



Ministry of Health

Kenya AIDS Strategic Framework II

Sustain Gains, Bridge Gaps and Accelerate Progress



maisha!

National AIDS Control Council

www.nacc.or.ke

Kenya AIDS Strategic Framework II

2020/21-2024/25

Sustain Gains, Bridge Gaps and Accelerate Progress



Core Review Team

1. Dr. Ruth Laibon-Masha CEO, NACC
2. Dr. Catherine Ngugi Head NASCOP
3. Dr. Celestine Mugambi Head Technical Support, NACC
4. Dr. Violet Oramisi Head, Strategic Information, Research and Implementation Science Unit, NASCOP
5. Geoffrey Obonyo Head Strategy, NACC
6. Helgar Musyoki Head Prevention Unit and Key Populations, NASCOP
7. Joshua Gitonga Head M&E, NACC
8. Mary Mugambi Head, HTS and PrEP Section, NASCOP
9. Maureen Inimah Quality Improvement Officer, NASCOP
10. Nelson Otwoma Director, NEPHAK
11. Parinita Bhattecharjeet Technical Advisor, NASCOP

Thematic Team Leads

1. Bryan Okiya PO- Strategy and Planning, NACC
2. Caroline Ngare PO- Development and Implementing Partners, NACC
3. Fridah Muinde Head Research, NACC
4. Joab Khasewa PO- HIV Prevention, NACC
5. Njeri Maina PO-legal, NACC
6. Peter Kinuthia Economist-Financing Strategy, NACC
7. Reuben Musundi Head Stakeholder Co-ordination, NACC
8. Steve Oyugi PO- IEC Materials, NACC

Editors: Dr. Samuel Siringi, Deepti Sreeram

Design and layout: Peter Cheseret, 129 Degrees Design Studio

Table of Contents

Abbreviations and Acronyms.....	vii
Foreword.....	1
Preface.....	2
Acknowledgement.....	3
Executive Summary.....	4
Introduction.....	6
1.1 Addressing HIV is critical to achieving the right to health.....	7
1.2 Global, regional and national commitments guiding KASF II implementation.....	7
1.3 KASF II in Relation to Devolution.....	8
1.4 KASF II and multi-sectoral perspectives.....	8
1.5 Progress and trends in the HIV response against global and country commitments.....	9
1.6 HIV and non-communicable diseases.....	12
1.7 End term review of KASF 1 performance against key target indicators.....	12
The Framework.....	15
2.1 Thematic Areas.....	18
2.2 Overall Implementation Approach.....	18
2.3 Thematic Area 1: Universal access to comprehensive, quality, and integrated HIV and STIs prevention services.....	22
2.4 Thematic Area 2: Revitalise shared fast-track commitment towards achieving of treatment Targets.....	41
2.5 Thematic Area 3: Protect the rights of people to live a life free of violence, stigma and discrimination.....	44
2.6 Thematic Area 4: Invest in resilient systems for HIV and other health outcomes.....	47
2.7 Thematic Area 5: Leverage on communities led programmes for an effective response.....	51
2.8 Thematic Area 6: Integrate HIV in humanitarian and emergency responses.....	54
2.9 Thematic Area 7: Promote translation of strategic information, research, surveillance, innovations and implementation of science to inform HIV programming.....	57
2.10 Thematic Area 8: Invest in Long-term HIV financing models.....	60
2.11 Thematic Area 9: Promote Leadership, Communication and Advocacy.....	64
 Kenya AIDS Strategic Framework II Guiding Documents.....	 68

List of Figures

Figure 1: Annual new HIV Infections among Children aged 0-14 years across Counties, 2019	10
Figure 2: Trends in HIV Testing, Treatment and Viral Suppression Cascade	11
Figure 3: Causes of HIV Transmission from Mother to Child	35

List of Tables

Table 1: Summary of KASF II Thematic Areas and Strategic Focus Areas	5
Table 2: Progress in Reduction of HIV Incidence Across 47 Counties 2018-2020	9
Table 4: Impact level indicators achievements of KASF I	12
Table 3: Key Achievements of KASF I 2014/2015-2018/2019	12
Table 5: Lessons from KASF I Implementation	14
Table 6: HIV prevalence (15-49 years) by County	20
Table 7: Example of prioritizing Counties for intensified focus	23
Table 8: Examples of Comprehensive HIV prevention packages for sub-populations	27
Table 9: Recommended interventions to effectively prevent, control and manage sexually transmitted infections and viral hepatitis	32
Table 10: Proposed interventions to scale up elimination of Mother to Child Transmission of HIV and Syphilis	36
Table 11: Recommended Interventions to Scale Up Differentiated HIV Testing Services	38
Table 12: Recommended actions to improve treatment, care and support for people living with HIV	42
Table 13: Recommended Interventions to safeguard human rights in the HIV response	45
Table 14: Proposed interventions to strengthen resilient and sustainable systems for HIV response and other health outcomes	48
Table 15: Proposed Interventions to Strengthen Community Led Approaches in HIV Response	52
Table 16: Summary of priority strategies on integrating HIV in humanitarian and emergency response	55
Table 17: Summary of strategies to strengthen strategic information, research and innovation to inform policy and practice	58
Table 18: Total cost by KASF II thematic area (Ksh. billions)	60
Table 19: Recommended Intervention on HIV investments models for longer term sustainability	62
Table 20: KASF II Coordination Mechanisms	66
Table 21: Key Interventions Leadership, Accountability, Coordination and Communication	67

Abbreviations and Acronyms

AGYW	Adolescent Girls and Young Women	EWI	Early Warning Indicators
AIDS	Acquired Immuno-Deficiency Syndrome	FBO	Faith-Based Organisation
ANC	Antenatal Care	FC	Faith Communities
APNS	Assisted Partner Notification Services	FSW	Female Sex Workers
ART	Antiretroviral Treatment/Therapy	FWID	Females Who Inject Drugs
AYP	Adolescents and Young People	GBV	Gender-Based Violence
BCC	Behaviour Change Communication	GF	Global Fund
CAC	County AIDS Coordinator	HAT	HIV and AIDS Tribunal
CAIP	County AIDS Implementation Plan	HCV	Hepatitis C Virus
CALHIV	Children and Adolescents Living with HIV	HIPORS	HIV Implementing Partners Online Reporting System
CAPR	Community Activity Programmes Reporting	HIV	Human Immunodeficiency Virus
CASP	County AIDS Strategic Plan	HPV	Human Papilloma Virus
CBO	Community-Based Organisation	HRH	Human Resources for Health
CCC	Comprehensive Care Centre	HTS	HIV Testing and Services
CDC	Centre for Disease Control	IBBS	Integrated Biological and Behavioural Study
CEO	Chief Executive Officer	ICT	Information and Communication Technology
CHC	County HIV Committee	IEC	Information, Education and Communication
CHEW	Community Health Extension Workers	IGA	Income Generating Activities
CHV	Community Health Volunteers	ILO	International Labour Organisation
CHW	Community Health Workers	IPC	Infection Prevention and Control
CIDP	County Integrated Development Plan	KAIS	Kenya AIDS Indicator Survey
CoG	Council of Governors	KAM	Kenya Association of Manufacturers
CS	Cabinet Secretary	KASF	Kenya AIDS Strategic Framework
CSO	Civil Society Organisation	KDHS	Kenya Demographic and Health Survey
CSR	Corporate Social Responsibility	KEBS	Kenya Bureau of Standards
DATIM	Data for Accountability, Transparency and Impact Monitoring	KEMRI	Kenya Medical Research Institute
DDIU	Data Demand and Information Use	KEMSA	Kenya Medical Supplies Agency
DoD	Department of Defence	KENPHIA	Kenya Population-based HIV Impact Assessment
EBI	Evidence-Based Interventions	KEPI	Kenya Expanded Programme for Immunisation
ECHO	Extended Community Health Outcomes	KEPSA	Kenya Private Sector Alliance
EGH	Elder of the Golden Heart	KHIS	Kenya Health Information System
EID	Early Infant Diagnosis	KHQIF	Kenya HIV Quality Improvement Framework
EMR	Electronic Medical Record	KHSA	Kenya Health System Assessment
eMTCT	Elimination of Mother to Child Transmission	KHSSP	Kenya Health Sector Strategic Plan
		KLRC	Kenya Law Reform Commission
		KMLTTB	Kenya Medical Laboratory Technicians and Technologists Board

KMoT	Kenya Mode of Transmission	PETS	Public Expenditure Tracking System
KMTC	Kenya Medical Training College	PLHIV	People Living with HIV
KNBS	Kenya National Bureau of Statistics	PMTCT	Prevention of Mother to Child Transmission
KP	Key Population		
KSH	Kenya Shillings	PNS	Peripheral Nervous System
LISTEN	Local Innovations Scaled Through Enterprise Network	POC	Point- of- Care
LMIS	Logistics Management Information System	POCT	Point-of-Care Testing
M&E	Monitoring and Evaluation	PPB	Pharmacy and Poisons Board
MAT	Medication-Assisted Treatment	PPE	Personal Protective Equipment
MCDAs	Ministries, Counties, Departments and Agencies	PrEP	Pre-Exposure Prophylaxis
MDAs	Ministries, Departments and Agencies	PWD	Persons with Disabilities
MEDS	Mission for Essential Drugs and Supplies	PWID	People Who Inject Drugs
MoE	Ministry of Education	QI	Quality Improvement
MoH	Ministry of Health	R&D	Research and Development
MSM	Men who have Sex with Men	RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
MSW	Male Sex Workers	RMNCH	Reproductive, Maternal, Newborn and Child Health
MTCT	Mother to Child Transmission	RNM	Resource Needs Model
MTEF	Medium-Term Expenditure Framework	RSSH	Resilient Sustainable Systems for HIV and AIDS and Health
MTP	Medium-Term Plan	RTKs	Rapid Test Kits
MWIDs	Males Who Inject Drugs	SCAC	Sub-County AIDS Coordinator
NACADA	National Authority for Campaign against Alcohol and Drug Abuse	SDGA	State Department of Gender Affairs
NACC	National AIDS Control Council	SGBV	Sexual and Gender-Based Violence
NASA	National AIDS Spending Assessment	SGS	Second-Generation Surveillance
NASCOP	National AIDS and STIs Control Programme	SOP	Standard Operating Procedures
NCDs	Non-Communicable Diseases	SRH	Sexual and Reproductive Health
NCPWD	National Council for Persons with Disability	SRHR	Sexual and Reproductive Health and Rights
NEPHAK	National Empowerment Network of People Living with HIV and AIDS in Kenya	STIs	Sexually Transmitted Infections
NGO	Non-Governmental Organisation	TB	Tuberculosis
NHA	National Health Accounts	TVET	Technical and Vocational Education and Training
NHIF	National Hospital Insurance Fund	TWG	Technical Working Group
NHRL	National HIV Reference Laboratory	UHC	Universal Health Coverage
NTSA	National Transport and Safety Authority	UNAIDS	Joint United Nations Programme on HIV and AIDS
OSH	Occupational Safety and Health	UNDP	United Nations Development Programme
OSHA	Occupational Safety and Health Act	UNFPA	United Nations Population Fund
OVC	Orphaned and Vulnerable Children	UNICEF	United Nations Children's Fund
PBFW	Pregnant and Breast Feeding Women	USAID	United States Agency for International Development
PEP	Post-Exposure Prophylaxis		
PEPFAR	President's Emergency Plan for AIDS Relief	VL	Viral Load
		VMC	Voluntary Medical Male Circumcision
		WHO	World Health Organization
		WLHIV	Women Living with HIV

Foreword



A handwritten signature in black ink, appearing to read 'Mutahi Kagwe', written over a white background.

**Hon. Senator Mutahi
Kagwe, EGH**
*Cabinet Secretary for
Health*

Kenya strives to remain on the right path towards ending AIDS as a public health threat by the year 2030, in line with the global Sustainable Development Goals (SDGs). Over the last few years, great progress has been made leading to a significant reduction in new HIV infections and AIDS-related deaths. Key success factors include swift translation of scientific evidence in programmes, implementation of robust policy and strategic frameworks, multi-sectoral approach that engages all levels of governance, different sectors of the economy, various stakeholders and partners. Despite notable progress, HIV and AIDS continues to impact on mortality rates, burden households and strain national health systems in Kenya.

With this understanding, the Kenya AIDS Strategic Framework (KASF II) hinges on the commitment of national and county governments and their partners to scale up cost-effective and socially inclusive interventions for its successful implementation. KASF II re-emphasises on the need for strengthened community engagement and leadership, an equitable HIV response achieved through effective prioritisation of interventions, populations and counties. This framework is aligned with the Constitution of Kenya (2010), Vision 2030 development blueprint and its supporting third Medium-Term Plan (MTP) III, national Universal Health Coverage (UHC) aspirations, the East African Community HIV and AIDS Prevention and Management Act (2012), and the African Union goals on HIV control.

Kenya will continue to invest in a multi-sectoral HIV response and strengthen coordination and governance structures led by the National AIDS Control Council (NACC). Further, the Ministry of Health takes cognisance of the devolved system of governance and functions of the different levels of government, the role of other Ministries, Departments and Agencies to draw from the policy direction in the implementation of KASF II.

To sustain the national response to HIV, KASF II outlines the need for innovative approaches to secure domestic resources, including through a ring-fenced fund. Kenya aims at increasing the domestic resource envelope, in line with the Universal Health Coverage agenda. The Country will invest in both preventive and treatment programmes to sustain the gains made and address emerging challenges. I call upon all levels of governance, sectors, stakeholders and partners to remain committed in their efforts to implement KASF II.

Preface



A handwritten signature in cursive script that reads "Angeline Siparo".

Ms Angeline Siparo
Chairperson, National AIDS
Control Council

The Kenya AIDS Strategic Framework (KASF II) (2020/21-2024/25) marks a critical juncture of the country's response to HIV. The development and implementation of KASF II is happening at the time of the emergence of another global pandemic of COVID-19. The National AIDS Control Council (NACC) has taken into consideration this unprecedented social, political, and economic challenge that is likely to impact on the implementation of KASF II. Kenya has made progress over the last decade in her response to HIV, evidence of which is the reduction of new HIV infections, increased access to life-saving antiretroviral therapy, and reduction of AIDS-related deaths. In this regard, KASF II calls for the building of national and county-led AIDS responses that can withstand disruptions, manage uncertainties and unforeseen emergencies to secure these gains.

The Kenya's HIV response will remain embedded within people-centred approaches. We will continue to respect constitutionally guaranteed human rights and ensure that scientific evidence and knowledge are translated into concrete programmatic actions. KASF II highlights the need to prioritise geographical locations and reach all marginalised and excluded populations in need of HIV services. The Council urges all Kenyans to eliminate HIV related stigma and discrimination that continues to undermine the success of interventions focusing on priority groups.

We encourage meaningful stakeholders' engagement in the development and implementation of County AIDS Implementation Plans (CAIPs). We call on all stakeholders to support NACC to deliver on the promise of '**A Kenya free of HIV infections, stigma and AIDS-related deaths**'.

Acknowledgement



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

The successful development of the Kenya AIDS Strategic Framework (KASF II) (2020/21 - 2024/25) has been a result of enormous contribution and active participation of multiple stakeholders. KASF II draws from recommendations based on lived experiences, epidemic analyses and previous programme implementation. Key lessons learnt from the implementation of the Kenya AIDS Strategic Framework (KASF I) and the County AIDS Strategic Plans (CASPs) were considered.

The NACC would like to thank its staff, partners and stakeholders who contributed to the development of this framework. They include the leadership from state actors including the National AIDS and STIs Control Programme (NAS COP), Ministry of Health (MoH) Directorates, County Governments, the Council of Governors (CoG) and non-state partners. We convey our sincere gratitude to the networks of People Living with HIV (PLHIV), Civil Society Organisations and community representatives, including Key Populations (KPs), Adolescents and Young People (AYPs), Persons with Disabilities (PwDs), women organisations and representatives of elderly persons whose enormous contribution has been captured in the development of this framework.

Incredible appreciation goes to members of the KASF II steering committee, technical and thematic working groups and peer review teams drawn from civil society and community-led organisations, public sector institutions, private sector, faith-based organisations, research and academic institutions and development partners.

We wish to acknowledge with gratitude the financial and technical contribution of various partners during the development, review and printing of this framework. Specifically, we thank the Global Fund to Fight AIDS, Tuberculosis and Malaria; UN Joint Team on HIV led by UNAIDS, UNDP, WHO, ILO, UNICEF, UNFPA, the World Bank among other agencies; the US Government for its support through the President's Emergency Plan for AIDS Relief (PEPFAR) and its agencies (USAID, CDC and DoD); Beyond Zero; the International AIDS Vaccine Initiative (IAVI) and Clinton health Access Initiative (CHAI). NACC remains committed to working with all stakeholders to implement KASF II.

Executive Summary

The Kenya AIDS Strategic Framework (KASF II) (2020/2021 - 2024/2025) provide the strategic directions that will lead to accerelated progress towards a Kenya free of HIV infections, stigma and AIDS related deaths.

The Kenya AIDS Strategic Framework (II) provides guidance for implementing an evidence-based HIV response. It outlines priority interventions and emphasis on the need to create an enabling system to maximise on the impact of interventions. KASF II leverages the gains made under Kenya AIDS Strategic Framework I (KASF I) which was implemented through the County AIDS Strategic Plans (CASPs). It promotes the need to strengthen and bring to scale interventions and approaches that have yielded results. It is also premised on the Constitution of Kenya (2010) that stipulates the right to highest attainable standard of health to all citizens and guides the full engagement of counties in the national health response. The framework builds on the gains made in the devolved system of planning and governance of the AIDS

programmes in Kenya. It is aligned with the Kenya Universal Health Coverage agenda and its roadmap, Kenya's Vision 2030, the Kenya Health Sector Strategic Plan (KHSSP) of 2018/2019 - 2022/2023, as well as global and regional health commitments.

The development of this framework has been informed by epidemic appraisals and the response. The framework has been developed during a period when the world is faced with global COVID-19 pandemic challenge and thus has taken COVID-19 related disruptions into consideration. It provides guidance on priority interventions for implementation. The vision, goal and the nine thematic areas of the framework are summarised.

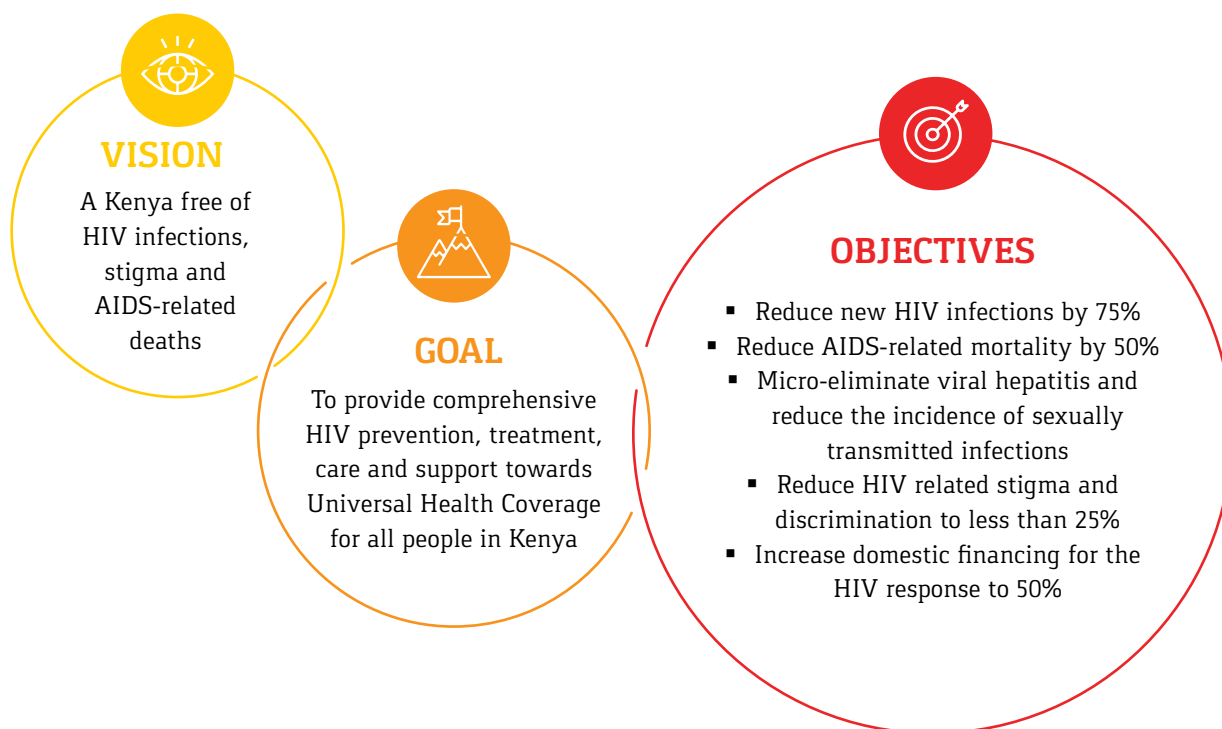




Table 1: Summary of KASF II Thematic Areas and Strategic Focus Areas

Thematic Area	Strategic Focus Areas
 <p>Thematic Area 1: Universal access to comprehensive, quality, and integrated prevention of HIV and Sexually transmitted infections</p>	<ul style="list-style-type: none"> ▪ Adapt and scale up comprehensive and high impact HIV prevention interventions ▪ Accelerate efforts towards elimination of mother to child transmission of HIV and syphilis ▪ Re-invigorate and scale up prevention, management and control of Sexually Transmitted Infections (STIs) and Viral Hepatitis ▪ Enhance identification and linkages to HIV prevention, treatment, care and support services
 <p>Thematic Area 2: Revitalise shared fast-track commitment to achieve treatment targets</p>	<ul style="list-style-type: none"> ▪ Optimise ART treatment for all sub-populations to improve patient health outcomes. ▪ Strengthen differentiated service delivery models to improve access ▪ Strengthen management of TB, NCD's and comorbidities among PLHIV ▪ Strengthen multisectoral engagement including private sector in HIV service delivery to enhance coverage and effectiveness ▪ Prioritise mental health and control of substance and alcohol abuse interventions in HIV programmes
 <p>Thematic Area 3: Protect the rights of people to live a life free of violence, stigma and discrimination</p>	<ul style="list-style-type: none"> ▪ Promote accountability and responsiveness for enhanced human rights protection ▪ Promote access to justice through public awareness of legal frameworks and redress institutions ▪ Institutionalise progress monitoring of HIV related stigma and discrimination and other health and human rights violations ▪ Reduce all forms of violence among vulnerable priority groups
 <p>Thematic Area 4: Invest in resilient systems for Health to improve HIV response and other health outcomes</p>	<ul style="list-style-type: none"> ▪ Integrated service delivery and quality improvement ▪ Improve the management of human resources for health including community health workers ▪ Strengthen health management information systems and monitoring and evaluation ▪ Strengthen the health product management systems ▪ Harmonise and strengthen financial management system ▪ Enhanced infrastructure and equipment management systems and services
 <p>Thematic Area 5: Leverage on communities led programmes for an effective HIV response</p>	<ul style="list-style-type: none"> ▪ Design and implement people centred responses ▪ Reinforce the critical role of community-led interventions ▪ Strengthen community-led data monitoring and social accountability
 <p>Thematic Area 6: Integrate HIV in humanitarian and emergency responses</p>	<ul style="list-style-type: none"> ▪ Enhance multi-level and multi-sectorial capacity for risk preparedness, reduction and mitigation against impact of disasters ▪ Establish a framework to ensure continuity of HIV services during humanitarian and emergency crisis ▪ Strengthen community centred emergency responses
 <p>Thematic Area 7: Swift translation of innovations, strategic information, research, surveillance, and implementation of science into programmes</p>	<ul style="list-style-type: none"> ▪ Strengthen routine programme reporting capacities for HIV, STIs and other co-morbidities ▪ Promote timely translation of research into policy and practice ▪ Strengthen surveillance and periodic surveys for HIV, STIs and other co-morbidities ▪ Develop and disseminate timely strategic information products and capacities to improve data access, demand and use
 <p>Thematic Area 8: Invest in long-term HIV investments and efficiency in use of resources</p>	<ul style="list-style-type: none"> ▪ Enhanced domestic resource mobilisation to respond to HIV ▪ Enhanced efficiency and effectiveness in resource utilisation ▪ Put in place regularly updated plans to manage HIV resources transitions
 <p>Thematic Area 9: Promote Leadership, Communication and Advocacy</p>	<ul style="list-style-type: none"> ▪ Promote transformational leadership among political and technical leaders for the national and county HIV and AIDS responses ▪ Enhance the use of data-led and results-based coordination mechanisms for the multi-sectoral HIV and AIDS response ▪ Ensure social accountability of the HIV programme promoted at all levels ▪ Ensure sustained communication and advocacy

01

Introduction



The Kenya AIDS Strategic Framework II is the 5th agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners involved in the HIV response in Kenya. KASF II will be operationalised through 47 County AIDS Implementation Plans in line with principles of devolved governance and reported through agreed country level Monitoring and Evaluation System. The National AIDS Control Council will coordinate the broad based multi-sector partners involved in implementation.



1.1 Addressing HIV is critical to achieving the right to health

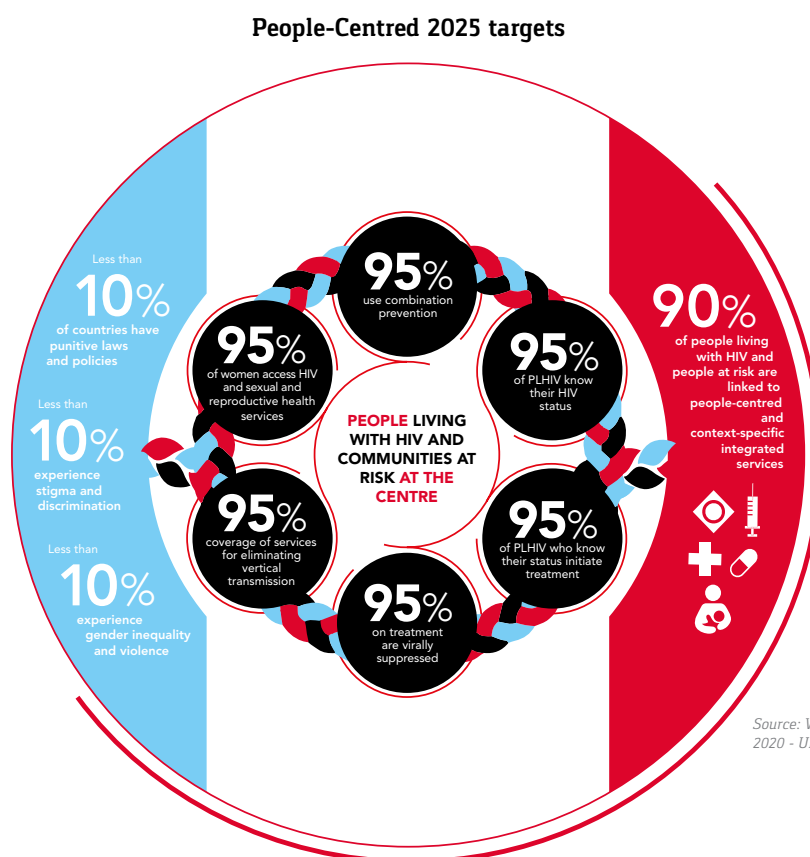
The Kenyan Health Policy 2014-2030 prioritises the elimination of communicable diseases including HIV and AIDS in line with the right to the highest attainable standard of health mandated by the Constitution of Kenya (2010). Despite the tremendous progress made in more than three decades of the HIV and AIDS response, the epidemic continues to be a significant contributor to the national disease burden. In 2017, HIV accounted for 19% of all years of life lost in that year. Since the first case was officially reported in 1984 in Kenya, about 2 million people have lost their lives due to AIDS-related deaths (Kenya HIV Estimates, 2020). At the peak of the epidemic in the mid-1990s, HIV caused a decline in life expectancy by about 12 years and led to an increase in child mortality by 20%. Fortunately, there has been a reversal of this trend in the last two decades, spurred by significant progress in preventing new infections, increasing access to life-saving antiretroviral therapies (ART) and scaling up of care and support services for the PLHIV. By the end of 2019, at least, 1.5 million Kenyans were found to be living with HIV while 41,416 new infections were reported and 20,997 AIDS-related deaths had occurred.

This strategic framework maps out priority areas, strategic interventions, population groups, geographical areas and identifies critical social and programmatic enablers to effectively respond to the HIV challenge. It also provides implementation and management arrangements that will promote effective coordination for programme coherence. KASF II emphasis on the need to consolidate the gains made over the years by identifying programmatic gaps and appropriate interventions that will ensure high impact interventions and approaches are strengthened and scaled up.

1.2 Global, regional and national commitments guiding KASF II implementation

Kenya has made several global, regional and national commitments that will guide the implementation of KASF II:

- Sustainable Development Goals (SDGs) commitment to end AIDS by 2030:** KASF II is aligned to the SDGs including the goal to end the AIDS epidemic by 2030, inspired by a global vision to progress towards 'zero new HIV infections, zero AIDS-related deaths and zero discrimination'.



- The **African Union Agenda 2063**: KASF II is aligned to the African Union Agenda 2063 under Goal 3 for a prosperous Africa, focusing on healthy and well-nourished citizens. Ending the AIDS epidemic by 2030 is also a part of the African Union Agenda 2063.
- **East African Community HIV and AIDS Prevention and Management Bill (2012)**: This Bill directs governments in the East African Community to ensure that persons living with or are affected by HIV and AIDS are protected from all forms of abuse, discrimination and are provided with appropriate support, care and treatment services.
- **The Constitution of Kenya (2010)**: KASF II is aligned to the Constitution of Kenya in its commitment to provide the highest attainable standard of health to its citizens. In line with the constitution, KASF II will adopt a devolved and participatory planning and service delivery approach by counties, sectors and the people of Kenya through CASPs and sector-specific plans. These plans will be aligned with the KASF II based on county and sector-specific needs.
- The **Kenya Vision 2030**: Kenya Vision 2030 is the long-term development blueprint for the country. The aim of the Vision is to create 'a globally competitive and prosperous country with a high quality of life by 2030'. As a part of its long-term development objectives, it identifies HIV and AIDS as a challenge that needs to be addressed. The Vision is divided into 5-year plans and KASF II is aligned with the current MTP III (2018 - 2020).
- **The Kenya Health Sector Strategic and Investment Plan (KHSSP) of 2018/2019 - 2022/2023**: The KHSSP recognises the contribution of the HIV response to the achievement of targets under the President's 'Big-Four' agenda related to affordable health care for all. This therefore means that KASF II is well-placed to support the KHSSP by prioritising activities to reach the most vulnerable and marginalised population. It aims to achieve the health aspirations of all Kenyan citizens.

1.3 KASF II in Relation to Devolution

Kenya has a decentralised system of governance made up of two levels of government namely: the national government and the 47 county governments as established by the Constitution of Kenya (2010). Devolution of

power, resources and representation of citizens facilitate Counties to address HIV related challenges within their local context. KASF II will continue to entrench citizen participation in formulating and implementing AIDS strategies that respond to local needs. To facilitate this process, granulation and dissemination of strategic information will be done at various levels of governance to provide evidence for localised decision-making.

Under the devolved system of governance, county governments have the primary mandate of establishing relevant structures, and prioritising interventions and investments in the provision of HIV and AIDS and other health services. The county governments, in collaboration with stakeholders and partners, are the principal implementers of KASF II. In line with devolved governance, county governments have an obligation to coordinate resource allocation for priority HIV and AIDS and other health interventions so as to fully address priority areas identified. The second generation of County AIDS Implementation Plans will be aligned to country Roadmap to achieve Universal Health Coverage. NACC will provide technical support to County governments to provide quality HIV services that meet localised needs and context across all health, education and community level implementation platforms. Greater attention will be the need to address to social determinates of health and HIV, building of strong community responses, putting in place effective governance and coordination structures and domestic allocation of resources to sustain the HIV response.

1.4 KASF II and multi-sectoral perspectives

In order to ensure maximum participation of stakeholders and partners, HIV prevention, treatment, care and support interventions need synergy and unified coordination across all sectors, including non-health sectors at the county. KASF II lays emphasis on a multi-sectoral approach to AIDS response that aligns with the globally *"Three Ones Principles of one One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad based multi-sector mandate and One agreed country level Monitoring and Evaluation System"*. It calls out for re-energised platforms for engagement of the public and private sectors, CSOs, FBOs, networks of PLHIV, PwDs, Key Populations and AYPs, research institutions, among other stakeholders in decision-making, implementation of programmes and tracking of results at both levels.

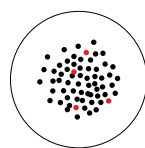
1.5 Progress and trends in the HIV response against global and country commitments



New HIV infections

New HIV infections declined from 75,000 in 2010 to 41,416 in 2019. This amounts to a 44% reduction of cases, which is indicative of substantial progress, but short off the reduction by 75% envisioned by 2020.

New HIV infections among children declined from 18,000 to 6,806, while new HIV infections among adults declined from 56,000 to 34,610. Kenya needs to accelerate progress in the reduction of new HIV infections in a new context: an HIV epidemic that has evolved, the global COVID-19 pandemic, the increasing role of new technologies and a rapidly changing society. Altogether, this requires an HIV prevention response that is persistent in its drive towards core objectives but reflecting innovation. The existing high impact and quality interventions including condom programming, Voluntary Medical Male Circumcision (VMMC), prevention and treatment of Sexually Transmitted Infections, Pre-Exposure Prophylaxis (PrEP), HIV testing and treatment, elimination of Mother-to-Child Transmission (eMTCT), keeping girls in schools, elimination of all forms of gender related violence, ending HIV related stigma and discrimination will need to be expanded to scale.



HIV prevalence

Kenya has made commendable progress in the HIV response as evidenced by the progressive decline in HIV prevalence among adults (15-49 years) in the general population, from a peak of about 10% in the mid-1990s to 4.5% in 2020. The HIV epidemic in Kenya continues to be disproportionately higher among females than males. The burden of HIV remains highest for the age category of 15-49 years. The epidemic shows a pattern of generalisation across the country, concentrated among sub-populations, and a mix of both in some geographical locations. The geographical diversity of HIV prevalence ranges from a high of 20.1% in Homa Bay County to a low of 0.2% in Mandera and Wajir counties (Kenya HIV Estimates 2020).

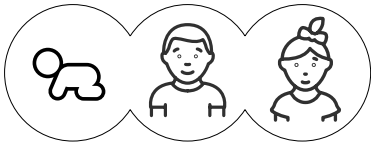


Kenya has made commendable progress in the HIV response noted through progressive decline in HIV prevalence among adults (15-49 years) in the general population, from a peak of about 10% in the mid-1990s down to 4.5% in 2020 and reduction of new HIV infections and AIDS related deaths

Table 2: Progress In Reduction of HIV Incidence Across 47 Counties 2018-2020

Increased Infections Reverse Gear		Minimal Decline <50% Parking		Large Improvement >50% Forward Gear	
Nandi	Baringo	Mombasa	Meru	Kwale	Kirinyaga
Narok	Samburu	Busia	Machakos	Makueni	Murang'a
Nakuru	Uasin Gishu	Kakamega	Kericho	Nyeri	Kilifi
Elgeyo-Marakwet	Kisii	Siaya	Nairobi	Bungoma	Taita-Taveta
Laikipia	Kisumu	Migori	Lamu	Vihiga	Tana River
Kajiado	Turkana	Homa Bay	Tharaka-Nithi	Nyandarua	Isiolo
Bomet	Trans-Nzoia	Nyamira	West Pokot	Kiambu	Kitui
Marsabit		Garissa	Wajir		
		Mandera	Embu		

*Kenya HIV Estimates 2020 NACC: Changes in HIV incidence per 1000 population



Prevention and management of HIV among children aged 0-14

The main mode of HIV transmission among children aged 0-14 is from mother to child during pregnancy, birth and breastfeeding. In 2019, a total of 59,304 (94%) of women living with HIV received ARV prophylaxis to prevent HIV transmission during pregnancy and breastfeeding period. Despite the annual decline of the number of women in need for prevention of mother to child transmission services from about 85,400 in 2010 to approximately 63,000 in 2019, an estimated 6,696 HIV positive pregnant women did not access treatment for

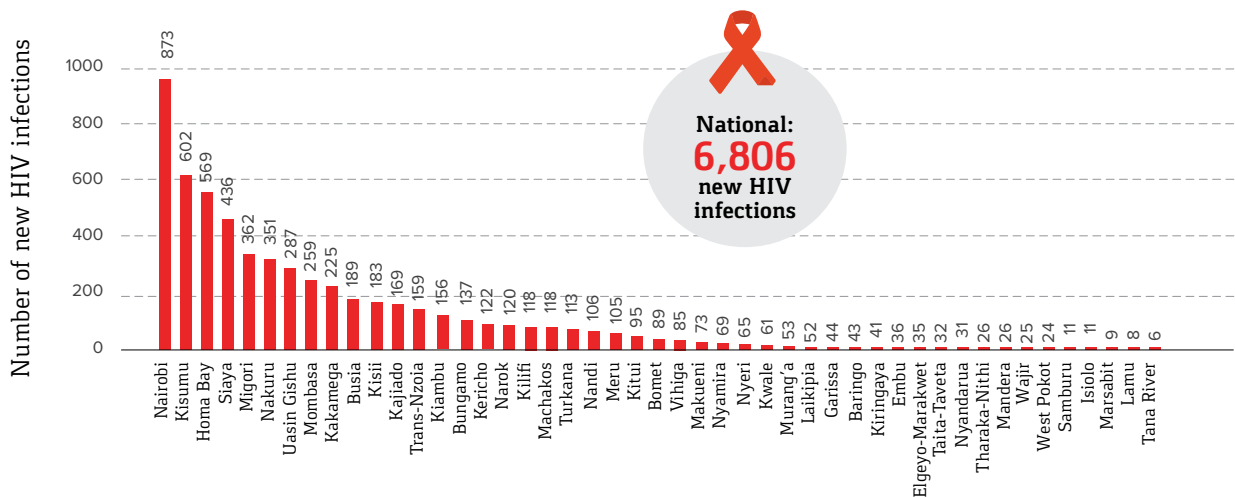
their health and that of their unborn and newborns in 2019. The situation demands increased focus to minimise the missed opportunities to provide HIV testing and treatment services for HIV positive women.

HIV transmission among children due to early sexual debut and defilement cases are worrying. In 2019, programme data showed that 20,362 children aged 10-14 were pregnant. Factors such as high number of orphans (656,300) who require social protection services, low retention, and low transition rates from primary to secondary school - 18% of girls who do not complete primary education (KDHS 2014) and elimination of all forms of violence against children must be addressed. There is need to target locations with high teenage pregnancies as a proxy-indicator of heightened risk to HIV infections among girls. Kenya Health Information System (KHIS) shows 28% (399,028) of all pregnancies registered were among adolescents aged 10-19. In 2019 a third of these teenage pregnancies occurred in nine counties, namely, Nairobi (26,545), Kakamega (17,555), Nakuru (16,502), Meru (15,826), Narok (14,962), Bungoma (14,512), Kiambu (13,562) Homabay (13,644) and Kwale (11,251).

The success of ART treatment programmes among children (0-14yrs) is largely dependent on early diagnosis and prompt ART initiation. Some 34,337 (32%) children living with HIV were not on ART treatment by the end of 2019. Among those on treatment, only 51% were virally suppressed leaving a large cohort of children prone to HIV related co-morbidities and ill health.

Estimates models shows that by end of 2019, Kenya has averted 118,300 mother to child HIV infections due to scale up of Prevention of transmission of HIV from mother to child during pregnancy and breastfeeding since 2004

Figure 1: Annual new HIV Infections among Children aged 0-14 years across Counties, 2019



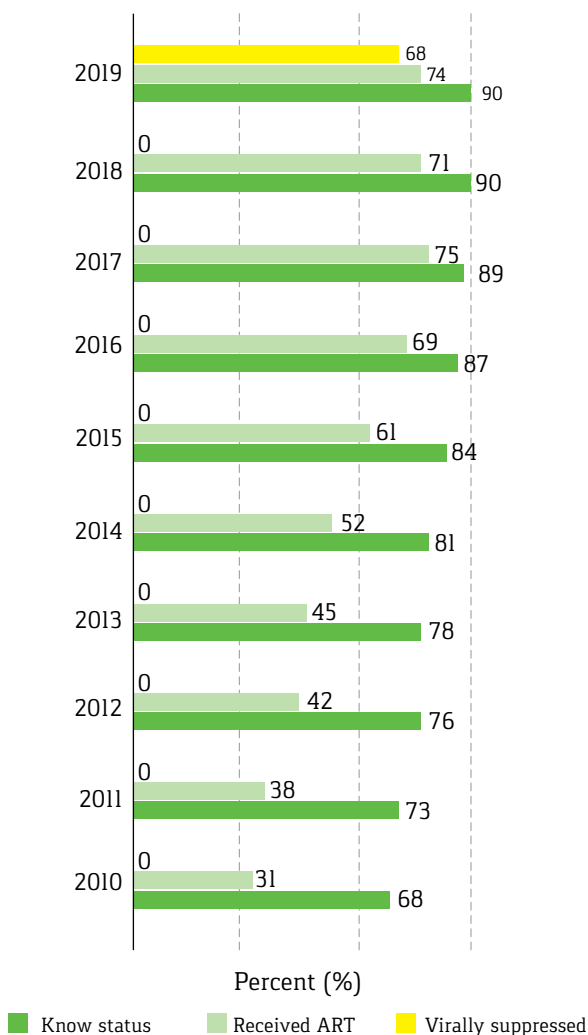
Source: Kenya HIV Estimates 2020



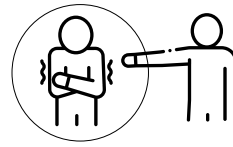
Access to Treatment

The number of people living with HIV on treatment increased dramatically since 2010. The increase is largely attributed to the evolution and rapid adoption of global guidelines for HIV treatment. By the end of 2019, a total of 1,160,479 (1,087,511 adults and 72,968 children) were on antiretroviral therapy, representing an estimated treatment coverage of 80% among adults (68% among children). Positive health outcomes attributed to ART still remain elusive for close to half a million Kenyans who are not aware of HIV status.

Figure 2: Trends in HIV Knowledge Status, Treatment and Viral Suppression Cascade

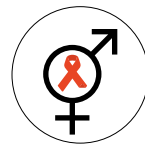


Source: Kenya HIV Estimates 2020



HIV-related stigma and discrimination

Progress in elimination of HIV related stigma and discrimination is off track. According to the KDHS 2014 the percentage of women reporting accepting attitudes towards PLHIV reduced from 33% in 2010 to 26% in 2014. Similarly, the same indicator showed a decrease from 48% to 44% among men who reported accepting attitudes. Programmatic reports show that specific groups, such as key populations, continue to face stigma and discrimination even in health care settings. There is need to address policy and legal barriers that impact negatively on access to HIV services.



HIV and Gender issues

In recent decades, incremental gains towards gender equality have fallen short of improving educational and economic opportunities for women and girls. For this reason, women and girls remain disproportionately affected by poverty, violence and injustice that make them vulnerable to HIV. Unequal gender norms deny women and girls the ability to make their own choices about health care. Domestic work along with caregiving responsibilities curtail their freedom to enter and remain in the labour force on terms that suit their needs. This ultimately impacts women's economic independence, security, decision making and control. KASF II will prioritize efforts that build synergies with other development agendas that seek to empower women and girls thus reducing their vulnerability to HIV.



AIDS Related Deaths

AIDS related deaths declined rapidly from 51,000 in 2010 to 20,997 in 2019, representing a 59% reduction. AIDS related deaths declined more significantly among children - from 16,000 in 2010 to 4,300 in 2019. AIDS related deaths among women also declined from 22,000 to 7,300, while the deaths among men only declined moderately from

13,000 in 2010 to 9,400 in 2013. In 2019, 90% of all Kenyans living with HIV knew of their HIV status, which means that the 2020 target of achieving 90 percent across the cascade was achieved. Some 74% of people living with HIV were on treatment against a target of 81% and 68% had a suppressed viral load against a target of 73%. Progress varies by age and sex, as 74% of adult women had a suppressed viral load, achieving the 2020 targets was however only 61% of adult men and 51% of children had a suppressed viral load. The lower levels of viral suppression among men contribute to higher mortality rates among men and impact negatively on increased number of new HIV infections among their sexual partners. The low level of viral suppression among men and children points to continued service gaps and barriers that need to be urgently addressed.

1.6 HIV and non-communicable diseases

The Kenya Non-Communicable Diseases (NCDs) 2019 Estimates mathematical model showed that an estimated 33% of Kenyan adults suffered from one NCD in 2018 with 29% suffering from two or more NCDs. Adults living with HIV are more likely to suffer (one 36%) or (two 46%) forms of NCDs as compared to people without HIV diagnosis at 28% suffering from one or two NCDs. The model showed that the prevalence of people living with HIV suffering from two NCDs would increase to 55% by 2035 compared to 33 percent among those with negative HIV diagnosis. Prevention and management of NCDs among PLHIV should remain a key priority.

1.7 End term review of KASF I performance against key target indicators

Table 3: Key Achievements of KASF I 2014/2015-2018/2019



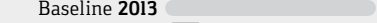
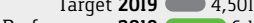
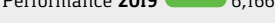


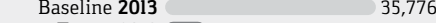
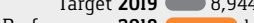
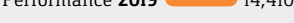


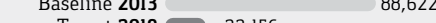
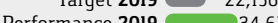
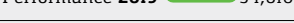



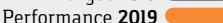
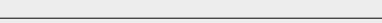



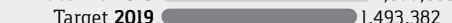




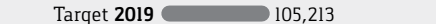




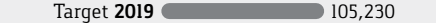




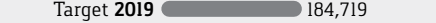

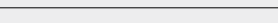










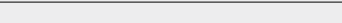



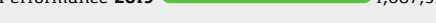
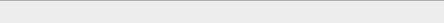



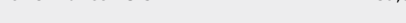
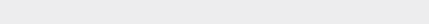



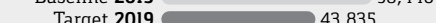






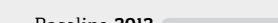



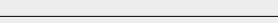
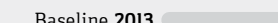




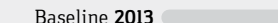








Objective	Achievement
Reduce new HIV infections by 75%	44%
Reduce AIDS-related mortality by 25%	64%
Reduce HIV-related stigma and discrimination by 50%	*
Increase domestic financing of HIV response to 50%	32%

*There was no new HIV stigma index available to assess progress on this indicator.

Table 4: Impact level indicators achievements of KASF I

HIV prevalence 	Overall Baseline 2013 6.0% Target 2019 4.8% Performance 2019 4.5% 1.5% reduction in prevalence rate
	Female Baseline 2013 7.6% Target 2019 5.2% Performance 2019 5.8% 1.8% reduction in prevalence
	Male Baseline 2013 5.6% Target 2019 4.5% Performance 2019 3.1% 2.5% reduction in prevalence
Incidence per 1,000	Adults (15-49) Baseline 2013 3.2% Target 2019 0.97% Performance 2019 1.2% 2.0% reduction in incidence since
New HIV Infections 	Overall Baseline 2013 101,488 Target 2019 25,362 Performance 2019 41,416 59% reduction in new HIV infections
	Children (0-14) Baseline 2013 12,826 Target 2019 3,207 Performance 2019 6,806 47% reduction in children new infections

New HIV Infections (continued) 	Adolescents (10-19) 	Baseline 2013  18,004 Target 2019  4,501 Performance 2019  6,166	 66% reduction in new HIV infections
	Young Adults (15-24) 	Baseline 2013  35,776 Target 2019  8,944 Performance 2019  14,410	 25% reduction of new Young Adult infections
	Adults (15+) 	Baseline 2013  88,622 Target 2019  22,156 Performance 2019  34,610	 61% reduction in new infections
	MTCT rate 	Baseline 2013  13.9% Target 2019  Less than 5% Performance 2019  10.8%	 3.1% reduction in MTCT rate
People living with HIV 	Overall 	Baseline 2013  1,599,358 Target 2019  1,493,382 Performance 2019  1,508,405	 Number reduced by 90,963
	Children (0-14) 	Baseline 2013  191,743 Target 2019  105,213 Performance 2019  106,807	 Number reduced by 84,936
	Adolescents (10-19) 	Baseline 2013  133,455 Target 2019  105,230 Performance 2019  91,634	 Number reduced by 41,821
	Young Adults (15-24) 	Baseline 2013  268,586 Target 2019  184,719 Performance 2019  145,471	 Number reduced by 46%
	Adults (15+) 	Baseline 2013  1,407,615 Target 2019  1,388,169 Performance 2019  1,401,598	 Number reduced by 6,017
Treatment 	Children on ART 	Baseline 2013  60,141 Target 2019  86,325 Performance 2019  72,968	 21% increase on ART Coverage among children
	Adults on ART 	Baseline 2013  596,228 Target 2019  1,035,618 Performance 2019  1,087,511	 82% increase in ART Coverage among Adults
	On PMTCT 	Baseline 2013  55,543 Target 2019  53,067 Performance 2019  59,304	 7% increase in PMTCT Coverage
HIV Related Deaths 	Total 	Baseline 2013  58,446 Target 2019  43,835 Performance 2019  20,897	 64% reduction in total AIDS related deaths
	Children (0-14) 	Baseline 2013  10,374 Target 2019  7,781 Performance 2019  4,333	 58% reduction in AIDS related deaths
	Adolescents (10-19) 	Baseline 2013  2,793 Target 2019  2,095 Performance 2019  2,275	 19% reduction in AIDS related deaths
	Young Adults (15-24) 	Baseline 2013  3,853 Target 2019  2,890 Performance 2019  2,621	 32% reduction in AIDS related deaths
	Adults (15+) 	Baseline 2013  48,072 Target 2019  36,054 Performance 2019  16,664	 65% reduction in AIDS related deaths

Lessons from implementation of the first Kenya AIDS Strategic Framework 2014/2015 - 2018/2019

Lessons from implementation of KASF I	Recommendations for KASF II
<p>A multi-sectoral approach to the HIV response remains highly relevant considering the multisectoral action needed to address structural drivers and unequal access to services.</p>	<p>Strengthen partnerships across key sectors and communities, including the private sector to bridge gaps in programmes and improve quality. There is need for skill transfer, capacity building and quality assurance interventions; promote programmatic reporting and accountability across sectors.</p>
<p>Community-led programming serves as a catalyst to expand HIV services.</p>	<p>Enhance community-led and based interventions such as use of trusted access platforms to improve coverage, quality and outcomes of HIV programmes.</p>
<p>Decline in external funding without increase in domestic resources affects uniform progress towards achievement of ambitious programme targets to end AIDS.</p>	<p>Develop alternative models for HIV investment to bridge funding gaps at the county and national level.</p>
<p>HIV programme resilience is critical to sustain gains during emergencies and interruptions such as those witnessed during COVID-19 pandemic.</p>	<p>Create contingency plans that are regularly reviewed and updated to sustain HIV services at the time of emergencies including the ongoing COVID-19 pandemic.</p>
<p>Programmatic gaps in elimination of HIV among children and adolescents, combination HIV prevention and HIV testing and treatment among men remain a major challenge.</p>	<p>Promote high level political and technical leadership for the HIV response especially for fragile programmes and areas with large gaps for sub-populations. Bring to scale combination HIV prevention to reach all sub-populations and expand coverage of elimination of mother to child transmission of HIV interventions; Swiftly translate programme data and research into policies and programmes as key priorities.</p>
<p>County level leadership and ownership for the HIV response is a key factor for programme success.</p>	<p>Enhance county-level HIV programme implementation and management capacities through training, mentoring, sharing, harmonisation and peer-accountability.</p>
<p>The persistence of human rights and legal barriers continues to hinder access to HIV services for key and vulnerable populations.</p>	<p>Scale up interventions to address human rights violations, access to justice against HIV related stigma and discrimination.</p>
<p>Integration and linkage of HIV programme with other disease management through a system wide strengthening approach should be prioritised.</p>	<p>Integrate and link HIV prevention and treatment with programmes addressing sexual and reproductive health and rights (SRHR) including sexually transmitted infections (STIs) and contraceptive services, viral hepatitis, cancers, non-communicable diseases (NCDs), other chronic diseases and nutrition</p>
<p>Fragile gains - such as in the elimination of mother to child transmission of HIV and syphilis programme - depends on resilient health systems.</p>	<p>Strengthen the health workforce, commodity security and laboratory infrastructure.</p>

02

The Framework



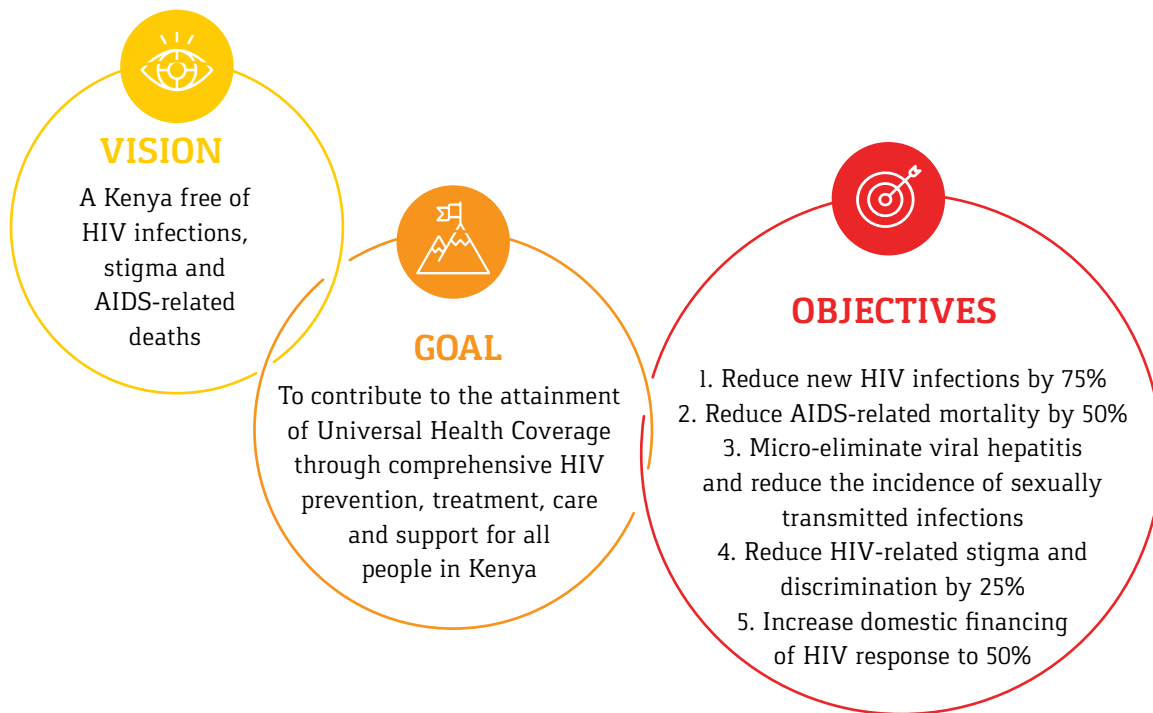
Despite the tremendous progress made in more than three decades, HIV continues to be a significant contributor to national disease burden. Kenya AIDS Strategic Framework II will focus on bridging the gaps in programme coverage through differentiated approaches that meet the needs of citizens within their geographical locations.





Process of developing Kenya AIDS Strategic Framework II

A participatory approach was adopted for the development of KASF II, which consisted of four distinct phases. Phase one was the preparatory stage that involved conceptualisation of the process, development of the tools and establishment of KASF II development steering committee and a technical committee. Phase two involved stakeholder consultations, including county consultations where counties were grouped into four clusters. Meetings with stakeholders were convened to conduct a Joint AIDS End Term Review (JAETR) of KASF I . Phase three involved data analysis and development of the KASF I end-term report which documented the lessons. The fourth and final phase involved the development of KASF II where three drafting meetings were held by the technical teams. The draft KASF II was subjected to peer review processes before it was presented to stakeholders for validation. The validation was done virtually due to COVID-19 protocols. The validated KASF II was then finalised, designed and printed for implementation.









Guiding principles

This framework is guided by the following key principles:

- i. **Respect for and promotion of human rights** as well as principles of social justice, equality and equity in access to HIV and AIDS services in line with the provisions embedded in the Constitution of Kenya (2010)
- ii. **Universal Health Coverage and access** to quality and integrated HIV prevention, treatment, care and support services, embracing the principle of *'leave no one behind'*
- iii. **Inclusion and participation** of all stakeholders at national and county levels, including and not limited to, community representatives of networks of PLHIV, AYPs, KPs including sex workers, men who have sex with men (MSM), people who use drugs (PWUDs), transgender people, PwDs, representation from the public and private sectors, faiths sector, CSOs and development partners
- iv. **People-centred service delivery** placing people at the centre of the decision making, planning and implementation process towards achieving desired outcomes
- v. **Evidence-informed planning, prioritisation and investments** through use of evidence and strategic information for decision making
- vi. **Multi-sectoral partnership and accountability for collective responsibility**, coordination and shared accountability for results.
- vii. **Responsiveness to emergencies and humanitarian crisis such as calamities or pandemics through strengthening** of resilient health, education and community systems

2.1 Thematic Areas

Nine thematic areas are outlined whose implementation will accelerate the achievement of the overall goal:

 <p>Thematic Area 1: Universal access to comprehensive, quality, and integrated prevention of HIV and Sexually Transmitted Infections</p>	 <p>Thematic Area 2: Revitalise shared fast-track commitment to achieve treatment targets</p>	 <p>Thematic Area 3: Protect the rights of people to live a life free of violence, stigma and discrimination</p>
 <p>Thematic Area 4: Invest in resilient systems for Health to improve HIV response and other health outcomes</p>	 <p>Thematic Area 5: Leverage on communities led programmes for an effective HIV response</p>	 <p>Thematic Area 6: Integrate HIV in humanitarian and emergency responses</p>
 <p>Thematic Area 7: Swift translation of innovations, strategic information, research, surveillance, and implementation of science into programmes</p>	 <p>Thematic Area 8: Invest in longer-term HIV investments and efficiency in use of resources</p>	 <p>Thematic Area 9: Promote Leadership, Communication and Advocacy</p>

2.2 Overall Implementation Approach

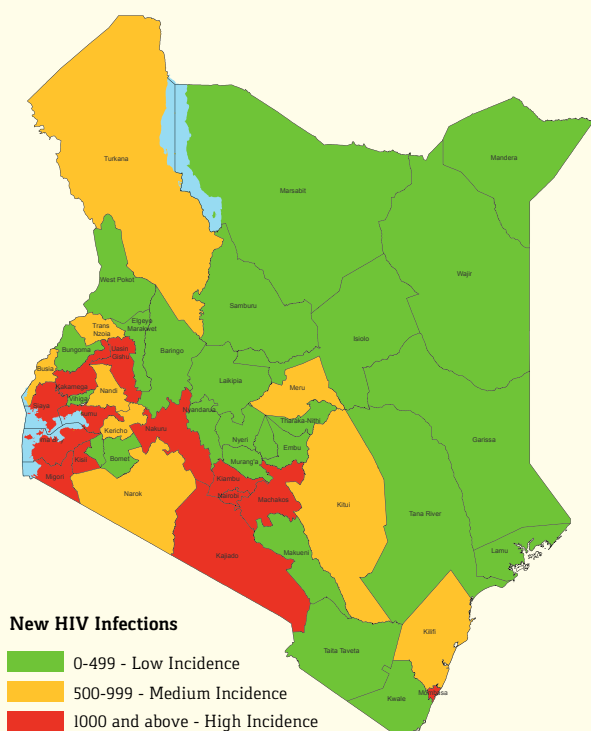
The following considerations will be key to guide implementation of KASF II:

- Coordinated county level operational plans and strategies in line with the devolved system of governance and local contexts
- Promotion of leadership for a coherent, synergised, and accountable multi-sectoral response
- Evidence-based prioritisation of population groups and geographic locations to address heterogeneity of the Kenyan epidemic
- Integration and layering of interventions for efficiency gains and maximal impact
- Differentiated approach to service delivery in respect to population needs and geographic context
- Enhanced community engagement in demand creation and monitoring of quality of services
- Scale up high impact interventions and continuous monitoring to measure outcomes and impact of the interventions
- Prioritisation of combination prevention interventions with equal emphasis on structural, biomedical and behavioural interventions

Status of HIV Epidemic in Kenya, 2020

	Children (0-14)	Adolescent Girls and Young Women	Female (15+)	Male (15+)	Adults (15+)
Prevalence	0.57%	1.96%	6.12%	3.53%	4.76%
New HIV infections	6,806	10,422	21,502	13,108	34,610
Treatment coverage	70%	76%	85%	73%	80%
AIDS Related deaths	4,333	2,604	7,255	9,317	6,572





Geographical distribution of new HIV infections in Kenya



13 counties had more than 1,000 new HIV infections, accounting for 72% of all new infections in the country

Table 6: HIV prevalence (15-49 years) by County

County	Prevalence	County	Prevalence	County	Prevalence
Homa Bay	20.2	Kajiado	3.6	Baringo	1.7
Kisumu	18.6	Machakos	3.6	Isiolo	1.8
Siaya	17.8	Makueni	3.5	West Pokot	1.2
Migori	12.8	Turkana	3.3	Samburu	1.1
Busia	7.2	Nandi	3.3	Marsabit	0.96
Mombasa	6.9	Kwale	3.2	Tana River	0.9
Uasin Gishu	6.0	Kirinyaga	3.2	Garissa	0.4
Kisii	5.4	Bomet	3.0	Mandera	0.3
Nairobi	5.4	Kiambu	2.97	Wajir	0.2
Vihiga	5.1	Narok	2.97		
Trans Nzoia	4.5	Tharaka-Nithi	2.9		
Nyeri	4.3	Meru	2.9		
Nyamira	4.2	Bungoma	2.8		
Kitui	4.2	Murang'a	2.8		
Nakuru	4.0	Nyandarua	2.7		
Kakamega	3.95	Laikipia	2.7		
Kericho	3.8	Embu	2.5		
Taita Taveta	3.8	Lamu	2.4		
Kilifi	3.7	Elgeyo Marakwet	2.2		

HIV prevalence
 11.1% and above
 5% - 11%
 2.1% - 4.9%
 0% - 2%



Homa Bay, Kisumu, Siaya and Migori counties have HIV prevalence at hyper epidemic levels



This framework will be implemented through partnership from multiple sectors including and not limited to Ministry of Health and its departments/agencies such as National AIDS and STIs Control Programme, Division of Nutrition and dietetics, Division of Non communicable diseases, department of Family and Reproductive Health, Tuberculosis programme, Pharmacy and Poisons Board, National HIV reference Laboratory, Kenya Medical Laboratory Technicians and Technologists Board, Kenya National Blood and Safety, Kenya Medical Training College. Ministries, Departments and Agencies such as Ministry of Education and related State Department of Technical and Vocational Training, State Department of University Education, Research institutions, Department of Children Services, State Department of Gender, Ministry of Interior, Judiciary, HIV Tribunal, National Council for Legal Aid, Kenya Law Reform Commission, National Council for Persons with Disability, People with Disability Associations, National Treasury, Council of Governors, County Governments, County Health Departments, among others.

Non-State Actors include, but are not limited to, representation of National Network of People Living with HIV (NEPHAK) and other networks of PLHIV, civil society organisations, community led organisations, Faith-based organisations, women rights organisations, Private Sector, Mission for Essential Drugs and Supplies, Trade Unions, Key population networks, Adolescent and young people networks, other Community led groups, Development Partners and Implementing Partners.





2.3 Thematic Area I: Universal access to comprehensive, quality, and integrated HIV and STIs prevention services



Goal: To maximise the impact of the HIV and STI prevention interventions in Kenya

The Kenya HIV Prevention Revolution Roadmap 2030 recommends the need for a focused approach in HIV prevention. It calls out for efforts to maximise efficiencies by prioritising implementation to scale of high impact interventions in prioritised geographical locations and population at higher risk of HIV infections. KASF II will adopt the prioritisation approach with the aim of bringing quality HIV prevention programmes to scale in line with universal health coverage. Structural barriers that limit sub-populations from accessing HIV services will be addressed through a sector wide approach. KASF II will strengthen the use of data to derive programmatic gaps and priority areas of action. Efforts to strengthen interventions that address Sexually Transmitted Infections (STIs) and viral hepatitis will be enhanced.



Strategic Focus Areas

To achieve universal coverage of HIV prevention programme, KASF II will:

1. Adapt and scale up comprehensive and high impact HIV prevention interventions.
2. Accelerate efforts towards elimination of mother to child transmission of HIV and syphilis.
3. Re-invigorate and scale up prevention, management and control of Sexually transmitted infections (STIs) and Viral Hepatitis.
4. Enhance identification and linkages to HIV prevention, treatment, care and support services.



Expected Results by 2025

- New HIV infections reduced by 75% among adults
- HIV transmission rates from mother-to-child reduced to less than 5%
- STIs incidences reduced and micro-elimination of viral hepatitis achieved.
- Community level viral suppression as a result of increased number of people living with HIV with knowledge of their status and treatment and care.

2.3.1 Strategic Focus Area I: Adapt and scale up comprehensive and high impact HIV prevention interventions

During the KASF II, the country will intensify support to scale up HIV and STI prevention programmes and increase coverage and quality of programmes for priority populations and geographies to maximise impact. Community driven interventions will remain central to the programme with an increased focus on use of evidence in HIV prevention programmes. KASF II will prioritise the integration and multi sectoral coordination to increase efficiency and impact of HIV and STI prevention programmes.



Strategies

- Focus on high priority geographies based on epidemic analysis
- Prioritise populations for comprehensive preventive interventions based on epidemic typology in the geographies

- Scale up comprehensive packages of interventions to address coverage and utilisation gaps
- Adopt and expand HIV prevention choices and technology to make the response effective



Implementation Approach

I. Focus on high priority geographies and settings based on epidemic analysis

Geographic prioritisation

The pattern of new infections in Kenya continues to remain heterogeneous with a few counties contributing towards a larger share. Nine counties with more than 2,000 new infections account for 44% of all new infections in the country.

On further analysis of HIV Incidence to Prevalence Ratio (IPR), average annual rate of change in HIV incidence and contribution to total new infections, 13 counties are identified as priority counties : Mombasa, Kisumu, Siaya, Kisii, Homabay, Migori, Busia, Nairobi, Nakuru, Kakamega, Kiambu, Uasin Gishu and Marsabit. Further granular analysis of new infections at the sub-county level will be done for better targeting and decision making on intensity of interventions. Cities and urban areas within the counties have higher HIV incidence and populations with heightened risk and vulnerabilities. KASF II recommends use of progressive coverage approach to gradually cover geographies and locations that contribute to high burden of infections and with emerging epidemic. KASF II also recommends initiation and maintenance of combination HIV prevention package in counties with low HIV incidence to mitigate against reverse in progress.

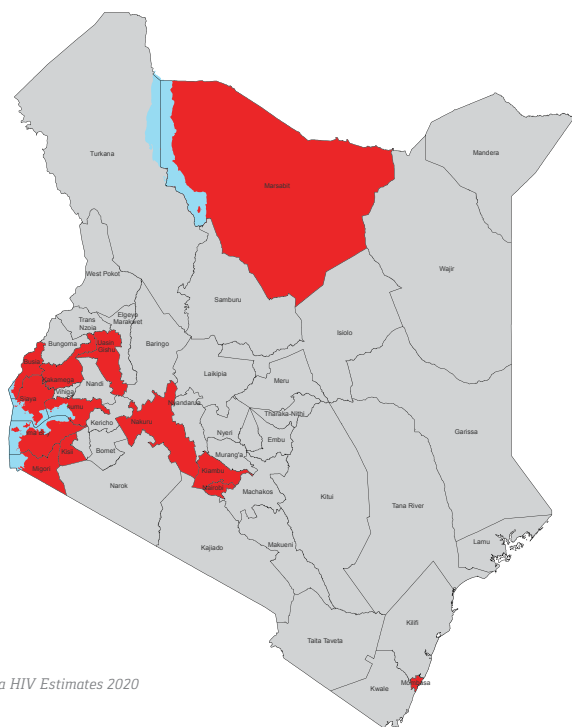
Table 7: Example of prioritizing Counties for intensified focus

Rank	Prevalence	Incidence	Incidence Prevalence ratio	Average Annual Rate of change in HIV incidence	% Contribution to total new infections
1	● Homa Bay	● Kisumu	● Kiambu	Vihiga	● Kisumu
2	● Kisumu	● Siaya	● Siaya	● Busia	● Siaya
3	● Siaya	● Homa Bay	● Kisumu	● Kakamega	● Nairobi
4	● Migori	● Migori	● Marsabit	Bungoma	● Homa Bay
5	● Busia	● Kisii	Laikipia	● Nairobi	● Migori
6	Turkana	● Mombasa	● Nakuru	● Marsabit	● Kisii
7	● Kisii	● Busia	Kericho	Lamu	● Nakuru
8	Kitui	● Uasin Gishu	● Nairobi	● Mombasa	● Mombasa
9	● Mombasa	Kajiado	Nandi	Tana River	● Kakamega
10	● Uasin Gishu	● Nairobi	● Mombasa	Meru	● Kiambu

Note: ● Mombasa is a priority on all 5 counts; ● Kisumu, Siaya and Nairobi are priority on 4 counts; ● Kisii, Homa Bay, Migori and Busia are priority on 3 counts; ● Kakamega, Nakuru, Kiambu, Marsabit and Uasin Gishu are priority on 2 counts.

Source: NACC, NASCOP HIV Epidemic Appraisal 2020

12 counties that require intensified focus



Source: Kenya HIV Estimates 2020

Key HIV epidemic and programme coverage indicators show gaps in Mombasa, Kisumu, Siaya, Nairobi, Kisii, Homa Bay, Migori, Busia, Kakamega, Nakuru, Kiambu and Uasin Gishu Counties that require intensified focus to stem new HIV infections. Marsabit County has an emerging HIV epidemic that needs to be mitigated

Settings with high risk and vulnerability

Worldwide, the levels of HIV infection among prison populations tend to be much higher than in the population outside prisons. This situation is often accompanied and exacerbated by high rates of hepatitis C (HCV), tuberculosis (TB), sexually transmitted infections (STIs), drug dependence, and mental health problems in prison populations. Inside prisons, the primary risk behaviours for the transmission of HIV are the sharing of injecting equipment and unprotected sex. Prisons present a good opportunity to provide health-care access to those who may not otherwise have regular access, and to improve the health of vulnerable groups and the communities they associate with. Health care settings are critical to reducing the risk of the potential spread of disease. These settings should follow infection prevention and control practices and maintain a safe environment. Other priority settings in Kenya include the refugee and migrant camps, long distance truck routes, army barracks and other concentrated work places like flower farms.

II. Prioritise populations for comprehensive preventive interventions based on epidemic typology in the geographies

To address long-term prevention goals, epidemic typology needs to be defined to differentiate epidemics based on their underlying transmission dynamics and epidemic potential. The epidemic typology in Kenya can be defined as:

- Concentrated epidemic** where ongoing transmission is within sub-populations who are at a higher risk due to sexual practices or needle-sharing networks.
- Generalising epidemic** where HIV transmission is largely sustained by high risk sexual behaviour in the general population, without any substantial contribution by defined sub population at risk.
- Mixed epidemic** where there is substantial contribution from both the general population sexual behavioural patterns and defined sub populations at risk due to shared networks of higher risk sexual behaviour practices. Based on epidemic typology, specific sub-population needs to be prioritised.

Priority populations

Adolescent and young people

Adolescent and young people contribute to 42% of the new HIV infections in the country and hence are a priority population. However, within this group, the focus of programming will be on adolescents and young girls and boys, and young men in priority geographies for high impact.

- **Adolescent girls and young women (10-24 years).** Adolescent girls and young women (AGYW) aged 15-24 years contribute to a third (30%) of the 41,728 new HIV infections in the country (HIV Estimates 2020). Factors such as intergenerational sex, teenage pregnancies, sexual and other forms of gender-based



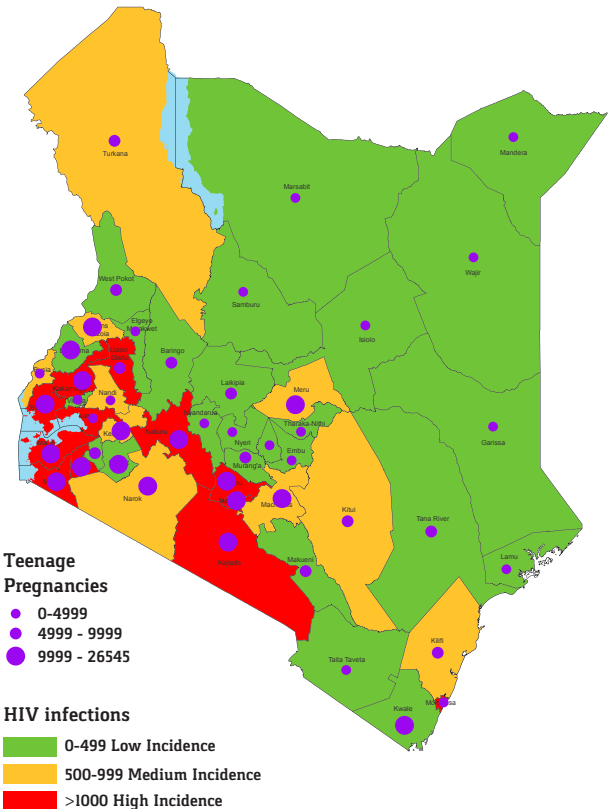
© Shutterstock

violence (GBV), discontinuation of school specially during transition from primary to secondary school, prevailing gender norms, poor access to comprehensive sexuality education, limited access to HIV, STI, SRHR services and low socio-economic status have largely been attributed to the high HIV incidence among AGYW compared to boys and young men of the same age group. KASF II will adopt a multi-sectoral approach to address the HIV and STI, risk and vulnerability of AGYW with special focus on at risk AGYW in priority counties. It will address multi-faceted vulnerabilities and reduce teenage pregnancies and gender-based inequalities.



6 Counties, Mombasa, Siaya, Kisii, Migori, Kisumu and Homabay have extremely high HIV incidence per 1,000 among adolescent girls and young women aged 15-24

Teenage Pregnancy and New HIV Infections



- **Boys and young men in priority geographies and settings.** Boys and young men aged 15-34 years account for 53% of the 13,320 new HIV infections that occurred among male adults in 2019. The peak of new HIV infections is among young men aged 20-34 years. Evidence from KENPHIA 2018 also shows that compared to women, awareness of HIV status is low among men. Delay in awareness of HIV status also delays entry into prevention and treatment services. KENPHIA 2018 also reveals that in traditionally non-circumcising counties (many of the counties with high incidence are traditionally non-circumcising), coverage of VMMC among boys and young men was lower than 60%. KASF II will prioritise reaching boys and young men in priority geographies and settings with HIV prevention interventions. Engaging men more extensively in HIV prevention can also potentially reduce girls and women's risk considering power imbalances in the circumstances of sex and safety considerations.

Key populations

Members of Key Populations (KPs), including Men who have Sex with Men (MSM), Female Sex Workers (FSWs), People Who Inject and Use Drugs (PWI/UDs) and transgender people, have higher HIV prevalence compared to the general population. They experience stigma, discrimination, criminalisation and violence which further increases their HIV and STI risk and vulnerability. The KP mapping and estimation exercise conducted in 2018 estimated that there are 206,000 FSWs, 50,000 MSM, 19,000 PWID, and 5,000 transgender people. The KP mapping and estimation exercise also reported that 9-11% of the KPs in the hotspots were below the age of 18, confirming the need for inclusion of younger KPs in programming. There is gender disparity among key populations in the way service provision is done. KASF II will continue with the prioritisation of KPs and scale up interventions to ensure complete coverage of the estimated populations and those left behind like women who inject or use drugs, young KP and KPs in migrant settings and prisons, through trusted access platforms.

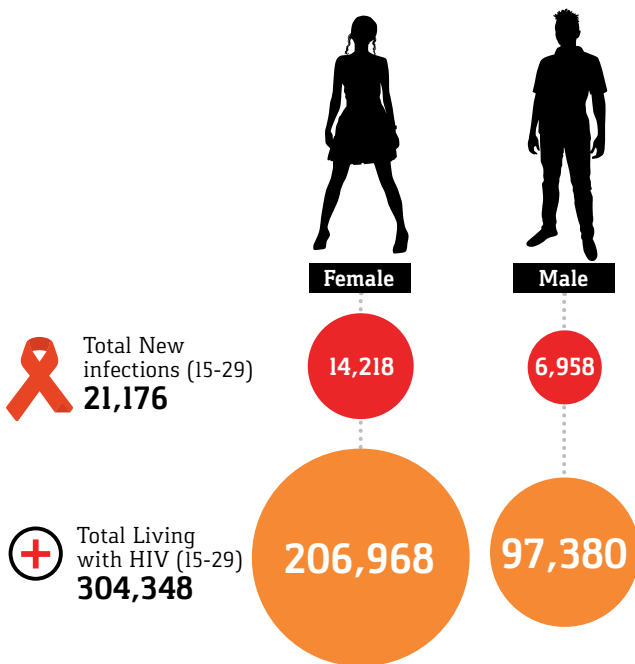
People in HIV sero-discordant sexual partnerships

In Kenya, it is estimated that at least two thirds of infected couples are discordant, meaning only one of the partners is HIV-infected¹. While discordant couples are at high risk of HIV transmission, use of HIV prevention methods in such partnerships is low as majority of such couples are in cohabiting relationships where condom use is generally low. Targeted HIV prevention programmes among sero-discordant couples with focus on ART for the positive partner, PrEP and consistent use of condoms (where applicable and feasible) for the negative partner, can reduce new infections. KASF II will prioritise these sero-discordant partnerships with comprehensive prevention interventions through strengthening community led structures and organisations.

Other priority and vulnerable populations

Priority and vulnerable populations include people living in closed settings such as people in prisons, internally displaced persons (IDPs), fisher folk, long distance truckers, refugees and migrant populations, people living in large scale agricultural plantations, people with disabilities and members of uniformed services. These populations have much higher HIV prevalence due to low condom use, unsafe sexual partnerships and heightened vulnerabilities to sexual violence and other forms of sexual exploitation. Limited access to education and healthcare along with the lack of information

Adolescents and young people aged 15-29 account for 61.2% of the total adult new HIV infections



Source: Kenya HIV Estimates 2020

¹ Florence Chizi et al. Challenges Facing HIV Discordant Couples in Kenya. International Journal of Business and Social Science Vol. 5, No. 10(1); September 2014

and resources needed to facilitate effective prevention interventions also expose these populations to HIV infections. KASFII will define a standard service package and differentiated service models to optimize reach and coverage among these populations.

III. Scale up comprehensive packages of interventions to address coverage and effectiveness gaps

Development of a standard package of intervention for each priority sub population is critical. Standardisation of packages ensures that a minimum programme package is received by all sub populations which has been developed based on their needs and priorities. Kenya has developed standard package of interventions for most of the priority sub populations. KASF II will prioritise development of costed minimum programme packages through community centred approaches and adaptation of available global guidance for sub-populations to suit local

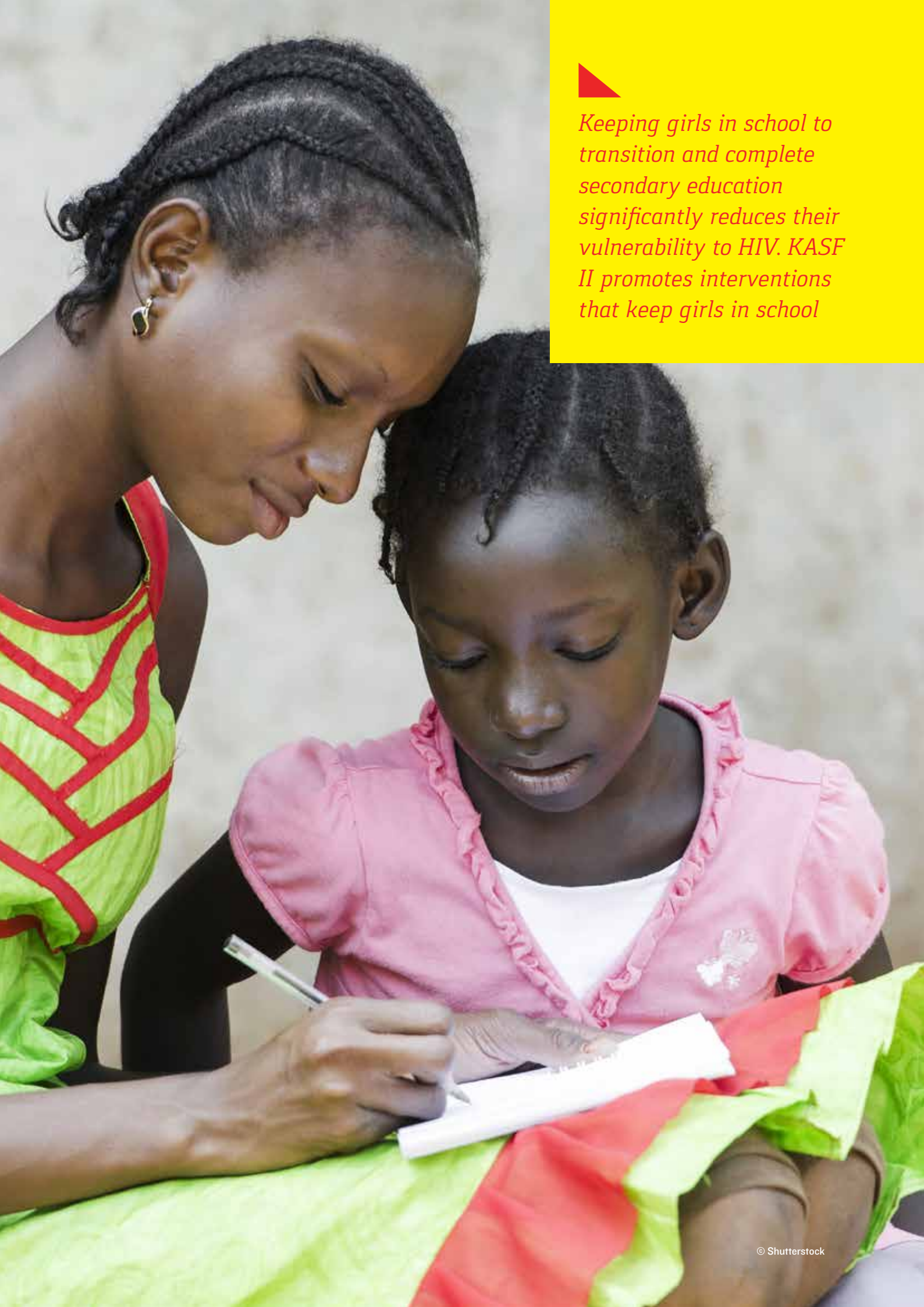
context. Service delivery channels will be contextualised to meet local needs.

KASF II outlines the need for a systematic approach to scale up the provision of comprehensive packages of services for all priority populations based on the epidemic typology in a geography. Gaps in coverage will be monitored on a regular basis to address supply barriers to address both availability and utilisation. Active investments in community led assessment and utilisation of the packages will be enhanced. There will be need for adoption of surveys, surveillance, evaluation, reviews and analysis to regularly measure and monitor progress towards prevention outcomes. Integration of HIV prevention services across HIV testing facilities, family planning, antenatal, post-natal services, and other health services will be promoted. HIV prevention interventions will be layered within broader development agenda including UHC.

Table 8: Examples of Comprehensive HIV prevention packages for sub-populations

Priority Population	Recommended Prevention Packages
Adolescent Girls and Young Women (10-24 years)	<ul style="list-style-type: none"> ▪ Condom and lubricant programming ▪ Behaviour change interventions ▪ Comprehensive Sexuality Education ▪ Pre-exposure prophylaxis ▪ Comprehensive sexual and reproductive health services ▪ Differentiated HIV testing ▪ Gender-based violence prevention and post violence care ▪ Addressing stigma, discrimination and violence ▪ Social protection interventions that address ▪ Interventions to keep girls in school and to transition to and complete secondary school. ▪ Menstrual health and hygiene ▪ Integration into national multi-sectoral responses of AGYW programmes ▪ Community empowerment and outreach including peer education ▪ Integration of HIV prevention in contraception clinics.
High risk boys and young men in high priority geographies	<ul style="list-style-type: none"> ▪ Voluntary Medical Male Circumcision ▪ Condom and lubricant programming ▪ Behaviour change interventions ▪ Pre-exposure prophylaxis ▪ Sexual and reproductive health services, including STIs ▪ Differentiated HIV testing - facility, community and self-test
Key Populations (FSW, MSM, PWID, Transgender People)	<ul style="list-style-type: none"> ▪ Behaviour change interventions including peer education ▪ Condom and lubricant programming ▪ Pre-exposure prophylaxis ▪ Comprehensive sexual and reproductive health services, including STIs ▪ Harm reduction interventions for drug use ▪ Addressing stigma, discrimination and violence ▪ Interventions for young Key Populations ▪ Community empowerment ▪ Prevention and management of co-infections and co-morbidities ▪ Differentiated HIV testing - facility, community and self-test

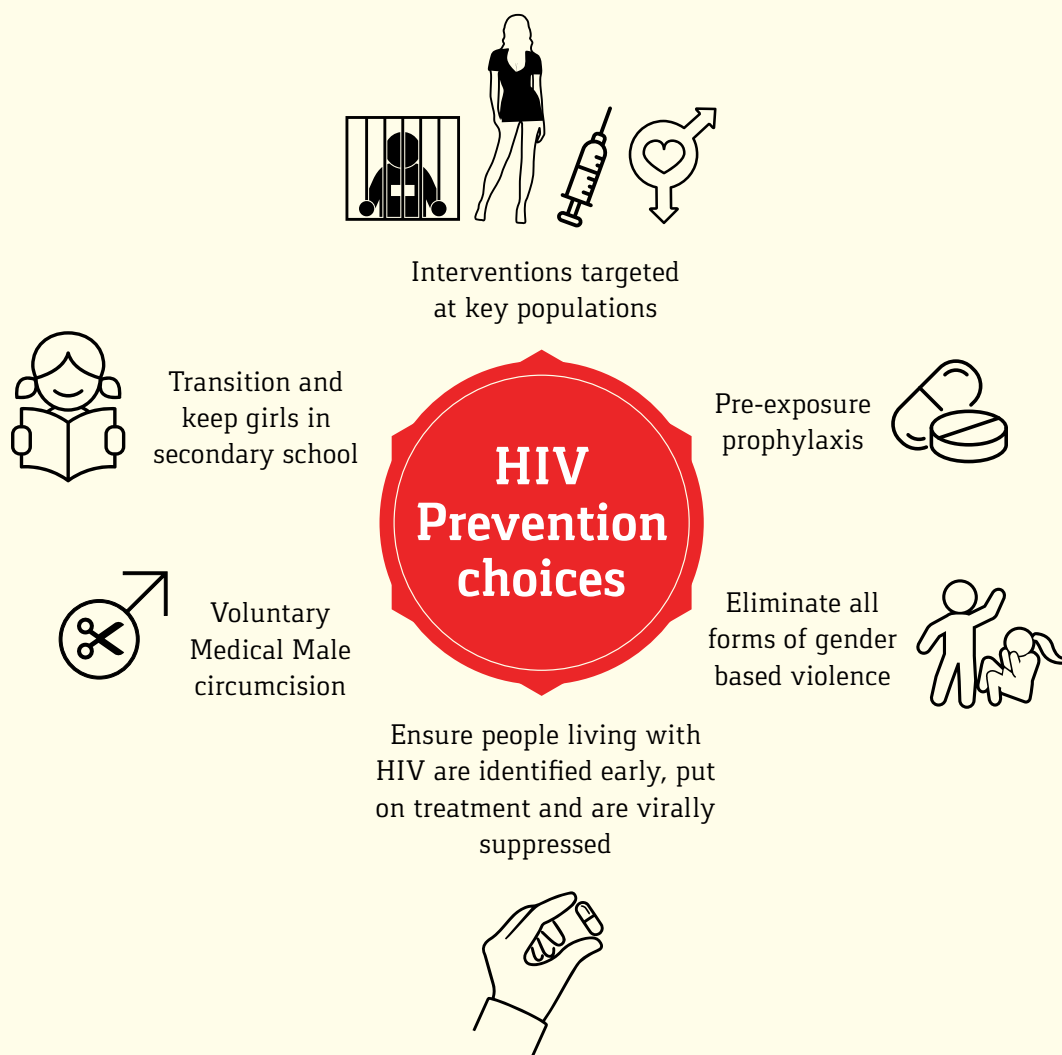
Priority Population	Recommended Prevention Packages
	<p>Additional services for People who Inject Drugs:</p> <ul style="list-style-type: none"> ▪ Needle and syringe programmes ▪ Opioid substitution therapy and other medically assisted drug dependence treatment ▪ Overdose prevention and management ▪ Sustainable livelihood support programmes
Sero discordant couples	<ul style="list-style-type: none"> ▪ Behaviour change interventions including peer education ▪ Condom and lubricant programming: ▪ Pre-exposure prophylaxis ▪ Sexual and reproductive health services, including STIs ▪ Addressing stigma, discrimination and violence ▪ Community empowerment ▪ Prevention and management of co-infections and co-morbidities ▪ Differentiated HIV testing - facility, community and self-test
People in prison settings	<ul style="list-style-type: none"> ▪ Condom and lubricant programming ▪ Pre-Exposure Prophylaxis ▪ Behaviour change interventions ▪ Community empowerment including vocational training and social integration programmes ▪ Sexual and reproductive health services, including STIs ▪ Harm reduction interventions for drug use ▪ Prevention and management of co-infections and co-morbidities ▪ Addressing stigma, discrimination and violence
Health care settings	<ul style="list-style-type: none"> ▪ Expand and prioritise access to vaccination programme (Hepatitis) ▪ Personal protection equipment ▪ Universal precaution trainings ▪ HIV testing ▪ Availability and utilisation of Post Exposure Prophylaxis
Other vulnerable population	<ul style="list-style-type: none"> ▪ Condom and lubricant programming ▪ Behaviour change interventions ▪ Sexual and reproductive health services, including STIs ▪ Addressing stigma, discrimination and violence ▪ Community empowerment ▪ Prevention and management of co-infections and co-morbidities ▪ Differentiated HIV testing - facility, community and self-test



Keeping girls in school to transition and complete secondary education significantly reduces their vulnerability to HIV. KASF II promotes interventions that keep girls in school

IV. Adopt and expand HIV prevention choices and technology to make the response effective

KASF II will prioritise expanding choices and options for available HIV prevention interventions. The country will assess effectiveness of emerging HIV prevention technologies through rigorous evaluation. Pilot interventions and learning sites will be put in place to conduct action research related to new prevention technologies such as those related to PrEP, Medication Assisted Therapy, voluntary medical male circumcision among others. Innovative and successful strategies will be adopted and scaled up to expand HIV prevention choices. KASF II recommends the use of mixed models of service delivery and use of strategic information generated from programmes to improve intervention outcomes.



KASF II promotes adoption of new technology to expand effective HIV prevention choices



The burden of Sexually Transmitted Infections (STIs) and Viral Hepatitis (VH) has been on the increase despite availability of effective preventive vaccines. There is need to target population at higher risk with effective prevention and treatment interventions

2.3.2 Strategic Focus Area 2: Re-invigorate and scale up prevention, management and control of Sexually Transmitted Infections and Viral Hepatitis

The burden of Sexually Transmitted Infections (STIs) and Viral Hepatitis (VH) has been on the increase despite availability of effective preventive vaccines and treatment. KASF II, outlines strategies to intensify efforts to scale up and improve access to quality STI and Viral Hepatitis (VH) prevention, control and management services in public and private sectors.



Strategies

1. Strengthen coordination structures to facilitate collaborative efforts and quality control of STIs and VH services.
2. Scale up targeted prevention and management of STI and Viral Hepatitis (VH) among high risk populations.
3. Strengthen integration of STI and VH care with other primary health care and reproductive health services at all levels and sectors.
4. Facilitate enabling environment for delivery of STI and VH prevention services at all levels.
5. Strengthen surveillance, monitoring and evaluation systems for STIs and VH



Expected Outcome

- Kenya moves towards micro-elimination of VH, and sufficient coverage on prevention and management of sexually transmitted infections.
- Re-invigorated national and county programmes for prevention, control and management of STIs and VH



Implementation Approach

KASF II will strengthen intergration of quality STIs diagnosis and treatment with HIV services. The need to target population at higher risk will be promoted. Data systems will be enhanced to provide strategic information to increase efficiency and impact of STI and VH programmes. The gaps in coordination of STIs programmes will be addressed.

Table 9: Recommended interventions to effectively prevent, control and manage sexually transmitted infections and viral hepatitis

Strategic Focus area	Recommended Interventions
Strengthen coordination structures to facilitate collaborative efforts and quality control of STIs and VH services	<ul style="list-style-type: none"> ▪ Strengthen coordination of multi-sectoral partners engaged in HIV and STIs control. ▪ Establish expert groups and task forces to coordinate knowledge management, validate and rapidly translate strategic information to practice.
Strengthen integration of STI and VH care with other primary health care and reproductive health services at all levels and sectors.	<ul style="list-style-type: none"> ▪ Harmonise service delivery models to support integration of STI, VH and other reproductive health services at all levels. ▪ Develop complementary training packages for provision of STI/VH/ Reproductive health issues. ▪ Support synchronised capacity building initiatives to strengthen integration of STI/VH/Reproductive and maternal child and adolescent Health at all levels. ▪ Create linkages and referrals from STI/VH, SRH services to HIV and TB services, and PHC services more broadly

Strategic Focus area	Recommended Interventions
Scale up targeted prevention and management of STI and Viral Hepatitis (VH) among high risk populations.	<ul style="list-style-type: none"> ▪ Assess the gaps and identify priority geography and populations to prioritise. ▪ Strengthen the community structures to ensure demand creation and provision of STI/VH services. ▪ Strengthen health facilities to ensure optimal delivery of STI/VH services. ▪ Ensure uninterrupted commodity supply and requisite laboratory support for STI and VH preventions and management interventions. ▪ Expand access to diagnostics for STIs and VH including use of dual or triple test kits. ▪ Ensure optimal human resources for health and enhance capacity building for service providers on STI /VH prevention and management.
Facilitate enabling environment for delivery of STI and VH prevention services at all levels.	<ul style="list-style-type: none"> ▪ Develop policies and frameworks to support provision of STI and Viral Hepatitis interventions at all levels. ▪ Strengthen advocacy for the prioritisation and resource allocation for STI and VH responses. ▪ Strengthen equipment and infrastructure for delivery of STI and VH services.
Strengthen surveillance, monitoring and evaluation systems for STIs and VH	<ul style="list-style-type: none"> ▪ Strengthen routine data collection, monitoring and evaluation of STI and VH interventions. ▪ Support timely and regular reporting for STI and VH ▪ Institutionalise periodic surveillance for STI and VH including embedment into special and population level impact surveys.



Elimination of mother to child transmission of HIV and Syphilis

In 2019, for every 100 pregnant women living with HIV, 12 children aged 0-4 became infected through mother to child transmission. Elimination of mother to child transmission of HIV and Syphilis will need strong community and health systems that facilitate HIV positive, pregnant and breast feeding mothers to access and be maintained in prevention of HIV from mother to child programme

© Shutterstock



6%
(102,000) of pregnant women do not attend at least one ANC visit



8%
(136,000) pregnant women do not know their HIV status



6%
of pregnant women living with HIV do not receive lifelong ART

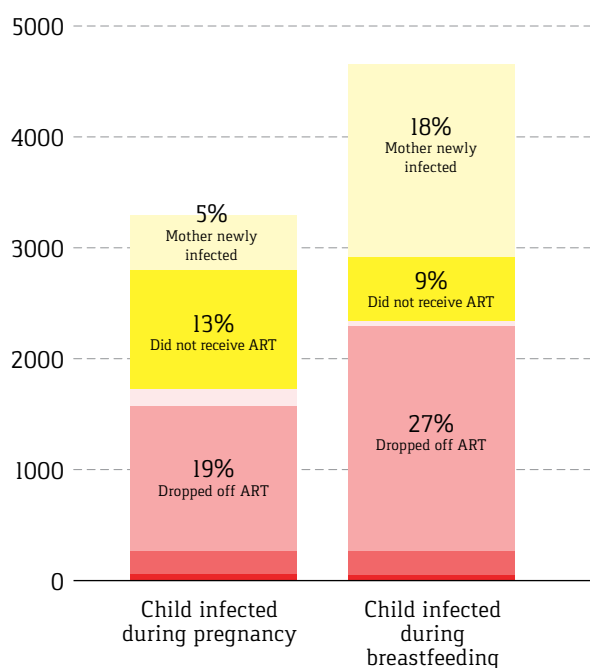


33%
of HIV-exposed infants do not get tested within two months of birth

2.3.3 Accelerate efforts towards elimination of HIV mother to child transmission of HIV and Syphilis

Though the number of children (0-14 years) newly infected with HIV has dropped over the years, in 2020, 10.8% of new infections among children were estimated to be infected with HIV vertically from mother-to-child (HIV Estimates 2020). MTCT rates are relatively high in low-medium prevalence areas, of the 29 counties, collectively contributing to 25% of the new HIV infections among children. Elimination of mother-to-child transmission of HIV, syphilis and viral hepatitis will be a critical marker of universal access. For this reason, pregnant and breastfeeding women (PBFW) will continue to be a priority for HIV and STI prevention in KASF II.

Figure 3: Causes of HIV Transmission from Mother to Child



Source: UNAIDS Global Estimates and Mushavi Kenya 2020

23 percent of the cases of transmission of HIV from mother to child during pregnancy and breastfeeding occur among mothers newly infected with HIV



Strategic Focus Areas

1. Sustain leadership, advocacy and coordination of the eMTCT programme.
2. Expand equitable and quality testing, prevention and treatment services for HIV and Syphilis to all pregnant women and children.
3. Strengthen partnerships between communities, private and public health systems.
4. Ensure routine monitoring of progress and accountability at all levels.



Implementation Approach

New HIV infections amongst children occur when major interventions are missed - primary prevention of HIV amongst the HIV-negative pregnant and breastfeeding women, delayed initiation to antiretroviral therapy, poor linkage and retention of positive mothers in ART, low re-testing rates and discordant partnership as a result of low partner testing. Strategic efforts should therefore be aimed at addressing these gaps during the antenatal and post-natal period. eMTCT interventions in the first 1,000 days of a child at risk of HIV infection should be ingrained within the tenets of primary health care. The window of opportunity to eliminate infections is dependent on strong and sustained leadership, resilient community and health systems that protect the programme from disruptions such as industrial strikes for health care workers, commodity stock-outs and displacement of population during emergencies. The implementation of eMTCT will include a four-pronged approach of 1) primary prevention of HIV infection among women of child bearing age 2) preventing unintended pregnancies among women living with HIV 3) preventing vertical HIV prevention, and 4) treatment care and support for mothers living with HIV, their children and families. While prioritising counties with high mother to child transmission rates, the programme will promote universal access to triple elimination of mother to child transmission of HIV, hepatitis B virus and syphilis.

Table 10: Proposed interventions to scale up elimination of mother to child transmission of HIV and Syphilis

Strategic Focus area	Recommended Interventions
Sustain leadership, advocacy and coordination of eMTCT programme.	<ul style="list-style-type: none"> ▪ Nurture championship for eMTCT among eminent persons at all levels (political, faith based, community and technocrats). ▪ Strengthen linkages between health and non-health leadership at national, county, sub county and community levels.
Expand equitable and quality testing, prevention and treatment services for HIV and Syphilis to all pregnant women and children.	<ul style="list-style-type: none"> ▪ Assess the gaps in reach of the eMTCT programme and identify priority geography and populations. ▪ Strengthen the community structures to ensure that all pregnant and breast-feeding women are identified and linked to primary care for ante-natal care, post-natal care and immunisation programme. ▪ Strengthen the facilities to ensure that all pregnant women have access to HIV testing and are aware of their HIV status. ▪ Expand linkages to contraception and family planning services to all HIV positive women to avoid unintended pregnancies.
Strengthening integration of HIV prevention and treatment services with all reproductive, maternal, child and adolescent health programmes	<ul style="list-style-type: none"> ▪ Expand the facility and community linkage to ensure all HIV positive pregnant women or mother and baby pair initiate treatment and are retained on treatment. ▪ Adapt the programme to address the unique needs of AGYW who are pregnant or are mothers. ▪ Ensure linkage of the facility with HIV positive mother to provide access to early infant diagnosis within the immunisation programme. ▪ Expand access to the eMTCT of HIV and syphilis for different sub populations through different service delivery models. ▪ Reduce missed opportunities for linkage to treatment through expansion of point of care services. ▪ Strengthening integration of HIV prevention and treatment services with all reproductive, maternal, child and adolescent health programmes.
Strengthen partnerships between communities, private and public health systems	<ul style="list-style-type: none"> ▪ Create demand and a norm among the AGYW (women in child bearing age) to be aware of their HIV status. ▪ Promote community-led eMTCT education strategies. ▪ Strengthen health facilities and community linkages by expanding the Kenya mentor mother programme. ▪ Strengthen community structures to increase demand generation for ante-natal, post-natal and immunisation
Ensure routine monitoring of progress and accountability at all levels	<ul style="list-style-type: none"> ▪ Promote system wide quality reporting and accountability. ▪ Provide platforms to regularly take stock of progress at all levels. ▪ Sustain positive service delivery and outcome data from both the public and private health sectors.



© Shutterstock



KASF II, will implement innovative and differentiated HIV testing models to reach sub-populations and geographical locations with highest gaps of HIV knowledge

2.3.4 Enhance identification and linkages to prevention, treatment, care and support services for HIV

In 2019, approximately 79% of Kenyans were aware of their HIV status. The country missed the opportunity to provide life saving medication to 11% (158,000) of people living with HIV who were not aware of their status. The knowledge of HIV status among men and boys is 88% much lower than that of women and girls at 94 %. Delay in awareness of HIV status results to poor health outcomes at an individual level and low levels of viral load suppression desired for interrupting HIV transmission at the population level.



Strategic Focus Areas

1. Scale up the use of evidence, innovative and differentiated HIV diagnostic services to increase access and meet diverse population needs.
2. Expand voluntary, client-centred and confidential partner and sexual/social network testing services through facility and community led interventions.
3. Promote integration of HIV testing with sexual and reproductive health services and the diagnosis of other co-infections including TB and viral hepatitis.



Implementation Approach

KASF II, will implement innovative and differentiated HIV testing models to reach sub-populations and geographical locations with highest gaps of HIV knowledge. Human rights based, voluntary, client-centred and confidential social and sexual network based HIV testing services will be expanded. This strategy will be implemented through effective partnerships with people living with HIV and key population network to provide opportunity to test people at risk of HIV, link them to treatment and care programmes if positive or offer risk reduction options such as the use of condoms and PrEP when they test negative. The HIV testing programme will utilise data from surveys and programmes to identify and prioritise geographical locations and sub-populations.



Human rights based, voluntary, client-centred and confidential HIV testing services will be promoted

Table 11: Recommended Interventions to Scale Up Differentiated HIV Testing Services

Strategic Focus Areas	Recommended Interventions
Scale up the use of evidence, innovative and differentiated HIV diagnostic services to increase access and meet diverse population needs.	<ul style="list-style-type: none"> ▪ Use evidence to expand HIV testing services to priority geography, settings and population. ▪ Support community-led HIV stigma free demand creation initiatives for testing among men and boys, children, key populations and other priority sub populations ▪ Promote options for testing by expanding access to testing products like HIV self-testing kits including using vending machines for distribution.
Expand voluntary, client-centred and confidential partner and sexual/social network testing services through facility and community led interventions	<ul style="list-style-type: none"> ▪ Develop a community-led framework to expand testing in sexual/social/injecting networks. ▪ Promote capacity building of service providers at facilities to provide HIV testing through sexual, social and injecting networks. ▪ Engage community in implementing and monitoring these testing strategies to identify adverse events and refine the service delivery model and approach.
Promote integration of HIV testing with sexual and reproductive health services and the diagnosis of other co-infections including TB and viral hepatitis	<ul style="list-style-type: none"> ▪ Develop and implement a framework to integrate HIV testing in other service delivery platforms including contraception, nutrition clinics, vaccination centres, TB clinics ▪ Establish systems of linkage to prevention and treatment services in these integrated platforms



The Kenya AIDS Strategic Framework II (2020/21- 2024/25) provides strategic direction for the country's HIV response for the next four years. The health sector platform remains a key pillar of the AIDS response. In the next five years, the National AIDS and STI Control Programme will scale up biomedical interventions focused on narrowing the gaps in diagnosis, HIV prevention, the commitment towards eliminating mother to child transmission of HIV and Syphilis, and universal ART for improved health outcomes for people living with HIV across all sub- populations. To improve, retain and achieve sustained viral suppression of People Living with HIV on treatment, the programme will spearhead ART optimisation through differentiated service delivery and the adoption of novel safe, and efficacious treatment regimens. Innovative differentiated models for test and treat will be scaled up with intensified focus on priority populations including key populations, adolescent and young people, pregnant and breast feeding mothers, among others. Effective HIV prevention interventions such as Voluntary Male Medical Circumcision, Pre-Exposure Prophylaxis and condoms distribution will be implemented to scale. Intergration of management of HIV across other disease management platforms will be promoted for efficiency gains and to improve the effectiveness of interventions. NASCOP will promote a coordinated approach to monitoring the HIV response for all health sector stakeholders while promoting national and county government strong leadership and management. NASCOP is committed to the goals of the KASF II, which underscore the importance of multi-sectoral response to HIV in Kenya.



Dr. Catherine Ngugi,
Head, National AIDS and STI Control Programme

HIV Treatment Programme Coverage Gaps in 2019



		Achieved	90 90 90 Target	Gap
Overall (All ages)	Total Number of people living with HIV	1,508,405	0	0
	Knowledge of Status among all people living with HIV	1,350,447	1,357,565	(7,118)
	ART access among people who know their HIV status	1,112,254	1,221,808	(109,554)
	Number of people virally suppressed among people on ART	1,024,795	1,099,627.25	(74,832)
Adults 15+ (Male & Females)	Total Number of people living with HIV	1,401,761	0	0
	Knowledge of Status among all people living with HIV	1,280,357	1,261,585	18,772
	ART access among people who know their HIV status	1,042,164	1,135,426	(93,262)
	Number of people virally suppressed among people on ART	967,769	1,021,884	(54,115)
Female 15+	Total Number of people living with HIV	889,627	0	0
	Knowledge of Status among all people living with HIV	829,700	800,664	29,036
	ART access among people who know their HIV status	710,993	720,598	(9,605)
	Number of people virally suppressed among people on ART	657,866	648,538	9,328
Male 15+	Total Number of people living with HIV	512,135	0	0
	Knowledge of Status among all people living with HIV	450,657	460,922	(10,265)
	ART access among people who know their HIV status	331,171	414,829	(83,658)
	Number of people virally suppressed among people on ART	309,904	373,346	(63,442)
Children	Total Number of people living with HIV	106,807	0	0
	Knowledge of Status among all people living with HIV	70,090	96,126	(26,036)
	ART access among people who know their HIV status	70,090	86,514	(16,424)
	Number of people virally suppressed among people on ART	57,026	77,862	(20,836)

■ Achieved
 ■ Gap (below target)
 ■ Achieved (above target)
 ■ Total Number of people living with HIV



KASF II will intensify focus on differentiated testing and treatment models to bridge gaps across sub-populations towards universal coverage of HIV services



2.4 Thematic Area 2: Revitalise shared fast-track commitment towards achieving of treatment Targets



Goal: To reduce AIDS-related deaths and improve health outcomes

Kenya HIV programme provides comprehensive treatment and care interventions for improved health outcomes among people living with HIV. Evidently, data shows significant improvement in viral suppression rates and reduction in mortality rates over the years. Estimates models demonstrate the scale up of ART treatment initiated since 2004, has averted over 733,600 AIDS related deaths by the end of 2019. With the adoption of the universal test and start policy, retention on ART at 12 months has declined from 92.4% in 2013 to 83% in 2019.

To sustain the gains and accelerate progress, KASF II will strengthen the treatment programme by focusing on early HIV diagnosis, screening and management of co-morbidities including cervical cancers, TB-HIV co-infection, Non-communicable diseases and severe malnutrition. Mental health and psycho-social interventions for people living with HIV. The programme will strengthen treatment preparation and adherence support to improve health and holistic wellness.

It is estimated that by the end of 2019 Kenya had averted over 733,600 AIDS related deaths as a result of the scale up of ART since 2004



Strategic Focus Areas

To achieve and sustain progress in line with global targets, KASF II will prioritise the following strategies:

1. Optimise ART treatment for all sub-populations to improve patient health outcomes.
2. Strengthen differentiated service delivery models to improve access
3. Strengthen screening and management of TB, cervical cancers and other NCD's and comorbidities among PLHIV
4. Strengthen multisectoral engagement including private sector in HIV service delivery to expand coverage and enhance effectiveness of interventions
5. Prioritise mental health, substance and alcohol control interventions in HIV programmes.



Expected Outcomes

- Increased ART coverage towards universal access to Care and Treatment
- Achieve population level sustained viral suppression
- Reduce comorbidity and mortality among PLHIV.



Implementation Approach

KASF II promotes implementation of high quality, integrated HIV treatment programme. It calls out for the integrated HIV treatment with sexual and reproductive health services, maternal and newborn health services, mental health and management of NCDs. Innovative

differentiated models of service delivery at both facility and community level will be promoted to accelerate progress on timely linkage, ART initiation, enhanced retention and retention in HIV care and treatment programmes. Strategic partnerships at national and county, private sector, developing and implementing partners with communities will be enhanced.

In order to manage donor transition, KASF II promotes the inclusion of HIV treatment and care within essential benefits package of universal coverage. Efforts to strengthen capacity of health providers with knowledge and skills to deliver optimal treatment services will be enhanced. People centred behaviour change and peer to peer communication strategies will be implemented to empower and stimulate positive actions among treatment to clients.

Table 12: Recommended interventions to improve treatment, care and support for people living with HIV

Strategic Focus Areas	Recommended Interventions
Optimise ART treatment for all sub-populations to improve patient health outcomes.	<ul style="list-style-type: none"> ▪ Optimise test and start policy for all sub-populations. ▪ Strengthen community and facility-based systems for treatment preparation. ▪ Strengthen the capacity of service providers at all levels, including care givers, guardians, parents/relatives and teachers on treatment support. ▪ Focus on addressing barriers to treatment access for key and vulnerable populations, including persons with disability and geographies with low treatment coverage ▪ Sustained engagement of the PLHIV communities. ▪ Timely adoption of novel treatment regimens.
Strengthen differentiated service delivery models to improve access	<ul style="list-style-type: none"> ▪ Adopt, implement and scale up comprehensive Differentiated Service Delivery (DSD) Models. ▪ Promote knowledge management to inform DSD implementation. ▪ Strengthen documentation and monitoring and evaluation of DSD.
Strengthen management of comorbidities among PLHIV	<ul style="list-style-type: none"> ▪ Support utilisation and coverage of UHC Essential Health Packages among PLHIV. ▪ Increase efficiency in management of NCDs e.g. Diabetes, Hypertension and cancers ▪ Mentorship of healthcare workers on NCDs/HIV management ▪ Facilitate mechanisms to improve treatment outcomes among TB-HIV co-infected ▪ Improve management of STI's and Viral Hepatitis.
Strengthen multisectoral engagement including private sector in HIV service delivery to enhance coverage and effectiveness	<ul style="list-style-type: none"> ▪ Expand access to treatment, care and support in the private sector ▪ Improve reporting and quality of data on HIV treatment data among private sector providers in Kenya Health information System
Prioritise mental health, substance and alcohol control interventions in HIV programmes.	<ul style="list-style-type: none"> ▪ Support development and dissemination of technical tools for prevention, identification, diagnosis, treatment and management of health conditions due to alcohol and substance use ▪ Scale up services for mental, neurological and substance use disorders among PLHIV



PP *The commitment to leave no one behind requires that we eliminate HIV related stigma, human rights discrimination and legal barriers that impede access to health services. The barriers only serve to fuel new HIV infections and lead to worse health outcomes for people living with HIV. An effective HIV response must be anchored on the foundation of health justice.* QQ

Nelson Otwoma,
*Director, National Empowerment Network
of People Living with HIV in Kenya*



2.5 Thematic Area 3: Protect the rights of people to live a life free of violence, stigma and discrimination



Goal: Protect human rights and eliminate all forms of violence and HIV related stigma and discrimination against people living with HIV, key and priority populations

Protection of human rights of marginalised groups, persons at heightened risk of HIV infection and those who risk rights violation because of their HIV positive status is of utmost importance. It is critical that policies and services address wider structural, social and environmental determinants of health for individuals and populations. The universal health coverage agenda is embedded in a human rights-based framework. Legal and structural barriers to access services coupled with prevalent HIV related stigma and discrimination exacerbate the risks and pan out as key determinants of HIV programme outcomes. The HIV stigma index of 2014 showed high category of HIV related stigma and discrimination at 45 % with marked regional variations. This situation exists despite high levels of HIV awareness in Kenya. People most at risk of HIV still face high levels of HIV-related stigma, discrimination and violence, deterring them from accessing vital HIV services. Criminalised populations living with HIV experience multiple human violations for being HIV positive and for their sexual orientation.

The link between violence and HIV has been well established. Violence constitutes a human rights violation that not only impedes progress in ending the HIV epidemic but also in alleviating poverty and promoting peace and security. People living with HIV, people living with disabilities, sex workers and sexually active adolescent girls are among populations that are often denied access to sexual reproductive health and rights services, despite the constitutional guarantee for the right to the highest attainable standard of health, including reproductive health.



Strategic Focus Area

1. Promote accountability and responsiveness for enhanced human rights protection.
2. Promote access to justice through public awareness of legal frameworks and redress institutions.
3. Institutionalise progress monitoring of HIV related stigma and discrimination and other health and human rights violations
4. Reduce all forms of violence among vulnerable priority groups.



Expected Outcomes

- Reduced HIV related stigma and discrimination index from 45% to less than 25%.
- Increased access to justice among HIV vulnerable sub-populations, people living with HIV and people living with disabilities.
- Reduced number of people living with HIV, key and priority populations who experience all forms of violence by 25%.



Implementation Approach

Kenya will enhance legal and policy environment for marginalised, criminalised and vulnerable groups who have heightened risks of HIV infection or aggravated violations as a critical step. This approach will be guided by the provision of the Constitution, which guarantees a broad range of rights. KASF II promotes rights based approaches in the management of HIV, STIs TB and other comorbidities. An enabling legal and policy environment

will facilitate provision of quality health services towards Universal Health Coverage. It will enhance social support and promote cost-effectiveness of the HIV response.

A multi-sectoral response that seeks lasting solutions will be critical for HIV response to remain effective among vulnerable populations such as people living with disabilities and other vulnerable populations that experience multiple forms of stigma and discrimination in all spheres of life.

Public awareness on legal redressal mechanisms against HIV related violations and gender based violence will be promoted. Access to justice and protection from discrimination will enhance the well being of sub-populations who need to access HIV services.



Despite progressive policies in Kenya, gender-based and other forms of violence against key and vulnerable populations remain high. Gender -based violence is largely unreported or, in reported instances, retracted and settled outside of appropriate legal mechanisms.

Table 13: Recommended Interventions to safeguard human rights in the HIV response

Strategic Focus Area	Recommended Interventions
Promote access to justice	<ul style="list-style-type: none"> ▪ Strengthen the capacity of institutions that provide access to legal and social justice such as the HIV and AIDS Tribunal and other National Human Rights Institutions ▪ Increase public awareness of legal frameworks, institutions and mechanisms to access justice against GBV, HIV related stigma, discrimination, and other human rights violations ▪ Facilitate access to justice and redressal for marginalised populations, people living with and vulnerable to HIV, including people living with disabilities. ▪ Enhanced legal literacy about human rights and laws relevant to HIV and TB for PLHIV, KP, People with disabilities and other priority populations ▪ Review and monitor the implementation of laws, regulations and policies that are barrier to universal coverage of HIV, TB and SRHR interventions.
Promote accountability and responsiveness for enhanced human rights protection	<ul style="list-style-type: none"> ▪ Promote accountability and responsiveness for enhanced human rights protection of people living with HIV, key populations, people living with disabilities and other priority groups among law enforcement organs and human rights protection agencies ▪ Institutionalise trainings on access to HIV and SRHR as a basic human right for all sub-populations among health care workers, state legal reform agencies, law enforcers and workplaces. ▪ Promote community led assessments of sexual and reproductive health and rights policies that impede access to services among sex workers, women who inject drugs, people living with HIV, adolescent girls, people with disabilities among other vulnerable groups. ▪ Annual reviews of declarations and international commitments
Reduce HIV related stigma and discrimination among PLHIV, KP, people with disabilities and other priority populations	<ul style="list-style-type: none"> ▪ Review and implement laws and policies that address HIV-related stigma and discrimination
Reduce all forms of violence perpetrated against PLHIV, KP, priority and vulnerable populations	<ul style="list-style-type: none"> ▪ Eliminate all forms of gender-based violence, gender disparities, socio-cultural and religious practices that hinder access to HIV and health services. ▪ Strengthen the capacity building of health care providers and law enforcement officers who come in contact with survivors of SGBV ▪ Promote gender equality and put in place frameworks to address all forms of violence (including sexual harassment and sexual and gender-based violence) prevention programmes in the community, educational institutions, workplaces, among others



Weak health systems result in high levels of inefficiencies and massive wastages that compromise delivery and the quality of services. There is need to invest in a system that shows real-time facility data for commodities to facilitate the last-mile distribution to all the satellite sites



2.6 Thematic Area 4: Invest in resilient systems for HIV and other health outcomes



Goal: Develop resilient and sustainable health systems

Robust and resilient health systems are essential for effective response to HIV and other health outcomes. These systems are affected by aspects such as supply chain management and pharmacovigilance; Laboratory management and technology; Human resource for health; Service quality improvements; and HIV services during emergencies, humanitarian settings and climate change. Health actors and institutions can ensure that core functions are maintained in the face of a crisis and re-organise, if required to effectively respond to crises.



Strategic Focus Areas

1. Integrated service delivery and quality improvement.
2. Improve the management of human resources for health including community health workers.
3. Strengthen health management information systems and monitoring and evaluation.
4. Strengthen the health product management systems.
5. Harmonise and strengthen financial management system.
6. Enhanced infrastructure and equipment management systems and services.



Expected Outcomes

- Improved supply chain system, commodity security and pharmacovigilance.
- Robust, reliable and expanded health infrastructure including laboratory systems and services.
- Adequate and well-trained workforce for improved health service delivery.
- Integrated quality improvement in HIV service delivery.



Implementation Approach

Strong HIV commodity management requires effective and efficient management of health products and technologies. Weak health systems result in high levels of inefficiencies and massive wastages that compromise delivery and the quality of services. There is need to invest in a system that shows real-time facility data for commodities to facilitate the last-mile distribution to all the satellite sites. Parallel reporting platforms will need to be eliminated to eliminate duplication of efforts. Pharmacovigilance of all HIV commodities, including laboratory and nutrition supplies, among others will need to be expanded.

Effective laboratory drug resistance monitoring has been strengthened over time but gaps in laboratory infrastructure that includes sustained quality assurance during emergencies still exist. Routine and specialised laboratory tests that require specialised skill sets (e.g. molecular gene sequencing and molecular laboratory data analysis) need to be put in place to cope with unforeseen disruptions. Quality assurance of testing platforms and new technologies such as self-testing, expanded point-of-care viral load testing is required for better monitoring of treatment outcomes. In addition, HIV testing infrastructure (HTS, Recency testing, EID, VL and DR) has to be scaled up and expanded.

Human resource is a critical component required for the delivery of HIV and other health services. Given there are gaps in the required number of healthcare workers, and the training for health workers, there has to be realistic transition plans. Counties should be supported to maintain and recruit additional health care workers, ensuring equitable distribution of staff across cadres

and geographies. There is need for proactive measures at the inter-governmental level to address frequent health care workers' industrial disruptions. Existing staff need opportunities for capacity building through quality trainings and mentorship models.

The national scale up of evidence-based Quality Improvement (QI) interventions in routine HIV service delivery can be considered and will be anchored within the Kenya HIV Quality Improvement Framework (KHQIF)

Table 14: Proposed interventions to strengthen resilient and sustainable systems for HIV response and other health outcomes

Strategic Focus Area	Recommended Interventions
Integrated service delivery and quality improvement	<ul style="list-style-type: none"> ▪ Develop a framework and tools to provide high quality services which are people centred ▪ Strengthening strategic frameworks for quality of care related essential packages ▪ Develop framework to protect patient rights ▪ Develop a framework to monitor comorbidities ▪ Develop a community monitoring approach to receive community feedback ▪ Scale up quality improvement interventions towards improving HIV service delivery. ▪ Establish monitoring systems for quality improvement initiative within existing infrastructure
Improve the management of human resources for health including community health workers	<ul style="list-style-type: none"> ▪ Develop and implement comprehensive health personnel medium and long-term plans for facility and community level ▪ Streamline engagement of Community Health Volunteers and strengthen their capacity to address NCDs and emerging challenges ▪ Build capacity of community health workers to provide services across all health spectrums ▪ Facilitate continuous professional development. ▪ Support proper working environment and better pay for the workforce ▪ Provide the relevant protective gear, supplies and capacity for health care workers at facility and community levels ▪ Empower the community to participate in social protection schemes ▪ Continuous capacity building of healthcare workers on pharmacovigilance
Strengthen health management information systems and monitoring and evaluation	<ul style="list-style-type: none"> ▪ Streamline routine reports in a timely manner using the health information management system ▪ Develop an approach to conduct routine surveys, surveillance and reviews to monitor programmes and address gaps ▪ Develop an approach to conduct special studies to test innovations ▪ Develop a system for regular service quality improvement assessment ▪ Development of policies for data security, data sharing and use ▪ Capacity building of national and sub national staff to develop prevention and treatment dashboards and cascades
Strengthen the health product management systems	<ul style="list-style-type: none"> ▪ Strengthen procurement, warehousing and distribution systems for commodities ▪ Establish and support mechanisms for managing waste and pilferage at the facility level ▪ Establish supportive policies on production and the use of local HIV and health commodities to ensure sustainable access ▪ Institute supportive structures to reduce the turnaround time of obtaining tax waivers and other vital importation documents, to prevent delays in HIV commodities supply chain. ▪ Establish a system that allows for quick reverse logistics of HIV and health commodities, and allows for faster inter- and intra-county redistribution ▪ Establish a pharmacovigilance system that not only caters for programme drugs but also for all other HIV commodities ▪ Enhance quality control and post-market surveillance to include all HIV related diagnostics ▪ Strengthen the existing pharmacovigilance feedback mechanisms in the regulatory bodies.

Strategic Focus Area	Recommended Interventions
Harmonise and strengthen financial management system	<ul style="list-style-type: none"> ▪ Streamline budgetary and financial investments systems to consider domestic and external resources. ▪ Strengthen human resource capacity on financial management ▪ Enhance risk assurance and efficient grant management ▪ Support timely and quality reporting of financial reports to sustain funding streams ▪ Enhance accountability and oversight structures at all levels of implementation.
Enhanced HIV infrastructure and equipment management systems and services including laboratory systems	<ul style="list-style-type: none"> ▪ Strengthen laboratory infrastructure to support HIV and AIDS and other comorbidities. ▪ Develop a framework for strengthening health laboratory services to support HIV and AIDS, comorbidities in the context of UHC ▪ Ensure sustainability of laboratory quality assurance systems by building laboratory capacities for quality testing, monitoring and data collection at national regional and county level ▪ Expand utilisation of laboratory services through establishment of sustainable, sufficient and competent human resources for laboratory service delivery that requires specialised skills set ▪ Promote effective laboratory referral networking ▪ Draw legal frameworks to correct gaps in human resources for laboratory services. ▪ Sustain and scale up HIV drug resistance testing and molecular waste management ▪ Strengthen the capacity of the national blood safety programme to provide safe blood.



Putting people at the centre of the HIV response is key to unlocking the barriers to demand and uptake of services. Resourced community led responses will benefit from localised innovations and solutions to accelerate progress.



Geoffrey Obonyo,
Head, Policy and Strategy, NACC





2.7 Thematic Area 5: Leverage on communities led programmes for an effective response



Goal: Implement community-led innovations and differentiated approaches to improve access to HIV and other health services

Community engagement is key to the design, plans and implementation of HIV and other health programmes. Their role in enhancing ownership through demand creation, service delivery and advocacy is paramount to the sustainability of interventions. Peer-to-peer and other community outreaches remain the backbone of reaching all populations especially those marginalised, the underserved and those who are hard to reach. Community empowerment ensures that populations are not just recipients of services. It helps build a social movement where the community collectively exercises their rights and is recognised as an authority as equal partners in the planning, implementation and monitoring of health services. Over the years, communities have established platforms that have considerably increased access to acceptable HIV and other health services while providing safe spaces for them to engage, share experiences and insights. Such platforms have broken barriers to access, improved strategies to deal with stigma and discrimination besides acting as a catalyst for the adoption of livelihood support programmes. The emergence of pandemics such as COVID-19 and other humanitarian emergencies have demonstrated the value addition of community-led and trusted access platforms. Virtual platforms led by community members such as those by Adolescent girls and young women, PLHIV and KPs provided a safe space for continuous demand generation and referrals for HIV, SRHR and other health services.



Strategic Focus Areas

1. Design and implement people centred responses.
2. Reinforce the critical role of community-led interventions.
3. Strengthen community-led data monitoring and social accountability.



Expected Results by 2025

- Increased number of trusted community access platforms.
- Community led network sustained and strengthened.
- Social accountability of the HIV and health interventions enhanced.



Implementation Approach

KASF II will strive to strengthen and establish more robust community-led platforms towards the delivery of comprehensive HIV and other health prevention services. Communities will continue to be a part of the design, planning and implementation of services and focus on scaling up programmes that foster ownership and empowerment of affected communities towards sustainability. This framework will build on best practices and promising interventions that have been implemented in the past and scale up new approaches, in consultation with the communities.

Table 15: Proposed Interventions to Strengthen Community Led Approaches in HIV Response

Strategic Focus Area	Recommended Interventions
Design and implement people centred responses	<ul style="list-style-type: none"> ▪ Actively seek community participation in design, implementation and monitoring of interventions ▪ Design layered HIV interventions that address other community needs. ▪ Expand access to social health insurance for vulnerable and marginalised communities to meet UHC. ▪ Expand partnerships with other key sectors to respond to community concerns that impact on HIV and health.
Reinforce the critical role of community-led interventions	<ul style="list-style-type: none"> ▪ Establish communities of practice that effectively address HIV and other health services ▪ Strengthen management and advocacy capacity of existing and emerging community-led organisations including networks of PLHIV ▪ Adopt to scale community-led best practices and innovations ▪ Promote remuneration of standardised community level HIV and health personnel. ▪ Draw and implement frameworks for targeted contracts with community-led organisations to directly receive, implement and report on grants.
Strengthen Community led data monitoring and social accountability	<ul style="list-style-type: none"> ▪ Support communities to develop and implement score cards for monitoring HIV and health interventions ▪ Formulate and operationalise community monitoring frameworks for the HIV and other health programme implementation ▪ Strengthen the capacity for data led advocacy among community leaders. ▪ Provide platforms and foster community-led advocacy for an enabling environment for service delivery



The emergence of pandemics such as COVID-19 and other humanitarian emergencies has demonstrated the value addition of community-led and trusted access platforms. Virtual platforms led by community members including Adolescent Girls and Young Women, People Living with HIV and Key Populations provided a safe space for continuous demand generation and referrals for HIV, SRHR and other health services in the context of COVID-19 related disruptions in Kenya



2.8 Thematic Area 6: Integrate HIV in humanitarian and emergency responses



Goal: People are protected from vulnerability to HIV and poor health outcomes in emergencies and humanitarian context

The resilience of the HIV response is determined by the preparedness of the health and community systems to deal with disruptions. Natural disasters like climate change, floods and droughts can adversely impact the social, community and health delivery systems. They follow pathways that are similar to those of HIV with the potential to exacerbate poverty, gender vulnerability, exploitation of children and strains on the health care delivery systems. Rapidly spreading severe epidemics such as Ebola and COVID-19 strain the public health response capacity to deal with HIV and other chronic diseases. Health systems are often disrupted due to industrial strikes and commodity stock outs, which can alter the projected trajectory of disease management. The emergence of COVID-19 pandemic is likely to have far reaching social and economic impacts in Kenya that are likely to manifest along, poverty, health systems and gender aspects such as inequalities around the burden of care. In addition, Kenya hosts two of the largest refugee camps in the world, which are equally vulnerable to fragility settings. The situation poses the challenge of coping with both external and internal displacement of populations.

Disasters can negatively determine how individuals respond to changes in the macro and micro-economic environments, especially when it includes income shocks. Such situations are likely to shape population-level outcomes of control and management of HIV. In situations of food insecurity, measures to protect women and child-headed homesteads from HIV vulnerabilities should be prioritised. Coping mechanisms of vulnerable populations have often resulted in earlier sex debut, forced and early marriages, transactional sex and, particularly in the case of girls, teenage pregnancies and school drop-outs. In cases of emergency settings, the number of incidences of sexual and gender-based violence against women and girls is reportedly

high amidst complete or partial disruption of health infrastructure. Sexual and reproductive health services often collapse, including the provision of contraception, PEP and PMTCT programmes thus undermining preventive care. People living with HIV face added vulnerabilities during humanitarian emergencies owing to the displacement of patients and health workers or the disruption of services. These include loss of ART supplies and means of personal identification that can negatively impact on the treatment regimen. High levels of stigma and discrimination hamper disclosure of HIV status when people are displaced. Each of these factors contribute to increased vulnerability to ill health and result in increased morbidity and mortality for those on treatment. Interruption of procurement and supply management is also a key challenge during emergencies period.



Strategic Focus Areas

1. Enhance multi-level and multi-sectoral capacity for risk preparedness, reduction and mitigation against impact of disasters
2. Establish a framework to ensure continuity of HIV services
3. Strengthen community centred emergency responses



Expected outcomes

- Functional, integrated emergency response system for HIV and other related comorbidities established
- Sustained HIV services during emergencies



Implementation Approach

A key priority of an HIV response contingency plan is to maintain PLHIV on the first-line regimen, and reduce complications during and post-emergency period from drug resistance. Additional elements of provision of pre-exposure prophylaxis (PrEP) for vulnerable populations remains a critical prevention strategy. With the decentralised system of government and the provision of health care, national preparedness and contingency plans will be contextualised based on the situation at the county level. The contingency plans

should be regularly updated to stay abreast of multi-dimension of humanitarian crisis, emerging science and technology to ensure that actions reflect the realities and meet local needs. These plans should be inclusive and draw on respective areas of advantage from a sector wide humanitarian response plan. A well rolled-out plan of action during emergencies will ensure reductions of HIV related vulnerabilities and avert treatment crisis for people living with HIV. KASF II recommends the need for layering comprehensive HIV sensitive social safety to build resilience of community and health systems during periods of emergencies. Communities will remain at the centre of HIV emergency responses.

Table 16: Recommended Interventions on integrating HIV in humanitarian and emergency response

Strategic Focus Areas	Recommended Interventions
Enhance multi-level and multi-sectoral capacity for risk preparedness, reduction and mitigation against impact of disasters	<ul style="list-style-type: none"> ▪ Integrate HIV indicators into humanitarian multi-sector initial rapid assessments and progress tracking platforms ▪ Conduct assessment of HIV disaster preparedness, contingency and response plans at county and national level ▪ Develop surge capacity of health personnel to sustain ongoing HIV services including capacity strengthening ▪ Establish contingency budget plans for procurement and distribution of personal protective equipment and commodities for community and health service providers ▪ Integrate plans to screen and provide treatment for other comorbidities such as TB among PLHIV
Establish a framework to ensure continuity of HIV services	<ul style="list-style-type: none"> ▪ Develop guidelines for differentiated models of HIV services in emergency settings ▪ Adopt innovations and technological solutions to minimise disruption of services ▪ Cushion HIV vulnerable groups against negative economic and social impacts
Strengthen community centred emergency responses	<ul style="list-style-type: none"> ▪ Conduct community-led needs assessment ▪ Strengthen facility and community linkages ▪ Engage with community leadership to design social protection measures and maintain HIV interventions ▪ Strengthen strategies for follow-up with clients on HIV and other comorbidities during emergencies.



KASF II promotes increased access to, and utilisation of quality location and population granulated strategic information. There will be continuous effort to ensure alignment of M&E sub-systems with the national system to improve data quality





2.9 Thematic Area 7: Promote translation of strategic information, research, surveillance, innovations and implementation of science to inform HIV programming



Goal: Increased access to, and utilisation of, location and population granulated strategic information for evidence informed HIV programming

Strategic information, research and innovation are key to enhancing evidence-based decision-making and policy formulation for the HIV response. Despite the various achievements made during KASF I implementation, there were emerging issues such as increased cases of comorbidities and change in policy landscape, which led to the renewed focus on STIs and the adoption of the UHC agenda. KASF II, therefore, proposes to strengthen the utilisation of strategic information, research and innovation to address emerging challenges.



Strategic Focus Areas

1. Strengthen routine programme reporting capacities for HIV, STIs and other comorbidities.
2. Promote timely translation of research into policy and practice
3. Strengthen surveillance and periodic surveys for HIV, STIs and other comorbidities.
4. Develop and disseminate timely strategic information products and capacities to improve data access, demand and use.



Expected Outcomes

- Increased access to, and utilisation of, quality location and population granulated strategic information.
- Programme reviews, surveillance and periodic surveys for HIV, STIs and other co-morbidities conducted in a timely manner.
- County, country, regional and global reporting obligation for the HIV programme honoured.



Implementation Approach

Over the years, Kenya has invested in data management systems. Despite the progress made, some of the data systems are not aligned with the one country level monitoring and evaluation system which remained fragmented. During KASF II implementation, there will be continuous effort to ensure alignment of M&E sub-systems with the national system. The implementation and dissemination of programme-based evaluations and other studies to inform policy and programming will be enhanced. Kenya has implemented periodic national population-based surveys such as the Kenya Demographic and Health Survey (KDHS), Kenya AIDS Indicator Survey (KAIS), Integrated Biological and Behavioural Studies (IBBS), Size Estimates for at risk groups, HIV Stigma and Discrimination Survey, Kenya Population-Based HIV Impact Assessment (KENPHIA), among others, that have informed trends in HIV epidemic. Based on those trends, various interventions have been identified and implemented to guide decision-making for the HIV response at all levels. These surveys and studies have traditionally relied heavily on external resources. There is need for increased domestic financing to fund surveys and studies.

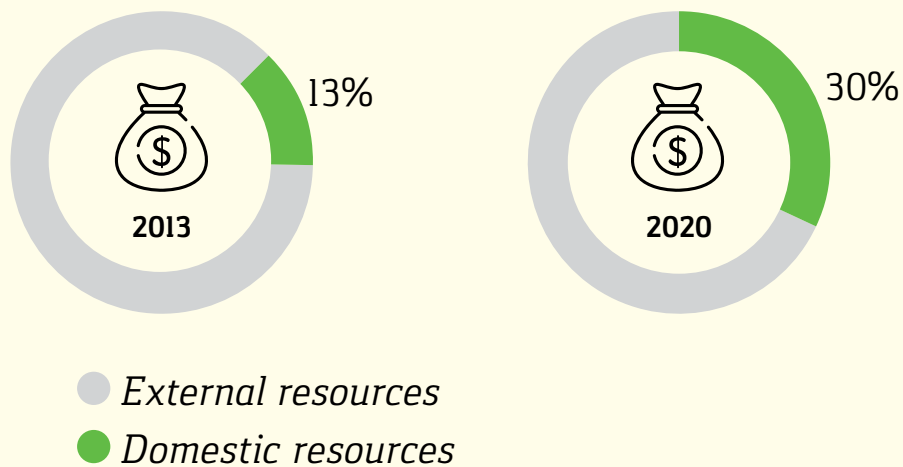
Table 17: Recommended Interventions to strengthen strategic information, research and innovation to inform policy and practice

Strategic Focus Areas	Recommended Interventions
Strengthen capacity for routine HIV programme reporting	<ul style="list-style-type: none"> ▪ Develop, implement and review the monitoring and evaluation framework ▪ Develop and implement a quality assurance plan. ▪ Promote system Integration and Interoperability ▪ Strengthen the KHIS, community, public and private sector routine programme reporting. ▪ Leverage on technology for real time, location and population granulated data. ▪ Strengthen coordination and capacities for a functional M&E system at all levels and across sectors.
Promote timely translation of research into policy and practice	<ul style="list-style-type: none"> ▪ Develop, implement and review HIV Programme Research Agenda. ▪ Track implementation of priority research for HIV, STIs and Comorbidities. ▪ Establish and strengthen research coordination mechanisms. ▪ Build capacity for research and develop resource mobilisation mechanisms.
Strengthen programme reviews, surveillance and periodic surveys for HIV, STIs and other co-morbidities.	<ul style="list-style-type: none"> ▪ Strengthen surveillance for HIV, STIs and other comorbidities including case-based, recency, STIs, drug resistance, mortality, phylogenetic, size estimates, injection, and commodities among others. ▪ Conduct periodic population-based surveys for HIV, STIs and other comorbidities. ▪ Implement AIDS financing, spending and transition assessments. ▪ Conduct HIV programme and strategic framework reviews. ▪ Strengthen estimation and modelling for HIV, STIs and other comorbidities.
Develop and disseminate timely strategic information products and capacities to improve data access, demand and use	<ul style="list-style-type: none"> ▪ Strengthen data analytics and visualisation to improve data demand and utilisation at all levels. ▪ Develop and disseminate timely Strategic Information Products. ▪ Leverage on technology to provide access to real time strategic information. ▪ Honour county, national, regional and global reporting obligations for HIV, STIs and co-morbidities.



KASF II recommends the need to draw and implement a transition Roadmap towards securing longer term resources for the AIDS response. The HIV response is largely dependent on external resources. The country's domestic resource envelope increased from 13% in 2013 to 32% in 2020 against a target of 50% for the same period. KASF II will strive to secure an increase on the share of domestic resources to safeguard against disruptions related to external resources.

Resources for the AIDS response





2.10 Thematic Area 8: Invest in Long-term HIV financing models



Goal: To ensure HIV financing models for resourcing HIV and comorbidities response are sustained, expanded, and leveraged for the longer term

Kenya will require **Ksh. 647.7 billion** to fully fund the HIV response for the next five years. Based on funding trends, a gap of **Ksh. 288.2 billion** will need to be resourced to fully fund the response. Cognisant of the disruption of the global health landscape by the COVID-19 pandemic, the resource mobilisation plans under KASF II focus on efficiency gains of the available grants and domestic resources while expanding the resource base. Prior to the COVID-19 pandemic, the global economy was struggling to regain a broad-based recovery due to the lingering impact of growing trade protectionism, trade disputes among major trading partners, falling commodity prices, economic uncertainties, climate change and refugee crisis. With large economies facing the pressure to impose lock downs, the impact in terms of both the loss in economies and the COVID-19 disease, is likely to negatively influence overseas development aid, including that for HIV. Locally, the impact of the COVID-19 pandemic is likely to manifest around poverty, gender related inequalities and access to care.

The share of external financing is also likely to decline because of rapid growth and rebasing of the Kenyan economy. In 2020, Kenya had the third largest economy in Sub-Saharan Africa with a GDP of US\$ 1,817 per capita (World Bank 2019). Global patterns show external funding accounts for less than one-third of public health spending in most countries with GDP per capita around US\$ 2,000. This will result in significant impact for the country whose HIV response has been heavily dependent on external resources. The country's domestic resource envelope increased from 13% in 2013 to 32% in 2020 against a target of 50% for the same period. The country, therefore, needs a robust resource mobilisation plan that will sustain the gains and bridge the gaps in the context of the UHC agenda. KASF II will aim to achieve an increased resource base for the HIV response to continue reducing HIV incidence in the country.

Table 18: Total cost by KASF II priority investment areas (Ksh. billions)

KASF II Priority Investment Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
HIV prevention	22.8	22.8	22.8	23.6	25.3	117.3
Treatment care and support for HIV/STI and Viral Hepatitis.	58.6	62.3	65.6	68.7	71.4	326.6
Resilient sustainable systems for HIV and AIDS and Health (RSSH).	7.2	8.7	10.4	12.6	15	53.9
Strengthening strategic information, research and innovation.	2.7	2.9	3.1	3.2	3.4	15.3
Human rights-based approach to HIV response.	8.2	8.2	8.5	8.9	9.3	43.1
Sustainable financing of the HIV response.	0.2	0.2	0.2	0.2	0.2	1.0
Communication and advocacy for HIV and STIS.	3.4	3.6	3.7	3.8	4	18.5
Leadership and accountability for delivery of the KASF results.	13.3	13.9	14.4	14.9	15.5	72.0
Total	116.4	122.6	128.7	135.9	144.1	647.7

Source: Calculation from the Resource Need Model



Strategic Focus Areas

- Enhanced domestic resource mobilisation for the HIV response
- Enhanced efficiency and effectiveness in resource utilisation
- Resource transition planning



Expected Outcomes

1. Increased domestic resource mobilisation and investment in the HIV and priority NCDs' response
2. Improved efficiency in resource allocation and utilisation
3. County governance and accountability of HIV resources enhanced.
4. Resource base transitions managed and HIV interventions sustained.



Implementation Approach


Kenya transitioned to a lower middle-income country raising the expectation on counterpart financing and borrowing interest rates. HIV contributes to 29% of the country's mortality and hence it continues to be a priority agenda across all sectors. While the global resource envelope for the HIV response is expected to shrink, an increase in domestic resources will be imperative to bridge the gaps and sustain the more than 1.5 million Kenyans on lifelong treatment, while reducing new HIV infections. Therefore, Kenya will need to take proactive steps to increase domestic financing options and fund at least 50% of the resources required for the HIV response. With the geographical heterogeneity of the burden of HIV, inclusion of HIV indicators in equalisation frameworks for sharable revenue is a priority. Alternative innovative models of resource mobilisation and allocation such as social contracting mechanisms, social impact bonds and investments through social responsibility frameworks will also be explored.

The KASF will focus on enhancing efficiency and effectiveness in resource utilisation. This will include cost effectiveness analyses to re-allocate resources towards high-impact interventions, explore procurement options to gain high cost savings, streamline drugs and commodities supply chain systems and the integration of HIV services within health care settings. Lessons on the positive outcome of applying differentiated care models, facility-based fast track models for quality improvement that lead to better patient outcomes and providers' satisfaction will be maintained and developed. Other measures will include the use of models to determine and estimate real time programme data on cost savings due to efficiency gains. The generated data will be used to review programme unit costs to advise the annual work plans. Accurate programmatic unit costs will improve the quality of epidemiological estimates, HIV programme performance reviews including public expenditure tracking surveys, national AIDS spending assessment, resource needs and impact analysis and allocative efficiency analysis models. Information generated from these tools will provide the basis for making smarter investment cases for the HIV response.

Shrinking donor funding calls for bold country leadership and political commitment to safeguard the gains made in the HIV and AIDS response. Kenya will need to explore and secure fiscal space for the domestic funding of the HIV and AIDS response. Country-led dialogue with existing donors will support the creation of realistic transition models. Commodities and human resources that are currently externally funded, will require smooth transition plans with the engagement of the national and county governments. Special attention will be given to HIV, emerging NCDs prevention services and commodities for inclusion in transition plans. The integration of HIV services with other comorbidities, NCDs and emerging epidemics such as COVID-19, will require proper attention so that we do not lose the gains of more than three decades of the HIV response.

Table 19: Recommended Intervention on HIV investments models for long term sustainability

Strategic Focus Area	Recommended Intervention
Enhanced domestic resource mobilisation for the HIV response	<ul style="list-style-type: none">▪ Increase county level budgetary allocation for HIV and ring-fence through legal frameworks▪ Develop frameworks to streamline public-private partnerships in the HIV response▪ Develop HIV investment criteria for resource allocation to counties aligned to resource needs
Enhanced efficiency and effectiveness in resource utilisation	<ul style="list-style-type: none">▪ Develop costing and expenditure reference bureau for HIV programming and UHC▪ Implement models of efficiency gain through integration of HIV services with related comorbidities▪ Develop the Public Expenditure Tracking Systems (PETS) for HIV and UHC
Resource transition planning	<ul style="list-style-type: none">▪ Develop and implement a realistic transitional framework for HIV financing that include mechanism to secure human resource capacities▪ Integrate HIV financing within the UHC model▪ Develop framework to manage transitions and secure short-term human resources for health funded by donors.



Effective leadership and enhanced accountability are critical to address the decline in resource envelope and the growing demand for sustainability of programmes that are aligned to the Universal Health Coverage



2.II Thematic Area 9: Promote Leadership, Communication and Advocacy



Goal: To ensure multi-sector HIV programme stewardship, ownership, optimal coordination, communication and advocacy are strengthened at national and county level

Coordination of KASF II is aligned with the globally agreed “Three Ones Principles” of one agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners, One National AIDS Coordinating Authority, with a broad based multi-sector mandate, and One agreed country level Monitoring and Evaluation System that guide HIV responses. KASF II coordination structures are aligned with the Constitution of Kenya (2010) and the relevant legislative instruments along with the national policies and strategies including the Kenya Vision 2030 and the Third Medium-Term Plan (MTP III) that define the service delivery and institutional framework. The coordination Framework aims at strengthening the mechanism for multi-sectoral implementation, tracking of progress enhance accountability for resources with stakeholders meaningfully engaged at all levels. Stakeholders will be engaged based on their implementation platforms to create coherence. Programme implementation platforms include those based within the health sector, workplaces, education settings, community level and digital spaces. Facilitative, effective leadership and oversight will be enhanced through data centric accountability processes that promote efficiency and sustainability of the HIV response



Strategic Focus Areas

1. Promote transformational leadership among political and technical leaders for the national and county HIV/AIDS responses
2. Enhance the use of data-led and results-based coordination mechanisms for the multi-sectoral HIV and AIDS response
3. Ensure social accountability of the HIV programme is promoted at all levels
4. Ensure sustained communication and advocacy



Expected Outcomes

- Good governance practices and accountability mechanisms enhanced in the delivery of KASF II results
- Functional coordination and leadership structures established at all levels.
- Results focused multi-sectoral engagement platforms established.
- Visibility of the HIV agenda maintained throughout implementation period.



Implementation Approach

Leadership and accountability of KASF II will be enhanced at multiple levels within the national and county governance structures. These structures will provide opportunities for engaging the leadership from both state and non-state actors and to facilitate synergies at the political and technical levels.

- 1. Presidency:** Since the HIV response is a national priority enshrined with the Vision 2030 development blueprint, KASF II will maintain accountability to the national development agenda whose apex is the Presidency. Kenya, as a member of the United Nations, is also committed to maintaining its accountability role within the globally agreed frameworks.
- 2. Ministry of Health:** Under the leadership of the Cabinet Secretary, the Ministry of Health is responsible for leading the health sector response to HIV. In addition, the multi-sectoral approach to HIV response will require transformative leadership to leverage on other non-sectors and strengthen

health systems. NASCOP, established to spearhead the Ministry of Health's HIV interventions, will be central to the successful implementation of KASF II. Engagement and leadership of other departments and divisions of the Ministry responsible for family health, NCDs, health care financing, disease surveillance, public health laboratory, quality and standards, blood transfusion and intergovernmental affairs, will also influence the successful implementation of KASF II.

3. **National AIDS Control Council:** The key mandate of the NACC is to provide strategic leadership and coordination of the implementation of KASF II. Under the leadership of the NACC Council and secretariat, stakeholders from across sectors will be engaged in the implementation, resource mobilisation and accountability for results. Further, NACC will provide technical support for the development and implementation of county specific HIV plans. NACC will be responsible to identify effective mechanisms to engage stakeholders.
4. **On-state actors:** Under the leadership of the County Governors, and in line with the devolved health functions, counties will be expected to draw operational plans for KASF II. The leadership of the county will be expected to mobilise localised resources to maintain the multi-sectoral HIV response. During the implementation of KASF II, stakeholders at the county level will be critical in ensuring that the multi-sectoral approach adopted by KASF II is achieved.
5. **County Executive Committee for Health:** The office of the County Executive for Health will provide leadership in the multi-sectoral response at the county level. It is expected to provide oversight and guidance for the implementation of the HIV programme. With engagement of the county health management team and partners, the office will provide mechanisms for the coordination of county level programme implementation platforms.
 - **Inter-governmental forum:** In line with the Intergovernmental Act 2012, the forum will provide a platform to address key emerging issues that require consensus between counties and national government.
 - **Coordination of stakeholders** - The framework will bring together stakeholders from diverse constituencies including, but not limited to; community-led networks for PLHIV, KPs, PWDs, AGYW; sector-led partners including faith communities, CSOs, implementing partners, public and private sectors.
 - **Thematic working groups:** These will be established to provide technical direction for the implementation of KASF II.

Coordination Platforms

KASF II coordination platforms will promote advocacy, social mobilisation and accountability through participatory process that actively seek for citizen engagement to build on positive collective influence of the HIV programme. Community-led monitoring of the HIV response will be reinvigorated at all levels. The capacities of key, vulnerable and priority populations will be enhanced to effectively apply their lived experiences to shape the HIV response.

Monitoring and Evaluation of the Kenya AIDS Strategic Framework II



A monitoring and evaluation framework will be developed to provide the basis for tracking progress and results of implementation of KASF II

Monitoring and Evaluation (M&E) is an indispensable function for guaranteeing that priority HIV response actions outlined in KASF II are implemented as planned against stated objectives and expected outcomes. A monitoring and evaluation framework will be developed to guide management data sets to extract key indicators required to monitor process and impact of KASF II. The monitoring and evaluation framework will further define the responsibilities of stakeholders and identify appropriate data sources to provide baselines data for proposed interventions outlined in KASF II. Stakeholders at the National and County level will conduct timely joint assessments and performance reviews to determine priorities and subsequent action plans during implementation of KASF II. A mid-term review will be conducted in year 2023 and an end-term evaluation will be undertaken at the end of five years of implementation in year 2025.

Table 20: KASF II Coordination Mechanisms

Coordination Mechanisms	Key Interventions
KASF II Steering Committee	<ul style="list-style-type: none"> ▪ Guide programme implementation and directions ▪ Address policy and programme barriers ▪ Resource mobilisation for the HIV programme
Inter-Agency Coordination Committee	<ul style="list-style-type: none"> ▪ Create multi-stakeholder’s open forum to deliberate on key programmatic issues ▪ Create a major space for consensus building around major programmatic and policy decisions
HIV response in the Health Sector Coordination Group	<ul style="list-style-type: none"> ▪ Coordinate health sector led response ▪ Promote efficiencies in the delivery of health sector HIV and comorbidities response
HIV Response in Education Sector Coordination Group	<ul style="list-style-type: none"> ▪ Coordinate HIV related interventions implemented in education institutions ▪ Promote synergies among multiple partners ▪ Enhance scale, quality and standards of the education-based HIV response ▪ Promote use of innovation and technology
HIV Response in Workplaces Coordination Group	<ul style="list-style-type: none"> ▪ Promote coordination of state and non-state partners engaged in HIV response at workplaces ▪ Promote coherence and quality of workplace ▪ Promote use of innovation and technology
Community led HIV Response Coordination Group	<ul style="list-style-type: none"> ▪ Enhance coordination of community-based partners in the HIV response ▪ Promote reporting among community-based HIV programme implementing partners.
HIV Response in Digital platforms Coordination Group	<ul style="list-style-type: none"> ▪ Promote use of innovation and technology
HIV investments and resource mobilisation working Group	<ul style="list-style-type: none"> ▪ Enhance gap analysis, forecasting, costing, domestic and external resource mobilisation, resource tracking and reporting.
Strategic information, Research and Innovation Technical workings Groups	<ul style="list-style-type: none"> ▪ Promote use of programme data to bridge gaps. Ensure timely translation of research into programmatic actions.
Multi-sector Sub-populations and priority interventions Coordination groups	<ul style="list-style-type: none"> ▪ Prioritise key populations, PLHIV, adolescent and young people, people living with disability, elimination of mother to child transmission of HIV and Syphilis.

Table 21: Key Interventions Leadership, Accountability, Coordination and Communication

Strategic Focus Areas	Recommended Interventions
Promote transformational leadership among political and technical leaders for the national and county HIV and AIDS responses	<ul style="list-style-type: none"> ▪ Ensure HIV leadership gives communities a seat at the decision-making table ▪ Promote citizen participation in review and develop sectoral policies and programmes on HIV and AIDS ▪ Align HIV programmes to respond to the national and international frameworks and development
Enhance the use of data-led and results-based coordination mechanisms for the multi-sectoral HIV and AIDS response	<ul style="list-style-type: none"> ▪ Develop, review and implement policies and legislation on HIV and AIDS to enhance multi-sectoral coordination based on data evidence ▪ Conduct annual joint planning and review forums between State and non-State actors at the national and county levels to review progress achieved in implementation of KASF II, CASPs and sectoral plans
Ensure social accountability of the HIV programme promoted at all levels	<ul style="list-style-type: none"> ▪ Strengthen accountability forums for results and resources at both national and county levels ▪ Establish reporting and monitoring frameworks for all sectors and levels. e.g. Dash Boards, HIPORS, MAISHA certification reporting systems
Sustain communication and advocacy	<ul style="list-style-type: none"> ▪ Develop and implement a national communications and advocacy strategy targeting all sectors (public and private), stakeholders and partners. ▪ Promote high impact communications interventions ▪ Establish community led communication and advocacy networks.

Kenya AIDS Strategic Framework II Guiding Documents

1. KASF Mid-Term Review Report
2. Kenya HIV Research Agenda 2014/15-2018/19
3. Monitoring and Evaluation Framework 2014/15-2018/19
4. HIV and STI Surveillance Strategy 2020-2024
5. HIV Drug Resistance Testing Strategy 2020-2024
6. Kenya HIV Prevention Revolution Roadmap
7. Kenya HIV Testing Guidelines 2015
8. Policy for the Prevention of HIV infections among Key Populations in Kenya 2016
9. Kenya's Fast Track Plan to End HIV and AIDS among Adolescents and Young People
10. Framework for Implementation of Pre-Exposure Prophylaxis of HIV in Kenya 2017
11. Kenya Framework for Elimination of Mother to Child Transmission of HIV and Syphilis 2016-2021
12. National Voluntary Medical Male Circumcision Strategy 2014/15-2018/19
13. Operational Manual for the Delivery of HIV Self-testing Services in Kenya 2017
14. Kenya National Aids Spending Assessment Report 2012/2013-2015/2016
15. HIV Financing County Profiles 2018
16. Ministry of Health Programmes Gap Analysis Report 2019
17. NACC Guidelines for Health and HIV Impact Assessment in Infrastructure Development Projects 2018
18. Kenya Roads Board Allocation 2019
19. Kenya AIDS Strategic Framework II 2020/2021-2024/2025 Communication Strategy
20. Kenya Population-based HIV Impact Assessment (KENPHIA) 2020

List of Contributors

1. Dr. Nduku Kilonzo Ministry of Health
2. John Kamigwi Head Policy, Monitoring and Research, NACC
3. Prof. Elizabeth Bukusi KEMRI
4. Dr. Samson Ndege AMPATH
5. Dr. Nelly Mugo KEMRI
6. Dr. Irene Mukui Ministry of Health
7. Prof. Silvester Kimaiyo AMPATH
8. Dr. Jonah Magare NASCOP
9. Japheth Gituku NASCOP
10. Ambrose Juma NASCOP
11. Dr. Barbara Mambo NASCOP
12. Dr. Maureen Kimani Ministry of Health
13. Dr. Bob Agwata NASCOP
14. Dr. Carol Asin NASCOP
15. Dr. Evans Imbuki NASCOP
16. Dr. Evelyne Muthoni NASCOP
17. Roseline Warutere NASCOP
18. Ruth Kamau NASCOP
19. Faith Ngari NASCOP
20. Franklin Songok NASCOP
21. Rose Ayugi NASCOP
22. Betty Chepkwony NASCOP
23. Dr. Newton Omale NASCOP
24. Ruth Musyoki NASCOP
25. Janet Muema NASCOP
26. Esther Papa NASCOP
27. Eunice Ambani NASCOP
28. Ethel Makila IAVI
29. Michael Onyango MMAK
30. Philip Nyakwana MMAK
31. Sheilla Masasabi UNDP
32. Joshua Nzeka KEFRI
33. William Sila INERELLA Kenya
34. Grace Kariuki INERELLA Kenya
35. Joseph Mwangi KEMRI
36. Dorothy Omollo University of Nairobi
37. Samantha Ariri WOFAK
38. Maq C Eric Gitau Development Dynamics
39. Gabriel Mutuku YAP
40. Irene Kuria KP Consortium
41. Jack Ndegwa KANCO
42. Dr Jessie Kwatampora AHF Kenya
43. Maurine Murenga Lean On Me
44. Onesmus Musau LVCT Health
45. Judy Ouma Technical University of Kenya
46. John Kimani KENPUD
47. Brenda Asiko US Embassy

48. Maxwell Marx PEPFAR/USG
49. Medhin Tsehaiu UNAIDS, Kenya Country Director
50. Dr. R. Muthama COG
51. Brigid Walioba COG
52. Tracie Muraya EPN
53. James Kamau KETAM
54. Dr. Musa Nyandusi DOSHS
55. Sophia Njuguna KRCS
56. Salome Ochola NACC
57. Christine Njogu NACC
58. Dr Stephen Mutuku NACC
59. Rebecca Nyambeki NACC
60. Caroline Kinoti NACC
61. Mercy Khasiani, NACC
62. Irene Gomba, NACC
63. Dr. Lazarus Momanyi, NASCOP
64. Gloria Bille, UNAIDS
65. Henry Damisoni, UNAIDS
66. Dr. Moses Muriithi, UoN

NATIONAL AIDS CONTROL COUNCIL

Landmark Plaza, 9th Floor, Argwings Kodhek Road | P.O. Box 61307 - 00200 Nairobi, Kenya
Tel: 254 (020) 2896000, 2711261 Fax: 254 (020) 2711231, 2711072 | E-mail: communication@nacc.or.ke

maisha!

National AIDS Control Council

www.nacc.or.ke