and use of strategic information to ensure that HIV prevention choices and technologies are accessible

to all, with special focus on priority populations. Kenya will adopt a human-centred approach to introduce new HIV prevention products and technologies.

Some of the emerging options are shown in figure 12.

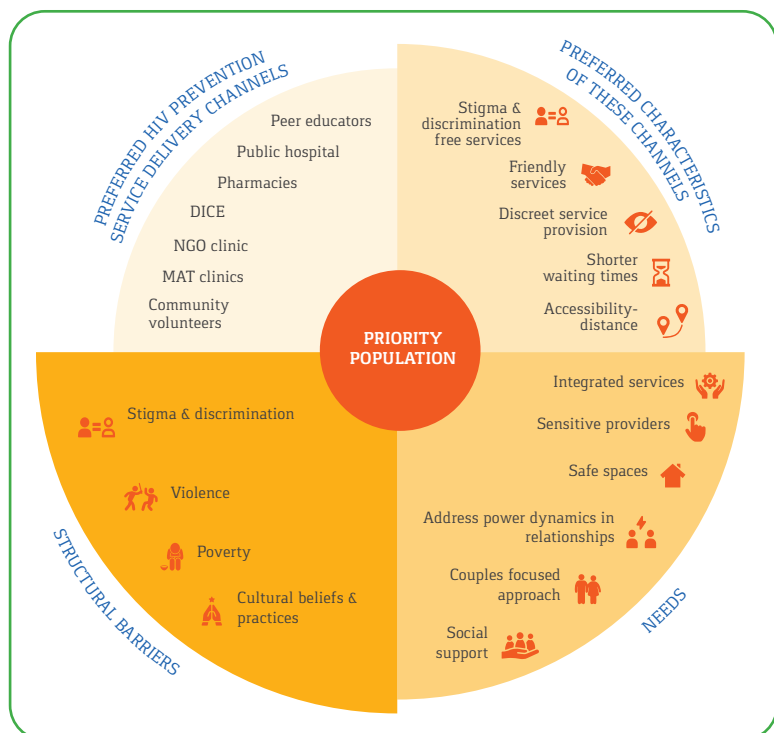
**FIGURE 12: Emerging HIV prevention technologies**



An assessment conducted by NSDCC and NASCOP explored the preferred service delivery channels of priority populations, the preferred characteristics of these delivery channels, and the needs of the populations (figure 13). It was clear that the service delivery channels adopted to provide existing and new HIV prevention technologies, whether they are standalone or integrated, need to address the priorities of the population that the services are targeting. Without addressing the structural drivers that impact the lives of the priority population, accessing these services will be challenging.

As the country is exploring sustainable options for service delivery, the platforms delivering the services should address these needs and barriers.

**FIGURE 13: Preferred service delivery channels, preferred characteristics of these channels, needs of the priority populations, and barriers to access and utilisation**



   Priority actions

1. Conduct annual consultative forums involving all stakeholders to review research evidence and rally support for introduction of new technologies and approaches.
2. Develop policy briefs and knowledge products to communicate the research findings in a community friendly manner.
3. Conduct assessment with priority populations to understand their needs and preferred delivery modalities for new prevention technology.
4. Develop policy and guidance and seek regulatory approvals to introduce new and approved prevention technology, including supply and distribution.
5. Develop scale up plans adopting innovative delivery models acceptable or led by the priority populations.
6. Develop communication materials to generate demand for new technology among the priority populations.
7. Create centres of excellence to pilot delivery of new prevention technologies.



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# 08

## **STRATEGY 6:**

**Develop and Implement Innovative Country Investment and Financing Approaches for a Sustainable HIV Prevention Response**






Transition from external aid is imperative, as Kenya has graduated to a lower middle-income country. As external financing for Kenya's health programmes significantly declines, the government through the Ministry of Health has recognised the need to ensure long-term sustainability of the country's health programmes by strengthening domestic resource mobilisation efforts to

finance gaps left by donors. This will secure the gains made so far and scale up the national response to HIV and AIDS.

The five-year resource requirement for essential and comprehensive prevention intervention packages are broken down by subpopulation and year in Table 3 and Table 4.

**TABLE 3: Essential HIV prevention package resource requirement for a 5-year period**

| Population   | Total Resources in Year 1 (US\$ million) | Total Resources in Year 2 (US\$ million) | Total Resources in Year 3 (US\$ million) | Total Resources in Year 4 (US\$ million) | Total Resources in Year 5 (US\$ million) | Total (US\$ million) | Proportion  |
|--|--|--|--|--|--|----------------------|-------------|
|  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%         |
| <b>Total</b>   | <b>148.23</b>                            | <b>163.40</b>                            | <b>179.82</b>                            | <b>196.21</b>                            | <b>210.26</b>                            | <b>897.92</b>        | <b>100%</b> |



**TABLE 4: Comprehensive HIV prevention package resource requirement for a 5-year period**

| Population   | Total Resources in 2021 | Total Resources in 2022 | Total Resources in 2023 | Total Resources in 2024 | Total Resources in 2025 | Total          | Proportion  |
|--|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|----------------|-------------|
|  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%          |
|  PWID               | 4.65                    | 6.44                    | 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%         |
| <b>Grand Total</b>   | <b>199.35</b>           | <b>223.81</b>           | <b>249.15</b>           | <b>274.96</b>           | <b>301.07</b>           | <b>1247.81</b> | <b>100%</b> |



   Priority actions

1. Include HIV in County Integrated Development Plans (CIDPs) and county annual budgets based on the epidemic typology and need of the county.
2. Raise funds from capital projects using guides developed by NSDCC for gazette to help identify, quantify the need and cost, and define the impact of the interventions under Sections 68 and 69 of the Health Act, 2017.
3. Develop and enact County HIV and STIs Management Bill to ensure annual county allocations and ring-fencing of funds by the county assemblies for the HIV response.
4. Explore innovative local financing options to finance the resource gaps generated by donor shocks/fluctuations in donor preferences.
5. Explore public-private partnerships/collaborations as potential sources for financing for HIV.
6. Lobby for establishment of pooled HIV resources from all sources.
7. Advocate with workplace programmes to improve their contributions towards HIV prevention continuum.
8. Advocate with UHC initiative to incorporate insurance coverage for essential package of HIV services through NHIF.



# 09

## **STRATEGY 7:**

**Strengthen National, Sub-National Coordination and Management of HIV Response through Multisectoral Collaboration and Accountability of All Stakeholders**



The HIV prevention coordination structures of Kenya AIDS Strategic Framework II that will guide the rollout of this acceleration plan are as follows:

### 9.1 The National Multisectoral HIV Prevention Steering Committee

The National Multisectoral HIV Prevention Steering Committee will provide expert leadership, mobilise resources, and ensure accountability towards achieving the targets of this acceleration plan. The committee convened by the National Syndemic Diseases Control Council, will bring together senior leaders representing national and county governments, people living with HIV, representatives of priority sub-populations, implementing, bilateral and multilateral partners, and other key stakeholders, including the education sector, researchers, pharmaceutical industry, business community (employers and workers), informal sector, justice and legal sector, media, information and communications sector, transport sector, microfinance, tourism and hotel industry, labour sector, private health sector, and the religious sector among others.

### 9.2 Secretariat for the National HIV Multisectoral Steering Committee

The technical secretariat will provide technical leadership to consolidate HIV prevention interventions from multiple sectors and facilitate a target-based, well-coordinated and comprehensive population-based approach to HIV prevention. Membership of the secretariat will be drawn from national managers of HIV prevention programmes, technical leads from multi/bi-lateral development partners, private health sector, private sector, and the research community. This secretariat will ensure that this plan is implemented with fidelity and monitored to measure progress.

### 9.3 County Multisectoral HIV Coordination Committee

In each county, the County Executive Committee Member for Health, and the County Commissioner will co-chair the County Multisectoral HIV Coordination Committee. The NSDCC Regional HIV Coordinator will serve as the secretariat for this committee. This committee will provide leadership at county level for HIV response, mobilise resources, ensure compliance with national HIV policies and guidelines, and promote accountability towards achieving the county targets.



#### Priority actions

1. Develop Terms of Reference for the coordination structures and provide guidance towards selection of members.
2. Ensure membership and participation of all constituencies in these structures with special focus on affected and infected communities.
3. Ensure regular meetings of the coordination structures and documentation of decisions taken.
4. Use data to measure programmes at national and sub-national level and build accountability among all stakeholders.
5. Develop multisectoral solutions to address the national and sub-national gaps, and seek accountability for implementation of those plans.
6. Provide space to test innovations to address challenges and gaps.
7. Take responsibility for achieving the county-level targets based on the epidemic appraisal to reduce new infections.

# 10

## **STRATEGY 8:**

**Adopt Programme Science and Use Data to Enhance HIV Prevention Programme Effectiveness**



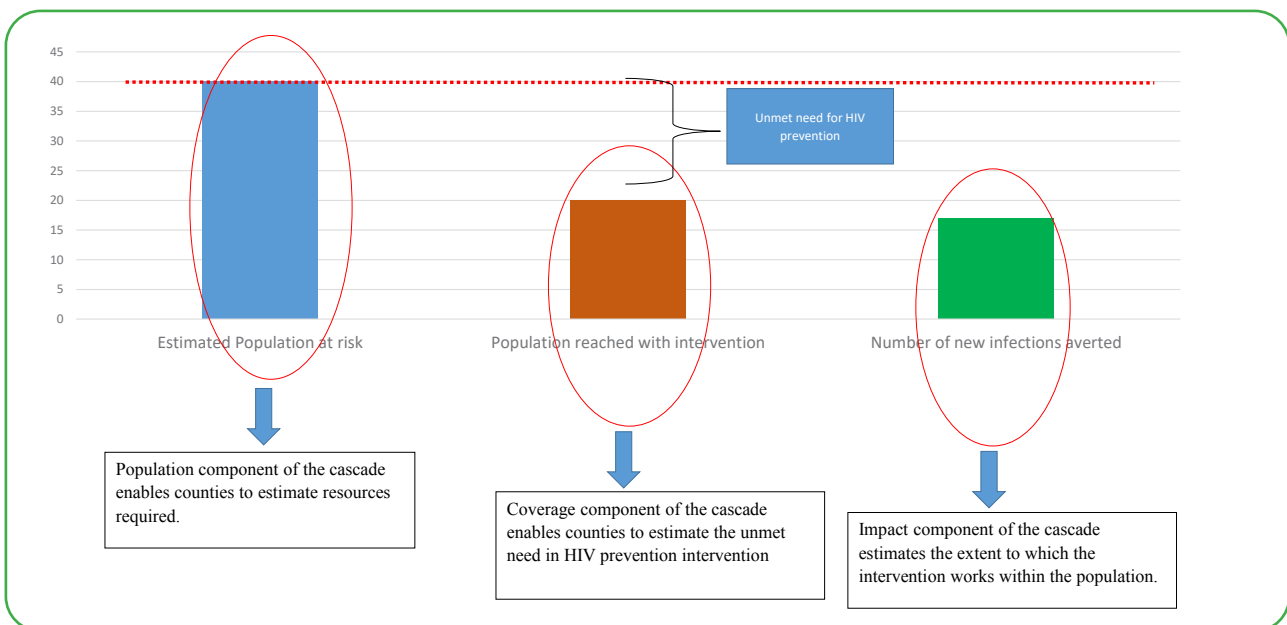
Kenya has prioritised the need to improve the quality, effectiveness, and sustainability of HIV prevention programmes by using a 'Programme Science'<sup>15,16</sup> approach, in which embedded research facilitates improved programme development and implementation to, ultimately, optimise programme and population-level outcomes. Refining, contextualising, and integrating existing research methods into a framework for effective programming in Kenya is critical.

The tools to embed research into programmes are illustrated by HIV prevention cascades and the effective programme coverage framework.

## 10.1 HIV prevention cascades

HIV prevention and care cascades identify important steps in the continuum of prevention and care services and function as frameworks to estimate population-level rates of service coverage at each step (figure 14). They are used at the macro level (national and sub-national) and at the micro (implementation) level for planning and programming.

**FIGURE 14: Basic HIV prevention cascades model**



## 10.2 The effective programme coverage framework

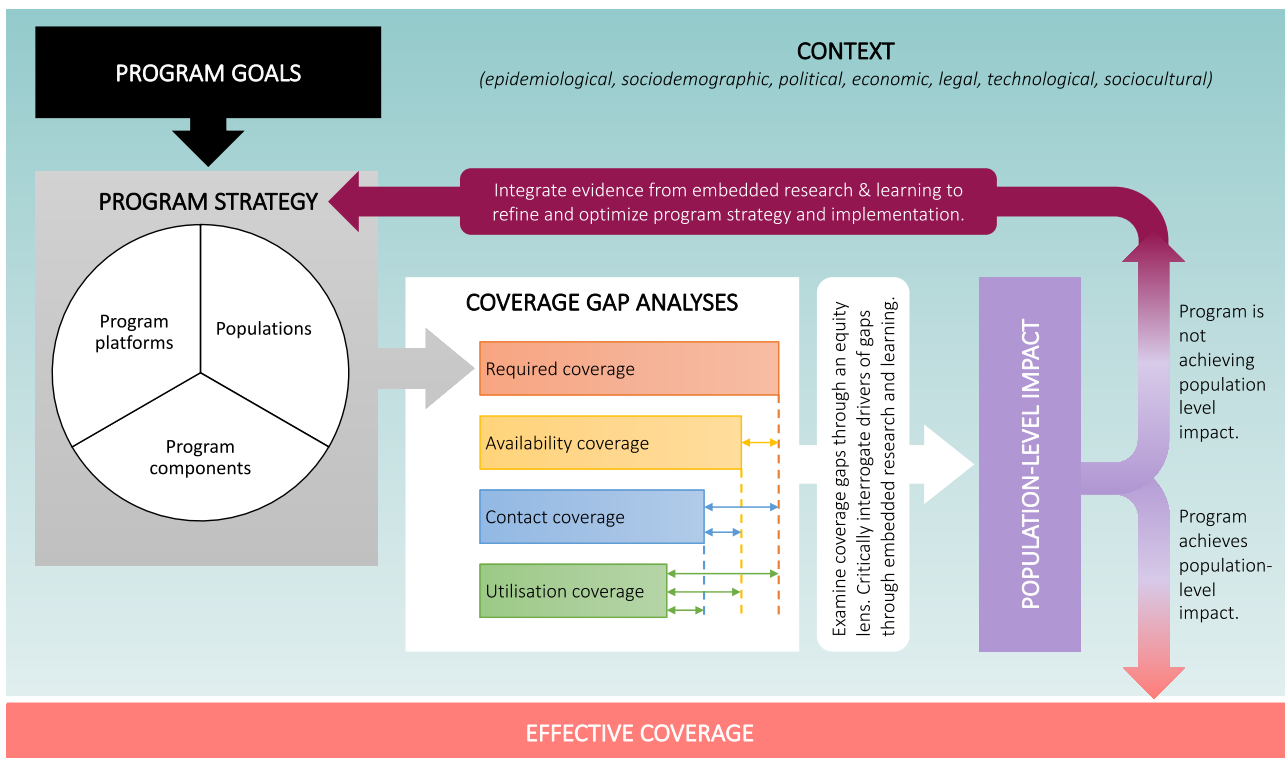
The effective programme coverage framework begins with a programme's strategy, which should inform its required coverage target(s) for each component of intervention and prioritised population (and geography) (figure 15). Coverage for each of the programme's component interventions is monitored using an adapted cascade model that measures indicators for four dimensions of coverage—required, availability,

contact, and utilisation. Coverage gap analyses are simultaneously performed through embedded research processes to identify, quantify, understand, and address gaps in the coverage cascade. Evidence from gap analyses and research findings are fed back into the programme to inform adjustments to the programme strategy, which begins the cycle again. The framework can also provide insight into how a programme's goal(s), its strategy, and its context influence the coverage cascade.

<sup>15</sup> Aral SO and JF Blanchard. 2012. The Program Science initiative: improving the planning, implementation, and evaluation of HIV/STI prevention programs. *Sex Transm Infect.* 88(3):157-9. doi:10.1136/sextrans-2011-050389

<sup>16</sup> McClarty LM, Bhattacharjee P, Isac S, et al. 2018. Key Programme Science lessons from an HIV prevention 'Learning Site' for sex workers in Mombasa, Kenya. *Sex Transm Infect.* 94(5):346-52. doi: 10.1136/sextrans-2017-053228

**FIGURE 15: Effective programme coverage framework**



**Priority actions**

1. Advocate for resources to adopt a programme science approach to programming for HIV prevention at national and sub-national level.
2. Advocate for integration of programme science in donor funding for HIV prevention.
3. Strengthen capacity of national and county programme teams to embed programme science in their planning, implementation, and monitoring.
4. Routinely use appropriate programme science tools to identify gaps and innovative solutions in HIV prevention programmes.
5. Conduct annual national and county HIV prevention cascade and effective coverage cascade analysis to facilitate effective national and county planning for HIV prevention interventions.
6. Develop a research agenda emerging from the cascade analysis to answer the real-time questions of the programme.
7. Engage with affected communities to generate solutions to address emerging programme gaps.
8. Test these innovations to address programme gaps and document the successful and challenging stories.

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National AIDS Control Council

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HIV Status**





# 11

## STRATEGY 9:

### Strengthen the HIV Prevention Programme Monitoring and Evaluation System



To achieve the desired national prevention targets and contribute to the global goal, there is a need to consistently track and monitor the HIV prevention programme outcomes and outputs, disaggregated by geography and population groups. The impact of recommended evidence-based combination prevention should regularly be evaluated at national and county levels against specific outcomes, using standard and innovative evaluation methods, and in collaboration with stakeholders.

### 11.1 Development and implementation of a comprehensive HIV prevention monitoring framework

This plan reiterates the need to use an integrated performance framework that comprehensively measures HIV prevention programme performance at the national and sub-national levels in alignment with the country's needs and global targets. This framework would include measures used to determine achievement of stated programme goals and objectives and the continuum of HIV prevention services received by individuals. The monitoring framework is presented in Annexure 3.

### 11.2 Routine HIV prevention programme monitoring

Routine HIV prevention programme monitoring will be done at facility, community, sub-national, and national levels, using standard data collection and reporting tools. Programme data will be analysed and used regularly at

all levels to facilitate decision making for programme improvement. Digital solutions will be scaled up and interoperability layers that link multiple data sets (e.g., HIV, violence, and pregnancy) to strengthen users' understanding of multidimensional challenges will be ensured. The establishment and operationalisation of data management systems will be guided by relevant policies, including the national guidelines for Electronic Medical Record Systems and the national Data Protection Act of 2019.

### 11.3 HIV prevention-related outcome and impact measurement

As Kenya aligns to the targets of the HIV Prevention Revolution Road Map and the global targets for HIV prevention,<sup>17</sup> this plan commits to strengthening outcomes measurement. The new global guidance recommends ambitious targets related to population and geography, and emphasises the need to measure reduction in combination prevention barriers. This requires enhanced data systems and analysis that shifts from averages to individuals, and from aggregates to gaps. This also requires development of robust and sustainable information and surveillance systems that provide the required information and data in a timely and meaningful manner, and that feed into the national and Global AIDS Monitoring reporting system. These outcome and impact measurements will also support prioritisation of national and sub-national decision making, including identifying areas that require more intensive interventions.

#### Priority actions

1. Conduct real-time tracking of the progress in implementing the prevention plan through a comprehensive dashboard.
2. Use data at national and county levels for programme improvement and decision making.
3. Strengthen HIV prevention data reporting in the Maisha platform, national data warehouse, and KHIS.
4. Train users to navigate and interpret the HIV prevention data systems and use the data for decision making.
5. Develop and operationalise a community monitoring approach by involving priority populations in tracking progress.
6. Institute regular high-level dialogues, joint reviews, and data reviews at national and regional levels through the coordination mechanisms.
7. Conduct regular data quality audits to improve the quality of data.

<sup>17</sup> UNAIDS. No date. Global AIDS Strategy 2021-2026: End Inequalities. End AIDS. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS).

# ANNEXURE 1

## DRAFTING AND REVIEW TEAMS

### DRAFTING TEAM

| Name                 | Organisation          |
|----------------------|-----------------------|
| Dr. Rose Wafula      | NASCOP                |
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| Margaret Ndubi       | UNAIDS                |
| Mary Nyaguthii       | AHF \                 |
| Omari Mwanjama       | NSDCC                 |
| Rebecca Nyankieya    | NSDCC                 |
| Faith Koskei         | NSDCC                 |
| Lilian Langat        | UNFPA                 |
| Jafred Mwangi        | PHDA, TSU             |
| Bryan Okiya          | Georgetown University |
| Prof. Sylvia Ojoo    | Georgetown University |
| Dr. Sharon Kibwana   | Georgetown University |
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| Gladys J. Tuitoek    | MoH Baringo           |
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| Davies N. Kanah      | NETEL                 |
| Michael Onyango      | MMAAK                 |
| Jane Gichuru         | NASCOP                |
| Gideon Obuya         | Maisha Youth          |
| Charles Karuga Kamau | Maisha Youth          |
| Moses Otieno         | NASCOP                |
| Dr. Tom Marwa        | Value Impact          |
| Paul Mwaura          | MPEG-KP Consortium    |
| Benard Nyauchi       | NEPHAK                |
| Dr. Hermes Gichane   | PHDA, TSU             |
| Caroline Mumbo       | LVCT Health           |

|                          |               |
|--------------------------|---------------|
| Dr. Hellen Muttai        | CDC           |
| Obwiri Kenyatta          | CDC           |
| Julius Oliech            | CDC           |
| Erick Gitau              | Dance4life    |
| Anangwe Samson Munalu    | USAID (DoD)   |
| Dr. Leonard Soo          | USAID         |
| Dr. Odoyo June           | CDC           |
| Irene Kuria              | KP Consortium |
| Dr. Rose Patricia Oluoch | USAID         |
| Dr. Muthoni Karanja      | DoD           |
| Abdifatah Mohamed        | NSDCC         |
| Lydia Gathogo            | NSDCC         |
| Susan Olum               | NSDCC         |
| Rollaine Karimi          | NSDCC         |
| Marystella Mabuka        | NSDCC         |
| Caroline Wanga           | NSDCC         |
| Lydia Wasafisia          | NSDCC         |

### Review team

|                        |                        |
|------------------------|------------------------|
| Dr. Ruth Laibon-Masha  | NSDCC                  |
| Dr. Celestine Mugambi  | NSDCC                  |
| Joshua Gitonga         | NSDCC                  |
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| Morris Ogero           | NSDCC                  |
| Irene Gomba            | NSDCC                  |
| Dennis Maosa           | NSDCC                  |
| Dr. Michael Kiragu     | Bell Consultant        |
| Jannet Aluoch          | NSDCC                  |

# ANNEXURE 2

## SPECIFIC PACKAGES OF INTERVENTIONS FOR EACH SUBPOPULATION

The specific packages of recommended interventions for each subpopulation are defined as follows:

| Priority Population                     | Recommended Interventions  |
|---|--|
| <b>Pregnant and breastfeeding women</b> | <p><b>Biomedical</b></p> <ul style="list-style-type: none"> <li>■ Differentiated HIV testing services, including partner testing, self-testing, dual HIV and syphilis testing with emphasis on re-testing during pregnancy, labour and delivery, and postnatal period</li> <li>■ Use of PrEP for HIV negative women in discordant relationships</li> <li>■ Condom promotion and distribution</li> <li>■ Family planning services and commodities, with good integration in HIV clinics</li> <li>■ Provision of ARVs for HIV positive pregnant and breastfeeding women</li> <li>■ Viral load testing</li> <li>■ Intensive adherence support for pregnant women on ART</li> <li>■ Early infant diagnosis (EID)</li> <li>■ Postnatal prophylaxis and prophylaxis for high-risk babies</li> <li>■ Counselling on exclusive breastfeeding and introduction of complementary feeds</li> <li>■ Linkages to ANC and PNC services</li> <li>■ Linkage to voluntary medical male circumcision for HIV negative male partners in high-prevalence settings</li> </ul> <p><b>Behavioural</b></p> <ul style="list-style-type: none"> <li>■ Counselling on the heightened risks of HIV infection during pregnancy and breastfeeding</li> <li>■ Adolescent-oriented services</li> <li>■ Psychosocial support clubs and adolescent peer groups to promote retention</li> <li>■ Community mobilisation and couple-based services to boost male involvement in partner's PMTCT services</li> </ul> <p><b>Structural</b></p> <ul style="list-style-type: none"> <li>■ Prevent and respond to gender-based violence</li> <li>■ Prevent and address stigma and discrimination</li> <li>■ Strengthen multisectoral collaboration and linkage with other sectors and prevention services</li> </ul> |

| Priority Population              | Recommended Interventions  |
|----------------------------------|--|
| Adolescent girls and young women | <p><b>Biomedical</b></p> <ul style="list-style-type: none"> <li>■ Provide sexual and reproductive health services, including contraception and cervical cancer screening and menstrual hygiene and health promotion</li> <li>■ Provide post-abortal care services</li> <li>■ Implement condom and lubricant programming</li> <li>■ Provide services for STI diagnosis and treatment</li> <li>■ Provide pre- and post-exposure prophylaxis</li> <li>■ Provide differentiated age-appropriate HIV testing, care, and treatment services</li> <li>■ Address comorbidities, including mental health and drug and alcohol dependence</li> <li>■ Prioritise voluntary medical male circumcision in the non-circumcising counties</li> </ul> <p><b>Behavioural</b></p> <ul style="list-style-type: none"> <li>■ Implement behaviour change evidence-based interventions using physical and virtual platforms</li> <li>■ Provide age-appropriate and culturally sensitive comprehensive family health education for in and out of school youths</li> <li>■ Scale up peer-led interventions with behaviour change communication</li> <li>■ Risk assessment and counselling for HIV prevention</li> </ul> <p><b>Structural</b></p> <ul style="list-style-type: none"> <li>■ Integrate AGYW programmes within the national multisectoral response</li> <li>■ Prevent gender-based violence and provide post-violence care</li> <li>■ Prevent and address stigma and discrimination</li> <li>■ Promote universal access and completion of secondary school education</li> <li>■ Link with social protection interventions and economic empowerment</li> <li>■ Meaningfully engage AGYW in planning, designing, implementing, and monitoring interventions</li> <li>■ Strengthen agency of AGYW by forming and supporting AGYW-led organisations</li> <li>■ Develop supportive policies to enhance access to services</li> <li>■ Conduct male sexual partner characterisation for linkage to appropriate HIV prevention and treatment interventions</li> <li>■ Advocate adolescent responsive services</li> </ul> |

| Priority Population | Recommended Interventions  |
|---------------------|--|
| Key populations     | <p><b>Biomedical</b></p> <ul style="list-style-type: none"> <li>■ Intensify condom and lubricant programming</li> <li>■ Provide ART-based prevention: pre-exposure and post exposure prophylaxis</li> <li>■ Provide sexual and reproductive health services, including family planning, post-abortion care, ANC, STI screening and treatment, HPV, cervical cancer screening, and anal health</li> <li>■ Viral hepatitis screening and treatment</li> <li>■ Implement harm reduction interventions, including needle syringe programme, overdose management, and opioid substitution therapy</li> <li>■ Provide differentiated HIV testing, care, and treatment services</li> <li>■ Provide services for prevention and management of coinfections and comorbidities, including mental health and alcohol dependence</li> <li>■ TB screening and referral to treatment</li> <li>■ Provide VMMC to eligible population</li> </ul> <p><b>Behavioural</b></p> <ul style="list-style-type: none"> <li>■ Provide peer-to-peer behaviour change interventions using physical and virtual platforms</li> <li>■ Targeted information, education, and communication</li> <li>■ Promotion, demonstration, and distribution of male and female condoms and water-based lubricants, needles, and syringes</li> <li>■ Risk assessment, risk-reduction counselling, and skills-building</li> <li>■ Evidence-informed behavioural interventions</li> </ul> <p><b>Structural</b></p> <ul style="list-style-type: none"> <li>■ Map and estimate the key population subpopulations in counties where there are no estimates</li> <li>■ Implement interventions for young key populations in participation with them</li> <li>■ Facilitate economic empowerment of the key population community</li> <li>■ Prevent and address violence, stigma, and discrimination</li> <li>■ Meaningfully engage key populations in intervention design, implementation, and monitoring</li> <li>■ Support key population led organisations to strengthen key populations’ agency to access services</li> <li>■ Develop supportive policies and create an enabling environment to enhance access to prevention and treatment services</li> <li>■ Strengthen referral and linkage systems</li> </ul> |

| Priority Population           | Recommended Interventions   |
|-------------------------------|---|
| <b>Vulnerable populations</b> | <p><b>Biomedical</b></p> <ul style="list-style-type: none"> <li>■ Provide condoms and lubricant programming</li> <li>■ Provide pre- and post-exposure prophylaxis</li> <li>■ Provide sexual and reproductive health services, including STI management, cervical cancer screening, ANC, family planning, and post-abortion care</li> <li>■ Provide differentiated HIV testing, care, and treatment services</li> <li>■ Voluntary medical male circumcision</li> </ul> <p><b>Behavioural</b></p> <ul style="list-style-type: none"> <li>■ Incorporate evidence-informed behavioural interventions</li> <li>■ Risk assessment, risk-reduction counselling, and skills-building</li> <li>■ Provide peer-to-peer behaviour change interventions using physical and virtual platforms</li> <li>■ Promotion, demonstration, and distribution of male and female condoms and water-based lubricants</li> <li>■ Targeted information, education, and communication</li> <li>■ Provide differentiated psychosocial support groups</li> </ul> <p><b>Structural</b></p> <ul style="list-style-type: none"> <li>■ Provide gender-based violence prevention and post-violence care</li> <li>■ Map and estimate the vulnerable population subpopulations in counties where there are no estimates</li> <li>■ Facilitate economic empowerment of the vulnerable population community</li> <li>■ Prevent and address violence, stigma, and discrimination</li> <li>■ Meaningfully engage vulnerable populations in intervention design, implementation, and monitoring</li> <li>■ Develop supportive policies and create an enabling environment to enhance access to prevention and treatment services</li> <li>■ Strengthen referral and linkage systems</li> </ul> |
| <b>Men</b>                    | <p><b>Biomedical</b></p> <ul style="list-style-type: none"> <li>■ Male friendly clinics</li> <li>■ Voluntary medical male circumcision</li> <li>■ Partner testing</li> <li>■ Integrated screening and testing for HIV, STIs and noncommunicable diseases</li> <li>■ Provide PrEP and PEP</li> <li>■ Condom promotion and distribution</li> </ul> <p><b>Behavioural</b></p> <ul style="list-style-type: none"> <li>■ Workplace evidence-based behavioural strategies</li> <li>■ Male support groups</li> <li>■ Mental health and substance abuse counselling and referral</li> <li>■ Family planning education</li> </ul> <p><b>Structural</b></p> <ul style="list-style-type: none"> <li>■ Address gender-based violence</li> <li>■ Address stigma and discrimination</li> </ul>  |





| Level of measurement                                    | Indicator   | Disaggregation                    | Baseline (2022) | 2023  | 2024  | 2025  | 2026  | 2027  | 2028  | 2029  | 2030 | Data Source                   | Frequency |
|---|---|-----------------------------------|-----------------|-------|-------|-------|-------|-------|-------|-------|------|-------------------------------|-----------|
| Reduction in harm among PWID users                      | Proportion of PWID using sterile needles and syringes in the last injecting episode | Age, sex, population type, county | 88%             | 89.5% | 91.0% | 92.5% | 94.0% | 95.5% | 97.0% | 98.5% | 100% | PBS/ IBBS                     | 5 years   |
|   | Proportion of PWID using Medically Assisted Therapy                                 | Age, sex, population type, county | 32%             | 38%   | 44%   | 50%   | 56%   | 62%   | 68%   | 74%   | 80%  | KHIS                          |           |
| Increase in PrEP use                                    | Proportion of at risk populations initiated on PrEP                                 | Age, sex, population type, county | 39%             | 44%   | 49%   | 54%   | 60%   | 65%   | 70%   | 75%   | 80%  | KHIS                          | Monthly   |
| Increase in STI screening and treatment                 | Proportion of people screened and diagnosed for STIs                                | Age, sex, population type, county | 34%             | 31%   | 27%   | 24%   | 20%   | 17%   | 14%   | 10%   | 7%   | IBBS/ PBS                     |           |
| Increase in awareness of HIV status                     | Proportion of PLHIV aware of HIV status   | Age, sex, population type, county | 95%-Total       | 95%   | 96%   | 96%   | 97%   | 98%   | 99%   | 99%   | 100% | HIV Estimates/ IBBS           | Annual    |
|   |   |                                   | 90%-Male        |       |       |       |       |       |       |       |      |                               |           |
| Increase in number of PLHIV on ART                      | Proportion of PLHIV with known HIV status on ART                                    | Age, sex, population type, county | 94%-Female      | 90%   | 91.3% | 91.9% | 92.5% | 93.1% | 93.8% | 94.4% | 95%  | KHIS/ IBBS                    | Monthly   |
|   |   |                                   | 84%             | 85.4% | 86.8% | 88.1% | 89.5% | 90.9% | 92.3% | 93.6% | 95%  | KHIS/ IBBS                    | Monthly   |
| Increase in transition from primary to secondary school | Proportion of AYP transitioning from primary to secondary school                    | Sex, county                       | 79.5%           | 100%  | 100%  | 100%  | 100%  | 100%  | 100%  | 100%  | 100% | Education department reports  | Annual    |
|   |   |                                   | 1%              | 2%    | 3%    | 4%    | 5%    | 6%    | 7%    | 8%    | 10%  | Partner online reporting tool | Annually  |
| Reduction in prevalence of gender based violence        | Proportion of girls and women who have experienced gender based violence            | Age, sex, population type, county | 20%             | 18%   | 16%   | 14%   | 12%   | 10%   | 9%    | 7%    | <5%  | KDHS/ IBBS/ PBS               | 5 years   |
|   |   |                                   |                 |       |       |       |       |       |       |       |      |                               |           |

| Level of measurement  | Indicator  | Disaggregation   | Baseline (2022) | 2023  | 2024  | 2025  | 2026  | 2027  | 2028  | 2029  | 2030 | Data Source                  | Frequency |
|---|--|--|-----------------|-------|-------|-------|-------|-------|-------|-------|------|------------------------------|-----------|
|   | Reduction in adolescent pregnancies  | Age, population type, county   | 15%             | 14%   | 13%   | 11%   | 10%   | 9%    | 8%    | 6%    | <5%  | KDHS/ IBBS/ PBS              | 5 years   |
|   | Increase in access to family health education  | Age, sex, county   | 10%             | 12%   | 14%   | 16%   | 18%   | 20%   | 22%   | 24%   | 25%  | Education department reports | Annually  |
|   | Increase in male circumcision in priority counties   | Age, county  | 41.0%           | 45.9% | 50.8% | 55.6% | 60.5% | 65.4% | 70.3% | 75.1% | 80%  | KHIS                         | Monthly   |
| <b>Output level</b>   |  |  |                 |       |       |       |       |       |       |       |      |                              |           |
| <b>S.A. 1: Apply a precision and differentiated prevention approach based on current evidence, geographic prioritisation, subpopulation groups, and epidemic typology</b> |  |  |                 |       |       |       |       |       |       |       |      |                              |           |
| <b>Outcome 1: HIV prevention interventions prioritised in geographies and sub populations based on epidemic appraisal and implemented</b>                                 |  |  |                 |       |       |       |       |       |       |       |      |                              |           |
| <b>Training and capacity building on epidemic appraisal</b>   | Increased number of counties trained in epidemic appraisal   | Proportion of counties trained to conduct epidemic appraisal for prioritisation of interventions                     | 0               | 47    | 47    | 47    | 47    | 47    | 47    | 47    | 47   | Training reports             | Annual    |
|   | Increased number of counties conducting epidemic appraisals  | Proportion of counties conducting epidemic appraisal for prioritisation of interventions                             | 0               | 47    | 47    | 47    | 47    | 47    | 47    | 47    | 47   | Reports/ Plans               | Annual    |
| <b>Epidemic appraisal analysis</b>  | Increased number of counties utilizing appraisal data for prioritisation of HIV prevention interventions | Proportion of counties utilising the epidemic appraisal data for geographic prioritisation                           | 0               | 50%   | 75%   | 100%  | 100%  | 100%  | 100%  | 100%  | 100% | Reports/ Plan                | Annually  |
|   |  | Proportion of counties utilising epidemic appraisal data for prioritisation of population based on epidemic typology | 0               | 50%   | 75%   | 100%  | 100%  | 100%  | 100%  | 100%  | 100% | Special surveys              | 2 years   |

| Level of measurement  | Indicator  | Disaggregation   | Baseline (2022) | 2023  | 2024  | 2025  | 2026  | 2027  | 2028  | 2029 | 2030                             | Data Source     | Frequency |
|---|--|--|-----------------|-------|-------|-------|-------|-------|-------|------|----------------------------------|-----------------|-----------|
| <b>S.A. 2: Scale up provision of effective comprehensive combination prevention interventions, tailored to meet the specific needs and contexts of subpopulations</b> |  |  |                 |       |       |       |       |       |       |      |                                  |                 |           |
| <b>Outcome 2: Priority geographies and populations covered with HIV combination prevention services at scale</b>  |  |  |                 |       |       |       |       |       |       |      |                                  |                 |           |
| <b>Plan funding for combination prevention interventions in all counties based on epidemic typology</b>   | Increased number of counties with funded programmes for priority populations based on the epidemic appraisal | Proportion of counties with funded programmes for coverage of priority population based on their epidemic typology (example: Counties with concentrated epidemic have funded programmes to reach and saturate key populations, pregnant women and children and PLHIV etc.) | 30%             | 50%   | 100%  | 100%  | 100%  | 100%  | 100%  | 100% | 100%                             | KHIS/ Reports   | Annual    |
|   |  |  |                 |       |       |       |       |       |       |      |                                  |                 |           |
| <b>Reach priority populations with combination prevention interventions</b>   | Increased number of priority populations reached with combination prevention interventions                   | Proportion of individuals reached with comprehensive appropriate combination HIV prevention packages   | 55%             | 58%   | 61%   | 64%   | 67%   | 70%   | 74%   | 77%  | 80%                              | KDHS/ IBBS/ PBS | 5 Years   |
|   |  |  |                 |       |       |       |       |       |       |      |                                  |                 |           |
| Increased number of condoms distributed   | Number of condoms distributed per year   | Age, sex, type of population, county   | 25              | 26.88 | 28.75 | 30.63 | 32.50 | 34.38 | 36.25 | 40   | AYP- 40 FSW- 912 MSM- 336 GP- 40 | KHIS            | Monthly   |
|   | Number of men and boys voluntarily circumcised in priority counties  | Age, county  | 6862            | 6219  | 5575  | 4932  | 4289  | 3645  | 3002  | 2359 | 1716                             | KHIS            | Monthly   |
|   | Proportion of pregnant women who receive at least one ANC services   | Age, county  | 89%             | 90%   | 91%   | 91%   | 92%   | 93%   | 94%   | 94%  | 95%                              | KHIS            | Monthly   |
| Increased number of needles and syringes distributed  | Number of needles- syringes distributed per PWID per month/ year   | Age, sex, population type  | 21              | 28    | 35    | 42    | 49    | 55    | 62    | 69   | 76                               | KHIS            | Monthly   |

| Level of measurement   | Indicator  | Disaggregation   | Baseline (2022)  | 2023   | 2024   | 2025   | 2026   | 2027   | 2028   | 2029   | 2030   | Data Source                         | Frequency |         |
|--|--|--|--|--------|--------|--------|--------|--------|--------|--------|--------|-------------------------------------|-----------|---------|
|  | Increased number of violence reported                                      | Number of survivors reporting cases of violence  | Age, sex, type of violence, county, type of population (KP, Adolescents 10-17 years) | 20%    | 25%    | 35%    | 40%    | 45%    | 50%    | 60%    | 70%    | KHIS, Partner online reporting tool | Monthly   |         |
|  | Increased number of reported violences receive adequate support/ response  | Proportion of survivors linked/provided with psychosocial support, legal, health services)                       | Age, sex, type of violence, county, type of population (KP, Adolescents 10-17 years) | 70%    | 73%    | 75%    | 80%    | 83%    | 90%    | 95%    | 100%   | KHIS                                | Quarterly |         |
|  | Improved health care provider competencies to provide stigma free services | Proportion of counties trained to provide stigma free services   | County, type of facility, type of population   | 50%    | 56%    | 63%    | 69%    | 75%    | 88%    | 94%    | 100%   | Training reports                    | Annual    |         |
|  | Increased number of AGYW receiving contraceptives                          | proportion of AGWY using modern contraceptives   | Age, type of population, county  | 55%    | 56%    | 57%    | 58%    | 59%    | 61%    | 62%    | 65%    | KDHS                                | 5 years   |         |
|  | Increased number of girls in secondary school                              | Proportion of girls in secondary school as per age   | Age, county  | 83%    | 85%    | 87%    | 89%    | 92%    | 96%    | 98%    | 100%   | Economic Survey/ KNBS Census data   | Annual    |         |
| <b>S.A. 3-Strengthen and expand community-centred HIV prevention services</b>  |  |  |  |        |        |        |        |        |        |        |        |                                     |           |         |
| <b>Expected Outcome 3: Community led and owned HIV prevention responses established and strengthened</b>                                   |  |  |  |        |        |        |        |        |        |        |        |                                     |           |         |
| <b>Establish community led platforms</b>   | Establishment of County HIV prevention Communities of Practice             | Proportion of counties with community-based HIV Prevention Communities of Practice                               | County, sub county, population programme type  | 0      | 10%    | 20%    | 30%    | 50%    | 70%    | 80%    | 90%    | 100%                                | KHIS      | Monthly |
| <b>S.A. 4: Promote integration of HIV prevention into essential related services to improve HIV outcomes</b>                               |  |  |  |        |        |        |        |        |        |        |        |                                     |           |         |
| <b>Expected Outcome 4: HIV prevention services are integrated across HIV programmes, health programmes and other non health programmes</b> |  |  |  |        |        |        |        |        |        |        |        |                                     |           |         |
| <b>Building Health care provider competencies</b>  | Improved health care provider competencies in HIV integrated services      | Proportion of health providers trained in integrated service provision   | Age, sex, county, type of programmes   | -      | 83%    | -      | 100%   | -      | 100%   | -      | 100%   | Training reports                    | Annual    |         |
| <b>Integration of HIV prevention services with other sectors</b>   | Increased HIV prevention programmes within non-health sectors              | Number of staff and family members facilitated to access health screening package for HIV, NCD and mental health | Type of sector   | 100000 | 200000 | 300000 | 400000 | 500000 | 500000 | 500000 | 500000 | Partner online reporting tool       | Monthly   |         |

| Level of measurement  | Indicator  | Disaggregation  | Baseline (2022)                                    | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | Data Source | Frequency |
|---|--|---|--|------|------|------|------|------|------|------|------|-------------|-----------|
| <b>SA 5: Institute mechanisms for rapid introduction of new HIV prevention technologies and programme innovations</b>                                     |  |   |  |      |      |      |      |      |      |      |      |             |           |
| <b>Expected Outcome 5: Options and choice of HIV prevention options are available for users</b>   |  |   |  |      |      |      |      |      |      |      |      |             |           |
| <b>Regulatory approvals for new HIV prevention technologies and innovations</b>   | Increased mix of new HIV prevention technologies and innovations receiving regulatory approval in Kenya. | New HIV prevention technologies and innovations licensed for introduction in the Kenya market         | Numbers and type of technologies and innovations   | 1    | 1    | 1    | 1    | 1    | 1    | 1    | 1    | Reports     | 5 years   |
| <b>Demonstration pilots to introduce new technologies and innovations conducted</b>   | Acceptability and cost-effectiveness pilots conducted  | Number of pilots conducted among target populations in Kenya  | Technology type, innovation type, population type  | 1    | 1    | 1    | 1    | 1    | 1    | 1    | 1    | Reports     | Annual    |
| <b>National scale-up of cost-effective technologies and innovations</b>   | Increased access and utilisation of new technologies and innovations in Kenya                            | Proportion of targeted populations utilising new HIV prevention technologies and innovations in Kenya | Age, sex, county, technology type, population type | 1    | 1    | 1    | 1    | 1    | 1    | 1    | 1    | KHIS        | Monthly   |
| <b>S.A. 6: Develop and implement innovative country investment financing approaches for a sustainable HIV prevention response</b>                         |  |   |  |      |      |      |      |      |      |      |      |             |           |
| <b>Expected Outcome 6: Domestic funding allocated for HIV prevention at national and county level</b>   |  |   |  |      |      |      |      |      |      |      |      |             |           |
| <b>HIV Prevention prioritised in County Integrated Development Plans (CIDPs)</b>  | Counties enact bills for ring fencing HIV prevention budget  | Number of counties enacted laws ringfencing HIV prevention within their health budget                 | Counties   | 1    | 5    | 15   | 47   | 47   | 47   | 47   | 47   | CIPDs       | 5 years   |
| <b>S.A. 7: Strengthen national coordination and management of HIV response through multisectoral collaboration and accountability of all stakeholders</b> |  |   |  |      |      |      |      |      |      |      |      |             |           |
| <b>Expected Outcome 7: Mechanisms of coordination and management of HIV prevention response established and operationalised</b>                           |  |   |  |      |      |      |      |      |      |      |      |             |           |
| <b>Operationalise national HIV prevention coordination mechanism</b>  | Improved coordination of HIV prevention response at national level                                       | Number of national HIV prevention committee meetings held at the national level                       | Number   | 47   | 47   | 47   | 47   | 47   | 47   | 47   | 47   | Reports     | Quarterly |
|   | Constituencies represented in national HIV coordination committee  | Constituencies represented in national HIV coordination committee                                     | Constituency type                                  | 0    | 47   | 47   | 47   | 47   | 47   | 47   | 47   | Reports     | Annually  |

| Level of measurement  | Indicator  | Disaggregation  | Baseline (2022) | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | Data Source      | Frequency |
|---|--|---|-----------------|------|------|------|------|------|------|------|------|------------------|-----------|
| Operationalise County HIV prevention coordination structures  | Number of counties with operational multisectoral HIV prevention committees                            | Number  | 0               | 47   | 47   | 47   | 47   | 47   | 47   | 47   | 47   | Reports          | Annually  |
| <b>S.A. 8: Adopt programme science and use data to enhance HIV prevention programme effectiveness</b>                       |  |   |                 |      |      |      |      |      |      |      |      |                  |           |
| <b>Expected Outcome 8: Evidence generated and research conducted and used to embed science in HIV prevention programmes</b> |  |   |                 |      |      |      |      |      |      |      |      |                  |           |
| HIV prevention cascade analysis conducted   | Counties trained to conduct cascade analysis   | Number of trainings   | 0               | 47   | 47   | 47   | 47   | 47   | 47   | 47   | 47   | Training reports | Annually  |
| Programme science policy briefs used to redesign HIV prevention strategies  | Number of counties using programme science policy briefs to revise HIV prevention programme strategies | Number of strategies revised based on programme science policy briefs | 0               | 24   | 47   | 47   | 47   | 47   | 47   | 47   | 47   | Program reports  | 2 years   |
| <b>S.A. 9: Strengthen the HIV prevention programme monitoring and evaluation system</b>                                     |  |   |                 |      |      |      |      |      |      |      |      |                  |           |
| <b>Expected Outcome 9: Routine monitoring data collected and used for decision making in HIV prevention programmes</b>      |  |   |                 |      |      |      |      |      |      |      |      |                  |           |
| Routine data is used for decision making  | Number of county teams trained on data use for HIV prevention  | County  | 0               | 47   | 47   | 47   | 47   | 47   | 47   | 47   | 47   | Training reports | Annual    |
| Data quality audits are conducted   | Proportion of counties conducting HIV prevention Data Quality Audits                                   | County  | 0               | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | DQA report       | Bi-annual |





**NATIONAL SYNDemic DISEASES  
CONTROL COUNCIL**



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