MAISHA HIV AND AIDS CONFERENCE 2019

"Leveraging the HIV Response to Accelerate Impact for UHC"

CONFERENCE REPORT

May, 2019

CREDIT AND ACKNOWLEDGEMENTS

The National AIDS Control Council (NACC) wishes to acknowledge all stakeholders and partners for their contributions towards making the Maisha HIV and AIDS Conference 2019, held between 9th - 10th May, 2019, a great success.

We recognise the Cabinet Secretary, Ministry of Health, Sicily K. Kariuki (Mrs.), EGH, for gracing the conference opening as Chief Guest, and her entire team at National and County level for the support throughout the entire conference period. We also appreciate the commitment from the Council of Governors and its Committee on Health, Parliamentary Health Committee, Senate Committee on Health, and County Executive Committee (CEC) Health members for their active participation and sharing their County experiences and lessons on the HIV response. This indicates the commitment accorded to Kenyan HIV response.

We also appreciate the commitment and contribution of international, national and county level partners, scientists and researchers, policy makers, all implementing and development partners, Networks of PLHIV, the various HIV and AIDS communities, and all the various speakers, presenters, session chairs, and moderators without whom there would be no Conference outcomes to document. To the Exhibitors, Media, Conference Venue, and Conference Rapporteur team, led by Dr Echoka Elizabeth, we say a very big thank you.

We further extend special thanks to the Directors of National AIDS Councils from Member States of the Global Prevention Coalition for extending their stay to share their Country experiences during Maisha HIV and AIDS Conference 2019.

Finally, to the NACC Board, led by our able Chair, Ms. Angeline Siparo, the Conference Chair, the various Working Groups responsible for Pre-conference Meetings and Panel Sessions, and all the Members of both the Administrative and Technical Committees from NACC and partners, who worked tirelessly to put everything together, and without whom this conference would not have kicked off, smoothly.

To you all we say, ASANTE SANA!

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EXECUTIVE SUMMARY

The biennial Maisha HIV and AIDS Conference 2019 in Nairobi, Kenya convened on 9th -10th May by the National AIDS Control Council (NACC) presented a momentous opportunity to highlight the diverse nature of Kenya's HIV response. At the same time, the platform brought together key stakeholders locally, regionally and internationally ranging from policymakers, researchers, programmers, implementing partners and communities from all levels to share emerging evidence and lessons learnt for the Kenya HIV response.

The theme of Maisha Conference 2019 was on *"leveraging the HIV Response to Accelerate Impact for Universal Health Coverage (UHC)"*. This theme was informed by the fact that while the country's HIV response has made significant progress in reducing new annual HIV infections by almost 50% in the life of the Kenya AIDS Strategic Framework; reducing AIDS-related mortality by 25%; and increasing resources in health and HIV, there still exist opportunities for inclusion of HIV as a core component to UHC. Maisha 2019 aimed to address the following key questions:

i. What are the key lessons from the HIV response (in programming, governance, coordination, implementation, stakeholder engagement, community ownership and sustainability) that can be applied to the UHC agenda to accelerate its impact?
ii. What specific opportunities are existing in the HIV response that can be harnessed for the UHC agenda and what needs to be done?
iii. What adjustments are required on our HIV programmes at National and County levels to accelerate progress towards HIV prevention 2020 targets and 90-90-90 targets?
iv. What commitments can key HIV constituencies make towards accelerating progress towards HIV prevention and treatment targets and towards UHC?
v. What are the potential pitfalls in the implementation of UHC for the HIV response, and what are the specific mitigation actions for enhanced program and service delivery?

MAISHA CONFERENCE AT A GLANCE

- 850 delegates from 32 countries
- Representation from all 47 Counties in Kenya
- 17 Panel sessions
- 115 session Chairs, Moderators and Panelists
- One keynote
- Four sponsors
- 6 Pre-conference Meetings:
  1. Adolescents and Young People (AYP) Advocacy Forum
  2. Women Opinion Leaders Forum
  3. National MIPA Forum
  4. County Inter-Faith Chairs Meeting
  5. Joint AIDS End Term Review Meeting on Leadership & Sustainability
  6. Private Sector Service Delivery within the UHC Agenda
- A meeting of Directors of National AIDS Commissions of the Global HIV Prevention Coalition member states.

Key outcomes and deliberations of Maisha HIV and AIDS Conference 2019 addressed the following broad areas, in line with the conference theme:

- Reaching HIV Prevention 2020: What is Needed?
- Emerging Prevention and Treatment Technologies: What is the Future?
- Condom Revolution: Pathways to Change
- Status of HIV Research: Vaccines or Cure?
- Making the first 90 Work
- PLHIV and UHC: What is at Stake?
- Evidence-Based Strategies for Reaching Men

- HIV, Sex, Drugs and Young People
- EMTCT: 8,000 Children Newly Infected – Where Do We Go from Here?
- The Re-emergence of STIs and Hepatitis B
- HIV and NCDs in the Context of UHC
- Private Sector Service Delivery within the UHC Agenda
- HIV, Human Rights, and UHC
- Sustainable Financing for HIV in the Context of UHC
- Scaling Oral PrEP: Kenya's leadership within the UHC Context
- Multi-sector Action and Leadership: Lessons from the HIV Response
- County Leadership for the HIV Response

UHC at it best…A call to Commit to

- Human-centered UHC
- Rights affirming UHC
- UHC with Meaningful Engagement of all Persons and Sectors
- Sustainably financed UHC
- UHC with effective accountability mechanisms
- UHC that is informed by evidence

The Maisha 2019 Conference programme focused on using recent developments to scale up treatment and biomedical prevention efforts, to review of progress and identification of next steps for accelerating HIV prevention and treatment targets and what this could offer to UHC. Repeatedly highlighted during the two-day meeting and in line with the conference theme on "*Leveraging the HIV Response to Accelerate Impact for UHC"*, was consensus that in the case of UHC and the global HIV prevention agenda, it would require certain commitments to attain UHC and accelerate progress towards ending AIDS by 2030:

- A human-centered UHC, one that is centred to the health needs of individuals and communities, rather than focused on diseases;
- An Equitable and Rights Affirming UHC, in that equal access to health will not be achieved without first enabling equitable access to the population groups that are often left behind;
- UHC that meaningfully engages participation of communities and civil societies with focus on equal partnership of government and other partners in designing, implementing, budgeting for, and reviewing health policies and plans that affect us;
- UHC that considers community and civil society participation as an essential;
- An effectively and sustainably financed UHC, with focus on health as a business or investment, with improved health outcomes as the return on investment;
- Accountability mechanisms in that, UHC is implemented in the context of political courage of Governments and an environment of accountability mechanisms: and
- UHC that uses data for decision making, that UHC monitoring should quantify not just inputs, such as individuals enrolled, but also process indicators, such as the utilization and quality of key services, and disease-specific health outcomes, including for HIV, NCDs and other co morbidities.

Key Recommendations from Maisha Conference 2019

I.) HIV

HIV prevention

- Develop and implement combination interventions packages underpinned by evidence, community involvement and that are human right based for effective HIV prevention
- Political leadership to move beyond political commitments to courage in addressing the challenges and structural barriers that hinder HIV prevention
- Advocacy on HIV Prevention be strengthened through learning and capacity building to communicate effective advances in prevention re-search, and support research and development as a critical part of

the HIV and AIDS response

- Targeted testing including self-testing modalities be enhanced, especially among men and universal HIV Testing Services for PMTCT
- Male interventions to be tailored to the needs of men to maximize uptake, including reaching them at their places of work, flexible hours, multiple follow up visits, and convenient and private access to care
- Potential of Private public partnership (PPP) be harnessed for cost-effective local production of HIV related commodities including condoms
- Upscale the promotion, demand creation, correct usage and disposal of condoms to reach all populations including communities in rural set ups.

Treatment and Prevention Technologies

- Advocacy, demand creation and literacy on PrEP be strengthened
- Research agenda prioritisation of efforts to identify an effective vaccine and/or cure for HIV and AIDS. Both are crucial in responding to the burden of HIV globally and advancing the UHC agenda.

Adolescents and Young People

- Young people be actively and meaningfully engaged in the design and delivery of interventions on HIV and other relevant health programmes.
- Address the low knowledge among adolescent and young people through peer-to-peer engagement, capitalizing on social media and related technologies to provide HIV and sexual and reproductive health information among other interventions.

PLHIV and Emerging Issues

- National Health Insurance Fund (NHIF) be repositioned to include HIV treatment as part of the health insurance package for predictability and sustainability of treatment services for Persons Living with HIV (PLHIV).
- Integrate NCDs and HIV interventions by jointly addressing common issues such as supply chain, human resources, referral systems, patient education, addressing stigma, and monitoring and evaluation.
- Real-time information on NCDs be made available to guide decision making at national and county levels to facilitate prioritisation in re source allocation.
- More attention to be paid on HIV and NCD comorbidities as an emerging research priority.
- The research agenda to prioritise HIV and NCD comorbidities.
- Address gaps in supervision, reporting and mentoring on STIs and Reproductive Health programmes.

Governance, Leadership, Financing and Sector Engagement

- Institutionalize policy instruments for managing the private sector, including regulatory mechanisms for licensing, certification and accreditation of health workers, medical products, services and facilities which lack in low and middle-income countries.
- Lessons learnt in innovative financing, resource mobilization strategies and efficiency of HIV Programmes be documented and used in lever-aging UHC, while leveraging on strong political stewardship.
- Counties to adopt a *"business model"* approach with a focus on improved HIV and health programme outcomes as the return on investment in the design of HIV and UHC Programmes.
- Partnership Accountability Framework be developed and implemented to track results and re-sources utilised.

II.) UNIVERSAL HEALTH COVERAGE (UHC)

There are existing opportunities within the HIV response that can be leveraged on for the success of the UHC program. During the Maisha HIV and AIDS Conference 2019, these opportunities were identified as follows:

- Refocusing the HIV response using the UHC framework to address some of the key short-comings in the response so far, involving greater attention on promoting health equity, improving the quality of services, ensuring financial and social security, strengthening health and community systems, building coherence across different health programmes, addressing the social and economic determinants of HIV related burden and guaranteeing human rights.
- UHC could offer the possibility of integrated services to holistically address the health needs of various populations and further harness the opportunity to strengthen primary health care and deployment of appropriate strategies and interventions taking into account the rising impact of HIV related comorbidities.
- Opportunities for UHC in affirming rights of those traditionally left behind inservice provision and access, by providing a pathway to ensuring that rights of access to quality services for all population groups are not hindered.
- UHC to draw lessons from the HIV Programme on strong political stewardship, multi-sectoral engagement, innovative HIV financing, resource mobilization strategies and efficiency to scale-up and improve service delivery.
- Lessons learnt from the HIV multi-sectoral approach by building capacities and creating an enabling environment for all sectors beyond health for effective service delivery.
- Opportunities exist for NCDs and UHC to leverage on the HIV programme to provide current strategic information at all levels through the use of existing Monitoring and Evaluation System and estimation and modelling capacities

1.0. INTRODUCTION

1.1. Context

Significant progress has been made in the Kenya HIV response with the current prevalence being at 4.9% (15-49 years); a total number of 1,493,400 PLHIV; 52,800 annual new HIV Infections; 28,200 annual AIDS related deaths; ART Coverage at 75% among adults and 84% among children. However, there remains paucity of data on HIV stigma reduction. Despite the progress made, there is realization that Kenya will not reach her Prevention 2020 targets and her 90-90-90 goals unless there are adjustments to programming at the service delivery level.

HIV and AIDS in Kenya (2017)

- 1,493,400 PLHIV
- 4.9% prevalence for adults (15-49 years)
- 52,800 Annual New HIV Infections
- 28,200 Annual AIDS Related Deaths
- 75% Adults on ART; 84% Children on ART

Source: 2018 Kenya AIDS Response Progress (KARP) Report

Such adjustments must be accompanied by joint stocktaking exercises by Government (National and County), development and implementing partners and key constituencies such as the faith sector, women opinion leaders, persons living with HIV and the private sector, that address the challenges related to policy, technical and operational programming, as well as those related to accountability, governance and sustainability of the HIV response. Critical issues of consideration for the HIV response are the implications of the scale-up of Universal Health Coverage, a key priority of the Kenyan Government and the African region. This means there are lessons to learn from other Countries in the region through a South to South collaboration that can be leveraged on to promote the impact of UHC, but also, very importantly, accelerate HIV incidence reduction, which remains the most sustainable cost-containment strategy for the HIV response. Thus, as the Kenya AIDS Strategic Framework 2014/15 – 2018/19 comes to its end and a new national strategy initiated in the coming financial year, it must be articulated within the context of UHC.

1.2. Maisha 2019 Conference structure

The biennial Maisha HIV and AIDS Conference held at the Kenya School of Monetary Studies in Nairobi, Kenya on 9th - 10th May, 2019 by the National AIDS Control Council brought together delegates from more than 32 countries and representation from all the 47 counties in Kenya. Nearly 850 participants attended this biennial conference, which serves as the premier gathering for those working in the field of HIV and AIDS, including scientists, health care providers, policymakers, people living with HIV (PLHIV), and other stakeholders committed to ending the HIV epidemic.

OBJECTIVES OF MAISHA 2019

i. To review progress and identify next steps for accelerating HIV prevention and treatment target attainment
ii. To identify lessons, opportunities and critical drivers for the HIV response that can be used to accelerate UHC targets
iii. To identify specific actions by different constituencies in the HIV response that can be leveraged to accelerate UHC
iv. To identify potential challenges for HIV programming in the scale-up of UHC and propose mitigation measures for achievement of UHC

The 2019 Conference, whose theme was *"Leveraging the HIV Response to Accelerate Impact for UHC"* was unique in structure and organization. First, six Pre-conference forums and meetings featuring Adolescents and Young People (AYP) Advocacy Forum; Women Opinion Leaders Meeting; National MIPA Forum, County Inter-Faith Chairs' Meeting; Joint AIDS End Term Review Meeting on Leadership

& Sustainability; and Private Sector Service Delivery within the UHC Agenda were convened and contributed directly to conference's key outcomes and recommendations. The conference also saw a shift from the usual abstract driven presentations to 17 panel sessions organized along key thematic areas aligned to the conference theme. Finally, two days prior to the conference, Directors of National AIDS Commissions of the Global HIV Prevention Coalition Member States met, and were subsequently incorporated into the Conference to share Country experiences and best practices.

1.3. Maisha 2019 Programme at a Glance

The Maisha 2019 Technical and Administrative Teams constructed a balanced and representative conference programme for the benefit of both delegates and the wider community of HIV prevention stakeholders. The conference featured mainly panel discussion-driven sessions, a variety of presentations within panel sessions, a keynote presentation and the Pre-conference Meetings' recommendations.

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2.0. SETTING THE STAGE

The Conference opening ceremony was presided over by the Cabinet Secretary (CS) of Health, Sicily K. Kariuki (Mrs) EGH. She made reflections on lessons that can be drawn on the HIV response, that can apply to UHC: First, the power of common purpose, with clearly articulated goals and priorities against which the entire world and countries commit. It is this focus, common purpose and pulling together that the UHC agenda can draw lessons from. Second, is the power of a multi-sectoral response, whose application has included collaboration for specific actions between the HIV response players and other identified sectors; and third is on the use of data and research results for decision making. While appreciating that research remains key in the breakthroughs of HIV prevention and control, she pointed out that it is the power to turn-around these results into policy and practice at scale that makes a difference. She added that these reflections cannot be complete without recognizing the value of investments in community action. In particular, the communities of PLHIV, who have been at the forefront of pushing the agenda. The CS also pointed out that the Ministry of Health recognizes that for UHC to become a reality, these gains must be safeguarded. She concluded by urging all partners, researchers, health practitioners and students to make the necessary resource investments to gaining new knowledge that would push towards the HIV Response goals.

Other opening remarks were made by representatives of PEPFAR, UNAIDS and Civil Society Organizations. As in previous Maisha Conferences, there was experience sharing on HIV and NCDs, not only in the opening but also at cross-sections of panel sessions. The opening session also featured a keynote presentation by Prof. Mark Dybul, Georgetown University, USA, on UHC and HIV: Global Perspectives, Challenges, Opportunities and the Future, describing new and noteworthy initiatives relevant to the conference theme.

> *For the first time I stand here a proud cabinet secretary because I have seen the largest increase in terms of our national budgeting directed at the ministry of health and the programs around health. .... Quality of health services will remain key the primary driver of UHC success. However, the legacy of UHC will be determined by our ability to prevent new infections and diseases both for quality of wellbeing of Kenyans and as the most effective cost containment strategy. I therefore invite the Counties, to take the deliberations from this conference and apply what works*
>
> ***Sicily K. Kariuki (Mrs), EGH, Chief Guest, Cabinet Secretary, Health***

Ms. Angeline Siparo, the NACC Chairperson, in her opening remarks made reference to the tremendous gains in unique areas through multi-sector action; ART coverage improved with 1.2 Million on lifelong medication, AIDS related deaths reduced by 25% against a target of 25% by 2020, and annual new infections reduced by over 50% from 101,000 in 2013 to 46,000 in 2018.

"... NACC has continuously been a critical part of the HIV Response. We are devolved, offering HIV services in 18 regions covering all the 47 counties thereby enhancing health systems at the grassroots. We have engaged different constituencies, strengthened collaborations, mobilized resources and maintained a robust stakeholder programme to bring Kenyans closer to these health services".

Ms. Angeline Siparo, Chairperson, NACC

The Conference Chair, Dr. Josephine Kibaru-Mbae, CEO, National Council for Population and Development (NCPD) provided an overview of the Conference, outlining the structure of the Conference and what the delegates were to expect over the two days.

Dr. Josephine Kibaru-Mbae, CEO, NCPD

- ***Power of multisectoral response and the need to safeguard gains made…***

The great gains as a result of multi-sectoral action was echoed by the NEPHAK representative, Mr. Nelson Otwoma, who spoke of the key lessons the UHC can learn from the HIV response. She further indicated that the response recognised that HIV is not solely a biomedical issue, but requires other sectors. Sicily K. Kariuki (Mrs.), EGH, the Cabinet Secretary (CS), Health, and Chief Guest, in her opening remarks also reflected on the power of a multi-sectoral response, emphasizing the need to engage all partners in a multi-sectoral approach to achieve UHC goals.

One of the lessons UHC movement can learn is that HIV went multi sectorial, with recognition that HIV is not solely a biomedical issue but requires other sectors...

Mr. Nelson Otwoma, NEPHAK

- ***Power of multisectoral response and the need to safeguard gains made…***

"Promoting UHC as a way to prevent HIV, and treat those who are already living with HIV, provides the best shot at simultaneously achieving multiple goals". These were the words of the PEPFAR representative, Dr. Tamu Daniel, while lauding Kenya for having one of the most successful PEPFAR country programs which was attributed to the leadership and partnership of the Government of Kenya. She raised the need to create a stronger partnership between HIV and the UHC agenda, adding that this has greater potential to

drive the change that is needed to achieve the 2030 Agenda's health goals and targets. Delegates were reminded that marginalized groups are more vulnerable to HIV infection, which means there is a need to urgently scale up prevention, testing and treatment services for these groups. She added that time to integrate HIV services into UHC is ripe, and that by improving UHC, it simultaneously addresses the needs of women that may otherwise go unseen. Echoing these sentiments, the CS, Health, raised the need to define the packages of curative, preventive and promotive health that must be integrated into UHC in order to move closer to realizing our goals for health security and self-sustaining health care

Kenya has been one of the most successful PEPFAR country programs and this is because of the leadership and partnership of the GoK…If approached strategically, UHC can significantly benefit people living with and affected by HIV. Both UHC and the AIDS response share common goals around equity, non-discrimination, dignity, and social justice...It is time to integrate HIV services into UHC and make good on the 'health for all' promise. Together we changed the course of an epidemic, now it is time to change the system so that no one is left behind

Dr. Tamu Daniel, PEPFAR, Kenya

- ***Rising impact of NCDs and comorbidities complicating long-term HIV requires urgent attention…***

While positive gains in the Kenya HIV programme have been witnessed; ART coverage improved, AIDS related deaths reduced, and a decline in annual new infections, the complex association of HIV with a host of other comorbidities and conditions in the era of effective therapy for HIV was highlighted.

The NEPHAK representative, Mr. Nelson Otwoma reminded delegates that it is not just PLHIV who need to be brought on board and sensitized on UHC, but also those affected by NCDs. He highlighted one of the reflections from the Pre-conference Meetings that HIV is a lifelong condition. It means the moment one tests positive, they will be on lifelong treatment. He made reference to young people aged as young as 12 years on lifelong treatment and who desire to live up to age 90. They not only require HIV services but all others that UHC encompasses, noting that one can be virtually suppressed yet another condition like NCD kills them. This calls for the need to strengthen primary health care and deployment of more complex strategies and treatments that recognize the rising impact of comorbidities complicating long-term HIV infection. This sentiment was reflected in a moving story by Ms. Sally Agallo who shared experiences of her journey battling HIV, a host of co-infections and cancer. She noted that stigma and discrimination is still a barrier and the need for a psycho social support system to ease the burden of those battling HIV and NCDs. She expressed her desire to see better quality of life for PLHIV with NCDs, with more investments in prevention programmes and not just

As we concentrate on HIV prevention and treatment, which has been well funded, with a lot of focus and attention, let us not forget NCDs..I was diagnosed with HIV in 1999 after losing two babies…I went into deep depression following pain that came with opportunistic infections: TB, Herpes Zoster, Pneumonia, Cytomegalovirus and skin rash...I was initiated on ART in 2003 and I have religiously taken them to date… Just when I thought I was done with the pain of HIV diagnosis, I was diagnosed with stage II Cervical Cancer. This was the beginning of a long, rough and uncertain journey...

Ms. Sally Agallo, NEPHAK

curative. She lauded NACC on leading the way on meaningful engagement by providing a rich platform for PLHIV to share their views as well as participate effectively in the HIV response.

- ***More is needed towards sustainable financing for HIV and UHC…***

We are standing at a critical crossroads of the response to AIDS where on one hand we have lots to celebrate but also have a long way to go and cannot afford to be complacent…Our response in many countries stands in a fragile footing of international funding which remains the major challenge for us. The discussions on UHC which are taking place here in Kenya are providing us a golden opportunity to ensure sustainability of the AIDS response. The target of achieving UHC is ambitious but if met it could be an important step towards ensuring that all people have good health and the HIV services are available for everyone who needs them.

Dr. Catherine Sozi, UNAIDS

The UNAIDS Regional Director, Eastern and Southern Africa, Dr. Catherine Sozi, speaking during the opening ceremony made note that it is essential that efforts to achieve UHC include a fully funded AIDS response; strong community engagements, including building on the gains on the human rights and gender equality made by PLHIV and key and priority populations. The NEPHAK representative speaking on the same subject made an appeal to the Ministry of Health to reposition NHIF to include HIV treatment as part of the package because PLHIV need treatment that is predictable and sustainable, and the need for more funding for HIV and UHC and that this should come from government. The PEPFAR Coordinator in Kenya raised the need to mobilize resources and align investments. She further noted that while the UHC agenda can help mobilize new health funding from domestic and private sources, UHC and HIV financing plans must be well aligned for efficiency and sustainability. In the same tune, the CS Health noted that the Country's commitment to UHC targets has had corresponding commitments in resources from the National Treasury. She spoke of having witnessed the largest increase ever in terms of National budget directed at the Ministry of Health and the programs around health. On the request put forward by the NEPHAK representative, the CS made a commitment to a purposeful and determined journey of repositioning NHIF as the primary provider of health insurance. The repositioning is geared towards making NHIF responsive to the current needs, including anchoring UHC around an insurance-based process. She called on the delegates and other stakeholders to champion this course by providing input on the Public Engagement Portal: NHIF Reform Towards Attainment of UHC in Kenya (www.mohnhifreforms.com) towards repositioning NHIF. The CS added that quality of health services remains key as a primary driver of UHC success and that the legacy of UHC would be determined by our ability to prevent new infections and diseases, both for the quality of wellbeing of Kenyans as well as the most effective cost containment strategy.

- ***Data use and research for decision making for UHC is critical…***

Critical analysis of routine data for continued decision making and use of research results for policy formulation as key towards scale up and sustainable UHC delivery was highlighted by the CS Health. She pointed out that while research remains key in the breakthrough of HIV prevention and control, it is the power of the players in the sector to turn-around these results into policy and practice at scale that makes a difference. Speaking on behalf of the CoG Health committee, Dr Andrew Mulwa acknowledged that County participation in research as well as monitoring of programmes must be promoted during implementation of the County AIDS Strategic Plans. He pointed out the critical need to invest in data and information management at grassroots, and capacity building towards costing and prioritization of the HIV Strategic plan. He made a commitment as part of the Council of Governors (CoG) leadership to continually

provide requisite support to guide in the planning, implementation and monitoring of HIV and health programmes and assured that the lessons learnt in the HIV response will be used to deliver quality programmes within the UHC agenda.

As part of the UHC Program, investments have been made and will continue to be made to ensure the provision of quality health services in all the 47 counties, thereby ensuring that no one is left behind….We also know that we must supplement national level resources to deliver a model that will ensure sustainable financing for Health. All these are critical lessons, which I am certain will also apply to UHC delivery at county level.

Dr. Andrew Mulwa, COG

- ***UHC and HIV: Global Perspectives, Challenges, Opportunities and the Future***

Professor Mark Dybul, Georgetown University, USA, in his key note address restated that it is impossible to achieve UHC without dealing with HIV. That without reductions in HIV prevalence, there is zero hope for UHC because the high burden of new HIV infections and ART burden would destroy any hope of being able to provide UHC. He made reference to the remarkable tension between HIV and UHC being a reality. He highlighted the need to maximize synergies in order to overcome these tensions by capitalizing on HIV investment where billions of dollars have already been spent in the last 15 years on building HIV infrastructure, health workforce, procurement, supply chain to logistic systems, and data systems. These are systems that UHC can integrate into, and planning for transition and sustainable financing is critical for both UHC and HIV.

Build on the HIV investment: Billions of dollars have been spent on the HIV response in the last 15 years on building of HIV infrastructure, health workforce, procurement, supply chain to logistic systems, data systems. Those systems are not HIV systems those are health systems and if we integrate properly and use those systems those are UHC systems and so building off and using those systems, we can absolutely use the investment for UHC, not just for HIV.

Prof. Mark Dybul, Georgetown University, USA

3.0. MAISHA 2019 CONFERENCE OUTCOMES

Key highlights and outcomes within each of the 17 panel sessions are presented along the four key conference broad focal areas: HIV prevention and Treatment; HIV in the context of UHC; Leadership, Accountability and Sustainability of the HIV Response; and HIV and Emerging Co-Morbidities.

3.1. HIV PREVENTION AND TREATMENT

3.1.1. WHAT IS NEEDED TO REACH HIV PREVENTION BY 2020

Moderator: Wanjiru Mukoma, LVCT Health, Kenya and Clemens Benedikt, UNAIDS, Switzerland
Panelists: Catherine Sozi, UNAIDS, South Africa; Rahab Mwaniki, KANCO, Kenya; Susan Njau, Directorate Youth Affairs, Kenya; Matteo Cassolato, Frontline AIDS, UK; and Elizabeth Bukusi, KEMRI, Kenya.

While Kenya is widely regarded as one of sub-Saharan Africa's HIV prevention success stories, some challenges and gaps exist in accelerating HIV incidence reduction towards achieving 2020 HIV prevention targets. Dr. Celestine Mugambi, NACC, highlighted what is needed to be addressed to reach HIV prevention by 2020[1]:

- Inadequate basic information on HIV Prevention which is suboptimal in specific populations, specifically among the AYP
- Stigma and discrimination
- Harmful cultural practices that still impede prevention efforts (gender inequality, SGBV, early childhood marriages)
- Community and structural sides of prevention are still left behind
- Culture and religion: Sex remains a taboo
- A shift from silo approach to HIV programming to intergration
- Data not measuring what matters, including inadequate disaggregation, poor analytical capacity and data use, poor feedback mechanisms to relevant stakeholders, and silo approach to data analysis and use.

"HIV spread is linked to certain patterns of human behaviour. HIV is a social problem and not a medical one- therefore a medical solution alone for a social problem will not work..... a biomedical response aimed at rapidly scaling up testing and treatment is essential but will not be sufficient to control the epidemic..."

Dr. Celestine Mugambi, NACC

She spoke of the need to rethink HIV prevention, and this would require a shift from political commitment to political courage to address sensitive political issues and structural barriers surrounding HIV prevention; and leadership in mobilizing adequate domestic funding of HIV prevention programmes.

[1] Celestine Mugambi, NACC: Accelerating HIV incidence towards achieving 2020 HIV prevention targets: What Policy and programmatic shifts are needed?

Professor Quarraisha Karim, CAPRISA[1] , South Africa spoke of inadequate programme penetration for key populations, and ongoing high burden of HIV in adolescent girls and young women as a barrier in what has driven success and the most critical lessons learnt for sustaining reductions in new HIV infections.

She presented evidence showing cycle of HIV transmission in teenage girls is mainly from men in their 30s, and which shows the need to break the cycle of HIV transmission by targeting adolescent girls and young women and their male partners.

Current thinking on tackling the recalcitrant African HIV epidemics

Option 1: Do more and better with what we have

Option 2: Wait for a vaccine and a cure

Option 3: An idea to disrupt current thinking and approaches that:

- Breaks the treatment vs prevention dichotomy through a single intervention for both
- Move HIV care out of health care institutions to the household in the community
- Create a new equality to break the difficult problem of stigma, with an intervention that is agnostic to HIV status.

Prof. Quarraisha Karim, CAPRISA

3.1.2. MAKING THE FIRST 90 WORK

Session Moderator: Mary Mugambi, NASCOP, Kenya and Judith Lusike, CHAI, Kenya
Presenters: Joyce Wamicwe, NASCOP, Kenya; Winnie Nzioka, AMREF Kibera, Kenya; Moraa Kiangoi, Leleshwa Pharmacy, Kenya
Panellists: Jonathan Mwangi, CDC, Kenya, Richard Muga, Homabay County, Kenya, Lillian Otiso, LVCT, Kenya, Daniella Munene, PSK, Kenya, Churchill Alumasa, DISCOK, Kenya

The 90–90–90, is an ambitious treatment target to help end the AIDS epidemic. The narrative is that by 2020, 90% of all PLHIV will know their HIV status, by 2020, 90% of all people diagnosed with HIV will receive sustained antiretroviral therapy, and by 2020, 90% of all people receiving antiretroviral therapy will have achieved viral suppression[2] .The tone for the panel session on making the first 90 work was set by Dr. Joyce Wamicwe, NASCOP, who gave a synopsis on HIV testing services in Kenya[3] .While Kenya's first 90 is currently at 71%, there is realization that the other 90-90 goals may not be realised unless there are adjustments to programming at the service delivery level. While HTS has become a major feature of Kenya's HIV response, more than half (53%) of the 1.6 million PLHIV in Kenya are unaware of their HIV status, and may not receive lifesaving treatment if they are unaware that they are HIV positive. This shows the need to change tact in getting to the last mile of the first 90 in Kenya.

[1] What has driven successes and are the most critical lessons we have learnt for sustaining reductions in new HIV infections. Quarraisha Karim, CAPRISA, South Africa
[2] UNAIDS, 2017. 90–90–90 - An ambitious treatment target to help end the AIDS epidemic https://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf
[3] HIV Testing Services in Kenya, Dr Joyce Wamicwe, NASCOP

Making the First 90 work

- Future casting of HTS through targeted testing – mainly index testing driven through provider-initiated testing and counselling (PITC)
- Increased self-testing modalities – for self-screening
- HTS for PMTCT would still need to be universal if eMTCT is to be achieved; and
- Roll out of case-based surveillance and incorporation of recency in the national HTS algorithm.

Dr. Joyce Wamicwe, NASCOP

Another presentation by Winnie Nzioka, AMREF[1], highlighted some challenges in HTS sites and innovative interventions to address them. Challenges in accessibility of data where the volume of files needed on site and the number of documents within those files take up space quickly; lack of security/ confidentiality of clients' records; data inconsistency/duplication and loss of data were highlighted. One innovative intervention to address these challenges is a shift from paper to card. P-SMART is a Health Smart Card-based system designed to allow storage and portability of clinical information for the purpose of continuity of care between providers. Smart cards are issued to clients and are expected to be presented during every visit to the health facility during service delivery. The system is designed to be implemented together with EMRs/HTS mobile applications. P-SMART has an advantage in that unnecessary pricking is eliminated, improves confidentiality, reduces waiting time, and provides convenience compared to a paper card. Elsewhere, it is documented that several gaps in HIV testing coverage exist, particularly among adolescents, the least educated, and men. While the need to target demographic groups at greatest risk of HIV continues, additional interventions focused on reaching men and on reaching socially vulnerable populations such as adolescents, those of low socio-economic status, and the least educated are essential. Additionally, expansion of HTS, outreach through mobile clinics, home-based and self-testing, broad coverage through outreach campaigns, community-based approaches, and an integration of opportunities to be tested during regular medical care are key[2].

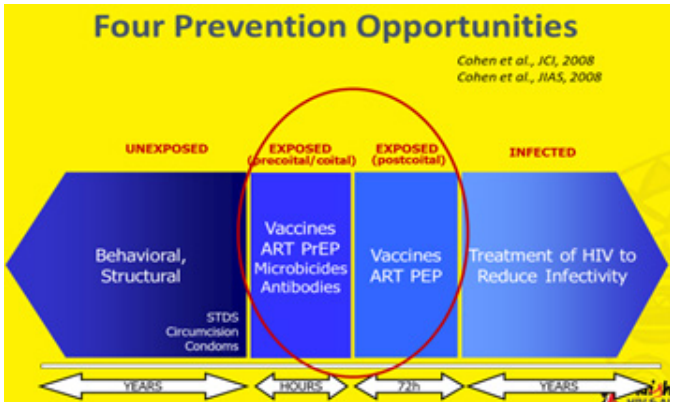
Summing up… More innovative and effective ways of making the first 90 Work

- Optimize program data to use it effectively. Program data analysis will identify areas/issues that need to be addressed and the manner in which that will be done.
- Need for more effective ways to encourage the men to get tested.
- Control the quality of service in the private sector
- Move from mass testing to other ways that will ensure accurate representation of data.

[1] Innovative Data Solution Strategies Through e-HTS, Winnie Nzioka, AMREF
[2] Staveteig, S., Croft, T. N., Kampa, K. T., & Head, S. K. (2017). Reaching the 'first 90': Gaps in coverage of HIV testing among people living with HIV in 16 African countries. PloS one, 12(10), e0186316. doi:10.1371/journal.pone.0186316

3.1.3. THE FUTURE OF EMERGING PREVENTION AND TREATMENT TECHNOLOGIES

Session moderator: Kenneth Ngure, JKUAT/IAS, and Jordan Kyongo, LVCT Health, Kenya
Panelists: Nelly Mugo, KEMRI, Kenya, Lilian Otiso, LVCT Health, Kenya, Peter Okoth, Jaramogi Oginga Odinga Teaching and Referral Hospital, Kenya, Mercy Mutonyi, Bar Hostess and Empowerment Support Programme (BHESP), Kenya, Florence Anam, MSF Africa, South Africa, Abednego Musau, JHPIEGO, Kenya.



In this session that focused on why new prevention and treatment technologies are needed, there was consensus that these tools and new technologies need to work with, and complement, existing prevention methods. Two presentations by Dr. Nelly Mugo, KEMRI , and Dr Irene Mukui, NASCOP set the tone for the panel discussion. It was clear that new prevention opportunities existed, and new prevention technologies are needed that allow conception, that individuals have more control of, those that do not form a physical barrier, those that people don't have to remember to use daily, are easy to use and have options to choose from, drawing lessons from contraceptives. As more options become available, there is need to understand user needs and preferences and preparations needed for new technologies. Some lessons that can be drawn from PrEP include having guidelines, protocols, job aids; pharmacovigilance systems; capacity building of providers; communication, advocacy and demand creation; setting up supply chain systems; laboratory monitoring systems; data systems; quality assurance systems; addressing regulation/registration mechanisms. The guidelines must address how to assess risk or who needs a product; how to match options with individual needs; how to support adherence, manage risk compensation, retention; how to manage side effects for clinicians and consumers; and how to communicate about efficacy and effectiveness.

Summing up… Future of Emerging Prevention and Treatment Technologies

- Effective HIV prevention will require complementary approaches: ensuring a significant increase in access and uptake of existing prevention tools with proven efficacy, developing new prevention tools, and addressing the socio-economic, political and cultural structures that increase vulnerability.
- Advocates have an important role to play in learning about and communicating advances in prevention research, and supporting research and development as a critical part of the HIV and AIDS response. Advocates can also work to ensure the inclusion of the voices of all stakeholders, particularly those communities most affected by HIV and AIDS, in discussions around prevention research.
- Creating access is critical and requires responding to:
  a. What are the service delivery channels?
  b. What level of expertise is needed to deliver the products?
  c. To what level can product be available?
- Products need to be usable by and have most impact among the most vulnerable or in need populations (DTG)
- Continued evolving advocacy, communication and demand creation

[1] What is New? What is next? A quick overview of the Prevention Pipeline by Prof. Nelly Mugo, KEMRI
[2] Adoption & Uptake of New Technologies: What is Required, what is Possible and What Preparations are Needed? Irene Mukui, NASCOP

3.1.4. STATUS OF HIV RESEARCH: VACCINES OR CURE?

Session Chair: Gloria Omosa-Manyonyi, University of Nairobi, Kenya and Stanley Luchters, Aga Khan University, Kenya
Panelists: Prof. Walter Jaoko, KAVI, Kenya, Sam Kalibala, Population Council, Kenya, Jane Ng'ang'a, KAVI community engagement staff, Kenya

Professor Walter Jaoko, KAVI[1], Kenya, set the pace for the panel session on Status of HIV Research. He noted that globally, approximately 40 Million PLHIV and despite current treatments, 1.2 million die yearly from AIDS-related complications. He reminded delegates that in addition to HIV treatment still being beyond reach for many, drug resistance and side-effect is still a problem. He made it clear that HIV cure is needed because latent HIV reservoir is an obstacle in achieving cure. Approaches to HIV Cure Research include going after the hidden HIV reservoir - "shock and kill"; Agents activate latent HIV, then ART kills; Double vaccine - one stimulates, then one blocks; Immunotherapy (supercharge immune system); and Gene therapy to edit CCR5 gene.

Some hope that HIV cure is possible

- Mississippi Baby – ART at birth, apparent cure
- Johannesburg Baby – ART at birth, apparent cure
- Berlin Patient – after bone marrow transplant
- London Patient – after stem cell transplant
- Stem cell donors in both cases had mutated CCR5 allele

Speaking on the same subject Dr. Sam Kalibala, Population Council[2], noted that PrEP can be used as a surrogate for Vaccine and Treatment as Prevention (TasP), as a surrogate for cure, and can also be used to learn translation lessons as we prepare for success of vaccine and cure discovery. He added that while lessons from recently discovered HIV prevention and treatment tools are promising for vaccine and cure preparedness, scientists still need to engage stakeholders in order to translate the discovery of a vaccine or cure into public health benefits.

Speaking on the role of the community in HIV research, Jane Ng'ang'a[3], KAVI highlighted the need to create a new paradigm for community engagement. There is need to recognize that health systems have a fundamental responsibility and obligation to engage with patients, their families and local communities, leveraging on both concerns and priorities of communities. In addition, community members desire to acquire research literacy such that they are in a position to understand research terminologies. Research literacy prepares community members for collaborative work with academic researchers, and empowers them to utilize scientific research methods to create social change in their communities. The translation of findings from the bench to the community such as the discovery of a HIV preventive vaccine or cure, into population level benefits, is going to require strategies for overcoming client- and program-related obstacles. Therefore, a scientific research agenda is needed to provide the answers to pertinent UHC questions in pursuit of UHC achievement.

[1] HIV Research: Vaccines or Cure? Prof Walter Jaoko, KAVI, Kenya
[2] Effective Translation of Research to Policy and Practice: What Needs to Get Done? Learning from what we have, to prepare for a vaccine or cure, Dr Sam Kalibala, Population Council, Kenya.
[3] Role of Community in HIV Research, Jane Ng'ang'a, KAVI, Kenya

Summing up…. Vaccines or cure?

- Overall, vaccines are the best prevention strategy while a cure remains the best treatment strategy. Both are essentially very crucial in responding to the burden of HIV globally and advancing the UHC agenda even as we focus on strategic advances in vaccination and cure interventions.
- Translation of the discovery of a HIV preventive vaccine or cure into population level benefits is going to require strategies for overcoming client- and program-related obstacles.
- Researchers and decision makers should enhance current efforts to discover a preventive vaccine or cure.
- Researchers are called upon to engage with stakeholders from inception, design and conduct implementation science studies on PrEP. Engaging stakeholders, from inception and throughout the studies healthy towards promoting translation of research into practice and policy.

3.1.5. EVIDENCE-BASED STRATEGIES FOR REACHING MEN

Session chair: Samuel Kalibala, Project SOAR, Palladium, Kenya
Panellists: Jerry Okal, Project SOAR, Population Council, Kenya; Scott Geibel, Project SOAR, Population Council, Kenya; Dr Kinuthia, Kenyatta National Hospital, Kenya; Abednego Musau, Jilinde Project, JHPIEGO, Kenya.

The panel session focused on sharing experiences on effective interventions for engaging men. Three presentations on evidence-based strategies for engaging men opened the floor for discussion about the policy/programmatic implications as well as consensus building on research gaps that need to be addressed towards closing the gaps on reaching men in HIV prevention. Abednego Musau, JHPIEGO[1] shared experience from a study to demonstrate an effective model for scaling up oral pre-exposure prophylaxis (PrEP) as an HIV-prevention intervention in low-resource settings. The intervention leveraged on existing service platforms already reaching men, where PrEP was integrated through drop in centers, public health facilities, private health facilities, outreaches, and community safe spaces. He shared key lessons on PrEP delivery for men in Kenya:

- Men initiating PrEP as part of Kenya's national scale up report high risk behaviors; Suggests recruitment approaches are reaching men that will optimally benefit from PrEP
- Integrate user-centered approaches e.g. segmentation and human centered design to develop effective demand creation interventions
- Wide-scale routine eligibility screening for men to optimize coverage of PrEP among men
- Access through multiple channels presents opportunities for interventions to further expand PrEP access/uptake
- Address insensitivities and inefficiencies in primary care facilities, which are disincentives for uptake of PrEP among men
- Positive reinforcement, affirmation and empathetic providers increase self-efficacy, especially among young men

Site-level pre-requisites for PrEP delivery[1]

- Competently trained providers and sensitized facility staff
- A conspicuously mapped PrEP delivery pathway
- Continuous demand generation - user-driven approaches preferable
- Reliable and adequate commodities and tracking
- A client record management and reporting system – preferably an electronic system
- Continuous quality review and improvement mechanisms
- Adherence support mechanisms

Dr John Kinuthia, KNH, shared findings of a study to understand how home-based antenatal couple education and HIV testing intervention influences male partner follow-up to clinic-based HIV and STI services (HIV and STI care and treatment, medical male circumcision). The study concluded that one-

[1] Reaching Men with Oral Pre-exposure Prophylaxis (PrEP), Abednego Musau JHPIEGO, Kenya

Barriers to linkage men to ART services[2]

- Privacy/ confidentiality
- "Busy" schedules
- Change of residence
- Transfer of workstation
- Competing priorities
- Clinic operating time

time home-based couple education encouraged men to seek clinic STI treatment. However, men identified as HIV positive in home-based testing may require specific outreach for linkage to HIV care and treatment[1]. In another presentation, Dr Jerry Okal, Project SOAR/ Population Council, shared on key lessons on engaging men in HIV services . One of the lessons is that while repeat testing is common among men who access HTS, there is need to address barriers/delay in linkage to care. The vast majority of first-time and repeat testers tested as part of routine healthcare likely points to the progress made with the integration of HIV services at facilities. Although location, cost, and provider attitudes are facilitators for testing, stigma and confidentiality concerns still persist and impede access to HTS.

Summing up…. Reaching Men effectively with HIV services

- The evidence that men are less likely than women to engage in HIV services across the care cascade calls for effective interventions that reach men.
- Barriers in reaching men include confidentiality concerns, distance to the facility, inconvenient hours, and perceptions that facilities provide women-centered services.
- There is evidence that interventions designed for men only have greater effectiveness compared to interventions targeting both men and women, calling for a shift to male centred approaches to close the gender gap
- Men need to be reached where they are, such as in social places, home based visits, and community-based testing interventions (particularly home and mobile), as these have high acceptability and reach more men than health care facility-based approaches.
- Male interventions should be tailored to the needs of men to maximize uptake, including flexible hours, multiple follow up visits, and convenient and private access to care.
- Need to rebrand clinics as family clinics to attract men into visiting health facilities for HIV testing.

[1] Male Partner Linkage to Clinic-based Services for Sexually Transmitted infections and HIV. Dr John Kinuthia, KNH
[2] What are we learning from men about engaging them in HIV services? Dr Jerry Okal, Project SOAR/Population Council

3.1.6. eMTCT: 8,000 CHILDREN NEWLY INFECTED: WHERE DO WE GO FROM HERE?

Moderator: Rose Wafula, UNICEF, Kenya Presenter: George Githuka, NASCOP, Kenya
Panelists; Joseph Lenai, Laikipia County, Kenya; Lucy Wanjiku- Mentor mother and Tomas Ukola, National AIDS Co-ordination Programme (NACOP), Namibia

Dr George Githuka, NASCOP[1], opened the floor by providing the background and facts on eMTCT in Kenya. It is estimated that 8,000 children were infected with HIV in 2017, and the trend has been very erratic since 2012-2018, mainly driven by lack of HIV viral suppression before pregnancy due to unplanned pregnancies, low level of knowledge of HIV status, and late access to ART. He spoke of two strategies spearheaded by the Beyond Zero programme aimed at contributing towards achieving the elimination of mother to child transmission agenda. Early HIV testing, prompt return of test results, and rapid initiation of treatment are critical for reducing morbidity and mortality among HIV-infected infants. Point-of-care (PoC) for early infant diagnosis (EID) technology provides a timely solution to this challenge of delayed diagnosis and delayed treatment initiation, which often results in preventable deaths. Primary prevention of HIV infection for PMTCT entails targeting women before pregnancy such as at FP clinics; during pregnancy and until complete cessation of breastfeeding (Re-testing as per the guidelines, testing for syphilis a part of ANC profiles), and HTS in the PMTCT context beyond identification of HIV infected to primary prevention of HIV. Those who test HIV negative should be assessed and counselled on HIV risk reduction behaviors and linked to combination HIV prevention services depending on individual risk profiles.

EMTCT facts and figures (NASCOP)

- 105,200 children living with HIV (0-14)
- 70,000 Women living with HIV will become pregnant in 2019
- 70% (49,000) of pregnant women will know their HIV positive status and on ART
- Negligible transmission from 40,670 (83%) – on ART and suppressed
- 17% (8,330) will not be virally suppressed – high risk of transmission: pre-conception care, adherence to ART, treatment failure
- 21,000 do not know their positive HIV status
- Old vs New infections.... High viral loads, high transmission rate
  - » Will not attend ANC…… will not deliver at a health facility
  - » Will not be tested for HIV – initial and especially re-testing as per guidelines
  - » Will be tested but will not start ART
  - » Will start ART but will not adhere – 85% retention at 12 months
- Late 1st ANC attendance……. Deliver before achieving viral suppression
- Overall 12.4% MTCT in Kenya (8,680 new pediatric HIV cases) from 29,330 mothers **(29.6%)**
- Modern FP at 6 weeks Post delivery

[1] EMTCT: 8,000 Children Newly Infected – Where Do We Go from Here? George Githuka, NASCOP

3.1.7. CONDOM REVOLUTION: PATHWAYS TO CHANGE

Session Chair: Amos Kutwa, Vihiga County, Kenya
Presenters: Tomas Ukola, National AIDS Co-ordination Programme (NACOP), Namibia; Bidia Deperthes, UNFPA, USA
Panelists; Maggie Gitu, Marriage and Family Therapist, Kenya; Eliud Muriithi, KEMSA, Kenya; Carol Ngunu, Nairobi County, Kenya; Andrew Juma, PSK, Kenya; Ademola Olajide, UNFPA, Kenya; Wambere Kibicho, East African Latex, Kenya

Challenges in condom supply and commodity security

- Reduced funding for condom manufacture, distribution and promotion,
- Inadequate warehousing occasioned by lack of adequate storage facilities for condoms,
- Sub optimal condom use among key populations and young people, including prohibition of condoms in prisons, and
- limited acceptability or utilization of female condom by both women and men

Tomas Ukola, National AIDS Co-ordination Programme, Namibia

The panel session's main focus was to identify opportunities to increase condom use, availability and access arising from experience sharing and discussions on practices and opportunities for condom programming. Dr Tomas Ukola, of National AIDS Co-ordination Programme, Namibia[1], opened the floor by presenting on condom programming best practices and lessons learnt from Namibia . He spoke of high coverage of condoms distribution approximated at 31 million annually and high condom use (80%) among the general populations. The Government of Namibia funds 100% procurement of condoms, and no stock outs are experienced. Condom distribution in Namibia is run on a beer distribution network through a Public Private Partnership between the Ministry of Health and Namibia Breweries, and this has seen a significant increase in condoms distributed. He highlighted the need to intensify condom demand creation, establish and maintain functional PPPs for condom manufacturing, promotion and distribution, support targeted social marketing, strengthen supply chain including utilisation of private sector supply chains, and strengthen condom integration with other health care and social services as an integral part of the combination prevention package.

Ms. Bidia Deperthes UNFPA[2] shared experiences on what is needed to make condom use more efficient and effective. She shared some good and bad news on the global state of condom use. She presented evidence that all countries fall short of global condom targets, some by substantial amounts. Secondly, there is observed double-digit gaps in condom use between urban and rural populations as well as between wealthier and poorer populations in most countries. Finally, condom use in younger segments shows signs of stagnation or decline in at least a few key countries. She noted the good news on low but steady progress toward higher levels of condom use and improved equity; condom use by sex workers with last client is high (80-90%) in many countries; and gaps in condom use between urban/rural and high income/ low income segment are shrinking.

Summing up…Condom Revolution: Pathways to Change

- Opportunities for public private partnership in condom manufacturing, distribution and promotion exist and need to be explored towards addressing condom supply and commodity security.
- There is need to link and strengthen condom integration with health care and social services.
- Need to address the use of online media that portrays condom as a pleasure tool as opposed to prevention tool

[1] Condom Programming best practices and lessons learnt. A case of Namibia. Tomas Ukola, National AIDS Co-ordination Programme, Namibia
[2] Making condom use more efficient & more effective. Bidia Deperthes, UNFPA, USA

- More initiatives towards sensitization and promotion on the correct usage of condoms particularly in rural set ups.
- Need for a legal framework to address advertisement of condom promotion.
- The opportunity exists for youth as champions for condoms in institutions of higher learning.

3.1.8. SCALING ORAL PREP: KENYA'S LEADERSHIP WITHIN THE UHC CONTEXT

Session Chair: Abednego Musau, JHPIEGO, Kenya

Session Moderator: Jordan Kyongo, LVCT Health, Kenya

Panelists: Daniel Were, Jilinde Project, Kenya, Prof. Kenneth Ngure, JKUAT/IAS, Kenya, Irene Mukui, NASCOP, Kenya, Carol Ngunu, Nairobi County, Kenya, Dr. Patricia Oluoch, CDC, Kenya

The World Health Organization (WHO) recommends oral pre-exposure prophylaxis (PrEP) for HIV negative individuals at substantial risk of HIV acquisition. PrEP has gained traction globally, especially in developed countries. However, scale-up in lower and middle-income countries, which have a higher HIV burden has been slower than anticipated. This session focused on sharing lessons learnt in the introduction of PrEP in Kenya and reflect on the opportunities UHC can be tapped to guarantee safeguarding the gains made in HIV prevention.

Irene Mukui, NASCOP[1], opened the session by sharing experiences on the PrEP journey in Kenya, which is now incorporated into the Kenyan HIV Prevention Revolution Roadmap and is also identified as an evidence-based intervention in the most recent Kenya AIDS Strategic Framework (KASF). PrEP is also included in the Guidelines on Use of ARV Drugs for Treating and Preventing HIV Infections in Kenya. Coordination of PrEP service in Kenya has been successful because of government leadership and engaging stakeholders from various sectors in ensuring continuity in rolling out PrEP. On lessons learnt, she emphasised the need for a guiding framework, aligning vision and results on PrEP and clarity of roles for the different stakeholders to avoid overlap in service delivery. In addition, there is need to bridge the gap between research and implementation and most critical is understanding the needs of the community and aligning programs based on that information .

On evidence that PrEP works, Prof. Kenneth Ngure, JKUAT/IAS[2] , made reference to clinical trials around the world that have demonstrated how PrEP works. He pointed out that maximum benefits for PrEP adherence are achieved when PrEP is used during HIV exposure, a concept called "prevention-effective adherence" (Haberer et al., AIDS 2015). On considerations for effective PrEP delivery, success is reflected in uptake denominator, adherence, retention, cost, cost effectiveness, funding, and sustainability.

Carol Ngunu, Nairobi County[3], speaking on lessons learned and gaps in PrEP as part of routine HIV combination prevention services in Nairobi, noted that the county was among early adopters of PrEP in Kenya. The city employed a systematic approach to introduce PrEP services within the existing health systems through core components of: county ownership and leadership; coordination and resource pooling from government and implementing partners through the county PrEP technical working group (TWG); integration and leveraging on existing infrastructure; and capacity building and health system strengthening. Daniel Were, JPIEGO[4] speaking on reaching diverse populations with PrEP, shared experiences from the JILINDE Project, highlighting the myths and misinformation that exists around PrEP. This, coupled with users' negative clinic experiences are a barrier to PrEP uptake and that providers struggle with judgmental and moralizing beliefs. Still on sharing lessons on PrEP, Dr. Patricia Oluoch, CDC, Kenya[5] brought into perspective what matters for young people and PrEP and lessons learnt from the DREAMS project. Facilitating factors to PrEP continuation include adherence to guidelines (who is given, risk status, dispensing, fidelity to testing); Personalized client assessment and counseling for PrEP; Client Flow (Integration of service delivery); correct messaging; Adolescent friendly services; Robust M &E and quality monitoring.

[1] Coordination of PrEP Service in Kenya. Irene Mukui, NASCOP
[2] We know PrEP works: Considerations for Optimal Scale up. Kenneth Ngure, JKUAT/IAS, Kenya
[3] PrEP as Part of Routine HIV Combination Prevention Services in Nairobi. Carol Ngunu, Nairobi county, Kenya.
[4] Reaching Diverse Populations with PrEP. Daniel Were, JILINDE Project, Kenya,
[5] PrEP for young people: experiences from DREAMS. Patricia Oluoch, CDC, Kenya

Summing up….

- Successful PrEP rollout is understanding the needs of the community and aligning the programs based on that knowledge as opposed to rolling out the program without knowing the needs in the community.
- Sustained Advocacy, demand creation and literacy: messaging and community awareness using IEC material and peer to peer education is key to enhance uptake and dispel myths and misconceptions on PrEP
- Tackling misconceptions: Community mobilization, Integration of PrEP education in EBIs sessions including for care givers and sexual partners and use of social media
- PrEP delivery settings: Integrated services, MCH and FP settings, youth-friendly, peer engagement community-based, online, standard of care in prevention trials and Pharmacy delivery effective strategies for providing PrEP
- Systematic PrEP scale-up is feasible through government ownership and leadership for integration into existing health care systems
- Retention remains an issue in PrEP driven by lack of parameters that can measure the success/impact of PrEP.
- Stigma remains a key issue and there is need to establish proper counselling and sensitization to clients and families in the community on the function of PrEP, the associated seasons of risk, and role in HIV prevention.

What matters for young people and PrEP

- Where PREP is offered matters – community vs facility, HIV or other clinic
- How we communicate PrEP matters!
  - » Counselling and community activation need to be sensitive
  - » Need to know what matters to young women
  - » Judgmental attitudes will be detrimental
- AGYW want to feel supported by providers, peers, families and communities
- HIV Combination prevention packages e.g. socioeconomic and other behavioural interventions are useful
- Package of Interventions that mitigate vulnerabilities

Patricia Oluoch, DREAMS Project

3.1.9. HIV, SEX, DRUGS AND YOUNG PEOPLE

Session moderator: Celestine Mugambi, NACC, Kenya
Presenters: Rebecca Nyankieya, NACC, Kenya and Gloria Bille, UNAIDS, Kenya
Panelists: Nelly, Kenya Film and Classification Board, Kenya, Jessy Mbugua, Pastor, Kenya; Shaffie Weru, Entertainer and Radio Host, Kenya; Rebecca Nyankieya- NACC, Kenya; Bramwel Agan, Student and Entertainer, Kenya

Young people (10 to 24 years) and adolescents (10 to 19 years), especially young women and young key populations, continue to be disproportionately affected by HIV[1]. In 2016, 2.1 million people aged between 10 and 19 years were living with HIV and 260,000 became newly infected with the virus in Africa[2]. The number of adolescents living with HIV has risen by 30% between 2005 and 2016[3]. These numbers put into context the "millennials" popular panel session on HIV, sex, drugs and young people that was set rolling by Jerry Okal, Population Council[4].

The presentation by Dr. Jerry Okal, Population Council, focused on findings from DREAMS, an implementation science study focusing on assessing effectiveness of community-based girl-centered programming, identifying and reaching male partners of adolescent girls and young women in HIV services, and introduction of oral PrEP among adolescent girls and young women. Shifts in gender norms and relationship power, increase in HIV testing, and reduction in experience of physical and sexual violence from intimate and non-partners were significant findings from the DREAMS project. The study found negligible shifts in sexual risk behaviors, and an increase in transactional relationships/sex among participants, revealing the need to assess how different intervention components (e.g. social asset building, economic support, educational support) or combined exposure to different components influences key HIV-related outcomes. Another key lesson from the DREAMS project is that gender inequity and poor relationship power contribute to HIV risk, and sexual violence is associated with HIV acquisition for young women. This calls for continued investment in interventions to shift these norms in HIV prevention programming. Rebecca Nyankieya[5], NACC speaking on Achieving Positive Sexual Health Outcomes for the "Millennial" highlighted the dynamics of a millennial and what matters most to them.

- Young people desire to be "active participants, not bystanders" and when granted the opportunity to actively participate, they act.
- Millennials are purpose driven and are well aware of key issues and problems in society and want to make a difference.
- Meaningful youth engagement; youth leadership and advocacy; reaching young people where they are, and leveraging on their interests is key

Rebecca Nyankieya, NACC, Kenya

The panel discussion featuring millennials, representatives from media, entertainment, academic institutions and faith leadership speaking on the same topic reiterated the concern on addiction, not just

[1] AVERT. YOUNG PEOPLE, HIV AND AIDS. 2018 https://www.avert.org/node/389/pdf
[2] UNAIDS (12 August, 2015) 'Update: Active involvement of young people is key to ending the AIDS epidemic by 2030' (Accessed 21/3/2017)
[3] UNICEF (2017) 'Statistical Tables'
[4] Shifts in HIV risk outcomes among AGYW: Findings from DREAMS sites in Kisumu, Kenya, Jerry Okal, Population Council
[5] Achieving Positive Sexual Health Outcomes for the "Millennial" Rebecca Nyankieya, NACC

to drugs and substance abuse, but also to pornographic movies and gambling among young people. It was highlighted that parents need to face the glim reality of rising drug use among young people and its role in irresponsible sexual behavior. While social media was an asset that could be used to campaign positively about the issues affecting young people, it was also a driver to those issues affecting them, such as gambling and access to illicit sexual material. But social media could also be turned around positively and used to reach young people with positive health messages. The Kenya Film Classification Board was challenged on regulation of what is aired to protect culture and children from harmful content. Another topic focused on the heavy attention given to girl issues at the expense of neglecting the boychild, drawing the attention that each gender is unique, with unique needs that need to be addressed specifically.

Summing up…. HIV, Sex, Drugs and Young People

- There is need to address low HIV and sexual health knowledge among young people, which is a key barrier to reducing HIV infections among this population. It may require a 'life-cycle' approach to HIV prevention to help respond to the changing challenges people face at different ages.
- Key to protecting millennials health and addressing the HIV epidemic requires enabling them to be actively involved and meaningfully engaged in the design and delivery of SRHR interventions, including for the HIV response, as well as understanding the way in which age and other contexts such as gender and sexuality impact on access, and are key to the provision of effective interventions.
- Social media platforms and associated technologies are a valuable and auspicious initiative, and to a great extent already integrated into the lives of young people. They need to be embraced more and taken advantage of to provide HIV awareness messaging among other interventions that fit into the already complex and challenging lives of young people.
- It is conceivable that *relationship* dynamics such as *power*, play an important role in partners' decision-making processes. These norms contribute to issues such as HIV risk, and sexual violence and are associated with HIV acquisition for young women. Therefore, the relationship context should be considered in future HIV interventions for advancing UHC. Need to invest in interventions that shift gender inequity and poor relationship power.
- The boychild-girlchild agenda: Focus should be on youth in general as opposed to driving agendas along gender lines because there is perception that the boy-child is forgotten and has no role models or mentorship in sexual health, drugs and alcohol abuse, general life and social skills.

3.2. HIV IN THE CONTEXT OF UHC: PROGRAMMING, ADVOCACY AND SUSTAINABILITY

Universal Health Coverage (UHC) entails that "all individuals and communities receive the health services they need without suffering financial hardship, and includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care" [1]. The HIV response is at a defining moment: technically, the existing knowledge and tools make it feasible to end HIV as a major public health concern; financially, global and domestic economic pressures are demanding new thinking around HIV funding and financing mechanisms; and politically, commitments will need to be made for a renewed HIV framework and targets to take us into the future[2]. While the connection between ending HIV and achieving UHC is clear, success in ending the HIV epidemic will not be achieved without a responsive UHC platform.

3.2.1. PLHIV AND UHC: WHAT IS AT STAKE?

Session Chair: Mohammed Haji, Isiolo County, Kenya
Session Moderator: Ludfine Bunde Anyango, UNAIDS, Kenya
Panelists: Nelson Otwoma, NEPHAK, Kenya; Solomon Wambua, Key Population consortium, Kenya; Muthoni Karanja, NASCOP, Kenya; Benson Ulo, AMREF, Kenya; Brenda Bakobye, Sauti Skika

Opportunities to use the UHC framework to strengthen HIV programme

- ensuring that financial protection schemes cover the full range of HIV intervention and services required by a population, including relevant out-of-pocket expenses;
- integrating HIV into broader health planning and using a single framework for situation analysis, costing, planning and budgeting for all major health issues;
- identifying new approaches for sustainable financing of comprehensive HIV responses, including through domestic funding opportunities;
- removing financial and other barriers to enable equitable access to services, with particular focus on those populations most vulnerable and in need; and
- promoting greater efficiency in programmes and eliminating waste, including through integration and decentralization of services.

One of the most lamented risks of UHC is that the marginalized people whom the HIV response has fought to keep at the center, may be left behind. These are people most affected by HIV, TB and HCV. PLHIV are desperately in need of UHC, "because they are dying from many other things, such as HCV and overdoses"[3]. The panel discussions gave particular attention to the tension and relationship between HIV and UHC, the connection between ending HIV and achieving UHC and what will need to be achieved to build a responsive UHC platform to address the shortcomings in the response so far. These words by Prof. Mark Dybul, Georgetown University, USA[4] in his keynote address during the Conference opening ceremony gave sharp focus to

[1] WHO
[2] WHO, 2014. HIV, Universal Health Coverage and the post-2015 development agenda: a discussion paper.
[3] Global Fund Observer. Global health leaders discuss 'ending' AIDS in context of UHC. NEWSLETTER Issue 340: 22 August 2018. http://www.aidspan.org/gfo_article/global-health-leaders-discuss-%E2%80%98ending%E2%80%99-aids-context-universal-health-coverage
[4] UHC and HIV: Global Perspectives, Challenges, Opportunities and the Future. Mark Dybul, Georgetown University, USA

the panel discussion on PLHIV and UHC: What is at Stake?

> ... *"Remarkable tension between people involved with HIV programmes and people involved with UHC is a reality. People involved with HIV programmes are scared that UHC is going to take away the money and the focus and they will not be able to achieve their objective and people involved with UHC are scared that HIV has all the money…The reality is that it is impossible to achieve UHC without dealing with HIV…if we don't get the HIV rate down, there is zero hope for UHC because there will be so many new HIV infections that the ART burden would destroy any hope of being able to provide UHC"*

Dr. Jeremiah. Laktabai, AMPATH[1] opened up the panel discussion, noting that PLHIV have specific roles to play to achieve UHC goals. He highlighted the HIV response innovative ways in which health services are delivered and funded, that are particularly relevant for the achievement of UHC:

- » defining comprehensive intervention and service delivery packages that should be funded through the public system;
- » strengthening quality assurance and quality improvement systems;
- » developing and applying multisectoral costing methods and tools;
- » championing health access strategies, which have reduced the price of health commodities and improved the efficiency of service delivery;
- » pioneering innovative financing models and increasing overall investments in health; and
- » addressing health inequities, particularly by engaging civil society, key and priority populations.

Summing up…. PLHIV and UHC: What is at Stake?

- UHC presents several key opportunities for PLHIV and those traditionally left behind, and if well implemented, UHC could offer the possibility of integrated services that recognize the whole health of PLHIV and key populations.
- UHC if well implemented provides a platform to ensuring the right to health for KP and other priority populations is not violated and possibility of addressing structural barriers that violate human rights.
- The inclusion of communities living with HIV is needed to attain UHC and the SDGs. The SDGs and their targets are interdependent; achieving one is reliant on achieving the others. In the case of UHC and ending AIDS, it will take effective implementation of UHC to achieve this goal.
- HIV response to date has embraced most of the principles of UHC. The UHC movement can learn from the HIV response, but also, opportunities exist to refocus the HIV response using the UHC framework to address some of the key shortcomings in the response so far.
- A people centered UHC can be ensured through community engagement from policy making to implementation.
- Key opportunities exist for PLHIV and those from communities most left behind to shape the health systems that we will have for generations to come. Their skills and expertise, developed over years of activism in the HIV response as well as well as for the human rights of key populations will be central to ensuring that health responses going forward are truly inclusive[2].

[1] HIV response lessons for UHC. Dr. Jeremiah. Laktabai, AMPATH
[2] OPINIONS. HIV and the High-Level Meeting on Universal Health Coverage: What's at Stake? The global networks of people living with HIV sound the alarm for inclusion. April 11, 2019. https://www.poz.com/article/hiv-high-level-meeting-universal-health-coverage

3.2.2. HIV AND NCDs IN THE CONTEXT OF UHC

Session chair: Anisa Omar, Kilifi County, Kenya
Presenters: Kibachio Joseph Mwangi, MOH, Kenya and Joshua Gitonga, NACC, Kenya
Session moderator: Rachel Kamau, Nyeri County, Kenya and Rahab Mwaniki, KANCO, Kenya
Panelists: Gordon Okomo, Homabay County, Kenya; David Makumi, Association/Diabetes Management Institute, Kenya; Ezekiel Macharia, MD Kenbright Insurance, Kenya; Kuhora Samson, NHIF, Kenya; Patricia Ochieng', NEPHAK, Kenya (experience sharing)

The complex association of HIV with a host of other comorbidities and conditions in the era of effective therapy[1] being witnessed may be eroding positive gains in the Kenya HIV programme such as increased ART coverage and reduced AIDS related deaths. This calls for strengthening primary health care and deployment of more effective strategies and treatments that recognize the rising impact of comorbidities complicating long-term HIV infection.

> *"… HIV is a lifelong condition…the moment you test positive for HIV you are on lifelong treatment. PLHIV not only require HIV services but all that UHC encompasses…You can be viraly suppressed yet another condition kills you… My appeal is to reposition NHIF to include HIV treatment as part of the package because PLHIV need treatment that is predictable and sustainable".*

These words by Mr Nelson Otwoma, NEPHAK, in his remarks during the opening ceremony of the conference resonated with the panel session on HIV and NCDs in the Context of UHC. Dr. Gordon Okomo, Homa Bay County[2], opened the floor to the panel session by sharing the county's experiences on the HIV and NCD response. While Homabay County has unfavorable statistics regarding HIV prevalence, NCDs are also on the rise. Some lessons to learn from Homabay on HIV and NCD integration were that the existing HIV health system infrastructure provided a good platform for hypertension screening for the general population as well as routine screening among HIV positive clients on care and treatment. The low stigma associated with hypertension screening provided an opportunity to draw in new clients, especially men, who are hard to reach to screen for HIV and that engagement of CHVs in screening and referrals was key. Some pitfalls include commodity security and supplies (drugs, gas) and funding for sustainability. He recommended more effort in integration of services, partnership in HIV and NCD care and partnerships and increase in domestic financing as key in attaining UHC.

David Makumi, NCD Alliance, Kenya[3], shared experience on two case studies on the complex interaction between HIV and NCDs and lessons to learn. He pointed out that NCDs like hypertension may be a result of earlier generations of ARVs. The risk of NCDs in PLHIV needs to be addressed in the context of integration in HIV clinics. Additionally, integration of NCDs and HIV will require addressing supply chain, human resources (NCD and HIV joint clinical teams), referral systems, patient education, addressing stigma, and monitoring and evaluation. Ezekiel Macharia, KenBright Insurance[1] while sharing a HIV Actuarial Model developed for NACC noted that Kenya has unique health challenges and that PLHIV are projected to increase. That cost of ART is invisible to insurers since this is currently funded mainly by donor communities. The audience was reminded that the cost of HIV drugs was still a challenge to many and that UHC will not be achieved without proper quality drugs for PLHIV. He pointed out the need for better models of health financing, such as those Paid on Behalf (Fully funded option where Government

[1] Casper C, Crane H, Menon M, et al. HIV/AIDS Comorbidities: Impact on Cancer, Noncommunicable Diseases, and Reproductive Health. In: Holmes KK, Bertozzi S, Bloom BR, et al., editors. Major Infectious Diseases. 3rd edition. Washington (DC): Available from: https://www.ncbi.nlm.nih.gov/books/NBK525185/ doi: 10.1596/978-1-4648-0524-0/ch3
[2] HIV and NCD response in Homa Bay County, Kenya Gordon Okomo, Homabay County, Kenya
[3] NCDs and HIV: Role of the NCDAK in the Management David Makumi. NCD Alliance Kenya.
[4] HIV and NCD in the Context of UHC; Ezekiel Macharia, Kenbright Insurance

pays for cost of insurance premium), Self-Payments (Pay as You Go/ Health Savings Account and Hybrid, Partially Funded by Third Party.

NHIFs' strategic goals towards UHC

- Contributing to universal health insurance coverage* objective 2 – product mix
- Increasing revenue pooling
- Creating a suitable legal and regulatory framework
- Strengthening governance and management systems
- Enhancing strategic alliances, collaborations, and linkages
- Leveraging on technology to enhance service delivery
- Integration of HIV and NCDs management in Social Health Insurance in any population will have a significant impact on financing dynamics.
- Governments, Financing agencies and policy makers play a central role in outcomes achievement and cost management.

Dr Kuhora Samson, NHIF[1] in his presentation on *"Integrating HIV and NCD Treatment and Care Packages within the NHIF"* highlighted the journey of the evolution of the NHIF benefits packages and the Fund's strategic goals towards UHC. To date, it includes Imaging services, Chronic Disease Management Package and Evacuation services. He recommended a product mix that supports curative, rehabilitative, and palliative services versus preventive and promotive services.

Dr Kibachio Joseph Mwangi, MoH[2] presented possible HIV/NCD integration scenarios[3]:

1. Parallel Services "Inter" Scenario
2. Coordinated Services "intra" Scenario
3. Integrated Services "into the health system"

He reminded the audience that integration takes advantage of primary health care and referral systems and creates the opportunity to take away focus from disease-centred approach to a people-centred one.

Foreseen benefits of HIV/ NCD Integration[6]

- HIV programmes (individual level)
  - » Healthier and longer lives for PLHIV
  - » Measurable through looking at cohorts of PLHIV living longer with less NCD issues
- NCD programmes (health systems)
  - » Utilize existing health and community systems of prevention, treatment and care e.g., adherence clubs, support groups, community health workers networks, civil society

The foreseen benefits of HIV/NCD integration have been acknowledged[4]. Mr. Joshua Gitonga, NACC[6], speaking on lessons on revolutionizing the NCD response in Kenya noted that HIV and NCDs have commonalities which provide an opportunity for cross-pollination and cross-learning across the two disease areas. Since the HIV epidemic interacts with other epidemics, the response cannot be considered in isolation in light of the heightened risk of NCDs in ageing PLHIV. Additionally, policies and interventions targeting PLHIV should prioritize prevention of the risk of common NCDs along with the rapid scale up of HIV treatment which results in chronicity of the disease.

Policy basis for HIV-NCD integration in Kenya[6]

- KASF 2014/15 – 2018/19: Calls for different agencies to maximize efficiency in service delivery through integration and creation of synergies for HIV prevention
- Kenya National Strategy for the Prevention and Control of NCDs 2015 – 2020: Calls for linkages and synergies between major NCDs and communicable diseases
- Kenya HIV and AIDS Research Agenda: In line with KASF Strategic Direction 2, the Research Agenda proposes modelling the future trends and impact of HIV on NCDs to bridge the existing gap of lack of data on prevalence and impact of co-infections and co-morbidities on HIV care and treatment

[1] Integrating HIV and NCD Treatment and Care Packages within the NHIF, Dr Kuhora Samson, NHIF, Keny
[2] A Crisis Within A Crisis: Integrating HIV/NCDS Care, Kibachio Joseph Mwangi, MOH
[3] Miriam Rabkin , Margaret E. Kruk and Wafaa M. El-Sadr (ICAP Columbia)
[4] UNAIDS. HIV and noncommunicable diseases integration. Second meeting of the WHO Global Coordination Mechanism Working Group on the inclusion of NCDs in other programmatic areas.
https://www.who.int/global-coordination-mechanism/working-groups/STKH-2HIV-UNAIDS-Sandoval.pdf

[5] Lessons learnt in HIV program that can revolutionize NCD response in Kenya. Joshua Gitonga, NACC.

Summing up… HIV and NCDs in the Context of UHC

- Unique features shared between HIV and NCD epidemics well acknowledged (Chronic; co-morbidities; comprehensive; multisectoral; and life course)
- UHC at its best, with integration of HIV services, could offer the possibility of integrated services that recognize the whole health of PLHIV and key populations. This is by ensuring the availability of fully resourced community-led service delivery and of fully resourced public facilities that do not discriminate and do provide the opportunity for our multiple health needs to be addressed in one place[1].
- Integration of NCDs and HIV will require addressing supply chain, human resources- (NCD and HIV joint clinical teams), referral systems, patient education, addressing stigma, and monitoring and evaluation.
- The importance of NCDs among PLHIV cannot be underestimated. In the era of effective therapy for HIV, health professionals will need to deploy more complex strategies and treatments that recognize the rising impact of comorbidities complicating long-term HIV infection.
- More attention needs to be paid to HIV and NCDs comorbidities as an emerging research priority
- Innovative mechanisms are needed to ensure sustainable financing and effective prioritisation of the limited resources to ensure effective capacity at the county level including human resources, supplies and infrastructure are available to meet the increased workload of UHC expansion with integrated NCD services.
- There is need for real-time information on NCDs to guide decision making at national and county levels, and to prioritise resources. Opportunities exist for NCDs to leverage on the HIV programme to provide program data, use existing M&E sub-systems and estimation and modelling techniques.

[1] Opinions. HIV and the High-Level Meeting on UHC: What's at Stake? The global networks of PLHIV sound the alarm for inclusion. April 11, 2019. https://www.poz.com/article/hiv-high-level-meeting-universal-health-coverage

3.2.3. PRIVATE SECTOR SERVICE DELIVERY WITHIN THE UHC AGENDA

Moderator: Vernon Mochache, University of Maryland, Kenya
Presenter: Nyaim Opot, KMA, Kenya
Panellists; Louis Machogu, PSK, Kenya, Nyaim Opot, KMA, Kenya, Elizabeth Wala, Africa Healthcare Federation, Kenya, Martin Osumba, RTI, Kenya, Meshack Ndirangu, AMREF, Kenya

Suggestions on engaging private sector towards achieving UHC

- First, governments should take the lead and formulate domestic health goals and priorities. Based on these goals, governments can then formulate public policies about the role of the private sector for UHC, orienting the health systems towards achieving UHC.
- Second, as the private sector is heterogeneous, context-specific policy approaches are required to align the work of the private sector with the goal of achieving UHC. Therefore, the choice and implementation of public-private UHC policies need to be informed by an understanding of the different private sector actors that operate in a country. After mapping the different private sector actors in a health system, governments should engage in multi-stakeholder dialogues to establish their policy on the private sector and UHC.
- Third, is implementation of the government's policy on the role of the private sector for UHC, with a mix of legal and financial regulatory tools to manage the private sector and steer efforts towards achieving UHC.

Source: David Clarke et al. The private sector and UHC. Bulletin of the WHO. 2019

The sustainable development goals (SDGs) of transforming our world, the 2030 agenda for sustainable development[1], and specifically SDG 17, call for cooperation, collaboration and partnership between government, civil society and businesses. At the same time, the SDGs are integrated and indivisible, with progress in one area dependent upon progress in others. Both the private and public sector are needed to meet the health-related SDG 3, including the target of UHC[2]. The panel session on the role of the private sector service delivery within the UHC agenda was timely. Dr Nyaim Opot, KMA[3] provided the background for the session which focused on what the public sector has offered and how that can be made better in the private sector and ensure access to care for everyone. He made note of the many things that are not included in the scope of UHC. UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis; UHC is not just about health financing. It encompasses all components of the health system: health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation; and UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available. Investing in the primary health care workforce is the most cost-effective way to ensure access to essential health care is improved. Good governance, sound systems of procurement and supply of medicines and health technologies and well-functioning health information systems are other critical elements. Thus, from the foregoing, HIV services squarely fit in the UHC agenda considering the steps: Public/community awareness, Screening and prevention services, Referral procedures for those who require higher level interventions, rehabilitation and long-term follow-up.

Many countries do not have an explicit government policy position on the role of the private health sector, lack concrete plans to implement public policy on the private sector, and few have engaged in structured debate or multi-stakeholder dialogue about the role of the private sector and UHC. As a result, there is often no consensus among domestic stakeholders, including health systems users and civil society groups, about the role the private sector should play in health[4]. While the business model of many not-

[1] Resolution A/RES/70/1. Transforming our world: the 2030 agenda for sustainable development. In: Seventieth UN General Assembly, New York, United Nations; 2015. Available from: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E
[2] David Clarke et al. The private sector and UHC. Bulletin of the WHO. 2019; 97:434-435. http://dx.doi.org/10.2471/BLT.18.225540
[3] The UHC Agenda: Where Does HIV Service Delivery Fit? Dr Nyaim Opot
[4] Harnessing the private sector for UHC, a decision-making model. Geneva: World Health Organization; 2019.

for-profit private providers aligns well with UHC, governments often have incomplete information about the not-for-profit providers and lack the governance tools to help align the activities of these providers with national systems and priorities[1]. Therefore, a public policy vacuum exists regarding the private sector and UHC. In this vacuum, the private sector could pursue its own objectives, which may or may not be closely aligned to UHC.

Summing up…. Private Sector Service Delivery within the UHC Agenda

- Efforts towards UHC cannot ignore the private sector. The private sector's involvement in health systems is significant in scale and scope and includes the provision of health-related services, medicines and medical products, financial products, training for the health workforce, information technology, infrastructure and support services.
- Strengthen both private and public sector for successful UHC to enhance efficiency.
- Government should establish and implement and monitor policies on referrals, costing and pricing of health care services.
- Kenya has mixed health systems, with goods and services provided by the public and private sector, and health consumers requesting these services from both sectors. Therefore, efforts towards UHC cannot ignore the private sector.
- Considering the rapid development of the private sector, there is need for institutionalised policy instruments for managing the private sector, including regulatory mechanisms for licensing, certification and accreditation of health workers, medical products, services and facilities which lack in low- and middle-income countries. At the same time, countries need to adopt accountability mechanisms to ensure that any public-private partnership serves the health of the population and the goal of UHC

[1] Bloom G, Standing H, Lucas H, Bhuiya A, Oladepo O, Peters DH. Making health markets work better for poor people: the case of informal providers. Health Policy Plan. 2011 Jul;26 Suppl 1:i45–52. http://dx.doi.org/10.1093/heapol/czr025pmid: 21729917

3.2.4. HIV, HUMAN RIGHTS, AND UHC

Session Chair: Esther Somaire, Kajiado, Kenya

Session Moderator: Ludfine Bunde, UNAIDS, Kenya

Panelists: Kenneth Munge, KEMRI, Kenya, Olivia Obell, Kenya Prisons Service, Kenya; Nelson Otwoma, NEPHAK, Kenya; Annerita Murungi, HIV and AIDS Tribunal, Kenya; William Sila, INERELA+, Kenya; Martin Pepela, Kenya National Commission on Human Rights (KNCHR), Kenya

One of the issues that came into sharp focus during the Maisha HIV and AIDS Conference 2019 was on human rights in the context of UHC for PLHIV. There was general consensus that UHC at its best should be rights affirming to ensure that those traditionally left behind are brought along. The panelists highlighted gaps that need to be addressed to ensure that *"all individuals and communities receive the health services they need without suffering financial hardship, and includes the full spectrum of essential, quality health services"*

- Stigma in schools particularly boarding schools needs to be addressed.
- Need for guidelines to address issues of young sex workers since it is assumed that when you provide services to young sex workers you are abetting their sex work.
- HIV and AIDS Tribunal has many conflicting laws with the constitution causing confusion on legal matters addressing HIV.
- Lack of awareness on the existence and the mandate of the HIV and AIDS Tribunal.
- UHC to address barriers facing access to health care and avail information that should include but not limited to stigma, disclosure and coerced procedures to patients.
- UHC should be based on human rights; a legal framework to address the ethical issues and good governance needed.
- Align human rights with UHC through legal sub-committees/platforms
- Demystify the prevention and treatment costs under UHC to ensure provision of quality health care services to local communities.
- Establishment of Alternative Dispute Resolution (ADR) in communities to alert police and health facilities where rights are violated.

Summing up…. HIV, Human Rights, and UHC

- One of the opportunities UHC could offer in affirming rights of those traditionally left behind is that it could provide a pathway to ensuring the right to health for people who are criminalized and often denied their rights, and those who are denied legal recognition and documentation, including people in detention, transgender people, sex workers, people who use drugs, gay men and lesbians, and migrants[1].
- UHC presents the possibility of reviewing and repealing laws and policies that violate human rights, as UHC will never become a reality for all without equal access to opportunity and protection from violence, discrimination and stigma
- There is need for political will to ensure that HIV remains a priority in UHC.

[1] Opinions. HIV and the High-Level Meeting on UHC: What's at Stake? The global networks of PLHIV sound the alarm for inclusion. April 11, 2019. https://www.poz.com/article/hiv-high-level-meeting-universal-health-coverage

3.3. LEADERSHIP, ACCOUNTABILITY AND SUSTAINABILITY OF THE HIV RESPONSE

3.3.1. SUSTAINABLE FINANCING FOR HIV IN THE CONTEXT OF UHC

Session Chair: Vivian Serety, Narok County, Kenya

Presenters: Regina Ombam, NACC, Kenya

Session Moderator: Catherine Mumma, Kenya; Stephen Masha, National Treasury, Kenya

Panelists; Sabina Chege, Parliamentary Health Committee, Kenya; Raymond Yekeye, National AIDS Council of Zimbabwe, Director, PPP Implementation Unit; Arif Neky, UN, Kenya; Nelson Otwoma, NEPHAK, Kenya

The panel session focused on how the main constructs of the HIV response can be used as a learning curve for sustaining health sector financing and achieving UHC. Regina Ombam, NACC, Kenya opened the session by providing highlights on implementation of the health sector financing sustainability plan for the delivery of UHC in Kenya.

Five-point action plan for achieving sustainability in funding for HIV/Health

1. Adopt an approach of urgent incrementalism towards 13% health allocation by 2022
2. Priority focus on increasing efficiency in delivery of health care services
3. Explore innovative ways of raising domestic resources for health
4. Leverage on ICT consumption to achieve more health for the money spent
5. Create synergies with other key sectors that are critical health enablers to health service delivery

Regina Ombam, NACC

She highlighted the need to focus on increasing efficiency in delivery of health care services by streamlining service delivery through integration and implementation of differentiated care in the management of chronic conditions in Kenya. There exist opportunities to explore innovative ways of raising domestic resources for health, such as blended finance mechanisms within the framework of the existing fiscal space and negotiations for pay for performance financing mechanisms such as those of Global Fund resources.

Summing up….

- The changing disease patterns have implications for financing, and combination prevention is the most cost containment strategy for UHC and sustaining its benefits in perpetuity.
- Renewed political commitment and UHC financing offers potential synergies with HIV financing: when UHC reforms invest in health systems, HIV budgets can focus on HIV-specific interventions. One option is to fund HIV-related health services through the broader pool devoted to UHC.
  - » UHC could draw lessons from considerable success in the HIV response that have resulted from innovative approaches in areas including governance, financing, service delivery, political mobilization, accountability, and human rights.
  - » UHC and HIV efforts must capitalize on potential synergies, especially in settings with a high HIV burden and major resource limitations.

3.3.2. MULTI-SECTOR ACTION AND LEADERSHIP: LESSONS FROM THE HIV RESPONSE

Moderator: Pamela Kaithuru, Ministry of Environment, Water and Natural Resources, Kenya. Faith Macharia, NACC, Kenya.

Panellists: Salome Ochola, NACC; Lenga Gome, Kenya Ports Authority, Martina Aloo Dawson, KURA; Stephen Jelanga, Ministry of Education; Kakamega County.

It is widely acknowledged that no single sector can address the multiple drivers and impacts of HIV and AIDS, and that integrated, multi-level efforts by government, working together with various sectors, including civil society and the private sector, are needed . In Kenya, multi-sector collaboration as a central tenet of the national response to HIV has evolved over time. The role of NACC in providing leadership for multi sectoral coordination of the response to HIV and AIDS was highlighted by Salome Ochola, NACC[2]. She spoke on NACC's Achievements on multisector action; Streamlined responses of different categories of stakeholders; More programmatic impact and coverage, Sustainability of HIV programmes; Enhanced coordination and ownership of programmes because of involvement of different stakeholders; and Increased accountability and compliance to the "three ones" principles. This success can be attributed to strong and committed political will providing high level support; comprehensive programme design work plan templates and reporting tools; empowerment approach including developing stakeholder capacity, and effective communication and coordination. The panel session focused on sharing experiences of HIV interventions as players in various sectors, the contribution of a multi-sector approach and opportunities for UHC. The Kenya Urban Roads Authority (KURA) has instituted a requirement for HIV and AIDS awareness and prevention campaigns as well as a HIV and AIDS training component in all road construction contracts. The important role of Education Sector in the HIV response was also highlighted.

Summing up……

Consensus on what is required to support the effective implementation of the Multi Sector Approach (MSA):

- Facilitate the process of building the capacity of stakeholders to ensure effective coordination of the multi-sectoral response at local level, and help to address the poor relations between sectors
- An enabling environment for effective implementation of MSA should be created through political commitment and support for MSA, providing AIDS Control Units (ACUs) with the resources needed for effective coordination of a multi-sectoral response to HIV and AIDS.

[1] Gavian S, Galaty D, Kombe G. Multisectoral HIV/AIDS Approaches in Africa: how are they evolving
[2] Multi-sector Leadership and Action: Kenya Case Study, Salome Ochola, NACC Kenya

3.3.3. COUNTY LEADERSHIP FOR THE HIV RESPONSE

Session chair: Ruth Koech, Nandi County, Kenya

Moderator: Sylvia Ojoo, Georgetown University, Kenya

Panelists: Daniel Oliech, Public Service Commission, Kenya, Richard Matlhare, National AIDS Coordinating Agency, Botswana, Gilchrist Lokoel, Turkana County, Kenya, Andrew Mulwa, Makueni County, Kenya, Meshack Ndolo, CoG, Kenya

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This session focused on teasing out policy issues that affect HIV programme performance both at the national and county levels. While there has been notable progress in the HIV response in Kenya, there exists challenges. One key challenge relates to leadership and governance in terms of creating a seamless flow of services and follow through in execution of planned programmes, optimization of the resources available as well as alignment of partner operations to the needs on the ground. Another challenge regards application and implementation of uniform standards and norms across the counties.

Richard Matlhare, National AIDS Coordinating Agency, Botswana, noted that the top-down analysis done in his country has helped to identify key areas in healthcare that need action. These efforts have significantly contributed towards optimization. In Kenya, some gaps in County Leadership for the HIV response highlighted include:

- Funding from national government to counties show disparities in allocations, with specific funding allocated for HIV in county health budgets
- Funding received from partners and national government depends on different parameters and thus funding cannot be uniform.
- There are different priorities in each county and these variations affect the burden of disease.

Dr Gilchrist Lokoel, Turkana County shared experience on how the county has managed to stabilize partnerships in healthcare by focusing on interventions on settlements along the highway. These collaborations have led to improved accountability and service delivery in the provision of healthcare.

Dr Andrew Mulwa, Makueni County, in presenting "The Big Picture" County Leadership for The HIV Response summarized the session as follows:

- Need to rethink health as business, by focusing improved health outcomes such as lower mother-child transmission, reducing new infections, viral suppression, as the returns on investment in health initiatives.
- There is relevance in bringing all partners to the table by engage partners at both individual, county and national levels.
- Engaging leadership and providing quality data to inform proper policy making and delivery is key.
- Need for clarity between policy formulation at national level and policy implementation at county level.

Summing up…

- Effective coalition between various sectors in health and outside health is needed to properly tackle the challenges that face service delivery in healthcare especially in the HIV Response.
- Constructive engagement of synergies in the implementation process to ensure healthcare delivery at sub-county levels is achieved is an opportunity that can be considered by those in leadership roles.
- Counties need to think of health as a business model with improved health outcomes as the return on investment.
- Building effective partnerships for accountability on results and resources

3.4. HIV AND EMERGING CO-MORBIDITIES

3.4.1. THE RE-EMERGENCE OF STIS AND HEPATITIS B

Session chair: Anthony Walela, Bungoma County, Kenya

Presenters: Victor Omollo, KEMRI RCTP, Kenya, Amos Otedo, Lake Clinical Centre, Kenya

Session Moderator: Catherine Ngugi NASCOP, Kenya, Stella Bosire, Nairobi County, Kenya

Panelists: Richard Banda, WHO, Kenya, Richard Chesang, CDC, Kenya, Amos Otedo, Lake Clinical Centre, Kenya, Joel Gondi, MOH, Kenya

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While there is a connection between ending HIV and achieving UHC, success in ending the HIV epidemic will not be achieved if we do not build a UHC platform. One of the most lamented risks of UHC is that the marginalized people whom the HIV response has fought to keep at the center may be left behind. These are the people most affected by HIV and most common comorbidities: diabetes mellitus, cardiovascular disease (CVD, e.g. hypertension), respiratory diseases (e.g. chronic obstructive pulmonary diseases and pneumonia), and hepatic diseases (hepatitis B and C).

In this session, the complex association of HIV with a host of other diseases and conditions in the era of effective therapy for HIV was highlighted. It was repeatedly emphasized that health professionals will need to deploy more complex strategies and treatments that recognize the rising impact of comorbidities complicating long-term HIV infection. Other recommendations towards refocusing attention on HIV and Emerging Co-Morbidities pointed to the following:

- Need for adequate and right information on Hepatitis to community members
- Addressing the gap on supervision, reporting and mentoring on STIs and Reproductive health.
- Address the gap in screening of STIs in PrEP implementation.
- Community Health Volunteers could be empowered to screen for STIs in the community.
- To bring back conversations of general population STI infections as opposed to only focusing on key populations.
- Continuous revision and training on Reproduction health curriculum with a greater focus on STIs.

CONFERENCE CLOSING

The Maisha HIV and AIDS Conference 2019 closing ceremony was presided over by the NACC Chairperson. Summaries of key actions and recommendations from the various Pre-conference Meetings were presented. The Chief Rapporteur presented the key conference outcomes and recommendations followed by some reflections on shifts required towards accelerating progress within the HIV response:

- From evidenced based programs to systematic data driven segmentation and targeting of programs
- From estimation of data to direct population-based measurements and tracking
- From political commitment to political courage
- From governmental accountability to mutual accountability
- From capacity building to capacity building plus leadership development
- From community involvement and consultation to meaningful community engagements and inclusive governance
- From resource mobilization, centered around donor financing to more structured diversified resource partnerships, centered around domestic financing
- From coordinating multi-sectoral response to addressing the challenges with stewardship on effective leadership

3.5. SUMMARY OF KEY ACTIONS AND RECOMMENDATIONS FROM PRE-CONFERENCE MEETINGS OF THE MAISHA HIV AND AIDS CONFERENCE 2019

Over a period of two months prior to the Maisha HIV and AIDS Conference 2019 held between May 9th-10th, 2019, a total of six (6) Pre-conference Meetings were held. The outcomes of these meetings contributed towards the key recommendations of the Conference. A summary of the key actions and recommendations from each Pre-conference Meeting is presented below:

3.5.1. Religious Leaders Meeting

Engagements captured during the Religious Leaders Meeting

Religious leaders held two Pre-conference Meetings:

- County Inter-faith Religious Leaders Meeting on April 9th – _10th, 2019 in Nakuru.
- Top Religious Leaders Meeting on April 30th, 2019 in Nairobi.

Commitments

Support Sexual and Gender Based Violence (SGBV) response

- Speak out against SGBV within their places of worship and related activities
- Provide information related to SGBV to their congregants
- Address harmful cultural practices that fuel SGBV
- Create safe spaces for survivors of SGBV
- Report on SGBV to relevant authorities

Support the Universal Health Coverage (UHC) by:

- Using religious platforms to leverage on and promote UHC by scaling up congregational response
- Advocating for majority of the UHC funding to go towards primary health care
- Supporting domestic financing/resource mobilization for the HIV response

3.5.2. Women Women Opinion Leaders Forum

This meeting was held on 7th May, 2019 in Naivasha.

Commitments:

Support reduction of new HIV infections through:

- Encouraging uptake of HIV testing for all for HIV prevention
- Encouraging women to attend ANC clinic (at least 4 visits) and deliver babies in health facilities as well as advocate for breastfeeding.
- Providing economic empowerment opportunities for women, and young people to promote adherence to treatment.

Support the Universal Health Coverage (UHC) through:

- Rallying the communities through community women groups at grass root level for enrolment and uptake of UHC
- Advocating for pregnant women to attend antenatal clinics and seek for skilled delivery to prevent MTCT
- Advocate for UHC package to include services which addresses HIV and SRH issues for women of child bearing age
- Advocating and educating parents to discuss openly about sexual value-based education to their children

Support for the boy-child and men in the HIV response through:

- Actively supporting young boys and girls by educating them on HIV prevention, alcohol, drugs and prevention of sexual and gender-based violence.
- Partnering with stakeholders and community gate-keepers to advocate for safe spaces for girls and boys afflicted by SGBV and HIV stigmatization
- Supporting initiatives in the community that promote youth empowerment
- Addressing teenage pregnancy in the community by advocating for increased school enrollment, retention and transition rates in collaboration with relevant stakeholders

Support for NHIF by:

- Educating the people in the grassroots on NHIF and referring them to NHIF centers
- Advocating for enrolment to NHIF by their household and community members
- Encouraging registration for pregnant mothers to the ***Linda Mama Clinic***

3.5.3. National MIPA Forum

The National MIPA Forum was held from May 6th - 7th, 2019, in Machakos County.

Key recommendations:

- Advocate for Universal Health Coverage to leverage on critical foundations laid down by the HIV response such as community and health system structures
- Champion for legislation that is rights-based and all-inclusive to ensure that Universal Health Coverage includes people living with HIV and all key populations.
- Inclusion of HIV and AIDS treatment and commodities for prevention, treatment, care and support in the NHIF sys-tem and UHC package
- Promote health seeking behaviour and the uptake of HIV and AIDS services among men

Sharing of experiences in the context of living with HIV and NCDs

3.5.4. Private Sector Service Delivery within the UHC Agenda

This meeting was held on 7th May, 2019 at the Kenya School of Monetary Studies in Nairobi. Recommendations from the meeting were as follows:

- ***Multi-sectoral approach in HIV management:*** A multi-sectoral approach is critical in HIV management: this would include the infrastructure and related eco-development sectors where population migration and related social interactions lead to new infections
- ***Quality control mechanisms:*** Quality control is critical at both National and County level. FBOs have very strong coordinated systems that could be replicated to other private entities.
- ***Leveraging on the Chronic Care Model:*** UHC implementation could borrow from the Chronic Care Model within the private health sector, while leveraging on national quality systems. The model adopts the hub-and-spoke referral mechanism.

- ***Integration of HIV Management and Profit Mechanisms:*** The role of the private sector in HIV management is long overdue. However, mechanisms for integration in line with profit mechanisms should be put in place.
- ***Putting PPPs into Action:*** PPPs need to be put into action, with the conversation moving away from discussing what we are going to do regarding Partnerships.
- ***Human Rights Approach:*** The HIV/AIDS epidemic should be treated as a humanitarian crisis. Therefore, a denial of health services would be unconstitutional and a violation of one's human rights.
- ***Ownership of the HIV Response and UHC:*** Various sectors should take up ownership without NACC always being involved. For example, if it's the water sector, they need to be able to determine how they can support health.
- We need to have ownership as citizens over health in the community. For example, running leaders out of the community similar to the education sector where senior officials such as principles are held accountable for their children's education.

3.5.5. Adolescents and Young People (AYP) Advocacy Forum

The AYP Advocacy Forum was held from 3rd to 5th May, 2019 in Nairobi. Recommendations from the forum were captured in a communique.

Key highlight of AYP communique:

- ***Availing relevant and accurate information on UHC to young people:*** Young people in their different constituencies need to have relevant and accurate information on UHC and how they can work in their various spaces to push for advocacy on access to quality services. As much as young people want to push the agenda on UHC, information is still a setback for many of them in the community and the advocacy field.

- ***Young people taking action for UHC:*** For UHC to be achieved, it is the young people to take action for UHC is basically focusing on them. They have the numbers and all that is needed is for them to find their space in the various tables.
- ***Need for data and facts:*** Cognizant of the need for young people to seek relevant and accurate information on UHC to have SMART advocacy strategies that yield relevant action from various stakeholders, there is need for data and facts that will back up the various asks they bring forth to governments and policy makers.
- ***Adaptive health systems:*** It is important to engage everyone in the call for advocacy and implementing UHC. For UHC to be effective, the government needs to ensure the health system is adaptive to the various groups and people in the community.
- ***Use of technology in reaching young people:*** Trends in technology are growing and becoming more

dynamic. Hence, the various social media platforms can be utilized to have information and activities on UHC reach a wider range of young people. It is the role of young people to identify the various groups they represent and work with the right kind of tools to pass information.

- ***Addressing new HIV Infections:*** HIV infections among young people is still on the rise and this needs to be addressed as we focus on achieving UHC. This calls for young people to adopt health seeking behavior and utilize the various services available in the community. As much as health is a human right, the responsibility lies with young people to access the various services, both preventive and curative.

3.5.6. Joint AIDS End Term Review Meeting (Consensus Building Meeting)

This meeting was held on 8th May, 2019 in Nairobi.

Key Recommendations

- Counties to take lead in conducting End Term Evaluation of the current County AIDS Strategic Plans (CASPs) and Kenya AIDS Strategic Framework (KASF) and in development of the second generation CASPs and KASF.
- Counties to focus on strategic interventions that are situation specific and have high impact results during the development of the County Specific Plans.
- Counties to adapt and implement Partner implementation framework/mechanisms/models such as Business Process for Impact (BPI) that enhance accountability for results

"As part of the UHC Program, investments have been made, and will continue to be made, to ensure the provision of quality health services in all the 47 counties, thereby ensuring that no one is left behind. We also know that we must supplement national level resources to deliver a model that will ensure sustainable financing for Health. All these are critical lessons, which I am certain will also apply to UHC delivery at county level.

Dr. Andrew Mulwa, COG Rep