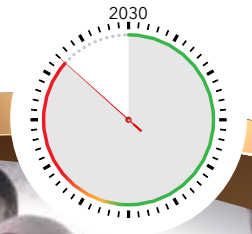




NATIONAL SYNDEMIC DISEASES
CONTROL COUNCIL

WORLD AIDS DAY REPORT 2022

IT IS A RACE AGAINST TIME



The journey to end AIDS as a public health threat by 2030 is getting tighter. In the last decade, Kenya brought treatment to scale, new infections and AIDS-related deaths have declined, but the progress is not enough. We must redouble our efforts.



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Most of the AIDS-related deaths in 2021 occurred among men, who are less likely than women to be diagnosed, start and stay on treatment and reach an undetectable viral load. We call on communities to support men's access to testing and retention to care.

Nelson Otwoma

National Coordinator, Network of People Living with HIV in Kenya-NEPHAK



We join the global community to commemorate the World AIDS Day on 1st December 2022 with satisfaction over the progress made in combating the HIV epidemic. On this day, we celebrate our heroes - the people living with HIV, health care providers, scientists, donors and policymakers who have dedicated all their efforts to address the HIV epidemic. We observe the day in memory of the more than 2 million lives lost to AIDS-related deaths since the first case was officially documented in 1984.

Kenya remains committed to ending AIDS as a

Ending the epidemics of HIV, Tuberculosis and Malaria is a key priority under Sustainable Development Goal three, which aims to ensure healthy lives and promote well-being for all.

We are presented with a unique opportunity to catalyse the end of these syndemics whose **synergistic** interaction results in excess disease burden. *We shall align the political goodwill of Kenya Kwanza Government, resources, science and technical capacities to implement high-impact interventions to realize this vision.*

Susan N. Wafula, Cabinet Secretary, Health

public health threat by 2030. We are focused on advancing a response that is people, rights and science centred. The *World AIDS Report 2022* outlines key achievements in the HIV response. In line with the Kenya AIDS Strategic Framework II 2020/21 to 2024/25, the report also examines the gaps while outlining key recommendations to accelerate progress in the HIV response.

We highlight and celebrate the milestone reached in HIV treatment. In one decade we doubled the number of people living with HIV. The hallmark of success for HIV treatment is a suppressed viral



We highlight and celebrate the HIV programme for reaching more than 1.1 million people with Antiretroviral Therapy (ARTs) and 73% achieving viral suppression by the end of 2021.

load for an individual and others living with HIV in the same community. We highlight and celebrate the HIV programme for reaching more than 1.1 million people with Antiretroviral Therapy (ART) and 73% achieving viral suppression by the end of 2021. Treatment success depends on the correct use of ARVs supplied through a coordinated supply chain system. The World AIDS Report 2022 report highlights the key strengths and gaps that require our attention in commodity security.

In 2021, the estimated number of new HIV

infections increased by more than 2000 cases from 32,027 in 2020 to 34,540 in 2021. The report identifies key challenges including the clustering of new HIV infections among children, adolescents and younger people. We underscore the need to bridge the programmatic gaps and accelerate progress in our prevention efforts for these subpopulations. The interventions include addressing syndemic factors such as sexual and gender-based violence and adolescent pregnancies that significantly contribute to vulnerability to new HIV infections. We emphasize on the need for sustained momentum to re-invigorate primary HIV prevention. This is as a critical litmus test for successful universal health coverage and sustainable development goals.

What Now?

1 Invest in primary prevention strategies delivered through a model that is efficient for the diagnosis, treatment and control of epidemics.

2 Increase access to HIV diagnosis and treatment among sub-populations left behind including children and men

3 Prioritize programmatic gaps, select the right interventions for the disparate epidemic typologies across 47 counties.

4 Intergrate services and invest beyond health facility-based interventions to address the syndemic factors that reinforce the HIV epidemic.

5 Promote technological innovations in diagnosis, treatment and accountability for efficiency gains.

6 Close the gaps in delivering essential HIV commodity security through a predictable and strong supply chain system.



We have demonstrated resilience in our strive to swiftly protect the gains made in responding to other syndemics in the context of the COVID-19 pandemic. We thank our stakeholders who galvanised their efforts to keep us on track.

Mr. Geoffrey Mbirua Gitu,
Board Chairperson, NSDCC

The National Syndemic Diseases Control Council appreciates all its stakeholders who have significantly contributed to the progress made in the HIV response. We have jointly achieved and sustained a positive trajectory whose gains we must safeguard.

For the last two years, the global health community faced an unprecedented challenge of the COVID-19 pandemic. Lessons learned in the many years of responding to the HIV epidemic were instrumental in shaping the interventions for the new pandemic.

In the HIV sector, we moved fast to protect the gains made in the response over the years from the COVID-19 related disruptions. We have witnessed the resilience of our stakeholders, especially in people living with HIV and vulnerable communities. We commend the health providers who quickly developed policies and guidelines that appreciated the difficulties we faced due to movement restrictions.

In the *World AIDS Day Report 2022*, we applaud all stakeholders for their resilience in dealing with the syndemics of HIV, Tuberculosis and Malaria.

COVID 19 related disruptions, instability in global economies and other emerging challenges have resulted in increased vulnerability to HIV and a decline in resources available for the HIV response.

The World AIDS Day, reminds us of the need to recommit to ending AIDS as public threat

by 2030. We must do everything in our power to secure the gains made. We now have the science and tools that we can utilise to accelerate progress.

It is indeed a race against time to end AIDS.

Letter of Appreciation



Dr Ruth Laibon-Masha (PhD)

Chief Executive Director, National Syndemic
Diseases Control Council

The successful development of the *World AIDS Report 2022* would not have been possible without the incredible efforts of a multi-sectoral team of stakeholders. On behalf of the National Syndemics Diseases Control Council, I appreciate all our partners in the HIV response who significantly contributed to the results outlined in this report.

We acknowledge the work of the multi-sectoral coordination committee members responsible

for managing strategic information for their efforts to collate data that was utilised to compile this report.

We recognise the significant contributions of other government agencies including the National AIDS and STI Control Programme, the National Council for Population and Development, and the County Governments who have contributed to the development of the report. The results outlined in this report

demonstrate the leadership of the County Government in the implementation of the Kenya AIDS Strategic Framework II 2020/21-2024/25.

The role of the National Empowerment Network of People Living with HIV and AIDS in Kenya for shaping the HIV response in Kenya is appreciated. Indeed in the race against time is a tribute to many lives lost along the way.

Special thanks to Clinton Health Access Initiative, the Bill and Melinda Gates Foundation through the University of Manitoba, Elizabeth Glaser Pediatric AIDS Foundation for their technical and financial support in drafting this report.

We recognise the efforts of staff from the National Syndemics Diseases Control Council led by Joshua Gitonga, who steered the processes of developing the report.

Executive Summary

The Kenya World AIDS Day Report 2022 outlines key achievements in the HIV response as guided by the targets set in the Kenya AIDS Strategic Framework II (KASF II 2020/21 -2024/25) and other regional and global commitments. In ten (10) years, Kenya has doubled the number of people diagnosed with HIV and on life saving antiretroviral treatment from 490,437 in 2012 to 1,122,334 million people at the end of 2021, with 73.3 % of those on treatment attaining viral suppression.

Despite these and other successes in the HIV program, the estimated number of new HIV infections increased by more than 2000 cases from 32,027 in 2020 to 34,540 in 2021. This report identifies key challenges contributing to this reversal in progress, including the clustering of new HIV infections among children, adolescents and younger people, and the impact of commodity insecurity. Further, this

report highlights the urgent need to address inequalities that reinforce injustice and promote negative health outcomes. The report also underscores the need to bridge all gaps that hinder progress for the most vulnerable subpopulations, particularly girls, young women, and children while addressing syndemic factors such as sexual and gender-based violence and adolescent pregnancies that reinforce their vulnerability and risk of HIV.

The Country continues to explore avenues for health services integration, to achieve universal health coverage. The need for increasing domestic resources to bridge the gaps in the procurement of essential HIV commodities is emphasized. The report underscores the urgent need for country ownership towards implementing high-impact interventions to end HIV as a public health threat.



TOHARA BILA MALIPO

VOLUNTARY MEDICAL MALE CIRCUMCISION

vmmc

kutahiriwa ni Kujijali

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HIV testing during community outreach at Loyangalani, Marsabit County



New HIV infections continue to outpace those newly placed on treatment

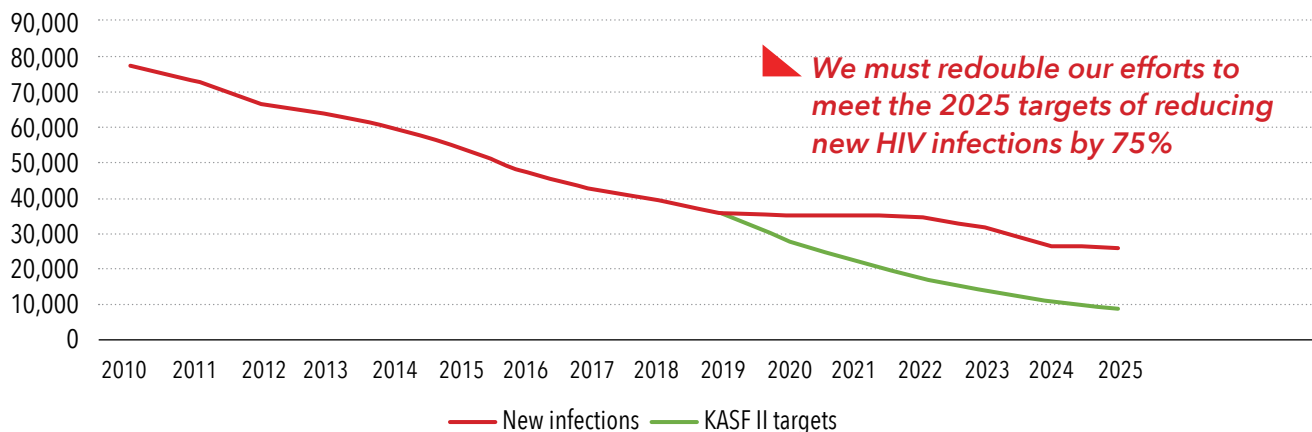
The Kenya AIDS Strategic Framework II (2020/2021 -2024/2025) outlines the need to reduce new HIV infections by 75% (less than 8,838) by 2025 towards ending AIDS as a public health threat by 2030.

For the first time in more than a decade, the number of new HIV infections increased in 2021 by 7.3%, from 32,025 in 2020 to 34,540 in 2021. Ten (10) counties, Nairobi, Kisumu, Homabay, Siaya, Migori, Nakuru, Mombasa Kakamega, Kisii and Uasin Gishu accounted for 57% of all new HIV infections that occurred in 2021.

Laikipia County led the country with a 25% reduction of new HIV infections between 2020 and 2021. Other counties including Nairobi, Uasin Gishu, Nakuru, Nyeri, Kilifi, Bomet, Kericho, Kiambu, Makueni and Elgeyo-Marakwet, made progress in the reduction of new HIV infections.

During the same period, there was an increase in new HIV cases by more than 30% in other low-burden counties of Samburu, Isiolo, Wajir, Marsabit, Turkana, Lamu and Tana River with the highest increase occurring in Samburu County.

Trends in the reduction of new HIV infections against Kenya AIDS Strategic framework II targets



There was one new infection (34,540) for every three people (109,557) newly put on ART programme in 2021, which undermined the efforts to end the epidemic



Women and girls continue to bear the brunt of the epidemic. In 2021, an estimated 70% (20,505) of all new HIV infections occurred among women and girls. Women and girls tended to become infected at a much earlier age than men and boys of the same age with 8 out of every 10 new HIV infections occurring among adolescent girls and young women aged 15-24.

Among adult men and boys, those aged 20-39 contributed to 76% (6,700) of the 8,874 new HIV infections that occurred among those aged 15 and above.

The size of key populations groups is estimated at 61,650 men who have sex with men, 197,016 female sex workers, 26,673 people who inject and use drugs, and 4,370 transgender people. Key populations have higher HIV prevalence compared to the general population. They experience stigma, discrimination, criminalisation and violence, which further increase their risk and vulnerability to HIV and Sexually transmitted infections. About 9-11% of those who were found in HIV hot spots are below the age of 18.



Total new HIV infections

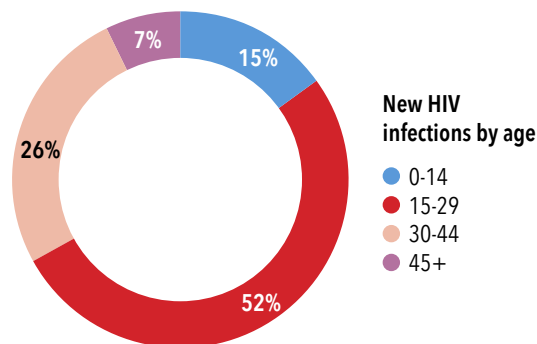


34,540

66.7%
23,051

33.3%
11,489

An estimated 52% of all new infections occurred among adolescents and young adults aged 15-29



Source: Kenya HIV Estimates 2022; NSDCC



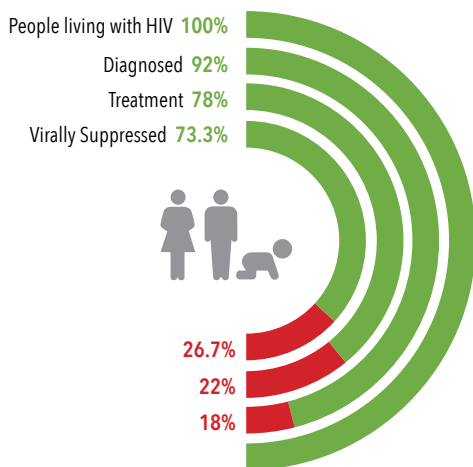
Access to HIV Treatment

Kenya has committed to diagnose, treat and achieve viral suppression for at least 95% of the 1,437,267 people living with HIV by 2025. Women and girls comprise 65% of the people living with HIV.

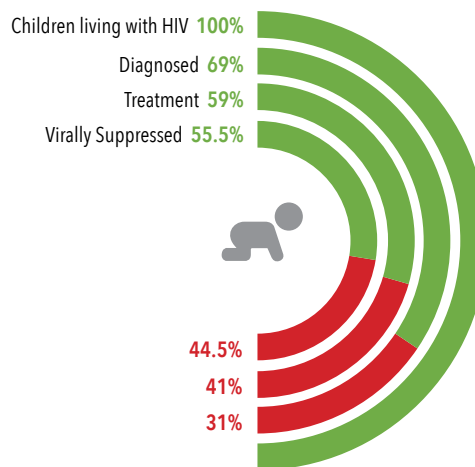
In 2004, Kenya established the HIV prevention and treatment programme underpinned by the principles of universal health coverage. The programme provides free to-use antiretroviral therapy (ARV) medicines for opportunistic

infections, nutrition products, laboratory supplies for HIV testing and monitoring, condoms for the prevention of HIV and Sexually Transmitted Infections (STIs), and unplanned pregnancies, and medically assisted therapy for people who inject drugs. By the end of 2021, Kenya had 1,122,334 million people living with HIV on treatment with 73.3% of them virally suppressed.

All ages 95-95-95 Cascade

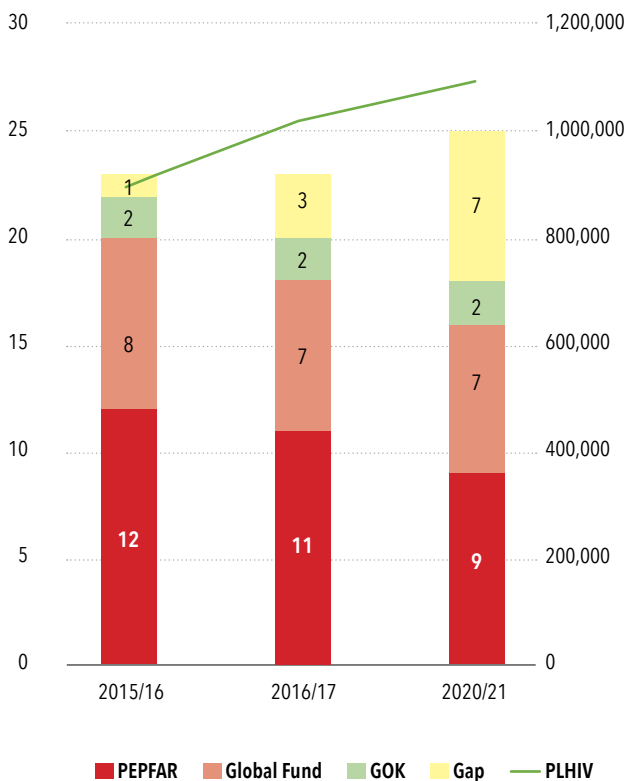


Children 95-95-95 Cascade



■ Achieved ■ Gap

Over the last five years, while the number of people living with HIV on treatment increased, there is disproportionate decrease of both external and domestic resources for procurement of commodities



The burden of the HIV epidemic is disproportionate across counties



58% (835,803) of people living with HIV are from 10 counties

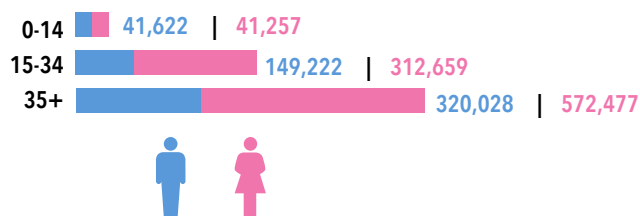
Nairobi	153,818	Nakuru	58,678
Kisumu	130,036	Mombasa	54,303
Homa Bay	122,954	Kakamega	50,991
Siaya	97,922	Kiambu	46,571
Migori	77,690	Kisii	42,842

Kenya has an overarching challenge where new HIV infections are dominant among younger adults below the age of 34, while the larger cohort of the people living with HIV are older adults, many of whom might have been infected at a younger age.

The country must invest in both primary and secondary prevention strategies through effective interventions to control the epidemic. Aging with HIV is associated with an increased risk of co-morbidities, which requires an integrated care model. Adults living with HIV are more likely to suffer (36%) forms of non-communicable diseases as compared to 28% of people without HIV diagnosis likely to suffer one or two NCDs of the same age group respectively. These NCDs include cancer, diabetes and high blood pressure.

In 2021, the majority 62.1% (892,508) of the estimated people living with HIV were young and older adults aged 35 and above

People Living with HIV by age and sex



Access and adherence to life saving HIV Treatment remains a priority

Access and adherence to available HIV treatment are inhibited by other factors including the perception of good health; denial of HIV diagnosis; poor family support following positive diagnosis; and anonymity and stigma concerns in HIV care services.

Most adults (85%) aged 35 and above living with HIV were on treatment by the end of 2021 as compared to 66% of those below the age of 34, including children. Gender dynamics are also observed among adolescents and adults aged 15 and above with 72% of men and boys living with HIV accessing treatment as compared to 80% of women and girls of the same age.

People Living with HIV on treatment



0-34 years

32%

35 years and above

68%





AIDS-related Deaths

Preventable deaths continue to occur

Kenya loses an estimated 65,000 people annually to HIV, Tuberculosis and Malaria related illnesses. The HIV epidemic has had far-reaching social, economic, health, and population effects. Since the first case was officially recorded in 1984, there have been more than 2 million AIDS-related deaths in the country. By 2011, an estimated one million children in Kenya had lost both parents to AIDS-related deaths. Chronic illness and death are the most common cause of households slide into poverty across the globe.

In 2021, the country lost an estimated 4,098 children and adolescents below 19 to AIDS-related deaths. These deaths were attributed to low diagnosis and treatment coverage for this sub-population. Among the estimated 82,879 children living with HIV aged 0-14, about 31% were not diagnosed, 41 % of those diagnosed were not on treatment while 45% of those on treatment had not achieved viral suppression.

AIDS-Related Deaths by Age and Sex

Age	Male	Female	Total
0-4	1,182	1,156	2,338
5-9	135	134	269
10-14	266	265	532
15-19	506	453	959
20-24	626	679	1,304
25-29	833	926	1,759
30-34	1,071	1,225	2,296
35-39	1,519	1,304	2,823
40-44	1,597	1,331	2,928
45-49	1,514	1,197	2,711
50-54	1,149	823	1,971
55-59	700	486	1,186
60-64	387	272	659
65-69	201	151	352
70-74	93	77	169
75-79	39	35	74
80+	21	22	43

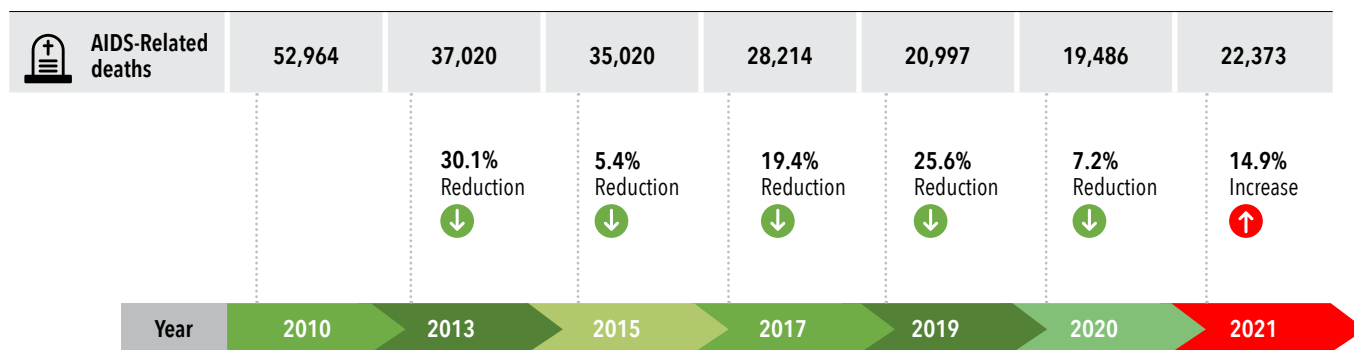
The lower treatment coverage for men and boys is evident by the number of AIDS-related deaths. In 2021, an estimated 8,270 men aged 30 and above died of AIDS-related deaths as compared to 6,902 women of the same age group

AIDS-Related deaths increased in 2021 for the first time in a decade

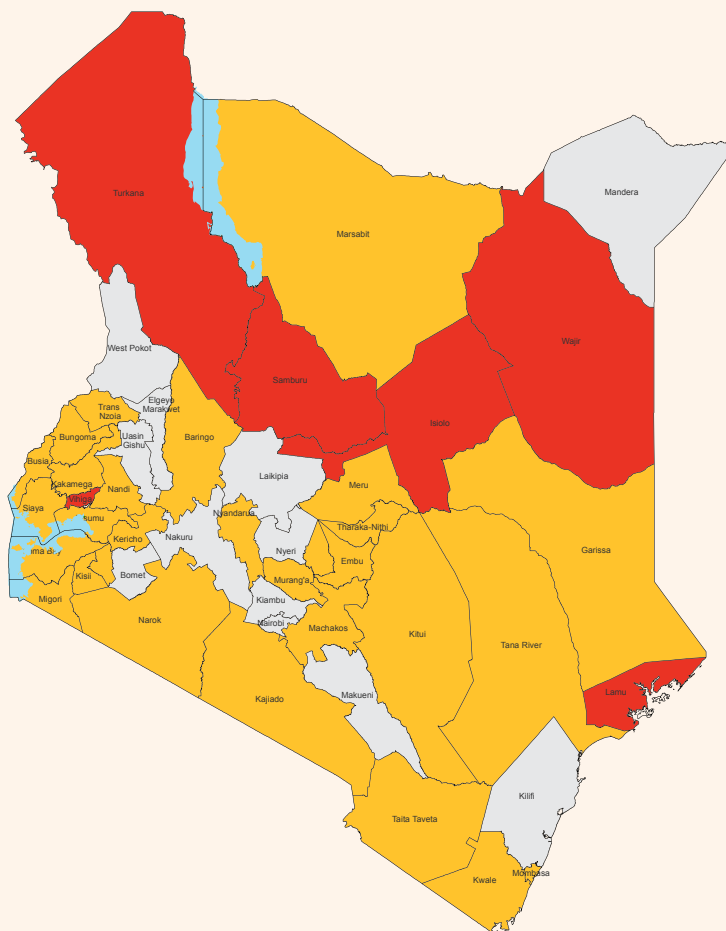
Kenya has made significant progress towards ending AIDS through a large-scale treatment programme. In the last decade, the estimated AIDS-related deaths reduced by 57.7%, from 52,964 in 2010 to 19,486 in 2020. However, the number of AIDS-related deaths increased by 15%, from about 19,486 in 2020 to 22,373 in 2021. Half of these deaths occurred in 10

counties - Nairobi, Kisumu, Homabay, Siaya, Migori, Nakuru, Mombasa, Kakamega, Kiambu and Kisii.

In six counties (Samburu, Isiolo, Turkana, Lamu, Wajir, and Vihiga) the estimated number of AIDS-related deaths increased by more than 50% in 2020 as compared to 2021. In Samburu County, the number of AIDS-related deaths increased 3-fold.



HIV-related deaths by county, 2021/2022



▲ **AIDS-related deaths increased across 35 counties. In six counties (Samburu, Isiolo, Turkana, Lamu, Wajir, and Vihiga) the estimated number of AIDS-related deaths increased by more than 50% in 2021 as compared to 2022. In Samburu County, the number of AIDS-related deaths increased nearly 3-fold**

We are off track on ending AIDS among children, adolescents and young people, at the 7th year of the 2030 Agenda for Sustainable Development Goal

Elimination of mother-to-child transmission of HIV is feasible

Kenya is committed to the triple elimination of mother-to-child transmission of HIV, hepatitis, and syphilis as a public health priority. The programme is focused on improving health

outcomes for both mothers and children through large-scale and high quality interventions that include: Prevention of mother-to-child transmission of HIV programmes, HIV testing during pregnancy, ensuring access to antiretroviral treatment, safe childbirth and breastfeeding, infant testing and treatment.

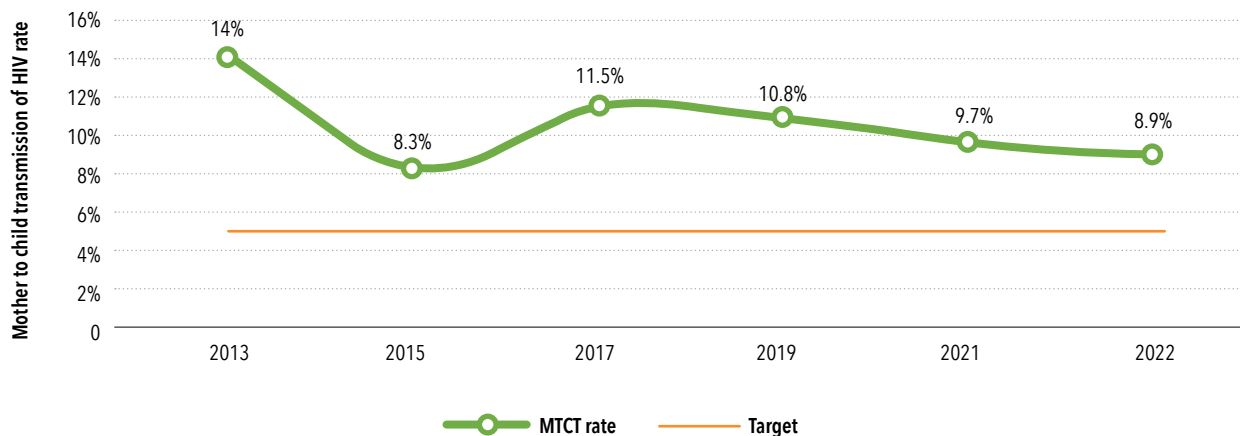


Coverage of prevention of HIV from mother to child services

Year	Number receiving	Coverage %
2009	67,061	76.82
2010	61,563	73.04
2011	58,127	71.2
2012	51,028	64.06
2013	50,101	64.65
2014	52,049	69.8
2015	59,214	86.64
2016	59,444	88.46
2017	53,236	80.89
2018	54,708	85.38
2019	52,494	84.89
2020	50,612	85.29
2021	52,578	90.89

The country had envisioned a fast track approach that would reduce mother-to-child transmission of HIV to less than 5% by 2021. While significant progress has been made, the targets remain elusive. Across the country, the gains in ending new HIV infections among children have plateaued. In 2021, none of the counties had

achieved less than 5% HIV transmission rates from mother to child, with a country average of 8.9%. Some counties, including Mandera, Wajir, Marsabit, West Pokot, Isiolo, Garissa and Samburu, have high HIV mother-to-child transmission rates of 20%.



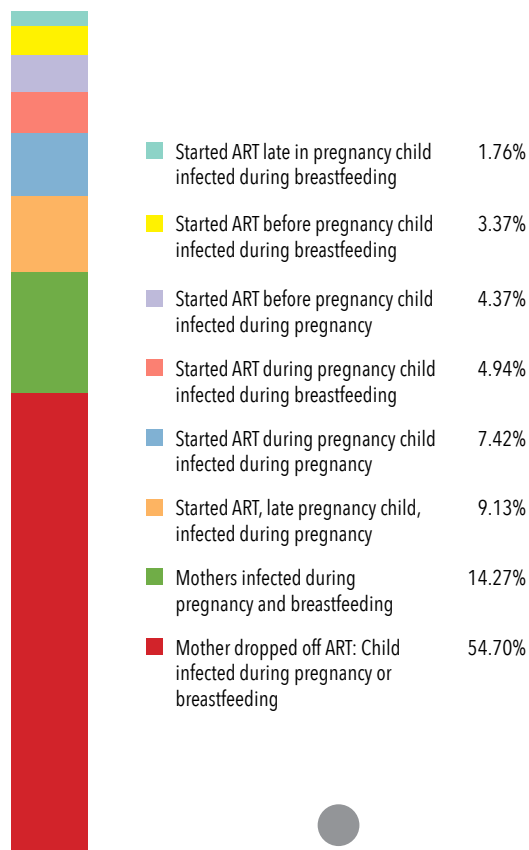
Despite the gains in HIV response, Kenya is yet to meet the target on elimination of mother to child transmission of HIV

Diagnose, treat and achieve viral suppression among all children, adolescents, and young people living with HIV

The use of antiretrovirals for pregnant women, their partners and infants effectively interrupts the transmission of HIV during pregnancy and the breastfeeding period. Most (54.7%) of the cases of mother-to-child transmission of HIV occur when an HIV-positive mother drops off ART during this period.

▶ **Most (54.7%) of the cases of mother-to-child transmission of HIV occur when an HIV-positive mother drops off ART**

Sources of Mother-to-Child Transmission of HIV

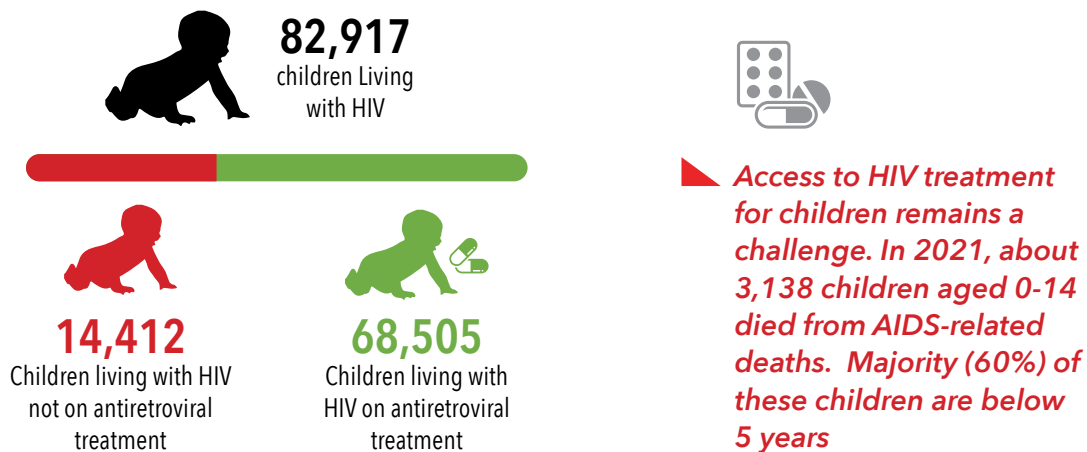


5,160
new HIV infections among children in 2021

In the last decade, Kenya has progressed in the ARV treatment coverage for children aged 0-14 living with HIV. In 2021, this progress faltered with the ART coverage for children dropping from 76.5% in 2020 to 59.0%. There is evidence to show that 3 out of every 10 children living with HIV who do not receive antiretroviral therapy for HIV die after one year of life. The mortality rate increases to 52.5% by the second year of life.

The viral load suppression in children under one year is also sub-optimal compromising their health, and well-being and may increase mortality.

Early HIV diagnosis and treatment for children significantly reduces morbidity and mortality rates. Kenya can leverage the Global Alliance to end AIDS among children and adolescents platform to end inequalities faced by children living with HIV by ensuring early identification with timely linkage to care, and strengthening social protection mechanisms while supporting guardians and caregivers.



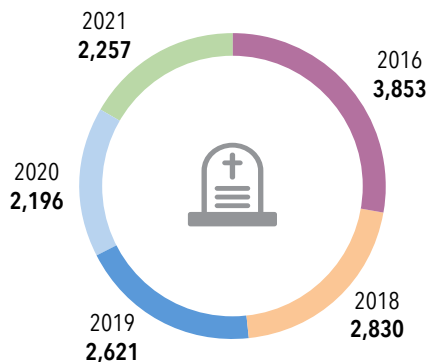
Treatment outcomes for adolescents and young people remain sub-optimal, with significant gaps in knowledge of HIV status and treatment uptake



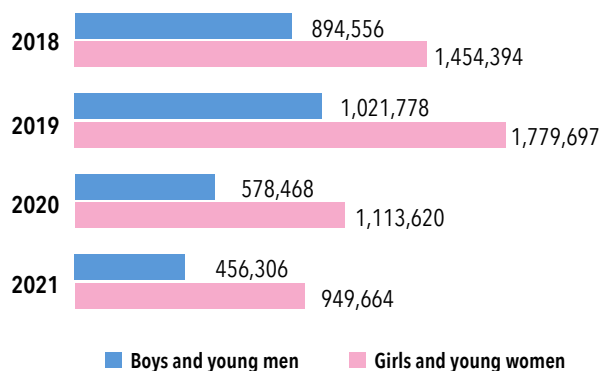
Kenya loses about 6 adolescents and young people aged 15-24 daily to AIDS-related illnesses

Source: National Syndemic Diseases Control Council 2022 HIV Estimates

AIDS-related deaths among adolescents and young people aged 15-24 years



Uptake of HIV diagnostic services among adolescents and young people 15-24

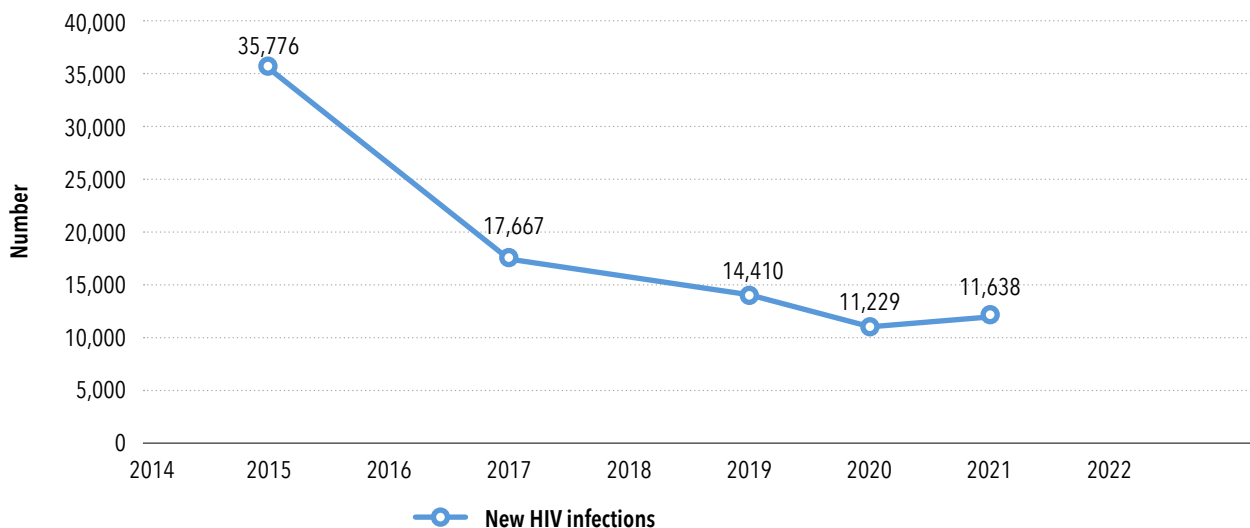


Source: Ministry of Health, Kenya Health Information System

Ending Sexual Transmission of HIV among children, adolescents and young people

Sexual and gender-based violence and adolescent pregnancies are predictors of vulnerability to HIV among children, adolescents, and young people. A national survey conducted among adolescents in 2019 showed that the average age of sexual debut in Kenya is 17¹. In 2021, the number of new HIV infections among those aged 15-24 increased by 7.7% as compared to the previous year.

New HIV infections among adolescents and young people aged 15-24



Source: HIV Estimate 2021, National Syndemic Diseases Control Council

¹ Violence against Children Survey, UNICEF 2019

Kenya has made significant investments to ensure adolescents and young people are educated, enjoy a healthy life and attain their aspirations. The overlapping challenge of new HIV infections, unintended pregnancies, and sexual and gender-based violence among children, adolescents and young women, dubbed the Triple Threat, undermines this investment's impact. Increasing new HIV infections among adolescents and young people makes it challenging to end AIDS as a public health threat in Kenya.

Adolescent pregnancies

- Adolescent mothers diagnosed with HIV must cope with the mistimed pregnancy and initiation onto lifetime treatment during antenatal care.
- Adolescent mothers are likely to be diagnosed with HIV and have poor ART adherence rates compared to adults, and are hence likely to transmit HIV to their babies during pregnancy and breastfeeding. They have poor outcomes of the mother-to-child transmission continuum of services.
- Girls who do not complete secondary school education have higher vulnerabilities to HIV and other sexually transmitted infections. An additional year of schooling decreases the probability of an adult woman testing positive for HIV by 6%².
- Adolescent pregnancies are associated with increased risks of HIV, premature birth, low birth weight, perinatal death, and disability, school dropout, child labor and early marriages. They perpetuate the vicious cycle of increasing social services burden, such as healthcare.
- Poverty is one of the key reasons that lead to transactional sex among women and girls³. Sex workers and their clients contribute about 14% of new HIV infections in the country.

Adolescent pregnancy infringes on young people's fundamental rights to complete education, leading to the loss of economic opportunities.

 ***In 2021, pregnancies among children aged 10-14 increased by 28.7% from 16,956 to 21,823.***

² Behrman, J. A. (2015). The effect of increased primary schooling on adult women's HIV status: Universal Primary Education as a natural experiment. *Social science & medicine*, 127, 108-115.)

³ HIV and AIDS situational analysis on sex workers and their clients in Kenya

Trends in adolescent pregnancies from 2016-2021

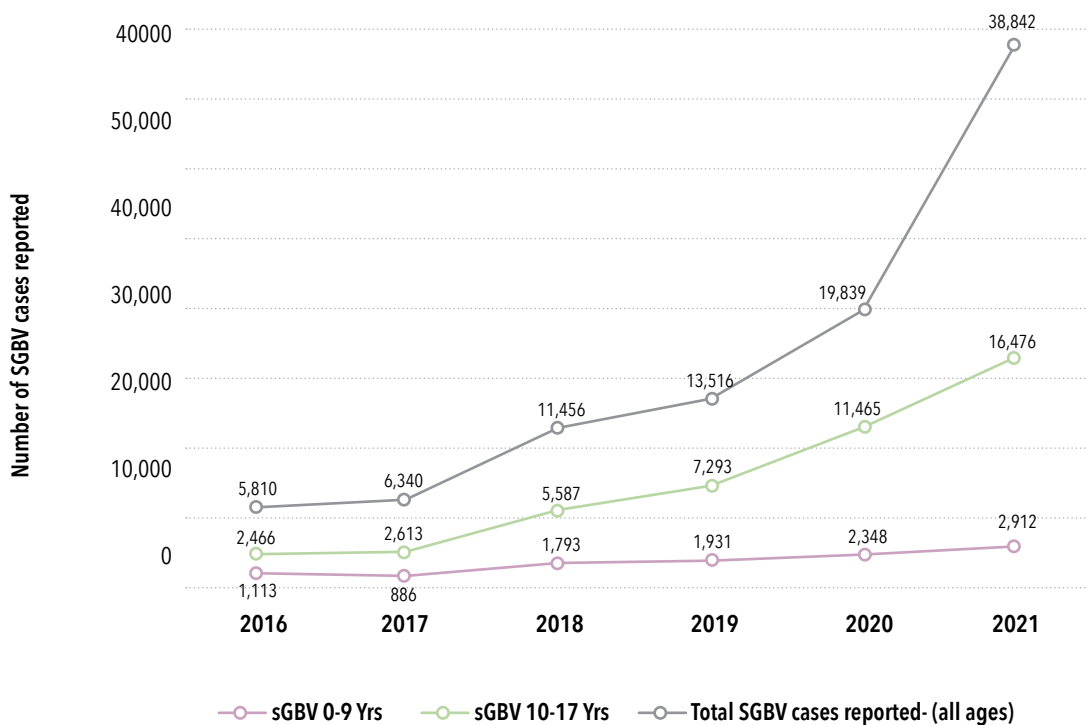
Year	10-14 years	15-19 years	Total adolescent pregnancies	Antenatal clinic clients	Proportion of adolescents attending antenatal clinic
2016	23,356	252,277	275,633	1,296,168	21%
2017	23,516	316,160	339,676	1,223,317	28%
2018	22,451	404,684	427,135	1,435,246	30%
2019	20,121	376,719	396,840	1,429,951	28%
2020	16,956	314,593	331,549	1,465,589	23%
2021	21,823	294,364	316,187	1,547,656	20%

Source: Ministry of Health Kenya Health Information System



We must provide all girls with menstrual and other hygiene commodities to reduce their vulnerabilities to sexual exploitation

Sexual violence, including rape, defilement and incest, infringes on a child's and human rights while narrowing opportunities for women and girls to meaningfully participate in socio-economic development. It can lead to HIV infection, sexually transmitted infections, mis-timed pregnancies and increased risk of chronic physical and mental ill health. A survey conducted in 2019 established that 46% of women and 52% of men aged 18-24 had faced at least one type of violence during their childhood in Kenya. Orphans and other vulnerable children face an increased risk of violence with delayed access to healthcare.⁴ The number of reported cases of sexual and gender-based violence against children and adolescents increased by more than three-fold between 2016 and 2021, with most of the perpetrators being relatives.

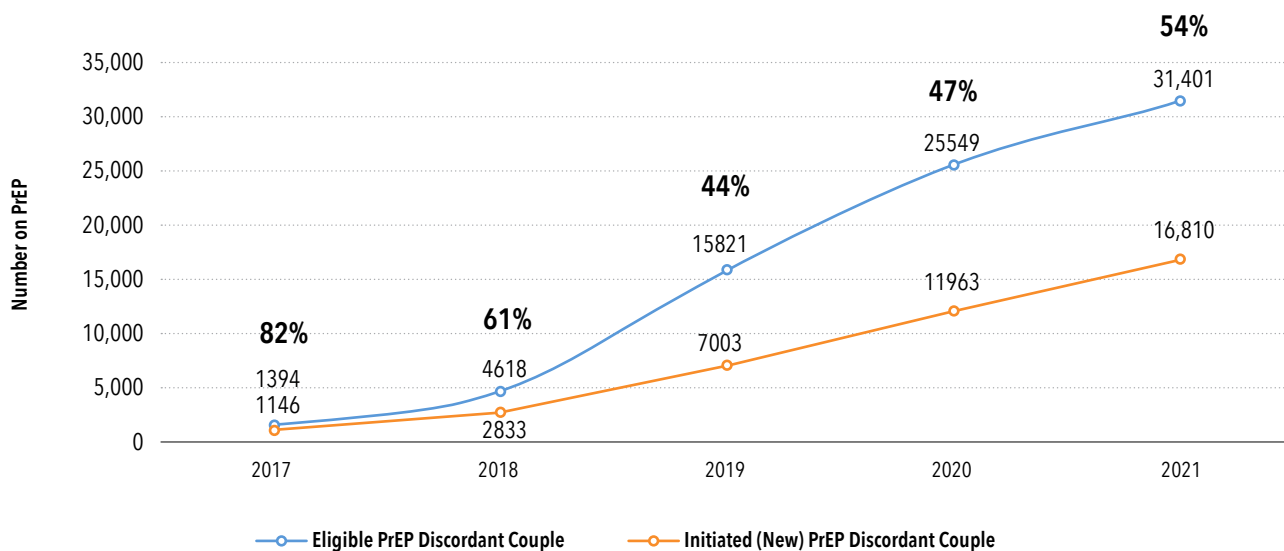


4 The Plight of Orphans in Kenya

Expanding access to HIV prevention choices

Kenya was among the first African countries to roll out a national programme to provides pre-exposure prophylaxis (PrEP) for preventing HIV acquisition in 2016. While the programme is successful, coverage among sub-populations such as discordant couples and young girls and women is still sub-optimal.

Uptake of pre-exposure prophylaxis among discordant couples



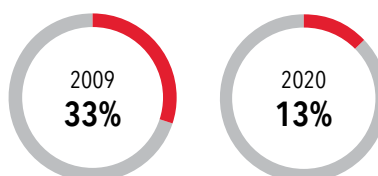
Source: Kenya Health Information System

Progress in reducing new HIV infections among key populations

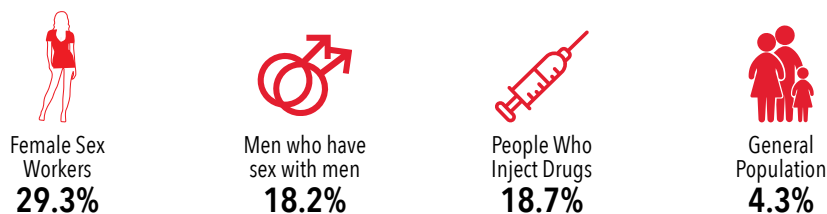
The estimated number of key populations, including female sex workers, men who have sex with men, people who inject drugs and transgender people has increased over time. These populations are at higher risk for HIV, irrespective of the epidemic type or local context. They face additional social and legal challenges that increase their vulnerability to HIV. HIV prevalence among these sub-populations is 4-times higher than that of general population. The HIV programme targeting key populations has yielded impressive results. The contribution of new HIV infections from key populations reduced from 33% in 2009 to 11% in 2020.

HIV AMONG KEY POPULATIONS

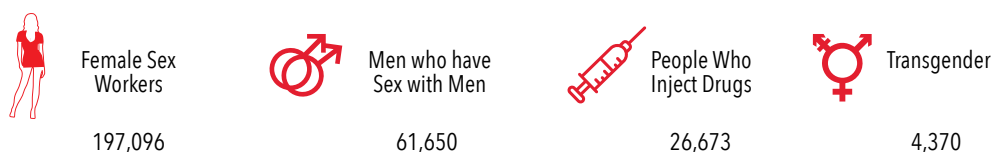
Contribution to New HIV Infections



HIV prevalence



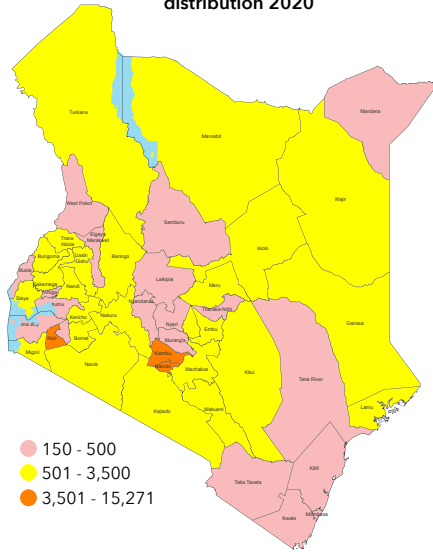
Population size estimates



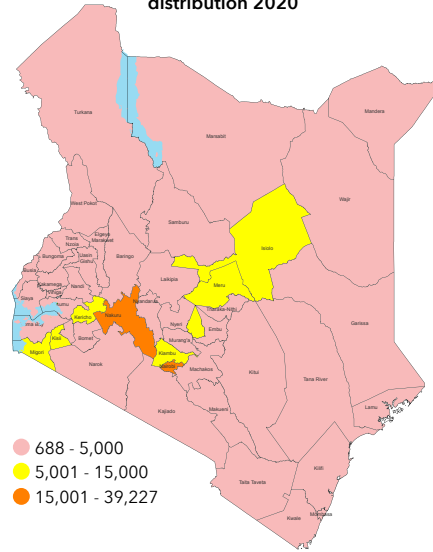
Sources: NASCOP IBBS 2011, NASCOP KP Size estimates, 2020, NASCOP KP Size estimates, 2012 (Source: KPSE II report, NASCOP 2020)

Distribution of Key populations across counties

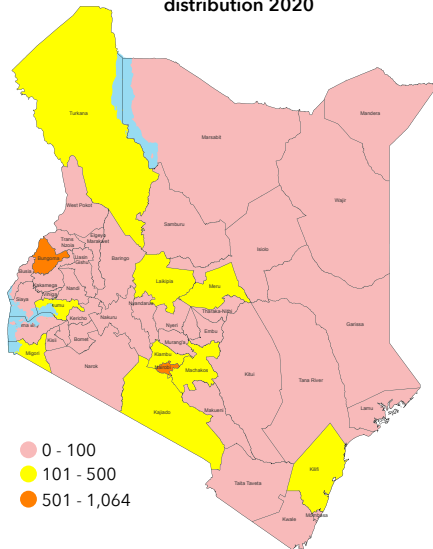
**Men who have sex with men
distribution 2020**



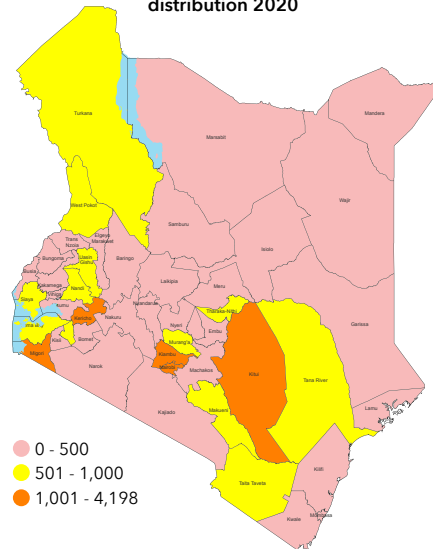
**Female sex workers
distribution 2020**



**Transgender
distribution 2020**



**People who inject drugs
distribution 2020**



Prevention of HIV among people with untreated substance use disorders

Kenya has intensified efforts to provide harm reduction services to people who inject drugs. The number of people who inject drugs on medically assisted therapy increased from 45 in 2015 to 8,557 in 2022. Harm reduction for people injecting drugs is one of the key interventions for reducing HIV transmission.



2015

People who inject drugs
enrolled on Medically
Assisted Therapy

45

2022

People who inject drugs
enrolled on Medically
Assisted Therapy

8,557



We are making progress in harm reduction, including reducing exposure to risk and HIV transmission among people who inject drugs. More than 20,000 people who inject drugs are reached with the needle and syringe program. Over 8,000 people who inject or use drugs are on opiate substitution therapy program as part of Medically Assisted Therapy (MAT) in Kenya, with 9 clinics established within public health facilities.

The burden of substance use disorders in sub-Saharan Africa is very high. In Kenya, there are an estimated 26,673 people who inject drugs. More than 10% of people aged between 15 and 65 also have an alcohol use disorder. The median age of onset of any substance use is 11 years and considerably lower than that (16–19 years) reported elsewhere in the world. One in five adolescents reported having used at least one substance in their lifetime with substance abuse linked to risky sexual behaviour, which is a significant driver of HIV and viral hepatitis transmission⁵.

Young people are also likely to show more high-risk behaviour, such as sharing needles and other drugs paraphernalia. In both adults and adolescents in Kenya, substance use has been linked to risky sexual behaviour, which is a significant driver of HIV and viral hepatitis transmission. The global rate of Hepatitis C (HCV) among people who inject drugs is 52%. People who inject drugs also have higher rates

of tuberculosis than the general population. HIV prevention programs should reach out to vulnerable youth to prevent them from starting to inject or help them to end their addiction if they have already started. Supporting people who inject drugs and are living with HIV to adhere to their treatment is essential to ensure success. There should be enhanced legal and policy environment to address substance use disorder through public education, establishing preventive programs, community-based services, and incorporating psycho-social rehabilitation into SUD treatment.



⁵ National Authority for The National Authority for the Campaign Against Alcohol and Drug Abuse 2019 Report

I have lived with HIV for the last 37 years. Aging with HIV also presents a higher risk of other non-communicable diseases, including cancers, diabetes and hypertension. Along the way, I have lost many friends, including Joe Muriuki who was a social pillar in combating HIV stigma. Last year, I battled COVID-19 to the verge of death at the intensive care unit. I was privileged to access quality health services to celebrate another birthday. We must strengthen an integrated health systems model that is responsive to both the prevention and management of diseases

Reverend Anisia Karanja



Aging and HIV

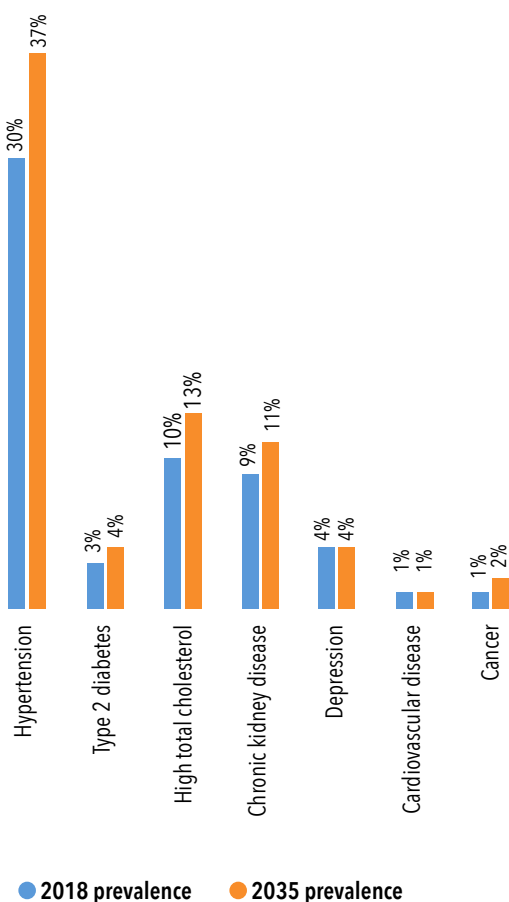
Older people are less likely than younger people to get tested for HIV. Older adults might be coping with other diseases associated with aging, which can mask the signs of HIV. Access to high-quality health facilities and services could also lead to late HIV diagnosis, allowing the virus to progress to AIDS.

Kenya has a growing number of older people living with HIV due to improved access to treatment. **An estimated 883,694 of the 1.4 million people living with HIV aged between 35 and 74 years** many of whom were diagnosed with HIV in their younger years. Between 2010 and 2021, about 622,724 deaths have been averted, attributed to ART uptake. With the survival trends, more aged people will live with HIV over time. This means that there is a need to place more emphasis on the provision of services to protect the elderly from age-related conditions that may worsen the quality of life.

Aging with HIV has several challenges, including the onset of other chronic illnesses that increase morbidity and mortality rates. People living with HIV are at a heightened risk of acquiring non-communicable diseases due to increased inflammatory markers and associated adverse effects of antiretroviral medicines for HIV treatment. The cohort of aging people living with HIV is likely to significantly contribute to NCDs'

burden in the absence of interventions. The cost of managing NCDs is also projected to increase by 58% from Ksh 230 billion in 2016 (3.4% of GDP) to Ksh 607 billion by 2030.

Projection of the proportion of people living with HIV with one or two non-communicable diseases



Other Sexually Transmitted Infections

Kenya relies on the syndromic management of other sexually transmitted infections. Laboratory-based testing requires expensive resources, facilities, and trained personnel and can also result in loss-to-follow-up, given the delay in reporting results. The most commonly reported sexually transmitted infections of public health significance include chlamydia, gonorrhoea, mixed fungal infections and syphilis. There is an unabated trend on the reported cases of sexually transmitted diseases for the last four years. The number of pregnant mothers diagnosed with syphilis increased by 35% from 10,000 in 2018 to 14,873 in 2021.

Sexually Transmitted Infections

2018		310,572
2019		331,187
2020		324,626
2021		316,824

Source: Kenya Health Information System

Syphilis is one of the most common sexually transmitted infections globally, with approximately 6 million new cases occurring annually. Kenya has intensified efforts to eliminate mother-to-child transmission of syphilis.

Mother-to-child transmission of syphilis, or congenital syphilis, is usually devastating to the

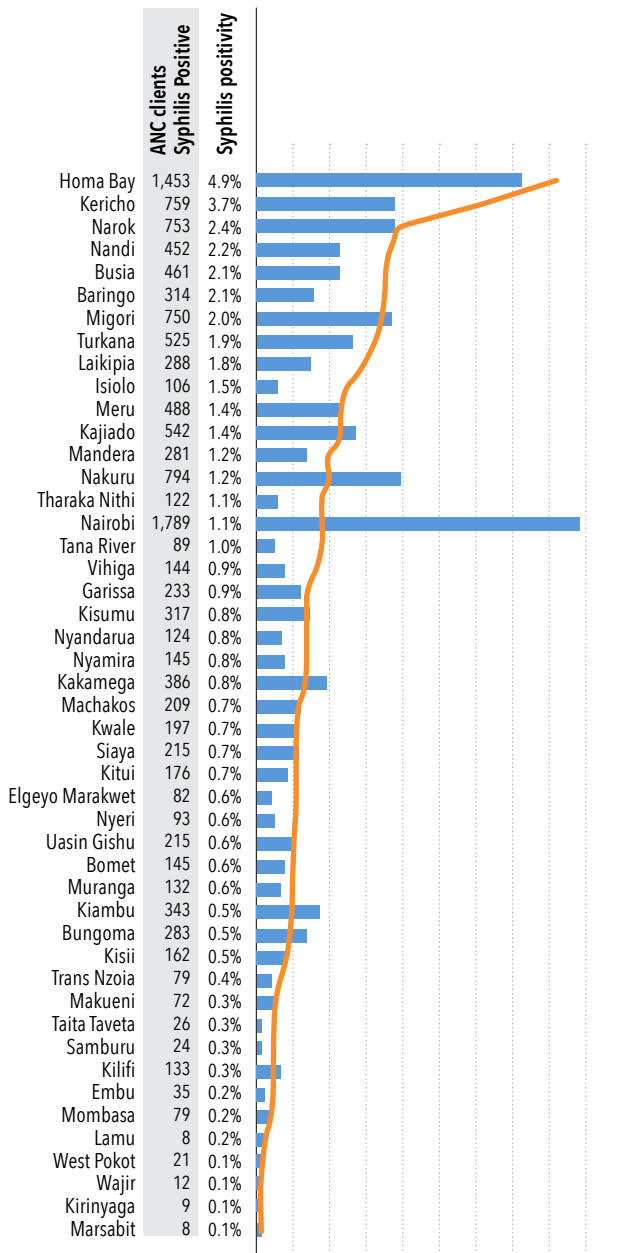
fetus if the maternal infection is not detected and treated sufficiently early in the pregnancy. Most untreated primary and secondary syphilis infections in pregnancy result in severe adverse pregnancy outcomes. In early maternal syphilis, the risk of mother-to-child transmission of syphilis can be **up to 80%**. **Early diagnosis and adequate treatment of the mother**, ideally before the second trimester, can quickly cure the fetus and minimize adverse outcomes.

The number of women and infants affected by syphilis remains unacceptably high. In five counties, Homabay, Kericho, Narok, Nandi, Busia, Baringo and Migori, the positivity rates among women attending the antenatal clinic are higher than 2%.



► ***It is crucial that all women are provided with early syphilis screening and treatment as part of high-quality antenatal care, to enable a positive pregnancy experience. In addition, all women diagnosed with syphilis and their infants require treatment. Sexual partners of ANC clients need to be reached for testing and treatment too***

Syphilis positivity rate among mothers attending antenatal clinic by county



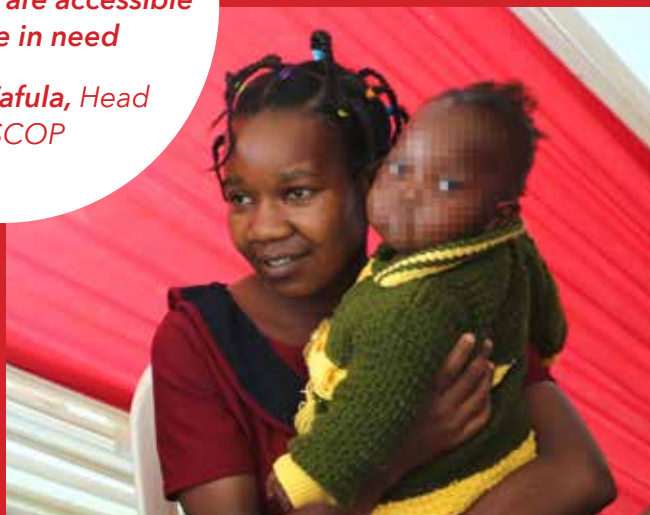
Homa Bay, Kericho, Narok, Nandi, Busia, Baringo and Migori have Syphilis positivity of 2% and above among pregnant mothers attending the antenatal clinic

What now?



We need to scale up effective interventions for prevention and treatment that are accessible for people in need

*Dr. Rose Wafula, Head
NASCOP*



1. Invest in primary prevention strategies delivered through a model that is efficient for the diagnosis, treatment and control of epidemics

Children adolescents and young people aged 10- 24 years account for 34% of the population but new HIV infections among those aged 15-24 accounted for 42.2% of the 29,380 new adult infections in 2022. This sub-population is projected to increase to **20,168,446** by 2030 (KNBS 2019), requiring additional investments to prevent new HIV infections and avert deaths.

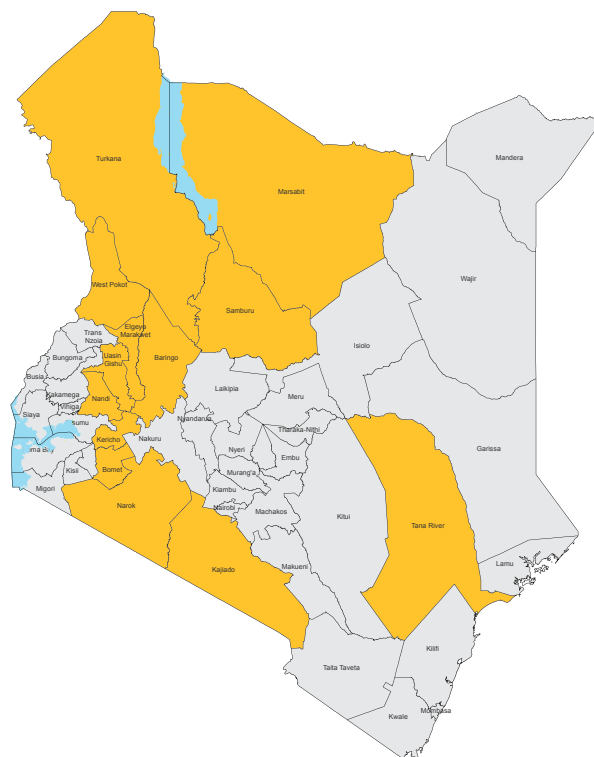
Investing more in HIV prevention among children, adolescents and young people is critical to preventing new HIV infections and ending AIDS-related deaths. The projected cost saving of averting HIV infections from birth to current life expectancy (67 years) is about **KES 17,642,047.74**.

2. Prioritize programmatic gaps, select the right interventions for the disparate epidemic typologies across 47 counties.

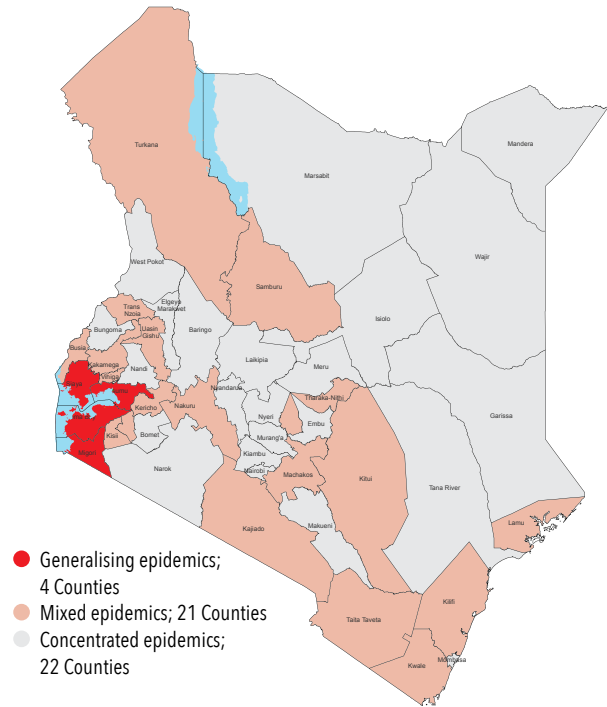
In line with KASF II, the Incidence to Prevalence Ratio (IPR) is a critical indicator to measure progress. **IPR refers to the number of new infections occurring per year in a population divided by the number of persons living**

with HIV in that same population. Globally, a benchmark value of 0.3 and below is indicative of optimal trajectories. The 2021 data shows that 34 counties were on the right path with Muranga County leading the efforts to control new HIV infections, indicating effective prevention efforts. It is feasible for Kenya to achieve a 75% reduction in new HIV infections by 2025 if all counties reduce their IPR by 20%.

HIV Incidence Prevalence Ratio per county



The Kenya HIV epidemic is disparate by population and geography, with the HIV prevalence ranging from as high as 15.8% in Homabay to as low as 0.2% in Garissa and Wajir counties. An epidemic appraisal for Kenya defined the epidemic typologies as Concentrated, Generalising, and Mixed. The classification reflects the specific behaviours present for each infection to lead, on average, to more than one new infection. The epidemic in 22 counties was classified as Concentrated, Mixed epidemic in 21 counties and Generalized in 4 Counties.



Epidemic Typologies: Definitions

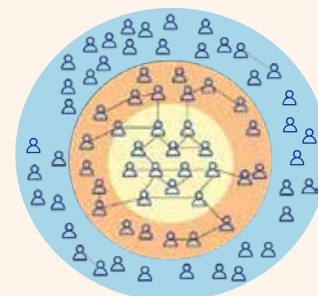
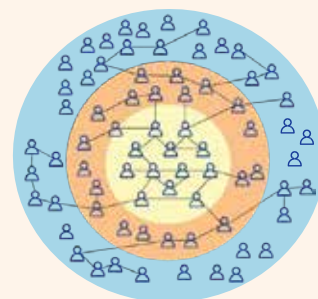
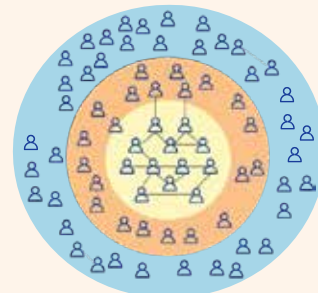
Concentrated epidemics are those where ongoing transmission is within subpopulations at higher risk due to sexual practices or needle-sharing networks. In all concentrated epidemics, the appropriate intervention is to scale up effective and focused HIV prevention programmes to reduce transmission in the high-risk networks. In addition, the intervention should maintain high coverage of pregnant women for HIV testing and HAART for those living with HIV.

Generalising epidemics is where HIV transmission is mainly sustained by high-risk sexual behaviour in the general population, without any substantial contribution by the defined subpopulation at risk. In all generalising epidemics, appropriate intervention should focus on changing sexual behaviour patterns in the general population. In particular, the focus should be on reducing multiple and concurrent partnerships and using other prevention measures, such as increasing the proportion of men who are circumcised, where relevant. Additionally, there should be a high coverage of pregnant women for HIV testing and HAART for those living with HIV.

Mixed epidemics occur when there is a substantial contribution from the general population's sexual behaviour patterns and defined subpopulations at risk due to shared networks of higher risk practices. In a mixed epidemic, the programming focus should be on a dual strategy of changing sexual behaviour patterns in the general population and reducing transmission in the key and priority populations. In addition, interventions should maintain high coverage of pregnant women for HIV testing and HAART for those living with HIV.

Black coloured lines indicate high risk sexual or needle sharing contact between individuals

Contributors: B.M. Ramesh, Parinita Bhattacharjee, Franklyn Songkok, Joshua Gitonga, Shem Kaosa, Japheth Kioko, Faran Emmanuel, Souradet Shaw, Helgar Musyoki, Mary Mugambi, Stephen Moses, Catherine Ngugi, Ruth Laibon Masha, James Blanchard





3. Intergrate services and invest beyond health facility-based interventions to address the syndemic factors that reinforce the HIV epidemic

The word syndemic is a blend of syn, meaning “together,” and -demic, as in epidemic or pandemic introduced to label **the synergistic interaction of two or more coexistent diseases and the resultant excess burden of disease.**

It describes a situation in which two or more interrelated factors work together to make a disease or health crisis worse⁶.

In Kenya, due to geographical burden, the presence of HIV, Tuberculosis, sexually transmitted infections (STI) and malaria has resulted in syndemic situations. The diseases cause sickness and death, reducing the size and productivity of the country’s workforce while imposing an indirect economic burden. For example, the interaction between HIV and tuberculosis in Kenya is syndemic. While one is caused by bacteria and the other a virus, infection with HIV makes a person much more susceptible to TB and complicates the clinical progression, management, and control of both conditions. These two diseases are interrelated in that the presence of one indirectly helps the success of the other.

⁶ Medical Anthropologist Merrill Singer in the early 1990s

HIV is also a sexually transmitted infection and shares transmission dynamics with other STIs. People who have STIs are more prone to acquiring HIV. People living with HIV who are not on treatment are also prone to suffer from active tuberculosis.

Factors such as sexual and gender-based violence, poverty, food insecurity, incarceration, substance abuse disorders make people vulnerable to HIV, STIs, and TB. People living with HIV and those infected with STIs and TB are often stigmatized, which often constitutes an obstacle to the effective implementation of interventions.⁷



⁷ Bromberg, D. J., Mayer, K. H., & Altice, F. L. (2020). Identifying and Managing Infectious Disease Syndemics in Patients with HIV. *Current opinion in HIV and AIDS*, 15(4), 232. <https://doi.org/10.1097/COH.0000000000000631>

The association between food insecurity and HIV is syndemic; a complex cycle that increases the vulnerability to one and complicates the severity of the other. Although food insecurity affects entire communities primarily through decreased household economic capacity, women and children are disproportionately affected.

Food insecurity also leads to an increase in transactional sex for money or food, migration in search of food, and additional vulnerabilities such as condom-less sex, sexual and gender-based violence, poor mental health, and substance abuse. Inadequate nutrition negatively impacts the HIV continuum of care, specifically through disrupting ART adherence and engagement with care. In addition, malnutrition, and unsafe infant feeding practices, such as mixed feeding, increase the risk of mother-to-child transmission of HIV⁸.

The success of the HIV response depends on the design of policies and programs that address facilitating factors such as ensuring food security, particularly among those most vulnerable, eliminating gender-based violence and homelessness, among others.

8 Lieber, Mark, et al. "The synergistic relationship between climate change and the HIV/AIDS epidemic: a conceptual framework." *AIDS and Behavior* 25.7 (2021): 2266-2277



4. Promote technological innovations in diagnosis, treatment and accountability for efficiency gains

Closing financial gaps in the HIV response will require an examination of the efficiencies and effectiveness of the vertical models of service delivery, formulation of policies, resource mobilization, monitoring, and evaluation, setting standards, coordinating stakeholders, standards and norms, and quality assurance. Technological innovations such as point-of-care diagnostics and integration of services will result in technical and allocative efficiencies that are central to ensuring value addition to the clients communities and health system.

5. Close the gaps in delivering essential HIV commodity security through a predictable and strong supply chain system

The hallmark of success for HIV treatment is suppressed viral load for an individual and others living with HIV in the same community. Kenya has committed to *accelerating progress towards the achievement of the global targets of 95-95-95 targets by 2025. Increasing the number of people living with HIV who are aware of their status, access to treatment and viral suppression across all sub-populations and geographies* is dependent on the consistent and sustained use

of antiretroviral drugs (ARVs) for life within a stable supply chain. To achieve an uninterrupted supply of preventions commodities, diagnostics tools and HIV treatment countries are required to consolidate their demand and maintain a minimum stock of 9 months (6 months of supply at the central store level and 3 months at the facility level).

The Kenya HIV Programme is designed on a universal health coverage model where treatment and prevention commodities are provided free to the user. Since it was brought to scale in 1994, the procurement of essential HIV commodities including long-life treatment has largely, (80%) depended on external resources. Urgent and proactive steps are required to secure domestic resources that will maintain both HIV primary prevention and treatment programmes amidst other competing priorities such as climate change. ***Any level of disruption in the HIV programme can result to the unforgiving resurgence of AIDS.***

Over the last 10 years, while external resources have significantly declined, there has been no proportionate increase in domestic resources. In the FY 2022/2023, the country has a funding gap of KES 10 billion required to maintain a stable supply of essential commodities.

Funding Landscape for Essential HIV Commodities for FY 2022/23 in US Dollars

Program Area	Annual Funding required (KSh) (including 6 months buffer stock)	Global Fund	Government of Kenya			Annual Funding gap (including 6 months buffer stock)
			Counterpart Financing	Ministry of Health	US Government	
ARV medicines (for ART, PMTCT, PrEP, PEP)	121,477,703.04	38702534.64	18,221,655.46		44,203,910.00	20,349,602.95
Medicines for opportunistic infections	16,299,874.03	0.00		5,564,571.69	827,183.00	9,908,119.34
Nutrition Products	18,985,734.93	0.00		2,807,922.64		16,177,812.29
Laboratory	65,050,676.23	2,434,336.27	6,853,572.64		22,561,500.00	33,201,267.32
Condoms (male and female), condom lubricants and dispensers	7,001,144.64	2,621,794.09				4,379,350.55
Other commodities for Key populations Opioid Substitution Therapy and STI medicines	9,485,431.57	488,444.58				8,996,986.99
Voluntary Medical Male circumcision (VMMC)	901,791.83			901,791.83		0.00
Total Commodity Costs	239,202,356.28	44,247,109.58	25,075,228.10	9,274,286.16	67,592,593.00	93,013,139.45
Procurement and Supply Management (PSM) related cost	19,136,188.50	3,539,768.77	3,385,155.79	1,252,028.63	5,407,407.44	7,441,051.16
Total Costs (Commodity Costs+8 % PSM Cost)	258,338,544.79	47,786,878.34	28,460,383.89	10,526,314.79	73,000,000.44	100,454,190.61

Source: National STI and AID Control Programme 2022

The country will need to explore and secure fiscal space to bridge the rising financing gaps due to the global dwindling resource envelope. The transition of resource streams for procurement of commodities and human resources that are externally funded will require realistic domestic plans.

Annexes

County	People Living with HIV (2021)	County	New HIV Infections (2021)	County	AIDS Deaths (2021)
Nairobi	153,818	Nairobi	3,828	Kisumu	1,703
Kisumu	130,036	Kisumu	3,118	Homa Bay	1,589
Homa Bay	122,954	Homa Bay	2,696	Nakuru	1,332
Siaya	97,922	Siaya	2,180	Nairobi	1,300
Migori	77,690	Migori	1,943	Siaya	1,276
Nakuru	58,678	Nakuru	1,496	Mombasa	1,031
Mombasa	54,303	Mombasa	1,241	Migori	998
Kakamega	50,991	Kakamega	1,198	Uasin Gishu	826
Kiambu	46,571	Kisii	1,065	Kakamega	712
Kisii	42,842	Uasin Gishu	1,048	Kajiado	685
Busia	36,813	Kajiado	966	Kiambu	663
Uasin Gishu	36,310	Busia	828	Machakos	587
Machakos	34,889	Machakos	821	Kisii	561
Meru	31,186	Bungoma	796	Kilifi	558
Bungoma	30,594	Meru	782	Trans-Nzoia	551
Kajiado	30,255	Kiambu	729	Meru	522
Kilifi	29,962	Narok	725	Busia	513
Kitui	27,919	Kilifi	713	Kericho	502
Trans-Nzoia	24,459	Trans-Nzoia	709	Narok	483
Kericho	22,182	Kericho	666	Kitui	462
Narok	21,848	Turkana	665	Turkana	448
Makueni	21,644	Kitui	614	Bungoma	424
Murang'a	21,550	Nandi	555	Nandi	423
Vihiga	20,825	Makueni	464	Makueni	363
Turkana	20,092	Bomet	457	Kwale	355
Kwale	19,140	Kwale	453	Bomet	346
Nandi	18,681	Vihiga	434	Murang'a	307
Nyamira	16,691	Nyamira	391	Vihiga	293
Nyeri	16,522	Samburu	307	Nyeri	237
Bomet	15,372	Baringo	262	Nyamira	219
Kirinyaga	13,502	Laikipia	243	Laikipia	208
Embu	11,017	Murang'a	239	Samburu	205
Nyandarua	10,570	Embu	230	Kirinyaga	194
Taita-Taveta	9,952	Elgeyo-Marakwet	218	Taita-Taveta	189
Samburu	9,307	Taita-Taveta	209	Embu	186
Laikipia	9,130	Nyeri	193	Baringo	174
Tharaka-Nithi	7,937	Tharaka-Nithi	175	Elgeyo-Marakwet	151
Baringo	7,777	Kirinyaga	157	Nyandarua	149
Elgeyo-Marakwet	6,722	Nyandarua	137	Tharaka-Nithi	133
Isiolo	3,347	West Pokot	126	Mandera	121
West Pokot	3,311	Isiolo	98	Garissa	83
Marsabit	2,717	Marsabit	89	West Pokot	73
Lamu	2,568	Mandera	88	Isiolo	54
Tana River	2,259	Tana River	65	Lamu	48
Mandera	2,190	Lamu	58	Wajir	48
Garissa	1,391	Garissa	38	Marsabit	44
Wajir	835	Wajir	27	Tana River	42
Kenya	1,437,267	Kenya	34,540	Kenya	22,373

ADOLESCENT PREGNANCY (10-19 years)							
County	2016	2017	2018	2019	2020	2021	Score
Kisumu	12,853	13,837	8,371	7,552	6,514	6,763	
Busia	10,590	9,924	11,425	6,700	5,707	6,003	
Migori	15,071	12,882	13,000	10,733	9,342	10,107	
Siaya	10,557	11,055	13,696	10,858	7,758	7,161	
Mombasa	4,757	7,532	6,922	3,684	2,365	3,358	
Kilifi	10,335	11,142	15,590	9,478	7,058	7,440	
Kwale	9,186	9,888	12,480	11,251	8,279	6,640	
Lamu	1,113	1,771	1,465	1,307	1,062	871	
Uasin Gishu	6,611	8,704	9,948	9,455	4,750	5,258	
Kiambu	9,641	10,947	14,859	13,526	10,382	8,330	
Homa Bay	11,324	14,646	14,733	13,644	11,867	10,116	
Kisii	11,301	10,923	13,542	10,980	9,601	10,149	
Nyamira	4,781	4,965	5,919	8,255	5,403	4,446	
Murang'a	4,396	4,591	6,681	6,660	5,519	4,195	
Makueni	4,829	6,552	8,157	7,234	5,396	4,724	
Taita-Taveta	1,438	2,413	3,594	1,590	1,428	1,421	
Nairobi	18,178	25,814	27,239	26,545	22,128	17,990	
Kirinyaga	2,331	3,127	4,298	3,311	2,422	2,347	
Machakos	5,796	7,534	9,955	10,898	5,432	5,857	
Nakuru	10,712	13,875	18,040	16,496	12,450	11,469	
Kitui	6,826	9,015	11,486	8,471	6,468	7,666	
Embu	2,105	3,077	2,108	2,151	2,310	2,416	
Nyeri	1,623	2,723	2,611	3,022	2,380	1,898	
Nyandarua	2,087	2,462	3,836	3,924	2,306	2,497	
Kericho	5,514	5,397	9,020	10,523	8,427	7,150	
Nandi	4,422	5,911	8,237	8,071	7,089	5,781	
Baringo	3,978	4,194	6,223	4,917	4,376	5,214	
Wajir	2,342	2,642	3,153	2,954	3,457	3,252	
Tana River	3,366	3,532	5,569	5,467	4,584	4,712	
Kajiado	7,721	7,510	10,342	12,856	10,872	11,084	
Bomet	6,984	9,552	10,075	11,153	9,154	10,147	
Tharaka-Nithi	1,904	2,714	4,016	4,015	3,563	2,767	
Elgeyo-Marakwet	2,545	3,002	4,137	4,019	4,004	3,757	
Laikipia	2,684	3,798	4,999	5,506	5,489	4,030	
Meru	9,414	13,346	16,057	15,826	14,669	14,417	
Isiolo	1,457	1,679	2,772	2,865	2,092	2,256	
Bungoma	8,845	17,636	19,186	14,512	13,376	14,054	
West Pokot	5,664	5,704	8,756	8,560	9,808	9,111	
Narok	8,359	10,861	15,287	14,962	15,225	13,593	
Turkana	4,272	6,463	7,882	8,390	8,450	6,973	
Samburu	2,406	2,093	3,938	4,648	4,905	4,201	
Vihiga	2,621	3,900	6,620	7,355	6,322	4,674	
Trans-Nzoia	3,985	5,532	11,979	11,997	11,601	7,413	
Garissa	2,524	3,395	4,460	4,890	3,168	6,033	
Marsabit	1,547	1,751	2,933	3,684	3,873	3,799	
Kakamega	4,206	8,465	16,969	17,489	14,768	15,166	
Mandera	432	1,200	4,570	4,456	3,950	7,481	
KENYA	275,633	339,676	427,135	396,840	331,549	316,187	

Source: 2021 Estimates and Kenya Health Information System

KEY: Teenage pregnancies and SGBV (2016-2021)

■ More than 50% increase

■ Less than 50% increase

■ Decline

SGBV (10-17 Years)							NEW HIV INFECTIONS (10-19)					
2016	2017	2018	2019	2020	2021	Score	2015	2017	2019	2020	2021	Score
170	246	707	1,903	1,198	976		2688	884	852	579	495	
66	100	144	94	259	607		154	136	120	109	111	
61	79	177	204	394	485		1557	620	426	353	290	
12	20	126	153	496	1,598		2355	890	760	447	371	
15	39	228	306	413	522		681	289	190	166	211	
396	419	770	707	805	900		397	229	96	107	114	
1	5	9	9	21	213		300	134	48	55	72	
0	2	1	1	19	29		29	18	9	6	10	
81	145	237	508	520	248		158	120	173	195	184	
18	26	24	21	155	211		353	222	171	96	86	
28	38	92	161	261	697		2945	1004	582	566	462	
68	46	135	136	461	832		634	274	275	182	163	
95	61	72	115	403	872		454	137	66	68	64	
26	7	14	18	94	236		135	114	24	37	40	
36	35	53	144	274	308		441	81	63	73	65	
15	1	1	2	13	60		148	71	23	26	39	
223	221	522	538	803	1,341		1035	1222	386	433	338	
36	24	42	33	132	189		61	54	18	24	25	
32	15	13	90	148	197		490	99	118	105	106	
439	388	503	409	712	1,099		243	185	239	287	297	
43	9	99	63	180	238		435	95	84	80	83	
58	65	82	74	128	82		167	35	26	32	33	
52	78	138	69	294	227		93	81	35	38	31	
51	39	35	34	82	240		63	60	20	19	19	
3	5	14	15	117	64		97	65	119	106	112	
1	2	12	24	45	69		66	48	83	76	94	
4	0	2	5	5	30		33	22	41	35	39	
0	3	3	6	13	0		9	0	1	1	2	
0	0	4	5	4	37		35	16	6	6	8	
12	112	199	237	329	336		119	93	140	120	153	
10	5	53	56	92	46		66	40	83	74	77	
2	3	30	88	112	102		137	28	20	19	24	
1	5	1	0	17	30		26	18	26	34	34	
40	26	40	44	94	96		46	35	40	49	46	
41	70	80	73	118	163		391	79	80	91	94	
0	0	3	1	9			54	10	14	6	10	
32	55	174	333	684	1,127		120	106	29	98	92	
4	0	3	0	14	24		28	22	20	16	16	
16	11	67	43	127	86		94	68	138	75	108	
79	37	65	31	202	172		133	87	120	59	100	
0	4	5	8	16	25		17	11	15	12	46	
39	48	94	61	74	279		77	70	49	56	63	
99	47	329	286	574	483		154	108	125	102	123	
0	1	0	0	19	62		17	0	2	1	4	
0	1	0	18	20	3		43	8	21	6	8	
61	69	183	168	523	824		203	187	189	166	154	
0	1	2	0	0	2		23	0	1	2	5	
2,466	2,613	5,587	7,293	11,465	16,476		18,004	8,177	6,166	5,294	5,123	

KEY: NEW HIV INFECTIONS (2016-2021)

75% decline in new HIV infections

Increase in new HIV infections

Less than 75% decline in new HIV infections

PLHIV distribution by age (2021)			
	Total	Male	Female
0-4	19,869	10,017	9,853
5-9	27,713	13,926	13,787
10-14	35,296	17,679	17,617
15-19	64,563	26,455	38,108
20-24	99,250	33,346	65,903
25-29	135,186	42,248	92,937
30-34	162,883	47,173	115,711
35-39	187,235	55,737	131,498
40-44	198,165	63,977	134,188
45-49	186,340	66,922	119,417
50-54	137,426	55,460	81,966
55-59	86,824	37,280	49,543
60-64	49,105	21,474	27,631
65-69	26,066	11,037	15,029
70-74	12,533	4,983	7,550
75-79	5,514	2,057	3,456
80+	3,300	1,101	2,199
Total	1,437,267	510,874	926,393

New infections by age (2021)			
	Total	Male	Female
0-4	5,160	2,614	2,546
5-9	0	0	0
10-14	0	0	0
15-19	5,332	641	4,692
20-24	6,765	1,978	4,786
25-29	5,719	2,040	3,679
30-34	4,371	1,593	2,778
35-39	2,949	1,089	1,860
40-44	1,734	665	1,069
45-49	987,381	381	607
50-54	596,210	210	385
55-59	389,125	125	264
60-64	25,176	76	175
65-69	15,844	44	113
70-74	8,722	22	65
75-79	4,210	10	32
80+	0	0	0
Total	34,540	11,489	23,051

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